with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION

Thursday, 27 July 2023

10:00 – 13:00

The Green Room, Churchdown Community Centre

AGENDA

TIME	Agenda Item	Title	Purpose	Comms	Presenter
OPENING BUSINESS					
10:00	01/0723	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/0723	Declarations of interest	Assurance	Verbal	Chair
10:05	03/0723	Patient Story Presentation (Art Psychotherapy)	Assurance	Verbal	DoNTQ
10:25	04/0723	Draft Minutes of the meetings held on 25 May 2023	Approve	**Paper**	Chair
	05/0723	Matters arising and Action Log	Assurance	**Paper**	Chair
10:30	06/0723	Questions from the Public	Assurance	**Paper**	Chair
PERFORMANCE AND PATIENT EXPERIENCE					
10:35	07/0723	Quality Dashboard Report	Assurance	**Paper**	DoNTQ
11.00	08/0723	Performance Report	Assurance	**Paper**	DoF
11.20 – BREAK – 10 Minutes					
11:30	09/0723	Learning from Deaths Report Q4	Assurance	**Paper**	Dep. MD
11:40	10/0723	Finance Report	Assurance	**Paper**	DoF
STRATEGIC ISSUES					
11:50	11/0723	Report from the Chair	Assurance	**Paper**	Chair
12.00	12/0723	Report from Chief Executive • NHS Long term Workforce Plan • Wotton Lawn Quality Review	Assurance	**Paper**	CEO DoHR&OD DoNTQ
GOVERNANCE					
12:20	13/0723	Audit & Assurance Committee Annual Report	Assurance	**Paper**	Audit Chair
12:30	14/0723	Corporate Governance Update Report	Assurance	**Paper**	ATS
12:35	15/0723	Council of Governor Minutes – May 23	Information	**Paper**	Chair
BOARD COMMITTEE SUMMARY ASSURANCE REPORTS					
12.40	16/0723	Great Place to Work Committee (8 June)	Information	**Paper**	GPTW Chair
	17/0723	Charitable Funds Committee (8 June)	Information	**Paper**	CF Chair
	18/0723	Audit & Assurance Committee (19 June)	Information	**Paper**	Audit Chair

TIME	Agenda Item	Title	Purpose	Comms	Presenter
	19/0723	FoD Assurance Committee (21 June) • Terms of Reference	Approve	**Paper**	FoD Chair
	20/0723	Resources Committee (29 June)	Information	**Paper**	Resources Chair
	21/0723	Quality Committee (6 July)	Information	**Paper**	Quality Chair
	22/0723	Appointments and Terms of Service Committee (13 July)	Information	**Paper**	Chair
	23/0723	Mental Health Legislation Scrutiny Committee (19 July)	Information	Verbal	MHLS Chair
	24/0723	Working Together Advisory Committee (19 July)	Information	**Paper**	WTAC Exec Lead
CLOSING BUSINESS					
12:55	25/0723	Any other business	Note	Verbal	Chair
	26/0723	**Dates of future 2023 Board Meetings** Thursday, 28 September (MS Teams) Thursday, 30 November (MS Teams)	Note	Verbal	All

MINUTES OF THE TRUST BOARD MEETING

Thursday, 25 May 2023

Meeting held at the Business School, University of Gloucestershire

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

IN ATTENDANCE:
Lavinia Rowsell, Director of Corporate Governance / Trust Secretary
Kate Nelmes, Head of Communications
Louise Moss, Deputy Head of Corporate Governance
Anna Hilditch, Assistant Trust Secretary
Bren McInerney, Member of the Public

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 Steve Alvis.

1.2 The Board officially welcomed Douglas Blair to his first Board meeting. Douglas had commenced in post as Chief Executive on the 17 April 2023.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. PATIENT STORY PRESENTATION

3.1 The Board welcomed Colin to the meeting who was in attendance to speak to the Board about his experiences. Amjad Uppal had worked with Colin as his consultant for some time and supported him to tell his story.

3.2 Colin had been under the care of mental health services for a number of years with a diagnosis of 'treatment resistant' Paranoid Schizophrenia. His illness is characterised by persistent auditory hallucinations. Colin was at significant risk of self-neglect when he came to the attention of the mental health services initially in 2003.

3.3 Colin moved into his current accommodation in March 2022, and this has enabled him to live more independently in a supported living environment. He manages his finances himself and likes cooking for himself. His self-care and quality of life have improved significantly over the last few years despite his persistent auditory hallucinations. Colin has been with the Gloucester Assertive Outreach Team since September 2016, and it was felt that he was now ready to be 'stepped down' to the Recovery Team in Gloucester.

3.4 Colin told the Board that the Teams that he had worked with at GHC had been very helpful and had done a lot to support him. They had always been there and provided encouragement. Colin said that he had received a consistency in his care, seeing the same team members throughout which had been really important. He said that he felt more confident to talk to colleagues openly about any new issues and concerns that he was experiencing now.

3.5 The Board noted that Colin had a passion for music and cooking. He was learning how to play the keyboard and had a real interest in music software. To progress this interest, Colin said that he had tried to access The Music Works in Gloucester who provide studio space, but unfortunately, he had not been successful. Board colleagues agreed that it would be helpful to explore this opportunity further on Colin's behalf and see if it was possible to assist. **ACTION**

3.6 The Board thanked Colin for attending and talking about his experience, which demonstrated his courage, strength and determination.

4. MINUTES OF THE PREVIOUS BOARD MEETING

4.1 The Board received the minutes from the previous Board meeting held on 30 March 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 There were no matters arising.

6. QUESTIONS FROM THE PUBLIC

6.1 One question had been received in advance of the meeting from Bren McInerney, Member of the Public. A verbal response was provided at the meeting from David Noyes. A full written response would be sent to Bren McInerney following the meeting, and the question and response would be included as an annex to the meeting minutes for future record. **ACTION**

7. QUALITY DASHBOARD REPORT

7.1 This report provided an overview of the Trust's quality activities for April 2023.

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

7.3 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:

- 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 an 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.

7.4 Those areas showing a positive improvement this month included:

- 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.
- Improvement in the compliance to target in cardiometabolic assessments in both inpatient and community settings with continued 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.

7.5 In relation to the closed culture work, Marcia Gallagher asked about the provision of independent advocates. John Trevains reported that PowHer had experienced problems with recruitment; however, this had now been addressed and had generated some helpful conversations with commissioners about this provision. John Trevains advised that further detail on the provision of advocates would be included in future dashboard reports.

7.6 Graham Russell made reference to the waiting times for CAMHS and MSK Physio. There were some substantial waiting times and Graham queried whether this was still related to the post-Covid backlog or if this was now the business as usual position with increased demand for services. Sandra Betney advised that the average wait for CAMHS was 38 weeks. Data did suggest that the Trust was tackling the backlog so slow and steady progress was being made. David Noyes noted that a large element of the waiting list position was post-Covid demand, and discussions would be taking place again to look at evening and weekend provision, in particular within MSK Physio to try and reduce the backlog. The Board was asked to note that CAMHS was a big concern, with 588 children on the waiting list currently and capacity within the core CAMHS team being challenged. A huge amount of work was taking place to address this. David Noyes advised that the Trust continued to flag the priority that CYPS services should have, and additional funding had been received, however, the key issue was recruitment and the inability to recruit into the vacant posts. Douglas Blair said that there was some emerging thinking around the triage stage and the ability to offer a lower level of assessment. The service needed to look at ways to adapt to address the increasing demand and acuity issues. Positively, an app was currently being developed which would enable the service to stay in touch with children and families who were on the waiting list and be able to monitor changes in presentation and levels of acuity. Amjad Uppal added that a system wide Navigation Hub was being created which would ensure that all referrals were

made to the right places such as health, social care, education etc. This would be a very welcome development.

7.7 A statistically significant increase in moderate harm incidents linked to skin integrity and pressure ulcer harms could be seen. The data showed an increase overall of 71 skin integrity harm over the past year. The Board noted that there were three key factors 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 figure was 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. A lot of work had taken place within GHC over the past 4 years to try to understand the position around pressure ulcers, and John Trevains and Amjad Uppal informed the Board that this would be a key area of focus for the Patient Safety Team over the coming months. The Board agreed that a further update on this position should take place at the Quality Committee. **ACTION**

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

8. PERFORMANCE DASHBOARD

8.1 Sandra Betney presented the Performance Dashboard to the Board for the period April 2023 (Month 1 2023/24). In line with the planned Performance Indicator Portfolio reconfiguration, the Board noted that this report now presented performance indicators to the Board across four new domains including Nationally measured, Specialised & Direct Commissioning, Locally contracted and a Board focus. A fifth Operational domain, which includes measures such as waiting times would 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) had been transitioned into this 2023/24 dashboard. There were c.49 new indicators identified for 2023/24 that required further clarification (requiring definition, methodology or threshold clarification) or were in various development stages of automation. Additional indicators need to be developed for service areas such as Sexual Health, Dental and Low Secure and these were in the plan for 2023/24. Progress will be monitored through BIMG from June 2023.

8.2 In terms of Business Intelligence business planning highlights, the Board noted:

- 36 PH Community Health integrated service level (profile) reports have been 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 Health 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 the Resources Committee in June 2023. There is a plan for benchmarking to integrate into business-as-usual activities.

8.3 David Noyes presented his Chief Operating report to the Board. It was noted that activity across the system had remained busy but over the past few months the Trust has been able

to create improved flow opportunities in physical health. There has been improved bed availability in our community hospitals and a sustained improvement in HomeFirst performance. Pleasingly, it was reported that the Trust's MIIUs remained busy and well utilised, with the latest data showing a 99.8% achievement of the four hours wait target. The Board noted that system funding had now been agreed for CATU and MIIU going forward.

8.4 The Board noted that the delivery element of the Newton Europe work was now starting to commence. The Trust had already been making changes to ensure that we could sustain our own improvement agenda.

8.5 The stroke pathway remained one of the areas most challenged in terms of Community Hospital beds and flow. Some recent caseload validation work had taken place in the Early Supported Discharge Team, and this had eased the pressure slightly, however, David Noyes suggested that this was an area where the system needed to focus its attention.

8.6 A continued improvement in performance within the HomeFirst service was being seen with regular starts of between 30 and 40 per week. The numbers of people waiting to access the service has come down from over 100 to approximately 30, and flow out of the service has improved over recent months. The Board noted that GCC partners had recently agreed some additional investment into this service which would enable us to add an onboarding and training team to enhance effectiveness and care navigators to assist flow.

8.7 Steve Brittan welcomed the news that CATU funding had been received and he asked whether there were plans to extend this service across the county. David Noyes said that there were plans and a business case was in development to look in more detail at the roll out of the service.

8.8 Graham Russell asked about line of sight on inequalities and the provision of services for communities that are harder to reach. Sandra Betney made reference to CORE20PLUS5. Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies '5' focus clinical areas requiring accelerated improvement. The approach, which initially focussed on healthcare inequalities experienced by adults, has now been adapted to apply to children and young people. Sandra Betney said that the Trust aimed to get this data into the Performance Dashboard in the future but advised that the approach was already being used at service level for certain cohorts. Population Health Management work was taking place with the ICB and this needed to be applied across the ICS. Marcia Gallagher said that primary care was the main access point into services for the majority of people but referred to the challenges in being able to access GP appointments. Angela Potter noted that discussions had taken place about this previously and a GP Access report was produced annually and shared with the HOSC.

9. FINANCE REPORT

9.1 Sandra Betney informed the Board that the draft annual accounts had been submitted on 27th April and were currently being audited by KPMG. The audited accounts were due by 30th June 2023. It was noted that there were no material amendments to the position presented at the Resources Committee in April, and the year-end performance for GHC was a surplus of £0.038m

9.2 At month 1 the Trust had a surplus of £0.061m. The Trust is forecasting a year end position of break even in line with the plan. The cash balance at month 1 is £60.53m.

9.3 Capital expenditure was £1.57m at month 1 against the plan of £17.785m.

9.4 The Cost improvement programme has delivered £2.747m of recurring savings through budget setting, of which £0.562m remains subject to QEIA sign-off. The target for the year is £5.443m.

9.5 The 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.

9.6 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%.

9.7 Vicci Livingstone-Thompson referred to the balance sheet entry for *property, plant and equipment* and noted that the actual spend was much less than planned and queried the reason for this. Sandra Betney advised that the Trust had carried out a modern equivalent asset value (MEAV) exercise looking at the valuation of what it would cost to rebuild our own assets. The original plan had overstated the assets, hence the actual figure appeared to be much lower.

9.8 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.

10. CHAIR'S REPORT

10.1 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 March. 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.

10.2 Ingrid Barker had attended a recent NHS Confederation Mental Health Chairs' Network meeting where discussions had taken place around the Hewitt review and colleagues 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. The Network also discussed the outcome of the Good Governance Institute's governance and assurance review into the Greater Manchester Mental Health NHS Foundation Trust following the BBC Panorama programme on the Edenfield Centre in Prestwich. Ingrid Barker advised that there was much for our Board to reflect on from their findings and an additional Board Development session would be scheduled to consider this. **ACTION**

10.3 On 27th April, Ingrid Barker had co-Chaired the Better Care Together Event 'What matters to you…?'. Her Co-Chair was Erin Murray, Self-Management Facilitator and Staff Governor. 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. Jan Marriott noted that this had been a hybrid event and she had received some comments from attendees on possible

improvements to this format for future events. These comments would be fed back to Angela Potter for consideration. **ACTION**

10.4 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.

11. CHIEF EXECUTIVE'S REPORT

11.1 Douglas Blair 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 he commenced in post on 17 April 2023.

11.2 Douglas Blair advised that as part of his introduction to the Trust, he had undertaken an extensive programme of visits and meetings with services and teams. Visits so far had 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. Douglas had also met with several of our corporate teams at sites across Gloucestershire.

11.3 Douglas said that he had received a warm welcome from all teams and had valued the opportunity to learn about our many services and meeting a wide range of colleagues. It had provided valuable insight into colleagues' experiences within their working environment and any challenges the teams are currently facing. Douglas would 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.

11.4 The Board noted that Douglas Blair had also been involved in meetings both within and outside the Trust to maximise his understanding of the work carried out by the Trust and the wider Gloucestershire Health system. The Board noted that Douglas would continue the leadership role for inequalities within the system.

11.5 Douglas Blair made reference to the recent media reports around care provided at Wotton Lawn. The Trust was aware of all incidents that had been referenced within the story and these had already been fully investigated or were in the process of being investigated. Douglas noted that the media story had included edited photos of staff members allegedly sleeping whilst on shift. The Trust had requested unedited versions of the photographs to be able to investigate but these requests had been denied. However, Douglas Blair said that the Trust took the allegations very seriously and would be investigating with senior colleagues at Wotton Lawn. In terms of support for staff at Wotton Lawn, it was reported that colleagues had visited the unit and spoken to staff who thankfully remained positive. Executive Directors were working with Becky Antis, Matron at Wotton Lawn to ensure the necessary support was available. The Board noted that there had been some good news in terms of recruitment at Wotton Lawn which would see the reduction in the use of bank and agency staff at the unit.

11.6 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 Douglas reported that this had been well used within his first few weeks, either for raising questions and issues, or simply to wish him well in his new role.

11.7 At a 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.

11.8 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.

12. RESEARCH AND INNOVATION STRATEGY

12.1 The Board welcomed Mark Walker, Head of Research to the meeting who was in attendance to present the Research and Innovation Strategy 2023 – 2028 to the Board for endorsement.

12.2 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.

12.3 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.

12.4 Mark Walker advised that the Strategy had been presented to, discussed and supported by both the Executive Team meeting and Quality Committee in March 2023.

12.5 Marcia Gallagher referenced objective 5 about increasing representation from underrepresented communities, and she asked whether the Trust's research would cover both physical health and mental health. Mark Walker confirmed that the research would cover both.

12.6 Vicci Livingstone-Thompson asked about the scope for co-production in developing and designing areas for research. Mark Walker said that the Trust was especially keen to involve patients, carers and experts by experience as much as possible and this would be built into the implementation of the strategy.

12.7 Steve Brittan noted the links to universities referenced in the report and queried which ones. Mark Walker advised that GHC already had good links in place with the University of Gloucestershire and had also worked with the University of Birmingham and Warwick University previously as well.

12.8 The Board fully supported the direction of travel and endorsed the R&I Strategy for 2023-2028.

13. BOARD ASSURANCE FRAMEWORK

13.1 The Board received the Board Assurance Framework for the year ending 2022/23. 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.

13.2 It was reported that 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 has been considered at Board Governance Committees.

13.3 A Board development session to review the Trust's risk appetite statement was scheduled for 7 June 2023. This session will also provide the board with the opportunity to review current and identify new strategic risks. This would be delivered by Mike Gill (Kirby House Consulting, and consultant with NHS Providers).

13.4 The Board was asked to note that following recent discussion at governance committees, consideration would be given to an additional strategic risk relating to closed culture and whether the wording of *Risk 10: Sustainability* requires review. These points would be raised as part of the risk review workshop.

13.5 Steve Brittan noted *Risk 4: Recruitment and Retention*, the current risk score for which remained 16. He asked when the Trust might look to reduce this risk score given the improving picture being seen. It was reported that good progress had been made and this risk was reviewed monthly; however, there was a need to see a sustained picture before considering a reduction in risk score.

13.6 *Risk 3: Demand for Services* continued to be one of the 2 highest scoring risks at 16. The Board was assured that this was reviewed monthly, however, this was not expected to reduce any time soon given the continued challenges and pressures in the system.

14. FREEDOM TO SPEAK UP (FTSU) REPORT

14.1 The Board welcomed Sonia Pearcey, FTSU Guardian who was in attendance to present the six monthly FTSU Report. 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.

14.2 This report for Q3 & Q4 2022-23 provided an overview of the cases, national and regional updates and the proactive work undertaken by the Freedom to Speak Up Guardian.

14.3 There were 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. 28 cases were received in quarter 4 which was a marked increase from 10 cases received in quarter 3. Of the 28 cases, 11 of these related to bullying and/or harassment. Feedback continues to be positive from colleagues who have accessed the Freedom to Speak Up Guardian and this was also reflected in the NHS Staff Survey 2022.

14.4 Since the last report received at the Board in November, various National reports have been published and as a Trust, we have had an opportunity to reflect on these and capture some learning.

14.5 The results of the 2022 National Education and Training Survey (NETS) continue to show an improved speaking up culture from our learners. The Trust has improved in all areas of speaking up and is above the national and south-west averages.

14.6 Sumita Hutchison referred to the benchmarking data within the report. In response to the question "If I spoke up about something that concerned me, I am confident my organisation would address my concern", GHC performed above average; however, it was 13% below the best performers and she said it was important to look at what more could be done for GHC to become the best.

14.7 Lavinia Rowsell noted that 71.9% of colleagues had declared that they would feel safe raising concerns related to unsafe clinical practice but looking at the themes, the Trust received very few FTSU cases related to patient safety or quality issues. Neil Savage added that this figure also meant that 3 out of 10 people didn't feel safe raising concerns which was important to be aware of as this is where the focussed attention was needed. John Trevains informed the Board that a robust training and induction programme was in place for International Recruits and this included clear guidance on speaking up to ensure colleagues were confident and felt safe to do this.

14.8 Sonia Pearcey highlighted that the National Guardian's Office had 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 at the Trust Board Development session in November 2022. Trust Boards are required to evidence this by the end of January 2024. Sonia Pearcey would be working to complete the self-reflection tool by September 2023 and as part of this, Board members were invited to review *Principle 8: Continually improve our speaking up culture* and to feed back any thoughts, comments or narrative directly to Sonia. An update on progress would be reported back to the Board as part of the next 6 monthly FTSU report in November.

14.9 The Board expressed their thanks to Sonia Pearcey for her continued work in this very important area. There was a lot that still needed to be done to ensure there was continued progress in raising the bar in embedding our positive speaking up culture at GHC.

15. PROVIDER LICENCE DECLARATIONS

15.1 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.

15.2 The Board received this report and supported the recommendations set out, as follows:

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

15.3 With regard to seeking feedback from Governors, it was noted that this report was 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.

15.4 The Board was asked to note that following the introduction of the new provider licence guidance from 1 April 2023, there would no longer be a requirement to publish a declaration of compliance with the licence conditions.

16. SENIOR INFORMATION RISK OFFICER (SIRO) ANNUAL REPORT

16.1 The Senior Information Risk Owner is responsible for ensuring that organisational information risk is identified and managed across the organisation. This Annual Report provided assurance on practice, progress and developments around Information Governance, Clinical Coding and Records, Data Quality and Cyber/Data Security.

16.2 The Trust achieved 'Standards Met' for the 2021/22 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.

16.3 There continued 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.

16.4 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. It was noted that this increase was a national trend and not

specific to GHC. The Board agreed that it was important to be transparent and all FOI requests were added to the Trust's publication scheme available for anyone to view on the website.

16.5 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.

16.6 The Board noted this annual report and took good assurance from the work taking place. Sandra Betney expressed her thanks to Paul Griffiths-Williams, Information Governance Manager for producing the report and overseeing this important area of work.

17. USE OF THE TRUST SEAL 2022/23

17.1 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 had been used seven times.

17.2 The Board noted the use of the Trust seal for the period 2022/23 (1st April 2022 – 31st March 2023).

18. COUNCIL OF GOVERNOR MINUTES

18.1 The Board received and noted the minutes from the Council of Governor meeting held on 15 March 2023.

19. BOARD COMMITTEE SUMMARY REPORTS

19.1 **Great Place to Work Committee**
The Board received and noted the summary report from the Great Place to Work Committee meeting held on 29 March 2023.

19.2 **Working Together Advisory Committee**
The Board received and noted the summary report from the WTAC meeting held on 20 April 2023. Jan Marriott noted that this had been a face-to-face workshop session which had been welcomed. Membership of the Committee included people who could contribute their personal experience and voices on personalisation and co-production.

19.3 **Resources Committee**
The Board received and noted the summary report from the Resources Committee meeting held on 26 April 2023.

19.4 **Mental Health Legislation Scrutiny Committee**
The Board received and noted the summary report from the MHLS Committee meeting held on 26 April 2023. Discussions had taken place on the disproportionate use of the MHA on ethnic minorities and an update on the work being carried out on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

19.5 **Quality Committee**
The Board received and noted the summary report from the Quality Committee meeting held on 4 May 2023. The Committee had received a helpful clinical presentation on reducing restrictive interventions.

19.6 **Audit and Assurance Committee**
The Board received and noted the summary report from the Audit & Assurance Committee meeting held on 11 May 2023. The Committee had received the draft Annual Accounts and Annual Report 2022/23, which would be presented back to the Committee for sign off in June following completion of the annual external audit. Marcia Gallagher expressed her thanks on behalf of the Board to all colleagues who had worked so hard to prepare these key documents.

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, 27 July 2023.

APPENDIX 1

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

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AGENDA ITEM: 05/0723

TRUST BOARD PUBLIC SESSION: Matters Arising and Action Log – 27 July 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
25 May 2023	3.6	Board colleagues agreed that it would be helpful to explore access to The Music Works on Colin's behalf and see if it was possible to assist.	John Trevains / Jan Marriott	July 2023	**Closed.** Discussions with The Music Works, facilitated by Jan Marriott and other local music groups have taken place and will be progressed via care team.	
	6.1	A full written response would be sent to Bren McInerney following the meeting, and the public question and response would be included as an annex to the meeting minutes for future record.	Trust Secretary	July 2023	**Complete.**	
	7.7	The Board agreed that a further update on Pressure Ulcers should be received at the Quality Committee.	John Trevains	July 2023	**Complete.** Verbal update received at the July Quality Committee.	
	10.2	An additional Board Development session would be scheduled to consider the Edenfield report.	Trust Secretary	August 2023	**Complete.** Board seminar session scheduled for 12 September 2023.	
	10.3	Jan Marriott to feedback comments received from BCT event on the use of hybrid technology to Angela Potter for consideration.	Jan Marriott	July 2023	**Complete.**	

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 July 2023**

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

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

SUBJECT: **QUALITY DASHBOARD REPORT- JUNE 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 June 2023 Quality Dashboard.

Executive summary

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

Quality issues showing positive improvement:

- Sustained improvements in CPA compliance rates which have consistently met or exceeded the 95% performance indicator for the last 8 consecutive months.
- The 11 Trust Quality Priorities have been agreed with the ICB, these priorities have been developed following triangulation of data that focuses upon the 3 pillars of quality; Experience, Safety and Effectiveness.
- Good assurance via the Medical Examiners (ME) Q1 report of Community Hospital deaths that demonstrates effective and compassionate end of life care is delivered across our units.
- A further 16 Trust sites have now had Patient Safety and Quality noticeboards installed.

- Continued focus from NTQ colleagues has produced improvement within Cardiometabolic assessment across MH inpatient and community environments which is a sustainable trajectory.

Quality issues for priority development:

- The Nursing, Therapies and Quality Directorate (NTQ) 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 patient safety related measures/interventions. We are providing additional assurance information to Gloucestershire Integrated Care Board (ICB) as part of our period of enhanced surveillance that was applied following their recent rapid review of Wotton Lawn Hospital.
- Progress has been made in providing easy access to accurate statutory and mandatory and essential to role training data to enable effective quality monitoring and improvement in team level compliance. We will be able to provide improved reporting on this area for Board Assurance in the next report.
- Ongoing work in improving patient safety data is making progress. Particular attention is being applied to our analysis and understanding of moderate harm events inclusive of pressure ulcer rates, improving recording of rapid tranquilisation and continued focused work in falls reduction.
- In partnership with operational colleagues the safeguarding team are providing additional focus to safeguarding supervision attendance.

Are our services SAFE?

In line with NHSE pressure ulcer reporting standards we have removed the **acquired** and **inherited** label from the dashboard. The focus has moved to presenting data over time (using run charts) and understanding the patient story behind the category of pressure ulcer. We continue to monitor the effect that a prolonged hospital admission has upon a patient. Our summary of data relating to long length of stay in Community Hospitals continues to concentrate on delays in excess of 30 days rather than 50, following sustained improvements in flow. There is robust assurance that there has been a continued overall reduction in the number of pathway 1 discharge delays for > 30 days no criteria to reside, however we continue to see noticeable delays with pathway 3 discharges sourced through system partners with a slight increase of 3 this month. In mental health settings we note a slight improvement with 16 discharges delayed mainly as a result of social care/accommodation capacity but continued focus is required. Patient Safety Syllabus E-learning Level 1 training has increased to 80% with Level 2 training now available on Care2Learn and will become part of the 'Essential to Role' programme.

There were a total of 1316 patient incidents reported in month. 1208 were reported as No and Low harm incidents and 108 Moderate, Severe or Catastrophic incidents. The top four categories of incident were skin integrity, self-harm, falls and medication errors. There were 2 serious incidents confirmed and reported in June. Falls continue to be closely monitored within the Trustwide falls prevention group with progress highlighted through a presentation at the most recent Quality Committee. Colleagues from PST have established a monthly meeting to review a range of incidents related to transfer between GHFT and GHC which includes skin integrity where we have identified incidents that are pre-existing. In addition, PST have

established a monthly meeting with the matrons of Wotton Lawn & Charlton Lane to review SI actions and share learning from the recent homicide plan. The team are also supporting clinical reviews and SWARM huddles have commenced in some services as part of the PSIRF pilot, a recent SWARM at Wotton Lawn in June to review bed management and flow challenges has led to improvements in assessing the quality impact of early discharge and movement between wards which will be embedded into the revised bed management policy. The Nursing, Therapies and Quality Directorate 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 patient safety related measures/interventions. We are also providing additional assurance information to Gloucestershire Integrated Care Board (ICB) as part of our period of enhanced surveillance that was applied following their recent rapid review of Wotton Lawn Hospital.

Are our services EFFECTIVE?

This month we have provided a summary of 11 Trust Quality Priorities alongside 7 CQUIN's that have been agreed with Gloucestershire ICB. We are currently developing the individual performance and improvement measures for each of these areas and this will inform the reporting over the next 2 years in line with the mandate of the quality strategy. The Safeguarding Team continue the 'Safeguarding Learning Lunch' sessions, the June session covered the work of the Children's Multiagency Safeguarding Hub (MASH). This ongoing engagement by the team will support the work around improvements to Mental Capacity and SystmOne safeguarding templates. The business intelligence team are developing a clinical system to automatically report safeguarding referrals to the local authority. This will be live from Nov 23, however, in the interim the team continue to monitor this manually for assurance. We have assuring data around the use of the safeguarding advice line, with a network of safeguarding champions within operational teams being developed. A full summary of Safeguarding key performance data is provided in **Appendix 1**.

International Nurse recruitment continues with 89 new colleagues now in post since January 2021 with 1 AHP in active recruitment. This month there is a slight reduction in the vacancy rate for HCSW, there are a number of approaches to improving recruitment in place including exploring HCA rotational roles, application workshops and taster days and 'itchy feet' conversations to support retention. Safer staffing data acknowledges the continuing challenges for inpatient teams, however, notes a reduction in code 1 code exceptions as a result of the improving regular staffing numbers at Wotton Lawn Hospital. Appendix 2 summarises wider key performance operational data. We note that recovery rates remain challenged in a number of the selected indicators in June. Owing to limited interoperability with the BI Tableau System and the Training Teams database we are unable to provide the planned deeper analysis of Statutory & Mandatory Training in the month's dashboard. Access to individual team data is now available to support team managers with compliance monitoring, however, it will require further development to support service level data to include the 'Essential to Role' training.

Are our services CARING?

June saw an increase in the number of compliments received and is the highest number so far this year. Response numbers to FFT continue to rise (3116 responses received against 2699 in June 2022) and the focussed work to improve response rates within our Mental Health services continues. 94% of respondents reported a positive experience following contact with Trust services. In June 2023, there were 6 formal complaints, a reduction of 7 from the previous month. 53% of complaints were closed within three months and 47% closed within six months. To date 92% complaints have been closed within 6 months, this compares to 87% last year. There is currently 1 open complaint over six months old due to ongoing complex health issues which have made it challenging to resolve within the agreed timeframe. There are currently 3 re-opened complaints, reflecting our approach to collaboratively working with patients and carers to resolve issues; rather than signposting directly to the PHSO. The Patient Carer Experience Team continues to work with operational colleagues to achieve improved governance/oversight of all feedback received in order to embed learning and recommendations. In month, GHC received good assurance via the Medical Examiners (ME) Q1 report of Community Hospital deaths that demonstrates effective and compassionate end of life care is delivered across our units. The ME receives significant information from families and carers regarding the death of their relative.

CQC Update

The actions arising from the CQC core inspection are now 96% complete with final audits planned in July prior to a full and final review of progress against actions. We are putting additional work into improving Rapid Tranquilisation monitoring recording as this is an important patient safety related matter noted with the inspection. The Trust has completed 3 peer reviews within Recovery and CLDT services which have highlighted many positive examples of good practice and some areas for improvement. Core themes for improvement focus on quality of care plans, cross boundary working with social workers and transition between CYPS and Adult CLDT. Improvement plans are being developed and these will be monitored via the Quality & Regulatory Compliance Group on a monthly basis. There are further peer reviews planned with the Later Life and Crisis teams over the coming months. A recent visit with the CQC relationship manager to Charlton Lane Hospital enabled us to share the progress of the CLH improvement plan which is now complete. CQC have welcomed and acknowledged the report alongside the completed action plan and visible improvements.

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:	**AI-07.1** Quality Dashboard Report - June 2023/24

Report authorised by: John Trevains	**Title:** Director of Nursing, Therapies and Quality

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AGENDA ITEM: 07.1/0723

Quality Dashboard 2023/24

Physical Health, Mental Health and Learning Disability Services

Data covering June 2023

Executive Summary

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.

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In line with NHSE PU reporting standards we have removed the **acquired** and **inherited** label from the dashboard. The focus has moved to presenting data over time (using run charts) and understanding the patient story behind the category of pressure ulcer. We continue to monitor the effect that a prolonged hospital admission has upon a patient. Our summary of data relating to long length of stay in Community Hospitals continues to concentrate on delays in excess of 30 days rather than 50, following sustained improvements in flow. There is an overall reduction in the number of pathway 1 discharge delays for > 30 days nCTR aligned with a gradual decrease in number of pathway 3 discharge delays, there are still noticeable delays with these discharges sourced through system partners with a slight increase of 3 this month. In mental health settings we note improvements with 16 discharges delayed mainly as a result of social care/accommodation capacity. Patient Safety Syllabus E-learning Level 1 training has increased to 80% with Level 2 training now available on Care2Learn and will become part of the 'Essential to Role' programme. There were a total of 1316 patient incidents reported in month. 1208 were reported as No and Low harm incidents and 108 Moderate, Severe or Catastrophic incidents. The top four categories of incident were skin integrity, self-harm, falls and medication errors. There were 2 serious incidents confirmed and reported in June. Falls continue to be closely monitored within the Trustwide falls prevention group with progress highlighted through a presentation at the most recent Quality Committee. Colleagues from PST have established a monthly meeting to review a range of incidents related to transfer between GHFT and GHC which includes skin integrity where we have identified incidents that are pre-existing. PST have established a monthly meeting with the matrons of Wotton Lawn & Charlton Lane to review SI actions and share learning from the recent homicide plan. The team are also supporting clinical reviews and SWARM huddles have commenced in some services as part of the PSIRF pilot, a recent SWARM at Wotton Lawn in June to review bed management and flow challenges has led to improvements in assessing the quality impact of early discharge and movement between wards which will be embedded into the revised bed management policy. In line with the NHSE Quality framework a discussion of issues of concern raised via media reports in June took place with the ICB. WLH services were placed under a period of "Enhanced Surveillance" to provide more detailed assurance to the ICB. A report will be submitted to the ICB monthly detailing staffing and use of agency, shift fill ratios, length of stay, readmission rates, patient safety data, patient experience and good practice initiatives . We will share this detailed report with Quality Committee for Board assurance.

Are our services EFFECTIVE?

This month we have provided a summary of 11 Trust Quality Priorities alongside 7 CQUIN's that have been agreed with Gloucestershire ICB. We are currently developing the individual performance and improvement measures for each of these areas and this will inform the reporting over the next 2 years in line with the mandate of the quality strategy. The Safeguarding Team continue the 'Safeguarding Learning Lunch' sessions, the June session covered the work of the Children's Multiagency Safeguarding Hub (MASH). This ongoing engagement by the team will support the work around improvements to Mental Capacity and SystmOne safeguarding templates. The business intelligence team are developing a clinical system to automatically report safeguarding referrals to the local authority. This will be live from Nov 23, however, in the interim the team continue to monitor this manually for assurance. We have assuring data around the use of the safeguarding advice line, with a network of safeguarding champions within operational teams being developed. A full summary of Safeguarding key performance data is provided in **Appendix 1**.

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Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

Quality Priorities 2023 - 2024:

A summary of the agreed quality priorities (to run for 2 years) which is now incorporated in to the final Quality Account which was published on 30th June 23.

SUMMARY QUALITY PRIORITIES 2023-2024		
Priority tykl;/	**Description**	**Status 23/24**
1	**Tissue Viability (TV) - with a focus on reducing through improvement in the recognition, reporting, and clinical management of chronic wounds.**	In Development
2	**Dementia Education - with focus on Increased staff awareness of dementia through training and education, improving the care and support that is delivered to people living with dementia and their supporters across Gloucestershire.**	In Development
3	**Falls prevention – with a focus on reduction in medium to high harm falls based on 2022/23 data .**	In Development
4	**End of Life Care (EoLC) - with a focus on patient centered decisions, including the extent by which the patient, their carers and families wish to be involved in the End of Life Care decisions.**	Scoping Underway
5	**Friends and Family Test (FFT) - with a with a focus of building upon the findings of the 22/23 CQC Adult Community Mental Health Survey action plan.**	Scoping Underway
6	**Reducing suicides - with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services.**	Continues from 22-23
7	**Reducing Restrictive Practice – with a focus on continuing our strategy in line with the Southwest Patient Safety Strategy to include restraint and rapid tranquilisation.**	In Development
8	**Learning disabilities - a focus on developing a consistent approach to training and delivering *trauma informed* Positive Behavioral Support (PBS) Plans in line with National Learning Disability Improvement Standards. This includes training all learning disability staff in PBS by April 2025.**	In Development
9	**Children's Services - with a focus on the implementation of the SEND and alternative provision improvement plan.**	In Development
10	**Embedding learning following patient safety Incidents - with a focus on the implementation of the Patient Safety Improvement Plan.**	In Development
11	**Carers – with a focus on achieving the Triangle of Care Stage 3 accreditation.**	In Development

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

The National CQUINs applicable to GHC for 23-24 are tabled in summary below, progress reporting commences at the close of H2. (Q3 for Flu) . Agreement reached with commissioners that reporting will be for information purposes only with no financial penalties linked to thresholds.

SUMMARY CQUIN INITIATIVES 2023-2024

CCG Ref	Description	Mental Health	Physical Health	Reporting Process	Status
CCG1	**Flu vaccinations for frontline healthcare workers, (70%-90% compliance)**	✓	✓	Established process via Immform to continue as per previous years.	Planning for Q3
CCG12	**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.		✓	Manual Audit. H1 & H2	Audit being scoped.
CCG13	**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.		✓	Suspended	CQUIN suspended due to national challenges with audit tool , work stream incorporated in 23-24 by the implementation of the tissue viability quality priority.
CCG14	**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.		✓	Manual Audit. H1 & H2	Audit being scoped.
CCG15a	**Achieving 50% of adults and older adults accessing select Community Mental Health Services (CMHS's), having their outcomes measure recorded at least twice**. Separately, achieving 10% of adults and older adults accessing select Community Mental Health Services, having their patient-reported outcomes measure (PROM) recorded at least twice.	✓		Routine submission (via MHSDS)	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. Engagement and training is underway with the remainder of the Recovery Teams.
CCG15b	**Routine outcome monitoring in CYP and community perinatal mental health services** . Achieving 50% of children and young people and women in the perinatal period accessing mental health services, having their outcomes measure recorded at least twice.	✓		Routine submission (via MHSDS)	Audit being scoped.
CCG17	**Reducing the need for restrictive practice in adult/older adult settings** . Achieving 90% of restrictive interventions being recorded in adult and older adult acute mental health, PICU and learning disability and autism inpatient settings with all mandatory and required data fields completed.	✓		Routine submission (via MHSDS)	Audit being scoped.

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	2,699	3,115										8,233			
% of respondents indicating a positive experience of our services	N - T	95%	94%	94%	94%	94%										94%			
Number of compliments received in month	L - R		2081	202	160	256										618			
Number of other contacts received in month	L - R		619	44	75	82										201			
Number of concerns received in month	L - R		692	66	65	48										179			
Number of complaints received in month	N - R		136	8	13	6										27			
Number of open complaints (not all opened within month)	L - R			43	39	30													
Percentage of complaints acknowledged within 3 working days	N - T	100%	100%	100%	100%	100%										100%			
Number of complaints closed in month	L - R			6	17	15										38			
Number of complaints closed within 3 months	L - I			5	9	8										22			
Number of re-opened complaints (not all opened within month)	L- R			7	5	3													
Number of external reviews (not all opened within month)	L - R			2	4	4													

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)

Key Highlights:.

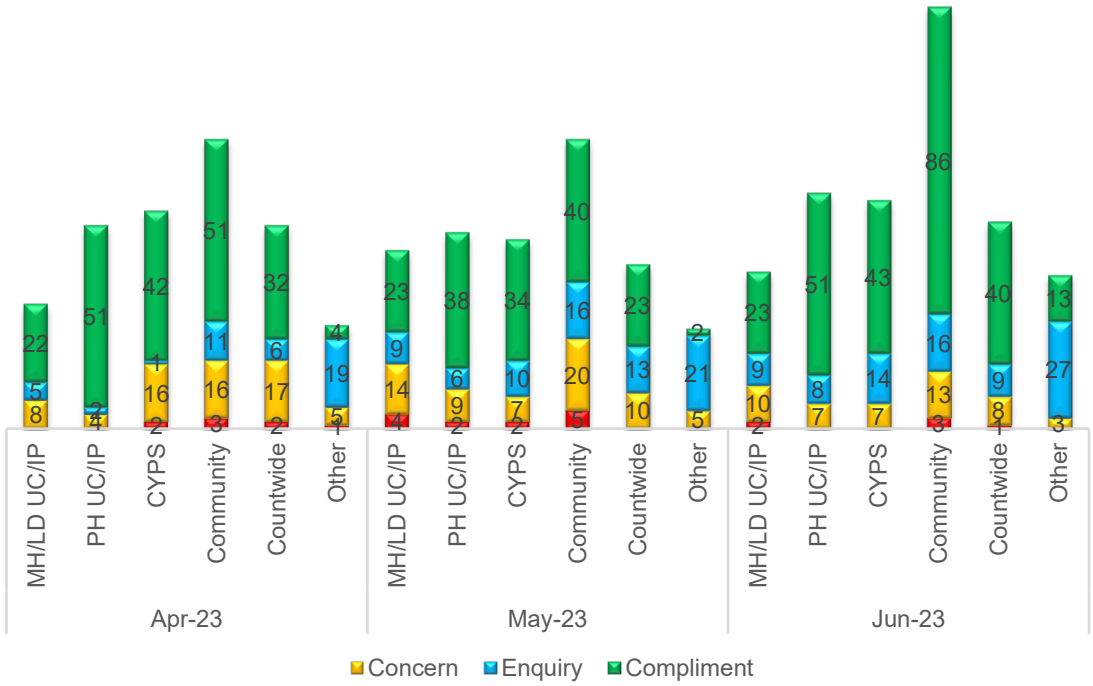
- Numbers reported broken down by operational channels/directorates, then by type.
- Monthly meetings with SDs, P&D leads and NTQ links continue to enable interrogation of service specific data; this time is also be used to discuss ongoing investigations and emerging themes, hotspots and learning.

This table shows all reported PCET data received this month by type and directorate
It is important to note that this is a snapshot and does not consider footfall/caseloads/acuity of patients.

Directorate	Complaint	Concern	Enquiry	Compliment
MH/LD urgent care and inpatient	2	10	9	23
PH urgent care and inpatient	0	7	8	51
CYPS	0	7	14	43
PH/MH/LD Community	3	13	16	86
Countywide	1	8	9	40
Other	0	3	27	13
Totals	6	48	83	256

Summary of complaints:

- **MH UC/IP**: care linked with a patient who died (being supported by the Patient Safety Team); early discharge planning for a high risk patient.
- **PH UC/IP**: no new complaints this month.
- **CYPS**: no new complaints this month.
- **Community**: patient unhappy at being contacted unexpectedly and asked for personal details, and queried why private diagnosis has been declined; delay in community treatment leading to inpatient admission; OT was disrespectful in arriving late for an appointment.
- **Countywide**: staff were not understanding when a patient with specialist need was in crisis.



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 want to start shifting our focus to 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.

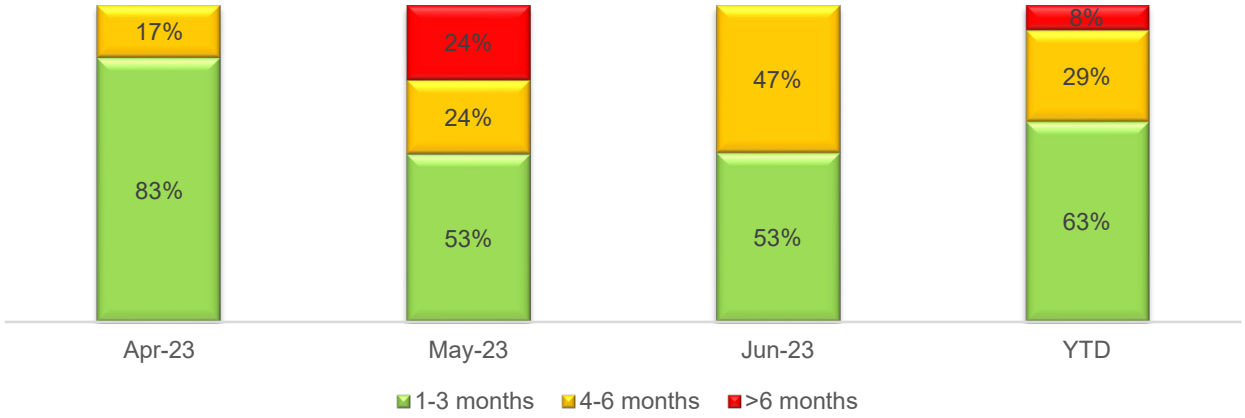
Directorate	Upheld	Partially upheld	Not upheld	Other	Total
MH/LD urgent care, inpatient	0	1	1	3	**5**
PH urgent care, inpatient	0	0	1	0	**1**
CYPS	0	1	1	0	**2**
PH/MH/LD Community	1	0	2	2	**5**
Countywide	1	0	1	0	**2**
Other	0	0	0	0	**0**
Totals	**2**	**2**	**6**	**5**	**15**

Upheld themes for complaints closed this month

1. **Communication and staff attitude** (*Community* and *Countywide*)
   - Incorrect information shared regarding dates and diagnoses
   - Callers feel like they're wasting their time
2. **MHA** (*MH UC/IP*)
   - Difficulties in appealing section
3. **Care and treatment** (*Community*)
   - Nurse "overruled" doctor re administering oral morphine
4. **Access to services** (*CYPS*)
   - Priority given to patients if self-harm requires Emergency Department treatment

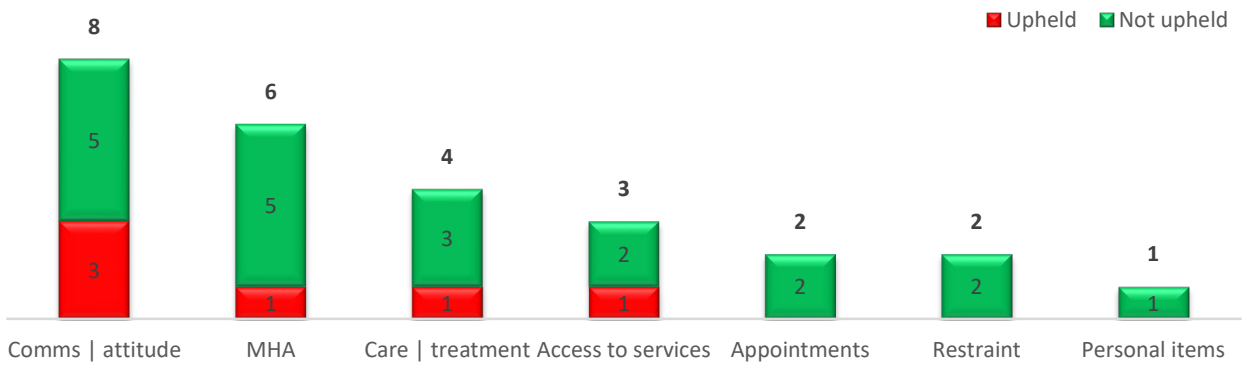
The below graph shows improvements in the length of time taken to close complaints.

- This month, **53%** were closed within three months (target = 95%) and **47%** closed within six months (target = 5%)
- YTD, **92%** of complaints have closed within six months (87% for 2022/23).
- There is currently 1 open (complex) complaint over six months old



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

- Communication and attitude – upheld in **2** directorates
- MHA – upheld in **1** directorate
- Care and treatment – upheld in **1** directorate
- 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 59 closed concerns were escalated to a formal complaint after they were unable to be resolved at a local level

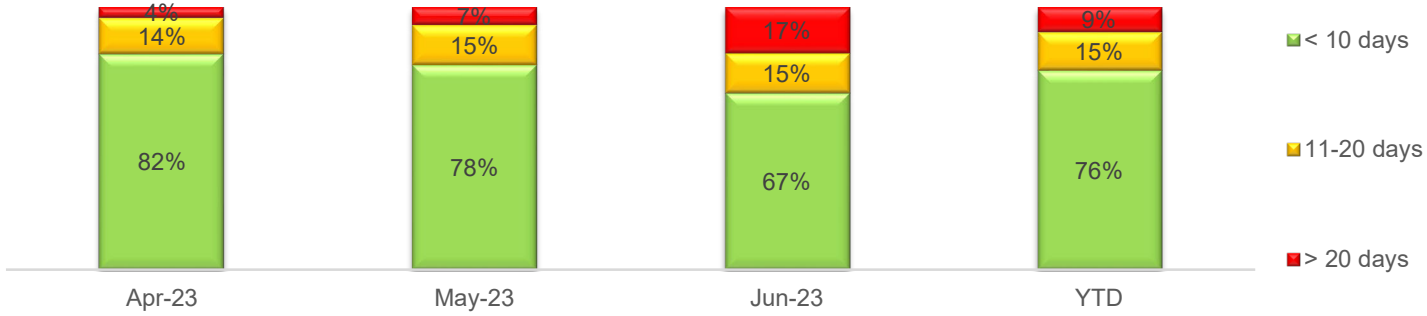
Directorate	Resolved	Escalated	Other	Total
MH/LD urgent care and inpatient	7	1	0	8
PH urgent care and inpatient	4	0	0	4
CYPS	5	0	0	5
PH/MH/LD Community	13	0	0	13
Countywide	11	0	1	12
Other	4	0	0	4
Totals	44	1	1	46

Key themes for concerns closed this month

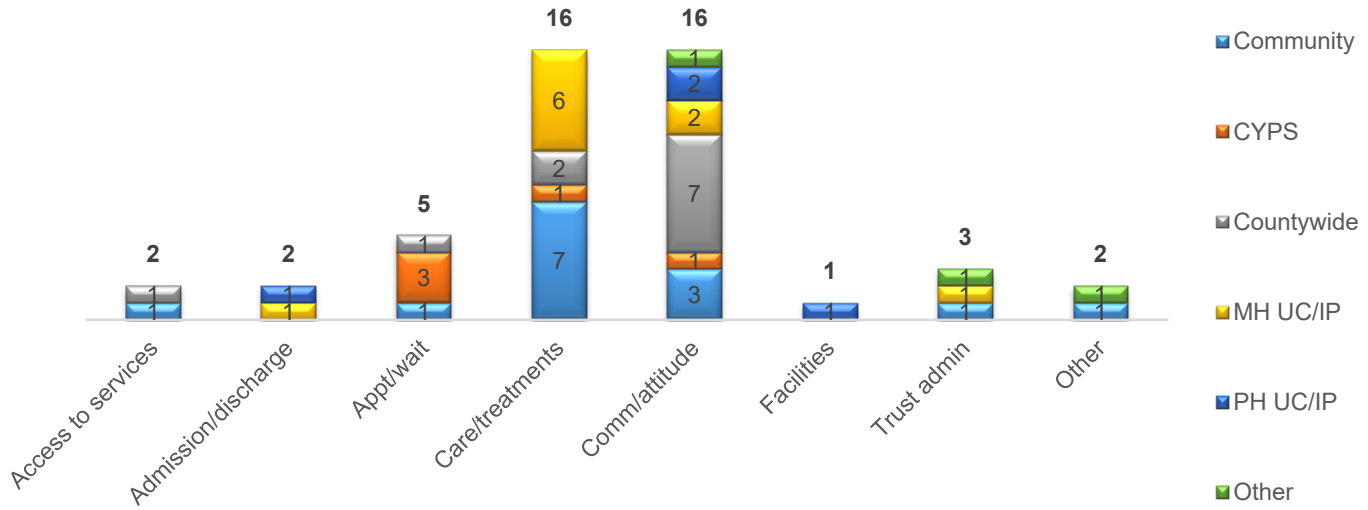
1. Communication [all directorates]: lack of contact from services, not feeling listened to, confirmation of diagnosis.
2. Care/treatment [not CYPS]: treatment not available, lack of support, over-medicating instead of talking therapy.

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

- This month, **67%** of concerns were closed within 10 days (target = 80%) and **15%** closed within 20 days (target = 20%)
- YTD, **91%** 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.

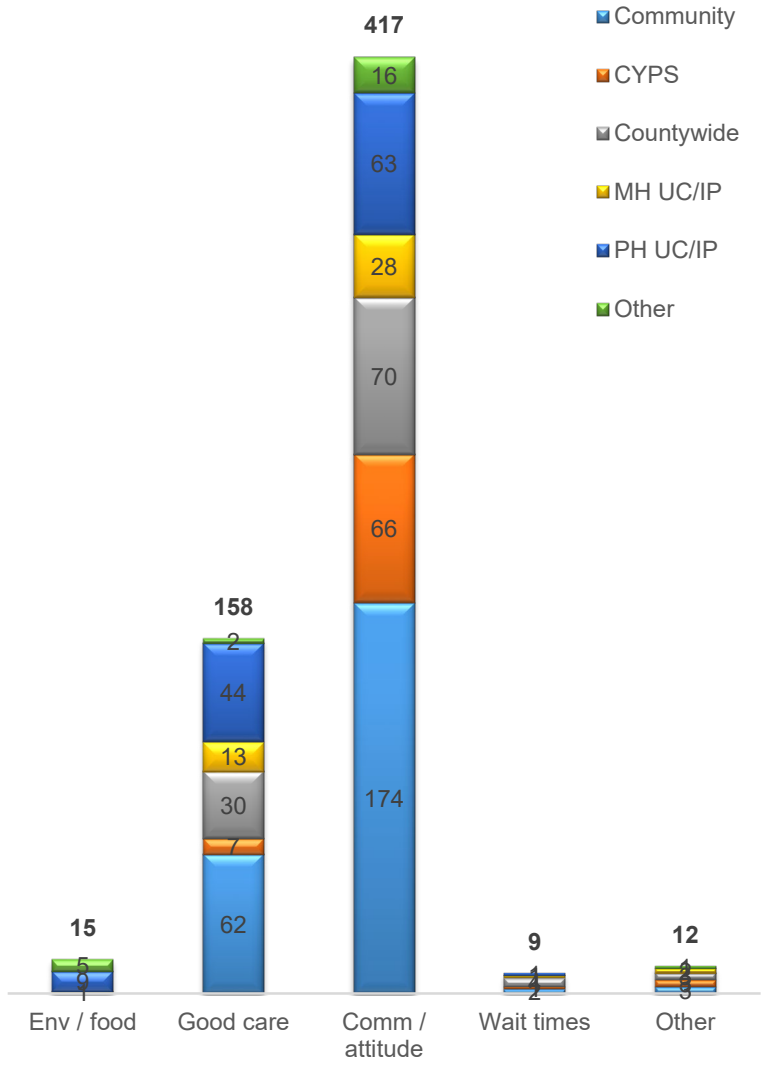


CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

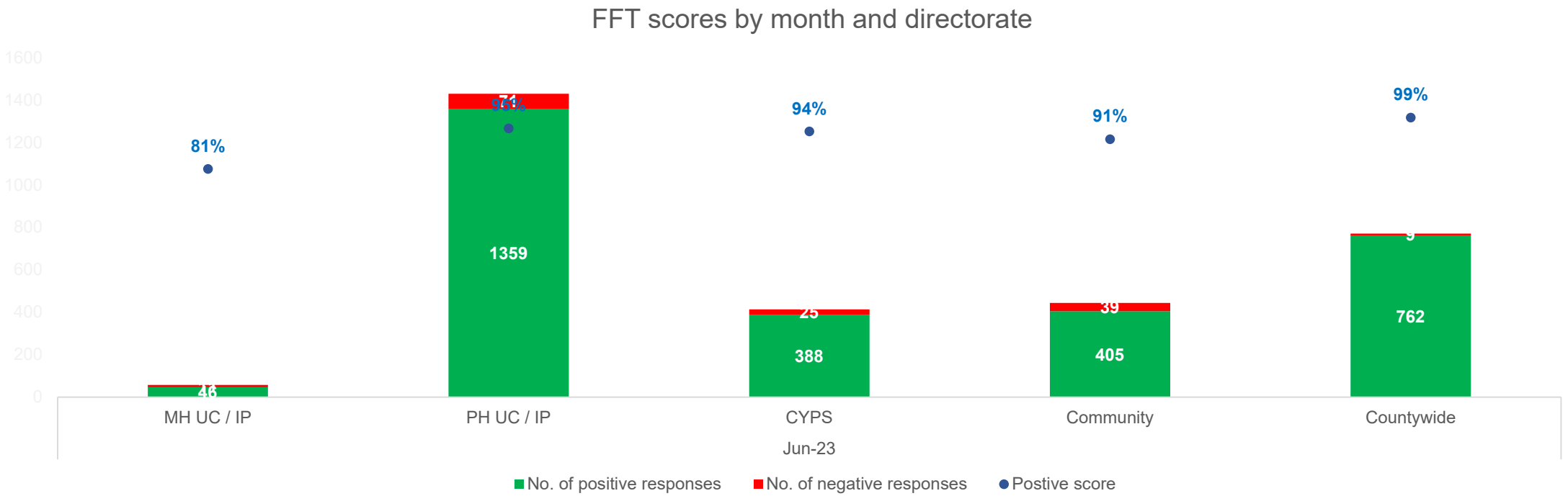
The table below is a sample of COMPLIMENTS received this month, and the chart opposite shows all COMPLIMENTS received this month by theme and directorate.

The **256** 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 in some teams.

Date	ID	Team	Compliment
02/06/2023	9661	ICT Chelt Referral Centre	You are so helpful. I couldn't do it without you. Our residents and myself are really grateful for your time and help you give to us.
08/06/2023	9726	Recovery Stroud	Letter feedback following a 6 week art psychotherapy group of how helpful the course has been for the client's recovery.
06/06/2023	9701	Dental Telephone Triage	Pt contacted Triage. Pt was booked a domi visit. When calling pt to confirm appointment, patient asked me to share that the nurse on the triage line that he spoke to was very caring, kind and helpful.
28/06/2023	10109	Cardiac Rehabilitation Service	Patients gave some bars of 'Dairy Milk' to some the cardiac rehab staff who had been involved in his rehabilitation to express his gratitude to them.
06/06/2023	9700	CYPS/PH- Childrens Physio	Parent of the child complimented the physiotherapist for creating a patient focused treatment plan with achievable goals.
28/06/2023	9972	CAMHS - Admin	Reception staff are so lovely. Clinician very understanding and kind.
12/06/2023	9752	MIiU- Stroud Hosp	Letter of thanks - the patient was impressed with how quickly she was seen and felt that all of the members of staff she came in contact with were excellent
01/06/2023	9646	Tewk Hosp- Abbey View Ward	Email regarding amazing EOL care his father in law had at Tewkesbury hospital recently. Every single member of staff went above and beyond for them all during his short stay on ward and that they all made a really sad time bearable.
17/06/2023	9853	MH Contact Centre	i just wanted to say that *staff member* answered the phone from me tonight, i had od'd last night and i felt extremely tired with everything and hopeless and they helped me so much with how i felt, they really made me feel like i wasn't alone in all this and it helped me feel motivated to try again ;-; so thank you to them and thank you for having them on your team
26/06/2023	9915	Charlton Lane- Chestnut Ward	We would like to take this opportunity to say thank you to all the staff on Chestnut Ward and any other staff within the unit that have helped and cared for *patient*. We thank you.



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



Highlights for this month:

- The FFT response continues to be at a high level in line with recent months.
- 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 orange folder, as part of the 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).
- **9** requests for contact have generated further action/investigation through the new 'open' question.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

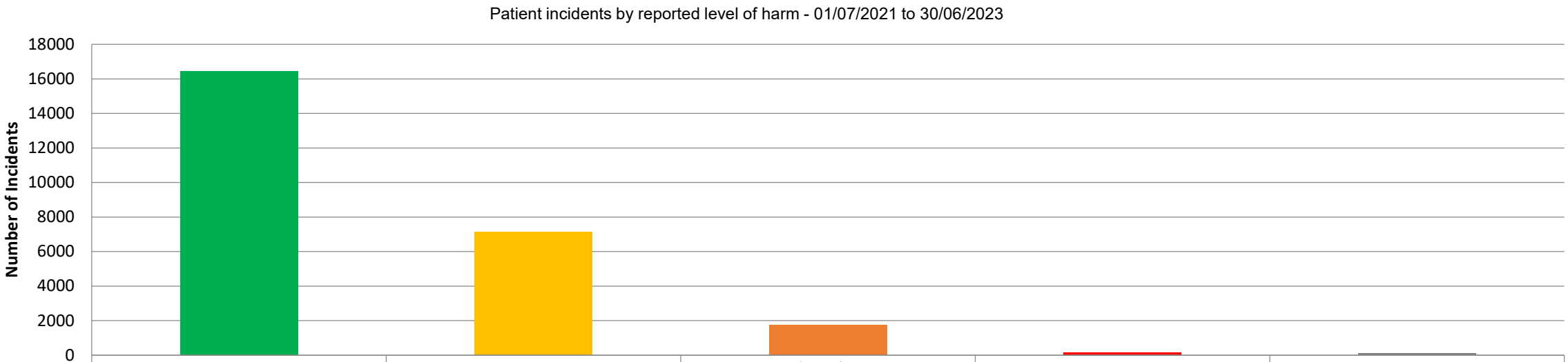
CQC DOMAIN - ARE SERVICES SAFE? INCIDENTS (Whole Trust data)

	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	0										0			N/A
Number of Serious Incidents Requiring Investigation (SIRI)	N - R		39	5	2	2										9			N/A
No of overdue SI actions (incomplete by more than I month)	L - R		N/A	0	0	0										0			N/A
No of unallocated SI investigations (waiting more than 1 month for allocation).	L - R		0	1	0	1										1			N/A
Number of Serious Incidents Requiring Investigation (SIRI) regarding self harm or attempted suicide	N - R		5	0	0	0										0			N/A
Number of Embedding Learning meetings taking place	L - R		9	2	6	4										8			N/A
Total number of Patient Safety Incidents reported	L - R		13029	1057	1111	1316										2168			N/A
Number of incidents reported resulting in low or no harm	L - R		11967	964	1007	1208										1971			N/A
Number of incidents reported resulting in moderate harm, severe harm or death	L - R		1062	93	104	108										197			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	2	1										4			N/A
Total number of medication errors reported as resulting in moderate harm, severe harm or death	L - R		5	1	0	2										3			N/A
Total number of sexual safety incidents reported	L- R		129	7	5	10										22			N/A
Total number of Rapid Tranquilisations reported	N - R		981	46	30	61										137			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



None (no harm caused by the incident)	Low (minor harm, e.g. takes up to 1 month to rectify)	Moderate (significant but not permanent harm e.g. takes up to 1 year to rectify)	Severe (permanent or long term harm caused)	Death
16452	7124	1741	169	108

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.

In June there were 1316 patient incidents reported in Datix, 205 more than May. 1208 were reported as No and Low harm incidents (201 more than May) and 108 as Moderate or Severe harm or Death (4 more than May). We note the increase in Rapid Tranquilisation in month. 80% of the incidents reported in month related to 2 patients who were acutely unwell and have higher incidents of violence towards staff and other service users. Both have a personalised plan in place and the ward has increased 1:1 time with these patients to reduce their distress. At the time of reporting both are making progress and have stabilised with input and changes made on the ward.

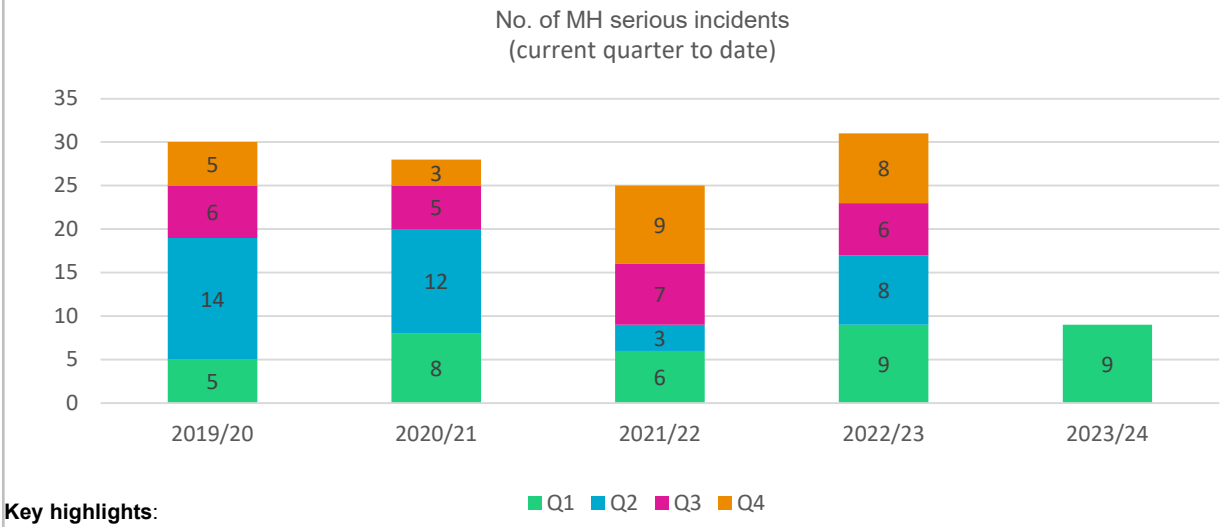
We have received feedback from the Medical Examiner regarding a review of patient deaths between April – June 23, this highlights the experiences from families about the care their families received whilst in our Community Hospitals, overall this captured some very positive observations which has been fed back to colleagues.

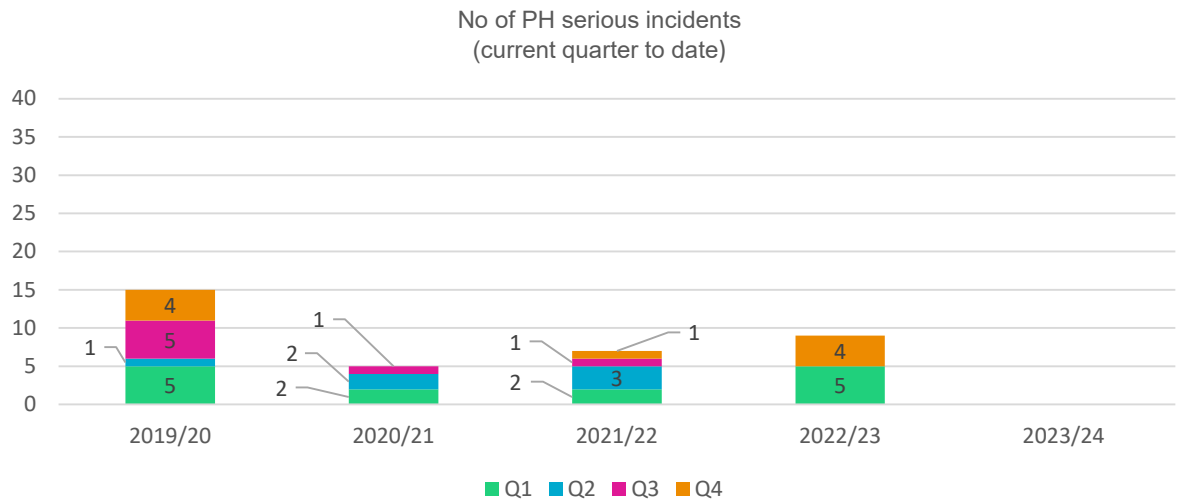
The PST continues to review incidents in teams with reporting anomalies and shares comprehensive reports with service level Ops and Governance meetings to support the development of insights in to patient care. Additionally, to support widening the lens around harm the PST and PCET meet weekly to describe new issues, complaints and moderate harm incidents and will draw in mortality data and themes that drive our QI process. From June the legal team will join this forum to share learning from claims and other legal processes.

In readiness for the LFSE, the PST are preparing training options for staff and have initiated an expert user group. Key milestones in the transition to LFPSE have been achieved.

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 June, the Trust reported 2 new serious incidents and investigations have commenced.

- GHC51525 Suspected suicide – MHICT
- GHC52438 Suspected suicide – Recovery

GHC supported Berkshire Healthcare with an investigation in to the death of a young adult who was resident in Gloucestershire temporarily who died in Berkshire by serious self harm.

The team are also supporting clinical reviews and SWARM huddles have commenced in some services as part of the PSIRF pilot. We completed a SWARM at Wotton Lawn in June to review bed management and flow challenges. The output of this has led to improvements in assessing the quality impact of early discharge and flow between wards which will be embedded into the revised bed management policy.

The SI investigation that is recorded as not having an investigator allocated is related to an incident, first reported in April which was not initially allocated a lead investigator until mid June owing to workforce challenges. The family were kept updated and we have maintained our liaison with them. We have now allocated an investigator at the time of reporting.

Embedded Learning and Learning Assurance:

The draft Learning Assurance Framework has been produced and is out for consultation. It broadly focusses upon these core elements:

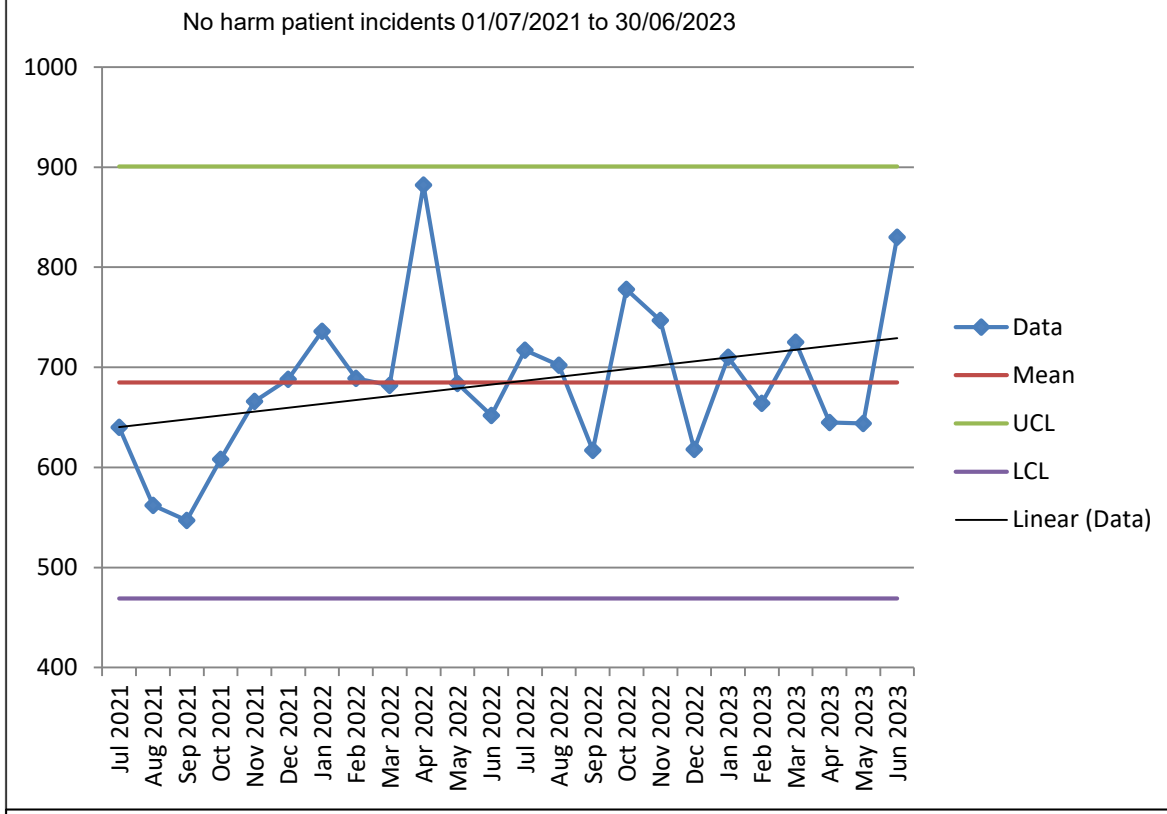
- highly visible and accessible support;
- clear, measurable and time-specified actions developed from areas for improvement;
- scheduled longer-term monitoring ('fidelity testing');
- defined markers of benefit for patients/service users, families and carers and effective dissemination of learning.

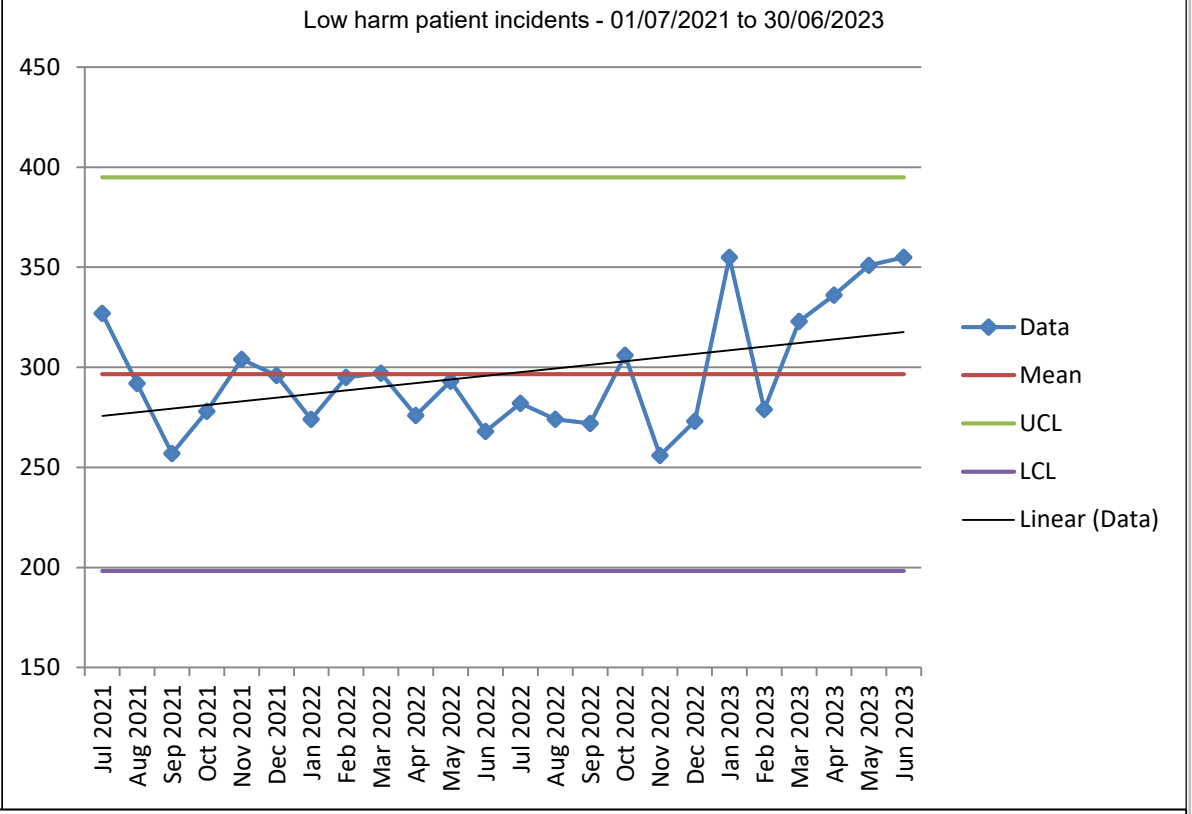
Work continues on collating assurance for the Wotton Lawn homicide action plan and weekly information and assurance meetings have commenced. The plan has been shared with the ICB Quality Team for additional scrutiny and assurance. All of the 14 recommendations are progressing and within the timescales agreed with the ICB. The Learning Opportunities Group continues to meet weekly and receives representation from the Learning Assurance Team (PST), PCET, Mortality Review, CQC Lead, QI and Duty of Candour Lead. Legal Department will now attend on a monthly basis to share their learning from claims and other legal issues.

The draft PSIRF plan and policy have been devised, outlining our approach to investigations and learning priorities for 2023-24. The framework and toolkit is subject to pilot and consultation and will be presented to QAG in August 2023 and is central to the development of high quality, reliable learning from harm.

Currently 80% of Trust staff have completed the level 1 e learning Patient Safety Training. Level 2 e learning is now available in Care to Learn.

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



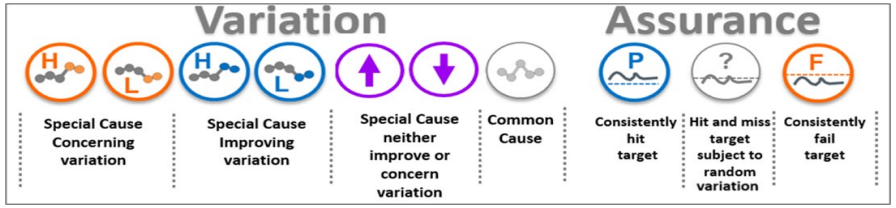


Key Highlights:

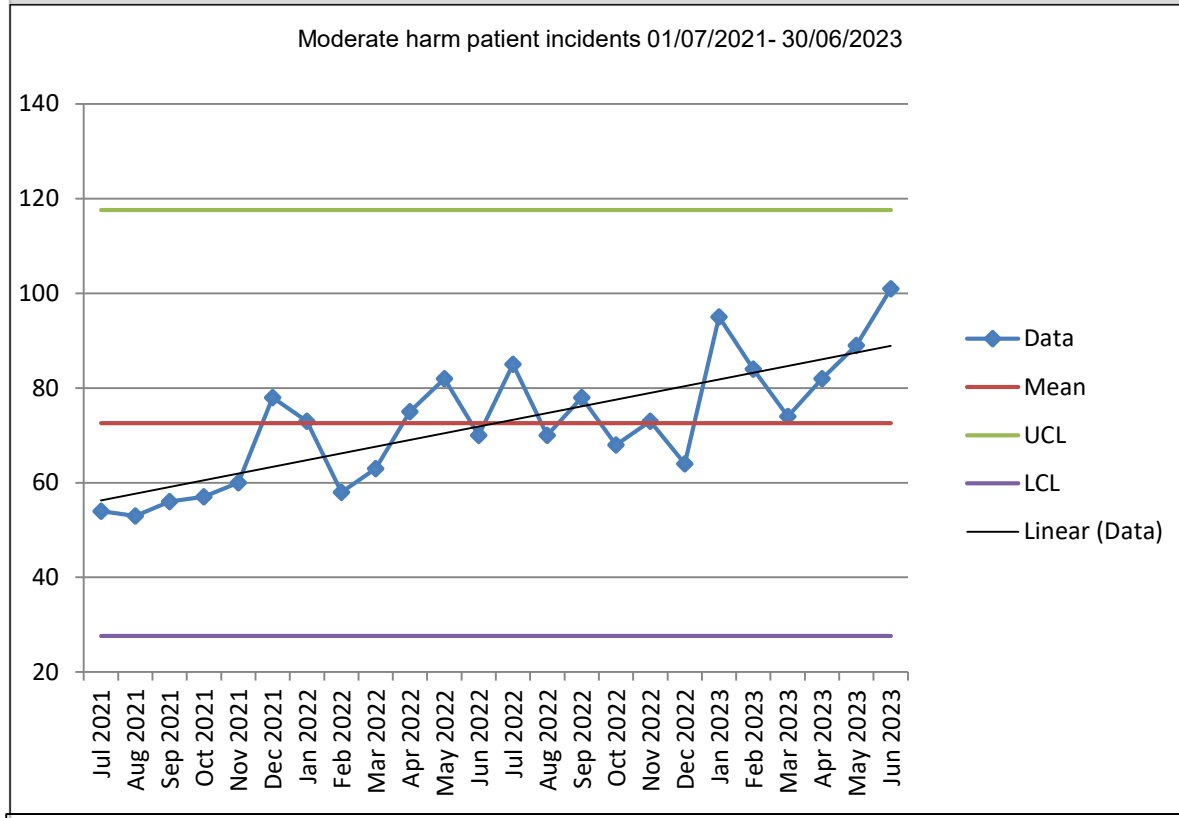
- **No Harm Incidents over time –** This data shows the level of reporting being generally in line with the mean.
- **Low Harm Incidents over time -** The Patient Safety Team are engaged in activity to refine the reporting forms and support staff to correctly assess and grade incidents and therefore stabilise our view of current or emerging risks. The 4 data points apparent above the mean are not significant and the pattern will be monitored for a variation.

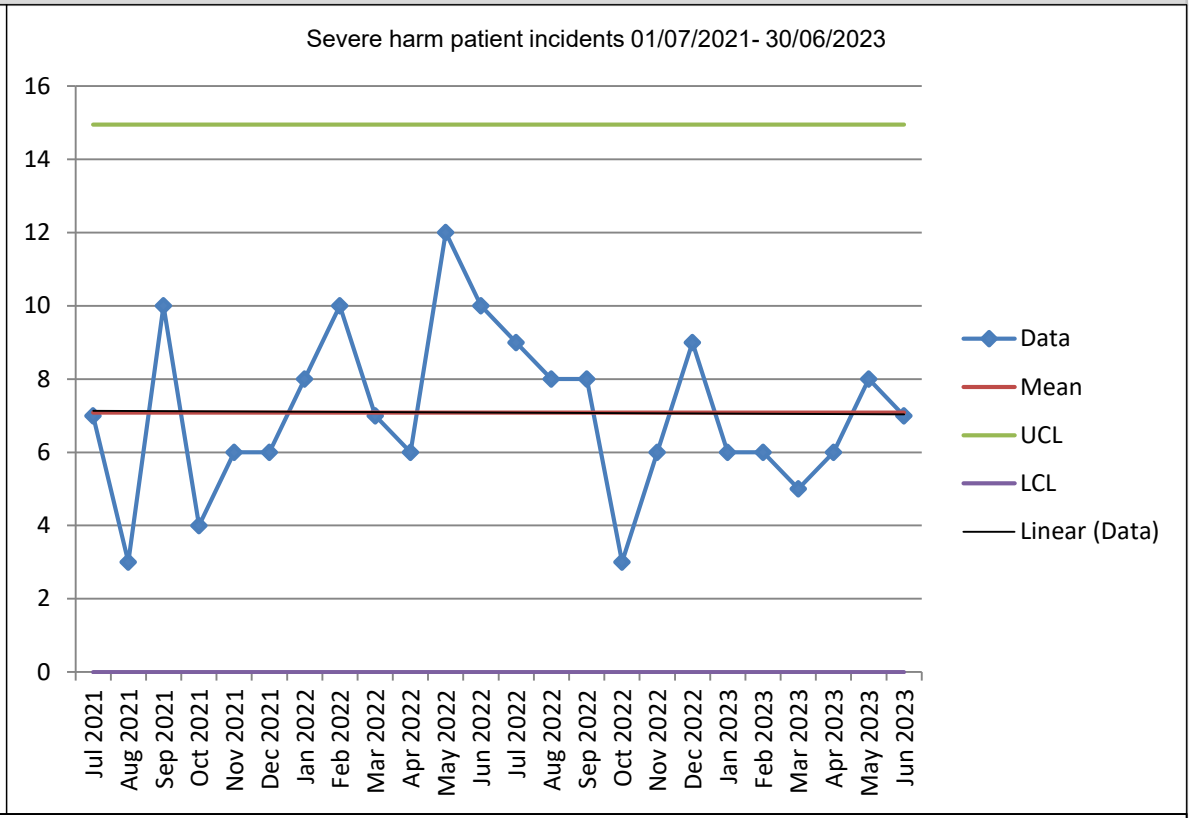
Developing the clarity of SPC charts

During Q2 the PST will develop the nature and quality of reporting from SPC charts with the use of a tool that highlights variation in data and adds assurance measures to support decision making. This will then become a feature of reports derived from the new LFPSE commencing September 2023 and the methodology is supported by the Making Data Count workstream at NHSE.



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





Key Highlights:

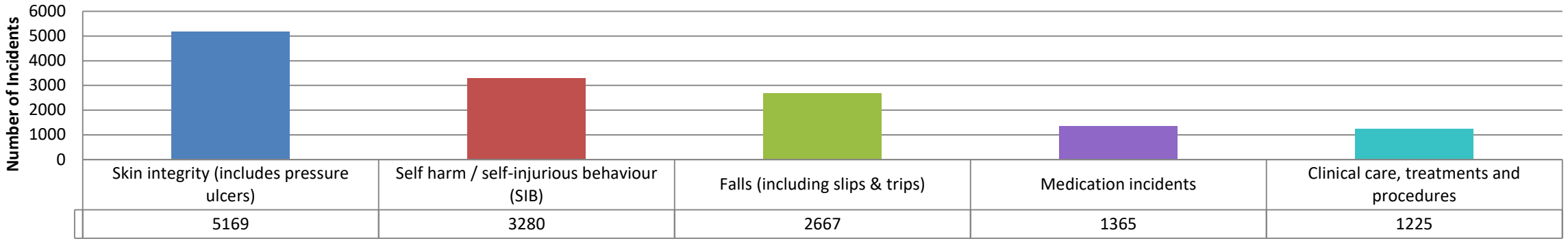
Moderate Harm Incidents over time - The picture emerging here, despite the mean not altering at present, is of a statistically significant rise in the number of reported moderate harm incidents. Currently 6 data points emerge above the mean.

The PST monitor these incidents daily and capture these on a team tracker which as then reviewed at regular points in the working week. The rise is related to an increase in moderate skin integrity/pressure ulcer related harms. Over the period Q1 23/24 there were 939 Moderate harm incidents reported in the Trust. Of these, 714 relate to skin integrity. Q2 will see activity to identify further detail required to fully understand reporting and harm and new resource, seconded to the PST will support this activity. 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.

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

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

Top 5 patient incident categories (excluding restraint) 01/07/2021 to 30/06/2023



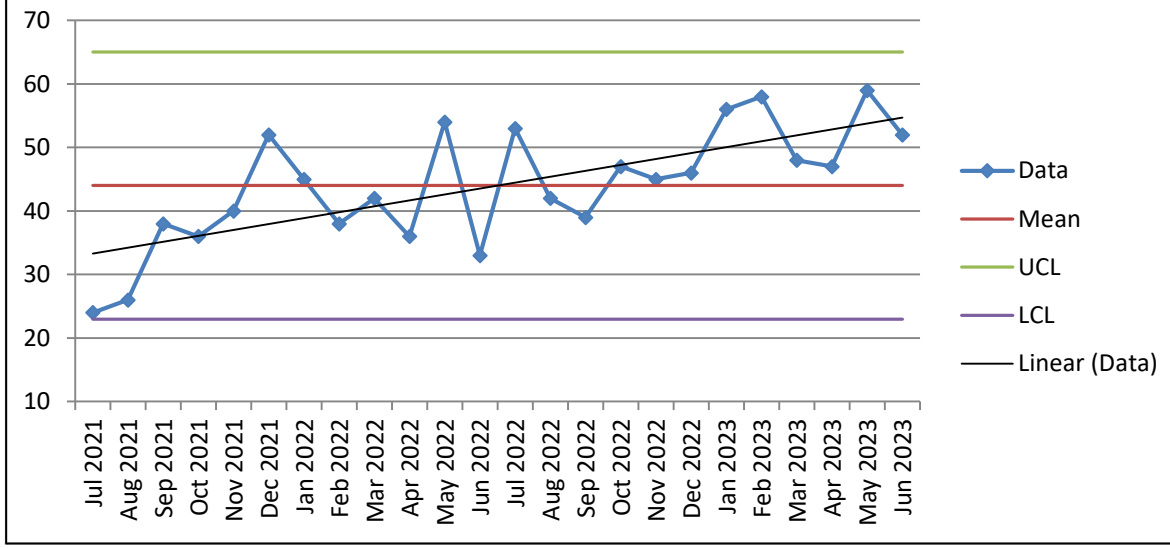
Skin integrity (includes pressure ulcers)	Self harm / self-injurious behaviour (SIB)	Falls (including slips & trips)	Medication incidents	Clinical care, treatments and procedures
5169	3280	2667	1365	1225

Key highlights in June

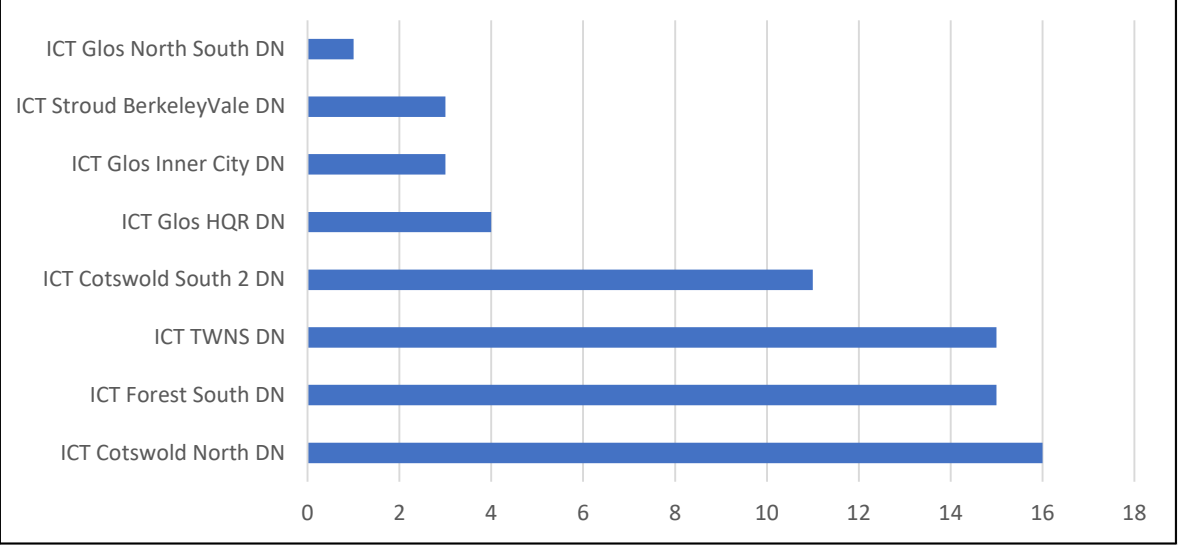
The chart above shows the 5 highest reported categories of patient incident (excluding restraint) over 24 months.

As described, the increase in moderate harm incidents has been recognised and is predominantly related to an increase in reporting across all ICT's of pressure ulcers. There is a significant cause variation apparent as there are 9 data points above the mean. Some variation in reporting patterns around confirmed moderate harm pressure ulcer reports is noted and this will be included in work to understand reporting culture and caseload size and harm.

Confirmed Moderate/Severe Harm Skin Integrity/PU incidents - ICTs
01/07/2021 - 30/06/2023



ICT teams where moderate+ skin integrity/PU incidents increased
Q1 21/22 to Q1 23/24



Quality Dashboard

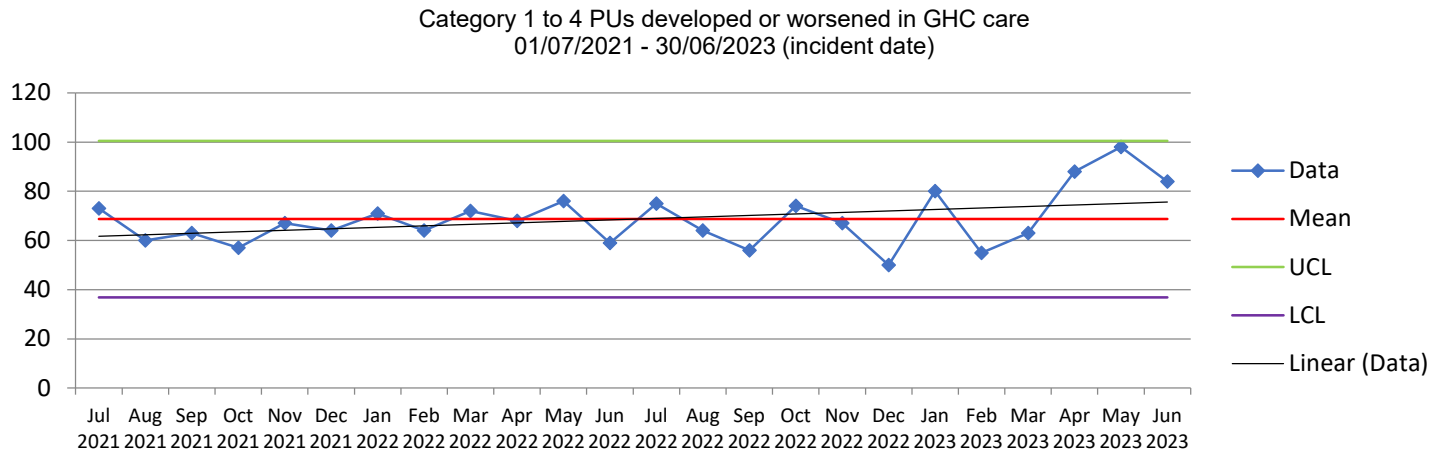
Gloucestershire Health and Care NHS Foundation Trust

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

	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
VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	98.61	97.0%	99.0%	100%										98.17%	G		
Number of HODA Clostridium Difficile Infections (C Diff)	N	15	10	3	0	0										3	G		
Number of C Diff cases (days of admission plus 2 days = 72 hrs) - avoidable	N	0	0	0	0	0										0	N/A		
Number of MRSA Bacteraemia	N	0	0	0	0	0										0	N/A		
PU Data threshold removed therefore no longer RAG rated – in line with revised national guidance.																			
Total number of developed or worsened pressure ulcers	L - R		**683**	88	95	84*										**267**			
Total number of Category 1 & 2 pressure ulcers	L - R		621	82	91	73*										246			
Number of Category 3 pressure ulcers	L - R		41	5	4	10*										19			
Number of Category 4 pressure ulcers	L - R		21	1	0	1*										2			

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

HCAI: There were 0 post 48-hour Clostridium Difficile in June (C. Diff), and no MRSA infections recorded in June. The collaborative ICS ICP event took place on 4th July to raise awareness. "Tackling a Difficile problem". Note our ICB threshold has been set at 16 for the year.

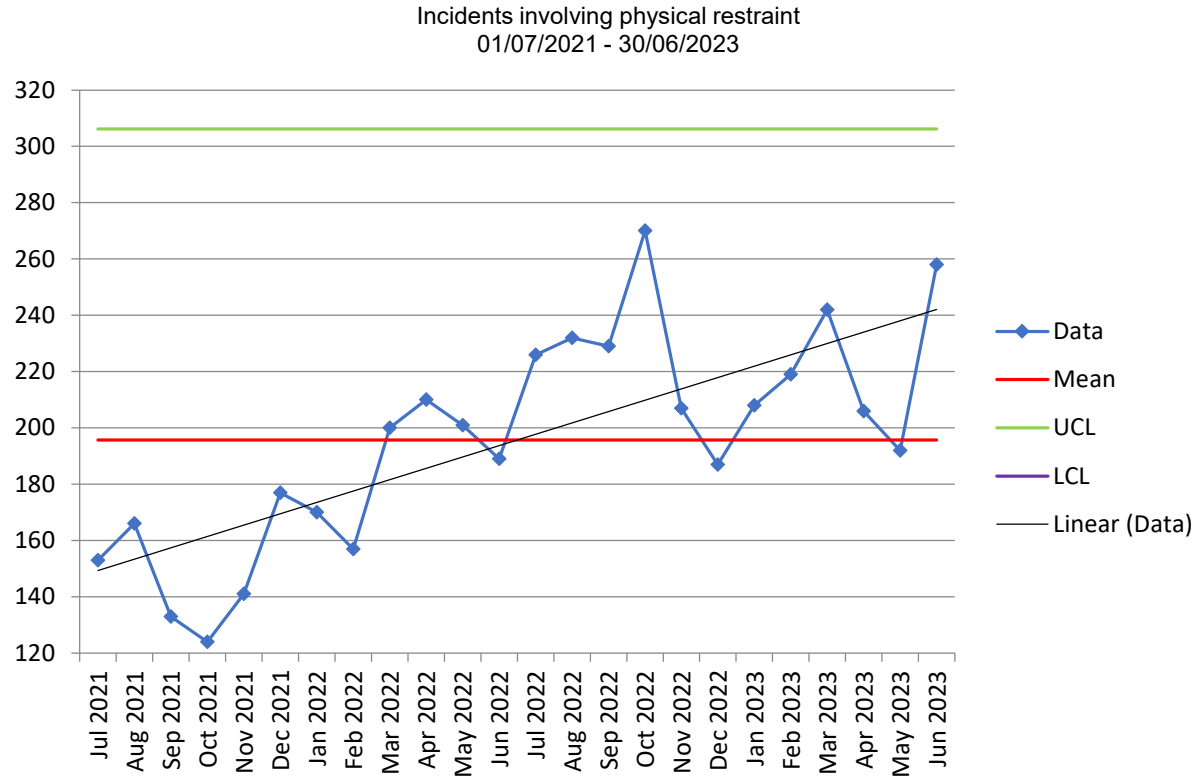


Pressure Ulcers:
In line with NHSE PU reporting standards we have removed the **acquired** and **inherited** label from the dashboard. The focus has moved to presenting data over time (using run charts) and understanding the patient story behind the category of pressure ulcer. This month's slide has refreshed the data from May as all incidents were reviewed. Duplication of incident reports was the highest cause, mis-categorisation was the second finding, feedback has been sent to the clinical teams involved.

*June data had not been fully validated so likely to reduce due to duplication of reporting etc
All cat 3, 4 & unstageable pressure ulcers each month are subject to senior clinical review as part of our validation process.

In addition to the moderate harm data provided in slide 14 & 15 - Opposite is an SPC chart showing data from 2020 to 2023 displaying the number of PU 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.

Incidents involving restraint



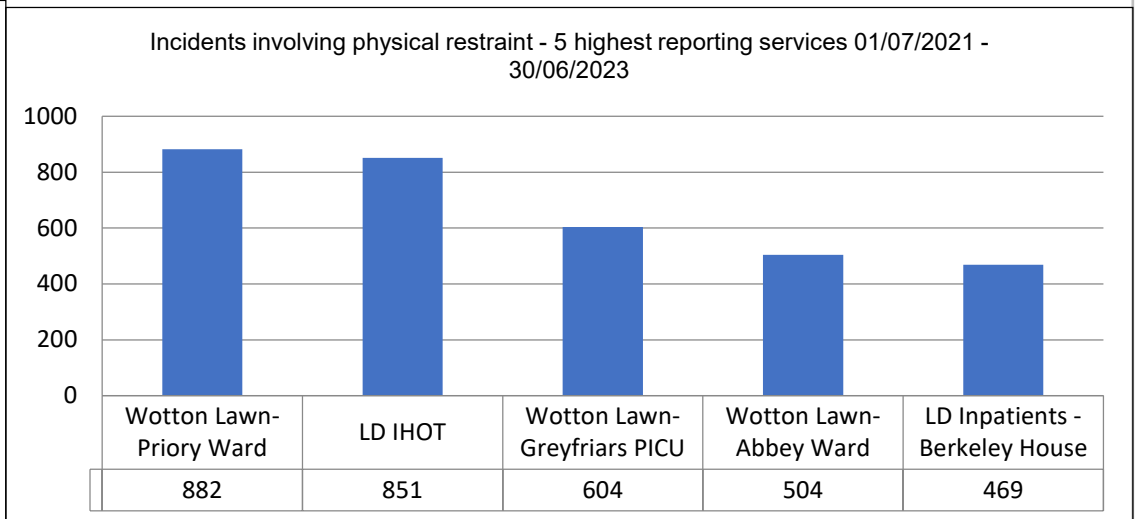
Reductions in interventions in both April & May 2023 relates to changes within the inpatient demographic. (discharge of patients who present with behaviour that is challenging. This data will be reviewed at Positive & Safe Meeting June 2023). An audit has commenced to reassess compliance rates for post physical observations. This will support the CQC action plan related to rapid tranquilisation policy.

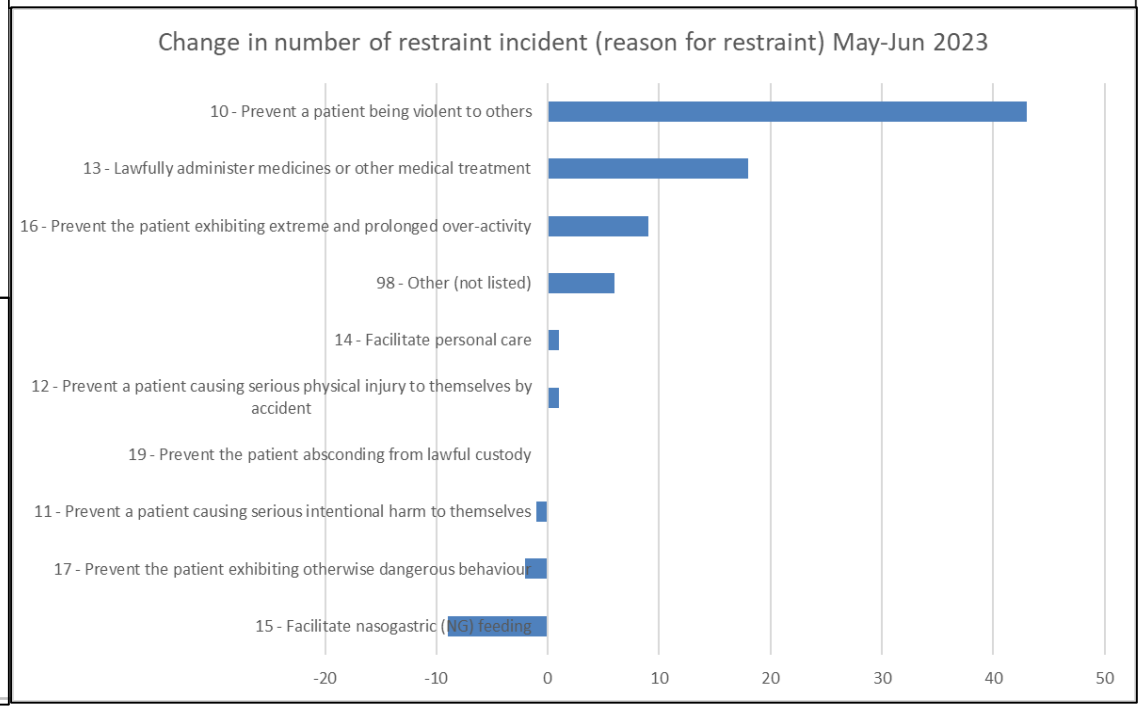
The data for June shows 66 episodes above the mean for the 2 year period and this is accounted for increases in use of restraint seen on Priory Ward, Dean Ward and at Berkeley House. The largest increases in reasons for restraint are:

1. Prevent a patient being violent to others
2. Lawfully administer medicines or other medical treatment
3. Prevent the patient exhibiting extreme and prolonged over-activity

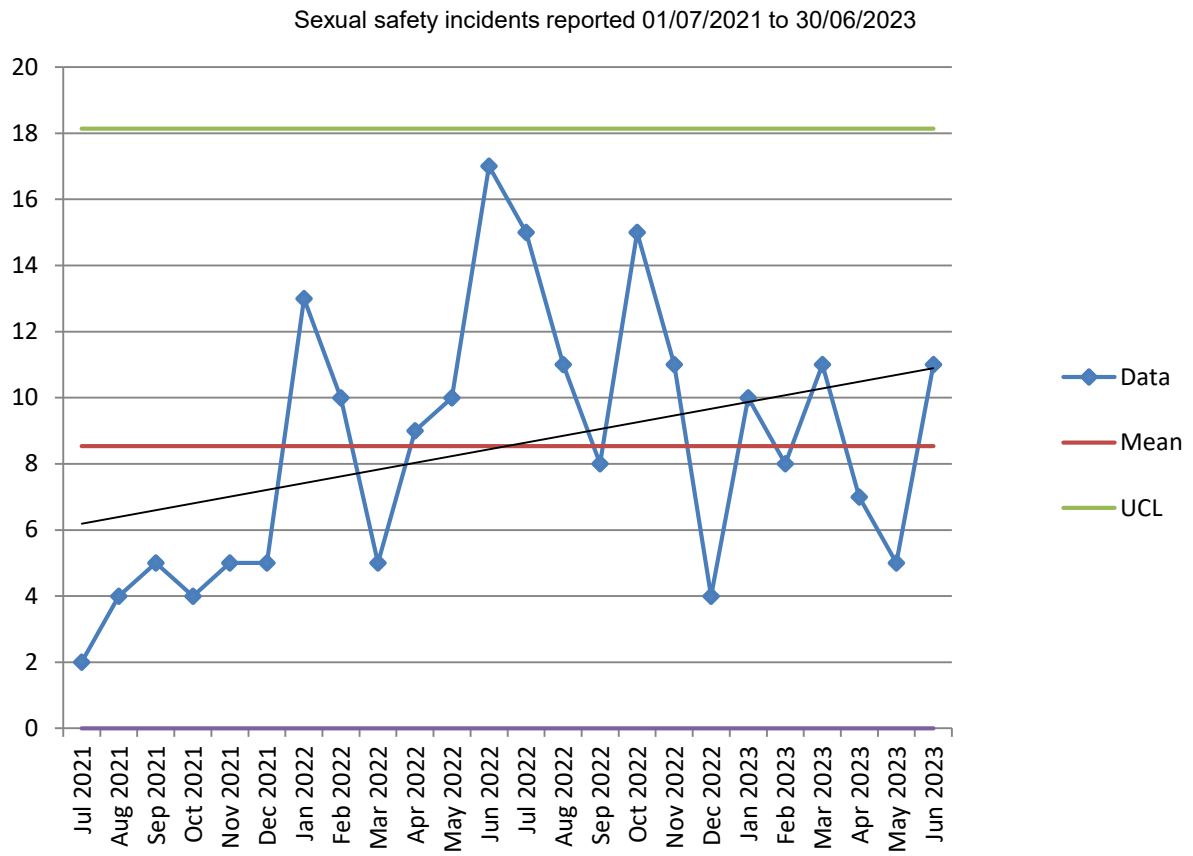
4 patients account for 59 of 66 increased restraint incidents from May to June.

Seated restraints and clinical holds remain the highest categories and reflect the ongoing training programme and approaches to reducing prone restraint.



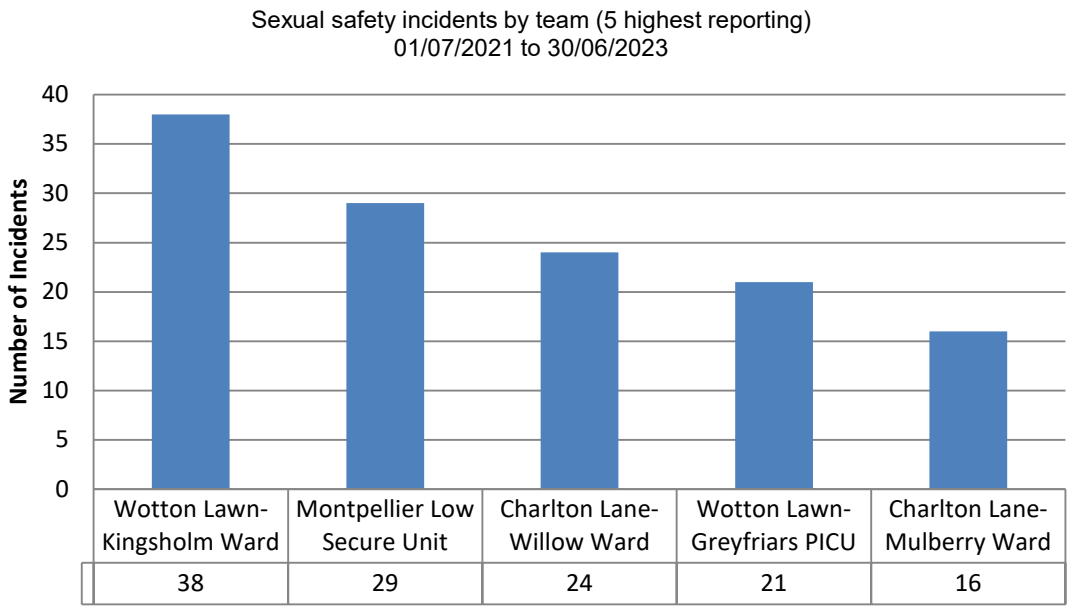


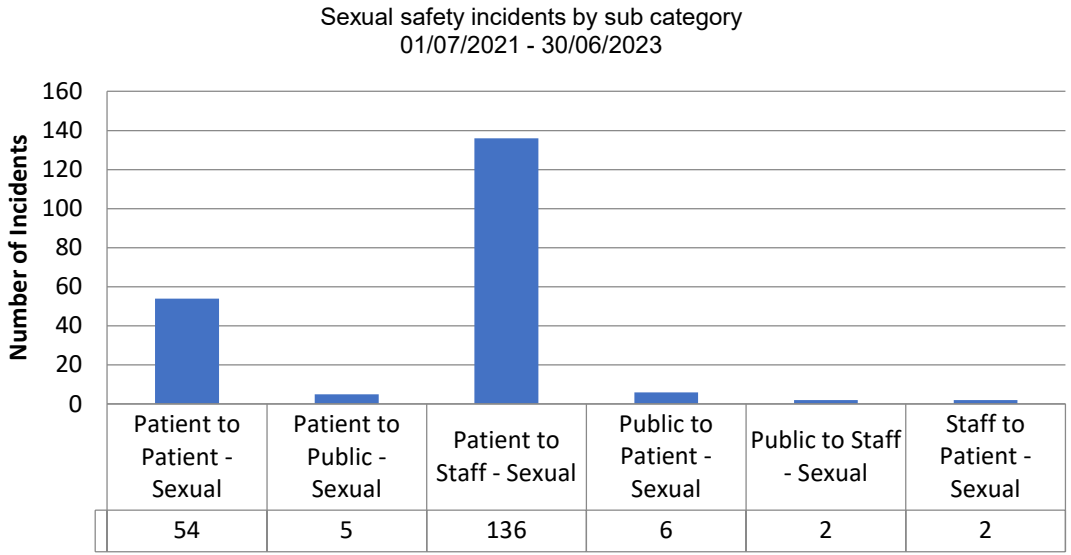
Sexual Safety Incidents



There has been an increase in reported incidents within the 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. **For Board assurance al sexual safety incidents are subject to additional assurance and monitoring via the sexual safety lead for the Trust**. Of note their work featured in a recent BMJ article on good practice in this area.

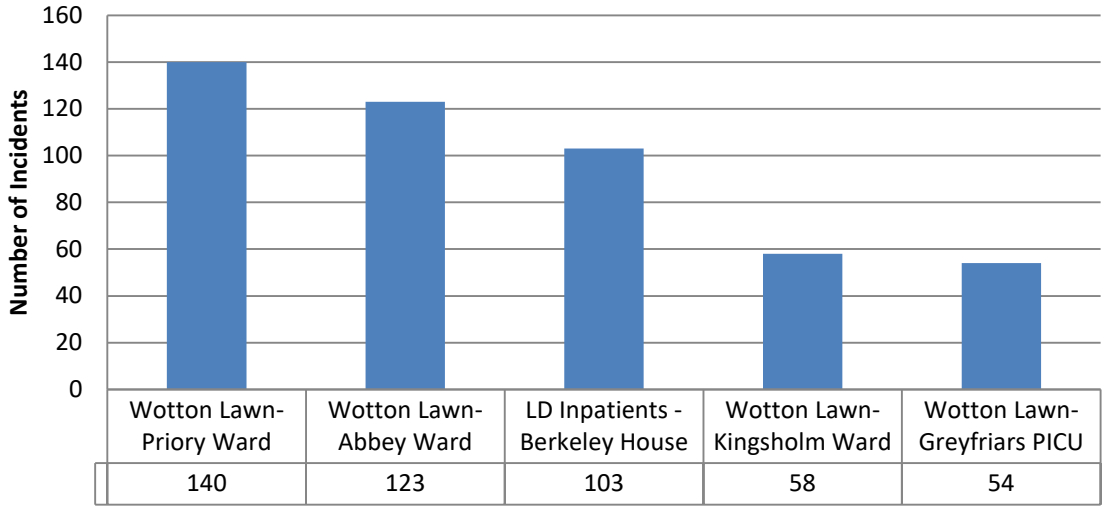
A GHC Sexual Safety Awareness Training (SSAT) pathway has been developed, aimed initially at unregistered staff. This has been piloted at Kingsholm and Willow Wards plus Berkeley House, and the initial evaluation shows that different clinical areas experience different sexual safety issues, and therefore 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. .



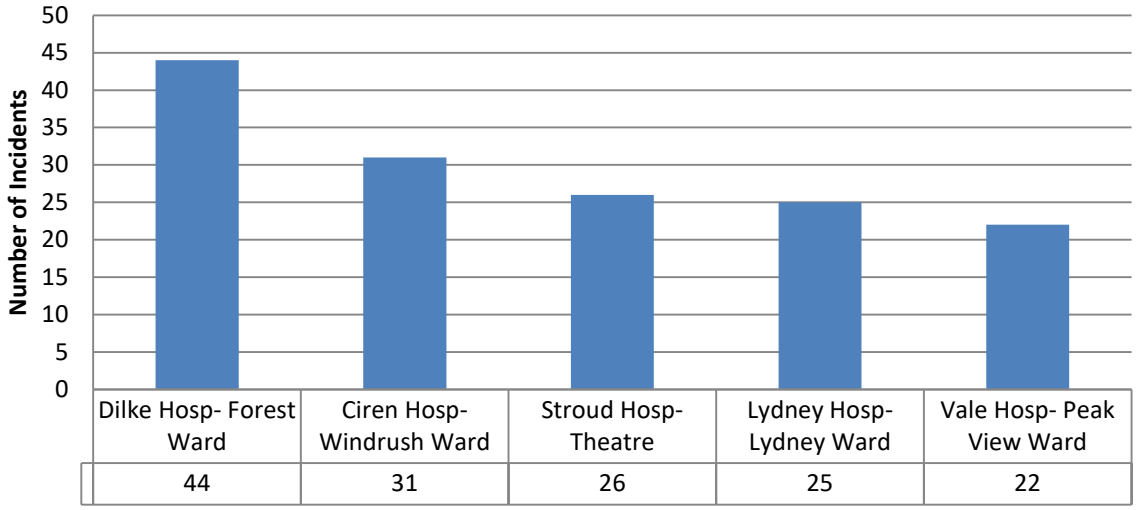


Incidents awaiting review and confirmation of level of harm: data priority areas and actions underway

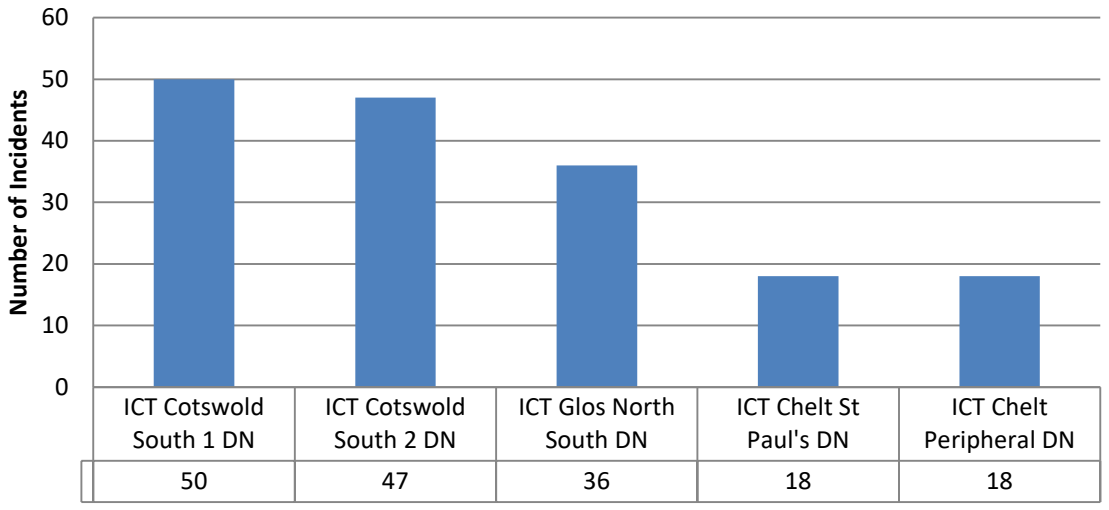
MH inpatient wards/units (Top 5) – incidents awaiting review as of 12/07/2023



Community hospital wards (Top 5) – incidents awaiting review as of 12/07/2023



ICT teams (Top 5) – incidents awaiting review as of 12/07/2023



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, that have yet to be reviewed by Managers has decreased by 1703 since 8 March 2023 (3529 on 08/03/2023 compared to 1826 on 12/07/2023). **This represents a 48.3% 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 12/07/2023 open incidents decreased by 81.4% at Wotton Lawn Hospital and by 79.0% across MH/LD inpatient services. Please note all moderate harm and above incidents are reviewed within timescales, incidents outside of targets are no harm or low harm incidents.**

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

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 - June 2023

There has been an average of 3 patients in total not meeting the criteria to reside for over 30 days in June 2023, 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** - There is an overall reduction in the number of pathway 1 discharge delays for > 30 days nCTR.
- **Pathway 3** -Whilst there is a gradual decrease in number of pathway 3 discharge delays, there are still noticeable delays with these discharges sourced through system partners with a slight increase of 3 this month.
- There has been a noticeable reduction in the number of discharges that are privately funded – support from care navigators is offered, and is now being supported by Adult Social Care representatives
- While there has been an increased 'slowing down' in discharges from our patients with a longer nCTR, there has been a steady number of total discharges from community hospitals.

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

Total Discharges per week > 30 days nCTR

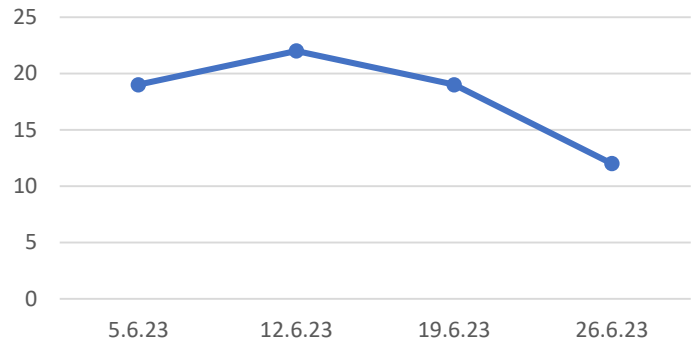


Chart 1 - Showing the number of patients in a community hospital that have not met the criteria to reside for over 30 days. Date range: w/commencing 05.06.23 – 25.06.23.

Pathway 1 Discharge Delays for > 30 days nCTR

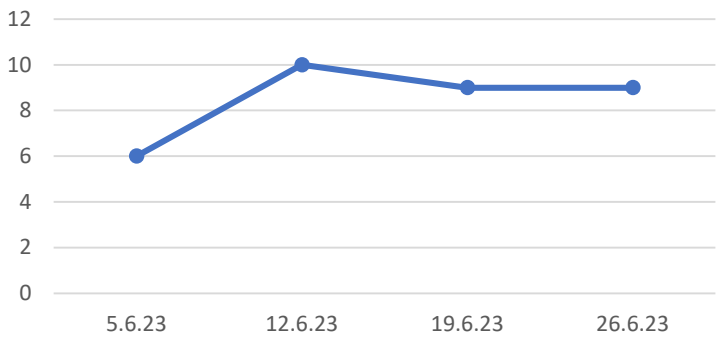


Chart 2 - Showing the number of patients delays on Pathway 1 for over 30 days. Date range: w/commencing 05.06.23 – 25.06.23

Pathway 3 Discharge Delays for > 30 days nCTR

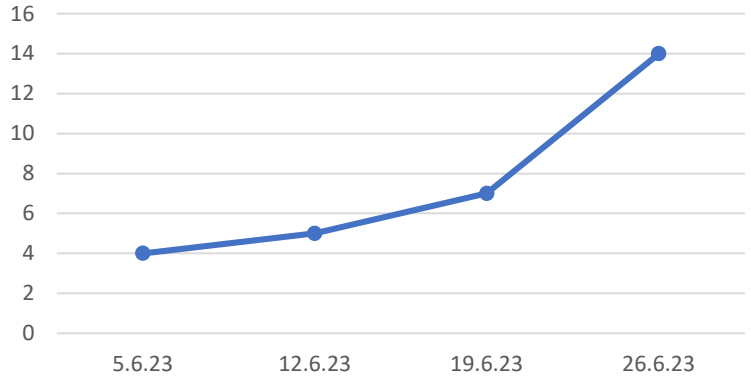


Chart 3 - Showing the number of patients delayed on Pathway 3 for over 30 days. Date range: week commencing 05.06.23 – 25.06.23

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 developed and these categories describe the reasons that a persons discharge is delayed.

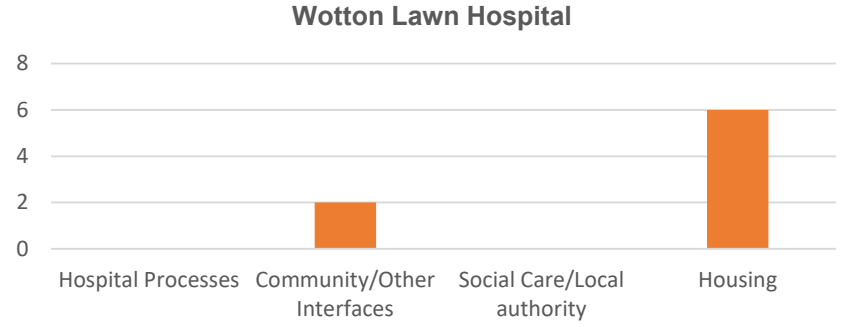
Hospital Processes - defined as any process that is the responsibility of the inpatient service that is related to the delay.

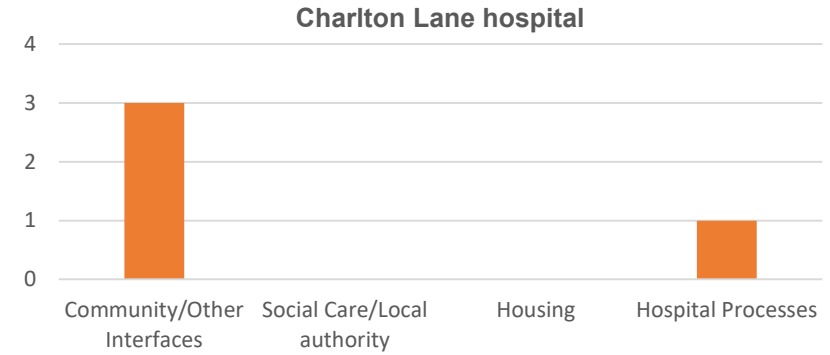
Community/other interfaces – defined as any team or service (excluding social care/local authority or housing partners) that are responsible for/related to the delay.

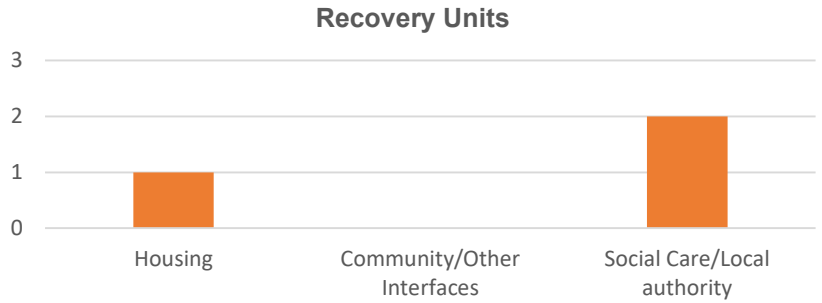
Social Care/Local Authority – defined as any factors that are due to social care provision or are the responsibility of social care/local authority partners, related to the delay.

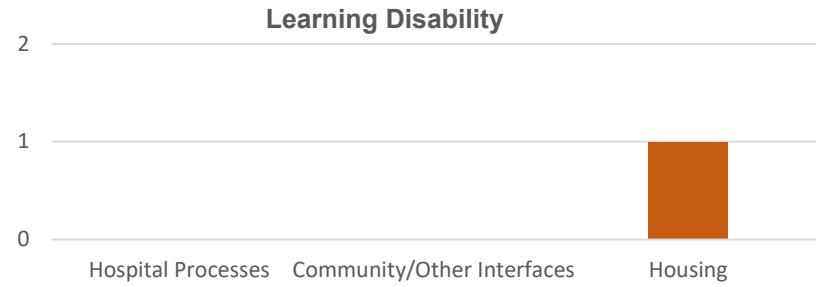
Housing /accommodation – defined as any factors that are due to housing provision or are the responsibility of housing partners/teams, related to the delay.

Headline Data - June 2023
Total of patients across WLH, CLH, Recovery, LD = 16 WLH = 8 CLH = 4 Recovery Units = 3 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

- = Improving the number of patients receiving their depots in primary care
- = (s) Improve communication and liaison between maternity service and health visiting service
- + Increasing service user and carer involvement in QI

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) Leadership opportunities for AHP students
- = Reducing delayed transfer of care - MH LoS
- = ECT in WLH
- ↑ Development of peer support for B7 CYPS
- = (s) Improving sustainability in medicines usage across GHC
- ↑ (s) Paired ROMs compliance – CAMHS

3. Improvement idea initiated

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

- = (s) How do we provide services for lung cancer patients
- ↑ (s) Creating a sustainable placement offer for AHP Students in GHC
- = Reducing medication errors in CLH
- = Reducing restrictive practice in Dean Ward, WLH
- = Improving Sexual Safety in MH inpatient areas
- = (s) Nutritional pathways (Dilke)
- = Single handed personalised care approach
- = Neuro-fitness group
- + School nursing duty system
- = Substance misuse in CAMHS
- = (s) Length of time on core CAMHS caseload
- = Improve clinical pathways in CYPS OT
- + Improving the therapy triage process in Gloucester ICT
- + Health checks for those with SMI
- = (s) MDT working in therapies CYPS

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
- = Improving standard of observations on Priory Ward, WLH
- = Reducing restrictive practice in Mulberry Ward, CLH
- = Reducing restrictive practice in Greyfriars, WLH
- = (s) Improving mouthcare standards in inpatient areas
- = Optimising flow in community hospitals
- = (s) Improving timely access to Urgent Care pathways
- = Referrals into SNS service
- = (s) Increasing the use of FFT feedback in our organisation
- = Carers' Working Group

5. Improvement idea sustained & implemented

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

Directorate	No of Projects
Countywide	4
MH Hospitals and UC	11
PH Hospitals and UC	3
Adult MH/PH/LD Community	7
CYPs	8
Corporate	5
Total:38	

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

Training data June 2023:
26 Silver – 0.4% workforce
526 Bronze -11.7% workforce
405 Pocket QI – 9% workforce

Supervision

Childrens: Group Supervision Compliance **56%**

Integrated Group Supervision Sessions: **25**

One to One Supervision Sessions: **2**

Adults Group Supervision Sessions **2**

Training

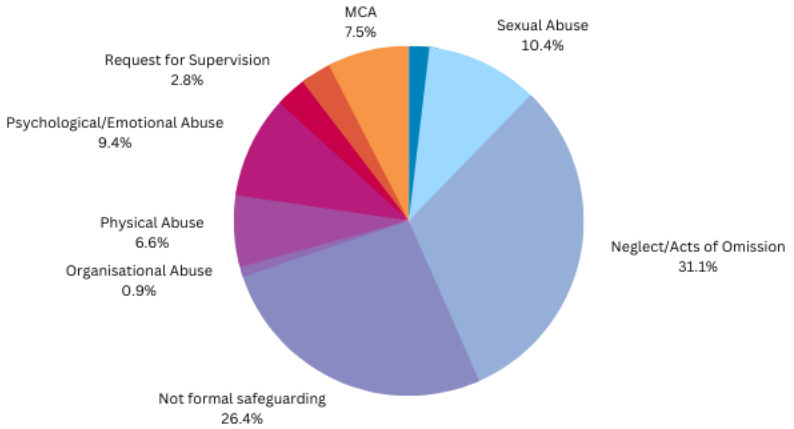
96%	91%	88%	82%	74%
LEVEL 1: INDUCTION	**LEVEL 2: THINK FAMILY**	**LEVEL 3: CHILD PROTECTION**	**LEVEL 3: ADULT PROTECTION**	**LEVEL 4: ADULT PROTECTION**
Jun 23:96% May 23: 96% Apr 23: 96%	Jun 23: 91% May 23: 91% Apr 23:90%	Jun 23: 88% May 23:88% Apr 23: 87%	Jun 23: 82% May 23: 82% Apr 23: 88%	Jun 23: 74% May 23: 74% Apr 23: 77%

Referrals and Advice Line

148 Contacts to Advice Line (adults and children combined)
Apr 23: 111 May 23: 122

35 Referrals made to GCC (adults and children combined)
Apr 23: 14 May 23: 30

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

- 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. Target date for completion Nov 2023.
- Continued good use 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. We have 39 Safeguarding Champions across mental health, learning disability, adult and children's services. Our first Safeguarding Champion Forum has been arranged for September 2023.
- Our new monthly 'Safeguarding Learning Lunch' is going well. Staff attendance at the April lunch was 54 staff, May 52 and June 65. Anecdotal feedback on the structure and value of Learning Lunches has been overwhelmingly positive. The July session is on the Allegations Management Policy/Process.Invitations are sent widely across the Trust.

Challenges/Risks

- Audit has identified some variation in how Safeguarding related data is recorded on our clinical systems and the quality of information. We have an 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. The adult safeguarding template is nearing completion, with staff consultation and testing underway. The children's template is progressing though drafting stages.Target completion end of November 2023.
- Staff engagement with safeguarding supervision is a concern. A review of our current supervision model is underway with a staff consultation, the re-introduction of some face-to-face supervision sessions and a move towards providing more team specific supervisions for areas of the Trust who have high levels of and complex safeguarding cases.
- Auditing has highlighted the need to improve compliance across the Trust with Mental Capacity Act Assessments and Best Interest Decisions. This has been reported as a Trust risk. A working group has formed and developed a work plan for improvement. MCA training compliance is reported as part of this dashboard.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES SAFE

Safe Staffing Inpatient data June– 2023	Code 1		Code 2		Code 3		Code 4		Code 5	
Ward Name	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	
Dean	0	0	10	1	0	0	0	0	0	0
Abbey	67.5	9	32.5	3	0	0	0	0	0	0
Priory	0	0	37.5	5	0	0	0	0	0	0
Kingsholm	15	2	0	0	0	0	0	0	0	0
Montpellier	15	2	0	0	0	0	0	0	0	0
Greyfriars	15	2	0	0	0	0	0	0	0	0
Willow	0	0	157.5	21	0	0	0	0	0	0
Chestnut	7.5	1	60	8	0	0	0	0	0	0
Mulberry	22.5	3	15	2	0	0	0	0	0	0
Laurel	0	0	15	2	0	0	0	0	0	0
Honeybourne	0	0	0	0	0	0	0	0	0	0
Berkeley House	0	0	222.5	26	0	0	0	0	0	0
Total In Hours/Exceptions	142.5	19	550	68	0	0	0	0	0	0

The Director of 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. We have cross referenced highest exceptions with patient safety and experience data. Abbey has reported the highest code 1 exceptions, however, the Matron reports that this didn't adversely impact on care delivery or patient experience. Code 1 exceptions on 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 shifts with Berkley's shortages relating mainly to HCA's on all shifts. Deficits correlate to those with a higher vacancy rate, 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 national tools, we will be reporting on its outputs in September/October 2023

Mental Health & LD			
Ward	**Average Fill Rate %**	**Sickness %**	**Vacancy %**
Dean Ward	128.67%	5.0	6.8
Abbey Ward	103.61%	8.2	26.8
Priory Ward	154.67%	6.9	17.1
Kingsholm Ward	122.61%	17.0	4.6
Montpellier	131.25%	4.6	9.9
PICU Greyfriars Ward	120.00%	4.4	26.2
Willow Ward	105.42%	3.5	4.4
Chestnut Ward	102.04%	12.4	-3.4
Mulberry Ward	107.94%	4.4	10.9
Laurel House	100.56%	14.3	-0.1
Honeybourne Unit	107.78%	12.4	-12.4
Berkeley House	99.00%	11.7	27.4
MHH Totals Avg (June 2023)	**115.29%**	**7.4**	**12.3**
Previous Month Totals	115.21	7.4	11.7

Physical Health			
Ward	**Average Fill Rate %**	**Sickness %**	**Vacancy %**
Coln (Cirencester)	114.49%	7.5	8.6
Windrush (Cirencester)	107.37%	17.1	15.2
The Dilke	113.92%	4.7	10.2
Lydney	102.82%	6.7	2.8
North Cotswolds	100.26%	7.8	5.8
Cashes Green (Stroud)	116.89%	3.4	6.7
Jubilee (Stroud)	120.75%	20.2	9.3
Abbey View (Tewkesbury)	146.29%	8.7	-7.4
Peak View (Vale)	92.95%	7.1	12.0
PHH Totals Avg (June) 23	**112.86%**	**7.9**	**7.0**
Previous Month Totals	104.55	6.4	5.6

NHSE Zero HCSW Vacancy Commitment Inc. bank – 3 month report	
April	90.43
May	92.65
June	91.99

NHSE Zero HCSW Vacancy Commitment : This month there is a slight reduction in the vacancy rate for HCSW, there are a number of approaches to improving recruitment in place including exploring HCA rotational roles, application workshops and taster days, a different initiative has been launched via social media to encourage people who are thinking of leaving our employment to make contact with a view to addressing issues early in order to retain staff. Those areas with a negative value (vacancy rate) indicate being over recruited to their funded establishment. For example, Honeybourne Unit are currently over recruited as they are supporting newly appointed International Nurses. Chestnut Ward remain over recruited in HCSW from a recent event as recruits had a preference on where they wished to work.

IR/Recruitment: 1 AHP remains in the pipeline for 2023. 89 international colleagues have been recruited to date (from Jan 2021) 45 RGNs, 41 RMN,s 2 Community ICT's and 1 AHP. Scoping of potential pipelines with agencies and NHS Trust collaborations is in plan in anticipation of further IR between now and November 2023.

Appendix One

Safeguarding Information - June 2023

with you, for you

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:

- 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. Target date for completion Nov 2023.
- 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. We have 39 Safeguarding Champions across mental health, learning disability, adult and children's services. Our first Safeguarding Champion Forum has been arranged for September 2023.
- Our new monthly 'Safeguarding Learning Lunch' is going well. Staff attendance at the April lunch was 54 staff, May 52 and June 65. Anecdotal feedback on the structure and value of Learning Lunches has been overwhelmingly positive. The July session is on the Allegations Management Policy/Process. Invitations are sent widely across the Trust.

Challenges/risks:

- Audit has identified some variation in how Safeguarding related data is recorded on our clinical systems and the quality of information. We have an 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. The adult safeguarding template is nearing completion, with staff consultation and testing underway. The children's template is progressing though drafting stages. Target completion end of November 2023.
- Staff engagement with safeguarding supervision is a concern. A review of our current supervision model is underway with a staff consultation, the re-introduction of some face-to-face supervision sessions and a move towards providing more team specific supervisions for areas of the Trust who have high levels of and complex safeguarding cases.
- Auditing has highlighted the need to improve compliance across the Trust with Mental Capacity Act Assessments and Best Interest Decisions. This has been reported as a Trust risk. A working group has formed and developed a work plan for improvement. MCA training compliance is reported as part of this dashboard.

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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	Q1			Additional Information
SAFEGUARDING ACTIVITY								
Advice Line Calls	194	47	57	77	181			Operational colleagues continue to make good use of the Safeguarding Advice Line. Marked increase in calls during June.
Multi-Agency Request for Service Forms submitted to MASH	67	8	17	30	55			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 (target date Nov 2023). June saw a marked increase in safeguarding referrals made to LA Children's Services, however it should be noted that this increase could be due to staff becoming more aware of the need notify the GHC Safeguarding Team when they make a referral.
Number of Safeguarding Escalations	2	0	1	2	3			This information is currently obtained from our Safeguarding Advice Line data, this does not give an accurate picture of the number of escalations made to partner agencies. Further work is underway with Clinical Systems/Business Intelligence Teams to accurately identify the number of escalations made to partner agencies (target date Nov 2023).
CHILD DEATH NOTIFICATIONS								
Expected	6	1	2	0	3			Expected deaths are infants with known life limiting conditions or cases of extreme neonatal prematurity. No child deaths in June.
Unexpected	3	3	3	0	6			Gloucestershire Child Death Overview Process is followed for each unexpected death. Cause of each death has not yet been formally reported. No child deaths in June.
RAPID REVIEWS/LCSPR'S								
Number of Serious Incident notifications made by LA	1	0	1	0	1			No Serious Incident Notifications submitted to the National Safeguarding Review Panel by the LA in June.
Number of Rapid Reviews attended	1	0	1	0	1			No multi-agency rapid reviews undertaken in June.
Number of LCSPR's in progress	2	2	2	1	1			1 Gloucestershire LCSPR's in progress, nearing its conclusion and development of recommendations – this review is relating to a CIC, considerable GHC involvement. The joint Surrey/Glos LCSPR was published in June, there was no GHC involvement in this review.
MASH HEALTH TEAM ACTIVITY								
Children researched/info shared	2,255	477	782	867	2,126			Expected variation in month as expected with MASH activity. April MASH activity was lower than usual, May and June has seen a return to usual activity levels.
Adults researched/info shared	346	99	123	97	319			Expected variation in month as expected with MASH activity.
MASH strategy meetings attended	125	10	25	33	68			Expected variation in month as expected with MASH activity. Number of Strategy meetings in April was lower than usual, May and June has seen a return to usual activity levels. The MASH health team attend 100% of strategy discussions they are invited to.
Demographic information sharing	527	197	230	257	684			MASH health are frequently asked for demographic data from multiagency partners - this is due to referral data quality and incomplete data. The number of requests continues to increase.
AUDITS								
Single Agency	0	1	1	1	3			Monthly Safeguarding Children dip sample audit
Multi-Agency sub group activity	1	1	1	1	3			Monthly MASH multi-agency audit
UNDER 18'S ADMISSIONS								
Number of under 18's admitted to Adult MH Wards	0	0	0	1	1			1 child was admitted to adult mental health ward in June.
Number of under 18's assessed under S.136 of the MHA 83/07	4	0	4	3	7			Recent increase in the number assessments
OTHER WORKSTREAMS								
Allegations management – number of referrals to/from the LADO	1	2	4	0	6			0 referrals made to the LADO in June.

GHC - Safeguarding Dashboard 2023/24 Adults safeguarding Data

	Q4	Apr-23	May-23	Jun-23	Q1			Additional Information
SAFEGUARDING ACTIVITY								
Contacts to GHC advice Line	197	64	65	71	200			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 June.
Safeguarding Referrals made to GCC	27	6	13	5	24			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%	56%	56%	56%			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	0	1	1			1 new Domestic Abuse Related Death Review notification in June - no Mental Health Service involvement.
Number of Reviews ongoing	14	14	14	15	15			Consistently high number of safeguarding reviews relating to adults (DHR's DARDR's and SARs).
Action Plans Ongoing	6	6	6	7	7			This includes single and multi agency action plans
MAPPA								
Level 2 Meetings Held	16	*	*	*	15			
Level 2 Meetings Attended	16	*	*	*	15			100% attendance at MAPPA meetings
Level 3 Meetings Held	1	*	*	*	6			
Level 3 Meetings Attended	1	*	*	*	6			100% attendance at MAPPA meetings
PREVENT								
Number of Prevent Referrals Made	0	0	0	0	0			No Prevent concerns raised with the police
Information requests received & completed from Police/Channel	15	1	2	1	4			100% response to all police and channel panel information sharing requests, supportive effective planning and decision making. Lower number of prevent requests in Q1.
MARAC								
Families screened/researched	395	106	139	163	408			Continued high level of MARAC activity. Minor variation in month.
No.of children open to MH Services	38	19	20	18	57			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	21	23	76			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	22	23	55			Identifies the number of perpetrators open to MH services. Expected minor variation in month.
Un-uploaded MARAC Action Plans	144	132	48	59	59			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.
DOLS - No. of referrals for standard authorisation from:								
Mental Health Services Total	7	2	4	6	12			Continued pattern of DOLS applications
Mental Health Services Authorised	3	1	1	3	5			Minor variation in month
Physical Health Services Total	20	14	15	10	39			Physical health urgent applications (not requiring LA authorisation)
Physical Health Services Authorised	0	0	0	0	0			Nil authorised as patients have moved on before being application assessed.
AUDITS								
Single Agency - Safeguarding Related	8	1	1	1	1			Monthly Safeguarding Adults dip sample auditing commenced in November 2022 and continues each month.
Multi Agency Sub - Group Related	2	0	0	1	1			1 multi agency safeguarding case based audit in June.
OTHER WORKSTREAMS								
Allegations management - use of PiPoT guidance	1	2	1	0	3			0 new allegations in relating to a member of GHC staff in June.

Quality Dashboard

NHS Gloucestershire Health and Care NHS Foundation Trust

GHC - Safeguarding Dashboard 2023/24 Training and Supervision Data

	Q4	Apr-23	May-23	Jun-23	Q1			Additional Information
TRAINING								
Level 1 – Induction	96%	96%	96%	96%	96%			Consistent month on month compliance level
Level 2 – Think Family	92%	90%	91%	91%	91%			Overall a minor variation in month
Level 3 – Multi-Agency Child Protection	88%	87%	88%	88%	88%			Overall a minor variation in month. Training compliance review being undertaken to identify specific Teams to target to improve compliance.
Level 3 Adult Protection	82%	88%	82%	82%	84%			Overall a minor variation in month. Training compliance review being undertaken to identify specific Teams to target to improve compliance.
Level 4 Adult Protection	80%	77%	74%	74%	75%			Overall a minor variation in month. Training compliance review being undertaken to identify specific Teams to target to improve compliance.
PREVENT:								
Level 1	99%	97%	97%	99%	98%			Continued high level of compliance with Level 1 Prevent Training
Level 2	83%	84%	84%	84%	84%			Training compliance review being undertaken to identify specific Teams to target to improve compliance.
Level 3	94%	90%	91%	96%	92%			Good compliance with minor variation in month
MENTAL CAPACITY ACT:								
Level 1	*	*	89%	90%	90%			New item to the dashboard. Level 1 MCA training is an online package, mandatory for all clinical staff who work with adults.
Level 2	*	*	63%	69%	66%			New item to dashboard. During the Covid 19 Pandemic, Level 2 MCA training was put on hold. Training recommenced in July 2022 and compliance is improving, but taking time due to the volume of staff requiring update.
SAFEGUARDING SUPERVISION								
CHILDREN:								
Group Supervision Sessions	60	20	22	25	67			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%	52%	56%	55%			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. A piece of work is underway to breakdown compliance at team level for targeted work to address low compliance rates – this is a safeguarding team priority.
One to One Supervision Sessions	22	3	1	2	6			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	2	2	4			A new offer/model of Adult Safeguarding Supervision being developed to address poor attendance and engagement with supervision
Number of Staff who attended Supervision	*	0	2	3	5			
One to One Supervision Sessions	*	1	1	0	2			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 Two

Trust Operational Data Extract – June 2023

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%	43%	41%										47.5%	R		
	ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	63.93%	78%	68%	65%										69.78%	R		
	ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	72.81%	77%	78%	78%										77.96%	R		
	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	50.59%	44%	41%	40%										41.6%	R		
	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	90.16%	88%	88%	82%										86.4%	R		
	Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	14.35%	11.0%	12.0%	8%										10.8%	R		
	Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R	3,279	13437	1241	1415	1447										4103			
	Wheelchair Services Adults : New referrals assessed within 8 weeks	L - C	90%	83.24%	86.0%	85%	90%										87.2%	A		
	Wheelchair Services : Under 18's new referrals assessed within 8 weeks	L - C	90%	84.66%	94.0%	83.0%	94%										90.2%	G		
Mental Health Services (CPA and Eating Disorders)																				
	CPA Review within 12 Months %	N - T	95%	95.2%	95.0%	96.0%	95.1%										95.8%	G		
	Adolescent Eating Disorder - routine referral to NICE treatment start within 4 weeks %		95%	46.95 %	30.0%	30.0%	64.0%										45.95%	R		
	Adolescent Eating Disorder - Urgent referral to NICE treatment start within 1 week %		95%	45.1%	87.5%	100%	88.8%										90.91%	A		
	Eating disorders - Wait time for adult assessments will be 4 weeks %		95%	47.04%	30.0%	30.0%	64.7%										54.04%	R		
	Eating disorders - Wait time for adult psychological interventions will be 16 weeks %	N – T	95%	68.96%	85.0%	100%	100%										96.21%	R		

Additional information

Governance statement: - The completion of the Simplicity project has resulted in the correction of significant inaccuracies within data and has acted as a change catalyst to ensure SystmOne remains accurate into the future. 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. While this programme has reached its conclusion, there is follow-up work to standardise the way SystmOne is used across the Trust, and will continue to provide colleagues with the appropriate training and support. 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.
Paediatric Speech and Language Therapy: Increased demand and complexity of cases impact on the wait lists for this service and is further compounded by the current vacancies in the service.
Podiatry: Continues to suffer from the backlog caused by redeployment during Covid and is carrying high vacancy levels , there are positive steps with the recruitment of a substantive B6 and a regular Bank B6.
Paediatric Occupational Therapy: Targeted measures being introduced to reduce wait times. (Blitz clinics and EHCP sessions).
Wheelchair Services: The backlog of patients which was 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, an improving picture is seen this month with compliance rates increasing and reaching target.

Mental Health : CPA rates are on target with compliance being maintained for the past 9 months.
Eating Disorders:. Achieving expected performance levels remains a challenge however compliance with the "wait time for adult psychological interventions" will be 16 weeks remains above target for the second month since Nov 2020. The service continues to offer assessments to patients that have been waiting for an extended period based on clinical decision and continues to offer assessments for those on the waiting list that have been waiting over 4 weeks. The team has significantly reduced the wait time for adult psychological interventions with all referrals being seen in timeframe this month. 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, Ops 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%	98%	98%										98.%			
*** 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%	61%										60%	G		
Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered																				
Inpatient Wards		N - T	95%	68%	72%	63%	69%										69.0%	R		
Community		N - T	90%	70.2%	76%	9.0%	25%										25%	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%	51%	51%										51.0%	G		
Admissions to adult facility of patient under 16yrs		N - R		0	0	0	0											N/A		
Inappropriate out of area placements for adult mental health services		N - R	Occupied bed days	950	0	0	4										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 2023		N - T	90%*	79.1%	12%	70%	80%	85%	90%											.
					43.%	69%	70%													
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%	85.0%	95%	95%	95%								95%	G		
					82.5%	91.0.%	96.9%													
Percentage of children in Year 6 with height and weight recorded		N - T	95%*	96.1%	75%	87%	95.0%	95%	95%								88.0%	G		
					89.7%	94.0%	96.4%													

Additional Information

OOA: This month we are reporting four OOA bed days and reflects significant demand on beds in June. All people were monitored by the Bed Management Team through a virtual ward approach.
IAPT: Performance level in year is above target and it is envisaged that this trend will continue.
EIP: Performance level in year is on target with no know barriers to prevent continuation of achievement.
Cardio-metabolic assessment – April's data was the year end position and is reset from May which then impacts on its comparative position against the previous month. This will be a cumulative figure and notes an increase since May. Input continues from two Physical Health Nurses within WLH and CLH, 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%	83.0%	93%	95%									62.0%	G	N	
					85%	94%	98%										98%			
Number of Antenatal visits carried out				505	54	53	60										167	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%	92%	95%										95%	A	Y	
Percentage of children who received a face to face, telephone or video 6-8 weeks review.			95%	93.1%	96%	96%	96%										96%	A	Y	
Percentage of children who received a 9-12 month review by the time they turned 12 months.			95%	81.5%	81%	85%	89%										89.%	A	Y	
Percentage of children who received a 12 month review by the time they turned 15 months.			95%	90.25%	92%	91%	92%										91.0%	A	Y	
Percentage of children who received a 2-2.5 year review by 2.5 years.			95%	81.06%	90%	89%	92%										92%	A	Y	
Percentage of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence).			58%	53.73%	56%	58%	57%										57%	A	Y	
Breastfeeding- % of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks			80%	82. 1%	78.0%	87.0%	83%										83%	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. This month there are slight increases in compliance within the breastfeeding indicators which bring 3 of the reported workstreams into a compliant with threshold situation. 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 parents to understand & breakdown the analysis of why parents are declining this review.

- **Breastfeeding**: Breastfeeding rates are slightly improved on last month with both indicators becoming 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%	92%	92%										92. 0%	G		
% of Staff with completed Personal Development Reviews (Appraisal)	L - I	90%	85.0%	80%	79%	79%										81%	R	Y	
Sickness absence average % Rate	L - I	<4%	5.9%	5. 8%	6.2%	6.3%										N/A	R	Y	

Additional information

Mandatory training – Although we have an overall summary position of 92.0 % compliance of mandatory training there are a number of subjects that show high variability across the organisations. Despite the migration of data to the business information system we do not have the functionality to build or present a more detailed analysis of training in this months dashboard.

We continue to independently review training figures in the following areas: Level 3 Resus (MERT), PMVA and PBM, Breakaway, Safeguarding, Mental capacity Act (Levels 1 & 2), Mental Health Act & Rapid Tranquillisation. Owing to limited interoperability with the Business Intelligence Tableau System and the Training Teams database we are unable to provide the planned deeper analysis of Statutory & Mandatory Training in the month's dashboard. Access to individual team data is now available to support team managers with compliance monitoring, however, it will require further development to support service level data to include the 'Essential to Role' training.

The Learning & Development Team are sending out monthly reminders to staff and the Resus Committee is overseeing the compliance rates for level 3 training. We aim to improve training places by reducing non attendance and late notice cancellations. The training team are reviewing data with team managers and developing training dates 4 months in advance to support the clinical rosters that are due to be centralised from September.

Sickness absence - At 6.3% in month indicates a marginal increase from the previous month of 0.1%. Rates remain above target and in June the percentage figure equated to 7454 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.

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 July 2023**

PRESENTED BY: Sandra Betney, Director of Finance and Deputy CEO

AUTHOR: Chris Woon, Deputy Director of Business Intelligence

SUBJECT: **PERFORMANCE DASHBOARD JUNE 2023/24 (Month 3)**

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 June (Month 3 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 June 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

2023/24 Business Intelligence business planning highlights are presented on page 1. Highlights include:

- There are currently around 260 indicators across all domains within the new 2023/24 Performance Indicator Portfolio although this is a dynamic position. 156 legacy indicators remain untouched (59%) from the 2022/23 portfolio. 68 indicators (26%) are in Phase 1 of development. 29 of these indicators within Phase 1 are already complete and deployed, whilst a further 39 are in various stages of analysis, development and testing. This puts the total portfolio position

at the end of June at 185 indicators (70%) active. Once Phase 1 is complete (aiming for end of Quarter 2) the position will be 224 (85%) active. The remaining 39 indicators (15%) remain on hold for a second phase of development as they currently require further evaluation of definitions and/ or thresholds. They will be scheduled through 2023/24 from September 2023. There are more indicators that need to be developed for service areas such as Sexual Health and Dental and these will be reviewed in 2023/24.

- Of the 41 planned Physical health Service Line Dashboards (some services do not require one or they have been amalgamated into existing reports), 40 (98%) have now been published with the remaining Stroke ESD planned for the end of July. Key finance and training measures are being introduced into the Service Line dashboards and these will be mostly complete by the end of August, a slight delay due to wider priorities. MH/ LD Service Line Dashboard needs are still being discussed with services as it is anticipated that localities will need to be accommodated alongside a 'service level' view. Service Level Dashboard planning for MH and Community Hospitals will begin in now that Quarter 2 has started as scheduled.

- Project sprints have enabled the first draft Clinical Supervision data reports to be published at the end of Quarter 1 however work is now underway to improve recording with users.

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 within the new four domain format for Board:

- **Nationally measured domain** (under threshold)
  4 indicators covering Care Programme Approach (CPA), U18 Inpatient admissions and Adolescent Eating Disorder treatment wait were under threshold for the period.

- **Specialised & directly commissioned domain** (under threshold)
  In addition, attention is drawn to a further 7 health visiting indicators and a school aged immunisation indicator which did not meet their thresholds for the period.

- **Locally contracted domain** (under threshold & outside of statistical control rules)
  Talking Therapies (IAPT) Access, CAMHS initial appointment wait and Eating Disorders were the areas in exception for the period.

- **Board focus domain** (under threshold & outside of statistical control rules)
  3 indicators deemed a focus for Board were in exception for the period which included Physical Health occupancy rate, GHT 6-week echocardiogram diagnostic tests 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 items are presented to highlight signs of positive performance (such as IAPT recovery) or potential areas for closer awareness and monitoring (such as documented risk assessment for service users not on CPA).

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 Meeting – 20 June 2023

Appendices:	AI-08.1 Performance Dashboard Report Month 3

Report authorised by: Sandra Betney	**Title:** Director of Finance and Deputy CEO

Gloucestershire Health and Care NHS Foundation Trust

Snapshot Month
June

Performance Dashboard Report & BI Update

Aligned for the period to the end June 2023 (month 3)

In line with the planned Performance Indicator Portfolio reconfiguration, this report presents performance indicators across four new domains including **Nationally measured**, **Specialised & Direct Commissioning**, **ICS Agreed** (formally Locally contracted) and **Board focus**. Indicators within the Operational domain are presented to the Resources Committee.

In support of these metrics a monthly Operational Performance & Governance report (with action plans) is presented to the Business Intelligence Management Group (BIMG). A new, operationally led Quality Forum has also been recently established and will be reporting into BIMG when fully operational.

There are currently around 260 indicators across all domains within the new 2023/24 Performance Indicator Portfolio although this is a dynamic position. 156 legacy indicators remain untouched (59%) from the 2022/23 portfolio. 68 indicators (26%) are in Phase 1 of development. 29 of these indicators within Phase 1 are already complete and deployed, whilst a further 39 are in various stages of analysis, development and testing. This puts the total portfolio position at the end of June at 185 indicators (70%) active. Once Phase 1 is complete (aiming for end of Quarter 2) the position will be 224 (85%) active. The remaining 39 indicators (15%) remain on hold for a second phase of development as they currently require further evaluation of definitions and/ or thresholds. They will be scheduled through 2023/24 from September 2023. There are more indicators that need to be developed for service areas such as Sexual Health and Dental and these will be reviewed in 2023/24.

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 41 planned Physical health Service Line Dashboards (some services do not require one or they have been amalgamated into existing reports), 40 (98%) have now been published with the remaining Stroke ESD planned for the end of July. Key finance and training measures are being introduced into the Service Line dashboards and these will be mostly complete by the end of August, a slight delay due to wider priorities. MH/ LD Service Line Dashboard needs are still being discussed with services as it is anticipated that localities will need to be accommodated alongside a 'service level' view. Service Level Dashboard planning for MH and Community Hospitals will begin in now that Quarter 2 has started as scheduled.

Project sprints have enabled the first draft Clinical Supervision data reports to be published at the end of Quarter 1 however work is now underway to improve recording with users.

Chief Operating Officer's Report May 2023

David Noyes, Chief Operating Officer (COO)

A further period of steady performance across the system, and pleasingly our community offer has remained consistently strong, with low numbers of patients in the Acute waiting on a community bed (usually less than 20, often less than 10) and good flow generated, albeit we continue to have around 20% of our bedded capacity occupied by patients who have completed their journey with us. This period has seen continued industrial action from both junior doctors and consultants, with the consequence that in mid July Cheltenham A&E was closed entirely; as previously in order to bolster system resilience we augmented our MiiU offer in support. Internally, our own contingency arrangements held up well, with some disruption in the form of cancelled appointments in our sexual health services. The stroke pathway remains under pressure and as previously reported will be reviewed at system level, although pleasingly we have started our recruitment process for the new Community Neuro team.

MiiUs have continued to be well utilised, which is encouraging, and resilience has been good; recently at the onset of the junior doctors strike we had one day with almost 450 patient contacts. Elsewhere we have commenced the work to look at the next phase of transforming our Rapid offer in line with the Newton review work, which should further enhance the effectiveness of this service. On the subject of the Newton work, now called UEC Transformation, the system arrangements and governance are just being finalised with the implementation due to start in the next month, albeit as Board colleagues are aware we started our own implementation work in the autumn, and hence are well placed. Accordingly, while subject to short term fluctuations, we are pleased to be seeing a steady increase/improvement in the number of Homefirst starts offered each week, while numbers waiting and times in service are all showing very positively, with Length of Stay in service at a very competitive 21 days.

The demand on Mental Health beds has remained consistently high over the past month, with demand outstripping capacity, following a period (the first in a while) where we had managed to create some capacity. That said we continue to drive ahead with our work to endeavour to reduce Length of Stay, hosting the fourth of four workshops earlier this month, and while the current situation is frustratingly difficult, there are some indications which give cause for optimism in this regard, we eliminated, although briefly, out of area bed usage for three months from March – May 2023. This registered the first month with no inappropriate out of area admissions since April 2021. Additionally, since December we have seen the discharge of 7 stranded patients, each with LoS of over 1 year, we have not seen a similar discharge in the preceding 6 months.
Pleasingly we remain on track to have a full establishment of permanent RMN staff by September, noting this is largely the result of some successful international recruitment and so there will likely be a settling period.

As reported last month to resources committee, the system has agreed to conduct a review of all our mental health crises services and how they operate together. As promised, we continue to seek to improve the environment within the 136 suite, although quite high occupancy rates do make this a challenge; the team have also derived some more fundamental long term alterations (based on feedback from staff and service users) that would help, but which we will need to source an alternative provision to enable them to be completed – hence this will take some time.

Progress continues positively with turning around the Eating Disorders service and in particular Im delighted that we are continuing to achieve 100% for urgent adolescent referrals being seen within a week. The number of routine adolescent referrals not seen within the target of 14 days continues to reduce with a final rump of around 70 to be worked through, we anticipate that the trajectory for consistent threshold compliance is October 2023. We continue to review options for pivoting resources both internally and with current partners to address the routine adult waiting list which currently sits at just over 300, and hope to shortly report on plans and trajectories leading to consistent compliance with the 28 day threshold.

As Board colleagues are aware, CAMHS remains a significant challenge and consequent high risk, not least due to a very stretched medical capacity in the service. Significant work to plan a way ahead and recovery is underway, and includes reviews of triage and assessment protocols, ongoing reviews of waiting lists, additional weekend (and scoping of evening) clinics, and more admin support to free up clinical time. In the longer term we are working up plans to launch our own CAMHS Academy; in the short term the successful recruitment of an additional 6 b5 colleagues onboarding in the next month is very welcome. The latest figures show there are 662 on the core CAMHS waiting list; however there is growing evidence that the referral demand for core CAMHS is starting to drop (on or below average numbers over last 5 months), most likely due to the success of the Young Minds Matter (first line offer) being launched in Tewkesbury, Stroud and Gloucester areas, and the pilot multiagency navigation hub.

Performance in Podiatry remains challenged but I remain confident that we will see improvement here over the summer following successful recruitment (new B5 and apprentices achieving B5 from late Aug); in Jul the 8 week RTT was archived in 48% of cases (improving albeit target is 95%), and the waiting list is 21% reduced at 1904 from 2404. The situation in MSK is slowly improving achieving an improved 53% against the 8 week RTT (target 95%), but 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, and we are starting to offer weekend and evening catch up clinics when possible, while we are seeking to treat the longest waiters (of course taking account of clinical need. In MSKAPS recovery is going well, now achieving 84.1% (target 95%) for 8 week RTT, nicely on the recovery trajectory presented in April; the team are now at full establishment.

Colleagues will notice from the performance report a deterioration in the Echo performance provided for us by GHFT. Our colleagues in GHFT have felt the cessation of a contract which was helping them deliver and the switch across from previous provision to an internal, albeit locum delivered solution was not as smooth as they had hoped. New arrangements are now in place and so we should see this position recovering shortly.

Good progress is being made in our Dental Service where the recovery plans have delivered a notable reduction in patients waiting over 8 weeks, and the overall numbers of patients waiting reduced from 507 in march to 158 in July. Further, the waiting list for patients with safeguarding needs has been reduced from 60 in March to just 1 by July.

Elsewhere, the background and preparatory work to enable the next stage of restructuring to be consulted upon (the bringing together of community physical and mental health teams) continues, and this

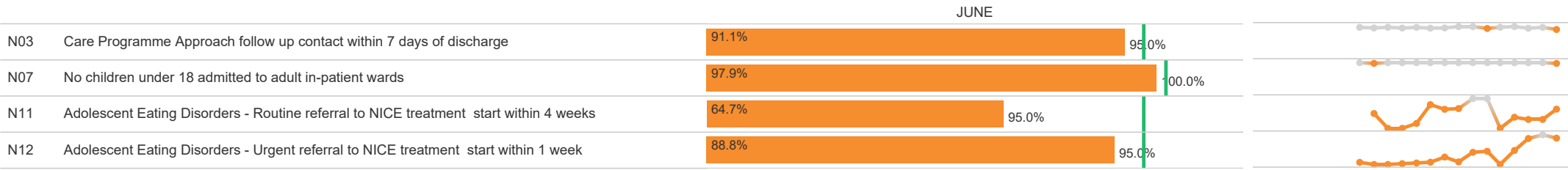
important stage should conclude within the next month. And the operational plan and focus for the decommissioning of Lydney and Dilke and migration to the brand new Forest of Dean Hospital are gaining momentum and necessarily are increasingly a focus for the Ops team.

Performance Dashboard: *National Contract Domain*

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*.

N03: Care Programme Approach follow up contact within 7 days of discharge
June is reported at 91.1% against a performance threshold of 95% and is below SPC (Statistical Process Control) limits. There were 4 non-compliant cases reported in June.

The GHC ward team set up the discharge meeting with the out of county Recovery team for one of these patients. The agreed plan between organisations was for the out of county duty team to organise follow up within 72hrs. The patient was discharged by GHC but not seen by them until the 8th day after discharge. The patient is safe, well and is engaging with their local out of county recovery team. An assurance review is underway to ensure there is always an adequate and regular assurance process in place to support timely follow-ups for all patients.

Several attempts were made to see another patient after discharge however the patient, who has a history of avoiding care coordinator intervention, did not engage. A successful contact was made 13 days after discharge.

One patient was on extended Section 17 leave and was followed up within 48 hours after leaving the ward by their community team. The patient did not return to the ward and a discharge date was recorded, however there was no follow-up within 7 days of this recorded discharge date.

The remaining patient was also on leave, however the follow-up occurred on the same date that the discharge was recorded. National guidance states that a follow-up must be within 7 days commencing the day after discharge. As no further follow-ups were made within 7 days, this record is non-compliant.

N07: No children Under 18 admitted to adult in-patient wards
There was 1 admission of an under 18 to Wotton Lawn during June. The patient was 9 days away from becoming 18 and not known previously to the Trust. After a Mental Health Assessment in the Acute Emergency department they were sectioned and admitted. Length of stay was 2 weeks, after which they were discharged with a follow-up and care from the EI service.

N11: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks [Community MH Services]
June performance is reported at 64.7% against a performance threshold of 95%. There were 6 non-compliant cases in June.

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

During June 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. At the beginning of July there were 67 routine adolescent clients on the assessment waiting lists, (81 in April) compared to 201 at its highest peak in June 2022.

Work has begun with the Business Intelligence Service to produce a waiting list model to give an indication of the capacity required to address the routine assessment waiting list backlog.

N12: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week [Community MH Services]
June performance is reported at 88.8% against a performance threshold of 95%. Nine young people commenced treatment and there was 1 non-compliant case in June. The patient was offered an assessment within 7 days; however the family were difficult to engage, and clinicians were unable to commence treatment at this appointment. A further appointment was booked; however the family did not attend. Treatment commenced at the next attendance which was 25 days after referral.

Note on N11 & N12 Adolescent (U19) Eating Disorder waiting times
The service has recently adopted a new triage process which involves all patients receiving an initial call within 24 hours of the service receiving a referral. Self Help guidance will be provided as appropriate and will be recorded as a treatment start in line with relevant SNOMED coding.

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 72 referrals have been made and 48 spaces remain. The Service continue to work with TIC+ to refer patients to a counselling programme and then discharge from the caseload. The team have now referred over 130 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 75 referrals have been made of which the ORRI have started to treat 29 patients.

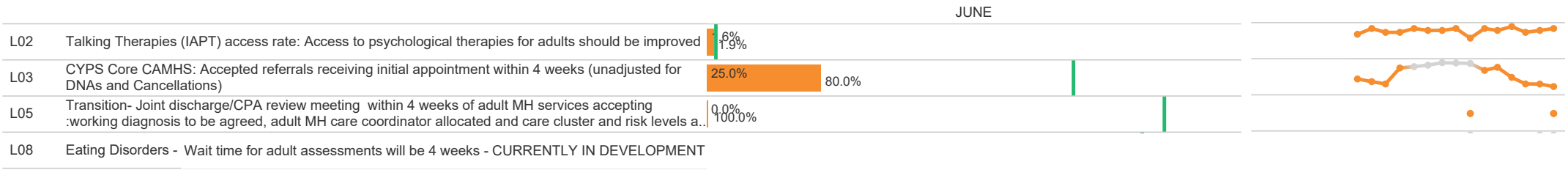
Establishment WTE and skill mix have been reviewed to increase recruitment into hard-to-fill posts. Recent appointments: 3 x Band 5 ED Clinicians (one is a 12month FTC/Secondment). Vacancies: 2 x Band 6 Clinicians, 1.0 Band 7 ED Clinician, 3 x Band 4 Assistant Clinicians. The service is working through the challenges of the potential long wait between initial assessment and subsequent treatment sessions and continues to rely on bank staff and staff from the wider trust offering additional hours. This set of indicators has a Service Improvement Plan and is on the Performance Governance Tracker and risk register ID 149 (Score 16).

Performance Dashboard: *ICS Agreed Domain*

KPI Breakdown

Compliant Non Compliant

ICS Agreed Domain



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

L02: Talking Therapies (IAPT) Access rate: Access to psychological therapies for adults should be improved [Community MH Services]
In June the service achieved 84.2% of expected performance which equates to 1.6% of the prevalent population (1117 people) against a performance threshold of 1.9% (1326 people) and is within SPC (Statistical Process Control) limits , however there is special cause variation with this and the previous 4 months being below average.

Referrals remain significantly lower than needed to meet the access target, which has been an issue since 2021/22 Referrals in April were 1192 and May 1334 with a slight increase to 1404 in June. The service requires approximately 1500 referrals per month to mitigate the number of people who have been referred / self-referred who never book or attend a first appointment. The dropout rate for June is 19.6% compared to a planned rate of 15%. Nationally it has been recognised there are lower referrals into the programme than expected, particularly during and since the pandemic which led to the national targets being remodelled. The ongoing National NHS Talking Therapies rebrand is part of the national solution to increase referrals and access to the programme.

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.

Locally, the service has robust systems to contact clients to book into a first appointment as well as implementing a digital choose and book system to make booking easier. The Service has also been working closely with the communications team to promote the service though social media channels and local events, as well as commissioning a radio Advertising Campaign though 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 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.

L03: CYPS (CAMHS Core) Referral to initial contact (direct or indirect) within 4 weeks [CYPS MH]
June performance is reported at 25.0% against a performance threshold of 80%. There were 81 non-compliant cases reported in June. This is a decrease in performance compared to May (32.1%).
As the methodology for CAMHs waiting times has been revised, SPC (Statistical Control Process) limits cannot be calculated. A review of SPC limits for this indicator will take place in 6 to 8 months.
Capacity continues to be affected by staff taking part in the CAMHs Diploma Training Programme, however, the training does finish in July. The Navigation Hub pilot, which ended in June also took some Resource from CAMHS front door. The service has been unable to meet its planned recovery trajectory of 5 weeks and a new trajectory shows that additional clinics will stop waiting times growing but not significantly reduce the current length of waiting time.

L05: CAMHs Transition to Recovery within 4 weeks [CYPS MH]
June performance is reported at 0% against a 100% threshold. There was 1 non-compliant case reported in June. The data item missing from the clinical system is the care coordinator allocation date. The service has been advised to update the record however it has also been recognised for a while that the current methodology for this indicator does not provide reassurance that the transition of the

young person follows the trust policy. As such, it has been agreed with commissioners for the 2023/24 contract that a periodic quality audit reported by the service to commissioners would provide better assurance. Therefore this indicator will now be removed from the performance dashboard and replaced by this new assurance process.

L08: Adult Eating Disorders: Referral to Assessment within 4 weeks [Community MH Services]
June performance is reported at 84.6% against a 95% performance threshold. There were 8 non-compliant cases reported in June.

The service continues to work through the assessment waiting list and the number of adults waiting for assessment at the end of June was at 285 compared to 517 at its highest peak in August 2022.

The service has recently adopted a new triage process and all new patients will receive an initial call within 24 hours of the service receiving the referral. Self Help guidance will be provided as appropriate and will be recorded as a treatment start in line with relevant SNOMED coding. The service is aiming to provide adults triaged as urgent with an assessment within 4 weeks of referral.

Work has begun with the Business Intelligence Service to produce a waiting list model to give an indication of the capacity required to address the routine assessment waiting list backlog.

The service continues to work with BEAT (an Eating Disorders Charity) for adults on the momentum programme and with TIC plus for under 25's in order to refer patients to a counselling programme and then discharge from the caseload.

Establishment WTE and skill mix have been reviewed to increase recruitment into hard-to-fill posts. Recent appointments: 3 x Band 5 ED Clinicians (one is a 12month FTC/Secondment). Vacancies: 2 x Band 6 Clinicians, 1.0 Band 7 ED Clinician, 3 x Band 4 Assistant Clinicians. The service is working through the challenges of the potential long wait between initial assessment and subsequent treatment sessions and continues to rely on bank staff and staff from the wider trust offering additional hours. This set of indicators has a Service Improvement Plan and is on the Performance Governance Tracker and risk register ID 149 (Score 16)

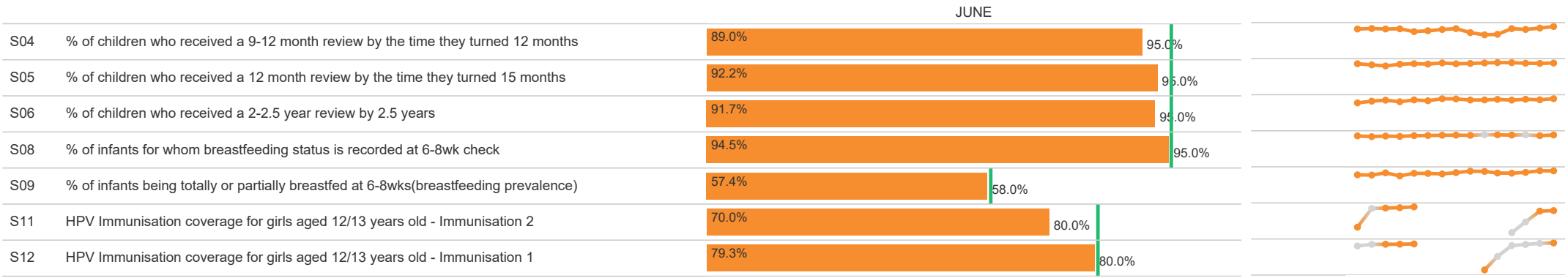
Performance Dashboard: *Specialised Commissioning Domain*

Gloucestershire Health and Care NHS Foundation Trust

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.*

S04: Percentage of children who received a 12-month review by the time they turned 12 months. [Children and Young People Service]
In June performance was 89.0% (May was 84.7%) compared to a threshold of 95%. 53 out of 486 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.

Narrative and actions by exception reason:
Out of timeframe – staffing capacity. Team Leaders are meeting on weekly basis to forecast any issues raised by sickness absence or staffing issues to try and ensure cover from other areas. ASQ (Ages and Stages) clinics not to be cancelled unless all other staffing has been exhausted. Feedback on exceptions are being made Locality specific rather than countywide in effort to reduce exceptions.
DNAs – We are gathering data from SystmOne and from the Children's Centres to look at our DNA demographics and identify trends so we are able to put in area specific interventions to engage communities that may not be fully accessing our service.

Declined Review – Consider working closer with local Nurseries to access those children whose parents decline due to working full time.

Delayed by parent – Look at age that first appointments are offered to ensure sufficient timeframe is being offered.

Record Error – Data Governance Analyst to double check all record corrections done by supporting staff to ensure correct amendment. Continue to support staff to record accurately.

Medical Diagnosis – The ASQ Champion team are undertaking training to support practitioners to undertake sensitive and supportive ASQ on children with significant medical needs.

S05: Percentage of children who received a 12-month review by the time they turned 15 months. [Children and Young People Service]
In June performance was 92.2% (May was 91.2%) compared to a threshold of 95%. 37 out of 478 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.

See narrative for S04.

S06: Percentage of children who received a 2-2.5 year review by 2.5 years. [Children and Young People Service]
In June performance was 91.7% (May was 88.5%) compared to a threshold of 95%. 34 out of 412 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.

See narrative for S04.

S08: Percentage of infants for whom breastfeeding status is recorded at 6-8wk check. [Children and Young People Service]
In June performance was 94.5% (May was 92.5%) compared to a threshold of 95%. 27 out of 491 children are showing as not being breastfed at their 6-8 week review. Performance is within SPC chart upper and lower control limits.

Influencing factors - Increasingly, more babies are born prematurely and require long NICU (Neonatal Intensive Care Unit) stays/re-admission for complex needs when they are discharged early.

HV staff need to ensure they are using the NICU template to ensure feeding status can be captured.

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

In June performance was 57.4% (May was 57.5%) compared to a threshold of 58%. 209 out of 491 children are showing as not being breastfed at their 6-8 week review. Performance is within SPC chart upper and lower control limits.

Influencing factors - The Midwifery Service continued to be understaffed, which impacts on the specialist feeding service / tongue tie service waiting list in midwifery. New staff in place from April - Infant Feeding Lead HV has set up weekly meetings to address needs identified with plans (including Referral Pathways, Training, Policy/G-Care Reviews) to improve feeding status.

S11: HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 2
63.7% of the estimated cohort of children eligible for HPV 2nd dose in the 2022/23 academic year had been immunised at the end of June 2023. This is cumulative performance compared to June target of 80%. Overall national target at the end of the programme is 90%.

The service has seen a high level of pupil absence on scheduled visits that has impacted on uptake of HPV2 delivery.
The service is undertaking further visits to catch up on missed opportunities and a robust community offer is in place for the forthcoming summer holidays to improve uptake for both HPV1 and HPV2.

S12: HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 1
79.4% of the estimated cohort of children eligible for HPV 1st dose in the 2022/23 academic year had been immunised at the end of June 2023. This is cumulative performance compared to June target of 80%. Overall national target at the end of the programme is 90%.

Performance reflects the national picture of lower uptake than forecasted for the HPV 1 delivery.
The service is undertaking further visits to catch up on missed opportunities and a robust community offer is in place for the forthcoming summer holidays to improve uptake for both HPV1 and HPV2.
79.4% of the estimated cohort of children eligible for HPV 1st dose in the 2022/23 academic year had been immunised at the end of June 2023. This is cumulative performance compared to June target of 80%. Overall national target at the end of the programme is 90%.

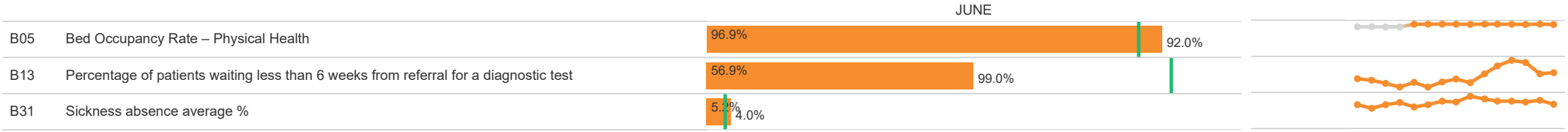
Performance reflects the national picture of lower uptake than forecasted for the HPV 1 delivery.
The service is undertaking further visits to catch up on missed opportunities and a robust community offer is in place for the forthcoming summer holidays to improve uptake for both HPV1 and HPV2.

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.*

B05: Bed Occupancy Rate – Physical Health
Bed occupancy for June is 96.9% (May was 98.1%) against a threshold of 91%. and is above the upper SPC limit. This position is being closely monitored through monthly inpatient governance meetings. The following wards were above the 91% threshold:

- Cirencester Hospital – Coln Ward (96.6%)
- Cirencester Hospital – Windrush Ward (95.9%)
- Dilke Hospital (97.3%)
- Lydney Hospital (97.0%)
- North Cotswold Hospital (97.6%)
- Stroud Hospital – Jubilee Ward (96.6%)
- Stroud Hospital – Cashes Green Ward (98.5%)
- Tewkesbury Hospital (93.6%)
- Vale Hospital (98.7%)

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 Jun 2023 indicates a performance of 57% (compared with 53.8% in May) 83 out of 193 patients referred for an echocardiogram had been waiting 6 weeks or more for the scan at the end of Jun 2023. (This includes a cohort of 21 in the 6 -7 week bracket). Target is 99%. This is below the SPC chart lower control limit.

Locum staff employed at GHT as an initiative to clear the waiting lists have recently completed their contracts.

The GHC Heart Failure service reported that on 4th July 2023, 43 patients are on the Priority Echo waiting list for an echocardiogram, and 188 patients on the Routine Echo Waiting list, which has increased from 145 at the end of May. 27 patients are still to be triaged for Echo which includes awaiting GPSI opinion. In addition, 3 patients on the Priority list have been admitted in the last 2 weeks; this has been escalated as part of the inpatient MDT.

B31: Sickness absence average % rolling rate - 12 months
Sickness absence rate in June 2023 was 5.2%. This does not include data from the e-rostering system (Allocate) because it is not available at the time of reporting. Sickness absence rate in May was 6.1% (including Allocate data) compared to a threshold of 4%. May performance is above the SPC chart upper control limit. The figure indicates in-month sickness absence, excluding Bank Staff.

An assessment has been undertaken to validate this indicator against native ESR reporting. Initial findings suggest an alignment between the measures, however with some minor methodology improvements required. This will not significantly change performance levels.

Operations Directorate sickness absence was 6.9% in May.
Sickness absence in May increased in the following sub-directorates within Operations:
Adult Community PH, MH & LD (7.7% to 8.5%), CYPS (5.1% to 5.5%), MH Urgent Care & Inpatient (7.3% to 7.6%), Operational Management (6.1% to 7.4%) and PH Urgent Care and Inpatient (6.2% to 6.4%)
Sickness absence in April decreased in the following sub-directorates within Operations:
Countywide (4.5% to 4.3%)

Nursing, Therapies and Quality Directorate sickness absence was 4.7% in May

Within the Nursing sub-directorate, sickness absence increased from 0% in April to 4.5% in May.
Within the Quality Assurance sub-directorate, sickness absence increased from 24.7% in April to 27.9% in May.

Executive Directorate sickness absence was 5.6% in May
Within the Corporate Governance sub-directorate, sickness absence increased from 5.1% in April to 6.8% in May.

Finance Directorate sickness absence was 3.9% in May.
Within the Facilities sub-directorate, sickness absence increased to 6.7% in May. The sites with the highest sickness absence levels within the Facilities sub-directorate are:
Forest 36.0% (increased from 0%), The Vale Hospital 21.7% (increased from 11.7%), Wotton Lawn Campus 20.1% (increased from 17.4%),
Pullman Place 10.9% (increased from 0%), Lydney Hospital 9.4% (increased from 6.5%), Cirencester Hospital 9.2% (decreased from 12.4%), Stroud Campus 7.4% (decreased from 7.6%), Rikenel 6.5% (decreased from 8.8%),

This reflects the sickness absence information on Tableau on 06/07/2023.

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This reflects the sickness absence information on Tableau on 06/07/2023.

Non-Exception highlights

The following indicators are not in exception but are highlighted for note:

- **L01: Talking Therapies (IAPT) Recovery rate: Access to psychological therapies for adults should be improved [Community MH Services]**

Performance for June is reported at 56.6% against an expected performance of 50%. This is the highest the recovery rate been since October 2020. Quarter 1 performance is 53.0%. The National Recovery threshold is defined as people who come in to service above casesness on symptom scores and leave below case. The 50% is the expected efficacy of CBT derived from randomised controlled trials that support the evidence base of CBT in this population. The Trust also monitors reliable improvement which isn't monitored Nationally – which is where people achieved a clinically significant reduction in their symptom scores. Reliable improvement fluctuates between 65% and 70% for GHC.

- **B07: Assessment of risk: Services users (excluding CPA) to have a documented risk assessment [Community MH Services]**

Although compliant in June at 85.8% against a performance threshold of 85% this indicator is highlighted for awareness as performance is below the lower SPC limit. Performance has shown a consistent downward trend since April 2022 when it was at 94.4%.

The services with most non-compliant cases are, Dementia, and Memory Assessment. To note; indicator *B06: Service users on CPA to have a documented risk assessment* is compliant in June at 99.6% against a performance threshold of 95%.

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AGENDA ITEM: 09/0723

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 July 2023**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Jo Masters, Mortality Review Officer
Gordon Benson, Quality Lead (Mortality, Engagement & Development)

SUBJECT: **LEARNING FROM DEATHS 2022/23 QUARTER 4 REPORT**

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:

The purpose of these reports is to inform the Trust Board of the learning from the mortality review process, data analysis and outcomes during Quarter 4 2022/23 (including year-end trend analysis) and also learning from End-of-Life care incidents, concerns and queries.

It is a regulatory requirement for all NHS Trusts to identify, report, investigate and learn from deaths of patients in their care, as set out in the National Quality Board *National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care*, published March 2017.

These reports aim to present a broad range of available demographic and clinical data, and a trend analysis comparing current data with previous years as requested by the Trust Board.

Recommendations and decisions required

The Trust Board is asked to **note** the contents of this Learning from Deaths Report.

Executive summary

Quarter 4 2022/23 Learning from Deaths Report

- No concerning trends or themes have been identified.
- This contains learning from End-of-Life care incidents, concerns and queries. 63% of reported incidents related to medicines management issues across the system; this has been fed back to the ICB via the End-of-Life Lead.
- There was an increase in the inpatient death rate for CoHos and Charlton Lane in December 2022; it has been observed that more patients are being transferred from the acute trust who require end-of-life care, and there was a higher number of patients on Willow Ward in receipt of end-of-life care in the last quarter.
- The mean age of death of community mental health patients for 2022/23 was 73 years, higher than that observed in 2021/22 (67 years). The importance of an annual health check for this cohort of patients continues to be promoted via Learning on a Page. Data re natural cause deaths for community mental health patients has been requested and this will be included in the quarterly reports for 2023/24 going forward.
- 'Learning on a Page' documents (available in the Reading Room in Diligent) are only generated where novel learning has been identified and 5 such learning summaries were generated this quarter. These have been shared with operational services via operational management email cascade, Pan-Ops Governance Group, and through display on the Patient Safety Notice Boards within inpatient services. These documents have also been shared with medics through Medical Directorate email cascade systems.
- Feedback from the Medical Examiner service continues to provide significant assurance that that the care provided to inpatients at the time of their death was of a good standard, that families were appreciative of the ME service input and were happy with the cause of death given, and gladly gave feedback about care when asked. The increase in referrals to the Coroner in Q4 relate to post operative patients being transferred to CoHos who subsequently died, with the operation being listed as a cause of death.
- Outcome of inquests are also shown, and it is clear that suicide prevention remains a key priority for the Trust, and as such, will continue as a Quality Priority in 2023/24.

Risks associated with meeting the Trust's values

There are no identified risks associated with learning from deaths associated with the Trust's values.

Corporate considerations	
Quality Implications	Required by National Guidance to support system learning
Resource Implications	Significant time commitment from clinical and administrative staff
Equality Implications	None

Where has this issue been discussed before?
Mortality Review Group meetings.

Appendices:	**AI-09.1 (PowerPoint slides)** Q4 2022/23 Learning from Deaths Report

Report authorised by: Dr Amjad Uppal	**Title:** Medical Director

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AGENDA ITEM: 09.1/0723

Q4 2022/23 Learning from Deaths Report

Jovelyn Masters, Mortality Review Officer
Gordon Benson, Quality Lead (Mortality, Engagement & Development)

Please see reading room for Learning on a Page Slides

Overview

Gloucestershire Health and Care
NHS Foundation Trust

- During 2022/23, 507 Gloucestershire Health and Care NHS Foundation Trust (GHC) patients died:

No. of GHC patient deaths reported during 2022/23				
Q1	Q2	Q3	Q4	Total
175	112	89	131	**507**

- During 2022/23 67 case record reviews and 30 comprehensive investigations were completed.

Number of comprehensive investigations and care record reviews completed during Q1-4 2022-23 for deaths occurring in:										
	Q2 20-21	Q1 21-22	Q2 21-22	Q3 21-22	Q4 21-22	Q1 22-23	Q2 2022-23	Q3 2022-23	Q4 2022-23	Total
Comprehensive investigations	0	2	0	1	14	8	3	2	0	**30**
Care record reviews	1	3	1	7	17	15	12	10	1	**67**
Total	**1**	**5**	**1**	**8**	**31**	**23**	**15**	**12**	**1**	**97**

- The numbers above do not include open comprehensive investigations and care record reviews.
- 3, representing 0.6% of the patient deaths reviewed during 2022/23, were judged more likely than not to have been due to problems in the care provided to the patient.
- **Learning**
- Learning from completed mortality reviews is presented as Learning on a Page. The following 5 slides show learning during Q4 2022/23 (Note that MR774 has been updated from Q1 so included here again). Learning on a Page documents are only generated where novel learning has been identified . For learning relating to comprehensive investigations, please refer to the Patient Safety Report. No Learning from LeDeR reviews documents were received during this quarter.
- Learning from End of Life care incidents, complaints and queries is shown in slides 8 & 9.

End of Life Learning from Datix, Concerns and Queries

Gloucestershire Health and Care NHS Foundation Trust

A total of 48 Low/No Harm end of life related Datix were raised in Q4 2022/23 (excluding Datix for Falls or Skin Integrity):

Month	No. of Low/No Harm Datix
January	22
February	10
March	16
Total	48

This number is slightly lower than Q3, however, there is still a high proportion (63% or 30 out of 48) of Datix that were medication related. The main themes were:

- Drug chart available but not the medication, medication available but not the drug chart or drug chart incorrect
- Stock sheet does not tally with the medication
- Request made to GP prior to incident for urgent prescriptions but not actioned in a timely manner resulting in OOH GP being contacted

The remaining Datix related to equipment delays, communication failures, discharge planning failures.

The End of Life Lead also reviewed and responded to 1 concern raised by a family in Q4 to identify learning.

Specific End of Life Learning

Gloucestershire Health and Care
NHS Foundation Trust

Learning for the Trust in Q4

- Confirmation that Verification of Death can be undertaken by any suitably trained clinician irrespective of when the patient last saw their GP
- Some incidents have highlighted the need for increased compassionate communication education and training across both our non-registered and registered colleagues. There are plans in place to implement this.
- Process/checklist developed for recording jewellery, dentures and pacemakers after a Community Hospital death

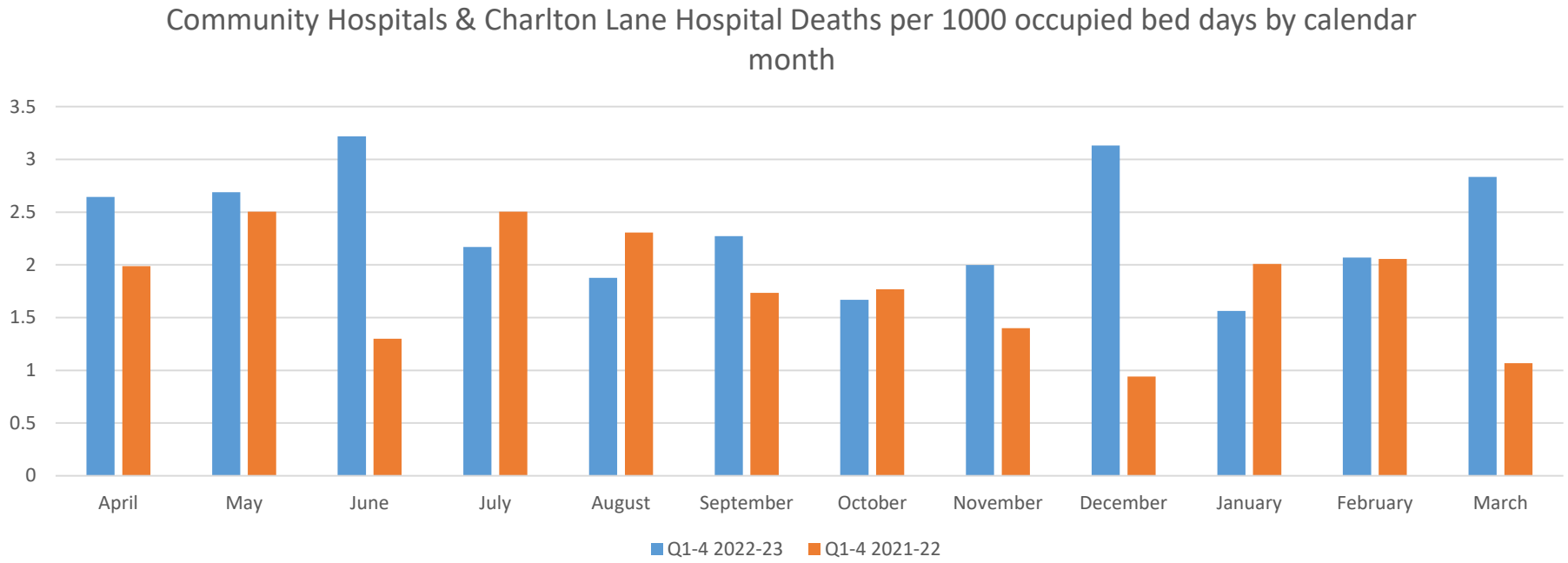
Learning for system partners in Q4

- All acute discharge issues are fed back to GHNHSFT as appropriate (e.g. discharges home with no equipment or care in place and no medication). End of Life lead at GHNHSFT aware and work is in progress to improve discharges. Rapid discharge (from acute) home to die pilot undertaken during Q4
- Feedback to ICB regarding GP's and timely issuing of prescriptions to avoid an OOH GP response
- Advice around the correct storage of controlled drugs given to a care home

Community Hospitals & CLH Inpatient Death Rate per Month

Gloucestershire Health and Care
NHS Foundation Trust

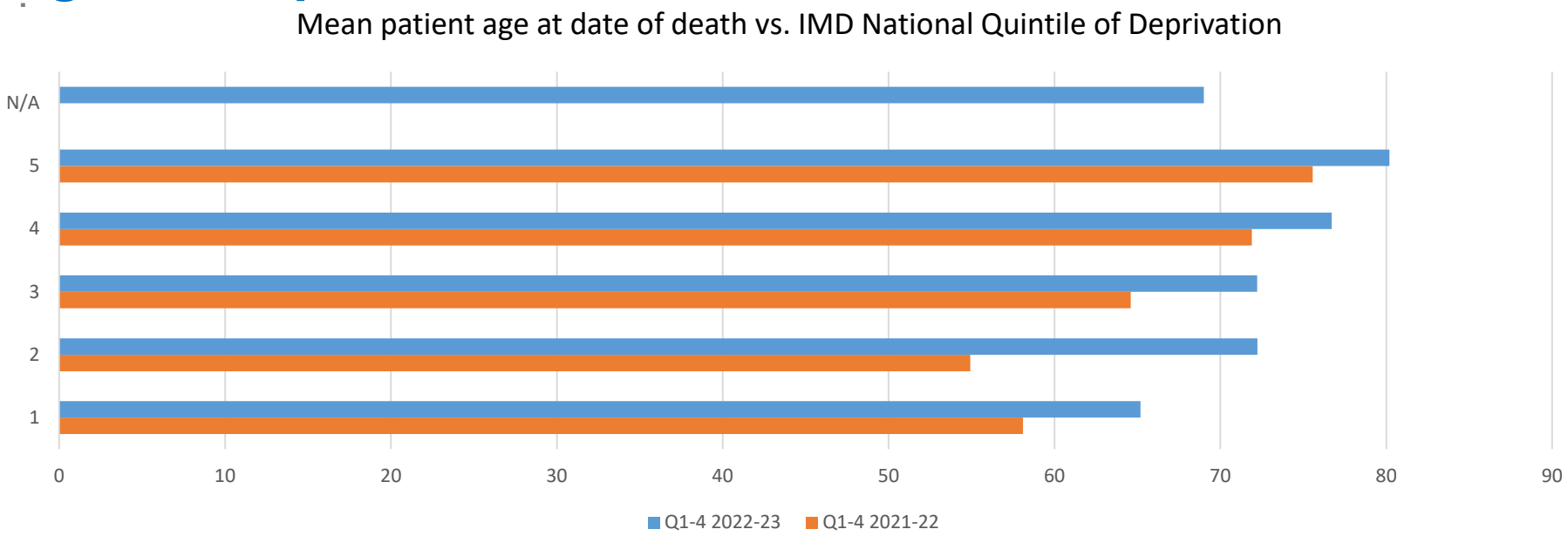
- During Q4 2022-23 there were 47 community hospital (CH) & Charlton Lane Hospital (CLH) inpatient deaths. Death rates in the chart below are given per 1000 occupied bed days. Comparison with rates observed in Q1-4 2021-22 are also shown, wherein there were 152 inpatient deaths in total for the whole financial year.



- There was an increase in the number of deaths during March 2023, which contrasts with information from March 2022

Community Mental Health Patients (Excluding those with a primary diagnosis of dementia and those on the MHICT caseload) Age vs. Deprivation

Gloucestershire Health and Care
NHS Foundation Trust



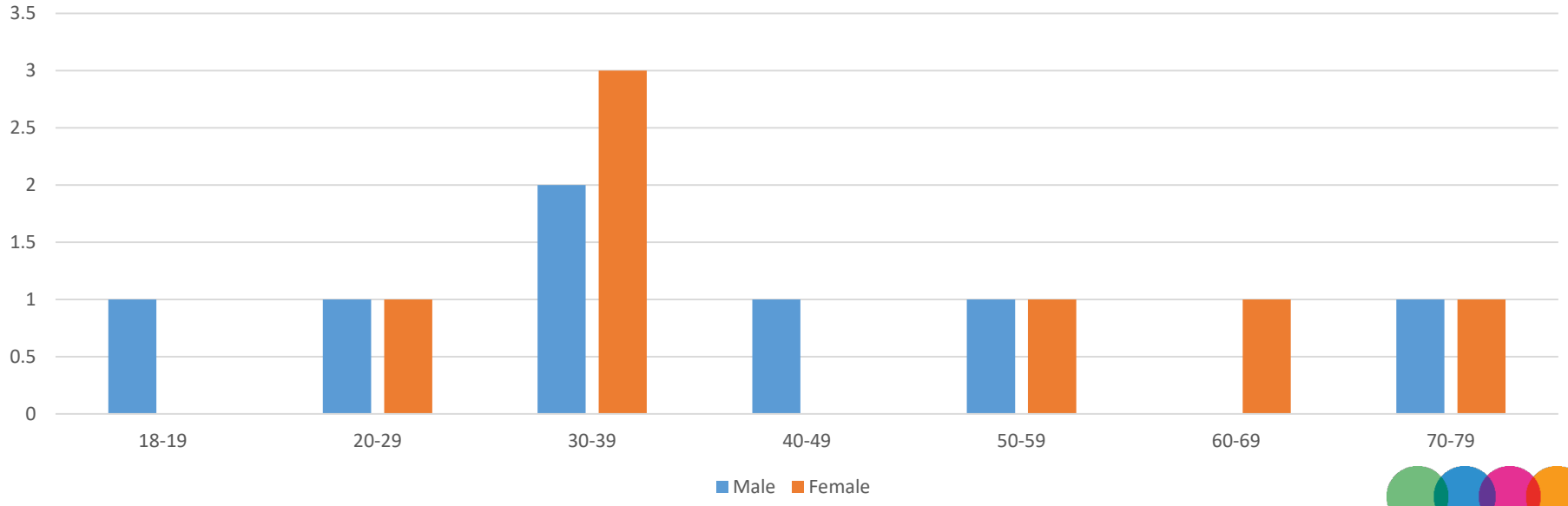
- Mean age at date of death by Index of Multiple Deprivation (IMD) 2019, national quintile of deprivation (1 most deprived, 5 least deprived), is shown in the chart above with comparison to Q1-Q4 2021-22 data.
- The data from Q1-4 2021-22 and Q1-4 2022-23 (small data set) shows a correlation between reduced deprivation and living longer, most noticeably at quintile 5 (least deprived) and remains consistent with our historical data.
- 2 patients were from out of county; as such, they were excluded from the county deprivation dataset and are shown as N/A.

Mental Health Patients (Excluding those with a primary diagnosis of dementia and those on the MHICT caseload) Patient Confirmed/Suspected Suicides – Age & Gender

Gloucestershire Health and Care NHS Foundation Trust

- During Q1-4 2022-23, there were 14 patient deaths by suspected suicide. All were patients open to community mental health teams.
- Distribution by age group and gender is shown below. There is a larger number of deaths of patients in the 30-39 age group.
- Of the 14 suspected deaths by suicide, 7 patients were male and 7 patients were female.

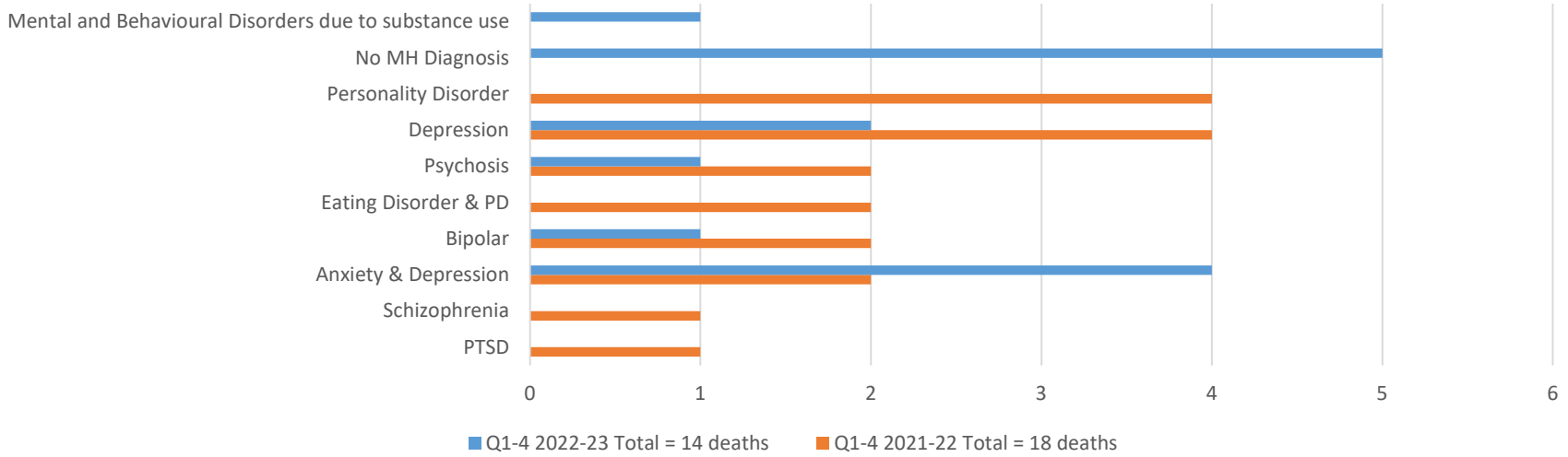
Q1-4 2022-23 Suspected patient deaths by suicide by age group and gender



Mental Health Patients (Excluding those with a primary diagnosis of dementia and those on the MHICT caseload) Patient Confirmed/Suspected Suicides - Diagnosis

Gloucestershire Health and Care NHS Foundation Trust

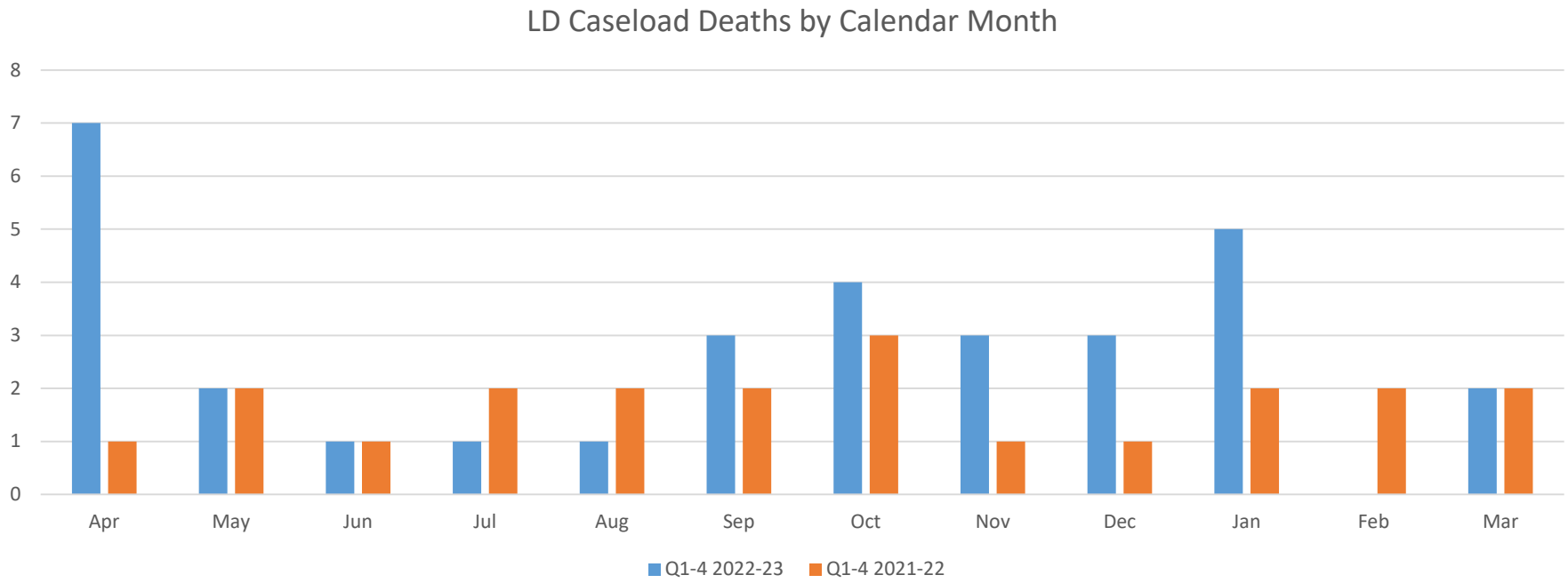
Q1-4 2022-23 Suspected suicide deaths by diagnosis compared to Q1-4 2021-22



- The diagnoses of the 14 patient deaths by suspected suicide which occurred during Q1-4 2022-23 are shown in the chart above, which included: depression, psychosis and anxiety & depression. 2 patient deaths that occurred in Q2 2022-23 have no formal mental health diagnosis due to no previous mental health input from GHC. 2 patient deaths that occurred in Q3 2022-23 were due to overdose, the nature of these overdoses are not yet established and are being investigated as serious incidents. 3 of the patient deaths that occurred in Q4 2022-23 fall under the No MH diagnosis category due to having no formal diagnosis.
- During 2021-22 Q1-Q4 depression and personality disorder were the most prevalent patient diagnoses.

Learning Disability Patients Deaths per Month

Gloucestershire Health and Care
NHS Foundation Trust

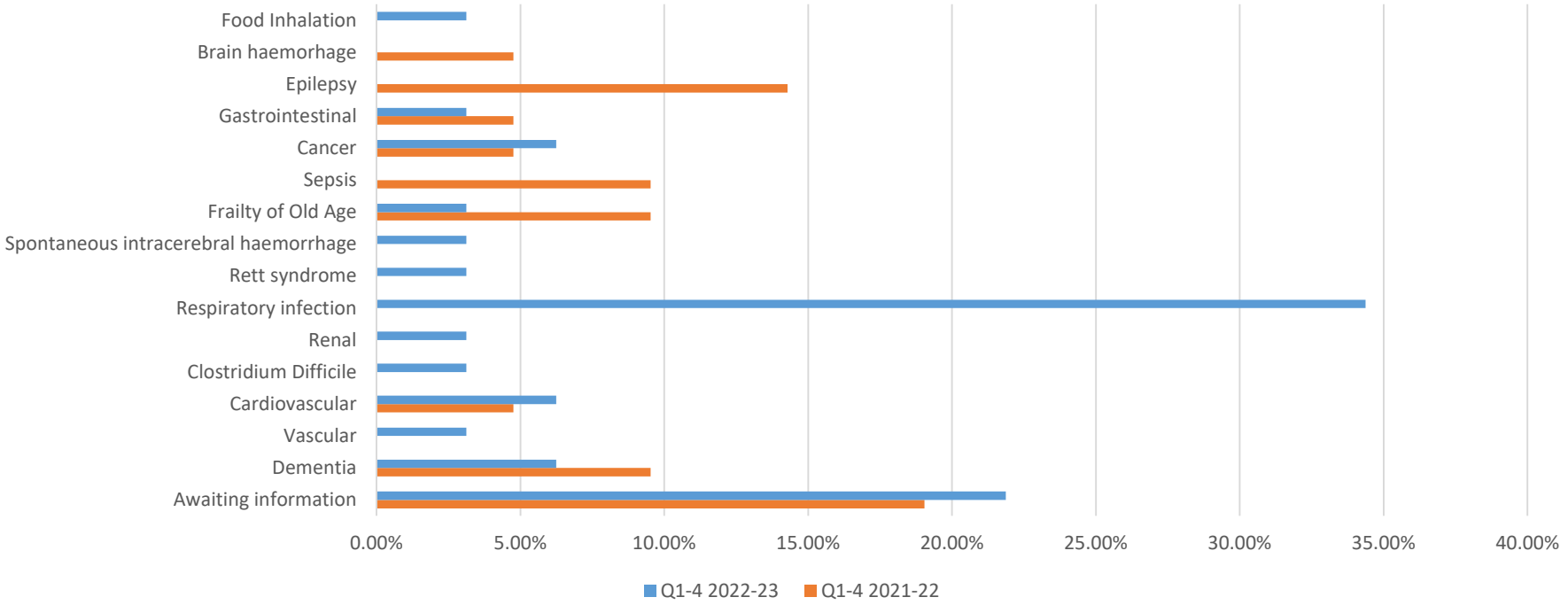


- During Q1-4 2022-23, there were 32 deaths of patients open to trust Learning Disability (LD) caseloads. Deaths per month are shown above with comparison to 2021-22 figures, wherein there were 21 LD caseload deaths in total.
- An increase in the number of LD caseload deaths was seen in January 2023, compared to 2021-22 monthly figures. Any attributable significance of this is currently unclear. All deaths have been referred to LeDeR for review.

Learning Disability Patients Cause of Death

Gloucestershire Health and Care
NHS Foundation Trust

Q1-4 2022-23 and Q1-4 causes of death categories expressed as a percentage of total deaths



- Of the 32 LD caseload deaths occurring during Q1-4 2022-23, respiratory infections are reported to be the most prevalent cause of death.
- Epilepsy was the most prevalent cause of death during Q1-4 2021-22.
- During Q1-4 2022-23, **zero** LD caseload deaths were reported to be COVID-19 related.

Medical Examiner KPIs

Gloucestershire Health and Care
NHS Foundation Trust

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD
Number of deaths generating MCCD resolved with the input of the ME service													
Number	54			51			52			55			212
Number of times a MCCD is rejected by Registrar and reason this occurs	0			0			1*			0			1
Number of referrals to the Coronial Service													
Number	2 referred to Coroner for PM and 3 with a 100A form issued to cover MCCDs featuring unnatural events e.g., fractured hips			2 referred to Coroner for inquest. 2 patients with a 100A form issued to cover MCCDs featuring unnatural events e.g., falls			1 referred to Coroner for inquest. 2 patients with a 100A form issued to cover MCCDs featuring unnatural events e.g., falls			8 referred to Coroner of which 7** patients with 100A form issued to cover MCCDs featuring fractures/operations.			13
Complaints made by bereaved relatives due to perceived delays to completion and release of MCCD (end to end timescales examined)	0			0			0			0			0

* MCCD rejected as Dr completing the form had not looked after the patient in life, or in the last 28 days prior to death. This is covered by Learning on a Page MR1280

** More patients were transferred from GHFT who had operations during Q4, with operations being listed a cause of death but with no further investigation required.

Feedback & Learning from ME Input

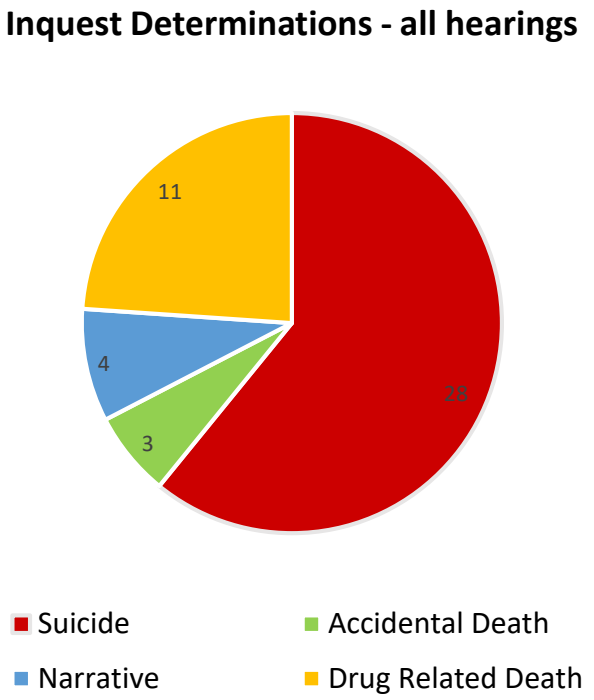
Compliments - Examples received at the end of Q4 2022-23. Full details are now shared quarterly via MRGs

- ***Lydney Hospital.*** *Feedback from relative: 'Wonderful supportive care'*
- ***Cirencester Hospital.*** *Feedback from relative: 'Faultless care, very happy'*
- ***Stroud Hospital.*** *Feedback from relative: 'Very pleased with care'*
- ***The Dilke Hospital.*** *Feedback from relative: 'Fantastic level of care'*
- ***Tewkesbury Hospital.*** *Feedback from relative: 'High quality care'*
- ***North Cotswolds Hospital.*** *Feedback from relative: 'Received wonderful care'*
- ***The Vale****. Feedback from relative: 'Wonderful care to patient and relatives'*
- ***Charlton Lane Hospital, Willow Ward.*** *Feedback from relative: 'Fantastic care'*

Complaints **-** *None received*

Coronial Activity

During 2022/23, 46 inquests were heard which touched on the deaths of Trust patients. The outcomes of these inquests are shown in the graph below. Based on the outcomes of inquests *suicide prevention* remains a key priority for the Trust.



No Prevention of Future Deaths Reports were issued to the Trust during 2022/23. This is a good indicator that the Trust implements appropriate recommendations following investigations and is able to assure HM Coroners, through evidence, that care is of a good standard and identified learning is robustly carried out.

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AGENDA ITEM: 10/0723

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 July 2023**

PRESENTED BY: Sandra Betney, Director of Finance

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 30th June 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 is asked to:

- **Note** the month 3 position
- **Approve** the amendment to disposals in the capital programme

Executive summary

- Final accounts were submitted to NHS Improvement on 29th June 2023
- The current system plan is break even and the Trust's plan is break even
- At month 3 the Trust has a surplus of £0.046m compared with a planned surplus of £0.12m
- 23/24 Capital plan is £17.785m and spend to month 3 is £3.188m against a plan of £5.241m
- Cash at the end of month 3 is £47.614m
- The Trust spent £2.304m on agency staff in month 3. This equates to 4.2% of total pay compared to the agency salary cap of 3.7%.
- An additional capital disposal of £400k has been added to the capital plan for 24/25.

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:	**AI-11.2** Presentation: Finance Report Month 3

Report authorised by:	**Title:**
Sandra Betney	Director of Finance and Deputy CEO

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AGENDA ITEM: 10.1/0723

Finance Report
Month 3

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

Overview

- Final accounts were submitted to NHS Improvement on 29th June 2023
- There were no material amendments to the position from the Trust Board report in May, and the year end performance for GHC was a performance surplus of £0.036m
- The current system plan is break even and the Trust's plan is break even
- At month 3 the Trust has a surplus of £0.046m compared with a plan of £0.12m
- 23/24 Capital plan is £17.785m and spend to month 3 is £3.188m against a plan of £5.241m
- Cash at the end of month 3 is £47.614m
- Cost improvement programme has delivered £3.129m of recurring savings, of which £0.562m remains subject to QEIA sign-off. Target for the year is £5.443m.
- Non recurring savings delivered in month 3 of £1.122m
- The Trust spent £2.304m on agency staff in month 3. This equates to 4.2% of total pay compared to the agency salary cap of 3.7%.
- Better Payment Policy shows 99.1% of invoices by value paid within 30 days, the national target is 95%
- System position at month 3 is a £683k over spend which reflects the financial impact of the Industrial Action at GHFT
- An additional capital disposal of £400k has been added to the capital plan for 24/25. The Board is asked to approve this addition.

GHC Income and Expenditure

Gloucestershire Health and Care
NHS Foundation Trust

Statement of comprehensive income £000	2023/24 NHSE Plan	2023/24 Original Budget	2023/24 Revised budget	2023/24 YTD revised budget	2023/24 YTD Actuals
Operating income from patient care activities	251,464	252,915	255,733	63,933	65,886
Other operating income	12,792	11,409	15,288	3,822	4,582
Employee expenses - substantive	(184,330)	(201,415)	(206,620)	(51,655)	(47,927)
Bank	(11,698)	(1,704)	(1,984)	(496)	(4,514)
Agency	(7,952)	(863)	(863)	(216)	(2,304)
Operating expenses excluding employee expenses	(59,034)	(59,076)	(59,743)	(14,936)	(15,627)
PDC dividends payable/refundable	(2,580)	(2,590)	(2,590)	(648)	(647)
Finance Income	1,383	1,383	825	206	627
Finance expenses	(153)	(153)	(153)	(38)	(48)
Surplus/(deficit) before impairments & transfers	**(108)**	**(94)**	**(108)**	**(27)**	**28**
Remove central PPE stock impact					
Remove capital donations/grants I&E impact	108	94	108	27	18
Surplus/(deficit)	**0**	**0**	**0**	**0**	**46**
WTEs	4433	4405	4413	4413	4065

NB: WTE actuals only include substantive

GHC I & E Forecasts

Gloucestershire Health and Care
NHS Foundation Trust

Statement of comprehensive income £000	2023/24	2024/25	2025/26	2026/27	2027/28
	Forecast £000s	Forecast £000s	Forecast £000s	Forecast £000s	Forecast £000s
Operating income from patient care activities	261,179	254,495	256,540	258,598	260,585
Other operating income	16,866	15,961	16,149	16,339	16,841
Employee expenses - substantive	(187,038)	(184,985)	(186,100)	(187,648)	(189,223)
Bank	(18,055)	(18,676)	(19,050)	(19,431)	(19,819)
Agency	(8,716)	(7,535)	(7,591)	(7,662)	(7,735)
Operating expenses excluding employee expenses	(62,360)	(57,334)	(57,917)	(58,062)	(58,408)
PDC dividends payable/refundable	(2,590)	(2,690)	(2,790)	(2,890)	(2,990)
Finance Income	825	825	825	825	825
Finance expenses	(209)	(162)	(164)	(165)	(169)
Surplus/(deficit) before impairments & transfers	**(97)**	**(101)**	**(97)**	**(97)**	**(93)**
Remove central PPE stock impact					
Remove capital donations/grants I&E impact	97	106	103	98	98
Surplus/(deficit)	**(0)**	**5**	**6**	**1**	**5**

PAY ANALYSIS

Gloucestershire Health and Care
NHS Foundation Trust

Pay analysis month 3									
	Budget year to date £000s		Budget plus Pay award £000s		Actual £000s		Variance £000s		Actual as % of Total
Substantive	51,665		53,215		47,927		5,288		87.5%
Bank	496		511		4,514		(4,003)		8.2%
Agency	216		222		2,304		(2,082)		4.2%
Total	**52,377**		**53,948**		**54,745**		**(797)**		**100.0%**

Comments

- 23/24 pay award of 5% processed in June and included in Actual costs, including back dated to April
- Budgets not yet uplifted for full 5% increase while level of income to cover the award is assessed
- Potential recurring cost pressure of c. £1.77m
-4.2% of pay bill spent on agency year to date. System agency cap 3.7%

GHC Balance Sheet

Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		2022/23	2023/24				2023/24	2024/25	2025/26	2026/27	2027/28
		Actual	Plan	YTD Plan	YTD Actual	Variance	Full Year Forecast	Forecast £000s	Forecast £000s	Forecast £000s	Forecast £000s
Non-current assets	Intangible assets	1,370	821	1,028	1,278	250	1,002	832	589	346	103
	Property, plant and equipment: other	113,537	143,163	135,667	115,170	(20,497)	125,629	131,118	131,390	131,112	130,896
	Right of use assets*	17,715	19,028	20,126	17,120	(3,006)	17,211	17,707	16,157	14,607	13,057
	Receivables	1,085	511	514	1,028	514	992	820	796	772	748
	Total non-current assets	**133,707**	**163,522**	**157,334**	**134,596**	**(22,738)**	**144,834**	**150,477**	**148,932**	**146,837**	**144,804**
Current assets	Inventories	406	494	494	398	(95)	398	398	398	398	398
	NHS receivables	14,538	4,300	4,230	7,495	3,265	9,995	13,174	13,124	13,094	13,064
	Non-NHS receivables	7,165	8,738	8,738	8,404	(333)	6,904	6,446	6,346	6,296	6,246
	Credit Loss Allowances	(2,163)	(2,163)	(2,163)	(2,135)	28	(2,135)	(2,135)	(2,135)	(2,135)	(2,135)
	Property held for Sale	3,697	0	0	3,697	3,697	0				
	Cash and cash equivalents:	48,836	42,044	46,215	47,641	1,426	43,605	39,435	40,898	42,836	44,821
	Total current assets	**72,480**	**53,412**	**57,513**	**65,500**	**7,987**	**58,767**	**57,318**	**58,631**	**60,489**	**62,394**
Current liabilities	Trade and other payables: capital	(4,343)	(5,594)	(2,594)	(3,408)	(814)	(4,408)	(4,049)	(4,049)	(4,049)	(4,049)
	Trade and other payables: non-capital	(38,870)	(25,865)	(28,509)	(34,846)	(6,337)	(35,556)	(36,918)	(36,918)	(36,918)	(36,918)
	Borrowings*	(1,446)	(1,345)	(1,584)	0	1,584	(1,345)	(1,345)	(1,345)	(1,345)	(1,345)
	Provisions	(7,882)	(6,511)	(6,079)	(7,283)	(1,204)	(7,238)	(7,349)	(7,349)	(7,349)	(7,349)
	Other liabilities: deferred income including contract liabilities	(1,107)	(2,478)	(2,478)	(1,086)	1,393	(1,086)	(1,115)	(1,115)	(1,115)	(1,115)
	Total current liabilities	**(53,649)**	**(41,793)**	**(41,244)**	**(46,622)**	**(5,378)**	**(49,632)**	**(50,776)**	**(50,776)**	**(50,776)**	**(50,776)**
Non-current liabilities	Borrowings	(15,298)	(18,265)	(18,367)	(16,207)	2,160	(14,986)	(16,426)	(16,291)	(16,161)	(16,036)
	Provisions	(2,480)	(2,538)	(2,538)	(2,480)	58	(2,480)	(2,480)	(2,480)	(2,480)	(2,480)
	Total net assets employed	**134,761**	**154,338**	**152,698**	**134,788**	**(17,910)**	**136,504**	**138,113**	**138,016**	**137,909**	**137,906**
Taxpayers Equity	Public dividend capital	130,166	132,056	130,215	130,166	(49)	132,007	133,848	133,848	133,848	133,848
	Revaluation reserve	10,053	13,124	13,124	10,052	(3,071)	10,052	10,052	10,052	10,052	10,052
	Other reserves	(1,241)	(1,241)	(1,241)	(1,241)	0	(1,241)	(1,241)	(1,241)	(1,241)	(1,241)
	Income and expenditure reserve	10,733	10,508	10,508	(4,217)	(14,725)	(4,217)	(4,431)	(4,649)	(4,741)	(4,848)
	Income and expenditure reserve (current yea	(14,950)	(108)	93	28	(65)	(97)	(115)	6	(9)	95
	Total taxpayers' and others' equity	**134,761**	**154,338**	**152,698**	**134,788**	**(17,910)**	**136,504**	**138,113**	**138,016**	**137,909**	**137,906**

Cash Flow Summary

Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	YEAR END 22/23		YTD ACTUAL 23/24		FULL YEAR FORECAST 23/24		2024/25 Forecast £000s	2025/26 Forecast £000s	2026/27 Forecast £000s	2027/28 Forecast £000s
Cash and cash equivalents at start of period		**58,896**		**48,836**		**48,836**	**43,605**	**39,435**	**40,898**	**42,836**
Cash flows from operating activities										
Operating surplus/(deficit)	(13,138)		96		1,877		**1,806**	**2,039**	**2,130**	**2,338**
Add back: Depreciation on donated assets	84		18		97		0	0		0
Adjusted Operating surplus/(deficit) per I&E	**(13,054)**		**114**		**1,974**		**1,806**	**2,039**	**2,130**	**2,338**
Add back: Depreciation on owned assets	7,918		2,013		5,768		9,605	9,839	10,144	10,082
Add back: Impairment	14,781				0		0	0	0	0
(Increase)/Decrease in inventories	88		8		8		0	0	0	0
(Increase)/Decrease in trade & other receivables	(7,765)		5,862		4,869		650	174	104	104
Increase/(Decrease) in provisions	3,576		(599)		(644)		(500)	0	0	0
Increase/(Decrease) in trade and other payables	10,119		(4,666)		(3,317)		(2,649)	0	0	0
Increase/(Decrease) in other liabilities	(1,301)		(22)		(22)		0	0	0	0
Net cash generated from / (used in) operations		**14,362**		**2,710**	**0**	**8,636**	**8,912**	**12,052**	**12,378**	**12,524**
Cash flows from investing activities										
Interest received	1,144		627		825		825	825	825	825
Interest paid			(2)		(209)		0	(7)	(7)	(7)
Purchase of property, plant and equipment	(22,650)		(4,123)		(12,534)		(15,209)	(15,318)	(8,073)	(8,073)
Sale of Property	0				0		2,454	7,000	0	0
Net cash generated used in investing activities		**(21,506)**		**(3,498)**	**0**	**(11,918)**	**(11,930)**	**(7,500)**	**(7,255)**	**(7,255)**
Cash flows from financing activities										
PDC Dividend Received	1,886				1,841		**1,841**	**0**	**0**	**0**
PDC Dividend (Paid)	(3,217)				(2,194)		**(2,690)**	**(2,790)**	**(2,890)**	**(2,990)**
Finance lease receipts (principal and interest)	216		12		48					
Finance Lease Rental Payments	(1,632)		(373)		(1,492)		**(162)**	**(164)**	**(165)**	**(169)**
Finance Lease Rental Interest	(169)		(46)		(153)		**(141)**	**(135)**	**(130)**	**(125)**
		(2,916)		**(407)**	**0**	**(1,950)**	**(1,152)**	**(3,089)**	**(3,185)**	**(3,284)**
Cash and cash equivalents at end of period		**48,836**		**47,641**	**0**	**43,605**	**39,435**	**40,898**	**42,836**	**44,821**

Capital – Five year Plan

Gloucestershire Health and Care
NHS Foundation Trust

Capital Plan	Plan	Plan ytd	Actuals to date	Forecast Outturn	Plan	Plan	Plan	Plan
£000s	2023/24	2022/23	2023/24	2023/24	2024/25	2025/26	2026/27	2027/28
Land and Buildings								
Buildings	2,400	125	23	2,400	1,000	3,000	3,000	3,000
Backlog Maintenance	1,045	120	67	1,045	1,250	1,393	1,393	1,393
Buildings - Finance Leases	784			784	1,945	0	0	0
Vehicle - Finance Leases	384			459	239	0		0
Net Zero Carbon	500			500	500	500	500	500
LD Assessment & Treatment Unit					2,000	0	0	
Cirencester Scheme						5,000	0	
							0	
Medical Equipment	500	125	1	500	1,030	1,030	1,030	1,030
IT								
IT Device and software upgrade			0		600	600	600	600
IT Infrastructure	1,130	295	0	1,130	1,300	1,300	1,300	1,300
Clinical Systems Vision	2,191	70	10	2,191	3,161	1,250	250	250
Sub Total	**8,934**	**735**	**101**	**9,009**	**13,025**	**14,073**	**8,073**	**8,073**
Forest of Dean	8,851	4,313	3,087	8,851	0	0	0	0
Total of Original Programme	**17,785**	**5,048**	**3,188**	**17,860**	**13,025**	**14,073**	**8,073**	**8,073**
Disposals	(3,749)			(3,749)	(2,854)	(2,000)	0	0
Total CDEL	**14,036**	**5,048**	**3,188**	**14,111**	**10,171**	**7,073**	**8,073**	**8,073**
New Leases								
Buildings	784	97	0	784	1,945			
Vehicles	384	96	0	384	239			
Total	**1,168**	**193**	**0**	**1,168**	**2,184**	**0**	**0**	**0**

Additional disposal of £400k added to the capital plan in 24/25

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	2,100	2,100	0	3	4	12
Cost share changes for Section 117 patients leads to additional costs not reimbursed	1,000	1,000	0	2	3	6
Savings without a plan don't deliver	1,732	1,732	0	4	3	12
Maintenance costs rise due to inflationary pressures	750	750	0	3	3	9
Utility, fuel, waste costs rise due to inflationary pressures	500	500	0	3	2	6
23/24 pay award under funded	1,777	1,777	0	4	3	12
Capital cost inflation leads to capital programme being reduced	750	1,000	-250	3	3	9
Mental Health Act White paper reforms	750	1,000	-250	4	3	12
Microsoft Licenses cost pressure from national deal	250	250	0	4	2	8
Risk of loss from disposal of land and building sales (CDEL)	400	0	400	2	2	4
Total of all risks	**10,009**	**10,109**	**-100**			

System position

Gloucestershire Health and Care
NHS Foundation Trust

Draft System Position Month 3 23/24		Net Expenditure Plan 31/05/2023 YTD £'000	Net Expenditure Actual 31/05/2023 YTD £'000	Net Expenditure Variance 31/05/2023 YTD £'000
Total ICB Net Expenditure		**318,626**	**318,351**	**275**
Provider 1 - Gloucestershire Health And Care NHS Foundation Trust		**120**	**46**	**(74)**
Provider 2 - Gloucestershire Hospitals NHS Foundation Trust		**(6,946)**	**(7,831)**	**(885)**

with you, for you

NHS

Gloucestershire Health and Care

NHS Foundation Trust

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

AGENDA ITEM: 11/0723

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 JULY 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** Non-Executive Director – Summary of Activity – May and June 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:

- The Non-Executive Directors and I continue to meet regularly as a group, and a meeting took place on 18th July. 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 July meeting we had a focused discussion on the System Oversight Framework and the Director of Finance joined the meeting to provide an overview.

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

- On 11th July, Non-Executive Directors and I visited the new **Forest hospital** site. Since my last visit, I was delighted to see the amount of progress made.

- Our programme of Quality Visits continues to be a crucial part of Non-Executive and Chair activity. Since the last meeting, we have participated in four visits across the breadth of Trust services including Complex Leg Wound Service, Adult Speech and Language Therapy Service, Gloucester Recovery Service and Speech and Language Therapy – Children and Young People Service. Quality Visits are an important way for Non-Executive Directors to gain a greater understanding of, and insight into the services provided by the Trust and to seek assurance around the quality of care provided.

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.

- Following a competitive tender process, the Trust has engaged with TheValueCircle to support the next phase of our development to ensure that the Board is best placed to lead the organisation through a period of change and ensure the delivery of the five-year strategic plan for the benefit of the people we serve.

- The **Board Strategic Away Day,** facilitated by TheValueCircle, took place on 3rd and 4th July. The purpose of the session was to:
  - To explore our strategy in a dynamic and engaging environment
  - To test our ambition and appetite for change
  - To discuss what we are envisaging as the Board to make this feel different to what has come before
  - To begin developing the boundaries for our strategy and what Board leadership will be required
  - To develop relationships and behaviours as a Board

- I am sure Board colleagues will agree the Away Day was very rewarding with significant progress made. We are in the process of reviewing the outputs from this session which will inform our future development programme.

- A Board seminar on **Risk Appetite** took place on 7th June. The session was an opportunity to refresh Board members on the importance of risk appetite and tolerance, introduce best practice and agree an updated and refreshed risk appetite statement for the Trust. This is currently being finalised and will be presented to a future meeting of the Board.

3. GOVERNOR UPDATES

- I continue to meet on a regular basis with the **Lead Governor Chris Witham** along with Director of Corporate Governance & Trust Secretary, Lavinia Rowsell, and Assistant Trust Secretary, Anna Hilditch, to discuss agenda planning for Council of Governors meetings.

- A short Council of Governors meeting took place on 12th July. Governors approved the **reappointment of Dr Steve Alvis**, Non-Executive Director, to serve a further three-year term from 19th November 2023. The Council of Governors also formally received the Trust's Annual Report and Accounts 2022/23 in advance of presentation to the Annual Members Meeting on 13 September 2023.

- A **Council of Governors Development Session** also took place on 12th July where the Council received a helpful service presentation from our Eating Disorders Service. The Council also received the outcome of the Annual Governor self-assessment exercise. The NHS Code of Governance says that the Council of Governors should carry out periodic assessments on its own

performance. Due to Covid, this is the first self-assessment of effectiveness that the Council has done for a number of years and it provides a useful baseline for the Council to consider any improvements it wishes to make to the way in which it carries out its role.

- Our **programme of visits to sites for Trust Governors** is progressing well with visits to Tewkesbury Hospital and Charlton Lane in Cheltenham having taken place since the last meeting. 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 meeting of the **Nominations and Remuneration Committee** took place on 29th June. The Committee noted the positive outcome from the annual NED appraisals for 2022/23, noted the guidance from NHSE providing clarification around Chair and NED reappointments and independence, and noted the work underway for the recruitment of a new Trust Chair.

- The Trust commenced its **nomination process** for six Public Governor positions on 11th July. We have a number of Governors coming to the end of their first terms over the summer. Communications have gone out to all Public Members inviting people to consider standing for the very important role of Governor. I will include a further update on the outcome of the elections in my next report in September.

4. NATIONAL AND REGIONAL MEETINGS

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

- **NHS Confederation Mental Health Chairs' Network** – meetings take place weekly and I attend when my diary permits. Following the Metropolitan Police policy announcement that they would stop attending emergency calls relating to mental health, a special network meeting took place on 9th June Chaired by Claire Murdoch, National Mental Health Director, NHSE. Jan Marriott attended on my behalf. In response to a question from one of our public governors in relation to this announcement, we have considered the impact of the National Police Strategy *Right Care Right Person 2023* and will continue to work closely with Gloucestershire Constabulary to ensure there is a joint, partnership approach to these issues.

- I joined the **NHS Providers Chair and Chief Executives Network** meeting on 29th June. At the meeting we received strategic policy updates from Sir Julian Hartley, Chief Executive, NHS Providers and Miriam Deakin, Director of Policy and Strategy, NHS Providers. Luisa Stewart, Director of Policy for Mental Health, Learning Disability and Autism discussed tackling health inequalities for people with a learning disability and autism and we received an update on

CQC's developing approach to inspection, rating and regulation from Ian Trenholm, Chief Executive, CQC.

- As a Trust we will be participating as a sponsoring organisation in GatenbySanderson's **Insight South West Programme** for aspiring Non-Executive Directors. The programme is designed to support individuals from under-represented groups to become Non-Executive Directors. As part of the programme I will provide mentoring and support to aspiring NHS NEDs.

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:

- Following recent Wotton Lawn press coverage, the Chief Executive and I met with **Councillor Andrew Gravells**, **Chair** and **Councillor David Drew, Vice Chair** of the **Health Overview and Scrutiny Committee** in order to provide a briefing.

- The Chief Executive, Director of Strategy and Partnerships and I attended the County Council's **Health Overview and Scrutiny Committee on** 11th July. The meeting primarily focused on GHT Maternity Services (Temporary Changes) Update, and reports from the Gloucestershire Integrated Care System and NHS Gloucestershire Integrated Care Board.

- On 20th June, I was invited by **Deborah Evans, Chair of Gloucestershire Hospitals NHS Foundation Trust** to take part in a Focus Group session as part of the recruitment process for a **Chief Executive Officer. Deborah Lee**, **Chief Executive Officer** will stand down in March 2024. Subsequently, **Kevin McNamara,** currently Chief Executive at Great Western Hospitals, has been appointed as the new Chief Executive.

- A meeting of the **Integrated Care Board** took place on 26th July where a number of important operational and strategic issues were discussed. The Chief Executive, Vice-Chair, Graham Russell and I were in attendance. An **Integrated Care Board Extraordinary** meeting took place on 28th June where the annual report and accounts for NHS Gloucestershire ICB for 2022-23 were approved.

- A full day **ICB Board Development Session** took place on 6th June and was attended by myself, the Chief Executive and Vice-Chair, Graham Russell. Further detail is provided in the Chief Executive's report.

- Vice-Chair, Graham Russell and I visited the **SWAST Emergency Services Triage Clinical Hub** on 13th June where we met with Mental Health Teams. Graham and I also had the opportunity to meet with Matt Truscott, Head of Mental Health.

- 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. Deborah and I look forward to the next round of joint Chairs' visits which are in the process of being organised.

- I met with **Dame Gill Morgan, Chair of the NHS Gloucestershire Integrated Care Board** on 12th July. On a quarterly basis I also meet with Dame Gill Morgan, and Deborah Evans, Chair of the Gloucestershire Hospitals NHS Foundation Trust.

6. WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

- As the development of the new Forest of Dean Hospital takes shape, it was my pleasure to provide an update on progress to the **Forest Health Forum** on 6th July and to **Chris Brown, Chief Executive of Forest Voluntary Action Forum in Cinderford** on 19th July. More information on progress can be found in the Chief Executive's report.

- I was delighted to receive a letter from The Rt Hon Dr Andrew Murrison MP at the Ministry of Defence congratulating the Trust on achieving **Gold status under the Defence Employer Recognition Scheme**. This is a wonderful achievement which the Trust can be very proud of. My big thanks and congratulations to Andy Collins-Mills, Associate Director Workforce Systems, Planning & Temporary Staffing and the team who have led on this.

- The Chief Executive, Director of Strategy and Partnerships and I held a quarterly meeting with the **Chairs of the County's Leagues of Friends** on 22nd June. This was an opportunity for the Trust to provide updates on a number of important activities that have been taking place over the last few months, including an update from Dawn Allen, Service Director on the Community Assessment Treatment Unit (CATU) and progress on the new Forest hospital. The next meeting will be held in September.

- I attended the annual **Bishop's Garden Party** on 19th July. This is always a wonderful networking event, particular amongst third sector, voluntary agencies and other public sector agencies and this year was no exception.

- Regular briefings with the county's MPs continue. I met with **Richard Graham, MP for Gloucester** on 24th July and will meet with **Alex Chalk, MP for Cheltenham** on 8th September and **Laurence Robertson, MP for Tewkesbury** on 13th September.

7. ENGAGING WITH OUR TRUST COLLEAGUES

- On Saturday 10th June, I attended the **Dilke Hospital Centenary Celebrations**. The weather played its part which enabled everyone to enjoy an afternoon of light refreshments, music and entertainment. Huge thanks to the **Dilke League of Friends** who organised the event.

- I had the pleasure of supporting and participating in the **15th Big Health and Wellbeing Open Day – "All Age all Disability"** which took place on 16th June at Oxstalls Sports Centre.

  My sincere thanks to Simon Shorrick, Strategic Health Facilitator – Learning Disabilities and Big Health and Wellbeing Open Day – Lead Co-ordinator and his team for once again making the day a huge success.

- As part of the **National Healthcare Estates and Facilities Day** on 21st June, I recorded a video thanking all of our Estates and Facilities colleagues for everything they do, every day, to keep our services running. I also had the opportunity to meet staff at Southgate Moorings where I handed out thank you cards as well as department fleeces. I hope the day went some small way towards helping our estates and facilities colleagues feel valued and recognised for the very important work that they do.

- I carried out a very interesting **quality visit** on 21st June with Che-Ming Leung, Principal Speech and Language Therapist. I spent time in discussion with Che-Ming and her team who are based at Southgate Moorings.

- To celebrate with local people and communities the **NHS's 75th birthday** on 5th July, along with Gloucestershire leaders from the NHS, local authorities, VCSE and public sector partners, I was delighted to be invited to participate in filming a short video clip focussing on shared priorities to build a better Gloucestershire - covering both health and wellbeing and joined up care and service. The film which was aired on social media on 5th July gave personal perspectives on the importance and value of the NHS today and highlighted the power of partnership and integration and how this benefits local people and communities.

- On 6th July, the Chief Executive and I attended the **NHS75 Service** at **Gloucester Cathedral**. Following Evensong, I, along with NHS leaders and community partners, offered reflections on the significant contributions made by the county's dedicated health and care professionals over the years.

- On 8th July I represented the NHS at the NHS birthday **Park Run** at Plock Court and presented a certificate to Greg Adams in recognition of his embodiment of the ethos of mutual support underpinning both the NHS and Park Run.

- I continue to attend the Trust's Committees on a rotational basis. Due to a previous commitment in my calendar, I was unable to attend the **Working**

Together Advisory Committee which took place on 19th July and Vice-Chair, Graham Russell, attended in my absence.

- 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.

- I have dedicated a significant proportion of my time throughout April, May and June preparing and undertaking **annual appraisals** for the Trust's seven Non-Executive Directors. This opportunity for reflection is a valuable experience on both sides. The outcome of the appraisal process was reported to the July Meeting of the Council of Governors.

- I have also met with the Chief Executive to discuss and agree 2022/23 **performance objectives**.

- I attended the **Senior Leadership Network Meeting** on 25th July.

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 May and June 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 May - 30th June 2023

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Dr Stephen Alvis	Quarterly Staff Governor Meeting Mental Health Act Manager Development Meeting Quality Improvement Celebration Mental Health Act Managers Forum	Good Governance Institute Webcast	Quality Committee Board Seminar: Review of Clinical Model for Community Hospital Beds Board Presentation – Eating Disorders Service Update Forest of Dean Assurance Committee
Steve Brittan	Private meeting with Auditors Council of Governors Meeting NEDs Meeting Resources Committee Agenda Planning Pre-Audit & Assurance Meeting Appraisal with Chair Tewkesbury Hospital governor Visit	Research4Gloucestershire: Elevating Public Involvement in Research	Audit and Assurance Committee Board Seminar: Review of Clinical Model for Community Hospital Beds Board Presentation: Eating Disorders Service Board – Public Board – Private Board Development: Risk Appetite GPTW Committee Audit & Assurance committee Forest of Dean Assurance Committee
Marcia Gallagher	Quarterly Staff Governors Meeting Meeting in private with Auditors NEDs Meeting Meeting with Chair and Vice Chair ICB Audit Committee Appraisal with Chair Meeting with Head of Counter Fraud ICB Audit Committee NED/Lay Member Agenda setting meeting with ICB colleagues Quality visit - Complex Leg Wound Clinic		Nomination and Remuneration Committee Quality Committee Audit Committee Board Seminar: Review of Clinical Model for Community Hospital Beds Board Presentation: Eating Disorders Service Update Council of Governors Meeting Board – Public Board – Private Board Development: Risk Appetite

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	Participation in National Estates and Facilities Day – Dilke and Lydney Hospitals Chair of NED/Lay Member Meeting Forest of Dean Health Forum Dilke Hospital 100th Anniversary Celebrations NHSP Digital Boards Event		Great Place to Work Committee Charitable Funds Committee Nomination and Remuneration Committee
Sumita Hutchison	1:1 with Neil Savage Quarterly Staff Governors Meeting IEN Celebratory Conference Council of Governors Meeting NEDs Meeting Senior Leadership Network Meeting Appraisal with Chair Diversity Network Agenda Planning Meeting SW HWB Guarding Network Board Development: Risk Appetite follow up meeting with Lavinia Rowsell All Staff Diversity Network Meeting ICS NEDs Network Meeting Senior Leadership Network Meeting		Board Seminar: Review of Clinical Model for Community Hospital Beds Board Presentation: Eating Disorders Service Update Board – Public Board – Private Charitable Funds Committee
Jan Marriott	Audit and Assurance pre-meet Quality Committee pre-meet Quarterly Staff governor Meeting 1:1 with FTSU Guardian NEDs meeting ICB Working with People and Communities Committee 1:1 with Dr Scheepers ICB System Quality Committee Appraisal with Chair National Estates and Facilities Day at Charlton Lane ICS NED Network Meeting		Quality Committee Audit and Assurance Committee Board Seminar: Review of Clinical Model for Community Hospital Beds Board – Public Board – Private Audit and Assurance Committee Board Development: Risk Appetite

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	Gloucester Recovery Team Quality Visit Mandatory Training Mental Health Chairs Weekly Meeting IncFest, Music Works, Bacon Theatre Celebrating 20 years Heart Failure Service Quality Improvement Celebration		
Graham Russell	Health Overview and Scrutiny Committee ICB Board Meeting 1:1/Appraisal with Chair Meeting with Chair and SID Quality visit to CAMHS ICB Board Development Additional housing scoping meeting Meeting with Mary Hutton and Access Social Care Neighbourhood Transformation CMH Transformation Event 15th Big Health and Wellbeing Day QI Celebration		Nomination and Remuneration Committee Audit Committee Board Seminar: Review of Clinical Model for Community Hospital Beds Board Presentation: Eating Disorders Service Update Council of Governors Meeting Board – Public Board – Private Board Development: Risk Appetite GPTW Committee Forest of Dean Assurance Committee
Nicola de longh	Council of Governors NEDs Meeting Senior Leadership Meeting		Board Seminar: Review of Clinical Model for Community Hospital Beds Board Development: Risk Appetite Great Place to Work Committee Resources Committee Meeting (via correspondence)
Lorraine Dixon	1:1 with Chair		Board – Private
Vicci Livingstone Thompson	Council of Governors NEDs Meeting ICS Volunteering Network Meeting Introduction meeting with Angela Potter NHSP Non-Executive Director Induction		Board – Public Board – Private

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	NHSP Race Equality Training Introduction meeting with John Trevains 1:1 with Chair ICS Volunteering Network Meeting Introduction with Sandra Betney 15th Big Health and Wellbeing Day		

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 July 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 Overview
- System updates
- Events
- Achievements / Awards
- NHS Oversight Framework
- NHS Long Term Workforce Plan

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 authorised by:	Title:
Douglas Blair	Chief Executive Officer

CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM REPORT

1.0 CHIEF EXECUTIVE OVERVIEW

1.1 Wotton Lawn Quality Review

As reported to the last Board meeting, Wotton Lawn Hospital was the subject of a series of high-profile media stories in May, including on Sky News and the local BBC.

The stories were based on reports from patients and their families, about incidents which had taken place at the hospital – all of which had previously been investigated in accordance with national and local protocols – as well as allegations about staff behaviour.

Following the coverage, Gloucestershire Integrated Care Board convened a rapid quality review meeting under NHS England National Quality Board Guidance. It was agreed that there would then begin a period of 'enhanced surveillance' to enable the ICB to receive additional regular reports and information about the hospital, to include:

- Staffing levels and use of agency staffing
- Data relating to patient discharges and leave
- Length of stay and admissions/occupancy levels
- Patient experience data
- Good practice examples

In addition, the ICB have established a task and finish group involving service users, to explore how discharge communication can be improved, and a review of the advocacy service.

This will be on top of ongoing work already underway within the Trust, including regular quality audits and reporting, and the introduction of additional security measures within the hospital.

1.2 Chief Executive – Service/Team Visits

I have continued to carry out an extensive programme of service visits, team meetings and to 'hot desk' from different sites. I have welcomed the opportunity to meet new colleagues and it has provided valuable insight into colleagues' experiences within their working environment and any challenges the teams are currently facing. My visits since the last Board meeting have included:

- Stroud Hospital
- Weavers Croft, Stroud
- Independent Living Centre, Cheltenham
- George Moore Community Clinic, Bourton-on-the-Water

- North Cotswold Hospital
- Pullman Place
- Vale Hospital
- Rikenel
- Wotton Lawn Hospital
- Montpelier Unit
- Cirencester Hospital
- Quedgeley Health Clinic
- Colliers Court, Cinderford

1.3 Update on industrial action

Due to industrial action by junior doctors and consultants of the British Medical Association during July, the Trust and wider system partners have been operating a number of contingency arrangements to ensure that we are able to continue to operate safe and resilient services. Changes to local services included:

- Cheltenham A&E switched to a Minor Injury and Illness Unit (MIIU) from 8pm on 11th July to 8pm on 12th July.
- Cheltenham A&E/MIIU temporarily closed from 8pm on 12th July to 8am on 18th July.
- Emergency care services (A&E) were centralised at Gloucestershire Royal Hospital 24/7 during this period.
- GP practices and other Community Minor Injury and Illness Units across the county continued to provide services. GHC boosted clinical staffing at selected MIIUs during this period in anticipation of increased demand.

1.4 Wotton Lawn Sanctuary Garden

The Queen's Nursing Institute and the National Garden Scheme have announced that the Wotton Lawn Sanctuary Garden will be one of the five new gardens and health projects led by nurses taking place in 2023. Each project will receive funding as well as a year long professional development programme by the QNI.

This project seeks to provide a safe space for women with serious mental health illness. The garden will provide an area for women to relax, meet, and for therapy to take place within a designated area that is peaceful and designed with them in mind.
Read the full announcement here: New QNI NGS Gardens and Health Projects for 2023 – The Queen's Nursing Institute

1.5 Countywide Services – Service Director appointed

Following an interview process, Charlotte Tucker has been appointed Service Director in Countywide Services. Charlotte has been on secondment in the role since November 2022 and so has taken up the position on a permanent basis with immediate effect.

1.6 Stakeholder Engagement

I continue to participate in regular discussions with MPs and other key stakeholders on matters affecting the Trust and our local communities. Further information on specific engagements with MPs and the Health Overview and Scrutiny Committee are included in the Chair's report.

2.0 SYSTEM UPDATES

2.1 Gloucestershire Health Inequalities

I have agreed to act as joint Senior Responsible Officer for Health Inequalities for the Gloucestershire system, alongside Siobhan Farmer, Director of Public Health. I will be working closely with Siobhan to shape up the programme and I will update the Board in due course on the system-wide work and GHC's role in it.

2.2 Community Mental Health Transformation

I attended the Community Mental Health Transformation Partnership Board in June, which is overseeing the progress being made with implementing a new approach to mental health support in the community for adults and older adults with a serious mental illness, working with a range of voluntary and community sector partners. Partners indicated that real progress was now being made in the way that that the programme was being designed and rolled out. A series of engagement events have been held to discuss the transformation of community mental health services across the county. The events have taken place in the Forest of Dean, Gloucester, Stroud, Cheltenham and the Cotswolds.

The events have been an opportunity to meet with people who use mental health services, carers, professionals and representatives from the voluntary and community sector to provide updates and seek feedback on various initiatives including a new Locality Community Partnership (LCP) approach with primary care and the voluntary sector in each locality.

Overall the programme continues to make progress with some of the key headlines being:

- **Core CMHT Model** – co-produced design and development of the multidisciplinary LCPs, has now enabled the service in the Forest of Dean to commence in April, with Gloucester City due to follow in the next few weeks. The requirement is to roll this model out across each Integrated Locality Partnership in Gloucestershire and, whilst we are slightly behind our trajectory at this stage, we have recently recruited two clinical leads which will help support capacity moving forward. A new assessment approach, DIALOG, is being implemented across mental health services and key VCSE partners, however the scope of roll out has increased significantly since the programme commenced which is putting additional pressure on our capacity. DIALOG is being received well by both service users and professional colleagues as a goal-based assessment and reporting approach.

- **Additional MH roles in Primary Care** – we have successfully completed the first round of recruitment and there is now a practitioner within all PCNs. A joint evaluation is underway with primary care with a view to develop a case for further expansion of these roles if the evaluation is positive.
- **Physical Health Checks for SMI** – a systematic approach is now in place but recruitment to key roles has been challenging. Current performance is at 56% against a target of 65%.
- **Rehabilitation** – the national guidelines on key requirements is still awaited but we have reviewed the current rehab offer and completed an options appraisal for a future model that spans both secondary care to provide a countywide service and we are now building in the housing/accommodation opportunities.
- **Complex Emotional Needs** – we continue to implement the Open Access Therapy model.

Ongoing challenges at a national level remain in terms of a lack of agreed methodology for automated data flows within the VCSE/primary care which is now requiring a local workaround to be developed and this is being trialled in August.

Continued oversight of progress of the programme is internally through the Mental Health Transformation Programme Board and then through Strategic Oversight Group to Resources Committee. Governance externally is through the aforementioned Partnership Board.

2.3 Urgent Care Transformation Programme

The Trust is playing an active role in the urgent and emergency care work which is now moving into a delivery phase and continues to be supported by our partners Newton Europe who supported with the diagnostic exercise last year. This will be a major transformation programme with input from all partners across the system.

Six major workstreams have been identified:

- Prevention
- Community urgent response and front door
- Hospital flow and decision making (for which I will be acting as Workstream Sponsor)
- Intermediate Care
- Use of community care packages (for which Angela Potter will be acting as Workstream Sponsor)
- Workforce and OD

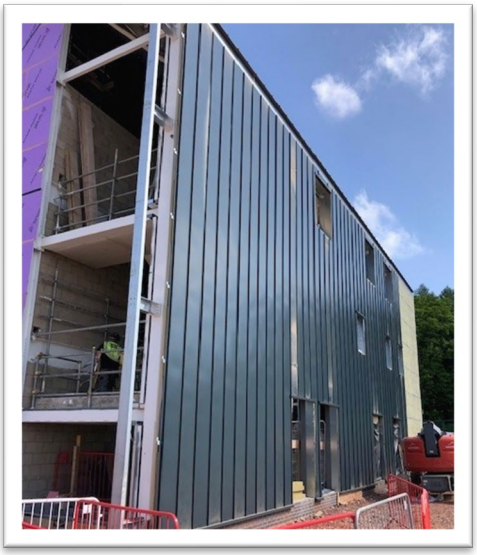
2.4 ICB Board Development Session

Gloucestershire ICB held a Board Development session on 6th June which was attended by the Chair, Ingrid Barker, Vice-Chair, Graham Russell, and I. Neil Savage and Sandra Betney were also in attendance due to the focus of the session. The main aims of the session were to explore key risks and challenges for each organisation and to review the Gloucestershire People Plan and key priorities for 2023/24.

2.5 New Forest of Dean Hospital

It is good to report that the construction programme remains on time and on budget. Detailed plans around the commissioning and equipping of the new hospital are underway and progress has been reviewed by the Assurance Committee who noted that there were some pressures emerging in terms of equipping costs, particularly associated with the inflationary impact on endoscopy equipment that are currently being worked through.

We remain on schedule for Spellers Metcalfe to hand over the building as planned at the end of this year. Following handover there is a programme of fit out for our equipment which will take approximately 12 weeks. We are in the final stages of developing our own commissioning plan which is due to be reviewed by the Forest of Dean Assurance Committee at its meeting in September prior to being shared more widely with stakeholders.



2.6 Healthwatch - Report into social support for young people

Healthwatch Gloucestershire has published a new report about the social support that is available for young people locally, calling for more to be done to help young people manage their mental health. During January and February 2023, Healthwatch Gloucestershire gathered feedback from over 200 people, through an online survey, one-to-one interviews, and focus group discussions.

The key findings from this feedback acknowledged the continued high levels of young people who are experiencing poor mental health and the number that are impacted by stress and anxiety with pressures coming from various sources, including school, exams, social media, climate change, and friendship groups. It made a range of recommendations for improving this situation including actions to improve social support and early intervention for young people and suggested ways to increase awareness and accessibility to support.

The full report is available via the following link: Helping young people manage their mental health: Young people's views and experiences of social support in Gloucestershire

3.0 EVENTS

3.1 NHS 75th Anniversary Celebrations

On 5th July the NHS celebrated 75 years. This significant milestone provided an opportunity to celebrate with our colleagues and communities and a number of events were held to mark the occasion, including:

- Tea parties at a number of our hospitals, including Cirencester, Charlton Lane, Wotton Lawn and the site of the new Forest of Dean hospital.
- Some of our colleagues attended a commemorative service at Westminster Abbey.
- Commemorative evensong service at Gloucester Cathedral on Thursday 6th July. Following the evensong there was an opportunity to visit a small exhibition in the Nave of the Cathedral, including reflections on the important contribution of the Windrush generation, which was celebrating its 75-year anniversary.
- Speller Metcalfe, the Forest of Dean hospital contractor, hosted 15 of our Forest of Dean staff for a lunch visit.
- The NHS teamed up with parkrun UK to mark the anniversary and NHS staff and volunteers, as well as local communities, were encouraged to 'parkrun for the NHS' at parkrun events on Saturday 8th July.
- Charitable funds have been used to purchase commemorative badges for colleagues.

3.2 National Healthcare Estates and Facilities Day 2023

On 21st June it was National Healthcare Estates and Facilities Day – a day to recognise and celebrate the critical work of all Estates and Facilities staff and their role in the provision of our healthcare services.

I spent the morning volunteering with our housekeeping staff at the Vale and the afternoon visiting our estates and facilities teams at Wotton Lawn and Rikenel. Several of our Executive and Non-Executive Directors joined up with our Estates and Facilities Senior Management team to visit sites across the Trust to say a huge 'thank you' to our incredible colleagues, for doing such an amazing job of keeping our community hospitals, inpatient units, outpatient services and corporate sites running day in, day out, 365 days a year.

3.3 Quality Improvement Celebration Event

On 20th June our Quality Improvement (QI) team hosted an event at the School of Business and Technology, Oxstalls Campus. The event focused on exploring

the theme of 'Creating the Conditions for Improvement' as well as celebrating and learning from the Trust's Quality Improvement projects.

Taking the time to understand and create the conditions for improvement is fundamental in providing a springboard for action and building a strong foundation for establishing sustained improvement.

4.0 ACHIEVEMENTS / AWARDS

4.1 Apprenticeships

Congratulations to the following learners who have all recently completed their apprenticeships with distinction:

- Vicky Smith – Level 3 Healthcare Support Worker
- Natalie Christmas – Level 3 Healthcare Support Worker
- Robert Mullen – Level 5 Operational/Departmental Manager

South West Apprenticeship Award

The Trust is celebrating the news that it has been named **Large Employer of the Year** at the South West Apprenticeship Awards ceremony held at Ashton Gate Stadium in Bristol on 6th July. The awards expanded this year to cover the entire South West so we were up against employers across all seven of the South West regions.

The event also featured Healthcare Assistant Vicky Smith as a finalist in the Apprenticeship of the Year for Health, Wellbeing and Care category.

4.2 Cavell Star Awards

Congratulations to Sal Leat and Sarah Gizzard who have recently been awarded the prestigious Cavell Star Award for Excellence in Nursing Care.

The Cavell Star Awards are designed to give amazing nursing and midwifery teams up and down the county a morale boost and is a way to say a big thank you for the incredible work nurses, midwives and healthcare assistants do every day.

4.3 National Bristol Patient Safety Conference

Professional Development and Clinical Skills Lead Sylvia Jellyman and Training and Development Facilitator Julie Lerigo received a runner-up award at the National Bristol Patient Safety Conference on 17th May for their Improving Mouthcare Standards QI Poster Presentation. Congratulations Sylvia and Julie and thank you for all your hard work.

4.4 Montpellier Allotment team

The Montpellier Allotment Project Team celebrated success at the national

'Design in Mental Health Community Awards' when they received a 'Highly Commended' in the 'Outside Space of the Year' category.

The therapeutic allotment and green site at Horton Road, Gloucester, is regularly accessed for rehabilitation, development and meaningful engagement by our patients at Montpellier Low Secure Unit, and those who access our Trust's services countywide. It is also a resource which is utilised by our colleagues, community groups, local organisations and education providers in Gloucestershire.

Having secured funding for its redevelopment in 2021, Victoria Woodruff, Senior Occupational Therapist and EAP Team Lead at Montpellier Secure Recovery Service, and her team of service users, occupational therapists and fellow colleagues from the Montpellier Unit, have worked tirelessly to transform the site.

You can read more about the project and what has been achieved so far here: https://www.ghc.nhs.uk/news/montpellier-allotment-redevelopment-project/

The project team were honoured to receive a visit from HRH the Princess Royal in January this year, when she officially reopened the therapeutic allotment.

4.5 Employer Recognition Scheme Gold Award 2023

The Trust is delighted to have achieved the Employer Recognition Scheme (ERS) Gold award for our commitment to supporting the armed forces and their families.

The Defence Employer Recognition Scheme Gold Award is the highest badge of honour and recognises the positive role that employers play in supporting the Armed Forces community. Employer organisations are asked to pledge, demonstrate and advocate support to defence and the armed forces community, and align their values with the Armed Forces Covenant.

4.6 National Preceptorship Interim Quality Mark

The Trust is delighted to have been awarded the Interim Quality Mark for our preceptorship programme.

The National Preceptorship Programme, established in November 2021, provides a framework for Nursing for England and associated quality standards for all health and social care organisations. It plays a key role in retention by setting in place a structure to support newly qualified professionals, allowing them to translate their knowledge into everyday practice, grow in confidence and have the best possible start in their careers.

Thank you to Sylvia Jellyman and her team for all the hard work they have put into developing our programme. Preceptorship is aimed at supporting and

guiding newly registered colleagues joining the Trust and we will be using the Quality Mark prominently in our advertising of roles.

5.0 NHS OVERSIGHT FRAMEWORK QUARTER 4 – 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 was assessed as being in segment 2 for quarter 4 – Plans that have the support of system partners in place to address areas of concern. NHSE also considered four acute based metrics covering Length of Stay, Non-Criteria to Reside and proportion of residents discharged to their normal place of residence. It would appear that these were applied to Mental Health inpatient beds, Older Adult MH acute patient Length of Stay was noted as being a segment 3 performance.

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 Mental Health placements and Older Adult Acute Length of Stay over 90 days. In addition to this non-metric qualitative information is considered by the ICB and the NHSE.

A national review and refresh of the 2023/24 Oversight Framework is underway, and we await publication of this.

6.0 NHS LONG TERM WORKFORCE PLAN

The long awaited and anticipated NHS long term workforce plan (LTWFP) was published on 30 June 2023, shortly ahead of the NHS 75th birthday. The full plan can be viewed using the above link, but an executive summary is provided below.

Building on the ambitions of the NHS People Plan, the LTWFP represents a timely and welcome step forward, placing workforce firmly on the centre stage for government and policy makers. Outlining the proposed direction of travel for the next 15 years until 2036/37, this is the first ever workforce strategy for the NHS's 1.2 million strong workforce.

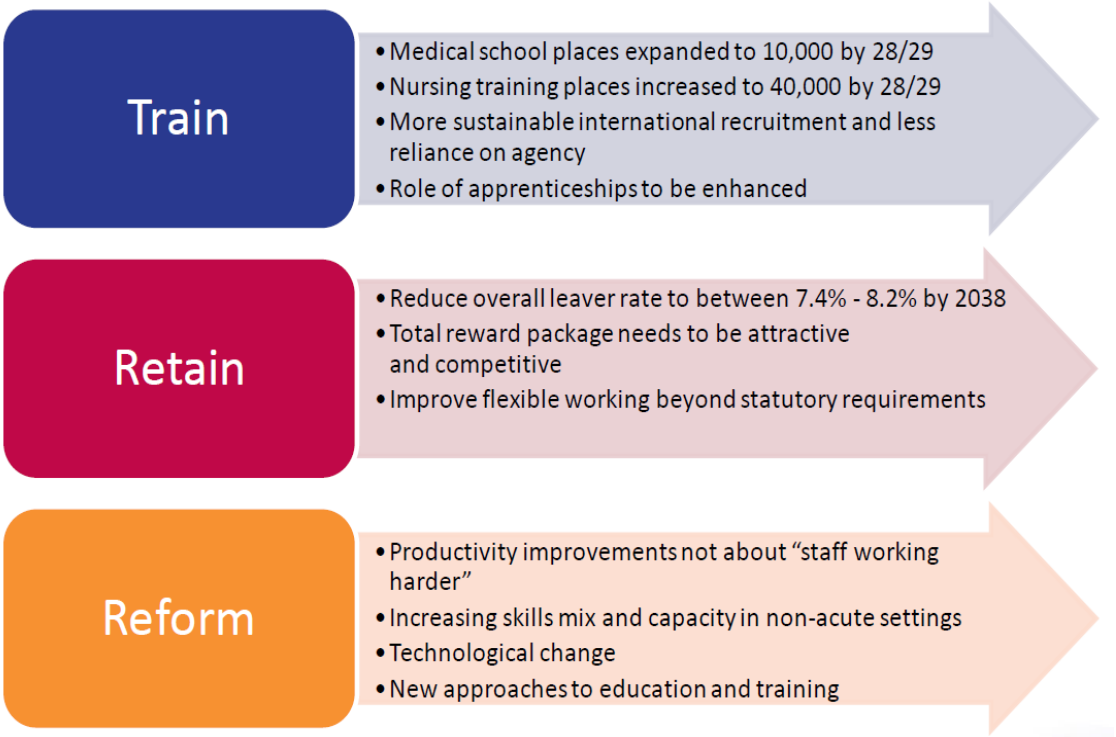
The plan has been well received and provides many opportunities to tackle critical workforce issues in a longer term and sustainable way. Ultimately, it aims to address workforce demand and supply. Its publication instils a degree of hope for a better future for the NHS workforce after the challenges and impact of the pandemic.

The plan's scope is workforce employed by the NHS and delivering NHS-funded services in NHS trusts and primary care. It states delivery the need for government support for:

- **Infrastructure (physical and digital)**
- **Education funding**
- **Social care provision (assume access remains at current levels)**

While much still needs to be worked through to understand the detail of how the plan will be funded and implemented, positively there is a commitment to co-design, co-develop and co-deliver its ambitions. This is also supported by a further commitment to regularly review and update the plan at least every two years. ICBs and ICSs are identified as key delivery agents of the plan's ambitions.

Setting out strategic direction for both long term and short to medium term actions to be undertaken, the LTWFP identifies three key priority areas**: (1) train, (2) retain and (3) reform**. Some of the main elements of these themes are captured in the below infographic.



Many of the plan's aspirations are already contained as Trust aspirations and actions agreed through our GHC Recruitment and Retention Strategic Framework. We have commenced reviewing the wider content of our People Strategy and other workforce related strategic frameworks to ensure alignment with the plan.

Helpfully much of the plan's focus is on recruitment and building a more sustainable home supply pipeline. For example, the plan confirms £2.4 billion investment over the next six years to bolster education and training aiming to boost training places by 27%. However, Julian Kelly, the NHS Finance Director confirmed that it could take another 6 to 8 months to work through and fully identify the detail and sequencing of this spend.

Unsurprisingly there are few easy solutions identified for short term resolution of retention challenges within the clinical workforce, with the focus being on longer term solutions.

The plan recognises that *"the total reward package which goes beyond headline pay will need to be attractive and competitive to respond both to changes in people's career aspirations and the labour market."* However, there is no explicit mention of more related funding, and no new interventions named. This is particularly notable regarding pensions, with flexibilities for lower paid staff still a concern to be addressed.

To succeed, we believe that the plan's implementation must put emphasis on positive leadership cultures, values and behaviours, alongside quality and productivity improvements. Success will also be reliant on investment in the themes mentioned earlier of NHS infrastructure, education funding and investment in social care to improve service levels. The plan does not cover or tackle any of the challenges in social care, many of which have significant knock-ons to shared pathways, and NHS services and staffing generally.

While the national plan is very encouraging and will help to provide much needed focus and support, it needs borne in mind that the returns from the plan will take time and significant investment, the clarity of which is yet to be fully understood. In the short term, locally and nationally, we expect to still be challenged with higher vacancy, turnover and sickness absence rates, further complicated by ongoing industrial action from doctors in training, consultants and other healthcare unions such as UNITE and Society of Radiographer. However, positive benefits will be reaped as implementation gains traction.

As further information in the LTWFP Is made available actions will be taken forward within the ICS and the Trust. The ICS People Committee and steering groups will also be considering the details over the coming month.

The full report can be accessed here: NHS Long Term Workforce Plan (england.nhs.uk)

7.0 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: 13/0723

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 27 July 2023**
PRESENTED BY:	Marcia Gallagher, Chair of the Audit and Assurance Committee
AUTHOR:	Lavinia Rowsell, Director of Governance and Trust Secretary
SUBJECT:	**AUDIT AND ASSURANCE ANNUAL REPORT TO THE BOARD, 1 APRIL 2022 – 31 MARCH 2023**

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

The purpose of this report is to

Receive the annual report of the Audit and Assurance Committee for 2022/2023.

Recommendations and decisions required

The Trust Board is asked to **note** the Committee's Annual Report 2022/23.

Executive summary

The Committee's terms of reference require that:

"*The Audit and Assurance Committee will update each routine Board meeting on its activity, highlighting decisions made, issues being progressed and concerns requiring further consideration or decision by the Board*"

"*The Committee will report to the Board annually on its work in support of the Annual Governance Statement*."

The attached report provides an overview of the Committee's work in the last financial year, from 1 April 2022 to 31 March 2023 in sections which reflect the headings of the Committee's terms of reference. The report also provides an overview of the work of the Committee in overseeing internal control mechanisms in the Trust as reflected in the Annual Governance Statement. No issues have been highlighted as areas of concern. The Committee has operated in line with its terms of reference to meet the functions delegated to it by the Board.

Risks associated with meeting the Trust's values

Failure to identify and mitigate corporate and strategic risks may adversely affect the achievement of the Trust's strategic goals.

Corporate considerations	
Quality Implications	Effective management of risk provides assurance that patient services are being delivered safely.
Resource Implications	None other than those identified in the report.
Equality Implications	None other than those identified in the report.

Where has this issue been discussed before?
Audit and Assurance Committee meeting 13 June 2022,

Report authorised by:	**Title:**
Marcia Gallagher	Chair, Audit and Assurance Committee

Gloucestershire Health and Care NHS Foundation Trust

Audit and Assurance Committee Annual Report

1 April 2022 – 31 March 2023

1.0 INTRODUCTION

1.1 The Audit and Assurance Committee was established in its current form under Board delegation from 1 October 2019 in line with the governance arrangements agreed and set in place from the date of the merger of the Trust with Gloucestershire Care Services NHS Trust. Its terms of reference are informed by good practice and Audit and Assurance Committee guidance within the NHS sector and other sectors and reviewed annually.

1.2 All Non-Executive Directors are members of the Committee, with the exception of the Trust Chair, with four NEDs as core members. This membership enables the Committee to triangulate information and assurance received at other Board Committees, each of which is chaired by a member of the Audit and Assurance Committee.

1.3 A number of officers are in regular attendance in accordance with the Committee's Terms of Reference. These include the Director of Finance (or a delegated alternate), the Director of Governance/Trust Secretary (or a delegated alternate), Internal and External Auditors, and the Local Counter Fraud Specialist. Other Directors and Managers attended at the request of the Committee, for example where further information is required on actions and/or issues being raised through an Internal Audit. After each meeting of the Committee, the Audit and Assurance Committee Chair provides a summary report of the Committee's deliberations and decisions to the next Board meeting.

1.4 The Committee met 5 times during the period 1 April 2022 to 31 March 2023, and has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the Trust's business through self-assessment and review, and by requesting assurances from Trust Officers. Each meeting was quorate.

1.5 Attendance by members at the Committee during the period was as follows:

Members*	12/05/22	13/06/22	24/08/22	10/11/22	9/02/23
Marcia Gallagher (Chair)	Y	Y	Y	Y	Y
Graham Russell	Y	Y	Y	Y	N
Steve Brittan	Y	Y	Y	Y	Y
Sumita Hutchison	N	Y			
Jan Marriott			Y	Y	Y

**There are four core members of the Committee but all Non-Executive Directors (excluding the Board Chair) are invited to attend and can count towards the quorum.*

All Non-Executive Directors receive papers and have the opportunity to raise any concerns with the Chair even where they do not attend.

1.6 The following were in attendance at the Committee during the period with their attendance dependent on issues to be discussed.

- Director of Finance
- Deputy Director of Finance
- Other Directors as required
- Head of Counter Fraud and/or Team members (receives papers and can raise any concerns with the Chair or Director of Finance if not attending.)
- Members of the Trust Secretariat
- Internal Audit
- External Audit
- Members of the Management Team for specific items (including Data Protection Officer and Assistant Director of Digital Services)

2.0 PRINCIPAL REVIEW AREAS

2.1 This annual report is divided into five sections, reflecting the five key duties of the Committee as set out in its terms of reference.

Governance, Risk Management and Internal Control

2.2 The Committee has reviewed relevant disclosure statements, in particular the Annual Governance Statement together with the Head of Internal Audit Opinion, external audit opinion and other appropriate independent assurances.

2.3 The Head of Internal Audit Opinion was based on the audit work carried out during the year in line with the plan approved by the Committee, and also had regard to the Trust's Board Assurance Framework, Risk Register, and other control mechanisms. This opinion contributed to the Committee's assessment of the effectiveness of the Trust's system of internal control, and to the completion of its Annual Governance Statement.

2.4 The Committee reviewed the Corporate Risk Register and the Board Assurance Framework at regular intervals in order to provide challenge and receive assurance that strategic and corporate risks are being adequately monitored.

2.5 The Committee reviewed both the draft and final versions of the Annual Governance Statement which set out the systems and processes for internal control and formed part of the Trust's 2022/23 Annual Report.

2.6 Compliance reports on governance processes including the Register of Directors' Interests, and the Register of Gifts and Hospitality are reviewed annually.

2.7 The Chairs of all Gloucestershire Trusts' Audit and Assurance Committees are able to meet to discuss governance and other matters of mutual interest. It was agreed that in order to a greater understanding on issues facing partner organisations within the system, Audit Committee Chairs may attend each other's meetings as observers. The GHC Audit and Assurance Committee Chair is a voting member of the Integrated Care Board Audit Committee.

2.8 The Committee has reviewed the completeness of the risk management system and the extent to which it is embedded within the organisation. This has included a review of the Trust's Risk Management Policy. The Committee acknowledges the progress made in year and believes that while adequate systems for risk management are in place, continued management focus is required to ensure that risk management continues to be embedded within the Trust.

Internal Audit

2.9 In completing its work, the Committee places considerable reliance on the work of the Internal Auditors, BDO, who have just completed their first year as the Trust's Internal Auditors replacing PWC on 1 April 2022. Throughout the year the Committee has worked effectively with internal audit to strengthen the Trust's internal control processes. During the year the Committee reviewed and approved the internal audit plan for 2022/23 and considered the findings of internal audit in relation to work on the following areas:

	REPORT FINDINGS	
	Design	Effectiveness
Safeguarding Adults	Moderate	Limited
Learning from Deaths	Moderate	Substantial
HFMA Financial Sustainability	N/A maturity assessment	
Data Quality	Moderate	Moderate
Equality, Diversity & Inclusion	N/A maturity assessment	
Environmental Sustainability	N/A maturity assessment	
Key Financial Systems	Substantial	Substantial
Data Security & Protection Toolkit	Moderate	Substantial
Business Planning	TBC	TBC
Workforce Planning/ Recruitment	TBC	TBC

2.10 5 audits were completed in year (including the independent DSPT review – see below) and 3 maturity assessments. The reviews produced a total of 45 recommendations. There were 16 low, 26 medium and 3 high risk-rated findings. In respect of each of these findings the Committee sought and received assurance on the mitigating actions being taken, following up outstanding actions as necessary and referring issues to other Committees as appropriate in order for progress with action plans to be monitored.

2.11 The Internal Auditors (BDO) were commissioned to undertake an Independent Assessment of our information governance arrangements as set out in the Data Security and Protection Toolkit (DSPT). The Trust is required to commission an independent assessment against the mandatory assertions of the DSPT chosen by NHS Digital for testing.

2.12 The Committee has been pleased to note during the period, continued good performance in terms of the timely completion of management actions arising from Internal Audit Reviews. Tracking of IA recommendations is reviewed at each meeting.

External Audit

2.13 During the year, the Committee:

- received and noted the final audit in respect of the 2022/2023 Annual Report Financial Accounts.
- reviewed and agreed the external audit plan for 2022/23.
- reviewed and commented on the reports prepared by external audit which have kept the Committee apprised of progress against the External Audit Plan.

2.14 Following approval by the Council of Governors in March 2022, KPMG was reappointed as the Trust's external auditors for a further two years.

Private Meeting with the Auditors

2.15 The Committee Chair met privately with internal and external auditors during the period. No concerns were raised by either auditor, and both gave positive feedback about the reputation of the Trust and the working relationships that had been established.

Other Assurance Functions

2.16 The Committee has reviewed the findings of other significant assurance functions where appropriate, and has considered any governance implications for the Trust.

2.17 The Committee received regular Counter Fraud updates, and received the Counter Fraud Annual Report for 2021/22 and the Counter Fraud work plan for 2022/23. Throughout the year the Counter Fraud have met with the Committee Chair, Director of Finance and Counter Fraud Champion.

2.18 During the year, four proactive exercised were undertaken relating to Petty Cash, Salary Overpayments, Single Tender Waiver Benchmarking and Contract splitting (Disaggregated Spend) together with the national fraud referral benchmarking exercise.

Management

2.19 The Committee has challenged the assurance process when appropriate, and has requested and received assurance from Trust management and various other sources both internally and externally throughout the year.

2.20 The Committee works to an annual plan of scheduled agenda topics. In setting this annual plan, the Committee considers items currently on the Risk Register, items of current interest, and items raised by the auditors and the Executive Team. In addition the Committee follows up risk items previously identified to ensure that it remains informed of progress against previously agreed actions. A rolling programme of actions is maintained and monitored accordingly for all Committee meetings. In year a Committee triangulation report has been introduced to keep track of items referred between Governance Committees.

Compliance Reporting

2.21 The Committee received Losses and Special Payments reports at various points through the year, as required by the Trust's Standing Financial Instructions. The Committee sought assurance in each case as to the processes in place to recover these amounts, and prevent recurrence. In response to the findings of a proactive exercise by Counter Fraud, it was agreed that salary overpayments would be reported as part of the compliance report going forward.

2.22 The Committee has regular reports at meetings on waivers over £25k applied in the preceding period. This reporting includes nil returns.

2.23 The Committee reviewed the 2022/23 financial statements and annual report at the May 2023 meeting prior to recommending the final accounts for Accounting Officer signature, in line with authority delegated by the Board.

2.24 The Committee was pleased to note the external audit report which indicated that an unqualified audit opinion was to be given to the accounts, and that the auditors had not identified any significant weaknesses in systems of accounting and financial control.

3.0 OTHER MATTERS

3.1 The Committee formally reviewed its effectiveness during the year. Its format and operation has been informed by best practice and no issues have been identified to date.

3.2 The Committee compiled an Annual Report on its activities which will be considered by the Board.

3.3 The Committee reviewed its terms of reference during the year with minor amendments approved by the Board.

4.0 CONCLUSION

4.1 The Committee's primary contribution to the achievement of the Trust's strategic objectives is to ensure that Governance, Control, Risk Management and Audit systems are sound, reliable, and robust. The work of the Committee in the last financial year, and the triangulation of information and assurance received both at the Audit and Assurance Committee and at other Committees chaired by members of the Audit and Assurance Committee, have enabled the Audit and Assurance Committee to conclude that the Trust's systems are in the main sound, reliable and robust.

Marcia Gallagher
Chair, Audit and Assurance Committee
May 2023

REPORT TO: **TRUST PUBLIC BOARD – 27 July 2023**

PRESENTED BY: Anna Hilditch, Assistant Trust Secretary

AUTHOR: Anna Hilditch, Assistant Trust Secretary

SUBJECT: **CORPORATE GOVERNANCE UPDATE 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:

The purpose of this report is to update the Trust Board on recent governance updates, developments and national publications. It is important that the Trust regularly monitors the publication of new guidance and can ensure that robust processes are in place to review and effectively enact this guidance where it may impact upon the Trust.

Recommendations and decisions required

The Board is asked to **note** this report for information and assurance.

Executive summary

This report provides an update on:

- New Code of Governance - NHSE Clarification on Chair and NED Reappointments and Independence
- Conflicts of Interests for Foundation Trust and NHS Trust Directors on Integrated Care Boards

Any implications or resulting changes to governance practices/polices required as a result of the new or updated guidance have been considered by the Trust Secretariat and the relevant governance Committees.

Risks associated with meeting the Trust's values

Corporate Considerations	
Quality implications	
Resource implications	
Equalities implications	

Where has this issue been discussed before:
Nominations and Remunerations Committee – 29 June 2023

Appendices:	

Report authorised by:	**Title:**
Lavinia Rowsell	Director of Corporate Governance & Trust Secretary

CORPORATE GOVERNANCE UPDATE REPORT

1.0 INTRODUCTION

The purpose of this report is to update the Trust Board on recent governance updates, developments and national publications. It is important that the Trust regularly monitors the publication of new guidance and can ensure that robust processes are in place to review and effectively enact this guidance where it may impact upon the Trust.

2.0 NEW CODE OF GOVERNANCE - NHSE CLARIFICATION ON CHAIR AND NED REAPPOINTMENTS

2.1 The new Code of Governance for NHS Provider Trusts was published in October 2022 and came into force on 1 April 2023. The code applies to both NHS Trusts and Foundation Trusts. The Code is built around a set of principles emphasising the value of good corporate governance as best practice advice. It asks all trusts to comply or, where there are exceptions that are appropriate, explain why the trust has departed from it.

2.2 Since its publication, NHSE have received requests from Trusts seeking clarification around the provisions relating to chair and non-executive independence and reappointments, particularly where individuals have already served 6 or more years with an organisation. The Code requires "rigorous review" and NHS England approval in such cases.

2.3 NHSE have now updated their website (https://www.england.nhs.uk/non-executive-opportunities/support-for-nhs-organisations/) with further clarification on:

- good practice around re-appointments,
- what exceptional circumstances might look like
- what NHSE would expect to see as part of a rigorous review;
- signposting on who to contact regarding NHS England approval.

2.4 The new Code of Governance is very clear about the importance of independence for the Chair and NEDs, with any term over 6 years only being accepted in exceptional circumstances, with NHSE approval and requiring rigorous review.

2.5 Previously, colleagues could serve a full term of 6 years as a NED and be eligible to serve at the same Trust as Chair at the end of this period for a further 6 years. The two roles were seen as distinctly different. However, the new Code makes it clear that any term served as a NED within a specific organisation will count toward the 6 year maximum term, and if an existing NED applied for the position of Trust Chair within the same organisation, they should only serve up to their remaining term (e.g. if served 3 years as a NED, could only hold the post of Chair for 3 years). Any term that went over the 6-year maximum would require NHSE approval.

2.6 The new Code also clarifies the terms of appointment and reappointment for Associate NEDs. If someone is appointed into an Associate role, once this position is stepped up to a full NED role, the time as an Associate will count toward the full term of 6 years. However, if someone is appointed into a specific Developmental Associate position, if this role is stepped up into a full NED position, then the term will be reset from the NED appointment date, and they may serve for a full 6-year term.

2.7 The Board is asked to note that this revised guidance was considered by the Nominations and Remuneration Committee, as the responsible Committee for NED and Chair appointments on the 29 June 2023 and the Committee was assured that the Trust is compliant with the guidance which will be reflected in future recruitment approaches.

3.0 CONFLICTS OF INTEREST: CONSIDERATIONS FOR DIRECTORS IN SYSTEMS

3.1 NHS Providers recently commissioned legal advice to support Trust and Foundation Trust directors working in systems, particularly those who are also partner members on Integrated Care Boards (ICBs). conflicts-of-interest-nhsp-advice-from-mwe-jun23.pdf (nhsproviders.org)

3.2 The advice serves as a useful reminder of the current legal duties on NHS directors and outlines considerations for providers and ICBs, regarding interests, transparency, and managing declarations under the Health and Care Act 2022.

3.3 An initial review of the advice has been carried out and there are no immediate actions that the Trust needs to take, with current practice and policy already aligned. A full review of the Trust's Managing Conflicts of Interests Policy is scheduled for November 2023, at which point the policy will be reviewed and updated to make sure that Board members with other NHS directorships, are able transparently, to declare any and all potential conflicts of interest, to any particular organisation and that they are comfortable in discharging their respective statutory (and corporate) duties and responsibilities, to their respective bodies lawfully.

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS MEETING

Wednesday, 17 May 2023
Held via Microsoft Teams

PRESENT:

Ingrid Barker (Chair)	Chris Witham	Kizzy Kukreja
Alicia Wynn	Mick Gibbons	Jacob Arnold
Bob Lloyd-Smith	Sarah Nicholson	Rebecca Halifax
Steve Lydon	Cath Fern	Tracey Thomas
Paul Winterbottom		

IN ATTENDANCE:
Douglas Blair, Chief Executive
Jeremy Marchant, Trust Member
Kat Cleverly, Trust Secretary (GHT)
Lisa Evans, Assistant Trust Secretary (GHT)
Graham Russell, Non-Executive Director/Deputy Chair
Neil Savage, Director of HR & OD
Jan Marriott, Non-Executive Director
Kate Nelmes, Head of Communications
Lavinia Rowsell, Director of Corporate Governance / Trust Secretary
Marcia Gallagher, Non-Executive Director
Nicola de Iongh, Non-Executive Director
Steve Brittan, Non-Executive Director
Vicci Livingstone-Thompson, Associate Non-Executive Director
Anna Hilditch, Assistant Trust Secretary
Gillian Steels, Governance Advisor (from Item 11)

1.0 WELCOMES AND APOLOGIES

1.1 Ingrid Barker welcomed colleagues to the meeting.

1.2 Apologies had been received from the following Governors: Alan Cole, Dan Brookes, Alison Hartless, Nic Matthews, Jenny Hincks, Erin Murray, Ismail Surty, Juanita Paris, Graham Hewitt and Laura Bailey. Apologies had also been received from Sumita Hutchison and Steve Alvis, Non-Executive Directors.

1.3 The Governors welcomed Douglas Blair, Chief Executive to his first Council of Governors meeting. Douglas had commenced in post on 17 April 2023. The Council also welcomed Cath Fern who had been elected as a new Staff Governor representing Medical, Dental & Nursing staff. Cath took up her position on 4 April 2023.

1.4 Since the March meeting it was noted that the Trust had sadly received the resignation of Ruth McShane (Public Governor, Greater England & Wales). Ruth had decided that this was the right time for her to stand down to allow her to focus on other ventures. Ruth was a very active Governor, as well as an Expert by Experience for GHC and would be missed for her contributions across the Trust.

2.0 DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3.0 MINUTES OF THE PREVIOUS MEETING

3.1 The minutes from the previous meeting held on 15 March 2023 were agreed as a correct record.

4.0 MATTERS ARISING AND ACTION POINTS

4.1 The actions from the previous meeting were either complete or progressing to plan. There were no other matters arising.

5.0 GOVERNOR PRE-MEETING UPDATE

5.1 Chris Witham provided a verbal report on those key issues discussed at the Governor pre-meeting. It was noted that the main points would be picked up as part of other items on the agenda for the meeting.

6.0 CHAIR'S REPORT

6.1 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 March 2023. It was noted that this report had been presented in full to the Trust Board at its meeting on 30 March.

6.2 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.

6.3 Ingrid Barker had participated in the judging panel for the Trust's Better Care Together Awards. There were 184 nominations received across the eight categories, and the panel spent a whole day at Churchdown Community Centre carefully considering and choosing a shortlist of 3 entries per category. The panel comprised of a Governor, Experts by Experience and Trust colleagues representing our teams and services. The standard of nominations was incredibly high, and the final shortlist was a great mix of entries from physical health, mental health, inpatient, community and learning disability services with some really innovative and impressive examples of projects and initiatives being showcased. A very enjoyable Awards Ceremony took place at Gloucester Rugby Club on 23rd March.

6.4 The Council received and noted the content of this report.

7.0 CHIEF EXECUTIVE'S REPORT

7.1 Douglas Blair informed the Council that as part of his introduction to the Trust, he had undertaken an extensive programme of visits and meetings with services and teams. Visits so far had 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. Douglas had also met with several of our corporate teams at sites across Gloucestershire.

7.2 Douglas said that he had received a warm welcome from all teams and had valued the opportunity to learn about our many services and meeting a wide range of colleagues. It had provided valuable insight into colleagues' experiences within their working environment and any challenges the teams are currently facing. Douglas would

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.

7.3 The Council noted that Douglas Blair had also been involved in meetings both within and outside the Trust to maximise his understanding of the work carried out by the Trust and the wider Gloucestershire Health system. Governors noted that Douglas would continue the leadership role for inequalities within the system.

7.4 On behalf of the Council, Chris Witham welcomed Douglas Blair and said that he and his fellow Governors were very much looking forward to working with him.

7.5 Chris Witham said that a discussion had taken place at the Governor pre-meeting about the pressures within the wider system and some of the negative experiences reported by patients and members of the public that Governors had spoken to. Looking at the data presented to the Council of Governors via the dashboard and other reports, there didn't appear to be a correlation between that and the actual experiences of patients. Douglas Blair noted that there were some significant issues, with long waiting times in certain services such as CAMHS, but the Trust was fully aware of these issues and was actively working with system partners to address them. Improvements had been seen but the scale of the challenge was not underestimated and included factors such as Covid backlog, increased demand and high vacancies within the services. Alicia Wynn suggested that it would be helpful for the Governors to receive more detail on those "priority" areas to be addressed as this would equip Governors with the awareness. Steve Lydon agreed, noting that Governors would welcome a clearer picture of what was happening and a drill down into those key areas of concern and what action was being taken. Steve Brittan advised that the Resources Committee received and scrutinised the Performance Dashboard at its meetings and received deep dive presentations on those areas in exception to get a fuller understanding of the position. It was noted that the Governor Dashboard provided a snapshot of key performance information but did not drill down into operational level data. However, it was suggested that the service presentation slots on the Council agendas could be used to provide that focus on the areas that Governors wanted greater understanding of. This would be considered further. **ACTION**

8.0 MEMBERSHIP UPDATE REPORT

8.1 The Council received this report which provided an update on Trust membership activity and statistics for the period up to 12 May 2023.

8.2 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 12 May 2023, the Trust had 5886 Public members. Of these public members, 2732 receive communication from the Trust via Email.

8.3 Vicci Livingstone-Thompson asked whether the Trust had Easy Read Membership forms. It was confirmed that easy read membership forms had been produced and were in use by the Trust's Partnership & Inclusion Team. It was agreed that a copy of the easy read form would also be uploaded and made available to complete on the Trust's website. **ACTION**

8.4 The Council received and noted the content of this report.

9.0 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 3 May 2023. Kizzy Kukreja presented this item.

9.2 The Committee received a report setting out a recommendation for the reappointment of Steve Brittan, Non-Executive Director for a further term of 3 years. Steve Brittan's first term of office would come to an end on 16 September 2023, and as set out in the Trust's Standing Orders, Steve is eligible to be re-appointed for a further 3 years. The Committee noted that Steve was a valued and experienced Non-Executive Director who had the confidence of fellow Directors on the Board. Steve was fully compliant with the Trust's Fit and Proper Persons checks and had an excellent attendance record. As part of its considerations, the Committee also received and noted the positive outcome of Steve Brittan's appraisal for 2021/22. The Nominations and Remuneration Committee recommended that the Council of Governors approve the reappointment of Steve Brittan, Non-Executive Director for a further term of 3 years, commencing on 17 September 2023. This reappointment was **approved**.

9.3 The Committee received a report from Marcia Gallagher, Senior Independent Director, which provided a summary of the 2022/23 appraisal of Ingrid Barker, Trust Chair. The report highlighted the key themes emerging from the feedback received from Directors, Governors and stakeholders and identified areas that had arisen out of that feedback that might contribute to development plans for the forthcoming year, alongside the key objectives for Ingrid Barker in 2023/24. The Committee noted the feedback and positive outcome of this year's Chairs appraisal process and agreed to report formally to the full Council that this information was received and noted. On behalf of the Council of Governors, the Committee wished to extend their thanks to the Chair for her ongoing work and dedication to the Trust.

9.4 The Nominations & Remuneration Committee received a report setting out the initial proposals and timeline for the recruitment of a new Trust Chair. Ingrid Barker's term of office as Trust Chair will come to an end in April 2024. This term was recently extended by 4 months from the original end point of 31 December 2023. Approval for this extension was received from the Council of Governors at their meeting on 15 March 2023. It is good practice to allow at least 6 months for the recruitment, and on this basis, a proposed timetable has been produced. The recruitment timetable followed the same template as that used for recent NED appointments and would be developed to include all touch points, including Nomination & Remuneration Committee and Council of Governor meetings. Further work would take place over the next few months, including a review of the Job Description and terms and conditions, with the aim of commencing the search in October 2023. Initial consideration was given to the use of an Executive Search Agency to support the recruitment process, and this would be further explored at a future meeting. The Nominations and Remuneration Committee would be required to oversee and approve all appointment documents, working closely with the Senior Independent Director and Director of HR&OD. The Committee noted the proposed timeline and next steps.

10.0 GOVERNOR DASHBOARD

10.1 The Governors received the Governor Dashboard, presenting data up to 31 March 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 The increase in 2022/23 for both the number of complaints and compliments received as compared to the previous year was noted. The Council noted that the ability for people to express their views on the services that they had received, negative or positive was important and GHC had done a real push on this. GHC's data in this area was in line with other Trusts but it did correlate with earlier discussions about people's experiences and the challenges currently being faced.

10.3 Sarah Nicholson said that she found the presentation of the facts and figures throughout the Governor Dashboard really helpful, and it was a thorough document however, she queried whether it would be helpful to hold another session for Governors to revisit the context and background of the data. A number of new Governors had joined the Council and it was important to ensure that everyone understood what the data being presented actually meant and to review whether the current areas reported on remained relevant/current or, given the earlier discussion on waiting times and priority areas, whether different metrics should be included going forward to enable the identification of themes and trends. It was noted that the content of the Dashboard was steered by the Governors, and it was agreed that Chris Witham would liaise with the Assistant Trust Secretary to discuss the development of the dashboard further. **ACTION**

10.4 Bob Lloyd-Smith noted that one area that received a higher number of complaints and concerns to Healthwatch related to the Crisis Services, and this was also reflected in the outcome of the recent 2022 MH Patient Survey Results, in particular access to services. He asked for NED assurance on the work taking place to improve this service. Ingrid Barker advised that she had carried out a recent NED Quality visit to the Crisis service and she had received good assurance from this. A piece of work was taking place as a system to look at the service model and the way it works with the police, probation services etc. It was noted that a deep dive into the crisis service had been received at the Quality Committee in March and this had provided good detail on access times, referrals and assessments. It was agreed that a copy of this presentation would be shared with Governors for reference. **ACTION**

10.5 Kizzy Kukreja asked about workforce planning and sought assurance that the Trust had its own workforce plan in place. She made reference to the 9.4% vacancy rate within the Trust and the importance of using those colleagues who "retire and return" and their skillset to help grow our own workforce. Neil Savage advised that an update was presented to the Great Place to Work Committee in March on the Trust's Strategic Framework for Recruitment and Retention which included flexible working and retire and return. Graham Russell, Chair of the GPTW Committee added that it was important how we welcome new colleagues to the organisation in terms of their induction and training needs, but equally how we develop our own colleagues and their talents. Kizzy added that people talk and share their experiences with others, and therefore being seen as a great place to work was key to recruitment and retention.

10.6 Chris Witham noted that the staff sickness rate was not on a consistent trajectory and queried whether this was a hang over from Covid. Neil Savage advised that there had been an increase in sickness across the whole NHS since Covid and this had not yet reduced. However, by way of assurance it was noted that GHC had scored well in the recent Staff Survey on positive action taken in relation to staff health and wellbeing and this was an area that continued to be monitored.

10.7 The Governors welcomed the dashboard report and noted the actions to review its future development.

11.0 SYSTMONE SIMPLICITY PROJECT – HOLDING TO ACCOUNT

11.1 The Council welcomed Steve Brittan, Non-Executive Director and Chair of the Resources Committee who presented the Governors with the Programme overview, outcomes & challenges of the SystmOne Simplicity Project.

11.2 The project started in 2021, initially as a project to improve our internal, local and national data reporting. This evolved to examine the way SystmOne had been configured, how different parts of the (recently merged) organisation used it and the impact that was having on the quality of information we had.

11.3 Following the merger in 2019, GHC was looking to provide a single data quality report for our community services in the same way as our mental health services. As we worked through this, we began highlighting issues within SystmOne. There was inconsistency between operational processes and system configuration, and inaccurate or absent data. There were 42 different SystmOne Units configured differently, none of which aligned to National NHS Data dictionary values and were essentially localised databases, with no common formats. As a result, our Clinical Record and subsequent Local and National reporting had significant inaccuracies.

11.4 The project had faced a number of challenges including the regularly changing priorities across Directorates and wider workstreams, the impact on the day-to-day requirements of those not on SystmOne, long term engagement of staff and acknowledging that the architecture of the clinical system does not always support the delivery of community services.

11.5 Steve Brittan said that the project represented an enormous amount of hard work and great collaboration – but there was still a way to go to embed the cultural change. The Trust has moved a long way forward to ensuring that our patient record is accurate and that operational teams can have confidence in the reporting from the system – ongoing focus on data quality is critical to sustaining the improvement. The project has been valuable as a foundation for the Clinical Systems Vision Programme and also a key step to allow us to move to integrated reporting. Some of the outcomes from the project were set out:

- Caseload reduction to **109,000** (↓ from 288,000 in 2020)
- We have **24,000** people waiting to be seen (↓ from 193,000 in 2020)
- All referrals (**100%**) included in CSDS (↑ from 24% in 2020)
- Nearly all (**97%**) of MIIU referrals included in the ECDS (↑ from 55% in 2020)
- Nearly all (**93%**) activity accurately recorded (↑ from 65% in 2020)
- Configured lists **aligned** with NHS data dictionary ☺
- An **80% reduction** in recording of administrative activity (equivalent to **624,000** appointments ↓)
- Recording of clinically appropriate contacts **in line** with national guidance ☺

11.6 For clarity, the Council noted that SystmOne was the clinical patient record for physical health services. Mental Health services used a clinical system called RiO.

11.7 Sarah Nicholson said that she had been involved with the project and it had been very challenging. She asked whether any impact assessments had been carried out as there had been reduced team capacity due to the work involved in continually updating and refreshing data and the use of the new reporting templates. Sarah welcomed the new integrated reporting dashboards, however, she added that it felt like people could manipulate the data to make it tell us what we wanted to hear, and the system was still not fully linked in with other systems such as booking systems. Sarah Nicholson referred to one of the challenges highlighted earlier in the presentation related to the

engagement of staff, noting that the Clinical Systems Vision Project was due to commence and at the end of that it may be that the Trust will not be using SystmOne so colleagues will have carried out a huge amount of work and effort for a system that will no longer be used. She welcomed the increased functionality but said that teams across the Trust were feeling frustrated.

11.8 Steve Lydon suggested that if SystmOne was an essential tool for people to do their jobs then there was a need to ensure that the appropriate training, review, and assessment of performance was carried out. Staff using the system needed to be able to view it as helpful and a way to aid them to do their job better, not as a hindrance. Steve Brittan noted that the use of SystmOne was not a new thing as the Trust had always had the clinical system, the issues had arisen due to there being lots of different ways to input data into the system so there was no consistency and inaccuracies.

11.9 Ingrid Barker thanked colleagues for their input and said that it was helpful to have these conversations. The Clinical Systems Vision Project was going to be a major strategic decision for the Trust Board, and it was really valuable to hear the views and experiences of both staff colleagues and users.

12.0 ANNUAL STAFF SURVEY RESULTS 2022

12.1 Neil Savage presented the Council of Governors with a summary of the results from the 2022 Staff Survey.

12.2 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 Council was asked to note that the Executive team, the Great Place To Work Committee and the Trust Board, had already received and discussed the results in detail.

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

12.4 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 included within the presentation.

12.5 Neil Savage advised that the results helped to 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.
- 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).

12.6 Sarah Nicholson noted that there were plans to share the breakdown of the results by directorate and asked whether this had happened yet. Neil Savage advised that the results could be broken down into staffing groups (AHPs, Administration etc) and service areas but there was a limit to the level of breakdown available to ensure that staff felt confident responding to the survey and the level of anonymity applied. The breakdown of the results would be made available in due course.

12.7 Mick Gibbons noted the reference to gender discrimination and said that the number of female employees far outweighed males until you hit the higher pay bandings. Neil Savage agreed, noting that 85% of the workforce was female, however, he clarified that this matter did not relate to the gender pay gap which was an issue reported on separately. Further work was required to look at the specific issues and concerns raised in this area, as had been identified as one the focus areas for the coming year.

12.8 The Council of Governors agreed 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. The key areas of focus for the coming year were noted and welcomed. Governors had been invited to attend a number of Staff Survey sessions to discuss the results in more detail with Trust colleagues.

13.0 PROVIDER LICENCE DECLARATIONS

13.1 The Council received this report which aimed to provide Governors with an opportunity to feed into the Trust's Annual Provider Licence Self-Assessment process.

13.2 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. The Board is responsible for ensuring compliance with the Trust's licence and any constitutional, statutory and contractual obligations placed upon the Trust. The Board makes these declarations 'having regard to the views of Governors'.

13.3 The individual declarations comprise:

- Corporate Governance Statement
- Governor Training declaration
- Systems for Compliance with Licence Conditions declaration

13.4 The Council of Governors reviewed this report and was assured by the process by which the Board makes its annual licence declarations. The Council fully supported the Governor Training declaration which stated 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.

14.0 GOVERNOR ANNUAL DECLARATIONS

14.1 The purpose of this report was to present the annual Governor declarations to the Council to provide assurance that these have been carried out for 2022/23 and as evidence that the Governors continue to meet the requirements of the 'Fit and Proper Persons Test'. All Governors are required to complete a FPPT self-declaration and annual conflicts of interest return. In addition, Governors are asked to reconfirm their commitment to acting in line with the Trust's Code of Conduct for Governors.

14.2 This report was noted, and it was noted that there were no issues to be brought to the attention of the Council following the checks.

15.0 COUNCIL OF GOVERNOR MEMBERSHIP AND ELECTION UPDATE

15.1 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.

15.2 As highlighted earlier in the meeting the Council had welcomed Cath Fern as a Staff Governor representing Medical, Dental & Nursing colleagues. Sarah Nicholson, Staff Governor for Health & Social Care Professionals had been successfully reappointed for a second term.

16.0 GOVERNOR QUESTIONS LOG

16.1 The Governor Questions Log is 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 no new questions had been received since the last meeting.

17.0 GOVERNOR ACTIVITY UPDATE

17.1 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.

17.2 Bob Lloyd-Smith informed the Council that he had attended the Mental Health Awareness Training that had been promoted. He said that this had been excellent and he praised the course trainers.

17.3 It was noted that the Trust had been invited to nominate 2 Governors to attend the Gloucestershire Patient Participation Group Network meetings. Following expressions of interest, it was confirmed that Jacob Arnold and Bob Lloyd-Smith would join the network.

17.4 Following Ruth McShane's resignation, a Governor position had opened up on the Trust's Working Together Advisory Committee. Governors had 2 positions on this Committee. Following expressions of interest, the Council supported the nomination of Mick Gibbons who would join Steve Lydon as members of this Committee.

18.0 ANY OTHER BUSINESS

18.1 The Council welcomed Simon Shorrick who was in attendance to talk to the Governors about the Trust's 15th Big Health Day that would be taking place on Friday 16th June 2023. The event, held in Gloucester, is aimed at helping people with learning

disabilities with complex physical and health needs and those with physical and mental health needs to stay active and healthy. On average, the popular day attracts 1,500 people with 120 volunteers giving up their time to make the day happen. This year's event is expected to be even bigger than usual with 120+ health and social care stalls. Visitors will also be able to visit the private and voluntary organisations creating awareness of activities and voluntary work. With our links to Inclusive sports organisations, we are excited to be offering sporting activities again, including adapted tennis, Boccia, Powerchair Football, golf, snooker, kin-ball, adapted bikes and trikes, and trampolining. The short 5-minute film highlights of last years' Big Health Day had been shared with Governors in advance, to get a flavour of this fantastic, interactive and inclusive day. All Governors were encouraged to come along to the event.

18.2 There was no other business.

19.0 DATE OF NEXT MEETING

19.1 The next meeting would take place on Wednesday 12 July 2023. This would be a short Council meeting followed by a development session.

20.0 PRIVATE SESSION – DRAFT QUALITY ACCOUNT AND INDICATORS

20.1 The Council of Governors received the draft Quality Account 2022/23 for comment and review. The Quality Team have been working with a number of stakeholders to bring this account together to enable the Trust to formally submit this by 30th June in line with our statutory duty.

20.2 The structure and content of the quality account is prescribed by NHSE guidance and there are a number of mandated fields which informs a standardised approach for providers to report on activity.

20.3 It was noted that the Board would receive the final draft Quality Account at its meeting on 25th May. Governors were therefore invited to provide any feedback on the report directly to James Wright, to enable this to be fed into the final draft.

Action Log on next page

ACTION LOG

Date	Ref	Action	Status
15 March	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.	Business Planning discussions to commence in autumn, will be built into considerations at that time.
17 May	7.5	Further consideration to be given to the method of providing Governors with more timely information on those "priority" service areas and key areas of concern.	Use dedicated Service presentation slots at Council meetings.
	8.3	A copy of the easy read membership form would be uploaded and made available to complete on the Trust's website.	**Complete** Easy read form now available on Trust website.
	10.3	Chris Witham to work with the Assistant Trust Secretary to discuss the development of the Governor dashboard, reviewing whether the current areas reported on remained relevant or whether different metrics should be included going forward to enable the identification of themes and trends.	Initial discussions have taken place. Further discussion with wider Council to take place during the summer to seek views and feedback on future content and presentation.
	10.4	Governors to receive a copy of the presentation from the deep dive into the Crisis Service, as presented to the Quality Committee.	**Complete** Presentation sent out to Governors alongside July meeting papers.

GPTW COMMITTEE SUMMARY REPORT
DATE OF MEETING: 08 JUNE 2023

COMMITTEE GOVERNANCE	• Committee Chair – Graham Russell, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

STAFF STORY – MY RETURN TO PRACTICE IN PHYSIOTHERAPY

The Committee welcomed Ketki-Maulik Shelat, to the meeting who shared her story about her return to practice experience in physiotherapy. Ketki-Maulik spoke about how she had initially trained as a physiotherapist in India before relocating to the UK and having a family. When her son had grown up, she decided to return to work and was introduced to a Matron who offered her support and advice. Her first role within the NHS was as a band 4 senior rehab assistant in Cheltenham Hospital, where she worked for 4 months. Since then, she had progressed and was now a band 5 physiotherapist at Charlton Lane Hospital and had been in the role for seven months. Ketki-Maulik Shelat shared that she valued her experience and the support that she had been given and shared that she enjoyed working with her current team. Her ambition was to progress further within mental health services, as mental health was close to her heart.

The Committee thanked Ketki-Maulik Shelat for sharing her story and experience returning back to work and praised her hard work and commitment

DEEP DIVE – ALLIED HEALTH PROFESSIONAL (AHP) WORKFORCE

The Committee welcomed Sarah Birmingham, Tina Craig, Alexandra Harper and Melissa Reed to the meeting, who shared a presentation and deep dive into Allied Health Professional (AHP) workforce. Sarah Birmingham shared the presentation, which provided a high-level profile of the AHP workforce, and also highlighted the proposed GPTW ambitions and deliverables within the AHP strategic framework. The presentation also sought consideration of how to fulfil potential through apprenticeship pathways.

The Committee was informed that there were just under 500 registered AHP colleagues from ten AHP disciplines employed within the Trust. It was highlighted that there were low numbers of AHP within Dietic and Art Therapy services and that there may be some opportunity to increase this. The Committee was informed that the Trust had approximately 140 AHP Support Workers within the Trust.

The vacancy data was shared with the Committee and it was noted that the Trust had a registered AHP vacancy factor of 9%, and AHP Support Worker vacancy factor of 1%. The turnover data was shared and it was reported there were marginally more starters than leavers, and the turnover rate was 12%.

The reasons for leaving data was shared with the Committee and it was reported 25% of leavers had done so due to work life balance. Other reasons for leaving included; retirement 13%, lack of progression opportunities 5.88% and end of fixed term contracts 5.88%.

The demographics of the AHP workforce were shared, and the Committee noted that the majority of the workforce (14%) were aged between 35-54. 2% of the workforce were age 55 – 69 years. Sarah Birmingham noted that she had been working with Ali Koeltgen, Deputy Director of HR and

OD to develop an AHP workforce plan to develop the workforce and talent management. The Committee was informed of the development of the AHP Strategic Framework, which was comprised of 12 ambitions and 33 deliverables aligned with the Trust strategic aims and the National AHP Strategy.

After consideration of options, the requirement to develop apprenticeship opportunities across all professions in order to enhance the transformation and upskill of the existing workforce had been identified. The benefits of increasing the Trust's apprenticeship offer were shared, and it was highlighted that this would improve recruitment and retention and enable stability for teams. The different levels of apprenticeships available were shared with the Committee, and it was noted that the uptake numbers were very low. Feedback from colleagues was shared and this highlighted some of the barriers which were preventing the uptake, and these included, lack of capacity, commitment to 2/4 years' learning and the capacity to ensure study time could be taken. Sarah Birmingham asked for consideration to be given to having an overall Trust policy to overcome barriers in place and to support decision making and reinforcing the sharing of career pathways, ensuring this was fair across different services.

The Committee thanked colleagues for attending the meeting and providing this update.

STAFF ENGAGEMENT: 2022 STAFF SURVEY & PEOPLE PULSE SURVEY UPDATE

The Committee received the Staff Engagement: 2022 Staff Survey and People Pulse Survey Update, which provided an update on the engagement activities following publication of the 2022 NHS Staff Survey results and Quarter 4 of the People Pulse Survey.

The Committee was informed of the additional work which would be undertaken regarding appraisals and ensuring that they were valuable. Information had been sought from high performing NHS trusts and would be reviewed later in the month.

The Committee noted the results from the People Pulse Survey and the good feedback received across themes. It was noted that QR codes had been introduced, to make it easier for colleagues to complete, especially clinical colleagues who did not have everyday access to computers.
The Committee noted the survey results and related report content and were assured that the Trust's strategic approach to people management, engagement, culture and communications over the past year was paying dividends.

WORKING WELL ANNUAL ASSURANCE REPORT

The Committee received the Working Well Annual Assurance Report, which provided assurance that the Occupational Health Team was managed and governed appropriately, and that timely and appropriate funding was made available by the Trust to ensure the service was adequately resourced to provide both core occupational health and proactive wellbeing services.
The Trust had received confirmation from the Faculty of Occupational Medicine that the Service had achieved its 5-year SEQOHS re-accreditation (Safe, Effective, Quality, Occupational Health Service).

There had been an increasing trend of referrals for mental health and stress and reported a 4% increase from the previous year.

The Committee was assured that international students and colleagues were made aware of the tools and support available. This was included in the Corporate Induction and also brochures which were sent out with the recruitment paperwork. Occupational Health presentations had also been shared with the cohort.

The Committee noted the contents of the report and agreed that appropriate assurance mechanisms were in place in the Workforce Management Group (WOMAG) to monitor the Trust's delivery of occupational health services by Working Well.

PERFORMANCE REPORT – WORKFORCE KPIS

The Committee received the Performance Report, Workforce KPIs, which provided a high-level view of the key people performance indicators across the Trust. The starters and leavers information was highlighted and it was reported there had been a net gain of 177 whole time equivalents (WTE) over the previous 12 months. In regards to workforce establishment trend, this had increased by 3.6% in the same 12-month period. The Trust's vacancy data was shared with the Committee and it was reported there had been a reduction over the 4 months from November to March, with the lowest rates reported since June 2022. The main reason reported for leaving the Trust was retirement, however this was closely followed by work life balance. The Committee was informed that 85% of appraisals had been completed.

The Committee:

- **Noted** the performance report – workforce KPIs - for April 2023/24
- **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 the Trust's workforce performance measures or that appropriate service action plans were being developed to address areas requiring improvement.

OTHER ITEMS RECEIVED

The Committee:

Received and **noted** the Recruitment & Retention Strategic Framework Annual Report
Received and **noted** the Nursing & Retention Toolkit & HCSW Retention Update
Received and **noted** the Health & Wellbeing Strategic Framework Annual Review
Received and **noted** the Learning & Development Strategic Framework Annual Review
Received and **noted** the Corporate Risk Register
Received and **noted** the Board Assurance Framework
Received and **noted** the HR Policy Manual Project - Overview
Received and **noted** the Summary Report of the Workforce Management Group
Received and **noted** the Summary Report of the Joint Negotiating and Consultative Forum (JNCF)
Received and **noted** the Summary Report of the ICS People Committee

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of the report.

DATE OF NEXT MEETING	3 August 2023

CHARITABLE FUNDS COMMITTEE SUMMARY REPORT
DATE OF MEETING: 8 JUNE 2023

COMMITTEE GOVERNANCE	• Committee Chair – Sumita Hutchison, Non-Executive Director • Attendance (membership) – 80% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

FINANCE REPORT

The Committee received the Finance Report, which provided an overview of the Trust's Charities funds as of 31 March 2023. The Committee was informed the funds balance, at 31st March 2023, had increased by £35k during the year, from £350k to £385k. A breakdown of the income received was included within the report. The Committee **noted** the report.

APPROACH TO FUNDRAISING IN THE FOREST OF DEAN

The Committee received the Approach to Fundraising in the Forest of Dean, following the successful lottery grant award.

It was reported that the Trust would be working in partnership with the Forest Voluntary Action Forum (FVAF), who had agreed to support and lead the community engagement required to create a fundraising strategy and ongoing community engagement following the transition to the new community hospital.

The Committee **noted** the progress on developing a community engagement approach to understand the options for a fundraising approach in the Forest of Dean (FOD).

CHARITY LOGO & BRANDING

The Committee received the Charity Logo and Branding report, which provided an update on the progress made of rebranding and relaunching the Trust's Charitable Funds, raising its profile both inside and outside of the Trust. The Committee noted the progress made on developing new branding and endorsed the approach, including the new logo.

BROKENBOROUGH UPDATE

The Committee received the Brokenborough update which provided an update on progress towards the disposal of the land at Sherston Road, Malmesbury (Brokenborough land).

The Committee was informed that an update had been received from Hollins Strategic Land (HSL) indicating that they expected to see a draft Wiltshire Development plan going to their Cabinet and Council meetings in July which would then lead to a public consultation scheduled for September. The Committee would then be updated on the decision agreed. The Committee **noted t**he contents of the report.

OTHER ITEMS RECEIVED

The Committee:
Received and **noted** the League of Friends Update for information purposes only.

ACTIONS REQUIRED BY THE BOARD
The Board is asked to:

- **Note** the contents of the report.

DATE OF NEXT MEETING	6 September 2023

AUDIT & ASSURANCE COMMITTEE SUMMARY REPORT
DATE OF MEETING: 19 JUNE 2023

COMMITTEE GOVERNANCE	• Committee Chair – Marcia Gallagher, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

INTERNAL AUDIT (BDO)

The Committee **received** and **noted** the Accounts Payable internal audit report for consideration and noted this was rated substantial, for both design opinion and design effectiveness.

CONSIDERATIONS PRIOR TO APPROVAL OF THE ANNUAL ACCOUNTS

The Committee received the Considerations Prior to Approval of the Annual Accounts and **considered** the evidence presented in the report and declared it was satisfied with the reliability of the Annual Accounts and the Letter of Representation.

FINAL ACCOUNTS & CERTIFICATES

The Committee received the Final Accounts and Certificates for 2022/2023 for Gloucestershire Health and Care NHS Foundation Trust.

The Committee **approved** the 2022/2023 Annual Accounts for Gloucestershire Health and Care NHS Foundation Trust on behalf of the Board.

The Committee **approved** the signing of:

- The Statutory Accounts for Gloucestershire Health and Care NHS Foundation Trust 2022/2023
- TAC Confirmations tab (NHS Improvement's Accounts) (TACs)
- TAC Summarisation Schedule Certificate (NHS Improvement's Accounts) (TACs)
- The Letter of Representation

The Committee formally thanked the Finance Team for their work in finalising the accounts.

FINAL ANNUAL REPORT

The Committee received the Final Annual Report 2022/23 for Gloucestershire Health and Care NHS Foundation Trust and noted the changes made since the previous meeting.

The Committee **noted** the final draft and **approved** it for signing by the Chief Executive and Chair before being laid before Parliament; subject to the inclusion of amendments discussed. An updated version of the report would be circulated to the Committee for comments prior to submission on 30 June.

EXTERNAL AUDIT

VALUE FOR MONEY RISK ASSESSMENT 2023

The Committee received the Value for Money (VFM) Risk Assessment 2022/23, which provided the outcomes of the External Audit Value for Money Risk Assessment procedures under the VFM responsibilities for 2022/23.

The Committee received assurance that no significant risk had been identified.

The Committee **noted** the content of the report.

OTHER ITEMS RECEIVED

The Committee:

Received and **noted** the External Audit ISA260 Report
Considered and **endorsed** the Committee's Annual Report for presentation to trust Board in July.
Received and **noted** the Annual Finance Compliance Report.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of the report.

DATE OF NEXT MEETING	10 August 2023

FOD ASSURANCE COMMITTEE SUMMARY REPORT
DATE OF MEETING: 21 JUNE 2023

COMMITTEE GOVERNANCE	• Committee Chair – Steve Brittan, Non-Executive Director • Attendance (membership) – 83% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

COMMISSIONING & EQUIPPING PLANS

The Committee received an update on the Commissioning and Equipping Plans. A range of equipment needed to be transferred from the Trust's existing sites to the new FoD hospital. It was assumed, according to the timetable, that handover from Speller Metcalfe would occur 5 January 2024. The Committee was informed that the Trust's own commissioning work was scheduled for approximately 6 weeks, from 5 January to 23 February 2024.

The plans for the x ray equipment were outlined, and that currently this has an extended timetable for re-commissioning due to the need to test and seek sign off from the Radiation Protection Lead at GHT. The Committee were assured that alternative options continue to be explored both in terms of the options to purchase a new machine and contingency arrangements whilst we are working through the transition phase.

The Committee was informed that the team are exploring the opportunities to seek early access to the new hospital for the movement of the equipment ahead of the building handover, and dental colleagues were expected to move to the new hospital 28 February 2024. The bed reduction options were discussed with the Committee recognising that there is a need to reduce the number of patients on a phased basis prior to the final move, this may include consolidating onto a single site for a short period of time prior to the final move.

An example timeline for the commissioning of the new hospital was discussed but this still needs to be finalised, and it was noted that the endoscopy move is likely to be the final area to be commissioned.

WORKFORCE TRANSITION PLANS

The Committee received an update on the workforce transition plan and the ongoing processes of engagement with colleagues across both existing hospital sites. The Committee recognised that this process is particularly unsettling and stressful for colleagues and therefore the team have moved forward with this ahead of the previously scheduled timetable. The precise staffing models and formal consultation proposals are now being finalized and it is anticipated will be signed off by the Executive Team shortly.

The committee noted the report and actions being taken to finalise the proposals and continue dialogue with colleagues across both existing sites.

UPDATE ON THE INTERNAL NAMING APPROACH

The Committee received the update on the Internal Naming Approach paper, which provided an update on the approach to naming of the internal rooms and facilities within the new FoD Hospital. The Committee was informed, following engagement with operational teams that apart from the inpatient ward and the day room the proposal was that rather than name rooms, a numbering system within each department would be used supported with a description of their purpose.

A list of suggestions was being collated by the ward manager for the naming of the inpatient ward and the day room. This list would then be shared with members of the Project Board to ensure suggestions meet the Trust's Naming Policy and a vote would take place on the final names.
The Committee **noted** the progress being made and **endorsed** the approach being taken.

FINANCIAL UPDATE

The Committee received the Finance Update and Early Warning Notices, which provided an update on the progress against the budget and current position.

The Committee was informed that expenditure in 2022/23 was as expected and £17.5m had been spent as of the end of April 2023.

The spend analysis and the equipping and commissioning costs were highlighted and it was reported there was a revenue challenge of c£400k and a capital challenge of c£545k.

The Committee was informed that this element of the project was a Trust risk with the majority of the cost increase was due to inflation and noted that the cost of the endoscopy equipment had increased significantly in the previous two years.

The Committee **noted** that the construction of the project was continuing on time and to schedule. The FoD Assurance Committee would continue to monitor and review these over the upcoming months.

A.O.B. – COMMITTEE TERMS OF REFERENCE

The Committee agreed to have oversight of the disposal approach and process of the two existing hospitals. It was agreed that the Committee's Terms of Reference would be updated with this addition and presented back to the Trust Board in July for approval.

OTHER ITEMS RECEIVED

The Committee:

Received and **noted** the Workforce Transition Report
Received and **noted** the Construction update
Received the Risk Register & **endorsed** the recommendation to amend risk 292 to a score of 16.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of the report.
- **Approve** the updated Terms of Reference for the Committee (attached at Appendix 1).

DATE OF NEXT MEETING	TBC

TERMS OF REFERENCE

Forest of Dean (FoD) Assurance Committee

Version 2

1.0	**Purpose**
1.1	The purpose of the FoD Assurance Committee is to receive and provide assurance to the Trust Board on the overarching delivery of the FoD Hospital programme, ensuring that the programme is delivered on time, to the agreed budget, and to a satisfactory quality.
2.0	**Membership**
2.1	Membership Steve Brittan (Chair) Graham Russell (NED/GPTW Committee Chair) Steve Alvis (NED/Quality Committee Vice Chair) Angela Potter (Director of Strategy and Partnerships) Sandra Betney (Director of Finance) Neil Savage (Director of HR&OD) In Attendance Kevin Adams (Associate Director of Estates, Facilities & Medical Equipment) Andrew Paterson (Strategic Project Manager) Trust Secretariat In Attendance (at Request of Committee) Alison Halmshaw (Gleeds) Adrian Speller (Speller Metcalfe)
2.2	Other Officers or Directors of the Trust may attend at the discretion of the Chair.
3.0	**Quorum**
3.1	**Three** members, at least two of whom should be Non-Executive Directors and one should be an Executive Director. Where a member is unable to attend a meeting of the Committee, that member may, with the agreement of the Committee Chair, nominate a deputy who will count towards the quorum.
4.0	**Reporting Arrangements**
4.1	The FoD Assurance Committee will update each routine Board meeting on its activity, highlighting decisions made, issues being progressed and issues requiring further consideration or decision by the Board.
4.2	The Committee will highlight any key issues or concerns to the Audit and Assurance Committee or the Resources Committee which require consideration by one or both of these committees.

5.0	**Powers**
5.1	The Trust's Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation shall apply to the FoD Assurance Committee.
6.0	**Responsibilities**
6.1	The Committee will receive regular progress assurance reports from the FoD Project Board who are leading on the development of the Full Business Case The Committee will provide an oversight and assurance function on the delivery of the new hospital. The Committee will have oversight of the costing plan and will review and consider any significant changes to this. The Committee will also oversee and approve any value engineering recommendations. To oversee the land disposal strategy and marketing/transaction process for the existing Lydney and Dilke Hospital sites acknowledging that there are significant reputational, commercial and social value parameters to be considered throughout the process and the sites can only be vacated according to the agreed mobilisation timescales.
7.0	**Frequency and Review of Meetings**
7.1	Committee meetings will initially be held monthly, commencing in February 2021. The Chair may agree further meetings if necessary. Virtual meetings, at the discretion of the Committee Chair, may take place using appropriate electronic methods.
7.2	These Terms of Reference will be reviewed annually, with any change recommended to the Trust Board.
8.0	**Administration**
8.1	The Trust Secretary will ensure appropriate support is provided to the Committee.

Version:	**Date Approved:**	**Approved by:**
Version 1	04/03/2021	FoD Assurance Committee
Version 1	31/03/2021	Trust Board
Version 2	27/07/2023	Trust Board

RESOURCES COMMITTEE SUMMARY REPORT
DATE OF MEETING: 29 JUNE 2023

COMMITTEE GOVERNANCE	• Committee Chair – Steve Brittan, Non-Executive Director

THIS MEETING WAS HELD BY CORRESPONDENCE.
THE ITEMS SUMMARISED BELOW HAD SOUGHT COMMITTEE ENDORSEMENT OR APPROVAL AND A RECORD OF APPROVALS RECEIVED HAS BEEN MAINTAINED BY THE TRUST SECRETARIAT FOR FUTURE RECORD.

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

NHS PREMISES ASSURANCE MODEL – SUBMISSION SIGN OFF

The Committee **received** and **endorsed** the submission of the NHS Premises Assurance Model self-assessment.

ICS JOINT FORWARD PLAN

The Committee received the ICS Joint Forward Plan and **noted:**

- The progress on the first One Gloucestershire Joint Forward Plan as a high-level summary of how the health community intends to deliver improving health and care to the people of Gloucestershire to meet the ambitions of the Integrated Care Strategy
- The annual refresh cycle of the Joint Forward Plan, and the aim to ensure system planning processes are as integrated and efficient as possible, notably with operational planning and medium-term financial and workforce planning.

The Committee **endorsed** the Integrated Care Board approval to publish the Joint Forward Plan on 30 June.

CLINICAL SYSTEMS VISION PROGRAMME – UPDATE

The Committee received the Clinical Systems Vision Programme (CSVP) Update. Due to the meeting taking place via correspondence, the Chair, Steve Brittan met with Lee Charlton to discuss this further. The Chair sought assurance that the CSV programme was building on the lessons learnt from the SystmOne simplicity programme, and that a broad review of operational processes was being undertaken in order to improve efficiencies and inform CSV requirements.
The Board is asked to **note** that this assurance was received.

OTHER ITEMS RECEIVED

The Committee:
Received and **noted** Finance report – Month 2
Received and **noted** Performance report – Month 2
Received and **noted** Service Development Report
Received and **noted** National Cost Collection Methodology
Received and **noted** Summary Reports of relevant Management Groups

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of the report.

DATE OF NEXT MEETING	31 August 2023

QUALITY COMMITTEE SUMMARY REPORT
DATE OF MEETING: 06 JULY 2023

COMMITTEE GOVERNANCE	• Committee Chair – Jan Marriott, Non-Executive Director • Attendance (membership) – 71% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

CLINICAL PRESENTATION – FALLS WORK AT CHARLTON LANE HOSPITAL

The Committee welcomed Naymond Campbell, Physio Lead and Brad Watkins, Matron to the meeting who provided a presentation on the falls work at Charlton Lane. They spoke about the work that had implemented to effectively reduce the falls rate at Charlton Lane, and how this work translated across the Trust.

The Committee was informed of the culture change which had been a key focus. Naymond Campbell shared the further steps which would be taken and spoke about the review of the Trust's Falls Policy, as well as the increased levels of training available on site at Charlton Lane Hospital.

The Committee was impressed with the amount of work achieved and congratulated Naymond Campbell and Brad Watkins on the progress and achievements in reducing the falls rate at Charlton Lane Hospital.

QUALITY DASHBOARD REPORT

The Committee received the Quality Dashboard Report, which provided 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 sustained improvements in CPA compliance was highlighted and the Committee was informed that compliance rates had either met or exceed 95% for the previous 8 consecutive months.
The Committee was informed that a GHC Sexual Safety Awareness Training pathway pilot would be concluded at the end of June.

The Committee was informed that assurance relating to the media concerns raised regarding the care provided at Wotton Lawn Hospital would be brought to future Quality Committee meeting and also Trust Board. The Committee noted that the issues raised had triggered a review and scrutiny from ICB, CQC and NHS England colleagues. The Committee was informed that following review by the CQC, the output of that was no further action was required, because CQC were satisfied with the quality of the data reported and also from their intelligence of their regular scheduled and unscheduled visits to the Trust's services. The Trust would be working with the ICB to produce further data for review and regular meetings were being held.

The Committee **noted** the report.

NICHE FINAL CLOSURE REPORT

The Committee received the Niche Final Closure Report, which demonstrated the closure of all actions relating to the Gloucester Recovery Team Mental Health Homicide action plan and subsequent findings from the NICHE quality assurance review.

The Committee:

- **Noted** the completed action plan and supporting evidence to affect the closure of the original improvement plan.
- **Noted** the completed action plan and supporting evidence to affect the closure of the NICHE quality assurance review.

PERSONALISED CARE PROJECT UPDATE

The Committee received the Personalised Care Project Update, which provided information on the Personalised Care and Support Plan Standard, and Information Standard Notification which requires the *About Me* standard to be implemented by 31st January 2024.

The standard commissioned by NHSE, NHSI delivered by the Professional Record Standards Body (PRSB) has the intent to establish consistency in information capture regarding personalised care and support planning. The report outlined how a trial established on Kingsholm Ward and Chestnut Ward incorporated the standards, the associated learning and requested an expansion of the trial.

The Committee **approved** the use of the trial to expand throughout Mental Health Inpatient service.

The Committee welcomed this update and agreed that this would be a helpful piece of work to share with the Trust's Governors at a future meeting.

OTHER ITEMS RECEIVED

The Committee:

Received and **noted** the Learning from Deaths Report
Received and **noted** the Psychological Services Annual Report
Received and **noted** the Annual Patient Safety Report
Received and **noted** the Quality Assurance Group Summary Report

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of the report.

DATE OF NEXT MEETING	7 September 2023

APPOINTMENTS AND TERMS OF SERVICE COMMITTEE SUMMARY REPORT

DATE OF MEETING: 13 JULY 2023

COMMITTEE GOVERNANCE	• Committee Chair – Ingrid Barker, Trust Chair • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

EXECUTIVE DIRECTOR PERFORMANCE REVIEW

A key role of the Appointments and Terms of Service Committee (AToS) is to provide scrutiny of the performance of the Executive Team and to agree remuneration and terms of service of the team. The Committee noted that the previous CEO Paul Roberts had completed an interim appraisal in February 2023, and this was shared with the Committee on 1st March, summarising the performance appraisal of six Executive Directors for 2022/23. The Chief Executive advised that the assessment made by Paul Roberts in February 2023 remained current and accurate and he therefore recommended that these interim appraisals be used as the full year appraisal outcome. The Committee agreed that this was a sensible way forward.

The Committee noted that the Chief Executive had met with all the Executive Directors in the last few weeks to discuss and agree a set of objectives for the 2023-24 delivery year. The individual objectives were summarised within the report. It was noted that one common objective had been included which related to increasing and maintaining Executive visibility within the organisation. Each Executive Director also had a personalised objective specifically related to Equality, Diversity and Inclusion.

The Committee received and **noted** this report.

REVIEW OF EXECUTIVE DIRECTOR PORTFOLIOS

This report provided a summary of the outcome of the review of Executive Director portfolios undertaken in discussion with members of the Executive team, individually and collectively and considering recent performance review discussions. The Chief Executive informed the Committee that he was satisfied that the report clearly represented the current portfolios held by each Executive Director and that the portfolios were appropriately distributed across the team.

The Committee **noted** the report.

CHIEF EXECUTIVE OBJECTIVES 2023/24

This report provided the Committee with the agreed performance objectives for the Chief Executive for 2023/2024. Progress against objectives will be reviewed by the Chair and reported to the Committee in line with the annual performance review cycle for the Chief Executive and Executive Directors.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	8 November 2023

WORKING TOGETHER ADVISORY COMMITTEE SUMMARY REPORT
DATE OF MEETING: 19 JULY 2023

COMMITTEE GOVERNANCE	• Committee Chair – Jan Marriott, Non-Executive Director • Attendance (membership) • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

This quarters meeting was an MS Team meeting and had a greater focus on sharing information and updating members on the work that the Trust is undertaking.

TERMS OF REFERENCE

The Committee supported the amendment to the Committee's name and that it was now the Working Together Advisory Committee. There will be a fuller Committee review and refresh of the ToR later in the year.

QI APPROACH – BIG I AND LITTLE I

The Committee received an update on the work that the QI hub have been taking forward with a particular focus on the increasing levels of patient/service user participation in our QI activities. Currently 37.6% of our projects include participation either from the outset or at a later stage and the QI team have set themselves a QI project to increase that level to 50% initially.

EXPERT BY EXPERIENCE PARTICIPATION

The Committee received an update on the ongoing EBE programme noting that we currently have 239 adult experts and 8 CYP experts, of which 52 were new starters in 22/23. There have been circa 500 expert by experience involvement activities and the Committee reviewed the range of activities that were in place over the upcoming months.

The Committee heard about the upcoming EBE tea party proposed for September to celebrate the activities of our experts and volunteers.

PERSONALISED CARE ACTIVITIES

The Committee received the presentation previously shared with Quality Committee looking at the range of activities that we have been taking forward in terms of personalised care planning and specifically the amendments to the Orange *What Matters to Me* folder. The Committee agreed that they would look forward to receiving further updates in this area at a future meeting.

LOCALITY PARTNERSHIP ACTIVITIES

The Committee were provided with an overview of the Integrated Locality Partnership priorities and where the Trust is supporting these activities.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to **note** the content of this report and **support** the change of name to the Working Together Advisory Committee.

DATE OF NEXT MEETING	19th October 2023