[2]GETHER NHS FOUNDATION TRUST

BOARD MEETING

THURSDAY 29 SEPTEMBER 2016 AT 10.00AM

TRUST HQ, RIKENEL

AGENDA

10.00	1	**Apologies**	
	2	**Declaration of Members Interests**	
10.05	3	**Minutes of the Board meeting held on 28 July 2016**	**PAPER A**
	4	**Action Points and Matters Arising**	
10.10	5	**Questions from the Public**	
IMPROVING QUALITY			
10.15	6	**Patient Story Item – Young Person's Experience**	**PRESENTATION**
10.45	7	**Performance Dashboard Report**	**PAPER B**
10.55	8	**Quality Report Quarter 1**	**PAPER C**
11.05	9	**Service Experience Report Quarter 1**	**PAPER D**
11.25	10	**Safe Staffing 6 Monthly Update**	**PAPER E**
11.25	11	**Infection Control Annual Report**	**PAPER F**
11.35	12	**Medical Revalidation Annual Report**	**PAPER G**
11.45	13	**Transition of Patients in line with Engagement, Activity and Physical Health (EAP)**	**VERBAL**
BREAK – 11.55AM			
IMPROVING ENGAGEMENT			
12.05	14	**Workforce Race Equality Standard Report**	**PAPER H**
12.15	15	**Chief Executive's Report**	**PAPER I**
IMPROVING SUSTAINABILITY			
12.25	16	**Summary Financial Report**	**PAPER J**
12.30	17	**Audit Committee Annual Report**	**PAPER K**
12.35	18	**Board Committee Summaries** • Audit Committee – August • Delivery Committee – July, August and September (Verbal) • Governance Committee – July, August and September (Verbal) • MHLS Committee – September (Verbal)	**PAPER L1** **PAPER L2, L3** **PAPER L4, L5**

INFORMATION SHARING (TO NOTE ONLY)			
12.55	19	**Chair's Report**	**PAPER M**
	20	**Council of Governor Minutes – July 2016**	**PAPER N**
12.55	21	**Any Other Business**	
13.00	22	**Date of Next Meeting** Thursday 24 November 2016 at The Kindle Centre, Hereford	

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
28 JULY 2016

PRESENT

Ruth FitzJohn, Trust Chair
Stephen Andrews, Deputy Director of Finance and Commerce
Shaun Clee, Chief Executive
Marie Crofts, Director of Quality
Dr Chris Fear, Medical Director
Martin Freeman, Non-Executive Director
Marcia Gallagher, Non-Executive Director
Charlotte Hitchings, Non-Executive Director
Jane Melton, Director of Engagement and Integration
Colin Merker, Director of Service Delivery
Quinton Quayle, Non-Executive Director
Nikki Richardson, Non-Executive Director
Carol Sparks, Director of Organisational Development
Jonathan Vickers, Non-Executive Director

IN ATTENDANCE

Hilary Bowen, Member of the Public
David Farnsworth, Community Services Director, One Herefordshire
Anna Hilditch, Assistant Trust Secretary
Frances Martin, Director of Transformation
John McIlveen, Trust Secretary
Jeanette Wilkins, Otsuka Pharmaceuticals

1. WELCOMES, APOLOGIES AND INTRODUCTIONS

1.1 Apologies were received from Andrew Lee and Duncan Sutherland.

2. DECLARATIONS OF INTERESTS

2.1 The Director of E&I informed the Board that her Honorary Professorship at Queen Margaret's University in Edinburgh had been extended for a further 3 years.

2.2 The Chief Executive advised that he had been made a Fellow of the Royal Society of Arts for his services to health.

2.3 The Director of Quality had been appointed as a Trustee of the Board (yet to be constituted) of the University Technical College (UTC).

3. MINUTES OF THE MEETING HELD ON 26 MAY 2016

3.1 The minutes of the meeting held on 26 May were agreed as a correct record.

4. MATTERS ARISING AND ACTION POINTS

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

5. QUESTIONS FROM THE PUBLIC

5.1 There were no questions received from members of the public.

6. PATIENT STORY PRESENTATION

6.1 The Board welcomed Pam and Richard to the meeting who gave a very honest and reflective account of their experiences of the early symptoms of Dementia, their search for a diagnosis, post diagnosis support and their involvement in Dementia research.

6.2 Pam and Richard live on the border of Gloucestershire and Worcestershire and were fortunate enough to see their GP in Gloucestershire who referred them to 2gether. The referral to Managing Memory was made; however, it took 4 months for an initial appointment and then a further 4 months for a Consultant appointment. Richard said that after researching the signs and symptoms for such a long time it was somewhat of a relief for Pam to get a formal diagnosis of Posterior Cortical Atrophy (PCA) as "if I know what it is, I can work out how to live with it".

6.3 Richard said that the diagnosis services had been very helpful, offering Pam lots of tests and lots of information. He said that they had been treated with openness and kindness and were offered support throughout the diagnosis process.

6.4 Eleven months on from the diagnosis, Richard informed the Board that both himself and Pam had carried out lots of training with both 2gether and Carers Gloucestershire on living well with dementia and positive caring.

6.5 Richard advised that there was a lot of information that people could view about dementia, and PCA in particular; however, he said that there was no one place to go and no "one" organisation to seek guidance from and this lack of integration had proved difficult to navigate. However, University College London had a PCA support group which Richard said had been excellent and he and Pam had now set up a local PCA support group in Gloucestershire (Stow-on-the-Wold) that met quarterly for people to come along and talk about their experiences.

6.6 Pam said that she had enrolled on the research programme with 2gether and had been very happy to get involved. She said that contributing to research felt like she was "doing something for the future" and was helping to develop and improve things for people in the future by broadening people's knowledge.

6.7 Richard summarised some of the key points that he wished the Board to take away:

- Patients need a proper diagnosis and this needs to be specific, especially for early-onset dementias
- Diagnosis needs to be timely as patients cannot move forward without this
- More is needed to demonstrate that things are progressing given the long waiting lists as patients start to get feelings of helplessness
- Clinical staff to understand how service users require information and when, and be open and verbalise their thinking of what could be wrong
- General support offered by services has been helpful but access to support groups have been key
- Support needs to be accessible and integrated – organisations need to know about services available in other places and there is a need for signposting
- Think about ways of improving expectation management of patients e.g., tell them how long they will need to wait for a referral and where they can access support groups

6.8 Martin Freeman strongly agreed with the point that early diagnosis was vital, and specifically the type of dementia in question. Martin asked how 2gether could get more people involved in research studies. It was noted that people did want to be involved; however, there was a misunderstanding about "research", noting that this included practice based studies and not simply drug trials. There was a need to educate people about the types of research trials that were carried out. The Director of E&I suggested that this might be a helpful topic to discuss at Pam and Richard's next PCA Support Group to get the research message out to potential contributors.

6.9 The Director of Quality asked whether there was anything that the Trust could do to improve its letters or information. Pam said that she would prefer that people not use the word "dementia" as this was a frightening term and had a lot of stigma around it.

6.10 The Medical Director noted a point raised by Richard earlier in the discussion that following the formal diagnosis they had gone home and "googled" it. He queried whether the Trust had provided them with sufficient information at the appointment. Richard said that there was no leaflet available specifically for PCA and there was not enough time at the appointment for them to receive all of the necessary information. It was agreed that this needed to be thought about going forward as the Medical Director added that the information on some websites could be alarming and patients needed to be supplied with as much relevant information as possible at the point of diagnosis.

6.11 Quinton Quayle asked Pam and Richard if there was one thing that they could change about the process for referral and diagnosis, what this would be. Richard said that when the referral to Managing Memory was made via the GP a letter was received back saying that they had been added to the waiting list. He suggested that it would be much more helpful by way of managing expectations if this referral letter could include some indication of the waiting time and when the appointment was likely to take place. The Chief Executive said that there was focus on waiting lists nationally and work was underway to try and write to people and tell them exactly how long they would be waiting and to make clear the places to get support in the interim.

6.12 The Board thanked Pam and Richard for coming and talking so openly about their experiences. Both said that they had welcomed the opportunity.

7. PERFORMANCE DASHBOARD

7.1 The Board received the performance dashboard report which set out the performance of the Trust for the period to the end of May 2016 against Monitor, Department of Health, Contractual and CQUIN key performance indicators. Of the 162 contractual measures, 98 were reportable for May with 77 being compliant and 18 non-compliant at the end of the reporting period. 3 were Not Yet Available or Under Review. The information team were working with operational colleagues to build and implement reporting solutions to report on these 3 indicators which would be included in future reporting. The Board noted that this report had been received and scrutinised in detail at the June Delivery Committee meeting.

7.2 The Director of Service Delivery asked the Board to note that a number of indicators were duplicated as they were included in either Monitor or Department of Health indicators, as well as local commissioner contract indicators. The Delivery Committee had discussed this and had agreed that future performance dashboard reports would only show unique indicators, referencing where these were duplicated.

7.3 Where non-compliance had highlighted issues within a service, Service Directors were taking the lead to address issues with a particular focus continuing to be on IAPT services which accounted for 6 of the 18 non-compliant indicators. Work was ongoing to further understand the service issues and to develop plans to improve these indicators. A more detailed report on IAPT would be received later in the meeting.

7.4 The Board noted that a graph had been added to the report which showed the percentage compliance by month at the time of reporting, with the previous year's compliance included as a comparator. Charlotte Hitchings informed the Board that she had asked that a further line be added to the graph to show actual compliance against the Key Performance

Indicators, noting that late data entry and data quality checks often meant that final month-end compliance was different from that received at the meetings. This would be included in future reports.

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

8. CHIEF EXECUTIVE'S REPORT

8.1 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.

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

8.3 Jonathan Vickers noted that the Trust was asking staff to move toward different ways of working, for example with the new office arrangements at Pullman Place, and the "improving care through technology" and "digital dictation" projects, and asked whether enough was being done to support staff through the OD aspect of these changes; he also noted the reference in the report to issues with Trust mobile phones not being compatible with the new Trust Corporate Wi-Fi and suggested that this was not a helpful start. The Director of OD informed the Board that those staff members moving into the Gloucester Hub had already made changes to their working practices to include hot desking and that a Workforce Workstream was underway and focus groups had been carried out with teams where the new technologies would be introduced. The Chief Executive said that supporting staff through these changes would be one of the Trust's key priorities for the coming year. The move to the Gloucester Hub was a positive step and feedback from staff in the existing Hubs in Stroud and the Forest had been excellent.

8.4 In terms of IT, Martin Freeman advised that he had participated in a Board visit to the 2gether IT team earlier in the week. He said that the team had a strong commitment to change; however, there were some concerns about moving into strategic partnerships and losing local ownership.

8.5 Nikki Richardson noted that the Delivery Committee had received an update on progress against the CLDT Action Plan. She said that the Committee was concerned about the lack of sign up to this plan in the wider system. It was appreciated that the relevant teams were currently being reconfigured within the CCG and Local Authority, however, this had been a difficult and long review and there was a need to ensure that staff remained fully briefed on the position. The Director of Quality advised that she had recently met with staff at Westridge and Hollybrook to discuss this with them and would be taking on board some of their suggestions. The Board noted these concerns but agreed that the Delivery Committee should continue to lead on monitoring progress with this.

9. SUMMARY FINANCIAL REPORT

9.1 The Board received the Finance Report that provided information up to the end of June 2016. The month 3 position was a surplus of £70k compared to the planned surplus of £6k. The budgets had been revised to include the £650k Sustainability and Transformation Fund

monies that have been allocated to the Trust. One quarter of this fund has been included in the month 3 position. The Trust was allocated £650k from the Sustainability and Transformation Fund (STF) by NHS Improvement. The Trust also had its 2016/17 control total of a surplus of £4k adjusted upward by £650k to a revised 2016/17 revenue control total of £654k surplus. The month 3 forecast outturn is a £654k surplus, excluding impairments, as per the revised revenue control total and Trust budgets. The Trust is anticipating it will receive the full allocation from the STF.

9.2 The Trust has a Financial Sustainability Risk Rating of 4, the highest rating achievable.

9.3 The Trust has a straight line forecast agency spend of £5.04m at month 3, significantly above the £3.404m control total. A number of initiatives had commenced that are anticipated to reduce this forecast in the coming months. The Deputy Director of Finance and Commerce advised that more detailed information around these agency initiatives would be presented to the Board later in the meeting.

9.4 NHS Improvement has issued a new consultation document on changes to the Foundation Trust performance regime for next year which the Trust has responded to.

9.5 The Board noted that the purchase of the Gloucester Hub at Pullman Place had now gone through so the Trust was ahead of its capital programme.

9.6 The Board noted the summary Finance Report for the period ending June 2016.

10. IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT)

10.1 The Board received a report which provided an overview of issues relating to IAPT services in both Gloucestershire and Herefordshire. The Board noted that IAPT services in both counties had received a diagnostic review by the NHS Improvement (NHSI) IAPT Intensive Support Team (IST) which had resulted in a number of recommendations for both CCG Commissioners and the Trust to take forward.

10.2 Both Services were found to be under resourced and the review identified key areas of concern for both counties relating to Recovery and Access rates, Waiting Times, Staff Productivity, Service Capacity and resources and Waiting List Back log clearance. In Gloucestershire the IST had advised that the primary mental health nursing part of the service did not provide IAPT compliant interventions, therefore activity data for this part of the service should not be included in the IAPT data set (this was actioned from April 2016 onwards). This had impacted both access and recovery rates in Gloucestershire

10.3 The Board noted that the review had identified insufficient capacity to meet the national standards in both services, with Herefordshire in particular struggling to meet demand. Commissioners were recommended to review levels of investment and it was reported that a project team was now in place and Service Improvement Plans, including county specific actions had been developed with Commissioners. The Director of Service Delivery confirmed that additional funding had now been agreed with both commissioners, with £130k investment in Herefordshire and £1.2m in Gloucestershire.

10.4 The Director of Service Delivery advised that the Trust had presented its IAPT Service Improvement Plans at a meeting with IST colleagues and commissioners and these had been well received and they had been supportive, noting however that this was a theoretical model at this stage. Monthly reports would be run to ensure that trajectories remained on track and that early warnings could be identified.

10.5 It was reported that the Trust now had a much improved understanding and oversight of how to deliver an excellent service and actions were in place to deliver this. The IAPT System was now live, dynamic and updated daily. Long waiters had been identified and waiting lists were improving. A monthly IAPT report would be presented to the Delivery Committee going forward for assurance on progress and a whole service assurance report would be brought to the Committee in August.

10.6 Ruth FitzJohn said that this offered good assurance that as a Board our systems had drawn out these problems and had therefore made it possible to seek a review.

11. QUARTERLY REPORTING TO MONITOR – QUARTER ONE

11.1 This quarterly Monitor Board report for quarter 1 – April to June 2016 – outlined Monitor's key developments and requirements, the latest published Monitor risk ratings for the Trust and the quarter 1 compliance report in line with the Risk Assessment Framework. The Board was asked to note that Monitor and the Trust Development Authority had merged to form NHS Improvement (NHSI). Future quarterly reports would therefore be titled NHS Improvement Quarterly Monitoring Submission.

11.2 The latest Monitor risk ratings for the Trust were Financial Sustainability Risk (3) and Governance (Green). The Board noted that all of the Quarter 1 Board and Governor changes had been reported in accordance with Monitor's requirements.

11.3 The Deputy Director of Finance and Commerce informed the Board that all of the Trust's targets had been achieved, with the exception of IAPT performance; however, as already advised a detailed recovery plan was in place and had been shared with NHSI.

11.4 As part of the Quarter 4 submission the Board had agreed to include an additional note regarding 7 day and 48 hour follow up after discharge targets following a reporting error that had been picked up as part of the audit on the Quality Report. The Deputy Director of Finance and Commerce informed the Board that this had been done and it was agreed that a follow up note be included again this time setting out the work that had been done to correct this position and the Trust's current performance against this target.

ACTION: Follow up note to be included in the Monitor Qrtly return setting out the work that had been done to correct the 48 hour and 7 day follow up position and the Trust's current performance against this target.

11.5 Given the discussions that had taken place it was agreed that the following Governance statement to Monitor be made:

The Board:

a) Agrees the financial compliance statement as recommended following consideration of the Board Finance report.
b) Confirms to Monitor that for Quarter 1 there is compliance with the governance requirements as outlined in this report and can confirm that:
'The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards'.
c) Note that the Quarter 1 reporting on suicides, homicides, absconsions and never events will be submitted to our Monitor Relationship Manager as outlined in this report.

12. BOARD COMMITTEE REPORT – MH LEGISLATION SCRUTINY COMMITTEE

12.1 Martin Freeman presented the summary report from the MH Legislation Scrutiny Committee meeting held on 6 July 2016 and noted the key points raised during the meeting and the assurance received by the Committee.

12.2 The Committee received a report summarising some of the key issues raised by the Mental Health Act Managers following hearings. Martin Freeman noted that there had been two issues raised relating to the availability of advocates. The Committee requested that an Advocacy Assurance report be brought to the Mental Health Legislation Scrutiny Committee at the November meeting.

12.3 The Committee also received an update on the current national debate regarding the Deprivation of Liberty Safeguards. The DoLS procedures were reviewed by the Law Commission in 2015 and interim guidance was produced in May 2016. This guidance identified that the new scheme would not be available for use in mental health hospitals and there would not be any additions into the Mental Health Act (MHA). Existing powers of the MHA should be used for compliant incapacitated patients. In the meantime, the use of DoLS within a psychiatric setting was suggested by some of the legal advisors to be non-lawful. Committee members considered the impact that these changes may have on both service users and staff. It was thought unlikely to have a direct impact regarding the care of service users although concern was expressed that this may result in more service users needing to be subject to the Mental Health Act. Staff members were understandably concerned about the changing guidelines; however, significant assurance was given to the Board that these issues were being considered within the Trust and appropriate legal advice requested. It was suggested that this issue be considered for referral to the Risk Register.

ACTION: Changes in guidance around DoLS to be reviewed and considered for referral to the Trust's Risk Register is necessary

13. BOARD COMMITTEE REPORTS – DELIVERY COMMITTEE

13.1 The Board received the summary report from the Delivery Committee meeting held on 29 June 2016 and noted the key points raised during the meeting and the assurance received by the Committee.

13.2 Charlotte Hitchings provided a verbal report from the Delivery Committee meeting held on 27 July. 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 to the end of June 2016. Of the 158 contractual measures, 113 were reportable in June with 101 compliant and 9 indicators non-compliant at the end of the reporting period, 3 indicators were not yet available. Particular focus continued to be on IAPT services which accounted for 5 of the 9 non-compliant indicators.
- 3 Herefordshire measures that were non-compliant in May were now compliant which was excellent.
- A new Social Care indicator "Percentage of service users asked if they have a carer" was currently non-compliant. This was the first time this indicator had been reported, with the new data collection form going "live" on RiO two months ago. The Committee was assured that service users were being asked this question but this needed to be evidenced and recorded in the right place on RiO. A random sample manual Audit would be carried out and a reasonable trajectory for compliance against this indicator would be agreed.

- The Committee received an update on progress with the IAPT developments
- The CLDT Action plan was received and the Committee was concerned about the lack of progress and engagement with commissioners. An update would be received in October
- A report on workforce indicators was received and the Committee noted a lack of assurance around hitting these targets. A renewed focus on appraisal compliance was suggested, to be taken forward via the Executive Committee.

14. BOARD COMMITTEE REPORTS – GOVERNANCE COMMITTEE

14.1 Martin Freeman presented the summary report from the Governance Committee meeting that had taken place on 17 June 2016. One of the key issues raised at the meeting related to Fire safety training compliance. The Director of Quality informed the Board that she had raised this at the Executive Committee and reported that current compliance was now 73% of Herefordshire staff trained and 81% in Gloucestershire. She offered the Board assurance that all members of staff had received basic Fire training and this compliance related to refresher training. It was noted that additional training sessions had been arranged and work was underway to enable staff to be released. It was envisaged that full compliance would be achieved by October. Assurance was received that all inpatient unit shifts had an appropriately trained appointed fire officer.

14.2 Following discussion of this item at the Governance Committee, it had been agreed that a new process would be put in place for ensuring that these issues were addressed at the Executive Committee first before being presented at the other Committees. Some reports received by the Committees had not been previously reviewed and there was a need to ensure that the information within them had been scrutinised and appropriate mitigation was in place before being presented.

14.3 A verbal report was given from the meeting held on 15 July 2016 and a full written report would be presented at the next Board meeting.

15. INFORMATION SHARING REPORTS

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

- Chair's Report
- Council of Governors Minutes – March and May 2016
- Use of the Trust Seal – Quarter 1 2016/17

15.2 During July, Ruth FitzJohn had been interviewed by Radio Gloucestershire and a query was raised as to whether Board members and staff could get access to the links to these interviews. The Director of E&I agreed to circulate the link to this interview to all Board members and to look at developing a new section on the Trust's website to post all future interviews of this nature for people to access.

ACTION: Director of E&I to circulate the link to the Chair's interview with BBC Radio Gloucestershire to all Board members and to look at developing a new section on the Trust's website to post all future interviews of this nature for people to access.

16. ANY OTHER BUSINESS

16.1 The Board noted three care homes in the Forest of Dean area where the Crisis Team had been asked to monitor the provision of care to our service users. The Director of Quality reported that these were exceptional circumstances involving vulnerable people and it was

therefore imperative that our staff engaged with this monitoring as vulnerable patients may be at risk. Although it wasn't usual practice to ask the Crisis team to check and assess these service users, owing to such circumstances it was essential to ensure patient safety. The Board was assured however that these concerns related to the continuity of staffing at the homes and did not relate in any way to abuse.

17. DATE OF THE NEXT MEETING

17.1 The next Board meeting would take place on Thursday 29 September 2016 at Trust HQ, Rikenel, Gloucester.

Signed: …….. **Date: …….**
Ruth FitzJohn, Chair

BOARD MEETING
ACTION POINTS

Date of Mtg	Item ref	Action	Lead	Date due	Status/Progress
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	**Complete** Item on the agenda for the September 2016 Board
28 July 2016	11.4	Follow up note to be included in the Monitor Qrtly return setting out the work that had been done to correct the 48 hour and 7 day follow up position and the Trust's current performance against this target.	Andrew Lee	July	**Complete**
	12.3	Changes in guidance around DoLS to be reviewed and considered for referral to the Trust's Risk Register is necessary	Colin Merker/Alan Bourne-Jones	September	**Complete**
	15.2	Director of E&I to circulate the link to the Chair's interview with BBC Radio Gloucestershire to all Board members and to look at developing a new section on the Trust's website to post all future interviews of this nature for people to access.	Jane Melton / Anna Hilditch	September	**Link to interview circulated**

Agenda item 7 **PAPER B**

Report to: [2]gether NHS Trust Board 29th September 2016

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 Report for the period to the end of July 2016**

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

EXECUTIVE SUMMARY:

Overview

This month's report sets out the performance of the Trust for the period to the end of July 2016 against our Monitor, who are now known as NHS Improvement, Department of Health, Contractual and CQUIN key performance indicators.

We have introduced changes to the report to highlight the duplicate performance indicators which appear in both Schedule 4 of our CCG Contractual indicators and in our NHSI or Department of Health Indicators. For ease of Trust wide reporting, we have reported the duplicate indicators within our NHSI or Department of Health performance sections only, but have also included them for information at the end of each Commissioners performance section. This revised presentation hopefully provides a more accurate overall picture of our performance. The duplicated indicators are listed below:

Performance Measure	National Requirement	ID
Zero tolerance MRSA - avoidable	NHS Improvement	1.01
Minimise rates of Clostridium difficile - avoidable	NHS Improvement	1.02
CPA Approach - follow-up within 7 days of discharge	NHS Improvement	1.03
Delayed transfers of care to be maintained at a minimum level	NHS Improvement	1.05
Inpatient admissions gatekept by Crisis	NHS Improvement	1.06
Early Intervention - Referral to Treatment within 2 weeks	NHS Improvement	1.08
IAPT - Referral to Treatment within 6 weeks	NHS Improvement	1.09
IAPT - Referral to Treatment within 18 weeks	NHS Improvement	1.10
Mixed Sex Accommodation Breach	Department of Health	2.18
Under 18 admissions to Adult wards	Department of Health	2.21
All Sis reported within 2 working days of identification	Department of Health	2.25
Interim report for all SIs received within 5 working days	Department of Health	2.26
Final report for all Sis received within 60 working days of identification	Department of Health	2.27

Of the 141 contractual measures, 85 are reportable in July with 74 being compliant and 11 indicators non-compliant at the end of the reporting period. 1 indicator (5.18, CYP-IAPT Dataset) is under review and the Information team are currently working with Commissioning and operational colleagues to build and implement reporting solutions to report on this indicator which will be included in future reporting.

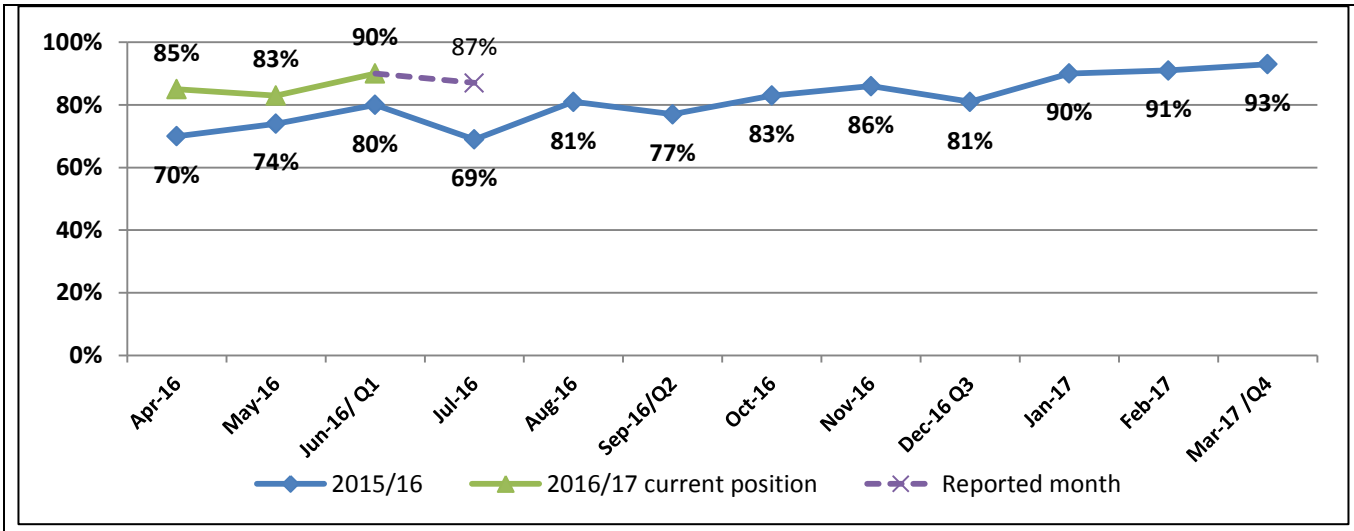
Where performance is not compliant, Service Directors are taking the lead to address issues with a particular focus continuing to be on IAPT services which account for 7 of the 11 non-compliant indicators (1.09, 1.10, 3.18, 3.19, 3.30, 5.08 and 5.09). Work is ongoing to further understand the Service issues and plans which need to be put in place to improve these indicators.

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

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

Indicators Reported in Month and Levels of Compliance							
Indicator Type	Total Measures	Reported in Month	Compliant	Non Compliant	% non-compliance	Not Yet Required	NYA / UR
NHSi Requirements	13	13	11	2	15	0	0
Never Events	17	17	17	0	0	0	0
Department of Health	10	9	8	1	11	1	0
Gloucestershire CCG Contract	56	16	12	4	25	40	0
Social Care	15	12	10	2	17	3	0
Herefordshire CCG Contract	22	18	16	2	11	3	1
CQUINS	8	0	0	0	0	8	0
Overall	141	85	74	11	13	55	1

The following graph shows updated percentage compliance by month and the previous year's compliance as a comparator. We are reporting the previous month as the confirmed final position with the reported month true up to the point of writing this report.



Summary Exception Reporting

The following 11 key performance thresholds were not being met at the end of July 2016:

NHS Improvement Requirements

- 1.09 – IAPT: Waiting times - Referral to Treatment within 6 weeks
- 1.10 – IAPT: Waiting times - Referral to Treatment within 18 weeks

Department of Health Requirements

- 2.21 – No children under 18 admitted to adult in-patient wards

Gloucestershire CCG Contract Measures

- 3.11 – 2G bed occupancy for Gloucestershire CCG patients
- 3.18 – IAPT Recovery rate : Access to psychological therapies should be improved
- 3.19 – IAPT Access rate : Access to psychological therapies should be improved
- 3.30 – IAPT Integrated service: 14 days from referral to screening assessment.

Social Care –Gloucestershire CCG Contract Measures

- 4.06 – Percentage of service users asked if they have a carer
- 4.07 – Percentage who have a carer who has been offered a carer's assessment

Herefordshire CCG Contract Measures

- 5.08 – IAPT Recovery rate – those who have completed treatment and have "caseness"
- 5.09 – IAPT maintain 15% of patients entering the service against prevalence

RECOMMENDATIONS

The Board is asked to:

- Note the Performance Dashboard Report for July 2016.
- Be assured that there is ongoing work to review all of the indicators not meeting the required performance threshold. This includes a review of the measurement and data

quality processes as well as clinical delivery and clinical practice issues.

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

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

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

Reviewed by:		
Colin Merker	Date	July 2016

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

What consultation has there been?		
Not applicable.	Date	

Explanation of acronyms used:	
	AOT Assertive Outreach Team AKI Acute kidney injury ASCOF Adult Social Care Outcomes Framework CAMHS Child and Adolescent Mental health Services C-Diff Clostridium difficile CIRG Clinical Information Reference Group CPA Care Programme Approach CPDG Contract Performance and Development Group CQUIN Commissioning for Quality and Innovation CRHT Crisis Home Treatment CYPS Children and Young People's Services DASH Drug and Alcohol Service Herefordshire ED Emergency Department

	EI Early Intervention EWS Early warning score HoNoS Health of the Nation Outcome Scale IAPT Improving Access to Psychological Therapies IST Intensive Support Team (National IAPT Team) KPI Key Performance Indicator LD Learning Disabilities MHL Mental Health Liaison MRSA Methicillin-resistant Staphylococcus aureus MUST Malnutrition Universal Screening Tool NHSI NHS Improvement NICE National Institute for Health and Care Excellence SI Serious Incident SUS Secondary Uses Service VTE Venous thromboembolism YOS Youth Offender's Service

1. CONTEXT

This report sets out the performance Dashboard for the Trust for the period to the end of July 2016, month four of the 2016/17 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.
    - NHSI Requirements
    - Never Events
    - Department of Health requirements
    - NHS Gloucestershire Contract – Schedule 4 Specific Performance Measures
    - Social Care Indicators
    - NHS Herefordshire Contract – Schedule 4 Specific Performance Measures
    - NHS Gloucestershire CQUINS
    - Low Secure CQUINS
    - NHS Herefordshire CQUINS

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

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

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

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

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

DASHBOARD CATEGORY - NHSI REQUIREMENTS

NHS Improvement Requirements				
	In month Compliance			Cumulative Compliance
	May	Jun	Jul	
Total Measures	13	13	13	13
	4	2	2	2
	9	11	11	11
NYA	0	0	0	0
NYR	0	0	0	0
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month

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

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

Following the recent review of services by the NHSI IST, we have adopted the recommendation that changes the methodology for this indicator. The screening/treatment appointment that has previously been used as the trigger for indicating a patient has entered treatment is now seen as an assessment only and patients are only recorded as entering treatment when they receive a therapeutic intervention.

Revising this indicator to the beginning of this financial year shows that we have a backlog of waiters for treatment that needs to be cleared.

All key stakeholders including NHSI and the Commissioners have been informed and are aware of the current challenges the service faces in clearing the backlog.

This indicator has been red flagged as it requires further work to fully understand the requirements needed before becoming compliant.

Expected compliance: Previously this was unknown but trajectory work indicates compliance is expected in late Q4 / Early Q1 2017-18.

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

Following the recent review of services by the NHSI IST, we have adopted the recommendation that changes the methodology for this indicator. The screening/treatment appointment that has previously been used as the trigger for indicating a patient has entered treatment is now seen as an assessment only and patients are only recorded as entering treatment when they receive a therapeutic intervention.

Revising this indicator to the beginning of this financial year shows that we have a backlog of waiters for treatment that needs to be cleared.

All key stakeholders including NHSI and the Commissioners have been informed and are aware of the current challenges the service faces in clearing the backlog.

This indicator has been red flagged as it requires further work to fully understand the requirements needed before becoming compliant.

Expected compliance: Previously this was unknown but trajectory work indicates compliance is expected in late Q4 / Early Q1 2017-18.

Cumulative Performance Thresholds Not being Met

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

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

Changes to Previously Reported Figures

1.07: New psychosis (EI) cases
The number of new cases in Gloucestershire in May was 4 but reported as 6 due to duplicate entries. The service is ensuring that all staff are entering data on RiO accurately.

Early Warnings / Notes

1.07: New psychosis (EI) cases – Gloucestershire

To date, Gloucestershire have reported 23 new cases against an expected threshold of 24 new cases. As cases do not present evenly across the months, it means compliance fluctuates between months. Work continues to understand what an accurate threshold looks like for both the Gloucestershire and Herefordshire counties. The Committee will be updated once work in this area has been completed.

Services that the Trust can offer are continuing to be promoted with external agencies.
This indicator has been red flagged as it requires further analysis to fully understand the issues and identify the actions required.

NHS Improvement Requirements

ID	Performance Measure (PM)		2015/16 Outturn	May-2016	June-2016	July-2016	Cumulative Compliance
1							
1.01	Number of MRSA Bacteraemias	PM	0	0	0	0	0
		Gloucestershire	0	0	0	0	0
		Herefordshire	0	0	0	0	0
		Combined Actual	0	0	0	0	0
1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs)	PM	0	0	0	0	0
		Gloucestershire	0	0	0	0	0
		Herefordshire	0	0	0	0	0
		Combined Actual	0	0	0	0	0
1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%
		Gloucestershire	95%	100%	99%	97%	98%
		Herefordshire	96%	90%	100%	100%	96%
		Combined Actual	96%	98%	99%	97%	97%
1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%
		Gloucestershire	99%	99%	99%	97%	99%
		Herefordshire	98%	99%	99%	96%	98%
		Combined Actual	99%	99%	99%	97%	99%
1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%
		Gloucestershire	1.0%	1.2%	0.9%	0.0%	0.8%
		Herefordshire	1.2%	2.4%	4.9%	0.8%	2.7%
		Combined Actual	1.0%	1.5%	2.0%	0.2%	1.3%
1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%
		Gloucestershire	99%	100%	98%	100%	99%
		Herefordshire	100%	100%	100%	100%	100%
		Combined Actual	99%	100%	98%	100%	99%
1.07	New psychosis (EI) cases as per contract	PM	72	6	6	6	24
		Gloucestershire	76	4	9	8	23
		PM	24	2	2	2	8
		Herefordshire	41	0	7	3	13
		PM	92	8	8	8	32
		Combined Actual	117	4	16	11	36
1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%
		Gloucestershire	66%	25%	78%	88%	65%
		Herefordshire	61%	N/A	57%	100%	69%
		Combined Actual	64%	25%	69%	91%	67%

NHS Improvement Requirements

ID	Performance Measure		2015/16 Outturn	May-2016	June-2016	July-2016	Cumulative Compliance
1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%
		Gloucestershire	87%	34%	30%	33%	34%
		Herefordshire	95%	52%	50%	54%	57%
		Combined Actual	89%	38%	34%	38%	40%
1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%
		Gloucestershire	99%	89%	89%	88%	89%
		Herefordshire	99%	93%	90%	83%	92%
		Combined Actual	99%	90%	89%	87%	90%
1.11	**MENTAL HEALTH SERVICES DATA SET PART 1 DATA COMPLETENESS: OVERALL**	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.6%	99.8%	99.8%	99.9%	99.8%
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%
		Combined Actual	99.6%	99.8%	99.9%	99.9%	99.8%
1.11a	Mental Health Services Data Set Part 1 Data completeness: DOB	PM	97%	97%	97%	97%	97%
		Gloucestershire	100.0%	100.0%	100.0%	100.0%	100.0%
		Herefordshire	100.0%	100.0%	100.0%	100.0%	100.0%
		Combined Actual	100.0%	100.0%	100.0%	100.0%	100.0%
1.11b	Mental Health Services Data Set Part 1 Data completeness: Gender	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	99.9%	99.9%	99.9%	99.9%
		Herefordshire	100.0%	100.0%	100.0%	100.0%	100.0%
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%
1.11c	Mental Health Services Data Set Part 1 Data completeness: NHS Number	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	99.9%	99.9%	99.9%	99.9%
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%
1.11d	Mental Health Services Data Set Part 1 Data completeness: Organisation code of commissioner	PM	97%	97%	97%	97%	97%
		Gloucestershire	98.8%	100.0%	100.0%	100.0%	100.0%
		Herefordshire	99.9%	100.0%	100.0%	100.0%	100.0%
		Combined Actual	99.1%	100.0%	100.0%	100.0%	100.0%
1.11e	Mental Health Services Data Set Part 1 Data completeness: Postcode	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.5%	99.7%	99.7%	99.7%	99.7%
		Herefordshire	99.6%	99.7%	99.8%	99.7%	99.7%
		Combined Actual	99.5%	99.7%	99.7%	99.7%	99.7%
1.11f	Mental Health Services Data Set Part 1 Data completeness: GP Practice	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.1%	99.3%	99.4%	99.3%	99.3%
		Herefordshire	99.5%	99.6%	99.7%	99.6%	99.6%
		Combined Actual	99.2%	99.3%	99.5%	99.4%	99.4%

NHS Improvement Requirements

ID	Performance Measure		2015/16 Outturn	May-2016	June-2016	July-2016	Cumulative Compliance
1.12	MENTAL HEALTH SERVICES DATA SET PART 2 DATA COMPLETENESS : OVERALL	PM	50%	50%	50%	50%	50%
		Gloucestershire	97.9%	97.5%	97.4%	97.4%	97.5%
		Herefordshire	95.3%	94.8%	94.4%	94.4%	94.7%
		Combined Actual	97.4%	97.0%	96.9%	96.9%	97.0%
1.12a	Mental Health Services Data Set Part 2 Data completeness: CPA Employment status last 12 months	PM	50%	50%	50%	50%	50%
		Gloucestershire	97.2%	96.3%	96.5%	96.3%	96.4%
		Herefordshire	93.7%	93.0%	92.4%	92.6%	92.8%
		Combined Actual	96.4%	95.7%	95.8%	95.7%	95.8%
1.12b	Mental Health Services Data Set Part 2 Data completeness: CPA Accommodation Status in last 12 months	PM	50%	50%	50%	50%	50%
		Gloucestershire	97.1%	96.6%	96.3%	96.2%	96.5%
		Herefordshire	93.8%	93.3%	92.7%	93.0%	93.2%
		Combined Actual	96.5%	96.0%	95.6%	95.7%	95.7%
1.12c	Mental Health Services Data Set Part 2 Data completeness: CPA HoNOS assessment in last 12 months	PM	50%	50%	50%	50%	50%
		Gloucestershire	99.6%	99.5%	99.5%	99.5%	99.5%
		Herefordshire	98.5%	98.2%	97.9%	97.8%	98.0%
		Combined Actual	99.4%	99.2%	99.2%	99.2%	99.2%
1.13	Learning Disability Services: 6 indicators: identification of people with a LD, provision of information, support to family carers, training for staff, representation of people with LD; audit of practice and publication of findings	PM	6	6	6	6	6
		Gloucestershire	6	6	6	6	6
		Herefordshire	6	6	6	6	6
		Combined Actual	6	6	6	6	6

DASHBOARD CATEGORY – DEPARTMENT OF HEALTH PERFORMANCE

DoH Performance				
	In month Compliance			Cumulative Compliance
	May	Jun	Jul	
Total Measures	27	27	27	27
🔴	2	0	1	2
🟢	25	25	25	24
NYA	0	0	0	0
NYR	0	1	0	0
UR	0	0	0	0
N/A	0	1	1	1

Performance Thresholds not being achieved in Month

2.21: No children under 18 admitted to adult inpatient wards
There was one under 18 admission in July in Herefordshire. The patient was admitted on Section 2 due to presenting with symptoms of self-harm, suicidal behaviour and aggression. Whilst in Stonebow, presentation remained very challenging which led to a change in emphasis in terms of placement and it was felt that a PICU placement was more appropriate. The patient was transferred, when an appropriate bed became available, 9 days after first being admitted.

Cumulative Performance Thresholds Not being Met

2.21: No children under 18 admitted to adult inpatient wards
Including this admission in July there have been 5 admissions to date, 1 admission in Gloucestershire and 4 in Herefordshire.

2.26: Interim report for all SIs received within 5 working days of identification
2 initial reports submitted late in May have resulted in this indicator being cumulatively non-compliant.

Changes to Previously Reported Figures
None

Early Warnings
None

DOH Never Events

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

DOH Requirements

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

DOH Requirements

ID	Performance Measure		2015/16 Outturn	May-2016	June-2016	July-2016	Cumulative Compliance
2.24	Serious Incident Reporting (SI)	Glos	32	3	4	0	13
		Hereford	11	1	0	1	3
2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%
		Gloucestershire	100%	100%	100%	N/A	100%
		Herefordshire	100%	100%	N/A	100%	100%
2.26	Interim report for all SIs received within 5 working days of identification (unless extension granted by CCG)	PM	100%	100%	100%	100%	100%
		Gloucestershire		33%	100%	N/A	85%
		Herefordshire		100%	N/A	100%	100%
2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM	100%	100%	100%	100%	100%
		Gloucestershire		NYR	NYR	100%	100%
		Herefordshire		NA	NA	NYR	NYR
2.28	SI Report Level 3 - Independent investigations - 6 months from investigation commissioned date	PM	100%	100%	100%	100%	100%
		Gloucestershire		N/A	N/A	N/A	N/A
		Herefordshire		N/A	N/A	N/A	N/A
2.29	SI Final Reports outstanding but not due	Gloucestershire	3	2	4	0	7
		Herefordshire	0	0	0	1	1

DASHBOARD CATEGORY – GLOUCESTERSHIRE CCG CONTRACTUAL REQUIREMENTS

Gloucestershire Contract				
	In month compliance			Cumulative Compliance
	May	Jun	Jul	
Total Measures	56	56	56	56
	2	5	4	4
	14	19	12	20
NYA	0	3	0	3
NYR	39	27	39	27
UR	0	0	0	0
N/A	1	2	1	2

Performance Thresholds not being achieved in Month

3.11: 2G bed occupancy for Gloucestershire CCG patients

Performance for July is 90% against an expected threshold of more than 91%. A drop in the total number of occupied bed days contributed to non-compliance. This was due to the facilities work being carried out following CQC recommendations in Willow Ward during June and July.

Expected compliance: Willow Ward re-opened mid-July and compliance is expected in August.

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

Performance fell in July to 47% against an expected performance threshold of 50%. Cumulatively, performance is reported at 51%. The Service is under a joint review with the Commissioners to look at and improve the Service model. Until this work has been completed, the Recovery Rate compliance will fluctuate from month to month.

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

Expected compliance: Previously reported as unknown, recent trajectory work indicators compliance that Gloucestershire Recorvery Rate will fluctuate around 50% throughout the year but cumulative compliance should remain compliant through to March 2017.

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

Following on from the recommendations of the IST review report, we are now only reporting on the Therapist Arm of the MHICT service. The figures in this report therefore exclude the Nursing element which has led to a decrease in the Access Rate for the service. The cumulative access rate to the end of July was 2.32% against an expected 5.00% cumulative access rate for the period. Further work is currently underway jointly with the Commissioners to review this service and its pathways.

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

Expected compliance: Unknown until further work has been completed, but recent trajectory work shows that we are likely to be non-compliant this financial year.

3.30: 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 NHSI 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.

Expected compliance: It's likely this indicator will either be removed or amended following the IST review. It is unlikely to be compliant until that piece of work is complete. Service Specifications are currently being reviewed and it is expected that this indicator will be amended in Quarter three.

Cumulative Performance Thresholds Not being Met

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

3.27: CYPS Level 2 & 3: Referral to treatment within 8 weeks
For Quarter 1 performance was just 2% below the expected performance threshold of 80%. Performance in both May and June exceeded this (84% and 93% respectively); however, a lower reported performance in April due to a change over to the new methodology agreed with the CCG has meant that this indicator is cumulatively non-compliant for Quarter 1

Expected compliance: As the indicator is now compliant on a monthly basis it is expected that it will also be compliant when reported again in Quarter 2.

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

Changes to Previously Reported Figure
None

Early Warnings
None

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	May-2016	June-2016 / Quarter 1	July-2016	Cumulative Compliance
	B. NATIONAL QUALITY REQUIREMENT						
3.01	Zero tolerance MRSA	PM	0	0	0	0	0
		Unavoidable	0	0	0	0	0
3.02	Minimise rates of Clostridium difficile	PM	0	0	0	0	0
		Unavoidable	0	0	0	0	0
3.03	Duty of candour	PM	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant	Compliant	Compliant
3.04	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS,	PM	99%	99%	99%	99%	99%
		Actual	100%	100%	100%	100%	100%
3.05	Completion of Mental Health Services Data Set ethnicity coding for all detained and informal Service Users	PM	90%	90%	90%	90%	90%
		Actual	97%	97%	100%	97%	98%
3.06	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	PM	90%	90%	90%	90%	90%
		Actual	85%	99%	99%	99%	99%
	C. Local Quality Requirements						
	Domain 1: Preventing People dying prematurely						
3.07	Increased focus on suicide prevention and reduction in the number of reported suicides in the community and inpatient units	PM	Report				Annual
		Actual	Complete				NYR
3.08	To reduce the numbers of detained patients absconding from inpatient units where leave has not been granted	PM	N/A		<36		<36
		Actual	55		21		21
3.09	Compliance with NICE Technology appraisals within 90 days of their publication and ability to demonstrate compliance through completion of implementation plans and costing templates.	PM			PM		PM
		Actual			NYR		NYR
3.10	Minimum of 5% increase in uptake of flu vaccination (15/16 55.3%)	PM					Annual
		Actual					NYR

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	May-2016	June-2016 / Quarter 1	July-2016	Cumulative Compliance
	Domain 2: Enhancing the quality of life of people with long-term conditions						
3.11	2G bed occupancy for Gloucestershire CCG patients	PM	N/A	>91%	>91%	>91%	>91%
		Actual	92%	94%	91%	90%	92%
3.12	Care Programme Approach: 95% of CPAs should have a record of the mental health worker who is responsible for their care	PM	95%	95%	95%	95%	95%
		Actual	100%	100%	100%	100%	100%
3.13	CPA Review - 95% of those on CPA to be reviewed within 1 month (Review within 13 months)	PM	95%	95%	95%	95%	95%
		Actual	99%	100%	99%	99%	99%
3.14	Assessment of risk: % of those 2g service users on CPA to have a documented risk assessment	PM	85%		95%		95%
		Actual	99%		99%		99%
3.15	Assessment of risk: All 2g service users (excluding those on CPA) to have a documented risk assessment	PM			85%		85%
		Actual			94%		94%
3.16	Dementia should be diagnosed as early in the illness as possible: People within the memory assessment service with a working diagnosis of dementia to have a care plan within 4 weeks of diagnosis	PM	85%	85%	85%	85%	85%
		Actual	89%	98%	98%	100%	98%
3.17	AKI (previous CQUIN 1516) 95% of pts to have EWS score within 12 hours	PM			95%		95%
					100%		100%
	Domain 3: Helping people to recover from episodes of ill-health or following injury						
3.18	IAPT recovery rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%
		Actual	35%	52%	58%	47%	51%
3.19	IAPT access rate: Access to psychological therapies for adults should be improved	PM		2.50%	3.75%	5.00%	5.00%
		Actual		1.11%	1.87%	2.32%	2.32%
3.20	IAPT reliable improvement rate: Access to psychological therapies for adults should be improved	PM	N/A	50%	50%	50%	50%
		Actual	55%	74%	74%	74%	73%
3.21	Care Programme Approach (CPA): The percentage of people with **learning disabilities** in inpatient care on CPA who were followed up within 7 days of discharge	PM	95%	95%	95%	95%	95%
		Actual	100%	N/A	N/A	N/A	N/A
3.22	To send :Inpatient and day case discharge summaries electronically, within 24 hours to GP	PM			Report		Report
		Actual			NYA		NYA

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	May-2016	June-2016 / Quarter 1	July-2016	Cumulative Compliance
	Domain 4: Ensuring that people have a positive experience of care						
3.23	To demonstrate improvements in staff experience following any national and local surveys	PM	Annual				Annual
		Actual	Compliant				NYR
	CYPS						
3.24	Number of children that received support within 24 hours of referral, for crisis home treatment (CYPS)	PM	95%		95%		95%
		Actual	97%		N/A		N/A
3.25	Children and young people who enter a treatment programme to have a care coordinator - (Level 3 Services) (CYPS)	PM	98%	98%	98%	98%	98%
		Actual	99%	99%	99%	99%	99%
3.26	95% accepted referrals receiving initial appointment within 4 weeks (excludes YOS, substance misuse, inpatient and crisis/home treatment and complex engagement) (CYPS)	PM	95%		95%		95%
		Actual	98%		99%		99%
3.27	Level 2 and 3 – Referral to treatment within 8 weeks , excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	80%		80%		80%
		Actual	65%		78%		78%
3.28	Level 2 and 3 – Referral to treatment within 10 weeks (excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	95%		90%		90%
		Actual	78%		91%		91%
3.29	Adults of working age - 100% of MDT assessments to have been completed within 4 weeks (or in the case of a comprehensive assessment commenced within 4 weeks)	PM	85%	85%	85%	85%	85%
		Actual	94%	95%	95%	94%	95%
3.30	Adults Mental Health Intermediate Care Teams (New Integrated service) Wait times from referral to screening assessment within 14 days of receiving referral	PM	85%	85%	85%	85%	85%
		Actual	70%	67%	66%	64%	63%

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	May-2016	June-2016 / Quarter 1	July-2016	Cumulative Compliance
	Vocational Service (Individual Placement and Support)						
3.31	100% of Service Users in vocational services will be supported to formulate their vocational goals through individual plans (IPS)	PM	98%		98%		98%
		Actual	100%		100%		100%
3.32	The number of people finding paid employment or self-employment (measured as a percentage against accepted referrals into the (IPS) Excluding those in employment at time of referral - Annual	PM	50%				50%
		Actual	45%				NYR
3.33	The number of people retaining employment at 3/6/9/12+ months (measured as a percentage of individuals placed into employment retaining employment) (IPS)	PM	50%				50%
		Actual	65%				NYR
3.34	The number of people supported to retain employment at 3/6/9/12+ months	PM	50%				50%
		Actual	73%				NYR
3.35	Fidelity to the IPS model	PM	Annual				90%
		Actual	NYA				NYR
	General Quality Requirements						
3.36	GP practices will have an individual annual (MH) ICT service meeting to review delivery and identify priorities for future.	PM	Annual				Annual
		Actual	NYA				NYR
3.37	Care plan audit to show : All dependent Children and YP <18 living with adults know to Recovery, MAHRS, Eating Disorder and Assertive Outreach Services. Recorded evidence in care plans of impact of the mental health disorder on those under 18s plus steps put in place to support.(Think family)	PM			TBC		TBC
		Actual			NYA		NYA
	New KPIs for 2016/17						
3.38	Transition- Joint discharge/CPA review meeting to be held within 4 weeks of acceptance into adult MH services during which a working diagnosis to be agreed, adult MH care coordinator allocated and care cluster and risk levels agreed as well as CYPS discharge date. The meeting will be recorded on RIO.	PM			100%		100%
		Actual			NYA		NYA
3.39	Number and % of crisis assessments undertaken by the MHARS team on CYP age 16-25 within agreed timescales of 4 hours	PM					90%
		Actual					NYR
3.40	MHARS wait time to assessment (4 hours)	PM					TBC
		Actual					NYR

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	May-2016	June-2016 / Quarter 1	July-2016	Cumulative Compliance
	New KPIs for 2016/17 LD						
3.41	To define LD clearly and the route into specialist LD service	PM					Annual
		Actual					NYR
3.42	LD: To implement Pathways for work within specialist service with easy read supporting information	PM					Annual
		Actual					NYR
3.43	The CLDT will ask when an annual health check is due and will notify GP where one is needed, and offer support regarding reasonable adjustments.	PM					80%
		Actual					NYR
3.44	LD: All clients referred will have a risk assessment completed when core assessment is completed	PM					80%
		Actual					NYR
3.45	LD:All clients referred for difficulties they are expressing through their behaviour will have an assessment and formulation completed within 56 days of case being opened by the relevant clinician	PM					80%
		Actual					NYR
3.46	LD: All clients referred for difficulties they are expressing through their behaviour will have single support plan, containing (as appropriate) changes within the person, changes external to the person (systems), and reactive interventions completed within 56 days of case being opened by the relevant clinician	PM					80%
		Actual					NYR
3.47	LD: All new patients have a risk assessment completed within 48 hours of admission	PM					80%
		Actual					NYR
3.48	LD: All new patients have a psychological assessment and formulation of behaviours and emotions completed within 28 days of admission.	PM					80%
		Actual					NYR
3.49	LD: All new patients have a single support plan to support their behavioural and emotional presentation completed within 28 days of admission. This will contain, as appropriate, goals targeting changes within the person, changes external to the person, and reactive interventions.	PM					80%
		Actual					NYR

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	May-2016	June-2016 / Quarter 1	July-2016	Cumulative Compliance
3.50	LD: All new patients receive a health check within 48 hours of admission.	PM					95%
		Actual					NYR
3.51	LD: All new patients have a Health Action Plan completed within 3 days of admission	PM					95%
		Actual					NYR
3.52	LD: All new patients requiring a health screening are supported to access screenings where appropriate.	PM					95%
		Actual					NYR
3.53	LD: All clients referred for challenging behaviour will have a risk assessment completed within five days of case being allocated to clinician	PM					80%
		Actual					NYR
3.54	LD: All clients have a functional assessment / formulation of behaviours completed within 28 days on completion of assessment	PM					80%
		Actual					NYR
3.55	LD: All clients referred for challenging behaviours will have a single plan describing how their behaviour will be supported positively. It will contain primary, secondary and reactive interventions. Goals for the person and the wider system will be clear. The plan will be completed within 30 days of case being opened by the clinician.	PM					80%
		Actual					NYR
3.56	LD: All clients being admitted for challenging behaviour to Learning Disability Assessment and Treatment services will have a blue light meeting where feasible. This will be notified to Commissioners for Commissioners or their designee to Chair	PM					80%
		Actual					NYR

DASHBOARD CATEGORY – GLOUCESTERSHIRE SOCIAL CARE

Gloucestershire Social Care				
	In month compliance			Cumulative Compliance
	May	Jun	Jul	
Total Measures	15	15	15	14
	4	2	2	2
	8	10	10	10
NYA	0	0	0	0
NYR	1	1	1	1
UR	0	0	0	0
N/A	2	2	2	2

Performance Thresholds not being achieved in Month

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

This is the second month this indicator has been reported. The new data collection form went "live" in RiO a few months ago and work is needed to ensure that all staff are aware that it is available and that information is collected at the right time in the pathway.

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

Expected compliance: Previously reported as unknown, the Services are aware of the new forms on RiO and are working towards compliance. The service will work on promoting this indicator throughout the year with compliance expected in Quarter four.

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

This is the second month this indicator has been reported. The new data collection form went "live" in RiO a few months ago and work is needed to ensure that all staff are aware that it is available and that information is collected at the right time in the pathway.

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

Expected compliance: Previously reported as unknown, the Services are aware of the new forms on RiO and are working towards compliance. The service will work on promoting this indicator throughout the year with compliance expected in Quarter four.

Cumulative Performance Thresholds Not being Met

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

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

Changes to Previously Reported Figures
None

Early Warnings
None

Gloucestershire Social Care

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

Gloucestershire Social Care

ID	Performance Measure		2015/16 outturn	May-2016	June-2016 / Quarter 1	July-2016	Cumulative Compliance
4.01	The percentage of people who have a Cluster recorded on their record	PM	TBC	90%	90%	90%	90%
		Actual	96%	97%	96%	97%	97%
4.02	Percentage of people getting long term services, in a residential or community care reviewed/re-assessed in last year	PM	95%	95%	95%	95%	95%
		Actual	96%	94%	97%	96%	95%
4.03	Ensure that reviews of new packages take place within 12 weeks of commencement	PM	95%				95%
		Actual	96%				NYR
4.04	Current placements aged 18-64 to residential and nursing care homes per 100,000 population	PM	TBC	13	13	13	13
		Actual	13.01	13.15	12.90	12.90	12.65
4.05	Current placements aged 65+ to residential and nursing care homes per 100,000 population	PM	TBC	22	22	22	22
		Actual	21.21	15.56	16.34	16.34	17.12
4.06	% of WA & OP service users on caseload asked if they have a carer	PM		100%	100%	100%	100%
				6%	8%	9%	7%
4.07	% of WA & OP service users on the caseload who have a carer, who have been offered a carer's assessment	PM		100%	100%	100%	100%
		Actual		32%	24%	34%	30%
4.08a	% of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC
		Actual	NYA	67%	60%	53%	53%
4.08b	Number of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC
		Actual	NYA	6	9	16	16
4.09	% of eligible service users with Personal budgets	PM	80%	80%	80%	80%	80%
		Actual	97%	100%	97%	100%	100%

DASHBOARD CATEGORY – HEREFORDSHIRE CCG CONTRACTUAL REQUIREMENTS

Herefordshire Contract				
	In month Compliance			Cumulative Compliance
	May	Jun	Jul	
Total Measures	22	22	22	22
	4	2	2	3
	15	17	16	16
NYA	0	0	0	0
NYR	0	0	0	0
UR	1	1	1	1
N/A	2	2	3	2

Performance Thresholds not being achieved in Month

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

Performance fell in July to 48% against an expected performance threshold of 50%. Cumulatively, performance is reported at 45%. The Service is under a joint review with the Commissioners to look at and improve the Service model. Until this work has been completed, the Recovery Rate compliance will fluctuate from month to month.

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

Expected compliance: Previously reported as unknown, recent trajectory work indicators compliance that Herefordshire Recorvery Rate will fluctuate throughout the year with compliance expected to consistently be met through Quarter four.

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

126 people entered treatment in July which is 55 lower than the expected threshold.

This indicator has been red flagged as further analysis is being carried out to fully understand the issues and identify the actions required.

Expected compliance: Unknown until further work has been completed, but recent trajectory work shows that we are likely to be non-compliant this financial year.

Cumulative Performance Thresholds Not being

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

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

5.11 – IAPT High Intensity – number of patients that received Step 3 treatment
This indicator has an annual threshold of 350 per year which averages out to 29 per month. This indicator is compliant for July and cumulatively is 5 short of the 117 expected number of people as at the end of July

Expected compliance: The compliance for this indicator will fluctuate throughout the year but it is expected to achieve 350 by March 2017.

Changes to Previously Reported Figures

5.19: All admitted patients aged 65+ should have a completed MUST assessment.
Previously reported as not yet available. This indicator is can now be reported on and is cumulatively compliant at 95%.

5.20: ED attendances with mental health needs should have rapid access to a MH assessment within 2 hours of referral
Previously reported as not yet available. This indicator can now be reported on and is cumulatively compliant at 75%.

5.21: ED attendances for self-harm receive a mental health assessment
Previously reported as not yet available. This indicator is now be reported on and is cumulatively compliant at 97%.

Early Warnings / Notes

5.18: CYP IAPT Dataset
The dataset for CYP IAPT is extensive and we are seeking clarity from the Commissioners to ensure we use the correct methodology in our reporting. The service is now reporting from RiO having previously being hosted by COMMIT and we will be able to report on this once the details with the Commissioners are confirmed.

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 Outturn	May-2016	June-2016 / Quarter 1	July-2016	Cumulative Compliance
5.01	Duty of candour	Plan	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant	Compliant	Compliant
5.02	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS	Plan	99%	99%	99%	99%	99%
		Actual	100%	99%	99%	99%	99%
5.03	Completion of Mental Health Services Data Set ethnicity coding for all detained and informal Service Users	Plan	90%	90%	90%	90%	90%
		Actual	100%	100%	100%	100%	100%
5.04	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	Plan	90%	90%	90%	90%	90%
		Actual	96%	100%	100%	100%	99%
5.05	Zero tolerance MRSA - Unavoidable	Plan	0	0	0	0	0
		Unavoidable	0	0	0	0	0
5.06	Minimise rates of Clostridium difficile - Unavoidable	Plan	0	0	0	0	0
		Unavoidable	0	0	0	0	0
5.07	VTE risk assessment: all inpatient service users to undergo risk assessment for VTE	Plan	95%	95%	95%	95%	95%
		Actual	99%	100%	100%	100%	100%
5.08	IAPT Recovery Rate - The number of people who are "moving to recovery" (those who have completed IAPT treatment and have "caseness" at the final session did not)	Plan	50%	50%	50%	50%	50%
		Actual	33%	34%	57%	48%	45%
5.09	IAPT Roll-out (Access Rate) - IAPT maintain 15% of patient entering the service against prevalence	Plan	2,178	363	545	726	726
		Actual	2,005	237	370	496	496
5.10	IAPT waiting times and completed treatments - Number of ended referrals in the reporting period that received a course of treatment against the number of ended referrals that received a single treatment appt	Plan	N/A	TBC	TBC	TBC	TBC
		Actual		45%	49%	46%	48%
5.11	IAPT High Intensity - Number of discharged patients that received step 3 treatment	Plan	350	29	29	29	117
		Actual	356	24	33	32	112

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 Outturn	May-2016	June-2016 / Quarter 1	July-2016	Cumulative Compliance
5.12	Emergency referrals to Crisis Resolution Home Treatment Team seen within 4 hours of referral (8am-6pm)	Plan	98%	95%	95%	95%	95%
		Actual	99%	100%	100%	100%	100%
5.13a	Dementia Service - number of new patients aged 65 years and over receiving an assessment	Plan		45	45	45	180
		Actual		37	57	46	187
5.13b	Dementia Service - total number of new patients receiving an assessment	Plan					
		Actual		37	60	49	198
5.14	Waiting times - Specialist Memory Service: All patients are offered a first appointment within 4 weeks of referral	Plan	100%	95%	95%	95%	95%
		Actual	97%	100%	100%	100%	100%
5.15	Reduce those people readmitted to inpatient care within 30 days following discharge.	Plan	<8%	<8%	<8%	<8%	<8%
		Actual	6%	6%	6%	6%	5%
5.16	Number of service users on the caseload who have been seen (face to face) within the previous 90 days (Recovery Service). Excludes service users with a medic as Lead HCP.	Plan	100%	98%	98%	98%	98%
		Actual		98%	99%	98%	98%
5.17	Patients are to be discharged from local rehab within 2 years of admission (Oak House). Based on patients on ward at end of month.	Plan	80%	80%	80%	80%	80%
		Actual	86%	100%	100%	100%	100%
5.18	CYPS IAPTOutcomes - Consistent with the data specification for CYP-IAPT CAMHS V2 (Dec 2012)	Plan		20%	20%	40%	40%
		Actual		UR	UR	UR	UR
5.19	All admitted patients aged 65 years of age and over must have a completed MUST assessment	Plan		95%	95%	95%	95%
		Actual		100%	83%	100%	95%
5.20	Any attendances at ED with mental health needs should have rapid access to mental health assessment within 2 hours of the MHL team being notified. (Urgent/emergency referrals).	Plan		30%	30%	50%	50%
		Actual		50%	100%	N/A	75%
5.21	Attendances at ED for self-harm receive a mental health assessment	Plan		35%	35%	55%	55%
		Actual		100%	100%	94%	97%

DASHBOARD CATEGORY – GLOUCESTERSHIRE CQUINS

Gloucestershire CQUINS				
	In month Compliance			Cumulative Compliance
	May	Jun	Jul	
Total Measures	2	2	2	2
	0	0	0	0
	0	2	0	2
NYA	0	0	0	0
NYR	2	0	2	0
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month

None

Cumulative Performance Thresholds Not being Met

None

Changes to Previously Reported Figures

Following confirmation that the following, previously reported, CQUINS have not been adopted by the CCG for 16/17, they will no longer be included in this report

- Improving physical health care: Cardio Metabolic assessment for patients with schizophrenia
- Improving physical healthcare: Communication with GPs

Early Warnings

None

Gloucestershire CQUINS

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

DASHBOARD CATEGORY – LOW SECURE CQUINS

Low Secure CQUINS				
	In month Compliance			Cumulative Compliance
	May	Jun	Jul	
Total Measures	1	1	1	1
	0	0	0	0
	0	1	0	1
NYA	0	0	0	0
NYR	1	0	1	0
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month

None

Cumulative Performance Thresholds Not being Met

Following confirmation that the following, previously reported, CQUIN has not been adopted for 16/17, it will no longer be included in this report

- Improving physical health care: Cardio Metabolic assessment for patients with schizophrenia

Changes to Previously Reported Figures

None

Early Warnings

None

Low Secure CQUINS

ID	Performance Measure		2015/16 Outturn	Quarter 1		Cumulative Compliance
	Local CQUINs					
	CQUIN 1					
8.01	Reducing the length of stay in specialised MH services	PM		Report		Qtr 1
		Actual		Compliant		Compliant

DASHBOARD CATEGORY – HEREFORDSHIRE CQUINS

Herefordshire CQUINS				
	In month Compliance			Cumulative Compliance
	Apr	May	Jun	
Total Measures	5	5	5	5
	0	0	0	0
	0	4	0	4
NYA	0	1	0	1
NYR	5	0	5	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		2015/16 Outturn	Quarter 1		Cumulative Compliance
	National CQUINs					
	CQUIN 1					
9.01a	Improving physical healthcare: Cardio Metabolic Assessment for patients with psychoses	PM	Qtr 4	Report		Qtr 1
		Actual	Compliant	Compliant		Compliant
9.01b	Improving physical healthcare: Communication with GPs	PM	Qtr 2	Report		Report
		Actual	Awarded	NYA		NYA
	Local CQUINs					
	CQUIN 2					
9.02	Urgent and Emergency Care: Development of an adult personalised discharge care plan	PM	Qtr 4	Report		Qtr 1
		Actual	Compliant	Compliant		Compliant
	CQUIN 3					
9.03	Personalised relapse prevention plans for children and young people accessing and using MH services			Report		Qtr 1
				Compliant		Compliant
	CQUIN 4					
9.04	Appropriate care and management for frequent attenders to WVT A&E dept			Report		Qtr 1
				Compliant		Compliant

Agenda Item **8** **Paper C**

Report to: Trust Board – 29 September 2016
Author: Gordon Benson, Assistant Director of Governance & Compliance
Presented by: Marie Crofts, Director of Quality

SUBJECT: **Quality Report: Report for 1st Quarter 2016/17**

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

EXECUTIVE SUMMARY

This is the first review of the Quality Report priorities for 2016/17. The quarterly report is in the format of the annual Quality Report format.

Assurance

- The report shows the progress made towards achieving targets, objectives and initiatives identified in the Annual Quality Report
- Overall, there is currently limited assurance that the majority of targets will be met. 3 of the 11 targets are being achieved with a further 3 being rated "amber" and 5 not achieved.
- The Committee should not that 3 of the safety targets (suicide minimisation, AWOL and prone restraint) are dependent on the clinical presentation of service users and therefore challenging to meet.
- It is within the gift of services; however, to improve individual team responses/performance in regard of discharge planning, joint CPA reviews, improved service user experience and 48 hr follow up.

Improvements

- The data within relates to Quarter 1 and will, therefore, be subject to change throughout the year as the supportive evidence base grows.
- Targets which teams need to consider how to improve performance are, therefore:
    1. 1.2 – Personalised Discharge Care Planning
    2. 1.3 – Joint CPA reviews for young people transitioning to adult services
    3. 2.1 – Involving service users in agreeing the care they receive
    4. 2.2 – Involving service users in decisions about their medication
    5. 3.4 – 48 Hour Follow up

- The above targets have been flagged to Service Directors to progress via Locality Delivery Committees

RECOMMENDATIONS

The Board is asked to:

- Note the progress made to date;
- Note actions required through Locality Delivery Committees
- Agree that the Quarter 1 Quality Report update be shared with partner organisations, commissioners and governors.

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	Date	10 August 2016

Where in the Trust has this been discussed before?		
Governance Committee	Date	August 2016

What consultation has there been?		
	Date	

Explanation of acronyms used:	

1. CONTEXT

1.1 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.

Quality Report 2016/17

Quarter 1

CONTENTS

Part 1: Statement on Quality from the Chief Executive

Introduction

This will be completed at year end.

Part 2a: Looking ahead to 2017/18

Quality Priorities for Improvement 2017/18

This will be completed at year end.

Effectiveness

These will be developed during Quarter 4

User Experience

These will be developed during Quarter 4

Safety

These will be developed during Quarter 4

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

This will be completed at year end.

Participation in Clinical Audits and National Confidential Enquiries

This will be completed at year end.

Participation in Clinical Research

This will be completed at year end.

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

A proportion of [2]gether NHS Foundation Trust's income in 2016/17 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 2016/17 are available electronically at http://www.2gether.nhs.uk/cquin

2016/17 CQUIN Goals

Gloucestershire

Gloucestershire Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
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	£564256	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.	1.7	£1199044	Effectiveness

Herefordshire

Herefordshire Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
1a (b) National CQUIN – Staff health and wellbeing	The introduction of health and wellbeing initiatives covering physical activity, mental health and improving access to physiotherapy for people with MSK issues	.25	£41100	Effectiveness
1b National CQUIN – Staff health and wellbeing	Healthy food for NHS staff, visitors and patients	.25	£41100	Effectiveness
1c National CQUIN - Staff health and wellbeing	Improving the uptake of flu vaccinations for front line staff	.25	£41100	Safety
Improving Physical Healthcare	The purpose of this CQUIN is twofold. Firstly, to improve the physical health of service users who	.25	£41100	Effectiveness
Local CQUIN personalised relapse prevention plans for adults	Personalised relapse prevention plans for adults accessing services, specifically Assertive Outreach Team and Early Intervention Service	0.52	£85488	Safety
Local CQUIN personalised relapse prevention plans for Children and Young People	Personalised relapse prevention plans for adults accessing services, specifically children and young people accessing and using CAMHS services	0.52	£85488	Safety
Local CQUIN 3 – Frequent attenders	Care and management for frequent attenders to WVT Accident and Emergency	0.46	£75624	Safety

Low Secure Services

Low Secure Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
Reduction in length of stay	Aim to reduce lengths of stay of inpatient episodes and to optimise the care pathway. Providers to plan for discharge at the point of admission and to ensure mechanisms are in place to oversee the care pathway against estimated discharge dates.	2.5	£45000	Effectiveness

The total potential value of the income conditional on reaching the targets within the CQUINs during 2016/16 is £2,219,300 of which we anticipate £2,219,300 will be achieved.

In 2015/16, the total potential value of the income conditional on reaching the targets within the CQUINs was £2,107,995 of which £2,107,153 was achieved.

2017/18 CQUIN Goals

These will be developed during Quarter 4.

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:

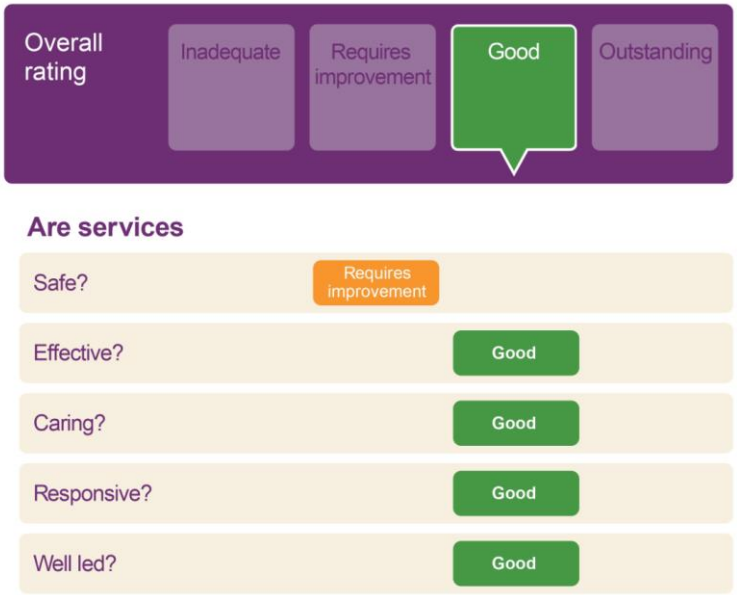
- Assessment or medical treatment to persons detained under the Mental Health act 1983;
- Diagnostic and screening procedures;
- Treatment of disease, disorder or injury.

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

The CQC has not taken enforcement action against [2]gether NHS Foundation during 2016/17 or the previous year 2015/16.

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 30th June 2016 in taking such action:

- Setting up a Project Group to manage all actions through to their conclusion;
- Progressing and monitoring the associated actions with reporting to both the CQC and local CCGs

Changes in service registration with Care Quality Commission for 2016/17

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

This will be completed at year end.

Information Governance Toolkit

This will be completed at year end.

Clinical Coding Error Rate

This will be completed at year end.

Part 3: Looking Back: A Review of Quality during 2016/17

Introduction

The 2016/17 quality priorities were agreed in May 2016.

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 2016/2017

		2015 - 2016	2016 - 2017
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**	**Achieved**
1.2	To improve personalised discharge care planning in: a) Adult inpatient wards and; b) Older people's wards.	**Achieved**	**Not achieved**
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.	**-**	**Not achieved**
User Experience			
2.1	Were you involved as much as you wanted to be in agreeing what care you will receive? **> 78%**	**78%**	**75%**
2.2	Were you involved as much as you wanted to be in decisions about which medicines to take? **> 73%**	**73%**	**67%**
2.3	Do you know who to contact out of office hours if you have a crisis? **>71%**	**71%**	**80%**
2.4	Has someone given you advice about taking part in activities that are important to you? **> 48%**	**48%**	**77%**
Safety			
3.1	Reduce the numbers of deaths by suicide (pending inquest) of people in contact with services when comparing data from previous years.	**24**	**11**
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	**13** **23** **78** **114 total**	**5** **11** **35** **51 total**
3.3	To reduce the number of prone restraints by 5% year on year (on all adult wards & PICU) based on 2015/16 data.	**120**	**33**
3.4	**95%** of adults will be followed up by our services within 48 hours of discharge from psychiatric inpatient care.	**90%**	**90%**

Effectiveness

In 2016/17 we remained committed to ensure that our services are as effective as possible for the people that we support. We set ourselves 3 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;
- 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.

In 2015/16 the National Physical Health CQUIN was repeated within the inpatient services and was extended to include the Early Intervention teams within Herefordshire and Gloucestershire. We successfully achieved full compliance with this CQUIN and using the same methodology for both the inpatients and community teams, the Trust achieved overall 93% compliance (see Figure 1)

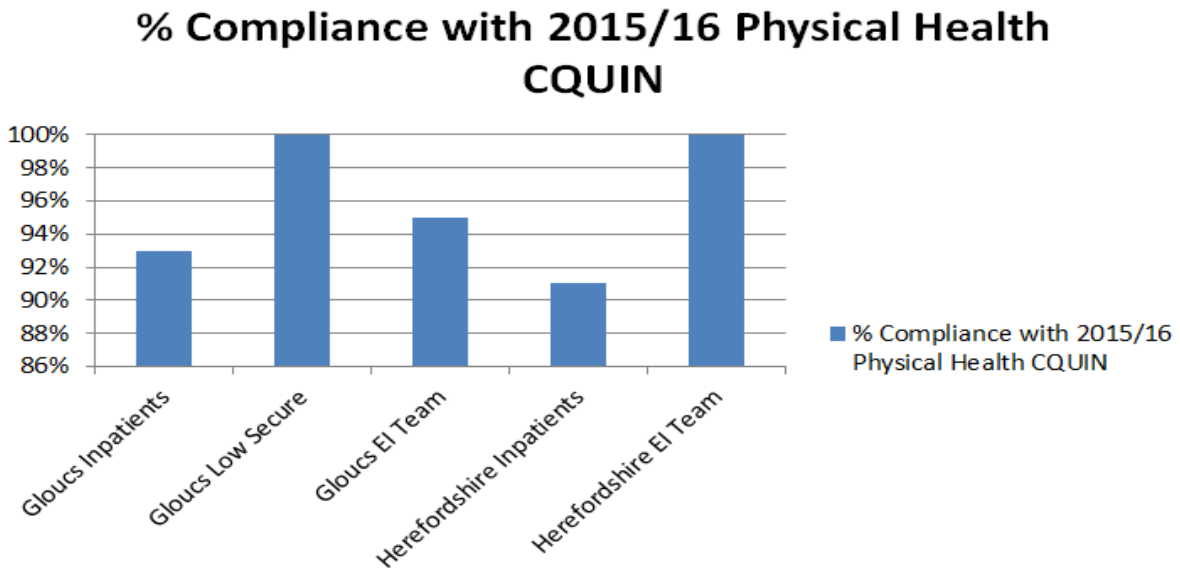


Figure 1

This year 2016/17 the Physical Health CQUIN has been adapted slightly to continue to build on the good work already in place. The sample group has now been extended to include both inpatients and patients from all community mental health teams who have a diagnosis of psychosis and are on CPA. (This year the CQUIN only relates to Herefordshire, however internal audits continue within Gloucestershire to ensure standards are maintained trust wide).

In order to support this work a substantial Lester Tool training programme for both inpatient areas and community mental health teams has been undertaken by the Physical Health Facilitator. The training department have also facilitated a one day Physical Health Awareness course, designed to complement the Lester tool training and increase staff awareness of coronary heart disease, chronic obstructive pulmonary disease and diabetes.

All teams currently working with the Lester tool have an allocated 'lead' professional who receives regular feedback regarding progress in implementing and completing the Lester tool.

The medical doctor's induction programme includes a section on the Lester tool. This training focuses on the role of the medical teams to support the Lester tool as well as an overview of the need for increased physical health screening for patients with serious mental illnesses.

The roll out of the screening programme within the community teams highlighted the need for a standardisation of physical health equipment needed as a minimum to undertake the screening. A set stock list is now available for community teams to access and the training team have offered a clinical skills training package for staff that are unfamiliar with how to use the equipment. Lack of staff trained in venepuncture skills again was highlighted as a potential barrier to completing the Lester tool and a group of staff have now received this training and are competent to take the blood samples needed.

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 has taken place 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. This system has now gone live and staff are familiarising themselves with the new pages within RiO. Feedback from staff so far has been positive and appears to reduce the need for duplication of data.

Plans are in place to revise and update the Physical Health information pages within the Trust intranet. It is hoped to be a central point for obtaining information regarding the Lester tool, along with general physical health information, updates, audits and quality improvement projects.

Following the success of the Physical Health Day for staff and patients at Wotton Lawn hospital in January 2016, a second similar event is planned for February 2017. External providers invited to attend include; The Independence Trust, Stop Smoking Service, Slimming World, Sexual Health clinic and Dental Access Centres. The Trust's Working Well team, dietician and health and exercise practitioners will also be represented.

The Trust is continuing with its plans to achieve "Smoke Free" status in spring next year, and ground work is being undertaken by a small team to ensure this transition takes place smoothly. Plans are already in place for this years "flu" immunisation campaign, and again a team of identified staff are booked to have refresher or new peer immuniser training in the next two months.

We are currently meeting 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. During 2015/16 we focused 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. There were different criteria in use across Gloucestershire and Herefordshire due to audit criteria changing from the original set of questions which were influenced by the West Midlands Quality Review which agreed a differing set of standards within Herefordshire.

This year identical criteria are being used in the services across both counties as follows:

1. Has a Risk Summary been completed?
2. Has the Clustering Assessment and Allocation been completed?
3. Has the Pre-Discharge Planning Form been completed?
4. Have the inpatient care plans been closed within 7 days of discharge?
5. Has the patient been discharged from the bed?
6. Has the Nursing Discharge Summary Letter to Client/GP been sent within 24 hours of discharge?
7. Has the 48 hour follow up been completed?

We are also including discharge care planning information from within our Recovery Units, as they too discharge people back into the community.

Results from the Quarter 1 audit against these standards are seen below.

Gloucestershire Services

Criterion	***Compliance Quarter 4 (2015/16)***	**Compliance Quarter 1 (2016/17)**
Overall Average Compliance (Gloucestershire)	***75% (712/950)***	**73% (1311/1794)**
Chestnut Ward	*84% (62/74)*	83% (78/94)
Mulberry Ward	*75% (83/110)*	77% (100/130)
Willow Ward	*59% (37/63)*	66% (73/110)
Abbey Ward	*72% (113/158)*	73% (272/371)
Dean Ward	*79% (169/215)*	73% (117/160)
Greyfriars PICU	*50% (13/26)*	64% (45/70)
Kingsholm Ward	*75% (55/73)*	72% (98/136)
Priory Ward	*80% (173/217)*	77% (214/277)
Montpellier Unit	*50% (7/14)*	42% (6/14)
Honeybourne*	*N/A*	68% (23/34)
Laurel House*	*N/A*	56% (10/18)

* Data for Honeybourne and Laurel House (Recovery Units) was not collected in 2015/16 – only hospital wards were audited to reflect comparable data across both Gloucestershire and Herefordshire.

Overall compliance in Gloucester with these standards has decreased during Quarter 1, there will be an increased focus on this important work during Quarter 2.

Herefordshire Services

Criterion	*Compliance Quarter 4 (2015/16)*	Compliance Quarter 1 2016/17)
Overall Average Compliance (Herefordshire)	*N/A*	**73% (279/384)**
Cantilupe	*N/A*	77% (54/70)
Jenny Lind	*N/A*	65% (17/26)
Mortimer	*N/A*	72% (200/276)
Oak House	*N/A*	67% (8/12)

There is no 2015/16 data for Herefordshire. This is due to the audit criteria changing from the original set of questions which were influenced by the West Midlands Quality Review which agreed a differing set of standards within Herefordshire. As the audit widened to the whole Trust across two counties, the criteria within the audit changed to reflect the standards outlined within the clinical system in relation to discharge care planning. Compliance for Herefordshire services will, therefore, be measured using Quarter 1 results as the baseline.

We have not met this target in Gloucestershire Services
We will report on performance against this target in Herefordshire Services in the Quarter 2 report.

Target 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.

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 by undertaking joint Care Programme Approach (CPA) reviews between children's and adult services.

Gloucestershire Services

During Quarter 1, there were 7 young people who transitioned into adult services, of these 7, 6 (86%) had a joint CPA review. All young people received input from the relevant services but this is not clearly documented within RiO.

Herefordshire Services

During Quarter 1, there were 3 young people who transitioned into adult services, of these 3, 1 (33%) had a joint CPA review. All young people received input from the relevant services but this is not clearly documented within RiO.

To improve our practice and documentation in relation to this target a number of measures have been developed as follows:

- Transition will be included as standard agenda item for teams, to provide the opportunity to discuss transition cases;
- Transition will be included as a standard agenda item in caseload management to identify emerging cases;
- Teams are encouraged to contact adult mental health services to discuss potential referrals;
- There is a data base which identifies cases for transition;
- SharePoint report identifies 17.5 years open to CYPS. Team Managers will monitor those who are coming up to transition and discuss in supervision.

We have not 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 Were you involved as much as you wanted to be in agreeing what care you will receive? > 78%

Questions	Treatment Setting	Sample Size Glos	Number 'yes' Glos	Sample size Hereford	Number 'yes' Hereford	Total % giving 'yes' answer
Question 1 Were you involved as much as you wanted to be in agreeing what care you will receive? > 78%	Inpatient	19	13	5	3	**75%**
	Community	22	17	5	5	
	Total Responses	41	30	10	8	

This target has not been met.

Target 2.2 Were you involved as much as you wanted to be in decisions about which medicines to take? > 73%

Questions	Treatment Setting	Sample Size Glos	Number 'yes' Glos	Sample size Hereford	Number 'yes' Hereford	Total % giving 'yes' answer
Question 2 Were you involved as much as you wanted to be in decisions about which medicines to take? **> 73%**	Inpatient	19	11	5	4	**67%**
	Community	20	13	5	5	
	Total Responses	39	24	10	9	

This target has not been met.

Target 2.3 Do you know who to contact out of office hours if you have a crisis? >71%

Questions	Treatment Setting	Sample Size Glos	Number 'yes' Glos	Sample size Hereford	Number 'yes' Hereford	Total % giving 'yes' answer
Question 3 Do you know who to contact out of office hours if you have a crisis? **>71%**	Inpatient	11	7	4	3	**80%**
	Community	20	17	5	5	
	Total Responses	31	24	9	8	

This target has been met.

Target 2.4 Has someone given you advice about taking part in activities that are important to you? > 48%

Questions	Treatment Setting	Sample Size Glos	Number 'yes' Glos	Sample size Hereford	Number 'yes' Hereford	Total % giving 'yes' answer
Question 4 Has someone given you advice about taking part in activities that are important to you? **> 48%**	Inpatient	18	13	5	5	**77%**
	Community	20	15	4	3	
	Total Responses	38	28	9	8	

This target has been met.

Friends and Family Test (FFT)

FFT responses and scores for Quarter 1

Service users are asked "How likely are you to recommend our service to your friends and family if they needed similar care or treatment?", and have six options from which to choose:

1. Extremely likely
2. Likely
3. Neither likely nor unlikely
4. Unlikely
5. Extremely unlikely
6. Don't know

The table below details the number of responses received each month; the FFT score is the percentage of people who chose either option 1 or 2 – they would be extremely likely/likely to recommend our services.

	Number of responses	FFT Score (%)
April 2016	126	97%
May 2016	236	94%
June 2016	281	94%
Quarter 1 Total	**643**	**94%**

Table 1

Friends and Family Test Scores for 2gether Trust for the past year

The following graph shows the FFT Scores for the past rolling year, including this quarter. The Trust receives consistently positive feedback, which has improved over the past year.

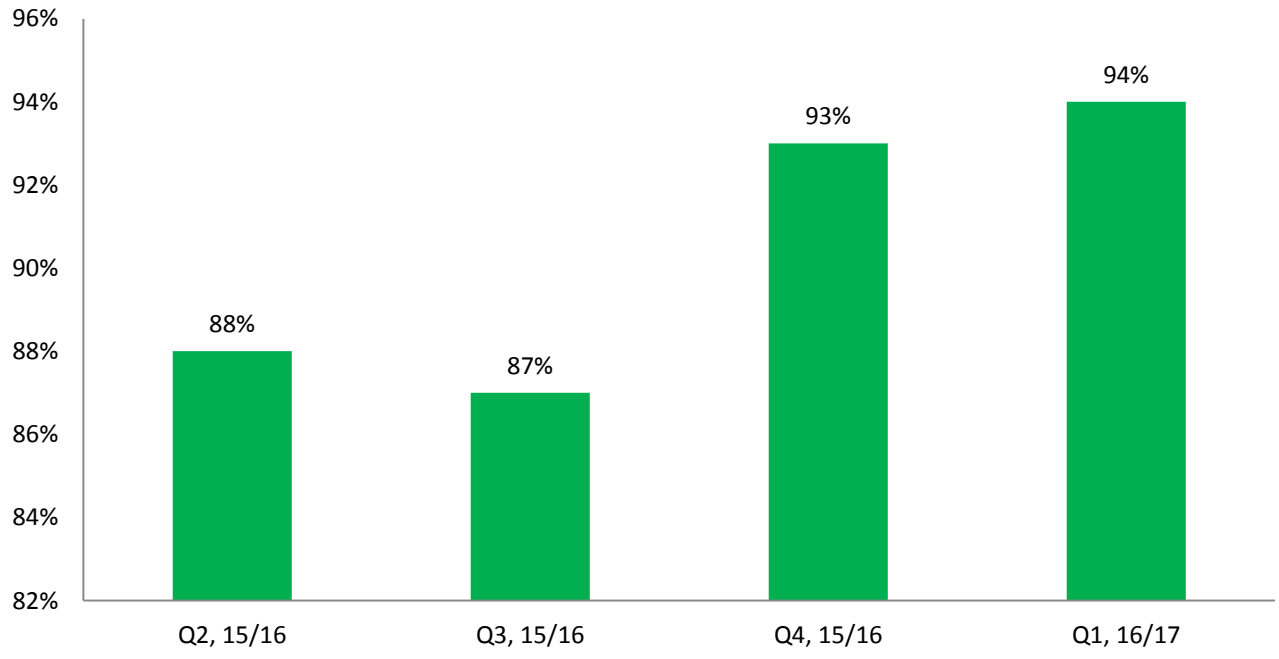


Figure 2

Friends and Family Test Scores – comparison between 2gether Trust and other Mental Health Trusts across England

The following graph shows the FFT Scores for the past six months, including this quarter. The Trust receives consistently higher percentage recommendation than other mental health trusts in England (*June 2016 data for England is not yet available*)

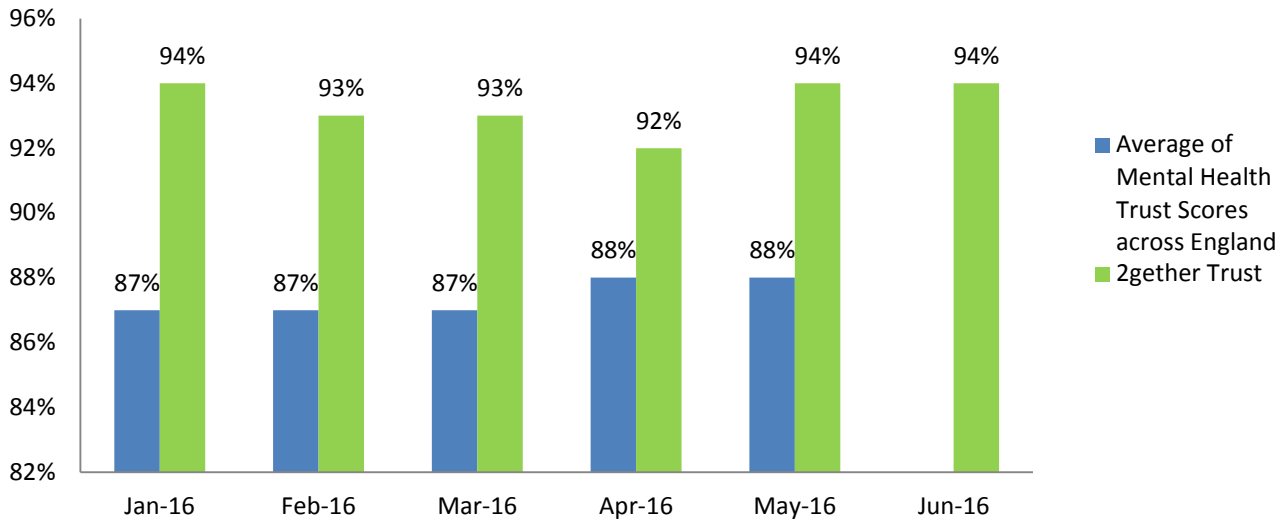


Figure 3

Friends and Family Test Scores – comparison between 2gether Trust and other Mental Health Trusts in the NHSE South Central Region

The following graph shows the FFT Scores for the April and May 2016 (the most recent data available). The Trust receives a slightly higher percentage recommendation than other mental health trusts in the region (*June 2016 data for the region is not yet available*)

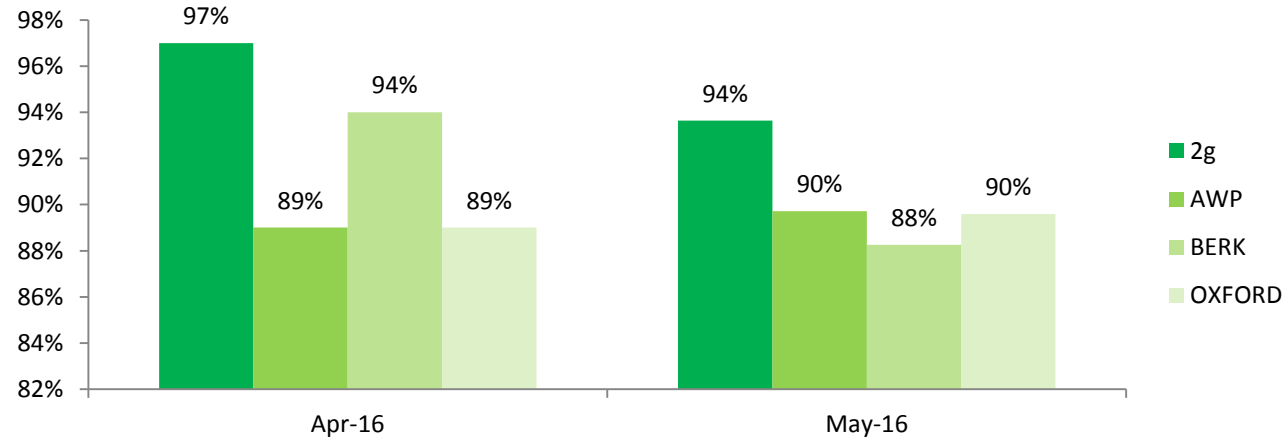


Figure 4

2g – 2gether NHS Foundation Trust, AWP – Avon and Wiltshire Mental Health Partnership NHS Trust
BERK – Berkshire Healthcare NHS Foundation Trust, OXFORD – Oxford Health NHS Foundation Trust

Complaints

This will be completed at year end.

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 4 goals to:

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

There are 4 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 and we have continued with this important target each year. Last year we reported **24** suspected suicides, **4** more than last year, therefore we did not meet the target. This year has seen a marked rise in these tragic incidents during Quarter 1.

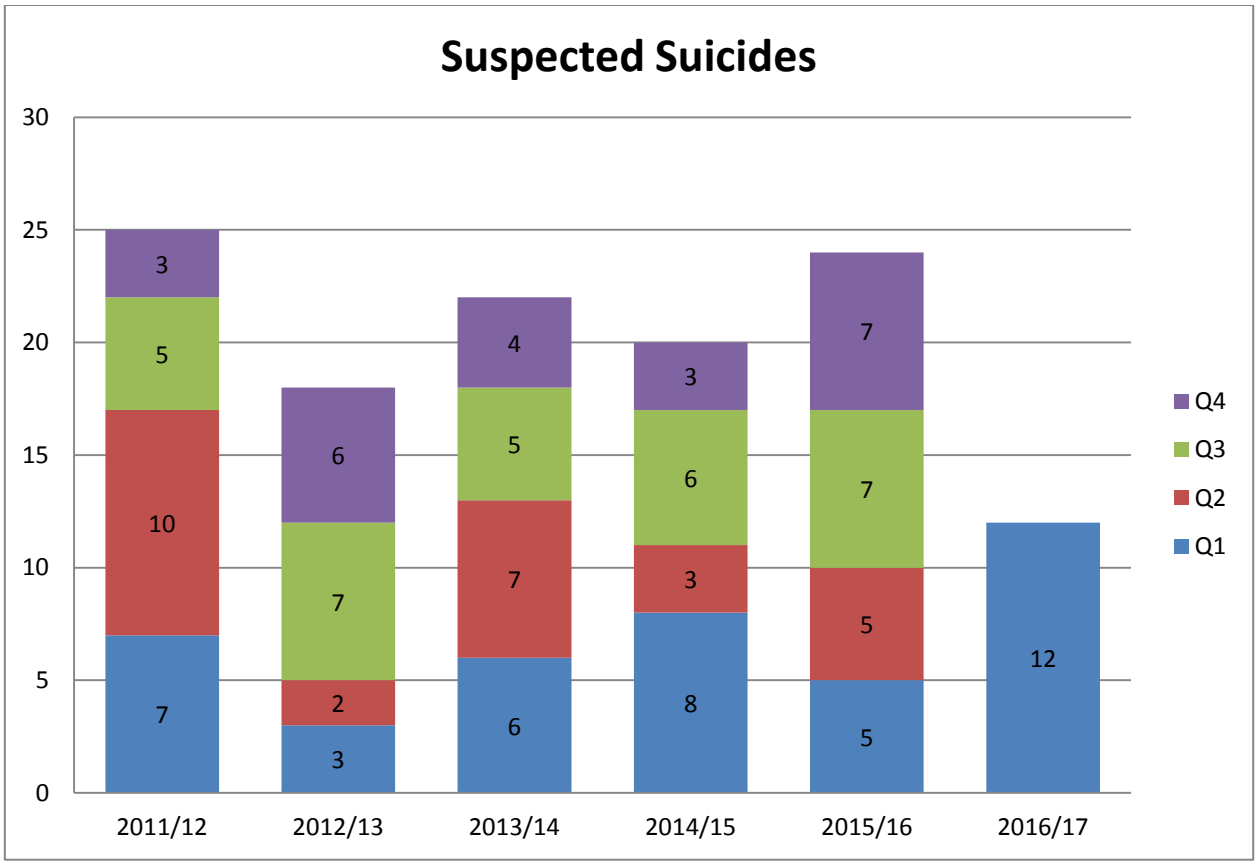


Figure 5

This information is provided below in Figures 6 & 7 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.

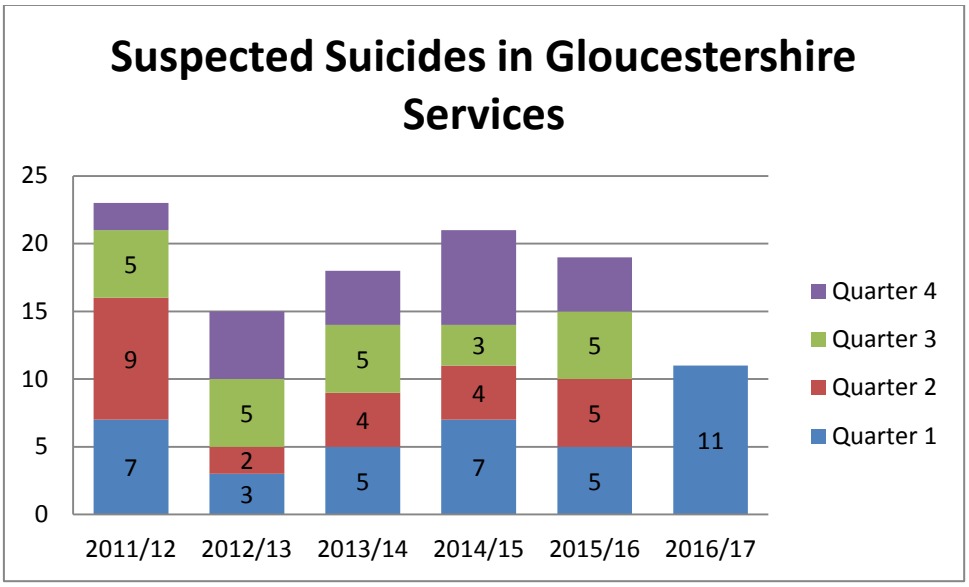


Figure 6

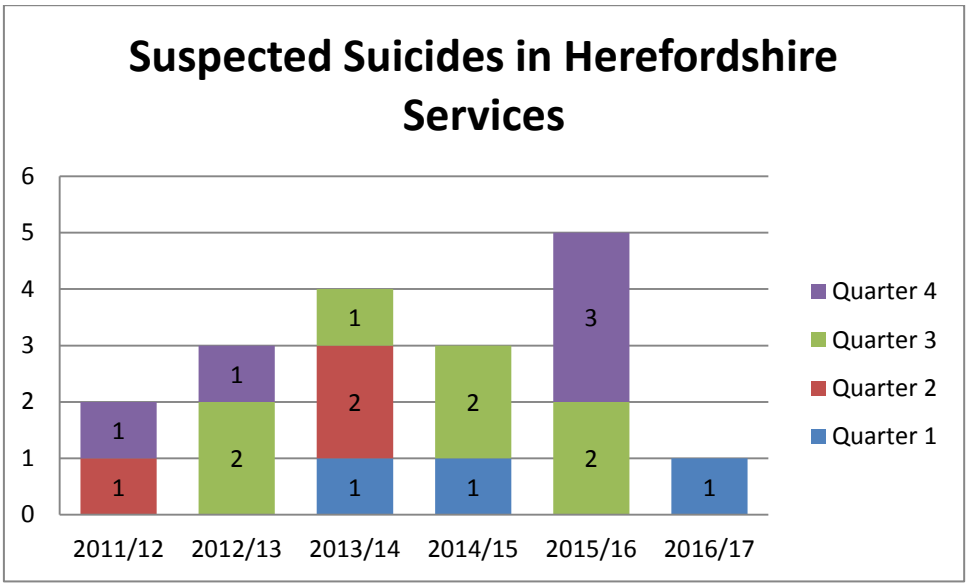


Figure 7

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 8 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 9 & 10.

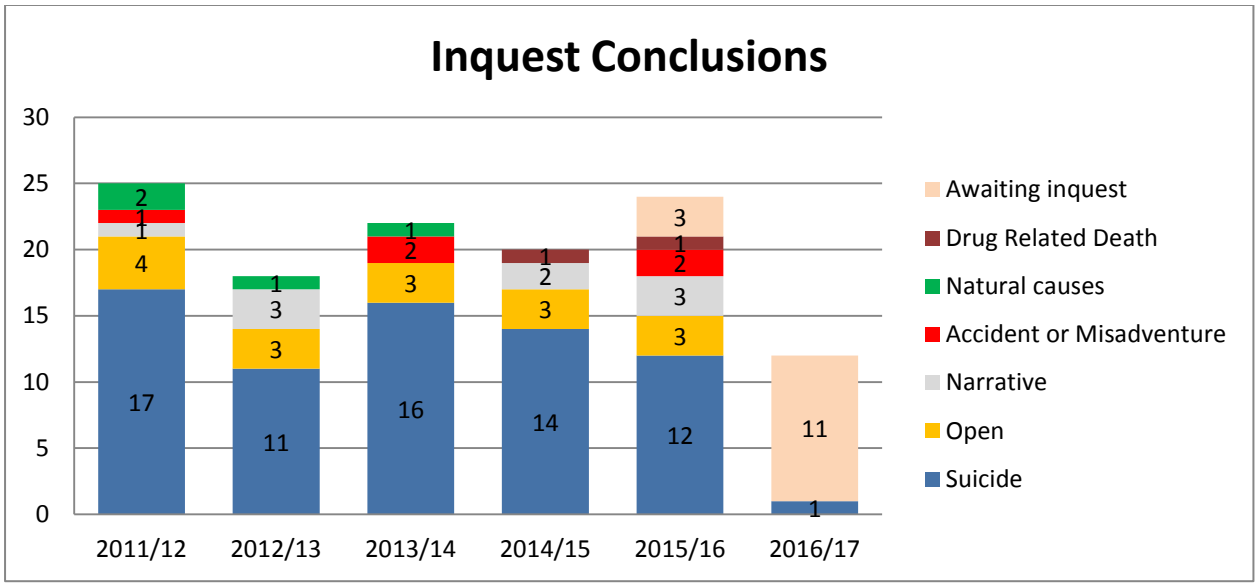


Figure 8

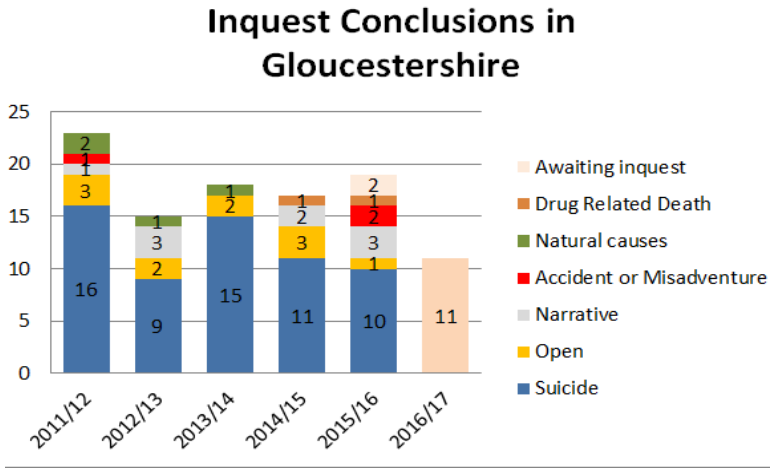


Figure 7

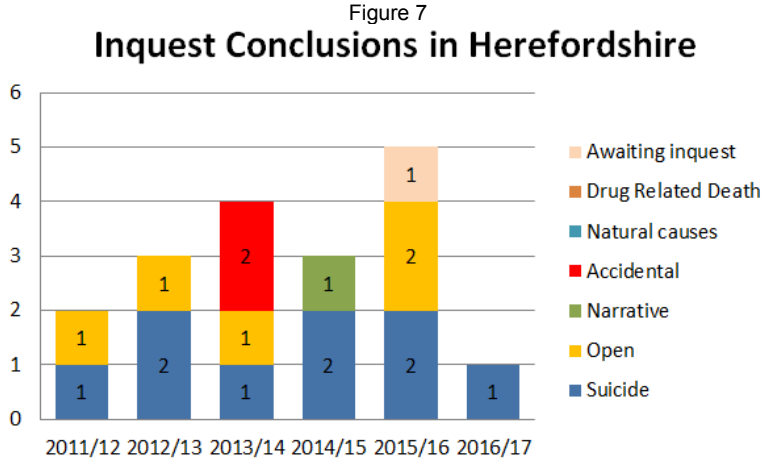


Figure 8

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 are currently meeting this target as the total number remains below 24; however we have reported more suspected suicides in Quarter 1 this year than in the previous 5 years.

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.

During 2015/16 **114** episodes of AWOL were been reported with the overall target being met, but there was 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. A breakdown of the 3 categories of AWOL for each county showing the year-end figures for 2015/16 and the Quarter 1 figures for 2016/17 are seen below.

Herefordshire

	Total 2015/16	Quarter 1 2016/17	Quarter 2 2016/17	Quarter 3 2016/17	Quarter 4 2016/17
Absconded from a ward	23	15			
Did not return from leave	4	2			
Absconded from an escort	4	2			
Totals for year	**31**	**19**			

Gloucestershire

	Total 2015/16	Quarter 1 2016/17	Quarter 2 2016/17	Quarter 3 2016/17	Quarter 4 2016/17
Absconded from a ward	55	20			
Did not return from leave	19	9			
Absconded from an escort	9	3			
Totals for year	**83**	**32**			

A total of **51** episodes of AWOL for Quarter 1 is seen which represents an increase of **36** incidents when compared to Quarter 1 in 2015/16.

For the category “Did not return from leave” the team on Mortimer Ward at the Stonebow Unit in Hereford have tested out, and now use “Leave Cards”. These are cards given to patients, along with a conversation on what the expectations of returning from leave are as agreed. For example, planned leave arrangements can be documented on the back of the credit card sized “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.

This piece of work is part of the greater understanding around AWOLS that has developed through measurement and focus. Levels of harm from AWOLS have reduced over time although reported numbers of AWOLs have generally increased.

There will be a continued focus on positive engagement within our inpatient services to try to reduce the number of occasions where detained patients abscond from the ward environment.

We are currently meeting this target as the total number remains below 114; however we have reported more AWOLs in Quarter 1 this year than in the previous year.

Target 3.3 To reduce the number of prone restraints by 5% year on year (on all adult wards & PICU)

This is a new target for 2016/17. During 2015/16, the Trust developed an action plan to reduce the use of restrictive interventions, in line with the 2 year strategy – Positive & Safe: developed from the guidance Positive and Proactive Care: reducing the need for restrictive interventions. This strategy offered clarity on what models and practice need to be undertaken to support sustainable reduction in harm and restrictive approaches, with guidance and leadership by the Trust Board and a nominated lead.

The Trust developed its own Positive & Safe Sub-Committee during 2015/16 which is a sub–committee of the Governance Committee. The role of this body is to:

- Support the reduction of all forms of restrictive practice;
- Promote an organisational culture that is committed to developing therapeutic environments where physical interventions are a last resort;
- Ensure organisational compliance with the revised Mental Health Act 1983 Code of Practice (2015) and NICE Guidance for Violence and Aggression;
- Oversee and assure a robust training programme and assurance system for both Prevention & Management of Violence & Aggression (PMVA) and Positive Behaviour Management (PBM);
- Develop and inform incident reporting systems to improve data quality and reliability;
- Improve transparency of reporting, management and governance;
- Lead on the development and introduction of a Trust wide RiO Physical Intervention Care Plan/Positive Behavioural Support.

As use of prone restraint (face down) is sometimes necessary to manage and contain escalating violent behaviour, it is also the response most likely to cause harm to an individual. Therefore, we want to minimise the use of this wherever possible through effective engagement and occupation in the inpatient environment. All instances of prone restraint are recorded and this information was used to establish a baseline in 2015/16. Overall, there were **121** occasions when prone restraint was used in our acute adult wards and PICU and the breakdown of this information by month is shown in Figure 9 below.

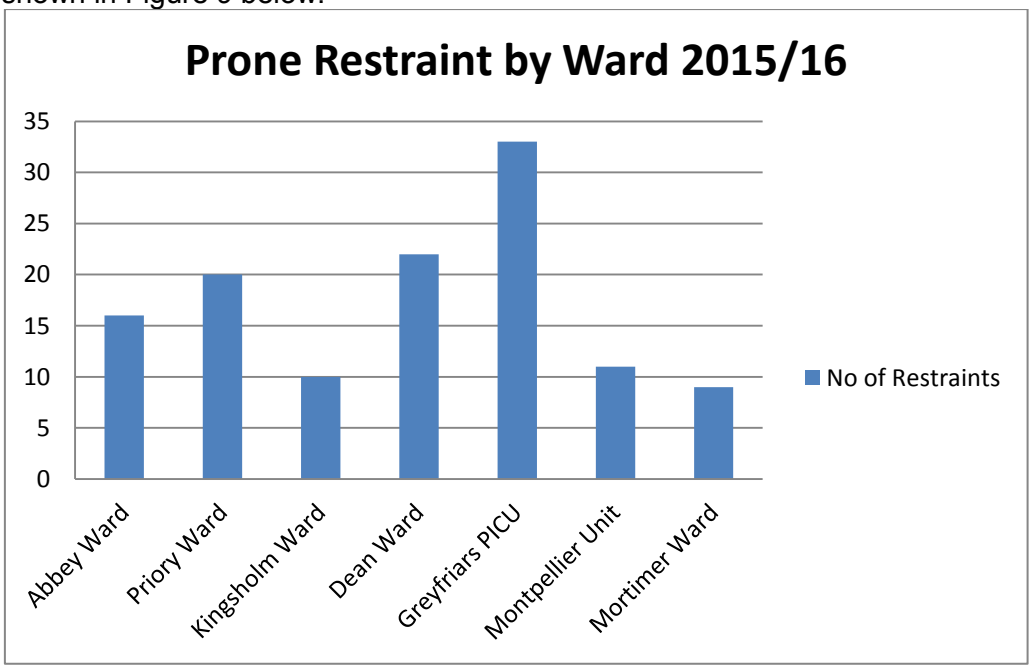


Figure 9

At the end of Quarter 1, 33 instances of prone restraint were used as seen in Figure 10.

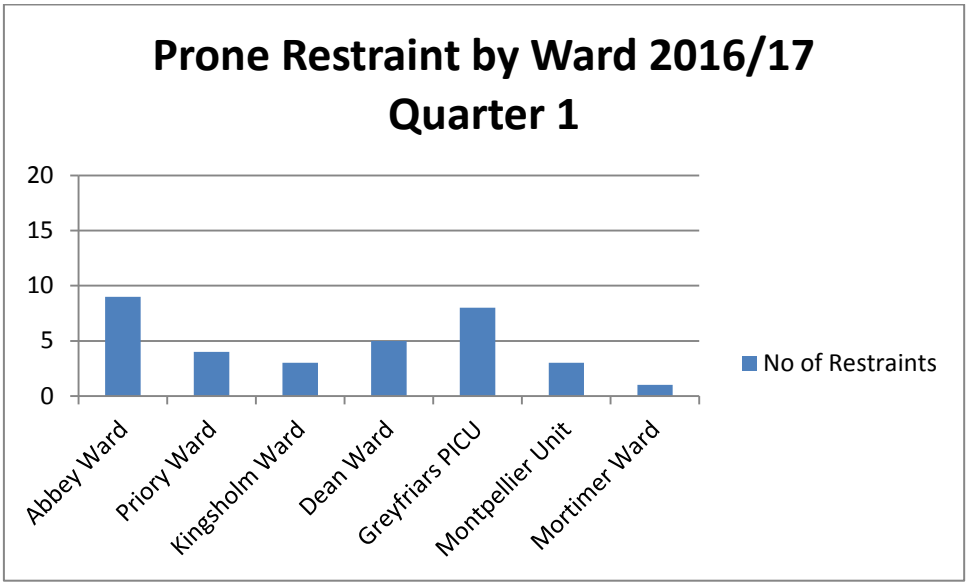


Figure 10

We are currently meeting this target as the total number remains below 120; however there is a risk that the 5% reduction target may not be met at year end.

Target 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 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[1].

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[2] 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.

During 2015/16 we took 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 2015/16 organisational performance fell to **90% (**Herefordshire services followed up **91%** (**25** breaches) of people discharged from inpatient care and Gloucestershire services have followed up **90%** (**83** breaches) which is below our stretch target.

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

We are confident that the practice changes we introduced have strengthened the patient safety aspects of this measure and that our performance in both our 7 day and 48 hour follow ups will ultimately return to being well above the national performance requirement and our local stretch target.

At the end of Quarter 1, Herefordshire services followed up **84%** (**9** breaches) of people discharged from inpatient care and Gloucestershire services followed up **92%** (**18** breaches). This gives an overall organisational compliance of **90%.** Each of these breaches will be reviewed to establish if there are any themes and trends, and the learning from this review will be used to promote practice.

	Target	2012-13	2013-14	2014-15	2015-16	2016-17 Q1
Gloucestershire Services	>95%	89%	95%	95%	90%	92%
Herefordshire Services	>95%	70%	95%	92%	91%	84%

We are not currently meeting this target.

Serious Incidents reported during 2016/17

At the end of Quarter 1 2016/17, **14** serious incidents were reported by the Trust, and the types of incidents reported are seen in Figure 11.

Figure 12 overleaf shows a 6 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 2016/17. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

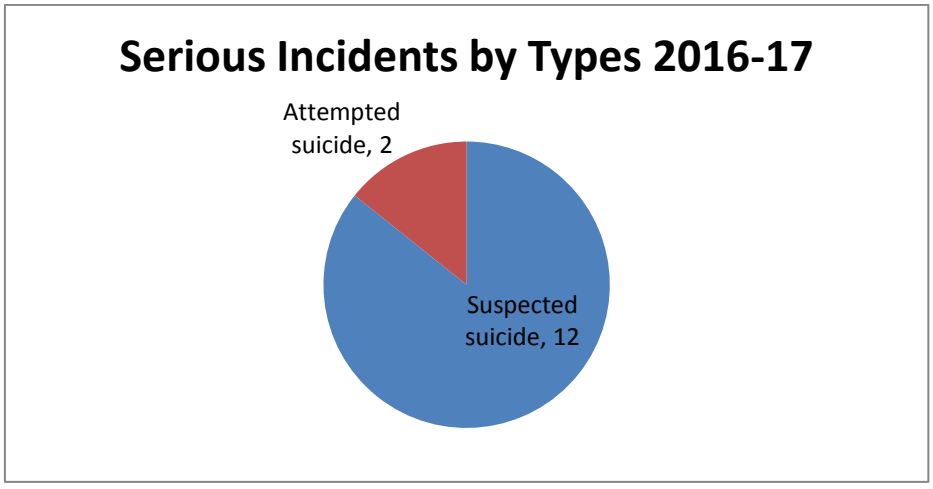


Figure 11

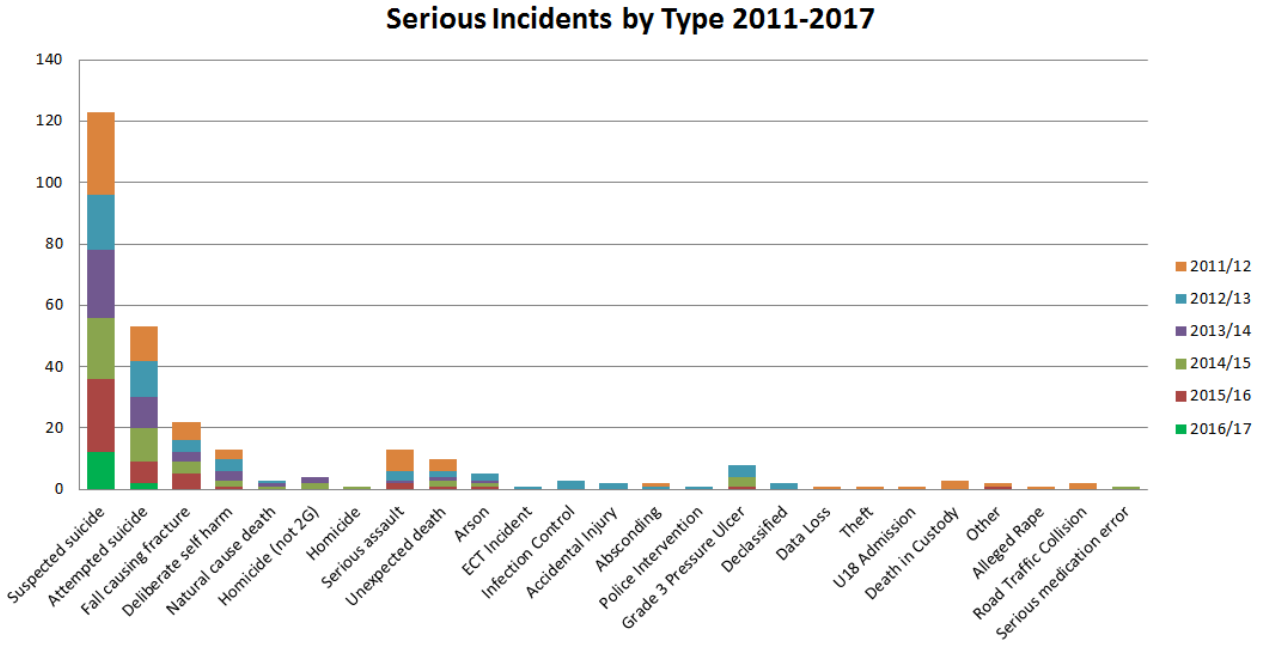


Figure 12

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."

Our upgraded Incident Reporting System (Datix) has been configured to ensure that any incidents graded moderate or above are flagged to the relevant senior manager/clinician, who in turn can investigate the incident and identify if the Duty of Candour has been triggered. Only the designated senior manager/clinician can "sign off" these incidents.

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 2016/2017

The following table shows the 10 metrics that were monitored during 2016/17. 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	2015-2016 Actual	National Threshold	2016-2017 Quarter 1
1	Clostridium Difficile objective	1	3	0	0	**0**
2	MRSA bacteraemia objective	0	0	0	0	**0**
3	7 day CPA follow-up after discharge	99.1%	97.73%	95.63%	95%	**97.06%**
4	CPA formal review within 12 months	96.4%	97.1%	99.35%	95%	**98.61%**
5	Delayed transfer of care	0.12%	0.06%	1.02%	≤7.5%	**1.66%**
6	Admissions gate kept by Crisis resolution/home treatment services	99.1%	99.57%	99.74%	95%	**98.87%**
7	Serving new psychosis cases by early intervention teams	100%	100%	63.56%	50%	**53.85%**
8	MHMDS data completeness: identifiers	99.7%	99.71%	99.57%	97%	**99.85%**
9	MHMDS data completeness: CPA outcomes	80.6%	97.06%	97.42%	50%	**97.40%**
10	Learning Disability – six criteria	6	6	6	6	**6**

Mandated Quality Indicators 2016 -2017

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 1 2015-16	Quarter 2 2015-16	Quarter 3 2015-16	Quarter 4 2015-16	Quarter 1* 2015-16
[2]gether NHS Foundation Trust	98.4%	97%	97.2%	98.10%	97.1%
National Average	97%	96.8%	96.9%	97.2%	96.2%
Lowest Trust	88.8%	83.4%	50%	80%	28.6%
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 1 2015-16	Quarter 2 2015-16	Quarter 3 2015-16	Quarter 4 2015-16	Quarter 1* 2016-17
[2]gether NHS Foundation Trust	99.5%	98.6%	100%	98.4%	98.9%
National Average	96.3%	97%	97.5%	98.2%	98.1%
Lowest Trust	18.3%	48.5%	61.9%	84.3%	78.9%
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 1 2016/17 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	Quarter 1 2016-17
[2]gether NHS Foundation Trust 0-15	0%	0%	0%	0%	0%
[2]gether NHS Foundation Trust 16 +	10%	7%	10%	6%	7%
National Average	Not available	Not available	Not available	Not available	Not available
Lowest Trust	Not available	Not available	Not available	Not available	Not available
Highest Trust	Not available	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 2gether 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 2016

This will be added following publication of the survey.

Staff Survey 2015

This will be added following publication of the results.

Annex 1: Statements from our partners on the Quality Report

These will be provided at year end.

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

This will be completed at year end.

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.
PBM	Positive Behaviour Management
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.
PMVA	Prevention and Management of Violence and Aggression
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@nhs.net

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 9 **PAPER D**

Report to:	2gether NHS Foundation Trust Board – 29th September 2016
Author:	Sian Waygood, Interim Service Experience Clinical Manager Lauren Wardman, Deputy Director for Engagement
Presented by:	Jane Melton, Director of Engagement and Integration
Subject:	**Service Experience Report Quarter 1 2016/17**

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

EXECUTIVE SUMMARY

(1) Assurance

This Service Experience Report provides a high level overview of feedback received from service users and carers in Quarter 1 2016/2017. Learning from people's experiences is the key purpose of this paper which provides assurance that service experience information has been reviewed, scrutinised for themes and considered for both individual team and general learning across the organisation.

Significant assurance that the organisation has listened to, heard and understood Service User 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 1, 94% of people who completed the Friends and Family Test said that they would recommend 2gether's services. This is a small improvement (1 percentage point) from the previous quarter. This represents a higher percentage than results from other Trusts nationally.

Limited assurance that people are participating in the local survey of quality in sufficient numbers.

Further work is underway to raise the profile of the Local Survey amongst staff and also to explore additional ways of collecting this information.

The establishment of a Task and Finish working group to review how people are involved in planning their care and treatment will also raise the profile of this source of feedback amongst staff.

Limited assurance that services are consistently reporting details of compliments they have received.

The Service Experience Department are working with Service Directors and the Communications Team to encourage consistent returns of compliments received. The profile of compliment reporting will be raised within ²gether and compliments will be shared with colleagues via the intranet in order to encourage reporting.

Full Assurance that complaints have been acknowledged in required timescale
During quarter 1 100% of complaints received were acknowledged within 3 days.

Limited assurance that all people who complain have received a letter detailing the complaint investigation outcome within the initially agreed timescale.

74% of complaints were closed within timescales agreed with the complainant. This figure has not been reported previously but performance against this measure will be reported in future reports.
The stages involved in the conclusion and reporting of investigations are continually reviewed for improvements by both the Service Experience Department and the clinical services that undertake the investigations. The handling of more initial contacts as concerns rather than formal complaints may also impact on the ability to adhere to initially agreed timescales.

Significant assurance is given that all people who complain have received regular updates on any potential delays to the response being provided.

(2) Learning and Improvement recommended

The Trust continues to seek feedback about service experience from multiple sources on a continuous basis.

This quarter there have been concerns raised by Service Users regarding their right to record consultations. This may be related to the publication of new guidance, 'Patients recording NHS staff in health and social care settings' May 2016. A Trust policy is being developed to guide staff and this will be cascaded throughout the organisation once ratified.

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

- Consistent application of information sharing policy when dealing with other statutory organisation. Staff have been advised to follow the guidance contained within 'Common-sense Confidentiality' and 'Data Protection and Confidentiality Policy'.
- Regular completion, recording and review of risk management plans in conjunction with and in relation to other relevant individuals.

Recommendations from the Parliamentary and Health Service Ombudsman are included within the report and this relates to a review which commenced in 2014 and relates to interventions provided between 2010 and 2013.

RECOMMENDATIONS

The Board is asked to:

- Note the contents of this report
- Note that the report has been scrutinised by the Trust's Governance Committee in September 2016.

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 Q1 2016/17 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 and inclusion of 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	September 22nd 2016

Where in the Trust has this been discussed before?		
Trust Governance Committee	Date	September 16th 2016

What consultation has there been?		
Service Experience Committee members	Date	August 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 MHA- Mental Health Act GHNHSFT – Gloucestershire Hospitals NHS Foundation Trust CCG – Clinical Commissioning Group BME – Black and Minority Ethnic Groups IAPT – Improving Access to Psychological Therapies PHSO – Parliamentary Health Services Ombudsman 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 1

1st April 2016 – 30th June 2016

"Thank you from the bottom of my heart for giving our beautiful girl back to us. Your support, guidance, inspiration and dedication has been appreciated beyond words. As you say the recovery is only just starting, but with your help we are out of the darkest place and ready for the continued journey."

Eating Disorders Service, Gloucestershire

"Thank you for your swift response in relation to my request for an urgent LD assessment on this young man. Your comprehensive recording and input has been extremely helpful in a difficult multiagency situation.

The last few days people have been going above and beyond what is expected and really making a difference to the lives of this family."

Learning Disabilities Team, Herefordshire

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 Service
GRIP	Gloucestershire Recovery in Psychosis
HR	Human Resources
CDW	Community Development Worker
CEO	Chief Executive Officer
BME	Black and Minority Ethnic Groups
IAPT	Improving access to psychological therapies
PHSO	Parliamentary and Health Service Ombudsman
CBT	Cognitive Behavioural Therapy
DMHOP	Department of Mental Health for Older People
CAMHS	Child and Adolescent Mental Health Service
CRHTT	Crisis Resolution and Home Treatment Team
MHA	Mental Health Act
MCA	Mental Capacity Act
CCG	Clinical Commissioning Group
GHNHSFT	Gloucestershire Hospitals NHS Foundation Trust
Q4	Quarter 4 (previous quarter)
FFT	Friends and Family Test (survey)

Service Experience Report – Quarter 1

1st April 2016 – 30th June 2016

Complaints 	**27** complaints (170 separate issues) were made this quarter. This is nearly the same as last time (n=26).	↔
Concerns 	**57** concerns were raised through PALS. This is 15 more than last time. We encourage people to tell us about any concerns about their care. This means we can make it better.	↑
Compliment 	**533** people told us they were pleased with our service. This is a lower number than last time (n=646). We will ask teams to tell us about every compliment they get.	↓
FFT 	**94%** people said they would recommend our service to their family or friends. This is nearly the same as last time (93%).	↔
Local Survey 	Gloucestershire: **48 people told us what they thought** Herefordshire: **11 people told us what they thought** We need to ask more people to tell us what they think.	↓
We must listen 	People can make recordings of their meetings with staff if they want to.	
We must listen 	People were unhappy that we shared information with other people, like the Police.	

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 provides an overview of people's reported experience of ²gether NHS Foundation Trust's services between **1st April 2016 and 30th June 2016**. It provides examples of the learning that has been achieved through service experience reporting, and an update on activity to enhance service experience.

1.1.2 **Section 1** provides an introduction to give context to the report.

1.1.3 **Section 2** provides information on emerging themes from reported experience of Trust services. It includes complaints, concerns, comments, compliments and survey information. Conclusions have been drawn via triangulation of information provided from:

- A synthesis of service experience reported to ²gether NHS Trust (complaints, concerns, comments, compliments)
- Patient Advice and Liaison Service (PALS)
- Narrative reports made by members of the Service Experience Committee
- Meetings with stakeholders
- ²gether meetings with patients in the ward environment
- ²gether local patient surveys
- National Friends and Family Test (FFT) responses
- ²gether Carer focus groups
- HealthWatch Gloucestershire reports and engagement events
- 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 Listening and responding to comments, concerns and complaints and being proactive about the development of inclusive, quality services is of great importance to [2]gether. This is underpinned by the NHS Constitution (2015[1]) and is a key component of the Trust's core values.

1.2.2 [2]gether NHS Trust's Service User Charter, Carer Charter and Staff Charter outline the commitment to delivering our values and this is supported by active implementation of [2]gether's Service Experience Strategy (2013). The Service Experience Strategy will be reviewed and updated during 2016/17 in collaboration with our stakeholders.

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.

Through a continuous cycle of learning from experience we will provide the best quality service experience and care.

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

Section 2 – Emerging Themes about Service Experience

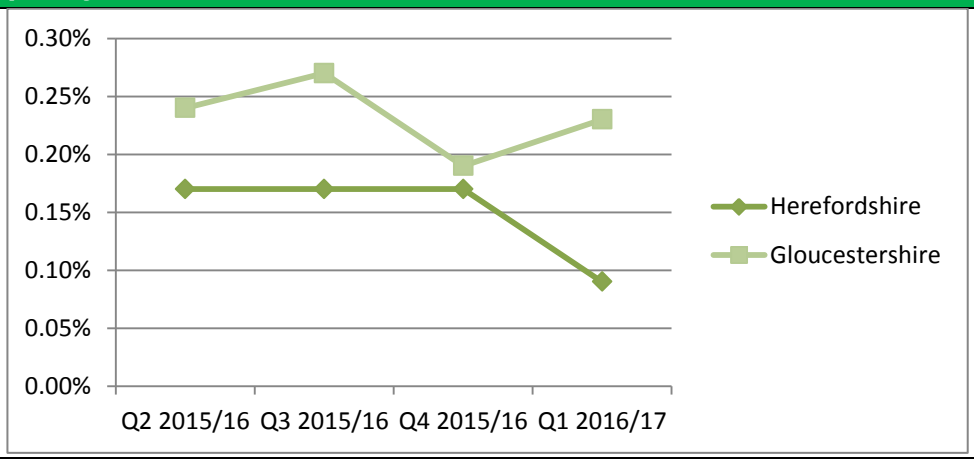
2.1 Complaints

Formal complaints to NHS service providers are highly governed and responses must follow specific procedures (for more information, please see the Trust's Complaints Policy). Complaints are welcomed by the Trust. We value feedback from service users and those close to them relating to the services they receive as this enables us to make services even more responsive and supportive.

Table 1: Number of complaints received this quarter

County	Number (including numerical direction and assurance)		Interpretation	Assurance
Gloucestershire	24	↑	There has been a small increase in the number of Gloucestershire complaints (Q4 = 20)	Significant
Herefordshire	3	↓	There has been a decrease in the number of Herefordshire complaints (Q4 = 6)	Significant
Total	27	↔	The total number of complaints received is similar to the previous quarter (n=26) and lower than the same period in 2015/16 (n=43)	Significant

Table 2: Number of complaints by population seen

County	Contacts*	Chart showing percentage of complaints to contacts over the past year
Gloucestershire	10,219	
Herefordshire	3,477	

this does not include primary care contacts

The proportion of complaints to contacts remains relatively consistent.

Table 3: Number of complaints closed this quarter

County	Number (including numerical direction and assurance)		Interpretation	Assurance
Gloucestershire	27	⇔	The number of complaints closed for Gloucestershire is similar to the last quarter (n=24)	Significant
Herefordshire	6	⇔	The number of complaints closed for Herefordshire is similar to the last quarter (n=7)	Significant
Total	33	⇔	The overall number of complaints closed is similar to the last quarter (n=31)	Significant

Table 4: Responsiveness

Target	Number (including numerical direction and assurance)		Interpretation	Assurance
Acknowledged with three days	100%	⇔	**All** complaints were acknowledged within target timeframes	FULL
Complaint closed within agreed timescales	74%		This has not been reported previously	Limited
Concerns escalated to complaint	12%		Of 57 concerns received, 7 were not resolved and so were escalated. This has not been reported previously.	Limited

Despite a slight increase in the number of complaints received, the Service Experience Department and clinical services have maintained closure rates. National standards for response times are adhered to and complainants receive regular updates on any potential delays in the investigation process.

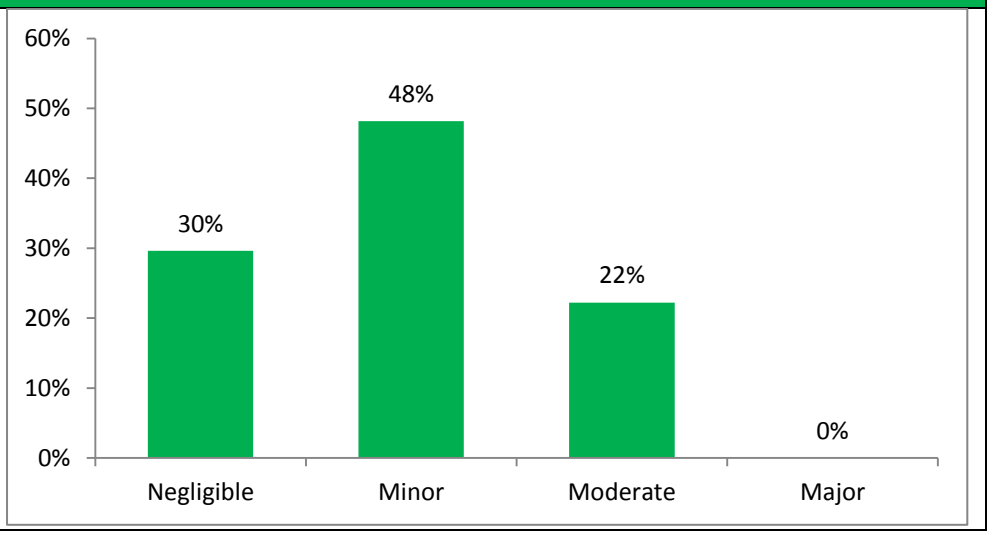
A change in the triage process has resulted in a greater number of contacts received by the Service Experience Department being handled as a concern rather than a complaint. This has resulted in a more prompt and less formal response to the issues raised. The relatively low number of concerns being escalated to complaints suggests that people are largely satisfied with this approach.

Table 5: Satisfaction with complaint process

Measure	Number (including numerical direction and assurance)		Interpretation	Assurance
Reopened complaints	4	⇓	This figure is lower than the previous quarter (n = 9) suggesting improved satisfaction with the complaint process.	Significant
Local Resolution Meetings	6	⇓	4 resolution and 2 engagement/ clarification meetings have been undertaken to assist in understanding complainants' concerns	Significant
Referrals to PHSO	1	⇓	One new complaint is being reviewed by the PHSO (previous quarter n = 2).	Significant

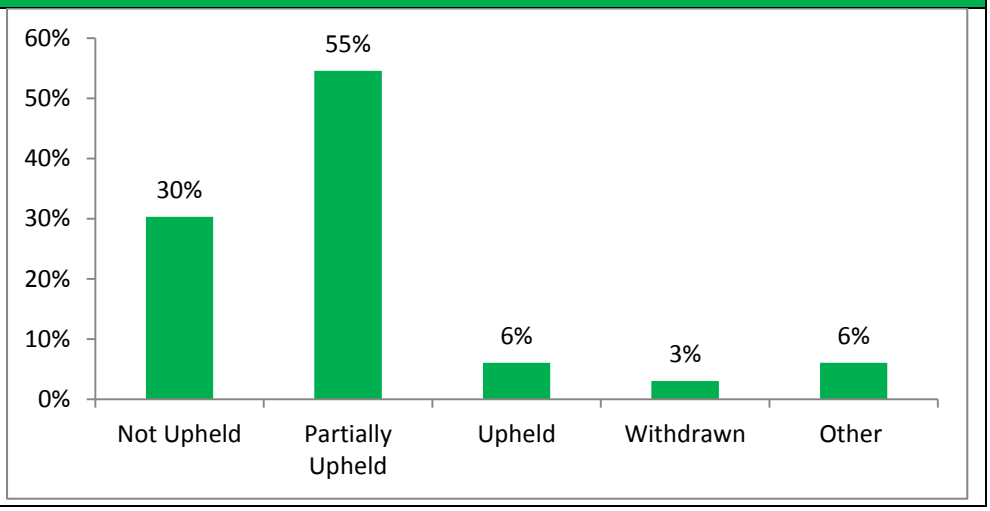
A reduction across these three areas provides some indication and assurance of general satisfaction with the concerns and complaints processes.

Table 6: Risk rating of complaints received this quarter

Rating	No.	Chart showing percentages
Negligible *Minimal impact on individual or organisation*	8	
Minor *Minor implications, reduced performance, single failure*	13	
Moderate *Significantly reduced effectiveness, failure to meet internal standards*	6	
Major *Complaint regarding serious harm or death*	0	

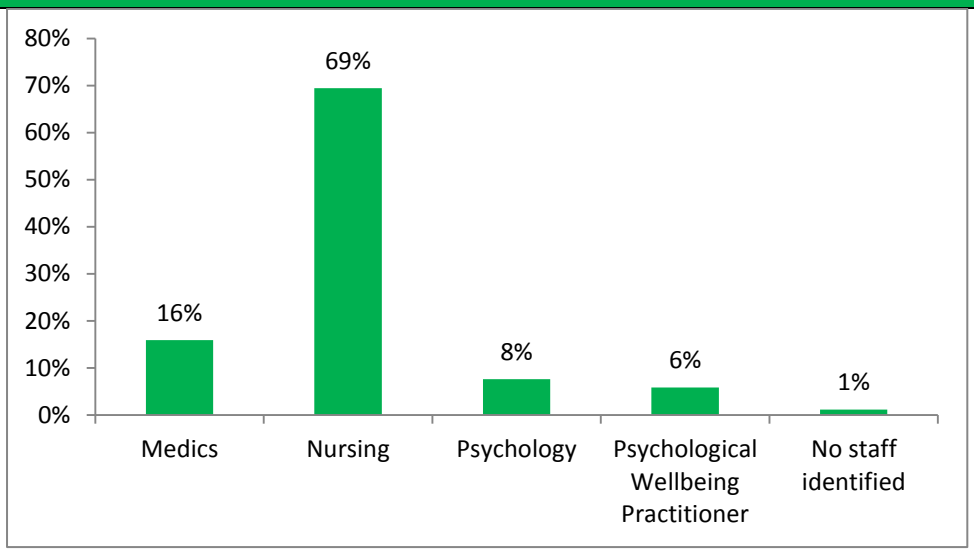
78% of the complaints received were classified as negligible or minor in terms of their impact on the individual or the organisation. All complaints are regarded as important for individuals and resolution is a key aim.

Table 7: Outcome of complaints closed this quarter

Outcome	No.	Chart showing percentages
Not upheld *No element of the complaint was upheld*	10	
Partially upheld *Some elements of the complaint were upheld*	18	
Upheld *All elements of the complaint were upheld*	2	
Withdrawn *Complaint was withdrawn*	1	
Other *Complaint issues did not relate to 2gether Trust*	2	

61% of the complaints closed this quarter (see Table 3) had their concerns upheld or partially upheld. This is the same as the previous quarter (58% partially upheld, 3% upheld).

Table 8: Breakdown of complaints by staff group for this quarter

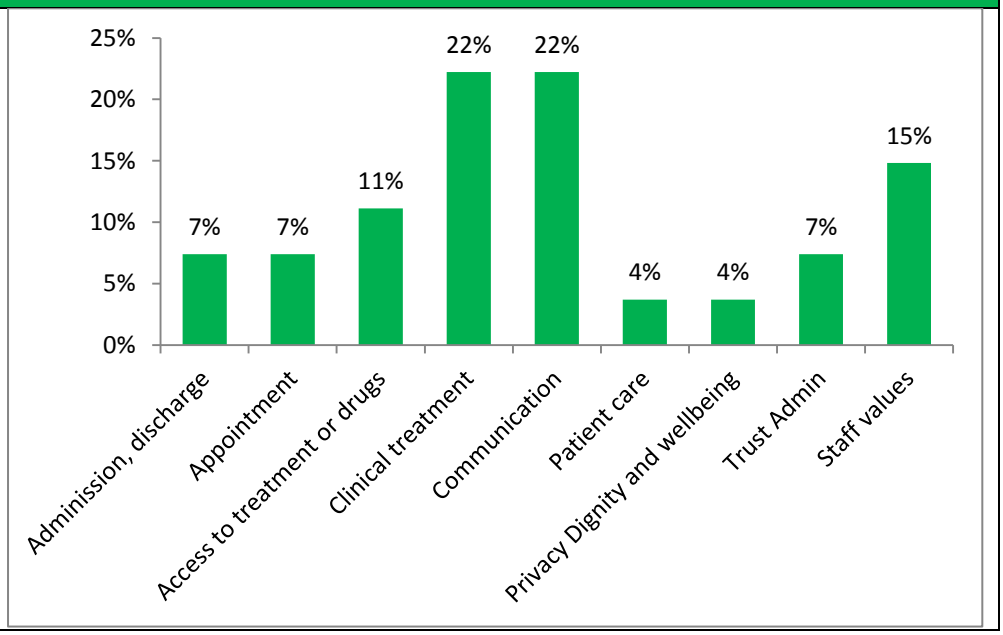
Outcome	No.*	Chart showing percentages
Medical	27	
Nursing	118	
Psychology	13	
Psychological Wellbeing Practitioner (PWP)	10	
No staff identified	2	

**The numbers represented in these data relate to a breakdown of individual complaint issues and relate to different staff groups.*

The number of complaint issues involving different disciplines and staff groups has been recorded for Health and Social Care Information Centre (HSCIC) this year. It has been possible to categorise the complaint issues by staff group and these data are presented in the table below.

Nursing represents the largest staff group in the Trust and has the greatest number of contacts. It is therefore understandable that they are associated with a higher proportion of complaint issues. Work is underway to ensure that professional leads are made aware of any themes relating to their professional group.

Table 9: Overarching complaint themes this quarter

Theme	No.	Chart showing percentages
Admission/discharge *Community or inpatient*	2	
Appointments *e.g. cancelled, staff DNA*	2	
Access to treatment *Treatment or medication*	3	
Clinical treatment *e.g. diagnosis, medication*	6	
Communication *Internal and external*	6	
Patient Care *e.g. observation, support*	1	
Privacy, Wellbeing *e.g. confidentiality, noise*	1	
Trust Admin *e.g. Health Records, MHA*	2	
Staff Values *Attitude and action*	4	

The two main complaint themes are ***clinical treatment*** and ***communication***. These two themes have been broken down into more detail overleaf:

*Figure 1: Breakdown of complaint issues relating to **clinical treatment***

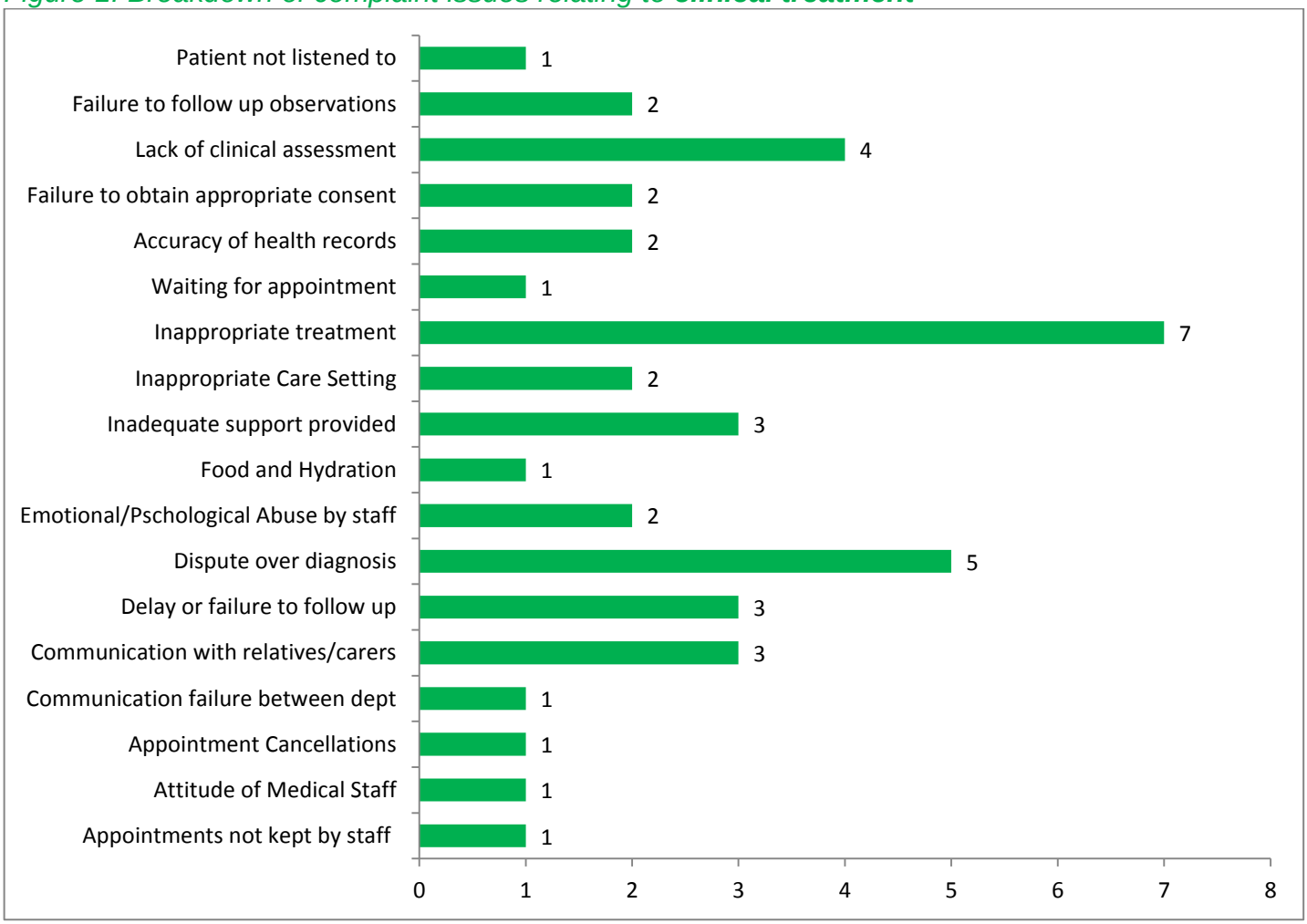
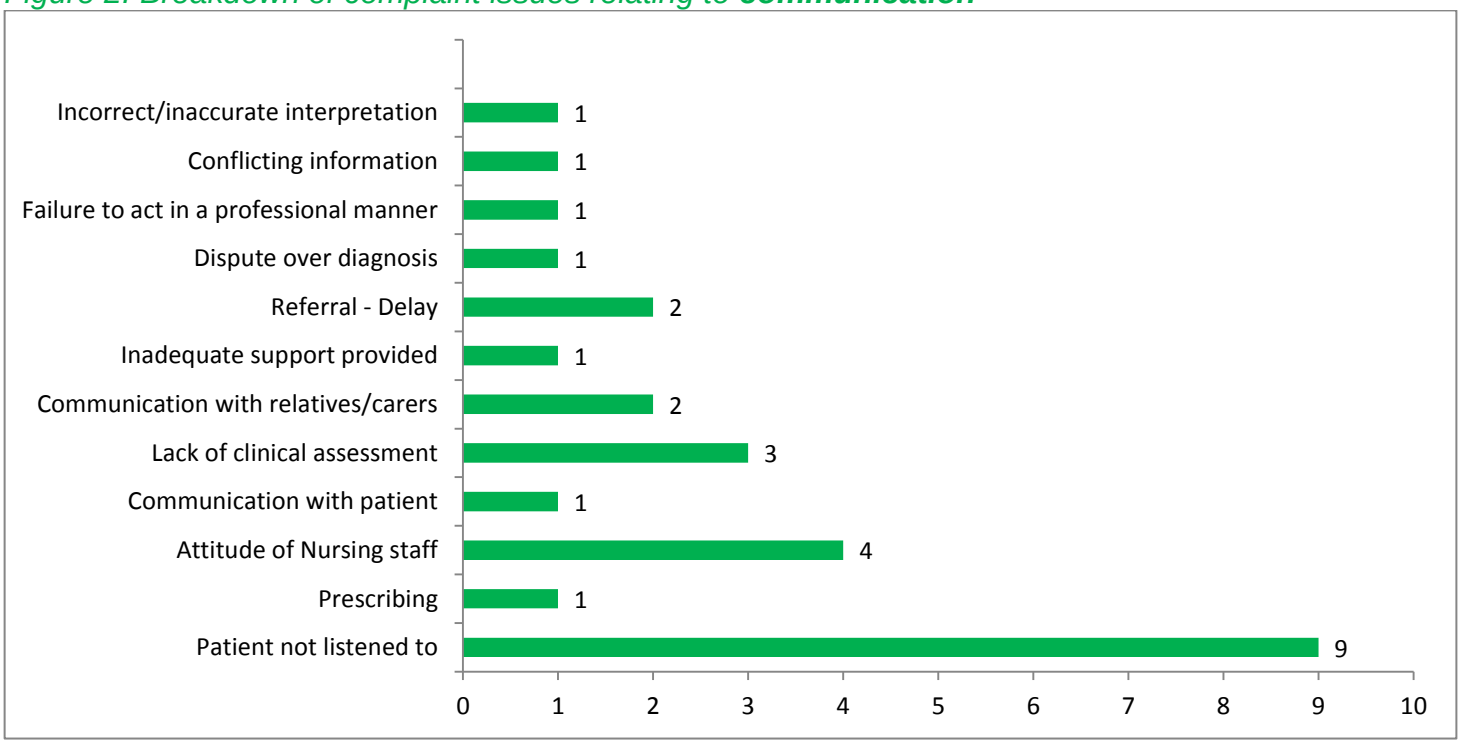


*Figure 2: Breakdown of complaint issues relating to **communication***



Analysis of data is undertaken by the Service Experience Department in order to identify any patterns of clinical concern e.g. similar issues being raised regarding the same service or practitioner. No such themes have been identified within the above data. However, nine people report that they do

not feel listened to and this is particularly important. The Time to Change Mental Health Practitioners work underway aims to address this.

Table 10: Examples of complaints and action taken

Example	You said	We did
Communication	You believed you were being discriminated against because of your religion	We explained that staff had recently completed 'Prevent Training', which highlights the risks of people being drawn into terrorism. We apologised and advised that the subject could have been broached more sensitively.
Clinical Treatment	You said treatment was valuable but there was a lack of cover if staff were away	We apologised and agreed to deliver for continuity of treatment and staff wherever possible. Teams will strive for timely and effective cover in the event of staff absence.
Staff values	You told us you were unhappy with the team administering your medication	We listened to how you would like your care delivered and arranged for your treatment to be managed through your GP in Primary Care.

2.2 Concerns

The Service Experience Department endeavours to be responsive to feedback and to resolve concerns before they become formal complaints. This has resulted in complaint numbers being maintained at a lower level this quarter and a corresponding increase in the number of concerns.

DatixWeb, a new complaints and concerns recording and reporting system, was piloted this quarter. The information gathered will allow greater data interrogation and improved opportunities for learning from feedback. The pilot highlighted that it has not been possible to draw themes and trends due to an omission in the collecting system. This has been rectified and this information will be available next quarter.

Table 11: Number of concerns received this quarter

County	Number (including numerical direction and assurance)		Interpretation	Assurance
Gloucestershire	47		There has been an increase in the number of Gloucestershire concerns (Q4 = 36)	Significant
Herefordshire	10		There has been an increase in the number of Herefordshire concerns (Q4 = 6)	Significant
Total	57		The overall number of concerns received has increased (Q4 = 42)	Significant

Table 12: Number of concerns closed this quarter

County	Number (including numerical direction and assurance)		Interpretation	Assurance
Gloucestershire	48		This is higher than last quarter	Significant
Herefordshire	7		This is higher than last quarter	Significant
Total	55		The overall number of concerns closed has increased (Q4 = 31)	Significant

Table 13: Other contacts and activity

Advice	Signposting
There were 34 episodes of advice offered this quarter	There were 26 episodes of signposting this quarter
9 episodes advised people on how best to raise issues regarding their experiences	18 were signposting to internal teams, such as Health Records, CYPS, and Social Inclusion
Advice was offered regarding how to access services, what advocacy is, and issues relating to the Mental Health Act	8 were signposting to external teams, such as the CCG, GHNHSFT, and advocacy

Examples of concerns and action taken

2.3 Compliments

Table 14: Number of compliments received

County	This quarter		Last quarter
Gloucestershire	513	↓	600
Herefordshire	15	↓	41
Corporate	5	↔	5
Total	533	↓	646

**this does not include primary care contacts*

The numbers of compliments that have been reported over time is noted to fluctuate. Currently, there is limited assurance that compliment information is consistently forwarded for collation and reporting. The Service Experience Department will work with Service Directors to encourage consistent returns and the profile of compliment reporting will be raised within the organisation. Compliments are being shared with colleagues via the Trust Intranet system to encourage reporting.

Example compliments

2.4 Comments received via HealthWatch

HealthWatch Gloucestershire gathers people's experiences and tries to understand people's needs in a variety of ways including:

- Supermarket information stands
- Events
- Working with Parish or Town Councils
- Working with specific groups, such as young people, BME communities, and people in the military

HealthWatch Gloucestershire has gathered 13 separate pieces of feedback relating to 2gether Trust this quarter. The feedback can be broadly broken down into the following feedback areas:

- Insufficient support offered by services (n=7)
- Reduced understanding, awareness, and confidence regarding the complaints process (n=2)
- Pleased with the service overall (n=2)

A selection of the comments can be seen below:

2.5 – Parliamentary and Health Service Ombudsman (PHSO)

One new case has been referred to the PHSO for review this quarter.

We received feedback from one PHSO investigation and this included recommendations for service improvements (see Table 15). The review related to issues raised by a complainant between 2010 and 2013. A comprehensive action plan is in place to address the areas of development.

Table 15: Recommendations from the PHSO from one case review

Development area identified by PHSO	Actions	Assurance
Risk assessments In addition to considering the risks to the individual patient, risk assessments must also be undertaken for all significant others in a person's situation.	All new clinical staff complete 'Clinical Risk, Planning Care and Electronic Recording' training	Significant
	Electronic recording training incorporates risk assessment and documentation management	
	Refresher training takes place every 3 years	
	Policy update training is completed as appropriate	
	'Learning from Complaints' to be a standing agenda item at Forum and Team meetings	
	Revised 'Assessing and Managing Clinical Risk and Safety Policy' due for ratification	
Effective communication must be undertaken with all significant others in a patient's environment including, and especially, matters of safety	All significant others to be offered copies of Care Plans as appropriate	Significant
	Dissemination of 'Common Sense Confidentiality' booklet	
	Triangle of Care being rolled out across the Trust	
	Revised staff guide on concern and informal complaint resolution (awaiting cascade)	
Complaints process The Trust needs to ensure a thorough, person-centred complaints process including: • Understanding concerns • Investigating complaint issues • Consent and capacity assessment and communication	Complaint issues are now reviewed and agreed by the complainant prior to commencing an investigation	Significant
	Investigation template introduced to support a review of the issues	
	Service User experience, including complaints, is part of induction for all new staff	
	Additional investigation training is in place for senior staff	
	A quality review is completed by identified service/ locality lead prior to the investigation being submitted	
	MCA – training available bi-monthly	
	Mandatory reading for all staff	
	Network of MCA leads and substantive MCA lead	
	Complaint Policy review	
	Meeting with Service Users and carers to review current complaints process	

2.6 Surveys

2.6.1 Friends and Family Test (FFT)

Service users are asked "*How likely are you to recommend our service to your friends and family if they needed similar care or treatment?*", and have six options from which to choose:

1. Extremely likely
2. Likely
3. Neither likely nor unlikely
4. Unlikely
5. Extremely unlikely
6. Don't know

The Trust has played a key role in the development of an Easy Read version of the FFT. Roll out of this version across our services ensures that all client groups are supported to provide feedback.

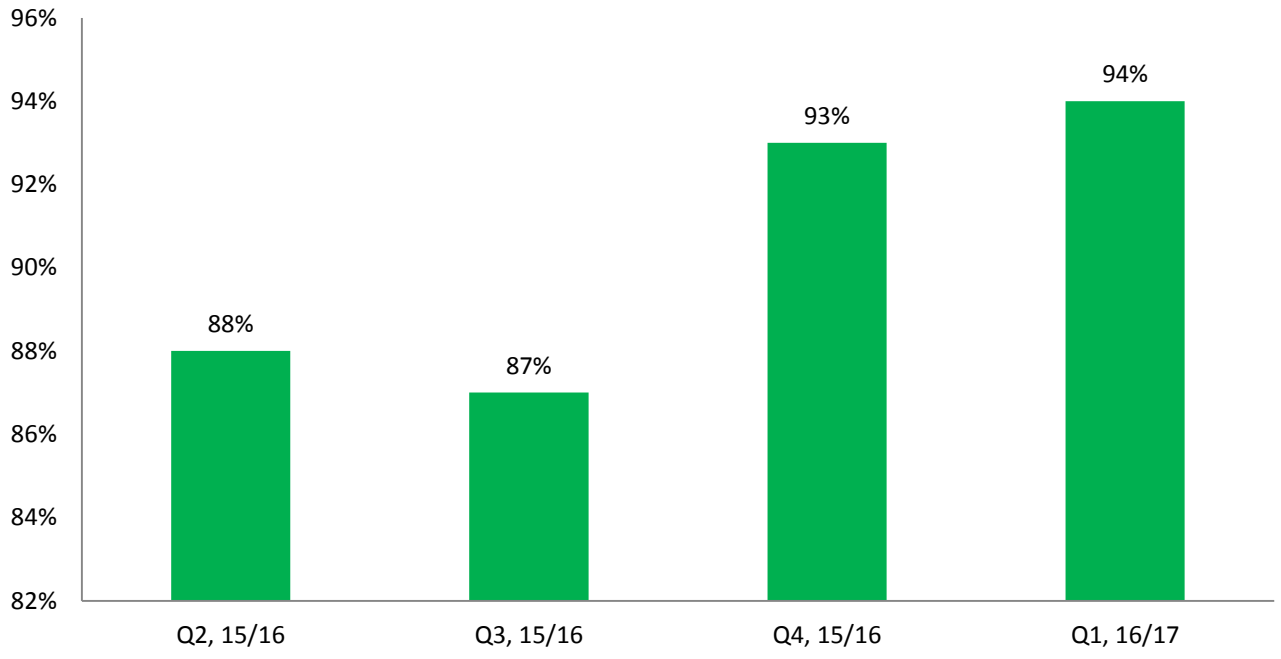
The table below details the number of responses received each month. The FFT score is the percentage of people who stated that they would be 'extremely likely' or 'likely' to recommend our services

Table 16: Returns and responses to Friends and Family Test in Quarter 1

	Number of responses	FFT Score (%)
April 2016	126	97%
May 2016	236	94%
June 2016	281	94%
Quarter Total	**643** (Q4=558)	**94%** (Q4=93%)

Figure 3: Friends and Family Test Scores for [2]gether Trust for the past year

The following graph shows the FFT Scores for the past rolling year, including this quarter. The Trust has received consistently positive feedback, which has improved incrementally over the past year.



Friends and Family Test Comments

What was good about the visit?

"To meet other people with this illness and be able to talk with them and gain a bit more information and understanding to feel not so isolated."
Managing Memory, Gloucestershire

Relaxed atmosphere, you can be yourself.
ASC Gloucestershire

Support to enable a patient to be able to attend appointment and have the extra assistance needed
IHOT, Gloucestershire

Felt at ease, explained no right and wrong answers, which reassured so a true assessment could be carried out.
Managing Memory, Herefordshire

My wife has really benefited from CPN and support worker visits
DMHOP North, Herefordshire

Hopeful for future
Honeybourne

I found the Stress and Anxiety course very informative, it helped me to identify what I was feeling and thinking, it gives good strategy to deal with the symptoms and helps to plan your time to stop you feeling anxious. It gave me the tools I needed to get back on top and the confidence to stay there. Medicine free.
Let's Talk, Gloucestershire

I am not sure what is the fuss all about I guess you got me better but leave me alone I want to finish my sandwich
DMHOP South, Herefordshire

Because the staff are amazing. I don't know how patient would have coped without them.
Priory Ward, Wotton Lawn

What would have made the visit better?

No radio playing during waiting, I do not like getting a song stuck in my head.
Dursley MHICT

More time to talk to other attendees
Managing Memory, Gloucestershire

Disabled parking absolutely horrible. Most cars parked in disabled bays do not display badges.
Herefordshire AOT
[Parking not managed by 2g]

I needed to speak to my nurse and from 9am-10:30am got put through to answer phone, I was distressed and unable to get through.
Recovery West, Gloucestershire

Feedback from surveys is analysed to ensure any themes are identified and is used to inform organisational learning.

Figure 4: Friends and Family Test Scores – comparison between 2gether Trust and other Mental Health Trusts across England

The following graph shows the FFT Scores for the past six months, including this quarter. The Trust receives consistently higher percentage recommendation than other mental health Trusts in England.

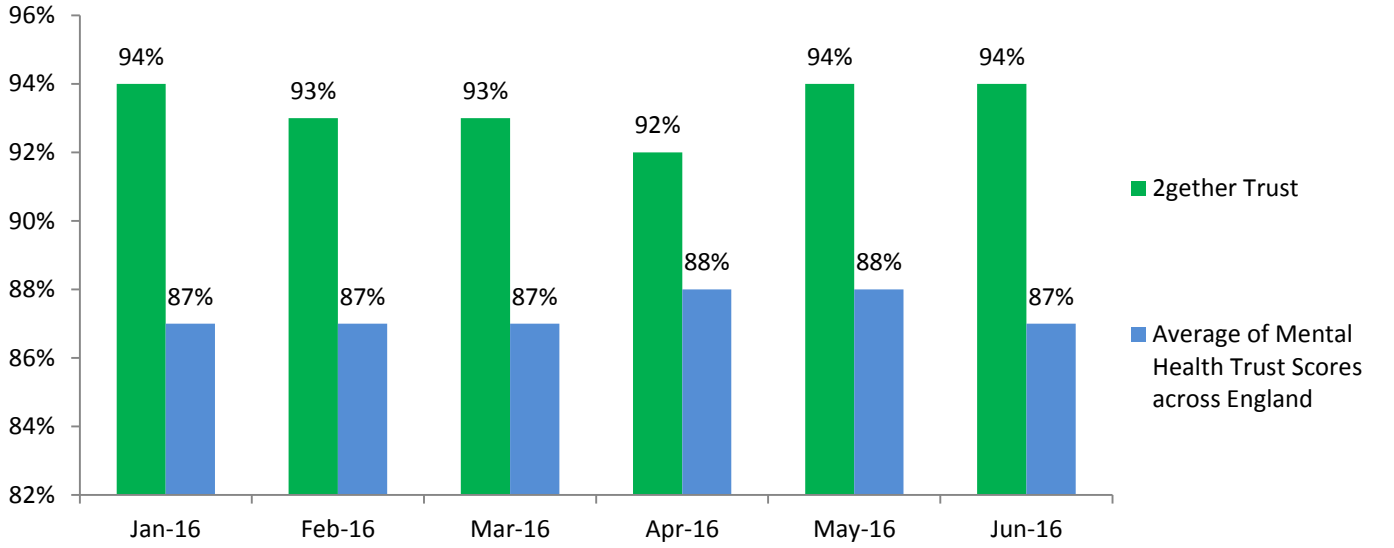
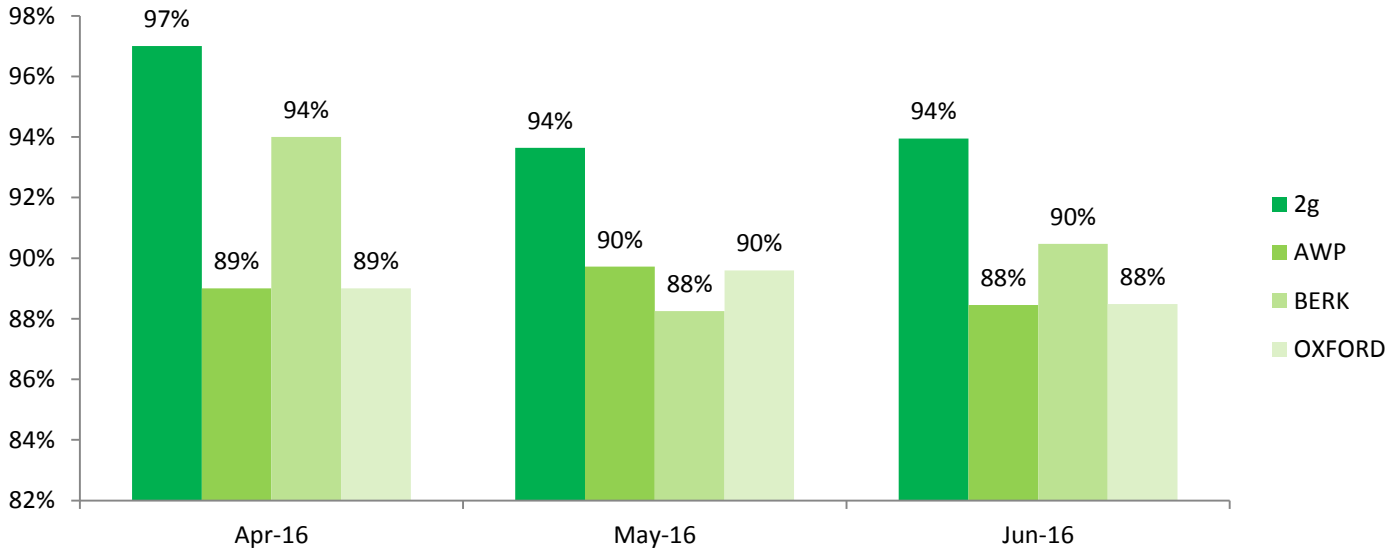


Figure 5: Friends and Family Test Scores – comparison between the 2gether Trust and other Mental Health Trusts in the NHS England South Central region

The following graph shows the FFT Scores for the April and May 2016 (the most recent data available). The Trust receives a higher percentage recommendation than other mental health Trusts in the NHS England South Central region.



2g – 2gether NHS Foundation Trust // AWP – Avon and Wiltshire Mental Health Partnership NHS Trust
BERK – Berkshire Healthcare NHS Foundation Trust // OXFORD – Oxford Health NHS Foundation Trust

2.6.2 Local Survey

The Local Survey provides Service Users with an opportunity to comment on key aspects of the quality of their treatment. It is available as a paper questionnaire and an online survey. We currently receive low numbers of returns and work continues to increase Service Users' and staff awareness of this method of feedback.

Table 17: Local Survey questions and responses

	Question	Treatment setting	Sample size (Gloucestershire)	Number 'yes' (Gloucestershire)	Sample size (Herefordshire)	Number 'yes' (Herefordshire)	Total % giving 'yes' answer
1	Were you involved as much as you wanted to be in agreeing what care you will receive?	Inpatient	19	13	5	3	75% TARGET: 78%
		Community	22	17	5	5	
		Total Responses	41	30	10	8	

	Question	Treatment setting	Sample size (Gloucestershire)	Number 'yes' (Gloucestershire)	Sample size (Herefordshire)	Number 'yes' (Herefordshire)	Total % giving 'yes' answer
2	Were you involved as much as you wanted to be in decisions about which medicines to take?	Inpatient	19	11	5	4	67% TARGET: 73%
		Community	20	13	5	5	
		Total Responses	39	24	10	9	

	Question	Treatment setting	Sample size (Gloucestershire)	Number 'yes' (Gloucestershire)	Sample size (Herefordshire)	Number 'yes' (Herefordshire)	Total % giving 'yes' answer
3	Do you know who to contact out of office hours if you have a crisis?	Inpatient	11	7	4	3	80% TARGET: 71%
		Community	20	17	5	5	
		Total Responses	31	24	9	8	

	Question	Treatment setting	Sample size (Gloucestershire)	Number 'yes' (Gloucestershire)	Sample size (Herefordshire)	Number 'yes' (Herefordshire)	Total % giving 'yes' answer
4	Has someone given you advice about taking part in activities that are important to you?	Inpatient	18	13	5	5	77% TARGET: 77%
		Community	20	15	4	3	
		Total Responses	38	28	9	8	

	Question	Treatment setting	Sample size (Gloucestershire)	Number 'yes' (Gloucestershire)	Sample size (Herefordshire)	Number 'yes' (Herefordshire)	Total % giving 'yes' answer
5	Has someone given you help or advice with finding support for physical needs?	Inpatient	19	15	4	2	70% TARGET: NONE SET
		Community	17	11	4	3	
		Total Responses	36	26	8	5	

	Question	Treatment setting	Sample size (Gloucestershire)	Number 'yes' (Gloucestershire)	Sample size (Herefordshire)	Number 'yes' (Herefordshire)	Total % giving 'yes' answer
6	Do you feel safe in our services?	Inpatient	19	14	5	4	85% TARGET: NONE SET
		Community	23	21	5	5	
		Total Responses	42	35	10	9	

Service Users have access to the Choice and Medication website which is available on our external website. Within the inpatient setting there are opportunities for 1:1 discussions with clinicians and pharmacists. A further improvement could be to support service users in community teams to seek out similar opportunities.

A Trust-wide focus on involving people in planning their care and treatment, including medication, has been established. A Task and Finish working group has been established and engagement with Service Users has been undertaken in order to better understand experience to date and how we can improve this moving forward. Collaboration amongst staff, Service Users and carers will ensure the design and delivery of an effective action plan to improve Trust performance in these key areas.

Section 3 – Learning from Service Experience Feedback

Section 3.1 – learning themes emerging from individual complaints

The Service Experience Team, in partnership with Service Managers, routinely record, report and take actions based upon the valuable feedback from complaints, concerns and comments. This table illustrates the lessons learnt from **individual** complaints and concerns. This includes learning when a complaint or concern has been upheld, partially upheld or not upheld.

*Table 18: Lessons learnt from **individual** complaints and concerns.*

Learning	Action taken	Assurance of action
You told us you were unhappy with what we said and wrote in your health records	We said we were sorry and advised that staff have been reminded of the importance of clear, balanced, objective and factual communication that meets professional standards.	Significant
	Patient information is kept on two electronic record systems and staff have been reminded to review all appropriate record systems	
	Staff will use appropriate assessment tools for face to face and telephone screening for clarity regarding assessment decisions	
I felt rejected by the Trust when I was not accepted for treatment	All staff must be person centred, ensuring individual's current and long term needs are considered.	Significant
	When input is not deemed appropriate the patient will be informed of the rationale and signposted to other services as appropriate.	
You failed to respond to my letter / telephone call	We said we were sorry and teams have been reminded to acknowledge letters and return telephone calls	Significant
You told us you were unhappy with the waiting time for services	We said we were sorry and advised that we are working with other partners to improve timeliness	Significant
Your care co-ordinator was absent from work and you were unsure who could give you support	Staff need to be clear who has accountability for someone's care when individuals are absent from work	Significant
You were unhappy about your diagnosis, level of care and discharge arrangements.	Staff use the CPA process and must be clear about needs that have been met and those that haven't.	Significant
	CPA review to be completed on RiO. Discharge summaries should be sent to the Service User/family and should identify both met and unmet needs.	
Your sleep was disturbed because you were cold	We said we were sorry the underfloor heating system was not working. The timer was adjusted to stop this happening again.	Significant

Learning	Action taken	Assurance of action
You said your partner needed treatment but the process was unclear	The review recommended that a visual flowchart of the referral route be developed so that the patient pathway between services is clearer.	Significant
You felt that you were barely acknowledged when you visited one of our wards	We said we were sorry as every visitor should be acknowledged when visiting our establishments	Significant

Section 3.2 – Aggregated learning themes emerging from feedback from this quarter

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 points of learning from Service Experience feedback. Localities, in partnership with corporate services, are asked to develop action plans to ensure that the learning is incorporated into future practice.

Table 19: Points of learning from Service Experience feedback – action plan to be sought from locality leads

Organisational Learning	Action Plan (to be sought)
People can make recordings of their consultations if they wish: • Staff need to be familiar with new guidance 'Patients recording NHS staff in health and social care settings' May 2016 • A Trust Policy is being developed to guide staff and this will be cascaded throughout the organisation once ratified.	
A person said they felt at risk and staff did not listen to their concerns: • Staff need to ensure they regularly complete, record and review risk management plans including consideration of risks to others • Risk assessment and management need to be carried out in collaboration with service users and other relevant individuals	
People said they were unhappy that another statutory agency was given information about their or their family member's mental health: • Staff to follow '*Common-sense Confidentiality - A guide for staff, carers, family and friends*' '*Data Protection & Confidentiality*' Policy, February 2016	

Section 3.3 – Assurance of learning and action from aggregated learning themes from last quarter

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 the assurance that services have provided around actions that have been completed as a result of previous aggregated lessons learnt.

Table 20: Points of learning from Service Experience feedback Q4 – action plan has been completed

Organisational Learning	Locality Directorate Plan	Date Assurance provided
Informing and involving service users in information that is shared with others about them is desirable.	Children's Services across both counties This has been addressed via practice notes to all clinicians and administrative staff and updates at Team meetings	August 2016
	Gloucestershire Lead nurses to be asked to incorporate this issue into their care planning work – where information is being shared, this is noted in the care plan. Lead nurses to share this advice and take to forums	June 2016
	Herefordshire An email has been sent to all Team/Ward Managers requesting that staff inform and involve service users that information may be shared with others and to record in RiO when this has been done	August 2016
People value bespoke, clear, jargon-free communication to share information and advice (both written and verbal).	Children's Services across both counties This has been addressed via practice notes to all clinicians and administration staff. Services are using information from participation sessions and patient feedback to develop written information which is clear and jargon free and to improve communication to reflect the views of patients and their families.	August 2016
	Gloucestershire As above, care plans to be written in accessible language. In relation to wider communication approaches used throughout the organisation the Communications Team have agreed to support work in developing advice and guidance regarding plain English and Easy Read information. Gloucestershire Localities and Countywide services to discuss way forward at Delivery Committee in June 2016.	June 2016
	Herefordshire An email has been sent to all Team/Ward Managers asking them to remind staff to communicate with service users and carers in a clear non-jargon way	August 2016

Agenda item 10 **Paper E**

Report to: Trust Board –29th September 2016
Author: Marie Crofts, Director of Quality
Presented by: Marie Crofts, Director of Quality

SUBJECT: **Safe Staffing Inpatient Services – 6 monthly update**

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

EXECUTIVE SUMMARY

The Trust Board is mandated to receive a 6 monthly report outlining the requirements of the NHS National Quality Board (NQB) guidance on safe staffing levels *'How to ensure the right people, with the right skills are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability* (November 2013)

The Trust Board received the last 6 monthly update in March 2016. The Governance Committee continues to receive a monthly report detailing staffing levels across all inpatient sites.

This six monthly update paper outlines :

- Progress on each of the ten expectations within the NQB guidance
- National reporting requirements, latest developments and a summary of the latest data (August 2016) in the required format
- Local Trust exception reporting
- Latest information regarding the use of temporary staff

This paper provides **significant assurance** regarding delivery against the 10 national expectations and **significant assurance** in relation to actual staffing levels against planned. The last six months (March-August 2016 inclusive) has seen continued high compliance against planned staffing levels.

In summary for August 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
- **96.7%** of the hours exactly complied with the planned staffing levels
- **2.7%** of the hours during August had a different staff skill mix than planned staffing however overall the staffing numbers were compliant and the needs of

patients were met
- **0.6%** of the hours during August had a lower number of staff on duty than the planned levels, however this met the needs of the patients on the ward at the time

There was 1 shift where it was reported that the skill-mix of staff was non-compliant and the needs of patients were not met

The report also includes a narrative from the wards where there have been a high number of exceptions to ensure that the Board is sighted on the reasons for such exceptions.

Current developments:

- Safer staffing guidance update:

The National Quality Board (NQB) is currently reviewing the safer staffing guidance for all specialities. We are still awaiting publication of the mental health work-stream guidance which is due to be published in late September/ early October 2016. This will inform future staffing across inpatient and community teams.

- Temporary staffing and agency control mechanisms:

In order to maintain the actual against planned levels of nursing staff and at times of high clinical acuity, wards will use temporary staffing (bank and agency). NHSI, from November 2015, mandated all Trusts to report the use of agency shifts on a weekly basis. In addition NHSI have issued a control total for each Trust. For 2gether NHSFT this is a reduction in agency use of £2m.

In order for the Trust to ensure the required focus on temporary staffing a project board chaired by the Director of Quality has been established with representation from both the Director of Finance and Director of Workforce and OD. Focussing initially on nursing inpatient agency use there has been significant progress. The next focus is with both medics and AHP professionals.

RECOMMENDATIONS

The Board is asked to :

- Note the assurance regarding staffing levels within inpatient units
- Note the national developments and progress made locally across all 10 expectations
- Note the work to reduce reliance on agency spend through the Project Board

Corporate Considerations	
Quality implications:	The quality of patient care is directly linked to staffing capacity and capability.
Resource implications:	Investment in in-patient staffing of £1m occurred in Gloucestershire in-patient units in 2013/14. Herefordshire in-patient unit staffing is reviewed in line with planned contractual bed reductions. There are resource implications where agency staff are necessary to ensure safe delivery of services.
Equalities implications:	Equality implications and responding to specific patient need are reflected in the agreed staffing levels
Risk implications:	There is a risk to the quality and safety of patient care if staffing levels fall below the agreed staffing levels, or are not flexibly increased if the patient acuity and dependence increases. Use of agency staff is now one of the top 5 risks for the Trust (ID 116)

WHICH TRUST STRATEGIC OBJECTIVE(S) DOES THIS PAPER PROGRESS OR CHALLENGE?	
Continuously Improving Quality	P
Increasing Engagement	
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		Can do	
Valuing and respectful	P	Efficient	

Reviewed by:		
Marie Crofts Director of Quality	Date	22 September 2016

Where in the Trust has this been discussed before?		
The published guidance was discussed at the Nursing Professional Advisory Committee	Date	5th December 2013
Executive Committee		December 2013
Governance Committee		Every month since January 2014
Trust Board		March; September 2015 and March 2016

What consultation has there been?		
Matrons have been involved in the agreement of minimum staffing levels in their areas during 2013	Date	December 2013
Matrons were consulted on how the format of presenting the staffing levels on their wards		
Feedback from Charlton Lane Matron on staffing		February 2014
Oak House staffing levels Execs & Herefordshire		June 2014
Hollybrook staffing levels from Matron and Ward Manager		September 2014
Review of all wards using MH framework from NHSE		September 2015
Engagement with community teams		August 2015

Explanation of acronyms used:	NHSE – NHS England NQB - National Quality Board NHSI- NHS Improvement AHPP- Allied Health Professionals and Psychologists NMC- Nursing and Midwifery Council

1. CONTEXT

1.1 The National Quality Board, sponsored by Jane Cummings, Chief Nursing Officer in England, on 19th November 2013 published new guidance to support providers and commissioners to make the right decisions about nursing, midwifery and care staffing capacity and capability: '**How to ensure the right people, with the right skills, are in the right place at the right time:** ***A guide to nursing, midwifery and care staffing capacity and capability'.***

1.2 The Trust Board reviewed the above guidance at its meeting in January 2014 and approved the core planned staffing levels for all inpatient areas. The Board has received four further 6 monthly updates in September 2014, March 2015; September 2015 and March 2016

1.3 This paper is required to update the Board on the progress with the 10 key expectations within the NQB guidance. In addition this report also includes:

- National reporting requirements, latest developments and summary of the latest data (August 2016) in its required format
- Local Trust exception reporting
- Latest information regarding the use of temporary staff

2. PROGRESS ON THE NQB 10 KEY EXPECTATIONS

Expectation 1: *Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability*

Progress to date:

- The Trust Board receives 6 monthly updates on staffing levels – this report being the fifth of such updates
- There is a robust mechanism in place through the Governance Committee to assure the Board that staffing levels are safe throughout the inpatient units; that staff are involved in the assessment of appropriate staffing levels and the information is publically accessible
- A quarterly report is presented to the Governance Committee to update regarding the use of temporary staffing

Expectation 2: *Processes are in place to enable staffing establishments to be met on a shift-to-shift basis*

Progress to date:

- Planned staffing levels against actual staffing levels are routinely monitored by the Director of Quality and through the Governance Committee
- Actual staffing levels are on average over 96% compliant (against planned) month on month

- An escalation protocol is in place in order that the nurse in charge of each shift can raise any concerns regarding staffing levels directly with the Director of Quality
- Reporting of temporary staff in particular agency staffing has been highlighted to the Governance Committee from April 2016 and a separate quarterly report on the use of temporary staffing will be presented to the Committee
- The Trust has been given an agency control total for 2016/17 which includes inpatient nursing spend (also includes medical and other agency spend)
- Where actual staffing levels are above planned (ie over 100%) these are routinely explored by the Director of Quality at ward level and reported to the Governance Committee
- There has been large scale recruitment of qualified nurses within inpatient wards which will result in a reduction in the use of agency from the end of September 2016 (19 newly qualified nurses)

Expectation 3: *Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability*

Progress to date:

- No specific mental health or learning disability tools are nationally available however staffing levels were determined following consultation with ward managers and Matrons and have been reviewed at regular intervals. These have been benchmarked against other Trusts to ensure rigorous challenge
- The nurse in charge of each shift uses their professional judgement to determine whether there is an appropriate level of staffing on the ward to ensure patient safety. This is in addition to the planned levels of staff being established to ensure patient safety on each shift
- The Trust internal monitoring system ensures the Director of Quality is aware of mitigation put in place where staffing levels have fallen below the expected planned levels
- The National Quality Board (NQB) is currently reviewing all safer staffing guidance including mental health. This is due to be published in late September/ early October 2016

Expectation 4: *Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns*

Progress to date:

- All ward managers are aware of the escalation protocol which enables them to report any concerns directly to the Director of Quality should they wish to do so
- The nurse in charge of each shift has overall responsibility to ensure their wards are staffed appropriately such as requesting additional staffing subject to increased acuity of patients
- Ward level managers report on a monthly basis reasons for exceptions to planned levels (either over or under) in an open and transparent way

- The Trust has implemented 'Speak in Confidence' to enable all staff to report concerns in an anonymous way
- Around 750 staff have attended four 'Care and Compassion' conferences to build resilience and engender a culture of openness, responsiveness and compassionate care
- Around 200 staff have attended a 'Glimpse of Brilliance' workshop
- A Collective Leadership programme has been invested in for Band 7 staff to enhance leadership skills and engender delivery of value based high quality care and creating a culture of organisational responsibility
- A programme of patient safety visits is a core part of the patient safety programme where staff at all levels have the opportunity to raise concerns or issues or highlight good practice

Expectation 5: *A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments*

Progress to date:

- Initial staffing levels were agreed by the Trust Board including all relevant Executive Directors
- Following publication of the revised safer staffing guidance further discussion will take place if any significant changes are required
- Any revised guidance will take into consideration other professional groups delivering care within inpatient environments (such as AHPP's etc)
- The STP workforce work-streams will identify the skills and knowledge needed from the workforce going forward which will cut across professional groups

Expectation 6: *Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties*

Progress to date:

- Staffing levels have been set to ensure all ward managers are supernumerary to the agreed levels and the band 6 level nurses have sufficient time to fulfil other duties
- No inpatient wards have reported to the Director of Quality an inability to deliver safe care owing to either direct or indirect duties

Expectation 7: *Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review*

Progress to date:

- The Governance Committee (on behalf of the Board) receives a detailed monthly report on actual staffing levels against planned levels
- The summary of this report is reported to the Trust Board each month
- All mandated information is uploaded onto the 'Unify' site and in addition staffing reports are uploaded onto our Trust website

- The Trust Board receives a 6 monthly update in full regarding capacity and capability as outlined in the current NQB guidance
- Following the establishing of the Project Board for Temporary staffing the Governance Committee has received quarterly updates on progress of this project board

Expectation 8: *NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift*

Progress to date:

- Each ward clearly displays information relating to planned versus actual staffing on a shift by shift basis which is publically accessible
- Monthly submissions to 'Unify' take place in line with national reporting requirements
- Uploading to the Trust website and NHS Choices continues as planned

Expectation 9: *Providers of NHS services take an active role in securing staff in line with their workforce requirements*

Progress to date:

- Recruitment and retention is a key strand of the nursing strategy – large scale recruitment of qualified nurses has recently taken place which will impact on the use of agency from September 2016
- An innovative approach has taken place within Herefordshire where first year students have been recruited onto our staff bank on annualised hours contracts. This will reduce the use of agency and create a workforce aligned to the Trust when they qualify
- Workforce remains one of the top 5 risks for the Trust
- Our CEO is leading the STP workforce work-stream in both Counties ensuring the mental health and learning disability workforce requirements are at the forefront of any new models of care
- A bid to pilot the newly proposed 'Associate Nurse' training programme has been submitted by both the University of Gloucestershire and the University of Worcestershire. The Director of Quality has had a key role in the submission for Gloucestershire
- The University of Gloucestershire is applying for accreditation and validation with the NMC to establish a pre-registration nurse training course with a preferred start date of September 2017
- The University of the West of England has commenced a mental health cohort of pre-registration nurses at their Gloucester campus
- A project board in relation to temporary staffing including recruitment and retention is being led by the Director of Quality with other key executive directors supporting

Expectation 10: *Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract*

Progress to date:

- Local CCG Directors of Nursing are members of the Trust Governance Committee where nurse staffing is a standing agenda item
- All reports relating to safer staffing are shared with the CCGs at the Clinical Quality Review Groups in each County
- The GCCG chief nurse continues to chair a strategic nurse education forum (involving all the Directors of Nursing in the County) in order to move forward the nursing workforce challenges across the County

3. NATIONAL GUIDANCE AND DEVELOPMENTS:

3.1 Safer staffing guidance:

The National Quality Board (NQB) is currently reviewing the guidance across all specialities. The mental health work stream is being led by the Director of Nursing from MerseyCare. This revised guidance is due to be published in late September/ early October 2016. Any relevant changes will be reported through the Governance Committee to the Board

3.2 Use of temporary staffing:

The use of temporary staffing is both a national and local priority in terms of understanding use and ensuring the Trust is managing any potential risks. The monthly safe staffing report assures the Governance Committee and the Board that the inpatient units consistently have a high compliance rate with our planned v actual staffing levels. However, this includes the use of bank and agency staff to ensure compliance

3.3 In order to ensure high quality services are delivered it is important that not just the numbers of qualified and unqualified staff are appropriately monitored but also the level of temporary staffing to fill these shifts. Reduced patient safety may be associated with increased use of agency staff who may be unfamiliar with the ward or unit

3.4 The Trust has been mandated to reduce overall agency spend (across all staff groups) by over £2m in 2016/17. This is being monitored closely through the Project Board and the Executive Committee. A Senior Leadership Forum session has also been used to raise this with all professional heads in order to gain grip and focus on this important issue.

3.5 The Trust alongside all other NHS providers has been mandated to report on numbers of agency shifts (across all staff groups) weekly since November 2015. NHSI has mandated the use of the NHS agency framework and issued price caps on agency rates. Those Trusts using off framework and above price cap agencies are scrutinised on a weekly basis by the CQC and NHSI. We continue to use agencies off framework and above price cap. In addition the Trust now has to report where the individual agency worker receives payment above the wage cap

3.6 Reporting of use of bank and agency within the inpatient settings shows that in Herefordshire agency use has reduced from around 80% to around 60-65% of

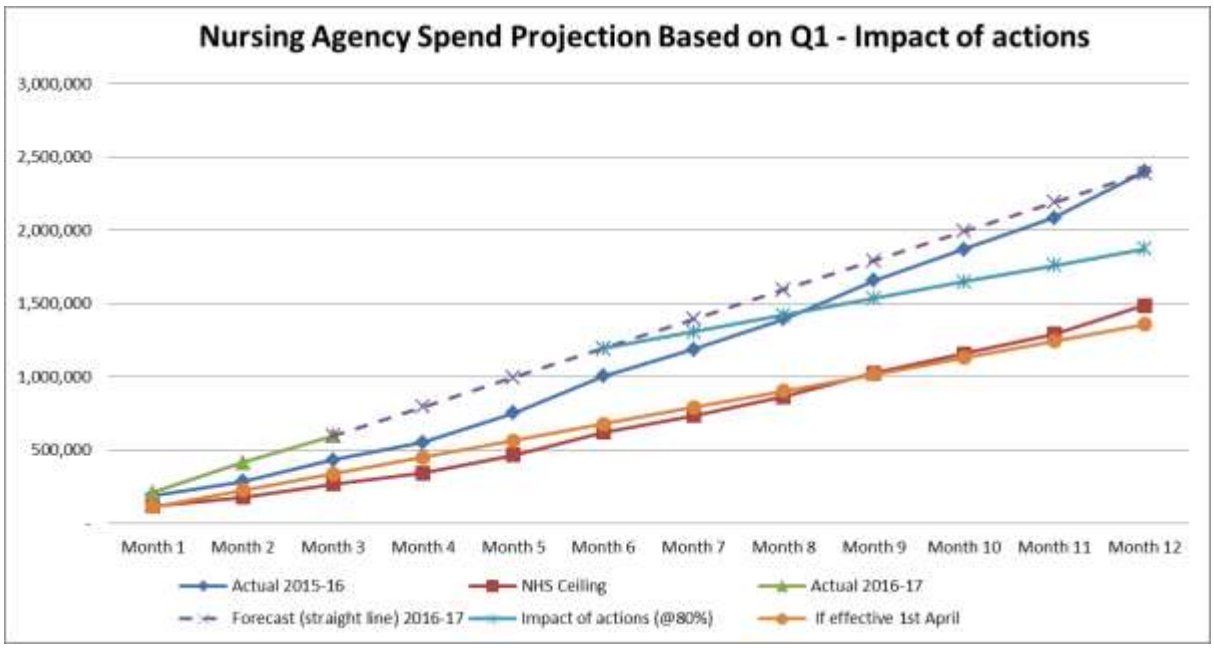
shifts covered whilst in Gloucestershire that is remains around 20%. The most common reasons for use of agency within both Counties are management of vacancies, clinical need and sickness. There has been a series of events to enhance use of bank within Herefordshire which will show results over the coming weeks.

3.7 There are currently around 22 actions ongoing with regards to nursing agency reduction. These include:

- Satellite staff bank set up in Herefordshire (RMN's and HCA's)
- 19 newly recruited registered nurses commencing in post in Aug/Sept
- 9 PWP workers recruited to IAPT
- Student /practitioner programme to commence in September across Herefordshire
- Up to 128 shifts per week can be saved
- Potential monthly nursing saving = £86,000

3.8 For the purposes of the trajectory we have assumed an 80% impact of the above actions. Evidence of progress on a weekly basis has been demonstrated with Herefordshire reduction in the percentage of agency use per week which has fallen from 80%-60+%.

3.9 The graph below details projected nursing agency spend once the actions currently progressing have impacted. Although this suggests the NHSI target will not be met it will have significantly reduced the nursing agency spend.



3.10 The project Board has now focused on both the medical agency spend and the AHPP and admin spend. All Heads of profession have been tasked with examining every agency post currently being funded. The Medical Director is

identifying any actions which can be put in place to reduce medical locum spend.

3.11 E-rostering is a key action within the action plan and will impact on the agency use and spend. It is currently planned to be implemented during this financial year. The service specification will be signed off by the Matrons and Executive team in September.

3.12 It is worth noting that often agency staff are used when there is high levels of acuity (for example of number of service users requiring 1;1 support). This is over and above what the current establishment on the wards can manage and is in effect 'extra contractual activity'. We are working with the CCG's and NHSI as to how best to capture this information.

3.12 The temporary staffing project board will continue to push forward at pace actions to reduce agency spend and report to both the executive committee and the Governance committee.

4. LOCAL TRUST EXCEPTION REPORTING

4.1 In line with previous internal Trust reporting, the Director of Quality has continued to collect and collate the reasons where core planned staffing levels have not been met through the internal exception codes. This includes both fill rates which are under and over planned levels. It is important to note that these are relatively rare events (in terms of percentages of overall fill rates) within our inpatient services and that in August 2016 over 96% of planned levels actually occurred. This local reporting is in addition to the national reporting and supports analysis of any issues which may arise regarding skill mix within the units and how the nurse in charge mitigates these risks. However, the fill rates do include the use of temporary staffing to support this.

4.2 <u>Ward specific information</u>
There are shifts where the core actual staffing hours may not exactly reflect the core planned staffing levels - the main reasons are outlined below:

- Increase numbers of staff on duty to provide one to one care for patients;
- Decrease in staff, if the patient need does not require it e.g. patients on leave, or staff supporting other wards where the need is higher;
- The planned staffing numbers are based on pre-empted activity and dependency levels. This is determined by the nurse in charge for a set time frame and these may vary, for example; decisions may be made to replace a qualified nursing shift with a health care assistant who know the patients and the ward, rather than a bank/agency qualified nurse who may not. National Quality Board guidance states that the nurse in charge must use their professional judgement alongside the planned staffing requirements to meet the needs of the patients on the ward at any particular time
- The reasons for internal exceptions will only be reported where they are significantly high in number

4.3 In summary for **August 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
- **96.7%** of the hours exactly complied with the planned staffing levels
- **2.7%** of the hours during August had a different staff skill mix than planned staffing however overall the staffing numbers were compliant and the needs of patients were met
- **0.6%** of the hours during August had a lower number of staff on duty than the planned levels, however this met the needs of the patients on the ward at the time

There was 1 shift where it was reported that the skill-mix of staff was non-compliant and the needs of patients were not met

The report also includes a narrative from the wards where there have been a high number of exceptions to ensure the Board is sighted on the reasons for such exceptions.

4.3.1 Wotton Lawn Hospital:

Abbey
All Code 1 exceptions are due to vacancies and sickness.

Greyfriars
The Code 1 and 2 exceptions are due to staff vacancies and sickness.

Priory
The Code 1 exceptions were due to four staff vacancies

4.3.2 Stonebow Unit:

The unit has only seen code 1 variations on Cantilupe Ward. This remains an issue due to current staff nurse vacancies on the ward. Whilst all staff are rotating, staff nurses cannot be depleted in the day time due to named nurse commitments e.g. ward rounds etc. Therefore regular HCA staff are covering the second staff nurse role at night

4.3.3 Learning Disability Units:

Hollybrook is on target to be fully functioning as an Assessment and Treatment service in November 2016 and staff are actively involved in merging both staff teams. Work is underway to transfer the two Westridge patients to their new care provider and staff will gradually withdraw between over a period consistent with patient need. Discussions with CQC regarding the de-registration of Westridge continue.

Staff bank have apparently been struggling to cover the large amount of shifts required for both Hollybrook and Westridge and we have seen an increase in agency usage at Hollybrook.

Westridge and Hollybrook :
Following the recent skill mix review concluded in December 2015 only one qualified staff is required per shift as a minimum. This is due to low patient numbers in both Units.

At Hollybrook code 2 exceptions were reported, where the Unit was safely managed with reduced staffing numbers.

There are low patient numbers in the Unit and staff work flexibly across busy shift times to minimise impact of reduced staffing, this has enabled safe management at Hollybrook. When necessary, staff have been relocated from LDISS to support Hollybrook.

4.3.4 Gloucestershire Recovery Units:

During August Laurel House had one qualified vacancy and one member of staff on long term qualified sickness. This shortfall has been reduced by rota changes to report Code 1 exceptions where the skill mix has been reduced but staffing numbers remain correct, therefore providing an effective and safe environment.

Honeybourne has one qualified staff and the Unit manager on long term sick and two qualified 'acting up 'to manager and deputy roles. This has potentially produced a substantial loss of planned shifts. Creative rostering has reduced the reported exceptions to code 1, where skill mix is reduced but staffing numbers are correct to provide a safe and effective environment. In addition there is one reported occasion where a code 3 exception occurred. This was due to a staff member having an unexpected family bereavement. Due to last minute notification shift cover was not possible and decision was made that the unit was safe with the extra input from an Allied professional for half of the shift and further support from Laurel House should it be required.

4.3.5 Charlton Lane Hospital:

Chestnut Ward
The ward has reported a number of Code 1 exceptions- Minimum staffing numbers were not compliant but met the needs of the patients.

Exception Reports August 2016

			Exception Code 1	Exception Code 2	Exception Code 3	Exception Code 4	Exception Code 5
Ward	**Bed number**	**Number of required staff hours in the month**	**Minimum staff numbers met – skill mix non-compliant but met needs of patients**	**Minimum staff numbers not compliant but met needs of patients**	**Minimum staff numbers met – skill mix non-compliant and did not meet needs of patients**	**Minimum staff numbers not compliant and did not meet needs of patients**	**Minimum staffing nos and skill mix not met. Resulting in clinical incident / harm to patient or other**
Gloucestershire							
Dean	**14**	**3255 monthly hours**	**0**	**15**	**0**	**0**	**0**
Abbey	**18**	**3255 monthly hours**	**180**	**0**	**0**	**0**	**0**
Priory	**22**	**3255 monthly hours**	**165**	**7.5**	**0**	**0**	**0**
Kingsholm	**15**	**3255 monthly hours**	**15**	**0**	**0**	**0**	**0**
Montpellier	**12**	**3565 monthly hours**	**30**	**47.5**	**0**	**0**	**0**
Greyfriars	**10**	**4030 monthly hours**	**230**	**0**	**0**	**0**	**0**
Willow	**16**	**4495 monthly hours**	**0**	**0**	**0**	**0**	**0**
Chestnut	**14**	**3022.5 monthly hours**	**157.5**	**0**	**0**	**0**	**0**
Mulberry	**18**	**3255 monthly hours**	**22.5**	**0**	**0**	**0**	**0**
Laurel	**12**	**2015 monthly hours**	**172.5**	**0**	**0**	**0**	**0**
Honeybourne	**10**	**2015 monthly hours**	**127.5**	**0**	**7.5**	**0**	**0**

			Exception Code 1	Exception Code 2	Exception Code 3	Exception Code 4	Exception Code 5
Ward	**Bed number**	**Number of required staff hours in the month**	**Minimum staff numbers met – skill mix non-compliant but met needs of patients**	**Minimum staff numbers not compliant but met needs of patients**	**Minimum staff numbers met – skill mix non-compliant and did not meet needs of patients**	**Minimum staff numbers not compliant and did not meet needs of patients**	**Minimum staffing nos and skill mix not met. Resulting in clinical incident / harm to patient or other**
Westridge	**8**	**3565 monthly hours**	**0**	**0**	**0**	**0**	**0**
Hollybrook	**8**	**5580 monthly hours**	**0**	**252.5**	**0**	**0**	**0**
Herefordshire							
Mortimer	**21**	**3069 monthly hours**	**0**	**0**	**0**	**0**	**0**
Jenny Lind	**8**	**1705 monthly hours**	**0**	**0**	**0**	**0**	**0**
Cantilupe	**12**	**2867.5 monthly hours**	**368.5**	**0**	**0**	**0**	**0**
Oak House	**10**	**1705 monthly hours**	**0**	**0**	**0**	**0**	**0**
Total		**53909 monthly rs**	**1468.5**	**322.5**	**7.5**	**0**	**0**

Appendix 1: NATIONAL SAFE STAFFING REPORTING Ward information – August 2016

Only complete sites your organisation is accountable for			Day				Night				Day		Night	
Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
Dean	710 - ADULT MENTAL ILLNESS		930	937.5	1395	1530	620	640	310	400	100.8%	109.7%	103.2%	129.0%
Abbey	710 - ADULT MENTAL ILLNESS		1395	1245	930	1530	620	640	310	590	89.2%	164.5%	103.2%	190.3%
Priory	710 - ADULT MENTAL ILLNESS		1395	1297.5	930	1110	620	590	310	420	93.0%	119.4%	95.2%	135.5%
Kingsholm	710 - ADULT MENTAL ILLNESS		930	907.5	1395	1462.5	620	620	310	350	97.6%	104.8%	100.0%	112.9%
Montpellier	710 - ADULT MENTAL ILLNESS		930	930	1395	1425	620	620	620	620	100.0%	102.2%	100.0%	100.0%
Greyfriars	710 - ADULT MENTAL ILLNESS		1395	1185	1395	1545	620	570	620	680	84.9%	110.8%	91.9%	109.7%
Willow	715 - OLD AGE PSYCHIATRY		930	1005	2325	2225.7	310	310	930	960	108.1%	95.7%	100.0%	103.2%
Chestnut	715 - OLD AGE PSYCHIATRY		930	787.5	1162.5	1402.5	310	310	620	640	84.7%	120.6%	100.0%	103.2%
Mulberry	715 - OLD AGE PSYCHIATRY		930	945	1395	1830	310	320	620	610	101.6%	131.2%	103.2%	98.4%
Laurel	710 - ADULT MENTAL ILLNESS		697.5	525	697.5	907.5	310	310	310	310	75.3%	130.1%	100.0%	100.0%
honeybourne	710 - ADULT MENTAL ILLNESS		697.5	570	697.5	825	310	310	310	310	81.7%	118.3%	100.0%	100.0%
Westridge	700- LEARNING DISABILITY		465	577.5	1860	1732.5	310	370	930	880	124.2%	93.1%	119.4%	94.6%
Hollybrook	700- LEARNING DISABILITY		465	525	3255	2962.5	310	310	1550	1530	112.9%	91.0%	100.0%	98.7%
Mortimer	710 - ADULT MENTAL ILLNESS		1023	1083.25	682	909	682	713	682	839.5	105.9%	133.3%	104.5%	123.1%
Cantilupe	715 - OLD AGE PSYCHIATRY		682	649.5	1023	1984.5	682	368.5	480.5	1925.5	95.2%	194.0%	54.0%	400.7%
Jenny Lind	715 - OLD AGE PSYCHIATRY		682	732	341	811.5	341	356.5	341	701.5	107.3%	238.0%	104.5%	205.7%
Oak House	710 - ADULT MENTAL ILLNESS		682	736.5	341	425.5	341	356.5	341	356.5	108.0%	124.8%	104.5%	104.5%

Agenda item 11 **Paper F**

Report to: [2]gether Trust Board – 29 September 2016
Author: Philippa Moore, Joint Director of Infection Prevention and Control
Marie Crofts, Director of Quality and Joint Director of Infection Prevention and Control
Presented by: Philippa Moore, Joint Director of Infection Prevention and Control
Alison Curson, Deputy Director of Nursing

SUBJECT: **Annual Infection Prevention and Control Report 2015/16**

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

EXECUTIVE SUMMARY

- The Trust remains compliant with the Health and Social Care Act: Code of Practice for Health and Adult Social Care on the prevention and control of infections and related guidance (The Hygiene Code).
- Risks for healthcare associated infection remain low in the Trust.

Assurance

The paper demonstrates to the Board and gives assurance that the Trust is committed to providing high standards of infection control across all its services. This paper provides evidence of infection control related activity, monitoring and governance during 2015/16.

RECOMMENDATIONS

The Board is asked to:

- Note the Annual Infection Prevention and Control report
- Continue to support the infection prevention and control programme to minimise the risks of healthcare associated infection, as required by the Health and Social Care Act.

Corporate Considerations	
Quality implications:	Included in the body of the report
Resource implications:	External expertise in infection control is purchased from GHNHSFT and Gloucestershire Care Services NHS Trust.

	Provision of infection control services from Herefordshire is purchased from Wye Valley Trust.
Equalities implications:	None
Risk implications:	Low risk with continued support of the agenda

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

Reviewed by:		
A Curson	Date	

Where in the Trust has this been discussed before?		
IC Committee	Date	

What consultation has there been?		
Open to discussion with ICC members from	Date	

Explanation of acronyms used:	GHNHSFT – Gloucestershire Hospitals NHS Foundation Trust DIPC - Director of Infection Prevention and Control ATP - adenosine triphosphate MRSA – Meticillin Resistant Staphylococcus aureus MSSA – Meticillin Sensitive Staphylococcus aureus CPE – Carbapenamase producing Enterobacteriaceae PVL – Panton Valentine Leucocidin (producing S. aureus) PLACE – Patient Led Assessments of the Care Environment

1. Introduction

[2]gether NHS Foundation Trust ([2]gether) has a comprehensive programme of infection prevention and control which has supported declaration of full compliance with the Health and Social Care Act 2012: Code of Practice for health and adult social care on the prevention and control of infections and related guidance. This annual report from the joint Directors of Infection Prevention and Control (DIPC) provides documentation of how [2]gether has sought to prevent and control infection during 2015/16.

2. Overview of infection control activities during 2015/16.

The 2015/16 year presented local infection prevention and control challenges, as the Ebola outbreak of the previous year was gradually brought under control internationally. The trust stepped down from active screening for Ebola risk in July 2015.

Provision of infection prevention and control services in Herefordshire remained challenging at times due to staffing issues within the Wye Valley Trust team, however most of the year's programme was provided.

3. Description of infection control arrangements

3.1 The infection prevention and control team

The role of Director of Infection Prevention and Control (DIPC) in [2]gether remains shared between the Director of Quality, Marie Crofts, as board lead, and Dr Philippa Moore, Consultant Microbiologist and Infection Prevention and Control Doctor. Louise Forrester continues as nursing lead within [2]gether for infection control. She is supported by specialist infection control nurses contracted from Gloucestershire Care Services and from Wye Valley Trust.

During 2015/16 there were some ongoing concerns with the contract with the Wye Valley infection control team due to ongoing staff sickness however all area audits were completed with appropriate feedback to the areas audited and action plans completed. The inpatient wards were contacted on a weekly basis to ensure that there were no infection prevention or control issues and advice was given on a number of topics.

The infection control agenda is delivered within the trust with the help and engagement of many infection control link practitioners and hand hygiene champions. There are well established good working relationships with inpatient units and estates and facilities, and community links are growing.

3.2 Reporting to the Trust Board

Infection Control has been at a low level of risk for some years and therefore there is exception reporting rather than regular formal reports. No formal reports were required to be submitted during the year 2015/16. The annual report for 2014/15 was presented to the Governance Committee and Trust Board during September 2015.

3.3 Infection Prevention and Control and Decontamination Committee

The infection prevention and control and decontamination committee (ICC) meets quarterly. Committee membership includes the Director of Quality, and Directors of Infection Prevention and Control, the Deputy Director of Nursing, the [2]gether infection control lead, the infection control teams from both Gloucestershire and Herefordshire. Representatives from Hotel Services and Estates and Facilities are regular attenders and other representatives attend according to the agenda. The committee monitors and oversees infection prevention and control and decontamination work in the trust providing assurance for the organisation that

standards are being met for compliance with the Health and Social Care Act. The Water, Environment, Equipment and Buildings group (WEEB) reports to the Infection Prevention and Control and Decontamination Committee, as does the Infection Control Focus Group. There are countywide infection prevention and control forums in both Gloucestershire and Herefordshire that provide links with infection prevention and control activities with other trusts in these counties.

3.4 Infection Control Focus Group

The infection control focus group is a subcommittee of the Infection Control Committee and meets monthly during those months when there is no infection control committee. This group is chaired by the [2]gether infection control lead, Louise Forrester. The group is a forum in which staff can discuss any infection control concerns. This group is the main action group for infection control that presents the solutions to issues to the infection control committee or highlights where issues require further input to achieve resolution.

4. Healthcare Associated Infections Level of Assurance: Significant

4.1 MRSA

[2]gether participates in the national mandatory surveillance of MRSA bacteraemias (blood stream infections). During 2015/16 there were no MRSA bacteraemias detected from patients in Gloucestershire or Herefordshire.

Selective screening is undertaken to detect MRSA colonisation of the nose or groin in susceptible individuals. A planned audit during 2015/16 to test compliance with policy has not yet been completed and has been deferred to the 2016/17 work plan.

4.2 Clostridium difficile

[2]gether participates in the mandatory surveillance scheme for C. difficile infections. During 2015/16 there were no reportable cases of *C. difficile* in Gloucestershire or Herefordshire.

4.3 Other bacteraemia surveillance (GRE, E. coli, MSSA)

In addition to MRSA there is established mandatory reporting of other organisms that cause bacteraemias, including E. coli and MSSA. There were no cases in Gloucestershire or Herefordshire during 2015/16.

4.4 Outbreaks and Incidents

4.4.1 Influenza

There were no Influenza outbreaks in [2]gether during 2015/16. Assessments were undertaken on patient admissions and eligible long term inpatients received influenza vaccine if they had not received it from their General Practitioner.

During 2015/16 923 staff were vaccinated across Gloucestershire and Herefordshire, compared to 954 during 2014/15.

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Gloucestershire				762	795	780
Herefordshire				149	159	143
Total	**474**	**671**	**846**	**911**	**954**	**923**

In order to inform planning for the 2016/17 influenza vaccination year, and improve staff uptake of vaccine, an anonymous survey was undertaken of staff attitudes towards influenza vaccine. 269 people responded: 204 who had received vaccine and 65 who had not. Staff

were asked why they agreed to have the vaccine or not and the answers proved interesting and helpful for informing the next vaccination campaign. A number of staff were happy to share their stories with the trust and many helpful suggestions were made for the next campaign, particularly around access to vaccine.

4.4.2 Other outbreaks

During 2015/16 there were 2 outbreaks of diarrhoeal illness requiring ward closure reported to the Gloucestershire infection prevention and control team, one proven and one likely to be due to Norovirus. Strict infection prevention and control measures were put in place.

HOSPITAL / UNIT	ORGANISM	DATE REPORTED	START DATE (first symptoms)	FINISH DATE (ward open)	DURATION	BED DAYS LOST	PATIENTS AFFECTED	STAFF AFFECTED
Greyfriars	None identified	10/12/15	10/12/15	17/12/15	8	3	4	4
Kingsholm	Norovirus (proven)	24/03/16	24/03/16	30/03/16	6	0	6	5
Total 2015/16					**14**	**3**	**10**	**9**

This compares to 3 outbreaks during 2014/15 with a total of 28 patients and 32 staff affected, and a loss of 24 bed days.

There were no outbreaks in 2gether Herefordshire sites during 2015/16. The infection control team did assist the Health Protection Team in providing additional advice of an outbreak of giardiasis in linked learning disability facilities (Rowden house and Wilmslow court).

4.4.3. Contamination Exposures

Working Well provide the occupational health service for ^{2}gether staff across both Herefordshire and Gloucestershire.

Contamination exposure: initial assessment	2011/12	2012/13	2013/14	2014/15	2015/16
Total incidents	**31**	**41**	**37**	**21**	**24**

4.4.4 Other

During 2015/16 the Infection Control teams also gave advice for individual patients and issues on a wide variety of topics including: HIV, Hepatitis C infection, TB lymphadenitis, wound infections, conjunctivitis, head and body lice, scabies, pertussis, diarrhoeal illnesses, influenza, shingles, MRSA colonisation, PVL Staph aureus colonisation, CPE screening, as well as general enquiries related to estates and facilities, cleaning, and equipment decontamination.

5. Audit — Level of Assurance: Significant

5.1 Inpatient area audits: Gloucestershire

The audit programme uses the Infection Prevention Society (IPS) Quality Improvement Tool (QIT) which states that scores of 85% or more are green, 84% or less red, with no intermediate category. Previous years are included in the table below for comparison as not all sites are audited annually.

Location/Audit Scores	2013/14	2014/15	2015/16
Honeybourne	**93%**	**91%**	**96%**
Laurel House	**Deferred**	**90%**	**97%**

Location/Audit Scores	2013/14	2014/15	2015/16
Westridge	92%	80%	91%
Hollybrook	92%	86%	93%
Abbey Ward, Wotton Lawn	86%	91%	92%
Dean Ward, Wotton Lawn	85%	91%	93%
Greyfriars, Wotton Lawn	95%	97%	89%
Kingsholm Ward, Wotton Lawn	91%	85%	93%
Priory Ward, Wotton Lawn	88%	85%	95%
Montpellier Ward, Wotton Lawn	92%	92%	88%
Maxwell 136 Suite	84%	90%	89%
Therapies (inc OT & Physio), Wotton Lawn	OT: 86% Physio: 87%	For 2015/16	OT 88% Physio: 89%
Waste and Portering, Wotton Lawn	91%	98%	
ECT	96%	For 2015/16	97%
Chestnut ward, Charlton Lane	81%	88%	90%
Mulberry ward, Charlton Lane	85%	92%	93%
Willow ward, Charlton Lane	82%	86%	92%
Charlton Lane OT	78%	For 2015/16	85%
Charlton Lane Physio	91%	For 2015/16	
Inpatient ward average	89%*	89%*	92%*

*= inpatient wards only

All areas of non-compliance resulting in low scores are followed up. Action plans to remedy problems are monitored and the areas are rechecked during subsequent clinical visits by the infection prevention and control nurses.

5.2 Outpatient Area Audits: Gloucestershire

Location	2013/14 Audit score	2014/15 Audit score	2015/16
Albion Chambers	63%	86%	81%
Park House	64%		87%
Avon House	80%		86%
Weavers Croft	64%	97%	90%
Cirencester Memorial Centre		66%	
Denmark Road		86%	77%
Brownhills		74%	88%
London Road			73%
Tyndale Centre			46%

Specific reasons for any falls in audit scores and the necessary rectification work were identified by the infection prevention and control team.

Other outpatient areas including Leckhampton Lodge, Evergreen, Field View, and Managing Memory will be audited next year.

The infection control focus group and, where appropriate, WEEB (Water, Environment, Equipment and Buildings) group or infection prevention and control and decontamination committee oversees actions taken to ensure infection control compliance.

5.3 Audits: Herefordshire

The Herefordshire audit tool is also based on the IPS audit tool.

Location	Audit Frequency	Overall Score 2012/13	Overall Score 2013/14	Overall Score 2014/15	Overall Score 2015/16
Jenny Lind- Ward	Annual	98%	100%	76%	87%
Mortimer- Ward	Annual	97%		84%	84%
Cantilupe - Ward	Annual	96%		66%	87%
Day care	Annual			90%	88%
ECT	Annual	95%			87%
Oak House	Annual	Booked 2013/14	93%	84%	90%
27a St Owen Street	2 yearly	94%			40%
Rose Cottage	2 yearly	Due 2013/14	78%		97%
Etnam street	2 yearly	86%			85%
The Knoll	2 yearly	95%			93%
CAMHS		73%	87%		51%
IAPT Belmont					95%
Let's talk Belmont					95%

6. Hand hygiene — Level of Assurance: Significant

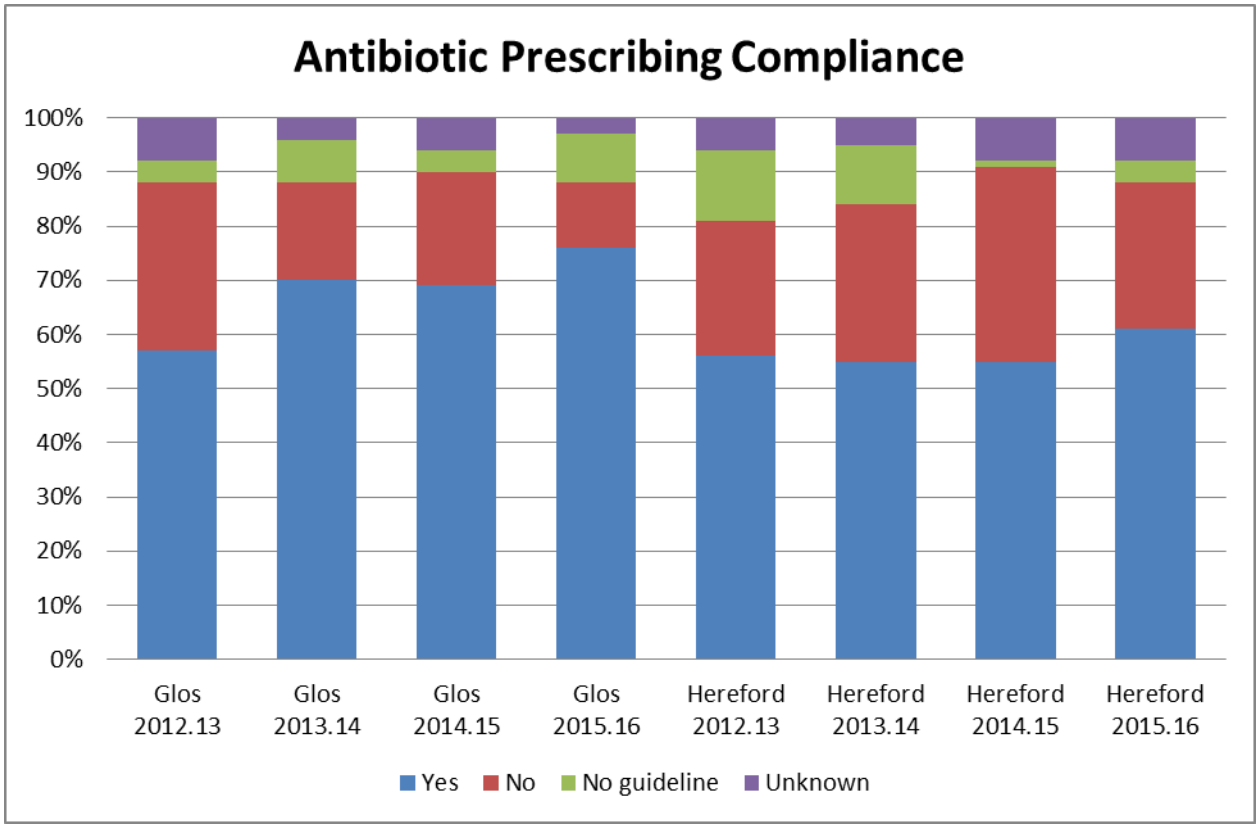
Hand hygiene is considered the most important part of preventing healthcare associated infections. Mental health organisations are different from acute trust hospitals in that many of the WHO hand hygiene 'moments' (opportunities for hand hygiene) are patient initiated rather than staff initiated. Given this, [2]gether aims to ensure compliance with hand hygiene that protects patients and has a compliance target of 90%. Audits are performed quarterly and reported 6 monthly. During 2015/16 the overall compliance was maintained at 96%, similar to 2014/15 (which was an improvement on previous years).

7. Antibiotic Stewardship — Level of Assurance: Significant

2gether keeps a database of all antibiotics prescribed for inpatients, established in July 2010 for Gloucestershire and in October 2011 for Herefordshire. Antibiotic guideline booklets are distributed to junior doctors and are available on line and provide prescribing advice for most common conditions.

Compliance is defined as the correct antibiotic choice for the indication, given via the correct route, at the correct dose for the correct duration. All elements must be correct before

considering the prescription to be compliant. Compliance is also considered to be 'yes' if there is documentation of a reasonable rationale for prescribing off guideline, or prescribing on Microbiologist advice that might otherwise be different from the guidelines. Prescribing compliance has improved compared to last year, particularly in Gloucestershire. The data for April 2015 was missing from the Herefordshire data and therefore the % totals reflect May to March prescribing.



8. Infection Prevention and Control Education **Level of Assurance: Limited**

During 2015/16 infection control education continued to be delivered principally by e-learning however training was also undertaken in order for face to face learning to be facilitated.

Overall Compliance (non-clinical and clinical) on 10/12/15	**80 %**
Overall Compliance (non-clinical and clinical) on 29/02/16	**66%**

Mandatory training has remained an issue and is now being addressed with additional face to face training sessions with 2gether staff trained to deliver the sessions, the content of which has been developed with infection control team input.

The annual infection control study day was held on 14th May 2015 and covered topics including outbreak management, personal protective equipment and infection control issues in learning disability units. Staff from both Herefordshire and Gloucestershire attended.

9. Infection Prevention and Control and Estates and Facilities

Level of Assurance: Significant

9.1 Departmental Structure

The Estates and Facilities Department, headed by Adrian Eggleton is structured into the following areas, each area under a specialist manager: Facilities; Estates and Estates Project Management (2 x part time); The Department is under the overall leadership of the Director of Finance

The Estates and Facilities Department is responsible for the management of all catering and cleaning in the Trust, apart from in the three recovery units and the two learning disability units.

The Department reports to: Infection Prevention and Control and Decontamination Committee, Delivery Committee, Development Committee, Governance Committee, Health and Safety Committee, Capital Review Group, and the Water, Environment, Equipment and Buildings (WEEB) Group. The latter is an operational group that covers the business areas of the Department, with strong representation from the Infection Prevention and Control professionals.

Estates and Facilities Information is available on a sharepoint site available through the Trust Intranet. This site is the repository for all plans, risk assessments, cleaning schedules and servicing, testing and inspection records. It is available to all staff. The quality and extent of the data available is constantly improving; in collaboration with users and contractors.

During the last 12 months the Estates and Facilities Department has reviewed its policies, practices, reporting and assurance and undertake a step change in the way in which it operates. At the heart of this is the reporting to the WEEB group on every policy governed area of activity, at a frequency appropriate to the level of risk and scale of operation. For instance cleaning reports are prepared quarterly, water management bi-annually and air handling annually. The reports are linked into CQC domains and the Premises Assurance Model, and the Department is now working towards completion of the Department of Health's voluntary Premises Assurance Model.

An example of the new header sections that are now used on Estates and Facilities Department Reports is shown below. This example is from the Annual Capital Report.

Links to NHS Premises Assurance Model	Estate Strategy & Development Control Plans Sustainability Asset Management & Maintenance The design and layout of premises Health and safety at work Mechanical Systems Fire Safety Security management Resilience, Emergency & Contingency Planning Undertaking New Build and Refurbishment Works Safety and suitability of premises and services	E2 E6 S1 S2 S3 S10 S15 S20 S21 S26 S27
Links to CQC Domains	Safe Caring Effective Well Led Responsive to people's needs	P P P P

9.2 Performance

PLACE is now in its fourth year and the 2016 assessments took place between March and May this year. The 2016 PLACE inspection scores were entered onto the Health and Social Care Information Centre (HSCIC) database, submitted and validated to the HSCIC by June 10th 2016. The results are not yet publically available and national benchmarking data is not yet published however we can compare to the 2015 national average shown in the table 9.2a below. Overall the Trust has generally stabilised its position and seen some marginal gains in its outcomes in the three domains which relate to infection control as can be seen in table 9.2b below with the exception of cleaning at Oak House, which has dropped 0.9%. The tartan rug (table 9.2b) below scores sites against the 2015 national benchmarks (green if the trust is above the score for the upper quartile and amber if the trust scores between the national average and the upper quartile, red if the trust scores below the national average for 2015):

Table 9.2a

2015	Cleanliness	Food	Privacy, Dignity and Wellbeing	Estates – Condition, Appearance & Maintenance
National Average	97.57%	88.50%	86.00%	90.10%
Upper Quartile	99.90%	94.50%	92.70%	95.80%

Table 9.2b

Site Code	PLACE Site Type	Cleanliness		Food		Privacy, Dignity and Wellbeing		Facilities	
WOTTON LAWN	Mental Health Only	2013	98.83%	2013	86.40%	2013	90.93%	2013	95.34%
		2014	99.28%	2014	96.38%	2014	97.55%	2014	96.84%
		2015	99.28%	2015	96.66%	2015	99.01%	2015	98.92%
		2016	100.00%	2016	94.14%	2016	96.91%	2016	98.17%
CHARLTON LANE	Mental Health Only	2013	98.02%	2013	90.77%	2013	90.15%	2013	91.59%
		2014	99.33%	2014	95.85%	2014	98.51%	2014	99.17%
		2015	95.98%	2015	95.94%	2015	98.53%	2015	99.35%
		2016	99.72%	2016	93.16%	2016	93.15%	2016	99.28%
LAUREL HOUSE	Mental Health Only	2013	98.84%	2013	85.47%	2013	88.89%	2013	89.00%
		2014	97.22%	2014	97.04%	2014	93.33%	2014	96.55%
		2015	99.82%	2015	93.40%	2015	94.44%	2015	96.32%
		2016	100.00%	2016	95.17%	2016	100.00%	2016	100.00%
HONEYBOURNE, CHELTENHAM	Mental Health Only	2013	99.44%	2013	82.70%	2013	83.33%	2013	93.00%
		2014	100.00%	2014	96.59%	2014	89.66%	2014	99.18%
		2015	100.00%	2015	97.70%	2015	82.86%	2015	100.00%
		2016	99.21%	2016	91.58%	2016	96.55%	2016	99.58%
STONEBOW UNIT	Mental Health Only	2013	98.49%	2013	84.19%	2013	87.78%	2013	90.18%
		2014	97.51%	2014	90.03%	2014	97.35%	2014	99.21%
		2015	98.32%	2015	90.04%	2015	93.75%	2015	97.54%
		2016	99.89%	2016	79.76%	2016	95.89%	2016	93.82%
OAK HOUSE	Mental Health Only	2013	97.30%	2013	n/a	2013	78.06%	2013	57.14%
		2014	100.00%	2014	n/a	2014	87.10%	2014	86.89%
		2015	93.16%	2015	n/a	2015	88.10%	2015	87.29%
		2016	92.26%	2016	n/a	2016	86.49%	2016	91.12%
HOLLYBROOK	Learning Disabilities Only	2013	93.79%	2013	76.67%	2013	92.80%	2013	89.62%
		2014	98.94%	2014	93.71%	2014	100.00%	2014	98.31%
		2015	100.00%	2015	83.41%	2015	86.90%	2015	96.92%
		2016	100.00%	2016	95.11%	2016	100.00%	2016	99.58%
WESTRIDGE	Learning Disabilities Only	2013	96.07%	2013	91.56%	2013	84.17%	2013	87.04%
		2014	99.51%	2014	96.40%	2014	90.33%	2014	97.50%
		2015	99.90%	2015	95.04%	2015	94.59%	2015	100.00%
		2016	100.00%	2016	82.73%	2016	94.12%	2016	100.00%

There were poor cleaning results for Oak House this year. In Oak House the cleaning staff do not work 7 days a week nor at weekends; the assessment took place during a period of flux where the substantive longstanding post-holder had resigned leaving a reliance on agency staff and nursing staff. The unit took the opportunity when advertising for a replacement to cover 5 days a week and have been successful in recruiting a suitable applicant. In Oak House patients take an active role in keeping their environment clean and whilst this has benefits and works well in bedroom areas, the age of the internal and external decorations in this property make it more difficult for cleanliness to be maintained without causing damage to the fabric of the walls, painted woodwork, carpets etc. Overall as a Trust we performed very well in the Cleaning domain achieving 99.5%, an improvement on last year's already high 98.2% and above last year's national average of 98.4%.

The Facilities score has been poor at Oak House for the past 4 years and although the score is improving (up 3.8% on last year) it is not yet satisfactory. This is being addressed through capital resources being secured by NHS Property Services.

Disability was a new domain added in 2016 for which there is currently no benchmarking data. Scores in this domain range from 84.62% (Oak House) to 100% for Honeybourne, Hollybrook and Laurel House. The organisational average for this domain is 91.04%.

9.3 Catering and Cleaning

All catering and cleaning in Herefordshire is managed by Sodexo, via Wye Valley NHS Trust. Although 2gether now holds the budget it has no contractual relationship with Sodexo. In the last 12 months the quality and performance of Sodexo has fallen significantly with recurrent issues. Monthly audit of Sodexo's performance is now in place as results from their own audits were inconsistent with other reporting. The contract with Sodexo ends on 30th March 2017 and options for the future are being considered.

In Gloucestershire all catering and cleaning, apart from at Honeybourne, Laurel House, Westridge and Hollybrook, is now managed by the Estates and Facilities Department.

On a Trustwide basis the cleaning products have been reviewed and rationalised to limit the number of different chemicals used and associated risk assessments and data sheets have been updated. Cleaning schedules have been reviewed for all sites in line with the National Cleaning Standards and are available on SharePoint.

A small working group has been convened taking members from the three Trusts in Gloucestershire tasked to look at the trial implementation of PAS5748: an alternative to the 2007 national cleaning specifications but not designed to replace them. Work has begun risk assessing cleaning elements of sample areas in all three Trusts, the next stage will be to complete a cleaning audit to compare the outcome of the results between the old and new standards.

The Facilities department has commented on several Infection Control policies which has initiated an action to develop a post outbreak deep clean checklist which is currently at review and consultation stage.

Cleaning and swabbing audits continue to take place on a monthly basis, a particular challenge around the collection of cleaning audits has been the persistent software and Wi-Fi issues that have led to intermittent results, however sites have reverted to manual collection of results in the interim. Sodexo are tasked with swabbing the ward areas at Stonebow but despite efforts have failed to deliver a full years collection of results as they are not contracted to perform this task.

In Herefordshire Sodexo reports cleanliness audit scores:

MONTHLY AUDITS STONEBOW	**Apr 15**	**May 15**	**Jun 15**	**Jul 15**	**Aug 15**	**Sep 15**	**Oct 15**	**Nov 15**	**Dec 15**	**Jan 16**	**Feb 16**	**Mar 16**
2013/14	96%	98%	99%	97%	99%	99%	96%	99%	98%	95%	98%	99%
2014/15	99%	99%	99%	99%	99%	99%	99%	99%	99%	98%	99%	99%
2015/16	99%	98%	98%	99%	98%	99%	99%	95%	98%	96%	90%	88%

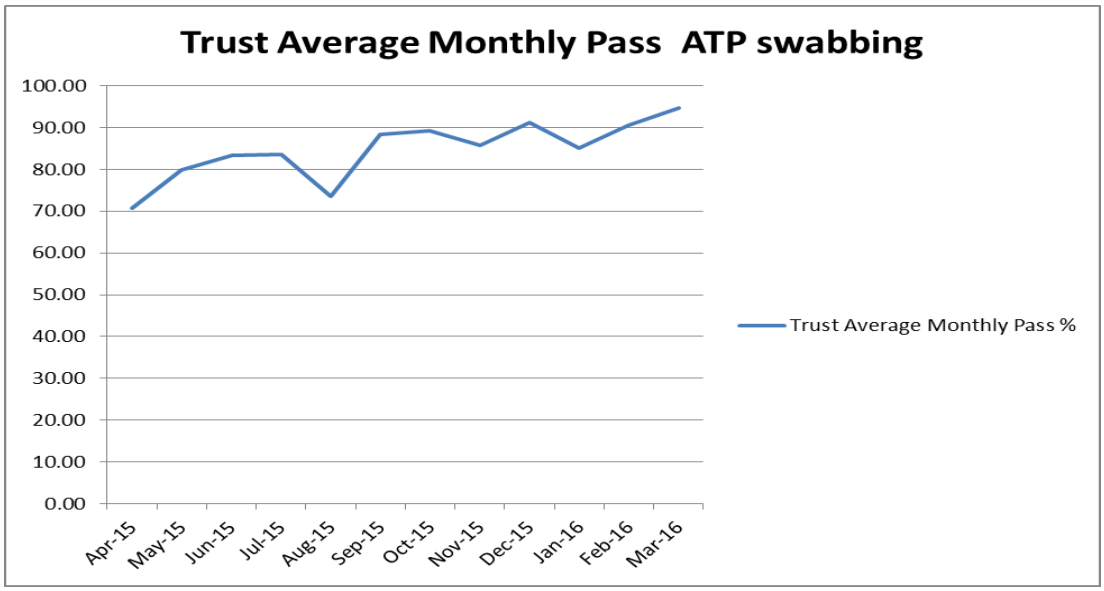
TWO MONTHLY AUDITS	Apr-14	Apr -15	Jun-14	Jun - 15	Aug-14	Aug -15	Oct-14	Oct-15	Dec-14	Dec -15	Feb -15	Feb -16
DASH	97%	95%	96%	98%	98%	98%	98%	99%	98%	Site closed	n/a	n/a
ETNAM ST	100%	100 %	98%	100 %	100 %	100 %	100 %	96%	100%	100 %	100 %	92%
48 GAOL ST	100%	100 %	100 %	100 %	100 %	100 %	100 %	100 %	98%	Site closed	98 %	n/a
ST OWEN'S STREET	97%	98%	96%	100 %	98%	99%	98%	94%	96%	93 %	96 %	94%
THE KNOLL	100%	100 %	100 %	100 %	98%	100 %	100 %	100 %	100%	100 %	100 %	100 %
MONKMOOR COURT	100%	95%	99%	98%	100 %	98%	97%	96%	99%	Site closed	99 %	n/a
ROSE COTTAGE	100%	100 %	100 %	100 %	100 %	100 %	100 %	97%	100%	97 %	100 %	98%

Credits for cleaning audits have been introduced in Gloucestershire. Data collection this year has improved from last years 9% of data returned to a 58% return. Recent re-training on Credits for Cleaning by MiCAD trainers will improve the data collection for next year.

MONTHLY AUDITS	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
WOTTON LAWN	nil	nil	96%	98%	97%	97%	nil	96%	93%	96%	98%	99%
CHARLTON LANE	nil	nil	93%	90%	94%	92%	94%	94%	92%	94%	nil	nil

Data from ATP swabbing supplements assurance around cleaning processes.

ATP swabbing has improved this year and is becoming more embedded as training has been rolled out. As the year has progressed an improvement in the pass rates has been seen. On a quarter by quarter basis we have seen an improvement in pass rates from 78% in Q1 to 90% in Q4. The appropriate staff group is notified of all areas or items that fail to ensure feed back to the staff who clean and the area or item is recleaned. The data below includes both the environment and patient equipment for all inpatient sites.



Food Hygiene – All Trust sites have a 5 star rating for food hygiene. In addition to the Environmental Health Officer (EHO) inspections the Trust commissions an external annual audit of all catering premises, that is to a higher standard than EHO inspections. Those audits were undertaken in July with no serious issues identified. Action plans are underway to address any shortcomings identified.

[2]gether NHS FT Food Hygiene Ratings as at 12th July 2016

Site	Latest Food Hygiene Rating	Date Of last Inspection	Inspection Risk Category	Inspection Frequency
Wotton Lawn Hospital	5	12/07/2016	D	Every 2 Years
Charlton Lane Hospital	5	19/05/2016	D	Every 2 Years
Laurel House	5	25/04/2016	D	Every 2 Years
Stonebow Unit	5	22/03/2016		
Honeybourne	5	31/07/2015	C	Every 18 Months
Oak House	5 (AES)*	27/05/2015	E	Every 3 Years
Hollybrook	5	24/04/2015	E	Every 3 Years
Westridge	5	04/07/2014	D	Every 2 Years
Brownhills Centre	5	09/01/2014	D	Every 2 Years

*AES – **A**lternate **E**nforcement **S**trategy – the FSA national code of practice identifies Oak House as 'low risk' which allows local authorities to adopt alternative methods. Future inspections are not guaranteed.

9.4 Estates and Maintenance

In Herefordshire all planned and reactive maintenance is managed by Wye Valley NHS Trust except for work at Oak House, Belmont, and Widemarsh Street; these premises are maintained by Mitie, under contract to NHS Property Services.

In Gloucestershire all planned and reactive maintenance is managed operationally by Lorne Stewart.

Both Wye Valley Trust and Lorne Stewart have achieved 100% compliance on Statutory and Mandatory maintenance throughout 2015/16.

The Mitie / NHS Property Service arrangement commenced on 1st April 2016. Unfortunately to date they have not demonstrated that they are undertaking any maintenance. An action plan, in discussion with the Trust's Authorised Engineer - Water Management has been developed to step in at the end of August 2016 on water management, should no compliance be provided.

9.5 Building Improvements

During 2015/16 the Trust's spent £4,677,260 of its Capital Programme on the Trust Estate. The Programme areas of expenditure are outlined in the following table:

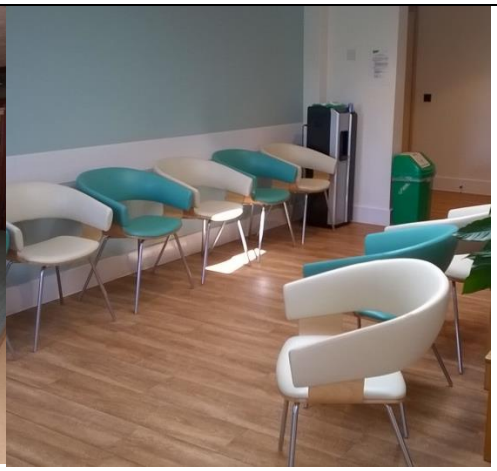
Programme	**2015/16 Spend on the Estate**
Gloucestershire Major Capital	£3,314,750
Herefordshire Major Capital	£283,960
Minor Capital Improvements	£130,680
Fire Precautions	£84,690
Health and Safety	£101,210
Security	£16,980
Patient Safety	£572,480
Estate Infrastructure	£169,760
Miscellaneous (fixed asset disposal)	2,750
Total	**£4,677,260**

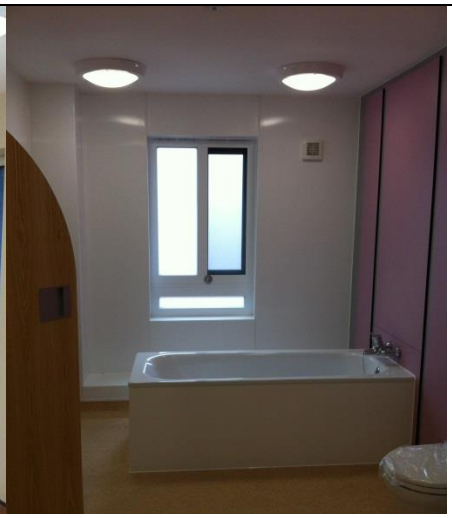
Capital funding is only available if it meets one or more of the following criteria:

- How it Improves the Clinical Environment or Safety
- How it Addresses Capital Asset end of life
- How it leads to financial savings

Infection Control advice is sought on capital projects, with some projects arising as a consequence of Infection Control inspections and in some cases Infection Control inspections brought forward to inform an upcoming project. The following projects had an Infection Control component:

Project	**Narrative**
Forest Team Base	Reconfiguration of Colliers Court to create a single base for the Forest of Dean resulting in the closure of Belle Vue, Coleford House and Underleaf

	
Stroud Team Base	Reconfiguration of Weavers Croft and Park House to create a single site for Stroud resulting in the closure of Marsburg House and Southfield Old House. Project also includes for re-roofing of Park House and additional Car Parking
	
LD inpatients Hollybrook Bungalow	Conversion of domestic 3 bedroom bungalow into 2 specialist residential LD units

 	
Wotton Lawn Ceilings & LED Lighting	Anti-ligature ceilings and light fittings to therapy department
Dean & Priory Ward	Complete ward Refurbishment of Priory Ward to create 100% en-suited individual bedrooms, with anti-ligature fittings.
	
Stonebow De-escalation suite	Design Fees for the creation of an additional en-suite bedroom and a de-escalation suite on Mortimer Ward

9.6 Water Management

The Trust's independent Authorising Engineer for water management undertook an audit of the water management systems during December 2015. There was only one area of 'low' compliance which was paucity of evidence of the water maintenance procedures undertaken by Lorne Stewart and Wye Valley Trust on the 2 days of audit. Subsequently both organisations were able to provide their procedures closing out this action.

The second audit by the Authorising Engineer is taking place during July 2016.

A new Health Technical Memorandum for water management was launched in June 2016, which is currently under review for implementation into the Trust. An initial scoping exercise with regard to the Trust's Policy and WEEB Group has been undertaken by the Trust's independent Authorising Engineer and there will be no significant changes; however the rainwater harvesting at Greyfriars and Colliers Court will require review.

CONCLUSIONS

[2]gether NHS Foundation Trust continues to control the risk of healthcare associated infections, and is improving with antibiotic stewardship, a topic that is an international priority. Patients, visitors and the Trust can be confident that appropriate work is ongoing to minimise the risk of healthcare associated infection in [2]gether and that the risk of acquisition of a healthcare associated infection within the Trust remains low. This provides details significant levels of assurance for all areas except training for which the level of assurance is limited currently but being addressed.

Dr Philippa Moore and Marie Crofts
Joint Directors of Infection Prevention and Control
12th September 2016

Agenda item 12 **Paper G**

Report to: Trust Board, 29th September 2016
Author: Dr B Major, Clinical Director & Dr C Fear, Medical Director
Presented by: Dr Chris Fear, Medical Director

SUBJECT: **Medical Appraisal Annual Report**

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

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

EXECUTIVE SUMMARY

- Medical Appraisal has continued to be instituted within 2gether NHSFT aligned with national policy.
- Investment in SARD JV and transfer to that system is supporting effective monitoring, recording and review of the quantity, quality and uptake of appraisal.
- The Medical Appraisal Committee has instituted a work plan that will further deliver assurance annually and sustain quality.
- Headline figures at the end of March 2016 demonstrate that at that time 90.9% of Doctors had a currently valid appraisal. 6.5% non-compliant are explained by exclusion criteria such as long term sick leave. There are 2.6% who at that point were classified as being non-engaged. A further review of these cases suggests that they are accounted for by short term delays and all those doctors have since completed an annual appraisal.
- Recruitment processes provide appropriate safety and quality checks aligned with national policy and best practice.
- Use of locum practitioners is being monitored and used to sustain service commitments and activity appropriately.
- Medical Appraisal and Revalidation whilst being proportionately resourced and supported in 2gether NHSFT has a significant cost associated with the support and engagement that is inescapable.
- To note Appendix F that indicates the current compliance rates.

RECOMMENDATIONS

1) That the Trust Board accept and endorse the Medical Appraisal Annual Report and:

- Recognise the continued progress that has been made in the application of appraisal, recording and quality assuring is recognised and that this has occurred without significant additional funding.
- Recognise that the figures for engagement in appraisal reflect a snap shot at one point in the year and that the Trust will continue to achieve appraisal consistent with the provision of safe medical services on an annual basis supported by the Revalidation statistics provided.
- Recognise that there are a number of exceptions / reasons for non-compliance that contribute to a compliance point of less than 100%.
- Recognise that effective appraisal has supported timely and appropriate Revalidation for all Doctors to date.
- Recognise the good employment practice with regard to recruitment is supporting safe practice.
- That locum use remains necessary for the safe provision of clinical services but that this is monitored appropriately.

2) That the Board agrees the content and submission of the Statement of Compliance to NHS England (Appendix G).

Corporate Considerations	
Quality implications	Appraisal contributes to patient safety.
Resource implications:	Continuing use of administrative and managerial time with clinician input to revalidation process.
Equalities implications:	The annual appraisal monitoring process addresses equalities issues. This process is a particular issue for people on part time contracts.
Risk implications:	There are significant risks both to quality, safety and reputation of failure to implement Revalidation and annual appraisal effectively.

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

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

Reviewed by:		
Dr Chris Fear	Date	9th August 2016 / 21st Sept 2016

Where in the Trust has this been discussed before?		
Medical Appraisal Committee	Date	6th May 2016

What consultation has there been?		
Medical Appraisal Committee	Date	6th May 2016

Explanation of acronyms used:	SARD - Strengthened Appraisal & Revalidation Database MAC – Medical Appraisal Committee

1. CONTEXT

1.1 The Medical Appraisal and Revalidation Report provides a summary of the work that has been undertaken within the Trust to support the safe provision of clinical services through the medical practitioners working to this Designated Body aligned with national policy.

1.2 It provides assurance as to the application of national policy with regard to the regulation and Revalidation of Medical Practitioners and insight into the processes and resources that are required to undertake this work.

Annual Medical Appraisal Board Report

Appraisal year:	**1st April 2015 – 31st March 2016**
Author:	**Dr Barnaby Major (Chair of Medical Appraisal Committee)** ***On behalf of Medical Appraisal Committee***
Prepared for:	**Trust Board via Trust Governance Committee**

1. Executive summary

Of the 77 doctors requiring appraisal during the last year 70 (90.9%) were compliant as at 1st April 2016; this demonstrates year-on-year improvement (75% end of 2014, 89.5% end of 2015).

When the Medical Appraisal Committee (MAC) was set up in 2013 the focus was on developing and implementing the basics required to ensure doctors engaging in and completed a standardised medical appraisal. Since then the MAC have focussed on improving the quality of medical appraisals undertaken in the organisation.

In July 2015 the Trust's appraisal and revalidation systems were scrutinised by an NHS England Independent Verification Review Team; overall the trust was highly commended and scored at least 5 out of 6 (equating to 'Excellence') in all of the core standards. No required actions were recommended and many areas of good practice were noted. The Trust was subsequently invited to present at the SW Region Responsible Officers network as an example of good practice. These outcomes provide significant independent validation and assurance to the Governance Committee and Board that the organisation is fulfilling its statutory obligations.

2. Purpose of the Paper

The purpose of this paper is to report on the state of medical appraisal to the Trust Board over the preceding appraisal year. It is also to report on further progress made towards developing and refining systems and procedures to support medical appraisal and to improve the quality of medical appraisals taking place in the organisation. In

addressing these two issues the paper provides assurance to the Trust regarding both the quality of the medical workforce and its sustainability.

3. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. The strengthened annual appraisal process is the primary supporting mechanism by which revalidation recommendations are made to the General Medical Council (GMC) for the re-licensing of doctors.

All non-training grade doctors in an organisation relate to a senior doctor, the Responsible Officer (usually the Medical Director). Completion of satisfactory annual appraisal over a five year period is a crucial factor in enabling the Responsible Officer (RO) to make a positive affirmation of fitness to practice to the GMC.

4. Governance Arrangements

The Trust Medical Appraisal Committee (MAC) was set up in 2013. The aim and objectives of the committee are; to oversee the process of appraisal of all licensed doctors employed within the trust; to develop robust systems for the recruitment, training, support & performance review of all medical appraisers within the organisation; and to review and quality assure the standard of appraisals conducted within the trust.

The MAC comprises of the Medical Director/RO, a separate chair, the director of medical education, at least 2 consultant representatives/lead appraisers (selected to represent the geographical & sub-specialty spread of consultants within the Trust) and at least 1 SAS doctor representative (currently 2; representing both counties).

The MAC convenes quarterly; including holding an appraisal year-end away day to review the results of the quality assurance audit and to scrutinise the end of year appraisal compliance figures. The committee review the annual work plan and the progress made against the Terms of Reference developed at inception of the committee.

Key developments delivered by the MAC during the last year include development of a user-friendly guide for completion of appraisal portfolios (including how to obtain and what supporting information to include); development of a new appraisal & revalidation leaflet for patients; provision of new 6-monthly medical appraiser forums; invited presentation on SARD JV (see below) as example of good practice at NHS England SW Region RO network; benchmarking & comparison of our collated appraisee feedback against other comparable organisations; further improvement in our systems for disseminating learning from the annual quality assurance audit; and further improvement in our systems for performance review of established and newly qualified medical appraisers.

Alongside these new developments the MAC continues to regularly monitor appraisal compliance rates and engagement in the process; provide approved baseline & refresher training for medical appraisers (provision is determined by current need); monitor training compliance & output of approved appraisers; enforce required minimum and maximum numbers of completed appraisals conducted by each approved appraiser within a 2 year cycle; and regularly review appraisee feedback.

The Strengthened Appraisal and Revalidation Database (SARD JV) was introduced in 2013 and training made available for all users. All appraisals and now also job planning are completed and documented in this software package. Use of SARD JV has contributed significantly to the process of compliance monitoring and hence maintaining the overall high compliance rates seen since its introduction.

Administrative support for the MAC, and for the use of SARD JV, is provided by the Medical Director's office. Additional technical support is also provided by SARD JV staff. All doctors requiring appraisal are sent email reminders 3 months and 6 weeks before their appraisal due dates. Weekly emails and correspondence are then undertaken from the due date onwards. If a doctor becomes non-compliant the Medical Director sends an assertive reminder. If the doctor remains non-compliant after 1 month and no appraisal meeting date has been set, a face to face meeting with the Medical Director is arranged.

Priorities for the MAC for the next year include further consideration of ways to improve patient and public involvement in appraisal and revalidation processes; development of an IT dashboard tool to support the collection of data to inform medical appraisal; and further refinement of the number and nature of qualified medical appraisers within the organisation.

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

Of the 77 doctors requiring appraisal during the last year 70 (90.9%) were compliant as at 1st April 2016; this demonstrates year-on-year improvement (75% at end of 2014, 89.5% at end of 2015). Sub-group numbers were insufficient to conduct any meaningful statistical analyses; however general trends in the data reviewed suggest that there were no significant differences in compliance rates between different grades of doctor, or locality or specialty worked (except possibly overall compliance being lower in Gloucestershire compared to Herefordshire). Notably compliance remains high within trust locums (consistently above 80%); typically a group in which engagement and compliance is hard to establish and maintain.

Of the 7 doctors which were non-compliant; 5 (71.4%) had reasons (2 on or returning from long term sickness, 2 on or returning from maternity leave and 1 'other' reason agreed with the RO). Of the 2 (28.6%) without reasons; 1 was overdue by 1 month and the other by 2 months.

The system for monitoring compliance (SARD JV) does not allow for any flexibility

around the appraisal due date. Once the due date has passed (even by a day) the appraisee is deemed non-compliant. This is at odds with the Trust policy which allows for one month before or after the due date for completion of appraisal. Compliance rates are therefore never likely to regularly reach 100% and will fluctuate monthly throughout the appraisal year.

To account for this, and given that at any one time there are likely to be a small proportion of doctors who are currently non-compliant with a reason, the MAC recently agreed that overall compliance rates maintained above 75% should provide adequate assurance of engagement in the process and completion of medical appraisals within the medical workforce.

For further details see appendix A.

b. Appraisers

There are currently 34 trained medical appraisers within the establishment of non-training grade doctors; this includes 3 newly approved appraisers; several doctors have also been removed from the list during the last appraisal year. All consultants and SAS doctors continue to be offered access to training in order to both provide a cohort of appraisers and increase awareness and knowledge of appraisal for appraisers and appraisees alike.

The majority of appraisers are not currently conducting regular appraisals (for example 13 approved appraisers on SARD conducted no appraisals within the last year). The current number of approved appraisers within the Trust is not sustainable; the MAC have set and enforce minimum numbers of completed appraisals required in a 2 year period in order to ensure that those approved are able to maintain their skills. These standards were introduced in October 2014; the end of the first 2 year cycle will occur in the coming appraisal year, at which point it is likely that a significant number of appraisers will be removed from the list.

The MAC have developed a formal recruitment process and set minimum baseline and refresher training requirements. The MAC continue to encourage SAS doctors to become trained and practising appraisers.

Appraiser refresher training was last provided within the Trust in January 2016. The training was delivered by a recognised leader in the field. The training has been reviewed and further developed to bring it more in line with Trust policy and use of SARD JV.

Not all appraisals undertaken by appraisers are captured by SARD JV or relate to doctors with whom 2gether has a prescribed connection. Some appraisals are undertaken for colleagues working outside 2gether, in retirement or within other roles such as the Deanery.

c. Quality Assurance

In July 2015 the Trust was visited and scrutinised by the NHS England Independent Verification Review Team; the purpose of which is to assess and validate the status of appraisal and revalidation systems within all designated bodies. The process is designed to provide independent assurance to trust boards that the organisation is fulfilling its statutory obligations in respect of the RO's statutory responsibilities.

Overall the trust was highly commended and scored at least 5 out of 6 (equating to 'Excellence') in all of the core standards; with the highest score achieved for 'Engagement & Enthusiasm'. No required actions were recommended by the scrutiny panel, and only a few suggestions made for improvement mainly in relation to HR procedures (which have since been enacted). Many areas of good practice were noted including the overriding focus on the quality of medical appraisals taking place within the organisation, use of SARD JV as a tool to support quality and compliance, automatic inclusion of complaints and serious incidents within individual appraisal portfolios, and the processes to support learning and quality improvement from the annual quality assurance audits.

In addition the MAC have recently reviewed all 27 of NHS England's current medical appraisal position statements (designed to represent current opinion on a variety of appraisal/revalidation issues and, where relevant, state current best practice). The statements are however not designed to be prescriptive. This process was akin to an (albeit informal) benchmarking exercise; the outcome was reassuring that our current practices and policy are consistent with the majority of the position statements.

As RO the Medical Director is required to individually review all completed appraisals for both completion and quality. The MAC has developed additional assurance processes to support this.

Alongside ensuring robust recruitment and training processes for medical appraisers, regular support and review of the role takes place within existing consultant CPD peer groups, as part of appraisers' own appraisals and via informal support offered by members of the MAC itself.

Appraisee feedback forms are automatically generated by SARD JV and sent to individual appraisees after all completed appraisals. Once completed these are screened by the medical director's office and then reviewed quarterly at MAC meetings. Collated (anonymised) feedback covering the entire appraisal year is circulated to all appraisers; it was also recently agreed to provide individualised (anonymised) feedback to appraisers as well. Summarised feedback has been benchmarked against feedback collated from other similar organisations (and has been considered comparable).

The Medical Director's office automatically populates individual doctor's SARD JV portfolios with anonymised complaints and anonymised serious incident reports. The expectation is that these will then be referred to and reflected on as part of appraisal.

The annual medical appraisal quality assurance re-audit was recently conducted by all members of the MAC; 8 out of 76 (10.5%) completed appraisal summaries were randomly audited for completeness and quality. Consent was sought from individual appraisees. Two different quality assurance audit tools were piloted and subsequently a decision taken to carry one forward for use in future re-audits. Results were reviewed at an away day and an action plan subsequently developed; including dissemination of key learning points to all appraisers and appraisees and individualised feedback provided to appraisers in relation to the specific cases audited. A separate audit report has been completed. The audit will be repeated annually.

See Appendix B for further details.

d. Access, security and confidentiality

Appraisees are advised to only upload anonymised documents to their appraisal portfolios so that no patient identifiable information is included. The Medical Director's office has administrative access to SARD portfolios in order to support appraisees and upload information with the agreement and knowledge of appraisees.

e. Clinical Governance

Work is ongoing to develop an IT dashboard tool to enable appraisees to access standardised clinical and performance related data to benchmark themselves and their services against similar individuals/services to inform appraisal. Not as much progress has been made during the last year as had been hoped for; this has primarily been due to the limited capacity of the IT department to prioritise this work. Work is ongoing in this area and it is hoped that this resource will be developed and piloted within the coming appraisal year.

The Medical Director's office automatically populates individual doctor's SARD JV portfolios with anonymised complaints and anonymised serious incident reports. The expectation is that these will be readily available to both appraiser and appraisee so that they can be discussed and reflected on in the course of the pre-appraisal preparation and appraisal meeting.

The MAC has set an expectation of 2 completed multi-source feedback (MSF) exercises within each 5 year revalidation cycle. This is greater than the national minimum standard but provides opportunity to gain more frequent and appropriate feedback allowing the identification, addressing and review of any issues highlighted. Provided the national standard is achieved and there is appropriate consideration in appraisal of one MSF this does not prevent recommendation for revalidation being made. NHS England has a position statement on when to repeat MSF exercises following a change of role which the trust adheres to.

6. Revalidation Recommendations

During the last year 33 revalidation recommendations were due; for 27 of the 33 (82%) positive recommendations were made; the remaining 6 (18%) were recommended for deferral; 1 within 2015/16 and 5 for deferral to 2016/17. The GMC are clear that deferral should not be considered as a negative outcome; rather acknowledgement that doctors require more time (for a variety of valid reasons) to gather sufficient evidence for appraisal to take place and revalidation recommendations to be made.

The deferrals made within the year have been either due to long term sickness or to provide additional time in order to gather further evidence required; such as Statutory and Mandatory training compliance or completion of a multi-source feedback exercise.

See appendix C for further details.

7. Recruitment and engagement background checks

Recruitment and engagement checks are completed when doctors are first employed at the 2gether NHS Foundation Trust; they are in line with the Trust's Pre-Employment Checks Policy. These checks include:

- Occupational Health Clearance, including any night working
- Identity Verification
- Qualifications
- Right to Work
- DBS - Disclosure and Barring Service - Enhanced Level checks
- References from two line managers over the last two years
- Medical Practice Transfer Form - information from previous medical director

All pre-employment checks for substantive doctors are completed before employment is started.

Please see Appendix E.

8. Monitoring Performance

The performance of Doctors is monitored through the combination of perspectives provided by the following source materials and processes:-

- Initial design of Job Description and Person Specification
- Effective recruitment and selection processes
- Job planning
- Peer Group membership and attendance
- Appraisal
- Monitoring of Serious Incidents, Complaints and Compliments
- Participation in Supervision
- Activity data

- Participation in Continuing Professional Development
- Completion of Statutory and Mandatory Training
- Diary Monitoring Exercises
- Attendance / sickness absence

These perspectives are available through a combination of routine reports and intermittent reviews reporting to the RO, Clinical Directors, Clinicians and Managers. Most also constitute areas that are considered as part of the Appraisal process.

Please refer to appendix D.

9. Responding to Concerns and Remediation

The Policy on the Management and Remediation for Concerns about the Professional Conduct and Clinical Performance of Medical Practitioners provides a framework that interprets national policy and best practice for local delivery.

One doctor is currently in receipt of input within the framework provided by this policy.

Please refer to appendix D.

10. Risk and Issues

Overall engagement in and compliance with appraisal has remained high throughout the last appraisal year. This is largely due to the improved engagement of doctors achieved over recent years and also to the ongoing work of the Medical Director's team in monitoring compliance and providing prompting and support. This has been possible due to the universal use of the SARD JV software.

However the sensitivity of the monitoring system which allows no latitude in completion date before being non-compliant is recorded, combined with the limited range of exceptions, mean that the rolling compliance rates vary from month to month without appraisal uptake having altered markedly. Exceptions this year are accounted for mostly by long term sickness or maternity leave.

There is a significant time and therefore cost associated with both completion of appraisals as an appraisee (estimate 16-36 data collection hours per annum) and appraiser (4-6 hours per appraisal). This does not take account of the activity associated with populating appraisal documentation or undertaking multi-source feedback, audits, peer groups, supervision and training. This is having an impact on the availability of retired doctors to undertake locum and part time work and will create a particular pressure in Mental Health service provision in the future.

Recruits from outside the UK have not been taking part in this process and thus for the first year of any practice will not have undertaken appraisal whilst they are collecting data. This group provide a further exception for periods.

The scope of work that a doctor can undertake is determined by and determines their CPD and CME requirements. There is a raised expectation that any activities have an associated CME/CPD function. This does limit practitioner flexibility and cover to specialist areas, a particular issue in relation to on-call rotas and 7 day working.

11. Corrective Actions, Improvement Plan and Next Steps

The MAC will continue to review its work plan against the terms of reference annually. The Trust medical appraisal policy is due for review in October 2016. Priorities for the MAC for the next year include further consideration of ways to improve patient and public involvement in appraisal and revalidation processes; development of an IT dashboard tool to support the collection of data to inform medical appraisal; and further refinement to the number and nature of qualified medical appraisers within the organisation.

The MAC will investigate individual cases where appraisal has not been completed (without reason) within a reasonable time frame. Subsequent investigation reports will be submitted to the Medical Director/Responsible Officer who will decide on further action. Doctors who have not completed an annual appraisal will not be eligible for routine pay progression or local clinical excellence awards; ²gether NHS Foundation Trust has the right to terminate the contract of a doctor if they do not undergo an annual appraisal without having good reason.

Workforce planning will need to take account of the possible limitations to the scope of practice and perhaps the limited workforce that may be available due to retirement.

12. Recommendations

The Board is asked to accept the Annual Report on Medical Revalidation and Appraisal and:

- Recognise the progress that has been made in the support provided to Appraisal and Revalidation within 2gether NHSFT through the use of SARD JV and the engagement of clinicians in this.
- Recognise the work that has been undertaken and is planned by the Medical Appraisal Committee to support the work of the Medical Secretariat and Responsible Officer in providing, maintaining and developing sustainable recording, reporting and assurance systems.
- Recognise that snap shot compliance figures do not reflect the annual uptake of appraisal but are primarily a function of the way in which data is collected. In any year the expected outturn will be for 100% of doctors with a prescribed connection to this Designated Body to be appraised; however there will be exceptions which will reduce the overall figure.
- Appropriate processes are in place for the review of Appraisals, Appraiser performance, maintenance of Appraisal capacity and the quality of appraisals.
- Employment checks are undertaken consistent with national standards and best practice.

- Locum use whilst significant is reviewed and regulated, aimed at maintaining clinical provision to cover mostly medium to long term absence including long term sickness and recruitment.

Annual Report Appendix A

Audit of all missed or incomplete appraisals

Doctor factors (total)	**7**
Maternity leave during the majority of the ‘appraisal due window’	2
Sickness absence during the majority of the ‘appraisal due window’	2
Prolonged leave during the majority of the ‘appraisal due window’	0
Suspension during the majority of the ‘appraisal due window’	0
New starter within 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	0
Postponed due to incomplete portfolio/insufficient supporting information	1
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	1
Lack of engagement of doctor	0
Other doctor factors	1
Appraiser factors	
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	0
Other appraiser factors (describe)	0
(describe)	
Organisational factors	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

Annual Report Appendix B

Quality assurance audit of appraisal inputs and outputs

Excellence audit tool

		Percentages (%)		
Number	**Criterion**	absent	room for improvement	well done
1	Includes whole scope of work?	0	72	25
2	Free from bias?	0	13	88
3	Challenging & supportive?	13	13	75
4	Exceptions explained?	0	13	88
5	Reviews & reflects?	0	38	63
6	Review of previous PDP?	25	13	63
7	Encourages excellence?	13	50	38
8	Gaps identified?	0	13	88
9	SMART PDP?	13	25	63
10	Relevant PDP?	0	50	50

Annual Report Template Appendix C

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2015 to 31 March 2016	
Recommendations completed on time (within the GMC recommendation window)	28 (Positive) 5 (Deferrals)
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	28 (Positive) 5 (Deferrals)
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	0
Describe other – Trust was in negotiations with Doctor and GMC	0
TOTAL [sum of (late) + (missed)]	0

Annual Report Appendix D

Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level[1]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	1	0	3	4
Capability concerns (as the primary category) in the last 12 months	1	0	0	1
Conduct concerns (as the primary category) in the last 12 months	0	0	0	0
Health concerns (as the primary category) in the last 12 months	0	0	3	3
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2015 who have undergone formal remediation between 1 April 2014 and 31 March 2015 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*				1
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				0
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				1
General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0

[1] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies	0
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	0
TOTALS	0
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	1
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	4 mths
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	1
GMC Actions: Number of doctors who:	
Were referred by the designated body to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	1
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	0
Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment	0
Number of NCAS assessments performed	0

Annual Report Appendix E

Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	0
Temporary employed doctors	0
Locums brought in to the designated body through a locum agency	40
Locums brought in to the designated body through 'Staff Bank' arrangements	0
Doctors on Performers Lists	0
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	0
TOTAL	0

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	Disclosure and Barring Service (DBS)	2 recent references	Name of last responsible officer	Reference from last responsible officer	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Permanent employed doctors																
Temporary employed doctors																
Locums brought in to the designated body through	40	40				40	40					40				

a locum agency																
Locums brought in to the designated body through 'Staff Bank' arrangements																
Doctors on Performers Lists																
Other (independent contractors, practising privileges, members, registrants, etc)																
Total	40	40				40	40					40				

For Providers of healthcare i.e. hospital trusts – use of locum doctors:

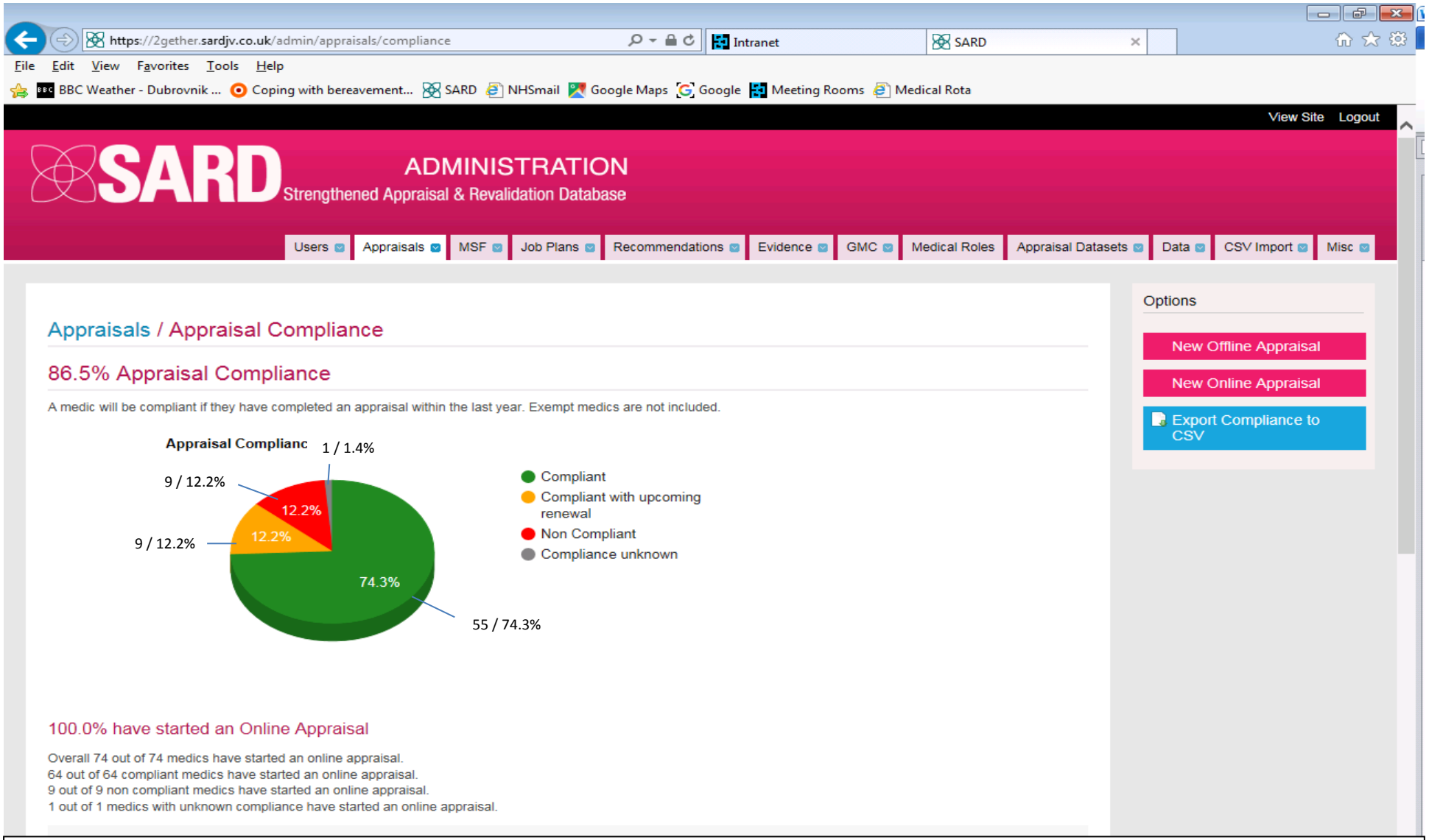
Explanatory note: Number of locum sessions used (days) as a proportion of total medical establishment (days)

The total WTE headcount is included to show the proportion of the posts in each specialty that are covered by locum doctors

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum days used
Surgery					
Medicine					
Psychiatry	8	22	10	6	
Obstetrics/Gynaecology					
Accident and Emergency					

Anaesthetics					
Radiology					
Pathology					
Other – Occ Health	0.2	40			
Total in designated body (This includes all doctors not just those with a prescribed connection)		1635	707	335	
Number of individual locum attachments by duration of attachment (each contract is a separate 'attachment' even if the same doctor fills more than one contract)	Total	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less	40	40	40		0
3 days to one week					
1 week to 1 month					
1-3 months					
3-6 months					
6-12 months					
More than 12 months					
Total	40	40	40		1

Appendix F



SARD does not show doctors that are currently classed as exempt from appraisal due to maternity, long term sick etc. of which there are 6 doctors (in the graph above these are included in the non compliant and compliance unknown categories). This reduces the total non-compliant figure to 5.5% / 4 doctors and increases the total compliance figure to 94.5% / 70 doctors.

Figures as of 20th September 2016

Appendix G

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Version 4, April 2014

NHS England INFORMATION READER BOX

Directorate		
Medical	Operations	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

Publications Gateway Reference:	**01142**
Document Purpose	Guidance
Document Name	A Framework of Quality Assurance for Responsible Officers and Revalidation, **Annex E - Statement of Compliance**
Author	NHS England, Medical Revalidation Programme
Publication Date	4 April 2014
Target Audience	All Responsible Officers in England
Additional Circulation List	Foundation Trust CEs , NHS England Regional Directors, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Area Directors, NHS Trust Board Chairs, Directors of HR, NHS Trust CEs, All NHS England Employees
Description	The Framework of Quality Assurance (FQA) provides an overview of the elements defined in the Responsible Officer Regulations, along with a series of processes to support Responsible Officers and their Designated Bodies in providing the required assurance that they are discharging their respective statutory responsibilities.
Cross Reference	The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012
Superseded Docs (if applicable)	Replaces the Revalidation Support Team (RST) Organisational Readiness Self-Assessment (ORSA) process
Action Required	Designated Bodies to receive annual board reports on the implementation of revalidation and submit an annual statement of compliance to their higher level responsible officers (ROCR approval applied for).
Timings / Deadline	**From April 2014**
Contact Details for further information	england.revalidation-pmo@nhs.net http:// www.england.nhs.net/revalidation/

Document Status

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Annex E – Statement of Compliance

Designated Body Statement of Compliance

The Board of 2gether NHS Foundation Trust as carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments: Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: Yes

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments: Yes.

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments: Yes

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Comments: Yes

[1] Doctors with a prescribed connection to the designated body on the date of reporting.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments: Yes

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

Comments: Yes

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments: Yes

Signed on behalf of the designated body

Name: Ruth FitzJohn Signed: _ _ _ _ _ _ _ _ _ _

Chair, 2gether NHS Foundation Trust

Date: 29th September 2016

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Agenda item 14 **Paper H**

Report to: Trust Board – 29th September 2016
Author: Nick Grubb - Assistant HR Director
Presented by: Carol Sparks - Director of Organisational Development

SUBJECT: **Workforce Race Equality Standard**

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

EXECUTIVE SUMMARY

The Workforce Race Equality Standard was introduced as a mandatory report with effect from April 2015. It is designed to highlight where staff from a Black or Minority Ethnic (BME) background have a different experience of working in the NHS to White colleagues.

The Standard examines a series of nine indicators where the data is taken from workforce information and the national Staff Attitude Survey.

Undertaking the Workforce Race Equality Standard was incorporated into the NHS Standard Contract in 2015.

The Standard will form part of the CQC inspection schedule from 2016.

2016 is the second year that the Trust had completed and submitted data for the Workforce Race Equality Standard. It should be noted that the Staff Attitude Survey data used to inform the results are taken from the year previous to the year in which the Workforce Race Equality Standard data is submitted. Therefore the Trust's 2015 results utilised the 2014 Staff Attitude Survey data and the 2016 Trust results utilised 2015 Staff Attitude Survey data.

Comparison between the Trust's 2015 results and 2016 show this year's results to be broadly the same. However no comparison is available for one indicator, Indicator 5, because there was an insufficient response rate from the Staff Attitude Survey in 2015 for the response to be published.

Nationally the 2015 results were collated and published in 2016 and reviewed by the Trust's Executive Committee in June 2016.

The Trust's Executive Committee reviewed the 2016 submission on 15th August 2016. The Committee agreed that the report be published on the Trust's website, and also

agreed a number of additional actions which are included in this report and the attached action plan. The national results for 2016 have not yet been released and therefore no comparison is available for this Trust's results against other Trusts.

Assurance

Significant assurance is provided to the Board that:

- the Workforce Race Equality Standard submission for 2015 was submitted in accordance with the 2015 requirements, and that the national comparative results were scrutinised by the Executive Committee when released in June 2016.
- the Workforce Race Equality Standard submission for 2016 has been completed within the given timescales and an action plan has been produced in advance of the national comparative data but which builds on the Trust's own comparison of its 2015 and 2016 results.

Limited assurance is provided to the Board that the underpinning data which informs the Workforce Race Equality Standard is sufficient to fully understand the experience of BME staff employed by the Trust.

RECOMMENDATIONS

The Board is asked to note:

- the information contained in this report
- the assurances provided
- the action plan developed to better understand the data and identify any trends or issues

Corporate Considerations	
Quality implications:	The Trust aims to provide equality of opportunity for all staff, in recognition that engaged and motivated staff deliver quality patient care.
Resource implications:	The completion of the Workforce Race Equality Standard is managed within existing resources as is the implementation of the action plan.
Equalities implications:	The Equalities Act 2010 sets out the duties of the Trust and the Equality and Human Rights Commission gives clear guidance which the Trust should endeavour to meet. This report and the Workforce Race Equality Standard action plan is intended to meet these duties and guidance and to ensure compliance.
Risk implications:	Failure to provide equality of opportunity may result in claims of discrimination, damage to the reputation to the Trust as a fair employer and difficulty in recruiting valued staff.

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

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	P	Can do	P
Valuing and respectful	P	Efficient	P

Reviewed by:		
Carol Sparks, Director of Organisational Development	Date	19th September 2016

Where in the Trust has this been discussed before?		
Executive Committee		6th June 2016
Executive Committee	Date	15th August 2016

What consultation has there been?		
	Date	

Explanation of acronyms used:	WRES – Workforce Race Equality Standard BME – Black and Minority Ethnic VSM – Very Senior Manager ESR – Electronic Staff Record

1. Context

1.1 The Workforce Race Equality Standard was introduced across NHS England in April 2015, and incorporated into the standard NHS Contract.

1.2 The Workforce Race Equality Standard was developed following research[1] primarily in London that demonstrated that the experience of staff from a Black or Minority Ethnic (BME) background have a different and significantly worse experience of working in the NHS to white colleagues working in the NHS.

1.3 The research also showed that BME staff were absent from the leadership of many organisations, even where the workforce had substantial numbers of BME staff. It also showed that BME staff were treated less favourably against a range of indicators including promotion, grading, disciplinaries, being subjected to bullying and lack of access to non-mandatory training.

[1] The Snowy White Peaks of the NHS – Roger Kline

1.4 The Workforce Race Equality Standard is therefore a tool for identifying a number of key gaps in the experience of BME staff compared with White staff, against the identified indicators – see **Appendix A.** Closing these gaps should achieve progress in tackling discrimination and promoting a positive culture, and it is widely recognised that motivated and engaged staff positively impact upon the quality of patient care.

1.5 The Trust has a workforce of whom 6% come from a BME background. In Agenda for Change and VSM pay bands there is only one person from a BME background. However, including Consultants the percentage rises to 6.8%, broadly reflective of the workforce.

1.6 It should be noted that The Workforce Race Equality Standard only focuses on one of the nine 'protected characteristics', is limited in the indicators it uses and does not take into account the overall make-up and culture of a Trust nor the geographical area where it delivers its services.

2 The 2015 Workforce Race Equality Standard Submission

2.1 The Trust completed its first Workforce Race Equality Standard data submission in 2015, and a report setting out the data was considered by the Executive Committee on the 13th July 2015. All Trusts were required to publish their baseline date in July 2015, and the Trust complied with this by publishing the data on the Trust website.

2.2 It is also a requirement of the Workforce Race Equality Standard that the data is provided to our commissioners. This was completed in 2015 after the Executive Committee had reviewed the data.

2.3 The 2015 submission provided baseline data against which progress in reducing any gaps in the work experience between White and BME colleagues can be measured.

2.4 Nationally, the Workforce Race Equality Standard implementation team collated all Trusts' data within NHS England. The analysis of this data for comparative purposes was not available or published nationally until May 2016. It was presented to the Executive Committee on 6th June 2016.

2.5 The national comparative data for 2015 published in May 2016 can be accessed from NHS England via the following link: https://www.england.nhs.uk/2016/06/wres-publication/ . This is a large document and it breaks down the data into comparisons by different categories of Trusts. This Trust is included in the Mental Health and Learning Disability Trust grouping and the extract for this part of the document is at **Appendix B**.

2.6 This data is important as it provides the Trust with a benchmark against which it can assess progress and plan actions to address the feedback of BME staff and their experience at work.

2.7 Of particular note is indicator 5 which is '*Percentage of staff who report experiencing harassment, bullying or abuse from patients, relatives of the public in the last 12 months*'. The 2015 Workforce Race Equality Standard

shows that [2]gether NHS Foundation Trust had the largest (worst) gap between the experience of BME staff and White staff.

2.8 As noted previously this data is extracted from the 2014 Staff Attitude Survey. The overall score in the Staff Attitude Survey (the amalgamated score for all staff and not broken down by ethnicity) is 26%, being an improvement on the previous year and below the average for similar Trusts. The value of the Workforce Race Equality Standard is that it provides a different picture of the national Staff Attitude Survey results and one which has not been previously available to Trusts.

2.9 The Workforce Race Equality Standard notes that for indicator 6 '*Percentage of staff who report experiencing harassment, bullying or abuse from staff in the last 12 months*' shows a very different picture for BME staff in that for many Trusts including this Trust, the figures are favourable. The report therefore suggests that the concerns about harassment, bullying and abuse from '*patients, relatives of the public'* are very real for staff.

2.10 The detail sitting behind Indicator 5 is that nineteen staff who declared they had a BME background responded in the Staff Survey to this Key Finding. Of those nineteen staff, 53% said 'yes', and this equates to 10 staff. So although a small number by headcount, it was a large percentage of the number who reported '*experiencing harassment, bullying or abuse from staff in the last 12 months'.* Regardless of the small number by headcount, this should not detract from the different experience of those staff at work.

2.11 In reviewing the data the Executive Committee acknowledged that the Trust is doing a lot to support staff through our 'Speak in Confidence' system and our new 'Dignity at Work Officers', however the key issue from the Workforce Race Equality Standard data related to staff being bullied harassed or abused by patients, carers and the public. Most of our processes are aimed at relationships between staff. Therefore the Executive Committee agreed the following actions to be taken immediately, and which were completed:

- A message via Team Talk that highlighted the figures; a statement that says this is unacceptable; a reminder that staff should log any such incidents perpetrated by public, patients or carers via Datix, and that they can if they wish raise via 'Speak in confidence' and seek support from our 'Dignity at Work Officers'. This included a clear reminder to managers to monitor and support staff who are targeted and ensure that care plans are appropriately developed to manage unacceptable patient behaviour.
- A short statement to go in Payslips encouraging staff to report unacceptable behaviour from service users, carers and the public; reminding staff that such behaviours are not in keeping with our values; and to report incidents via Datix etc.

3. THE 2016 WORKFORCE RACE EQUALITY STANDARD SUBMISSION

3.1 In 2016 the Workforce Race Equality Standard implementation team provided Trusts with a specially designed template to assist Trusts in providing data in a consistent format and using the same definitions.

3.2 The data from the Trust was successfully uploaded within the required timescale and will be analysed alongside data from all other NHS Trusts as part of the national publication process.

3.3 As previously noted it remains a requirement of the Workforce Race Equality Standard that the data is provided to our commissioners and published on the Trust website.

3.4 The 2016 data has been added to the standard reporting template provided by the Workforce Race Equality Standard implementation team and is attached as **Appendix C.** The standard template shows the comparison between this year's data and the baseline data but is very user-unfriendly and difficult to both complete and read. It should be noted that the format of the template means that unless the template and text is read electronically, not all the words are visible as the text boxes cannot be expanded for the purposes of providing the detail in Appendix C.

3.5 A detailed action plan is also required to demonstrate the steps the Trust is taking to close any gaps between the experience of BME and White staff. The accompanying action plan is attached as **Appendix D**. A number of the actions will be used to address more than one Workforce Race Equality Indicator or more than on Key Finding. The 2016 Staff Attitude Survey will run between September and November 2016 with the results available late February 2017. It is not yet clear when the 2016 national comparative Workforce Race Equality Standard data will be available. However both sets of results will be used to inform and update the action plan.

4 COMPARISON OF 2015 AND 2016 DATA

Indicator 1 - *Percentage of staff in each of the AfC bands and VSM including executive Board members compared with the percentage of staff in the overall workforce.*

4.1 This indicator has changed since the previous year as the baseline data originally asked for the percentage of BME staff at Band 8 and above compared with White colleagues. For 2016, the template asks for the percentage of White and BME staff in each pay band, both for clinical staff and non-clinical staff.

4.2 Although there are slight differences due to staff turnover, the data shows that BME staff remain under-represented in grades above Band 7 although BME colleagues are better represented within the Consultant body.

Indicator 2 – *Relative likelihood of staff being appointed from shortlisting across all posts.*

4.3 The baseline information showed that White people were 2.32 times more likely to be appointed from shortlisting than applicants from a BME background. The latest data shows a small improvement in that White colleagues were 2.21 times more likely to be appointed from shortlisting than BME applicants.

4.4 It is not known why there is such a disparity. All posts are advertised via NHS jobs and shortlisting is done without sight of personal details or protected

characteristics. The Trust has been using 'Values Based Recruitment' supported by training for managers and our training will be amended to incorporate raising awareness of unconscious bias during the selection process.

Indicator 3 – *Relative likelihood of staff entering the formal disciplinary process*.

4.5 The data for this is based on a two year rolling average of formal disciplinary cases. Baseline information shows that from the number of formal disciplinary cases BME staff were 1.63 times more likely to enter the formal disciplinary process than White colleagues. The data for 2016 shows that BME are 1.74 times more likely to enter the formal disciplinary process than White colleagues.

4.6. However during the current review period the breakdown of case numbers by ethnicity shows there were 28 white colleagues and 3 BME colleagues subject to a formal disciplinary process (ethnicity was undisclosed in 8 other cases). The Trust has a robust policy for the management of conduct and each individual has the right of appeal against any decision that may be made against them following due process. There is no record of any appeal made citing racial discrimination. The Disciplinary policy will continue to be applied fairly and consistently.

4.7 It is acknowledged that there is a lack of ethnicity data held in ESR. Without a full record for all staff, the numbers do not help in understanding whether BME staff are more likely to enter the disciplinary process that non-BME staff. For example, if the ethnicity was known for the 8 individuals noted above, this could significantly change the proportion of White and BME staff entering a Disciplinary process.

Indicator 4 – *Relative likelihood of staff accessing non-mandatory training and CPD.*

4.8 The baseline information showed that BME staff were 0.8 times more likely to access non-mandatory training than White colleagues and this has increased to 0.9 for the current data submission.

4.9 It is clear form those figures that colleagues from a BME background are able to access the wide range of non-mandatory training the Trust offers. It should be noted that our training records are based on the number of times in-house training courses have been accessed rather the number of courses an individual has attended. Other CPD events are not recorded centrally. The Trust has recently introduced new software called 'Learn2gether' which will enable each employee to have an individualised training profile rather than a role-based training profile which was the former system using ESR. Consideration is being given as to whether or not the new learning system could be developed to build a record of supplementary training and CPD accessed by staff. This would provide a much clearer picture of how BME staff access training and development compared with non-BME staff.

Indicators 5 to 8 are based on the responses to the 2015 Staff Survey and are shown here in an extract from the Survey.

			Your Trust in 2015	Average (median) for mental health	Your Trust in 2014
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	29%	32%	24%
		BME	-	37%	53%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	21%	21%	19%
		BME	-	23%	17%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	92%	88%	86%
		BME	-	75%	69%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	5%	7%	6%
		BME	-	13%	16%

4.10 Indicator 5 based on Key Finding (KF) 25 of the Staff Survey was referenced in respect of the 2015 Workforce Race Equality Standard as it was an outlier when compared with similar Trusts.

4.11 For the 2016 Workforce Race Equality Standard no data has been reported as the response rate from BME colleagues to the 2015 Survey was too low to be published, to avoid possible identification of individuals. Clearly it will require another year or two of data to determine whether actions the Trust has and will take can make a difference to the experience of BME staff at work.

Indicator 9 – *The percentage difference between the organisation's Board voting membership and its overall workforce.*

4.12 As with the previous year there are no voting members of the Board who have declared themselves to be from a BME background.

5. RECOMMENDATION

5.1 The Board is asked to note:

- the information contained in this report
- the assurances provided
- the action plan developed to better understand the data and identify any trends or issues

Appendix A

The NHS Workforce Race Equality Standard Indicators (April 2016)

	Workforce indicators For each of these four workforce indicators, compare the data for White and BME staff
1.	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce Note: Organisations should undertake this calculation separately for non-clinical and for clinical staff
2.	Relative likelihood of staff being appointed from shortlisting across all posts
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two year rolling average of the current year and the previous year
4.	Relative likelihood of staff accessing non-mandatory training and CPD
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7.	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion
8.	Q217. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
	Board representation indicator For this indicator, compare the difference for White and BME staff
9.	Percentage difference between the organisations' Board voting membership and its overall workforce Note: Only voting members of the Board should be included when considering this indicator

NHS
Equality and Diversity Council

NHS WORKFORCE RACE EQUALITY STANDARD

2015 DATA ANALYSIS REPORT FOR NHS TRUSTS

FOREWORD

Research and evidence strongly suggest that less favourable treatment of Black and Ethnic Minority (BME) staff in the NHS, through poorer experience or opportunities, has significant impact on the efficient and effective running of the NHS and adversely impacts the quality of care received by all patients.

That is exactly why the NHS Workforce Race Equality Standard (WRES) was introduced in 2015. The WRES seeks to prompt inquiry to better understand why it is that BME staff often receive much poorer treatment than White staff in the workplace and to facilitate the closing of those gaps.

That is exactly why the NHS Workforce Race Equality Standard (WRES) was introduced in 2015. The WRES seeks to prompt inquiry to better understand why it is that BME staff often receive much poorer treatment than White staff in the workplace and to facilitate the closing of those gaps.

Gathering and understanding the data is only the first step. WRES data is leading NHS organisations to develop evidence-based action plans to continuously improve on workforce race equality. There are organisations and parts of the NHS that are embracing this challenge well, but there are other employers that still have a lot of progress to make.

We simply cannot afford the cost to staff and patient care that come from the unfairness and discrimination of a large section of the NHS workforce. As co-directors of the national WRES Implementation Team, we look forward to working with and supporting NHS organisations to make the difference that our diverse staff, communities and all patients need and deserve.

Yvonne Coghill and Roger Kline
Co-directors
WRES Implementation Team
NHS England

INTRODUCTION

In 2014, NHS England and the NHS Equality and Diversity Council agreed action to ensure employees from Black and Minority Ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. It was agreed that a Workforce Race Equality Standard (WRES) should be developed, and in April 2015 it was made available to the NHS.

The WRES requires organisations employing almost the entire 1.4 million NHS workforce to demonstrate progress against nine indicators of workforce race equality. The indicators focus upon Board level representation and differences between the experience and treatment of White and BME staff
in the NHS.

The WRES was included in the 2015/16 NHS standard contract for NHS providers, and from 1 July 2015, provider organisations submitted their baseline data against the nine WRES Indicators. This report provides overview analyses of the WRES baseline data returns by NHS trusts in England.

All NHS organisations are encouraged to implement the WRES with an open mind and an honest heart. Consequently, the self-reported WRES data received from individual NHS trusts, and analysed for the purpose of this report, have been taken at face value, on the assumption that NHS trusts have published accurate and valid data.

We are aware that in some cases, there is a difference between self-reported staff survey data presented
in organisations' WRES reports and data from the national NHS Staff Survey publications. A conscious decision has been taken to use the self-reported data; hence individual NHS trusts will want to check any differences. We are also aware that in a large number of organisations, the samples of staff completing the NHS Staff Survey are small or very small. In such cases, the organisations' ability to use staff survey data to "drill down" and understand the causes of differences may be limited.

One conclusion from the analyses is the need for all NHS trusts to use the staff survey across the whole workforce. This will provide data that can help identify good and poor experience for staff overall and in doing so, highlight areas that require concerted focus and action. We are also conscious that identifying and understanding the differences between BME and White staff experiences is greatly assisted by considering the overall picture, across the whole of the workforce, on each of the four Indicators. The analyses presented in this report reflect that.

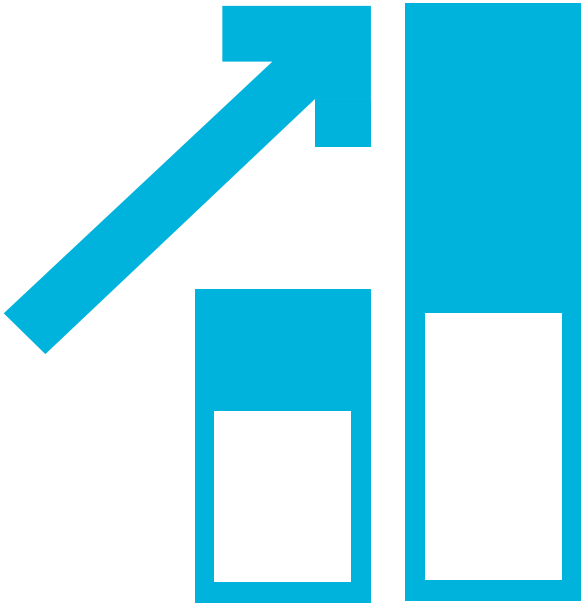
This report presents the 2015 WRES baseline data for the four WRES Indicators that align to the NHS Staff Survey. It presents analyses against the four indicators by NHS trust type. The report is intended to prompt discussion and inquiry within each organisation and encourage good practice. Hence the primary aim of the report is
not to make explicit comparisons between organisations with regard to performance. Following the return of the 2016 WRES data, inter and intra-organisational comparisons and benchmarking will be undertaken and reported.

Individual NHS trusts should take a 'learning organisation' approach to this report. Understanding the data and producing robust action plans to make continuous improvements in these areas will be essential first steps in helping to bring about workplaces that are free from discrimination. We hope the publication of the data will assist peer to peer support between trusts, and trigger inquiry as to root causes of issues and patterns in the data. It will also assist the national WRES Implementation Team in identifying replicable good practices and processes which we can learn from and share.

In discharging their roles and functions, national healthcare bodies also have an important role to play in supporting workforce race equality. Embedding the WRES within key policy levers and ensuring effective system-wide strategic alignment will support local NHS organisations in their implementation and use of this tool.

Commitment to promoting equality and improving diversity amongst the NHS workforce is crucial because we know that a diverse workforce and inclusive leadership is associated with more patient-centred care, greater innovation, higher staff morale and access to a wider talent pool. Understanding data and the root causes of discrimination will be key steps in achieving these aspirations.

The online version of this report contains the raw data for the charts presented in Section 5. It also contains additional analyses of the 2015 WRES data by geographical region. The online version of this report can be accessed from the WRES web page: *https://www.england.nhs.uk/about/ gov/equality-hub/equality-standard/*



KEY FINDINGS

- Higher percentages of BME staff report the experience of harassment, bullying or abuse from staff, than White staff, regardless of trust type or geographical region. Community provider and ambulance trusts are more likely to report this pattern.

- NHS Staff Survey responses from BME staff were, in a significant number of cases, too small to report. In some cases, given the demographics of the trust or the locality served, this was surprising. NHS trusts are strongly recommended to carry out the survey using full rather than small staff samples.

- BME staff are generally less likely than White staff to report the belief that the trust provides equal opportunities for career progression or promotion. This pattern is strikingly widespread regardless of type of trust or geographical location.

- Following learning from the WRES baseline returns and engagement with the NHS, key initiatives are underway to further support WRES implementation, including simplified and improved WRES data returns for 2016 and beyond.

- BME staff are more likely to report they are experiencing discrimination at work from a manager, team leader or other colleague compared to White staff, regardless of trust type or geographical location.

- Sharing replicable good practice and processes will be an essential element to help facilitate system-wide improvements in workforce race equality.

- Community provider trusts and mental health and learning disability trusts generally report a higher percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public when compared to White staff.

- Organisations can draw on the support and guidance initiatives and materials developed by the national WRES Implementation Team to implement and use the WRES effectively.

DATA AND METHODOLOGY

The WRES indicators

The WRES requires NHS trusts to self-assess against nine indicators. Four of the indicators relate specifically to workforce data; four are based upon data from the national NHS Staff Survey questions, and one considers BME representation on boards. The WRES aims to highlight differences between the experience and treatment of White staff and BME staff in the NHS, with a view to closing the experience gap in those metrics.

The WRES Indicators were co-developed in partnership with the NHS, and were based on existing data collection and analysis requirements, which all good performing NHS organisations are already undertaking. The nine WRES Indicators are presented in Annex 10.1.

Together, the WRES Indicators are not intended to provide a blueprint on how "good" can be achieved; however, they do provide the necessary platform and direction that both encourages and helps NHS organisations to:

- Reduce the differences in the treatment and experience between White and BME staff in the NHS.
- Compare not only their progress in reducing the gaps in treatment and experience but to make comparisons with similar organisations about the overall level of such progress over time.
- Identify and take necessary remedial action on the causes of ethnic disparities in the metric outcomes.

The WRES holds a mirror to us, and enables employers to confront the very different experience of our BME colleagues. The challenge remains though in the response to what we see in this mirror. We must not be defensive or complacent, but must change our cultures, biases, attitudes and behaviours as well as improve our processes and policies. We are committed to ensuring that the talent of all our colleagues is fully realised, to the benefit of the communities and patients we all serve.

Danny Mortimer
Chief Executive
NHS Employers

Baseline data returns

All providers subject to the NHS standard contract 2015/16, except 'small providers' (with contracts less than £200,000) and primary care, were expected to implement the WRES from April 2015. The contract required organisations
to publish their baseline data against the nine WRES Indicators, on their website, by 1 July 2015.

To help NHS organisations respond to the WRES Indicators, a number of support materials were developed and made available to local NHS organisations; in particular, these included the WRES Technical Guidance, a frequently asked questions document, and the WRES Reporting Template.

Initial flow of data returns from the 238 NHS trusts subject to implementing the WRES, was slow. A large number of organisations were required to take their WRES reports through their own internal processes and committees before publishing on their website and sending the report to NHS England (the latter was optional in 2015).

On 31 December 2015, 196 (82%) of all NHS trusts required to implement the WRES had published their WRES baseline data on their respective websites.

Data analysis

In light of the issues with the recording and reporting of the workforce data (see Section 6) the analyses have been carried out in relation to WRES Indicators 5 to 8, which are aligned to specific NHS Staff Survey questions. Figure 1 outlines the measurements for Indicators 5 to 8 of the WRES.

For the purpose of analyses, organisations have been grouped by NHS trust type in the following ways: acute trust; ambulance trust; community provider trust, and mental health and learning disability trust.

Additional analyses by geographical region have been carried out and can be viewed in the online version of this report that can be found on the WRES webpage at https://www.england.nhs.uk/about/gov/equality-hub/ equality-standard/

The bar charts provided in Section 5 detail the percentage point differences between White and BME responses to the staff survey questions. The bar charts have been plotted against the primary vertical axis (left hand side of each chart) and are displayed in red or green to indicate the positive/negative outcome for BME staff.

To add further context, each chart also contains an additional data series to present the overall staff survey results (irrespective of ethnicity), as published in the 2014 NHS Staff Survey results. The data series is displayed with a ' ' notation and has been plotted against the secondary vertical axis (right hand side of each chart). When interpreting the data on each chart, ensure you are reading against the correct scale for the data series by checking the axis labels on the left and right hand side of each chart.

The data presented in this report are predominantly drawn from the 2015 WRES returns, where organisations reported on their 2014 NHS Staff Survey results. However it has been necessary, in two sets of cases, to derive the data directly from the 2014 NHS Staff Survey publication. These being:

- Instances in which the national WRES Implementation Team did not locate a submitted or published copy of the trust's WRES publication by 15 February 2016.

- Instances in which the trust reported that a specific answer was not available (a zero or null return) but the national NHS Staff Survey website indicated that one existed.

Throughout this report, the analyses present the gap between BME and White staff results, expressed as percentage point differences in the bar chart series. In some instances, the gap is displayed as a blank value in the bar chart series. This may be due to one of two reasons. Firstly, it may be that there is a diminutive or nil difference between the reported results of BME and White staff. Secondly, it may be that the BME sample size for completing the particular survey question is less than 11. If sample sizes are less than 11, results are not published due to data protection issues, and therefore it is not possible to calculate the difference between BME and White results. In such cases, the overall staff results for the indicator can be used to determine the position for the organisation in question.

To supplement the analyses presented in section 5, the online version of this report contains additional tables citing the raw data figures for all charts, as well as listing differentials and sample sizes used by NHS trusts when undertaking the 2014 NHS Staff Survey. The online version of this report can be found on the WRES web page: https:// www.england.nhs.uk/about/gov/equality-hub/equality- standard/

Indicator 5

Percentage of staff who report experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

Lower score = better 

Indicator 6

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

Lower score = better 

Indicator 7

Percentage of staff who believe that trust provides equal opportunities for career progression or promotion

Higher score = better 

Indicator 8

In the last 12 months have you personally experienced discrimination at work from any of the following? - Manager/Team Leader or other colleagues

Lower score = better 

DETAILED FINDINGS

Mental Health & Learning Disability Trusts

Over 80% of the mental health and learning disability trusts report higher percentages of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months, in comparison to White staff. In the largest outlier, 53.0% of BME staff reported harassment, bullying or abuse from patients,
relatives or the public compared to just 24.0% of White staff, a gap of 29.0 percentage points.

There are just ten organisations where BME staff report lower rates of harassment, bullying or abuse from patients, relatives or the public with a smaller average gap in reported experience.

Data for four mental health and learning disability trusts could not be analysed due to low BME responses rates to or null answers provided to Indicator 5 in the WRES return.

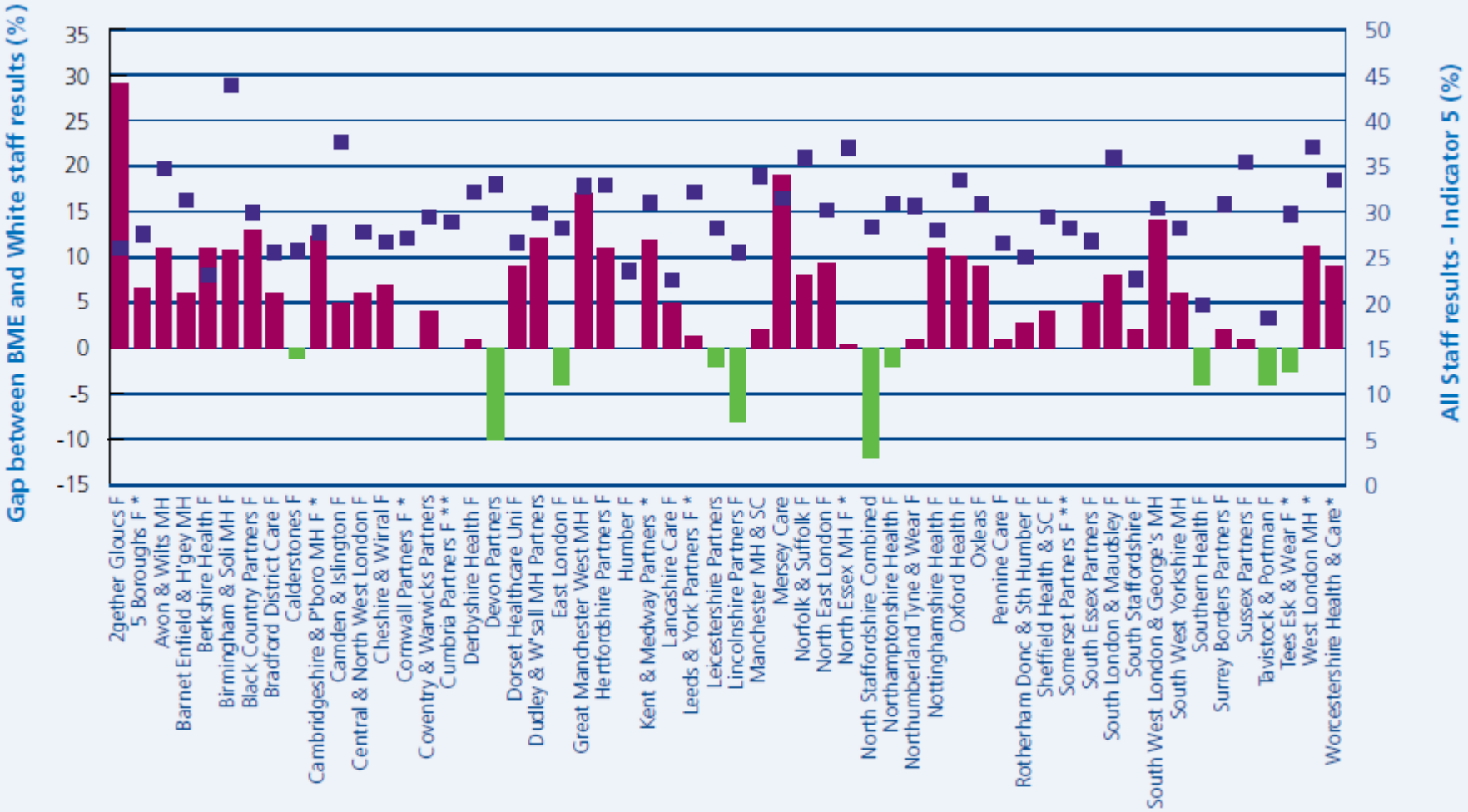
For seven organisations, overall figures of reported harassment, bullying or abuse from patients, relatives or the public in the last 12 months are above 35%; in all of these cases the organisations also report unfavourable results for BME staff on this indicator.

The overall average figure of reported experience of harassment, bullying or abuse from patients, relatives or the public in the last 12 months, as published in the NHS Staff Survey 2014, is 41.5%.

Indicator

5

Percentage of staff who report experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months



Unfavourable results for BME staff **Favourable results for BME staff** **All staff results for this indicator**

**Published staff survey data used; WRES report unavailable* ***Published staff survey data used; WRES report incomplete/inconsistent*

In 78% of all mental health and learning disability trusts, a higher proportion of BME staff reported experiences of harassment, bullying or abuse from staff in comparison to White staff. For one organisation, 13.6% of White staff reported harassment, bullying or abuse from staff in comparison to 36.4% of BME staff - a gap of 22.7 percentage points.

Within this group of trusts, thirteen organisations have a lower percentage of BME staff reporting experiencing harassment, bullying or abuse from staff in comparison to White counterparts. Three trusts reported the same figures for White and BME staff – thus indicating there is no gap in the experience of the overall workforce.

It is worth noting the very significant difference between whether BME staff report being harassed, bullied or abused by patients, relatives and the public (Indicator 5) and whether they report being experiencing harassment, bullying or abuse from staff (Indicator 6). There is little difference overall between the White and BME experience on Indicator 5 but a significant difference on Indicator 6. This suggest the concerns arising from harassment, bullying and abuse by staff are real.

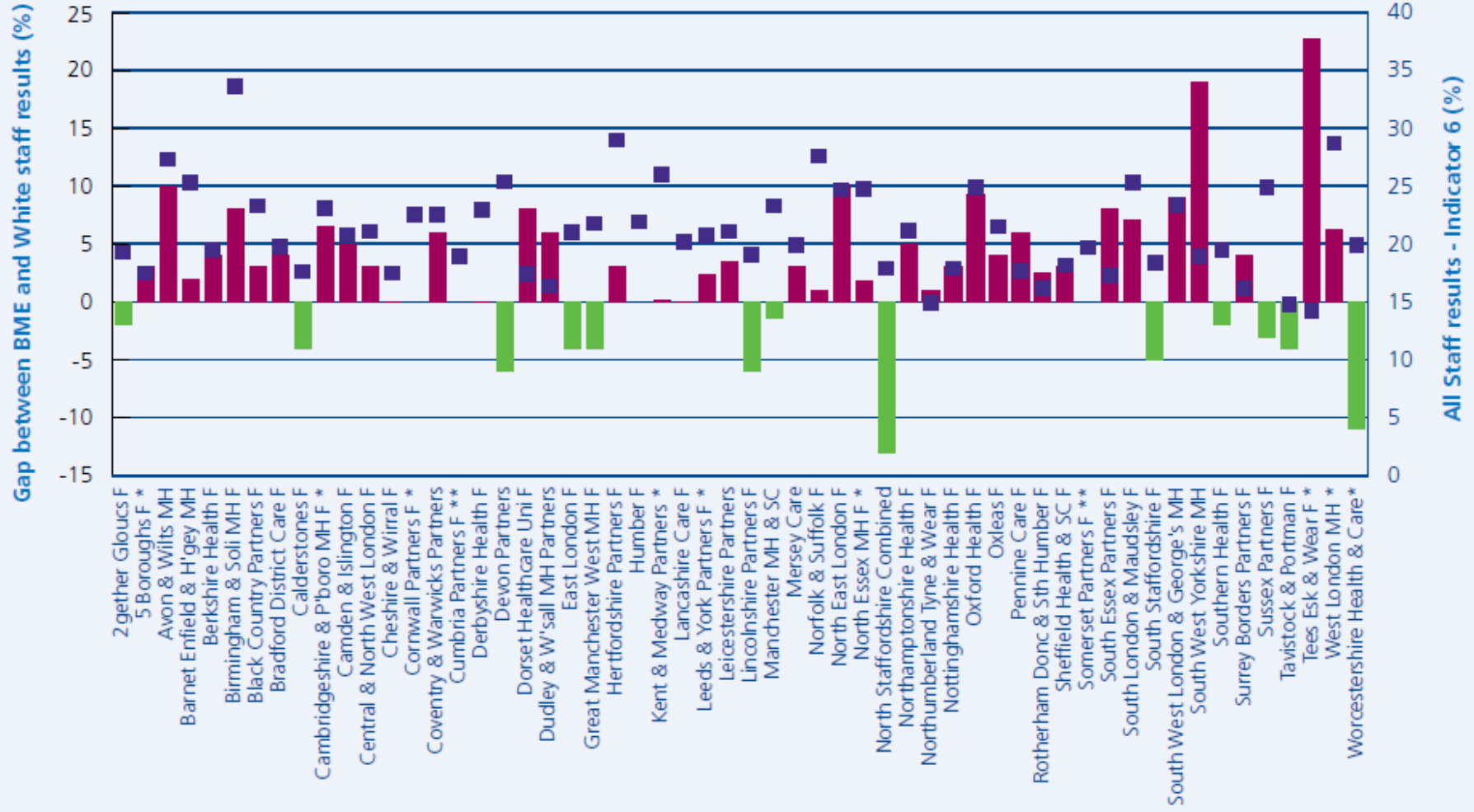
For thirteen trusts, the overall figures of harassment, bullying or abuse from staff in the last 12 months are above 25%, with three organisations reporting overall figures of 15% or below on this indicator.

The average figure of reported experience of harassment, bullying or abuse from staff, as published in the NHS Staff Survey 2014, is 21.1%.

Indicator

6

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



*Published staff survey data used; WRES report unavailable **Published staff survey data used; WRES report incomplete/inconsistent

In 80% of all mental health and learning disability trusts, lower percentages of BME staff believe that their organisation offers equal opportunities for career progression or promotion in comparison to responses from White staff.
In the least favourable return, only 14.0% of BME staff believes that their organisation offers equal opportunities for career progression or promotion in comparison to 93.0% of White staff - a gap of 79.0 percentage points.

Only five trusts reported a higher percentage of BME staff believing that their organisation offers equal opportunities for career progression or promotion compared to White staff and in one the responses of BME and White were statistically equal.

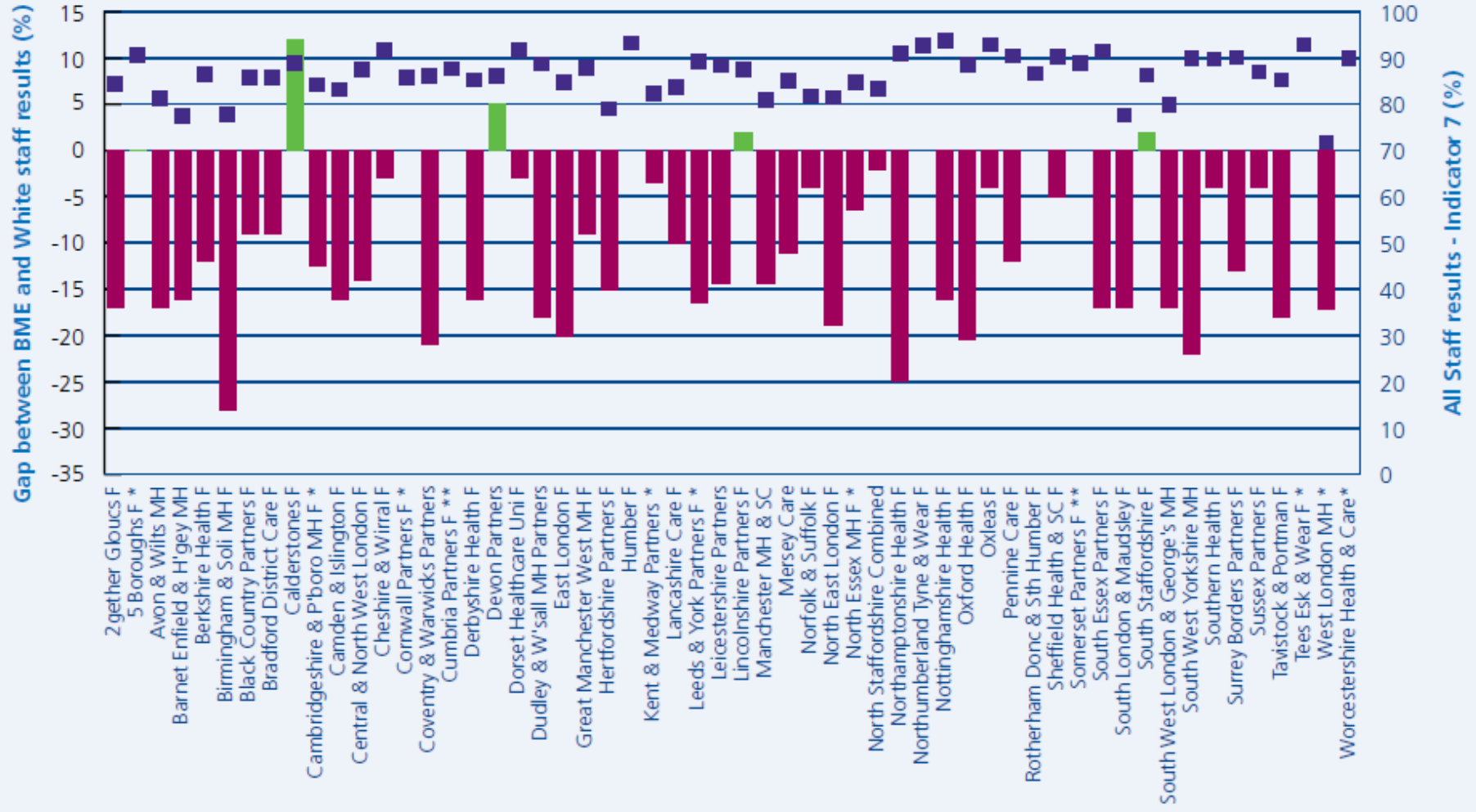
For eight trusts, it is not possible to analyse the data for this Indicator due to small BME samples or null returns.

For the majority of trusts, between 80-90% of all staff responses indicate the belief that the organisation offers equal opportunities for career progression or promotion. In ten organisations, the overall staff response is above 90%.

The average figure of reported belief that trust provides equal opportunities for career progression or promotion, as published in the NHS Staff Survey 2014, is 86.3%.

Indicator 7

Percentage of staff who believe that trust provides equal opportunities for career progression or promotion



Unfavourable results for BME staff **Favourable results for BME staff** **All staff results for this indicator**

**Published staff survey data used; WRES report unavailable* ***Published staff survey data used; WRES report incomplete/inconsistent*

In 73% of all mental health and learning disability trusts, higher proportions of BME staff reported personal experience in discrimination from a manager, team leader or colleague in comparison to White staff.

The largest outlier reported 5.5% of White staff having personally experienced discrimination from a manager, team leader or colleague in comparison to 27.7% of BME staff – a difference of 22.2 percentage points. Two trusts report the same response rate for this Indicator from BME and White staff.

In contrast, only 5% of all trusts in this group report a lower proportion of BME staff than White staff personally experiencing discrimination from a manager, team leader or colleague.

Data for eleven trusts was not analysed due to small BME sample sizes or null answers. Please see Section 6.1 for more details on data quality issues for Indicator 8.

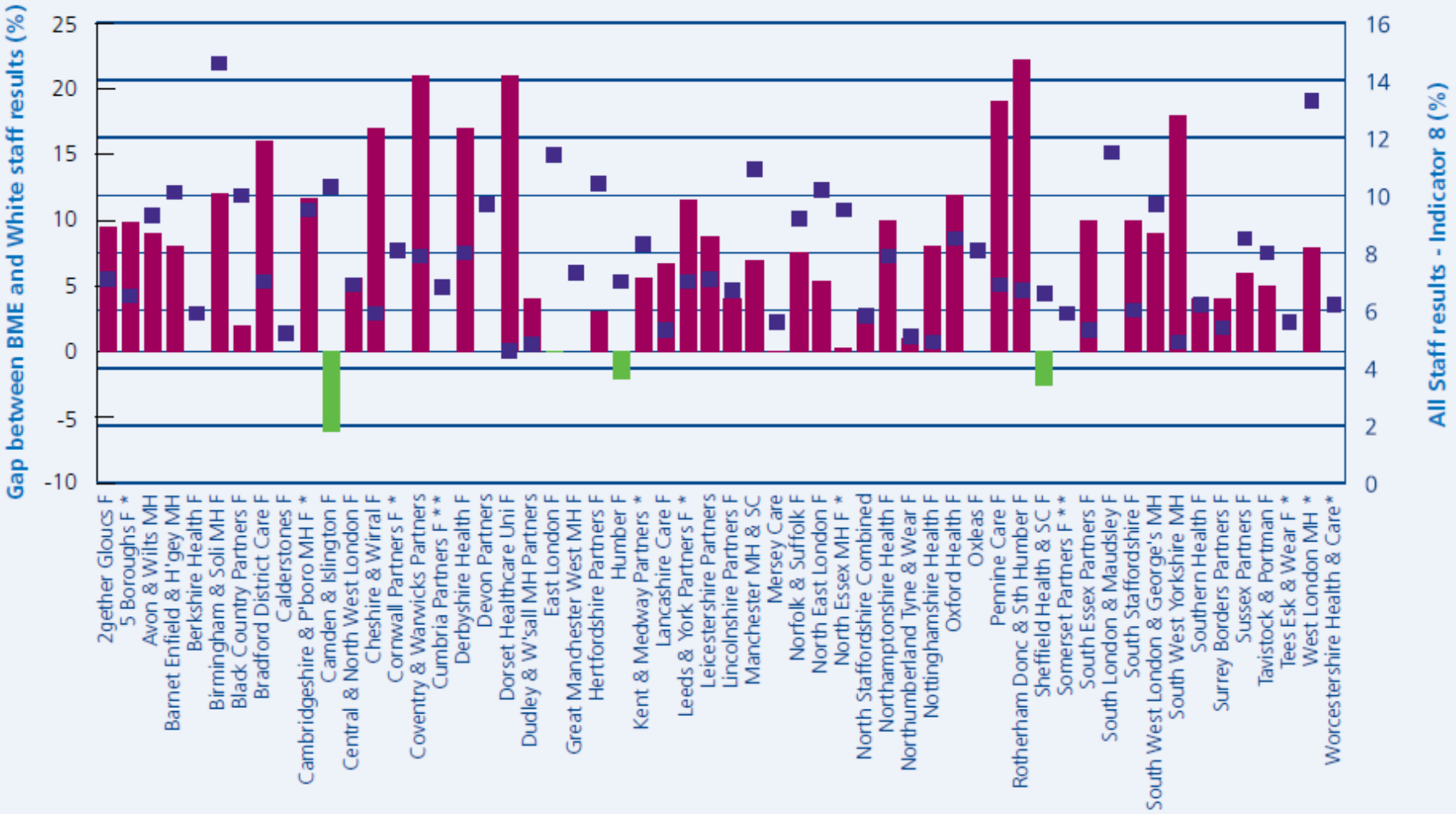
In two mental health and learning disability trusts, all staff responses to indicator 8 show more than 13.0% of all staff have experienced discrimination at work from a manager, team leader or other colleagues. For the remaining trusts, all staff responses to the question are within a range of 4-12%.

The average figure of reported discrimination at work from a manager, team leader or other colleagues, as published in the NHS Staff Survey 2014, is 7.8%.

Indicator

8

In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/Team Leader or other colleagues



*Published staff survey data used; WRES report unavailable **Published staff survey data used; WRES report incomplete/inconsistent

REPLICABLE GOOD PRACTICES AND PROCESSES

Continuous improvement from using the WRES, and on the workforce race equality agenda in general, will benefit greatly from the sharing of replicable good practices and processes.

As the implementation of the WRES develops further, it will be essential to draw together local good practice threads into explicit national patterns, exploiting where possible, opportunities for transformation in workplace race equality. Below are key good practice considerations which should be considered by all organisations implementing and using the WRES. They should be read alongside the recommendation on good practice highlighted by The King's Fund in 2015.

The King's Fund (2015)

'Making the Difference: Diversity and inclusion in the NHS' report: https:// www.england.nhs.uk/wp-content/ uploads/2015/11/making-the-difference.pdf

Leadership and governance

Work on the WRES will only make an impact when it is located within mainstream business and governance structures, and when NHS Boards and senior leaders lead the way through not only what they say but also what they do within and outside of their organisations. Boards are encouraged to avail themselves to developmental initiatives and leadership programmes where the emphasis is on inclusive workforces and healthcare services. Indeed, from April 2016 onwards, progress on the WRES will be considered as part of the "well led" domain in the Care Quality Commission's (CQC) inspection programme for both NHS and independent provider hospitals.

Successful equality, diversity and inclusion work, including work to implement the WRES, requires specialist advice and support. It is increasingly recognised that without good leadership, work on these agendas is very often short-lived, or at best, has little organisation-wide impact. At the outset, the organisation's Board and senior leaders should confirm their own commitment to workplaces that are free from discrimination – where all staff are able to thrive and flourish based on their diverse talent. This is particularly important as the WRES may well challenge the leadership of the organisation to positively demonstrate their own commitment to equality and inclusion, and in particular, to race equality. Indeed, some organisations are increasingly identifying a Board member to lead on and promote the WRES.

One of the most important resources available to NHS organisations is the staff they employ to drive forward equality for patients and in the workplace. Due to recent organizational restructures and financial pressures, the numbers of specialist staff with expertise in equality and diversity will have reduced across some organisations. In taking forward work on the WRES, and on equality in general, organisations should consider their capacity to deliver on this important agenda and what level of support, developmental opportunities and training should be made available to their staff – at all levels. Board and senior management level support with regard to this will be critical.

Board-level sponsorship and support of this work, allied with shared ownership across the organisation, is essential if organisations are to meet their contractual and legal equality requirements, the expectation of regulators,
the aspirations of staff and the best interests of their patients.

We know from the CQC that the strongest determinant of a successful organisation is staff engagement. This translates into better outcomes for patients. The WRES data can help focus action on those with the worst experience and accelerate our progress towards consistently high levels of engagement and the best outcomes for patients.

Dame Gill Morgan
Chair
NHS Providers

Engagement

In adopting and implementing the WRES, NHS organisations should engage with staff, staff networks and local staff-side organisations. This engagement will provide the organisation with the opportunity to ensure that staff feel valued and respected for the outstanding contribution they often make, and that their BME staff in particular, are fully involved in the organisation's work on implementing the WRES. Staff that are supported by their leaders will make the WRES work in the best way.

Organisations will be more successful in their implementation of the WRES when engagement with staff, staff networks, with trades unions and other staff organisations is both meaningful and sustained. In a number of organisations, Board members have met with their BME workforce to hear, at first hand, their experiences of the workplace and to act on what they have heard.

In implementing the WRES, it is essential that the voice of BME staff is heard loud and clear during the processes of identifying the challenges in making continuous improvements against the WRES indicators. Organisations are strongly encouraged to help establish and support BME staff networks – alongside networks for the other protected characteristics – as an important source of knowledge, support and experience.

As part of this, it will be critical for organisations to provide a safe place for BME staff to share their concerns and be listened to in a meaningful and sustained way. Such an approach has been seen to contribute significantly towards the overall success of the organisation's work on equality, diversity and inclusion.

For staff, engagement should mean helping to respond to the WRES data; to plan, develop and manage workplaces and activities that aim to improve working lives. It should also mean working together in identifying the barriers and challenges that often restrict organisations from having senior management and Boards that are reflective of the total workforce.

Data sources and action plans

Accessing robust data and evidence by ethnicity for each of the 9 WRES Indicators should not be a challenge for NHS organisations. Typically, data required for WRES indicators 1-4 and 9 can be sourced from the Electronic Staff Record, whilst the NHS Staff Survey (or local equivalent) presents the data for WRES Indicators 5-8. Organisations should ensure that similar questions from the NHS Staff Survey, as
used in indicators 5-8, are factored into any equivalent local staff survey.

It is good practice for organisations to move from conducting the NHS Staff Survey with a sample of their workforce, to carrying out a full survey across the whole of their workforce. Sample surveys often result in data reflecting small sample size, especially when this is further disaggregated by ethnicity, thus questioning the validity of the data. Data also indicate BME staff as being less likely to take part in staff surveys; organisations are strongly encouraged to increase response rates amongst all staff, and to have a concerted focus upon BME staff groups.

WRES data point organisations towards the direction of focus and attention required to make continuous progress on workforce race equality. Implementing the WRES should therefore not be viewed as an academic or “tick-box” exercise. Of equal importance to an organisation’s WRES outcomes against the 9 Indicators will be the action plans that will sit alongside the data.

The WRES is intended to focus trusts on what “good” looks like and, through the sharing of replicable good practice, on how “good” may be achieved and maintained. It does this by providing the necessary platform and direction that encourages and enables NHS organisations to:

- compare not only their progress in reducing the gaps in treatment and experience over time, but to make comparisons with similar types of organisations on the overall level of such progress;
- undertake meaningful and sustained engagement with staff, staff networks, staff-side organisations and other stakeholders with regard to progress on this agenda;
- produce organisational-level improvement plans to take necessary remedial action following further considerations on the causes of the disparities in the indicator outcomes;
- reduce the differences in the workplace treatment and experience between White and BME staff on each of the WRES Indicators.

MILESTONES FOR WRES IMPLEMENTATION

Milestone	Activity
1 July 2015	Publication of 1st April 2015 data (the WRES baseline data) including actions required to make continuous progress (the WRES action plan).
April 2015 – March 2016	Work to address any data shortcomings and to understand and address the concerns raised in the organisation's WRES baseline data should be undertaken.
1st July 2016 and annually thereafter	Baseline to 31st March 2016 data should be: • shared with the Board, staff and other local interests • submitted centrally via Unify 2 – together with a WRES action plan • presented to the lead commissioner (for NHS providers) • published on organisations' websites.

ANNEX

Analysesby region

South of England

Indicator 5: Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months compared to White staff

Almost half (49%) of the trusts in the South of England region report a higher percentage of BME staff being harassed, bullied or abused from patients, relatives or the public in comparison to White staff. The largest gap between the experience of BME and White staff is reported in one trust where 53.0% of BME staff reported harassment, bullying or abuse from patients, relatives or the public in comparison to just 24.0% of White staff, a gap of 29.0 percentage points.

42% of trusts in the South of England region report lower percentages of harassment, bullying or abuse from patients, relatives or the public from BME staff than their White counterparts so the split between positive/negative outcomes for BME staff is fairly equal for Indicator 5. In the largest positive outlier for BME staff, 13.0% of BME staff experienced harassment, bullying or abuse from patients, relatives or the public in comparison to 30.0% of White staff.

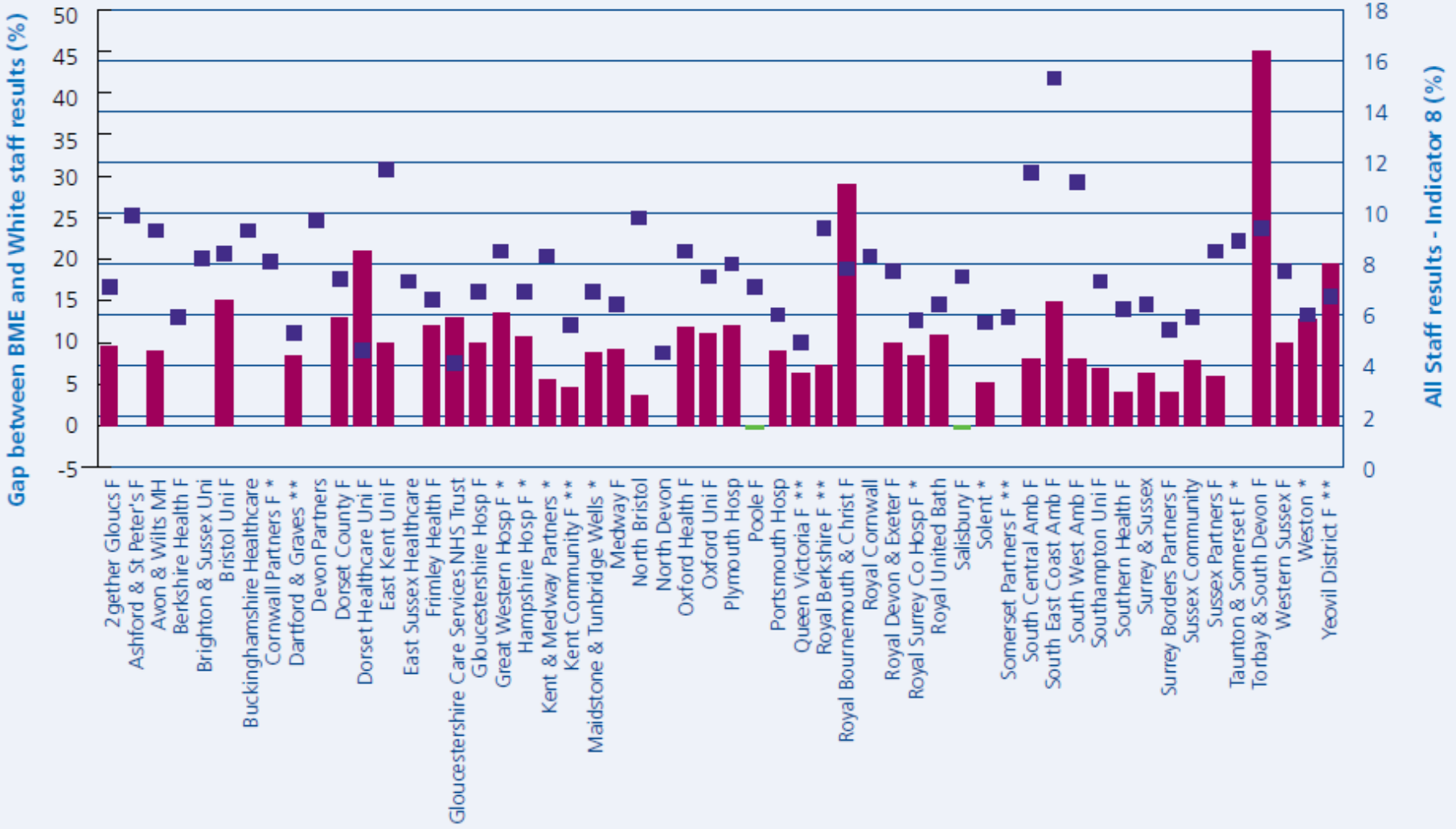
Comparative figures are not available for three trusts due to small BME sample sizes. Two trusts report no difference in the responses for White and BME staff.

For the majority of trusts in the South of England region, between 20-40% of all staff responses report the experience of being harassed, bullied or abused from patients, relatives or the public in the last 12 months. For three trusts, all staff responses to the question are above the 40% mark.

Indicator

8

In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/Team Leader or other colleagues



*Published staff survey data used; WRES report unavailable **Published staff survey data used; WRES report incomplete/inconsistent

Indicator 6: Percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months compared to White staff

In 62% of all trusts in the South of England region, a higher proportion of BME staff report being harassed, bullied or abused by staff in comparison to the responses of White counterparts. In the largest outlier, 25.0% of White staff reported harassment, bullying or abuse from staff in comparison to 56.0% of BME staff – a gap of 31.0 percentage points.

Within this region, 31% of organisations have a lower percentage of BME staff who reported harassment, bullying or abuse from staff in comparison to responses from White counterparts. This equates to 17 trusts.

One trust reported the same figures for White and BME staff – thus indicating there is no gap in between BME and White staff experiences in the workplace. Data is unavailable for a further 3 organisations due to small BME sample sizes or null answers.

For the majority of trusts in the South of England region, between 15-30% of all staff responses report the experience of being harassed, bullied or abused from staff in the last 12 months. Three trusts report overall staff responses that are above 30%, one of those being at the 41% mark.

Indicator 6

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

*Published staff survey data used; WRES report unavailable **Published staff survey data used; WRES report incomplete/inconsistent

Indicator 7: Percentage of BME staff believing that the Trust provides equal opportunities for career progression or promotion compared to White staff

80% of all trusts within the South of England region report lower percentages of BME staff who consider that their employer offers equal opportunities for career progression or promotion in comparison to the responses of White staff.

The least favourable return is from a trust where 44.0% of BME staff believes that their organisation offers equal opportunities for career progression or promotion in comparison to 86.0% of White staff, a difference of 42.0 percentage points. There are a number of other significant outliers.

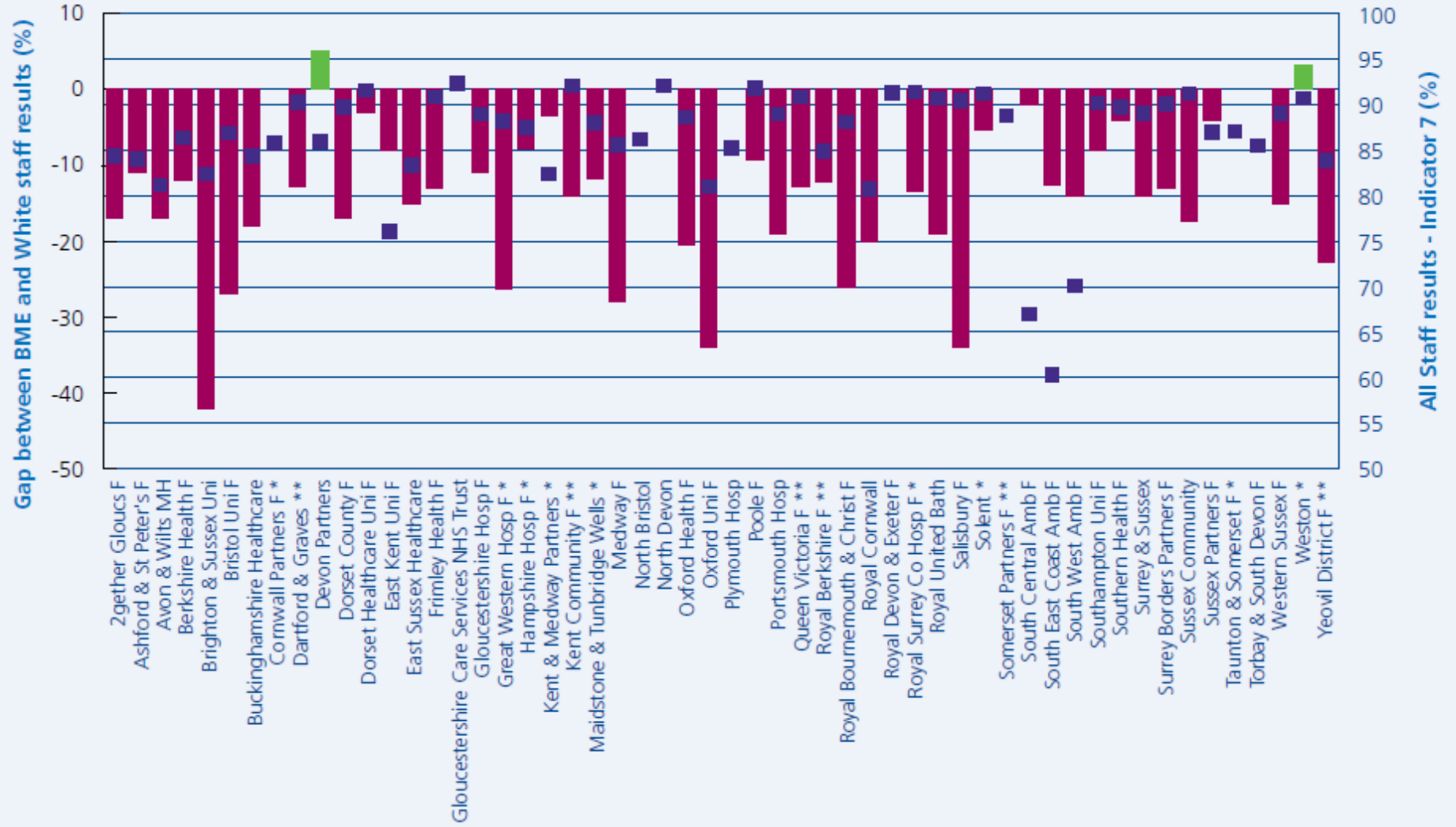
Only 4% of trusts within this region report higher percentages of BME staff who consider that their employer offers equal opportunities for career progression or promotion in comparison to the responses of White staff. This translates to 3 organisations. However, in all of these organisations, the gap between BME and White experience is only 5.0 percentage points or less.

Comparative figures for nine organisations are unavailable due to small BME sample sizes or null answers. For further details on data quality, see section 6.1 of this report.

The majority of trusts in the South of England region, report between 80-91% of all staff responses indicate that their employer offers equal opportunities for career progression or promotion. Four trusts in the region report overall staff responses lower than 80%, including one at 60%.

Indicator 7

Percentage of staff who believe that trust provides equal opportunities for career progression or promotion



*Published staff survey data used; WRES report unavailable **Published staff survey data used; WRES report incomplete/inconsistent

Indicator 8: BME staff experiencing discrimination at work from a manager, team leader or other colleagues compared to White staff

In 74% of trusts in the South of England, higher proportions of BME staff have personally experienced discrimination from a manager, team leader or colleague in comparison to White staff.

In the largest outlier, 12.0% of White staff reported having personally experienced discrimination from a manager, team leader or colleague in comparison to 57.0% of BME staff – a difference of 45.0 percentage points.

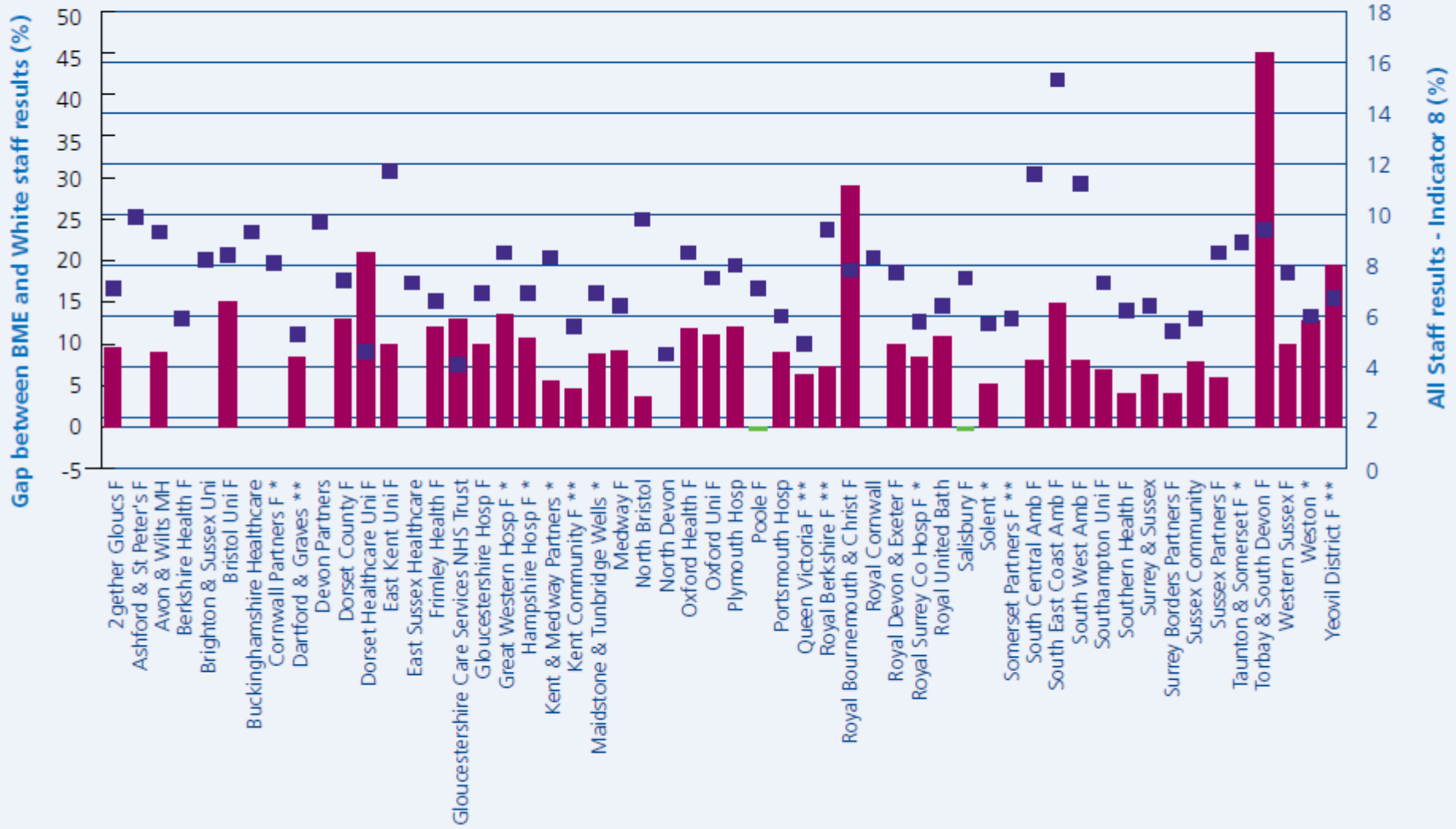
Only 5% of organisations (3 organisations) in this region report a lower proportion of BME staff than White staff personally experiencing discrimination from a manager, team leader or colleague.

Data for 11 trusts was not available to analyse due to small BME sample sizes or null answers. Further details on data quality issues with WRES indicator 8 can found in section 6 of this report.

All but one trust in the South of England region report between 4-12% of all staff responses indicate personally experienced discrimination from a manager, team leader or colleague. One trust in the region reports an overall response of 15% for the question.

Indicator 8

In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/Team Leader or other colleagues



*Published staff survey data used; WRES report unavailable **Published staff survey data used; WRES report incomplete/inconsistent

Workforce Race Equality Standard

REPORTING TEMPLATE (Revised 2016)

Template for completion

Name of organisation

2gether NHS Foundation Trust

Date of report: month/year

July 2016

Name and title of Board lead for the Workforce Race Equality Standard

Carol Sparks, Director of Organisational Development

Name and contact details of lead manager compiling this report

Nick Grubb, Assistant HR Director

Names of commissioners this report has been sent to (complete as applicable)

Gloucestershire CCG, Herefordshire CCG

Name and contact details of co-ordinating commissioner this report has been sent to (complete as applicable)

Unique URL link on which this Report and associated Action Plan will be found

This report has been signed off by on behalf of the Board on (insert name and date)

Publications Gateway Reference Number: 05067

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data

Data relating to accessing non/mandatory training and CPD is incomplete. The number of occasions in house training or cpd is accessed is recorded. Therefore the data relating to indicator 4 shows that people have accessed non-mandatory training and CD on multiple occasions. The data does not detail individual training records.

The data for indicators 5 to 8 is incomplete as the return to the 2015 Staff Survey was too low. Only 10 staff from a BME background responded to the survey. in order to preserve anonymity, the score is not shown if less that 11 people reply

b. Any matters relating to reliability of comparisons with previous years

The data for indicators 5 to 8 is incomplete as the return to the 2015 Staff Survey was too low. Only 10 staff from a BME background responded to the survey. in order to preserve anonymity, the score is not shown if less that 11 people reply. Therefore it has not been possible to compare this years results with the previous year. For 2016 all staff will be invited to take part in the survey which should increase the number of responses and provide more robust data.

2. Total numbers of staff

a. Employed within this organisation at the date of the report

1978 (not including Bank staff)

b. Proportion of BME staff employed within this organisation at the date of the report

5.56%

Report on the WRES indicators, continued

3. Self reporting

a. The proportion of total staff who have self–reported their ethnicity

96% compared with 96% in the previous reporting period

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity

Although self reporting of protected characteristics is not compulsory, all colleagues are invited to do so when completing any in-house survey such as the Staff Friends and Family Test, training evaluation forms or applications.

c. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity

We will continue to encourage self reporting of all protected characteristics by explaining the reasons for seeking the information.

4. Workforce data

a. What period does the organisation's workforce data refer to?

The data sample relates to March 2016, to correspond with the same period in the previous year. Data relating to disciplinary cases are from the years April 2014 to March 2016. The baseline data showed formal disciplinary cases from the period April 2013 to March 2015.

Report on the WRES indicators, continued

5. Workforce Race Equality Indicators

Please note that only high level summary points should be provided in the text boxes below – the detail should be contained in accompanying WRES Action Plans.

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	For each of these four workforce indicators, compare the data for White and BME staff				
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	Non Clinical BME W B1 0.1% 2.2% B2 0.2% 2.7% B3 0.2% 6.7% B4 0.2% 6.7% B5 0.1% 1.9% B6 0% 2.6%	Non Clinical BME W B1 0% 0.25% B2 0.1% 1.8% B3 0.2% 7% B4 0.1% 6.8% B5 0.1% 1.8% B6 0% 2.1%	This indicator has changed since the previous year. The ethnicity profile of the trust shows that 5.8% of staff are from a BME background. however BME staff are under-represented in senior positions at band 8 and above. No Executive Board members have declared themselves to be from a BME background. 36% of the Consultant body are from a BME	The trust has a comprehensive leadership development programme and all staff are encouraged to discuss their career aspirations with their managers during the appraisal process and during supervision. Linked to EDS2 Goal 3, A representative and supported workforce.
2	Relative likelihood of staff being appointed from shortlisting across all posts.	Statistically white people were 2.21 times more likely to be appointed from shortlisting than people from a BME background	Statistically, white people were 2.32 times more likely to be appointed from shortlisting than people from a BME background	It is not known why there appears to be a disparity in the relative likelihood of BME people being appointed compared with white colleagues. All posts are advertised through NHS Jobs and shortlisting is done without reference to personal details.	Training in values based recruitment has been designed and rolled out for all recruiting managers. further work is required to understand the reasons behind each appointment. Linked to EDS2 Goal 3, A representative and supported workforce.
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	BME staff were 1.74 times more likely to enter the formal disciplinary process than white colleagues	BME staff were1.63 times more likely to enter the formal disciplinary process than white colleagues.	Relatively small numbers of staff enter the formal disciplinary process. The trust has a robust and effective disciplinary policy that is applied equally in the case of suspected misconduct regardless of background.	The outcome of all disciplinary cases are reviewed and processes are adjusted if shortcomings are identified. The Trust's appeal process allows anyone subject to a formal disciplinary process to appeal against the decision. There is no record of any appeal based on racial grounds. Linked to EDS2 Goal 3, A representative and supported workforce.
4	Relative likelihood of staff accessing non-mandatory training and CPD.	BME staff were 0.9 times more likely to access non-mandatory training and cpd than white staff.	BME staff were 0.8 times more likely to access non mandatory training and cpd than white staff.	Our training records show the number of in-house training courses and the number of times they have been accessed. Other CPD events such as external seminars are not recorded. individuals are encouraged to keep a record of their own CPD but this is not recorded centrally.	The Trust has introduced a new online training system that records the uptake and completion of training courses in real time. Linked to EDS2 Goal 3, A representative and supported workforce.

Report on the WRES indicators, continued

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.				
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White 29% BME -	White 24% BME 53%	It has not proved possible to compare the experience of BME staff with the baseline data as the return on the 2015 Staff Survey, to preserve anonymity was too small to publish. The overall response rate to the Survey was 40%, of which	The trust has a wide range of mechanism for staff to report any unacceptable behaviour including Speak in Confidence. For 2016, the Trust will be inviting a staff to take part in the Staff Survey rather than the random sample. The return should
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White 21% BME -	White 19% BME 17%	It has not proved possible to compare the experience of BME staff with the baseline data as the return on the 2015 Staff Survey, to preserve anonymity was too small to publish. The overall response rate to the Survey was 40%, of which	The Trust has a network of Dignity at Work Officers and the Speak in Confidence system to enable staff to report and seek support with any unacceptable behavior. For 2016, the Trust will be inviting a staff to take part in the Staff Survey
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White 92% BME -	White 86% BME 69%	It has not proved possible to compare the experience of BME staff with the baseline data as the return on the 2015 Staff Survey, to preserve anonymity was too small to publish. The overall response rate to the Survey was 40%, of which	For 2016, the Trust will be inviting a staff to take part in the Staff Survey rather than the random sample. The return should be larger and the data more reliable. there will be an extensive campaign to encourage staff to respond to the
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White 5% BME -	White 6% BME 16%	It has not proved possible to compare the experience of BME staff with the baseline data as the return on the 2015 Staff Survey, to preserve anonymity was too small to publish. The overall response rate to the Survey was 40%, of which	For 2016, the Trust will be inviting a staff to take part in the Staff Survey rather than the random sample. The return should be larger and the data more reliable. there will be an extensive campaign to encourage staff to respond to the
	Board representation indicator For this indicator, compare the difference for White and BME staff.				
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	percentage difference between Board's voting membership an	Trust Executive Board consisted of 7 members, 3 female, 7 male. There were 6	Indicator 9 has changed since the previous year. however, no member of the Board has declared themselves to be from a BME background.	When recruiting Board members, executive search agencies are instructed to seek interest from potential BME candidates but it is essential that the right people with the right skills are appointed to take the Trust forward regardless of

Note 1. All provider organisations to whom the NHS Standard Contract applies are required to conduct the NHS Staff Survey. Those organisations that do not undertake the NHS Staff Survey are recommended to do so, or to undertake an equivalent.

Note 2. Please refer to the WRES Technical Guidance for clarification on the precise means for implementing each indicator.

Report on the WRES indicators, continued

6. Are there any other factors or data which should be taken into consideration in assessing progress?

Comparisons with the baseline data for indicators 5 to 8 has not been possible due to the limited response to the 2015 staff survey by staff which showed a return of 40%, of which only 3% of respondents were from a BME background. The 2016 Staff Survey will be a census of all staff carried out online to encourage a greater response rate from all staff including those from a BME background. The Trust has also developed a number of mechanisms to enable staff to report unacceptable behaviour whether from service users, carers and the public or from colleagues or managers. These mechanisms include a network of Dignity at Work Officers and the Speak in Confidence confidential dialogue system. There have been no record of issues relating to racial discrimination via these mechanisms but we continue to promote these systems to enable staff to be confident to speak up about issues that are of concern to them. We are also in the process of appointing our Freedom to Speak Up Guardian.

7. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.

See Action plan.

Click to lock all form fields and prevent future editing

Workforce Race Equality Standard Action Plan 2016-2017					
Workforce Race Equality Standard Indicator	**Actions to be taken**	**Which Trust Strategy / Policy / Procedure does the action support?**	**Lead**	**Timeline**	**Status R,A,G**
Indicator 1. % of staff in each Agenda for Change pay band and VSM (inc. Executive Board Members) compared with the % of staff in the overall workforce (Clinical and Non-clinical)	• Continue to work with Executive Search Agency to increase BME applicants for Board level posts . • Examine grades/posts where BME staff are under- represented and compare with number of applications – decide any further action required to address identified issues • Embed succession planning and talent management as part of appraisal process	Recruitment Policy and Procedure Promoting Dignity at Work Policy Succession Planning	Director of Organisational Development Asst. Dir. HR – Engagement	For each recruitment process March 2017	
Indicator 2. Relative likelihood of staff being appointed from shortlisting across all posts	As above and: • Review non-attendance rates at interviews • Introduce unconscious bias awareness training for recruiting managers and leadership development programme. • Promote equality and diversity training	Recruitment Policy and Procedure Training Strategy Promoting Dignity at Work Policy	Asst. Dir. HR – Engagement Asst. Dir. HR - Training	January 2017	
Indicator 3. Relative likelihood of staff entering the formal disciplinary process as measured by entry into a formal disciplinary process	• Review process for capturing organisational learning from formal disciplinary cases to ensure any issues relating to ethnicity are captured and lessons learnt shared. • Improve recording of ethnicity for staff being managed through the disciplinary process • Monitor feedback from 'Speak in Confidence' and 'Dignity at Work Officers' for any complaints of racial bias	Promoting Dignity at Work Policy Health and Wellbeing Strategy Disciplinary policy	Asst. Dir HR – Operations Asst. Dir. HR - Engagement	October 2016	

Indicator 4. Relative likelihood of staff accessing non-mandatory training or CPD	• Ensure that as part of the review of appraisal paperwork, there is sufficient emphasis on promoting access to non-mandatory training or CPD	Succession Planning	Asst. Dir. HR - Engagement	December 2016	
Indicator 5. KF25 % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12months	• Appoint Freedom to Speak Up Guardian • Continue to publicise 'Speak in Confidence', 'Dignity at Work Officers', Datix reporting and other mechanisms to ensure all staff know how to report unacceptable behaviour and are aware of the support available to them. • Service Directors to remind staff of the importance of reporting any unacceptable behaviour to enable a record of all such events to be kept, remedial action where necessary and preventative action where possible through care plans if patient related. • Monitor results from 2016 Staff Survey • Develop guidance for staff with Local Security Management specialist and Service Directors	Promoting Dignity at Work Policy Health and Wellbeing Strategy	Director of Organisational Development Asst. Dir. HR – Engagement	October 2016	
Indicator 6. KF26 % of staff experiencing harassment, bullying or abuse from staff in last 12 months	• Appoint 'Freedom to Speak Up Guardian' • Continue to publicise 'Speak in Confidence', 'Dignity at Work Officers', Datix reporting and other mechanisms to ensure all staff know how to report unacceptable behaviour and are aware of the support available to them. • Engage with Service Directors and other key stakeholders to agree how to campaign and highlight the need for respectful behaviour • Monitor results from 2016 Staff Survey • Utilise focus groups to discuss issues of behaviour and seek feedback from staff.	Promoting Dignity at Work Policy Health and Wellbeing Strategy	Director of Organisational Development Asst. Dir. HR – Engagement	October 2016	
Indicator 7. KF21 % of staff believing that the Trust provides equal opportunities for career	• Ensure that as part of the review of appraisal paperwork, there is sufficient emphasis on promoting access to non-mandatory training or CPD Monitor attendance on non-mandatory	Promoting Dignity at Work Policy Health and Wellbeing	Assistant Dir HR. – Engagement	December 2016	

progression or promotion	training and CPD. • Encourage staff to declare protected characteristics to enable identification of areas where minority groups are under-represented and what if any barriers are there. • Monitor results from 2016 Staff Survey • Utilise focus groups to discuss issues of behaviour and seek feedback from staff.	Strategy Training Strategy Succession Planning	Assistant Dir HR - Training		
Indicator 8. Q17 In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	• Appoint Freedom to 'Speak Up Guardian' • Continue to publicise 'Speak in Confidence', 'Dignity at Work Officers', Datix reporting and other mechanisms to ensure all staff know how to report unacceptable behaviour and are aware of the support available to them. • Monitor results from 2016 Staff Survey • Monitor results from quarterly Staff Friends and Family test • Utilise focus groups to discuss issues of behaviour and seek feedback from staff.	Promoting Dignity at Work Policy Health and Wellbeing Strategy Engagement Strategy	Director of Organisational Development Asst. HR Director - Engagement	October 2016	
Indicator 9. % difference between the organisations' Board voting membership and its overall workforce	• Continue to work with Executive Search Agency to increase BME applicants for Board level posts .	Workforce and Organisational Development Strategy	Director of Organisational Development	For each recruitment process	

Agenda item **15** **PAPER I**

Report to: 2gether NHS Foundation Trust Board - 29th September 2016
Author: Shaun Clee – Chief Executive
Presented by: Shaun Clee – Chief Executive

SUBJECT: **Chief Executive's Report**

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

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

EXECUTIVE SUMMARY
This paper provides the Board with:

1. An update on key national communications via the NHS England NHS News
2. A summary of key progress against organisational major projects

RECOMMENDATIONS

The Board is asked to note the contents of this report

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

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

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

Reviewed by:		
Executive Team	Date	

Where in the Trust has this been discussed before?		
CEO	Date	*22.09.2016*

What consultation has there been?		
N/A	Date	

Explanation of acronyms used:	

1. CONTEXT

1.1 National Context

1.1.1 Children and Young People's Mental Health Research Campaign

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

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

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

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

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

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

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

1.1.5 Inspiring leaders in learning disability services

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

1.2 Delivering our Three Strategic Priorities

1.2.1 Continuously Improving Quality

1.2.2 Building Engagement

Internal Board engagement

Internal Board engagement

01.07.16` The Chief Executive attended MSC

04.07.16` The Chief Executive Hosted the Leadership Forum

04.07.16 The Director of Quality attended the Leadership Forum at the Hatherley

04.07.16 The Director of Engagement and Integration took part in a meeting re Student Practitioner/ Bank Staff Initiative

04.07.16 The Medical Director attended the Leadership Forum

04.07.16 The Director of Engagement and Integration attended the Leadership Forum

05.07.16 The Medical Director attended the Medical Staffing Committee

05.07.16 The Director of Engagement and Integration held a meeting with Senior Managers

05.07.16 The Director of Engagement and Integration was a guest speaker at the Finance and Commerce, Estates and Facilities and IT Away Day at Dowty Sports and Social Club

05.07.16 The Director of Quality attended a Patient Safety Learning Sessioon

07.07.16 The Director of Quality attended a LD Inpatient Services Meeting at Rikenel

08.07.16 The Director of Engagement and Integration met with Time to Change Mental Health Professionals Operational Facilitators

11.07.16 The Director of Engagement and Integration presented at the Corporate Induction at Dowty Sports and Social Club

13.07.16 The Medical Director attended the CYPS Consultant Meeting

13.07.16 The Director of Engagement and Integration led a Patient Safety Visit in Willow Ward at Charlton Lane, Cheltenham

13.07.16 The Director of Engagement and Integration led a Patient Safety Visit to Cheltenham Assertive Outreach Team in Cheltenham

14.07.16 The Director of Quality attended Governance Committee

15.07.16 The Director of Quality chaired an SI review at Rikenel

15.07.16 The Director of Engagement and Integration attended the Governance Committee

18.07.16 The Director of Quality attended Exec Business Meeting at Rikenel

19.07.16 The Director of Engagement and Integration conducted a Board Visit at Priory Ward, Wotton Lawn

21.07.16 The Medical Director attended the Annual General Meeting

21.07.16 The Director of Quality attended a meeting at Colliers Court following the Clinical day at Forest of Dean Recovery

21.07.16 The Director of Engagement and Integration attended and presented at the Trust's AGM at Cheltenham Town Hall

.07.16` The Chief Executive welcomes new colleagues at Corporate Induction

25.07.16 The Director of Engagement and Integration attended Corporate Induction at Dowty's Sport and Social Club to greet the new Head of Communications

25.07.16 The Director of Quality attended execs meeting at Rikenel

25.07.16 The Director of Quality attended Patient Safety Programme update meeting with Clinical Director

27.07.16` The Chief Executive attended Trust Board

27.07.16 The Director of Quality attended Delivery Committee

27.07.16 The Director of Quality attended Transformation project board at Rikenel

28.07.16 The Director of Engagement and Integration attended the Board

28.07.16 The Director of Quality attended Board

01.08.16 The Director of Service Delivery attended the Senior Leadership Forum

01.08.16 The Director of Engagement and Integration attended the Senior Leadership Forum

01.08.16 The Director of Quality attended the Senior Leadership Forum at Rikenel

01.08.16 The Director of Organisational Development attended Senior Leadership Forum

02.08.06 The Director of Service Delivery attended a meeting regarding S12 Medical Expenses

02.08.16 The Director of Service Delivery attended a Crisis Resolution Home Treatment meeting

02.08.16 The Director of Quality attended a E-Roster Spec Review Meeting at Rikenel

02.08.16 The Director of Quality attended Smoking Cessation project Board at Rikenel

03.08.16` The Chief Executive attended the opening of the Fritchie centre

03.08.16 The Director of Service Delivery met with a Non-Executive Director regarding Patient Safety Assurance

03.08.16 The Director of Quality attended Audit Committee

03.08.16 The Director of Finance and Commerce attended Audit Committee Meeting

03.08.16	The Director of Quality attended SI Action Plan Meeting at Rikenel
03.08.16	The Director of Organisational Development attended a Board Visit to Stroud Recovery Team at Weavers Croft
04.08.16	The Director of Engagement and Integration met with Quinton Quayle, the new Non-Executive Director
04.08.16	The Director of Engagement and Integration held at Team Meeting with her Direct Reports
04.08.16	The Director of Quality attended NPAC at Rikenel
05.08.16	The Director of Service Delivery participated in the recruitment of a Clinical Director
05.08.16	The Director of Service Delivery conducted a Board visit to Stroud Crisis Team at Weavers Croft
08.08.16`	The Chief Executive welcomed new colleagues at Corporate Induction
08.08.16	The Director of Quality attended Corporate Induction at Dowtys
08.08.16	The Director of Service Delivery attended a meeting to discuss Student Practitioners
08.08.16	The Director of Service Delivery attended a meeting regarding Shift Patterns.
09.08.16`	The Chief Executive attended a Board visit to Gloucester CRHTT
09.08.16	The Director of Quality attended a Risk Review Workshop at Rikenel
09.08.16	The Director of Service Delivery attended a meeting regarding CAMHS Management in Herefordshire
10.08.16	The Director of Service Delivery attended an Inpatient Activity meeting
10.08.16	The Director of Service Delivery attended a meeting to discuss LD (Learning Disability) Units
10.08.16	The Director of Quality attended the Trust Wide Quality Improvement project board (CQC) at Rikenel
11.08.16	The Director of Organisational Development chaired the Workforce & Organisational Development Sub-Committee
11.08.16	The Director of Quality attended the Safeguarding Committee at Rikenel

12.08.16 The Director of Quality attended the Bed Management meeting at WLH.

12.08.16 The Director of Quality engaged in a Clinical Shift at Montpellier, WLH

17.08.16 The Director of Finance and Commerce attended an introduction meeting with Andrew Smart, Head of Communications

18.08.16 The Director of Quality attended the Temporary Staffing Board at Rikenel

18.08.16 The Director of Engagement and Integration conducted a Board visit at Cantilupe Ward, Stonebow Unit, Hereford

18.08.16 The Director of Engagement and Integration conducted a Board visit at Mortimer Ward, Stonebow Unit, Hereford

19.08.16 The Chief Executive attended LNC

19.08.16 The Director of Organisational Development attended the Local Negotiating Committee

22.08.16 The Director of Finance and Commerce attended an introduction meeting with Lauren Wardman, Deputy Director of Engagement/Trust Head of Speech and Language Therapy Dietetics

22.08.16 The Director of Engagement and Integration joined the 'meet and greet' new colleagues team at Corporate Induction, Collingwood House

24.08.16 The Director of Service Delivery attended the Delivery Committee meeting

24.08.16 The Director of Service Delivery attended the Holding to Account Review meeting

24.08.16 The Director of Service Delivery attended a Crisis Resolution Home Treatment meeting

25.08.16 The Director of Organisational Development attended an induction session to welcome new Trust Governors

25.08.16 The Director of Service Delivery attended the Executive Committee Business meeting

25.08.16 The Director of Service Delivery participated in the Governor Induction Session

30.08.16 The Director of Service Delivery conducted a Board visit to Glos and Forest AO Team and Recovery at Albion Chambers

30.08.16 The Director of Service Delivery attended a patient communications meeting

31.08.16 The Director of Service Delivery attended a Mental Health Team meeting at The Concourse, Gloucester Royal Hospital

Board Stakeholder engagement

01.07.16 The Director of Engagement and Integration met with the Chief Executive of Cobalt

04.07.16 The Director of Quality attended a Directors of Nursing Meeting at Oxstalls Campus

06.07.16 The Medical Director attended the Herefordshire HCOSC meeting

06.07.16 The Director of Quality attended Herefordshire HCOSC - 2g CQC and scrutiny presentation at Shire Hall, Hereford

06.07.16 The Director of Engagement and Integration attended and presented at the Herefordshire HCOSC meeting for the 2G and CQC Scrutiny presentation

07.07.16 The Director of Engagement and Integration attended the Healthwatch Gloucestershire AGM in Longlevens

07.07.16 The Medical Director attended the Gloucestershire Healthwatch Annual General Meeting

08.07.16 The Medical Director held a meeting with relatives of a patient following a serious incident

11.07.16 The Director of Quality a review into how NHS Trust investigate and learn from Deaths

11.07.16 The Director of Engagement and Integration met with John Bensted of the Police Crime Commission Office to review community safety

11.07.16 The Director of Engagement and Integration participated in a Forest of Dean Community Review information meeting with Anthony Andediran from CCG

12.07.16` The Chief Executive attended the STP Workforce development meeting in Worcestershire

12.07.16 The Director of Engagement and Integration attended the Gloucestershire HCOSC meeting at Shire Hall, Gloucester

13.07.16` The Chief Executive attended the New Models of Care Board

13.07.16` The Chief Executive attended the Gloucestershire CEO's STP meeting

13.07.16 The Director of Quality attended 2gether NHS Foundation Trust Contract Board Meeting at Sanger House.

14.07.16 The Director of Quality attended the Annual CD Incidents meeting at Rikenel

14.07.16 The Director of Quality attended the Council of Governors

15.07.16` The Chief Executive attended the SW STP meeting in Reading

15.07.16 The Director of Quality attended a Teleconference for Gloucester UTC Education

18.07.16` The Chief Executive attended the Worcestershrie STP Programme Board

18.07.16 The Director of Engagement and Integration attended a meeting with Stephen Marston, Vice Chancellor the University of Gloucestershire with Gloucestershire Hospitals NHSFT colleagues

18.07.16 The Director of Engagement and Integration attended the Forest of Dean Community Services Review Steering Group at Sanger House

19.07.16` The Chief Executive was part of the interview panel for the WM Chief Constable

19.07.16` The Chief Executive attended the Herefordshire Redesign Management Group

19.07.16 The Director of Engagement and Integration chaired the Tackling Mental Health Stigma Group at Sanger House

19.07.16 The Director of Engagement and Integration hosted a visit to the Fritchie Centre with colleagues from Cobalt

19.07.16 The Director of Quality attended a Service Directors Meeting at Rikenel

20.07.16` The Chief Executive attended the Herefordshire and Worcestershire STP AO's meeting

20.07.16` The Chief Executive attended the One Herefordshire Tripartite Checkpoint meeting

20.07.16 The Director of Quality attended 2gether CQRF/CMB in Hereford

21.07.16 The Director of Engagement and Integration chaired the Service Experience Committee at Rikenel

25.07.16 The Director of Engagement and Integration met with an individual with lives experience as a follow up meeting from her questions asked at the Healthwatch AGM

26.07.16` The Chief Executive attended the Gloucestershire Strategic Forum

26.07.16 The Medical Director attended the Gloucestershire Strategic Forum

27.07.16` The Chief Executive chaired the Worcestershire STP workforce and OD meeting

27.07.16 The Medical Director visited the University of West of England with the Director of Medical Education to explore opportunities

29.07.16 The Director of Engagement and Integration attended the Quarterly Partners Meeting between Healthwatch and 2getherFT at Community House

29.07.16 The Director of Engagement and Integration chaired a meeting with Swindon Mind at Cirencester Memorial Hospital

29.07.16 The Director of Quality attended the Quarterly Pharmacy Meeting

02.08.16 The Director of Engagement and Integration attended the HCOSC Planning Meeting at Shire Hall, Gloucester

03.07.16` The Chief Executive attended the Worcestershire STP CEO's meeting

03.08.16 The Director of Service Delivery participated in an "Expert Report and next steps" meeting with Trust Solicitors.

03.08.16 The Director of Engagement and Integration facilitated the opening of the Fritchie Centre in Cheltenham

04.08.16 The Director of Service Delivery attending a meeting regarding Mental Health and Physical Issues with Gloucestershire Clinical Commission Group

04.08.16 The Director of Finance and Commerce attended an introduction meeting with NED Quinton Quayle.

05.08.16 The Director of Engagement and Integration and 2gether colleagues met with colleagues from The Pied Piper Appeal

05.08.16 The Director of Engagement and Integration met with a Commissioning Officer from Gloucestershire County Council to discuss recovery practice

08.08.16 The Director of Engagement and Integration met with the AHSN Link Director

09.08.16 The Director of Service Delivery attended a System Resilience Group meeting with Gloucestershire Clinical Commission Group

09.08.16 The Director of Service Delivery attended a Tewkesbury, Newent and Staunton Locality 30,000 Model Meeting with Gloucestershire Clinical Commission Group

09.08.16 The Director of Engagement and Integration met with Director of Public Health for Herefordshire and Cllr Summers in Herefordshire re Lets Listen Herefordshire initiative

09.08.16 The Director of Engagement and Integration presented at the NHS Reference Group with the new Head of Communications and the Service Director for Gloucester Locality at Sanger House

09.08.16 The Director of Quality attended a STP Planning Group Meeting in Worcester

09.08.16 The Director of Engagement and Integration attended the presentation by service users of GRIP about their "Newgale Adventure Week Experience"

09.08.16 The Director of Organisational Development attended a closed discussion session organised by Gloucestershire Care Services NHS Trust regarding their review of the Minor Injury & Illness Units

10.08.16` The Chief Executive Chaired the Worcestershire STP Workforce and OD Committee meeting

10.08.16 The Director of Service Delivery attended a Data Sharing/Info Governance Stroud and Berkley Vale meeting with Gloucestershire Clinical Commission Group

10.08.16 The Director of Organisational Development attended the STP Herefordshire & Worcestershire Workforce & OD Group meeting

10.08.16 The Director of Engagement and Integration participated in the Forest of Dean Community Services Review Steering Group at Colliers Court

11.08.16 The Director of Service Delivery attended a Stroud and Berkley Vale Pilot Board meeting with Gloucestershire Clinical Commission Group

11.08.16 The Director of Engagement and Integration attended an evening engagement event with BBC West to meet the new Head of Regional and Local Programming

11.08.16 The Director of Quality attended a Board Visit to IAPT in Herefordshire

15.08.16` The Chief Executive sat on the interview panel for the Gloucestershire Independent Chair

16.08.16` The Chief Executive attended the Worcestershire STP Programme Board

16.08.16 The Director of Quality attended Sodexo Meeting at Rikenel

16.08.16 The Director of Engagement and Integration attended a private view of "The Elephant in the Room" (Tackling Stigma initiative by Independence Trust) at Nature in Art, Twigworth

17.08.16 The Chief Executive attended the Herefordshire AO's meeting.

17.08.16 The Director of Engagement and Integration facilitated a meeting with colleagues from Gloucestershire County Council and Gloucestershire CCG to discuss World Mental Health Day activities and publishing articles from multiagency work

18.08.16 The Chief Executive Chaired the Community Collaborative Board

18.08.16 The Director of Organisational Development met with the regional RCN representative

18.08.16 The Director of Engagement and Integration Chaired a Strategic Partnership Meeting between Swindon Mind and 2gether in Cirencester

19.08.16 The Chief Executive attended the Worcestershire STP Budget Prioritisation meeting

22.08.16 The Director of Finance and Commerce attended a Monitor Q1 conference call

23.08.16 The Chief Executive attended the Local Digital Roadmap Meeting

23.08.16 The Director of Service Delivery attended a North Cotswolds 30,000 Model - Data Meeting with Gloucestershire Clinical Commission Group

23.08.16 The Director of Service Delivery attended a Local Digital Roadmap meeting with Gloucestershire Clinical Commission Group

23.08.16 The Director of Finance and Commerce attended a Board Visit with Martin Freeman (NED) to Greyfriars PICU, Wotton Lawn with Steve Ireland

23.08.16 The Director of Finance and Commerce attended a STP Finance Meeting in Malvern

24.08.16 The Director of Engagement and Integration attended the "Cart Shed" Woodland Experience in Norton Canon, Herefordshire

24.08.16 The Director of Organisational Development chaired the STP Herefordshire & Worcestershire Workforce & OD Group meeting

24.08.16 The Director of Finance and Commerce attended a Board Visit with Sally Ashton to Kingsholm Ward, Wotton Lawn with Simon Webster

24.08.16 The Director of Finance and Commerce attended a STP CIP Meeting with Luke De Lord of GE Healthcare

Board National engagement

01.07.16 The Director of Quality attended a HEE Associate Nurse Event at Aston Villa Football Club

05.07.16` The Chief Executive Chaired the Patient Safety Collaborative

07.07.16 The Director of Quality attended Nursing, Midwifery & Social Care Senate at St Johns Campus, Worcester

14.07.16` The Chief Executive attended the NHS Confed Board of Trustees meeting

14.07.16 The Director of Quality attended Nurse Education Strategic Workforce at Francis Hall

14.07.16 The Medical Director attended the South West Responsible Officer Network Meeting

14.07.16 The Director of Engagement and Integration attended a Celebration of Excellence Awards in Occupational Therapy in London

26.07.16 The Director of Engagement and Integration presented at a Time to Change Mental Health Professionals Round Table Event held in London at the Royal College of Psychiatrists

26.07.16 The Director of Quality attended a RePAIR Case Study Session in London

02.08.16 The Director of Engagement and Integration gave a telephone interview to a journalist for the College of Occupational Therapists re Time to Change, Mental Health Practitioners

1.2.3 Ensuring Sustainable Services

Major Project Update – August 2016

Temporary Staffing Demand quality/sustainability

The Executive Team continues to monitor the use of agency on a weekly basis (agency spend and shifts covered), and the effectiveness of the enabling and control actions implemented..

Some of the actions will start to take effect from September. In that month, 19 newly qualified nurses commence employment in Gloucestershire inpatients, substantially reducing the vacancies level (and therefore reducing the shift cover requirements). A Staff Bank hub

is being set up in Herefordshire, and with the additional 20-30 HCAs recently recruited will start to reduce the high agency use in that area caused by limited bank staff. Additionally, Herefordshire has launched a student practitioner scheme with the first year student nurses and AHPs at the University of Worcestershire, and in return for the support provided by the Trust each of the 8 students will annually cover a minimum of 37 bank shifts - the scheme commences in September 2016. PWP workers (9) have been appointed to the IAPT service which will also reduce the agency requirement.

In addition to the implementation of e-rostering this year: other potential opportunities are being considered in order to attract more staff onto staff bank (e.g. weekly pay); recruitment continues to be proactively pursued; and potential to make locum savings through 'direct engagement', and partnership working to achieve improved agency rates is being investigated.

SLR/PLICS 2016/17 quality

The 2015/16 accounts and activity have now been entered into the SLR/PLICS system, and the Qlikview dashboards are in place. Prior to rolling out access to nominated users, the Executive Team will be presented with updated information on the scheme.

In readiness for roll out, a number of papers have been produced, e.g. an SLR training paper and training manual and a Qlikview policy on use and reporting.

Discussions have and continue to take place around ensuring that SLR/PLICS will easily fit into the day to day working environment. These discussions look at the resource implications of this change, and the options were discussed at the August SLR project board meeting.

The Capital Resources Group was asked to accept the need for an additional £40k to cover the requirement for an additional server to host the Qlikview software, additional RAM to keep processing speeds at an optimal level, and to keep the SLR Consultant on until the end of September (to assist with presentations, support the final hand over to the costing accountant, and to help with Qlikview training during roll out).

Improving Care Through Technology sustainability

The project continues to move forward, and previously identified risks and issues around the Gloucestershire and Herefordshire infrastructure are being addressed – Two way Trust is in place between 2gether and Shakespeare and the file migration complete; all user accounts in Herefordshire domain have been recreated in 2gether; from 1st August CITS have taken the Herefordshire support calls.

During August and September the focus has shifted to Herefordshire. Digital Dictation training, laptop handover and user migration to 2gether domain has commenced in Herefordshire, beginning with colleagues based at 27A St. Owen's Street. The Herefordshire integration is due to complete before 30 September, at which time the project returns to Gloucestershire and planning begins for full rollout to community teams.

Digital Call recording quality

The introduction of digitally recording telephone conversations between clinicians and people contacting the Crisis service is progressing. The technical elements are now in place and attention is focussed on ensuring all governance and information management responsibilities are met.

A new policy is being drafted supported by Privacy and Equality Impact Assessments and it is planned to seek authorisation to proceed in September. Call recording will initially be trialled with the Crisis service in Gloucestershire before being evaluated for other services delivered by the Trust.

Major Project Update – September 2016

Improving Care Through Technology sustainability

The Herefordshire rollout has now been underway for a month and a half. Two hundred users have been provided with new laptops and set-up with their 2gether accounts. The 2gether domain has now been made available via fixed line Ethernet (Wi-Fi is still pending) at all Trust buildings in Herefordshire except Stonebow.

Technical input is required "at the desk" to move each user from Shakespeare to 2gether, and due to resourcing and technical difficulties, this part of the rollout has not kept pace with the laptop handover. Consequently, significant project activity is expected to continue at the Herefordshire sites until the end of October.

CITS service desk began taking calls for our ICTT users at the beginning of August, and since then pressure on the 2gether project team has reduced significantly, allowing us to focus more resource on the project.

Digital Transcription and Speech Recognition (DTSR) sustainability

Since August, equipment has been rolled out to all of Herefordshire, and currently staff are all completing their pre-learning phase (just over 200 staff members). In this phase staff 'teach' the system their voice. The plan is that by the end of October all Herefordshire staff will be using BigHand. This will help staff write their progress notes and complete tasks such as initial assessments. This deployment has been very well received in Herefordshire with great attendance from all and really positive feedback from staff members.

Currently, the Gloucestershire Memory Assessment Service and the Stroud Community Learning Disability Team are using BigHand for clinical work. Commencing 13 September, the Recovery team based at Cirencester Memorial Hospital joined them in fully using the system (this will bring us to 100 active users approx.).

Digital Call recording quality

The introduction of digitally recorded telephone conversations is progressing. The technical elements are now in place and attention is focussed on ensuring all governance and information management responsibilities are met.

A new policy has been drafted and consultation has been held with the Information Governance Advisory Sub Committee. To support the policy, Privacy, Equality and Quality Impact Assessments have been developed and it is planned to seek further consultation with the Information Governance & Health Records Committee at the end of September.

Local level Standard Operating Procedures will be developed for use in the Crisis and IT Departments. A System Administrator training guide has been produced in preparation for training staff who need to access the recordings. Training is to be designed and delivered for call handlers. Call recording will initially be trialled with the Gloucestershire Crisis (MHARS) service before being evaluated for use in other Trust services.

Smoking Cessation sustainability

The Trust's objective is to achieve, by 02 April 2017, full implementation of the National Institute for Clinical Excellence - NICE (2013) PH 48 - Smoking Cessation in secondary care: acute, maternity and mental health services. The Trust has a duty of care to provide staff and service users with support to stop or abstain from smoking while using or working in our services.

Originally it was planned to deliver the project in Q3 of 2016/17. This has slipped due to resource availability.

However, considerable foundation work has been completed. Additional staff and user engagement and consultation to support the considerable cultural change is underway, and the 'Smoke Free' Policy to support the smoke free environment is being drafted.

Communication will commence 01 October 2016, and coincides with the national 'Stoptober' campaign – a month in which people are encouraged to stop smoking. Branding has been agreed and is starting to be placed on posters, banners, leaflets etc. A short film has been produced to promote the Trust's intention to become smoke free - available from 01/10/16.

Trust-wide Quality Improvement (CQC actions) quality

There are a total of 73 CQC observations being addressed, split between "must do" (15) and "should do" (58). For each there are one or more tasks that need to be completed to meet the CQC's requirements.

Of the 15 "must do":

- 10 are completed
- 4 are all scheduled to be completed by end December
- 1 is due to complete by March 2017

Of the 58 "should do":

- 32 are completed
- 20 are due to complete by end December
- 3 are due to complete by end March 2017
- 3 are due to be completed during 2017/18

The Trust has met with the CQC twice over the past months who are pleased with the progress the Trust has made. In addition, an audit recently undertaken by PwC reports full assurance with the Trust's stated position against the CQC action plan.

Agenda item 16 **Paper J**

Report to: 2gether NHS Foundation Trust Board 29th September 2016
Author: Stephen Andrews, Deputy Director of Finance
Presented by: Andrew Lee, Director of Finance and Commerce

SUBJECT: **Finance report for period ending 31st August 2016**

Can this report be discussed at a public Board meeting?	No
If not, explain why	This report contains commercially sensitive information

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

EXECUTIVE SUMMARY

- The month 5 position is a deficit of £211k compared to the planned deficit of £207k. The budgets have been revised to include the £650k Sustainability and Transformation Fund monies that have been allocated to the Trust. One quarter of this fund was included at month 3 position.
- The Trust was allocated £650k from the Sustainability and Transformation Fund (STF) by NHS Improvement. The Trust also had its 2016/17 control total of a surplus of £4k adjusted upward by £650k to a revised 2016/17 revenue control total of £654k surplus.
- The month 5 forecast outturn is a £654k surplus, excluding impairments, as per the revised revenue control total and Trust budgets. The Trust is anticipating it will receive the full allocation from the STF.
- The Trust has a Financial Sustainability Risk Rating of 3.
- The Trust has a revised forecast agency spend taking into account the impact of the considerable number of actions taken of £3.903m at month 5, which is above the £3.404m control total, but £1.6m below the spend in 2015/16. This equates to achievement of 76% of NHS I's required reduction in agency spend in 2016/17. The Trust also projects it will meet the run rate to fully deliver the target reduction in 2017/18.
- The Trust is ahead of plan against its Capital programme following the earlier than planned purchase of Pullman Place as the site for the Trust's Gloucester Hub for clinical services.
- The Trust has a cost pressure of £500k to absorb from an increase in the forecast of Public Dividend Capital in 2016/17.
- The Trust has completed a mid year review of its financial position. It remains confident that it will meet its plan. Revenue budgets, capital expenditure, savings schemes, balance sheet provisions and potential risks and opportunities have all been reviewed. This review is the subject of a separate Board paper.

RECOMMENDATIONS

It is recommended that the Board:

- note the month 5 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	15th September 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	3.0	FS Risk rating of at least 3
Income	FOT vs FT Plan	102.7%	
Operating Expenditure	FOT vs FT Plan	102.2%	
Cash	Number of creditor days	27	Balance of £16.8m (including investments) which equates to 27 creditor days.
PSPP	%age of invoices paid within 30 days	97.0%	88% paid in 10 days
Capital Income	Monthly vs FT Plan	95.3%	
Capital Expenditure	Monthly vs FT Plan	253.7%	£6,858k 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	<15 days	15-40	>40 days
Public Sector Payment Policy - YTD	<80%	80% - 95%	>95%
Capital Income - Monthly vs FT Plan	<90%	90% - 100%	>100%
Capital Expenditure - Monthly vs FT P	>115% or <85%	110% - 115% or 85% to 90%	>90% to <110%

- The financial position of the Trust at month 5 is a deficit of £211k which is £4k behind the plan.
- Income is £761k over recovered against budget and operational expenditure is £492k over spent, and non-operational items are £273k 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	(4,950)	(2,059)	(2,043)	16	(4,925)	24
Stroud & S Cots Locality	(4,052)	(1,688)	(1,803)	(114)	(4,411)	(359)
Gloucester & Forest Locality	(4,433)	(1,847)	(1,815)	32	(4,414)	19
Social Care Management	(3,497)	(1,457)	(1,954)	(497)	(4,731)	(1,234)
Entry Level	(5,266)	(2,194)	(2,182)	12	(5,218)	48
Countywide	(29,394)	(12,248)	(12,415)	(167)	(29,944)	(550)
Children & Young People's Service	(5,007)	(2,086)	(1,798)	288	(4,822)	185
Herefordshire Services	(13,396)	(5,587)	(5,786)	(199)	(13,730)	(333)
Medical	(14,936)	(6,223)	(6,557)	(334)	(15,609)	(673)
Board	(1,375)	(573)	(642)	(69)	(1,680)	(305)
Internal Customer Services	(1,649)	(687)	(663)	24	(1,627)	22
Finance & Commerce	(6,678)	(2,765)	(2,440)	325	(6,390)	287
HR & Organisational Development	(3,148)	(1,312)	(1,345)	(33)	(3,184)	(36)
Quality & Performance	(2,604)	(1,085)	(1,102)	(17)	(2,642)	(38)
Engagement & Integration	(1,350)	(562)	(539)	24	(1,364)	(14)
Operations Directorate	(1,155)	(481)	(489)	(7)	(1,243)	(88)
Other (incl. provisional / savings / dep'n / PDC)	(4,792)	(2,220)	(2,259)	(38)	(4,648)	144
Income	108,336	44,868	45,619	750	111,236	2,900
TOTAL	**654**	**(207)**	**(211)**	**(4)**	**654**	**(0)**

The key points are summarised below;

In month

- Stroud locality was over spent due to higher than budgeted Supporting People costs. This is matched by additional income.
- Social Care Management was over spent due to over performance against the funded level for Community Care, which is offset by additional income.
- Herefordshire was over spent due to agency costs to cover specialling costs on Mortimer ward and vacancies across all wards.
- CYPs was under spent due to a number of vacancies across many services.
- Medical budgets over spent due to agency usage in Countywide, Children and Young People, Herefordshire, Localities and Learning Disabilities to cover vacancies, sickness, maternity leave and a significant backdated pay adjustment.
- Countywide was over spent due to complex care costs from new high cost placements and additional inpatient costs covering vacancies and clinical need.
- Finance was under spent due across a range of uncommitted non pay budgets such as IT, transport and laundry.
- Income is over recovered due to additional funds from Supporting People, Community Care and development income.

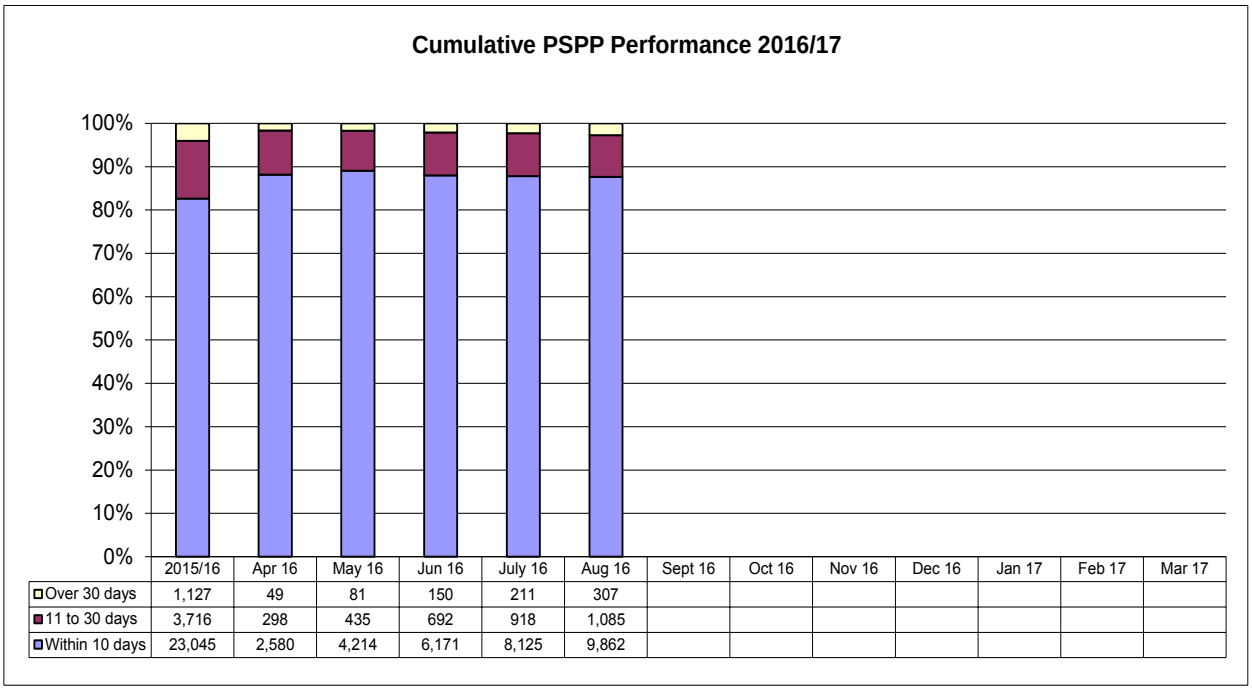
Forecast Outturn

- Stroud locality is forecast to be over spent due to higher than budgeted Supporting People costs. This is matched by additional income.
- Social Care Management is forecast to be over spent due to over performance against the funded level for Community Care, which is offset by additional income.
- Countywide is forecast to be over spent due to complex care costs from new high cost placements (£200k) and additional inpatient costs covering vacancies and clinical need.
- Herefordshire is forecast to be over spent due to agency costs to cover specialling and vacancies across all wards.
- Medical costs are forecast to be over spent due to agency usage across many areas.
- Board is forecast to be over spent due to expenditure on the Improving Patient Safety programme for which there is £290k of income to match the spend.
- Income will over recover due to additional funds for Supporting People, Community Care, Improving Patient Safety and development income.

A mid year review of the financial position has been undertaken, and is addressed in a separate Board paper, and will be reflected fully in the month 6 report. All aspects of financial performance have been reviewed from budgets to agency spend and savings and capital. As part of the review the financial plans and assumptions for 2017/18 are also being updated in the report to reflect our latest assumptions on income, expenditure, capital, savings and reserves in light of the work on the Sustainability and Transformation Plans process. The work to date has concluded that the Trust remains on track to deliver its financial control total of a £654k surplus in 2016/17.

The cumulative Public Sector Payment Policy (PSPP) performance up to month 5 is

88% of invoices paid in 10 days and 97% paid in 30 days. The cumulative performance to date is depicted in the chart below and compared with last year's position. It highlights that the Trust has a strong balance sheet and has the cash available to continue to pay its invoices promptly:



	2015/16	Apr 16	May 16	Jun 16	July 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Over 30 days	1,127	49	81	150	211	307							
11 to 30 days	3,716	298	435	692	918	1,085							
Within 10 days	23,045	2,580	4,214	6,171	8,125	9,862							

Agenda item 17 **PAPER K**

Report to: Trust Board – 29 September 2016
Author: John McIlveen, Trust Secretary
Presented by: Marcia Gallagher, Audit Committee Chair

SUBJECT: AUDIT COMMITTEE ANNUAL REPORT 2015/16

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

EXECUTIVE SUMMARY

The Committee's terms of reference require that it reports to the Board, at least annually, on its performance against its terms of reference, and on its work in support of the Annual Governance Statement.

The attached report provides an overview of the Committee's work in the last financial year, in sections which reflect the headings in the Committee's terms of reference. The report also provides an overview of the work of the Committee in overseeing internal control mechanisms in the Trust, in support of the Annual Governance Statement.

RECOMMENDATIONS

The Board is asked to note the Audit Committee's Annual Report 2015/16.

Corporate Considerations	
Quality implications:	Effective management of risk provides assurance that patient services are being delivered safely
Resource implications:	None other than those identified in the report
Equalities implications:	None other than those identified in the report
Risk implications:	Failure to identify and mitigate corporate and strategic risks may adversely affect the Trust's strategic goals of engagement, quality and sustainability.

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

Reviewed by:		
Andrew Lee	Date	29 June 2016

Where in the Trust has this been discussed before?		
Audit Committee	Date	3 August 20165

What consultation has there been?		
Audit Committee Chair Director of Finance		29 June 2016

Explanation of acronyms used:	

2gether NHS Foundation Trust

Audit Committee Annual Report 2015/16

1 Introduction

1.1 The Audit Committee was established in its current form under Board delegation in late 2010 following a review of Board Committee structures. Its terms of reference are aligned with the Audit Committee Handbook, published by HFMA and the Department of Health.

1.2 All Non-Executive Directors are members of the Committee, with the exception of the Trust Chair. A number of officers are in regular attendance in accordance with the Committee's Terms of Reference. These include the Director of Finance & Commerce, the Trust Secretary, Internal and External Auditors, and the Local Counter Fraud Specialist. Other Directors and Managers attended at the request of the Committee. After each meeting of the Committee, the Audit Committee Chair provides a summary report of the Committee's deliberations and decisions to the next Board meeting.

1.3 The Committee met 5 times during the period 1 April 2015 to 31 March 2016, and has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the Trust's business through self-assessment and review, and by requesting assurances from Trust Officers. Each meeting was quorate.

1.4 Attendance by members at the Committee during the period was as follows:

	21/04/2015	26/05/2015	21/07/2015	20/10/2015	03/02/2016
Maggie Deacon (Chair)[1]	✓	✓			
Charlotte Hitchings	✓	✓	✓	✓	
Martin Freeman	✓	✓	✓	✓	✓
Jonathan Vickers	✓	✓	✓	✓	✓
Nikki Richardson	✓	✓	✓	✓	✓
Richard Szadziewski (Chair)[2]					✓

1.5 The following were in attendance at the Committee during the period:

	21/04/2015	26/05/2015	21/07/2015	20/10/2015	03/02/2016
Andrew Lee, Director of Finance & Commerce	✓	✓			
Sallie Cheung, Local Counter Fraud Specialist		✓			✓
Lisa Evans, Board Committee Secretary	✓		✓	✓	✓
Marie Crofts, Director of Quality	✓		✓		✓
John McIlveen, Trust Secretary	✓	✓	✓		✓
Jane Melton, Director of Engagement and Integration	✓				
Peter Stephenson, PWC			✓		
Michelle Hopton, Deloitte		✓	✓	✓	
Ian Howse, Deloitte	✓	✓			✓

[1] Left the Trust on 30/11/2015

[2] From 1/12/2015

Gordon Benson, Asst Director of Governance		✓			
Steve Moore, Head of Information Management & Clinical Systems			✓		
Alan Bourne-Jones, Risk Manager			✓	✓	
Shaun Clee, Chief Executive		✓		✓	
Ruth FitzJohn, Trust Chair[3]		✓			
Tanya Hartley, Asst Director of Finance		✓			✓
Stephen Andrews, Deputy Director of Finance	✓	✓	✓	✓	✓
Anna Hilditch, Asst Trust Secretary		✓		✓	
Rayna Kibble, Local Counter Fraud Specialist				✓	
Lynn Pamment, PWC	✓	✓		✓	✓
Claire Edge, Deloitte					✓
Lucy Bubb, Deloitte			✓		
Natalie Tarr, PWC	✓			✓	✓
Carol Sparks, Director of Organisational Development	✓				

1.6 Each meeting of the Committee is observed by a Governor, who provides onward assurance to the Council of Governors regarding the performance of Committee members.

2 Principal Review Areas

2.1 This annual report is divided into five sections, reflecting the five key duties of the Committee as set out in its terms of reference.

2.2 Governance, Risk Management and Internal Control

2.3 The Committee has reviewed relevant disclosure statements, in particular the Annual Governance Statement together with the Head of Internal Audit Opinion, external audit opinion and other appropriate independent assurances.

2.4 The Head of Internal Audit Opinion was based on the audit work carried out during the year in line with the plan approved by the Committee, together with regard to the Trust's Board Assurance Framework, Risk Register, and other control mechanisms. This opinion contributed to the Committee's assessment of the effectiveness of the Trust's system of internal control, and to the completion of its Annual Governance Statement.

2.5 The Committee maintained a continued focus on Incident Reporting systems following a 'Critical Risk' Internal Audit finding in 2013/14, receiving a follow-up report to assess progress and provide assurance against the action plan drawn up to mitigate this risk, and referring receipt of ongoing assurance against the Incident Reporting action plan to the Delivery Committee. The follow up report was assigned a Medium Risk

[3] The Trust Chair is not a member of the Audit Committee, but may attend a meeting of the Committee by invitation

classification, recognising the progress made since the initial audit in 2013/14. The Audit Committee agreed to receive a further follow-up report early in 2016/17.

2.6 The Committee reviewed the Board Assurance Framework and the Corporate Risk Register at regular intervals, and received summary reports from other Board Committees in order to provide challenge and receive assurance that strategic and corporate risks assigned to those Committees are being adequately monitored.

2.6 The Committee reviewed both the draft and final versions of the Annual Governance Statement which set out the systems and processes for internal control and formed part of the Trust's 2014/15 Annual Report.

2.7 The Committee reviewed the Register of Directors' Interests, and the Register of Gifts and Hospitality.

2.8 The Committee reviewed the Trust's Standing Financial Instructions and Scheme of Delegation, and endorsed these revised documents for approval by the Trust Board.

2.9 The Committee has reviewed the completeness of the risk management system and the extent to which it is embedded within the organisation. The Committee believes that while adequate systems for risk management are in place, continued management focus is required to ensure that risk management continues to be embedded within the trust and in particular to address outstanding issues concerning Incident Reporting systems.

2.10 Internal Audit

2.11 In completing its work, the Committee places considerable reliance on the work of Internal Auditors. Throughout the year the Committee has worked effectively with internal audit to strengthen the Trust's internal control processes and during the year the Committee:

- Reviewed and approved the internal audit plan for 2015/16
- Considered the findings of internal audit in relation to work on the following issues

    - Corporate Governance & Risk Management
    - Information Governance
    - Service Line Reporting Phase 1
    - Contracting
    - Estates and Capital
    - Cost Improvement Plan
    - Core Financial Systems
    - Incident Reporting – Follow-up
    - HR – Objectives, Appraisals and Stat/Mand Training
    - ICT – Hoople Follow-up
    - Data Quality
    - Incident Reporting
    - Procurement
    - RiO Implementation – lessons learnt

2.12 These audits produced a total of 39 findings (an increase from 30 findings the previous year) in respect of which the Committee sought and received assurance on the

mitigating actions being taken, following up outstanding actions as necessary, and referring issues to other Committees as appropriate in order for progress with action plans to be monitored. All audit reports were classified as either Medium or Low risk. The Audit report on RiO implementation was an advisory report, with no risk rating assigned. A number of these audits were undertaken at the Committee's request in order to examine areas where known areas of risk exist.

2.13 External Audit

- The Committee received and noted the final audit in respect of the 2014/15 Financial Accounts and the 2014/15 Quality Report, and approved the Financial Accounts and the Quality Report on behalf of the Trust Board.
- The Committee reviewed and agreed the external audit plan for 2015/16.
- The Committee reviewed and commented on the reports prepared by external audit which have kept the Committee apprised of progress against the External Audit Plan.
- The Committee also received regular Sector Development Reports which proved a useful source of intelligence on key national issues and developments.

2.14 **Private Meeting with the Auditors**

2.15 The Committee did not meet privately with internal and external auditors during the year as the scheduled meeting had to be postponed. A meeting with the auditors took place in April 2016. No concerns were raised by either auditor, and both gave positive feedback about the reputation of the Trust and the working relationships that had been established.

2.16 Other Assurance Functions

2.19 The Committee has reviewed the findings of other significant assurance functions, and has considered any governance implications for the Trust. For example, the Committee received a report on Data Quality Assurance, a report on pressures on the Medical budget, and considered the appropriate governance mechanisms for obtaining assurance about NHS Gloucestershire Shared Services. The Committee also received a report which provided assurance regarding the numbers of clinical and non-clinical claims against the Trust.

2.20 The Committee received regular Counter Fraud updates, and received the Counter Fraud Annual Report for 2014-15 and the Counter Fraud action plan for 2015/16. The Counter Fraud Service completed 95 days of activity during 2015/16, fewer than the planned 145 days but the same level of activity as in the previous year. The Committee expects the level of Counter Fraud activity to meet the planned level of 145 days during 2016/17 in order to reduce fraud and corruption to an absolute minimum.

2.21 The NHS Protect self-review tool provided assurance that the Trust has a robust and effective Counter Fraud Service, with the overall level of risk being rated as 'Green' the same rating as for 2014/15, and there were no further quality assessment recommendations from NHS Protect arising from this self-assessment.

2.22 Management

2.23 The Committee has challenged the assurance process when appropriate, and has requested and received assurance reports from Trust management and various other

sources both internally and externally throughout the year. The Committee has, for example, requested and received:

- further assurance regarding procedures in respect of staff leaving the Trust;
- further assurance on timely completion of audit actions and processes for deferment of audit actions;
- further assurance on the most effective mechanism to gain assurance regarding Shared Services;
- further assurance that risks around data quality are being adequately recognised and addressed

2.24 The Committee works to an annual plan of scheduled agenda topics. In setting this annual plan, the Committee considers items currently on the Risk Register, items of current interest, and items raised by the auditors and the Executive Team. In addition the Committee follows up risk items previously identified to ensure that it remains informed of progress against previously agreed actions. A rolling programme of actions is maintained and monitored accordingly for all Committee meetings.

2.25 Financial Reporting

2.26 The Committee received Losses and Special Payments reports at various points through the year, as required by the Trust's Standing Financial Instructions. The Committee sought assurance in each case as to the processes in place to recover these amounts, and prevent recurrence.

2.27 The Committee reviewed the 2014/15 financial statements and annual report at the May 2015 meeting prior to recommending the final accounts for Accounting Officer signature, in line with authority delegated by the Board.

2.28 The Committee was pleased to note the external audit report which indicated that an unqualified audit opinion was to be given to the accounts, and that the auditors had not identified any significant weaknesses in systems of accounting and financial control.

3 Other matters

3.1 The Committee reviewed its own effectiveness during the year using the checklist contained in the Healthcare Finance Management Association's Audit Committee Handbook. The assessment provided broadly positive assurance that the Committee was effectively undertaking the duties required of it, and an action plan was implemented to address areas for improvement.

3.2 The Committee compiled an Annual Report on its activities which was received by the July 2015 Board.

3.3 The Committee reviewed its terms of reference during the year.

4 Conclusion

4.1 The Committee's primary contribution to the achievement of the Trust's strategic objectives is to ensure that Governance, Control, Risk Management and Audit systems are sound, reliable, and robust. This report gives an overview of the work of the Committee in the last financial year, which has enabled the Committee to conclude that the Trust's systems are in the main sound, reliable and robust.

Marcia Gallagher
Chair, Audit Committee

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Making life better

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PAPER L1

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Audit Committee

DATE OF COMMITTEE MEETING: 3 August 2016

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

Internal Audit Plan 2016/17
The Committee received and approved the internal audit plan for 2016/17, which was driven by the Trust's organisational objectives and priorities. The HR follow up review of mandatory training had been added to the plan to be undertaken in Quarter 3 and the IT Projects review would take place in Quarter 4. These were two areas that the Audit Committee had asked to be considered and would use up the remaining two internal audit contingency days.

Internal Audit Progress Report
The Committee received an update on progress against the Internal Audit Plan.

Internal Audit Recommendations Tracker
Additional columns had been added to the Recommendation Tracker to provide further clarity regarding the position of the review. 12 recommendations had been implemented and validated this quarter, 12 further recommendations had been implemented and were awaiting review. 3 risk management recommendations were in progress and due.

The updates to the HR Objectives, Appraisals and Mandatory Training recommendations were noted and a query was raised as to whether the right people were being asked to comment. It was reported that managers had confirmed that all relevant recommendations had been implemented but there were system issues with providing evidence.

The Committee noted that reports being received through ESR on E-Expenses were not fitting Trust requirements. Discussions were underway with Financial Shared Services to make improvements to the system and an audit of the Financial Shared Services E-Expenses provision was required. There was a Service Level Agreement in place and the Director of Finance agreed to meet with the Director of Finance at the Gloucestershire Hospitals Trust to discuss this further.

External Audit Sector Developments
This report included information on the Changes to Britain's relationship with the EU, particularly around freedom of movement which had the potential to significantly affect the NHS. The Committee noted that the Department of Health was moving to a single Group Accounting Manual in 2016/17, this would replace the majority of the ARM. NHS Improvement was consulting on a single oversight process for NHS providers and NHS Improvement. 2gether had responded to this consultation and it was agreed that the Trust's response would be circulated to Audit Committee members. The Committee also agreed that in future the Trust's management response to these developments would be distributed with the papers for the Audit Committee.

Counter Fraud
The Committee noted that all activity was progressing and it was anticipated that all actions within the Counter Fraud Action Plan would be completed by year end. For the period 1 April - 10 July 2016, Counter Fraud had participated in all Trust inductions and provided fraud awareness to 104 staff. Two Counter Fraud newsletters had been published and were now accessible to staff via the Trust's intranet. In July 2016, Counter Fraud visited nine Trust sites across both counties and met with staff to promote awareness of the department. Counter Fraud material was also distributed including newsletters, bulletins and posters to be displayed in staff areas.

A revised Counter Fraud Policy was presented to the Committee. The policy had been updated to reflect changes in personnel and had been reviewed against national guidance. Subject to some minor typos, the Committee approved the revised policy.

Losses and Special Payments
The Committee received a Losses and Special Payments report for the periods Q4 2015/16 and Q1 2016/17. The Trust had recorded 1 loss during the period which totalled £23.02. The Trust made 9 special payments during the period. These payments were ex-gratia and totalled £12,679.80.

An overpayment of salary of £12,564 from 2015/16 was highlighted. The Committee was assured that once this had been identified the individual had been written to and a repayment plan was agreed. The Committee noted that overpayments of salary were at an all-time low and in the majority of cases were due to the person's manager not telling payroll that the staff member had left the Trust.

Board Assurance Framework
The Committee received an updated Board Assurance Framework (BAF) which set out those risks drawn from the Corporate Risk Register which scored 12 or higher. The Board had discussed potential changes to the BAF at its development session on Risk Management and agreed to trial a new approach based on assurance mapping. A template was provided to the Trust secretary by PWC on which the draft assurance map had been based. The assurance map was similar to the BAF in that it contained only those corporate risks scoring 12 or more and 'Top 5' risks were indicated. Overall assurance levels were indicated as was committee 'ownership' of risks, along with lead Executive Director. The assurance map would be a dynamic document comprising strategic risks to the achievement of the Trust's strategy, with risks added and removed as they were identified or mitigated. The assurance map presented contained 11 risks compared with 12 risks at the time of the Committee's review of the BAF in April.

One new risk, around IAPT services and waiting lists, had been included in the report with a risk score of 15. A further risk, regarding agency spend and control total targets, was currently being evaluated and would be included in the next report subject to its risk score.

The Audit Committee found the assurance map format useful, and agreed that it would receive only the assurance map and covering report to the Committee in future. The Committee asked that the map be brought back at the next meeting once the levels of assurance were confirmed and the risks were checked for accuracy.

Audit Committee Annual Report
The Committee received an overview of its work in the last financial year, in sections which reflected the headings in the Committee's terms of reference. The report also provided an

overview of the work of the Committee in overseeing internal control mechanisms in the Trust, in support of the Annual Governance Statement. The Committee endorsed the report for presentation at Trust Board, subject to a few minor amendments.

Annual Effectiveness Review
An annual self-assessment of performance formed part of the Audit Committee's Terms of Reference, and was considered good practice. The Audit Committee Handbook contained two checklists for this self-assessment and checklist 2 had been used for this year's self-assessment, which was concerned with how the Committee operated.

Respondents were asked to indicate their agreement or otherwise to a series of statements grouped under 5 themes: Committee Focus, Committee Team Working, Committee Effectiveness, Committee Engagement and Committee Leadership. A total of 6 responses were received and these had been collated and provided to the Committee.

The Committee noted that the result of the self-assessment was broadly positive, while highlighting a number of issues which the Committee considered. These issues included:

- Whether the Committee should set itself annual objectives over and above its Terms of reference, and be more explicit about the information it required. Andrew Lee reported that in his view the Committee's Terms of Reference should cover the objectives of the Committee he did not feel that it was necessary to set annual objectives over and above these. The Auditors and the Chair agreed.
- Whether the Committee clearly understands and receives assurances from third party organisations the Trust used. Andrew reported that the Committee did not currently receive third party assurance and it was agreed that this would be added to the work plan as a standing item.
- The attendance of relevant Executives at the meeting. Andrew advised that he always planned to attend Audit Committee and other Executives would attend when required.
- The completeness of information about risks. The Committee agreed that this would be kept under review.
- The support provided to the Audit Committee by other Committees. The Committee agreed that where necessary issues were referred between committees.
- How the Committee deals with late or missing assurances, and whether agreed actions were reliable/realistic. Andrew reported that a new process had been agreed and this would be circulated to the Committee.
- Whether the Committee should have a 'mop up' session at the end of each meeting to reflect on outcomes and what went well/not so well. Andrew reported that there was no requirement for a 'mop up' session but actions would be outlined following the meeting.

It was noted that some members of the Committee had disagreed with statements on the self-assessment form but had not provided any comment to back this up. It was agreed that in future if this occurred the Trust Secretary would go back to the member to ask them why they disagreed.

Review of Committee Terms of Reference
The Committee's Terms of Reference had been reviewed and a small number of minor changes were proposed. The Audit Committee noted the review of its Terms of Reference and agreed the changes indicated to the format. The revised Terms of reference would be included in the Committee's summary report to enable the Board to approve these changes.

Review of Risk Register
The Committee received the Trust's Corporate Risk Register (Risk Score 12 and above) as at

quarter 1 (2016/17) and assurance was provided around the Trust's reporting and oversight arrangements. In addition an update on progress in respect of the recommendations from the annual Internal Audit review of risk management was provided.

It was agreed that report authors were not good at completing the risk box in the Committee report template and this would be raised at the next Risk Co-ordinators meeting. Work was being undertaken on a supplement to the Board report templates to provide additional clarity regarding risks and levels of assurance. The Trust needed to ensure that the risk register was dynamic and it was confirmed that conversations took place regularly to ensure that the register was updated and items removed where possible.

Audit of 48 Hour and 7 Day Follow Up after Discharge Indictor (Delivery Referral)
Deloitte's review of the Trust's 7 day and 48 hour indicator as part of the Quality Report audit had identified two issues around the timing and the quality of recording of visits. The Committee noted that follow up visits had been taking place on day zero and Monitor required that the visits took place after day zero. Therefore the indicator had been recalculated and although it was found that the majority of those visited on day zero had been visited again within 7 days, the indicator was not compliant. The Committee was assured that the policy and practice guidance was currently being reviewed and compliance with the indicator was improving.

Concern was raised that this indicator had been audited in previous years but yet no issue had been identified. The External Auditor reported that this was down to the sample used; previously the samples had complied with Monitor's definition. He added that where the visits had taken place on day zero this may have been in the best interests of the patient clinically and that where necessary service users would continue to be contacted on day zero.

Appointment of the External Auditors
Marcia Gallagher reported that the appointment of the External Auditor Working Group had met in July and agreed a timetable for the tender process. The tender was published on 1 August and would close on 31 August. The evaluators would receive the tenders as soon as possible after the closing date and the top three would be invited to give presentations. The new contract would begin on 1 April 2017 but would require a dual process if the current provider was not appointed. The current tender had been appointed on a 3 year contract followed by two 1 year extensions. The Trust was now required to retender although there was no reason the current provider could not reapply and there was no limit regarding how long they could remain in post.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to note the contents of this summary and to approve the revised Terms of reference for the Audit Committee.

SUMMARY PREPARED BY: Marcia Gallagher ROLE: Committee Chair

DATE: 5 August 2016

PAPER L2

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Delivery Committee

DATE OF COMMITTEE MEETING: 27 July 2016

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PERFORMANCE DASHBOARD OUTTURN REPORT

The Committee reviewed the Trust's performance against NHS Improvement (NHSI), Department of Health (DOH) and Contractual measures to the end of June 2016. Out of 113 indicators reportable for June, 101 were compliant and 9 non-compliant at the end of the reporting period. 3 were not yet available. Five of the non compliant indicators related to IAPT[1], now referred to as 'Let's Talk'. IAPT services were the subject of a separate report to the Committee (see below for commentary).

NHSI (formally Monitor)

- *IAPT Waiting times – Referral to Treatment within 6 weeks (Gloucestershire and Herefordshire)*
- *IAPT Waiting times – Referral to Treatment within 18 weeks (Gloucestershire)*

Gloucestershire CCG (GCCG) Contract

- *2gether NHS Foundation Trust bed occupancy for Gloucestershire CCG patients:* Performance for June stood at 90.9% against an expected threshold of more than 91%. A drop in the total number of occupied bed days had contributed to non-compliance, due to facilities work being carried out and an episode of diarrhoea and vomiting which required Abbey ward to be closed for deep cleaning. Compliance was expected in August.
- *Children and Young People Service (CYPS) Level 2 & 3 referral to treatment within 8 weeks:* Quarter 1 performance was 2% below the target of 80%. Performance in May and June exceeded target; however, a lower performance was reported in April due to a change to a new methodology agreed with the CCG. As the indicator was now compliant on a monthly basis it was expected that it would also be compliant when reported in Quarter 2.
- *Percentage of service users asked if they have a carer*
- *Percentage with a carer that have been offered a carer's assessment*
  This was the first month these Social Care indicators had been reported. Data collection via RiO started two months ago and clinicians were going through caseloads manually to update RiO and ensure that information was correctly recorded. The Committee was assured that carers were being offered assessments but this needed to be evidenced and recorded. A random sample manual audit would be carried out and a trajectory for compliance would be reported at the next meeting.
- *IAPT Access rate*
- *IAPT integrated service – 14 days from referral to screening assessment*

Herefordshire CCG (HCCG) Contract (excluding NHSI indicators included above)

- *IAPT maintain 15% of patients entering the service against prevalence*

Risks: The Trust underperforms against statutory, contractual and Trust targets, posing risks to the provision of a quality service, contractual income and the Trust's reputation.
Assurance: Significant as the majority of indicators are compliant, limited on specific indicators not meeting required performance thresholds, in particular IAPT indicators.

IAPT SERVICE IMPROVEMENT PLANS

The Committee received the IAPT Service Improvement Plans which provided information on the

[1] Improving Access to Psychological Therapies

findings of the Intensive Support Team (IST) in Gloucestershire and Herefordshire and the actions being taken to address these. The Plan had now been agreed by Commissioners. The Committee was informed that:

- Trajectories for improvement in all key indicators had been put in place
- Revised care pathways were being put in place to address IST conclusions on the correct model for service delivery to meet National Standards, including assessment.
- An improved process for supporting and managing people waiting for appointments had been put in place; all long waiters were being written to advising them of the current position and anticipated future contact and support; those with high level needs were being offered support through Primary Care or access to Group programme; all new referrals were being written to advising them of current waiting times and anticipated dates for future contact and support, along with guidance around accessing other help and support in the interim
- New, easy to use, highly visible patient tracking lists had been developed and staff trained in how to use them
- Additional substantive staff had been recruited and put into training and agency staff had been deployed until substantive staff were trained.
- Staff productivity was already showing improvements
- Additional funding had been agreed with both commissioners, to address the need for increased capacity.

The Trust had presented its Improvement Plans to IST colleagues and Commissioners and these had been well received. Governance arrangements had been put in place for the CCG Governing Bodies, with a Project Board established to oversee the implementation of the Service Improvement Plan. The Delivery Committee would continue to provide scrutiny and assurance to the Trust Board. A report on progress in achieving the planned trajectories would be presented to the Committee monthly covering access rates, recovery rates, staffing, staff productivity and waiting times.

The Committee discussed broader learning from the IST findings for Trust services; there was a need to keep simplifying information in relation to service delivery and performance for clinical and managerial staff and to develop individual clinical staff/team reporting/team accounts. A programme of work was underway in relation to this. The need for training for managers in data analysis and interpretation was discussed. Greater scrutiny of waiting times across Trust services was also required and the Committee would receive a report on waiting times at the next meeting.

Risks: The Trust continues to underperform against IAPT targets, posing risks to the Trust's Governance rating from NHSI, provision of a quality service, contractual income and the Trust's reputation.
Assurance: Limited until the impact of Service Improvement Plans is clear.

UPDATE ON THE REVIEW OF SPECIALIST LEARNING DISABILITY SERVICES
The Committee received an update on progress with implementation of the 'Reshaping the Focus; Specialist Community Learning Disability Teams Action Plan'. This was signed off in January 2016 and included a number of key actions for the Trust to take forward jointly with Health and Social Care Commissioning colleagues. Since then the NHS Gloucestershire and County Council Learning Disability Joint Commissioning Team had commenced a team restructuring, which had led to a delay in some of the Commissioner led actions; however, areas which were the responsibility of 2gether were being progressed. Further discussions were taking place with Commissioners regarding the specification and outcome measures based on the Health Framework. The lack of progress was noted and the Committee asked that an update report on progress against the action plan be provided in October.

Risks: Delays to, and poor implementation of, plans for services has a negative impact on quality of service for patients and creates reputational damage to the Trust.
Assurance: Limited as Commissioner actions are not being progressed in a timely manner.

LOCALITY REVIEW
The Committee received a review of Herefordshire Services, with a focus on the workforce challenges and measures being taken to address these. A number of initiatives had been undertaken in order to

increase staffing in view of both the workforce profile and difficulties in recruitment. These included recruitment events in London and Bristol. An increase in the number of Herefordshire staff and students on the staff bank was also being sought.

The Committee noted that there were plans to manage CAMHS[2] as part of a Trust wide service merging CAMHS with CYPS from September and this would see a Service Director and Clinical Director manage services across the two counties.

The Committee noted the plans for Herefordshire services and their achievements over the past year.

Risks: Poor service performance impacts on quality of service and contractual income
Assurance: Significant overall, with limited assurance around workforce.

REPORT ON HR INDICATORS
A report was received focussing on current compliance figures for statutory and mandatory training, appraisal and sickness absence and the current position regarding workforce turnover.

These figures were not included in the Performance Dashboard in the latter part of 2015/16 whilst the accuracy of the data was explored alongside seeking improvements in recording, with the intention of improving managers' confidence in the data held in ESR[3]. Measures had now been put in place to address this and the Trust had implemented a new Training System called Learn2gether, which was being very positively received by staff. This new system would give managers access to real time data for their teams and would allow them to manage training compliance in their area of responsibility. Based on currently available figures there has been a slight increase in training compliance over the past year.

The Committee expressed some concern that there had been no increase in performance against appraisals, with the June 2016 figure 2% down on the same month last year. It was agreed that improved accuracy of data reporting would help; however, Service Directors were asked to discuss the issue with managers in their localities and to provide additional narrative on compliance in their next Locality Exceptions Reports. It was also agreed that this issue would be referred to the Executives Committee, as the target applied across the Trust.

The Committee noted that there was limited assurance in relation to meeting the Trust's 4% target for sickness absence, although there were plans in place to address sickness absence levels. It was reported that sickness absence due to 'stress and anxiety' was rising across the NHS. Work was being undertaken to triangulate the Trust's information on this in order to get a better understanding of the position and to be able to offer the appropriate support mechanisms.

Turnover remained broadly constant over the past two years and was lower than that reported by mental health trusts in the South West and across England. The Committee noted that the Trust excludes TUPE transfers and the Junior Doctor rotation from its figures and is aware that other trusts may compile their figures on a different basis.

Risks: Staff not undertaking statutory and mandatory training may be at greater risk of being involved in accidents or incidents and/or may place service users/carers at greater risk of not receiving a service of an acceptable standard. Failure to conduct appraisals risks de-motivating staff and creating non alignment with Trust plans. High sickness rates risk staff at work being under greater pressure with negative impact on motivation. Teams with high sickness rates use more agency staff with safety and financial risks.
Assurance: Limited as performance is still below Trust targets and further work is required to provide assurance that the new recording system will lead to improvements in rates of training and appraisal compliance.

[2] Child and Adolescent Mental Health Services
[3] Electronic Staff Records

ORGANISATIONAL DEVELOPMENT (OD) ANNUAL ASSURANCE STATEMENTS

The Committee was provided with assurances that the OD strategy and its underpinning action plan were being progressed. The content of the strategy was aligned to the Trust's three strategic objectives and was underpinned by the OD action plan. This was being monitored through and supported by the Workforce and OD sub-committee, reporting progress to the Executive Committee. The action plan had been progressed during 2015/16 and further work was being undertaken to address those actions not achieved in year one.

The OD action plan was interconnected with Staff Engagement, Training and Health and Wellbeing action plans, which were also received. Significant assurance was provided that these action plans had been developed with sufficient staff engagement, were monitored appropriately and that good progress had been made.

The Committee asked about progress in supporting staff to adapt to changes in working practices resulting from mobile working and the new working environment at the Gloucester hub and was informed that staff were being engaged with to raise awareness and seek their feedback on the changes, which was so far broadly positive, and a Project Board had been set up to consider what further support was required.

The actions and information on processes and actions contained within the report were noted; however, a request was made for more information on strategic direction and outcomes in the next report.

Risks: The Trust is unable to adapt and respond to external challenge and change as a result of OD plans not being fit for purpose or not being implemented in a timely way.
Assurance: Significant assurance that the action plans are aligned to Trust strategies and have appropriate monitoring and oversight; limited on being clear on the strategic outcomes the OD plan aims to deliver.

REVIEW OF DELIVERY RISKS

This report detailed all of the higher scoring risks on the Corporate Risk Register (risk score 12 and above) as at quarter 1 (2016/17) including those for which the Delivery Committee had specific oversight responsibility - Workforce - Specialist Skills/Retention /Succession Planning Risk and the new IAPT Services Risk which was a higher scoring risk with Limited Assurance.

The Committee was informed that in future the Executive Committee would receive the Risk report and would provide an assurance report to each Board Committee on the action being taken to mitigate risks.

Risks: That Service Delivery Risks are not being proactively identified and managed.
Assurance: Significant assurance that the process to identify risks is being reviewed and that actions to mitigate risks will be owned and reported on by the Executive Committee. Limited assurance in respect of those risks identified in the report.

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Charlotte Hitchings **ROLE: Committee Chair**

DATE: 27 July 2016

PAPER L3

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Delivery Committee

DATE OF COMMITTEE MEETING: 24 August 2016

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PERFORMANCE DASHBOARD OUTTURN REPORT

The Committee reviewed the Trust's performance against NHS Improvement (NHSI), Department of Health (DOH) and Contractual measures to the end of July 2016. Out of 141 indicators reportable for June, 74 were compliant and 11 non-compliant at the end of the reporting period. 1 indicator was under review. Seven of the non compliant indicators related to IAPT[1], now referred to as 'Let's Talk'. IAPT services were the subject of a separate report to the Committee (see below for commentary).

NHSI (formally Monitor)

- *IAPT Waiting times – Referral to Treatment within 6 weeks (Gloucestershire and Herefordshire):* performance of 38% against a threshold of 75%
- *IAPT Waiting times – Referral to Treatment within 18 weeks (Gloucestershire):* performance of 87% against a threshold of 95%

Gloucestershire CCG (GCCG) Contract

- *2gether NHS Foundation Trust bed occupancy for Gloucestershire CCG patients:* July performance was 90% against an expected threshold of over 91%. The drop in total number of occupied bed days was due to facilities work being carried out in Willow Ward during June and July. Compliance was expected in August.
- *Percentage of service users asked if they have a carer*
- *Percentage with a carer that have been offered a carer's assessment*: Compliance was still significantly below the 100% threshold for both these indicators. An audit had been carried looking at 10 random cases and found that 4 were compliant, 5 had identified carers but the information had not been recorded in the right place and in 1 case the team were working with the carer but the carer information had not been input into RiO. The aim was to meet the 100% compliance target by year end. The Committee asked for more information in the next report on actions being taken and expressed concern at the trajectory, asking the Service to assess whether earlier compliance could be achieved. An additional line would be included in the Performance Dashboard report to show the trajectory of expected performance against expected performance and a Service Performance Focus Report would be presented to the January meeting of the Delivery Committee.
- *IAPT Recovery rate:* performance of 47% against a 50% threshold
- *IAPT Access rate:* performance of 2.32% against a 5% threshold
- *IAPT integrated service – 14 days from referral to screening assessment:* performance of 64% against an 85% threshold

Herefordshire CCG (HCCG) Contract (excluding NHSI indicators included above)

- *IAPT Recovery rate – those who have completed treatment and have 'caseness':* performance of 48% against a threshold of 50%
- *IAPT maintain 15% of patients entering the service against prevalence:* performance of 496 (number) against a threshold of 726.

Risks: The Trust underperforms against statutory, contractual and Trust targets, posing risks to the provision of a quality service, contractual income and the Trust's reputation.

[1] Improving Access to Psychological Therapies

Assurance: Significant as the majority of indicators are compliant, limited on specific indicators not meeting required performance thresholds, in particular IAPT indicators.

IAPT (LET'S TALK) SERVICE IMPROVEMENT PLAN UPDATE

The Committee received the IAPT Service Improvement Plan which provided a comprehensive summary of the key issues relating to the progress made against IAPT Service Improvement Plans for both Gloucestershire and Herefordshire. An IAPT Project Delivery Team was now in place and met every two weeks to oversee the implementation of this comprehensive work programme. Commissioners in both Gloucestershire and Herefordshire had put in place specific monthly contract monitoring arrangements for IAPT services.

The recovery rate was currently fluctuating around the national target of 50% and remained a concern; however compliance was expected to be reached by year end. Improvements had been made to the waiting lists and long waiters had reduced. The Committee noted the targets for increasing the numbers of referrals in both counties. Capacity planning had factored this in and forecasts would be amended against referral rates. It was reported that the trajectory was likely to get worse before it improved due to the focus on long waiters.

The Committee noted this very detailed report and asked that it continue to be received monthly, with the addition of more information on waiting times, greater granularity of analysis on staff productivity and explanatory narrative in relation to the trajectory graphs. The Committee requested inclusion in the next report of the level of assurance being offered and details of the biggest risks affecting the service along with any mitigating actions.

Risks: The Trust continues to underperform against IAPT targets, posing risks to the Trust's Governance rating from NHSI, provision of a quality service, contractual income and the Trust's reputation.
Assurance: Limited until the impact of Service Improvement Plans is clear.

BENCHMARKING REPORT

The Committee received a report summarising the main points from the National Benchmarking 2016 activity submission for 2gether's Adult and Older Adult Mental Health Services. Further analysis was required on measures where Trust performance was outside the national mean or varied significantly from the 2014/15 submission, to understand whether variances reported indicated positive or negative performance. In addition a national piece of work was underway to provide guidance on interpretation of the findings. The Trust was in the lower quartile on Delayed Transfers of Care and the National Benchmarking team had noted that there may be different interpretations of national guidance relating to the recording of this measure. The Trust was therefore reviewing its measurement against the guidance to ensure consistency. Work to compare this year's results with those provided last year would be carried out and reported to the October meeting, along with an action plan for any improvement activity.

Risks: The Trust fails to understand its performance benchmarked against other Trusts and fails to make improvements, impacting on the provision of high quality services to patients.
Assurance: Significant that information is available for this understanding to be developed and that work is in progress to develop appropriate actions resulting from this.

LOCALITY EXCEPTION REPORTS

- Feedback regarding the new training system had been positive with easier access to training modules. It was hoped that the system would in future be able to provide information on local training compliance.
- Focussed work was being carried out to look at appraisal compliance across the localities and this had highlighted those teams where there were particular concerns.
- Focussed work was being undertaken to reduce the use of agency staff and significant improvements had been seen in Herefordshire with 60% agency usage versus 40% bank staff which was a move in the right direction. Regular reports on bank/agency usage were being looked at in

depth by the Governance and Executives Committees.
- The CAMHS[2]/CYPS[3] integration was moving forward and was now likely to be completed in October.

Risks: Poor service performance impacts on quality of service and contractual income
Assurance: Significant overall, with limited assurance around workforce.

INPATIENT COSTING REVIEW
The Committee received confirmation that adjustments had been made to inpatient budgets, in particular around the application of the vacancy factor and the level of sickness funding. The vacancy factor for all inpatient wards would be reduced to zero, with costs of this funded by increasing the vacancy factor for Community and Corporate services. Sickness funding would be increased from the current level of 4.5% to 6%. Costs for specialling and Complex Care had also been addressed as part of contract negotiations and budgets adjusted accordingly. Budget adjustments would be made retrospectively from 1st April and would be reflected from the month 6 reporting onwards.

Risks: Unrealistic budgets lead to de-motivation of services and inhibits the ability of management to have a true picture of financial performance and manage this appropriately.
Assurance: Significant as budgets have now been amended.

WORKING WELL ANNUAL ASSURANCE STATEMENT
The Committee received the Working Well assurance report. There was increased activity in some of the services provided internally, impacting on the ability to generate private income. In addition the Service continued to experience difficulty in recruiting and retaining staff, and had high levels of sickness absence. Although most of the initial work for SEQOHS[4] accreditation was completed within timescales the Service took the decision to defer accreditation until January 2017 due to other service pressures. Without SEQOHS accreditation Working Well was at risk of being unable to compete or retain government and other national supplier contracts. A report was to be presented to the Executive Committee in September on the costs of Occupational Health services and the ability of the Service to generate private income sustainably. The Committee requested advice from the Executive Committee following this report as to whether the Service was viewed as a cost centre to support the wellbeing of staff or as a business expected to generate a return on investment.

Risks: That the service does not achieve SEQOHS accreditation and so is unable to retain existing business or bid for government contracts, continues to experience staffing issues inhibiting the ability to gain private business to support financial performance, and is unable to generate a surplus to support an upgrade in accommodation.
Assurance: Limited on achieving SEQOHS accreditation in 2017 due to staffing recruitment, retention and sickness issues. Limited on financial performance.

CLINICAL SERVICES STRATEGY UPDATE
The Committee received an update on progress with implementation of the Trust's Clinical Services Strategy. Significant progress was reported in many areas, including; the Gloucestershire Autistic Spectrum service, health and well-being house development and personality disorders service development, which had been revisited to provide a more supportive service and will be established on a pilot basis initially. In Herefordshire the Community Hospital Liaison Service had been implemented, development of the CAHMs Hospital Liaison Services was agreed and work continued on the alignment/integration of Mental Health, Community Physical Health and GP services. Other areas of significant work in Gloucestershire included the development of Crisis Services and 24/7 Hospital Liaison services and the implementation of a full CYPS Hospital Liaison service; all of which had been affected by staffing issues. A number of issues around Learning Disability services were moving forward with agreed terms of reference and/or timeframes. IAPT remained a significant area of work in both counties as a range of service delivery and performance issues were addressed.

[2] Children and Adolescent Mental Health Services
[3] Children and Young People Services
[4] Safe, Effective, Quality Occupational Health Services

Risks: The Trust's Clinical Services Strategy is not implemented effectively, impacting on the ability of the Trust to achieve its strategic plan.
Assurance: Significant assurance that there has been considerable progress with the implementation of the Clinical Services Strategy. Limited with regard to staffing issues affecting some developments.

BED MANAGEMENT REPORT
The Committee was updated on the continuing work being undertaken to maintain an active overview of the acute care pathway functioning across the Trust. Average length of stay had reduced from 183 to 150 days as a result of focused work on Assertive Outreach admissions in Gloucestershire and revised bed management processes had resulted in movement of some of Gloucestershire's longest stay patients. However, bed occupancy remained at between 93% and 94% for both Gloucestershire and Herefordshire. Different models of Crisis Resolution & Home Treatment capacity meant an increased possibility of admission in Herefordshire compared to Gloucestershire. The report listed areas for further work and the Committee requested a report back in February on the conclusions and actions arising from this.

Risks: Poor management leads to inappropriate use of acute in-patient beds, reduced capacity for urgent care and/or increased out of county placements with negative impacts on quality of service and financial performance.
Assurance: Significant, in that actions are being taken to understand the pattern of bed usage across both counties and further reviews are planned to address issues identified.

CARBON REDUCTION STRATEGY AND SUSTAINABILITY REPORT
The Committee received an updated Sustainable Development Management Plan, which has become a contractual requirement, and the Trust's Annual Carbon Report, which would form part of the 2016/17 Annual Trust Report. Further progress had been made on the management of waste and the consequential greenhouse gas and environmental impact. Landfill had been virtually removed from Trust waste streams and recycling was now available throughout the Trust. Electricity data was not available for the report, due to poor performance by British Gas, the Trust's electricity supplier. British Gas was currently under contract review nationally in relation to their performance. The Committee asked that the Director of Finance and Commerce provide assurance at the next meeting that the British Gas contractual issues were being appropriately managed and had been escalated as necessary.

Risks: There are reputational risks from not achieving Carbon Reduction Targets and contractual risks from not having a Sustainable Development Management Plan and Carbon Report.
Assurance: Significant that progress is being made to achieve the Carbon Reduction Targets and that there a Sustainable Development Management Plan and Carbon Report is in place

LOCAL SECURITY MANAGEMENT UPDATE
The Committee received an update providing assurance on security related risks using the standards set out by NHS Protect. Although there was significant assurance that Violence and Aggression Policies and Procedures were in place there was limited assurance around their application within services. However, it was anticipated that this level of assurance would improve once risk assessments had been completed by individual teams, services and premises and checked by the Local Security Management Specialist (LSMS). Significant Assurance was provided regarding data accuracy for all security related incidents. The Committee noted that for some areas rated as 'green' within a report of assurance against NHS Protect standards a system was in place but there was no information to provide assurance that the system was being adhered to. The LSMS would be asked to provide further assurance on this in future reports, linked to the NHS Protect Standards, and the annual work plan for the LSMS team would be brought to the Committee for information.

Risks: Incidents are not identified promptly or accurate on Datix, or effectively evaluated so that mitigating action can be taken.
Assurance: Significant that all relevant security policies and procedures are in place and that all Security related Datix reports are accurate and correctly reported. Limited for violence and aggression, pending completion of departmental risk assessments and verification checks. Limited that policies and procedures are being put into practice at an operational level.

TECHNOLOGY STRATEGY IMPLEMENTATION

The Committee received an update on progress in implementing the Trust's Technology Strategy. Within Key theme 1; *supporting clinicians and operational managers in the delivery of high quality cost effective clinical services*; most development areas were progressing well. The "Improving care through Technology" programme was being rolled out across the Trust, with implementation for community services expected to be completed by December 2016. No significant progress had been made against Key theme 2; *Supporting service users in empowering them and their carers so that they are better informed about their health needs and can actively participate in self-management*; or Key Theme 3; *Supporting clinicians and service users so that we can improve the monitoring of a service user's health and well-being and deliver aspects of their direct care in different ways* as no affordable system/service had been identified to date. However, developments specific to supporting Armed Forces Veterans in Herefordshire had been progressed in partnership with Big White Wall under the military support programme which was centrally funded. The Committee noted that within Key theme 4; *Support the wider Trust Services in improving the efficiencies of our Corporate Systems*; considerable progress had been made with investments in additional corporate support systems which would feed into operational delivery reporting. The cultural change required to enable staff to achieve the benefits from proposed investments was a significant area of development and would be considered at an Executive Team summit in September/October.

Risks: The Trust's Technology Strategy is not implemented effectively, impacting on the ability of the Trust to achieve its strategic plan.
Assurance: Significant overall in that the Trust is progress the Technology Strategy, with some areas of challenge identified in the paper, where there is limited assurance.

QUALITY REPORT – REFERRAL FROM GOVERNANCE COMMITTEE

The Committee received a referral from the Governance Committee relating to quality indicators not achieving performance thresholds as reported in the Trust's Quality Report. The Director of Service Delivery would review these with Service Directors and consider a process for providing accurate assurance on progress in these areas for the Quality Report. A report would be made to the October Governance and Delivery Committees on actions being taken to address areas of under-performance and on ensuring a robust, joined up assurance process for the future.

Risks: That actions to meet Quality Report indicators are not identified and managed, with risks to the provision of a quality service to service users, and that there is no clear process for providing accurate assurance on this for inclusion in the Quality Report, with risk of reputational damage.
Assurance: Limited until further assurance is provided in October.

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Charlotte Hitchings **ROLE: Committee Chair**

DATE: 24 August 2016

2gether Making life better

2gether NHS Foundation Trust

PAPER L4

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Governance Committee

DATE OF COMMITTEE MEETING: 15th July 2016

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PATIENT SAFETY AND SERIOUS INCIDENT REPORT

4 new Serious Incidents (SIs) were reported for Gloucestershire during June 2016, there were no serious incidents reported for Herefordshire. There had been zero Never Events within Trust services and all required reports had been submitted within agreed timescales

The Committee noted that 13 SIs had been reported to Gloucestershire Commissioners this financial year and 1 in Herefordshire. No patterns had been identified.

AGGREGATED LEARNING REPORT

This update provided an analysis of data relating to incidents, audits and complaints and had been assessed to identify trends and common risks requiring action. An Aggregated Learning Group meeting was held in June 2016. Assurances were provided regarding progress in relation to the defined actions.

The group identified 2 new themes:

- That some service users on Recovery Team caseloads would benefit from low intensity psychological therapy, but were considered too "risky" to be accepted onto the IAPT caseload. Also, some service users receiving support from the Mental Health Intermediate Care Team caseload would benefit from accessing Complex Psychological Therapy but had not met the referral criteria. Action - The Committee agreed that a report on Access to Psychological Therapies would be brought to the Governance Committee.
- Service users are at times wishing to record their appointment with a clinician. It had been established that NHS Protect issued guidance regarding this in May 2016. The Group agreed that Local guidance would be developed and disseminated to all Localities to ensure that clinicians were aware of service user's rights.

The Committee discussed concerns around overt patient recordings and requested that a policy on recording of patient consultations be developed

SAFE STAFFING LEVEL REPORT

The Committee noted the Safe Staffing data for June 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.
- 96.8% of the hours exactly complied with the planned staffing levels.

The Committee noted that the staffing fill rates at this Trust were high; however these fill rates included the use of temporary staff which is also reported to the Committee on a regular basis.

Significant assurance is noted in respect of the Trusts duty to maintain safe staffing levels.

MEDICINES MANAGEMENT ANNUAL REPORT
The Committee received significant assurance that the appropriate medicine management arrangements were in place within the Trust.

Points to note included:

- The development of service specifications for the clinical pharmacy and supply services from Gloucestershire Hospitals NHS Foundation Trust and the Wye Valley NHS Trust. This had included an increase in clinical pharmacy input from 1 day per week to 5 days per week in Herefordshire
- All controlled drug discrepancies were investigated and reported to the Controlled Drugs Local Intelligence Network (CDLIN) and changes in practice were implemented to improve compliance with legislation and good practice
- That there is a challenge to achieving medicines savings following the introduction of newer more expensive drugs. There are only few branded to generic savings to be made and any savings will need to be made through prudent prescribing
- The Committee also noted that there had been a 30% rise in medicines expenditure in Gloucestershire Inpatients. Further work will be undertaken to understand this.

JUNIOR DOCTOR CONTRACT
The Medical Director reported that the proposed national contract for junior doctors was rejected by 52% of the Junior Doctors who voted. An updated report would be taken to the Trust Board at the end of July. It was agreed that this issue will be reviewed at each Governance meeting until resolved.

BREACHES OF UNDER 18 ADMISSION INDICATOR DURING 2015/16
There is an expectation that young people under the age of 18 should not be admitted to a general adult mental health unit and that they should be admitted to a specialist provider appropriate to their age and needs. However specialist facilities are not currently available nationwide to meet the needs for the growing number of young people and it is at times necessary to admit in an emergency to an adult ward within the Trust. This paper considered the care during such admissions.

The Committee received assurance that the Trust had complied with Trust guidance and that admissions had been safe, timely and appropriate. The Committee requested audit results to ensure full compliance with Trust guidelines.

LOCALITY GOVERNANCE BRIEFINGS
A) Gloucestershire and Gloucestershire Countywide Localities
Significant assurance was given that the Gloucestershire Localities had reviewed the arrangements for the Clozaril service across all the community teams.

Risks included:

- 3 risks on the Gloucestershire Localities risk register: Staffing Compliment for One Stop Teams, Ligature Assessments at Albion Chambers and Burleigh House and increasing complexity of patients in MHICT.
- 3 risks on the Countywide risk register; Recruitment and Retention, Cuts to Social Services Funding and High Bed Occupancy, over 85%, Complex Discharges and Bed

Management.

B) Children and Young People's Services (CYPS)

Key highlights in CYPS:

- The Committee noted that a joint CYPS Gloucestershire/Children and Adolescent Mental Health Services (Hereford) steering group had been set up to oversee the alignment of Hereford CAMHS and the Gloucestershire CYPS
- Clinicians from Gloucestershire CYPS and Hereford CAMHS undertook a 5 day training course in the Autism Diagnostic Observation Schedule (ADOS2) and the fully ratified Transition of Care policy for 17.5 year olds had now been disseminated throughout the service.

Currently the top risks were; CYPS performance measures, inability to document indirect recording of consultation activity on RiO, non-compliance regarding RiO record keeping standards and the increased likelihood of admissions of Under 18's to Wotton Lawn Hospital due to lack of timely access to adolescent psychiatric units.

C) Herefordshire

Key highlights in the last month in the Herefordshire locality.

- The Committee noted that a report would be presented to the Executive Committee regarding options for enhancing single sex compliance through en-suite facilities within Stonebow
- Following a range of initiatives a large number of applications for bank Health Care Assistants in Hereford had been received, a further bank recruitment event would take place. A temporary post had been appointed to take forward the planned Herefordshire staff bank hub.
- The positive Herefordshire Clinical Commissioning Group assurance visit which had taken place at Oak House
- That a new project was being launched for Herefordshire to offer annualised salaries for a number of student nurses with the agreement that they work a set number of shifts on the bank. Student nurses in their second year of training would now be able to apply for future posts likely to occur at the time of their qualification.

Risks on the Herefordshire Risk Register continue to be recruitment and cleaning at the Stonebow Unit. Weekly cleaning inspections were now taking place to ensure previous problems did not re-emerge.

ASSESMENT AND CARE MANAGEMENT PROCESSES

The Committee received an audit measuring compliance against the Trust's Assessment and Care Management (ACM) Policy. This provided a 'snap shot' of the levels of compliance as of 5th July 2016 and focused on the quantitative aspects of recording within the clinical record across both counties. The Committee noted that 77% of people in secondary care now had contingency plans which had risen from 33%. Despite significant improvement compliance is still below the expected standard. A 'Task and Finish Group' had been set up to explore the recommendations made in previous audits and to develop new initiatives aimed at supporting clinical staff to improve population of the clinical record.

The Committee agreed that there was limited assurance around compliance but

significant assurance around the process and developments in place to take this forward.

LIBRARY SERVICE ANNUAL REPORT

This Annual report provided the Committee with a summary of library service activity for the year 2015 – 2016 for 2gether NHS Trust and Gloucestershire Care Services NHS Trust. Health Education England (HEE) has a Learning and Development contract with Every NHS Trust; this ensures that library services are provided for staff and students on Placement, supporting education, training and lifelong learning

The Committee was assured around 2gether's compliance with the NHS Library Quality Assurance Framework (LQAF). The Committee noted that Trusts had to evidence 90% compliance; 2gether's current level of compliance was 96%

The Committee noted that the Library Service was trying hard to support staff in the furthest parts of Gloucestershire and Herefordshire; however there was still no dedicated library provision in Herefordshire. The Committee requested a report on access to the Library Service in Herefordshire to include the key issues, mitigation and proposed developments. The Committee also asked that work be undertaken to widen awareness of the Library Service throughout the Trust and making people aware of the benefits of having access to this service.

ACTIONS REQUIRED BY THE BOARD

That the Board notes the content of this report

SUMMARY PREPARED BY: Martin Freeman **ROLE: Committee Chair**

DATE: 15th July 2016

2gether Making life better

2gether NHS Foundation Trust

BOARD COMMITTEE SUMMARY SHEET

PAPER L5

NAME OF COMMITTEE: Governance Committee

DATE OF COMMITTEE MEETING: 19 August 2016

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PATIENT SAFETY/SERIOUS INCIDENT UPDATE JULY 2016

One new Serious Incident (SI) was reported for Herefordshire during July 2016, there were no serious incidents reported for Gloucestershire. There had been zero Never Events occurring within Trust services and all required reports had been submitted within agreed timescales.

The Committee noted that there had been an increase in suspected suicides which was in line with the national trend. 2gether had reported 12 incidents (suspected suicides) concerning persons who were not in contact with Trust services. In terms of investigation reporting, the Committee received significant assurance that the processes were robust.

The Committee received the serious incident action plans, noting that there were 12 Amber actions remaining open and an additional 3 Red actions overdue from the 2015/16 plan. There were no actions overdue in the 2016/17 plan.

DATIX PROGRESS REPORT

The Committee were informed that 4 of the 7 Datix Modules had now been successfully implemented. A Datix User Group was in place and people were happy with the progress made to date.

SAFE STAFFING LEVELS REPORT

The Committee noted the Safe Staffing data for July 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

Significant assurance was received regarding the provision of safe staffing levels within 2Gether NHS FT.

An update was also given regarding the Trust's target to reduce the proportion of shifts and resulting spend with agency staff. There are currently 22 actions with regards to nursing agency reduction. These include:

- Satellite staff bank set up in Herefordshire
- 19 newly recruited registered nurses commencing in post in August/Sept
- Student /practitioner programme to commence in September across Herefordshire and Gloucestershire

The next report to Governance Committee in 3 months will be extended to include plans for reducing agency costs in respect of medical and allied health professional cover.

INFECTION CONTROL ANNUAL REPORT

Dr Philippa Moore presented the Infection Control Annual Report 2015/16. The Trust remains compliant with the Health and Social Care Act: Code of Practice for Health and Adult Social Care on the prevention and control of infections and related guidance (The Hygiene Code). The risks for healthcare associated infection remain low in the Trust.

Some of the key highlights within the report included:

- During 2015/16 there were no MRSA bacteraemias detected from patients in Gloucestershire or Herefordshire and no reportable cases of C. difficile.
- There were 2 outbreaks of diarrhoeal illness requiring ward closure reported to the Gloucestershire infection prevention and control team, one proven and one likely to be due to Norovirus. Strict infection prevention and control measures were put in place**.** There were no outbreaks in 2gether Herefordshire sites during 2015/16.
- Hand hygiene is considered the most important part of preventing healthcare associated infections. Audits are performed quarterly and reported 6 monthly. During 2015/16 the overall compliance was maintained at 96%, similar to 2014/15.
- During 2015/16 infection control education continued to be delivered principally by e-learning; however, mandatory training has remained an issue and is now being addressed with additional face to face training sessions with 2gether staff trained to deliver the sessions

The Committee agreed that this report demonstrated significant assurance that the Trust is committed to providing high standards of infection control across all its services.

SAFEGUARDING ADULTS AND CHILDREN UPDATE

This report provided an update of safeguarding activity in the Trust during Quarter 1. Significant assurance was noted regarding safeguarding activity within the Trust. Assurance remains limited however, regarding compliance in safeguarding training.

It was agreed that a further report would be presented back to the Committee in September clearly setting out the actions in place to address the problems highlighted within the report in respect of training.

MEDICAL PROFESSION QUARTERLY AND ANNUAL REPORTS

Doctors continued to submit their appraisals via the Strengthened Appraisal and Revalidation Database (SARD) and there was evidence of increased registration on the system with 100% online appraisal engagement.

Compliance with appraisal was 82.4% with 17.6% shown as non-compliant. These figures included those doctors who were unable, at the present time, to complete appraisal for other reasons such as being absent from work, maternity leave etc. Once those that were non-compliant with an accepted reason were taken into account, 8% were non-compliant and compliance was therefore 92%.

The Committee noted that the system that 2gether used was very robust and had been held up as an area of good practice. Significant assurance is offered in respect of medical appraisal within the Trust.

The Governance Committee accepted and endorsed the Medical Appraisal Annual Report and the significant assurance that this provided.

NHS Claims Quarterly Report
The purpose of this paper was to provide summary details of the quarterly review of clinical and non-clinical claims. As part of a financial review, it provides information around the Trust's 2016/17 contributions to the Schemes and how the NHS Litigation Authority rate the Trust's claims profile.

The Committee received significant assurance that these claims were generally managed and processed in an effective manner working in conjunction with the NHS Litigation Authority with the Trust meeting all legal requirements and protocols under the Rules of the CNST (Clinical) and RPST (Non-clinical) Schemes.

The Committee noted that although the number of claims had not increased the review of a historical claim had resulted in a revised valuation sufficient to adversely affect the Trust's contribution.

Risk Register Quarter 1 Update
The Committee reviewed the higher scoring risks for which Governance Committee has oversight responsibility:

- Agency spend control - (ID 116) – New
- Crisis Contingency / Relapse Plans - (ID 20)
- Violence and Aggression - (Risk ID 13)
- Trust Reporting (Datix) - (Risk ID 38)

The Committee received Significant assurance that these are currently being reviewed as a part of the Committees work plan,

Clinical Audit Plan Update
The Trust's performance against the Audit Programme 2016-2017 (including audits carried over from 2015-2016) was currently:

- Audits completed in line with 2016/2017 programme = 27 (18%)
- Audits progressing as per 2016/2017 programme = 30 (20%)
- Audits running behind schedule but with evidence of progress = 23 (15%)
- Audits running behind plan with no evidence of progress = 0 (0%)
- Number of audits not yet due to be started = 52 (34%)
- Number of audits taken off the programme = 19 (13%)

The Committee was presented with the number of completed audits to date on the 2016–17 audit programme (between 1st May 2016 – 5th August 2016), with RAG ratings of Green (6), Amber (6) and Red (13).

The Committee reviewed those audits graded as red to ensure action plans were in place and subject to timetabled update at the Committee. The Committee noted that the individual audits were discussed at Locality level.

It was agreed that in future the Governance Committee would receive an assurance statement on the progress/status of audits via the localities or the Governance sub-Committee rather than receiving the full detail.

Significant assurance is noted regarding the progress of the audit plan and Locality review of recommended action plans.

Care Quality Commission (CQC) Update
This paper provided a summary of the work undertaken towards achieving full compliance with the CQC requirements made as a result of the 2015 inspection. The latest plan showed that from the original 15 "Must do" actions 9 were now complete and from the original 58 "Should do" actions 28 were now complete. The high level action plan has been submitted to the CQC to provide assurance that all issues identified have already been, or will be rectified within identified timescales. This report therefore provided significant assurance that the Trust was meeting the standards expected of the organisation by the CQC.

An assurance visit was undertaken by Herefordshire Clinical Commissioning Group to Oak House. No immediate areas of concern were identified and made 5 recommendations for improvement were made.

Quality Report – Quarter 2 2016/17
The Committee received the first quarterly review of the Quality Report priorities for 2016/17.

The report showed the progress made towards achieving targets, objectives and initiatives identified in the Annual Quality Report. Overall, there was currently limited assurance that the majority of targets would be met. 3 of the 11 targets were being achieved with a further 3 being rated "amber" and 5 not achieved.

The Committee expressed concern about this quarter 1 report. Insufficient information was included within the report on the measures in place to address the areas of non-compliance. It was agreed that these concerns would be referred to the Delivery Committee, asking for assurance that those indicators such as discharge planning and Care Plan Approach reviews were being appropriately addressed by the Localities.

Cost Improvement Plans and Quality Impact Assessments
Quarterly reporting of the Cost Improvement Programme (CIP) savings and Quality Impact Assessment (QIA) process was put in place in response to the Well Led Governance Review 2015. The objective of the report was to provide assurance that the CIP and QIA governance process was effective.

Quality of care underpins the Trust's values and therefore all savings schemes require an authorised Quality Impact Assessment (QIA) which details the potential quality risks and mitigating actions. The Medical Director and the Directors of Quality, Finance, and Engagement & Integration authorise each QIA.

Significant assurance was noted that the process for CIA and QIA are being implemented within the Trust.

Centralised Recruitment Update
The Governance Committee received a report on the 15th July which provided assurance regarding the management of delays occurring since the implementation of a centralised recruitment process. The Committee had previously requested regarding changes to address these delays.
This report offered the following assurances:

- Significant assurance is provided that an IT solution has been found which will provide managers with the access they need to view the recruitment tracker.

However, this may be a short to medium term solution and a more robust longer term solution would be preferable.

- Significant assurance is provided that the pre-employment processes as now managed through the HR Operations Team have reduced from a variable eight to twelve weeks to an average of five weeks. This is against a target set of six weeks.
- Significant assurance is provided that the process for DBS (Disclosure and Barring Service) checks is managed in line with the Trust policy, that DBS checks are undertaken for all new staff, and for staff who move internally within the Trust or take up additional Trust employment, where the DBS is either more than 6 months old or a different level of DBS check is required.
- Work on making the Recruitment tracker available to managers was underway and it was hoped that a system would be in place by the end of September.

ACTIONS REQUIRED BY THE BOARD

That the Board note the content of this report

SUMMARY PREPARED BY: Martin Freeman **ROLE: Committee Chair**

DATE: 19th August 2016

Agenda item 19 **Paper M**

Report to: Trust Board, 29 September 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**
If not, explain why	

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

1. PURPOSE, ASSURANCE AND RECOMENDATION

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

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

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

2. CHAIR'S KEY ACTIVITIES

- Chairing ²gether NHS FT's Annual General Meeting in Cheltenham
- Chairing a Board meeting in Gloucester
- Attending the Gloucestershire Strategic Forum in Brockworth
- Teleconferencing with the chair of South Western Ambulance Service NHS Foundation Trust
- Meeting with a Non-Executive Director and the Director of Human Resources from Gloucestershire Hospitals NHS Foundation Trust to discuss their Trust Chair appointment

- Participating in the recruitment of the appointment of the Chief Executive Officer for Gloucestershire Care Services NHS Trust
- Participating in a Wye Valley NHS Trust Board development teleconference
- Attending the South West NHS Chairs meeting in Taunton
- Attending the opening of ²gether NHS FT's new Fritchie Research Centre at Charlton Lane
- Liaising with the Matron of Laurel House about a recent governors' visit
- Meeting with the Lead Governor
- Meeting with the Director of Integration and Engagement
- Meeting with a newly elected Governor
- Participating in an Induction Session for newly elected Governors
- Meeting with the Director of Organisational Development
- Meeting with a Non-Executive Director
- Attending an informal meeting with Non-Executive Directors
- Participating in an Executive Director's appraisal
- Meeting with the new Head of Communications
- Conducting three 6 monthly review with three individual Governors
- Attending a Gloucestershire Constabulary Aston Project Stakeholder meeting in Cheltenham
- Accepting a donation on behalf of ²gether NHS FT's charitable funds from the Chelsea Building Society at their branch in Cheltenham
- Attending a meeting with BBC Hereford and Worcester in Worcester
- Attending the National Star College Leaver's Awards Ceremony in Ullenwood
- Attending the Kingfisher Children's Summer Activity Week at Kingfisher Church in Gloucester
- Meeting with the MP for Cheltenham in Cheltenham
- Being interviewed by BBC Radio Gloucestershire
- Attending a Bishop's Breakfast meeting in Gloucester

- 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;

- Prepared for and attended a July Board meeting
- Prepared for and participated in Audit Committee meeting
- Attended formal opening of the Fritchie Centre for research
- Attended a 1:1 meeting with Chair
- Attended a 1:1 meeting with Director of Quality
- A member of interview panel for a Mental Health Act Manager
- Panel member of Mental Health Act hearing
- Prepared for and chaired two Governance Committees
- Attended Board Visit of PICU
- Attended Mental Health Act Managers Forum
- Prepared for and chaired Mental Health Legislation Scrutiny Committee
- Prepared for and chaired a Delivery Committee

Charlotte Hitchings

Since her last report Charlotte Hitchings has;

- Prepared for and attended the July Board meeting
- Prepared for and chaired the August Delivery Committee
- Prepared for and attended the August Audit Committee
- Attended the opening of the Fritchie Centre in Cheltenham
- Participated in a Board Visit to the Crisis Home Treatment Team in Gloucester
- Participated in a Board Visit to Herefordshire IAPT services
- Participated in a stakeholder group as part of the process to recruit an Independent Chair for the Gloucestershire STP
- Attended an induction session for new Governors
- Prepared for and chaired the September Council of Governors meeting
- Briefed the Lead Governor following the Delivery Committee to discuss the forthcoming holding to account session on IAPT services
- Participated in a Board conference call
- Attended a Chair's lunch with other non executive directors

Jonathan Vickers

Since his last report Jonathan Vickers has;

- prepared for and attended a board meeting
- prepared for and chaired a meeting of the development committee
- sat on 2 MHAM panels
- prepared for and attended a Council meeting
- prepared for and attended a meeting of the MHAM forum

Nikki Richardson

Since her last report Nikki has;

- Preparation for and attendance at Trust Board
- Meeting with Clinical Director CYP Services

- Preparation for and attendance at Audit Committee
- Attendance at the opening of the Fritchie Centre
- Meeting re Charitable Funds Committees
- Board visit to Herefordshire IAPT Services
- Telephone call with Hereford Community Collaborative Co-Chair
- Meeting with Hereford CCG Lay NED
- Preparation for and Chairing of Hereford Community Care Collaborative
- Preparation for and Attendance at Governance Committee
- Meeting with Chair of Gloucestershire Healthwatch
- Preparation for and attendance at Delivery Committee
- Attendance at Chair/NED meeting
- Attendance at presentation re NZ Alliance model (GCCG)
- Attendance at MHAM hearing
- Visit to Trust Information Service
- Preparation for and attendance at Council of Governors
- Attendance at MHAM Forum
- Preparation for and attendance at Governance Committee
- Preparation for and attendance at MHLS Committee
- Telephone conference with NEDs/CEO

Marcia Gallagher

Since her last report Marcia has;

- Met with Director of Operations as part of Non -Executive Director induction process
- Prepared for and chaired an Audit Committee
- Second and third observations of Mental Health Act Managers hearings at Stroud and Gloucester
- Member of Mental Health Act Managers hearing in Gloucester
- Attended Council of Governors meeting
- Evaluated Audit Tenders
- Chaired and attended Audit tender presentation panel
- Pre Board meeting with Director of Finance
- Visit to Fritchie Centre, Charlton Lane re managing memory/Dementia
- Teleconferencing re CEO Board briefing
- Prepared for and attended September Board meeting

Duncan Sutherland

Since his last report Duncan has;

- Prepared for and attended a Board meeting
- Prepared for and attended a New Highways Committee meeting
- Prepared for and attended a Charitable Funds Committee meeting
- Attended a Council of Governors meeting

Quinton Quayle

Since his last report Quinton has;

- Prepared for and attended a Board meeting
- Met with the Chief Executive
- Prepared for and attended a meeting of the Audit Committee
- Attended the Opening of the Fritchie Centre
- Had separate meetings with each member of the Executive team
- Had a briefing on the Mental Health Act
- Met the Matron of Charlton Lane and visited the ward

- Met the Matron of Honeybourne and visited the ward
- Prepared for and attended a meeting of the Delivery Committee
- Prepared for and attended a meeting of the Council of Governors
- Prepared for and attended a meeting of the Mental Act Forum
- Met the Service Director for Herefordshire in Herefordshire
- Met the Matron of Stonebow, Hereford and visited the ward
- Prepared for and attended a meeting of the Mental Health Legislation Scrutiny Committee
- Attended a one-day staff induction course

4. OTHER MATTERS TO REPORT

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

[2]GETHER NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING
THURSDAY 14 JULY 2016
BUSINESS CONTINUITY ROOM, RIKENEL, GLOUCESTER

PRESENT:

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

IN ATTENDANCE: Marie Crofts, Director of Quality
Martin Freeman, Non-Executive Director
Marcia Gallagher, Non-Executive Director
Anna Hilditch, Assistant Trust Secretary
Charlotte Hitchings, Non-Executive Director
John McIlveen, Trust Secretary
Bren McInerney, Member of the Public
Nikki Richardson, Non-Executive Director
Carol Sparks, Director of Organisational Development

1. WELCOMES AND APOLOGIES

1.1 Apologies for the meeting were received from Amjad Uppal and Simon Hairsnape. Jennifer Thomson did not attend the meeting. Apologies were also received from Shaun Clee, Chief Executive.

1.2 The Council noted that the recent round of Governor elections had been very successful, with a number of new appointments made from 1 July. Ruth FitzJohn welcomed the newly appointed Governors to the meeting. These were:
Richard Butt-Evans (Public, Tewkesbury)
Mervyn Dawe (Public, Stroud)
Ann Elias (Public, Stroud)
Hilary Bowen (Public, Forest)
Dee Drinan (Public, Cotswolds)
Said Hansdot (Public, Gloucester)
Dr Tristan Lench (Appointed, Gloucestershire CCG)

It was noted that a half day induction session for all new Governors had been arranged for 25 August.

2. DECLARATION OF INTERESTS

2.1 There were no changes in the declaration of interests.

3. COUNCIL OF GOVERNOR MINUTES

3.1 The minutes of the Council meeting held on 24 May were agreed as a correct record.

4. MATTERS ARISING, ACTION POINTS AND EVALUATION FORM

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

4.2 Ruth FitzJohn informed the Council that a briefing paper on the current position with IAPT services had been produced; however, due to the late receipt of this, she was reluctant to take the item at this meeting as Governors would not have had sufficient time to read and digest the content. It was therefore proposed that the briefing be circulated to Governors and an item would be scheduled for the September meeting to discuss this in more depth, as part of the Holding to Account session.

ACTION: IAPT Report to be scheduled for the September meeting, as part of the Holding to Account session

4.3 Al Thomas asked whether it would be possible to ensure that the presentations and key reference documents from the Council meetings were uploaded onto the Governor Portal within a few days of the meeting.

ACTION: Items from Council meetings to be uploaded in a timely manner to the Governor Portal

4.4 The Council was asked to note that the action from the previous meeting in relation to reviewing the fields within the Membership Application form would be carried forward to December. The Trust had appointed a new Head of Communications who would be commencing in post on 1 August and part of his role would be to carry out a full review of membership materials. This was agreed and would be revisited in November.

ACTION: Review of the Membership Application form to be carried forward to the November meeting.

4.5 The Council of Governors asked that the Trust make more effort to remove the use of jargon, acronyms and abbreviations within its key documents. Ruth FitzJohn said that she would ensure that all contributors to Council meetings were reminded of the need to use plain English within communications and reports. It was noted that a "Dictionary of NHS Terms and Abbreviations" was available to download via the Governor Portal, and hard copies were made available at the meeting.

4.6 The Council reviewed the collated Evaluation form which had been completed by those people in attendance at the last meeting. The feedback overall had been positive and it was agreed that the evaluation forms would continue to be used. An amendment to the form would be made at Question 14, to change the wording into a positive response, rather than a negative.

ACTION: Question 14 on the Council Meetings Evaluation form to be reworded

4.7 A discussion took place about the timing of items on the agenda for Council meetings, with some Governors expressing concern that no time was allocated for Any Other Business. Ruth FitzJohn said that she would normally expect people to advise her in advance of the meetings if they wished to raise any additional business and the agenda reflected this; however, it was acknowledged that Governors often discussed a number of important matters at their pre-meeting which they collectively wished to have raised. It was therefore agreed that future Council agendas would ensure that 10 minutes was allocated where items already discussed and agreed at the Governor pre-meetings could be raised by the Lead Governor.

ACTION: Future agendas to allocate 10 minutes for items to be raised following the Governor pre-meeting

4.8 Paul Toleman said that he had spoken to someone at the last Council meeting about the Alzheimer's Action Group and had sent some further information. However, he could not remember who this was sent to.

5. NHS BENCHMARKING (PRESENTATION)

5.1 Steve Moore, the Trust's Head of Information and Clinical Systems was in attendance to present the Council with an overview of NHS Benchmarking. A copy of the presentation would be uploaded onto the Governor portal.

5.2 The Benchmarking Network is the in-house benchmarking service of the NHS. The Network works with over 340 members to understand the wide variation in demand, capacity and outcomes evident within the NHS and define what 'good' looks like. This supports providers in delivering optimal services within resource constraints, whilst also allowing commissioners to achieve the best balance from available commissioning resources.

5.3 2gether submits information to the Network on an annual basis and Steve advised that the 2014/15 submission was the first time that the Trust had submitted data for Gloucestershire, Herefordshire and Trustwide. The 2015/16 data submission was due later this month.

5.4 The Governors were presented with some examples of the data received from the Network, including benchmarks around Bed Occupancy, Serious Incident rates, Lengths of Stay and Patient Experience scores.

5.5 Rob Blagden asked about the level of information around Performance that the Governors should be sighted on and how assurance could be gained that those 'outliers' were identified and actions put in place to address these. Charlotte Hitchings, Chair of the Delivery Committee said that the NHS Benchmarking exercise was an annual activity and the full report was received at that Committee for scrutiny. She advised that the Committee would review the results and would identify keys areas of focus where further detailed reports would be prepared. The Council of Governors was assured that 2gether carried out monthly scrutiny of its national and local target indicators via the Performance Dashboard.

5.6 Roger Wilson said that he had found this to be a helpful and welcome report and suggested that this information should be shared with the Health Overview and Scrutiny Committee at the Local Authority. He expressed concern however around the timescales and delay in receiving this information, noting that the Council was just receiving the outcome of the 2014/15 submission, at the same time that the 2015/16 submission was being completed. Roger also highlighted a number of terms within the presentation that were unfamiliar to Governors such as the use of 'clusters' and he asked that this be considered in future. Roger noted the benchmark within the presentation around Delayed Transfers of Care (DToC), with 2gether reporting performance at 0.4% against the mean of 4.7%. He said that DToC was a huge issue in Gloucestershire and would therefore like to understand this data further. It was agreed that a short briefing paper would be produced for the Governors on DToC.

ACTION: Briefing paper on the current Delayed Transfers of Care position to be produced and circulated to Governors for information

5.7 Al Thomas said that once the Governor observation process at the Board Committees was underway it would help people understand the performance measures better and help in seeing how these were received and scrutinised, in particular by the Delivery Committee. Al Thomas noted that overall the Trust's outcomes from the benchmarking demonstrated a good level of performance; however, he asked that those areas highlighted as 'outliers' be expanded to state whether they were positive or negative in future reports to make this clear to Governors.

5.8 The Governors thanked Steve for attending and presenting. It was agreed that it would be helpful to receive a similar presentation on an annual basis, and this would be scheduled in to the work plan.

ACTION: NHS Benchmarking presentation to be scheduled annually for Governor information

6. CHIEF EXECUTIVE'S REPORT

6.1 The Chief Executive's report to the Council of Governors is intended to draw Governors' attention to key areas for awareness, information or for exploring further if of sufficient interest. Marie Crofts presented this report to the Council in the absence of the Chief Executive.

6.2 The Council was asked to note that this had been a very busy time for the Trust; with members of the Trust Board and Executive Team being focussed during June and July on service delivery and the continued production of the STPs in both Gloucestershire and Herefordshire. Rob Blagden, on behalf of the Council, asked that given the importance of the STP process, a standing agenda item be added for a verbal update at each future meeting. This was agreed.

ACTION: Standing agenda item for a verbal STP update to be included from September onwards

6.3 Cherry Newton asked for more information about One Herefordshire and what this was. Marie Crofts advised that this was the collective name given to all

providers and stakeholders who were coming together to develop services in Herefordshire. It was agreed that it would be helpful to provide a short briefing for Governors on the development and work of One Herefordshire.

ACTION: Short briefing to be provided for Governors on the developments and work of One Herefordshire

7. NON-EXECUTIVE DIRECTOR RECRUITMENT

7.1 The purpose of this report was to update the Council of Governors on the appointment of Non-Executive Directors.

7.2 The Council will be aware that Quinton Quayle was recently appointed as a Non-Executive Director and commenced on 1st June 2016. Through that recruitment process, a second appointable candidate was identified and alongside this, the Nominations and Remuneration Committee noted that Charlotte Hitching's term of office would cease at the end of February 2017. As part of planning ahead, a proposal was put to the Council that the second candidate would be approached with a view to accepting a deferred start date, to ensure continuity of appointments to the Board. This action was progressed and the candidate – Maria Bond, accepted a deferred start date in 2017.

7.3 Separately and since the last Council of Governors meeting, Martin Freeman has confirmed that he wishes to resign before the formal end date of his term of office and has agreed he will finish at the end of October 2016. The Trust therefore took the opportunity to renegotiate a start date with Maria Bond who has agreed to take up her appointment commencing 1st November 2016. Forward planning has enabled the Trust to have a smooth transition and continuity of Non-Executive Director appointments.

7.4 The revised schedule of appointments consequently leaves the Trust with a requirement to recruit a further Non-Executive Director to replace Charlotte Hitchings from the end of February 2017. As part of planning ahead, a recruitment timetable is currently being developed with a view to this being considered by the Nominations and Remuneration Committee in the early autumn. This will enable an appointment to be made in good time for the end of February 2017.

7.5 The Council of Governors collectively expressed their sadness at Martin Freeman's decision to resign, thanking him for all of his work and contributions. He would be sorely missed.

7.6 Roger Wilson noted that the Trust would have a number of Non-Executive Directors ending their terms at the same time and asked whether the Trust tried to stagger these appointments. Ruth FitzJohn said that the Trust tried to fill vacant NED posts as and when these arose and in advance where possible; however, it was difficult to control when these vacancies would come up, with not all NEDs ending their terms at the stated date. She informed the Council however that this had not proved problematic thus far, but would of course continue to be monitored.

7.7 Mervyn Dawe asked where the Trust found its NED candidates from. It was noted that 2gether used an external search agency and would provide them with the necessary information about required skills and experience. The agency would then go out and speak to networks of people and seek candidates on the Trust's behalf. Assurance was given that the external search agency had been appointed following a cross county procurement exercise and used by other Trusts in Gloucestershire.

7.8 The Council of Governors were offered an opportunity to receive training for those Governors who wished to be involved in future NED recruitment processes. Dawn Lewis, Richard Butt-Evans, Mervyn Dawe, Katie Clark and Al Thomas asked to be considered for this training session, which would be facilitated by the Trust in-house training team.

7.9 The Council of Governors noted Martin Freeman's resignation from 31 October, and the appointment of Maria Bond from 1 November.

8. JOINT BOARD AND GOVERNOR DEVELOPMENT PROGRAMME UPDATE

8.1 This report provided an update on the joint Board/Governor development programme, and on implementation of the recommendations agreed at the last and earlier Council meetings.

8.2 The Team Charter group's work has been completed and was agreed at the May Council of Governors meeting. The Council agreed at that meeting to allow the Team Charter and associated documents time to become embedded, and to review the Team Charter in 2017. The Charter is circulated with every set of papers for Council of Governor meetings, and evaluation forms are now in use at every Council of Governors meeting.

8.3 The Governor role description has also been completed and the output agreed by the May Council. The role description has been posted to the Trust website, is circulated with Council of Governor papers, and was issued to prospective Governors alongside nomination forms during the latest Governor elections. The role description will be reviewed every 2 years to ensure it remains fit for purpose.

8.4 The proposals from the Working Collaboratively Together group agreed by the last Council of Governors meeting, have now been put in place, and a revised process for Holding To Account has been implemented. This process comprises Governor observation of Board Committees, a separate meeting of Governor observers, and the relevant Committee Chair and Lead Executive to discuss a particular topic, and then formally relay the assurance received back to the Council at the Holding To Account agenda item. The first cycle of this process culminates at this meeting where the topic for the Holding to Account agenda item has already been discussed at the Governance Committee with Governors observing the meeting, and subsequently at a separate session to enable those Governors to provide assurance to the Council today. Arrangements are in hand to replicate this process with regard to the Chair of the Delivery Committee ahead of the next formal Holding to Account session at the September meeting of the Council. Governors were asked to put themselves forward to take part in the Delivery Committee observation process. Rob Blagden and Dee Drinan

volunteered and contact would be made with the Committee Chair, Charlotte Hitchings in advance of the July meeting.

8.5 A full induction programme would be taking place for those new Governors joining the Council as a result of the elections in July. The date was now confirmed as Thursday 25 August at 2.00 – 5.00pm. Arrangements and content of the session was under development and a draft agenda would be shared with all Council members once this was confirmed. All Governors would be invited to attend the session.

ACTION: Details of Governor induction session on 25 August to be circulated to all Governors for information

9. GOVERNORS' CODE OF CONDUCT

9.1 The Code of Conduct for Governors was agreed in June 2013 and is therefore due for review. At its last meeting the Council agreed that a revised draft should be produced for review and agreement by the Council. That draft, which had also been reviewed by the Lead Governor prior to today's meeting, was received. Key points relating to the draft Code of Conduct are:

- The revised Code of Conduct has been shortened significantly compared to the existing version.
- The Governor Role Description which formed part of the original document, and which has itself been replaced by an updated version which was agreed by the Council in March, has been removed from the Code of Conduct.
- The Code of Conduct has been written in a 'first person' style, and includes as its final page an annual declaration which Governors will be asked to complete
- The Code of Conduct has been written so as to complement the Team Charter agreed by the Council and the Board in March, and references the 'Signposting' document agreed as part of the Team Charter.
- The Nolan Standards in Public Life remain prominent within the Code of Conduct.
- Currently the only sanction available to the Council in dealing with a breach of the Code of Conduct is to terminate the tenure of the Governor concerned. The revised Code of Conduct refers to a more proportionate response including warnings and temporary suspension. Should the Code of Conduct be approved, the Council will need to determine a mechanism for investigation of any alleged breach in order to determine whether any such sanctions should be applied.

9.2 The Council agreed that the draft Code of Conduct was a very good starting point; however, a request was made for more information to be included on the process for appealing decisions relating to breaches of the Code and the sanctions.

9.3 The Trust Secretary would revise the Code of Conduct accordingly, in liaison with Rob Blagden as the Lead Governor, and present a final version back to the Council in September for approval.

ACTION: John McIlveen to revise the draft Code of Conduct as per comments received and present a final version back to the Council in September for approval

10. FORMAL RECEIPT OF THE ANNUAL REPORT 2015/16

10.1 The Council of Governors were asked to note that the Trust's Annual Report 2015/16 had now been laid before Parliament and printed copies were made available for Governors at the meeting.

11. HOLDING TO ACCOUNT – CONTINUALLY IMPROVING QUALITY

11.1 Martin Freeman and Marie Crofts gave the Council a presentation focussing on Continuous Quality Improvement – learning following the CQC comprehensive inspection.

11.2 Marie Crofts provided an overview of the inspection process, including the results, those areas identified for improvement and the process for ensuring that progress against the actions was monitored. The Council noted that of the 15 "Must Do" actions arising from the inspection, 2gether had completed 9 of these and the remaining 6 had significant assurance. Out of the 58 "Should Do" actions, 27 had been completed and the remaining 26 had significant assurance.

11.3 Martin Freeman outlined the process that was carried out to hold the Board and Executive Directors to account on quality issues, and in particular the outcome of the CQC Inspection.

11.4 The Council thanked Martin and Marie for this very thorough and helpful presentation. The presentation would be uploaded onto the Governor portal.

11.5 Paul Toleman asked whether the Trust had a Risk Management Strategy. Martin Freeman said that it did and that the Trust had a very robust system in place for managing risk, with the Board carrying out annual development sessions on risk and risk appetite.

11.6 Rob Blagden firstly acknowledged the really good CQC report. He made reference to the "Must Do" and "Should Do" actions arising from the inspection, and noted that these were actions that the CQC had picked up that 2gether had not previously identified. Martin Freeman said that a number of areas picked up related to work that was ongoing in the Trust and changes were already being made. Martin added that the CQC inspection involved some 80 inspectors who saw different things which was really helpful and enabled lots of immediate changes to be made.

11.7 Hilary Bowen asked whether 2gether was sharing the learning from the inspection with other organisations. Martin Freeman said that 2gether was a member of a number of different networks and groups which fed learning into both commissioners and other provider organisations.

11.8 Cherry Newton asked whether Non-Executive Directors ever carried out unplanned visits to Trust sites, as well as those that people were made aware of in advance. Martin Freeman said that members of the Board could visit Trust

units at any time. Ruth FitzJohn informed the Council that she had carried out an unplanned visit to Wotton Lawn at midnight on Christmas Day last year. Carrying out unplanned visits gave Board members a real insight into the workings of a unit, as team members were not "prepared" for the visit.

12. MEMBERSHIP REPORT

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

12.2 Al Thomas informed the Council that he had met with Communication Team colleagues and fellow Cheltenham Governor Vic Godding to start making arrangements for a Membership Event in Cheltenham. Further details would be shared in the next report.

13. GOVERNOR ACTIVITY

13.1 Vic Godding and Rob Blagden had participated in the Governor visit to Honeybourne, Laurel House and the Brownhill Centre, Cheltenham earlier in the week. Vic said that he thought the visit had been excellent and encouraged all Governors to think about attending future visits. It was agreed that the visiting schedule for the remainder of 2016 would be circulated again to all Governors.

ACTION: Schedule of dates for Governor inpatient visits to be circulated to all Governors

13.2 Katie Clark had participated in the Governor visit in June to the Charlton Lane Centre. She said that she was very impressed and it had been really helpful for her as a member of staff to go out and see the Trust's services in action.

13.3 Jenny Bartlett informed the Council that the Dementia Action Alliance Group in Leominster was now up and running and she would be happy to share information with any interested Governors.

14. ANY OTHER BUSINESS

14.1 In relation to the STP, a question was raised as to whether there would be any impact on the Council of Governors, particularly in relation to county boundaries or responsibilities. It was agreed that this would be picked up and more information provided to Governors as part of the standing agenda item on STPs commencing at the next meeting.

15. DATE OF NEXT MEETING

Business Continuity Room, Trust HQ, Rikenel		
Date	**Governor Pre-meeting**	**Council Meeting**
2016		
Tuesday 13 September	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 10 November	1.30 – 2.30pm	3.00 – 5.00pm

Council of Governors – Action Points

Item	Action	Lead	Progress
24 May 2016			
4.3	MOU with Wye Valley to be shared with Governors once the necessary communications with staff in both Trusts had been carried out	Colin Merker	**Ongoing** Arrangements for staff briefings still in consultation with Wye Valley. Verbal update at the Sept meeting
14 July 2016			
4.2	IAPT Report to be scheduled for the September meeting, as part of the Holding to Account session	Anna Hilditch	**Complete**
4.3	Items from Council meetings to be uploaded in a timely manner to the Governor Portal	Anna Hilditch	**Complete**
4.4	Review of the Membership Application form to be carried forward to the November meeting.	Head of Communications	**Ongoing** Scheduled for November
4.6	Question 14 on the Council Meetings Evaluation form to be reworded	Anna Hilditch	**Complete**
4.7	Future agendas to allocate 10 minutes for items to be raised following the Governor pre-meeting	Anna Hilditch	**Complete**
5.6	Briefing paper on the current Delayed Transfers of Care position to be produced and circulated to Governors for information	Colin Merker	Verbal update at September meeting
5.8	NHS Benchmarking presentation to be scheduled annually for Governor information	Anna Hilditch	**Complete**
6.2	Standing agenda item for a verbal STP update to be included from September onwards	Anna Hilditch	**Complete**
6.3	Short briefing to be provided for Governors on the developments and work of One Herefordshire	Shaun Clee	Verbal update at September meeting
8.5	Details of Governor induction session on 25 August to be circulated to all Governors for information	Anna Hilditch	**Complete**
9.3	John McIlveen to revise the draft Code of Conduct as per comments received and present a final version back to the Council in September for approval	John McIlveen	**Complete** On agenda for the September meeting
13.1	Schedule of dates for Governor inpatient visits to be circulated to all Governors	Anna Hilditch	**Complete** Circulated again with the draft minutes from July