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NHS
Gloucestershire Health and Care
NHS Foundation Trust

# TRUST BOARD MEETING

## PUBLIC SESSION

Thursday, 25 May 2023

**10:00 – 13:30**

**Room BG224, Business School, University of Gloucestershire, Oxstalls Campus, Gloucester**

## AGENDA

| TIME | Agenda Item | Title | Purpose | | Presenter |
|---|---|---|---|---|---|
| **Opening Business** | | | | | |
| **10.00** | 01/0523 | Apologies for absence and quorum | Assurance | Verbal | Chair |
| | 02/0523 | Declarations of interest | Assurance | Verbal | Chair |
| **10.05** | 03/0523 | Service User Story Presentation - *Serious and enduring mental illness* | Assurance | Verbal | DoNTQ |
| **10.25** | 04/0523 | Draft Minutes of the meetings held on 30 March 2023 | Approve | **Paper** | Chair |
| | 05/0523 | Matters arising and Action Log | Assurance | **Paper** | Chair |
| **10.30** | 06/0523 | Questions from the Public | Assurance | **Paper** | Chair |
| **Performance and Service User Experience** | | | | | |
| **10.35** | 07/0523 | Quality Report | Assurance | **Paper** | DoNTQ |
| **10.55** | 08/0523 | Performance Report | Assurance | **Paper** | DoF/COO |
| **11.15** | 09/0523 | Finance Report | Assurance | **Paper** | DoF |
| **11.25 - BREAK – 10 Minutes** | | | | | |
| **Strategic Issues** | | | | | |
| **11.35** | 10/0523 | Report from the Chair | Assurance | **Paper** | Chair |
| **11.45** | 11/0523 | Report from Chief Executive | Assurance | **Paper** | CEO |
| **12.00** | 12/0523 | Research and Innovation Strategy | Approve | **Paper** | MD |
| **12.15** | 13/0523 | Board Assurance Framework | Approve | **Paper** | DoCG |
| **12.25** | 14/0523 | Freedom to Speak Up 6 Monthly Report | Assurance | **Paper** | DoNTQ |
| **Governance** | | | | | |
| **12.40** | 15/0523 | Provider Licence Declarations | Approve | **Paper** | DoCG |
| **12.45** | 16/0523 | SIRO Report 2022/2023 | Assurance | **Paper** | DoF |
| **12.55** | 17/0523 | Use of the Trust Seal 2022/23 | Assurance | **Paper** | DoCG |
| **13.00** | 18/0523 | Council of Governor Minutes – March 23 | Information | **Paper** | DoCG |

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|---|---|---|---|---|---|
| **Board Committee Summary Assurance Reports** | | | | | |
| **NOTE** | 19/0523 | Great Place to Work Committee (29 March) | Information | **Paper** | GPTW Chair |
| **NOTE** | 20/0523 | Working Together Advisory Committee (20 April) | Information | **Paper** | WTAC Chair |
| **NOTE** | 21/0523 | Resources Committee (26 April) | Information | **Paper** | Resources Chair |
| **NOTE** | 22/0523 | MHLS Committee (26 April) | Information | **Paper** | MHLS Chair |
| **NOTE** | 23/0523 | Quality Committee (4 May) | Information | **Paper** | Quality Chair |
| **NOTE** | 24/0523 | Audit & Assurance Committee (11 May) | Information | **Paper** | Audit Chair |
| **Closing Business** | | | | | |
| **13.15** | 25/0523 | Any other business | Note | Verbal | Chair |
| | 26/0523 | **Date of Next Meetings**<br><br>**<u>Board Meetings 2023</u>**<br>Thursday, 27 July<br>Thursday, 28 September<br>Thursday, 30 November | Note | Verbal | All |

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**AGENDA ITEM: 04/0523**

# MINUTES OF THE TRUST BOARD MEETING

**Thursday, 30 March 2023**

**Churchdown Community Centre**

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**PRESENT:**
Ingrid Barker, Trust Chair
Steve Alvis, Non-Executive Director
Sandra Betney, Director of Finance
Steve Brittan, Non-Executive Director
Marcia Gallagher, Non-Executive Director
Sumita Hutchison, Non-Executive Director
Vicci Livingstone-Thompson, Associate Non-Executive Director
Jan Marriott, Non-Executive Director
David Noyes, Chief Operating Officer
Angela Potter, Director of Strategy and Partnerships
Paul Roberts, Chief Executive
Graham Russell, Non-Executive Director
Neil Savage, Director of HR & Organisational Development
John Trevains, Director of Nursing, Therapies and Quality
Dr Amjad Uppal, Medical Director

**IN ATTENDANCE:**
Jacqui Cooper, CQC
Jordan Doig-Davis, Feel Complete
Anna Hilditch, Assistant Trust Secretary
Kate Nelmes, Head of Communications
Louise Moss, Deputy Head of Corporate Governance

## 1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting. Apologies had been received from, Nicola de Iongh, Helen Goodey, Lorraine Dixon, and Lavinia Rowsell.

1.2 The Board welcomed Vicci Livingstone-Thompson to her first Board meeting. Vicci had been appointed as an Associate NED, commencing in post on 1 March 2023.

## 2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

## 3. PATIENT STORY PRESENTATION

3.1 The Board was asked to note that the patient who was due to attend today's meeting to provide the patient story presentation was unwell and therefore unable to attend. The Board sent their good wishes and agreed that the story would be rescheduled for a future meeting.

## 4. MINUTES OF THE PREVIOUS BOARD MEETING

4.1 The Board received the minutes from the previous Board meeting held on 26 January 2023. The minutes were accepted as a true and accurate record of the meeting.

## 5. MATTERS ARISING AND ACTION LOG

5.1 The Board reviewed the action log and noted that all actions were now complete or progressing to plan.

5.2 David Noyes provided a verbal update on the action from the previous meeting around Crisis Services and the need to take forward work with Commissioners to undertake a system wide review of mental health crisis services. He noted that he had spoken to colleagues at the ICB and work was underway with surveys issued around service provision. It was agreed that it would be helpful to keep the review of crisis services separate from the overall system review of MH services as this was a key issue. The Board noted that there would be regular updates on progress presented through the QAG and the Quality Committee, and a summary update would be scheduled for a future Board meeting to keep the Board fully sighted on progress.

## 6. QUESTIONS FROM THE PUBLIC

6.1 There were no questions from the public.

## 7. CQC PROGRESS REPORT

7.1 The purpose of this report was to provide an update on the current status of the CQC 2022 action plan and outline the plan to prepare services who have not been inspected by the CQC in the most recent inspection.

7.2 John Trevains informed the Board that the Trust had completed 63% (53 actions) of the current plan that was submitted to the CQC last year. The remaining 37% (20 actions) are monitored daily by the CQC Manager and we continue to work with teams to support the areas of improvement and generate the evidence needed to assure the CQC on our progress. There were 2 CQC "Must Do" actions outstanding, as follows:

- *Assurance around Rapid Tranquillisation improvements* – we are waiting for completion of a planned audit in March which will form the evidence that we need to provide to the CQC to demonstrate the embedded status of the action.
- *Wider Trust work relating to the quality of Care Plans* – work is being carried out in individual service areas to improve this and there is a wider piece of work within the Trust related to personalised care and shared decision making which are informed by changes in national policy and NICE guidance.

7.3 The MIIU action plan was 86% complete and the remaining 14% on target for completion. The Trust was completing a fidelity check for those actions that have been completed. Outstanding actions are around the recording of supervision on Care to Learn and MIIU triage call back times. A service lead is in place to capture the MIIU Triage call back times and results are to be analysed before sign off. This is on schedule for completion in March 2023.

7.4 The Charlton Lane action plan was 97% complete and the remaining 3% were on target for completion and due for review early March 2023. Outstanding actions related to a QI project for time critical medications and ligature alarms. The Trust was expanding the remit of the

action relating to the ligature alarms to include the use of assisted technology for a range of patient safety issues, e.g. slips, trips, falls, night time observation and capturing non-evasive physical observations. A trial of new equipment would be taking place in the coming months.

7.5 Although the Trust underwent several inspections, including an in-depth Core and Well-Led inspection during April and May 2022, there were some services that were not inspected. These relate to services in the legacy 2G organisation and date back to 2016 in some cases. In total there are 7 distinct areas that span across Community Mental Health Adult and Children's Services and includes Montpellier Low Secure and our inpatient rehabilitation services at Laurel House and Honeybourne in Cheltenham. To prepare those teams and understand any quality risk associated with the current regulatory framework, an initial self-assessment has been completed with all of those teams and have planned peer reviews scheduled as part of our ongoing quality assurance approaches to regulatory compliance. The Board was assured that all areas had been able to demonstrate initial evidence of good compliance against the standard CQC criteria. This self-assessment forms the foundation of a peer review programme which will run over the next 12 months. The programme is overseen by a dedicated CQC Quality Manager. We have planned the first peer review for April 2023 with the Stroud Community Mental Health Team. The peer review programme will enable us to develop a data/evidence set of information for each area and submit this to the CQC utilising their existing provider portal. John Trevains confirmed that people with lived experience would be involved in the peer review programme.

7.6 John Trevains informed the Board that this report provided good assurance on the wide range of work taking place across the Trust to evidence compliance against the standard CQC criteria. He added that the Trust had a good working relationship with the CQC, with regular updates and meetings taking place with local inspectors to keep them up to date on progress.

7.7 Sandra Betney asked whether any new risks had been identified through the peer review process that may not already have been included on the Trust's Risk Register. John Trevains advised that no new themes had been identified. Estates issues were often raised but the NTQ Team were represented on the Trust's Capital Management Group to ensure that these issues were fed in and addressed appropriately.

7.8 Marcia Gallagher had carried out a recent Quality Visit to Charlton Lane and said that she had been impressed with the progress made. Referring to the assisted technology she asked how long the trial would be in place and when the system would be implemented. She said that staffing was a challenge, and the new system could assist in terms of carrying out night-time observations. John Trevains advised that the technology had just come on to the market and the Trust would trial it over the next 2 months to see if it would work. Colleagues were connected into the MH Patient Safety Technology Group to share learning. A verbal update on progress would be presented back to the Quality Committee.

7.9 In terms of wellbeing at Charlton Lane the Board noted that a good management team was in place and a new long term OD programme was underway. More focus was needed to try and increase colleague engagement with the Staff Survey as response rates for Charlton Lane and Wotton Lawn had been relatively low in comparison to the overall Trust response. In response to a query from Sumita Hutchison around the Messenger Review, John Trevains assured the Board that the Trust did not run a blame culture and there was good evidence that when issues and concerns did arise, colleagues worked together to improve. The Trust had worked very hard to create an environment where colleagues could feel confident to speak up about concerns.

7.10 John Trevains advised that a re-inspection of Charlton Lane by the CQC would take place; however, the timescales for this were not yet known. However, with the progress made he said that colleagues felt confident about a re-inspection.

## 8. QUALITY DASHBOARD REPORT

8.1 This report provided an overview of the Trust's quality activities for February 2023.

8.2 John Trevains informed the Board that overall, the report demonstrated that some fantastic and dynamic work was being carried out and high-quality services were being delivered.

8.3 The report highlighted those Quality issues for priority development to the Board and it was noted that this data was triangulated with the Performance Dashboard report:

- The quality directorate continue to work in partnership with colleagues from Learning and Development to improve access and visibility of granular training data in areas that directly impact quality,
- The quality directorate will continue to develop assurance on Trust safeguards against closed culture risks, e.g. analysis of staff survey data, independent advocacy, reducing restrictive practices amongst other measures/interventions
- Senior Mental Health nurse leadership and capacity is being provided to inpatient colleagues to improve cardio metabolic assessment within inpatient environments,
- Ongoing work supporting areas with access challenges and associated risk management,
- Ongoing work supporting workforce focussed initiatives as staffing challenges remain our main risk to delivering high quality care and treatment. It was noted that a bespoke recruitment event for HCSWs at Wotton Lawn would be taking place in the next month.

8.4 Those areas showing a positive improvement this month included:

- Detail provided this month reports good achievement against the Trust Quality Priorities and Commissioning for Quality and Innovation (CQUIN) activity.
- Sustained improvements in CPA compliance rates which have consistently met the 95% performance indicator for the last 5 consecutive months.
- This month there has been an overall decrease in the numbers of reported pressure ulcers with all categories being either at, or below threshold for the first time this year.
- Continued improvement in the overall number of completed Friends and Family Tests (FFT) in month noting that the number of responses has almost doubled since the introduction of new processes in October, particularly encouraging to see increases from mental health services.

8.5 John Trevains reported that a new cohort of International Recruits (IRs) would be commencing with the Trust shortly. It was noted that GHC had a near perfect 100% retention rate for IRs and this was helped by the very high level of pastoral care provided to colleagues. The Board noted that the Trust also provided support to IRs in relation to the completion of the necessary exams to be able to practice. John Trevains reported that the next phase was to look at moving IRs into community nursing teams. The Board was assured that GHC continued to operate in line with national guidance and protocols and did not recruit any IRs from designated "red" areas. Jan Marriott queried whether IRs would be considered for community mental health nursing positions moving forward, as this would be very different from carrying out standard nursing duties such as wound care and injections. This would need to be fully considered. Amjad Uppal confirmed that the GMC provided a comprehensive induction session for Internationally recruited Doctors.

8.6 Graham Russell made reference to the "stubborn" reds on the KPI performance. The first related to the waiting list for the Stroud Physiotherapy team, where Graham had carried out a recent Quality visit. He asked whether there were any quick wins to reduce the waiting list, such as the provision of weekend sessions in the community. David Noyes reported that the waiting list position was improving. The Trust had tried pop-up weekend and evening sessions, but Trust colleagues had advised that they did not have the capacity to take on the extra time commitment.

8.7 The second red KPI related to appraisals. Graham Russell noted that a detailed discussion about appraisals had taken place at the recent GPTW Committee. It was reported that 90% of colleagues have appraisals but up to two thirds of these felt that they get no value from them. The Trust focussed on ensuring that colleagues received and recorded an appraisal to achieve compliance, but it was suggested that more focus was needed to look at whether these were valuable. More work on this was required.

8.8 Ingrid Barker once again welcomed the breakdown of the longer Length of Stay (LOS) patients within the report. She noted that some patients were being delayed due to housing issues and she asked for further information on this position. Angela Potter advised that a housing workstream had been set up as part of the CMH Transformation programme as there was a need for this to be looked at and taken forward as a whole system. Sumita Hutchison said that many people with mental health issues were triggered by societal issues such as housing and poverty. Angela Potter advised that a key part of the CMHT programme was to consider whether those people who were suffering with mental health issues were doing so due to situational factors, and it was therefore key to have the correct partners and VCS organisations involved in this work with us to be able to provide the appropriate support and signposting.

8.9 The Board once again welcomed this report, noting the developments underway and the good level of assurance provided.

## 9. LEARNING FROM DEATHS – QUARTER 3 2022/23

9.1 The Board received the Learning from Deaths Report for quarter 3, which provided the learning from the mortality review process, data analysis and outcomes.

9.2 There had been a total of 89 patient deaths reported during quarter 3. None of the reported deaths were judged more likely than not to have been due to problems in the care provided to the patient.

9.3 The Board noted that an increasing number of patients were being transferred from the Acute Trust who required end of life care. There was also a higher number of patients on Willow Ward in receipt of end-of-life care than in the previous quarter. The highest cause of death in Community Hospitals and Charlton Lane Hospital was cancer, and this was the cause of 38.6% of deaths occurring in quarter 3.

9.4 It was reported that 73 community mental health patient deaths occurred in quarter 3. The primary cause of deaths was natural causes. It was noted suspected suicide contributed to 4% of mental health patient deaths. The relatively young mean age of patients at date of death was consistent with accepted research indicating that people with a mental health illness died on average at an earlier age, than those without. This information had been fed into the physical health work stream for the Community Mental Health Transformation work.

9.5 During Q1-3 2022-23, there were 25 deaths of patients open to Trust Learning Disability (LD) caseloads. These had been referred to LeDeR for review. It was reported that the mean age at date of death for people with a learning disability was 59 years of age. Amjad Uppal confirmed that the Trust did draw on the LeDeR Annual Report and this had been received at the Quality Committee.

9.6 Marcia Gallagher queried whether there was the ability to influence respiratory illness deaths, and queried the input that GHC had, specifically in relation to the provision of the pneumonia vaccinations for LD patients. John Trevains said that the Trust's IHOT Team were actively involved with this and provided assurance that the well-staffed Team continued to educate and provide health promotion. GHC was an active system player in this area.

9.7 Marcia Gallagher asked whether information was available to monitor the provision of physical health checks carried out for learning disability patients. It was noted that this information was held by the ICB.

9.8 The Board noted the content of this report, and the continued positive feedback received from the Medical Examiner was also noted.

## 10. PERFORMANCE DASHBOARD

10.1 Sandra Betney presented the Performance Dashboard to the Board for the period February 2023 (Month 11 2022/23). This report provided a high-level view of key performance indicators (KPIs) in exception across the organisation.

10.2 The Board received the 2022/23 Business Intelligence business planning highlights. Sandra Betney advised that the Measuring What Matters milestones that are incomplete have been reconfigured into a strategic portfolio for 2023/24 and a proposal paper has been shared with Executives and engagement sessions setup to collate feedback before wider sharing.

10.3 The SystmOne Simplicity programme for physical health services was scheduled to conclude at the end of March 2023. The Priority Template Project will continue into Q1. 24 integrated service level (profile) reports have been published (47%) with a further 11 (increasing the total to 69%) scheduled for deployment through April and May 2023.

10.4 The Board noted that there were no national Mental Health indicators in exception at month 11 which was excellent. There were 6 MH key performance thresholds in exception within the dashboard. There were 13 PH key performance thresholds in exception. Six of these were wait time measures, and data recording and data quality were noted as factors, alongside capacity (higher sickness and turnover) and demand (higher referrals).

10.5 The indicators of Sickness Absence and WF2 Turnover were both in exception for the period. Sickness absence remains above the 4% threshold at 5.3%.

10.6 Sandra Betney informed the Board that a new presentation of the Performance Dashboard was planned for May 2023 (for April 2023/24, Month 1), aligning to the Performance Indicator Portfolio reconfiguration that has been presented to the Trust's Resources Committee. Through new domains, this will setup a foundation for presenting indicators that matter to the organisation as well as external stakeholders.

10.7 David Noyes presented his Chief Operating Officer report to the Board, highlighting key issues around system pressure, industrial action and MIIU utilisation. The Board noted that

the pressure in the system had steadied following the challenging Christmas and new year period.

10.8 The Trust was continuing its journey to improve the length of stay of its mental health inpatient units and hosted a second workshop with clinical colleagues in late January. The range of measures and initiatives in place as a result have seen good progress made in this area and at the time of writing this report there were no MH patients placed out of area which was excellent.

10.9 It was reported that the Trust was making steady progress and remained on track for recovery in the Children's OT services. Children's Speech and Language Therapy continued to be a challenge and the ICB was conducting a system wide review of speech and language therapy provision. CAMHS performance continues to hold steady with workforce capacity remaining a real challenge. However small progress had been made in relation to the waiting list with a reduction from 800 to 636 over the past month. The Trust was looking at a new CAMHS Academy style concept/approach to try and build a more resilient longer-term workforce.

10.10 Steve Alvis made reference to the indicator for Diabetes Nursing. The narrative noted that the service was experiencing unprecedented demand with caseloads more than double compared to this time last year and that access to adequate clinic space continued to be a challenge. He asked whether consideration had been given to utilising existing space within the Vale Hospital or at Beeches Green. David Noyes agreed to pass this suggestion on to operational colleagues to investigate further. In terms of the increase in demand for the service, David Noyes advised that this was a growing condition and that this had been raised with commissioners to take forward.

10.11 In relation to the indicator for the Stroke Supported Discharge service, the proportion of patients assessed within 2 days was 75% in February compared to a threshold of 95%. 8 non-compliant cases were identified out of 32 patients that were assessed in February. David Noyes advised however, that a new Neuro Team had now been commissioned and would be set up over the next year to help manage demand for this service.

## 11. FINANCE REPORT

11.1 At month 11 the Trust had a surplus of £0.954m. The Trust is forecasting a year end position of break even in line with the revised plan. The cash balance at month 11 is £55.366m. The Trust has recorded Covid related expenditure of £0.966m up to February.

11.2 Capital expenditure was £14.581m at month 11 against the plan of £13.455m. The 2022/23 revised capital plan, including £1.671m Digitisation funding was £19.551m.

11.3 The Cost improvement programme has delivered £5.257m of recurring savings against the target of £5.612m. The Non-Recurrent target is £1.15m and all of this has now been delivered. In addition to Trust savings, GHC has made a £160k system saving on Covid, and a further £400k in year.

11.4 The Better Payment Policy shows 96% of invoices by value paid within 30 days, the national target is 95%. 84.6% of invoices by value were paid within 7 days.

11.5 The Trust spent £8.906m on agency staff to month 11, and against a proposed 2023/24 agency cap of 3.7% of total pay the Trust would be an estimated £2.263m over year to date. The quality impact on the use of agency staff was acknowledged.

11.6 Sandra Betney informed the Board that work was underway to prepare the annual accounts for 2022/23. The Trust had a stable financial position at year end, with a small surplus and good cash position. The Board expressed their huge thanks to Sandra Betney and the wider Finance Team for their work to manage what had been another challenging financial position this year.

## 12. TRUST BUSINESS PLANNING PROCESS 2023/24

12.1 This report set out the business planning process that was launched in November to support Directorates and Teams in developing their business planning objectives for 2023/24. The business plan is key to the delivery of the Trust Strategy and the business planning structure is underpinned by our four strategic aims. This paper also set out the known national and local priorities that have informed the business planning objectives.

12.2 A quality assurance mapping process has been introduced this year to ensure the business plan aligns internal and external priorities and resources across operational and corporate functions.

12.3 A business planning refresh will take place in quarter 1 to ensure our objectives include any system changes following the outcome of the System Delivery Planning process that is expected to be finalised in April and to ensure any impact of the Clinical Systems Vision Project is fully aligned across the business plan. The Board noted that the Council of Governors were supportive of the proposed business planning refresh.

12.4 Steve Brittan asked for the timescales associated with the Clinical Systems Vision Project. Angela Potter noted that market testing was underway, and it was proposed that a business case would be developed and presented to the Board in November 2023 which would include a full analysis of potential options, benefits analysis etc. She said that this project would be a huge change programme, involving a change in IT systems but in culture as well.

12.5 Marcia Gallagher asked about the scale of ambition, making reference to the list of objectives identified (219). She asked how realistic it was that these would be achieved given how many there were. Sandra Betney said that there were slightly less objectives than 2022/23 but advised that 90% of last years' objectives had been achieved. There was a possibility that the Clinical Systems Vision Project could impact on some of these, and this would be reviewed at the Q1 refresh point.

12.6 One of the key aims for the business planning process is to demonstrate a preferred balance of objectives across the Trust's 4 strategic aims. It was noted that "Better Health" and "Sustainability" themes had the least objectives identified. The Board agreed that the business plan was all about outcomes, and it was therefore important to challenge ourselves.

12.7 The Board noted the excellent progress that had been made in achieving the 2022/23 objectives, and thanks were given to Lisa Proctor for co-ordinating the Business Planning process.

12.8 The Board approved the business planning objectives for 2023/24 and noted the planned refresh during quarter 1 to ensure alignment with the System Delivery Plans and to ensure the capacity is appropriately balanced to support the Clinical Systems Vision Project.

## 13. BUDGET SETTING 2023/24

13.1 Sandra Betney presented this report which set out the budget setting process for 2023/24. The report highlighted the links with the NHSE planning, contracting and business planning processes and set out risks and opportunities within the financial targets that have been set for each service and directorate.

13.2 Budget setting for 2023/24 has been completed prior to the final agreement of the contract schedule with Gloucestershire Integrated Care Board (ICB) and MHIS/SDF funding. The financial regime for 2023/24 is underpinned by funding allocations given to each Integrated Care System (ICS). This is allocated between all partners in the system. The key financial aim is for the system to be in financial balance.

13.3 The Trust has continued with its usual thorough process to develop a set of budgets that reflect the plans of the business and has also been mindful of the system's financial position and the resource constraints within the Gloucestershire system. The Trust's budget setting position as part of the current system position is break even.

13.4 The system plan showed the system consuming c£3.716m resources above allocation. The Trust has actively supported minimising the deficit and will continue to work with system partners to achieve system financial balance. For 30th March planning submission the system has submitted a break-even position and resolved to collectively work to close the last part of the gap. The Trust's share of the £3.716m deficit based on expenditure budget size is £610k which is reflected as a non-recurring CIP in budgets while the system identifies how to close the gap.

13.5 The Board noted that these budgets provided a clear financial framework in which all Trust staff can continue to operate and make financial decisions, and form the basis of the plans on which the Trust will deliver its business planning objectives and strategic aims for the year ahead.

13.6 National planning guidance for 2023/24 provides tariff uplift funding to the system envelope of 2.9% and a 1.1% efficiency target as well as a convergence target reduction of 0.5% for Gloucestershire. The level of covid funding within the system allocation for 2023/24 is significantly reduced but some recurring funds have been made available in the system allocation. National guidance indicated planning for a 2% pay award in 23/24 and budgets have been built on this assumption. The budgets do not reflect the recent announcement of a 5% pay award for 23/24 but all Trusts have been told to assume that the final pay settlement will be fully funded.

13.7 In order to deliver the proposed budgets, recurrent cost improvement schemes of £5.443m will be required. In addition, significant non-recurrent savings of £4.44m will need to be found to support non-recurrent expenditure and non-recurrent cost pressures. During budget setting 28% (£2.747m) of the total savings target has been delivered (50% of recurrent CIPs), with 22% (£2,156m) not yet identified. The Board noted that all recurrent CIP schemes would require QEIAs (Quality Equality Impact Assessments) to be completed to assess the impact on services, and these will be reviewed by the Medical Director, and the Director of Nursing, Therapies and Quality.

13.8 A capital expenditure budget of £14.302m, net of £3.749m disposals, is proposed for 23/24. There are three capital disposals planned for 23/24, and bids have been received for two of these sites already, and the third site is being actively marketed for disposal. The Capital

Management Group has agreed the priorities for next year and the main focus of the programme will be the completion of the new hospital in the Forest of Dean, commencement of the purchase of a new clinical IT system and the continuing reduction in backlog maintenance. The system has a capital CDEL of £37.665m for 23/24 and has a balanced programme incorporating all essentials requirements of each organisation. The capital programme as presented includes additional International Financial Reporting Standard 16 (IFRS16) leases not yet entered into. It is assumed that national funding will be made available.

13.9 Graham Russell noted the reference to disposals within the capital plan and asked for an update on progress with estate reconfiguration and rationalisation. Sandra Betney advised that a complete review of the Trust's estate had been carried out during 2022/23, looking at whether the estate was fit for purpose and identifying backlog maintenance. A clear plan was in place for each locality in terms of the Trust's residual estate. In terms of disposals, Angela Potter advised that the Trust was engaging with system partners to develop an ICS Estates Strategy which would feed into the work GHC was doing to review its estate, with options such as co-location with the VCS.

13.10 The Board noted the budget setting process and linkages within business planning, approved the revenue and capital budgets for 2023/24, approved in principle the five-year capital plan and noted the risks associated with the proposed budgets for 2023/24. The Board expressed its thanks to finance team colleagues for such a comprehensive report and the efficient and systematic process that had been put in place to prepare the budgets.

## 14. NATIONAL STAFF SURVEY RESULTS 2022

14.1 The purpose of this report was to present the final results of the Trust's 2022 Staff Survey. The Trust has committed, as a key part of our Trust People Strategy, to enabling colleagues to have a "Strong Voice" at work and the annual Staff Survey remains a central component to that commitment. The Board was asked to note that the Workforce Management Group (WOMAG), the Executive team and the Great Place To Work Committee had already received and discussed the results in detail.

14.2 Overall, the Trust was rated equal 1st provider in the South West by its workforce which was an excellent achievement. Against this, the results present a largely positive and improving view of how colleagues rate the Trust as an employer.

14.3 There were no changes in the 2022 NHS Staff Survey for the thematic labels and associated questions. This has allowed a more accurate year on year comparison, unlike previous years where there were a number of changes in theme and questions. Historically, the survey was only issued to substantive staff and excluded Bank workers. For the 2022 survey NHS organisations were provided with an option to run an additional survey for Bank Only workers. GHC adopted to make this survey available for our cohort of Bank Only workers and the results were presented within the report.

14.4 The results provide signposting to areas to prioritise for action over the coming year. Proposed key areas of focus for 2023 included the following:

- Supporting Directorates to find new ways of meeting and communicating results; supporting ideas such as directorate and team engagement initiatives where appropriate.
- Drilling down within Directorates which pockets of staff groups or team report that they struggle to meet conflicting demands on their time. This will directly feed into stress at

work, absence and health and wellbeing indicators. The first survey heat map has now been provided by IQVIA.

- Ensuring that colleagues are provided with reassurance about how concerns are handled and addressed. Seek to understand if there are any specific groups or departments where this is a particular issue and work closely with the Communication team and Senior Leaders to maximise related publicity throughout the year. This is expected to link in to anti closed culture work the NQT directorate are progressing reporting into Quality Committee
- Whilst coverage of appraisals is positive in the staff survey, review quality of appraisals and appraisal training particularly with a view to ensuring staff leave the appraisal feeling they can do their job more effectively.
- Increasing our programme of "itchy feet sessions" and wider publicity about career progression and development options within the Trust
- Improving how we tackle discrimination (in particular gender discrimination).

14.5 Sumita Hutchison welcomed the report and the areas of focus for 2023/24. She suggested that it would be helpful to look in more detail at flexible working as well, noting that 58.3% had agreed that they had a good work/home life balance. Discussion at the GPTW Committee had identified that 118 colleagues had left the Trust over the past year due to Work life balance reasons so this might be a helpful area to explore further.

14.6 Sandra Betney noted that discussions had taken place at the Women's Leadership Network and many things were dependent on who colleague's managers were. There was an inconsistency of response from immediate managers to requests such as flexible working and this made a huge difference.

14.7 Graham Russell said that the Trust should rightly celebrate the results and the achievement. A huge amount of work was taking place to ensure that GHC was a great place to work and colleagues should be commended. He noted that there were a number of areas to focus on going forward and suggested that the Trust look at the ones that would make the biggest impact. Plans were in place to cross thread the results from the survey with performance data and workforce KPIs which would provide a very helpful overview.

14.8 Marcia Gallagher noted that the response rate to the survey from colleagues at Charlton Lane was low, as reported in the earlier CQC update. From speaking to colleagues, they had suggested that there was no point completing the survey as nothing ever changed. Marcia asked what the Staffside view was of the results. Neil Savage advised that a meeting to discuss the results in more detail with Staffside colleagues would be taking place in the coming weeks and these matters would be picked up.

14.9 The Board noted the results from the 2022 Staff Survey and noted that the Great Place To Work Committee would oversee progress with the actions.

## 15. GENDER PAY GAP ANNUAL REPORT

15.1 The purpose of this report was to inform the Board of the 2022 gender pay gap across Gloucestershire Health & Care NHS Foundation Trust, to provide an update on related actions from the last report alongside an outline of proposed next steps.

15.2 While this past year's data again presents a modest improving picture for the Trust, it also shows that there is still far to go. It also continues to demonstrate the scale of challenge and the inherent unfairness in the nation more widely. As scale and sustainable improvements

ultimately require amendments to national legislation, the Trust continues to apply good practice, such as positive action, alongside changes in education, careers advice, flexible working, and promotes a leadership culture that consistently values diversity.

15.3 The Trust has continued to take positive action in actively encouraging women to participate in our various local leadership development offers including the One Gloucestershire Elements, Flourish, Thrive, and Leading Better Care Together. The impact and success of these is regularly assessed as part of their programme reviews, with input from the external programme developers and trainers.

15.4 The Deputy Chief Executive/Director of Finance has continued with personal support on the development of the Trust's Women's Leadership Network. Both this and the previous year's gender pay gap and related actions were shared and discussed with the network alongside ideas for action. This year's results were received at the Network in February 2023.

15.5 Following discussions with the Women's leadership network and wider colleagues, a number of actions were proposed to further progress tackling the pay gap within the Trust. One of these included the provision of a Leadership & Management Development Workshop for members of the Women's Leadership Network. The aim of this would be to provide a well-advertised showcase and Q&A session to ensure women colleagues are aware of the breadth of leadership and management development opportunities available within the Trust, the ICS, the region and nationally. The session would also address the psychological barriers to women in leadership roles. Neil Savage advised that if this development session was successful then this could form the basis of a new module within the Thrive leadership programme.

15.6 The Board noted this report, which had also been discussed in detail at the Appointments and Terms of Service Committee. The proposed recommendations and actions were agreed. The Board approved the statement (below in bold), for onward publishing on the Trust website and via the government website.

***"The Board of Gloucestershire Health and Care NHS Foundation Trust confirms its commitment to ongoing monitoring and analysis of its Gender Pay Gap data and to developing the appropriate actions which will reduce and eradicate this gap over time.***

***Additionally, the Board is fully committed to working in partnership with colleagues, stakeholder organisations and external agencies to learn from other organisations, apply good practice and to take innovative approaches, including positive action in its action to reduce and remove the gender pay gap."***

## 16. CHAIR'S REPORT

16.1 The Board received the Chair's Report which highlighted the activity of the Trust Chair and Non-Executive Directors since the previous meeting of the Board in January. Key areas of focus remain ensuring effective system working, ensuring equality, diversity and inclusion are at the heart of how we work as a Trust and that the voice of the Trust is heard locally and nationally to ensure the needs of our community are understood and inform policy and practice.

16.2 Ingrid Barker expressed her thanks and gratitude, on behalf of the Board, to Paul Roberts, Chief Executive, for his commitment and dedication to the Board and Trust. This was Paul's final Board meeting, and he would be leaving the Trust on 16th April. A small gathering had

been organised to take place following today's Board meeting for colleagues to say their farewells. The Trust's new Chief Executive, Douglas Blair would commence in post on Monday 17th April.

16.3 The Board noted that Lorraine Dixon, Associate Non-Executive Director had been successful in securing an appointment as Professor and Director of the School of Nursing and Midwifery at Oxford Brookes University and would therefore be leaving the Trust at the end of May. Ingrid Barker advised that consideration would now be given to the next steps in securing an Associate NED for the Board as a University nominee.

16.4 The Trust's Better Care Together Awards Ceremony took place at Gloucester Rugby Club on 23rd March. This was the first in person awards ceremony for a number of years and Ingrid Barker expressed her huge thanks to Kate Nelmes and the Communications Team for their organisation of this fantastic event, recognising the achievements of our Trust colleagues.

16.5 Following the successful appointment of our new Associate NED, Vicci Livingstone-Thompson, a review of the Non-Executive Portfolios had been carried out to ensure that we best utilise the skills and experience that individual NEDs bring to our Board and Committee Structure. The revised portfolios were attached as an appendix to this report for information and were implemented from 2nd March.

16.6 The Board noted the content of the Chair's report and the activity updates included within it covering attendance at regional and national meetings and events, and local meetings with partner organisations.

## 17. CHIEF EXECUTIVE'S REPORT

17.1 Paul Roberts presented this report which provided an update to the Board and members of the public on his activities and those of the Executive Team since the last meeting in January.

17.2 As noted during the previous item, Paul Roberts confirmed that this was his last Board meeting as Chief Executive. He expressed his thanks to Board members for all their support over the last five years. He said that it had been eventful, at times challenging, but it had been a great privilege to serve in Gloucestershire, our health and social care system and our Trust of which he was incredibly proud. Paul confirmed that he had met the new Chief Executive Douglas Blair and was working closely with him in terms of handover.

17.3 The updated Code of Governance for NHS Provider Trusts would come into effect from 1st April 2023. This replaces the 2014 NHS Foundation Trust Code of Governance and sets out an overarching framework for the corporate governance of trusts, supporting delivery of effective corporate governance, understanding of statutory requirements where compliance is mandatory and provisions with which trusts must comply, or explain how the principles have been met in other ways. The Board was asked to note that an initial review had been undertaken by the Trust Secretary and in general, the provisions of the Code do not greatly differ from the 2014 version since the statutory roles, responsibilities and liabilities of the Board of Directors have not changed. However, some underlying themes were included for the first time, and these were summarised in the report. Issued in conjunction with the Code of Governance, the addendum is to the NHS England 'Your statutory duties: A reference guide for NHS Foundation Trust Governors '(2013). This addendum is designed to explain how the legal duties of Foundation Trust Councils of Governors should support system working and collaboration.

17.4 The Board received an update on industrial action, noting that the BMA (junior doctors) would be striking on 11 – 14 April. Paul Roberts said that this would have more of an impact on the Acute Trust, however, as a Trust, we have continued to work in partnership with Trade Union colleagues ensuring that emergency plans and resilience response measures are in place to manage the impact of strike action and keep our patients and service users safe.

17.5 Paul Roberts advised that a Gloucestershire County Council cabinet meeting had taken place and approval was given for the commissioning of the next phase of the Gloucestershire Urgent and Emergency Care transformation work.

17.6 The Board noted the content of the Chief Executive's Report and recognised the huge amount of work that continued to take place by all members of the Executive Team, locally and nationally.

## 18. COUNCIL OF GOVERNOR MINUTES

18.1 The Board received and noted the minutes from the Council of Governor meetings held on 1 December 2022 and 18 January 2023.

## 19. BOARD COMMITTEE SUMMARY REPORTS

19.1 **Mental Health Legislation Scrutiny Committee**
The Board received and noted the summary report from the MHLS Committee meeting held on 25 January 2023. Key items to report included an update on the Reforms to the MHA, ethnicity and detentions data, and a review of MHA admissions to the Acute Trust.

19.2 **Great Place to Work Committee**
The Board received and noted the summary report from the Great Place to Work Committee meeting held on 2 February 2023. Key items to report included a deep dive focussing on learning and development, and a discussion about an increase in incidents of violence and aggression towards staff which had been referred to the GPTW Committee from the Audit & Assurance Committee.

The Board noted that a further meeting of the GPTW Committee had taken place on 29 March and a full written summary would be presented at the May Board meeting. It was noted that a deep dive had taken place on the results from the 2022 Staff Survey, and the Committee had received the Equality Delivery scheme.

19.3 **Audit and Assurance Committee**
The Board received and noted the summary report from the Audit & Assurance Committee meeting held on 10 February 2022. The Committee had received the Cyber Security Assurance Report, which provided assurance on the latest position for Cyber Security for the Trust. Marcia Gallagher, Chair of the A&A Committee informed Board colleagues that she had met with the Chair of the ICB Audit Committee following this meeting and helpful discussions had taken place in relation to developing an ICS approach to Cyber security. Marcia Gallagher would report back verbally to the next Committee meeting in May.

19.4 **Forest of Dean Assurance Committee**
The Board received and noted the summary report from the FoD Assurance Committee meeting held on 22 February 2023. It was reported that good progress was being made and the Trust was still on track with all sustainability targets.

Marcia Gallagher said that she had attended a recent consultation meeting with partners and VCS organisations on the Forest hospital and discussions had started to take place around the aesthetics and paint colours etc. She said that this had been an excellent meeting and was most welcomed by way of giving local people a sense of ownership in the final design.

Steve Alvis asked whether there had been any progress in terms of rebuilding the skatepark which had been relocated due to the hospital build. Angela Potter advised that subject to Forest of Dean Council planning confirmation, everything was now in place. The town council have appointed contractors to start the site ground works in the summer, with Mavericks (the Skatepark installation company) then on-site late August for a 10 – 12 week installation programme.

19.5 **Resources Committee**

The Board received and noted the summary report from the Resources Committee meeting held on 23 February 2023. Sandra Betney highlighted the discussion regarding the Assessment of Financial Reporting.

19.6 **Appointments and Terms of Service Committee**

The Board received and noted the summary report from the ATOS Committee meeting held on 1 March 2023. Key items to report included the interim performance reviews of the Executive Directors, discussions around the Gender Pay Gap annual report and an update on the CEO recruitment.

19.7 **Quality Committee**

The Board received and noted the summary report from the Quality Committee meeting held on 2 March 2023. Key items to report included a deep dive on MH Crisis Services, receipt of the Trust's Research and Innovation Strategy (to be presented to Trust Board in May) and receipt of the Medical Education Annual Report.

## 20. ANY OTHER BUSINESS

20.1 There was no other business.

## 21. DATE OF NEXT MEETING

21.1 The next meeting would take place on Thursday, 25 May 2023.

# TRUST BOARD PUBLIC SESSION: Matters Arising and Action Log – 25 May 2023

- 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.

| Meeting Date | Item No. | Action Description | Assigned to | Target Completion Date | Progress Update | Status |
|---|---|---|---|---|---|---|
| 30 March 2023 | | No actions identified | | | | |
| | | | | | | |

## Questions from the Public

I would like to thank all the staff at the Trust, and partners working alongside the trust, for all they tirelessly do for the people and communities they serve.

My question would be, and I am aware/read some of the material on crisis, is to look at how we are looking at access, experiences and outcomes, this being through a health inequalities lens around data collection, analysis of data, and use of data to ensure we are addressing and not increasing health inequalities?

**Bren McInerney**

## Trust Response

Thanks so much for your question, and of course for your kind words about the effectiveness and dedication of our people in supporting the population of Gloucestershire. Your point about the collection, compilation and our ability to analyse and apply data in terms of health inequalities (and importantly to ensure we are addressing them) is a really important issue for us, and is an area where we would acknowledge that while we are making some early progress there is a lot more work to do. Pleasingly our data maturity is pretty strong now in comparison with national benchmarks, and this has been enhanced by recent improvement programmes, most notably our successful programme to address historic issues within our main physical health patient record system – this system enables the recording of protected characteristic data, and naturally recording is an important step to formulating an impression of service users and trends of service use. We are also progressing a programme known as Patient Level Information and Costing Systems (PLICS) which is a nationally mandated annual cost collection process that will help us understand service use right down to patient level, which when fully mature should enable us to challenge ourselves and interrogate using a broad range of different fields, but clearly this will be a valuable tool in helping us plan to tackle areas of inequality. It is undergoing development to incorporate population health information such as Indices of Deprivation and Ethnicity, which can then be brought into analysis to better understand our local population – how they interact with our services across our localities and the impact on how we might configure our services. With strong data recording and better data quality, the Trust is developing the capability to examine a range of access and quality demographics for its own patients, and with support of the Integrated Care Board (ICB) and other partners we are continuing to push the agenda to establish better data sharing to do more in understanding what we can do for the patients that don't access our services. From a whole system perspective (ICB), like other areas of the country, our commissioning partners utilise the Joint Strategic Needs Assessment (JSNA), found in the Inform Gloucestershire website(Inform - Inform (gloucestershire.gov.uk). This enables commissioners to make an assessment of the need within the local population when services are commissioned or redesigned. In addition to this bespoke needs assessments may also be carried out; these would include analysis of quantitative data looking at access and uptake of services either by protected characteristic and geographic location (depending on the service in question). Such an assessment should also seek qualitative feedback from service users, their Carers, and staff about the service.

Within the Trust, there are a range of reporting tools available to services examining Access, Experiences and Outcomes. As a matter of course, newly developed reports and updated

reports now include filters on ethnicity, age and gender as routine, and specific tools are developed to support specific inequality hypotheses that projects or services may have. Some good examples include the Mental Health & Learning Disability cohorting tool which enables services to better determine the optimum model of care to meet their demand. It allows for the profiling of event types over time, and presentation by protected characteristics but also deprivation deciles. From a business-as-usual perspective, we are 88% of the way through our deployment of service profiling dashboards for physical health community so that alongside key clinical system activity, corporate system activity (such as Workforce, Training, Incidents, Service Experience and Finance) and performance metrics, services can work with their Corporate partners to examine demographic factors such as gender, age, ethnicity deprivation and location. Mental Health & Learning Disability Community and all inpatients are planned for completion within by September. This will provide services with a central repository of headline information but also links through to more specific reports for their service areas. Further opportunities for improving business partnering functions are in development.

So in summary, while there remains plenty to do in this important area, it is an issue that we are working hard on and which will naturally be at the centre of how we continue to evolve and develop our service offer.

**David Noyes**
**Chief Operating Officer**

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 25 MAY 2023**

**PRESENTED BY:** John Trevains, Director of Nursing, Therapies and Quality

**AUTHOR:** John Trevains, Director of Nursing, Therapies and Quality

**SUBJECT:** **QUALITY DASHBOARD REPORT - APRIL 2023 DATA**

| | |
|---|---|
| **If this report cannot be discussed at a public Board meeting, please explain why.** | *N/A* |

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

**The purpose of this report is to**

To provide the Gloucestershire Health & Care NHS Foundation Trust (GHC) Board with a summary assurance update on progress and achievement of quality priorities and indicators across Trust Physical Health, Mental Health and Learning Disability services.

**Recommendations and decisions required**

Board members are asked to:

- Receive, note and discuss the April 2023 Quality Dashboard.

**Executive summary**

This report provides an overview of the Trust's quality activities for April 2023. This report is produced monthly for Trust Board, Quality Committee, Operational Delivery and Governance Forums for assurance.

Quality issues showing positive improvement:

- Excellent improvement in the reduction of vacancies within MH inpatient services, reducing by 50% over the last 12 months
- Out of Area Placements (OOA) have remained at zero in April.
- Detail provided this month evidences good achievement against the Trust Quality Priorities and Commissioning for Quality and Innovation (CQUIN) activity for 2022/23
- Sustained improvements in CPA compliance rates which have consistently met or exceeded the 95% performance indicator for the last 7 consecutive months.

- Q4 Non-Executive Director (NED) audit of complaints reported good assurance that overall, the Trust is investigating and responding to complaints appropriately.
- This paper updates the Board on the Q4 22/23 NED Quality visit activity, findings and resulting actions.
- Improvement in the compliance to target in cardiometabolic assessments in both inpatient and community settings with continues focus on this area.
- Datix incident closures and open incidents decreased by 81.4% at Wotton Lawn Hospital and by 71.6% across MH/LD inpatient services.

Quality issues for priority development:

- Ensuring easy access to accurate statutory and mandatory training data to enable effective quality monitoring and improvement in team level compliance
- NTQ have developed a rapid action plan to address findings following audit to assess compliance against improvement work connected with Rapid Tranquilisation. Progress has been made in a number of ward areas but additional focus is required to fully meet the original recovery plan milestones.
- The Quality Directorate will continue to develop assurance on Trust safeguards against closed culture risks, e.g. analysis of staff survey data, independent advocacy, reducing restrictive practices amongst other measures/interventions.

**Are our Services Safe?**

NTQ continue to monitor the effect that a prolonged hospital admission has upon a patient. When a patient is deemed to 'no longer meet the criteria to reside' (nCTR), timely and effective discharge plans should be in place to enable a discharge. Our summary of data relating to long length of stay in Community Hospitals now concentrates on delays in excess of 30 days rather than 40 (originally 50 days) following sustained improvements in flow. In April there was an average of 6.25 patients who were ready for discharge a decrease from 8.25 in March. However, in mental health settings there are increasing challenges with 31 peoples discharge delayed due to numerous onward care factors outside of the Trust. In April, the Patient Safety Team (PST) have continued to promote the Patient Safety Syllabus E-learning Level 1 course which is aimed at all levels of staff irrespective of role to strengthen their approach to patient safety. To date 78.2% of GHC staff have completed the training on Care2Learn. In April, there were a total of 1057 incidents reported affecting patients. 964 were reported as No and Low harm incidents and 93 Moderate, Severe or Catastrophic incidents. The top four categories of incident occurring were skin integrity, self-harm, falls and medication errors. There were 5 serious incidents confirmed and reported in April from our mental health services. Falls continue to be closely monitored within the Trustwide falls prevention group with best practice identified and shared. We note a statistically significant increase in moderate harm linked to increase in skin integrity and pressure ulcer harms. The data shows an increase overall of 71 skin integrity harm over the past year. There are three key factors that are driving an increase in number and severity of pressure ulcers; circulatory changes following Covid infection, deconditioning of patients who live at home and have become more socially isolated and physical immobility during and following Covid infection. This is also impacted by an overall increase in admissions to inpatient beds with pre-existing pressure ulcers and an increase in referrals to community nursing caseloads with people who have an existing PU which requires effective management. The PST have continued to oversee and support Datix

incident closures and note from 17/03/2023 to 26/04/2023 open incidents decreased by 81.4% at Wotton Lawn Hospital and by 71.6% across MH/LD inpatient services.

**Are our services Effective?**

International Nurse recruitment continues with 89 new colleagues now in post since January 2021 with a further 3 in active recruitment. We see this month a small decline in the progress rate towards the Zero HCSW target which is reflective of a number of staff qualifying into band 4 roles and routine turnover. Safer staffing data acknowledges the continuing challenges for inpatient teams, however Board are asked to note there has been a 50% reduction in MH inpatient vacancies within the last 12 months as a result of successful local and IEN recruitment alongside retention work, this is excellent progress. The organisational risk associated with staffing in mental health will be reviewed noting potential for a zero-vacancy factor by the end of Q1. In the interim period the matrons and team leaders are continuing to monitor the impact on staffing and ensure safe delivery of services using the escalation protocols when required. The Trust continues to work on a range of actions to address these challenges and this is further reported via the Great Place to Work Committee, this includes improved enhancements for high risk vacancies within Wotton Lawn Hospital. Appendix 3 – summarises wider key performance operational data. We note that recovery rates remain challenged with 3 out of the selected indicators showing an outcome for April of near or at/above target. We continue to work on addressing access to training data to drive improvement in compliance at individual team level in areas that strongly relate to quality of care.

This month we have provided an end of year summary of Trust Quality Priorities alongside CQUIN performance, this is summarised at the front of the dashboard with more detail provided in Appendix 4. Cardio metabolic assessment rates have increased in month in both community and inpatient environments which is reflective of the improvement work being led by NTQ nurses in partnership with ward-based colleagues. Mental Health CPA, (an established proxy measure of community mental health quality), compliance has remained at target level in April meaning that it has been above threshold for seven consecutive months. April saw the launch of the new 'Safeguarding Learning Lunch', 54 staff from across the Trust attended the event. The session explored the topic of hoarding and in May the session will focus on the Gloucestershire Safeguarding Multi Agency Hub. The sessions are designed to increase awareness and learning across a number of safeguarding topics. Monthly auditing of Safeguarding Adult and Children's practice and record keeping has commenced. Plans to develop a Safeguarding Champion Network are in progress. There is an improving picture with Level 4 Adult Safeguarding Training, Prevent Level 3 Training, and Level 4 Adult Protection compliance. A full summary of Safeguarding key performance data is provided in Appendix 2.

**Are our services Caring?**

The Patient Carer & Experience activity reflects ongoing development and improving data to support the newly configurated operational directorates. There was a reduction in concerns raised in April compared to March, however, year on year April to April concerns raised have increased by 65%, this progression is in line with our ambition to manage more feedback at local level and that this is consistent with the 12-month data (84% of feedback managed as a concern in 2022/23 up from 79% the year before). There were 8 new complaints received in April which is a decrease on March. The number of

complaints acknowledged within the 3-day timeframe remains at 100% as per last year with the FFT compliance rate remaining at 94% again narrowly missing the 95% target. The overall number of completed FFT in month responses have more than doubled since this time last year, this being directly attributable to the implementation of new processes. The work to identify, mitigate and prevent risk within areas vulnerable to developing a closed culture continues and is highlighted in more detail within the dashboard. Included in this month's dashboard is the summary of the NEDS Audit of complaints for Q4 and the NEDs Quality visits at Appendix 5. This month we have included a slide that highlights the Trusts NACEL results demonstrating our high performance within a number of End of Life metrics that demonstrates our continued commitment to providing excellent end of life care across the trust.

**CQC Update**

The Trust continues to make good progress with the actions arising from the CQC core inspection and is now 88% complete. One of the MUST DO's from the CQC Core inspection that relates to Wotton Lawn Hospital is now complete with additional work being undertaken to fully assure the Rapid Tranquilisation work which hasn't achieved the milestones in the original recovery plan. Owing to workforce challenges there are delays in training places for inpatient staff and there remains variation on recording of post physical health monitoring. A recent audit has identified the areas of noncompliance and a rapid action plan has commenced which includes the first wave of training for HCSW's which forms a crucial component of the improvement plan. The Trust is undertaking self-assessment and peer review work with services that were not inspected in 2022 to provide support and assurance that these services are meeting the regulatory requirements. The first peer review took place at Weaver's Croft in April with the Community Mental Health Recovery Teams, and further reviews are diarised for June and July for the other recovery teams.

**Risks associated with meeting the Trust's values**

Specific initiatives or requirements that are not being achieved are highlighted in the Dashboard.

| **Corporate considerations** | |
|---|---|
| **Quality Implications** | By the setting and monitoring of quality outcomes this provides an escalation process to ensure we identify and monitor early warning signs and quality risks, helps us monitor the plans we have in place to transform our services and celebrates our successes. |
| **Resource Implications** | Improving and maintaining quality is core Trust business. |
| **Equality Implications** | No issues identified within this report |

| **Where has this issue been discussed before?** |
|---|
| Quality Assurance Group, updates to the Trust Executive Committee and bi-monthly reports to Quality Committee/Public Board. |

| | |
|---|---|
| **Appendices:** | Quality Dashboard Report - April 2023 |

| | |
|---|---|
| **Report authorised by:**<br>John Trevains | **Title:**<br>Director of Nursing, Therapies and Quality. |

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

# Quality Dashboard 2022/23

# Physical Health, Mental Health and Learning Disability Services

**Data covering April 2023**

working together | always improving | respectful and kind | making a difference

# Executive Summary

Gloucestershire Health and Care NHS Foundation Trust

**This Quality Dashboard reports quality focussed performance, activity, and developments regarding key quality measures and priorities for 2022/23 and highlights data and performance. This data includes national and local contractual requirements. Certain data sets contained within this report are also reported via the Trust Resources Committee; they are included in this report where it has been identified as having an impact on quality matters. Feedback on the content of this report is welcomed and should be directed to John Trevains, Director of Nursing, Therapies and Quality (NTQ).**

The Quality Dashboard summary is informed by NHS England's shared single view of quality – which aims to provide high quality, personalised and equitable care for all. The primary drivers in this shared view focus on systems and processes that deliver care that is safe, effective and has a positive experience which is responsive, personalised and caring. We frame our quality reporting in line with this view. This provides an escalation process to ensure we identify and monitor early warning signs and quality risks, helps us monitor the plans we have in place to transform our services and celebrates our successes.

**Are our services SAFE?**

We continue to monitor the effect that a prolonged hospital admission has upon a patient. When a patient is deemed to ' *no longer meet the criteria to reside'* (nCTR), timely and effective discharge plans should be in place to enable a discharge. Our summary of data relating to long length of stay in Community Hospitals now concentrates on delays in excess of 30 days rather than 40 (Originally 50 days) following sustained improvements in flow. In April there was an average of 6.25 patients who were ready for discharge a decrease from 8.25 in March. However, in mental health settings there are increasing challenges with 31 peoples discharge delayed due to numerous onward care factors outside of the Trust. In April, the Patient Safety Team (PST) have continued to promote the Patient Safety Syllabus E-learning Level 1 course which is aimed at all levels of staff irrespective of role to strengthen their approach to patient safety. To date 78.2% of GHC staff have completed the training on Care2Learn. In April, there were a total of 1057 incidents reported affecting patients. 964 were reported as No and Low harm incidents and 93 Moderate, Severe or Catastrophic incidents. The top four categories of incident occurring were skin integrity, self harm, falls and medication errors. There were 5 serious incidents confirmed and reported in April from our mental health services. Falls continue to be closely monitored within the Trustwide falls prevention group with best practice identified and shared. We note a statistically significant increase in moderate harm linked to increase in skin integrity and pressure ulcer harms. The data shows an increase overall of 71 skin integrity harm over the past year. There are three key factors that are driving an increase in number and severity of pressure ulcers; circulatory changes following Covid infection, deconditioning of patients who live at home and have become more socially isolated and physical immobility during and following Covid infection. This is also impacted by an overall increase in admissions to inpatient beds with pre-existing pressure ulcers and an increase in referrals to community nursing caseloads with people who have an existing PU which requires effective management. The PST have continued to oversee and support Datix incident closures and note from 17/03/2023 to 26/04/2023 open incidents decreased by 81.4% at Wotton Lawn Hospital and by 71.6% across MH/LD inpatient services.

**Are our services EFFECTIVE?**

International Nurse recruitment continues with 89 new colleagues now in post since January 2021 with a further 3 in active recruitment. We see this month a small decline in the progress rate towards the Zero HCSW target which is reflective of a number of staff qualifying into band 4 roles and routine turnover. Safer staffing data acknowledges the continuing challenges for inpatient teams, however, there has been a 50% reduction in MH inpatient vacancies within the last 12 months as a result of successful local and IEN recruitment alongside retention work, this is excellent progress. The organisational risk associated with staffing in mental health will be reviewed noting potential for a zero-vacancy factor by the end of Q1. In the interim period the matrons and team leaders are continuing to monitor the impact on staffing and ensure safe delivery of services using the escalation protocols when required. The Trust continues to work on a range of actions to address these challenges and this is further reported via the Great Place to Work Committee, this includes improved enhancements for high risk vacancies within Wotton Lawn Hospital. **Appendix 3** – summarises wider key performance operational data. We note that recovery rates remain challenged with 3 out of the selected indicators showing an outcome for April of near or at/above target. We continue to work on addressing access to training data to drive improvement in compliance at individual team level in areas that strongly relate to quality of care.

This month we have provided an end of year summary of Trust Quality Priorities alongside CQUIN performance, this is summarised at the front of the dashboard with more detail provided in **Appendix 4.** Cardio metabolic assessment rates have increased in month in both community and inpatient environments which is reflective of the improvement work being led by NTQ nurses in partnership with ward-based colleagues. Mental Health CPA, (an established proxy measure of community mental health quality), compliance has remained at target level in April meaning that it has been above threshold for seven consecutive months. April saw the launch of the new 'Safeguarding Learning Lunch', 54 staff from across the Trust attended the event. The session explored the topic of hoarding and in May the session will focus on the Gloucestershire Safeguarding Multi Agency Hub. The sessions are designed to increase awareness and learning across a number of safeguarding topics. Monthly auditing of Safeguarding Adult and Children's practice and record keeping has commenced. Plans to develop a Safeguarding Champion Network are in progress. There is an improving picture with Level 4 Adult Safeguarding Training, Prevent Level 3 Training, and Level 4 Adult Protection compliance. A full summary of Safeguarding key performance data is provided in **Appendix 2.**

**Are our services CARING?**

The Patient Carer & Experience activity reflects ongoing development and improving data to support the newly configurated operational directorates. There was a reduction in concerns raised in April compared to March , however, year on year April to April concerns raised have increased by 65% , this progression is in line with our ambition to manage more feedback at local level and that this is consistent with the 12 month data (84% of feedback managed as a concern in 2022/23 up from 79% the year before). There were 8 new complaints received in April which is a decrease on March. The number of complaints acknowledged within the 3-day timeframe remains at 100% as per last year with the FFT compliance rate remaining at 94% again narrowly missing the 95% target . The overall number of completed FFT in month responses have more than doubled since this time last year , this being directly attributable to the implementation of new processes. The work to identify, mitigate and prevent risk within areas vulnerable to developing a closed culture continues and is highlighted in more detail within the dashboard. Included in this months dashboard is the summary of the NEDS Audit of complaints for Q4 and the NEDs Quality visits at **Appendix 5 .** This month we have included a slide that highlights the Trusts NACEL results demonstrating our high performance within a number of End of Life metrics that demonstrates our continued commitment to providing excellent end of life care across the trust.

**CQC Update**

The Trust continues to make good progress with the actions arising from the CQC core inspection and is now 88% complete. One of the MUST DO's from the CQC Core inspection that relates to Wotton Lawn Hospital is now complete with additional work being undertaken to fully assure the Rapid Tranquilisation work which hasn't achieved the milestones in the original recovery plan. Owing to workforce challenges there are delays in training places for inpatient staff and there remains variation on recording of post physical health monitoring. A recent audit has identified the areas of non compliance and a rapid action plan has commenced which includes the first wave of training for HCSW's which forms a crucial component of the improvement plan. The Trust is undertaking self-assessment and peer review work with services that were not inspected in 2022 to provide support and assurance that these services are meeting the regulatory requirements. The first peer review took place at Weaver's Croft in April with the Community Mental Health Recovery Teams, and further reviews are diarised for June and July for the other recovery teams.

# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

## Quality Priorities 2022-2023:

A summary of quality priority activity in 2022-23 is summarised below

**SUMMARY QUALITY PRIORITIES 2022-2023**

| Priority | Description | Status 21/22 | Status 22/23 |
|---|---|---|---|
| 1 | Pressure Ulcers (PU's) - with a focus on reducing incidence and severity through improvement in the recognition, reporting, and clinical management of PU's , developing a PU collaborative within the One Gloucestershire Integrated Care System. | Achieved | . Achieved |
| 2 | Falls prevention – with a focus on reduction in medium to high harm falls based on 2020/21 data . Continuing to work to maintain a falls collaborative within the One Gloucestershire Integrated Care System. | Not achieved | Achieved |
| 3 | End of Life Care (EoLC) - with a focus on refreshing the collaborative One Gloucestershire approach to improving EoLC across the county . This will support the 6 ambitions for Palliative and End of Life Care including improving systems to identify those eligible using the Supportive and Palliative Care Indicators Tool (SPICT), improving the access to advance care planning and the ReSPECT V3 , and increasing symptom management training for staff to support non - cancer patients. | Achieved | Achieved |
| 4 | Patient and Carer Experience - with a focus on incrementally reducing the time taken to provide a final response letter to people who have raised a formal complaint about Trust services, improvement in completion times will be achieved quarter on quarter . | Partially Achieved | Partially Achieved |
| 5 | Friends and Family Test (FFT) - with a question to ask people for their views on the quality of their care, as highlighted in our 2020 CQC Audit Community Mental Health Survey action plan. | Achieved | Achieved |
| 6 | Reducing suicides - with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services. We will work to the aspirations of the Zero suicide Alliance to support the aim for zero suicides within our mental health inpatient units by 2023. | Not achieved | Achieved |
| 7 | Learning disabilities - a focus on the Hospital /personal Passport utilisation, and roll out of the Oliver McGowan Tier 1 and tier 2 training programme .The trust aims to train 90% of our workforce. | Achieved | Partially achieved |
| 8 | Children's Services - transition to adult services with a focus on ensuring a safe and prompt transfer between services, developing pathways, standardising practice, and reducing delays in care . Fidelity to the care pathways will be evaluated through participation in the NCEPOD study. | Not achieved | All actions within our control achieved |
| 9 | Embedding learning following patient safety Incidents - with a focus on sharing and learning from experience and investigations to develop and improve standards of care . This will be measured through the numbers of post investigation embedding learning workshops delivered and the number of lessons bulletins issued. alongside implementation of the Civility Saves Lives initiative, with assurance measured against the project implementation goals and evaluation over the reporting period. | Not achieved | Achieved |

# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

The National CQUINs applicable to GHC are tabled in summary below, progress reporting began at the close of Q1. (Q3 for Flu) . Agreement reached with commissioners that reporti [illegible] only with no financial penalties linked to thresholds. We have a separate CQUIN for Liaison and Diversion services. New reporting systems are primarily manual sampling with BI working to support automated collection. Overall we are progressing as planned and to the expectations of commissioners.

| CCG Ref | Description | Mental Health | Community | Reporting Process | Status |
|---|---|---|---|---|---|
| CCG1 | **Flu vaccinations for frontline healthcare workers, ( 70%-90% compliance )** | ✓ | ✓ | Established process via Immform to continue as per previous years. | Q4 (55.76% ). **We are in the top 3 providers in the SW and SW are the highest performing region. (**nationally this indicator is performing at a lower level than in previous periods). |
| CCG9 | **Cirrhosis and fibrosis tests for alcohol dependent patients :** Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis. | ✓ | | New - National CQUIN collection . | H1 and H2 achieved. |
| CCG10a | **Routine outcome monitoring in CYP and perinatal health services** : Achieving 40% of CYP and women in the perinatal period accessing MH services, having their outcomes measured at least twice | ✓ | | Routine submission via MHSDS) | H1 and H2 achieved Reporting – 49.6% Q4 |
| CCG10b | **Routine outcome monitoring in community mental health services**. Achieving 40% of adults and older adults accessing select Community Mental Health Services (CMHSs), having their outcomes measure recorded at least twice. In order to meet the requirements of this indicator, Patient Reported Outcome Measures (PROMs) data will need to be submitted (either in combination with Clinician Reported Outcome Measures (CROMs), or only PROMs) as part of the numerator for this CQUIN during the financial year | ✓ | | At present paired outcomes are not consistently recorded. As part of the Community Mental Health Transformation we are trialling DIALOG+ which is a self assessment and Patient Rated Outcome Measure (PROM). This will give an opportunity for outcomes to be assessed. We are in the testing stage with teams in the Forest locality where the pilot was initiated. Engagement and training is underway with the remainder of the Recovery Teams. | |
| CCG11 | **Use of anxiety disorder specific measures in IAPT** 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 (ADSM). | ✓ | | Routine submission to (IAPT) Data Set | H1 and H2 achieved Reporting – 70.4% Q4 |
| CCG12 | **Biopsychosocial assessments by mental health liaison services** Achieving 80% of self-harm referrals receiving a biopsychosocial assessment concordant with NICE guidelines. | ✓ | | New - National CQUIN collection . | H1 and H2 achieved . |
| CCG13 | **Malnutrition screening in the community - applicable to inpatients in community settings** . Achieving 70% of community hospital inpatients having a nutritional screening that meets NICE Quality Standard QS24 (Quality statements 1 and 2), with evidence of actions against identified risks | | ✓ | New - National CQUIN collection . | H1 and H2 achieved |
| CCG14 | **Assessment, diagnosis and treatment of lower leg wounds** Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines. | | ✓ | New - National CQUIN collection . | CQUIN suspended due to national challenges with audit tool , work stream incorporated in 23-24 by the implementation of the tissue viability quality priority. |
| CCG15 | **Assessment and documentation of pressure ulcer risk** Achieving 60% of community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks. | | ✓ | New - National CQUIN collection . | H1 & H2 achieved |

# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

## CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

| No | Reporting Level | Threshold | 2022/23 Outturn | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | 2023/24 YTD | R A G | Exception Report? | Benchmarking Report |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Friends and Family Test Responses Received | N - R | | 20,256 | 2,419 | | | | | | | | | | | | 2,419 | | | |
| % of respondents indicating a positive experience of our services | N - T | 95% | 94% | 94% | | | | | | | | | | | | 94% | | | |
| Number of compliments received in month | L - R | | 2081 | 202 | | | | | | | | | | | | 202 | | | |
| Number of other contacts received in month | L - R | | 619 | 44 | | | | | | | | | | | | 44 | | | |
| Number of concerns received in month | L - R | | 692 | 66 | | | | | | | | | | | | 66 | | | |
| Number of complaints received in month | N - R | | 136 | 8 | | | | | | | | | | | | 8 | | | |
| Number of open complaints (not all opened within month) | L - R | | | 43 | | | | | | | | | | | | | | | |
| Percentage of complaints acknowledged within 3 working days | N - T | 100% | 100% | 100% | | | | | | | | | | | | 100% | | | |
| Number of complaints closed in month | L - R | | | 6 | | | | | | | | | | | | 6 | | | |
| Number of complaints closed within 3 months | L - I | | | 5 | | | | | | | | | | | | 5 | | | |
| Number of re-opened complaints (not all opened within month) | L- R | | | 7 | | | | | | | | | | | | | | | |
| Number of external reviews (not all opened within month) | L - R | | | 2 | | | | | | | | | | | | | | | |

RAG Key: R – Red, A – Amber, G - Green

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

## CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

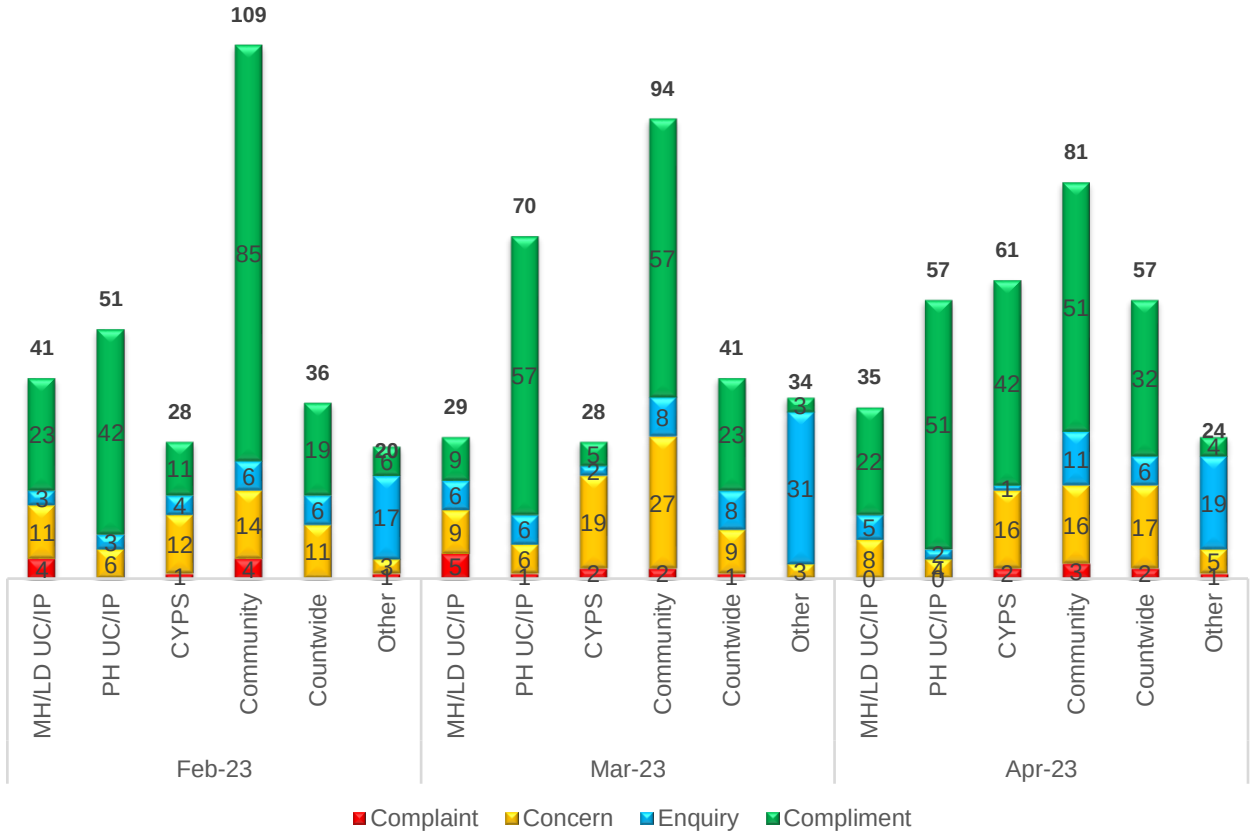
- We are redesigning the way in which we present PCET data to give greater oversight and opportunity – this is an iterative process and we welcome all feedback.
  - Numbers are now broken down by operational channels/directorates, then by type.
  - Monthly meetings with SDs, P&D leads and NTQ links will enable interrogation of service specific data; this time can also be used to discuss ongoing investigations and emerging themes, hotspots and learning.

**The below table shows all reported PCET data received this month by type and directorate**
**I**t is important to note that this is snapshot and does not consider footfall/caseloads/acuity of patients.

| Directorate | Complaint | Concern | Enquiry | Compliment |
|---|---|---|---|---|
| MH/LD urgent care and inpatient | 0 | 8 | 5 | 22 |
| PH urgent care and inpatient | 0 | 4 | 2 | 51 |
| CYPS | 2 | 16 | 1 | 42 |
| PH/MH/LD Community | 3 | 16 | 11 | 51 |
| Countywide | 2 | 17 | 6 | 32 |
| Other | 1 | 5 | 19 | 4 |
| Totals | 8 | 66 | 44 | 202 |

**Concerns snapshot April:**

- **MH UC/IP**: patient required readmission within 24 hours of discharge; inpatient attended ED unescorted, absconded and was injured; relative concerned that a patient was not detained.
- **PH UC/IP**: missed fracture which later healed incorrectly; a different missed fracture which later required surgery; advice given at MIiU resulted in admission at an acute hospital
- **Community**: relative asked when promised equipment would be available; patient requested formal diagnosis; patient complained about diagnostic process for ASC/ADHD; patient reported being unhappy about a further detention under the MHA; patient concerned about his catheter.
- **Countywide**: patient requested confirmation she had paid appropriately for dental treatment; relative unhappy about a lack of support to repair or replace a wheelchair; and a patient raised concerns about bloodwork and Hep B injections.
- **CYPS**: various feedback relating to CAMHS waiting lists; concerns raised about being asked about domestic abuse; parent concerned about a number of cancelled physio appointments; parent upset by national child measurement programme letter.




**The above graph shows feedback by type and directorate over the past three months.**
Whilst there have been a number of complaints, there have been significantly more compliments across every directorate. Moving forward, we aim to increase our learning from excellence too.

## CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

**The below table shows all COMPLAINTS closed this month by outcome and directorate.**

- This month two complaints were withdrawn.

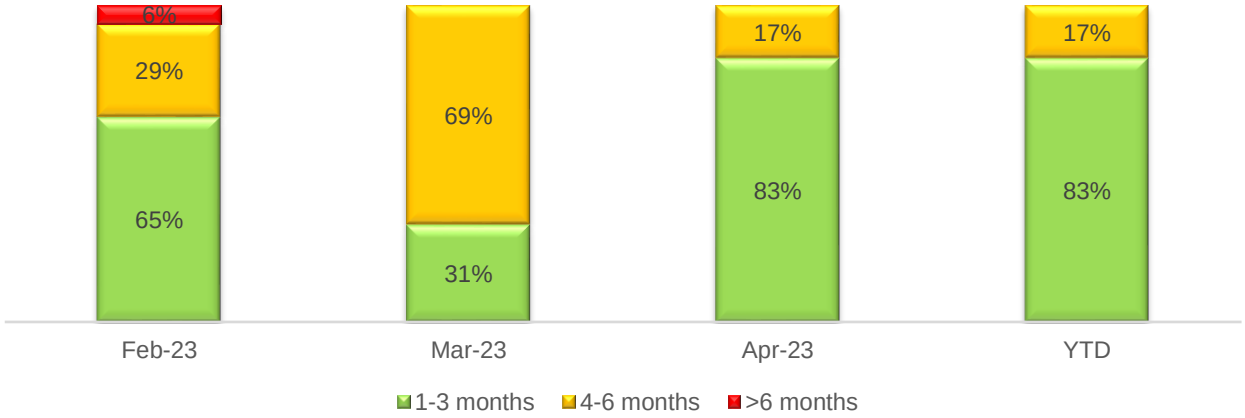
| Directorate | Upheld | Partially upheld | Not upheld | Other | Total |
|---|---|---|---|---|---|
| MH/LD urgent care, inpatient | 0 | 0 | 1 | 1 | **2** |
| PH urgent care, inpatient | 0 | 1 | 0 | 0 | **1** |
| CYPS | 0 | 1 | 0 | 0 | **1** |
| PH/MH/LD Community | 1 | 0 | 0 | 1 | **2** |
| Countywide | 0 | 0 | 0 | 0 | **0** |
| Other | 0 | 0 | 0 | 0 | **0** |
| **Totals** | **1** | **2** | **1** | **2** | **6** |

**Upheld themes for complaints closed this month**

1. **Communication and staff attitude** (*CYPS* and *Community*)
   - Letters not sent, and staff did not attend a meeting
   - Patient did not receive an expected telephone call
2. **Patient care and treatment** (*MH UC/IP* and *PH UC/IP*)
   - Incorrect pathway of care followed
   - Lack of assessment for potential blood clot
3. **Access to services** (*CYPS*)
   - Patient not formally assessed for ASC / ADHD

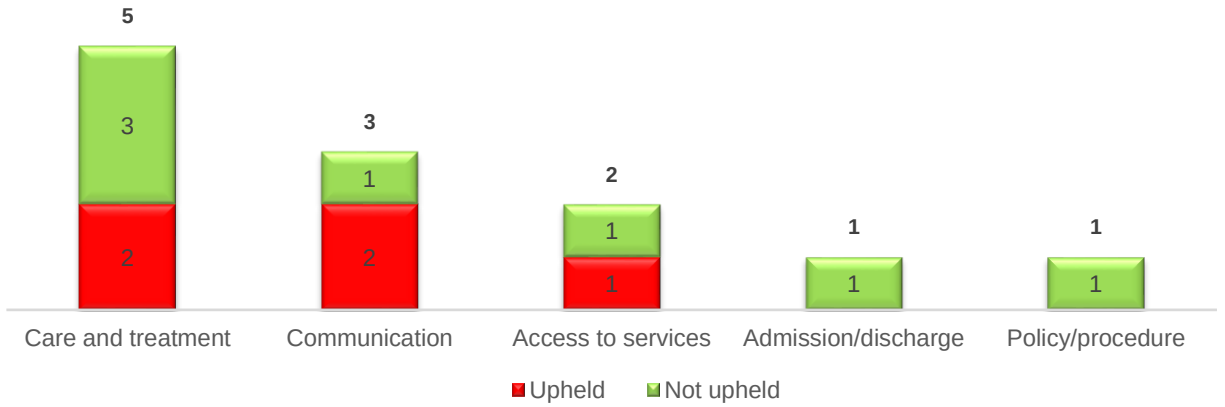
**The below graph shows improvements in the length of time taken to close complaints.**

- This month, **83%** were closed within three months (target = 95%) and **17%** closed within six months (target = 5%)
- YTD, **100%** of complaints have closed within six months (87% for 2022/23).




**The chart below shows the themes highlighted in complaints closed over the past month**

- Care and treatment – upheld across **2** directorates
- Communication and attitude – upheld across **3** directorates
- Access to services – upheld in **1** directorate



## CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

**The below table shows all CONCERNS closed this month by outcome and directorate.**

- This month, **4** of the 73 closed concerns were escalated to a formal complaint after they were unable to be resolved at a local level
- One concern was referred to the Patient Safety Team

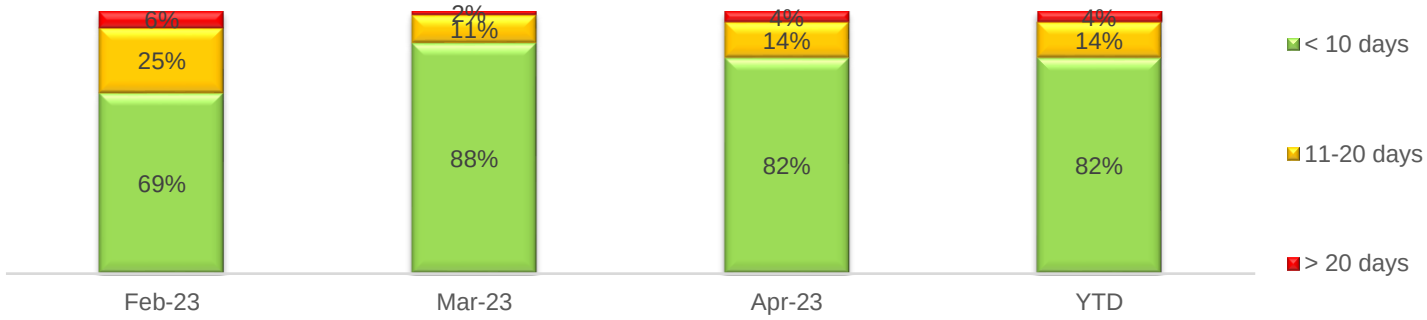
| Directorate | Resolved | Escalated | Other | Total |
|---|---|---|---|---|
| MH/LD urgent care and inpatient | 11 | 0 | 1 | 12 |
| PH urgent care and inpatient | 7 | 0 | 0 | 7 |
| CYPS | 15 | 2 | 0 | 17 |
| PH/MH/LD Community | 14 | 2 | 0 | 16 |
| Countywide | 17 | 0 | 0 | 17 |
| Other | 4 | 0 | 0 | 4 |
| **Totals** | 68 | 4 | 1 | 73 |

**Key themes for concerns closed this month**

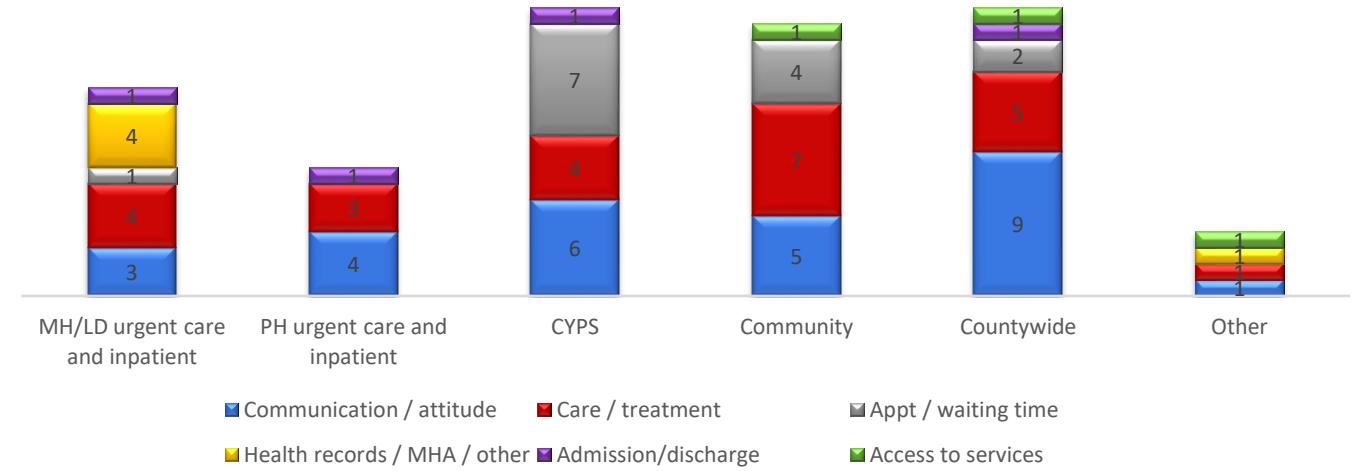
1. Communication [all directorates]: lack of contact from services, not feeling listened to, and rescheduling of appointments.
2. Care/treatment [all directorates]: insufficient support from services – patient doesn't meet the criteria, service not available for certain conditions, and not enough contact from services.
3. Waiting times and appointments [*CYPS* and *Community*]: ADHD team, CAMHS SCAAS, and OT (adult and child)

**The below chart shows the length of time taken to close concerns.**

- This month, **82%** of concerns were closed within 10 days (target = 80%) and **14%** closed within 20 days (target = 20%)
- YTD, **82%** of concerns have closed within 20 days (85% for 2022/23)




**The chart below shows the themes by type and directorate for all concerns closed this month.**



## CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

**The chart shows all COMPLIMENTS received this month by theme and directorate.**

The **202** compliments recorded contained comments that were distributed over **10** different themes. Some compliments contained more than one theme. It is very likely that more compliments were received but not recorded, therefore, not reported; this is due to operational challenges on teams.

**A variety of compliments were received across the different directorates, including:**

*Thank you for all the kindness, compassion & professional care you all gave to "patient" and to me over the 9 months he was with you on Willow Ward. The amazing job that you do is beyond me-I had no understanding of the ravages of Alzheimer's disease, and just hope that a cure will be found in the not too distant future.* **Willow Ward**

*Some really positive feedback around the support the SCFT have given a patient. They commented that the discharge for this patient would not be proceeding without our support. Thanked the team for our efforts.*
**Specialist Community Forensic Team**

*We'd like to pass on our sincere gratitude for the wonderful care and attention given to 'patient' by the team in the North Cotswolds Hospital. It's a huge comfort to us that 'patient's' last weeks were spent in such wonderful surroundings being cared for by such a dedicated team. You are all amazing!*
**Cotswold View Ward, NCH**

*I recently had my second hip replacement and needed to get my wound checked after 2 weeks. …Just to say how excellent the service I received at stroud minor injuries. They were gentle, caring and supportive. I felt the service and advice I received was exceptional. The hospital was spotless, the staff considerate.*
**Stroud MIiU**

*Patient emailed to thank therapist for their session, and explained they were unsure having never had therapy how it would be, but found it incredibly helpful and invaluable.*
**NHS Talking Therapies**

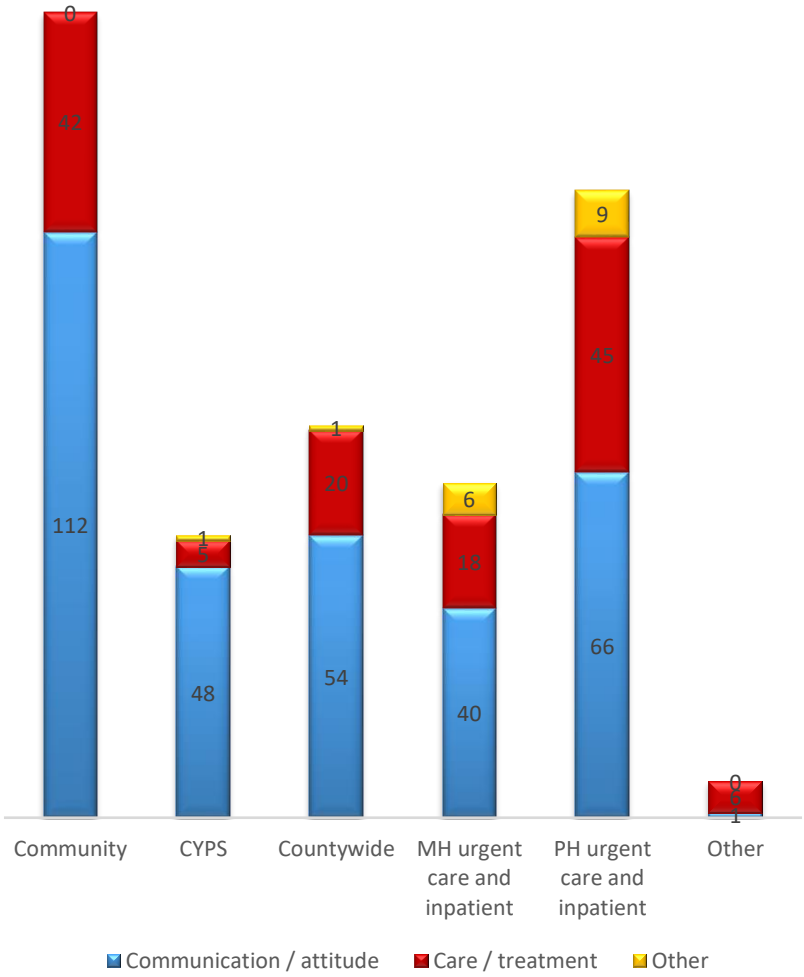
*To all the nurses who came to help, thank you. You were all absolutely fantastic and very caring. This heartfelt thanks is from all his family.*
**ICT Cots North DN**

*"You've given me the tools, I can use them all" "I'm feeling like I've got everything I want and need from these sessions".*
**SARC**

*Patient reported he was very pleased he had attended his falls assessment appt and was very grateful for the time spent and information provided. Reported he felt reassured and motivated to progress his exercises.*
**Falls assessment**

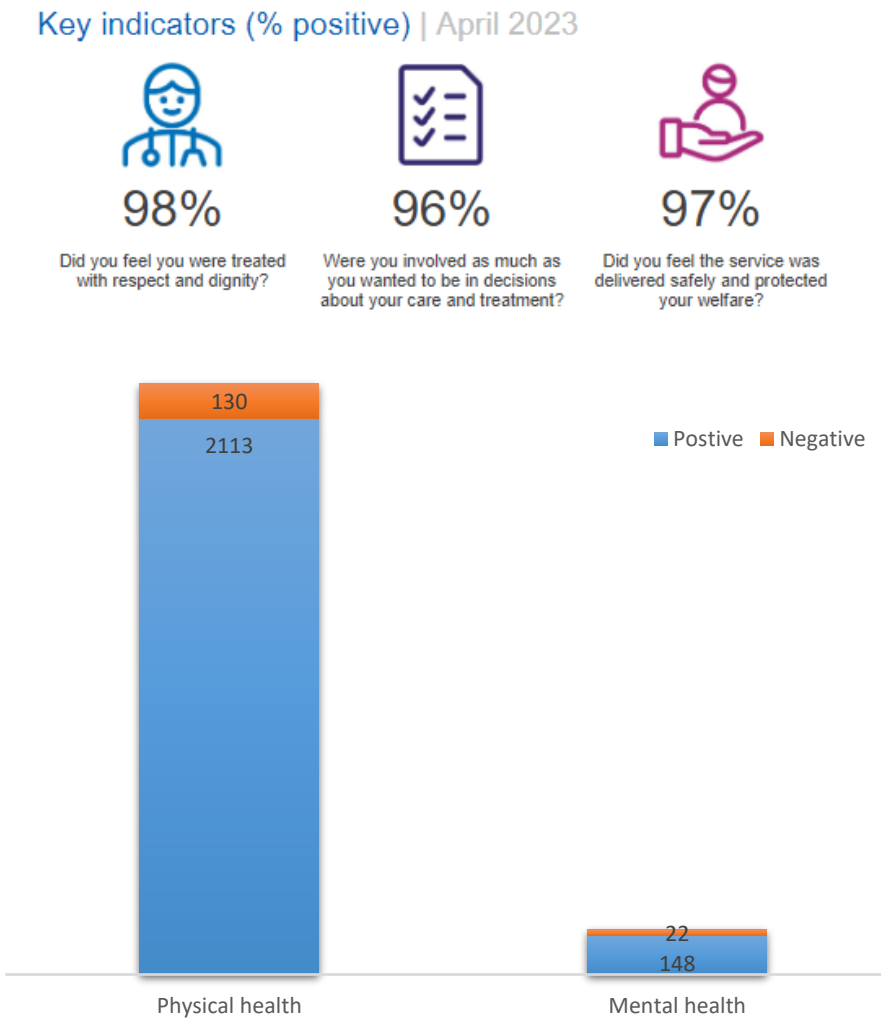
*Brownies and blondies and a card, made by a young person who has been discharged today after being open to us for a long time. She has written a card to the whole of CAMHS, thanking receptionists, DBT clinic, family therapy clinic, art therapy, outreach team and clinicians …The brownies are her own famous recipe.*
**CAMHS**

*I'm quite emotional listening to this! I can't even remember him talking like this, he's come so far. Thank you so much for all your hard work and commitment to seeing him. What an incredible improvement!*
**CYPS SLT**



## CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

| Service Area | Total Responses | Total POSITIVE Responses | % Positive Responses |
|---|---|---|---|
| **Hospitals overall** | **112** | **109** | **97%** |
| Hospitals - physical health | 83 | 81 | **98%** |
| Hospitals - mental health | 29 | 28 | **97%** |
| **Specialist overall** | **340** | **326** | **96%** |
| Specialist - physical health | 292 | 285 | **98%** |
| Specialist - mental health | 48 | 41 | **85%** |
| **Adult community overall** | **475** | **408** | **86%** |
| Adult community - physical health | 409 | 353 | **86%** |
| Adult community - mental health | 66 | 55 | **83%** |
| **Urgent care overall** | **1261** | **1207** | **96%** |
| Urgent care - physical health | 1256 | 1204 | **96%** |
| Urgent care - mental health | 5 | 3 | **60%** |
| **CYPS/CAMHS overall** | **225** | **211** | **94%** |
| CYPS - physical health | 203 | 190 | **94%** |
| CAMHS - mental health | 22 | 21 | **95%** |



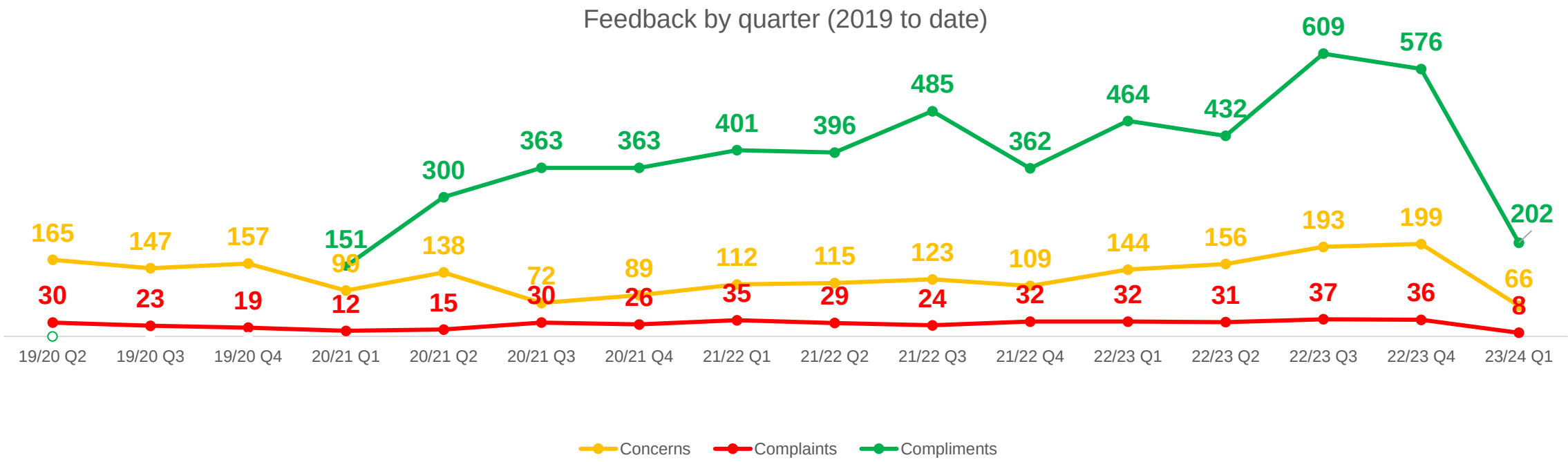

**Highlights for April 2023:**

- The FFT response continues to be at a high level in line with recent months, and is up by **48%** in comparison with April 2022.
- The overall positive experience rating remains at **94%**, which is in line with last year.
- We are continuing to work with services where responses are low to promote a variety of survey methods, such as iPads, QR codes and paper where this is appropriate.
- A paper copy of the FFT is included in the 'What matters to me' orange folder, as part of a pilot on 2 x MH wards.
- A QI project is underway which is looking into the value of the FFT reports and how the data is being used and shared across Trust services (staff and patients).
- **7** requests for contact have generated further action/investigation through the new 'open' question.

## CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

The chart below shows the number of complaints, concerns and compliments received by quarter over past four years. Key dates impacting these figures are:

- 2g and GCS merged in October 2019 to become GHC
- Between April and June 2020, the complaint process was paused as per National NHSE Covid Emergency guidance - complaints were accepted but not processed



## ADDENDUM TO QUALITY DASHBOARD

## ARE SERVICES SAFE? Non-Executive Director audit of complaints Q4 2022/23

### INTRODUCTION

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

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

### PROCESS

- Three complaint files closed in the quarter are randomly selected by the nominated Non-Executive Director auditor
- The Patient and Carer Experience Team completes section 1 of the audit tool and provide the auditor with copies of the initial complaint letter, the investigation report, and the final response letter.
- Having studied the files, the auditor completes sections 2-4
- The auditor compiles a report of their findings, to be presented at the Quality Committee and Trust Board

### SUMMARY OF FINDINGS

- Audit findings are summarised within the table on the following slide
- The Q4 2022/23 audit provides **good** assurance that overall, the Trust is investigating and responding to complaints appropriately.
- The Trust's responsiveness to complaints is monitored via the monthly Quality Dashboard.

### FUTURE AUDITS

- The Trust Secretary's office will continue to allocate the audits to NED colleagues
- An ongoing programme for NED audit of complaints has been established
- Audit reports will continue to be presented within the Quality Dashboard for the Quality Committee and for Trust Board

### RECOMMENDATIONS

- To note the contents of the report
- To note the assurances provided regarding the Trust's management of complaints

**ADDENDUM TO QUALITY DASHBOARD**
**ARE SERVICES SAFE? Non-Executive Director audit of complaints Q4 2022/23**

| | Time scale of response | Quality of investigation | Accessibility, style and tone of letter | Learning actions identified | Comments |
|---|---|---|---|---|---|
| **Complaint 1**<br>• Mother of patient reported staff discussed the clinical impression in front of the patient, including the conclusion he does not have an ASC. Mother reported she feels this constitutes poor conduct, and she is now concerned CAMHS will discharge him with no support. | **FULL ASSURANCE**<br>• Appropriate acknowledgement and clarification, plus updating of the complainant. | **FULL ASSURANCE**<br>• Very thorough investigation. | **FULL ASSURANCE**<br>• Warm response letter completed to a high standard. | **FULL ASSURANCE**<br>• Accountability of learning actions not clear in letter, although clear in notes.<br>• No timescale given. | • Service has put in place a full response and management plan to the patient's needs. |
| **Complaint 2**<br>• Son unhappy with the lack of communication from the Vale hospital when his father was an inpatient. | **FULL ASSURANCE**<br>• This complaint experienced delays due to additional questions being raised after the investigation. | **SIGNIFICANT ASSURANCE**<br>• A thorough investigation that was difficult due to a marked different in perception of events, particularly around attitude.<br>• A lot of work took place after the initial investigation to determine the outcome of some of the issues. | **FULL ASSURANCE**<br>• Letter addressed the individual issues raised.<br>• Appropriate apologies were offered. | **FULL ASSURANCE**<br>• Learning was identified and actions agreed. | • The audit queried why patients are awoken early for medication they probably take later at home. The findings are that some particular medications are time sensitive and some are needed to be given prior to food. |
| **Complaint 3**<br>• Patient is unhappy with amount of time allocated for a meeting and does not believe the mental health team are taking her concerns seriously. | **PARTIAL ASSURANCE**<br>• There was a slight delay to the investigation process and final sign off. | **SIGNIFICANT ASSURANCE**<br>• The investigation covered the main points using a plainer format which the investigator preferred.<br>• A difficult complaint with issues added after the original complaint. | **FULL ASSURANCE**<br>• Letter was empathetic and understanding, but the outcome was possibly not the findings the complainant would want. | **FULL ASSURANCE**<br>• Learning was identified and actions agreed. | |

# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

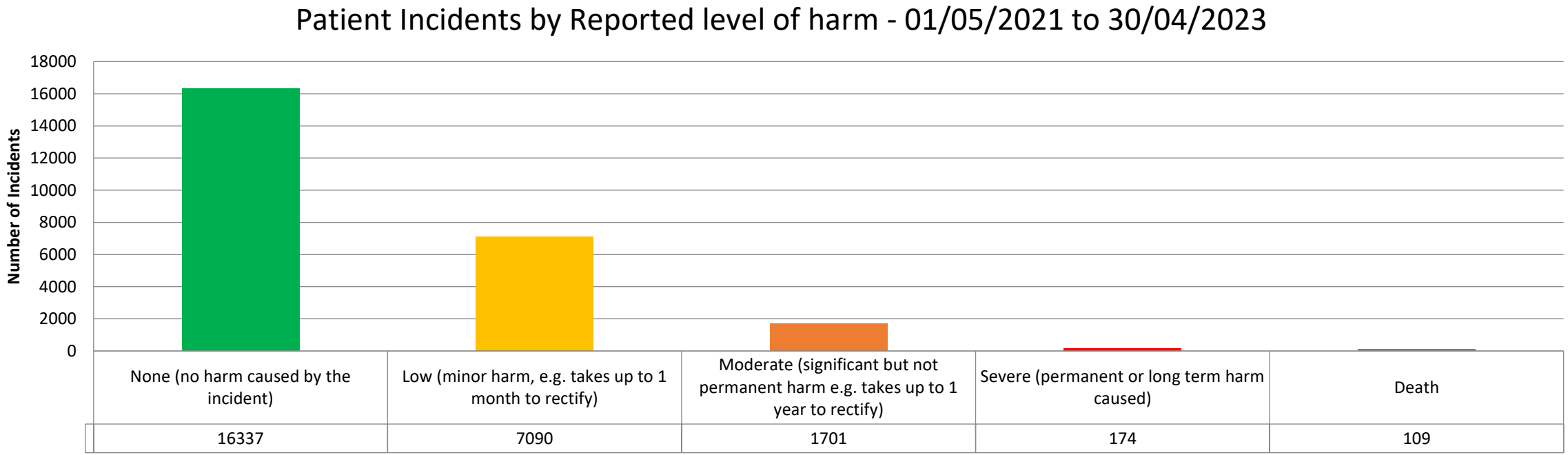
**CQC DOMAIN - ARE SERVICES SAFE? INCIDENTS** (Whole Trust data)

| | Reporting Level | Threshold | 22-23 Outturn | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | 2023-24 YTD | R / A / G | Exception Report? | Benchmarking Report |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Never Events | N - T | 0 | 1 | 0 | | | | | | | | | | | | 0 | | | N/A |
| Number of Serious Incidents Requiring Investigation (SIRI) | N - R | | 39 | 5 | | | | | | | | | | | | 5 | | | N/A |
| No of overdue SI actions (incomplete by more than I month) | L - R | | N/A | 0 | | | | | | | | | | | | 0 | | | N/A |
| No of unallocated SI investigations (waiting more than 1 month for allocation). | L - R | | 0 | 1 | | | | | | | | | | | | 1 | | | N/A |
| Number of Serious Incidents Requiring Investigation (SIRI) regarding self harm or attempted suicide | N - R | | 5 | 0 | | | | | | | | | | | | 0 | | | N/A |
| Number of Embedding Learning meetings taking place | L - R | | 9 | 2 | | | | | | | | | | | | 2 | | | N/A |
| Total number of Patient Safety Incidents reported | L - R | | 13029 | 1057 | | | | | | | | | | | | 1057 | | | N/A |
| Number of incidents reported resulting in low or no harm | L - R | | 11967 | 964 | | | | | | | | | | | | 964 | | | N/A |
| Number of incidents reported resulting in moderate harm, severe harm or death | L - R | | 1062 | 93 | | | | | | | | | | | | 93 | | | N/A |
| Total number of patient falls (hospitals and inpatient units) reported as resulting in moderate harm, severe harm or death | L - R | | 29 | 1 | | | | | | | | | | | | 1 | | | N/A |
| Total number of medication errors reported as resulting in moderate harm, severe harm or death | L - R | | 5 | 1 | | | | | | | | | | | | 1 | | | N/A |
| Total number of sexual safety incidents reported | L- R | | 129 | 7 | | | | | | | | | | | | 7 | | | N/A |
| Total number of Rapid Tranquilisations reported | N - R | | 981 | 46 | | | | | | | | | | | | 46 | | | N/A |

| | | | |
|---|---|---|---|
| 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-RL-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

**CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Serious Incident Data**




**Key highlights:**

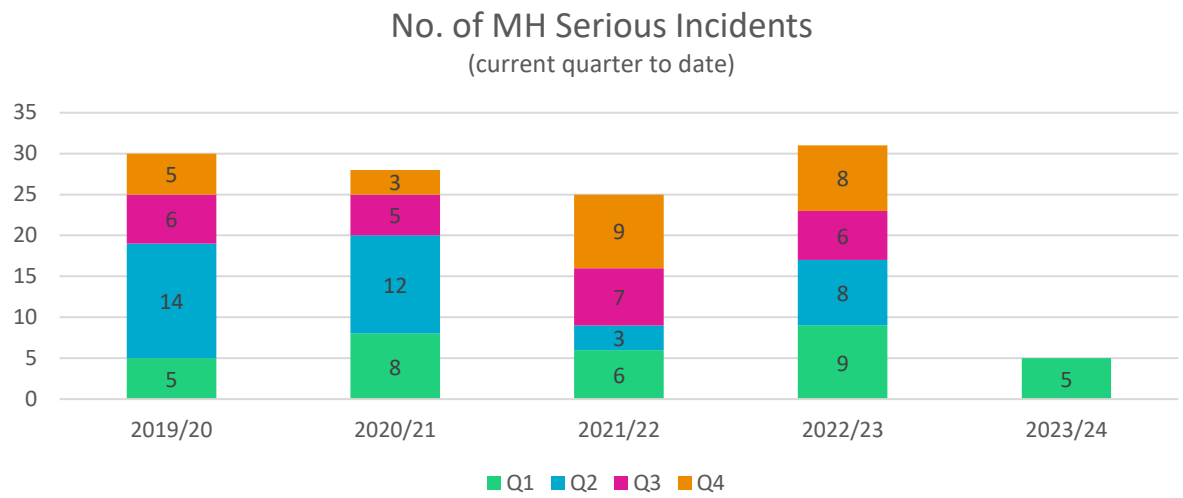
We have included in this dashboard a summary of patient safety incidents reported over the last 2 years and seek to present data that can identify patterns requiring deeper analysis. This also includes a focus summary view on the prevalence of patient safety incidents by categories including how these have adjusted over time.

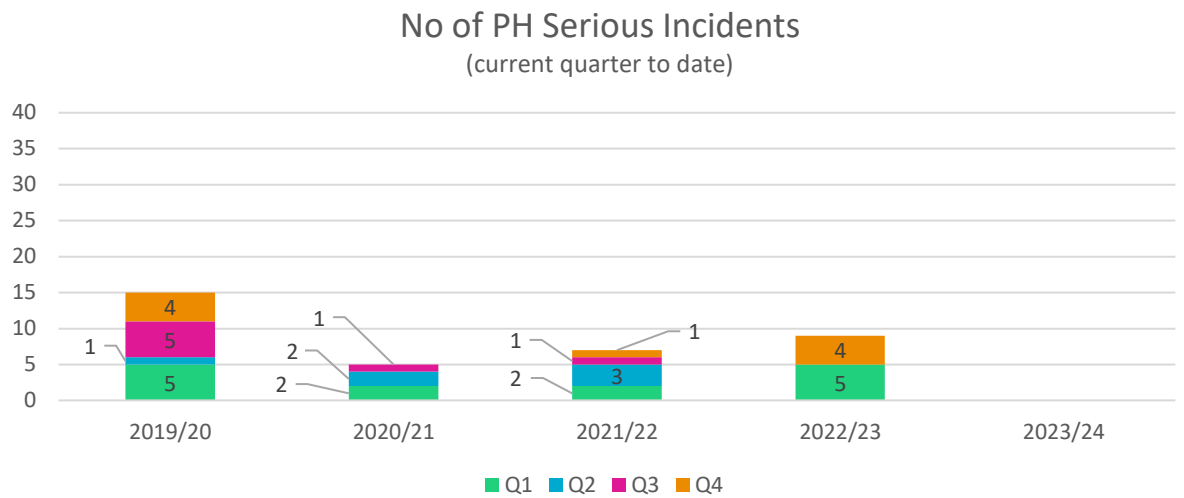
In April there were 1057 patient incidents reported in Datix, 103 less than March. 964 were reported as No and Low harm incidents (111 less than March) and 93 as Moderate or Severe harm or Death (8 more than March).

The PST continues to review incidents in teams with reporting anomalies and shares comprehensive reports with service level Ops and Governance meetings to support the development of insights in to patient care.
Additionally, to support widening the lens around harm the PST and PCET will meet weekly to describe new issues, complaints and moderate harm incidents and bi weekly will draw in mortality data and themes that drive our QI process.

There are no patterns of reporting that are significant to discuss in this report.

## CQC DOMAIN - ARE SERVICES SAFE? – Serious Incidents and Embedded Learning




**Key highlights**:

In April, the Trust reported 5 new serious incidents and investigations have commenced:

- GHC34692 Medical Emergency
- GHC49147 Suspected suicide
- GHC49486 Suspected suicide
- GHC49583 Suspected suicide
- GHC49843 Road Traffic Accident while absconding

The team are also supporting several clinical reviews in to patient care and experience. The SWARM Huddle approach to moderate harm incidents has commenced as a PSIRF pilot and is focussed upon MIIU, community hospitals, older adult inpatients and community nursing. Two risk notes were issued in April 2023. One related to the identification of failed batteries and out of date electrode pads that may be carried by our Trust automated external defibrillators. The other related to the requirement to carry out routine checks on medical devices to check the currency of service dates. We have one mental health incident without an identified investigator. The PST have started some preparatory work, drawing up the timeline and key information on this case whilst an investigator is identified.

**Embedded Learning and Learning Assurance:**

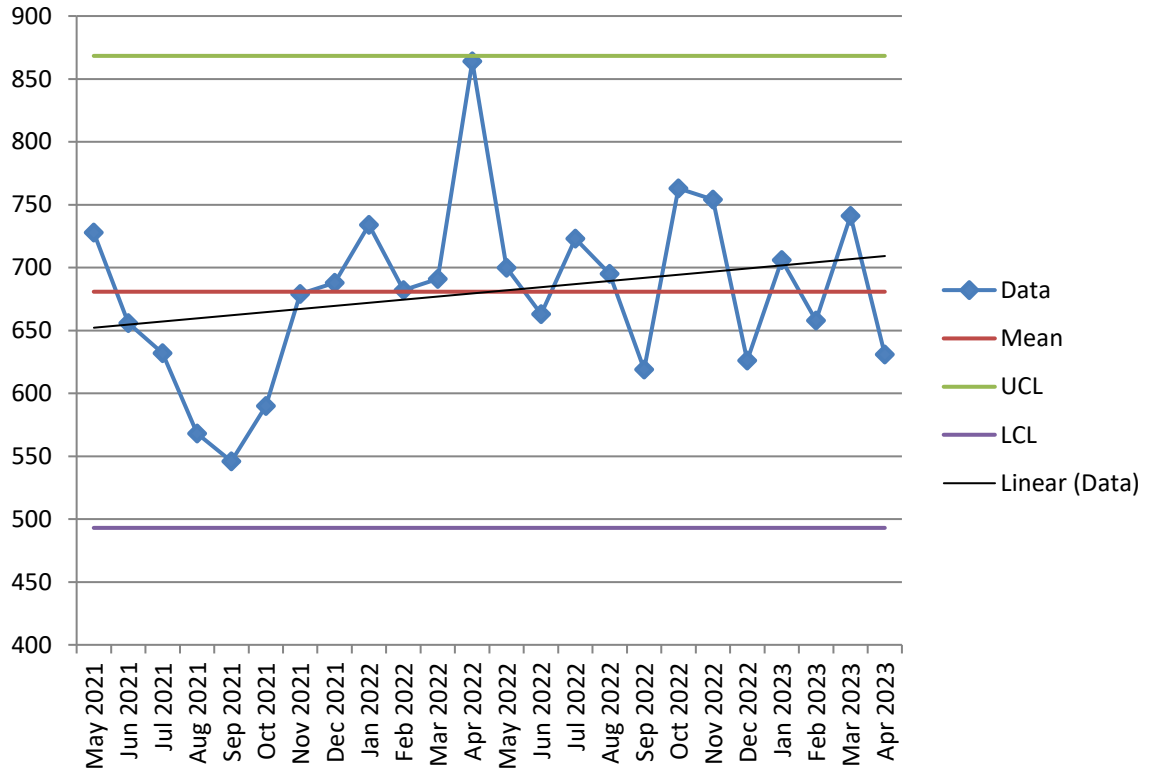
Patient Safety and Learning noticeboards are displaying current information and several Trust teams have requested boards to be displayed in their team areas. This has included Mental Health and Learning Disability in-patient units, Health Visiting, Children in Care and Children's Community Nursing teams. April's content included 'Learning on a Page' from Serious Incident Investigations, Mortality Reviews and a Sexual Safety incident, results from Family and Friends Tests (FFT), site specific data for Restrictive Interventions and the annual report and key messages from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). A further 17 teams (including community hospitals, CAMHS, school nurses and the learning and development team) have requested Patient Safety and Quality noticeboards and these have been ordered and are due to be fitted in the middle of May.

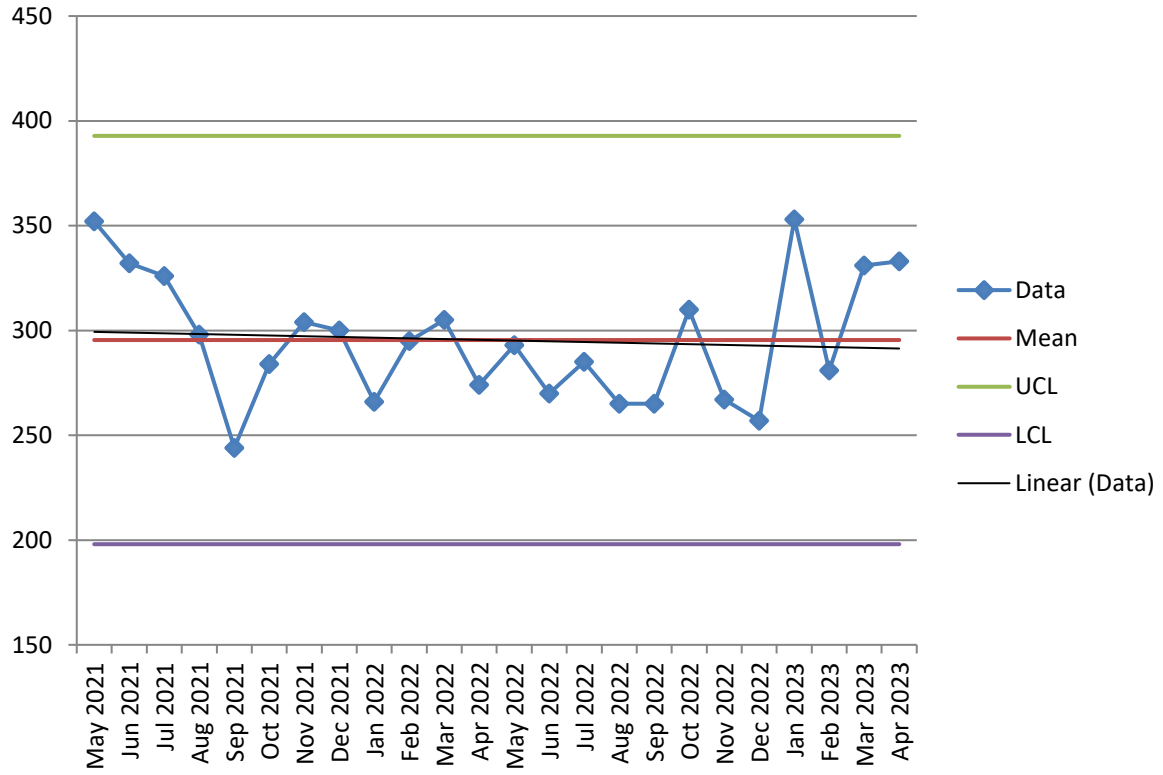
Learning on a Page has been reviewed and a new process map is underway alongside the development of the Learning Assurance Framework.

The Head of Patient Safety and Learning met with colleagues in GHT and SWAST in order to accelerate plans to collaborate on learning from incidents as described in the PSIRF. A date is confirmed for a peer support group for both Trusts' Patient Safety Partners. The third task and finish group supporting the implementation of the Patient Safety Incident Response Framework met in April. This cross service group discussed the work plan and has received the pilot templates for new investigation approaches. The Patient Safety Partners have attended QAG and ICG .

Currently 78.2% of Trust staff have completed the level 1 elearning Patient Safety Training. Level 2 will commence in May 2023.
Weekly triangulation meetings continue with the Learning Assurance Lead and PCET Manager.

**CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Serious Incident Data**



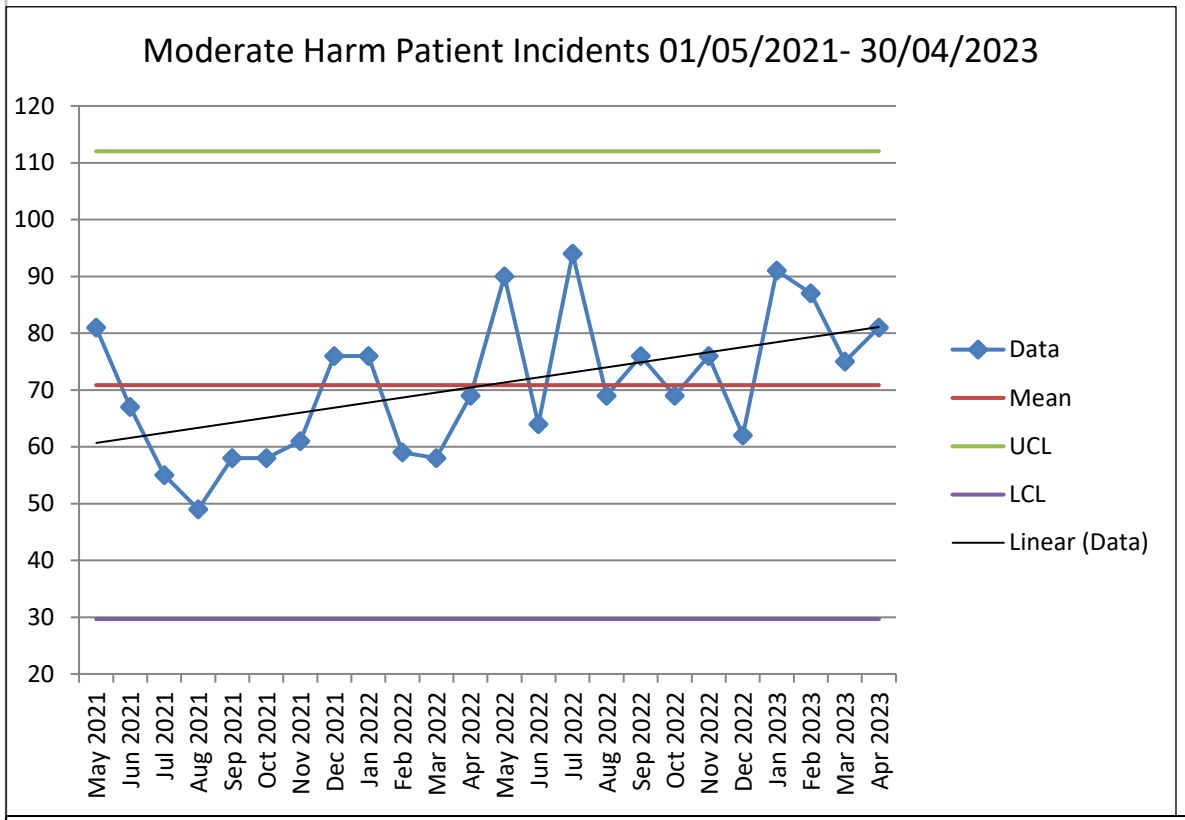

**Key highlights**:

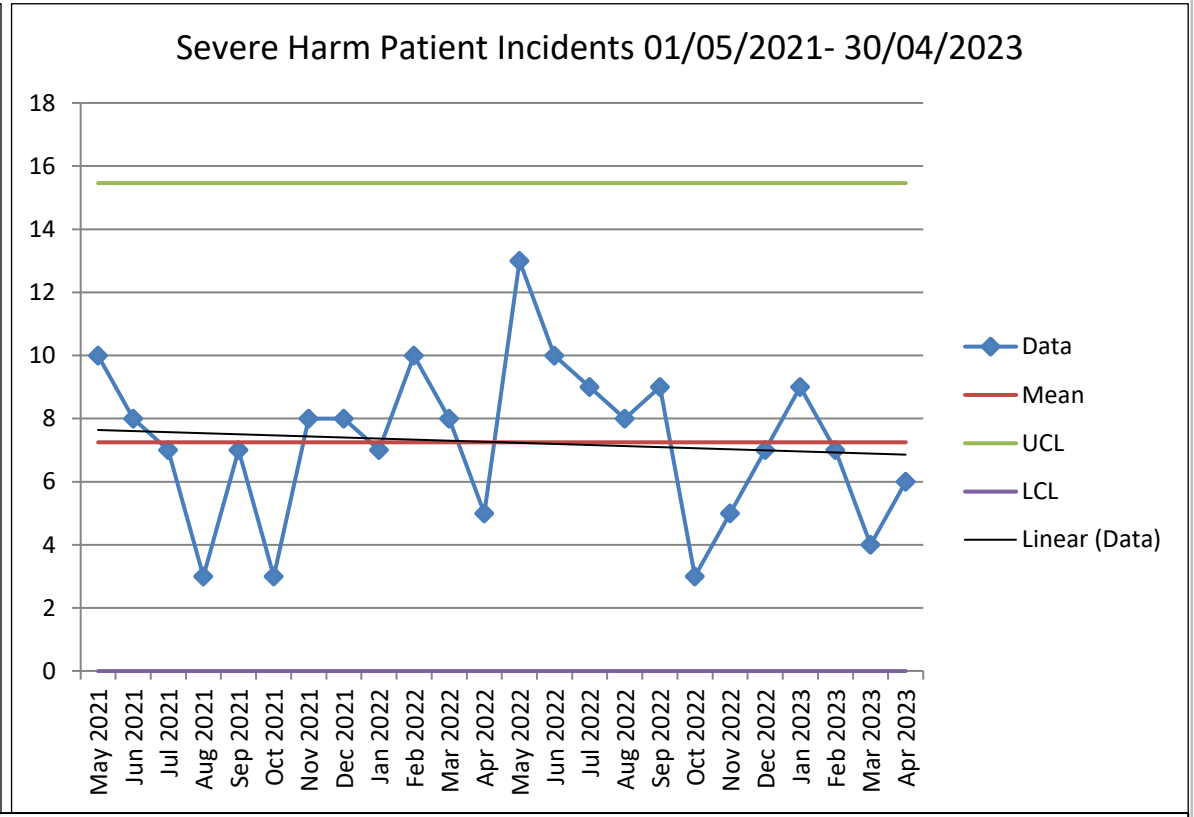
This slide provides data in the form of statistical process control charts. These enable the visualisation of change over time which is essential in tracking and monitoring improvement. Future reports can begin to overlay other measures with this data and add narrative to identify chronologies of events, decisions, QI activity, periods of high acuity and staffing changes. The functionality of the LFPSE will enable comparisons with other NHS organisations.

**No Harm Incidents over time –** This data shows the level of reporting being generally in line with the mean.

**Low Harm Incidents over time -** The **r**eduction visible each month for 10 months of reported low harm incidents may be accounted for in the developing rise in reported incidents of moderate harm seen on the next slide. The Patient Safety Team are engaged in activity to refine the reporting forms and support staff to correctly assess and grade incidents and therefore stabilise our view of current or emerging risks. Additionally the PST re trialling a more nuanced approach to visualising trends that is currently not possible in Datix.

**CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Serious Incident Data**



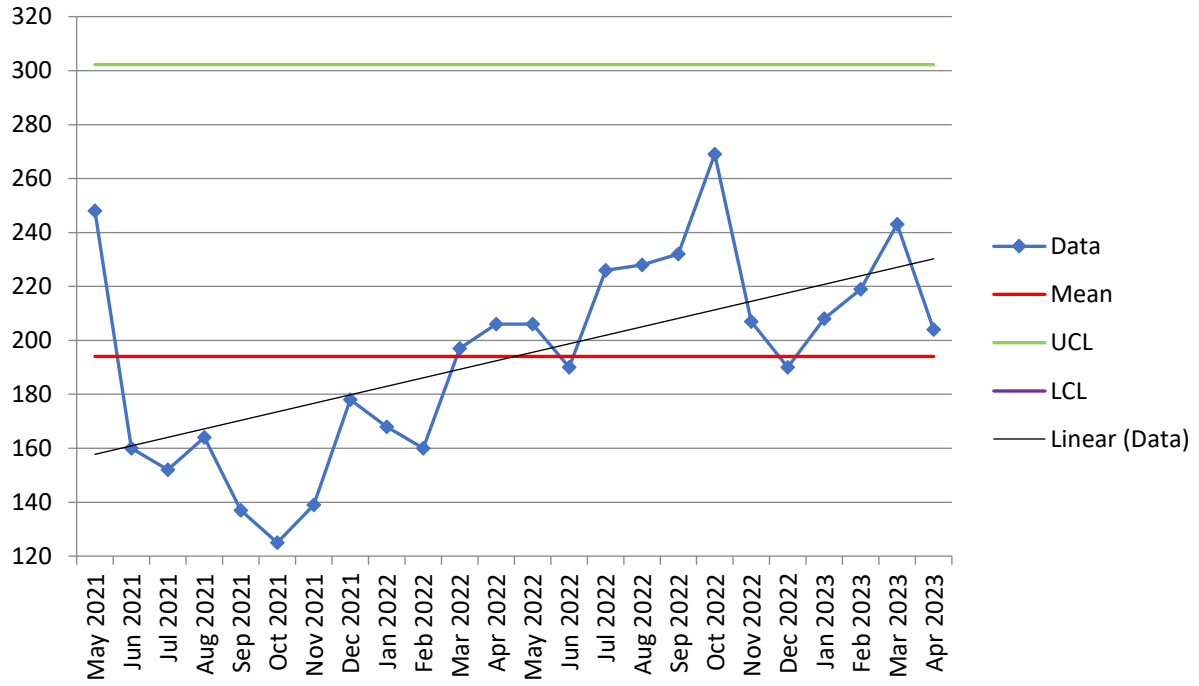




**Key highlights**:

**Moderate Harm Incidents over time -** The picture emerging here, despite the mean not altering at present, is of a statistically significant rise in the number of reported moderate harm incidents. The PST monitor these incidents daily and capture these on a team tracker which are reviewed at regular points in the working week. The rise is largely related to an increase in moderate skin integrity/pressure ulcer related harms with an increase of 71 moderate harms related to skin integrity over a year, of which, 51 are unstageable, category 2 or deep tissue injury. This developing picture is well understood across the Trust, the increase should be viewed in the context of the continued impact from the Covid -19 pandemic. There are three key factors that are driving an increase in number and severity of pressure ulcers; circulatory changes following Covid infection, deconditioning of patients who live at home and have become more socially isolated and physical immobility during and following Covid infection. Active work across teams continues in terms of improving practice with enhanced monitoring and oversight. Localities and inpatient units have a seen a sustained increase in the number of patients referred with existing pressure damage.

**Severe Harm Incidents over time -** The data reflects a largely static position in relation to severe harm events.

## Patient Safety Data- Incidents involving restraint



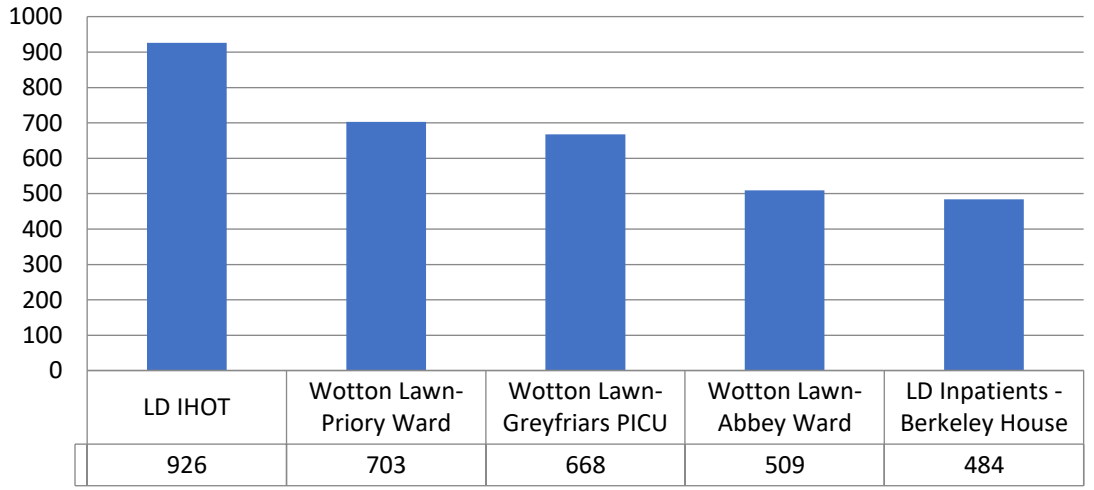

May 2021 – Increase seen due to the combination of 54 physical restraints in IHOT, primarily related to the Covid-19 vaccination programme and 57 physical restraints on Greyfriars PICU, primarily related to an individual patient.

October 2022 – Increase seen due to the combination of 79 physical restraints in IHOT, primarily related to seasonal vaccination programme and 42 physical restraints on Abbey Ward WLH, primarily related to an individual patient.

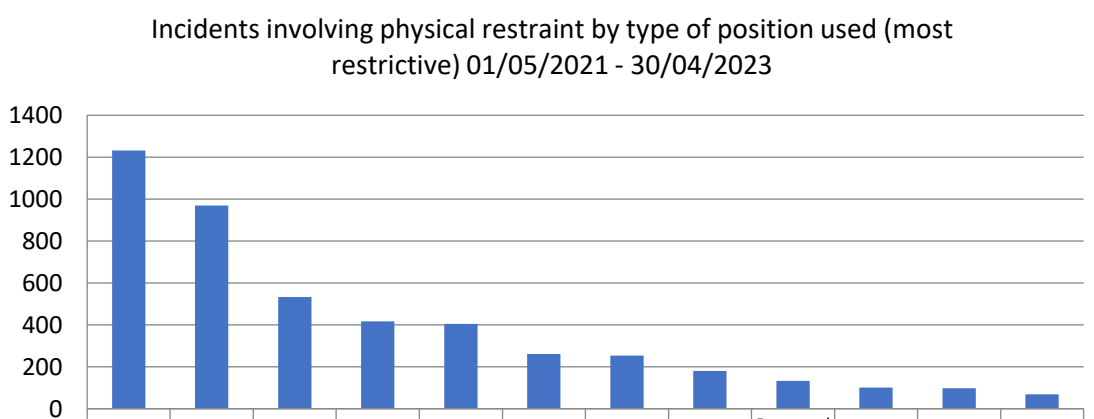
February 2023 - Increase in IHOT clinical holds (50) due to bespoke phlebotomy clinic being established for blood testing.

February- March 2023 – Increase seen in use of POD seated restraint as both alternate to supine restraint on general ward population, and bespoke care planning to assist a patient with NG feeding (95). 22 Escorted restraint utilised on a patient to minimise absconding risk in March 2023

Data is monitored and reviewed at Positive & Safe Meeting

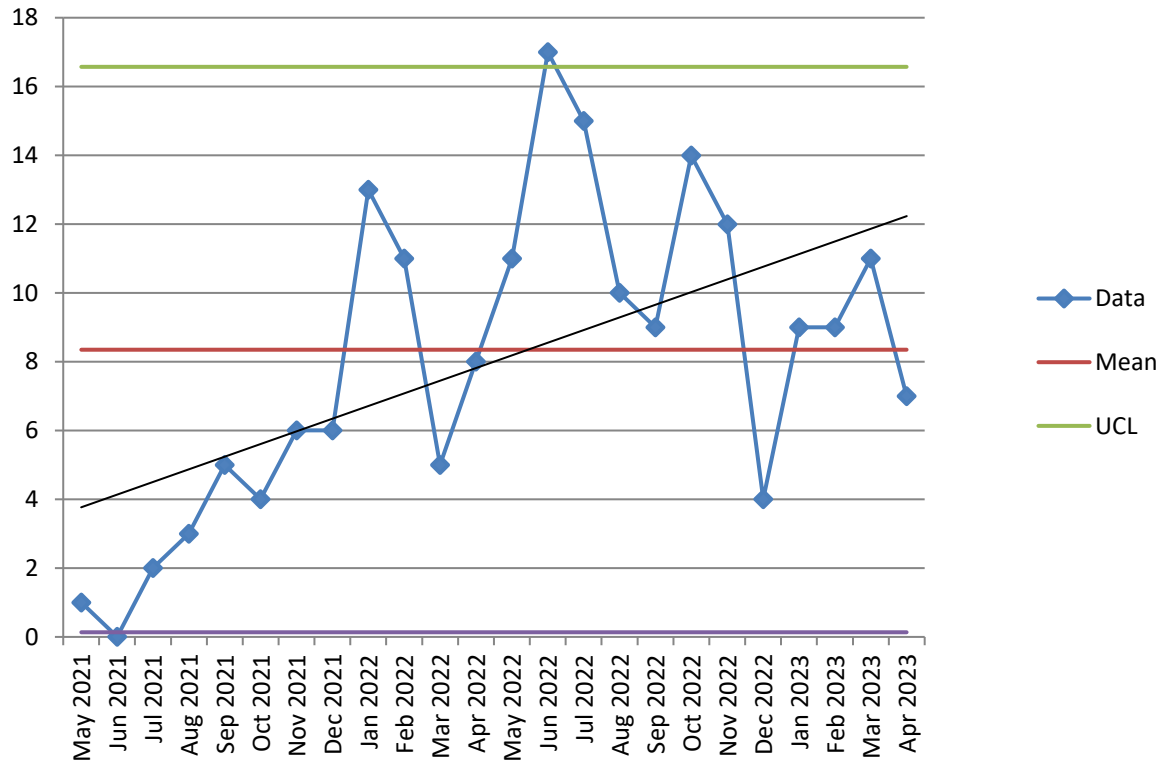



| LD IHOT | Wotton Lawn- Priory Ward | Wotton Lawn- Greyfriars PICU | Wotton Lawn- Abbey Ward | LD Inpatients - Berkeley House |
|---|---|---|---|---|
| 926 | 703 | 668 | 509 | 484 |



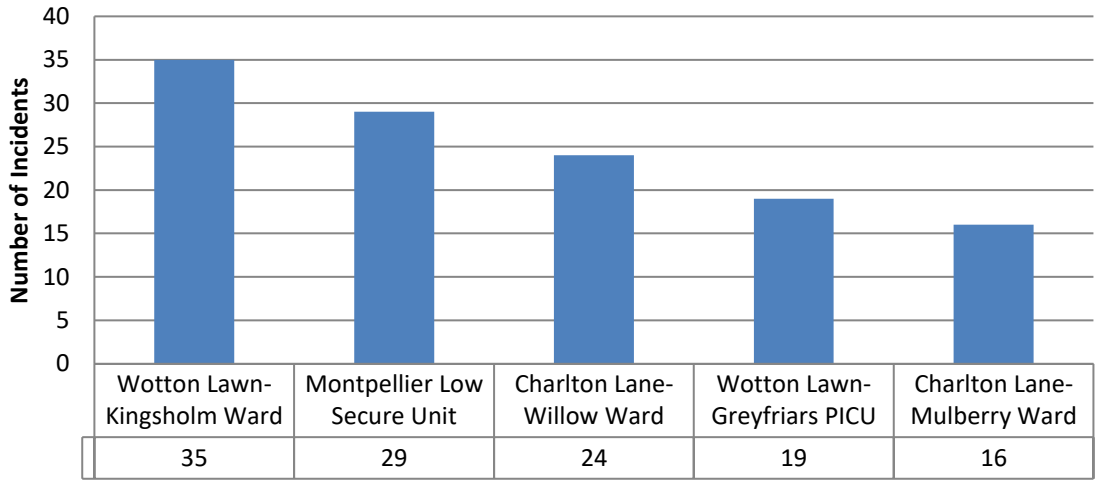

| Seated (other) | Clinical hold (seated) | Escort | Supine (face up) | Seated (POD used) | Precautionary hold | Standing | Assisted support | Personal care (standing) | Prone (face down) | Non-standard hold | Personal care (bed) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1233 | 970 | 533 | 417 | 405 | 262 | 254 | 180 | 134 | 101 | 98 | 69 |

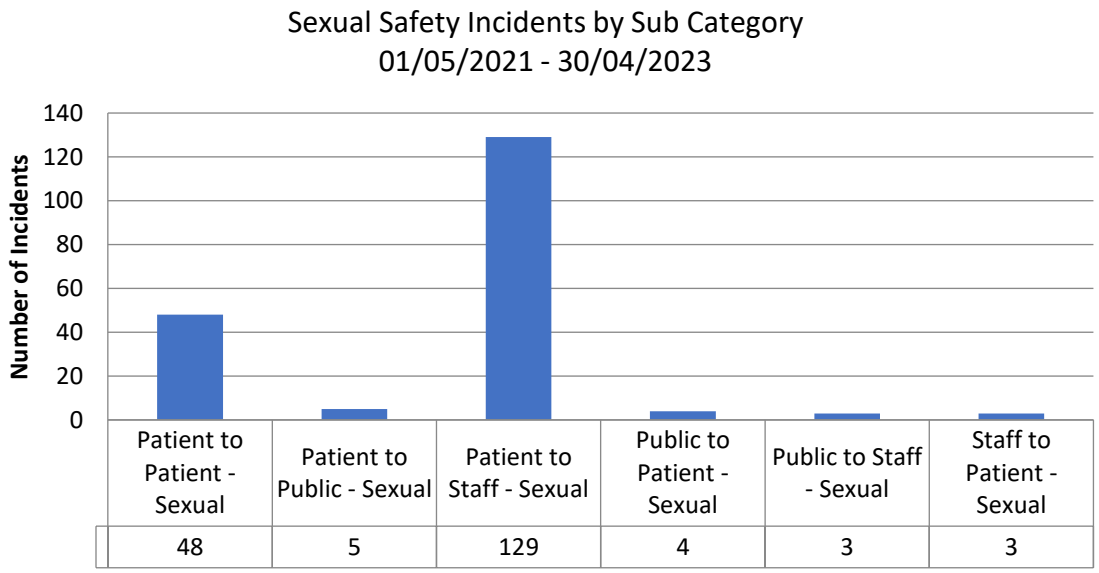
## Patient Safety Data- Sexual Safety Incidents



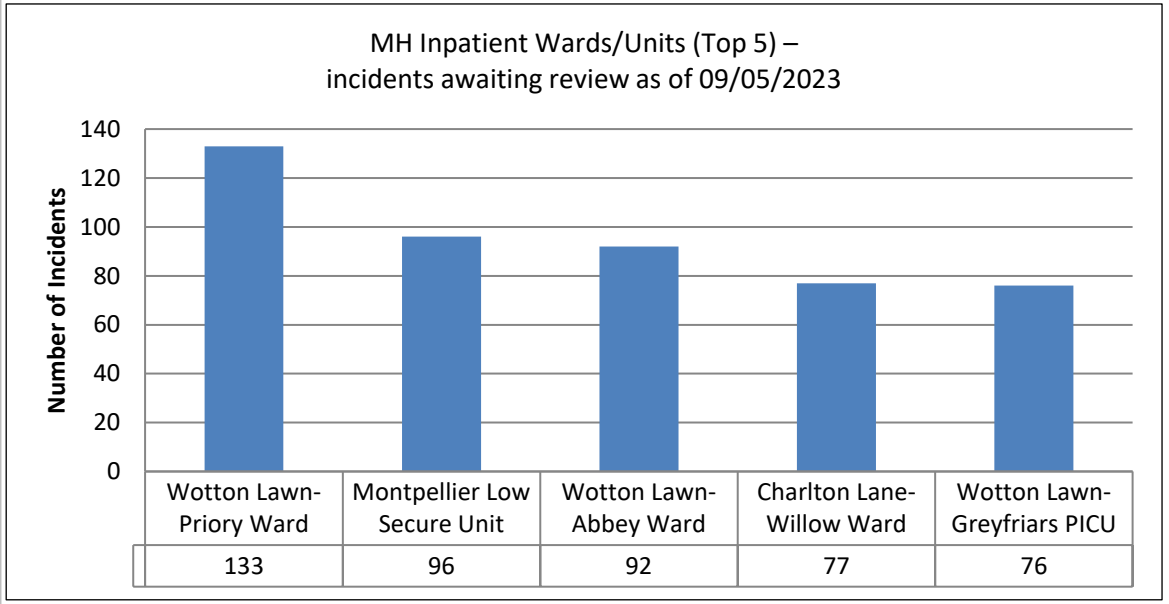

There has been an increase overall in reported incidents within the Datix field of sexual safety. The majority relate to disinhibited behaviour of our patients, particularly in the early periods of acute illness and includes the use of inappropriate language. Reporting levels appear to be good, reflecting a culture of reporting and openness in combination with renewed ward leadership. Sexual safety incident reporting categories were revised as per national guidance in July 2021 with subsequent reporting increasing across the categories. 2 staff to patient sexual safety incidents were reported (Dec 2020 and Feb 2023). Investigation concluded that there was no evidence that sexual abuse had taken place in either case.

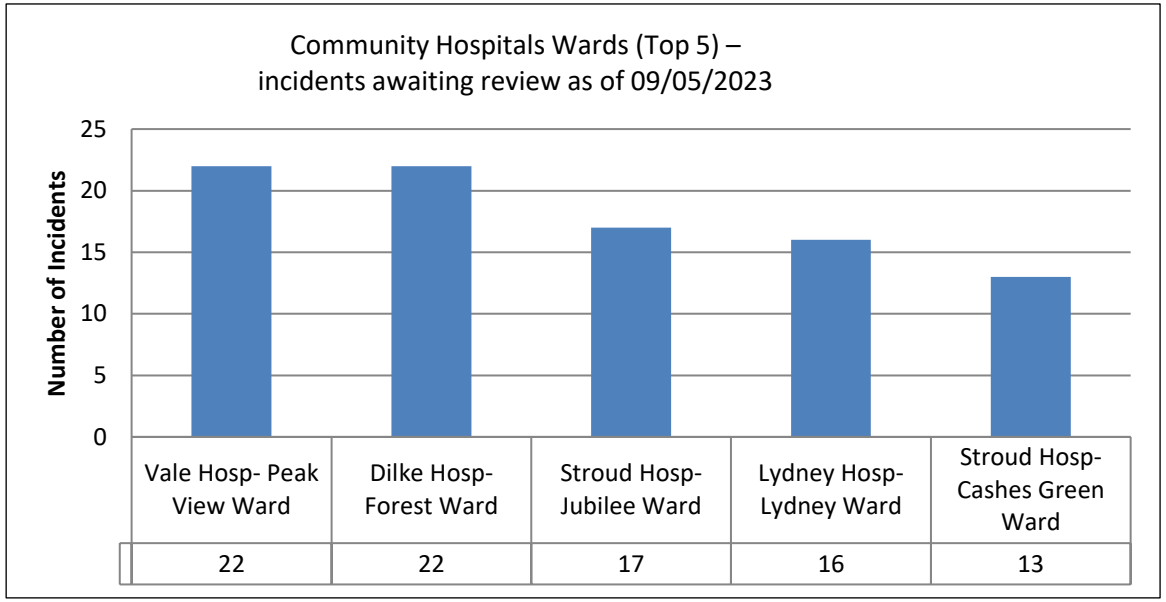
A GHC Sexual Safety Awareness Training (SSAT) pathway has been developed, aimed initially at unregistered staff. This has been piloted at Kingsholm and Willow Wards plus Berkeley House, the initial evaluation shows that different clinical areas experience different sexual safety issues, and therefore training needs also differ. Cashes Green Ward, Stroud General Hospital commenced a training pilot with Healthcare Assistants. There is a plan to expand this training offer and currently there is no increase in reporting identified on the ward.

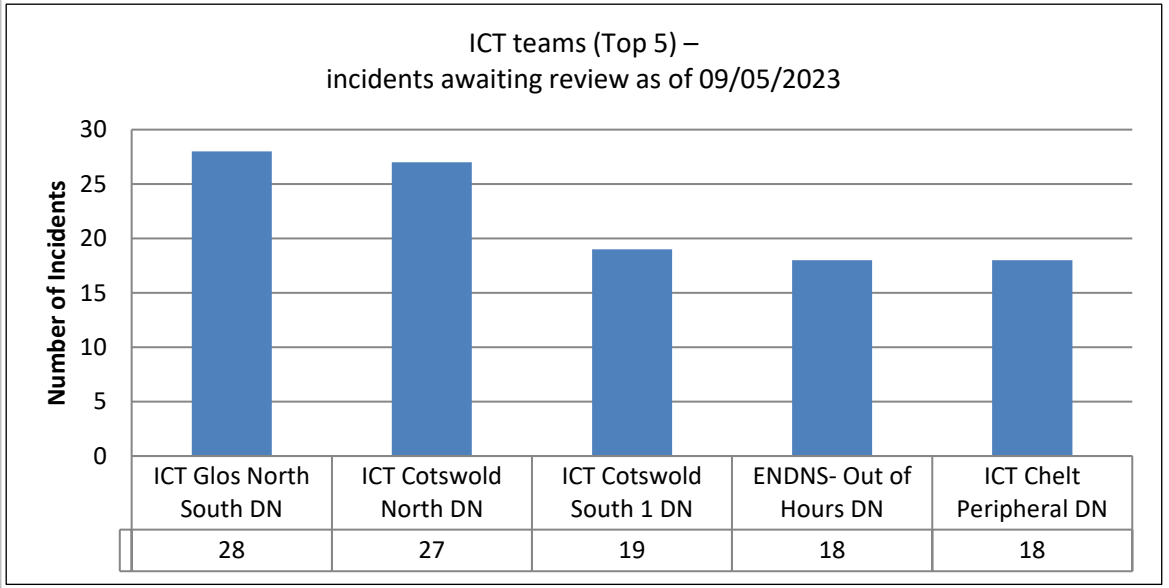


## Patient Safety Data- Incidents awaiting review and confirmation of level of harm: data priority areas and actions underway




The Datix incident reporting system captures reported incidents and requires managers to review the incident and allocate the correct level of harm.

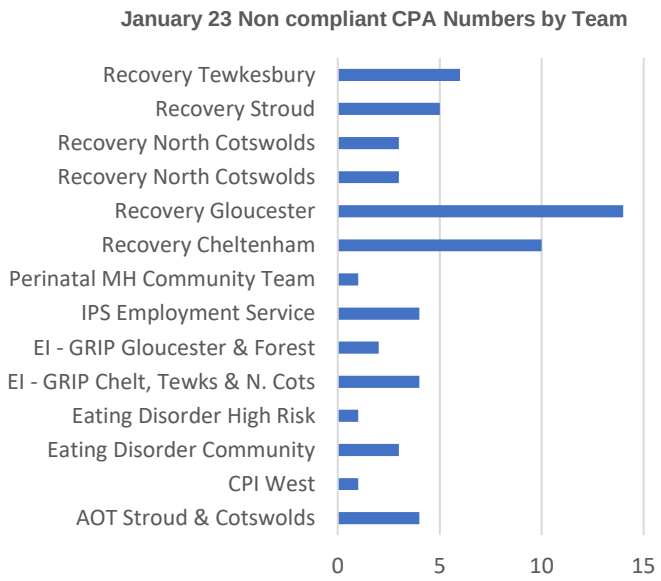
The number of incidents, excluding serious incidents, reported in the 2022/23 financial year that have yet to be reviewed by Managers has decreased by 2110 since 8 March 2023 (3529 on 08/03/2023 compared to 1419 on 09/05/2023). This represents a 59.8% decrease in open incidents across the Trust.

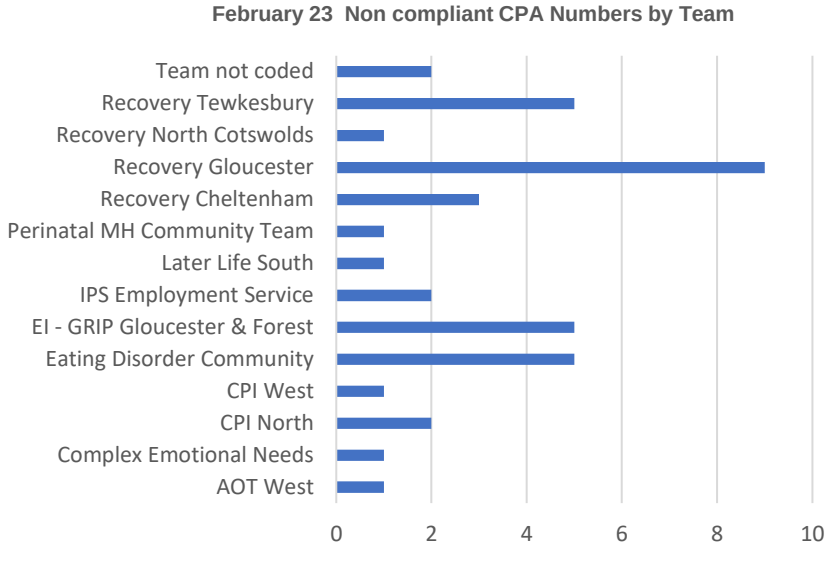
In March 2023 a variance from policy was identified in Mental Health inpatient services and escalated by the PST, with a higher than expected number of incidents awaiting review and confirmation of level of harm. A Service Improvement and Recovery Plan was implemented by the Service Director and Deputy Service Director (Performance and Development) within inpatient Mental Health on 16 March 2023, with support from PST. From 17/03/2023 to 26/04/2023 open incidents decreased by 81.4% at Wotton Lawn Hospital and by 71.6% across MH/LD inpatient services.

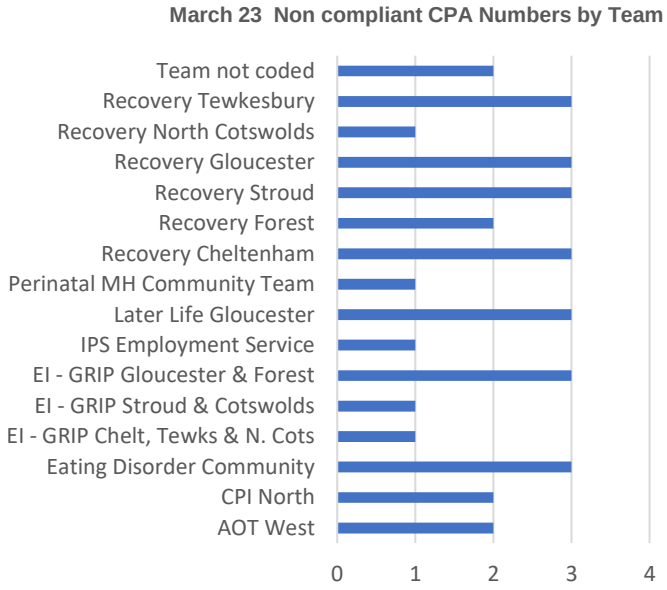
This process of escalation and support will continue up to the implementation of LFPSE in Datix in September 2023.

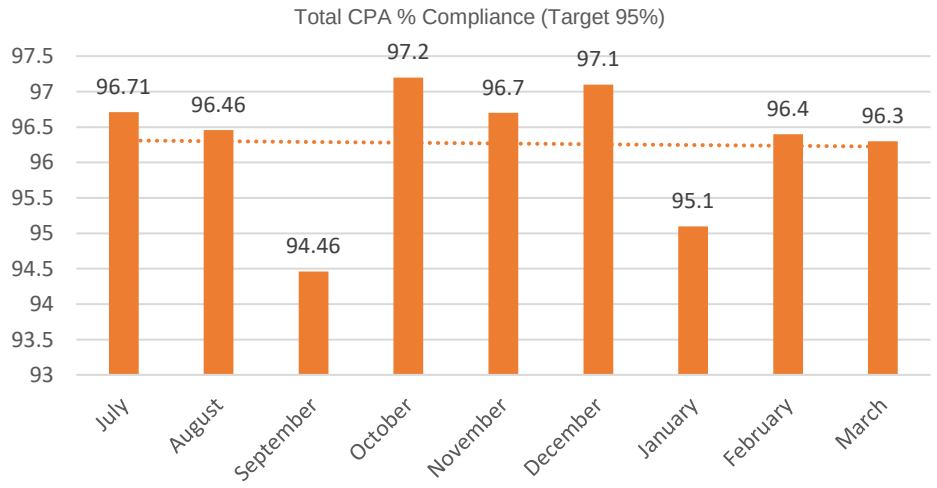
There is little risk to the trust around our understanding and monitoring of our risk profile related to these incidents, noting the backlog provides administrative complication and teams may be missing full oversight of their local risks and opportunities for learning.

## CQC DOMAIN - ARE SERVICES SAFE? – CPA: Analysis of Recovery Position




**Key Highlights: This slide will be stood down in future dashboards as we have been able to sustain the improvement. Monitor for this will continue though routine operational reporting. This reflects the work and commitment of our teams in focusing on this long standing challenge.**

The data charts gives a summary of activity over the past 9 months up until end of the financial year. Continuing the progress in April there were 924 people on the total caseloads who require CPA annual review. In total **95.0**% were compliant with their annual review despite the overall number (46) cases waiting for a review beyond the 12 month period.

The trend in compliance rate with CPA requirements has been showing improvement to reach or exceed the 95% expected target for the last 6 months. There are variances contained within this data with previously reported reasons. This month the highest non compliance level moves away from Gloucester Recovery to EI – GRIP Gloucester & Forest who have 5 non compliant cases. Overall as we report at year end it is pleasing to note that the continued focus by teams and Quality Directorate in these areas has resulted in an improvement to exceed target for H2 and it is envisaged that this position, which will continue to be monitored, will continue in the new financial year and that the spotlight on this slide will be discontinued from April data Dashboard.

## Long Length of Stay Patients – Community Hospitals

The information presents a summary of data relating to long length of stay in our Community Hospitals. For assurance, both Operational and Nursing, Therapies and Quality senior colleagues have good visibility of the data and attend appropriate system groups that identifies the impact of a long length of stay together with system meetings that seek to improve the challenges. The detrimental effect that a prolonged hospital admission has upon a patient is well evidenced. When a patient is deemed to ' *no longer meet the criteria to reside'* (nCTR), timely and effective discharge plans should be in place to enable a discharge. Unfortunately due to the flow and capacity challenges across the system, we often see patients delayed. We are keen to ensure our 'super stranded' patients (over 50 days nCTR) have a continued focus and support in escalation with system partner working to expedite their discharge pathway. It is imperative we learn and shape services around the needs of the population, so by collecting data and identifying themes of the delays, we can support discharge pathways that meet the needs of the patients, and also target our approach to escalation and requests of support. At system request, the focus is now on over 30 days not meeting the criteria to reside (nCTR).

### Headline Data as of April 2023

There has been an average of 6.75 patients in total not meeting the criteria to reside for over 40 then 30 days in April 2023 (the reduction occurred wc 10/04/23), This currently excludes time waiting in the Acute Trust prior to admission, we will add that data to future reports for completeness

### Delay Themes

- **Pathway 1** - Homefirst Capacity in locality and reduced flow from the Homefirst Service where there has been a focus on Community Hospital waits to improve flow across the whole system.
- **Pathway 3** - Capacity in Care homes. All assessment units are currently full, names and assessments already planned for when discharges take place.
- 4 Complex patients, one with a Learning Disability and difficulty sourcing, 2 requiring support plans to be reviewed and HNA to be completed, and 1 ASC working with brokerage to source appropriate placement.
- 2 with funding issues- one self-funded and the other is rates to be agreed with the home and Brokerage.
-

There has been system agreement, due to the reduction in numbers of patients waiting longer than 50 days, to now review the patients who have not met the criteria to reside for over 30 days.

Pathway Zero – 'Simple Discharge' 0
*No formal care arranged but could include follow up appt, district nurse or community and voluntary sector input*

Pathway One 'Homefirst' – Return Home with additional Support 1
*Homefirst principle with support to recovery or pre-existing Domiciliary Care that needs to be increased*

Pathway Two – Bedded Recovery/Reablement/Rehabilitation 2
*Bedded facilities, such as Community Hospitals, bed based reablement units with the aim to recover people to get back home*

Pathway Three – Longer Term Setting 3
*Short Term Residential/Nursing Respite after recognised ongoing needs, which lead to long term nursing or residential placements if not home*

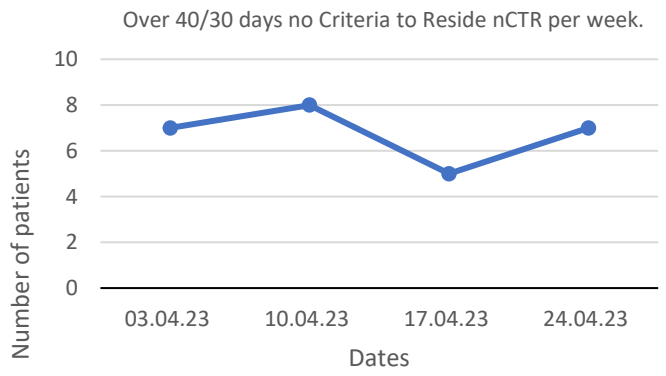



**Chart 1 -** Showing the number of patients in a community hospital that have not met the criteria to reside for over 40 days (delayed/super stranded patient). Date range: w/commencing 03.04.23 – 24.04.23.

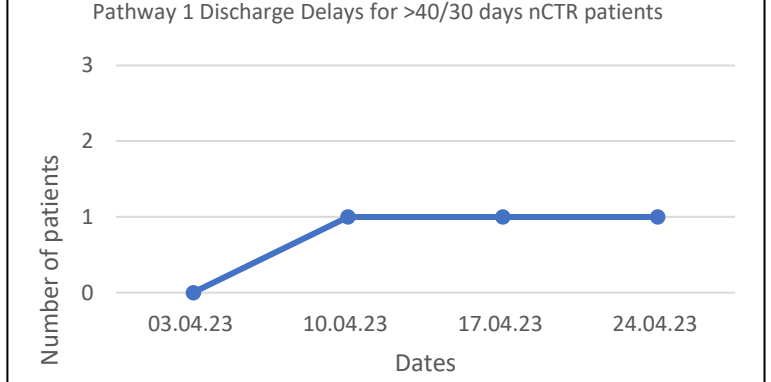



**Chart 2 -** Showing the number of patients delays on Pathway 1 for over 40 days. Date range: w/commencing 03.04.23 – 24.04.23

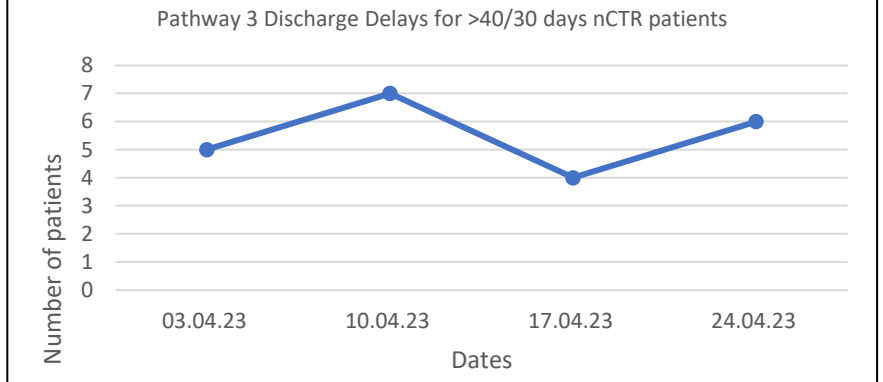



**Chart 3 -** Showing the number of patients delayed on Pathway 3 for over 50/40 days. Date range: week commencing 06.03.23 – 27.04.23

**Long Length of Stay Patients- MH Hospitals.**

Clinically Ready for Discharge, formally known as DTOC, is the new terminology for reporting delays since January 2023. "Clinically Ready" does not indicate complete recovery, it is the point at which a person could be safely assessed, cared for and treated at home or in a less restrictive setting. Being "Clinically Ready for Discharge" (CRfD) is an indication that a person could continue their recovery outside of a hospital setting – with adequate support/services in place.

*For reporting and descriptive purposes four high level sub-categories have been created and these categories describe the reasons that a persons discharge is delayed.*

**Hospital Processes - defined as any process that is the responsibility of the inpatient service that is related to the delay.**

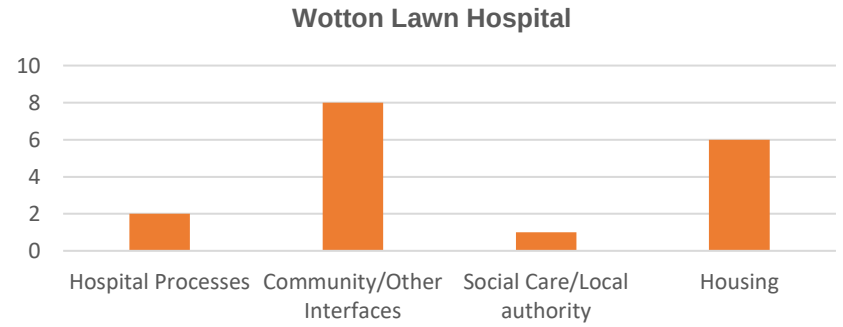
**Community/other interfaces – defined as any team or service (excluding social care/local authority or housing partners) that are responsible for/related to the delay.**

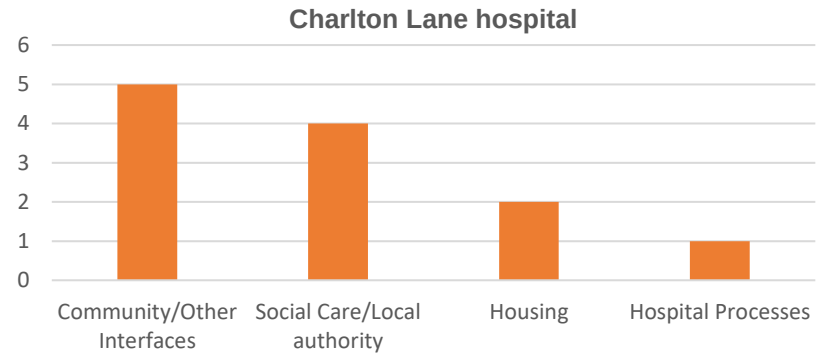
**Social Care/Local Authority – defined as any factors that are due to social care provision or are the responsibility of social care/local authority partners, related to the delay.**

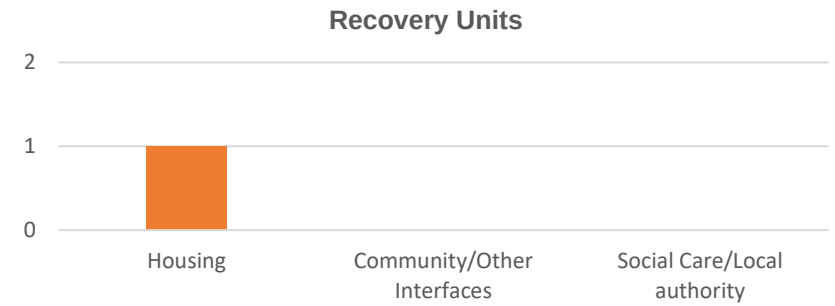
**Housing /accommodation – defined as any factors that are due to housing provision or are the responsibility of housing partners/teams, related to the delay.**

**Headline Data as of April 2023**

Total of patients across WLH, CLH, Recovery, LD = **31** WLH = **17** CLH = **12** Recovery Units = **1** Learning Disability = **1**




# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

- The Quality Improvement Hub is a dedicated Trust team of subject matter experts whose primary aim is to provide leadership to the organisation in the field of improvement science. The team seek to support the experts – the people who use our services and those that deliver them, to understand problems identified and the associated data, find change ideas, test them out at small scale, upscale as appropriate and make them sustainable using proven methodology.
- This update provides a brief overview of the Trust QI training programme- with its intention to ensure that a QI approach is embedded across the whole organisation by;
    1. Providing a complete range of training packages that demonstrate learning outcomes in alignment with the Kirkpatrick Evaluation Framework
    2. It also shows the active QI projects recorded on Life QI- the system the trust utilises to capture and share QI activity.

## Quality Improvement Hub Support along the Improvement Lifecycle

### 1. New improvement opportunity/concept/idea

- National mandate
- New service bid
- GHC Strategic priority
- ICS/CCG mandate
- Colleagues
- Service users/Carers
- Quality Issue

- = (s) Improve communication and liaison between maternity service and health visiting service
- = Improving the number of patients receiving their Depots in primary care
- + Creative Therapies promotion
- + ECT

### 2. Improvement idea scoping

- What is it
- Why are we doing it
- What are the benefits/risks
- Is the problem clear, understood and agreed
- Is there data

- = (s) Length of time on core CAMHS caseload
- = (s) Increasing the use of FFT feedback in our organisation
- = (s) Creating a sustainable placement offer for AHP Students in GHC
- = (s) How do we provide services for lung cancer patients
- = Reducing incidences of medicine errors at Charlton Lane Hospital
- = Improve clinical pathways in OT CYPS
- = (s) Improving sustainability in medicines usage across GHC
- + Single handed personalised care approach

### 3. Improvement idea initiated

- Stakeholder mapping
- Tools to understand the problem
- Baseline data
- Early team tasks
- Life QI

- = Improving sexual safety in Mental Health inpatient areas
- = Optimising Flow in Community Hospitals
- =(s)Nutritional screening risk
- = Neuro-fitness group
- =(s) MDT working in therapies CYPS
- = RRP Dean Ward
- = Substance misuse in CAMHS

### 4. Improvement idea testing – e.g.: PDSAs

- Using the Model for Improvement to test change ideas
- Data to show towards progress and inform next steps

- ↑ (s) Improving access to support for administrators to ensure the delivery of high-quality health care.
- ↑ (s) Improving access to training opportunities for AHP support workers
- = (s) Improving Mouthcare standards within our inpatient areas
- = Carers Working Group
- = Observations in inpatient mental health settings
- ↑ Referrals into the SNS
- = RRP Greyfriars Ward
- = RRP Mulberry Ward
- = (s) Improving timeliness of access to urgent care pathways

### 5. Improvement idea sustained & implemented

- Evidence of sustained improvement through data
- Ongoing quality control & assurance agreed

Key:
+ new to tracker
= no movement
↑ moved forwards
↓ moved backwards
*Restarted
(s) Silver project

**Training data April 2023:**
**26 Silver – 0.6% workforce**
**491 Bronze - 11% workforce**
**454 Pocket QI – 10% workforce**

| Directorate | No of Projects |
|---|---|
| Operations | 24 |
| Nursing, Therapies & Quality | 7 |
| Medical | 0 |
| HR and Finance | 0 |
| Strategy & Partnerships | 1 |
| **Total:** | |

## Supervision

Childrens: Group Supervision Compliance **56%**

Integrated Group Supervision Sessions: **20**

One to One Supervision Sessions: 3

Adults Group Supervision Sessions **0**

## Training

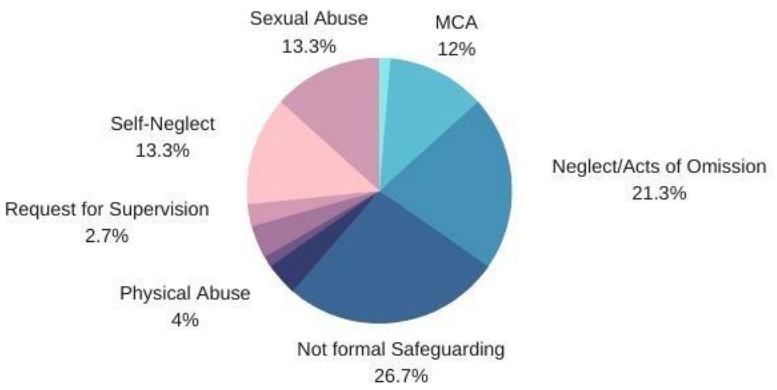
| LEVEL 1: INDUCTION | LEVEL 2: THINK FAMILY | LEVEL 3: CHILD PROTECTION | LEVEL 3: ADULT PROTECTION | LEVEL 4: ADULT PROTECTION |
|---|---|---|---|---|
| 96% | 90% | 87% | 88% | 77% |
| Q4 22/23: 96% | Q4 22/23: 92% | Q4 22/23: 88% | Q4 22/23: 82% | Q4 22/23: 80% |
| Q3 22/23: 95% | Q3 22/23: 89% | Q3 22/23: 85% | Q3 22/23: 82% | Q3 22/23: 56% |
| Q2 22/23: 97% | Q2 22/23: 85% | Q2 22/23: 82% | Q2 22/23: 81%: | Q2 22/23: 28% |
| Q1 22/23: 97% | Q1 22/23: 86% | Q1 22/23: 84% | Q1 22/23: 83% | Q1 22/23: 27% |

## Referrals and Advice Line

**111** Contacts to Advice Line (adults and children combined)
Jan 23: 124 Feb 23: 126 Mar 23: 162

**14** Referrals made to GCC (adults and children combined)
Jan 23: 30 Feb 23: 19 Mar 23:45

## Referral Themes




### Summary information

The Safeguarding Dashboard provides assurance that:

- Safeguarding activity is a Trust priority function that is closely monitored
- Safeguarding is being delivered as per the requirements of the Gloucestershire

Safeguarding Adults Board (GSAB), the Safeguarding Children Partnership (GSCP), commissioning expectations, and national guidance and legislation.
Safeguarding children and adults is a key element of the assessment and care management processes for staff. There are arrangements in place to ensure that staff are appropriately trained, supervised and supported in their safeguarding related work. The Trust's Safeguarding Group monitors safeguarding activity and reports quarterly into the Quality Assurance Group.

The Safeguarding Dashboard is presented in 3 sections:

1. Safeguarding Children Activity
2. Safeguarding Adults Activity
3. Safeguarding Training Compliance and Safeguarding Supervision

## Summary

### Highlights

- The GHC Safeguarding Notifications inbox which captures the number of safeguarding referrals made to the Local Authority is operating well. This provides the Safeguarding Team with improved oversight of organisational safeguarding activity.
- Monthly auditing of Safeguarding adult practice and record keeping is underway. Monthly auditing of Safeguarding children practice commenced in April 2023. Work is progressing with Clinical Systems to enable a BI solution to report the number of safeguarding referrals made to the Local Authority and the number safeguarding escalations.
- Continued good used of the Safeguarding Advice Line by children and adult services, demonstrating a good awareness of the service across the Trust. A Service Evaluation Project evaluating the Advice Line (adult related activity only) is underway, which will conclude in July 2023.
- A network of Safeguarding Champions is being developed across the Trust. Champions will be key links for operational teams and the Safeguarding Team for the dissemination of key safeguarding messages and priorities.
- April saw the launch of our new monthly 'Safeguarding Learning Lunch.' 54 staff across the Trust attended the first MST session. The session explored the topic of hoarding. The theme of May's Learning Lunch is the Gloucestershire Multi-Agency Safeguarding Hub (MASH).

### Challenges/Risks

- Audit has identified some variation in how Safeguarding related data is recorded on our clinical systems and the quality of that information. We have a Safeguarding Action Plan in place to address risk and apply mitigations. We are working closely with Clinical Systems, Business Intelligence and Safeguarding Task and Finish Group working to find solutions that address risk. Central to the action plan is the development one Trust wide safeguarding template, the development and application of this is complex. Target completion November 2023.
- Children's Safeguarding Supervision attendance compliance has dropped and the number of staff attending Safeguarding Adult supervision sessions remains low despite considerable efforts to promote supervision across our operational teams. Safeguarding supervision has been identified as a key recommendation within several local Safeguarding Practice Reviews. A review of both the adult and children's safeguarding supervision offer is underway, with a move towards providing more team specific supervisions for areas of the Trust who have high levels of and complex safeguarding cases, such as the Children in Care Team, the Assertive Outreach Team, Integrated Care Teams.

# Quality Dashboard

NHS
Gloucestershire Health and Care
NHS Foundation Trust

**CQC DOMAIN – Patient Safety– Closed Cultures – eliminating the risk of our patients experiencing abuse**

## Closed Cultures – Identification and risk factors

NHS England wrote to all Mental Health, Learning Disability and Autism provider Trusts on 30th September following the BBC Panorama documentary about failures of care at the Edenfield Centre, a medium secure forensic mental health hospital managed by Greater Manchester Mental Health NHS Foundation Trust. This documentary showed disturbing hidden camera footage of patients being abused by NHS care staff. "Closed culture" is a helpful descriptive term used by the Care Quality Commission (CQC 2022) to describe "a poor culture in a health or care service that increases the risk of harm. This includes abuse and human rights breaches. The development of closed cultures can be deliberate or unintentional – either way it can cause unacceptable harm to a person and their loved ones." The scenes relayed in the BBC documentary are very much descriptive of a closed culture.

The CQC Closed Culture related work has also applied to services that can be described as locked environments or areas where open access is restricted. Alongside these areas, services that deliver care to people that have communication or significant cognitive challenges are also considered at risk of closed culture risks. We have identified the following areas for raised risk of potential closed culture challenges in the Trust and are the focus of increased monitoring and support to eliminate this risk

**Berkley House - Learning Disabilities Assessment and Treatment**
**Montpelier Ward - Mental Health Forensic Low Secure**
**Willow Ward - Dementia Unit**
**Greyfriars Ward - Psychiatric Intensive Care Unit**

Objectively however it should be considered all our Trust inpatient services are potentially vulnerable to delivering poor care due to a complex range of organisational and individual factors ranging from staffing issues, frail/vulnerable patients, organisational mandated tasks that divert staff from care giving through to an individual's personal values and behaviours that in turn can lead to poor care.

## New Closed Culture report for reading and action

We are utilising recent work published by the Good Governance Institute (2023) who completed a substantial governance review into the Manchester Edenfield Unit matter. We are using this report to inform associated development in improving our governance approach and implement learning the report developed on anti closed culture interventions Trust's can deliver. We are planning board development session on this reports findings and will bring further updates on outputs from this work.

***Good Governance Institute (2023) Greater Manchester Mental Health NHS Foundation Trust - Governance and assurance review***. https://www.gmmh.nhs.uk/download.cfm?doc=docm93jjjm4n12151.pdf&ver=15410

## April 2023 Update

The following "Anti – Closed Culture" activity has been conducted since last update

- The level of post incident scrutiny applied by the Trust physical restraint training team has been reviewed and assured as of good standard
- The Trust Quality Committee paper of 4th May 2023 detailed Trust updates regarding the related NHSE programme *-Mental Health, Learning Disability & Autism Quality Transformation Programme*
- Trust Director of NTQ Met with and updated ICB Mental Health & Learning Disabilities Commissioner on Trust work to date on this matter – Positive feedback received from ICB on our work on this issue
- Assurance received that advocacy vacancies are now resolved – a monitoring report has been requested that will be included in the data set for future editions of this slide and we are working with commissioners on developments

## Trust safeguards against Closed Culture Risks

- **Trust Culture and Values *see staff survey data**
- **Clinical Supervision**
- **Staff wellbeing support**
- **Physical restraint monitoring– weekly dashboard and scrutiny**
- **Freedom to Speak Up activity**
- **23/24 Internal audit of reporting abuse mechanisms**
- **Safeguarding Training & Monitoring**
- **Breakaway & De-escalation Training**
- **Independent Advocacy****
- **Unannounced CQC MHA visits**
- **Safe Staffing and agency reduction activity**

### Safeguards Delivery Risks

**Independent advocacy input has been reported as improved as vacancy issue now resolved - we need assurance on activity levels as next step

Access to team level training and supervision data is being improved to enable better use for quality monitoring.

## Anti- Closed Culture- Best Practice Examples of Open Cultures

### Greyfriars Ward

The team are currently involved in a Reducing Restrictive Practice project, exploring change ideas to limit restrictive interventions on the ward. Work includes:

- A new positive behaviour support plan questionnaire to support personal plans
- Reducing and communicating blanket restrictions
- The female patient garden space has been revitalised

### Montpellier Ward

Montpellier Ward was recently visited by HRH Princess Anne to see their well regarded "Allotment Project". Patients, staff and families have worked together to develop an exceptional horticulture project that is also accessed by other teams in the Trust and external agencies.

The ward regularly delivers "family days" for patients families to visit the ward for social activities.

### Berkley House

Team engaged in South West restraint reduction project with good results in reducing restrictive practices reported through patient safety report

"Circle of support" initiative inclusive of patients, families and independent supporters to help people progress to discharge.

Good feedback from the national CETR review process that demonstrates we consider the person holistically

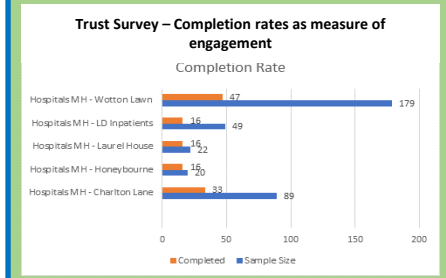
### Willow Ward

The New Matron and team relaunched the carer's group, rebranded as the "CASA – Care and Support always" Group. It includes various guest speakers/clinicians such as the carer's hub & rethink

Charitable funds for "Music in Hospitals" to attend CLH monthly. This is open to carers to attend also. This a music event run by a professional musician, which brings joy, social interaction & fun to the patients/ carers.

## Supportive Trust datasets and monitoring metrics

This section incudes data that we have identified as helpful in informing the Board of performance measures that support safeguards against closed culture issues in Trust areas of identified raised risk, across areas such violence and aggression related reports, training and staff engagement in improving Trust culture work – This data will be developed and refined in future dashboards




| | Breakaway | | Full PBM *(Physical Interventions) | | Full PMVA * (Physical Intervention) | |
|---|---|---|---|---|---|---|
| | 27/1/22 | 16/05/23 | 27/1/22 | 16/05/23 | 27/1/22 | 16/05/23 |
| Willow | Nil rtn | 93% | 92% | 93% | n/a | n/a |
| Greyfriars | 62.0 % | 69% | n/a | n/a | 90% | 70% |
| Montpellier | 57.0 % | 64% | n/a | n/a | 60% | 93% |
| Berkeley House | Nil rtn | 100% | 98% | 92% | n/a | n/a |

| V&A Data Comparison | Jan-22 | Jan-23 | Feb-22 | Feb-23 | Mar-22 | Mar-23 | Apr-22 | Apr-23 |
|---|---|---|---|---|---|---|---|---|
| Wotton Lawn Hospital | 74 | 32 | 77 | 21 | 77 | 32 | 50 | 29 |
| Charlton Lane Hospital | 44 | 34 | 36 | 11 | 38 | 28 | 24 | 21 |
| Berkeley House | 44 | 37 | 36 | 47 | 35 | 59 | 40 | 65 |
| Total Across All Sites | 193 | 127 | 174 | 127 | 150 | 121 | 114 | 115 |

# Quality Dashboard

**Please Note – due to server issues we have been unable to extract April 23 data for the following 3 slides in time for submission – data will be refreshed for presentation at Board**

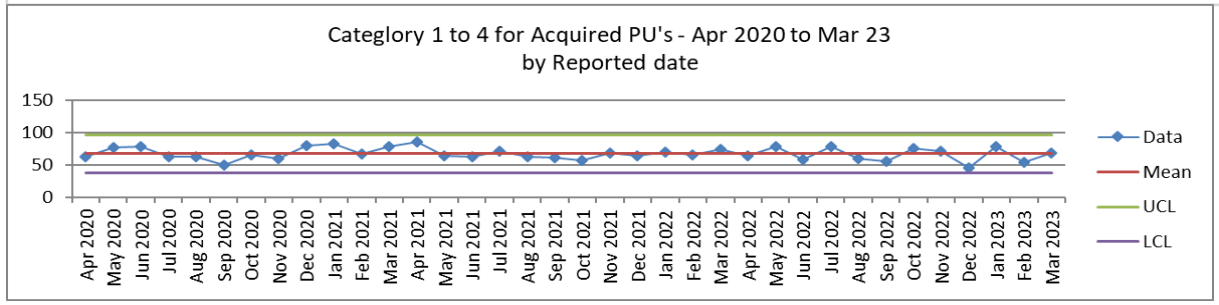
Gloucestershire Health and Care NHS Foundation Trust

## CQC DOMAIN - ARE SERVICES SAFE? Trust Wide Physical Health Focus

| | Reporting Level | Threshold | 2021/22 Outturn | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | 2022/23 YTD | R / A / G | Exception Report? | Benchmarking Report |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| VTE Risk Assessment - % of inpatients with assessment completed | N - T | 95% | 98.3% | 99.1% | 100% | 99.2% | 99.1% | 96.6% | 98.2 | 98.1 | 100% | 97.9% | 97.3% | 97.5% | 99.0% | 98.70 | G | | |
| Number of post 48 hour Clostridium Difficile Infections (C Diff) | N | 1 | 21 | 0 | 1 | 3 | 0 | 0 | 1 | 2 | 1 | 1 | 1 | 3 | 0 | 13 | R | | |
| Number of C Diff cases (days of admission plus 2 days = 72 hrs) - avoidable | N | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | N/A | | |
| Number of MRSA Bacteraemia | N | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | N/A | | |
| Total number of developed or worsened pressure ulcers | L - R | 61 | 779 | 70 | 77 | 60 | 79 | 65 | 56 | 77 | 69 | 49 | 80 | 55 | 65 | 811 | R | | |
| Total number of Category 1 & 2 Acquired pressure ulcers | L - R | 56 | 702 | 66 | 71 | 56 | 69 | 59 | 53 | 65 | 63 | 48 | 74 | 53 | 59 | 727 | R | | |
| Number of Category 3 Acquired pressure ulcers | L - R | 0 | 57 | 3 | 5 | 3 | 2 | 4 | 2 | 9 | 4 | 0 | 4 | 2 | 6 | 51 | R | | |
| Number of Category 4 Acquired pressure ulcers | L - R | 0 | 19 | 1 | 1 | 1 | 8 | 2 | 1 | 3 | 2 | 1 | 2 | 0 | 0 | 21 | R | | |

## ADDITIONAL INFORMATION - Health Care Acquired Infections (HCAI) & Pressure Ulcers (PU)

**HCAI:** There were 0 post 48-hour Clostridium Difficile (C. Diff) infections recorded in March.
**Pressure Ulcers:** This month we present the most recent validated and approved data, there are system pressures which have delayed normal process and the reviewed data will be included in the next iteration of the Dashboard. With regard to validated data there has been an increase in the number of newly acquired category 1 & 2 pressure ulcers this month compared to February, which will in part be due to March being a longer month but also noting a higher EoL caseload. Overall there has been a reduction when compared to January. We acknowledge that as an organisation we will always have pressure ulcers evident within our Trust as a large proportion of patients are referred to us with an existing PU, Community nursing caseloads have patients referred with existing pressure ulcers obtained whist under primary care, residing in care homes or acute hospital transfers. The pressure ulcer data is monitored via improved reporting, verification/alteration of classification and improved operational tolerances.

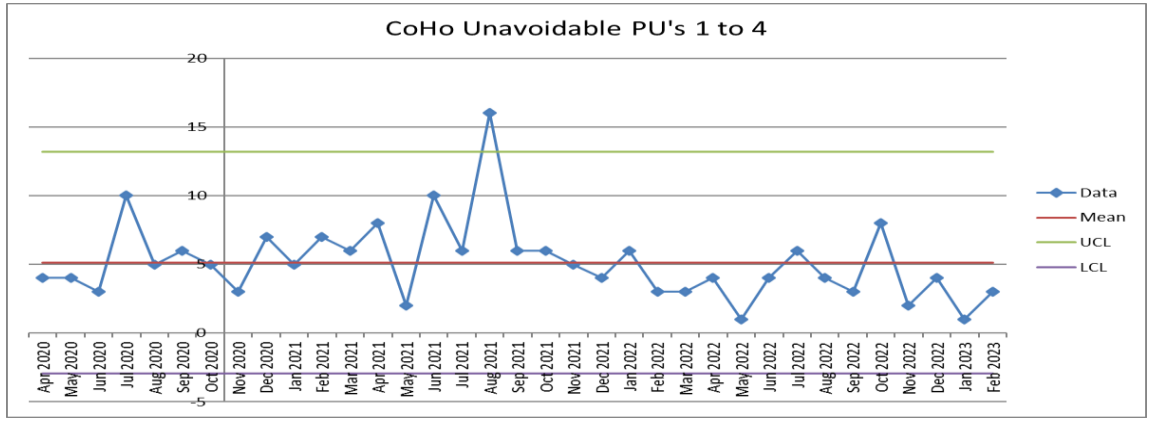


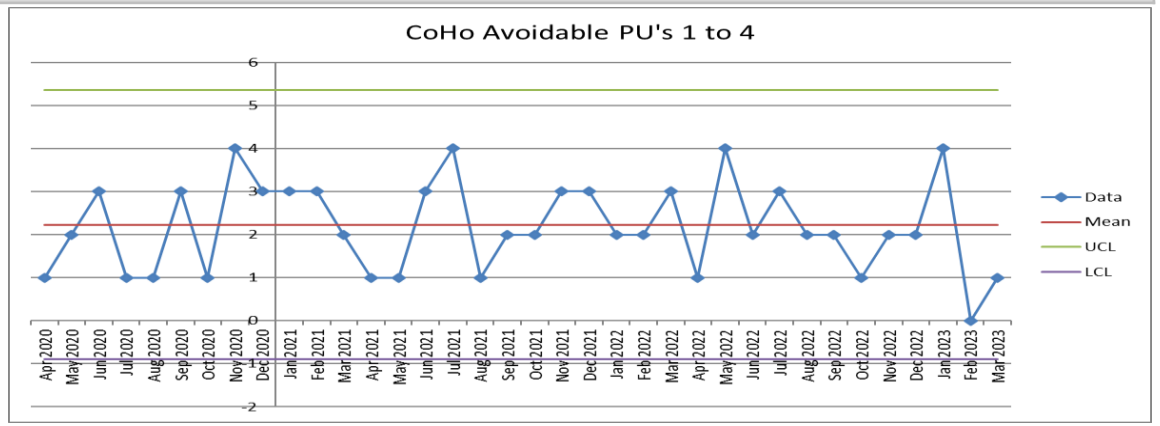

- As well as reporting month on month fluctuation we are plotting the PU trends emerging over time. Opposite is an SPC chart that shows data from 2020 to 2023 where we see the number of incidents at generally the middle third of the mean. This is a useful visual representation of incidence over time and compliments the tabled month by month detailed analysis.
- The Patient Safety Team are working with the senior nursing colleagues across the inpatient and community teams to enhance the validation process to ensure incidents are reviewed earlier and learning shared with teams. The aim is to improve the data quality for teams and make learning from PU incidents more accessible

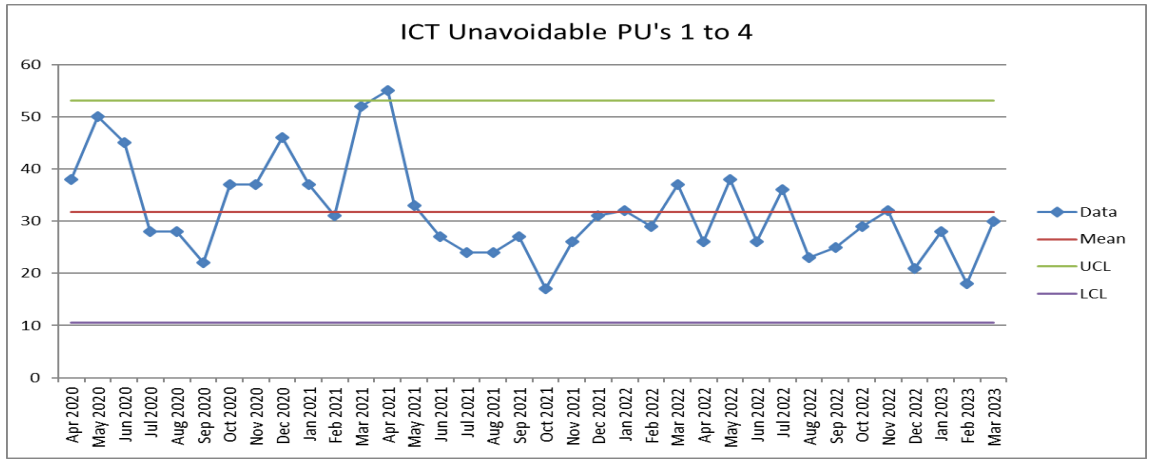
# Quality Dashboard

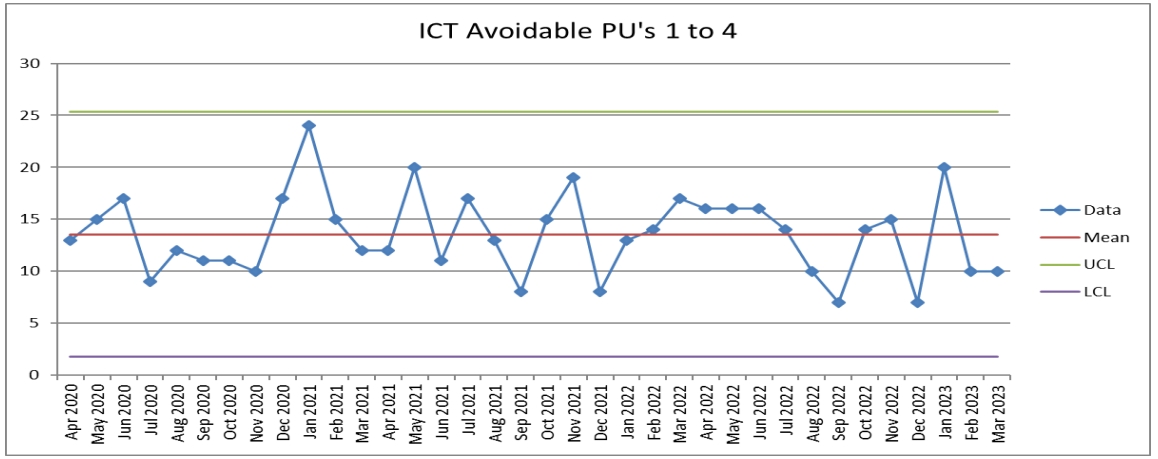
Gloucestershire Health and Care NHS Foundation Trust

**CQC DOMAIN - ARE SERVICES SAFE?**
**Pressure Ulcers – March 2023 Additional Information Trust Wide**




This is a new slide which is being developed to show and highlight the monthly fluctuations in data relating to avoidable/unavoidable PU's from April 2020 to Mar 2023 where the changes can be mapped against months and a richer picture is viewed rather than a single data snapshot.

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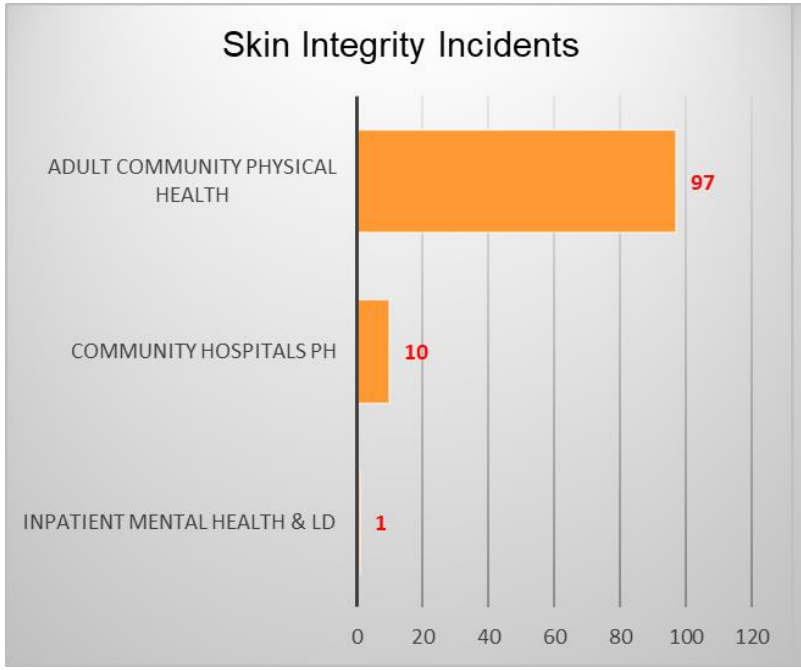
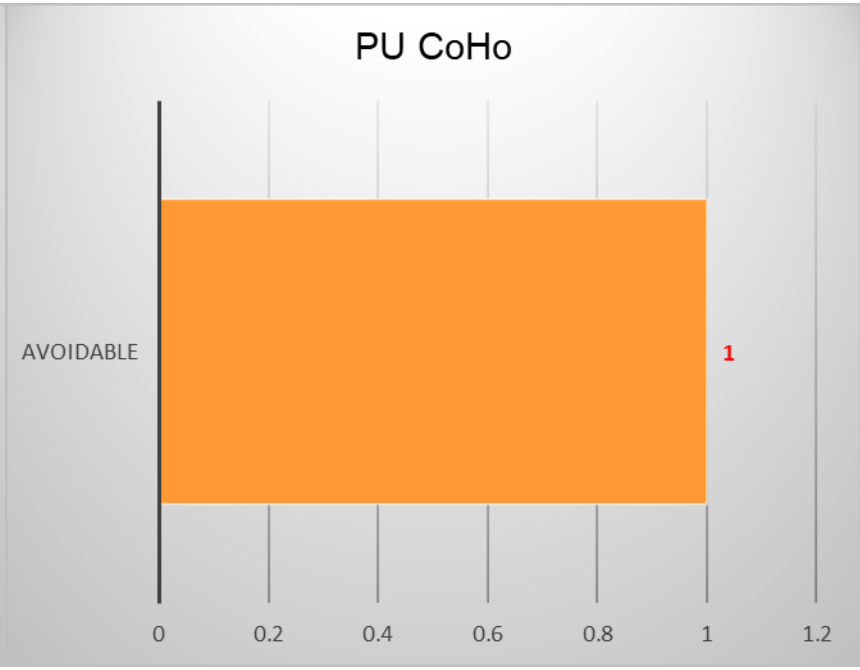
**CQC DOMAIN - ARE SERVICES SAFE?**
**Pressure Ulcers – March 2023 Additional Information Trust Wide**



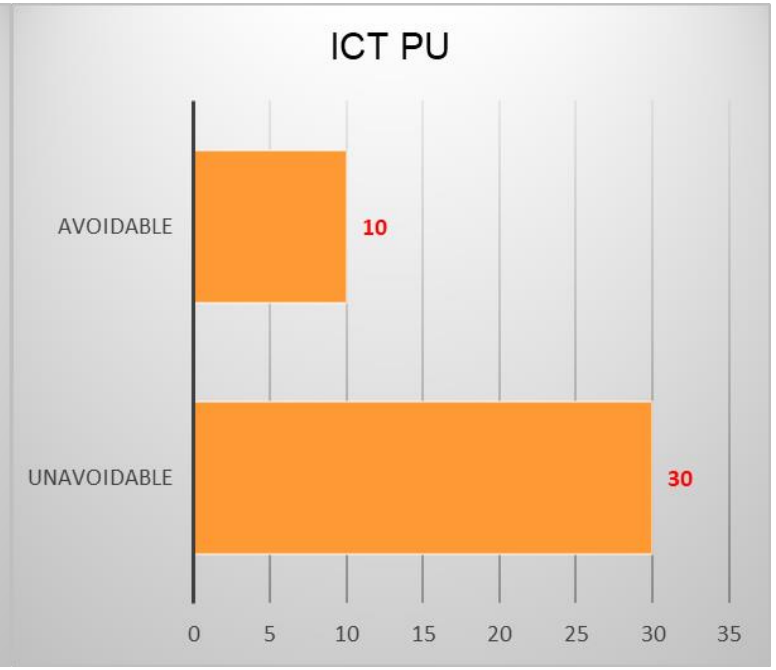

**Bar chart showing skin integrity incident reports per service.**

- Adult Community PH 97
- Community Hospitals PH 10
- PH Urgent Care 0
- Inpatient MH & LD 1
- Countywide Services 0




**Bar chart showing PU's developed or worsened under GHC care (acquired) in our Community Hospitals in March 2023**

- Community PH hospitals pressure ulcers that have developed or worsened under our care (acquired under our care). ***Reviewed*** as being unavoidable or avoidable due to comorbidities, patient choice (for example patients may decline to use equipment or clinical advice.)
- 1 unavoidable
- 0 avoidable




**Bar chart showing data reported in community PH in March 2023**

- Snapshot of Community PH pressure ulcers that have developed or worsened under our care (acquired under our care). ***Reviewed by handlers*** as being unavoidable or avoidable due to; comorbidities, patient choice (for example patients may decline to use equipment or clinical advice.)
- 30 unavoidable
- 10 avoidable

## NACEL Audit 2022/23

### National Audit of Care at the End of Life (NACEL)

The National Audit of Care at the End of Life is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death In Acute hospitals, community hospitals and mental health inpatient providers in England, Wales and northern Ireland. The latest audit took place in September with results published in Q4 this year covering community hospitals.

**Highlights from the Audit of Community Hospitals**

- Good recognition of dying (**94%** of patients notes recorded patient might die within hours or days, UK average was 87%)
- Well documented evidence of a range of assessments having been completed in the individuals plan of care (and improvement from last audit) e.g. **97%** of case notes recorded patient's hydration and nutrition status was assessed daily once the dying phase was recognised (UK average was 79%)
- Good prescribing of anticipatory medications, **100%** of patients had been prescribed anticipatory medication and **90%** were administered
- Excellent feedback from families regarding the care received by the person who died, **100%** felt the quality of care was **good, excellent** or **outstanding** (UK average was 71%)
- Excellent feedback from families regarding their needs being met and the emotional and practical support they received, **100%** agreed or strongly agreed (UK average was 54%)
- **90%** of staff felt they worked in a culture that prioritises care, compassion, respect and dignity

**Staff confidence levels have improved from last year and staff felt more confident in the following areas**:

- How to access specialist palliative care advice (100% agree or strongly agree)
- How to respond to requests to die outside of the hospital (60% agree or strongly agree)
- How to assess and manage pain (90% agree or strongly agree)

| Theme | Trust Score 2022/23 | National Score 2022/23 | Trust Score 2021 |
|---|---|---|---|
| • Communication with the dying person | 8.2 | 8.0 | 7.5 |
| • Communication with families and others | 7.2 | 7.1 | 7.2 |
| • Involvement in decision making | 9.0 | 9.2 | 9.4 |
| • Individualised plan of care | 8.7 | 7.6 | 9.2 |
| • Needs of families and others | 8.3 | 5.5 | 8.8 |
| • Families' and others' experience of care | 9.5 | 6.3 | 9.4 |
| • Staff confidence | 7.9 | 7.5 | 7.6 |
| • Staff support | 6.1 | 7.1 | 6.6 |
| • Care and culture | 8.2 | 7.6 | 7.9 |

# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

## CQC DOMAIN - ARE SERVICES SAFE

| Safe Staffing Inpatient data – April 2023 | Code 1 | | Code 2 | | Code 3 | | Code 4 | | Code 5 | |
|---|---|---|---|---|---|---|---|---|---|---|
| Ward Name | Hours | Exceptions | Hours | Exceptions | Hours | Exceptions | Hours | Exceptions | Hours | Exceptions |
| Gloucestershire | | | | | | | | | | |
| Dean | 0 | 0 | 102.5 | 13 | 0 | 0 | 0 | 0 | 0 | 0 |
| Abbey | 67.5 | 9 | 30 | 4 | 0 | 0 | 0 | 0 | 0 | 0 |
| Priory | 15 | 2 | 17.5 | 2 | 0 | 0 | 0 | 0 | 0 | 0 |
| Kingsholm | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Montpellier | 10 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Greyfriars | 195 | 26 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Willow | 52.5 | 7 | 95 | 12 | 0 | 0 | 0 | 0 | 0 | 0 |
| Chestnut | 30 | 4 | 7.5 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Mulberry | 0 | 0 | 55 | 7 | 0 | 0 | 0 | 0 | 0 | 0 |
| Laurel | 30 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Honeybourne | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Berkeley House | 7.5 | 1 | 147.5 | 18 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total In Hours/Exceptions | 272.5 | 35 | 522.5 | 65 | 0 | 0 | 0 | 0 | 0 | 0 |

The Director NTQ reviews safe staffing reports every month ahead of submission to NHSE, this acts as a rolling review of safe staffing and is informing a detailed Trustwide safe staffing review that is currently being finalised. We have cross referenced highest exceptions with patient safety and experience data. We have completed the NHSE staffing assurance framework and have reported our assurance and development plans to Quality Committee. Greyfriars and Abbey have reported the highest code 1 exceptions however the Matrons report this didn't adversely impact on care delivery or patient experience. Code 1 exceptions on Greyfriars and Abbey were as last month attributable to RN shortages on early and late shifts . Code 2's on Willow ward related to predominately HCA shortages on late shifts and RNs on early with Dean being HCAs on late. Berkley's shortages relate mainly to HCA's on all shifts. Deficits due to vacancy, long term sickness & maternity leave. Shifts have been predominantly filled with regular HCA's, who are familiar with ward environments. A working group is progressing work on our large scale safe staffing review that commenced in 2022 using new national tools.

| Mental Health & LD | | | |
|---|---|---|---|
| **Ward** | **Average Fill Rate %** | **Sickness %** | **Vacancy %** |
| Dean Ward | 98.94 | 5.10 | 10.0 |
| Abbey Ward | 101.08 | 0.7 | 26.8 |
| Priory Ward | 137.11 | 2.0 | 17.1 |
| Kingsholm Ward | 128.28 | 18.2 | 8.7 |
| Montpellier | 142.67 | 7.6 | 9.5 |
| PICU Greyfriars Ward | 105.14 | 4,7 | 27.3 |
| Willow Ward | 100.95 | 4.9 | 1.6 |
| Chestnut Ward | 102.96 | 17.10 | -7.5 |
| Mulberry Ward | 104.11 | 3.4 | 8.1 |
| Laurel House | 99.17 | 8.4 | 0.1 |
| Honeybourne Unit | 110.83 | 10.0 | -12.4 |
| Berkeley House | 98.36 | 6.1 | 23.4 |
| **MHH Totals Avg (April 2023)** | **110.80** | **7.1** | **9.39** |
| Previous Month Totals | 111,11 | 7.0 | 13.9 |

| Physical Health | | | |
|---|---|---|---|
| **Ward** | **Average Fill Rate %** | **Sickness %** | **Vacancy %** |
| Coln (Cirencester) | 103.75 | 5.5 | 3.3 |
| Windrush (Cirencester) | 113.35 | 13.7 | 2.3 |
| The Dilke | 101.14 | 8.1 | 4.0 |
| Lydney | 91.90 | 7.0 | -4.8 |
| North Cotswolds | 102.56 | 7.8 | 5.5 |
| Cashes Green (Stroud) | 94.63 | 3.0 | 2.2 |
| Jubilee (Stroud) | 115.67 | 15.7 | 14.5 |
| Abbey View (Tewkesbury) | 106.13 | 4.8 | -10.6 |
| Peak View (Vale) | 96.08 | 5.2 | 9.6 |
| **PHH Totals Avg (April) 23** | **103.33** | **7.1** | **6.3** |
| Previous Month Totals | 93.96 | 7.1 | 6.3 |

| NHSE Zero HCSW Vacancy Commitment Inc. bank – 3 month report | |
|---|---|
| **February** | 63.53 |
| **March** | 86.52 |
| **April** | 90.43 |

**NHSE Zero HCSW Vacancy Commitment :** This month there is a decrease in the vacancy rate in Mental Health owing to the recruitment and starts of international nurses on Priory Ward. Those with a negative value indicate being over recruited to their funded establishment. For example, Honeybourne Unit are currently over recruited against their establishment as they are supporting the newly appointed International Nurses. Chestnut Ward have over recruited in HCSW from a recent recruitment event as recruits had a preference on where they would like to work. The small increase in Zero HCSW is impacted by a number of people qualifying into band 4 roles.

**IR/Recruitment.** 2 MH nurses remain in the pipeline for May and I AHP for June 2023. 89 international colleagues have been recruited to date (from Jan 2021) 45 RGNs, 41 RMN,s 2 Community ICT's and 1 AHP.

# Appendix One

## IPC/COVID 19 Data - April 2023

# Quality Dashboard

Please note this slide will no longer be required in future dashboards due to the recent downgrading from a national level incident by NHS England

NHS
Gloucestershire Health and Care
NHS Foundation Trust

**COVID-19 (Whole Trust data, reporting nationally mandated Covid-19 focused safety and activity information)**

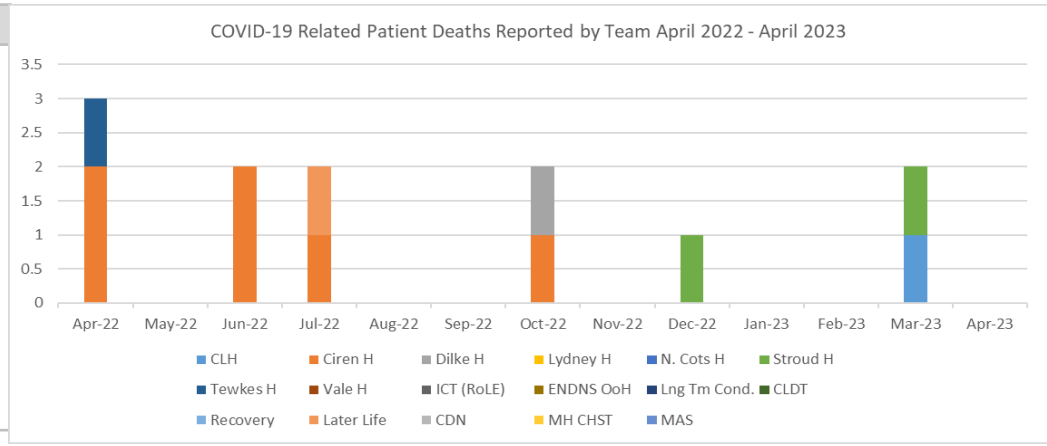
| | | 2022/23 Outturn | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | 2023/24 YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No of C-19 Inpatient Deaths reported to CPNS | | 10 | 0 | | | | | | | | | | | | 0 |
| Total number of deaths reported as C-19 related. | | 11 | 0 | | | | | | | | | | | | 0 |
| Community onset (positive specimen <2 days after admission to the Trust) | | 55 | 0 | | | | | | | | | | | | 0 |
| Hospital onset (nosocomial) indeterminate healthcare associated - HOIHA (Positive specimen date 3-7 days after admission to the Trust) | | 34 | 4 | | | | | | | | | | | | 4 |
| Hospital onset (nosocomial) probable healthcare associated - HOPHA (Positive specimen 8-14 days after admission to the Trust) | | 18 | 3 | | | | | | | | | | | | 3 |
| Hospital onset (nosocomial) Definite healthcare associated - HODHA (Positive specimen date 15 or more days after admission to the Trust | | 176 | 7 | | | | | | | | | | | | 7 |
| No of staff self-isolating: new episodes in month | | | 6 | | | | | | | | | | | | |
| No of staff returning to work during month | | | 8 | | | | | | | | | | | | |

**Additional Information**

- There were zero mental health patient community deaths reported in April.
- There were zero inpatient Covid-19 related deaths reported in April where Covid was a contributory factor but not the primary cause, however there was a death in March with a delayed report to NHSE occurring.
- 0 cases of community onset were identified in March
- 4 cases of HOIHA were identified in March
- 3 cases of HOPHA were identified in March
- 7 cases of HODHA were identified in March

This month we report an increase of 7 cases in the HODHA levels with the highest number of cases being reported on Coln and Willow wards. Current IPC practices continue to be followed across all Trust areas with good assurance in place as demonstrated by relatively low levels of nosocomial transmission alongside monthly audits of compliance.

The NHS response to Covid 19 is stepping down from an NHS Level 3 incident therefore this will inform reporting going forward.



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# Summary
# Trust Safeguarding Data

NHS
Gloucestershire Health and Care
NHS Foundation Trust

**Summary information**:

The Safeguarding Dashboard provides assurance that:

- Safeguarding activity is a Trust priority function that is closely monitored
- Safeguarding is being delivered as per the requirements of the Gloucestershire Safeguarding Adults Board (GSAB), the Safeguarding Children Partnership (GSCP), commissioning expectations, and national guidance and legislation.

Safeguarding children and adults is a key element of the assessment and care management processes for staff. There are arrangements in place to ensure that staff are appropriately trained, supervised and supported in their safeguarding related work. The Trust's Safeguarding Group monitors safeguarding activity and reports quarterly into the Quality Assurance Group.

The Safeguarding Dashboard is presented in 3 sections:
1. Safeguarding Children Activity
2. Safeguarding Adults Activity
3. Safeguarding Training Compliance and Safeguarding Supervision

**Highlights:**

- The GHC Safeguarding Notifications inbox which captures the number of safeguarding referrals made to the Local Authority is operating well. This provides the Safeguarding Team with improved oversight of organisational safeguarding activity.
- Monthly auditing of Safeguarding adult practice and record keeping is underway. Monthly auditing of Safeguarding children practice commenced in April 2023. Work is progressing with Clinical Systems to enable a BI solution to report the number of safeguarding referrals made to the Local Authority and the number safeguarding escalations.
- Continued good used of the Safeguarding Advice Line by children and adult services, demonstrating a good awareness of the service across the Trust. A Service Evaluation Project evaluating the Advice Line (adult related activity only) is underway, which will conclude in July 2023.
- A network of Safeguarding Champions is being developed across the Trust. Champions will be key links for operational teams and the Safeguarding Team for the dissemination of key safeguarding messages and priorities.
- April saw the launch of our new monthly 'Safeguarding Learning Lunch.' 54 staff across the Trust attended the first MST session. The session explored the topic of hoarding. The theme of May's Learning Lunch is the Gloucestershire Multi-Agency Safeguarding Hub (MASH).

**Challenges/risks:**
- Audit has identified some variation in how Safeguarding related data is recorded on our clinical systems and the quality of that information. We have a Safeguarding Action Plan in place to address risk and apply mitigations. We are working closely with Clinical Systems, Business Intelligence and Safeguarding Task and Finish Group working to find solutions that address risk. Central to the action plan is the development one Trust wide safeguarding template, the development and application of this is complex. Target completion November 2023.
- Children's Safeguarding Supervision attendance compliance has dropped and the number of staff attending Safeguarding Adult supervision sessions remains low despite considerable efforts to promote supervision across our operational teams. Safeguarding supervision has been identified as a key recommendation within several local Safeguarding Practice Reviews. A review of both the adult and children's safeguarding supervision offer is underway, with a move towards providing more team specific supervisions for areas of the Trust who have high levels of and complex safeguarding cases, such as the Children in Care Team, the Assertive Outreach Team, Integrated Care Teams.

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# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

**GHC - Safeguarding Dashboard 2023/24 Children's Safeguarding Data**

| | Q4 Total | Apr-23 | May-23 | Jun-23 | | | | Additional Information |
|---|---|---|---|---|---|---|---|---|
| **SAFEGUARDING ACTIVITY** | | | | | | | | |
| Advice Line Calls | 194 | 47 | | | | | | Operational colleagues continue to make good use of the Safeguarding Advice Line. Expected minor variation in month. |
| Multi-Agency Request for Service Forms submitted to MASH | 67 | 8 | | | | | | The Local Authority are unable to provide referral data and current GHC clinical systems are unable to accurately capture referral figure. This is a documented risk – Risk 298. An action plan is underway to address this. Safeguarding Referral data is captured via the Safeguarding Notifications Inbox as a mitigation until a digital solution is in place. |
| Number of Safeguarding Escalations | 2 | 0 | | | | | | This information is currently obtained from our Safeguarding Advice Line data. Further work is underway with Clinical Systems/Business Intelligence Teams to accurately identify the number of escalations made to partner agencies. |
| **CHILD DEATH NOTIFICATIONS** | | | | | | | | |
| Expected | 6 | 1 | | | | | | Expected deaths are infants with known life limiting conditions or cases of extreme neonatal prematurity. |
| Unexpected | 3 | 3 | | | | | | Gloucestershire Child Death Overview Process is followed for each unexpected death. Cause of each death has not yet been formally reported. No safeguarding concerns identified in relation to the unexpected child death in April. |
| **RAPID REVIEWS/LCSPR'S** | | | | | | | | |
| Number of Serious Incident notifications made by LA | 1 | 0 | | | | | | No SIN were submitted in April.1 |
| Number of Rapid Reviews attended | 1 | 0 | | | | | | 1 Safeguarding Rapid Review attended in Q relevant health information shared. Case will not progress to a Child Safeguarding Practice Review. |
| Number of LCSPR's in progress | 2 | 2 | | | | | | 2 Gloucestershire LCSPR's in progress. 1 is a joint Surrey/Glos LCSPR - no GHC involvement. 1 LCSPR relating to a Child in Care underway with GHC involvement. |
| **MASH HEALTH TEAM ACTIVITY** | | | | | | | | |
| Children researched/info shared | 2,255 | 477 | | | | | | MASH activity remains stable. Usual minor variation in month. |
| Adults researched/info shared | 346 | 99 | | | | | | Expected variation in Month |
| MASH strategy meetings attended | 125 | 10 | | | | | | Significant reduction in MASH strategy discussion due to a change in Children's Social Care triage process. The MASH health team attend 100% of strategy discussions they are invited to. |
| Demographic information sharing | 527 | 197 | | | | | | MASH health are frequently asked for demographic data from children's social care - this is due to referral data quality and incomplete data. |
| **AUDITS** | | | | | | | | |
| **Single Agency** | 0 | 1 | | | | | | Monthly Safeguarding Children dip sample audit |
| **Multi-Agency sub group activity** | 1 | 1 | | | | | | MASH multi-agency audit in preparation for JATI (Joint Area Targeted Inspection) |
| **UNDER 18'S ADMISSIONS** | | | | | | | | |
| Number of under 18's admitted to Adult MH Wards | 0 | 0 | | | | | | No children were admitted to adult mental health wards in April. |
| Number of under 18's assessed under S.136 of the MHA 83/07 | 4 | 0 | | | | | | No children were assessed during the month of April. This is not unusual. |
| **OTHER WORKSTREAMS** | | | | | | | | |
| **Allegations management – number of referrals to/from the LADO** | 1 | 2 | | | | | | 2 referrals made to the LADO in April. Neither relate to GHC staff. |

# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

**GHC - Safeguarding Dashboard 2023/24 Adults safeguarding Data**

| | Q4 | Apr-23 | May-23 | Jun-23 | | | | Additional Information |
|---|---|---|---|---|---|---|---|---|
| **SAFEGUARDING ACTIVITY** | | | | | | | | |
| **Contacts to GHC advice Line** | 197 | 64 | | | | | | Calls to the GHC advice line re. adult safeguarding enquiries - may or may not proceed to a referral to the Local Authority. Continued good use of the Advice Line throughout April. |
| **Safeguarding Referrals made to GCC** | 27 | 6 | | | | | | This data is obtained from the Safeguarding Team Notifications Inbox. Work is underway with Clinical Systems and Business Intelligence to identify mechanisms across our clinical systems which capture this data accurately. |
| **MH/LD Household Member Form Compliance** | | 57% | | | | | | Linked to Risk 107 – recording of household members. Household & Family form completion (MH/ LD Current caseload) – added as new 2023/24 Performance indicator - Threshold: 100% |
| **CASE REVIEWS** | | | | | | | | |
| **New Safeguarding Adult Reviews/Domestic Homicide Reviews** | 3 | 0 | | | | | | No new DHR notifications in April |
| **Number of Reviews ongoing** | 14 | 14 | | | | | | Consistently high number of safeguarding reviews relating to adults (DHR's DARDR's and SARs). |
| **Action Plans Ongoing** | 6 | 6 | | | | | | This includes single and multi agency action plans |
| **MAPPA** | | | | | | | | |
| **Level 2 Meetings Held** | 16 | * | * | * | | | | * MAPPA data only available quarterly |
| **Level 2 Meetings Attended** | 16 | * | * | * | | | | |
| **Level 3 Meetings Held** | 1 | * | * | * | | | | |
| **Level 3 Meetings Attended** | 1 | * | * | * | | | | |
| **PREVENT** | | | | | | | | |
| **Number of Prevent Referrals Made** | 0 | 0 | | | | | | No Prevent concerns raised with the police |
| **Information requests received & completed from Police/Channel** | 15 | 1 | | | | | | 100% response to all police and channel panel information sharing requests, supportive effective planning and decision making. |
| **MARAC** | | | | | | | | |
| **Families screened/researched** | 395 | 106 | | | | | | Continued high level of MARAC activity. Minor variation in month. |
| **No.of children open to MH Services** | 38 | 19 | | | | | | Number of children open to mental health service highlights the emotional impact of domestic abuse on children. Expected minor variation in month. |
| **No.of victims open to MH Services** | 38 | 13 | | | | | | Highlights the link between the impact of domestic abuse on victims mental health. Expected minor variation in month. |
| **No.of perpetrators open to MH Services** | 58 | 10 | | | | | | Identifies the number of perpetrators open to MH services. Expected minor variation in month. |
| **Un-uploaded MARAC Action Plans** | 144 | 132 | | | | | | MARAC Action Plans are uploaded to clinical records of all related parties. They contain detail of the Domestic Abuse incident and agreed multi agency action plan. Currently there is a backlog of 132 action plan to upload. Minor process changes have been made to reduce the heavy administrative process, however number of action plans is currently outweighing admin capacity. |
| **DOLS - No. of referrals for standard authorisation from:** | | | | | | | | |
| **Mental Health Services Total** | 7 | 2 | | | | | | Continued pattern of DOLS applications |
| **Mental Health Services Authorised** | 3 | 1 | | | | | | Minor variation in month |
| **Physical Health Services Total** | 20 | 14 | | | | | | Physical health urgent applications (not requiring LA authorisation) |
| **Physical Health Services Authorised** | 0 | 0 | | | | | | Nil authorised as patients have moved on before being application assessed. |
| **AUDITS** | | | | | | | | |
| **Single Agency - Safeguarding Related** | 8 | 1 | | | | | | Monthly Safeguarding Adults dip sample auditing commenced in November 2022 and continues each month. |
| **Multi Agency Sub - Group Related** | 2 | 0 | | | | | | No multi agency safeguarding audits in April |
| **OTHER WORKSTREAMS** | | | | | | | | |
| **Allegations management - use of PiPoT guidance** | 1 | 2 | | | | | | 2 new allegations in April. 1 relating to a member of GHC bank staff, 1 related to a member agency staff working with in GHC hospital. |

# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

**GHC - Safeguarding Dashboard 2023/24 Training and Supervision Data**

| | Q4 | Apr-23 | May-23 | Jun-23 | | | | Additional Information |
|---|---|---|---|---|---|---|---|---|
| **TRAINING** | | | | | | | | |
| **Level 1 – Induction** | 96% | 96% | | | | | | Overall a minor variation in month |
| **Level 2 – Think Family** | 92% | 90% | | | | | | Overall a minor variation in month |
| **Level 3 – Multi-Agency Child Protection** | 88% | 87% | | | | | | Overall a minor variation in month |
| **Level 3 Adult Protection** | 82% | 88% | | | | | | Overall a minor variation in month |
| **Level 4 Adult Protection** | 80% | 77% | | | | | | Minor dip in compliance in April but over all an improving picture of compliance over the last 12 months. |
| **PREVENT:** | | | | | | | | |
| **Level 1** | 99% | 97% | | | | | | Continued high level of compliance with Level 1 Prevent Training |
| **Level 2** | 83% | 84% | | | | | | Prevent Training was reviewed in Q1 and 'stand alone' Level 2 Training introduced as no longer available within the Think Family Training, as a result it will take several months for staff to catch up with the necessary Level 2 prevent training, improved compliance is expected. |
| **Level 3** | 94% | 90% | | | | | | The review of Prevent Training in Q1 identified that a large group of Adult Services Staff did not have Prevent Level 3 attached to their Learning Profiles, this has been rectified. Overall picture of improving compliance. |
| **SAFEGUARDING SUPERVISION** | | | | | | | | |
| **CHILDREN:** | | | | | | | | |
| **Group Supervision Sessions** | 60 | 20 | | | | | | Clinical staff working with children need to attend this supervision 3x per year. 5 x sessions are delivered per week. Attendance at sessions is excellent, with a maximum of 8 participants per session. Feedback is sought and captured following every session via a Snap Survey – feedback helps to shape future sessions. |
| **Group Supervision Compliance** | 55% | 56% | | | | | | In April 22 Safeguarding Group Supervision was added as an 'essential to role requirement' on staff Care to Learn Training Profiles. Operational line managers are responsible for monitoring individual staff member compliance. |
| **One to One Supervision Sessions** | 22 | 3 | | | | | | 121 Supervision is available to all upon request. In line with learning from recent child safeguarding reviews that recommend focused case reflection and discussion the team have been promoting 121 supervision across operational teams. |
| **ADULTS:** | | | | | | | | |
| **Group Supervision Sessions** | 6 | 0 | | | | | | 6 Safeguarding Adult supervision sessions were planned for April, however due to staff not booking onto the sessions no sessions were run. New offer/model of Adult Safeguarding Supervision being developed to address poor attendance and engagement with supervision |
| **Number of Staff who attended Supervision** | * | 0 | | | | | | |
| **One to One Supervision Sessions** | * | 1 | | | | | | 121 Supervision is available to all upon request. In line with learning from recent adult safeguarding reviews that recommend focused case reflection and discussion the team have been promoting 121 supervision across operational teams. |

# Appendix Three
## Trust Operational Data Extract

**Additional information**:

The information provided in the following slides is a snap shot of activity data that was created to monitor performance whilst the Operational Governance Structures were being redesigned. The information supporting the activity data is detailed in the BI Performance Dashboard that has visibility throughout the organisation. Currently the larger data set reports though:

- PFIG & Directorate Governance meetings on a monthly basis
- Business Intelligence Management Group - monthly which reports onward into the Resources Committee
- Pan Ops Directorate who escalate issues from individual Directorates which reports into QAG & Quality Committee.

In future iterations of the dashboard, the Operational Data Extract will be stood down, however, all reporting will channel through the operational governance route and an overview of data will be provided within the QAG paper to the Quality committee. This will reduce the duplication of data and the commitments on operational teams. The dashboard will focus on quality themes from services and give an overview on any enhanced surveillance in place to oversee quality in areas that have higher risk or emerging themes The dashboard will focus on quality themes from services and give an overview on any enhanced surveillance in place to oversee quality in areas that have higher risk or emerging themes.

# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

## CQC DOMAIN - ARE SERVICES RESPONSIVE?

| | | Reporting Level | Threshold | 2022/23 Outturn | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | 2023/24 YTD | R / A / G | Exception Report | Benchmarking Report |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Referral to Treatment physical health** | | | | | | | | | | | | | | | | | | | | |
| | Podiatry - % treated within 8 Weeks | L - C | 95% | 42.67% | 47.0% | | | | | | | | | | | | 47.0% | R | | |
| | ICT Physiotherapy - % treated within 8 Weeks | L - C | 95% | 63.93% | 78.0% | | | | | | | | | | | | 78.0% | R | | |
| | ICT Occupational Therapy Services - % treated within 8 Weeks | L - C | 95% | 72.81% | 79.0% | | | | | | | | | | | | 79.0% | R | | |
| | Paediatric Speech and Language Therapy - % treated within 8 Weeks | L - C | 95% | 50.59% | 44.0% | | | | | | | | | | | | 44.0% | R | | |
| | Paediatric Physiotherapy - % treated within 8 Weeks | L - C | 95% | 90.16% | 87.0% | | | | | | | | | | | | 87.0% | R | | |
| | Paediatric Occupational Therapy - % treated within 8 Weeks | L - C | 95% | 14.35% | 10.0% | | | | | | | | | | | | 10.0% | R | | |
| | Single Point of Clinical Access (SPCA) Calls Offered (received) | L - R | 3,279 | 13437 | 1241 | | | | | | | | | | | | 1241 | | | |
| | Wheelchair Services Adults : New referrals assessed within 8 weeks | L - C | 90% | 83.24% | 85.0% | | | | | | | | | | | | 85.0% | A | | |
| | Wheelchair Services : Under 18's new referrals assessed within 8 weeks | L - C | 90% | 84.66% | 94.0% | | | | | | | | | | | | 94.0% | A | | |
| **Mental Health Services (CPA and Eating Disorders)** | | | | | | | | | | | | | | | | | | | | |
| | CPA Review within 12 Months % | N - T | 95% | 95.2% | 95.0% | | | | | | | | | | | | 95% | G | | |
| | Adolescent Eating Disorder - routine referral to NICE treatment start within 4 weeks % | | 95% | 46.95 % | 14.0% | | | | | | | | | | | | 14.0% | R | | |
| | Adolescent Eating Disorder - Urgent referral to NICE treatment start within 1 week % | | 95% | 45.1% | 67.0% | | | | | | | | | | | | 67.0% | R | | |
| | Eating disorders - Wait time for adult assessments will be 4 weeks % | | 95% | 47.04% | 39.0% | | | | | | | | | | | | 39.0% | R | | |
| | Eating disorders - Wait time for adult psychological interventions will be 16 weeks % | N – T | 95% | 68.96% | 85.0% | | | | | | | | | | | | 85.0% | R | | |

### Additional information

**Governance statement:** - The SystmOne Simplicity programme concluded in April after two years of work to improve the functionality, accuracy and usability of the clinical record system. It has resulted in the correction of significant inaccuracies as well as acting as a catalyst for work to ensure SystmOne remains accurate into the future. The S1 caseload has reduced from 288,000 to 109,000, and waiting list from 193,000 to 24,000, indicating a far more accurate picture of our clinical activity on which to base decisions. All community referrals are now part of the Community Services Data Set (compared with a quarter in 2020) and 97% of MIIU referrals are in the Emergency Care Data Set (compared with 55% in 2020) showing a major improvement in the quality of data being reported by the Trust. So while this programme has reached its conclusion, there will be follow-up work to standardise the way SystmOne is used across the Trust, and continue to provide colleagues with the appropriate training and support. Those Services who are not achieving performance target compliance continue to work through their improvement plans, mitigate risk and manage demand, which is monitored and challenged through operational and quality governance routes

**Wheelchair Services**: Wheelchair service has made significant progress this year with an overall improvement in performance more consistently meeting KPIs. The backlog of patients, initially caused by increasing demand for service and Covid redeployment coupled with vacancies and sickness has reduced by almost 50% over the last 12 months. The clinical team is now fully established and the service expects to continue with a positive trajectory in the coming year.

**Mental Health :** CPA rates are on target with a data refresh showing that compliance has been maintained for the past 7 months. There is a data slide earlier in the presentation that details trends .

**Eating Disorders:**. Achieving expected performance levels remains a challenge. The service continues to offer assessments to patients that have been waiting for an extended period based on clinical decision of non-urgency. From April onwards the service will continue to offer assessments for those on the waiting list that have been waiting over 4 weeks. There are currently 81 routine adolescent clients on the assessment waiting list, compared to 201 at its highest peak in June 2022. The team has significantly reduced the urgent adolescent assessment waiting list numbers and waiting times over the autumn and winter. The service now receives an average of 4 urgent adolescent referrals a week. When treatment is identified at the point of assessment, the service is able to offer patients an assessment and / or treatment start within a week of the referral being received. The team are working collaboratively with partners to reassess staffing skill mix and competency development to meet the current population demand, and Op leads are working with Bi colleagues to refresh demand and capacity figures and to refine referral questions and templates. Additionally benchmarking is planned against other regional all age ED services.

# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

## CQC DOMAIN - ARE SERVICES EFFECTIVE?

| | | Reporting Level | Threshold | 2022/23 Outturn | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | 2023/24 YTD | R / A / G | Exception Report? | Benchmarking Report |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Community Hospitals** | | | | | | | | | | | | | | | | | | | | |
| Bed Occupancy - Community Hospitals | | L - C | 92%* | 97.5% | 97.0% | | | | | | | | | | | | 97.0% | | | |
| *** Indicates optimum occupancy to enable flow** | | | | | | | | | | | | | | | | | | | | |
| Early Intervention in psychosis EIP: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral | | N - T | 60% | 69.2% | 60.0% | | | | | | | | | | | | 60% | G | | |
| **Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered** | | | | | | | | | | | | | | | | | | | | |
| Inpatient Wards | | N - T | 95% | 68% | 72% | | | | | | | | | | | | 72% | R | | |
| Community | | N - T | 90% | 70.2% | 76.4% | | | | | | | | | | | | 76.4% | R | | |
| 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 | | N - T | 50% | 52.1% | 51.0% | | | | | | | | | | | | 51.0% | G | | |
| Admissions to adult facility of patient under 16yrs | | N - R | | 0 | 0 | | | | | | | | | | | | | N/A | | |
| Inappropriate out of area placements for adult mental health services | | N - R | Occupied bed days | 950 | 0 | | | | | | | | | | | | | G | | |
| **Children's Services – Immunisations** | | | | 2021/22 Outturn | Academic Year 2022/23 - Target 90% of all 2 immunisations by end of academic year (July 2023) and new cohort 1st immunisations | | | | | | Academic Year 2023/24 . | | | | | | | | | |
| HPV Immunisation coverage for girls aged 12/13 years old (Target for all 2 immunisations to be completed) HPV 2 begins March 202 | | N - T | 90%* | 79.1% | 12%<br>43.0% | 70% | 80% | 85% | 90% | | | | | | | | | | | . |
| **Childrens Services - National Childhood Measurement Programme** | | | | 2021/22 Academic Year | Academic Year 2022/23 - Target 95% of children measured by end of academic year - Cumulative target (July 2023) | | | | | | Academic Year 2023/24. | | | | | | | | | |
| Percentage of children in Reception Year with height and weight recorded | | N - T | 95%* | 57.0% | 65%<br>85.0% | 85.0% | 95% | 95% | 95% | | | | | | | | 85% | G | | |
| Percentage of children in Year 6 with height and weight recorded | | N - T | 95%* | 96.1% | 75%<br>84.0% | 87% | 95.0% | 95% | 95% | | | | | | | | 84.0% | G | | |

### Additional Information

**OOA:** This month we are reporting xx OOA bed days. **MH inpatients** is in a better position although still challenged in terms of bed flow – 3rd workshop completed in order to generate momentum within the system as it remains under a lot of pressure.

**IAPT:** Performance levels commence in year at above target and it is envisaged that this trend will continue.

**EIP**: Performance levels commence in year on target with no know barriers to prevent continuation of achievement.

**Cardio-metabolic assessment –** Input continues from two Physical Health Nurses within WLH and CLH, a recovery plan is being developed and a data refresh takes place from 1st April. We are increasing governance and oversight to include a training programme for staff who complete health checks and this will be monitored by the Physical Health Expert Reference Group on a monthly basis.

# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

## Additional KPIs - Physical Health

| | | Reporting Level | Threshold | 2022/23 Outturn | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | 2023/24 YTD | R / A / G | Exception Report? | Benchmarking Report |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of eligible children who receive vision screens at or around school entry.(Cumulative target) | | | 52%* | 73.9% | 62.0%<br>84.0% | 83.0% | 93.0% | 95% | | | | | | | | | 62.0%<br>84.0% | G | N | |
| Number of Antenatal visits carried out | | | | 505 | 54 | | | | | | | | | | | | 54 | NA | NA | |
| Percentage of live births that receive a face to face, telephone or video NBV (New Birth Visit) within 7- 14 days by a Health Visitor | | | 95% | 93.53% | 92. 0% | | | | | | | | | | | | 92.0% | A | Y | |
| Percentage of children who received a face to face, telephone or video 6-8 weeks review. | | | 95% | 93.1% | 92.0% | | | | | | | | | | | | 92.0% | A | Y | |
| Percentage of children who received a 9-12 month review by the time they turned 12 months. | | | 95% | 81.5% | 82.2% | | | | | | | | | | | | 82.2% | A | Y | |
| Percentage of children who received a 12 month review by the time they turned 15 months. | | | 95% | 90.25% | 91.0% | | | | | | | | | | | | 91.0% | A | Y | |
| Percentage of children who received a 2-2.5 year review by 2.5 years. | | | 95% | 81.06% | 85.0% | | | | | | | | | | | | 85.0% | A | Y | |
| Percentage of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence). | | | 58% | 53.73% | 56.0% | | | | | | | | | | | | 56.0% | A | Y | |
| Breastfeeding- % of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks | | | 80% | 82. 1% | 78.0% | | | | | | | | | | | | 78.0% | A | Y | |

### Additional Information

**Governance statement: -** Information on this page is triangulated with performance reporting, with improvements being made in recovering the reported position. The Simplicity data quality project has impacted and improved he accuracy of data in physical health teams in this and prior reporting periods**.** There has been a reduction in the number of recording errors since the service delivered record keeping training. The service has also ensured reminders and demonstration to all practitioners to use SystmOne SMS to remind parents of appointments From a quality perspective there have not been any adverse indicators reported in terms of safety or experience noting that some targets are not achieved in the data above. We are expecting to be able to report a further improved position in future.

**Health Visiting:**

- **NBV and Child reviews**: Service continues to build on significant increase and recovery of performance position. Contributing factors specific to this month's performance include an increase in the number of children admitted to NICU (Neonatal Intensive Care Unit) and hospital. All other children who were not seen within timeframe have since had contact, and they have prioritised targeted and specialist families when allocating the available capacity. There has been a large number of DNAs in April, therefore a locality wide scoping exercise is in place to ensure there is equity in the number of additional appointment slots to offer DNAs a further appointment within timeframe and to also understand why service user's DNA, particularly around specific sites and times. Additionally work progresses across each locality to address the percentage increase of appointments required to accommodate DNAs. The largest contributing factor specific to this month's performance is parents declining the 2-year visit and the HV service is engaging with the parents and to understand & breakdown the analysis of why parents are declining this review.

- **Breastfeeding**: Breastfeeding rates are similar to last month and the % of mothers continuing with breastfeeding has remained above target. Breastfeeding prevalence is impacted by babies moving out/in to area after reaching 6-8 weeks. The Service is exploring a broader range of voluntary Breastfeeding Support Groups/1:1 to engage with and signpost service users to support prevalence of breastfeeding. There is a programme of work with other stakeholders, infant feeding champions in place and updates are sent to all HV teams giving reminders to liaise/refer to locality infant feeding champion with any queries or support when required.

# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

## CQC DOMAIN - ARE SERVICES SAFE?

| | Reporting Level | Threshold | 2022/23 Outturn | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | 2023/24 YTD | RAG | Exception Report? | Benchmarking Report |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mandatory Training | L - I | 90% | 92.4% | 92.0% | | | | | | | | | | | | 92. 0% | G | | |
| % of Staff with completed Personal Development Reviews (Appraisal) | L - I | 90% | 85.0% | 81.0% | | | | | | | | | | | | 81% | R | Y | |
| Sickness absence average % Rate | L - I | <4% | 5.9% | 5. 8% | | | | | | | | | | | | N/A | R | Y | |

### Additional information

**Mandatory training –** Currently at 92.0 % overall, however, there are areas specific areas that impact on quality identified by NTQ at team level that need additional scrutiny, these include; Level 3 Resus (MERT), PMVA and PBM, Breakaway, Safeguarding, Mental capacity Act (Levels 1 & 2), Mental Health Act & Rapid Tranquillisation. NTQ are working with colleagues in the Learning and Development Team and Business Intelligence gain better access to information and facilitate operational colleges to improve training compliance.
**International Nurse Training -** We are supporting enhanced training packages for the new wave of International Nurses with an increase in face to face training, reflecting feedback from last cohort.
**Sickness absence** - At 5.8% in month indicates a marginal decrease from the previous month of 0.1%. Rates remain above target and in April the percentage figure equates to 6767 sickness days across the Trust. Data is now automatically received from workforce providing a robust single data source. This data can vary from BI sourced data as that data stream does not include information from E-roster and is subject to timing.

**March 2022 Preceptees - T**he retention figures for this workstream show that we had a total of 22 preceptees who attended our preceptorship programme and as of March 2023 all 22 are still employed at the trust, meaning our retention rate at 12 months of 100% for this cohort.

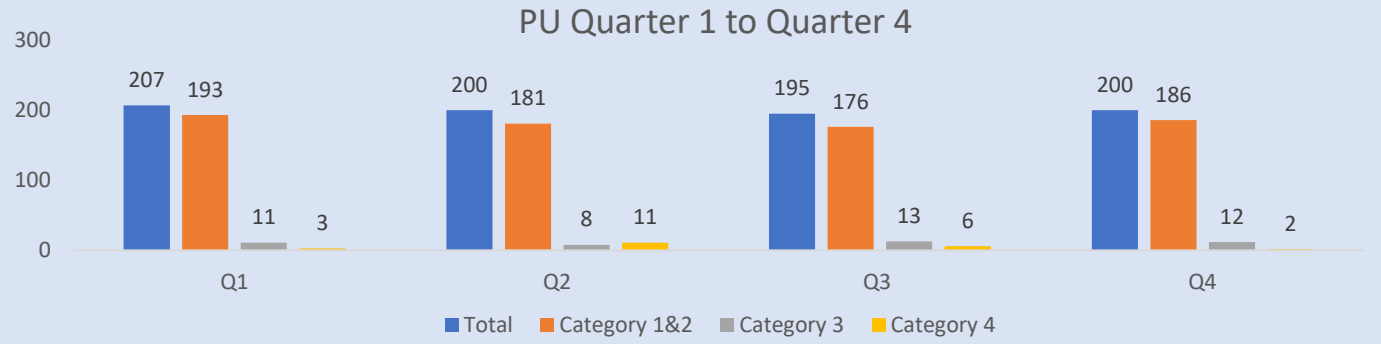
# Appendix Four

## Trust Quality Priorities 2022/23

# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

| SAFE : QUALITY PRIORITIES 2022-2023 | |
|---|---|
| **Standard** | **1 Pressure Ulcers (PU's) - with a focus on reducing incidence and severity through improvement in the recognition, reporting, and clinical management of PU's , developing a PU collaborative within the One Gloucestershire Integrated Care System.** |
| **Performance** | **Target** – the reduction quarter on quarter in the amount and severity of pressure ulcers within GHC |
| **Commentary** | • As an organisation we will always have Pressure Ulcers evident within our caseloads due to localities and inpatient units having patients referred with existing pressure ulcers obtained whist under primary care, residing in care homes or acute hospital transfers. The pressure ulcer data is monitored via improved reporting, verification/alteration of classification and improved operational tolerances with emphasis being given to learning lessons from avoidable incidents.<br>• There are key factors that drive an increase in number and severity of pressure ulcers; Circulatory changes following Covid - 19 infection, deconditioning of patients who live at home and have become more socially isolated and physical immobility during and following Covid - 19 infection.<br>• During the year the frequency and severity of pressure ulcers has remained relatively static with an overall reduction of 7 (3.3%) seen between Q1 and Q4.<br>• Avoidable PU in the trust are reviewed for data quality and potential for reclassification and learning, these cases can occur as a result of patients being in a non GHC environment, not being concordant with advice given and also attributable is the increase in EoL patients in community caseloads, the trend is that the numbers of avoidable PU's are in decline throughout the organisation.<br>• GHC Deputy Director of Nursing has agreed with ICS peers that the arrival of the new National Wound Care Strategy provides a platform for a true system approach to the prevention, identification and management of PU across all partners.<br>• Although there has been some variation in quarterly data over the year we have achieved an overall year on year reduction. This is a significant achievement when considering that GHC have had an increase in admissions to CoHo inpatient beds with pre-existing pressure ulcers. This has also coincided with an increase in the community nursing caseload with people who are referred in with pre-existing PU's. Woven into these challenges are those with reduced mobility arising from COVID infections over the year. Overall the recovery rates have improved throughout the year reducing the impact for those presenting with a pressure ulcer. |
| **Lead** | NF |




| | |
|---|---|
| **Target Achieved H1** | Y |
| **Target Achieved H2** | Y |

**Next steps : Continuation of the monthly monitoring of pressure ulcer incidents throughout the Trust .**

| SAFE : QUALITY PRIORITIES 2022-2023 | |
|---|---|
| **Standard** | **2 Falls prevention with a focus on reduction in medium to high harm falls based on 2021/22 data . Developing a falls collaborative within the One Gloucestershire Integrated Care System** |
| **Performance** | **Target** – the % reduction quarter on quarter in the number of medium and high harm falls within inpatient units. |
| **Commentary** | • The number of falls recorded which resulted in medium to high harm in Q4 22-23 compared to the same time period last year and previous quarters this year is significantly reduced with the total number of falls year on year remaining stable at 27 in (21-22) and 28 in (22-23) respectively. (Data in relation to higher harm falls is reactive to slight change in numbers due to the low percentage of instances in the source data.)<br>• The leadership of the Trust wide Falls group has recently been transferred to the Nursing Quality and Therapies directorate (NQT) to ensure consistency of practice, and a strong focus on evidence based falls prevention in all areas of GHC.<br>• This refreshed group is looking to produce and implement a framework with the ambition of:<br>• A reduction in the number, and impact of falls in both **community and inpatient** settings, (hence widening the reach of the indicator)<br>• Improving both staff **and patient awareness** of falls risks,<br>• Reduce the variation of practice in falls prevention.<br>• The focus will be to promote a culture in which falls prevention, risk assessments and interventions are everybody's business. |
| **Lead** | HW |

| Year 21-22 | No | Year 22-23 | No |
|---|---|---|---|
| Q1 | 5 | Q1 | 12 |
| Q2 | 4 | Q2 | 9 |
| Q3 | 5 | Q3 | 5 |
| Q4 | 13 | Q4 | 2 |

| | |
|---|---|
| **Target Achieved H1** | N |
| **Target Achieved H2** | Y |

# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

**SAFE : QUALITY PRIORITIES 2022-2023**

| | |
|---|---|
| **Standard** | **3 End of Life Care (EoLC) - with a focus on refreshing the collaborative One Gloucestershire approach to improving EoLC across the county . This will support the 6 ambitions for Palliative and End of Life Care including improving systems to identify those eligible using the Supportive and Palliative Care Indicators Tool (SPICT), improving the access to advance care planning, the ReSPECT V3 form, and increasing symptom management training for staff to support non - cancer patients.** |
| **Performance** | **Target** – Our aim is to enable all our staff to be compassionate, confident and competent in delivering EoLc in our hospitals and in the community |
| **Commentary** | |

| Quality Priority Plan | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| **GHC EoLc priorities align with the One Gloucestershire approach to improving EoLc across the county and support the Six Ambitions for Palliative and EoLc. Our aim is to enable all our staff to be compassionate, confident and competent in delivering EoLc in our hospitals and in the community.** | **Compassionate:**<br>• Achieve a continued reduction in number of EoLC complaints<br>• Celebrate and share good practice<br>**Confident:**<br>• Continually provide and review the delivery of End of Life Masterclasses<br>**Competent**:<br>• Monitor number of people attending education and training<br>• Consider the CQC recommendation of ensuring that EOL training is mandatory for all clinical staff | • Develop and share workstreams with Experts by Experience | | Compassionate<br>• Evaluation of annual rate of reduction against previous year.<br><br>**Confident**<br>• Annual evaluation of Masterclass feedback<br><br>**Competent**<br>• Annual evaluation of Masterclass attendance. |

| | |
|---|---|
| **Lead** | DW |
| • **Plan - Reduction in number of EoLc complaints**<br><br>• Celebrate and share good practice/ compliments | The EoL lead is involved in complaints or concerns at an early stage in the process to enable issues to be addressed in a compassionate and timely manner and at a point where a real difference can be made to the care path for the patient. Data from 2021/22 compared to 2022/23 evidenced a 50% reduction in the number of formal complaints that related to EoL.<br>During Q2, "Dying Matters week" was held and well received. Service Directors from community teams and CoHo's routinely share a monthly summary of compliments received, the CQC Report (where EoL care was specifically inspected across GHC, and was rated as "good" for Safe, effective, responsive and well led" and **"outstanding**" for caring) was shared internally and externally.<br><br>The NACEL audit which benchmarks EoL care against other NHS providers took place in September 2022 and demonstrated that GHC were above the national average with scores of good and excellent being recorded . |
| • Plan – Continually provide and review the delivery of the EOL Masterclasses for Registered Practitioners Give consideration to the CQC recommendation to ensure that EOL training is made mandatory for clinical staff<br>• Review training for Non registered staff | The education Programme was collaboratively developed following discussions with Community Hospital staff and District Nurse teams EoL Masterclass dates were available for staff to self book throughout the year resulting in positive feedback from attendees stating that the course outcomes were achieved and the course was either "very beneficial" or "beneficial" to their present role.<br><br>Face to Face (F2F) sessions for non registered practitioners were held at Charlton Lane Hospital (CLH) on 8th December and 9th Feb, it is proposed that this session for non reg staff is rolled out across the whole trust in Coho's, community teams and reablement.<br>Communication skills training for call handlers and ward clerks who have difficult conversations with families are being planned<br><br>Specific Comms skills training for Registered staff is also being planned for 23/24 Masterclasses |
| • Plan - Number of people attending education and training<br>• Develop and share workstreams with Experts by Experience (EbE) | Progress – As at end of Q1 122 people had attended the End of Life Masterclass, the most popular classes being 'Recognising when someone was dying' (27 attendees) and Spinal Cord Compression (25 attendees). In Q2 there were 53 attendees to 6 Masterclasses, In Q3 31 people attended 5 different Masterclass sessions. Q4 – 163 people attended 11 Masterclasses.<br>The difficult story of an Expert By Experience (ExbE) whose dad experienced EOL care at home has been filmed and plans are in place to share the film during Dying Matters week May 2023 with the aim to educate. |

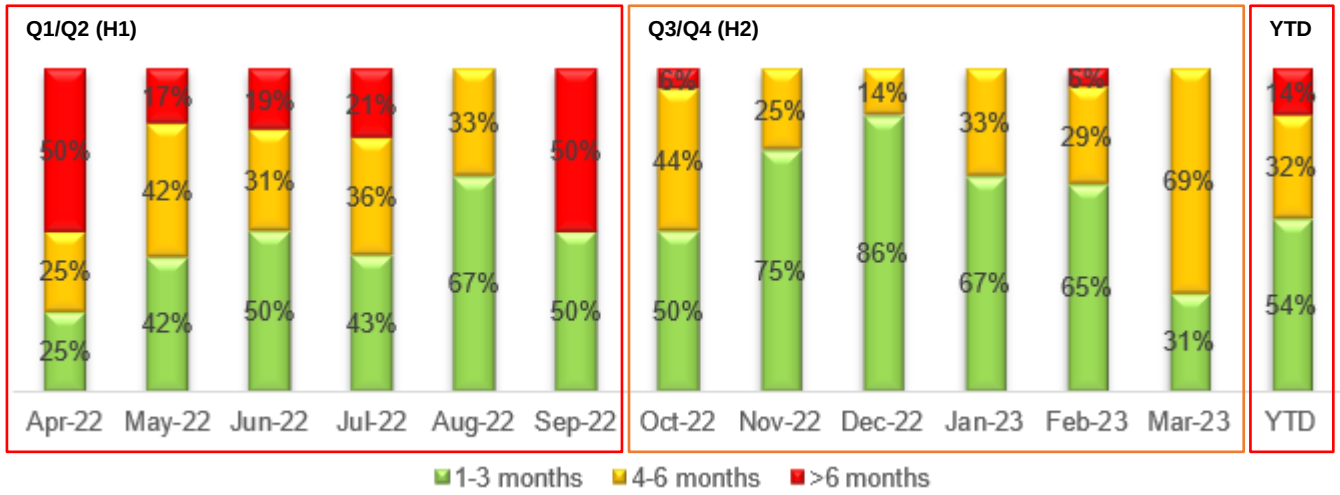
| | |
|---|---|
| **Target Achieved H1** | Y |
| **Target Achieved H2** | Y |

**Next steps : Continuation of the Quality Priority throughout 22-23 and associated reporting of year on year analysis.**

# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

| RESPONSIVE : QUALITY PRIORITIES 2022-2023 | |
|---|---|
| **Standard** | **4-Patient and Carer Experience Team (PCET) Focus on incrementally reducing the time taken to provide a final response letter to people who have raised a formal complaint about Trust services improvement in completion times will be achieved quarter on quarter.** |
| **Performance** | **We set ourselves an ambitious target for 2022/23 to reinvigorate the complaints process, drive up performance and provide a better experience for patients, carers and staff.**<br>In 2021/22, 12% of complaints were closed within 3 months and 37% of complaints were closed within 6 months.<br>For 2022/23, the target was: 95% of all complaints closed within 3 months<br>100% of all complaints closed within 6 months |
| **Commentary** | • At the beginning Q1 of 2022/23 there were **54** open complaints, **50%** of which had been open for more than six months and **0** of which had been open for more than twelve months.<br>• At the beginning Q2 of 2022/23 there were **43** open complaints, **21%** of which had been open for more than six months and **0** of which had been open for more than twelve months.<br>• At the beginning Q3 of 2022/23 there were **38** open complaints, **6%** of which had been open for more than six months and **0** of which had been open for more than twelve months.<br>• At the beginning Q4 of 2022/23 there were **44** open complaints, **0%** of which had been open for more than six months and **0** of which have been open for more than twelve months.<br>• Overall, 54% of complaints were closed within 3 months and 86% with six months; as such, the target for the year was not met. However, the target for 6 months was achieved in H2.*<br>• 100% of complaints were acknowledged within 3 days, which met the national target (up from 94% in 2021/22)<br>*1 x complaint referred to PHSO due to complexity and challenge, which is reported in our figures for this period. |
| **Lead** | HW |




Target Achieved H1

Target achieved H2

N

Partially

# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

| RESPONSIVE : QUALITY PRIORITIES 2022-2023 | |
|---|---|
| **Standard** | **5 Friends and Family Test (FFT) - with a question to ask people for their views on the quality of their care, as highlighted in our 2020 CQC Audit Community Mental Health Survey action plan .** |
| **Performance** | **Target** – To establish a new question in the survey with a focus on "What really matters" to the patient continued from 21-22 |
| **Commentary Asking people for their views on the quality of their care** | **Scoping exercise on Quality of Care**<br>• A scoping exercise will take place as part of the wider Community MH Transformation work to identify what is important and meaningful to service users and carers and What Matters to Me…<br><br>**Friends and Family Test**<br>• Rollout of the new Friends and Family Test (FFT) to ensure regular feedback about care.<br>• Copies of the FFT to be made available across all services.<br>• Patients providing for feedback on discharge via SMS and email.<br>• Patient providing feedback via link on Attend Anywhere<br>• Launch of a carers FFT to seek feedback on the experience of carers who are in contact with our services – to be launched during Carers week in June 2021<br>• FFT, Carers FFT, and Carers survey all available on Trust website<br>• Communications campaign to raise awareness of our feedback mechanisms<br><br>**Leaflets and comment cards**<br>• New complaints leaflets, posters and comment cards to be made available throughout all Trust service. |
| **Lead** | HW |

| Action | Update Q4 |
|---|---|
| Scoping Exercise | • A new question has been being added to the new Friends and Family Test (FFT) in order to form a baseline for our understanding of whether patients are giving the opportunity to discuss the aspects of their care that are particularly important to them: '*Did you have the opportunity to talk about the aspects of care/treatment that matter to you?'* This is followed by a freetext question for respondents to add additional information. Monitoring of feedback from this question will be ongoing. |
| FFT | • The new Friends and Family test (FFT) process was implemented in October 2022. During Q1 the new FFT survey was designed by PCET in the updated Snap survey tool 'Snap XMP'. During Q2 the IT Applications Team and the BI Team tested the updated automated process to ensure this encompasses all Trust services where automated surveys are required. Other methods for surveying using the FFT are also being implemented by PCET, including paper, iPads, QR codes and electronic survey links. The new FFT also allows carers to provided feedback about their own experiences. The new FFT process was launched during Q3 (20th October 2022).<br>• The current FFT question does encompass quality of care, although is broader: <u>The question currently asked is:</u><br>*Overall, how was your experience of our service* (this is the National FFT question). Answer options: very good - good – neither good nor poor – poor – very poor – don't' know<br>• Additional questions have also been added including: '*Did you have the opportunity to talk about the aspects of care/treatment that matter to you?'* and *'Has the outcome or next steps of your care/treatment been discussed with you?'*<br>• Q4: A QI project has been initiated to consider how the FFT is used within clinical teams across the Trust |
| Leaflets and Comment Cards | • New complaints leaflets, posters and comment cards are now available and have been distributed across the Trust.<br>• Additional copies available from PCET on request. |

| | |
|---|---|
| **Target Achieved H1** | NA |
| **Target Achieved H2** | Y |

**Next steps : Continuation of the Quality Priority to 23-24 and associated reporting of year on year analysis.**

# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

**SAFE : OUALITY PRIORITIES 2022-2023**

| | |
|---|---|
| **Standard** | **6 Reducing suicides - with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services. We will work to the aspirations of the Zero suicide Alliance to support the aim for zero suicides within our mental health inpatient units by 2022.** |
| **Performance** | **Target** – To establish an outcome of zero suicides within our mental health inpatient units by 2023 |
| **Commentary** | There will be a staged implementation of NHSE/I mandated zero Suicide Plan for inpatient MH services. |
| **Plan 1 - The Positive & Safe Group will develop and deliver a work plan with a clear focus on suicide prevention, ligature reduction programmes, use of assistive technologies, and proactive and collaborative clinical risk management.** | **Progress**<br>• Positive & Safe Group meets bimonthly and has oversight of suicide prevention activity including routine review of themes and trends concerning self-harm and ligature incidents.<br>• The Clinical Protocol for the Removal and Physical Management of Ligatures and Near Hanging was ratified in Q2<br>• Reduction of Ligature Risk Policy was revised to include training requirements and ratified in Q4<br>• The mental health inpatient ligature audit cycle 2022/23 was completed during Q3. Additional governance of progress continues via quarterly Ligature Audit Action Planning Meetings chaired by Hospitals Directorate Service Director, with further oversight via quarterly Executive Led Ligature Management meetings. All reduced ligature capital works identified for WLH (windows, doors and door top alarms) were completed by March 2023<br>• Ward based suicide prevention champions are in place at WLH.<br>• Weekly ligature and self-harm incident reports were developed and launched during Q1 and are now produced and disseminated weekly by the Patient Safety Team. These provide ward managers with near 'real time' weekly analysis of this activity. |
| **Plan 2 – To develop a comprehensive and robust training programme focussed on suicide reduction, suicidal thinking, assessment and conversation. This will be provided for all grades of staff, across all fields, beginning with those working in inpatient settings.** | • GHC now offers 2 online courses via Care to Learn 1) 'Suicidal Thoughts and Assessment' – Having the Conversation, 2) 'We need to talk about suicide' – Health Education England.<br>• In addition, the Positive & Safe Group identified 3 other freely available online course which are indicated in the 'Its safe to talk about suicide' leaflet' these are – Zero suicide alliance -www.zerosuicidealliance.com,'Real talk' – Grassroots, 'Suicide Prevention Awareness' – The learning pool.<br>• Statutory & Mandatory training for inpatient staff also includes assessing and managing clinical risks, searching of patients and observations and therapeutic engagement<br>• The online training resource for undertaking inpatient ligature audits was finalised and launched during Q2 and is available for all staff via Care to Learn. Following ratification of the Reduction of Ligature Risk Policy in Q4, this is now mandatory for all staff undertaking ligature audits. |
| **Plan 3– To fully integrate, where possible, experts by experience, carers and families in the action plan to improve overall outcomes and service delivery in keeping with trust values. To further promote existing good practice such as the Letter of Hope, Little Red Book and the Stay Alive app and also to develop and implement the Its safe to talk about suicide leaflet.** | • Letter of Hope was relaunched and circulated via the Gloucestershire Suicide Prevention Partnership Forum during 2021/22. This was updated during Q2 to signpost people to the Gloucestershire Support after Suicide Service and reprinted during Q3. Reprints were distributed during Q4.<br>• The 'Its safe to talk about suicide' leaflet was updated during Q2 to signpost people to the Gloucestershire Support after Suicide Service. It was reprinted during Q3 and distributed during Q4<br>• The Stay Alive app was refreshed during Q2, liaison with the App Developers will occur during 2023/34 for the next refresh. |
| **Plan 4– To develop specialist practitioner roles. The focus of the Advanced Nurse Practitioners will be working with complex patients at risk of harm, supporting ward teams and medical staff in assessing, managing and reducing risk inclusive of serious self-harm.** | • Appointment of 3 x Advanced Nurse Practitioners (ANPs) to work with complex patients at risk of harm in MH & LD inpatient units completed.<br>• The 3 ANPs are currently undertaking training and development |

## SAFE : QUALITY PRIORITIES 2022-2023

| | |
|---|---|
| **Standard** | **6 Reducing suicides - with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services. We will work to the aspirations of the Zero suicide Alliance to support the aim for zero suicides within our mental health inpatient units by 2022.** |
| **Performance** | **Target** – To establish an outcome of zero suicides within our mental health inpatient units by 2023 |
| **Commentary** | There will be a staged implementation of NHSE/I mandated zero Suicide Plan for inpatient MH services. |
| **Plan 5 – For the Inpatient teams to continues to assist in the provision of good follow-up and transition across teams to reduce risks and ensure safe discharges.** | • 48hr follow up post discharge remains a KPI for the Trust and is monitored monthly via the Performance Dashboard.<br>• Dialogue with community mental health teams began during Q1 to consider the validity of continuing to complete the Community Mental Health Team Suicide Prevention Toolkit developed by the NPSA over a decade ago. Feedback indicates that this may no longer be fit for purpose. During Q2 Crisis and Recovery Teams agreed to embed the learning identified through the National Confidential Inquiry into Suicide and Safety In Mental Health. via the NCISH self assessment process. Work on this will commence during 2023/24 following the Trust's review of the 2023 NCISH Report published in Q4 |
| **Plan 6 – To fully engage with the Gloucestershire Suicide Prevention Partnership Forum (GSPPF), neighbouring trusts and those further in the South to work together to share thoughts, ideas and experiences** | • GHC remains an active member of the Forum and inputs actively into the multiagency suicide surveillance group within the county. The GSPPF Steering Group is in the process of refreshing its workplan for 2023/24.<br>• During 2021/22 the Trust played an active role in the GSPPF tendering process for developing a Suicide Bereavement Support Service for the County. The contract was awarded to Rethink and the Gloucestershire Support after Suicide Service was launched in March 2022. Awareness raising and signposting to this service continues to be promoted through the refreshed *Letter of Hope* and *Safe to Talk about Suicide leaflets.* |
| **Lead: JW** | |

| | |
|---|---|
| **Target Achieved H1** | NA |
| **Target Achieved H2** | Y |

# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

| | |
|---|---|
| **Standard** | **7 Learning Disabilities - a focus on the Hospital /Personal Passport utilisation, and roll out of the Oliver McGowan Tier 1 and tier 2 training programme. The trust aims to train 90% of our workforce.** |
| **Performance** | **Target** – To achieve a target of circa 90% of the workforce to be trained at L1 by the end of Q4. To provide an update and focus on the utilisation of patient passports . |
| **Commentary** | Oliver McGowan - Level 1 training:<br>• The independent evaluation carried out by NDTi (the National Development Team for Inclusion) found the Gloucestershire version of Tier One training to be the most highly rated by participants. In light of this it is this model, co-designed by GHC, Inclusion Gloucestershire and Family Partnership Solutions in Gloucestershire that has been rolled out nationally as part of the mandatory training and has been launched on the e-learning for healthcare platform.<br>• Gloucestershire has developed and is now delivering Train the Trainer courses in line with its contract with HEE. These began in November 2022 and were due to be completed by March 2023. However, take-up of places was lower than anticipated and it is likely that the contract will need to be extended to offer some additional dates.<br>• GHC worked collaboratively with Mencap, NAS and HEE to develop the one day training package for Tier Two, which encompasses several elements of the package developed locally. GHC sent a representative to attend the first Train the Trainer course at the end of January 2023.<br>• The locally developed training at both Tier 1 and Tier 2 has continued to be provided whilst the national models are being developed. Training dates had been advertised both on Care to Learn and on LearnPro, which is accessible to staff working across both health and social care to enable as many people as possible to access the training places. However new courses need to be organised for dates beyond March 2023. This work is underway but capacity is limited as many of the Gloucestershire Experts with Lived Experience are currently busy with Train the Trainer provision.<br>• The Compliance level for all staff (level 1) is currently at 77.3% inclusive of staff bank and **82.1%** if Staff Bank staff are excluded which is an exceptional figure when offset against all of the challenge<br>• 335 members of staff (GHC) have completed the Tier 2 training.<br>• There has been enormous amounts of positive feedback received in relation to the training , some of the quotes which come from social media (e.g. Facebook and Twitter) are shown below .<br>• We actively promote and share the My Health Passports however due to the impact of Covid the planned scoping work with other organisations such as the Hospitals Steering Group and Inclusion Gloucestershire was halted with the intention being to resume this workstream in 23/24. |
| **Lead** | KA |


**Target Achieved H1** NA

**Target Achieved H2** Partially

**Next steps : Continuation of the Quality Priority through to 23-24 and associated reporting of year on year analysis.**

| SAFE : QUALITY PRIORITIES 2022-2023 | |
|---|---|
| **Standard** | **8 Children's Services - transition to adult services with a focus on ensuring a safe and prompt transfer between services, developing pathways, standardising practice, and reducing delays in care . Fidelity to the care pathways will be evaluated through participation in the NCEPOD study .** |
| **Performance** | **Target** – To engage and report in line with the NCEPOD Study. |
| **Commentary** | • In 2021-22 GHC were approached to support a NCEPOD submission around CYP with specific conditions transitioning to adult services. Data collection tools and methodology were circulated however in GHC we were not in a position to complete as we are unable to identify the cohort of children required as we don't hold diagnosis codes in electronic records and also don't see CYP in our community hospitals. The transition team who are leading and coordinating this project were contacted and agreed to send us cases from other trusts where GHC has been identified as a partner in the care delivery .<br>• The initiative continues to 22-23, clinical questionnaires have been completed for one child for CCN, CCT PT and OT they came through as separate requests and the case notes for all have been submitted. We have received no further contact from NCEPOD . However as an organisation we adopted the Ready Steady Go Transition Tool a number of years ago. A recent audit has shown that this tool is not well used and is not relevant to the majority of young people supported by our community services. There is now a whole system approach to review the transition to adults pathway, tools and processes led by the ICB. In the first instance the group aims to explore and better understand the challenges and barriers, with a view to coproducing solutions to enable more effective transitions.<br>• No further data requests were received in 22-23 to enable reporting in line with the NCEPOD study therefore the target was not achieved but the mitigation for this is that the circumstances were beyond organisational control and the appropriateness of this indicator will be reviewed . |
| **Lead** | JR |

**Target Achieved H1** NA

**Target Achieved H2** N

**Next steps : the receipt of data requests is is not within the gift of GHC to control. Consideration to be given to removing this KPI in the forthcoming year.**

| SAFE : QUALITY PRIORITIES 2022-2023 | |
|---|---|
| **Standard** | **9-Embedding learning following patient safety Incidents - with a focus on sharing and learning from experience and investigations to develop and improve standards of care . This will be measured through the numbers of post investigation embedding learning workshops delivered and the number of lessons bulletins issued. alongside implementation of the Civility Saves Lives initiative, with assurance measured against the project implementation goals and evaluation over the reporting period .** |
| **Performance** | **Target** – To deliver 5 embedded learning events by the end of Q3 and 8 embedded learning events by the end of Q4. |
| **Commentary:**<br>**This indicator is carried forward from 21-22 where increased clinical need caused by winter pressures prevented the achievement of the H2 target.** | • At the close of Q4 there were 9 embedding learning events that have been held throughout the organisation and therefore the H2 target of achieving a minimum of 8 embedding learning workshops being delivered has been achieved. We are seeking and will amalgamate feedback from these sessions which will be reported upon .<br>• The events covered both general and specific themes generated from the learning associated with individual SI's and involved presenting to teams from Wotton Lawn, Charlton Lane and the Dilke Hospitals plus Post and Neonatal Care teams and Health Visiting.<br><br>**Civility Saves Lives :**<br><br>This is a grass roots campaign aimed at raising awareness of the impact of incivility on team and individual performance. Incivility and rudeness is surprisingly common and on the rise, thus patient safety outcomes are affected and there is a negative impact on clinical performance. This programme is progressing with resources available on our intranet for colleagues. These resources for awareness raising include 'The Power of Civility in Healthcare', how civility leads to better outcomes and the training available on Care to Learn. Many teams are requesting support for team development sessions on this work to gain a greater understanding. A coproduction approach continues with four teams to design as a 'test and learn' for Civility Saves Lives. The four early adopter teams are Estates and Facilities, Digital Services, FOD Hospitals and Charlton Lane Hospital and next steps are to come together in March to share commonalities, focus on the next steps and prioritise top key areas. Review of progress at Improving Care Group in May 2023 |
| **Lead JW** | NM |

| Narrative | Number |
|---|---|
| SI Incidents on a page included in Patient Safety Team (PST) monthly reports since April 2022 | 6 |
| Clinical Incidents on a page included in PST monthly reports since April 2022 | 7 |

| | |
|---|---|
| **Target Achieved H1** | NA |
| **Target Achieved H2** | Y |

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# GHC Exec's Update
# Non Executive Directors Quarterly Service Review
# Q3/4 2022/23
# April 2023

working together | always improving | respectful and kind | making a difference

# Working together – Service visits Q3 & Q4 * note delayed visit dates from Q3

| Q3 | Q4 |
|---|---|
| | **Eating Disorder Clinic**<br>19 January 2023 |
| | **Complex Needs Service**<br>25 January 2023 |
| | **Tewkesbury MIIU**<br>06 February 2023 |
| | **Adult MSK Physiotherapy, Stroud**<br>08 March 2023 |
| | **Charlton Lane Hospital**<br>13 March 2023 |
| | **IAPT –** Report being finalised<br>20 March 2023 |
| | **Patient Flow Team -** Report being finalised<br>28 March 2023 |
| **Crisis Team, Lexham Lodge**<br>15 February 2023 | **EDNS** Report being finalised<br>10 May 2023 |

# Living our Trusts Values - *Making a difference*

## Positive Feedback from NED colleagues (as described in visit reports) - Q4 (1)

*I was very impressed with the enthusiasm and energy of this extremely busy team. They are managing remarkably well in the face of recent overwhelming new referrals. I strongly recommend colleagues to visit this excellent service.*
**Eating Disorder Service**

*They embody all the Trust values, particularly the total commitment to coproduction and personalisation, and are having a major impact on both current NHS and partner services as well as the individuals, families they directly support. We should be nominating the service for awards but also providing support to enable them to seek to publish in relevant journals.*
**Emotional Complex Needs Service**

*For me, the team have got it right. They know their strengths, they continue to learn and develop, they put patients first and they support each other.*
**Tewkesbury MIIU**

*The member of staff I spoke to said that they felt listened to by the Trust. The staff interaction with patients and relatives was calm, kind and approachable.  I particularly liked the pictures of staff with pen portraits with details about them and their likes and dislikes as well as hobbies etc.*
**Charlton Lane Hospital**

*I was hugely impressed with how X effectively used the time with the patient to understand the issues and demonstrate exercises and also the use of support tape on knees. X demonstrated great focus upon the needs of the patient and had a caring and un-rushed approach despite the busy schedule which she had for the day.*
**Stroud Therapy Department**

# Visit Outcomes Update – postponed visits Q2/Q3

| Service | Recommendation/Questions | Progress | Status |
|---|---|---|---|
| **Podiatry Service** | 1. Concern raised about staffing levels due to vacancies resulting in increased wait times.<br>2. Reported senior and experienced staff are leaving due to limited career progression.<br>3. Explore work with care homes to develop their expertise to support patients with podiatry related needs | **Current position 9 vacancies, new band 6 from outside of the Trust joining us in May July 23 - our 2 apprentices qualify and will be staying with us and 2 planned newly qualified jogging us in August 2023 – So vacancy rate will be reduced to 4. Our Lead Podiatrist has been central to this progress and is presenting regionally on the Trust apprenticeship programme in this clinical area. This is positive in light of the national shortage of podiatrists.**<br>**From exit interviews and management feedback - colleagues leave for a variety of reasons e.g. moving closer to elderly parents, childcare issues, retirement and leaving to work in private practice (money and less responsibility).To aid retention, all colleagues are offered access to training courses to help career progression. Noting the service is funded on band 5/6 workforce model we are seeking to utilise apprenticeship routes to deliver a supply of capable podiatrists.**<br>**Additional care home work is being explored with commissioners noting service capacity and funding limitations**<br>**Discussed at Exec Committee via the monthly report and learning shared through Operational Governance routes.** | **CLOSE** |

# Visit Outcomes Update – postponed visits Q2/Q3

| Service | Recommendation/Questions | Progress | Status |
|---|---|---|---|
| **Crisis Team, Lexham Lodge** | 1. Service last inspected by CQC in 2016 (rated Outstanding). Since then model has changed and pressures re inpatient demands. How CQC ready is the service?<br>2. Assurance required about change to the 'triage in a police car' model<br>3. Team could operate a more effective service with more non-medical prescribers. Can this be considered?<br>4. How is the inpatient bed pressures impacting on MHA assessments and flow into hospitals from crisis teams? | **The team is prepared for a CQC inspection and has been supported via NTQ in terms of peer review work as presented recently at Quality Committee and Public Board . The model changed so that patients and carers have faster access to care and support but we not the demand pressures on the service and feedback from stakeholders and users on this issue**<br>**Delivery of the car based service has been challenge due to sickness , operational issues with SWAST and Police. We pleased to report that as of April 6 the Mental Health Rapid Response Vehicle has commenced however due to funding it is only currently operational Mon – Thurs 2pm – midnight. Work is ongoing re commissioning and developments. Positively we have seen benefit to service users in reduction of 136 with our current Police Triage model.**<br>**We are assured we have appropriate numbers of colleagues going through medication management courses, there was a delay in due to Covid and staff availability , positively this is now not a issue.**<br>**Flow issues are challenging but the Exec team are assured safe process are in place to manage pressure on admissions via the Trust AHMP hub and bed management team**<br>**Discussed at Exec Committee monthly report and learning shared through Operational Governance routes. Alongside recent " Deep Dive " presentation to Quality Committee.** | **CLOSE** |

# Visit Outcomes Update – completed visits Q4

| Service | Recommendation/Questions | Progress | Status |
|---|---|---|---|
| **Eating Disorder Service** | 1. Review cover arrangements for blood tests and ECGs as safety risk if not assessed in a timely manner.<br>2. Consider option for additional team spaces<br>3. Explore arrangements with the Acute Trust regarding shared inpatients and support | **Cover arrangements have been checked with service lead and robust plan is in operation.**<br>**Additional space has been utilised at Eastgate House and colleagues are co-located with other teams and VCS's working with eating disorders, so this has been a very positive action.**<br>**Ongoing discussions via the *ICS Eating Disorders Pathway work*. We also developing plans with commissioners and Acute to explore use Expert by Experience/Peer Support Workers.**<br>**Discussed at Exec Committee via monthly report and learning shared through Operational Governance routes.** | **CLOSE** |

| Service | Recommendation/Questions | Progress | Status |
|---|---|---|---|
| **Tewkesbury MIIU** | 1. Review options for accessing X ray equipment and staff at weekends.<br>2. Develop relationships with colleagues in GHFT<br>3. Review mental health capability and development in the team.<br>4. Follow up commissioning of telephone triage system.<br>5. Review signage at the entrance. | **X Ray access issue is sadly not resolvable in the near future. And access matters are on risk register.**<br>**We are supporting GHFT through our Telephone Triage System and endeavour to ensure good communications.**<br>**Mental Health related devilment is being addressed via MIIU Governance.**<br>**Our Service Directors are currently working on the commissioning of the TT system so hopefully that will be completed in the next couple of months.**<br>**Service manager reviewing signs with team.**<br>**Discussed at Exec Committee monthly report and learning shared through Operational Governance routes.** | **CLOSE** |

# Visit Outcomes Update – completed visits Q4

| Service | Recommendation/Questions | Progress | Status |
|---|---|---|---|
| **Complex Emotional Needs Service** | 1. Career/reward structure for Peer Support Workers alongside good support for wellbeing.<br>2. Family and Friends Group is incredibly valuable both in supporting health and wellbeing Is it a model we could use in other areas?<br>3. When will the OATS service commence?<br>4. Investment in the further enhancement to the service to support hospital admissions and GP practice appointments | **Service lead addressing peers support structure and development matter**<br>**Family groups are also delivered in our AOT, GRIP, Eating Disorders and Perinatal**<br>**OATS service funding has been secured and is planned to commence in Q1.**<br>**Although some expansion funds have now been announced that will help us to deliver to more of the county but isn't progressed at the scale we had hoped.**<br>**Work within Glos City has been reviewed with an option appraisal completed as to the for roll out across the county. This is being discussed with commissioners and recommendations will be taken forward within the 23/24 budget allocations for CMHT developments.**<br>**Discussed at Exec Committee monthly report and learning shared through Operational Governance routes.** | **CLOSE** |

# Visit Outcomes Update – completed visits Q4

| Service | Recommendation | Progress | Status |
|---|---|---|---|
| **Charlton Lane Hospital** | 1. To support discharge, reduce falls and ensure good interplay between the wards ideally there should be a seven-day therapy service available.<br>2. It is hoped that the Capital Programme can facilitate the creation of a more appropriate female lounge.<br>3. Closed cultures within MH Units are a concern. There are MH advocates (funded by the ICB) that have visited CL but there has been a reduction in visits due to vacancies of late.<br>4. Each ward has an EAP (an unregistered role) that supports engagement, activity and physical exercise. It is hoped that a business case will support further funding given the importance of physical activity.<br>5. Staffing remains an issue. There are a number of staff vacancies at CL.16.5 vacancies of which 5 are qualified nurses<br>6. 6. NED did not see any posters on boards about Freedom to Speak up | **Plans in place with OT & Physio Lead, discussions around budget required to support a seven-day service. Working group is being set up and the clinical roles for OT & Physio are going to be mapped out to understand how we can develop the therapy provision within MH hospitals. Plans are in place to create a more appropriate space for female patients..**<br>**"Closed Culture" issue is featured on IP managers monthly meeting and raised with a leaders within the Hospital.**<br>**ICB lead have given assurance that advocacy vacancies are now addressed NTQ are developing an activity monitoring metric for reporting in the Quality Dashboard Anti- Close Culture section. The Engagement Activity and Physical Health Co-ordinator roles are funded by non-recurring HEE monies to support the development of HCSW across the South West. Work is underway to see how fusing for this can be made permanent as it is well noted as great benefit to our patients.**<br>**There are currently 6 RMN vacancies across the three wards of CLH but following International Nurse Recruitment, there are eight International Nurses joining CLH and these staff will arrive in April 2023. In addition, three Newly Qualified Nurses have been recruited from a recent recruitment event at the University of Gloucestershire, who will be joining us in December. Following the ICB Healthcare support workforce event last year, we are likely to be over recruited to B3's. Now waiting for these staff to complete all the necessary recruitment paperwork before they can start on the wards within the next 3 months. There are posters around the Hospital, however in the reception area, during the time of the visit no poster was. and posters are now being added in this area. Issue discussed with FSUG.**<br>**Discussed at Exec Committee monthly report and learning shared through Operational Governance routes.** | **CLOSE** |

# Visit Outcomes Update – completed visits Q4

| Service | Recommendation/Questions | Progress | Status |
|---|---|---|---|
| **MSK Physiotherapy Service - Stroud** | 1. Operational issues since move to new premises (signage, waste, post)<br>2. Is there a case for there being only one provider Trust of MSK Physiotherapy services in the County?<br>3. Actions to address waiting lists and length of waiting times.<br>4. Significant staff vacancy rates (14% - 9 WTE) in the physio team Thereby significant reduction in capacity. How is this being addressed? | **Operational issues from move to new premises have been addressed. There is no current commissioning discussion regarding a single provider or intentions of this. Both providers work well together and collaborate to ensure a standardised approach in delivering the ICB MSK Pathway. This is supported by an established MSK Clinical Programme Group.**<br>**Current work streams and Recovery to address this are documented in Service Recovery Document and are multi-faceted in approach. With Reference to new initiatives, we are considering options of *blitz Clinics*, Phone not Paper triage, Change to operating models. Rapid appointments with emphasis on patient initiated Follow ups(PIFU)**<br>**Re vacancies there are a range of initiatives seeking to address this challenge, including retention, agency, new recruitment initiatives etc. Since NED visit there are circa 7 WTE appointment now in the recruitment pipeline.**<br>**Discussed at Exec Committee monthly report and learning shared through Operational Governance routes.** | **CLOSE** |

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**AGENDA ITEM: 08**/0523

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 25 MAY 2023**

**PRESENTED BY:** Sandra Betney, Director of Finance & Deputy CEO

**AUTHOR:** Chris Woon, Deputy Director of Business Intelligence

**SUBJECT:** **PERFORMANCE REPORT – APRIL 2023/24 (MONTH 1)**

| | |
|---|---|
| **If this report cannot be discussed at a public Board meeting, please explain why.** | *N/A* |

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

**The purpose of this report is to**
This performance dashboard report provides a high-level view of performance indicators in exception across the organisation. Performance covers the period to the end of April (Month 1 2023/24). Where performance is not achieving the desired threshold, operational service leads are prioritising appropriately to address issues. Service led Operational & Governance reports are presented to the Business Intelligence Management Group (BIMG) and more widely account for performance indicators in exception and outline service-level improvement plans.

**Recommendations and decisions required**
The Board are asked to:

- **Note** the Performance Dashboard Report for April 2023/24 as a **significant level of assurance** that the Trust's performance measures are being met or
- Appropriate service action plans are being developed or are in place to address areas requiring improvement

**Executive summary**

**Business Intelligence Update**
2022/23 Business Intelligence business planning highlights are presented on page 1.
Highlights include:

- 36 PH Community Health integrated service level (profile) reports are published (85%) with a further 5 scheduled for deployment by the end of July. Finance and Learning will be incorporated into these reports over June and July. Equivalent MH reporting is currently in development. Community and Mental Heath inpatients will follow in Q2.
- Learning and Development Tableau reports have been published for staff use in May 2023.
- Mental Health Community, Inpatient and CYPS Benchmarking summary reports were presented to Execs in May and will come to Resources Committee in June 2023. There is a plan for benchmarking to integrate into business as usual activities.

**Chief Operating Report**
A Chief Operating Report authored by the Chief Operating Officer can be found on Page 2.

**Performance Update**
The performance dashboard is presented from page 3.

- **Nationally measured domain**

3 indicators covering Clostridium Difficile and adolescent Eating Disorder services (2) were under threshold for the period.

- **Specialised & directly commissioned domain**

In addition, attention is drawn to a further 6 health visiting indicators which did not meet their thresholds for the period.

- **Locally contracted domain**

Talking Therapies (IAPT), Eating Disorders (3), Carers assessments, Social care reviews and a new wait measure for Children & Adolescent Mental Health Services (CAMHS) were the areas in exception for the period. These were not only outside of their expected threshold, but where applicable would have also demonstrated unusual variation (within Statistical Performance Control SPC limits) for the period.

- **Board focus domain**

5 indicators were deemed in exception (outside of SPC and threshold) for the period which included Pressure Ulcers, Physical Health Inpatient Length of Stay, Personal Development Reviews (Appraisals) and Sickness Absence.

- **Indicators not in exception**

It is further noted that there are additional indicators outside of threshold but are either within normal, expected variation or have confirmed data quality issues that are administrative only and resolution is assured. These indicators are not formally highlighted for exception but are available for routine daily monitoring by operational and support services within the online Tableau reporting server.

However, some of these items are presented to highlight signs of positive performance (such as cumulative leave recording and turnover) or potential areas for closer awareness and monitoring. An end of 2022/23 Cumulative leave (recorded) position is also reported within this report as it wasn't available last period.

**Risks associated with meeting the Trust's values**
Where appropriate and in response to significant, ongoing and wide-reaching performance issues; an operationally owned Service led Improvement Plan which outlines any quality impact, risk(s) and mitigation(s) will be monitored through BIMG.

| **Corporate considerations** | |
|---|---|
| **Quality Implications** | The information provided in this report can be 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 provided. Data quality measures are being introduced for 2023/24. |
| **Resource Implications** | The Business Intelligence Service works alongside other Corporate service areas to provide the support to operational services to ensure the robust review of performance data and co-ordination of the combined performance dashboard and its narrative. |
| **Equality Implications** | Equality information is monitored within BI reporting. |

| | |
|---|---|
| **Where has this issue been discussed before?** | BIMG 18 May 2023 |

| | |
|---|---|
| **Appendices:** | *None* |

| | |
|---|---|
| **Report authorised by:**<br>Sandra Betney | **Title:**<br>Director of Finance |

Gloucestershire Health and Care NHS Foundation Trust

**Snapshot Month**
April

# Performance Dashboard Report & BI Update

Aligned for the period to the end April 2023 (month 1)

This is the first Performance Dashboard for the new financial year covering the period of April 2023 (Month 1). In line with the planned Performance Indicator Portfolio reconfiguration, this report - for the first time - presents performance indicators to the Board across four new domains including **Nationally measured**, **Specialised & Direct Commissioning**, **Locally contracted** and a **Board focus**. All items in exception are presented this month however once this format establishes itself, the intention is for the Board to focus on a smaller selection of specific indicators as defined by their membership, leaving the Resources Committee to monitor the full exception list.

A fifth **Operational** domain, which includes measures such as waiting times will be monitored operationally each month to examine frontline performance, identify trends or potential recommendations for domain escalation. In support of these metrics a monthly Operational Performance & Governance report (with action plans) is presented to the Business Intelligence Management Group (BIMG).The Resources Committee will routinely consider all exceptions within the fifth Operational domain.

All agreed 2022/23 performance indicators (c.89) have been transitioned into this 2023/24 dashboard. There are c.49 further new indicators identified for 2023/24 that require further clarification (requiring definition, methodology or threshold clarification) or are in various development stages of automation. There are more indicators that need to be developed for service areas such as Sexual Health, Dental and Low Secure Unit and these are in plan for 2023/24. There is an intention for all these indicators to come online as manual lines if automation isn't imminent (or possible). Progress will be monitored through BIMG from June 2023.

## Performance Dashboard Summary

An Executive level observation of operational performance for the period is provided through the Chief Operating Officer's *'Chief Operating Report*' on Page 2.

The dashboard (from page 3) provides a high level view of Key Performance Indicators (KPIs) in exception across the organisation for the period. Indicators within this report are underperforming against their threshold or are showing special cause variation (as defined by Statistical Process Control SPC rules) and therefore warrant escalation and wider oversight. To note, confirmed data quality or administrative issues that are being imminently resolved will inform any escalation decision unless there has been consecutive, unresolved issues across periods. A full list of all indicators (in exception or otherwise) are available to all staff within the dynamic, online server version of this Tableau report. Services are using this tool to monitor wider performance.

Where performance is not achieving the desired results, operational service leads are prioritising appropriately to address issues. Additionally, where appropriate and in response to significant, ongoing and wide-reaching performance issues a single performance improvement plan is held at Directorate level to outline the risks, mitigation and actions.

Finally, areas of note are presented on the last page of the report entitled '**Non-exception highlights**'. These are indicators not in formal exception but acknowledge either positive progress, possible areas for caution and monitoring or context to wider indicators that may be in exception.

## Business Intelligence Summary Update

Of the 55 planned Physical health integrated reports, 14 have been identified as no longer required or have been amalgamated into existing reports and 36 have now been published. Of the remaining 5 reports, 1 is due to be published during May (Lymphoedema), 2 by the end of June (Tewkesbury ARU, Wheelchair Service) and 2 by the end of July (Complex Care at Home, Stroke ESD). Key finance reporting items have been identified and agreed with the Finance Team and published reports will be updated with this during June and July. This has been slightly delayed because Learning & Development data has now become available and it will make sense to include both sources in one exercise. A MH/ LD integrated template has been drafted but requires further testing and further engagement with services will be undertaken through Q1 to establish needs as service profiling will likely need to accommodate localities alongside a 'service level' view. Plans for MH and Community Hospitals will begin in Quarter 2.

The Learning and Development Tableau reports reflect the Care to Learn system and are now published. Promotion of these reports will be during May 2023. Allocate e-rostering data is also now available within Tableau. Further work needs to be undertaken to automate Allocate data into the Performance Dashboard Sickness Absence performance indicator. Appraisal information will be replacing manual monitoring in Quarter One 2023 .

NHS Benchmarking outlier summary reports for GHC Mental Health services have been shared with Executives in May 2023 and learning will be taken to the Resources Committee in June 2023. There is a plan for benchmarking to integrate into business as usual activities.

# Chief Operating Officer's Report April 2023 David Noyes, Chief Operating Officer (COO)

Activity across the system have remained busy, but largely at a manageable level; there remain (as will always be the case) short periods of increased activity which put pressure on the system, but over the past few months we have been able to create improved flow opportunities in physical health. This is manifesting itself in improved bed availability in our Community Hospitals and what feels like a sustained improvement in Home First performance, both enabled by a better discharge profile for patients who have completed their treatments with our services. There is still work to do, and scope to improve further. Pleasingly our MIIUs (Minor Injury & Illness Units) remain busy and well utilised, with the latest data showing a 99.8% achievement of the 4-hour wait target; at the time of writing, we are still waiting to hear the system decision over the funding for the telephone triage service (which if not sustained I would anticipate challenging the current MIIU attainment). The CATU capability at Tewksbury is similarly awaiting confirmation; my sense is that everyone wants to continue with this service, given its well documented and evident success in improving patient outcomes and easing pressure on the Acute hospitals, but of course funding is difficult. The pilot to enable SWAST to push appropriate patients to our Urgent care services continues well, with plenty of learning to build on and enhance – importantly this capability eases the pressure on the Emergency Departments at our Acute partner sites. Rapid Response continues to achieve all of its KPIs including the 2-hour response timeline in more than 70% of cases (latest achievement 77.9%). Improvements in Rapid form an important part of our contribution to the system improvement work arising from the Newton Europe diagnostic work – the delivery element of that work is just starting to mobilise now, but as Board colleagues are aware we have already been making changes to ensure we sustain our own improvement agenda.

The stroke pathway does remain the area most challenging in terms of community hospital beds and flow. Some recent caseload validation work in the ESD team has eased the pressure slightly, but this does feel like an area where our system needs to focus attention. The putative Community Neuro Team will help in time, albeit we remain in conversation about the sustainability of funding for that team which needs clarification before we can recruit.

In the community teams area, over recent months we have seen staffing challenges in particular in the Cheltenham team, but pleasingly after some successful recruitment we have 5 whole time B5 nurses and 2 B3, which will really help. The work to define and scope the potential integration of physical health and mental health teams has commenced, albeit at a very conceptual stage currently.

As reported last month (Resources Committee) and mentioned above, we continue to see improved performance in the Home First service, with regular starts of between 30 and 40 per week, trending upwards. The numbers of people waiting to access the service has come down from well over 100 to around 30 pretty consistently, and flow out has improved over recent months (we share a system aspiration to have no more than 10% waiting at the “back door”). I’m delighted to report that our GCC partners have recently agreed some additional investment into this service, which will enable us to add an onboarding and training team to enhance effectiveness, and care navigators to assist flow. Myself and Sarah Scott (Director of Adult Services at GCC) also co-hosted an EIO (Enhanced Independance Offer) reset day, including colleagues from every part of the system who have a stake in this vital service, at which we agreed a combination of short term improvement ideas and some longer term service development opportunities in a pleasingly open and collaborative space. Our Mean Length of Stay in the service is down to 18 days and the median sits at 15 – which indicate that we are successfully intervening and delivering reablement really effectively. Internally we continue to drive ahead on our productivity improvement work, having now successfully digitised the processes and helped colleagues adapt to digital working – this is an important component of the ongoing improvement work across the system that arose from the Newton Europe diagnostic last year.

The work to improve in patient Length of Stay in our inpatient units continues to bed in – the main objective of course being to thereby deliver better patient experience and outcomes. At this stage it remains too early to assess the sustainable impact of what we have done so far, although in general it feels like we aren’t consistently under pressure for beds; but that observation remains subject to short term increase in presentations which can still challenge capacity. We are now sharing some of the learning from the successful Enhanced Pathway 2 (EP2) project undertaken at Stroud (in physical health) with colleagues at Charlton Lane to see what such an approach could deliver there.

Progress continues positively with turning around the Eating Disorders service (circa 86% Compliance on Urgent Children KPI at time of writing), and the Board received a brief on progress here in early May. We now also have a transformation programme director in place, who can work up options for the future of the service.

While the situation in CAMHS services is stabilising, and in some areas improving slightly, this service remains a concern, and recruitment and retention remains challenging. There are 588 children and young people waiting for first treatment with a current average wait of 38 weeks; the service do conduct regular reviews of people on the list – we on average have capacity to accept 65 for treatment each month. What is not stabilising are referrals for neurodiversity which continue to climb. The risks are captured and reported, but Board would wish to be aware that our new CEO has called for a deep dive round table within the Trust to help understand the key issues at play here. Pleasingly we have successfully recruited 6 B5s to join the service who are due to start in Sep.

Board colleagues will recall that we have identified some performance concerns within our dental service, although the risk identified in Intermediate minor oral surgery has been mitigated thanks to a successful recruitment, and the service is open with no waits. We have created a comprehensive action and recovery plan which will report monthly to the physical health board, and risks have been formally recorded for performance monitoring. There are some early signs of encouraging changes, greatly assisted by improved visibility and use of data, that show some improvement in numbers waiting over 18 weeks and a reduction of 77 patients on the waiting list (to a total of 415); within this we are prioritising patients of highest need (and hence numbers waiting who have a safeguarding need are down from 60 in March to 7).

Performance in Podiatry remains challenged, and at face value performance has dipped this month, but largely due to a focus on clearing the longest waiters. I am still confident that we will see improvement here over the summer following successful recruitment. The situation in MSK remains stable, but the team have done well to cleanse their data, and good progress here with recruitment too, with 7 successful applicants in the last few weeks who will start with us over the next few months. The MSKAPS team have had another successful month with achievement of 8-week RTT up again now to 77.3% (albeit target is 95%) – a combination of increased capacity post recruitment and data cleansing at play here.

In Childrens Occupational Therapy (OT) we continue to make some progress but not quite as quickly as I would like, and so the improvement plan has been re-set and more leadership resource put in place; Childrens Speech and Language therapy continues to be challenged notwithstanding the service improvement day in February supported by the Trust's new head of profession. Here recruitment coming on stream in Jul and Aug should help. While the achievement of the 8-week referral to treatment target achieved 47% (target 95%), all exceptions were seen within 18-weeks.

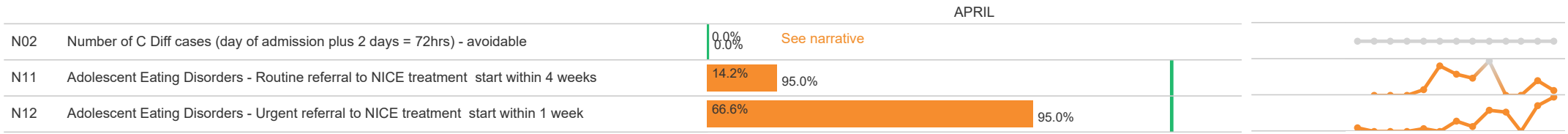
# Performance Dashboard: *National Contract Domain*

Gloucestershire Health and Care NHS Foundation Trust

## KPI Breakdown

Compliant  Non Compliant

## National Contract Domain




**Performance Thresholds not being achieved in Month** - *Note all indicators have been in exception previously in the last twelve months*.

**N02: Number of C Diff cases (day of admission plus 2 days = 72hrs) – avoidable**
The bullet chart is not currently presenting accurately due to a changeover from the 2022/23 metric. However, there were 3 post 48 hours cases reported in April compared to a threshold of 1. This is within SPC chart upper and lower control limits.

Two occurred at the Dilke Hospital and one on Jubilee Ward at Stroud Hospital.

One of the Dilke patients was transferred to the Dilke hospital from Gloucester Royal Hospital (GRH). The patient was admitted following a fall and had confusion. The patient was treated for a community acquired pneumonia and then medication was switched. The patient was exhibiting C.Diff symptoms and a sample was obtained. The result confirmed CDiff and the patient was commenced on medication with good effect.
The other Dilke patient was also reported in January 2023 as a C.Diff case. The patient continued to exhibit C.Diff symptoms and treatment was provided. The patient continues to be reviewed by a consultant weekly. The patient remains in a side room, has a care plan and the C.Diff policy is being followed.
The Jubilee Ward patient was transferred from Gloucester Royal Hospital (GRH). C.Diff symptoms were noticed and C.Diff was confirmed. Patient was treated and responded well to the second treatment. The patient has recovered from the C.Diff infection.

**N11: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks [Community MH Services]**
April performance is reported at 14.2% against a performance threshold of 95%. There were 6 non-compliant cases in April.

Achieving expected performance levels remains a challenge. The service continues to offer assessments to patients that have been waiting for an extended period based on clinical decision of non-urgency.

During April and the next few months the service will continue to offer assessments for those on the waiting list that have been waiting over 4 weeks. There are currently 81 routine adolescent clients on the assessment waiting list, compared to 201 at its highest peak in June 2022.

**N12: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week [Community MH Services]**
April performance is reported at 66.6% against a performance threshold of 95%. There were 3 non-compliant cases reported in April.

One of the non-compliant cases was initially triaged as an urgent case, however after further assessment it was deemed clinically appropriate, due to the high volume of urgent waiters, that the patient could be placed on a treatment waiting list.

The other 2 non-compliant cases were recording errors. In both cases the treatment was started but a treatment intervention not recorded. Interventions have now been recorded in the clinical system and performance for April can be reported at 85.7%.

**Note on N11 & N12 Adolescent (U19) Eating Disorder waiting times**
The team has significantly reduced the urgent adolescent assessment waiting list numbers and waiting times over the autumn and winter. The service now receives an average of 4 urgent adolescent referrals a week. When treatment is identified at the point of assessment, the service is able to offer patients an assessment and / or treatment start within a week of the referral being received. The waiting list for urgent adolescents remain at 2 patients. For patients with complex needs, an obvious treatment cannot be identified at the point of assessment and therefore, in some cases, it is not possible to meet the required 7 day threshold.

The service continues to work with BEAT (an Eating Disorders Charity) for those waiting for family based therapy (FBT) and are referring parents and carers to the Developing Dolphins programme at the point of assessment. To date 64 referrals have made and 56 spaces remain.

The Service continue to work with TIC+ in order to refer patients to a counselling programme and then discharge from the caseload. The team have now referred over 120 patients to the TiC TEDS programme, TiC regularly attend the EDS triage and a support officer is now actively contacting patients to support the referral.

A treatment pathway has been secured with the ORRI for CYPS aged 16 to 19 that remain on the urgent treatment waiting lists. The ORRI can treat 75 young people and over 60 referrals have been made of which the ORRI have started to treat 19 patients.

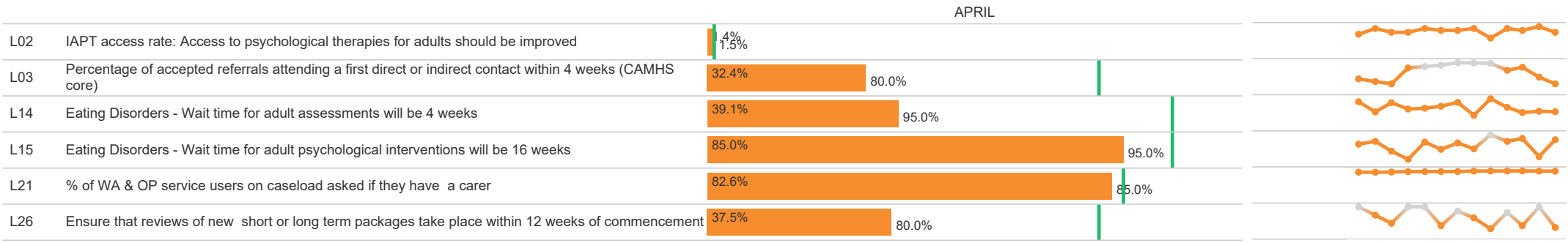
# Performance Dashboard: *Local Contract Domain*

Gloucestershire Health and Care NHS Foundation Trust

## KPI Breakdown

Non Compliant

## Local Contract Domain




**Performance Thresholds not being achieved in Month** - *Note all indicators have been in exception previously within the last twelve months.*

**L02: IAPT access rate: Access to psychological therapies for adults should be improved [Community MH Services]**
*Note: the bullet chart above is showing an historic performance threshold of 1.5%, 2023/24 thresholds have been agreed and this has now been updated to 1.7%*

In April, the service achieved 87.8% of its expected performance threshold. This equates to 1.46% of the prevalent population (1006 people) against a performance threshold of 1.67% (1146 people). Performance is within SPC (Statistical Process Control) limits but has special cause variation with this month and the previous 7 months being below average.

There was a higher than expected dropout rate in April at 21.1% compared to a planned rate of 15%. The service is currently doing some research into dropout rates. Therapy of any nature requires work on behalf of the recipient and a commitment for change which is not always followed through.

Mental Health Analytics for the Southwest Region Mental Health Programme Board have identified that there has been a reduction in referrals in the Southwest region and this is influencing IAPT services being able meet access targets. A Radio Advertising Campaign has been financed which is part of the Bauer Media Group. This will ensure Gloucestershire wide digital advertising on stations such as Greatest Hits radio. There will be a considerable number of impressions (adverts) per day. All magazine and newspaper advertising has also been renewed.

The service has started on a significant piece of work to completely renew their website. Every piece of copy is being re written and updated and they have commissioned four media films to be used on the website and across social Media to reflect a new branding.

The service is on track to meet workforce projections set out in its plan in March 2023, however, external recruitment of qualified staff remains challenging, leaving a reliance on training new staff to replace those who have left. This is has being experienced by other IAPT services in the region. Currently there appears to be more of an issue with High Intensity therapists and the service are continually working to improve this. There has been movement of therapists to other providers who are happy to provide a completely online service, however, this is something the service feel is not right for Gloucestershire.

The service attended a successful Long term Conditions/Personalisation event, and this has focused the need to work with this client group with the service now going out to recruitment for the new structure

**L03: CAMHs Core: Referral to first (direct or indirect) contact within 4 weeks [CYPS MH]**
The methodology for this indicator has been revised. It has been split into two parts, L03 for the Core CAMHS Service and L04 for the CAMHs Learning Disabilities service. L04 will be reported from May 2023 onwards. Both indicators will measure from referral to 1st contact with no adjustments made for DNAs or cancellations. The 1st contact may be with the patient, parent or with a healthcare or educational professional (nationally indicated as an indirect contact). The agreed performance threshold for each of these new indicators is 80%.

April performance is reported at 32.4% against a performance threshold of 80%. There were 79 non-compliant cases reported in April.

The service has reduced staff capacity for assessments at the CAMHS “Front Door” and 30% of assessment slots were lost during April due to training of staff (CAMHS Academy Training programme).

This also coincided with an increase in urgent referrals that were prioritised, 6.4% of referrals in April were urgent compared to an average of 3.8% over the previous 4 months. A recovery plan with additional Saturday clinics for May is in place. Further Saturday clinics in June and July are being explored.

**L14: Adult Eating Disorders: Referral to Assessment within 4 weeks [Community MH Services]**
April performance is reported at 39.1% against a 95% performance threshold. There were 14 non-compliant cases reported in April.

The service continues to work through the assessment waiting list and the number of adults waiting for assessment at the end of April was 274 compared to 517 at its highest peak in August 2022.

**L15: Adult Eating Disorders: Assessment to Treatment within 16 weeks [Community MH Services]**
April performance is reported at 85.0% against a 95% performance threshold. There were 3 non-compliant cases reported in April.

The service is working through the treatment waiting list and the number of adults waiting to start treatment at the end of April was 111 compared to 327 at its highest peak in May 2022.

The service continues to work with BEAT which offers the momentum programme to Adults and Tic+ who will work with patients aged under 25.

**L21: Percentage of WA & OP services users on caseload asked if they have a carer [Community MH Services]**
April performance is reported at 82.6% against a performance threshold of 85% and is below SPC (Statistical Process Control) limits.

The majority of cases are within MHICT (Mental Health Intermediate Care Team), (357) and Eating Disorders Services (299).

The MHICT service recently transitioned from recording on IAPTus to RIO and non-compliance is due to clinicians not yet fully understanding when and where to record on RIO. Service leads are working with the teams to ensure that staff are trained, and this should see compliance improve over the next few months.

The Eating Disorders service continue to experience many changes including new staff working for the service and non-compliance reflects clinicians either being aware of the carer position and/or asking the question but not recording the information. The service lead has investigated non-compliance cases and noted that the majority of these are patients on the routine waiting list with no booked appointment, due to the capacity and demand issues within the service, therefore, the service will remain non-compliant for several months, but performance will start to improve once these patients can be seen.

The service will be introducing a new triage, assessment, and for some, start of treatment process and will be asking and recording carer's information at this point in the patient pathway. This will ensure compliance for new referrals.

**L26: Ensure that review of new short or long term packages take place within 12 weeks of commencement [Community MH Services]**
April performance is reported at 37.5% against an 80% performance threshold. There were 5 non-compliant cases reported in April.

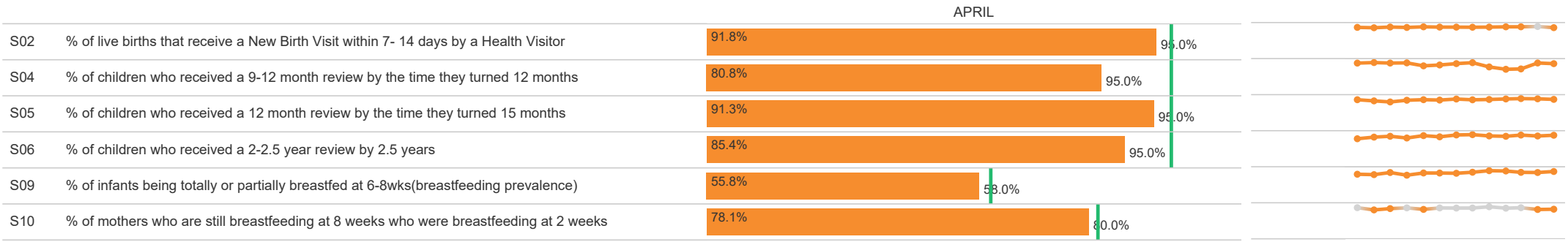
Two cases are due to staff capacity. Due to the high level of Social Work vacancies across Teams (6.6 WTE) and the lack of response to recruitment for Social Work posts in both inpatient and community settings the Social Care Specialists have been undertaking case work which would not usually be part of their role. Vacancies and staff sickness / absence have resulted in increased pressure of work and delays in undertaking reviews within 12 weeks as expected. There is a need to prioritize work and any hospital discharges and urgent new assessments of situations at risk of breakdown have needed to be prioritized over 12 week reviews. The service has an Agency Social worker now covering Wotton Lawn and continue to work on recruitment and Apprenticeship solutions going forwards. One case was completed within time but not yet updated on the clinical system and the remaining 2 cases are being investigated by the service.

# Performance Dashboard: *Specialised Commissioning Domain*

## KPI Breakdown

Non Compliant

## Specialised Commissioning Domain




**Performance Thresholds not being achieved in Month** - *Note all indicators have been in exception previously in the last twelve months.*

**S02: % of live births that receive a New Birth Visit within 7- 14 days by a Health Visitor [Children and Young People Service]**
In April performance was 91.8% (March was 95.1%) compared to a threshold of 95%. 35 out of 431 children are showing as not having received a new birth visit within 14 days of birth. Performance is within SPC chart upper and lower control limits.

Contributing factors specific to this month's performance include an increase in the number of children admitted to NICU (Neonatal Intensive Care Unit) and hospital. All other children who were not seen within timeframe have since had contact. The service's recruitment continues, and they have prioritised targeted and specialist families when allocating the available capacity.

**S04: Percentage of children who received a 9–12-month review by the time they turned 12 months. [Children and Young People Service]**
In April performance was 80.8% (March was 82.5%) compared to a threshold of 95%. 88 out of 495 children are showing as not having received a 9-12 month review by the time they turned 12 months. Performance is within the SPC chart upper and lower control limits.

A scoping exercise across each locality is in place to address percentage increase of appointments required to accommodate DNAs. Last month 69 appointments were booked out of timeframe, this month this had reduced to 14.

**S05: Percentage of children who received a 12-month review by the time they turned 15 months. [Children and Young People Service]**
In April performance was 91.3% (March was 92.9%) compared to a threshold of 95%. 43 out of 497 children are showing as not having received a 9-12 month review by the time they turned 15 months. Performance is within the SPC chart upper and lower control limits.

There has been a reduction in the number of recording errors since the service delivered record keeping training. The service has also ensured reminders and demonstration to all practitioners to use SystmOne SMS to remind parents of appointments. Additional hours and bank work to are being offered to nursery nurses to be able to support demand. The service plan to review a wider Scope of ASQ tool and using it with children with additional needs.

**S06: % of children who received a 2-2.5 year review by 2.5 years [Children and Young People Service]**
In April performance was 85.4% (March was 83.4%) compared to a threshold of 95%. 73 out of 501 children are showing as not having received a 2-2.5 year review by 2.5 years. Performance is within SPC chart upper and lower control limits.

The largest contributing factor specific to this month's performance is parents declining the 2-year visit. Further scoping of how the service can engage with the parents and understanding the analysis of why parents are declining this review is going to be undertaken with service users.

There has also been a large number of DNAs in April. A locality wide scoping exercise is in place to ensure there is equity in the number of additional appointment slots to offer DNAs a further appointment within timeframe and to also understand why service user's DNA, particularly around specific sites and times.

**S09: Percentage of infants being totally or partially breastfed at 6-8wks (breastfeeding prevalence) [Children and Young People Service]**

In April performance was 55.8% (March was 54%) compared to a threshold of 58%. 218 out of 494 children are showing as not being breastfed at their 6-8 week review. Performance is within SPC chart upper and lower control limits.

The midwifery service continues to be severely short staffed. The breastfeeding figures are recognised to be negatively countered by breastfeeding difficulties that start with initiation in Midwifery and affect the figures at 2 weeks when the service receive the families and subsequently the figures at 6-8 weeks.
The Service is exploring a broader range of voluntary Breastfeeding Support Groups/1:1 to engage with and signpost service users to support prevalence of breastfeeding.

**S10: Percentage of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks [Children and Young People Service]**
In April performance was 78.1% (March was 77.4%) compared to a threshold of 58%. 74 out of 338 children are showing as not having continued breastfeeding at their 6-8 week review. Performance is within SPC chart upper and lower control limits.

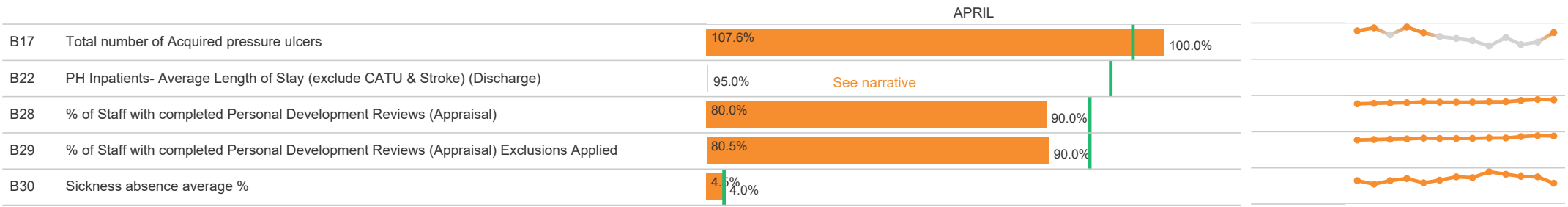
*See narrative please review S09 above.*

# Performance Dashboard: *Board Focus Domain*

Gloucestershire Health and Care NHS Foundation Trust

## KPI Breakdown

## Board Focus Domain




**Performance Thresholds not being achieved in Month** - *Note all indicators have been in exception previously within the last twelve months.*

**B17: Total number of Acquired pressure ulcers**
In April there were 98 acquired pressure ulcers (in March there were 64) compared to a threshold of 91. This is above the SPC chart upper control limit.

This increase is reflected in the number of acquired category 3 pressure ulcers in April (17,in March there were 6) compared to a threshold of 7. This is also above the SPC chart upper control limit.

• The context of the following commentary in relation to reported pressure ulcer incidents should take into account the continued impact from the Covid -19 pandemic. There are three key factors that are driving an increase in number and severity of pressure ulcers; Circulatory changes following Covid infection, deconditioning of patients who live at home and have become more socially isolated and physical immobility during and following Covid infection.

• Active work across teams continues in terms of improving practice with monitoring and oversight of PU's developed in their own localities. Localities and inpatient units have met significant rising demand in pressure area care referrals from primary care, care homes and acute hospital transfers.

• Colleagues across the trust continue to identify with support pressure ulcers as being "everybody's business" using signposting to educational resources, evidence from data and quality improvement methodology.

• Clinician review of the monthly category 3, 4 & unstageable pressure ulcers continues, any corrections in category will refresh with the data next month. For any category 3 pressure ulcers miscategorised, feedback will be given to the reporters & handlers of these incidents to support learning & improvement.

• In response to the increase in reporting pressure ulcers this month, the review of the category 3 incidents will be undertaken by Head of Profession for community nursing.

**B22: PH Inpatients- Average Length of Stay (Discharge)**
This measure does not currently exclude Community Assessment and Treatment Unit (CATU) and Stroke ward length of stays. Work is in progress to develop measures that separate out the different ward types and present them within separate indicators.

The average length of stay for inpatients in Community Hospitals was 44 days in April (44 days in March) compared to a threshold of 38 days. Performance is above SPC chart upper control limits.

8% (11/137) of all discharges in April had a length of stay of 100 days or more. Excluding these patients, the average length of stay reduces to 36 days. This performance indicator has been exceeding the upper SPC control limits since October 2021.

The higher figures are due to system wide delays in sourcing onward care for people who no longer meet the criteria to reside (nCTR) (including care home beds, packages of care and Home First placement) as well as escalation beds being in service at different periods of the month. Due to infection outbreaks several people have remained in hospital longer than expected as care homes would not accept them until covid negative or until they recovered from illness. Furthermore, a number of people have been unable to source care home placement as they have required 121 support in hospital, this has protracted their admission LoS.

Improvement programmes have commenced on all wards to reduce length of stay through improved collaborative working and assessment and the Enhanced Pathway 2 (EP2) programme is delivering positive change. System conversations focusing on the long waiters continue as a priority and an over 21 days review has been completed with the ICS.

**B28: % of Staff with completed Personal Development Reviews (Appraisal) - [Workforce]**
Performance for April was 80.0% (March was 80.8%) compared to a threshold of 90%. Performance is within SPC chart upper and lower control limits. The appraisal performance figure includes Bank Staff.

*For narrative see below within B29.*

**B29: % of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only. [Workforce]**
Performance for April was 80% (March was 81.4%) compared to a threshold of 90%. Performance is within SPC chart upper and lower control limits. The appraisal performance figure includes Bank Staff.

Excluding Bank staff, the Trust compliance figure remained static at 85% (with exclusions applied). Work is ongoing to reach the Trust's 90% target.

The Operations Directorate, despite having the largest number of staff, continues to have the highest completion rate at 86%, the same as the previous month. The Human Resources (HR) Directorate (excluding Staff Bank figures) is the next highest Directorate at 84%. The Finance and Medical Directorates are both in joint third position at 83%, a slight improvement from last month for the Medical Directorate. The Executive Directorate is at 73% which is a drop of 7% from last month, whilst the Strategy and Partnerships Directorate is now at 72%, and increase of 16% from March. The Nursing, Therapies and Quality Directorate position has decreased by 2% to 65% and are the lowest performing Directorate.

The HR Directorate including Staff Bank is at 62%, a decrease of 2% from the month before.

**B30: Sickness absence average % rolling rate - 12 months**
Sickness absence rate in April 2023 was 4.6%. This does not include data from the e-rostering system (Allocate) because it is not available at the time of reporting. March was 6.0 % (including Allocate data, 4.8% without) compared to a threshold of 4%. March performance is above the upper SPC chart control limit. The figure indicates in-month sickness absence, excluding Bank Staff.

Operations Directorate sickness absence was 6.7 % in March.

Sickness absence in March increased in the following sub-directorates within Operations:
• Adult Community PH, MH & LD (7.8% to 8.1%)
• Countywide (4.6% to 4.8%)
• CYPS (5.3% to 5.5%)
• Operational Management (1.2% to 3.4%)

Sickness absence in March decreased in the following sub-directorates within Operations:
• - MH Urgent Care & Inpatient (7.3% to 6.8%)
• PH Urgent Care and Inpatient (7.4% to 6.9%)

Executive Directorate sickness absence was 4.1 % in March

Within the Corporate Governance sub-directorate, sickness absence decreased from 5.2% in February to 4.9% in March.

Finance Directorate sickness absence was 3.2 % in March.
• Within the Business Intelligence sub-directorate, sickness absence decreased from 8.2% in February to 5.1% in March.
• Within the Facilities sub-directorate, sickness absence remained at 6.2% in March. The sites with the highest sickness absence levels within the Facilities sub-directorate are:
Wotton Lawn Campus 17.9% (increased from 17.2%), The Vale Hospital 16.1% (decreased from 24.7 %), Cirencester Hospital 10.0% (increased from 5.3%), Stroud Campus 9.8% (decreased from 11.7%), Rikenel 8.5% (decreased from 17.7%),

This reflects the sickness absence information on Tableau on 04/05/2023

# Non-Exception highlights

All indicators within the Operational Domain have been reviewed and there are no highlights to Board this month. Exceptions within the Operational domain will be considered at Resources Committee as routine.

- **B13: Percentage of patients waiting less than 6 weeks from referral for a diagnostic test [Urgent care]**

GHC is no longer responsible for the national submission for this activity which is now made by Gloucestershire Hospitals NHS FT.

Submitted data (by GHNHSFT) for GHC patients in April 2023 indicates a performance of 85.4% (compared with 91.5% in March) 17 out of 117 patients referred for an echocardiogram had been waiting 6 weeks or more for the scan at the end of April 2023. Target is 99%. This is within SPC limits.

The GHC Heart Failure service reported that on 3rd May 2023, 28 patients are on the Priority Echo waiting list for an echocardiogram, and 156 patients on the Routine Echo Waiting list, which has increased slightly from 118 at the end of March. 22 patients are still to be triaged for Echo.

- **B27: Turnover (12 month rolling)**

Note: Methodology updated to count turnover based on WTE rather than head count to align with reporting methodology across the Trust. 12 months to April Turnover was 13.94%, above the 11% threshold. This is within the SPC chart upper and lower control limits.

This is a continuing reduction on the previous months due to low an average monthly turnover rate for the past 4 months. There are 197 teams out of the 462 (43%) across the Trust which have had a turnover level over 11% over the last 12 months.
At a staff group level, Estates and Ancillary remain highest at 17.00% with Additional Clinical Services at 16.21%.

Some teams have low workforce numbers or are actively restructuring so these teams may expect a higher turnover.
Breaking the data down by age groups, the smaller average FTE numbers are showing as highest. there appears to be higher turnover for younger and older staff. Overall, those aged over 56 have the highest % of leavers v starters as might be expected, retirement etc.

- **B28: Cumulative Leave [Workforce]**

At the end of April, percentage of annual leave taken across the Trust was positively 8.66%. April target is 8.33%. However, this is noted because the end of 2022/23 Financial Year figure is now available. At the end of March 2023 (M12), the percentage of annual leave taken across the Trust was 94.0% compared to the target of 100%.

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**AGENDA ITEM: 09**/0523

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 25 MAY 2023**

**PRESENTED BY:** Sandra Betney, Director of Finance

**AUTHOR:** Stephen Andrews, Deputy Director of Finance

**SUBJECT:** **FINANCE REPORT FOR PERIOD ENDING 30 APRIL 2023**

| | |
|---|---|
| **If this report cannot be discussed at a public Board meeting, please explain why.** | |

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

**The purpose of this report is to**

Provide an update of the financial position of the Trust.

**Recommendations and decisions required**

- The Board to **note** the month 1 position

**Executive summary**

- Draft accounts submitted 27th April 2023, being audited by KPMG, audited accounts are due 30th June 2023
- The system plan submitted on 4th May showed a break even position for both the system and the Trust
- The Trust's position at month 1 is a surplus of £0.061m
- The Trust is forecasting a year end position of break even
- The cash balance at month 1 is £60.53m
- Capital expenditure is £1.57m at month 1

**Risks associated with meeting the Trust's values**

Risks included within the paper

| Corporate considerations | |
|---|---|
| **Quality Implications** | |
| **Resource Implications** | |
| **Equality Implications** | |

| Where has this issue been discussed before? |
|---|
| |

| **Appendices:** | Finance Report |
|---|---|

| **Report authorised by:** | **Title:** |
|---|---|
| Sandra Betney | Director of Finance |

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# Finance Report
# Month 1

working together | always improving | respectful and kind | making a difference

# Overview



- Draft accounts submitted 27th April 2023, being audited by KPMG, audited accounts are due 30th June 2023
- There were no material amendments to the position from the Resource Committee summary in April, and the year end performance for GHC was a performance surplus of £0.038m
- The current system plan is break even and the Trust's plan is break even
- At month 1 the Trust has a surplus of £0.061m
- 23/24 Capital plan is £17.785m and spend to month 1 is £1.57m
- Cash at the end of month 1 is £60.53m
- Cost improvement programme has delivered £2.747m of recurring savings through budget setting, of which £0.562m remains subject to QEIA sign-off. Target for the year is £5.443m.
- The Trust spent £0.825m on agency staff in month 1. This equates to 4.6% of total pay compared to the Agency salary cap of 3.7%.
- Better Payment Policy shows 99.6% of invoices by value paid within 30 days, the national target is 95%
- The 7 day performance at the end of April was 88.6% of invoices by value paid
- Further analysis is being completed on a detailed I & E variance analysis, a reconciliation of uploaded budgets to the NHSE plan and workforce analysis

# GHC Income and Expenditure

Gloucestershire Health and Care
NHS Foundation Trust

| Statement of comprehensive income £000 | 2023/24 Budget | 2023/24 YTD Actuals | 2023/24 Variance |
|---|---|---|---|
| Operating income from patient care activities | 252,915 | 21,873 | 796 |
| Other operating income | 11,409 | 1,243 | 293 |
| Employee expenses | (203,982) | (17,869) | (870) |
| Operating expenses excluding employee expenses | (59,076) | (5,170) | (247) |
| PDC dividends payable/refundable | (2,590) | (216) | 0 |
| Finance Income | 1,383 | 191 | 75 |
| Finance expenses | (153) | (1) | 12 |
| **Surplus/(deficit) before impairments & transfers** | **(94)** | **52** | **60** |
| Remove central PPE stock impact | | | 0 |
| Remove capital donations/grants I&E impact | 94 | 9 | 1 |
| **Surplus/(deficit)** | **0** | **61** | **61** |

Employee expenses includes substantive, bank and agency costs

# GHC Pay and WTEs

Gloucestershire Health and Care
NHS Foundation Trust

| | Sum of WTE Contracted | Sum of YTD Actuals |
|---|---|---|
| Operational Management | 34 | 184,466 |
| Countywide | 446 | 1,844,289 |
| PH Urgent Care & IP | 640 | 2,816,619 |
| Children & Young People (CYPS) | 506 | 1,927,604 |
| MH Urgent Care & IP | 541 | 2,787,191 |
| Adult Community PH MH & LD | 1,077 | 4,186,912 |
| Medical | 153 | 1,311,148 |
| Finance | 354 | 1,216,344 |
| Nursing, Therapies & Quality | 105 | 483,625 |
| Human Resources | 142 | 717,095 |
| Strategy & Partnerships | 33 | 149,052 |
| Executive | 45 | 244,347 |
| Total | 4,074 | 17,868,691 |
| | | |

Contracted WTEs only include substantive WTEs but Actual costs include bank and agency too

# GHC Balance Sheet

Gloucestershire Health and Care
NHS Foundation Trust

| STATEMENT OF FINANCIAL POSITION (all figures £000) | | 2022/23 | 2023/24 | | | |
|---|---|---|---|---|---|---|
| | | Actual | Plan | YTD Plan | YTD Actual | Variance |
| **Non-current assets** | Intangible assets | 1,370 | 821 | 1,074 | 1,343 | 269 |
| | Property, plant and equipment: other | 113,537 | 143,163 | 134,773 | 111,280 | (23,493) |
| | Right of use assets* | 17,715 | 19,028 | 20,370 | 17,715 | (2,655) |
| | Receivables | 1,085 | 511 | 515 | 250 | (264) |
| | **Total non-current assets** | **133,707** | **163,522** | **156,731** | **130,588** | **(26,143)** |
| **Current assets** | Inventories | 406 | 494 | 494 | 406 | (88) |
| | NHS receivables | 14,538 | 4,300 | 4,210 | 1,168 | (3,042) |
| | Non-NHS receivables | 5,002 | 6,575 | 6,575 | 2,307 | (4,268) |
| | Property held for Sale | 3,697 | 0 | 0 | 3,697 | 3,697 |
| | Cash and cash equivalents: | 48,836 | 42,044 | 49,074 | 60,533 | 11,459 |
| | **Total current assets** | **72,480** | **53,412** | **60,352** | **68,111** | **7,759** |
| **Current liabilities** | Trade and other payables: capital | (4,343) | (5,594) | (4,594) | (1,041) | 3,553 |
| | Trade and other payables: non-capital | (38,870) | (25,865) | (28,524) | (24,160) | 4,364 |
| | Borrowings* | (1,446) | (1,345) | (1,636) | (1,401) | 235 |
| | Provisions | (7,882) | (6,511) | (6,379) | (7,894) | (1,515) |
| | Other liabilities: deferred income including contract liabilities | (1,107) | (2,478) | (2,400) | (119) | 2,281 |
| | **Total current liabilities** | **(53,649)** | **(41,793)** | **(43,533)** | **(34,615)** | **8,918** |
| **Non-current liabilities** | Borrowings | (15,298) | (18,265) | (18,391) | (15,343) | 3,048 |
| | Provisions | (2,480) | (2,538) | (2,538) | (2,480) | 58 |
| | **Total net assets employed** | **134,761** | **154,338** | **152,621** | **146,261** | **(6,360)** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Taxpayers Equity** | Public dividend capital | 130,166 | 132,056 | 130,215 | 130,166 | (49) |
| | Revaluation reserve | 10,053 | 13,124 | 13,124 | 10,052 | (3,071) |
| | Other reserves | (1,241) | (1,241) | (1,241) | (1,241) | 0 |
| | Income and expenditure reserve* | (4,217) | 10,400 | 10,524 | 7,284 | (3,240) |
| | **Total taxpayers' and others' equity** | **134,761** | **154,338** | **152,621** | **146,261** | **(6,360)** |

# Cash Flow Summary

Gloucestershire Health and Care
NHS Foundation Trust

| Statement of Cash Flow £000 | YEAR END 22/23 | | YTD ACTUAL 23/24 | |
|---|---|---|---|---|
| **Cash and cash equivalents at start of period** | | **58,896** | | **48,836** |
| | | | | |
| **Cash flows from operating activities** | | | | |
| **Operating surplus/(deficit)** | (13,138) | | (14) | |
| Add back: Depreciation on donated assets | 84 | | 4 | |
| **Adjusted Operating surplus/(deficit) per I&E** | **(13,054)** | | **(10)** | |
| Add back: Depreciation on owned assets | 7,918 | | 551 | |
| Add back: Impairment | 14,781 | | | |
| (Increase)/Decrease in inventories | 88 | | 8 | |
| (Increase)/Decrease in trade & other receivables | (7,765) | | 2,012 | |
| Increase/(Decrease) in provisions | 3,576 | | 12 | |
| Increase/(Decrease) in trade and other payables | 10,119 | | 9,322 | |
| Increase/(Decrease) in other liabilities | (1,301) | | (51) | |
| Net cash generated from / (used in) operations | | **14,362** | | **11,842** |
| | | | | |
| **Cash flows from investing activities** | | | | |
| Interest received | 1,144 | | 190 | |
| Interest paid | | | | |
| Purchase of property, plant and equipment | (22,650) | | (336) | |
| Sale of Property | 0 | | | |
| **Net cash generated used in investing activities** | | **(21,506)** | | **(146)** |
| | | | | |
| **Cash flows from financing activities** | | | | |
| PDC Dividend Received | 1,886 | | | |
| PDC Dividend (Paid) | (3,217) | | | |
| Finance lease receipts (principal and interest) | 216 | | | |
| Finance Lease Rental Payments | (1,632) | | | |
| Finance Lease Rental Interest | (169) | | | |
| | | **(2,916)** | | **0** |
| | | | | |
| **Cash and cash equivalents at end of period** | | **48,836** | | **60,533** |

# Capital – Five year Plan

Gloucestershire Health and Care
NHS Foundation Trust

| Capital Plan | Plan | Actuals to date | Plan | Plan | Plan | Plan | |
|---|---|---|---|---|---|---|---|
| £000s | 2023/24 | 2023/24 | 2024/25 | 2025/26 | 2026/27 | 2027/28 | Total |
| **Land and Buildings** | | | | | | | |
| Buildings | 2,400 | 2 | 1,000 | 3,000 | 3,000 | 3,000 | 12,400 |
| Backlog Maintenance | 1,045 | 21 | 1,250 | 1,393 | 1,393 | 1,393 | 6,474 |
| Urgent Care | | 0 | 0 | 0 | 0 | 0 | 0 |
| Buildings - Finance Leases | 784 | | 1,945 | 0 | 0 | 0 | 2,729 |
| Vehicle - Finance Leases | 384 | | 239 | 0 | | 0 | 623 |
| Net Zero Carbon | 500 | | 500 | 500 | 500 | 500 | 2,500 |
| Fleet Vehicles | | 0 | | | | | 0 |
| | | | | | | | |
| LD Assessment & Treatment Unit | | | 2,000 | 0 | 0 | | 2,000 |
| Cirencester Scheme | | | | 5,000 | 0 | | 5,000 |
| | | | | | 0 | | |
| **Medical Equipment** | 500 | (0) | 1,030 | 1,030 | 1,030 | 1,030 | 4,620 |
| | | | | | | | |
| **IT** | | | | | | | |
| IT Device and software upgrade | | 0 | 600 | 600 | 600 | 600 | 2,400 |
| IT Infrastructure | 1,130 | (3) | 1,300 | 1,300 | 1,300 | 1,300 | 6,330 |
| Clinical Systems Vision | 2,191 | 0 | 3,161 | 1,250 | 250 | 250 | 7,102 |
| | | | | | | | |
| Unallocated | | | | | | | |
| **Sub Total** | **8,934** | **20** | **13,025** | **14,073** | **8,073** | **8,073** | **52,178** |
| | | | | | | | |
| Forest of Dean | 8,851 | 1,550 | 0 | 0 | 0 | 0 | 8,851 |
| **National Digital Programme** | | | | | | | 0 |
| Wotton Lawn Clinical Treatment Rooms | | 0 | | | | | 0 |
| **Total of Original Programme** | **17,785** | **1,570** | **13,025** | **14,073** | **8,073** | **8,073** | **61,029** |
| Disposals | (3,749) | | (2,454) | (2,000) | 0 | 0 | (8,203) |
| Donation - Cirencester Scheme | **0** | | | (5,000) | 0 | 0 | (5,000) |
| **Total CDEL** | **14,036** | **1,570** | **10,571** | **7,073** | **8,073** | **8,073** | **47,826** |
| | | | | | | | |
| **New Leases** | | | | | | | |
| Buildings | 784 | | 384 | 73 | | | 1,241 |
| Vehicles | 384 | | 0 | 0 | | | 384 |
| | | | 784 | 2,559 | | | 3,343 |
| | | | | | | | 0 |
| **Total** | **1,168** | **0** | **1,168** | **2,632** | **0** | **0** | **4,968** |

# Risks

Gloucestershire Health and Care
NHS Foundation Trust

23/24 potential risks are as set out below:

| Risks 23/24 | 23/24 Risks | Made up of: Recurring | Made up of: Non Recurring | Likelihood | Impact | RISK SCORE |
|---|---|---|---|---|---|---|
| Agency costs are not able to be reduced in Hospitals | 1,500 | 1,500 | 0 | 3 | 3 | 9 |
| Cost share changes for Section 117 patients leads to additional costs not reimbursed | 1,000 | 1,000 | 0 | 2 | 3 | 6 |
| Delivering Value savings without a plan don't deliver | 1,732 | 1,732 | 0 | 4 | 3 | 12 |
| Maintenance costs rise due to inflationary pressures | 1,000 | 1,000 | 0 | 4 | 3 | 12 |
| Utility, fuel, waste costs rise due to inflationary pressures | 800 | 800 | 0 | 4 | 3 | 12 |
| Capital cost inflation leads to capital programme being reduced | 1,000 | 1,000 | 0 | 3 | 3 | 9 |
| Mental Health Act White paper reforms | 1,000 | 1,000 | 0 | 4 | 3 | 12 |
| Risk of loss from disposal of land and building sales | 400 | 0 | 400 | 2 | 2 | 4 |
| Total of all risks | **8,432** | **8,032** | **400** | | | |

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NHS

Gloucestershire Health and Care

NHS Foundation Trust

working together | always improving | respectful and kind | making a difference

**AGENDA ITEM: 10**/0523

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 25 MAY 2023**

**PRESENTED BY:** Ingrid Barker, Chair

**AUTHOR:** Ingrid Barker, Chair

**SUBJECT:** **REPORT FROM THE CHAIR**

| | |
|---|---|
| **If this report cannot be discussed at a public Board meeting, please explain why.** | N/A |

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

**The purpose of this report is to**
To update the Board and members of the public on my activities and those of the Non-Executive Directors to demonstrate the processes we have in place to inform our scrutiny and challenge of the Executive and support effective Board working.

**Recommendations and decisions required**

The Board is asked to:

- **Note** the report and the assurance provided.

**Executive summary**

This report seeks to provide an update to the Board on the Chair and Non-Executive Directors activities in the following areas:

- Board developments – including updates on Non-Executive Directors
- Governor activities – including updates on Governors
- Working with our system partners
- Working with our colleagues
- National and regional meetings attended and any significant issues highlighted

**Risks associated with meeting the Trust's values**
None.

| Corporate considerations | |
|---|---|
| **Quality Implications** | None identified |
| **Resource Implications** | None identified |
| **Equality Implications** | None identified |

| Where has this issue been discussed before? |
|---|
| This is a regular update report for the Trust Board. |

| | |
|---|---|
| **Appendices:** | **Appendix 1**<br>Non-Executive Director – Summary of Activity – March and April 2023 |

| Report authorised by: | Title: |
|---|---|
| Ingrid Barker | Chair |

# REPORT FROM THE CHAIR

## 1. INTRODUCTION AND PURPOSE

This report seeks to provide an update to the Board on the Chair and Non-Executive Directors activities in the following areas:

- Board developments
- Governor activities
- Working with our system partners
- Working with our colleagues
- National and regional meetings attended and any significant issues highlighted

## 2. BOARD UPDATES

### 2.1 Non-Executive Director (NED) Update:

- Sadly, this will be Lorraine Dixon's last Board meeting with us. As an Associate NED nominated by the University of Gloucestershire, Lorraine has made a valuable contribution and we will miss her. Upon the arrival of the new VC for the university, we will request that a successor is nominated.

- The Non-Executive Directors and I continue to meet regularly as a group, and meetings took place on 20th April and 18th May. NED meetings are helpful check in sessions as well as enabling us to consider future plans, reflect on any changes we need to put in place to support the Executive and to continuously improve the way we operate. At the April meeting we had a focused discussion on progress with the Community Mental Health Transformation Programme and the importance of partnership working.

- I continue to have regular meetings with the **Vice-Chair and Senior Independent Director**, along with individual 1:1s with all Non-Executive Directors.

- At their meeting on 17th May, our Council of Governors approved the reappointment of **Steve Brittan**, Non-Executive Director, to serve a further three-year term from 17th September 2023. Steve is a valued and experienced Non-Executive Director and Chair of our Resources Committee.

### 2.2 Trust Board Meetings:

<u>Board Development:</u>

- We continue to devote significant time to our Board Development Programme and how we ensure that transformation remains central to the way we work, whilst the necessary focus is maintained on ensuring high quality care and colleagues' wellbeing. As previously reported at Trust Board, we are currently designing the next phase of our Board development programme with planning

underway for a Strategic Away Day scheduled for 3/4 July, where the Board will undertake of an annual review of progress against the strategy.

- A seminar on the transformation of our **Community Hospital Bed Clinical Model** took place on 11th May and was led by the Chief Operating Officer, David Noyes, Deputy Chief Operating Officer, Sharon Buckley, Service Director Dawn Allen and Nicola Moore, Associate Director of Transformation. This informative seminar focussed on the vision and aims for transformation, addressing health inequalities and equity of access versus specialist provision and a group discussion on aspirations, opportunities and barriers.

- A Board presentation from the Trust's **Eating Disorders Team** took place on 11th May. Colleagues from the team attended the session to present on the improvement plan and progress made since the last Board deep dive which took place in 2022, acknowledging that significant challenges still remained.

- On 1st June a seminar will take place on **Safeguarding** and will be led by the Director of Nursing, Therapies & Quality and Head of Safeguarding

## 3. GOVERNOR UPDATES

- I continue to meet on a regular basis with the **Lead Governor Chris Witham,** and we met on 20th April, to discuss agenda planning for the Council of Governors meeting on 17th May and matters relating to our Council of Governors.

- Our **programme of visits** to sites for Trust Governors is progressing well with a visit undertaken to Cirencester Hospital. These visits offer Governors the opportunity to see our sites, speak to colleagues and to gain a better understanding of the services we provide. Non-Executive colleagues accompany Governors on each of the visits.

- A further **Quarterly Staff Governor meeting** took place with NEDs on 9th May with 'peer support workers and career progression for people with lived experience working in the Trust' as the topic for discussion. Some of the key points from this meeting will be referred to our Working Together Advisory Committee for further consideration.

- A **Council of Governors meeting** took place on 17th May where the Council received an update on the Annual Staff Survey Results, were updated on progress with the Trust's SystmOne Simplicity project, and received the draft Quality Account and Quality Indicators. Simon Shorrick also attended the meeting and updated Governors on the 15th Annual Big Health Day which is due to take place on Friday 16th June.

- I am delighted to announce Catherine Fern was successfully elected as a new Staff Governor representing Medical, Dental & Nursing colleagues and I had an introductory meeting with Catherine on 17th May. I am also very pleased

to advise Sarah Nicholson (Staff Governor, Health & Social Care Professions) was successfully re-elected for a second term.

With sadness, we received the resignation of Ruth McShane (Public Governor, Greater England & Wales). Ruth had made the decision to stand down from her role with the Trust to allow her to focus on other ventures. Ruth was a very active Governor and Expert by Experience and will be missed by colleagues.

- A meeting of the **Nominations and Remuneration Committee** took place on 3rd May at which initial consideration was given to the timeline for the recruitment of my successor.

## 4. NATIONAL AND REGIONAL MEETINGS

Since the last meeting of the Trust Board in March, I have attended the following national meetings and visits:

- **NHS Confederation Mental Health Chairs' Network** – meetings take place weekly and I attend when my diary permits which I was able to on 6th April and 11th May. At this meeting we discussed the Hewitt review and were joined by the Rt Hon Patricia Hewitt, the author of the report and Chair of NHS Norfolk and Waveney and Dr Kathy McClean OBE, Chair. We also discussed the outcome of the Good Governance Institute governance and assurance review into the Greater Manchester Mental Health NHS foundation Trust following the BBC Panorama programme on the Edenfield Centre in Prestwich. As a Board, there is much for us to reflect on from their findings and we will be doing so as part of our board development.

  Unfortunately, due to annual leave, I was unable to attend on the 13th April. However, Graham Russell, Vice-Chair attended on my behalf. Tim Kendall, NHSE's National Clinical Director for Mental Health joined the meeting and spoke about transforming mental health and new models of care that focus on prevention and early intervention. Tim shared his views on the amount of inpatient beds and forensic services, as well as insights into the opportunities to move to community-based service options.

- **2023/24 Operational and Financial Planning Webinar for Chairs** – arranged by NHS England, to discuss 2023/23 operational and financial planning.

- I was delighted to be invited by **NHS Providers** to speak at their national **Governor Focus Conference** on 23rd May in London on 'Diversity, Inclusion and Health Inequalities: the role of governors'.

## 5. WORKING WITH OUR PARTNERS

I have continued my regular meetings with key stakeholders and partners where the working of the health and care system and the way we can mutually support each other are key issues for consideration. Highlights are as follows:

- Although unable to attend myself, the County Council's **Health Overview and Scrutiny Committee** took place on 23rd May. The meeting primarily focused on an update from South Western Ambulance Service NHS Foundation Trust and Maternity Services (Temporary Service Changes) Review.

- A meeting of the **Integrated Care Board** will take place on 31st May where a number of important operational and strategic issues will be discussed. The Chief Executive, Vice-Chair, Graham Russell and I will be in attendance.

- **ICB Board Development Sessions** took place on 18th/19th and 26th April. Sessions were attended by myself, the Chief Executive and Vice-Chair, Graham Russell. Topics for discussion included our approach to digital inclusion and how we use data to better understand population health at locality level.

- As you will see from the NEDs activity report, they continue to represent the Trust on a variety of **ICB Committees** including; the Audit Committee, System Resources Committee and System Quality Committee.

- The **Chair of Gloucestershire Hospitals NHSFT**, **Deborah Evans**, and I meet on a regular basis to discuss matters of mutual interest.

- I meet on a regular basis with **Dame Gill Morgan, Chair of the NHS Gloucestershire Integrated Care Board** and on a quarterly basis with **Dame Gill Morgan,** and **Deborah Evans, Chair of the Gloucestershire Hospitals NHS Foundation Trust**.

## 6. WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

- On 27th April, I was delighted to Co-Chair with Erin Murray, Self-Management Facilitator and Staff Governor, the **Better Care Together Event 'What matters to you…?'**. The event took place in person for a full day and was well attended by Trust colleagues, colleagues from partner organisations and people with lived experience. The aim of the event was to raise awareness of the Personalised Care agenda for adults living with long-term conditions. Professor Alf Collins, National Clinical Director for Personalised Care also joined the event and spoke about Personalisation Strategy – view from the national team. The event was very informative and well received by those in attendance.

- Angela Potter, Director of Strategy and Partnerships and I met with League of Friends Chairs John and Mary Thurston and Bob Young to discuss their future plans ahead of the closure of Lydney and Dilke Hospitals. The Trust recognises the invaluable support provided by the Chairs over the years and acknowledges all of their hard work.

- I had the honour of being invited to by the Bishop of Gloucester to attend, on behalf of the Trust, the special Coronation service at Gloucester Cathedral on 8th May. The service was part of the Big Help Out day to celebrate the Coronation of The King and Her Majesty The Queen Consort and was attended

by The Princess Royal. I was delighted to be joined by Trust volunteer Mike Smart.

## 7. ENGAGING WITH OUR TRUST COLLEAGUES

- On 16th April, we bid a fond and final farewell to Paul Roberts as he retired as Chief Executive. Douglas Blair was welcomed to the Trust as Chief Executive on 17th April.

- On 4th April, I joined colleagues in saying a sad farewell to Dr Philip Fielding, Deputy Medical Director. Philip retired from the Trust on 23rd April and I am sure will be missed by colleagues.

- I carried out an early evening **quality visit** on 10th May with Jo Daniel, Community Manager from the **Evening and Night District Nursing Service**. I spent time in discussion with Jo and her Team who are based at Edward Jenner Court.

- Following my **quality visit** to the Cheltenham Crisis Team in February, I met with the Director of Nursing, Therapies & Quality to discuss further the actions raised within my report.

- I continue to attend the Trust's Committees on a rotational basis and I regularly attend the **Working Together Advisory Committee**.

- I joined the face to face **Senior Leadership Network Meeting** at the Friendship Café on 25th April.

- On 3rd April I joined the virtual **Women's Leadership Network**.

- As part of the Trust's leadership development offer and to support the THRIVE module on Collaborative Leadership, on 11th May, along with senior leaders, I was delighted to take part in a recorded interview to talk about the Trust's emphasis in collaboration and working together.

- As part of my regular activities, I continue to have a range of virtual **1:1 meetings with Executive colleagues**, including a weekly meeting with the Chief Executive and regular meetings with the Director of Corporate Governance/Trust Secretary.

As always, I continue to try to make myself available to support colleagues and recognise their endeavours.

I recorded a Vlog for colleagues following the last Board meeting which highlighted issues discussed and key decisions.

I also have an active presence on social media to fly the GHC flag and highlight great work across the county.

## 8. NED ACTIVITY

The Non-Executive Directors continue to be very active, attending meetings in person and virtually across the Trust and where possible visiting services.

See **Appendix 1** for the summary of the Non-Executive Directors activity for March and April 2023.

## 9. CONCLUSION AND RECOMMENDATIONS

The Board is asked to **NOTE** the report and the assurance provided.

Appendix 1

## Non-Executive Director – Summary of Activity – 1st March - 28th April 2023

| NED Name | Meetings with Executives, Colleagues, External Partners | Other Meetings | GHC Board / Committee meetings |
|---|---|---|---|
| Dr Stephen Alvis | Council of Governors<br>Mental Health Act Managers Forum<br>NED Chair Appraisal Discussion<br>NEDs Meeting<br>1:1 with Chair<br>Senior Leadership Network<br>Job Plan Scrutiny Committee<br>IT Equipment collection<br>Deputy Medical Director Retirement<br>Governor visit Cirencester Hospital<br>Outreach Vaccination Service Quality Visit<br>NEDs Meeting<br>Appraisal with Chair | GGI National NED Development Programme<br>GGI Programme<br>GGI Webinar – Patricia Hewitt | Quality Committee<br>Board Seminar: Implications of the New MHA<br>Board – Public<br>Board – Private<br>Resources Committee<br>MHLS Committee |
| Steve Brittan | Council of Governors<br>NED Chair Appraisal Discussion<br>1:1 with Chair<br>NEDs Meeting<br>ICS NED Network Meeting<br>ICS NED Network Get-Together<br>Forest Hospital Consultation Meeting<br>Patient Flow Quality Visit<br>Resources Committee Agenda Planning Meeting<br>NEDs Meeting<br>Better Care Together Event | | ATOS<br>Board Seminar: Implications of the New MHA<br>Board – Public<br>Board – Private<br>Resources Committee |
| Marcia Gallagher | Council of Governors<br>ICB Audit Committee<br>Meeting with DNTQ ahead of Quality Visit<br>1:1 with Chair | GGI – Balancing the Books<br>Forest Health Forum<br>GGI – Joanna Watson<br>GGI Webinar - Patricia Hewitt | ATOS<br>Nomination and Remuneration Committee<br>Quality Committee |

| NED Name | Meetings with Executives, Colleagues, External Partners | Other Meetings | GHC Board / Committee meetings |
|---|---|---|---|
| | Chair and Vice Chair Meeting<br>NED Chair Appraisal Discussion<br>Head of Counter Fraud Workplan meeting<br>Senior Leadership Network<br>ICB Audit Chair<br>Charlton Lane Quality Visit<br>New Hospital Consultation Meeting<br>Women's Leadership Forum<br>1:1 with Chair<br>Chair Appraisal<br>NEDs Meeting<br>Director of HR/OD &Head/Deputy Head of Governance-Chair recruitment<br>Better Care Development Event | | Board Seminar: Implications of the New MHA<br>Board – Public<br>Board – Private |
| Sumita Hutchison | Council of Governors Meeting<br>Meeting with Des Gorman and Laura Harvey<br>Meeting with Lavinia Rowsell<br>IAPTS Quality Visit<br>NEDs Meeting<br>NHS Providers Chief Executive and Chairs Network Meeting<br>Meeting with Nadine Exner<br>NEDs Meeting<br>Brief on MH Service Offer | NHSP Development Programme: Chairs role in developing an effective unitary Board<br>GTi Finance Meeting<br>GGI Webinar - Patricia Hewitt | ATOS Committee<br>Board Seminar: Implications of the New MHA<br>GPTW Committee<br>Board – Public<br>Board – Private<br>MHLS Committee |
| Jan Marriott | Council of Governors<br>Quality assurance Group<br>NED Meeting<br>ICB NED Network Meeting<br>ICB Network Meeting<br>1:1 FSU Guardian<br>Working Together Advisory Committee<br>ICB System Quality Committee | 3rd Sector and Health/Social Care Co-Commissioning<br>NHS Provider MH Leads Network Meeting<br>NHS Webinar FSU NED Network | ATOS<br>Quality Committee<br>Great Place to Work Committee<br>Board Seminar: Implications of the New MHA<br>Board – Public<br>Board – Private |

| NED Name | Meetings with Executives, Colleagues, External Partners | Other Meetings | GHC Board / Committee meetings |
|---|---|---|---|
| | NEDs and CEO Farewell Meeting<br>NEDs Meeting<br>Quality Assurance Group<br>1:1 with Chair<br>Better Care Together Personalisation Event<br>Meeting of FTSU Champions<br>Safer Staffing in Community Hospitals Meeting | | |
| Graham Russell | Council of Governors<br>NEDs Meeting<br>1:1 with Sandra Betney<br>Stroud Therapy Quality visit<br>Meeting with Mary Morgan and Sara Crofts<br>Chair/Marcia Gallagher 1:1:1<br>Meeting with Neil Savage and Ali Koeltgen<br>NED Chair Appraisal Discussion<br>Governor Visit to Stroud Hospital<br>Visit to Carpenter House, Gloucester<br>Transforming Neighbourhoods meeting with ICB<br>1:1 with Chair<br>Better Care Together Awards<br>ICB Neighbourhood Committee Pre-agenda<br>ICB Board Development<br>ICB Neighbourhoods Committee<br>ICB Board Development<br>CEO Farewell<br>NEDs Meeting<br>Better Care Development Event | | ATOS<br>Nomination and Remuneration Committee<br>Board Seminar: Implications of the New MHA<br>Great Place to Work Committee<br>Board – Public<br>Board – Private |
| Nicola de longh | Council of Governors<br>NEDs Meeting<br>NED Chair Appraisal Discussion | | ATOS<br>Board Seminar: Implications of the New MHA<br>Great Place to Work Committee |

| NED Name | Meetings with Executives, Colleagues, External Partners | Other Meetings | GHC Board / Committee meetings |
|---|---|---|---|
| | Board Development Tender Evaluation and Shortlisting Meeting<br>CEO Farewell<br>Board Development Tender - Provider Clarification Meeting<br>NEDs Meeting<br>Appraisal with Chair<br>Board Development Tender - Provider Clarification Meeting | | Board – Public<br>Board – Private |
| Lorraine Dixon | 1:1 with Chair | | Great Place to Work Committee<br>Board – Public<br>Board – Private |
| Vicci Livingstone Thompson | Council of Governors Meeting<br>NEDs Meeting<br>Induction with Chair<br>NED Meeting<br>Working Together Advisory Group Meeting<br>1:1 with Chair<br>Better Care Development Event | | Board – Public<br>Board – Private |

**AGENDA ITEM: 11**/0523

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 25 MAY 2023**

**PRESENTED BY:** Douglas Blair, Chief Executive Officer

**AUTHOR:** Douglas Blair, Chief Executive Officer

**SUBJECT:** **REPORT FROM THE CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM**

| | |
|---|---|
| **If this report cannot be discussed at a public Board meeting, please explain why.** | N/A |

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

**The purpose of this report is to**

Update the Board on significant Trust issues not covered elsewhere as well as on my activities and those of the Executive Team.

**Recommendations and decisions required**

The Board is asked to **note** the report.

**Executive Summary**

The report summarises the activities of the Chief Executive (CEO) and the Executive Team and the key areas of focus since the last Board meeting, including:

- Chief Executive service/team visits
- Direct to Douglas
- Covid measures
- New Deputy Chief Operating Officer
- New home and name for 'Let's Talk'
- New sensory room at Evergreen House
- New Forest Hospital name
- Update on industrial action and pay dispute
- System updates
- Events
- NHS Oversight Framework

| **Risks associated with meeting the Trust's values** |
|---|
| None identified |

| **Corporate considerations** | |
|---|---|
| **Quality Implications** | Any implications are referenced in the report |
| **Resource Implications** | Any implications are referenced in the report |
| **Equality Implications** | None identified |

| **Where has this issue been discussed before?** |
|---|
| N/A |

| **Appendices:** | Report attached |
|---|---|

| **Report authorised by:** | **Title:** |
|---|---|
| Douglas Blair | Chief Executive Officer |

# CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM REPORT

## 1. CHIEF EXECUTIVE OVERVIEW

### 1.1 Chief Executive – Service/Team Visits

As part of my introduction to the Trust I have undertaken an extensive programme of visits and meetings with services and teams. While it will take some time to visit all services, my visits so far have included physical and mental health inpatient wards, mental health liaison service, crisis team, rapid response, sexual health, dental, long-term condition and therapy teams, learning disability, integrated community teams, children and young people services, peri-natal mental health service, eating disorder service, individual placement and support, occupational health service, physiotherapy and evening and overnight nursing. I have also met with several of our corporate teams at our sites across Gloucestershire.

I have received a warm welcome from all teams and have valued the opportunity to learn about our many services and meeting a wide range of colleagues. It has provided valuable insight into colleagues' experiences within their working environment and any challenges the teams are currently facing. I will continue to visit more services and teams over the coming weeks and months, and also 'hot desk' from different sites once initial visits have been completed.

I have also been involved in meetings both within and outside the Trust to maximise my understanding of the work carried out by the Trust and the wider Gloucestershire Health system.

### 1.2 Direct to Douglas

The desktop app previously called 'Paul's Open Door' has been relaunched as 'Direct to Douglas'. The app is a completely confidential way for staff to contact the Chief Executive directly and has been well used within my first few weeks, either for raising questions and issues, or simply to wish me well in my new role.

### 1.3 Covid measures scaled back – Testing and PPE

On 1st April national UK HSA guidelines on COVID-19 testing and Infection Prevention Control (IPC) guidance changed as a result of the COVID-19 vaccination programme, increased access to therapeutic treatments and high immunity amongst the population.

In response to these national changes our Trust has worked with system partners and, as of 26th April, new IPC guidance was implemented across our Trust and the wider system. Key changes include:

- Mask use - Masks are no longer required to be worn universally across clinical settings. However staff can continue to wear masks as a personal choice. There are additional IPC guidelines in certain circumstances, e.g. delivering care to Covid-positive patients, in areas where there is a Covid outbreak or to immune-suppressed patients.

- Testing - No routine patient and staff testing.

- Visitors - Open visiting unless ward in outbreak. No masks required for visitors but can wear as personal choice

Covid Spring Booster Vaccinations

The NHS is offering a Spring booster to those at highest risk of severe illness from COVID. This will help protect them if COVID-19 rates are high over the summer months and reduce their chances of needing hospital treatment if they do catch the virus.

Those who can get a spring vaccination include people aged 75 and over (by 30 June 2023), people with a weakened immune system, and residents of care homes for older adults. Those who are eligible will receive an invitation from their local NHS services to book in for their vaccination.

## 1.4 New Deputy Chief Operating Officer appointed – Derek Hammond

Following an extensive recruitment and interview process I am pleased to report the appointment of **Derek Hammond** as the new **Deputy Chief Operating Officer** for Group 1 Services (detailed below).

Derek has been acting up into this role since September 2022 and his mental health professional background and experience are relevant to his portfolio responsibilities, which are Mental Health and Learning Disabilities Urgent Care and In-Patient, Children's services, Community Physical Health, Mental Health and Learning Disability Community.

## 1.5 New home and name for '*Let's Talk*'

The '*Let's Talk*' service is moving into St Paul's Medical Centre in Cheltenham, and is also being renamed as '*NHS Gloucestershire Talking Therapies*' in order to be consistent with new national branding.

Our talking therapies colleagues, currently based at Lexham Lodge, will soon occupy the spacious, newly-refurbished suite at St Paul's. The newly-acquired therapy area, located on the second floor of the medical centre, will help meet the increasing demands of the service.

The service offers support for mental health conditions such as:

- Depression
- Emotional wellbeing with a baby
- Anxiety
- Panic disorder
- Post traumatic stress disorder
- Obsessive compulsive disorder
- Phobias

### 1.6 New sensory room at Evergreen House

Colleagues from Evergreen House have been working closely with the Estates and Facilities Capital Delivery Team to deliver a sensory room for its service users.

The CAMHS Learning Disability Team at Evergreen House have created the room for the use of all children who access the building.

Using a generous donation from the Pied Piper charity appeal of £10,000, the room will provide a relaxing therapeutic environment to for children and young people to enjoy.

### 1.7 New Forest Hospital name

'Forest of Dean Community Hospital' has been agreed by the Trust as the official name for the new building which will replace Dilke Memorial Hospital and Lydney District Hospital.

The name was agreed by both the Hospital Programme Board and the Oversight Committee and is in line with NHSE guidelines which recommend names which are clear, logical and descriptive and contain a geographical reference.

Work on the hospital in Steam Mills Road, Cinderford, is progressing to schedule, with the steel frame complete, roof and external walls nearly finished and work progressing on the internal layouts.

Building work is due to be complete by early 2024 in preparation for a process of cleaning and equipping to allow teams to transfer onto the site.

### 1.8 Update on Industrial Action and Pay Dispute

Planned industrial action has continued across Health and Education during April and May. For many colleagues who are parents or carers in our Trust, the education strikes and school closures have presented additional challenges. As a Trust we empathise with colleagues in this situation and have been working to support our staff through these difficult times.

The following NHS strike action has taken place since the last Board meeting:

- British Medical Association (BMA), UNITE and the Hospital Consultants and Specialists Association (HCSA) (Junior doctors) – 11th to 15th April
- Royal College of Nursing (RCN) – 28th April to 1st May

A number of changes to services in the county were implemented in response to the industrial action to support safe staffing. Most notably, Cheltenham A&E temporarily closed during the RCN strike and emergency care services were provided at Gloucester A&E only during this period. There were also some closures of Minor Injury and Illness Units and disruption to other community healthcare services.

To ensure the NHS was in the strongest possible position during industrial action, the Gloucestershire system has been urging the public to use health services responsibly and use alternative services, such as pharmacies, primary care and minor injury and illness units where possible.

Gloucestershire system partners have continued to work together on staffing plans during periods of industrial action. Within the Trust we have also worked to ensure that emergency plans and resilience response measures were in place to manage the impact of strike and to keep our patients and service users safe. We have continued to work in partnership with the RCN and staff side locally over related planning.

Agenda for Change Pay Negotiation Update

An extraordinary meeting of the NHS Staff Council was held on 2nd May to discuss the pay offer made by the government for staff on NHS Agenda for Change Pay and Conditions of Service.

At the meeting, the NHS Staff Council trade unions confirmed the outcome of their individual ballots, and made a majority recommendation that the pay offer made to them by the government should be accepted. In outline this was for a 5 per cent pay increase for 2023-24; a one-off award of 2 per cent of 2022-23 salary; and a one-off “NHS backlog bonus”, which varies by pay band. The deal does not cover doctors, who are on separate pay frameworks.

Employer representatives at the meeting noted the individual trade union positions and endorsed the recommendation of the NHS Staff Council trade unions that the pay offer should now proceed to be implemented.

While the pay offer has been accepted by the council, some unions – including the RCN, Unite and the Royal College of Podiatry – did not accept the offer and remain in dispute with the Government. The RCN has already announced its intention to re-ballot its members to secure another strike

action mandate, and it is likely that other unions that voted to reject the offer, including the Society of Radiographers, may also wish to do so.

## 2. SYSTEM UPDATES

### 2.1 Director of Public Health Annual Report

Gloucestershire County Council's Director of Public Health has published their annual report, highlighting how important connecting with others is for good health and wellbeing. The report, which is called ***No Person is an Island: Social Connections in Gloucestershire***, also reflects on the challenge of staying connected during the pandemic and how this led to an increase in isolation and loneliness, and it includes suggestions for creating a more connected Gloucestershire. The report can be accessed through the following link annual-public-health-report-2022_23.pdf (gloucestershire.gov.uk)

### 2.2 University Opens New Medical School

The University of Worcester has opened its new **Health and Medical Building**. The building will become the home of the University's new Three Counties Medical School and will welcome 1,500 medical students to the new campus in September.

We are a partner in this initiative and medical students will be placed in our Trust as well as Gloucestershire Hospitals NHS Trust for student placements.

## 3. EVENTS

### 3.1 Better Care Together

We hosted our Better Care Together event – *What Matters To you* on 27th April. The event was held at Gloucester Rugby Club in Kingsholm and streamed live via MS Teams. Further information on this event is provided in the Chair's report.

### 3.2 Senior Leadership Network

On 25th April, we held our first face-to-face Senior Leadership Network (SLN) meeting since the pandemic. The meeting was held at the Friendship Café in Gloucester and provided a welcome opportunity for me to meet personally our senior team.

At the meeting we had presentations and discussions on a number of important issues, including an update on our SystmOne Simplicity programme which concluded in April after two years of work to improve the functionality, accuracy and usability of the clinical record system.

There were also updates from the Community Sentence Mental Health Treatment team and a presentation on "Educating to invest in and develop our future workforce". Due to the success of the face-to-face meeting we will be reviewing the format of future meetings.

### 3.3 ICB Board Development Session

Gloucestershire ICB held a Board Development session on 19th April which was attended by the Chair, Ingrid Barker, Vice-Chair, Graham Russell, and I. The session was a useful opportunity to me to meet the ICB Board during my first week. The main aims of the session were to reflect on progress as an ICS, allow some detailed time to focus on current key issues and to continue to build and reinforce new behaviours and ways of working.

### 3.4 NHS Assembly – 75th Anniversary

The NHS Assembly has been set up during the 75th anniversary year of the NHS, to help the health service grow and evolve. Trusts have been asked to host conversations with colleagues to help the Assembly and NHS England make decisions about the future based on the people who work within and use NHS services.

The NHS now is very different to what it was like 75 years ago and the NHS of tomorrow needs to continue to change and adapt to meet new challenges. These in particular include:

- Increased demand for services
- Higher levels of chronic, long term ill health
- Workforce shortages
- The need to make the best use of new treatments and technologies.

On Wednesday 17th May I hosted a MS Teams meeting to allow all colleagues to share their thoughts. The interactive discussion covered the following three areas:

1. How far has the NHS come in the last 75 years?
2. Where is it now?
3. What would you like from it in the future?

We had good engagement and input, which will be fed into the national NHS Assembly process for gathering views.

## 4. NHS OVERSIGHT FRAMEWORK QTR 3 – 2022/23 SEGMENTATION REVIEW

At the recent meeting of NHSE SW Regional Support Group, the segmentation of NHS organisations within the ICS was considered in line with the NHS Oversight Framework and on the recommendation of the ICB. GHC has been assessed as being in segment 2 for quarter 3 – *Plans that have the support of system partners in place to address areas of concern.*

To be placed in segment 1 in the future, the Trust would need to demonstrate performance against the oversight themes and be in the top quartile nationally, based on the relevant oversight metrics which include reducing Out of Area MH placements, having an actual and forecast breakeven position or better, and attaining CQC 'Outstanding'. In addition to this non metric qualitative information is considered by the ICB and the NHSE.

The Quarter 4 segmentation review commenced in April, and it is likely our segment will remain 2. A national review and refresh of the 2023/24 Oversight Framework is underway, and we await publication of this in early 23/24.

## 5. CONCLUSION AND RECOMMENDATIONS

*The Board is asked to **NOTE** the report.*

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

**AGENDA ITEM: 12/0523**

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 25 MAY 2023**

**PRESENTED BY:** Mark Walker, Head of Research

**AUTHOR:** Mark Walker, Head of Research
Dr Mark Scheepers, Consultant and Medical Lead Innovation

**SUBJECT:** **RESEARCH AND INNOVATION STRATEGY**

| **If this report cannot be discussed at a public Board meeting, please explain why.** | |
|---|---|

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

**The purpose of this report is to:**

This paper provides a brief overview of the new Research and Innovation Strategy that has been developed to guide the development of the Research function in the organisation for the next 5 years.

**Recommendations and decisions required**

The Trust Board is asked to **note** and **endorse** the R&I Strategy for 2023-2028.

**Executive summary**

GHC has been supporting NIHR Portfolio Research for over 15 years since the NIHR's creation in 2006. The limits of working purely on the NIHR Portfolio means that local research and innovation opportunities have been missed. The importance of supporting a wider portfolio of research and innovation across the organisation was recognised at a board seminar in August 2021 when we were starting to develop the new Research and Innovation Strategy. It was recommended that we develop a Core Trust Research Function (not NIHR Funded) to enable the GHC Research Team to diversify, facilitate non-NIHR portfolio activity and support the trust to become more research active across all teams and services.

The new Research and Innovation Strategy is guided by the advice from the attendees at the Board Seminar and identifies 7 main objectives that will develop the Core Trust Research Function and support the wider Trust Strategic aims. The Strategy will aim to develop the organisation as a Centre of Excellence for Research and Innovation to help make life better. It will:

1. Develop a Core Trust Research Function to support Non-NIHR research, innovation and evaluation
2. Create a Virtual Hub to provide research and evaluation support to local teams and services
3. Explore more opportunities to develop research in collaboration with other local organisations
4. Increase patient and public involvement in research and evaluation that benefits the organisation
5. Increase representation for communities which are traditionally under-represented in research
6. Explore opportunities for additional funding
7. Strengthen promotion and awareness of Research and Innovation to embed a research culture within the organisation.

All of this will ensure that we can develop GHC as a truly 'research-active' organisation, which is attractive to job-seekers and will lead to greater job-satisfaction amongst our staff.

**Risks associated with meeting the Trust's values**

There are minimal risks to the trust for supporting the new R&I strategy. However, the Core Trust Research Function will be impossible to deliver without investment and additional income from other partners. Support is being requested through a business case alongside the Strategy and the Strategy itself will aim to explore new opportunities for funding outside of the core NIHR funding already received.

| **Corporate Considerations** | |
|---|---|
| **Quality Implications** | The strategy is designed to support the development of local research projects aimed at answering questions important to clinical services and our service users/carers. As such, there is a great opportunity to improve care and services across the trust, improving the overall quality of care in the organisation. |
| **Resource Implications** | The delivery of the strategy, especially the Core Trust Research Function will need resources. Staffing is already available within the research team, but there is a financial implication related to releasing staff from their NIHR duties. A business case is being developed to request support from the organisation to develop the Core Function requested by the Board. The strategy will also aim to explore other opportunities for external funding to enable continued support for the Research Team. |
| **Equality Implications** | The Strategy aims to increase awareness and understanding of research and increase the number of people, teams and services who can get involved in research. We aim to develop research as something that everyone can get involved in, ensuring equity of access to all. The successful application of the R&I strategy will also ensure the organisation is seen as a great place to work, attracting new staff and retaining existing. |

| **Where has this issue been discussed before?** |
|---|
| The development of the strategy was discussed at a Board Seminar in August 2021 where the main themes and direction of the strategy were identified.<br><br>The Strategy was presented to and discussed at the following:<br>Executive Team meeting - 28th February 2023<br>Quality Committee - 2nd March 2023 |

| | |
|---|---|
| **Appendices:** | N/A |

| | |
|---|---|
| **Report authorised by:**<br>Dr Amjad Uppal | **Title:**<br>Medical Director |

# Research and Innovation Strategy 2023 to 2028

## BE PART OF THE DISCOVERY

### Health Research Changes Lives

Our **vision** is to become a **CENTRE OF EXCELLENCE** for research and innovation to help **MAKE LIFE BETTER**

## Executive Summary

Over the last ten years, Gloucestershire Health and Care NHS Foundation Trust (GHC) has demonstrated that it is proficient in providing support to National Institute for Health and Care Research (NIHR) portfolio studies via the NIHR funded Research Team.

To ensure GHC can claim to be an inclusive Research Active Trust, it is important that the Research Team is able to expand and diversify to support a wider variety of researchers, both external and internal to the Trust, and facilitate the development of projects inspired by local teams, service users and carers. Developing such a mixed portfolio alongside the NIHR portfolio will ensure GHC becomes a research active trust that is an attractive place to work and be a patient.

Our NIHR funding is unlikely to increase by any significant amount during the strategy period unless there is a significant increase in funding at a national level. Our NIHR funding is also not available to support activity that is not related to NIHR portfolio studies.

In order to develop as a truly research active trust, with a wide and diverse portfolio of research, development and innovation, it is vital that we seek out and identify new sources of income other than the NIHR, to invest in the research team to allow this development to take place.

With investment, the local Research Portfolio will expand, offering more opportunities for local staff to get involved in research, generate income from that research and position GHC as a Research Active Trust that attracts high quality staff across the organisation and the region. We will be able to explore opportunities to work outside the restrictions of our NIHR Funding and develop strong links with teams within the trust and external organisations .

This Strategy sets out the current context for research within GHC, where we want to take research over the next few years and how we will get there. It provides a robust plan for taking GHC from a competent research centre to a Centre of Excellence for Research and Innovation.

## Introduction

**THE NIHR is:**

**"…the nation's largest funder of health and care research and provides the people, facilities and technology that enables research to thrive."**

**THE NHS CONSTITUTION pledge to patients is to:**

**"…inform you of research studies in which you may be eligible to participate."**

**In order to enable:**

**The promotion, conduct and use of research to improve the current and future health and care of the population.**

The message from the NIHR and the NHS Constitution is clear, Research should be embedded within organisational culture, strategy and structure; it should be considered part of Core Trust Business.

Sadly, this is not always the case for a variety of reasons including funding, protected research time, general awareness, and knowledge of research and research processes.

Our strategy is designed to evolve the GHC research function to ensure we can develop our ways of working to meet the expectations of both the NIHR and the NHS Constitution, while also ensuring our staff, service users and carers are able to access and get involved in research wherever they want to.

## Where we are now and where we want to be


The Fritchie Research Centre offers clinic rooms, interview rooms, a research lab, pharmacy facilities and a bright and welcoming waiting area. The space was created following investment from the Trust and, following its opening in 2016, has allowed us to develop our research portfolio in a way that would have been impossible before.

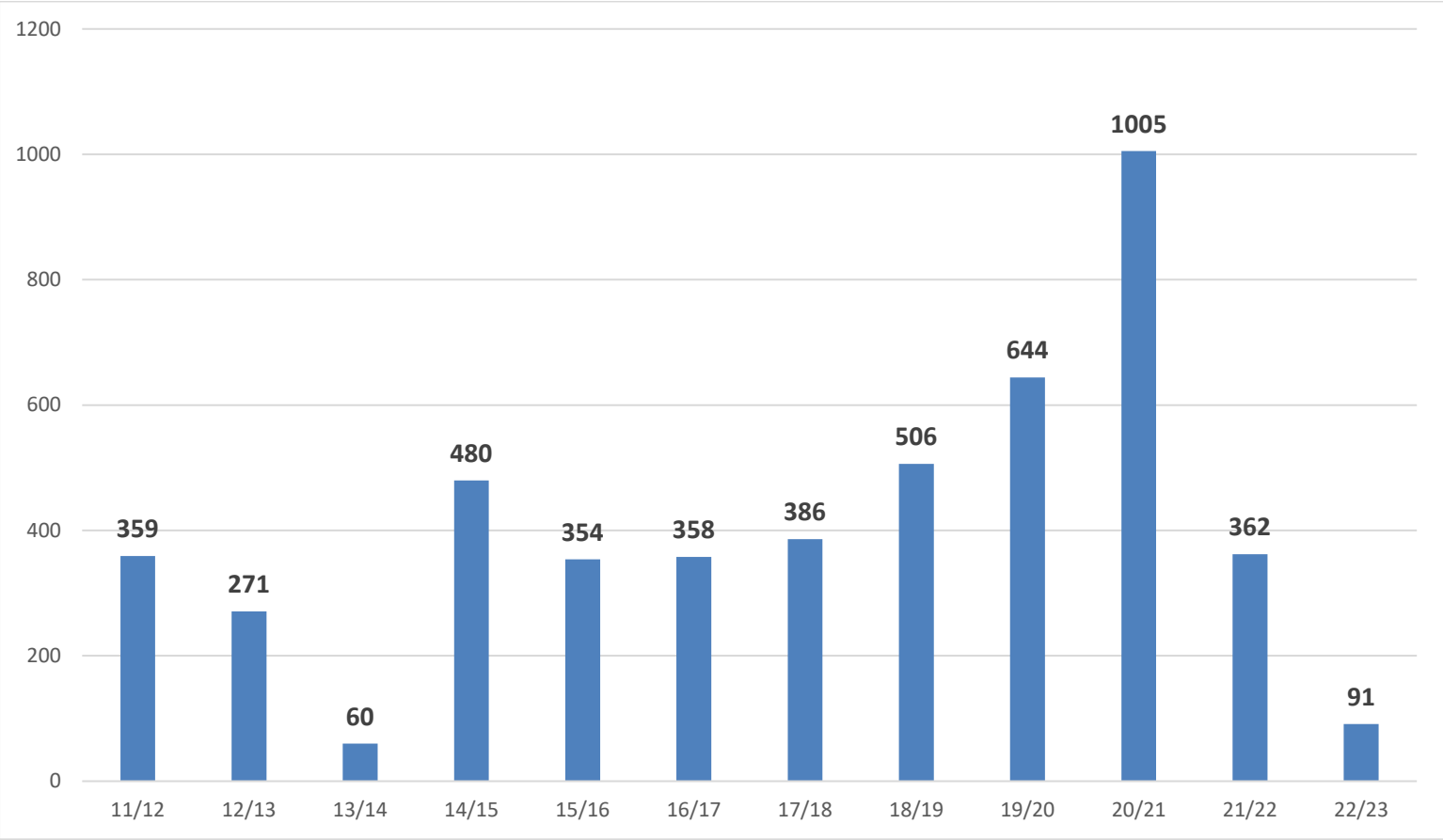
The Research Team has been able to run clinical trials and complex commercially-sponsored research studies using the facilities at the Fritchie Research Centre, often studies that other local Trusts are unable to open as they do not have the same facilities.

The centre has allowed us to forge collaborative links with commercial sponsors, such as ROCHE, who now use GHC as a preferred partner for their Alzheimer's studies and for who a local consultant has been able to act as the UK Chief Investigator for a past study.

The space has also enabled us to develop our NIHR portfolio and, since the opening of the centre, we have seen a steady increase in recruitment as can be seen on the next page.

The Fritchie Centre is a fantastic facility that we hope to develop to the continued benefit of the Trust.

# Recruitment to NIHR Portfolio Studies (to November 2022)

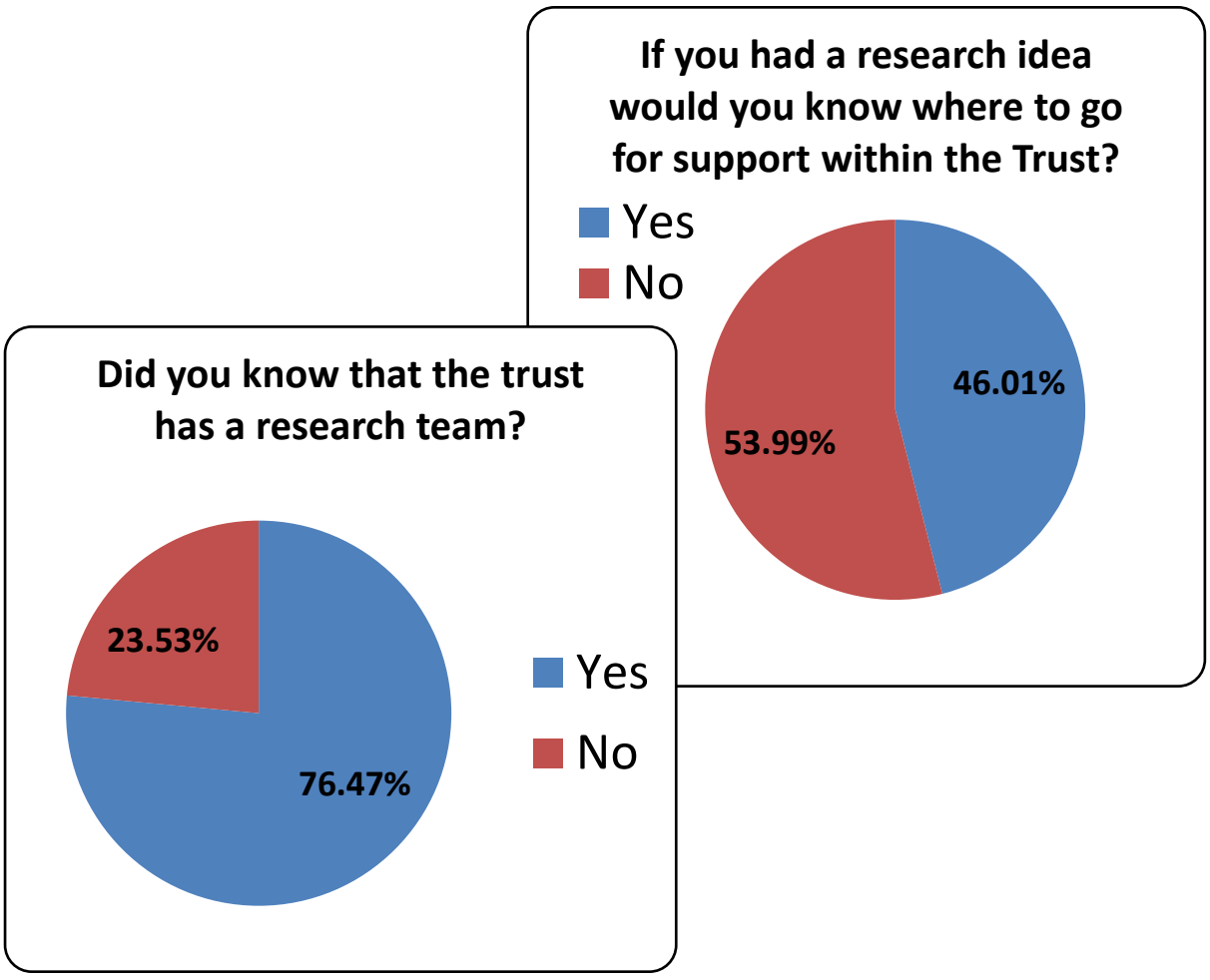



The COVID Pandemic saw a brief rise in recruitment and then a sharp fall as studies were developed with remote working in mind, meaning the research team have not been as involved in recruitment as they have in the past. As recruitment levels remain low, it is important that we explore other opportunities for the Research Team outside of the traditional NIHR portfolio studies.

In October 2022, the Research Team conducted a survey exploring awareness and understanding of research in the Organisation. The survey highlighted some issues that could conflict with the aims of the NIHR and the NHS Constitution and which could make reaching our Strategic vision difficult.

The full report will be fed back in meetings and research events, but there were a number of findings that helped us focus our strategic objectives.

Staff appeared to be aware of the Research Team, but were not entirely sure who to come to for advice and support on research, which suggests they were not completely aware of what services the Research Team can offer.




The survey also identified a number of Barriers to getting involved in research which backed up existing beliefs that there is a general lack of awareness of research in the trust, but also highlighted that there may be a large number of staff wanting to do research, but who do not have the time or capacity to do this.

The top barriers to research identified were:

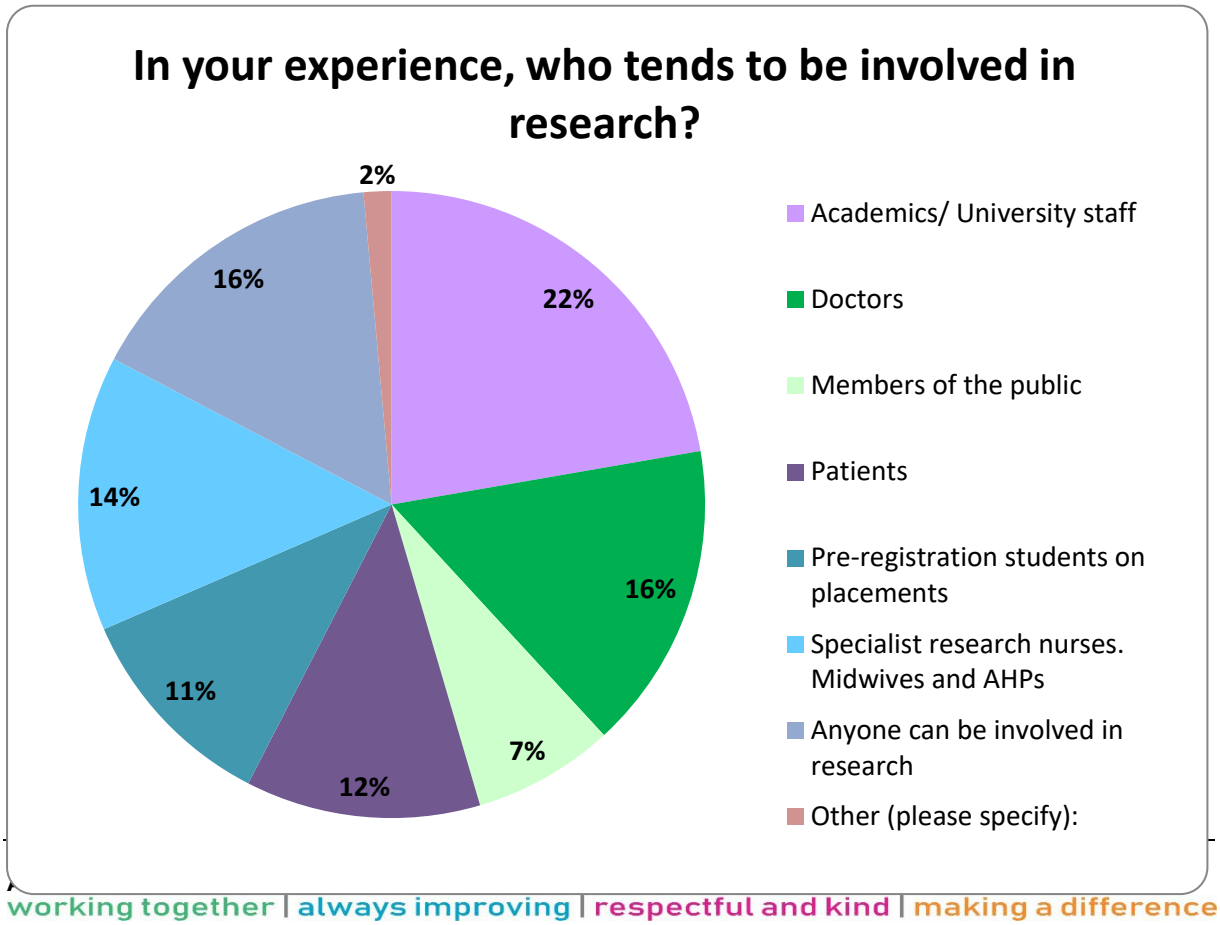
- Lack of time for research (70.8%)
- Other work takes priority (67%)
- Lack of awareness of opportunities to get involved with research (50.4%)

A subsequent question highlighted the same issues, but from the perspective of what could be done to increase engagement in research and, once more protected time and general awareness were seen to be important.

The top things identified that would help people engage more in research activities were:

- Having protected time for research (67.8%)
- Knowing who to speak to about research (49.4%)
- Training events (48.1%)

We also asked about the perceptions staff have about who does research and, while 16% believe anyone can do research, there is a persistent view that research is undertaken by academics and doctors.



This all suggests that staff awareness and understanding of research support in the Trust is lower than we would hope. It indicates that what we have long expected is true; people are aware that the Research Team exists and undertakes research for the NIHR, but that research is considered something other people do and is not something they can get involved with.

We want to tackle this through our Strategy by developing a work programme that changes perceptions, raises awareness and opens up research to everyone across the organisation. We want to raise awareness of the support that is available from the Research Team for anyone who wants to get involved with research at any level.

To do this, we will need to change the way the Research Team works and open it up to more than just the NIHR Portfolio of studies. To achieve this, we need to identify new ways of funding the research Team to secure time to work on activity outside of their current NIHR roles.

## Identifying the way forward

In August 2021, a Trust Board Strategy Development Session was held to celebrate the work of the Research Team and local research activity, but also to steer future developments. The seminar included four workshops in which the strategy for Research and Innovation in the Trust was considered in relation to the (at the time) four trust values of:

- WORKING TOGETHER
- ALWAYS IMPROVING
- RESPECTFUL AND KIND
- MAKING A DIFFERENCE

The main themes that arose around the strategy and the Trust's ability to achieve its vision included:

1. **Leadership is Key –** The research team have good Clinical and Service Director input, but the key to developing greater opportunity and penetration is to demonstrate that this is a key development area from the Trust Board all the way to new staff. If there is a better way to do things, then we should try to find a way to make this happen.

2. **Research is Core Trust Business –** This is prime focus of the NHS, reiterated by the NHS Constitution, but something we, along with many trusts around the country, are not always very good at recognising or putting into practice.
3. **Awareness –** Research and Innovation are under-promoted across the Trust. This needs to change to achieve a shift in cultural attitudes to Research and Innovation.
4. **Core Research Function –** The Trust lacks a core research function to support its staff and patients involved in research that is not part of the NIHR portfolio.
5. **Supporting Staff –** Staff need to be supported to do research in the same way they are supported with Audit, Service Evaluation and Quality Improvement.
6. **Training –** Staff should have access to training around Research and Innovation.
7. **Collaboration –** The Trust needs to explore more opportunities for collaborative working across the county and wider, to include partnerships with other NHS Organisations, Universities (especially the University of Gloucestershire) Charities and other organisations.
8. **Representation -** Service users and carers are often represented as participants in NIHR portfolio studies, but underrepresented in other Research and Innovation related functions. Other socio-economic groups are also underrepresented in research.

The key take-away from the event was the need to identify a Core Trust Research Function. This would free up resources in the current Research Team that can be redirected from looking outward at the NIHR Portfolio to looking internally at hitherto untapped potential and opportunities. This would allow us to develop research, evaluation and innovation that positions the organisation as a research active Trust making us an attractive place to work; a trust that puts patients and staff first in terms of making life better.

This approach still supports the updated GHC Trust Strategy, 2021-26 which focuses on "Better Care Together – with you, for you". We want to echo this in the Research Strategy which will also strive to support the wider Trust Strategic Aims:

- High Quality Care
- Better Health
- Great Place to Work
- Sustainability


Our Research Strategy will help the organisation meet its overall vision through our own strategic aims.

## GHCFT Research and Development Strategic Aims:

Our Research and Innovation Strategy will focus on 4 main principles:

- Research is Core Trust Business
- Research is for everyone
- Research is stronger through collaboration
- Research active trusts are great places to work.

The strategy will deliver on these principles to support the Trust Strategic Aims through the 7 following objectives:

### 1 – Trust Core Research Function

**High Priority – by Q2 2023/24**

**We will develop a specification for a Core Research Function, funded outside of the NIHR budget to allow the Research Team to work on a wider portfolio of studies. This will enable more Trust Staff and, potentially, service users to get involved in research and promote GHC as an attractive destination for new staff.**

**Research is Core Trust Business**

## 2 – Research and Innovation Hub

**Medium Priority – by Q1 2024/25**

**We will develop a virtual Research and Innovation, Service Evaluation (RaISE) Hub to provide a "one-stop shop" for staff, service-users and students who want to develop research and innovation projects or simply want to learn more about research in the organisation.**

**Research is for everyone**

## 3 – Collaboration

**Ongoing Priority – constant review**

**We will work to strengthen links with other local and regional organisations, such as Universities, NHS Trusts, Charities and Social Care to promote activity and Innovation that directly benefits our staff and patients**

**Research is Stronger through Collaboration**

## 4 – Patient and Public Involvement

**Ongoing Priority – constant review**

**We will explore potential to link with our service users and carers to identify opportunities to develop service-user and carer-led research and evaluation that focuses on the issues of importance to them.**

**Research is for everyone**

**Research is Stronger through Collaboration**

## 5 – Representation

**Ongoing Priority – constant review**

**We will explore opportunities to strengthen engagement with under-represented groups in research to ensure everyone has the opportunity to take part in research.**

**Research is for everyone**

**Research is Stronger through Collaboration**

## 6 – Funding Opportunities

**Ongoing Priority – constant review**

**We will explore alternative funding opportunities to supplement the NIHR funding and help us strengthen and widen our local portfolio. We will consider the potential for fund-raising, charitable funding and research grant applications.**

**Research is for everyone**

**Research active Trusts are great places to work**

## 7 – Promotion and Awareness

**Ongoing Priority – plan for at least 1 Research and Innovation event per year. Aim to develop 2+ per year**

**We will develop a range of options for promoting and raising awareness of research and Innovation in the Trust. We will also explore options for offering training and education events across the organisation to support research awareness and understanding.**

**Research is Stronger through Collaboration**

A Strategy Work Plan will be developed (see appendix 1) detailing the specific projects and initiatives that will be undertaken to meet the 7 objectives. This will be implemented by the end of Q1 2023/24 following consultation with the Research and Development Team and the Clinical Directors for Research.

The priority Objective will be the Core Trust Research Function. This is a key development as it will be very difficult to deliver on the rest of the Strategy without resource to create this core function. A business care is currently being developed to seek support from the Trust for this Core Function. However, other potential sources of funding will be explored so that, if the planned Business Case is unsuccessful, the Strategy and associated Workplan can still be delivered.

Performance against the objectives and the Work Plan will be reviewed and monitored through the quarterly Research Overview Committee where the Research Strategy will be a standing agenda item. The Head of R&D also has regularly meetings with the Medical Director as well as the two Clinical Directors for Research to discuss Research and Innovation in the Trust and issues relating to the Strategy will be discussed there.

## Summary

The Gloucestershire Health and Care Research and Development Team has been very successful over the last few years in developing its NIHR Portfolio and forging links with Commercial Companies.

However, research awareness and activity outside of the NIHR portfolio is lacking, with staff not sure where to get advice about research and not being aware of the services that the Research Team can provide.

We want to change this by creating a Core Research Trust Function that will allow the team to diversify and raise research awareness and interest, develop new projects and innovation within the organisation, involve service users and carers in developing research that is important to them and push research to the forefront of the organisation.

By doing this, we will ensure that a Research and Innovation Culture is embedded within Gloucestershire Health and Care NHS Foundation Trust and we can be proud to call ourselves a Research Active Organisation.

The key to achieving this is the development of the Core Research Function and, without investment in this area, we will struggle to achieve the wider aims of the strategy and it will take much longer to realise our vision to become a centre of research excellence.

# Case Studies

## DIRP – Dissociation in Psychosis – A Case Study

In early 2019, the Head of R&D was approached by Dr Claudia Calciu who was developing a research idea and wanted information about organisational application forms and approval.

This led to discussions between the Head of R&D and Claudia to understand her project and what would be needed to develop the protocol and make an application to an NHS Research Ethics Committee and for national Health Research Authority (HRA) approval.

After many discussions a small steering committee was formed, led by Claudia, with support from the Head of R&D, the University of Gloucestershire, local staff and trainees interested in the project.

In collaboration with the University of Gloucestershire, the R&D Department joint funded the project for a total of around £1,200 to cover the costs of the assessment tool required for the study and a £5 thank you voucher for each participant.

The study was looking at dissociation as a predictor of recovery from Psychosis and aimed to recruit around 76-80 patients.

The COVID pandemic impacted on the study on slowed recruitment, but there were also restrictions on how much help we could provide from the R&D Team because the DIRP study was not on the NIHR portfolio and we are not funded to work on these studies.

With a core Trust Research Function, funded externally from the NIHR, we would have been able to provide more support directly from the research team in the form of a research nurse to help with recruitment and, notwithstanding the effects of the Pandemic, the study would have been able to recruit faster than it did.

The DIRP study is a perfect example of a small local study that was built on the collaboration of a small team to develop research that is both interesting and important for the service users involved.

By meeting the objectives of our strategy, we would be able to support a larger number of similar studies as well as develop more complex studies by using the Core R&D resource, the increased awareness and interest in research across the organisation and strengthened links with other collaborators and potentially service users and carers.

## My Life Service Evaluation – A Case Study

In early 2022 the Head of R&D had some discussion with one of the Research Champions, Nicola, who was working with a group of service users in her physiotherapy role, delivering a group intervention that was designed to improve the health and well-being of people with mental health through physical activity.

The Head of R&D was able to provide guidance and support in relation to the study proposal, how data could be collected securely and putting Nicola in touch with colleagues in Gloucestershire Hospitals NHS Foundation Trust and the University of Gloucestershire who could also provide guidance.

Part of the project was designed to involve fitness trackers for the participants so they could record their activity, such as step counts. Nicola was not able to fund these herself. Although only a few hundred pounds, there was no money available in her budget to cover the cost.

The R&D Department was able to fund Nicola's project so that she was able to provide the participants with a fitness tracker they could use for the project. Without this input, it would have been difficult for Nicola to conduct the study in the way she wanted and it may not have even gone ahead.

Ultimately the evaluation has been a success and Nicola is embarking on her data analysis which shows some early indications that the group has helped the participants' recovery with increased activity and well-being.

The evaluation was undertaken on a small scale with just one group of participants, but has led to further discussion between Nicola and the Head of R&D to explore the opportunities for a larger, follow-on Randomised trial to explore the effects of the group in more detail.

Without the original input and support from the Head of R&D and other colleagues, it is likely that the evaluation would not have gone ahead and there would have been no enthusiasm for a larger study. The follow-on study would be a perfect opportunity for the research team to work on research outside of the NIHR portfolio and prove the worth of a Core Trust Research function

## Appendix 1 – Research and Innovation Strategy Work Plan.

This is a draft and not final. The initial workplan will be completed and ready for implementation by end Q1 2023/24 and reviewed on a regular basis at the Research Overview Committee to ensure it is on track and to add/amend objectives as required.

| Objective | Due date |
|---|---|
| **1 – Trust Core Research Function** | |
| • Develop Business Case for Trust | By Q1 2023/24 |
| **2 – Research and Innovation Hub RaISE** | |
| • Define purpose of hub with Innovation Lead and Clinical Directors for Research | By end Q3 2023/24 |
| • Generate TOR for Hub | By end Q3 2023/24 |
| • Develop Website presence and promotion for HUB | By end Q4 2023/24 |
| **3 - Collaboration** | |
| • Continue to work with Research4Gloucestershire to develop opportunities for collaboration in research and innovation | Ongoing |
| • Explore opportunities for collaboration with other regional organisation within the Clinical Research Network West of England | Ongoing |
| • Explore opportunities for collaboration with other regional organisation outside of the Clinical Research Network West of England | Ongoing |
| **4 – Patient and Public Involvement** | |
| • Undertake a survey with service users and carers to find out what their priorities are for Research and Innovation in the Trust | By end Q2 2023/24 |
| • Develop a piece of service user/carer-led led Research and Innovation | By end Q1 2024/25 |
| • Develop further service user/carer-led research and Innovation | From 2024 onwards |

| | |
|---|---|
| **5 - Representation** | |
| • Review other organisation's (AWP) work on underserved populations | By end Q2 2023/24 |
| • Identify underserved populations in the Trust/County | By end Q3 2023/24 |
| • Explore opportunities for developing Research and Innovation to support underserved communities and include them in Research | By end Q1 2024/25 |
| | |
| | |
| **6 – Funding Opportunities** | |
| • Explore potential for external funding from support organisations | ongoing |
| • Explore potential for charitable funding | ongoing |
| • Explore potential for fund-raising | ongoing |
| | |
| | |
| **7 – Promotion and Awareness** | |
| • Develop outline for potential educational programme | By end Q2 2023/24 |
| • Deliver educational session to support awareness raising in Trust | By End Q3 2023/24 And then regularly |
| • Deliver annual Research Celebration event | By end Q4 2023/24 And then yearly |
| • Re-Run Research Awareness Survey | At mid-point and end of strategy period to assess changes in attitudes |
| • Research and Innovation to be included on Trust Induction | By Q1 24/25 |

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

**AGENDA ITEM: 13**/0523

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 25 MAY 2023**

**PRESENTED BY:** Lavinia Rowsell, Director of Corporate Governance/Trust Secretary

**AUTHOR:** Lavinia Rowsell, Director of Corporate Governance/Trust Secretary

**SUBJECT:** **BOARD ASSURANCE FRAMEWORK**

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

**The purpose of this report is to:**

Provide assurance to the Board on the management of the Trust's strategic risks.

**Recommendations and decisions required**

The Board is asked to:

- **Receive** and **consider** the revised BAF (Q4 year-end review)
- **Note** the overarching risk profile for the Trust **(Page 1 BAF – Appendix 1)**

**Executive summary**

Along with the Corporate Risk Register the Board Assurance Framework (BAF) supports the creation of a culture which allows the organisation to anticipate and respond to adverse events, unwelcome trends and significant business and clinical opportunities. It helps to clarify what risks are likely to compromise the trust's strategic and operational objectives and assists the executive team in identifying where to make the most efficient use of their resources in order to improve the quality and safety of care.

The Board Assurance Framework (BAF) for 2022/23 reflects the Trust's Strategic Aims and Objectives. The BAF has been reviewed by Executive owners and the Executive Team to confirm the year end position for 2022/2023 and considered at Board Governance Committees.

- *Changes since last quarterly review:* Amendments made since last review are highlighted in red.

- *Strategic risks added or removed since quarterly review:* None

- *Movements in risk ratings:*

| | | Score |
|---|---|---|
| **Risk 8** | *Resources targeted at acute care* - The 23/24 operating plan guidance that underpins the Financial Regime and contracting is again acute biased, and this results in more pressure on acute services to improve productivity and achieve recovery as well as more funding for these priorities. This remains issue of concern, due to significant acute demand and financial pressures, although resource skew is potentially mitigated by agreed MHIS. It is now confirmed that the MHIS will remain in place for 23/24 and we are working with system partners to develop a fair way of managing financial risk in year and there has been a transparent prioritisation process for new developments. | Decreased to **9** |
| **Risk 9** | *Funding – National Economic Issues* – The year end position has further improved from the last review with a reduction of the risk score to 6. The system financial position for 23/24 is a challenging but break even plan. | Decreased to **6** |

- *Issues for the attention of the Board*

*Risk Review* A Board development session to review the Trust's risk appetite statement is scheduled for **7 June 2023**. This session will also provide the board with the opportunity to review current, and identify new strategic risks. This will be delivered by Mike Gill (Kirby House Consulting, and consultant with NHS Providers).

Following recent discussion at governance committees, consideration will be given to an additional strategic risk relating to closed culture and whether the wording of *Risk 10: Sustainability* requires review. These points will be raised as part of the workshop.

**Risks associated with meeting the Trust's values**
Ensuring a BAF is in place which helps to effectively manage Strategic Risks is a core element of the Trust's Risk Management Policy.

| **Corporate considerations** | |
|---|---|
| **Quality Implications** | The Trust must have a robust approach to risk management in order to maintain the highest standards of quality care provided to patients. Identification and mitigation of risk is an important tool in being able to manage events that could have an impact. |
| **Resource Implications** | There are no financial implications arising from this paper. |
| **Equality Implications** | There are no financial implications arising from this paper. |

| Where has this issue been discussed before? |
|---|
| ▪ Governance Committees<br>▪ Executive Team<br>▪ Board / Seminar |

| | |
|---|---|
| **Appendices:** | Board Assurance Framework Review |

| | |
|---|---|
| **Report authorised by:**<br>Lavinia Rowsell | **Title:**<br>Director of Corporate Governance & Trust Secretary |

| Risk No | Strategic Risk Description | Strategic Aim | | | | Risk Type(s) | | | | | | | Lead Committee | Initial Risk Score | Target Risk Score | Risk Score | | | | | Lead Exec | Last Exec Review | Last Comm Review | Issue to be raised By Exec / Comm. (Y/N) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | High Quality Care | Better Health | Great Place to Work | Sustainability | Quality/Outcomes | Compliance / Regulatory | Reputational | Innovation | Partnerships / Collaboration | Workforce | Finance Inc. VFM | | | | Target Date Aim By When | Qtr 1 | Qtr 2 | Qtr 3 | Qtr 4 | | | | |
| 1 | Quality Standards | ✓ | ✓ | | | ✓ | ✓ | ✓ | | | | | Quality | 12 | 8 | April 2024 | 8 | 12 | 12 | 12 | Dir NTQ | April 2023 | Feb 2023 | N |
| 2 | Research & Innovation | ✓ | ✓ | ✓ | | | | ✓ | ✓ | | | ✓ | Quality | 12 | 6 | April 2024 | 8 | 8 | 8 | 8 | MD | April 2023 | Feb 2023 | N |
| 3 | Demand for Services | ✓ | ✓ | | | ✓ | ✓ | ✓ | | | | ✓ | Resources | 16 | 12 | April 2024 | 16 | 16 | 16 | 16 | COO | April 2023 | Feb 2023 | N |
| 4 | Recruitment & Retention | ✓ | ✓ | ✓ | | ✓ | | | | | ✓ | | GPTW | 12 | 12 | April 2025 | 16 | 16 | 16 | 16 | DIR HR& OD | April 2023 | Feb 2023 | N |
| 5 | Workforce Wellbeing | ✓ | | ✓ | | ✓ | | | | | ✓ | | GPTW | 9 | 6 | March 2024 | 9 | 9 | 12 | 9 | DIR HR& OD | April 2023 | Feb 2023 | N |
| 6 | Culture (Internal) | | ✓ | ✓ | | | | ✓ | | | | | GPTW | 9 | 4 | April 2024 | 6 | 6 | 6 | 6 | DIR HR& OD | April 2023 | Feb 2023 | N |
| 7 | Partnership Culture | | ✓ | | | ✓ | | ✓ | | ✓ | | | Board | 9 | 6 | April 2024 | 9 | 9 | 9 | 9 | Dir S&P | April 2023 | Feb 2023 | N |
| 8 | Resources Targeted at Acute Care | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ | | | ✓ | Board | 16 | 8 | April 2025 | 16 | 12 | 12 | 9 | DoF | April 2023 | Feb 2023 | N |
| 9 | Funding – Nat. Econ. Issues | ✓ | ✓ | ✓ | | | | | ✓ | ✓ | | ✓ | Board | 15 | 10 | March 2024 | 16 | 12 | 12 | 6 | DoF | April 2023 | Feb 2023 | N |
| 10 | Sustainability (environment) | | | | ✓ | | ✓ | | ✓ | ✓ | | | Resources | 12 | 6 | March 2024 | 9 | 9 | 9 | 9 | Dir S&P | April 2023 | Feb 2023 | N |
| 11 | GPTW | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | Board | 9 | 6 | March 2024 | 9 | 9 | 9 | 9 | Dir S&P | April 2023 | Feb 2023 | N |
| 12 | Cyber | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | Audit | 20 | 8 | April 2024 | 12 | 12 | 12 | 12 | DoF | April 2023 | Feb 2023 | N |

<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="2">High Quality Care<br>Better Health</td><td>Exec Risk Owner</td><td>John Trevains, Dir NTQ</td><td>Date of review:</td><td>April 23</td></tr>
<tr><td>Risk ID:</td><td>01</td><td>Description:</td><td colspan="2" rowspan="2">Quality Standards:<br><br>There is a risk that failure to:<br><br>(i) monitor & meet consistent quality standards for care and support;<br>(ii) address variability across quality standards;<br>(iii) embed learning when things go wrong;<br>(iv) ensure continuous learning and improvement,<br>(v) ensure the appropriate timings of interventions<br><br>will result in poorer outcomes for patients / service user and carers and poorer patient safety and experience.</td><td>Lead Committee</td><td>Quality</td><td>Date of next review:</td><td>June 23</td></tr>
<tr><td colspan="3">Risk Rating:<br>(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:<br>(taken from the Performance Report/ Quality Dashboard)</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td colspan="3">1st April 2020 (Updated Mar. 22)</td><td colspan="4" rowspan="5">• Number of Complaints<br>• Timeliness of reviews into Concerns<br>• Patient Safety Incidents<br>• Friends & Family Test measures<br>• Safe Staffing Levels<br>• Embedding learning /Quality Improvement activity reporting<br>• Waiting times<br>• Vacancy rates – aggregate position</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>2</td><td>4</td><td>8</td></tr>
<tr><td colspan="2">Target Date to Achieve Tolerable Score</td><td colspan="3">1st April 2024 ~~2021~~</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="6">This Risk was on 2019/20 BAF. Recognising its core importance to the work of the Trust it has been confirmed as an area for ongoing monitoring at both the Board Strategic Risk Session in Jan 2021 and March 2022.</td></tr>
<tr><td colspan="9">Rationale for current score:<br>(What is the justification for the current risk score)</td></tr>
<tr><td colspan="9">The work of the Quality Committee and their reviews of the Quality Indicators provides ongoing assurance. The development, implementation and monitoring of the Quality Strategy/Framework approved by the Board in July 2021, will ensure this risk is effectively managed and continues to be central to our ways of working. The majority of KPIs identified to inform the scoring of this risk are within agreed parameters excluding waiting times/access and ongoing challenges with safe staffing. In light of this and with reference to the reduction in CQC rating at Charlton Lane and impact of staffing challenges on quality, the risk score was increased in July 2022. Additional mitigations have been put in place to reflect this. CL action plan progressing with regularly reporting via quality committee. Positive feedback from unannounced MHA inspections at CL has been received .</td></tr>
<tr><td colspan="9">Links to Risk Register</td></tr>
<tr><td colspan="9">149/273: Eating Disorders, 165: Core CAMHS Waiting List, 180: Mental Health Act Changes, 190: Safe Staffing; 196 Demand and Capacity MH Inpatient Beds. 114: Acquired Pressure Ulcers; 109 Safeguarding. 107: Ligatures, 160: Patient Doc Storage, ~~211: Delayed Onward Transfer,~~ 247: Agency and Bank Reliance, 232/243: CYPS, 222: Echocardiogram capacity (↓9). 280: Out of Area Placements (↓9), 294 C&YP with SEND, 293: ADHD/ASC Waiting List (score reduced to 8). 320: CAHMS Workforce. 335: Safety of core CAMHS. 326; Social worker capacity. 325: Charlton Lane alarms</td></tr>
</table>

| Controls: (What do we currently have in place to control the risk?) | | Last Review Date: | Next Review Date: | Reviewed by: | Gaps in Controls: (What additional controls should we seek?) |
|---|---|---|---|---|---|
| 1. | Quality Dashboard | Monthly | 2022/23 | Dir NTQ/ Quality Committee / Board | Implementation and embedding of Quality Strategy. Work in progress on delivering this |
| 2. | Patient Safety Controls – including Freedom to Speak Up mechanisms | As above | As above | Dir NTQ | Quality Dashboard and patient safety, experience and Freedom to speak up reports consistently produced – to maintain. |
| 3. | Patient Experience Controls | As above | As above | As above | As above |
| 4. | Workforce Controls | As above | As above | Dir NTQ | Ongoing monitoring. Safe staffing report in quality dashboard, community services staffing data being developed. Recovery reporting in performance report. |

| Sources of Assurance: (How do we know if the things we are doing are having an impact?) | | Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent | Last Received | Received by | Assurance Rating | Gaps in Assurance: (What additional assurances should we seek?) |
|---|---|---|---|---|---|---|
| 1 | Reports on Quality Standards/Performance | L2 | Rec'd each Mtg | Qual/Res Comm or Board | Satisfactory | KPIs within Monthly reports and regularly review to ensure measures being used are the most appropriate and timely. |
| 2 | Reports on Service User Experience | Includes L3 | monthly reports | Qual Comm/Board | Satisfactory | Complaints waiting times closely monitored and improving |
| 3 | Internal Audit Reports on Freedom to Speak Up | L3 | Mar 2020 | Audit Committee | Satisfactory | Revised FTSU policy and reporting process proposed |
| 4 | Reports on Freedom to Speak up actions & issues raised | L2 | 6 monthly Reports | Board | Satisfactory | None highlighted since recommendations within Internal Audit Report implemented. Roll out of civility saves lives programme |
| 5 | Service Experience Stories to Board | L3 | Every other month | Board | Satisfactory | Feedback loop from service user stories built into Quality Committee agenda cycle. |

| Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?) | | Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions: | Action Owner: | Deadline [revised deadline] Complete / In Progress / Delayed / Not Started |
|---|---|---|---|---|
| 1 | Freedom to Speak Up revised Policy & Reporting process in place – review to ensure required impact achieved. | To be discussed at Board | FSUG | Feb 23 – in progress |
| 2 | Measuring What Matters Work to be progressed | Ongoing | DoF | In Progress |
| 3 | KPI Review to be implemented | High-level milestones agreed to be monitored via resources comm | DoF | In progress |
| 4 | Quality Strategy/Framework implementation to be reviewed | Overarching Trust Strategy in place for 2021/22. Quality Strategy in place. Biannual implementation update to Quality Comm – Sept 22 | DoNTQ | Ongoing |
| 5 | Quality mechanism processes KPIs to be kept under review to ensure being undertaken within required timelines. | Quality Committee to Monitor | DoNTQ | Refreshed dashboard being developed |
| 6 | CQC action-planning and review in response to improvements plan | Quality Committee review in Feb and March Board | DoNTQ | Ongoing |
| 7 | Ongoing review and prioritisation for recruitment focus of safer staffing hotspots | See Risk 4 (Recruitment and Retention) | DoNTQ / DHR&OD | Ongoing |
| 8 | Development of service heat maps, triangulating data and scoring mechanism as early warning and detection. | Rec arising from well led review and considered further at quality seminar. Further development required. | DoNTQ / MD | Ongoing |

Return to Summary Page

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Strategic Aim:** | | | **High Quality Care**<br>**Better Health**<br>**Great Place to Work** | **Exec Risk Owner** | Amjad Uppal, Medical Director | **Date of review:** | April 23 |
| **Risk ID:** | **2** | **Description:** | **Research & Innovation**<br>There is a risk that Research and Innovation are not supported through sustainable funding and are not embedded in our ways of working, resulting in failure to identify and implement leading edge practice to inform our care | **Lead Committee** | Quality | **Date of next review:** | June 23 |
| **Risk Rating:**<br>(Consequence x Likelihood): | | | | **Relevant Key Performance Indicators:** | | | |
| **Date Risk Identified/confirmed** | **1/4/20** (Updated Mar. 22) | | | • Number of studies open<br>• Number of locally-led studies<br>• Trust R&D Income<br>• Number of clinical areas research active<br>• Trust R&D Budget | | | |
| | **Likelihood** | **Impact** | **Overall** | | | | |
| **Inherent Risk Score:** | **4** | **3** | **12** | | | | |
| **Current Risk Score:** | **4** | **2** | **8** | | | | |
| **Tolerable Risk:** | **2** | **3** | **6** | | | | |
| **Target Date to Achieve Tolerable Score** | **1st April 2024** | | | | | | |
| **Potential or actual origin of the risk:** | | | Risk identified at Board Risk Seminar 14th Jan 2021. This risk brings together elements of risks within the prior year BAF relating to Research and Innovation. It was updated in March 2022 to include need to focus on sustainable funding and using leading edge practice. | | | | |

**Rationale for current score:**
(What is the justification for the current risk score)

The Research and Innovation Agenda is an area of increasing focus for the Trust. A Research Champions initiative has been put in place with 6 Research Champions to promote awareness across the Trust, including in areas we have not been traditionally research active. Positive outcome of the evaluation of the first 6 months of the value of the champion scheme but there are challenges to sustain model at same scale. Processes to ensure we can identify individuals to act as Principal Investigators are being developed. Staff availability to take on these roles whilst balancing additional demands in their main role is being kept under review. The research and innovation strategy was received by the Quality Committee in March. As part of the strategy, a business case for the sustainable funding for a core research function is in development with Business Manager in place. Medial Lead for Innovation in place to work alongside the R&I team. There are no concerns in achieving the tolerable risk score by April 2024.

**Links to Risk Register**

194: Non-NIHR Research funding

| Controls: (What do we currently have in place to control the risk?) | | Last Review Date: | Next Review Date: | Reviewed by: | Gaps in Controls: (What additional controls should we seek?) |
|---|---|---|---|---|---|
| 1. | Staff Engagement - Research Champions in place, staff briefed on Research at induction. | 1/12/22 | 1/12/23 | Head of R&D | Evaluation undertaken. Future sustainable plans for champions model to be confirmed - reduced to 2 champions due to funding. Future funding arrangements to be confirmed. |
| 2. | Trust membership of Research4Gloucestershire – ICS Group to support collaboration and support. | 1/10/22 | 1/10/23 | Head of R&D | Launch event March 2023 |
| 3. | Clinical Directors for research in place to support embedding research into core Trust activity | 1/4/22 | - | Med Dir | Research and Innovation Strategy to be completed, with focus on funding & practice. CD for research for physical health |
| 4. | Associate Director of Research links junior doctors & trainees with research activity. | 1/4/21 | - | Med Dir | |

| Sources of Assurance: (How do we know if the things we are doing are having an impact?) | | Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent | Last Received | Received by | Assurance Rating | Gaps in Assurance: (What additional assurances should we seek?) |
|---|---|---|---|---|---|---|
| 1. | Quarterly Reporting | L1 | 10/11/22 | Research Overview Committee | Satisfactory | Reports to increase focus on changes to practice. |
| 2. | Annual Report on Res & Inn to Qual Comm | L2 | Oct 22 | Quality Committee | Satisfactory | |
| 3. | Research Champions Feedback | L1 | 10/11/22 | Research Overview Committee | Satisfactory | |
| 4. | Sponsor Reviews – (includes consideration if standards met) | L3 | Ongoing | Research Overview Committee | Satisfactory (reported if issues raised) | |

| Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?) | | Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions: | Action Owner: | Deadline [revised deadline] Complete / In Progress / Delayed / Not Started |
|---|---|---|---|---|
| 1. | Put in place relationships with QI and Audit to improve knowledge of research & evaluation & work together to support local projects | Discussions ongoing to map ways of working and agree processes to support | Head of R&D | In progress – informal mechanisms in place. |
| 2. | Innovation Lead role to be put in place. | Lead identified | Med Dir | Completed |
| 3. | Process to enable research to be built into job plans to ensure staff have dedicated time to work on projects to be developed | To be considered as element Research and Innovation Strategy | Med Dir | Completed |
| 4. | Research and Innovation Strategy to be developed to pull together Res & Inn. Activities and consider overall impact on care. | Methodology for development to be considered and taken forward | Med Dir | Completed |
| 5. | Pilot of Research Champions to be reviewed for impact | Initial 6 months from 1 Oct, extended 6 months with summer review | Exec | Completed. |
| 6. | Implement training sessions on research to raise awareness. | | Head of R&D | April 2023 |
| 7. | Executive to review funding and sustainability. | Business case in development | Exec | Q1 2023/2024 |

Return to Summary Page

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Strategic Aim:** | | | **High Quality Care**<br>**Better Health** | **Exec Risk Owner** | David Noyes, COO | **Date of review:** | April 23 |
| **Risk ID:** | **3** | **Description:** | **Demand for Services**<br><br>There is a risk of demand for services beyond planned and commissioned capacity, which cannot be managed through usual mechanisms, resulting in services not meeting the expectations of our community leading to poorer outcomes for patients and service users and-potentially reinforced health inequalities. The risk is exacerbated by the challenge of recovery from the pandemic, with potential for more disruption in the event of further spikes/variants.<br><br>It is recognised that there is an inter relation of this risk and Risk 4 Recruitment and Retention and Risk 5 staff Wellbeing. | **Lead Committee** | Resources | **Date of next review:** | June 23 |
| **Risk Rating:** (Consequence x Likelihood): | | | | **Relevant Key Performance Indicators:** (taken from the Performance Report) | | | |
| Date Risk Identified/confirmed | 1st April 2020 (Updated Mar. 22) | | | • Waiting times<br>• Referral and Access Reports<br>• Length of Stay<br>• No. Complaints and Compliments (access related)<br>• Out of Area Placements<br>• Increased number of individuals with long term conditions – once available<br>• Health Inequalities key metrics<br>• User Satisfaction<br>• Levels staff sickness<br>• Quality Data | | | |
| | **Likelihood** | **Impact** | **Overall** | | | | |
| Inherent Risk Score: | **5** | **4** | **20** | | | | |
| Current Risk Score: | **4** | **4** | **16** | | | | |
| Tolerable Risk: | **3** | **4** | **12** | | | | |
| Target Date | **1st April 2024** | | | | | | |
| **Potential or actual origin of the risk:** | | | | Risks relating to demand incorporated in previous BAFs – 2021 and 2022. | | | |

**Rationale for current score:** (What is the justification for the current risk score)

Demand for our services remains high. The enduring and consistent level of high pressure on our services has an ongoing impact on staff wellbeing and retention. The relationship between health and social care (and social care funding) remains to be resolved at a national level. This continues to manifest itself locally. The recent Newton Europe diagnostic intervention identified areas for improvement which are currently being prioritised; the next phase of implementation is being mobilised at system level in early summer 2023 (in the meantime, actions under our direct control are being taken forward and monitored through physical health transformation board). To date relationships with Commissioners remain supportive, but we need to ensure clear understanding of the volumes we are dealing with and how we are supporting Health & Care provision across the County. We are now in the early stages of work to define the future capacity and capability required of the community estate with a view to enhancing our service offer to support independence alongside a countywide discharge to assess pathways led by GCC. We maintain a full suite of service improvement plans which are regularly reviewed at operational and governance level. Project being undertaken to resolve data quality issues relating to physical health and the information held in the clinical system to enable an accurate waiting list position across services continues to make strong progress, with the next phase focussing on the transition to BAU. We have developed a plan to reconfigure service around local partnerships will be brought to Board in due course.

**Links to Risk Register**

149/273: Eating Disorders, 165: Core CAMHS Waiting List, 190: Safe Staffing; 196 Demand & Capacity MH Inpatient Beds. ~~211: Delayed Onward Transfer~~, 247: Agency & Bank Reliance, 232/243: CYPS, *222: Echocardiogram capacity (↓9). Out of Area Placements (↓9),* 285: Cost of Living Crisis, 294 C&YP with

SEND293: ADHD/ASC Waiting List (score reduced to 8); ~~302: Clinical Records syncing to Spine~~. 320: CAHMS Workforce. 339: Covid Medicines Delivery Unit; 338: Heart Failure Service. 335: Safety of core CAMHS. 326; Social worker capacity. 323: G. Anaesthetic Provision/Spring bank

| Controls: (What do we currently have in place to control the risk?) | | Last Review Date: | Next Review Date: | Reviewed by: | Gaps in Controls: (What additional controls should we seek?) |
|---|---|---|---|---|---|
| 1 | Contract Management Board | Monthly | | DoF | |
| 2 | ICS Board | Monthly | | CEO | |
| 3 | Board and Committee Monitoring | Monthly | | Board | |
| 4 | Business plan – process & monitoring | Annual | | CEO/Chair | |
| 5 | Relationship GCC and GCCG | Ongoing | | CEO/Chair/Board | GCC not formal member ICS |

| Sources of Assurance: (How do we know if the things we are doing are having an impact?) | | Lines of assurance: L1 – Operational L2 – Board oversight L3 – Independent | Last Received | Received by | Assurance Rating | Gaps in Assurance: (What additional assurances should we seek?) |
|---|---|---|---|---|---|---|
| 1 | Performance Report | L2 | Monthly | Res Comm/Board | Satisfactory | Improved integrated reporting |
| 2 | ICS Operating Plan | L2 | Annual | Board | Limited | ICS Control Total will impact funds available to meet demand |
| 3 | Business Plan monitoring | L2 | 6 monthly | Board | Satisfactory | Delays in provision guidance business plan & budget mean 6-month review planned. |
| 4 | Quality Account – including stakeholder feedback | L2/L3 | Annual | Board | Satisfactory | |
| 5 | HoSC feedback | L3 | Every other month | Chair/CEO/ | Satisfactory | |
| 6 | Service User Feedback | L3 | Annual | Board/Qual | Limited | National issue impacts, ensure comms effective |
| 7 | Quality Report | L2 | Monthly | Qual Comm/Board | Satisfactory | |
| 8 | Quality Dashboard | L2 | Monthly | Qual Comm/Board | Satisfactory | |

| Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?) | | Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions: | Action Owner: | Deadline [revised deadline] Complete / In Progress / Delayed / Not Started |
|---|---|---|---|---|
| 1 | Recovery Clinics being undertaken with service leads to understand demand and capacity and determine service lines that need review with Commissioners | Change of focus due to Covid surge preparedness including service prioritisation and redeployment (as required). | COO | Complete – review of service improvement plans |
| 2. | Continue work to build capacity and understanding of self-care and develop more admission avoidance schemes. | To be built into service reviews & developments. Focus on co-production for service developments to continue | COO DS&P | In progress –incremental adoption in conjunction with ILPs |
| 3 | Continue work to improve joined up working across the county to make best use of Gloucestershire pound | Ongoing work across ICS | Exec | **In progress** |
| 4 | Continue relationship building with GCC and County MPs | Regular Exec yearly update to GCC to continue. Regular meetings with MPs to continue. | CEO | **In progress** |
| 5 | Continue performance report monitoring & deep dives to focus on patient outcomes. | Established within agenda cycles | COO | **In progress** |
| 6 | Project to improve data quality on physical health services in SystmOne to resulting in improved reporting | 6 months of data quality clerking obtained through the CSU to support project. Progressing well with improvements in data recording and quality seen. | COO | 31 March 2023 |
| 7 | Consider further how health inequalities can be measured and targeted as a system (links to item 6). | Localisation plan develop and discussion with Trust Senior Team. To be discussed by Board | Exec/ICS | |
| 8 | Development and continuation of CATU at Tewkesbury | Business case developed and accepted | COO | **Complete** |
| 9 | Embed learning from enhanced pathway 2 project and system wide therapy review. | Project underway, full evaluation March 2023 | COO | **In progress** |
| 10 | OD intervention to address length of stay for acute mental health services. | In planning stage. OD sessions to be undertaken in September. Second held session Jan 23. | COO/MD | May 2023 |
| 11 | Integrated reporting in newly configured performance report | Executive objective for 23/24. Service profile reports in the interim | Exec | |

Return to Summary Page

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|---|---|---|---|---|---|---|---|
| **Strategic Aim:** | | | **Great place to work**<br>**Better Health**<br>**High Quality Care** | **Exec Risk Owner** | N Savage D of HR & OD | **Date of review:** | March 23 |
| **Risk ID:** | **4** | **Description:** | **Recruitment & Retention**<br><br>There is a risk that we fail to recruit, retain and plan for a sustainable workforce to deliver services in line with our strategic objectives. | **Lead Committee** | GPTW | **Date of next review:** | June 23 |
| **Risk Rating:** (Consequence x Likelihood): | | | | **Relevant Key Performance Indicators:** | | | |
| **Date Risk Identified/confirmed** | 1st April 2020 (Updated Mar. 22) | | | • Staff Turnover<br>• Annual Staff and Pulse Surveys<br>• Staff Friends and Family FFT scores<br>• Vacancy Rates<br>• Bank and Agency Usage<br>• Recruitment & Retention Report – exit trends<br>• Education & Development Report<br>• Appraisals<br>• Probationary periods<br>• Statutory & Mandatory Training Update | | | |
| | **Likelihood** | **Impact** | **Overall** | | | | |
| **Inherent Risk Score:** | **4** | **4** | **16** | | | | |
| **Current Risk Score:** | **4** | **4** | **16** | | | | |
| **Tolerable Risk:** | **3** | **4** | **12** | | | | |
| **Target Date to Achieve Tolerable Score** | **1st April 2025** | | | | | | |
| **Potential or actual origin of the risk:** | | | Board Risk Seminar 14 Jan 2021 and related risk within 2020/21 BAF. Reworked in 2022 to focus on GHC Strategy rather than wider system and national issues. | | | | |

**Rationale for current score:** (What is the justification for the current risk score)

A range of revised processes and initiatives were implemented during 2021/22 and continue to be embedded and further developed. This work is now overseen by the Great Place to Work Committee, Executive Committee and the Sustainable Staffing Oversight Group. The risk has been refocused to incorporate Learning and Development metrics and a range of operational risks developed to support progress on this strategic risk. It is recognised that many aspects of supply, terms, conditions and competitive remuneration remain outside the Trust's immediate control. It also recognises that the workforce supply pipeline for degree level registered medical, AHP and nursing roles has between a 3 and 10 year tenure with, for example, our local RNLD degree programme only commenced in September 2022 and the 3 Counties Medical School opening is now delayed to Sept 2023 and will initially not be abel to enrol UK students. Due to these factors recruitment and retention will remain a significant risk, impacted by wider issues which include, funding, impact of the pandemic, shortages of staff nationally, although it is also recognised that significant progress has been made in establishing processes to support recruitment and retention. It should be noted that delays in the current registered staff pipeline will continue to significantly impact our ability to reduce this risk in the short or medium term.

**Links to Risk Register**

149/273: Eating Disorders, 165: Core CAMHS Waiting List, 247: Agency and Bank Reliance, 232/243: CYPS. *222: Echocardiogram capacity (↓9). Out of Area Placements (↓9),* 285: Cost of Living Crisis, 294 C&YP with SEND, 293: ADHD/ASC Waiting List (score reduced to 8), *287 Industrial Action (↓6);* 320: CAHMS Workforce. 335: Safety of core CAMHS. 326; Social worker capacity

| Controls: (What do we currently have in place to control the risk?) | | Last Review Date: | Next Review Date: | Reviewed by: | Gaps in Controls: (What additional controls should we seek?) |
|---|---|---|---|---|---|
| 1. | International Recruitment Programme for RMN, RGN and AHP | 17/05/22 | 30/01/23 | Exec | Programme under monthly review. |
| 2. | Relationships with a number of universities to build supply New Programmes developed Uni of Glos – LD Nursing, Established RGN, RMN & Physiotherapy Degrees and student placement UoG. Three Counties Medical School – local medical supply line | Ongoing | 1/7/22 | Exec | Lead time for RN LD degree training to complete i.e 2025. |
| 3. | Recruitment Policy in place to fast track recruitment | 20/04/22 | 01/04/23 | Exec | Policy under review as part of 22/23 policy manual project |
| 4. | ICS Workforce Steering Group | Ongoing | 11/05/22 | Exec | ICS people strategy and recruitment and retention plan not yet agreed |
| 5. | Wotton Lawn Task and Finish Group | 24/07/22 | 30/09/22 | Exec | Completed |
| 6. | Health Care Support Worker Recruitment and Retention Project | 24/07/22 | 30/10/22 | Exec | Retention focus through targeting Health Care Support Worker interventions. Analysis of leaver data – Winter 2022 |
| 7. | Recruitment and Retention Strategic Framework | 24/07/22 | 30/09/22 | Exec and GPTW | Evaluation of effectiveness of action plan |

| Sources of Assurance: (How do we know if the things we are doing are having an impact?) | | Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent | Last Received | Received by | Assurance Rating | Gaps in Assurance: (What additional assurances should we seek?) |
|---|---|---|---|---|---|---|
| 1 | Monthly Recruitment Activity Reports to SSOG | L1 | Monthly | Exec | Work in progress | ~~Recruitment Strategy to be finalised~~ - complete |
| 2 | Staff Survey and Staff FFT | Ls 1,2 and 3 | August 2022 | GPTW | Satisfactory | |
| 3 | Retention Data | Ls 1 and 2 | Ongoing | GPTW | Satisfactory | |
| 4 | Turnover Data | Ls 1 and 2 | Ongoing | GPTW | Satisfactory | |

| Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?) | | Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions: | Action Owner: | Deadline [revised deadline] Complete / In Progress / Delayed / Not Started |
|---|---|---|---|---|
| 1 | Launch of Recruitment and Retention Framework. | Draft Recruitment and Retention Framework presented to GPTW Committee April 2022 and approved and launched in June 2022. R&R progress report presented to Board Sept 2022. | D HR&OD | **Complete** |
| 2 | Recruitment & Retention Premium Business case in development for higher vacancy/hard to recruit areas | Interim financial incentivisation* for Home First/Reablement, Facilities/ Mental Health (WLH) | D HR&OD | **Complete** |
| 3 | Targeted temporary staff bank recruitment and review of bank incentives | Bank rates were increased from July 1st, late booking incentives were removed. Sustained increase to the number of bank hours worked and an increase to number opting to join the bank. | D HR&OD | **Complete** |
| 4 | Review and implementation Guaranteed Volume contract. | Sustainable Staffing Oversight Group in place. Contract reviewed and renewed in 2021 and other agency provider contracts under regular review. | D HR&OD | **Complete** |
| 5 | Implementation of TRAC system and QI review of recruitment process. | Implementation phase. Project governance in place. | D HR&OD | **Complete – delivered in Q4** |
| 6 | HSCW Recruitment and Retention Project | HCSW Council launched June 2022. Joint ICS HCSW recruitment event at the end of September 2022, supported by Indeed. Itchy Feet clinics launched Jan 22. | D HR&OD | **April 2023 - Ongoing** |

| | | | | |
|---|---|---|---|---|
| 7 | International Recruitment – additional partnering for RMNs | 35 MH Nurses, Community ICT's: 10 Nurses, Community Hospitals: 28 Nurses. 2022/23 Target for Mental Health Nurses achieved | D HR&OD | |
| 8 | Return to practice | Review opportunities to increase RTP recruits for 2023 cohort | D HR&OD | Q4 |
| 9 | Remuneration Review | 2022 pay review paid at end Sept. Work to calculate the implications of paying the Living Wage underway. Will require ICS and regional consultation. | D HR&OD | Q4 |
| 10 | ICS Providers Cost of Living Support review | ICS wide cost Cost of Living support review commended in July 22, with further recommendations expected at end Q2. | D HR&OD | Ongoing |
| 11 | Launch International AHP Recruitment | Yet to secure a pipeline of suitable candidates, despite help from a number of international agencies. | DHR&OD/DNTQ | Q4 |
| 12 | Maximise student placement activity for 2022 | Engagement with HEIs, ICS and internal stakeholders to optimise student placement activities (in May and June for September intake) | DHR&OD | **Complete** |
| 13 | Improved long term nursing workforce supply modelling | A "Supply Scenario Modelling (Optioneering) Tool Scoping Workshop" is being run with Health Education England assistance in Q4 | DHR&OD | In progress |
| 14 | Implementation of the Nursing and Midwifery Self-Assessment Tool and action plan | This new work stream commenced in Q3 and an updated was provided to GPTW in December 22. The next update is due to be presented to the GPTW committee in August 2023. | DHR&OD | Ongoing |
| 15 | Increase careers, widening access and apprenticeship engagement | GHC Careers and Engagement Officer connecting with schools, DQP, communities and diversity groups including recruitment to apprenticeship talent pool | DHR&OD | Ongoing |
| 16 | Agreement for use of Section 256 monies to run a series of 2023/24 ICS wide recruitment campaigns | Funding confirmed in April 2023, with Expressions of Interest to be sought and appointed by May/June. | DHRD&OD | Q 1-4 |
| 17 | Submission of a bid to NHSE for £350k to support IR recruitment for social care in GCC and GHC | Bid outcome outstanding | DHRD&OD | TBC |

Return to Summary Page

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|---|---|---|---|---|---|---|---|
| **Strategic Aim:** | | | **Great Place to Work**<br><br>**High Quality Care** | | **Exec Risk Owner** | Neil Savage, D of HR&OD | **Date of review:** April 23 |
| **Risk ID:** | **5** | **Description:** | **Workforce Wellbeing**<br><br>There is a risk that we are unable to consistently ensure the health and wellbeing of colleagues, particularly during periods of exceptional demand. | | **Lead Committee** | GPTW | **Date of next review:** June 23 |
| **Risk Rating:** (Consequence x Likelihood): | | | | | **Relevant Key Performance Indicators:** | | |
| **Date Risk Identified/confirmed** | 1st April 2020 (Updated Mar. 22) | | | | • Staff Survey wellbeing metrics – positive action on HWB<br>• Pulse survey data<br>• Sickness Absence KPI<br>• Health & Wellbeing Report | | |
| | **Likelihood** | **Impact** | **Overall** | | | | |
| **Inherent Risk Score:** | **4** | **3** | **12** | | | | |
| **Current Risk Score:** | **3** | **3** | **9** | | | | |
| **Tolerable Risk:** | **2** | **3** | **6** | | | | |
| **Target Date to Achieve Tolerable Score** | **31st March ~~23~~ ~~24~~** | | | | | | |
| **Potential or actual origin of the risk:** | Board Risk Seminar 14 Jan 2021 and also elements from risks within 2020/21 BAF. In 2022 the risk was refocused to reflect work done to embed and improve Health & wellbeing and now considers from ongoing perspective to ensure embedded. | | | | | | |

**Rationale for current score:** (What is the justification for the current risk score)

Sickness absence has climbed steadily since 2021~~, up to 7.6% for December 2022 (~~and remains above the target threshold 4% (5.9% March 23). The Trust has a dedicated Health and Wellbeing NED. A Health and Wellbeing Strategic Framework was approved by the GPTW Comm in summer 2022, after engagement with colleagues to establish our workplace H&W priorities. The Trust hosts the system-wide Mental Health and Wellbeing Line, funded through NHSE until March 24, and our Health and Wellbeing team have been instrumental in the launch of the Health and Wellbeing Champions initiative (launched May 22). The 22 Staff Survey feedback tells us that 69.3% of colleagues feel that the organisation takes positive action on health and wellbeing (increased from 65.3% in 21), the detailed results have been used to inform 23/24 action plans to address areas of concern, which therefore help mitigate the risk. Colleagues rated the Trust better than the NHS-wide, South West providers and benchmark Trust group rating on "We are safe and healthy". In recognition of the risk associated with the end of funding for the Wellbeing Line in 23, the risk score was been increased to 12 in the last quarter. While we have since sourced fixed term system funding for Wellbeing Line for 23/24 the non-recurrent nature of this means we expect the service's staffing turnover and provision to remain at higher risk until there is long term funding identified. If funding is not resolved the service will need to commence closure in Dec 23.

**Links to Risk Register**

285: Cost of Living; *287 Industrial Action (↓).* 311: Alarm at Southgate Moorings.

| Controls: (What do we currently have in place to control the risk?) | | Last Review Date: | Next Review Date: | Reviewed by: | Gaps in Controls: (What additional controls should we seek?) |
|---|---|---|---|---|---|
| 1 | Health & Wellbeing (HWB) Team in place. | 24/07/23 | 01/04/23 | Exec & Board within Business Plan & Budget setting | |
| 2 | Health & Wellbeing Communication Plan in place – intranet, website | Ongoing | - | Exec/Board | |
| 3 | NED Wellbeing Lead, Exec Wellbeing Lead & HWB Champions | 24/07/23 | 30/06/23 | Board | |
| 4 | Health & Wellbeing built into budget and business plan | 24/07/23 | 31/03/23 | Board | |
| 5 | Staff Support processes include HWB conversations – management supervisions, 121 meetings and appraisals | 24/07/23 | 30/06/23 | | Assurance Audit to confirm if staff survey highlights concerns. |
| 6 | Activities: Staff Counselling, MSK self-referral, Health & Hustle, Long Covid support, signposting Let's Talk Therapies | 24/07/23 | 30/06/23 | | |
| 7 | Health & Wellbeing Strategic Framework in place | 03/08/22 | 29/03/23 | | GPTW review June 23 meeting |

| Sources of Assurance: (How do we know if the things we are doing are having an impact?) | | Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent | Last Received | Received by | Assurance Rating | Gaps in Assurance: (What additional assurances should we seek?) |
|---|---|---|---|---|---|---|
| 1 | Annual Working Well Assurance Report | L2 | June 2022 | GPTW | Satisfactory | |
| 2 | Internal Audit HR to review compliance with processes | L3 | 2022 | Audit Committee | Satisfactory – following completion follow up issues | |
| 3 | Working Well Occupational Health Safe Effective Quality Review (SEQOHS) accreditation & annual assurance process | L3 | Dec 2022 | Exec | Satisfactory | ~~Next SEQOHS external assessment is October 2022.~~ Achieved Nov 2022 |
| 4 | Employee Assistance Programme | L3 | Monthly | HR | Satisfactory | |
| 5 | Staff Survey & Pulse Surveys | L3 | Annual/Quarterly | Exec/GPTW | Satisfactory | |

| Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?) | | Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions: | Action Owner: | Deadline [revised deadline] Complete / In Progress / Delayed / Not Started |
|---|---|---|---|---|
| 1. | HWB strategic framework to be developed to reflect national strategy and local needs. | Approved by GPTW August 2022 | D HR&OD | **Completed** |
| 2 | Face to face counselling times to be reduced. | Target 1-2 weeks, has reduced from 12 to 8 weeks. Triage and signposting to VIVUP telephone counselling and Let's Talk. Private contractor support. Remote working. Triage in place. Slots offered within 3 days of self-referral, with 4-week option beyond. | D HR&OD | **Completed** |
| 3 | Review current HWB offer to maximise colleague take up . | Target end Q2 2022/2023 | Head of OD | Completed |
| 4 | Audit of Quality HWB conversations to be undertaken if staff survey indicators raise as issue. | Not highlighted in 2022 Survey | - | Not currently required |
| 5 | Working well income generation programme to fund service provision and development. | To be reported on within revised HWB strategic framework | D HR&OD | **Completed** |
| 6 | ICS wide Health and Wellbeing Gap Analysis project 2023 | New project to inform a future ICS-wide HWB approach to ensure we maximise provision across health and social care providers and get the best value for staff support | D HR&OD | **In Progress Q4 22/23** |

Return to Summary Page

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|---|---|---|---|---|---|---|---|
| **Strategic Aim:** | | | **Great Place to Work**<br>**Better Health** | | **Exec Risk Owner** | N Savage, DHR&OD | **Date of review:** Jan 23 |
| **Risk ID:** | **6** | **Description:** | **Culture (Internal)**<br><br>There is a risk that we fail to deliver our commitment to having a fully inclusive and engaging culture with kind and compassionate leadership, strong values and behaviours which negatively impacts on retention and recruitment, colleagues experience and engagement and on our ability to address inequalities in service delivery (access, experience and outcomes). | | **Lead Committee** | GPTW | **Date of next review:** March 23 |
| **Risk Rating:** (Consequence x Likelihood): | | | | | **Relevant Key Performance Indicators:** | | |
| **Date Risk Identified/confirmed** | 1st April 2020 (Updated Mar. 22) | | | | • Staff Survey and Pulse Surveys<br>• HR Formal Casework report<br>• Just & Learning Culture e-learning<br>• Diversity levels at Band 8 and above – area of ongoing work<br>• Freedom to Speaking up Data<br>• WRES Data<br>• WDES Data<br>• Gender Pay Gap Data<br>• Service User Equality Access Data – when available | | |
| | **Likelihood** | **Impact** | **Overall** | | | | |
| **Inherent Risk Score:** | **3** | **3** | **9** | | | | |
| **Current Risk Score:** | **3** | **2** | **6** | | | | |
| **Tolerable Risk:** | **2** | **2** | **4** | | | | |
| **Target Date to Achieve Tolerable Score** | **1st April 2024** | | | | | | |
| **Potential or actual origin of the risk:** | | | Board Risk Seminar Jan 2021. Revised in April 2022 to incorporate description of targeted internal culture. | | | | |

**Rationale for current score:**
(What is the justification for the current risk score)

The organisation Values & Behaviours work was co-developed, agreed and is now embedded within key policies, reward/award process, recruitment, inductions and appraisals to help ensure the culture reflects Trust and Board commitments. The Speaking Up at Work and Freedom to Speak Up Policies plus the developing Diversity Networks are used to inform and develop practice provide assurance that the values and behaviours are being lived throughout the organisation. The Civility Saves Lives programme is now being implemented alongside a Restorative, Just & Learning Culture approach. Leadership Development Programme (Thrive) and ICS Flourish Programme (positive action/stepping up programme) in place. Equality and Diversity Lead Role in place and revised Managing Diversity policy approved. The 2022 Staff Survey results are being were used for action plans to address areas of concern and help mitigate the risk. A new Freedom To Speak Up Policy is in the final stages of development following a new national template policy. The Trust received positive compliments on its Freedom To Speak Up approach and culture in the 2022 Care Quality Commission report, noting however that more publicity was still needed. The 2022 Staff Survey indicators for 'compassionate and inclusive culture' place our Trust above the average score for all trust wide indicators, with 69.8% of colleagues stating they would recommend the organisation as a place to work.

**Links to Risk Register**

| Controls: (What do we currently have in place to control the risk?) | | Last Review Date: | Next Review Date: | Reviewed by: | Gaps in Controls: (What additional controls should we seek?) |
|---|---|---|---|---|---|
| 1 | Co-developed Values & Behaviours organisational values | 27/09/22 | 01/06/23 | Board | Post-merger review with UoG of effectiveness of values and behaviours. Complete Q1 23/24 |
| 2 | Just culture and appreciative enquiry processes included in performance management & Disciplinary Processes | 14/04/23 | 01/06/23 | Executive | Learning from HR casework event and wider benchmarking |
| 3 | Valuing Difference Leadership Strategy in place | 14/04/23 | 01/06/23 | Executive | |
| 4 | Freedom to Speak Up, Speaking up at work policies | 27/09/22 | 01/06/23 | Board | Policy under review |
| 5 | Co-production commitment to service design | Ongoing | | Board | |
| 6 | Learning and Development Strategic Framework | 14/04/23 | 08/06/23 | GPTW | |

| Sources of Assurance: (How do we know if the things we are doing are having an impact?) | | Lines of assurance: L1 – Operational L2 – Board oversight L3 – Independent | Last Received | Received by | Assurance Rating | Gaps in Assurance: (What additional assurances should we seek?) |
|---|---|---|---|---|---|---|
| 1 | Feedback from appraisals and reward award processes | L1 | Ongoing | Exec | Satisfactory | Gap between colleagues reported uptake and internal ESR records. Reported usefulness. |
| 2 | Disability Confident Leader Accreditation | L3 | Aug 2022 | Exec | Satisfactory | |
| 3 | Annual Workforce Race Equality Scheme & Action Plan | Ls 2 and 3 | July 2022 | Board | Satisfactory | |
| 4 | Annual Disability Equality Scheme & Action Plan | Ls 2 and 3 | July 2022 | Board | Satisfactory | |
| 5 | Patient & Staff Surveys | Ls 1,2 and 3 | Mar 2022 | Board | Satisfactory | |
| 6 | Freedom to Speak Up 6 monthly report | Ls 2 and L3 | Nov 2022 | Board | Satisfactory | |
| 7 | Diversity Network (sub groups women, LGBTQ+, Disabled, RCAN) with Lead NED in place | L2 | Ongoing | Board/Exec | Satisfactory | |
| 8 | Gender Pay Gap Reporting | Ls 2 and 3 | Mar 2023 | Board | Satisfactory | |
| 9 | Work in Confidence in place | L2 | Ongoing | Exec | Satisfactory | |

| Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?) | | Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions: | Action Owner: | Deadline [revised deadline] Complete / In Progress / Delayed / Not Started |
|---|---|---|---|---|
| 1. | Senior management diversity – Bands 8 and above to be developed. | Reciprocal Mentoring and Flourish Leadership Development programmes in place and ongoing. Flourish review scheduled. | D HR&OD | **In progress** |
| 2 | Equality &Diversity Training to be updated. | New ED focussed 'safer recruitment' training implemented. E&D Training being reviewed 2021/22 and new arrangement will be implemented after the current surge and recovery, Q1 2022/23 - "Dignity at Work practice review - Just and Learning Culture" | D HR&OD | **Delayed** - 23/24 business planning objective |
| 3 | Equality & Managing Diversity Policy to be updated | Reviewed with Trade Unions and approved by Executive Committee and JNCF following engagement with Diversity groups. | D HR&OD | **Complete** |
| 4 | Annual EDI action plan formalised, which includes key statutory requirements and stretch milestones. | Currently in development | D HR&OD | **In Progress** |
| 5 | Values and Behaviours Review survey | Scoping work with UoG commenced delivery through Qs 3 and 4. | D HR & OD | **In progress – Q1 23/24** |
| 6 | Review of Apprenticeship (widening access) policy and pay | Commenced Q4 – delayed due to prioritisation of b2/3 project | ADELD | **In progress** |
| 7 | EDS22 | Completion of EDS22 in progress with stakeholders | D HR & OD | **In progress** |

Return to Summary Page

<table>
<tr><td colspan="3">Strategic Aim:</td><td>Better Health</td><td>Exec Risk Owner</td><td>Angela Potter, Director of Strategy and Partnerships</td><td>Date of review:</td><td>March 23</td></tr>
<tr><td>Risk ID:</td><td>7</td><td>Description:</td><td rowspan="2">Partnership Culture<br><br>There is a risk that the Trust is not seen as an organisation which actively engages with its patients, staff and wider community partners impacting on our ability to deliver co-produced, personalised, high-quality services and address inequalities in service delivery (access, experience and outcomes).</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>June 23</td></tr>
<tr><td colspan="3">Risk Rating:<br>(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:<br>(taken from the Performance Report)</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td>1st April 2020 (Updated Mar. 22)</td><td rowspan="5">• Number of Engagement Partners<br>• Number of services redesigned using co production<br>• Number and breadth of services covered by Experts by Experience?<br>• Staff Diversity data reflects our community<br>• Patient Diversity Data reflects our community – this is information to be developed. Not yet in place<br>• Working Together Advisory Group feedback</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>2</td><td>3</td><td>6</td></tr>
<tr><td colspan="3">Target Date to Achieve Tolerable Score</td><td colspan="3">1st April 2024</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="5">Discussion Board Risk Seminar 14/1/21 and elements of risks within BAF 2020/21. Updated 2022 to include “Transformed”. Wording reviewed/streamlined and - Jan 2023</td></tr>
<tr><td colspan="8">Rationale for current score: (What is the justification for the current risk score)</td></tr>
<tr><td colspan="8">The Trust has a strong commitment to partnership working, co-production and personalised care within its ways of working which was a central tenet within its rationale for merger. There is now clear leadership around the personalisation agenda through the Quality Improvement Team and the Partnership Team providing a clear approach to how the Trust is taking forward co-production and working with stakeholders to achieve this. The Working Together Advisory Group is now in place providing strong oversight and engagement with system partners. CMHT programme has strong partner engagement throughout. All actions proposed have now been completed and experts by experience cohort is growing however work is required to further embed co-production within the organisation.</td></tr>
<tr><td colspan="8">Links to Risk Register</td></tr>
<tr><td colspan="8"></td></tr>
</table>

| Controls: (What do we currently have in place to control the risk?) | | Last Review Date: | Next Review Date: | Reviewed by: | Gaps in Controls: (What additional controls should we seek?) |
|---|---|---|---|---|---|
| 1 | Directorate for Strategy and Partnership with engaged team embedded in the communities we serve | Agreed as part merger | - | Board | |
| 2 | Joint Director with GCCG to support working with GP Network | Agreed as part merger | - | Board | |
| 3 | Expert by Experience Programme | 21/22 | 22/23 | D S&P | |
| 4 | Governor Membership & Engagement Strategy | 31/3/21 | March 23 | Council of Governors/Board | Action Plan to be implemented |
| 5 | Walk in My Shoes Programme | Ongoing | March 23 | Exec/Board | To be reviewed for impact |

| Sources of Assurance: (How do we know if the things we are doing are having an impact?) | | Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent | Last Received | Received by | Assurance Rating | Gaps in Assurance: (What additional assurances should we seek?) |
|---|---|---|---|---|---|---|
| 1 | Friends and Family Test Patient Feedback Report | L2 | Monthly (in quality report) | Quality Comm/Board | Satisfactory | |
| 2 | Compliments & Complaints Report | L2 | Monthly (in quality report) | Quality Comm/Board | Satisfactory | |
| 3 | Staff Diversity Data | L2 | Annual | Resources | Satisfactory | |
| 4 | Patient Diversity Data | L2 | Ad hoc | | Low | Reporting to be enhanced |
| | | | | | | |

| Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?) | | Update since last reviewed (this should be high-level actions – the detail of the actions part of regular committee discussions: | Action Owner: | Deadline [revised deadline] Complete / In Progress / Delayed / Not Started |
|---|---|---|---|---|
| 1 | Better Together Events to recommence. | Better Together Events taking place and well received. Next event focused on Personalisation and Self Care. | D S&P | **Completed -** Dec 2021 |
| 2 | People Participation Strategic Framework to be developed | Working Together Framework in place and Group actively meeting | D S&P | **Completed –** Jan 2021 |
| 3 | Personalisation of Care to be confirmed element of co-production and service review | Personalisation of Care to be built into co-production and service review. The SDM focused on personalisation is having good impact. WTAG to focus on children and young people in April. Better Together event in April to focus on personalised care | D S&P | **In progress** |
| 4 | Experts by Experience Review | Ongoing recruitment programme – focus on young experts and those with physical health conditions | D S&P | **In progress** |
| 5 | Governor Membership & Engagement Action Plan | To be implemented – partners and members to be put in place | H CG&TS | **In Progress** |
| 6 | Walk in My Shoes Programme | To be reviewed for impact in July 2022 | CEO | Not started |
| 7 | Patient Access and Involvement Data to be developed | To be developed and reviewed against health inequalities | D S&P | Not started |

Return to Summary Page

<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">Better Health<br><br>High Quality Care</td><td>Exec Risk Owner</td><td>Sandra Betney, Director of Finance</td><td>Date of review:</td><td>March 23</td></tr>
<tr><td>Risk ID:</td><td>8</td><td>Description:</td><td colspan="3" rowspan="6">Resources Targeted at Acute Care<br><br>There is a risk that the ICS prioritises acute care demand over the demands of Mental Health, Community, Primary Care and Learning Disabilities resulting in under resourcing of non-acute care and restricting the ability to provide joined up care and ensure effective patient flow</td><td>Lead Committee</td><td>Board/ Resources</td><td>Date of next review:</td><td>June 23</td></tr>
<tr><td colspan="3">Risk Rating:<br>(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:<br>(taken from the Performance Report)</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed</td><td colspan="4">1st April 2020 (Updated Mar. 22)</td></tr>
<tr><td></td><td colspan="2">Likelihood</td><td>Impact</td><td>Overall</td><td colspan="4" rowspan="3">• To be considered</td></tr>
<tr><td colspan="3">Inherent Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td colspan="3">Current Risk Score:</td><td>3</td><td>4 3</td><td>~~12~~ 9</td></tr>
<tr><td colspan="3">Tolerable Risk:</td><td>2</td><td>4</td><td>8</td><td colspan="4"></td></tr>
<tr><td colspan="3">Target Date to Achieve Tolerable Score</td><td colspan="3">1st April 2025</td><td colspan="4"></td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Risk identified at Risk Seminar 4th Jan 2021, also an element of risk within 20/21 BAF. Revised 2022 to show link to patient flow.</td></tr>
<tr><td colspan="10">Rationale for current score: (What is the justification for the current risk score)<br>Acute services tend to have a higher profile in the media, to be more easily understood by service users and are often have more growth built into funding which can mean that growth in acute services is more easily recognised and reflected in funding allocations than non-acute services. The role non-acute care plays in prevention and supporting service users post-acute care needs to be reflected in funding mechanisms to provide holistic care, which makes best use of the Gloucestershire pound, in the county. Currently the allocations of funding in the ICS remain strongly focused on the acute trust. The joint working in response to the pandemic should help to strengthen understanding of the way acute and non-acute services work most effectively in partnership, but the focus on returning acute services but “normal” needs to be achieved without reducing funding to non-acute services which have also experienced growth in demand, particularly highlighted in relation to mental health within the media, but also the position across services. The 23/24 operating plan guidance that underpins the Financial Regime and contracting is again acute biased, and this results in more pressure on acute services to improve productiry and achieve recovery as well as more funding for these priorities. This remains issue of concern, due to significant acute demand and financial pressures, although resource skew is potentially mitigated by agreed MHIS. It is now confirmed that the MHIS will remain in place for 23/24 and we are working with system partners to develop a fair way of managing financial risk in year and there has been a transparent prioritisation process for new developments.</td></tr>
<tr><td colspan="10">Links to Risk Register<br>339: Covid Medicines Delivery Unit; 338: Heart Failure Service</td></tr>
</table>

| Controls: (What do we currently have in place to control the risk?) | | Last Review Date: | Next Review Date: | Reviewed by: | Gaps in Controls: (What additional controls should we seek?) |
|---|---|---|---|---|---|
| 1 | Strong partner within ICS – maintain our voice – Chair and CEO active within ICS Board meetings and planning | Report to each Board | Each Board | Board | |
| 2 | Active engagement in ICS groups - maintain our voice | Ongoing | Each Board | Board | |
| 3 | Active lead by CEO of a number of ICS groups | Ongoing | | | Evidence that community care reducing acute demand. |
| 4 | ICS Pathway planning | Ongoing | Exec | Board | |
| 5 | Active member NHS Providers, Mental Health Bodies and Community Trusts | Ongoing | Each Board | Board | |
| 5 | Communications Plan | Annual- within Business Planning | Mar 22 | Board | Communication has been impacted by pandemic with greater focus internal comms. |
| 6 | Independent Chair of ICS | Annual | | ICS | |

| Sources of Assurance: (How do we know if the things we are doing are having an impact?) | | Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent | Last Received | Received by | Assurance Rating | Gaps in Assurance: (What additional assurances should we seek?) |
|---|---|---|---|---|---|---|
| 1 | Annual Funding allocations | L2 | Annual budget | Board | Satisfactory | |
| 2 | Interim Allocations to respond to pandemic | L2 | Ongoing | Board | Satisfactory | |
| 3 | Trust media profile | L1 | Reports to CEO weekly | CEO | Satisfactory | Need to reinforce reputation and knowledge of services, service quality and contribution to Glos Health System on ongoing basis |
| 4 | Benchmark data across acute, MH, Community services and LD services to demonstrate VfM | L3 | Annual- gen Nov | Resources | Satisfactory | Agreed to use some Mental Health and Community KPIS in Aligned incentive Contract to highlight our services contribution to system |

| Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?) | | Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions: | Action Owner: | Deadline [revised deadline] Complete / In Progress / Delayed / Not Started |
|---|---|---|---|---|
| 1 | Develop Evidence Base which is able to measure the role that community care plays in keeping people healthy and reducing acute demand. | Trust to put in place measures to enable this to be assessed & to work with ICS to support measurement across the system. | Exec | Not Started |
| 2 | Build knowledge base to demonstrate quantifiable results of investment in non-acute services | Trust building knowledge base and to build into communication strategy to improve understanding of impact non-acute care. Commissioners invited to benchmarking workshops to understand Trust performance compared with peers | DoF | **In progress** |
| 3 | Review Communicating Business Plan and Objectives to ensure role Comms plays in maintaining reputation and profile of the Trust recognised by all Teams, with early engagement in service developments. | Comms Plan Objectives set for 2021/22 and to be kept under review to ensure internal and external comms needs balanced. Relationship management mapping exercise completed and presented to Exec Team . ICS delivery plans mapped to Trust Business plan | CEO | **In Progress** |
| 5 | Ensure Trust's voice is heard within the Gloucestershire ICS | CEO and Chair active part of the ongoing discussions to ensure understanding roles of different services built into proposed new structures. 3 x Executive Directors attending strategic Executives and relevant ICS Committees | CEO | **In progress** |

Return to Summary Page

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|---|---|---|---|---|---|---|---|
| **Strategic Aim:** | | | **High Quality Care**<br>**Better Health**<br>**Great Place to Work** | **Exec Risk Owner** | Sandra Betney D of F | **Date of review:** | March 23 |
| **Risk ID:** | **9** | **Description:** | **Funding - National Economic Issues**<br><br>There is a risk that national economic issues impact on the funding settlement available for healthcare, meaning care is not adequately funded to improve and develop to meet needs, and services do not keep pace with demand and best practice, and the organisation ceases to be sustainable. | **Lead Committee** | Board | **Date of next review:** | June 23 |
| **Risk Rating:** (Consequence x Likelihood): | | | | **Relevant Key Performance Indicators:** | | | |
| **Date Risk Identified/confirmed** | 1st April 2020 (Reviewed Mar 2022) | | | • NHS Funding Settlement | | | |
| | **Likelihood** | **Impact** | **Overall** | | | | |
| **Inherent Risk Score:** | **3** | **5** | **15** | | | | |
| **Current Risk Score:** | **~~3~~ 2** | **3** | **~~9~~ 6** | | | | |
| **Tolerable Risk:** | **2** | **5** | **10** | | | | |
| **Target Date to Achieve Tolerable Score** | **March 2024** | | | | | | |
| **Potential or actual origin of the risk:** | | | Board Risk Seminar 14th Jan 2021 and elements of existing risks within the 2020/21 BAF. Reviewed and agreed maintained risk 2022. | | | | |

**Rationale for current score:**
(What is the justification for the current risk score)

The pandemic has impacted on the wider economic health of the country, the potential impact of this has been reflected in proposed pay award levels for NHS Staff which has the potential ability to impact on staff recruitment and retention thus impacting on ability to resource levels of care required. The Trust's ability to directly impact on this risk is limited. The Controls, Assurances and Mitigations from risk 9 also help manage this risk. Whilst Gloucestershire has been able to submit a balanced plan for 21/22 following additional inflation pressures. There are still considerable risks to delivery and although the national pay award has been confirmed as funded there appears to be a cost pressure to the system arising from the pay awards. However it looks likely that the system may be able to achieve 21/22 breakeven, which is being incentivised with additional system capital limits (CDEL) for 23/24. For 23/24 the inflation settlement appears more realistic and the pay award is publicised to be fully funded in addition to reasonable although not complete funding for the additional 22/23 offer. The efficiency required through contracts is set at 1.1% with a further 0.7% convergence adjustment for Gloucestershire. Whilst it will be difficult to achieve this level of efficiency and deal with the reduction in Covid funding it does not appear as if the national economic position has had a disproportionate effect on NHS funding, although the cost of living crisis for our workforce will lead to significant workforce issues. The system financial position for 23/24 is a challenging but break even plan.

**Links to Risk Register**

| Controls: (What do we currently have in place to control the risk?) | | Last Review Date: | Next Review Date: | Reviewed by: | Gaps in Controls: (What additional controls should we seek?) |
|---|---|---|---|---|---|
| 1 | Active Member NHS Providers | Ongoing | Each Board | Board | |
| 2 | Active member ICS | Ongoing | Each Board | Board | |
| 3 | Communication Plan and objective. | Annual – Bus Plan | Mar Board | CEO – ongoing | |
| 4 | Business & Financial Planning & Budget Setting processes | Annual & 6 monthly review | Sept Board | Board | These reflect internal processes to support sustainability, which are within the parameters of any funding settlement achieved by both the NHS and the local authority. |
| 5 | Financial Management processes including QuIP and CQuin | Monthly | April | Resources & Board | As above |

| Sources of Assurance: (How do we know if the things we are doing are having an impact?) | | Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent | Last Received | Received by | Assurance Rating | Gaps in Assurance: (What additional assurances should we seek?) |
|---|---|---|---|---|---|---|
| 1 | Management Accounts | L2 | Monthly | Resources/ Board | Satisfactory | |
| 2 | Performance Reports | L2 | Monthly | Resources/ Board | Satisfactory | |
| 3 | Staff recruitment & Retention data | L2 | Monthly | Resources/ Board | Satisfactory | |
| 4 | Funding allocations achieved with commissioners | L2 | Annual – Jan- Mar | Exec/Board | Satisfactory | |
| 5 | Updates on relationships – commissioners, GCC, GCCG, MPs, Councillors. | L2 | Every other month | Board | Satisfactory | |

| Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?) | | Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions: | Action Owner: | Deadline [revised deadline] Complete / In Progress / Delayed / Not Started |
|---|---|---|---|---|
| 1 | Continue to provide information to NHS Providers to demonstrate wider impact of the NHS settlement in keeping individuals able to return to work/self-care. | Ongoing | CEO/DoF | **In progress** |
| ~~2~~ | ~~Continue to take active role in consideration potential NHS reorganisation to attempt to minimise potential reorganisation costs (financial, time and emotional).~~ | ~~Ongoing~~ | ~~CEO~~ | ~~**In progress**~~ |

285: Cost of Living Crisis; 292; Forest of Dean

Return to Summary Page

<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">Sustainability</td><td>Exec Risk Owner</td><td>Angela Potter, Director of S&P</td><td>Date of review:</td><td>April 23</td></tr>
<tr><td>Risk ID:</td><td>10</td><td>Description:</td><td colspan="3" rowspan="2">Sustainability (environment)<br><br>There is a risk that responding to the climate emergency is not prioritised resulting in the failure to transform and deliver the Green Plan..<br><br>[risk wording to be reviewed as part of annual risk review]</td><td>Lead Committee</td><td>Resources</td><td>Date of next review:</td><td>June 23</td></tr>
<tr><td colspan="3">Risk Rating:<br>(Consequence x Likelihood):</td><td colspan="5" rowspan="6">Relevant Key Performance Indicators:<br><br>• Green Plan in Place – Mar 22<br>• Targets/KPIs to be included in Green Plan</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td>1st April 2020 (Updated Mar. 22)</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>4</td><td>3</td><td>12</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>2</td><td>3</td><td>6</td></tr>
<tr><td colspan="2">Target Date to Achieve Tolerable Score</td><td colspan="3">March 2024</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Reflection on Strategic Aims by Executive.</td></tr>
<tr><td colspan="10">Rationale for current score:<br>(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">Sustainability (environment) has been identified as an area of increased focus for the Trust. A Green Plan has been developed to support this work. Green Plan Guidance (A three-year strategy towards net zero) has been issued by NHSE/I with Trust plans required by January 2022 and system-wide plans by end March 2022. Board development session held in December 2021 to feed into Green Plan which was presented to January 2022 Board. The focus of the risk has moved from set up to taking forward of breadth of actions. Positive progress is being made in overall carbon reduction and the Sustainability Steering Group is now in place to bring together a wider Trust wide focus to the broader issues of sustainability development including workforce, procurement, anchor institution work. External funding bid has been successful and the works to upgrade the Charlton Lane boilers in now scheduled in for 23/24.</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10">Corporate risks relating to sustainability have been added to the risk register</td></tr>
</table>

| Controls: (What do we currently have in place to control the risk?) | | Last Review Date: | Next Review Date: | Reviewed by: | Gaps in Controls: (What additional controls should we seek?) |
|---|---|---|---|---|---|
| 1 | Estates Environment Measures monitoring | Ongoing | Mar 23 | Head of Sustainability | Baseline dataset completed and monitoring in pace |
| 2 | Management structure to support sustainability in place – Directorate responsibility DSP and Head of Resources in Place | Nov 2020 | - | DSP | |
| 3 | Relationships in place to support joint working on this issue | Ongoing | - | DSP | |
| 4 | Commitment to sustainability within Trust Business Plan | Mar 22 | Mar 23 | Board | S&P have local business plan objectives in relation to delivery of the sustainability agenda |
| 5 | Commitment to sustainability within Trust Strategy | Mar 22 | Mar 23 | Board | |

| Sources of Assurance: (How do we know if the things we are doing are having an impact?) | | Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent | Last Received | Received by | Assurance Rating | Gaps in Assurance: (What additional assurances should we seek?) |
|---|---|---|---|---|---|---|
| 1 | Estates Reporting on environmental measures within annual report | L2 L3 | May 22 | Board | Environmental maturity assessment underway by BDO as a developmental audit. | Environmental maturity assessment underway by BDO as a developmental audit. Report expected end April 23 |
| 2 | Procurement processes in place which include high level consideration of sustainability | L1 | 2020 | Resources | Satisfactory | Embed sustainability within procurement at all levels. |
| 3 | Climate Emergency Reporting at Board level to contextualise this work. | L2 | 2020 | Board | - | Section within Annual Report being developed. Recommendations for reporting anticipated within the internal audit report |

| Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?) | | Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions: | Action Owner: | Deadline [revised deadline] Complete / In Progress / Delayed / Not Started |
|---|---|---|---|---|
| 1 | Develop baseline green position, and develop and Embed Green Plan. | Green Implementation action plan developed and Strategic Sustainability Action Group established to drive Green actions across the Trust. Update to Resources Committee highlighted areas of progress in carbon reduction and achievement of current targets | DSP | **Completed** |
| 2 | Build partnerships to help us meet our green aspirations. | Joint development of the ICS Green Plan bringing together all health organisations individual plans and ICS Sustainability group established | DSP | **In progress** |
| 3 | Embed sustainability considerations into Trust Procurement processes | Work ongoing to further develop sustainability considerations into Trust wide procurement processes – beyond estates procurement | DSP | **In progress** |
| 4 | Consider future reporting mechanisms for sustainability to ensure impact is recognised and built upon | Metrics for wider monitoring of sustainability to be considered as part of the green plan development | H of Sustainability | **In progress** – discussions with BI |

Return to Summary Page

<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care<br>Better Health<br>Great Place to Work</td><td>Exec Risk Owner</td><td>Angela Potter Dir S&P</td><td>Date of review:</td><td>April 23</td></tr>
<tr><td>Risk ID:</td><td>11</td><td>Description:</td><td colspan="3" rowspan="6">System Working<br><br>There is a risk that the time required to contribute as a full system partner results in diversion of time and energy impacting on the delivery of organisational priorities, in the short, medium and long term.</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>June 23</td></tr>
<tr><td colspan="3">Risk Rating:<br>(Consequence x Likelihood):</td><td colspan="4" rowspan="2">Relevant Key Performance Indicators:<br>(taken from the Performance Report/ Quality Dashboard)<br><br>It is recognised that there is an inter relation of this risk and risks 8 – Partnership Culture, Risk 4 Recruitment and Retention and that if risk 12 increases in likelihood that risks 8 and 4 are also likely to increase.</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td>1st April 2020 (Updated Mar 22)</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>3</td><td>2</td><td>6</td></tr>
<tr><td colspan="2">Target Date to Achieve Tolerable Score</td><td colspan="3">March 2024</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">This Risk was recognised as a potential risk in January 2023 and replaces, in part, the previous Risk 4 – NHS reorganisation which focussed more on the potential risk of the impact of changes to the system structure as a result of the creation of the ICB.</td></tr>
<tr><td colspan="10">Rationale for current score:<br>(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">With the establishment of the ICS on 1st July 2022 directors, management and staff within the Gloucestershire health system are required to engage in revised ways of working including a new range of Board and Committee commitments whilst continuing to deliver within the already stretched capacity. Across GHC 3 Execs attend the ICS Strategic Executive Level group and the Chair, CEO and NED colleagues attend a range of other ICB Board and sub-committee forums. The system wide work to support the urgent care delivery is now impacting on operational capacity and the further development of the urgent care transformation agenda may impact on our ability to focus on other Trust wide transformation agendas.</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10"></td></tr>
</table>

| Controls: (What do we currently have in place to control the risk?) | | Last Review Date: | Next Review Date: | Reviewed by: | Gaps in Controls: (What additional controls should we seek?) |
|---|---|---|---|---|---|
| 1. | ICS Executive and Board oversight – GHC Chair & CEO engaged | July | Aug 23 | Board | |
| 2. | GHC membership and representation on ICB Board and Committees | July | Aug 23 | Boards | |
| 3. | GHC Board Reporting mechanisms | Every other month | Jan 24 | Board | |
| 4. | GHC Communication Processes | Monthly | Ongoing | Executive | Clear feedback process to Executive team following ICS Execs is now in place |

| Sources of Assurance: (How do we know if the things we are doing are having an impact?) | | Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent | Last Received | Received by | Assurance Rating | Gaps in Assurance: (What additional assurances should we seek?) |
|---|---|---|---|---|---|---|
| 1 | Board Strategy Reporting | L2 | Every other month | Board | Satisfactory | Now incorporated into the CEO report as BAU |
| 2 | Quality, Finance & Workforce Reporting | L2 | Monthly | Board/Related Committee | Satisfactory | Exception Reporting in place and any significant changes in performance to be considered to identify if they are being impacted by this risk. |
| 3 | Staff Family and Friends Data | L3 | Annual (Mar) | Board | Satisfactory | |
| 4 | Staff Pulse testing | L3 | Qtrly | Board/ Comm | Satisfactory | |
| 5 | Urgent care transformation programme | L1 | Monthly | Board/Comm | | Clear governance and reporting process for the system wide urgent care transformation yet to be developed. As yet unable to fully estimate time commitments required. |

| Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?) | | Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions: | Action Owner: | Deadline [revised deadline] Complete / In Progress / Delayed / Not Started |
|---|---|---|---|---|
| 1 | Ensure that performance reporting is considered through this lens to identify if performance is being impacted by this risk and remedial action considered. | | DNTQ DHR&OD | |
| 2 | Ensure that Strategy achievement progress is considered through this lens to identify if performance is being impacted by this risk and remedial action considered. | Strategic oversight group mapping the organisational programmes of work with the ICS clinical programme groups and ensuring alignment and attendance. | Execs | **In progress** |
| 3 | Develop Relationships further as ICS continues to develop | ICB Board minutes included within the CEO update report. HWBP Strategy signed off and noted by the Trust.<br><br>Strategy alignment with ICS work to now commence | Execs | **In progress** |
| 4 | Annual strategy review took place to reconfirm overarching direction of travel and impacts of ICS strategy | Board Development session took place January 2023 and further session planned for July 2023 | DS&P | **In progress** |
| 5 | Full participation in the urgent care transformation programme | Newton Europe now appointed and reported to Trust Board in March 23. Further clarification awaited on Trust input into the delivery and governance structure. | Execs | **In progress** |

<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care<br>Better Health</td><td>Exec Risk Owner</td><td>Sandra Betney DofF</td><td>Date of review:</td><td>April 23</td></tr>
<tr><td>Risk ID:</td><td>12</td><td>Description:</td><td colspan="3" rowspan="6">Cyber<br>There is a risk that we do not adequately maintain and protect the breadth of our IT infrastructure and software resulting in a failure to protect continuity/ quality of patient care.</td><td>Lead Committee</td><td>Audit</td><td>Date of next review:</td><td>June 23</td></tr>
<tr><td colspan="3">Risk Rating:<br>(Consequence x Likelihood):</td><td colspan="4" rowspan="2">Relevant Key Performance Indicators:<br>(taken from the Performance Report/ Quality Dashboard)<br>Cyber Essentials Certification</td></tr>
<tr><td colspan="2">Date Risk<br>Identified/confirmed</td><td colspan="2">15th March 2022</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>4</td><td>5</td><td>20</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>2</td><td>4</td><td>8</td></tr>
<tr><td colspan="2">Target to Achieve Tolerable Score</td><td colspan="3">1 April 2023</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">This Risk was identified at the Board Risk Seminar on 15th March 2022, and informed by the growing risks in the corporate risk register relating to cyber security</td></tr>
<tr><td colspan="10">Rationale for current score: (What is the justification for the current risk score)</td></tr>
<tr><td colspan="10"></td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10"></td></tr>
</table>

| Controls: (What do we currently have in place to control the risk?) | | Last Review Date: | Next Review Date: | Reviewed by: | Gaps in Controls: (What additional controls should we seek?) |
|---|---|---|---|---|---|
| 1. | Information Governance/ Digital policies and procedures | At review date | | Information Governance Group/ Digital Group | |
| 2. | Continued staff awareness through communication | Ongoing | | | |
| 3. | Anti Virus & Advanced Threat Protection | Ongoing | | | |
| 4. | Email Scanning | Ongoing | | | |
| 5. | Secure Boundary | Ongoing | | | |
| 6. | Cyber Tools | | | ICS Cyber Group | Work in progress with ICS Cyber Team |
| 7. | Cyber Security Operations alert actions | Annual | | | |
| 8. | Cyber Essentials Plus certification | Annual | Annual | Digital Group | |
| 9. | Information Governance Training and Testing | Ongoing | | | |
| 10 | Information Governance requirements built into system development processes | Ongoing | | | |
| 11 | Multi-factorial authentication implemented | Complete | | | |

| Sources of Assurance: (How do we know if the things we are doing are having an impact?) | | Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent | Last Received | Received by | Assurance Rating | Gaps in Assurance: (What additional assurances should we seek?) |
|---|---|---|---|---|---|---|
| 1 | Internal Audit of DSPT | L3 | June 22 | Audit and Assurance Committee | Satisfactory | |
| 2 | Digital Group Reporting including phishing testing and tracking of cyber operational risks | L1 | Quarterly | Resources Committee | Satisfactory | ICS Cyber Reporting to understand system risk as well as organisational risk |
| 3 | ICS Cyber reporting | L1 | Regular | ICS Digital Execs | Satisfactory | |
| 4 | Annual SIRO Report | L2 | Annual – last Aug 22 | Board | Satisfactory | |
| 5 | Information Governance Group Reporting | L1 | Quarterly – Aug 22 | Audit and Assurance Committee | Satisfactory | |
| 6 | Ad hoc cyber reports e.g. log4shell | L2 | As required | Audit and Assurance Committee | | In place. |

| Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?) | | Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions: | Action Owner: | Deadline [revised deadline] Complete / In Progress / Delayed / Not Started |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

Return to Summary Page

| RISK MATRIX | | LIKELIHOOD | | | | |
|---|---|---|---|---|---|---|
| CONSEQUENCE | | 1 | 2 | 3 | 4 | 5 |
| | | Rare | Unlikely | Possible | Likely | Almost certain |
| 5 | Catastrophic | 5 | 10 | **15** | **20** | **25** |
| 4 | Major | 4 | 8 | 12 | **16** | **20** |
| 3 | Moderate | 3 | 6 | 9 | 12 | **15** |
| 2 | Minor | 2 | 4 | 6 | 8 | 10 |
| 1 | Negligible | 1 | 2 | 3 | 4 | 5 |

| KEY: | 1 – 3<br>LOW RISK | 4-6<br>MODERATE RISK | 8-12<br>SIGNIFICANT RISK | 15 and over<br>HIGH RISK |
|---|---|---|---|---|

| WHO | ROLE | WHEN |
|---|---|---|
| Audit and Assurance Committee | To ensure that overall risk management framework is in place and working effectively. For the BAF the Committee ensures that the process of identifying, naming, managing and mitigating the risks works well, and ensures Committee challenge. The Audit & Assurance Committee will consider scoring consistency. | Quarterly (each regular Meeting) |
| Executive Leads | Executive Leads to update the area of the BAF which they lead on in discussion with the Trust Secretary who will own the document. Updates will be kept at high level, recognising the detailed work ongoing in the Committees which is reflected, but not duplicated in the BAF. | Quarterly – as a minimum – if there is a significant change to a risk score or a new strategic risk proposed this would be brought to the next Executive meeting. |
| Executive Meeting | Executive to review updates within the BAF to ensure it is considered holistically and that to review and challenge scorings, particularly when a score changes or has not changed beyond the timeframe where target score was anticipated to be achieved.<br>Overall Executive to:<br>(i) confirm the Qtr. Risk Score<br>(ii) to confirm whether the Risk needs to be highlighted to the Committee.<br>(iii) Review any proposed new risks and agree proposed addition | Quarterly |
| Quality/Resources/ GPTW Committee | Committees to consider the Board Assurance Framework as last item on their meeting agendas to:<br>(i) Challenge Current Risk Scores and mitigations and controls<br>(ii) Confirm whether the Risk needs to be highlighted to the Board or whether there is sufficient assurance on ongoing work to mitigate the risk.<br>(iii) Review any proposed new risks and agree proposed addition<br>(iv) Confirm the risks as set out reflect relevant issues<br>(v) Hold the Executive Lead to account for actions and progress. | Quarterly |
| Board | Board to consider Board Assurance Framework to confirm<br>(i) continues to cover all risks, or agree any proposed new risks.<br>(ii) Note progress towards mitigating strategic risks<br>(iii) Note current position and highlight if any further action required<br>(iv) Ensure BAF reflects current risks – informed by horizon scanning work. | 6 monthly |

Return to Summary Page

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**AGENDA ITEM: 14**/0523

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 25 MAY 2023**

**PRESENTED BY:** Sonia Pearcey, Ambassador for Cultural Change & Freedom to Speak Up Guardian

**AUTHOR:** Sonia Pearcey, Ambassador for Cultural Change & Freedom to Speak Up Guardian

**SUBJECT:** **FREEDOM TO SPEAK UP GUARDIAN SIX MONTHLY UPDATE**

| | |
|---|---|
| **If this report cannot be discussed at a public Board meeting, please explain why.** | *N/A* |

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

**The purpose of this report is to:**

Provide assurance to the Board:

- That speaking up processes are in place and remain open for colleagues to speak up, be listened to and follow up action occurs
- That speaking up processes are in line with national guidance
- That there is continued progress in raising the bar in embedding our positive speaking up culture

**Recommendations and decisions required:**

The Board is asked to:

- **Note** that Freedom to Speak Up processes are in place and continue to be utilised by colleagues

**Executive summary**

This report for Q3 & Q4 2022-23 gives an overview of the cases, national and regional updates and the proactive work undertaken by the Freedom to Speak Up Guardian.

There have been 77 cases raised to the Freedom to Speak Up Guardian in 2022-23 compared to 54 cases 2021-22, 120 cases in 2020-21 and 60 in 2019-20.

Since my last report various National reports have been published and as a Trust, we have had an opportunity to reflect on these and capture some learning.

A positive speaking up culture is reflected nationally in the People Plan and People Promise, and locally in our strategic commitments to High Quality Care and being a Great Place to Work. It is a core component in our health and wellbeing offer, in our 'Strong Voice' commitment to colleagues.

Feedback continues to be positive from colleagues who have accessed the Freedom to Speak Up Guardian and is reflected in the NHS Staff Survey 2022.

The results of the 2022 National Education and Training Survey (NETS) continue to show an improved speaking up culture from our learners.

Appendix 1 includes data from Paul's Open Door for 2022-23. The aim is to ensure a wide range of voices are heard and themes can be shared regarding speaking up throughout the organisation.

| **Risks associated with meeting the Trust's values** |
|---|
| All risks are clearly identified within the paper. |

| **Corporate considerations** | |
|---|---|
| **Quality Implications** | A positive speaking up culture within our workforce will ensure that patient safety matters are heard and that colleagues are supported. |
| **Resource Implications** | Specifics that are not being achieved are highlighted in the report |
| **Equality Implications** | No issues identified within this report |

| **Where has this issue been discussed before?** |
|---|
| PowerPoint presentation to the Workforce Management Group 15th March 2023<br>Paper presented to the Great Place to Work Committee 29th March 2023<br>Paper presented to the Quality Assurance Group 21st April 2023 |

| **Appendices:** | Paul's Open-Door Data for Q3 & Q4 and the totals for 2022-23. |
|---|---|

| **Report authorised by:**<br>John Trevains | **Title:**<br>Director of Nursing, Therapies & Quality |
|---|---|

# FREEDOM TO SPEAK UP REPORT

## 1. INTRODUCTION

1.1 This bi-annual report is to give assurance to the Board that speaking up processes are in place and remain open for colleagues to speak up, to be listened to and that follow-up action takes place and colleagues receive feedback with outcomes.

1.2 This paper is presented in a structured format to ensure compliance with the newly published, June 2022, Freedom to Speak Up: A guide for leaders in the NHS and organisations delivering NHS services.

## 2. ASSESSMENT OF FTSU CASES

2.1 Speaking up for Q3 & Q4 are detailed in Table 1. Speaking up for these periods has been received via different routes and some colleagues may also have raised more than one concern. Cases raised through the Work in Confidence portal can be found on table 4.

Table 1

| **Quarter 2021-22** | **Number of cases raised** |
|---|---|
| Q1: April – June | 18 |
| Q2: July – September | 15 |
| Q3: October – December | 10 |
| Q4: January – March | 11 |
| **Quarter 2022-23** | |
| Q1: April – June | 19 |
| Q2: July – September | 20 |
| Q3: October – December | 10 |
| Q4: January – March | 28 |

## 2.2 Themes

Table 2

| Theme | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|
| Patient safety/quality | 2 | 0 | 2 | 4 | 8 |
| Bullying and/or harassment | 2 | 3 | 1 | 11 | 17 |
| Worker safety/wellbeing | 11 | 12 | 3 | 12 | 38 |
| Inappropriate Attitudes / or behaviours | 12 | 9 | 4 | 3 | 28 |
| Systems and/or process | 4 | 5 | 0 | 0 | 9 |

Some examples of speaking up in Q3 & Q4 are:

- A colleague contacted via Work in Confidence describing the inappropriate behaviour of some colleagues when they are discussing lgbtqi+ issues. Their behaviour included repeated misgendering of a transgender patient with uncomfortable speculations about trans and non-binary peoples' gender presentation and transition choices. The colleague identifies as non-binary and does not feel safe sharing this with their team.

- A colleague shared their experiences of what they described as punitive, and harmful language towards them in a team meeting where no one else spoke up. The behaviour was undermining, critical and disempowering and although upset they managed to speak to the colleague after who shared how it made them feel. They felt that this was dismissed and the 'blame passed back'. With support from the Wellbeing line initially and then myself they have been supported to a positive outcome and team awareness re speaking up and Civility Saves Lives is being promoted.

- A colleague contacted us from another organisation for a safe space as they felt they were suffering detriment following speaking up. They described harassment by another colleague, concerns raised re professional practice and victimisation from their line manager following speaking up. Support was given to access the Non-Executive Director for Freedom to Speak Up at their organisation, how to speak up to NHS England » Speaking up to NHS England and on their behalf we contacted the National Guardian's Office for further support.

Table 3

| Professional Group | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|
| Allied Health Professionals | 3 | 2 | 1 | 1 | 7 |
| Medical and Dental | 0 | 1 | 0 | 1 | 2 |
| Registered Nurses and Midwives | 7 | 4 | 4 | 15 | 30 |
| Administrative and clerical | 1 | 3 | 3 | 3 | 10 |
| Additional professional scientific and technical | 0 | 0 | 0 | 2 | 2 |
| Additional clinical services | 7 | 6 | 0 | 5 | 18 |
| Estates and ancillary | 1 | 3 | 0 | 0 | 4 |
| Healthcare scientists | 0 | 0 | 0 | 0 | 0 |
| Students | 0 | 1 | 0 | 1 | 2 |
| Not Known | 0 | 0 | 2 | 0 | 2 |
| Other | 0 | 0 | 0 | 0 | 0 |

In 2022/23 within the Trust, registered nurses as a group accounted for 39% of speaking up followed by additional clinical services at 23% and then administrative and clerical at 13%.

Work in Confidence

Work in Confidence, an anonymous, secure and independent platform remains another route for colleagues to speak up, acknowledging that colleagues accessing speaking up through this anonymous portal is at a low at seven contact this year.

Table 4

| Quarter 21-22 | Number of contacts | Category |
|---|---|---|
| Q1 | 5 | Bullying and/or harassment-4<br>Patient safety/quality-1 |
| Q2 | 3 | Bullying and/or harassment-2<br>Other-1 |
| Q3 | 3 | Bullying and/or harassment-1<br>Other-1<br>Cultural-1 |
| Q4 | 1 | Bullying and/or harassment-1 |
| **Quarter 22-23** | | |
| Q1 | 3 -Other Colleagues | Bullying and/or harassment -1<br>Other-2 |
| Q2 | 1-Other Colleague | Other-1 |
| Q3 | 2-FTSU Guardian | Patient safety/quality-1<br>Worker Safety/wellbeing-1 |
| Q4 | 1-FTSU Guardian | Bullying and/or harassment-1 |

## 3. COLLEAGUE EXPERIENCE FEEDBACK

Feedback is requested from all colleagues and qualitative feedback is shared from colleagues as below from Q3 & Q4 and links to the examples of speaking up in section 2.2:

- "I think you have a good action plan and I have noticed an improvement in the way my colleagues are discussing trans patients in the workplace. I also think that I would use this to speak up again in future if it was needed."

- "Yes, I would speak up again. I was ready to look for another job so speaking with you and (Wellbeing Line colleague) has enabled me to continue in this role which I have worked hard at."

- "Given my experience and who I am and my values, I would speak up as that is me personally, but based on my experience to date with speaking up, I am sure it would discourage staff to speak up if they were treated like me. In terms of learning, the support from you at GHC has been supportive, kind and compassionate, noting which is lacking at…. So much that I have had no welfare calls and the duty of care is non-existent. I can see why staff become so fearful and leave rather than speak up, something which in my role I have always advocated for. You personally have been extremely helpful and supportive with no judgement and if any lesson learnt it would be for my Trust to take this approach."

Table 5

| Quarter | Number of cases where people indicate that they are suffering disadvantageous and/or demeaning treatment (detriment) |
|---|---|
| Q1 | 3<br>(Disability 1) |
| Q2 | 0 |
| Q3 | 0 |
| Q4 | 2 (other Trusts) |

## 4. LEARNING AND IMPROVEMENT LINKED WITH PROACTIVE WORK

- The Committee on Standards in Public Life (24 January 2023) published Leading in Practice, on the role of leadership in embedding an ethical culture in organisations.

  ***Recommendation**: The Trust Board to reflect and for potential wider discussion on 'Questions for Leaders' within the report.*

- The National Guardian's Office (23 February 2023) published Listening to Workers following its Speak Up review of NHS ambulance trusts in England.

  ***Action**: The Freedom to Speak Up Guardian to complete the self-review tool, by **Q1 2023** to identify and improve gaps in organisations' speaking up arrangements and to develop plans and actions for improvement.*

- The Care Quality Commission (29th March 2023) published Listening, learning, responding to concerns - Care Quality Commission (cqc.org.uk) two reports looking at the handling of protected disclosures and wider review (phase 2).

  ***Action**: The Freedom to Speak Up Guardian to complete the self-review tool, by **Q1 2023** to identify and improve gaps in organisations speaking up arrangements and to develop plans and actions for improvement.*

- NHS England in June 2022 published its new and updated national Freedom to Speak Up policy, which is applicable to primary care, secondary care and integrated care systems.

  ***Action**: The Freedom to Speak Up Guardian to complete the draft by **Q1 2023** (NHS England requirement by January 2024).*

- Together with NHS England, the National Guardian's Office also published new and updated Freedom to Speak Up guidance and a Freedom to Speak Up reflection and planning tool. This tool was included in a call to action with the Trust Board Development session in November 2022. And all trust boards are to be able to evidence this by the end of January 2024.

***Recommendation**: The Board to complete the self-reflection tool by **September 2023** to assess further scope for improving our speaking up culture through Principle 8.*

Nationally the NHS Staff Survey 2022 data re raising concerns and speaking up has declined. Although our data has also declined slightly it is over both our comparators and nationally.

**Comparator Data**

**Q19a** I would feel secure raising concerns about unsafe clinical practice

| | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|
| Your org | - | - | 76.1% | 82.8% | 79.1% |
| Best | - | - | 82.0% | 86.2% | 84.3% |
| Average | - | - | 75.7% | 79.7% | 76.7% |
| Worst | - | - | 68.7% | 66.4% | 62.5% |

**Q19b** I am confident that my organisation would address my concern

| | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|
| Your org | - | - | 65.5% | 70.0% | 65.4% |
| Best | - | - | 76.6% | 79.5% | 76.7% |
| Average | - | - | 63.1% | 64.2% | 61.5% |
| Worst | - | - | 46.8% | 48.0% | 38.9% |

**Q23e** I feel safe to speak up about anything that concerns me in this organisation

| | 2020 | 2021 | 2022 |
|---|---|---|---|
| Your org | 68.4% | 70.6% | 70.1% |
| Best | 78.5% | 78.8% | 78.5% |
| Average | 68.3% | 66.9% | 67.0% |
| Worst | 59.0% | 47.7% | 50.5% |

**Q23f** If I spoke up about something that concerned me, I am confident my organisation would address my concern

| | 2021 | 2022 |
|---|---|---|
| Your org | 58.5% | 56.6% |
| Best | 71.3% | 69.2% |
| Average | 55.0% | 55.0% |
| Worst | 34.2% | 31.1% |

**National Data**

## Concerns about clinical safety

**The following percentage of staff said they...**

**71.9%** ...would **feel secure raising concerns about unsafe clinical practice** (q19a) (2021: 75.0%, 2020: 72.7%, 2019: 71.9%, 2018: 70.9%)

**56.7%** ...were **confident that their organisation would address their concern** (q19b) (2021: 59.5%, 2020: 60.5%, 2019: 59.9%, 2018: 58.6%)

## Speaking up about concerns

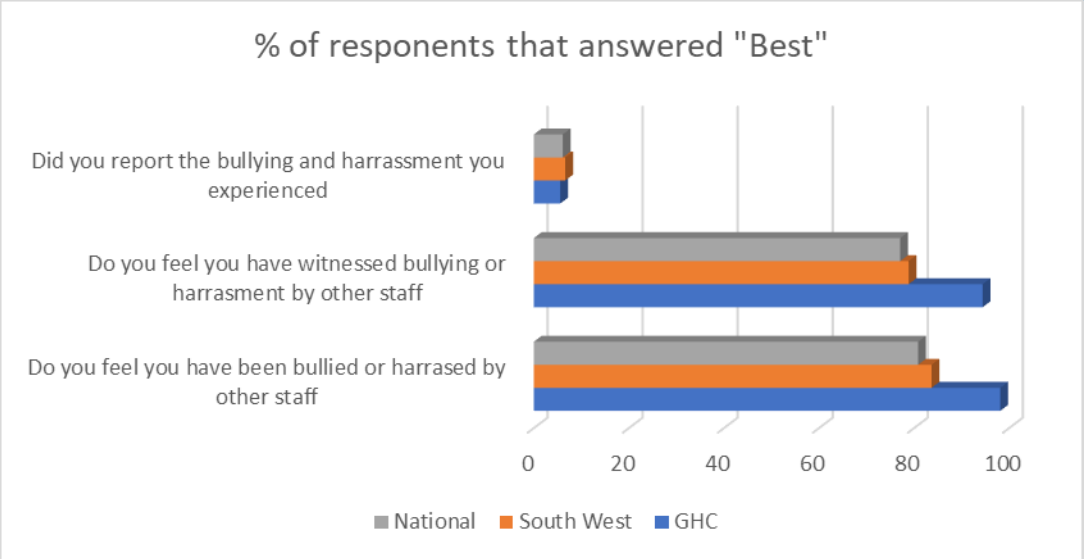
**The following percentage of staff said they...**

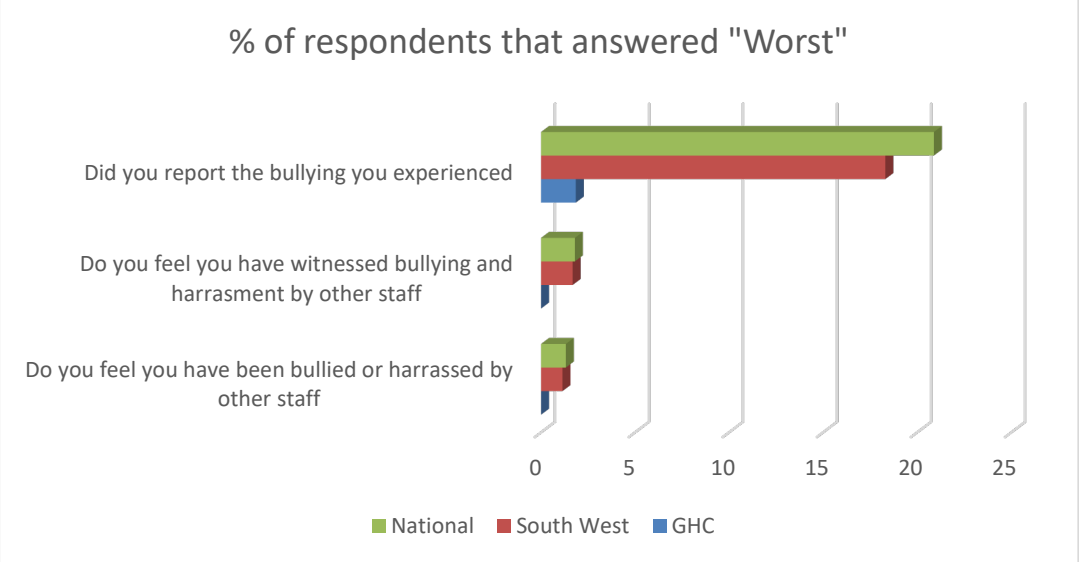
**61.5%** ...feel **safe to speak up about anything that concerns them** in their organisation (q23e) (2021: 62.1%, 2020: 65.7%)

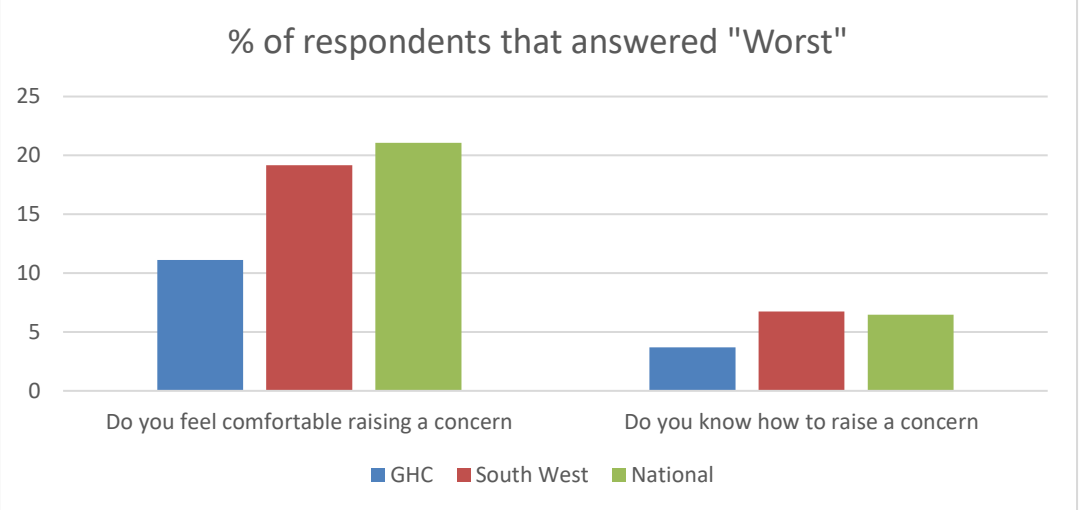
**48.7%** ...were **confident that their organisation would address their concern** (q23f) (2021: 49.8%)

***Action**: The Freedom to Speak Up Guardian to continue to review more detailed data alongside the Organisational Development team to plan priority work.*

- The results of the 2022 National Education and Training Survey (NETS) have been published. The Trust has improved in all areas of speaking up and is above the national and south-west averages.




When asked if they had experienced bullying, 53 of 54 respondents reported best and 1 reported good. When asked if they had witnessed bullying, 51 respondents reported best and 3 reported good. 6 students within GHC reported they didn't feel

comfortable raising a concern and 2 stated worst when asked if they know how to raise a concern.

Over the past twelve months the Freedom to Speak Up Guardian has embedded speaking up further within education and a designated Freedom to Speak Up Champion within the Learning and Development team supports the delivery of this.

- ***Action**: The Freedom to Speak Up Guardian to continue to plan further work within our Trust and the Universities of Gloucestershire and Worcestershire to further embed Freedom to Speak Up across all learner pathways.*

**FURTHER PROACTIVE WORK TO IMPROVE OUR SPEAKING UP CULTURE ALONGSIDE ASSOCIATED WORK OF THE FREEDOM TO SPEAK UP GUARDIAN**

- Work continues to further develop and strengthen the **Gloucestershire ICS Guardian network** and to gain a greater understanding from a national perspective regarding a future ICS model. A new full-time substantive Freedom to Speak Up Guardian started at Gloucestershire Hospitals NHS Foundation Trust in April 2023.

- **Freedom to Speak Up Strategic Framework -** An initial draft is being shared with colleagues through networks and team sessions. This will include agreeing on a 3-year plan, 2023-2025 of objectives, actions and measures of success.

  ***Action**: The Freedom to Speak Up Guardian to arrange final engagement sessions to then be approved by **June 2023.***

- **Civility Saves Lives** - A coproduction approach with four early adopter teams design as a 'test and learn' for Civility Saves Lives is progressing and recently came together to share commonalities and prioritise key areas.

  ***Action**: The Freedom to Speak Up Guardian to share review of progress at Improving Care Group in July 2023.*

- **Restorative Just and Learning Culture** - The initial overview presentation to the Executive Team in March was well received.

  ***Action**: Commencement of further engagement April - June 2023(Scoping).*

- **NHS Patient Safety Strategy -** Many enablers currently in place to further develop a positive patient safety culture. This will be further developed through the 'umbrella' of Restorative Just and Learning Culture**.**

- **Diversity Networks** - The Freedom to Speak Up Guardian is an integral member of the network and offers guidance, support and leadership to the Chair of the Race and Cultural Awareness Network.

- **Co-Chair Regional Network** - The Trust Freedom to Speak Up Guardian

steps down as Chair of the South West Freedom to Speak Up Guardian Regional Network in May 2023, although will continue to mentor new Guardians nationally.

- **Freedom to Speak Up Champion Network** - This continues to grow and meets on a monthly basis for peer support and development.

## Appendix 1 - Paul's Open Door

Paul's Open Door is a confidential portal to share with our Chief Executive any issues colleagues think he should be aware of or ask for a response to something they are concerned about. There are also opportunities to make suggestions for improvement. This route to speaking up sits alongside others including our Freedom to Speak Up Guardian, via line managers, Staff Side, Staff Forums, Team Talk and more. Paul's Open Door is accessible via a desktop Icon on all Trust laptops.

The number of colleagues contacting us through this route has seen a slight increase from 77 in 2021-22 to 89 this year.

Number of cases raised

| Quarter 2022-23 | Number of cases raised | Number of cases raised anonymously |
|---|---|---|
| Q1: April - June | 34 | 7 |
| Q2: July – September | 26 | 6 |
| Q3: October – December | 16 | 2 |
| Q4: January - March | 13 | 4 |

Themes

| | Patient safety/ quality | Bullying and/or harassment | Worker safety | Other behaviours | Systems and/or process | Other | Ideas/ learning | Thank You |
|---|---|---|---|---|---|---|---|---|
| **Q1** | 0 | 4 | 1 | 0 | 11 | 1 | 1 | 4 |
| **Q2** | 1 | 3 | 0 | 1 | 10 | 2 | 8 | 2 |
| **Q3** | 1 | 0 | 3 | 0 | 9 | 0 | 0 | 2 |
| **Q4** | 0 | 1 | 2 | 0 | 6 | 1 | 3 | 0 |

- No overall trends in issues raised
- Only repetition was where colleagues had not seen communications and queried this. For example, celebrating Nurses Day in May, annual pay increases, and employment contracts
- Some issue around the Operational Restructure which included how this has affected staff's mental health
- Compliments about specific managers and how well they support their teams
- An increase in enquiries from staff who were not utilising the usual information channels, for example mask wearing or access to some community resources.

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**AGENDA ITEM: 15/**0523

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 25 May 2023**

**PRESENTED BY:** Lavinia Rowsell, Director of Corporate Governance/Trust Secretary

**AUTHOR:** Lavinia Rowsell, Director of Corporate Governance/Trust Secretary

**SUBJECT:** **PROVIDER LICENCE DECLARATIONS: SELF-CERTIFICATION APPROVALS**

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

**The purpose of this report is to:**

To provide the Board with the information and assurances required to enable it to make the required annual self-certification regarding compliance with the conditions of its provider licence and the systems and processes for ensuring such compliance.

**Recommendations and decisions required**

On the recommendation of the Audit and Assurance Committee, the Board is asked to:

a) **Agree** to make a declaration confirming compliance with each of the statements listed in the Corporate Governance Statement.

b) **Agree** to make a declaration of **'Confirmed'** in relation to the Governor training declaration.

c) **Agree** to make a declaration of **'Confirmed'** by the due date of 31 May in respect of systems for compliance with licence conditions (Condition G6) for the financial year just ended

d) **Agree** to publish on the Trust website the declaration in respect of systems for compliance with licence conditions (Condition G6) by 30 June.

e) Have **regard** to feedback received from Governors in respect of these declarations

**Executive summary**

In order to comply with NHSE regulatory requirements, the Board is required to make a number of declarations each year regarding compliance with the Trust's provider licence and the systems and processes for ensuring such compliance.

## 1. Corporate Governance Statement

It is a requirement of the governance condition of the Trust's licence that the Board signs off a Corporate Governance Statement within three months of the end of each financial year.

The Corporate Governance Statement requires the Trust Board to confirm:

- Compliance with the governance condition **at the date of the statement**; and
- **Forward compliance** with the governance condition for the current financial year, specifying (i) and risks to compliance and (ii) any actions proposed to manage such risks

In making its Corporate Governance Statement declaration, the Board can rely on a range of evidence which is summarised in Appendix 1 of this report. The Board is asked to confirm **compliance at the date of the statement** and **forward compliance**, for each section of the Corporate Governance Statement.

## 2. Training of Governors

The Board is required to make a declaration regarding the provision of necessary training to Governors. At its meeting on 17 May 2023, the Governors confirmed that, in their view, this was the case. Training opportunities provided for Governors are set out on page 5 of the report.

The Board is therefore recommended to make a declaration of '**Confirmed'** in respect of the provision of Governor training.

## 3. Compliance with Licence conditions

Foundation Trusts are also required to make an annual declaration that they have their systems and processes for compliance with provider licence conditions (General Condition G6). Appendix 2 provides evidence which the Board may rely on to make this declaration. The Board is invited to make a declaration of '**Confirmed'** in respect of both parts of this declaration.

The Board's declarations must be made *having regard to the views of Governors.* The appendices to this Board report were provided to Governors at its meeting on 18 May. The Governors noted the report and no concerns were raised in respect of systems and processes for compliance with licence conditions.

It should be noted that following the introduction of the new provider licence guidance from 1 April 2023, there will no longer be a requirement to publish a declaration of compliance with the licence conditions.

## Risks associated with meeting the Trust's values

Regulatory risk the Trusts fails to make the required declarations with in the prescribed timescales and/or makes and false declaration.

| Corporate considerations | |
|---|---|
| **Quality Implications** | None |
| **Resource Implications** | None |
| **Equality Implications** | None |

| Where has this issue been discussed before? |
|---|
| These declarations are considered on an annual basis. The process involves the Executive, Council of Governors and Board. |

| | |
|---|---|
| **Appendices:** | **Appendix 1**<br>Corporate Governance Declaration - evidence<br>**Appendix 2**<br>Provider Licence conditions - overview additional evidence |

| **Report authorised by:** | **Title:** |
|---|---|
| Lavinia Rowsell | Director of Corporate Governance & Trust Secretary |

**PROVIDER LICENCE SELF ASSESSMENT – 2022/2023**
**REPORT TO THE BOARD**

## 1.0 INTRODUCTION

1.1 The NHS provider licence forms part of the oversight arrangements for the NHS. It sets out conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients, now and in the future. All NHS foundation trusts and NHS trusts are required to hold a licence.

1.2 The licence requires the Board to make a series of annual declarations to confirm the Trust's compliance with the licence conditions, and also to confirm that the Trust has and intends to keep in place systems and processes to implement appropriate standards of corporate governance.

1.3 The individual declarations comprise:

- Corporate Governance Statement
- Governor Training declaration
- Systems for Compliance with Licence Conditions declaration

1.4 Declarations must be made by the Board, having regard to the views of Governors.

1.5 The licence has now been modified following statutory consultation to bring it up to date to reflect the new system working arrangements with the new licence applying from 1 April 2023. After this year, there will no longer be a requirement to publish a declaration of compliance. Monitoring compliance with the licence will sit with the ICB.

## 2.0 CORPORATE GOVERNANCE STATEMENT

2.1 Condition FT4 is about the systems and processes in place to ensure good governance and requires to the Trust to self-certify that this is in place. This includes compliance with the condition at the date of the statement and forward compliance for the current financial year.

2.2 The Board has during the course of the year received a number of documents which provide evidence of compliance. **Appendix 1** provides a summary of the available evidence to support the Board in making its declaration.

2.3 The Board is required to consider risks to compliance with the Trust's licence conditions, and set out mitigating actions taken to address those risks. The licence conditions are primarily concerned with the establishment of systems and processes to maintain compliance, and as such there are no obvious risks to the maintenance of such systems and processes.

2.4 Accordingly, the Board is recommended to make a declaration of **'Confirmed'** in respect of compliance at the time of the declaration, and in respect of forward compliance for the current year.

## 3.0 GOVERNOR TRAINING DECLARATION

3.1 Additionally, the Board is required to make a declaration that it has provided Governors with the necessary training, pursuant to Section 151 (5) of the Health and Social Care Act 2012, to enable Governors to fulfil their roles. The Act does not specify the nature or content of training to be provided.

3.2 A number of training opportunities provided by external organisations are made available to Governors throughout the year. Governors also receive a local induction, and have opportunities to learn about the work of the Trust through a series of induction meetings and presentations. Access to Trust services and site visits have recommenced but have been more limited due to the Covid. A detailed handbook and induction session is in place for governors and an ongoing training plan developed. Governors have taken part in development sessions focusing on Membership and Public Engagement, Governor Duties and the Role of the Board and Effective Challenge. The Governor meeting schedule includes two scheduled development sessions, the topics of which will be determined in discussion with Council.

3.3 The Board is therefore recommended to make a declaration of **'Confirmed'** in that it is satisfied that the Trust has provided the necessary training to Governors to ensure they are equipped with the skills and knowledge they need to undertake their role.

## 4.0 GENERAL CONDITION G6 – SYSTEMS FOR COMPLIANCE WITH LICENCE CONDITIONS

4.1 General Condition 6 requires that the Trust takes necessary precautions against the risk of failure to comply with the conditions of its licence, any requirements imposed by the NHS Acts, and the requirement to have regard to the NHS Constitution in providing health care services for the purpose of the NHS.

4.2 The licence condition states that the steps the Trust must take should include:

'*the establishment and implementation of processes and systems to identify risks and guard against their occurrence'*, and

*'regular review of whether those processes and systems have been implemented and of their effectiveness'*.

4.3 The declaration asks the Board having reviewed the evidence, to confirm (or otherwise) by the due date of 31 May 2023 that:

'*Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that,* ***in the Financial Year most recently ended****, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any*

*requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.'*

4.4 An overview of the provider licence conditions is given at **Appendix 2**. Much of the evidence given in support of the Corporate Governance Statement (listed at Appendix 1) may also be relied upon by the Board in order to make the declaration regarding the processes and systems in place to comply with the Trust's licence conditions and general obligations.

4.5 The Board is therefore recommended to respond '**Confirmed'** in respect of the declaration above.

4.6 The Trust is required to publish its G6 declaration by 30 June 2023. As the minutes of this meeting will not be approved by that date, a template provided by NHS England will be used to publish the declaration on the Trust website.

## 5.0 HAVING REGARD TO THE VIEWS OF GOVERNORS

5.1 The Board is required to make the above declarations "*having regard to the views of Governors".* Governor views should be expressed in the context of the Council's statutory duty to hold the NEDs to account for the performance of the Board. This means that Governors should comment on the robustness of the assurance process undertaken in deciding these declarations. A separate report was made available to Governors providing assurance regarding the process for the Board to make these declarations. The appendices to this report have also been made available to Governors alongside the summary assurance report.

5.2 The Board is therefore asked to have regard to the views of Governors regarding these declarations.

## 6.0 RECOMMENDATIONS

6.1 The Board is asked to:

a) Have **regard** to feedback received from Governors in respect of these declarations
b) **Agree** to make a declaration confirming compliance with each of the statements listed in the Corporate Governance Statement.
c) **Agree** to make a declaration of **'Confirmed'** in relation to the Governor training declaration.
d) **Agree** to make a declaration of **'Confirmed'** by the due date of 31 May 2023 in respect of systems for compliance with licence conditions (Condition G6) for the financial year just ended
**e)** **Agree** to publish on the Trust website the declaration in respect of systems for compliance with licence conditions (Condition G6) by 30 June 2023.

## APPENDICES

**Appendix 1:** Corporate Governance Declaration - Evidence
**Appendix 2:** Provider Licence conditions - Overview and Additional Evidence

APPENDIX 1 - Corporate Governance Declaration – Evidence

**AGENDA ITEM: 15**/0523

| GOVERNANCE STATEMENT | EVIDENCE FOR CURRENT COMPLIANCE | | SUGGESTED DECLARATION |
|---|---|---|---|
| The Board is satisfied that GHC NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. | • Organisational leadership through Board<br>• Local accountability through Council of Governors<br>• Engagement programme with stakeholders<br>• Scheduled Board meetings including public meetings<br>• Committee structure and Committee meeting programme<br>• Performance dashboards to Resources Committee and Board<br>• Quality monitoring and reporting to Quality Committee<br>• ICB observers at Quality Committee<br>• Quality Report and indicators<br>• Financial reporting monthly to Board/Resources Committee<br>• Financial control systems in place<br>• Information Governance function and reporting<br>• Risk management framework and governance reporting<br>• Assignment of key risks to relevant governance Committees<br>• Regular update and review of risk register<br>• Datix incident reporting system<br>• Council of Governors statutory roles in holding NEDs to account<br>• Patient safety reports to Board and Quality Committee<br>• Patient Stories agenda item at public Board meetings<br>• Meeting evaluation at each Board meeting<br>• Whistleblowing and other organisational policies and procedures in place (including Freedom to Speak Up Guardian)<br>• External audit and internal audit programme<br>• Clinical audit programme<br>• Compliance with FT Code of Governance<br>• Trust Constitution<br>• Trust vision and values | No unmitigated risks identified | Confirmed |

| | | | |
|---|---|---|---|
| | • Annual Governance Statement<br>• Mandatory disclosures in Annual Report<br>• Statutory and mandatory training<br>• Corporate induction for all new starters<br>• Fit and proper person test for Board and Governors<br>• Conflicts of Interests and Risk Management Policies<br>• Statutory registers in place<br>• Positive CQC inspection report – Well Led and Core Services<br>• Governance arrangements regularly reviewed to ensure fit for purpose and responsive, | | |
| The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time | • CEO Reports to Board highlight relevant new publications/ guidance<br>• Policy and guidance regular item at Board and appropriate Committees<br>• External Auditor Sector development report<br>• Annual Reporting Manual guidance<br>• Compliance with FT Code of Governance confirmed in Annual Report<br>• Response to consultations on Governance Code and Provider Licence changes<br>• Legal bulletins and updates | No unmitigated risks identified | Confirmed |
| The Board is satisfied that GHC NHS Foundation Trust implements effective board and committee structures | • Annual Committee effectiveness reviews<br>• Positive external Well Led Developmental Review<br>• CQC Well Led Review - Good<br>• Committee membership focused to reflect skills – based on skills identified during appointment process<br>• Internal Audits on Governance and Risk Management<br>• Strong clinical presence on Board<br>• Committee summary reports to Board<br>• Management Committees mapped | No unmitigated risks identified | Confirmed |

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| The Board is satisfied that GHC NHS Foundation Trust implements clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees | • Constitution sets out Board responsibilities<br>• Committee duties aligned to core Board responsibilities<br>• Committee Terms of Reference reviewed annually and substantive changes approved by the Board<br>• Committee agenda planners reviewed regularly<br>• Scheme of Delegation in place setting out delegated responsibilities and powers reserved to Board and reviewed<br>• Revised Standing Financial Instructions in place and reviewed<br>• Positive external Well Led Developmental Review<br>• CQC Well Led Review - Good | No unmitigated risks identified | Confirmed |
| The Board is satisfied that GHC NHS Foundation Trust implements clear reporting lines and accountabilities throughout its organisation | • Clear Executive portfolios<br>• Defined management and committee structure<br>• Chief Executive is Accounting Officer<br>• Director of Nursing, Therapies and Quality & Medical Director lead on quality and service experience matters<br>• Medical Director is Caldicott Guardian<br>• Deputy CEO is Senior Information Risk Owner<br>• Named LED NED for FTSU, Health, Safety and Security and Well Led Guardian<br>• Lead Executive for each Committee<br>• Assignment of organisational risks to appropriate Committees<br>• Committees are accountable and report regularly to the Board<br>• Staff appraisals and objectives processes in place | No unmitigated risks identified | Confirmed |
| The Board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively | • Going concern report to Audit and Assurance Committee<br>• Board Finance Reports<br>• Savings Plans in place<br>• Quality Impact Assessments process in place, overseen by Quality Committee<br>• Budget setting process<br>• Strategic Plan<br>• Capital Programme | No unmitigated risks identified | Confirmed |

| | | | |
|---|---|---|---|
| | • Performance dashboard to Board/Quality Committee<br>• Quality reports to Board/Quality Committee<br>• Outcomes reporting<br>• Clinical audit programme<br>• Internal audit programme<br>• External auditor in place<br>• CQC registration<br>• NHS Oversight Framework segment 2 rating<br>• Service/business planning process | | |
| The Board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes to ensure compliance with the Licence holder's duty to provide timely and effective scrutiny and oversight | • Executive meetings<br>• NED oversight on Board and Committees<br>• Board and Committee agenda planners<br>• Monthly performance dashboards and exception reports<br>• Executive Engagement processes<br>• NED Quality visits<br>• CQC compliance reports to Quality Committee / Board<br>• Overall control total achieved<br>• Cost Improvement Programme | No unmitigated risks identified | Confirmed |
| The Board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes to ensure compliance with health care standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions | • Performance reports to Board/Resources Committee<br>• Safety/quality oversight by Quality Committee<br>• CQC/Mental Health Act compliance reports<br>• CQC inspection report<br>• Medical/nursing revalidation programmes<br>• Mental Health Legislation Scrutiny Committee oversight<br>• Executive engagement processes with staff to ensure connection in place with front line staff<br>• Paul's Open Door/Direct to Douglas<br>• Freedom to Speak Up Guardian and advocates<br>• Board visits | No unmitigated risks identified | Confirmed |

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|---|---|---|---|
| | • Clinical audit programme<br>• Statutory and mandatory training requirements<br>• Clinical policies<br>• PLACE visits<br>• Mental Health Act/Mental Capacity Act policies<br>• Mental Health Act Managers in place<br>• Quality Report<br>• Regulatory inspection reports/action planning<br>• Inquest reports/action planning<br>• Quality Impact Assessments for efficiency and transformation proposals<br>• QIAs reviewed by Medical Director & Director of Nursing, Therapies and Quality<br>• Staff Survey action plan | | |
| The Board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern) | • Budget setting process<br>• Savings and transformational change programmes<br>• Fully funded capital programme<br>• Monthly finance reports to Resources Committee and Board<br>• Standing Financial Instructions<br>• Authorised signatories in ledger<br>• Scheme of Delegation<br>• Audit Committee Going Concern reports<br>• Audit Committee Losses/Special Payments reports<br>• Counter Fraud Service and annual action plan<br>• Resources Committee oversight of service developments and business cases<br>• Tender submission procedures<br>• Governor approval process for significant transactions<br>• NHSR Clinical Negligence Scheme for Trusts<br>• NHSR Risk Pooling Scheme for Trusts | No unmitigated risks identified | Confirmed |

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| | • Annual financial plan approved by Board before the start of the year<br>• Agency staffing controls | | |
| The Board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making | • Board/Committee agenda planners<br>• Monthly Finance and Performance reports<br>• Business Intelligence Management Group<br>• Clinical audit programme provides assurance on data quality<br>• Data quality requirement in Information Governance Toolkit<br>• Finance and performance reporting aligned to Board/Committee cycle<br>• Chief Executive's Reports to Board | No unmitigated risks identified | Confirmed |
| The Board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence | • Risk register reviews by 'owning' Committees and overseen by Audit and Assurance Committee and Board<br>• Board Assurance Framework review by Executive, Audit Committee and Board<br>• Internal audit programme<br>• Clinical audit programme<br>• Risk consideration as standing Committee agenda item<br>• Incident Reporting policy and culture<br>• Whistleblowing policy and procedure – Freedom to Speak Up<br>• Paul's Open Door/ Direct to Douglas<br>• Quality Impact Assessments process | No unmitigated risks identified | Confirmed |
| The Board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery | • Annual operational planning process<br>• Plans aligned to commissioners' stated intentions<br>• Resources Committee oversight<br>• Executive oversight<br>• Governor involvement on business plan<br>• monitoring reports to Resources Committee<br>• Performance reports<br>• Finance reports<br>• Annual Quality report – external consultation | No unmitigated risks identified | Confirmed |

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| The Board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes to ensure compliance with all applicable legal requirements | • Access to retained lawyers<br>• Internal and external auditors<br>• Executive leads for each key area of business<br>• Trust Secretariat responsible for constitutional and corporate governance matters/updates<br>• Legal briefings/updates received from a variety of sources<br>• Executive oversight<br>• Information Governance policies and procedures<br>• Clinical policies and procedures<br>• Mental Health Legislation Scrutiny Committee and MHA Managers<br>• Fit and proper person tests<br>• FT Code of Governance compliance reports | No unmitigated risks identified. | Confirmed |
| The Board is satisfied that systems and processes in place ensure that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided | • Medical Director and Director of Nursing, Therapies and Quality and are clinicians<br>• Non-Executive Director engagement and review provides rigorous quality challenge – a number of Non-Executive Directors have clinical backgrounds or have experience as Non-Executives at other NHS Trusts to inform their challenge | No unmitigated risks identified. | Confirmed |
| The Board is satisfied that systems and processes in place ensure that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations | • Quality Impact Assessments for savings plans<br>• Quality framework under development<br>• Quality Report is key element of organisational vision and values<br>• Quality Report defines key quality themes for the coming year<br>• Evaluation of each Board meeting | No unmitigated risks identified | Confirmed |
| The Board is satisfied that systems and processes in place ensure the collection of accurate, comprehensive, timely and up to date information on quality of care | • Monthly performance dashboard to Resources Committee/Board<br>• Performance Exception reports to Board<br>• Update reports on Quality Report<br>• Regular Patient Safety report to Board | No unmitigated risks identified | Confirmed |
| The Board is satisfied that systems and processes in place ensure that the Board receives and considers | • Performance Exception reports to Board<br>• Regular update reports on Quality Report | No unmitigated | Confirmed |

| | | | |
|---|---|---|---|
| accurate, comprehensive, timely and up to date information on quality of care | • Regular Patient Safety report to Board<br>• Performance reports to Resources Committee and Board | risks identified | |
| The Board is satisfied that systems and processes in place ensure that GHC NHS foundation trust including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and considers as appropriate views and information from these sources | • Quality Report consultation<br>• Update reports on Quality Report shared with stakeholders including the ICB, Health Watch and Overview and Scrutiny Committee, and feedback encouraged<br>• Engagement & Communication processes<br>• Patient survey<br>• Staff Survey<br>• Complaints and Comments process<br>• Patient and Staff Friends & Family Tests<br>• Patient Story is regular agenda item at public Board meetings<br>• Stakeholder Engagement Events (limited due to Covid)<br>• Quality Outcomes published through public Board papers and in Annual report<br>• Joint Negotiating and Consultative Committee<br>• Local Negotiating Committee and Medical Staff Committee<br>• “One Gloucestershire” ICS Clinical and non-clinical workstreams | No unmitigated risks identified | Confirmed |
| The Board is satisfied that systems and processes in place ensure that there is clear accountability for quality of care throughout GHC NHS foundation trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate | • Quality Governance assigned to Exec Directors<br>• Non-Exec Director oversight of Quality<br>• Clinical Leads<br>• Service Leads<br>• Heads of Profession<br>• Lead Nurses<br>• Board Committee and management committee structure | No unmitigated risks identified | Confirmed |
| The Board of GHC NHS foundation trust effectively implements systems to ensure that it has in place | • Board recruitment processes<br>• Governor appointment of Non-Exec Directors | No unmitigated | Confirmed |

| | | | |
|---|---|---|---|
| personnel on the Board, reporting to the Board and within the rest of the Licence holder's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence. | • Appointment & Terms of Service Committee for Executive recruitment<br>• Budgeted establishment<br>• Delegated recruitment processes<br>• Recruitment and selection policy<br>• Appraisal and revalidation policies<br>• Ward staffing levels information | risks identified | |

**APPENDIX 2**

**PROVIDER LICENCE CONDITIONS – OVERVIEW AND ADDITIONAL EVIDENCE**

| | Licence Condition | Condition summary | Evidence for compliance |
|---|---|---|---|
| **General Conditions** | | | |
| G1 | Provision of Information | Provision of information to NHS I | Operating plan<br>Ad hoc submissions to NHS I via portal |
| G2 | Publication of information | Publish information as directed by NHS I | Information on website e.g. Board profiles |
| G3 | Payment of fees to Monitor | Pay fees to NHS I as required | Not applicable - no fees requested to date |
| G4 | Fit and Proper Persons | Not to appoint unfit persons as Directors or Governors | Directors' recruitment procedures<br>Governor election rules<br>*'Fit & Proper Persons: Directors'* test incorporated into Board recruitment<br>Annual FFPT declarations by Board/Governors |
| G5 | NHS I guidance | Have regard to NHS I guidance | Code of Governance compliance<br>System Oversight Framework compliance |
| G6 | Systems for compliance with licence conditions | Have systems in place to comply with licence conditions | Outlined in the appendices to this report – App 1 |
| G7 | CQC registration | Be registered with the CQC | CQC registration in place |
| G8 | Patient eligibility & selection criteria | Set and apply transparent criteria to determine who can receive health care | Commissioner service specifications |
| G9 | Application of Section 5 – Continuity of Services | States that the Continuity of Services conditions apply where commissioner-requested services are provided | Not applicable |
| **Pricing** | | | |
| P1 | Recording of Information | Record pricing information if required by NHS I | Not required to date. |
| P2 | Provision of Information | Provide information to NHS I | Provision of information via portal |
| P3 | Assurance report on submissions to NHS I | Provide an assurance report re Condition P2 if required by NHS I | Not required to date |
| P4 | Compliance with the National Tariff | Comply with national tariff | There is no national tariff in place for community and mental health contract, where tariffs apply for other areas |

| | Licence Condition | Condition summary | Evidence for compliance |
|---|---|---|---|
| | | | these are complied with as demonstrated through reports to commissioners. |
| P5 | Constructive engagement re local tariff modifications | Engage with local commissioners re tariff modifications | Agreements in place with Gloucestershire ICB re price tariff. Regular monthly meetings take place where performance reports are presented and discussed. |
| **Choice & competition** | | | |
| C1 | Patients' right of choice | Patient notified of choice of provider | Not applicable to Mental health Services<br>In place other services as required. |
| C2 | Competition oversight | Not to restrict or distort competition | Legal advice obtained where appropriate when bidding for services/entering partnerships. |
| **Integrated care** | | | |
| IC1 | Provision of integrated care | Not to act detrimentally to the provision of integrated care | Collaborative working within the One Gloucestershire system<br>Participant in two provider collaborative – Thames Valley and Southwest<br>Member of all ILP and on Personalised Care Board. |
| **Continuity of services** | | | |
| CoS1 | Continuing provision of Commissioner Requested Services | Continue to provide CRS as specified except in certain circumstances eg with Commissioner agreement | Not applicable as Trust does not provide Commissioner Requested Services |
| CoS2 | Restriction on the disposal of assets | Not to dispose of any asset without written consent from NHS I | No assets disposed of that provide Commissioner Requested Services |
| CoS3 | Standards of corporate governance and financial management | Apply suitable systems of corporate and financial governance | See evidence in Appendix 1 of this report |
| CoS4 | Undertaking from the ultimate controller | Undertaking from any parent company not to cause a breach of the provider licence | Not applicable |
| CoS5 | Risk pool levy | To pay a risk pool levy to NHS I | Not applicable |
| CoS6 | Cooperation in the event of financial stress | To co-operate with the NHS I and others in the event of financial stress | Not applicable |

| | Licence Condition | Condition summary | Evidence for compliance |
|---|---|---|---|
| CoS7 | Availability of resources | Ensure and certify the availability of financial, physical and human resources for the next 12 months | Not applicable as Trust does not provide Commissioner Requested Services |
| **NHS Foundation Trust Conditions** | | | |
| FT1 | Information to update the register of Ft's | Provision of certain documents to NHS I | Provision of annual accounts and annual report<br>Provision of current version of the constitution<br>Updates regarding relevant Board and Lead Governor changes |
| FT2 | Payment to NHS I in respect of registration and related costs | Payment of a licence fee to NHS I | Not applicable |
| FT3 | Provision of information to advisory panel | Provision of any information requested by an advisory panel | Not applicable – no information requested |
| FT4 | NHS FT governance arrangements | Apply and certify appropriate systems and processes for good corporate governance | Internal Audit reports<br>Head of Internal Audit opinion<br>External Audit |

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**AGENDA ITEM: 16**/0523

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 25 May 2023**

**PRESENTED BY:** Sandra Betney, Director of Finance / Deputy CEO

**AUTHOR:** Paul Griffith-Williams, Head of Information Governance & Records/DPO

**SUBJECT:** **ANNUAL SENIOR INFORMATION RISK OFFICER (SIRO) REPORT**

| | |
|---|---|
| **If this report cannot be discussed at a public Board meeting, please explain why.** | N/A |

**This report is provided for:**

Decision ☐ Endorsement ☒ Assurance ☒ Information ☐

**The purpose of this report is to:**

To provide assurance to the Board on the effectiveness of controls for Information Governance, data protection and confidentiality and to document the Trust's compliance with legislative and regulatory requirements.

**Recommendations and decisions required**

On the recommendation of the Audit and Assurance Committee, the Board is asked to:

- Take **assurance** that the Trust has effective systems and processes in place to maintain the security of information.

**Executive summary**

The SIRO report has been edited for presentation in a public arena to ensure that our cyber resilience is not adversely affected by disclosures therein.

The Senior Information Risk Owner is responsible for ensuring that organisational information risk is identified and managed across the organisation. This Annual Report provides assurance on practice, progress and developments around Information Governance, Clinical Coding and Records, Data Quality and Cyber/Data Security.

It should be noted that the Trust was able to achieve 'Standards Met' for the 2021/22 the DSPT submission and is expecting to meet the standards for 2022/23. The Trust

has met the 95% mandatory IG training target for 2022/23. There have been two data breaches that met the threshold for onward reporting to the Information Commissioners Office, these were reported within 72 hours.

There continues to be knock-on effects for the Information Governance environment during the year with a continued move toward new ways of working and embracing the changing digital arena. This has continued to increase the demand for advice and support from the IG team and the IG Group, with the IG Group approving 25 Data Protection Impact Assessments.

The Trust has continued to see an increase in Subject Access Requests though it has been modest circa 5%. The Freedom of Information Requests have seen the greatest increase in requests circa 35.8 %, though the team has managed to bring down the number that went over the statutory timeframe.

Cyber security continues to be a very real risk to the Trust, with IT reviewing cyber threats at weekly meetings. Phishing attacks continue to be a top three cyber risk for the Trust, with the Trust experiencing 30,000 unsafe emails per day. It is worth note that a system partner continues to be impacted by a previous phishing attack.

This report provides assurance that robust governance mechanisms are in place to ensure we are holding data safe and securely and remains legally compliant with a complex range of national guidance and legislation.

**Risks associated with meeting the Trust's values**

- IG and cyber breaches can result in the disclosure of sensitive patient and staff information;
- IG and cyber breaches can result in significant financial penalties and have a negative impact on the Trust's reputation if breaches occur; and,
- IG and cyber breaches can result in a negative impact on patient care.

| **Corporate considerations** | |
|---|---|
| **Quality Implications** | Ensures the quality of information available to deliver patient care. |
| **Resource Implications** | Can result in financial penalties if IG breaches occur. |
| **Equality Implications** | |

| **Where has this issue been discussed before?** |
|---|
| Information Governance Group<br>Audit and Assurance Committee |

| | |
|---|---|
| **Report authorised by:** Sandra Betney | **Title:** Director of Finance/Deputy CEO |

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# Annual SIRO Report
# 2022 – 2023

## INTRODUCTION


Annual report from the Senior Information Risk Owner (SIRO) for Gloucestershire Health and Care NHS Foundation Trust (GHC). The purpose of the report is to provide assurance to the Board on the effectiveness of controls for Information Governance (IG), data protection and confidentiality. This assurance is provided by the SIRO who has responsibility for information risks and information assets.

The role of SIRO is well established in GHC. The SIRO advocates at Board for relevant control and safety measures to manage and reduce information and security risks in controlling or processing the data the Trust holds. Ensuring effective use of resource, relevant Board commitment, execution of tasks and appropriate communication to all staff of the measures in place. The aim is to create a culture in which information is valued as an asset and information risk is managed in a realistic and effective manner within the legislative frameworks.

During 2022/23 the governance model and structures for IG and Records have continued to develop. The IG and records functions for the Trust, have continued to ensure greater resilience and improved governance. There is evidence that IG & records practices are being developed across the organisation, with the SystmOne simplicity programme, and the continued onboarding of an Electronic Management Data System (EMDS) in addition to an increased volume of DPIAs and sharing agreements.

This report provides assurance that robust governance mechanisms are in place to ensure that the Trust remains legally compliant with national guidance and legislation whilst also achieving an ability to ensure operational effectiveness.

Recognising the breadth of the legislation, the SIRO report is divided into four sections:

Section 1: Information Governance

Section 2: Clinical Coding and Health Records

Section 3: Data Quality

Section 4: Cyber / Data Security

**Key highlights 2022/2023**

- The Information Governance Group and met six times and approved 25 Data Protection Impact Assessments to support services;
- The 21/22 final submission for the Data Security and Protection Toolkit was assessed as ‘standards met’ and 22/23 is expected to meet the standards;
- There have been 2 data breaches that have met the threshold for onward reporting to the Information Commissioners Office;

- The Trust achieved the 95% mandatory target for Data Security and Awareness training;
- There have not been any significant health records incidents or losses reported; and,
- 2500 boxes of records have been processed by the EDMS team.

## 1.0 INFORMATION GOVERNANCE

The IG Group (IGG) has maintained scrutiny and assurance for the security, integrity and availability of the data utilised. This is while reviewing and approving more DPIAs and sharing agreements than previously.

### 1.1 Information Governance & Records Team

The IG&R team continues to develop and embed processes and support the recruitment and development of new colleagues within the team. Freedom of Information requests have seen 35.8% increase year on year. Due to recruitment challenges and staff absence Subject Access Requests have not always been returned within the 30-day timeframe and on occasion an extension to 90 days has been requested. This has been communicated to the requestor and extensions agreed.

The IG&R team has delivered operational support, advice, and guidance to colleagues. It also represents the Trust's information governance interests at the ICS level. The Team is an active member of the Gloucestershire Information Governance Group, and the Southwest Strategic Information Governance Network. The Team also delivers the Data Protection role in support of the Trust's compliance with data protection legislation and good practice.

### 1.2 Information Governance Group

The IGG is chaired by the Director of Corporate Governance, with the SIRO, Caldicott Guardian and DPO as key members. The IGG's role is to and guide the strategic direction of IG within the Trust, ensure IG compliance, support best practice and ensure that all Trust information is:

- Confidential and Secure;
- Of High Quality;
- Relevant and Timely; and,
- Processed Lawfully, Transparently and Fairly.

The IGG met bimonthly throughout the year, due to an increase in the volume of business, held 3 additional ad-hoc meetings. The agility to convene adhoc reviews has ensured there is capacity to meet the Trust's business needs.

During 2022/2023, the group has:

- ✓ Set a work plan for the group to formalise and focus activity;
- ✓ Reviewed the asset register and the assigned asset owners;
- ✓ Reviewed the data flows;
- ✓ Reviewed and approved the Data Security & Protection Toolkit (DSPT) interim submission for 22/23 and final submission for 21/22

- ✓ Reviewed and approved 25 Data Protection Impact Assessments (DPIA);
- ✓ Reviewed and approved 14 data sharing agreements; and,
- ✓ Reviewed and agreed the Trusts training analysis for IG training.

The IGG reports to the Audit and Assurance Committee, a Committee of the Board. This ensures the Board is kept suitably aware of issues and progress being made.

## 1.3 Data Security and Protection Toolkit

The Trust has submitted both the final submission for 21/22 and the interim baseline submissions for the 22/23 toolkit within the required timescales. The 21/22 final submission was assessed as 'standards met' in June 22, while the 22/23 final submission will be June 23 and is expected to meet standards.

A mandatory requirement for the submission of the DSPT, is that an Independent Assessment of our DSPT submission. The assessment is against a set number of standards set by NHS Digital (NHSD). This was undertaken by the Trust's Internal Auditors, 2021/22 was undertaken by PWC, 22/23 was undertaken by BDO. PWC's audit assessed the Trust across all 10 data standards and involved reviewing a total of 38 assertions. Two assertions were rated medium, however only one data standard (standard 4) was subsequently rated moderate. Although the assessment found only one standard to be moderate the NHS D audit reporting standard requires a moderate rating for the whole report. The BDO report is issued as final.

## 1.4 Breaches and Near Misses

There have been 300 IG incidents reported in year of which three were referred to the SIRO and Caldicott Guardian for review and consideration of onward reporting. Two breaches were reported to the ICO, these were reported within the 72 hours requirement. The third incident was a near miss.


On both incidents, the ICO concluded no enforcement action, and made recommendations. On one incident where a set of records went missing in the post, the records were eventually located by the post office and delivered, thereby negating the breach. The recommendations are being taken forward by the teams involved.

**Case Study**

One of the reported incidents involved a patient admitted to a mental health inpatient ward following the breakdown of their abusive relationship. The patient was managed as a high-risk victim of domestic abuse/safeguarding during their stay. Although during the admission the patient had regular contact with their ex-partner, there was no consent given to share information. It was specifically requested that the ex-partner not be made aware of their discharge.

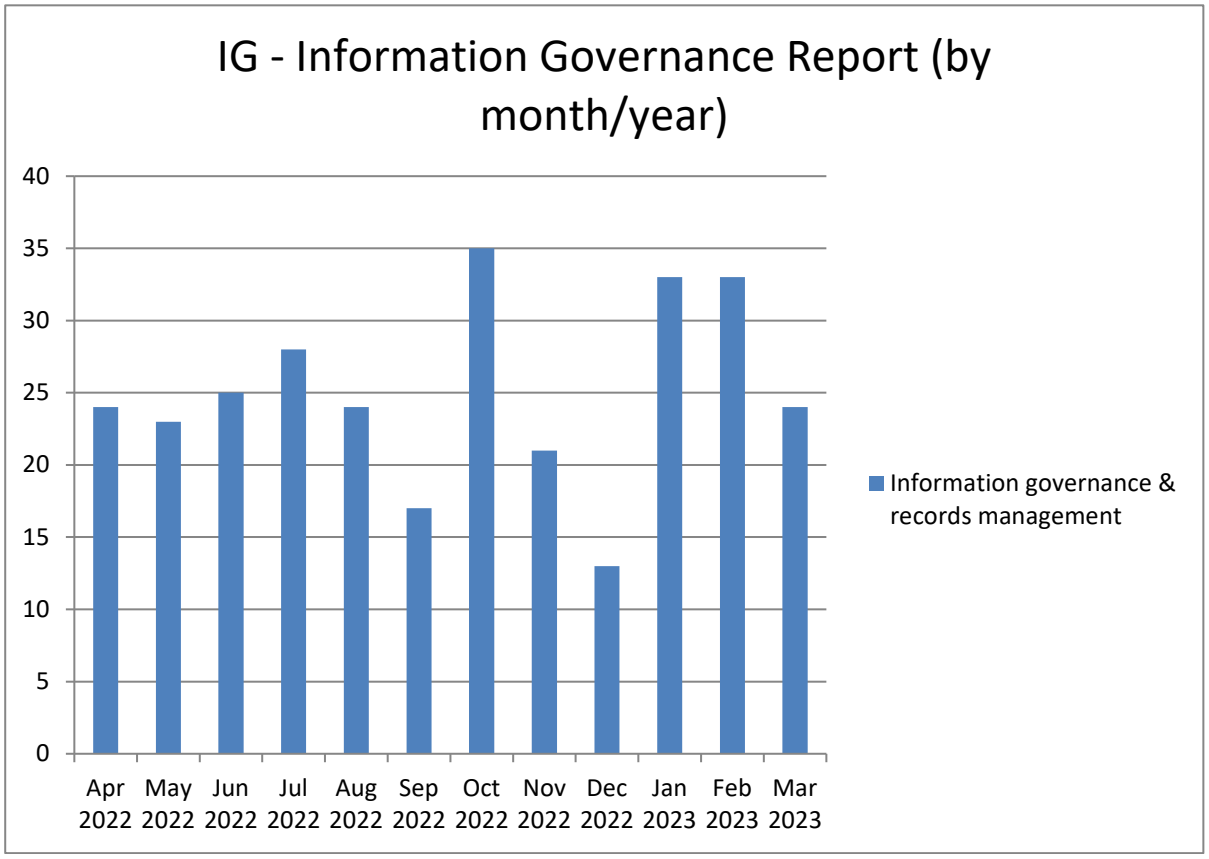
The ex-partner contacted the ward for information about the patient and although they respected the wish not to share information the ward secretary disclosed that the patient was no longer on the ward. Following this, the ex-partner contacted the patient directly. The patient advised that they were distressed by the subsequent contact resulting from our disclosure, though their mental health has not deteriorated, they did

feel harm was caused and wish to complain.

A full review was carried out of the process for receiving inbound calls requesting information about patients. This resulted in a change of process.

Incidents are logged in Datix and an email alert forwarded to the IG & R Team. The team assess and score the severity of the incident, and, decide in conjunction with the SIRO and Caldicott Guardian if the incident meets the reporting threshold. The IG & R team liaises with the incident handlers to ensure appropriate remedial action is considered and learning taken from incidents.

Below is a report on incident by month for the last financial year taken from Datix.




There is an increase of 18 incidents from 2021/22, which was 282, there is apparent pattern to when there are incidents or incident type. Although there has been learning for teams and individuals from breaches there has been no organisational learning or trends identified.

## 1.5 Subject Access Requests (SARs) and Freedom of Information Requests (FOIRs)

The following table sets out activity data for the current and previous years.

| | Total requests | | Total over time | |
|---|---|---|---|---|
| Request | **2021/22** | **2022/23** | **2021/22** | **2022/23** |
| **FOIRs** | 293 | 398 | 55 | 35 |

| | | | | |
|---|---|---|---|---|
| **SAR Mental Health** | 367 | 386 | 0 | 7 |
| **SAR Physical Health** | 601 | 588 | 0 | 0 |

Physical Health (PH) SARs have decreased by 2% while Mental Health (MH) SARs have increased by 5%. The 7 MH SARs over the one-month response time where no extensions agreed with the requester were by no more than 2 days over.

The number of FOI requests received has increased by 35.8%. Not all of the FOIRs were answered in the timeframe, the reason for the delay was advised to the requesters.

A review of the 35 FOIRs over the statutory limit Indicates the delays were because of complexity of requests, data issues and staff vacancies.

**Breakdown of the days over time**

| **Total FOIR requests for 2022/23: 398** | | |
|---|---|---|
| **Days Over time** | **Number** | **% of FOIRs** |
| 21 – 25 | 15 | 3.7% |
| 26 - 46 | 13 | 3.2% |
| 47 + | 7 | 1.7% |
| Total | 35 | 8.7% |

A review of themes for SARs and FOIs has been carried out. This has not identified anything that would reduce requests.

## 1.6 IG Training Standard 95%

The Trust achieved the 95% mandatory target for Data Security and Awareness training in compliance with the DSPT. This was evidenced by the training team from the training system, Care to Learn. This year the Trust achieved the 95% standard once, which is the standard, however the previous year the Trust achieved this twice. The IGG and SIRO regularly review training statistics and ways in which to improve compliance to ensure that good IG practices are embedded across the Trust.

The SIRO, Caldicott Guardian and the DPO have undertaken their annual update training specific to their roles in line with the IG training needs analysis. Trust Board Members will complete appropriate IG training in year.

The IGG reviewed and signed off the Trust's IG training needs analysis.

## 1.7 Summary of DPIAs completed and any high risks identified

The IGG has reviewed and approved 25 DPIAs so far. There have not been any residual high-risk processing issues identified that needed onward reporting to the ICO.

## 1.8 Information Asset Registers

The Trust maintains an information asset register that is reviewed with IT and clinical

systems regularly, along with the IGG periodically. As assets are identified as part of the DPIA process they are added accordingly. The asset register also details the assigned Information Asset Owners (IAO). Further work is required to embed the role of IAO within the Trust.

### 1.9 Updated media statement in the event of a data breach

The Trust has a prepared a base media statement that was drafted in conjunction with the Head of Communications, the statement has been shared with the IGG.

### 1.10 Data Processor update on any issues, contractual updates on compliance with UK GDPR

The IGG has reviewed and approved 14 data sharing agreements in year. There have been no reported issues raised with or by a processor, or UK GDPR compliance concerns.

### 1.11 Data Flows

The Trust maintains a list of its data flows and information asset owners are developing their own to feed into the Trust's flows register. The Group has reviewed the flows register this year and agreed that all known flows were identified and mapped.

## 2.0 CLINICAL CODING AND RECORDS

### 2.1 Privacy Officer

Privacy officer checks are performed across System One and RIO to ensure staff do not access deducted patient records without a valid reason. At times clinicians and administrators are required to access patient records after the patient has been deduced, on doing so the administrator or clinician will be asked to enter a valid reason on SystmOne or RIO. Privacy reports are run monthly to validate these reasons.

There have been 30,607 privacy officer checks performed between April 2022 and April 2023. Of the checks carried out 300 resulted in queries being raised with staff as to why patient records were accessed. Reasons for access have been queried and responses received, although all of January's queries (193) have not been checked / completed yet. No concerns have been raised following the responses received from staff.

There have been no Summary Care Record privacy officer checks performed between April 2022 and March 2023. Checks have not been performed due to SAR and SystmOne privacy officer work taking priority and staff shortages. There is therefore a risk that summary care records were accessed inappropriately.

### 2.2 Clinical Coding Report Clinical Coding

Finished completed episodes for coding are outsourced to Capita who review episodes across GHC services and ensure they are coded correctly. All clinical coders are fully trained Accredited Clinical Coders and have attended a clinical coding standards course, regular three yearly refresher training and specialty workshops.

Capita ensures that episodes are coded in a timely manner. A few issues have been raised by us relating to data quality, and the fact that only a certain number of codes

are available for use within Lillie, resulting in codes not being able to be assigned to fully reflect the patients stay. All issues raised with the services are being addressed.

**Mental Health**

- Predominantly the coding team is relying upon the Nursing/Doctors summaries to code episodes.
- Patient lists are sent to coding upon request from the coding team and completed in a timely manner.

**Sexual health**

- There are monthly issues with coding sexual health episodes, where proformas or SRHAD's are not available. Coding reports are provided to the service so that coding can be completed at a later date. There have also been issues around codes not being available on Lillie to fully reflect the episode. The risk is that full accurate costs of episodes are not being coded, the consequence of which is funding may not be correct.
- Coders are able to access the clinic lists to see which episodes require coding.

**Rehabilitation**

- On rare occasions some episodes are unable to be coded. This has primarily been down to data quality or insufficient data in the patient's journal (the journal is the narrative of the patient's care in the clinical record).
- Episodes that require coding appear on an uncoded report the coders are able to access whenever needed.

These issues have all been highlighted to the relevant teams in GHC and the coding team continue to work with GHC on improving coding. There have not been any significant issues that warranted escalation.

## 2.3 Health Records

There has been 1 significant health records loss that needed escalating. This was escalated to the ICO, however the record was later found by the Post Office and delivered, effectively negating the loss. No physical health records were destroyed between April 2022 and March 2023. The destruction of hospital deceased records is on hold due to the infected blood enquiry. GHC records management retention aligns with the NHS Records Management Code of Practice and the health records and clinical record keeping policy has been updated to reflect this.

Historic archive records are being reviewed against retentions before sending to CIVICA for uploading to CITO the Trust's Electronic Document Management System (EDMS). This has identified several historic physical health records were batch archived without a complete schedule, circa 5% of the 17,000 boxes held in archive. This presents a risk that records may not be available if needed either clinically or linked to a SAR. There have been no datix reports identifying this has impacted clinical care or SARs to date.

## 2.4 CITO EDMS Project

Deployment of the CITO Electronic Document Management System (EDMS) to the trust's Mental Health, Physical Health and corporate teams, includes migration of documents from RiO + System One and digitisation of the historical paper health records, currently stored in Crown commercial storage.

Following sign-off by the executive team in November 2022 the health records workstream recruited additional staff on fixed term contracts.

The team now consists of a total of 28 FTE and the rate of work has increased significantly. Over 9000 boxes of mental health records have been processed to date. The team are on track to complete processing all historical mental health records by the end of 2022-2023.Mental Health records have now been sent for scanning. Learning Disabilities and Physical Health records are remaining, with a projected end date of November 2023.

Further work has been completed in order to understand the physical health records. It is now expected that only 20% of records the trust holds in commercial storage will be suitable for scanning. The projected completion date for processing all physical health records is June 2023.


One of the biggest challenges in 2023 will be The Phoenix Partnership, suppliers of the SystmOne clinical system, integration work required between CITO and SystmOne. The project team has agreement from TPP to meet most of the trust's requirements. Some details and timescales for delivery are yet to be agreed, which may affect the go-live date for physical health services.

<u>Key Milestones Planned for 2023</u>:

- CITO Soft-launch (access to scanned historical records) – April 2023
- CITO eLearning Go-live – April 2023
- Full Go-live Mental Health Services – Late May 2023
- Full Go-Live Physical Health Services – Estimate late 2023/Early 2024

The EDMS project has made progress in a number of areas during the 2022/23 financial year:

An in-context click-through from the patient record in RiO to CITO has been developed and successfully tested. Due to compatibility issues with the current version of RiO, this currently opens in a separate window. This will be changed to a fully integrated view within the patient record, following the planned upgrade to the latest version of RiO in May 2023.

A Microsoft Word plugin has been developed by the GHC IT Applications team, in order to save RiO editable letters to CITO. This is in the final stages of development, with testing planned to begin in February 2023.

System Configuration and folder structure for Mental Health Services has been agreed and signed-off by the project board. The folder structure for physical health services is in the final stages of development, following engagement sessions with the trust's clinical and administrative staff working in those teams.

### 2.5 Summary of audits which have Data Privacy/Quality Implications

The clinical audit programme has delivered on a varied programme of audits. There were 154 national and locally agreed clinical audits.

The programme for 23/24 is under review and capacity is being created in the team to support a number of clinical interest audit requests. The outputs of the audits enable us to benchmark a range of quality indicators, share good practice and identify areas for improvement. We monitor the progress of the audit programme through a group of well-established governance and reporting structures which forms part of our Quality Management System. The team reports findings into the Regulatory Compliance Group, Improving Care Group and the Quality Assurance Committee. The audit team have strong links with the Quality Improvement Hub and have supported a number of improvement programmes over the year. The audit team ensure there is a consistent approach to data management and reporting utilising the SNAP digital audit software.

The embedding learning function has been enhanced during the year and the quality team has been testing actions through the fidelity testing process. A structure of assessment using quantitative and qualitative approaches to test the embedded nature of actions arising from a number of learning vehicles has been established. Activity is tracked using the Datix system. Any significant issues that have implications on the Trust's compliance with Data Protection Legislation will be raised with the SIRO, Caldicott Guardian and DPO.

## 3.0 DATA QUALITY

### 3.1 Policies

The Trust has IG related policies currently being reviewed with changes expected to be completed for the DSPT final submission for 22/23. There has been no legislative change to reflect.

### 3.2 Business Continuity / Disaster Recovery

The Trust has an incident response policy that forms the backbone of its disaster recovery and business continuity planning. The policy and the supporting

arrangements have been tested this year through our continued response to the C19 pandemic as well as seasonal extreme weather events such as heatwave and snow. They have also, been utilised in response to periods of Industrial Action and system escalation. There have been a number of technical incidents this year that have required teams to utilise their business continuity plans including:

- Wi-Fi partial outage – Wi-Fi Access points (AP) lost connectivity to Wi-Fi controllers at various sites within the trust, impact lasted several days, therefore colleagues resorted to using hardwired connections and data SIM connectivity.
- Telephony Crisis migration – Migration of Crisis 2g extensions to GHC telephony environment caused unintentional consequences with IVR call routing and voicemail, causing delays in diverting phone extensions and call recording.
- SAN Performance – Endpoints device were impacted by having slow performance for 2 hours causing slow running of applications. A full review of the incidents was completed with a number of recommendations made to improve resilience, communication and business planning.

### 3.3 Business Intelligence

Datix and ESR feeds were embedded to produce corporate reporting within Tableau, new system extracts were established for Training & Development (Care to Learn) with important developments to setup E-Rostering and Appraisal sources.

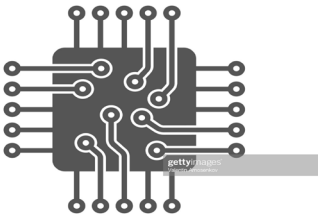
The introduction and ongoing maintenance of these corporate data tables are offering a new layer of governance and understanding to corporate practice and user habits and will offer the potential as we progress to align data sets and analyse correlations and causations.

The SystmOne Simplicity project continues to provide a transparency to the clinical record and enables a better awareness of data quality amongst physical health operational services. This programme has extended and although larger than first anticipated, has provided a robust foundation to support ongoing operational delivery, aligned reporting and any future development needs. There is now alignment between National, Commissioner and local Provider datasets which is reflective of clinical data capture and presents a single version of the truth. This is driving operational and management confidence in many areas with Data Quality monitoring reports being reintroduced and a clinical systems audit programme underway.

There has been major work to manage a single Trust Hierarchy across all systems, and the maintenance of this has been paramount to the success of the overall product and outputs available. Change control mechanisms to support in-system developments, particularly within SystmOne have become more robust.

The Trust currently maintains a full BI reporting suite of information reports that maintains pseudonymised data (through clinical system or NHS numbers) with the following exceptions that use patient identifiable information however these are used for direct patient care and clinical monitoring, not research or planning purposes:

- Bed Management Report - Digital Whiteboard (Name and Age) Secure to bed management team and select senior operational managers to manage patient flow and went through a DPIA process.
- C19 Patient Pathology Details Results report (Patient Name)>>Secure to significantly reduced list (from Covid period) of pandemic response leads.



- Covid Self Isolation Dashboard Details (Staff Names) >> Secure to workforce team and select senior operational managers to manage workforce management and assure service delivery.
- Criteria to Reside LoS Reports (Patient Name) >> Secure to significantly reduced list (from Covid period) of pandemic response leads.
- Covid Lateral Flow Test Results (Patient Name) >> Secure to significantly reduced list (from Covid period) of pandemic response leads.
- There are comparable controls to manage access to corporate reports such as financial budget statements (to budget holders and associated management accountants) and HR Workforce reports (Workforce leads).

There are controls in place to manage access to these reports, and although an automated IT owned, Active Directory solution will manage this in the future, it is currently managed through a list of responsible names. The access list for all of the above reports were reviewed in 2022.

It is recognised that, as with any large organisation, managing multiple corporate and clinical systems, there will be underlying data quality issues, both stemming from business as usual data entry errors or user oversights. To mitigate this, data quality reports are published and available to all staff which help feed audit and help monitor operational practice to mitigate this issue. The clinical systems team also runs starter and refresher user training to maintain a good level of data recording. BI manage the portfolio of these reports however it is a combination of the Nursing, Quality and Therapies directorate, the Operations Directorate and Clinical Systems that monitor compliance and undertake corporate and clinical audits.

Although the majority of our *identifiable* data use is for direct patient care (acceptable) and any planning or development reporting uses *confidential* data (also acceptable); the Trust does have a technical solution and process in place for instances such as research where future disclosures should have data opt-outs applied.

### 3.4 ESR

There have not been any system or data security issues in year. Data quality audits and reviews continue to be carried out monthly using system reports. There are no emerging themes or trends following these reviews.

## 4.0 CYBER / DATA SECURITY

### 4.1 Access Controls

The Trust has an established process for starters and leavers access to our IT and Clinical Systems. The leaver process is automated based on an ESR report from workforce on a weekly basis. The process disables the account and archives it in leavers accounts. There have been 1,434 new AD accounts set up, while there have been 832 leavers processed. It is noted the number of accounts that have been removed is less than expected, this is due to an increase of leavers moving to bank. It is recognised that this process does not suitably cover inter organisational moves as this is reliant on leads notifying IT of the access changes needed. There is a project underway to streamline this process. Microsoft Identity management (MIM) will be used to automate the Joiners, Leavers and Movers process. Implementation of this project was expected to be undertaken in Q2, 2022. There have been significant complexities with, supplier engagement and data sets and the high risk of removing live user accounts. The project is currently at early testing stages. and the revised go live date is under review pending resolution of synchronisation issues. Current revised date is Q2 of 2023.

### 4.2 Cyber Report

The Countywide IT service (CITS) is responsible for managing the cyber response for the ICS. CITS provides cyber security updates to the ICS Digital Executive steering Group, which the SIRO is a member. GHC reviews Cyber threats during weekly meetings with actions assigned to Deployment, Server, Infrastructure and Applications teams to resolve potential threats. These threats are identified from Carecert alerts, Microsoft Defender alerts, vendor notifications and CITS security scans using products such as Nessus.

GHC are also responsible for ensuring accreditation, such as Cyber Essentials Plus. Re-certification assessment was successfully completed in October 2022. CITS undertake penetration testing for GHC on a monthly basis, with vulnerabilities raised on GHC IT Service Management systems and discussed at GHC Cyber meeting. GHC engaged with an external organisation to run penetration testing during September 2022. NHS England (Exeter) undertake monthly penetration testing of externally facing links, with Infrastructure team progressing areas of concerns. Reports are provided to the ICS Cyber group and Corporate Systems Working Group.

The National Cyber Security Centre (NCSC) continues to issue updates on likely Russian state-sponsored and criminal cyber threats. There have been no additional alerts in recent months, however organisations are being reminder to stay on alert.
This year has seen the introduction of quarterly reporting on cyber to the Trust's Audit and Assurance Committee.

## 4.3 Data Destruction

IT equipment


There have been no reported issues around data destruction or disposal. The contract is held with Hewlett Packard (HP) and was reviewed July 2021. Devices are collected by HP who in turn issue reports of what has been destroyed, recycled etc. All data is wiped / destroyed to the required standard and a HPEFS Disposal Certificate is provided for each collection. 8 collections have taken place in the last 12 months, 3975 devices in total. There is a project underway to review disposal processes to ensure that workflow captures inventory updated, validation of equipment removed and received at disposal locations.

Print waste

There have been no reported data issues with the print waste contract or supplier. Additionally, the supplier has not highlighted any data issues.

## 4.4. Cyber Data Security Risks

The Digital Group manages the cyber security risks for the Trust with oversight provided by the Audit and Assurance Committee.

## 4.5 Phishing

Phishing remains to be a high risk to the Trust, with the Trust's Office 365 tenant identifying 30,000 unsafe emails per day. It is estimated, by industry experts, that one in ninety-nine emails are a phishing attack. Phishers are getting more sophisticated in their efforts to trick recipients. Malicious emails and attachments continues to be utilised by Phishers.

The Trust has a number of technological measures to protect against cyber-attacks, however attackers are increasingly relying on users. As part of the Trust's response plan and to help protect against phishing attacks we carry out annual phishing simulations and target phishing campaigns to departments. The results and recommendations falling out of the simulation are reported to and managed through the Digital Group.

In August 2020 a system partner was subject to a ransomware attack that resulted in their systems being compromised and as a result NHS 111 service. Some healthcare service in the UK still do not have access to their patient's data (BCS Report).

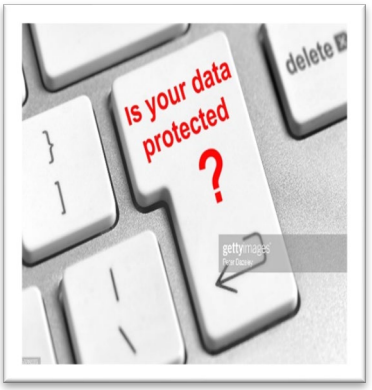
## 4.6 Patching

Windows Servers Update Service (WSUS) is a Microsoft Solution for deploying Microsoft operating system patches. Microsoft release these patches on a monthly basis as an accumulative update and by using WSUS and KACE these patches are deployed to server and end point devices after successful testing. Critical updates are

deployed within 14 days of release. Any updates with errors are managed through the IT support desk and on-site technicians. The 'KACE' patch management system is also used for non-Microsoft applications and Microsoft Defender is used for reporting.

### 4.7 Unsupported Software

The Trust has a process and tools to identify devices or servers that are running unsupported Operating Systems (OS). Laptops and desktop that are running unsupported operating systems are isolated from the network.




The Trust has a review process for replacing it older server estate. Microsoft Defender is used to identify applications that may be unsupported, these are monitored and rectified by GHC Server team. The ICS Cyber Security Meeting reviews risks regularly.

Images, courtesy of Canvas and Getty images

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

**AGENDA ITEM: 17**/0523

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 25 May 2023**

**PRESENTED BY:** Lavinia Rowsell, Director of Corporate Governance/Trust Secretary

**AUTHOR:** Anna Hilditch, Assistant Trust Secretary

**SUBJECT:** **USE OF THE TRUST SEAL 2022-2023**

| **This report is provided for:** | | | |
|---|---|---|---|
| Decision ☐ | Endorsement ☐ | Assurance ☐ | Information ☑ |

**The purpose of this report is to:**

To provide information to the Trust Board on the use of the Trust Seal, as required by the Trust's Standing Orders, reference section 7.3.

**Recommendations and decisions required**

The Board is asked to **note** the use of the Trust seal for the period 2022/23 (1st April 2022 – 31st March 2023).

**Executive summary**

The Trust's Standing Orders require that use of the Trust's Seal be reported to the Trust Board at regular intervals. The common Seal of the Trust is primarily used to seal legal documents such as transfers of land and lease agreements. Up to the 31 March 2023, the seal has been used seven times.

**Risks associated with meeting the Trust's values**

All actions have been taken in accordance with the Trust Board's Scheme of Delegation and no inherent risks are to be reported to the Trust Board in the application of the Corporate Seal.

| **Corporate considerations** | |
|---|---|
| **Quality Implications** | Nil |
| **Resource Implications** | Nil |
| **Equality Implications** | Nil |

| **Where has this issue been discussed before?** |
|---|
| Bi-annual reporting to Trust Board |

| **Appendices:** | Appendix 1: Register of Seals (1 April 2022 – 31 March 2023) |
|---|---|

| **Report authorised by:**<br>Lavinia Rowsell | **Title:**<br>Director of Corporate Governance/Trust Secretary |
|---|---|

APPENDIX 1

## Gloucestershire Health and Care NHS Foundation Trust

## Register of Seals – 1st April 2022 – 31st March 2023

- Q1 & Q2 – 1st April 2022 to 30th September 2022 – 4 x documents signed/sealed
- Q3 & Q4 – 1st October 2022 – 31st March 2023 – 3 x documents signed/sealed

| Seal No. | Date of Sealing | Document Description | No. of Copies | Document Signatory (1) | Document Signatory (2) | Attested by | Attested Date |
|---|---|---|---|---|---|---|---|
| **27/2022 Q1** | 07/04/22 | **Underlease / Schedule of Condition** between GHCNHSFT and the Landlord Chaleworth Ltd re **2 Southgate Moorings**, Southgate Street, Gloucester Docks, Gloucester, ***Background:*** *Lease renewal as part of the IFRS16 discussion – Schedule of Condition forms part of the overall lease agreement.* | 1 | Sandra Betney Director of Finance and Deputy CEO | David Noyes Chief Operating Officer | Lavinia Rowsell Trust Secretary | 07/04/22 |
| **28/2022** | 07/04/22 | **Deed of Covenant** between GHCNHSFT and the Council of the City of Gloucester re **2 Southgate Moorings**, Southgate Street, Gloucester Docks, Gloucester ***Background:*** *agreement to pay GCC the service charges that they impose on all businesses that operate out of properties at the docks for the upkeep/maintenance.* | 1 | Sandra Betney Director of Finance and Deputy CEO | David Noyes Chief Operating Officer | Lavinia Rowsell Trust Secretary | 07/04/22 |
| **29/2022** | 07/04/22 | **Deed of Surrender** re **2 Southgate Moorings**, Southgate Street, Gloucester Docks, Gloucester between GHCNHSFT and the Landlord Chaleworth Ltd ***Background:*** *states that GHC are surrendering the existing agreement in favour of the new agreement/renewal.* | 1 | Sandra Betney Director of Finance and Deputy CEO | David Noyes Chief Operating Officer | Lavinia Rowsell Trust Secretary | 07/04/22 |

| Seal No. | Date of Sealing | Document Description | No. of Copies | Document Signatory (1) | Document Signatory (2) | Attested by | Attested Date |
|---|---|---|---|---|---|---|---|
| **30/2022** | 29/04/22 | **Form of Agreement**<br>re **new Community hospital in Cinderford**<br>between GHCNHSFT and Speller Metcalfe Malvern Ltd<br>***Background:*** *Contract for the construction of the new Forest of Dean Community Hospital* | 1 | Sandra Betney Director of Finance and Deputy CEO | Angela Potter Director of Strategy and Partnerships | Lavinia Rowsell Trust Secretary | 29/04/22 |
| **31/2022 Q3** | 21/10/22 | **Agreement of Lease**<br>between Stroud Regeneration Ltd and GHCNHSFT **Re Part 2nd Floor, 1b King Street, Stroud, Gloucestershire**<br>***Background:*** *New agreement of Lease Term 25 Year* | 1 | Paul Roberts CEO | Dr Amjad Uppal Medical Director | Lavinia Rowsell Trust Secretary | 21/10/22 |
| **32/2022** | 24/10/22 | **Amendment to Contract**<br>Between Speller Metcalfe Malvern Ltd and GHCNHSFT<br>Re Southgate Moorings Refurbishment<br>***Background:*** *Work on Air Handling Unit element must be specifically mentioned in the contract* | 1 | Sandra Betney Director of Finance and Deputy CEO | Angela Potter Director of Strategy and Partnerships | Lavinia Rowsell Trust Secretary | 24/10/22 |
| **33/2023 Q4** | 30/03/23 | **Lease Agreement**<br>Between Hesters Way Partnership Ltd and GCSNHSFT re The Surgery, Springbank Community Resource Centre, Springbank Way, Springbank, Cheltenham<br>***Background:*** *amended licence to underlet returned by the Council* | 1 | Angela Potter Director of Strategy and Partnerships | Neil Savage Director of HR & OD | Anna Hilditch Deputy Trust Secretary | 30/03/23 |

**GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST**

**COUNCIL OF GOVERNORS MEETING**

Thursday 15 March 2023

Held via Microsoft Teams

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| | | | |
|---|---|---|---|
| **PRESENT**: | Ingrid Barker (Chair) | Nic Matthews | Graham Hewitt |
| | Tracey Thomas | Jenny Hincks | Chris Witham |
| | Kizzy Kukreja | Alicia Wynn | Mick Gibbons |
| | Jacob Arnold | Bob Lloyd-Smith | Sarah Nicholson |
| | Erin Murray | Juanita Paris | Paul Winterbottom |
| | Steve Lydon | Ruth McShane | |

**IN ATTENDANCE:** Steve Alvis, Non-Executive Director
Steve Brittan, Non-Executive Director
Marcia Gallagher, Non-Executive Director
Anna Hilditch, Assistant Trust Secretary
Vicci Livingstone-Thompson, Associate Non-Executive Director
Jan Marriott, Non-Executive Director
Kate Nelmes, Head of Communications
Paul Roberts, Chief Executive
Graham Russell, Non-Executive Director/Deputy Chair
Neil Savage, Director of HR & OD
John Trevains, Director of Nursing, Therapies & Quality

## 1. WELCOMES AND APOLOGIES

1.1 Graham Russell, Deputy Chair welcomed colleagues to the meeting. It was noted that Ingrid Barker was in attendance; however, Graham had been asked to Chair the meeting due to Ingrid Barker currently recovering from Covid.

1.2 Apologies had been received from the following Governors: Alan Cole, Dan Brookes, Rebecca Halifax, Alison Hartless, Ismail Surty and Laura Bailey. Apologies had also been received from Sumita Hutchison and Nicola de Iongh, Non-Executive Directors.

1.3 The Governors welcomed Vicci Livingstone-Thompson to the meeting. Vicci had been appointed as an Associate NED and had commenced in post on 1 March 2023.

## 2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

## 3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes from the previous meetings held on 1 December 2022 and 18 January 2023 were agreed as a correct record.

## 4. MATTERS ARISING AND ACTION POINTS

4.1 No actions had been identified from the previous meetings. There were no other matters arising.

## 5. CHAIR'S REPORT

5.1 The Council received the Chair's Report, which outlined the key activities of the Trust Chair and Non-Executive Directors up to the end of January 2023. It was noted that this report had been presented in full to the Trust Board at its meeting on 26 January.

5.2 The Council noted that it continued to be a very busy time, but the Chair's report demonstrated that some great work was taking place, both within GHC and with wider system partners.

5.3 Lorraine Dixon, Associate Non-Executive Director had been successful in securing an appointment as Professor and Director of the School of Nursing and Midwifery at Oxford Brookes University and would therefore be leaving the Trust at the end of May. Consideration would now be given to the next steps in securing an Associate NED for the Board as a University nominee.

5.4 The Council received and noted the content of this report.

## 6. CHIEF EXECUTIVE'S REPORT

6.1 Paul Roberts provided the Council with a verbal update on key news and developments.

6.2 At the last meeting in December, Governors were updated on the upcoming industrial action and the Trust's preparations for this. Since then, a series of strikes had taken place by nurses, physios, junior doctors and ambulance workers. Paul Roberts advised that the Trust and the wider system had good arrangements in place and had managed the situation well; however, the longer this continued the more impact it would have on patients and colleagues. It was everyone's hope that there was an agreement and settlement soon.

6.3 The Trust and system had experienced extreme operational pressure over the Christmas and new year period. There had been improved performance since mid-January however, with far fewer patients awaiting discharge and onward care packages. Inpatient mental health services remained under pressure currently. Paul Roberts said it was a real tribute to colleagues for continuing to work under this pressure.

6.4 Along with system partners, GHC was working with an external consultant to review the Gloucestershire Urgent and Emergency Care system pathways. Phase 2 of this transformation programme was due to commence in May/June and it was hoped that this would have a beneficial impact.

6.5 Paul Roberts informed the Council that GHC was good in its financial stewardship and was due to hit year end on target. However, next year was expected to be financially challenging so it was important to be mindful of this.

6.6 The NHS Staff Survey Results had now been published and it was reported that GHC had performed well, and was the top performing Trust in the south west region. Paul Roberts said that colleagues should be very proud of the results; however, there was still a lot of work to do to improve in certain areas such as inpatient mental health services and lower paid staff groups. A full presentation of the results would be received at the Council of Governors meeting in May.

6.7 The Trust had also received the results of the GMC Survey of Doctors in Training. GHC had received excellent feedback and was the top performer nationally which was a fantastic achievement.

6.8 Paul Roberts advised that he was having regular meetings with the new Chief Executive Douglas Blair as part of the handover process. Douglas would commence in post on 17th April.

6.6 This was Paul Roberts' final Council meeting and Chris Witham expressed his thanks, on behalf of the Council of Governors. He said that colleagues had been

lucky to have Paul at the helm over what had been challenging times through the merger and Covid. He had steered the Trust to a strong place, making reference to the "Good" CQC rating, positive national survey results and the achievement of financial balance. Paul's values had consistently shone through and the whole Council had valued his input. Governor colleagues wished Paul Roberts well for the future.

## 7. MEMBERSHIP UPDATE REPORT

7.1 The Council received this report which provided an update on Trust membership activity and statistics for the period up to 8 March 2023.

7.2 An overview of Trust membership was presented and included a breakdown of public members by constituency, ethnicity, disability and age profile. The Council was asked to note that public membership data had remained relatively static over the past few years, with little change in the statistics month on month. As of 8 March 2023, the Trust had 5864 Public members. Of these public members, 2698 receive communication from the Trust via Email.

7.3 Vicci Livingstone-Thompson said that some people might be put off by completing a Membership "Application Form" and suggested that this could be renamed. This was a really helpful suggestion, and it was agreed that this would be taken back for a further discussion with the Communications Team. **ACTION**

7.4 The Council received and noted the content of this report, which also included a summary of the key points discussed at the recent Membership & Engagement Committee held on 15 February.

## 8. UPDATE FROM GOVERNOR PRE-MEETING

8.1 Chris Witham provided a verbal report on those key issues discussed at the Governor pre-meeting.

8.2 A Governor visit to Stroud Hospital had taken place earlier in the day and colleagues had reported on the huge improvements that had been made to the fabric of the hospital. This had been a very positive visit.

8.3 Reference was made to the Governor Dashboard and the deep dive on Sexual Health Services that had taken place at the recent Quality Committee meeting. Governors agreed that this was a helpful inclusion.

8.4 Governors had discussed the need to seek assurance on being able to continue to deliver good quality services and to maintain staff experience, alongside the challenges with sickness absence, high vacancy rates and ongoing strike action. Neil Savage informed the Council that workforce was the Trust's biggest challenge and was currently the highest risk on the Trust's Board Assurance Framework. The South West region was the most challenged area for workforce. A new Recruitment and Retention Strategic Framework was now in place, and positively the Trusts vacancy rate had reduced to 9% which was the lowest rate since April 2022. There had been a slight decrease in reported sickness levels, but it was acknowledged that this was still high. Huge efforts had been made to provide excellent staff health and wellbeing offers and work was taking place at a system level to increase the levels of support available to colleagues.

## 9. NOMINATIONS AND REMUNERATION COMMITTEE SUMMARY

9.1 The purpose of this report was to provide a summary to the Council of Governors of the business conducted at the Nominations and Remuneration (N&R) Committee, held on 1 March 2023.

9.2 The Committee was asked to note that discussions about NED and Chair remuneration remained on pause, in line with the statement as presented to the Council of Governors in January.

9.3 The Committee received the annual Board declarations report, which provided assurance that these checks had been carried out for 2022/23 and as evidence that the Non-Executive Directors continue to meet the requirements of the 'Fit and Proper Persons Test'. There were no issues to be brought to the attention of the Committee following the checks.

9.4 The Committee received a report setting out the process and proposed timeline for the Chair and Non-Executive Director appraisals for 2022/23. These were endorsed.

9.5 The Committee received a report setting out a recommendation for the extension to the term of office of the Trust Chair. It was noted that Ingrid Barker would come to the end of her final term on 31 December 2023. The Trust has recently appointed a new Chief Executive who will commence in post in April 2023. It was proposed that Ingrid Barker's term be extended by 4 months (up to end of April 2024) to enable a one year embedding period and to ensure that there is continuity and stability in Board leadership during 2023/24. The Trust's Constitution has provision for the extension of the term of office of the Chair and NEDs, in exceptional circumstances. Ingrid Barker had been consulted on this proposal and had confirmed that she would be willing to continue for this additional period. Informal conversations had also taken place with Elizabeth O'Mahoney, NHSE Regional Director and fellow Board members who are all supportive of the proposal. The Council of Governors discussed and supported this proposal and approved the term extension.

## 10. GOVERNOR DASHBOARD

10.1 The Governors received the Governor Dashboard, presenting data up to 30 January 2023. The purpose of this dashboard was to provide a high-level overview on the performance of the Trust through the work of the Board and Committees, with particular focus on the core responsibilities of governors in holding the NEDs to account for the performance of the Board.

10.2 A query was raised as to whether the Trust had the ability to seek feedback via the Friends and Family Test (FFT) from people who were on a waiting list to access services, as well as those already on the caseload. John Trevains reported that this function was not currently built in to the FFT process.

10.3 The Governors noted that the Resources Committee had carried out a deep dive in December into ADHD and Autistic Spectrum Condition (ASC) Disorder services. This had provided an in depth briefing on the current strategic and operational position of the services, detailing the current performance against key performance indicators and the strategic steps taken to improve the position. It was noted that the ADHD Service's demand significantly outweighed the capacity available. The team were commissioned to provide 30 treatment review sessions per year and the team received, on average, 22 referrals each week, which equated to 1144 per year. There had been a 200% increase in referrals received. Assurance was received that updates would continue to be included in the Chief Operating Officer's Report received at future Resources Committee meetings.

10.4 The Governors welcomed and noted the dashboard report. It had been agreed in earlier discussions that more information on the current position with Length of Stay patients would be included in the next Dashboard report for information. **ACTION**

## 11. TRUST BUSINESS PLANNING PROCESS 2023/24

11.1 The Council welcomed Lisa Proctor, Associate Director of Contracts and Planning who was in attendance to present the Business Planning approach for 2023/24 to ensure the Council of Governors were appropriately involved in the process and had an opportunity to give views for Board consideration.

11.2 The business plan is key to the delivery of the Trust Strategy and each business planning objective is linked to one of our strategic themes. The business planning objectives are monitored through the year against a set of metrics to inform the delivery of the Trust Strategy.

11.3 The business planning process for 2023/24 was launched on 1st November 2022. The planning timescale has been aligned and forms a coordinated annual planning cycle that brings together the operational and corporate requirements to ensure the capacity, capability and affordability is planned appropriately to deliver the business planning objectives in the coming year. These are also aligned to the ICS planning process which is linked to system prioritisation.

11.4 It was noted that the business planning process had been audited and in response to a recommendation, an enhanced quality assurance mapping process had been introduced this year to formalise the alignment and cross referencing of objectives. Directorates and Teams were currently updating their business planning objectives following the feedback from the quality assurance process as part of the final stage of the business planning process for 2023/24.

11.5 Lisa Proctor advised that a refresh of the plan would take place at the end of Quarter 1 in 2023/24 to update business planning objectives and reset milestones to reflect any national policy changes or new local requirements including aligning with the System Delivery Plans as necessary. The business planning objectives would be informed by national policy changes and would be monitored as 'live' plans throughout the year enabling adjustments to be made in-year when necessary.

11.6 Steve Lydon asked for clarity on the purpose of this report being presented to Governors at this stage, and the Governor role in receiving it. It was noted that the views of Governors were being sought on the approach that the Trust was taking in relation to its business planning process, not necessarily on the content and objectives identified. It was for the Trust Board to oversee the detail and to sign off the final business plan.

11.7 Nic Matthews said that he had previously queried the involvement of the Heads of Profession in the business planning process. Lisa Proctor confirmed that all directorates had had the opportunity to comment on the plans and the objectives and would be fully involved in the refresh at the end of quarter 1.

11.8 Graham Hewitt said that he felt assured that the Trust had a thorough planning process in place. In terms of strengthening the process around how the Trust works with system partners, he suggested that the objectives identified within the plan needed to align with the wider system plans. Lisa Proctor agreed that alignment with the system plan was crucial, and this would take place during the quarter 1 refresh. It was noted that the system delivery plans were due to be approved at the end of April 2023.

11.9 Paul Roberts said that the context for planning in the NHS was very tricky; however, referring to Steve Lydon's earlier points, he suggested that discussions should take place to consider the format, content and timing of future business planning reports to ensure that Governors have the opportunity to feed in comments and to see how the process was progressing in a more timely and valuable way. This would be considered further, and the Council agenda work plan would be updated accordingly. **ACTION**

## 12. CQC COMMUNITY MH PATIENT SURVEY RESULTS 2022

12.1 The Council welcomed Marit Endresen, Patient Survey Manager who was in attendance to present a summary of the results of the 2022 CQC National Community Mental Health survey and to provide assurance that the results of this national survey had been used to identify areas of focus for practice development activity over the next 12 months.

12.2 Enabling people to have positive experiences of NHS services which meet their needs and expectations is a key national strategic goal and an underpinning core value of GHC. The CQC requires that all providers of NHS mental health services in England undertake an annual survey of patients in their care. The Trust commissioned Quality Health to carry out this work. The 2022 survey involved 53 providers in England, including combined mental health and social care trusts, Foundation Trusts and community healthcare social enterprises that provide NHS mental health services.

12.3 The results for the 2022 CQC survey were published on 27th October 2022. The Trust's response rate was 29% (358 responses). This is significantly above the national average of 21%. However, both the Trust's and the national response rates have decreased from the 2021 survey (Trust 34%, national average 26%).

12.4 As in previous years, GHC scored well across most survey questions, being classed as 'better than expected' or 'the same' as other trusts in all questions. However, some areas have been identified where further development and continued effort may enhance the experience of people using our services. There are two areas specifically identified as needing improvement: Crisis Care and NHS Talking Therapies.

12.5 Ruth McShane said that she was a member of the Survey Reference Group and had already met with Trust colleagues to discuss the results and the actions required. Overall, she said that the results were excellent, and the Trust and Trust colleagues should be commended for this performance. In terms of the two improvement areas, Ruth noted that these had historically been lower performers. Access to Crisis support differed across the county, with many cases going through A&E services. Paul Roberts advised that the Trust was leading a piece of work with the Acute Trust to look at this in more detail. He said that crisis services were under pressure as they were dealing with more people in mental distress, not necessarily those people with long term mental health conditions. A whole approach to crisis services was taking place with system partners. Erin Murray noted the importance of Experts by Experience and suggested that having colleagues in place within services to assist and signpost patients to appropriate services would be really valuable.

12.6 The Council received and noted this report and associated infographic, and was assured of the Trusts ongoing delivery of high-quality adult community mental health services.

## 13. QUALITY ACCOUNT TIMELINE

13.1 The Council of Governors welcomed James Wright, Associate Director of Patient Safety, Quality & Clinical Compliance who was in attendance to provide a briefing for the Governors on the proposed timetable for approval of the Quality Account and to present an outline of the methodology used in its preparation.

13.2 This report was noted, and the Council would receive a full presentation of the draft Quality Account at their May meeting.

## 14. COUNCIL OF GOVERNOR MEMBERSHIP AND ELECTION UPDATE

14.1 The Council received and noted this report which provided an update on changes to the membership of the Council of Governors and an update on progress with upcoming Governor elections.

## 15. GOVERNOR QUESTIONS LOG

15.1 The Council received and noted the Governor Questions Log up to end of February 2023. The log would be updated and presented at each Council meeting, and any questions received between meetings would be presented in full, alongside the response for Governors' information. It was noted that one new question had been included on the log on this occasion.

## 16. GOVERNOR ACTIVITY UPDATE

16.1 The Governor activity log was received and noted. Governors were reminded to keep a record of their activity and to ensure that this was sent to the Assistant Trust Secretary when requested in advance of future Council meetings.

## 17. ANY OTHER BUSINESS

17.1 There was no other business.

## 18. DATE OF NEXT MEETING

18.1 The next meeting would take place on Wednesday 17 May 2023.

### ACTIONS LOG

| Date | Ref | Action | Status |
|---|---|---|---|
| 15 March | 7.3 | Renaming the Membership "Application Form" to be considered with the Communications Team | **Complete** Agreed to refer to this as simply "Membership Form". |
| | 10.4 | More information on the current position with Length of Stay patients would be included in the next Dashboard report for information | **Complete** Included in May dashboard report. |
| | 11.9 | Discussions to take place to consider the format, content and timing of future business planning reports to ensure that Governors have the opportunity to feed in comments and to see how the process was progressing in a more timely and valuable way. | **Ongoing** |

# GPTW COMMITTEE SUMMARY REPORT
# DATE OF MEETING: 29 MARCH 2023

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|---|---|
| **COMMITTEE GOVERNANCE** | • Committee Chair – Graham Russell, Non-Executive Director<br>• Attendance (membership) – 75%<br>• Quorate – Yes |

## KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

### STAFF STORY – MY CAREER JOURNEY

Becky Anstis attended the meeting and shared her career journey with the Committee. Becky shared how she had started working in the NHS has an HCA 30 years ago. The Committee was told how she had progressed from an HCA to a band 7 ward manager and how she had been supported throughout her journey. The Committee thanked Becky Anstis for sharing her inspirational story and valuable experiences.

### DEEP DIVE – STAFF SURVEY

The Committee received a deep dive presentation and report of the Staff Survey and was informed that the Staff Survey was the largest survey in terms of surveying employees as to what it is like to work with an organisation, with 1.3 million people working within the NHS being asked their views annually. The Committee was informed that 264 NHS organisations had taken place in the survey in the previous year.

It was reported 2492 surveys had been completed within the Trust in 2022, and that this was a 55% response rate. It was noted that this included a response via both digital and paper surveys. The South West Provider Trust Ranking was shared with the Committee and it was highlighted that the Trust (GHC) was joint first.

The Committee was informed that an action plan would be received at the next GPTW Committee, following further discussions with the Trust Board and Staff Side colleagues.

The Committee:

- **Noted** the Staff Survey results and related report content.
- Was **assured** that the Trust's strategic approach to people management, engagement, culture and communications over the past year was paying dividends.
- **Recognised** that there was further improvement work to do to become a consistent top quartile performer in the survey outcome.

### PERFORMANCE REPORT – WORKFORCE KPIS

The Committee received the Performance Report, workforce KPIs for month 9, which provided a high-level view of the KPIs across the Trust. Positively it was highlighted that the Trust's Vacancy FTE and percentages had stabilised over the past 4 months reflecting less leavers and the increase in new starters. The vacancy rate had reduced from 12.2% to 9.9%.

The staff turnover rates were shared with the Committee, and it was noted the areas with the high turnover rates were BI and IT services. This was not uncommon in these areas.
The inclusion of the work/life balance deep dive in reference to leavers of the Trust via staff groups and areas was highlighted in the report. The deep dive also showed the split between male and female leavers, which was recorded as 86.4% female and 13.5% male.

The Committee:

- **Noted** the aligned performance report, workforce KPIs - for February 2022/23
- **Acknowledged** the ongoing impact of the pandemic and service recovery on workforce operational performance, particularly on sickness absence and appraisal compliance.
- **Noted** the report as adequate level of assurance of our workforce performance measures or that appropriate service action plans are being developed to address areas requiring improvement.

## EQUALITY DELIVERY SYSTEM

The Committee received the Equality Delivery System (EDS) Report, which provided an update and assurance on the Trust's planning for submission for the annual return on the EDS22 by end of March 2023. The Committee was informed that the EDS was a framework designed to help facilitate NHS organisations in assessing and improving services provided for their local communities and to provide better working environments; free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010.

The Committee noted this report and approved the ratings and the publication of the report and the Trust submission Template.

## OTHER ITEMS RECEIVED

The Committee:
**Received** and **noted** the Freedom to Speak Up Report
**Received** and **noted** the Corporate Risk Register
**Received** and **noted** the Board Assurance Framework
**Received** and **noted** the HR Policy Manual Project - Overview

## ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of the report.

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|---|---|
| **DATE OF NEXT MEETING** | 7 June 2023 |

# WORKING TOGETHER ADVISORY GROUP SUMMARY REPORT
# DATE OF MEETING: 20 April 2023

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|---|---|
| **COMMITTEE GOVERNANCE** | • Chair – Jan Marriott, Non-Executive Director |

**KEY POINTS TO DRAW TO THE BOARD'S ATTENTION**

**NB: This meeting was the first in-person event held at the Chamwell Centre, a discussion-based workshop was held rather than the previous more formal meeting. Out puts from the meeting were therefore captured as themes to inform the development of a CYP Strategic Framework aims and ambition.**

**Children and Young People's Services – GHC's CYP strategic framework ambition**

Mel Harrison, Director of Children and Young People's Services (CYPS) attended the meeting to provide an overview of GHC CYP services and set the scene to enable discussion about authentic co-production. Some key points and questions posed included:

- U19's comprises 22% of the population in Gloucestershire but do they take up 22% of discussion time in meetings?
- GHC services work with over 60 other agencies with a goal to wrap services around the child/families and carers. How can we build bridges with Education, Police, and wider partners in CYP health & care strategic discussions?
- Language that Cares campaign and initiative. Gloucestershire County Council Ambassadors have been involved in an initiative called 'Language that Cares'. This is a very powerful and incredibly important initiative, CYP's have worked very hard on producing a brilliant suite of resources and within GHC we are working closely with GCC YP Ambassadors to embed key messages about the importance of language that is used to speak with, CYP care experiences and potential impact this has both in the long and the short term. Labels we give to children are harmful – we all need to reflect on our attitudes to change our behaviour and tackling stigma.

The presentation provoked discussion around the essential requirement to work with multiple system partners, particularly education sector colleagues. Questions were raised about why Education leaders are not represented at ICS partnership boards. The Chair thanked Mel for her presentation and the good work taking place in this area.

**Working together authentic co-production in practice: GHC's approach to Young People's Participation**

Charlie Presley (CYP & Digital Specialist Inclusion Lead) provided a presentation about the GHC coproduction approach, highlighting achievements and change impacts of coproduction. Charlie highlighted the co-produced working together plan on a page that is committed to growing involvement and coproduction. Co-production with young people, parents and professionals across GHC & wider system is in early stages in GHC. However, participation programmes are becoming established and have become highly valued by colleagues and young people in a relatively short period of time. The current focus is on expanding both membership and work undertaken: there are currently young experts (8), youth representatives (16) and On Your Mind Gloucestershire (OYMG) influencers, undertaking co-producing promotional material, checking letters to ensure they are accessible, taking part in staff recruitment, 15 step challenges, supporting forums and listening events amongst other activities.

As a part of the presentation Charlie highlighted how the development and participation work with CYP's supporting working together implementation plan aims and ambition. The group then welcomed Katie (GHC Youth Expert by experience & GCC Ambassador) and Sam (GHC Youth Expert by experience), both shared their lived experiences including the benefits and challenges of accessing and using Children's services.

Sam was able to share information about himself and the challenges he faces. He is a 16yr old and finds everyday a challenge living with mental health conditions, Autism and ADHD. He is currently supported by CAMHS and his mum who is his full-time Carer and was also in attendance contributing to discussion. Sam had previously presented at the GHC Trust Board meeting. Sam identified how being a Youth Expert has enabled him to think about changes to services and making a difference to help others. Sam highlighted how the EbE role is an intrinsic part of his recovery, providing him with meaningful activity, building skills, and expanding his contact with others.

Katie is 18yrs old and has lived experience of CAMHS and foster care, she is currently at college and talked about her future ambitions and plans to become a Social Worker. Katie shared her experience of being labelled complex and of being described as having complex needs. From her perspective she was just a child who found a lot of things difficult and needed help, but by being described as complex she found she was sometimes excluded from services, not fitting criteria, or viewed as 'too difficult'. Katie expressed how support from lots of different organisations and people helped her, but also identified the impact on her when people she respected or liked moved on in their careers leaving her behind. Katie highlighted the importance of language and illustrated experiences of how people/professionals talked to her led to mistrust or to being described as disengaged. Katie identified how becoming an expert and a young Ambassador has helped her build personal skills and enabled her to help others by talking about her experiences to bring about change, specifically in co-designing the Language that cares campaign. She is also involved in a GCC executive mentoring scheme – helping leaders to consider different perceptions.

The presentations from Mel, Charlie, Sam, and Katie provoked open discussion particularly focusing on language. The question was raised as to why language that care can't be expanded to incorporate all ages – as the issues of labelling are known to impact people generally. The Chair and Ingrid agreed to explore how to engage more with education and Police sector at a strategic level. Jan thanked the presentation team and Sam's mum who contributed as a Parent Carer, for the quality of the presentation and interesting discussion that was stimulated.

**Working Together Authentic Co-production and Partnership Working**

An open whole group discussion was held to explore authentic co-production, challenges, and barriers for CYPS and youth participation. A summary of discussion and associated actions linked to themes is attached as an annex for information.

**Any other business**

Ingrid to explore renaming the WTAG a Committee, in line with other Trusts. Changes to the setup of the Advisory Committee will need to be identified and shared with the coordinators for future planning.

| **ACTIONS REQUIRED BY THE BOARD** | |
|---|---|
| The Board is asked to **note** the contents of the summary and look at "How can we further support and enhance the status of CYPS and to ensure young voices are included in the work undertaken by the Trust'. | |
| **DATE OF NEXT MEETING** | Thursday, 19th July 2023 |

## 22% of air time

- Ingrid & Jan to discuss with Board and GHC committee's how we make sure CYP issues get 22% of the air time & investment.
- GHC needs to ensure there is adequate finance and resource to support the infrastructure required to develop CYP EBE programmes and ensure the voice of CYP's are represented
- Coproduction is the right thing to do not a 'nice to have'
- Inclusion Glos have produce Coproduction standards that are value based: 1)have a clear purpose – SMART goal; 2)Empowering EbE at the centre of decision making; 3)Provide support – easy and accessible to all; 4)Communicate effectively – using critical reflection to challenge; 5) Build trust and relationships. (Vikki to share for circulation)

## Rights of CYP

- We need to make explicit – the rights as a child to be heard, right to choices, what we can offer.
- Reasonable adjustment AKA workplace adjustments – services need to communicate what the options & choices are rather than just asking 'what adjustments do you need'?
- What are the funding implications of adjustment – can expectations about adjustments be met?
- Strategy needs to promote adjustments question as a conversation had in a thoughtful and respectful way
- GHC needs to share CYP stories to communicate the challenges and experiences in accessing services.
- Offering different ways to communicate: Options such as voice recording; pictures; writing; support person

## Getting the voice of CYP

- We need more EbE's – more voices to provide a better picture of how we can improve services: recruiting CYP's from diverse communities and representing different GHC services.
- Ensure all services ask the question – would you like to be involved? Consider different roles that CYP EbE can be involved in
- We need to link up and access other Youth Forums
- Social inclusion and coproduction needs to be resourced effectively. Supporting participation for CYP takes significant support to ensure their voices are heard.
- System wide approach to payment threshold – guidance not mandatory.
- Options for payment: pre-payment cards; help with setting up bank accounts; Fairer payments; carers rewards need to be considered
- Challenge is only 11+ currently

## System wide working

- ICB development day to focus on CYP issues. How will the voices of CYP be represented at the ICB event?
- How do we include the voice of CYP's in ICS strategic plans and conversation? There are growing number of youth forums being set up in the county as ILP projects. Stroud and Berkley Vale have a long established model that already links in with national health and well being boards. How can ICP & ICB link into these groups to make sure the voice of CYP's is present?

## Culture Change

- Expand and endorse language that cares as a trust wide programme. This sits alongside personalisation, compassionate care agendas (I think another was mentioned?).
- Communication – CYP's tell us that they prefer connecting via social media. GHC has a Digital CYP forum to support the co-design and production of digital communication methods. The recent Musicworks production was a great example of a different way of communicating with CYP's.
- Communications such as banners, posters and letters need to incorporate language that cares
- Consider a young ambassador mentor programme for execs and service leads.

## Think Family

- CYP co-production needs to consider the voice of the carer.
- How do we communicate about what is already available to families? Having a family focused approach to the care we provide to individuals – signposting to resources available.
- How do we promote EbE roles to CYP carers (formal and informal) of parents accessing our services? Social media/posters/contact partnership team
- GHC strategy needs to include an approach to include CYP views and experiences of accessing services with parents/carers. CYP's may be young carers, provide support, or spend time in adult provision.

# RESOURCES COMMITTEE SUMMARY REPORT
# DATE OF MEETING: 26 APRIL 2023

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|---|---|
| **COMMITTEE GOVERNANCE** | • Committee Chair – Steve Brittan, Non-Executive Director<br>• Attendance (membership) – 87.5%<br>• Quorate – Yes |

## KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

### FINANCE REPORT – MONTH 12

The Committee received the Finance Report for month 12, which provided an update of the financial position of the Trust.

The draft year end position was a £32k surplus and the draft final accounts and full audited accounts would be submitted on 30 June 2023. The Committee was informed the revised Capital plan was £19,502m, and included an increase of £1.671m for national IT Digitisation, and £215k for Mental Health ward improvements. The Cost Improvement Programme (CIP) had delivered £5,565m of recurring savings against the target of £5,612m.

The Committee thanked Sandra Betney and acknowledged the hard work which had been carried out by the Trust and the finance teams.

The Committee **noted** the month 12 position.

### PERFORMANCE REPORT

The Committee received the Performance Report, which provided a high-level view of the key performance indicators in exception across the organisation.

The Committee was informed that 32 integrated service level reports had been rolled out in physical health services. Integrated reporting would also be rolled out in community mental health services during quarter one. It was proposed integrated reports be received by the Resources Committee going forward. The Committee supported this.

The Chief Operating Officer highlighted ongoing issues relating to the financial uncertainty affecting both CATU and the MIIU Telephone Triage and raised as a concern for the Trust and the System.

The Chief Operating Officer David Noyes spoke about concluding the SystmOne Simplicity Project and the work he was undertaking on the development of the work which had been done. The key achievements of the project were shared with the Chair post meeting, as follows:

- Caseload reduction to **109,000** (from 288,000 in 2020)
- We have **24,000** on waiting lists (from 193,000 in 2020)
- All referrals (**100%**) included in Community Services Data Set (CSDS) (from 24% in 2020)
- Nearly all (**97%**) of MIIU referrals included in the Emergency Care Data Set (ECDS) (from 55% in 2020)
- Nearly all (**93%**) activity accurately recorded (from 65% in 2020)
- An **80% reduction** in administrative activity releasing clinical time (equivalent to **624,000** appointments)

The Committee **noted** the aligned Performance Dashboard Report for March 2022/23.

## SERVICE DEVELOPMENT REPORT

The Committee received the Service Development Report, which provided an update on the Trust's service development activities and income streams.

## UPDATE ON THE DELIVERY OF THE TRUST'S STRATEGIC AIMS

The Committee received the Update on the Delivery of the Trust's Strategic Aims Report, which provided an update on the Trust's progress in the delivery of the strategic aims outlined in its 5-year Strategy. The report highlighted the progress which had been made to date against the key metrics at the Trust Board September 2022 and further recommended areas where metrics needed to be reviewed to reflect either changes in the measurement approach; the ability to capture data or the appropriateness of measure against the objective.

The Committee was assured on the delivery of our overall strategic direction from the progress against our Trust strategic objectives; and supported the recommendation to review the metrics.

## OTHER ITEMS RECEIVED

The Committee:
**Received** and **noted** the Business Planning Report – Quarter 4
**Received** and **noted** the Digital Maturity Assessment
**Received** and **noted** the update on System Finance Risk Shares
**Received** and **noted** the Corporate Risk Register
**Received** and **noted** the Board Assurance Framework

## ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of the report.

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|---|---|
| **DATE OF NEXT MEETING** | 29 June 2023 |

**MHLS COMMITTEE SUMMARY REPORT**
**DATE OF MEETING: 26 APRIL 2023**

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|---|---|
| **COMMITTEE GOVERNANCE** | • Committee Chair – Sumita Hutchison, Non-Executive Director<br>• Attendance (membership) – 100%<br>• Quorate – Yes |

## KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

### DISPROPORTIONATE USE OF THE MENTAL HEALTH ACT WITH ETHNIC MINORITIES

The Committee received this report which provided information on the use of the Mental Health Act with ethnic minorities in the Trust, compared with national use. The report showed the rate of MHA detention per 100,000 population by broad ethnic categories in England for 2021/22 in comparison to the rate of MHA detentions per 100,000 by broad ethnic categories in the Trust for both 2021/22 and 2022/23. The data compared showed that the there was a disproportionate use of MHA detentions with people who were black or black British in 2021/22. It was noted that this had improved in 2022/23.

A report had previously been received by the Committee on Black Lives Matter and it was suggested that an update report be brought to the next Committee meeting focusing on the Patient and Carer Race Equality Framework (PCREF).

### MHAM FORUM UPDATE

The Committee was informed of discussions held regarding the remuneration of managers and for consideration to be given to the chair to receive a higher rate in recognition of the additional workload. Louise Moss, Deputy Head of Corporate Governance confirmed that this had been discussed with the Finance Lead and the recommendation was for expenses to increase from £50 to £65. The Committee supported this recommendation.

### AMHP SERVICE UPDATE REPORT

The Committee received the AMHP Service Update Report, which provided an update on the AMHP activity within the service for quarter 4. The Committee noted that the service was operating as business as usual and that there were no concerns around safety or risk to escalate.

### REVIEW OF MCA PRACTICE, DOLS APPLICATIONS AND LPS

The Committee received the Review of Mental Capacity Act (MCA) Practice, DoLS Applications Update Report and the Liberty Protection Safeguards Update.

The Committee was informed that an MCA audit had been completed, which reviewed the practice of the MCA within community hospitals. It was reported that the audit had revealed that there was a lack of understanding of when MCAs needed to be undertaken and when DoLS should be implemented. The Committee was further informed that as a result of the MCA audit, an action plan had been developed and would be monitored. The Committee was informed that part of the action plan included weekly drop-in sessions which had been organised in which people could seek advice and information relating to the MCA. The sessions were open to anyone in the Trust.

The number of inpatient referrals made across the previous year was shared with the Committee, and it was reported 129 referrals had been made. Of the 129, 93 were community physical health patients in community hospitals and 36 were mental health patients in psychiatric hospitals. The

Committee was informed, of the 93 community hospital DoLS referrals, none resulted in the local authority authorising a standard authorisation. Of the 36 mental health DoLS, only 12 were authorised by the local authority.

The Committee **noted** the outcomes of MCA related audits and the plans to improve practice.
The Committee **noted** the information provided in relation to DoLS activity and LPS implementation.

**CORPORATE RISK REGISTER**

The Committee received the Corporate Risk Register and was informed that risk 180, Mental Health Act Changes, had reduced to 12.

The Committee **noted** the information and assurance provided.

**OTHER ITEMS RECEIVED**

The Committee:
**Received** and **noted** the MHLOG Group Update.
**Received** and **noted** the Use of Mental Health Act at GHFT Report

**ACTIONS REQUIRED BY THE BOARD**

The Board is asked to:

- **Note** the contents of the report.

| | |
|---|---|
| **DATE OF NEXT MEETING** | 19 July 2023 |

# QUALITY COMMITTEE SUMMARY REPORT
# DATE OF MEETING: 4 May 2023

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|---|---|
| **COMMITTEE GOVERNANCE** | • Committee Chair – Jan Marriott, Non-Executive Director<br>• Attendance (membership) – 100%<br>• Quorate – Yes |

## KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

### CLINICAL PRESENTATION – REDUCING RESTRICTIVE INTERVENTION

Ross Runciman, Consultant Psychiatrist was welcomed to the meeting and shared a presentation on restrictive invention. Data was shared on the use of both supine and prone restraints used from April 2018 to present. Data on restrictive practice and Seni's law was also shared with the Committee, and work on deep dives relating to these.
The Committee was informed that any concerns raised were monitored through QAG and reported back to the Committee, via Hannah Williams
The Committee thanked Ross Runciman for his informative and helpful presentation on the work taking place on reducing restrictive practice.

### QUALITY DASHBOARD

The Committee received the Quality Dashboard Report, providing a summary assurance update on the progress and achievement of quality priorities and indicators across Trust's physical health, mental health and learning disability services.
The Director of Nursing, Therapies and Quality highlighted the quality issues which were now showing improvements, including:

- Work had been progressed on the Trusts Falls prevention plan in order to further reduce injurious falls under the new focus of Hannah Williams.
- Good sustained improvements in CPA compliance rates meeting the 95% performance consistently in the previous 6 consecutive months.
- Quarter 4 NED audit of complaints in the report, which provided assurance that the Trust was investigating and responding to complaints appropriately.

The Committee **noted** and **discussed** the Quality Dashboard

### CORPORATE RISK REGISTER

The Committee received the Corporate Risk Register, which provided information and assurance in respect of the Trust's risk management framework, to support the Committee to meet its risk management responsibilities under their Terms of Reference.
It was highlighted *risk 302: Clinical Records – bulk syncing to the National Spine*, had been closed. This risk was discussed at the previous Committee meeting and had now been resolved. Other movements on the risk register were noted by the Committee.
The Committee **noted** and **discussed** the information and assurance provided.

### DRAFT QUALITY ACCOUNT 2022/23

The Committee received the Draft Quality Account 2022/23, which reported on activities and targets from the previous year's Account and set out and introduced new objectives and proposed developments for the following year.
The draft report enabled the Committee to see the work in progress of the account and to agree on the proposed quality priorities that have been identified for 23-25.

The Committee **noted** the content of the quality account and quality priorities for 23-25
The Committee **agreed** and **supported** the quality priorities set out within the report.

**ANNUAL LIGATURE REDUCTION STRATEGY**

The Committee received the Annual Ligature Reduction Strategy, which provided an update on the refreshed work to provide a Trust corporate level strategy for the areas of work, both planned and currently being undertaken to reduce deaths by ligature across all Trust inpatient units. The framework focussed on the area of ligature reduction which supports the Trust Inpatient Zero Suicide Plan 2022/24. The Committee welcomed this update.

**OTHER ITEMS RECEIVED**

The Committee:
**Received, noted** and **supported** the Mental Health, Learning Disability and Autism Quality Transformation Programme update
**Received** and **noted** the Learning from Deaths Internal Audit, for information purposes.
**Received** and **noted** the Board Assurance Framework
**Received** and **noted** the Quality Assurance Group Summary Report
**Received** and **noted** the Improving Care Group Annual Summary Report

**ACTIONS REQUIRED BY THE BOARD**

The Board is asked to:

- **Note** the contents of the report.

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|---|---|
| **DATE OF NEXT MEETING** | 6 July 2023 |

# AUDIT & ASSURANCE COMMITTEE SUMMARY REPORT
# DATE OF MEETING 11 MAY 2023

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|---|---|
| **COMMITTEE GOVERNANCE** | • Committee Chair – Marcia Gallagher, Non-Executive Director<br>• Attendance (membership) – 100%<br>• Quorate – Yes |

## KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

### INTERNAL AUDIT

The Committee received the following Internal Audit reports:

| Internal Audit | Level of Assurance | |
|---|---|---|
| | Design | Effectiveness |
| Data Quality | Moderate | Moderate |
| DSPT | Moderate | High |
| Equality Diversity and Inclusion | N/A - Maturity Assessment | |
| Environmental Sustainability | N/A - Maturity Assessment | |

The Committee received and noted the I**nternal Audit Progress Report** and final **Audit Plan 2023/2024.**

**Internal Audit Annual Report & Head Of Internal Audit Opinion (2022/2023):** The internal auditor's opinion was that they were able to provide ***'moderate** assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently.'*

### EXTERNAL AUDIT

The Committee received an update on recent and planned external audit activities. The Committee was informed that whilst the interim audit had not been completed as expected, the auditors did not envisage any issues within completing the audit within the required timeframe. It was noted that the final audit plan for 2023 had been circulated outside the meeting.

### COUNTER FRAUD, BRIBERY & CORRUPTION

The Committee received and considered the Counter Fraud progress report and summary of current investigation.

The *Draft Annual Report for 2022/2023* was received, which would be finalised with the addition of the Counter Fraud Functional Standards Return and approved by the Chair and DoF outside the meeting. The self-assessment of the CFFRS for 22/23 concluded that of the twelve components; 11 were rated as green and 1 as amber with significant progress made in relation to risk assessments. The areas of focus in the *Annual Work-plan for 2023/2024* reflected the outcome of the self-assessment.

### DRAFT ANNUAL REPORT

The Committee received and considered the draft Annual Report noting that the report had been prepared in line with the NHS Foundation Trust Annual Reporting Manual for 2022/23. The draft report would be reviewed by the External Auditors with the final version presented to the June meeting prior to submission.

### DRAFT ANNUAL ACCOUNTS (INCLUDING ACCOUNTING POLICY REPORT)

The Committee received the Draft Annual Accounts which showed the draft position of the final accounts for 2022/23. The Committee:

- Noted the reconciliation from the management reported position to the Accounts
- Approved the updates to the Accounting Policies

- Reviewed the draft Accounts
- Endorsed the Trust's assessment of Going Concern and associated disclosures and recommended statements

The draft accounts were being audited by the external auditors, KPMG, with the final accounts being presented to the Committee for sign-off in June.

## FINANCE COMPLIANCE REPORT

The Committee received the Finance Compliance report which provided an update on actions taken under delegated powers since the last meeting of the Committee. The Committee welcomed the focus on, and progress made, in understanding the reasons behind Staff Overpayments. The balance outstanding at 31 March 2023 was £85,015. Two breaches in SFIs were reported to and considered by the Committee. It was agreed that a full-year finance compliance report would be produced for the June meeting of the Committee.

## ANNUAL ASSURANCE REPORTS AND DECLARATOINS

The Committee received:

- the **Governance Compliance Report** providing assurance on the progress and achievement with meeting the required standards for registers, held and maintained in line with statutory requirements and good practice.
- the **Procurement Shared Services** annual assurance report noting that c95% of SLA KPIs had been met however challenges remained over resourcing.
- and agreed to recommend to the Board for approval in May the **Annual Provider Declarations.**
- the **Annual SIRO Report,** providing assurance to the Committee on the effectiveness of controls for information governance, data protection and confidentiality.

## RISK

The Committee received the **Board Assurance Framework (BAF)** noting changes since the last review. It was noted that a Board Development Session on risk appetite and strategic risk was scheduled for early June. The Board received and noted the **Corporate Risk Register.**

The Committee **approved** the revised Organisational Risk Management Strategy that had been updated in line with best practice and to reflect developments made in risk management arrangements over the past two years.

## ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

| | |
|---|---|
| **DATE OF NEXT MEETING** | 19 June 2023 |