2gether NHS Foundation Trust
Gloucestershire Care Services NHS Trust

Meeting in Common of the Trust Boards

Thursday, 26th September 2019 - 10:00 am – 1:00 pm
Forest Hills Golf Club, Mile End Road, Coleford GL16 7QD

Agenda

		GENERAL BUSINESS	PRESENTER	PURPOSE
10:00	1.	**Apologies for Absence and Confirmation the Meeting is Quorate**	Joint Chair	To note
	2.	**Declarations of Interest** To receive any declaration of interest from Board members in relation to items on the agenda.	Joint Chair	To note
	3.	**Service User Story**	Director of Engagement and Integration / Deputy Director of Nursing	To note
	4.	**Minutes of the previous Joint Board Meetings -** Held on 25th July 2019 **– 2g & GCS**	Joint Chair	For Approval
	5.	**Matters Arising/ Action Log** **Matters arising not covered by other items on the agenda 2g & GCS**	Joint Chair	To note
	6.	**Questions from the Public**	Joint Chair	To note
		LEADERSHIP & STRATEGY		
10:30	7.	**2g -** Annual Review Risk Register	Director of Quality	To note
	8.	**Chair's Report**	Joint Chair	To note and approve
	9.	**Chief Executive and Executive Team Report**	Joint Chief Executive Officer	To note
	10.	**One Gloucestershire - Integrated Care System Update**	Joint Chief Executive Officer	To note
	11.	**Medical Director – Annual Report and Revalidation update**	Medical Director	To note and approve
	12.	**Interim People Plan** (NHS E/I)	Director of HR & OD	To note and approve
		REPORTS FROM COMMITTEES*		
	13.	**Quality and Performance Committee update**	Director of Nursing/ Committee Chair	To note
	14.	**Service Experience**	Director of Engagement and	To note

			Integration	
	15.	**Resources Committee update – GCS**	Committee Chair	To note
	16.	**Governance Committee – 2g** Governance Committee Update NED Audit of Complaints Learning from Deaths Q1 Guardian of Safe Working Report Q1 Quality Report	 Maria Bond Sumita Hutchison Medical Director Medical Director Director of Quality	To note
	17.	**Delivery Committee Update - 2g**	Committee Chair	To note
	18.	**Audit and Risk Assurance Committee update - GCS** **Audit Committee Update – 2g** **Audit Committee Annual report 2018/19 – 2g**	Committee Chair Interim Trust Secretary	To note
Monitoring Reports				
	19.	**Financial Report** **2g & GCS**	Director of Finance	To note
	20.	**Performance Dashboard – 2g**	Chief Operating Officer	To note
	21.	**Quality and Performance Report – GCS**	Director of Nursing	To note
	22.	**6 Monthly Safe Staffing**	Director of Quality	To note
	23.	**Winter Plan**	Director of Service Delivery	To note
FOR INFORMATION*				
	24.	**Governance update - Use of the seal** 2g & GCS	Interim Trust Secretary	To note
OTHER ITEMS*				
	25.	**Any Other Business**	Chair	To note
	26.	**Chair's Closing Remarks**		

Date of Next Meeting

- GHC, 28th November 2019

Lunch 1-2pm

* These items will be discussed where a Committee has highlighted issues to be escalated to the Board or where a Director advises the Chair and Trust Secretary that they wish to raise an item which has been discussed within a Committee.

Quorum:

GCS: 4 Directors, including two Executive Directors and two Non-Executive Directors, one of whom must be the Chair or Vice Chair

2g: One-third of the whole number of the Chair and Directors (including at least one Executive Director and one Non-Executive Director)

Agenda Item 10

Governing Body

Meeting Date	**Thursday 26th September 2019**
Report Title	**Integrated Care System (ICS) Lead's Update**
Executive Summary	This report provides an update on Gloucestershire Integrated Care System. The report provides an insight into the progress being made in the ICS transformation programmes against the system vision and priorities.
Key Issues	This report provides focus in the main programme areas; • Enabling Active Communities; • Reducing Clinical Variation; • One Place, One Budget, One System • Clinical Programme Groups.
Risk Issues: **Original Risk (CxL)** **Residual Risk (CxL)**	ICS programme risks are regularly reported to ICS Executive as a standing item. Further consideration is being given to the development of a view of system-wide risk.
Management of Conflicts of Interest	N/A
Financial Impact	N/A
Legal Issues (including NHS Constitution)	N/A
Impact on Health Inequalities	The report supports the effort to reduce health inequalities
Impact on Equality and Diversity	The report positively impacts on improving equality and diversity
Impact on Sustainable Development	N/A

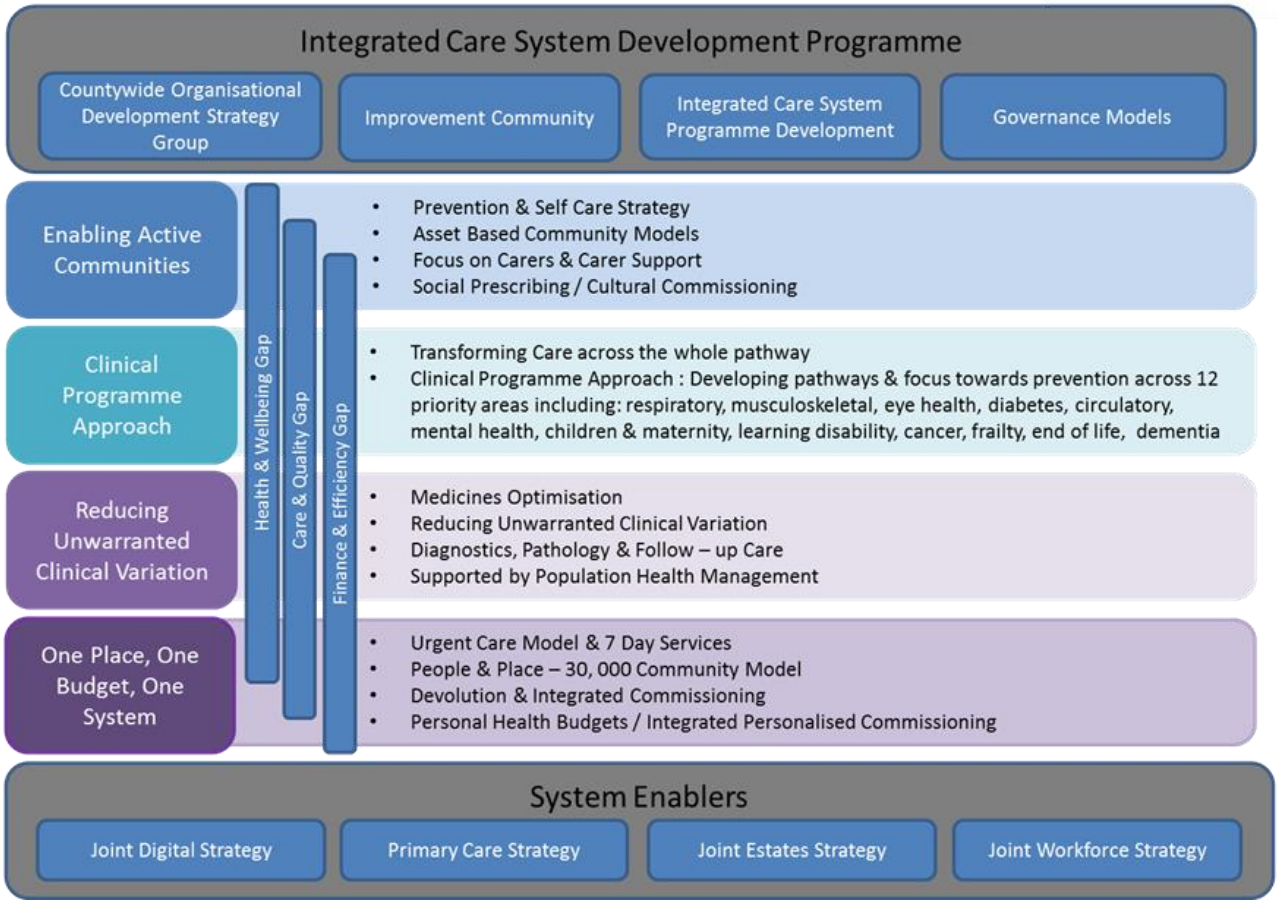
Patient and Public Involvement	The report considers the matters of public engagement and is also submitted to the Health and Care Overview and Scrutiny Committee.
Recommendation	Governing Body/Board members are asked to note the content of the report.
Author	Emily Beardshall: Deputy ICS Programme Director
Sponsoring Director (if not author)	Ellen Rule: Director of Transformation & Service Redesign

One Gloucestershire Integrated Care System Lead Report – September 2019

1. Introduction

The following report provides an update to Board members on the progress of key programme and projects across Gloucestershire's Integrated Care System (ICS) to date.

Gloucestershire's Sustainability & Transformation Plan commenced year three of four in April 2019 continuing priorities against the central transformation programmes with refreshed delivery plans in place that will transition the system into delivering against the Long Term Plan. In this report we provide an update on 2019/20 plans and the progress made against the priority delivery programmes and supporting enabling programmes included within the One Gloucestershire Integrated Care System.



Gloucestershire's ICS Plan on a page

2. Enabling Active Communities

The Enabling Active Communities programme looks to build a new sense of personal responsibility and improved independence for health, supporting community capacity and working with the voluntary and community sector.

The development of the Gloucestershire Prevention and Shared Care Plan, led by Public Health, aims to reduce the health and wellbeing gap and recognises that more systematic prevention is critical in order to reduce the overall burden of disease in the population and maintain financial sustainability in our system.

Key priorities for 2019/20 will align to the refreshed Health & Wellbeing Strategy and are split across the 4 main workstreams: supporting pathways, supporting people, supporting places and communities and supporting our workforce.

Supporting Pathways

- The provider of the **Tier 2 Child weight management service** is in a steady phase of co-production with the focus on planning and delivery of focus groups with 57 families have identified interest in focus group participation.
- The **Blue Light change resistant drinkers** project is currently, working with 16 active clients. Alcohol Concern has run a training event for Change Grow Live (CGL) Gloucestershire Drug and Alcohol Service preparation for the Cheltenham expansion.

Supporting People

- The **Early identification of domestic abuse** pilot project that was due to end on 30th June 2019 has identified further funding. The service will be commissioned by Gloucestershire County Council through the Gloucestershire Framework for Domestic Abuse.
- The **Breathe in Sing out** programme delivered by the charity Mindsong was featured on the ITN regional news recently. Mindsong also held a celebration event on 23rd July in which all 6 respiratory singing groups across the county participated. They were joined by a similar group called Singing for Wellness from Devon.
- Children, clinicians and artists from the **Flying High** programme took part in the Gloucester Carnival on 13th July. The Flying High programme offers children and young people with Type 1 diabetes an arts based programme to increase self-management of their physical and emotional wellbeing. The programme includes circus, dance and other arts based activities

Supporting Places & Communities

- The **Community Wellbeing Service** is demonstrating positive impact for individuals and communities, with emerging positive impact on the health system.
- **Gloucestershire Moves Programme Update:**
    - **Special Olympics Gloucestershire** and inclusive activity opportunities were presented at the Learning Disability Partnership Board. The presentation was co-delivered by an athlete representative who participated in an inclusive sports competition at the 2019 Big Health Check and Social Care Open Day
    - A strength and balance network event has been held as part of the **Falls** project. Community groups are starting to receive booklets and talks and the website is now live.
    - 3 Schools have positively engaged with the **Girls Active** project. Active Gloucestershire have offered support to the schools to be a part of a wider promotional event in the autumn.
    - A total of 80,336 miles have been recorded during **Beat The Street** launched in June 2019.

Supporting Workforce

- **Workplace Health and Wellbeing:** The workplace wellbeing newsletter is now reaching an audience of 720 people. Engagement activities across Gloucestershire continue, with 2 new workplaces having initial meetings in Stroud and Tetbury.

3. Clinical Programme Approach

The Clinical Programme Approach has been adopted across our local health care system to ensure a collaborative approach to systematically redesign the way care is delivered in our system, by reorganising care pathways and delivery systems to deliver right care, in the right place, at the right time. During 2019/20 we have identified 4 clinical programmes for acceleration with faster paced work with Integrated Locality Partnerships. These Clinical Programmes are Respiratory, Diabetes, Circulatory and Frailty & Dementia.

Respiratory

The Respiratory CPG has made strong progress with integration, initially concentrating on the Chronic Obstructive Pulmonary Disease (COPD) pathway. A COPD self-management plan has been developed and will be tested in primary and community care from August.

Skills development for the Respiratory workforce is current focus. Spirometry training places are fully allocated and due to be completed by September 2019 which will mean patients will be able to access spirometry tests much more widely.

The Sleep Apnoea pathway has made some really positive changes which has enabled a significant reduction in the number of patients waiting to be seen. The pathway is now compliant with the standard for seeing patients within 18 weeks of referral and also has a 4 week pathway for HGV drivers and other high risk occupations.

A focus will be placed on prevention in 2019/20 including smoking cessation, the use of pulmonary rehabilitation and links with local communities

Diabetes

The CCG has been selected as an early implementer site to use the HeLP online tool for people with type 2 diabetes. The new offer will mean people with type 2 diabetes have evidence-based information and support available at the touch of a button, via an online portal, giving them convenient and quick help to deal with the physical and mental challenges of diabetes.

The resource will make the right advice available from home, work or on the move, helping people manage their health and wellbeing independently, potentially preventing the need for extra medical attention or the condition becoming worse. Trials of the online package showed people making use of the online courses and information reduced their blood glucose levels, a crucial part of managing type 2 diabetes.

At least 15 children with Type 1 Diabetes are now using Continuous Glucose Monitoring (CGM) which should support greater control of the condition.

The GP Clinical Champion has commenced virtual clinics with practices to provide an opportunity to discuss 10 complex patients and agree a management plan for the next year. Diabetes Nurse Specialists will also take part in these virtual clinics to support achieving treatment standards.

Engagement with practices remains high with over 65.3% signed up to the 2019-20 Diabetes Charter.

Over 301 patients enrolled onto the KiActiv programme to date. User feedback demonstrates improvement to mental health as well as physical health outcomes. Some of the additional benefits identified as reduction in fatigue, improved sleep patterns, increased social interaction and connection with others.

The number of patients attending the NHS Diabetes Prevention Programme continues to increase with 3300 patients having attended this programme aimed at supporting those at high risk of developing diabetes with behaviour change and reducing their risk.

A draft 10 Year Diabetes Strategy has been produced and is being reviewed by stakeholders.

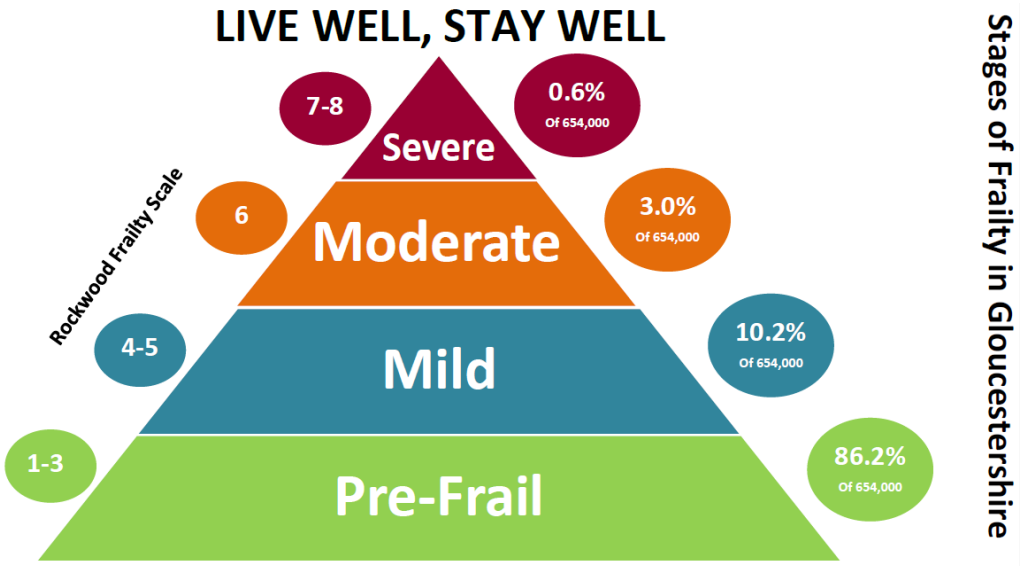
Circulatory

- The Cardio Vascular Disease (CVD) prevention work has been well aligned with NHS Long Term Plan priorities
- The Atrial Fibrillation (AF) pathway has been finalised and published to all GPs.
- The Nature on Prescription project with Gloucestershire Wildlife Trust started 22nd July in Gloucester and the Forest of Dean. Discussions surrounding trying to increase referrals have taken place
- An evaluation workshop to look at the successes and challenges of the first 8 months of the Stroke Rehabilitation Unit has been arranged for September and will result in a short interim report
- A training event for the detection if hypertension (high blood pressure) has been arranged for the end of August with an increased focus for voluntary organisations along with the community.

Frailty & Dementia

Work is underway to agree a **Frailty Strategy** for Gloucestershire. As part of the Frailty Strategy, the Frailty CPG will develop and agree a core set of requirements for PCN based frailty services. The Frailty Clinical Programme Group, inclusive of stakeholders from across health and social care, has agreed a clinical and patient definition for frailty. The aim of the programme is 'Gloucestershire recognises and values positive ageing and has an integrated approach to frailty through early identification, personalised care and support planning'.

The articulation of the programme is shown in the diagram below, underpinned by the 4 assumptions:



Assumption 1: People want to age well and slow the progression of frailty whilst staying independent and living in their preferred place of residence

Assumption 2: People want to feel supported

Assumption 3: People do not want to be admitted to hospital if it could be avoided. Once in hospital people want to return to their preferred place of residence as soon as possible

Assumption 4: People want to die well, having been involved in decisions about their death and in their preferred place

Focus on Adult Social Care Employment for People with Learning Disabilities

There is excellent work going on with the Learning Disability and Autism CPG alongside Gloucestershire County Council to support people in finding and sustaining employment. We have included some case studies to show the benefit of this work.

Community Placement

- B is a young man who has a learning disability and attends the Apperley Centre in Stonehouse.
- He was supported by a Community Placement Broker started in January 2019, his ambition was to gain voluntary work involving sport.
- A taster session was arranged at Wheels for All in Gloucester to compliment his love of physical activity and his sporting abilities.
- This resulted in a regular weekly placement
- Quickly the 1:1 support that had been arranged became unnecessary and B was able to support the event independently.
- The placement has been really positive for both Wheels for All who now have a highly motivated, valued and capable regular volunteer and for B whose independence, skills, and confidence have all been positively impacted by the experience which he hopes to continue long term.

Forwards

- J is blind and supported by a blind dog. She had been employed in the banking industry for 22 years. She contacted Forwards when she was put at risk of redundancy.
- She has always worked and was worried about finding another job which could utilise her skills, accommodate the adjustments to the work place, including support from a blind dog, and which would enable her to continue her career.
- J was interested in working in a medical environment and applied for a role as a medical audio typist. J was successful at interview and secured a permanent role with providing audio transcriptions support services
- The role uses J's experience and skills and with some reasonable adjustments which including some equipment funded by DWP's Access to Work Scheme J is quickly settling in to the role and is already making an impact.

4. Reducing Clinical Variation

The Reducing Clinical Variation programme looks to elevate key issues of clinical variation to system level and have a new joined up conversation with the public around some of the harder priority decisions we will need to make. This includes building on the variation approach with primary care, promoting 'Choosing Wisely' and a Medicines Optimisation approach, undertaking a diagnostics review and working to optimise Outpatient services.

Key priorities for 2019/20 are

- We will make continued use of the successful Prescribing Improvement Plan (PIP) to ensure the early in-year savings, and subsequent in-year benefit for as much of the year as possible. Actions include working with GP practices via the prescribing support team to identify and record beneficial changes to prescribing activity.
- We will continue to work with secondary care colleagues to consider areas for mutual benefit within medication choice and supply routes.
- Continued inclusion of Medicines Optimisation topics within the annual Primary Care offer to support primary care colleagues to maximise efficiencies available from appropriate prescribing
- Continue the successful provision of the Clinical Pharmacist team working within many GP practices by recruiting to fill current vacancies.
- Implement a two year programme Medicines Optimisation in Care Homes (MOCH) scheme, specifically in residential homes.
- Develop and improve mechanisms to allow GPs to access specialist opinion/advice and guidance.
- Develop appropriate alternatives to secondary care outpatient services where there are opportunities to manage patients in a less specialist and lower cost setting.
- Support transformation in the outpatient approach across the system.
- Strengthen our approach to commissioning thresholds through changes and developments to the CCGs Effective Clinical Commissioning Policies list.
- Develop stronger secondary care gatekeeping functions through effective referral triage/management processes.
- Undertake a review of diagnostic provision across the system to support transformational programmes.

What we've achieved so far:

- Work within the practices is progressing towards achievement of the **2019-2020** Prescribing Savings target through the updated Prescribing Improvement Plan and Primary Care Offer which have been merged for the first time this year.
- Our team of Prescribing Support Pharmacists (PSPs), Prescribing Support Technicians (PSTs) and Clinical Pharmacists (CPs) are working to continue to interact with their allocated practices and provide support to achieve the allocated prescribing savings to individual practices.
- Agreement reached with the dermatology department to move ahead with a pilot of Cinapsis as an alternative advice and guidance platform alongside the 2 Week Wait triage project.
- Referrals into the new Ear Nose and Throat (ENT) community service have been increasing during, with volumes expected to increase further as new clinic sites are opened in August. The introduction of video consultations for osteoporosis follow up appointments through the Attend Anywhere platform is being developed.
- Outpatient service transformation is focusing on 5 key workstreams at Gloucestershire Hospitals with the intent to roll-out improvements. The focus specialties are dermatology, diabetes, neurology rheumatology alongside booking functions and patient communications.
- A Diagnostic Programme plan has been drafted which draws together the plans for the development of a diagnostic strategy, regional plans for imaging and pathology networks, the implications of the Long Term Plan and links to other diagnostic programmes. Point of Care Testing is an early focus to support quick testing in community settings preventing patients having to travel for tests. All 5 point of care testing pilot sites have now been trained and have

equipment assigned with a total of 145 patients having had tests through this initiative. Early indications suggest this is supporting a high proportion of patients being given appropriate care without the need to attend A&E for further tests.

5. One Place, One Budget, One System

New Models of Care & Place Based Model

The One Place, One Budget, One System programme takes a place based approach to resources and ensures we deliver best value. Our community care redesign will ensure responsive community based care is delivered through a transformative system approach to health and social care.

The intention is to enable people in Gloucestershire to be more self-supporting and less dependent on health and social care services, living in healthy communities, benefitting from strong networks of community support and being able to access high quality care when needed. New locality led 'Models of Care' pilots commenced in 2016/17 to 'test and learn' from their implementation and outcomes, working across organisational boundaries, and leading to the formation of 16 locality clusters across the county.

Key priorities for 2019/20 are

- Operational and Strategic partnership of senior leaders of health and social care providers and locally elected government and lay representatives informing and supporting integration at Primary Care Network (PCN) level, unlocking issues and sharing responsibility for finding local solutions to deliver ICS priorities and tackling issues which arise for their population which can only be resolved collectively.
- Clinically-led integration, involving staff and local people in decisions, to support more people in the community and out of hospital.
- Integrated Locality Partnerships (ILP) Plan to deliver defined population strategy including prevention and public health, with aligned priorities agreed to improve outcomes.
- Develop multidisciplinary workforce models which will operate at PCN level.

What we've achieved so far:

- Integrated Locality Partnerships (ILPs) have now commenced in all geographical areas.
- Primary Care Networks have confirmed their boundaries and Clinical Directors have been appointed.
- The first Public Health and CCG jointly hosted Place development session took place in July.. Over 100 people from across the county benefited from hearing how Population Health Management aided patients in Leeds. Delegates then spent the later part of the afternoon understanding data specific to their local areas and using the new Integrated Locality Reporting tool to support the groups to focus on what matters most to their population.
- The South Cotswolds Frailty Team are working with the community to develop 'Live Well, Stay Well' Café's. There will be support and facilitation alongside local people to help set up and run the café's. The café's will be a place that communities, both urban and rural, can come together socially to provide a common purpose and be a resource of support and information about services and support available for those in need. They will be accessible to all ages and offering skills exchanges
- The Frailty Clinical Programme Group (CPG) and Palliative Care specialists are working together to explore End Of Life in frailty and how or if this differs from end of life more generally and the impact this has on decision making and care planning.

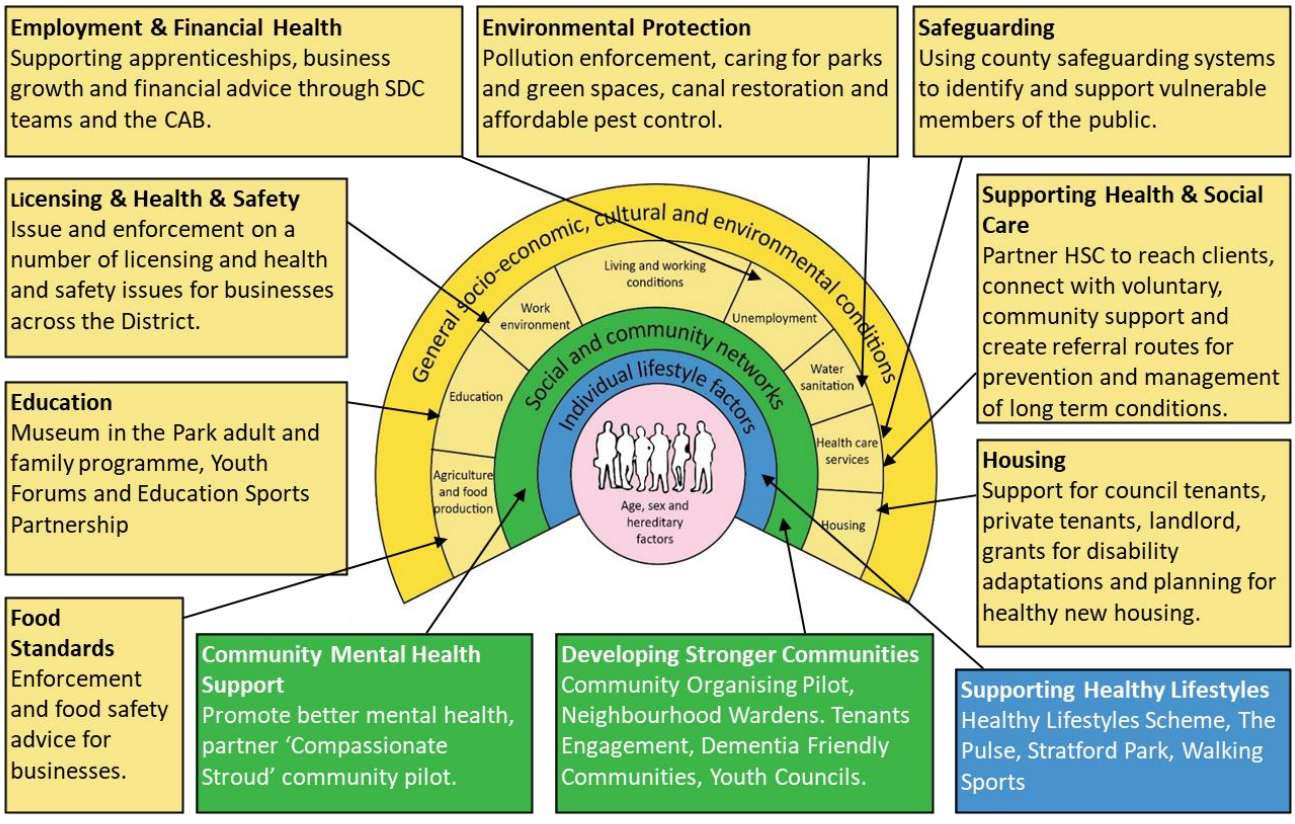
Focus on Stroud District Council Health and Wellbeing Plan 2019-2022

Stroud District Council's Health and Wellbeing planned is based on population health data, local information and the District Council's statutory duties. The following Health & Wellbeing issues have been prioritised.

- Priority 1. Supporting Healthy Lifestyles
- Priority 2. Developing Stronger Communities
- Priority 3. Improving Housing
- Priority 4. Protecting the Public and our Environment
- Priority 5. Partnering the Statutory, Voluntary and Community Sectors

Work on these priorities is supporting health and wellbeing across the community in the following ways,

Examples of what SDC do now for Health and Wellbeing.



The Wider Determinants of Health – Dahlgren & Whitehead 1991

Here is an example of how Stroud District Council have been local with Local NHS Partners with regards to referral pathways into Better Balance Classes:

Jim

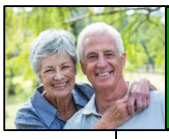
Hospital Physio Referral
Jim had a fall at home and went to hospital, he was referred to the Falls Team

Physio refers Jim to Better Balance Classes

Maria

GP Referral
Maria hasn't fallen but is having some balance issues. Maria asks her GP if there is anything she can do to help her balance.

GP refers Maria to the Better Balance team.



Doris & Dave

Self Referral
Doris has been referred by her GP to attend the classes but her husband Dave would like to attend as well.

Dave completes his own referral form and sends it to the Better Balance team.

Better Balance team check suitability of each referral form.

Once approved, Jim, Maria and Dave come to their nearest **Better Balance Class**!

5. One Place, One Budget, One System

Fit For The Future

Our vision for Urgent Care will deliver the right care for patients, when they need it. In order to make this vision a reality and provide safe and sustainable services into the future, we need to consider how to make best use our resources, facilities and beds in hospitals and in the community.

We want to improve arrangements for patients to access timely and senior clinical decision making about their treatment and ensure specialist support is accessed as soon as possible. We propose potentially changing the way some care and support is organised in Gloucestershire to meet changing demands, make best use of our staff, their skills and the money we have.

Regular updates on the One Place Programme have been shared with HOSC, describing how the programme aims to deliver an integrated urgent care system and hospital centres of excellence to ensure we realise the vision for urgent care a further update on progress is given at the July meeting in addition to this paper.

Our key deliverables for 2019/20 include;

- Continue to develop and refine the “One Place” strategy focussing upon development of same day urgent care services, Centres of Excellence and Integrated Urgent Care (Clinical Advice and Assessment Service).
- To further develop and deliver schemes identified within the Emergency Department attendance, admission avoidance programme and length of stay management (overseen by the Urgent and Emergency Care Alliance).
- To further develop and deliver schemes identified within the improving system flow programme which will reduce bed occupancy of long stay patients by 25%:
- To further develop and deliver schemes identified within the Community Admission Prevention programme.
- To further develop and deliver schemes identified within the Find and Prevent programme.

6. Enabling Programmes

Our vision is underpinned by our enabling programmes which are working to ensure that the system has the right capacity and capability to deliver on the clinical priorities.

Joint IT Strategy: Local Digital Roadmap - The draft ICS Digital Strategy is in development and workshops have been held to define the priorities. Cyber security action plans have been consolidated. The latest Primary Care data shows Gloucestershire has 25.27% of patients registered for patient facing services such as online booking. All practices have enabled patient online services with some practices achieving in excess of 30%. E-Consultations are now live across the 5 pilot practices within the County, with 5 more being planned to go live. . There are 1300+ users now live on Joining Up Your Information (JUYI) providing an, average of over 220 accesses per day and over 28,000 patient records viewed overall since initial Go-live. This is an additional 300+ users since the previous report. With regards to Cinapsis (a digital tool that allows GPs to get advice from hospital doctors) 57 GPs have used the service from 19 practices and 11 acute medical consultants have offered advice and guidance

Joint Workforce Strategy – Health Education England (HEE) has clarified the 2019/20 Workforce Development (WD) funding. The total One Gloucestershire HEE Workforce Development funding allocation is £715,458 although some of this is for use at a regional level. ICS Leaders are currently prioritising how these funds will be used to support the ICS workforce including with education and training. Cohort 4 of the ICS Leadership Development Programme started in July with 26 attendees. Organisation executives will shortly be asked to make nominations for cohorts 5 and 6 which both commence in October. Cohort 5 is prioritised for Cardiovascular & Diabetes and cohort 6 for Respiratory & End of Life Care. Workforce planning workshops have commenced; these will support individual organisations to develop 5 year workforce plans and support workforce professional in developing long-term workforce planning skills, which in turn will contribute to the ICS 5 year workforce plan.

Joint Estates Strategy – The ICS Estates Strategy is being developed which brings together updated organisational estates strategies of each constituent, as part of the long term plan. Within the Primary Care Infrastructure Plan, an updated Primary Care Infrastructure Plan with forward look to 2026 is being drafted and developed. The South Western Ambulance NHS Foundation Trust strategy for future estate provision will deliver a range of operational sites. These will consist of the development of new Hubs (Make Ready Centres) mainly close to Acute hospitals and supported by a network of Book On locations (staff start and finish shifts) and Spokes (standby points). Each Hub will be subject to a detailed Business Case for approval by the Trust.

Primary Care Strategy – Our local digital first primary care strategy is to have a core offer for all practices, while also testing further digital enhancements to establish the benefits for patients and practices, while keeping an eye to the future developments with 111 Online and the NHS App roll out. The 2019-2024 Primary Care Strategy must demonstrate how the ICS will: build on resilience and sustainability, improve integration and partnership working, detail priorities and actions and how Primary Care Networks will be the focus as the key enable to the strategy.

7. Integrated Care System

As a Wave 2 Integrated Care System we are working towards increased integration to improve health and wellbeing, we believe that by all working better together, in a more joined up way, and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to local people.

The System Development work stream captures the work to develop the overarching ICS programme. The responsibilities of this programme are as follows:

- Provide Programme Direction to the Gloucestershire ICS
- Manage a Communications and Engagement approach on behalf of the ICS, including ensuring the Health and Social Care Act duties regarding significant services changes are met in relationship to the ICS
- Ensure the ICS has a robust resources plan in place that all ICS partners are signed up to and that is aligned to organisational level plans.
- To ensure that the ICS has clear governance and performance management in place to ensure the system can manage and oversee delivery.

Our key achievements made since the last report include;

- Completion of the “what matters to you” engagement on the deliverables within the Long Term Plan. The final output of public engagement has been completed and will be used it to inform our next steps in building the One Gloucestershire response to the NHS Long Term Plan.
- Further work has continued to seek additional transformational funding for the county to support being at the forefront of developments in care.
- We have relaunched the ICS Strategic Stakeholder Group which brings together a wide variety of stakeholders to steer the direction of the ICS and support delivery of our priorities. The next stakeholder’s forum is due to convene in September.
- The ICS Non-Executive Network is continuing to meet to further increase communication between partner organisations.

8. Recommendations

This report is provided for information and Board members are invited to note the contents.

Mary Hutton
ICS Lead, One Gloucestershire ICS

Agenda item 11 (1)

Report to: 2gether Trust Board, 26th September 2019
Author: Dr E Abbey, Medical Appraisal Committee Chair
Presented by: Dr A Uppal, 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.
- 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 2019 demonstrate that at that time 88.6% of Doctors had a currently valid appraisal. 10.1% non-compliant are explained by exclusion criteria such as being a new starter or long term sick leave. There was 1.3% (equivalent to 1 doctor) who at that point was classified as being non-compliant; this is accounted for by short term delay and that doctor has since completed an annual appraisal.
- Doctors' revalidation was effectively managed with no non-engagement referrals.
- 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.
- During 18/19 the MAC welcomed Ivars Reynolds, a long established MH Act Manager to the Committee in order to provide Lay oversight for the work of the Committee and input in to medical appraisal.

RECOMMENDATIONS

1) That the Governance Committee accept and endorse the Medical Appraisal Annual Report and:

- Recognise that levels have been maintained 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.
- To note in particular the assurance for NHS England in section 13 that the Trust meets requirements.

2) That the Board agrees the content and submission of the Statement of Compliance to NHS England and that this signed by the Chair on behalf of the Trust (section 13 page 11-16).

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 Amjad Uppal	Date	22nd August 2019

Where in the Trust has this been discussed before?		
Medical Appraisal Committee	Date	1st May 2019

What consultation has there been?		
	Date	

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 2018 – 31st March 2019**
Author:	**Dr Emma Abbey** ***On behalf of Medical Appraisal Committee***
Prepared for:	**Trust Board via Trust Governance Committee**

1. Executive summary

Of the 79 doctors requiring appraisal during the last year 70 (88.6 %) were compliant as at 1st April 2019; this is the same as in the previous year (88.6% at end of 2018); and represents a sustained improvement (75% end of 2014).

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

Each year a quality assurance audit of appraisal outputs is conducted; to date this has demonstrated sustained improvement in quality, providing significant validation and assurance to Governance Committee and Board that the organisation is fulfilling its statutory obligations.

In July 2015 the Trust's appraisal and revalidation systems were scrutinised by the NHS England Independent Verification Review Team; overall the trust was highly commended, scoring at least 5 out of 6 (equating to 'Excellence') in all core standards. No required actions were recommended and many areas of good practice noted. A Verification Visit by NHSE was completed in early June 2019, and reinforced the excellent standards achieved by the Trust. Future visits are expected on a 5-yr cycle.

2. Purpose of the Paper

The purpose of this paper is to report on the state of medical appraisal and revalidation to the Trust Board over the preceding appraisal year. It is also to report on progress made towards further 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 maintain robust systems for the recruitment, training, support and 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/Responsible Officer, Revalidation Officer, 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; this includes a year-end away half-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 outputs from the MAC during the last year include:

- Review of the medical appraisal policy
- Review of the appraisal systems for doctors joining the trust following the merger process, and how these will be included into the current systems.
- Further refinement of the user-friendly guide for completion of appraisal portfolios (including how to obtain data, and what supporting information to include)
- Development, printing and circulation of an appraisal and revalidation leaflet for patients, personalised for this trust from a national template.
- Further refinement / development of 6-monthly medical appraiser support forums
- Review of the membership of the MAC (including proactive turnover of members) to ensure compliance with the aim of 3-year terms

- Completion of the annual quality assurance audit and further improvement in systems for disseminating learning from this
- Continued review of the currently active list
- Performance review of newly qualified medical appraisers

Alongside these new and ongoing developments, the MAC continues to regularly monitor appraisal compliance rates and engagement in the process; provide approved baseline and refresher training for medical appraisers (provision is determined by current need); monitor training compliance and 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 job plans are completed and documented in this software package. Use of SARD JV contributes significantly to the ease and transparency 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. A process for escalation to the GMC if non-engagement continues is also in place.

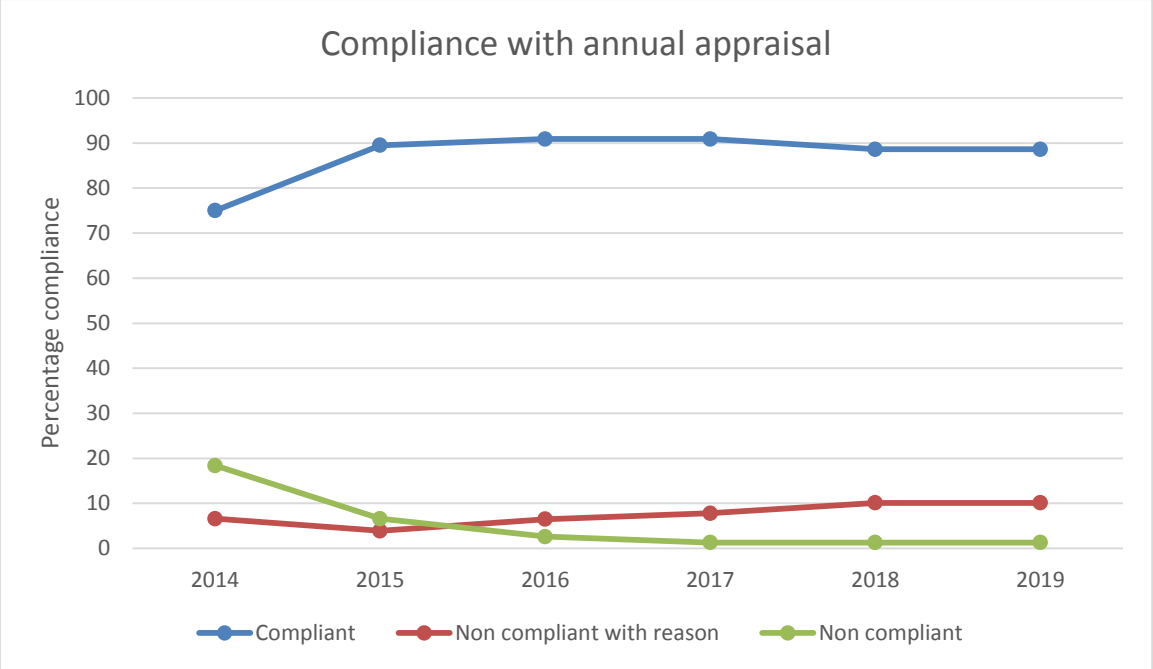
Priorities for the MAC for the next year include further consideration of ways to improve patient and public involvement in appraisal and revalidation processes (held back by continuing difficulty in identifying a fit-for-purpose process); further refinement of the number and nature of active qualified medical appraisers within the organisation; and focus on moving beyond compliance towards further quality improvement.

5. Medical Appraisal

5.1. Appraisal and Revalidation Performance Data

Of the 79 doctors requiring appraisal during the last year 70 (88.6 %) were compliant as at 1st April 2019; this is the same as the previous year (88.6% at end of 2018); and represents a sustained improvement (75% end of 2014). Of particular note is the reduction in non-compliant without a reason (see chart below).

In 2018-19 the "appraisal year" was introduced, from 1 April to 31 March. This aims to prevent slippage of appraisal date, and expects that each appraisee will have one completed appraisal per appraisal year unless authorised by the RO.



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. Notably compliance remains reasonable within trust locums (currently 50%; and of those non-compliant all had an acceptable reason); typically a group in which engagement and compliance is hard to establish and maintain.

Of the 9 doctors who were non-compliant; 8 (89%) had acceptable reasons (4 being new starters; 2 on or returning from long term sickness; and 1 on or returning from maternity leave), and 1 having an agreed extension. The 1 (11%) without a reason was overdue by less than 1 month.

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 unlikely to regularly reach 100% and will fluctuate monthly throughout the appraisal year.

To account for this, and given that at any time there will be a small number of doctors currently non-compliant with a reason, the MAC agreed in 2018 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.

5.2. Appraisers

There are currently 22 trained medical appraisers within the establishment of non-training grade doctors, unchanged from 2018. All consultants and SAS doctors continue to be offered access to training though in order to both provide a cohort of appraisers

and increase awareness and knowledge of appraisal for appraisers and appraisees alike.

The merger with GCS has brought 12 doctors into the Trust workforce. These doctors currently receive appraisal via an external source who have a contract to undertake all of their appraisals. Over the next 3 years these doctors will transition over to the 2gether appraisal system. This will increase the requirement for appraisers within the Trust.

The MAC have set minimum numbers of completed appraisals required in a 2-year period by an appraiser. These standards were introduced in October 2014 and enforced at the end of the first 2-year cycle in Oct 2016; 8 appraisers were then removed from the active list, and this review of activity has continued annually, with appraisers who consistently do very small numbers being reminded of the limits and asked whether they wish to continue in this role. However, in 2019 following discussion at the away-day, it was agreed that the minimum annual activity is unhelpful for the Herefordshire appraisers due to the small pool of appraisees available. In order to provide assurance that quality is nevertheless maintained, all Herefordshire appraisers will have at least one appraisal included in the annual audit for 2020.

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.

During the previous appraisal year, the committee considered the ratio of female to male appraisers within the Trust. The gender ratio of appraisers in April 2018 was 1:2.7 compared to the body of medical staff within 2gether (1:1.6). Dr Major wrote to female medical staff during this appraisal year to encourage them to become appraisers in an effort to address the gap.

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.

5.3. 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. A comparator report is received each year from NHS England and allows the Trust to benchmark itself against other Trusts. As 2gether NHSFT is comparatively small compared to other Trusts, a small number of doctors can make a significant difference to percentages quoted.

Overall the trust was highly commended and scored at least 5 out of 6 (equating to 'Excellence') in all 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 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.

An Independent Verification Visit by NHS England took place in June 2019 and found no further actions required.

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, as below:

5.3.1. Support for appraisers

Alongside ensuring robust recruitment and training processes for medical appraisers, regular support and review of the role takes place within 6 monthly appraiser support forums, existing consultant CPD peer groups, as part of appraisers' own appraisals and via informal support offered by members of the MAC itself.

5.3.2. Feedback from appraisees

Appraisee feedback forms are automatically generated by SARD-JV and sent to appraisees after all completed appraisals. Return rates are high. Completed returns are screened by the medical director's office and reviewed quarterly by the MAC. Any concerning feedback is followed up individually by the MAC chair in order to address potential problems in a timely manner. Collated (anonymised) feedback covering the entire appraisal year is circulated to all appraisers, and individualised (anonymised) feedback to appraisers. Summarised feedback has previously been benchmarked against feedback collated from other similar organisations (and considered comparable).

5.3.3. Automatic uploading of complaints and anonymised SI reports

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.

5.3.4. Annual Quality Assurance audit

The annual medical appraisal quality assurance re-audit was conducted in April 2019 by all members of the MAC, using a nationally recognised medical appraisal QA tool. New appraisers were audited at the time of completion to avoid delay in scrutiny.

8 (12% of all) completed appraisal summaries were randomly selected for audit for completeness and quality; none were done by new appraisers this year. Consent was sought from individual appraisees. Results were reviewed at an away day and an action plan subsequently developed, including:

- Preparation of a comprehensive audit report,
- dissemination of key learning points to all appraisers and appraisees and

- individualised feedback provided to appraisers in relation to the specific cases audited.

The results demonstrated maintenance of quality of appraisal outputs. This year the average score from the Excellence Tool stayed the same but the score range was very tight, indicating a more uniform high standard of appraisal documentation. In 2019 the ASPAT tool was used alongside the Excellence tool and its relative usefulness considered. The view of the MAC was that the Excellence tool still provided better scrutiny of appraisal, but there were useful elements to the ASPAT. It is proposed that as part of a Quality Improvement Project, a new tool is developed within 2gether Trust, incorporating the best of both tools, and this will be piloted alongside the Excellence for the 2020 audit.

The audit will be repeated annually.

Please refer to appendix B.

5.4. 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.

5.5. Lay Participation in medical appraisal

During the last appraisal year we welcomed Ivars Reynolds, a long established member of the Mental Health Managers Review panels, to the MAC. His background is in social work and performance management.

5.6. Clinical Governance

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 (one completed cycle per 5 years) 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 13 revalidation recommendations were due; positive recommendations were made for 12 of these (92%); the remaining 1 (8%) was

recommended for deferral. 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.

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

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.

No doctors are 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 a doctor is flagged as non-compliant, combined with the limited range of exceptions, mean that rolling compliance rates vary from month to month without appraisal uptake having altered markedly. Exceptions this year are again accounted for mostly by new starters.

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 impacts 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 taken part in this process and thus for the first year of any practice have not undertaken appraisal whilst they are collecting data. This is a nationally recognised issue and one further expanded on in the Pearson review.

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 was reviewed in January 2019. Priorities for the MAC for the next year include ongoing consideration of ways to improve patient and public involvement in appraisal and revalidation processes; further refinement of the number and nature of active qualified medical appraisers within the organisation, with particular focus this year on gender inequality; and continuing focus on moving beyond compliance towards further quality improvement.

The MAC will investigate individual cases where appraisal is not 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 annual appraisal are not 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 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 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 undertaken and 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 snapshot compliance figures do not reflect annual uptake of appraisal but are primarily a function of the way data is collected. In any year the expected outturn is 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.
- To note in particular the assurance in section 13 and for the Chair of the Trust to complete the Statement of Compliance on behalf of the Trust.

13. NHSE Qualitative Assurance

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 30th May 2019 Action from last year: None Comments: Repeated annually. Action for next year: As this year.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: None Comments: Dr Uppal has already been appointed at Responsible Officer for the new merged organisation. Action for next year: None

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes/No [delete as applicable] Yes Action from last year: None Comments: Action for next year: None

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

Action from last year: Yes Comments: Maintained by Medical Director's office. Action for next year: None

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: None Comments:

Action for next year: Policies will need to be reviewed and aligned for new merged organisation.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: None

Comments: Undertaken in April/May 2019 on 18/19 by the Medical Appraisal Committee.

Action for next year: Repeated annually at the MAC away half day.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: None

Comments: Process is in place and actively monitored by the Medical Secretariat

Action for next year: Continue with current provision.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: None

Comments: Except those where there is an accepted reason by the Responsible Officer.

Action for next year: Continue with current practice.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: None

Comments: Yes a full record of non-compliance and reasons for exemption is maintained by the Medical Secretariat.

Action for next year: Continue with current practice.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: None

Comments: Submitted to the board annually.

Action for next year: Continue with current practice.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: None

Comments: Appraiser numbers are regularly monitored by the MAC, and a minimum and maximum number of appraisals per year stipulated for appraisers.

Action for next year: Continue with current practice.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: None

Comments: 10% appraisals audited annually for quality control. Appraisers are monitored for attendance at update training. Feedback is sought from appraisees and followed up by the MAC chair.

Action for next year: Continue with current practice.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: None

Comments: Annual audit of 10% appraisals, and the first 3 appraisals done by each new appraiser. This considers whether the appraisal has covered (at appropriate depth) scope of work, progress towards previous year's PDP, and a SMART PDP for next year which reflects the trust's aims and objectives. It considers whether appropriate challenge and support has been present, and whether the doctor is on course for successful revalidation.

Action for next year: Continue with current practice.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: None

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

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

Comments: A thorough system is in place with the Medical Secretariat.

Action for next year: Continue with current practice.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: None

Comments: Doctors are informed at regular intervals of the status of their revalidation and what recommendation will be made. If a recommendation other than positive is made the doctor would be fully informed as to the reasons for this.

Action for next year: Continue with current practice.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: None

Comments: The appraisal system combined with job planning is an effective means of delivering effective clinical governance for doctors.

Action for next year: Continue with current practice.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: None

Comments: A thorough system is in place with the Medical Secretariat.

Action for next year: Continue with current practice.

3. There is a process established for responding to concerns about any licensed medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: None

Comments: A thorough system is in place with the Medical Secretariat and supported by a current responding to concerns policy.

Action for next year: Continue with current practice.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

Action from last year: None Comments: An annual report to the board provides quality assurance on concerns. Action for next year: Continue with current practice.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

Action from last year: None Comments: Yes Action for next year: Continue with current practice.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: None Comments: Yes Action for next year: Continue with current practice.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: None Comments: A thorough process is in place within Medical Staffing and HR.

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action for next year: Continue with current practice.

Section 6 – Summary of comments, and overall conclusion

The Medical Appraisal committee supports the RO and his office by ensuring high quality appraisals for all doctors within the trust. These systems are now established and repeated annually; they ensure medical governance. Data collection is possible via the SARD JV software, with all doctors using this for appraisal to ensure immediate knowledge of poor compliance.

There are no actions outstanding for this report, as the annual reviews will continue to ensure the provision of high quality appraisals for trust doctors. However, policies will need to be reviewed and aligned for the new merged organisation over the coming year.

Section 7 – Statement of Compliance:

The Board of 2gether NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: 2gether NHS Foundation Trust

Name: Ingrid Barker Signed: _ _ _ _ _ _ _ _ _ _

Role: Chair

Date: _ _ _ _ _ _ _ _ _ _

Annual Report Appendix A

Audit of all missed or incomplete appraisals (as of 1st April 2019)

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

Annual Report Appendix B

Quality assurance audit of appraisal inputs and outputs

Excellence audit tool

		Frequency (% in brackets)		
Number	**Criterion**	absent	room for improvement	well done
1	Includes whole scope of work?	0	6 (75)	2 (25)
2	Free from bias?	0	0	8 (100)
3	Challenging & supportive?	0	0	8 (100)
4	Exceptions explained?	0	0	8 (100)
5	Reviews & reflects?	0	3 (37.5)	5 (62.5)
6	Review of previous PDP?	0	1 (12.5)	7 (87.5)
7	Encourages excellence?	0	1 (12.5)	7 (87.5)
8	Gaps identified?	2 (25)	2 (25)	4 (50)
9	SMART PDP?	1 (12.5)	1 (12.5)	6 (75)
10	Relevant PDP?	0	2 (25)	6 (75)

Annual Report Template Appendix C

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2018 to 31 March 2019	
Recommendations completed on time (within the GMC recommendation window)	12 (Positive) 1 (Deferral)
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	12 (Positive) 1 (Deferral)
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 (1st April 18 to 31st March 19)

Concerns about a doctor's practice	High level[4]	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	1		
Capability concerns (as the primary category) in the last 12 months	Concerns cover all areas			
Conduct concerns (as the primary category) in the last 12 months				
Health concerns (as the primary category) in the last 12 months		1		
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2018 who have undergone formal remediation between 1 April 2017 and 31 March 2018 *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*				0
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)				0
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
Temporary or short-term contract holders (temporary employed staff including				0

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

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	
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	Restricted to non-clinical practice only for 6-12 months
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	0
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	1 (c/f from 17/18)
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:	
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	1
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	4
Temporary employed doctors	20
Locums brought in to the designated body through a locum agency	47
Locums brought in to the designated body through 'Staff Bank' arrangements	5
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	76

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	4	4	4	4	4	4	4	4	4	N/A	N/A	4				
Temporary employed doctors	20	20	20	20	20	20	20	20	20	N/A	N/A	20				
Locums brought in to the designated body through	47	47	47	47	47	47	47	N/A	N/A	N/A	N/A	47				

a locum agency																
Locums brought in to the designated body through 'Staff Bank' arrangements	5	5	5	5	5	5	5	5	5	N/A	N/A	5				
Doctors on Performers Lists	0	0	0	0	0	0	0	0	0	0	0	0				
Other (independent contractors, practising privileges, members, registrants, etc)	0	0	0	0	0	0	0	0	0	0	0	0				
Total	76	76	76	76	76	76	76	29	29	N/A	N/A	76				

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	N/A	N/A	N/A	N/A	N/A
Medicine	N/A	N/A	N/A	N/A	N/A
Psychiatry	2314.5	1128	1108.5	78	2314.5
Obstetrics/Gynaecology	N/A	N/A	N/A	N/A	N/A
Accident and Emergency	N/A	N/A	N/A	N/A	N/A

Anaesthetics	N/A	N/A	N/A	N/A	N/A
Radiology	N/A	N/A	N/A	N/A	N/A
Pathology	N/A	N/A	N/A	N/A	N/A
Other – Occ Health	N/A	N/A	N/A	N/A	N/A
Total in designated body (Includes all doctors, not just those with a prescribed connection)					
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	6	5	5	0	0
3 days to one week	4	4	4	0	0
1 week to 1 month	18	16	16	0	0
1-3 months	15	15	15	0	0
3-6 months	5	4	4	0	0
6-12 months	2	2	2	0	0
More than 12 months	1	1	1	0	0
Total	51	47	47	0	0

Trust Board

Date of Meeting: **26 September 2019**

Report Title: **Responsible Officer's Annual Report to the Board**

Agenda reference Number	11(2)
Reason for Being Heard in Confidential Session	
Accountable Executive Director (AED)	Dr Amjad Uppal
Presenter (if not AED)	
Author(s)	Amanda Bye
Board action required	
Previously considered by	
Appendices	1. Appraisal Activity: Appraisal Year 1st April 2018 - 31st March 2019. 2. Quality Governance Information. 3. A Framework of Quality Assurance for Responsible Officers and Revalidation: Annex D - Statement of Compliance

Executive Summary:
During the appraisal year 1/4/18-31/319, Gloucestershire Care Services NHS Trust (GCS) employed 11 medical colleagues, 1 of whom was due revalidation during that period. The doctor had recently joined GCS and had had insufficient appraisals during the revalidation cycle. The RO therefore recommended deferral of revalidation for a further year. Of 3 due revalidation in the appraisal year 1st 1/4/19-31/3/20, the Responsible Officer has made 3 positive recommendations. In terms of engagement with appraisal, there was 100% compliance.

As seen from a paper submitted to the Quality and Performance Committee paper in February 2019, significant work has been undertaken to ensure that the Trust is discharging its responsibilities for medical appraisal and revalidation. This is evidenced by audits and information at Appendix 1, 2 and 3.

Recommendations:

The Board is asked to **NOTE** the content of this report and to:

Approve the Statement of Compliance, completed by the Responsible Officer to confirm the Trust's compliance with the statutory Responsible Officer duties. This is to be signed by the Chief Executive and is due to be submitted to NHS England by 27 September 2019, (Appendix 3).

Agree to continue to fund external appraisal costs until each doctor is transferred to an in-house appraiser (see Appendix 2).

Related Trust Objectives	
Risk Implications	Risk issues are clearly identifed within the report
Quality/Equality Impact Assessment (QEIA) Requirements/Implications	No equality implications identified
Financial Implications	Finance implications are clearly referenced in the report
Legal/Regulatory Implications	Legal/Regulatory implications are clearly referenced in the report

Responsible Officer's Annual Report to the Board

1 Introduction and Purpose

This report aims to assure the Board of the effective quality governance processes designed to ensure that the Responsible Officer is fully supported in his role and enabling the Chief Executive to sign the Statement of Compliance with confidence. Supporting evidence is provided at Appendix 1, 2 and 3.

2 Background

As a designated body for revalidation purposes, GCS has a statutory duty to comply with the Medical Profession (Responsible Officers) (Amendment) Regulations 2013. The Medical Director, as Responsible Officer for the Trust, plays a crucial role in improving and maintaining the quality and safety of patient care. NHS England require designated bodies to submit a Statement of Compliance following an Annual Report to the Board.

3 Appraisal Activity

Appraisal activity for the appraisal year 1/4/18-31/3/19 is at Appendix 1.
Since 1/4/19, there has been a requirement to make 3 recommendations to the GMC regarding revalidation.

Appraisal data, in the format submitted to NHS England, for Quarter 1 of the 2019-20 appraisal year is shown below. There has been 100% compliance.

1.	Name of Designated Body: **Gloucestershire Care Services NHS Trust**	**QUARTER 1** 1/4/2019 – 30/6/19
2	Number of doctors with whom the DB has a prescribed connection	11
3	Number of doctors **due** to have an appraisal in the reporting period	3
4	Number of doctors who **had** an appraisal meeting in the reporting period	2
5	Number of doctors in question 3 above, who **did not** have an appraisal meeting in the reporting period	1
6	Number of doctors in question 5 above for whom the RO **accepts** the postponement is reasonable	1
7	Number of doctors in question 5 above, for whom the RO **does not** accept that the postponement is reasonable.	0

GCS has a small number of connected doctors and a pool of 3 experienced, external appraisers (one of whom is a regional appraiser of ROs for NHS England and one the founder of 'Doctors Training' who is also a recognised appraiser trainer.)

Doctors are ordinarily appraised by the same appraiser for 3 consecutive years. After this point GCS doctors will be transferred to an in-house 2gether NHS Foundation Trust (2g) appraiser. Any new doctors will automatically be assigned a 2g appraiser.

The cost implication for appraisals is £500 per appraisal with 9 appraisals planned in the financial year 6/4/19-5/4/20.

4 Support for Doctors

A"*Guide to the GCS Appraisal Process for Appraisees (March 2018)"* was been produced and circulated, together with pertinent information sheets on topics such as confidentiality in appraisal reflection.

The GCS Medical Appraisal & Revalidation policy was been updated to reflect current GMC, NHS England and local GCS requirements. The GCS NHS Trust Medical Appraisal Documentation Access Statement was published in October 2018.

Personal advice and support is available to doctors on all aspects of medical appraisal and revalidation.

5 Collaborative Working

The majority of doctors providing care to GCS service users are <u>not</u> connected to GCS as their Designated Body. They are GPs on the National Performers' List (connected to NHS England for appraisal and revalidation), or Elderly Care consultants (connected to Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT). As such, the RO for GCS does not have oversight of medical appraisal documentation.

In agreement with appraisal leads for NHS England (South Central Region) and GHNHSFT, non-connected doctors are required to complete and return an "Annual Declaration Form" (see Appendix 2, page 2.)

Responses to pertinent questions asked in this simple form provides assurance to GCS that the doctor is up to date, fit to practise, is discussing their GCS work at appraisal and is fully engaged with the appraisal and revalidation process.

At 25/7/19, all 39 non-connected doctors had completed the declaration form. The GCS Responsible Officer is aware of each non-connected doctor's Responsible Officer so that any sharing of information can take place, should the need arise.

6 Information Sharing

Good practice dictates that doctors and ROs share relevant information; i.e. where a doctor takes up or leaves employment and changes DB; pre- and post-appraisal and regarding any 'information of note'.

Permanent Staff

Relevant information about a doctor's appraisal and revalidation status is captured during the recruitment process. The GCS Medical Application Form includes pertinent questions and these are also requested by the Medical Appraisal & Revalidation Coordinator when first contact is made with the newly employed doctor.

In order to communicate with ROs of organisations when a doctor leaves the employ of GCS and moves to another DB, a process is in place to ensure that the relevant form is sent to the doctor's new DB a timely manner.

Locum Staff

GCSNHST has arranged for locum cover to be provided by GDOC, Gloucestershire's GP Cooperative; a GP provider company. Locum cover is minimal and the Medical Appraisal & Revalidation Coordinator is notified of any doctor working in this capacity so that she can ensure they are connected to a RO and up to date with appraisal and revalidation.

Doctors working under Service Level Agreements or other contracts

By use of the Annual Declaration form, GCSNHST are aware of all doctors' ROs and is therefore in a position to use the most appropriate method of communication, should the need arise, to discuss any issues with a doctor's RO.

7 Conclusion and Recommendations

The Board is asked to

1. **Note** the content of this report and

2. **Approve** the Statement of Compliance, completed by the Medical Director to confirm the Trust's compliance with the statutory Responsible Officer duties. This is to be signed by the Chief Executive and is due to be submitted to NHS England by 27 September 2019, (Appendix 3).

Abbreviations Used in Report

GCS - Gloucestershire Care Services NHS Trust

2g - 2gether NHS Foundation Trust

GHNHSFT - Gloucestershire Hospitals NHS Foundation Trust

NHS - National Health Service

RO - Responsible Officer

Appraisal Activity
Appraisal Year 1st April 2018 - 31st March 2019

The following data was included in the Annual Organisational Audit sent to NHS England in May 2019. This shows full compliance, with explanations recorded for any variance against the completed appraisal as defined at 1(a) in the key overleaf.

Number of doctors with a connection to GCSNHST at 31/3/19	Completed Appraisal 1	Completed Appraisal (1a)	Incomplete or Missed (Approved)	Incomplete or Missed (Unapproved)	NOTES
	1				Appraisal 2 weeks later than same date last year due to appraiser illness
	1	1			No records held in GCS but informed by NHS England that appraisal was complete last year. Doctor was due first appraisal with GCS in July but retired on 6/5/19.
	1				Appraisal 4 days later than same date last year due to appraiser illness
	1	1			
	1				Appraisal one week later than last year due to appraiser/appraisee availability
	1	1			
	1				Patient Satisfaction survey not signed within 28 days following appraisal meeting.
	1				Appraisal one week later than last year due to appraiser/appraisee availability
	1	1			
	1				Patient Satisfaction survey not signed within 28 days following appraisal meeting.
	1				Appraisal form (MAG) not signed off within 28 days of meeting due to appraiser being abroad on leave and having technical issues with the MAG.
11	**11***	**4**	**0****	**0*****	

GCS had success rates as follows, compared with other organisations in the same sector:
* 100% (vs 95%) ** 100% (vs 95.7%) *** 100% (vs 99.4%)

KEY

1	A *completed annual medical appraisal* is one where either: a) All of the following three standards are met: i. the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*, ii. the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, iii. the entire process occurred between 1 April and 31 March. Or b) the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the three standards in a) has been missed. However, the judgement of the responsible officer is that the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation. For doctors who have recently completed training, it should be noted that their final ACRP equates to an appraisal in this context.
1a	For designated bodies who wish to and can report this figure, this is the number of completed medical appraisals that meet all three standards defined in Measure 1 a) above. This figure is not reported nationally and is intended to inform the internal quality processes of the designated body.
2	An *approved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of a Category 1 co*mpleted annual medical appraisal*, but the Responsible Officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal for it to be counted as an app*roved incomplete or missed annual medical appraisal.*
3	An *unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of a Category 1 *completed annual medical appraisal,* and the Responsible Officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *unapproved incomplete or missed annual medical appraisal.*

Doctors providing care within the Trust but connected to another designated body for medical appraisal and revalidation

Between 1/4/18 – 31/3/19, GCS employed 11 medical colleagues to provide care within the Sexual Health department and at Cirencester and Tewkesbury Community Hospitals. Alongside these employees, approximately 39 doctors provided care to service users throughout the Trust, being connected to the either the GHNHSFT or NHS England for appraisal and revalidation purposes.

Having no oversight of their medical appraisal documentation, the RO seeks confirmation (by means of a declaration form) that they are discussing their work at GCS with their appraiser and engaging with the appraisal and revalidation system. This process is carried out annually. (See example overleaf, sent to GPs. A variation was sent to hospital doctors.)

At 29/7/19, all 39 doctors had completed the declaration form which provided the assurance required. The RO is aware of each doctor's RO so that any sharing of information can take place, should the need arise.

.

DECLARATION

Dear Doctor

You provide care and services under the auspices of Gloucestershire Care Services Trust (GCS). Since you are not connected to GCS as your designated body, Dr Mike Roberts (Medical Director and Responsible Officer for GCS) requires assurance that you are engaged in the appraisal and revalidation process and include GCS in your scope of work at appraisal.

To that end, I would be grateful if you could complete this form and return it to me via the email address below.

Kind regards

Amanda Bye
Medical Appraisal & Revalidation Coordinator
amanda.bye@glos-care.nhs.uk

Name	
GMC registration (yes/no)	
GMC number	
Inclusion on National Performers List (yes/no)	
I have appropriate indemnity covering work within GCS (yes/no)	
Date of last appraisal	
Date last revalidated	
Date of next revalidation	
GCS work is included in my scope of practice at appraisal (yes/no)	
Evidence is available from GCS for inclusion in my appraisal (yes/no)	
Any comments:	

Collaborative Working

General Medical Council

The RO and Deputy Medical Director meet the regional GMC Employer Liaison Adviser (ELA) on a biannual basis. The ELA works together with ROs, providing advice and support to ensure GMC fitness to practise thresholds are applied consistently and to discuss any pertinent issues, e.g. concerns about underperforming doctors.

Gloucestershire Hospitals NHS Foundation Trust

Liaison between the Medical Directorate and the GHNHSFT Medical Directorate continues, with GCS appraisers being invited to attend Medical Appraisal Networking and Update events run by the GHNHSFT.

NHS England (South West Region)

Liaison between the Medical Directorate and NHS England (South West Region)'s Appraisal and Revalidation team continues. A representative from the Medical Directorate attends the NHS England (South West) "Responsible Officer and Appraisal Network" events which take place quarterly.

2gether NHS Foundation Trust

The Appraisal & Revalidation Coordinator is working closely with the 2gether Appraisal & Revalidation Manager to ensure a smooth transition of appraisal management systems and processes throughout the merger.

Financial implications associated with appraisal

With the proposed merger with 2gether NHS Foundation Trust, the requirement for external appraisers, and associated costs (currently £500 per appraisal), will diminish to zero over the next few years. When a GCS doctor has had 3 consecutive appraisals with an external appraiser, they will be appraised by a 2gether NHS Foundation Trust appraiser.

Appraisal Year	Appraisals required	Appraisals by GCS appraiser	Appraisals by 2g appraiser
2018-19	10	10	0
2019-20	10	9	1
2020-21	9	6	3
2021-22	9	0	9

Recruitment of permanent staff

There is a process in place for obtaining relevant information when the Trust enters into a contract of employment for the provision of services with doctors. This ensures the doctor is sufficiently qualified and experienced to carry out the role. A wide variety of checks are undertaken and relevant references obtained, both for permanent and locum doctors.

When a doctor is employed, they must connect to GCS for appraisal and revalidation purposes and the GMC must be informed. The process for informing the Appraisal and Revalidation Coordinator, who is responsible for ensuring the doctor is connected and fully informed on appraisal matters within GCS is currently not reliable. This needs addressing. The Appraisal and Revalidation Coordinator is not always informed in a timely manner, and on occasion not at all.

Recruitment audit

An audit was commenced, to ascertain whether the following information was available within a month of the doctor's starting date.

HR and Procurement were enlisted. HR were able to produce the detail in the table overleaf. The Medical Appraisal & Revalidation Coordinator became aware of one doctor and ascertained GMC number, previous RO, last appraisal, revalidation status and obtained appraisal outputs. The second doctor was employed for 5 months and the Medical Directorate was never made aware of his employment. HR did not gather/record information.

Regarding non-connected doctors (GPs, GPWSIs, consultants providing care in the community hospitals etc: SLA holders were contacting, asking them to provide information for any doctors employed during the previous 12 months. The response was scanty and there was not the resource available to follow this up with every GP practice and every organisation providing doctors to GCS. The recommendation was that contracts are amended to require this information to be available for any doctor employed who provides services for GCS.

Recommendations:

1. HR are required to collect this information when recruiting doctors and inform the Medical Appraisal & Revalidation Coordinator that a doctor is being recruited. The current situation is that HR feel that the recruiting department should inform the medical directorate and vice versa. The result is that neither do.

2. Contracts with SLA are amended to require them to gather and record information below and provide it on request.

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	Disclosure and Barring Service	2 recent references	Name of last responsible officer	Reference from last responsible	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance
Permanent employed doctors																
Temporary employed doctors	2	2	1	1	1	2	2					2	2	1		

Audit of concerns about a doctor's practice

There were no concerns requiring formal investigation in the year in question.

Quality assurance audit of appraisal inputs

An audit was undertaken to assess the quality of evidence provided by doctors being appraised. Five appraisal portfolios were audited. Results are shown overleaf.

The audit highlighted 2 issues, both requiring action:

1. That doctors need to complete patient and colleague feedback exercises by year 3 of the revalidation cycle, thus allowing time for reflection and any change in practise before a revalidation recommendation is submitted. This was addressed by a communication to all doctors last year, reminding them of the requirement and sending the relevant NHS England guidance on the matter, and will be repeated.

2. That doctors should provide evidence regarding roles from their whole scope of practice. Evidence relating to roles outside the GCS role is not readily obvious in appraisal portfolios. This will be addressed in a communication to doctors, sending relevant NHS England guidance on the matter.

Audit of Appraisal Inputs 1/4/18-31/3/19:

Appraisal inputs	Sample 1	Sample 2	Sample 3	Sample 4	Sample 5
Scope of work: Has a full scope of practice been described?	yes	yes	yes	yes	yes
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	yes	yes	yes	yes	yes
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	partially	yes	yes	yes	yes
Patient feedback exercise: Has a patient feedback exercise been completed by year 3 of the revalidation cycle?	yes	yes	no	no	N/A
Colleague feedback exercise: Has a colleague feedback exercise been completed by year 3 of the revalidation cycle?	yes	N/A	no	no	N/A
Review of complaints: Have all complaints been included?	yes	yes	yes	yes	yes
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	yes	yes	yes	yes	yes
Is there sufficient supporting information from all the doctor's roles and places of work?	no	no	no	no	yes
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)?	yes	yes	no	no	yes
Explanatory notes:	Limited quality improvement activities. Addressed by appraiser	New to role. Colleague feedback not undertaken.			First year of revalidation cycle. Feedback exercises not undertaken.

Quality assurance audit of appraisal outputs

Doctors are required to provide written evidence relating to their professional practise ("appraisal inputs"). Evidence is categorised into four domains:

1. Knowledge, Skills & Performance
2. Safety & Quality,
3. Communication, Partnership & Teamwork
4. Maintaining Trust.

This evidence forms the basis of the appraisal discussion.

The medical appraiser has a responsibility to check that the doctor has produced evidence of an appropriate quantity and quality to facilitate a productive appraisal meeting.

Using the NHS England Appraisal Summary and PDP Audit Tool (see overleaf), an audit was undertaken during the first half of the appraisal year to gauge the quality of appraisal outputs produced by appraisers (i.e. the summary of appraisal, personal development plan and appraiser statements). Three appraisals were assessed for each appraiser and the scores are shown below:

Appraiser	**Average Score (Maximum of 50)**
1	46
2	44
3	40

The quality of appraisal outputs is extremely high, providing reassurance that GCS fulfils its duty to support doctors through the 5 year revalidation cycle by provision of formative, motivating and supportive appraisals.

Appraisal Summary and PDP Audit Tool Template

Appraiser identifier	Click here to enter text.
Doctor identifier	Click here to enter text.
Date of appraisal	Click here to enter a date.
Organisation	Click here to enter text.
Auditor (usually the senior appraiser)	Click here to enter text.

Scale:
0 Unsatisfactory
1 Needs improvement
2 Good

Score each item out of two

1.1.1 Setting the scene and overview of supporting information

a) The appraiser sets the scene summarising the doctor's scope of work	Choose an item.
b) The evidence discussed during the appraisal is listed *(not all senior appraisers feel that this is necessary, so if not required score 2)*	Choose an item.
c) There is documentation of whether the supporting information covers the whole scope of work	Choose an item.
d) Specific evidence is summarised with a description of what it demonstrates	Choose an item.
e) Objective statements about the quality of the evidence are documented	Choose an item.
f) All statements made by the appraiser are supported by evidence	Choose an item.
g) Appraiser comments about evidence refer/fit in to the four GMC domains and associated attributes set out in the GMC guidance *Good medical practice framework for appraisal and revalidation*	Choose an item.
h) Reference is made to whether speciality specific guidance for appraisal has been followed e.g. college recommendations for CPD and quality improvement activity *(this is not a GMC requirement so if the senior appraiser does not feel that this is necessary, score 2)*	Choose an item.
i) Reference to completion of locally agreed required training (e.g. safeguarding training, basic life support training) is made *(please insert agreed requirements, score 2 if none agreed)*	Choose an item.

This form has been extracted from, and should be used in accordance with, the NHS England Medical Appraisal Policy, version 2, April 2015, MAPS Annex J: Routine Appraiser assurance tools (http://www.england.nhs.uk/revalidation/appraisers/app-pol/).

Comments: Click here to enter text.

1.1.2 Reflection and effective learning

a) There is documentation of evidence showing that reflection on learning has taken place or that the appraiser has discussed how the doctor should document their reflection	Choose an item.
b) There is documentation of evidence showing that learning has been shared with colleagues or that the appraiser has challenged the doctor to do so	Choose an item.
c) There is documentation of evidence showing that learning has improved patient care/practice or that the appraiser has explored how this might be taken further with the doctor	Choose an item.
Comments: Click here to enter text.	

1.1.3 The PDP and developmental progress

a) There is positive recording of strengths, achievements and aspirations in the last year	Choose an item.
b) There is documentation of appropriate challenge in the discussion and PDP e.g. significant issues discussed and new suggestions made	Choose an item.
c) The completion (or not) of last year's PDP is recorded	Choose an item.
d) Reasons why any PDP learning needs that were not followed through are stated *(if the PDP was completed then score 2)*	Choose an item.
e) There are clear links between the summary of discussion and the agreed PDP	Choose an item.
f) The PDP has SMART objectives (specific, measurable, achievable, relevant, timely)	Choose an item.
g) The PDP covers the doctor's whole scope of work and personal learning needs and goals	Choose an item.

This form has been extracted from, and should be used in accordance with, the NHS England Medical Appraisal Policy, version 2, April 2015, MAPS Annex J: Routine Appraiser assurance tools (http://www.england.nhs.uk/revalidation/appraisers/app-pol/).

h) The PDP contains between 3-6 items	Choose an item.
Comments: Click here to enter text.	

1.1.4 General standards and revalidation readiness

a) The documentation is typed and uploaded onto an electronic toolkit in clear and fluent English	Choose an item.
b) There is no evidence of appraiser bias or prejudice or information that could identify a patient/third party information	Choose an item.
c) The stage of the revalidation cycle is commented on	Choose an item.
d) There is documentation regarding revalidation readiness relating to supporting information (e.g. states that feedback and satisfactory QIA are already done). Any outstanding supporting information/other requirements for revalidation are commented on with a plan of action to address them	Choose an item.
e) Appraisal statements (including health and probity) have been signed off or if not, an explanation given *(if signed off score 2)*	Choose an item.
Comments: Click here to enter text.	

TOTAL SCORE (OUT OF 50)	Click here to enter text.

General comments from the senior appraiser:

Click here to enter text.

The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

This form has been extracted from, and should be used in accordance with, the NHS England Medical Appraisal Policy, version 2, April 2015, MAPS Annex J: Routine Appraiser assurance tools (http://www.england.nhs.uk/revalidation/appraisers/app-pol/).

Audit of feedback from doctors regarding their GCS medical appraisal

Doctors are asked to provide feedback following their appraisal by completion of a simple form. The following results assure the RO that doctors feel well supported by the Trust's appraisers and administrative systems, though the value doctors place on appraisal and revalidation as a whole is more variable.

Appraiser	The appraiser (55 = lowest score 11 = highest score)	The administration and management of the appraisal system (30 = lowest score 6 = highest score)	The GMC appraisal and revalidation system (30 = lowest score 6 = highest score)
1 (Feedback from the 3 appraisals undertaken 1/4/18-31/3/19)	11.3	7.6	10
2 (Feedback from the 4 appraisal undertaken 1/4/18-31/3/19)	11	8.3	8.75
3 (Feedback from the 3 appraisals undertaken 1/4/18-31/3/19)	11	7.6	8.3

Comments received
Very clear on explaining gaps and areas of improvement.
Gave professional encouragement on my new PDP
I received timely communication via e-mail from GCS and the appraiser.
I feel that my meeting has highlighted the overall value of the appraisal system.
Very helpful discussion to assist with my development.
I could have benefitted from additional advice about the amount and type of preparation required. Overall it remained a valuable process.
I found this appraisal meeting hugely useful. This was by far the best appraisal I have had.
Whilst I appreciate that appraisal preparation is meant to have got less arduous, I still find it a time- consuming task with regard to the MAG form and evidence collation, and still am not convinced by the usefulness of appraisal in its current form.
A very constructive conversation.
Appraiser was very supportive and encouraging. The feedback was very helpful. Appraisal was useful for my professional and personal development. Very helpful in preparation for revalidation. Thank you to appraisal team.
An excellent appraiser. Appropriately challenging yet very supportive throughout and his experience is priceless to guide me towards self-development
The discussion was worthwhile but the preparation of the folder was of dubious value. I have more than exceeded the requirements for CPD but to input all the information in the right way was fraught.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

(See Separate Annual Report)

Statement of Compliance:

The Executive Board of Gloucestershire Care Services NHS Trust has reviewed the content of the Responsible Officer's Annual Report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body ……

Date: ……..

Name: Paul Roberts

Role: Joint Chief Executive Gloucestershire Care Services NHS Trust and 2gether NHS Foundation Trust

Official name of designated body: Gloucestershire Care Services NHS Trust

The LTP: NHS Interim People Plan

Board Briefing September 2019

2gether NHS Foundation Trust

NHS Gloucestershire Care Services NHS Trust

Overview of the People Plan

- The NHS People Plan forms part of the overall Implementation Plan for the NHS Long Term Plan (LTP) and comprises:
    1. **An Interim People Plan** published in June 2019
    2. **A full 5-year plan** within two months of the final 2019/20 Spending Review – likely to be around Christmas / New Year 2020
- The Interim People Plan lays the foundations nationally for the workforce transformation necessary to bring about and make a reality of the new service models and ways of working set out the LTP, with a focus on the immediate actions for 2019/20

Phase 1 of the work has been completed nationally with the development of the interim Plan

Phase 2 of the work has begun nationally and will involve implementing immediate actions of the interim plan, and developing the full People Plan

2gether NHS Foundation Trust

NHS Gloucestershire Care Services NHS Trust

The Interim People Plan – key themes

The Plan sets out a transformative vision for the NHS workforce, including doctors, nurses, AHPs, pharmacists, healthcare scientists, dentists, non-clinical professions, apprentices and volunteers

1. **Make the NHS a better place to work**: making the NHS an employer of excellence – valuing, supporting, developing and investing in our people.

2. **Improve our leadership culture**: developing a positive, compassionate and improvement focussed leadership creates the culture that delivers better care.

3. **Prioritise urgent action on nursing shortages:** tackling the shortages across a wide range of NHS staff groups, noting that the most urgent challenge is the current shortage of nurses.

4. **Develop a workforce for the 21st century:** growing our overall workforce but acknowledging that growth alone will not be enough. We need a transformed workforce, a more varied and richer skill mix, new types of roles and different ways of working.

5. **Develop a new operating model for workforce:** continuing to work collaboratively and being clear about what needs to be done locally, regionally and nationally, with more responsibility for people planning activities undertaken by local integrated care systems (ICSs).

6. **Take immediate action in 2019/20 while we develop a full 5-year plan**: taking action immediately, with a set of focussed actions for the year ahead while continuing collaborative work to develop a fully costed 5-year People Plan later this year.

National / Regulator / ICS Actions 1

Delivering 21st century care	**Owner(s)**	**Timescale**
Support local health systems (STPs/ICSs) to develop five-year workforce plans, as an integral part of service and financial plans, enabling us to understand better the number and mix of roles needed to deliver the *NHS Long Term Plan* and inform national workforce planning.	HEE NHSE/NHSI	By November 2019
Develop plans for further expansion of undergraduate medical placements. Implement post-foundation Internal Medicine Training to expand the number of doctors with generalist skills.	HEE/DHSC NHSE/NHSI	By March 2020
Support every STP/ICS to put in place a collaborative approach to apprenticeships and provide further tools and practical resources to help them maximise the use of the Apprenticeship Levy.	NHSE/NHSI, HEE	By March 2020
A new operating model for workforce		
Co-produce an ICS maturity framework that benchmarks workforce activities in STPs/ICSs, informs the support that STPs/ICSs can expect from NHS England/NHS Improvement and Health Education England regional teams and informs decisions on the pace and scale at which ICSs take on workforce and people activities.	NHSE/NHSI, HEE	By May 2019
Regional teams and ICSs to agree respective roles and responsibilities, associated resources, governance and ways of working.	NHSE/NHSI, HEE	By March 2020
Implement a collaborative system-level approach to delivery of international recruitment and apprenticeships.	NHSE/NHSI, HEE	By March 2020
Agree development plans to improve STP/ICS workforce planning capability and capacity.	NHSE/NHSI, HEE STPs/ICSs	By April 2020
Deliver a rapid expansion programme to increase clinical placement capacity by 5,000 for September 2019 intakes. Work directly with trust directors of nursing to assess organisational readiness and provide targeted support and resource to develop the infrastructure required to increase placement capacity.	NHSE/NHSI, HEE	By September 2019
Undertake a more comprehensive review of current clinical placement activity, identify outliers and provide support to remove barriers to expansion for future intakes. This will include options for expanding the provision of placements in primary and social care and explore how innovative approaches and best practice can support expansion.	NHSE/NHSI, HEE	By March 2020
Develop a toolkit for supervisors and assessors to enable them to support the wide diversity of learners	HEE	By March 2020

National / Regulator / ICS Actions 2

Making the NHS the best place to work	**Owner(s)**	**Timescale**
All local NHS systems and organisations to set out plans to make the NHS the best place to work as part of their *NHS Long Term Plan* implementation plans, to be updated to reflect the people offer published as part of the full People Plan.	ICSs & STPs	By end November 2019
Improving the leadership culture		
Support NHS boards to set targets for Black and Minority Ethnic (BME) representation across their workforce and develop robust implementation plans, as part of their *NHS Long Term Plan* implementation five-year plans.	NHS England/ NHS Improvement	By November 2019
Tackling the nursing challenge		
Work with primary care to extend the retention programme into general practice, in addition to incentives to support entry to and return to general practice nursing.	NHSE/NHSI	By March 2020
Provide additional support in specialised areas where the need is greatest, including high secure hospitals and emergency departments.	NHSE/NHSI	By March 2020
Deliver a rapid expansion programme to increase clinical placement capacity by 5,000 for September 2019 intakes. Work directly with trust directors of nursing to assess organisational readiness and provide targeted support and resource to develop the infrastructure required to increase placement capacity.	NHSE/NHSI HEE	By September 2019
Undertake a more comprehensive review of current clinical placement activity, identify outliers and provide support to remove barriers to expansion for future intakes. This will include options for expanding the provision of placements in primary and social care and explore how innovative approaches and best practice can support expansion.	NHSE/NHSI HEE	By March 2020
Develop a toolkit for supervisors and assessors to enable them to support the wide diversity of learners	HEE	By March 2020

Developing our new Trust's People Strategy

Locally, a number of workshops and engagement events have taken place since the launch of the interim People Plan on developing our new merged Trust's People Strategy. Further engagement processes are planned after completion of the Phase 3 structural organisations.

A current top priority is working in partnership with Trust leads, and ICS colleagues to develop the Gloucestershire and Herefordshire ICS and STP LTP workforce narratives and numbers. To inform this a series of workforce planning workshops have been held within the Trust and across partner organisation, with more planned. The final local and ICS submission of this is expected for mid November 2019.

Additional local priorities include developing the new Trust's Recruitment & Retention and Health and Well-being strategies.

In tandem with the development of the new Trust's own strategic objectives, planned for March, in terms of headlines, our future People Strategy aims to cover:

- Supporting Our Current Workforce
- Recruiting, Growing & Retaining Our People
- Leadership Development ("Leading Care Together") & Valuing Diversity
- Enabling Productive Working through QI & IT
- Supporting New Models Of Care and Future Workforce Roles & Development
- Digitally Ready Workforce
- Succession & Talent Management
- Patients, Volunteers & the Third Sector

Supporting for the people agenda

Nationally, regionally, ICS-wide and locally within the Trust, we have a great opportunity to embed the ambitious agenda set out in the interim Plan by…

- **Promoting** culture change through a greater focus on the people agenda – culture, leadership, equalities and inclusion, people management, Just Culture, Freedom to Speak Up and in how we all go about all our work

- **Contributing** to the process of creating a national leadership compact, and competency frameworks, which will apply across the system and within the regulators

- **Encouraging** colleagues from across the NHS to participate in the engagement exercise that will shape the new national 'offer' to our people. Encouraging staff and manager to get involved within the Trust to participate in workforce planning and people strategy sessions over the coming months.

Trust Board

Date of Meeting: **26th September 2019**

Report Title: **Quality and Performance Committee Report**

Agenda reference Number:	13
Accountable Executive Director: (AED)	Susan Field, Director of Nursing
Presenter: (if not AED)	Nicola Strother Smith, Non-Executive Director
Author(s):	Susan Field, Director of Nursing
Board action required:	To **Note** and **Receive**
Previously considered by:	Quality and Performance Committee – 29th August 2019
Appendices:	

Executive Summary

The Quality and Performance Committee meeting took place on 29th August 2019 and this report provides an overview of the Trusts Quality and Performance activities that were discussed at this meeting. It also highlights achievements made as well as how the Trust is responding to areas of risk or where improvements need to be made.

Recommendations:

The Trust Board is asked to:

1. **Discuss, Note** and **Receive** the contents of the Quality and Performance Committee Report.

Related Trust Objectives:	1, 2, 3
Risk Implications:	Risk issues are clearly identifed within the report
Quality and Equality Impact Assessment: (QEIA)	Implications are clearly referenced in the report
Financial Implications:	No finance implications identified
Legal/Regulatory Implications:	Legal/Regulatory implications are clearly referenced in the report

Quality and Performance Committee Update

1 INTRODUCTION AND PURPOSE

The Trusts Quality and Performance Committee reviewed July 2019 data, when it met on 29th August 2019 and in line with the Trust's scheme of delegation, this paper reports:

- Decisions made by the Quality and Performance Committee.
- Risks and achievements currently overseen by the Committee.

2 DECISIONS MADE BY THE COMMITTEE IN LINE WITH SCHEME OF DELEGATION

2.1 Podiatry

The service has continued to experience challenges in achieving its eight week Referral To Treat (RTT) standards and because of this the Committee received the outcomes of an in-depth review of the risks, mitigations and potential opportunities to both transform and improve the service.

The purpose of the review was to provide an understanding to the Committee about the multi-faceted challenges in delivering the eight week RTT and to provide assurances about the work underway to improve access and quality care. Key outcomes of the review included:

- Each element of the podiatry service is currently commissioned separately.
- Workforce challenges that the service was managing included a staff turnover rate of **11.37%**, a sickness level of **2.58%** (well below the Trust average of 4.7%) and the service having a range of speciality roles, some of which are hard to recruit to.
- The Service receiving an average of 273 referrals per week (Total 14,217 per year).
- The waiting time for patients to be seen has increased. As at June 2019 there were 1,817 people waiting.
- That appointment cancellation rates were high, **24.8%** and that Did Not Attend (DNA) rates were also high, **9.2%** compared to the **7.36%** national average.
- That the service had undertaken some initial demand and capacity modelling work which indicated the need for some role/service changes between practitioners; more effective management of re-referral and DNA rates.
- That there is an additional risk emerging regarding the diabetes foot care funding ceasing by March 2020. **NB:** This is NHS England non-recurrent funding.

The Committee supported the recovery plans shared by the service, which included:

- Cleansing and refining the patient waiting profiles, referral source codes and the reporting parameters with the Trusts performance team.

- Improving patient access by setting up a consistent clinically significant telephone call service and introducing more effective communication for those patients waiting more than six weeks.
- Undertaking more in-depth analysis into practitioner productivity to assess any potential variations.

The Committee also **recommended** that the work should be handed over to the new Trust and be more aligned to the medium term transformational change agendas and that there is a continued robust monitoring of improved performance.

2.2 Risk Management

The Committee reviewed the Quality related risks (rating 12 and above) across the Trust. It also reviewed proposals about the future risk management arrangements and supported the notion of the new Trust having a Risk Steering Group and that there be a continued alignment with the refreshed Board Assurance Framework currently being reviewed and developed by the Interim Trust Secretary.

2.3 National Patient Safety Strategy

The Committee **received** the outcomes of an internal "gap analysis" undertaken by the Trusts Head of Clinical Governance and reviewed by its Clinical Reference Group (CRG). The Committee **supported** on behalf of the Trust Board that there was a requirement to align with the Freedom to Speak Up agendas and recognised that the new Trust Board will be required to respond, align and be clear about its own Patient Safety Strategy by Qtr. 4 2019-20.

3 ISSUES ESCALATED TO BOARD

The Committee **discussed** a range of matters where it was agreed the following should be escalated to the Trust Board. These included:

3.1 Mortality Reviews

The Committee was not fully assured about what the future arrangements will be for undertaking Mortality Reviews so that physical and mental health death reviews (including Learning Disability Mortality Review (LeDeR)) are aligned more cohesively and that the recent recommendations made within the National Patient Safety Strategy (published July 2019) are reflected within these new arrangements

3.2 EU Exit

It was recognised and acknowledged by the Committee that there will be a considerable amount of "ramping up" with regards to EU Exit planning and the levels of assurance that the Trust will be required to provide both internally and externally. The Trust Board

will need to maintain a strategic focus on this over the coming months. It was also **noted** that the leadership of EU Exit plans will transfer to the Chief Operating Officer for the new Trust (John Campbell) supported by the resilience lead and other colleagues across the Trust.

3.3 Friends and Family Test Changes

The Committee **noted** that there are some imminent changes associated with the Patient Family and Friends Test (FFT). These will include:

- Taking effect from 1st April 2020.
- A new question will be asked "*Overall how was your experience of our service*".
- That the changes will include six responses to the above question.
- Further national guidance is expected September 2019 and it is likely that data capture reporting arrangements will need to change accordingly.

3.4 Coroner's Report

The Committee **received** the Trusts annual report and **noted** that there had been no Prevention of Death Report requests or Regulation 28 of the Coroner's (Investigations) Regulation (2013) applied for the Trust. The Committee also **noted** that responsibility for any Coroners activity will transfer to the medical director for the new Trust.

3.5 Quality and Performance Report

The Committee **discussed** and **noted** the Quality and Performance data for July 2019. The Committee was **assured** that mitigations and actions were being put into place and especially with regards to service improvements in order to achieve the 8 week Referral To Treat (RTT) most notably within Musculoskeletal (MSK) Physiotherapy, podiatry and Integrated Community Team (ICT) Occupational Therapy.

4 RECOMMENDATIONS

The Trust Board is asked to:

1. **Discuss, Note** and **Receive** the contents of the Quality and Performance Committee Report.

ABBREVIATIONS USED IN THE REPORT

CRG – Clinical Reference Group
DNA – Did Not Attend
FFT – Family and Friends Test
MSK – Musculoskeletal
RTT – Referral To Treat

LeDeR – Learning Disability Mortality Review

Agenda Item 14

Report to: Trust Board 26th September 2019
Author: Angie Fletcher, Service Experience Clinical Manager
Presented by: Jane Melton, Director of Engagement and Integration

Subject: **Service Experience Report Quarter 1 2019/20**

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 2019/20. 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 service-specific 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 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 85% of people who completed the Friends and Family Test said that they would recommend 2gether's services, this is similar to the previous quarter (n=87%).

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

Our **How did we do?** survey was launched during Quarter 1 2017/18. Whilst feedback given by respondents has generally been positive, response rates remain lower than hoped for. For the first time in four consecutive quarters, we have a decrease in the numbers of responses received. Our SED are continuing to implement and embed a new system for and with practice settings encourage more responses to our local surveys.

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

Compliments continue to be reported to the Service Experience Department.

Numbers have decreased slightly during Quarter 1 and work continues to increase reporting by colleagues throughout the Trust.

Significant Assurance that complaints have been acknowledged in required timescale
During Quarter 1 93% of complaints received were acknowledged within 3 days.

Limited assurance that all people who complain have their complaint dealt with by the initially agreed timescale.
53% of complaints received final response letters within timescales agreed with the complainant. This is higher than the previous quarter (50%). The SED are working with Trust colleagues to ensure that future complaints are investigated and responded to in a timely way.

Full assurance is given that all complainants receive regular updates on any potential delays in the response being provided.

(2) Recommended learning and improvement
The Trust continues to seek feedback about service experience from multiple sources on a continuous basis.
This quarter concerns and complaint themes continue to focus on communication issues by our services with service users and/or their carers. Colleagues across the Trust are working hard to develop practice in this area.

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

- We must clearly explain to people what we are doing and why we are doing it.
- We must make sure that we involve families and carers.

(3) Risk issues discussed at QCR in August 2019
3.1 Survey response rates continue to be lower than hoped. Although the number of respondents have increased in Quarter 1 this area is identified as having *limited assurance* within the Quarter 1 report.
This risk is logged on the Trust Risk Register and a structured plan is in place, led by the Service Expereince Clinical Manager to increase response numbers so that more people who use our services can provide local survey feedback. This will support the development and delivery of best standards of practice.

3.2 Response times to complaints from the Trust have increased slightly during Quarter 1. However, they remain lower than hoped for and are identified as having *limited assurance* within the Quarter 1 report. The SED have learnt that it is better to negotiate a lengthier timeframe for responses to be provided with the complainant especially at times of challenge with staff capacity.
(4) Recommendations from the Trust Governance Committee
A ‘deep dive’ into the feedback received about matters of ‘communication’ will be undertaken to provide information about how we can communicate with people more effectively. The Service Expereince Department will lead this review.

RECOMMENDATIONS
The Trust Board is asked to:

- Note the contents of this report

Corporate Considerations	
Quality Implications	Patient and carer experience is a key component of the delivery of best quality of care. The report triangulates what is known about experience of ^{2}gether's services in Q1 2019/20 and makes key recommendations for actions to enhance quality.
Resource Implications	The Service Experience Report offers assurance to the Trust that resources are being used to support best service experience.
Equalities Implications	The Service Experience Report offers assurance that the Trust is attending to its responsibilities regarding equalities for service users and carers.
Risk Implications	Feedback on service experience offers an insight into how services are received. The information provides a mechanism for identifying performance, reputational and clinical risks.

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

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

Reviewed by:		
Jane Melton	Date	22nd August 2019

Where in the Trust has this been discussed before?		
Quality and Clinical Risk Sub-committee	Date	16th August 2019
Governance Committee		31st August 2019

What consultation has there been?		

Explanation of acronyms used:

NHS	National Health Service
PALS	Patient Advice and Liaison Service
CYPS	Children and Young People Service
SED	Service Experience Department
HR	Human Resources
CEO	Chief Executive Officer
BME	Black and Minority Ethnic Groups
IAPT	Improving access to psychological therapies
PHSO	Parliamentary and Health Service Ombudsman
CQC	Care Quality Commission
CHI ESQ	Children's Experience of Service Questionnaire
CAMHS	Child and Adolescent Mental Health Service
MHA	Mental Health Act
MCA	Mental Capacity Act
CCG	Clinical Commissioning Group
Q3	Quarter 4 (previous quarter (2018/19)
FFT	Friends and Family Test (survey)

Service Experience Report

Quarter 1

1st April 2019 to 30th June 2019

"I so desperately needed help with a problem that was causing me intense distress. The service experience team took immediate action. I am so grateful for this support because had you not been there I would have been in crisis. I am slowly recovering. Thank you so much, once again."

SED

"I just want to say thank you, as you clearly care about the people you see and it shows."

Vocational Services

Contents

Key

NHS	National Health Service
PALS	Patient Advice and Liaison Service
CYPS	Children and Young People Service
SED	Service Experience Department
HR	Human Resources
CEO	Chief Executive Officer
IAPT	Improving Access to Psychological Therapies
PHSO	Parliamentary and Health Service Ombudsman
CQC	Care Quality Commission
CHI ESQ	Children's Experience of Service Questionnaire
CAMHS	Child and Adolescent Mental Health Service
Mental Health Act	Mental Health Act
LGO	Local Government Ombudsman
Q4	Quarter 4 (previous quarter 2018/19)
FFT	Friends and Family Test (survey)

Service Experience Report

1st April 2019 to 30th June 2019

Complaints 	**29** complaints were made this quarter. This is more than last time (Q4=21). We want people to tell us about any worries about their care. This way we can help to make things better.	↑
Concerns 	**54** concerns were raised through PALS. This is less than last time (Q4=60).	↓
Compliments 	**466** people told us they were pleased with our service. This is less than last time (Q4=685). We want teams to tell us about every compliment they get.	↓
FFT 	**85%** of people said they would recommend our service to their family or friends. This is about the same as last time (Q4=87%).	↔
Quality Survey 	Gloucestershire: **102** people told us what they thought. This is less than last time (Q4=227) Herefordshire: **124** people told us what they thought. This is more than last time (Q4=58) We want more people to tell us what they think.	↓ (number of replies)
We must listen 	We must clearly explain what we are doing and why we are doing it. We must make sure that we involve families and carers.	

Key

			Full assurance
↑	Increased performance/activity		Significant assurance
↔	Performance/activity remains similar		Limited assurance
↓	Reduced performance/activity		Negative 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 2019 and 30th June 2019**. 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
- Patient Advice and Liaison Service (PALS)
- Meetings with stakeholders
- ²gether quality surveys
- National Friends and Family Test (FFT) responses

1.1.4 **Section 3** provides examples of the learning that has been identified through analysis of reported service experience and the 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 ²gether. This is underpinned by the NHS Constitution (2015[1]), a key component of the Trust's core values.

1.2.2 ²gether NHS Trust's Service User Charter, Carer Charter and Staff Charter outline the commitment to delivering our values and this is supported by our vision for best Service Experience:

A shared goal to listen to, respond to, and improve service experience; through a continuous cycle of learning from experience we will provide the best quality service experience and care:

Our vision for best Service Expereince:
As we serve patients and their carers, we will go beyond what people expect of us to ensure that we earn their trust, confidence, and foster hope for the future.

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

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

Section 2 – Emerging Themes about Service Experience

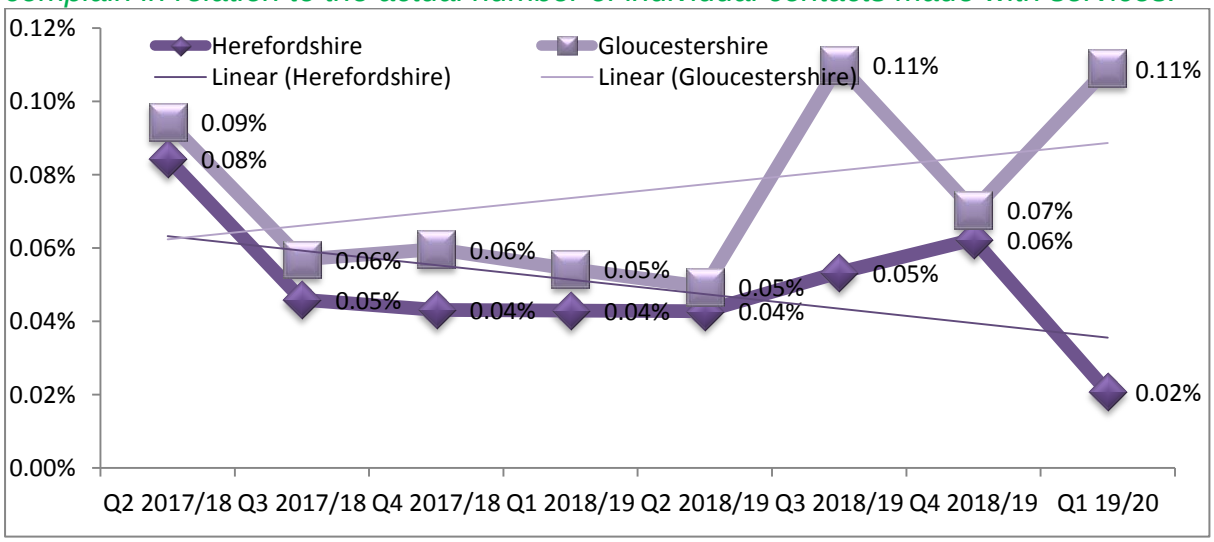
2.1 Complaints

2.1.1 Formal complaints to NHS service providers are highly governed and responses must follow specific procedures (for more information, please see the Trust's Policy and Procedure on Handling and Resolving Complaints and Concerns). We value feedback from those in contact with our services as this enables us to make services even more responsive and supportive. We encourage people to let us know if they are concerned so that we can resolve issues at the earliest possible opportunity.

Table 1: Number of complaints received this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	28	↑	The number of complaints reported in Gloucestershire is much greater than the previous quarter (Q4-18)	Significant
Herefordshire	1	↓	The number of complaints reported in Herefordshire is less than the previous quarter (Q4=3)	Significant
Total	29	↑	The total number of complaints received has increased from the previous quarter (Q4=21)	Significant

Figure 1: Trend line of complaints received over time in Herefordshire and Gloucestershire. Figure 1 also illustrates quarterly % numbers of people who complain in relation to the actual number of individual contacts made with services.



2.1.2 Figure 1 shows the percentage of complaints received in relation to the number of individual contacts made with our services during each quarterly period since Q2 2017/18. During Quarter 1 2019/20 Gloucestershire experienced a slight increase in the rate of complaints received in relation to individual contacts whilst Herefordshire saw a slight decrease. Whilst there

have been minor fluctuations quarter by quarter, a continual low level of complaints to contacts has been observed over time.

2.1.3 Table 2 summarises our responsiveness. This quarter has seen a continued high level of responsiveness from our Service Experience Department when acknowledging complaints, although is slightly lower than the previous quarter.

We have continued to encounter challenges during this quarter when meeting agreed timescales to respond to complainants with the findings of our investigations. This has been due to a combination of factors such as availability of operational and medical colleagues to allocate and participate in the investigation process, along with a lack of protected time for operational colleagues to undertake investigations whilst maintaining clinical roles.

Work remains ongoing to review the way investigations and protected time is allocated as identified in our Internal Audit report 2018/19 - Learning from Service Experience Feedback (detailed in Quarter 3 2018/19 SE report)

Table 2: Responsiveness

Target	% Number	Direction compared with Q3	Interpretation	Assurance
Acknowledged with three days	93%		**27 of 29** complaints were acknowledged within target timeframes, which is lower than last quarter (Q4=100%)	**Significant**
Response received within agreed timescales	53%		This is slightly higher than last quarter (Q4=50%). Nine letters of response were not received by the complainant within the timescale agreed (19 were due out in this quarter).	**Limited**
Concerns escalated to complaint	9%		Of 65 concerns closed (Q4=59 closed), six were escalated to a formal complaint; this is more than last quarter (Q4=0%)	**Significant**

2.1.4 Nine complaint responses were not received within initially agreed timescales. Four responses were late due to delays in appointing a suitable investigator, three due to SED resources, and two due to delays within our quality review processes. On each occasion the complainant was contacted in order to provide an explanation, an apology, and an expected date that our response would be sent to them.

2.1.5 The SED continue to monitor delayed response rates carefully, working closely with operational and corporate colleagues to ensure that our Complaints Policy is adhered to in relation to all aspects of complaint handling.

Table 3: Satisfaction with complaint process

Measure	Number (numerical direction)		Interpretation	Assurance
Reopened complaints	3		This figure is slightly more than the previous quarter (Q4=2)	**Significant**
Local Resolution Meetings	2		This figure is the same as in the previous quarter (Q4=2)	**Significant**
Referrals to external review bodies	0		No complaints were referred for external review (Q4=1). See Table 13 for more detail.	**Full**

2.1.6 In Quarter 1, three recently closed complaints were reopened. One is awaiting a Local Resolution Meeting, and two have been reopened for additional investigation following further information being provided by the complainants

2.1.7 Analysis of data is undertaken by the SED in order to identify any patterns or themes. Analysis of complaints closed during Quarter 1 is shown by the status of complaint outcome (Table 4).

Table 4: Outcome of complaints closed this quarter

Outcome	No.	%	
Not upheld *No element of the complaint was upheld*	9	39%	Following feedback from complainants and stakeholders, the Trust no longer uses the terms upheld/partially upheld/not upheld within our response letters. However, these categories are required to be recorded for national reporting purposes. In total, 23 complaints were closed this quarter. This is a lot more than the number of complaints closed in Quarter 4 (n=12). 43% of the complaints closed this quarter had at least some or all issues of complaint upheld. This is very similar to Quarter 4 (41% upheld/partially upheld).
Partially upheld *Some elements of the whole complaint were upheld*	10	43%	
Upheld *All elements of the whole complaint were upheld*	0	0%	
Withdrawn *All elements of the whole complaint were withdrawn*	4	17%	

**Individual issues within each formal complaint are either upheld or not upheld. Partially upheld is not used for individual issues, the term is used to classify the overarching complaint where some but not all of the issues were found to have been upheld. Percentages rounded to nearest whole number*

2.1.8 Table 5 shows the outcome following investigation of complaints in relation to the staff group involved in individual issues of complaint.

Nursing and Medical colleagues have the most amount of contacts with people and continue to feature as the staff groups most frequently involved in complaints received. It is reassuring to see that following investigation the

numbers of investigations that are partially or fully uphold the issues raised is low.

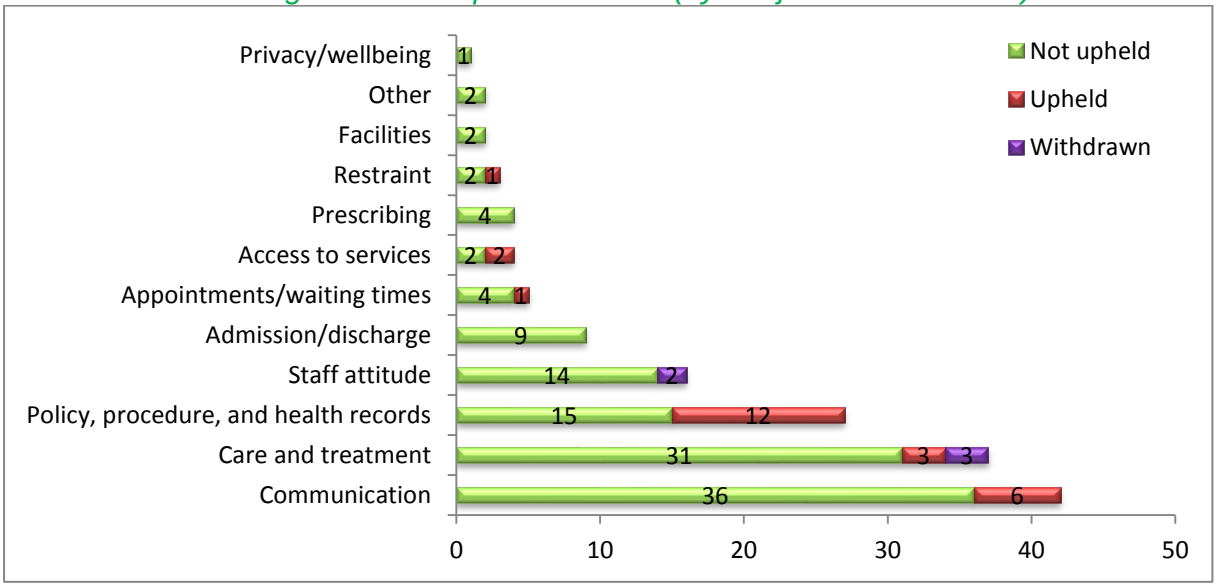
Table 5: Breakdown of closed complaint issues by staff group

	Not upheld	**Upheld**	Withdrawn	Total
Admin	1	**0**	0	1
Medical	23	**0**	0	23
Nursing	67	**19**	3	89
HCA	3	**0**	0	3
Social Worker	7	**3**	0	10
AHPP	6	**0**	0	6
Other	12	**1**	2	15
No staff involved	3	**2**	0	5
Total	122	**25**	5	152

**The numbers represented in these data relate to a breakdown of individual complaint issues following investigation*

2.1.9 Table 6 provides an overview of the issues of complaint in the context of the investigation outcome (upheld or not upheld). Analysis of this information shows that the main theme emerging from the Q1 issues of complaint that were upheld (n=25) following investigation, related to aspects of the reported experience of ***policy, procedure, and health records***.

Table 6: Overarching closed complaint themes (by subject and outcome)



2.1.10 Communication and care and treatment are recurrent themes found to be reported as issues of complaint that are also found to dominate thematic data nationally.

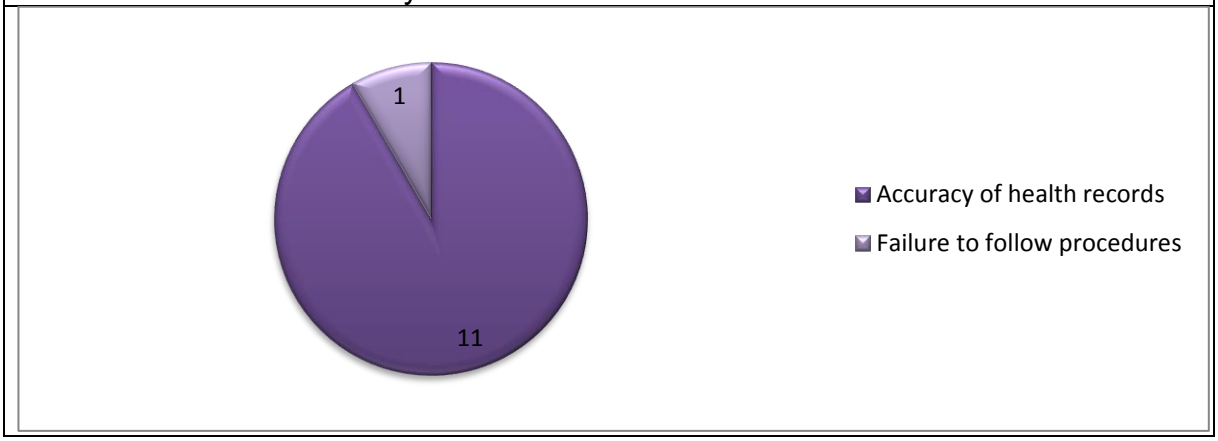
Following the investigation of complaints raised these areas are found to have a low level of issues being upheld.

The area with the greatest number of issues upheld following investigation relate to ***policy, procedure, and health records***, further analysis of this is shown in Figure 2.

Figure 2: Review of identified complaint themes

Breakdown of upheld complaint issues

Our Trust takes all concerns very seriously. The themes reflected below demonstrate the outcomes of complaint issues that have been investigated and upheld. The main upheld complaint theme relates to ***policy, procedure, and health records*** and is analysed further below:



2.1.11 SED have undertaken further analysis of the issues of complaint relating to aspects of policy, procedure and health records that were upheld following investigation of these matters and found that the majority of issues related to a multifaceted complaint that reviewed written communication that was found to contain factual inaccuracies.

The SED have continued to work with operational colleagues throughout Quarter 1 to implement systems of learning from service experience feedback. Practice notes detailing learning from complaints continue to be produced monthly and disseminated throughout our locality governance boards for onward review and discussion by our teams and services. The learning from issues represented in Figure 2 has been included in this quarter's practice notes and is detailed further in section 3 of this report.

Some individual examples of actions taken by Trust colleagues linked to the thematic data are detailed further in Table 8.

Table 8: Examples of complaints closed and action taken

Example	You said	We did	Assurance
Communication	We attended an MDT meeting to discuss mum's care, only to discover it was actually a meeting to plan her discharge – mum's Care Co-ordinator was not told about this either	We explained that the service user had had regular reviews which indicated discharge was appropriate, and apologised that this was not communicated to the family or Care Co-ordinator	**Significant**

Example	You said	We did	Assurance
Care and treatment	I reported various symptoms including hallucinations but my PRN medication was not given to me	We apologised and explained that the prescription for PRN medication did not specify the conditions under which it should be administered, which caused some confusion	Significant
Communication	I have not been kept informed about my mum's assessments and financial matter regarding her care	We explained which agencies are responsible for funding certain areas, and ensured the carer had contact details for any queries	Significant

2.2 Concerns

2.2.1 Our Trust endeavours to be responsive to feedback and to resolve concerns with people at the point at which they are raised. This has resulted in complaint numbers being maintained at a lower level and a corresponding increase in the number of PALS contacts overtime. Data regarding the concerns received by our SED have been analysed and are reflected in Table 9.

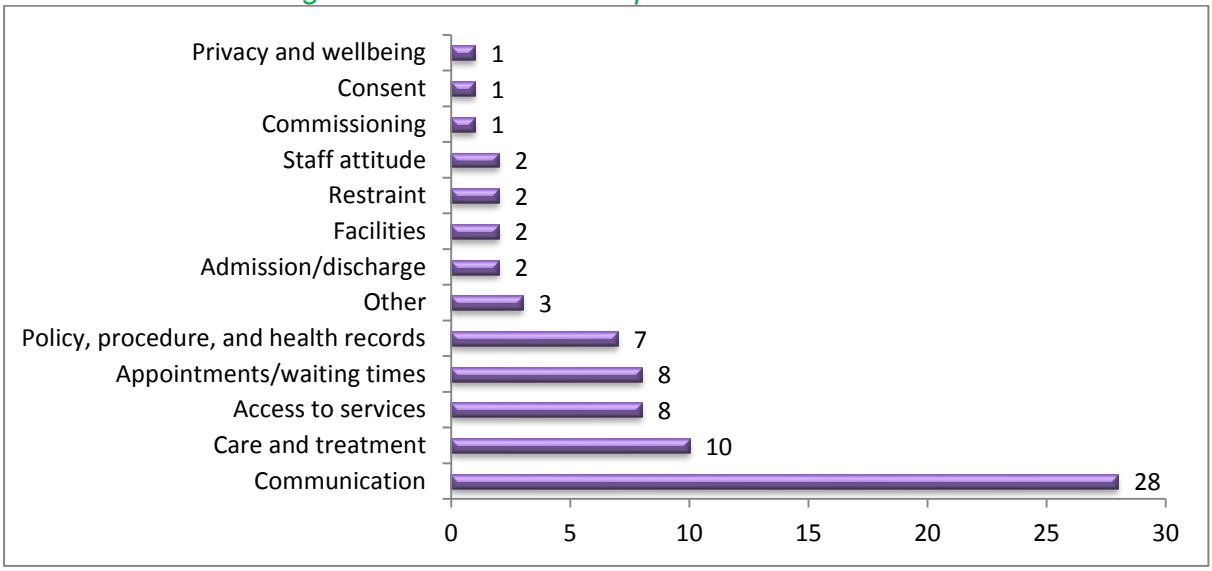
Table 9: Number of concerns received this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	44		The number of concerns raised in Gloucestershire is less than the last quarter (Q4=53)	Significant
Herefordshire	7		The number of concerns raised in Herefordshire is more than the last quarter (Q4=5)	Significant
Corporate	3		There were about the same number of concerns relating to corporate services compared to last quarter (Q4=2)	Significant
Total	54		The number of concerns raised is lower than last quarter (Q4=60)	Significant

2.2.2 The number of concerns raised remains relatively consistent with previous quarters but has reduced slightly by comparison to last quarter. The themes of concerns raised during this quarter are captured in Table 10.

There were also 55 other contacts with our Service Experience Department during Quarter 1 (Q4=85) covering a range of topics. The decrease in contact seen in Quarter 1 is viewed in the context of overall Service Experience activity where there has been an increase in the number of formal complaints this quarter, this continues to offer assurance that people are continuing to access the SED as a resource to respond to queries relating to our Trust.

Table 10: Overarching concern themes this quarter



**The numbers represented in this data relate to a breakdown of individual issues and do not equal the number of concerns*

2.2.3 Table 10 outlines the themes from concerns that have been closed this quarter. The main theme identified is ***Communication***, which is also a recurrent theme within analysis of issues of our formal complaints and is found to tie in closely with the theme of policy procedure and health records in terms of explaining what our services are able to offer in order to meet people's expectations of the support and services that are available.

2.2.4 Table 11 demonstrates the staff groups referred to in individual concerns.

Table 11: Breakdown of closed concerns by staff group for this quarter

Staff group	No	
Nursing	26	Nursing represents the largest staff group in the Trust and has the greatest number of contacts with service users and carers. Work is ongoing to ensure that professional leads are made aware of any themes relating to their staffing group.
Medical	12	
Admin	11	
None	6	
AHPP	6	
PWP	6	
Other	4	
Social Worker	3	
Hotel Services	1	

2.2.5 Examples of concerns and actions taken during this quarter are shown in Table 12.

Table 12 Examples of concerns and action taken:

Example	You said	We did	Assurance
Health Records	Not happy with inaccuracies in health records between the years 2012-2016; therefore the service	Confirmation sent to the service user confirming that the addendum report was added to their health records	Significant

Example	You said	We did	Assurance
	user would like matters rectified.		
Communication	Numerous miscommunications and poor communication which are impacting on son	Offered a meeting with team which was accepted	**Significant**
Appointment / waiting time	Letter received for a telephone appointment on the day of the actual appointment. Service user was not able to take the call due to poor reception and now has to wait a month for the next appointment.	Raised with Clinical Lead and new appointment expedited	**Significant**

2.2.5 PALS Visits

2.2.5.1 Patient Advice and Liaison Service (PALS) visits are undertaken in our clinical services to ensure that people's concerns are heard and resolved as soon as possible. Visits to Wotton Lawn Hospital and Charlton Lane Hospital in Gloucestershire, and Stonebow Unit in Herefordshire, were undertaken during Quarter 1. PALS also visited Pullman Place and are planning visits to other community hubs in the near future.

2.2.5.2 During each visit the SED PALS Officers visited the designated wards and community hub to speak with service users and families/carers.

2.2.5.3 PALS provided the following types of support and assistance during visits undertaken in Quarter 1:

- Assisting service users to resolve queries relating to the ward environment.
- Providing support about how to give feedback about Trust services.
- Receiving compliments about the ward and our staff from both service users and members of their families.
- Listening to service users' and carers' experiences of our wards.
- Responding to concerns and queries through liaison with staff and ward managers

2.2.5.4 The following **emerging themes** have been identified from analysis of PALS reports following visits to our inpatient services across our Trust:

- Feedback about food served on the wards has been mixed with some service users reporting too much food and others saying the portions are too small. Some feel the quality of the food is bad, others say it is excellent

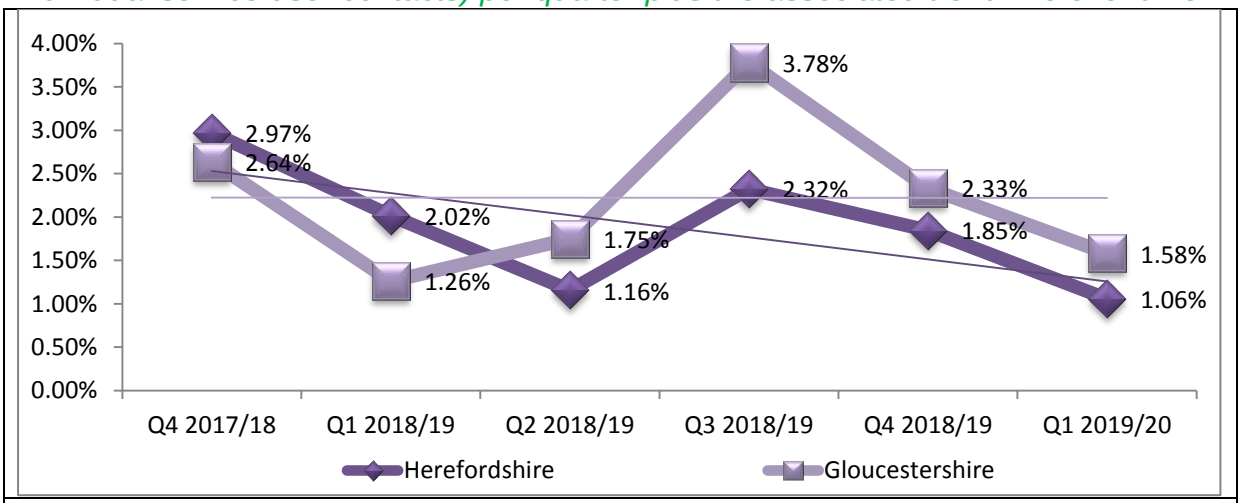
- Varied views about the ward environment with some people saying the ward was too loud and others commenting that they felt safe and enjoyed the activities on offer
- Feedback about the ward staff has been mainly positive in nature, such as, staff are all very good, supportive, and approachable. Other comments related to busy staff not always being available, and there not being enough staff on the ward

2.2.5.5 The majority of feedback given has been positive and any issues raised were reported directly to the ward for timely resolution wherever possible. A summary report of each visit is sent by the PALS Officers to the Ward Manager, Modern Matron, Deputy Director of Nursing, Estates and Facilities and Locality Governance Lead.

2.3 Compliments

2.3.1 The SED continues to encourage the reporting of compliments received by Trust services. **466** compliments were received this quarter. This is a decrease when compared to Quarter 4 (n=685). A dedicated email address is set up to simplify the process for colleagues to report compliments that they have received: 2gnft.compliments@nhs.net. Figure 3 shows the percentage of compliments to contacts as reported during Quarter 1 and the previous 4 quarters.

Figure 3: Percentage of compliments received (calculated by the number of individual service user contacts) per quarter plus the associated trend line over time



Compliments are being shared and regularly updated with colleagues via the Trust intranet system to further encourage reporting.

Examples of compliments received during this quarter:

Patient said when she first began her sessions she felt like she was in a dark tunnel. She now feels she has moved through the tunnel into the light and feels like herself after years of not knowing what was going on.

IAPT, Gloucestershire

Thank you for coming to her house to see her, and for the help with the council tax form

CLDT, Gloucestershire

Client expressed his gratefulness to team for responding to his needs last week; a good reflection of where he has come from to where he is now.

AOT. Herefordshire

2.4 Complaints referred for external review following investigation by our Trust

2.4.1 Current open referrals for external review:

Table 13: current open referrals for external review

Reviewing organisation	Date of first contact from reviewing organisation	Date official investigation confirmed	Current status of referral	Assurance Level
LGO (172)	23/01/2018	03/04/2018	Investigation ongoing	
PHSO (1243)	04/09/2018	29/10/2018	Investigation ongoing	
PHSO (415)	18/10/2018	24/01/2019	PHSO accepted complaint for further investigation	
PHSO (1498)	19/03/2019	Status unconfirmed	Awaiting further update from PHSO	
PHSO (1723)	07/03/2019	Declined	14/05/2019: PHSO declined to investigate this complaint	**Full**
PHSO (2743)	14/03/2019	Declined	20/05/2019: PHSO declined to investigate this complaint	**Full**
PHSO (1359)	30/04/2019	Status unconfirmed	Awaiting further update from PHSO	
PHSO (2538)	03/05/2019	Status unconfirmed	Awaiting further update from PHSO	
PHSO (2478)	22/05/2019	Status unconfirmed	Awaiting further update from PHSO	
PHSO (1567)	24/05/2019	Status unconfirmed	Awaiting further update from PHSO	

PHSO - Parliamentary and Health Service Ombudsman, LGO - Local Government Ombudsman

2.4.2 Referrals made for external review of complaint this quarter

There were four referrals made to the PHSO during this quarter by complainants requesting an external review of complaints that had previously been investigated by and responded to by our Trust. The PHSO have not confirmed the status of these referrals as yet.

2.4.3 Completed external complaint investigations

No investigations have been completed by external organisations during Quarter 1.

2.5 Surveys

2.5.1 'How did we do?' Survey

2.5.1.1 The Trust continues to implement the Trust's **How did we do?** survey. This survey combines the "Friends and Family Test" and "Quality Survey" and is used for all Trust services apart from IAPT and CYPS/CAMHS, where alternative service experience feedback systems are in place.

2.5.1.2 Survey results are reported internally, locally to our Commissioners, and nationally to NHS Benchmarking. It is important that colleagues encourage and support people who use our services to make their views and experiences known so we can learn from feedback and make improvements where needed.

2.5.1.3 For the past 3 years we have utilised an external provider to input and manage our survey feedback. Following a review of our processes and a desire to seek more feedback, a new system to manage Trust feedback has been commissioned that commenced in Quarter 4 2018/19. This will bring us in line with processes used by Gloucestershire Care Services NHS Trust.

2.5.1.3 The two elements of the **How did we do?** survey are reported separately below as Friends and Family Test and Quality Survey responses.

2.5.2 Friends and Family Test (FFT) Service User/ Carer feedback

2.5.2.1 Service users are asked "*How likely are you to recommend our service to your friends and family if they needed similar care or treatment?*" Our Trust has played a key role in the development of an Easy Read version of the FFT. Roll out of this version ensures that everybody is supported to provide feedback.

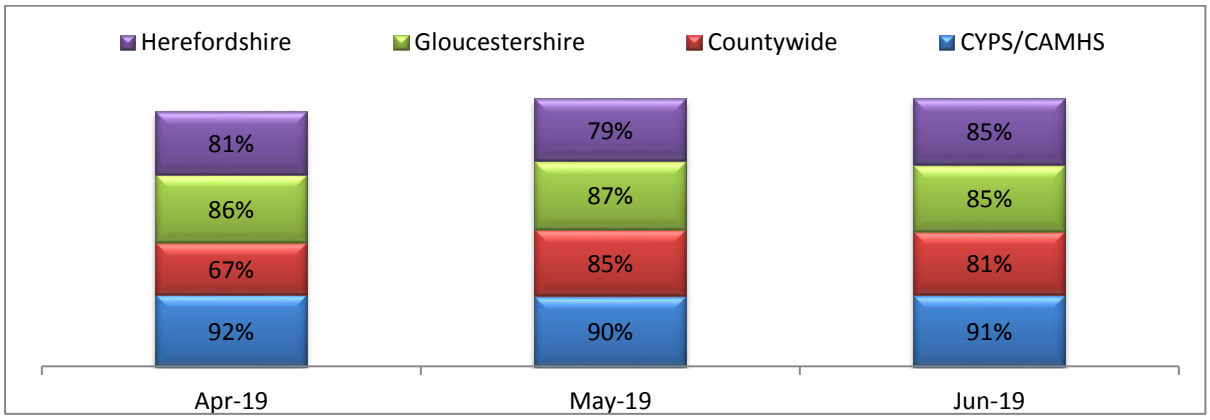
2.5.2.2 Table 14 details the Trust-wide number of responses received each month. The FFT score is the percentage of people who stated that they would be 'extremely likely' or 'likely' to recommend our services. The FFT questionnaire is available in all Trust services.

Table 14: Returns and responses to Friends and Family Test

	Number of responses	FFT Score (%)
April 2019	291 (248 positive)	85%
May 2019	257 (220 positive)	86%
June 2019	184 (157 positive)	85%
Total	732 (394 positive) **(last quarter = 545)**	**85%** **(last quarter = 87%)**

2.5.2.3 The FFT score for our Trust this quarter is about the same as last quarter. The response rate has increased. There is a suggestion that the majority of people who responded to our survey experienced a high level of satisfaction with the services that we provide.

Figure 4: FFT percentage of respondents recommending our services by month and locality

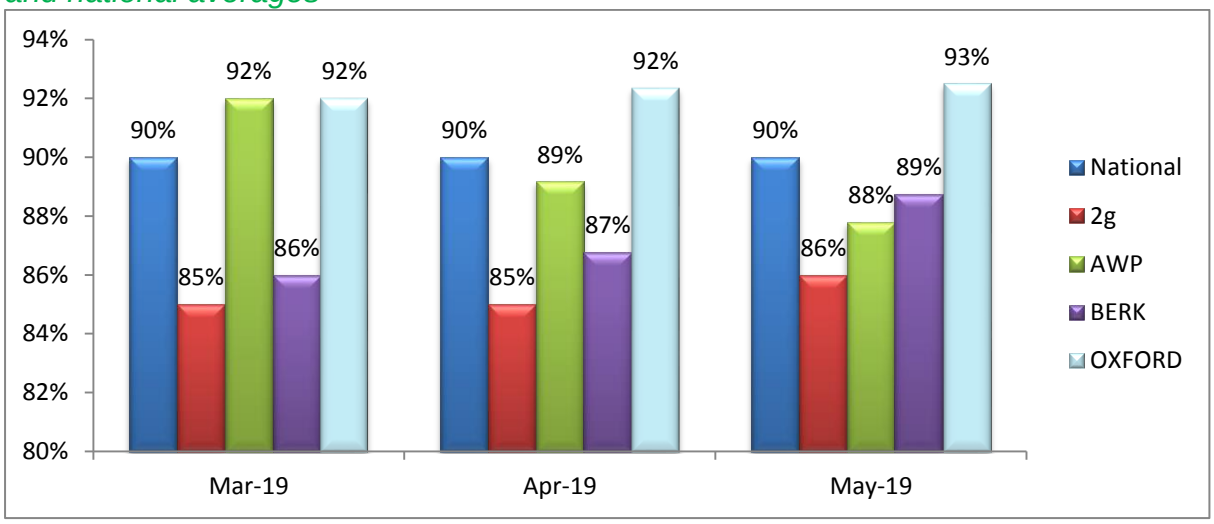


2.5.2.5 The FFT score for our Trust has remained about the same this quarter; this continues to be encouraging news following disappointing decreases seen in previous quarters last year.

SED continue to monitor FFT scores and undertake further analysis of scores to identify any areas that are influencing lower scores.
Implementation of our new system to seek FFT feedback has continued throughout Quarter 1 where a gradual increase can be seen from the previous quarter.

2.5.2.6 Figure 5 shows the FFT Scores for March, April and May 2019, (the most recent data available) compared to other Mental Health Trusts in our region, and the average of Mental Health Trusts in England. Whilst our Trust has not achieved the highest percentage of recommendation compared with some neighbouring Trusts, our response rates have increased suggesting that the feedback is reflective of a larger group of respondents. This gives some assurance and can be triangulated with national scores of patient survey.

Figure 5: Friends and Family Test Scores – comparison between the regional data and national averages[2]



[2] 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

Friends and Family Test Comments

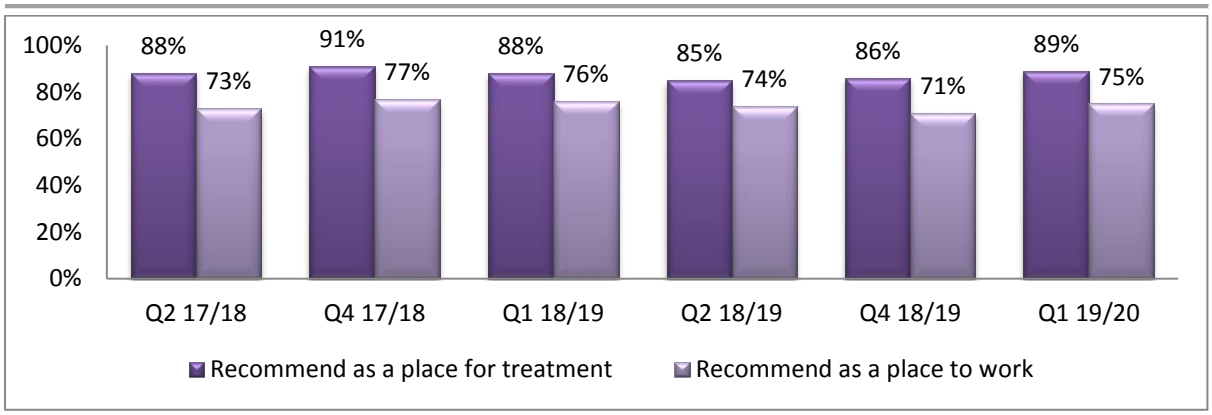
Comments are fed back to services in order that they can be shared with team members and for appropriate actions to be taken as a result of the valuable learning. Our increased high percentage of recommendation continues to indicate the large amount of positive comments received about our services.

2.5.3 [2]gether Staff Friends and Family Test (FFT) feedback

Our staff are asked about their experience of working for our Trust during quarters 1, 2 and 4 each year. In Quarter 3 the FFT is replaced by the annual Staff Survey.

Figure 6 shows the latest staff FFT scores along with previous quarters.

Figure 6: Staff Friends and Family Test Scores



2.5.3.1 The results of the Staff FFT continue to align closely with the observed trend seen from service user feedback and remain relatively unchanged across time.

2.5.4 How did we do?

2.5.4.1 The How Did We Do? survey (Local Quality Survey questions) provides people with an opportunity to comment on key aspects of the quality of their treatment.

Table 15: How Did We Do? Quality survey questions and responses

Question	County	No. of responses	Target Met?
Were you involved as much as you wanted to be in agreeing the care you receive?	Gloucestershire	95 (85 positive)	90% TARGET 84%
	Herefordshire	115 (104 positive)	
Have you been given information about who to contact outside of office hours if you have a crisis?	Gloucestershire	102 (87 positive)	86% TARGET 71%
	Herefordshire	124 (108 positive)	
Have you had help and advice about taking part in activities that are important to you?	Gloucestershire	97 (77 positive)	81% TARGET 64%
	Herefordshire	117 (96 positive)	
Have you had help and advice to find	Gloucestershire	92 (74 positive)	82%

support for physical health needs if you have needed it?	Herefordshire	111 (92 positive)	TARGET 73%

2.5.4.2 Feedback from the Quality Survey along with the annual National Community Mental Health survey results helped us to identify the need to increase the involvement of people in the development of their care plans. This is the focus of our work to implement an Always Event as part of the NHS England campaign and an increased drive for co-production across our services.

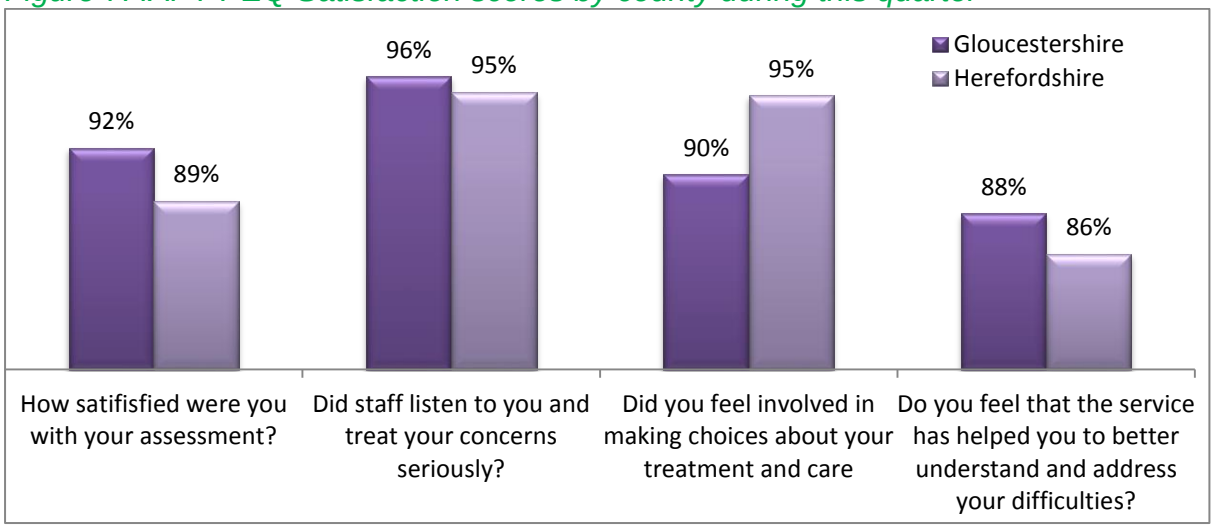
2.5.4.3 Although response rates for the survey have increased over time the level of response continues to be lower than we would like. During Quarter 1 we have continued to implement a new system to capture survey feedback with aim to increase the number of responses we receive to both aspects of the 'How did we do?' survey.

2.5.5 Improving Access to Psychological Therapies – Patient Experience Questionnaire (IAPT PEQ)

2.5.5.1 Our IAPT Let's Talk services use a nationally agreed survey to gain feedback and measure levels of satisfaction with the service.

2.5.5.2 Feedback questionnaires are sent to people following the initial assessment and after discharge from the service. Quarter 1 feedback (figure 7) shows that people are largely satisfied with these elements of the Let's Talk service.

Figure 7: IAPT PEQ Satisfaction scores by county during this quarter



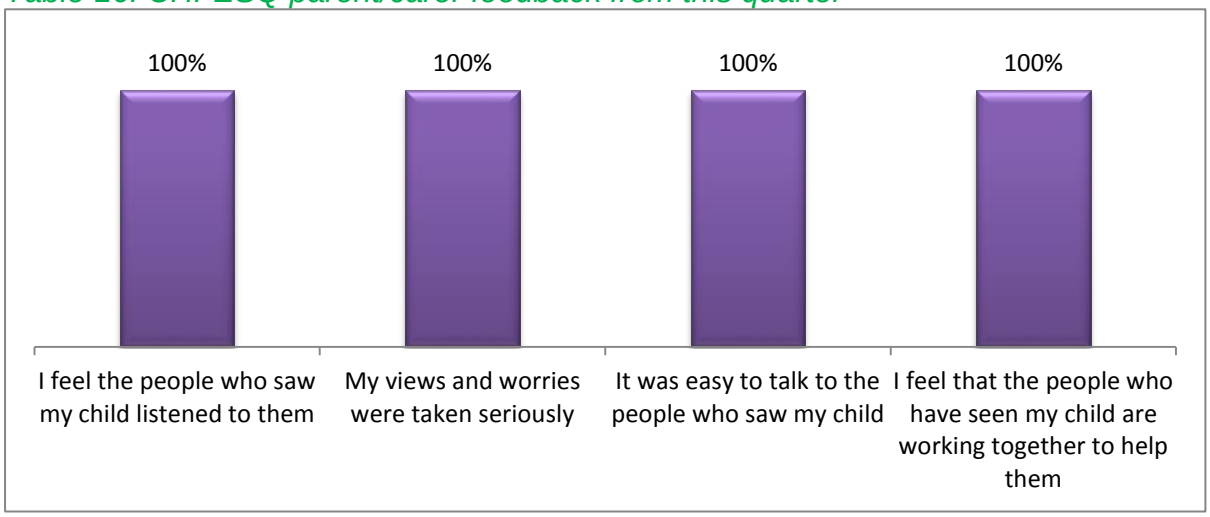
2.5.6 Children and Young People Service (CYPS)

2.5.6.1 CYPS gather service feedback using the Experience of Service Questionnaire, known as CHI-ESQ. CHI-ESQ is a nationally designed survey to gain feedback from children, young people and their parents/carers. There are three versions of the CHI-ESQ survey used, these are identified by age and role type as follows: Age 9 -11 yrs, Age 12 -18 yrs and Carer or Parent.

All the surveys ask questions based upon the same theme but are presented differently in an age appropriate format.

2.5.6.2 Tables 16 and 17 reflect responses to questions asked to the differing groups of respondents during the quarter.

Table 16: CHI-ESQ parent/carer feedback from this quarter



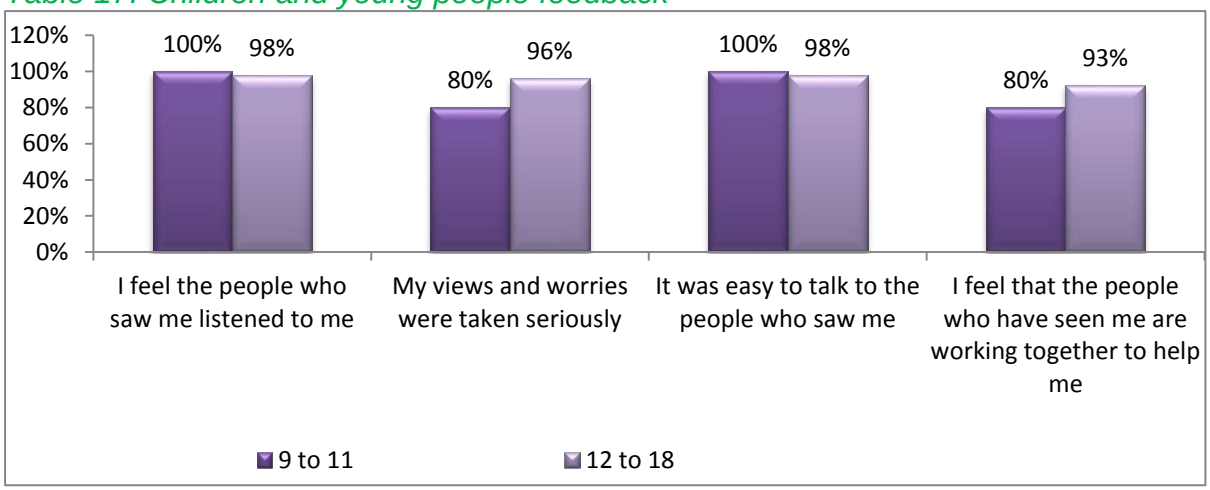
Examples of some feedback given by carers/parents:

Follow up advice by telephone when things were difficult with my son. Quick response on a request for son to be seen

I think she got the help she needed and was listened to. Also got medication

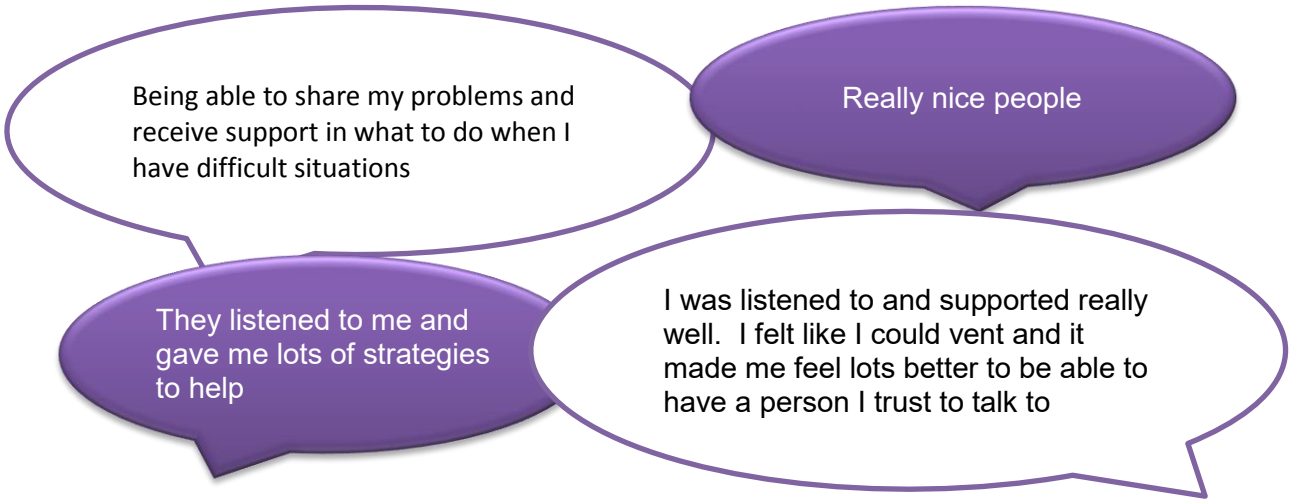
The staff member has been amazing. She has listened to my concerns as well as my son. She is not judgemental and has been great at challenging my son's thought process and bringing him back on track.

Table 17: Children and young people feedback



2.5.6.3 This information is shared with CYPS colleagues so that it can be used by them to deliver service improvements.

Examples of some feedback given by children and young people:

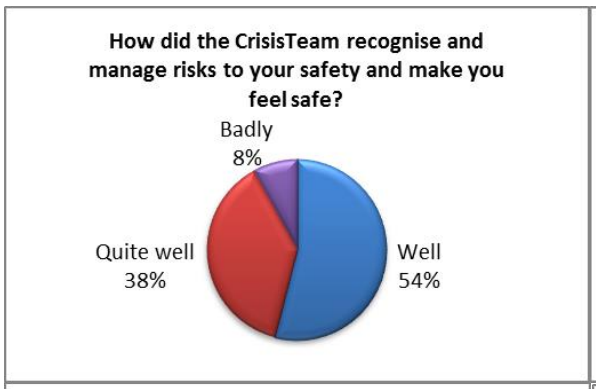


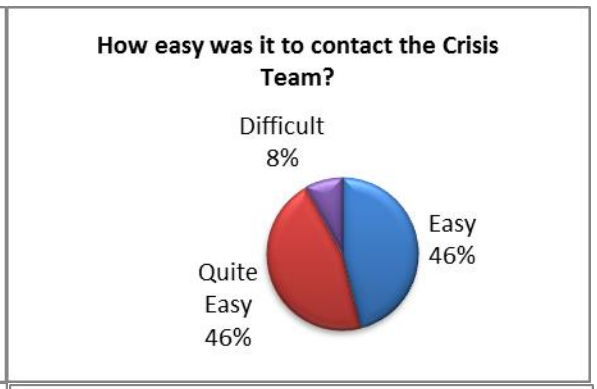
2.5.7 Crisis Team Service User led survey

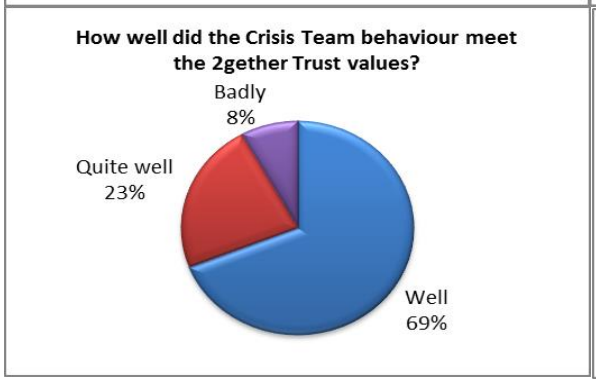
A project lead by Service Users and Experts by Experience to request feedback from people who have had recently had contact with our Gloucestershire Crisis Teams remains ongoing and is continued to be reported with the SED quarterly reports.

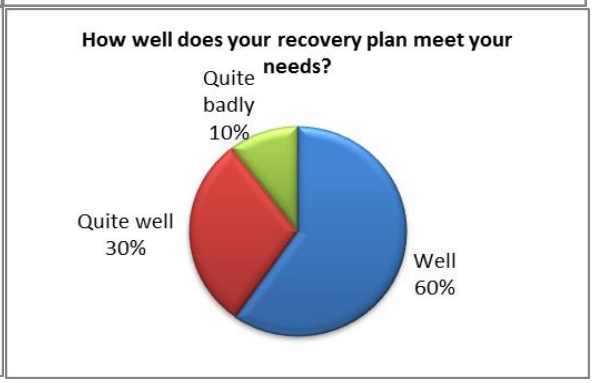
The latest available data for the responses received for this survey covers the period of January – May 2019 inclusively and includes responses from 13 individuals.

The questions and responses for this time period are shown below and responses continue to be analysed by the project group to feedback to the teams involved:









Section 3 – Learning from Service Experience Feedback

Section 3.1 – learning themes emerging from individual complaints

The SED, in partnership with Service Managers, routinely record, report and take actions based upon the valuable feedback from complaints, concerns, compliments and comments.

Reporting of local service experience activity and learning from feedback continues on a monthly and quarterly basis at each locality governance meeting. The SED is also attending these meetings regularly to discuss local themes, trends and learning and disseminate practice notes regarding elements of Trust wide learning, detailed in Table 18.

Table 18 illustrates points of learning from Service Experience feedback. Localities, in partnership with corporate services, are asked to disseminate local and Trust-wide learning and embed in practice to ensure that it informs quality improvement of our services and shapes future practice

Table 18: Trust-wide points of learning from Service Experience feedback Q1 closed complaints disseminated to localities via Practice Notes– assurance of actions to be sought from locality leads

Practice Note number	Organisational Learning
2567	• Wards should contact all relevant Care Co-ordinators by email with the outcomes of MDTs so they are kept informed of planned discharges

Practice Note number	Organisational Learning
	• Staff to be reminded of the importance of clear communication with families
2539	• Staff to ensure that carers and service users are clear who is responsible for funding, and who to contact if there are queries • When involving service users and carers in assessments, staff should provide copies to them following completion to ensure that all information is an accurate reflection of the current care needs, and have an opportunity to discuss any conflicting opinions • Staff to ensure clarity with service users and their carers when completing specific assessments, including MCA, so all parties involved are aware of the process taking place, and know that they are being involved in any best interest decisions • Staff to be clear and transparent when giving advice to service users and carers with regards to care planning, recommendations and reasons why, ensuring that it is clear and all parties understand the rationale • Staff should always include service user and their family / next of kin in the risk assessment process as much as possible to ascertain risks and develop a management / support plan for service users Guidance on how to record consent to share information should be followed and updated regularly

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

Effective dissemination of learning across the organisation is vital to ensure ²gether's services are responsive to people's needs and that services continue to improve. Service Experience feedback has continued to contribute to our learning from Incidents, Complaints and Claims.

Section 3.3 – Assurance of learning and action from aggregated learning themes from Quarter 4 2018/19

The learning shown in Table 18 is shared with localities via practice notes on a monthly basis who disseminate these amongst colleagues and feedback learning and actions through our Quality & Clinical Risk Committee (QCR) where aggregated learning themes are identified and compiled to be included in the Learning ²gether from Incidents, Complaints and Claims reports. The process by which learning is embedded within the organisation is described our *Policy for Continuous Improvement (Aggregated Learning Policy).*

ITEM 16(1a)

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Governance Committee

DATE OF COMMITTEE MEETING: 28 June 2019

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

TEMPORARY STAFFING AND AGENCY UPDATE

The Committee received an update on the use of temporary staffing (agency) during 2018/19 and the forecast for 2019/20. The Committee noted that 2018/19 agency spend was above the 2017/18 total, but reductions in agency spend were achieved in Medical, Admin & Clerical, and Support Workers. The Committee noted that actions were in place and the Committee was assured that the Trust would get make improvement within 6 months.

IAPT still required additional agency posts and work was continuing with the master vendor; however it was reported that there was a national shortage of qualified professionals. The Committee noted that IAPT was being monitored by Delivery Committee and the Committee agreed to take assurance from the Delivery Committee. Medical locum agency spend was lower than in 2017/18 and financial savings could be achieved by employing a higher percentage of locums through direct engagement.

The Committee noted that the Guaranteed Volume Contract for RMNs had been enacted and this was addressing quality, safety, and cost. All locum vacancies were covered and the Committee congratulated the Medical Directorate on this achievement.

MEDICAL STAFFING UPDATE

The Medical Director updated the Committee on the number of Medical vacancies across the Trust. In addition to permanent vacancies there were also a number of clinicians on long term sick leave. Vacancies were being covered by colleagues in addition to locums as there was not sufficient availability of locums or permanent candidates. There was concern about consultants working over their planned hours and the Medical Director was asked to consider how the Trust used the medical work force. The Committee also noted that some Trusts over recruited to avoid agency costs.

The Committee noted that recruitment events were taking place and a proposal from Medacs was awaited which would provide more planned access to agency staff and less reliance on the current workforce. It was agreed that a further report would be provided at the next Governance Committee meeting which would detail current vacancies at 2gether and GCS and levels of sickness amongst Medical colleagues.

GREEN LIGHT TOOLKIT

The Committee received the Green Light for Mental Health activity 2018-19 annual report. The Committee was significantly assured that the Green Light programme had been implemented in those teams who had so far been involved. Progress and assurance ratings against the corporate action plan and the scheduled activity at locality and corporate level to embed and evidence Green Light practice as business as usual were noted. The report offered limited assurance around the reliability of the information about how many people with a learning disability or autism were accessing 2gethers secondary mainstream mental health services. The Committee noted that the Quality and Clinical Risk Committee had requested an update on progress in this area in consultation with 2g's

RiO development Team.

The Committee noted that the Green Light for Mental Health required continuation of the self-assessment process and further systemic work to evidence consistent implementation and good practice throughout the organisation. It was noted that as the organisation merged and services were incorporated under One Gloucestershire there would need to be consideration of the role of Green Light principles across the wider organisation and how assurance of an equitable service for people with learning disabilities was assessed.

PWC – AUDIT FINDINGS – TRIANGULATION OF SI REVIEW WORK

The Committee noted that the Trust Serious Incident Review Process was reviewed by Price Waterhouse Coopers (PWC) internal audit team. This review had been undertaken as part of the 2018 2019 internal audit plan approved by the Trust Audit Committee. PWC had assessed the effectiveness of the change in the Trust's Serious Incidents requiring Investigation (reporting mechanisms, examined the processes in place for implementing relevant SIRI action plans and how lessons learned identified were shared across the Trust.

Overall, the SIRI process had seen significant improvements in terms of timely submissions of SI reports, whilst also maintaining the quality Investigations. These investigations were now undertaken by the central investigation team with the support of a relevant team manager, as the reports were now prepared by dedicated experts it was felt that the quality had improved. There had been improvements in the process including overall turnaround time in producing reports, consistency in the quality of the reports, and the utilisation of a family liaison officer to support the families impacted. There was further scope to strengthen key areas that impacted on the SIRI process to ensure the foundation and outcome of the investigations process was sustainable.

The Committee noted that PWC raised 4 recommendations for Trust action and was assured that these recommendations had all been actioned and reported to the Trust audit committee. Work was on-going via the quality team regarding improving embedding lessons learned from incidents. Progress on this work will be reported through QCR into Trust Governance.

BERKELEY HOUSE – UPDATE AND CQC THEMATIC REVIEW

The Committee noted that Berkeley House had previously been rated as requires improvement and the Committee was assured that staff were making improvements. The Committee noted that the facility received a good deal of external scrutiny and the CQC had carried out investigations into extended segregation. It was reported that this was due to a nil return by the Trust for extended segregation and high levels of restraint. John Trevains reported that the Trust’s view of what amounted to segregation was different to that of the CQC, however a recent visit by the CQC national team had provided broadly positive feedback on the Trust’s practice which would be fed into a national review.

The Committee noted that a report on the work undertaken by the Trust on Berkeley House and Extended Segregation would be brought to the Committee in August.

CYPS WAITING LISTS

The Committee was updated on the CYPS waiting list. This was an historical issue and was an active risk. John Trevains reported that there were young people waiting up to 2 years for treatment although he assured the Committee that they would be in receipt of other services.

Work was taking place and areas of good practice had been identified. John Trevains was working with John Campbell to ensure that any work undertaken on behalf of this Committee was triangulated with the work of the Delivery Committee. The Committee noted that an update would be provided to QCR next month. It was noted that CYPS waiting lists were being monitored at the Delivery Committee within the performance dashboard. However, the Committee noted that Learning Disability waiting lists were not being received and assurance had been requested that there were no concerns.

MERGER QUALITY GOVERNANCE UPDATE

John Trevains reported that he had met with GCS colleagues to present the Quality Governance Plan. He had received some critical challenge and would produce an updated Plan which would set out how Quality would be delivered in the new merged Trust. There had been some challenge around unrealistic meeting dates and new dates were to be agreed as soon as possible. The Committee noted that Grant Thornton had questioned whether the Trust should hold monthly meetings until year end while it adjusted to a new process. John reported that he had requested that work on the Committee dates be undertaken as soon as possible. He assured the Committee that any risks were well managed and mitigated and the Committee agreed that the new committee process would be discussed at the next meeting.

OTHER ITEMS

- The Committee received the Safe Staffing data for April and May 2019 and significant assurance was received regarding the levels of staffing on all wards during this time.
- The Committee also received the Patient Safety and Serious Incident Report and the Quarter 4 Patient Safety and Near Miss Report
- The Committee received the NHS Resolution Claims report which provided an annual review of clinical and non-clinical claims for 2018/19.
- The Committee received a review of the Governance Committee risks and noted the Top 5 risks. There were 3 Top 5 risks with limited assurance currently allocated for the Governance Committee, Agency Management Control, Workforce - Workforce – [Strategic] and Workforce - Recruitment [Operational].
- The Committee received the Service Experience Report for Quarter 4
- The Committee noted that the Quality Report had been approved at the last meeting of the Audit Committee on 24th May
- The Committee received updates from the QCR Committee and the Positive and Safe Sub-Committee

ACTIONS REQUIRED BY THE BOARD

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

2gether Making life better

2gether NHS Foundation Trust

ITEM 16(1b)

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Governance Committee

DATE OF COMMITTEE MEETING: 30 August 2019

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

MEDICINES MANAGEMENT ANNUAL REPORT

The Committee received a Medicines Management annual report. The report covered core medicines management activities throughout 2018/19 and the key developments that had been undertaken.

The Committee noted the significant assurance provided in the report that the appropriate medicines management arrangements were in place within the Trust.

The Medicines Management team were asked about concerns regarding an EU Exit and its potential impacts on the supply of medications. The Committee noted that the supply of medications was being monitored on a national level and assurance had been received that contingency plans were in place for high risk medications. There was national advice to continue business as usual and to not stockpile. The Director of Nursing reported that an EU Exit group had recently been re-established and assurances had been received on a government level regarding medications and stockpiles.

FUTURE ARRANGEMENTS FOR QUALITY GOVERNANCE

The Director of Nursing provided a presentation on the future arrangements for Quality Governance in the merged organisation. John Trevains reported on the work taking place to ensure a Day 1 to 100 safe delivery of services. He provided an organisational chart which highlighted the structure of Working Groups that would feed into the new Quality and Performance Committee. He reported on the need to improve on current levels of assurance. The Committee noted that on Day 1 a work stream would be implemented to prepare for a CQC inspection with the focus being on achieving an Outstanding rating; the focus on achieving this rating was around which the structure changes were based.

Nikki Richardson thanked John for the presentation and said that not only were the first 100 days critical in ensuring that no safety issues were lost, but that it was important to ensure that business as usual continued during the transition. Nikki added that the Non-Executive Directors had discussed identification of KPIs to ensure that any slippage was identified early; she recommended that this be considered within the subcommittee structures.

MEDICAL STAFFING UPDATE

The Medical Director provided an update on Medical Staffing. He reported that there was full cover in all Wotton Lawn wards, with one NHS Locum and one vacancy being covered by internal colleagues. The Committee noted that the biggest issues in Medical Staffing were related to shortages of agency Locums and he added that the Trust's positions were not as attractive as some nearby Trusts. There was a need for more support for clinicians and the Director of Quality was working with the Medical Director on a plan for nurse practitioners to assist medical staff. The Committee agreed to highlight to the Board the need for support for this work.

SAFEGUARDING (ADULTS AND CHILDREN) ANNUAL REPORT

The Committee received a report of the key issues and activities associated with Safeguarding Children and Adults in Herefordshire and Gloucestershire for 2018/19. The report significant assurance that safeguarding was a Priority function of the Trust and was being delivered as per the 4 Safeguarding Strategic Boards across Gloucestershire and Herefordshire; and in line with national guidance and legislation.

The Committee noted that during 2018/19 the children safeguarding team were contacted on 52 occasions in Herefordshire, down from 73 in 2017/18, and 155 occasions in Gloucestershire, matching the figure for 2017/18. The reduction in contacts in Herefordshire could have been attributed to a 3 month gap between staffing changes. The adult safeguarding team were contacted on 44 occasions in Herefordshire, down from 57 in 2017/18, and 262 occasions in Gloucestershire, up from 257 in 2017/18. The Committee received good assurance for Safeguarding training compliance.

Nikki Richardson raised a concern that staff had been contacting the Local Authority, who were unable to capture data, as the Trust was unable to evidence it. The Committee was assured that progress had been made in both counties and therefore there were no concerns. The Committee noted the Local Authority's lack of availability of training dates for both counties and commended the Safeguarding teams for achieving high compliance despite this. CCG colleagues assured the Committee that the CCG was aware of the issues and were working to improve training options.

THERAPEUTIC ALLOTMENT PROJECT

The Committee received a presentation from colleagues and a service user regarding the Montpellier Unit Allotment Project located on Horton Road. The Committee noted the benefits of horticultural activity for those who experienced mental illnesses.

The Committee noted the opportunities that the Allotment Project offered to service users and the potential opportunities that could arise once future developments to the site had been made. The impact the Allotment was having on service users which included helping them to develop a routine and additional skills and also the social aspect was noted.

Nikki Richardson praised the innovative and transformative work undertaken by the Unit at the Allotment Project. Colleagues from the Allotment Project agreed that it had been incredibly useful for service users; they added that additional funding was needed for repairs and improvements at the project and it was agreed that this would be highlighted to Board.

HEALTH SAFETY AND ENVIRONMENT RELATED INCIDENTS

The Committee received a breakdown of the Health & Safety related incidents reported on Datix for Quarter 1. There were 27 Health and Safety incidents recorded during the quarter Of which 20 had been closed. These incidents were related to staff, visitors and contractors. Gloucestershire Countywide Services had the greatest proportion of incidents reported across all types of Health and Safety incidents however this reflected the nature of the services provided. There were 3 RIDDOR reportable, incidents in this quarter.

The Committee took significant assurance from the report and noted that in-depth discussions had been held in the QCR sub-committee around this report previously. Nikki Richardson suggested there could be a benefit in the Health and Safety report being part of the dashboard in the new organisation.

SERVICE EXPERIENCE REPORT Q1

The Committee received overview of feedback received from service users and carers in

Quarter 1 2019/20. The report offered assurance that the Trust listened to people's experiences and took action as a result of the important learning gathered.

The Committee was significantly assured that service experience information had been reviewed, scrutinised for themes, and considered for both service-specific and general learning across the organisation. Nikki Richardson highlighted an issue in the report related to the time taken to investigate complaints, and difficulties were identified in assigning staff to review complaints. Nikki noted that this issue had been raised previously and it was agreed that it would be highlighted at Executives Committee and Trust Board.

SOCIAL INCLUSION ANNUAL REPORT

The Committee received a Social Inclusion Annual Report which provided significant assurance that the Trust had undertaken a broad range of engagement activity during 2018/19 to support a socially inclusive approach to mental health and learning disability practice. The Social Inclusion team had taken part in 85 events across both Counties during the financial year, and delivered 80 training and awareness sessions delivered to colleagues and external organisations.

The Committee noted that the team had 529 involvements by Experts by Experience, and 67% of Experts would recommend taking on the role. The Trust also had Volunteers engaged in 67 roles, and that 75% of Volunteers would recommend volunteering with the Trust, as reported in the Friends and Family Test.

Nikki Richardson asked if there were any particular advantages or challenges for social inclusion in relation to the upcoming merger. The Committee noted that the merger would offer more co-production and awareness; however managing the resources for a bigger organisation would be a challenge. Jane Melton agreed that awareness was an important factor and she reported that Dominika Lipska-Rosecka had been invited to present at an event for the NDTi (National Development Team for Inclusion).

OTHER ITEMS

- The Committee received the Safe Staffing data for June and July 2019 and significant assurance was received regarding the levels of staffing on all wards during this time.
- The Committee also received the Patient Safety Report and the Q1 Patient Safety Incident & Near Miss Report and Analysis
- The Committee received the Annual Medical Appraisal Report and the Learning from Deaths Report.
- The Committee received an update from the QCR Committee

ACTIONS REQUIRED BY THE BOARD

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

Agenda Item 16(2)

Report to:	2gether NHS Foundation Trust Board – 26 September 2019
Author:	Sumita Hutchison, Non-Executive Director
Presented by:	Sumita Hutchison, Non-Executive Director

SUBJECT: **NON EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS QUARTER 1- 2019/20**

This Report is provided for:

Decision Endorsement **Assurance** **Information**

EXECUTIVE SUMMARY

A Non-Executive Director Audit of Complaints was conducted covering three complaints that have been closed between 1 April and 30 June 2019.

RECOMMENDATIONS

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

1. INTRODUCTION

1.1 The agreed aim of the audit is to provide assurance that standards are being met in relation to the following aspects:

1. The timeliness of the complaint response process
2. The quality of the investigation, and whether it addresses the issues raised by the complainant
3. The accessibility, style and tone of the response letter
4. The learning and actions identified as a result

2. PREPARATION

2.1 In accordance with standard procedure, three cases for the quarter were chosen at random for review.

3. SUMMARY OF FINDINGS

3.1 Case 1

3.1.1 Summary of complaint.

An inpatient in Charlton Lane hospital was deeply traumatised about her 1.5 month stay and as a result wanted to be discharged quickly when she needed further support.

The complaint was in relation to:

1. A discussion that took place about medication that could have been given to her but was not and she felt nothing was done after this discussion.
2. Little being done to offer her support with her distressing hallucinations (which were audible) which may have been caused by the side effects of her medication.
3. Little being done to support her with insomnia which she feels made her situation worse
4. Poor communication amongst staff at Charlton Lane hospital and with her GP.

3.1.2 Audit findings

A full and timely complaints procedure was followed as the delays were caused by the complainants' lack of capacity.

The investigation was thorough and comprehensive. It appears to be done from a clinical perspective and not necessarily through the eye of a patient in the position of the claimant. Putting aside the detail of whether the right medication or dose was given to the patient, the key issue is about communication and empathy and what can be done to avoid such a traumatic experience of a service user within our hospital. More could have been done to ask and answer this question. There was very little organisational learning from this case and no action plans or next steps to address this issue.

The CEO's letter was well written and sympathetic and addressed well the concerns raised by the complainant.

3.1.3 Conclusion of auditor

I would offer some assurance against standards 1, 2 and 4 although:

- In relation to standard 1, delays were caused in the investigation due to the complainant's lack of capacity,
- In relation to standard 2, the investigation does address all of the specific concerns raised by the complainant but does not address her underlying concern that more could have been done to make her experience less traumatic.
- In relation to standard 4, there was very little organisational learning. Clarity from the complainant about what she needed during her stay would have been helpful for organisational learning.

I would offer full assurance against standard 3.

3.2 Case 2

3.2.1 Summary of complaint

An inpatient at Wotton Lawn Hospital for 1.5 months and was unhappy about restrictions imposed on him and the service given by some of the staff.

His complaints were in relation:

1. Being detained under the Mental Health Act and the subsequent increase in restrictions placed on him including his leave and driving licence.
2. The conduct of some of the staff

3. The timing of his discharge

3.2.2 Audit findings

A full and comprehensive investigation took place and the findings were fair and balanced and addressed the issues raised by the complainant. The CEO's letter was well written, sympathetic and provided a comprehensive response to the issues raised. However the letter could have been written in plain language as the complainant may not have been able to understand some of the content of the letter. There was very little organisational learning from this case.

3.2.3 Conclusion of Auditor

I would offer full assurance against 1, 2 and 4. I would offer some assurance against standard 3 as the letter is not written in plain language and in an accessible format and could be more accessible to the complainant. There is a risk that he may not be able to understand the language.

3.3 Case 3

3.3.1 Summary of complaint

The complainant was very unhappy with the way he was treated when he was admitted to Wotton Lawn Hospital. He was already distressed and vulnerable and felt the situation worsened because of the way the situation was managed.

His complaints were in relation to:

1. The physical conditions of Maxwell Suite
2. The way he was handled by the Positive Management of Violence and Aggression team.
3. Lack of adequate suicide prevention support
4. His overall experience

3.3.2 Audit findings

A timely full and comprehensive investigation took place and the findings were fair and balanced with some clear organisational learning mainly around recording information and ensuring privacy for staff and patients. More could have been done to understand what could have been done to make the complainant's experience less traumatic which could have translated into organisational learning. Also the response letter had a good style and tone although it could have been more accessible in its language and possibly presentation.

3.3.3 Auditor conclusion

I would offer full assurance against standard 1. I would offer some assurance against standards 2, 3 and 4

- In relation to standard 2, the investigation does address all of the specific concerns raised by the complainant but does not address his underlying concern that more could have been done to make his experience less traumatic.
- In relation to standard 4, further learning could have taken place, based on the outcome of a discussion with the complainant.

- In relation to standard 3, the letter could have been written in a more accessible manner perhaps using plain language.

4. SUMMARY

4.1 More could be done to understand the service the complainant would have wanted. This information is not clear from the papers.

The response letter is not in plain language. Some people may not be able to understand its contents, especially those with lower educational attainment, those whose first language is not English and those who have learning impairments such as Learning Disabilities.

Agenda item **16(3)**

Report to:	Trust Board – 26th September 2019
Author:	Zoë Lewis, Patient Safety Administrator, and Paul Ryder, Patient Safety Manager
Presented by:	Dr Amjad Uppal, Medical Director

SUBJECT: **Learning from Deaths 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

The data presented represents those available for the period April to June 2019 (Q1 2019/20).

Changes to the selection criteria and the Mortality Review function – RCPsych SJR adopted in November 2018, applied to open deaths and incorporated into the Learning from Deaths process.

72 deaths have been closed without further review due to being open to solely ACI-Monitoring caseloads (38) or excluded due to a primary diagnosis of dementia and over 70 years of age (34).

1 death raised a cause for concern within the 2gether NHS Foundation Trust, which was escalated to a Clinical Incident Investigation by the Mortality Review Committee.

The key post vacant since August 2018 has now been recruited to following Director approval and the substantive Patient Safety Administrator is now in post.

This report has been presented and reviewed at the Quality and Clinical Risk subcommittee on Friday 16th August 2019. There have been no changes to this report following the subcommittee.

The Committee is asked to note the contents for information.

RECOMMENDATIONS

The Committee is asked to note the contents of this Mortality Review Report which covers Quarter 1 of 2019/20.

Corporate Considerations	
Quality implications	Required by National Guidance to support system learning
Resource implications:	Significant time commitment from clinical and administrative staff
Equalities implications:	None
Risk implications:	None

WHICH TRUST STRATEGIC OBJECTIVE(S) DOES THIS PAPER PROGRESS OR CHALLENGE?	
Continuously Improving Quality	Yes
Increasing Engagement	No
Ensuring Sustainability	No

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

Reviewed by:		
Amjad Uppal	Date	16 September 2019

Where in the Trust has this been discussed before?		
Mortality Review Committee (MoReC) QCR subcommittee	Date	19 July 2019 16 August 2019

What consultation has there been?		
	Date	

Explanation of acronyms used:	MoReC – Mortality Review Committee LD MRG - Learning Disabilities Mortality Review Group SJR - Structured Judgement Review CRR - Care Record Review EOL - End of Life SI – Serious Incident CI – Clinical Incident MHA – Mental Health Act

1. INTRODUCTION

1.1 In accordance with national guidance and legislation, the Trust currently reports all incidents and near misses, irrespective of the outcome, which affect one or more persons, related to service users, staff, students, contractors or visitors to Trust premises; or involve equipment, buildings or property. This arrangement is set out in the Trust policy on reporting and managing incidents.

1.2 In March 2017, the National Quality Board published its *National Guidance on Learning from Deaths: a Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care*. This guidance sets out mandatory standards for organisations in the collecting of data, review and investigation, and publication of information relating to the deaths of patients under their care.

1.3 Since Quarter 3 2017/18, the Trust Board has received a quarterly (or as prescribed nationally) dashboard report to a public meeting, following the format of Appendix D, including:

- number of deaths
- number of deaths subject to case record review (now SJR Part 2+)
- number of deaths investigated under the Serious Incident framework (and declared as serious incidents)
- number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care
- themes and issues identified from review and investigation (including examples of good practice)
- actions taken in response, actions planned and an assessment of the impact of actions taken.

1.4 From June 2018, the Trust will publish an annual overview of this information in Quality Accounts, including a more detailed narrative account of the learning from reviews/investigations, actions taken in the preceding year, an assessment of their impact and actions planned for the next year.

1.5 This paper offers the subsequent iteration of data for the period April to June 2018.

2. PROCESS

2.1 All 2gether NHS Foundation Trust staff are required to notify, using the Datix system, the deaths of all Trust patients. This comprises anyone open to a Trust caseload at the time of their death and who dies within 30 days of receiving care from 2gether. Following discussion at Mortality Review Committee (MoReC) in and at countywide Mortality Steering Groups in both Gloucestershire and Herefordshire, it was agreed to exclude from active review those open for ACI Monitoring only and those with a primary diagnosis of dementia who are over 70 years old. MoReC had become very aware that older people with dementia die whilst this had resulted in very little learning from this cohort of patients. There will be a continued focus on those 70 years and under.

2.2 Mandatory mortality reviews are required for:

- All patients where family, carers, or staff have raised concerns about the care provided.
- All patients with a diagnosis of psychosis or eating disorders during their last episode of care, who were under the care of services at the time of their death, or who had been discharged within the 30 days prior to their death.

- All patients who were an inpatient in a mental health unit at the time of death or who had been discharged from inpatient care within the last month.
- All patients who were under a Crisis Resolution & Home Treatment Team (or equivalent) at the time of death (noting that these deaths will likely be categorised as Serious Incidents).

2.3 The format of a Mortality Review was modified following the publication of the Royal College of Psychiatrists Structured Judgement Review in January 2019. With regard to process detail, "Table Top Reviews" are now referred to as SJR Part 1, and "Care Record Reviews" are SJR Part 2+ (including parts 2-7). The RCPsych SJR is attached for reference. The parts of the review consider:

- Part 1 The allocation and initial review or assessment of the patient (this is usually completed within Datix only) resulting in a Mazars categorisation
- Part 2 The ongoing care of the patient, including both physical health and mental health
- Part 3 Care during admission
- Part 4 Care at the end of life
- Part 5 Discharge planning
- Part 6 An option for organisations to rate particular aspects of care the reviewers feel is necessary for that individual
- Part 7 Overall care

2.4 Based upon the information provided, patient deaths are assigned to one of the six categories developed by the Mazars report into Southern Health NHS Foundation Trust (2015) (Table 1).

2.5 Expected Natural deaths (EN1 & EN2) are sorted into those where there may be concerns and those where no possible concerns are identified. Unexpected Natural deaths (UN1 & UN2) are subjected to a case record review and sorted into those where there may be concerns and those where no possible concerns are identified.

Table 2.1 Mazars Categories

Type	Description
Expected Natural (EN1)	A group of deaths that were expected to occur in an expected time frame, e.g. people with terminal illness or in palliative care services. These deaths would not be investigated but could be included in a mortality review of early deaths amongst service users.
Expected Natural (EN2)	A group of deaths that were expected but were not expected to happen in that timeframe. E.g. someone with cancer but who dies much earlier than anticipated These deaths should be reviewed and in some cases would benefit from further investigation.
Expected Unnatural (EU)	A group of deaths that are expected but not from the cause expected or timescale E.g. some people on drugs or dependent on alcohol or with an eating disorder These deaths should be investigated.
Unexpected Natural (UN1)	Unexpected deaths which are from a natural cause e.g. a sudden cardiac condition or stroke. These deaths should be reviewed and some may need an investigation.
Unexpected Natural (UN2)	Unexpected deaths which are from a natural cause but which didn't need to be e.g. some alcohol dependency and where there may have been care concerns These deaths should all be reviewed and a proportion will need to be investigated.
Unexpected Unnatural (UU)	Unexpected deaths which are from unnatural causes e.g. suicide, homicide, abuse or neglect. These deaths are likely to need investigating.

All Unnatural deaths (EU & UU) are discussed, individually with the Patient Safety manager to identify those that fall into the category of serious incidents requiring investigation, within statute, and according to the relevant Trust policy. Where there appears to be further information required or learning to be derived, incidents that do not require a serious incident review are notified to the relevant team manager for a clinical incident review. The remaining incidents are sorted into those where there may be concerns and those where no possible concerns are identified.

2.7 Where no concerns are identified, the Datix incident is closed without further action.

2.8 Where concerns are raised, the case is be elevated to the clinical leads for review and, depending upon the outcome, can be treated as a serious incident, referred for multiagency review or notified to the relevant team manager for a clinical incident review.

2.9 The data obtained will be subjected to a modified version of the structured judgement review methodology defined by the Royal College of Physicians and assigned to one of three categories:

Category 1: "not due to problems in care"

Category 2: "possibly due to problems in care within ^{2}gether"

Category 3: “possibly due to problems in care within an external organisation”

2.10 For those deaths that fall into Category 2, learning is collated and an action plan developed to be progressed through operational and clinical leads and reported to Governance Committee. For Category 3, the issues identified are escalated to local partner organisations through the relevant Clinical Commissioning Group lead for mortality review. For distant organisations, issues will be shared with the local lead for learning from deaths within the organisation.

2.11 All deaths of patients with a learning disability will be also reported through the appropriate Learning Disabilities Mortality Review Program (LeDeR) process, and deaths of people under the age of 18 will be reported through the current child death reporting methodology.

2.12 During the first year of implementation, the MR process has proven to have a demonstrably high administrative burden. The quality of the output from a large proportion of Mortality Reviews indicated that, within that large proportion, the care afforded to the patient during their End of Life Care was not provided by 2gether teams, but often from 3rd sector providers (i.e. care homes) and GP practices. There has been limited learning produced from reviewing these cases.

3. DATA

3.1 During 1 April 2019 – 30 June 2019 124 patients of ^{2}gether NHS Foundation Trust died (correct as of 8th August 2019). This comprised the following number of deaths which occurred in each month of that reporting period:

63 in April,
32 in May,
29 in June.

3.2 The terminology used to describe the stages of Mortality Review changed in December 2018 following publication of the Royal College of Psychiatrists’ Structured Judgement Review

(SJR) documentation. The Mortality Review Committee (MoReC) adopted this methodology in January 2019 following discussion and agreement by the Mortality Review Committee (MoReC). The LD Mortality Review Group (LD MRG) have decided to continue with the Care Record Review (CRR) of LD patient deaths in order to facilitate continuity with the LeDeR process.

3.3 Following discussion at MoReC in and at countywide Mortality Steering Groups in both Gloucestershire and Herefordshire, it was agreed to exclude from active review those patients open for ACI Monitoring only and those with a primary diagnosis of dementia who are over 70 years old. MoReC had become very aware that older people with dementia die as a natural consequence of the illness process resulting in limited learning from this cohort of patients. There will be a continued focus on those 70 years and under.

3.4 At the time of writing this paper, a total of 17 RCPsych Structured Judgment Reviews (SJRs) at MoReC and Care Record Reviews at LD MRG had been completed.

3.5 In 1 case a death was subjected to escalation from Structured Judgement Review at MoReC to a Clinical Incident Investigation. This patient had been seen by Recovery Team staff 3 days prior to their death, and although the patient's serious physical ill health was noted, it is unclear what steps were taken to facilitate a physical health review. The cause of death was given as UTI, a treatable infection. This investigation is ongoing.

3.6 The number of deaths in each month for which a Structured Judgement Review, Clinical Incident Review or a Serious Incident investigation was carried out was:

8 in April
7 in May
3 in June.

3.7 The above figures do not include current open SJRs, CRRs, CI Investigations and SI Investigations from 2019/20 Q1.

3.8 At the time of writing this paper, 0 deaths representing 0.0% of the 124 patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided ^{2}gether NHS Foundation Trust to the patient (Table 3.1). In relation to each month, this consisted of:

0 representing 0% for April
0 representing 0.0% for May
0 representing 0% for June.

3.9 At time of writing, 18 deaths, which represented 14.5% of the 124 patient deaths during the reporting period were still open and undergoing mortality review (Table 3.2). 9 patient death incidents were awaiting death information, which included waiting for toxicology results, and 5 were awaiting Structured Judgement Review at MoReC or Care Record Review at LD MRG. There were 2 open Serious Incident Investigations and 2 open Clinical Incident Investigations.

Table 3.1.Completed Mortality Reviews 2019/20 Q1

Mortality Review Closure Category		Month			Quarterly Totals
		April	May	June	
Closed - Mortality Review Criteria Unmet		42	15	15	72
Closed Following SJR Section 1	Category 1: Not Due to Problems in Care	6	5	4	15
	Category 2: Possibly Due to Problems in Care within 2gether	0	0	0	0
	Category 3: Possibly Due to Problems in Care Within an External Organisation	0	0	0	0
Closed Following SJR Section 2 (MoReC) or Care Record Review (LD MRG)	Category 1: Not Due to Problems in Care	7	7	3	17
	Category 2: Possibly Due to Problems in Care within 2gether	0	0	0	0
	Category 3: Possibly Due to Problems in Care Within an External Organisation	0	0	0	0
Closed following Clinical Incident Review	Category 1: Not Due to Problems in Care	0	0	0	0
	Category 2: Possibly Due to Problems in Care within 2gether	0	0	0	0
	Category 3: Possibly Due to Problems in Care Within an External Organisation	0	0	0	0
Closed following Serious Incident Review	Category 1: Not Due to Problems in Care	1	1	0	2
	Category 2: Possibly Due to Problems in Care within 2gether	0	0	0	0
	Category 3: Possibly Due to Problems in Care Within an External Organisation	0	0	0	0
Monthly Totals		56	28	22	106

Table 3.2 Open Mortality Reviews 2019/20 Q1

Mortality Review Status	Month			Quarterly Totals
	April	May	June	
Awaiting Death Information (incl. tox results) for SJR Section 1	5	2	2	9
Awaiting SJR Section 2 (MoReC) or Care Record Review (LDMRG)	1	0	4	5
Open Clinical Incident Investigation	1	1	0	2
Open Serious Incident Investigation	0	1	1	2
Monthly Totals	7	4	7	18

4. LEARNING

4.1 Learning from Structured Judgement Reviews at MoReC during 2019/20 Q1

4.1.1 During 2019/20 Q1, following Structured Judgment Reviews of patient deaths, together with patient deaths brought for discussion only, MoReC has made the following Recommendations:

- The Committee noted that junior medics on call may not feel comfortable prescribing end of life (EOL) medication. The Committee asked the Ward Manager to consider a form of words to state that EOL medication will be written up beforehand and what conditions need to be met to allow EOL care to be commenced. This was discussed and acknowledged at the EOL Steering Group, with the outcome being that the Consultant will make an entry in RiO outlining a "what if" plan.

- Following SJR of an expected inpatient death on Cantilupe Ward, the Committee noted the patient's Section 3 of the MHA had not been rescinded upon commencement of EOL care. The Committee advises that once EOL care is commenced and psychotropic medication withdrawn, the patient's mental illness is no longer being treated, which is incompatible with MHA and DoLS should be applied instead. This Recommendation was taken to the Clinical Director for Herefordshire.

- Following an expected inpatient death at Charlton Lane Hospital, the Committee noted that once the Shared Care Plan is up and running, current local policy dictated that the junior medic on call is contacted before Palliative Care. The Committee recommended a change to local policy so that the ward team contact Palliative Care in the first instance and then contact the junior medic on call and to inform of Palliative Care's advice.

- The Committee noted that a major cause of agitation in patients suffering dementia is pain they are unable to verbalise. The Committee recommended that the rationale for using opiates as either an EOL medication or for pain needs to be made clear in the notes. This recommendation was taken to the North Locality Clinical Director and was added to the agenda for the Old Age Psychiatry Consultants Meeting.

- Following the difficulty in finding death information regarding deaths of patients who pass away whilst inpatients at 2gether Trust hospitals, the Committee considered that it is appropriate for documentation completed by medics regarding a patient's death, to include death certificates issued by the 2gether Trust, to be uploaded to the patient's record on RiO. This recommendation was taken to the End of Life Steering Group.

- Following an unexpected death of a 65 year old inpatient placed out of county, the Committee noted that although very complex in nature, one of the reasons people with mental health difficulties die prematurely is because they do not access screening programmes. The Committee noted that for patients placed out of county there was no provision in the 2gether Trust's contracts with out of county providers to ensure patients are offered access to an annual physical health check with Primary Care. Subsequently, the Committee recommended that mental health patients placed out of county should be registered with a GP who will provide physical health care on a day-to-day basis. Also, an annual physical health check should be commissioned for each patient placed out of county. The recommendation was taken to the Commercial & Planning Manager for inclusion in the 2gether Trust's contract negotiations with out of county providers. This requires resolution.

- Following a death of an elderly patient who had been referred by their GP three times before being seen by CMHT, the Committee sought clarification regarding DNA policy and what is done to mitigate elderly people living alone not attending their out-patient appointments, and to consider if a home visit would be more appropriate. The enquiry was taken to the North Locality Clinical Director and was added to the Old Age Psychiatry Consultants Meeting.

4.1.2 Learning from deaths reviewed by the Learning Disability Mortality Review Group is currently developing.

4.2 Learning from Serious Incident Investigations completed during 2019/20 Q1

4.2.1 During Q1 2019/20 6 Serious Incident Investigations concerning patient deaths were completed. The Lessons Learned generated from the 6 SI Investigations are as follows:

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-30-19

Incident Category:
Patient death

What happened? ***(Describe the incident)***

- **A patient who had recently been assessed by the Crisis Assessment & Home Treatment Team (CAHTT) was found deceased in a field.**

What did the Investigation find? ***(What was done well? Did anything go wrong?)***

- **The patient presented at the A&E Department with intrusive suicidal thoughts, reduced mood and poor sleep.**
- **The patient had a history of excessive alcohol intake and had been using this as a coping mechanism for Post Traumatic Stress Disorder. The patient had stopped drinking recently following a seizure, which was thought to be the result of alcohol use.**
- **The patient agreed to engage with the CAHTT and to attend a medical review.**
- **The patient was assessed as a MEDIUM risk of suicide.**
- **The patient had recently been diagnosed with small vessel disease.**
- **The patient's family felt that the impact of not sleeping for a prolonged period and the patient being ex-military was not fully taken into consideration. The Deputy Medical Director will meet with The Regimental Association to better understand ex-servicemen and women's needs.**

What can we learn from this incident? ***(What does this remind us about good practice? What can we change?)***

- **Limited information from the patient's family was collected due to the patient's reluctance to allow clinicians to speak to family members.**
- **The CAHTT should provide GPs with a full copy of assessments of patients whether they are accepted for treatment or not, especially important where the GP is not the referrer.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-33-19

Incident Category:
Patient death

What happened? ***(Describe the incident)***

- **The patient was found deceased at the side of a railway line the day after leaving his home address.**

What did the Investigation find? ***(What was done well? Did anything go wrong?)***

- **The patient had a diagnosis of late onset anxiety with agitated depression and experienced suicidal thoughts.**
- **The patient had been discharged from the Crisis Assessment & Home Treatment Team three months prior to his death, had been referred to the Recovery Service for on-going support, but was discharged back to the care of his GP as at the time of the assessment, the patient was well.**
- **The patient engaged with a number of private clinicians for Cognitive Behaviour Therapy and Counselling.**
- **The patient had reduced his antidepressant medication due to side effects and started to experience Tinnitus, which had a negative impact on his mental state and sleep pattern.**
- **On the day of his death, his GP had referred him back to the Recovery Service for an assessment of mental health needs.**

What can we learn from this incident? ***(What does this remind us about good practice? What can we change?)***

- **Little or no information was received by 2gether or by the GP from the private Psychologist or Counsellors following their sessions and the only information about content came from the patient himself.**
- **The patient was appropriately assessed and discharged from the mental health services back to the care of his GP surgery.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-34-19

Incident Category:
Patient death

What happened? ***(Describe the incident)***

- An inpatient was witnessed falling backwards, hitting their head on the floor.
- The patient was transferred to Gloucestershire Royal Hospital, where a CT scan confirmed a bleed to the brain with skull fractures.
- The patient sadly passed away two days later.

What did the Investigation find? ***(What was done well? Did anything go wrong?)***

- The patient had experienced two collapses whilst in hospital and there were no apparent precipitating factors to either.
- The patient was assessed as a LOW risk of falls.
- South Western Ambulance Service and the Gloucester Hospitals' Accident & Emergency Department acknowledged the good practice demonstrated by 2G staff for the care, handover and support given to GHT staff in the Accident & Emergency Department.

What can we learn from this incident? ***(What does this remind us about good practice? What can we change?)***

- Although not contributory to the final collapse of the patient, it was identified that clarification of the Trust's slips and falls policy would be beneficial, with particular regard to collapses due to medical causes. This will be completed by the Matron, in liaison with the Lead Physiotherapist at Charlton Lane Hospital.

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-35-19

Incident Category:
Patient death

What happened? ***(Describe the incident)***

- The patient left home informing their partner they were going to "end it all".
- The patient was found deceased in the river the next day.

What did the Investigation find? ***(What was done well? Did anything go wrong?)***

- There were ongoing and unaddressed safeguarding issues relating to mutual domestic abuse.
- The Mental Health Team did not fully undertake their responsibilities under Section 117 (Aftercare) of the Mental Health Act in terms of working jointly with Social Services.
- The Mental Health Team did not receive any contact from the Local Authority (LA) Safeguarding Team regarding Safeguarding referrals it had received regarding the patient. The team did not actively chase up what action was being taken or escalate any concerns when it was aware a referral to the LA had been declined.
- Whilst there were incidents of verbalised suicidal thinking, there had been no previous suicide attempts.
- The Mental Health Team sought to provide flexible but boundaried care, having recognised that intensive input would act to increase dependence and, in the longer term, anxiety.

What can we learn from this incident? ***(What does this remind us about good practice? What can we change?)***

- The review has identified lack of clarity regarding the escalation of concerns regarding patient safety, and safety of others, to agencies such as Multi Agency Risk Assessment Conference (MARAC).
- Additional training will be provided to teams to ensure staff understand their responsibilities under Section 117, are aware of and implement the Herefordshire Safeguarding Board's Escalation Policy and improve the awareness of Domestic Violence and Sexual Abuse pathway as referenced within the Safeguarding Adults Framework.

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-36-19

Incident Category:

Patient death

What happened? ***(Describe the incident)***

- **A concern for welfare was raised by the patient's neighbours. When policed entered the property, they found the patient deceased. Medication and a note was found close by.**

What did the Investigation find? ***(What was done well? Did anything go wrong?)***

- **The patient had a long history of intermittent episodes of depression and had struggled to cope after the loss of her husband three years previously.**
- **The patient had recently been made aware of a possible diagnosis of Dementia, although further assessment was required.**
- **The patient often spoke about a 'stockpile of medication' that she kept as her safety net.**
- **The patient did not give Consent to Share information with her family, but this decision was not recorded in the clinical record.**
- **At the time of the incident, the community team was experiencing an unusually high level of staff sickness, which led to staff working over capacity.**
- **There was evidence of good communication between the community team and the patient's GP.**

What can we learn from this incident? ***(What does this remind us about good practice? What can we change?)***

- **When conversations have been had about Consent to Share information, these conversations must be documented within the patient's clinical record as detailed in the Triangle of Care, and as required by the Assessment & Care Management Policy.**
- **Appropriate risk management plans must be formulated following risk assessments.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-38-19

Incident Category:

Patient death

What happened? ***(Describe the incident)***

- **The patient was found hanged at their home address.**

What did the Investigation find? ***(What was done well? Did anything go wrong?)***

- **The patient had recently been given a diagnosis of Emotionally Unstable Personality Disorder, which they were struggling to come to terms with.**
- **The patient was assessed as a MEDIUM risk of suicide in the long term and had a history of self-harm and voicing suicidal thoughts.**
- **The patient had experienced a number of traumatic events, which had impacted significantly on day to day life.**
- **The patient had a rare physical health condition, which had an unpredictable course.**
- **The patient was heavily involved and reliant upon two private therapists and the GP. These professionals, although not part of the same team, would meet regularly to discuss the patient's progress and to support each other.**
- **The patient had been discharged from CRHTT in a planned manner on the day of their death and care had been transferred to the community team.**
- **There was evidence of flexible, thoughtful care provided by clinicians.**

What can we learn from this incident? ***(What does this remind us about good practice? What can we change?)***

- **Gloucestershire Hospitals NHS FT may not be adequately aware of a patient's risk of overdose, to inform their prescribing on discharge. The Director of Quality will, in the first instance, discuss this with GHNHSFTs senior management team.**

The Lessons Learned are routinely taken to Locality Governance Committee meetings for onward cascade. The SI Action-Planning Sub-Committee oversees the gathering of Assurance for each Action generated.

The Trust believes that by implementing the above actions, patient safety and quality of care has improved.

4.3 Learning from Clinical Incident Investigations Completed During 2019/20 Q1

4.3.1 There was no learning from Clinical Incident Reviews during 2019/20 Q1.

5. CONCLUSION

5.1 This, the Q1 report for 2019/20 of mortality review data under the Learning from Deaths policy focusses on the progress made during Q1.

5.2 The Bank Patient Safety Team Administrator, Zoë Lewis, has now been recruited to the substantive post and continues to make a positive impact upon the mortality review process resulting in timely review of patients, as demonstrated by the date contained in Tables 3.1 and 3.2, together with the output from MoReC (Section 4.1). Zoë's aim is to improve on this still further, whilst being mindful of the impact of Trust merger upon the mortality review process.

5.3 Mortality Review Committees have convened regularly since November 2018. However, whilst learning from these reviews is limited, the active review of patient deaths does provide assurance that End of Life Care and the care provided to our patients is of an excellent quality which seldom results in unexpected deaths, natural or otherwise.

5.4 As a Trust we are committed to the National Quality Boards (2017) Learning from Deaths guidance. The Trust ensures that it seeks to actively learn and implement changes in practice identified from reviews of death. The Trust is an active supporter of the Learning Disabilities Premature Mortality Review programme (LeDeR) in Gloucestershire and Herefordshire.

5.5 Learning from Deaths continues to provide vital guidance. As a Trust we are fully committed to recognising the need to improve services following learning from events both nationally and locally such as Gosport, Mid Staffordshire and the Learning Disabilities Premature Mortality Review (LeDeR), alongside our own local serious incidents.

Agenda item 16(4)

Report to:	Trust Board, 26 September 2019
Author:	Dr Nader Abbasi, Consultant & Guardian of Safe Working Hours
Presented by:	Dr Amjad Uppal, Medical Director
SUBJECT:	**Guardian of Safe Working Hours Quarterly Report covering February , March, and April 2019**

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

All new Psychiatry Trainees, Foundation Trainees and GP Trainees rotating into a Psychiatry placement are now on the new 2016 Terms and Conditions of Service with occasional exceptions. There are currently 42 trainees (junior doctors) working in the 2gether NHS Foundation Trust, all on the new Terms and Conditions of Service on different sites.

The 'exception' reporting process, which is part of the new Juniors Doctors Contract enables them to raise and resolve issues with their working hours and training. The trainees can raise 'exception reports' for excessive hours worked, missed breaks, or missed educational opportunities and this system is now well established in the Trust. These 'exception reports' where possible have been resolved by the preferred option of time off in lieu (TOIL); those where TOIL will impact on colleagues' workload or educational opportunities have received payments. Exception reports may also trigger work schedule reviews and if necessary fines can be imposed on the Trust by the Guardian of Safe Working if issues remain unresolved. Exception reporting rates are variable between different sites.

The Quarterly Board report from the Guardian which summarises all exception reports, work schedule reviews and rota gaps, and provides assurance on compliance with safe working hours by both the employer and doctors in approved training programs, will be considered by CQC, GMC, and NHS employers as key data during reviews. The purpose of the report is to give assurance to the Board that the doctors in training are safely rostered and their working hours are complaint with the TCS.

RECOMMENDATIONS
1) The Board is asked to note this report from the Guardian of Safe Working. Full engagement remains a challenge and this work is being progressed.

Corporate Considerations	
Quality implications	Implementing the new contract is a DoH requirement justified by a need to ensure consistent quality of care and working conditions for junior doctors.
Resource implications:	There is a cost implication of implementation of the new contract. It is important that the Trust avoids fines due to non-compliance.
Equalities implications:	Nil
Risk implications:	Financial risk if the Trust breaches, a number of issues have been identified in the implementation phase which are identified in the report, together with the plans to resolve them.

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

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

Reviewed by:		
Dr Amjad Uppal	Date	18 September 2019

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

What consultation has there been?		
	Date	

Explanation of acronyms used:	CQC – Care Quality Commission DME – Director of Medical Education HEE – Health Education England

1.0 CONTEXT

1.1 The safety of patients is of paramount importance for the NHS and staff fatigue is a hazard both to patients and the staff. The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours. It was agreed during negotiations with the BMA that a 'Guardian of Safe Working Hours' will be appointed in all NHS Trusts employing trainees (junior doctors) to ensure safe working practice.

1.2 The role of 'Guardian of Safe Working Hours' is independent of the Trust management structure, with the primary aim to represent and resolve issues related to working hours for the junior doctors employed by it. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and will provide assurance to the Trust Board or equivalent body that doctors' working hours are safe.

1.3 The work of the Guardian will be subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by the continued scrutiny of the quality of training by Health Education England (HEE). These measures should ensure the safety of doctors and therefore of patients.

1.4 The Trust has invested in relevant software to help monitor the 'Exception Reports' in line with national guidance and the system is relatively well established in the Trust now.

1.5 The Guardian's Quarterly Report, as required by the junior doctor's contract, is intended to provide the Board with an evidence based report on the working hours and practices of junior doctors within the Trust, confirming safe working practices and highlighting any areas of concern.

2. THE GUARDIAN OF SAFE WORKING HOURS REPORT

2.1 Exception Reporting

The Trust uses 'Allocate' as the reporting software system, which appears to function reasonably well for this purpose.

Since beginning of February 2019 till end of April 2019, 6 exception reports have been generated and a break down has been provided in following tables.

2.2 The table below shows the number of trainee posts available and filled by junior doctors in training.

Grade	Trainees	Glos	Hereford	New Contract	Old Contract
F1	5	4	1	5	0
F2	5	3	2	5	0
GP	8	5	3	8	0
CT	12	10	2	12	0
ST	12	11	1	12	0
Total	**42**	**33**	**9**	**42**	**0**

Exception reports by site	
Gloucester	2
Hereford	4
Total	6

Exception reports by grade						
Grade	F1	F2	GP	CT	ST	Total
	1	3	0	2		6

Exception reports, response time					
	Addressed within 48 hrs	Addressed within 7 days	Addressed in longer than 7 days	Addressed by Guardian	Still open
F1	1	0	0	0	0
F2	2	0	1	0	0
GP	0	0	0	0	0
CT	0	0	0	0	2
ST	0	0	0	0	0
Total	3	0	1	0	2

2.3 All of 6 reports in this period have been related to hours. We had 4 resolutions and 2 of exception reports is still open at the time one pending a meeting with educational supervisor and one waiting further information.

Resolutions have included:

- 2/6 No further action
- 2/6 time in lieu agreed
- 0/6 overtime payment agreed
- 1/6 pending meeting with Educational Supervisor
- 1/6 Request for more information
- There was no need for work schedule reviews in this period, which is a significant improvement as result of collaborative work of Guardian of Safe Working with DME, and Medical Staffing on rota.

We had four Exception Reports from Hereford site and two from Gloucestershire site during this period which is a significant improvement. There was not any overtime payment during this time period and reports mainly were closed by option of time in lieu or no further action.

There are some historical reports still open and we are in discussion with the software provider Allocate to find a way to resolve this problem in future. These reports have not been closed down by trainees who have left the Trust.

2.5 Work Schedule reviews

During this rota since February 2019 we have had no formal work schedule reviews and it has not been recommended through the reports' outcome. This is due to close collaboration between the Guardian of Safe Working, the Director of Medical Education and Medical Staffing.

2.6 Locum Booking and Vacancies

2.6.1 During this period four on call shifts in Gloucester were covered by agency doctors and none in Hereford.

2.6.2 In this time period we had no long term vacancy or sickness on Hereford site but four of our trainees on Gloucester site not able to complete on calls as normal.

2.7 Fines

2.7.1 At this stage no fines have as yet been applied.

3.0 Challenges:

3.1 Completion of Exception Reports / Knowledge of the System: There has been significant improvement in the number of Exception Reports, response time and outcome. There is still room for improvement mainly in regard to response time and trainees and their educational supervisors need to address the concerns as soon as a report is raised. The Guardian will continue to support junior doctors and supervisors in resolving these issues as soon as possible. The Guardian has arranged a meeting with trainees to discuss these issues in a confidential setting.

3.2 Software System: The Trust uses a nationally procured system for medical staff rotas called 'Allocate Software System'; this system is now used for Exception reporting. All our junior doctors and educational supervisors are registered with the system. There are some issues with the system, which are nationwide and not limited to our Trust, and have been highlighted to the software company.

3.3 Junior doctor rota: Since changing rota in Gloucestershire to working 'waking' nights there has been a significant decline in number of exception reports. There has been significant improvement in number of reports raised by trainees working in Hereford following increase time allocated to on-call call out hours.

3.4 Workload: The new contract does have workload implications for the Guardian, administrator, DME, Educational and Clinical supervisors when a trainee submits an exception report.

3.5 Administrative support for the Guardian role: The Guardian is assisted by admin from medical staffing and they have been very supportive in introducing the new system and answering queries from users.

3.6 Junior Doctors Forum: Our Junior Doctors Forum predates the introduction of the new contract and has been further strengthened by the Guardian and the DME meeting quarterly. The attendance by junior doctors has been variable despite a proactive approach by the current junior doctors' rep to engage colleagues.

4. Exception Reports and Fines

4.1 There have been 6 exception reports during this period with 2 still open and needs addressing by the concerned doctor and their supervisor.

4.2 There has been no breach of contract to initiate any fines against the Trust yet.

5. Networking

5.1 The Guardian regularly attends the South West Guardians peer group, which meets quarterly. I also attended the annual national training. I have email contact with a number of other Guardians in the region to share updates and experiences. Intelligence from this network suggests that the level of exception reporting has been similar across similar size Trusts within the region. The Guardian also regularly meets with the Director of Medical Education.

5.2 There is a national view that there is a surge of exception reports in February and August every year when junior doctors start in new posts. This usually settles when junior doctors become familiar with the system and their work schedules. We have included a presentation by Guardian in all Induction Programs of Trust on both sites to address this issue.

6.0 CONCLUSION

6.1 All of our junior doctors now are on the new contract and committed to use the exception reporting system to ensure safe working practice. Information gleaned from the exception

reports enables the DME to keep informed of the challenges and threats to the provision of quality Trainee placements at the Trust.

6.2 The Exception Reporting process allows Trainees to give the Guardian notice of working unsafe hours. It is important that these issues are resolved in a timely manner.

6.3 The Guardian of Safe Working Quarterly Report provides assurance that Trust is positively engaged with its junior doctors via a number of routes and meetings. There was a surge of exception reports at the start of the implementation of the new contract but this has improved significantly with better understanding of the system through regular presentations at Induction and educating trainees and their supervisors.

6.4 There has been significant reduction in the number of exception reports raised by trainees on both sites. This is the result of collaborative work by The Guardian of Safe Working, DME and medical staffing on rotas.

6.5 There are some ongoing issues regarding engagement of both trainees and educational supervisors which are being addressed through regular training updates.

7.0 RECOMMENDATIONS

7.1 The Board is asked to note the assurance provided in the report.

7.2 Ongoing issues are being addressed through regular training updates and initial training at trainees' Induction which is mandatory.

Item 16(5)

Report to:	Trust Board –26 September 2019
Author:	Gordon Benson, Assistant Director of Governance & Compliance
Presented by:	John Trevains, Director of Quality

SUBJECT: **Quality Report: Quarter 1 2019/20**

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

EXECUTIVE SUMMARY

This is the first review of the Quality Report priorities for 2019/20. The quarterly report is in the format of the annual Quality Report.

Assurance

- The report shows the progress made towards achieving targets, objectives and initiatives identified in the Annual Quality Report.
- All Quality Indicators were fully met in Quarter 1 bar one.
- The one target not fully met:

3.5 – Further develop a quality improvement led approach to robustly embed lessons learned following serious incidents.

We have been working through our zero suicide initiative and reducing restrictive practice groups to progress this indicator. Further work has been paused whilst we complete the Phase 3 merger management of change process. We will be driving this work forward through the combined Trust quality team in Q3 & 4.

Improvements/developments

- As reported to QCR in July 2019, there continues to be detailed monthly focus on indicators 1.2 – Discharge Care Planning and 3.3 Reduction in use of prone restraint to gain improved consistency of practice.

Risks

- A mid Quarter 2 review of information shows that;
  1. Indicator 3.3. To increase the use of supine restraint as an alternative to prone – Quarter 2 data will show that this target will not be met. This is due to personalised and informed approaches to managing restrictive interventions. Outside of this individual case good progress is being made in reducing variation.
  2. Indicator 3.1. Reduction of reported suspected suicides. The number of reported suspected suicides has increased within Quarter 2, the current position (16, at September 2019) shows the same overall total of these tragic incidents as at the end of Quarter 2 last year.

RECOMMENDATIONS
The Board is asked to note the progress made to date and actions in place to improve/sustain performance where possible.

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: J Trevains		
	Date	18/9/2019

Where in the Trust has this been discussed before?		
QCR	Date	August 2019
Governance	Date	August 2019
Trust Board	Date	

What consultation has there been?		
	Date	

Explanation of acronyms used:	ACM – Assessment & Care Management Policy

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 NHS Improvement (incorporating the Department of Health Guidance for Quality Accounts) and the Quality Report checked for consistency against the defined regulations.

Quality Report 2019/20

CONTENTS

Part 1: Statement on Quality from the Chief Executive

Introduction

To be completed at year end.

Part 2.1: Looking ahead to 2020/21

Quality Priorities for Improvement 2020/21

These will be considered post merger after Gloucestershire Health & Care NHS Foundation Trust has been established and will reflect priorities spanning both physical and mental health care.

Effectiveness

User Experience

Safety

Part 2.2: Statements relating to the Quality of NHS Services Provided

Review of Services

To be completed at year end.

Participation in Clinical Audits and National Confidential Enquiries

To be completed at year end.

Participation in Clinical Research

To 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 2019/20 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 goals for 2019/20 and for the following 12 month period are available electronically at **www.2gether.nhs.uk/cquin**

2019/20 CQUIN Goals

Gloucestershire

Gloucestershire Goal Name	Description	Goal weighting	Expected value	Quality Domain
CCG 2: Staff Flu Vaccinations.	Improving the uptake of flu vaccinations for front line staff	.25	£199000	Safety
CCG4: 72 hour follow up Post Discharge : Routine Submission to MHSDS	72 hour follow up is a key part of the work to support the Suicide Prevention Agenda. The NCE into Suicide and Safety in Mental Health found that the highest number of deaths occurred on day 3 post discharge.	.25	£199000	Safety
CCG 5 :Mental Health Data Quality: MHSDS (a)Data Quality Maturity Index (b) Mental Health Data Quality Interventions:	Accurate data is a key enabler for improvement in MH services The MHSDS DQMI score is an overall assessment of data quality for each provider, based on a list of key MHSDS data items. The MHSDS DQMI score is defined as the mean of all the data item scores for percentage valid & complete multiplied by a coverage score for the MHSDS. Achieving 70% of referrals where the second attended contact takes place between Q3-4 with at least one intervention (SNOMED CT procedure code) recorded using between the referral start date and the end of the reporting period.	.25	£199000	Safety
CCG 6: Use of Anxiety Disorder Specific Measures in IAPT: Routine submission to IAPT Data Set.	Achieving 65% of referrals with a specific anxiety disorder problem descriptor finishing a course of treatment having paired scores recorded on the specified Anxiety Disorder Specific Measure	.5	£398000	Safety

Herefordshire

Herefordshire Goal Name	Description	Goal weighting	Expected value	Quality Domain
CCG 2: Staff Flu Vaccinations.	Improving the uptake of flu vaccinations for front line staff	0.25	£52800	Safety
CCG4: 72 hour follow up Post Discharge :	72 hour follow up is a key part of the work to support the Suicide Prevention Agenda.	0.25	£52800	Safety

Herefordshire Goal Name	Description	Goal weighting	Expected value	Quality Domain
Routine Submission to MHSDS	The NCE into Suicide and Safety in Mental Health found that the highest number of deaths occurred on day 3 post discharge.			
CCG 5 :Mental Health Data Quality: MHSDS (a)Data Quality Maturity Index (b) Mental Health Data Quality Interventions:	Accurate data is a key enabler for improvement in MH services The MHSDS DQMI score is an overall assessment of data quality for each provider, based on a list of key MHSDS data items. The MHSDS DQMI score is defined as the mean of all the data item scores for percentage valid & complete multiplied by a coverage score for the MHSDS. Achieving 70% of referrals where the second attended contact takes place between Q3-4 with at least one intervention (SNOMED CT procedure code) recorded using between the referral start date and the end of the reporting period.	0.25	£52800	Safety
CCG 6: Use of Anxiety Disorder Specific Measures in IAPT: Routine submission to IAPT Data Set.	Achieving 65% of referrals with a specific anxiety disorder problem descriptor finishing a course of treatment having paired scores recorded on the specified Anxiety Disorder Specific Measure	0.25	£52800	Safety
5.Preventing ill health by risky behaviours – Alcohol and Tobacco	To offer advice and interventions aimed at reducing risky behaviour in admitted patients	0.25	£52800	Safety

Low Secure Services

Low Secure Goal Name	Description	Goal weighting	Expected value	Quality Domain
Maintenance of healthy weight	Substantial consequential health benefits and cost savings.	1.25	£24592	Effectiveness

Liaison Diversion

Low Secure Goal Name	Description	Goal weighting	Expected value	Quality Domain
Maintenance of healthy weight	Substantial consequential health benefits and cost savings.	1.25	£24592	Effectiveness

The total potential value of the income conditional on reaching the targets within the CQUINs during 2019/20 is £1,294,257.00 of which xxxx (to be completed at year end) was achieved.

In 2018/19, the total potential value of the income conditional on reaching the targets within the CQUINs was £2,440,000.00 of which £2,440,000.00 was achieved

2020/21 CQUIN Goals

To be completed at year end.

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 2019/20 or the previous year 2018/19.

[2]gether NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

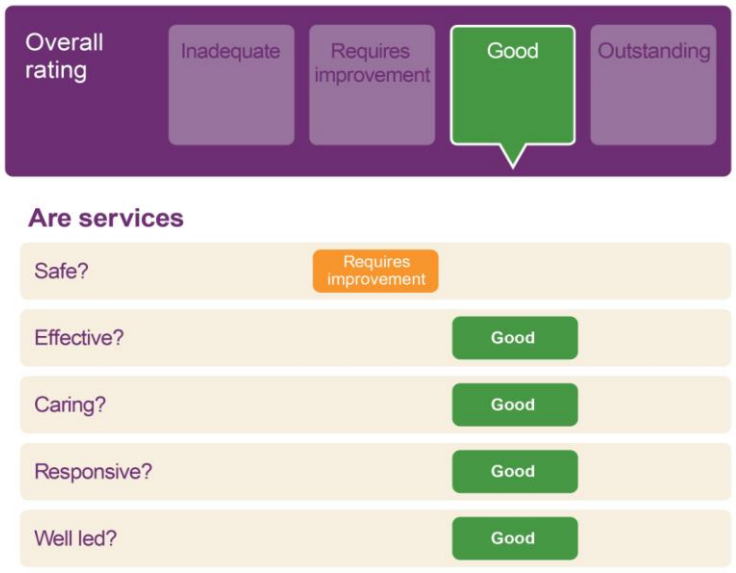
CQC Inspections of our services

The CQC have moved away from the previous Comprehensive Inspection model to one which consists of an annual Well Led review which is announced, and unannounced inspections of specific services. The CQC undertook the following inspections during the period: 12th February to 29th March 2018.

1. Unannounced inspection of community based mental health services for older people
2. Unannounced inspection of wards for older people with mental health problems
3. Unannounced inspection of wards for people with learning disabilities or autism
4. Unannounced inspection of specialist community mental health services for children and young people
5. Well Led Review

New Ratings from latest review

The overall Trust rating remains GOOD and the CQC recognised that there have been many improvements made since the last inspection in 2015.



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. The Trust has developed an action plan in response to the 11 “must do” recommendations, and the 23 “should do” recommendations identified by the inspection and has managed the actions through to their completion.

In 2019/20 we are contributing to the CQC National review of seclusion and Long term segregation.

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

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

Quality of Data

To be completed at year end.

Information Governance

To be completed at year end.

Clinical Coding

[2]gether NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2019/2020 by the Audit Commission.

Learning from Deaths

During 1 April 2019 – 30 June 2019 124 patients of [2]gether NHS Foundation Trust died (correct as of 8th August 2019). This comprised the following number of deaths which occurred in each month of that reporting period:

63 in April,
32 in May,
29 in June.

The terminology used to describe the stages of Mortality Review changed in December 2018 following publication of the Royal College of Psychiatrists' Structured Judgement Review (SJR) documentation. The Mortality Review Committee (MoReC) adopted this methodology in January 2019 following discussion and agreement by the Mortality Review Committee (MoReC). The LD Mortality Review Group (LD MRG) have decided to continue with the Care Record Review (CRR) of LD patient deaths in order to facilitate continuity with the LeDeR process.

Following discussion at MoReC in and at countywide Mortality Steering Groups in both Gloucestershire and Herefordshire, it was agreed to exclude from active review those patients open for ACI Monitoring only and those with a primary diagnosis of dementia who are over 70 years old. MoReC had become very aware that older people with dementia die as a natural consequence of the illness process resulting in limited learning from this cohort of patients. There will be a continued focus on those 70 years and under.

At the time of writing this paper, a total of 17 RCPsych Structured Judgment Reviews (SJRs) at MoReC and Care Record Reviews at LD MRG had been completed.

In 1 case a death was subjected to escalation from Structured Judgement Review at MoReC to a Clinical Incident Investigation. This patient had been seen by Recovery Team staff 3 days prior to their death, and although the patient's serious physical ill health was noted, it is unclear what steps were taken to facilitate a physical health review. The cause of death was given as UTI, a treatable infection. This investigation is ongoing.

The number of deaths in each month for which a Structured Judgement Review, Clinical Incident Review or a Serious Incident investigation was carried out was:

8 in April
7 in May
3 in June.

The above figures do not include current open SJRs, CRRs, CI Investigations and SI Investigations from 2019/20 Q1.

At the time of writing this paper, 0 deaths representing 0.0% of the 124 patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided [2]gether NHS Foundation Trust to the patient. In relation to each month, this consisted of:

0 representing 0% for April
0 representing 0.0% for May
0 representing 0% for June.

At time of writing, 18 deaths, which represented 14.5% of the 124 patient deaths during the reporting period were still open and undergoing mortality review (Table 3.2). 9 patient death incidents were awaiting death information, which included waiting for toxicology results, and 5 were awaiting Structured Judgement Review at MoReC or Care Record Review at LD MRG. There were 2 open Serious Incident Investigations and 2 open Clinical Incident Investigations.

During 2019/20 Q1, following Structured Judgment Reviews of patient deaths, together with patient deaths brought for discussion only, MoReC has made the following Recommendations:

- The Committee noted that junior medics on call may not feel comfortable prescribing end of life (EOL) medication. The Committee asked the Ward Manager to consider a form of words to state that EOL medication will be written up beforehand and what conditions need to be met to allow EOL care to be commenced. This was discussed and acknowledged at the EOL Steering Group, with the outcome being that the Consultant will make an entry in RiO outlining a "what if" plan.

- Following SJR of an expected inpatient death on Cantilupe Ward, the Committee noted the patient's Section 3 of the MHA had not been rescinded upon commencement of EOL care. The Committee advises that once EOL care is commenced and psychotropic medication withdrawn, the patient's mental illness is no longer being treated, which is incompatible with MHA and DoLS should be applied instead. This Recommendation was taken to the Clinical Director for Herefordshire.

- Following an expected inpatient death at Charlton Lane Hospital, the Committee noted that once the Shared Care Plan is up and running, current local policy dictated that the junior medic on call is contacted before Palliative Care. The Committee recommended a change to local policy so that the ward team contact Palliative Care in the first instance and then contact the junior medic on call and to inform of Palliative Care's advice.

- The Committee noted that a major cause of agitation in patients suffering dementia is pain they are unable to verbalise. The Committee recommended that the rationale for using opiates as either an EOL medication or for pain needs to be made clear in the notes. This recommendation was taken to the North Locality Clinical Director and was added to the agenda for the Old Age Psychiatry Consultants Meeting.

- Following the difficulty in finding death information regarding deaths of patients who pass away whilst inpatients at ^{2}gether NHS Foundation Trust hospitals, the Committee considered that it is appropriate for documentation completed by medics regarding a patient's death, to include death certificates issued by the 2gether Trust, to be uploaded to the patient's record on RiO. This recommendation was taken to the End of Life Steering Group.

- Following an unexpected death of a 65 year old inpatient placed out of county, the Committee noted that although very complex in nature, one of the reasons people with mental health difficulties die prematurely is because they do not access screening programmes. The Committee noted that for patients placed out of county there was no provision in the ^{2}gether NHS Foundation Trust's contracts with out of county providers to ensure patients are offered access to an annual physical health check with Primary Care. Subsequently, the Committee recommended that mental health patients placed out of county should be registered with a GP who will provide physical health care on a day-to-day basis. Also, an annual physical health check should be commissioned for each patient placed out of county. The recommendation was taken to the Commercial & Planning Manager for inclusion in the 2gether Trust's contract negotiations with out of county providers. This requires resolution.

- Following a death of an elderly patient who had been referred by their GP three times before being seen by CMHT, the Committee sought clarification regarding DNA policy and what is done to mitigate elderly people living alone not attending their out-patient appointments, and to consider if a home visit would be more appropriate. The enquiry was taken to the North Locality Clinical Director and was added to the Old Age Psychiatry Consultants Meeting.

Part 2.3: Mandated Core Indicators 2019/20

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

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

	Quarter 4 2017-18	Quarter 1 2018-19	Quarter 2 2018-19	Quarter 3 2018-19	Quarter 4 2018-19
[2]gether NHS Foundation Trust	98.4%	97.6%	98.4%	97.7%	99.1%
National Average	95.5%	95.8%	95.7%	95.5%	95.5%
Lowest Trust	87.2%	73.4%	88.3%	81.6%	83.5%
Highest Trust	100%	100%	100.%	100%	100%

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

- During 2015/16 we reviewed our practices and policies associated with both our 7 day and 48 hour follow up of patients discharged from our inpatient services, the changes were introduced in 2016/17. This has strengthened and continues to support the patient safety aspects of our follow up contacts.

[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;
- Continuing to ensure that service users are followed up within 48 hours of discharge from an inpatient unit whenever possible.

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

	Quarter 4 2017-18	Quarter 1 2018-19	Quarter 2 2018-19	Quarter 3 2018-19	Quarter 4 2018-19
[2]gether NHS Foundation Trust	98.6%	99.4%	99.4%	98.9%	99.3%
National Average	98.7%	98.1%	98.4%	97.8%	98.1%
Lowest Trust	93.7%	85.1%	81.4%	78.8%	88.2%
Highest Trust	100%	100.00%	100.00%	100%	100%

[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;

[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 both complete the 'Method of Admission' field with the appropriate option when admissions are made via the Crisis Team and 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 2018-19	Quarter 2 2018-19	Quarter 3 2018-19	Quarter 4 2018-19	Quarter 1 2019-20
[2]gether NHS Foundation Trust 0-15	0%	0%	0%	0%	0%
[2]gether NHS Foundation Trust 16 +	6.2%	6.1%	7.8%	5.6%	4.0%

[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.

[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 responded positively to " if a friend or relative needed treatment I would be happy with the standard of care provided by the Organisation"**

	NHS Staff Survey 2016	NHS Staff Survey 2017	NHS Staff Survey 2018	NHS Staff Survey 2019
[2]gether NHS Foundation Trust Score	72.6%	74.2%	74.5%	Not yet reportable
National Average Score	58.9%	61.2%	61.3%	
Worst Trust Score	44.1%	41.6%	38.2%	
Best Trust Score	82.2%	86.5%	80.8%	

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

- For the third year running, all staff in post were invited to take part in the survey. Previously the survey had only been sent to a random sample of staff. The overall response rate in the most recent survey was **40.55%** (reduced from 44% the previous year). This equated with **863** staff taking the time to contribute their views. The survey provides a rich and accurate picture of the staff views on the Trust's services to date.

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

- Improve response rates
- Improve further staff engagement
- Improve the quality of appraisals
- Improve our Safe Environment by reducing Bullying and Harassment
- Improving our Quality of Care

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 2016	NHS Community Mental Health Survey 2017	NHS Community Mental Health Survey 2018	NHS Community Mental Health Survey 2019
[2]gether NHS Foundation Trust Score	8.0	8.0	7.7	Not yet reportable
National Average Score	Not available	Not available	Not available	
Lowest Score	6.9	6.4	5.9	
Highest Score	8.1	8.1	7.6	

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

- ²gether is categorised as performing 'better' than the majority of other mental health Trusts in 5 of the 11 domains and 'about the same' as the majority of other mental health Trusts in the remaining 6 domains.

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

- Supporting people at times of crisis;
- Involving people in planning and reviewing their care;
- Involving family members or someone close, as much as the person would like;
- Giving people information about getting support from people with experience of the same mental health needs as them;
- Helping people with their physical health needs and to take part in an activity locally;
- Providing help and advice for finding support with finances, benefits and employment.

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 2017-31 March 2018				1 April 2018-30 September 2018			
	Number	Rate*	Severe	Death	Number	Rate*	Severe	Death
[2]gether NHS Foundation Trust	2901	83.69	2	28	2385	68.2	2	14
National	166787	-	569	1331	3414	54.17	10.74	25.21
Lowest Trust	1	14.88	0	0	1747	24.9	7	20
Highest Trust	8134	96.72	121	138	4634	114.3	8	28

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

[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 for severe harm and death will not correspond with the serious incident information shown in the Quality Report.

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

- Continuing to hold a Datix User Group to improve the processes in place for the timely review, approval of, response to and learning from reported patient safety incidents;

- Creating an additional part time Datix Administrator post to enhance data quality checks and further promote timeliness of reporting. This post commenced in 2017/18 and we have added some further support hours.

- Developing a suite of reports and Dashboards to aid monitoring of incidents on wards to assist staff in identifying themes and trends plus hot spots.

Part 3: Looking Back: A Review of Quality during 2019/20

Introduction

The 2019/20 quality priorities were agreed in May 2019.

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 2019/2020

Effectiveness		2017 - 2018	2018 - 2019	Q1 2019-2020
1.1	To improve the physical health of patients with a serious mental illness on CPA by a positive cardio metabolic health resource (Lester Tool).	Achieved	Achieved	Achieved
1.2	To further improve personalised discharge care planning in adult and older peoples wards, including the provision of discharge information to primary care services within 24hrs of discharge.	Not achieved	Not achieved	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	Achieved	Achieved
User Experience				
2.1	Were you involved as much as you wanted to be in agreeing the care you will receive? **> 84%**	Not achieved	Achieved	Achieved
2.2	Have you been given information about who to contact outside of office hours if you have a crisis? **> 71%**	Achieved	Achieved	Achieved
2.3	Have you had help and advice about taking part in activities that are important to you? **> 64%**	Achieved	Achieved	Achieved
2.4	Have you had help and advice to find support to meet your physical health needs if you needed it? **> 73%**	Achieved	Achieved	Achieved
Safety				
3.1	Reduce the proportion of patients in touch with services who die by suspected suicide when compared with data from previous years. This will be expressed as a rate per 1000 service users on the Trust's caseload.	Not achieved	Achieved	Achieved
3.2	Detained service users who are absent without leave (AWOL) will not come to serious harm or death. We will report against 3 categories of AWOL as follows; harm as a consequence of: 1. Absconded from escort 2. Failure to return from leave 3. Left the hospital (escaped)	Achieved	Achieved	Achieved
3.3	To increase the use of supine restraint as an alternative to prone restraint	Not Measured	Not achieved	Achieved
3.4	To ensure that 100% of service users within Berkeley House have a bespoke restrictive intervention care plan tailored to their individual need.	Not measured	Achieved	Achieved
3.5	To further develop a quality improvement led approach to robustly embed lessons learned following serious incidents.	Not measured	Not measured	On Target

Easy Read Report on Quality Measures for 2018/2019

Quality Report 	This report looks at the quality of [2]gether's services. We agreed with our Commissioners the areas that would be looked at.	
Physical health 	We increased physical health tests and treatment for people using our services. We met the target.	↑
Discharge Care Plans 	More people had all parts of their discharge care plan completed at the end of the quarter than previously. There is improvement being made. We met the target.	↑
Care (CPA) Review 	All people moving from children's to adult services had a care review. We met the target.	↑
Care Plans 	90% of people said they felt involved in their care plan. This is more than the target (84%). We met the target.	↑
Crisis 	86% of people said they know who to contact if they have a crisis. This is more than the target (71%). We met the target.	↑

Activity 	81% of people said they had advice about taking part in activities. This is more than the target (64%). We met the target.	↑
Physical Health 	82% of people said they had advice about their physical health This is more than the target (73%). We met the target.	↑
Suicide 	There were fewer suicides compared to this time last year. We met the target	↑
AWOL 	In patients who were absent without leave did not come to serious harm or death. We met the target.	↑
Face down restraint 	We have reduced the number of face-down restraints this year but we are still doing more of these than face up restraints. We met the target.	↑
Physical Intervention Care Plans 	Everyone at Berkley House has one of these. We met the target.	↑
Learning from serious incidents 	We are working hard to learn from serious incidents so that fewer people will come to harm. We aim to have met this target by March 2019.	↔

Effectiveness

In 2019/20 we remain committed to ensure that our services are as effective as possible for the people that we support. For the second consecutive year 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

2018/19 was the final year of the 'Improving Physical Healthcare to reduce premature mortality in people with a Serious Mental Illness' CQUIN. 2gether NHS Foundation Trust successfully achieved full payment for this CQUIN, meeting all the national targets set. As a Trust, we have committed to continue to achieve the same targets in 2019/20; 90% of inpatients and 75% of community patients will receive a full cardio vascular health check with the associated interventions given if needed.

Regular auditing will continue to ensure compliance, and feedback to nursing teams will continue to be sent monthly.

There are robust systems in place to ensure existing staff continue to receive refresher training, and that all new staff receive information on physical health checks on their induction to the Trust. Work continues to update the Health &Lifestyle form on the electronic patient record to include details of national screening, dental and contraception options available for service users. Further training will be rolled out to staff Trust wide later in the year.

Successful physical health clinics continue to run at Pullman Place and 27a St Owen Street, providing service users in the community access to physical health checks in an environment with staff who are familiar to them. Such is the success of the physical health clinics, it is hoped to employ a Physical Health nurse for one day a week to take a lead on developing the clinics further within Pullman Place.

The Trust has purchased nine ECG machines for the community hubs. These will provide the opportunity for routine ECG screening for possible cardiac anomalies for patients who are at an increased cardio metabolic risk, largely due to medication side effects and lifestyle factors. Training for staff to take ECG's has been provided by the Physical Health Facilitator, and refresher training for medics to interpret ECG's will be held internally by the Trust own Medical team.

Alongside the CQUIN work, ^{2}gether continues to increase access to physical health treatment for service users. Work around a Quality Improvement initiative 'Well Woman Wednesdays' at Wotton Lawn Hospital, where ladies are offered a full range of advice and success to cervical screening in house, has been recognised with the team of nurses winning the regional parliamentary award for 'Excellence in Healthcare'.

[2]gether has continued to work with “Equally Well” which is a national collaborative to support the physical health of people with a mental illness. The Trust have been approached by the RCN to collaborate with a parity of esteem/lived experience project where experts by experience have been involved, this will be presented in London in September 2019.

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 2016/17 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. 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?

Trust wide compliance for each of the individual criteria assessed is outlined in the table below. For future audits, services will focus on the criteria scoring an **AMBER** or **RED** RAG rating to promote improvement.

		Current compliance (Q1 2019/20)	Direction of travel and previous compliance (Year End 2018/19)
1.	Has a Risk Summary been completed?	100%	⇔100%
2.	Has the Clustering Assessment and Allocation been completed?	92%	⇔92%
3.	Has HEF been completed? (LD only)	100%	⇧83%
4.	Has the Pre-Discharge Planning Form been completed?	23%	⇩31%
5.	Have the inpatient care plans been closed within 7 days of discharge?	26%	⇧14%
6.	Has the patient been discharged from bed?	100%	⇔100%
7.	Has the Nursing Discharge Summary Letter to Client/GP been sent within 24 hours of discharge?	93%	⇧88%
8.	Has the 48 hour follow up been completed if the Community Team are not doing it?	92%	⇧70%

Overall compliance for the Trust (Gloucestershire and Herefordshire) for Quarter 1 was 75% compared to 70% at year end; this means compliance has increased by 5% across the Trust. Overall compliance for Gloucestershire only for Quarter 1 was 76% compared to 69% at year end, this means there has been a 7% increase in compliance. Overall compliance for Herefordshire only for Quarter 1 was 74% compared to 71% at year end, this means that there has been a 3% increase in compliance.

During Quarter 1 2019/20 there were 59 discharges from Herefordshire and 192 from Gloucestershire. The total number of discharges across the Trust was 251.

Quarter 1 results from the audits against these standards are seen below.

Gloucestershire Services

	Compliance			
Criterion	**Year End (2018/19)**	**Quarter 1 (2019/20)**	**Cumulative (2019/20)**	**Direction of Travel**
Overall Average Compliance	**69%**	**76%**	**76%**	⇧
Chestnut Ward	84%	85%	85%	⇧
Mulberry Ward	70%	74%	74%	⇧
Willow Ward	69%	70%	70%	⇧
Abbey Ward	70%	75%	75%	⇧
Dean Ward	71%	82%	82%	⇧
Greyfriars PICU	58%	70%	70%	⇧
Kingsholm Ward	72%	70%	70%	⇩
Priory Ward	76%	87%	87%	⇧
Montpellier Unit	61%	62%	62%	⇧
Honeybourne	64%	78%	78%	⇧
Laurel House	71%	79%	79%	⇧
Berkeley House	63%	N/A	N/A	

Herefordshire Services

Criterion	**Year End (2018/19)**	**Quarter 1 (2019/20)**	**Cumulative (2019/20)**	**Direction of Travel**
Overall Average Compliance	**71%**	**74%**	**74%**	⇧
Cantilupe Ward	78%	78%	78%	⇔
Jenny Lind Ward	70%	73%	73%	⇧
Mortimer Ward	66%	75%	75%	⇧
Oak House	65%	71%	71%	⇧

We are currently meeting this target.

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 (CYPS) 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 every time a young person transitions to adult services.

Results from 2018-19 transitions are also included below so that historical comparative information is available.

2018-19 Results

Gloucestershire Services

Criterion	Compliance Quarter 1 (2018/19)	Compliance Quarter 2 (2018/19)	Compliance Quarter 3 (2018/19)	Compliance Quarter 4 (2018/19)
Joint CPA Review	100%	100%	100%	100%

Herefordshire Services

Criterion	Compliance Quarter 1 (2018/19)	Compliance Quarter 2 (2018/19)	Compliance Quarter 3 (2018/19)	Compliance Quarter 4 (2018/19)
Joint CPA Review	100%	Not applicable	100%	100%

2019-20 Results

Gloucestershire Services

Criterion	Compliance Quarter 1 (2019/20)	Compliance Quarter 2 (2019/20)	Compliance Quarter 3 (2019/20)	Compliance Quarter 4 (2019/20)
Joint CPA Review	100%			

Herefordshire Services

Criterion	Compliance Quarter 1 (2019/20)	Compliance Quarter 2 (2019/20)	Compliance Quarter 3 (2019/20)	Compliance Quarter 4 (2019/20)
Joint CPA Review	100%			

We are pleased to report that during Quarter 1 2019/20 all young people who transitioned into adult services had a joint CPA review. This is consistent with last year's performance.

To improve our practice and documentation in relation to this target, a number of measures were developed and implemented during 2018-19 as follows:

- Transition to adult services for any young person will be included as a 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 those young people who are 17.5 years open to teams. Team Managers then monitor those who are coming up to transition discuss them with care coordinators in caseload management to see whether transition is clinically indicated.

These measures will continue to be used to promote good practice into 2019/20.

We are currently meeting 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 users in key areas. This was measured though defined survey questions for both people in community and inpatient settings.

The Trust's **How did we do?** survey combines the NHS Friends and Family Test and our local Quality Survey. The Quality Survey questions encourage people to provide feedback on key aspects of their care and treatment.

The two elements of the **How did we do?** survey will continue to be reported separately as Friends and Family Test and Quality Survey responses by county. A combined total percentage for both counties is also provided to mirror the methodology used by the CQC Community Mental Health Survey.

Data for Quality Survey (Quarter 1 2019/20 – April to June 2019) results:

Target 2.1 Were you involved as much as you wanted to be in agreeing the care you will receive? < 84%

Question	County	Number of responses	Target Met?
Were you involved as much as you wanted to be in agreeing the care you receive?	Gloucestershire	95 (85 positive)	90% TARGET 84%
	Herefordshire	115 (104 positive)	
	Total	210 (189 positive)	

This target has been met.

Target 2.2 Have you been given information about who to contact outside of office hours if you have a crisis? > 71%

Question	County	Number of responses	Target Met?
Have you been given information about who to contact outside of office hours if you have a crisis?	Gloucestershire	102 (87 positive)	86% TARGET 71%
	Herefordshire	124 (108 positive)	
	Total	226 (195 positive)	

This target has been met.

Target 2.3 Have you had help and advice about taking part in activities that are important to you? > 64%

Question	County	Number of responses	Target Met?
Have you had help and advice about taking part in activities that are important to you?	Gloucestershire	97 (77 positive)	81% **TARGET 64%**
	Herefordshire	117 (96 positive)	
	Total	214 (173 positive)	

This target has been met.

Target 2.4 Have you had help and advice to find support for physical health needs if you have needed it? > 73%

Question	County	Number of responses	Target Met?
Have you had help and advice to find support for physical health needs if you have needed it?	Gloucestershire	92 (74 positive)	82% **TARGET 73%**
	Herefordshire	111 (92 positive)	
	Total	203 (166 positive)	

This target has been met.

Feedback from the Quality survey along with the National Community Mental Health survey results helped us to identify the need to increase the involvement of people in the development of their care plans. This is the focus of our work to implement an Always Event as part of the NHS England campaign.

Although response rates for the survey have increased over time the level of response continues to be lower than we would like. During Quarter 1 we have introduced a new system to capture survey feedback with aim to increase the number of response we receive to both aspects of the How did we do? survey.

Friends and Family Test (FFT)

FFT responses and scores for Quarter 1, 2019/20

The FFT involves service users being asked "*How likely are you to recommend our service to your friends and family if they needed similar care or treatment?*"

Our Trust played a key role in the development of an Easy Read version of the FFT. Roll out of this version ensures that everybody is supported to provide feedback.

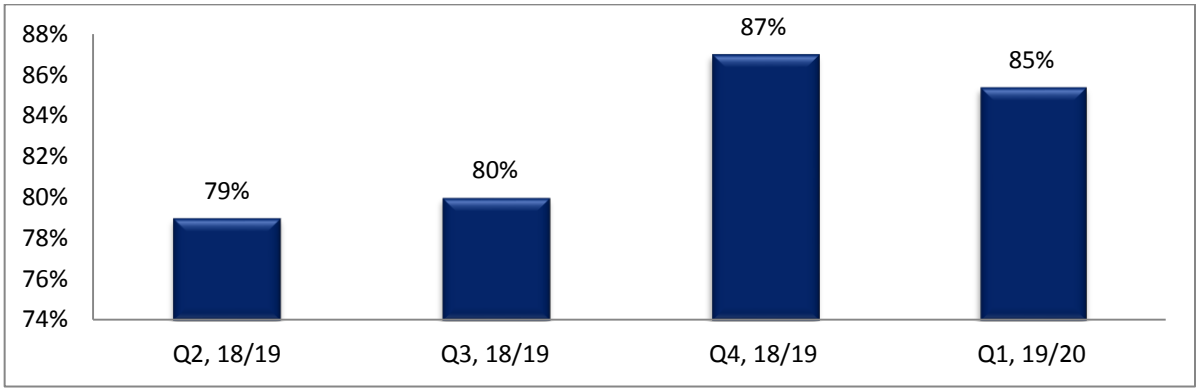
The table below details the number of combined total responses received by the Trust each month in Quarter 1. The FFT score is the percentage of people who stated that they would be 'extremely likely' or 'likely' to recommend our services. These figures are submitted for national reporting.

	Number of responses	FFT Score (%)
April 2019	291 (248 positive)	85%
May 2019	257 (220 positive)	86%
June 2019	184 (157 positive)	85%
Total	732 (625 positive) **(last quarter = 454)**	**85%** **(last quarter = 87%)**

The FFT score for our Trust this quarter has remained about the same as the previous quarter however the number of responses has increased, which suggests that those who responded to our survey have largely experienced a high level of satisfaction with the services that we provide. This is continues to be encouraging news as previous. Our Service Experience Department (SED) continue to embed systems to seek higher numbers of responses to our surveys in order to further inform us about peoples experiences of our services.

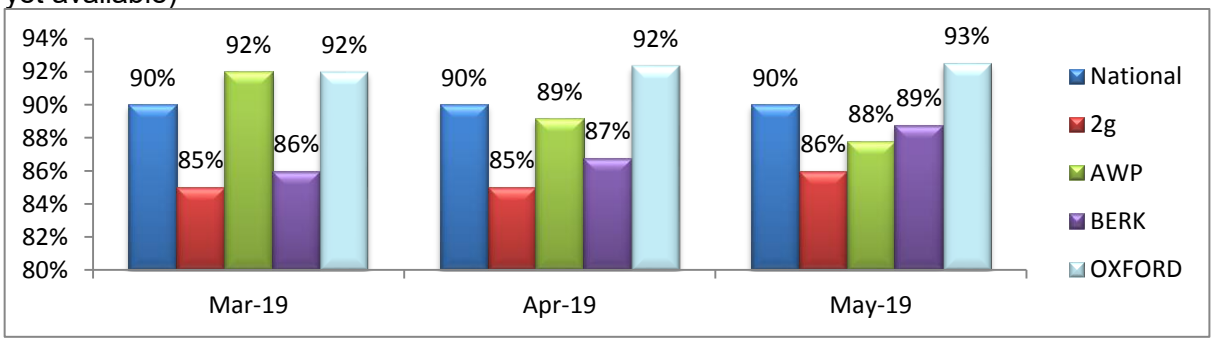
SED have undertaken further analysis of this quarter's FFT scores to review for any areas that are influencing decreased scores and are sharing with operational colleagues for further follow up and action.

FFT Scores for [2]gether NHS Foundation Trust for the past year. The following graph shows the FFT Scores for the past rolling year, including this quarter. The Trust generally receives mostly positive feedback.



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

The chart below shows the FFT scores for March, April, and May 2019 (the most recent data available) compared to other Mental Health Trusts in our region and the national average. Our Trust consistently receives a high percentage of recommendation although we have achieved lower scores than other Trusts in our region in recent quarters. This is a reversal from previous years and does not triangulate with our positive National Survey scores (June 2019 data are not yet available)



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

To 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 that we assess the safety of those who use our services as well as providing a safe environment for service users, staff and everyone else that comes into contact with us. In this domain, we have set ourselves 3 goals to:

- Minimise the risk of suicide of people who use our services;
- Ensure the safety of people detained under the Mental Health Act;
- Reduce the number of prone restraints used in our adult inpatient services;
- Embed the learning from our reported serious incidents:

There are 3 associated targets.

Target 3.1 **Reduce the proportion of patients in touch with services who die by suspected suicide when compared with data from previous years. This will be expressed as a rate per 1000 service users on the Trust's caseload**.

We aim to minimise the risk of suicide amongst those with mental disorders through systematic implementation of sound risk management principles. In 2013/14, during which year we reported **22** suspected suicides, 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. Sadly the number increased and during 2016/17 we reported **26** suspected suicides and in 2017/18 the number of reported suspected suicides increased to **28.** We are pleased to report that by the end of 2018/19 the number had reduced and that we reported **25** suspected suicides. At the end of Quarter 1 2019/20, 3 suspected suicides had been reported as seen in Figure 1.

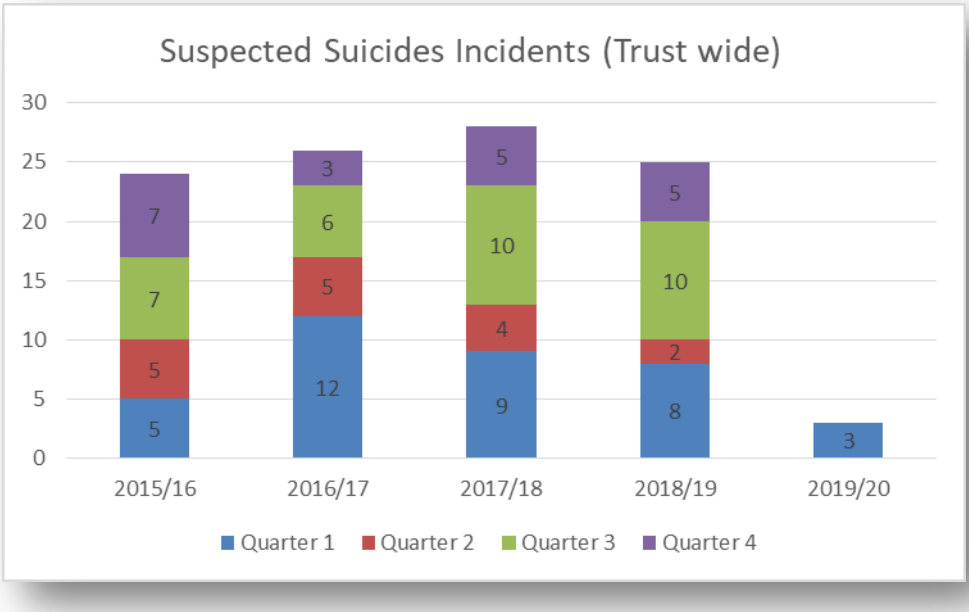


Figure 1

What we also know is that we are seeing more and more service users on our caseload year on year, so we measured this important target differently this year. This is also reported as a rate per 1000 service users on the Trust caseload. The graph in Figure 2 shows this rate from 2014/15 onwards for all Trust services covering Herefordshire and Gloucestershire, and we are aiming to see the median value (green line) get smaller. During 2015/16, 2016/17 and 2017/18 the median value was 0.09. By the end of 2018/19 the median value reduced to 0.06 and we are pleased to report that at the end of Quarter 1 2019/20 this has falled further to 0.04.

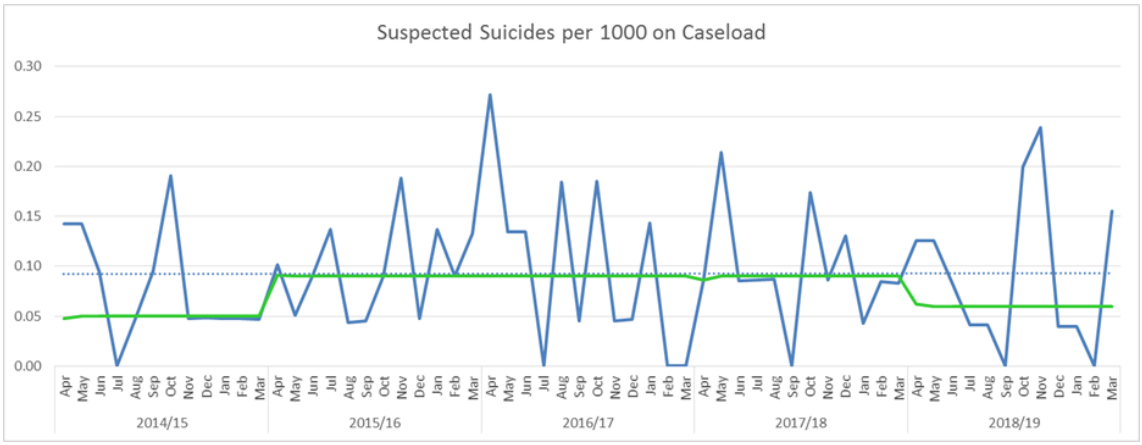


Figure 2

We will continue to work hard to identify and support those people experiencing suicidal ideation and aim to establish the interventions that will make the most impact for individuals. We launched the StayAlive App during 2017/18; this is a pocket suicide prevention resource for both people who are having thoughts of suicide and those who are concerned about someone else who may be considering suicide. This is available on AppStore and Google Play and may have had some role in reducing the suicide numbers seen this year.

In 2019/20 we are working with partners in our ICS and Public health to further improve suicide reduction approaches such as the “Zero Inpatient Suicide initiative”

We are currently meeting this target.

Target 3.2 Detained service users who are absent without leave (AWOL) will not come to serious harm or death.

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 Patient Safety and Quality Improvement Mental Health Collaborative. 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.

What we want to ensure is that no detained service users who are AWOL come to serious harm or death, so this year we are measuring the level of harm that people come to when absent.

In **2017/18** we reported **170** occurrences of AWOL (142 in Gloucestershire and 28 in Herefordshire detailed in the table below). There are a number of factors which influence this, including open wards, increased numbers of detained patients in our inpatient units, increased acuity, and on occasion, service users who leave the hospital without permission multiple times. **190** occurrences were reported during **2017/18.**

At the end of **2017/18** the following occurrences of AWOL were reported

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	72	59	11	**142**
Herefordshire	20	3	5	**28**
Total	**92**	**62**	**16**	**170**

None of these incidents led to serious harm or death.

At the end of **2018/19** the following occurrences of AWOL were reported.

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	62	66	16	**144**
Herefordshire	46	0	0	**46**
Total	**108**	**66**	**16**	**190**

None of these incidents led to serious harm or death.

At the ends of Quarter 1 2019/20 the following occurances were reported.

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	24	15	6	**45**
Herefordshire	14	0	1	**15**
Total	**38**	**15**	**7**	**60**

None of these incidents led to serious harm or death.

We are meeting this target

Target 3.3 To increase the use of supine restraint as an alternative to prone restraint (on all adult wards & PICU)

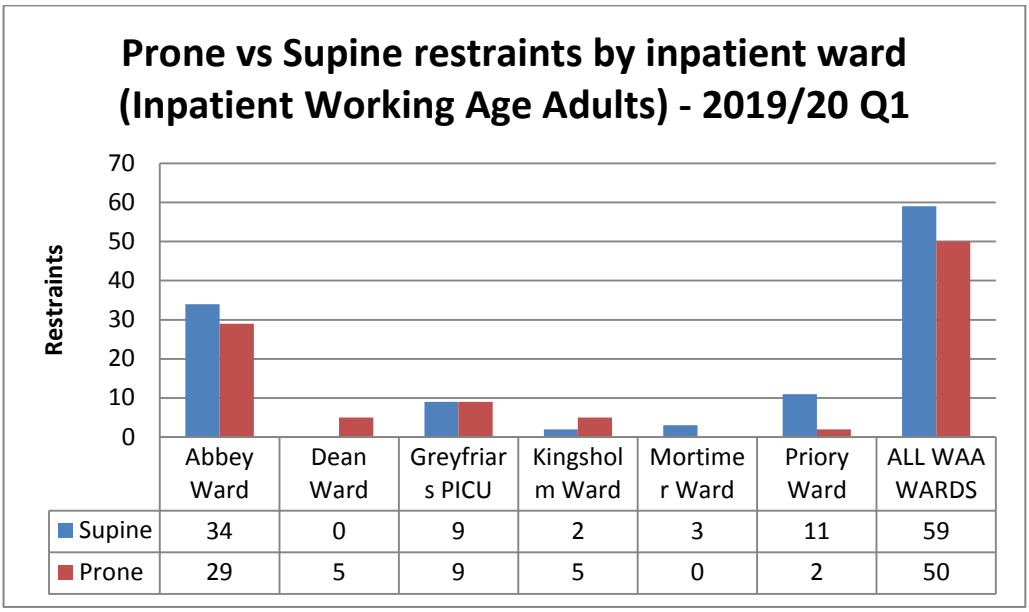
The use of prone restraint (face down) is sometimes necessary to manage and contain escalating violent behaviour, however it is also a response that has potential to cause harm to an individual. As a Trust we want to minimise the use of this wherever possible through therapeutic engagement and occupation in the inpatient environment; alongside effective de-escalation techniques and alternatives to prone restraint.

The Trust has a sub group focused on reducing physical restraint, in line with national guidance, reporting into our Trust Governance Committee. From reviewing our restraint data in detail over the past 3 years, we have seen a reduction in physical restraint and a positive increase in the use of supine restraint as an appropriate and safer alternative to prone restraint. This is due to active promotion of techniques used.

In 2018/19 our quality aim was to see a continued increase in the use of supine restraint as an alternative to prone restraint. During the year there were 124 prone restraints and 121 supine restraints, a difference of 3 more prone restraints. We, therefore, missed our 2018/19 quality improvement target for prone restraints to be lower than supine restraints, however, clinical staff

made good progress in this area and our analysis of the challenge has indicated where clinical exceptions have led to the use of prone restraint over supine.

In 2019/20 we will continue doing further work to address this including additional work on training staff in alternative injection sites, the development of new approaches to alternatives to prone restraint and, of course, on-going work to reduce all forms of restraint in inpatient services.



	Abbey Ward	Dean Ward	Greyfriars PICU	Kingsholm Ward	Mortimer Ward	Priory Ward	ALL WAA WARDS
Supine	34	0	9	2	3	11	59
Prone	29	5	9	5	0	2	50

Figure 3

Figure 3 above shows a ward by ward comparision of the use of these techniques during Quarter 1. The higher use of prone restraint on Abbey Ward is predominantly due to one patient who has specifically requested to be restrained (when such intervention is required) in the prone position.

Figure 4 below shows the spread of all physical inteventions used on our adult wards and the PICU and it is reassuring to note that, wherever possible, the least restrictive practices e.g seated or precautonary holds are used. Supine or prone restraint are only used when a person's safety becomes compromised.

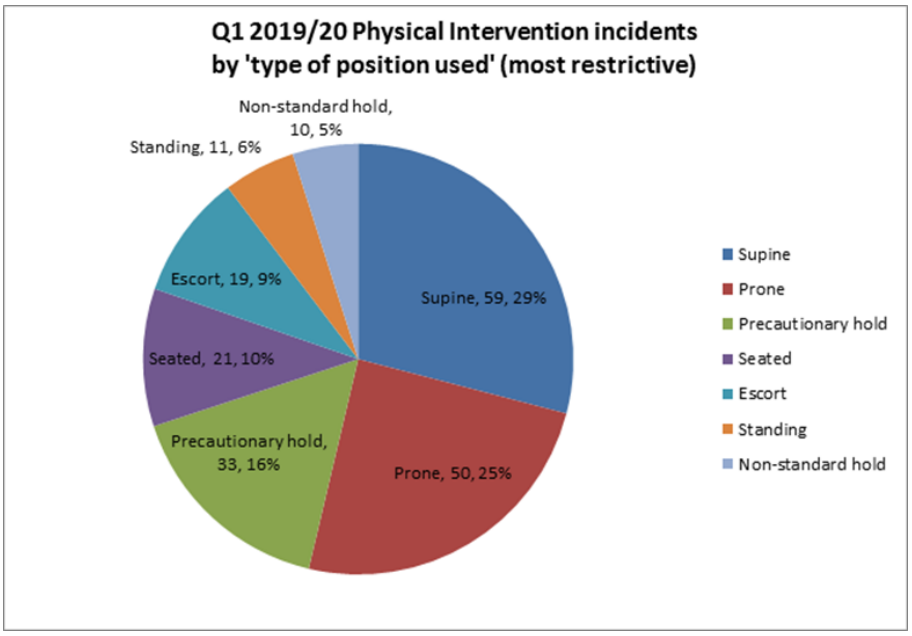


Figure 4

We are currently meeting this target.

Target 3.4 To ensure that 100% of service users within Berkeley House have a bespoke restrictive intervention care plan tailored to their individual need.

Berkeley House currently has 6 patients all of whom have specific care plans for Positive Behaviour Management (PBM) interventions; these care plans are on RiO and a copy of an accessible care plan is available for the patient.

They also have Positive Behavioural Support (PBS) plans which contain detailed information regarding primary, secondary and tertiary strategies for each person. Within these plans are functional assessments of behaviours that individuals may display. These include what a good day looks like and individualised strategies to manage behaviours when a patient begins to show signs of distress.

Primary prevention strategies aim to enhance the service users' quality of life and meet their unique needs thereby reducing the likelihood of behavioural disturbances.

Secondary prevention strategies focus on the recognition of early warning signs of impending behavioural disturbance and how to respond in order to encourage the patient to be calm.

Tertiary strategies guide the responses required to manage behavioural disturbance and acknowledge that the use of proportionate restrictive interventions may be required to minimise harm.

Alongside these strategies patients have activity care plans providing information on preferred activities, likes and dislikes and implementation of these activities for each individual. All patients also have a Health Action Plan and health and wellbeing care plan that gives information on health issues thus minimising possible influences pain may have an individual's behaviour.

All these plans are written following assessment and advice obtained from PBM trainers about any patient specific interventions (1 staff member at Berkeley House is also a PBM trainer). Also included in these plans are sensory interventions formulated by an occupational therapist which are implemented at associated primary and secondary phases appropriate for each individual.

All patients have a bespoke PBM assessment and care plan, this is written in conjunction with the Behaviour Support & Training Team, the PBM trainer we have within the staffing establishment at Berkeley House and the wider Multidisciplinary team. These plans include sensory interventions formulated by an occupational therapist. The PBM assessment (Individual Patient Physical Intervention Technique Checklist) clearly identifies techniques to be implemented for each individual as and when proportional to the risk to self and others.

Patients are physically monitored following all physical interventions to ensure that any concerns of physical harm or distress are acted upon within a timely manner. Where appropriate debriefs would be offered to patients post incident.

There are staff debriefs after any incidents of intervention, during which they are able to reassess and evaluate interactions and change care plans accordingly to better meet patient needs. Incidents are logged and discussed at MDT each week and interventions reviewed.

We are currently meeting this target.

Target 3.5 To further develop a quality improvement led approach to robustly embed lessons learned following serious incidents.

The Trust Serious Incident Review Process was reviewed during Quarter 4 2018/19 by Price Waterhouse Coopers (PWC) internal audit team. PWC assessed the effectiveness of the change in the Trust's Serious Incidents Requiring Investigation (reporting mechanisms, examined the processes in place for implementing relevant SIRI action plans and how lessons learned identified are shared across the Trust.

PWC Conclusion

Overall, the SIRI process has seen significant improvements in terms of timely submissions of SI reports, whilst also maintaining the quality. Investigations are undertaken by the central investigation team with the support of a relevant team manager, which has improved the quality, as the reports are now prepared by dedicated experts. There have been improvements in the process including overall turnaround time in producing reports, consistency in the quality of the reports, and the utilisation of a family liaison officer to support the families impacted, there is further scope to strengthen key areas that impact on the SIRI process and ensure the foundation and outcome of the investigations process is sustainable.

PWC raised 4 recommendations for Trust action

1. There is a robust and effective mechanism to share lessons learned across the Trust, however there is a scope to enhance the implementation in practice, embed the learning and the assurance mechanisms to determine effectiveness.

2. The incident policy document is not up to date and wholly reflective of the current process around engaging with local CCGs and related reporting mechanisms, elements were identified which would benefit from further clarity and detail matched to current activities and reporting mechanism.

3. The terms of reference for the SI action plan subcommittee has not been updated since April 2016 when the sub committee was formed there are opportunities to update the TOR and ensure it is reflective of current activities, roles and responsibilities.

4. Recommendations and actions arising from the serious incident reports should be measurable and realistic to ensure full implementation across the Trust a Sample tested found this not to be consistently the case

Action Taken to address

These recommendations have all been actioned and reported to the Trust audit committee. Work is on-going via the Quality Team regarding improving embedding lessons learned from serious incidents and this will be monitored and evaluated by the Quality Governance System within Gloucestershire Health & Care NHS Foundation when it becomes a legal entity from 1 October 2019.

We antipcate meeting this target by year end 2019/20.

Serious Incidents reported during 2018/19

By the end of Quarter 1 2019/20, **5** serious incidents were reported by the Trust; the types of these incidents reported are seen below. This is half the number we reported at the end of Quarter 1 last year.

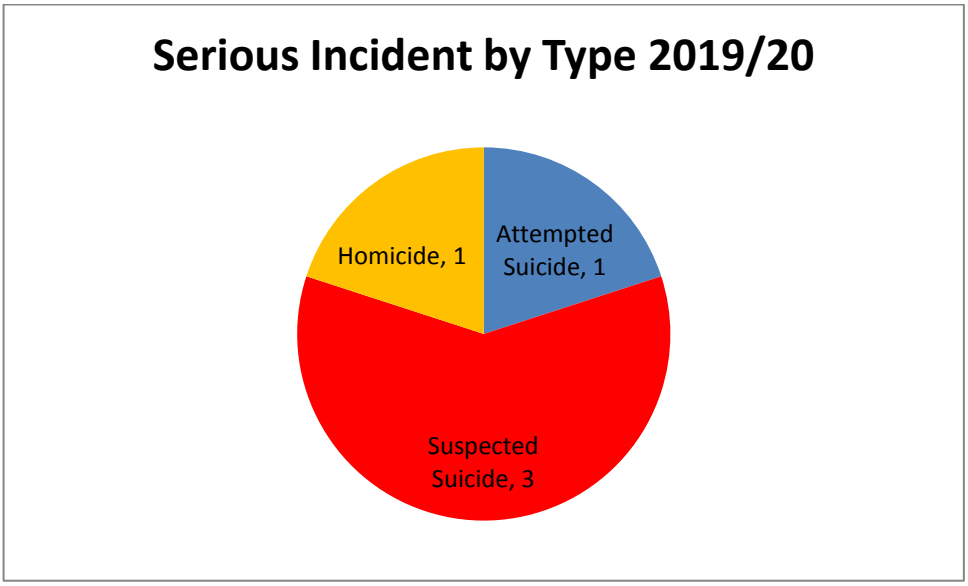


Figure 5

All serious incidents were investigated by a dedicated resource of clinicians, all of whom have been trained in root cause analysis techniques.

Wherever possible, we include service users and their families/carers to ensure that their views are central to the investigation, we then provide feedback to them on conclusion and copies of our investigation reports. During 2018/19 we continued to develop processes to provide improved support to people bereaved by suicide and in May 2018 18 staff were trained in Postvention techniques by the charity Suicide Bereavement UK. These trained staff now act voluntarily as Family Liaison Officers (FLOs) and are allocated to support families of service users on our caseload who have died by suspected suicide. We have plans for 2019/20 to train more staff in working positively with families.

The Trust also shares copies of our 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” reported within the Trust. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

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 historically 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 in 2015, they reviewed how the Duty of Candour was being implemented 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.

Freedom To Speak Up – Quality Account Statement

[2]gether NHS Foundation Trust have fully integrated the need for staff to speak up in line with the recommendations from the Robert Francis report following the Mid Staffordshire enquiry and also subsequent enquiries that have highlighted the need for staff to have various pathways through which to raise concerns. These have been integrated into the Trusts 'Speaking up at Work Policy' which describes the various routes that staff can employ in order to raise concerns. The following information outlines the current provision within the Trust in regard to how staff can raise concerns freely and without suffering detriment from doing so.

In October 2016 [2]gether NHS Foundation Trust appointed a Freedom to Speak up Guardian whose role is to help:

- protect patient safety and the quality of care
- improve the experience of workers
- promote learning and improvement

The Freedom to Speak up Guardian does this by ensuring that staff are supported in speaking up and that barriers to speaking up are addressed. They also help to ensure that a positive culture of speaking up is fostered and that any issues raised are used as opportunities for learning and improvement. To enhance the role, Freedom to Speak Up advocates have also been appointed who assist individuals to consider the available options to raise concerns and to identify appropriate routes to do so.

The Trusts 'Speaking up at Work Policy' clearly states that staff who genuinely raise a concern will not be at risk of losing their job or suffering any form of detriment or retribution as a result. Provided that they are acting in good faith, it does not matter if they are mistaken or if there is a genuine explanation for their concerns. It goes on to describe how, should any individual subject an employee to victimisation or harassment due to making a qualified disclosure, this would be seen and treated as a serious disciplinary offence.

Other options available to staff within the Trust include:

Dignity at Work Officers – A Dignity at Work officer is a member of staff who undertakes this role in addition to their day to day job. They have been identified as someone who has the skills, understanding and empathy that makes them approachable to other staff. They are volunteers. Their role is to provide support and guidance to anyone who feels that they are a victim of harassment or bullying in the workplace. They will provide unbiased and confidential independent advice as to the options available and try to help you gain an insight into what can be done about a situation. During 2018, we recruited and trained additional Dignity at Work Officers.

Speak in Confidence – Speak In Confidence is a web-based system enabling staff to have an anonymous and confidential dialogue about issues that you may be concerned about, with a manager of your choice (there is a list of managers to choose from on the system which also includes the Trusts Freedom to Speak up Guardian to enable anonymous reporting to occur) Speak In Confidence has been introduced primarily to support staff who are subjected to inappropriate behaviour but who do not feel able to raise the issue through existing channels. The need for an alternative method of reporting issues was highlighted by the 2014 Staff Survey.Additionally, the Trust is now working in partnership with Gloucestershire Care Service NHS Trust to train and support Freedom to Speak Up Advocates. These are staff members who are provided with training and a network to improve further how staff can access advice and be signposted appropriately.

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

[2]gether NHS Foundation Trust has continued to build on the work previously reported under the umbrella of "Sign up to Safety". Sign up to Safety has evolved since its launch in 2014 and over time has narrowed its mission to focus on safety culture. The Patient Safety and Quality improvement initiatives are ongoing and some embedded as part of the way we do things here, demonstrating how a safety culture is in development. Monitoring is ongoing but reported every 6 months via the Trust Governance Committee. An example of this is the Trust's ongoing commitment to the South of England Mental Health Collaborative and the work developing around sharing the learning from deaths in mental health where an expert by experience is working in partnership with clinicians to understand ligature risks and ultimately learn together to improve safety.

NHSI Indicators 2019/2020

The following table shows the NHSI mental health metrics that were monitored by the Trust during 2018/19.

		National Threshold	2017-2018 Actual	2018-2019 Actual	2019-2020 Actual
1	Early Intervention in psychosis EIP: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	50%	**70%**	**72%**	**72%**
2	Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered routinely in the following service areas: -inpatient wards -early intervention in psychosis services -community mental health services (people on CPA)		**95%** **92%** **90%**	90% 92% 78%	
3	Improving access to psychological therapies (IAPT): Proportion or people completing treatment who move to recovery (from IAPT database) Waiting time to begin treatment (from IAPT minimum dataset - treated within 6 weeks of referral - treated within 18 weeks of referral	50% 75% 95%	**50%** **67%** **85%**	**52%** **96%** **96%**	**49.9%** **99%** **99%**
4	Admissions to adult facilities of patients under 16 years old.		**1**	**0**	**0**
5	Inappropriate out-of area placements for adult mental health services		**24**	**52**	**6**

Community Survey 2018

To be completed when the national survey results are published.

Staff Survey 2018

To be completed when the national survey results are published.

PLACE Assessment 2018

To be completed when results are published.

Annex 1: Statements from our partners on the Quality Report

To be completed at year end.

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

To 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
NHSI	NHSI 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
MUST	The Malnutrition Universal Screening Tool is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.
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:

Paul Roberts
Chief Executive
2gether NHS Foundation Trust
Edward Jenner Court
Pioneer Avenue
Gloucester Business Park
Brockworth
Gloucester
GL3 4AW

Telephone: 0300 421 8100 Email: 2gnft.comms@nhs.net

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 0300 421 7146.

ITEM 17

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Delivery Committee

DATE OF COMMITTEE MEETING: 24 July 2019

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

FINANCE UPDATE

The HCA agency spend stood at £50k and this was an additional £27k on last year's performance. The Director of Quality was working to improve this position and discussions would take place at the temporary staffing group this afternoon.

The Capital Review Group would need to focus on figures net of asset sale as well as spend and spend would need to be reduced if major sales did not go ahead. The Committee was assured that this was being tracked by the Capital Review Group and detail would be included in the Finance Report to board.

There was to be additional investment in ADHD services and final figures were needed before recruitment could begin.

PERFORMANCE DASHBOARD

The Committee received the Performance Dashboard for the period to the end of June 2019. Of the 156 performance indicators, 98 were reportable in June with 83 being compliant and 15 non-compliant at the end of the reporting period. Where performance was not compliant, Service Directors were taking the lead to address issues and work was ongoing in accordance with agreed Service Delivery Improvement Plans to address the underlying issues affecting performance.

DEMAND MANAGEMENT REPORT

The Committee received an update on Demand and Capacity for CYPS/CAMHS. Work was being undertaken around the pathways and productivity, and also the recruitment and retention plan. Sarah said that she was building a report around the progress being made, and would bring the item back in the September Committee meeting; however, she added that she would attempt to distribute the report to the Committee as soon as it was ready to allow for feedback.

IAPT SERVICE IMPROVEMENT PLAN

The Delivery Committee received an overview of the key issues for June 2019 in the context of recent performance and the Trusts plan for 2019/20 for Gloucestershire. Jan Furniaux updated the Committee on all aspects of the IAPT recovery plans including the following issues:

- Access rates
- Waiting times update
- Recovery rates
- Referrals
- DNA rates
- Updates on key performance trajectories

The Committee noted the following key issues for June:

- In stage waiting list backlog clearance. The backlog waiting lists remained the most

significant concern and the Committee noted that teams in Gloucestershire were undertaking a range of actions and initiatives to address the backlog, and were developing a number of new approaches.

- Access rates for June 2019 were at 17.2% as part of a recovery plan to achieve a 17% Q1/Q2 target
- Recovery rates for June 2019 were above the national 50% target for Gloucestershire.
- Waiting time thresholds – Nationally, waiting time thresholds were reported against 2 measures – 6 and 18 week referral to treatment. The Committee noted that a change in methodology had meant that the Trust was regularly achieving the two front door markers.

ANALYSIS AND RISKS ARISING FROM RETROSPECTIVE ORDERS

The Committee received a report on purchase orders created after the date of receiving the invoice (retrospectively) for the period January to June 2019, excluding temporary agency staff.

The total value of retrospective orders for this period was £668,871.68 from 122 invoices; the ten highest invoices valued a total of £576,225.99 which represented 86% of the total value. These ten highest invoices were assessed against risk categories: there were no high or medium risks found.

It was noted that while the number of retrospective orders were decreasing the value had gone up. Procurement were beginning to run face-to-face training sessions with staff at 2gether and GHNHSFT, and these sessions would be used to raise awareness around proactively raising items before invoices came in.

UPDATE REPORTS ON OUT OF COUNTY

The Committee received an update on out of county placements. 4 out of county PICU placements; 2 female and 2 male were noted. One was specifically awaiting a London placement and was expected to be transferred in the following weeks, a second was awaiting a specific placement for PICU, and the final two were waiting for Gloucestershire beds; all four were with the Complex Care team who were actively managing their cases.

Marcia Gallagher queried the frequency that colleagues visited out of county placements; to not only review the patient but also the facility. Jan Furniaux advised Marcia that it would be with the Complex Care team to decide upon; however, she expected teams to be in touch with the placement on at least a weekly basis, and that the frequency would be highly dependent on the severity or complexity of the illness.

OTHER ITEMS

- The Committee received the Locality exception reports from the Herefordshire and CYPS / CAMHS Localities
- The Pre-Submission Report regarding National Reference Cost Collection was also received
- The Committee received the IT Delivery Plan 2016/17 – 2020/21 and the Trust Turnover report.

ACTIONS REQUIRED BY THE BOARD
The Board is asked to note the content of this report.

SUMMARY PREPARED BY: Maria Bond ROLE: Committee Chair

DATE: 16 September 2019

NHS
Gloucestershire
Care Services
NHS Trust

Trust Board

Date of Meeting: **26th September 2019**

Report Title: **Audit Committee Report**

Agenda reference Number:	18(1)
Accountable Executive Director: (AED)	Sandra Betney
Presenter: (if not AED)	Richard Cryer, Non-Executive Director
Author(s):	David Seabrooke, Interim Trust Secretary
Board action required:	To **Note** and **Receive**
Previously considered by:	-
Appendices:	

Executive Summary

This is the report of the final meeting of the CGS Audit Committee. The meeting was attended by the designate Chair of the GHC Audit Committee to assist with ensuring continuity with GCS matters in the merged Trust. We thanked both sets of auditors for their contribution.

Recommendations:

The Trust Board is asked to:

1. **Receive** the contents of the Audit Committee Report.

Related Trust Objectives:	1, 2, 3
Risk Implications:	Risk issues are clearly identifed within the report
Quality and Equality Impact Assessment: (QEIA)	Implications are clearly referenced in the report
Financial Implications:	No finance implications identified
Legal/Regulatory Implications:	Legal/Regulatory implications are clearly referenced in the report

Audit Committee Update

Committee members held their periodic private meeting with the auditors – there are no matters to report.

External Audit – our main topic with KPMG was a discussion of the requirement for part-year annual report and accounts 2019/20 for GCS, which will be the responsibility of the merged organisation. We asked KPMG to share their experiences of how this has been done elsewhere as not all the underpinning information will be available at this point in the year. There is a requirement for an AGM. A "year end" process has been commenced within GCS and a timetable for the audit of the accounts has been outlined.

Internal audit – there were no new audit review findings to report, and we discussed how the 2019/20 programme and resources would merge into the new organisation. We would encourage the GHC Audit Committee to pay close attention to the tracking arrangements for agreed audit recommendations.

We noted the Operational Resilience and Capacity Plan, the "winter" plan for 2019/20.

2gether NHS Foundation Trust

ITEM 18(2)

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Audit Committee

DATE OF COMMITTEE MEETING: 7 August 2019

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

INTERNAL AUDIT

Internal Audit Progress Report

The Committee received the Internal Audit progress report and noted that scoping was in progress regarding two audits due in phase 1 (before the merger). Fieldwork had begun on a further audit regarding corporate governance, and a scoping meeting was scheduled in respect of one other audit. The Committee was assured that no difficulties were envisaged regarding delivery of these audits to time.

The Committee noted that nine of the actions raised during 2018/19 were overdue, but were in progress. Given the good progress to date in ensuring timely completion of actions, and the fact that the Committee was not due to meet again until after the merger, the Committee asked the Deputy Director of Finance to chase up these outstanding actions. The Committee also requested that an interim assurance report regarding these outstanding actions be provided to the Committee Chair within one month.

EXTERNAL AUDIT REPORT

The Committee received the External Audit progress report and noted that audit submissions had been completed by the due date of 29 May. The Committee noted an offer from KPMG to attend a future Council of Governors meeting in order to inform Governors of the outcome of the annual audit of accounts, and agreed that this would be accepted if scheduling allows.

The Committee noted the technical updates provided by KPMG which included recent announcements from NHS Improvement, NHS England and the Department of Health, and asked the Deputy Director of Finance to ensure that relevant Executive Directors were aware of this information which covered e-rostering and CQUIN guidance for 2019/20.

COUNTER FRAUD PROGRESS REPORT AND ANNUAL REPORT

The Committee received the Counter Fraud progress report summarising the key counter fraud activity undertaken since the last report, including:

- a fraud awareness presentation
- 9 corporate induction sessions,
- Issue of a Counter Fraud newsletter to staff
- Proactive work to assess the management of counter fraud, bribery and corruption risks in both 2gether and Gloucestershire Care Services NHS Trust
- Data matching exercises for the National Fraud Initiative
- Development of an e-learning package

The Committee also received and noted the Counter Fraud annual report which summarized the activity undertaken in 2018/19. The Committee noted a fall in the number of referrals to Counter Fraud compared to previous years, and was assured that this was a national trend which was likely to be ascribed the amount of preventative work being undertaken. The

Committee heard that working while on sick leave was the biggest single issue for 2gether. While this was also the case nationally, the Committee nevertheless asked that consideration be given to development of a communications package for staff, and appropriate policies, to minimize the chance of employees undertaking fraudulent secondary employment.

The Committee noted some outstanding actions in connection with a proactive exercise concerning the security of prescription forms. The Committee asked for future reports to show progress regarding any such actions, and asked that an assurance report on these outstanding actions be provided to the Committee Chair before the next meeting of the Audit Committee.

LOSSES AND SPECIAL PAYMENTS

The Committee reviewed Losses and Special Payments Report and was disappointed to note a number of losses due to bad debts, where credit notes had not been reimbursed. The Committee asked whether in such circumstances the Trust should request a cheque from the debtor after a reasonable period of time. The Committee asked the Deputy Director of Finance to determine what the current process is, and consider whether an amendment to that process would be appropriate.

RISK REGISTER AND BOARD ASSURANCE MAP REVIEW

The Committee reviewed the corporate risk register and noted current high scoring risks. The Committee noted a risk around consultant psychiatrist capacity at Wotton Lawn, and asked that the Governance Committee look at this in further detail. The Committee also queried the increase in score regarding agency staffing, and noted that this was due to a rise in costs in respect of Health Care Assistants following some staff leaving the Trust, combined with more stringent agency framework controls. The Committee received assurance that the increase in score related to the need for tighter application of controls, and was assured that work was underway to achieve this.

The Committee also received and noted the Board Assurance Map, and received assurance that when the merger takes effect, there will be a process in place to report on the highest scoring risks. The Committee requested that such reporting clearly identifies the category of risk, for example financial, quality, patient safety, etc.

AUDIT COMMITTEE ANNUAL REPORT

The Committee received and approved its annual report to the Board, which sets out the Committee's performance against its terms of reference for the 2018/19 year. The annual report is appended to this summary report for the Board to note.

EXTERNAL AUDITOR EVALUATION REPORT

The Committee received the outcome of an evaluation of the External Auditor's performance, in order to consider an extension to KPMG's contract with the Trust, which expires in March 2020, but has the option of two 12 month extensions. The Committee noted that the responses received from Committee members and the Governor observer of the Committee were overwhelmingly positive in terms of KPMG's performance. Accordingly the Committee agreed that KPMG's contract should be extended for a further 12 months from 1 April 2020. While the appointment of the auditor is a matter for the Council of Governors, the decision on whether to extend an existing contract within the terms agreed is a matter for the Audit Committee. A report will therefore go to the next meeting of the Council of Governors to notify them of the Committee's decision.

OTHER ITEMS

The Audit Committee also:

- noted the minutes of the previous meeting which included an action to raise at the Shadow Board whether the indicators required in the External Audit Quality Report and Quality Governance Statement could be combined. The Committee Chair agreed to raise this issue at a future Shadow Board meeting.
- noted that this was the final meeting of the 2gether Audit Committee before the merger. The Committee Chair thanked all involved for their support. The Committee was assured that all actions and matters arising at this meeting would be rolled forward for the Gloucestershire Health & Care Audit Committee to consider.

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Marcia Gallagher ROLE: Committee Chair

DATE: 7 August 2019

Agenda item 18(3)

Report to: Trust Board – 26th September 2019
Author: John McIlveen, Trust Secretary
Presented by: David Seabrooke, Interim Trust Secretary

SUBJECT: AUDIT COMMITTEE ANNUAL REPORT 2018/19

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 Audit Committee is asked to note the Committee's Annual Report 2018/19 and endorse it for presentation to the Trust Board.

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:		
Marcia Gallagher	Date	July 2019

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
Audit Committee Chair Director of Finance		

Explanation of acronyms used:	

2gether NHS Foundation Trust

Audit Committee Annual Report 2018/19

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. This membership enables the Committee to triangulate information and assurance received at other Board's Committees, each of which is chaired by a member of the Audit Committee.

1.3 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.

1.4 The Committee met 5 times during the period 1 April 2018 to 31 March 2019, 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. The November 2018 meeting was attended by Richard Cryer, Chair of the Gloucestershire Care Services NHS Trust's Audit Committee, as part of the due diligence preparations for the merger with Gloucestershire Care Services.

1.5 Attendance by members at the Committee during the period was as follows:

	04/04/2018	25/05/2018	01/08/2018	07/11/2018	13/02/2019
Marcia Gallagher (Chair)	✓	✓	✓	✓	✓
Jonathan Vickers				✓	✓
Nikki Richardson	✓		✓		✓
Duncan Sutherland				✓	✓
Sumita Hutchison[1]					
Dominique Thompson			✓	✓	
Maria Bond	✓	✓	✓	✓	✓

1.6 The following were in attendance at the Committee during the period:

	04/04/2018	25/05/2018	01/08/2018	07/11/2018	13/02/2019
Andrew Lee, Director of Finance & Commerce	✓	✓	✓	✓	✓
Stephen Andrews, Deputy Director of Finance	✓	✓	✓		✓
Lee Sheridan, Head of Counter Fraud					

[1] Sumita Hutchison joined the Trust on 14 January 2019

Lisa Evans, Board Committee Secretary			✓	✓	✓
Marie Crofts, Director of Quality[2]			✓		
John McIlveen, Trust Secretary		✓	✓	✓	
Rayna Kibble, Local Counter Fraud Specialist	✓				
Paul Kerrod, Counter Fraud Service			✓	✓	
John Micklewright, Interim Head of Counter Fraud					✓
Jon Brown, KPMG	✓	✓		✓	✓
Duncan Laird, KPMG		✓	✓	✓	✓
Dominique Lord, PWC		✓	✓		
Philip Baillie, Integration Programme Director					✓
Sandra Betney, GCS Director of Finance					✓
Gordon Benson, Asst Director of Governance		✓			
Paul Roberts, Chief Executive		✓			
Ingrid Barker, Joint Trust Chair		✓			
Tanya Hartley, Asst Director of Finance		✓			
Anna Hilditch, Asst Trust Secretary	✓	✓			
Lynn Pamment, PWC					✓
John Sawyer, PWC	✓				
Kate Nelmes, Head of Communications		✓			
Dominique Lord, PWC	✓		✓	✓	
Ian Leese, Local Security Management Specialist			✓	✓	
Nadine Wachuku-King, PWC			✓		
Neil Savage, Director of Organisational Development		✓			
Richard Cryer, Chair of GCS Audit Committee				✓	

[2] Marie Crofts left the Trust on 27 September 2018

Jane Melton, Director of Engagement & Integration	✓			✓	
Mike Scott, Governor Observer		✓	✓	✓	
Ann Elias, Governor Observer			✓		

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, and also had regard to the Assurance Map (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 reviewed the Corporate Risk Register and the Assurance Map at regular intervals in order to provide challenge and receive assurance that strategic and corporate risks are being adequately monitored.

2.6 The Committee reviewed and approved a revised policy for the management of conflicts of interest which introduced more robust controls as recommended by NHS England.

2.7 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 2018/19 Annual Report.

2.8 The Committee reviewed the Register of Directors' Interests, and the Register of Gifts and Hospitality.

2.9 The Chairs of all Gloucestershire Trusts' Audit Committees met during the year to discuss governance issues around Integrated Care Systems and Sustainability and Transformation Plans for the County.

2.10 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. This will be particularly important as preparations for the merger with Gloucestershire Care Services proceed, with the attendant risk that management focus on the merger process coupled with finite executive capacity might impact on the maintenance of 'business as usual'.

2.11 Assurance work connected with the merger has been an important part of the Committee's work during the year. As part of that assurance work, the Committee received a report setting out the due diligence requirements contained in NHS Improvement's Transaction manual guidance. Due diligence reports covered the following areas:

- Clinical Governance
- Medical Directorate
- Engagement & Integration
- HR/workforce
- Finance
- Facilities
- Estates
- IT
- Performance and clinical/information systems

2.12 The due diligence work was subsequently audited by the Internal Auditor to provide further assurance that all necessary areas of work identified in the NHS I guidance had been covered effectively. That report confirmed that a reasonable approach had been taken. The Committee also received a report which provided assurance that the due diligence on which the Committee had been briefed had been appropriately reflected in transition planning.

2.13 The NHS I guidance also required the appointment of a reporting accountant to provide external validation in a number of areas including quality governance, financial reporting, and the post transaction implementation plan. The Chair of the 2gether Audit Committee and the Chair of the GCS Audit Committee, together with their respective Directors of Finance, comprised the appointment panel for the reporting accountant, with Grant Thornton being appointed to the role.

2.14 Internal Audit

2.15 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 2018/19
- Considered the findings of internal audit in relation to work on the following issues

  - Communications
  - Corporate Governance – Capital Review Group
  - HR – Objectives and Appraisals
  - Financial Budgeting and Monitoring
  - Learning from Service Experience
  - Information Security – Mass Phishing Simulation
  - Performance Management
  - Information Governance – General Data Protection Regulation
  - Clinical Governance – Violence and Aggression
  - Business Continuity – Transaction Governance
  - Ligatures
  - Due Diligence
  - Consultant Underpayments
  - Compliance with Clinical Standards – Serious Incidents

2.16 The Consultant Underpayments report had been included in the audit programme at management's request. This review was rated as a High Risk, and the Committee sought and received assurance that measures had been put in place to ensure that robust processes for consultants' pay progression had been put in place to minimise the risk of future underpayments. All other audit reports were classified as either Medium or Low risk. The audits produced a total of 42 findings, a reduction of one compared to the previous year. There were 22 Low, 14 medium and 2 high risk-rated findings, and a further 4 advisory findings were reported. In respect of each of these findings 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.

2.17 The Committee has been pleased to note during the year continued good performance in terms of the timely completion of management actions arising from Internal Audit Reviews, as evidenced by the IA recommendations tracker which the Committee receives and reviews at each meeting.

2.18 **External Audit**

- The Committee received and noted the final audit in respect of the 2017/18 Financial Accounts and the 2017/18 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 2018/19.
- 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.

2.19 **Private Meeting with the Auditors**

2.20 The Committee Chair met privately with internal and external auditors during the year. 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.

2.21 Other Assurance Functions

2.22 The Committee has reviewed the findings of other significant assurance functions where appropriate, and has considered any governance implications for the Trust.

2.23 The Committee received regular Counter Fraud updates, and received the Counter Fraud Annual Report for 2017/18 and the Counter Fraud work plans for 2018/19 and for 2019/20. The planned total of 145 days of counter fraud activity was delivered during 2017/18 across the 4 generic areas of Counter Fraud activity as defined by the NHS Counter Fraud Authority. The areas of activity for 2017/18 were apportioned thus: 15 to 'Strategic Governance' 25 to 'Inform and Involve', 45 to 'Prevent and Deter' and 60 to 'Hold to Account'. The total cost of the Counter Fraud service during 2017/18 was £56.8k.

2.24 The NHS CFA self-review tool provided assurance that the Trust was compliant with the NHS CFA's Standards for Providers, with the overall level of risk being rated as 'Green', the same rating as for the previous year.

2.25 Management

2.26 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

- An internal audit report on phishing ;
- A follow-up internal audit report on Procurement Shared Services;
- updates and assurance on implementation of actions within the Ligatures review

2.27 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.

2.28 Financial Reporting

2.29 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.

2.30 The Committee has visibility at each meeting (with the exception of the final accounts meeting) on waivers over £25k applied in the preceding period. This reporting includes nil returns.

2.31 The Committee reviewed the 2017/18 financial statements and annual report at the May 2018 meeting prior to recommending the final accounts for Accounting Officer signature, in line with authority delegated by the Board.

2.32 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 September 2018 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. The work of the Committee in the last financial year, and the triangulation of information and assurance received both at the Audit Committee and at other Committees chaired by members of the Audit Committee, has enabled the Audit Committee to conclude that the Trust's systems are in the main sound, reliable and robust.

Marcia Gallagher
Chair, Audit Committee
July 2019

Agenda item 19(1)

Report to: Trust Board, 26th September 2019
Author: Stephen Andrews, Deputy Director of Finance
Presented by: Sandra Betney, Director of Finance & Commerce

SUBJECT: **Finance report for period ending 31st August 2019**

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

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

EXECUTIVE SUMMARY

- The month 5 position is a surplus of £539k which is in line with the planned surplus.
- The month 5 forecast outturn is an £803k surplus in line with the Trust's control total. PSF accounts for £985k of this.
- The Trust has an Oversight Framework segment of 1 as at September 2019.
- The agency cost forecast is £4.669m which would be £183k above last year's expenditure total and £1.533m above the agency ceiling. A number of actions are being put in place and are beginning to bring this forecast down.
- The cash balance at month 5 is £21.0m which is £5.3m above the plan.
- Capital expenditure is £1.276m at month 5.
- The Trust has identified £585k of recurring savings up to August 2019 which is £150k behind the plan.

RECOMMENDATIONS

It is recommended that the Board:

- note the month 5 position

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: Sandra Betney, Director of Finance & Commerce		
	Date	19th September 2019

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
	Date	

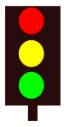
Explanation of acronyms used:	CDEL – Capital Delegated Expenditure Limit CCG – Clinical Commissioning Group PSPP – Public Sector Payment Policy FOT – Forecast Outturn PSF – Provider Sustainability Funds STF - Sustainability and Transformation Funds IAPT – Improving Access to Psychological Therapies

1. CONTEXT

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

2. EXECUTIVE SUMMARY

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

Indicator	**Measure**		
Year End I&E			
	Single Oversight Framework Segment	1.00	as at Sept 2019
Income	FOT vs FT Plan	101.8%	
Operating Expenditure	FOT vs FT Plan	101.9%	
Year end Cash position	£m	14.6	
PSPP	%age of invoices paid within 30 days	95.0%	88% paid in 10 days
Capital Income	Monthly vs FT Plan	110.6%	
Capital Expenditure	Monthly vs FT Plan	85.2%	£1,276k expenditure.

The parameters for the traffic light dashboard are as follows;

Indicator	RED 	AMBER 	GREEN 
NHS I FOT segment score	>3	2.5 - 3	<2.5
Use of Resources Score	>3	2.5 - 3	<2.5
INCOME FOT vs FT Plan	<99%	99% - <100%	=>100%
Expenditure FOT vs FT Plan	>101%	>100% - 101%	=<100%
CASH	<£8m	£8-£10m	>£10m
Public Sector Payment Policy - YTD	<=80%	>80% - <95%	>=95%
Capital Income - Monthly vs FT Plan	<90%	90% - 100%	>100%
Capital Spend - Monthly vs FT Plan	>115% or <85%	110% - 115% or 85% to 90%	>90% to <110%

3. DISCUSSION

INCOME POSITION

3.1 Contract negotiations have concluded with our key commissioners for the 2019/20 contracting round. A table of all our key contracts with commissioners for 2019/20 is shown below.

Table: Contract by commissioner

Commissioner	Value 2018/19 £000's	Value 2019/20 £000's	Contract Signed
Gloucestershire CCG	84,182	88,676	Yes
Herefordshire CCG	20,994	23,020	Yes
South Specialist Commissioning Group (NHS England)	1,837	1,939	Yes
Worcestershire CCGs	89	120	Yes
Aneurin Bevan Health Board	375	365	Yes
Total	107,477	114,120	

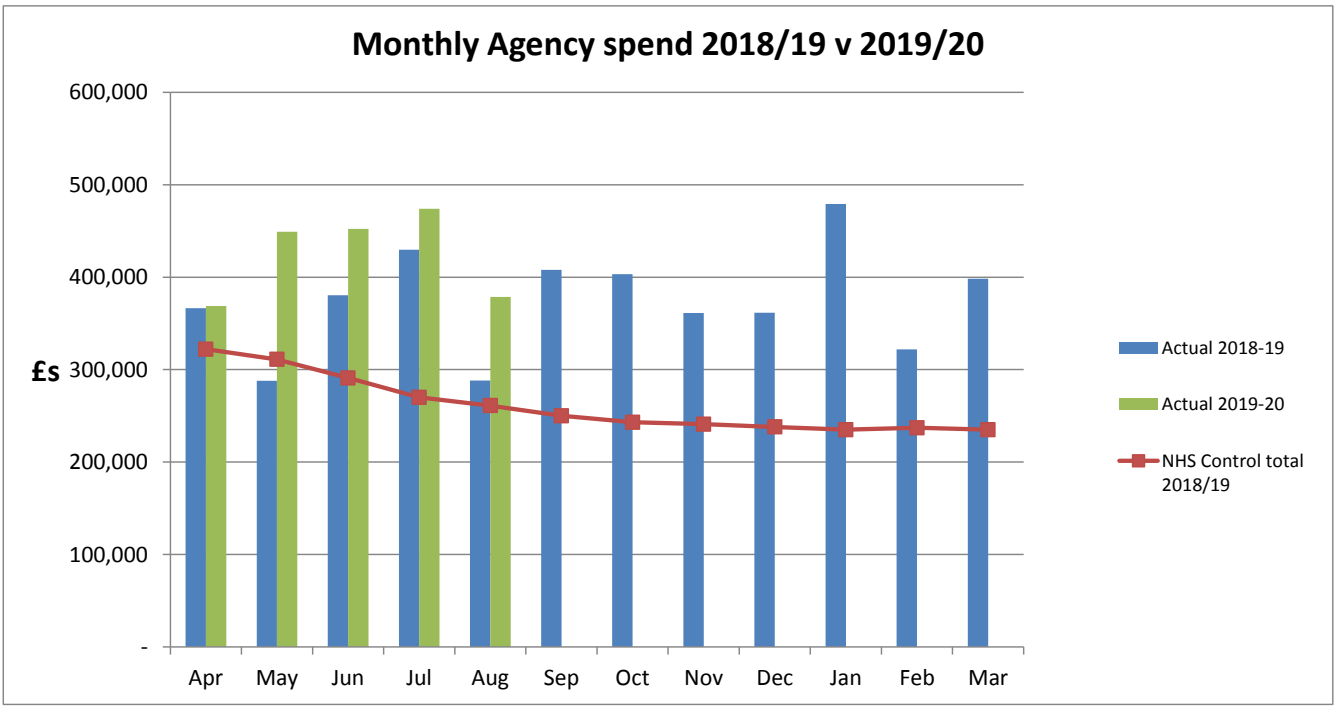
EXPENDITURE

3.2 Expenditure budgets have been broadly in line with expectations to date. Cost overspends in the Community Care budget are continuing in-line with last year's expenditure and this over performance is invoiced to the CCG in accordance with the terms of the contract.

Summary	Budgeted	Contracted	Vacancies	Vacancy %
WTEs in Month 5	2,128	1,933	195	9.2%

AGENCY

3.3 Agency spend in month 5 was lower than the trajectory of the previous months. The Trust continued to see high levels of HCA agency costs due to a combination of vacancies, staff turnover and acuity. The forecast of agency spend after the projected impact of the actions listed above shows a revised projection of £4.669m for 2019/20 a reduction of £28k in the forecast from last month. August is traditionally a lower spend month for agency spend so it is too early to say whether the measures the Trust is taking will lead to a significant reduction in the forecast. The Trust has instigated an action plan to focus on reducing the recent reliance on HCA agency staff by embarking on a focussed recruitment drive, strengthening the peripatetic teams and reviewing the use of Thornbury HCA agency. The Trust will need to eliminate all HCA Thornbury usage by the 16th September following changes to the national agency rules. As a result of these rule changes the Trust is also looking to ensure it will not use admin agency from 16th September either.



BALANCE SHEET

3.4 A summary balance sheet is provided at Appendix 2 and a cash flow summary is shown below ;

Statement of Cash Flow £000	Actual YTD 19/20		Forecast 19/20	
Cash and cash equivalents at start of period		14,637		14,637
Cash flows from operating activities				
Operating surplus/(deficit)	1,322		2,684	
Add back: Depreciation on donated assets	14		34	
Adjusted Operating surplus/(deficit) per I&E	**1,336**		**2,718**	
Add back: Depreciation on owned assets	1,126		2,361	
(Increase)/Decrease in trade & other receivables	2,452		2,201	
(Increase)/Decrease in trade & other payables	2,536		(1,201)	
(Increase)/Decrease in trade & other liabilities	5		(173)	
Net cash generated from / (used in) operations		**7,455**		**5,906**
Cash flows from operating activities				
Interest received	57		120	
Purchase of property, plant and equipment	(1,163)		(4,526)	
Sale of property, plant and equipment	0		529	
Net cash generated used in investing activities		**(1,106)**		**(3,877)**
Cash flows from financing activities				
PDC Dividend (Paid)	0		(2,000)	
Finance Lease Rental Payments	(20)		(46)	
Net cash generated used in financing activities		**(20)**		**(2,046)**
Cash and cash equivalents at end of period		**20,966**		**14,620**

RISKS and OPPORTUNITIES

3.5 The table below outlines the key risks and opportunities being managed by the Trust in 2019/20.

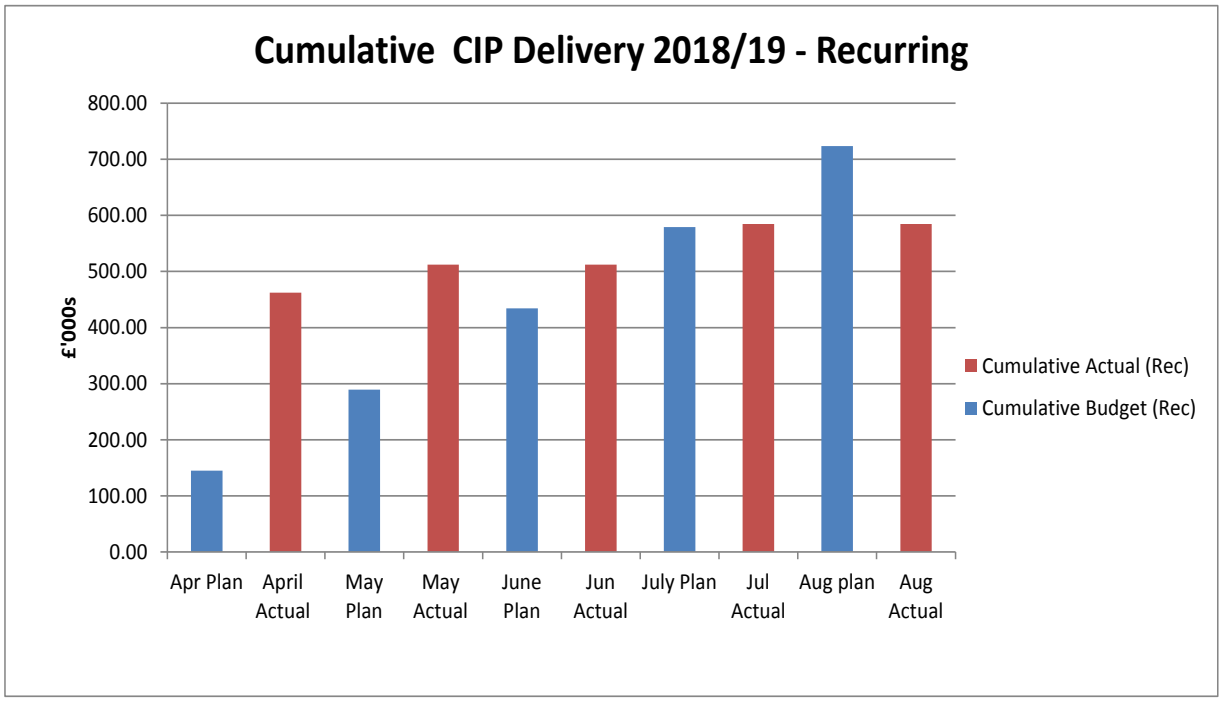
2gether Risks	Probability	(Risk) - 19/20 £000s	Recurring Risk 20/21 £000s	Opportunity £000s
Medical Agency. Additional vacancies could lead to increased expenditure above the forecast	Possible	(150)		
Delivery of Cost Improvement Plans does not fully deliver	Likely	(850)	(850)	
Cost of Depreciation is higher due to change in asset lives following national guidance	Possible	(450)	(450)	
Failure to meet the CQUIN targets leads to reduced income levels	Possible	(100)		
Out of County bed costs are greater than the forecast	Possible	(150)		
A failure to control costs due to some risks materialising leads the Trust to miss its Financial Control Total and lose Provider Sustainability Funding (PSF)	Unlikely	(246)		
TOTAL		(1,946)	(1,300)	-
Health Economy Risks	Probability	(Risk) - Recurring £000s	(Risk-Non recurring) £000s	Opportunity £000s
Delivery of GHT control total	Likely	(10,196)		
Delivery of CCG control total	Likely	(7,500)		
System Control total PSF risk (20%)	Unlikely		(99)	
TOTAL	-	(17,696)		-

SAVINGS

3.6 The Trust has a 2019/20 savings target of £2.387m made up of recurring savings of

1.737m and non-recurring savings of £0.650m.

3.7 In 2019/20 budgets are removed once the savings have been identified. £462k of recurring savings were identified through the budget setting process and reflected in the budgetary position. £585k of recurring savings have been identified to date. Appendix 9 shows the savings delivered to date.



CAPITAL

3.8 The Trust was set a Capital Departmental Expenditure Limit (CDEL) by NHS Improvement for 2019/20 of £4.610m which it cannot exceed. Due to the very limited availability nationally of capital funding the Trust has had to accommodate any slippage in spend from 2018/19 within its 2019/20 capital plan. A review of the programme has already identified that this slippage of c£400k can be accommodated within the capital limit (CDEL).

3.9 The CDEL for an organisation is measured as the net of capital expenditure less capital sales. Performance against the Trust's CDEL for 2019/20 is shown in the table below;

	CDEL Plan to date £000's	CDEL actual to date £000's	19/20 CDEL Plan £000's	19/20 CDEL Forecast 000's
Capital Expenditure	1,207	1,276	4,549	4,549
Capital Income	0	0	(529)	(529)
CDEL	1,207	1,276	4,020	4,020

Statement of Comprehensive Income
as at 31st August 2019

	ORIGINAL PLAN £000	REVISED BUDGET £000	BUDGET TO DATE £000	ACTUALS TO DATE £000	VARIANCE TO DATE £000	FORECAST 19/20	FORECAST 20/21	FORECAST 21/22	FORECAST 22/23	FORECAST 23/24	FORECAST 24/25
INCOME											
Cheltenham & N Cots Locality	6,009	5,906	2,569	2,552	(18)	6,213	5,908	5,926	5,962	5,998	6,034
Stroud & S Cots Locality	7,964	7,664	3,369	3,355	(14)	8,118	5,876	5,894	5,930	5,966	6,002
Gloucester & Forest Locality	4,907	4,733	2,100	2,119	19	5,129	4,918	4,934	4,964	4,994	5,024
Social Care Management	4,023	6,406	2,810	3,528	718	8,501	5,763	5,781	5,816	5,852	5,887
Entry Level	7,337	7,264	2,649	2,629	(20)	6,392	7,416	7,439	7,485	7,530	7,575
Countywide	40,143	38,169	15,802	15,780	(22)	38,248	40,788	40,914	41,164	41,414	41,663
Children & Young People's Service	9,747	12,226	4,467	4,030	(437)	10,316	8,011	8,036	8,085	8,134	8,183
Herefordshire	23,283	23,436	9,735	9,723	(12)	23,406	22,383	22,452	22,589	22,727	22,863
	0	0	0	0	0	0	0	0	0	0	0
Medical	19,000	17,893	7,890	7,917	27	19,090	19,057	19,116	19,233	19,349	19,466
Trustwide	2,444	2,561	1,064	1,558	494	3,096	3,178	3,188	3,208	3,227	3,246
Total Operational Income	**124,857**	**126,258**	**52,456**	**53,190**	**734**	**128,510**	**123,301**	**123,680**	**124,435**	**125,191**	**125,944**
OPERATIONAL EXPENDITURE											
Cheltenham & N Cots Locality	(5,419)	(5,688)	(2,293)	(2,296)	(3)	(5,678)	(5,500)	(5,562)	(5,625)	(5,687)	(5,751)
Stroud & S Cots Locality	(6,367)	(6,477)	(2,689)	(2,599)	90	(6,339)	(6,480)	(6,539)	(6,598)	(6,657)	(6,717)
Gloucester & Forest Locality	(4,643)	(4,786)	(1,998)	(2,072)	(74)	(4,943)	(4,709)	(4,778)	(4,841)	(4,905)	(4,969)
Social Care Management	(3,799)	(5,268)	(2,195)	(2,858)	(663)	(6,955)	(3,803)	(3,795)	(3,788)	(3,781)	(3,775)
Entry Level	(5,692)	(6,033)	(2,467)	(2,800)	(334)	(6,050)	(5,804)	(5,861)	(5,919)	(5,977)	(6,036)
Countywide	(32,990)	(33,300)	(13,907)	(13,791)	116	(33,760)	(33,204)	(33,542)	(33,863)	(34,187)	(34,514)
Children & Young People's Service	(7,019)	(8,529)	(3,516)	(2,712)	804	(7,470)	(7,216)	(7,288)	(7,359)	(7,430)	(7,503)
Herefordshire Services	(14,441)	(14,751)	(6,123)	(5,995)	127	(14,805)	(14,102)	(14,248)	(14,388)	(14,530)	(14,673)
Medical	(16,315)	(16,315)	(6,817)	(7,015)	(199)	(16,612)	(16,195)	(16,345)	(16,497)	(16,650)	(16,806)
Board	(1,640)	(1,640)	(683)	(1,087)	(404)	(1,896)	(1,500)	(1,515)	(1,530)	(1,545)	(1,561)
Internal Customer Services	(1,909)	(1,959)	(817)	(753)	64	(1,950)	(1,946)	(1,962)	(1,978)	(1,994)	(2,011)
Finance & Commerce	(6,479)	(6,479)	(2,751)	(2,724)	26	(6,692)	(6,539)	(6,543)	(6,548)	(6,552)	(6,557)
HR & Organisational Development	(3,776)	(3,784)	(1,556)	(1,485)	72	(3,955)	(3,672)	(3,705)	(3,738)	(3,771)	(3,805)
Quality & Performance	(3,349)	(3,411)	(1,421)	(1,440)	(18)	(3,457)	(3,329)	(3,341)	(3,354)	(3,367)	(3,380)
Engagement & Integration	(1,541)	(1,573)	(652)	(662)	(10)	(1,647)	(1,568)	(1,583)	(1,598)	(1,614)	(1,629)
Operations Directorate	(1,090)	(1,088)	(453)	(472)	(19)	(1,148)	(1,116)	(1,126)	(1,137)	(1,148)	(1,159)
Provisional Budgets	(4,888)	(1,576)	(414)	27	441	(1,576)	(4,603)	(5,014)	(5,525)	(6,025)	(6,536)
Savings	1,625	1,525	635	6	(630)	1,504	3,277	4,559	5,841	7,123	8,405
				0		0	11	8	5	3	4
Total Operational Expenditure	**(119,731)**	**(121,132)**	**(50,116)**	**(50,728)**	**(612)**	**(123,431)**	**(117,999)**	**(118,182)**	**(118,441)**	**(118,698)**	**(118,975)**
EBITDA Surplus/(Deficit)	***5,126***	***5,126***	***2,340***	***2,462***	***121***	***5,078***	***5,302***	***5,497***	***5,994***	***6,493***	***6,970***
Depreciation	(2,355)	(2,355)	(981)	(1,140)	(159)	(2,395)	(2,712)	(2,943)	(3,200)	(3,450)	(3,707)
Operating Expenses of Continuing Operations	**(122,086)**	**(123,487)**	**(51,097)**	**(51,868)**	**(771)**	**(125,826)**	**(120,711)**	**(121,125)**	**(121,641)**	**(122,148)**	**(122,682)**
Operating Surplus/(Deficit)	**2,771**	**2,771**	**1,359**	**1,322**	(37)	**2,683**	**2,590**	**2,554**	**2,794**	**3,043**	**3,263**
P & L Assets	0	0	0	0	0	**0**	0	0	0	0	0
Surplus/(Deficit) before Interest	**2,771**	**2,771**	**1,359**	**1,322**	(37)	**2,683**	**2,590**	**2,554**	**2,794**	**3,043**	**3,263**
Finance Costs											
Finance Income	32	32	13	56	43	120	32	32	32	32	35
Finance Expense - Financial Liabilities	0	0	0	0	0	0	(11)	(8)	(5)	(3)	(4)
PDC Dividends Payable	(2,000)	(2,000)	(833)	(840)	(7)	(2,000)	(2,300)	(2,540)	(2,790)	(3,040)	(3,240)
Fixed Asset Impairment	0	0	0	0	0	0	0	0	0	0	0
Total Comprehensive Income / (Expense) incl. impairments	**803**	**803**	**539**	**538**	**(1)**	**803**	**311**	**38**	**31**	**32**	**54**
Surplus / (Deficit) pre Impairments and Transfers	**803**	**803**	**539**	**538**	**(1)**	**803**					

Statement of Financial Position

as at 31st August 2019

	31st March 2019 £000	31st July 2018 £000	31st Aug 2019 £000	Movement £000	Forecast 31st March 2020 £000	Forecast 31st March 2021 £000	Forecast 31st March 2022 £000	Forecast 31st March 2023 £000	Forecast 31st March 2024 £000	Forecast 31st March 2025 £000	Forecast 31st March 2026 £000
Intangible Assets - net	1,990	1,864	2,039	175	1,810	1,810	1,810	1,810	1,810	1,810	1,810
Property,Plant & Equip	51,275	51,402	51,388	(14)	52,838	52,281	53,438	53,368	53,048	52,471	51,894
Trade & Other Receivables	303	295	294	(1)	282	263	244	225	206	187	168
Fixed Assets	**53,568**	**53,561**	**53,721**	**160**	**54,930**	**54,354**	**55,492**	**55,403**	**55,064**	**54,468**	**53,872**
Inventories	0	0	0	0	0	0	0	0	0	0	0
NHS Trade receivables	3,251	2,377	2,477	100	2,913	2,948	2,958	3,008	3,058	3,108	3,158
Non NHS Trade Receivables	438	295	304	9	539	552	572	602	632	662	692
Other receivables, Current	4,386	2,115	2,323	208	2,527	2,527	2,527	2,527	2,527	2,527	2,527
Trade & Other receivables	8,075	4,787	5,104	317	5,979	6,027	6,057	6,137	6,217	6,297	6,377
Accrued Income	0	6	16	10	21	38	38	38	38	38	38
Other Financial Assets	0	6	16	10	21	38	38	38	38	38	38
Prepayments	264	876	783	(93)	159	132	132	132	132	132	132
Prepayments	264	876	783	(93)	159	132	132	132	132	132	132
Cash	14,637	20,922	20,966	44	14,620	15,371	14,135	14,117	14,348	14,893	15,459
Current Asset Investments	0	0	0	0	0	0	0	0	0	0	0
Cash & Cash Equivalents	14,637	20,922	20,966	44	14,620	15,371	14,135	14,117	14,348	14,893	15,459
Non-Current Assets held for sale	500	500	500	0	500	500	500	500	500	500	500
Other Assets, Current	500	500	500	0	500	500	500	500	500	500	500
Assets, Current, Total	**23,476**	**27,091**	**27,369**	**278**	**21,279**	**22,068**	**20,862**	**20,924**	**21,235**	**21,860**	**22,506**
Deferred Income, Current	(108)	(98)	(69)	29	(100)	(100)	(100)	(100)	(100)	(100)	(100)
Trade Creditors, Current	(1,666)	(1,350)	(1,162)	188	(1,672)	(1,727)	(1,762)	(1,817)	(1,872)	(1,927)	(1,982)
Other Creditors, Current	(7,944)	(10,295)	(10,665)	(370)	(7,381)	(7,322)	(7,263)	(7,204)	(7,145)	(7,086)	(7,027)
Capital Creditors, Current	(326)	(467)	(440)	27	(440)	(420)	(420)	(420)	(420)	(420)	(420)
Trade & Other Payables	(9,936)	(12,112)	(12,267)	(155)	(9,493)	(9,469)	(9,445)	(9,441)	(9,437)	(9,433)	(9,429)
Accruals, Current	(1,818)	(1,986)	(2,137)	(151)	(1,174)	(1,147)	(1,117)	(1,117)	(1,117)	(1,117)	(1,117)
PDC dividend creditors	0	(806)	(865)	(59)	0	0	0	0	0	0	0
Other Financial Liabilities	(1,818)	(2,792)	(3,002)	(210)	(1,174)	(1,147)	(1,117)	(1,117)	(1,117)	(1,117)	(1,117)
Liabilities, Current, Total	(11,862)	(15,002)	(15,338)	(336)	(10,767)	(10,716)	(10,662)	(10,658)	(10,654)	(10,650)	(10,646)
Provisions, Non-Current	(616)	(655)	(667)	(12)	(451)	(451)	(451)	(451)	(451)	(451)	(451)
Finance Leases, Non-Current	(228)	(212)	(208)	4	(182)	(134)	(83)	(29)	27	48	48
Liabilities, Non-Current, Total	(844)	(867)	(875)	(8)	(633)	(585)	(534)	(480)	(424)	(403)	(403)
Total Assets Employed	64,338	64,783	64,877	94	64,809	65,121	65,159	65,190	65,222	65,276	65,330
Public dividend capital	46,680	46,680	46,680	0	46,680	46,680	46,680	46,680	46,680	46,680	46,680
I & E Account	14,082	14,527	14,621	94	14,553	14,865	14,903	14,934	14,966	15,020	15,074
Taxpayers Equity, Total	60,762	61,207	61,301	94	61,233	61,545	61,583	61,614	61,646	61,700	61,754
Revaluation Reserve	2,419	2,419	2,419	0	2,419	2,419	2,419	2,419	2,419	2,419	2,419
Other Reserves	1,157	1,157	1,157	0	1,157	1,157	1,157	1,157	1,157	1,157	1,157
Other Reserves	3,576	3,576	3,576		3,576	3,576	3,576	3,576	3,576	3,576	3,576
Taxpayers Equity, Total	64,338	64,783	64,877	94	64,809	65,121	65,159	65,190	65,222	65,276	65,330

Capital Expenditure

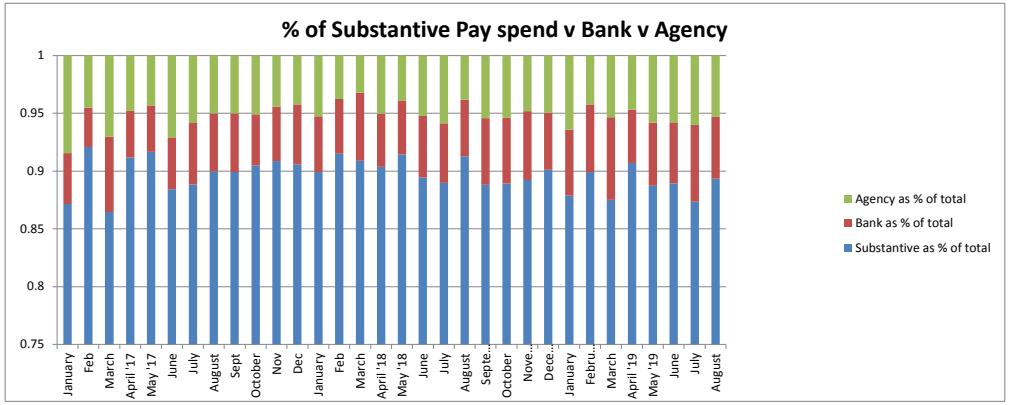
as at 31 August 2019

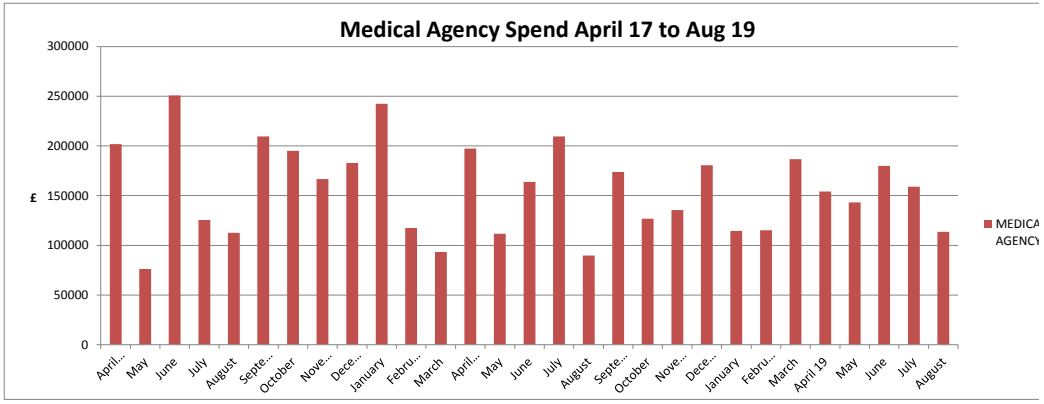
Scheme	YEAR TO DATE 2019/20 Budget Revised £'000	YEAR TO DATE 2019/20 Actual Spend £'000	YEAR TO DATE 2019/20 Variance £'000	Forecast Outturn 2019/20 Budget Revised £'000	Forecast Outturn 2019/20 Forecast Spend £'000	Forecast Outturn 2019/20 Variance £'000	2020/21 Forecast Spend £'000	2021/22 Forecast Spend £'000	2022/23 Forecast Spend £'000	2023/24 Forecast Spend £'000	2024/25 Forecast Spend £'000	Project Totals Budget Revised £'000	Project Totals Forecast Spend £'000	Project Totals Variance £'000
Significant Projects **														
Major Capital Programs				-399	-399		-2,592	-3,250	-1,500	-1,500	-1,500	-9,241	-9,241	0
Herefordshire sites Major Schemes Programme				-120	-120							-120	-120	0
Hereford 136 Suite Project		-1	1		-1	1							-1	1
Pullman Place Refurbishment		-5	5		8	-8							8	-8
Major Capital Project	-104	-97	-7	-494	-494							-509	-509	0
ICTT Programme				-6	-6		-350					-356	-356	0
ICTT Projects	-544	-568	24	-613	-613		-38					-703	-703	0
I&CS Programs				-276	-276		-340					-616	-616	0
I&CS Projects	-28	-23	-5	-61	-61		-81					-215	-215	0
IM&T Blueprint Programme				-199	-199		-300					-499	-499	0
IM&T Merger Costs Programme				-70	-70							-70	-70	0
IM&T Projects	-24	-42	18	-102	-127	25						-127	-152	25
Major Capital Expenditure	-700	-736	36	-2,340	-2,358	18	-3,701	-3,250	-1,500	-1,500	-1,500	-12,456	-12,474	18
Other Programmes														
Herefordshire sites Committed Projects	-8	-1	-7	-39	-39							-40	-40	0
Minor Capital Improvements Programme				-65	-65		-100	-100	-100	-100		-465	-465	0
Minor Capital Improvements Committed Projects	-44	-41	-3	-94	-98	4						-144	-148	4
Fire Precaution Works Programme				-200	-184	-16	-100	-100	-100	-100		-600	-584	-16
Fire Precaution Works Committed Projects		-16	16	-10	-26	16						-12	-28	16
Health & Safety Works Programme				-62	-62		-70	-70	-70	-70		-342	-342	0
Health & Safety Works Committed Projects	-9	-10	1	-15	-16	1						-29	-30	1
Security Works Programme				-40	-40		-30	-30	-30	-30		-160	-160	0
Security Works Committed Projects		-2	2	-15	-17	2						-17	-19	2
Patient Safety Programme				-183	-183		-432	-200	-200	-200		-1,215	-1,215	0
Patient Safety Committed Projects	-18	-17	-1	-191	-190	-1	-151					-363	-362	-1
Estates Infrastructure works Programme				-462	-462		-217	-300	-300	-300		-1,579	-1,579	0
Estates Infrastructure works Committed Projects	-404	-429	25	-640	-681	41						-678	-719	41
Medical Equipment Programme				-26	-26		-50	-50	-50	-50		-226	-226	0
Medical Equipment Projects	-24	-24		-29	-29							-29	-29	0
Unallocated				-108	-108			-750	-750	-750	-1,630	-2,358	-2,358	0
Fixed Asset Disposal Cost				-30	-30		-30	-30	-30	-30		-151	-151	0
Other Capital Expenditure	-507	-540	33	-2,209	-2,256	47	-1,180	-1,630	-1,630	-1,630	-1,630	-8,408	-8,455	47
													0	
Total Capital Expenditure (before slippage prediction)	-1,207	-1,276	69	-4,549	-4,614	65	-4,881	-4,880	-3,130	-3,130	-3,130	-20,864	-20,929	65
Schemes b/f												294	294	0
Planned Depreciation	975	1,114	-139	2,355	2,354	1	2,355	2,712	2,943	3,200	3,450	14,660	17,014	-2,354
Property Disposal				529	529		529	1,775	780			3,084	3,613	-529
PDC capital Draw Down													0	0
Donations from Charities													0	0
Donations from Charitable Funds													0	0
Funding from Surplus***	334	334		803	803		803	311	38	31	32	1,215	2,018	-803
Total Capital Grants Income													0	0
Total Capital Income	1,309	1,448	-139	3,687	3,686	1	3,687	4,798	3,761	3,231	3,482	19,253	22,939	-3,686
Net Capital Spend	102	172	-70	-862	-928	66	-1,194	-82	631	101	352	-1,611	2,010	-3,621
Net Cash Position				-862	-928	66	-1,194	-82	631	101	352			
Net Cash Position					-928		-2,122	-2,204	-1,573	-1,472	-1,120			

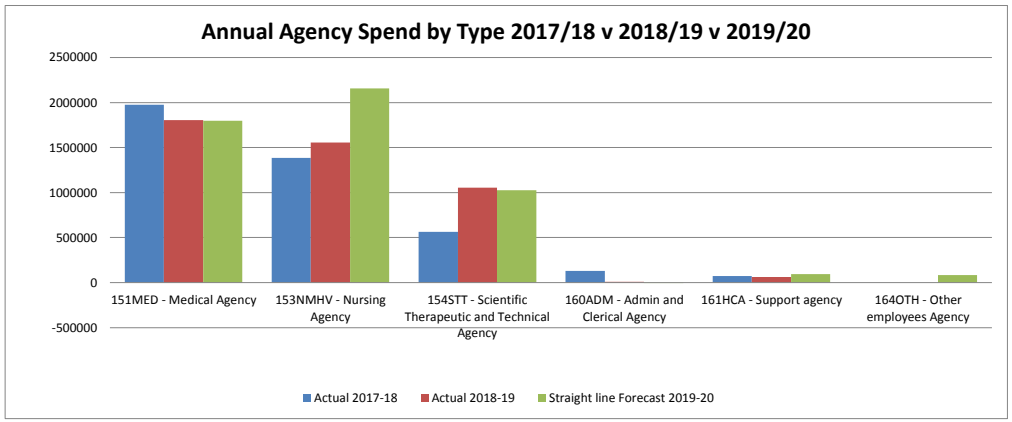
**** Significant Projects are projects where the total project budget is greater than £250 k**

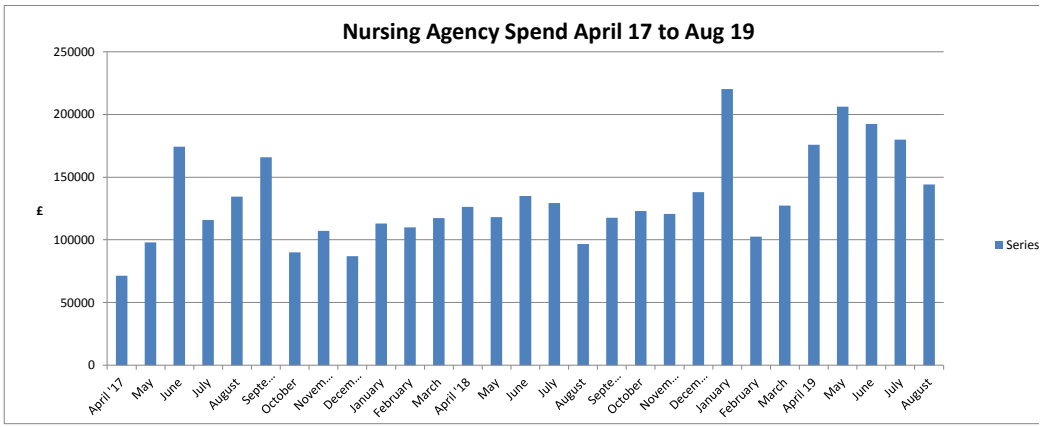
Capital Programme – a plan to spend money to address a particular issue.

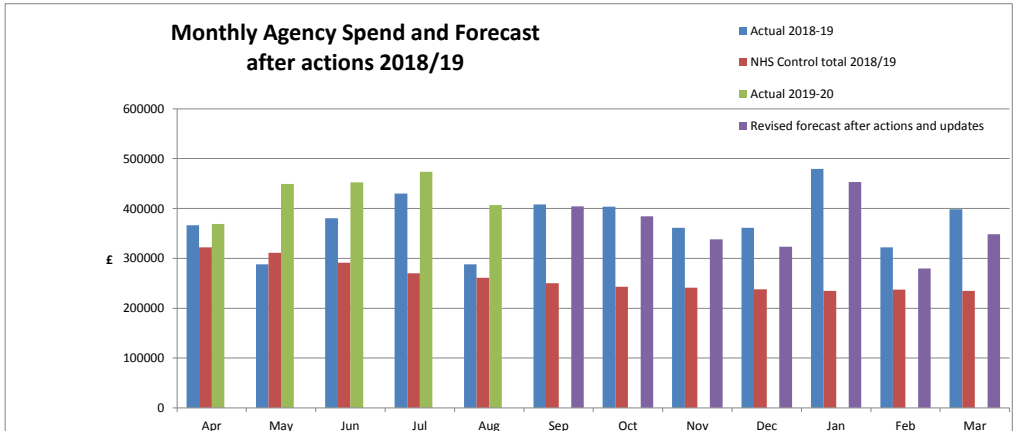
Capital Project – a specific scheme that has been allocated a budget from a Programme, and against which expenditure has been authorised. Every Project is issued a Capital Project Number and has a specific budget holder.

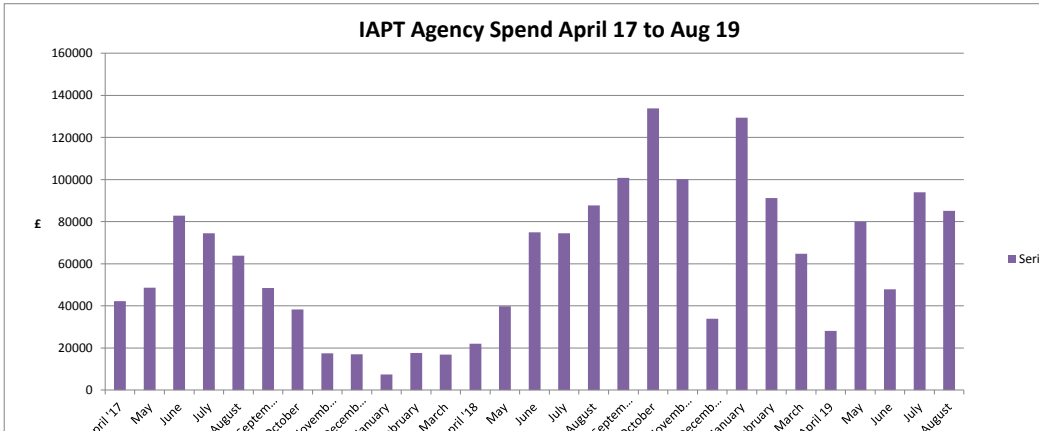

% of Substantive Pay spend v Bank v Agency
1
0.95
0.9
0.85
0.8
0.75
January
Feb
March
April '17
May '17
June
July
August
Sept
October
Nov
Dec
January
Feb
March
April '18
May '18
June
July
August
Septe...
October
Nove...
Dece...
January
Febru...
March
April '19
May '19
June
July
August
Agency as % of total
Bank as % of total
Substantive as % of total


Medical Agency Spend April 17 to Aug 19
300000
250000
200000
150000
100000
50000
0
£
April...
May
June
July
August
Septe...
October
Nove...
Dece...
January
Febru...
March
April...
May
June
July
August
Septe...
October
Nove...
Dece...
January
Febru...
March
April 19
May
June
July
August
MEDICA
AGENCY


Annual Agency Spend by Type 2017/18 v 2018/19 v 2019/20
2500000
2000000
1500000
1000000
500000
0
-500000
151MED - Medical Agency
153NMHV - Nursing Agency
154STT - Scientific Therapeutic and Technical Agency
160ADM - Admin and Clerical Agency
161HCA - Support agency
164OTH - Other employees Agency
Actual 2017-18
Actual 2018-19
Straight line Forecast 2019-20


Nursing Agency Spend April 17 to Aug 19
250000
200000
150000
100000
50000
0
£
April '17
May
June
July
August
Septe...
October
Novem...
Decem...
January
February
March
April '18
May
June
July
August
Septe...
October
Novem...
Decem...
January
February
March
April 19
May
June
July
August
Series


Monthly Agency Spend and Forecast after actions 2018/19
Actual 2018-19
NHS Control total 2018/19
Actual 2019-20
Revised forecast after actions and updates
600000
500000
400000
300000
200000
100000
0
£
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


IAPT Agency Spend April 17 to Aug 19
160000
140000
120000
100000
80000
60000
40000
20000
0
£
May
June
July
August
March
May
June
July
August
March
May
June
July
August
Seri

Current FT Financial Risk Rating - Single Oversight

Use Of Resource

Finance and use of resources rating Metric	Audited PY 31/03/2019 Year ending	Plan 31/03/2020 Year ending	Actual 31/08/2019 YTD	Forecast 31/03/2020 Year ending
Capital service cover rating	1	1	1	1
Liquidity rating	1	1	1	1
I&E margin rating	1	1	1	2
I&E margin: distance from financial plan	1	1	2	2
Agency rating	3	1	3	3
Risk ratings after overrides	1	1	2	2

dix 9

CIP Savings 2019-20 — TRANSFORMATION (CIP) PROJECT — as at 31st August 2019

	No	Work Stream	2019-20 Type of Saving (T/E)	Work Stream Lead	Finance Lead	Director	Target Saving £'000	Initial Revised Plan £'000	Delivered to date £'000	Draft PD/QIA	Approved PD	Approved QIA	RAG Delivery Confidence Against Original Target	RAG Delivery Confidence Against Forecast	2020-21 Target £'000		2020-21 RAG Delivery Confidence		2021-22 Target £'000	2022-23 Target £'000	2023-24 Target £'000	2024-25 Target £'000	Progress/Comment on 2019/20
		Transformation																					
Rec	1	**Digital Dictation & Transcription**	T	SM	SA	CM																	Digital transcription through speech recognition for clinicians and nurses to upload case records and issue letters
Rec	2	**Medicines Management**	E	JR	JE	MC	100	100	0	✓	✓	✓	G	G	50		A	n					Use of generic medicines as they become available and controlled use of FP10s.
Rec	3	**2 Shift System on wards**	T	LT	SA	CM/MC	300	300	0	✓	✓	✓	R	G	200		A	p					To consider a phased approach starting in 2017/18, split across four years
Rec	4	**Shared Service Procurement**	E	SA	SA	AL	100	100	0	✓	✓	✓	R	A	100		A	n					Targeted reduction in procurement costs - high cost items and review on contract renewal
Rec	5	**Corporate Service Review**	E	SA	KN	AL	50	50	73	✓	✓	✓	G	G	50		A	n					Ongoing review of structure and spend
	6	Cessation of clothing allowance																					Cessation of clothing allowance in line with Agenda for Change
Rec	7	**Estates**	E	AE	KN	AL	0	0	0	✓	✓	✓	G	G	100		A	n					Rationalisation of estate, utilities and cleaning
	8	Review use of pool cars		CS	BA	CS																	Rationalisation of pool cars - reduced number, more effective usage, lower rental costs per car, improved mpg
Rec	9	**Medical Review / Consultant Contracts**	E	CF	BA	CF	50	50	0	✓	✓	✓	G	G	50		A	p					Review of structure, number and profile of consultants
	10	Recovery - Holly House					-								-								More efficient use of premises - improved volumes and quality of care
	11	Women's Low Secure	T	LT	tba	CM									200								Market opportunity as national increase in demand/lack of provision for this type of care
Rec	12	**Improving Care Through Technology**	T	TM	SA	AL																	Use of mobile and other technology (e.g. text alerts) to more effectively and efficiently deliver care
Rec	13	**Reducing Business Mileage**	T	JF	SA	AL																	Through changes in practice and technology more efficiently plan travel, reduce DNAs, and challenge need for travel
Inc	14	**Income Generation**	T	AL	SA	AL	50	50	50	✓	✓	✓	R	A	100		A	i					Comprises several schemes involving 2gt specialisms - marketing those skills and used in new business partnerships
	15	New work																					Use of the Trust WOS to change the medium of delivery as contracts renew
	16	Use of WOS - Existing Business																					Ensuring the service costs of the WOS are correctly channelled through the WOS
	17	Use of WOS - Service Charges																					Reduce agency costs through better governance, effective recruitment and retention, e-rostering, and development of the staff bank
	18	Reduction to Bank Staff and Agency costs																					Both STPs the Trust is engaged in will include a specific element in respect of dempographic change.
Rec	19	**Personal Car Purchase Scheme**	E	NG	KN	NS																	Provision of a car purchase benefit scheme (salary sacrifice) that also provides NI and pension saving to the 2gt
Inc	20	**IAPT Income**	T	AL	SA	AL	100	100	0	✓	✓	✓	R	G	100		A	i					Marketing and licencing IAPT materials in the UK and internationally, and providing IAPT training to the UK market
Inc	21	**Working Well**	E	NS	KN	NS	100	100	0	✓	✓	✓	G	G	50		A	i					Marketing the established Working Well provision to the regional market
Rec	22	Service Line Reporting/Benchmarking		SA	GS	AL	325	325	0	✓	✓	✓	R	R	400		A	p					Utilise the new Service Line Reporting software to identify efficiencies
	23	Unidentified																	1400	1400	1400	1400	
		Transformation Savings Target					1,175	1,175	123						1,400				1,400	1,400	1,400	1,400	
	24	Income, reserves adjusted in budget setting																					
	25	Reduced surplus																					
Rec	26	**Budget setting - clinical**	E	JF	SA	AL	462	462	462	✓	✓	✓	G	G									
Rec	27	**Budget setting - corporate**	E	SA	KN	AL																	Savings schemes that are not yet fully developed or yet to be identified
	28	Budget setting savings 0.5%													576		A	p	585	590	595	595	
		Budget Setting Savings Target					462	462	462						576				585	590	595	595	
Rec	29	**Shift Patterns - Crisis Team (Glos)**	E	JF	SA	CM																	
Rec	30	**More effective use of smartphones**	E	RB	KN	AL																	
Rec		**Herefordshire SLA IT Savings**	E	TM	KN	AL																	
Rec		**Mitel Phone Network redesign**	E	TM	KN	AL																	
Rec		**Mobile Phone savings**	E	TM	KN	AL																	
Rec	31	**Medicines Optimisation**	E	JR	JE	AL	100	100	0	✓	✓	✓	A	A			A	n					
Rec	32	**SOP for Specialling**	E		JL	AL																	
		Additional Schemes					100	100	0						0				0	0	0	0	
		Non-recurring Savings																					
NR	33	**Review of provisions, miscellaneous**	E	SA	SA	AL	350	350	124.539	✓	✓	✓	G	G	350		A	n	350	350	350	350	Continuous (at budget setting and throughout the year) identification of non-recurrrent saving opportunities
NR	34	**Reduction in Agency costs**	E	MC	SA	MC	300	300	0	✓	✓	✓	R	R	300			n	-				Reduce agency costs through better governance, effective recruitment and retention, e-rostering, and development of the staff bank
		Non-Recurring Savings Target					650	650	125						650				350	350	350	350	

NHS
Gloucestershire
Care Services
NHS Trust

Trust Board

Date of Meeting: 26th September 2019

Report Title: Finance Report M05

Agenda reference Number	19(2)
Accountable Executive Director (AED)	Sandra Betney
Presenter (if not AED)	
Author(s)	Stephen Andrews
Board action required	To note
Previously considered by	Not Applicable
Appendices	App 1 : Main M05 Finance Report

Executive Summary

This report provides an overview of the Trust's financial position for Month 5 of 2019/20.

Background

The Trust financial context for 2019/20 is summarised below.

- Control Total surplus is £2.256m including £1.626m of Provider Sustainability Funding (PSF).
- Capital spend plan is £2.93m of in-year CRL request, plus £0.75m of multi-year CRL allocation for the Forest of Dean hospital. Total £3.68m.
- Cost Improvement Plan (CIP) target is £5.3m
- Agency spending ceiling is £1.865m
- Income potential Commissioning for Quality and Innovation (CQUIN) and Quality, Innovation, Productivity and Prevention (QIPP) are £1.06m and £3.9m respectively. Contracts have not yet been signed, with milestones and proportional values for respective periods not yet allocated.

M5 full year performance forecast is on plan, subject to the risks noted at page 6 of Appendix 1:

- Full Year surplus, including PSF, of £2.256m
- Capital spend of £3.68m
- Cash at the end of Month 12 of £19.7m
- YTD agency spend is £917k compared to a plan of £865k. Forecast agency spend is £1.864m, in line with the agency spend plan

Recommendations

The committee is asked to note the content of the report and the risks at page 6 of Appendix 1 to this report.

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2019/20 Month 5 Finance Report

v 1.0

Understanding You

Overview

Gloucestershire Care Services NHS Trust

- The year to date surplus is on plan at £0.6m. Full year forecast is to deliver control total of £2.256m, but there are significant risks to this if the Trust cannot deliver its Challenge CIP Schemes. PSF accounts for £1.626m of the control total surplus.
- Annual Agency ceiling is £2.232m (18/19 full year spend was £1.66m). The year to date actual is £917k which is over the spend plan by £52k. The full year forecast spend is £1.864m, in line with the agency spend plan.
- Full year Cost Improvement Plan (CIP) target for the full year is £5.28m. The CIP amount removed so far is £2.256m from the following schemes: 1% Schemes £1.372m; Differential Targets £0.776m and Challenge Schemes £0.108m.
- Capital spend is £996k.
- Cash balance at the end of month 5 is £1,108k above plan at £20.3m. £0.4k of the increase in cash relates to an underspend on capital against plan.

Understanding You

Income and Expenditure

Gloucestershire Care Services NHS Trust

Full Year performance at Month 5 is on plan at £2.3m surplus.
The summary I&E below shows differences to plan on Year to Date Income, Pay and Non Pay Costs.

Operational directorates are generally in surplus YTD, with Hospitals posting £154k deficit due to high bank and agency spend covering sickness, maternity leave and vacancies. Central cost areas are posting a deficit YTD and in forecast. This is due to MEA depreciation, agreed non-recurrent costs expected to be funded by Trust underspends and unidentified Challenge CIP.

Statement of comprehensive income £000	2018/19	2019/20	2019/20 YTD			2019/20
	Full Year Actual	Full Year Plan	Plan	Actual	Variance	Full Year Forecast
Operating income from patient care activities	112,668	113,540	38,087	38,122	35	114,232
Other operating income exc PSF	2,099	1,528	242	325	83	1,607
Provider sustainability fund (PSF) income	3,962	1,626	612	612	0	1,626
Employee expenses	(80,782)	(84,235)	(28,365)	(27,952)	413	(84,878)
Operating expenses excluding employee expenses	(31,719)	(28,202)	(9,296)	(9,899)	(603)	(28,503)
PDC dividends payable/refundable	(1,739)	(2,066)	(688)	(622)	66	(1,900)
Other gains / losses	(56)					
Surplus/(deficit) before impairments & transfers	**4,433**	**2,191**	**592**	**586**	**(6)**	**2,184**
Add back impairments	885					
Remove capital donations/grants I&E impact	(249)	65	20	26	6	72
Surplus/(deficit) inc PSF	**5,069**	**2,256**	**612**	**612**	**0**	**2,256**
Surplus/(deficit) exc PSF	**1,107**	**630**	**0**	**0**	**0**	**630**
Control total including PSF	**3,078**	**2,256**	**260**	**260**	**0**	**2,256**

	Budgeted	Contracted	Vacancies	Vacancy %
WTEs in Month 5	2,304	2,099	205	9%

Understanding You

Balance Sheet

STATEMENT OF FINANCIAL POSITION (all figures £000)		2018/19	2019/20 Year to Date			2019/20
		Full Year Actual	Plan	Actual	Variance	Plan
Non-current assets	Intangible assets	829	686	696	10	486
	Property, plant and equipment: other	63,315	63,428	63,154	(274)	63,837
	Total non-current assets	**64,144**	**64,114**	**63,850**	**(264)**	**64,323**
Current assets	Inventories	288	288	288	0	288
	NHS receivables	5,800	5,246	4,161	(1,085)	5,598
	Non-NHS receivables	2,978	2,978	3,121	143	2,978
	Cash and cash equivalents:	17,837	19,282	20,390	1,108	19,715
	Total current assets	**26,903**	**27,794**	**27,960**	**166**	**28,579**
Current liabilities	Trade and other payables: capital	(1,454)	(829)	(30)	799	(1,329)
	Trade and other payables: non-capital	(9,518)	(10,381)	(10,341)	40	(9,525)
	Borrowings	(76)	(76)	(200)	(124)	(2)
	Provisions	(371)	(371)	(371)	0	(371)
	Other liabilities: deferred income including contract liabilities	(389)	(389)	(1,139)	(750)	(389)
	Total current liabilities	**(11,808)**	**(12,046)**	**(12,081)**	**(35)**	**(11,616)**
Non-current liabilities	Borrowings	(1,593)	(1,493)	(1,368)	125	(1,456)
	Total net assets employed	**77,646**	**78,369**	**78,361**	**(8)**	**79,830**
Taxpayers Equity	Public dividend capital	80,276	80,276	80,276	0	80,276
	Revaluation reserve	4,679	4,679	4,679	0	4,679
	Other reserves	(2,398)	(2,398)	(2,398)	0	(2,398)
	Income and expenditure reserve	(4,911)	(4,188)	(4,196)	(8)	(2,727)
	Total taxpayers' and others' equity	**77,646**	**78,369**	**78,361**	**(8)**	**79,830**

Capital – Multi-Year Plan

	YTD	FOT					
£000s	**2019/20**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
Land and Buildings							
Buildings	802	1,375	740	750	1,000	1,000	1,000
Backlog Maintenance		100	120	500	250	250	250
Urgent Care		25	475				
IT Device and software upgrade		277	600	600	600	600	600
IT Infrastructure	11	300	420	300	1,400	300	300
Corporate Systems Replacement							
Medical Equipment	133	853	200	200	200	200	200
Sub Total	**946**	**2,930**	**2,555**	**2,350**	**3,450**	**2,350**	**2,350**
Forest of Dean	50	750	5,000	3,600			
Total	**996**	**3,680**	**7,555**	**5,950**	**3,450**	**2,350**	**2,350**

Year to Date capital spend is £996k.

Cash Flow Summary

Statement of Cash Flow £000	ACTUAL YTD 19/20		FORECAST 19/20	
Cash and cash equivalents at start of period		**17,837**		**17,837**
Cash flows from operating activities				
Operating surplus/(deficit)	1,435		3,965	
Add back: Depreciation on donated assets	32		72	
Adjusted Operating surplus/(deficit) per I&E	**1,467**		**4,037**	
Add back: Depreciation on owned assets	1,434		4,148	
(Increase)/Decrease in trade & other receivables	1,495		202	
Increase/(Decrease) in trade and other payables	(1,559)		(1,454)	
Increase/(Decrease) in other liabilities	750		742	
Net cash generated from / (used in) operations		**3,587**		**7,675**
Cash flows from investing activities				
Interest received	62		119	
Purchase of property, plant and equipment	(996)		(3,805)	
Net cash generated used in investing activities		**(934)**		**(3,686)**
Cash flows from financing activities				
PDC Dividend (Paid)			(1,900)	
Finance Lease Rental Payments	(100)		(211)	
		(100)		**(2,111)**
Cash and cash equivalents at end of period		**20,390**		**19,715**

Risks

Risks to delivery of the 2019/20 position are as set out below:

	19/20 Risk at month 05	Rec Risk for 20/21	Likelihood
Shared Glos deficit (FY £83k in position)	0	0	Certain
Challenge Scheme CIPs	0	1,948	Almost Certain
Unidentified Planned CIP for Differential Schemes:	370	370	Possible
Phasing of Differential CIP not covered above (50%not yet delivered)	0		Likely
Delivering required non recurrent underspends to cover non-recurrent pressures (FY £1m in position)	0	0	Almost Certain
VAT changes impacting recovery on Systm1 19/20 (FY £80k in position)	0	80	Certain
QIPP risk share and milestones	500		Possible
CQUIN	150		Possible
Asset lives depreciation impact - GCS acceptance (FY£423k in position)	0	423	Certain
Asset lives depreciation impact - Full DV value	0	0	Unlikely
Asset lives PDC impact - GCS acceptance (FY £117k in position)	0	117	Certain
Asset lives PDC impact - Full DV value	0	0	Possible
Vacancy abatement (FY£1.6m in position)	0		Unlikely
GCC Management Charge - Tranche 2 (FY £150k in position)	0	150	Certain
A failure to control costs due to some risks materialising leads to the Trust to miss its FTC and lose PSF	569		Unlikely
	1,589	**3,088**	

Health Economy Risks	**Proabability**	**Risk £000)**	**Opportunity (£000)**
Delivery of GHFT control total	Likely	10,196	
Delivery of CCG control total	Likely	7,500	
System Control Total PSF Risk	Unlikely	99	
		17,795	

Single Operating Framework Ratings

	Audited PY 31/03/2018 Year ending	Actual 30/08/2019 Year ending	Forecast 31/03/2020 Year ending
Capital service cover rating	1	1	1
Liquidity rating	1	1	1
I&E margin rating	1	1	1
I&E margin: distance from financial plan	1		1
Agency rating	1	1	1

All ratings are green

Agenda item 20

Report to:	Trust Board , 26th September 2019
Author:	Chris Woon, Head of Information Management and Clinical Systems
Presented by:	John Campbell, Director of Service Delivery
SUBJECT:	**Performance Dashboard Report for the period to the end of August 2019 (month 5)**

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

EXECUTIVE SUMMARY:

Overview

This month's report sets out the performance of the Trust's Clinical Services for the period to the end of August, (month 5 of the 2019/20 contract period); against our NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

Of the 156 performance indicators, 80 are reportable in August with 71 being compliant and 9 non-compliant at the end of the reporting period.

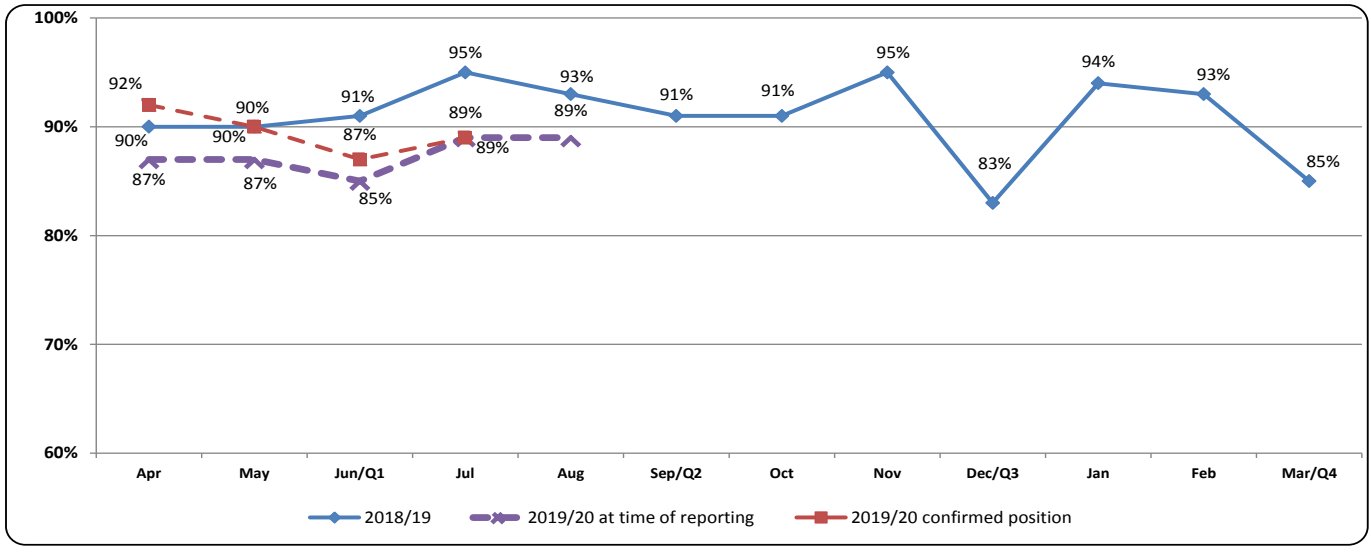
Where performance is not compliant, Service Directors are taking the lead to address issues and work is ongoing in accordance with our agreed Service Delivery Improvement Plans to address the underlying issues affecting this performance.

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

The following table summarises our performance position as at the end of August 2019 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 or N/A	NYA
NHSi Requirements	13	12	12	0	0	1	0
Never Events	17	17	17	0	0	0	0
Department of Health	10	8	8	0	0	2	0
Gloucestershire CCG Contract	71	19	12	7	37	50	2
Social Care	12	12	11	1	8	0	0
Herefordshire CCG Contract	19	12	11	1	8	7	0
CQUINS	14	0	0	0	0	14	0
Overall	156	80	71	9	11	74	2

The following graph shows our percentage compliance by month and the previous year's compliance for comparison. The 2019/20 "confirmed position" line shows the position of our performance reported a month in arrears to enable late data entry and late data validation to be taken into account.



The confirmed position for June has increased to 87% due to the following indicator now being reported as compliant:

- 5.03: Herefordshire - IAPT recovery rate

Summary Exception Reporting

The following 9 key performance thresholds were not met for the Trust for August 2019:

Gloucestershire CCG Contract Measures

- 3.12 – IAPT access rate
- 3.24 – IAPT DNA rate
- 3.35 – Adolescent Eating Disorders – Routine referral to NICE treatment within 4 weeks
- 3.36 – Adolescent Eating Disorders – Routine referral to non-NICE treatment within 4 weeks
- 3.37 – Adolescent Eating Disorders – Urgent referral to NICE treatment within 1 week

- 3.39 – Adult Eating Disorders: Wait time for assessments will be 4 weeks
- 3.40 – Adult Eating Disorders: Wait time for psychological intervention will be 16 weeks

Gloucestershire Social Care Measures

- 4.06 – Eligible service users for Social Care have a Personal Budget

There is ongoing dialogue with Commissioners regarding some of the content (select indicators and thresholds) within Gloucestershire's 2019/20 contract (Schedule 4). There has been resolution regarding the 2018/19 indicators where thresholds had been increased for 2019/20, however, negotiations continue for the indicators that are new for this financial year.

Herefordshire CCG Contract Measures

- 5.13 – CYP Access: Percentage of CYP in treatment against prevalence

RECOMMENDATIONS

The Delivery Committee is asked to:

- Note the Performance Dashboard Report for August 2019.
- Accept the report as a significant level of assurance that our contract and regulatory performance measures are being met or that appropriate action plans are in place to address areas requiring improvement.
- Be assured that there is ongoing work to review all of the indicators not meeting the required performance threshold. This includes a review of the measurement and data quality processes as well as clinical delivery and clinical practice issues.

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

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

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

Reviewed by:		
John Campbell	Date	September 2019

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

What consultation has there been?		
Not applicable.	Date	

Explanation of acronyms used:	
	AKI Acute kidney injury ARFID Avoidant restrictive food intake disorder ASCOF Adult Social Care Outcomes Framework CAMHS Child and Adolescent Mental health Services CBT Cognitive Behavioural Therapy C-Diff Clostridium difficile CLDT Community Learning Disability Teams CPA Care Programme Approach CQUIN Commissioning for Quality and Innovation CRHT Crisis Home Treatment CSM Community Services Manager CYPS Children and Young People's Services DNA Did not Attend ED Emergency Department EI Early Intervention EWS Early warning score GARAS Gloucestershire Action for Refugees and Asylum Seekers 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 MHARS Mental Health Acute Response Service 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 PBS Personal Behaviour Support plan PICU Psychiatric Intensive Care Unit 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 August 2019, month 5 of the 2019/20 contract period.

1.1 The following sections of the report include:

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

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

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

2.1 The following tables outline the performance in each of the performance categories within the Dashboard as at the end of August 2019. 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 Performance indicators include all relevant Trust activity allocated between Gloucestershire and Herefordshire based on locality of the service.

2.3 Where stated, 'Cumulative Compliance' refers to compliance recorded from the start of this contractual year April 2019 to the current reporting month, as a whole.

	=	**Target not met**
	=	**Target met**
NYA	=	**Not yet available**
NYR	=	**Not yet required**
N/A	=	**Not applicable: No data to report, methodology to be agreed or baseline data to inform 2020/21**

DASHBOARD CATEGORY - NHSI REQUIREMENTS

NHS Improvement Requirements				
	In month Compliance			Cumulative Compliance
	Jun	Jul	Aug	
Total Measures	13	13	13	13
🔴	0	0	0	0
🟢	12	12	12	12
NYA	0	0	0	0
NYR	0	0	0	0
N/A	1	1	1	1

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds not being met
None

Changes to Previously Reported Figures
None

Early Warnings / Notes
None

NHS Improvement Requirements

ID	Performance Measure (PM)		2018/19 Outturn	June-2019	July-2019	August-2019	(Apr - Aug) Cumulative Compliance	Forecast 19/20 Outturn
1								
1.01	Number of MRSA Bacteraemias	PM	0	0	0	0	0	0
		Gloucestershire	0	0	0	0	0	
		Herefordshire	0	0	0	0	0	
		Combined Actual	0	0	0	0	0	
1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	<3	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%	95%
		Gloucestershire	98%	100%	100%	98%	99%	
		Herefordshire	99%	100%	100%	100%	100%	
		Combined Actual	98%	100%	100%	99%	99%	
1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	98%	97%	98%	97%	98%	
		Herefordshire	98%	99%	99%	96%	97%	
		Combined Actual	98%	98%	98%	97%	98%	
1.05	Nationally reported - Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Gloucestershire	2.4%	2.6%	4.0%	2.9%	2.9%	
		Herefordshire	2.3%	3.0%	4.3%	2.2%	2.0%	
		Combined Actual	2.4%	2.7%	4.1%	2.7%	2.7%	
1.05b	- Delayed Discharges - Outliers	PM						
		Gloucestershire	7.4%	8.6%	7.5%	7.7%	9.2%	
		Herefordshire	3.6%	4.9%	4.1%	3.7%	4.5%	
		Combined Actual	6.5%	7.7%	6.6%	6.8%	8.1%	
1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	99%	100%	100%	97%	99%	
		Herefordshire	100%	100%	100%	100%	100%	
		Combined Actual	99%	100%	100%	98%	99%	
1.07	New psychosis (EI) cases treated within 2 weeks of referral	PM	53%	56%	56%	56%	56%	56%
		Gloucestershire	68%	100%	70%	80%	80%	
		Herefordshire	85%	75%	60%	100%	76%	
		Combined Actual	72%	86%	67%	86%	79%	

NHS Improvement Requirements

ID	Performance Measure (PM)		2018/19 Outturn	June-2019	July-2019	August-2019	(Apr - Aug) Cumulative Compliance	Forecast 19/20 Outturn
1.08	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Gloucestershire	97%	99%	99%	99%	99%	
		Herefordshire	94%	99%	99%	98%	99%	
		Combined Actual	97%	99%	99%	99%	99%	
1.09	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	99%	100%	99%	100%	99%	
		Herefordshire	95%	99%	100%	99%	99%	
		Combined Actual	98%	99%	99%	99%	99%	
1.10	**MENTAL HEALTH SERVICES DATA SET PART 1 DATA COMPLETENESS: OVERALL**	PM	97%	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%	
1.10a	Mental Health Services Data Set Part 1 Data completeness: DOB	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	100.0%	100.0%	100.0%	100.0%	100.0%	
		Herefordshire	100.0%	100.0%	100.0%	100.0%	100.0%	
		Combined Actual	100.0%	100.0%	100.0%	100.0%	100.0%	
1.10b	Mental Health Services Data Set Part 1 Data completeness: Gender	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%	
1.10c	Mental Health Services Data Set Part 1 Data completeness: NHS Number	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	100.0%	100.0%	99.9%	99.9%	
		Herefordshire	100.0%	100.0%	100.0%	100.0%	100.0%	
		Combined Actual	99.9%	100.0%	100.0%	99.9%	99.9%	
1.10d	Mental Health Services Data Set Part 1 Data completeness: Organisation code of commissioner	PM	97%	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%	
1.10e	Mental Health Services Data Set Part 1 Data completeness: Postcode	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.7%	99.8%	99.7%	99.7%	99.7%	
		Herefordshire	99.8%	99.9%	99.9%	99.8%	99.8%	
		Combined Actual	99.8%	99.8%	99.8%	99.7%	99.8%	
1.10f	Mental Health Services Data Set Part 1 Data completeness: GP Practice	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.6%	99.7%	99.7%	99.7%	99.7%	
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Combined Actual	99.7%	99.8%	99.8%	99.8%	99.8%	

NHS Improvement Requirements

ID	Performance Measure (PM)		2018/19 Outturn	June-2019	July-2019	August-2019	(Apr - Aug) Cumulative Compliance	Forecast 19/20 Outturn
1.11	**MENTAL HEALTH SERVICES DATA SET PART 2 DATA COMPLETENESS : OVERALL**	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	97.0%	97.1%	97.0%	97.1%	97.1%	
		Herefordshire	91.9%	92.7%	82.1%	92.0%	92.4%	
		Combined Actual	96.2%	96.5%	96.2%	96.3%	96.4%	
1.11a	Mental Health Services Data Set Part 2 Data completeness: CPA Employment status last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	95.7%	96.1%	95.9%	96.0%	96.0%	
		Herefordshire	87.8%	88.9%	87.7%	87.3%	88.2%	
		Combined Actual	94.5%	95.0%	94.7%	94.7%	94.8%	
1.11b	Mental Health Services Data Set Part 2 Data completeness: CPA Accommodation Status in last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	97.1%	97.2%	97.2%	97.2%	97.2%	
		Herefordshire	88.7%	89.8%	89.1%	88.7%	89.5%	
		Combined Actual	95.8%	96.0%	96.0%	95.9%	96.0%	
1.11c	Mental Health Services Data Set Part 2 Data completeness: CPA HoNOS assessment in last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	98.2%	98.1%	97.8%	97.9%	98.0%	
		Herefordshire	99.2%	99.6%	99.6%	100.0%	99.6%	
		Combined Actual	98.4%	98.3%	98.1%	98.2%	98.2%	
1.12	Learning Disability Services: 6 indicators: identification of people with a LD, provision of information, support to family carers, training for staff, representation of people with LD; audit of practice and publication of findings	PM	6	6	6	6	6	6
		Gloucestershire	6	6	6	6	6	
		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
	Jun	Jul	Aug	
Total Measures	27	27	27	27
🔴	0	1	0	1
🟢	25	24	25	25
NYA	0	0	0	0
NYR	0	1	1	0
N/A	2	1	1	1

Performance Thresholds not being achieved in Month

None

Cumulative Performance Thresholds Not being met

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

To date there have been 4 admissions of under 18s to adult wards, 3 in Gloucestershire and 1 in Herefordshire.

Changes to Previously Reported Figures

None

Early Warnings

None

Note in relation to year end compliance predictions (forecast outturn)

2.21: No children under 18 admitted to adult inpatient wards

Unfortunately the annual performance threshold is zero and as it has not been met, the performance for the year will be non-compliant. Historic performance indicates that without changes in the tier 4 services arrangements - outside of the remit of ^{2}gether - we will not be able to meet this indicator.

DOH Never Events

ID	Performance Measure (PM)		2018/19 Outturn	June-2019	July-2019	August-2019	(Apr - Aug) Cumulative Compliance	Forecast 19/20 Outturn
2								
2.01	Wrongly prepared high risk injectable medications	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.02	Maladministration of potassium containing solutions	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.03	Wrong route administration of oral/enteral treatment	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.04	Intravenous administration of epidural medication	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.05	Maladministration of insulin	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.06	Overdose of midazolam during conscious sedation	PM	0	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	0
		Actual	0	0	0	0	0	
2.08	Inappropriate administration of daily oral methotrexate	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.09	Suicide using non collapsible rails	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.10	Falls from unrestricted windows	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.11	Entrapment in bedrails	PM	0	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	0
		Actual	0	0	0	0	0	
2.13	Wrong gas administered	PM	0	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	0
		Actual	0	0	0	0	0	
2.15	Air embolism	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.16	Severe scalding from water for washing/bathing	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.17	Mis-identification of patients	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	

DOH Requirements

ID	Performance Measure (PM)		2018/19 Outturn	June-2019	July-2019	August-2019	(Apr - Aug) Cumulative Compliance	Forecast 19/20 Outturn
2.18	Mixed Sex Accommodation - Sleeping Accommodation Breaches	PM	0	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	0
		Gloucestershire	2	0	1	0	3	
		Herefordshire	3	0	0	0	1	
		Combined	5	0	1	0	4	
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 (PM)		2018/19 Outturn	June-2019	July-2019	August-2019	(Apr - Aug) Cumulative Compliance	Forecast 19/20 Outturn
2.24	Serious Incident Reporting (SI) reported to CCG	Gloucestershire	26	1	5	4	12	
		Herefordshire	12	0	0	2	4	
2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	100%	100%	100%	100%	100%	
		Herefordshire	100%	N/A	100%	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%	100%
		Gloucestershire	100%	100%	100%	100%	100%	
		Herefordshire	100%	N/A	N/A	100%	100%	
2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	100%	N/A	NYR	NYR	100%	
		Herefordshire	100%	N/A	NYR	NYR	100%	
2.28	SI Report Level 3 - Independent investigations - 6 months from investigation commissioned date	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	N/A	N/A	N/A	N/A	N/A	
		Herefordshire	N/A	N/A	N/A	N/A	N/A	
2.29	SI Final Reports outstanding but not due	Gloucestershire	14	1	5	4	11	
		Herefordshire	9	0	0	2	2	

DASHBOARD CATEGORY – GLOUCESTERSHIRE CCG CONTRACTUAL REQUIREMENTS

Gloucestershire Contract				
	In month Compliance			Cumulative Compliance
	Jun	Jul	Aug	
Total Measures	71	71	71	71
🔴	10	4	7	11
🟢	30	15	12	30
NYA	7	1	2	7
NYR	7	38	38	7
N/A	17	13	12	16

Definition Note

3.36: Adolescent Eating Disorders: Routine referral to Non-NICE treatment within 4 weeks

3.38: Adolescent Eating Disorders: Urgent referral to Non-NICE treatment within 1 week

"*Non-NICE treatment*" is a locally defined term used to transparently present all intervention activity within our Eating Disorder (ED) services such as Avoidant/ Restrictive Food Intake Disorder (ARFID). Due to the lack of NICE treatment codes for certain interventions this activity would otherwise be lost or incorrectly impact our NICE performance indicators. There are low incidences of non-NICE treatments (hence the common recording of Not Applicable).

Performance Thresholds not being achieved in Month

3.12: IAPT access rate

August numbers are below the specified threshold. This is an intentional position, to manage the waiting list, as in July we over achieved planned numbers. We are on target to reach the required 17% at the end of Quarter 2.

3.24: IAPT DNA rate

We are 0.5% above the required DNA rate for August. It is believed that this is due to school holidays and the warmer weather.

🚩 **3.35: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks**

There were 5 non-compliant cases in August.

One client was offered the first available appointment for assessment which was outside of the required 4 weeks. Treatment did not then begin until 15 weeks after referral due to cancellations by the client and late attendance to appointments.

One client was assessed within 7 days, the outcome of which was to commence CBT at the next appointment. This treatment started at the next available appointment which was within 6 weeks of referral.

The remaining 3 clients were offered and attended the next available appointments at which treatment was started. These were within 7 to 8 weeks after referral.

3.36: Adolescent Eating Disorders: Routine referral to non-NICE treatment within 4 weeks

There were 2 non-compliant cases during August.

One client was offered and attended the 1st available appointment which was within 5 weeks of referral

The other case is a data quality issue as the client began treatment in July. Once RIO has been updated this record will no longer show as non-compliant in August.

3.37: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week

There were 3 non-compliant cases in August.

One client was offered an appointment within 6 days but cancelled. Treatment began at their first attended appointment which was within 13 days of referral.

One client was offered an appointment within 2 days but was away on holiday. They began treatment the day after they returned which was 9 days after referral.

The remaining case is a data entry error. The referral was triaged as not-urgent, however, recorded as urgent on RiO. This cannot be changed retrospectively due to the amount of work involved in reversing and re-entering appointments against the referral.

3.39: Adult Eating Disorders: Wait time for assessments will be 4 weeks

There were 25 non-compliant cases in August.

In one case the 1st available appointment, which was just outside of the 4 weeks, was cancelled due to staff sickness. A number of further appointments were offered but cancelled by the client and one accepted appointment was cancelled due to staff training. The client was therefore assessed at the next mutually convenient appointment which was 21 weeks after referral.

Four clients were offered the 1st available appointment but due to client cancellations the assessment waiting times are reported in the range of 9 weeks to 22 weeks.

For the remaining 20 clients, all were offered the next available appointments which were all outside of the required 4 weeks and the average wait was 7 weeks from referral.

3.40: Adult Eating Disorders: Wait time for psychological interventions will be 16 weeks
There were 2 non-compliant cases during August.

These were clinically appropriate delays in starting treatment due to the clients' physical health.

Cumulative Performance Thresholds Not being met

3.12: IAPT access rate
See above

3.14: CYP who enter a treatment programme to have a care-coordinator
The service have met with commissioners to consider current challenges within this KPI around reporting self-harm follow-up appointments and Choice plus appointments (those that require more than 1 assessment attendance). It was agreed to revise the methodology to exclude these cases from Quarter 2 onwards.

3.15: CYPs: Referral to initial appointment within 4 weeks
Work is ongoing within our service delivery team to resolve this.

3.20: Care plan audit to show all dependent children and under 18s living with adults
This is one of four targeted areas for improvement which the Trust is taking forward. Trust Service Directors continue to be given trajectories for improvement which will be monitored through the Delivery Committee. Audit results will be shared with Service Directors to help inform this improvement work.

The 2018/19 quarter 4 position was 23%, since then remedial work has been undertaken within the teams to promote the need for recording dependent children on care plans and Quarter 1 of this financial year is at 68%.

3.27: Patients with Dementia have weight assessments at weekly intervals
There were 23 cases in Quarter 1 where it was not possible to weigh the patient within 7 days of the previous weight assessment:

Excluding these from the indicator would increase performance to 83% against a threshold of 85%.

Reason for not weighing	No of patients
Patient declined	19
Bed bound/non weight bearing	3
End of life plan in place	1
Total	23

Staff are being reminded to record the date that weighing takes place and not the date the information is entered on RiO which can be day 8 and therefore indicate non-compliance.

3.35: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks
Cumulative performance is 39% against a performance threshold of 95%. Non-compliant cases for August are outlined above and non-compliant cases for previous months outlined in prior months' reports.

3.36: Adolescent Eating Disorders – Routine referral to non-NICE treatment within 4 weeks
Cumulative performance is 0% against a performance threshold of 95%. Non-compliant cases for August are outlined above and non-compliant cases for previous months outlined in prior months' reports.

3.37: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week
Cumulative performance is 60% against a performance threshold of 95%. Non-compliant cases for August are outlined above and non-compliant cases for previous months outlined in prior months' reports.

3.39: Adult Eating Disorders: Wait time for assessments will be 4 weeks
Cumulative performance is 32% against a performance threshold of 95%. Non-compliant cases for August are outlined above and non-compliant cases for previous months outlined in prior months' reports.

3.40: Adult Eating Disorders: Wait time for psychological intervention will be 16 weeks
Cumulative performance is 92% against a performance threshold of 95%. Non-compliant cases for August are outlined above and non-compliant cases for previous months are outlined in prior months' reports.

3.64: Alexandra Wellbeing House: Bed occupancy maintained at 70%:
Cumulative performance is at 41%.

Currently there is a difference in the bed day occupancy reporting method used by MIND and ourselves. We follow the NHS Data Dictionary definition that an occupied bed day is a bed that is occupied at midnight, however, MIND are including exit days as a guest can stay until late afternoon and will still be receiving support.

We have been notified that their future intention is for guests to leave in the morning and new guests to arrive the same afternoon. Our reporting methodology should then be in line.

Changes to Previously Reported Figure
None

Early Warnings/Notes
None

Note in relation to year end compliance predictions (forecast outturn)

3.15: CYPS: Referral to assessment within 4 weeks
We were below the performance threshold for 2018/19 and although work is ongoing and issues being addressed, it is too early in the period to determine whether we will be compliant by the end of the financial year.

3.27 Patients with Dementia have weight assessments at weekly intervals
We were non-compliant for 2018/19; however investigations have shown that there is a delay in recording when actual weighing took place. Once this data quality area has been addressed, performance reported will improve, however it is too early in the period to confirm that this improvement will mean the indicator is compliant.

3.35: Adolescent Eating Disorders – Routine referral to NICE treatment within 4 weeks
3.36: Adolescent Eating Disorders – Routine referral to Non-NICE treatment within 4 weeks
3.37: Adolescent Eating Disorders –Urgent referral to NICE treatment within 1 week
3.38: Adolescent Eating Disorders – Urgent referral to Non-NICE treatment within 1 week
3.39: Adult Eating Disorders: Wait time for assessments will be 4 weeks

An unexpected increase in referrals during Quarter 4 2018/19 and staff vacancies meant that we were unable to further improve performance.

Work is ongoing to look further at the pathway and understand the increase in demand. It is too early in the financial year to determine compliance.

3.48: Perinatal: Preconception advice – Referral to assessment within 8 weeks
As the appointments are for advice only, they are more susceptible to client choice of date. This and the very small numbers involved means this indicator can become non-compliant due to 1 or 2 cases. There is, therefore, a possibility of this indicator being non-compliant at the end of the financial year.

3.64: Alexandra Wellbeing House: Bed occupancy maintained at 70%:
Bed occupancy for 2018/19 was 32%; it is too early in the financial year to determine compliance.

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2018/19 outturn	June-2019	July-2019	August-2019	(Apr-Aug) Cumulative Compliance	Forecast 19/20 Outturn
3.01	Mixed Sex Accommodation	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
3.02	Zero tolerance MRSA	PM	0	0	0	0	0	0
		Unavoidable	0	0	0	0	0	
3.03	Minimise rates of Clostridium difficile	PM	0	0	0	0	<3	<3
		Unavoidable	1	0	0	0	0	
3.04	Duty of candour	PM	Report	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant	Compliant	Compliant	
3.05	2G bed occupancy for Gloucestershire CCG patients	PM	> 91%	> 91%	> 91%	> 91%	> 91%	> 91%
		Actual	95%	95%	94%	94%	95%	
3.06	Care Programme Approach: 95% of CPAs should have a record of the mental health worker who is responsible for their care	PM	95%	95%	95%	95%	95%	95%
		Actual	100%	100%	99%	100%	99%	
3.07	CPA Review - 95% of those on CPA to be reviewed within 1 month (Review within 13 months)	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	99%	99%	99%	99%	
3.08	Assessment of risk: % of those 2g service users on CPA to have a documented risk assessment	PM	95%	95%			95%	95%
		Actual	99%	99%			99%	
3.09	Assessment of risk: All 2g service users (excluding those on CPA) to have a documented risk assessment	PM	85%	85%			85%	85%
		Actual	97%	95%			95%	
3.10	Implementation of NEWS 2 methodology for assessment of acute illness severity for Adult Service users and appropriate response to NEW score	PM		100%			100%	100%
		Actual		N/A			N/A	
3.11	IAPT recovery rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%	50%
		Actual	52%	50%	51%	50%	50%	
3.12	IAPT access rate: Access to psychological therapies for adults should be improved	PM	17.00%	1.42%	1.42%	1.42%	17.00%	19.00%
		Actual	18.24%	1.43%	1.55%	1.39%	16.68%	
3.13	Number of children in crisis urgently referred that receive support within 24 hours of referral by CYPS	PM	95%	95%			95%	95%
		Actual	100%	N/A			N/A	
3.14	All children and young people who enter a treatment programme to have a care-coordinator - (Level 3 services) (CYPS)	PM	98%	98%			98%	95%
		Actual	98%	97%			97%	
3.15	95% accepted referrals receiving initial appointment within 4 weeks (excludes YOS, substance misuse, inpatient and crisis/home treatment and complex engagement) (CYPS)	PM	95%	95%			95%	95%
		Actual	84%	29%			29%	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2018/19 outturn	June-2019	July-2019	August-2019	(Apr-Aug) Cumulative Compliance	Forecast 19/20 Outturn
3.16	Service Users in vocational services will be supported to formulate their vocational goals through individual plans (IPS)	PM	98%				98%	98%
		Actual	100%				NYR	
3.17	The number of people on the caseload during the year 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%	50%
		Actual	NYA				NYR	
3.18	The number of people retaining employment at 3/6/9/12+ months (measured as a percentage of individuals placed into employment retaining employment) (IPS)	PM	50%				50%	50%
		Actual	NYA				NYR	
3.19	The number of people supported to retain employment at 3/6/9/12+ months	PM	50%				50%	50%
		Actual	NYA				NYR	
3.20	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	75%	75%			75%	75%
		Actual	23%	68%			68%	
3.21	Transition- Joint discharge/CPA review meeting within 4 weeks of adult MH services accepting :working diagnosis to be agreed, adult MH care coordinator allocated and care cluster and risk levels agreed as well as CYPS discharge date.	PM	100%	100%	100%	100%	100%	100%
		Actual	17%	100%	NA	NA	100%	
3.22	MHARS Wait time to Assessment: Emergency assessments occur within 1 hour of triage	PM	TBC	80%	80%	80%	80%	80%
		Actual	92%	100%	100%	100%	100%	
3.23	MHARS Wait time to Assessment: Urgent assessments occur within 4 hours of triage	PM	TBC	80%	80%	80%	80%	80%
		Actual	81%	100%	89%	100%	97%	
3.24	IAPT DNA rate	PM	<16%	<16%	<16%	<16%	<16%	<16%
		Actual	14%	14%	15%	16.5%	15%	
3.25	% of CYP entering treatment in CYPS have pre and post treatment outcomes and measures recorded	PM	TBC				100%	100%
		Actual	NYA				NYR	
3.26	Patients with Dementia have weight assessments on admission	PM	85%	85%			85%	85%
		Actual	79%	88%			88%	
3.27	Patients with Dementia have weight assessments at weekly intervals	PM	85%	85%			85%	85%
		Actual	73%	75%			75%	
3.28	Patients with Dementia have weight assessments near discharge	PM	85%	85%			85%	85%
		Actual	84%	90%			90%	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2018/19 outturn	June-2019	July-2019	August-2019	(Apr-Aug) Cumulative Compliance	Forecast 19/20 Outturn
3.29	Patients with Dementia have delirium screening on admission	PM	85%	85%			85%	TBC
		Actual	NYA	NYA			NYA	
3.30	Patients with Dementia have delirium screening at weekly intervals	PM	85%	85%			TBC	TBC
		Actual	NYA	NYA			NYA	
3.31	Patients with Dementia have delirium screening near discharge	PM	85%	85%			TBC	TBC
		Actual	NYA	NYA			NYA	
3.32	CPI: Referral to Assessment within 4 weeks	PM	85%	90%	90%	90%	90%	90%
		Actual	96%	94%	100%	93%	97%	
3.33	CPI: Assessment to Treatment within 16 weeks	PM	85%	90%	90%	90%	90%	90%
		Actual	97%	90%	91%	93%	92%	
3.34	Daily submission of information to inform the daily escalation level	PM	Report	Report	Report	Report	Report	Report
		Actual	N/A	N/A	N/A	N/A	N/A	
3.35	Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	PM	95%	>95%	>95%	>95%	>95%	>95%
		Actual	46%	50%	54%	17%	39%	
3.36	Adolescent Eating Disorders - Routine referral to non-NICE treatment start within 4 weeks	PM	95%	95%	95%	95%	95%	95%
		Actual	10%	0%	0%	0%	0%	
3.37	Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week	PM	95%	>95%	>95%	>95%	>95%	>95%
		Actual	73%	75%	N/A	0%	60%	
3.38	Adolescent Eating Disorders - Urgent referral to non-NICE treatment start within 1 week	PM	95%	95%	95%	95%	95%	95%
		Actual	75%	N/A	N/A	N/A	100%	
3.39	Eating Disorders - Wait time for adult assessments will be 4 weeks	PM	95%	>95%	>95%	>95%	>95%	>95%
		Actual	68%	16%	42%	29%	32%	
3.40	Eating Disorders - Wait time for adult psychological interventions will be 16 weeks	PM	95%	>95%	>95%	>95%	>95%	>95%
		Actual	62%	80%	100%	90%	92%	
3.41	LD: Patients on the LD challenging behaviour pathway have a single positive behaviour support plan (containing primary, secondary and reactive interventions) completed within 30 days of allocation to clinician (CLDTs: 60 days)	PM	Q4 95%	75%			95%	95%
		Actual	100%	100%			100%	
3.42	LD: Active involvement in Care and Treatment Reviews & Blue Light protocol meetings to prevent admission and actively support and plan for integration/discharge in the community: 100% completion of the CTR Provider Checklist prior to CTR meetings	PM		100%			100%	100%
		Actual	98%	100%			100%	
3.43	LD: Active involvement in Care and Treatment Reviews & Blue Light protocol meetings to prevent admission and actively support and plan for integration/discharge in the community: 75% CTRs being completed within 10 days of admission to Berkeley House	PM		75%			75%	75%
		Actual	N/A	N/A			N/A	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2018/19 outturn	June-2019	July-2019	August-2019	(Apr-Aug) Cumulative Compliance	Forecast 19/20 Outturn
3.44	LD: Active involvement in Care and Treatment Reviews & Blue Light protocol meetings to prevent admission and actively support and plan for integration/discharge in the community:75% CTRs being followed up	PM		75%			75%	75%
		Actual		N/A			N/A	
3.45	Perinatal: Out of hours emergencies assessed by MHARS to be discussed with the Specialist Perinatal Service the next working day	PM					95%	95%
		Actual					NYR	
3.46	Perinatal: Urgent referrals with High risk indicators (following telephone screening) will be seen with 48 working hours	PM	95%	95%			95%	95%
		Actual	83%	100%			100%	
3.47	Perinatal: Preconception advice - Referral to assessment within 6 weeks	PM	50%	50%			50%	95%
		Actual	71%	100%			100%	
3.48	Perinatal: Preconception advice - Referral to assessment within 8 weeks	PM	90%	90%			90%	90%
		Actual	82%	100%			100%	
3.49	Perinatal: Routine referral to assessment within 2 weeks	PM	50%	50%			50%	95%
		Actual	74%	73%			73%	
3.50	Perinatal: Routine referral to assessment within 6 weeks	PM	95%	95%			95%	95%
		Actual	99%	100%			100%	
3.51	Perinatal: Number of women asked if they have a carer	PM	80%	80%			80%	80%
		Actual	90%	91%			91%	
3.52	Perinatal: Number of women with a carer offered carer's assessment	PM	90%	90%			90%	90%
		Actual	93%	100%			100%	
3.53	Perinatal: all perinatal care plans to be reviewed within 3 months	PM	95%	95%			95%	95%
		Actual	NYA	NYA			NYA	
3.54	GARAS: Accepted referrals receive an initial assessment appointment within 6 weeks	PM	95%	95%			95%	95%
		Actual	NYA	NYA			NYA	
3.55	GARAS: percentage of referrals completing the course of therapy	PM	90%	90%			90%	90%
		Actual	NYA	NYA			NYA	
3.56	Adult ADHD: Wait time to assessment 18 weeks	PM		80%	80%	80%	80%	80%
		Actual		NYA	NYA	NYA	NYA	
3.57	AMHPS: Requests of MHA assessments are acknowledged within 1 working day	PM		≥ 95%	≥ 95%	≥ 95%	≥ 95%	≥ 95%
		Actual		N/A	N/A	N/A	N/A	
3.58	AMHPS: Clear plan has been developed (where there are no grounds for delay) within 24 hours of the request or MHA assessment	PM		≥ 95%	≥ 95%	≥ 95%	≥ 95%	≥ 95%
		Actual		N/A	N/A	N/A	N/A	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2018/19 outturn	June-2019	July-2019	August-2019	(Apr-Aug) Cumulative Compliance	Forecast 19/20 Outturn
3.59	S136 response time to assess overall situation within 1 hour	PM		≥ 95%	≥ 95%	≥ 95%	≥ 95%	≥ 95%
		Actual		N/A	N/A	N/A	N/A	
3.60	S136 assessment to commence within 4 hours of referral upon arrival at Place of Safety (where there are no complicating factors)	PM		≥ 95%	≥ 95%	≥ 95%	≥ 95%	≥ 95%
		Actual		N/A	N/A	N/A	N/A	
3.61	MHA assessments at Emergency departments to commence within 4 hours of being triaged by Psychiatric Liaison (subject of medical fitness)	PM		≥ 95%	≥ 95%	≥ 95%	≥ 95%	≥ 95%
		Actual		N/A	N/A	N/A	N/A	
3.62	Alexandra Wellbeing House: % of referrals responded to within 4 working days by Swindon & Gloucestershire Mind	PM		95%			95%	95%
		Actual		100%			100%	
3.63	Alexandra Wellbeing House: Service Users report improved mental wellbeing following a stay	PM		80%			80%	80%
		Actual		80%			80%	
3.64	Alexandra Wellbeing House: Bed occupancy is maintained at 70% per month	PM		70%	70%	70%	70%	70%
		Actual		36%	37%	NYA	41%	
3.65	High Intensity Case Manager - Substance Misuse: Caseload with substance misuse need to have active case management program	PM		100%	100%	100%	100%	100%
		Actual		N/A	N/A	N/A	N/A	
3.66	High Intensity Case Manager - Substance Misuse: Where appropriate to reduce length of stay	PM		TBC	TBC	TBC	TBC	TBC
		Actual		N/A	N/A	N/A	N/A	
3.67	High Intensity Case Manager - Substance Misuse: To reduce number of attendances in Emergency Department	PM		TBC	TBC	TBC	TBC	TBC
		Actual		N/A	N/A	N/A	N/A	
3.68	Compliance with Section 11 of the Children's Act 2004 (Annual Audit)	PM					95%	95%
		Actual					NYR	
3.69	Paediatric Liaison Service: Caseload with substance misuse needs to have active case management program	PM		100%	100%	100%	100%	100%
		Actual		N/A	N/A	N/A	N/A	
3.70	Paediatric Liaison Service: Where appropriate to reduce length of stay	PM		TBC			TBC	TBC
		Actual		N/A			N/A	
3.71	Paediatric Liaison Service: To reduce number of attendances in Emergency Department	PM		TBC			TBC	TBC
		Actual		N/A			N/A	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2018/19 outturn	June-2019	July-2019	August-2019	(Apr-Aug) Cumulative Compliance	Forecast 19/20 Outturn
Metrics to be agreed								
3.72	Providers and CCG to work collectively to agree metrics that facilitate safe effective and timely transfer of care for patients	PM		TBC			TBC	TBC
		Actual		N/A			N/A	
3.73	ICS partners will participate in a cross organisation group to develop local quality requirements and reporting measures for Personalised care and support planning	PM		TBC			TBC	TBC
		Actual		N/A			N/A	

Schedule 4 Specific Measures that are reported nationally

Performance Thresholds not being achieved in Month

None

Changes to Previously Reported Figures

None

Early Warnings / Notes

None

Note in relation to year end compliance predictions (forecast outturn)

2.21: No children under 18 admitted to adult inpatient wards

See note on page 10.

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

ID	Performance Measure (PM)		2018/19 Outturn	June-2019	July-2019	August-2019	(Apr - Aug) Cumulative Compliance	Forecast 19/20 Outturn
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
NHSI 1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	<3	0
		Actual	0	0	0	0	0	
NHSI 1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Actual	98%	100%	100%	98%	99%	
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	2.4%	2.6%	4.0%	2.9%	2.9%	
NHSI 1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	100%	100%	97%	99%	
NHSI 1.07	New psychosis (EI) cases treated within 2 weeks of referral	PM	53%	56%	56%	56%	56%	56%
		Actual	68%	100%	70%	80%	80%	
NHSI 1.08	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Actual	97%	99%	99%	99%	99%	
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	100%	99%	100%	99%	
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	0	0	0	Yes	0
		Actual	0	0	0	0	0	
DoH 2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0	0
		Actual	2	0	1	0	3	

DASHBOARD CATEGORY – GLOUCESTERSHIRE SOCIAL CARE

Gloucestershire Social Care				
	In month Compliance			Cumulative Compliance
	Jun	Jul	Aug	
Total Measures	12	12	12	12
	1	1	1	1
	11	11	11	11
NYA	0	0	0	0
NYR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month

4.06: Eligible service users for Social Care have a Personal Budget
After an investigation of performance it has now become apparent that the methodology we are using is outdated. Therefore the service will review the definitions and advise on reframing. We have approached our Commissioners to advise them of the situation and they support us in reworking the indicator.

Cumulative Performance Thresholds Not being met

4.06: Eligible service users for Social Care have a Personal Budget
As above

Changes to Previously Reported Figures
None

Early Warnings/Notes
None

Note in relation to year end compliance predictions (forecast outturn)

4.06: Eligible service users for Social Care have a Personal Budget
Due to the need to revise the methodology it is too early in the financial year to determine compliance.

Gloucestershire Social Care

ID	Performance Measure		2018/19 outturn	June-2019	July-2019	August-2019	(Apr-Aug) Cumulative Compliance	Forecast 19/20 Outturn
4.01	Percentage of people getting long term services, in a residential or community care reviewed/re-assessed in last year	PM	95%	95%	95%	95%	95%	95%
		Actual	100%	100%	96%	97%	97%	
4.02	Current placements aged 18-64 to residential and nursing care homes per 100,000 population	PM	13	13	13	13	13	13
		Actual	9.10	11.01	11.01	11.57	10.82	
4.03	Current placements aged 65+ to residential and nursing care homes per 100,000 population	PM	22	22	22	22	22	22
		Actual	19.45	21.23	21.23	21.98	21.73	
4.04	% of WA & OP service users on caseload asked if they have a carer	PM	80%	85%	85%	85%	85%	85%
		Actual	87%	90%	86%	90%	90%	
4.05	% of WA & OP service users on the caseload who have a carer, who have been offered a carer's assessment	PM	90%	90%	90%	90%	90%	90%
		Actual	93%	95%	95%	93%	93%	
4.06	Eligible Service Users for Social Care have a Personal Budget	PM	80%	85%	85%	85%	85%	85%
		Actual	93%	49%	49%	49%	49%	
4.07	% of eligible service users with Personal Budget receiving Direct Payments (ASCOF 1C pt2)	PM	15%	15%	15%	15%	15%	15%
		Actual	14.9%	21%	20%	20%	20%	
4.08	Adults subject to CPA in contact with secondary mental health services in settled accommodation (ASCOF 1H)	PM	80%	85%	85%	85%	85%	85%
		Actual	87%	88%	88%	88%	88%	
4.09	Adults not subject to CPA in contact with secondary mental health service in settled accommodation	PM	90%	93%	93%	93%	93%	93%
		Actual	96%	97%	96%	96%	96%	
4.10	Adults subject to CPA receiving secondary mental health service in employment (ASCOF 1F)	PM	13%	13%	13%	13%	13%	13%
		Actual	16%	16%	16%	16%	16%	
4.11	Adults not subject to CPA receiving secondary mental health service in employment	PM	20%	21%	21%	21%	21%	TBA
		Actual	23%	24%	23%	23%	23%	
4.12	Ensure that reviews of new short or long term packages take place within 12 weeks of commencement	PM	80%	80%	80%	80%	80%	80%
		Actual	85%	100%	100%	100%	100%	

DASHBOARD CATEGORY – HEREFORDSHIRE CCG CONTRACTUAL REQUIREMENTS

Herefordshire Contract				
	In month Compliance			Cumulative Compliance
	Jun	Jul	Aug	
Total Measures	19	19	19	19
	3	3	1	3
	9	8	11	9
NYA	0	0	0	0
NYR	1	1	1	1
N/A	6	7	6	6

Performance Thresholds not being achieved in Month

5.13: CYP Access: percentage of CYP in treatment against prevalence
The performance threshold for 2019/20 remains at 30% of prevalence, which equates to 973 young people accessing treatment during 2019/20. We are 115 below the anticipated number required to achieve this at the end of August.

The service is currently running with a 25% to 35% vacancy rate and has been for a while. New staff will be starting in October and it is expected that the numbers in treatment will increase.

Cumulative Performance Thresholds Not being

5.09: CYP Eating Disorders: NICE Treatment waiting time for routine referrals within 4 weeks
Cumulatively performance is 89% against a performance threshold of 95%. To date there is 1 non-compliant case in June. This was due to the client cancelling the appointment which was booked within the required 4 weeks.

5.13: CYP Access: percentage of CYP in treatment against prevalence
See above

5.15: Zero inappropriate admissions of Herefordshire patients to hospitals outside of Herefordshire and Worcestershire and 2g bed base:
There have been 2 out of area admissions to date.

Changes to Previously Reported Figures

5:03: IAPT Recovery rate.
June performance has previously been reported as just under the expected threshold and therefore non-compliant. Following a data quality review, this indicator is now reported at just above the threshold and compliant.

5.09: CYP Eating Disorders: NICE Treatment waiting time for routine referrals within 4 weeks
Previously reported as non-compliant for July due to 1 case being erroneously recorded. RiO has now been updated and performance for July is now reported as compliant.

Early Warnings / Notes

None

Note in relation to year end compliance predictions (forecast outturn)

5.13: CYP Access: percentage of CYP in treatment against prevalence
As above

5.15: Zero inappropriate admissions of Herefordshire patients to hospitals outside of Herefordshire and Worcestershire and 2g bed base:
Unfortunately the annual performance threshold is zero and as it has not been met the performance for the year will be non-compliant.

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2018/19 Outturn	June-2019	July-2019	August-2019	(Apr-Aug) Cumulative Compliance	Forecast 19/20 Outturn
5.01	Zero tolerance MRSA	Plan	0	0	0	0	0	0
		Unavoidable	0	0	0	0	0	
5.02	Minimise rates of Clostridium difficile	Plan	0	0	0	0	0	0
		Unavoidable	0	0	0	0	0	
5.03	IAPT Recovery Rate: The number of people who complete treatment who are moving to recovery	Plan	50%	50%	50%	50%	50%	50%
		Actual	53%	50%	49%	54%	51%	
5.04	IAPT Roll-out (Access Rate) - IAPT maintain number of patients entering the service against prevalence	Plan	15.00%	1.29%	1.33%	1.33%	16.00%	18.00%
		Actual	14.76%	1.14%	1.33%	1.35%	16.20%	
5.05	IAPT Roll-out (Access Rate) - IAPT LTC: patients entering the service against prevalence - commencing October 2019	Plan						2.00%
		Actual					NYR	
5.06a	Dementia Service - number of new patients aged 65 years and over receiving an assessment	Plan	540	45	45	45	225	540
		Actual	770	52	64	58	287	
5.06b	Dementia Service - total number of new patients receiving an assessment	Plan						
		Actual	818	57	66	60	300	
5.07	Patients are to be discharged from local rehab within 2 years of admission (Oak House). Based on patients on w ard at end of month.	Plan	80%	80%	80%	80%	80%	80%
		Actual	89%	100%	100%	100%	100%	
5.08	All admitted patients aged 65 years of age and over must have a completed MUST assessment	Plan	95%	95%	95%	95%	95%	95%
		Actual	98%	100%	100%	100%	100%	
5.09	CYP Eating Disorders: Treatment waiting time for routine referrals within 4 weeks - NICE treatments	Plan	95%	95%	95%	95%	95%	95%
		Actual	91%	50%	100%	100%	89%	
5.10	CYP Eating Disorders: Treatment waiting time for routine referrals within 4 weeks - non-NICE treatments	Plan	95%	95%	95%	95%	95%	95%
		Actual	N/A	N/A	N/A	N/A	N/A	
5.11	CYP Eating Disorders: Treatment waiting time for urgent referrals within 1 week - NICE treatments	Plan	95%	95%	95%	95%	95%	95%
		Actual	100%	100%	N/A	100%	100%	
5.12	CYP Eating Disorders: Treatment waiting time for urgent referrals within 1 week - non-NICE treatments	Plan	95%	95%	95%	95%	95%	95%
		Actual	100%	N/A	N/A	N/A	N/A	

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2018/19 Outturn	June-2019	July-2019	August-2019	(Apr-Aug) Cumulative Compliance	Forecast 19/20 Outturn
5.13	CYP Access: Number and percentage of CYP entering treatment (30% of prevalence)	Plan - %	100.0%	9.5%	8.5%	8.5%	54.5%	100%
		Actual %	90.5%	8.1%	8.0%	7.2%	42.7%	
		Plan - numbers	973	92	83	83	530	973
		Actual - numbers	881	79	78	70	415	
5.14	Any attendances at ED with mental health needs should have rapid access to mental health assessment within 2 hours of the MHL team being notified.	Plan	80%	80%	80%	80%	80%	80%
		Actual	93%	90%	94%	100%	93%	
5.15	Zero inappropriate admissions of Herefordshire patients to hospitals outside of Herefordshire and Worcestershire STP area / or 2g bed base	Plan	0	0	0	0	0	0
		Actual		0	1	0	2	

Herefordshire Carers Information

5.17	Working Age and Older People service users on the caseload asked if they have a carer. (Only includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan						
		Actual	87%	80%	86%	86%	86%	
5.18	Working Age and Older People service users on the caseload who have a carer who have been offered a carer's assessment. (Includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan						
		Actual	83%	83%	81%	81%	81%	
5.19	Working Age and Older People service users/carers who have accepted a carers assessment. (Only includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan						
		Actual	22%	19%	18%	18%	18%	

Performance Thresholds not being achieved in Month

None

Changes to Previously Reported Figures

None

Early Warnings / Notes

None

Note in relation to year end compliance predictions (forecast outturn)

2.21: No children under 18 admitted to adult inpatient wards

See note on page 10.

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

ID	Performance Measure (PM)		2018/19 Outturn	June-2019	July-2019	August-2019	(Apr - Aug) Cumulative Compliance	Forecast 19/20 Outturn
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
NHSI 1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	<3	0
		Actual	0	0	0	0	0	
NHSI 1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	100%	100%	100%	100%	
NHSI 1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%	95%
		Actual	98%	99%	99%	96%	97%	
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	2.3%	3.0%	4.3%	2.2%	2.0%	
NHSI 1.07	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	56%	56%	56%	56%	56%
		Actual	85%	75%	60%	100%	76%	
NHSI 1.08	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Actual	94%	99%	99%	98%	99%	
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	195%	95%	95%	95%	95%
		Actual	95%	99%	100%	99%	99%	
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
DoH 2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0	0
		Actual	3	0	0	0	1	

DASHBOARD CATEGORY – GLOUCESTERSHIRE CQUINS

Gloucestershire CQUINS				
	In month Compliance			Cumulative Compliance
	Jun	Jul	Aug	
Total Measures	5	5	5	5
🔴	0	0	0	0
🟢	0	0	0	0
NYA	0	0	0	0
NYR	5	5	5	5
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/Notes

7.02: Improved discharge follow up (within 72 hours)
This CQUIN is reportable from Quarter 3 onwards. The Trust has an internal target of 48 hours which is monitored regularly and shows good performance; therefore we are anticipating compliance of the 72 hour requirement.

7.03a: Improved Data Quality and Reporting – Day Quality Maturity Index
This CQUIN is reportable from Quarter 2 onwards. Work continues to develop local reporting and we are concentrating on those metrics that are currently below the threshold. We are anticipating that we will be compliant for Quarter 2.

7.03b: Improved Data Quality and Reporting – Interventions
This CQUIN is reportable from Quarter 3 onwards.
Staff will be able to record interventions on RiO from mid-September. The required field has been made mandatory and therefore we are expecting compliance.

7.04: IAPT – Use of Anxiety Disorder Specific Measures
This CQUIN is reportable from Quarter 2. We are compliant for Quarter 1 and therefore anticipate that we will be compliant for Quarter 2.

Gloucestershire CQUINS

ID	Performance Measure (PM)		2018/19 Outturn	June-2019	July-2019	August-2019	(Apr - Aug) Cumulative Compliance	Forecast 19/20 Outturn
	CQUIN 1							
7.01	Staff Flu vaccinations	PM		Report			Report	Report
		Actual		NYR			NYR	
	CQUIN 2							
7.02	Improved Discharge Follow Up	PM		Report			Report	Report
		Actual		NYR			NYR	
	CQUIN 3							
7.03a	Improved Data Quality and Reporting - Data Quality Maturity Index	PM		Report			Report	Report
		Actual		NYR			NYR	
7.03b	Improved Data Quality and Reporting - Interventions							
		Actual		NYR			NYR	
	CQUIN 4							
7.04	IAPT - Use of Anxiety Disorder Specific Measures	PM		Report			Report	Report
		Actual		NYR			NYR	

DASHBOARD CATEGORY – LOW SECURE CQUINS

Low Secure CQUINS				
	In month Compliance			Cumulative Compliance
	Jun	Jul	Aug	
Total Measures	1	1	1	1
	0	0	0	0
	0	0	0	0
NYA	0	0	0	0
NYR	1	1	1	1
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

Low Secure CQUINS

ID	Performance Measure (PM)		2018/19 Outturn	June-2019	July-2019	August-2019	(Apr - Jul) Cumulative Compliance	Forecast 19/20 Outturn
	CQUIN 1							
8.01	Achieving Healthy Weight in Adult Secure MH Services	PM		Report			Report	Report
		Actual		NYR			NYR	

DASHBOARD CATEGORY – HEREFORDSHIRE CQUINS

Herefordshire CQUINS				
	In month Compliance			Cumulative Compliance
	Jun	Jul	Aug	
Total Measures	8	8	8	8
🔴	0	0	0	0
🟢	3	0	0	3
NYA	0	0	0	0
NYR	5	8	8	5
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/Notes

9.03: 72 hour follow-up

This CQUIN is reportable from Quarter 3 onwards. The Trust has an internal target of 48 hours which is monitored regularly and shows good performance; therefore we are anticipating compliance of the 72 hour requirement.

9.04: Mental Health Data Quality Set

This CQUIN is reportable from Quarter 2 onwards. Work continues to develop local reporting and we are concentrating on those metrics that are currently below the threshold. We are anticipating that we will be compliant for Quarter 2.

9.05: Mental Health Data Quality Interventions

This CQUIN is reportable from Quarter 3 onwards.
Staff will be able to record interventions on RiO from mid-September. The required field has been made mandatory and therefore we are expecting compliance.

9.06: Use of Anxiety Disorder Specific Measures in IAPT

This CQUIN is reportable from Quarter 2. We are compliant for May and June and therefore anticipate that we will be compliant for Quarter 2.

Herefordshire CQUINS

ID	Performance Measure (PM)		2018/19 Outturn	June-2019	July-2019	August-2019	(Apr - Aug) Cumulative Compliance	Forecast 19/20 Outturn
7								
	CQUIN 1							
9.01	Staff Flu vaccinations	PM		Report			Report	Report
		Actual		NYR			NYR	
	CQUIN 2							
9.02a	Alcohol & Tobacco - Screening	PM	Qtr 4	Report			Qtr 1	Report
		Actual	Awarded	Compliant			Compliant	
9.02b	Alcohol & Tobacco - Tobacco Brief advice	PM	Qtr 4	Report			Qtr 1	Report
		Actual	Awarded	Compliant			Compliant	
9.02c	Alcohol & Tobacco - Alcohol Brief advice	PM	Qtr 4	Report			Qtr 1	Report
		Actual	Awarded	Compliant			Compliant	
	CQUIN 3							
9.03	72 hour follow up	PM		Report			Report	Report
		Actual		NYR			NYR	
	CQUIN 4							
9.04	Mental Health Data Quality Set	PM		Report			Report	Report
		Actual		NYR			NYR	
	CQUIN 5							
9.05	Mental Health Data Quality Interventions	PM		Report			Report	Report
		Actual		NYR			NYR	
	CQUIN 6							
9.06	Use of Anxiety Disorder Specific Measures in IAPT	PM		Report			Report	Report
		Actual		NYR			NYR	

NHS
Gloucestershire
Care Services
NHS Trust

Trust Board

Date of Meeting: **26th September 2019**

Report Title: **Quality and Performance Report**

Agenda reference Number	21
Reason for Being Heard in Confidential Session	N/A
Accountable Executive Director (AED)	Susan Field – Director of Nursing Candace Plouffe - Chief Operating Officer
Presenter (if not AED)	Candace Plouffe – Chief Operating Officer Michael Richardson – Deputy Director of Nursing
Author(s)	Susan Field – Director of Nursing Candace Plouffe - Chief Operating Officer
Committee action required	To Discuss, Note and Receive
Previously considered by	
Appendices	Appendix 1 – Quality and Performance Report August 2019 data

Executive Summary:

This report and attached appendix provides an overview of the Trust's Quality and Performance activities.

It is also intended to highlight key achievements and outlines those areas where improvements are being made or need to improve further.

Recommendations:

The Trust Board is asked:

- **Discuss**, **Note** and **Receive** the August 2019 Quality and Performance report

Related Trust Objectives	
Risk Implications	Risk issues are clearly identifed within the report
Quality/Equality Impact Assessment (QEIA) Requirements/Implications	No equality implications identified
Financial Implications	Finance implications are clearly referenced in the report
Legal/Regulatory Implications	Legal/Regulatory implications are clearly referenced in the report

Quality and Performance Report

1 Introduction and Purpose

This report summarises the key highlight and exceptions in the Trusts August 2019 Quality and Performance data.

2 Background

The Trust's Quality and Performance Committee reviewed July 2019 data at its meeting on 29th August 2019.

3 Key Areas to Note

3.1 Quality Matters

As previously reported the Trust noted that there had been a decline in the New Harms only data within Safety Thermometer. This has now been rectified and resubmitted nationally. Safety Thermometer data (August) for Harm Free Care is **93.89%** and for New Harms only **98.5%.**

3.2 Responsiveness Matters

The three key service areas in which the Trust has had challenges in offering timely services continue to be subject to in depth reviews and/or focus to improve performance against the locally set 8 week referral to treatment key performance indicator.

- *Adult Speech and Language Therapy services:*

As noted in the Quality and Performance board report, performance has continued to improve from the previous low position of 55.8% YTD performance in 18/19 to 69.7% in August. This is as a result of successful recruitment as well as focus on transforming how the service is delivered. In particular to note is that an Advanced Speech Language therapist has been recruited with a start date in January with a specific remit to lead the community service provision.

The system-wide service review is underway and anticipated to be completed by the end of October 2019. This will include both a report detailing its findings as well as a revised service specification for the community provision.

As the Board is aware, while the review is underway the commissioners have agreed to monitor access times into the service but to suspend the RAG rating of performance. Work continues however within the service to improve access as noted above.

- Musculoskeletal (MSK) Therapy services:

The Quality and Performance board subcommittee received the first iteration of the detailed review into Podiatry, including the demand and capacity analysis

Although there is further analysis work to do, this has informed the current remedial action plan with a focus on three main areas:

- Systm1 process review and redesign to improve data quality and performance reporting
- Review and redesign care pathway by speciality level to improve efficiency
- Redesign workforce plan based on demand and capacity outcome findings

In relation to MSK Physiotherapy, ongoing discussions continue with the Commissioners concerning the mismatch of demand vs capacity, noting this is a similar issue across both community MSK therapy providers.

- Integrated Community Teams therapy services:

For Occupational therapy, there has been an increase in referrals, up by 7% compared to last year. This combined with vacancies, particularly in Gloucester locality and in more junior roles (i.e. Band 5) has made impacted on the achievement of the target.

To address the demand-capacity gap, the service has secured clinicians via temporary contract and are actively seeking locums, recognising there is a further 2 years in the re-structuring of the service model to align to the revised commissioning intentions and resources available.

For Physiotherapy, the ongoing issue remains with recruitment into vacancies, with overall pressure across all localities. The service has secured locum cover and therefore improvements should continue over the next quarter.

3.3 Workforce Matters

It should be noted that for the first time for this reporting year Mandatory training compliance has shifted to green (**91.08%**). The learning and development team should be congratulated for their perseverance in promoting processes and working with operational colleagues to achieve this.

The Trusts sickness absence rates has reduced further to **4.76%.**

4 Conclusion and Recommendations

The Trust Board is asked to:

- **Discuss**, **Note** and **Receive** the August 2019 Quality and Performance report

Abbreviations Used in Report

MSK – Musculoskeletal

Gloucestershire Care Services NHS
NHS Trust

Quality & Performance Report

Trust Board
26th September 2019

Data for August 2019

Understanding you

Executive Summary

NHS Gloucestershire Care Services NHS Trust

Are Our Services Caring?

- Friends and Family Test response rate in August was **11.5%** this is reduced from **15.1%** in July.
- The proportion of patients indicating Likely or Extremely Likely to recommend our services increased in August to **94.1%** from **92.7%** in July (Apr-2017 – Aug-2019 mean **93.0%**).

Are Our Services Safe?

- Safety Thermometer Harm free score was **93.5%** in August, reduced from **94.4%** in July, target (95%), and slightly below the mean **93.89%** (Apr-2017 – Aug-2019).
- Based on new harms only, the Trust achieved harm-free care of **98.5%** in August, a slight increase from **98.4%** in July, (target 98%) (Apr-2017 – Aug-2019 mean **98.1%**).
- The Trust recorded **one Never Event** in August. This was a wrong tooth extraction carried out within the Community Dental Service.

Are our Services Effective?

- Bed Occupancy rate was **94.6%** in August, an increase from **93.4%** in July, but slightly below the mean of **94.81%** (Apr-2017 – Aug-2019).
- Target for HPV Immunisations of girls aged 12/13 in 2018/19 academic year was missed. 1st immunisation rate **89.5%** (target 90%), 2nd immunisation rate **86.5%** (target 90%). However this does represent an improvement from the 2017/18 performance of 84.4% (1st immunisation) and 87.7% (2nd immunisation).

Are Our Services Responsive?

- Performance in the '% seen and discharged within 4 hours' measure remains above the 95% target with performance of **99.3%** in August and mean of **99.14%** since April 2017.
- SPCA abandoned call rate was **1.1%** in August, and continues to be below the threshold of <5%. Calls answered within 60 seconds continues to be above the 95% target at **97.1%**.
- Referral to Treatment targets continue to prove challenging is some services. Six services are identified from Statistical Process Control charts as consistently missing the 95% within 8 weeks target (pages 16-19) continue to be a focus for improvement.
- Percentage of patients waiting less than 6 weeks from referral for a diagnostic test was **95.9%** in August compared to target (>99%) and previous performance of 100%. 3 patients were waiting longer than 6 weeks at the end of August.

Are Our Services Well Led?

- Mandatory training compliance rate was **91.08%** in August, now above the revised target of 90%.
- Sickness absence (rolling 12 months to August) reduced further to **4.76%** compared to a local target of <4%.
- **82.57%** of all staff Personal Development Reviews were completed by the end of August 2019, a very slight increase from July 2019 (**82.22%**), and highest since April 2018, but below revised target (90%). For active assignments only, the figure for August 2019 is **86.72%,** a slight reduction from July (**87.38%),** but remains below revised target (90%)**.**

Statistical Process Control (SPC) Charts

- The criteria for exception reporting in this report uses SPC charts to identify where performance falls outside of control limits, and is viewed in conjunction with RAG ratings. This report contains a number of SPC charts and is supported by a separate SPC Addendum pack that covers all measures within the Performance Dashboard (pages 12-14).

Data Quality

The Performance Dashboard (pages 12-14) includes a data quality rating for each metric. The basis of this is the Trust Reference Cost report and additional interpretation from Performance and Information team. The methodology incorporates consideration of completeness, validity and reporting methodology of activity recorded within systems used for performance reporting. However this approach does not have a statistical basis to the methodology or RAG rating. The metrics rated red are:

- % of terminations carried out within 9 weeks and 6 days of gestation – the current spreadsheet reporting tool used for medical terminations of pregnancy is subject to recording error and a plan is currently being developed to transition this onto the Clinical System used in Sexual Health. Work has been completed to ensure all data items are available to be collected on dynamic forms, and a Task and Finish Group commenced work in May 2019 to resolve all issues by end of Qtr.2 2019/20.
- Wheelchair Service metrics – data quality rated red as the service is in transition to go-live on SystmOne in September 2019. System configuration involving Service, Clinical Systems and Performance & Information teams in progress.
- SUS+ data quality – Decrease in performance in 2019/20 due to issues with submission of Emergency Care Data Set. The Trust is working with TPP to resolve configuration issues. Data will be resubmitted from April 2019 and data quality rating anticipated to return to green rating. This is expected to be complete by the end of September 2019.

Quality Priorities

Quality Priorities for 2019/20 included in this report are based on a mixture of metrics and audits. Where audits or actions are to be reported on a quarterly basis a RAG rating will be applied and updated during the quarter to provide an update of progress towards completion of actions.

Quality Priority | Are Service Safe?

1. Medication Incidents

Outcome: Improve learning from "no-harm" and "low-harm" medication incidents to enhance patient safety and quality of care

Gloucestershire Care Services NHS Trust

This priority will enable (1) identification and theming of factors contributing/causing low and no harm medication incidents and (2) recommendations to address identified themes

Improve the learning from "no-harm" and "low-harm" incidents		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Actions		Establish a baseline of quality of reporting of harm reported medication incidents using quality audits - Completed, see below.			Quality Improvement working group will establish a training needs analysis on baseline data and agree actions required to improve quality of reporting			Implementation of actions agreed from Qtr. 2			A repeat audit of harm reported medication incidents will be performed to determine if the aims of the outcome have been achieved		
Low/no harm incidents have been investigated and closed by end of each quarter	Target				45%			60%			75%		
	No-harm medication incidents	Baseline: 32%											
	Low-harm medication incidents	Baseline: 29%											
Low/no harm incidents should state the medication involved	Target				91%			95%			100%		
	No-harm medication incidents	Baseline: 87%											
	Target				80%			90%			100%		
	Low-harm medication incidents	Baseline: 71%											
Low/no harm incidents should state the indication for the medication involved	Target				33%			66%			100%		
	No-harm medication incidents	Baseline: 0%											
	Low-harm medication incidents	Baseline: 0%											

Additional information:

Performance
There were 26 medication incidents with GCS responsibility reported in August.
- 2 resulted in low harm
- 24 resulted in no harm

SPC charts show the number of medication incidents, no harm medication incidents and low harm medication incidents to be within control limits (normal variation).

Actions
Work continues to source and develop e-learning, essential for role training to support safe and secure management of medicines for colleagues.

2. Mental Capacity Act

Outcome: Improve the usage of mental capacity assessments in our hospital and community settings to ensure that individuals who lack the ability to make decisions are the focus of any decisions made, or actions taken on their behalf

Mental capacity Act and DoLS operational practice
Reference – 559
Rating – 12

The philosophy of the Mental Capacity Act 2005 (MCA) is to ensure that individuals who lack the capacity to make specific decisions are the focus of any decisions, or actions taken, on their behalf. It is a legal requirement to carry out an assessment when a person's capacity is in doubt. MCA needs to become a "business as usual" exercise, to ensure that the Trust is compliant with legislation and to achieve optimum benefits to our patients and families. Metrics will focus on the completion of the MCA2 and Deprivation of Liberty Safeguards (DoLS) assessments for significant decisions.

MCA Metrics		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Has an MCA2 been completed for restrained or restricted patients in our community hospitals? (Baseline from March 2019 audit 11%. Measured from dip test audit mid quarter)	Target	15%			30%			60%			90%		
	Actual	33%			Audit available end September 2019			Audit available end December 2019			Audit available end March 2020		
Has a deprivation of Liberty Safeguards application been made for all patients who do not have capacity to consent to being restricted or restrained? (Baseline 22% from March 2019 audit)	Target	25%			40%			60%			90%		
	Actual	33%			Audit available end September 2019			Audit available end December 2019			Audit available end March 2020		

Actions:

- Training for ward staff by Mental Health Liaison nurses planned for September and December 2019, with additional training in March 2020.

3. "Better Conversations" and Personalised Care

Outcome: Develop a programme of personalised care planning to enable patients to manage their long term conditions more effectively

NHS Gloucestershire Care Services NHS Trust

Personalised care is a priority in the Long Term Plan, with a stated objective that it should become "business as usual across the health and care system". In the ICS workforce strategy the vision is to see this facilitated by a health coaching approach, called "Better Conversations". It is noted that both the Trust's and 2G Contracts for 2019-20 include a commitment to work with the GCCG to develop "5 core measurable statements for the ICS personalised care programme that define outcomes for patients and success". This programme will directly feed in to this growing body of work.

NHSE have committed to "*consider, develop and test the most appropriate personalised care activity metrics*" including the development of a new Long Term Conditions Patient Recorded Outcomes Measure (PROM).

The Patient Activation Measure (PAM) will be a key tool in these early stages. Patient "activation" describes the knowledge, skills and confidence a person has in managing their own health and care. The concept of patient activation links to all the principles of person-centred care, and enables the delivery of personalised care that supports people to recognise and develop their own strengths and abilities. Services included will be MacMillan Next Steps, Self Management, Diabetes Education, and part of the ICTs (Complex Care at Home and Berkeley Vale ICT where health coaching training has taken place).

Actions completed:

- Meeting held with Insignia (owners of the Patient Activation Measure (PAM) along with discussions/meetings held with NHSE. We have been supported by CCG in our efforts to improve our access to PAM data and analytics. The timing of the release of PAM has not changed and NHSE have "improved" the data presentation in a way that prevents us from isolating the data by service. This prevents us reporting at service level, and it makes it difficult to identify teams behind trajectory. We are working with colleagues in CCG to resolve this before the end of Q2.

Better Conversations and Personalised Care Measures	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4
Number of care planning conversations taking place for the identified cohorts	Set by individual teams and based on relevance to patient cohort(s)	Available end September 2019	Available end December 2019	Available end March 2020
Number of patients completing a Patient Activation Measure (PAM) questionnaire	Baseline: 1,500 per annum; target + 30%	Available end September 2019	Available end December 2019	Available end March 2020
Number of patients completing a second PAM	Baseline: 500 per annum; target + 30%	Available end September 2019	Available end December 2019	Available end March 2020
The use of PAM data to tailor interventions to further the personalisation agenda	Narrative reporting - commenced June 2019 in Complex Care at Home, MacMillan Next Steps	Available end September 2019	Available end December 2019	Available end March 2020
Delivery of a quarterly qualitative report detailing ongoing developmental activities and examples of good practice, patient stories and shared learning	Linked to quarterly PAM data; most teams dependent upon CCG feed and Qtr. 1 data; delivery expected during Qtr.2.	Available end September 2019	Available end December 2019	Available end March 2020

4. Catheter Management

Outcome: Commence a Quality Improvement programme to improve the management of catheters in community settings

Gloucestershire Care Services NHS Trust

Long term catheters whilst beneficial for some patients are also associated with morbidity. Infections (including sepsis) and other complexities which include anxiety over unpredictability of catheter problems (e.g. sudden blockage), difficulties managing away from home (e.g., taking equipment on holiday), sense of physical restraint, limited clothing choices, interruptions to sleep due to discomfort or pulling, and self-identity issues.

It has been identified that some patients appear to have clinically unnecessary urinary catheters in situ; the above risks and problems can therefore impact on the safety, morbidity and quality of life of these cohorts of patients.

Catheter Management metrics	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4
Reduce the amount of community nursing contacts to patients between planned routine catheter changes to manage catheter associated problems.	Target	95% of baseline (3,705 contacts)	90% of baseline (3,510 contacts)	85% of baseline (3,315 contacts)
	Set targets for use in Qtrs. 2 to 4 Baseline: 3,900 Contacts per quarter (1,300 per month)	Available end September 2019	Available end December 2019	Available end March 2020
Reduce the number of (clinically unnecessary) urinary catheters inserted in the community setting.	Establish baseline and set targets for use in Qtrs. 2 to 4 Delay due to determining percentage of patients whose first catheter insertions were not on GCS Nurse caseloads, or may have a positive TWOC* outcome.	Audit available end September 2019	Audit available end December 2019	Audit available end March 2020

* TWOC – Trial Without Catheter to determine if clinically indicated.

Actions completed:

- A countywide continence formulary is in final stages of development between the Continence Specialist Lead, the CCG and the Head of Community Nursing. This will standardise equipment in use, identify best value for money and reduction in unwarranted variation which will help improve practice. This is now appraised by GCS and agreed.
- ICTs, Community Hospitals and the Evening & Overnight Community Nursing Services have each been asked to bring PDSA proposals for the next meeting in October to identify and commence local, small scale projects to improve catheter care in those areas.
- The SystmOne care plans in the ICT unit are now live and have a specific care plan established for catheter care – education has been provided to support colleagues in use of this
- Measuring nightly contacts in the evening and overnight service to review whether this has reduced catheter related problems. The initial scoping in May 2019 showed 39 contacts in 1 week for out of hours (excluding weekend daytime) difficulties.
- Established the learning and development offer regarding catheter (and bowel) assessment and management and this is in the process of being booked into the 2020 plans and will be available to book via ESR.

5. Wound Care

Outcome: Increase the quality of wound assessments and management countywide in order to reduce clinical variation and improve wound healing rates

NHS Gloucestershire Care Services NHS Trust

This priority builds on the 2017-2019 CQUIN which was put in place nationally following UK studies that identified inconsistencies in the assessment and management of wounds and the opportunities to improve both efficiency of working and patient outcomes.

There are two principle reasons why wound assessment has been targeted:
1. A need to improve the quality and consistency of care delivered,
2. A need to reduce the cost burden of wounds. Clinical practice and wound outcomes should ultimately improve.

The Trust has been working to improve wound care as per the 2017-19 CQUIN, performance from Qtr. 4 of year 2 of the CQUIN is used below as a baseline for the Quality Improvement.

Wound Care Metrics		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
To increase the number of patients who receive a fully compliant assessment (to the "leading change adding value" clinical assessment domains of the 2017-19 wound assessment CQUIN) on admission to Community Nursing caseloads, Complex Leg wound services, Podiatry Service or Inpatient Settings from baseline.	Target	**30%**						**40%**			**60%** by the end of Year 1 of the QI project. Metrics to be reviewed again if project goes in to Year 2		
	Actual	Audit available end September 2019						Audit available end December 2019			Audit available end March 2020		
To increase the number of patients who have received a full wound assessment according to the "leading change adding value" Clinical Assessment domains of the 2017-19 wound assessment CQUIN AND whose wounds have healed within 4 weeks.	Target	**60%**						**65%**			**70%**		
	Actual	Audit available end September 2019						Audit available end December 2019			Audit available end March 2020		

Actions completed:

A revised education offer for all aspects of wound assessment is under development – this includes all areas where wound assessment will be discussed and will be:
- A primary (core) wound assessment and tissue viability offer
- A refresher offer for wound assessment to be undertaken every 3 years for those regularly practicing
- A revised offer for primary complex leg wound assessment & management
- A refresher offer for complex leg wound assessment & management to be undertaken every 3 years for those regularly practicing
- A new offer called Specialist Tissue Viability Therapies which will cover assessment for and use of complex therapies which includes Topical Negative Pressures and larvae therapy
- A new offer called Advanced Practice Tissue Viability which will cover non-surgical debridement, exudate management, risk assessment and major on senior decision making

Pressure risk and prevention as well as management is covered in all relevant sessions.

- There is a new emollient quick formulary established which will be ratified at the November meeting
- The burns pathway is agreed and Trust policy is being updated to reflect this.
- The wound formulary exceptions form link has been recirculated to primary care and attached into G-Care next to the wound formulary.
- There is a trial in Cheltenham locality planned using images at the point of District Nursing referral from care homes for wound review. This will support triage and assessment and timely response. This is due to launch in September / October. Early engagement with the care homes is underway.
- There is work starting to asses how written information, care plans can be left in care homes to enable carers to know what is happening with their residents wounds. This will progress in Qtr.3 / Qtr.4 and will need to go to trial – likely trial in Cheltenham.

6. Pressure Ulcers

Outcome: Build on our success of reducing pressure ulcers by working with the NHSI Stop the Pressure Collaborative framework. This will focus on specific community programmes to reduce pressure ulcers

NHS Gloucestershire Care Services NHS Trust

The prevention of pressure ulcers remains one of our top priorities with regards to patient safety. Despite great strides in the past 2 years our aim will be to continue to monitor the number and incidence of pressure ulcers and to continue to drive our reduction plans forward. Metrics for measuring performance therefore are:

1. Pressure ulcers will continue to reduce across our patient facing services where our span of influence can have an impact.
2. Quality improvement methodology continues to target areas of high incidence and as a response to incident reports to understand the issues, current focus on Cotswolds, Cheltenham and Forest hospitals to showcase improvement. The PDSA cycle will report quarterly on these areas and will include a qualitative report.

Plans also include working collaboratively with GHFT and / or care homes where specific incidences or themes demonstrate the potential for system wide learning. Qualitative reporting will also include case studies where pressure ulcers have been managed and healed, following the patient journey and taking in to account other factors such as nutrition and hydration.

Pressure Ulcers		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Pressure Ulcers that develop or worsen under our care will continue to reduce across patient facing services where our span of influence can have an impact	Target (Number of avoidable acquired pressure ulcers over total pressure ulcers)	**8%** (2018-19 Q4 baseline 8.9%)			**7%**			**6%**			**5%**		
	Actual	8.6%			Audit available end September 2019			Audit available end December 2019			Audit available end March 2020		
	Number of aquired and avoidable pressure ulcers	37											
	Total number of pressure ulcers in audit	430											

Preventing Pressure Ulcers update:

- There is improved recognition of risk and increased reporting of earlier skin integrity damage. Evidence that the posture and risk management approach to education is improving patient safety.
- Community Hospitals commenced first quality improvement PDSA cycle on 2 wards across the Forest Community Hospitals and 45 clinical colleagues have taken part in the workshops.
- North Cotswolds Physiotherapy and Occupational Therapy leads are commencing 'everybody's business awareness training' (September 2019) to focus on risk assessment and posture. This approach is a result of the #stopthepressure PDSA results which highlighted training to reduce avoidable harm should focus on holistic assessment and posture management. Baselines from Datix data will be available to review the efficacy of the training.
- North Cotswolds and Cheltenham ICT's are using the training materials to support governance and learning and each locality has access to Datix reporting the locality in report format.

Risks (Pressure Ulcers)
Reference – 562 - Rating – 12

Compliance with published standards from NHS Improvement (July 2018) and NRLS (March 2019 have been achieved: Definitions of acquired and inherited have been updated on the Datix incident reporting system. This has completed the outstanding actions from the gap analysis report for the Quality and Performance Committee (July 2018): Pressure ulcer developed or worsened during care by this organisation. (previously: acquired). Pressure ulcer present before admission to this organisation. (previously: *inherited*)

Benchmarking: In the 'Rate of new grade 2,3,4 avoidable pressure ulcers acquired in a Community Hospital setting per 1,000 occupied bed days' the Trust submitted a figure of 1.06 in July. The benchmarking figure is 0.89 for Community Hospital settings.

7. Nutrition and Hydration

Outcome: Increase the use of nutrition and hydration assessments in all appropriate settings in order for patient's to be optimally nourished and hydrated

NHS Gloucestershire Care Services NHS Trust

The quality improvement group is adopting a Quality Improvement methodology and the metrics include:

- Patients will have a baseline MUST on admission to wards or clinical caseloads (the maximum time frame is 72 hours for in-patient settings or 2 visits for Integrated Community Teams - ICTs).
- An audit approach to measure performance will be used until more reliable reporting can be assured from SystmOne.
- Qualitative, quarterly reporting will also be included as part of the Quality Improvement approach (using a PDSA methodology). This will focus on reviewing samples of patients where MUST scores have triggered the need for interventions to establish whether patients are being managed appropriately and to a high quality. This will include all aspects of the patient's care such as food charts, supplements, referrals to dieticians and impacts on other aspects of care such as the prevention or healing of pressure ulcers.

Hydration will also be included, with retrospective analysis of some patients who have delirium or confusion to determine whether dehydration was a cause, in order to possibly inform future work streams and performance measures.

Nutrition and Hydration metrics 2019/20 (performance from audit data)						
Service area	Baseline		Q1	Q2	Q3	Q4
ICTs	December 2018 audit 66%	Target	65%	70%	75%	95%
		Actual	66.0%	Audit end September 2019	Audit end December 2019	Audit end March 2020
Community Hospitals	March 2019 audit 80%	Target	80%	85%	90%	95%
		Actual	91.4%	Audit end September 2019	Audit end December 2019	Audit end March 2020

Actions completed:

- Community hospitals removed from risk register due to their percentage compliance with MUST assessments

8. End of Life Care

Our aim will be to embed as "business as usual" with dedicated leadership.

End of Life Care improvements will continue to be reported during 2019/20.

- Percentage of patients on an End of Life template has not increased. Efforts are focussing on our Community teams as Community Hospitals consistently use the template in most cases.

End of life Care	Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Percentage of Community Hospital inpatients who have End of Life care recorded on SystmOne EoL template	81.0%	77.8%	100.0%	90.0%	87.5%	82.4%							
Percentage of all Trust patients who have End of Life care recorded on SystmOne EoL template	48.6%	49.3%	52.2%	52.8%	56.2%	57.9%							
Number of patients who have End of Life care recorded on SystmOne EoL template	n/a	75	83	75	82	77							
Number of patients who died in the month	n/a	152	159	142	146	133							

Actions completed:

- A review of SystmOne data is currently being undertaking to identify themes for why the EoL template is not being used more fully. From the initial review it has been agreed that the following exemption criteria would be applied – any unexpected deaths, deaths that occurred within 24 hours of admission to a service and OT/Physio services (with the exception of palliative care OTs)
- ReSPECT: GCS and 2gether Trusts are working closely together to support the countywide roll out of ReSPECT. The agreed implementation date is 10th October 2019, educational resources for colleagues will be live on the intranet later this week.
- National Audit of Care at End of Life (NACEL): GCS has now completed the collection of data and the audit is now closed. A meeting with the matrons is being held in October to review the action plan from last year's audit.
- Mortality Reviews (Stroud Community): This remains on hold due to temporary loss of support from the GP involved due to re-structuring in primary care.
- Mortality Reviews (Homeless Health Care): Initial meeting held, with the following actions identified - establish a support system for the nurses following the death of a patient (emotionally/psychologically) particularly for sudden deaths, and to understand how the lack of housing can affect the quality of care at the end of life and to identify best practice for this patient group.
- There has been an improvement in recording performance due to exclusions being applied to the cohort of patients counted for any unexpected deaths, or deaths within 24 hours of referral/admission, and patients referred to the Physiotherapy & OT services (with the exception of the Palliative Care OTs).

9. The Deteriorating Patient

Outcome: Continue to train and support front line colleagues to recognise and manage deteriorating patients to ensure that they are managed quickly and effectively

Gloucestershire Care Services NHS Trust

The metrics are:

- All patients admitted onto Trust caseloads (Community and Inpatients) will have their NEWS recorded as a baseline. This will be measured with a snapshot audit which also extracts information about deterioration, recognition of sepsis and appropriate escalation.
- The qualitative data from the snapshot) audits will establish whether rapidly deteriorating patients have been identified and escalated appropriately within the service where their care is being managed (according to the Trust policy action cards).

For some patients this will include looking to assess whether there were any challenges evident to colleagues identifying early enough that the patient was deteriorating and at risk of sepsis and to identify key issues that may be used to develop further measures for improvement. For example, this may be clinical practice such as the frequency of observations once a NEWS has raised above a certain threshold for a patient – or around ensuring the NEWS scale 2 is used is for patients who have COPD with a clinically diagnosed oxygen (O_2) deficit and therefore need prescribed oxygen (O_2) at an lower rate (88-92).

NEWS Recording Targets 2019/20 (performance from audit data)						
Service area	**Baseline**		**Q1**	**Q2**	**Q3**	**Q4**
Community Hospital In-patients	March 2019 audit 89%	Target	89%	91%	93%	95%
		Actual	92%	Monthly snapshot audits commence July, on each ward. Quarterly figure available end September 2019	Audit end December 2019	Audit end March 2020
ICTs	March 2019 audit 33%	Target	33%	40%	50%	60%
		Actual	54%	Audit end September 2019	Audit end December 2019	Audit end March 2020

Actions completed:

- Community hospitals removed from risk register due to their percentage compliance with NEWS assessments
- Quality Improvement work commenced at the end of April with North Cotswold Community Nurses using a PDSA approach to understand why the recording of NEWS was low. Subsequent mid point data had improved, however SystmOne data captured is still lower than expected. Therefore all new patients in Qtr. 2 will be audited for baseline NEWS compliance.
- Participation in National Sepsis raising awareness programmes.

10. Falls Prevention and Management

Our aim will be to embed as "business as usual" with dedicated leadership.

Gloucestershire Care Services NHS Trust

The Trust will be participating in a national CQUIN associated with falls and especially with regards to:

- Lying and standing blood pressures
- Rationale for documenting prescribed hypnotic or anxiolytic medications
- Mobility Assessments

Falls Prevention and Management	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD RAG
Quarterly national CQUIN. Percentage of patients meeting **all three** actions shown individually below:	80%		28.4%											R
CQUIN element 1: Lying and Standing Blood Pressure recorded on SystmOne at least once	80%	55.6%	51.3%	53.3%	63.3%	57.9%								R
CQUIN element 2: No hypnotics, antipsychotics or anxiolytics prescribed **or** rationale for prescribing documented	80%	100.0%	100.0%	100.0%	100.0%	100.0%								G
CQUIN element 2: Mobility assessment completed within 24 hours **or** walking aid provided within 24 hours	80%	41.5%	38.8%	50.3%	71.2%	61.6%								R
Mobility assessment completed at any time during inpatient spell	No Target	67.7%	74.5%	85.0%	95.0%	87.8%								N/A
% of those assessed where a walking aid was not required	No Target	88.2%	83.7%	87.2%	86.4%	90.2%								N/A
Post fall SWARM completed	80%	N/A	78.5%	79.4%	91.0%	93.4%								G

Actions required:

The national CQUIN identifies three key actions that should be completed as part of a comprehensive multidisciplinary falls intervention and result in fewer falls, bringing length of stay improvements and reduced treatment costs. The three key actions which must **all** be completed are:

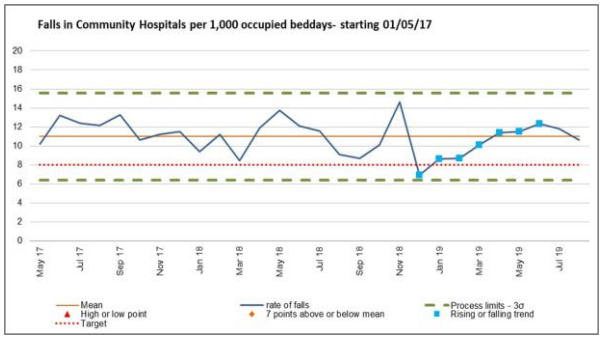
- Lying and standing blood pressure recorded.
- No hypnotics or anxiolytics prescribed OR rational documented.
- Mobility assessment completed or walking aid provided within 24 hours.

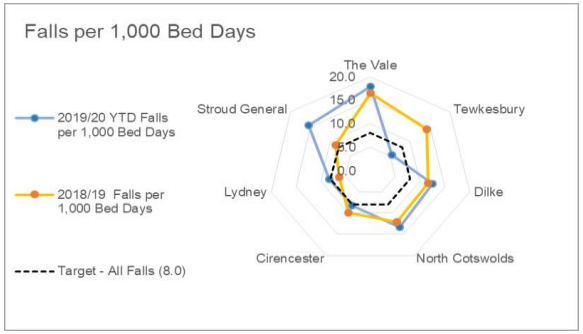
Work continuing with colleagues to ensure lying and standing BP are recorded on SystmOne at least once during admission.

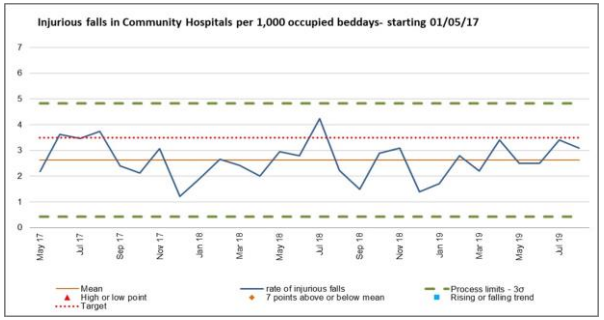
Mobility assessment in SystmOne has been moved to the 6 hour assessment template from the 48 hour assessment template.

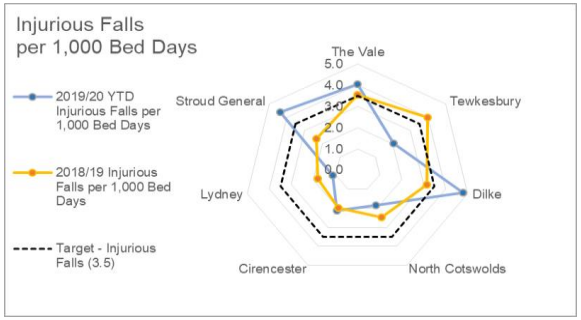
Actions completed:

- Reminder to colleagues to ensure lying and standing BP is recorded on SystmOne on admission (observations are usually recorded on the paper NEWS chart). Added box to SystmOne to enable 'not appropriate' to be selected, e.g. if patient hoisted or unwell/end of life.
- Pop-up box on e-prescribing module so that if hypnotics or anxiolytics are prescribed, the prescriber has to provide their clinical rationale – this is a mandatory field. This went live on 11th June 2019.
- Post falls SWARM completed now a mandatory field on DATIX to enable reporting. Changes made to post falls protocol to make clearer that post falls SWARM should be completed immediately after a fall. This is now being evidenced by significant improvements.









The SPC charts show all falls and injurious falls to be within control limit.

The internal target of 8 falls per 1,000 occupied bed days is close to the lower control limit and below the mean, and only achieved in December 2018 suggesting this may need to be reviewed.

74.1% of all falls reported in the year to date are **without harm.**

Radar charts show 2019/20 total falls and injurious falls per 1,000 bed days compared to 2018/19 and to target.
All units with the exception of Tewkesbury are outside of the falls per 1,000 bed days target in 2019/20.
The Vale, Dilke and Stroud are outside of the target for Injurious falls per 1,000 bed days in 2019/20.
Actions to reduce falls rates include ensuring assessments are completed, actions based on post falls SWARMs and ensuring walking aids are available.

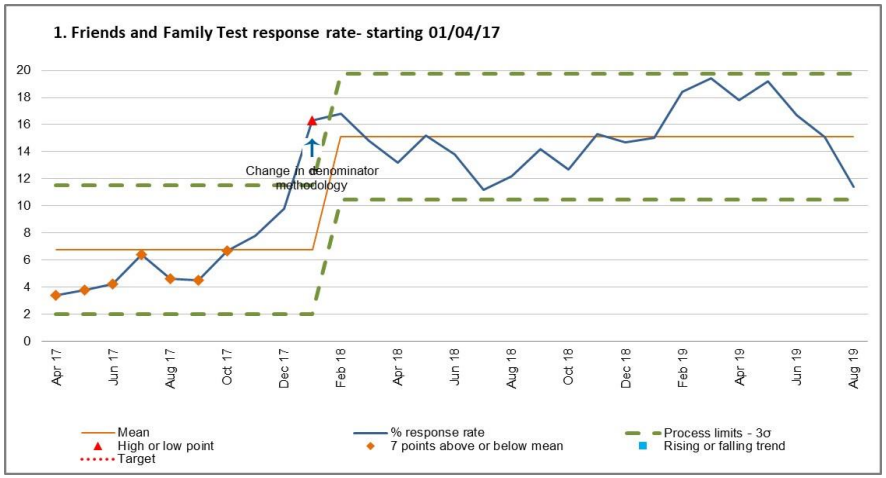
Quality | Are Services Caring?

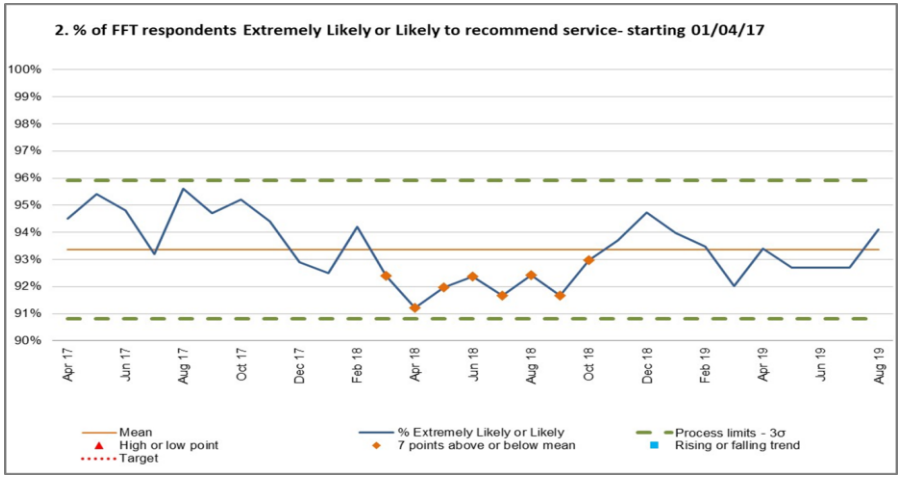
Patient Experience

Gloucestershire Care Services NHS Trust

CQC DOMAIN - ARE SERVICES CARING?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report July Figure
1	Friends and Family Test Response Rate	N - T	15%	14.5%	17.8%	19.2%	16.7%	15.1%	11.5%								16.0%		No - within SPC limits	G	
2	% of respondents indicating 'extremely likely' or 'likely' to recommend service	N - R L - I	95%	92.7%	93.4%	92.7%	92.7%	92.7%	94.1%								93.1%		No - within SPC limits	G	95.9%
3	Number of Compliments	L - R	1,317	1,317	124	104	180	178	132								718			G	
4	Number of Complaints	N - R	42	42	6	5	6	2	5								24			G	
5	Number of Concerns	L - R	485	485	40	32	23	40	34								169			G	





Additional information related to performance	What actions have been taken to improve performance?
SPC chart for response rate shows a significant decrease in rate since May 2019. The percentage of FFT respondents recommending our services increased in August following a number of constant months.	• There was a significant decrease in the overall response rate in August and this will monitored over the next few months. The largest decrease was seen in Children's Immunisation along with a decrease from Inpatient Wards. • The overall satisfaction (likelihood of recommending the service) increased to 94.1% (which is an increase from 92.7% in the previous three months).

Note: there is no formal benchmark for the level of extremely likely/likely response to the Friends and Family test, but the average from NHS Benchmarking Network for July is 95.9%.

SPC charts have also been created for Concerns, Complaints and Compliments. These charts show the following:
Concerns – Number of Concerns within normal variation since April 2017.
Complaints – Number of Complaints within normal variation with the exception of high point in November 2018 which is close to the Upper Control Limit.
Compliments – Number of Compliments above the recalculated mean and within normal variation.

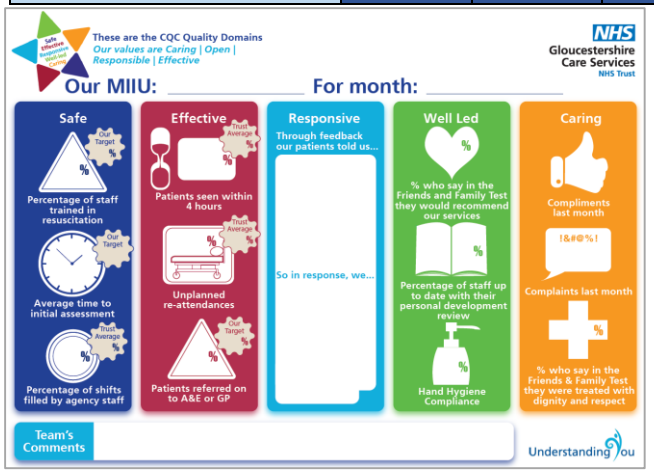
Quality | Are Services Caring?

Quality Dashboards

NHS Gloucestershire Care Services NHS Trust

Community Hospital inpatient and Minor Injury and Illness units Quality dashboards

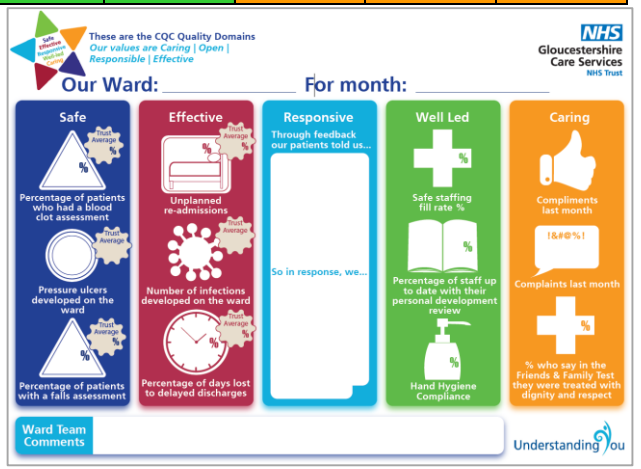
Aug-19	Safe	Safe	Safe	Effective	Effective	Effective	Well Led	Well Led	Well Led	Caring	Caring	Caring
CoHos	% Patients - Blood Clot (VTE) Assessment	Pressure Ulcers Developed (Acquired)	% Patients - Falls Assessment	% Unplanned Re-admissions (CoHo 30 Days)	Number of Infections	% Days lost to Delayed Discharges	% Safe Staffing fill rate	% Staff up to date PDR	% Hand Hygiene Compliance	Compliments	Complaints	% in FFT say treated with Dignity & Respect
Trust Average	96.1%	1	98.5%	10.5%	0	2.4%						
Cirencester - Coln Ward	100.0%	6	92.0%	16.0%	0	4.8%	100.7%	92.9%	100.0%	4	0	100.0%
Cirencester - Windrush Ward	100.0%	0	100.0%	11.5%	1	0.0%	106.8%	90.0%	100.0%	2	0	100.0%
Dilke - Forest Ward	96.7%	0	96.9%	5.9%	0	2.4%	97.4%	93.0%	100.0%	27	0	100.0%
Lydney	90.0%	1	100.0%	9.5%	0	0.7%	97.4%	85.4%	100.0%	13	0	88.0%
North Cots - Cotswold View Ward	96.0%	0	100.0%	8.0%	0	1.8%	100.1%	87.5%	100.0%	1	0	100.0%
Stroud - Cashes Green Ward	100.0%	0	100.0%	4.8%	0	4.4%	98.6%	80.0%	N/A	4	0	86.0%
Stroud - Jubilee Ward	95.2%	0	100.0%	9.5%	0	4.4%	100.3%	82.8%	90.0%	3	0	Not Available
Tewkesbury - Abbey View Ward	82.4%	0	100.0%	22.2%	0	3.8%	105.1%	83.1%	95.0%	0	0	71.0%
Vale	100.0%	0	100.0%	11.1%	0	0.0%	102.2%	87.0%	100.0%	2	0	100.0%
Winchcombe	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
MIIUs	% Staff Trained in Resuscitation (Target: 92%)	Average Time to Initial Assessment (Target: 15 min)	% of shifts filled by agency staff	% Patients seen within 4 hours	% Unplanned Reattendances	% Referred on to A&E or GP (Target: 4.4%)	% Who say in the FFT they would recommend our services	% Staff up to date PDR	% Hand Hygiene Compliance	Compliments	Complaints	% in FFT say treated with Dignity & Respect
Trust Average			2.5%	99.3%	1.1%							
Cirencester MIIU	100.0%	11	1.0%	99.5%	1.2%	Not available	96.8%	60.0%	100.0%	2	0	93.0%
Dilke MIIU	100.0%	12	3.3%	98.7%	0.5%	Not available	81.1%	80.0%	N/A	1	0	90.0%
Lydney MIIU	100.0%	12	3.3%	99.2%	1.5%	Not available	96.6%	100.0%	100.0%	1	0	94.0%
NCH MIIU	100.0%	8	0.0%	100.0%	1.9%	Not available	96.3%	100.0%	100.0%	0	0	97.0%
Stroud MIIU	100.0%	12	6.9%	99.0%	0.3%	Not available	94.5%	82.4%	100.0%	0	0	93.0%
Tewkesbury MIIU	100.0%	8	2.2%	99.3%	1.2%	Not available	89.9%	83.3%	100.0%	1	1	92.0%
Vale MIIU	100.0%	10	3.2%	99.6%	1.9%	Not available	95.9%	88.9%	100.0%	0	0	98.0%



The Trust compiles a quality dashboard covering the Community Hospital Inpatient and Minor Injury and Illness units, updated on a monthly basis and displayed within each of the units.

The dashboard includes measures from the Safe, Effective, Well Lead and Caring domains.

The table above illustrates the data for August 2019 and compares each of the units with the Trust average. The data is copied onto posters which are visible in public areas (examples shown on this slide).



Performance Dashboard

NHS Gloucestershire Care Services NHS Trust

CQC DOMAIN - ARE SERVICES CARING?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report July Figure
1	Friends and Family Test Response Rate	N - T	15%	14.5%	17.8%	19.2%	16.7%	15.1%	11.5%								16.1%		No - within SPC limits	G	
2	% of respondents indicating 'extremely likely' or 'likely' to recommend service	N - R L - I	95%	92.7%	93.4%	92.7%	92.7%	92.7%	94.1%								93.1%		No - within SPC limits	G	95.9%
3	Number of Compliments	L - R	1,317	1,317	124	104	180	178	132								718			G	
4	Number of Complaints	N - R	42	42	6	5	6	2	5								24			G	
5	Number of Concerns	L - R	485	485	40	32	23	40	34								169			G	

CQC DOMAIN - ARE SERVICES SAFE?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report July Figure
6	Number of Never Events	N - R		0	0	0	0	0	1								1			G	
7	Number of Serious Incidents Requiring Investigation (SIRI)	N - R		11	0	2	3	0	0								5			G	
8	Number of Serious Incidents Requiring Investigation (SIRI) where Medication errors caused serious harm	N - R		0	0	0	0	0	0								0			G	
9	Total number of incidents reported	L - R		4,443	398	410	342	424	371								1,945			G	
10	% incidents resulting in low or no harm	L - R		96.4%	97.2%	95.1%	94.4%	95.5%	95.7%								95.6%			G	
11	% incidents resulting in moderate harm, severe harm or death	L - R		3.6%	2.8%	4.9%	5.6%	4.5%	4.3%								4.4%			G	
12	% falls incidents resulting in moderate, severe harm or death	L - R		1.8%	3.1%	3.1%	2.9%	0.0%	0.0%								1.8%			G	
13	% medication errors resulting in moderate, severe harm or death	L - R		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%								0.0%			G	
14	Number of post 48 hour Clostridium Difficile Infections	N - R L - C	1*	15	0	0	1	1	1								3	G		G	
15	Number of MRSA bacteraemias	N - R L - C	0	0	0	0	0	0	0								0	G		G	
16	Number of MSSA Infections	L - R	0	0	0	0	0	0	0								0			G	
17	Number of E.Coli Bloodstream Infections	L - R	0	2	0	0	0	0	0								0			G	
18	Safer Staffing Fill Rate - Community Hospitals	N - R		100.2%	102.0%	100.7%	101.3%	99.7%	100.8%								100.9%			G	
19	VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	96.9%	99.5%	98.9%	97.0%	95.5%	96.1%								97.4%	G		G	
20	Safety Thermometer - % Harm Free	N - R L - C	95%	93.7%	94.3%	92.6%	93.4%	94.4%	93.5%								93.6%	R	Pg. 15	A	
21	Safety Thermometer - % Harm Free (New Harms only)	L - I	98%	98.1%	98.3%	98.1%	98.4%	98.4%	98.5%								98.3%	G		A	97.0%
22	Total number of Acquired pressure ulcers	L - R		728	79	63	56	64	60								322			G	
23	Total number of grades 1 & 2 Acquired pressure ulcers	L - R		671	74	59	60	59	56								308			G	
24	Number of grade 3 Acquired pressure ulcers	L - R		52	5	4	3	4	4								20			G	
25	Number of grade 4 Acquired pressure ulcers	L - R		5	0	0	0	1	0								1			G	

*In-month threshold (i.e. August)

N - T	National measure/standard with target	L – I	Locally agreed measure for the Trust (internal target)
N - R	Nationally reported measure but without a formal target	L – R	Locally reported (no target/threshold) agreed
L – C	Locally contracted measure (target/threshold agreed with GCCG)	N – R/L – C	Measure that is treated differently at national and local level, e.g. nationally reported/local target

RAG Key: R – Red, A – Amber, G - Green

Performance Dashboard

NHS Gloucestershire Care Services NHS Trust

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report July Figure
CQC DOMAIN - ARE SERVICES EFFECTIVE?																					
Community Hospitals																					
26	Re-admission within 30 days of discharge following a non-elective admission**	N - R		8.2%	9.5%	11.6%	6.9%	9.8%	10.5%								9.5%			G	
27	Inpatients - Average Length of Stay	L - R		27.7	30.5	29.9	27.9	30.6	28.6								29.5			G	26.1
28	Bed Occupancy - Community Hospitals	L - C	92%	93.6%	94.1%	93.4%	95.0%	93.4%	94.6%								94.1%	A		A	89.7%
29	% of direct admissions to community hospitals	L - R		19.3%	18.9%	12.6%	10.4%	16.1%	7.7%								13.1%			G	
30	Delayed Transfers of Care (average number of patients each month)	L - R		2	2	2	3	3	2								2			A	
31	Bed days lost due to delayed discharge as percentage of total beddays	L - R	<3.5%	1.4%	1.5%	1.6%	2.7%	2.0%	2.4%								2.0%	G		A	9.9%
Childrens Services - Immunisations				2017/18 Academic Year	Academic Year 2018/19					Academic Year 2019/20											
31a	HPV Immunisation coverage for girls aged 12/13 years old (2nd Immunisation)	N - T	90%*	84.4%	84.5%	84.8%	85.1%	85.2%	86.5%								86.5%	A	Pg. 17	G	
31b	HPV Immunisation coverage for girls aged 12/13 years old (1st Immunisation)	N - T	90%*	87.7%	87.9%	88.3%	88.7%	88.9%	89.5%								89.5%	A	Pg. 17	G	
Childrens Services - National Childhod Measurement Programme																					
31c	Percentage of children in Reception Year with height and weight recorded	N - T	95%*	96.7%	84.8%	91.2%	96.5%	97.7%	97.7%								97.7%	G		G	
31d	Percentage of children in Year 6 with height and weight recorded	N - T	95%*	97.0%	89.6%	92.1%	95.9%	97.2%	97.2%								97.2%	G		G	
CQC DOMAIN - ARE SERVICES RESPONSIVE?																					
Minor Injury and Illness Units																					
32	MIIU % seen and discharged within 4 Hours	N - T	95%	99.0%	99.1%	98.9%	99.5%	98.8%	99.3%								99.1%	G		G	
33	MIIU Number of breaches of 4 hour target	L - R		828	59	75	30	95	50								309			G	
34	Total time spent in MIIU less than 4 hours (95th percentile)	L - I	<4hrs	02:58	03:07	03:01	02:46	03:06	02:49								02:57	G		G	
35	MIIU - Time to treatment in department (median)	L - I	<60 m	00:34	00:34	00:35	00:31	00:36	00:24								00:34	G		G	
36	MIIU - Unplanned re-attendance rate within 7 days	L - C	<5%	0.9%	0.4%	1.5%	1.5%	1.3%	1.1%								1.2%	G		G	
37	MIIU - % of patients who left department without being seen	L - C	<5%	3.9%	4.3%	4.9%	3.9%	4.2%	4.3%								4.3%	G		A	
38	Time to initial assessment for patients arriving by ambulance (95th percentile)	N - T	<15 m	00:20	00:14	00:12	00:13	00:14	00:13								00:13	G		A	
39	Trolley waits in the MIU must not be longer than 12 hours	N - T	< 12 hrs	0	0	0	0	0	0								0	G		G	
Referral to Treatment																					
40	Adult Speech and Language Therapy - % treated within 8 Weeks	L - C	#	55.8%	69.4%	56.3%	53.6%	63.8%	69.7%								62.1%			A	
41	Podiatry - % treated within 8 Weeks	L - C	95%	97.2%	88.8%	81.2%	76.5%	82.1%	75.2%								81.0%	R	Pg. 17	A	
42	MSKAPS Service - % treated within 8 Weeks	L - C	95%	96.5%	92.4%	87.7%	96.4%	95.1%	90.7%								92.5%	A		A	
43	MSK Physiotherapy - % treated within 8 Weeks	L - C	95%	89.7%	80.4%	69.1%	65.6%	64.1%	68.1%								69.3%	R	Pg. 18	G	
44	ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	82.8%	81.0%	81.9%	79.8%	80.7%	83.1%								81.3%	R	Pg. 18	A	
45	ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	75.5%	82.6%	83.7%	81.4%	84.6%	85.2%								83.6%	R	Pg. 18	A	
46	Diabetes Nursing - % treated within 8 Weeks	L - C	95%	93.5%	100.0%	97.2%	97.0%	95.8%	97.6%								97.3%	G		A	
47	Bone Health Service - % treated within 8 Weeks	L - C	95%	99.1%	99.4%	99.4%	100.0%	99.5%	100.0%								99.6%	G		A	
48	Contraception Service and Sexual Health- % treated within 8 Weeks	L - C	95%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%								100.0%			G	
49	HIV Service - % treated within 8 Weeks	L - C	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%								100.0%	G		G	
50	Psychosexual Service - % treated within 8 Weeks	L - C	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%								100.0%			G	
51	Sexual Health - % of terminations carried out within 9 weeks and 6 days of gestation	L - C	70%	77.6%	78.4%	86.3%	89.0%	88.7%	82.2%								84.8%	G		R	
52	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	97.5%	90.9%	90.9%	67.3%	86.9%	93.0%								86.0%	R	Pg. 19	G	
53	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	91.9%	87.2%	86.5%	90.4%	89.0%	85.8%								87.7%	R	Pg. 19	G	
54	Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	95.7%	97.9%	91.5%	91.7%	94.2%	97.1%								94.2%	A		A	

** I.e. Admission to a GCS hospital within 30 days of the end of a previous GCS hospital spell. *In-month threshold (i.e. August)

Adult Speech and Language Therapy RAG rating and target temporarily removed following discussion with Commissioners.

RAG Key: R – Red, A – Amber, G - Green

Performance Dashboard

NHS Gloucestershire Care Services NHS Trust

CQC DOMAIN - ARE SERVICES RESPONSIVE?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report July Figure
55	MSKAPS Service - % of referrals referred on to secondary care	L - C	<30%	15.9%	18.3%	14.2%	18.0%	13.2%	3.2%								13.7%	G		A	
56	MSKAPS Service - Patients referred to secondary care within 2 days of decision to refer onwards	L - C	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%								100.0%	G		A	
58	Stroke ESD - Proportion of new patients assessed within 2 days of notification	L - C	95%	84.3%	100.0%	97.1%	100.0%	89.7%	90.3%								94.9%	A		A	
59	Stroke ESD - Proportion of patients discharged within 6 weeks	L - C	95%	97.0%	97.1%	84.6%	100.0%	93.8%	94.4%								94.2%	A		A	
60	Social Care ICT - % of Referrals resolved at Referral Centres and closed	L - C		48.8%	46.8%	50.4%	50.8%	48.3%	47.5%								48.8%			A	
63	Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R		39,348	2,975	3,045	3,048	3,033	3,007								15,108			G	
64	SPCA % of calls abandoned	L - C	<5%	1.4%	0.9%	0.5%	0.9%	0.7%	1.1%								0.8%	G		G	
65	95% of priority 1 & 2 calls answered within 60 seconds after introductory message finishing	L - C	95%	97.2%	97.9%	98.5%	98.0%	98.1%	97.1%								98.1%	G		G	
66	Rapid Response - Number of referrals	L - C	*1,550	3,905	346	318	333	356	329								1,682	G		A	
67	Wheelchair Service. Adults: New referrals assessed within 8 weeks	L - C	90%	26.9%	4.5%	23.1%	7.1%	40.9%	35.7%								22.4%			R	
68	Wheelchair Service. Adults: Priority Referrals seen within 5 working days	L - C	95%	20.0%	100.0%	0.0%	No priority Assessments	No priority Assessments	0.0%								25.0%			R	
69	Wheelchair Service. Under 18s: New referrals assessed within 8 weeks	L - C	90%	35.3%	50.0%	50.0%	50.0%	33.3%	0.0%								40.0%			R	
70	Wheelchair Service. Under 18s: Priority Referrals seen within 5 working days	L - C	95%	75.0%	No priority Assessments	No priority Assessments	No priority Assessments	No priority Assessments	No priority Assessments								No priority Assessments			R	
71	Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral	L - C	92%	31.8%	No Deliveries	100.0%	100.0%	0.0%	0.0%								33.3%			R	
72	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	N - T	>99%	100.0%	100.0%	100.0%	100.0%	100.0%	95.9%								99.0%	G	Pg. 19	G	
Cancelled operations																					
73	No urgent operation should be cancelled for a second time	N - T	0	0	0	0	0	0	0								0	G		G	
74	Number of patients who have had operations cancelled for non-clinical reasons that have not been offered another binding date within 28 days	N - T	0	0	0	0	0	0	0								0	G		G	

CQC DOMAIN - ARE SERVICES WELL LED?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report July Figure
75	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place of work	N - R L - T	61%	58.5%			52.00%										52.00%	R	Pg.20	G	
76	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place to receive treatment	N - R L - T	67%	84.6%			83.0%										83.0%	G		G	
77	Mandatory Training	L - I	90%	85.90%	85.8%	86.62%	86.71%	86.40%	91.08%								87.32%	A	Pg. 20	A	89.4%
78	% of Staff with completed Personal Development Reviews (Appraisal)	L - I	90%	77.1%	76.42%	77.72%	79.42%	82.22%	82.57%								79.67%	R	Pg. 21	A	82.2%
78a	% of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only	L - I	90%	81.4%	81.24%	82.54%	85.35%	87.38%	86.72%								84.65%	R	Pg. 21	A	
79	Sickness absence average % rolling rate - 12 months	L - I	<4%	4.8%	4.90%	4.87%	4.82%	4.80%	4.76%								4.83%	A	Pg. 21	A	4.7%
80	SUS+ (Secondary Uses Service) Data Quality Validity - Available in arrears	N-R	96.7%	99.1%	74.30%	74.30%	84.60%	₸	₸								84.60%	R	Pg. 19	R	

Wheelchair Service RAG rating removed following discussion with Commissioners.

* Threshold is for cumulative referrals to August

₸ Month 4 data quality dashboards are not yet available from NHS Digital.

RAG Key: R – Red, A – Amber, G - Green

Exception Report | Are Services Safe?

Safety Thermometer

NHS Gloucestershire Care Services NHS Trust

CQC DOMAIN - ARE SERVICES SAFE? RAG Key: R – Red, A – Amber, G - Green

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report July Figure
20	Safety Thermometer - % Harm Free	N - R L - C	95%	93.7%	94.3%	92.6%	93.4%	94.4%	93.5%								93.6%	R	Pg. 15	A	
21	Safety Thermometer - % Harm Free (New Harms only)	L - I	98%	98.1%	98.3%	98.1%	98.4%	98.4%	98.5%								98.3%	G		A	97.0%

Additional information related to performance

- The overall sample number has decreased from 639 in July to 522 in August.
- Harm free care remains below target at **93.5%** in August.

What actions have been taken to improve performance?

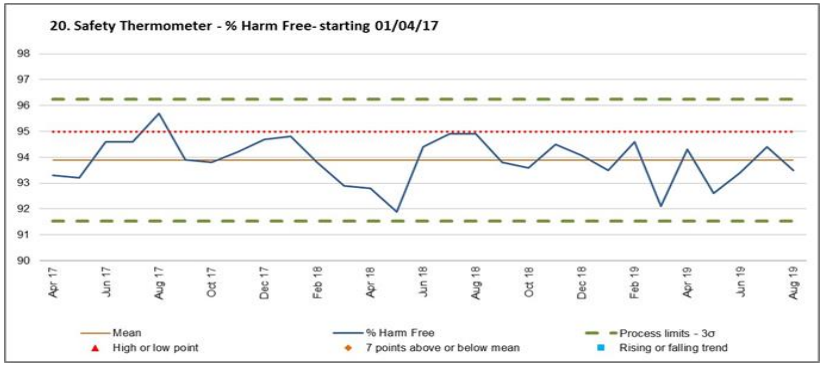
- Quality Improvement projects are being planned or currently underway to build on the success of reducing pressure ulcers over the past year which will align with our quality priorities for 2019-20.

There are three Quality Improvement projects currently in progress:

- North Cotswold ICT community nursing.
- Forest Community Hospitals.
- Alongside AHP's 'Everybody's Business' training on risk assessment & posture management. Project will focus on prevention of pressure ulcers by identifying those at risk across AHP professions. This has previously been highlighted as an issue.

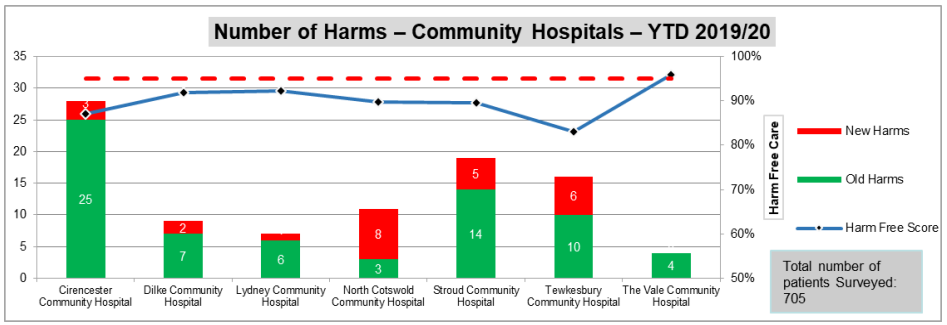
Risks
Pressure Ulcers
Reference – 562
Rating – 12

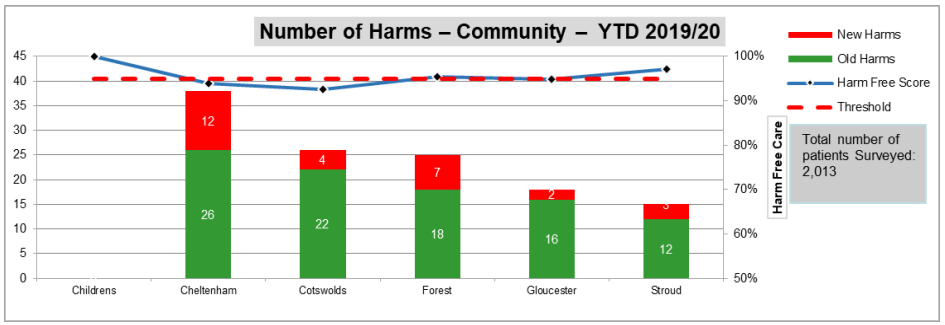
- **Benchmarking:** In the 'Safety Thermometer – Percentage of 'Harm Free Care (New Harms Only)' measure, the Trust submitted a figure of 98.4% in July. The benchmark is 97.0% for July.



Safety Thermometer Harm Free Care within normal variation. However target consistently missed.

SPC Charts have been reviewed for other harms: VTE harms fluctuate above and below the mean – but remain within control limits and are very low numbers. UTI / Catheter harms show a steady reduction over the period. Falls resulting in harm fluctuate above and below the mean – but remain within control limits and are very low numbers. Pressure Ulcers show a sequence of 9 consecutive points below the mean 2 out of the last 5 months are above the mean.





Exception Report | Are Services Responsive?

NHS Gloucestershire Care Services NHS Trust

8 Week Referral to Treatment (RTT) Measures

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report July Figure
CQC DOMAIN - ARE SERVICES EFFECTIVE?																					
CQC DOMAIN - ARE SERVICES RESPONSIVE?																					
Referral to Treatment																					
41	Podiatry - % treated within 8 Weeks	L - C	95%	97.2%	88.8%	81.2%	76.5%	82.1%	75.2%								81.0%	R	Pg. 17	A	
43	MSK Physiotherapy - % treated within 8 Weeks	L - C	95%	89.7%	80.4%	69.1%	65.6%	64.1%	68.1%								69.3%	R	Pg. 18	G	
44	ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	82.8%	81.0%	81.9%	79.8%	80.7%	83.1%								81.3%	R	Pg. 18	A	
45	ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	75.5%	82.6%	83.7%	81.4%	84.6%	85.2%								83.6%	R	Pg. 18	A	
52	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	97.5%	90.9%	90.9%	67.3%	86.9%	93.0%								86.0%	R	Pg. 19	G	
53	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	91.9%	87.2%	86.5%	90.4%	89.0%	85.8%								87.7%	R	Pg. 19	G	

Referral to Treatment – comparison between local 8 week standard and 18 week target

	8 week RTT target	% seen within 8 weeks	RAG	Number seen within 8 weeks	Number seen above 8 weeks	18 week RTT target	% seen within 18 weeks	RAG	Number seen within 18 weeks	Number seen above 18 weeks	Median RTT in days
Podiatry	95%	75.2%	R	473	156	92%	100.0%	G	629	0	48
MSK Physiotherapy	95%	68.1%	R	924	433	92%	99.9%	G	1355	2	38
ICT Physiotherapy	95%	83.1%	R	319	65	92%	96.1%	G	369	15	19
ICT Occupational Therapy Services	95%	85.2%	R	381	66	92%	97.1%	G	434	13	19
Paediatric Speech and Language Therapy	95%	93.0%	A	172	13	92%	100.0%	G	185	0	30
Paediatric Physiotherapy	95%	85.8%	R	217	36	92%	100.0%	G	253	0	2

RAG Key: R – Red, A – Amber, G - Green

Gloucestershire Care Services NHS Trust

Additional information related to performance

HPV Immunisations

Performance

- 2nd Immunisation (Dashboard ref. 31a, year 9) **86.5%** in August (90% threshold) compared to 84.4% in 17/18 academic year.
- 1st Immunisation (Dashboard ref. 31b, year 8) **89.5%** in August (90% threshold) compared to 87.7% in 17/18 academic year.

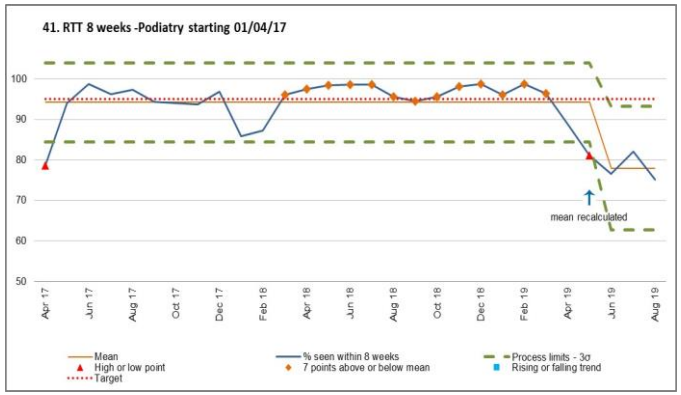
Actions

- Year 9 HPV (2nd immunisation) impacted by 1st dose performance in 2018/19 of 87.7%. This consequently limited the cohort number available for a 2nd immunisation in 2019/20 making target challenging for this year.
- All families who have not yet responded to the offer have been individually contacted by the team to enable a discussion regarding the benefits of the immunisation. Follow up and catch up clinic offers will continue with this group of young people even though outside of academic year performance cohort.

Podiatry (95% to be treated within 8 weeks)

Performance

- **75.2%** in July compared to **82.1%** in July
- 156 out of 629 patients were seen outside the 8 week threshold.
- 18 week target performance was 100%
- SPC chart shows performance continues to decline. The mean has been recalculated. Target missed since March 2019. Upper control limit now below target and target therefore not likely to be achieved.



Actions

- The Quality and Performance board subcommittee received the first iteration of the detailed review into Podiatry, including the demand and capacity analysis.

With further analysis work to do, this has informed the current action plan with a focus on three main areas:

- SystmOne process review and redesign to improve data quality and performance reporting.
- Review and redesign care pathway by speciality level to improve efficiency.
- Redesigned workforce plan based on demand and capacity outcome findings.

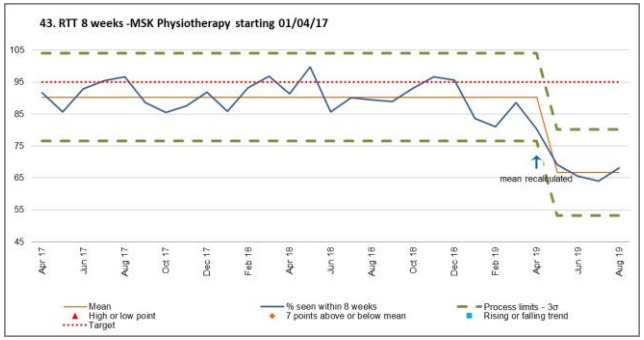
NHS Gloucestershire Care Services NHS Trust

Additional information related to performance

MSK Physiotherapy (95% to be treated within 8 weeks)

Performance

- **68.1%** in August compared to **64.1%** in July.
- 433 out of 1,357 patients were seen outside the 8 week threshold.
- 18 week target performance was 99.9% (2 out of 1,357 patients seen outside the 18 week threshold)
- SPC chart shows performance continues to be significantly below target. The mean has been recalculated. Upper control limit now below target and therefore target not likely to be achieved.



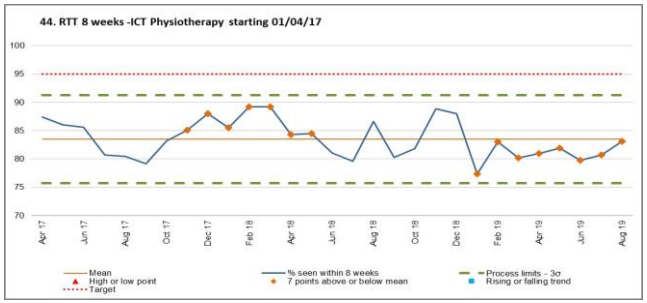
Actions

- Ongoing discussions continue with the Commissioners concerning the mismatch of demand versus capacity, noting this is a similar issue across both community MSK therapy providers.

Adult ICT Physiotherapy (95% to be treated within 8 weeks)

Performance

- **83.1%** in August compared to **80.7%** in July.
- 65 out of 384 patients were seen outside the 8 week threshold.
- 18 week target performance was 96.1% (15 out of 384 patients seen outside the18 week threshold).
- SPC chart shows performance to be within control limits but target to be above the upper control limit and therefore target not likely to be achieved.



Actions

- In the first 5 months of 2019/20, the Physiotherapy service saw 64.2% of people within 4 weeks of referral. 95% of people seen year to date were seen within 16-17 weeks.
- When we include the activity in the referral centre, performance against the contracted KPI of 95% of people seen within 8 weeks of referral increases to 86.1%.
- Ongoing issue with vacancy recruitment, with overall pressure across all localities. Locum cover secured and therefore improvements should continue over the next quarter.

Adult ICT Occupational Therapy (95% to be treated within 8 weeks)

Performance

- **85.2%** in August compared to **84.6%** in July.
- 66 out of 447 patients were seen outside the 8 week threshold.
- 18 week target performance was 97.1% (13 out of 447 patients seen outside the18 week threshold).
- SPC chart shows performance to be within control limits but target to be above the upper control limit and therefore target not likely to be achieved.

Actions

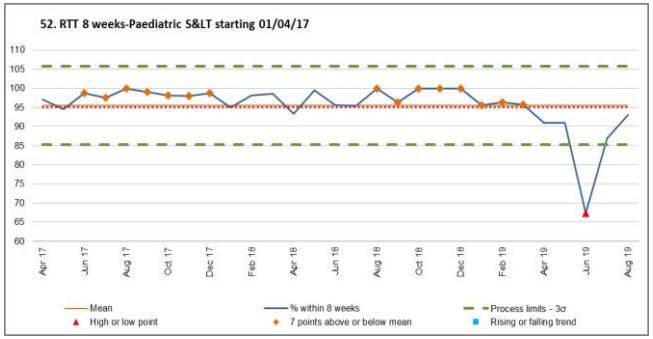
- In the first 5 months of 2019/20, the OT service saw 66.5% of people within 4 weeks of referral. 95% of people seen year to date were seen within 13-14 weeks.
- When we include the activity in the referral centre, performance against the contracted KPI of 95% of people seen within 8 weeks of referral increases to 91.8%.
- 7% increase in referrals compared to last year. Vacancies, particularly in Gloucester locality and in more junior roles (i.e. Band 5) have also impacted on target achievement.
- Service has secured clinicians via temporary contract and are actively seeking locums, recognising there is a further 2 years in the re-structuring of the service model to align to the revised commissioning intentions and resources available.

Gloucestershire Care Services NHS Trust

Additional information related to performance

Paediatric Speech and Language Therapy (95% to be treated within 8 weeks)

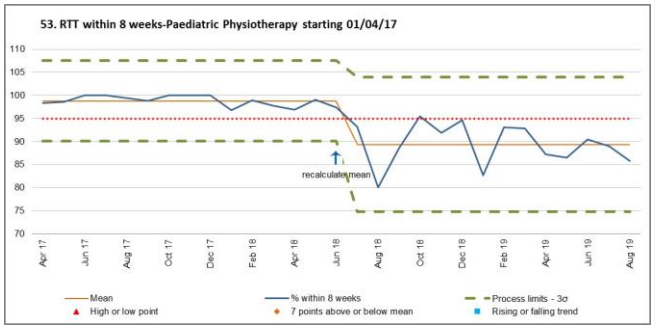
Performance
- **93.0%** in August compared to **86.9%** in July.
- 13 out of 185 patients were seen outside the 8 week threshold.
- 18 week target performance was 100%.
- SPC chart shows performance to be within control limits until June 2019 when performance was below the lower control limit. This is now recovering.



Actions:
- Good recovery of performance this month.
- Established additional clinic space within children's centre following fire at Rikenel.
- Band 5 WTE vacant post has been appointed to with additional capacity in place over the next quarter.
- Exploring the option of extending drop-in sessions to mainstream children.

Paediatric Physiotherapy (95% to be treated within 8 weeks)

Performance
- **85.5%** in August compared to **89.0%** in July.
- 36 out of 253 patients were seen outside the 8 week threshold.
- 18 week target performance was 100%.
- SPC chart shows performance to be within control limits but below the sustained performance when target was achieved between April 2017 and June 2018.



Actions
- Internal recovery action plan, monitored by Service lead and clinician actions reviewed in supervision
- Induction of 2 new WTEs with anticipated additional capacity coming on line over next 2 months
- 1 remaining vacancy, recruited to and new therapist to start in November.
- Service working with Performance & Information team to create Demand and Capacity model.

Percentage of patients waiting less than 6 weeks from referral for a diagnostic test – Heart Failure Echo-cardiograph

Performance
- **95.9%** in August compared to **100%** in July.
- 3 out of 74 waiting longer than 6 weeks at end of August.

- There are ongoing discussions with GHFT regarding the Echo contract. Several clinics were cancelled by GHFT in July and August meaning there was not sufficient clinic capacity and patients could not be seen within the timeframe.

SUS+ (Secondary Uses Service) Data Quality Validity

Performance
- **84.6%** for combined April to June compared to 2018/19 outturn of 99.1%

- Decrease in performance in 2019/20 due to issues with submission of Emergency Care Data Set. The Trust is working with TPP to resolve configuration issues. Data will be resubmitted from April 2019 and data quality rating anticipated to return to green rating. This is expected to be complete by the end of September 2019.

Exception Report | Are Services Well Led?

Workforce / HR page 1 of 2

NHS Gloucestershire Care Services NHS Trust

CQC DOMAIN - ARE SERVICES WELL LED?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report July Figure
75	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place of work	N - R L - T	61%	58.5%			52.00%										52.00%	R	Pg.20	G	
76	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place to receive treatment	N - R L - T	67%	84.6%			83.0%										83.0%	G		G	
77	Mandatory Training	L - I	90%	85.90%	85.8%	86.62%	86.71%	86.40%	91.08%								87.32%	A	Pg. 20	A	89.4%
78	% of Staff with completed Personal Development Reviews (Appraisal)	L - I	90%	77.1%	76.42%	77.72%	79.42%	82.22%	82.57%								79.67%	R	Pg. 21	A	82.2%
78a	% of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only	L - I	90%	81.4%	81.24%	82.54%	85.35%	87.38%	86.72%								84.65%	R	Pg. 21	A	
79	Sickness absence average % rolling rate - 12 months	L - I	<4%	4.8%	4.90%	4.87%	4.82%	4.80%	4.76%								4.83%	A	Pg. 21	A	4.7%

Additional information related to performance - What actions have been taken to improve performance?

Staff Friends and Family Test - How likely are you to recommend Gloucestershire Care Services NHS Trust to friends and family as a place to work?

Performance: Qtr. 1: 52%

38.22% of the Staff FFT responders are general managers, senior and administrative staff (many likely to be based at Edward Jenner Court).

Actions:

- We will be continuing to increase our approach to engagement.
- Our communications and overall approach to the merger has encouraged staff participation and feedback and we are continuing to run regular pulse checks.
- A programme of Edward Jenner Court focus groups commenced last month with a report on themes and recommendation to Executive Committee (due Sept 2019).
- We have developed a action plan in response to the staff survey.

Mandatory Training

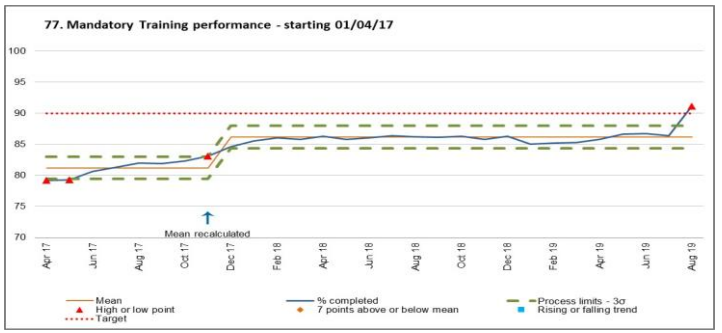
Performance:
Latest performance 91.08%. SPC chart below shows this to be above upper control limit and target.

21 out of 22 measures have increased in performance in August compared to July, with 10 above the new 90% target.

Risks (Mandatory training Compliance - CQC)
Reference – 858
Rating – 9

Actions:
Changes have been made to the revised Training Report and applied to the HR Scorecard:

- All agreed exclusions have been applied
- Additional Headcount column has been included to show the number of staff the figures now relate to
- Compliance target has been changed to reflect Green to 90% from 92%
- Additional Total column has been included so that each area can easily see their overall compliance levels, and this has also been RAG rated.



Exception Report | Are Services Well Led?

Workforce / HR page 2 of 2

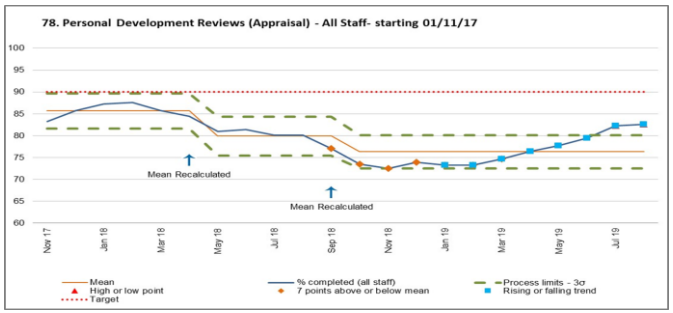
NHS Gloucestershire Care Services NHS Trust

Additional information related to performance - What actions have been taken to improve performance?

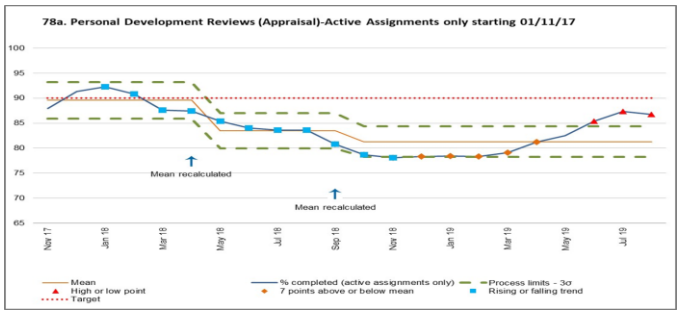
Staff with completed Personal Development Reviews (PDRs)

- Developing PDR for colleagues returning to work following a period of sickness, maternity leave, secondments etc.
- Revised PDR paperwork for bank, staff who are retiring/leaving and lower banded posts has been piloted and tested and are now being published on the intranet for wider use.
- Liaison with ESR National to get glos-care.net on NHSMail platform which will allow for better ESR notifications to staff including those about PDR's.
- Liaising with HR around development of 3 step process/warning letters for non-compliance for PDR's.
- Reviewing Bank Staff List and removing employees that have not worked a shift for over a year, where appropriate.
- Considering idea of carousel training course for managers, including PDR training.
- Continued work with different teams to understand and improve their compliance.
- Thank you letters have been sent to team managers who have excellent compliance rates.
- A consultant has been employed to continue working on PDR and stat/mandatory training.
- Compliance target has been changed to reflect Green to 90% from 92%

Risks (PDR) Reference – 643
Rating – 9



SPC charts show Personal Development reviews (active assignments and all staff).
Target has not been achieved and is outside of current upper control limit.
Performance has been increasing since January 2019 and is now above the upper control limit for both targets.
The mean will be recalculated next month and upper control limit will be closer to target.



Sickness absence

Latest performance 4.76%
Benchmarking. In the 'Sickness absence rate (Short and Long Term)' measure, the Trust submitted a figure of 4.5% in July.
Benchmarking figure is 4.77% for July (individual month's absence).

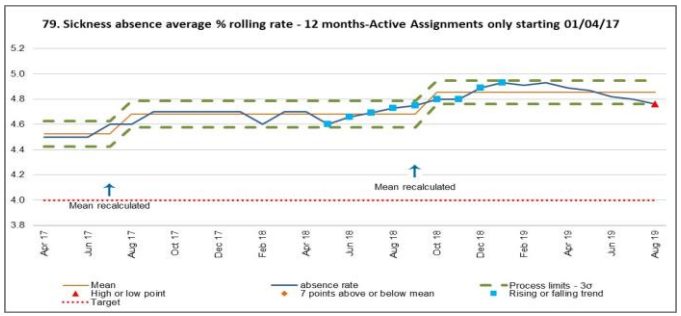
Risks (Staff Sickness) Reference – 633
Rating – 9

- Review of policy, guidance and letter templates and workshops offered by HR, HR Advisors being primarily assigned to business areas.
- Discussion at the Performance and Finance meetings and an HR business partner model implemented to offer consistency and local intelligence for each area.
- Health and Well Being agenda adopted by the Trust to promote healthy lifestyles.
- Introduction of business intelligence on ESR for all managers to review workforce metrics.
- New joint policy being developed with 2gether.

In line with a national 10-year trend, sickness rates are in normal variation and have been steadily falling since March 2019.

SPC chart shows sickness absence decreasing since March 2019 indicating a decreasing trend.

Target has not been achieved and is significantly below the current lower control limit. The mean will be recalculated next month.



Agenda Item 22

Report to: Joint Trust Board – 26th September 2019

Author: John Trevains, Director of Quality
Presented by: John Trevains, Director of Quality

SUBJECT: **6 Monthly Safe Staffing Update**

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

EXECUTIVE SUMMARY

This paper provides an update regarding revised safe staffing guidance issued by the National Quality Board (NQB) in July 2016. This paper also includes related updates through the developmental inpatient quality dashboard and temporary staffing.

This 6 monthly update outlines :

- National reporting requirements, latest developments and the latest data in their required format (Appendix 1)
- Local Trust exception reporting
- Update of agency use across wards
- Confirmation of achievement of the NQB expectations

National reporting with regards to fill rates continues to be uploaded monthly and reported to the Governance Committee on behalf of the Board. From April 2018 the Trust has been mandated to also include the Care Hours Per Patient Day (CHPPD) within the upload. The Trust continues to have strong compliance with planned versus actual fill rates – over 98% compliant for July 2019. Appendix 1 details the latest figures presented at the Governance Committee in August 2019.

With regard to temporary staff - we continue to use high levels of agency locum medics, nursing and agency IAPT workers. The current predicted forecast for total agency spend for 2018/19 is £4.697m. This remains above the NHSI control total of £3.134m.

Effective from 16th September 2019 there are new NHSI agency rules that require Trusts to stop using off-framework agency cover for non-clinical and unregistered clinical shifts (e.g. HCAs), and no longer use agency workers in admin and estates. Exception to this include patient safety and special projects. We remain

within the scope of this new guidance and are working to eliminate off framework agency usage.

Regarding NQB expectations, this report confirms achievement of all expectations as per guidance. Some areas are currently being progressed further such as workforce development, safe staffing reviews and ensuring diversity of the workforce is representative of the communities we serve.

ASSURANCE

This update paper gives **SIGNIFICANT ASSURANCE** on safe staffing and monthly reporting.

RECOMMENDATIONS

The Board is asked to:

- Note the current assurance against the revised NQB guidance and safe staffing levels
- Note monthly reporting and compliance with fill rates
- Note current position regarding temporary staffing spend

Corporate Considerations	
Quality implications	Safe staffing is fundamental to ensuring high quality safe services are delivered. This guidance ensures that all relevant triangulation regarding safe services is highlighted and noted for the Board
Resource implications:	No resource implications currently have been identified
Equalities implications:	No equalities implications as this guidance applies to all population groups
Risk implications:	If all the expectations are not met fully there may be some level of risk regarding delivery of safe and effective services.

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	
Valuing and respectful		Efficient	

Reviewed by:		
John Trevains, Director of Quality	Date	17.09.2019

Where in the Trust has this been discussed before?		
Every 6 months at Board	Date	September 2017
		March 2018
		September 2018
		March 2019

What consultation has there been?		
N/A	Date	

Explanation of acronyms used:	
NQB	National Quality Board
CHPPD	Care Hours Per Patient Day
NHSI	NHS Improvement
HCA	Health Care Assistant
HEI	Higher Education Institution
HEE	Health Education England

1. **CONTEXT**:

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 (2013). This guidance was updated in July 2016 *"Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time"* and outlines three main expectations below:

Safe, Effective, Caring, Responsive and Well Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags) - -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

The Trust Board received the last 6 monthly update in March 2019. The Governance Committee continues to receive bi-monthly reports detailing staffing levels across all inpatient sites as well as updates regarding the use of temporary staffing.

This 6 monthly update outlines :

- National reporting requirements, latest developments and the latest data in their required format (Appendix 1)
- Local Trust exception reporting
- Update of agency use across wards
- Conformation of achievement of NQB expectations

2. PROGRESS ON THE NQB REVISED KEY EXPECTATIONS

Following on from the detailed update regarding the NQB expectations through the September 2018 6-monthly paper, this report confirms achievement of all expectations as per the guidance. Some areas of work continue to be progressed

further, such as workforce development, safe staffing reviews, and ensuring diversity of the workforce is representative of the communities we serve.

3. NATIONAL GUIDANCE

The Trust is now required from August 1st 2019 to report the utilisation of Registered and Unregistered nursing associates within submitted safe staffing data returns. This is being enacted, noting that we report our currently small numbers of nurse associates within our HCA numbers.

We are mandated to report on the Care Hours Per Patient Day (CHPPD) from April 2018 which we upload each month alongside the safe staffing fill rates. The Director of Quality has developed a Quality Dashboard which triangulates information relating to inpatient wards which was reported to Board in March and September 2018 and March 2019 as part of the 6 monthly safe staffing update.

The Trust continues to report high fill rates. Appendix 1 outlines the national safe staffing requirement for July 2019. Since March 2019, actual fill rates have improved by a further 1% to over 98% compliant against planned levels.

4. LOCAL TRUST EXCEPTION REPORTING

In line with previous internal Trust reporting, we have continued to collect and collate the reasons where core planned staffing levels have not been met through the internal exception codes. It is important to note that these are relatively rare events (in terms of percentages of overall fill rates). 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.

4.1 WARD SPECIFIC INFORMATION

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 in staff on duty to provide one to one care for patients (specialling);
- 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 staff member with a health care assistant who knows the patients and the ward, rather than a bank or agency 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

In summary for July 2019:

- No staffing issues were escalated to the Director of Quality or the Deputy Director of Nursing.
- Where staffing levels dipped below the planned fill rates of 100% for qualified nurses this was usually offset by increasing staffing numbers of unqualified staff based on ward acuity and dependence and the professional judgement of the nurse in charge of the shift.
- **98.21%** of the hours exactly complied with the planned staffing levels.
- **1.44%** of the hours during May had a different staff skill mix than planned staffing however overall the staffing numbers were compliant and the needs of the patients were met.
- **0.35%** of the hours during May 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.

Internal exceptions January 2019

Wotton Lawn

- Abbey Ward
  - All code 1 exceptions were due to staff sickness and vacancies.
- Kingsholm
  - The code 1 exceptions were due to staff sickness
- Montpellier
  - The Code 1 & 2 exceptions were all due to staff sickness.
- Greyfriars
  - The code 1 exceptions were due to qualified sickness, one qualified vacancy and one HCA sickness.
- Dean
  - The code 1 and 2 exceptions were due to staff sickness and vacancies.
- Priory
  - The code 1 and 2 exceptions were due to qualified nurse vacancies and one long-term sickness.

Berkeley House

- 8 code 2 exceptions were reported for July, this is an increase of the 7 that were reported for June, this remains due to an increase in short term sickness.

Current roster pressures;

- 3 staff (1 band 5's and 2 band 3's) not available as either on Maternity or pregnant (light duties).
- 2 band 3 staff undertaking TNA training (started September 2018), however there are no TNA's swapping due to pregnancy.
- 1 band 3's on long term sick.
- Time taken form interview to staff appearing on the unit. We are still awaiting a start date for 2 staff who were interviewed in March 2019.

Future Roster Pressures:

- A third band 3 starting the Training in September 2019.
- 3 band 3 staff recruited to Wotton Lawn, currently going through the recruitment process.
- 2 band 3 retiring in October 2019
- 1 band 5 returning home to Scotland in October 2019.

Current Recruitment

- 6 band 3's and 1 band 2 going through the recruitment process
- 1 band 5 vacancy, two candidates shortlisted
- 1 band 5 currently going through the recruitment process
- Where there are staffing shortfalls during the week, the team management and at times the Matron assist in covering where possible to ensure patients activities and safety are not compromised.
- It needs to be noted that while staff are unclear of the future plans for Berkeley House and A & T services this will impact on recruitment and retention.

Stonebow - Herefordshire

- There were 5 code 1 exceptions this month. 1 on Jenny Lind and 4 on Oak House where they managed with one qualified staff member rather than 2.

- The higher HCA fill rate on the wards is when additional staff are required when acuity is high. Often the fill rate can be increased for qualified staff when the agreed additional management days are created when possible for the deputy ward managers. Early July saw high acuity, bed occupancy and turn over across the Unit requiring additional HCAs for specialing. The old age wards have seen an increase of working age adults admitted often requiring 1:1 specialing due to the higher risks posed by these clients in that environment.

Charlton Lane Hospital

- Mulberry Ward
  - 1 code 1 exception, staffing numbers compliant but the skill mix was non-compliant however met the needs of the patients. The ward was considered safe and there was no harm to patients.
  - 1 code 2 exceptions, staffing numbers not compliant but met the needs of the patients. The Ward was considered safe and there was no harm to patients.
- Chestnut Ward
  - 9 code 1 exceptions, staffing numbers compliant but the skill mix was non-compliant however met the needs of the patients. The ward was considered safe and there was no harm to patients.
  - 4 code 2 exceptions. Minimum staffing numbers compliant but the skill mix was non-compliant however met the needs of the patients. The ward was consider safe and there was no harm to patients.
- Willow Ward
  - 6 code 2 exceptions. Minimum staffing numbers not compliant but met the needs of the patients. The ward was considered safe and there was no harm to patients.
  - 1 code 1 exception, staffing numbers compliant but the skill mix was non-compliant however met the needs of the patients. The ward considered safe and there was no harm to patients.

Recovery Units

- Laurel House

- There were 10 code 1 exceptions for Laurel House. These relate to current band 5 RMN vacancies (recruited to but awaiting PIN) and maternity leave. There has also been a high level of sickness within the Unit. We use regular HCA band or substantive staff are offered overtime rather than use an agency RMN who may not know the patients and therefore can affect continuity of care.

There was 1 code 2 where the Unit ran with x 2 RMN's and no HCA due to last minute sickness that staff bank or agency were unable to cover. Minimum staffing numbers not met but the needs of the patients were able to be met.

Exception reporting in hours – all wards July 2019

			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 # and skill mix not met. Resulting in clinical incident / harm to patient or
Dean	15	3255	0.00	15.00	0.00	0.00	0.00
Abbey	18	3255	230.00	0.00	0.00	0.00	0.00
Priory	18	3255	192.50	0.00	0.00	0.00	0.00
Kingsholm	15	3255	7.50	0.00	0.00	0.00	0.00
Montpellier	12	3565	157.50	70.00	0.00	0.00	0.00
Greyfriars	10	4030	180.00	0.00	0.00	0.00	0.00
Willow	16	4495	30.00	15.00	0.00	0.00	0.00
Chestnut	14	3022.5	15.00	52.50	0.00	0.00	0.00
Mulberry	18	3255	52.50	15.00	0.00	0.00	0.00
Laurel	13	2015	90.00	0.00	0.00	0.00	0.00
Honeybourne	10	2015	60.00	0.00	0.00	0.00	0.00
Berkeley House	7	8680	0.00	70.00	0.00	0.00	0.00
Herefordshire							
Mortimer	21	3208.5	0.00	0.00	0.00	0.00	0.00
Cantilupe	10	2991.5	0.00	0.00	0.00	0.00	0.00
Jenny Lind	8	1782.5	46.00	0.00	0.00	0.00	0.00
Oak House	10	1782.5	21.00	4.00	0.00	0.00	0.00
TOTAL		53,862.5	1082.00	241.50	0.00	0.00	0.00

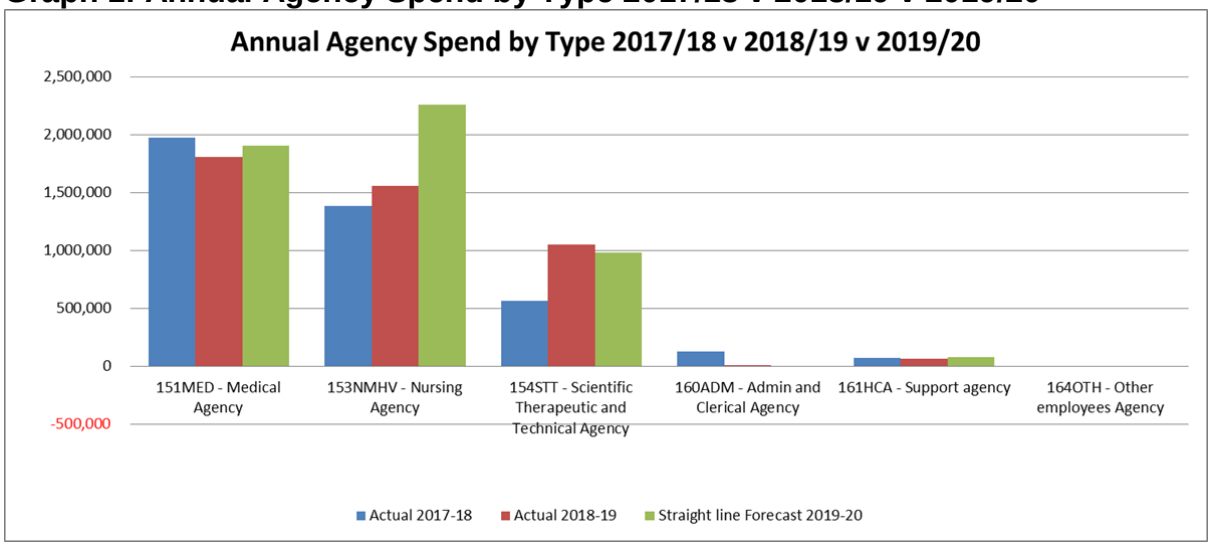
5. USE OF TEMPORARY STAFFING

- Nationally there had been significant spend on agency workers, and consequently in 2015/16 the NHSI set, for each trust, a 'ceiling' agency spend. The NHSI set 2gether a total agency spend ceiling of £3.134m, against a 2015/16 Trust agency spend of £5.502m.
- The NHSI has acknowledged the national picture of increasing demand for nursing staff, and successes in controlling the costs of nursing agency since 2015/16. However, from 16 September 2019 trusts must no longer use off-framework agency cover for non-clinical and unregistered clinical shifts (e.g. HCAs), and no longer use agency workers in admin and estates.
- The spending on agency staff and use of bank staff is continually reviewed by the Trust, and where anomalies are identified they are subject to review.
- In order to reflect the challenges going forward into 2019/20, the Temporary Staffing Project Board has been reformed and renamed the 'Agency Nursing & Support Staff project'. It continues to meet on a monthly basis, is chaired by the Director of Quality, supported by the Director of Operations, and includes representation from all services, and comprises 5 work-streams:
    1. Recruitment to and management of Peripatetic Teams
    2. Review, trialling, and proposals around ward skill mix
    3. Clinical threshold management
    4. Recruitment and Retention
    5. Business Intelligence
- Although the HCA agency spend in 2018/19 was lower than previous years (and below the NHSI ceiling), demand for both HCA and RMN shifts showed an increase in the final quarter of 2018/19, and this has continued into 2019/20.
- Medical agency spend fell in 2018/19, but the forecast for 2019/20 predicts an increased spend.
- The 2019/20 month 4 agency outturn indicates a full year agency spend projection of £5,231,624, but actions described in later sections are predicted to mitigate some areas of spend but the forecast predicted spend is £4.697m based on the assumption that the actions Trust is taking will bring down the spend in the last 8 months of the financial year. (see Table 1 and Graph 1 below):

Table 1: Agency spend, NHSI ceiling, and straight line forecast

²gether Agency Spend 2019/20			As at July 2019		
	Actual 2017-18	Actual 2018-19	NHS Ceiling	Spend to date 2019-20	Straight line Forecast 2019-20
151MED - Medical Agency	1,974,301	1,805,369	1,503,888	636018.94	1,908,057
153NMHV - Nursing Agency	1,383,636	1,554,969	1,049,677	754135.07	2,262,405
154STT - Scientific Therapeutic and Technical Agency	562,854	1,054,632	427,001	328146.73	984,440
160ADM - Admin and Clerical Agency	128,395	7,699	97,405	-75	-225
161HCA - Support agency	73,856	62,972	56,030	25649.08	76,947
164OTH - Other employees Agency	-0	0	-0	0	0
Total	4,123,041	4,485,641	3,134,000	1,743,875	5,231,624

Graph 1: Annual Agency Spend by Type 2017/18 v 2018/19 v 2019/20



Nursing / HCA

- Although HCA agency spend fell each year between 2016 and 2019, the HCA agency spend for Q1 2019/20 has significantly increased. The current full year, straight line, projection is £889,695 against a 2018/19 agency spend of £401,741. The main reasons for increased spend are vacancies (including the peripatetic teams), and clinical need 1:1 (including the support of under 18's on inpatient wards).
- To address this increased spend, and ensure the Trust adheres to the new NHSI rule to stop using off-framework agency cover for unregistered clinical shifts, the Trust has brought forward planned recruitment events, accelerated the recruitment checks, and will be introducing a scheme to create a pool of Trust trained HCA band 3 staff, through a progression route from Band 2.
- The RMN straight line forecast for 2019/20 is £1,368,223 against a 2018/19 spend of £1,153,228, and an NHSI ceiling target of £632,975. The major cause of RMN demand is vacancies (in 2018/29, vacancies accounted for 70% of demand for RMN shift cover).
- Initiatives to mitigate this spend include:
    - investment in the Nursing Associate programme
    - increased recruitment activity to gain substantive and bank only staff
    - investigating different skill mixes on inpatient wards
- The Guaranteed Volume Contract (GVC) for RMNs, provided through Medacs, remains in place and contributes to the reduction in the use of high cost, off-framework agencies. Although the GVC is operating at above 90% provision, if non-provision results in the use of a Thornbury shifts the extra cost is recoverable from Medacs.

IAPT

- The straight-line 2019/20 forecast is £749,441, against a 2018/19 agency spend of £953,177, and an NHSI ceiling target of £360,998.
- The use of agency has ensured the 17% access target has been achieved.
- Availability of appropriately qualified staff remains a challenge, and consequently both the Trust and agencies experience difficulties in accessing staff, creating a risk to the delivery of the IAPT access targets. Alternative methods of delivering the service are under consideration.
- The service continues a robust training programme of trainees (total = 26 in financial year) to mitigate turnover in the workforce and to meet staffing needs as the service targets and requirements increase.
- IAPT performance is reported monthly to Delivery Committee.

Medical

- The straight line forecast for 2019/20 is £1,908,057, against the NHSI target of £1,503,888, and a 2018/19 agency spend of £1,805,369.
- There is 1.0 wte unfilled vacancy, which is currently going through the recruitment process.
- Financial savings can be achieved by employing a higher percentage of locums through direct engagement rather than through umbrella companies. This enables the recovery of VAT, and is in line with HMRC's preferred method of engaging locums. Six of the 10 agency locums used in July were employed through Direct Engagement.

Domestic Staff

- 2019/20 forecast agency spend £76,947 (spend at month 4 = £25,649)
- 2018/19 agency spend £62,972, and an NHSI ceiling of £56,030
- NHSI new rules require zero agency use for domestic staff from 16/09/2019
- Agency staff are being encouraged to join the Trust's staff bank

Wotton Lawn

- 1 vacancy at Pullman Place 10 hrs
- 1 vacancy at WLH 32 ½ hours (re-advertised as no suitable candidates)
- Agency – 37 ½ hours a week partly covering 2 x staff on long term sick

Charlton Lane

- 2 x B2 F/T vacancies - both filled and waiting on pre-employment checks
- 2 x B2 P/T vacancies - re-advertising as no interviewees attended
- 1 x B3 vacancy - re-advertised
- 1 x B4 vacancy - closed 12/8/19, interview planned 22/8/19
- Agency – 37 ½ hours a week covering various hours that existing staff cannot fulfil with overtime

Stonebow

- 1 x B3 F/T vacancy - re-advertised as no interviewees attended

- 1 x 25 hr vacancy Stonebow
- 1 x 29 hr vacancy Stonebow
- 1 x 25 hr vacancy Benet Building
- Agency – 24 hrs a week covering various hours and locations

AHP

- Currently there is no AHP agency usage in 2019/20, and there was £zero AHP agency spend in 2018/19.
- To support the Trust's work to reduce agency spend, and ensure the Trust does not use off-framework agency to cover unregistered clinical shifts (e.g. HCAs), the AHP service has made available 10 AHP shifts per week in Wotton Lawn to help cover some HCA demand, for example enhanced level of care shifts (1:1) which generally go to agencies, in particular Thornbury.
- At present there are no AHP posts which remain vacant due to challenges with workforce supply. It should be acknowledged that this is variable over time and there are often small numbers of applicants for posts particularly those at higher band and specialist areas of practice. Those posts require multiple rounds of advertising.
- Work is underway within the Trust to develop an increased understanding of the AHP workforce and recruitment and retention. A summary tool has been developed to aid information gathering.
- Work is required in conjunction with ESR workforce colleagues to ensure the coding for AHPs is correct. This will ensure workforce data generated is reliable. There is national guidance issued from NHS Improvement to support this. This is expected to be completed by the end of Q3.
- Further work across the One Gloucestershire ICS is also being considered to map the AHP workforce and understand recruitment and retention to ensure sustainable services for the future. This will commence with an AHP joining the ICS workforce work-stream and leading further activity through the ICS.

6. CONCLUSION:

In summary the Trust is progressing well with all of the expectations within the revised NQB guidance and will use continue to use and develop the quality dashboards to further triangulate quality indicators.

7. RECOMMENDATIONS:

The Board is asked to:

- Note the current assurance against the revised NQB guidance and safe staffing levels
- Note monthly reporting and compliance with fill rates
- Note current position regarding temporary staffing spend

Appendix 2 July 2019 – National safe staffing upload

NURSING STAFF FILL RATES	Day				Night				Day		Night		TOTAL STAFFING DAY/NIGHT		STAFF GROUP		CHPPD			
	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 (%)	Average fill rate - All staff DAY (%)	Average fill rate - All staff NIGHT (%)	Average fill rate - registered nurses/mid wives (%)	Average fill rate - care staff (%)	Midnight Occupancy	Registered nurses/ midwives	Care staff	Overall
Jul-2019	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												
Gloucestershire																				
WL- Dean Ward	930	938	1395	1673	620	630	310	490	100.81%	119.89%	101.61%	158.06%	112.26%	120.43%	101.13%	126.83%	448	3.5	4.8	8.3
WL- Abbey Ward	1395	1125	930	2138	620	590	310	960	80.65%	229.84%	95.16%	309.68%	140.32%	166.67%	85.11%	249.80%	522	3.3	5.9	9.2
WL- Priory Ward	1395	1283	930	1208	620	670	310	400	91.94%	129.84%	108.06%	129.03%	107.10%	115.05%	96.90%	129.64%	527	3.7	3.1	6.8
WL- Kingsholm Ward	930	908	1395	1425	620	620	310	320	97.58%	102.15%	100.00%	103.23%	100.32%	101.08%	98.55%	102.35%	441	3.5	4.0	7.4
WL- Montpellier Unit	930	878	1395	1425	620	620	620	630	94.35%	102.15%	100.00%	101.61%	99.03%	100.81%	96.61%	101.99%	306	4.9	6.7	11.6
WL- Greyfriars PICU	1395	1388	1395	1905	620	720	620	1180	99.46%	136.56%	116.13%	190.32%	118.01%	153.23%	104.59%	153.10%	284	7.4	10.9	18.3
CL - Willow Ward	930	983	2325	2325	310	310	930	930	105.65%	100.00%	100.00%	100.00%	101.61%	100.00%	104.23%	100.00%	473	2.7	6.9	9.6
CL - Chestnut Ward	930	870	1163	1268	310	310	620	620	93.55%	109.03%	100.00%	100.00%	102.15%	100.00%	95.16%	105.89%	382	3.1	4.9	8.0
CL - Mulberry Ward	930	938	1395	1815	310	310	620	810	100.81%	130.11%	100.00%	130.65%	118.39%	120.43%	100.60%	130.27%	477	2.6	5.5	8.1
WA - Laurel House	698	675	698	840	310	310	310	310	96.77%	120.43%	100.00%	100.00%	108.60%	100.00%	97.77%	114.14%	363	2.7	3.2	5.9
WA - Honeybourne	698	585	698	818	310	310	310	310	83.87%	117.20%	100.00%	100.00%	100.54%	100.00%	88.83%	111.91%	295	3.0	3.8	6.9
LD - Berkeley House	930	1118	4650	4440	310	390	2790	2400	120.16%	95.48%	125.81%	86.02%	99.60%	90.00%	121.57%	91.94%	186	8.1	36.8	44.9
Herefordshire																				
SB - Cantilupe Ward	713	759	1070	1587	356.5	391	1069.5	1621.5	106.45%	148.39%	109.68%	151.61%	131.61%	141.13%	107.53%	150.00%	358	3.2	9.0	12.2
SB - Jenny Lind Ward	713	733	357	552	356.5	357	356.5	414	102.73%	154.84%	100.00%	116.13%	120.10%	108.06%	101.82%	135.48%	245	4.4	3.9	8.4
SB - Mortimer Ward	1070	1116	713	1196	713	759	713	1092.5	104.30%	167.74%	106.45%	153.23%	129.68%	129.84%	105.16%	160.48%	532	3.5	4.3	7.8
WA - Oak House	713	667	357	679	356.5	368	356.5	586.5	93.55%	190.32%	103.23%	164.52%	125.81%	133.87%	96.77%	177.42%	286	3.6	4.4	8.0

Agenda item 23

Report to: Trust Board, 26th September 2019
Author: John Hudson – Emergency Planning and Business Continuity Officer
Presented by: John Campbell, Director of Service Delivery

SUBJECT: **OPERATIONAL RESILIENCE & CAPACITY PLAN (INCL. WINTER PLANNING)**

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

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

EXECUTIVE SUMMARY

- The Trust is required to demonstrate its ability to adapt to variations in demand throughout the year, with particular emphasis placed on the winter period (November – March). The Operational Resilience and Capacity Plan represent the core aspects of the assurance process and are submitted to Gloucestershire and Herefordshire Clinical Commissioning Groups annually as part of the health system assurance process.
- The process involved in developing and approving a joint plan for Gloucestershire Health and Care NHS Foundation Trust involved the following: -
    - 2nd August – Gloucestershire Health System winter workshop held at Sanger House (draft plans to be submitted week beginning 26th August 2019)
    - GCS Winter plan review process started July 2019
    - 2g Plan review process started August 2019
    - 9th August decision taken to combine plans from GCS and 2g
    - 14th August 1st draft combined plan completed and sent out for consultation
    - 19th – 22nd August Feedback received and revised draft plan developed
    - 23rd August draft plan submitted to Gloucestershire CCG
    - 5th September final draft plan presented to GCS Audit Committee for approval – Plan approved, though questions raised about the effectiveness of the 4x4 vehicles for snow: communications, supply of vehicles and of drivers
    - 5th September – 1st November 2019 Organisational Resilience Team have a delivery action plan in place to address capability deficiencies in relation Operational Resilience and Capacity Plan including 4x4 vehicle support and communication.
- The Board is asked to note this report and the capability assessment at appendix 1

RECOMMENDATIONS

The Board is asked to note:

- The contents of this report
- The risks and associated mitigation planned by the Trust to manage disruptions during the winter period outlined in appendix 1

CONTEXT

Resilience and Security Team at 2gether NHS Foundation Trust (2g) have coordinated an annual review of the 2g RST 012 Operational Resilience and Capacity Plan and Gloucestershire Care Services NHS Trust's Surge and Escalation Plan, combining both documents into a single Gloucestershire Health and Care Foundation Trust Operational Resilience and Capacity Plan. The plan has been summited in draft to Gloucestershire CCG and has been consulted on internally (between 01 August 2019 and 13 September 2019). The review has included learning from last winter (2018/19) in particular the Trust's preparedness and capabilities in relation to adverse weather.

In order to take a system-wide approach to managing operational problems the NHS recognises the need to establish sustainable year-round delivery. This requires NHS service providers, such as Gloucestershire Health and Care NHS Foundation Trust's capacity planning to be on-going, robust and aligned with other organisations plans across the Health and Social Care system, with a move towards a proactive system of year round operational resilience.

Gloucester and Hereford A&E Delivery Boards represent the forums in which capacity planning and operational delivery across the health and social care system in both counties is coordinated.

The plan outlines the Trust's approach to managing the challenges of increased demand and/or reduced capacity by proactively reviewing, improving and implementing its operational resilience and capacity measures to minimise the impact on service users, partner agencies and the health and social care systems of Gloucestershire and Herefordshire as a whole and the Trust's ability to adapt to variations in demand throughout the year, with particular emphasis placed on the winter period (November – March)

This briefing is to provide Trust Board members with a brief synopsis of the development and approval of the Operational Resilience & Capacity Plan, and any remaining actions to be completed.

Report authorised by:	**Date:**

Where has this issue been discussed before?	Date:
Gloucestershire Care Services NHS Trust Audit Committee	5th September 2019
2gether NHS Foundation Trust Delivery Committee	24th September 2019

Explanation of acronyms used:	CCG – Clinical Commissioning Group GCS – Gloucestershire Care Services NHS Trust 2g – 2gether NHS Foundation Trust ICC – Incident Co-ordination centre

1. INTRODUCTION

1.1 All NHS Service provider organisations are required to demonstrate their ability to adapt to variations in demand throughout the year, with particular emphasis placed on the winter period (November – March). A and E delivery Boards (Sub Group of Clinical Commissioning Groups) are now common place across CCG areas and support the planning and assurance process across Gloucestershire and Herefordshire Health Systems.

1.2 The Gloucester and Hereford Systems Resilience Groups represent the forums in which capacity planning and operational delivery across the health and social care system in both counties is coordinated.

2. GOVERNANCE AND ASSURANCE

2.1 The Operational Resilience and Capacity Plan has been widely circulated for comment and action and a capability assessment monitored and updated as required (see Appendix 1).

2.2 Based on the review of current procedures and activities carried out by the Resilience and Security Team on behalf of colleagues across services and localities in both 2gether and Gloucestershire Care Services a **significant level of assurance** can be provided to the Board on the new joint Gloucestershire Health and Care NHS Foundation Trust's readiness to enter the winter period (Nov-Mar).

3. OPERATIONAL RESILIENCE & CAPACITY PLAN DEVELOPMENT PROCESS

- 2nd August – Gloucestershire Health System winter workshop held at Sanger House (draft plans to be submitted week beginning 26th August 2019)
- GCS Winter plan review process started July 2019
- 2g Plan review process started August 2019
- 9th August decision taken to combine plans from GCS and 2g
- 14th August 1st draft combined plan completed and sent out for consultation
- 19th – 22nd August Feedback received and revised draft plan developed
- 23rd August draft plan submitted to Gloucestershire CCG
- 5th September final draft plan presented to GCS Audit Committee for approval – Plan approved, though questions raised about the effectiveness of the 4x4 vehicles for snow: communications, supply of vehicles and of drivers
- 24th September final draft plan presented to 2g Delivery committee

- 5th September – 1st November 2019 Organisational Resilience Team have a delivery action plan in place to address capability deficiencies in relation Operational Resilience and Capacity Plan including 4x4 vehicle support and communication.

APPENDIX 1 CAPABILITY ASSESSMENT

<table>
<tr><th></th><th>Capability (Assurance RAG rating)</th><th>Narrative and actions</th><th>Timescales</th></tr>
<tr><td rowspan="8">CAPABILITY ASSESSMENT:

(Please also see ‘Responsibilities: Responding to severe weather’)</td><td rowspan="2">Incident coordination (in hours) process managed by the Organisational Resilience Team.</td><td colspan="2">• Incident Coordination Centre (ICC)
• ‘Severe Weather’ Incident Response folder (complete with templates and tools to support the response)</td></tr>
<tr><td>Actions:
• Arrange for provision of ICC at Edward Jenner Court including revision of ICC set up guide
• Update severe weather incident response folder to include former GCS services</td><td>01/10/19</td></tr>
<tr><td rowspan="2">Incident coordination (out of hours) process managed by the Operational On-call Manager (unless decision made to request Resilience and Security Team to support an Incident Management Team).</td><td colspan="2">As above, including;

4. On-call Pack (including contact details)</td></tr>
<tr><td>Actions:
5. Briefing for On-call Teams on accessing supporting templates/tools/ resources/setting up ICC.</td><td>31/10/19</td></tr>
<tr><td rowspan="2">Severe weather communications strategy (including severe weather notifications).</td><td colspan="2">Briefings and core messages for staff/ management set out for cascade (different mediums) at appropriate intervals (see Annex 1).</td></tr>
<tr><td>Actions:
6. Initiate severe weather comms strategy</td><td>01/11/19</td></tr>
<tr><td>4x4 transportation (patient transport contract)</td><td colspan="2">Last year 2g secured a 4x4 transport service contract through 365 Response who at the time provided our patient transport service; this is no longer the case. The Contracts Team have spoken to the current 2g patient transport provider, ER Systems and had confirmation that they have several 4x4 vehicles. Pricing for their use is yet to be confirmed. The contract with ER systems will require revision and is intended to include a requirement specification (where capacity and resources allow) to support the Trust during</td></tr>
</table>

		periods of severe weather with the transportation of staff.	
		Actions: 7. Organisational Resilience Team to assist in compiling a transport specification.	31/10/19
		8. Contracts team to review the current patient transport contract and ascertain whether a severe weather emergency support clause could be added and met by a current provider.	01/10/19 - Complete
		9. Service Directors to consider and decide on the use of 4x4 contingencies and their priority for use.	01/11/19
	4x4 transportation Herefordshire (primary support: the transportation of key staff to and from a place of work; secondary support: logistics e.g. medication and suppliers).	The Herefordshire Locality Management Team has previously secured access to the Wye Valley Trust 4x4 volunteer pool, which was well established as part of the 2017/18 severe weather response. There is no indication that this will differ for winter 2019/20 The Organisational Resilience Team will be recruiting for a pool of additional 4x4 driver volunteers from within the Trust to support transportation challenges in Herefordshire.	
		Actions: 10. Herefordshire Locality Management to confirm contact information for the lead(s) operating in Wye Valley Trust's control room.	01/11/19
		11. Resilience and Security Team to document the details of all volunteers in the 'Severe Weather Incident Response Folder'.	01/11/19
	4x4 transportation Gloucestershire (primary support: the transportation of key staff to and from a place of work; secondary support: logistics	There is work being done as a system , led by Julie Doyle who is seconded to the CCG at the moment, to ensure we have robust coverage and access to 4x4 vehicles as part of the adverse weather planning. This includes proactive action that needs to occur by every provider – i.e. if predicting poor weather	

	e.g. medication and suppliers).	colleagues are asked to consider how they will get in for their shifts and consider staying closer (e.g. in hotels, alternate arrangements) to avoid the demand on the Trust's having to provide transport to and from work. Two providers of 4x4 services are being arranged – one for transporting critical staff into sites, and one for transporting staff to domiciliary visits. There is also a view being taken to centralise requests across the system to ensure best use of resources. The Organisational Resilience Team will be recruiting for a pool of additional 4x4 driver volunteers from within the Trust to support transportation challenges in Gloucestershire.	
		Actions: 12. In liaison with GCCG the Organisational Resilience Team to confirm process for requesting 4x4 Support through a centralised resource and ensure guidance documents are made available within the 'Severe Weather Incident Response Folder'.	01/11/19
		13. Organisational Resilience Team to document the details of all internal volunteer 4x4 drivers for Gloucestershire and Herefordshire in the 'Severe Weather Incident Response Folder'.	01/11/19
	Site snow clearance and gritting	Last year 2g had a contract in place for the winter period with Nurture First, who use predicative weather forecasts to plan gritting and snow clearance and would deploy without any notification from the Trust. This was the best response to date from a contracted service. Discussions on renewal of this contract have recently taken place between Estates and Facilities and Procurement colleagues, however, Nurture First is not on any national framework, so the Trust needs to undertake a full re-tender or mini completion via a framework during September, with the intention to appoint during October	
		Actions: 14. Estates and Facilities Team to confirm contract arrangements in place for key sites.	31/10/19

		15. Locality Management Teams to confirm whether current snow clearance and gritting arrangements meet service needs.	31/10/19
		16. Locality Management Teams to confirm whether snow clearance equipment is available at key sites	31/10/19
		17. Locality Management Team to confirm under what circumstances staff should use snow clearance equipment and whether it is line with an appropriate risk assessment to prevent injuries and possible claims.	31/10/19
		18. Estates and Facilities Team to outline additional resource requirements (including costs) to meet snow clearing and gritting requirements in.	31/10/19
		19. Approval sought from appropriate Executive Director for the purchase of additional snow clearance/ gritting capabilities to meet service needs.	31/10/19
	Accessing emergency accommodation	During the now in 2017/18 a number of staff members were unable to return home and/or were willing to cover additional shifts, but required accommodation. A number of issues arose relating to a credit card number being required. For 2018/19 accounts were set up with local hotels and B&Bs to support the provision of emergency accommodation on a case by case basis.	

		Actions: 20. Organisational Resilience Team to contact NHS Shared Services – Procurement to confirm agreements still remain with accommodation establishments near to main inpatient units with accounts set up to enable staff members to access emergency accommodation without credit cards.	31/10/19
		21. Organisational Resilience Team having liaised with Procurement to update list of pre-identified accommodation locations and codes for booking rooms.	31/10/19
	Operational Services Gloucestershire – Preparation and Readiness to Respond	To be discussed at appropriate management meetings	
		Actions: 22. Management to confirm readiness and business continuity arrangements.	01/11/19
		23. Management to raise any concerns/ challenges/ risks associated with winter that have not been identified/ addressed.	01/11/19
	Operational Service Herefordshire – Preparation and Readiness to Respond	To be discussed at appropriate management meetings	
		Actions: • Management to confirm readiness and business continuity arrangements.	01/11/19
		• Management to raise any concerns/ challenges/ risks associated with winter that have not been identified/ addressed.	01/11/19
	Corporate/Support Services - Preparation and Readiness to Respond	To be discussed at appropriate management meetings	
		Actions: • Management to confirm readiness and business	01/11/19

		continuity arrangements.	
		• Management to raise any concerns/ challenges/ risks associated with winter that have not been identified/ addressed.	01/11/19

Agenda item 24(1)

Report to:	Joint Trust Board, 26th September 2019
Author:	Lisa Evans, Assistant Trust Secretary
Presented by:	**David Seabrooke, Interim Trust Secretary**
SUBJECT:	**USE OF THE TRUST SEAL**

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

This Report is provided for:

Decision | Endorsement | Assurance | **Information**

PURPOSE

To present the Board with a report on the use of the Trust Seal for the period April –June (Q1 2019/20).

SUMMARY OF KEY POINTS

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

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

During Quarter 1 2019/20, the Seal was used on one occasions, as follows:

Seal 1
Sale of Westridge Assessment and Treatment Unit, Stonehouse to PJ Livesey Homes Ltd
Signed: Andrew Lee
Date: 17 April 2019

RECOMMENDATIONS

The Board is asked to note the use of the Trust seal for the reporting period.

NHS
Gloucestershire
Care Services
NHS Trust

Trust Board

Date of Meeting: 26th September 2019

Report Title: Year End Governance Compliance Report

Agenda reference Number	24(2)
Reason for Being Heard in Confidential Session	N/A
Accountable Executive Director (AED)	Paul Roberts, Chief Executive Officer
Presenter (if not AED)	David Seabrooke, Interim Trust Secretary
Author(s)	Louise Moss, Deputy Trust Secretary
Board action required	To note
Previously considered by	None
Appendices	

Executive Summary:

This report provides the Board with assurance on compliance with statutory register maintenance relating to:

- Register of Declaration of Interests (Directors)
- Register of Declaration of Interests (all Budget Holders)
- Register of Fit and Proper Persons Test
- Register of Gifts and Commercial Sponsorship
- Register of Seals

Recommendations:

The Board is asked to:

1) **RECEIVE** this report.

2) **NOTE** that the registers detailed above are being held, maintained and updated as required in line with statutory requirements and good practice.

Related Trust Objectives	**1,5**
Risk Implications	No risks identified
Quality/Equality Impact Assessment (QEIA) Requirements/Implications	No equality implications identified
Financial Implications	No finance implications identified
Legal/Regulatory Implications	No legal or regulatory implications identified

Year End Governance Compliance Report

1 Introduction and Purpose

To provide the Board with assurance that statutory governance compliance is being maintained.

2 Register of Declaration of Interests

The NHS Code of Accountability requires Board members to declare interests which are relevant and material to the NHS Board of which they are a member.

It is also a requirement that budget holders declare any interests that they have which may conflict with the interests of the Trust itself.

The following registers have been updated for 2019/20

- Register of Declaration of Interests (Directors)
- Register of Declaration of Interests (all Budget Holders)

For Board Members the following processes are in place, equivalent processes are in place for staff if required.

- Declarations made during the course of Board meetings are recorded in the Trust Board minutes. Any changes in interests are declared at the next Board meeting following the change and recorded in the minutes of that meeting.
- Board members' directorships of companies likely or possibly seeking to do business with the NHS are signposted in the statutory Annual Report & Accounts.
- Conflicts which arise during the course of a meeting are declared and if established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

Declarations of Interest have been completed by all Board Members and Budget holders in line with the revised statutory guidance on managing conflicts of interest, which came into force 1 June 2017 for NHS Trusts.

This register for Board members is available on the public website under the "our publications" section.

3. Register of Fit and Proper Person Test

Since 27 November 2014, all NHS bodies that are required to register with the Care Quality Commission (CQC) must consider the fit and proper person requirements when making appointments to director level positions. A person's continued fitness should be assessed as part of the existing appraisal process. Following further guidance from the CQC in March 2018 all GCS Board members have also completed an Enhanced Disclosure and Barring Service (DBS) check.

All Board members have completed the Fit and Proper Person Declaration for 2019/20.

4. Register of Gifts and Commercial Sponsorship

The revised guidance on Managing Conflicts of Interest in the NHS came into force on 1st June 2017 and there is also increased public scrutiny in this area with the Association of the British Pharmaceutical Industry publishing records of gifts and hospitality given by their members to NHS organisations and staff.

The Trust's Gifts and Commercial Sponsorship forms are completed, recorded on the register and then authorised (if suitable) by the Director of Nursing or Medical Director for all applications.

5. Register of Seals

The common Seal of the Trust is primarily used to seal legal documents such as transfers of land, lease agreements. The seal has been used twice since the last year end compliance report submitted to Board in June 2019 in line with the Standing Orders.

i. Staff agreement signed by Chief Operating Officer and Joint Director of HR
ii. Lease for 2nd floor Alexander Warehouse, Gloucester – signed by Joint Director of Finance and Chief Operating Officer

6. Conclusion and Recommendations

The Board is asked to:

1) **RECEIVE** this report.

2) **NOTE** that the registers detailed above are being held, maintained and updated as required in line with statutory requirements and good practice.

[2]GETHER NHS FOUNDATION TRUST

BOARD MEETING
TOWN HALL, HEREFORD
25 July 2019

PRESENT

Ingrid Barker, Joint Trust Chair
Sandra Betney, Joint Director of Finance
Maria Bond, Non-Executive Director
John Campbell, Director of Service Delivery
Marcia Gallagher, Non-Executive Director
Sumita Hutchison, Non-Executive Director
Jane Melton, Director of Engagement and Integration
Colin Merker, Deputy Chief Executive
Paul Roberts, Joint Chief Executive
Neil Savage, Joint Director of HR & Organisational Development
John Trevains, Director of Quality
Dr Amjad Uppal, Joint Medical Director

IN ATTENDANCE

Karen Bent, Social Inclusion Development Worker (item 3)
Richard Cryer, Non-executive Director (GCS)
Lisa Evans, Assistant Trust Secretary
Sue Field, Director of Nursing (GCS)
John McIlveen, Trust Secretary
Bren McInerney, Member of the public
Jan Marriott, Non-Executive Director (GCS)
Sue Mead, Non-Executive Director (GCS)
Kate Nelmes, Head of Communications
Brian O'Donoghue, Expert by Experience (item 3)
Candace Plouffe, Chief Operating Officer (GCS)
Nick Relph, Non-Executive Director (GCS)
Graham Russell, Non-Executive Director (GCS)
David Seabrooke, Interim Trust Secretary (GCS)
David Smith, Executive Director for Transition (GCS)
Nicola Strother Smith, Non-Executive Director (GCS)

1. WELCOMES, APOLOGIES AND INTRODUCTIONS

1.1 Apologies were received from Nikki Richardson, Jonathan Vickers, Duncan Sutherland and Helen Goodey

2. DECLARATIONS OF INTERESTS

2.1 Jane Melton reported that she had begun a two day per week secondment to the ICS. The Joint Chief Executive congratulated Jane on this appointment.

3. SERVICE USER STORY

3.1 The Board welcomed Brian O'Donoghue a Herefordshire based service user and Expert by Experience to the meeting. Brian was in attendance to talk about his experiences of suffering from mental health issues following his service in the Armed Forces. He reported that he had joined the army in 1990 and had undertaken tours of duty all over the world including two tours of Bosnia. He reported that he had been in many conflict situations over the years and had not suffered any ill health, however he took on a training role in 2001 and following an incident during this assignment he began to feel unwell. He had already planned to leave the army but after visiting his GP who confirmed that he was suffering from depression he decided to leave the army with immediate effect. He did not feel he could

raise his diagnosis with the army as he was concerned about the culture where he had heard people told to 'man up' or 'get a grip'.

3.2 Brian reported that in 2015 things deteriorated and his GP suggested talk therapy and he was referred to 2gether. He received an initial telephone consultation and was diagnosed with PTSD. He was told that his depression would need to be resolved before the PTSD could be dealt with and he asked the Trust to ensure that all veterans were made fully aware of this. Brain said that he did not want to take anti-depressants when they were first suggested but when the treatment was fully explained during his first IAPT session he felt comfortable with the process.

3.3 The talk therapy helped Brian to resolve a number of issues and while he waited for the PTSD treatment he reached out to Combat Stress. He was offered a two week full time programme, however he was unable to leave his wife and employment to attend. He later began IAPT and went through some very difficult sessions where he discussed the triggers for his PTSD. He was signed off after 9 sessions.

3.4 Following his treatment Brian was asked to become an Expert by Experience. He said that he hoped that the Armed Forces were now treating their men and women better, he added that debriefs needed to improve and the culture needed to change. He also said that veteran care must improve. He strongly advocated physical activity to help combat mental illness and although there was no 'quick fix' he was now in recovery.

3.5 Marcia Gallagher asked if the Trust could have done any more and if support was offered to his wife. Brian said that the Trust should be very clear to service users about the type of treatment being offered and the anticipated timeline. Brian added that his wife had been very well supported; he said that she was bi-polar and was receiving support and treatment through the GP.

3.6 The Director of Service Delivery asked how the Trust could get senior leaders of the Armed Forces to recognise the effects of service. Brian said that the Trust should approach the Government for support; he said that for many veterans it was 6 -13 years before they became really unwell. He suggested that servicemen and women who had suffered mental health issues were needed in Leadership positions. The Chief Operating Officer (GCS) asked how the army could be encouraged to develop an understanding of Mental Health issues. Brian said that funding was needed for the Army to provide training in Mental Health awareness and he recommended that the Trust tried to gain access into the armed forces community.

3.7 The Joint Chair thanked Brian for sharing his story, she said that the Trust had signed up to the Armed Forces Covenant and would look into what more could be done.

4. MINUTES OF THE PREVIOUS MEETINGS

- **Minutes of the Meeting held on 6th June 2019**

4.1 The minutes of the 6th June were agreed as a correct record subject to the following amendment;

- Minute 3.5 – *Sonia was asked whether social care was being discussed as the CQC did not currently have a Freedom to Speak Up Guardian.* CQC would be amended to Gloucestershire County Council.

5. MATTERS ARISING AND ACTION LOG

5.1 The Board reviewed the action points, noting those that were complete or progressing to plan.

- Action 7.6: The Director of Quality reported that he was liaising with network colleagues on how to obtain comparative data regarding readmissions to hospital within 28 days of discharge. This would be brought back to a future Board meeting. Complete.
- Action 3.5: The Joint Director of Finance reported that the development of Freedom to Speak Up work would be raised by the Chief Executive with the ICS Executive. Complete.

5.2 There were no matters arising.

6. LEADERSHIP AND STRATEGY

- **Chair's report**

6.1 The Board received and noted the Chair's Report.

- **Chief Executive Report**

6.2 The Chief Executive presented his report to the Board which provided an update on key national communications and a summary of progress against local developments and initiatives.

6.3 The Board noted that he continued to spend time visiting front-line services in both organisations and extensive engagement activities had taken place during the past month by both the CEO and the Executive Team. The Board noted that as the strategic intent progressed colleagues from both trusts were regularly working together. The Chief Executive reported that he had attended the Complex Psychological Interventions (CPI) Service away day to provide an update on service developments. He continued to attend meetings across the Trust including Council of Governors, Team Talks, the Gloucestershire Leadership Network and Hereford Senior Managers Network. A number of areas of Partnership working were noted, along with Herefordshire integrated working developments.

6.4 The Joint CEO reported that the Joint Annual General meeting had taken place on 23 July, at the Friendship Café at Chequers Bridge in Gloucester. This venue was chosen as it belonged to a Charitable Organisation and was at the heart of the local community. The Board agreed that this had been a really successful event.

6.5 Progress on the strategic intent to merge Gloucestershire Care Services NHS Trust (GCS) with [2]gether NHS Foundation Trust was noted and the Chief Executive reported that the Trusts were still on track to become one organisation as of 1 October 2019.

6.6 The Director of Nursing (GCS) reported on EU Exit Planning. The Board noted that the Trust continued to follow national guidance and was responding to all information requests from the Department of Health and Social Care and NHS England. The Director of Nursing (GCS) reported that all Trusts had been asked to undertake an assessment and it was noted that Brexit fatigue was a concern across all organisations. The Board noted that Trusts had been asked not to stockpile medicines and had asked for assurance around vaccinations. The Director of Nursing (GCS) reported that the Work Force was a concern and the Joint Director of HR and OD was aware.

6.7 The Medical Director reported that the National Patient Safety Strategy was published in July. The Board noted that the aim of this strategy was to make the NHS the safest healthcare system in the world, this new strategy for patient safety set out plans to focus on continuous learning and measurable improvements.

6.8 The Chief Operating Officer (GCS) reported that the June Accident and Emergency Delivery Board had reviewed the findings of the Urgent Care summit as part of the refresh of the Gloucestershire urgent care improvement plan and support planning for the 2019/20 winter season. The Board noted that the Chief Operating Officer (GCS) and her team were supporting Priority 2: Design and Implement an Enhanced Independence Offer (EIO).

- **One Gloucestershire Integrated Care System Update**

6.9 The Joint Chief Executive updated the Board on the progress being made in the ICS transformation programmes against the system vision and priorities. The Board noted the updates on the main programme areas;

- Enabling Active Communities;
- Reducing Clinical Variation;
- One Place, One Budget, One System;
- Clinical Programme Groups.

6.10 The Board also noted an overview of the NHS Long Term Plan Implementation Framework and an outline of the One Gloucestershire approach to developing the local system response to the Long Term Plan. The Joint Chief Executive reported that the response was due for final submission by mid-November 2019 (with draft submission September 2019). The Board noted that the Implementation Framework outlined the expectations on systems to ensure that system responses were clinically led and locally owned and summarised the "foundation commitments" within the Long Term Plan that had specified timelines for delivery. It was reported that Partner Organisation Boards and the Governing Body were to be consulted on the draft response in October/November. Nick Relph asked about the long term system approach, the Joint Director of Finance reported that the draft response would be received before the merger and Lisa Proctor would be leading on the long term approach.

6.11 Nicola Strother Smith asked how NEDs would receive assurance around the ICS, The Joint Chair assured the Board that as Audit Chairs Marcia Gallagher and Richard Cryer had been involved in discussions. Nick Relph said that the ICS was keen to get more NEDs involved although it was currently unable to have a committee in common.

- **One Herefordshire and Worcestershire**

6.12 The Deputy Chief Executive provided Board members with an update in relation to work ongoing within Herefordshire and the Herefordshire and Worcestershire STP.

- **One Herefordshire**

6.13 The Deputy Chief Executive reported that since the last meeting of the Board Duncan Sutherland had been confirmed as Chair of the Integrated Care Alliance Board (ICAB). This Board brought together the Clinical Directors of the Primary Care Networks, Wye Valley Trust, Clinical Commissioning Group, Social Care, Taurus (the GP federation) and the Trust. The Deputy Chief Executive reported that Duncan's role would be pivotal in the success of this work and would help ensure that equitable views around physical and mental health were considered. Duncan would take up the Chair's role formally from the September 2019 meeting. Tamar Thompson was to take on the role of independent chair to the ONE Herefordshire Executive Board from September 2019 and similarly would help ensure that the Trust's overall strategic direction was balanced.

6.14 It was noted that the main focus of this Board was on improving community services delivery through integration and collaborative working. These revisions to the Governance arrangements should ensure a more equitable and challenged approach to progressing the transformation and integration arrangements in Herefordshire.

6.15 The Deputy Chief Executive reported that additionally, the Trust continued to engage with Senior Leadership across Herefordshire Services in relation to the review of the future delivery of mental health and learning disability services. The Board members noted that 50-60 colleagues attended the last Senior Leadership forum (SLF) and supported management in identifying a range of issues they would like to be considered as work progressed. Governor Representatives had also attended and contributed to the SLF.

- **Herefordshire and Worcestershire STP**

6.16 The Deputy Chief Executive reported that the revised governance arrangements around the Herefordshire and Worcestershire STP (H&W STP) had also progressed since the last Board meeting. Initial meetings of the refreshed H&W STP Executive Forum chaired by Sir David Nicholson and the H&W STP ICS Partnership Board Chaired by Dr Iain Tait had taken place. The Terms of Reference for these groups were noted.

6.17 Both groups had been considering how to approach the implementation of the NHS Long Term plan across Herefordshire and Worcestershire alongside our commitment to integration, transformation, improving experiences and achieving a sustainable STP. To support this, Herefordshire and Worcestershire Healthwatch groups had been commissioned to undertake a range of engagement events to provide user, carer and the public's views, on the eight priority areas for development. A self-assessment had also been commissioned from the Executive Board members to get a view of development as a system. Some 15 colleagues had completed the self-assessment and the analysis of this was noted.

- **Annual Membership Report**

6.18 The Head of Communications provided a full analysis of the 2018/19 financial year membership data for [2]gether NHS Foundation Trust. The Board noted that in September 2016, the Council of Governors agreed the Trust's current Membership Strategy. The focus had been on retaining members and recruiting new members, with a specific emphasis on young members, members from black, Asian and minority ethnic backgrounds and men, who were all under-represented. More recently, there had been a focus on attracting new members who used the services of, or had an interest in the work of Gloucestershire Care Services, in advance of the proposed merger.

6.19 The Director of Engagement and Strategy reported that there were currently 8,116 members of the Trust at the end of the 2018/19 financial year. This represented an increase of 311 members (4%) over the year. Graham Russell asked if the Trust should be more ambitious and look to double the number of members, he noted that the Trust would have to change the approach to recruitment and look at new ways of attracting members. The Head of Communications said that there may need to be a debate about meaningful engagement and investment. Marcia Gallagher asked whether the Trust would be maximising the links with the Barton and Tredworth Community following the recent AGM held at the Friendship Café. The Head of Communications reported that the Trust had met the target for Black and Ethnic Minority membership; this was achieved mainly through attendance at Barton and Tredworth fare and through links with Bren McInerney and the Friendship Café.

6.20 The Director of Engagement and Integration reported that the Trust would need to consider what people wanted from membership, some may only want to receive information about services while others may be happy to be more involved. The Director of Service Delivery reported that the long term aim was to address health inequalities and to effectively engage with hard to reach groups. The Trust Secretary added that engagement needed to be improved; he reported that turn out for recent Governor Elections had been very low.

7. REPORTS FROM COMMITTEES

- **Governance Committee**
  - **Governance Committee Update – 28th June 2019**

7.1 The Director of Nursing reported that there were no significant risks to report to the Board at this time.

  - **Quality Report**

7.2 The Director of Nursing reported that the Quality Report had been approved at the last meeting of the Audit Committee on 24th May. KPMG had reviewed the draft report for consistency and tested a number of mandated indicators; an unqualified audit opinion was issued. It was noted that the report had not been brought to this Committee prior to that meeting due to the timing of the meetings.

7.3 It was reported that 2 indicators were not met. 1 related to Discharge Care Planning and 1 was regarding the recommendation to increase supine restraint rather than using prone. The Director of Nursing assured the Committee that he was monitoring those indicators and he hoped to be in a position to report some improvement on discharge planning at the next Governance Committee meeting.

  - **Service Experience report**

7.4 The Director of Engagement and Integration provided the Committee with an overview of feedback received from service users and carers in Quarter 4 2018/19. It was reported that learning from people's experiences was the key purpose of this paper, which provided assurance that service experience information had been reviewed, scrutinised for themes, and considered for both service-specific and general learning across the organisation.

7.5 The Board noted that there was limited assurance that people were participating in the local survey of quality in sufficient numbers, this risk was logged on the Trust Risk Register and a structured plan was in place to increase response numbers.

7.6 Adherence with complaint response timescales had also been identified as having limited assurance this quarter. Service Experience and operational colleagues were working hard to investigate and respond to complaints in a timely way, however challenges had been encountered due to staffing levels and availability this quarter. This was also logged on the Risk Register for onward monitoring and action.

- **Delivery Committee Updates – 22 May and 26 June 2019**

7.7 The Board received the summary reports from the Delivery Committee meetings held on 22 May and 26 June 2019. The reports and the assurances provided were noted.

- **Appointments and Terms of Service Committee Update – 17th July 2019**

7.8 Marcia Gallagher reported that the recent AToS Committee had been chaired by Nikki Richardson. The Committee had discussed and noted the Executive Performance reports and the Joint Chief Executive had taken some actions away. The Joint Chief Executive had then left the meeting and the Director of HR and OD presented his report on the CEO.

8. MONITORING REPORTS

- **Financial Report Prior month 3**

8.1 The Joint Director of Finance provided the Board with an overview of the Trust's financial position for Month 3 of 2019/20. The Board noted that the Trust's Control Total surplus was £2.256m including £1.626m of Provider Sustainability Funding (PSF). Capital spend plan was £2.93m of in-year CRL request, plus £0.75m of multi-year CRL allocation for the Forest of Dean hospital. Total £3.68m. The Board noted that the Cost Improvement Plan (CIP) target was £5.3m and the Agency spending cap was £1.865m.

8.2 The Joint Director of Finance reported that Income potential Commissioning for Quality and Innovation (CQUIN) and Quality, Innovation, Productivity and Prevention (QIPP) were £1.06m and £3.9m respectively. Contracts had not yet been signed, with milestones and proportional values for respective periods not yet allocated. The Board noted that the month 3 full year performance forecast was on plan, subject to the risks set out in the report.

- **Performance Dashboard Operational Exceptions Report – Prior month 2**

8.3 The Director of Service Delivery reported on the performance of the Trust's Clinical Services for the period to the end of May, (month 2 of the 2019/20 contract period); against our NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

8.4 The Board noted that of the 156 performance indicators, 77 were reportable in May with 67 being compliant and 10 non-compliant at the end of the reporting period. Indicators that were new for 2019/20 had been identified with dark blue in the indicator number column. Where performance was not compliant, Service Directors were taking the lead to address issues and work is ongoing in accordance with our agreed Service Delivery Improvement Plans to address the underlying issues affecting this performance.

8.5 The following 10 key performance thresholds were not met for the Trust for May 2019:

Department of Health Requirements

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

Gloucestershire CCG Contract Measures

- 3.36 – Adolescent Eating Disorders – Routine referral to NICE treatment within 4 weeks
- 3.40 – Adult Eating Disorders: Wait time for assessments will be 4 weeks
- 3.41 – Adult Eating Disorders: Wait time for psychological intervention will be 16 weeks

The Director of Service Delivery reported that it was felt that some of the content (indicators and thresholds) within Gloucestershire's Schedule 4 did not reflect the Trust's 2019/20 contract negotiations with Commissioners. Further negotiations had begun to resolve this position. The Trust had proposed the removal of incomplete indicators and the reassessment of altered indicators via a contract variation. These would then be reintroduced when appropriately prepared. This was progressing through Contract Management Board (CMB).

Gloucestershire Social Care Measures

- 4.02 – Current placements aged 18-64 to residential and nursing care homes per 100,000 population

- 4.03 – Current placements aged 65+ to residential and nursing care homes per 100,000 population
- 4.06 – Eligible service users for Social Care have a Personal Budget
- 4.07 – Percentage of eligible service users with Personal Budget receiving Direct Payments

Herefordshire CCG Contract Measures

- 5.13 – CYP Access: Percentage of CYP in treatment against prevalence
  The Director of Service Delivery reported that he was currently investigating how to speed up appropriate placements for CYPS; it was anticipated that the IROS project would help.
- 5.15 – Zero inappropriate admissions of patients to hospitals outside Herefordshire and Worcestershire

8.6 The Board noted that although performance wasn't a current concern, IAPT was one of the areas which remained a priority for the Trust due to the potential to carry contractual, financial, reputational or quality risk. The Director of Service Delivery reported that significant improvements were being made in IAPT. Staff turnover had been reduced and the service was now looking at how in-stage waits could be improved. CYPS/CAMHS Referral to Assessment waiting times were another area of continued focus. The Director of Service Delivery reported that Gloucestershire Clinical Commissioning Group were aware that this was a challenge and work was taking place with NHS England.

9. FOR INFORMATION

- **Forward Planner for the Board**

9.1 The Board noted the Forward Planner for the next meeting of the Board.

10. ANY OTHER BUSINESS

- **Change to the Trust Constitution**

10.1 The Board received an additional paper which proposed an amendment to the current provision that disqualified Non-Executive Directors from holding concurrent NED positions in 2gether and in another Trust, save where this was as a preparatory measure for a merger or was a joint appointment in the local health system.

10.2 The Board noted that the original provision in the constitution dated back to a time when foundation trusts were competing for business, for example through services being tendered. The current climate was very different, as trusts come together in Integrated Care Systems to manage the local health economy, and the most recent amendment to this provision, in August 2017, was incorporated to allow joint directorships in these circumstances, or when a merger was contemplated.

10.3 The Board noted that multiple NED appointments had been encouraged by NHS Improvement for some time in respect of NHS Trusts. However, there were also circumstances beyond these where it would be helpful for a NED's development (and thus beneficial for the Trust) to hold positions in more than one organisation, (provided that any potential conflicts of interest could be managed or avoided), particularly if the other trust provided a different range of services to those provided by 2gether. Accordingly, the following change to paragraph 32.1.14 of the Trust's constitution was proposed, with the additional provision in bold text:

- *The following may not become or continue as a member of the Board of Directors: a person who is a director of an NHS trust or another NHS foundation trust. This exclusion shall not apply in the context of any joint appointments in contemplation of a merger or acquisition in accordance with section 56/section 56A of the 2006 Act or in the context of a joint local health system-wide appointment**, or where the Chair and Chief Executive are satisfied that any proposed or existing concurrent appointment would not constitute a conflict of interests which could not be managed or avoided.***

10.4 The Trust Secretary reported that amendments to the constitution must be agreed both by the Board of Directors and the Council of Governors. The Joint Chair reported that this brought the Trust in line with other NHS Organisations; she said that some conflicts of interest may be evident in advance but others may need to be managed as they arose. Maria Bond noted that a decision had been taken a while ago which meant that Governors were unable to be on the Council of more than one NHS Trust. The Joint Chair said that the Board would need to consider its response if this was raised.

10.5 The Board approved this amendment to the Trust's constitution and noted that the proposed amendment to the constitution would go to the Council of Governors meeting on 21st August for final approval

- ***Trust Secretary - Retirement***

10.6 The Board noted that this would be the Trust Secretary's last Board meeting with the Trust. The Chair wished him the very best for the future and said that said that she had huge gratitude for all the work he had done for 2Gether and for GCS. The Chief Executive agreed and said that he had been a very professional colleague who was greatly respected across both Trusts and would be sorely missed. He added that John was an excellent leader who had developed an effective team. The Board noted that John's interests outside of the Trust included his work as magistrate, his political interests and his work for animal rights. The Trust Secretary thanked the Board members for their kind words and he also thanked his colleagues for their support.

11. DATE OF THE NEXT MEETING

11.1 The next Board meeting would take place on Thursday 26th September 2019, venue to be confirmed.

Signed: …….. Date: …….
Ingrid Barker, Chair

[2]GETHER NHS FOUNDATION TRUST

BOARD MEETING
TOWN HALL, HEREFORD
25 July 2019

PRESENT

Ingrid Barker, Joint Trust Chair
Sandra Betney, Joint Director of Finance
Richard Cryer, Non-executive Director
Sue Field, Director of Nursing
Jan Marriott, Non-Executive Director
Sue Mead, Non-Executive Director
Candace Plouffe, Chief Operating Officer
Nick Relph, Non-Executive Director
Paul Roberts, Joint Chief Executive
Graham Russell, Non-Executive Director
Neil Savage, Joint Director of HR & Organisational Development
David Smith, Executive Director for Transition
Nicola Strother Smith, Non-Executive Director
Dr Amjad Uppal, Joint Medical Director

IN ATTENDANCE

Karen Bent, Social Inclusion Development Worker (item 3) (2g)
Maria Bond, Non-Executive Director (2g)
John Campbell, Director of Service Delivery (2g)
Lisa Evans, Assistant Trust Secretary (2g)
Marcia Gallagher, Non-Executive Director (2g)
Sumita Hutchison, Non-Executive Director (2g)
Jane Melton, Director of Engagement and Integration (2g)
Colin Merker, Deputy Chief Executive (2g)
John McIlveen, Trust Secretary (2g)
Bren McInerney, Member of the public
Kate Nelmes, Head of Communications (2g)
Brian O'Donoghue, Expert by Experience (item 3)
David Seabrooke, Interim Trust Secretary
John Trevains, Director of Quality (2g)

1. WELCOMES, APOLOGIES AND INTRODUCTIONS

1.1 Apologies were received from Nikki Richardson, Jonathan Vickers, Duncan Sutherland and Helen Goodey

2. DECLARATIONS OF INTERESTS

2.1 There were no Declarations of Interest received from those present.

3. SERVICE USER STORY

3.1 The Board welcomed Brian O'Donoghue a Herefordshire based service user and Expert by Experience to the meeting. Brian was in attendance to talk about his experiences of suffering from mental health issues following his service in the Armed Forces. He reported that he had joined the army in 1990 and had undertaken tours of duty all over the world including two tours of Bosnia. He reported that he had been in many conflict situations over the years and had not suffered any ill health, however he took on a training role in 2001 and following an incident during this assignment he began to feel unwell. He had already planned to leave the army but after visiting his GP, who confirmed that he was suffering from depression, he decided to leave the army with immediate effect. He did not feel he could raise his diagnosis with the army as he was concerned about the culture where he had heard people told to 'man up' or 'get a grip'.

3.2 Brian reported that in 2015 things deteriorated and his GP suggested talk therapy and he was referred to 2gether. He received an initial telephone consultation and was diagnosed with PTSD. He was told that his depression would need to be resolved before the PTSD could be dealt with and he asked the Trust to ensure that all veterans were made fully aware of this. Brian said that he did not want to take anti-depressants when they were first suggested but when the treatment was fully explained during his first IAPT session he felt comfortable with the process.

3.3 The talk therapy helped Brian to resolve a number of issues and while he waited for the PTSD treatment he reached out to Combat Stress. He was offered a two week full time programme, however he was unable to leave his wife and employment to attend. He later began IAPT and went through some very difficult sessions where he discussed the triggers for his PTSD. He was signed off after 9 sessions.

3.4 Following his treatment Brian was asked to become an Expert by Experience. He said that he hoped that the Armed Forces were now treating their men and women better, he added that debriefs needed to improve and the culture needed to change. He also said that veteran care must improve. He strongly advocated physical activity to help combat mental illness and although there was no 'quick fix' he was now in recovery.

3.5 Marcia Gallagher asked if the Trust could have done any more and if support was offered to his wife. Brian said that the Trust should be very clear to service users about the type of treatment being offered and the anticipated timeline. Brian added that his wife had been very well supported; he said that she was bi-polar and was receiving support and treatment through the GP.

3.6 The Director of Service Delivery asked how the Trust could get senior leaders of the Armed Forces to recognise the effects of service. Brian said that the Trust should approach the Government for support; he said that for many veterans it was 6 -13 years before they became really unwell. He suggested that servicemen and women who had suffered mental health issues were needed in Leadership positions. The Chief Operating Officer (GCS) asked how the army could be encouraged to develop an understanding of Mental Health issues. Brian said that funding was needed for the Army to provide training in Mental Health awareness and he recommended that the Trust tried to gain access into the armed forces community.

3.7 The Joint Chair thanked Brian for sharing his story, she said that the Trust had signed up to the Armed Forces Covenant and would look into what more could be done.

4. MINUTES OF THE PREVIOUS MEETINGS

- **Minutes of the Meeting held on 6th June 2019**

4.1 The minutes of the 6th June were agreed as a correct record subject to the following amendment;

- *Minute 3/0619 - Sonia was asked whether social care was being discussed as the CQC did not currently have a Freedom to Speak Up Guardian.* CQC would be amended to Gloucestershire County Council.
- Minute 9/0619 – Sue Field reported that a discussion had taken place as part of the Joint Chief Executive's report and it was agreed that an additional paragraph would be added to the minutes. *'Appended to the CEO's report was correspondence from OFSTED following their April 2019 monitoring visit to Gloucestershire Children's Social Care (CSC) services, which was highlighted by Sue Field. It was also noted*

that Gloucestershire County Council were now experiencing reductions in the rate of agency use (now at 38%) and that there had been a decrease in the number of social worker vacancies. The service had been rated inadequate in 2017 and the letter described slow progress being made in some areas and that variability across CSC teams was still evident. There remained a strong steer across all partners and from the CSC senior leadership team that all must remain "steadfast" with delivering the agreed Improvement Plan to safeguard children across Gloucestershire. It was also noted that the ICS had been invited to strengthen its focus on children's services generally.'

5. MATTERS ARISING AND ACTION LOG

5.1 The Board reviewed the action points, noting those that were complete or progressing to plan.

5.2 There were no matters arising.

6. LEADERSHIP AND STRATEGY

- **Board Assurance Framework**

6.1 The Interim Trust Secretary presented the Board Assurance Framework which provided details of the Trust's Strategic risks. The Board noted any gaps in controls and assurance and the mitigating actions in place. The Interim Trust Secretary reported that this document would be reviewed in full once the new organisation was in place. The Joint Chair said that the Shadow Board was undertaking work on the Strategic Objectives.

6.2 The Joint Chief Executive noted the red risk SR5 which concerned '*the failure to recruit and retain colleagues with the right knowledge, skills, experience and values required to deliver sustainable services and support transformation; resulting in care which does not meet the needs of service users'.* Sue Mead said that there was a lack of investment in Community Services and she asked what progress was being made. The Joint Chief Executive reported that this would always be a risk but he assured the Board that progress was being made. A long term plan was in place and there were encouraging signs in the system. It was anticipated that as a merged organisation the new Trust would have more influence in any future plans.

6.3 Richard Cryer noted that the majority of risks had seen no change and he asked if the Board was satisfied with the mitigation. The Joint Chief Executive reported that he was not comfortable with the current position and he said that as this Trust moved into the new merged organisation improvements needed to be made.

6.4 Marcia Gallagher asked when the Shadow Board would be asked to agree the new risk process. The Joint Chief Executive reported that this was discussed at the last Shadow Board, a draft risk statement had been considered and the new Director of Strategy and Partnerships would be taking on this work as part of her portfolio.

- **Chair's report**

6.5 The Board received and noted the Chair's Report.

- **Chief Executive Report**

6.6 The Chief Executive presented his report to the Board which provided an update on key national communications and a summary of progress against local developments and initiatives.

6.7 The Board noted that he continued to spend time visiting front-line services in both organisations and extensive engagement activities had taken place during the past month by both the CEO and the Executive Team. The Board noted that as the strategic intent progressed colleagues from both trusts were regularly working together. The Joint Chief Executive reported that he had attended the Complex Psychological Interventions (CPI) Service away day to provide an update on service developments. He continued to attend meetings across the Trust including Council of Governors, Team Talks, the Gloucestershire Leadership Network and Hereford Senior Managers Network. A number of areas of Partnership working were noted, along with Herefordshire integrated working developments.

6.8 The Joint Chief Executive reported that the Joint Annual General meeting had taken place on 23 July, at the Friendship Café at Chequers Bridge in Gloucester. This venue was chosen as it belonged to a Charitable Organisation and was at the heart of the local community. The Board agreed that this had been a really successful event.

6.9 Progress on the strategic intent to merge Gloucestershire Care Services NHS Trust (GCS) with [2]gether NHS Foundation Trust was noted and the Chief Executive reported that the Trusts were still on track to become one organisation as of 1 October 2019.

6.10 The Director of Nursing (GCS) reported on EU Exit Planning. The Board noted that the Trust continued to follow national guidance and was responding to all information requests from the Department of Health and Social Care and NHS England. The Director of Nursing (GCS) reported that all Trusts had been asked to undertake an assessment and it was noted that Brexit fatigue was a concern across all organisations. The Board noted that Trusts had been asked not to stockpile medicines and had asked for assurance around vaccinations. The Director of Nursing (GCS) reported that the Work Force was a concern the Joint Director of HR and OD was aware.

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6.12 The Chief Operating Officer (GCS) reported that the June Accident and Emergency Delivery Board had reviewed the findings of the Urgent Care summit as part of the refresh of the Gloucestershire urgent care improvement plan and support planning for the 2019/20 winter season. The Board noted that the Chief Operating Officer (GCS) and her team were supporting Priority 2: Design and Implement an Enhanced Independence Offer (EIO).

- **One Gloucestershire Integrated Care System Update**

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The Board noted that the Implementation Framework outlined the expectations on systems to ensure that system responses were clinically led and locally owned and summarised the "foundation commitments" within the Long Term Plan that had specified timelines for delivery. It was reported that Partner Organisation Boards and the Governing Body were to be consulted on the draft response in October/November. Nick Relph asked about the long term system approach, the Joint Director of Finance reported that the draft response would be received before the merger and Lisa Proctor would be leading on the long term approach.

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7. REPORTS FROM COMMITTEES

- **Quality and Performance Committee Update – 27 June 2019**

7.1 The Board received the Quality and Performance Update report from the meeting held on 27th June. Nicola Strother Smith reported that the Musculoskeletal (MSK) Physiotherapy Service continued to experience significant demand and capacity risks including consistent non-achievement of its eight week referral to treat standards. An in-depth review of the service had been undertaken by operational colleagues and the Board noted that the service was receiving a high number of out of county referrals. The Chief Operating Officer reported that work was taking place to improve this.

- **Resources Committee Update – 11 July**

7.2 Graham Russell provided the Board with assurance that the Resources Committee was discharging its responsibility for oversight of the Trust's resources on behalf of the Board. The Board noted the progress made against the Trust's operating plan and the work being undertaken on the Gender Pay Gap. The key risks and issues identified by the Committee and the actions taken to mitigate these risks were also noted and the approval of the 2018/19 Reference Costs were ratified.

8. MONITORING REPORTS

- **Financial Report Prior month 3**

8.1 The Joint Director of Finance reported that the year to date surplus was on plan at £0.4m. The full year forecast was to deliver a control total of £2.256m, it was noted that there were significant risks to this if the Trust could not deliver its Challenge CIP Schemes. The Joint Director of Finance reported that PSF accounted for £1.626m of the control total surplus.

8.2 The Board noted that the Annual Agency ceiling was £1.865m (18/19 full year spend was £1.66m) and the year to date actual was under the ceiling at £558k. The full year Cost Improvement Plan (CIP) target was £5.28m. The CIP amount removed so far was £2.001m from the following schemes: 1% Schemes £1.372m; Differential Targets £0.521m and Challenge Schemes £0.108m.

8.3 It was reported that the asset lives changes following the District Valuer's work in 2018/19 had led to £540k of additional cost and this was currently being managed through non-recurrent underspends. Capital spend was £503k and the cash balance at the end of month 2 was £382k below plan at £18.1m. The PSF cash payment for 18/19 was expected in July, improving the cash position by £2.7m.

Quality and Performance Report Prior month 3

8.4 The Director of Nursing provided an overview of the key achievements of the Quality and Performance Committee and outlined those areas where improvements were being made or where further improvement was required.

8.5 The Board noted a decline in Safety Thermometer percentage of Harm free Care (New Harms only). The percentage of harm free score for new harms only had fallen significantly from **98.1%** in May to **96.9 %** in June. The Board noted that the New Harms were made up of pressure ulcers, falls with low harm and urine infections where catheters were in situ. The Director of Nursing reported that a review of every harm reported for June had been undertaken, she said that improvements would be made but these were not likely within the next 6 months. The Board noted that the Quarter 1 outcomes of the quality improvements with regards to the Trusts Quality Priorities were favourable across the board and most notably with:

- Deteriorating Patient (Sepsis)
- Nutrition and Hydration
- Completed Mental Capacity Assessments (MCAs)

8.6 The Board noted that three key service areas continued to have challenges in meeting the Trusts locally set 8 week referral to treatment key performance indicator, these were:

- Adult Speech and Language Therapy services
- Musculoskeletal (MSK) Therapy services
- Integrated Community Teams therapy services

8.7 The Board was disappointed to note that the Staff Family and Friends Test – Quarter 1 results had seen a decline of *"How likely you are to recommend Gloucestershire Care Services NHS Trust as a place to work?"* to **52%** compared to **57%** from the 2018-19 Quarter 4 outcomes. The Director of Nursing reported that a high percentage of responses had come from Corporate Services and work was taking place to ensure that more representative responses were received next time.

9. FOR INFORMATION

- **Forward Planner for the Board**

9.1 The Board noted the Forward Planner for the next meeting of the Board.

10. ANY OTHER BUSINESS

10.1 The Chief Operating Officer reported on work being undertaken with Fit Bits. She asked how this work could be shared with the Board and it was agreed that the Joint Chief Executive would consider how this could be done.

ACTION: Joint Chief Executive to consider how the work being undertaken with Fit Bits could be shared with the Board.

11. DATE OF THE NEXT MEETING

11.1 The next Board meeting would take place on Thursday 26th September 2019, venue to be confirmed.

Signed: …….. Date: …….
Ingrid Barker, Chair

TRUST PUBLIC BOARD: PUBLIC SESSION - Matters Arising Action Log – as at the 25 July 2019

Key to RAG rating:

- Action completed (items will be reported once as complete and then removed from the log).
- Action deferred once, but there is evidence that work is now progressing towards completion.
- Action on track for delivery within agreed original timeframe.
- Action deferred more than once.

Minute reference (Item No.& Date)	Item	Action Description	Assigned to	Target Completion Date	Progress Update	Status
10/0718	Medical Revalidation process	Propose similar framework be considered for dentists	Medical Director	August 2019	Continues to be under consideration	
13/0918	E&D	Board Session to be arranged for shadow board	Chair	Ongoing	Kings Fund led development sessions in place consideration of specialist provider for E&D Development also being considered.	
10.1	Fit Bits	Joint Chief Executive to consider how the work being undertaken with Fit Bits could be shared with the Board.	Joint Chief Executive	September 2019		

Agenda item 7

Report to:	Trust Board, 26th September 2019
Author:	Alan Bourne-Jones, Risk Manager
Presented by:	John Trevains, Director of Quality
SUBJECT:	**Risk Register - Review**

Can this report be discussed at a public Board meeting?	**No**
If not, explain why	Contains potentially commercial information

This Report is provided for:

Decision **Endorsement** **Assurance** **Information**

EXECUTIVE SUMMARY

The purpose of this paper is provide the Board with information and assurance in respect of;

- Trust's Top 5 risks and Higher Scoring risks (Risk Score 12)
- Risk Management Framework [Key risk processes, including reporting and oversight arrangements].

TOP 5 RISKS - (Appendix 1)

The following risks have been designated a Trust Top 5 Risk by the Executive Committee as at July 2019. It is noted that;

- Agency Management Control and Workforce [Operational] risk scores have increased recently – plans are in place to address this increase in risk
- Executive Management Committee to agree a new Top 5 Risk to replace the Planned Merger risk which has seen its risk score reduced and therefore removed from the Top 5 list.

ID	Risk Title	Risk Score	Assurance	Committee
116	Agency Management Control	16 ↑	Limited	Governance
173	Workforce - Recruitment [Operational]	16 ↑	Limited	Governance
177	Delivery of CIP Programme [2019/20]	12	Significant	Executive
48	Workforce - Workforce – [Strategic]	12	Limited	Governance

HIGHEST SCORING RISKS (Risk Score 12) - (Appendix 1)
These risks have been reviewed by each Directorate and Executive Management Committee prior to being reported to the appropriate Board Committee;

ID	Risk Title	Assurance	Committee
31	Data Quality	Limited	Delivery
112	IAPT Services (Gloucestershire & Herefordshire) - Performance Standards	Limited	Delivery
232	Section 12 Approved Doctors – Mental Health Act Assessments	Limited	MHLSC
121	Safeguarding - RiO Records Compliance	Limited	Governance
253	Reduced Consultant Psychiatrist capacity in Wotton Lawn and Crisis Services	Limited	Governance

Full details of each of the above risks are provided in this report. This includes the latest progress commentary available provided by the risk owner/handler
[Appendix 1]

RISK REVIEW
The following risks have been recently reviewed by the Executive Management Team who agreed that the following risk scores be reduced and removed from the list of Top 5 risks. However, these will be kept under review and scores updated to reflect the latest position for each of these key risks. This particularly applies to the Brexit risk as preparations for the "No Deal" option preparations step up.

216	Planned Merger (GCS)	Executive
243	Brexit - impact service delivery as a result of a No Deal Brexit position	Delivery

RISK FRAMEWORK
The Board approved a Risk Management Framework document in November 2016 which features a new "3 lines of Defence" model. This has been introduced to provide assurance to Board Committees (2nd Line of Defence) that there are robust arrangements in place (1st Line of Defence) to review, challenge and mitigate risks before they are escalated to Board committees. (Appendix 2)

1st Line of Defence (Directorates)
Arrangements are in place within all Directorates to review the risks that they have oversight responsibility for and each has a Risk Co-ordinator in place to ensure that the Risk Management Framework is applied. In addition, it is agreed that all higher scoring risks are reviewed by the Executive Committee to ensure appropriate reporting to Board Committees.

2nd Line of Defence (Board Committees)
Board committee reporting are well established with regular reports received in respect of the corporate risk register with the focus on those risks that score 12 and above [i.e High Risk].

RECOMMENDATIONS
The Board noted the contents of this report and the assurance provided.

Corporate Considerations	
Quality implications	Evidence of effective risk management provides assurance that risks are being identified and addressed thereby improving the safety of staff and patients.
Resource implications:	This paper views a range of risks across the whole trust any one of which may have resource implications and it is therefore not appropriate to highlight these individually here.
Equalities implications:	N/A
Risk implications:	This report provides information that helps identify risk implications and promotes their mitigation.

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	
Valuing and respectful		Efficient	

Reviewed by:		
John Trevains, Director of Quality	Date	1st August 2019

Where in the Trust has this been discussed before?		
N/A	Date	

What consultation has there been?		
N/A	Date	

Explanation of acronyms used:	

1. INTRODUCTION

1.1 The corporate Risk Register is a key document within the Trust and is designed to support senior management in managing their risks.

1.2 The purpose of this paper is to provide Board Committees with details of the Trust's higher scoring risks and to provide assurance around the effectiveness of the risk management framework.

2. RISK MANAGEMENT FRAMEWORK

2.1 The Board approved a new Risk Management Framework document in November 2016 which features a new "3 lines of Defence" model. This has been introduced to provide assurance to Board Committees (2nd Line of Defence) that there are robust arrangements in place (1st Line of Defence) to review, challenge and mitigate risks before they are escalated to Board committees. **(Appendix 2).**

3. REPORTING & OVERSIGHT

The following arrangements are in place;

3.1 Directorates / Localities - 1st Line of Defence

Arrangements are now in place within Directorates to review the risks that they have oversight responsibility for and each has a Risk Co-ordinator in place to support the process.

In addition, it is agreed that all higher scoring risks are reviewed by the Executive Committee to ensure appropriate reporting to Board Committees.

3.2 Board Committees - 2nd Line of Defence

Board committee reporting was already well established with regular reports received in respect of the corporate risk register, including those where the Board Committee has oversight responsibility.

4. RISK MANAGEMENT PROCESS

4.1 Datix

All risk registers (Corporate & Localities) are held on the new Datix system and enables the Risk Manager and Locality/Directorate Risk Co-ordinators to support the risk management process, particularly through the production of reports.

4.2 Risk Scoring Matrix

The Trust has adopted a risk scoring methodology based on that recommended by the NPSA where risks are scored based on an impact and probability score, which, when multiplied together produce a total risk score. The impact and probability scores are evaluated on a scoring range of 1 to 5 and so the maximum risk score possible is 25 (5 x 5). The risk scoring matrix is incorporated into the Datix system (**Appendix 3)**

4.3 Risk Scores

The following risk scores are provided;

- Initial This score is applied at the time the risk is first identified and assessed. The score represents the risk without any mitigation in place.
- Current This is the risk score with mitigation that has taken place to date.
- Target dates - The use of target dates to meet the target risk score (i.e. risk appetite) is under further consideration, recognising these need to be used effectively and consistently. There is an issue for those risks which are unlikely to meet their target in the short/medium term. However, there is more focus on setting realistic target dates and providing rationale if these need to be changed. This date is also a prompt to Board Committees to request a detailed review of the risk and its progress.

4.4 Risk Co-ordinator Role

Locality/ Directorate Risk Registers are maintained by Risk Co-ordinators and reviewed at their respective oversight Committees/management meetings.

4.5 Levels of Assurance

Each risk has been allocated a Level of Assurance by their Action/Risk Owner (in line with Trust standard definitions) that is based upon the effectiveness of the controls in place around that risk. (**Appendix 3)**

4.6 Assurance Map

All Corporate & Locality higher scoring risks (risk score 12 and above) are formally considered for inclusion in the Assurance Map

5. TRAINING

5.1 Training has been provided at a number of meetings with Risk Co-ordinators to enable each area of the Trust to support the risk management process.

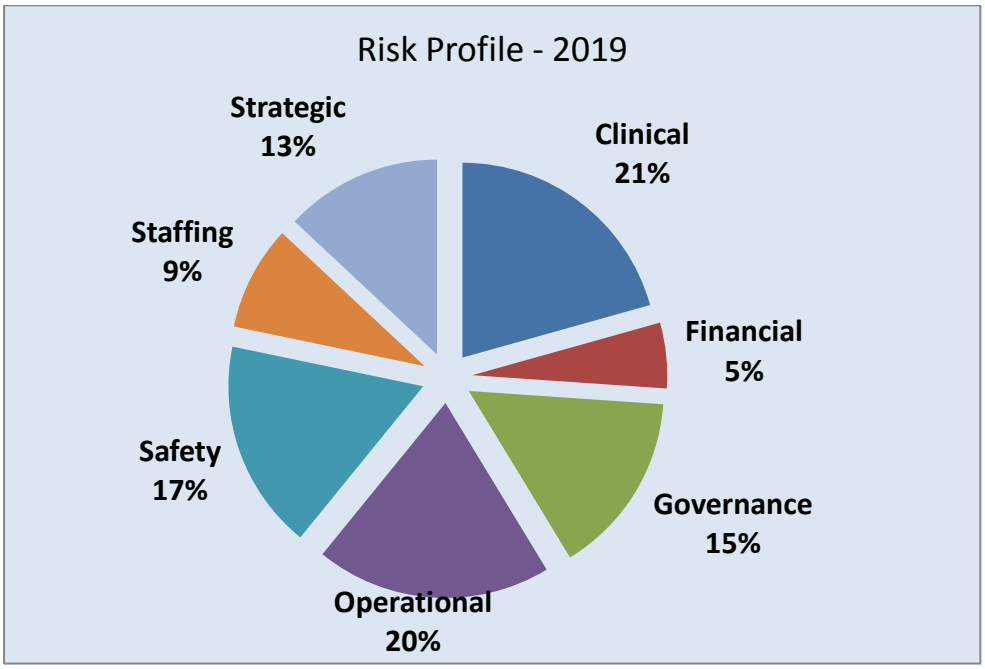
6. CORPORATE RISK REGISTER – OVERVIEW – (APPENDIX 1)

6.1 The focus in this report is on the corporate risks scoring 12 and above.

6.2 This approach is in line with advice from the Executive Committee who are responded to an internal audit review and benchmarking information around the excessive number of corporate risks. Risks below score 12 will be held on Locality and Directorate registers and will be overseen by their governance forums.

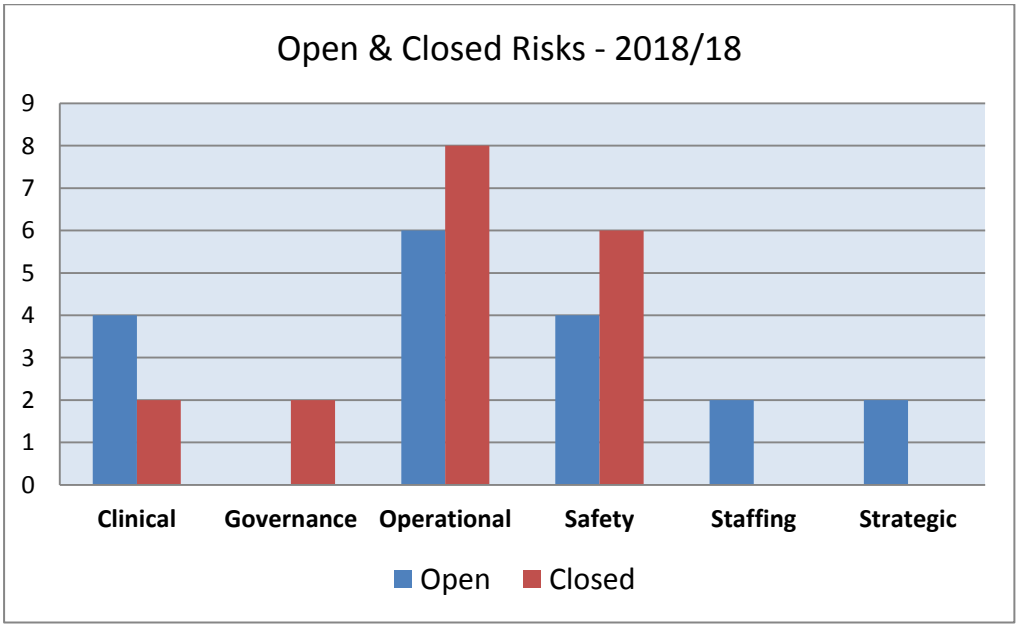
7.3 **Risk Profile**

The following shows the risk spread by category;



7.4 **Risk Registers**

There currently some 92 risks on the Trust Risk Registers. Since April 2018 some 18 risks have been closed whilst a further 18 have been opened (within Directorates and Localities), thereby indicating that the risk register process is dynamic and is becoming embedded within the Trust.



7.5 **Datix Developments**

The Datix Risk Module is vital in supporting the risk management process. There are regular meetings with Risk Co-ordinators in order to identify system changes to improve the recording of risks and providing effective reporting. However, the focus will now be on the development of a new risk module to be introduced in April 2020.

9. SUMMARY

9.1 Risk Management Framework

The Trust has established robust risk reporting arrangements to its Board Committees, ensuring that the appropriate information is reviewed.

The development of the Risk Management Framework approved in 2016 provides clarity around risk management responsibilities and reporting. It also provides assurance that risks are being identified and managed at the appropriate level (i.e. – the 1st Line of Defence) before they are escalated to Board Committees (2nd Line of Defence).

9.2 Merger

Work has commenced to harmonise the risk management policies of 2gether and GCS and to develop management reports. The following has been achieved;

- Datix Risk Module – project work commenced
- Risk Management Policy – draft completed for consultation
- Risk Appetite agreed

APPENDIX 1

TOP 5 RISKS

ID	Title	Description	Opened	Initial Risk Score (i.e. No mitigation)	Risk Commentary/Progress	Rating (Target) Consequence x Likelihood)	Target Date	Q2 2018/19 Consequence x Likelihood)	Q3 2018/19 Consequence x Likelihood)	Q4 2018/19 Consequence x Likelihood)	Q1 2019/20 Consequence x Likelihood)	Level of Assurance	Senior Risk Owner	Board committee responsibility [Last Review]
173	**Workforce - Recruitment [Operational] -**	That we fail to recruit to the medical and nursing workforce which may impact on patient safety and service delivery.	02/05/2017	4x4 =16	**Qualified Nursing Staff** The Trust continues to have vacancies for qualified nurses – See May position below NURSING VACANCIES **Nursing Posts available** Glos. 526.37 Hereford 148.3 **Nursing post filled** 457.99 125.96 **Nursing Vacancies** 68.38 22.34 **Vacancy % against Nursing only** 13% 15% **Trust Total Establishment** 1734.63 390.2 **Vacancy % against Total establishment** 4% 6% **Trust Total In-Post** 1567.62 351.78 **Vacancy % against Total In-Post** 4% 6% A number of newly qualifying Student nurses have been recruited and are due to start once training is completed late summer 2019. The Trust is attending recruitment events, promoting return to practice initiatives, has recently welcomed 7 newly qualified nursing associates back from their period of training and is monitoring recruitment through the temporary staffing group meeting. This group has recently been reviewed and the Director of Operations is now attending to support focus on both qualified and unqualified recruitment. To mitigate there is as master vendor contract with the MEDACS agency to supply qualified staff at both Stonebow and WLH. We are seeking to extend this arrangement with the provider. Medium term plans include a number of staff from Hereford and Gloucestershire on secondment to complete nurse training, they will be due to completing circa 2 years time. Long Term, University of Gloucester are recruiting 40 student nurse per year commencing this September 2019, this is set against traditional recruitment of circa 20 places per year. This will have a significant positive impact on future supply of qualified nurses.	3x2=6	~~31/03/2019~~ 31/03/2020	4x3=12	4x3=12	4x3=12	4x4=16	Limited	Trevains, John - Director of Quality John Campbell - Director of Service Delivery	Governance Committee
					The Deputy Director of Nursing has completed a scoping exercise of vacancies, retirees and nursing supply other the next 4 years. It is planned to use this information into a refreshed nursing workforce recruitment strategy and action plan to be produced on completion of the merger. This will be Gloucestershire Health & Care Trust work inclusive of an improved vacancy tracker and a dashboard to monitor nursing workforce. Unregistered Nursing Staff We have identified an escalating issue in Q1 2019 regarding increasing use of agency HCA's. This has been driven by increasing vacancies in bank, peri team and a rise in acuity increasing need for additional 1:1's. This is being urgently addressed with a stronger focus on vacancy management and recruitment, a HCA recruitment event in Glos is planned for 24/7/19 with a strong response to advert for applicants (this event will process applicants on the day) alongside changes to the B3/B2 ratio's. We are also working with the GCS bank office to commence sharing staffing resources.**[Director of Quality - July 2019]**								
				4x3=12	**Medical** **Consultants** There is a national shortage of consultants in psychiatry especially child and adolescent psychiatrists. We have vacancies that we are endeavouring to fill. We will need to invest in order to fill those vacancies. **Trainees** Although we had better recruitment this year we still need to see if strategies put in place will enable us to present as attractive employers to trainees who have a wide choice of placements. **[Medical Director - July 2019]**	4x1=4	~~31/03/2019~~ 31/03/2020	4x3=12	4x3=12	4x3=12	4x4=16	Limited	Dr Amjad Uppal - Medical Director / Caldicott Guardian	
116	**Agency Management Control**	If Agency Management control is not effective then this may impact both on quality and safety of services as well as the Trust's overall financial control total.	21/07/2016	4x4 =16	**Background** The Trust has an Agency Control total for 2019/20 of £3.134m which is set by NHSI. Financial Update In 2018/19 the Trust spent £4.486m on Agency staff which was £1.4m above the Agency Control total for that year. The risk is that without significant actions and intervention we will miss this target in 2019/20. Projections based on agency usage between January and March indicate this is a risk. Mitigation An Action Plan (with RAG status) is in place: (plan to be updated through temporary staffing group July 2019) > Reduce the use and cost of agency = Amber > Improve efficiency through the use of e-rostering = Green (to be reviewed) > Introduce financial monitoring & projections to aid agency management = Green > Changes to HR processes to speed recruitment, reduce agency, and improve retention = Amber > Action Plan to reduce IAPT costs effective from Q4 = Amber > Direct Engagement and use of PAYE Medics in place and savings being made = Amber **Risk Score & Assurance** The risk score was increased to 16 by Executive due to increase in costs being sustained at end of Q4 2018/19 into Q1 2019/20. Objective assessment is there is no increased risk to quality and safety. The increase is predominantly in the usage of HCA's [See below]. Agency usage is maintaining safe staffing levels and meeting increased demand for 1:1 observations to safely manage fluctuations in acuity **[Executive - July 2019].** **Unregistered Nursing Staff** We have identified an escalating issue in Q1 2019 regarding increasing use of agency HCA's. This has been driven by increasing vacancies in bank, peri team and a rise in acuity increasing need for additional 1:1's. This is being urgently addressed with a stronger focus on vacancy management and recruitment, a HCA recruitment event in Glos is planned for 24/7/19 with a strong response to advert for applicants (this event will process applicants on the day) alongside changes to the B3/B2 ratio's. We are also working with the GCS bank office to commence sharing staffing resources. **[Director of Qulity - July 2019]**	4x1=4	~~31/03/2019~~ 31/03/2020	4x3=12	4x3=12	4x3=12	4x4=16	Limited	Trevains, John - Director of Quality John Campbell - Director of Service Delivery	Governance Committee

TOP 5 RISKS														
ID	Title	Description	Opened	Initial Risk Score (i.e. No mitigation)	Risk Commentary/Progress	Rating (Target) Consequence x Likelihood)	Target Date	Q2 2018/19 Consequence x Likelihood)	Q3 2018/19 Consequence x Likelihood)	Q4 2018/19 Consequence x Likelihood)	Q1 2019/20 Consequence x Likelihood)	Level of Assurance	Senior Risk Owner	Board committee responsibility [Last Review]
177	**CIP Programme [Delivery]**	If Cost Improvement Plan [2018/19] is not delivered there is a significant risk that the Trust will not meet its financial control total.	13/06/2017	4x4 =16	**Overview** • Close monitoring via Transformation Board and PMO • Reporting to board monthly as part of finance report • Reported to other committees (e.g. Governance) • Confirm and Challenge sessions held • Detailed Executive Committee review and debate of the 2019/20 CIP plan as part of the overall 2019/20 Financial Plan. • QIA's have been completed and signed off by clinical Executives. • Ongoing Executive Committee consideration of CIP delivery. • Reviewed in detail as part of the Mid Year Review. • Trust is identifying additional schemes to ensure mitigations are in place for slippage or non delivery of current programme. • Good track record of CIP delivery in 2017/18 and 2018/19.**[Director of Finance & Commerce - July 2019]**	4x1=4	~~31/03/2019~~ 31/03/2020	4x3=12	4x2=8	4x2=8	4x3=12	Significant	Sandra Betney - Joint Director of Finance and Commerce	Executive Committee
48	**Workforce - Strategic** **Agreed by Executives restructure the Top 5 Workforce risks i.e. Workforce [Strategic] and Workforce [Operational] - [February 2018]**	That we fail to secure, retain and develop the workforce and evolve the organisational culture necessary to deliver our strategic objectives. (Appropriately skilled, engaged, equipped and led): **> Recruitment:** If the Trust fails to recruit the right number of staff with appropriate skills and who have values and attitudes which reflect the Trust values, it will not be able to maintain current services in line with our strategic objectives or regulatory requirements.	23/06/2014	4x4 =16	Review by Executives agreed to restructure the Top 5 Workforce risks i.e. Workforce [Strategic] and Workforce [Operational] -[February 2018] - Agreed by Executive Committee that Governance is the oversight Board Committee.This is a complex risk, consisting of three interlinked but separate topics which fall under the heading of Workforce Skills, Retention and Succession Planning. Recruitment: this captures concerns about potential (and actual) shortages of skilled staff. A range of actions have been put in place, both to increase recruitment in the short term but also to look at addressing skills shortages in the longer term, such as the implementation of Foundation Trust contracts to recruit agency medical staff on to our books, participation in the "Fast Follower" Nurse Associate programme, Gloucestershire-wide Advanced Practice workshops and work stream, local/regional/national recruitment fairs and a new more flexible Relocation Expenses Policy. Both a Herefordshire and IAPT action plans have been developed to tackle locality and service specific challenges and was considered by Executive Committee in Summer 2018 with further action planning following on from this. Through the ICS and STP, the Trust is working in partnership with other local providers, local authorities and educational partners to further develop apprenticeship options and funding for an ICS Apprenticeship Hub has been identified (June 2019). A nurse training guaranteed job and bursary replacement scheme has been enacted for this year's first ever UoG intake of degree nurse trainees. However, recruitment shortages remain a significant national problem and there are few 'quick fix' solutions. However, once the sustainability of existing plans and actions is assured, we expect to be able to continue providing improved levels of assurance. To support this, the Trust has joined a Department of Health Flexible Working Pilot to improve recruitment and retention. Fortnightly bank pay has been introduced to improve the Bank offer and work continues to make this a weekly offer. The Trust is piloting "Locum's Nest" to recruit new temporary medical staff. A series of Workforce Planning training sessions have been and will continue to be run across services this year to better equip managers to inform HEI commissioning and use of new roles. In July 2019 a large HCA recruitment event and interview process is being run in Kingsholm Rugby stadium.	4x2= 8	~~31/03/2019~~ 31/03/2020	4x3=12 Overall Risk Score}	4x3=12 Overall Risk Score}	4x3=12 Overall Risk Score}	4x3=12 Overall Risk Score}	Limited	Neil Savage - Director of Organisational Development	Governance Committee
		> Retention: If the Trust fails to retain its staff it will not be able to deliver its strategic objectives.		4x4 =16	**Retention:** The Trust wants to ensure that skilled and motivated staff remain working for the organisation. A number of initiatives are in place to help achieve this, including mechanisms to help people retire but remain working on the staff bank. Similarly, a new Flexible Retirement Scheme for medical staff was launched in June 2017 which is now offered to many other staff groups. The Trust is part of Cohort 3 of the NHS Improvement Retention Pilot Programme aimed at tackling RMN retention. A related action plan is being worked through based on the learning from the first two cohorts. This includes work on exit questionnaires, focus groups, a review of the Trust's probationary model. GCS has joined the Trust in this endeavour. The Trust has participated in the Department of Health Flexible bank scheme to improve retention of bank staff. Trust staff Turnover has reduced over the past 12 months in June was at just over 7%.	4x1=4	~~31/03/2019~~ 31/03/2020					Limited		
		> Leadership Development: If the Trust fails to develop the skills and succession planning of its leadership it will also be unable to recruit and retain its leaders and be unable deliver its strategic objectives.		4x3=12	**Leadership:** The Trust needs to ensure it has effective leaders who are fully equipped to develop and retain our employees. A range of activities and actions have been put in place including the establishment of a Leadership Forum. The programme for Band 7 managers is now complete and the Trust has agreed a Talent Management toolkit. In 2018, the Trust trained two cohorts on an STP Leadership Development Programme – Five Elements of Leadership - which was assessed and evaluated as highly successful. The ICS has been successful in bidding for additional funding and the Trust is working with ICS partners in delivering another 4 cohorts of this programme. We also continue to work with the Leadership Academy, Health Education England and STP partners to maximise the leadership development, succession planning/talent management and training opportunities available. The Trust has joined the South West Regional Leadership Academy Talent Board. A Board Development programme is in place with the King's Fund. ILM 3, 5,6 and 7 management courses are being provided alongside a LEAD programme. Successful in becoming part of the High Potential Talent programme to be rolled out in late 2019/20 by Leadership Academy. A Gloucestershire Managers Toolkit has been produced. The Trust continues to make use of the national and regional Leadership Academy programme. Original risk reviewed by Executives [February 2018] and agreed to include in this overarching strategic risk [i.e. ID 48]- Board [March 2019] supported a discussion paper " Leadership for a diverse & transformational organisation" Leadership discussion paper in July 2019 agreed the related Action plan for 2019/20 delivery and beyond. **[Joint Director of HR / Organisational Development - July 2019]**	4x1=4	~~31/03/2019~~ 31/03/2020					Significant		

Risk Score 12														
ID	Title	Description	Opened	Initial Risk Score (i.e. No mitigation)	Risk Commentary/Progress	Rating (Target) Consequence x Likelihood)	Target Date	Q2 2018/19 Consequence x Likelihood)	Q3 2018/19 Consequence x Likelihood)	Q4 2018/19 Consequence x Likelihood)	Q1 2019/20 Consequence x Likelihood)	Level of Assurance	Senior Risk Owner	Board committee responsibility [Last Review]
31	**Data Quality**	If Information provided by key electronic health record systems (i.e. RiO, IAPTUS) is not accurate or complete then this may adversely affect key business decisions, our services, Trust reputation and may also result in a regulatory breach. (Note: this risk description excludes Datix (Risk ID 263 - Governance Committee) and ESR).	06/01/2016	3X3=9	Data quality is overseen through Locality forums, locality boards and our Operational Performance Network (OPeN). Automated Internal monitoring reports are used to inform management, improve processes and documentation, and identify training needs. These are regularly monitored by operational staff via the Trust's Business Intelligence Portal. This reporting includes Performance & Assessment & Care Management dashboards, data quality exception reports and patient tracking lists. Wider corporate data quality audits are undertaken on a regular planned basis by our quality team and external auditors. These will be reported to the Trust's Governance Committee and recommended actions will be recorded on the Trust audit log along with associated action plans. There is a new DQUIP – Data Quality Improvement Plan which has been agreed as part of the contract negotiations for 2019/20 which puts a specific focus on improving data quality in the Trust. The Data Quality is now a risk that is overseen by the Delivery Committee with Locality Reports having to explicitly demonstrate what is being done to improve data quality. All Locality services continue to review data quality using two primary tools; our Patient Tracking List (PTL) and Assessment Care Management (ACM) Reporting tool. Service Directors have accepted responsibility to embed these tools into routine operational process to offer significant mitigation against our data quality risk. Our PTL has not improved over the last 6 months so a more is being done with services to refocus attention. This includes the engagement of Executives to drive momentum. Regular monitoring of patient tracking and ACM compliance is managed through our Operational Performance Network (OPeN), Service Director Meetings and Delivery Committee. Service Directors and Performance Leads have a new Locality reporting template to improve their focus on quality. This includes a performance exception section. This area continues to carry a high profile. **[Head of Information Management and Clinical Systems - July 2019]**	3 x2 = 6	~~31/03/2019~~ 31/10/2019	3x4= 12	3x4= 12	3x4= 12	3x4= 12	Limited	John Campbell - Director of Service Delivery	Delivery Committee
112	**IAPT Services (Gloucestershire & Herefordshire) - Performance Standards**	A failure to provide adequate capacity to address In Stage waiting lists will adversely impact on the delivery of IAPT Access Targets	14/07/2016	5 x3 =15	**Background** Delivery Committee reviewed 2018/19 full year performance at the July 2019 meeting. Performance against the improvement plan objectives and key performance indicators during 2018/19 has been largely successful. The services have delivered sustained achievement of RTT waiting times (both for 6 and 18 weeks) and recovery rates for patients (>50%) who access our services in Gloucestershire and Herefordshire. This significant improvement was recognised nationally with the Trust's Financial Risk Rating being moved to a '1' – maximum autonomy. Whilst achieving Access rates in line with our recovery plans for both Counties, we remain behind the national target of 19% (nationally mandated since March 2019). Whilst substantial improvements have been achieved, we have continued to hold a significant waiting list backlog throughout the year due to lower than planned staffing capacity levels in our services in both localities. Tackling these 'in-stage waits' will be a key focus of our plans in 2019/20. National expectations are that two thirds of the increase in access from 16/17 (15% national target) to 20/21 (25% national target) will be to support people with long-term conditions. This presents an affordability challenge for commissioners as at least two thirds of LTC activity will require high intensity interventions in comparison to general 'core' access which is approximately 70:30 between low intensity: high intensity interventions. Contract negotiations for 19/20 have provided additional funding to increase access, however this does not fully cover the requirement to achieve the national 22% access target by the end of 20/21. For Gloucestershire additional funding will enable 19% 'core' access to be delivered and up to 1.5% access via LTC. For Herefordshire funding will support delivery of 18% in core access and agreement has yet to be reached re LTC element given funding limitations. **Strategy for 2019/20** Strategy for 19/20 consists of three main elements: Address in-stage waits – plans being developed – will be reviewed by Delivery Committee Sept 19 Implement IAPT LTC – this will initially focus on supporting Cardiac Rehab and COPD patients – commenced July 19 Continue to increase 'core' access in line with additional funding **Risk Score & Assurance** In line with the current update the Risk Score remains 12 with Limited Assurance **[Director of Service Delivery]**	3x3= 9	~~01/04/2019~~ 31/03/2020	4x3=12	4x3=12	4x3=12	4x3=12	Limited	John Campbell - Director of Service Delivery	Delivery Committee

Risk Score 12														
ID	Title	Description	Opened	Initial Risk Score (i.e. No mitigation)	Risk Commentary/Progress	Rating (Target) Consequence x Likelihood)	Target Date	Q2 2018/19 Consequence x Likelihood)	Q3 2018/19 Consequence x Likelihood)	Q4 2018/19 Consequence x Likelihood)	Q1 2019/20 Consequence x Likelihood)	Level of Assurance	Senior Risk Owner	Board committee responsibility [Last Review]
253	**Reduced Consultant Psychiatrist capacity in Wotton Lawn and Crisis Services**	The availability of substantive Consultant Psychiatrist capacity in Wotton Lawn Hospital and Crisis Services is significantly reduced. There are 8 wte posts in all; 2 consultants are absent due to long term sick leave and 2 are vacant.	05/06/2019	**4x3=12**	**Background** The availability of substantive Consultant Psychiatrist capacity in Wotton Lawn Hospital and Crisis Services is significantly reduced. There are 8 wte posts in all; 2 consultants are absent due to long term sick leave and 2 are vacant. This is leading to: Reduction in continuity and consistency in care delivery and disruption to treatment plans for patient with increasingly complex needs. Potential increased risk around positive risk management and a delay in discharge and increased LOS. Increase pressure on other medical colleagues, nursing and allied health professionals and overall disruption to ward based therapeutic process and structure. Disjointed delivery of MDT meetings and increased challenge in the engagement of family and carers. We are receiving increased complaints/concerns raised by service users and carers – Service users are experiencing multiple consultants during their admission, recently 10 complex patients have had X3 different consultants in 2 weeks. **Mitigation** Cover is being provided through the non-medical RC and locum arrangements. However, a recent advertisement failed to produce an applicant which is evidence of the challenge the Trust faces. **[Joint Medical Director - July 2019]**	1x3=3	31/10/2019				**4x3=12**	**Limited**	Dr Amjad Uppal - Medical Director / Caldicott Guardian	Governance Committee
121	**Safeguarding - RiO Records Compliance**	If Trust fails to ensure that RiO records (Child in household) are accurate and complete then this may result in a serious incident/poor communication and information sharing between partner agencies.	23/08/2016	**4x3=12**	A number of Actions in place to address include: > This forms part of the Top 5 ACM Compliance Indicators. Team performances monitored by CSM's and Safeguarding Sub-Committee and QCR on a monthly basis. > Think Family Training incorporates session on how to document RiO > Safeguarding Team have visited Operational Teams to promote essential documentation. These actions have shown a gradual improvement over time. Risk Score & Assurance Whilst the gradual improvement is noted further assurance is required before the Level of Assurance and Risk Score can be moved. See additional actions below instigated by DoQ following further analysis of barriers to improvement fo this risk [Director of Quality - May 2019] • Current position on data and plateauing raised at QCR and with ops colleagues • Additional analysis and support from Jess Blakeman/RIO systems team now in place • Letter to team mangers re attention and resolution sent 15/7/2019 • Focus at QCR on static performance and risks – Monthly reporting at QCR to include recovery trajectories being agreed **[Director of Quality - July 2019]** Compliance - July 2019 Update **Directorate** **On CPA** **Standard care** **All** Glos Locality 76% 67% 69% Glos Countywide 67% 71% 64% CYPS 81% 69% 75% Hereford 85% 65% 67%	**4x1= 4**	~~01/09/2017~~ ~~01/09/2018~~ ~~1/12/2018~~ ~~1/07/2019~~ 31/12/2019	**4x3=12**	**4x3=12**	**4x3=12**	**4x3=12**	**Significant**	Trevains, John - Director of Quality	Governance Committee

Risk Score 12														
ID	Title	Description	Opened	Initial Risk Score (i.e. No mitigation)	Risk Commentary/Progress	Rating (Target) Consequence x Likelihood)	Target Date	Q1 2018/19 Consequence x Likelihood)	Q2 2018/19 Consequence x Likelihood)	Q3 2018/19 Consequence x Likelihood)	Q4 2018/19 Consequence x Likelihood)	Level of Assurance	Senior Risk Owner	Board committee responsibility [Last Review]
232	**Section 12 Approved Doctors - Lack of availability to undertake Mental health Act Assessments [Gloucestershire & Herefordshire]**	The availability of section 12 approved doctors out of hours is creating significant delays in Mental Health Act assessment taking place. This has resulted in patients experiencing unnecessary delays in assessment and treatment whilst waiting for several hours in the 136 suite. For urgent assessments the timescale for response is 1 hour and to have completed the assessment within 4 hours. This occurs more frequently out of normal weekly working hours but also occurs on weekdays as well.	27/06/2018	**4x3=12**	**Background** Risk paper taken to MHLSC 14th November 2018 by Risk Manager and it was agreed that; > Executive Risk Ownership - Director of Service Delivery and the Medical Director [who has now joined the MHLSC] > Committee agreed that risk was appropriate and MHLSC committee will continue to review. [Director of Service Delivery - December 2018] Mitigation Approach made to Section 12 solutions which is an interactive app to assist with securing section 12 doctors. Unfortunately we have not been unable to progress the app as the funding was only available for 18/19 and the provider could not commence work until later this year. As such we have had to pause this until we have a better understanding of our financial position for 19/20. **MHSLSC - May 2019** Detailed discussion and agreed that a paper to be brought back detailing the issues noting the risk score remains static. It was AGREED that the risk be escalated to the Board. [MHLSC - May 2019] Regardless there are still a number of things we can progress around this area of work: 1. Introduce revised system for processing s12 fee requests - Working on transferring the current process from the county council to the CCG. We would hope that this is in place by October. This will still be paper based claims but would hope that we can switch to electronic claims assuming we can implement the s12 solution app as above. 2. Produce guidance for s12/AMHPs regarding fee requests: This to be covered in the meeting offered by Amjad Uppal. 3. Explore possibility of OOH GPs undertaking MHAA either as s12 or second medic. To be progressed and reported on at the next scrutiny committee. **[Karl Gluck - CCG - July 2019]**	**4x1=4**	~~01/11/2018~~ 01/09/2019	**4x3=12**	**4x3=12**	**4x3=12**	**4x3=12**	**Limited**	Dr Amjad Uppal - Medical Director / Caldicott Guardian, John Campbell - Interim Director of Service Delivery	MLSC Committee, Governance Committee

APPENDIX 2

<table>
<tr><th colspan="8">RISK MANAGEMENT FRAMEWORK</th></tr>
<tr><th colspan="6">1st LINE of DEFENCE</th><th colspan="2">2nd LINE of DEFENCE</th><th>3rd LINE of DEFENCE</th></tr>
<tr><th colspan="2">DIRECTORATES</th><th>RISK CO-ORDINATOR</th><th colspan="2">OVERSIGHT MEETINGS/ COMMITTEES</th><th>OVERSIGHT COMMITTEE</th><th colspan="2">BOARD COMMITTEES</th><th>REGULATORY OVERSIGHT</th></tr>
<tr><td rowspan="4">FINANCE & COMMERCE</td><td>Estates & Facilities</td><td rowspan="4">Risk Co-ordinator</td><td colspan="2" rowspan="4">HOF / DEPUTIES of FUNCTION MEETING</td><td rowspan="15">EXECUTIVE COMMITTEE (MONTHLY & QUARTERLY RISK REVIEW PRESENTED by

RISK MANAGER</td><td rowspan="3">Development</td><td rowspan="15">AUDIT COMMITTEE</td><td rowspan="15">BOARD</td><td rowspan="15">Internal Audit
External Audit
Care Quality Commission
Commissioners
NHS Improvement
HSE</td></tr>
<tr><td>Finance</td></tr>
<tr><td>IT</td></tr>
<tr><td>PMO & Commerce</td></tr>
<tr><td rowspan="4">QUALITY</td><td>Quality & Transformation</td><td rowspan="4">Risk Co-ordinator</td><td colspan="2" rowspan="4">QUALITY & CLINICAL RISK COMMITTEE (REPORTS TO GOVERNANCE)</td></tr>
<tr><td>Nursing</td></tr>
<tr><td>Governance & Compliance</td></tr>
<tr><td>Nurse Consultants</td></tr>
<tr><td rowspan="7">ORGANISATIONAL DEVELOPMENT</td><td>Training</td><td rowspan="7">Risk Co-ordinator</td><td rowspan="7">HR TEAM LEADS MEETING</td><td>OCCUPATIONAL HEALTH & SAFETY COMMITTEE (REPORTS TO GOVERNANCE)</td><td rowspan="7">Governance</td></tr>
<tr><td>Health & Safety</td><td rowspan="3">WORKFORCE & ORGANISATIONAL DEVELOPMENT COMMITTEE (REPORTS TO EXECUTIVE)</td></tr>
<tr><td>Board Secretariat</td></tr>
<tr><td>Working Well</td></tr>
<tr><td>Staffbank</td></tr>
<tr><td>HR</td></tr>
<tr><td>Information Governance</td><td>INFORMATION GOVERNANCE COMMITTEE (REPORTS TO GOVERNANCE)</td></tr>
<tr><td rowspan="5">SERVICE DELIVERY</td><td>IM&Clinical management Systems</td><td rowspan="5">Risk Co-ordinator</td><td>CIRG</td><td rowspan="5">OPERATIONAL RISK MANAGEMENT MEETING</td><td rowspan="5">DELIVERY</td></tr>
<tr><td>Continuity Planning</td><td>Resilience & Security Operational Board -</td></tr>
<tr><td>Security</td><td rowspan="2">LOCALITY GOVERNANCE / MANAGEMENT MEETINGS -</td></tr>
<tr><td>LOCALITIES</td></tr>
<tr><td>CYPS; Glos.Localities; Herefordshire; Countywide</td></tr>
<tr><td rowspan="5">ENGAGEMENT & INTEGRATION</td><td>Research & Development</td><td rowspan="5">Risk Co-ordinator</td><td colspan="2" rowspan="5">Senior Engagement & Integration Leads (SEIL)</td></tr>
<tr><td>Social inclusion</td></tr>
<tr><td>Communications</td></tr>
<tr><td>Service Experience</td></tr>
<tr><td>AHP Heads of Profession</td><td rowspan="4">MENTAL HEALTH LEGISLATION SCRUTINY</td></tr>
<tr><td rowspan="3">MEDICAL</td><td>Clinical Directors</td><td rowspan="3">Risk Co-ordinator</td><td colspan="2" rowspan="3">ASSOCIATE MEDICAL DIRECTORS MEETING</td></tr>
<tr><td>Medical Education Director</td></tr>
<tr><td>Occupational Health</td></tr>
</table>

APPENDIX 3

Risk Scoring Matrix / Levels of Assurance

Table 1 Consequence scores Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints /audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	Matrix	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims **Budget = circa £100m**	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L) - The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

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

Table 3 Risk scoring = consequence x likelihood

	Likelihood				
Consequence/Impact	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	**5** Moderate risk	**10** High risk	**15** Extreme risk	**20** Extreme risk	**25** Extreme risk
4 Major	**4** Moderate risk	**8** High risk	**12** High risk	**16** Extreme risk	**20** Extreme risk

Moderate	**3** Low risk	**6** Moderate risk	**9** High risk	**12** High risk	**15** Extreme risk
2 Minor	**2** Low risk	**4** Moderate risk	**6** Moderate risk	**8** High risk	**10** High risk
1 Negligible	**1** Low risk	**2** Low risk	**3** Low risk	**4** Moderate risk	**5** Moderate risk

RISK SCORING TOOL - ASSURANCE

Classification	Description
Full assurance	A sound system of controls has been effectively applied and manages the risks to the achievement of the objectives
Significant assurance	A sound system of controls has, for the most part, been consistently applied, minor inconsistencies have occurred but there is no evidence to suggest that the system's objectives have been put at risk
Limited assurance	Gaps in the application of controls as designed by management put the achievement of objectives at risk
Negative assurance	Gaps in the application of controls as designed by management have opened the system to risk of significant failure to achieve its objectives and left it open to abuse or error

Trust Board

Date of Meeting: 26th September 2019

Report Title: Joint Chair's Report

Agenda reference Number	08
Accountable Executive Director (AED)	Not Applicable
Presenter (if not AED)	Ingrid Barker - Chair
Author(s)	Ingrid Barker - Chair
Board action required	Note
Previously considered by	Not Applicable
Appendices	

Executive Summary

Recognising the Strategic Intent work and my role as both Chair of Gloucestershire Care Services and ²gether, this report format reflects the breadth of my activities across both Trusts. The production of a joint report does not impact on my existing accountability as the appointed Chair of each Trust.

The Report also provides an overview of Gloucestershire Care Services Non-Executive Director (NED) activity.

Recommendations:

The Board is asked to N**OTE** the Report.

1. Introduction and Purpose

This report seeks to provide an update to both Boards on Chair and Non-Executive Director activities in the following areas:

- Strategic Intent
- Board Development
- Working with our system partners
- Working with our colleagues
- National and Regional Meetings attended and any significant issues highlighted

1.1 Strategic Intent Update – Moving Towards Developing an integrated Physical and Mental Health Care Offer with 2gether NHS Foundation Trust

Shadow Board

On 16th July the Shadow Board met and discussed with the NHSI South West Regional Board the plans for the merger of the two Trusts. Paul and I subsequently circulated a report on what we felt had been an extremely positive meeting in which the Board, individually and collectively had shown its passion for the opportunities provided by the merger and mastery of the implementation detail. Our confidence was vindicated when we received an almost unprecedented Green Risk rating. Almost as pleasing as the result itself was the fact that most of the recommendations, such as that of exerting our raised influence to shape development of the ICS, echoed the briefings we had given to NHSI. As part of this process members of the Shadow Board, along with other colleagues, fielded the detailed external review undertaken by Grant Thornton and received a series of highly supportive reports.

The Shadow Board continued to oversee the detailed work of the Programme Management Executive and gave guidance and direction as the various official merger procedures and documentation was completed. On 9th September the Shadow Board was able to give assurance to both Boards that all was in place to deliver a merger that was safe and would not impact negatively on service delivery. This assurance was conveyed to the 2Gether Council of Governors and submission of the application to merge was approved. The Shadow Board continues to provide governance over the integration process as we bring colleagues, systems and structures together.

Looking beyond the mechanics of the integration the Shadow Board has been taking forward development of the committee and management group structures, formulating the approach to risk and reporting and looking to Board and management development.

I would like to acknowledge the huge contribution made over the last three years by Board members of both Trusts. Without their vision, courage, selflessness and professionalism, this merger would not have been possible. They deserve our deep gratitude.

1.2 National and Regional Meetings

NHS Providers Chairs and Chief Executives meeting was held on 10th September where the Trusts were represented on this occasion by Non-Executive Director Graham Russell. Matters included a presentation from the NHSP Chief Executive on Long Form Strategic and Policy Update and Dialogue; Primary Care Networks – panel discussion; Briefing on Brexit planning and “no deal” implications. Both the CEO and I were unfortunately unable to attend the NHSP meeting as it clashed with a requirement to be at Gloucestershire Health Overview Scrutiny Committee.

1.3 Working with our Partners

Maintaining **business as usual** remains a priority across both organisations. As part of this I have continued my regular meetings with key stakeholders and partners.

Following a personal invitation I made recently **to Prof. Ted Baker, Chief Inspector of Hospitals for the Care Quality Commission (CQC)**, 2gether NHSFT was pleased to host a visit to Wotton Lawn Hospital on 15th August, where Prof. Baker toured the therapy department, the acute ward, Greyfriars and Montpellier and spent time talking to colleagues and patients. He was impressed with our progressive approach to segregation and is keen to reflect this in national thinking.

On 21st August, I met with the **Chair of Worcestershire Health and Care Trust**, Chris Burdon, for a general discussion on both Gloucestershire and Worcestershire healthcare matters.

Along with the Joint CEO, I attended meetings of the **Gloucestershire ICS Board on 27th August and 24th September.** Matters discussed at the meeting on 27th August included Fit for the Future; Population Health Management; Primary Care Strategy; Respiratory Programme update; Long Term plan and System Strategy. A verbal update will be given about matters discussed at the meeting held on 24th September.

Two meetings of **Gloucestershire's ICS ongoing Chairs** have taken place on 30th July and 27th August. We are now being joined by Dr. Jeremy Welch as the County lead for Primary Care Networks.

The Chief Executive and I attended a regular meeting of the **Gloucestershire Health Overview and Scrutiny Committee** (HOSC) on 10th September. The meeting considered performance across the health and care system and matters discussed included Fit for the Future; Primary Care update; Update on Pharmacies; Winter planning; South Western Ambulance Service.

On 11th September, Prof. Jane Melton (Director of Engagement and Integration for 2gether NHSFT) arranged very successful **AHPs into action – a learning event for Hereford and Worcester**, where I was represented by Non-Executive Director, Duncan Sutherland.

A meeting of the **Gloucestershire Health & Wellbeing Board** took place on 17th September. Items discussed included Healthy Weight; Housing and Health, Annual report of the Director of Public Health; NHS Long Term Plan, Better Care Fund Plan 2019/20; Response to the Advancing our health: prevention in the 2020s Green Paper consultation. There was a particular focus on strengthening links between health and wellbeing and economic development in Gloucestershire. This is reflected in the DPH's Annual Report *"Healthonomics – Tackling Health Inequalities through Inclusive Growth".*

1.4 Working with the Communities and People We Serve

We were pleased to host **Richard Graham MP** for his yearly visit to Trust services on 7th August to Southgate Moorings and on 8th August to Pullman Place.

I was pleased to be able to visit **St. James City Farm**, which is located in Tredworth, Gloucester, for their 21st birthday event on Tuesday 30th July. The Farm is run by the Friendship Café as a non-profit making community project.

The Chief Executive and I met with **Stroud MP, David Drew**, on Tues 20th August. Matters discussed included an update on the merger, Fit for the Future, along with wider Trust activities.

The Chief Executive and I held a quarterly **meeting with the Chairs of the County's Leagues of Friends** on 11th September. This meeting was held at Southgate Moorings in Gloucester and concluded with an update on the work of the community dental service given by Sian Thomas, Deputy Chief Operating Officer for Gloucestershire Care Services. **The Chief Executive** gave an update on the ongoing work of the Trusts.

A very enjoyable afternoon was held at the Mercure Bowden Hall Hotel on the afternoon of 17th September where the **annual celebratory tea party for volunteers and experts by experience** was held**.** Cellist Robina Sabourin played for us, prior to hearing from speakers Sammy Roberts, Simon Shorrick, Sue Tomlinson and Dave Walters who each talked about their own individual experiences. I was very pleased to be able to say a big thank you and to present certificates to the Volunteers and Experts by Experience. My thanks go to Dominika Lipska-Rosecka, Social Inclusion Manager for 2gether NHSFT, for organising such a fabulous and enjoyable event.

1.6 Engaging with our Trust Colleagues

I continue to meet regularly with Trust colleagues at Gloucestershire Care Services and 2gether and visit services at both Trusts to inform my triangulation of information.

I attended the **Senior Leaders Network event on 30th July** and listened to a very interesting presentation by Rob Fountain, CEO of Age UK Gloucestershire, who gave a talk about "making Gloucestershire the best county in which to grow older".

Non-Executive Directors continue to be invited to attend the **Senior Leaders Network** as part of the Boards' ongoing commitment to our wider leadership team. Attendees have fed back that they find it very enjoyable to spend time with the leaders of both Trusts as they consider how best we can work together.

There have been 2 meetings of the **Council of Governors on 21st August and 10th September** since the last report. As always, these are important sessions focusing on matters of key concern for our community in particular focussing on our merger plans. On 10th September, the Council formally voted in favour of submitted the merger application.

I met with **Laura Pensom, Manager of the Psychiatric Intensive Care Unit at Wotton Lawn Hospital** on 28th August, who gave me a tour of the unit. I was impressed by the compassionate care and excellent practice in this CQC 'outstanding service'.

On 28th August I chaired the interview panel for the **Head of Corporate Governance** and following an assessment centre which included meeting with discussion groups, I am pleased to announce that we have appointed Lavinia Rowsell, who will be taking up her post on 2nd January 2020.

As the two individual Trusts draw to a close before the merger takes place on 1st October, two **"celebration events"** were held at the Walls Club in Gloucester on 18th September for Gloucestershire Care Services and 19th September for 2gether. Both were very enjoyable events, recognising with pride the many achievements of each Trust.

I continue to have a range of **1:1 sessions with Executive and Non-Executive** colleagues as part of my regular activities.

2. NED activity

NEDs meeting were held on 29th August and 18th September and a schedule of regular meetings and quality visits is being arranged post-merger.

Activities undertaken by the Gloucestershire Care Services Non-Executive Directors

Graham Russell
GCS Resources Committee
Interviews for Head of Corporate Governance
GCS Quality and Performance Committee
GCS Audit and Risk Committee
GCS Board
NHS Providers Chairs and Chief executives meeting
Meeting with Compassionate Stroud initiative
Shadow NEDs meeting
GCS Celebration event
Visit to Weavers Croft, Stroud
2g Delivery Committee

Jan Marriott
Joint Trust Board
1:1 Freedom to Speak Up Guardian
Senior Leaders Forum
Shadow Board meeting
Resources Committee
Discussion group for appointment to Head of Corporate Governance
Quality and Performance Committee
NEDs meeting re quality governance arrangements for new Trust
NEDs meeting re merger appointments
Meeting with John Campbell re Mental Health Legislative Scrutiny Committee
Attendance at Safeguarding Conference
Induction meeting with Director of Strategy & Partnerships
Extraordinary Board meeting
Shadow Board Meeting
Attendance at Mental Health Legislative Scrutiny Committee
Chair Sexual Health Clinical Director/Consultant Appointments Panel
Nursing Quality Visit re SystemOne with Senior Sister, The Dilke Community Hospital
Shadow NEDs meeting
Celebrations for GCS
Gloucestershire ICS Nursing Leadership Network
Senior Leaders Forum

Nicola Strother Smith
1:1 with Director of Nursing
NEDs meeting
Chaired Quality and Performance Committee
Audit & Risk Committee
Chaired Charitable Funds Committee
Extraordinary Trust Board
GCS Celebration Event

Richard Cryer
Interview panel member for Clinical Director – Dental Service
Audit & Risk Committee
Charitable Funds Committee
Extra-ordinary Trust Board

Sue Mead
NEDs meeting
Quality and Performance Committee

Nick Relph
Resources Committee
Audit & Risk Committee
Extra-ordinary Trust Board
Meeting with CEO
GCS Celebration Event
Meeting with Director of Finance

Quality Visit reports are reported to the Quality and Performance Committee.

Activities undertaken by 2gether Non-Executive Directors

Maria Bond
Attended 'Improving and supporting Mental Health and Wellbeing for our Communities' event
Prepare for and attend Shadow Board meeting
Prepare for and attend Council of Governors meeting
Prepare for and attend ATOS meeting
Visit to the Community Rehabilitation Team at Bearlands
Meeting with the Quality Director
Prepare for and Chair Delivery Committee
Prepare for and attend Joint GCS & 2gether Board
Visit the team at Berkeley House
Prepare for and attend Audit Committee
Prepare for and attend Shadow Board
Prepare for and attend Council of Governors
GCS NEDS and Shadow Board NEDS meeting
GCS NEDS and 2gNEDS meeting
Prepare for and attend Governance Committee meeting

Jonathan Vickers
Prepared for and chaired a meeting of the development committee
Prepared for and attended a meeting of the ATOS committee
Prepared for and attended the AGM
Prepared for and attended a meeting of the audit committee
Attended a farewell event
Held conversations with executive and non-executive colleagues on Trust matters

Marcia Gallagher
Meeting with Director of Finance for Board to Board preparation
Prepared for and attended a Shadow Board meeting
Prepared for and attended a Council of Governors meeting
Prepared for and attended a Board to Board meeting in Chippenham with NHSI
Prepared for and attended an ATOS/Remuneration Committee
Attended an ICS NED/Lay Members meeting at the CCG
Reviewed and shortlisted entries for the Hereford Times Health and Social Care Awards and attending a shortlisting meeting in Hereford
Attended the joint AGM of GCS and 2GFT at the Friendship Café
Prepared for and attended the Joint 2GFT and GCS Board meeting in Hereford
Prepared for and attended the Delivery Committee
Participated in a MH Act Panel at Pullman Place
Prepared for and Chaired the Audit Committee
Prepared for and Chaired Consultant interview panel
Prepared for and attended the Shadow Board meeting
Prepared for and attended the Council of Governors meeting
Attended Andrew Lee's farewell dinner

Sumita Hutchison
Prepared for and attended Board and Committee meetings
Attended NED meetings
Annual audit review/ quarterly complaints audit

Nikki Richardson
Prepared for and attended Committee meetings
Prepared for and attended Council of Governor meetings

Duncan Sutherland
Hereford Senior Manager Network
Meeting with Herefordshire CCG
Hereford Health and Well-being Board
Chairing Hereford Integrated Care Alliance Board
Shadow Board
Meeting with Taurus, Hereford
Development Committee
Phone discussion with Herefordshire CCG
Hereford Senior Manager Network
Chairing Hereford Integrated Care Alliance Board
Shadow Board
Meeting with Wye Valley Trust
Chairing Hereford future strategy group
Meeting with Hereford CCG
Senior Leadership Forum, Gloucester
NEDs meetings

3. Conclusion and Recommendations

The Board is asked to **NOTE** the report.

Trust Board	
Date of Meeting:	26th September 2019
Report Title:	Chief Executive and Executive Team's Report

Agenda reference Number:	09
Accountable Executive Director: (AED)	Paul Roberts – Joint Chief Executive
Presenter: (if not AED)	Not Applicable
Author(s):	Paul Roberts – Joint Chief Executive
Board action required:	Note
Previously considered by:	Not Applicable
Appendices:	

Executive Summary

Recognising my role as both Chief Executive of Gloucestershire Care Services and 2gether this report reflects the breadth of my activity across both Trusts. I remain accountable separately for the performance in each of these roles. I expect this to be my last report to the joint boards and look forward to the next one, to the Board of Directors of Gloucestershire Health and Care NHS Foundation Trust.

Recommendations:

The Board is asked to **NOTE** the Report.

1. Chief Executive Engagement

I remain committed to spending a significant proportion of my time vising front-line services and meeting frontline colleagues in a variety of settings in both organisations and continue to be impressed and heartened by the professionalism and commitment of colleagues across the organisations and in the pride that they take in the delivery of, in many cases, outstanding services.

Inevitably given the current focus of the Executive teams on the development of the structure for the merged organisation my visits have been reduced, but I continue to

make every effort to make time for this key activity which enables me to take the temperature throughout both organisations.

I have continued to attend a range of meetings across both Trusts including:

A competitive interview process has taken place for the **Head of Corporate Governance**. I am pleased to report that Lavinia Rowsell has been appointed and will be taking up her post on 2nd January 2020.

Council of Governors meetings on 21st August and 10th September – these are reported on in the Joint Chair's report and elsewhere in this agenda.

Corporate Induction – I have welcomed new colleagues at two sessions on 19th August and 16th September where I gave the Executive overview. I plan to attend, representing the Board, as many of these sessions as possible in the future.

Senior Leadership Network – meetings have been held on **30th July** where the guest speaker was Rob Fountain, CEO of AGE UK Gloucestershire, who gave a presentation about "making Gloucestershire the best county in which to grow older" and on **29th August** the guest speaker was Becki Barrow and a service user who talked about personalised care in Gloucestershire and Shadow Board Non-Executive Director, Duncan Sutherland, introduced himself to the meeting.

Hereford Senior Managers Network – I attended this network meeting held on 12th August. We were joined by Sarah Dugan, CEO of Worcestershire Health & Care Trust and colleagues. This meeting now also includes the governors for Herefordshire and other members of the senior team who work across both counties. The Network had been used as a forum for delivering "Team Talk" and to discuss the potential future of Herefordshire services within the STP context.

I went to the afternoon session of the **GCS Spotlight on Safeguarding** event held on 4th September where the keynote speaker was Chief Inspector Tim Wood from Gloucestershire Constabulary who gave a talk about partnership working and adverse childhood experiences. Helen Pritchard from the Gloucestershire Domestic Abuse Team gave a talk about domestic abuse – a professional's guide.

2g Countywide Admin away-day on 6th September, where I gave an update on progress with the planned merger.

Medical Staffing Committee on 6th September to give my regular CEO briefing, including an update on merger progress.

Team Talk session at Rikenel on 9th September.

As Gloucestershire Care Services and 2gether draw to as we currently know them jointly become Gloucestershire Health and Care NHS FT, **celebration events** were respectively held on 18th and 19th September at the Walls Club in Gloucester. These events provided colleagues with an opportunity to celebrate and recognise the great achievements of the two organisations over many years. At the 2gether event there was also an opportunity to recognise the long service of colleagues.

I continue to hold **regular meetings with Executive Directors and senior managers** from both Trusts.

2. Progress on the strategic intent to merge Gloucestershire Care Services NHS Trust (GCS) with 2gether NHS Foundation Trust

The Chair's merger update outlines the work undertaken by the Shadow Board to get us successfully through the NHSI review and approval process. I will provide an overview of the more organisational aspects of the merger.

The Shadow Board has now stood down, holding its last meeting on 20 August. It has been closely engaged in assuring and guiding the detailed merger work undertaken by executive colleagues, primarily through the Programme Management Executive (PME). At the same time, we have carefully monitored the impact on colleagues and service delivery to avoid unintended consequences, where necessary adjusting initial plans.

The Shadow Board has been particularly keen to ensure the re-structuring needed to become a "transforming organisation" is achieved in accordance with our new strategic intent and our values, through co-production and consultation with those colleagues most likely to be impacted by it. Whilst restructuring is always unsettling and some individuals will be personally disappointed with the outcome, the Board is assured that it has overseen a fair and equitable process which respects and values colleagues and the contributions they have made.

More generally the Shadow Board was able to assure the Trust Boards that the appropriate plans were in place to both merge safely and to go on to fully join the two Trusts.

Key to the integration is the developing of shared values and, over time, a common culture and the Shadow Board has been guiding this. The Shadow Board has been focussed on ensuring these values are embedded in the new organisation and that they translate into standards of behaviour.

As the date for merger approaches the Shadow Board has been preparing itself, through individual and collective development, for the inevitable challenges and exciting opportunities that the future presents.

3. Partnership Working

I continue to have regular meetings with the **CEO of Gloucestershire Hospitals NHS Foundation Trust (GHT)** and the **Accountable Officer for Gloucestershire Clinical Commissioning Group (GCCG).** I also continue to attend regular meetings of the **ICS Board** and **ICS Executive.**

As part of my work with the Gloucestershire ICS, I continue to lead on three major strategic works streams including chairing a meeting of the **Diagnostics Programme Board and the Urgent Care Project Board** (part of the Fit for the Future programme). On 5th September I joined the CEO of GHT and the Accountable Officer for GCCG in Westminster meeting **Sir Geoffrey Clifton-Brown MP, Laurence Robertson MP and Alex Chalk MP** to discuss the Fit for the Future Programme.

Gloucestershire Care Services and 2gether were pleased to be able to host the annual visit by **Richard Graham MP** to both Trusts on 7th and 8th August.

On 7th August, Mr. Graham visited Southgate Moorings, where he observed various GCS services including the Countywide Dental Service, Complex Care at Home Team and the Integrated Care Team. He also spent time talking to colleagues working in the various services based at Southgate Moorings.

I also met with Mr. Graham to give him an update on the merger and various Trust matters.

On 8th August, Mr. Graham visited Pullman Place in Gloucester where he was introduced to various 2gether services including the Perinatal Service; the Homeless Mental Health Team; Social Inclusion team, Gloucester Recovery team, Gloucester Assertive Outreach team, Gloucester Recovery in Psychosis (early intervention) and Gloucester Learning Disabilities and Older Persons. He also spent time visiting teams.

On 20th August, the Trust Chair and I met with **David Drew MP,** where discussions included an update on the Trust merger, Fit for the Future and wider Trust matters.

On 13th September I met with **Rt Hon Mark Harper MP** where we discussed our merger, progress on the development of plans for the Forest of Dean Hospital, Fit for the Future and wider Trust matters.

On 7th August, I visited **Charlie's Cancer Support and Therapy Centre,** based in Madleaze Road, Gloucester. This was an inspiring visit to a brilliant community organisation. The centre supports people with and post cancer, families and carers with complimentary and holistic therapies. My thanks to Bren McInerney BEM for organising this visit.

Following a personal invitation made by the Trust Chair to Prof **Ted Baker, CQC Chief Inspector of Hospitals**, a visit was made by him to Wotton Lawn Hospital on 15th August. The Chair's report contains further information on this visit.

On 2nd September, along with Professor Jane Melton, Director of Integration and Engagement, I met with **Peter Sharpe, CEO of Cobalt Health in Cheltenham** a medical charity who provide imaging and diagnostic services to sign the partnership agreement we have with them through which they fund some of our 2gether research activity.

Following on from a request made by the Gloucestershire Health and Care Scrutiny Committee in July, 2gether NHSFT hosted a **HOSC Members' Workshop** at Charlton Lane Hospital on 4th September to give Councillors an update on the work of the Intensive Home Outreach Team, the Perinatal Mental Health Service, along with work carried out by the Dementia and Rapid Response teams.

Fit for the future

The engagement programme for Fit for the Future commenced in August and continues with a series of workshops and opportunities for discussion across the County. It will continue with a **formal engagement hearing** in October followed by a "**Citizen's Jury**" in November/December which will focus on the "Centres of Excellence" element of the programme.

On 9th September I joined other system colleagues to discuss the programme with the **Cheltenham Borough Overview and Scrutiny Committee**.

On 16th September I joined GHT and GCCG colleagues for an informal meeting with the campaign group **REACH (Restore Emergency at Cheltenham general Hospital)**. As can be seen above we have also continued to discuss these matters with local, Gloucestershire, MPs.

On 9th September, Bren McInerney BEM arranged an informal visit to the county by **Yvonne Coghill (National Director for Implementation of the NHS Workforce Race Equality Standard) and Habib Naqvi (Policy Lead for the NHS Workforce**

Race Equality Standard). I was pleased to be invited to a short meeting with them at St. James City Farm in Gloucester.

The Trust Chair and I attended a meeting of the **Gloucestershire County Council Health Overview and Scrutiny Committee (HOSC)** on 10th September. The meeting considered performance across the health and care system and matters.

I attended the Joint Trust Chair's quarterly meeting on 11th September with the **Chairs of the Leagues of Friends** and gave an update on the ongoing work of the Trusts.

I attended a regular meeting of the **Local Medical Council** on 12th September.

Deputy CEO for Gloucestershire Care Services, Sandra Betney, represented me at the **South West Chief Executives'** meeting held in Taunton on 16th September. Matters discussed included the NHS Long Term Plan.

I was very pleased to be invited to attend the celebratory **afternoon tea party for Volunteers and Experts by Experience** on 17th September. A full update on this is included in the Trust Chair's report.

4. Herefordshire Integrated Working Developments

Colin Merker, Deputy Chief Executive 2gether and Duncan Sutherland Non-Executive Director, 2gether, continue to be heavily engaged in working with colleagues in **Herefordshire and Worcestershire** to further develop partnership working. We expect Herefordshire CCG to make decisions about the future provision of mental health and learning disability services in Herefordshire in October and November.

On 11th September, Professor Jane Melton (2g Director of Integration and Engagement) organised a **AHPs into Action learning event** which was held at the University of Worcester. I was represented at this event by Colin Merker, Deputy CEO for 2gether.

5. National and Regional meetings attended

On 10th September, both Trusts were represented at the NHS Providers Chairs and Chief Executives' meeting by Graham Russell, Non-Executive Director. An update on this is included in the Trust Chair's report.

6. EU Exit

The Trusts continue to follow national guidance on this issue and respond to information requests from the Department of Health and Social Care/ NHS England/Improvement.

7. Gloucestershire Care Services - Operational Service Overview

Community Stroke Rehabilitation Performance Update:

The Sentinel Stroke National Audit Programme (SSNAP) is a major national healthcare quality improvement programme based in the School of Population Health and Environmental Studies at King's College London. SSNAP measures the quality and organisation of stroke care in the NHS and is the single source of stroke data in England, Wales, and Northern Ireland.

In the first SSNAP return completed by the new Community Stroke Rehabilitation Unit we are pleased to have received an 'A' against the national benchmark standards, this is the highest grade possible. There are areas for improvement and some scores we need to further analyse in order to understand their rating; however we are delighted to see that the unit has delivered high quality care to the people of Gloucestershire following a stroke.

Appointment of two Clinical Directors

Dental Services:

I am pleased to announce that Patricia Phillips has been successfully appointed and started on 16 September 2019. Patricia has over 33 years' experience in Dentistry, including 16 years as Clinical Director in Nottingham. Most recently Patricia has been working in the GCS service as a dentist and therefore has a sound understanding of the opportunities and challenges facing the service. Patricia is passionate and enthusiastic about the role, and looking forward to working collaboratively with us all to meet the challenges ahead.

Sexual Health:

I am pleased to announce that Dr Ayo-ola Smith has been appointed to the Clinical Director role. Ayo-ola brings 17 clinical experience of Genitourinary Medicine and a wealth of HIV experience. Ayo-ola has previously been the Clinical Director for Sexual Health and HIV for Cumbria Partnership NHS Foundation Trust (2012 – 2015) and most recently has been working in the GCS since April 2019 as a Sexual Health and HIV Consultant.