2GETHER NHS FOUNDATION TRUST
BOARD MEETING
THURSDAY 26 MAY 2016 AT 10.00AM
OFFICE Q, THE KINDLE CENTRE, HEREFORD
AGENDA

10.00	1	**Apologies**	
	2	**Declaration of Members Interests**	
10.05	3	**Minutes of the Board meeting held on 31 March 2016**	**PAPER A**
	4	**Action Points and Matters Arising**	
10.10	5	**Questions from the Public**	
IMPROVING QUALITY			
10.15	6	**Patient Story Item**	**PRESENTATION**
10.45	7	**Performance Dashboard Report**	**PAPER B**
10.55	8	**Service Experience Report - Quarter 4**	**PAPER C**
11.05	9	**Quality Report 2015/16**	**PAPER D**
11.15	10	**Complaints Annual Report 2015/16**	**PAPER E**
11.25	11	**Smoke Free Implementation Interim Update**	**PAPER F**
BREAK – 11.35am			
IMPROVING ENGAGEMENT			
11.45	12	**Chief Executive's Report**	**PAPER G**
11.55	13	**Annual Membership Report**	**PAPER H**
12.05	14	**Workforce Strategy and Training Strategy**	**PAPER I**
12.15	15	**Allied Health and Psychological Professions Strategy**	**PAPER J**
IMPROVING SUSTAINABILITY			
12.30	16	**Summary Financial Report**	**PAPER K**
12.35	17	**Monitor Provider Licence Declarations**	**PAPER L**
12.40	18	**MH Legislation Scrutiny Committee Annual Report 2015/16**	**PAPER M**
12.45	19	**Board Committee Summaries** • Audit Committee – April and May (Verbal) • MHLS Committee – May • Delivery Committee – May (Verbal) • Governance Committee – April and May (Verbal) • Development Committee – May	 **PAPER N1** **PAPER N2** **VERBAL** **PAPER N3** **PAPER N4**
INFORMATION SHARING (TO NOTE ONLY)			
	20 21	Chair's Report Use of the Trust Seal	**PAPER O** **PAPER P**
12.55	22	**Any Other Business**	
1.00	23	**Date of Next Meeting** Thursday 28 July 2016 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

[2]GETHER NHS FOUNDATION TRUST

BOARD MEETING
TRUST HQ, RIKENEL
31 MARCH 2016

PRESENT

Ruth FitzJohn, Trust Chair
Shaun Clee, Chief Executive
Marie Crofts, Director of Quality
Martin Freeman, Non-Executive Director
Charlotte Hitchings, Non-Executive Director
Andrew Lee, Director of Finance and Commerce
Jane Melton, Director of Engagement and Integration
Nikki Richardson, Non-Executive Director
Carol Sparks, Director of Organisational Development
Richard Szadziewski, Non-Executive Director
Jonathan Vickers, Non-Executive Director
Paul Winterbottom, Medical Director

IN ATTENDANCE

Rob Blagden, Trust Governor
Hilary Bowen, Member of the Public
David Farnsworth, Community Services Director, One Herefordshire
Paul Grimer, Trust Governor
Anna Hilditch, Assistant Trust Secretary
Bren McInerney, Member of the Public
Dr Ross Runciman, SpR (Shadowing the Medical Director)
Becca Shute, Head of Profession, OT (for items 6 & 7)
Duncan Sutherland, Non-Executive Director Designate (from 1 April 2016)
Al Thomas, Trust Governor

1. WELCOMES, APOLOGIES AND INTRODUCTIONS

1.1 Apologies were received from Colin Merker.

2. DECLARATIONS OF INTERESTS

2.1 Charlotte Hitchings informed the Board that she had been appointed as the Independent Chair for the Local Education and Training Board for Health Education England in the West Midlands. The Board congratulated Charlotte on this appointment.

2.2 In advance of the patient story item on the agenda for the meeting, the Medical Director reminded the Board that he was a Trustee of Gloucestershire Young Carers.

3. MINUTES OF THE MEETING HELD ON 28 JANUARY 2016

3.1 The minutes of the meeting held on 28 January were agreed as a correct record, subject to a few minor typos.

4. MATTERS ARISING AND ACTION POINTS

4.1 The Board reviewed the action points, noting that these were now complete or progressing to plan.

4.2 At the last meeting, the Director of Quality agreed to carry out some work to look at the transition of patients from PICU back to open acute wards to see if there was something that could be done to improve their experience in line the with Engagement, Activity and Physical Health (EAP) initiative. It was noted that discussions had taken place with the

Matron at Wotton Lawn around care pathways and the Director of Quality agreed to provide an update back to the Board in September.

5. QUESTIONS FROM THE PUBLIC

5.1 Bren McInerney had asked a question at the January Board meeting in response to the recently published book by James Titcombe, titled Joshua's Story. 2gether had provided a response to the question which had been included in full within the minutes of the meeting. Bren McInerney said that James Titcombe had visited Gloucestershire in March and he had shared the responses to this question with Mr Titcombe. Bren said that Mr Titcombe had expressed his thanks to the Trust for its response and for the understanding of the issues that he had raised.

6. PATIENT EXPERIENCE PRESENTATION

6.1 The Board welcomed Mandy Bell and Kate Moss from Gloucestershire Young Carers to the meeting. Mandy and Kate were in attendance to support two young carers who provided a very compelling insight into the challenges that they face being a young carer. Michael and Keira spoke openly about their caring roles for their mothers, both of whom suffered from mental health illnesses and how this affected them on a day to day basis.

6.2 One of the key messages related to the 'whole family approach'. Keira said that if the whole family had been sat down together and told what was happening, then the family would be stronger and fully informed. Michael said that his family was never informed, with advice given directly to his mum who may then forget what had been said. Michael said that despite being his mum's carer, health professionals did not seem to understand and would not provide him with information. Keira noted that within the CYP Service, a letter was always copied to the parents of the young person and she therefore queried why this couldn't happen for adult services too. Not being fully informed meant that she couldn't be completely responsive to her mum's needs. Michael agreed with this point and urged people to "talk to us!" as young carers often felt invisible.

6.3 The Chief Executive thanked Keira and Michael for attending and speaking so clearly and honestly to the Board about their experiences. He thanked them both for what they did on a daily basis, acknowledging that 2gether and fellow health providers could not work without the dedication of carers.

6.4 Ruth FitzJohn asked about what potential support was needed for Keira and Michael to look forward and to think about their own futures. The Board noted that Keira had been accepted to study at Cambridge next year which was a fantastic achievement and it was therefore even more important that the right support and discussions were taking place to enable Keira to go and to not have to worry about leaving her family. Michael had started a course at the local college and he said that the spreading of awareness of both mental health and the role of young carers was key.

6.5 The Board thanked colleagues for attending and presenting, with particular thanks to Keira and Michael. Ruth FitzJohn urged Board members to complete the patient experience evaluation forms that had been circulated in advance of the item, which would enable a more detailed discussion to take place about the key issues and any immediate actions.

7. TRIANGLE OF CARE

7.1 The Triangle of Care programme was introduced to Inpatient Early Intervention and Crisis Resolution Home Treatment Team Services in 2015-16 and is due to be introduced to the Trust's Community Teams in 2016-18. An adjunct to Triangle of Care, adapting the recommendations to include Young Carers and young Adult Carers was published in 2015 and this report was provided to raise awareness of the additional effort being made to include young carers in the Triangle of Care initiative.

7.2 The Board noted that the Triangle of Care for Young Carers would be integrated into the Trust's practice development initiative to ensure that the standards in the Triangle of Care were fulfilled in practice.

7.3 The Director of Quality made reference to the "Top 10 tips" from Barnados that had been developed for Young Carers and suggested that the Trust might benefit from reviewing these as good and evidence based practice examples.

8. PERFORMANCE DASHBOARD

8.1 The Board received the performance dashboard report relating to the performance of the Trust for the period to the end of January 2016 against our Monitor, Department of Health, and Contractual and CQUINS key performance indicators. This report had been received and scrutinised in detail at the February Delivery Committee meeting.

8.2 Of the 88 reportable indicators, 79 were compliant and 9 non-compliant at the end of the reporting period. At the suggestion of the Board, the dashboard report now contained a trend line showing how compliance had increased throughout the year. The Trust was 90% compliant by the end of January compared to 71% at the end of April 2015 which demonstrated considerable improvement.

8.3 The Board noted that both counties had recorded their highest IAPT recovery rates year to date; Gloucestershire at 43% and 38% in Herefordshire against the 50% target. This reflected a change in the discharge policy and it was therefore still too early to be sure that recent pathway changes would lead to an improvement in the proportion of people recovering as a result of treatment.

8.4 Charlotte Hitchings advised that the main risks to the achievement of KPIs in 2016/17 lay with IAPT services and CYPS. She said that the Delivery Committee had requested that a report be provided at its next meeting on all 2016/17 KPI risks and the plans in place to mitigate these.

9. SERVICE EXPERIENCE REPORT – QUARTER 3

9.1 The Director of Engagement and Integration provided assurance that service experience information about Trust activity in Quarter 3 2015/16 had been reviewed in depth, scrutinised for themes and considered for both individual team and general learning across the organisation. The full report had been discussed in detail at the Governance Committee and the increased ownership of the report from the services had been welcomed.

9.2 The Board received significant assurance that the organisation had listened to, heard and understood patient and carer experience of 2gether's services. This assurance was provided across all domains of feedback including complaints, concerns, comments and compliments. Survey information had been triangulated to understand service experience.

The Board also received significant assurance that the Trust was responding to people who complained in a timely manner.

9.3 The Board noted that a number of broad themes and learning had been identified for countywide learning and dissemination. They were defined from the triangulation of all types of service experience information received. This learning included:

- People wanted their telephone calls returned promptly
- People sometimes thought that 2gether's record keeping did not reflect their views.
- People wanted 2gether staff to tell them if a student would be taking part in their care.
- Concerns had been raised that Music therapy in Herefordshire had been cancelled

9.4 The Board was assured that the number of complaints closed in the last quarter was higher than previously and the backlog had been reduced. A query was raised about whether as much learning was being taken from compliments. The Director of E&I confirmed that information gathered from a variety of patient and carer feedback, including compliments was included in the aggregated learning.

9.5 Charlotte Hitchings noted that the Trust had received two "major" complaints and she sought assurance that the necessary mitigation was in place to manage this. The Director of E&I advised that the complaints in question were taken very seriously and were regularly reviewed with the Complaints Manager. It was noted that the Governance Committee had discussed these in more detail alongside the HS Ombudsman's national report. A new process for the quarterly NED Audit of Complaints had also been developed, to be able to provide a deeper, more qualitative audit of complaints.

10. QUALITY REPORT – QUARTER 3

10.1 The Board received the third review of the Quality Report priorities for 2015/16. The quarterly report was in the format of the annual Quality Report.

10.2 The Board was assured that progress was being made towards achieving targets, objectives and initiatives identified in the Annual Quality Report. Overall, good progress was being made in carrying out the individual initiatives to improve the quality in the three major categories of Effectiveness, User Experience and Safety listed in the Quality Report.

10.3 Objectives were currently being met or on target to be met in 9 of the 11 targets, however there was a risk that the IAPT target for Herefordshire services may not be met. It was also reported that the target to reduce the number of deaths by suicide of people in contact with services would not be met as this had already been exceeded. The Director of Quality informed the Board that the total number of serious incidents had reduced this year; however, the number of completed suicides remained consistent, in line with the national trend. The Chief Executive said that the upward trend in suicide was tragic but 2gether's suicide rate has stayed the same, despite seeing a significant increase in referrals. However, there was more work to be done to continue to increase access to the Trust's services to people in Gloucestershire and Herefordshire.

10.4 The Director of Finance and Commerce said that it was excellent to see that the Trust was "above average" for staff who would recommend 2gether as a provider of care.

10.5 The Board noted the Quarter 3 data, which would be subject to change in Quarter 4 as the supportive evidence base grew. The Board also noted the mandated Monitor indicators subject to external audit this year:

- 7 day CPA follow-up after discharge (this will also include assurance testing of 48 hour follow-up)
- Admissions gate kept by Crisis Resolution & Home Treatment Teams

The local indicator chosen by the Council of Governors for testing would be:

- To improve personalised discharge care planning

11. SAFE STAFFING 6 MONTHLY UPDATE

11.1 The Board is mandated to receive a 6 monthly report outlining the requirements of the NHS National Quality Board (NQB) guidance on safe staffing levels. The Governance Committee continues to receive a monthly report detailing staffing levels across all inpatient sites.

11.2 The Director of Quality advised that this report provided significant assurance in relation to actual staffing levels against planned. The last six months (September-February 2015/16 inclusive) has seen continued high compliance against planned staffing levels.

11.3 In summary for February 2016:

- No staffing issues were escalated to the Director of Quality or the Deputy Director
- Where staffing levels dipped below the planned fill rates of 100% for qualified nurses this was usually offset by increasing staffing numbers of unqualified nurses based on ward acuity and dependency and the professional judgement of the nurse in charge of the shift
- 96.97% of the hours exactly complied with the planned staffing levels
- 2.7% of the hours during February 2016 had a different staff skill mix than planned staffing however overall the staffing numbers were compliant and the needs of patients were met
- 0.3% of the hours during February had a lower number of staff on duty than the planned levels.
- There was 1 shift where it has been reported that the skill-mix of staff was non-compliant and the needs of patients were not met however there were no patient safety issues

11.4 The National Quality Board (NQB) was currently reviewing the safer staffing guidance for all specialties. The mental health work-stream guidance is due to be published in late September/early October 2016. This will inform future staffing across inpatient and community teams

11.5 From October 2015 the Trust has been mandated to report to Monitor on agency nursing levels across the organisation (qualified only). The Trust was now completing weekly returns to Monitor in relation to agency costs, the number of agency shifts used and the use of any agencies not on the nationally agreed framework of providers. The Trust has received an agency expenditure control total for 2016/17 from NHS Improvement of £3.404m. This would be a reduction of c.38% on this year's agency expenditure. The Board noted that the targets that had been set in relation to agency usage could potentially affect the Trust's governance ratings if these were not met. A Project Board had been set up to ensure effective monitoring of the position, feeding in to the Executive Committee. The Project Board, chaired by the Director of Quality was focusing on four work streams including bank staff, recruitment and e-rostering. The Board was assured that there was a high level of clinical engagement from nursing and medical staff. The Board agreed that given the number of vacancies within the Trust it was not possible to simply stop using

agency staff; however the Board was assured that the position was being carefully monitored, and that the safety of staff and service users would always take priority.

12. CHIEF EXECUTIVE'S REPORT

12.1 The Chief Executive presented his 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.

12.3 The Chief Executive advised that the link to the Trust's CQC inspection report and action plan was on the Trust's website. The Trust had been rated as "Good" overall. The Board was asked to note that there were areas requiring further improvement; however, the Trust's PICU, Inpatient Services, S136 and Crisis Services had been rated as "outstanding" and these were the first and only services nationally to have received this rating which was excellent news. The Board acknowledged this achievement and it was agreed that reference to this should be made within the Quality Report.

ACTION: Reference to the Trust's services being the first in the country to be rated as "outstanding" to be included within the Annual Quality Report

12.4 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. The Chief Executive advised that 2gether was actively involved in discussions with both commissioners around this.

13. STAFF SURVEY AND FRIENDS AND FAMILY TEST

13.1 The Director of OD provided an overview and analysis of the 2015 NHS Annual Staff Survey. The Staff Survey was sent to a random sample of staff, which in 2015 was 750 staff in total. The Trust's response rate was 40%, down from 46% in the previous year. Whist this was disappointing the Board noted that it was consistent with the national trend. The response rate was below average (42%) for Mental Health / Learning Disability Trusts and meant that of the 750 who were sent the survey 300 staff had replied. For 2015, as for the previous year, the survey was offered to staff on-line and this may account for the low response rate, however the move to the on-line survey was a direct response to the stated preference of staff.

13.2 The Board noted that the Comparator groups changed in 2015 and 2gether was included in the Mental Health/Learning Disabilities comparator group with twenty eight other trusts. The 2015 survey was not directly comparable with the 2014 survey as a number of Key Findings had changed, although fourteen Key Findings remained directly comparable.

13.3 The Board noted that overall staff engagement in the Trust had improved and was above the national average for similar trusts. Three Key Findings had shown a statistically significant improvement and there was no statistically significant deterioration in any of the Key Findings. The Trust was above average in eighteen Key Findings, average in thirteen Key Findings and below average in one (Communications with Senior Managers). The

Board noted that the Delivery Committee had received this report and had discussed this indicator in detail. Comments relating to communication with senior managers were being analysed and work would be carried out to look in more detail at what staff meant when they referred to "senior managers".

13.4 The Director of OD reported that significant assurance could be given on the basis that there had been an overall increase in staff engagement and job satisfaction and the Trust was reported to be 'average' or 'above average' in 31 of the 32 key Findings. Although the response rate was low, since moving to an on-line survey, the number of free text comments had increased compared with the number of free text comments submitted via the paper-based survey and these comments enabled the Trust to better understand and respond to staff concerns. A new action plan had been developed to improve areas where staff had reported the lowest levels of satisfaction, and to maintain momentum in areas where progress had been achieved.

13.5 The Board noted the overall positive report but acknowledged that a higher response rate would have been welcomed. Charlotte Hitchings advised that the Delivery Committee had discussed the need to ensure that those staff members who are not office based are given the opportunity and encouragement to complete the online survey.

13.6 Jonathan Vickers noted that overall there were 3 areas where the Trust's performance had reduced from previous years; however, this still demonstrated good performance. He therefore queried whether the action plan should focus purely on the communication issue this time, with Communication with Senior Managers being the key action. The Director of OD suggested that there were a number of important areas where focus needed to be retained such as bullying and harassment and quality of appraisals, but she agreed that communications should be seen as the Trust's priority. The Chief Executive welcomed Jonathan Vickers' challenge, noting that this was clearly the Trust's number one issue. The Board was assured that the action plan and progress with defining what a "senior manager" was would be monitored via the Delivery Committee

Staff Friends and Family Test

13.7 From 1st April 2014, the Trust was required to implement the Staff Friends and Family Test. This requirement was set out by NHS England and applied to all Mental Health, Acute, Community and Ambulance Trusts. The Trust runs the Test for three out of four quarters, as in Quarter Three the questions were included in the annual NHS Staff survey.

13.8 This report provided the Board with a summary of the Trust Staff Friends and Family Test for 2014/15 and 2015/16, and a detailed analysis of the Trust's Quarter Four results for 2015/16.

13.9 Two hundred and eighty one colleagues responded to the survey; a reduction on Quarter Two of 2015/16 when three hundred and one staff responded. The response rate for Quarter Four equated to 14% of the total workforce. Although the response rate had reduced, the percentage of staff who would recommend the Trust as place to work (68%) and to receive treatment (85%) had increased from 63% and 79% respectively in Quarter Two. 5% of respondents would be unlikely or extremely unlikely to recommend the Trust as a place to receive care or treatment. This was an improvement from 7% in the previous Test. 13% of respondents would be unlikely or extremely unlikely to recommend the Trust as a place to work, an improvement on 19% in the previous Test.

13.10 The Board noted that these results would be shared with the Service Directors to give them an overview of the range of results and the comments, concerns and issues that staff had expressed. A series of focus groups were planned to meet with teams across the Trust. The take up of the new 'Speak in Confidence' system would continue to be monitored to look for trends and address issues or concerns that are raised and areas in which improvements could be made.

14. SUMMARY FINANCE REPORT

14.1 The Board received the Finance Report that provided information up to the end of February 2016. The month 11 position was a deficit of £491k compared to the planned deficit of £455k. The forecast outturn was a deficit of £541k. The Trust was no longer assuming a capital to revenue transfer of £500k which has been proposed to Monitor. Against the original planned deficit of £500k the Trust had a forecast outturn of £500k but now that the Herefordshire Community Services development has commenced with anticipated spend of £41k during 2015/16 the net forecast outturn deficit is £541k. Under the Financial Sustainability Risk Rating the Trust has a score of 3.

14.2 The Trust has received a revised control total from NHS Improvement of a £4k surplus for 2016/17 which is reflected in our financial plans. Budget setting for 2016/17 has progressed well.

14.3 The Director of Finance and Commerce updated the Board on progress with agreeing Contracts for 2016/17. It was noted that the deadline for signing off contracts had been extended to 25th April but good progress with the Trust's main commissioners had been made.

14.4 The Board noted the Finance Report for the period ending February 2016.

15. DELIVERY COMMITTEE ANNUAL REPORT 2015

15.1 Charlotte Hitchings presented the Board with the Delivery Committee Annual Report which provided an overview of the Committee's activities against its Terms of Reference during 2015.

15.2 Some of the key areas highlighted included:

- Increase in accountability/ownership of information by Service Directors
- Increased focus on data quality
- Good focus on key Committee owned Risks
- A very good year for the achievement of performance dashboard targets and indicators

15.3 Charlotte Hitchings informed the Board that strong relationships had been formed between the Information Team and Trust Services and this could be seen in the improvement during the year in data quality and the achievement of targets. Charlotte acknowledged the huge amount of work and effort carried out by the Services and she informed the Board that thanks had already been passed on via the Service Directors.

15.4 The Director of Finance and Commerce made reference to the attendance table and queried whether there needed to be a Finance representative at the Committee. This would be reviewed outside the meeting.

ACTION: Discussion to take place regarding the need for a finance representative at the Delivery Committee

16. BOARD COMMITTEE REPORT – AUDIT COMMITTEE

16.1 The Board received the summary report from the Audit Committee meeting held on 3 February 2016 and noted the key points raised during the meeting and the assurance received by the Committee.

17. BOARD COMMITTEE REPORT – MH LEGISLATION SCRUTINY COMMITTEE

17.1 The Board received the summary report from the MH Legislation Scrutiny Committee meeting held on 3 February 2016 and noted the key points raised during the meeting and the assurance received by the Committee.

18. BOARD COMMITTEE REPORTS – DELIVERY COMMITTEE

18.1 Charlotte Hitchings presented the summary reports from the Delivery Committee meetings that had taken place on 27 January and 24 February 2016. These reports were noted.

18.2 A verbal report was given from the meeting held on 30 March. A full written report would be presented at the next Board meeting. Key items received and discussed at the meeting included:

- The Committee received the performance dashboard report for February and noted 91% compliance with targets with only 8 non-compliant indicators
- DTOC in Herefordshire were noted with 4 cases being reported, 3 of which were social care delays. This was under review.
- KPI risks for 2016/17 were received, with 6 high risk indicators noted.
- The Committee asked for an assurance report to be produced for the Governance Committee reviewing all under 18 admissions during 2015/16
- A report on Eating Disorders was received and further work was requested on clinical outcomes and value for money of the 2 services in Gloucestershire and Herefordshire.

18.3 Ruth FitzJohn noted this verbal update, advising that all of the Board Committees played a key role but acknowledging the significant workload taken on by the Delivery Committee and thanking Charlotte Hitchings for her oversight of this Committee. Some significant improvements had been seen over the past year.

19. BOARD COMMITTEE REPORTS – GOVERNANCE COMMITTEE

19.1 Martin Freeman presented the summary reports from the Governance Committee meetings that had taken place on 22 January and 19 February 2016. These reports were noted.

19.2 A verbal report was given from the meeting held on 18 March. A full written report would be presented at the next Board meeting. Key items received and discussed at the meeting included:

- There had been 3 new SIs reported during February. This continued to be a very small number and no new themes had been identified but thorough investigations continued to take place. Outcomes from inquests were now received by the Committee.
- The Committee received the homicide action plan, noting that of the 46 actions identified, 3 actions still required final closure. This would remain as a standing agenda item.
- The Resuscitation Annual Report was received. This was a positive report; however, limited assurance was received in relation to training compliance
- The Committee received significant assurance around the IG Toolkit

- Reports on the revalidation of nursing staff and a Heads of Profession update were received.

20. BOARD COMMITTEE REPORT – DEVELOPMENT COMMITTEE

20.1 The Board received a verbal report from the Development Committee meeting held on 23 March. A full written report would be presented at the next Board meeting. Key items received and discussed at the meeting included:

- Receipt of the Financial Plan
- Discussions about the need to dovetail strategies and implementation plans
- Receipt of IT based business cases which were reviewed and gaps identified for further work.

21. BOARD COMMITTEE REPORT – CHARITABLE FUNDS COMMITTEE

21.1 The Board received the summary report from the Charitable Funds Committee meeting held on 10 February 2016 and noted the key points raised during the meeting and the assurance received by the Committee.

22. INFORMATION SHARING REPORTS

22.1 The Board received the following reports for information:

- Chair's Report
- Minutes from the Council of Governors meeting held on 19 January 2016

22.2 Ruth FitzJohn informed the Board that the Trust had been successful in recruiting 2 new NEDs who would commence in post from 1 April 2016 – Duncan Sutherland and Marcia Gallagher. It was noted that Marcia would be the new Audit Committee Chair. Ruth added that Richard Szadziewski would be coming to the end of his interim contract at the end of April.

23. ANY OTHER BUSINESS

23.1 Ruth FitzJohn informed the Board noted that this would be Paul Winterbottom's last Board meeting as Trust Medical Director. Paul became Medical Director in 2003 and since that time has become hugely valued for his experience, his values and his humour. Paul would continue to work for 2gether in his clinical role as a Learning Disability Consultant Psychiatrist. Paul Winterbottom said that he had welcomed the opportunity to work in an organisation that had such strong values and having had the opportunity to directly influence the delivery of mental health and learning disability services had been a real pleasure. Paul noted that he had worked alongside some of the most skilled people he had ever met and was pleased to have been part of selecting and mentoring the next generation of psychiatrists.

24. DATE OF THE NEXT MEETING

24.1 The next Board meeting would take place on Thursday 26 May 2016 at the Kindle Centre, Hereford

Signed: …….. **Date: …….**

Ruth FitzJohn, Chair

BOARD MEETING
ACTION POINTS

Date of Mtg	Item ref	Action	Lead	Date due	Status/Progress
28 Jan 2016	5.7	Director of Quality to carry out work to look at the transition of patients from PICU back to open acute wards to see if there was something that could be done to improve their experience in line the with EAP initiative.	Marie Crofts	September	**Ongoing.** Actions underway with a progress report back to the Board in September 2016
31 March 2016	12.3	Reference to those of the Trust's services being the first in the country to be rated as "outstanding" to be included within the Annual Quality Report	Marie Crofts	May	**Complete**
	15.4	Discussion to take place regarding the need for a finance representative at the Delivery Committee	Andrew Lee / Charlotte Hitchings	May	

Agenda item 7 **Enclosure** **Paper B**

Report to:	[2]gether NHS Trust Board 26th May 2016 – Open Session
Author:	Steve Moore, Interim Head of Information Management and Clinical Systems/Colin Merker Director of Service Delivery
Presented by:	Colin Merker Director of Service Delivery
SUBJECT:	**Performance Dashboard Outturn Report for the contract year 2015-16**

This Report is provided for:

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

EXECUTIVE SUMMARY

Overview

This outturn report sets out the performance of the Trust for the full 2015/16 contract period against Monitor, Department of Health, Contractual and CQUINS key performance indicators.

Of the 127 measures reportable, 109 are compliant, 14 non-compliant and 4 are either not yet available (NYA) or Under Review (UR) at the end of the reporting period.

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

Indicators Reported and Levels of Compliance for 2015/16

Indicator Type	Total Measures	Reportable	Not Yet Required	Compliant	Non Compliant	NYA / UR	% non-compliance
Monitor Requirements	13	13	0	13	0	0	0
Never Events	17	17	0	17	0	0	0
Department of Health	10	10	0	8	2	0	20
Gloucestershire CCG Contract	41	41	0	31	6	4	15
Herefordshire CCG Contract	29	29	0	23	6	0	21
CQUINS	17	17	0	17	0	0	0
Overall	127	127	0	109	14	4	11

Our Monitor, Never Events and CQUINs performance measures were all achieved with 100% compliance. For the Department of Health performance measures there were 2 indicators where we did not meet the threshold:

Department of Health Requirements

- 2.21 – No children under 18 admitted to adult inpatient wards
- 2.26 – SI Initial report to CCG within 3 working days

We had twelve non-compliant thresholds within our local contractual performance measures targets.

Gloucestershire CCG Contract Measures

- 3.09 – Completion of IAPT Minimum Dataset outcome data for appropriate service users
- 3.24 – Access to psychological therapies should be improved (IAPT recovery rate)
- 3.33 – New integrated service – 14 days from referral to screening assessment.
- 3.38 – Level 2 & 3 CYPS – Referral to treatment within 8 weeks.
- 3.39 – Level 2 & 3 CYPS – Referral to treatment within 10 weeks
- 3.42 – The number of people finding paid employment/self-employment

Herefordshire CCG Contract Measures

- 5.16 – Number of people moving to recovery with IAPT service intervention
- 5.17 – IAPT achieve 15% of patients entering the service against prevalence
- 5.19 – Care plans within 4 weeks of working diagnosis of Dementia
- 5.21 – Number on caseload who have not been seen, face-to-face, within 90 days
- 5.27– Waiting times – Specialist Memory Clinic: 4 week wait for offer of first appointment
- 5.28 – No children under 18 admitted to adult inpatient wards

There are currently four measures that are labelled as Not Yet Available to report:

- 3.27 - To ensure patients with dementia receive appropriate care for basic health needs (weight assessment)
- 3.45 - Fidelity to the IPS model
- 3.46 - Complex Psychological Interventions: Wait Times
- 3.47 - GP Practices will have an individual (MH) ICT service meeting to review delivery and identify priorities

Where non-compliance has highlighted issues within a service, Service Directors have taken the lead to address issues and indicators have been “red flagged” to show where further analysis and work has been undertaken to fully scope data quality and performance issues.

Section 2 of this report provides a detailed commentary on indicators which did not meet the required performance threshold level during the final month of the year and notes which indicators have previously been non-compliant.

RECOMMENDATIONS

The Board is asked to:

- Note the Performance Dashboard Outturn Report for the full 2015-16 contract period
- Be assured that Service Managers and Directors are aware of the outstanding areas of work required to address the performance measures not being met at the end of year position.

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	May 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 ASCOF Adult Social Care Outcomes Framework CAMHS Child and Adolescent Mental health Services CCG Clinical Commissioning Group CPA Care Programme Approach CPDG Contract Performance and Development Group CQUIN Commissioning for Quality and Innovation CRHT Crisis Home Treatment CYPS Children and Young People's Services DASH Drug and Alcohol Service Herefordshire EI Early Intervention HoNoS Health of the Nation Outcome Scale IAPT Improving Access to Psychological Therapies IST Intensive Support Team (National IAPT Team) KPI Key Performance Indicator SI Serious Incident YOS Youth Offender's Service

1. CONTEXT

This report sets out the performance outturn for the Trust for the complete 2015-16 contract period

1.1 The following section of the report includes:

- 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.

    - Monitor Requirements
    - Never Events
    - Department of Health requirements
    - NHS Gloucestershire Contract – Schedule 4 Specific Performance Measures
    - 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 completion of the 2015-16 contract period. 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 for the future.

2.2 Where stated, 'Cumulative Compliance' refers to compliance recorded from the start of this contractual year April 2015 to the current reporting month, as a whole.

'Previous Quarter Cumulative Compliance' is reported compliance recorded from the beginning of a financial year, onwards, and refers to the Quarter(s) preceding that which the current reporting month falls within.

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	=	**2015/16 data reporting to inform 2016/17**

DASHBOARD CATEGORY - MONITOR REQUIREMENTS

Monitor Requirements				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	13	13	13	13
	1	1	0	0
	12	12	13	13
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

None

Cumulative Performance Thresholds Not being Met

None

Changes to Previously Reported Figures

1.03: Care Programme Approach – follow-up within 7 days of discharge

Following an external audit, changes to the methodology have been applied and implemented for the whole of the 2015/16 contractual period. These changes include removing cases where patients were readmitted to an inpatient unit within 7 days and discounting contacts made within the same day (up to midnight) of discharge. This has reduced year end compliance to 95.6% compared to the 98% previously reported.

Our 7 day and 48 hour follow up policy, procedures and performance measutrement guidelines are being amended to support the recommendations of the auditors and will be distributed to staff during June 2016.

Early Warnings / Notes

None

Monitor Requirements

ID	Performance Measure (PM)		2014/15 Outturn	Previous Quarter Cumulative Compliance	January-2016	February-2016	March-2016	Cumulative Compliance
1								
1.01	Number of MRSA Bacteraemias	PM	0	0	0	0	0	0
		Gloucestershire	0	0	0	0	0	0
		Herefordshire	0	0	0	0	0	0
		Combined Actual	0	0	0	0	0	0
1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs)	PM	0	0	0	0	0	0
		Gloucestershire	2	0	0	0	0	0
		Herefordshire	1	0	0	0	0	0
		Combined Actual	3	0	0	0	0	0
1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	98%	96%	96%	95%	95%	95%
		Herefordshire	98%	96%	96%	87%	100%	96%
		Combined Actual	98%	96%	96%	93%	97%	96%
1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	97%	99%	99%	99%	96%	99%
		Herefordshire	97%	98%	98%	98%	97%	99%
		Combined Actual	97%	99%	98%	99%	96%	99%
1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Gloucestershire	0.8%	1.0%	0.9%	0.9%	0.9%	1.0%
		Herefordshire	1.3%	0.2%	0.0%	8.4%	4.3%	1.2%
		Combined Actual	0.9%	0.8%	0.7%	2.8%	1.7%	1.0%
1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	99%	99%	98%	98%	97%	99%
		Herefordshire	100%	100%	100%	100%	100%	100%
		Combined Actual	99%	99%	99%	98%	98%	99%
1.07	New psychosis (EI) cases as per contract	PM	72	54	6	6	6	72
		Gloucestershire	91	53	7	7	9	76
		PM	21	18	2	2	2	24
		Herefordshire	26	26	4	7	4	41
		PM	93	72	8	6	6	92
		Combined Actual	117	79	11	14	13	117
1.08	New psychosis (EI) cases treated within 2 weeks of referral (Target Q4: 50%)	PM		50%	50%	50%	50%	50%
		Gloucestershire		62%	43%	100%	89%	66%
		Herefordshire		58%	25%	71%	75%	61%
		Combined Actual		60%	36%	86%	85%	64%

Monitor Requirements

ID	Performance Measure		2014/15 Outturn	Previous Quarter Cumulative Compliance	January-2016	February-2016	March-2016		Cumulative Compliance
1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM		75%	75%	75%	75%		75%
		Gloucestershire		88%	88%	86%	84%		87%
		Herefordshire		95%	98%	89%	98%		95%
		Combined Actual		89%	90%	86%	86%		89%
1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM		95%	95%	95%	95%		95%
		Gloucestershire		99%	99%	98%	98%		99%
		Herefordshire		99%	100%	100%	100%		99%
		Combined Actual		99%	99%	98%	98%		99%
1.11	**MENTAL HEALTH MINIMUM DATA SET PART 1 DATA COMPLETENESS: OVERALL**	PM	97%	97%	97%	97%	97%		97%
		Gloucestershire	99.7%	99.6%	99.6%	99.6%	99.6%		99.6%
		Herefordshire	99.8%	99.9%	99.9%	99.9%	99.8%		99.9%
		Combined Actual	99.7%	99.7%	99.7%	99.6%	99.6%		99.6%
1.11a	Mental Health Minimum Data Set Part 1 Data completeness: DOB	PM	97%	97%	97%	97%	97%		97%
		Gloucestershire	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%
		Herefordshire	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%
		Combined Actual	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%
1.11b	Mental Health Minimum Data Set Part 1 Data completeness: Gender	PM	97%	97%	97%	97%	97%		97%
		Gloucestershire	99.9%	99.9%	99.9%	99.9%	99.9%		99.9%
		Herefordshire	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%		99.9%
1.11c	Mental Health Minimum Data Set Part 1 Data completeness: NHS Number	PM	97%	97%	97%	97%	97%		97%
		Gloucestershire	99.9%	99.9%	99.9%	99.9%	99.9%		99.9%
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%		99.9%
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%		99.9%
1.11d	Mental Health Minimum Data Set Part 1 Data completeness: Organisation code of commissioner	PM	97%	97%	97%	97%	97%		97%
		Gloucestershire	99.0%	98.8%	98.9%	98.9%	98.9%		98.8%
		Herefordshire	99.9%	99.9%	100.0%	100.0%	99.9%		99.9%
		Combined Actual	99.2%	99.1%	99.2%	99.2%	99.1%		99.1%
1.11e	Mental Health Minimum Data Set Part 1 Data completeness: Postcode	PM	97%	97%	97%	97%	97%		97%
		Gloucestershire	99.7%	99.6%	99.5%	99.5%	99.5%		99.5%
		Herefordshire	99.8%	99.7%	99.6%	99.7%	99.6%		99.6%
		Combined Actual	99.8%	99.6%	99.5%	99.5%	99.5%		99.5%
1.11f	Mental Health Minimum Data Set Part 1 Data completeness: GP Practice	PM	97%	97%	97%	97%	97%		97%
		Gloucestershire	99.3%	99.1%	99.2%	99.1%	99.1%		99.1%
		Herefordshire	99.3%	99.4%	99.5%	99.6%	99.6%		99.5%
		Combined Actual	99.3%	99.2%	99.3%	99.2%	99.2%		99.2%

Monitor Requirements

ID	Performance Measure		2014/15 Outturn	Previous Quarter Cumulative Compliance	January-2016	February-2016	March-2016	Cumulative Compliance
1.12	**MENTAL HEALTH MINIMUM DATA SET PART 2 DATA COMPLETENESS : OVERALL**	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	98.2%	98.0%	97.7%	97.6%	97.4%	97.9%
		Herefordshire	95.9%	96.2%	95.3%	94.9%	95.3%	95.3%
		Combined Actual	97.5%	97.6%	97.3%	97.1%	97.0%	97.4%
1.12a	Mental Health Minimum Data Set Part 2 Data completeness: CPA Employment status last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	97.2%	97.1%	96.8%	96.7%	97.0%	97.2%
		Herefordshire	94.4%	94.8%	93.6%	93.0%	93.0%	93.7%
		Combined Actual	96.4%	96.7%	96.2%	96.0%	96.0%	96.4%
1.12b	Mental Health Minimum Data Set Part 2 Data completeness: CPA Accommodation Status in last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	97.7%	97.0%	96.9%	96.8%	96.6%	97.1%
		Herefordshire	95.5%	95.5%	93.6%	93.0%	93.2%	93.8%
		Combined Actual	97.1%	96.7%	96.3%	96.1%	96.0%	96.5%
1.12c	Mental Health Minimum Data Set Part 2 Data completeness: CPA HoNOS assessment in last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	99.6%	99.8%	99.4%	99.3%	99.1%	99.6%
		Herefordshire	97.8%	98.4%	98.6%	98.7%	99.3%	98.5%
		Combined Actual	99.0%	99.5%	99.3%	99.2%	99.1%	99.4%
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	6
		Gloucestershire	6	6	6	6	6	6
		Herefordshire	6	6	6	6	6	6
		Combined Actual	6	6	6	6	6	6

DASHBOARD CATEGORY – DEPARTMENT OF HEALTH PERFORMANCE

DoH Performance				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	27	27	27	27
🔴	1	0	1	2
🟢	25	26	25	25
NYA	0	0	0	0
NYR	1	1	1	0
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month

2.21: No children under 18 admitted to adult inpatient wards

There was 1 admission in Gloucestershire. The patient was assessed in the 136 Suite but not admitted. However, later in the day the patient was again seen in the 136 Suite and detained under Section 2. They were transferred 2 days later to a specialist Child and Adolescent Mental Health service.

Cumulative Performance Thresholds Not being Met

2.21: No children under 18 admitted to adult inpatient wards

There have been 15 under 18 admissions to adult inpatient wards since April 2015, 11 in Gloucestershire and 4 in Herefordshire. This represents three more than in the 2014/2015 contract period.

2.26: SI Initial Report to CCG within 3 working days

There were 2 initial reports in July and 1 in September that exceeded the 3 working days threshold.

Changes to Previously Reported Figures

None

Early Warnings

None

DOH Never Events

ID	Performance Measure		2014/15 Outturn	Previous Quarter Cumulative Compliance	January-2016	February-2016	March-2016	Cumulative Compliance
2								
2.01	Wrongly prepared high risk injectable medications	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	0
2.02	Maladministration of potassium containing solutions	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	0
2.03	Wrong route administration of oral/enteral treatment	PM	0	0	0	0	0	0
		Actual	0	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	0
		Actual	0	0	0	0	0	0
2.06	Overdose of midazolam during conscious sedation	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	0
2.07	Opioid overdose in opioid naive patient	PM	0	0	0	0	0	0
		Actual	0	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	0
		Actual	0	0	0	0	0	0
2.10	Falls from unrestricted windows	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	0
2.11	Entrapment in bedrails	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	0
2.12	Misplaced naso - or oro-gastric tubes	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	0
2.13	Wrong gas administered	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	0
2.14	Failure to monitor and respond to oxygen saturation - conscious sedation	PM	0	0	0	0	0	0
		Actual	0	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	0
		Actual	0	0	0	0	0	0
2.17	Mis-identification of patients	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	0

DOH Requirements

ID	Performance Measure		2014/15 Outturn	Previous Quarter Cumulative Compliance	January-2016	February-2016	March-2016		Cumulative Compliance
2.18	Mixed Sex Accommodation - Sleeping Accommodation Breaches	PM	0	0	0	0	0		0
		Gloucestershire	0	0	0	0	0		0
		Herefordshire	0	0	0	0	0		0
		Combined	0	0	0	0	0		0
2.19	Mixed Sex Accommodation - Bathrooms	Gloucestershire	Yes	Yes	Yes	Yes	Yes		Yes
		Herefordshire	Yes	Yes	Yes	Yes	Yes		Yes
		Combined	Yes	Yes	Yes	Yes	Yes		Yes
2.20	Mixed Sex Accommodation - Women Only Day areas	Gloucestershire	Yes	Yes	Yes	Yes	Yes		Yes
		Herefordshire	Yes	Yes	Yes	Yes	Yes		Yes
		Combined	Yes	Yes	Yes	Yes	Yes		Yes
2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0		0
		Gloucestershire	9	7	3	0	1		11
		Herefordshire	3	4	0	0	0		4
		Combined	12	11	3	0	1		15
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		Yes
		Herefordshire	Yes	Yes	Yes	Yes	Yes		Yes
		Combined	Yes	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		Yes
		Herefordshire	Yes	Yes	Yes	Yes	Yes		Yes

DOH Requirements

ID	Performance Measure		2014/15 Outturn	Previous Quarter Cumulative Compliance	January-2016	February-2016	March-2016		Cumulative Compliance
2.24	Serious Incident Reporting (SI)	Glos	44	26	3	0	3		32
		Hereford	4	7	1	3	0		11
2.25	SI reported within 48hrs	PM	100%	100%	100%	100%	100%		100%
		Gloucestershire	100%	100%	100%	N/A	100%		100%
		Herefordshire	100%	100%	100%	100%	N/A		100%
2.26	SI Initial Report - to CCG within 3 working days	PM	100%	100%	100%	100%	100%		100%
		Gloucestershire	93%	89%	100%	N/A	100%		91%
		Herefordshire	100%	100%	100%	100%	NA		100%
2.27	SI Report Grade 1 - to CCG within 60 working days	PM	100%	100%	100%	100%	100%		100%
		Gloucestershire	100%	100%	NYR	N/A	NYR		100%
		Herefordshire	100%	100%	NYR	NYR	N/A		100%
2.28	SI Report Grade 2 - to CCG within 26 weeks	PM	100%	100%	100%	100%	100%		100%
		Gloucestershire	100%	100%	100%	100%	100%		100%
		Herefordshire	100%	100%	100%	100%	NYA		100%
2.29	SI Final Reports outstanding but not due	Gloucestershire	8	6	3	0	3		6
		Herefordshire	0	0	1	3	0		5

DASHBOARD CATEGORY – GLOUCESTERSHIRE CCG CONTRACTUAL REQUIREMENTS

Gloucestershire Contract				
	In month compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	41	41	41	41
	2	2	5	6
	20	20	32	31
NYA	0	0	3	3
NYR	19	19	0	0
UR	0	0	1	1
N/A	0	0	0	0

Performance Thresholds not being achieved in Month

3.24: Access to psychological therapies should be improved (IAPT recovery rate)

48% represents the highest recovery rate for the year to date.

The alternative recovery performance measure for the service, the Reliable Improvement Rate (3.24a) is 57%.

We have now received the IST review report and there is a meeting planned with key stakeholders to develop and agree a local action plan based on its recommendations. A full report will be peovided to the June 2016 Delivery Committee.

This indicator has been red flagged whilst the learning from the National IAPT team visit is fully understood.

3.33: Adult Mental Health Intermediate Care Teams (New Integrated Service): Wait times from referral to screening assessment within 14 days of receiving referral

This indicator relates to one of the performance thresholds within the IAPT care pathway. This has been reviewed as part of the National IST review and a detailed report and action plan will be provided to the delivery committee as part of the outcomes coming out of the review.

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

3.38: Level 2 & 3 CYPS – Referral to treatment within 8 weeks

The service is continuing with initiatives to achieve compliance which include

- Work to streamline the choice process
- Enhanced partnership working with Teens in Crisis

For 2016/17 the CCG have requested a change to the methodology in how this performance measure is calculated. In 2016/17, clients will be recorded as entering partnership at their 2nd appointment. This will reduce the number of non-compliant cases where the need for a choice plus appointment has been a contributory factor to the outturn performance issues.

The trajectory based on expected levels of vacancies reported this indicator as being compliant in Quarter 1 2016/17. Multiple CYPS internal monitoring procedures and close working with the Information Team will identify and flag any early warning indicators.

3.39: Level 2 & 3 CYPS – Referral to treatment within 10 weeks

As above in 3.38

For 2016/17 the CCG have requested a change to the methodology in how this performance measure is calculatedas detailed above in 3.38. The expected performance level for this indicator has also been reduced from 95% to 90% for the first 6 months of 2016/17.

The trajectory based on expected levels of vacancies sees this indicator as being compliant from Quarter 1 onwards. CYPS internal monitoring procedures and close working with the Information Team will identify and flag any early warning indicators.

3.42: The number of people finding paid employment or self-employment

45% of people entering the service were recorded as being able to find paid work or in self-employment; this is 5% below the performance threshold required. The team are under taking a review of the cases where employment has not been found to understand what steps may need to be taken to support these individuals into work and/or correct any information recording issues.

Cumulative Performance Thresholds Not being Met

3.09: Completion of IAPT Minimum Data Set outcome for Service Users

Significant work throughout the year has seen a steady increase in the compliance of this indicator. At 85% compliance this represents the highest level of cumulative performance achieved for the year to date. On a monthly basis the issues affecting this performance indicator have been resolved.

3.24: Access to psychological therapies should be improved (IAPT recovery rate)
As above

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

3.38: Level 2 & 3 CYPS – referral to treatment within 8 weeks
As above.

3.39: Level 2 & 3 CYPS – referral to treatment within 10 weeks
As above.

3.42: The number of people finding paid employment or self-employment
As above.

Changes to Previously Reported Figure
None

Early Warnings
None

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2014/15 outturn	Previous Quarter Cumulative Compliance	January-2016	February-2016	March-2016 / Quarter 4	Cumulative Compliance
	A.OPERATIONAL STANDARDS							
	Mixed Sex Accommodation Breaches							
3.01	Sleeping Accommodation Breach	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	0
	Mental health							
3.02	Care Programme Approach (CPA): Percentage of service users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	PM	95%	95%	95%	95%	95%	95%
		Actual	98%	96%	96%	95%	95%	96%
	B. NATIONAL QUALITY REQUIREMENT							
3.03	Zero tolerance MRSA	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	0
		Unavoidable	0	0	0	0	0	0
3.04	Minimise rates of Clostridium difficile	PM	0	0	0	0	0	0
		Actual	2	0	0	0	0	0
		Unavoidable	0	0	0	0	0	0
3.05	Publication of Formulary	PM	N/A	Report	Report	Report	Report	Report
		Actual	N/A	Compliant	Compliant	Compliant	Compliant	Compliant
3.06	Duty of candour	PM	N/A	Report	Report	Report	Report	Report
		Actual	N/A	Compliant	Compliant	Compliant	Compliant	Compliant
3.07	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS,	PM	N/A	99%	99%	99%	99%	99%
		Actual	N/A	100%	100%	100%	100%	100%
3.08	Completion of Mental Health Minimum Data Set ethnicity coding for all detained and informal Service Users	PM	N/A	90%	90%	90%	90%	90%
		Actual	N/A	97%	99%	100%	95%	98%
3.09	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	PM	N/A	90%	90%	90%	90%	90%
		Actual	N/A	82%	92%	93%	94%	85%

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2014/15 outturn	Previous Quarter Cumulative Compliance	January-2016	February-2016	March-2016 / Quarter 4	Cumulative Compliance
	C. Local Quality Requirements							
	Domain 1: Preventing People dying prematurely							
3.10	Increased focus on suicide prevention and reduction in the number of reported suicides in the community and inpatient units	PM	Q4 report				Annual	Annual
		Actual	Complete				Complete	Complete
3.11	To reduce the numbers of patients absconding from inpatient units	PM		Q3 Report			Q4 Report	Total
		Actual		36			19	55
	Domain 2: Enhancing the quality of life of people with long-term conditions							
3.12	IAPT access: 6 week wait referral to treatment (based on discharged patients)	PM		75%	75%	75%	75%	75%
		Actual		88%	88%	86%	84%	87%
3.13	IAPT access: 18 week wait referral to treatment (based on discharged patients)	PM		72%	95%	95%	95%	95%
		Actual		99%	99%	98%	98%	99%
3.14	2G bed occupancy for Gloucestershire CCG patients	PM		TBC	TBC	TBC	TBC	TBC
		Actual		91%	93%	94%	92%	92%
3.15	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%	95%
		Actual	100%	100%	100%	100%	100%	100%
3.16	CPA Review - 95% of those on CPA to be reviewed within 1 month (Review within 13 months)	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	99%	99%	99%	99%	99%
3.17	Assessment of risk: Patients on CPA to have a documented risk assessment	PM	85%	85%			85%	85%
		Actual	97%	99%			99%	99%
3.18	Dementia should be diagnosed as early in the illness as possible: 100% of people within the Memory Assessment Service with working diagnosis of dementia to have initial care plan agreed within 4 weeks - revised methodology	PM		85%	85%	85%	85%	85%
		Actual		82%	98%	98%	98%	89%
3.19	All inpatients at Hollybrook/Westridge have a health check	PM	Q4 report					
		Actual	Compliant					

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2014/15 outturn	Previous Quarter Cumulative Compliance	January-2016	February-2016	March-2016 / Quarter 4	Cumulative Compliance
3.20	All service users open to CLDT community nurses should be supported to have an annual health check and an updated Health Action Plan	PM	Q4 report					
		Actual	Compliant					
3.21	All community LD clients will be given information on how to access a person centred care plan and have a health action plan	PM	Q4 report					
		Actual	Compliant					
	Domain 3: Helping people to recover from episodes of ill-health or following injury							
3.22	Percentage of inpatient admissions that have been gatekept by crisis resolution/ home treatment team	PM	95%	95%			95%	95%
		Actual	99%	99%			100%	99%
3.23	People experiencing first episode psychosis must receive treatments delivered in accordance with NICE guidelines within 2 weeks	PM		50%			50%	50%
		Actual		62%			78%	66%
3.24	Access to psychological therapies should be improved (IAPT) (Recovery rate)	PM	50%	50%	50%	50%	50%	50%
		Actual	52%	32%	43%	47%	48%	35%
3.24(a)	Access to psychological therapies should be improved (IAPT) (Reliable Improvement rate)	PM		N/A	N/A	N/A	N/A	N/A
		Actual		54%	61%	62%	57%	55%
3.25	Access to psychological therapies should be improved: No waiters more than referrals	PM	<100%	<100%	<100%	<100%	<100%	<100%
		Actual	8%	14%	27%	14%	16%	16%
3.26	LD: 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	N/A	95%	95%	95%	95%	95%
		Actual	N/A	100%	100%	100%	100%	100%
3.27	To ensure patients with dementia receive appropriate care for basic health needs (weight assessment)	PM					95%	95%
		Actual					NYA	NYA
	Domain 4: Ensuring that people have a positive experience of care							
3.28	Health and wellbeing of staff	PM	N/A					
		Actual	N/A					
3.29	To demonstrate improvements in staff experience following any national and local surveys	PM	N/A				Annual	Annual
		Actual	N/A				Compliant	Compliant

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2014/15 outturn	Previous Quarter Cumulative Compliance	January-2016	February-2016	March-2016 / Quarter 4		Cumulative Compliance
3.30	Delayed transfers of care to be maintained at a minimal level	Plan	8%	7.5%	7.5%	7.5%	7.5%		7.5%
		Actual	0.8%	1.0%	0.9%	0.9%	0.9%		1.0%
3.31	Personal care plan for all CLDT clients including reasonable adjustments made and signposting to other services	PM	Q4 report						
		Actual	Compliant						
3.32	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%		85%
		Actual	91%	93%	97%	96%	95%		95%
3.33	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%		85%
		Actual	91%	68%	68%	67%	61%		69%
3.34	100% of all SI's reported within 24 hours	PM	100%	100%			100%		100%
		Actual	Compliant	100%			100%		100%
	CYPS								
3.35	Number of children that received support within 24 hours of referral, for crisis home treatment (CYPS)	PM	95%	95%			95%		95%
		Actual	96%	96%			100%		97%
3.36	Children and young people who enter a treatment programme to have a care coordinator - Level 3 Services (CYPS)	PM	98%	98%	98%	98%	98%		98%
		Actual	99%	99%	99%	99%	99%		99%
3.37	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%		95%
		Actual	89%	99%			100%		99%
3.38	Level 2 and 3 – Referral to treatment within 8 weeks (excludes YOS, inpatient and crisis/home treatment) (CYPS)	PM	80%	80%			80%		80%
		Actual	65%	65%			65%		65%
3.39	Level 2 and 3 – Referral to treatment within 10 weeks (excludes YOS, inpatient and crisis/home treatment) (CYPS)	PM	95.0%	95%			95%		95%
		Actual	72%	74%			79%		75%
3.40	Level 3 YOS Specific – proportion receiving treatment within 10 working days of assessment (CYPS)	PM							
		Actual							

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2014/15 outturn	Previous Quarter Cumulative Compliance	January-2016	February-2016	March-2016 / Quarter 4	Cumulative Compliance
	Vocational Service (Individual Placement and Support)							
3.41	100% of Service Users in vocational services will be supported to formulate their vocational goals through individual plans (IPS)	PM	98%	98%			98%	98%
		Actual	100%	100%			100%	100%
3.42	The number of people finding paid employment or self-employment against accepted referrals into the service (IPS)	PM	100%				50%	50%
		Actual	100%				45%	45%
3.43	The number of people retaining employment at 3/6/9/12+ months (IPS) (all clients)	PM	50%	50%			50%	50%
		Actual	83%	62%			65%	65%
3.44	The number of people supported to retain employment at 3/6/9/12+ months (employed at referral)	PM	50%	50%			50%	50%
		Actual	48%	72%			73%	73%
3.45	Fidelity to the IPS model	PM	Annual				Annual	Annual
		Actual	Yes				NYA	NYA
	General Quality Requirements							
3.46	Complex Psychological Interventions: Wait times:	PM		85%			85%	85%
		Actual		UR			UR	UR
3.47	GP Practices will have an individual annual (MH) ICT service meeting to review delivery and identify priorities	PM					Annual	Annual
		Actual					NYA	NYA

DASHBOARD CATEGORY – GLOUCESTERSHIRE SOCIAL CARE

Gloucestershire Social Care				
	In month compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	15	15	15	15
🔴	0	0	0	0
🟢	5	5	5	5
NYA	2	2	4	4
NYR	2	2	0	0
UR	0	0	0	0
N/A	6	6	6	6

Performance Thresholds not being achieved in Month

None

Cumulative Performance Thresholds Not being Met

As above

Changes to Previously Reported Figures

This report has been updated with February and March data not previously available.

Early Warnings

None

Gloucestershire Social Services

ID	Performance Measure		2014/15 outturn	Previous Quarter Cumulative Compliance	January-2016	February-2016	March-2016 / Quarter 4	Cumulative Compliance
4.01	Outcome measure reported against each care cluster	PM	TBC	TBC	TBC	TBC	TBC	TBC
		Actual	92%	96%	97%	97%	97%	96%
4.02	Delayed transfers of care (DTOC's) from hospital & those which are attributed to adult social care (ASCOF 2C pt 2)	Plan	TBC	TBC	TBC	TBC	TBC	TBC
		Actual	5	3	1	4	3	6
4.03	Ensure that reviews of new packages take place within 12 weeks of commencement	PM	95%	95%	95%	95%	95%	95%
		Actual	UR	NYA	NYA	NYA	NYA	NYA
4.04	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%	95%
		Actual	N/A	95%	96%	96%	96%	96%
4.05	Current placements aged 18-64 to residential and nursing care homes per 100,000 population	PM	TBC	TBC	TBC	TBC	TBC	TBC
		Actual	12.32	12.96	12.96	13.51	12.96	13.01
4.06	Current placements aged 65+ to residential and nursing care homes per 100,000 population	PM	TBC	TBC	TBC	TBC	TBC	TBC
		Actual	21.36	21.36	21.36	19.65	21.36	21.21
4.07	% of carers accepting an assessment of need	PM	TBC	TBC	TBC	TBC	TBC	TBC
		Actual	NYA	NYA	NYA	NYA	NYA	NYA
4.08	Ensure that there are sufficient number of integrated AMHPs to respond to requests for Mental Health Act assessments within working hours/operating times of their host team	PM	Annual				Annual	Annual
		Actual	NYA				NYA	NYA
4.09	Ensure 18 hours per annum of relevant CPD is available to all AMHPs regardless of substantive employer	PM	100%				100%	100%
		Actual	NYA				NYA	NYA
4.10	% of eligible service users with Personal budgets (Self Directed Support)	PM	80%	80%	80%	80%	80%	80%
		Actual	98%	97%	97%	97%	97%	97%

Gloucestershire Social Services

ID	Performance Measure		2014/15 outturn	Previous Quarter Cumulative Compliance	January-2016	February-2016	March-2016 / Quarter 4		Cumulative Compliance
4.11	% of eligible service users with Personal Budget receiving Direct Payments (ASCOF 1C pt2)	PM	15%	15%	15%	15%	15%		15%
		Actual	16%	19%	18%	18%	19%		19%
4.12	Adults subject to CPA in contact with secondary mental health services in settled accommodation (ASCOF 1H)	PM	80%	80%	80%	80%	80%		80%
		Actual	88%	87%	85%	85%	85%		86%
4.13	Adults not subject to CPA in contact with secondary mental health service in settled accommodation	PM		TBC	TBC	TBC	TBC		TBC
		Actual		92%	90%	91%	90%		91%
4.14	Adults subject to CPA receiving secondary mental health service in employment	PM	13%	13%	13%	13%	13%		13%
		Actual	13%	14%	13%	14%	13%		14%
4.15	Adults not subject to CPA receiving secondary mental health service in employment	PM		TBC	TBC	TBC	TBC		TBC
		Actual		23%	23%	24%	23%		23%

DASHBOARD CATEGORY – HEREFORDSHIRE CCG CONTRACTUAL REQUIREMENTS

Herefordshire Contract				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	29	29	29	29
🔴	5	6	3	6
🟢	23	22	26	23
NYA	0	0	0	1
NYR	1	1	0	0
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month

5.16: Number of people moving to recovery with IAPT service intervention

The recovery rate for March is 38% and the reliable improvement rate is 56%.

Following the recent IST visit, an action plan is being drawn up that will identify the actions which need to be taken to improve the Recovery Rate for patients using the service. A detailed report will be submitted to the Delivery Committee in June 2016.

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

By month 12, the service has seen 2,005 people which is 173 people short of the 2,178 expected to be seen for the period to meet the performance threshold of 15%. The final outturn position for the service is an access rate of 13.8%

Although the annual threshold was not been met, the service met the Quarterly access rate of 3.75% for Q4. 547 people started treatment in the Quarter, giving it a Quarterly access rate of 3.77%.

5.21: Number on caseload who have not been seen face-to-face within 90 days

The number of individuals is reducing on a monthly basis as staff are ensuring they see and review people within 90 days or if appropriate discharge them from care.

This indicator is to change next year to show the percentage of those on the caseload that should be seen within 90 days set at 98%.

Cumulative Performance Thresholds Not being

5.16: Number of people moving to recovery with IAPT service intervention
As above

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

5.19: Care plans within 4 weeks of working diagnosis of Dementia
Reporting of this indicator has only been available during in the last 6 months of this year and the service have continued to review all non-compliant cases to highlight improvements needed to internal processes.

5.21: Number on caseload who have not been seen face-to-face within 90 days
As above

5.27: Specialist Memory Clinic: service users offered an appointment within 4 weeks
This indicator was compliant for Quarter 3 but performance has fallen during Quarter 4. For 16/17 the performance threshold for this indicatorhas been reduced from 100% to 95%

5.28: No children under 18 admitted to adult in-patient wards
There were no under 18 admissions in March; however previous cases had meant that this indicator is cumulatively non-compliant for the year.

Changes to Previously Reported Figures

5.27: Specialist Memory Clinic: service users offered an appointment within 4 weeks
February was previously reported at 100% compliance; however a non-compliant case has now been recorded. A client was admitted to Hereford County Hospital and the service were unable to carry out the assessment until the client was discharged home. However, performance has continued to improve throughout the year and in 5 out of the last 6 months of year has been at 100% compliance

Early Warnings

None

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2014/15 Outturn	Previous Quarter Cumulative Compliance	January-2016	February-2016	March-2016 / Quarter 4	Cumulative Compliance
5.01	Sleeping Accommodation Breach	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	0
5.02	Care Programme Approach: Percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric inpatient care	Plan	95%	95%	95%	95%	95%	95%
		Actual	98%	96%	96%	87%	100%	96%
5.03	Zero tolerance MRSA	Plan	0	0	0	0	0	0
		Actual	0	0	0	0	0	0
		Unavoidable	0	0	0	0	0	0
5.04	Minimise rates of Clostridium difficile	Plan	0	0	0	0	0	0
		Actual	1	0	0	0	0	0
		Unavoidable	0	0	0	0	0	0
5.05	VTE risk assessment: all inpatients to undergo risk assessment for VTE	Plan	95%	95%	95%	95%	95%	95%
		Actual	99%	99%	100%	100%	100%	99%
5.06	Publication of Formulary (on provider's website)	Plan	Report	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
5.07	Duty of candour: Avoidable events which cause "significant harm" are reported to patient with agreement and written action plan	Plan	Report	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2014/15 Outturn	Previous Quarter Cumulative Compliance	January-2016	February-2016	March-2016 / Quarter 4	Cumulative Compliance
5.08	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS	Plan	99%	99%	99%	99%	99%	99%
		Actual	100%	100%	100%	100%	100%	100%
5.09	Completion of Mental Health Minimum Data Set ethnicity coding for all detained and informal Service Users	Plan	90%	90%	90%	90%	90%	90%
		Actual	98%	100%	100%	100%	100%	100%
5.10	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	Plan	90%	90%	90%	90%	90%	90%
		Actual	90%	96%	100%	100%	97%	96%
5.11	IAPT access: 6 week wait referral to treatment (based on discharged patients)	Plan		75%	75%	75%	75%	75%
		Actual		95%	98%	89%	98%	95%
5.12	IAPT access: 18 week wait referral to treatment (based on discharged patients)	Plan		95%	95%	95%	95%	95%
		Actual		99%	100%	100%	100%	99%
5.13	Treatment within 2 weeks for people experiencing a first episode of psychosis (Target Q4 = 50%)	Plan		50%	50%	50%	50%	50%
		Actual		58%	25%	71%	75%	61%
5.14	Elimination of avoidable pressure ulcers - category 2, 3 and 4	Plan	0	0	0	0	0	0
		Actual	0	0	0	0	0	0
		Unavoidable	4	0	0	0	0	0
5.15	Emergency referrals to Crisis Resolution Home Treatment Team seen within 4 hours of referral (8am-6pm)	Plan		98%	98%	98%	98%	98%
		Actual		98%	100%	100%	100%	99%
5.16	Number of people moving to recovery with IAPT service intervention. (Recovery rate)	Plan	50%	50%	50%	50%	50%	50%
		Actual	48%	28%	39%	60%	38%	33%
5.16(a)	Number of people moving to recovery with IAPT service intervention. (Reliable Improvement rate)	Plan		N/A	N/A	N/A	N/A	N/A
		Actual		53%	48%	63%	57%	53%
5.17	IAPT achieve 15% of patients entering the service against prevalence *(Annual Target of 2,178)*	Plan	2,186	1,634	1,815	1,997	2,178	2,178
		Actual	1,748	1,458	1,655	1,849	2,005	2,005

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2014/15 Outturn	Previous Quarter Cumulative Compliance	January-2016	February-2016	March-2016 / Quarter 4	Cumulative Compliance
5.18	Dementia Service - number of new inceptors (assessments) to achieve 50 per month	Plan		450	50	50	50	600
		Actual		542	54	57	57	710
5.19	100% of people within the memory assessment service with a working diagnosis of dementia to have an initial care plan agreed within 4 weeks of diagnosis or discharge from memory service	Plan		100%	100%	100%	100%	100%
		Actual		91%	91%	97%	100%	97%
5.20	Delayed transfers of care to be maintained at a minimum level	Plan	5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	1.3%	0.2%	0.0%	8.4%	4.3%	1.2%
5.21	Number of service users on the caseload who have not been seen (face to face) within the previous 90 days (Recovery Service). Excludes service users with a medic as Lead HCP.	Plan		0	0	0	0	0
		Actual		16	12	7	15	15
		Denominator		482	485	492	493	493
		% of caseload		4%	2%	1%	3%	3%
5.22	Reduce those people readmitted to inpatient care within 30 days following discharge.	Plan	NA	<8%	<8%	<8%	<8%	<8%
		Actual	17	6%	0%	6%	5%	6%
5.23	Service users receiving home treatments by the Crisis Home Treatment Team *(Annual target of 285)*	Plan		214	237	260	285	285
		Actual		453	490	538	587	587

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2014/15 Outturn	Previous Quarter Cumulative Compliance	January-2016	February-2016	March-2016 / Quarter 4	Cumulative Compliance
5.24	IAPT high intensity (HI) service user contacts on current caseload *(Annual target of 350. Monthly trajectory to be confirmed)*	Plan					350	350
		Actual					356	356
5.25	Access to psychological therapies should be improved - the number of patients that have waited longer than 28 days from referral for an assessment should not exceed the number of referrals in that month	Plan		<100%	<100%	<100%	<100%	<100%
		Actual		7%	12%	6%	9%	7%
5.26	CPA Review - % of people having had a formal care program approach review within 12 months	Plan		95%	95%	95%	95%	95%
		Actual		98%	99%	99%	99%	99%
5.27	Waiting times - Specialist Memory Clinic: 100% of service users are offered a first appointment within 4 weeks of referral	Plan	100%	100%	100%	100%	100%	100%
		Actual	48%	94%	100%	97%	100%	95%
5.28	No people aged under 18 admitted to adult inpatient wards	Plan	0	0	0	0	0	0
		Actual	3	4	0	0	0	4
5.29	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%	80%
		Actual	77%	84%	100%	100%	100%	86%
		No. of patients	3	4	0	0	0	4

DASHBOARD CATEGORY – GLOUCESTERSHIRE CQUINS

Gloucestershire CQUINS				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	7	7	7	7
	0	0	0	0
	0	0	6	7
NYA	0	0	1	0
NYR	7	7	0	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
None

Early Warnings
None

Gloucestershire CQUINS

ID	Performance Measure		2014/15 Outturn	Previous Quarter Cumulative Compliance		Quarter 4		Cumulative Compliance
	National CQUINs							
	CQUIN 1							
7.01	Acute Kidney Injury - EWS score within 12 hours (Charlton Lane)	PM		Qtr 3		Report		Qtr 4
		Actual		Compliant		Compliant		Compliant
	CQUIN 2							
7.02a	Improving physical healthcare: Cardio Metabolic Assessment for patients with schizophrenia	PM	4th Qtr	Qtr 3		Report		Qtr 4
		Actual	Awarded	Compliant		Compliant		Compliant
7.02b	Improving physical healthcare: Communication with GPS	PM	4th Qtr	Qtr 2		Report		Qtr 2
		Actual	Awarded	Awarded		NYA		Awarded
	CQUIN 3							
7.03	Identification and Assessment of Delirium	PM		Qtr 3		Report		Qtr 4
		Actual		Compliant		Compliant		Compliant
	Local CQUINs							
	CQUIN 4							
7.04	Triangle of Care	PM		Qtr 2		Report		Qtr 4
		Actual		Awarded		Compliant		Compliant
	CQUIN 5							
7.05	Transition from Young People's Service to Adult Mental Health Services	PM		Qtr 2		Report		Qtr 4
		Actual		Awarded		Compliant		Compliant
	CQUIN 6							
7.06	Perinatal Mental Health	PM		Qtr 3		Report		Qtr 4
		Actual		Compliant		Compliant		Compliant

DASHBOARD CATEGORY – LOW SECURE CQUINS

Low Secure CQUINS				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	4	4	4	4
	0	0	0	0
	0	0	4	4
NYA	0	0	0	0
NYR	4	4	0	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
None

Early Warnings
None

Low Secure CQUINS

ID	Performance Measure		2014/15 Outturn	Previous Quarter Cumulative Compliance		Quarter 4		Cumulative Compliance
	National CQUINs							
	CQUIN 1							
8.01	Improving physical healthcare: Cardio Metabolic Assessment for patients with schizophrenia	PM	4th Qtr	Qtr 3		Report		Qtr 4
		Actual	Compliant	Compliant		Compliant		Compliant
	Local CQUINs							
	CQUIN 2							
8.02	Supporting service users to stop smoking	PM		Qtr 2		Report		Qtr 4
		Actual		Awarded		Compliant		Compliant
	CQUIN 3							
8.03	Active engagement programme - Risk assessment secure unit and staff	PM	4th Qtr	Qtr 2		Report		Qtr 4
		Actual	Compliant	Awarded		Compliant		Compliant
	CQUIN 4							
8.04	Mental Health carer involvement strategies	PM	4th Qtr	Qtr 2		Report		Qtr 4
		Actual	Awarded	Awarded		Compliant		Compliant

DASHBOARD CATEGORY – HEREFORDSHIRE CQUINS

Herefordshire CQUINS				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	6	6	6	6
	0	0	0	0
	0	0	5	6
NYA	0	0	1	0
NYR	6	6	0	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
None

Early Warnings
None

Herefordshire CQUINS

ID	Performance Measure		2014/15 Outturn	Previous Quarter Cumulative Compliance		Quarter 4		Cumulative Compliance
	National CQUINs							
	CQUIN 1							
9.01a	Improving physical healthcare: Cardio Metabolic Assessment for patients with schizophrenia	PM	4th Qtr	Qtr 3		Report		Qtr 4
		Actual	Awarded	Compliant		Compliant		Compliant
9.01b	Improving physical healthcare: Communication with GPS	PM	4th Qtr	Qtr 2		Report		Qtr 2
		Actual	Compliant	Awarded		NYA		Awarded
	CQUIN 2							
9.02	Urgent and Emergency Care: Development of an adult personalised discharge care plan	PM		Qtr 2		Report		Qtr 4
		Actual		Awarded		Compliant		Compliant
	CQUIN 3							
9.03	Urgent and Emergency Care: Improvement in Crisis Contingency Planning	PM		Qtr 2		Report		Qtr 4
		Actual		Awarded		Compliant		Compliant
	Local CQUINs							
	CQUIN 4							
9.04	Development of Personality Disorder consultation	PM		Qtr 1		Report		Qtr 4
		Actual		Awarded		Compliant		Compliant
	CQUIN 5							
9.05	IAPT vulnerable service users	PM		Qtr 1		Report		Qtr 4
		Actual		Awarded		Compliant		Compliant

Agenda Item	**8**	**Enclosure Number**	**Paper C**

Report to: 2gether NHS Foundation Trust Board – 26th May 2016
Author: Sian Waygood, Interim Service Experience Clinical Manager
Presented by: Jane Melton, Director of Engagement and Integration

Subject: **Service Experience Report Quarter 4 2015/16**

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

EXECUTIVE SUMMARY

(1) Assurance

This Service Experience Report provides a high level overview from the feedback received from service users and carers in Quarter 4 2015/16. Learning from people's experiences is a key purpose of this work. This report provides assurance that service experience information has been reviewed in depth, scrutinised for themes and considered for both individual team and general learning across the organisation.

Significant assurance – **the organisation has listened to, heard and understood patient and carer experience of 2gether's services.**

This assurance is offered from a triangulation of information gathered across all domains of feedback including complaints, concerns, comments and compliments. Survey information has also been triangulated to understand service experience.

Significant assurance **- that service users value the service being offered and would recommend it to others.**

During Quarter 4 - 93% of people who responded to the invitation to complete the Friends and Family Test said that they would recommend 2gether's services.

Over the year 2015/2016 - 91% of people who responded to the invitation to complete the Friends and Family Test this quarter said that they would recommend 2gether's services.

Limited assurance - **numbers of people taking part in local survey activity**

A new system of gathering feedback has been introduced to operational services and the PALS officer responsible is offering weekly update on progress to the Director of Engagement and Integration. The aim is to ensure that surveys are

appropriately accessible to service users and to encourage more people to participate in the survey thus gain greater reliability of results.

(2) Learning and Improvement recommended

The trust will maintain rigorous and sustained effort to gain feedback about service experience, from multiple sources and on a continuous basis. We will continue to respond swiftly to people wherever possible, particularly where the feedback is of a negative nature.

Most of the learning this quarter has related to individual staff members and circumstances. A small number of broad themes and learning has been identified for Trust-wide dissemination and learning. They are defined from the triangulation of all types of service experience information received (not only complaints and concerns). The learning includes:

- Informing and involving service users when information is shared about them.
- People value bespoke, clear, jargon-free communication to share information and advice (both written and verbal).

RECOMMENDATIONS

The Board is asked to note the contents of this report

Corporate Considerations	
Quality Implications	Patient and carer experience is a key component of the delivery of best quality of care. The report aims to outline what is known about service experience of ^{2}gether's services in Q4 2015/16 and to make key recommendations for action to enhance quality.
Resource Implications	A service experience report offers assurance to the Trust that resources are being used to support best service experience.
Equalities Implications	The Service Experience Report offers assurance that the Trust is attending to its responsibilities regarding equalities for service users and carers.
Risk Implications	Feedback from service experience offers an insight into how services are received. The information provides a mechanism for identifying performance, reputational and clinical risks.

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			P
Excelling and improving	P	Inclusive, open and honest	P
Responsive	P	Can do	P
Valuing and respectful	P	Efficient	P

Reviewed by:		
Jane Melton, Director of Engagement and Integration	Date	12th May 2016

Where in the Trust has this been discussed before?		
Trust Governance Committee	Date	20th May 2016

What consultation has there been?		
Service Experience Committee members	Date	20th April 2016

Explanation of acronyms used:	NHS – National Health Service HW – Healthwatch PALS – Patient Advise and Liaison Service GP – General Practitioner MP – Member of Parliament OPS – Older Peoples Service LD – Learning Disabilities CYPS – Children and Young People's Service GRIP – Gloucestershire Recovery in Psychosis Team HR – Human Resources CDWs – Community Development Workers CEO – Chief Executive Officer BME – Black and Minority Ethnic Groups IAPT – Improving Access to Psychological Therapies PHSO – Parliamentary Health Services Ombudsman CBT – Cognitive Behavioural Therapy SMT – Substance Misuse Team DMHOP – Department of Mental Health for Older People CAMHS – Child and Adolescent Mental Health Service CRHTT – Crisis Resolution and Home Treatment Team

2gether
Making life better

2gether
NHS Foundation Trust

SERVICE EXPERIENCE REPORT

Quarter 4: 1st January 2016 – 31st March 2016

"I'd like to thank you for helping me during the last few weeks. Your treatment has helped no end. My confidence has returned"

"We have been very impressed by the genuine care, dedication and professionalism of the entire team (Early Intervention Unit, Hereford), all of whom have gone the extra mile to help towards recovery"

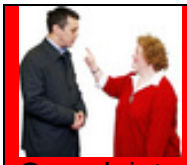
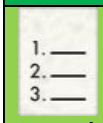
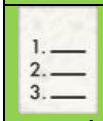
CONTENTS

Key

NHS – National Health Service
HW – Healthwatch
PALS – Patient Advice and Liaison Service
GP – General Practitioner
MP – Member of Parliament
OPS – Older People's Service
LD – Learning Disabilities
CYPS – Children and Young People's Service
GRIP – Gloucestershire Recovery in Psychosis Team
HR – Human Resources
CDWs – Community Development Workers
CEO – Chief Executive Officer
BME – Black and Minority Ethnic Groups
IAPT – Improving Access to Psychological Therapies
PHSO – Parliamentary Health Services Ombudsman
CBT – Cognitive Behavioural Therapy
SMT – Substance Misuse Team
DMHOP – Department of Mental Health for Older People
CAMHS – Child and Adolescent Mental Health Service
CRHTT – Crisis Resolution and Home Treatment Team

EXECUTIVE SUMMARY

Quarter 4, 2015/16: 1st January 2016 to 31st March 201

 Complaints	**26** complaints (129 separate issues) were made between 1st January and 31st March 2016 This is slightly lower than Quarter 3 but remains within the normal range for the year.	↔
 Concern	**42** concerns were expressed through PALS. This is similar to the previous Quarter.	↔
 Compliment	**646** people told us they were pleased with our service by giving us a compliment. The percentage of compliments reported as a proportion of patients seen is about the same (but just a little lower this quarter).	↔
 Local Survey **FFT**	**93%** people said they would recommend our service. This is slightly higher than the previous quarter	↑
 Local Survey **OTHER**	Gloucestershire: **84 responses** Herefordshire: **43 responses** We need to encourage more people to respond	↓
 We must listen	You want to know about and be involved in information that is shared about you	
 We must listen	You like information that is tailored to you, is clear and does not have jargon. You like staff to explain things to you as well as give written information	

Key

↑	Increased performance / activity		Significant assurance
↔	Performance / activity remains similar		Limited assurance
↓	Reduced performance / activity		No assurance

Section 1 INTRODUCTION

1.1 Overview of the paper

1.1.1 This paper informs the Trust about people's reported experience of 2gether NHS Foundation Trust's service between 1st January and 31st March 2016. It also provides examples of the learning that has been achieved through service experience reporting and update on activity to enhance service experience.

1.1.2 **Section 1** provides and broad introduction to provide a context to the report.

1.1.3 **Section 2** provides information about emerging themes from reported service experience of the Trust's clinical services. It includes complaints, concerns, comments and compliments and survey information. Conclusions have been drawn from triangulation of the information provided from:

- 2gether's Patient Advice and Liaison Service (PALS) report
- A synthesis of complaints and concerns reported to 2gether in Quarter 4
- Information from reported compliments and comments about 2gether's services
- Narrative reports made by members of the Service Experience Committee
- Ad hoc meetings with stakeholders
- 2gether meetings with patients in the ward environment
- 2gether local patient surveys
- 2gether Carer Focus groups
- HealthWatch Gloucestershire reports
- HealthWatch Herefordshire reports and engagement events

1.1.4 **Section 3** provides examples of the learning that has been gleaned through service experience reporting and subsequent action planning.

1.2 Strategic Context

1.2.1 **Trust values and strategic approach**
Listening to and responding appropriately to comments, concerns and complaints and being proactive about the development of inclusive, quality services is of great significance and importance to the delivery of services through [2]gether. The focus is underpinned by the NHS Constitution (2015[1]) and is a key component of the Trust value statements.

1.2.2 [2]gether's Service User Charter, Carer Charter and Staff Charter remain key documents to deliver our values and this work is underpinned guided by [2]gether's Service Experience Strategy (2013).

Figure 1: A shared goal to listen to, respond to and improve service experience.

1.2.3 **The overarching vision for service experience is that:**

Every service user will receive a flexible, compassionate, empathetic, respectful, inclusive and proactive response from [2]gether staff and volunteers.

As we serve patients and their carers, we will go beyond what people expect of us to ensure that we earn their trust, confidence and hope for the future.

[1] https://www.gov.uk/government/publications/the-nhs-constitution-for-england

SECTION 2
Formal Complaints – Quarter 4 (January to March 2016)

COMPLAINT	NUMBERS[2] Numerical direction and assurance	INTERPRETATION	LEVEL OF ASSURANCE
Gloucestershire	**20** ↓	The number of issues identified is slightly lower than the previous Quarter.	SIGNIFICANT
Herefordshire	**6** ↔	The same as previous quarter.	SIGNIFICANT
Total for Trust	**26** ↔	Overall the number of reported complaints remains consistent (when factoring in the number of concerns expressed also – see page 10)	SIGNIFICANT
RESPONSIVENESS			
Acknowledgement of complaint in 3 days	**100%** ↑	3 day response time – high level of achievement occasional exceptions - significant level of assurance	SIGNIFICANT
Number of complaints closed during Quarter 4	**31** ↓	The number of investigations and responses completed and signed off this quarter is slightly lower than Quarter 3.	SIGNIFICANT
SATISFACTION			
Referrals to PHSO	**2** ↔	Two new cases have been referred to the Ombudsman this quarter. The PHSO has informed us of the outcome of one investigation – none of the concerns has been upheld.	SIGNIFICANT
Complainant expressed dissatisfaction and case reopened	**9** ↑	There has been increase in the number of reopened complaints this quarter but this is consistent with the number of cases closed in the quarter.	SIGNIFICANT

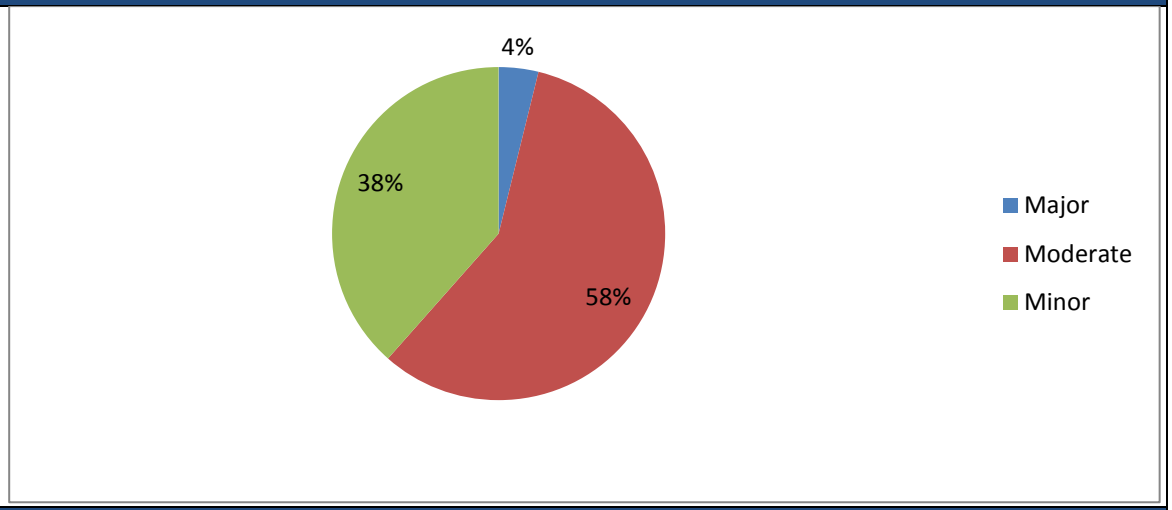
[2] For comparison with rate of individuals seen, please see page 10

Resolution Meetings	7 ↑	Resolution meetings continue to provide a helpful forum to address, resolve and clarify any outstanding queries or concerns.	SIGNIFICANT

RISK RATING OF COMPLAINT *

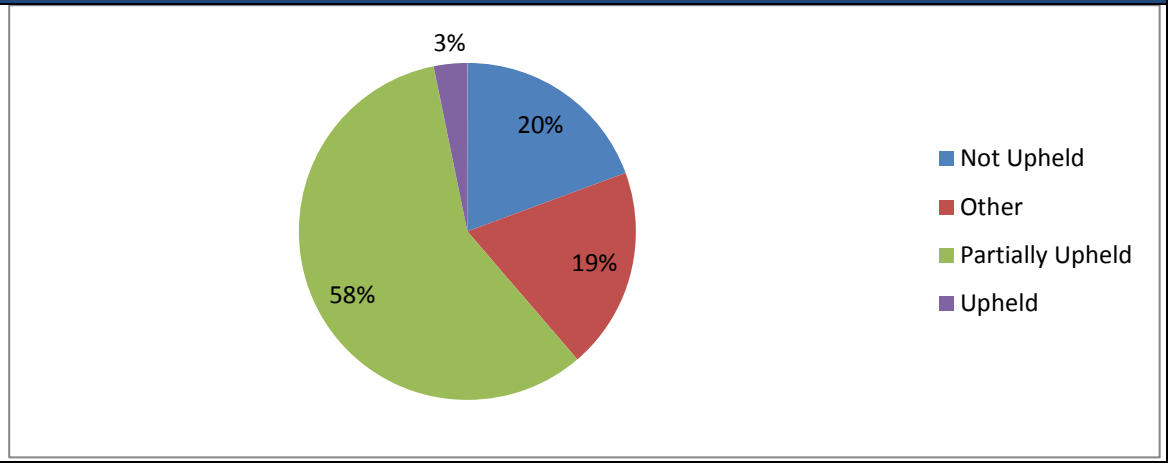
*This risk rating definition is Nationally determined and considers the risk rating of the complaint to the organisation

Insignificant Simple, non-complex issues	**n= 0 (0%)**
Minor Several issues relating to a short period of care	**n=10 (38%)**
Moderate Multiple issues relating to longer period of care/involving other organisations	**n=15 (58%)**
Major Multiple issues relating to serious failures, causing serious harm (Concerns about potential release of confidential information)	**n=1 (4%)**



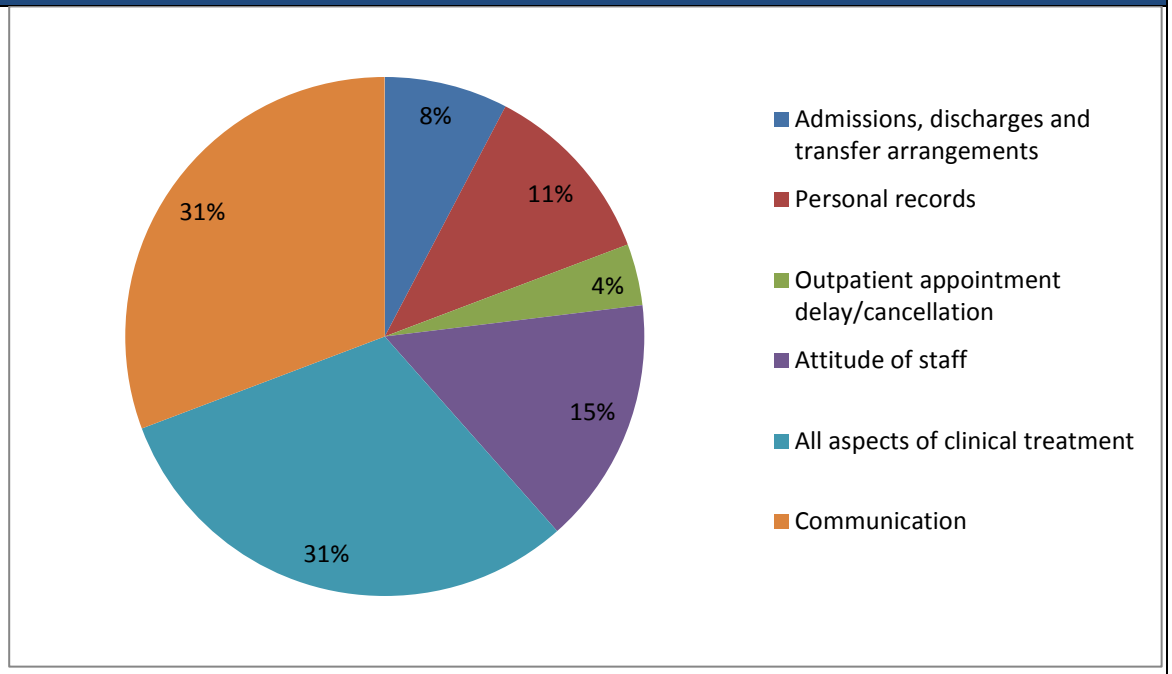
OUTCOME OF COMPLAINT INVESTIGATION * 'Other' refers to complaints held at a point in time to respect a person's need or wish.

Upheld	**n=1 (3%)**
Partially upheld	**n=18 (58%)**
Not Upheld	**n= 6 (20%)**
Other *(please see above)	**n=6 (19%)**



The proportion of complaints upheld or partially upheld in Quarter 4 is 18% lower this quarter. Learning identified within complaints is highlighted whatever the outcome.

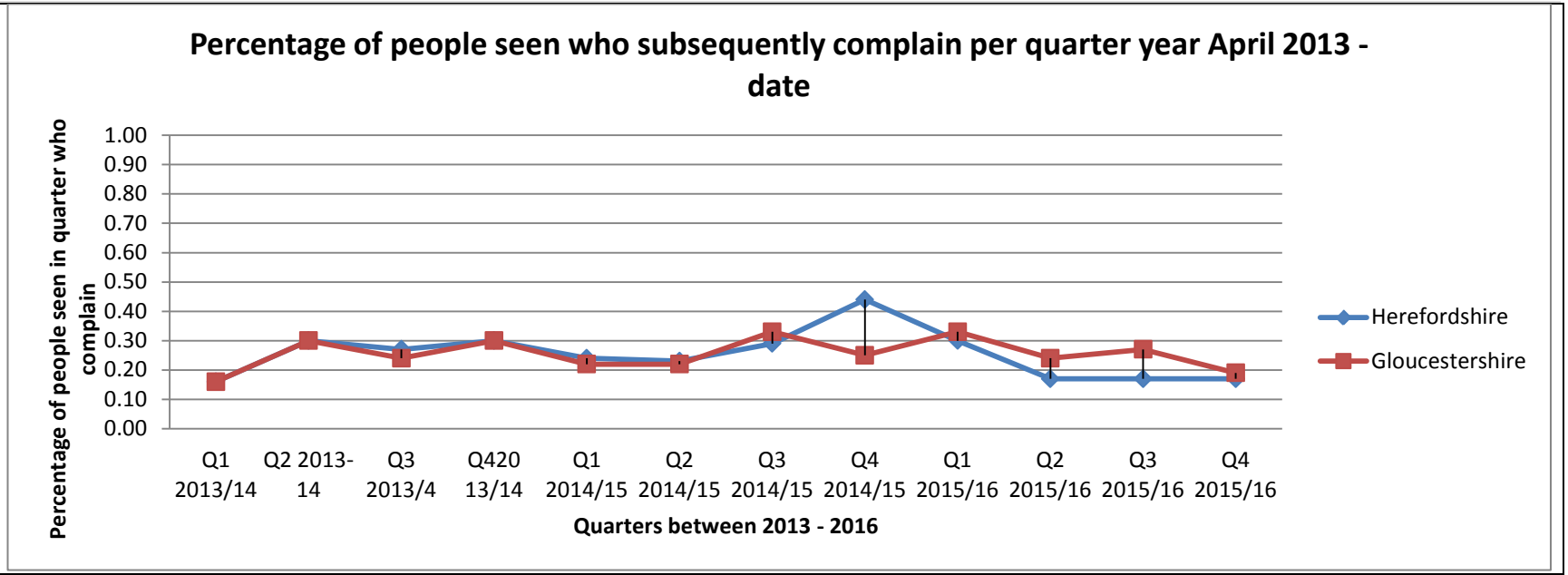
MAIN COMPLAINT THEMES AND PERCENTAGE	
Communication	**31%**
Clinical Treatment	**31%**
Attitude of staff	**15%**
Personal Records	**11%**
Admissions, discharges and transfer arrangements	**8%**
Outpatient appointment delay/cancellation	**4%**



Examples of complaints, and action taken			
You said	**We did**	**You said**	**We did**
PERSONAL RECORDS *I did not want information about my care and treatment sent to my GP*	We offered an apology. We liaised with the GP and arranged for the copies of correspondence to be	**CLINICAL TREATMENT:** *I was unhappy that I had to pay for a telephone call to a Trust*	We offered an apology and agreed that telephone calls via the pager system should be free of charge.

but letters were sent to the Practice.	removed from your records.	*Pager.*	The IT team have made the necessary changes to ensure future calls to the pager are free.
COMMUNICATION: *I was unhappy that the police came to my house*	We explained that staff had a responsibility to share safeguarding concerns. Staff will ensure that service users are made aware of the possible need to share information if they believe someone is at risk.	**TRANSFER between Teams:** *There was a delay in my receipt of support at home.*	We offered an apology and identified that the transfer of your care had been delayed. Changes to the clinical pathway have been made to improve the service.

NUMBERS OF COMPLAINTS BY POPULATION SEEN				
Locality	**People seen by 2gether's services in Q4*** includes individuals seen by more than one service	**No of Complaints received in Q4**	**% of Complaints in relation to people seen**	**Assurance**
Herefordshire	3,527	6	0.17%	SIGNIFICANT
Gloucestershire	10,230	20	0.19%	SIGNIFICANT

Percentage of people seen who subsequently complain, by Quarter and County.	

PALS enquiries (Concerns, Advice, Signposting) – Quarter 4 (January to March 2016), raised directly to the Service Experience Department

Concerns			
Gloucestershire	36 (0.35% of people seen in service)	**Total opened this quarter** (Gloucestershire and Herefordshire)	42
Herefordshire	6 (0.17% of people seen in service)	**Total closed this quarter**	31

	Concerns (n=42)	Advice (n=20)	Signposting (n=22)
Main themes	• Issues regarding communication and attitude **(27%)** • Concerns relating to medication and levels of care **(17%)** • Problems regarding accessing services, waiting times, and transfers between services **(19%)** • Issues relating to the MHA **(7%)**	• How to access services **(45%)** • How to complain about services **(15%)** • Tribunals **(15%)** • Other advice **(25%)**	• Internal Teams **(82%)** • External Organisations **(18%)**

	• Concerns relating to cleanliness **(7%)** • Miscellaneous issues **(23%)**		

Examples of concerns raised through the PALS service, and action taken			
You said	**We did**	**You said**	**We did**
'My husband's assessment did not include his family, and therefore led to a different conclusion'	The Team contacted the assessing team and a new, updated assessment was offered	*'I am really struggling with the number of people in a small room when I attend a group'*	We contacted the facilitator who arranged for the group to be held in a more spacious environment
'My son is in hospital and is not telling the staff what's really going on for him – how can we let staff know?'	We contacted the ward who contacted the family to take additional background information	*'There are inaccuracies in my Health Records – how can I get this changed?'*	The team discovered the inaccuracies were provided by an outside agency and this was resolved directly with them

Comments (HealthWatch) – Quarter 4 (January to March 2016)

The following are examples of areas of comments received via **HealthWatch Gloucestershire** engagement activity about the overall support of people experiencing mental illness in the county:

Aggregation of concerns and comments

- Disconnect between mental health and substance misuse services
- Telephones not being answered by the Crisis Team
- Difficult to access support for young people, and concerns about out-of-county care
- More support needed for those in the military community experiencing PTSD
- Reduction in social opportunities for those with a mental health issue and / or learning disability
- Waiting times for preventative therapies
- A suggestion that services need to recognise the impact of certain mental health medications and their impact on weight gain, as this may cause some people to stop taking their medication
- One agency said they received a lot of referrals regarding hoarding, but mental health services have been unable to help

- It would be useful to have the option of face to face meetings with Let's Talk, and not just support on the telephone
- More connected, holistic services for young people would be good
- People requesting a greater understanding of what other services, not necessarily NHS, are available for older people
- A perceived disconnect between services and supports for people who are homeless

The Trust continues to meet with senior members of Healthwatch on a quarterly basis to listen to concerns raised, to take action with operational services when possible and to feed comments into the wider systems to champion solutions for integrated working. For example, Healthwatch Gloucestershire is reviewing local healthcare support for people who are homeless which the trust is pleased to be making a contribution to.

Healthwatch Herefordshire has also reported their engagement activity. In addition, two Directors of ^{2}gether were invited to participate in an engagement event (Questions Time style) at a 6th Form College in Hereford to listen to the views about mental health, mental illness and tackling Stigma of the local community with a particular invitation to young people.

Compliments – Quarter 4 (January to March 2016)

COMPLIMENTS	NUMBERS	LAST QUARTER
Gloucestershire	**600**	**622**
Herefordshire	**41**	**62**
Corporate	**5**	**16**
Total for Trust	**646**	**700**

approximately

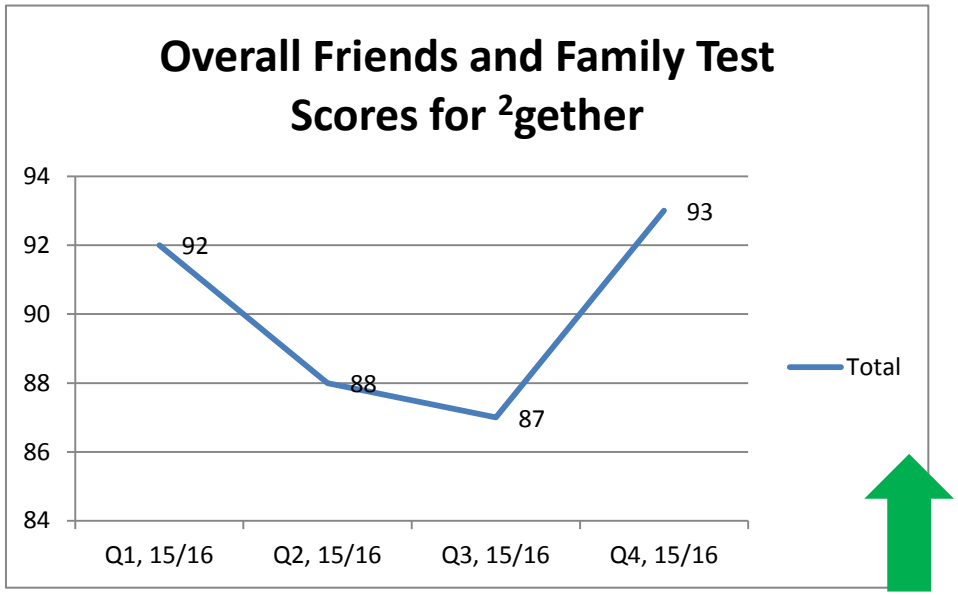
NUMBERS OF REPORTED COMPLIMENTS BY POPULATION SEEN			
Locality	**People seen by 2gether's services in Q4**	**No of Compliments received in Q4**	**% of Compliments in relation to people seen**
Herefordshire	3,527	41	1%
Gloucestershire	10,230	600	6%

Compliments are being uploaded to the Trust intranet to encourage colleagues to validate the work that staff are undertaking and to encourage colleagues to report the compliments that they receive.

EXAMPLE COMPLIMENTS		
HEREFORDSHIRE	*Thank you for all your help and support over these last two weeks, you are amazing and a true inspiration, we have so much respect and such high regard for you.*	Community Learning Disability Team
HEREFORDSHIRE	*Everyone I have dealt with, from telephone receptionist onward, have been most helpful, polite, courteous and sympathetic. I cannot express enough gratitude for their efforts.*	Crisis Resolution and Home Treatment Team, Stonebow Unit
GLOUCESTERSHIRE	*The high quality of care provided by the staff was such that there were many enjoyable activities (particularly OT and in the gym) which I am sure helped my recovery. I have some happy memories. Based on my own experience, I doubt that there is a better Mental Health Unit in the UK than the one at Wotton Lawn.*	Therapy Department, Wotton Lawn

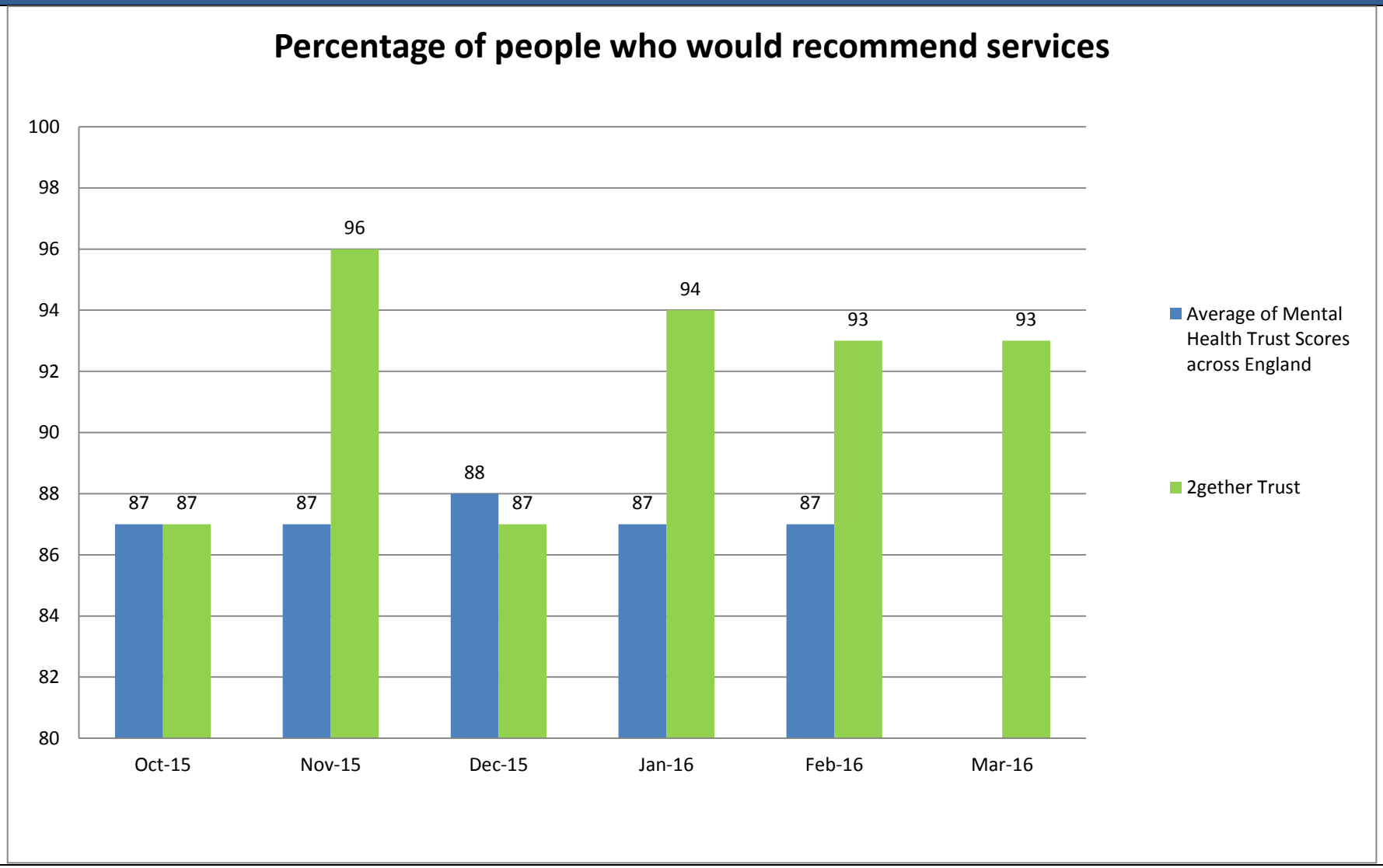
GLOUCESTERSHIRE	*Thank you for being so kind and accommodating towards me, I really appreciate your help.*	South Recovery Team
GLOUCESTERSHIRE	*Quality of care relative receives is 'absolutely brilliant'. As far as we are concerned everything possible has been achieved with good results. We are very pleased with how things have been done helping out our son to join in with living with others in the same situation health wise. Thank you and all the staff'.*	Honeybourne Ward
GLOUCESTERSHIRE	*I want to say a massive thankyou to all the staff, for going with the flow and treating me how you would like to be treated*	Functional Families Team
GLOUCESTERSHIRE	*I recently had the pleasure of staying at Wotton Lawn for an amazing two week break and would like to commend you and the amazing team of people there on a job well done.*	Abbey Ward, Wotton Lawn

Friends and Family Test – Quarter 4 (January 2016 to March 2016)

[2]gether NHS Foundation Trust	Interpretation		Level of Assurance
January 2016 48 responses	94%		Significant
February 2016 111 responses	93%		
March 2016 399 responses	93%		
Total responses 558	**93%**	A larger number of people responded to the invitation to complete the Friends and Family Test last Quarter. In March 2016, IAPT in Gloucestershire sourced a particularly large % of completed questionnaires which was added to the response numbers. Data are now being inputted by an independent organisation. It had been anticipated that there would be a fluctuation in response numbers as new collection procedures were implemented.	

Over **the year 2015-16** the Friends and Family Test results suggested that **91%** of those who completed the test would recommend our service

[2]gether Trust Friends and Family Test scores in comparison with other NHS England Mental Health Trusts



Significant

Comparative scores for March 2016 will not be available until 13th May 2016.

Additional Survey questions with a sample population in Quarter 4							
Questions	**Treatment Setting**	Sample Size **Glos**	Number 'yes' **Glos**	Sample size **Hereford**	Number 'yes' **Hereford**	**Total %** giving 'yes' answer	**Assurance**
Question 1 Have you been offered a written copy of your care plan or a letter about your care? **includes Easy Read (Q6)*	Inpatient	26	20	0	0	**73%**	On target this Qtr (73%). Needs sustained effort
	Community	3	2	8	5		
	Total Responses	29	22	8	5		
Question 2* Do [2]gether Trust staff help you to feel hopeful about things that are important?	Inpatient	23	19	0	0	**84%**	Beyond target (65%). Continues to require a sustained effort.
	Community	1	1	8	7		
	Total Responses	24	20	8	7		
Question 3 Have you been given advice with finding support for any physical health needs that you may have?	Inpatient	0	0	0	0	**50%**	Below target (58%). Continues to require a sustained effort. NB - numbers of respondents small*.
	Community	1	1	3	1		
	Total Responses	1	1	3	1		

Additional Survey questions with a sample population in Quarter 4							
Questions	**Treatment Setting**	Sample Size **Glos**	Number 'yes' **Glos**	Sample size **Hereford**	Number 'yes' **Hereford**	**Total %** giving 'yes' answer	**Assurance**
Question 4 Have you been given advice about taking part in activities that are important to you?	Inpatient	0	0	0	0	**100%**	Beyond target (51%). Continues to require a sustained effort – NB - numbers of respondents small*.
	Community	1	1	8	8		
	Total Responses	1	1	8	8		
Question 5 Do you feel safe in our services?	Inpatient	26	21	0	0	**86%**	No target set. Continues to require a sustained effort.
	Community	1	1	8	8		
	Total Responses	27	22	8	8		
Question 6 Have your views been taken into account in deciding which medication to take?	Inpatient	2	1	0	0	**90%**	No target set. Continues to require a sustained effort. NB - numbers of respondents small*.
	Community	0	0	8	8		
	Total Responses	2	1	8	8		

*A new system of gathering feedback has been introduced to operational services and the PALS officer responsible is offering weekly update on progress to the Director of Engagement and Integration. The aim is to ensure that surveys are appropriately accessible to service users and to encourage more people to participate in the survey thus gain greater reliability of results.

SECTION 3 LEARNING THEMES EMERGING FROM INDIVIDUAL COMPLAINTS		
The Service Experience Team, in partnership with Service Managers, routinely record, report upon and take actions where lessons are learnt from the valuable feedback from complaints, concerns and comments. This table illustrates the lessons learnt from all **individual** complaints and concerns. This includes learning gained when a complaint or concern has not been upheld, partially upheld and not upheld.		
LEARNING	**ACTION REQUIRED**	ASSURANCE of locality/service action
You told us you felt you needed additional support	Clinical teams to offer support to Employment Specialists when advice sought	Significant
You felt let down by the team	Staff to explain the function and role of the services to ensure service users have a clear understanding and realistic expectation of interventions.	Significant
You expressed concerns about the management of a physical condition whilst your relative was an in-patient.	Staff to ensure that information leaflets are available on the ward. Staff to be reminded re: hand hygiene protocols in wound management. Training programme to be reviewed.	Significant
You told us you were unhappy with your diagnosis.	Currently patients with a vascular dementia but no other mental health issues are discharged from the Memory Assessment Service following diagnosis. Service users need to be advised and signposted to alternative services for support on discharge.	Significant
You were unhappy about the police contacting you.	Staff to inform service users that they maybe required to share information without consent if safeguarding concerns are raised. Staff to adhere to the guidance in: • HM government Information sharing (March 2015) - Advice for practitioners providing safeguarding to children, young people, parents and carers. • The seven golden rules to information sharing "you may still share information without consent if, in your judgement, there is good reason to do so, such as where safety may be at risk." • Accurate records of discussions with safeguarding and other agencies need to be recorded in progress notes.The Nursing and Midwifery Council (NMC)2 state "good record-keeping is an integral part of nursing practice and is essential to the provision of safe and effective care".	Significant
You were unhappy about your diagnosis, level of care and discharge arrangements.	Staff to continue to use the CPA process and to be clear about needs that have been met, and those that haven't. CPA to be completed on Rio and discharge summaries should be sent to the service user / family and should identify both met and unmet needs.	Significant

You believe your injection was incorrectly administered	Staff to ensure that they explain planned treatment and provide information leaflets to assist communication whenever they are available	Significant
You complained about the attitude of a member of staff	Staff member to reflect on practice in supervision	Significant
You were unhappy about how your telephone call was managed	Staff have been reminded to provide their name and position when answering the telephone. Trust training has been provided on customer service and managing conflict during telephone communication	Significant
You were unhappy that you were advised that you would only need three months treatment	Staff are reminded to explain when time frames stated are tentative as opposed to definitive.	Significant

AGGREGATED LEARNING THEMES EMERGING FROM COMPLAINTS, CONCERNS, COMMENTS, COMPLIMENTS in Q4 2015/16

Effective dissemination of learning across the organisation is vital to ensure [2]gether's services are responsive to people's needs and that services continue to improve. The table illustrates two points of learning from Service Experience feedback. Localities in partnership with corporate supports are asked to develop actions to ensure that the learning is incorporated into future practice.

Organisational learning	ACTION PLAN [to be sought]
Informing and involving service users in information that is shared with others about them is desirable.	
People value bespoke, clear, jargon-free communication to share information and advice (both written and verbal).	

AGGREGATED LEARNING THEMES EMERGING FROM COMPLAINTS, CONCERNS, COMMENTS, COMPLIMENTS in Q3 2015/16		
Effective dissemination of learning across the organisation is vital to ensure we are responsive to people's needs and that services continue to improve. This table illustrates an aggregation of learning from Service Experience feedback. Localities have provided assurance that actions have been completed from all previous aggregated lessons learnt from experience reports.		
Organisational learning	**Locality Directorate plan**	**Date Assurance provided**
People want their telephone calls to be returned promptly	CYPS - We have addressed this via practice notes to all clinicians and administration staff	March 2016
	GLOUCESTERSHIRE - This will be raised at Locality Forum Meetings to remind staff of the importance of returning calls from service users and their carers. If for any reason the person being called is unable to return the call in a timely manner then they will arrange for a colleague to return the call so the caller receives a response until they are able to do so.	April 2016
	HEREFORDSHIRE - This will be raised in the monthly Team Managers Meeting with a request to remind all staff. Older People's Teams have implemented a new system to ensure calls are recorded and returned more promptly. May 2016	May 2016
People sometimes think that their 2gether health care record does not reflect their views	CYPS - We have addressed this via practice notes to all clinicians and administration staff	March 2016
	GLOUCESTERSHIRE - Triangle of Care is being rolled out across localities to promote carers involvement in care planning and delivery. Where possible recovery principles and care plans are being jointly completed to ensure care plans reflect the individual's views.	April 2016
	HEREFORDSHIRE - This will be raised in the monthly Team Managers Meeting with a request to remind all staff of the importance of reflecting service users views in documentation. June 2016	May 2016
People want 2gether staff to tell them if a student will be taking part in their care.	CYPS - Our delivery committee will ask all clinicians to ensure that they inform Children, Young people and their families if a student is involved in their care.	March 2016
	GLOUCESTERSHIRE - This will be raised at Locality Forum Meetings to ensure clinicians are reminded to obtain permission from service users prior to students being involved in their care.	April 2016
	HEREFORDSHIRE - The Service Director will write to all student mentors reminding them to tell service users if a student will be taking part in their care. May 2016	May 2016

Agenda item 9 **Enclosure** **Paper D**

Report to:	2gether NHS Foundation Trust Board – 26 May 2016
Author:	Gordon Benson, Assistant Director of Governance & Compliance
Presented by:	Marie Crofts, Director of Quality

SUBJECT: **Draft Quality Report for 2015-16**

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

2015-16 Draft Quality Report

- This final draft of the Annual Quality Report summarises the progress made in achieving targets, objectives and initiatives identified, and has been collated following an extensive review of all associated information received from a variety of sources throughout the year.

- The priorities for improvement during 2016-17 have been agreed in consultation with both internal and external stakeholders. These priorities were categorised under the three key dimensions of effectiveness; user experience and safety.

- Final CQUIN payment confirmation has not yet been received but it is hoped that this will be known by 24 May 2016 and included in the final draft which will be tabled. The anticipated amount is included within the report.

- The draft quality priorities were reviewed by the Council of Governors at its meeting on 10 March 2016 and they chose one of the local indicators for our external auditor to audit as part of the external audit process of the Quality Report.

- The draft Quality Report has been shared with commissioners in Herefordshire and Gloucestershire, and also both Healthwatch organisations and the Health and Community Care Overview and Scrutiny Committees (HCOSCs) in the two counties, in order for them to provide formal feedback which is published as part of the final report. At the time of writing written feedback is awaited from Healthwatch Gloucestershire and the HCOSCs in both counties, however, they have until 20 May 2016 to submit responses so any feedback received then will be included in the final draft which will be tabled.

- The Board should note the requirement that External Assurance on the Quality Report (provided by Deloittes) must provide a limited assurance report on the content of Quality Reports produced by Foundation Trusts. In providing this assurance, Deloittes have reviewed the draft report for consistency with the following:

1. Papers relating to the Quality Report reported to the Board over the year;
2. Feedback from commissioners;
3. Feedback from governors;
4. Feedback from Healthwatch organisations;
5. The trust" complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
6. Feedback from other named stakeholder(s) involved in the sign off of the Quality Report;
7. Latest national and local patient survey;
8. Latest national and local staff survey;
9. The Head of Internal Audit "annual opinion over the trust" control environment; and
10. Care Quality Commission quality and risk profiles.

Deloittes have also tested the following mandated indicators:

1. *7 day CPA follow –up after discharge from inpatient services.*
2. *Admissions to inpatient services has access to crisis resolution home treatment teams;*

And the local indicator

3. *To improve personalised discharge planning.*

Deloittes have indicated that they anticipate issuing an unmodified opinion in their public report and have identified a number of recommendations following testing of these indicators. They will issue their report on conclusion which will be received by the Audit Committee at their meeting on 25 May.

- The Quality Report must be included as part of the Trust Annual Report and be submitted to Monitor by 27 May 2016.

RECOMMENDATIONS

The Board is asked to:

1. Note that the Audit Committee will sign off the Quality Report on 25 May 2016.
2. Approve the Quality Report for submission to Monitor and wider publication.

Corporate Considerations	
Quality implications:	By the setting and monitoring of quality targets, the quality of the service we provide will improve.
Resource implications:	Collating the information does have resources implications for those providing the information and putting it into an accessible format
Equalities implications:	This is referenced in the report
Risk implications:	Specific initiatives that are not being achieved are highlighted in the report.

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:		
Marie Crofts, Director of Quality & Performance	Date	17 May 2016

Where in the Trust has this been discussed before?		
Governance Committee	Date	Quarterly
Council of Governors		Quarterly
Trust Board		Quarterly

What consultation has there been?		
Ongoing liaison with internal & external stakeholders, in particular commissioners, Healthwatch organisations & HCOSCs	Date	Quarterly

Explanation of acronyms used:	**HCOSC** = Health and Care Overview and Scrutiny Committee

1. CONTEXT

Every year the Trust is obliged by statute to produce a Quality Report, reporting on activities and targets from the previous year's Account, and setting new objectives for the following year. Guidance regarding the publication of the Quality Report is issued by Monitor (incorporating the Department of Health Guidance for Quality Accounts) and the Quality Report checked for consistency against the defined regulations.

The Board is required to approve the areas for quality improvement in the forthcoming year following the period of consultation with stakeholders, and to approve the content of the Quality Report in its entirety.

2gether
Making life better

2gether
NHS Foundation Trust

Quality Report 2015/16

CONTENTS

Part 1: Statement on Quality from the Chief Executive

Introduction

I am privileged to present, on behalf of the Trust Board and all Trust colleagues, our Quality Report for 2015/16.

As a Trust Board we have set three key strategic priorities for ourselves, the first and most important of which is 'Continuous Quality Improvement'. Only by focussing on continuous improvement can we continue to strive to achieve the quality of services which each of us would wish for a member of our own family. It is also one of the principal ways in which we strive to deliver our overall purpose of Making Life Better for our communities, our service users and carers.

Through this report you will learn how we monitor quality, how we seek to continuously improve quality, our main quality achievements during 2015/16 and what we will focus upon in the coming 12 months.

To summarise, our main quality initiatives this year included:

• measures focussed on improving the physical health of our service users;
• risk reduction (in the form of improving transitions from children's' to adult services, reducing opportunity for detained patients to be absent without leave, suicide prevention activities and improved inpatient discharge planning); and
• improving access to services.

We will continue to focus on many of these again in 2016/17 in recognition that these are all areas which impact greatly on the people we serve. We will also seek to build upon our commitment within 'The Triangle of Care' - supporting colleagues to work with families, including the needs of young carers. As a part of our contribution to a national initiative, we will also look to reduce the number of prone restraints used in our inpatient services, in acknowledgement of the associated potential risks and the distress this can cause.

The quality of services we provide is a continual focus of each and every Trust colleague. This year we were able to look at the quality of services we provide from an additional external perspective when we were subject to a comprehensive inspection by the Care Quality Commission (CQC). Having the CQC comprehensive inspection team with us seemed comparable to showing visitors around your home town - you see things differently.

When we received the inspection report, which rated our Trust as Good overall, we were reassured and recognised ourselves within it – both in the areas where we were found to be outstanding and those areas where we need to further improve.

We were pleased to note the many examples of good practice and care we are providing, and the fact that we were the first Trust in the country to be awarded an 'Outstanding' rating for crisis and place of safety services, and our adult acute inpatient and psychiatric intensive care services. This is entirely due to the talented, committed and caring staff we employ as well as the collaboration and support of our commissioners and partners. Where improvements were suggested or recommended we took steps to either make those improvements immediately or set in place the mechanisms for sustainable improvements to be made in the near future.

CQC inspections provide additional focus and raise the profile of quality, however continued openness and transparency on quality is of paramount importance to our Trust. We openly discuss quality through our Trust Board meetings and when our Council of Governors meet. Both of these gatherings are held in public and, wherever we can appropriately do so, we share details of these discussions publicly on our website. We also invite regular feedback and discussion from our service users and carers, as well as the communities we serve, through regular events and a wide range of

other methods. Full details of the feedback we receive and how we use that feedback in a continuous cycle of improvement is contained within this report.

The content of this report has been reviewed by the people who pay for our services (our commissioners), the Health and Care Scrutiny Committees of our local authorities and Healthwatch. Their views on this report are included on page 54. The report is also subject to review by our external auditor.

In preparing our Quality Report, we have used 'best endeavours' to ensure that the information presented is accurate and provides a fair reflection of our performance during the year. The Trust is not responsible, and does not have direct control for all of the systems from which the information is derived and collated. The provision of information by third parties introduces the possibility that there is some degree of error in our performance, although we have taken all reasonable steps to verify and validate such information. As Chief Executive, I confirm that to the best of my knowledge the information within this document is accurate.

On behalf of our services, I am proud to present the achievements contained within this report and determined to work with my colleagues, our Board, Governors, communities and partners to continue to Make Life Better with continued quality improvement throughout 2016/17.

Shaun Clee
Chief Executive
[2]gether NHS Foundation Trust

Part 2a: Looking ahead to 2016/17

Quality Priorities for Improvement 2016/17

This section of the report looks ahead to our priorities for quality improvement in 2016/17. We have developed our quality priorities under the three key dimensions of **effectiveness, user experience and safety** and these have been approved by the Trust Board following discussions with our key stakeholders.

Following feedback from service users, carers and staff, our Governors and commissioners as well as Herefordshire and Gloucestershire Healthwatch, we have identified **7** goals and **11** associated targets for 2016/17. These targets will be measured and monitored through reporting to the Trust Governance Committee with the period of time varying from monthly, quarterly or annually dependent upon what we measure and the frequency of data collection.

How we prioritised our quality improvement initiatives

The quality improvements in each area were chosen by considering the requirements and recommendations from the following sources:

Documents and organisations:

- Our 2016/17 Business Plan: The NHS England Business Plan 2016-2017;
- The Government's mandate to NHS England for 2016-17;
- Care Quality Commission (via Intelligent Monitoring Reports and CQC Comprehensive Inspection at our sites in October 2015);
- NHS Outcomes Framework 2016-17;
- Department of Health, with specific reference to 'No health, without mental health' (2011) and 'Mental health: priorities for change (January 2014);
- Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing. Department of Health 2015;
- Internal assurance inspections;
- Monitor;
- King's Fund report on Quality Accounts;
- National Institute for Health & Care Excellence publications including their quality standards;
- Preventing suicide in England: two years on. Second annual report on the cross-government outcomes strategy to save lives. Department of Health 2015;
- National Confidential Inquiry into Suicide & Homicide by People with Mental Illness: Annual Report July 2015.

The feedback and contributions have come from:

- Healthwatch Gloucestershire;
- Healthwatch Herefordshire;
- Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC) and Council colleagues;
- Herefordshire Overview and Scrutiny Committee and Council colleagues;
- Gloucestershire Clinical Commissioning Group;
- Herefordshire Clinical Commissioning Group;
- Internal assurance and Internal Audit reports;
- NHS South of England Mental Health Patient Safety Improvement Programme;
- Trust's Governors;
- Trust clinicians and managers.

Effectiveness

Goal	Target	Drivers
Improving the physical health care for people with serious mental illness.	1.1 To increase the number of service users (all inpatients and all Serious Mental Illness/Care Programme Approach service users in the community, inclusive of Early Intervention Service, Assertive Outreach and Recovery) with a LESTER tool intervention (a specialist cardio metabolic assessment tool) alongside increased access to physical health treatment**.**	To support NHS England's commitment to reduce the 15-20 year premature mortality in people with psychosis and improve their safety through improved assessment, treatment and communication between clinicians. We wish to continue to improve the physical health for those people in contact with our services. There is historical data available for year on year comparison.
Ensure that people are discharged from hospital with personalised care plans.	1.2 To further improve personalised discharge care planning in adult and older peoples wards, including the provision of discharge information to primary care services within 24hrs of discharge.	This was CQUIN for our Herefordshire services in 2015/16, but equally applicable to Gloucestershire services. We wish to continue to support this as a key quality priority during 2016/17 to ensure effective discharge from our inpatient services. There is historical data available for year on year comparison.
Improve transition processes for child and young people who move into adult mental health services.	1.3 To ensure that joint Care Programme Approach reviews occur for all service users who make the transition from children's to adult services.	We wish to build on previous years CQUINs to further improve our transition processes.

User Experience

Goal	Target	Drivers
Improving the experience of service user in key areas. This will be measure though defined survey questions for both people in the community and inpatients.	2.1 Were you involved as much as you wanted to be in agreeing what care you will receive? > 78% **Target :** To achieve a response 'Yes' for more than **78%** of the people surveyed. 2015 Local survey score = 78%	Questions 2.2 – 2.4 are areas relating to patient experience where we wish to improve following the 2015 Care Quality Commission (CQC) national community mental health survey results.
	2.2 Were you involved as much as you wanted to be in decisions about which medicines to take? > 73% **Target :** To achieve a response 'Yes' for more than **73%** of the people surveyed. 2015 Trust score = 73%	
	2.3 Do you know who to contact out of office hours if you have a crisis? >71% **Target :** To achieve a response of 'Yes' for more than **71%** of the people surveyed. 2015 Trust score = 71%	
	2.4 Has someone given you advice about taking part in activities that are important to you? > 48% **Target :** To achieve a response of 'Yes' for more than **48%** of the people surveyed. 2015 Trust score = 48%	

Safety

Goal	Target	Drivers
Minimise the risk of suicide of people who use our services.	3.1 Reduce the numbers of deaths by suicide (pending inquest) of people in contact with services when comparing data from previous years. During 2015/16 reported **24** deaths from suspected suicide which is higher than the previous 2 years, therefore we aim to reduce the number of deaths from suicide in 2016/17.	Gloucestershire Suicide Prevention Strategy and Action Plan Preventing suicide in England: Two years on. First annual report on the cross-government outcomes strategy to save lives. It is a high risk area with historical data available for year on year comparison.
Ensure the safety of people detained under the Mental Health Act.	3.2 Reduce the number of detained patients who are absent without leave (AWOL) when comparing data from previous years. We will report against 3 categories of AWOL as follows: 1. Absconded from escort 2. Failure to return from leave 3. Left the hospital (escaped) There were **125** total reported occurrences during 2014/15 and our target was to report fewer than 110 occurrences. During 2015/16 we reported **114** incidents and met the overall target but saw an increase of **9** incidents where service users left the hospital.	NHS South of England Patient Safety Improvement Programme It is a high risk area with historical data available for year on year comparison.
Minimise the risk of harm to service users within our inpatient services when we need to use physical interventions	3.3 To reduce the number of prone restraints by 5% year on year (on all adult wards & PICU) based on 2015/16 data. During 2015/16 we reported **127** such incidents.	Positive and safe: reducing the need for restrictive interventions. April 2014 There is historical data available for year on year comparison.
Ensure we follow people up when they leave our inpatient units within 48 hours to reduce risk of harm.	3.4 **95%** of adults will be followed up by our services within 48 hours of discharge from psychiatric inpatient care. (This is a local target. The national target is that 95% CPA service users receive follow up within 7 days).	During 2014/15 this percentage was **94%** and this reduced to **90**% in 2015/16. There is historical data available for year on year comparison.

Part 2b: Statements relating to the Quality of NHS Services Provided

The purpose of this section of the report is to ensure we have considered the quality of care across all our services which we undertake through comprehensive reports on all services to the Governance Committee (a sub-committee of the Board).

During 2015/2016, the [2]gether NHS Foundation Trust provided and/or sub-contracted the following NHS services:

Gloucestershire
Our services are delivered through multidisciplinary and specialist teams. They are:

- One stop teams providing care to adults with mental health problems and those with a learning disability;
- Intermediate Care Mental Health Services (Primary Mental Health Services & Improving Access to Psychological Therapies);
- Specialist services including Early Intervention, Crisis Resolution and Home Treatment, Assertive Outreach, Managing Memory, Children and Young People Services; Intensive Health Outcome Team and the Learning Disability Intensive Support Service;
- Inpatient care.

Herefordshire
We provide a comprehensive range of integrated mental health and social care services across the county. Our services include:

- Providing care to adults with mental health problems in Primary Care Mental Health Teams, Recovery Teams and Older People's Teams;
- Children and Adolescent Mental Health care;
- Specialist services including Early Intervention, Assertive Outreach and Crisis Resolution and Home Treatment and Substance Misuse Services (Until December 2015);
- Inpatient care;
- Community Learning Disability Services;
- Improving Access to Psychological Therapies.

The [2]gether NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these NHS services through a systematic plan of quality reporting and assurance that is considered by the Trust's Governance Committee and the Board.

The income generated by the NHS services reviewed in 2015/16 represents 94.5% of the total income generated from the provision of NHS services by the [2]gether NHS Foundation Trust for 2015/16.

Participation in Clinical Audits and National Confidential Enquiries

During 2015/16 two national clinical audits and three national confidential enquiries covered NHS services that [2]gether NHS Foundation Trust provides.

During that period**,** [2]gether NHS Foundation Trust participated in 50% national clinical audits and 100% of confidential enquiries of the national clinical audits and national confidential enquiries which we were eligible to participate in.

The national clinical audits and national confidential enquiries that [2]gether NHS Foundation Trust was eligible and participated in during 2015/16 are as follows:

National Clinical Audits

Clinical Audits	Participated Yes/No	Reason for no participation
Prescribing Observatory for Mental Health	No	The Trust is not a member of the Observatory.
Early Intervention in Psychosis audit	Yes	N/A

National Confidential Enquiries

National Confidential Enquiries	Participated Yes/No	Reason for no participation
Confidential Enquiry into Maternal and Child Health	Yes	N/A
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	Yes	N/A
Sudden Unexplained Death Study	Yes	N/A

The national clinical audits and national confidential enquiries that [2]gether NHS Foundation Trust participated in, and for which data collection was completed during 2015/2016 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Topic	Trust Participation		National Participation	
	Teams	Submissions	Teams	Submissions
Early Intervention in Psychosis	Early Intervention Service	Information not available*	Information not available*	Information not available*

*This information has not been provided by the Royal College of Psychiatrists

The report of 1 national clinical audit was reviewed in 2015/16 and [2]gether NHS Foundation Trust intends to take the following action to improve the quality of healthcare provided.

- Continued focus on the physical health of people diagnosed with schizophrenia via Target 1.1 2016/17 -to increase the number of service users with a LESTER tool alongside increased access to physical health treatment**.**

Participation in National Confidential Enquiries

Confidential Enquiries	% cases submitted	
	[2]gether	National Average
Confidential Enquiry into Maternal and Child Health	Information not published	Information Unavailable
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	98%	98%
Sudden Unexplained Death Study	Information unavailable	Information unavailable

Local Clinical Audit Activity

Within our services there is a high level of clinical participation in local clinical audits, demonstrating our commitment to quality across the organisation. All clinically led local audits are reported to the Governance Committee in summary form to ensure that actions are taken forward and learning is shared widely. The table below show the status of the audit plan at the end of the year. During this process we internally identified **375** recommendations to further improve our practice as part of our commitment to continuous improvement.

Clinical Audits	2014/15 audit programme	2015/16 audit programme
Total number of audits on the audit programme	122	168
Audits completed (at year end)	67	75
Audits that are progressing and will carry forward	30	49
Audits taken off the programme for specific reasons	25	44

The reports of **75** local clinical audits were reviewed by the provider in 2015/16 and ^{2}gether NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Building on the review of key clinical policies ***Assessment and Care Management CPA*** and ***Assessing and Managing Clinical Risk and Safety*** undertaken in 2013/ 2014, the Trust has now implemented and embedded these principles into polices and practice. There have been a number of audits carried out throughout the year to evidence improvements made and actions plan were developed to support improvements in compliance throughout the year. This action continues from last year;

- The Trust has continued to review and develop its training programme to all staff (clinical and non-clinical) in line with the learning that is established from the clinical audit programme. This has, and will continue, to drive the constant review and evaluation of training modules and their contents. This action also continues from last year.

Specific examples of change in practice that have resulted from clinical audits are:

- Following a Quality Improvement Project on inpatient wards in Gloucestershire, a re-audit of Capacity and Consent to Hospital Admission found significant improvement in documentation of capacity and consent for admission and treatment in Gloucestershire. Following the audit a number of further steps have been taken to improve recording of Capacity and Consent. To support implementation of the Trust wide Mental Capacity Act (MCA) policy, there is also MCA page on intranet with associated links to documents. A Mental Health Legislation Mandatory Read briefing document was posted on the intranet in November 2015 which includes guidance on the use of the MCA. Discussions have been held with the MCA Lead in Herefordshire to discuss what has worked well in Gloucestershire to help improve practice in Herefordshire;

- Following completion of a re-audit on NICE TA98 Methylphenidate, atomoxetine and dexamfetamine for attention deficit hyperactivity disorder (ADHD) in children and adolescents & CG72 Attention deficit hyperactivity disorder – Diagnosis and management of ADHD in children, young people and adults it was identified that there were areas of concern around record keeping/documentation and dual diagnosis. To address these concerns, four recommendations were made in the action plan to develop an ADHD referral pathway. Review of RiO documentation to adapt questionnaires and charts for blood pressure, pulse, weight, height and side effect profile. To devise ADHD checklist/proforma to go onto RiO and to provide a series of training programme on ADHD in Children and adolescent with Intellectual disability disorders.

Internal peer review assurance visits:

- The Trust has undertaken **14** peer review assurance visits during 2015/16 covering both community and inpatient services. During this process a number of team specific recommendations were made and individual services have developed agreed Specific, Measurable, Achievable, Realistic and Time Limited (SMART) action plans to address these recommendations.

Participation in Clinical Research

Research Activity in 2gether in 2015-16

The number of patients receiving relevant health services provided or subcontracted by 2gether NHS Foundation Trust in 2015/2016 that were recruited during that period to participate in research approved by a research ethics committee **275**.

This participation was from across **21** different studies[1] . This level of recruitment is less than the previous year's total of **482** participants. The difference was due to 2gether's involvement in a 2014/15 study which had an unusually large response[2]

In 2015/16, the Trust registered and approved **32** studies. Of these studies, **13** were based in mental health or dementia services. The remaining studies were made up from local, commercial (as a patient identification centre / PIC) or student studies. We currently have **5** service evaluation, and **11** educational research projects initiated and co-ordinated by Trust staff or students.

Leadership for 2gether's Research portfolio

Our dedicated team consists of the Head of Research and Development, two Research Nurse Practitioners and one Assistant Research Practitioner, working across mental health and dementia services in both Gloucestershire and Herefordshire. 2gether continues to offer clinical leadership at the West of England Clinical Research Network (WoE CRN) for the speciality of dementia. This year we were also delighted to welcome an Honorary Professorial Consultant Physician and Principle Investigator to the team who brings a wealth of experience in dementia research and leadership.

The Trust is pleased to be a member of the Gloucestershire Research and Development Consortium. We continue to work strategically with our Gloucestershire Health Community partners, and co-commission support from the skilled research specialists based at Gloucester Hospitals NHS Foundation Trust.

Seeking new research opportunities

The availability of research through the National Institute of Health Research (NIHR) and local portfolios fluctuated throughout 2015/16. The Research Team regularly scan the national portfolio for new studies that are open to new sites and proactively make contact with study teams. Currently we have **21** approved NIHR studies recruiting or active in Gloucestershire, an increase on the **13** open at this time last year. We continue to develop a rolling programme of studies open across the range of our services.

2gether is not currently recruiting to any commercial-sponsored research projects, and this has been identified as an area for development

Research 2gether strategy

In January 2016, the Trust Board approved our Research 2gether Strategy 2016 – 2020. This co-developed document outlines our bold vision to be a world class centre of practice-based research and development to help make life better. The strategy focuses on the Research 2gether values of people, partnerships, innovation and leadership, and features a number of work streams that include

[1] Data reported by the West of England Comprehensive Research Network, WoE CRN, from 1 April 2015 to 14 March 2016)
[2] The Viewpoint survey was about national attitudes to mental illness and accounted for nearly 60% of the total research recruitment for 2014/15).

strengthening internal and external partnerships, developing clinical research leadership, and finding creative and innovative ways to increase research opportunities for and with service users and carers.

A Research Centre for [2]gether's practice based research
During the year we have been developing a clinical trials facility at The Fritchie Centre, on our Charlton Lane Centre site in Cheltenham. This purpose built centre provides us with high quality facilities that will enable us to host clinical trials, making us an attractive prospect for partnership work in research and to commercial sponsors looking to host studies.

Future Developments
The National Institute of Health Research has been re-organised into streamlined clinical research networks. 2gether is represented at the regional forum (WoE CRN) by our Head of Research and Development who is also, responsible for leading the implementation of the Trust's Research Strategy Action Plan.

Nationally, there appears to be a reduction in studies investigating mental health practice and an increase in the number of dementia related studies. We are pursuing ways to influence partnerships with the academic establishments where research is designed to ensure that research reflects the future needs of clinical services.

Research Studies
Examples of the portfolio of activity for 2016/17 are listed below.

Mental Health
- SCIMITAR - Smoking Cessation Intervention for Severe Mental Ill Health Trial: a definitive randomised evaluation of a bespoke smoking cessation service;
- The MILESTONE Study: Improving Transition from Child to Adult Mental Health Care;
- QUEST - Quality and Effectiveness of Supported Tenancies (QuEST);
- LonDownS - The London Down Syndrome Consortium (LonDownS): an integrated study of cognition and risk for Alzheimer's Disease in Down Syndrome;
- Autism Cohort UK – Learning about the lives of adults on the autistic spectrum;
- PPiP – Prevalence of neuronal cell surface antibodies in patients with psychotic illness;
- DPIM Polymorphisms in Mental Illness: investigating genetic factors involved in schizophrenia, bipolar disorder, alcoholism and autism and exploring possible treatment options.

Dementias and Neurodegenerative Disease
- DAPA – Dementia and Physical Activity research programme;
- VALID - Valuing Active Life in Dementia: a randomised controlled trial of Community Occupational Therapy in Dementia (COTiD-UK);
- IDEAL: Improving the experience of dementia and enhancing active life; the IDEAL longitudinal research study;
- MADE: Minocycline in Alzheimer's Disease Efficacy, a clinical trial;
- MAS: Using Patient Reported Outcome Measures (PROMs) to Improve Dementia Services: Evaluation of Memory Assessment Services.

Use of the Commissioning for Quality & Innovation (CQUIN) framework

A proportion of [2]gether NHS Foundation Trust's income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between [2]gether NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed CQUIN goals for 2015/16 are available electronically at *http://www.2gether.nhs.uk/cquin*

2015/16 CQUIN Goals

Gloucestershire

Gloucestershire Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
Acute Kidney Injury	AKI is a sudden reduction in kidney function. It is not a physical injury to the kidney and usually occurs without symptoms. In England over half a million people sustain AKI every year with AKI affecting 5-15% of all hospital admissions. As well as being common, AKI is harmful and often preventable, thus representing a major patient safety challenge for health care. This CQUIN is concerned with demonstrating that 90% of patients have Early Warning Scores (EWS) within 12 hours of admission to Charlton Lane Hospital.	.10	£66160	Safety
Improving Physical Healthcare	The purpose of this CQUIN is twofold. Firstly, to improve the physical health of service users who are classed as having a severe mental illness (SMI) receiving high levels of support. Secondly, to improve the flow of useful clinical information between secondary and primary care.	.35	£231560	Effectiveness
Delirium Screening	Delirium is linked to dementia and frailty; it can be an unrecognised factor in a change or deterioration of a patient with dementia with significant impact upon their physical and mental health. This CQUIN monitors the development, and use of a delirium screening and assessment tool.	.30	£198480	Effectiveness

Triangle of Care	This CQUIN monitors the implementation of the six standards identified in the Triangle of Care best practice guide to achieve better collaboration and partnership with carers. The six key standards are: 1. Carers and the essential role they play are identified at first contact or as soon as possible thereafter. 2. Staff are 'carer aware' and are trained in carer engagement strategies. 3. Policy and practice protocols regarding confidentiality and sharing information are in place. 4. Defined posts responsible for carers are in place. 5. A carer introduction to the service and staff is available, with a relevant range of information across the care pathway. 6. A range of carer support services are available.	.20	£132320	User experience
Young Peoples Transitions	This CQUIN will improve outcomes in young people transitioning from ^{2}gether Young People's Services to Adult Mental Health Services.	.80	£529277	Effectiveness
Perinatal Mental Health	This CQUIN will focus on quality improvement across the perinatal mental health pathway to promote integration, knowledge and skills of staff and improve outcomes for women and families.	.75	£496200	Effectiveness

Herefordshire

Herefordshire Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
Improving Physical Healthcare	The purpose of this CQUIN is twofold. Firstly, to improve the physical health of service users who are classed as having a severe mental illness (SMI) receiving high levels of support. Secondly, to improve the flow of useful clinical information between secondary and primary care.	.25	£40900	Effectiveness
Personality Disorder	This CQUIN is concerned with demonstrating that improvements have been made to services for people with personality disorders by ensuring service delivery which is consistent with regional strategy.	1.0	£163600	User Experience
Crisis Contingency Planning	This CQUIN is concerned with preventing patients from having a relapse and encouraging service users to maintain their mental health at home by having a personalised crisis contingency plan.	.25	£40900	Effectiveness
Inpatient Discharge Planning	This CQUIN is about developing patient centred discharge care plans (based on a self-management recovery outcome approach) for use at the point of discharge from inpatients admissions.	.25	£40900	Effectiveness
IAPT Vulnerable Service Users	This CQUIN is about assessing ease of access for vulnerable service users and assessing the service user's experiences once it has been successfully accessed.	.75	£122700	Effectiveness

Low Secure Services

Low Secure Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
Improving Physical Healthcare	The purpose of this CQUIN is twofold. Firstly, to improve the physical health of service users who are classed as having a severe mental illness (SMI) receiving high levels of support. Secondly, to improve the flow of useful clinical information between secondary and primary care.	.25	£4500	Effectiveness
Mental Health Carer Involvement Strategies	This CQUIN continues the theme of the Carer Involvement Strategies developed during 2014/15 and requires providers to evaluate the effectiveness of the strategies.	.25	£4500	User Experience
Collaborative Risk Assessments	This CQUIN requires the provision of an education and training package for patients and qualified staff around collaborative risk assessment and management.	1	£18000	User Experience
Smoking Cessation	This CQUIN focuses on supporting service users in secure services to stop smoking.	1	£18000	Safety

The total potential value of the income conditional on reaching the targets within the CQUINs during 2015/16 is £2,107,995 of which we anticipate £2,107,153 will be achieved.

In 2014/15, the total potential value of the income conditional on reaching the targets within the CQUINs was £2,056,500 of which £2,053,407 was achieved.

2016/17 CQUIN Goals

CQUIN goals for 2016/17 have been drafted with Gloucestershire and Herefordshire Clinical Commissioning Groups and NHS England (for the provision of low secure mental health NHS services). These include:

National CQUINs applicable to Herefordshire mental health services

- Staff health and wellbeing;
- Physical health care.

Gloucestershire (Local)

- Young people's transitions;
- Perinatal mental health;

Herefordshire (Local)

- Crisis contingency planning for Early Intervention and Assertive Outreach services;
- Crisis contingency planning for Child and Adolescent Mental Health Services;
- Frequent attenders at Emergency Department.

Low Secure

- Length of stay.

Statements from the Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. From April 2010, all NHS trusts have been legally required to register with the CQC. Registration is the licence to operate and to be registered, providers must, by law, demonstrate compliance with the requirements of the CQC (Registration) Regulations 2009.

[2]gether NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is to provide the following regulated activities:

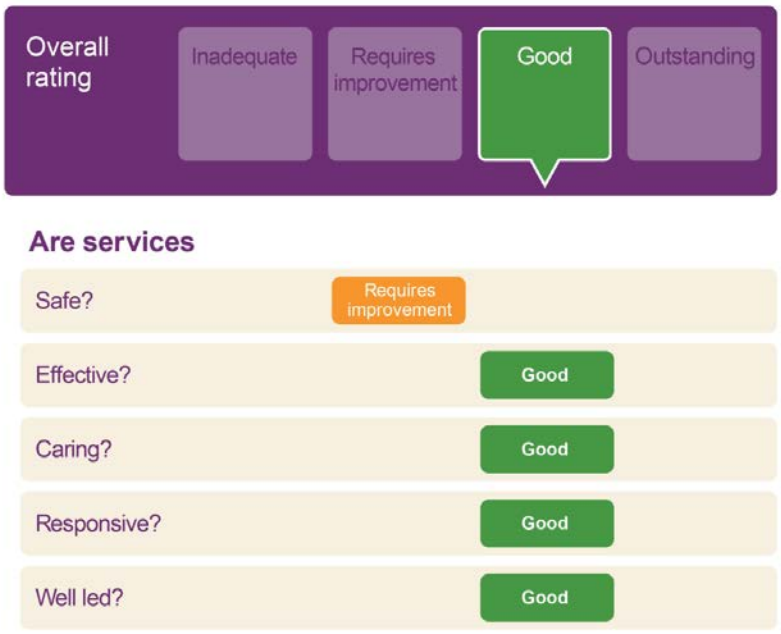
- Assessment or medical treatment to persons detained under the Mental Health act 1983;
- Diagnostic and screening procedures;
- Treatment of disease, disorder or injury.

[2]gether NHS Foundation Trust has no conditions on its registration.

The CQC has not taken enforcement action against [2]gether NHS Foundation during 2015/16 or the previous year 2014/15.

CQC Inspections of our services

[2]gether NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2015/16. The Care Quality Commission undertook a planned comprehensive inspection of the Trust week commencing 26 October 2015 and published its findings on 28 January 2016. The CQC rated our services as GOOD, rating **2** of the **10** core services as "outstanding" overall and **6** "good" overall.



The inspection found that there were some aspects of care and treatment in some services that needed improvements to be made to ensure patients were kept safe. However, the vast majority of services were delivering effective care and treatment.

	Safe	Effective	Caring	Responsive	Well led	Overall
Community-based mental health services for older people	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Long stay/rehabilitation mental health wards for working age adults	Requires improvement	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Requires improvement	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Requires improvement	Good	Good	Good	Good	Good
Specialist community mental health services for children and young people	Good	Good	Good	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Outstanding ☆	Good	Good	Good	Outstanding ☆	Outstanding ☆
Wards for people with learning disabilities or autism	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Mental health crisis services and health-based places of safety	Good	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆
Forensic inpatient/secure wards	Good	Good	Good	Good	Good	Good
Community mental health services for people with learning disabilities or autism	Good	Good	Good	Good	Requires improvement	Good

A full copy of the Comprehensive Inspection Report can be seen here.

[2]gether NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

- The Trust has developed an action plan in response to the **15** "must do" recommendations, and the **58** "should do" recommendations identified by the inspection.

[2]gether NHS Foundation Trust has made the following progress by 31st March 2016 in taking such action:

- Setting up a Project Group to manage all actions through to their conclusion.

Changes in service registration with Care Quality Commission for 2015/16

There have been no requests to change our registration with the CQC this year.

Quality of Data

Statement on relevance of Data Quality and actions to improve Data Quality

Good quality data underpins the effective provision of care and treatment and is essential to enabling improvements in care. [2]gether NHS Foundation Trust submitted records during 2015/16 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data (Month 11 data is reported below, as this was the only available information at the date of publication).

- The patient's valid NHS number was: **99%** for admitted patient care (**99.2%** national); and **99.4**% for outpatient care (**99.4**% national);

- The patient's valid General Practitioner Registration Code was: **100%** for admitted patient care (**99.9%** national); and **100%** for outpatient care (**99.8%** national).

[2]gether NHS Foundation Trust has taken the following action to improve data quality building on its existing clinical data quality arrangements:

- During 2015/16 the Trust has continued to progress data quality improvement. Based on the work undertaken in previous years to provide automated reports, we have introduced a new early warning report for Senior Managers so they are alerted to any identified gaps;

- A successful series of "Masterclasses" have taken place across all areas of the Trust. These have focused on educating staff on how to enter the right data, at the right time and how to effectively manage data quality through the use and interpretation of data that is available to them;

- As a result of the Masterclass series, a review of the current data quality systems was initiated. This has led to the design of a more intuitive "Team Sites" platform that aims to bring many data sources together into one place to help teams manage their individual and team data quality more effectively. This was trialed during Quarter Four and will be rolled out to all teams throughout 2016/17.

Information Governance Toolkit

Ensuring that patient data is held securely is essential, as such the Trust complies with the NHS requirements on Information Governance and assesses itself annually against the national standards set out in the Information Governance Toolkit which is available on the Health & Social Care Information Centre website:

http://systems.hscic.gov.uk/infogov

[2]gether NHS Foundation Trust Information Governance Assessment Report overall score for 2015/16 was **84%** and was graded green. This is the same as in 2014/15

The Toolkit has been the focus of regular review throughout the year by the Information Governance and Health Records Committee, and the Information Governance Advisory Committee. In this year's assessment of **45** key indicators:

- **23** key indicators were at level **3**;
- **21** key indicators were at level **2**;
- **1** key indicator was deemed not relevant.

The Toolkit has been the subject of an audit by the Trust's Internal Auditor, which produced a classification of low risk.

The Trust's efforts will remain focussed on maintaining the current level of compliance during 2016/17 and ensuring that the relevant evidence is up to date and reflective of best practice as currently understood, and that good information governance is promoted and embedded in the Trust through the work of the Information Governance and Health Records Committee, the IG Advisory Committee and Trust managers and staff.

Clinical Coding Error Rate

[2]gether NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2015/2016 by the Audit Commission.

Part 3: Looking Back: A Review of Quality during 2015/16

Introduction

The 2015/16 quality priorities were agreed in May 2015 and published in last year's Quality Report, and can be accessed through the following link:

http://www.2gether.nhs.uk/files/Quality%20Report_2014_15.pdf

The quality priorities were grouped under the three areas of Effectiveness, User Experience and Safety.

The table below provides a summary of our progress against these individual priorities. Each are subsequently explained in more detail throughout Part 3.

Summary Report on Quality Measures for 2015/2016

		2014 - 2015	2015 - 2016
Effectiveness			
1.1	To increase the number of service users (all inpatients and all SMI/CPA service users in the community, inclusive of Early Intervention Service, Assertive Outreach and Recovery) with a LESTER tool intervention (a specialist cardio metabolic assessment tool) alongside increased access to physical health treatment**.**	-	**Achieved**
1.2	To improve personalised discharge care planning in: a) Adult inpatient wards and; b) Older people's wards.	-	**Achieved**
1.3	To increase the number of vulnerable people who are able to access the IAPT service "Let's Talk" (Improving Access to Psychological Therapies).		**Achieved**
1.4	To develop a measureable data set to improve the experience of service users who make the transition from children and young people's services to adult services.	-	**Achieved**
User Experience			
2.1	Have you been offered a written or printed copy of your care plan? >72.5%	**72.5%**	**71%**
2.2	Do the people you see through NHS mental health services help you feel hopeful about the things that are important to you? >65%	**65%**	**86%**
2.3	In the last 12 months, did NHS mental health services give you any help or advice with finding support for physical health needs? >58%	**58%**	**79%**
2.4	Have you been given advice about taking part in local activities? >51%	**51%**	**81%**
Safety			
3.1	Reduce the numbers of deaths by suicide (pending inquest) of people in contact with services when comparing data from previous years.	**20**	**24**
3.2	Reduce the number of detained patients who are absent without leave (AWOL) when comparing data from previous years. Reported against 3 categories of AWOL as follows: 1. Absconded from an escort 2. Did not return from leave 3. Absconded from a ward	**27** **30** **69** **126 total**	**13** **23** **78** **114 total**
3.3	**95%** of adults will be followed up by our services within 48 hours of discharge from psychiatric inpatient care.	**94%**	**90%**

Effectiveness

In 2015/16 we remained committed to ensure that our services are as effective as possible for the people that we support. We set ourselves 4 targets against the goals of:

- Improving the physical health care for people with schizophrenia and other serious mental illnesses;
- Ensuring that people are discharged from hospital with personalised care plans;
- Ensuring appropriate access to psychological therapy;
- Improving transition processes for child and young people who move into adult mental health services.

Target 1.1 To increase the number of service users (all inpatients and all SMI/CPA service users in the community, inclusive of Early Intervention Service, Assertive Outreach and Recovery) with a LESTER tool intervention (a specialist cardio metabolic assessment tool) alongside increased access to physical health treatment

There is a long established association between physical comorbidity (the presence of multiple illnesses) and mental ill health. People with severe and enduring mental health conditions experience reduced life expectancy compared to the general population. People with Schizophrenia and Bipolar disorder die on average, 20 to 25 years earlier than the general population, largely because of physical health problems. These include coronary heart disease, diabetes, respiratory disease, greater levels of obesity and metabolic syndrome.

In 2014/15 the Trust introduced the LESTER screening tool within the inpatient services, as part of the National Physical Health Commissioning for Quality and Innovation (CQUIN) payment framework. The LESTER tool is a way of identifying service users at risk of cardiovascular disease and to implement interventions to reduce any risk factors identified. Specific areas covered in the tool are, diabetes, high cholesterol, high blood pressure, increased body mass index, smoking, diet and exercise levels, and substance and alcohol misuse. The Trust was also involved in the NHS Improving Quality, as a national physical health pilot site. This was a 2 year project which focused on improving physical health outcomes for service users.

As part of the project the Trust submitted an audit of 100 patients to the College Centre for Quality Improvement. Results demonstrated that improvements were required for collecting blood lipids and blood glucose screening as part of delivery of the LESTER tool.

Figure 1 overleaf demonstrates continued improvements in these areas over the last 2 years, with small improvement in the areas already well screened.

In 2015/16 the National Physical Health CQUIN was repeated within the inpatient services and has been extended to include the Early Intervention teams, in Herefordshire and Gloucestershire. The inpatient services have been externally evaluated by the Royal College of Psychiatrists, based upon a sample of 100 patients who spent time as an inpatient within our Trust between the 1 August 2015 and 30 September 2015. This data was submitted in November 2015 and is being reviewed by the Royal College of Psychiatrists.

An audit of our Early Intervention teams has been undertaken in Quarter 4 and included all service users accepted onto the team caseload, as well as patients who have a Care Programme Approach review within the audit period. The data will be submitted to the Clinical Commissioning Group to be assessed locally.

Figure 1 Lester Tool Screening progress to date

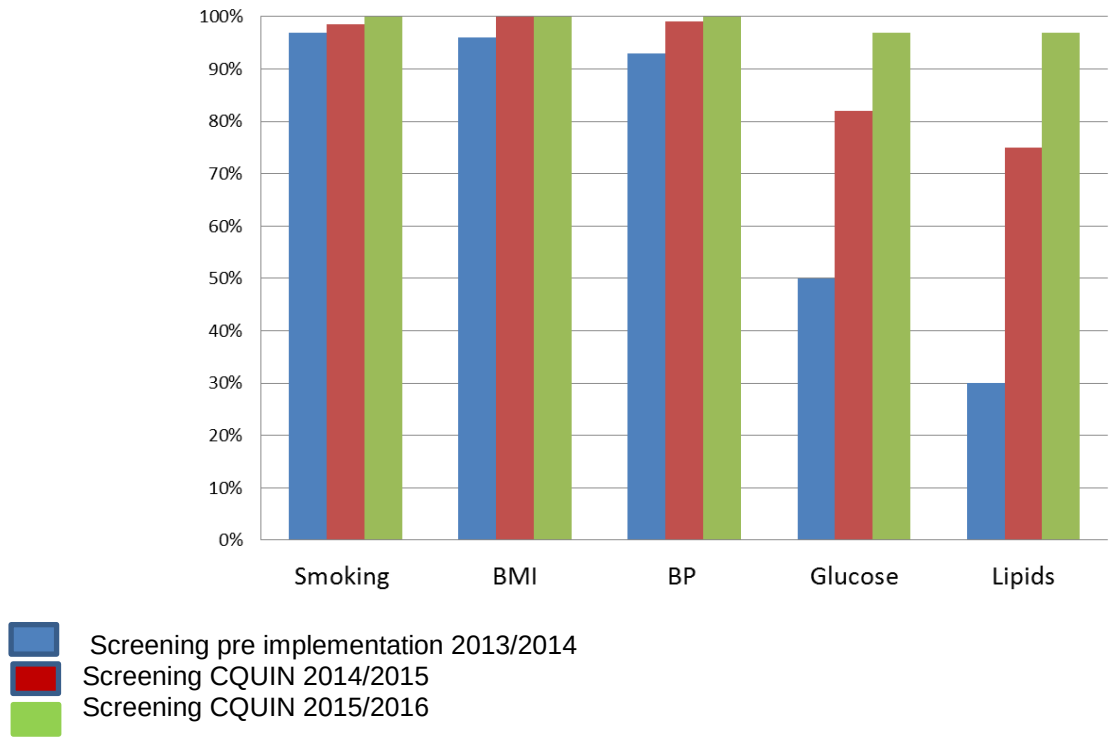


Figure 1

In order to support this work a training programme for all inpatient areas and including the Early Intervention teams has been undertaken by the Physical Health Facilitator. This has been ward-based using a cascade methodology upon the needs of the ward areas. The training department have designed a one day Physical Health course, designed to increase staff awareness of coronary heart disease, chronic obstructive pulmonary disease and diabetes and how these relate to the Lester Tool.

The LESTER tool is now embedded within the doctors Induction Programme. The training focuses on the role of the medical teams to support the LESTER tool.

All teams currently working with the LESTER tool have an allocated 'lead' professional who receives regular feedback regarding progress in implementing the LESTER tool. The ward lead professionals have played a key role in ensuring any advice is acted upon.

The National Physical Health CQUIN has only applied to service users with a diagnosis of psychosis. Within our inpatient services in order to widen the group of service users who receive the LESTER tool screening, all categories of the LESTER tool have been embedded within a nursing tool known as the Essence of Care. This tool is completed for all service users within 72hrs of admission. The Essence of Care guides the clinician to identify 'high risk' areas, and then prompts clinician's to use the LESTER tool care plan interventions. Junior doctors' work with the nursing staff to open LESTER care plans if the service user is screened as high risk and to consider if a referral needs to be made to a specialist or GP.

The Physical Health Policy has been reviewed to include the LESTER tool. The policy aims to identify roles and responsibilities of each professional. A minimum standard introduced for all service users being offered Blood Glucose and Lipids screening on admission to inpatient services.

Working with community teams is ongoing. One of the Assertive Outreach Teams (AOT) have designed their own tools (based on the LESTER tool), utilising the skills of the Health and Exercise practitioner to provide lifestyle interventions. It is anticipated to roll out the learning from this AOT team to the other AOT teams across the Trust in time.

As part of the NHS Improving Quality pilot site project work which identified that screening for blood glucose and cholesterol needed to be improved. The Trust has worked with the Clinical Skills Department at Gloucester Royal Hospital to facilitate venepuncture training for wards and teams.

Within Recovery Teams, current caseload sizes would restrict the capacity of teams to complete a robust and sustainable physical health check. In the longer term, the option to expand to the highest risk patient groups, for example, patients accessing the clozapine clinic to be considered.

Work has been undertaken in community teams to standardise physical health equipment as a minimum. Work needs to progress further with teams as this would support the expansion of the LESTER tool in Community teams.

The Trust has introduced a new letter used by Consultants Psychiatrists at service user reviews within community teams. The letter has a set paragraph requesting the GP conduct a physical health check annually, to include all elements of the LESTER tool. With a request to share any findings with the Trust to inform care plans accordingly. The letters will be continued to be embedded into practice.

Documentation has been highlighted as an issue nationwide, in that physical health information (screening details and interventions offered) are currently documented in multiple locations within the Electronic Patient Record RiO. The Trust received access to 'open RiO' in May 2015 which enabled the Trust to make changes to the Electronic Patient Record. Work is underway to streamline where Physical Health information is recorded within the Electronic Patient Record RiO system. This will improve the way in which information can be audited and fed back to the clinicians.

A physical health intranet page is now available for all staff with a wide selection of information about the Lester tool, as well as recent Quality Improvement projects and audits.

Members of the Physical Health Clinical Expert Reference Group supported a physical health event hosted at Wotton Lawn in January 2016. The event was well attended by patients and staff. External providers included independence Trust, Stop Smoking Service, Slimming World, Sexual Health clinic and dentists. The Trust's Working Well and the Dietician were present.

The Trust has commented on the Department of Health improving the physical health and wellbeing of people with mental health problems actions for mental health nurses.

We have met this target.

Target 1.2 To improve personalised discharge care planning in: a) Adult inpatient wards and; b) Older people's wards.

Discharge from inpatient units to the community can pose a time of increased risk to service users. Throughout 2015/16 we will be focusing on making improvements to discharge care planning to ensure that service users are actively involved in shared decision making for their discharge and the self-management care planning process.

By the end of the year we aim to have established a robust model to include the following information:

1. Risk Management Care Plan (RMCP) to identify high risks which may be potential 'triggers' informing possible service user deterioration.
2. Documentation to detail appropriate intervention strategies to inform relapse/contingency/pre-crisis planning with inclusion of a named health care co-ordinator.
3. Documentation regarding the involvement or relevant other services in the discharge process.

4. Documentation to confirm printed copies of personalised care plan shared with service user, GP, inpatient (if transferred) or community mental health team, care home/nominated other/carer and GP.

It should be noted that the models differ between Herefordshire and Gloucestershire to reflect commissioning requirements.

During Quarter 1 a baseline audit was undertaken in both Gloucestershire and Herefordshire services to establish compliance against different models. The sample in Herefordshire included services users at Mortimer Ward, Stonebow Unit (adult inpatient ward) and Oak House (adult recovery unit) and used the Recovery Star[3] as the basis for the model. The sample in Gloucestershire included service users at comparable units; Priory Ward, Wotton Lawn Hospital (adult inpatient ward) and both Honeybourne and Laurel House (adult recovery units); the model used was the Trust's current Discharge from Inpatients Policy.

An audit cycle was then established for each county at differing intervals and the results are seen in the tables below.

The table below shows compliance in Herefordshire services against the audited Recovery Star model.

Service	Compliance Quarter 1 2015-2016	Compliance Quarter 2 2015-2016	Compliance Quarter 3 2015-2016	Compliance Quarter 4 2015-2016	Average compliance for year
Overall Compliance	73% (91/125)	68% 32/47)	N/A	83% (283/342)	75% (406/514)
Jenny Lind Ward	N/A	68% (32/47)	N/A	96% (54/56)	83% (86/103)
Mortimer Ward	52% (34/65)	N/A	N/A	79% (209/266)	73% (243/331)
Cantilupe*	N/A	N/A	N/A	N/A	N/A
Oak House	95% (57/60)	N/A	N/A	100% (20/20)	96% (77/80)

*No service users on Cantilupe Ward met the criteria for inclusion in the audit.

Within Herefordshire it was necessary to demonstrate the development of an adult personalised discharge care plan in as part of the CQUINS 2015-2016 for the Trust.

The Quarter 4 audit demonstrates an improvement over previous audits. The discharge care plan was developed and improved upon over the course of 2015-16. Service users wanted a more concise and straight forward document to read and understand. By Quarter 4 a simplified document was developed that was positively received.

As a result of developing this care plan the Personal Safety Plan has been developed and incorporated into the Crisis, Relapse and Contingency Planning on RiO, reflecting the elements of the care plan created for the CQUIN.

Average compliance for the year for each ward will be used as the baseline to improve upon during 2016-17.

The table overleaf shows compliance in Gloucestershire services against the audited Discharge from Inpatients Policy.

[3] The Mental Health Recovery Star is a tool that can be used by people with mental health needs to help them think about where they are in terms of recovery and the progress they are making.

Service	Compliance Quarter 1 2015-2016	Compliance Quarter 2 2015-2016	Compliance Quarter 3 2015-2016	Compliance Quarter 4 2015-2016	Average compliance for year
Overall Compliance	73% (138/189)	83% (1153/1385)	78% (1017/1298)	75% (712/950)	79% (2988/3774)
Chestnut Ward	N/A	86% (60/70)	91% (86/95)	84% (62/74)	87% (208/239)
Mulberry Ward	N/A	82% (183/224)	82% (70/85)	75% (83/110)	80% (336/419)
Willow Ward	N/A	77% (61/79)	59% (40/68)	59% (37/63)	66% (138/210)
Abbey Ward	N/A	87% (279/322)	86% (243/284)	72% (113/158)	83% (635/764)
Dean Ward	N/A	91% (218/240)	78% (258/330)	79% (169/215)	82% (645/785)
Greyfriars PICU	N/A	69% (43/62)	62% (31/50)	50% (13/26)	63% (87/138)
Kingsholm Ward	N/A	79% (110/139)	73% (112/153)	75% (55/73)	76% (277/365)
Priory Ward	75% (106/141)	81% (196/242)	77% (169/219)	80% (173/217)	79% (644/819)
Montpellier Unit	N/A	43% (3/7)	57% (8/14)	50% (7/14)	51% (18/35)
Honeybourne	64% (23/36)	N/A	N/A	N/A	64% (23/36)
Laurel House	75% (9/12)	N/A	N/A	N/A	75% (9/12)

In April 2015, discharge care planning was considered within Priory Ward, Honeybourne and Laurel House to ascertain compliance against the policy. Subsequent audits in following quarters looked at a wider sample of wards and inpatient settings to achieve the same aim. It should be noted that the findings from Quarter 1 to subsequent quarters looks at different samples and, as such, are difficult to directly compare. Overall compliance from Quarter 1 to Quarter 4 increased by **2%** with the highest level of compliance being achieved in Quarter 2 (**83%**).

From Quarter 2 to Quarter 4 Discharge Care Planning was considered in all wards in Wotton Lawn Hospital and Charlton Lane. Overall compliance over this period decreased from **83%** to **75%**.

There were some notable areas where compliance was particularly high, these being completion of Risk Summaries, patient being discharged from bed and Nursing Discharge Summary letter being sent to the GP within 24 hours of discharge. The findings of these audits are being reviewed by the hospital sites and action plans will be developed to ensure that there is an improvement in compliance in future audits.

Average compliance for the year for each ward will be used as the baseline to improve upon during 2016-17.

Whilst there is variable compliance with these standards at differing points in the year, the models have now been developed and established within the two counties, with associated action plans being developed

We have met this target.

Target 1.3 To increase the number of vulnerable people who are able to access the IAPT service "Let's Talk" (Improving Access to Psychological Therapies).

The Improving Access to Psychological Therapies (IAPT Service) in Herefordshire and Gloucestershire provides psychological treatments based on a Cognitive Behavioural Treatment model to patients experiencing anxiety and depression. Treatment includes provision of appropriate books and literature, telephone based interventions, courses and individual face to face therapy.

We wanted to increase the numbers of people access the service from defined vulnerable service user groups, and we have identified this people as follows:

- Parental mental health. (we have defined this as parents experiencing mental health problems, with a particular emphasis in those in the perinatal period who are defined as at particular risk of mental health issues)
- Older people
- Carers
- People with literacy issues
- Veterans and their families
- People with long term conditions.

This target was a CQUIN for our IAPT service in Herefordshire, but the same approach was adopted in our Gloucestershire service. The tables below show the numbers of people from within these groups at the end of the year. It is important to note that a service user may sit within more than one identified vulnerable group e.g. they may be veteran and have a long term condition. Each service developed a detailed action plan for each cohort of service users which was implemented from December 2015.

Cohort	Herefordshire			
	Q1	Q2	Q3	Q4
Parental mental health	24	31	22	35
Older people	34	52	45	47
Carers	1	2	2	7
People with literacy issues	Not available*	8	5	5
Veterans and their families	18	20	7	3
People with long term conditions	121**	71	160	142

*This information was not currently flagged on IAPTus (the electronic system for recording service user care notes and related information for those accessing IAPT) during Quarter 1

** This figure has been adjusted from 334 as previously reported, as it has been established that some "double counting" of service user contacts was included in earlier reports.

It is seen that in Herefordshire at Quarter 1 there were **198** people in this cohort in contact with the service and at Quarter 4 this figure increased to **239**.

Cohort	Gloucestershire			
	Q1	Q2	Q3	Q4
Parental mental health	184	208	240	286
Older people	256	342	250	193
Carers	6	5	12	6
People with literacy issues	Not available	34	5	12
Veterans and their families	58	64	49	44
People with long term conditions	746	884	1106	1091

It is seen that in Gloucestershire at Quarter 1 there were **1250** people in this cohort in contact with the service and at Quarter 4 this figure increased to **1632**.

We have met this target.

Target 1.4 To develop a measureable data set to improve the experience of service users who make the transition from children and young people's services to adult services.

The period of transition from children and young people's services to adult mental health services is often daunting for both the young person involved and their family or carers. We want to ensure that this experience is as positive as it can be.

During 2014/15 there was a CQUIN for Herefordshire Child & Adolescent Mental Health Services (CAMHS) to capture and act upon feedback from young people. This identified a number of findings which has influenced practice within the county. The good practice findings included:

- Discussing transition with young people up to a year prior to their 18th birthday and documenting these discussions;
- Liaising with adult teams if transition to adult mental health services is indicated at approximately 6 prior to the transition period.
- Inviting adult teams to Care Programme Approach reviews 3-6 months prior to transition
- Identifying those young people with complex needs who need to follow the Herefordshire Transition Policy;
- Considering ways that the Children & Young Peoples - Improving Access to Psychological Therapy (CYP-IAPT) Participation Group can help reduce stigma;
- Using supervision to check that transition planning is taking place where required.

This information has been shared with Gloucestershire Children and Young Peoples Services (CYPS) to help inform ongoing service developments.

The numbers of young people in Herefordshire who transition to adult mental health services are still very small, but no service users refused a transition to adult mental health services where it was clinically indicated. To assist with process, an Adult Mental Health Team Psychologist provided support to young people undergoing transition to adult teams during Quarter 3, this was really beneficial and the team are considering how this can be continued in the future.

The Wellbeing Ambassadors (young people who are involved in CYP-IAPT Participation in Herefordshire) are actively working on reducing stigma and hosted a conference in October called 'Shout Out for Wellbeing'.

Within Gloucestershire CYPS, an initial data set was drafted in Quarter 1 to include the following quantitative information:

1. Completed transitions
2. Cases in transition
3. Did not attend (DNA) CYPS
4. Did not attend (DNA) Adult Services

Additionally, a further four criteria relating to lifestyle and self-management were also agreed:

1. Adherence to Care Plan
2. Engagement in Intervention
3. Compliance with Prescribed Medication
4. In Education or Employment/Not in Education, Employment or Training

This data set has subsequently been agreed for use in both counties, therefore the target has been met.

The “Your Transition Plan” was reviewed and ratified by the CYPS Children and Young People’s Board on 23 July 2015. “Your Transition Plan” aims to ensure that the “voice” of the young person is clearly heard and documented along the transition of care pathway. The plan is underpinned by best practice guidelines as well as the principles within the “Ready, Steady, Go” pathway model. The service is also in the process of creating a Top Tips sheet for clinical staff so that all areas are considered as transition planning begins.

Clinical practice was assessed and measured against policy for young people who have recently transitioned or are in the process of transitioning to adult mental health services. A gap analysis was completed through discussion with care co-ordinators and a review of RiO documentation. Wider discussions with clinicians experienced in supporting young people through the transition (CYPS and adult mental health staff) have informed both the gap analysis and the action plan. A review of the Policy for the Transition of Care from Children & Young People Services to Adult Services is underway with contribution from both CYPS and Adult Mental Health services. Policy development will ensure/guide quality of collaborative transitions between CYPS and adult services.

Reference to transitions has been embedded into statutory & mandatory training which aims to raise awareness of the policy and process and a checklist/flowchart has been developed and implemented which guides process in line with policy. Both aim to ensure seamless and well planned transitions from CYPS to adult mental health services.

To further consider best practice both Herefordshire CAMHS and Gloucestershire CYPS are participating in the Milestone Project. This is a research study which looks at how to improve the transition process and experience for young people moving into adult mental health services in the United Kingdom and across Europe.

We have met this target.

User Experience

In this domain, we have set ourselves 1 goal of improving service user experience and carer experience with 4 associated targets.

- Improving the experience of service user in key areas. This was measured though defined survey questions for both people in the community and inpatients

Local surveys using the same questions have been implemented in our community and inpatient settings using a paper based survey method. This has been across the Trust in both Gloucestershire and Herefordshire, and below are the cumulative responses to the returned service user questionnaires at year end. A combined total percentage for both counties is provided for these questions to mirror the methodology used by the CQC Community Mental Health Survey, as this does not differentiate by county.

Target 2.1 Have you been offered a written or printed copy of your care plan? <73%

Questions	Treatment Setting	Sample Size Glos	Number 'yes' Glos	Sample size Hereford	Number 'yes' Hereford	Total % giving 'yes' answer
Question 1 Have you been offered a written copy of your care plan or a letter about your care?	Inpatient	147	118	18	11	**71%**
	Community	250	170	147	100	
	Total Responses	397	288	165	111	

This target has not been met.

Target 2.2 Do the people you see through NHS mental health services help you feel hopeful about the things that are important to you? >65%

Questions	Treatment Setting	Sample Size Glos	Number 'yes' Glos	Sample size Hereford	Number 'yes' Hereford	Total % giving 'yes' answer
Question 2 Do ^{2}gether Trust staff help you to feel hopeful about things that are important?	Inpatient	138	110	12	12	**86%**
	Community	224	196	117	104	
	Total Responses	362	306	129	116	

This target has been met.

Target 2.3 In the last 12 months, did NHS mental health services give you any help or advice with finding support for physical health needs? >58%

Questions	Treatment Setting	Sample Size Glos	Number 'yes' Glos	Sample size Hereford	Number 'yes' Hereford	Total % giving 'yes' answer
Question 3 Have you been given advice with finding support for any physical health needs that you may have?	Inpatient	57	51	14	9	**79%**
	Community	204	147	116	102	
	Total Responses	261	198	130	111	

This target has been met.

Target 2.4 Have you been given advice about taking part in local activities? >51%

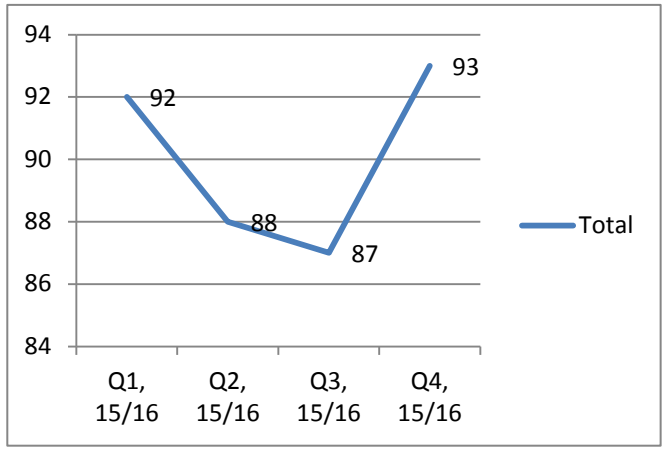
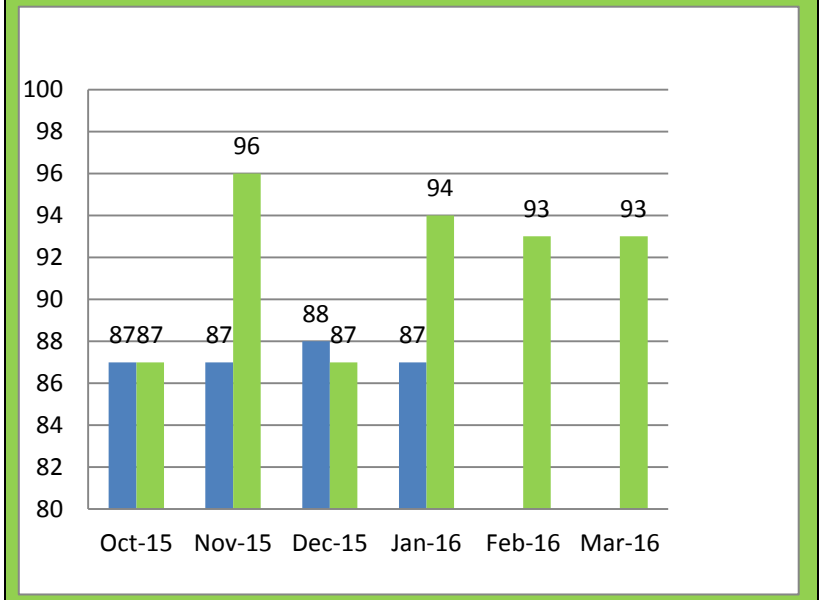
Questions	Treatment Setting	Sample Size Glos	Number 'yes' Glos	Sample size Hereford	Number 'yes' Hereford	Total % giving 'yes' answer
Question 4 Have you been given advice about taking part in activities that are important to you?	Inpatient	56	42	13	8	**81%**
	Community	213	167	133	121	
	Total Responses	269	209	146	129	

This target has been met.

Friends and Family Test

The Friends and Family Test question asks people to rate whether they would recommend the service should their friends or family require care. The following six-point response scale is used to answer the question: **Extremely likely, Likely, Neither likely nor unlikely, Unlikely, Extremely unlikely, Don't know**

The standard way to report the findings is by calculating the percentage of people who state that they would either be 'Extremely Likely' or 'Likely' to recommend the services of the Trust. Findings are provided in the tables below to illustrate local results and comparisons with figures from other similar organisations.

[2]gether NHS Foundation Trust Friends and Family Test responses in Quarter 4 2015 / 16	Percentage likely to recommend 2gether's services in Q4 2015/16	**Overall % scores for the Friends and Family Test for 2gether by quarter year in 2015 /16**	**[2]gether Trust Scores (in green) compared with national average for mental health Trusts (in blue) for Friends and Family Test (at time of writing no average scores had been published for Feb or March 16)**
January 2016 48 responses	94%		
February 2016 111 responses	93%		
March 2016 399 responses	93%		
Total responses in Q4 2015/16 = **558**	**93%**	The results of the Friends and Family Test are reported routinely in [2]gether's quarterly Service Experience report to the Board. During the year 2015/16 the data have consistently suggested that over 87% of people would recommend [2]gether's services (above). Further work is being undertaken to enhance the experience of using [2]gether's services.	

Complaints

Between 1 April 2015 and 31 March 2016 the Trust received **131** formal complaints, a reduction in actual number from the previous year. However, Figure 2 below (numbers of complaints received as a percentage number of people seen over a three year period, by quarter year) provides a trend line suggesting that the numbers of complaints received has been relatively consistent in relation to the number of people seen over a period of three years.

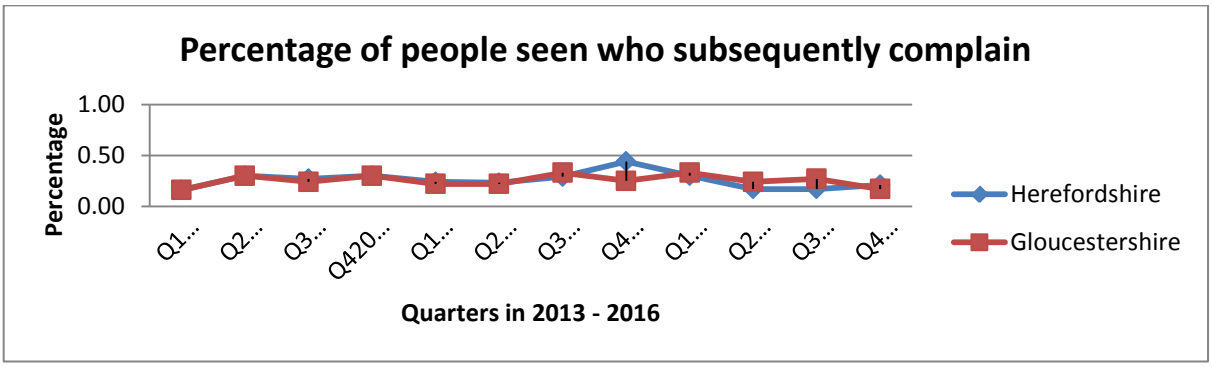


Figure 2

People who raise a new concerns or complaint about [2]gether NHS Foundation Trust are contacted by our Service Experience Department. The aim of this is to clarify issues with people and to identify the outcomes being sought from the complaint. The complaint process is explained and the opportunities for informal resolution are also explored.

A continuous year on year improvement in written acknowledgement of complaints within the expected three day timeframe has been demonstrated. **99%** (**130**) of complaints were acknowledged within the three day time standard this year.

People are encouraged to seek an independent investigation of their complaint via the Parliamentary Health Services Ombudsman (PHSO) if they are not satisfied with the outcome of [2]gether's investigation or if they feel that their concern remains unresolved.

This year the PHSO requested information about **11** complaints. The Ombudsman took **7** of these cases forward for review and investigation. This is the same number as last year and represents **5%** of complaints received overall in 2015/16. **3** of the cases referred this year and **1** referred the previous year have been closed following investigation by the PHSO. **None** of the cases referred to the PHSO were upheld. On average the PHSO uphold a third of cases referred from organisations across the country.

Further development of [2]gether's complaint process has included:

- Awareness raising activity with colleagues in clinical services to encourage the earliest possible response to complaints or concerns;
- Continued offer to meet with people who complain to seek local resolution;
- Advising people when delays in responses are expected and mitigating action to improve response times.
- Updating the Trust's Complaint Policy to reflect changes in practice and national guidance.
- Working with colleagues across the Trust to review and improve dissemination of learning from complaints to ensure service user feedback is considered and embedded in practice.

The quarterly Service Experience Report to the Trust Board outlines in detail the themes of complaints, the learning and the actions that have been taken. Learning from complaints, concerns, compliments and comments is essential to the continuous improvement of our services.

Safety

Protecting service users from further harm whilst they are in our care is a fundamental requirement. We seek to ensure we assess the safety of those who use our services as well as providing a safe environment for service users, staff and everyone else that comes into contact with us. In this domain, we have set ourselves 3 goals to:

- Minimise the risk of suicide of people who use our services;
- Ensure the safety of people detained under the Mental Health Act;
- Ensure we follow people up when they leave our inpatient units within 48 hours to reduce risk of harm.

There are 3 associated targets.

Target 3.1 Reduce the numbers of deaths relating to identified risk factors of people in contact with services when compared data from previous years.

We aim to minimise the risk of suicide amongst those with mental disorders through systematic implementation of sound risk management principles. In 2013/14 we set ourselves a specific quality target for there to be fewer deaths by suicide of patients in contact with teams. In that year we reported **22** suspected suicides, which was **4** more than in 2012/13 and did not meet the target. During 2014/15 we reported **20** suspected suicides which was lower than the previous year. This year we reported **24** suspected suicides, **4** more than last year, therefore we did not meet the target.

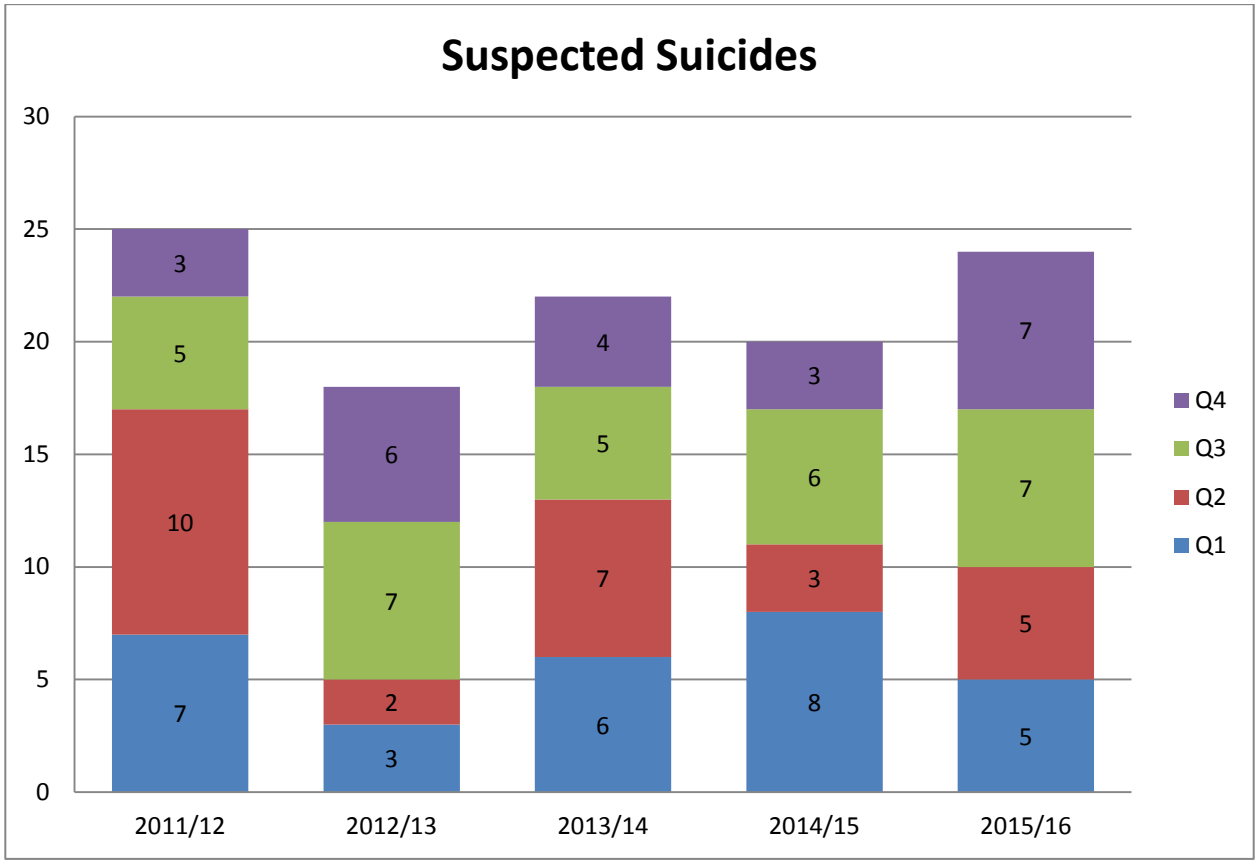


Figure 3

This information is provided below in Figures 4 & 5 for both Gloucestershire and Herefordshire services separately. It is seen that greater numbers of suspected suicides are reported in Gloucestershire

services. There is no clear indication of why the difference between the two counties is so marked, but it is noted that the population of people in contact with mental health services in Gloucestershire is greater, and the services in each county are configured differently to reflect individual commissioning requirements.

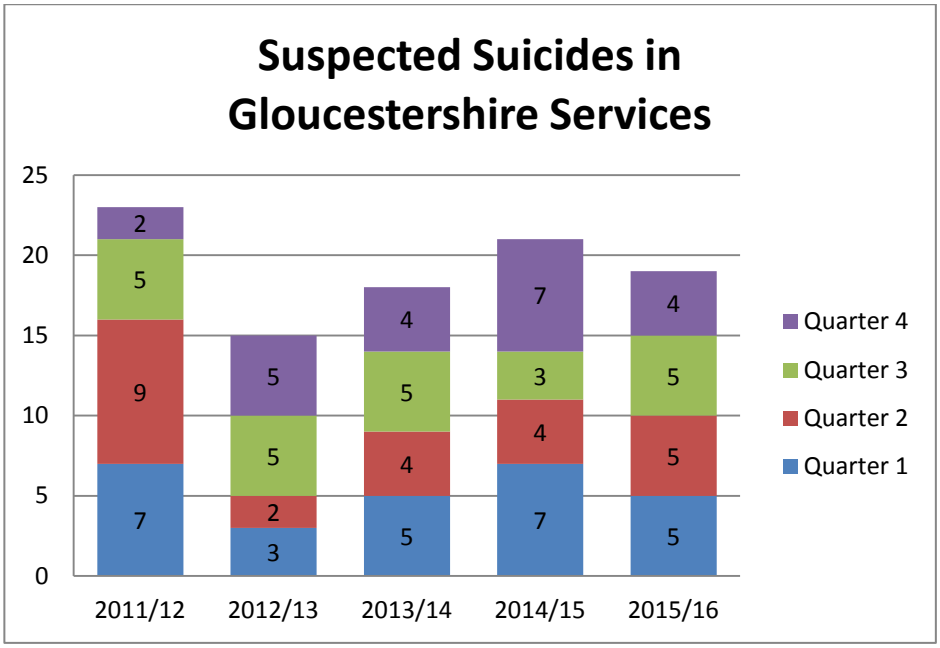


Figure 4

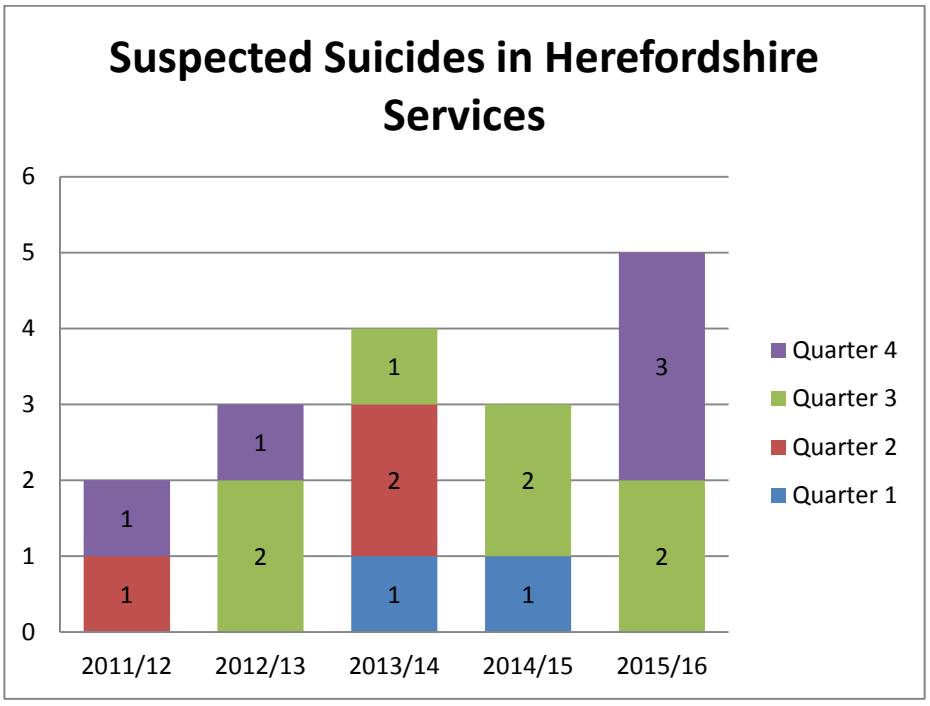


Figure 5

Whilst we report all deaths which appear to be as a consequence of self-harm as suspected suicide, ultimately it is the coroner who determines how a person came by their death. Figure 6 provides the number of suicide, open and narrative conclusions following an inquest being heard for the same cohort of service users. The outcome of inquests for each county is subsequently provided in Figures 7 & 8.

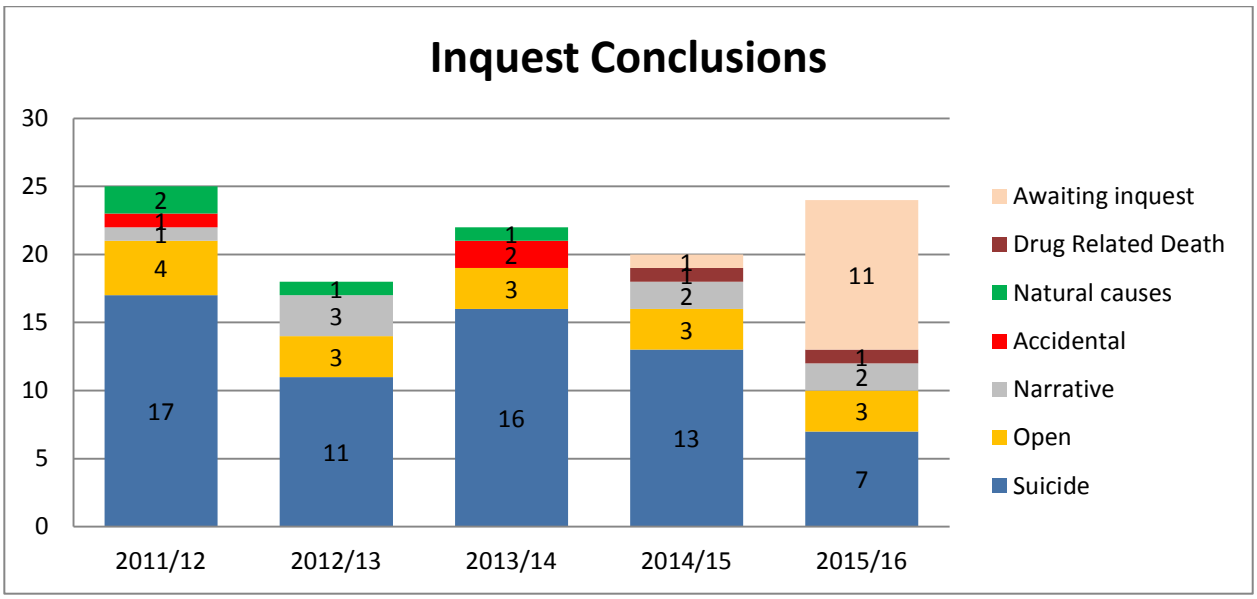


Figure 6

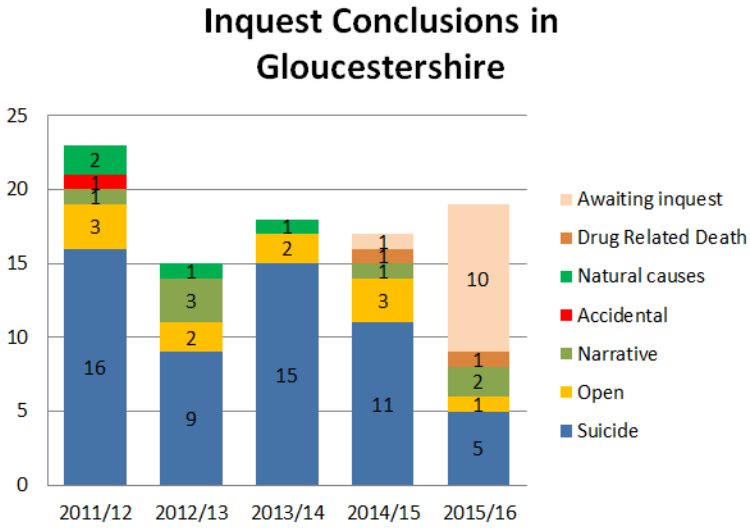


Figure 7

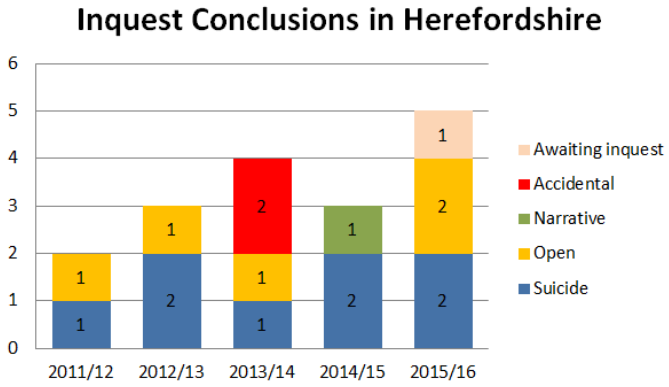


Figure 8

The Trust is an active member of the Gloucestershire Suicide Prevention Partnership Forum (GSPPF). This Forum brings together key stakeholders in the county to develop and deliver a countywide suicide prevention strategy and action plan and contribute to reducing the stigma around suicide and self-harm.

We did not meet this target.

Target 3.2 Reduce the number of people who are absent without leave from inpatient units who are formally detained.

Much work has been done to understand the context in which detained service users are absent without leave (AWOL) via the NHS South of England Mental Health Patient Safety Improvement Programme. AWOL reporting includes those service users who:

1. Abscond from a ward,
2. Do not return from a period of agreed leave,
3. Abscond from an escort.

In previous years, the Quality Report has only reported on the total number of detained patients reported as being absent without leave, without providing a breakdown of each of the 3 categories above. This year, we will focus on each of these 3 categories using the 2014/15 data as a baseline. The table below shows the past 2 years reported total incidents by quarter.

	2013/14	2014/15
Quarter 1	23	20
Quarter 2	25	39
Quarter 3	24	35
Quarter 4	38	32
Totals for year	**110**	**126**

Further analysis of the 2014/15 information by county against the 3 categories shows the following trend.

Herefordshire

	2014/15
Absconded from a ward	24
Did not return from leave	4
Absconded from an escort	11
Totals for year	**39**

Gloucestershire

	2014/15
Absconded from a ward	42
Did not return from leave	22
Absconded from an escort	10
Totals for year	**74**

Additionally, the system that we use to report incidents of AWOL, Datix, has the following incidents logged against “other place”, “public place”, “reception” and “service user’s home address”. It has not been possible to identify which county these incidents occurred in.

	2014/15
Absconded from a ward	3
Did not return from leave	4
Absconded from an escort	6
Totals for year	**13**

During 2015/16 the following **114** episodes of AWOL have been reported and, as such, the overall target has been met, but there has been an increase of **9** incidents where service users absconded from a ward. Therefore, we want to continue with this indicator as a quality priority during 2016/17.

Herefordshire

	Quarter 1 2015/16	Quarter 2 2015/16	Quarter 3 2015/16	Quarter 4 2015/16	Total 2015/16
Absconded from a ward	5	7	9	2	23
Did not return from leave	2	0	1	1	4
Absconded from an escort	1	0	1	2	4
Totals for year	**8**	**7**	**11**	**5**	**31**

Gloucestershire

	Quarter 1 2015/16	Quarter 2 2015/16	Quarter 3 2015/16	Quarter 4 2015/16	Total 2015/16
Absconded from a ward	4	13	19	19	55
Did not return from leave	2	9	6	2	19
Absconded from an escort	1	3	3	2	9
Totals for year	**7**	**25**	**28**	**23**	**83**

Regarding the category "Did not return from leave" the team on Mortimer Ward, Stonebow Unit in Hereford tested out, and now use "Leave Cards". These are credit card sized cards which are issued to service users at the time of agreeing periods of leave. The leave arrangements are discussed with the service users together with the expectations of returning to the ward. These arrangements are documented on the back of leave card, explicitly showing the time due to return and a prompt to contact the ward team if unable to return by the agreed time. The hospital/ward contact numbers are provided on the other side of the cards also.

Since July 2015, the Abbey Ward team at Wotton Lawn Hospital in Gloucestershire have also been piloting "Leave Cards". Feedback from services users going on leave has been positive in that the cards are helpful.

Based on the pilot, it has recently been agreed that the Abbey Ward Leave Card will be reproduced for all wards at Wotton Lawn Hospital bar changing the ward name and relevant contact details for use. This is in development. The Abbey Ward Leave Card is seen below.

Interventions that have not been measured but that may impact on reducing AWOL through increased engagement are the Safewards Interventions. At Wotton Lawn Hospital and the Stonebow Unit, staff and service users, have chosen a selection of interventions for implementation to make inpatient areas more peaceful places, improve engagement, enhance relationships, and increase safety. On visiting the wards, these interventions are visually evident and both staff and services users are positive regarding their implementation.

Staying true to the Safewards model is very important in terms of being able to evaluate in time and this is not quantifiable as numerical measurement. More information can be found at www.safewards.net

Overall we have met this target but seen a small increase in the numbers of service users who has absconded from ward. This will, therefore, remain a quality priority during 2016/17

Target 3.3 95% of adults will be followed up by our services within 48 hours of discharge from psychiatric inpatient care

This is a local target and one which we first established as a quality target in 2012/13. The national target is that 95% of CPA service users receive follow up within 7 days[4].

Discharge from inpatient units to community settings can pose a time of increased risk of self-harm for service users. The National Confidential Inquiry into Suicides and Homicides[5] recommended that *'All discharged service users who have severe mental illness or a recent (less than three months) history of self-harm should be followed up within one week'*

One of the particular requirements for preventing suicide among people suffering severe mental illness is to ensure that follow up of those discharged from inpatient care is treated as a priority and that care plans include follow up on discharge. Although the national target for following up service users on CPA is within 7 days, in recognition that people may be at their most vulnerable within the first 48 hours, we aim to follow up 95% of people within these 2 days. This has been an organisational target for two years, and the cumulative figures for each year end are seen in the table below.

In 2014/15 Herefordshire services followed up **92%** (**21** breaches) of people discharged from inpatient care and Gloucestershire services have followed up **95%** (**44** breaches), this gave an organisational compliance figure of **94%**.

During 2015/16 we have taken the opportunity to review our practices and policies associated with both our 7 day and 48 hour follow up of patients discharged from our inpatient services. Whilst the adjustments we have undertaken have strengthened the patient safety aspects of our follow up contacts, introducing these changes have led to an impact on our in year performance, in comparison to our previous year's performance against these performance standards.

In the case of our 48 hour local stretch target, our in year organisational performance has fallen to **90%** which is below our stretch target. We are confident that the practice changes we have introduced have strengthened the patient safety aspects of this measure and that our future years performance in both our 7 day and 48 hour follow ups will return to being well above the national performance requirement and our local stretch target as in previous years.

Therefore, at the end of 2015/16 our Herefordshire services followed up **91%** (**25** breaches) of people discharged from inpatient care and Gloucestershire services have followed up **90%** (**83** breaches). As we have not met this important target we will continue with this as a quality priority during 2016/17.

	Target	2012-13	2013-14	2014-15	2015-16
Gloucestershire Services	>95%	89%	95%	95%	90%
Herefordshire Services	>95%	70%	95%	92%	91%

We did not meet this target.

[4] Detailed requirements for quality reports 2014/15: Monitor, February 2015
[5] Five year report of National Confidential Inquiry into Suicide and Homicide by people with mental illness Department of Health – 2001

Serious Incidents reported during 2015/16

At the end of 2015/16, **45** serious incidents were reported by the Trust, and the types of incidents reported are seen in Figure 9. However, **2** incidents were subsequently declassified as serious incidents bring the actual total to **43**.

Figure 10 overleaf shows a 5 year comparison of reported serious incidents. The most frequently reported serious incidents are "suspected suicide" and attempted suicide which is why we will continue into 2016/17 with a target to reduce suicide of people in contact with services. All serious incidents are investigated by a senior member of staff who has been trained in root cause analysis techniques. Wherever possible, we include service users and their families/carers in this process to ensure their perspective is taken into account, and we provide feedback to them on conclusion of an investigation. We also share copies of our trust investigation reports regarding "suspected suicides" with the Coroners in both Herefordshire and Gloucestershire to assist with the Coronial investigations.

There have been no Department of Health defined "Never Events" within the Trust during 2015/16. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

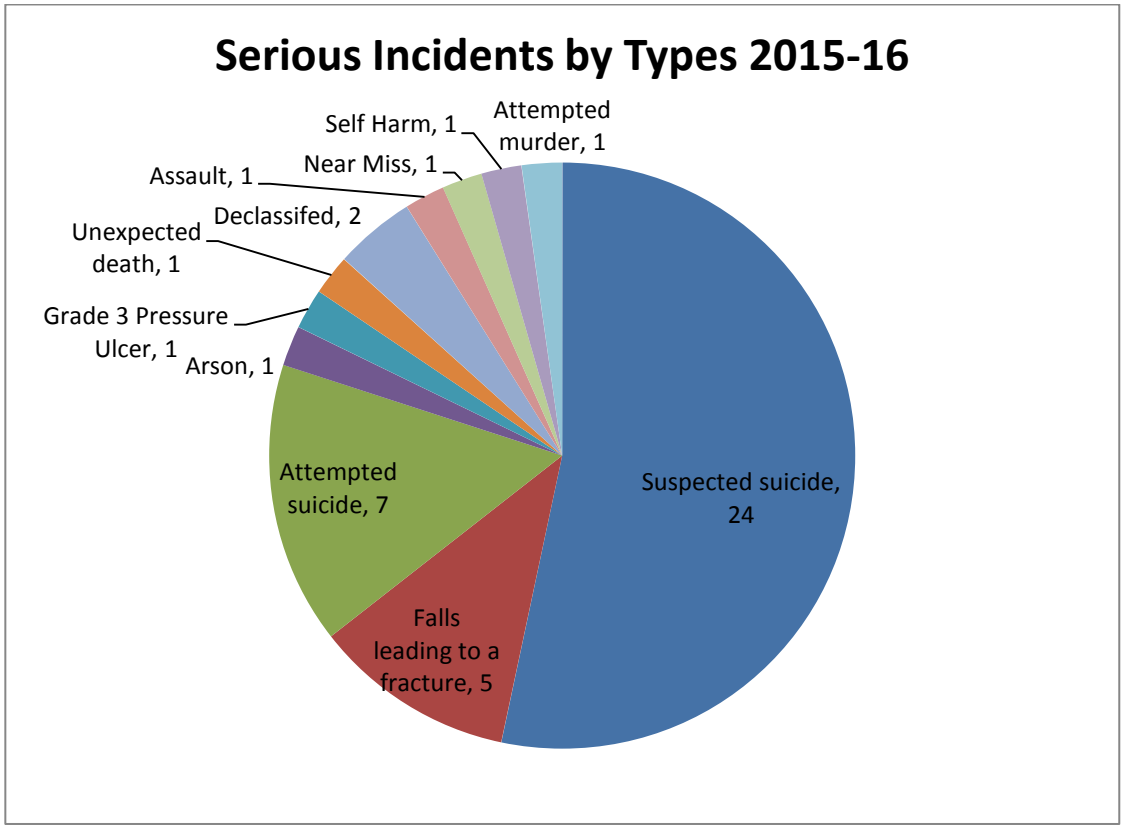


Figure 9

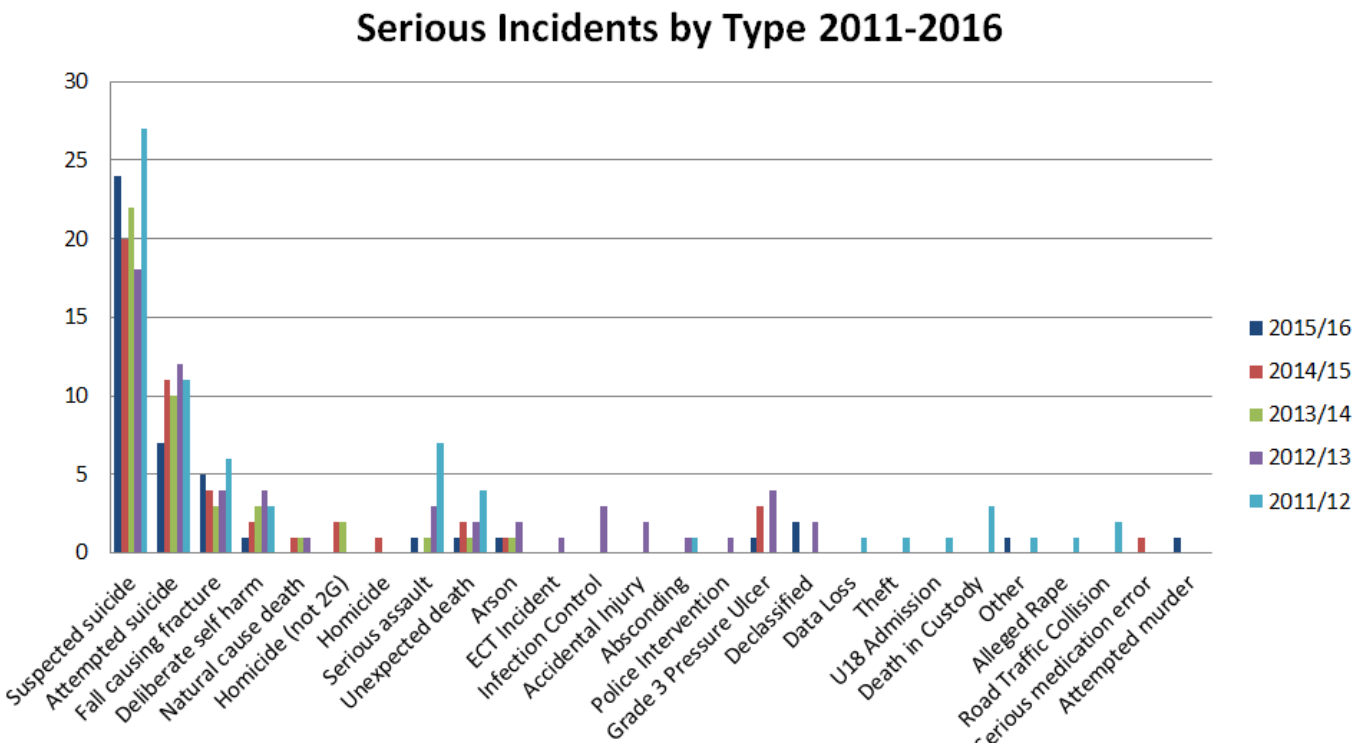


Figure 10

Duty of Candour

The Duty of Candour is a statutory regulation to ensure that providers of healthcare are open and honest with services users when things go wrong with their care and treatment. The Duty of Candour was one of the recommendations made by Robert Francis to help ensure that NHS organisations report and investigate incidents (that have led to moderate harm or death) properly and ensure that service users are told about this.

The Duty of Candour is considered in all our serious incident investigations, and as indicated in our section above regarding serious incidents, we include service users and their families/carers in this process to ensure their perspective is taken into account, and we provide feedback to them on conclusion of an investigation. Additionally, we review all reported incidents in our Datix System (incident reporting system) to ensure that any incidents of moderate harm or death are identified and appropriately investigated.

To support staff in understanding the Duty of Candour, we have provided training sessions through our Quality Forums and given all staff leaflets regarding this. There is also a poster regarding this on every staff notice board.

During the CQC comprehensive inspection of our services, they reviewed how the Duty of Candour was being implemented in across the Trust and provided the following comments in their report dated 27 January 2016.

"Staff across the trust understood the importance of being candid when things went wrong including the need to explain errors, apologise to patients and to keep patients informed."

"We saw how duty of candour considerations had been incorporated into relevant processes such as the serious investigation framework and complaints procedures. Staff across the trust were aware of the duty of candour requirements in relation to their role."

Sign up to Safety Campaign – Listen, Learn and Act (SUP2S)

[2]gether NHS Foundation Trust signed up to this campaign from the outset and was one of the first 12 organisations to do so. Within the Trust the campaign is being used as an umbrella under which to sit all patient safety initiatives such as the South of England Improving Patient Safety and Quality in Mental Health Collaborative, the NHS Safety Thermometer, Safewards interventions and the Reducing Physical Interventions project. Participation in SUP2S webinars has occurred, and webinar recordings are shared with colleagues. A Safety Improvement Plan has been developed, submitted and approved. Monitoring of progress as a whole is completed every 6 months via the Trust Governance Committee, but each work stream has its own regular forum and reporting mechanisms.

Indicators & Thresholds for 2015/2016

The following table shows the 10 metrics that were monitored during 2015/16. These are the indicators and thresholds from Monitor and follow the standard Department of Health national definitions. Note that some are also the Trust Quality targets, and some may have more stretching targets than Monitor require as a threshold.

		2013-2014 Actual	2014-2015 Actual	National Threshold	2015-2016 Actual
1	Clostridium Difficile objective	1	3	0	**0**
2	MRSA bacteraemia objective	0	0	0	**0**
3	7 day CPA follow-up after discharge	99.1%	97.73%	95%	**95.63%**
4	CPA formal review within 12 months	96.4%	97.1%	95%	**99.35%**
5	Delayed transfer of care	0.12%	0.06%	≤7.5%	**1.02%**
6	Admissions gate kept by Crisis resolution/home treatment services	99.1%	99.57%	95%	**99.74%**
7	Serving new psychosis cases by early intervention teams	100%	100%	50%	**63.56%**
8	MHMDS data completeness: identifiers	99.7%	99.71%	97%	**99.57%**
9	MHMDS data completeness: CPA outcomes	80.6%	97.06%	50%	**97.42%**
10	Learning Disability – six criteria	6	6	6	**6**

Mandated Quality Indicators 2014-2015

There are a number of mandated Quality Indicators which organisations providing mental health services are required to report on, and these are detailed below. The comparisons with the national average and both the lowest and highest performing trusts are benchmarked against other mental health service providers.

1. Percentage of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care

	Quarter 4 2014-15	Quarter 1 2015-16	Quarter 2 2015-16	Quarter 3 2015-16	Quarter 4* 2015-16
[2]gether NHS Foundation Trust	97.3%	98.4%	97%	99.3%	95.20%
National Average	97.2%	97%	96.8%	97.3%	97.2%
Lowest Trust	93.1%	88.8%	83.4%	90%	93.1%
Highest Trust	100%	100%	100%	100%	100%

The [2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- During 2015/16 we have taken the opportunity to review our practices and policies associated with both our 7 day and 48 hour follow up of patients discharged from our inpatient services. Whilst the adjustments we have undertaken have strengthened the patient safety aspects of our follow up contacts, introducing these changes have led to an impact on our in year performance, in comparison to our previous year's performance against these performance standards. Our 7 day performance has fallen to just over 95% in Gloucestershire and just over 96% in Herefordshire which are lower than our previous year's performance, but still above the national performance requirement of 95 %. We are confident that the practice changes we have introduced have strengthened the patient safety aspects of this measure and that our future years performance in both our 7 day and 48 hour follow ups will return to being well above the national performance requirement and our local stretch target as in previous years.

The [2]gether NHS Foundation Trust has taken the following action to improve this percentage, and so the quality of its services, by:

- Clearly documenting follow up arrangements from Day 1 post discharge in RiO;
- Ensuring that service users are followed up within 48 hours of discharge from an inpatient unit whenever possible.

2. Proportion of admissions to psychiatric inpatient care that were gate kept by Crisis Teams

	Quarter 4 2014-15	Quarter 1 2015-16	Quarter 2 2015-16	Quarter 3 2015-16	Quarter 4* 2015-16
[2]gether NHS Foundation Trust	100%	99.5%	98.6%	100%	100%
National Average	98.1%	96.3%	97%	97.9%	98.1%
Lowest Trust	59.5%	18.3%	48.5%	73%	59.5%
Highest Trust	100%	100%	100%	100%	100%

* Activity published on NHS England website via the NHS IC Portal is revised throughout the year following data quality checks. Activity shown for Quarter 4 2015/16 has not yet been revised and may change.

The [2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- Staff respond to individual service user need and help to support them at home wherever possible unless admission is clearly indicated;
- During 2015/16, crisis teams also gate kept admissions to older people's services beds within Gloucestershire.

The [2]gether NHS Foundation Trust has taken the following action to improve this percentage, and so the quality of its services, by:

- Continuing to remind clinicians who input information into the clinical system (RiO) to complete the 'Method of Admission' field with the appropriate option when admissions are made via the Crisis Team;
- Continuing to remind clinicians who input information into RiO to ensure that all clinical interventions are recorded appropriately in RiO within the client diary.

3. The percentage of patients aged 0-15 & 16 and over, readmitted to hospital, which forms part of the Trust, within 28 days of being discharged from a hospital which forms part of the trust, during the reporting period

	Quarter 1 2015-16	Quarter 2 2015-16	Quarter 3 2015-16	Quarter 4 2015-16
[2]gether NHS Foundation Trust 0-15	0%	0%	0%	0%
[2]gether NHS Foundation Trust 16 +	10%	7%	10%	6%
National Average	Not available	Not available	Not available	Not available
Lowest Trust	Not available	Not available	Not available	Not available
Highest Trust	Not available	Not available	Not available	Not available

The [2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust does not have child and adolescent inpatient beds;
- Service users with serious mental illness are readmitted hospital to maximize their safety and promote recovery;
- Service users on Community Treatment Orders (CTOs) can recalled to hospital if there is deterioration in their presentation.

The [2]gether NHS Foundation Trust has taken the following action to improve this percentage, and so the quality of its services, by:

- Continuing to promote a recovery model for people in contact with services;
- Supporting people at home wherever possible by the Crisis Resolution and Home Treatment Teams.

4. The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends

	NHS Staff Survey 2012	NHS Staff Survey 2013	NHS Staff Survey 2014	NHS Staff Survey 2015
[2]gether NHS Foundation Trust Score	3.19	3.46	3.61	3.75
National Median Score	3.54	3.55	3.57	3.63
Lowest Trust Score	3.06	3.01	3.01	3.11
Highest Trust Score	4.06	4.04	4.15	4.04

The [2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- The National Staff Survey does not report directly on this question but does report on 'Staff recommendation of the trust as a place to work or receive treatment'. This key finding is derived from the responses to three linked questions relating to care of patients, recommending the organization as a place to work and being happy with the standard of care provided by the organisation. The response to the component questions was more positive in 2015 than in the previous three surveys indicating increasing satisfaction with the trust as a place to receive treatment and to work as perceived by staff. The 2015 survey also shows the trust score continues to move ahead of the median score for other like-type trusts;
- The National Staff Survey results continues to be complemented by the introduction of the Staff Friends and Family Test that has now been in operation since April 2014 giving staff the opportunity to voice their opinion on the trust as an employer and provider of care, confidentially in three questionnaires during the year. In the most recent survey held in March 2016, 85% of respondents said they would be likely or extremely likely to recommend the trust to friends and family as a place to receive care or treatment;
- The staff survey showed an increase in the percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver;
- Staff have reported an increase in the level of motivation at work. Whilst the improved level of staff satisfaction is encouraging, the trust is very careful to also take note of feedback from colleagues who are less satisfied and where possible to address these concerns.

The [2]gether NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

- Administering the National Staff Survey entirely online in 2015 in response to staff feedback;
- Publicizing the Staff Friends and Family Test results widely in each quarter (excluding Quarter 3 which corresponds with the National Staff Survey). This has continued to prove to be a popular medium for staff to feedback how they perceive the trust as an employer and provider of care. Close monitoring of feedback from these regular surveys highlight areas where not only improvements can be made but also to celebrate success;
- Using the Trust's intranet, known as [2]getherNet to provide a more accessible resource for staff. This is the main method of communication throughout the Trust and development continues with feedback from staff. Work is continuing to ensure easy access to information relating to support available for the health and wellbeing of staff and of a range of benefits available locally for colleagues;
- Increasing the visibility of senior managers including a regular programme of site visits by Executive and Non-Executive Directors.

5. **"Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.**

	NHS Community Mental Health Survey 2012	NHS Community Mental Health Survey 2013	NHS Community Mental Health Survey 2014	NHS Community Mental Health Survey 2015
[2]gether NHS Foundation Trust Score	8.4	8.7	8.2	7.9
National Average Score	Not available	Not available	Not available	Not available
Lowest Score	8.2	8.0	7.3	6.8
Highest Score	9.1	9.0	8.4	8.2

The [2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- The survey results for this set of questions are broadly similar to the previous three years when compared with the national scores. In fact, in relation to previous years, [2]gether's scores are nearer the higher scores nationally. There is still work to do to enhance service experience and some of the actions being taken are reflected in the points below.

The [2]gether NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

- Ensuring that people are involved in the development and review of their plan of care including decisions about their medication
- Understanding people's individual interests and circumstances beyond health care.
- Signposting and supporting individuals to other agencies for social engagement
- Ensuring that service users are provided with information about who can be contacted out of office hours should they need support in a crisis.
- Providing information about getting support from people who have experience of similar mental health needs.

6. **The number and rate* of patient safety incidents reported within the Trust during the reporting period and the number and percentage of such patient safety incidents that resulted in severe harm or death.**

	1 October 2014 – 31 March 2015				1 April 2015 – 30 September 2015			
	Number	Rate*	Severe	Death	Number	Rate*	Severe	Death
[2]gether NHS Foundation Trust	1,309	34.58	0	8	1,464	39.61	1	6
National	135,995	-	500	941	144,850	-	492	992
Lowest Trust	4	4.83	0	0	8	6.46	0	0
Highest Trust	5,852	92.53	122	74	6,723	83.72	74	95

* Rate is the number of incidents reported per 1000 bed days.

The [2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- NRLS data is published 6 months in arrears; therefore data below for severe harm and death will not correspond with the serious incident information shown in the Quality Report;
- The Trust is in the highest 25% of reporters and it is believed that organisations that report more incidents usually have a better and more effective safety culture.

The [2]gether NHS Foundation Trust has taken the following action to improve this rate, and so the quality of its services, by:

- Re-auditing its Incident Reporting Systems (DATIX) to improve the processes in place for the timely review, approval of, and response to reported patient safety incidents.
- Appointing a Datix Systems Manager, upgrading the Trust's DATIX system and making the Incident Reporting Form more "user friendly";
- Setting up a DATIX User Group.

Community Survey 2015

The CQC published results of an independent survey taken in 2015 that tested the experience of service users who use [2]gether's community services. The published results compare ratings about 2gether's services with the results of other mental health trusts.

[2]gether NHS Foundation Trust received one of the highest percentage response rate in the country to the questionnaire at 38% returned. Full details of this survey questions and results can be found on the CQC website http://www.cqc.org.uk/provider/RTQ/survey/6. No significant differences were noted between the results for Herefordshire and Gloucestershire. Across most of the ten domains in the survey our scores were reported as 'About the Same' as other trusts. The results are tabulated below together with the scores out of 10 for [2]gether Trust calculated by the CQC.

[2]gether's scores compared with scores of other trusts

Score (out of 10)	Domain of questions	How the score relates to other trusts
7.9	**Health and Social Care workers**	**Same as others**
8.6	**Organising Care**	**Same as others**
7.1	**Planning care**	**Same as others**
7.7	**Reviewing Care**	**Same as others**
6.7	**Changes in who people see**	**Same as others**
6.4	**Crisis care**	**Same as others**
7.6	**Treatment**	**Same as others**
5.6	**Other aspects of life**	**Same as others**
7.6	**Overall view of care and services**	**Same as others**
7.1	**Overall**	**Same as others**

In one out of the **33** evaluative questions, [2]gether received particularly favourable results compared with other Trusts rated in the CQC Survey. This was Q5: Did the person or people that you saw listen carefully to you?

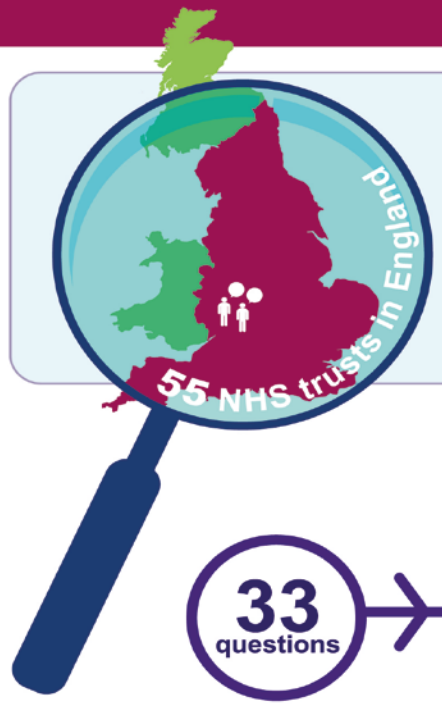
The results have been considered further for areas where improvements could be made. These include:

1. Increased emphasis to involve people in care planning meetings and decisions about their medications
2. Understanding people's individual interests and circumstances
3. Signposting and supporting individuals to other agencies for social engagement
4. Further work to ensure that service users are provided with information about contact points and out of office hours if they need support in a crisis.
5. Providing information and support from people with lived experience through the Recovery College Model

The Trust has also produced an infographic summarising the key messages from the CQC Survey and this can be seen overleaf.

National Mental Health Community Patient Survey Results 2015
Gloucestershire and Herefordshire

²gether NHS Foundation Trust



850 people sent the survey

323 people returned the survey

18 years plus

29% National response rate

39% Trust response rate
The highest nationally

33 questions → **10** domains → ²gether's results:
10 domains 'About the Same'
1 of 33 question areas 'Better than other Trusts'

Results of 10 domains

Each domain compared to other trusts

Better | About the same | Below

Health and social care workers	7.9/10
Organising care	8.6/10
Planning care	7.1/10
Reviewing Care	7.7/10
Changes in who people see	6.7/10
Crisis care	6.4/10
Treatments	7.6/10
Other areas of life	5.6/10
Overall views of care and services	7.6/10
Overall experience	7.1/10

Highlighted nationally as amongst the highest trusts rated:

- Listening carefully to our service users
- Knowing how to contact a care worker if concerned about care
- Checking if service users were getting along with their medication
- Proving help or advice in finding or keeping work
- Involving family as much as a service user would like
- Treating service users with respect and dignity

Areas for further focus:

- Involving service users in care planning meetings and decisions about medicines
- Understanding an individual's interests and circumstances
- Signposting and supporting individuals to other agencies for social engagement
- Supporting care in a crisis situation
- Providing information and support from people with lived experience through the Recovery College model

National Mental Health Community Patient Survey Results 2015
Gloucestershire and Herefordshire

2gether NHS Foundation Trust

Results of 33 questions

Each domain includes a number of questions. These are each compared to other trusts using this key:

Better | About the same | Below

Health and social care workers	7.9/10
Listen carefully	8.5/10
Enough time to discuss needs	7.8/10
Understand how mental health affects life	7.4/10
Organising Care	**8.6/10**
Kept informed of who organises care	7.7/10
Able to contact Care Co-ordinator	9.7/10
Care organised well	8.3/10
Planning care	**7.1/10**
Agreeing the care received	6.2/10
Involvement in care planning	7.2/10
Personal circumstances considered	7.7/10
Reviewing care	**7.7/10**
Discussed how care is working	7.7/10
Involvement in care review	7.7/10
Decisions made together	7.7/10
Changes in who people see	**6.7/10**
Continuity of care	7.2/10
Knowing who was in charge of care	6.3/10
Crisis care	**6.4/10**
Know who to contact out of hours	7.0/10
Support during a crisis	5.7/10
Treatment	**7.6/10**
Involved in decisions	6.8/10
Understandable medicines information	7.1/10
Medicines reviewed	8.5/10
Involved in deciding therapies to use	7.8/10
Other areas of life	**5.6/10**
Help finding physical health needs support	5.4/10
Help finding financial advice/benefits support	5.3/10
Help finding or keeping work	5.3/10
Help finding or keeping accommodation	5.2/10
Support to take part in local activities	4.1/10
Involving family or friends	7.2/10
Information about support from others with similar experiences	3.7/10
Understanding what is important to them	**6.6/10**
Help to achieve what is important to the service user	6.6/10
Helping them feel hopeful about what is important to the service user	6.3/10
Overall view and experience of services	**7.6/10**
Enough contact with services	6.7/10
Overall good experience of services	7.1/10
Treated with respect and dignity	8.5/10

Staff Survey 2015

Each year the Trust participates in the National NHS Staff Survey. This important survey provides an opportunity to understand in some depth how staff view the Trust as an employer, based on the staff pledges outlined in the NHS Constitution.

For the 2015 survey, a number of changes were made including increasing the number of Key Findings from **29** to **32**. This meant that for some findings there was no direct comparison with the previous year. In all cases however, the Trust was able to compare its findings with other Mental Health/Learning Disability Trusts.

Although the Trust's response rate was lower than anticipated at **40%**, the results have been very encouraging. It is also worth noting that the 2015 survey was conducted exclusively online for the first time by the Trust in response to feedback from staff.

Overall staff engagement has increased. This result is ascertained from the results of three Key Findings (KF) that include:

- KF1 -Staff recommendation of the Trust as a place to work or receive treatment;
- KF4 - motivation at work;
- KF7- Staff ability to contribute towards improvements at work.

This is better than average when compared with other Mental Health and Learning Disability Trusts.

The 2015 survey showed that the Trust was rated as better than average in **18** of the Key Findings, average in **13** and worse than average in only one Key Finding. This compares very favourably with the previous year when the Trust was viewed as average, or better than average in **19** Key Findings and worse than average in **10**.

It has also been very encouraging to see that staff have reported significant improvement in three key areas of their work experience, being:

- KF4 - Staff motivation at work;
- KF21- The percentage of staff who believe the organisation provides equal opportunities for career progression or promotion;
- KF31- Staff confidence and security in reporting unsafe clinical practice.

There was no significant deterioration in any of the Key Findings but the only area where the trust was viewed by staff as being worse than average was the percentage of staff reporting good communications between senior management and staff. But despite this and other small setbacks such as the lower response rate, the survey shows an overall increase in job satisfaction and staff engagement.

Results from the Staff Survey are also used to measure progress against the Workforce Race Equality Standard (WRES), which was introduced into the standard NHS contract in 2015. With this in mind, a Key Finding of the survey (KF26) showed that there had been a small increase in the number of staff reporting that they had experienced harassment, bullying or abuse from staff in the last 12 months. **22%** of respondents said that they had experienced this which although an increase on **20%** during the previous survey, equals the national average for similar Trusts. This behaviour is very much against our values and to help and support people, we have introduced a confidential system called 'Speak in Confidence' to enable staff have a confidential dialogue should they experience inappropriate behaviour at work. We are also increasing the number of Dignity at Work Officers as a further measure of support and our 'Promoting Dignity at Work' policy has been reviewed and refreshed for clarity and ease of use. Another Key Finding of the survey that forms part of the WRES is the percentage of staff believing the organisation provides equal opportunities for career progression or promotion. This was one of our most

improved findings from the survey with a response rising from 84% in the previous year to 96% of colleagues who agree with this statement, considerably better than the national average of 84%.

The survey also enables staff to add comments to explain or clarify their responses and perhaps due to the survey being online, the number of comments received has increased when compared to those received when the survey was paper based. The comments help the Trust to better understand and respond to staff concerns which is one of the key purposes of the survey.

A new action plan has been developed, taking into account the responses and comments to explore and improve areas where staff have reported the lowest levels of satisfaction. The action plan is also designed to continue to improve and maintain momentum in areas that have shown progress as we work toward improving the work experience for all our staff.

PLACE Assessment Results 2015/16

In April 2013, Patient Led Assessments of the Care Environment (PLACE) were introduced in England. PLACE assessments involve local people going into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance and for the first time in 2015, Dementia Friendly Environments. It focuses entirely on the care environment. It does not cover clinical care provision or how well staff are undertaking clinical duties.

PLACE is now in its third year and 2015 assessments took place between March and June 2015 with the results being seen in the table below.

Site Name	Cleanliness	Food Overall	Organisational Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia
Overall 2gether Trust Score	**98.16%**	**94.37%**	**88.76%**	**98.16%**	**95.33%**	**97.86%**	**96.09%**
HOLLYBROOK	**100.00%**	**83.41%**	**74.31%**	**96.87%**	**86.90%**	**96.92%**	**n/a**
WESTRIDGE	**99.90%**	**95.04%**	**91.36%**	**98.21%**	**94.59%**	**100.00%**	**n/a**
CHARLTON LANE	**95.98%**	**95.94%**	**91.56%**	**100.00%**	**98.53%**	**99.35%**	**99.36%**
WOTTON LAWN	**98.32%**	**96.66%**	**93.62%**	**100.00%**	**99.01%**	**98.92%**	**97.04%**
HONEYBOURNE, CHELTENHAM	**99.63%**	**97.70%**	**95.17%**	**100.00%**	**82.86%**	**100.00%**	**n/a**
LAUREL HOUSE (FORMERLY BRANCH LEA CROSS), CHELTENHAM	**99.82%**	**93.40%**	**86.84%**	**100.00%**	**94.44%**	**96.32%**	**n/a**
STONEBOW UNIT	**99.63%**	**90.40%**	**88.49%**	**92.04%**	**93.75%**	**97.54%**	**91.87%**
OAK HOUSE	**93.16%**	**n/a**	**n/a**	**n/a**	**88.10%**	**87.29%**	**n/a**
MH & LD National Average	98.43%	89.75%	86.25%	92.99%	89.34%	91.04%	85.28%

Key

At or above MH/LD National Average	
Below England MH/LD average	

The 2015 final PLACE results for the Trust demonstrate good overall compliance across all areas in comparison with the national average results apart from Cleanliness, which fell slightly below the national average.

As a result of the PLACE results, ^{2}gether Trust has developed a comprehensive action plan for each unit to improve compliance in the areas which are below average. There will be an increased focus on Hollybrook and Oak House as they did not score as well across a number of domains. The action plans highlight areas for improvement and resolution and are owned by the unit managers under the Matrons. Progress against these action plans is monitored by the Patient Environment Action Groups (PEAG) and supported by the Estates and Facilities Department.

Annex 1: Statements from our partners on the Quality Report

Healthwatch Herefordshire is pleased to have been a partner of 2gether over the past year. We congratulate the trust on its achievement of a 'Good' rating by the CQC following its recent inspection, this is something to be proud of and we believe makes 2gether one of only two mental health trusts to achieve this standard. We would also like to thank 2gether for participating in our recent Mental Health Question Time event which proved very successful and highlighted particularly the mental health service needs of young people.

There were highlighted some areas of improvement required, particularly in community services for older people , learning disabilities and autism and we look forward to progress being made on these in the coming year.

We also strongly support the Triangle of Care initiative and with our partner organisation HCS are working with 2gether to ensure that this is implemented throughout the Herefordshire services as soon as possible.

One issue we have continued to focus on during the past year has been the need to bridge the gap between 2gether's internal evidence of care plans provision and service users' experience of this. We support the Trust's efforts to raise the achievement of this important element of service delivery.

The higher than expected suicide rates in the county show the need to implement prevention strategies and in a similar way to the Gloucestershire initiative we look forward to plans being rapidly developed and implemented in Herefordshire.

During the past year addiction services responsibility was passed to Addaction and we strongly encourage effective liaison with them and 2gether for integrated care planning in those cases where people with addictions also have other mental health difficulties.

Continued development of crisis care planning is also an area in which we encourage attention to implementation of service improvement. In our rural area access to crisis services is particularly difficult and this requires careful attention to integrate a number of services effectively. Healthwatch is happy to be supportive of this development.

Continued development of IAPT and similar early intervention services is also strongly supported and it is clear that this is an area which is particularly important to younger people.

Oak House in Hereford provides excellent intermediate care services in a poor physical environment and we strongly urge the speedy investment in improvements for residents receiving their care there.

Once again Healthwatch Herefordshire thanks 2gether Trust for its open and supportive culture and its continued assistance to Healthwatch in achieving our mutual aim of better mental health services for the people of Herefordshire.

Ian Stead
Board Member - Healthwatch Herefordshire

NHS
Gloucestershire
Clinical Commissioning Group

NHS Gloucestershire CCG Comments in Response to 2gether NHS Foundation Trust Quality Report 2015/16

NHS Gloucestershire Clinical Commissioning Group (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by 2gether NHS Foundation Trust (2gNHSFT) for 2015/16.

The past year has presented major challenges across both Health and Social care in Gloucestershire and we are very pleased that 2gNHSFT have worked jointly with partnership organisations, including the CCG during 2015/16 to deliver a system wide approach to maintain, further develop and improve the quality of commissioned services and outcomes for service users and carers.

This year 2gNHSFT was subject to a comprehensive external inspection by the Care Quality Commission (CQC). The CCG were very pleased that the inspection report rated the Trust as Good overall which provided assurance. The Trust took immediate action to make changes where improvements were suggested or recommended. The CCG will work with the Trust to monitor the implementation of the CQC action plan developed to address areas identified for further improvement, with a focus on identified improvements in Learning Disabilities services in line with the recommendations of the Mazars report.

We were pleased to note the many examples of good practice and care provided by 2gNHSFT, as they were the first Trust in the country to be awarded an 'Outstanding' rating for crisis and place of safety services, and acute adult inpatient and psychiatric intensive care services.

The 2015-16 Quality Report is easy to read and understandable given that it has to be considered by a range of stakeholders with varying levels of understanding. The report clearly identifies how the Trust performed against the agreed quality priorities for improvement for 2015/16 and also outlines their priorities for improvement in 2016/17.

The CCG endorses the quality priorities included in the report whilst acknowledging the very difficult financial and partnership challenges 2gNHSFT have to address in the future,
and are pleased to note progress and achievement against these quality priorities.

We commend the achievement of the target for improving physical health care for people with schizophrenia and other serious mental illnesses in 2015/16, whilst recognising the commitment of staff to further improve the physical health and wellbeing outcomes for patients in 2016/17. Whilst we note that the Trust met the target to increase the number of vulnerable people who are able to access the Improving Access to Psychological Therapies (IAPT) service 'Lets Talk', 2gNHSFT recognise that further work is required to improving access to IAPT services to meet national targets. The CCG sees this as a high priority and will continue to work with the Trust in 2016/17 to improve performance and quality improvement in this area.

Whilst 2gNHSFT did not achieve the target for reducing the number of deaths relating to identified risk factors of people in contact with services when compared to data from previous years, we recognise that the number of suicides reported was in line with national reporting trends and that minimising the risk of suicide continues to be a priority for the Trust in 2016/17. The CCG note the Trust is an active member of the Gloucestershire Suicide Prevention Partnership Forum (GSPPF) and is working in partnership with other key stakeholders in Gloucestershire to reducing stigma around suicide and self-harm.

The Trust has demonstrated continued improvement in service user and carer experience of mental health services provided, and we welcome the focus on improvement of the experience of service users

in transition from children and young people's mental health service to adults. The CCG are pleased to note the Trust's focus on continuing improvement in identified priorities for effectiveness, service user experience and safety in 2016/17. We note achievement of targets in 2015/16, and whilst there are a number of areas where targets were partially or not achieved, the CCG are content that the Quality Report provides a balanced view.

The CCG also acknowledge the Trust's commitment to the 'Sign up to Safety Campaign' and all the patient safety initiatives such as the continued involvement in the NHS South of England Improving Patient Safety and Quality in Mental Health Collaborative, NHS Safety Thermometer, 'Safewards' interventions and Reducing Physical Interventions project to focus improvement on ways of working, and thereby improving the patient's experience of services provided by the Trust.

The CCG acknowledge 2g's continued strong focus on service user and carer experience and quality of caring, which demonstrates a joint commitment to delivering high quality, compassionate care, and also dignity and respect with which service users are treated. We are pleased to note that the Trust are seeking to build upon their commitment to the Carer's Trust Triangle of Care initiative CQUIN by supporting staff to work with families, including the needs of young carers.

We are pleased to note that although the Trust's response rate to the Staff Survey 2015 was lower than anticipated, the results have been very encouraging, with an overall increase in staff engagement, which was better than average when compared to other Mental Health and Learning Disabilities Trusts. One area identified as being worse than average was staff responses in relation to good communications between senior management and staff. The Trust will need to maintain a focus on improving communication with its staff to ensure these areas continue to improve over the coming year.

We were pleased to note there continues to be a high level of clinical participation in local clinical audits, and also a positive increase in activity in relation to Clinical Research.

2gNHSFT need to be in a strong position to manage both present and future challenges. The CCG will continue work with the trust to deliver mental health and learning disabilities services that provide best value with a clear focus on providing quality, safe and effective care for the people of Gloucestershire.

Gloucestershire CCG wish to confirm that to the best of our knowledge we consider that the Quality Report contains accurate information in relation to the quality of services provided by 2gNHSFT. During 2016/17 the CCG wish to work with 2gNHSFT, all stakeholders and the people of Gloucestershire to further develop ways of receiving the most comprehensive reassurance we can regarding the quality of the mental health and learning disability services provided to the residents of Gloucestershire and beyond.

Dr Marion Andrews-Evans
Executive Nurse & Quality Lead
NHS Gloucestershire CCG

NHS
Herefordshire
Clinical Commissioning Group

CCG response to 2g NHS Foundation Trust Quality Accounts

Herefordshire Clinical Commissioning Group (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by 2g NHS Foundation Trust (2gNHSFT) for 2015/16. The report is easy to read and understandable given that it has to be considered by a range of stakeholders.

Within the past year Herefordshire Health and Social Care partnerships have faced varied challenges, 2gNHSFT has worked together with partnership organisations, including the CCG to face the challenges whilst striving to deliver improved quality of care and outcomes for the residents of Herefordshire.

The 2014/15 Quality Report demonstrates some of the challenges, concerns and opportunities that the trust has faced. Herefordshire CCG continues to regularly attend the Trust Quality Committee meetings and contribute constructively at the Contract Quality Review Forum.

The CCG acknowledge 2gNHSFT's continuing focus on patient and carer experience and the delivery of high quality of care, which underpins all clinical work delivered by the Trust, the results of this focus is demonstrated in the outcomes from the Friends and Family test with over 90% of respondents reporting they would recommend 2gNHSFT. The links between poor mental health and poor physical health have been long established, The work 2gNHSFT has undertaken to improve the physical health of their patients is to be commended and also contributes to improving the patient's experience of services provided by the Trust.

The development of an adult personalised discharge care plan has enabled patients to better understand their mental health illness and take appropriate actions should a relapse occur.

2gNHSFT have demonstrated improvement in increasing the numbers of people accessing the adult IAPT service, especially from defined vulnerable service user groups and have supported the establishment of a child/young person IAPT service. The CCG would wish to see particular focus on continuing improvement in these areas for 2016/17.

The CCG was disappointed to note that the Trust did not reach its target of following up 95% of adults within 48 hours of discharge from psychiatric inpatient care, 91% of Herefordshire patients receiving follow up in the set timescales. The CCG will monitor this aspect of care to ensure that the practice changes undertaken by the Trust support improved outcomes.

We were pleased to note there continues to be a high level of 2gNHSFT engagement in both national and local clinical audits and research as well as participation in national confidential enquiries.

The CCG reviews 2gNHSFT's incident responses on a regular basis and find robust systems and processes in place with evidence of duty of candour has been undertaken in each report and evidence that learning is embedded within the wider Trust workforce.

We are aware that 2gNHSFT are actively engaged in partnership working with the Local Authority, other statutory partners and voluntary sector bodies in Herefordshire through many fora. We are confident that this engagement will continue throughout 2016/17.

The CCG endorses all 2gNHSFT's priorities for improvement as contained in this report in the expectation that they will lead to improved delivery against effectiveness, service user experience and safety, supporting improved outcomes for service users.

Following a review of the information presented within this report, coupled with commissioner led reviews of quality across all providers, the CCG is satisfied with the accuracy of the report. This recognises the Trust commitment to quality and demonstrates transparency, honest assessment and further development which mirrors the aspirations of commissioners.

Anne Owen
Interim Chief Nurse
Herefordshire CCG

The Royal College of Psychiatrists

Statement of Participation in National Quality Improvement Projects managed by The Royal College of Psychiatrists' Centre for Quality Improvement

	Trust Participation	National Participation
Service Accreditation Programmes and Quality improvement Networks		
Eating Disorder Inpatient Wards	0 Wards	32 Wards
Forensic Mental Health Services	1 Service	123 Services
Inpatient Child & Adolescent Wards	0 Wards	108 Wards
Inpatient Rehabilitation Units	2 Wards	52 Wards
Learning Disability Inpatient Wards	0 Wards	42 Wards
Mother & Baby Units	N/A	17 Units
Older Peoples' Inpatient Wards	5 Wards	68 Wards
Psychiatric Intensive Care Wards	1 Ward	39 Wards
Working Age Inpatient Wards	5 Wards	146 Wards
Child & Adolescent Community Mental Health Teams	1 Team	64 Teams
Crisis Resolution & Home Treatment Teams	4 Teams	40 Teams
Electroconvulsive Therapy Clinics	2 Clinics	99 Clinics
Memory Clinics	1 Clinic	105 Clinics
Perinatal Community Mental Health Teams	0 Teams	17 Teams
Psychiatric Liaison Teams	0 Teams	52 Teams

Annex 2: Statement of Directors' Responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2015 to April 2016
    - papers relating to Quality reported to the Board over the period April 2015 to April 2016
    - feedback from Gloucestershire commissioners dated May 2016
    - feedback from Herefordshire commissioners dated May 2016
    - feedback Governors dated 10 March 2015
    - feedback from Herefordshire Healthwatch dated May 2015
    - feedback from Gloucestershire Healthwatch dated XXXX
    - feedback from Gloucestershire Overview and Scrutiny Committee dated XXXX
    - feedback from Herefordshire Overview and Scrutiny Committee dated XXXX
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2016
    - the 2015 national patient survey
    - the 2015 national staff survey
    - the Head of Internal Audit's annual opinion over the trust's control environment dated XXXX
    - CQC Intelligent Monitoring Report dated February 2016
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report (available at www.monitor.gov.uk/annualreportingmanual) .

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

NB: sign and date in any colour ink except black

….....Date.....Chair

.....Date.....Chief Executive

Annex 3: Glossary

ADHD	Attention Deficit Hyperactivity Disorder
BMI	Body Mass Index
CAMHS	Child & Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
CPA	Care Programme Approach: a system of delivering community service to those with mental illness
CQC	Care Quality Commission – the Government body that regulates the quality of services from all providers of NHS care.
CQUIN	Commissioning for Quality & Innovation: this is a way of incentivising NHS organisations by making part of their payments dependent on achieving specific quality goals and targets
CYPS	Children and Young Peoples Service
DATIX	This is the risk management software the Trust uses to report and analyse incidents, complaints and claims as well as documenting the risk register.
GriP	Gloucestershire Recovery in Psychosis (GriP) is ^{2}gether's specialist early intervention team working with people aged 14-35 who have first episode psychosis.
HoNOS	Health of the Nation Outcome Scales – this is the most widely used routine Measure of clinical outcome used by English mental health services.
IAPT	Improving Access to Psychological Therapies
Information Governance (IG) Toolkit	The IG Toolkit is an online system that allows NHS organisations and partners to assess themselves against a list of 45 Department of Health Information Governance policies and standards.
MCA	Mental Capacity Act
MHMDS	The Mental Health Minimum Data Set is a series of key personal information that should be recorded on the records of every service user
Monitor	Monitor is the independent regulator of NHS foundation trusts. They are independent of central government and directly accountable to Parliament.
MRSA	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. It is also called multidrug-resistant

NHS	The National Health Service refers to one or more of the four publicly funded healthcare systems within the United Kingdom. The systems are primarily funded through general taxation rather than requiring private insurance payments. The services provide a comprehensive range of health services, the vast majority of which are free at the point of use for residents of the United Kingdom.
NICE	The National Institute for Health and Care Excellence (previously National Institute for Health and Clinical Excellence) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.
NIHR	The National Institute for Health Research supports a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.
NPSA	The National Patient Safety Agency is a body that leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector.
PHSO	Parliamentary Health Service Ombudsman
PICU	Psychiatric Intensive Care Unit
PLACE	Patient-Led Assessments of the Care Environment
PROM	Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective.
QRP	The Quality and Risk Profile is a monthly compilation by the CQC of all the evidence about a trust they have in order to judge the level of risk that the trust carries to fulfil its obligations of care
RiO	This is the name of the electronic system for recording service user care notes and related information within ^{2}gether NHS Foundation Trust.
ROMs	Routine Outcome Monitoring (ROMs)
SIRI	Serious Incident Requiring Investigation, previously known as a “Serious Untoward Incident”. A serious incident is essentially an incident that occurred resulting in serious harm, avoidable death, abuse or serious damage to the reputation of the trust or NHS. In the context of the Quality Report, we use the standard definition of a Serious Incident given by the NPSA
SMI	Serious mental illness
VTE	Venous thromboembolism is a potentially fatal condition caused when a blood clot (thrombus) forms in a vein. In certain circumstances it is known as Deep Vein Thrombosis.

Annex 4: How to Contact Us

About this report

If you have any questions or comments concerning the contents of this report or have any other questions about the Trust and how it operates, please write to:

Mr Shaun Clee
Chief Executive Officer
2gether NHS Foundation Trust
Rikenel
Montpellier
Gloucester
GL1 1LY

Or email him at: shaun.clee@glos.nhs.uk

Alternatively, you may telephone on 01452 894000 or fax on 01452 894001.

Other Comments, Concerns, Complaints and Compliments

Your views and suggestions are important us. They help us to improve the services we provide.

You can give us feedback about our services by:

- Speaking to a member of staff directly
- Telephoning us on 01452 894673
- Completing our Online Feedback Form at www.2gether.nhs.uk
- Completing our Comment, Concern, Complaint, Compliment Leaflet, available from any of our Trust sites or from our website www.2gether.nhs.uk
- Using one of the feedback screens at selected Trust sites
- Contacting the Patient Advice and Liaison Service (PALS) Advisor on 01452 894072
- Writing to the appropriate service manager or the Trust's Chief Executive

Alternative Formats

If you would like a copy of this report in large print, Braille, audio cassette tape or another language, please telephone us on 01452 894000 or fax on 01452 894001.

Agenda Item 10 **Enclosure Paper E**

Report to: 2gether Trust Board, 26 May 2016
Author: Siân Waygood, Service Experience Clinical Manager
Presented by: Jane Melton, Director of Engagement and Integration

SUBJECT: **Complaints Annual Report 2015/2016**

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

EXECUTIVE SUMMARY

(1) Assurance

This report provides **Significant Assurance** that the Trust has made significant effort to listen to, understand and resolve complaints over the past year. The themes of complaints received during the period 2015-16 have been reviewed and comparisons made with information from previous years. Systems have been refined and analysed in an effort to understand and ensure that complaints and concerns from individuals are responded to promptly and effectively. Methods of disseminating learning across the Trust continue to be refined and developed.

The number of complaints received during 2015-16 was lower than the previous year (n=131). Whilst the numbers of formal complaints has reduced there is **Significant Assurance** that individuals are increasingly prepared to share concerns. This can be evidenced by the increased number of 'concerns' resolved without the formality of the NHS complaints process.

In their Comprehensive Inspection of the Trust in October 2015, the Care Quality Commission reviewed complaints information and interviewed key staff involved in complaint resolution. They noted that the Trust detailed the nature of complaints and a summary of actions taken in response. They found that complaints had been appropriately investigated by the trust and included recommendations for learning offering further independent scrutiny as evidence of significant assurance.

(2) Improvement – practice developments planned

A number of developments for practice development are planned for the coming year including:

- Implementing and evaluating the revised Non-Executive Director Audit to enable review of national best practice in investigation and complaint management in line with recent PHSO national recommendations.

- Ensuring there is reasonable adjustment to the complaint process to raise awareness and ensure it is accessible to everyone using our services particularly older people, children and people with a learning disability.

- Continue to embed learning from complaints in practice and seek assurance that this is disseminated across the Organisation

- Reviewing and updating the Trust's Complaint Policy to reflect changes in practice and national guidance.

- Working with colleagues across the Trust to review and improve dissemination of learning from complaints to ensure service user feedback is considered and embedded in practice.

- Providing training and support to investigators to ensure they are confident in applying national and local best practice for complaint investigation.

- Continuing to triangulate complaints with concerns, comments and compliments and survey information received to gain rich information to inform practice and service development.

- Embedding the new Datix web data collection system in practice and utilise the additional functionality to develop and share information with Locality Boards and Clinical Teams.

RECOMMENDATIONS

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

Corporate Considerations	
Quality implications:	The Complaints Annual Report offers assurance that the Trust continues to strive to enable continuous improvement to the quality of services by implementing learning from service users and carers.
Resource implications:	The Complaints Annual Report offers assurance to the Trust that resources are being used to support the best service experience for service users and carers.
Equalities implications:	The Complaints Annual Report offers assurance that the Trust is attending to its responsibilities regarding equalities for service users and carers.
Risk implications:	Feedback from service experience offers an insight into how services are received. The information provides a mechanism for identifying performance, reputational and clinical risks.

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			P
Excelling and improving	P	Inclusive open and honest	P
Responsive	P	Can do	P
Valuing and respectful	P	Efficient	P

Reviewed by:		
Jane Melton	Date	18th May 2015

Where in the Trust has this been discussed before?		
Governance Committee	Date	22nd April 2016

What consultation has there been?		
	Date	

Explanation of acronyms used:	NHS – National Health Service HW – Healthwatch PALS – Patient Advise and Liaison Service GP – General Practitioner OPS – Older Peoples Service CYPS – Children and Young People's Service PHSO – Parliamentary Health Services Ombudsman HSCIC - Health and Social Care Information Centre

Annual Report of Complaints

1st April 2015 – 31st March 2016

CONTENT

[2]gether NHS Foundation Trust
Complaints Annual Report – 2015/16

1. INTRODUCTION

1.1 This report presents information regarding complaints (and for completeness) concerns received by the Trust between 1st April 2015 and the end of March 2016.

1.2 The Complaints Annual Report is an external audit requirement as part of the assurance processes for the Quality Report/Account. This report is a summary of complaints received during the year, which are more routinely reported in the Quarterly Service Experience Reports. The Service Experience Reports provide aggregated information gained from an in-depth analysis of service user and carer experience information from a variety of sources, including complaints and concerns. This process enables the organisation to understand how services are experienced, to take action to improve the experience of those who use our services, and to learn from both positive and challenging feedback.

1.3 The Annual Report of Complaints provides a broad overview of the national and local context to explain the background to the report. It goes on to provide specific information about the number of complaints received throughout the year, emerging themes of complaints during the year, a summary analysis of the issues that have arisen, and the lessons learned by the organisation. Comparative data is provided with previous years and where available, with other healthcare organisations. Some examples of individual experiences are also highlighted in vignettes to provide some context and context to the report. The report concludes with recommendations for developments in complaint handling, recording and reporting.

2. CONTEXT

2.1 National Context

Nationally and locally the experience of service users and carers remains vitally important when evaluating and improving services. Practice experience coupled with current national guidance[1] has informed developments within the Service Experience Department and the complaints process. Key actions and areas for development include:

- Ensuring a consistent approach to the investigations process
- Conducting complaint investigations through appropriately skilled and impartial members of staff who are allocated time to undertake the process as a priority activity.
- Ensuring a consistent and independent approach to the investigations process

[1] http://www.ombudsman.org.uk/reports-and-consultations/reports/health/a-review-into-the-quality-of-nhscomplaints-investigations-where-serious-or-avoidable-harm-has-been-alleged/5

2.2 Local Context

In their Comprehensive Inspection of the Trust in October 2015, the Care Quality Commission reviewed complaints information and interviewed key staff involved in complaint resolution. They noted that the Trust detailed the nature of complaints and a summary of actions taken in response. They found that complaints had been appropriately investigated by the trust and included recommendations for learning. In their published report about [2]gether NHS Foundation Trust, the CQC noted that:

> The *Trust operates an effective complaints system. Information relating to complaints past and present were orderly and up to date. The complaints staff were able to speak with knowledge, confidence and transparency of past and present complaints.*

The CQC also noted that:

> *Staff felt confident in handling complaints from patients. All staff we spoke to about complaints said they would make efforts to resolve any complaint before it became formal. Staff were also happy to support patients in making formal complaints. The complaints service fed back the outcome of complaints to the relevant team manager.*

Developments in complaint resolution this year have included:

- Revision of guidance and process for gaining consent
- Updating the complaints policy to reflect the organisations 'Duty of Candour'
- Development work to implement the new Datix Web information system to record complaints
- Draft informal learning pathway developed
- Draft Persistent / Vexatious Complainant Policy developed
- Ongoing work to assure that learning from complaints and concerns is embedded in practice.
- Recruitment to vacant posts within the Service Experience Department

2.3 Service Experience Committee

An engagement approach enables us to be a learning organisation, to address any areas for improvement, to provide evidence of service experience outcome and to acknowledge best practice. [2]gether's Service Experience Committee is held on a quarterly basis and membership is drawn from people who use our services, carers, partner organisations and senior members of operational staff.

2.4 Quarterly Service Experience Reports

The quarterly reports on Service Experience to the Trust Board reflect the importance of leading for positive service experience. The Trust culture is to welcome feedback

including complaints, concerns, comments and compliments from any service user or their representative, to aim to resolve the complaint and to learn from/take action whenever possible.

Insights from complaints are cascaded through governance forums to disseminate learning and inform practice. Key themes are highlighted and assurance is sought from Locality Directors regarding local implementation. Work continues to build on current practice to learn from service users experiences with work also progressing regarding cross organisational collaboration.

2.5 Service Experience Department

The Service Experience Department aims to deliver a robust, clinically led approach to the management of all aspects of the Trust's Service Experience procedures in partnership with operational colleagues across the Trust services.

This year a dedicated Complaints Manager and Complaints Officer have been appointed to the Team. In addition staff developments over the past twelve months have consolidated the Patient Advice and Liaison role within the service and enabled wider service user feedback to be coordinated by the department including the Friends and Family Test and Local Survey.

Work in ongoing in preparation for the new Datix Web based information system which is due to be launched in in May 2016.

2.6 Training and Practice Development to Resolve Complaints

Training at Trust Induction with regard to complaint handling and service experience continues for all new ^{2}gether staff.

Serious Incident and Complaint Training for senior staff continues to be offered regularly by a senior member of the Service Experience Department to support staff to have the appropriate skills for complaint resolution.

Additional training to support completing complaint investigators is planned for 2016-2017 and this will aim to update staff on current best practise, national guidance and local implementation.

Working with managers and professional leads, a focus on support and training for the staff groups who more regularly receive complaints will be offered.

2.7 Audit of Complaints

The Trust continues the good practice of commissioning regular audits of the complaint handling process which is undertaken by Non-Executive Directors (NED) of the Trust Board. Proposed revisions to the existing Audit were presented to the Governance Committee in March 2016. The new format will monitor if the Trust is meeting current standards for complaint management and will provide greater emphasis on the rigour of the investigation, the openness and candour of communication and the efficacy of the organisation in learning from complaints and concerns. Following scrutiny by Non-Executive Directors, the new audit is due to be introduced in July 2016.

Audits undertaken using the revised audit template will provide assurance that the Trust continues to use current evidence-based practice in line with the values of the organisation.

2.8 Teamwork across the Trust

The Service Experience Department works closely with colleagues in Localities, services and with corporate departments. Regular meetings have taken place with Service / Locality leads and Team Managers. Some examples of action taken as a consequence of liaison and feedback from operational staff include:

- Additional time allocated for investigations when the concerns expressed are extensive and / or complex.
- Training sessions to address needs highlighted by staff.
- Development of an informal concerns process to capture learning which has not escalated to a formal complaint.
- Revisions to the complaint investigation format and quality assurance check list to address omissions and promote learning

The team will continue to work closely with colleagues to support effective complaint resolution and dissemination of learning identified as part of the complaint handling process.

3. COMPLAINT INFORMATION 2015-16

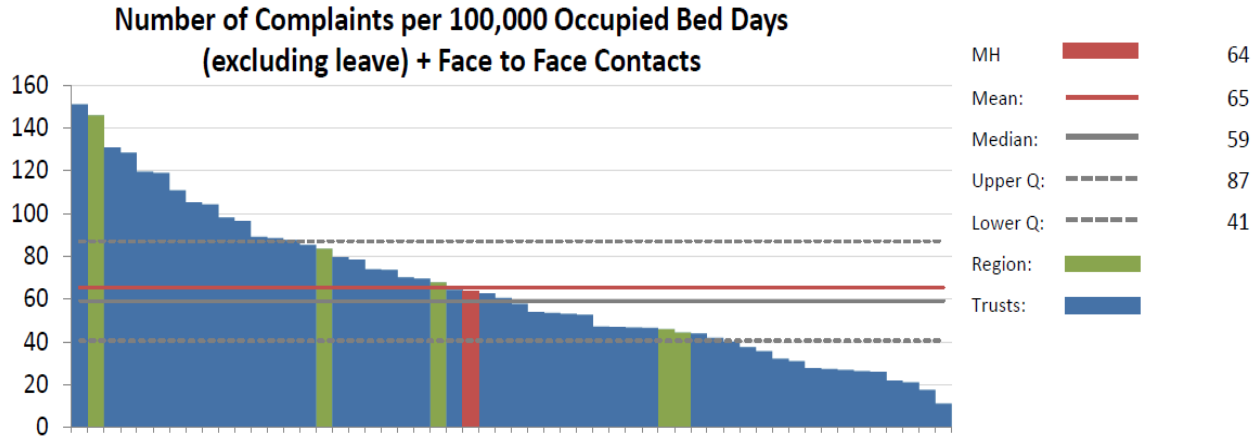
3.1 National Complaint Data

In 2015/2016 the Health and Social Care Information Centre (HSCIC) started collecting additional information about complaints to NHS organisations. Aggregated quarterly reports are emerging[2]. However, the HSCIC suggest caution in the interpretation of current information.

2gether also takes part in a separate national benchmarking process. The number of complaints reported across health care organisations in relation to people seen features in Figure 1. In this calculation, [2]gether NHS Foundation Trust had one complaint less than the national average as shown in Figure 1 below.

[2] http://www.hscic.gov.uk/searchcatalogue?productid=20567&topics=0%2fPatient+experience&sort=Relevance&size=10&page=1#top

Figure 1 – Benchmark of reported formal complaints



3.2 [2]gether NHS Foundation Trust Complaints and Concerns

Any service users or carer who raises a new complaint or concern is contacted by a member of the Service Experience Team. This individualised process enables the key issues that the person has to be identified and the outcomes required by the complainant to be established. It is also an opportunity for the NHS Complaint process to be explained and for a less formal approach to resolution to be explored. The priority is early resolution where matters can be addressed in a person's care.

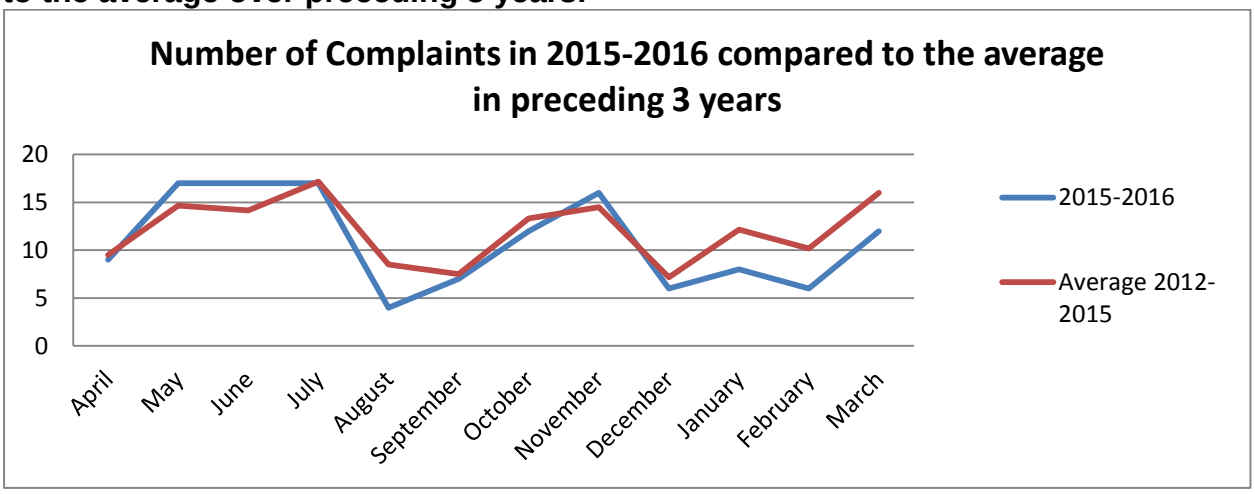
3.2.1 Numbers of reported formal Complaints

Between the 1st April 2015 and the 31st March 2016 the Trust recorded **131** formal complaints, a 17% reduction on the previous year (where n=158 complaints).

It is important to note that HSCIC request and report by number of individual complaints *issues* that are embedded within each complaint correspondence. The number of complaint issues reported to HSCIC this year by [2]gether was **605** and these were embedded in 131 individual complaints. The number of complaint issues within each complaint ranged between **1** and **20**. The outcome of investigations, that is whether aspects of complaints were Upheld, Partially Upheld or Not Upheld were also reported this way to the HSCIC this year.

The pattern of complaint numbers received month by month over the previous 4 years is relatively consistent with peaks in reported complaints in July, November and March (See Figure 2). This information is important for workforce considerations to ensure that individuals receive a timely response to their complaints.

Figure 2 – The numbers of complaints received in 2015-2016 by month compared to the average over preceding 3 years.

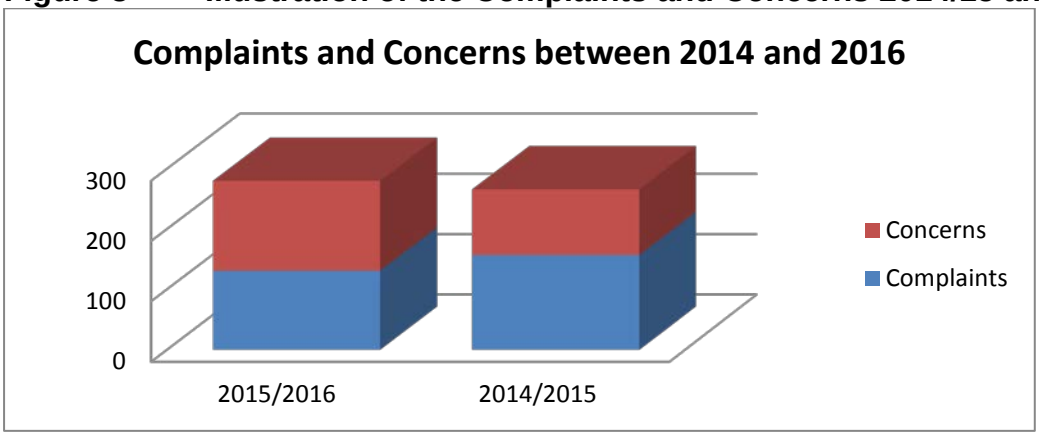


3.2.2 Comparison of formal Complaints and Concerns 2014/15 and 2015/16

A greater proportion of enquiries to the Service Experience Team were supported through our management of 'concerns' process in 2015-16 (see Figure 3).

Analysis of this information suggests that whilst there is a reduction in the actual number of formal complaints, there has also been a 26% increase in the number of 'concerns' (n=149) reported to the Service Experience Department (See Figure 3). Concerns of this type are also managed through the Service Experience Department with an emphasis of a more informal approach to resolution through negotiation between operational staff / the complainant and other service areas and organisations. One interpretation of the numbers could be that the increased emphasis in responding to and resolving concerns raised in a timely way has had a slight impact on reducing the number of formal complaints.

Figure 3 Illustration of the Complaints and Concerns 2014/15 and 2015/16



There is a 5% increase in the total number of complaints and concerns reported to the Service Experience Department 2015 – 2016. This is viewed as positive as we actively

encourage people to engage with us, share views of experience and seek resolution where concerns are raised.

3.2.3 Complaints by Staff Group Type

The number of complaint issues involving different disciplines and staff groups has been recorded for Health and Social Care Information Centre (HSCI) this year. It has been possible to attribute the majority of formal complaint issues to a particular staff group and these data are presented in Figure 4.

Figure 4 Actual number of complaint issues by staff group type

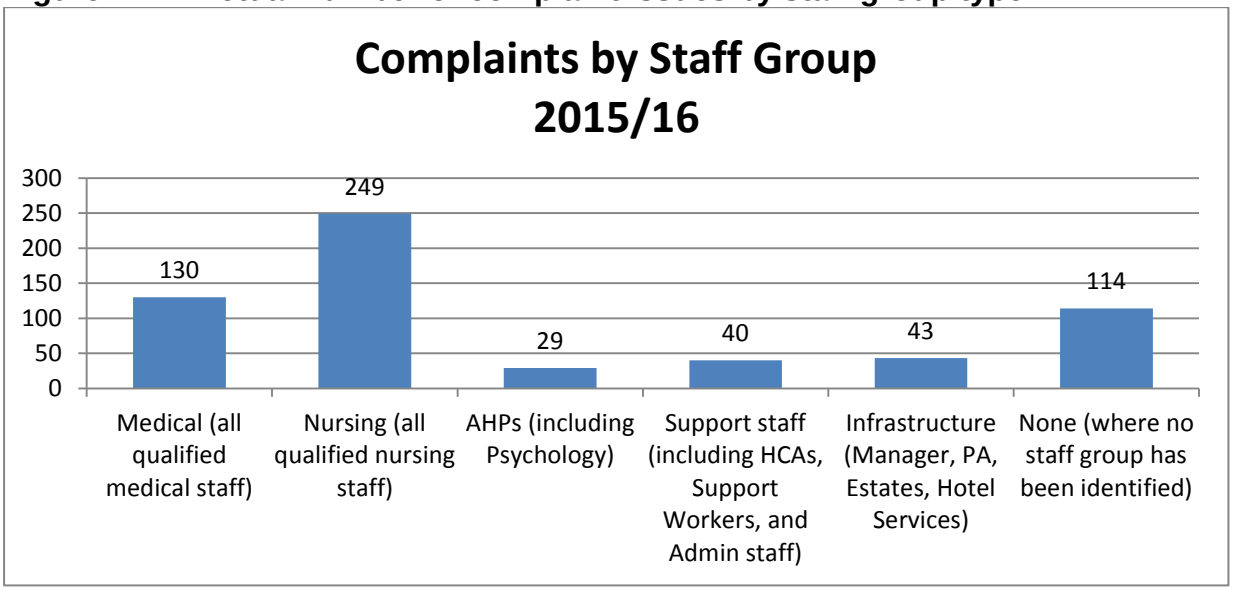


Figure 5 – Comparison of staff group % of complaint issues in 2015/16 compared with staff group % of workforce.

Staff Group	% of total complaint issues	% of workforce figures
Medical (qualified)	**22%**	**5%**
Nursing (qualified)	**41%**	**30%**
AHP's Psychology, Social Work	**5%**	**16%**
Support staff	**7%**	**22%**
Infrastructure staff	**7%**	**27%**
No staff group attributable to complaint issue	**19%**	

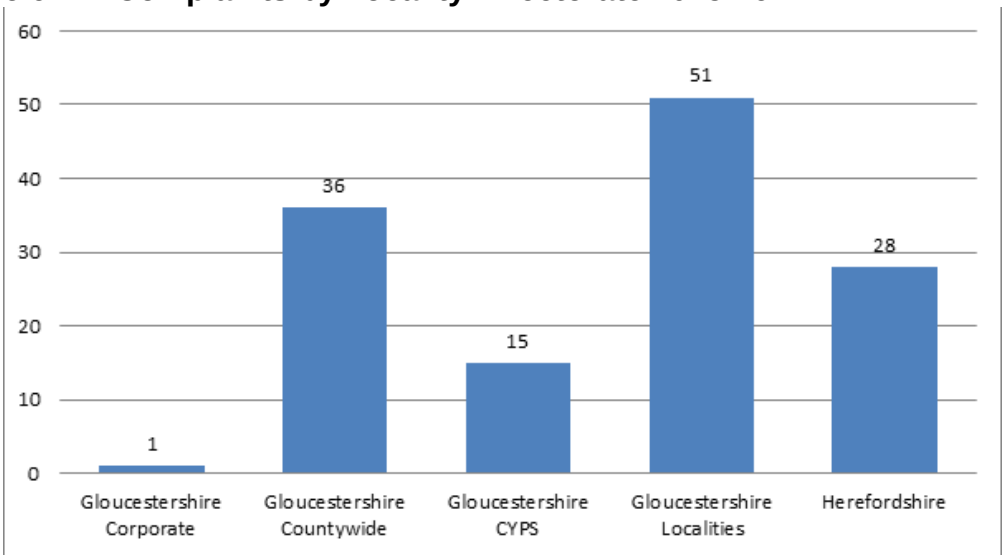
This analysis suggests that that the highest proportion of complaint issues are in relation to qualified medical and nursing colleagues**.**

3.2.4 Complaints by Locality Directorate

Actual numbers of complaints by Locality Directorate are shown in the bar chart of Figure 6. Levels of complaints by county served are consistent when compared to the number of client contacts (see Figure 10).

Further analysis of complaint activity at Locality and Team level will be facilitated by the new Datix Web Information System for 2016/17.

Figure 6 Complaints by Locality Directorate 2015-16



3.3 Time Taken to Acknowledge Complaints

Best practice standards suggest that each person contacting the department to raise a concern should be contacted within three working days. Service Experience staff will seek to resolve any concerns in the most timely and proportionate manner. Service users who wish to pursue a formal complaint will have their complaint issues clarified on the telephone and sent to them in writing for confirmation.

In 2015-2016, 99% (n=130) of complainants were contacted within 3 days or less to acknowledge and further clarify their concerns.

One person did not receive an acknowledgement within 3 working days. Investigation into this incident has identified that there were multiple complaints submitted on the same topic by members of one family and it was not immediately apparent that each representation needed to be dealt with individually.

3.4 Time Taken to Close Complaints

147 complaints[3] were closed between the 1st April 2015 and 31st March 2016.

- 3% of complaints were closed within 25 days
- 33% of complaints were closed between 25 and 60 days and
- 49% of complaints took over 60 days to close.
- 15% of complaints remained open at the end of the financial year.

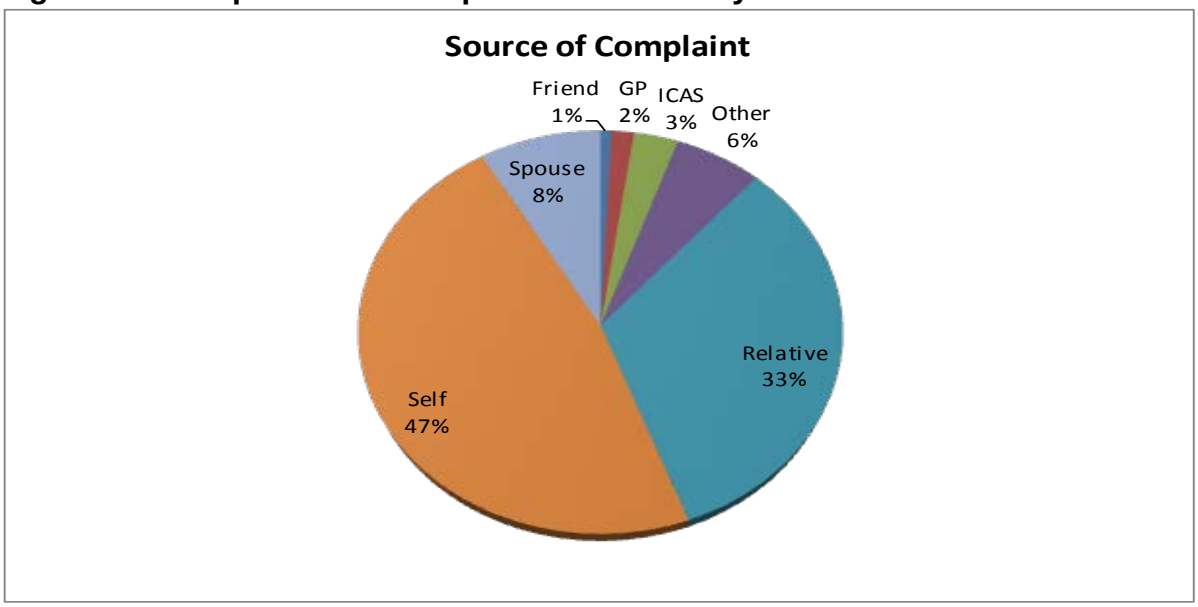
[3] This number includes complaints that were open in the previous reporting year.

The number of complaints across the year which have taken in excess of 60 days before being closed has increased. This matter has been of concern during the year as the timelines of responses is important for the service user/carer. The matter was escalated to the Trust's Risk Register during the reporting period and mitigating action was taken. Performance improved toward the end of the reporting period and this resulted in a lower proportion of complaints remaining 'open' into the new financial year.

3.5 Source of Complaints

The source of complaints remains similar to previous years. Figure 8 illustrates 47% of people who complained contacted us directly to raise concerns, which is 5% higher than 2014-2015. A similar proportion of complaints this year were made by family members and carers. In total 88% of complaints came from service users, their spouses or carers and relatives.

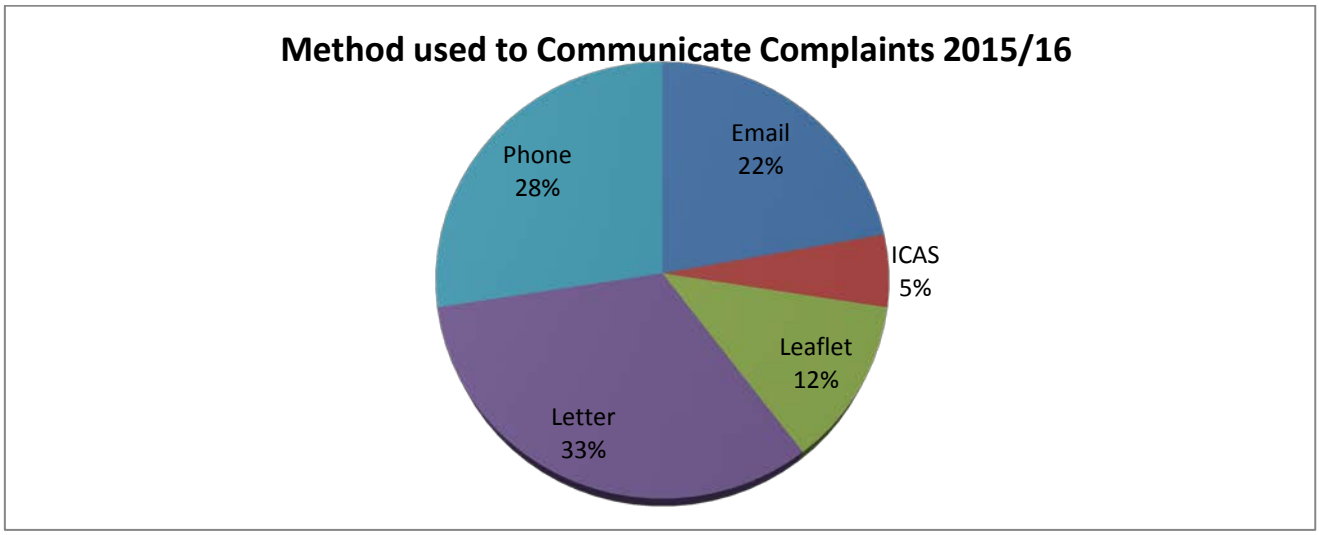
Figure 8 – Comparison of complaints received by source 2015-2016



3.6 Method Used to Communicate Complaints

The trend for submitting complaints electronically continues to grow. 22 % of complaints are now being received by email. The number of people raising complaints by telephone has doubled since 2013-2014. People writing to the Trust to articulate their concerns has remained consistent whereas those submitting complaints via the complaints, concern, compliments, comments leaflet has reduced.

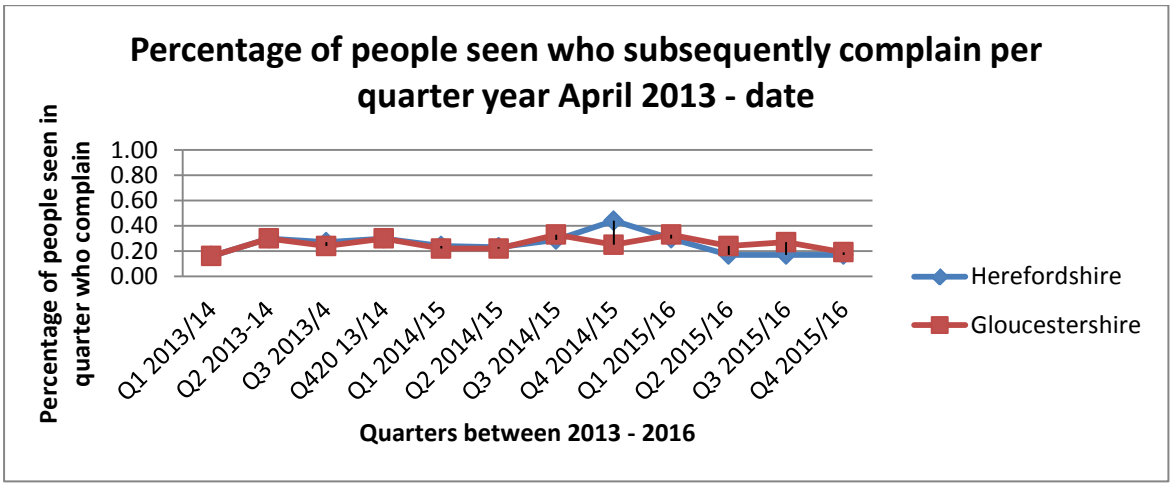
Figure 9: Method used to communicate complaint to the Trust



3.7 Number of patients on caseload each quarter compared to the number of complaints received

The number of patients on caseload each quarter in relation to the number of complaint submitted by service users and their carers has remained relatively constant over recent years.

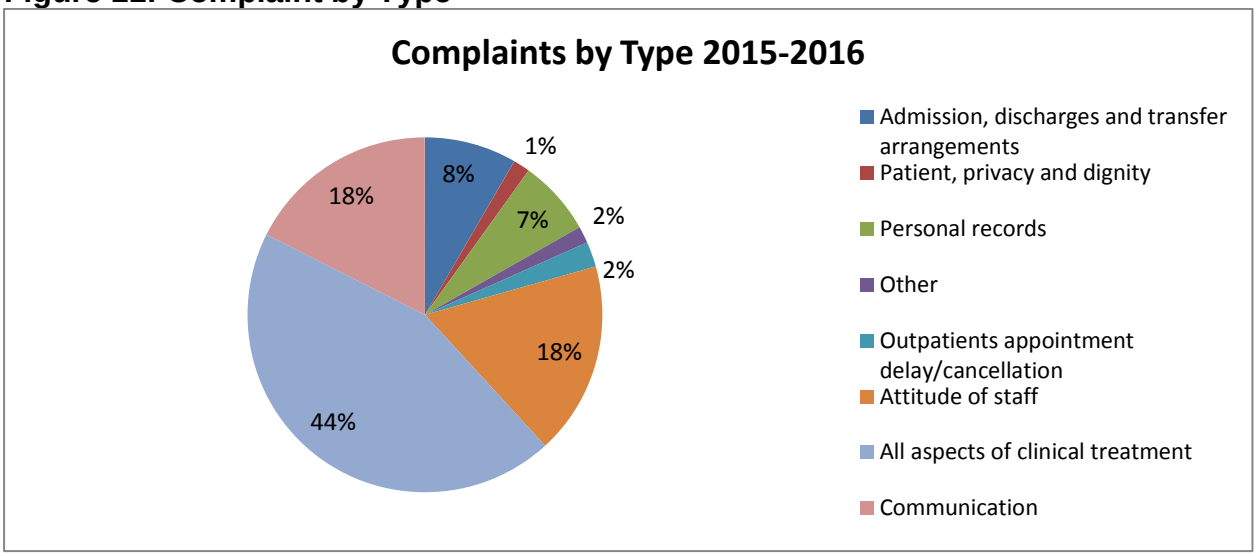
Figure 10 – Trend line of people seen each Quarter who subsequently complain



3.8 Complaints by Type and Sub-Type

The types of formal complaints submitted to the Trust over the last 12 months are presented in Figure 11. Complaints about 'All aspects of Clinical Treatment' remains the highest type of complaint reported although this has reduced from 56% (n=88) in 2014/15 to 44% (n=58) in 2015/2016. Concerns regarding staff attitude and discharge arrangements are similar to previous years. There have been a number of complaints regarding health care records which did not feature last year. Record keeping issues and factors relating to confidentiality were featured.

Figure 11: Complaint by Type



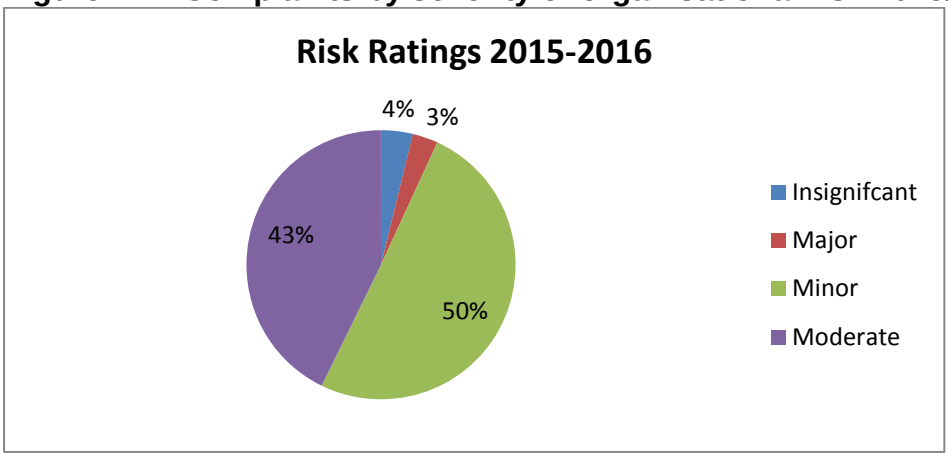
3.9 Complaint Level of Organisational Risk

Each complaint submitted for investigation is risk assessed by an officer with a clinical background from the Service Experience Department. The categorisation of risk is based on the National Patient Safety Agency format and this considers the likelihood of an issue recurring and the consequences of a complaint. As such, each complaint is evaluated and allocated a category:

- **Insignificant** – simple, non-complex issues
- **Minor** – several issues relating to a short period of care
- **Moderate** – multiple issues relating to longer period of care/involving other organisations
- **Major** – multiple issues relating to serious failures, causing serious harm

3.9.1 The Risk Ratings ascribed in 2015-16 are consistent with those reported in previous years. The majority of complaints were assessed as being Minor or Moderate. The number of risks assessed as Major is less than last year at 3% (n=4). One example of the type of complaint which may be assessed as a Major risk would be an issue where an actual or potential incident of serious harm has been reported.

Figure 12 – Complaints by severity of organisational risk 2015/16



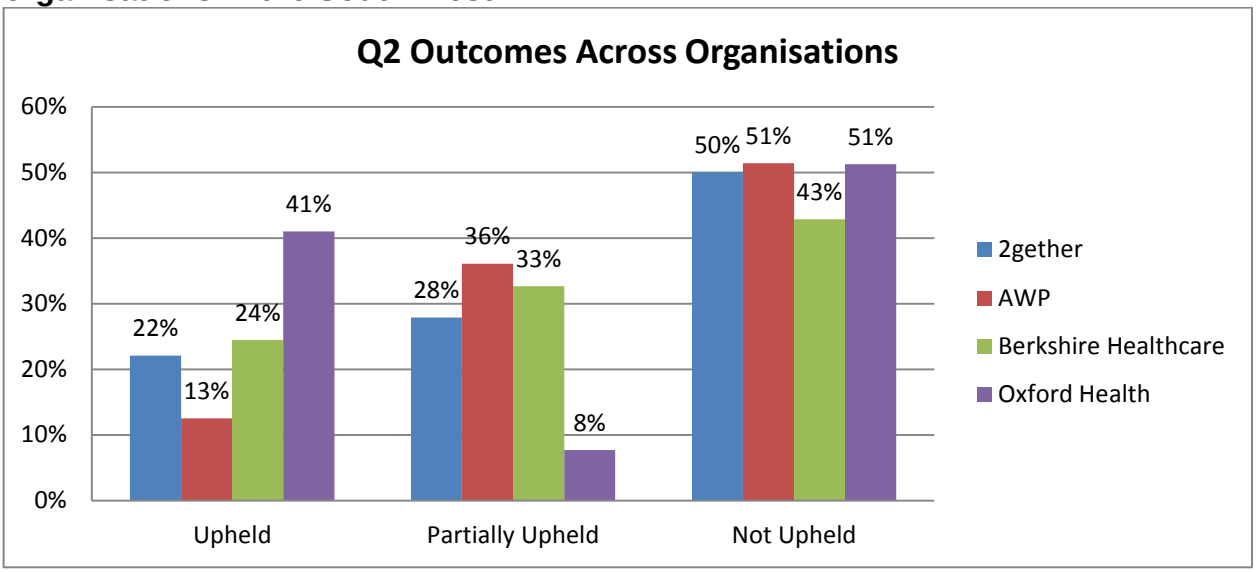
4. OUTCOME of COMPLAINTS

4.1 Outcome of Complaints

Section 3.2.1 refers to a new system where data are being collected nationally about the outcome of complaint investigations by organisation.

Information which compares the outcomes of investigation by organisation is emerging although a full year comparison had not been published at the time of writing. Only a snapshot of 2015 / 16 (Q2) is provided in Figure 13.

Figure 13: Outcome of complaints across a cohort of Mental Health organisations in the South West.



The Quarter 2 2015/16 results from the HSCIC featured in Figure 13 should be interpreted with caution as whole systems of resolving concerns need to be taken into account.

5. SATISFACTION WITH THE COMPLAINT RESOLUTION PROCESS

Resolving complaints to the satisfaction of people who complain remains a key focus. Service users and carers, who raised concerns or complaints, are routinely offered the opportunity to meet with clinical and service experience staff to make every effort to achieve a local resolution.

5.1 Resolution meetings in 2015/16

Of the 131 complaints received this year, 13 Local Resolution Meetings were undertaken representing 10% of the formal complaints. This suggests that at least 10% of people who complained were not satisfied with the findings presented to them in the initial letter of response from the Chief Executive which is routinely provided following a completed investigation.

5.2 Referrals to the Parliamentary Health Services Ombudsman (PHSO)

People are encouraged to seek an independent investigation of their complaint via the Parliamentary Health Services Ombudsman if they are not satisfied with the outcome of the complaint investigation or if they feel that their concern remains unresolved.

5.2.1 The PHSO requested information regarding eleven complaints over the last 12 months. The Ombudsman has taken 7 of these cases forward for review and investigation.

5.2.2 This is the same number as last year. and represents 5% of complaints received overall in 2015/16.

5.2.3 Three of the cases referred this year and one referred the previous year have been closed following investigation by the PHSO. **None** of the cases referred to the PHSO was upheld. On average the PHSO uphold a third of cases referred from organisations across the country.

6. LEARNING FROM COMPLAINTS

A significant number of learning and development opportunities have been identified as a consequence of feedback from service users and carers over the last 12 months. Members of the Service Experience Department continue to work in partnership with colleagues across the Trust to develop and implement systems to ensure. Figure 14 identifies some examples of complaints and the actions the Trust took in response to service users reported experiences.

Figure 14 Examples of complaints made and actions taken as a result of learning during 2015/2016

You said	We did
CLINICAL TREATMENT: ***I was not fully involved in the discharge plans of my spouse***	We offered an apology and explained that we are implementing the 'Triangle of Care' which recognises and encourages the full involvement in carers in all aspects of care and treatment
The care plan says you agreed to support my family member with managing his finances but this didn't happen	We assured you we had learnt from the experience. Staff were reminded that they must follow up on agreed actions
COMMUNICATION: ***Telephone communication***	Staff have been reminded that messages should be returned within 24 hours Children's services have addressed this via practice notes to all clinicians and administration staff.
You were unclear about the role of the Care Coordinator	A patient information leaflet to help clarify individual's roles is being developed.

ADMISSION, DISCHARGE, TRANSFER: ***I was unhappy about my family member being transferred to another hospital***	It is now expected best practice that a Care Programme Approach Meeting is always held between teams when someone's care is transferred from a secure hospital setting.
STAFF ATTITUDE: ***I was unhappy with a members of staff's manner***	We offered an apology and supported the staff member with personal reflection regarding partnership working and the importance of listening and respecting others' views
I was upset by the abrupt manner of a receptionist when I went for an appointment	The member of staff identified that a different approach and more information and explanation would have been helpful and has committed to changing their approach.
APPOINTMENTS: ***I've been waiting too long for an appointment***	We offered an apology and an appointment was also offered.
I did not know how long I would have to wait for an appointment for therapy	We have reviewed and revised our appointment letters to include more information on waiting times.
I was unhappy with the venue for my appointment for group treatment	An alternative venue was identified and future groups were relocated
CONSENT ***I was not fully aware of all the complaint issues that were raised on my behalf***	A summary of all complaint issues raised is sent to the service user with a request for their consent for us to undertake an investigation and share the results with a third party.

7. AREAS FOR DEVELOPMENT

Planned areas of complaints practice development in 2016-2017 include:

- Implementing and evaluating the revised Non-Executive Director Audit to enable review of national best practice in investigation and complaint management in line with recent PHSO national recommendations.

- Ensuring there is reasonable adjustments to the complaint process to raise awareness and ensure it is accessible to everyone using our services particularly the older people, children and people with a learning disability.

- Continue to embed learning from complaints in practice and seek assurance that this is disseminated across the Organisation

- Reviewing and updating the Trust's Complaint Policy to reflect changes in practice and national guidance.

- Working with colleagues across the Trust to review and improve dissemination of learning from complaints to ensure service user feedback is considered and embedded in practice.

- Providing training and support to investigators to ensure they are confident in applying national and local best practice for complaint investigation.

- Continuing to triangulate complaints with concerns, comments and compliments and survey information received to gain rich information to inform practice and service development.

- Embedding the new Datix web data collection system in practice and utilise the additional functionality to develop and share information with Locality Boards and Clinical Teams.

8. CONCLUSION

[2]gether NHS Foundation Trust is committed to learning from individuals 'experiences highlighted through complaints, concerns, comments and compliments. In this way we will provide the best quality service experience and care in line with our Service Experience Strategy.

The Service Experience Department are committed to working with service users, carers, operational colleagues and the wider health community to continue to develop robust systems for complaint handling and to ensure that learning from feedback is used to inform practice and service developments.

Agenda Item	**11**	**Enclosure**	**Paper F**

Report to: Trust Board – 26th May 2016
Author: Helen Elliott Nursing Lead for Smokefree, NMP and Medicines
Presented by: Marie Crofts, Director of Quality

SUBJECT: **NICE (2013) PH 48 Smoking cessation in secondary care: acute, maternity and mental health services - update**

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

EXECUTIVE SUMMARY

The purpose of this paper is to update the Trust Board on the implementation at of the National Institute for Clinical Excellence guidance - NICE (2013) PH 48 - Smoking cessation in secondary care: acute, maternity and mental health services.

This guidance is a game-changing approach to improving the physical health needs and ultimately extending life expectancy of our service users and the Trust is committed to delivery of this guidance. It does requires significant practice and cultural change within inpatient mental health services which needs a timescale for implementation proportionate to the cultural shift needed.

The target date for full implementation was set at October 2016. Whilst the Trust is committed to implementation of this guidance this needs strong clinical leadership. As a clinical lead was not been appointed until April 2016 this has created a short time delay in fully commencing the work.

A programme board has been established, chaired by the Director of Quality to monitor and oversee the implementation of smokefree. Much progress has been made with regards to each work stream however the programme board is recommending a delay in full implementation of a Smokefree environment within our inpatient services from October 2016 to April 2017. This is owing to the delay in the clinical lead start time and the 12 month timeframe needed to implement the guidance.

ASSURANCE

This update paper provides significant assurance on current progress and developments towards implementation of PH48, given the revised commencement date of the programme board and clinical lead.

RECOMMENDATIONS

The Board is asked to:

- Support the delay in full implementation to April 2017
- Note the current progress and assurance

Corporate Considerations	
Quality implications:	Implementation of NICE guidance is a quality and contractual requirement of NHS organisations.
Resource implications:	The resource implications of this paper need to further scoped.
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 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	

Reviewed by:		
Marie Crofts, Director of Quality	Date	19th May 2016

Where in the Trust has this been discussed before?		
Trust Board Committee	Date	Dates available with accompanying minutes of meetings
Trust Governance Committee		
Nursing Professional Advisory Group		
Trust Nicotine management steering group		
Programme Board		Monthly
Project work-streams		Monthly

What consultation has there been?		
Within Trust professional networks – as above and informally with services and teams		

Explanation of acronyms used:	Explained within body of paper

1. INTRODUCTION

1.1 The purpose of this paper is to brief the Board on progress related to implementation of the NICE (2013) PH 48 Smoking cessation in secondary care: acute, maternity and mental health services. This guidance was published November 2013. The full guidance is available at http://www.nice.org.uk/guidance/PH48

2. CONTEXT

2.1 It is widely accepted that stopping smoking at any time has considerable health benefits for both 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.

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

2.2 This guidance and its implementation is congruent with other national level strategic drivers to improve the physical health of those with a mental health issue. Recent 2016 publications include:

- **The Stolen Years** – 'The Mental Health and Smoking Action report' (April 2016). This report by ASH, endorsed by 27 health and mental health organisations, sets out recommendations for how smoking rates for people with a mental health condition could be dramatically reduced. These include improved training of healthcare staff, better access to stop smoking medication and a move towards smokefree mental health settings. http://www.ash.org.uk/current-policy-issues/health-inequalities/smoking-and-mental-health/the-stolen-years

- **Nicotine without smoke:** 'Tobacco harm reduction Royal College of Physicians' (April 2016). This report aims to provide a fresh update on the use of harm reduction in tobacco smoking, in relation to all non-tobacco nicotine products but particularly e-cigarettes. It concludes that, for all the potential risks involved, harm reduction has huge potential to prevent death and disability from tobacco use, and to hasten our progress to a tobacco-free society. In particular the report states:

  "..in the interests of public health it is important to promote the use of e-cigarettes, NRT and other non-tobacco nicotine products as widely as possible as a substitute for smoking in the UK."

  https://www.rcplondon.ac.uk/projects/outputs/nicotine-without-smoke-tobacco-harm-reduction-0

2.3 The Trust currently operates a permissive approach to service users smoking at 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 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

This work is aligned with the work of the Trusts Clinical Expert Reference Group (CERG) for physical health, The NHS IQ project for *improving the cardiovascular health of people in England with serious mental illness* – national pilot sites; and other associated holistic initiatives to improve the physical health of the populations that we serve.

2.4 Recent government guidance to support mental health Trusts has been published which includes lessons learnt from those mental health Trusts who have already completed implementation. The document - '**Smokefree mental health services in England:** Implementation document for providers of mental health services (2016)' has been published and is being actively used in our work-stream groups. A key aspect of implementation is described below:

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, "Smokefree policy implementation is a process not an event" ***35***

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/509262/SF_MH_services_in_England__Guidance_for_Providers.pdf

3. PROGRESS TO DATE

3.1 The Trust has established a Programme Board chaired by the Director of Quality to oversee and manage the implementation of Smokefree 2gether providing an organisational structure which includes staff and experts by experience. The work has been divided into five key work streams based on the NICE PH48 recommendations which are:

- Systems
- Treatments
- Training
- Engagement
- Communication

Each work stream has a lead and draws on clinical and management expertise to drive progress. Any blockers and challenges are then escalated to the Programme Board.

3.2 Progress within each work streams includes:

Communication -

- Global email distributed on No Smoking Day (March 9). Highlighted project to staff, contained clear leadership with message from Director of Quality, linked to PH48 guidance and intranet page, included link to survey to garner engagement from staff.
- Work begun on branding/identity with Trust volunteer starting April 4.
- Short smokefree film produced – awaiting final product
- Minor updates made to Smokefree intranet page

Engagement –

- Survey conducted to identify levels of support and opposition
- Meeting planned to determine next steps following survey results

Training –

- Level 2 quit advisor training commenced
- Training of medics taken place with over 30 attendees
- Discussions with Herefordshire public health leads

Systems –

- System for recording smoking status in RIO agreed via Physical Health ERG
- Request to complete for all 2gether patients sent out and a re-run of data collection planned

Treatments –

- Nicotine Replacement Therapy (NRT) product list agreed
- Algorithm for treatment drafted
- Agreement on prescribing and initial supply.
- Stock process agreed

The Programme Board initially anticipated that full implementation would take approximately 12 months from commencement. This was reported to the Trust Board earlier in the year. This timescale is based on feedback from other mental health Trusts. A recent review (March 2016) of the state of readiness of the Trust using the national self -assessment tool for PH48 was compared to the self-assessment made in September 2015.

The conclusions drawn from review:

a. The self-assessment tool is helpful in providing a coarse “point in time” reflection of the state of readiness of the organisation to introducing a smoke free environment. The tool does not recognise progress towards establishing the different elements required but purely the end state for each element

b. The state of readiness as measured by the tool has not demonstrated significant change since the initial assessment in September 2015 however, the project is reporting significant amounts of progress towards establishing the elements required to deliver full implementation which is detailed above

c. It should be recognised that many of the reporting strands of the self-assessment tool may not show any significant change until the project nears the date of the introduction of the smoke free environment

d. The tool does highlight the volume of work that is required to be completed with an awareness that culture changes to the attitudes and behaviour will take time to achieve

3.3 The outcome of the review demonstrated that whilst much planning and preparation had been completed there was insufficient time to complete the changes which would enable the Trust to go smoke free in October 2016. This is largely down to the lack of a clinical lead appointed to drive progress until April this year.

3.4 As previously mentioned in this paper recent guidance has indicated that 12-18 months is required for practice and cultural change. Consultation with service users and staff is a key factor in successful implementation. Phase one of staff and patient initial engagement is due to be completed by the end of June. The outcome of this engagement will inform our plans further.

4 SUMMARY AND CONCLUSIONS

4.1 The Smoking Cessation Programme Board concluded that insufficient time remained to enable the changes to be made and full staff engagement to be achieved in time to introduce a smokefree environment by October 2016

4.2 The project contains 5 workstreams and it is essential that all those workstreams are completed before a completely smokefree environment is introduced

4.3 Assimilation of recent guidance into the project implementation plan will ensure most recent experiences and evidence base informs the Trusts progress.

4.4 The introduction of a completely smoke free environment should be postponed until Spring of 2017

5. RECOMMENDATIONS

The Board is asked to:

- Support the delay in full implementation to April 2017
- Note the current progress and assurance

Agenda item 12 **Enclosure Paper G**

Report to: 2gether NHS Foundation Trust Board on 26th May 2016
Author: Shaun Clee – Chief Executive
Presented by: Shaun Clee – Chief Executive

SUBJECT: **Chief Executives 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	

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 (8 - 14 February 2016), 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, 16 March 2016

In March 2016 it will be 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

Internal Board engagement

01.03.16 The Director of Organisational Development attended an Organisational Development Training Session with Frances Allcock

01.03.16 The Director of Organisational Development attended an Organisational Development Training Session with Frances Allcock

03.03.16 The Director of Organisational Development participated in the Interview Selection Process for the Non-Executive Director vacancy

03.03.16 The Director of Organisational Development participated in the Interview Selection Process for the Non-Executive Director vacancy

03.03.16 The Director of Quality attached the Nursing Professional Advisory Committee meeting

03.03.16 The Director of Finance & Commerce attended Patient Safety Visit to Stroud Crisis Team

04.03.16 The Director of Quality carried out a clinical visit to Herefordshire Older People's Services

07.03.16	The Director of Organisational Development attended the Trust Board Away Day
07.03.16	The Director of Service Delivery attended a Board Away Day
07.03.16	The Director of Quality attended a 2gether Board away day
07.03.16	The Director of Organisational Development attended the Trust Board Away Day
07.03.16	The Director of Finance & Commerce attended Board Away Day
08.03.16	The Director of Organisational Development attended Team Talk, Gloucestershire
08.03.16	The Director of Organisational Development led Team Talk, Gloucestershire
08.03.16	The Director of Engagement and Integration hosted Team Talk in Herefordshire
09.03.16	The Director of Engagement and Integration chaired the Triangle of care Project Board
10.03.16	The Chief Executive attended Council of Governors
10.03.16	The Director of Organisational Development attended Council of Governors
10.03.16	The Director of Organisational Development attended Council of Governors
10.03.16	The Director of Service Delivery attended a Council of Governors meeting
14.03.16	The Director of Service Delivery attended the Executive Committee Business meeting
15.03.16	The Director of Quality attended the Infection Control Committee meeting
16.03.16	The Director of Quality attended the Transformation Project Board meeting
16.03.16	The Director of Organisational Development attended a Patient Safety Visit to Abbey Ward, Wotton Lawn
16.03.16	The Director of Organisational Development attended a Patient Safety Visit to Abbey Ward, Wotton Lawn
17.03.16	The Director of Organisational Development chaired the Workforce & Organisational Development Sub Committee
17.03.16	The Director of Organisational Development chaired the Workforce & Organisational Development Sub Committee
17.03.16	The Director of Service Delivery attended a Patient Safety Visit to Mortimer Ward
18.03.16	The Director of Quality attended the 2gether Governance Committee meeting

21.03.16	The Director of Service Delivery attended the Executive Committee Development meeting
21.03.16	The Director of Organisational Development attended Corporate Induction to welcome new members of staff
21.03.16	The Director of Organisational Development attended Corporate Induction to welcome new members of staff
23.03.16	The Director of Service Delivery attended a Development Committee meeting
23.03.16	The Director of Quality attended the 2gether Development Committee meeting
24.03.16	The Director of Organisational Development chaired the Occupational Health & Safety Sub Committee
24.03.16	The Director of Organisational Development chaired the Occupational Health & Safety Sub Committee
29.03.16	The Chief Executive attended the Gloucestershire Strategic Forum
30.03.16	The Chief Executive attended the AHPP Strategy Launch
30.03.16	The Director of Service Delivery attended the Delivery Committee meeting
30.03.16	The Director of Organisational Development attended Delivery Committee
30.03.16	The Director of Organisational Development attended Delivery Committee
31.03.16	The Chief Executive attended Trust Board
31.03.16	The Director of Organisational Development attended Trust Board
31.03.16	The Director of Organisational Development attended Trust Board
31.03.16	The Director of Service Delivery attended an Open Board meeting
31.03.16	The Director of Quality attended the 2gether Board Meeting
31.03.16	The Director of Finance & Commerce attended Open Board
01.04.16	The Chief Executive attended Medical Staffing Committee
04.04.16	The Chief Executive welcomed new colleagues at Corporate Induction
04.04.16	The Director of Service Delivery attended the Executive Committee Development meeting
04.04.16	The Director of Service Delivery attended the Senior Leadership Forum meeting
05.04.16	The Chief Executive attended a Patient Safety visit to Charlton Lane

05.04.16	The Director of Engagement and Integration met with members of the IAPT service, Gloucestershire
06.04.16	The Chief Executive attended the Colliers Court Opening Event
06.04.16	The Medical Director attended the opening of the Forest of Dean Community Hub
06.04.16	The Director of Engagement and Integration attended the official opening of Colliers Court, Cinderford
07.04.16	The Director of Engagement and Integration hosted a meeting with the AHPP leads
07.04.16	The Director of Engagement and Integration attended the Nursing Professional Advisory Committee
11.04.16	The Chief Executive chaired the Dementia Task and Finish Group
12.04.16	The Director of Engagement and Integration attended a meeting to discuss the Swindon Mind Specification
18.04.16	The Chief Executive attended Health and Safety training
18.04.16	The Chief Executive attended the LD Summit
18.04.16	The Medical Director attended the LD summit
18.04.16	The Director of Service Delivery attended Health and Safety Training for Directors
21.04.16	The Director of Engagement and Integration attended an engagement meeting at Honeybourne Recovery Unit
22.04.16	The Chief Executive chaired interviews for the Herefordshire Consultant post
22.04.16	The Director of Engagement and Integration chaired the final LD Practice Development Project Board
25.04.16	The Director of Service Delivery attended the Executive Committee Business meeting
25.04.16	The Director of Service Delivery attended a Task and Finish Group with Clinical Directors
25.04.16	The Director of Engagement and Integration attended an engagement meeting at the Mulberry Ward, Charlton Lane Centre
26.04.16	The Chief Executive chaired the Band 7 Leadership event.
26.04.16	The Director of Engagement and Integration hosted a meeting to discuss the Smoke Free project
26.04.16	The Director of Engagement and Integration hosted a Senior Leads for Directorate of E+I Planning session
28.04.16	The Chief Executive attended Trust Board
28.04.16	The Director of Service Delivery attended the Trust Board meeting
29.04.16	The Chief Executive Chaired the recruitment panel for the Head of Communications Post
29.04.16	The Medical Director attended the CYPS away day

29.04.16 The Director of Engagement and Integration hosted a Head of Communications with Stakeholder group session as part of the recruitment process

Board Stakeholder engagement

01.03.16 The Director of Service Delivery attended the IT Partnership Board

01.03.16 The Director of Service Delivery attended the Countywide IM&T Steering Group meeting

01.03.16 The Director of Organisational Development attended the West of England Membership Council

01.03.16 The Director of Organisational Development attended the West of England Membership Council

01.03.16 The Director of Finance & Commerce attended IT Partnership Board

01.03.16 The Director of Engagement and Integration met with elected members of Cheltenham Borough Council with the Trust Chair.

01.03.16 The Director of Engagement and Integration met with the Chair and Chief Executive of Healthwatch Gloucestershire

02.03.16 The Chief Executive attended a meeting of Chief Executives in Herefordshire

02.03.16 The Chief Executive attended the Herefordshire and Worcestershire STP Planning Board

02.03.16 The Director of Organisational Development met with Maureen Bignall of Wye Valley Trust

02.03.16 The Director of Quality attended the Gloucestershire Health Education Strategic Board

02.03.16 The Director of Engagement and Integration attended the Clinical Research Network: West of England Partnership Board.

02.03.16 The Director of Organisational Development met with Maureen Bignall – HR Director - Wye Valley NHS Trust

03.03.16 The Director of Service Delivery attended two STP Planning Footprint meetings

03.03.16 The Director of Finance & Commerce attended 2g Contract Negotiations in Hereford

03.03.16 The Director of Service Delivery attended the Herefordshire and Worcestershire System Oversight Board

04.03.16 The Director of Quality attended a 2gether/CCG walkaround of Jenny Lind Ward

08.03.16	The Director of Service Delivery attended a STP workshop
08.03.16	The Director of Quality attended the Herefordshire and Worcestershire STP planning meeting
08.03.16	The Director of Engagement and Integration attended the Health and Care Overview and Scrutiny Committee at Shire Hall in Gloucester.
08.03.16	The Director of Engagement and Integration attended the GGPET Annual meeting in Gloucester.
09.03.16	The Director of Service Delivery attended a Herefordshire Contract Proposal meeting
09.03.16	The Director of Finance & Commerce attended Finance Workstream and 2g Contract Proposal in Hereford
09.03.16	The Director of Finance & Commerce attended 2g GCCG Contract Monitoring Board
09.03.16	The Director of Service Delivery attended a Gloucestershire Contract Board meeting
09.03.16	The Director of Engagement and Integration met with the CEO of Carers Gloucestershire
10.03.16	The Chief Executive attended the Local Care Organisations meeting
10.03.16	The Director of Service Delivery attended two LCO Operational meetings
12.03.16	The Director of Engagement and Integration attended the Gloucestershire Intergenerational, multiagency dementia education play: Al's yellow slipper at the Roses Theatre, Tewkesbury.
14.03.16	The Director of Engagement and Integration attended Gloucestershire Research and Development Consortium meeting.
14.03.16	The Director of Service Delivery attended a GCCG SARC meeting
15.03.16	The Director of Service Delivery attended the System Resilience Group meeting
15.03.16	The Director of Engagement and Integration chaired the Gloucestershire Tackling Stigma Forum for the CCG
16.03.16	The Director of Engagement and Integration was invited to present at Gloucestershire CCG's Equalities & Health Inequalities Working Party
16.03.16	The Director of Service Delivery attended an urgent meeting regarding individual patients at Westridge
16.03.16	The Director of Service Delivery attended a Complex Care meeting
17.03.16	The Director of Finance & Commerce attended Contract Monitoring Board and Contract Negotiation in Hereford
17.03.16	The Director of Quality attached the 2gether/CCG Clinical Quality Review Group meeting

18.03.16	The Director of Service Delivery attended a Scoping Exercise Day with Gloucester County Council
21.03.16	The Director of Service Delivery attended a Multi-agency meeting
22.03.16	The Director of Service Delivery attended the IT Blueprint Programme Board meeting
22.03.16	The Director of Service Delivery attended a meeting with a representative from GCCG at Hollybrook
22.03.16	The Director of Engagement and Integration was invited to be a panel member at Healthwatch Herefordshire Question Time with Focus on Mental Health & Emotional Wellbeing At Hereford Sixth Form College
24.03.16	The Director of Service Delivery attended Sustainability and Transformation Planning Workshop
29.03.16	The Director of Service Delivery attended a Partnership Objectives meeting
30.03.16	The Chief Executive attended a meeting of Chief Executives in Herefordshire
30.03.16	The Chief Executive chaired the Community Collaboratives Board
01.04.16	The Director of Engagement and Integration hosted a meeting with Trish Dowling of GCS
04.04.16	The Director of Engagement and Integration presented the Cheltenham Borough Council re Place Based Mental Health
05.04.16	The Director of Service Delivery attended a meeting with Gloucestershire Clinical Commissioning Group at Westridge
05.04.16	The Director of Service Delivery attended a 2016/17 Contract meeting with Gloucestershire Clinical Commissioning Group
05.04.16	The Director of Service Delivery attended a Herefordshire Clinical Commissioning Group Out of County Placement meeting
05.04.16	The Director of Engagement and Integration met with members of the Gloucestershire Health and Care Scrutiny Committee as part of the scrutiny planning process
06.04.16	The Director of Service Delivery attended a meeting with an external consultant regarding the rescoping of CAMHS & CYPS
07.04.16	The Chief Executive attended the Gloucestershire STP Board Meeting
07.04.16	The Chief Executive attended the Gloucestershire CEO's meeting
08.04.16	The Director of Service Delivery attended a meeting with representatives from Powys Trust regarding consultant child and adolescence
09.02.16	The Director of Engagement and Integration attended the official opening of Colliers Court, Cinderford
11.04.16	The Director of Service Delivery attended a Sustainability and Transformation Working Group in Malvern

12.04.16	The Chief Executive attended the Herefordshire and Worcestershire System Oversight Board
12.04.16	The Director of Service Delivery attended a System Resilience Group meeting
12.04.16	The Director of Engagement and Integration met with colleagues of Healthwatch Gloucestershire to discuss the impact of the closure of The Vaughan Centre on people who are homeless
12.04.16	The Director of Engagement and Integration attended a the Forest of Dean Community Services Review with Gloucestershire CCG
12.04.16	The Director of Engagement and Integration attended a meeting to with Gloucestershire CCG re strategic partner developments
13.04.16	The Chief Executive Chaired the Herefordshire Transformation Directors Workshop
13.04.16	The Director of Service Delivery attended an Interface meeting with Gloucestershire Clinical Commissioning Group
13.04.16	The Director of Service Delivery attended a GP Event with Gloucestershire Clinical Commissioning Group
14.04.16	The Chief Executive met with Suzette Davenport, Gloucestershire's Chief Constable
14.04.16	The Medical Director attended an inquest in Gloucester
14.04.16	The Director of Service Delivery attended a Joining up Your Care meeting with Gloucestershire Clinical Commissioning Group
14.04.16	The Director of Service Delivery attended a meeting with Gloucestershire Clinical Commissioning Group regarding 2016/17 Contract
14.04.16	The Director of Service Delivery attended a Strategic Workforce Development meeting in Malvern
15.04.16	The Chief Executive met with Mandy Bell of the Gloucestershire Young Carers Group
19.04.16	The Director of Service Delivery conducting a staff briefing regarding Shift changes at Hollybrook and Westridge
19.04.16	The Director of Service Delivery attended a Countywide IM&T meeting with Gloucestershire Clinical Commissioning Group
19.04.16	The Director of Service Delivery attended a Taurus Healthcare meeting in Hereford
20.04.16	The Chief Executive chaired the Gloucestershire OD Workstream meeting.
20.04.16	The Chief Executive Chaired the Community Collaborative Board

20.04.16 The Chief Executive attended the Transformation Board

20.04.16 The Director of Service Delivery attended a Sustainability and Transformation Planning meeting in Malvern

20.04.16 The Director of Service Delivery attended a CLDT workshop

20.04.16 The Director of Engagement and Integration chaired the Service Experience Committee meeting in Hereford

21.04.16 The Director of Service Delivery attended a Band 7 Management Programme workshop

26.04.16 The Chief Executive Chaired interviews for the Transformation Directors Post in Herefordshire.

26.04.16 The Director of Service Delivery attended an IT Blueprint Programme Board meeting at Gloucester Royal Hospital

26.04.16 The Director of Engagement and Integration chaired the multi-agency Tackling Mental Health Stigma meeting at Gloucestershire CCG

27.04.16 The Chief Executive met with Herefordshire CEO's

27.04.16 The Chief Executive chaired the Gloucestershire OD Workstream Meeting.

27.04.16 The Director of Service Delivery attended a Sustainability and Transformation Programme Workshop Leaders meeting

27.04.16 The Medical Director met with the Medical Director from Worcestershire Health and Care NHS Trust

28.04.16 The Medical Director attended the South West Responsible Officer Network

29.04.16 The Director of Service Delivery attended a Gloucestershire CYPS and Herefordshire CAMHS away day

Board National engagement

01.03.16 The Chief Executive attended the West of England AHSN Leaders Seminar

03.03.16 The Chief Executive Chaired the NHS Confederation RemCon Committee

08/09.03.16 The Chief Executive chaired the South of England Patient Safety Collaborative event

08.03.16 The Director of Quality attended the West Mid Director of Nurses discussion and meeting

09.03.16 The Director of Quality completed Accountable Officer Controlled Drugs Training

22.03.16 The Director of Quality attended the Monitor West Midlands Clinical Forum event

08.04.16 The Chief Executive met with Dr Naoki Ikegami to discuss the NHS five year forward view

13.04.16 The Medical Director attended “Prescribing Observatory for Mental Health” by the RcPsych

15.04.16 Previous Medical Director attended inquest

25.04.16 The Chief Executive was interviews for the Health Service Journal

29.04.16 Previous Medical Director held a relatives meeting following a Serious Incident

1.2.3 Ensuring Sustainable Services

Major Project Update – April 2016

Health Research and Managing Memory Centre quality/sustainability

Following a complete refurbishment of a former day hospital at Charlton Lane, the Trust Research and Managing Memory teams have now moved into their high quality, fit for purpose accommodation.

The building, named the Fritchie Centre, houses the two teams in an environment which supports the delivery of high quality care and provides modern facilitates to support the research programme of the Trust. The facility will also be marketed to other organisations who wish to partner with the Trust for their own research purposes.

The construction works which took seven months were managed by the Trust’s Estates Team. The project has now closed.

Crisis Resolution Service (MHARS) quality/sustainability

These major changes are being implemented to the service delivered to those who consider themselves in crisis. A small team is now based within the Police Headquarters at Waterwells to commence the creation of the Urgent Response team (URT). This team will be the initial contact for service users, and will work closely with the Police to provide early interventions to prevent service users being admitted to hospital or detained by the Police. The service, which will be called the Mental Health Acute Response Service (MHARS), will include teams that also deliver home treatment, and will aim to stabilise service users before referring them on to more appropriate longer term care teams. The service is currently experiencing recruitment difficulty attracting the additional clinicians required meet the demands of an open referral service, and a staged implementation is being developed.

The project’s second phase has now commenced (end date - March 2017), and will bring children and young people aged 12 and over who are suffering a crisis into the scope of the service. This involves the inclusion of different assessment and treatment techniques, and the addition of the safeguarding processes and procedures applicable to that age range.

Social Care Review **quality**

Head of Practice for Social Care is now in post.

The new AMHP rota is in operation and working, although there is further development required, and rota options are being reviewed in the light of potential changes to commissioner requirements.

Locality Community Care panels are in place, with improved information available to them, and their progress is being monitored. A new RiO page has been drafted to capture financial cost information and make it visible to clinicians and to the panels.

A Skills Questionnaire has been launched on-line, and 38 (out of 50) people have completed it. Roles and Responsibilities interviews have been scheduled, and the Performance Management requirements have been drafted.

Triangle of Care **quality/engagement**

As part of the Carers Trust accreditation process, 2gether is undertaking self-assessments (set by the Carers Trust), audits of carer records, and surveys of carer experience of our service.

The first group of teams (In-patient, Recovery, Early Intervention and Crisis) completed Self-assessment #1 in September 2015 and reports for the Gloucestershire CQUIN and for the Carers Trust were submitted in October. Improvement action logs for each team were created from the Self Assessments and are being monitored by the project.

Self-assessment #2 for the same group has now been completed and analysis shows significant improvement between self-assessment #1 and #2. The 2nd CQUIN report has been submitted. Information was taken from Carer surveys and RiO dip tests, and has been triangulated with results of the self-assessments to add perspective to each team's self-assessment.

Self-assessment #1 for the second group (Community Services - North) is scheduled to be distributed in mid-May. The team has engaged with locality managers to clarify requirements and understand the impact on them and the staff, and will inform the phasing and timing of the plan.

Temporary Staffing Demand **quality/sustainability**

The project comprises four work-streams to identify and address the causes of temporary staffing demand: the introduction of e-rostering, changes to recruitment (reducing vacancies), improvements to the staff bank, and producing management information.

Changes to recruitment activity (e.g. engaging with final year nursing students and Trust-led recruitment fairs) and to the processes involved are already underway, and will result in a wider pool of candidates and reduced recruitment times. Significant work to analyse the options and challenges of e-rostering has been undertaken, and a proposal on the implementation of a scheme is to be made in May 2016. The Executive Team will receive a weekly appraisal of the temporary staffing demand and the impact on agency expenditure from w/c 25 April.

NHS Improvement (NHSI) has set a 2016/17 'agency expenditure ceiling' for the Trust of £3.404m – this applies to all agency expenditure, not only medical and nursing. This is circa 40% less than the £5.64m spent on agency in 2015/16.

Improving Care Through Technology **sustainability**

The Business Case for Improving Care through Technology was deliberated during March's Development Committee. While it was given broad approval, the project manager was asked to complete more substantial work detailing the Return On Investment and Benefits Realisation before the project could be given approval to move to the initiation stage.

Work was conducted and submitted to the Project Executive (Andrew Lee) and Senior User (Colin Merker), who consequently asked the project team to work with the Clinical Lead (Jan Furniaux) to ensure realistic baseline figures are used to project benefits. The project team is scheduled to meet with Jan Furniaux on 25th April, and will resubmit the business case to Andrew Lee and Colin Merker shortly afterwards with a view to re-engaging with the Development Committee in May, and if given approval by the committee, to take the Business Case to Board.

Major Project Update – May 2016

Trust-wide Quality Improvement (CQC actions) **quality**

At the project launch on 14/04/2016, the project board agreed the ToR, PID and the overall project structure, and initiated a Risk & Issue log. The next project board meeting is scheduled for 12/05/2016.

The project plan is being developed and currently:

- The accountable directors have all confirmed the actions required and are nominating staff responsible for delivery of the actions.
- Conversations are underway with responsible staff to clarify deliverables and establish realistic timescales – to be completed by the end of May.

Temporary Staffing Demand **quality/sustainability**

The Executive Team now receives a weekly appraisal of the temporary staffing demand and the NHSI weekly return (which comprises the numbers of times agencies that are not on framework or are above price caps).This has enabled the Executive to identify a number of short-term actions to aid the reduction in agency spend whilst maintaining or improving quality.

Recruitment support is being delivered through a range of job fairs, providing training to HCAs who are considering becoming qualified nurses, and investigating a range of marketing options – the recruitment microsite has recently been launched. A proposal on the implementation of an e-rostering scheme is to be made at the end of May 2016.

CIP 2016/17 **sustainability**

The CIP programme (2015/16) has recently been subject to an external audit (PwC) which concluded that the programme was a 'low' risk – a significant improvement from the judgement of a 'high' risk for 2013/14. Three recommendations were made:

- There should always be a representative of the Quality Directorate at each CIP Project Board
- Quality Impact Assessments should be authorised in a timely manner
- A small understatement of savings in a Monitor return was noted

Actions have already been taken to address all three recommendations.

The CIP saving target for 2016/17 is £4.116m, and 18 savings work-streams have been identified to deliver this saving. Work continues to identify additional saving streams to support the delivery of current and future years' savings.

Digital Transcription and Speech Recognition (DTSR) **sustainability**

Mobiles have been successfully deployed to the Stroud CLDT service, and training on BigHand has been delivered. To date over 500 dictations have been received from approximately 42 MAS and CLDT staff members as part of the pre-learning phase. MAS and CLDT will be going fully live over the next 6 weeks when those services will start using BigHand for clinical information. All staff members have a laptop to enable them to use BigHand on the go.

Deployment is behind schedule due to technical issues. However these were resolved in December and the beginning of January. Since January a few more technical issues have been uncovered after our local dictionaries were loaded into the Speech Recognition servers - BigHand located the issue and provided the Trust with a patch which has now resolved the issue. These issues are being found due to the fact that as a Trust we have a bespoke setup setup being implemented, to meet the needs of our staff. Both pilot services are now scheduled to go live in May with the first tranche 16 May, and second tranche 30 May.

There is an issue of Trust mobiles not being compatible with the new Trust Corporate Wi-Fi, but a work-around has been deployed to staff utilising the Trust's Guest Wi-Fi solution. However, the issue remains as staff are finding it hard to stay connected as they need to reconnect each time they get back to site.

Agenda item 13 **Enclosure No** **Paper H**

Report to:	Trust Board 26th May 2016
Author:	Kate Nelmes, Communications Manager
Presented by:	Jane Melton, Director of Engagement and Integration
SUBJECT:	**Membership Data 2015/16**

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

EXECUTIVE SUMMARY

- This paper provides a full analysis of the 2015/16 financial year membership data for 2gether NHS Foundation Trust.
- In November 2014, the Council of Governors agreed the Trust's Membership Plan. Its focus is to enable recruitment, retention and re-engagement of Foundation Trust members within our defined constituencies through targeted engagement activity.
- An annual report on membership was requested by the Council of Governors to provide a year-on-year comparison of membership data.
- There are **7473** members of our Trust at the end of the 2015/16 financial year. This represents an increase of 404 new members during the year.
- Further work is underway to review:
  - the format of membership events for recruiting members
  - new ways to reach potential members and
  - enhance engagement with our existing membership base

RECOMMENDATIONS

That the Trust Board endorse the Membership Data Report for 2015/16.

Corporate Considerations	
Quality Implications:	An active and representative group of members will assist the organisation to enhance understanding of service experience and provide link with the important constituencies of Herefordshire and Gloucestershire.
Resource implications:	Further membership activity may require further resource to utilise membership resource to best

	effect.
Equalities implications:	Understanding the diversity of membership will assist to target recruitment and retention resources to best effect. Ensuring diversity in membership will offer a range of important views and participation to influence 2gethers work.
Risk implications:	There are risks of marginalising certain groups within the local community if attention is not paid to membership demographics.

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

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:		
Jane Melton, Director of Engagement and Integration	Date	3rd May 2016

Where in the Trust has this been discussed before?		
Executive Committee Council of Governors	Date	9th May 2016 24th May 2016
What consultation has there been?		
	Date	

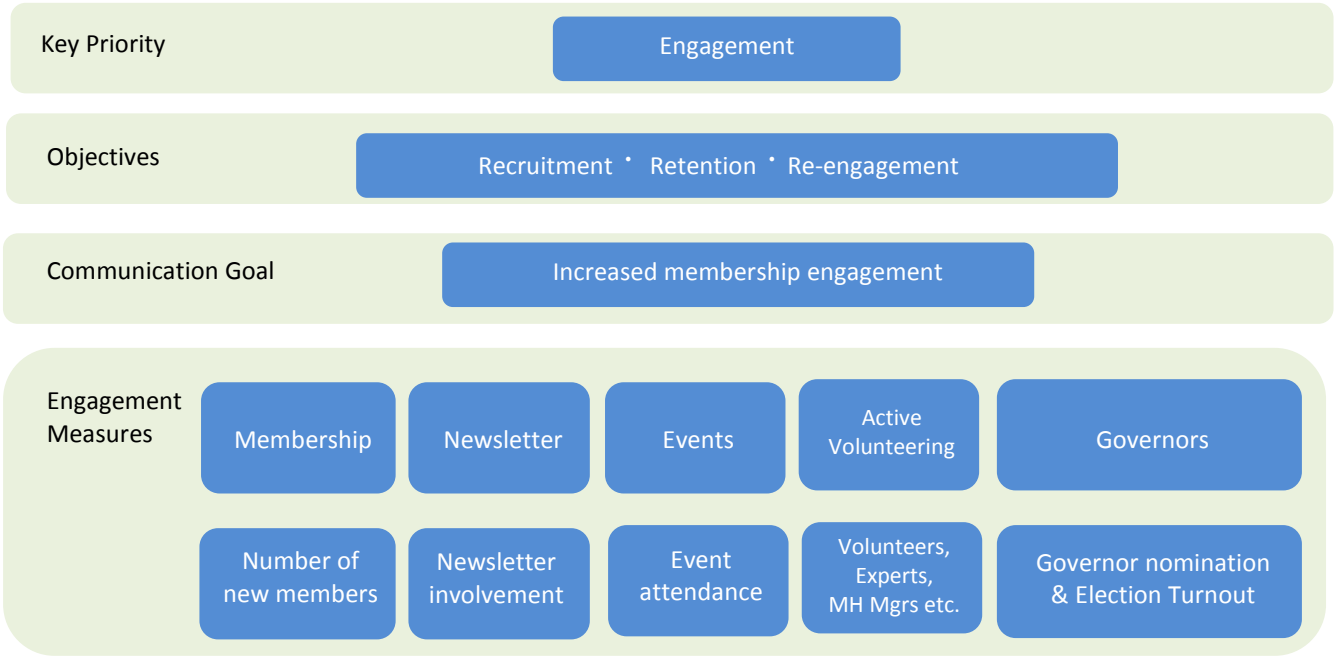
Explanation of acronyms used:	

1. Context

1.1. An annual membership plan was agreed by Governors in November 2014. The membership data presented here will be used to inform the appropriate focus and tactics to enable recruitment, retention and engagement of members. This report will focus on overall change within membership data.

1.2. Our strategic membership goal is to increase engagement. Figure 1 below features a summary of the Membership Engagement Plan.

Figure 1 Membership Engagement Plan



The Membership Engagement plan is being further developed in line with the Engagement and Communications Strategy which was informed by Governors and agreed by the Board in January 2016. Further thought will be given to:

- the format of membership events for recruiting members
- new ways to reach potential members and
- enhanced engagement with our existing membership base.

2. Public Membership

2.1 Membership data, at 31st March 2016, is as follows:

- There are **7473** members of our Trust **(**representing a **total of 104** additional members overall**)**
- **5155** are Public Members and **2318** are Staff Members
- **404** new members joined us during the financial year
- **241** records were removed with **185** members removed due to 'no forwarding address'
- On average, **34** people become members of the Trust every month which is a slight increase on the rate for 2014/15, when an average of **30** members joined each month. (NB This is balanced by those removed from the database)
- New members are sometimes recruited at Governor Membership Events although the results of this method of recruitment are currently modest. Most new members recruited are via the Trust website, other Trust engagement events and staff leavers whose membership status changes to public membership when they are no longer employed by the Trust.

2.2 Number of Public Members at 31 March 2016

Table 1 represents the actual numbers of members per constituency. However, the actual numbers do not provide information about the relative numbers of members in relation to the size of the associated constituency. This is considered in the additional tables below. Information regarding the demographics of ethnicity, disability, age and gender are also provided.

Table 1 Public Membership Numbers by Constituency at 31st March 2016

Cheltenham	Cotswolds	Forest of Dean
818	377	531
Gloucester	**Stroud**	**Tewkesbury**
1385	786	606
Greater England	**Herefordshire**	
337	315	

Figure 2 provides the percentage spread of membership by constituency whilst Table 2 shows the relative percentage of membership. This data suggests that membership in Herefordshire is significantly lower than in Gloucestershire. However, the number of members in Herefordshire has risen from 248 to 315 in the last 12 months (an increase of 27%). Gloucester City has the largest proportion of Trust members and the largest population.

Figure 2 Membership data by constituency as at 31 March 2016

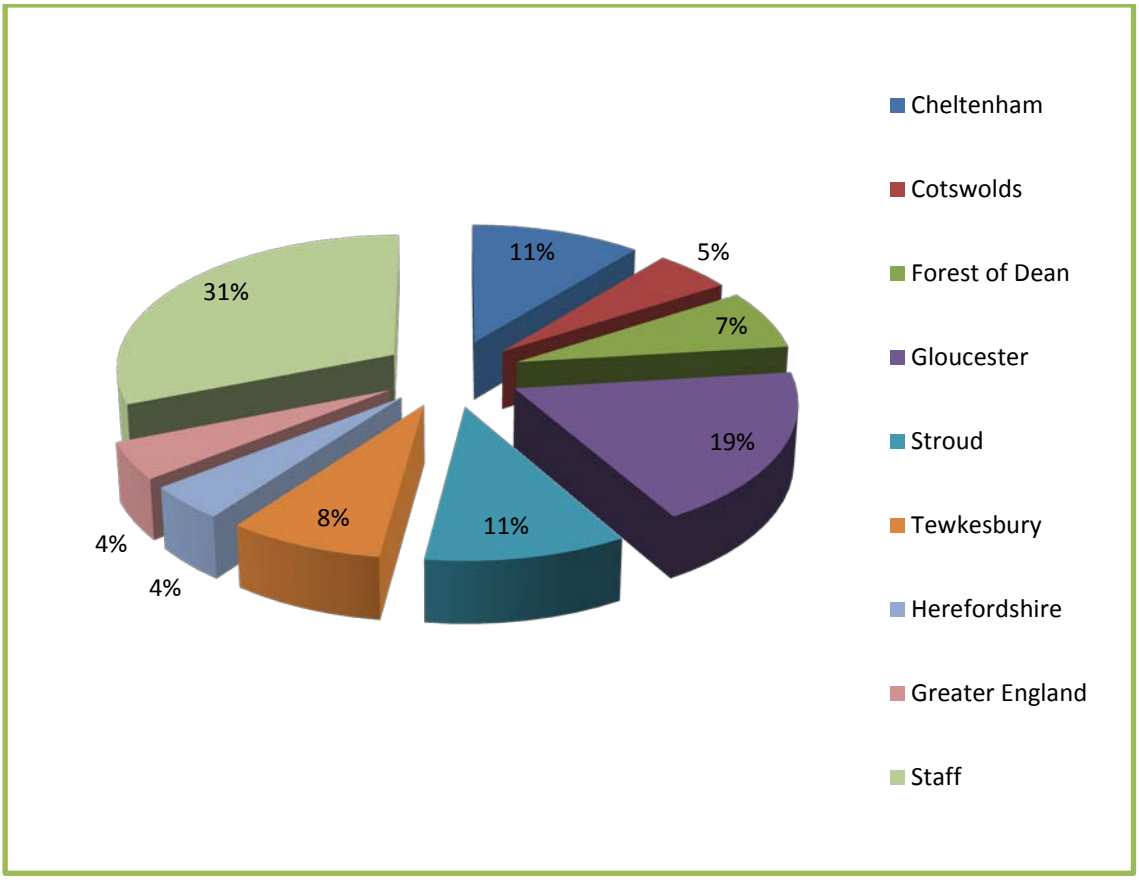


Table 2 **Public Membership as a total percentage of constituent population**

Constituency	Members	Population	%
Cheltenham	818	115,732	0.71
Cotswolds	377	82,881	0.45
Forest of Dean	531	81,961	0.65
Gloucester	1385	121,688	1.14
Stroud	786	112,779	0.70
Tewkesbury	606	81,943	0.74
Herefordshire	315	183,477	0.17

2.3 Ethnicity of Trust Members

Tables 3 and 4 suggest that the Trust has successfully recruited a reasonably representative group of people by ethnicity. This is particularly the case in Gloucestershire although in both counties there is more work to undertake.

Table 3

Ethnicity - Gloucestershire		
	White British/White Other	**Black and Minority Ethnic**
Gloucestershire Census 2011	92% (596,984 people)	5% (27,337 people)
Public membership	95%	4%

Table 4

Ethnicity - Herefordshire		
	White British/White Other	**Black and Minority Ethnic**
Herefordshire Census 2011	94% (183,477 people)	2% (3,308 people)
Public membership	99%	0.3 %

Table 5 **Ethnicity of members in relation to the associated population of Gloucestershire and Herefordshire**

Ethnicity	Gloucestershire	Glos Members	%	Herefordshire	Hfd members	%
White British	546,599	4166	0.76	171,922	303	0.18
Mixed	8,661	45	0.52	1,270	2	0.16
Black/Black British	5,150	64	1.24	331	0	0.00
Asian/Asian British	10,522	98	0.93	1,162	0	0.00
White Other	23,048	119	0.51	8,247	9	0.11
Chinese/Other	3,004	11	0.37	545	1	0.18
Total	**596,984**	**4503**		**183,477**	**315**	

2.4 Disability status of Trust Members

In relation to members' self-report of their disability status, a much larger proportion of Trust members report a disability than do the general population of Gloucestershire and Herefordshire. These figures are represented in Table 6 with 15% of Trust members in Gloucestershire reporting disability and 15.5% of people in Herefordshire.

Table 6 Disability status of members in relation to the associated population of Gloucestershire and Herefordshire

Disability – Gloucestershire	
Census data 2011	0.5%
Public membership (Glos)	15% (660 of 4503 members)

Disability – Herefordshire	
Herefordshire Census 2011	0.2%
Public membership (Hfd)	15.5% (49 of 315 members)

2.5 Age Distribution of Trust members

A wide distribution of membership age range is reported in Table 7. Whilst the largest number of members is between the ages of 20 and 64, in relation to the population size for adults who are older than 65, the Trust reports a higher percentage. Work is required to increase membership representation from younger people.

Table 7 Age group of members in relation to the associated population of Gloucestershire and Herefordshire

Age	Total Hfd & Glos	% of people in age group	Total Public Membership	% of membership (disclosed)
10 – 15	54,528	8%	6*[1]	1%
16 – 19	38,260	6%	42*	1%
20 – 44	236,952	34%	1,453	31%
45 – 64	216,612	31%	1,730	37%
65 – 74	78,706	11%	770	16%
75+	71,665	10%	663	14%
Did not disclose			**491**	
Total	**696,723**	**100%**	**5155**	**100%**

Table 8 Gender of Trust members

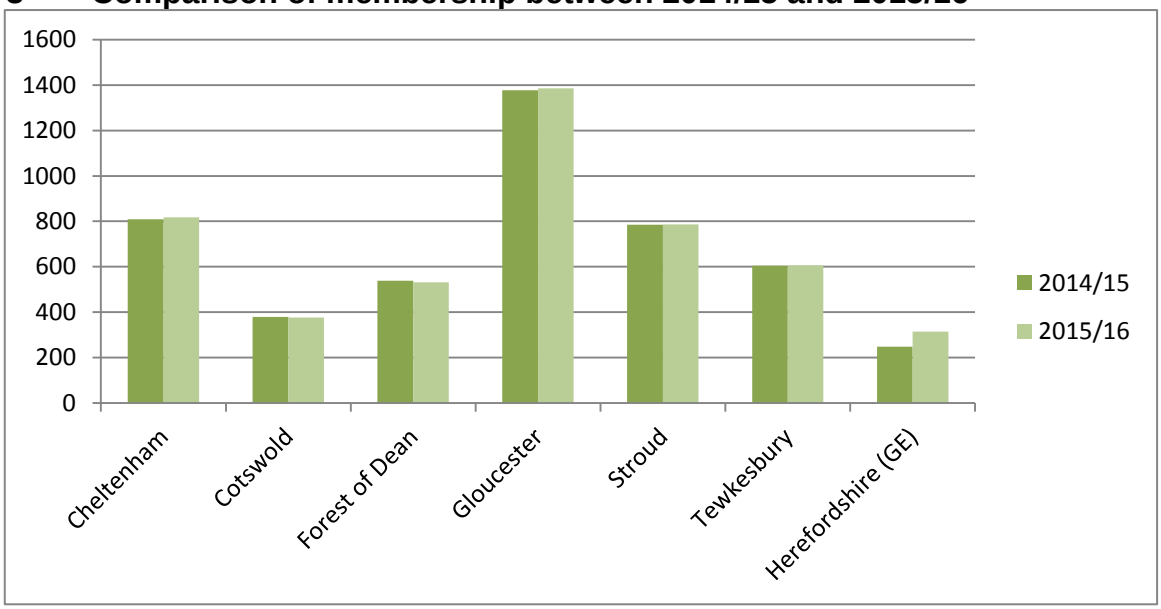
Gender – total public membership	
Male	1828
Female	3327

[1] * Please note that the 2011 Census age groups differ to how we currently collate membership data. The age range noted against the census age group 10 – 15 for members is 11 – 16; and the age range noted against the census age group 16 – 19 for members is 17 – 19.

3. Comparison of Annual Membership Data (2015/16)

The following chart (Figure 3) shows a modest overall increase in membership between 31st March 2015 and 31st March 2016. The graph indicates that overall, membership has been relatively constant in each constituency but with our largest constituency increase by population in Herefordshire. Concerted effort over the year has increased membership there by 67 people. However, there is still further work to achieve greater membership representation in Herefordshire.

Figure 3 Comparison of membership between 2014/15 and 2015/16



4. Conclusion

Analysis of the membership data suggests that:

- Membership currently appeals more to women than men, to people aged between 20 and 65 and to those with self-reported disability.
- Further tactics need to be developed to encourage membership from males, younger people, people from minority ethnic groups and from people who are without disability in order to reflect an accurate representation of the constituents of Gloucestershire and Herefordshire.
- Despite being the highest rate of membership increase across 2gether's constituencies this year, the number of members from Herefordshire remains significantly lower than in Gloucestershire. Gloucester City has the largest proportion of Trust members and represents the largest population of people.
- Further work is underway to review:
  - the format of membership events for recruiting members
  - new ways to reach potential members and
  - ways to enhance engagement with our existing members

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

Report to: Trust Board Meeting – 26th May 2016
Author: Carol Sparks – Director of Organisational Development
Presented by: Carol Sparks – Director of Organisational Development

SUBJECT: **Workforce Strategy and Training Strategy**

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

EXECUTIVE SUMMARY

The Organisational Development Strategy was developed in 2015 and endorsed by the Board in July 2015. The strategy is underpinned by two equally important strategies which help frame the workforce of the future. These are the Workforce Strategy and the Training Strategy.

Both strategies have been aligned to the Trust's three strategic objectives which are:

- Improve Quality – safety, outcomes and experience
- Engagement – increase internal and external engagement
- Sustainability – ensure we are sustainable, an effective partner, employer and advocate.

The Monitor 'Strategy Development Toolkit' has been used to ensure both strategies meet Monitor's expectations that the Trust through its workforce numbers and workforce profile can deliver our services now and in the future (Workforce Strategy), and furthermore that those staff have the knowledge, skills and leadership (Training Strategy) to meet the challenges of delivering quality care, adopting new technologies and remain sustainable.

A large range of documents, both national and local have been used to inform the content of these strategies to ensure consistency of messages. The content has been kept simple and the format is similar to that of the Staff Charter, is aligned to the Organisational Development Strategy, again to reinforce messages and consistency.

Both strategies are underpinned by implementation plans which will a period of five years and will have to be revised annually to ensure they remain appropriate to need. The Training Strategy is also informed and underpinned by the Training and Education annual plan

These two strategies set out a direction of travel, based on the Trust's values, which provides flexibility for the future, in language which can be understood and delivered by leaders and which staff can see put into practice.

Both strategies were considered by the Development Committee and have been revised in light of the feedback to better reflect current and future needs of the Trust.

RECOMMENDATIONS
The Board is asked to approve the Workforce and Training Strategies.

Corporate Considerations	
Quality implications:	Having the right number of staff in the right place at the right time, with the right skills, abilities and leadership will enable the Trust to deliver quality care in innovative ways.
Resource implications:	The implementation plans do not required additional resourcing unless separately specified
Equalities implications:	Workforce data and the staff profile (including data on protected characteristics) have been taken into account in developing the strategies and the implementation plans will address any equalities implications
Risk implications:	If services are not appropriately staffed with a flexible skilled and motivated workforce, the Trust risks being unable to adapt and respond to external challenge and change and risks being unable to deliver safe services.

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			P
Excelling and improving	P	Inclusive open and honest	P
Responsive	P	Can do	P
Valuing and respectful	P	Efficient	P

Reviewed by:		
Carol Sparks – Director of Organisational Development	Date	7th March 2016

Where in the Trust has this been discussed before?		
Workforce and Organisational Development Committee	Date	January 2016
Executive Committee		29th February 2016

What consultation has there been?		
Joint Negotiation and Consultative Committee	Date	22nd March 2016
Development Committee		23rd March 2016

Explanation of acronyms used:	

1. CONTEXT

1.1 The Workforce Strategy underpins the Trust's Organisational Development Strategy. It has three aims:

- To ensure workforce planning meets the short, medium and longer term business objectives of the Trust.
- To continue to improve data quality by ensuring data capture and reporting systems are robust, and managers have confidence in the accuracy of information
- To continue to improve the value of the information to better inform workforce planning intentions, and the Trust's understanding of key staffing metrics to enable the delivery of business objectives and refine Key Performance Indicators

1.2 The Training Strategy also underpins the Trust's Organisational Development Strategy. It has five aims:

- To provide a comprehensive programme of training activity which helps retain staff; which supports their wellbeing and which enables them to develop the values, skills and knowledge they need to deliver efficient, safe and compassionate care.
- To develop excellent leaders at all levels within the organisation who act in line with the Trust's values, who contribute to the achievement of the Trust's strategic objectives and who promote and encourage new ways of working and innovation.
- To work with local, regional and national partners to influence decisions and funding streams for training and education; and agree priorities for vocational training places to support our services into the future.
- To develop improved systems for data capture and recording which will ensure the Trust has access to accurate and timely information about training needs, course completions, staff competence and the organisational gain from training activity.
- To move away from more traditional, didactic training and development (such as classroom based) delivery and encourage opportunities for self-determined learning and the increasing use of technology enhanced sharing of information and knowledge.

1.3 A range of documents (internal and external) have been used to inform both strategies. Both documents set out the internal and external drivers for change and explain why the external context is important for the current and future workforce and enabling the Trust to deliver high quality services.

1.4 The Monitor 'Strategy Development Toolkit' was used to ensure both strategies meet Monitor's expectations that the Trust through its workforce numbers and workforce profile can deliver our services now and in the future (Workforce Strategy), and furthermore that those staff have the knowledge, skills and leadership (Training Strategy) to meet the challenges of delivering quality care, adopting new technologies and remain sustainable. The 'toolkit' describes a strategy as '*a set of choices and principles designed to help an organisation achieve long-term goals. It will influence how resources are allocated and how staff prioritise their time*.'

1.5 One of the challenges for any strategy is to keep the messages simple and clear yet with sufficient detail to inform an implementation plan which will have clear measures of success. The layout and format of these two strategies are sufficiently alike to

ensure there are relevant connections between them and both are different where they need to deliver different information or messages.

1.6 Finally the 'Strategy on a Page' (appendix A) uses the template from the Monitor 'Strategy Development Toolkit' and therefore does not attempt to 'reinvent the wheel'.

2. DO THE STRATEGIES MEET THE TRUST'S NEED?

2.1 The Monitor "Strategy development toolkit" recommends a whole range of questions which may enable a Board to "test" whether a strategy is fit for purpose. Whilst the questions have been developed to be used with an overarching 'organisation' strategy, a number of those questions are relevant to these strategies and are therefore offered below with answers.

Is it clear what the strategies are setting out to achieve?

2.2 Yes. This is described in the 'Strategy on a Page' (appendix 2 – Workforce Strategy; Appendix 3 – Training Strategy) and both set out the values, vision and priorities of the strategy. Both strategies are aligned to the Trust's three strategic objectives and reference the impact of Sustainability Transformation Plans on how our staff will we deliver our services.

2.3 We need both a Training Strategy and a Workforce Strategy to ensure our staff can continue to deliver high quality services at a time when NHS resources are reducing, there is increasing competition for the delivery of our services, and increasing integration of service delivery is required.

Has there been sufficient engagement and consultation on the strategies?

2.4 Probably. The strategies have been reviewed by:

- The Workforce and Organisational Development Committee
- JNCC
- The Executive Committee
- The Senior Leadership Forum which includes Clinical Directors; Heads of Profession and Service Directors
- Development Committee.

Has there been sufficient analysis of the underpinning data to demonstrate we need these strategies?

2.5 Yes. The annual Training Plan reviews in depth our training data and the content of and frequency of statutory and mandatory training is reviewed on an on-going basis by the Assistant HR Director - Training with the Trust's subject experts. Training data is regularly reported to operational managers.

2.6 Our Annual Equalities Report analyses our staff demographics and demonstrates that we have an ageing workforce with more staff who are aged 45 years plus than staff under 30 years of age. Many of our staff can retire at 55 years and although some staff either continue to work after this or wish to return to work having

accessed their pensions, we need to do more to address retention and employ more and younger staff.

2.7 We have a clear understanding of commissioning of student placements and programmes of training and education as provided through Health Education England in the South West and West Midlands.

2.8 We have access to information on the wider population demographics and access the research undertaken within the NHS about workforce pressures now and in the future via Health Education South West, and West Midlands.

2.9 We have analysed our recruitment data, turnover data and other key workforce information to better understand our recruitment difficulties. We therefore know that we need to develop our existing staff, assist them to work differently and better manage our talent in addition to reducing barriers to employment for staff of all ages. We are utilising the information that is becoming clearer on bank and agency usage to identify staffing gaps that are either short term or long term and not currently managed on a substantive basis.

2.10 We know that we have to improve the quality of workforce data that we provide to managers and increase the levels of confidence in the data.

How do the strategies improve the patient experience and support the delivery of quality services?

2.11 If we can improve our recruitment and retention, ensure our staff are trained and skilled and utilising their skills effectively, they will be better able to and more enthusiastic about delivering quality care. Staff are also more likely to participate in appraisal and completing their statutory and mandatory training which will ensure they understand what they need to do and be better able to work safely and provide safe, quality services.

2.12 If we can improve both staff and patient safety this will improve the patient experience and improve the quality of the service our staff provide.

2.13 We will be able to use our quarterly Staff Family and Friends Survey and our annual Staff Survey to assess levels of engagement and motivation of staff; their levels of satisfaction with the training they receive; whether they value their appraisal; their satisfaction with the quality of care they provide and the Trust as a place to work. We will work with the comments and feedback that staff provide from both these sources about how they perceive the patient experience and their work experience. We will use this information to take positive steps to address issues or concerns, and enhance staff motivation and engagement.

2.14 We have a range of patient feedback data to tell us how our service users and carers ‘rate’ our services. We can use this to work with staff to help them understand what they can do differently to improve the care they provide.

Are our strategies aligned to national and local priorities?

2.15 Yes. The strategies references a range of national and local priorities and specifically the Dalton Review (December 2014); the Five Year Forward View (October 2014); the Carter Review; and the Talent for Care Framework. The strategies also set out the local drivers. Careful attention has been paid to the content of the national reports to ensure the direction of travel is consistent with these documents, reflects the challenges outlined in them and uses consistent language. As already noted the strategies are aligned to the Trust's three key strategic objectives and recognise and respond to the Trust's business plan.

Will the strategies make our services competitive and sustainable?

2.16 No. Of themselves, the strategies will not make our services competitive and sustainable. However the actions underpinning the strategies are aimed at developing our workforce and ensuring we have well trained staff; staff are well-led; and we have the right number of staff in the right place at the right time. Our sustainability is dependent on a range of factors many of which are outside of these strategies and indeed external to the Trust. The strategies provide for flexibility which in turn will support sustainability of services.

Can we see a comprehensive picture of how our services will look in the future?

2.17 No. The strategies outline our aims for our workforce and aim to ensure we have the right staff to meet our service needs in the future.

Are the strategies sufficiently flexible and adaptable to respond to new or unexpected challenges or uncertainty?

2.18 Yes. As above, flexibility and uncertainty underpin the strategies and therefore the emphasis is being clear about, the levers for change, the local and national picture our current data and being vigilant and flexible to lead and managing positively to change.

Can the strategies be easily communicated to all our stakeholders?

2.19 Probably. We have a "strategy on a page" which uses a template recommended by Monitor. This has been used successfully with other Trust strategies. The "strategy on a page" is aimed at everyone. In any event, the language has been kept both as simple as possible, and consistent with other documents already shared with stakeholders. Any feedback as to how the language or format can be improved to make it more easily communicated will be welcome.

Will leaders be able to translate the strategies into what they and their teams need to do differently?

2.20 Yes. The strategies give a clear description of what leaders need to do, need to support or need to deliver. The implementation plans further define this.

Do the underpinning implementation plans have short, medium and long term goals?

2.21 Yes. The underpinning implementation plans set out a range of actions that need to be achieved with timescales. However the action plans need to be revised annually to ensure they continue respond as the internal and external drivers change. For example the implementation of a national levy for apprenticeships recently proposed from April 2017 may change both the shape of our workforce, the skills base, the training needs of staff who may be apprentices or may need to support apprentices, and the career pathway for staff who may commence in our services as apprentices.

Are there measurable criteria?

2.22 Yes – there are. Each of the action plans above have measurable criteria.

What would trigger a review of the strategies?

2.23 The strategies will need to be reviewed in the event that the Trust significantly changes the type of services it delivers, if the number of staff it employs significantly changes or if the skill mix of staff significantly changes. These are factors which will alter the underpinning data on which the strategies have been developed.

3 SUMMARY

3.1 Both the Workforce Strategy and the Training Strategy are aligned to national and local drivers, are consistent with a range of documents, use simple, clear language and is intended to be easily understood by anyone who reads them.

3.2 Both strategies have been amended based on the further feedback from Development Committee.

4 RECOMMENDATIONS

4.1 The Board is asked to approve the Workforce and Training Strategies.

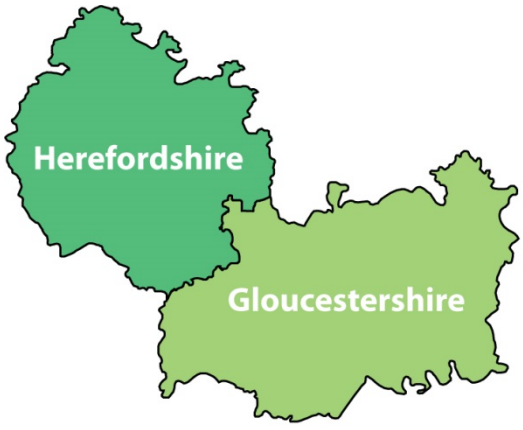
2gether
Making life better

2gether
NHS Foundation Trust

Workforce

Strategy

2016 - 2021



Introduction and purpose

This Workforce Strategy sets out the strategic workforce priorities for the 2gether NHS Foundation Trust for the next 5 years. One of the biggest challenges facing us is the uncertainty of future health needs and how our services will meet that need during the next 10 years, whilst also managing the challenges we face today.

The aim of this strategy is to set out a framework which will allow the Trust to ensure that the right numbers of staff are recruited and retained and that these staff have the right skills and values to enable them to deliver the Trust's current and future services. Our current and future workforce also needs to be adaptable, flexible and agile which will allow us to embrace new ways of working in new environments. Our strategy will support a culture of "can do" that enables engaged, competent and compassionate staff to deliver excellent patient care.

The NHS *five year forward view* (Forward View), published by NHS England and other national NHS bodies (2014) sets out a shared view on how services need to change and what models of care will be required in the future. Its key arguments are that much more attention should be given to prevention and public health; patients should have far greater control of their own care; and barriers in how care is provided should be broken down. This means putting in place new models of care in which care is much more integrated than at present.

This strategy expresses our view and approach to workforce planning, workforce information and the quality of workforce data. It also supports our Trust values and priorities and these are outlined in the section below.

Workforce Values, Vision and Priorities

The Trust has a well-established set of values that help to focus and shape the organisation. These values will be demonstrated throughout this workforce strategy and implementation plan that underpins the strategy.

Our Vision

Our vision has four main elements:

- to be the provider of choice for the population and commissioners we serve
- to be an employer of choice in a competitive employment environment
- to provide high quality, cost effective services that are attractive to commissioners and individuals
- to ensure the long term stability and viability of our organisation

Key Strategic Priorities

Our strategic and operational plans highlight three key priorities:

- Continuous quality improvements
- Internal and external engagement to support delivery of a challenging agenda
- Transformation to ensure sustainability

These values and priorities will be central to the development and implementation of this and all other strategies that involve shaping our future workforce.

External Drivers of Change

This strategy acknowledges that there are a number of trends and external drivers of change that will have and are currently having an impact on the shape and expectations of the workforce. Listed below are some of the key themes:

Ageing population

From 2012 to 2032 the populations of 65-84 year olds and the over 85s are set to increase by 39 and 106 per cent respectively whereas 0-14 and 15-64 year olds are set to increase by 11 per cent and 7 per cent respectively. The impact of the ageing population on health and social care services is hard to predict. It may lead to increased costs or the growing number of older people may create new economic and social opportunities.

It is also noted that Europe's loss of "baby boomers" from the workforce and the low birth rate mean that the active workforce will decline by 29 per cent by 2050. *(source: The Kings Fund, 2015). This will impact on the Trust's ability to recruit and will lead to an increased need to retain and re-train staff to maintain skills and experience.*

Impact of new technologies

Changing technologies and new models of care will have a significant impact on the workforce, but it is hard to predict the net impact on different professional roles. However we do know that staff will have to develop enhanced IT skills, adapt to new technology and therefore work differently.

Integration of health and social care providers

Moves to increase integration and personalisation of care will require professionals to adopt new roles and responsibilities that have a mix of health and social care competencies. The Trust will need to work closely with other Health and Social Care providers to ensure that where appropriate care pathways and therefore services are fully integrated and as a result care is seamless and roles are developed to support this new way of working.

Attractiveness of working in the Health and Social Care sector

The NHS has traditionally been an attractive place to work, commanding public respect, job security and good terms and conditions of employment. Increasingly there may be a need to locally manage those elements over which the Trust has influence, through consultation and negotiation with Staff Side to support integrated working with other partners and supporting a flexible, agile and multi-skilled workforce.

Patterns of work

Employment patterns and attitudes across the labour force as a whole have changed in recent decades. The proportion of women in the workforce has risen, while the proportion of men and younger people in work has fallen. Increasing numbers of people now work part-time, and it is expected that this will shift further towards flexible, part-time and home working. This means our managers will need to be supported to manage in a different way with an increasingly diverse workforce working out of different environments including developing appropriate roles for volunteers and also for carers who bring a special perspective on how we deliver services.

Understanding the demand for temporary staff

One of the key current and future focuses for all Trusts is to reduce use and reliance on agency staff. The use of agency staff still represents a significant cost to employers and a strategic approach is needed in order to develop a more flexible and responsive workforce and to avoid inappropriate responses to cost pressure. Our regulator Monitor together with the Trust Development Authority (TDA) has also implemented a cap on the amount of money trusts can pay per hour for agency staff working for the NHS. The cap came into force on 23 November 2015. This means that the Trust needs to focus on utilising its substantive and bank staff in the most effective and efficient way possible; this includes developing new types of contracts or roles, and retaining staff beyond the age at which they may retire.

Provision of a sustainable workforce

A key challenge facing organisations both now and in the future is the assurance of quality service delivery through a supply of suitably trained staff. This requires us to understand our recruitment markets, explore different avenues for recruitment, develop roles which balance service need against personal choice and to gain an insight into the terms and conditions that are expected, and are acceptable to, both the employee and employer.

The 2015 Kings Fund report "Workforce Planning in the NHS" states that *"the NHS workforce is the primary driver of future health costs. Given that around 70 percent of recurring NHS provider costs relate to staffing, and that the NHS is one of the world's largest employers, it is vital that the service invests in making the best use of staff to ensure they can deliver the care required by patients into the future. Focusing attention on this workforce is essential to addressing cost pressures and the delivery of future care models such as those outlined in the NHS five year forward view (Forward View)."*

This report along with other external drivers of change have been taken into account when developing this strategy and include:

- Francis Report
- Keogh Report
- Berwick Reports
- Dalton Review December 2014
- Commissioner intentions as described in current contracts
- Monitor Strategy Development Toolkit
- Talent for Care – A National Strategic Framework
- The Carter Review
- The NHS Mandate 2014 – 2015
- The Shape of Caring Review October 2013
- Implementing the NHS five year forward view: aligning policies with the plan 2015

There is little doubt that the next 5 years will provide significant workforce challenges, however, some of these can be mitigated by having a clear direction of travel and robust workforce plans.

This Workforce Strategy is one of a series of strategies that will support the Trust in delivering its Values, Vision and Priorities. It will support our commitment to deliver specialist mental health and learning disability services to the people of Gloucestershire and Herefordshire through a workforce that is flexible, adaptable and agile. Our workforce is our most expensive and valuable resource and therefore our staff are central to our ability to deliver the best care with the best outcomes which is underpinned by values of care, compassion, transparency, honesty and respect.

Internal Drivers of Change

This section outlines some of the key internal drivers that are influenced by the external drivers for change listed above:

Ageing workforce

Our current workforce profile places 19% (364) of our staff between the ages of 50 to 54 and a further 12% (234) between the ages of 55 to 59. Staff with Mental Health Officer Status can choose to retire from our services at age 55. Staff in these age groups often have considerable skills and experience. This means that our workforce plans will need to include strategies to mitigate the impact of loss of knowledge and experience on service delivery, or have strategies to retain key staff beyond the age at which they may retire. Our annual equalities report provides us with a detailed analysis of our workforce profile; the report can be found on the Trust website.

Impact of new technologies

A key challenge for the workforce over the next 5 years will be to change the way in which new technology is used to deliver services in a more effective and efficient way. This will mean that staff will have to acquire new skills in technology and be flexible in their approach to work. Working environments may change i.e. people working more remotely. It is important therefore that workforce plans identify changes in skills and competence and informs the Trust's annual training plan.

Integration of health and social care providers

Sustainability and Transformation Programmes will redefine existing roles together with the commissioning of new roles spanning health and social care which will facilitate greater integration of services. The workforce plan will need to clearly describe these new roles together with the skills, competencies and qualities that are needed to ensure care is delivered in a sustainable way and in line with our Trust values. The OD strategy will be particularly important to ensure there is strong leadership to facilitate and support transformation along with a culture that supports this new way of working.

Attractiveness of working in the Health and Social Care sector

Our workforce plans will identify the numbers and types of practitioners we will need in the future. We will need to ensure that we develop pro-active recruitment campaigns that address the gaps in workforce numbers, skills and capabilities. We will also need to take into account the lead in time for new practitioners to enter the labour market (a table of lead in times can be seen at appendix 3 of this document). Our campaigns will emphasis our staff benefits, support for health and wellbeing and the advantages of living in the 'shires'. Good terms and conditions of employment together with job security and public respect.

Patterns of work

The Sustainability and Transformation Programme work also will identify new types of roles and patterns of work. Our OD strategy will enable and support staff to transfer from current patterns and ways of working to new roles which will support the delivery of services that are person centred and flexible i.e. 7 day a week. This work will be balanced with the increasing diversity of employment patterns and expectations of people within the labour market.

Understanding the demand for temporary staff

In order to sustain and develop services in the short, medium and long term, service plans should describe the workforce required to deliver services both now and in the future. This information will be included in our workforce plans regional returns, such as those to Health Education England. The planning and delivery of a sustainable workforce depends upon strong links between recruitment, staff development (in particular leadership development), and succession planning, and these links must be developed collaboratively.

Provision of a sustainable workforce

Workforce plans will support better integration of working across Health and Social care and maximise the opportunities brought about by utilising the skills, experience and capabilities of non practitioner workers i.e. volunteers, carers, the role of apprentices and talent for care programme. They will need to be flexible and adaptable and take account of the changes in the labour market i.e. where shortage occupations exist. They will also need to take into account of succession planning and action plans as a result of this exercise i.e. development programmes for our future leaders.

Other influences on the Workforce Strategy are contained within:

- Organisational Development Strategy 2015 – 2018
- Training Strategy 2015 – 2018
- Commercial Strategy 2015 – 2020
- Corporate Strategy 2014 – 2019
- Strategic Plan 2014 – 2019
- Nursing Strategy 2014 – 2017
- Partnership Strategy 2015 – 2018
- Health and Wellbeing Strategy 2014 – 2017
- Staff Charter
- Investors in People Action Plan
- Annual Staff Survey Action Plan
- Finance Strategy
- Research Strategy
- Communications and Engagement Strategy
- Improving Care through Technology Plan

Aims of the Strategy

This document will focus on three key elements which are: Workforce Planning, Workforce Information and Data Quality. Each element has an aim and number of priorities that will be progressed over the coming 5 year period.

Workforce Planning

Aim 1: To ensure workforce planning meets the short, medium and longer term business objectives of the Trust.

How will this aim be achieved?

By working collaboratively with Service Directors, Heads of Profession and Trust experts to:

1. Produce high quality workforce profiles as and when required to do so
2. Establish the workforce profile needed to deliver future services that is aligned to the workforce planning outputs of the STPs and takes into account national and local data predictions
3. Monitor the existing workforce profile and identify gaps using contemporary and alternative processes, succession planning and an understanding of the ability to recruit and train new staff.
4. Highlight any risks associated with the agreed workforce profile and plan how to mitigate the risks i.e. shortage occupations
5. Produce high quality action plans to address the identified workforce needs which will include details on how these needs will be met i.e. by detailing recruitment and retention initiatives in particular relation to hard to recruit and retain staff groups and roles, succession planning and changes in skill mix.
6. Ensure that Trust workforce priorities are understood at a detailed level and taken into account by Health Education England in the South West and West Midlands in regional workforce planning
7. Work closely with our Commissioners to ensure that our workforce priorities are linked to and embedded in countywide workforce plans.
8. Ensure that Service Plans fully consider and detail the workforce needed to sustain and support service delivery including future changes to service provision.

9. Ensure that workforce planning is closely linked with workforce development and succession planning processes.

Workforce Information

Aim 2: To continue to improve the value of the information to better inform workforce planning intentions, and the Trust's understanding of key staffing metrics to enable the delivery of business objectives and refine Key Performance Indicators

How will this aim be achieved?

Through:

1. Ensuring that reports are fit for purpose and contain the appropriate level of information.
2. Reports are provided in a timely manner that meets managers' needs.
3. Managers have the appropriate skills to make best use of the data provided.
4. Exploring the benefits and challenges of holding staffing establishment information in ESR

Workforce Data Quality

Aim 3: To continue to improve data quality by ensuring data capture and reporting systems are robust, and managers have confidence in the accuracy of information

How will this aim be achieved?

Through:

1. Maximising the existing opportunities and planned improvements to ESR to improve both the speed and accuracy of data quality
2. Continuing with data quality checks and audits

Scope of the Strategy

This strategy will apply to all staff irrespective of contract type i.e. substantive, fixed term, bank, or agency, and takes into account the valuable role that volunteers, students and others play in delivering our services both now and in the future.

The Assistant HR Director for Workforce will work collaboratively with colleagues from across the health community, CCG's, Health Education England in the South West, Health Education in the West Midlands linking also with the Sustainability and Transformation Programmes to achieve the aims of the strategy.

What we will do?

We will have a focused approach to driving the strategy forward which means that we will:

- work in collaboration with STP workstreams to deliver a workforce plan that clearly articulates the numbers and types of practitioners needed to deliver future integrated services.
- carry out a gap analysis in specific areas and work with managers to discover innovative ways in which to fill the gaps this could mean using different staff groups in different ways, flexing jobs to meet service needs in the short and medium term.
- explore opportunities for other types of workers i.e. peer support workers, apprentices and the role of the advanced practitioner.
- concentrate our efforts where they are needed most i.e. CYPS recruitment and retention.
- work with our internal training team and other external providers to ensure our workforce is supported and developed in line with service need
- work with external workforce intelligence to ensure we understand the needs and aspirations of our future workforce and where possible flex our jobs accordingly i.e. meeting the expectations of generations 'X' and 'Y'.

Measuring, Monitoring and Reporting

Progress on this strategy and its underpinning implementation plan will be provided to the Workforce and Organisational Development Committee (WODC) on a quarterly basis. Any adjustments to the implementation will be reported to the WODC as and when the need arises. However the implementation plan must by its very nature be flexed and adapted to meet changing internal and external workforce needs.

Updates from the WODC are provided to the Trust Executive Committee and annually to the Trust's Delivery Committee.

What do we want our future workforce to be like?

We want a workforce that is made up of engaged, committed, skilled and flexible individuals that can consistently demonstrate Trust values through everything they do and who are compassionate about the care they provide. They will have the skills; competence and enthusiasm to work collaboratively across traditional boundaries to deliver packages of care that achieve the best outcomes for people who use our services.

What will success look like?

We will know that we have been successful in strategy implementation because we will have a robust, flexible workforce plan which will be informed by our involvement with the Sustainability and Transformation Programme workstreams, local health community and operational managers that will give us the confidence to manage our staffing requirements over the short, medium and long term. Managers will also have confidence that the information they receive is accurate, it will be in a format that meets their needs, will be provided at a frequency and quantity which will enable them to manage their teams effectively and efficiently.
Ultimately our staff will be in the right place and at the right time with the right skills and values to deliver caring and compassionate Mental Health and Learning Disability services to the communities we serve.

Consultation

Consultation on the Strategy will take place with our Staff Side colleagues through the Joint Negotiation and Consultative Committee, with managers and staff via the WODC and the Trust Executive Committee.

This strategy has been equality impact assessed using the Trust's template for assessment.

Communication

Regular updates and communication about progress will be made through a wide number of channels, namely:

- Workforce and OD Committee
- Joint Negotiation and Consultative Committee
- 2getherNet
- Trust Website
- Global e-mail
- Team Talk
- Managers Briefing
- ByteSize
- Microsite
- Delivery Committee
- Executive Committee

This list is not exhaustive.

A summary of this Workforce Strategy (strategy on a page) is attached at appendix 2.

References:

Addicott, R, Maguire, D, Honeyman, M and Jabbal, J, (2015), Workforce Planning in the NHS, Kings Fund, London.

Ham, C and Murray, R, (2015), Implementing the NHS five year forward view: aligning policies with the plan.

http://www.kingsfund.org.uk/time-to-think-differently/trends/demography

Appendix 1

Workforce Strategy Implementation Plan 2016 – 2021

What are we going to do?	How will we know if we have done it?	When will we do it?	Who will be responsible for it?	What difference will it make?
Workforce Planning – Aim 1: *To ensure workforce planning meets the short, medium and longer term business objectives of the Trust*				
Produce high quality workforce profiles as and when required to do so.	Accurate workforce profiles will be distributed as requested.	This item is ongoing as the need arises	Assistant HR Director, Workforce	Managers will have up to date profiles to aid decision making.
Establish the workforce profile required to deliver future services taking into account outputs from the STP, national and local data predictions	The profile will be agreed by Service Directors and other operational managers	As and when required i.e. when there is a service change needed or new service needs to be established.	Service Directors and operational managers.	Services can be delivered by having the right staff with the right skills and values in place within agreed timescales. Workforce plans will clearly identify the numbers and types of practitioners needed together with the skills, competencies and values to deliver integrated services.
Identify gaps in the current and future workforce profile.	When the Trust or individual services have a workforce profile that managers recognise as identifying the workforce issues they face and which they believe will be able to underpin an action plan to address gaps.	As and when the need arises. As part of developing service plans	Service Directors, operational managers and the Assistant HR Director, Workforce	It will mean that staff recruitment, retention and training is focused on ensuring the right people are in place to deliver our services in the way we would want them to be delivered.

What are we going to do?	How will we know if we have done it?	When will we do it?	Who will be responsible for it?	What difference will it make?
Highlight and log risks that are associated with gaps identified in the workforce and draw up action plans in order to mitigate the risk.	Risks will be highlighted on the Trust's Risk Register	As and when gaps are identified.	Service Directors with support from the Assistant HR Director, Workforce	It will mean that we have a clear understanding of the gaps in our workforce profile and how we are going to fill them.
Ensure that service plans fully consider current and future workforce implications.	Service plans will describe in detail what current and future workforce will be needed to deliver services.	To be included in 2017/18 service plans	Service Directors with support from the Assistant HR Director, Workforce	It will mean that we have the information available to support our processes for recruiting, retaining and developing staff which in turn will lead to the ability for workforce supply to meet workforce demand.
Produce high quality action plans to address the identified workforce needs	When the Trust or individual services have a workable and agreed action plan that takes into account recruitment, retention and training needs and delivers on closing identified gaps	As and when the need is identified As part of developing service plans	Service Directors, operational managers and the Assistant HR	Teams will experience minimal delay in recruitment of new staff, there will be appropriate retention of existing staff (skills and experience will be retained); service delivery will be maintained.
To work closely with Health Education in the South West and West Midlands to ensure that priorities are supported.	HEE SW and HEE WM deadlines are met and we have representation at working group meetings.	As and when required to do so.	Assistant HR Director, Workforce Deputy Finance Director	The Trust will receive funding support through educational tariffs and other mechanisms to support pre and post registration placements & activity. Educational places for professional groups and placed accurately by the HEE SW and HEE WM.

What are we going to do?	How will we know if we have done it?	When will we do it?	Who will be responsible for it?	What difference will it make?
To work closely with our Commissioners to ensure that workforce priorities are linked to Countywide workforce plans.	When Trust workforce priorities are reflected and integrated in outputs from the CCG Workforce Planning Group for Gloucestershire or other similar groups associated with other Commissioners.	On an on-going basis and through attendance at planned meetings.	Assistant HR Director, Workforce	The Trust will be actively engaged in developing integrated care which will reflect the Five year forward view and the Gloucestershire Strategic Framework.
Ensure workforce planning, recruitment, staff development and succession planning are aligned to maximise the quality and flexibility of the work force	Staff recruitment and retention levels improve, and the satisfaction of both staff and users increases	Process review completed by March 2017.	Assistant HR Director, Workforce	The Trust will be seen as an employer of first choice, and thereby attract the highest quality staff, motivate existing staff, and further raise our reputation with commissioners
Explore ways in which we can increase success in recruitment activities	We will be able to attract candidates for roles that we currently have difficulty in recruiting to	Throughout 2016/17	Assistant HR Director, Operations	Teams will operate more effectively leading to improved service delivery
Workforce Information – Aim 2: *To continue to improve the value of the information to better inform workforce planning intentions, the Trust's understanding of key staffing metrics to enable the delivery of business objectives and refine KPI's*				
Ensure that reports are fit for purpose and contain the appropriate level of information.	The content of reports will be developed collaboratively with operational managers; run and used regularly by them.	There will be an annual review of standard reports provided by the HR Workforce Information Team Where systems used are updated locally or as a result of national updates, the	Assistant HR Director, Workforce Service Directors and Trust Managers	Managers will have access to the data they need in a format that they can most easily use.

What are we going to do?	How will we know if we have done it?	When will we do it?	Who will be responsible for it?	What difference will it make?
	The Oracle Business Intelligence tool or other available tools will be used to structure reports and reduce manual workarounds for the HR Workforce Information Team.	impact on reporting format and content will be raised with operational managers within three months of the system changes. The Oracle Business Intelligence tool or other available tools will be reviewed by June 2016 and if advantages identified, in use by July 2016.	Assistant HR Director Workforce	
Reports are provided in a timely manner that meets managers' needs.	Managers will be able to confirm that reports are received at a time that is a) agreed with them b) meets their needs	There will be an annual review of reporting timelines Where systems used are updated locally or as a result of national updates, the impact on reporting timelines will be discussed with managers as part of any implementation plan	Assistant HR Director, Workforce Service Directors and Trust Managers	Managers will be able to make more effective use of the data available and respond more quickly to staffing issues, gaps or demands.
Managers have the appropriate skills to make best use of the data provided.	Managers will a) be able to confirm that they understand the data provided, b) requests from managers for ad hoc reports will clearly support the effective management of people issues.	On-going and specifically for Band 7 managers as part of our 2016/17 management development programme	All managers for their self development Senior Managers Service Directors Heads of Profession Assistant HR Director – Training	Managers will spend less time on analysis of data and release time for clinical / team management.

What are we going to do?	How will we know if we have done it?	When will we do it?	Who will be responsible for it?	What difference will it make?
Explore the benefits and challenges of holding staffing establishment information in ESR	When we are able to report vacancies through ESR.	Initial fact finding will commence in January/February 2016	Assistant HR Director, Workforce and Deputy Finance Director	The Trust will be able to accurately report on vacancies to inform recruitment , retention and workforce planning intentions
Workforce Data Quality – Aim 3: *To continue to improve data quality by ensuring systems are robust and managers have confidence in the accuracy of information*				
Maximise the existing opportunities and planned improvements to ESR to improve both the speed and accuracy of data quality	All staff that have access to a PC or laptop will be able to view their personal details, total reward statement and payslip All managers will be able to access HR information relating to their team in ESR	Changes will take place after the planned implementation of the ESR Enhanced System – due to be released at the end of Q3 2016	Assistant HR Director, Workforce	Data quality will improve by staff being able access and being responsible for their own information in ESR. Managers will have access to accurate information
Continue with data quality checks and audits	Improvement will be seen in the Health and Social Care Information Centre quarterly reports on data quality. Managers will have confidence in the data held within ESR Regular checks will take place with managers prior to the roll out of the self-service modules to ensure the information stored in ESR is up to date and accurate.	Ongoing	Assistant HR Director, Workforce Service Directors and their managers to be responsible for checking data and feeding back any discrepancies	Managers will have confidence in the data sent via reports from ESR.

Appendix 2

[2]GETHER NHS FOUNDATION TRUST
OUR WORKFORCE STRATEGY ON A PAGE
2016 – 2021

What is a Workforce Strategy?

This Workforce Strategy supports our Organisational Development Strategy and describes how we will manage our strategic workforce priorities for the [2]gether NHS Foundation Trust for the next 5 years. It sets out the external factors and the internal challenges that will influence our workforce priorities and describes how our workforce data and the people we employ can better meet our organisational priorities and deliver high quality care.

Why do we need a Workforce Strategy?

We need to have a framework and agreed approach that ensures the Trust is able to recruit and retain the right numbers of staff who have the right skills and values so that they can deliver the Trust's current and future services. Our current and future workforce also needs to be adaptable, flexible and agile which will allow us to embrace new ways of working in new environments. Our strategy will support a culture of "can do" that enables engaged, competent and compassionate staff to deliver excellent patient care.

What is the aim of our Workforce Strategy?

Our Workforce Strategy has three overarching aims which are:

- Workforce Planning – We will be able to meet our short, medium and long terms business plans through having staff with the right skills in the right place at the right time
- Workforce Information – We will have the right workforce information to understand our workforce profile and inform business objectives
- Workforce Data Quality – We will have good quality data and reporting systems

What do we want our future workforce to be like?

We want a workforce that is made up of engaged, committed, skilled and flexible individuals that can consistently demonstrate Trust values through everything that they do and who are compassionate about the care they provide.

What is the scope of our Workforce Strategy and who will deliver it?

This strategy will apply to all staff irrespective of contract type i.e. substantive, fixed term, bank, or agency, and takes into account the valuable role that volunteers, students and others play in delivering our services both now and in the future.

How will we know that we have delivered our Workforce Strategy?

Ultimately our staff will be in the right place and the right time with the right skills and values to deliver caring and compassionate Mental Health and Learning Disability services to the communities we serve.

Professional Training

Profession	Duration	Qualification	Regulatory Body
Nursing	3 years full-time	Nursing Degree – Registered Nurse	Nursing and Midwifery Council (NMC)
Nursing	*return to practice* 12 weeks to 1 year	Nursing Degree – Registered Nurse already held	Nursing and Midwifery Council (NMC)
Physiotherapy	3 years full-time	Physiotherapy Degree – Chartered Physiotherapist	Health and Care Professions Council (HCPC)
Occupational Therapy	3 years full-time or if relevant first degree is held 2 years	Degree in Occupational Therapy – BSc (Hons)	Health and Care Professions Council (HCPC)
Speech and Language Therapy	3 or 4 years full-time or if relevant first degree is held 2 years	Degree in Speech and Language Therapy – BSc (Hons)	Health and Care Professions Council (HCPC)
Clinical Psychology	3 years post graduate – possible range of qualifications MSc, PhD, BSc	Doctorate or Post Graduate Degree in Clinical Psychology	The British Psychological Society (BPS) and the Health and Care Professions Council (HCPC)
Psychotherapy	3 years – year one foundation degree	MA/Diploma	The British Psychological Society (BPS), UK Council for Psychotherapists (UKCP), British Association for Counselling and Psychotherapy
Low Intensity Improving Access to Psychological Therapies (IAPT)	Training 45 days in total (4 modules)	Low Intensity Therapist	British Association for Behavioural and Cognitive Psychotherapies (BABCP), The British Psychological Society (BPS),
High Intensity Improving Access to Psychological Therapies (IAPT)	1 year post graduate training	High Intensity Therapist	British Association for Behavioural and Cognitive Psychotherapies (BABCP), The British Psychological Society (BPS)

Profession	Duration	Qualification	Regulatory Body
Psychiatry	Medical Degree – 6 years Trainee programmes	Medical Degree Trainee: Foundation 1 – 1 year Foundation 2 – 1 year Core Psychiatry Training – 3 years Specialty Doctor Advanced Psychiatry Training – further 3 years Consultant	General Medical Council (GMC)

2gether NHS Trust

Training Strategy

2016 – 2021

Training Strategy 2016 - 2021

Why do we need a Strategy?

Change in the NHS has been, and will continue to be a constant. The Trust, in common with all organisations involved in health service provision, must transform to meet the changes. The Trust's Organisational Development strategy sets out our vision to develop a flexible, adaptive and agile organisational structure able to meet the changes and challenges of the next five years. This Training Strategy supports the aims of our Organisational Development Strategy and outlines the ways in which our training and development plans will be developed to help support the delivery of our Organisational Development Strategy, and the Trusts broader operational plans, our developing sustainability and transformational plans and our strategic aims.

The key to being flexible, adaptive and agile is to ensure staff have the right skills, values and approach to change, and that they are supported by transformational leadership, as this will enable us to deliver safe, effective, innovative and compassionate care, underpinned by evidence based practice.

This Strategy lays out our view of and approach to training and development across the Trust, and outlines how, over the next five years (2016-21), we will create appropriate learning opportunities and training infrastructure to support our staff and leaders, in terms of both organisational change and personal growth.

Training Strategy – Values and Priorities

Values

The shape and focus of an organisation is determined by the values it adopts, which in turn determines not only the type of services it will deliver, but also the way in which staff interact. The Trust has an established set of values and these will underpin all the training and development activities described in the Strategy.

Priorities

The Trust's three key priorities remain central to the development of all strategic plans and transformation.

Strategy Vision

Our vision is to:

Ensure the delivery of transformational training and development which is underpinned by our values; which helps us respond to changes in service requirements and which supports colleagues to deliver safe, effective, evidence based and compassionate care.

Internal Drivers of Change

This Training Strategy is one of a range of 'enabling strategies' that will help the Trust deliver its overarching vision of flexibility, adaptability and agility; supporting staff to deliver efficient, flexible and compassionate services whilst being responsive to changing demands and future requirements. These changes will be identified as part of the Trust's workforce planning process (as outlined in the Trust's Workforce Strategy), and will be influenced by a range of additional internal and external strategies and documents; namely:

- Organisational Development Strategy 2015 - 18
- Research & Development Strategy 2016 - 2020
- Workforce Strategy 2016 - 21
- Commercial Strategy 2015 - 20
- Corporate Strategy 2014 - 19
- Strategic Plan 2014 - 2019
- Nursing Strategy 2014 - 2017
- Partnership Strategy 2015 – 2018
- Health and Wellbeing Strategy 2014 - 2017
- Staff Charter
- Investors in People Action Plan
- Annual Staff Survey Action Plan
- Finance Strategy 2014 - 2019
- Improving Care Through Technology Plan
- Investors in People Action Plan
- Communication & Engagement Strategy 2016 - 2020

External Drivers of Change

This Strategy takes into account relevant legislation with regard to statutory training requirements, and is aligned to both the Health Education South West and the Health Education West Midlands "Workforce Skills and Development Strategy". The values and principles within it are underpinned by the NHS Constitution.

Other external drivers include relevant national reports, initiatives and strategy documents. These include:

- The NHS Mandate
- Talent for Care – A National Strategic Framework
- NHS Five Year Forward View (October 2014)
- The Shape of Training Review (October 2013)
- The Shape of Caring Review (March 2015)
- Commissioner intentions as described in current contracts.
- Francis Report
- Keogh Report
- Berwick Reports
- Carter Review
- Dalton Review (December 2014)
- Monitor 'Strategy Development Toolkit'

The Strategy will also need to be sufficiently flexible so that it can adapt to emerging influences, including recommendations stemming from the Trusts Sustainability and Transformational plans.

These external reviews and reports provide confirmation of the need to ensure high quality training, development and educational opportunities for staff in order to address the ongoing pressures facing the NHS and to deliver the organisational changes required to overcome them over the next five years. The NHS Mandate - Delivering high quality, effective, compassionate care: April 2015 to March 2016 states that "*The ability of our NHS to deliver world-class, compassionate care is dependent on the quality of training and education of our staff*".

The NHS Five Year Forward View delivers a commitment from Health Education England to "*work with employers, employees and commissioners to identify the education and training needs of our current workforce, equipping them with the skills and flexibilities to deliver the new models of care, including the development of transitional roles. This will require a greater investment in training for existing staff, and the active engagement of clinicians and managers who are best placed to know what support they need to deliver new models of care*".

However, it is not only the training and development of staff that we need to review to meet future needs, we also need to consider the way in which staff (and service users) access training information. Lord Willis in the Shape of Caring Review states that "*Technology will*

also play an increased role in the education and training of our workforce, as well as the education and empowerment of patients and their carers. E-learning, apps and simulators are currently assisting nursing and care support staff to access education and training outside the classroom, enabling regular updates of skills and knowledge. This results in a more educated and competent workforce that is able to deliver harm-free and clinically effective care".

The Trust's Organisational Development Strategy has outlined a vision for our future form and organisational culture. This Training Strategy, alongside our Workforce Strategy, provides a clear framework for the training and development structures and activities that we will need to have in place to deliver this vision.

Aims of the Strategy

This Training Strategy takes account of the internal drivers for change whilst also acknowledging the recommendations contained in national reports. It has five key aims: together they will provide a framework for formulating the Trusts strategic plans for training, development and education; enabling the Trust, its staff and others engaged in delivering its services to continue to adapt to future challenges and changing demands and to continue to deliver safe, compassionate and responsive services.

The five overarching aims of this strategy are:

1. To provide a comprehensive plan, which includes overarching themes and more detailed training activity which helps retain staff and which enables them to develop the values, skills and knowledge they need to deliver efficient, safe and compassionate care, responsive to current and future service needs.
2. To develop excellent leaders at all levels within the organisation who act in line with the Trust's values, who contribute to the achievement of the Trust's strategic objectives and who promote and encourage new ways of working and innovation supported by evidence based practice.
3. To work with local, regional and national partners to influence decisions and funding streams for training and education; and agree priorities for vocational training places to support our services into the future.
4. To develop improved systems for data capture and recording which will ensure the Trust has access to accurate and timely information about training needs, course completions, staff competence and the organisational gain from training activity.
5. To move away from more traditional, didactic training and development (such as classroom based) delivery and encourage opportunities for self-determined learning and the increasing use of technology enhanced sharing of information and knowledge which in turn supports technological innovations in service delivery.

The work required to achieve the aims of this Strategy are detailed in an Implementation Plan which describes in detail a wide range of actions and outputs for each of the five aims. The Implementation Plan will be regularly reviewed and revised wherever necessary in light of future changes or demands. Achievement of these aims will support the delivery of the Trusts operational, sustainability and transformational plans and our strategic objectives; enabling us to adapt to future challenges and embrace opportunities.

The Training Strategy Implementation Plan can be found at Appendix 1

Involvement

This Training Strategy and Implementation Plan will evolve organically through extensive involvement (achieving 'through' rather than 'doing to' people) and applies to:

- all staff including those on substantive, short term or agency contracts;
- students and volunteers who work alongside our substantive employees
- the wide range of external agencies and partners, including Health Education South West and Health Education West Midlands, who are involved in the commissioning, development and delivery of the extensive range of training and educational activity that takes place within the Trust.

Measuring, Monitoring and Reporting

The Implementation Plan contains discrete actions and measurements; progress towards achievement of these will be regularly reported.

Training data will continue to be captured and reported, as will progress regarding improvement in training compliance rates and data recording systems. There will be improvements made to the information that is gathered following training to ensure effective evaluation of training and to provide assurance about the transfer of knowledge into practice.

The Strategy and associated Implementation Plan, (which includes a number of separate Action Plans) is overseen by the Trust's Workforce and Organisational Development Committee. Updates from the Workforce and Organisational Development Committee are provided to the Executive Committee. Progress regarding a number of specific areas of activity is already reported at Governance and Delivery Committee but in addition to this, progress on the overall Implementation Plan will be reported at least annually to the Trust's Delivery Committee.

What will Success Look Like

We will know that our Training Strategy has been successful because our training processes will enable us to identify the knowledge and skills that our staff and leaders need to have, and it will support them to gain these wherever there is a deficit, using a range of effective training and development delivery methods. Staff will recognise the benefit of lifelong learning and will be keen to pursue development opportunities which support the delivery of services, their Continuing Professional Development and their own wellbeing. Managers will act in line with our organisational values, including facilitating an environment of continuous practice development, learning and reflection. Our information systems will help us accurately report training and development activity and our evaluation procedures will show us the organisational gain from this.

Consultation

Consultation on the Strategy has taken place with the Trust's Staff Side representatives through the Joint Negotiation and Consultation Committee, with managers via the Training and Development Working group and with Service Directors and Heads of Professions.

The Training Strategy has been equality impact assessed using the Trust's agreed template and processes.

Communication

This Strategy and its underpinning Implementation Plan needs to be supported by consistent, regular and appropriate communication and effective feedback mechanisms. Appendix 2 describes our 'communication map' although the list is not exhaustive.

A summary of this Training Strategy – our Strategy on a Page – is attached as Appendix 3

APPENDIX 1

TRAINING STRATEGY - IMPLEMENTATION PLAN 2016 – 2021

What are we going to do?	How will we know if we have done it?	When will we do it?	Who is responsible?	What difference will it make?
Aim 1: To provide a comprehensive plan, which includes overarching themes and more detailed training activity which helps retain staff and which enables them to develop the values, skills and knowledge they need to deliver efficient, safe and compassionate care, responsive to current and future service needs.				
Review our current statutory and mandatory training requirements to ensure they continue to accurately specify the knowledge and skills that our staff need to have and/or need to acquire to support changing service delivery plans.	Our staff will have the required skills and knowledge to carry out their roles competently, both now and in the future.	Every six months.	Assistant HR Director – Training, jointly with subject specialists/Service Leads & Heads of Profession	Service provision will be flexible, adaptive and will not be affected by skills shortages. We will meet the requirements of legislation and our regulatory bodies.
Increase the number of staff reporting that they receive job-relevant training, learning or development in last 12 month	The Key Finding in the annual NHS Staff Survey which measures job-relevant training, learning or development in last 12 month will increase	Annual review of Staff Survey results in February	The Assistant HR Director – Engagement	Staff will perceive that they have the necessary skills and competencies to work effectively, efficiently and safely
Design and introduce a Trust-wide Training Needs Analysis process which helps identify current levels of staff competence and which identifies staff skills and/or knowledge gaps.	We will have a data set which enables us to accurately identify skill shortages and training will be planned to address the identified gaps.	By December 2016	Assistant HR Director - Training	Our training programmes will be more accurately targeted to help support gaps in knowledge, resulting in more efficient use of resources. Staff will be able to identify the knowledge, skills and experience required to enable them to seek promotional or career enhancing sideways moves within the Trust.
Develop agreed policies/protocols which provide a framework for equitable access to routes of relevant, professionally recognised Continuous Professional Development (CPD)	There will be agreed, transparent procedures which are consistently applied across different disciplines, which support staff to access relevant CPD activities.	By December 2016	Assistant HR Director - Training	Staff will report they feel that there is a clear approach to, and fair distribution of funds and time allocation for CPD activities, and that these enable them to carry out their roles more effectively.

What are we going to do?	How will we know if we have done it?	When will we do it?	Who is responsible?	What difference will it make?
Review our offer of discretionary training programmes to ensure they continue to meet organisational needs.	A comprehensive list of agreed discretionary training will be available via the intranet to all managers and staff.	By June 2016	All providers of discretionary training, co-ordinated through Assistant HR Director – Training	Discretionary training will be clearly aligned to and support the Trust's business and service delivery objectives and individual well-being. Managers and the Trust Board will be clear about the totality of time spent on training activities; the way resources are spent, and have a better overview of the skills and knowledge staff have.
Review our physical intervention training programmes and amend them as necessary in line with the national Positive and Safe programme and our local Positive and Safe Sub Committee (and Action Plan).	Training will be delivered in line with the recommendations of both the national programme and our local Positive and Safe Sub Committee Action Plan.	Over the next 12 months	Assistant HR Director – Training and the Behaviour Support & Training Team	There will be a decrease in the use of prone restraint in line with the Positive and Safe Sub Committee Action Plan.
Aim 2: **To develop excellent leaders at all levels within the organisation who act in line with the Trust's values, who contribute to the achievement of the Trust's strategic objectives and who promote new ways of working and innovation supported by evidence based practice.**				
Ensure staff take up opportunities for leadership and development programmes – both in-house and regionally/nationally as appropriate.	We will monitor the number of staff taking part and the number completing the programmes. We know that as at March 2015 135 staff have applied for or completed such programmes	Programmes will be advertised on an ad hoc basis, as they occur.	Leadership Development Facilitator (supported by the Assistant HR Director – Training)	Leaders will have the skills and abilities to understand and enhance their team's performance and manage change effectively We will see an increase in the number of our staff working at Band 6 achieving promotional or career enhancing sideways moves within the Trust in line with our succession planning and talent management approaches.

What are we going to do?	How will we know if we have done it?	When will we do it?	Who is responsible?	What difference will it make?
Clearly articulate the values and behaviours that we expect our leaders to demonstrate, so that we have consistent values across the Trust by which staff can hold leaders to account.	Leaders will be able to articulate the values and behaviours they are required to demonstrate and will be committed to doing so.	As part of the leadership programmes we commission and/or design.	Executive Directors and Senior Leaders / All managers.	Key Findings from the annual Staff Survey will demonstrate that staff report positive support from their immediate line managers, and that they are more engaged and motivated. When asked, staff will say they are better informed about the strategic direction of the Trust and its services.
Introduce a new, bespoke Management Development programme for employees working at Band 7 who manage staff.	The majority of Band 7 managers will have attended the programme.	The programme will run during 2016/17	Assistant Director HR – Training is responsible for developing the programme.	Managers will have the skills and knowledge they need to effectively manage a team, including awareness of how to access relevant financial data and service level reporting tools.
Deliver a minimum of three briefing sessions a year on 'values based recruitment' to managers.	We will monitor take up by managers for formal training courses and ensure that as part of regular HR 'Managers Briefings' managers are signposted to VBR resources	At regular intervals throughout the year	Assistant HR Directors Progress will be monitored by the Workforce OD Committee	Staff recruited or promoted using VBR will have values that are consistent with Trust values and the NHS Constitution. They will deliver compassionate care and feel able to challenge care, attitudes and behaviours that are not of an appropriate standard.
Introduce new training activity which supports the acquisition of improvement methodology and service re-design skills, promotes creative thinking and equips staff with project management skills, tools and techniques.	A range of additional programmes and training activity will be in place.	Programmes will start during 2016/17	Assistant HR Director – Training and Deputy Director Nursing	Managers will be able to consider and model creative improvement methodology and service change ideas, supported by a range of service improvement/re-design tools and techniques. Where required, staff will be able to manage projects according to sound project management principles.
Provide a culture that supports management development by	Managers, including aspiring managers, will be aware of the	By March 2017 and then year	Assistant HR Director – Training	Manager, including aspiring managers, will have access to a range of

What are we going to do?	How will we know if we have done it?	When will we do it?	Who is responsible?	What difference will it make?
offering opportunities for 360º Appraisal; Coaching and Mentoring.	opportunities available and their managers will support them to access these opportunities as appropriate.	on year progression.	& leadership Development Facilitator	opportunities that will help them appraise their own management style in line with Trust values, and help them manage their own development.
Hold a minimum of four Senior Leadership forums each year.	Monitor attendance and feedback from senior leaders across the Trust.	Each year, year on year.	Executive Directors	Senior leaders will be involved in developing and informing our business so that there is a strong clinical input.
Aim 3: To work with local, regional and national partners to influence decisions and funding streams for training and education; and agree priorities for vocational training places to support our service into the future				
Participate in national and regional activity to simplify career progression, including supporting more part–time higher education courses as routes into nursing and other professions.	Career development pathways will be clear to staff and they will understand the routes available to attain the academic pre-requisites necessary for acceptance onto vocational training programmes.	Over the timeframe of the Strategy	Deputy Director of Nursing; Heads of Profession & Assistant HR Director – Training.	Non registered support staff will have increased opportunities to access pre-registration courses and higher apprenticeships.
Work with Health Education South West and Health Education West Midlands to develop improved opportunities for work experience, Apprenticeships and career development for staff working at Bands 1-4 in line with our commitment to the national Talent for Care Strategy and our local Action Plan.	There will be an increase in the number of work experience placements and Apprenticeships that we offer and staff will be clear about the career development opportunities available.	Over the timeframe of the Strategy	Assistant HR Director – Training, Deputy Director of Nursing, Social Inclusion Team & Service Leads.	There will be an increase in opportunities for work experience; to work for the Trust as part of an Apprenticeship, and at Bands 1-4. There will be clearer role development pathways for staff who do not have degree-level qualifications. Turnover in Bands 1 to 4 will decrease.
Continue to work with our local Health Education Boards, and with local educational establishments to	The supply of relevant skills will not be a limiting factor when we are looking to develop new	Over the timeframe of the Strategy	Deputy Director of Nursing & Assistant HR	We will be able to continue to provide our services and contemplate new, innovative ways of working and service

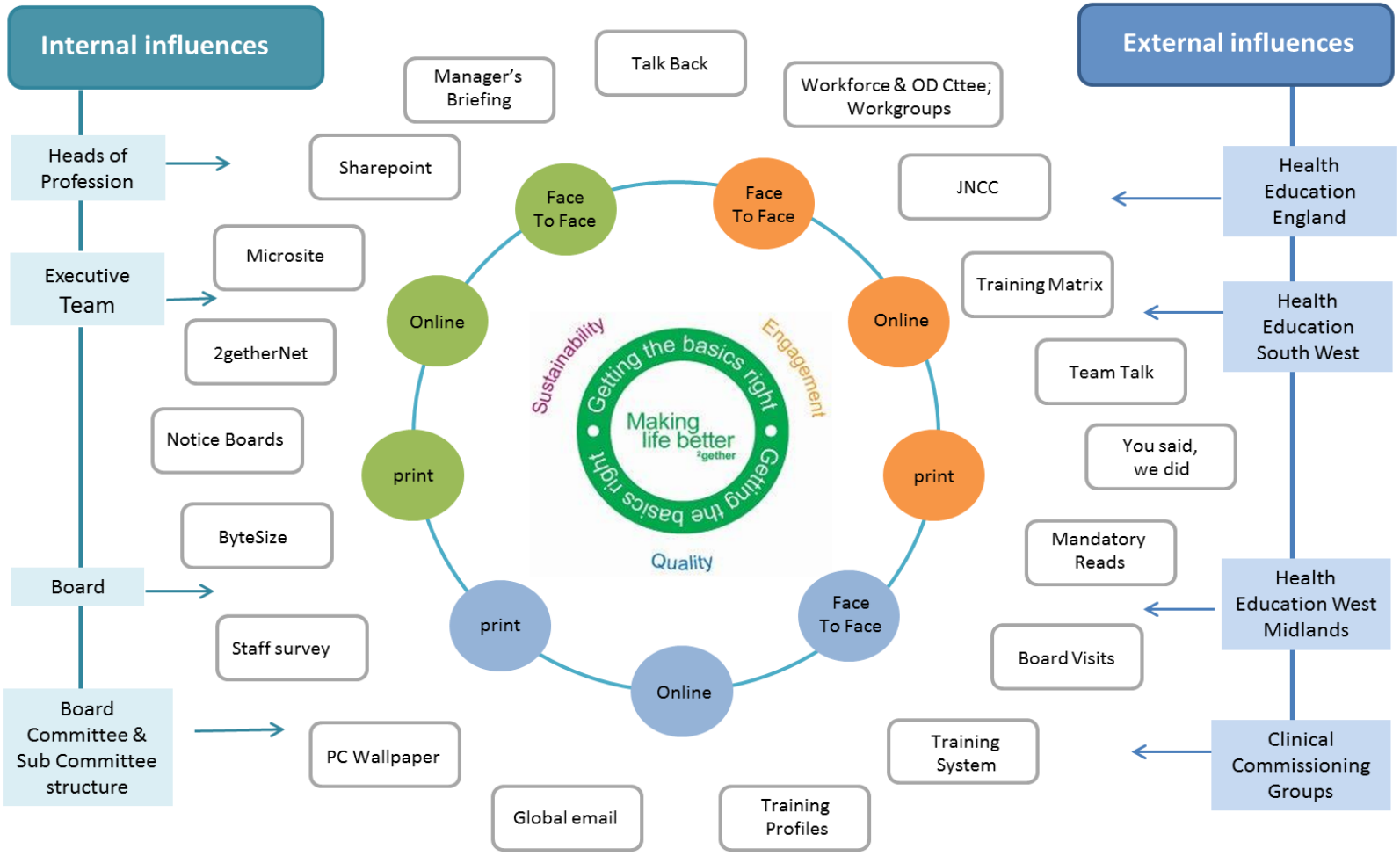
What are we going to do?	How will we know if we have done it?	When will we do it?	Who is responsible?	What difference will it make?
influence decisions about the planning and commissioning of education and training places to help secure the supply of the skills needed to deliver our services into the future.	services or roles to support the continuing provisions of safe, compassionate, high quality care to our service users.		Director – Training.	provision, confident in the knowledge that our future workforce recruits will have the skills and knowledge needed to support these developments.
To work with local, regional and national partners to help expand opportunities to share and co-create learning and educational activity and resources which reduces duplication and costs.	A range of activities and resources will exist which have been jointly developed and/or funded.	Over the timeframe of the Strategy	Assistant HR Director	We will have access to a greater range of learning activity and resources and staff will benefit from exposure to working alongside people from other services and organisations.
Aim 4: To develop improved systems for data capture and recording which will ensure the Trust has access to accurate and timely information about training needs, course completions, staff competence and the organisational gain from training activity.				
Achieve an increase in the numbers of staff having an appraisal year on year	Appraisal compliance is an HR Key Performance Indicator and is reported to the Delivery Committee via the monthly Dashboard.	Incremental month on month increases in appraisal compliance	All line managers	Staff will have objectives and training targets aligned to the current business objectives and training attendance will be more demonstrably linked to the achievement of organisational priorities.
Increase the numbers of staff who are up to date with their statutory and mandatory training year on year	Statutory and mandatory training is an HR Key Performance Indicator and is reported to the Delivery Committee via the monthly Dashboard.	Incrementally, month on month.	All line managers	Anyone who delivers our services will have access to the right training development and support to fulfil their roles.
Develop systems which better capture data about discretionary training which takes place across the Trust i.e. training over and above statutory/mandatory training so that we can quantify and analyse this activity.	We will have complete and accurate records of all training and development activity that takes place within the Trust.	Incrementally over the next two years.	Assistant HR Director – Training, Deputy Director of Nursing and other Service Leads.	We will have a clearer picture of the time and resources that are spent on training activity and a better overview of the skills and knowledge staff have across the Trust and the value this training adds.

What are we going to do?	How will we know if we have done it?	When will we do it?	Who is responsible?	What difference will it make?
Ensure that all in-house training activity is evaluated using at least two evaluation methods and produce regular reports of the feedback.	Evaluation data will be available and regularly captured and analysed for each course/programme.	From January 2016 and onwards as new courses are introduced.	Assistant HR Director – Training and Training Team members.	There will be more detailed information available about the benefit of training and the organisational gain from course attendance.
Aim 5:	**To move away from more traditional, didactic training and development delivery and encourage opportunities for self-determined learning and the increasing use of technology enhanced sharing of information and knowledge which in turn supports technological innovations in service delivery.**			
Review the current e-learning provision to ensure we are using the most effective packages/methods of training delivery.	We will have training delivered in a format, and with content, that staff find easy to use and which provides relevant and useful learning.	From March 2016 and onwards	Assistant HR Director – Training and subject leads/specialists	Staff will be able to access the courses they need to complete quickly and easily, and the course content will be relevant to the needs of their role, their service and takes account of their previous levels of knowledge.
Introduce an IT assessment tool for use during the recruitment process which will ensure all new employees can demonstrate an agreed, role-specific minimum IT skills set at appointment.	Our recruitment processes will include use of an IT skills assessment as deemed appropriate to the role requirements.	The assessment process will be introduced from March 2016 onwards	Assistant HR Director – Training.	Staff will have relevant IT skills and will be confident in the use of role-based technological requirements.
Review the current Learning Management System (LMS) to decide whether there are affordable alternatives which will provide more comprehensive reporting functionality, an easier user interface for staff and greater functionality for a wider range of training activity e.g. webinars.	There will be an improved LMS in place or improvements made to the current system.	Full functionality (of a new or improved system) by March 2017	Assistant HR Director – Training and Assistant HR Director – Workforce	Staff will have easy access to their training records and relevant e-learning and managers will have access to a range of accurate, real-time training reports.
Introduce a system(s) for assessing staff competence which negates the need for staff to undertake training they don't need.	Staff will be able to demonstrate competence by way of competence-based assessments and as a result the	From March 2016 and onwards	Assistant HR Director – Training, Training Team and Subject Specialists	Staff will be enthusiastic about their training. The time spent undertaking training will reduce without any corresponding

What are we going to do?	How will we know if we have done it?	When will we do it?	Who is responsible?	What difference will it make?
	time spent undertaking training will reduce.			reduction in outcomes or increase in incidents.
Increase the opportunity for staff to take part in technology-enhanced learning such as webinars by developing the technical skills of the Training Team.	Staff will have increased opportunities to take part in learning and knowledge-sharing without having to travel to a classroom/alternative venue.	From April 2017	Assistant HR Director – Training.	Staff will be offered a wider range of learning opportunities than at present. Staff training and travel time will be reduced.
Enhance the skills of the Training Team and Training Administration staff in e-learning authoring tools/software to enable the development / update of in-house, bespoke e-learning to address specific scenarios or situations.	Our e-learning courses will be engaging, easy to use and relevant to the setting/staff group/situation for which they are intended.	From April 2017	Assistant HR Director – Training.	Staff will be able to access engaging course content which is relevant to the needs of their role, service and/or situation and takes account of their previous levels of knowledge.

APPENDIX 2

Internal Communications Map



APPENDIX 3

[2]GETHER NHS FOUNDATION TRUST - OUR TRAINING STRATEGY ON A PAGE 2016 – 2021

What is a Training Strategy?

This Training Strategy supports our Organisational Development Strategy and describes our overall approach to training and development, it describes five key themes that we will seek to achieve over the next five years, and it outlines the ways in which development activities can help us deliver our Organisational Development Strategy, the Trusts broader operational plans, our developing sustainability and transformational plans and our strategic aims.

Why do we need a Training Strategy?

In order to transform to meet our Strategic priorities we need to ensure our Trust is flexible, adaptive and agile. To do this, we need a Training Strategy which will help us make sure that our staff have the right skills, values and approach to change, and that they are supported by transformational leadership, as we believe this is key in delivering safe, compassionate, evidence based and sustainable care.

What is the aim of our Training Strategy?

Our Training Strategy has five overarching aims:

1. To provide a comprehensive plan, which includes overarching themes and more detailed training activity which helps retain staff and which enables them to develop the values, skills and knowledge they need to deliver efficient, safe and compassionate care, responsive to current and future service needs.
2. To develop excellent leaders at all levels within the organisation who act in line with the Trust's values, who contribute to the achievement of the Trust's strategic objectives and who promote and encourage new ways of working and innovation supported by evidence based practice.
3. To work with local, regional and national partners to influence decisions and funding streams for training and education; and agree priorities for vocational training places to support our services into the future.
4. To develop improved systems for data capture and recording which will ensure the Trust has access to accurate and timely information about training needs, course completions, staff competence and the organisational gain from training activity.
5. To move away from more traditional, didactic training and development (such as classroom based) delivery and encourage opportunities for self-determined learning and the increasing use of technology enhanced sharing of information and knowledge which in turn supports technological innovations in service delivery.

Who is involved in delivering our Training Strategy?

Our Strategy applies to all of our staff, including those on substantive, short term or agency contracts; students and volunteers who work alongside our substantive employees; and the wide range of external agencies and partners, including Health Education South West, who are involved in the commissioning, development and delivery of the extensive range of training and educational activity that takes place within the Trust.

When will our Training Strategy be delivered?

The strategy covers 2016 – 2021. It will be delivered incrementally year on year through an Implementation Plan and associated action plans. Our Implementation Plan and Action Plans will be flexible to meet any new internal and external challenges and in response to feedback.

How will we know if we have delivered our Training Strategy?

Our training processes will enable us to identify the skills that our staff and leaders need to have, and will support them to gain those skills wherever there is a deficit, using a range of training delivery methods. Staff will be keen to pursue development opportunities and managers will support them to do so. Our information systems will be help us accurately report training activity and our evaluation procedures will show us the organisational gain from our training and education activity.

Agenda item 15 **Enclosure No Paper J**

Report to: 2gether Trust Board - 26th May 2016
Author: Jon Cash, Head of Profession for Psychological Services
Lauren Wardman-Davies, Head of Profession for Speech and Language Therapy and Dietetics
Karen Dawe, Head of Profession for Physiotherapy
Rebecca Shute, Head of Profession for Occupational Therapy
Jane Melton, Director for Engagement and Integration
Presented by: Jane Melton, Director for Engagement and Integration

SUBJECT: **Allied Health and Psychological Professions Practice Development Strategy 2016-2020**

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

EXECUTIVE SUMMARY

- The Allied Health and Psychological Professions Practice Development Strategy 2016-2020 has been developed through engagement with colleagues and consideration of context.

- A successful conference event with Allied Health and Psychological Professions (AHPP) colleagues and other stakeholders was held at the end of March 2016 to consider the proposed strategic vision. This engagement event was supported by the Chief Allied Health Professional at NHS England and an address was made by Shelagh Morris, Deputy AHP Lead at NHS England at the event.

- The strategic vision presented is aligned with the transformation and sustainability agenda and is structured to:

*Achieve an **outstanding** Allied Health and Psychological professions service delivered by skilled, energised, and compassionate people.*

RECOMMENDATIONS

The Board is asked to:

- Endorse the vision for Allied Health and Psychological professions practice development to support the Trust's overall strategic objectives and purpose.

Corporate Considerations	
Quality implications:	Allied Health and Psychological professions form an important element of the Trust's workforce to enable the delivery of safe, effective and best experience of care. The paradigm of care through AHPP supports the transformation agenda from 'care' to enablement' supporting prevention of illness, early intervention, self-care.
Resource implications:	The cost of implementing this strategy is minimal. A small investment in leadership structures in some disciplines will ensure quality is maintained through transformation and engagement is achieved. It is anticipated that most of the work associated with this strategy will be delivered through best use of existing human and financial resources. Additional resources may be required for measuring the success of new packages of care. There is a possibility that grant funding could be achieved for this assuming leadership capacity to write funding bids.
Equalities implications:	This strategy fundamentally exists to ensure that people from different backgrounds, circumstances and range of ability are considered and in particular people experiencing mental illness and people with learning disabilities are engaged in informing developments and become champions of the service. An easy read version of this strategy has been produced.
Risk implications:	Without a structured approach to this development there is a risk of a fragmented approach, inefficiencies, poor communication and ineffectiveness to deliver this key strategy and a major strategic objective of the Trust.

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			P
Excelling and improving	P	Inclusive open and honest	P
Responsive	P	Can do	P
Valuing and respectful	P	Efficient	P

Reviewed by:		
	Date	

Where in the Trust has this been discussed before?		
AHPP meetings	Date	During 2015 / 16
Executive Committee		9th May 2016
Development Committee		18th May 2016

What consultation has there been?		
Allied Health professionals and psychological professionals (via professional leads)	Date	During 2015
AHPP colleagues, Experts by Experience, colleagues from other disciplines at Conference event on 30th March 2016		30th March 2016

Explanation of acronyms used:	AHP – Allied Health Professionals AHPP – Allied Health and Psychological Professions

2gether's Allied Health and Psychological Professions Strategy

2016 - 2020

*Our vision is to provide **outstanding** Allied Health and Psychological professions service delivered by skilled, energised, and compassionate people.*

Allied Health and Psychological Professions
Developing an Outstanding Service

Contents

[2]gether's Allied Health and Psychological Professionals Strategy

Why do we need this Strategy?

The purpose of the strategy is to help us inspire a vision for practice development and demonstrate how Allied Health and Psychological Professionals (AHPP) will support the delivery of the trust's objectives, alongside other disciplines, between 2016 and 2020.
Our strategy sets out a co-ordinated and structured approach to how we achieve our vision:

To deliver '**outstanding'** Allied Health and Psychological Professions services through skilled, energised, and compassionate people.

Who are the Allied Health and Psychological Professionals?

The Allied Health Professions include 12 professions regulated by the Health and Care Professions Council (HCPC) which collectively make up the third largest workforce in the NHS. The Trust employs a number of these including Arts Therapists, Dieticians, Occupational Therapists, Physiotherapists and Speech and Language Therapists.

Additionally, the Trust employs a number of other professionals who are not Allied Health Professionals, Clinical and Counselling Psychologists, Child Psychotherapists, other psychological therapists and Health and Exercise Practitioners. We consider these professional to be a core part of the AHPP service.

How will the Allied Health Professionals Strategy change us?

Our goal is to deliver best quality care. We will continue to deliver services with our current stakeholders in a multidisciplinary manor *and* work with different partners in a more flexible and creative way. We will continue to develop the AHPP workforce so that we are better skilled and equipped to work in a changing environment.

When will our Allied Health Professionals Strategy be delivered?

Our strategy will be implemented over 2016 – 2020. It will be delivered, year on year through a range of action plans developed in collaboration with our stakeholders.

How will we know if we are making a difference?

Our actions plans will describe what success looks like and how this can be measured. We will monitor our progress routinely and share this. Delivery of our vision will ensure that care is safe, people live longer, physical health and mental health are equality considered, people will recover from illness and enabled to live well with disability and ultimately people will experience better care.

Above all, a successfully delivered strategy will mean that we continue to deliver quality services that our commissioners want to purchase, service users and carers want to use and staff would recommend.

1 National strategic context

***Prevention, access, integration, quality, equality** and a **positive experience of care** **are principles underpinning the national vision for health care**.*[1]

1.1 Recent years have seen significant efforts to improve health and care services for the people who use them. **Allied Health and Psychological professionals** are committed to the national quality agenda not only because of our responsibilities as staff and service providers but also because we and our families are actual or potential service-users.

1.2 The NHS has much to be proud of. It gets more right than it gets wrong and has strong public support. Nevertheless, there is much more to be done to ensure safe, effective, caring, responsive and well-led services[2],[3]. There is a need to ensure that people of all ages with mental health problems and people with learning disabilities are not marginalised, stigmatised or experiencing an NHS that treats minds and bodies separately.

1.3 The view is simple; services should be organised and delivered on the principle of there being no difference between 'you and me'. Dignity and compassion means people being treated in the ways we would want to be treated ourselves.

1.4 There are significant challenges ahead with a £30bn **projected financial gap** in NHS finances across the country by 2020/21[1]. **Significant transformation** is required to NHS services in order to prevent illness, treat illness early, enable better self-help and maintain the offer of acute and critical care.

1.5 Better use of new technologies and treatments and new ways to deliver care, dissolving traditional boundaries in how care is delivered and improving the co-ordination of care around patients will, in part, be a solution to the financial and quality challenges of the NHS as a whole.

1.6 **Allied Health and Psychological Professionals** offer a key resource to support transformation of services to achieve sustainability. By developing practice to be integrated, creative, flexible, and innovative, services will be able to respond to people, families and communities in effective and efficient ways.

Allied Health and Psychological Professions have training and skills to lead on preventative and health promotion interventions where citizens learn good habits for life. These reflect 5 Ways to Well-being[4], for example:

- Physical activity
- Dietary habits

[1] Five Year Forward View for Mental Health, February 2016 https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[2] Francis 2013 http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/report
[3] Winterbourne View Report 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/399755/Winterbourne_View.pdf
[4] Five Ways to Wellbeing http://www.nhs.uk/Conditions/stress-anxiety-depression/Pages/improve-mental-wellbeing.aspx

- Mindfulness
- Motivational interviewing
- Participation in occupation for health
- Education

Through interventions led by **Allied Health and Psychological Professions**, patients can gain greater control of their care, support self-management and self-care *supporting the shift in NHS philosophy* ***from 'caring to 'enabling'.***

1.7 A culture of engagement and partnership is essential to the empowering approach fostered through the interventions of **Allied Health and Psychological Professions**. Putting patients and the public at the heart of NHS activity is essential with involvement being the key to success. When the public were asked their priorities they included the following:

- A 7 day NHS – right care, right time, right quality
- An integrated approach to mental and physical health care
- Promoting good mental health and preventing poor mental health
- 'Hard-wiring' mental health across the NHS

1.8 **Allied Health and Psychological Professionals** are particularly well placed to lead on the delivery of rehabilitation[5] within multi-disciplinary teams. The AHPP disciplines' focus on outcomes of enablement, concerns to address people's need, orientation of hope through an active and motivational process, with an integration of core and specialist skills and ability to respond to change in need of the individual support the refocus to an enabling paradigm.

1.9 Use of and involvement in research is an important for **Allied Health and Psychological Professionals** practice. Supporting research activity by students, newly qualified, expert practitioners will continually drive quality improvement and influence and support policy development

1.10 Recently, the Government's mandate to NHS England 2016-2017 sets out the national context for NHS Providers. Key messages to all concerned with health and social, including **Allied Health and Psychological Professionals,** are described below.

- **Person Centred services and practice**
  Everyone deserves care that is safe, compassionate and effective at all times and regardless of their condition. There is a need to lead a step change in preventing ill health and supporting people to live healthier lives.

- **Effective and efficient services**
  Reducing inequalities in health outcomes and in people's experience of the health system is essential. We must ensure maximum value for patients and service users from every pound spent. We must maintain

[5] http://www.wessexscn.nhs.uk/about-us/latest-news/rehabilitation-reablement-and-recovery-quality-guidance-document-now-published/

and where possible improve access to timely, quality services for all patients.

- **Creativity, innovation, and evaluation**
  There is a need to support research, innovation and growth. Linked to this there is a need to make better use of digital services and technology to transform patient's access to and use of health and care, including online access to their personal health records.

- **Integrate multi-specialty services around the person**
  Services delivered out of hospital and greater integration with social care will provide more joined-up care to meet people's physical health, mental health and social care needs. For example, we need to reduce the health gap between people with mental health problems, learning disabilities and autism and the population as a whole, to support people to live full, healthy and independent lives. This will require great strides in improving care and outcomes through prevention, early intervention and improved access to integrated services to ensure physical health needs are addressed.

  The quality of care and support for people with dementia is an area for particular focus and takes on additional importance as our older population is increasing.

- **Meaningfully engage with the people that use services**
  People should be empowered to shape and manage their own healthcare and make meaningful choices.

1.11 **Allied Health and Psychological Professionals** are central to delivering the challenges ahead through a transformational approach. Reports by the Centre for Workforce Intelligence and others[6] have highlighted that AHPs have the enthusiasm, expertise and opportunity to make a significant difference to health and wellbeing. **Allied Health and Psychological Professions** stand ready, alongside other disciplines, to facilitate outstanding services by transforming to new ways of working through effective leadership.

[6] http://www.ahpf.org.uk/files/AHP%20Public%20Health%20Strategy.pdf

2. Local strategic context

Working [2]gether with a strong set of values

About us

[2]gether NHS Foundation Trust provides mental and social health care services to a combined population of 805,000 across Gloucestershire and Herefordshire's 1,900 square miles. We employ over 2,300 members of staff (including staff bank) and deliver services to 19,000 people at any one time.

Our vision

To be the:
Provider and employer of choice delivering sustainable high quality, cost effective, inclusive services

Our values

S	Seeing from a service user perspective
E	Excelling and improving
R	Responsive
V	Valuing and respectful
I	Inclusive, open and honest
C	Can do
E	Efficient, effective, economic and equitable

What we seek to achieve

Our purpose is to make life better through:

- Continuously improving the **Quality** of our service to service users, their families and carers.
- Ensuring the **Sustainability** of services to people in our communities
- **Engaging with people** to best support the delivery of an integrated approach to care.

2.1 In 2015 the Care Quality Commission carried out a comprehensive inspection and rated [2]gether's services as **'good'** overall in our service to people in Gloucestershire and Herefordshire. Whilst we perform well as an NHS Foundation Trust we continue to be committed to ensuring that practice develops further so that the communities with whom we work can access **'outstanding'** services across every part of our service.

2.2 The Trust has invested in a Board and Professional leadership structure which gives voice to Allied Health Professionals and Psychological Services at Board and service level. As a result, **Allied Health and Psychological Professionals** are in a position to inform decisions about practice at every level from 'Board to Ward'.

2.3 **Allied Health and Psychological Professionals** work collectively to ensure there are robust structures to support continuous development of practice including the implementation of evidence for practice. Using tools such as the FlightGate individual practice development model to identify development needs and ensure tailored support will be a key part of the action plan to deliver this strategy.

2.4 [2]gether NHS Foundation Trust is a key and active organisation in the development of the Sustainability and Transformation Plans for the areas in which we operate, Gloucestershire and Herefordshire. We are also working towards the implementation of key changes as set out in the Five Year Forward View for Mental Health and believe that **Allied Health and Psychological Professionals** offer leadership to the transformation required.

2.5 Other **Trust Strategies which connect with this one include:**

- Strategic Plan 2014/19
- Organisational Development Strategy 2015/18
- Quality Strategy 2012/15
- Partnership Strategy 2015/18
- Membership Strategy 2014
- Nursing Strategy 2015
- Commercial Strategy 2015
- Finance Strategy 2015-2020
- Marketing Strategy 2015 /2019
- Engagement and Communication Strategy (2016-2020)
- Research and Development Strategy (2016-2020)
- Service Experience Strategy 2013 / 18
- Volunteer [2]gether Strategy 2013 / 18
- Workforce Strategy 2016-2020
- Training and Development Strategy 2016-2020

3 Our AHPP Vision

[2]gether's Allied Health and Psychological Professions' vision is that by 2020 we will achieve:

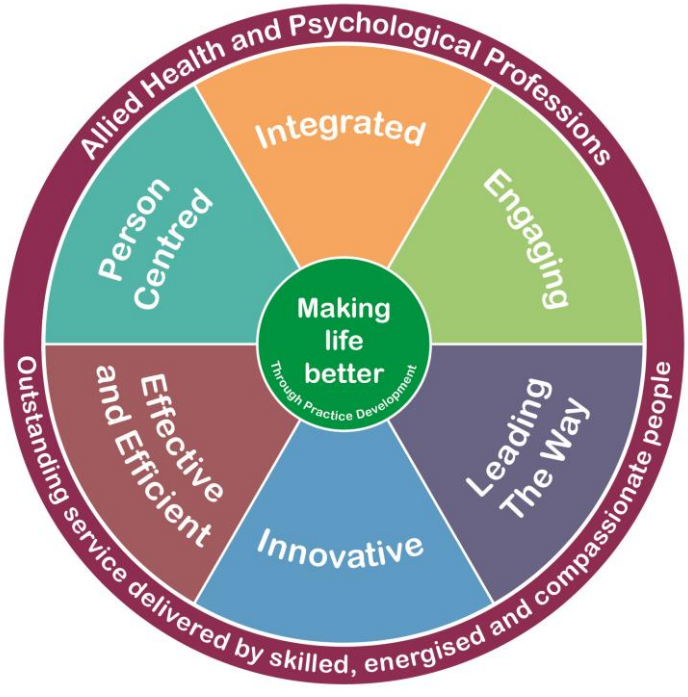
Outstanding Allied Health and Psychological Professions service delivered by skilled, energised, and compassionate people.

[2]gether NHS Foundation Trust NHS
AHPP
Allied Health and Psychological Professions
Developing an Outstanding Service

4 What will success look like?

The successful implementation of this strategy will significantly contribute to the deliver the Trusts objectives of **quality, engagement** and **sustainability**. It will also meet the transformation agenda of the Five Year Forward View for Mental Health[7].

4.1 To achieve our vision we will focus on 6 key development priorities.



[7] Five Year Forward View for Mental Health, February 2016 https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

The commitment is that the **Allied Health and Psychological Professions** will lead the way to successfully achieve:

1	Engagement	Enhance **meaningful engagement** with people that require services, those that know and care about them, AHPPs who deliver services and wider communities for **best experience of care**.
2	Person Centeredness	Lead practice across disciplines which respects the **individuality and involvement** of the people that we serve to maximise recovery potential and an empowered approach.
3	Leading the way	Further develop a sustainable workforce that is fit for the future to deliver packages of care enabling **prevention, promotion and self-management.**
4	Innovation	Facilitate an 'agile', 'can-do' and engaged culture to lead quality **improvement and innovation** through energy, creativity and evaluation.
5	Effectiveness and efficiency	Influence the transformation of NHS services so that **prevention of illness, health promotion and self-management** reduce the demand on NHS services
6	Integration	Inform and influence the **integration** of multi-specialty services around the person to ensure safe, quality and efficient physical and mental health care is provided.

4.2 Key Performance Indicators

Indicator and goal	Current performance	Target	Review date
1. More people will report feeling involved in planning their care (National Patient Survey) [8].	7.2 /10	7.6/10	July 2017
2. More people will experience being offered advice with finding support for their physical health needs (National Patient Survey).	5.4/10	5.8/10	July 2017
3. More people will experience someone from NHS mental health services supporting them to take part in an activity locally?	4.1 /10	4.5/10	July 2017
4. More people will experience being offered help or advice with finding for keeping work from a mental health practitioner?	5.3 /10	5.7 /10	July 2017
5. Information about each of [2]gether's AHPP services will be available in an accessible	0	4	April 2017

[8] KPI's 1-4 are CQC survey scores that reflect the contribution of all disciplines not only AHPPs

format.			
6. More people will report being willing to recommend 2gether's services (Friends and Family Test results)	91% in 2015-16	92%	April 2018
7. Service users of 2gether's services will have greater opportunities to co-develop and co-deliver AHPP research and development activity	0	2	April 2018
8. More 2gether's AHPPs will become Local Principle Investigators for local research studies and have involvement in health science networks.	3 AHPP's are Principle Investigators for NIHR studies this year	Aim to double this to 6 PIs	April 2018
9. Audits of supervision will demonstrate significant assurance of a high level of compliance across 2gether's AHPP disciplines	Significant assurance for all but OT	Significant assurance for all	April 2017
10. 2gether's AHPP's will report continued motivation at work (Staff survey)	**4.14/5** (AHP) **3.99 /5** (Clinical Psychologists	**4.2 /5***	April 2018
11. More volunteers will contribute to support AHPPs to deliver their recommendations.		4 new AHPP volunteer roles	April 2018
12. Peer workers will be established to support AHPP interventions.	1 peer work linked with OT in Recovery College	TBC	April 2018
13. AHPP's will demonstrate inclusive practice with carers and young carers (Triangle of Care evaluation).	Lead OT involved	All AHPP and senior practitioners assurance through supervision	April 2017
14. AHPP's will be at the forefront of tackling mental health stigma (Time to Change Mental Health practitioners).	Clinical psychologists part of TTC team	All AHPP groups undertake TTC workshop – 50% of AHPP workforce	September 2017

* Staff survey in 2015 had only 20 AHP respondents in sample

5 Year 1 Plan for implementing our AHPP strategy

An '**outstanding**' Allied Health and Psychological professions service delivered by skilled, energised, and compassionate people.

AHPP
Outstanding, Innovative, Engaging

5.1 Our Trust values have informed the key development priorities for taking 2gether's AHPP practice development forward. We will build a framework around which our practice development plan can be driven forward to improve quality and inspire confidence in our services.

5.2 Our annual action plan will set out the high level initiatives behind the vision and will be produced each year. Progress against plans will be

regularly reviewed and progress reported. A strong emphasis will be placed on our collaboration and engagement work with the wider community in a phased approach to meet our vision. Initiatives will be measured against the **key performance indicators** set in this strategy as we embark on transformational change.

Transformational change and better integration of services will largely depend:

"..not on new structures but on the people who work in health and social care, who will need to adapt to new roles and services and learn new skills" [9].

Priority	Success criteria	**Year 1 Goal**	By Who	By When
1. Engagement	Enhanced meaningful engagement with people that require services, those that know and care about them, AHPPs who deliver them and wider communities.	Stakeholder engagement sessions with: • Service Users • Cares • AHPP practitioners	AHPP Leads	Quarterly reports / Heat-map
2. Person Centeredness	Practice across disciplines which respects the **individuality and involvement** of the people that we serve to maximise recovery potential and an empowered approach.	Engage AHPPs, other disciplines and Experts by Experience in development work to routinely involve people in developing their plans of care and review of care.	AHPP Leads and senior colleagues	National (annual) and local (quarterly) survey results
3. Leading the way	Further develop a sustainable workforce that is fit for the future to deliver packages of care enabling prevention, promotion and self-management.	In light of the transformation agenda, review and report the AHPP workforce requirements for a transformed and sustainable NHS. This needs to include a model for NHS service provision that considers new ways of working, support roles (including volunteers, peer workers) and interagency working – new models of care to prioritise prevention of ill-health, promotion of health and self-management of care. Work with the 2gether 'bank' managers to enhance opportunity for temporary sustainable cover.	AHPP leads	Dec 16
4. Innovation	Facilitate an 'agile', 'can-do' and engaged culture to lead quality improvement and innovation through energy, creativity and	Co-design and report upon new ways of delivering enablement for preventing illness, promoting health, encouraging early intervention and facilitating self-management for mental health and learning disability.	AHPP leads with workforce and other partners	End of year

[9] Council of Deans for Health, March 2015

	evaluation.	Specific areas to include: • CYPS • Personality Disorders • Perinatal healthcare • dementia care • LD • Reducing obesity • Carers and Young Carers • Tackling stigma • Swifter supported discharge Consideration to evidence and new technology Factor in evaluation		
5. Effectiveness and efficiency	Influence the transformation of NHS services so that prevention of illness, health promotion and self-management reduce the demand on NHS services	Build stronger connections to inform the potential for enhanced pathways of care: • Wider Communities and partner (inc NHS / public health) organisations • Universities and AHSN	AHPP leads with workforce and other partners	End of Year
6. Integration	Inform and influence the **integration** of multi-specialty services around the person to ensure safe, quality and efficient physical and mental health care is provided.	Take part in STP developments	AHPP leads with workforce and other partners	End of Year

Allied Health and Psychological Professionals in ²gether NHS Trust 2020.

Allied Health and Psychological Professionals are known as **AHPPs**.

In ²gether **AHPPs** are:

- Arts Therapists
- Dietitians
- Occupational therapists
- Physiotherapists
- Speech and language therapists
- Psychologists
- Psychological therapists

We have a vision for the **AHPP** service:

- ²gether **AHPP** services will be brilliant.
- ²gether **AHPPs** will be working out new ways to work to be great at their job.
- ²gether **AHPPs** will help people to be healthy, happy and feel valued.
- ²gether **AHPPs** helping you to live well

AHPP
Allied Health and Psychological Professions
Developing an Outstanding Service

²gether AHPPs will achieve the vision in 6 main ways:

1		**Integrated** They will work together with any other team helping the person
2		**Engaging** They will involve the person in their care and people who care for them
3		**Leading the way** They will lead the way in giving the best care to the person
4		**Innovative** They will think of new ideas and better ways of helping the person
5	 	**Effective and efficient** They will work in ways that will get the best results. They will not waste time, energy or money.
6		**Person Centred** They will work in the best ways for the person

Agenda item 16 **Enclosure No** **Paper K**

Report to:	2gether NHS Foundation Trust Board 26th May 2016
Author:	Stephen Andrews, Deputy Director of Finance
Presented by:	Andrew Lee, Director of Finance & Commerce
SUBJECT:	**Finance report for period ending 30th April 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 1 position is a surplus of £22k compared to the planned deficit of £52k.
- The month 1 forecast outturn is a £4k surplus in line with the Trust's control total.
- The Trust has a Continuity of Service Risk Rating of 3.
- The 2016/17 contracts with Gloucestershire CCG, Herefordshire CCG, NHS England and Worcestershire Joint Commissioning Unit have been signed.
- Budgets were approved by the Board in March for 2016/17.
- The Trust submitted its one year Operational Plan to Monitor by the 11th April 2016.
- An update on the 2015/16 final accounts position is included.

RECOMMENDATIONS

It is recommended that the Board:

- note the month 1 position
- note the reasons for variances from budget

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?			
Quality and Safety		Skilled workforce	
Getting the basics right		Using better information	
Social inclusion		Growth and financial efficiency	
Seeking involvement		Legislation and governance	

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

Reviewed by: Andrew Lee, Director of Finance and Commerce		
	Date	20th May 2016

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	Financial Sustainability Risk Rating	3	FS Risk rating of at least 3
Income	FOT vs FT Plan	100.0%	
Operating Expenditure	FOT vs FT Plan	100.0%	
Cash	Number of creditor days	46	Balance of £18.6m (including investments) which equates to 46 creditor days. £7.0m of this cash is committed to fund the Trust's capital programme to improve facilities for patients over the next 4 years.
PSPP	%age of invoices paid within 30 days	98.0%	88% paid in 10 days
Capital Income	Monthly vs FT Plan	99.6%	
Capital Expenditure	Monthly vs FT Plan	44.3%	£286k expenditure.

The parameters for the traffic light dashboard are detailed below:

INDICATOR	RED 	AMBER 	GREEN 
Monitor FOT Financial Risk Rating	<2.5	2.5 - 3	>3
INCOME FOT vs FT Plan	<99%	99% - 100%	>100%
Expenditure FOT vs FT Plan	>100%	99% - 100%	<99%
CASH	<=50 days	51-60	>60 days
Public Sector Payment Policy - YTD	<80%	80% - 95%	>95%
Capital Income - Monthly vs FT Plan	<99%	99% - 100%	>100%
Capital Expenditure - Monthly vs FT Plan	>115% or <85%	110% - 115% or 85% to 89%	90% to 109%

- The financial position of the Trust at month 1 is a surplus of £22k which is £74k better than the plan (see appendicies 1 & 8).
- Income is £4k over recovered against budget and operational expenditure is £96k under spent, and non-operational items are £26k 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	(4,968)	(413)	(422)	(9)	(4,968)	0
Stroud & S Cots Locality	(4,052)	(338)	(364)	(26)	(4,052)	0
Gloucester & Forest Locality	(4,433)	(369)	(364)	5	(4,433)	0
Social Care Management						
Entry Level	(5,221)	(435)	(433)	2	(5,221)	0
Countywide	(32,600)	(2,717)	(2,736)	(19)	(32,600)	0
Children & Young People's Service	(4,960)	(413)	(358)	55	(4,960)	0
Herefordshire Services	(12,198)	(1,016)	(1,114)	(98)	(12,198)	0
Medical	(14,936)	(1,245)	(1,235)	9	(14,936)	0
Board	(1,375)	(115)	(122)	(8)	(1,375)	0
Internal Customer Services	(1,635)	(136)	(127)	9	(1,635)	0
Finance & Commerce	(6,402)	(530)	(532)	(2)	(6,402)	0
HR & Organisational Development	(3,128)	(261)	(271)	(10)	(3,128)	0
Quality & Performance	(2,572)	(214)	(204)	11	(2,572)	0
Engagement & Integration	(1,382)	(115)	(102)	13	(1,382)	0
Operations Directorate	(1,155)	(96)	(99)	(3)	(1,155)	0
Other (incl. provisional / savings / dep'n / PDC)	(6,643)	(577)	(434)	143	(6,643)	0
Income	107,664	8,939	8,940	2	107,664	0
TOTAL	**4**	**(52)**	**22**	**74**	**4**	**0**

The key points are summarised below;

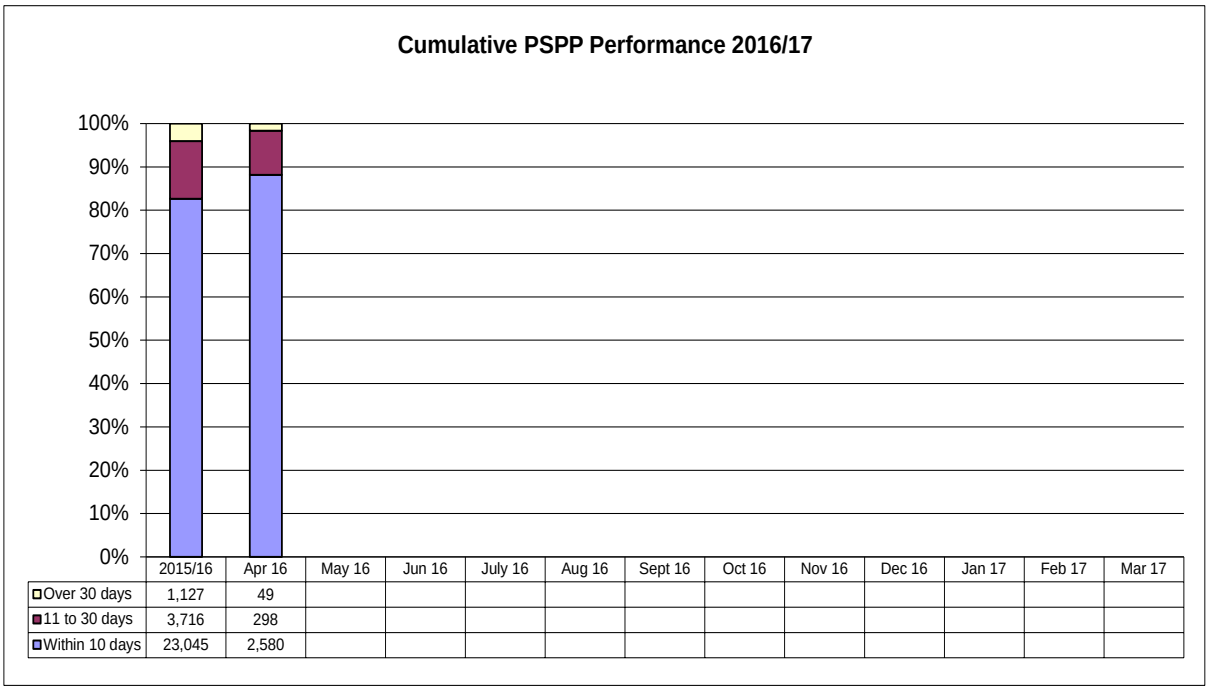
In month

- Herefordshire was over spent due to agency costs to cover specialling costs on Mortimer ward and vacancies in other wards. A limited amount of income will be received to offset this over spend.

Forecast

- All budgets are forecasting they will meet their budget at year end as no significant risks have arisen in month 1.

The cumulative Public Sector Payment Policy (PSPP) performance for month 1 is 88% of invoices paid in 10 days and 98% paid in 30 days. The cumulative performance to date is depicted in the chart below and compared with last year's position:



	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											
11 to 30 days	3,716	298											
Within 10 days	23,045	2,580											

Agenda item 17 **Enclosure Paper L**

Report to: [2]gether NHS Foundation Trust Board – 26 May 2016
Author: John McIlveen, Trust Secretary
Presented by: John McIlveen, Trust Secretary

SUBJECT: PROVIDER LICENCE DECLARATIONS

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 Board is required to make a number of declarations to Monitor each year regarding compliance with the terms of the Trust's provider licence.

1. Corporate Governance Statement

It is a requirement of the governance condition of the Trust's licence that the Trust submits a Corporate Governance Statement to Monitor within three months of the end of each financial year. The submission date for this declaration is 30 June 2016.

The Corporate Governance Statement requires the Trust Board to confirm:

- Compliance with the governance condition **at the date of the statement**; and
- **Forward compliance** with the governance condition for the current financial year, specifying (i) and risks to compliance and (ii) any actions proposed to manage such risks

The governance condition of the licence concerns the Trust's internal systems and processes. Hence, the references to risks within the corporate governance statement relate to risks to those systems and processes, rather than wider risks to the Trust or the achievement of the Trust's objectives.

In making its Corporate Governance Statement declaration to Monitor, the Board can rely on a number of key documents which it has received and reviewed during the year, and in particular the Trust's 5 Year Strategic Plan, quarterly reports submitted to Monitor, the Operational Plan submitted to Monitor, the Care Quality Commission inspection report, and the Well-Led Framework for Governance external review report.

A summary of the evidence supporting a declaration of compliance is available as Appendix 1 of this report. The Board is asked to confirm **compliance at the date of the statement** and **forward compliance**, for each section of the Corporate Governance Statement.

2. Academic Health Science Centres and training of Governors

Monitor also requires the Board to make declarations regarding:

a) governance systems and processes in place where the Trust is a member of, or considering taking part in a major joint venture or Academic Health Science Centre (AHSC). The Trust is not a member of an AHSC, and is not currently considering becoming part of a major joint venture. The Board is therefore asked to approve a declaration of 'Not Applicable'.

b) the provision of necessary training to Governors, pursuant to Section 151(5) of the Health and Social Care Act 2012. The joint Board/Governor engagement work undertaken during the year has produced a number of outputs intended to support Governors to undertake their role. The Board is therefore recommended to make a declaration of 'Confirmed' in respect of the provision of Governor training while recognising that these initiatives have only just been introduced and therefore are as yet untested.

The submission date for these declarations is 30 June 2016.

3. Compliance with Licence conditions

Foundation Trusts are also required to make an annual declaration to Monitor regarding their systems for compliance with provider licence conditions (General Condition G6). Appendix 2 provides evidence which the Board may rely on to make this declaration which is in two parts, with part 1 referring to the financial year just ended, and part 2 referring to continuing to meet the criteria for holding a licence. The Board is invited to make a declaration of 'Confirmed' in respect of both parts of this declaration.

The submission date for this declaration regarding is 31 May 2016. The Trust must also publish this declaration within one month of its submission to Monitor.

All declarations must be made *having regard to* the views of Governors. The Board is therefore asked to note that as agreed by the Council of Governors last year Governors have received a separate summary report intended to provide assurance regarding the process for making these declarations. The appendices to this Board report have been provided to Governors as background information alongside the summary report. Governors have been invited to submit comments to the Trust Secretary, who has incorporated feedback received from Governors into the Board's report in order to inform the Board's decision.

A declaration regarding the availability of resources is included in the 2016/17 Final Financial Template which will be submitted to Monitor in line with requirements for final operational plan submissions.

RECOMMENDATIONS

It is recommended that the Board:

a) Have regard to feedback received from Governors in respect of these declarations

b) Agree to make a declaration confirming compliance with each of the statements listed in the Corporate Governance Statement, as attached at Appendix 1 and

submit this to Monitor by the due date of 30 June

c) Agree to make a declaration of 'Not Applicable' in respect of the Academic Health & Science Centre declaration and submit this to Monitor by the due date of 30 June.

d) Agree to make a declaration of 'Confirmed' in relation to the Governor training declaration and submit this to Monitor by the due date of 30 June.

e) Agree to make a declaration of 'Confirmed' by the due date of 31 May in respect of systems for compliance with licence conditions for the financial year just ended

f) Agree to make a declaration confirming that the Trust continues to meet the criteria for holding a licence, and submit this to Monitor by the due date of 31 May.

g) Agree to publish on the Trust website the declaration in respect of systems for compliance with licence conditions within one month of its submission Monitor

Corporate Considerations	
Quality implications	The Monitor Quality Governance Framework has now been incorporated into the Well-Led Governance Review Framework. An external review against that framework was undertaken in 2015.
Resource implications:	None identified
Equalities implications:	None identified
Risk implications:	Should risks to compliance with the governance condition of the Trust's licence be identified, Monitor may require other actions or assurance, or may choose to maintain a watching brief.

WHICH TRUST STRATEGIC OBJECTIVE(S) DOES THIS PAPER PROGRESS OR CHALLENGE?	
Continuously Improving Quality	P
Increasing Engagement	
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:		
Executive Committee	Date	*25 April 2016*

Where in the Trust has this been discussed before?		
Executive Committee	Date	*25 April 2016*

What consultation has there been?		

Explanation of acronyms used:	CQC – Care Quality Commission AHSC – Academic Health Science Centre CCG – Clinical Commissioning Group

1. INTRODUCTION

1.1 It is a condition of the Trust's licence, and a requirement within Monitor's Risk Assessment Framework, that the Trust makes certain declarations to Monitor at the end of each financial year, regarding its corporate governance systems and processes.

1.2 Each declaration requires the Trust to indicate either 'Confirmed' or 'Not Confirmed' to a number of statements. The Trust has the option to declare 'Not Applicable' to one statement.

1.3 Declarations must be made by the Board, having regard to the views of Governors.

2. CORPORATE GOVERNANCE STATEMENT

2.1 The Corporate Governance declaration refers to the provisions within the governance condition of the Trust's provider licence. The declaration requires Trust Boards to confirm, within three months of the end of the financial year

- Compliance with the governance condition at the date of the statement; and
- Forward compliance with the governance condition for the current financial year, specifying
  - (i) and risks to compliance and
  - (ii) any actions proposed to manage such risks

2.2 The governance condition of the licence concerns the Trust's internal systems and processes. Hence, the reference to risks within the Corporate Governance declaration relate to risks to those systems and processes, rather than wider risks to the achievement of the Trust's objectives.

2.3 Where a statement in the declaration indicates a risk to compliance with the governance condition of the Trust's provider licence, Monitor will consider whether any actions or other assurances are required at the time of the declaration, or whether it is more appropriate to maintain a watching brief.

2.4 The Board has during the course of the year received a number of documents which provide evidence of compliance. These include, but are not limited to, quarterly reports to Monitor, the Trust's 5 year Strategic Plan, the Trust's Operational Plan, the Well-Led Governance review self-assessment, the CQC inspection report, Patient Safety reports, Risk Register reviews, and summary assurance reports from Board Committees. Appendix 1 provides a summary of the available evidence to support the Board in making its declaration.

2.5 Accordingly, the Board is recommended to make a declaration of 'Confirmed' in respect of each element of the Corporate Governance statement, as shown at Appendix 2, and to submit the declaration to Monitor by 30 June

3. ACADEMIC HEALTH SCIENCE CENTRE DECLARATION

3.1 The Board is also required to make a declaration regarding the governance systems and processes in place where the Trust is a member of, or considering taking part in a major joint venture or Academic Health Science Centre (AHSC).

3.2 The Trust is not a member of an AHSC, and is not currently considering becoming part of a major joint venture. The Board is therefore asked to make the declaration of 'Not Applicable' in respect of AHSC/joint venture governance systems, as shown at Appendix 4 by the due date of 30 June.

4. GOVERNOR TRAINING DECLARATION

4.1 Additionally, the Board is required to make a declaration that it has provided Governors with the necessary training, pursuant to Section 151 (5) of the Health and Social Care Act 2012, to enable Governors to fulfil their roles. The Act does not specify the nature or content of training to be provided.

4.2 The Trust is a member of the Foundation Trust Governors' Association, and through this membership Governors are able to attend FTGA events and development days, and events organised by other bodies. Governors are also provided with an induction on joining the Trust, and a range of material is made available to Governors through a website portal. Council of Governors' meetings provide learning opportunities for Governors to gain insights into various aspects of the Trust's services, and a programme of visits to key sites has also been put in place for Governors. A joint Board/Governor development programme was initiated during 2015/16 which resulted in a number of agreed initiatives intended to support Governors in undertaking their role.

4.3 While the effectiveness of these new initiatives has not yet been tested, the Board is therefore asked to make a declaration of 'Confirmed' in respect of Governor training as shown at Appendix 4 by the due date of 30 June.

5. GENERAL CONDITION G6 – SYSTEMS FOR COMPLIANCE WITH LICENCE CONDITIONS

5.1 General Condition 6 requires that the Trust against the risk of failure to comply with the conditions of its licence, any requirements imposed by the NHS Acts, and the requirement to have regard to the NHS Constitution in providing health care services for the purpose of the NHS.

5.2 The licence condition states that the steps the Trust must take should include:

'*the establishment and implementation of processes and systems to identify risks and guard against their occurrence'*, and

'regular review of whether those processes and systems have been implemented and of their effectiveness'.

5.3 The declaration asks the Board having reviewed the evidence, to confirm (or otherwise) by the due date of 31 May that:

PART 1 '*Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that,* ***in the Financial Year most recently ended****, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.'*

AND

PART 2 *'The Board declares that the Licensee continues to meet the criteria for holding a licence'*

5.4 An overview of the provider licence conditions is given at Appendix 2. Much of the evidence given in support of the Corporate Governance Statement (listed at Appendix 1) may also be relied upon by the Board in order to make the declaration regarding the processes and systems in place to comply with the Trust's licence conditions and general obligations. Significantly for this declaration, during the year the Board has received a positive Well-Led Framework for Governance external review report, and a CQC inspection which produced an overall rating of 'Good.

5.5 The Board is therefore recommended to respond 'Confirmed' in respect of both parts of the declaration above.

6. HAVING REGARD TO THE VIEWS OF GOVERNORS

6.1 The Board is required to make the above declarations "having regard to the views of Governors". As agreed by the Council of Governors last year, a separate report has been made available to Governors providing assurance regarding the process for the Board to make these declarations. The appendices to this Board report have also been made available to Governors alongside the summary assurance report. Governors have been asked to provide feedback to the Trust Secretary which has been incorporated into this report. The following comments were received from a Governor:

Given the comprehensive nature of the assurance, I am surprised at how infrequently Governors are mentioned.

*I wonder about the **extent** of assurance provided within some of the governor statements, eg on local accountability and holding NEDs to account. Training, too.*

6.2 Another Governor noted that the report to Governors would normally have come to the Council of Governors meeting for discussion, but for the exceptional circumstances applying this year, and asked for assurance that every effort would be made to do this in future. This assurance was given.

6.3 The Lead Governor commented about training for governors and the need to ensure we develop ideas from the recent joint working groups regarding, for example, induction and effective questioning. Another Governor endorsed the Lead Governor's comment.

6.4 The Board is therefore asked to have regard to the views of Governors regarding these declarations.

7. RECOMMENDATIONS

7.1 The Board is asked to:

a) Have regard to feedback received from Governors in respect of these declarations

b) Agree to make a declaration confirming compliance with each of the statements listed in the Corporate Governance Statement, as attached at Appendix 1 and submit this to Monitor by the due date of 30 June

c) Agree to make a declaration of 'Not Applicable' in respect of the Academic Health & Science Centre declaration and submit this to Monitor by the due date of 30 June.

d) Agree to make a declaration of 'Confirmed' in relation to the Governor training declaration and submit this to Monitor by the due date of 30 June.

e) Agree to make a declaration of 'Confirmed' by the due date of 31 May in respect of systems for compliance with licence conditions for the financial year just ended

f) Agree to make a declaration confirming that the Trust continues to meet the criteria for holding a licence, and submit this to Monitor by the due date of 31 May.

g) Agree to publish on the Trust website the declaration in respect of systems for compliance with licence conditions within one month of its submission Monitor

APPENDICES

The appendices provide the following information:

Appendix 1: **Corporate Governance Declaration - Evidence**

Appendix 2: **Provider Licence conditions - Overview and Additional Evidence**

2gether Making life better

2gether NHS Foundation Trust NHS

Appendix 1

CORPORATE GOVERNANCE STATEMENT – EVIDENCE FOR STATEMENT OF COMPLIANCE

Governance Statement	**Evidence for current compliance**	**Risks to future compliance and mitigating actions, or *supporting information***	***Suggested declaration***
The Board is satisfied that 2gether NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	• Positive 'Well Led Framework for Governance' external review report • Organisational leadership through Board • Local accountability through Council of Governors • Engagement programme with stakeholders • Scheduled Board meetings including public meetings • Committee structure and Committee meeting programme • Performance dashboards to Delivery Committee • Performance exception reports to Board • Quality monitoring and reporting to Governance Committee • CCG observers at Governance Committee • Quality Strategy aims translate into service planning objectives • Quality Report and indicators • Financial reporting monthly to Board • Financial control systems in place • Information Governance function and reporting • Risk management framework and reports to Board and Committees • Assignment of key risks to relevant Committees and ongoing risk identification • Quarterly update and review of risk register • Implementation of new incident reporting system • Overall risk regarding incident reporting now downgraded to Medium Risk in Internal Audit report to April 2016 Audit Committee • Risk reporting to Board and Committees • Council of Governors statutory roles in holding NEDs to account • Service experience function and reports to Board • Patient safety reports to Board and Governance Committee	No risks identified	Confirmed

Governance Statement	Evidence for current compliance	Risks to future compliance and mitigating actions, or *supporting information*	*Suggested declaration*
	• Patient Stories agenda item at public Board meetings • Burdett principles checklist used at each Board meeting • Mental Health Legislation Scrutiny Committee and Managers' Forum • Whistleblowing and other organisational policies and procedures in place • External auditors appointed • Internal audit programme • Clinical audit programme • Compliance with FT Code of Governance • Annual Governance Statement • Trust Constitution • Trust vision and values • Annual Governance Statement • Mandatory disclosures in Annual Report • Statutory and mandatory training • Corporate induction for all new starters • Fit and proper person test for Board appointments • Declarations of Interests • 'Green' Monitor rating for Governance • 'Good' rating in Openness and Learning From Mistakes league table		
The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time	• Monitor Quarterly Reports and monthly CEO Reports to Board reports highlight new publications/guidance • External Auditor Sector development report • FT Bulletins to Board members • Annual Reporting Manual guidance	No risks identified	Confirmed

Governance Statement	Evidence for current compliance	Risks to future compliance and mitigating actions, or *supporting information*	*Suggested declaration*
The Board is satisfied that [2]gether NHS Foundation Trust implements:			
(a) effective board and committee structures;	• Committee structures reviewed in year. • Committee membership streamlined • Board effectiveness review conducted during the year • Strengthened clinical presence on Board – Director for Engagement & Integration • Committee summary reports to Board • Committee annual reports to Board • Audit Committee annual effectiveness review • Locality Governance structures	No risks identified	Confirmed
(b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and	• Constitution sets out Board responsibilities • Committee duties reviewed and reassigned where appropriate to maintain focus • Committee Terms of Reference reviewed annually and changes approved by the Board • Committee agenda planners refreshed at each meeting • Revised Scheme of Delegation in place setting out delegated responsibilities and powers reserved to Board • Revised Standing Financial Instructions in place	No risks identified	Confirmed
(c) clear reporting lines and accountabilities throughout its organisation.	• Clear Executive portfolios • Defined management and committee structure • Chief Executive is Accounting Officer • Director of Quality and Medical Director lead on quality matters • Lead Executive for each Committee • Committee reviews in year • Assignment of organisational risks to appropriate Committees • Committees are accountable and report regularly to the Board	No risks identified	Confirmed

Governance Statement	Evidence for current compliance	Risks to future compliance and mitigating actions, or *supporting information*	*Suggested declaration*
	• Reporting lines agreed for Localities, Expert reference Groups and sub-committees • Staff appraisals and objectives linked to organisational objectives		
The Board is satisfied that [2]gether NHS Foundation Trust effectively implements systems and/or processes **(a) *to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively;***	• Going concern report to Audit Committee • Board Finance Reports • Savings Plans • Quality Impact Assessments process in place, overseen by Governance Committee • Budget setting process • Strategic Plan • Capital Programme • Performance dashboard reports to Delivery Committee • Performance exceptions reports to Board • Quality reports to Governance Committee • Outcomes reporting • Clinical audit programme • Internal audit programme • External auditor • CQC registration • Monitor quarterly reports • Aggregated Learning Reports to Governance Committee • Financial Sustainability Risk Rating of 3 • Governance Risk rating of Green • Service/business planning process • Service plans include actions for 5 Year Forward View	No risks identified	Confirmed

Governance Statement	Evidence for current compliance	Risks to future compliance and mitigating actions, or *supporting information*	*Suggested declaration*
(b) for timely and effective scrutiny and oversight by the Board of the Licence holder's operations;	• Executive Committee meetings • NED oversight on Board and Committees • MHLS Committee meetings • Delivery Committee meetings • Governance Committee meetings • Audit Committee meetings • Board and Committee agenda planners • Monthly performance dashboards and exception reports • Locality reviews at Delivery, Development and Governance Committees • Service performance focus reports to Delivery Committee • Executive Safety walkabouts • Board visits • Monitor quarterly reports to Board • CQC compliance quarterly reports to Governance Committee	No risks identified	Confirmed
(c) to ensure compliance with health care standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	• Performance dashboard reports to Delivery Committee • Safety/quality oversight by Governance Committee • Expert Reference Groups • Board performance exception reports • CQC compliance reports • CQC inspection report • Medical revalidation programme • Mental Health Legislation Scrutiny Committee oversight • Executive safety walkabouts • Board visits • Clinical audit programme • Statutory and mandatory training requirements • Clinical policies • Mental Health Act/Mental Capacity Act policies • Mental health Act Managers in place • Quality Report	No risks identified	Confirmed

Governance Statement	Evidence for current compliance	Risks to future compliance and mitigating actions, or *supporting information*	*Suggested declaration*
	• Monitor quarterly reports • Francis action plans • Regulatory inspection reports/action planning • Inquest reports/action planning • Montpellier action plan • Quality Impact Assessments for efficiency and transformation proposals • QIAs reviewed by Medical Director, Director of Quality and Director of Engagement & Integration • Practice Development Strategy and Triangle of Care implementation • Nursing Strategy and action plan • Social care strategy		
(d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern);	• Budget setting process • Savings and transformational change programmes • Fully funded capital programme • Surpluses in previous years to achieve strong liquidity position • Use of liquidity position for strategic plan transformation • Monthly finance reports to Delivery Committee and Board • Standing Financial Instructions • Authorised signatory lists • Scheme of Delegation • Audit Committee Going Concern reports • Audit Committee Losses/Special Payments reports • Counter Fraud Service and annual action plan • Business development function • Development Committee oversight of development opportunities and business cases • Commerce Reports and Opportunity Funnel • Tender submission procedures • Governor approval process for significant transactions	No risks identified	Confirmed

Governance Statement	Evidence for current compliance	Risks to future compliance and mitigating actions, or *supporting information*	*Suggested declaration*
	• Organisational development programme • NHSLA Clinical Negligence Scheme for Trusts • NHSLA Risk Pooling Scheme for Trusts		
(e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	• Board/Committee agenda planners • Monthly Finance and Performance reports • Performance Point system to provide up to date high quality data • Clinical audit programme provides assurance on data quality • Data quality policy • Data quality requirement in Information Governance Toolkit • Finance and performance reporting aligned to Board/Committee cycle • Chief Executive's Reports to Board	No risks identified	Confirmed
(f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	• Risk register reviews by 'owning' Committees and overseen by Audit Committees and Board • Board Assurance Framework review by Executive Committee, Audit Committee and Board • Performance early warning reports to Delivery Committee • Internal audit programme • Clinical audit programme • Risk identification as standing Committee agenda item • Incident Reporting policy and culture • Whistleblowing policy and procedure • Quality Impact Assessments process	No risks identified	Confirmed
(g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal	• Annual operational planning process • Service planning process involves service users and Governors • Annual plan submission to Monitor • Alignment of service planning wheel and organisational objectives	No risks identified	Confirmed

Governance Statement	Evidence for current compliance	Risks to future compliance and mitigating actions, or *supporting information*	*Suggested declaration*
and where appropriate external assurance on such plans and their delivery; and	• Plans aligned to commissioners' stated intentions • Development Committee oversight • Executive Committee oversight • Governor consultation on business plan • Quarterly monitoring reports to Delivery Committee • Performance reports • Finance reports • Quality report – external consultation • External auditors report on Quality report		
(h) to ensure compliance with all applicable legal requirements.	• Access to retained lawyers • Internal auditors • External auditors • Executive leads for each key area of business • Trust Secretariat responsible for constitutional and corporate governance matters/updates • Legal briefings/updates received from a variety of sources • Executive Committee oversight • Audit Committee • Charitable Funds Committee • Information Governance policies and procedures • Clinical policies and procedures • Mental Health Legislation Scrutiny Committee and MHA Managers • Directors' fit and proper person tests on recruitment • FT Code of Governance compliance reports	No risks identified	Confirmed

Governance Statement	Evidence for current compliance	Risks to future compliance and mitigating actions, or *supporting information*	*Suggested declaration*
The Board is satisfied that systems and processes in place ensure:			
(a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;	• Medical Director, Director of Quality and Director for Engagement & Integration are clinicians • Board strengthened in year • Chair of Governance Committee is former clinician • Non-Executive Director engagement and review provides rigorous quality challenge	No risks identified	Confirmed
(b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	• Quality Impact Assessments for savings plans • Quality Strategy • Quality Report is key element of organisational vision and values • Quality Report defines key quality themes for the coming year • Service Plan includes specific element on Quality, Service Users and carers, Staff and Volunteers • Quality Strategy aims translate into Service Planning Wheel requirements for staff • Burdett principles and exception checklist applied at each Board meeting • Evaluation of each Board meeting covers Patient Experience, Quality and Risk	No risks identified	Confirmed
(c) the collection of accurate, comprehensive, timely and up to date information on quality of care;	• Monthly performance dashboard to Delivery Committee • Performance Exception reports to Board • Quarterly update reports on Quality Report • Monthly Patient Safety report to Board • Data Quality assurance processes in place	No risks identified.	Confirmed

Governance Statement	Evidence for current compliance	Risks to future compliance and mitigating actions, or *supporting information*	*Suggested declaration*
(d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;	• Monthly performance dashboard to Delivery Committee • Performance Exception reports to Board • Quarterly update reports on Quality Report • Monthly Patient Safety report to Board • Data Quality assurance processes in place	No risks identified	Confirmed
(e) that 2gether NHS foundation trust including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and	• Quality Report consultation • Quarterly update reports on Quality Report shared with stakeholders including CCGs, Health Watch and Overview and Scrutiny Committees, and feedback encouraged • Governors select local indicator for Quality Report audit • Patient survey • Complaints and Comments process • Friends & family Test • Patient Story is regular agenda item at public Board meetings • Service Experience function and reports to Board • Quality Outcomes published through public Board papers and in Annual report	No risks identified	Confirmed
(f) that there is clear accountability for quality of care throughout 2gether NHS foundation trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	• Quality Governance assigned to Exec Directors • Non-Exec Director oversight of Quality • Clinical Directors • Service Directors • Heads of Profession • Lead Nurses • Board Committee and sub-committee structure • Locality Governance Committees have reporting line to Board through the Governance Committee	No risks identified	Confirmed

Governance Statement	Evidence for current compliance	Risks to future compliance and mitigating actions, or *supporting information*	*Suggested declaration*
The Board of [2]gether NHS foundation trust effectively implements systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licence holder's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.	• Board recruitment processes • Governor appointment of Non Exec Directors • Appointment & Terms of Service Committee for Executive recruitment • Budgeted establishment • Delegated recruitment processes • Recruitment and selection policy • Ward staffing levels information	No risks identified	Confirmed

Appendix 2

PROVIDER LICENCE CONDITIONS – OVERVIEW AND ADDITIONAL EVIDENCE

	Licence Condition	Condition summary	Evidence for compliance
General Conditions			
G1	Provision of Information	Provision of information to Monitor	Monitor quarterly reports Monitor annual plan Strategic plan submission Ad hoc submissions to Monitor via portal
G2	Publication of information	Publish information as directed by Monitor	Information on website eg Board profiles
G3	Payment of fees to Monitor	Pay fees to Monitor as required	Not applicable - no fees requested to date
G4	Fit and Proper Persons	Not to appoint unfit persons as Directors or Governors	Exclusion criteria in constitution for Directors and Governors Directors' recruitment procedures Governor election rules *'Fit & Proper Persons: Directors'* test incorporated into Board recruitment
G5	Monitor guidance	Have regard to Monitor guidance	Code of Governance compliance Risk Assessment Framework compliance
G6	Systems for compliance with licence conditions	Have systems in place to comply with licence conditions	Outlined in the appendices to this report
G7	CQC registration	Be registered with the CQC	CQC registration in place
G8	Patient eligibility & selection criteria	Set and apply transparent criteria to determine who can receive health care	Commissioner service specifications
G9	Application of Section 5 – Continuity of Services	States that the Continuity of Services conditions apply where commissioner-requested services are provided	See Continuity of Services section below
Pricing			
P1	Recording of Information	Record pricing information if required by Monitor	Not required to date.
P2	Provision of Information	Provide information to Monitor	Provision of information via portal
P3	Assurance report on submissions to Monitor	Provide an assurance report re Condition P2 if required by Monitor	Not required to date
P4	Compliance with the National Tariff	Comply with national tariff	There is no national tariff in place for mental health PbR
P5	Constructive engagement re	Engage with local commissioners re tariff	Agreements in in place with both Gloucestershire CCG and

	Licence Condition	Condition summary	Evidence for compliance
	local tariff modifications	modifications	Herefordshire CCG re price tariff. Regular monthly PbR meetings take place where performance reports are presented and discussed.
Choice & competition			
C1	Patients' right of choice	Patient notified of choice of provider	Not applicable to Mental health Services
C2	Competition oversight	Not to restrict or distort competition	Legal advice obtained where appropriate when bidding for services/entering partnerships
Integrated care			
IC1	Provision of integrated care	Not to act detrimentally to the provision of integrated care	Local health Economy 'Better Care Fund' proposals IAPT/primary care services integration Collaborative approach in Herefordshire
Continuity of services			
CoS1	Continuing provision of Commissioner Requested Services	Continue to provide CRS as specified except in certain circumstances eg with Commissioner agreement	Trust delivered all elements of block contracts. All services specifications met. Small fine imposed re Glos IAPT, reinvested in services by Commissioner. Activity targets in cost and volume contracts met.
CoS2	Restriction on the disposal of assets	Not to dispose of any asset without written consent from Monitor	No assets disposed that provide Commissioner Requested Services.
CoS3	Standards of corporate governance and financial management	Apply suitable systems of corporate and financial governance	See evidence set out in this report and Appendices
CoS4	Undertaking from the ultimate controller	Undertaking from any parent company not to cause a breach of the provider licence	Not applicable
CoS5	Risk pool levy	To pay a risk pool levy to Monitor	Not applicable
CoS6	Cooperation in the event of financial stress	To cooperate with Monitor and others in the event of financial stress	Not applicable
CoS7	Availability of resources	Ensure and certify the availability of financial, physical and human resources for the next 12 months	Rolling contract in place with main commissioner Herefordshire contract in place Audit Committee review of 'going concern' status Fully funded capital programme Savings programmes in place Budgeted establishment Strong liquidity position funding strategy and transformation

	Licence Condition	Condition summary	Evidence for compliance
			Financial strategy approved at Jan 2016 Board 2gether RiO procured and implemented Financial Sustainability risk rating = 3 Green-rated strategic plan
NHS Foundation Trust Conditions			
FT1	Information to update the register of FT's	Provision of certain documents to Monitor	Provision of annual accounts and annual report Provision of current version of the constitution Updates regarding Board and Governor changes
FT2	Payment to Monitor in respect of registration and related costs	Payment of a licence fee to Monitor	Not applicable
FT3	Provision of information to advisory panel	Provision of any information requested by an advisory panel	Not applicable – no information requested
FT4	NHS FT governance arrangements	Apply and certify appropriate systems and processes for good corporate governance	Positive 'Well Led Framework for Governance' external review report CQC inspection report and 'Good rating

Agenda item **18** **Enclosure** **Paper M**

Report to: Trust Board, 26 May 2016
Author: Leigh Clarke, Assistant Director of Service Continuity
Presented by: Colin Merker, Director of Service Delivery

SUBJECT: **Mental Health Legislation Scrutiny Committee – Annual Trust Board Report 2015/16**

Can this report be discussed at a public Board meeting?	Yes

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

EXECUTIVE SUMMARY

This Mental Health Legislation Scrutiny Committee (the Committee) Annual Board Report outlines the activities of the Committee between April 2015 and March 2016.

Section 2 provides comments on a range of internal and external monitoring information including; Care Quality Commission (CQC) Comprehensive Inspection, CQC Inpatient Monitoring visits, Key Performance Indicators and audits.

The Committee continues to monitor and request detailed action plans for those areas of the Mental Health Act (MHA), Mental Capacity Act (MCA), Human Rights Act and associated codes of practice, highlighted by either the CQC or by internal audit that are deemed not to be meeting the required standards.

The Committee is able to provide significant assurance on the controls it has in place for ensuring the Trust monitors and sustains compliance with the MHA, MCA, HRA (and their associated codes of practice) and where necessary takes action to address non-conformities.

RECOMMENDATIONS

The Board is asked to receive this report as assurance of the systems, processes and controls that are in place to ensure the Trust complies with the requirements of the; Mental Health Act (MHA), Mental Capacity Act (MCA), Human Rights Act and associated codes of practice.

Corporate Considerations	
Quality implications	Appropriate compliance with the MHA, MCA and HRA is a fundamental requirement of a competent Mental Health Service provider. Addressing the actions highlighted by the regulator is a priority to ensure that we meet the necessary standards consistently.
Resource implications:	None identified outside of currently agreed budgets.
Equalities implications:	Ensuring people with mental health needs are treated equitably within the framework of the various legislation is a fundamental requirement of the Trust.
Risk implications:	Legal, reputational and safety as they relate to individuals patients, carers, staff and the organisation.

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	Inclusive open and honest	P
Excelling and improving	P	Can do	P
Responsive	P	Efficient	P
Valuing and respectful	P		

Reviewed by:		
Colin Merker (Executive Director of Service Delivery)	Date	04 May 2016

Where in the Trust has this been discussed before?		
Colin Merker (Executive Director of Service Delivery)	Date	04 May 2016

What consultation has there been?		
Mental Health Legislation Scrutiny Committee	Date	11 May 2016

Explanation of acronyms used:		
	AMHP	Approved Mental Health Practitioner
	CoP	Code of Practice
	CTO	Community Treatment Orders
	CQC	Care Quality Commission
	DoLS	Deprivation of Liberty Standards
	HRA	Human Rights Act
	MCA	Mental Capacity Act
	MHA	Mental Health Act

1 INTRODUCTION

1.1 Purpose Statement

1.1.1 ²gether NHS Foundation Trust as a provider of Mental Health and Community Services is required to demonstrate that its systems, structures, controls for how it provides services are compliant with; the Mental Health Act (MHA), Mental Capacity Act (MCA), Human Rights Act and associated codes of practice.

1.1.2 The Mental Health Legislation Scrutiny Committee is the Committee responsible for ensuring compliance on behalf of the Board by holding the Executive to account and providing assurance to the Trust Board that appropriate integrated; systems, processes and reporting arrangements are established, monitored and maintained.

1.2 Scope of report

1.2.1 This report covers the structures, systems and activities that are in operation across the Trust to ensure ²gether NHS Foundation Trust's continued compliance with; the Mental Health Act (MHA), Mental Capacity Act (MCA), Human Rights Act and associated codes of practice. Internal and external monitoring mechanisms that support the provision of assurance are included in table 1 below.

Table 1: Internal and external monitoring mechanisms

Internal Monitoring	External Monitoring
MHL Scrutiny Committee meetings - Minutes - reviewed Terms of Reference Mental Health Act Managers Forum (including issues reports) Policy/Procedure submissions and approvals Key Performance Indicators Audits Training	CQC Monitoring visits CQC Inspection Bevan Brittan advice and guidance

Mental Health Legislation Scrutiny Committee members attendance

Date Core Member	18.03.15	20.05.15	22.06.15	16.09.15	18.11.15	03.02.16
Maggie Deacon (until 30/11/15)	✓	✓	o	✓	✓	o
Martin Freeman	✓	✓	✓	✓	✓	✓
Colin Merker	✓	✓	✓	✓	✓	✓
Nikki Richardson	o	✓	o	✓	✓	✓
Richard Szadziewski (from 01/12/15)	o	o	o	o	o	✓
STATUS	Quorate	Quorate	Quorate	Quorate	Quorate	Quorate

The following officers were in attendance at the Committee;

Date / Officers	18.03.15	20.05.15	22.06.15	16.09.15	18.11.15	03.02.16
Sarah Bennion	✓	✓	✓	o	o	o
Karl Gluck	✓	o	✓	o	o	o
Richard Butt-Evans	✓	✓	✓	o	-	-
Tina Kukstas	✓	✓	o	✓	✓	✓
Debbie McCarthy	✓	✓	✓	o	✓	o
Kim Humby	✓	✓	o	o	✓	o
Krishen Ranganath	✓	o	✓	✓	✓	o
Philip Southam	✓	o	o	✓	✓	✓
John Trevains	✓	✓	✓	✓	o	o
Kelwyn Williams	✓	✓	✓	✓	o	✓
Chris Woon	✓	o	o	o	o	o
Margaret Algar	o	✓	✓	✓	o	✓
Jez Leat	o	✓	✓	✓	o	✓
Jonathan Thomas	o	✓	✓	o	o	o
Paul Ward	o	✓	✓	o	o	o
Sally Simmonds	o	o	✓	✓	✓	✓
Steve Keech	o	o	✓	✓	✓	o
Eddie O'Neil	o	o	o	✓	o	✓
Anneka Rose	o	o	o	o	✓	o
Ruth Thomas	o	o	o	o	o	✓
Theresa Donoghue	o	o	o	o	o	✓

2 MENTAL HEALTH LEGISLATION SCRUTINY COMMITTEE ACTIVITY 2015/16

2.1 Activity Summary

Key:	
	Full assurance - A sound system of controls has been effectively applied and manages the risks to the achievement of the objectives
	Significat assurance - A sound system of controls has, for the most part, been consistently applied, minor inconsistencies have occurred but there is no evidence to suggest that the system's objectives have been put at risk.
	Limited assurance - Gaps in the application of controls as designed by management put the achievement of objectives at risk
	No assurance - Gaps in the application of controls as designed by management have opened the system to risk of significant failure to achieve its objectives and left it open to abuse or error

Item	Source	Description	Level of assurance
2.2	Care Quality Commission Inspection (26-30 October 2016)	A comprehensive CQC inspection carried out across the Trust.	Significant assurance
2.3	Care Quality Commission Inpatient monitoring visits (as at 31 March 2016)	A series of inpatient visits inspecting compliance with Domain 2: Detention in Hospital *1. Purpose, respect, participation and least restriction.* *2. Admission to the ward.* *3. Leave of absence* *4. Control and security* *5. Consent to treatment* *6. General Healthcare*	Significant assurance

Item	Source	Description	Level of assurance
2.4	Key Performance Indicators	A set of indicators that detail how the Trust applies the MHA and CoP relating to; *Sections 5(2) and 5(4) | Section 4 | Section 2 | Bed days occupied by detained patients |MHA Managers' Hearings and Tribunals | Extended Section 17 Leave and CTOs*	Significant assurance
2.5	Audits	A range of activities intended to monitor compliance with Trust Policies and to identify areas for improvement.	Significant assurance
2.6	Deprivation of Liberty Standards (DoLS) Applications	Standard agenda item looking at the Trust's application of DoLS legislation across the Trust.	Significant assurance
2.7	Review and approval of policies	The Committee provides a forum for the review, discussion and approval of policies appropriate to its remit and scope.	Full Assurance
2.8	Review of MHA Managers Panel Hearing Issues Reports	The Committee provides a forum for the review and discussion of MHA Managers Panel Hearing Issues and a platform to approval actions to prevent any such issues arising in the future.	Full Assurance
2.9	Review of MHA Managers Forum minutes and questions	The Committee provides a mechanism in which the MHA Managers Forum can raise questions relating to the Trust's structures, systems and activities for complying with MHA, MCA, HRA and their associated codes of practice.	Full Assurance

2.2 Review CQC Comprehensive Inspection Report

The Care Quality Commission conducted its comprehensive review of the Trust and the services it provides between the 26 and 30 October 2015, publishing their findings in January of this year. The Committee has scrutinised the report provided by the CQC in which a number of observations were made. The Trust has developed a centrally coordinated action plan in which the MH Legislation and Scrutiny Committee provides a vital role in ensuring the implementation and monitoring of actions to support ongoing, sustainable improvements and compliance.

2.3 Review CQC Inpatient Monitoring Visit Reports

2.3.1 The Care Quality Commission's role in conducting regular monitoring visits of inpatient facilities is to check that patients' human rights are being protected and to look at how ²gether NHS Foundation Trust are applying the safeguards of the Act and the guiding principles and standards of the Code of Practice, while they are being cared for or treated under the Mental Health Act in England.

2.3.2 During the period of this report the Trust has received seven inpatient monitoring visit reports for the following areas;

- Laurel House (Rehabilitation)
- Honeybourne (Rehabilitation)
- Westridge (Learning disabilities)
- Wotton Lawn – Abbey Ward (Acute Admission)
- Charlton Lane – Willow Ward (Old Age Psychiatry)
- Wotton Lawn – Kingsholm Ward (Acute Admission)
- Hollybrook (Learning Disabilities)

2.3.3 The CQC monitoring visit reports and associated action statements were responded to within the timescales set by the CQC and approved by the Executive Director of Service Delivery. A report highlighting the CQC's observations was presented to the Committee in May 2016 with the observations and actions considered as part of the overarching action plan that was developed following the CQC comprehensive inspection.

2.4 Review of Key Performance Indicators

2.4.1 The Head of Health Records presents a quarterly Key Performance Indicator report to the Committee that provides a Trust overview of compliance against the MHA and Code of Practice as it relates to; Sections 5(2) and 5(4) | Section 4 | Section 2 | Bed days occupied by detained patients |MHA Managers' Hearings and Tribunals | Extended Section 17 Leave and CTOs.

2.4.2 This report provides a useful monitoring tool and enables Committee members to consider and take action against specific trends that show a deteriorating picture of compliance.

2.5 Review of audit outcomes

2.5.1 The Committee requests, monitors and oversees the development and implementation of audits and their related outcomes and any improvements that arise. Audits are a useful tool when applied correctly and in the context of compliance the audits are designed to monitor service, department, directorate and Trust compliance with internal policies and external legislation and guidelines. Audits carried out and presented to the Committee during 2015/16 include:

- Audit Report (18.03.15) The documentation of Capacity to consent – Second cycle of an audit completed in 2014 looking at documenting of consent to hospitalisation and treatment and capacity to give consent.

- Audit Report (18.03.15) Compliance with Policy for the receipt and scrutiny of MHA documents – An audit reviewing a random selection of AMHP applications for admission and medical recommendation form compliance.

- Audit Report (20.05.15) Audit of Section 17 Leave arrangements – the purpose of the audit was to assess the level of Trust compliance with the Code of Practice. Main areas of non-compliance related to; the correct completion of the Section 17 form (fallen from 93% (2014) to 73% (2015)) and in discussing Section 17 leave arrangements in MDT meetings (fallen from 93% (2014) to 73% (2015)).

- Audit Report (20.05.15) Audit of Assessment on Admission

- Audit Report (20.05.15) Audit of the recording of the provision of rights to patients subject to the MHA – Identified areas for improvement including; increasing the percentage of reminders given within Trust Policy (45% for patients detained in hospital and 17% for CTO patients)

- Audit Report (20.05.15) Compliance with Policy for the receipt and scrutiny of MHA documents – An audit reviewing a random selection of AMHP applications for admission and medical recommendation form compliance.

- Audit Report (22.07.15) Compliance with Policy for the receipt and scrutiny of MHA documents – No issues identified.

- Audit Report (22.07.15) Assess compliance with the Code of Practice as it related to Section 17 of the MHA.

- Audit Report (16.09.15) Compliance with renewal of detention Policy

- Audit Update (22.09.15) Rolling audit of detained patients and reminders to them about their rights – issues raised relating to the accuracy of data and data collection methods.

- Audit Report (18.11.15) The documentation of Capacity to consent – third cycle of an audit looking at documenting of consent to hospitalisation and treatment and capacity to give consent.

- Audit Report (18.11.15) Compliance with Concerns of the Family Policy – compliance issues identified in information provided to carer.

- Audit Report (03.02.16) Compliance with Consent to Treatment.

- Audit Update (03.02.16) Rolling audit of detained patients and reminders to them about their rights.

2.6 Review of Deprivation of Liberty Standards (DoLS) Applications

The Mental Health Legislation Scrutiny Committee determined the need to monitor the Trust's position in relation to the number of DoLS applications and their outcome in order to assure itself that the application of MCA and DoLS legislation is correctly and consistently applied across the Trust. The review of DoLs forms a regular part of the Committee's agenda.

2.7 Review and approval of policies

The Committee provides a forum for the review, updating and where appropriate approval of policies associated with the application of MHA, MCA, HRA and their associated codes of practice across the Trust. The diverse membership of the Committee provides for robust challenge, ensuring policy requirements support staff in discharging their responsibilities.

2.8 Review of MHA Managers Panel Hearing Issues Reports

2.8.1 MHA Hospital Managers on behalf of ²gether NHS Foundation Trust have a duty to ensure that all relevant patients, and their nearest relative and, if different carer, are aware that a patient may ask to be discharged by the hospital managers and of the distinction between this (MHA Managers Panel Heating) and their right to apply for a Tribunal hearing (an independent judicial body).

2.8.2 The Trust continues to operate an effective system for MHA Managers to raise issues that arise at Panel Hearings. Initial concerns raised are shared with the MHA Administration Team at which point an investigation will determine any route causes that led to the issue arising and the actions that can be taken to prevent it from reoccurring in the future. Responses and reports are coordinated centrally and

approved by the Executive Director of Service Delivery, before being presented to the Committee for scrutiny.

2.8.3 Several issues have arisen from MHA Manager Panel Hearings in 2015/16 and their outcomes reported to the Committee.

2.9 Review of MHA Managers Forum minutes and questions

2.9.1 The MHA Managers Forum continues to meet on a quarterly basis under the Chairmanship of Les Trewin, with Non-Executive Director support provided by Martin Freeman.

2.9.2 Questions and discussion topics have been brought to the Committee throughout 2015/16 and this pattern of learning will be continued into 2016/17.

2.10 Overall level of Assurance

2.10.1 The Committee is able to provide **Significant Assurance** based on the controls it has put in place and its continued action in directing the activities of the Trust where non-conformities with the MHA, MCA, HRA and their associated codes of practice are identified.

3 KEY STRATEGIC RISKS 2015/16

During 2015/16 the Committee has highlighted a number of key strategic risks which will help to inform the work programme for the Committee into 2016/17. These risks are;

- Evidencing capacity to consent
- Awareness and application of MHA and MCA and associated CoPs (including a robust mechanism for cascading changes).
- Mechanisms to demonstrate compliance with the application of DoLS
- Managing the differences in systems and practice between Gloucestershire and Herefordshire
- Review of seclusion
- Developing a mechanism that reflects strategic risks that originate from or for which the Committee needs to gather evidence for assurance purposes.

4 PRIORITIES FOR 2016/17

4.1 Continue to provide a robust forum to ensure the Trust's continuing compliance with MHA, MCA, HRA and their associated codes of practice.

4.2 Continue to meet its requirements as set out in the MHA Scrutiny Committee Terms of Reference.

4.3 Overseeing where necessary the implementation and monitoring of actions and activities from the CQC comprehensive inspection and subsequent monitoring visits.

4.4 To ensure consistency and standardisation (where appropriate) of systems, structures and processes that support compliance across Gloucestershire and Herefordshire.

4.5 To progress work associated with the key strategic risks identified in section 3 of this paper.

5 RECOMMENDATIONS

5.1 The Board is asked to receive this report as assurance of the systems, processes and controls that are in place to ensure the Trust complies with the requirements of the; Mental Health Act (MHA), Mental Capacity Act (MCA), Human Rights Act and associated codes of practice.

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Audit Committee

DATE OF COMMITTEE MEETING: 13 April 2016

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

INTERNAL AUDIT

Internal Audit progress report

The Committee received the progress report against the 2015/16 Internal Audit plan and noted that all planned audits had been completed. An audit report on Data Quality remained outstanding, but this is currently being compiled.

HR monitoring controls

The review of controls relating to objective setting, appraisal and statutory/mandatory training produced 2 medium risk findings, 2 low risk findings and 1 advisory finding. Medium risk findings related to staff objectives not having been set and annual appraisals not having been done in 6 out of the 25 sample cases reviewed, and to staff not having completed their statutory and mandatory training by the due date in 11 out of the 25 sample cases. The review had produced a **Medium Risk** rating overall. The Committee recognised that the current audit represented an improvement on previous reports, and noted remedial measures. However, the Committee was concerned that appraisal and statutory/mandatory training compliance is unsatisfactory and remains a long standing issue which could pose a risk to the Trust, for example should a serious incident occur in which training compliance was a contributory factor. Consequently the Committee was **not assured** by the report, and agreed to refer the issue to the Executive Committee which would be asked to ensure appropriate action was taken by Service Directors, and provide an update on the issue to the Board.

Incident Reporting – follow-up

This review was undertaken at the request of the Audit Committee to provide an update on progress on implementation of the new incident reporting system. The review identified 1 high risk finding regarding timely review of incidents and capture of previous audit recommendations within the new system, and produced an overall rating of **Medium Risk.** The Committee noted that the Incident Reporting system was now more robust with the appointment of a Datix Systems Manager, the purchase of new modules and the implementation ahead of time of the incident reporting module on Datix. The Committee was **assured** regarding progress on implementing systems, and agreed to receive a further audit report on actual incident reporting in Q4 once the sytems were implemented.

Other reviews

The Committee received and noted a number of other reviews, including Information Governance, Cost Improvement Programmes, and Joining Up Your Information. The Committee noted that JUYI (a project led by the Commissioning Support Unit to share limited electronic health records information across Gloucestershire) had not yet been reported to a Board Committee, and Richard Szadziewski agreed to liaise with Andrew Lee to determine the most appropriate Committee to receive such reports.

Draft Internal Audit Annual Report and draft audit plan
The Committee received the draft Internal Audit Annual Report and noted the rating of 'Generally satisfactory with some improvements required'. This rating had been assigned because the Trust had received a high risk finding (relating to incident reporting), but for which the rating would have been 'Satisfactory' - the highest rating available.

The Committee received the draft audit plan for 2016/17 and noted that no specific review was planned in respect of IT projects such as mobile working and new technology. The Committee asked that the Director of Finance and Commerce give consideration to including an audit in this area, given the level of spend and the strategic importance of these initiatives.

Internal Audit Recommendation Tracker
The Committee received the IA recommendation tracker, and noted that the Director of Finance had chased responses from various individuals to ensure that recommendations were followed up in a timely fashion. There remained a number of recommendations still to be implemented, and the Committee recognised that a robust process for the deferment of actions was still to be agreed and put in place. Consequently, the Committee agreed that the tracker offered **limited assurance** while recognising that progress had been made since the last meeting of the Audit Committee.

EXTERNAL AUDIT – UPDATE REPORT

The Committee received the update report for the 2015/16 audit and noted that there had been no changes to significant risks as a result of the auditor's interim visit which had taken place in February. The Committee noted that interim fieldwork for the Quality Report audit had been completed, and that testing of selected indicators (Crisis Gatekeeping and 7 Day Follow Up, along with the Governor-selected indicator Inpatient Discharge Care Planning) would begin in late April. The Committee noted the benchmarking information within the report regarding delivery on Cost Improvement Plans, which showed that the Trust has achieved 77% of planned CIPs, and 15% of planned pay CIPs. The report noted that the sector as a whole is significantly behind on CIP delivery.

COUNTER FRAUD

The Committee received the Counter Fraud Service Annual Report and Plan for 2015/16, along with the draft plan for 2016/17. The Counter Fraud Self-Review Tool had been submitted to NHS Protect and had produced a 'Green' rating. The Committee noted the work undertaken by the Counter Fraud Service during the year, which included 40 presentations to staff and 3 proactive exercises regarding petty cash, additional employment, and residential care funding. Two investigations remained ongoing. The Committee agreed that the Annual Report offered the Trust **significant assurance** about the Counter Fraud activity being undertaken.

The Committee noted the draft plan for 2016/17 which sought to raise awareness of Counter Fraud within ^{2}gether, and particularly in Herefordshire. The Counter Fraud service allocated 145 days to counter fraud activity within the Trust, a figure recommended by NHS Protect. The Committee asked the Director of Finance to provide an update as to whether this level of activity was appropriate given the Trust's historical good performance regarding Counter Fraud.

DRAFT ANNUAL GOVERNANCE STATEMENT

The Committee received the draft Annual Governance Statement which the Chief Executive, as Accounting Officer, is required to draw up in order to review the Trust's system of internal control. The AGS forms part of the Trust's Annual Report.

A small number of amendments were suggested, and the Committee noted that the Trust Secretary would make these amendments before circulation of the draft AGS to the Executive Committee for comment. The final AGS would be presented to the May meeting of the Audit Committee for approval.

REVIEW OF DIRECTORS' INTERESTS AND GIFTS/HOSDPITALITY REGISTER

Review of Directors' Interests

The Committee received a report setting out interests declared by the Board of Directors during 2015/16 year.

Review of the Gifts and Hospitality Register

The Committee reviewed the small number of declarations of gifts and hospitality made during 2015/16 year, noting that the Business Conduct, Gifts and Hospitality Policy did not require gifts with a value below £25 to be reported. The Committee noted that gifts offered and refused were also recorded in the register. While the report suggested that the Committee should feel significantly assured, it asked that this information be included in the next report to provide greater assurance to the Committee.

BOARD ASSURANCE FRAMEWORK

The Committee received the Board Assurance Framework (BAF) as reviewed by the Executive Committee. The current iteration of the BAF contains 12 risks. The Committee noted the removal from the BAF of risks whose scores had fallen below the threshold for inclusion, and also noted an increase to the risk score about workforce and organisational culture.
The report offered **significant assurance** regarding the identification and mitigation of risks which may affect the quality or safety of services provided by the Trust. The Committee noted that the Board would have an opportunity to consider the content and use of the BAF at a risk management session planned to follow the Board meeting in April.

MEETING WITH AUDITORS

The Chair of the Audit Committee met privately with Internal and External Auditors prior to the Committee meeting. Neither Auditor reported any concerns regarding the working relationship with officers of the Trust.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to note this summary report.

SUMMARY PREPARED BY: Richard Szadziewski **ROLE:** Chair

DATE: 13 April 2016

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Mental Health Legislation Scrutiny Committee

DATE OF COMMITTEE MEETING: 11 May 2016

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

Review of Mental Health Act Commissioner Visits

Seven Care Quality Commission (CQC) inpatient monitoring visit reports had been received so far this year. These had been reviewed and an action statement submitted to the CQC by the required deadline dates. The Committee noted that the focus of inspections to date had centred on Domain 2 – Detention in hospital. Issues included:

- Insufficient completion of documentation, specifically the evidencing of discussions, actions and activities that had taken place between service users and service providers. Leave, presentation of rights, advanced decisions/statements and capacity to consent represented the majority of areas relating to documentation completeness.
- Taking of a photograph and the provision of a written description of a patient on their detention to ensure it was available should the service user abscond. The Committee noted that the Trust had sought the opinion of Bevan Brittan legal advisors who found no legal reason why the Trust should not comply with this code of practice and the issue would be discussed further within the Trust.
- Staff knowledge and training also featured highly in relation to the MHA Act and MHA Code of Practice, but no specific details of training needs or requirements were outlined by CQC inspectors.

The Committee noted that inpatient monitoring visit reports for around half of the wards visited were still awaited and the Trust was unsure when these would be released to the Trust. This is being discussed with the CQC relationship manager.

The continued efforts of teams in responding to report findings and of providing evidence of learning and improvement were noted. Significant assurance was received of the systems and processes in place for responding to external observations of how the Trust complied with the MHA and the Code of Practice.

Reports of issues arising at Mental Health Act Hearings

The Committee noted the process by which Mental Health Act Managers and /or a panel can raise an issue that they felt may have, in some way, negatively contributed to the effectiveness of a panel in discharging its responsibilities

Issues raised between 1 September 2015 and 31 March 2016 were explored and the investigations and planned actions were noted

Significant assurance was received that issues arising from Mental Health Act Hearings are investigated and actioned appropriately.

Key Performance Indicators and Benchmarking

This report reviewed key point indicators of performance relevant to monitoring the compliance of the Mental Health Act and Code of Practice within the Trust. Points noted included:

- The use of Section 136 shows an upward trend in Gloucestershire and slightly downward trend in Herefordshire.
- The use of Section 2 and 3 shows an upward trend in both Gloucestershire and Herefordshire.
- An upward trend in the use of the Mental Health Act for older people
- The proportion of the BME community subject to section 2 in Gloucestershire remains similar to that of the White British community but in Herefordshire it is higher.
- The committee reflected on one case of Extended Section 17 leave (in preference to a Community Treatment order) but were assured that in this case it was appropriate for the care of the service user.
- The variations reflected above remain overall small and further monitoring will continue.

Benchmarking against national figures was considered by comparison with national and Trust data on the use of the Mental Health Act. The Committee noted that all organisations detaining people under the Mental Health Act were required to make an annual submission to the Health & Social Care Information Centre (HSCIC) with data on the use of the Act.
Comparisons noted include:

- 2gether had a smaller proportion of its population detained in hospital on 31st March 2015 than 87% of other organisations
- 2gether had a higher proportion of its population subject to Community Treatment Orders (CTO) on 31st March 2015 than 77% of other organisations.

The Committee discussed these findings and noted that the numbers of CTO's were reducing and a recent study had found that use of CTO's did not reduce readmission rates. The CQC Annual report on the MHA due to be issued and would provide further information which will be reviewed by the Committee.

Audit of compliance against MHA policies

a) Receipt and Scrutiny Policy – an audit of the administrative scrutiny of applications by Approved Mental Health Professionals and accompanying medical recommendations. (October to December 2015). No errors detected which could have invalidated the application.

b) Review of detention issues and lessons learned. (January to March 2016) Review of applications demonstrated 2 apparently invalid applications. These were investigated and problems resolved. In the first incident the 2 medical recommendations were found to have professional conflict due to line management relationship. In the second scrutiny had not occurred at the correct time due to timing of transfer of the service user from out of county to a 2Gether Trust hospital. Both issues were appropriately resolved. Significant assurance is offered that systems are in place to identify and resolve errors in applications for detention.

c) Recording of Capacity and Consent Audit. Points to note:

- 18% compliance was demonstrated for recording of capacity and consent, although this figure was higher at 78% for either capacity or consent.
- Recording of information relating to Mental Capacity Act had increased over 3 audits from 0% to 45% and currently 65%. Considerable improvement was demonstrated.
- Concerns were expressed that information is recorded in the wrong place on RiO in an unknown number of cases.
- Actions include a line management response to findings to be considered at the next

meeting and a reminder to approved clinicians regarding the audit findings
- Limited assurance was noted regarding the recording of capacity and consent.

d) Audit of the use of seclusion. The aim of this audit is to ensure the seclusion at Hollybrook and Westridge Learning Disability Units were carried out in line with standards defined by NICE guidance, Mental Health Code of Practice and Trust policy. Compliance had reduced slightly from 99% to 97%. Lessons learnt were noted for action. Significant assurance offered regarding the use of seclusion at Westridge and Hollybrook. The committee noted the further work being done to review the Trust policy on seclusion and segregation.

Review of Mental Health Act / Mental Capacity Act and Deprivation of Liberties Training
In October 2015, the Care Quality Commission (CQC) raised a concern that 2gether Trust staff had a lack of knowledge around the new Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA) (2005). As a result, a review of training took place and a number of recommendations were agreed, including the publication of a mandatory read legislation briefing document and the development of a new, mandatory e-learning course for clinical staff. Points to note:

- The briefing document had been distributed by way of the Trust Intranet and to date 63% of staff had confirmed that they had read it. Some technical issues prevented receipt of the document via the intranet and as a result a manual process had had to be introduced to capture this data.
- A new, bespoke e-learning programme is in development and would be introduced in June. This would be mandatory and take around 40 minutes to complete. Staff would be given around six months to access and complete the training
- Face-to-face specialist training continued to be delivered as optional training and this had been updated in line with the comments contained within the CQC reports.
- Feedback on the training to be given to the Committee at the July meeting..

Review of Deprivation of Liberties Applications (DoLs)
The Committee received an update regarding the current legal review of DoLS procedures. The Committee has previously requested regular update on current DoLS applications to offer assurance best possible care of service users during the period of legal review and change. At the time of the writing of the report there were three service users subject to DoLs. 19 applications had been put forward this year for DoLs and 5 of those had been approved. The percentage of those applications for DoLs had decreased this year while the use of the Mental Health Act had increased. This is in keeping with current guidance. Work was ongoing within the Trust regarding the uncertainty over use of the MHA or DoLs

Section 135 Warrants - Guidance for Staff
Confusion had been reported by staff regarding the need to obtain Section 135 Warrants (Warrant to search for and remove patients) in relation to Absent without leave incidents. The Committee recommended that guidance for staff should be investigated and reported to the next meeting.

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Martin Freeman ROLE: Committee Chair
DATE: 11 May 2016

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Governance Committee

DATE OF COMMITTEE MEETING: 22 April 2016

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PATIENT SAFETY

Patient Safety/Serious Incident Update

Three new Serious Incidents (SIs) were reported in Gloucestershire during March 2016 and non in Herefordshire. There had been zero Never Events occurring within Trust services. The SI rate per 1000 caseload for March 2016 was 0.13.

The Committee noted there had been an increase in suicides which tragically is in line with National trends. The overall number of serious incidents had reduced

The Serious Incident Action Plan was reviewed. Points to note include:

- 2 amber actions remained on the Action Plan 2014/15with indication of significant progress
- There were 27 red actions and 16 amber actions on the 2015/16 Action Plan. These were reviewed to ensure progress and further reporting at the next meeting
- Discussions were continuing on the proposal to set up a sub-committee of the Governance Committee to monitor these actions

ASSURANCE: Significant assurance was received that robust systems are in place to identify and manage Serious Incidents. Plans are in place to increase assurance regarding the monitoring and closure of resulting planned actions.

2014 Homicide Update

The Committee received an update on the Homicide Action Plan. Additional assurance was awaited for 2 outstanding issues. It was agreed that a report would be brought to the next Governance Committee for further assurance prior to closure of the current planned actions.

SAFE STAFFING LEVELS REPORT

The Committee noted the Safe Staffing data for March 2016. No staffing issues were escalated to the Director of Quality or the Deputy Director.

Following the issuing of a letter from NHS Improvement (NHSI) in relation to agency spend the Trust had identified that it should reduce spend on all agency (including nursing; medical locums) by 38%. A Project Board had been set up to manage and understand the use of temporary staffing across the Trust. Progress of this work will be reported monthly to the

Committee.

RISK: To the quality and safety of patient care if staffing levels fall below agreed levels or are not flexibly increased if patient acuity increases.

ASSURANCE: The Governance Committee noted the compliance with planned staffing levels for April 2016 and the significant assurance that this provided.

PHYSICAL HEALTH ANNUAL REPORT

Significant assurance was received that the Trust is addressing the physical health needs of its service users in line with national and local policy. There was a clear plan for development and progress was being made. Areas that required further attention had been identified and plans to remedy were being actioned.

The Committee requested that the next Physical Health Annual report should include assessment of how this work had improved the Physical Health of service users along with benchmarking against the performance of other Trusts.

QUALITY IMPROVEMENT IN MENTAL HEALTH

This report offered details regarding the work of the Trust as part of the South of England Improving Quality and Safety in Mental Health Collaborative. The Committee received significant assurance regarding improvements in both mental and physical health care and noted the Trust's commitment to continuous clinical improvement

QUANTITATIVE AND QUALITATIVE RISK AUDIT – QUARTER 3 & 4

This twice yearly Audit offered quantitative and qualitative analysis of the Trust-wide policy on Assessing and Managing Risk and Safety

The quantitative data showed continued 100% compliance for inpatients, 85% for patients within community settings

The qualitative assessments indicated that risk management practice had improved since the previous audit with 88% of requirements being met, compared to 79% in the previous quarter. There were some examples of good, robust practice within the records reviewed but also some scope for improvement. There were still some key areas to address which would enhance the overall quality of the risk assessments. These would be reported back to staff and the ongoing audit would continue to identify further emergent themes.

RISK: Failure to comply with Trust Policy may increase possibility of harm to the service user, staff members or others.

ASSURANCE: Significant assurance was received regarding compliance with the Trust policy. Areas for further development have been identified.

LOCALITY GOVERNANCE BRIEFINGS

a) Gloucestershire and Gloucestershire Countywide Localities

There were currently 3 risks on the Localities register; Staffing Compliment for One Stop Teams, Ligature Assessments at Albion Chambers and Burleigh House and the increasing complexity of patients in Mental Health Intermediate Care Team.

There were 3 risks on the Countywide register; complex discharges and delayed transfers of care, recruitment and retention, and high bed occupancy levels above 85%

b) Children and Young People's Services (CYPS)

The final report from the Quality Network for Community CAMHS (children and adolescent mental health services) following the review of CYPS at the end of 2015 had been received. This positive report highlighted a range of achievements and an action plan had been provided.

The top risks in the locality were CYPS performance measures, inability to document indirect recording of consultation activity on RiO (computer record system), non-compliance regarding RiO record keeping standards and increased likelihood of admissions of Under 18's to Wotton Lawn Hospital due to lack of timely access to adolescent psychiatric units.

c) Herefordshire

The top risks on the Locality risk register included

- recruitment, (particularly nursing staff and community teams)
- shortage of Approved Mental Health Practitioners (currently 2 only in Herefordshire). It was noted that the Trust do not have jurisdiction over AMHPS within Herefordshire and it was the LA statutory responsibility to ensure access to an AMHP.

EXPERT REFERENCE GROUP (ERG) EXCEPTION REPORTS

Substance Misuse ERG.

The alcohol detoxification guidelines for Wotton Lawn and Charlton Lane were being reviewed to bring them into line with practice across the General Hospitals.

Forensic and Complex Care ERG. Work has included:

- Consideration of safe interviewing rooms and the ligature audit in community settings.
- A draft paper on locked rehabilitation
- A Liaison and Diversion workshop between 2gether providers and Prospects was taking place.

Physical Health ERG. Work has included:

- Developing ways to share National Early Warning Signs scores between services and on transfer documentation.
- Smoking Cessation work
- Cooperation with the RIO Design Group on recording physical health,

COMPLAINTS ANNUAL REPORT

The Committee noted that the numbers of complaints received during 2015-16 was lower than the previous year (n=131), however the Trust was not an outlier. Whilst the numbers of formal complaints had reduced there was significant assurance that individuals were increasingly prepared to share concerns. This could be evidenced by the increased number of 'concerns' resolved without the formality of the NHS complaints process.

A number of developments for practice development were planned for the coming year including:

- Implementing and evaluating the revised Non-Executive Director audit of complaints
- Ensuring there was reasonable adjustment to the complaint process to raise awareness and ensure it was accessible to everyone using our services particularly older people, children and people with a learning disability.
- Continue to embed learning from complaints in practice and seek assurance that this is disseminated across the Trust.
- Providing training and support to investigators to ensure they are confident in applying national and local best practice for complaint investigation.
- Embedding the new Datix (incident reporting and management tool) web data collection system in practice and utilise the additional functionality to develop and share information with Locality Boards and Clinical Teams.

RISK: Failure to address the complaints of service users may increase the possibility of harm for service users in the future, or lead to damage of Trust performance or reputation.

ASSURANCE: Significant Assurance was received that the Trust had made significant effort to listen to, understand and resolve complaints over the past year.

ASSESSMENT AND CARE MANAGEMENT PROCESSES - AUDIT

The Committee received two audits (quantitative and qualitative) measuring compliance against the Trust's Assessment and Care Management Policy. The quantitative audit sample included 100% sample of service users on open caseload within Gloucestershire and Herefordshire for service users of Children and Young people services (CAMHs in Herefordshire), working age adults and persons with a learning disability in the Audit of Mental Health Intermediate Care Teams.

The quantitative audit detected 48% compliance of standards set by the Assessment and Care Management policy in the Trust.

The qualitative audit demonstrated areas of good practice where staff were delivering person centred acre but there were areas in which information was recorded in the wrong place and therefore not identifiable in the quantitative audit process.

The Committee concluded that the audit demonstrated limited assurance of compliance in respect of the Assessment and Care Management Policy and asked for close monitoring by the Locality Governance Committees.

Actions agreed included:

- To provide Assessment and Care Management Audit exception reports at the Governance Committee quarterly.
- To discuss the limited assurance on these audits at the next Locality Governance Committee with a view to setting up a task and finish group to find a way forward. Representatives would be invited from all services.
- The limited assurance on these audits would be referred to the Executives Committee to provide assurance to the Governance Committee including assurance that risk assessments had been considered.

RISK: If the Trust is not compliant with the Assessment and Care Management Policy there

could be a significant risk with regards the delivery of care.

ASSURANCE: Limited assurance was received regarding areas of compliance of this policy.

CQC COMPLIANCE

A Project Board chaired by the Director of Quality had been established to monitor the CQC Action Plan. Progress will be reported monthly to the Governance committee.

QUALITY REPORT

The Committee received the updated draft of the Quality report and were assured that the process for engagement and external audit of the report were progressing according to plan.

REDUCTION IN RESTRICTIVE INTERVENTIONS

Following the publication of Transforming Care: A national response to Winterbourne View Hospital, DoH (2012), the Department of Health launched the "Positive and Safe" initiative, supported by Positive and Proactive Care: reducing the need for restrictive interventions (DoH, April 2014). In response to this a 2gether NHS Trust Positive and Safe Governance sub-committee was formed in 2015, with a remit to develop and oversee the Trusts organisational strategy for the reduction in restrictive interventions. This sub-committee was continuing to meet and was working to deliver outcomes on a number of work streams; Restrictive Intervention Reduction Plans, Data Quality/ Datix Project, Training and Development and Benchmarking.

RISK: Failure to comply with best practice guidelines on respect of reducing restrictive interventions may increase harm to service users or staff members.

ASSURANCE: Assurance at this time is limited. This is a reflection that much of this work is in its infancy and as such has not had time to make a significant impact. Progress is noted to be positive.

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Martin Freeman **ROLE: Committee Chair**

DATE: 22 April 2016

2gether
Making life better

2gether NHS Foundation Trust

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Development Committee

DATE OF COMMITTEE MEETING: 18 May 2016

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

COUNTYWIDE IT SERVICES BUSINESS CASE

The Committee received a report that provided the supplementary information and assurances requested by the Committee when it considered the CITS business case in February 2016. These assurances centred on the economic case originally put forward, and the evaluation of options. In respect of the economic case, the Committee was reminded that the original business case concerned the replacement of critical network infrastructure located in Gloucestershire Royal Hospital, but which enables an internet connection for the entire Gloucestershire network. The Committee noted that this infrastructure represents a single point of failure, and that replacement equipment could be procured at a lower revenue cost than the existing equipment. The Committee noted that as implementation moved forward final cost estimates had improved slightly meaning that revenue savings would be slightly greater than originally envisaged.

In respect of the evaluation of alternative options the Committee agreed that while replacement of this equipment was appropriate, the original business case ought to have considered other options, such as the feasibility of a 2gether only solution, even if these options were discounted on economic or technical grounds.

The Committee agreed that in hindsight, a business case focussing on the costs and implications solely for 2gether would have been helpful, and asked the Director of Finance and Commerce to include this information in future business cases, and to circulate to the Committee a retrospective one page summary of the implications for 2gether of the CITS business case.

AHPP PRACTICE DEVELOPMENT STRATEGY

The Committee received an updated version of the Allied Health and Psychological Professions Practice Development Strategy, which had been revised in the light of feedback received at a conference event held in March 2016. The Committee welcomed the clarity of the strategy, which had been amended to include key performance indicators and target dates, along with indicative costs where appropriate. The Committee endorsed the revised strategy which would go forward to the May Board for approval.

WORKFORCE AND TRAINING STRATEGY

The Committee received revised versions of the Workforce and Training Strategies which would be presented to the May Board meeting for approval.

The Committee noted the changes made to both documents, and welcomed the links both to other Trust strategies (such as the Information Technology strategy and the wider Organisational Development strategy) and to the work being done in respect of Sustainability and Transformation Plans. The Committee endorsed the strategies for presentation to the

Board.

IMPROVING CARE THROUGH TECHNOLOGY BUSINESS CASE
The Committee received the Improving Care through Technology business case, which set out the products that the Trust intends to develop as part of a wider programme intended to enable staff working in clinical roles to improve care through the use of technology. The business case included information on expected costs, risks, timelines and benefits which had previously been requested by the Committee.

The Committee noted the anticipated benefits envisaged by the business case, which included reduced travelling time, reduced time between service user contact and updating of electronic health records clinical systems, improved productivity and anticipated financial savings. The Committee recognised that achievement of these benefits was contingent upon delivery of a wider organisational change programme. However, the Committee was assured that there is a good level of buy-in amongst clinical staff, and that an appetite exists to bring about these changes. The Committee also received assurance regarding the project management structure in place to support delivery of the business case, and noted that the Director of Finance and Commerce is the lead Executive for the programme, which is being managed overall by the Programme Management Office to ensure consistency with related OD projects.

The Committee welcomed the business case and endorsed it for presentation to the May Board.

CAPITAL PROGRAMME REVIEW
The Committee noted the capital programme position as of month 1 which showed that capital expenditure was £286k for the month, £360k behind plan. The Committee noted however that once the purchase of the new Gloucester Team base had been completed, this would put the Trust ahead of plan.

The Committee noted the scheduled disposals for the year, and agreed to receive a report regarding Holly House at the next meeting. The Committee noted that disposal of Rikenel would be considered once the Gloucester Team base had been completed.

COMMERCE REPORT
The Committee received the Commerce Report and noted progress in the marketing of IAPT training materials. The Committee also received information on a number of development opportunities, and noted that these had not been pursued due to limited Executive capacity.

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Jonathan Vickers **ROLE: Committee Chair**

DATE: 18 May 2016

Agenda item **20** **Enclosure** **Paper O**

Report to: Trust Board, 26 May 2016
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

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

1. PURPOSE

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

This report is for information only.

2. CHAIR'S KEY ACTIVITIES

- Chairing two Board meetings in Gloucester
- Chairing an Appointments and Terms of Service Committee
- Attending a Development Committee meeting
- Attending the Gloucester Strategic Forum at Gloucestershire Clinical Commissioning Group's offices in Brockworth
- Attending a Gloucestershire Sustainability and Transformation Plan Board
- Participating in the recruitment of a Chair for Gloucestershire Clinical Commissioning Group
- Meeting with the Accountable Officer of Gloucestershire Clinical Commissioning Group in Brockworth
- Attending Herefordshire Health Overview and Scrutiny Committee in Hereford
- Teleconferencing with the newly appointed Chair of Gloucestershire Clinical Commissioning Group
- Meeting with the Herefordshire Healthwatch Chair in Ross-on-Wye
- Meeting with the Trust Secretary and Lead Governor to plan the remaining Council meeting for 2016
- Opening the newly refurbished Colliers Court in Cinderford
- Visiting the Honeybourne unit in Cheltenham
- Attending a colleague's funeral at Gloucester Crematorium

- Visiting Oak House in Hereford
- Attending an NHS Improvement South event for Chairs in Southampton
- Meeting with the Principal and Chief Executive Officer of Gloucestershire College
- Attending a Mental Health Network dinner in London with the Chair of NHS Improvement
- Visiting Ashford and St Peters Hospital NHS Foundation Trust in Surrey
- Visiting Surrey and Borders Partnership NHS Foundation Trust in Surrey
- Meeting with representatives of Gloucestershire Domestic Abuse Support Service together with the Trust's Head of Safeguarding
- Leading a development afternoon for Gloucestershire GP Specialty Trainees (ST3s) for the Severn Deanery
- Attending a Unitary Council event hosted by GlosFirst Local Economic Partnership in Cirencester
- Meeting with the Bishop of Gloucester
- Attending the Inauguration of the High Sheriff and the Annual Legal Service at Gloucester Cathedral
- Attending the opening of the new Police Station in Cheltenham
- Attending the Queen's 90th Birthday Service in Gloucester Cathedral
- Attending a celebratory event for the outgoing Chair of Gloucestershire Clinical Commissioning Group
- Attending a Diocesan community cohesion event on behalf of the NHS
- Meeting with an artist who has provided art for Rikenel
- Chairing the conference launching the Trust's Allied Health and Psychological Professions Strategy
- Meeting to discuss the Recognising Outstanding and Service Contribution Awards for 2016 and to plan for 2017
- Attending a leaving presentation for the Trust's outgoing Medical Director
- Participating in Non-Executive Director recruitment
- Participating in Non-Executive Directors' appraisals
- Meeting with newly appointed Non-Executive Directors
- Participating in my annual appraisal with the Senior Independent 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

Martin Freeman

Since his last report Martin Freeman has;

- Attended two Board meetings
- Prepared for and chaired two Governance Committees
- Prepared for and attended an Audit Committee
- Meeting with Chair for my annual appraisal
- Meeting with Director of Quality regarding work of Governance Committee
- Meeting with Nikki Richardson and Service Experience Team to review template for NED audit of complaints.
- Member of a Mental Health Act Managers hearing
- Attended a Service Experience Committee held in Hereford. Focus of meeting related to use of Care Plans.
- Participated in a discussion with representative of Human Resources department

regarding 2GT Clinical Excellence Awards programme and completed assessment of applications as a panel member
- Participation in the Board workshop on risk management
- Prepared for and chaired the May Mental Health Legislation Scrutiny Committee
- Prepared for and attended meeting of Delivery Committee
- Prepared for and attended meeting of Council of Governors
- Meeting with Jane Melton and Vic Godding regarding Governors working party on induction
- Prepared for and attended as panel member interview for Non-Executive Director position.
- Attended Gloucestershire Strategic Transformation Plan Engagement Event
- Meeting with Marcia Gallagher as part of her induction programme
- Completed NED audit of Complaints Quarter 3 2015/16

Charlotte Hitchings
Since her last report Charlotte Hitchings has;
- Prepared for and attended the March Board meeting
- Prepared for and chaired the March Delivery Committee
- Prepared for and attended the April Development Committee
- Prepared for and attended the April Audit Committee
- Conducted the Chair's appraisal
- Met with the Chair for own appraisal discussion

Jonathan Vickers
Since his last report Jonathan Vickers has;
- prepared for and attended a board meeting
- attended the opening of Colliers Court
- prepared for and attended an audit committee meeting
- held discussions with the director of finance on the Gloucester hub project
- prepared for and attended a meeting with the chair for my annual appraisal
- prepared for and chaired a meeting of the development committee
- chaired an interview panel for consultant recruitment
- prepared for and attended a board meeting
- held discussions with the new audit committee chair
- attended a MHAM panel
- discussed development committee matters with the director of Finance
- prepared for and chaired a meeting of the development committee
- held discussions with colleagues on the 15/16 accounts
- prepared for and attended a meeting of the audit committee

Nikki Richardson
Since her last report Nikki has;
- Prepared for and attended at Board meeting
- Panel member MHAM hearing
- Attended a Stroud LD team meeting
- Prepared and attended an Audit Committee
- Attending two meetings to review NED complaints assurance process
- Prepared and attended a Hereford Community Collaborative
- Meeting with a Non-Executive Director from the Wye Valley Trust
- Prepared for and attended a Governance Committee
- Prepared for and attended a Delivery Committee

- Prepared for and attended a Service Experience meeting
- Meeting with the Head of Speech and Language Therapy
- Visit to Ambrose House
- Meeting to discuss AHPP strategy
- Meeting with Trust Chair
- Meeting with new NED
- Preparation for and attendance at Governance Committee
- Preparation for and Chairing of Delivery Committee
- Participation in discussion groups for NED recruitment
- Telephone discussions re Community Collaborative Board
- Attendance at launch of Gloucestershire STP
- Attendance at CoG
- Preparation for and attendance at Audit Committee
- Preparation for and attendance at Board

Marcia Gallagher

Since her last report Marcia has;

- Met with the Chair of the Development Committee as part of the Non- Executive Director induction process
- Met with the Chair of the Charitable Funds Committee and Co- Chair Community Collaborative as part of the Non- Executive Director induction process
- Met with the Chair of the Governance Committee as part of the Non-Executive Director induction process
- Met Director of Finance as part of the Non –Executive Director induction process
- Attended a Council of Governors meeting
- Met with the Director of Finance to review the Annual Accounts
- Prepared for and Chaired the Audit Committee
- Prepared for and attended the May Board Meeting

4. OTHER MATTERS TO REPORT

The recruitment process for the Non-Executive Director vacancy continues on plan. I will update the Board at the meeting.

Agenda item **21** **Enclosure** **Paper P**

Report to: Trust Board, 26 May 2016
Author: John McIlveen, Trust Secretary
Presented by: John McIlveen, Trust Secretary

SUBJECT: **USE OF THE TRUST SEAL**

PURPOSE

To present the Board with a report on the use of the Trust Seal for the period January to March 2016 (Q4 2015/16).

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 used twice:

Transfer of Pear Tree Close to Kiddiwinks Nursery
Signed: Shaun Clee, Chief Executive and Andrew Lee, Director of Finance and Commerce
Date: 18 January 2016

Renewal Lease of Rikenel Pharmacy between 2gether and Badhams Pharmacy
Signed: Andrew Lee, Director of Finance and Commerce and Carol Sparks, Director of OD
Date: March 2016

RECOMMENDATIONS

The Board is asked to note the use of the Trust seal for the period January – March 2016