with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION

Thursday, 28 September 2023

10:00 – 13:00

Meeting Space, The Salvation Army, 27 Acre Street, Stroud, GL5 1DR

AGENDA

TIME	Agenda Item	Title	Purpose	Comms	Presenter
OPENING BUSINESS					
10:00	01/0923	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/0923	Declarations of interest	Assurance	Verbal	Chair
10:05	03/0923	Service User Story Presentation	Assurance	Verbal	DoNTQ
10:25	04/0923	Draft Minutes of the meetings held on 27 July 2023	Approve	**Paper**	Chair
	05/0923	Matters arising and Action Log	Assurance	**Paper**	Chair
10:30	06/0923	Questions from the Public	Assurance	Verbal	Chair
PERFORMANCE AND PATIENT EXPERIENCE					
10:35	07/0923	Quality Dashboard Report • Learning from Deaths Q1 23/24	Assurance	**Paper**	DoNTQ MD
11:00	08/0923	Performance Report • Workforce Performance Indicators	Assurance	**Paper**	DoF/COO
11:20	09/0923	Finance Report	Assurance	**Paper**	DoF
10/0923 - 11.30 – BREAK – 10 Minutes					
11:40	11/0923	Medical Appraisal Annual Report	Assurance	**Paper**	MD
STRATEGIC ISSUES					
11:50	12/0923	Report from the Chair	Assurance	**Paper**	Chair
12:00	13/0923	Report from Chief Executive	Assurance	**Paper**	CEO
GOVERNANCE					
12:20	14/0923	Risk Appetite Statement	Approval	**Paper**	Trust Sec
12:30	15/0923	Council of Governor Minutes – July 2023	Information	**Paper**	Chair
BOARD COMMITTEE SUMMARY ASSURANCE REPORTS					
12:35	16/0923	Great Place to Work Committee (3 Aug)	Information	**Paper**	GPTW Chair
	17/0923	Audit & Assurance Committee (11 Aug)	Information	**Paper**	Audit Chair
	18/0923	Resources Committee (31 Aug) • Terms of Reference	Approve	**Paper**	Resources Chair

TIME	Agenda Item	Title	Purpose	Comms	Presenter
	19/0923	Forest of Dean Assurance Committee (4 Sept)	Information	**Paper**	FoD Chair
	20/0923	Charitable Funds Committee (6 Sept)	Information	**Paper**	CF Chair
	21/0923	Quality Committee (7 Sept)	Information	**Paper**	Quality Chair
CLOSING BUSINESS					
12:50	22/0923	Any other business	Note	Verbal	Chair
	23/0923	**Dates of future 2023 Board Meetings** Thursday, 30 November	Note	Verbal	All

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AGENDA ITEM: 04/0923

MINUTES OF THE TRUST BOARD MEETING

Thursday, 27 July 2023

Meeting held at Churchdown Community Centre

PRESENT:
Ingrid Barker, Trust Chair
Steve Alvis, Non-Executive Director
Sandra Betney, Director of Finance
Douglas Blair, Chief Executive
Steve Brittan, Non-Executive Director
Sharon Buckley, Deputy Chief Operating Officer (Deputy)
Marcia Gallagher, Non-Executive Director
Sumita Hutchison, Non-Executive Director
Nicola de Iongh, Non-Executive Director
Dr Faisal Khan, Deputy Medical Director (Deputy)
Ali Koeltgen, Deputy Director of HR & Organisational Development (Deputy)
Vicci Livingstone-Thompson, Associate Non-Executive Director
Angela Potter, Director of Strategy and Partnerships
Graham Russell, Non-Executive Director
John Trevains, Director of Nursing, Therapies and Quality

IN ATTENDANCE:
Anna Hilditch, Assistant Trust Secretary
Bob Lloyd-Smith, Healthwatch Gloucestershire / Appointed Governor
Bren McInerney, Member of the Public
Louise Moss, Deputy Head of Corporate Governance (Deputy)
Annie Nightingale, Deputy Head of Communications (Deputy)

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting. Apologies had been received from Neil Savage, Dr Amjad Uppal, David Noyes, Jan Marriott, Helen Goodey and Lavinia Rowsell.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. SERVICE STORY PRESENTATION

3.1 The Board welcomed Kate to the meeting who was in attendance to speak to the Board about her experiences. Fiona Williams, Trust Lead for Art Therapies and Art Psychotherapist joined Kate and supported her to tell her story.

3.2 Kate was a singing and piano teacher and carried out the role of teaching assistant for children with special needs. Kate was 44 when she suffered a mental breakdown. Kate has had a lot of different treatments over many years including long hospital admissions and specialist out of area stays too. Kate informed the Board that it often felt that it had become her whole world, and she felt like she was just a person with a mental illness, nothing more.

3.3 Kate had started Art Psychotherapy which is a relational and practical therapy. Kate said that having a form of therapy where she was able to express herself and put her thoughts down on paper felt like a less combative approach which worked well for her. It had helped her to recognise the impact that events in her earlier years had had on her mental health. She added that it was the relationship that she had developed with Fiona during the treatment, along with the consistency, kindness and caring that had been shared that had made Kate feel she was able to trust and open up to staff and to really make the therapy work for her. Kate took the opportunity to thank Fiona Williams for her support.

3.4 Steve Alvis asked how people could access Art Psychotherapy as it was clear that this was a valuable service. Fiona Williams said that GHC only had 4 Art Psychotherapists. In her previous Trust before moving to GHC there had been 80. She said that colleagues had provided services not only in mental health but for physical health and learning disability services as well. With only 4 Art Psychotherapists, Fiona said that there was no opportunity for career progression, which could make colleagues feel undervalued. She said that a post had recently been recruited to and there had been a huge number of excellent applications received, suggesting that the staff were there if the posts were available. Marcia Gallagher said that she had visited the Art Therapy services a number of years ago and agreed that it was a valuable service. She said that it was important to be able to evidence the outcomes of the service, as demonstrating these outcomes was a powerful tool when speaking with commissioning colleagues about future service developments.

3.5 Nicola de longh said that it had been really moving to hear Kate's story and the journey she had been on. Kate was no longer defined by her illness and was once again the person, not the condition.

3.6 The Board thanked Kate for attending and talking about her experience, which demonstrated her courage, strength and determination. Thanks were also given to Fiona Williams for her support, and for speaking freely and passionately about the Art Psychotherapy service.

4. MINUTES OF THE PREVIOUS BOARD MEETING

4.1 The Board received the minutes from the previous Board meeting held on 25 May 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 relating to the provision of services to children and families with special educational needs. A verbal response was provided at the meeting from Sharon Buckley. 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**

6.2 A further question was received from Bob Lloyd-Smith. The question was "In the wake of the National Partnership Agreement: Right Care, Right Person (RCRP) published yesterday (26th) by the Department of Health and Social Care and the Home Office I was wondering how you anticipate the relationship with GHC's mental health services and Gloucestershire Constabulary changing?". John Trevains thanked Bob for his question. The Trust have a long standing, strong collaborative relationship with Gloucestershire Constabulary, particularly from an operational perspective, ensuring collaborative work on strategic developments. Historically these have included Crisis Care Concordat, Mental Health Act changes and local lessons learned from multi-agency incidents. GHC and Gloucestershire Constabulary have several joint collaborations consistent with the RCRP strategy, including Mental Health Response Vehicle, Frequent Engagement Response Network, joint Section 135/6 policy and recent joint work on AWOL Policy with Wotton Lawn. The Trust had been advised that Gloucestershire Police were not early adopters of the strategy and implementation would be a collaborative approach with system partners with an emphasis on a safe, legal and effective response. He said that there would be a change in dynamics and service delivery, but the Trust would continue to work closely with colleagues to ensure that safe services were maintained. There would be a phased and long term plan of work put in place to address the changes including checks and balances. He added that there would be no immediate changes to the service provision currently available. Bob Lloyd-Smith asked how this would be communicated to patients and community groups as people were worried about the impact. It was agreed that the Trust would continue to send out messages of reassurance but that discussions would take place with wider system partners about the development of broader communications that could be issued to patients and community groups to provide additional reassurance. **ACTION**

7. QUALITY DASHBOARD REPORT

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

7.2 John Trevains informed the Board that overall, the report demonstrated that some positive 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:

- 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. John Trevains noted that a detailed review of rapid tranquilisation was due at the next Quality Committee meeting.
- In partnership with operational colleagues the safeguarding team are providing additional focus to safeguarding supervision attendance.

7.4 Those areas showing a positive improvement this month included:

- 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.

7.5 Graham Russell asked whether it was possible to look at specific services, for example Wotton Lawn, and to see a report that covered the highlights such as HR, length of stay, finance, risk, and workforce. It was noted that work was taking place with Business Intelligence and integrated performance reporting was being used for indicators in exception. The Board noted this was work in progress, but the information was already used by teams at an operational level. Steve Brittan said that he had carried out a number of quality visits and he could see people using these reports. He said that systems were more sophisticated now so colleagues could use this data to recognise trends and see any drops in performance.

7.6 Sumita Hutchison asked whether there were any areas of concern that colleagues had that were not necessarily referenced within the report. John Trevains advised that the big concern continued to be recruitment and vacancies; however, there had been a huge improvement in recruitment over the past few months. Work was being carried out to refresh the safe staffing data currently available and this would give the Trust a good picture in line with new national guidance. The Board noted the low number of Locums currently used at Wotton Lawn noting that this was good for consistency. Steve Brittan said he had carried out a recent quality visit to the CYPS Speech and Language Therapy service. This team was fully staffed so it was clear that improvements were being made, noting that this team had a 20% vacancy rate last year.

7.7 Ingrid Barker referenced the data on physical restraint noting the upward trend. The disproportionate restraint of black men was also highlighted. John Trevains advised that this data was reported on and analysed in detail at the Trust's Positive and Safe Group. The upward trend related to two individuals and was driven by clinical issues. He assured the Board that Trust colleagues were aware of the position and there were currently no concerns that required escalation.

7.8 Ingrid Barker referred to pressure ulcers and those incidents of moderate harm, noting the differing rates by Integrated Care Teams around the county. John Trevains suggested that there were a number of factors that contributed to this position, for example more availability of domiciliary care in urban areas like Gloucester rather than in places such as the north Cotswolds. It was agreed that John Trevains would seek additional narrative to be presented back to the Board for information. **ACTION**

7.9 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 June 2023 (Month 3 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. There are currently around 260 indicators across all domains within the new 2023/24 Performance Indicator Portfolio although this is a dynamic position.

8.2 Of the 41 planned Physical health Service Line Dashboards, 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. 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.

8.3 Sharon Buckley presented the Chief Operating Officer report to the Board. It was noted that the past month had seen a further period of steady performance across the system, and GHC's community offer has remained consistently strong, with low numbers of patients in the Acute waiting on a community bed and good flow generated.

8.4 This period had seen continued industrial action from both junior doctors and consultants. Internally, GHC's contingency arrangements held up well. MiiUs continued to be well utilised, which is encouraging, and resilience has been good. John Trevains expressed his thanks to the Trust's Emergency Planning and Resilience Team for the preparatory work that had taken place in advance of the industrial action. He said that there had been no quality or safety issues arising and minimal impact on services.

8.5 It was noted that the demand on Mental Health beds has remained consistently high over the past month, with demand outstripping capacity, following a period where we had managed to create some capacity. However, the Trust continues to drive ahead with the work to endeavour to reduce Length of Stay.

8.6 Progress continues positively with turning around the Eating Disorders service and 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, and the Trust is continuing to review options for pivoting resources both internally and with current partners to address the routine adult waiting list. Board colleagues agreed that it was pleasing to see the positive progress being made within the Eating Disorders service.

8.7 The Board noted that 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 Band 5 colleagues onboarding in the next month was 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, 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. Sumita Hutchison noted this update on CAMHS and referred to the Healthwatch Report highlighted in the Chief Executive's report which looked into the social support for young people in Gloucestershire. She said that it was important to connect all of these things together. Douglas Blair referred to the multiagency navigation hub pilot that was taking place. He said that this pilot brought in voluntary sector and stakeholder involvement and engagement and was helping the system to look at how to use existing resources differently and more effectively.

8.8 Steve Alvis noted the update in the report around the deterioration in the Echo performance provided by GHFT. Sandra Betney advised that this related to the cessation of a contract, but new arrangements were now in place and this position should show some recovery shortly. This issue had been raised with commissioners.

8.9 Graham Russell asked about good practice in relation to waiting lists, and suggested that he would find it helpful to receive more information setting out how this process worked in terms of how the lists were managed, prioritised, patient profiles, identifying people that should be on a waiting list but weren't etc. Further consideration would take place to see how best this could be presented to the Board. **ACTION**

9. LEARNING FROM DEATHS – QUARTER 4 2022/23

9.1 The Board received the Learning from Deaths report covering the period quarter 4 2022/23. It was noted that no concerning trends or themes had been identified. The Board noted that the report now contained learning from End-of-Life care incidents, concerns and queries.

9.2 An increase in the inpatient death rate for Community Hospitals and Charlton Lane was seen 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 (Charlton Lane) in receipt of end-of-life care in the last quarter.

9.3 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. Data around 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.

9.4 'Learning on a Page' documents are 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.

9.5 Feedback from the Medical Examiner service continues to provide significant assurance 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.

9.6 The outcome of inquests were also shown within the report, and it was clear that suicide prevention remains a key priority for the Trust, and as such, would continue as a Quality Priority in 2023/24. Nicola de Iongh asked whether the Trust also reviewed suicides of people who were not in contact with the Trust. John Trevains said that GHC was a member of the

countywide Reducing Suicide Partnership and would feed into discussions about this important topic.

9.7 During Q1-4 2022-23, there were 14 patient deaths by suspected suicide. All were patients open to community mental health teams. Sandra Betney noted that 5 of the patient deaths that occurred in 2022-23 fell under the "No MH diagnosis" category due to having no formal diagnosis. She asked whether it would be possible to include additional narrative in future reports to explain this in more detail. **ACTION**

10. FINANCE REPORT

10.1 Sandra Betney informed the Board that the 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 surplus of £0.036m

10.2 The current system plan is break even and the Trust's plan is break even. At month 3 the Trust had a surplus of £0.046m compared with a plan of £0.12m. The 2023/24 Capital plan is £17.785m and spend to month 3 was £3.188m against a plan of £5.241m. Cash at the end of month 3 was £47.614m.

10.3 The Cost improvement programme has delivered £3.129m of recurring savings, of which £0.562m remains subject to QEIA sign-off. The target for the year is £5.443m. Non-recurring savings were delivered in month 3 of £1.122m

10.4 The Better Payment Policy shows 99.1% of invoices by value paid within 30 days, the national target is 95%.

10.5 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%. The Board noted that this would be a key area of focus for the Trust.

10.6 The System position at month 3 was a £683k overspend which reflects the financial impact of the Industrial Action at GHFT.

10.7 An additional capital disposal of £400k had been added to the capital plan for 2024/25. The Board reviewed and approved this addition.

11. CHAIR'S REPORT

11.1 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 May. 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.

11.2 Ingrid Barker advised that GHC would be participating as a sponsoring organisation in Gatenby Sanderson'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, Ingrid Barker would provide mentoring and support to aspiring NHS NEDs.

11.3 Ingrid Barker said that she 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. Ingrid expressed her 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.

11.4 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.

12. CHIEF EXECUTIVE'S REPORT

12.1 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 the last meeting in May.

12.2 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 and 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.

12.3 Douglas Blair had 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 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 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. The Board noted that overall the programme continued to make progress and some of the key headlines were set out within the report. It was agreed that it would be helpful to see the work to date mapped out, for sharing with the NEDs. **ACTION**

12.4 The Trust was 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.

12.5 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.

12.6 The NHS long term workforce plan (LTWFP) was published on 30 June 2023, shortly ahead of the NHS 75th birthday. 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. It was noted that many of the plan's aspirations are already contained as Trust aspirations and actions agreed through the GHC Recruitment and Retention Strategic Framework, and work has commenced to review the wider content of our People Strategy and other workforce related strategic frameworks to ensure alignment with the plan.

12.7 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.

13. AUDIT & ASSURANCE COMMITTEE ANNUAL REPORT

13.1 The Board received the annual report of the Audit and Assurance Committee for 2022/23. The report provided 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. The Board was asked to note that no issues had been highlighted as areas of concern, and the Committee has operated in line with its terms of reference to meet the functions delegated to it by the Board.

13.2 Marcia Gallagher as Chair of the Audit and Assurance Committee expressed her thanks to her NED colleagues for their attendance and contributions at the meetings, and to Sandra Betney and Lavinia Rowsell for their support and stewardship of the Committee.

14. CORPORATE GOVERNANCE UPDATE REPORT

14.1 The purpose of this report was 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.

14.2 This report provided 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

14.3 It was noted that any implications or resulting changes to governance practices/polices required as a result of the new or updated guidance had been considered by the Trust Secretariat and the relevant governance Committees.

15. COUNCIL OF GOVERNOR MINUTES

15.1 The Board received and noted the minutes from the Council of Governor meeting held on 17 May 2023.

16. BOARD COMMITTEE SUMMARY REPORTS

16.1 **Great Place to Work Committee**
The Board received and noted the summary report from the Great Place to Work Committee meeting held on 8 June 2023.

Sandra Betney noted the agency usage cap and asked whether narrative on this was provided at the GPTW Committee. It was noted that this would be picked up via the Workforce KPIs report. John Trevains suggested that the Quality Dashboard report could also be strengthened with additional agency data and would action this accordingly.

16.2 **Charitable Funds Committee**
The Board received and noted the summary report from the Charitable Funds Committee meeting held on 8 June 2023. The Committee had received an update on the fundraising approach for the Forest of Dean, progress with the rebranding of the Trust's Charity and an update on the Brokenborough land.

16.3 **Audit and Assurance Committee**
The Board received and noted the summary report from the Audit & Assurance Committee meeting held on 19 June 2023. The Committee had received and approved the final Annual Accounts and Annual Report 2022/23. Marcia Gallagher expressed her thanks on behalf of the Board to all colleagues who had worked so hard to prepare these key documents.

16.4 **Forest of Dean Assurance Committee**
The Board received and noted the summary report from the Forest of Dean Assurance Committee meeting held on 21 June 2023.

The Committee had received an update on the workforce transition plan and the ongoing processes of engagement with colleagues across both existing hospital sites. Marcia Gallagher suggested that more was needed to communicate with staff about the transition as she was still hearing colleagues' concerns. Ali Koeltgen informed the Board that the formal staff consultation period had now commenced, and this would include invites for colleagues to attend 1:1 meetings and team meetings. Wellbeing support was also being offered. Ali Koeltgen said that no redundancies were expected, and this was being made very clear to all colleagues working at the existing Forest Hospital sites.

The Committee agreed to have oversight of the disposal approach and process of the two existing Forest hospitals. The Committee's Terms of Reference had therefore been updated to reflect this addition and were presented in full to the Board for approval. The Board approved the amended TOR.

16.5 **Resources Committee**

The Board received and noted the summary report from the Resources Committee. It was noted that this meeting, scheduled to take place on 29 June had taken place via correspondence. The summary report provided an update on those items presented seeking Committee approval.

16.6 **Quality Committee**

The Board received and noted the summary report from the Quality Committee meeting held on 6 July 2023. The Committee had received an wclinical presentation on the falls work at Charlton Lane. Colleagues spoke about the work that had been implemented to effectively reduce the falls rate at Charlton Lane, and how this work translated across the Trust.

16.7 **Appointments and Terms of Service Committee**

The Board received and noted the summary report from the Appointments and Terms of Service Committee meeting held on 13 July 2023.

16.8 **Mental Health Legislation Scrutiny Committee**

The Board noted that the MHLS Committee meeting had taken place on 19 July 2023. Steve Alvis, deputy Chair of the Committee provided a verbal summary report. The overall positive outcome of recent CQC and MHA monitoring visits was noted. Mental Health Act Managers had recently been provided with Trust iPads to improve Information Governance. The AMHP report included the good news that an Expert by Experience has been recruited for the AMHP approval/reapproval panel, and this had proved successful in the July panel. The Committee received an update on Mental Health Act activity at GHFT. The Committee also received an encouraging report on MHA, MCA (mental capacity act) and DOLS (deprivation of liberty safeguards) which showed that good progress is being made across the whole of Trust staff who require this training.

16.9 **Working Together Advisory Committee**

The Board received and noted the summary report from the WTA Committee meeting held on 19 July 2023.

17. ANY OTHER BUSINESS

17.1 There was no other business.

18. DATE OF NEXT MEETING

18.1 The next meeting would take place on Thursday, 28 September 2023.

APPENDIX 1

Questions from the Public

How does the board assure and reassure itself that services to children and families with special educational needs is of a timely and outstanding quality so as to meet the needs of the children and families in Gloucestershire? What evidence does the Trust collect and collate to have this assurance and re assurance?

Bren McInerney

Trust Response

Responsibility for carrying out an Education, Health and Care Plan (EHCP) rests with the local authority, which is Gloucestershire County Council in this case.

Once they receive an EHC request, they will review the information provided and request additional evidence if needed; this might be from the child or young person; their parent or carer; nursery, school or college the child attends, educational psychology, other professionals as appropriate which might bring in services provided by GHC such as speech and language therapy, physiotherapy, occupational therapy, children's and adolescent mental health services alongside other health professionals (such as the GP) and social care services.

Once GHC receive a request, if the child/young person is known to us, then the most recent report will be shared with the local authority. If the EHCP Panel then wishes to progress with an EHC plan, health professionals will then be requested to fully assess need if this has not already been done, and complete the formal report template.

Each of our services has referral to treatment (RTT) performance indicators. These are reported to the Board via the Trust Performance dashboard with oversight of monthly performance in operational governance forums, and board committees. All referrals to children and young people's services are screened by our clinical leads and are prioritised based on clinical need and risk assessment. Due to the ongoing high demand across children's services, there is the potential that SEND statutory timeframes will not be met as a result of waiting times in children's and young people services and this is captured on the Trust's risk register which is also regularly reviewed by the Board and its committees.

In terms of system oversight, this sits with the Integrated Care Board (ICB) of which our Chief Executive and Chair are members. The ICB has a full time SEND/Designated Clinical Officer (DCO) and is the key point of contact for health queries and issues across the system. Gloucestershire is due to have its 2nd SEND Inspection in September 2023 which will set out system based priority deliverables and will inform an improvement plan for the pathway, which GHC will support.

Sharon Buckley
Deputy Chief Operating Officer

TRUST BOARD PUBLIC SESSION: Matters Arising and Action Log – 28 September 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
27 July 2023	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 Secretariat	Sept 2023	**Complete.**	
	6.2	It was agreed that discussions would take place with wider system partners about the development of broader communications that could be issued to patients and community groups to provide additional reassurance around the Right Care, Right Person strategy	David Noyes	Sept 2023	**Complete.** Communication agreed across the ICS and issued late August. Supporting those in need of emergency mental health support in Gloucestershire > Glos Health & Care NHS Foundation Trust (ghc.nhs.uk)	
	7.8	John Trevains would seek additional narrative on the reasons for the differing incident rates of pressure ulcers reported by Integrated Care Teams around the county.	John Trevains	Sept 2023	**Complete.** Additional information added into dashboard	
	8.9	Further consideration to be given as to how to provide information to the Board around waiting lists, looking at how the lists were managed, prioritised, patient profiles, identifying people that should be on a waiting list but weren't etc.	Sandra Betney	Sept 2023	Verbal update at the September Board on progress	

Meeting Date	Item No.	Action Description	Assigned to	Target Completion Date	Progress Update	Status
	9.7	Additional narrative to be included in future LfD reports to explain the "No MH diagnosis" category of patients who die by suicide who are open to the Trust's community mental health teams.	Amjad Uppal	Sept 2023	**Complete.** Action referred to the LfD team for future action	
	12.3	Following the update on progress with the CMHT programme within the CEO report, NED colleagues agreed that it would be helpful to see the work carried out to date mapped out.	Angela Potter	Sept 2023	**Complete.** CMHT Briefing circulated to Board members on 18 September.	

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 September 2023**

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

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

SUBJECT: **QUALITY DASHBOARD REPORT- AUGUST 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

The Board are asked to **RECEIVE, NOTE** and **DISCUSS** the August 2023 Quality Dashboard.

Executive summary

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

This month's report also includes additional information regarding:

- Learning from Deaths
- Non-Executive Director Quality Visits
- Overview of the changes from the NHS Complaint Standards

Quality issues showing positive improvement:

- To date 94% complaints have been closed within 6 months, this compares to 87% last year.

- Significant reduction over time in moderate harm falls incidents, much of this can be attributed to falls reduction work at Charlton Lane and Community Hospitals.
- An external audit undertaken by BDO (external auditors) to review our systems and process related Trust's 'Freedom To Speak Up' demonstrated that, 'The Trust has a robust Freedom to Speak Up service in place. Responses to concerns raised are timely and effective, with proactive measures in place to address barriers and promote a positive speaking up culture across the Trust. '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.
- Good progress has been made in providing more detailed reporting of Statutory and Mandatory training; and Clinical Supervision but more work is required to be able to use this data for full assurance.

Quality issues for priority development:

- Develop further assurance regarding moderate harm pressure area harms, noting potential increases in rates through increased reporting, improved identification and mindful of prior condition on transfer to our Trust's care.
- Continue to develop assurance on Trust safeguards against closed culture risks. We continue to provide additional assurance information to Gloucestershire Integrated Care Board (ICB) as part of our period of enhanced surveillance that was applied following the rapid review of Wotton Lawn Hospital, it is anticipated this enhanced reporting may be reduced in October due to good assurance information provided.
- To expand the range of training data to include 'essential to role' subjects. There is ongoing work with the Learning & Development Team to accommodate additional training for clinical staff to support them in practice. This includes for example Clinical Observation Training, Risk Assessment & Management & Incident Management Training.
- To expand patient safety data set to include themes related to restrictive practice. Particular attention is being applied to improving recording of rapid tranquilisation and continued focused work in falls reduction and pressure area care.
- To provide in partnership with operational colleague's additional focus to safeguarding supervision attendance (Currently at 62%) and recording of household contact details.

Are our services SAFE?

In August the Patient Safety Team (PST) have continued to separate skin integrity incidents and other incidents within the reporting tables, of note within moderate harm data. The increasing trend in moderate harms is being driven by tissue viability activity and a positive reporting culture, further analysis is ongoing re detection of issues for additional attention. There were a total of 1330 patient incidents reported in month. 1233 were reported as No and Low harm incidents and 97 Moderate, Severe or Catastrophic incidents. The top four overall categories of incident were skin integrity, self-harm, falls and medication errors. There were 3 serious incidents confirmed and reported in August. The team continue to support clinical reviews and

huddles within some services as part of the PSIRF pilot and during Q2 the team have facilitated 6 After Action Reviews within the Physical Health Directorates. A summary of the themes is provided on slide 12. The team attended/led internal meetings for two clinical incidents and met with the ICB to discuss learning assurance from past incidents. Wotton Lawn Hospital (WLH) remain under a period of "Enhanced Surveillance "and the Trust provide a monthly report to the ICB including detail on staffing and use of agency, shift fill ratios, length of stay, readmission rates, patient safety data, patient experience and good practice initiatives. An external audit undertaken by BDO (external auditors) to review our systems and process related to the Trust's 'Freedom To Speak Up' processes demonstrated that, 'The Trust has a robust Freedom to Speak Up service in place. Responses to concerns raised are timely and effective, with proactive measures in place to address barriers and promote a positive speaking up culture across the Trust.' The closed culture update notes the board development session on 'Reflecting on Edenfield' and the adoption of the 6 core strategies to reduce reliance on restraint. We also recognise the success of the 'Care and Support Always' group being facilitated at Charlton Lane Hospital attended by 8 families in September. A summary of the Q1 Learning from Deaths reports previously presented to Quality Committee has been included within the Quality Dashboard. Good assurance via the Medical Examiners (ME) Q1 report of Community Hospital deaths demonstrates effective and compassionate end of life care is delivered across our units.

Are our services EFFECTIVE?

This month we have provided a high-level overview of the 7 CQUIN's that have been agreed with Gloucestershire ICB. The business intelligence team are developing a clinical system to automatically report safeguarding referrals to the local authority with a go live date of Nov 23. In the interim the team continue to monitor this manually for assurance. Positive feedback has been received from the Joint Area Targeted Inspection (JATI) that took place from 12th to the 16th June 2023 with the headline findings being that "most children living in Gloucestershire who are initially identified to be in need of help and protection receive a swift and appropriate multi - agency response from the "front door". A full summary of Safeguarding key performance data is provided in **Appendix 1**. Safer staffing data acknowledges the continuing challenges and progress for inpatient teams and the ratios between registered and non-registered staff. There is a decrease in the vacancy rate for Healthcare Support Workers (HCSW) with Berkeley House recording the highest HCSW vacancy rate across the Trust. Overall, there is an improving position with a trajectory to be fully established at Band 5 level for the entire WLH site by end of November 2023. Longstanding inpatient vacancy issues have been positively addressed in recent months following an extensive piece of work to create an international recruitment supply route for mental health nurses. We have included a wider set of Statutory & Mandatory Training figures this month. Resus Level 3 & Safeguarding training compliance are the focus for teams in month. Access to individual team data is now available to support team managers with compliance monitoring but it will require further development to accommodate the 'Essential to Role' training. We have included a wider set of Statutory & Mandatory Training figures this month. Resus Level 3 & Safeguarding training are the focus for teams in month. Access to individual team data is now available to support team managers with compliance monitoring but it will require further development to accommodate

the 'Essential to Role' training. Baseline clinical supervision rates are recorded in month and follows development with the Training, BI team and NTQ. The current rate of 26.91% represents those captured in the revised reporting template. The current rate of 20.91% represents those captured in the revised reporting template. It is expected this rate will improve as the sessions being recorded on the Care 2 Learn system is embedded and performance managed. There are some inpatient teams reporting excellent supervision compliance, in particular Laurel House at 100% and Abbey ward at WLH with 78%. Overall sickness levels have dropped below threshold for the first time this year to (3.8%).

Are our services CARING?

The new NHS complaints process launched on 1st August which is in line with the revised PHSO standards. The Standards are designed to ensure that the right structures and systems are in place to capture and act on feedback, provide timely resolutions and deliver better patient and carer (and staff) experience. We will continue to review the process (including recording/reporting) and monitor feedback from patients/staff. FFT increased this month with the % of respondents reporting having had a positive experience attaining the 95% target for the first time this year. In August, there were 35 formal complaints which incorporates the changes in process and classifications. 72% of complaints were closed within three months, target (50%) and 94% closed within six months, target (80%). There are currently 4 re-opened complaints, reflecting our approach to collaboratively working with patients and carers to resolve issues in line with new PHSO guidance. 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.

CQC Update

The actions arising from the CQC core inspection remain at 96% complete. An audit of case notes at Wotton Lawn Hospital is now being completed weekly and last week showed 92% compliance since beginning of September for post physical health monitoring. Further testing is to be carried out to ensure it has been embedded before final sign off. Peer reviews continue with further services arranged throughout quarter 3 and continue to highlight positive examples of good practice and some areas for improvement. Services to be reviewed include Crisis Teams, Later Life and the remaining Recovery and CDLT Teams. Self-assessments are being reviewed with services with meetings arranged with Service Leads. 79% of self-assessments (an increase of 30% on last month) have been completed or are booked for review with findings being in the majority good with some areas requiring improvement. These areas include reporting of incidents, outcome measurements and facility issues.

Risks associated with meeting the Trust's values
Specific initiatives or requirements that are not being achieved are highlighted in the Dashboard.

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

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

Appendices:	Quality Dashboard Report - Aug 2023 Data

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

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Quality Dashboard 2023/24

Physical Health, Mental Health and Learning Disability Services

Data covering August 2023

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

Executive Summary

Gloucestershire Health and Care NHS Foundation Trust

This Quality Dashboard reports quality focussed performance, activity, and developments regarding key quality measures and priorities for 2023/24 and highlights data and performance. This data includes national and local contractual requirements. Certain data sets contained within this report are also reported via the Trust Resources Committee; they are included in this report where it has been identified as having an impact on quality matters. Feedback on the content of this report is welcomed and should be directed to John Trevains, Director of Nursing, Therapies and Quality (NTQ).

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

Are our services SAFE?

There were a total of 1330 patient incidents reported in month. 1233 were reported as No and Low harm incidents and 97 Moderate, Severe or Catastrophic incidents. The top four overall categories of incident were skin integrity, self-harm, falls and medication errors. There were 3 serious incidents confirmed and reported in August. The team continue to support clinical reviews and huddles within some services as part of the PSIRF pilot and during Q2 the team have facilitated 6 After Action Reviews within the Physical Health Directorates. A summary of the themes are provided on slide 12. The team attended/led internal meetings for two clinical incidents and met with the ICB to discuss learning assurance from past incidents. Wotton Lawn Hospital (WLH) remain under a period of "Enhanced Surveillance" and the Trust provide a monthly report to the ICB including detail on staffing and use of agency, shift fill ratios, length of stay, readmission rates, patient safety data, patient experience and good practice initiatives. An external audit undertaken to review our systems and process related to the Trust's 'Freedom To Speak Up' processes demonstrated that, 'The Trust has a robust Freedom to Speak Up service in place. Responses to concerns raised are timely and effective, with proactive measures in place to address barriers and promote a positive speaking up culture across the Trust. ' The closed culture update notes the Board development session on 'Reflecting on Edenfield' and the adoption of the 6 core strategies to reduce reliance on restraint. We also recognise the success of the 'Care and Support Always' group being facilitated at Charlton Lane Hospital attended by 8 families in September. A summary of the Q1 Learning from Deaths report previously presented to Quality Committee has been included within the Quality Dashboard. Good assurance via the Medical Examiners (ME) Q1 report of Community Hospital deaths demonstrates effective and compassionate end of life care is delivered across our units.

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Appendix 2 summarises wider key operational performance data. We note the gradual improvement within cardio metabolic assessment, HPV Immunisation and routine Health Visitor checks. There are targeted clinics to recover performance in Occupational Therapy treatment waits.

Are our services CARING?

The new PCET process launched on 1st August which is in line with the revised PHSO standards. The Standards are designed to ensure that the right structures and systems are in place to capture and act on feedback, provide timely resolutions and deliver better patient and carer (and staff) experience. We will continue to review the process (including recording/reporting) and monitor feedback from patients/staff. FFT increased this month with the % of respondents reporting having had a positive experience attaining the 95% target for the first time this year. In August, there were 35 formal complaints which incorporates the changes in process and classifications. 72**%** of complaints were closed within three months, target (50%) and 94**%** closed within six months, target (80%). There are currently 4 re-opened complaints, reflecting our approach to collaboratively working with patients and carers to resolve issues in line with new PHSO guidance. 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.

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Learning From Deaths Summary 2023/24 Quarter 1

Overview

This summary's aim is to inform the Board of the Trust's Learning from the Deaths review process, data analysis and outcomes during Quarter 1 2023/24, It includes learning from 'expected 'and 'unexpected' End-of-Life care incidents, concerns, queries and compliments, in addition to Gloucestershire LeDeR reviews.

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.

The full paper has been presented to the Trusts Quality Assurance group for approval and assurance and this summary has been presented to Quality Committee.

Quarter 1 2023/24 Learning from Deaths Summary

- Learning from 'expected' End-of-Life care incidents, concerns and compliments identifies opportunities for improvement within anticipatory prescribing both within the Trust but to a larger extent across the One Gloucestershire system.
- Opportunities for improvement within advance care planning, improved understanding and application of the mental capacity act, accessing the Gloucestershire Specialist palliative Care team in a timely manner, discharge and inter hospital transfers is noted both within GHC and the wider One Gloucestershire system. The Trusts End of Life lead Nurse is leading several workstreams to address this within the Trust.
- An emerging theme related to Continuing Health Care (CHC) fast track funding is evident, further work is underway to understand this in more detail in partnership with the CHC leads at the ICB.
- 'Learning on a Page' documents are generated where learning has been identified and 5 such learning summaries were generated this quarter. These have been shared with operational services via Pan-Ops Governance Group, and through display on the Patient Safety Notice Boards within inpatient services.
- The inpatient death rate for Community Hospitals (CoHo) and Charlton Lane is consistent with historical data; it has been observed that more patients are being transferred from the local acute trust who require end-of-life care.
- Cancer, frailty of old age, respiratory and cardiovascular illness remain the most prevalent causes of death, and respiratory infections remain the most prevalent cause of death of people with a learning disability, consistent with the findings from LeDeR reviews. Data regarding natural cause deaths for community mental health patients has been reported for the first time. This identifies that death from cardiovascular illness within the patient group with SMI is twice as prevalent as within the CoHo population. This supports the increased resource identified to promote annual physical health checks for patients with a severe mental illness (SMI).
- Feedback from the Medical Examiner (ME) 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 in agreement with the cause of death given and provided positive feedback in relation to their loved ones care experience within the Trust.
- Outcome of inquests are contained within the full report, 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.
- Outcome of inquests are 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. The Trust also received a Prevention of Future Deaths report from the Worcestershire Coroner regarding of the need for improved understanding between GHC and Herefordshire & Worcestershire Health & Care Trust as to how each other's mental health urgent care services operate. Additionally, there needed to be clarity regarding processes for urgent referrals. This issue has been addressed and will be subject to a audit in 6 months to ensure learning has been embedded.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

The National CQUINs applicable to GHC for 23-24 are outlined in summary below, progress reporting commences at the close of H1. (Q3 for Flu) . Agreement has been reached with commissioners that reporting will be for information purposes only as there are no financial performance measures against the current set of CQUINS.

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	Data collection has commenced for Quarter 2 (for H1, reporting in October) and will commence in Quarter 4 (for H2, reporting in April).
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	Data collection has commenced for Quarter 2 (for H1, reporting in October) and will commence in Quarter 4 (for H2, reporting in April).
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 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. Training has been well received and is complete for Recovery Gloucester and has now been rolled out to MHICT West with training booked at Laurel and Honeybourne, Further training will take place throughout September.
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)	This indicator requires further development and input from BI and will be noted as indicator N26 in the next phase of indicators to go live organisationally.
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)	This indicator requires further development and input from BI and will be noted as indicator N32 in the next phase of indicators to go live organisationally.

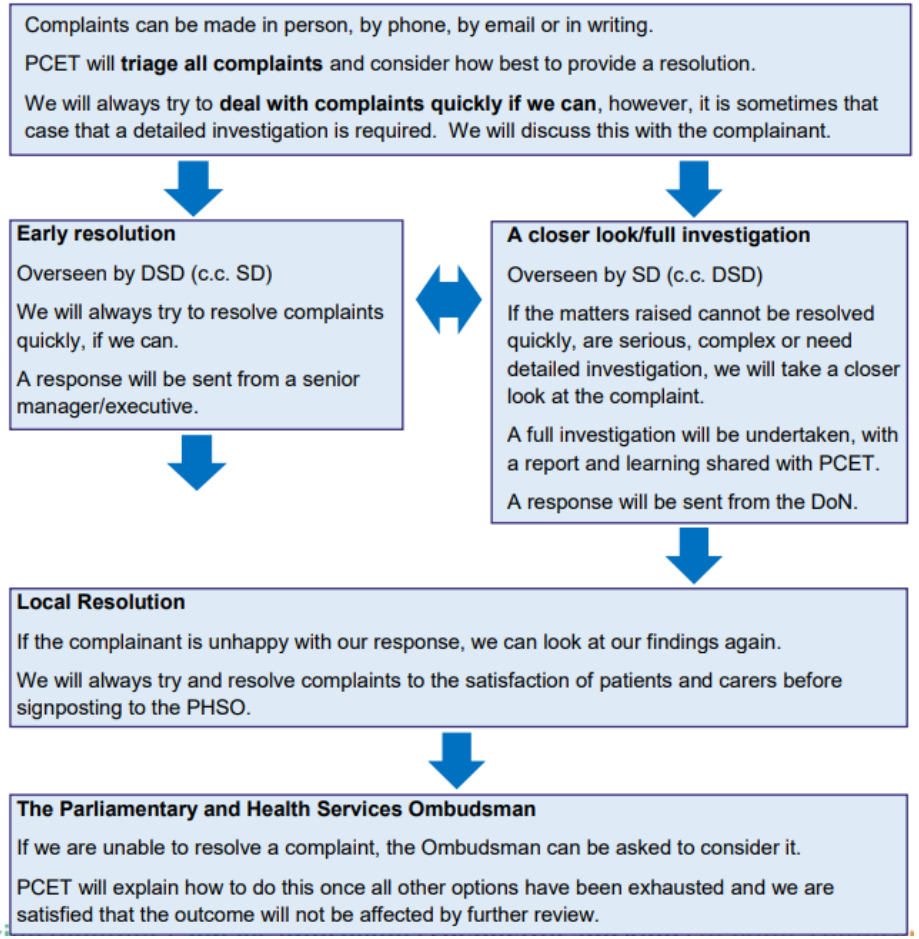
CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET) – New NHS Complaints Standard

The new NHS Complaint Standards focuses on four core pillars:

1. Welcoming complaints in a positive way and recognising them as important insight into how we can improve services
2. Supporting a thorough and fair approach and giving open, honest answers as quickly as possible
3. Encouraging fair and accountable responses that set out what happened and whether mistakes/good practice occurred
4. Promoting a learning culture by supporting the whole organisation to see complaints as an opportunity to develop its services and people

How we manage and respond to patient feedback (complaints)

It is important that Service Directors/Deputy Service Directors (SD's & DSD) have oversight, so that they can identify improvement opportunities but also so that they can ensure staff are supported through the process (which can often feel quite negative/personal). We adopted the new NHS Complaint Standards on 1st August 2023.



Where early resolution could be suitable:

- a service has not been provided that should have been
- a service has not been provided to an appropriate standard
- a request for a service has not been answered or actioned
- a service being provided is having an immediate negative impact
- an error has been made that can be corrected quickly
- a member of staff was perceived as rude or unhelpful
- a staff member or contractor did not attend a scheduled appointment.

Where a closer look could be suitable:

- the issues raised are complex and will require detailed investigation
- the complaint is about more than one area of care/service or multiple organisations
- the complaint is about both health and social care
- the complaint raises issues that might affect other service users
- the complaint relates to issues that have been identified as serious or high risk/high profile.

Definitions:

Enquiry	• The service user is asking for something or just needs an explanation/confirmation. • The process typically takes less than 3 working days to resolve. • No formal response is required.
Complaint	• The service user is clearly dissatisfied with something that has or has not actually happened to them. • The matter needs looking into (either through early resolution or a full investigation). • They require a formal written response.

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

	Reporting Level	Threshold	2022/23 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023/24 YTD	Notes
Number of Friends and Family Test Responses Received	N - R		20,256	2,419	2,699	3,115	2,705	2,877								13,815	
% of respondents indicating a positive experience of our services	N - T	95%	94%	94%	94%	94%	94%	95%								94%	
Number of compliments received in month	L - R		2081	202	160	256	306	205								1129	
Number of enquiries (other contacts) received in month	L - R		619	44	75	82	87	99								387	This feedback may previously have been categorised as a *concern*
Number of concerns received in month	L - R		692	66	65	48	40	0								219	NHS complaints standards: feedback is now either an enquiry (other contact) or a complaint.
Number of complaints received in month *Includes ALL complaints (closer look complaint / early resolution complaint)*	N - R		136	8	13	6	11	35								73	
Of complaints received in month, how many were early resolution complaints	L - R			0	0	0	0	33									
Number of open complaints (not all opened within month) *Includes ALL complaints (closer look complaint / early resolution complaint)*	L - R			43	39	30	33	50									
Percentage of complaints acknowledged within 3 working days	N - T	100%	100%	100%	100%	100%	100%	100%								100%	
Number of complaints closed in month *Includes ALL complaints (closer look complaint / early resolution complaint)*	L - R			6	17	15	8	18								64	Additionally, there were 22 concerns closed this month (opened under the old process)
Number of complaints closed within 3 months	L - I			5	9	8	4	13								39	We have adjusted our local KPIs in line with the NHS Complaints Standards targets
Number of re-opened complaints (not all opened within month)	L- R			7	5	3	4	4									
Number of external reviews (not all opened within month)	L - R			2	4	4	5	6									

Please note that the new PCET process launched on 1st August 2023 in line with the NHS Complaints Standards.

The Standards are designed to ensure that the right structures and systems are in place to capture and act on feedback, provide timely resolutions and deliver better patient and carer (and staff) experience. We will continue to review the process (including recording/reporting) and welcome all feedback from patients/staff via experience@ghc.nhs.uk

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:

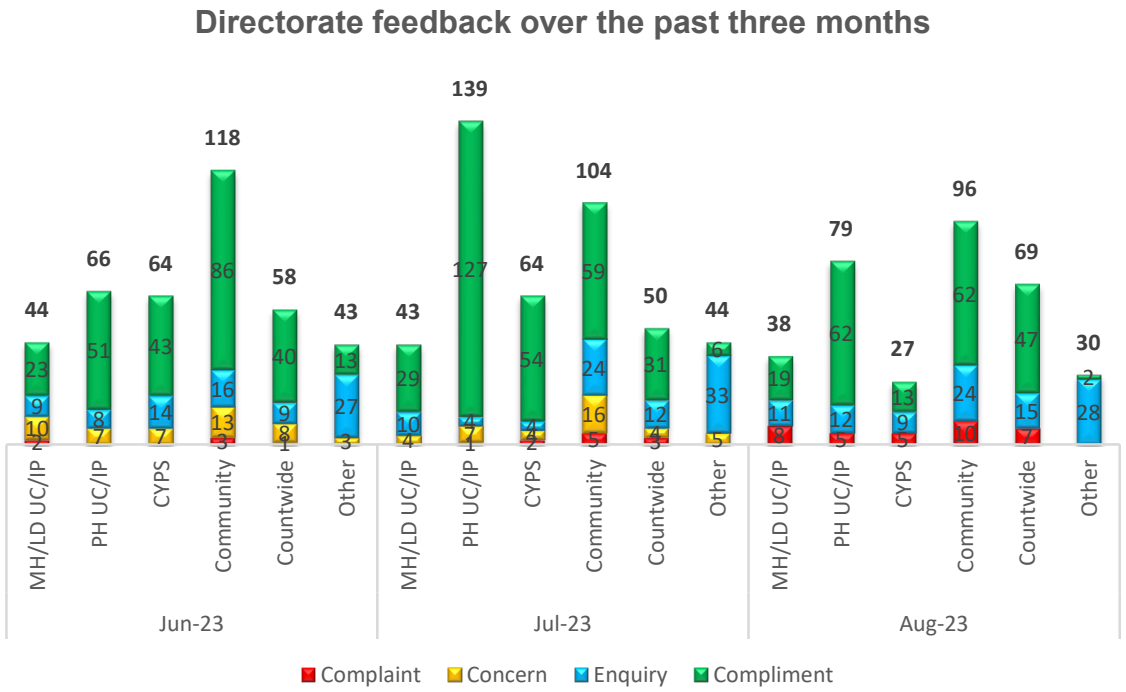
- The new PCET process launched on 1st August 2023 in line with the NHS Complaints Standards.
- The Standards are designed to ensure that the right structures and systems are in place to capture and act on feedback, provide timely resolutions and deliver better patient and carer (and staff) experience. We will continue to review the process (including recording/reporting) and welcome all feedback from patients/staff via experience@ghc.nhs.uk
- Numbers are reported by operational channels/directorates, then by type.
- Directorate level data is shared with SDs, DSDs, P&D leads and NTQ links each month to enable interrogation of service specific feedback; this time is also be used to discuss ongoing investigations and emerging themes/ 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			Enquiry	Compliment
MH/LD urgent care and inpatient	8	Early resolution:	**7**	11	19
		Closer look:	**1**		
PH urgent care and inpatient	5	Early resolution:	**5**	12	62
		Closer look:	**0**		
CYPS	5	Early resolution:	**5**	9	13
		Closer look:	**0**		
PH/MH/LD Community	10	Early resolution:	**9**	24	62
		Closer look:	**1**		
Countywide	7	Early resolution:	**7**	15	47
		Closer look:	**0**		
Other	0	Early resolution:	**0**	28	2
		Closer look:	**0**		
Totals	35	Early resolution:	**33**	99	205
		Closer look:	**2**		

Examples of complaints [as reported] for each directorate:

- **MH UC/IP**: patient causing nuisance and disturbance in area around hospital.
- **PH UC/IP**: with GHFT: two patients complained that road closures meant they missed appointments
- **CYPS**: waiting list for CAMHS; unhappy with physio assessment.
- **Community**: appointment "wasted" by going through paperwork; perceived lack of empathy for end-of-life patient .
- **Countywide**: rude member of staff when discussing a termination; wrong tooth extraction



The above graph shows feedback by type and directorate over the past three months.
Whilst there have been several complaints, there have been significantly more compliments across every directorate. Moving forward, we will focus on learning from excellence in addition to improvement opportunities.

The new NHS Complaint Standards were implemented in August 2023 – feedback is no longer categorised as a concern, and is instead either a complaint or an enquiry:

- **Complaints**: now divided into early resolution complaints (like concerns, except with a formal response) and closer look complaints (like formal complaints)
- **Enquiries:** this category now includes feedback that may have previously been categorised as a *concern*

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

The below table shows all COMPLAINTS closed this month by outcome and directorate.
These include closer look and early resolution complaints.

Directorate	Upheld	Partially upheld	Not upheld	Other	Total
MH/LD urgent care, inpatient	0	2	0	0	2
PH urgent care, inpatient	2	0	1	0	3
CYPS	0	1	3	0	4
PH/MH/LD Community	0	1	3	1	5
Countywide	1	0	3	0	4
Totals	**3**	**4**	**10**	**1**	**18**

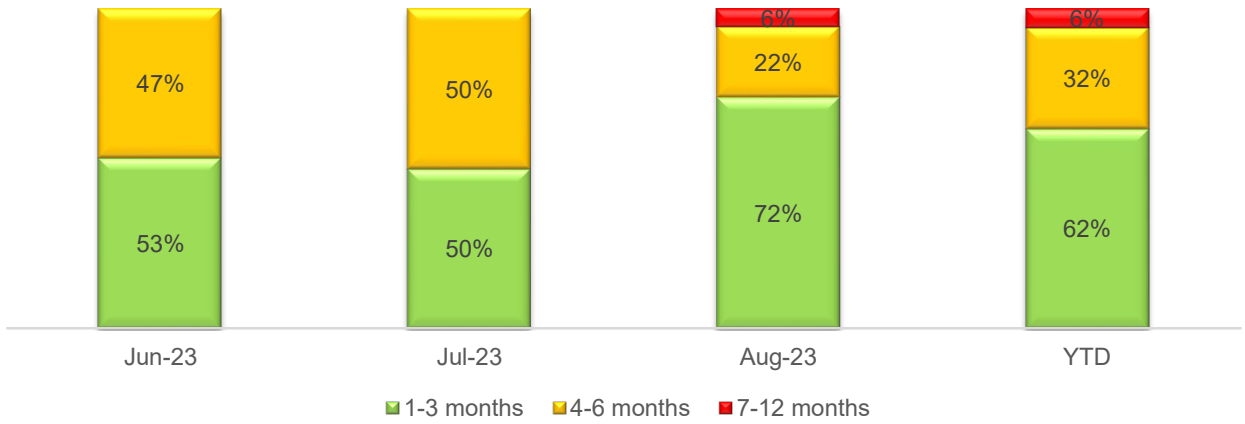
Upheld themes for complaints closed this month

1. **Communication and staff attitude** (*Community, MH UC/IP, Countywide, and CYPS*)
   - Nurse was not respectful or kind
   - Long wait for information
   - Unnecessary restrictions on patient and family
   - No updates

2. **Care and treatment** (*PH UC/IP, MH UC/IP, Countywide, and Community*)
   - Difficulties cannulating a patient
   - Poor management of syringe pump
   - Inadequate assessment and poor safety-netting

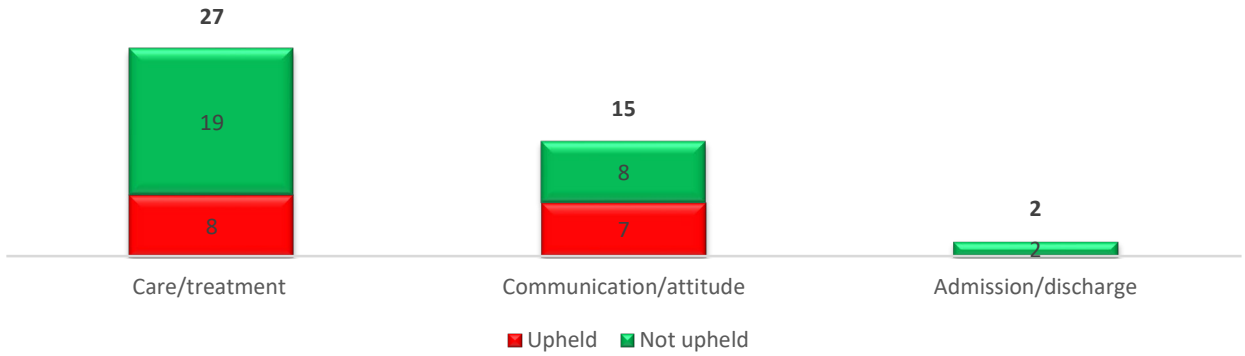
The below graph shows improvements in the length of time taken to close complaints.

- We have updated our local KPIs in line with the new national targets
- This month, **72%** were closed within three months (target = 50%), **94%** closed within six months (target = 80%), and **100%** within twelve months (target = 100%)
- YTD, **94%** of complaints have closed within six months (87% for 2022/23).



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

- Communication and attitude – upheld in **4** directorates
- Care and treatment – upheld in **4** directorates



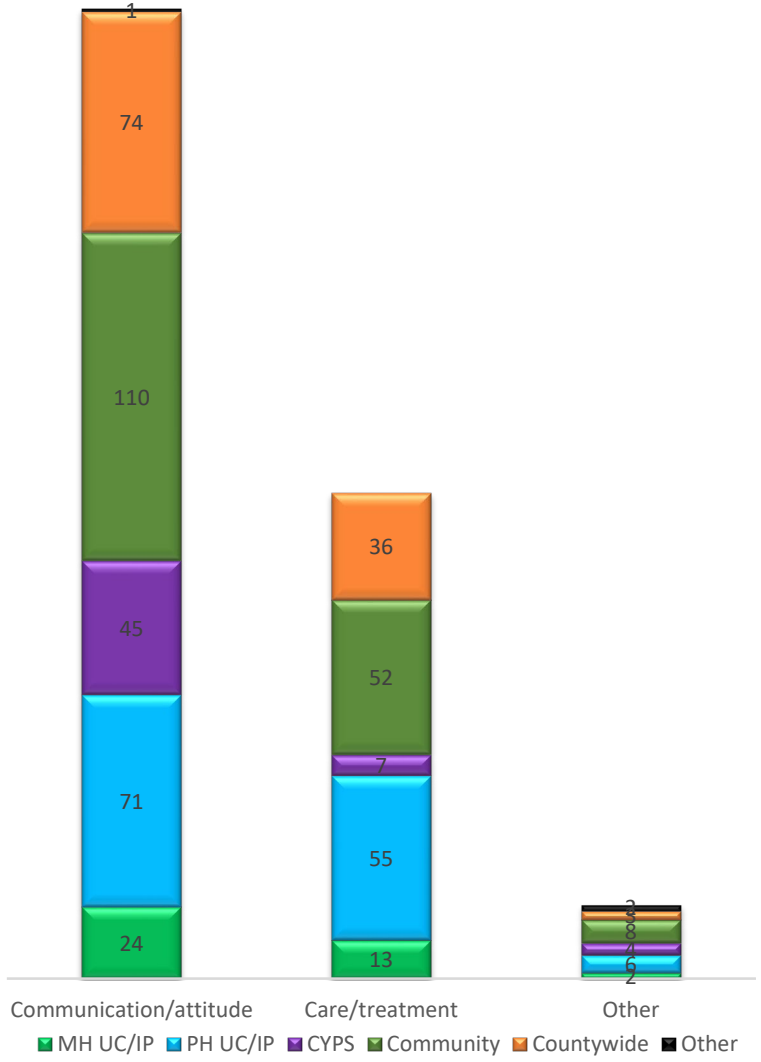
Due to the implementation of the new complaints standards, we expect an increase in the number of complaints received, and a corresponding increase in the number of complaints upheld (however, we will monitor this over time)..
We also anticipate being more responsive through the early resolution process.

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

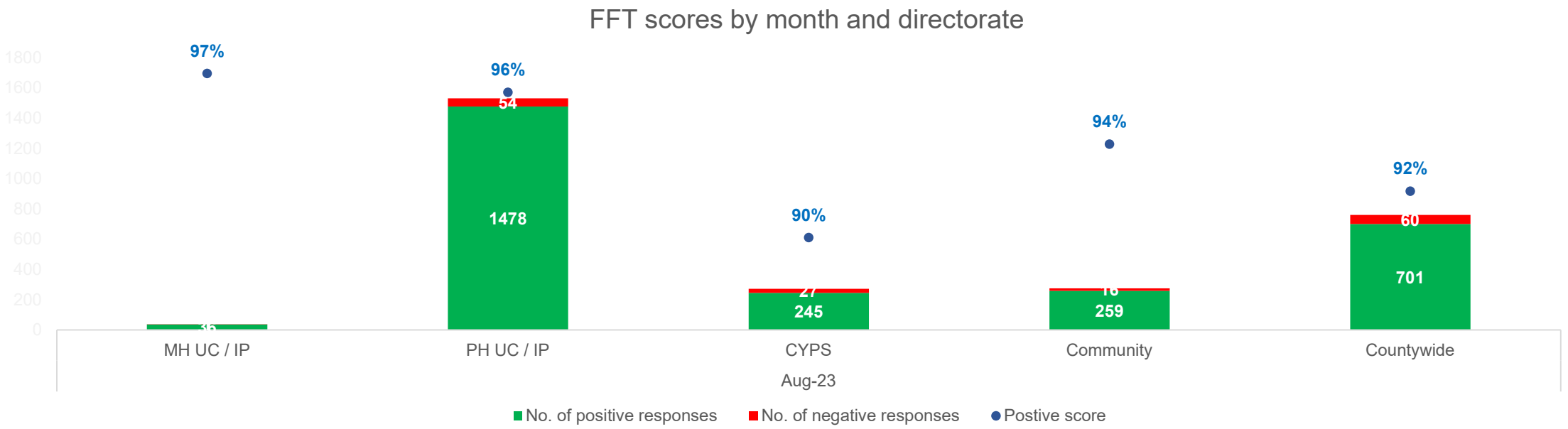
The table below is a sample of compliments received this month, and the chart opposite shows all COMPLIMENTS received this month by theme and directorate.

The **205** 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
02/08/2023	10649	ICT Chelt Town Centre DN	I've spoken with XXX wife today (Patient has passed away) and his wife would like to pass on her thanks for everything we did for him and said that XXX and XXX were amazing. Please could this compliment be passed on.
01/08/2023	10524	Recovery Tewkesbury	Patient's father thanked care co-ordinator for his help whilst he has worked with the patient.
24/08/2023	10860	Complex Leg Wound Service	Patient was very happy with service and has given a box of chocolates as a thank you.
31/08/2023	10925	Sexual Health Admin	Patient had triage call and new to service- wanted to say how lovely receptionist was and how re-assuring her manner was.
01/08/2023	10528	CYPS/PH-Immunisation Team	Can we just say an enormous THANK YOU to the whole team for your kindness and your brilliant service. Appreciate it so much. You are all awesome.
15/08/2023	10967	CAMHS Learning Disability	Sessions with *staff member* are going really well, she's lovely and X really likes her
27/08/2023	10915	Lydney Hosp-Lydney Ward	Gift of chocolate Thank you for the care
01/08/2023	10633	MIiU- Stroud Hosp	Thankyou card received for the "service delivered and kindness shown"
09/08/2023	10706	CRHT Chelt & Tewks	Patient gave positive feedback about staff. She felt that during the visit she was given the opportunity to be honest about her experiences and was really given the time and felt listened to.
17/08/2023	10787	Charlton Lane-Mulberry Ward	Patient expressed her thanks to all staff for the support she received during her stay in the Mulberry Ward and says she loves everyone.



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 has increased to **95%**, which is in line with last year (despite the increased response rate)
- 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 two mental health 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).
- **11** requests for contact have generated further action/investigation through the new 'open' question.

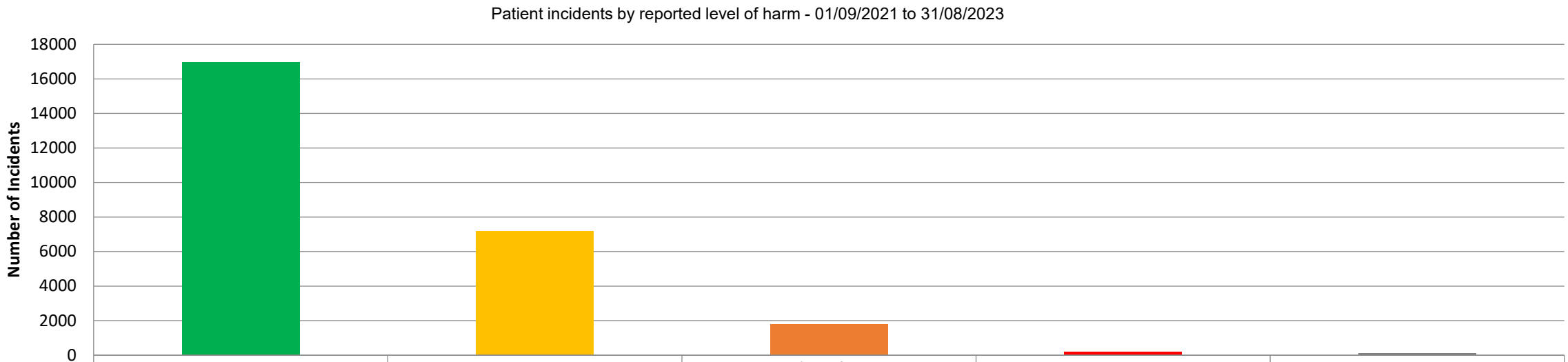
CQC DOMAIN - ARE SERVICES SAFE? INCIDENTS (Whole Trust data)

	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	0								0			N/A
Number of Serious Incidents Requiring Investigation (SIRI)	N - R		39	5	2	2	3	3								15			N/A
No of overdue SI actions (incomplete by more than I month)	L - R		N/A	0	0	0	0	0								0			N/A
No of unallocated SI investigations (waiting more than 1 month for allocation).	L - R		0	1	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	1								1			N/A
Number of Embedding Learning meetings taking place	L - R		9	2	6	4	2	0								8			N/A
Total number of Patient Safety Incidents reported	L - R		13029	1057	1111	1317	1237	1330								6052			N/A
Number of incidents reported resulting in low or no harm	L - R		11967	964	1007	1209	1145	1233								5558			N/A
Number of incidents reported resulting in moderate harm, severe harm or death	L - R		1062	93	104	108	92	97								494			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	0	3								7			N/A
Total number of medication errors reported as resulting in moderate harm, severe harm or death	L - R		5	1	0	2	0	1								4			N/A
Total number of sexual safety incidents reported	L- R		129	7	5	10	13	13								48			N/A
Total number of Rapid Tranquilisations reported	N - R		981	46	30	61	37	70								244			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 Incident Data



Key highlights:

We have included in this dashboard a summary of patient safety incidents reported over the last 2 years and seek to present data that can identify patterns requiring deeper analysis.

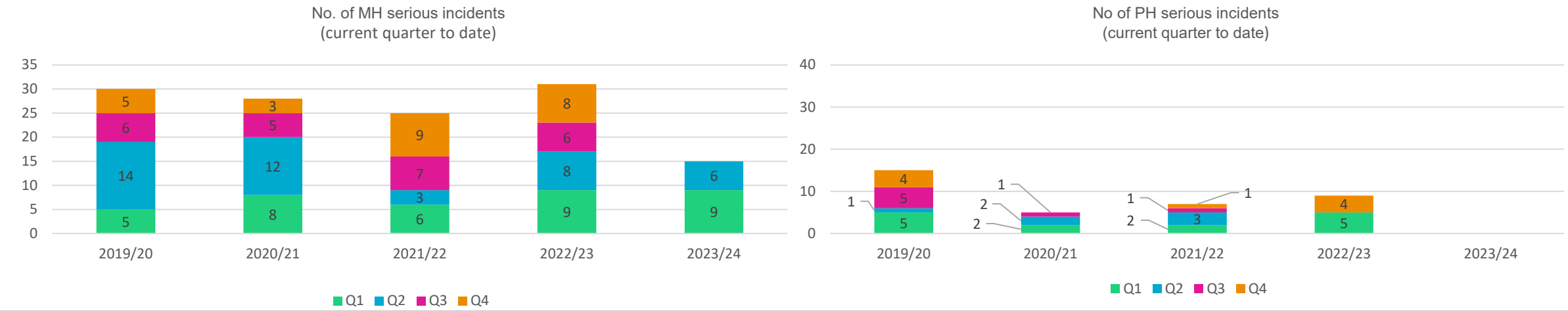
In August there were 1330 patient incidents reported in Datix, 93 more than July. 1233 were reported as No and Low harm incidents (88 more than July) and 97 as Moderate or Severe harm or Death (5 more than July).

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. The legal services team have joined 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 to draw in support from subject matter experts in changes to the forms within the reporting system over coming months. Key milestones in the transition to LFPSE have been achieved although a national software configuration issue has brought a delay to the testing and implementation phase of this project beyond the end of the September 30th deadline set by NHSE.

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 August, the Trust reported 3 new serious incidents and the learning response has commenced:

- GHC54287 – Forest Recovery
- GHC54481 – Tewkesbury Recovery
- GHC55505 – MHICT West

The team are also supporting clinical reviews and after-action reviews within some teams as part of the PSIRF pilot. These have included:

- Cirencester CoHo – huddle to explore learning and practice changes following collapse of a patient and transfer to ED.
- Dental Service – huddle focussed upon human factors and performance influencing factors around the removal of the incorrect tooth.
- Abbey Ward – MDT and subject matter expert review related to a violent incident
- Cotswold ICT - catheter related incident huddle.
- Cirencester CoHo – Huddle with team around rectal bleed and onward management of patient.
- North Cotswold ICT – Pressure damage related huddle to be added to the thematic review of skin integrity related harm.

Additionally, the PSIRF pilot includes the use the Care Review Tool, based upon the Royal College of Psychiatrists mortality review. This has been used in 9 recent and current learning responses. The new Patient Safety Incident Investigation report will be trialled in Q3.

Learning Assurance activity

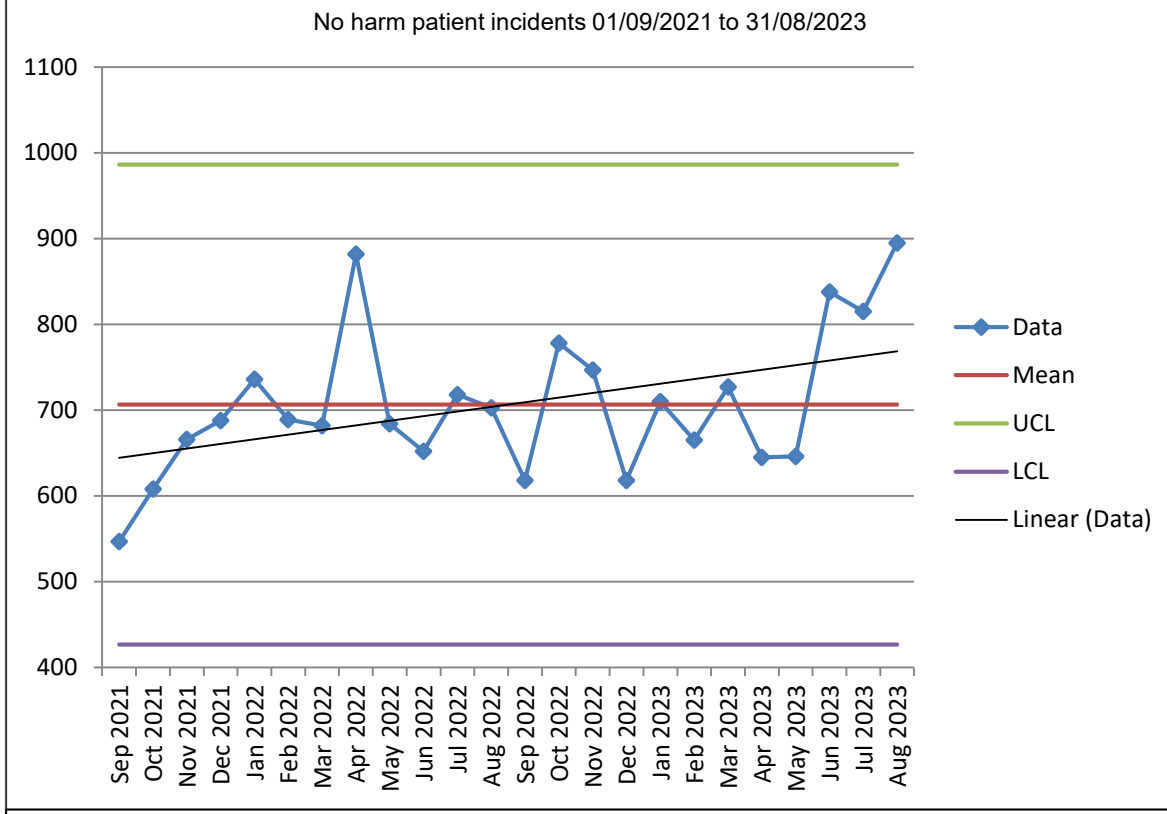
Learning Assurance attended two Directorate-level meetings to raise the profile of learning assurance, share updates on incidents, and inform and support learning assurance. Learning was disseminated via: Medical and Dental Staffing Committee meeting, Patient Safety and Quality of Care Noticeboards*; and the Learning Opportunities Group, which meets weekly. Ongoing learning assurance was supported through:

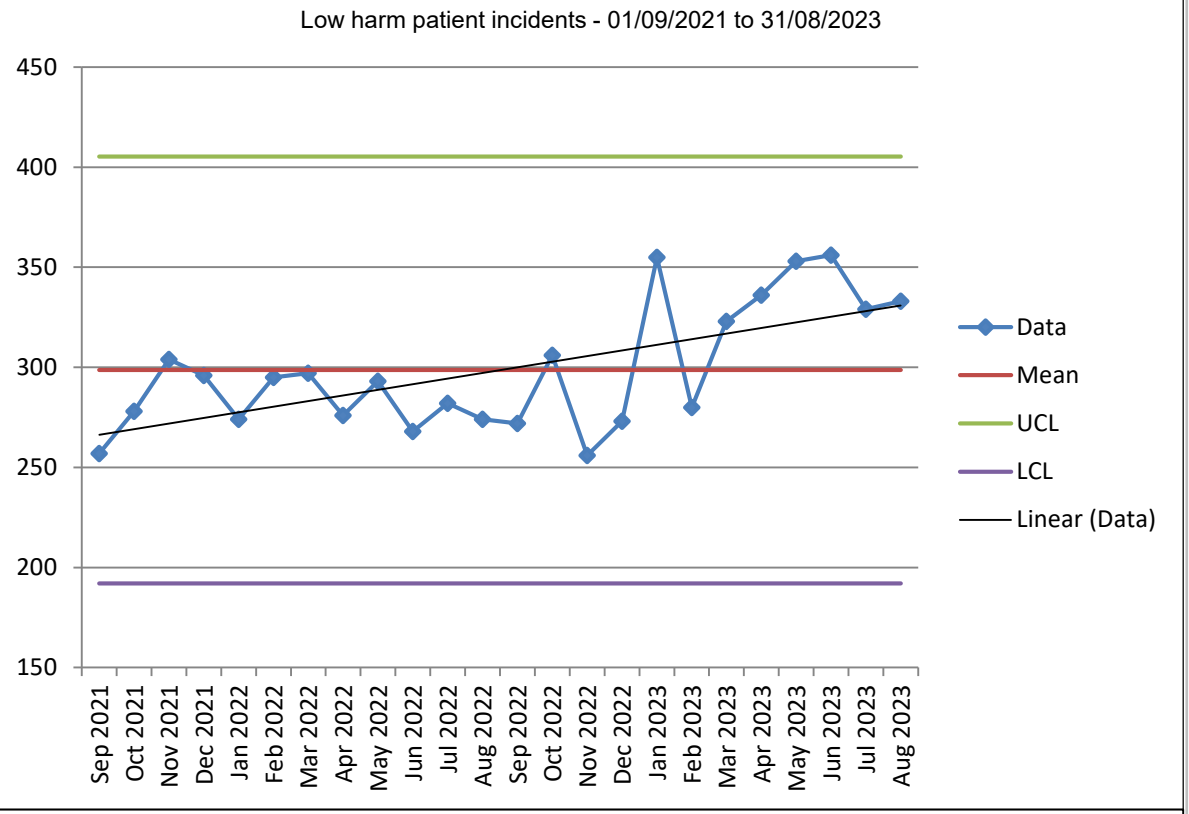
- Regular meetings with: the Matron at Wotton Lawn Hospital, together with the Clinical Development Manager and Duty of Candour Lead, to support with learning assurance work in the Hospital; the homicide action plan working group; and colleagues in PCET, QI and CQC Quality to share updates (weekly).
- One-off meetings on: 'language that cares' in CAMHS; pressure ulcer work; process mapping with QI.
- Meeting with frontline staff on Abbey Ward (Wotton Lawn Hospital) to discuss learning from the homicide action plan.

The team attended/led internal meetings for two clinical incidents and met with the ICB to discuss learning assurance from past incidents. The team attended drop-in national meetings of the Patient Safety Managers Network (sharing experience and good practice), continued with HSIB Level 2 Safety Investigation training and completed HSIB investigative interviewing and external human factors learning.

Level 2 e learning is now available in Care to Learn and will be mandated for colleagues at band 6 and over from December

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





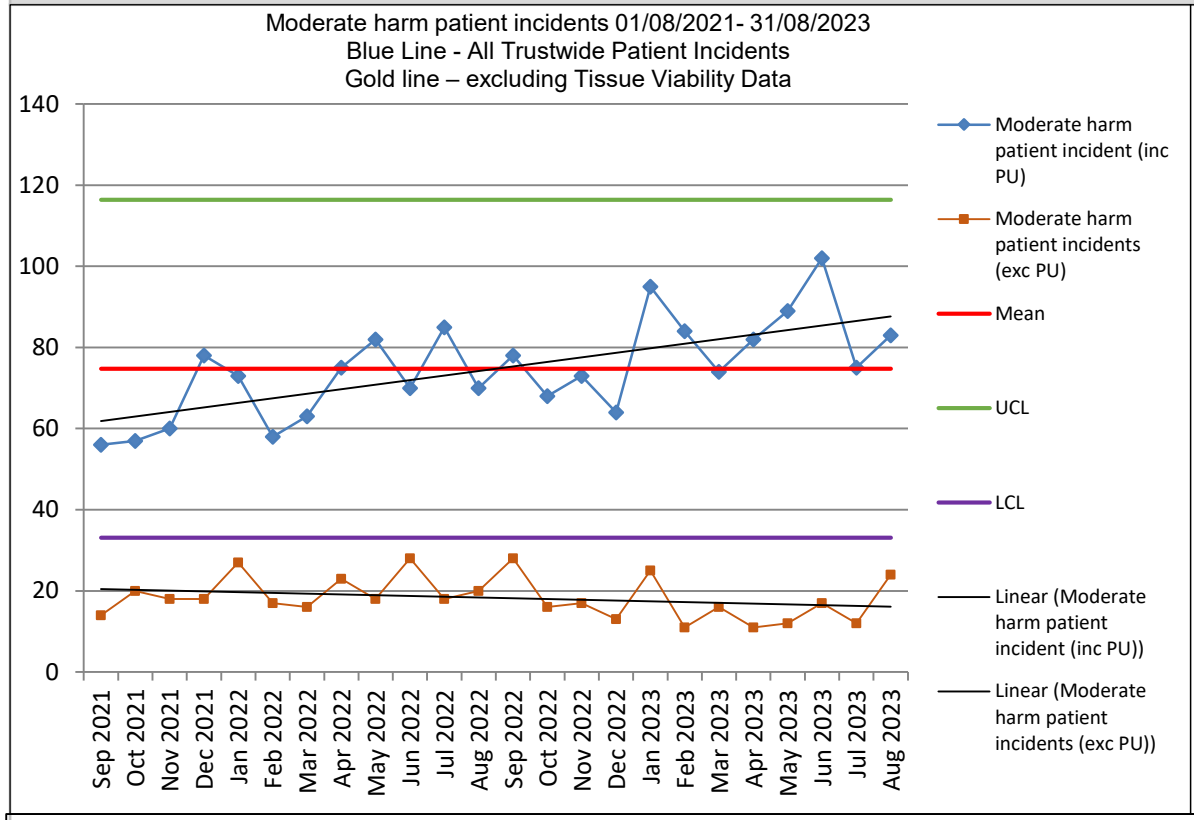
Key Highlights:

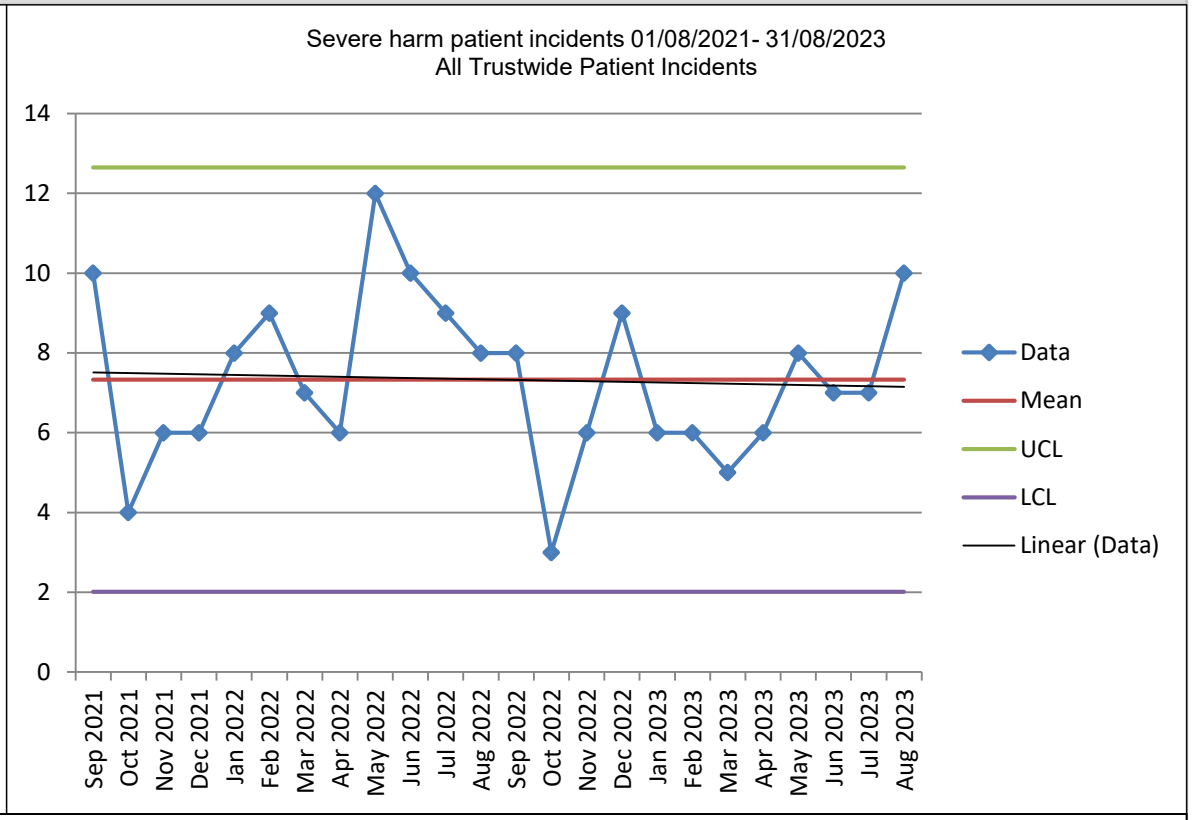
- **No Harm Incidents over time –** This data shows the level of reporting being generally in line with the mean.
- **Low Harm Incidents over time -** The Patient Safety Team are engaged in activity to refine the reporting forms and support staff to correctly assess and grade incidents and therefore stabilise our view of current or emerging risks. The 5 data points apparent above the mean are not significant and the pattern will be monitored for a variation.

Observing patterns of reporting

Q2 has seen a continued increase in no harm and low harm incident reporting. A high level of incident reporting is positive and patterns observed in these increases will be monitored and reported through services and QAG.

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





Key Highlights:

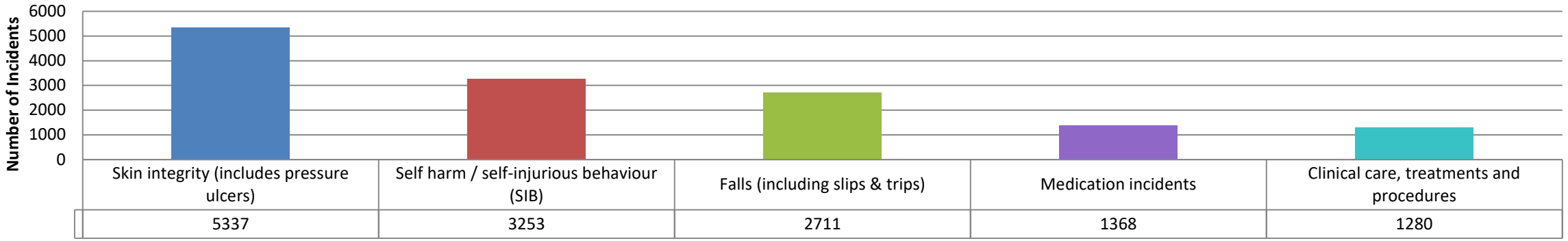
Moderate Harm Incidents over time - The picture emerging here, despite the mean not altering at present, is of a statistically significant rise in the number of reported moderate harm incidents. Currently 8 data points emerge on or above the mean. There is an increase in skin integrity incidents and a general reduction in all other moderate harm incidents reported.

The PST monitor these incidents routinely and capture these on a team tracker which is reviewed at regular points in the working week. During 22-23 there were 939 Moderate harm incidents reported in the Trust. Of these, 714 relate to skin integrity. Q2 and Q3 will see activity to further understand reporting and harm associated with PU. A new staff member recently seconded to the PST is working with clinical experts to support this activity. There are three key factors continue to drive 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/following Covid or other infections and illnesses. This picture is seen both locally and nationally.

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 Incident Data

Top 5 patient incident categories – all levels of harm (excluding restraint) 01/09/2021 to 31/08/2023

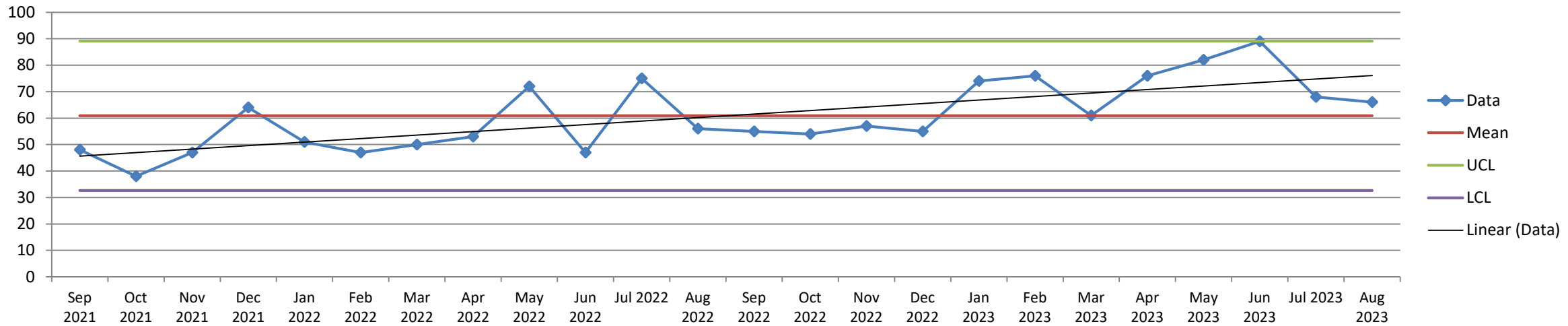


Skin integrity (includes pressure ulcers)	Self harm / self-injurious behaviour (SIB)	Falls (including slips & trips)	Medication incidents	Clinical care, treatments and procedures
5337	3253	2711	1368	1280

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

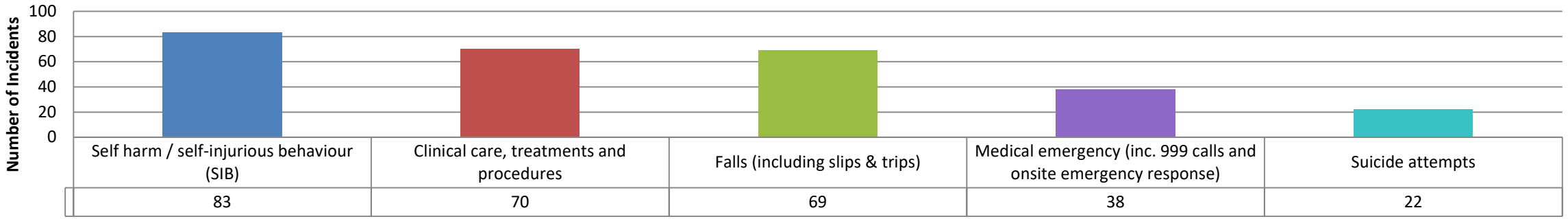
Commencing thematic review
As described, the recognised increase in moderate harm incidents is predominantly related to an increase in reporting across all ICT's of all grades of pressure ulcers. There is a notable cause variation apparent which can be seen as 9 data points above the mean. The PST together with expert clinicians, in support of the PSIRF will conduct a thematic review of 20 Cat 3 and above PU harms in Q3. Findings from this thematic review will inform the new ICB led systemwide PU workstream, acknowledging that GHC's data set, narrative and learning is key to identifying improvements required in the wider system to prevent and identify PU at a much earlier stage prior to patients being referred to Trust services. In addition, it is expected the findings will inform workforce scheduling particularly within ICT's.

Reported moderate/severe harm skin integrity/PU incident - Trustwide
01/09/2021- 31/08/2023



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

Top 5 moderate harm (as reported) patient incident categories (excluding skin integrity) 01/09/2021 to 31/08/2023

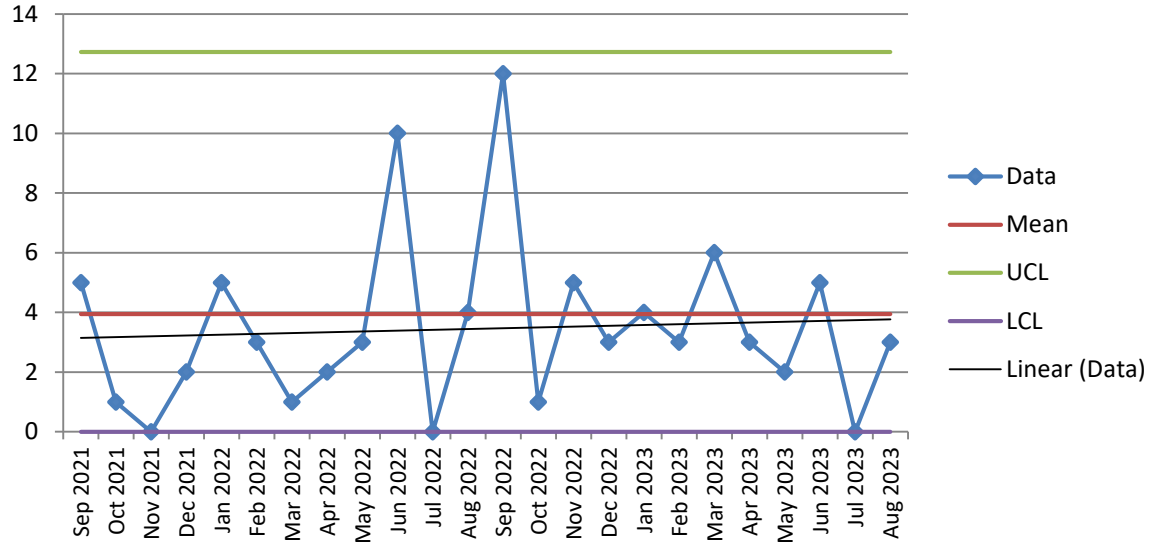


Self harm / self-injurious behaviour (SIB)	Clinical care, treatments and procedures	Falls (including slips & trips)	Medical emergency (inc. 999 calls and onsite emergency response)	Suicide attempts
83	70	69	38	22

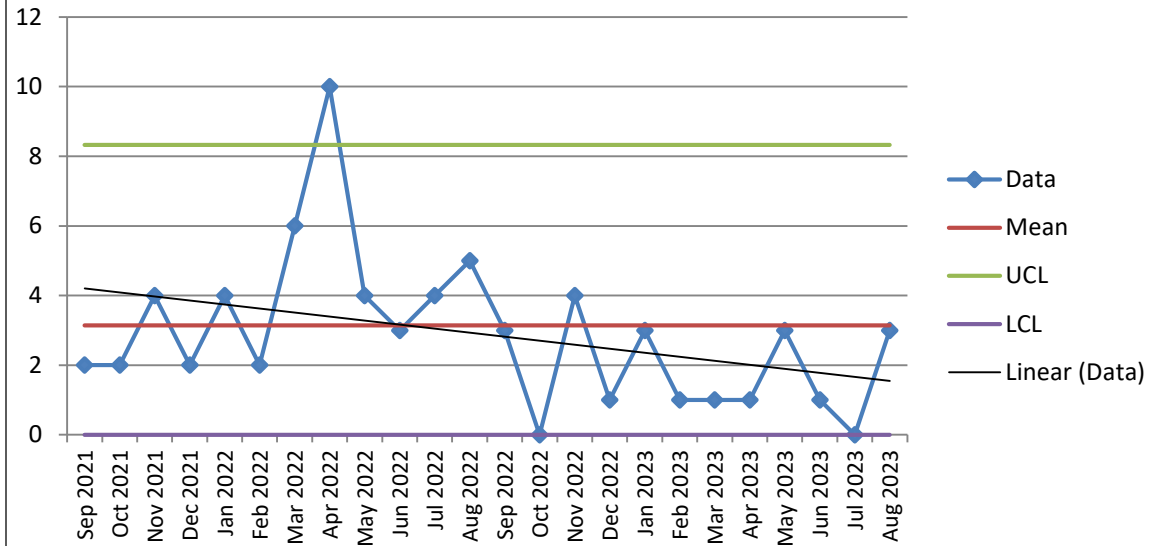
Key highlights in August

The chart above shows the 5 highest categories of reported moderate harm patient incidents (excluding skin integrity) over 24 months, conversely, moderate harm incidents of all types have reduced in number, the variation is statistically significant as shown in the bottom right. We continue to monitor moderate and severe harm self injury and ligatures activity on a weekly basis and this is shared with the Matrons, Team Managers, Heads of Profession and NTQ. We have developed 4 new Standard Operating Procedures to support the safe management for those that self injure and care plans are assessed against these standards on a weekly basis. The bottom right shows a significant reduction over time in moderate harm falls incidents, much of this can be attributed to falls reduction work at Charlton Lane and across Community Hospitals.

Reported moderate harm self harm / SIB incidents - Trustwide
01/09/2021- 31/08/2023



Reported moderate harm patient falls - Trustwide
01/09/2021- 31/08/2023



Quality Dashboard

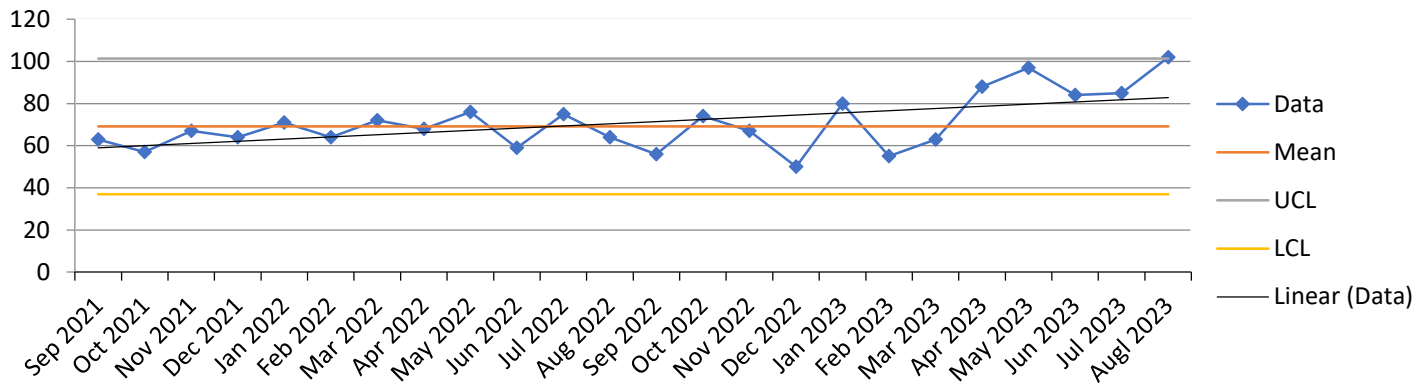
Gloucestershire Health and Care NHS Foundation Trust

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%	100%	100%	99%	99%								99%	G		
Number of HODA Clostridium Difficile Infections (C Diff)	N	16	10	3	0	0	0	2								3	G		
Number of C Diff cases (days of admission plus 2 days = 72 hrs) - avoidable	N	0	0	0	0	0	0	0								0	N/A		
Number of MRSA Bacteraemia	N	0	0	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 pressure ulcers developed or worsened within our care.	L - R		**683**	88	97	84	85	102*								**456**			
Number of Category 1 & 2 pressure ulcers developed or worsened within our care.	L - R		621	82	92	73	80	92*								419			
Number of Category 3 pressure ulcers developed or worsened within our care.	L - R		41	5	5	10	4	9*								33			
Number of Category 4 pressure ulcers developed or worsened within our care.	L - R		21	1	0	1	1	1*								4			

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

HCAI: There were 2 post 48-hour Clostridium Difficile in August (C. Diff), and no MRSA infections recorded in August. Note our ICB threshold has been set at 16 for the year.

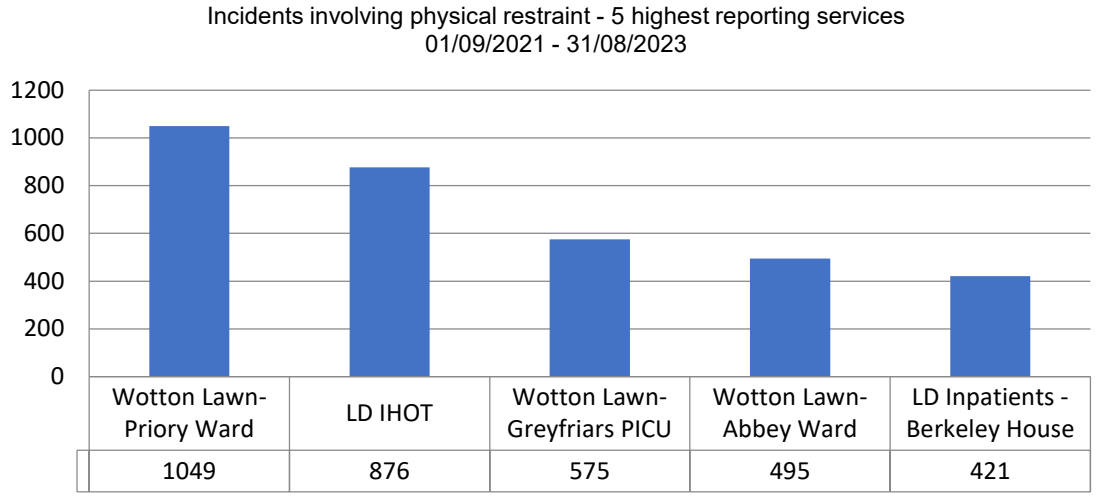


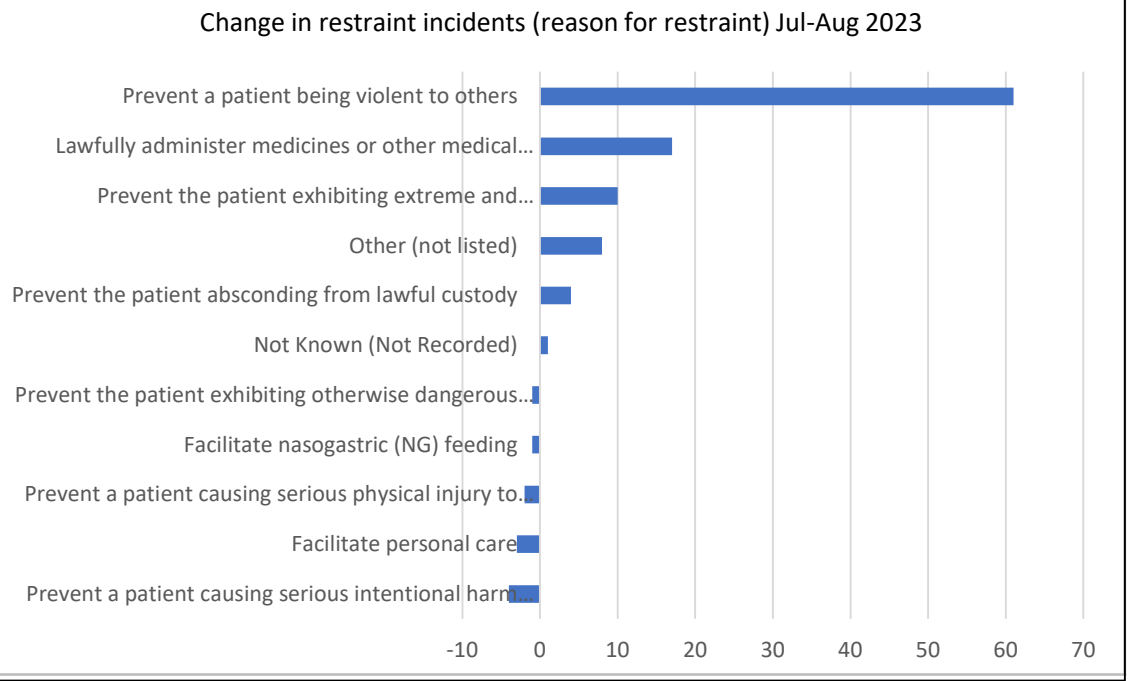
Pressure Ulcers:
*August data has not been fully validated so PU classification is likely to alter due to duplication of reporting and mis categorisation. Post validation a reduction in number and grade of PU is expected in line with previous months validations. Learning points are fed back directly to reporters and incident handlers in line with PSIRF

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 3 and 4 pressure ulcers. 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 - Opposite is an SPC chart showing data from 2021 to 2023 displaying the number of incidents at generally the middle third of the mean. This is a useful visual representation of incidence over time and compliments the tabled month by month detailed analysis.

CQC DOMAIN - ARE SERVICES SAFE? - Incidents involving restraint





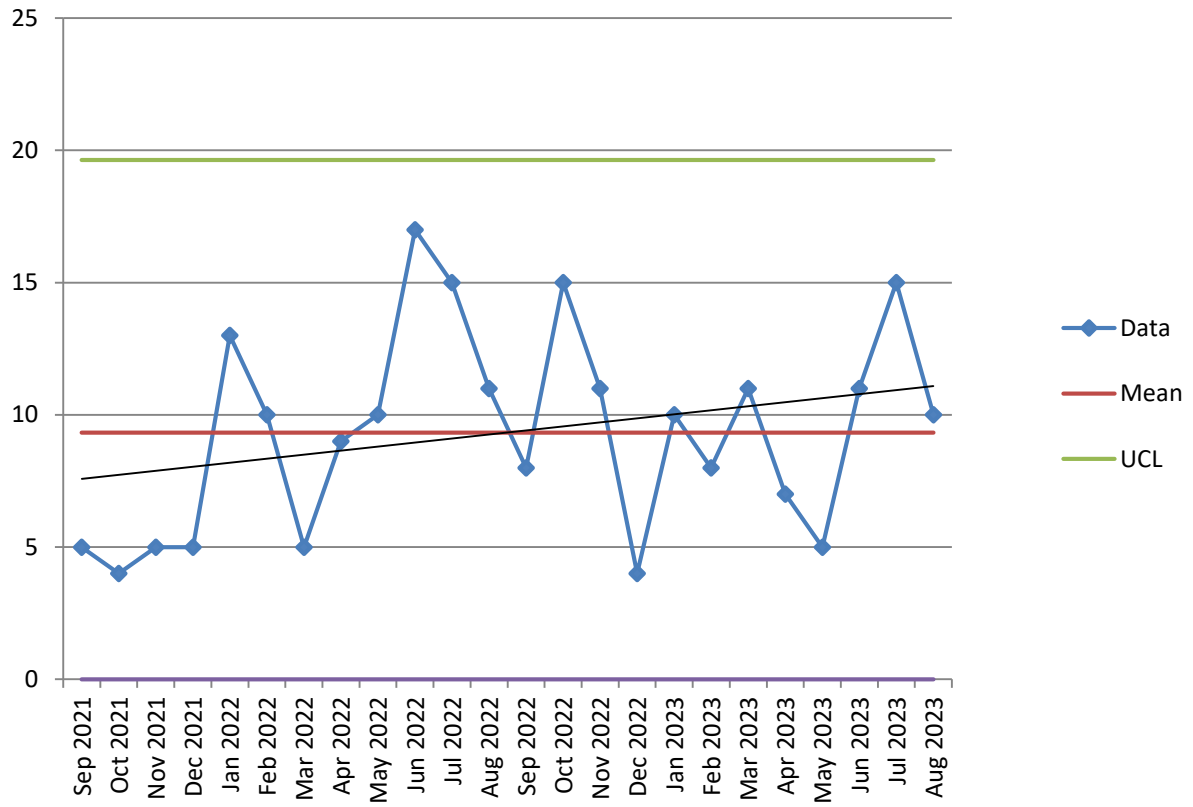
Key Highlights:

The Positive & Safe Meeting reviews all activity on a monthly basis and a weekly summary is provided to all team managers to ensure we have regular oversight of restraint and can take action to support teams. The data for August shows an increase above the mean 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: to prevent a patient being violent to others, lawfully administer medicines or other medical treatment, prevent the patient exhibiting extreme and prolonged over-activity

One aspect of the increase in reported restraint in August relates to incidents with one patient in the Low Secure Unit. Incidents related to this ward make up of 52% of reporting in month. The team is working proactively to reduce the need for restraint and this includes referral to a higher level of security which reflects the challenges and the needs of the individual. Seated restraints and clinical holds remain the highest categories and reflect the ongoing training programme and approaches to reducing prone restraint.

CQC DOMAIN - ARE SERVICES SAFE? - Sexual Safety Incidents

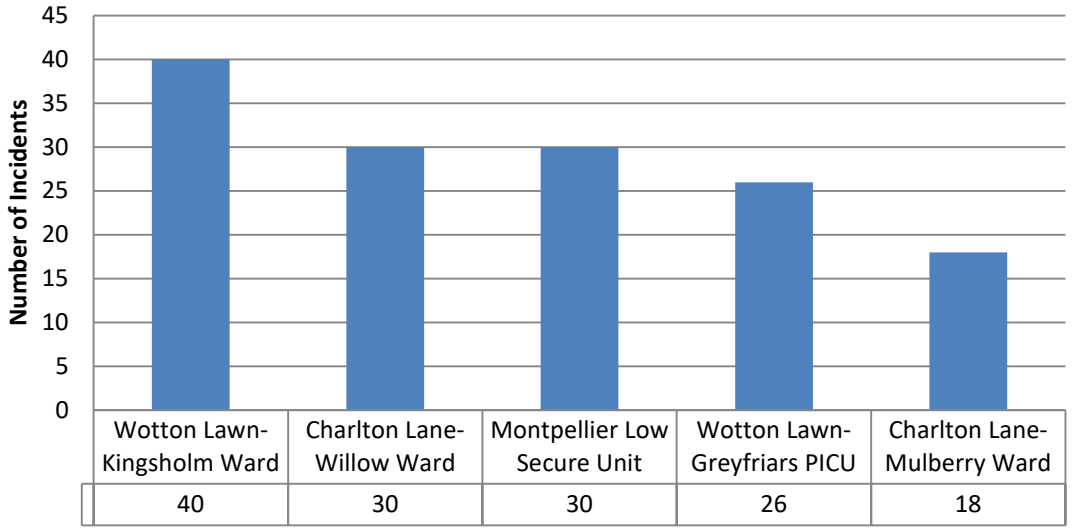
Sexual safety incidents 01/09/2021 to 31/08/2023



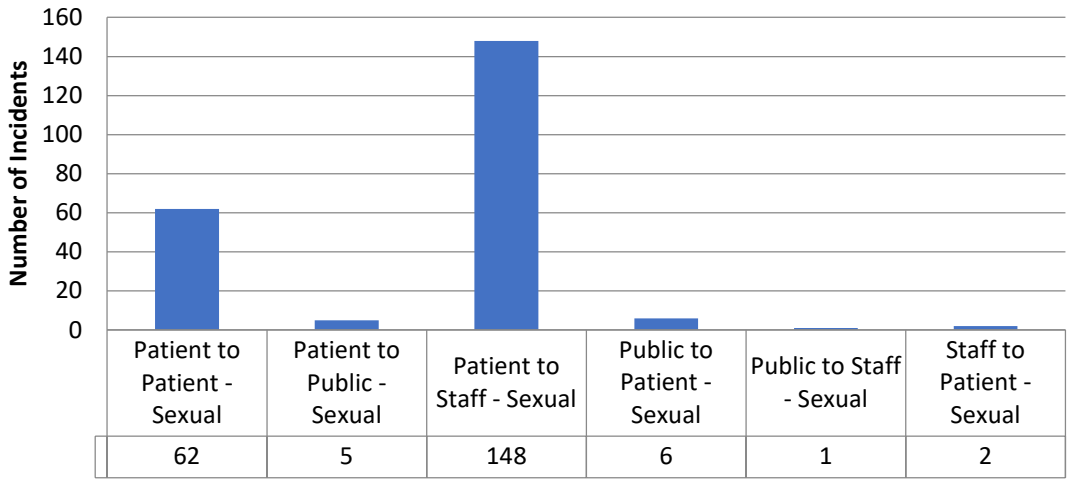
There has been an increase in reported incidents. The majority relate to disinhibited behaviour of patients, particularly in the early periods of acute illness and includes the use of inappropriate language. Reporting levels appear to be good, reflecting a culture of reporting and openness in combination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

A GHC Sexual Safety Awareness Training (SSAT) package has been developed, aimed initially at unregistered staff. This has been piloted at Kingsholm and Willow Wards plus Berkeley House, the initial evaluation shows that different clinical areas experience different sexual safety issues, and therefore training needs 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. Good work has been progressed aligning related policies to this work

Sexual safety incidents by team (5 highest reporting)
01/09/2021 to 31/08/2023



Sexual safety incidents by sub category
01/09/2021 - 31/08/2023



Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN- ARE SERVICES SAFE?- Closed Cultures: eliminating the risk of our patients experiencing abuse

Closed cultures – identification and risk factors

The CQC closed culture-related work applies to services that can be described as locked environments or areas where open access is restricted. Alongside these areas, services that deliver care to people that have communication or significant cognitive challenges are also considered at risk of becoming a closed culture. We have identified the following settings in the Trust as *potentially* having a raised risk of a closed culture; these are the focus of increased monitoring and support to eliminate this risk.

- **Berkeley House: Learning disabilities assessment and treatment**
- **Montpellier Ward: Mental health forensic low secure**
- **Willow Ward: Dementia unit**
- **Greyfriars Ward: Psychiatric intensive care unit**

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

We are using the recent substantial governance review of the Manchester Edenfield Unit, published by the Good Governance Institute (2023), to develop an improved governance approach and implement anti-closed culture interventions. We are planning a Board development session on the report's findings and will update on outputs from this work.

August/September 2023 update

The following activity to counter the risk of a closed culture has been conducted since the last update.

- Board Development Session (12th September) – Reflecting on Edenfield. Focused session to provide a check, challenge and assurance overview of Trust action undertaken to mitigate closed culture risks. The session focused specifically on our Positive & Safe Programme, Reducing Restrictive Practice, and adoption of the Six Core Strategies, an evidence-based tool to inform cultural changes, reduce restrictive interventions and blanket policies.
  The outputs from the sessions will inform future and ongoing development work
- Extensive work has been delivered promoting Freedom to Speak Up and the champions networks alongside detailed audit assessment of "speaking up".

Trust safeguards against closed culture risks

- Trust culture and values *see staff survey data
- Clinical supervision
- Staff wellbeing support
- Physical restraint monitoring – weekly dashboard and scrutiny
- Freedom to Speak Up activity
- 23/24 internal audit of reporting abuse mechanisms
- Safeguarding training and monitoring
- Breakaway and de-escalation training
- Independent advocacy
- Unannounced CQC MHA visits
- Safe Staffing and agency-reduction activities
- CTR activity

Independent Advocacy

Four Independent Mental Health Advocates (IMHAs) from POhWER provide the statutory independent mental health advocacy service across all hospitals and inpatient units (Wotton Lawn, Charlton Lane, Berkeley House, Laurel House and Honeybourne). Wards have a weekly IMHA 'drop in' so IMHAs are aware of the newly admitted patients.

IMHAs ensure patients are aware of their rights, support communication with professionals about their care and treatment at the weekly ward rounds and ensure that decisions to appeal detention under section are taken forward. They support patients to prepare for Mental Health Managers Hearings by reviewing the reports with them beforehand and supporting them during the Hearings.

Length of Stay Spotlight

The Trust Quality Team are developing revised reporting of all patients with extended lengths of stay using learning from Edenfield

Promoting an open culture

Greyfriars Ward

- Carers' group continues to meet on first Wednesday of the month (for carers of patients on all Wotton Lawn Hospital wards).

Charlton Lane Hospital (incl Willow Ward)

- Monthly 'Music in Hospital' sessions.
- Carers and families are invited for tea and cake on 12th September to celebrate 75 years of music and hospitals.
- The CaSA (Care and Support Always) carers group continues to meet on a monthly basis. Since it re-launched in Dec 22, the monthly meetings have been attended with good numbers, with new and returning carers/ families. The meeting w/c 4th Sept was attended by 8 family members/ carers.
- Improving recording of clinical supervision work is progressing well with high levels recorded on our new system

Berkeley House

- The Trust is supporting colleagues at Berkeley House to make improvements on issues raised through Trust promotion of open culture and raising issues safely.

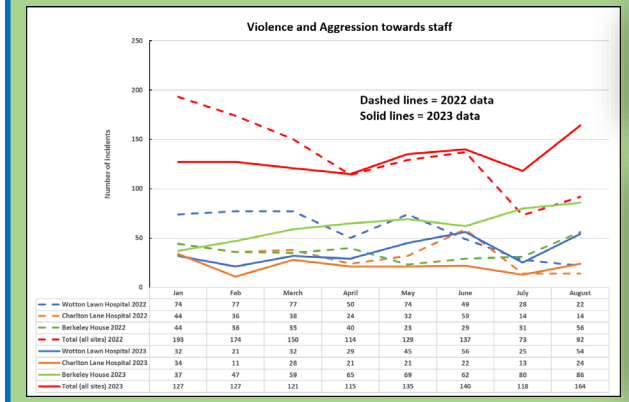
Montpellier Ward

- Deputy Unit manager attended a 5-day course to become a facilitator of the relational security training specific to secure care, equipping him with the skills to complete exercises with the team and deliver training on an annual basis.
- Improving recording of clinical supervision work is progressing well

Patient and Carer Experience Team

- Visit regularly to speak directly to patients and carers; capture experience and comment for FFT and provide support with complaints.
- FFT reporting levels from these areas is steadily improving but requires ongoing promotion

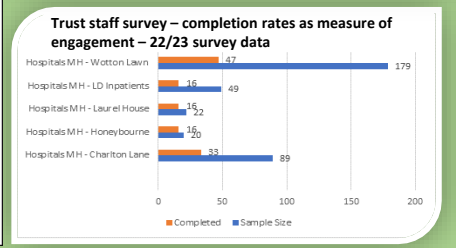
Supportive Trust datasets and monitoring metrics



	Jan 22	June 23	Aug 23	Sept 23
Wotton Lawn Hospital 2022	74	77	77	50
Charlton Lane Hospital 2022	44	36	38	24
Berkeley House 2022	44	36	35	40
Total (all sites) 2022	193	174	150	114
Wotton Lawn Hospital 2023	32	21	32	29
Charlton Lane Hospital 2023	34	11	28	21
Berkeley House 2023	37	47	59	65
Total (all sites) 2023	127	127	121	115

	Jan	Feb	March	April	May	June	July	August
Wotton Lawn Hospital 2022	74	77	77	50	74	49	28	22
Charlton Lane Hospital 2022	44	36	38	24	32	59	14	14
Berkeley House 2022	44	36	35	40	23	29	31	56
Total (all sites) 2022	193	174	150	114	129	137	73	92
Wotton Lawn Hospital 2023	32	21	32	29	45	56	25	54
Charlton Lane Hospital 2023	34	11	28	21	21	22	13	24
Berkeley House 2023	37	47	59	65	69	62	80	86
Total (all sites) 2023	127	127	121	115	135	140	118	164

	Breakaway (%)				Full PBM (%)				Full PMVA (%)			
	Jan 22	June 23	Aug 23	Sept 23	Jan 22	June 23	Aug 23	Sept 23	Jan 22	June 23	Aug 23	Sept 23
Willow	Nil rtn	91	77	71	92	92	89	97	n/a	n/a	n/a	n/a
Greyfriars	82	82	96	76	n/a	n/a	n/a	n/a	90	83	88	85
Montpellier	57	68	100	73	n/a	n/a	n/a	n/a	60	93	93	93
Berkeley Hs	Nil rtn	100	100	100	98	90	88	86	n/a	n/a	n/a	n/a



These performance measures support safeguards against a closed culture: violence- and aggression-related reports, training and staff engagement.

PBM and PVMA are physical interventions training. Snapshot dates: 27/1/22, 27/6/23, 2/8/23, 4/9/23.

CQC DOMAIN - ARE SERVICES SAFE?- Mandatory Training

Development Slide – Training and supervision – Please note this is a new slide and subject to further and development

Service – data as at 15/8/23	Conflict Resolution	Equality Diversity & human Rights	Fire Safety	Health Safety & Welfare	Infection Control	Information Governance	Moving & Handling	Prevent	Resus Level 3	Safe guarding	Safe guarding Children & adults L1	PBM/ PMVA
Cirencester & Fairford Hospital	97.3%	98.2%	98.2%	100%	97.3%	95.6%	92.9%	100%	82.7%	88.6%	97.7%	N/A
Dilke Hospital	100%	100%	94.7%	100%	98.2%	100%	98.2%	100%	87.0%	93.8%	100%	N/A
Lydney Hospital	100%	100%	85.0%	100%	97.5%	95.0%	100%	95.4%	89.7%	89.7%	100%	N/A
MIIU's	100%	100%	100%	100%	96.8%	98.9%	97.7%	99.2%	92.4%	88.0%	100%	N/A
North Cotswold Hospital	98.2%	100%	87.9%	98.2%	96.5%	96.5%	94.8%	100%	83.9%	86.3%	97.9%	N/A
Stroud Hospital	99.1%	100%	93.3%	99.1%	99.1%	98.3%	97.5%	100%	91.3%	81.0%	98.9%	N/A
Tewkesbury Hospital	98.7%	100%	97.4%	100%	100%	97.4%	88.7%	100%	85.3%	95.5%	100%	N/A
The Vale Hospital	100%	100%	84.2%	98.2%	98.2%	96.4%	98.2%	100%	89.0%	94.0%	100%	N/A
AMHP	100%	100%	100%	100%	100%	100%	100%	100%	100%	97.2%	100%	N/A
Charlton lane Hospital	100%	100%	87.0%	100%	97.8%	98.9%	96.7%	91.6%	85.5%	95.2%	100%	83%
Community Forensics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	N/A
Criminal Justice Liaison	100%	100%	100%	100%	100%	100%	100%	100%	N/A	95%	100%	N/A
Crisis Resolution HT	98.7%	100%	97.6%	100%	98.7%	98.7%	100%	99%	88.8%	87%	98.5%	N/A
Honeybourne	95.4%	100%	68.10%	100%	95.4%	100%	100%	100%	73.6%	89.3%	100%	N/A
Laurel	100%	100%	78.2%	100%	100%	100%	100%	100%	90.9%	92.3%	100%	N/A
Berkeley House	100%	100%	58.1%	100%	90..3%	96.7%	100%	100%	69.7%	92.3%	100%	88%
Psychiatric Liaison	100%	100%	96.7%	100%	90.3%	100%	100%	100%	100%	94.8	100%	N/A
Wotton Lawn Hospital	97.7%	99.4%	78.4%	100%	91.7%	94.4%	90.5%	98.3%	77.7%	88.8%	99.4%	82%

Additional information:

This is a developmental slide with a plan to develop the range of information and how this is presented over the next quarter. This is showing data that is currently pulled through to Tableau from Care 2 Learn and we acknowledge it is not yet representative of all services. A data validation exercise is underway and a review of the frequency of Statutory and Mandatory Training is taking place recognising the impact of an increasing level of essential to role requirements. Prevention and Management of Violence and Aggression (PMVA) compliance rates on one ward at WLH are lower than other wards which is impacting the overall compliance figure. This does not impede the hospitals ability to provide safe management of distress.

Appraisal - The August figure is 82% which is a decrease from previous months however this indicator is impacted by staff holidays and we will look for an increase in compliance rates post September.

Sickness - The August figure is 3.8 % -which is under threshold, the lowest rate since Sept 22 , it is 1.5 % less than last month and relates to 4628 days lost.

Clinical Supervision – The August figure is 26.9% Trustwide. New guidance to support the recording of clinical supervision has been provided to teams with a requirement for a minimum of 8 sessions a year with no more than 40 days in-between sessions. The current low rate reflects the transition from manual to the new system of recording and reporting.

CQC DOMAIN - ARE SERVICES EFFECTIVE ? – Community Hospital Delayed Patients

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 address 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, 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 - August 2023

- There has been an average of 45.8 patients that have Not Met the Criteria to Reside (nCTR) in a community hospital in August 2023
- There has been an average of 4.6 patients in total Not Meeting the Criteria to Reside (nCTR) for over 30 days in August 2023

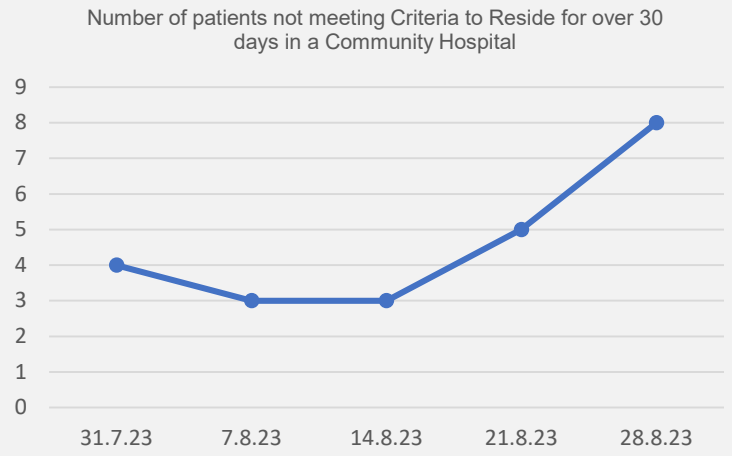
- **Delay Themes** : Overall, there has been a marked increase in the number of patients that have Not Met the Criteria to Reside in general, which includes the over 30 days.
- There has been an increase in the number of patients awaiting Pathway 1- however, there has been a system focus to improve the flow out of Homefirst.
- Significant number of bed days lost throughout August due to housing delays. This increase has been noted across the system, and escalated to the ICB. An initial meeting held to clarify the Housing discharge processes and ensure parity across the system.

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

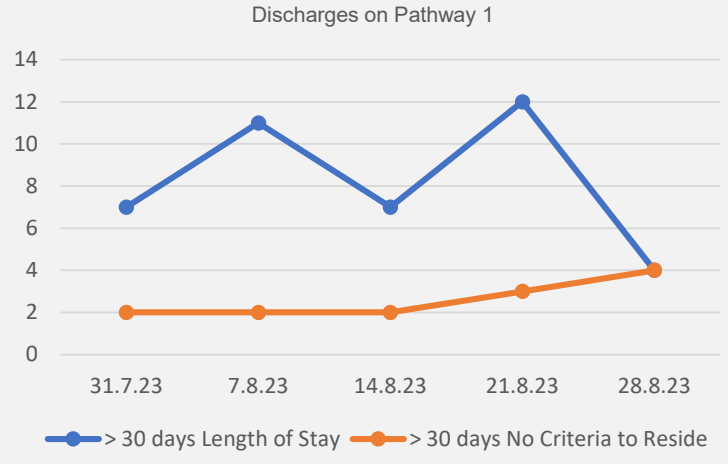
Pathway One 'Homefirst' – Return Home with additional Support 1
Homefirst principle with support to recovery or pre-existing Domiciliary Care that needs to be increased

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



Showing the number of patients that do not meet the Criteria to Reside for > 30 days. Date ranges w/commencing 31.7.23 – 3.9.23



Showing the number of patients **discharges** on Pathway 1 who did not meet the criteria to reside for > 30 days. Date range: w/commencing 31.7.23 – 3.9.23.

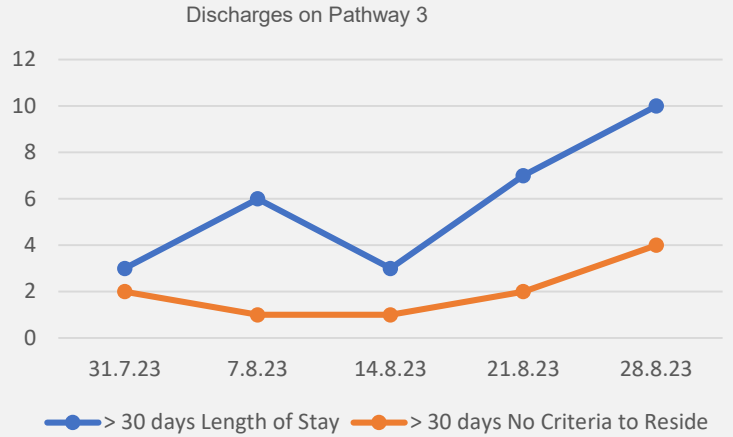


Chart 3 - Showing the number of patients delayed on Pathway 3 for over 30 days. Date range: week commencing 31.07.23 – 3.09.23. Pathway 3 is defined as discharge to a Care home, either funded by the individual or through Social Care funding.

CQC DOMAIN - ARE SERVICES Effective? – Mental Health Hospital Delayed Patients

Long Length of Stay Patients- MH Hospitals.

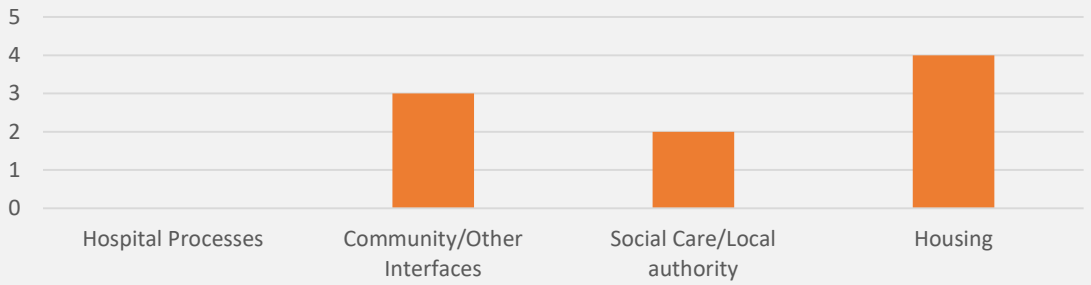
Clinically Ready for Discharge, formally known as DTOC, is the new terminology for reporting delays since January 2023. "Clinically Ready" does not indicate complete recovery, it is the point at which a person could be safely assessed, cared for and treated at home or in a less restrictive setting. Being "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.

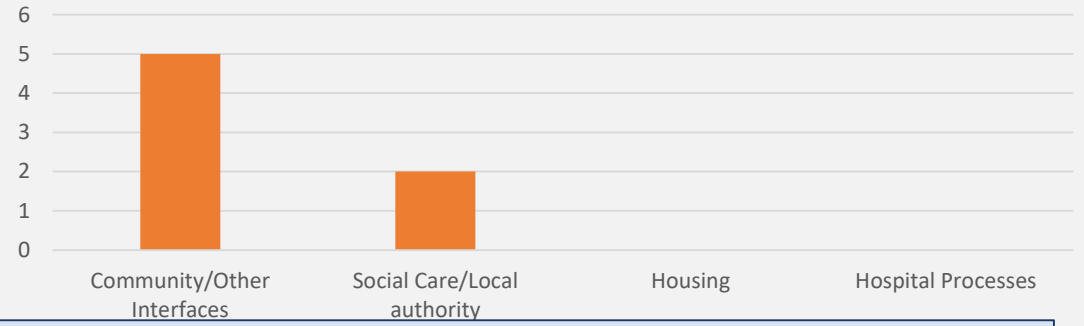
Headline Data - August 2023: Total of patients across WLH, CLH, Recovery, LD = 21 WLH = 9 CLH = 7 Recovery Units = 7 Learning Disability = **1**

No of clinically ready for discharge patients in Wotton lawn per theme of delay.



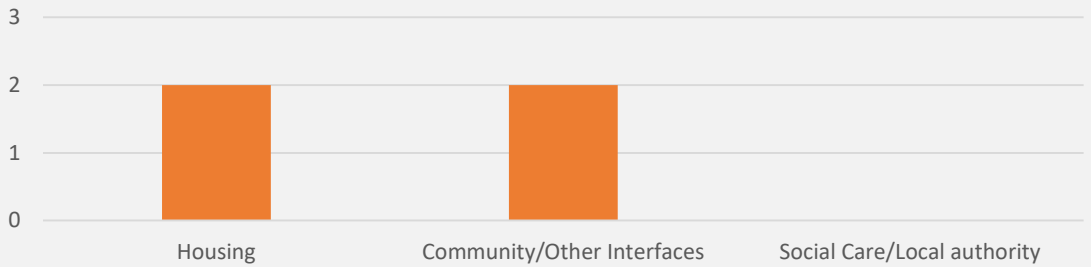
Themes related to delays:-
Community/Other Interfaces – lack of specialist health care provision.
Social Care/Local Authority – lack of Social care provision to support assessment/discharge.
Housing – homelessness; lack of appropriate supported accommodation

No of clinically ready for discharge patients in Charlton Lane hospital per theme of delay



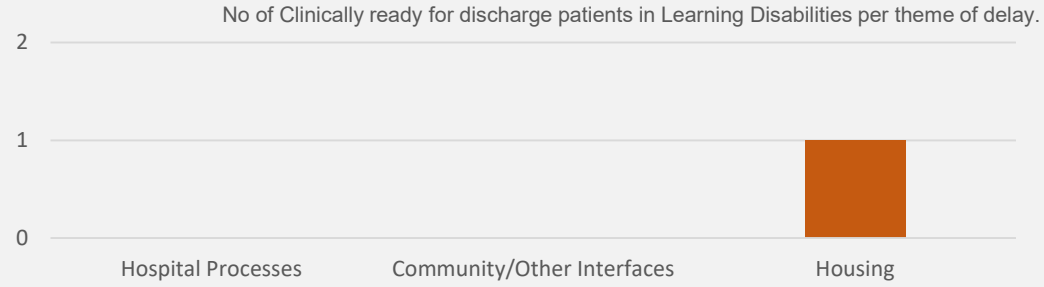
Themes related to delays:-
Hospital Processes – patient/family choice regarding care home placement
Community/Other Interfaces – awaiting care home placement (under care of hospital social work team).
Social Care/Local Authority – Awaiting care home through brokerage

No of clinically ready for discharge patients in Recovery Units per theme of delay.



Themes related to delays:-
Community/Other Interfaces – awaiting public funding; await outcome of legal requirements e.g. awaiting mental capacity assessment

No of Clinically ready for discharge patients in Learning Disabilities per theme of delay.



Themes related to delays:-
Lack of appropriate housing

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
- + Antipsychotic monitoring CAMHS
- + School nursing mental health pathway and resources

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

- + Sexual health specimen mis-labelling
- = (s) Leadership opportunities for AHP students
- = ECT in WLH
- + CYPS SLT waiting list
- + Staff retention - itchy feet
- = (s) Improving sustainability in medicines usage across GHC
- = Improving Access & Delivery of Family Interventions with Psychosis & bi-polar within the Early Interventions Team

3. Improvement idea initiated

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

- ↑ Increasing service user and carer involvement in QI
- = (s) Paired ROMs compliance – CAMHS
- = Reducing medication errors in CLH
- = Health checks for those with SMI
- = School nursing duty system
- = Substance misuse in CAMHS
- + CYPS physio service flow
- ↑ Development of peer support for B7 CYPS
- ↑ (s) Improve communication and liaison between maternity service and health visiting service
- + Patchwork project Infection Prevention Control
- + Decreasing laxative use CLH

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) How do we provide services for lung cancer patients
- ↑ (s) Creating a sustainable placement offer for AHP Students in GHC
- = Improving standard of observations on Priory Ward, WLH
- = (s) Improving mouthcare standards in inpatient areas
- = Optimising flow in community hospitals
- = (s) Increasing the use of FFT feedback in our organisation
- = (s) Improving access to support for administrators to ensure the delivery of high-quality health care
- = Improving the therapy triage process in Gloucester ICT
- = Reducing delayed transfer of care - MH LoS
- ↑ (s) Nutritional pathways (Dilke)
- ↑ Single handed personalised care approach
- ↑ (s) Length of time on core CAMHS caseload

5. Improvement idea sustained & implemented

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

- ↑ Carers' Working Group

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

Directorate	No of Projects
Countywide	4
MH Hospitals and UC	6
PH Hospitals and UC	2
Adult MH/PH/LD Community	5
CYPs	10
Corporate	7
Total: 34	

Training data August 2023:
26 Silver – 0.4% workforce
552 Bronze -12.3% workforce
488 Pocket QI – 10.8% workforce

Supervision

Childrens: Group Supervision Compliance **62%**

Integrated Group Supervision Sessions: **26**

One to One Supervision Sessions: **2**

Adults Group Supervision Sessions **2**

Training

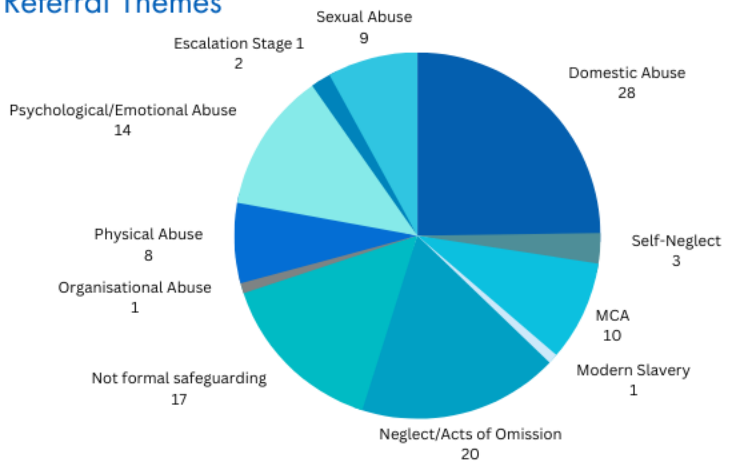
97%	91%	85%	88%	85%
LEVEL 1: INDUCTION	**LEVEL 2: THINK FAMILY**	**LEVEL 3: CHILD PROTECTION**	**LEVEL 3: ADULT PROTECTION**	**LEVEL 4: ADULT PROTECTION**
Jun 23:96%	Jun 23: 91%	Jun 23: 88%	Jun 23: 82%	Jun 23: 74%
May 23: 96%	May 23: 91%	May 23:88%	May 23: 82%	May 23: 74%
Apr 23: 96%	Apr 23:90%	Apr 23: 87%	Apr 23: 88%	Apr 23: 77%

Referrals and Advice Line

132 August Contacts to Advice Line (adults and children combined)
Apr 23: 111 May 23: 122 Jun 23: 148 Jul 23: 133

39 August Referrals made to GCC (adults and children combined)
Apr 23: 14 May 23: 30 Jun 23: 35 Jul 23: 39

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

- Joint Area Targeted Inspection (JATI) took place from 12-16th June 2023. The inspection looked at the multi-agency response to identification of initial need and risk in Gloucestershire. The inspection over all was incredibly positive and successful and demonstrated mature multi-agency partnership. Headline finding – "Most children living in Gloucestershire who are initially identified to be in need of help and protection receive a swift and appropriate multi-agency response from the 'front door'. Senior leaders' strategic partnership is strong, and this mature relationship is supported by effective governance in the Gloucestershire Safeguarding Children's Partnership (GSCP). Areas for improvement, relevant to GHC, align to our on-going work on clinical system template development, MASH Health team and function expansion, and the review of our current adult and children's safeguarding supervision offer.
- On Thursday 7th September the Gloucestershire LADO service delivered a Allegations Management Awareness Session to the GHC Safeguarding Team, senior HR managers, and CYPS directorate colleagues. Transferable risk, eligibility criterial, referral pathways and LADO outcomes were key areas of learning.
- 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.

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 to find solutions that mitigate and 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. Comms and training are currently being developed in preparation for the template launch.
- Staff engagement with safeguarding supervision is a concern. A review of our current supervision model is underway with a staff consultation, we are exploring the viability of the re-introduction 121 supervision for safeguarding case holders, as well as a move to some face-to-face supervision sessions and 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 August– 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	127.5	17	30	4	0	0	0	0	0	0
Priory	25	3	0	0	0	0	0	0	0	0
Kingsholm	0	0	0	0	0	0	0	0	0	0
Montpellier	0	0	0	0	0	0	0	0	0	0
Greyfriars	70	9	0	0	0	0	0	0	0	0
Willow	0	0	57.5	7	0	0	0	0	0	0
Chestnut	32.5	4	55	7	0	0	0	0	0	0
Mulberry	0	0	7.5	1	0	0	0	0	0	0
Laurel	135	18	22.5	3	0	0	0	0	0	0
Honeybourne	15	2	0	0	0	0	0	0	0	0
Berkeley House	170	21	0	0	0	0	0	0	0	0
Total In Hours/Exceptions	575	74	182.5	23	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 in line with NHSE guidance, this will be reported on in October 2023. We have cross referenced highest exceptions with patient safety and experience data. Berkeley House have reported the highest code 1 exceptions, followed by Laurel House and Abbey, the Matrons report no adverse impact on care delivery or patient experience. Code 1 exceptions at Berkeley were attributable to RN & HCA shortages on early and late shifts. Code 1's on Abbey ward related to RN shortages on early & late shifts and shortages at Laurel are attributable to HCA on early and late shifts. Shifts have been predominantly filled with regular HCA's, who are familiar with ward environments.

Mental Health & LD Ward	Average Fill Rate %	Sickness %	Vacancy %
Dean Ward	136.13%	6.3	3.6
Abbey Ward	101.00%	0.0	22.8
Priory Ward	134.35%	5.5	13.1
Kingsholm Ward	120.43%	5.2	0.4
Montpellier	135.65%	0.3	6.1
PICU Greyfriars Ward	110.62%	0.0	26.2
Willow Ward	105.01%	2.3	7.9
Chestnut Ward	109.68%	13.8	-3.4
Mulberry Ward	107.20%	8.1	15.1
Laurel House	99.73%	4.8	0.8
Honeybourne Unit	113.44%	0.4	-5.2
Berkeley House	98.84%	5.8	25.2
MHH Totals Avg (Aug 2023)	**111.18%**	**3.8**	**11.4**
Previous Month Totals	108.99	6.0	12.2

Physical Health Ward	Average Fill Rate %	Sickness %	Vacancy %
Coln (Cirencester)	117.11%	4.5	18.9
Windrush (Cirencester)	108.54%	4.2	13.9
The Dilke	115.42%	0.0	15.8
Lydney	97.35%	3.0	10.3
North Cotswolds	98.88%	3.6	12.2
Cashes Green (Stroud)	96.59%	2.0	11.5
Jubilee (Stroud)	100.24%	4.3	13.6
Abbey View (Tewkesbury)	102.13%	4.2	-9.8
Peak View (Vale)	94.72%	2.2	15.9
PHH Totals Avg (Aug 23)	**103.44%**	**3.4**	**10.6**
Previous Month Totals	112.86%	7.9	7.8

NHSE Zero HCSW Vacancy Commitment Inc. bank – 3 month report	
June	91.99
July	98.41
Aug	94.39

Organisation	FTE Budgeted	FTE Actual	FTE Variance
Grand Total	**608.63**	**514.24**	**-94.39**
327 E11850 LD Inpatients - Berkeley House	49	34.2	-14.8
327 B11201 Ciren Hosp- Coln Ward	20.16	12	-8.16
327 B11200 Ciren Hosp- Windrush Ward	17.06	9.67	-7.39
327 E11802 Vale Hosp- Peak View Ward	18.63	13.47	-5.16
327 G13693 Physical Health Checks	6	1.2	-4.8
327 E11700 Stroud Hosp- Cashes Green Ward	17.52	12.73	-4.79
327 E11701 Stroud Hosp- Jubilee Ward	14.34	9.67	-4.67
327 G15503 Rapid Response	6.07	1.8	-4.27

NHSE Zero HCSW Vacancy Commitment : The workstream continues with 5 main strands, Attraction, Innovative Recruitment, Learning and Development, Recognition and Value and Retention. There are 48 people in recruitment pipeline and in August there were 8 leavers. The table opposite is a breakdown of the current HCSW vacancy hotspots.
IR/Recruitment: 1 AHP remains in the pipeline for 2023. To date 89 international colleagues have been recruited (from Jan 2021). At the International Educated Nurse (IEN) celebration event nurses identified they would like a forum to enable them to meet as a group to have a collective voice and peer support. Sharing learning from the South West Retention meetings and the Southwest IEN Stay and Thrive community of practice, the first Council meeting will take place on September 20th.

CQC DOMAIN – ARE SERVICES SAFE - Quarter 1 - Guardian of Safe Working Report 2023/24

PURPOSE

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours. It was agreed with the BMA that a 'Guardian of Safe Working Hours' will be appointed in all NHS Trusts employing trainees (junior doctors) to ensure safe working practice. The role of 'Guardian of Safe Working Hours' is independent of the Trust management structure, with the primary aim to represent and resolve issues related to working hours for the junior doctors employed by it. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and will provide assurance to the Trust Quality Committee and Board or equivalent body that doctors' working hours are safe. The Guardian's Quarterly Report, as required by the junior doctor's contract, is intended to provide the Trust's Quality Committee and Board with an evidence based report on the working hours and practices of junior doctors within the Trust, confirming safe working practices and highlighting any areas of concern.

Reporting time period April 2023 – June 2023	**Guardian of Safe Working Hours: Dr Sally Morgan**
Number of doctors in training (all on 2016 contract)	**In Quarter 1 2023/24 (April - June) there were 36 MH doctors in training posts during this time period** • 8 Higher Trainees • 4 CT3s • 6 CT2s • 6 CT1s • 5 GP Trainees • 4 FY2s • 3 FY1s
Exceptions in this period	• **9 on call shifts had a junior doctor gap due to sickness.** • All of those shifts were covered by our own junior staff acting as locums • Due to strike action in April and June there were a further 11 on-call gaps (not including any daily normal working hours cover required) • **8 exception reports in this time period all relating to hours worked, all at Charlton Lane Hospital. TOIL agreed.** • **The Junior Doctors Forum in June was cancelled due to junior doctor strikes.** • There has been no success to date in making contact with the GOSWH in GHT (The post was re-advertised in July 2023) . • Ongoing efforts are being made to improve links between the 2 organisations to ensure that any work outside the work schedules is being exception reported. Particularly with regard to trainees in split posts between GHT and GCH. • A Trainee Away Day was held on 4 July 2023 which had a focus on Wellbeing . Although only relatively small numbers attended , the feedback from the day was excellent and there are plans to make this an annual event. The main challenge for the Wellbeing Day was ensuring that there was adequate cover in both WLH and CLH in order to allow trainees to attend. • There have been some challenges in ensuring that both supervisors and trainees have log ins on the Allocate system – this has caused some delays in the exception reporting process within this quarter. To help manage this issue, trainees will be encouraged to discuss exception reporting with their educational supervisors at their first meeting after rotation.

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

Non-Executive Directors Quarterly Service Review
Q4 2022/23 / Q1 2023/24
August 2023

Gloucestershire Health and Care
NHS Foundation Trust

Working together – Service visits Q4 22/23 & Q1 23/24

Q4 22/23	Q1 23/24
IAPT and MH Service 20 March 2023	**Outreach Vaccination Service** 17 April 2023
Integrated Patient Flow Team 28 March 2023	**CAMHS** 24 May 2023
EDNS 10 May 2023	**Complex Lower Leg, Lydney Hospital** 13 June 2023
	Adult Speech and Language Therapy 21 June 2023
	Gloucester Recovery Team 29 June 2023
	Children's Speech and Language Therapy 25 July 2023
	GRiP 2 August 2023
	Recovery College Date TBC

Living our Trusts Values - Making a difference (1)

Positive Feedback from NED colleagues (as described in visit reports)

All staff I met were respectful and kind both to each other and to the service users. They were friendly, approachable and welcoming. They went to some lengths to uphold and protect dignity and well-being. They were very respectful and welcoming to me, even though they were extremely busy.
IAPT

I think the work they are doing is to be applauded, and built upon, as a good "proof of concept". It is clearly a very well-motivated, and well led team, and I think with the right opportunity at system level will be able to make an increasingly valuable contribution to the system patient flow issue. This team is very keen to do more, and we should back them strongly to do so.
Integrated Patient Flow Team

I very much enjoyed my visit to this crucial service and would like to thank the nurse lead and the team members for their openness, positive approach and compassion for the people they serve.
Evening and Night District Nursing Team

This is a great team running a superb service.
Outreach Vaccination Service

Massive thanks to everyone whom I met on the visit. Really open conversations and a very warm welcome.
CAMHS

Living our Trusts Values - Making a difference (2)

Positive Feedback from NED colleagues (as described in visit reports)

It was clear that the nurse enjoys her job and finds it very rewarding. She also came across as very knowledgeable. The service appears to be delivering high quality care and good outcomes.
Complex Leg Wound Service

A very committed team with excellent leadership. Morale remains high despite all the recruitment and retention problems. It was a great pleasure to meet people and to be made very welcome.
Gloucester Recovery Team

This is a therapy that makes an incredible difference for the people it serves. The impact on people's lives of being able to communicate again, perhaps after an already traumatic event such as surgery or injury, is heart warming to see.
Adult Speech and Language Therapy Service

Visit Outcomes Update – completed visits postponed from Q4 (1)

Service	Recommendations/questions	Progress	Status
IAPT and MHICT Service	1. Colleagues can be required to deal with patients of higher acuity. What support is given to them?	1. **Nursing team:** weekly team meeting, monthly WLM as well as clinical supervision/MDT discussions. **NHS Talking therapies teams:** all clinicians have weekly supervision plus weekly team meetings in addition to being able to access a 'supervisor of the day'.	**Closed**
	2. Emotional burn out from work; service is dealing with so many people that they do not have the time to give them the care that they need, and then those people come back into the service. They describe it as a revolving door. (This was a comment that was made from the nursing team within MHICT)	2. Due to increased referral rates and levels of sickness, cases have been required to be reallocated across the current team increasing workloads. This can affect the client offer but all efforts are made to mitigate against this. The nursing team are commissioned to offer short term interventions, this is particularly an issue when there is not a service to refer onto and people fall into the gap between primary and secondary care services. All staff have access to and are regularly supported to access a variety of staff health and wellbeing services within the Trust.	
	3. There are some people who are too complex for the service but are unable to access other services as they do not meet the criteria.	3. The service has noted an increase in the complexity of clients referred . There is a perception within the team that other GHC services don't always accept our onward referrals, however data suggests there is a high level of acceptability for referrals to secondary care, this data has been shared with the staff. All localities have regular interface meetings with the Recovery teams to discuss issues and concerns around specific client referrals and the appropriate onward care route is identified.	

Visit Outcomes Update – completed visits postponed from Q4 (2)

Service	Recommendations/questions	Progress	Status
IAPT and MH Service ***continued***	4. Some colleagues pointed out the issues with the data systems, having moved from IAPTUS to Rio. 5. Value could be improved when working with other colleagues in GHC in mental health services. (Example; a patient entering the service was too complex and needed secondary mental health care. The nurse had to write a detailed report to another department and felt like she needed to fight the case of her patient. This is symptomatic of a very high demand, but also that the services could be more joined up).	4. Staff are building their confidence using Rio but this takes time, additional training has been made available to support this transition. The move supported the national Mental Health Services Data set compliance requirements, advantages for healthcare staff include: • Full access to historical records for each individual, IAPTus does not link with RIO (or any other clinical record) • Ability to see what referrals the person has had eliminating duplication and the person having to repeat their story • Any onward referral team have full access to their assessments and records (eliminating duplication and the person having to repeat their story). 5. There can be a variation regarding the level of detail required to make onward referral to other MH teams. When all the information is recorded in Rio, the referral form does not need to be so detailed which saves time for both teams and should offset the additional time to collect it.	**Closed** **In progress- SD and Deputy SD Continuing to analyse data**

Visit Outcomes Update – completed visits postponed from Q4 (3)

Service	Recommendations/questions	Progress	Status
Integrated Patient Flow Team	1. The limitations in our clinical systems, hamper the effectiveness of tools such as SHREWD; some data is not updated in real time and requires manual interventions. 2. A significant problem is with the 111-service escalating too many cases to emergency status, requiring ambulances etc. 3. The team stated that they think the average patient profile has changed post COVID; the overall model of care, and the metrics used to assess outcomes may be mismatched to the circumstances we have post-pandemic. 4. Will CATU be replicated across the system, delivering local care in non-acute settings. 5. There are significant opportunities for process and efficiency improvement, as well as increased collaboration across system partners.	1. Clinical systems are not always adaptive to what the data capture 'ask' is in order to inform of system demand capacity in real time– his is largely because S1 operates a once-a-day data pull – so manual updates are required. There are recent developments in certain aspects of 'flow' data which has lessened the impact of manual entry 2. This is anecdotal and will require the ICB to validate. However there is evidence that patients could have accessed alternative pathways instead of the ED. This is very reliant on population behaviours and cultures – but also an easy to navigate system to access a wide variety of services. Work is in progress to understand the direction of travel for a systemwide clinical assessment service alongside ICB commissioning intentions within urgent care. 3. Evidence is starting to be circulated regarding the impact of the pandemic, it will need to be factored into any system demand and capacity modelling for the future – particularly if higher levels of acuity and dependency is now apparent. Nationally and locally commissioners are sighted on the patient profile changes. 4. Community Hospital Vision for the future has accounted for this 5. In line with our Trust value of always improving and embracing QI methodology the patient flow team are well placed to identify and contribute to numerous system workstreams to influence improvements with a patient centred approach. Currently this is largely delivered within the ICS 'Working as One' program.	**Closed** **Closed, ongoing work is BAU** **Closed** **Closed** **Closed**

Visit Outcomes Update – completed visits postponed from Q4 (4)

	Recommendations/questions	Progress	Status
Evening and Night District Nursing Service	1. A designated triage nurse would be helpful, releasing time for the nurses on that shift to undertake their visits uninterrupted.	1. Following successful transfer of the EDNS into the ICT directorate, the teams activity, skills, competencies and capacity is being fully reviewed to inform the future business model. This includes the adoption of ICT nurse triage process.	**Closed**
	2. Greater access to training and supervision would be valued by the team.	2. Practice facilitation hours are required to support the team and are being reviewed as part of the wider service review. The EDNS workforce are being supported to adopt the competency framework that is used by District Nurses within ICT's. Locality based clinical competency sessions for ICT's and EDNS colleagues are being developed to enhance relationships between the teams. The band 7 Community Nursing Lead post for the team has now been successfully recruited to which will enable supervision to be provided sustainably to the team.	**Closed**
	3. The HCA roles could be further developed to make the most of the experience of these individuals and make the role more rewarding.	3. This is being reviewed in line with the training needs of the whole team. In addition it will be part of the Trust wide work that has commenced; Review all HCA job descriptions and banding, Training needs analysis led by L&D team and creation of a HCSW council .	**Closed**
	4. Team finding it difficult to see all the information they need on SystmOne, particularly care plans.	4. Visibility of records across services for thorough clinical assessment and associated care planning forms a priority narrative in our 'vision' procurement process and will be paramount in our configuration of systems going forward. To mitigate current challenges, all EDNS staff can be given access to the ICT S1 modules and this action is being addressed by the SD.	**Partially completed**
	5. The team does not have a designated team base so 'borrows' space alongside the SPCA.	5. SD exploring options with the space utilisation group and has requested space within EJC	**Partially completed**
	6. Further resources required to make the service more resilient.	6. Shift pattern review is taking place. In addition the team will be part of the community nursing safer staffing tool review in the autumn. The team now has a band 7 in post and has the additional support of an 8a clinical manager	**Closed**

Visit Outcomes Update – completed visits Q1 (1)

Service	Recommendations/questions	Progress	Status
Outreach Vaccination Service	1. Some sessions are underutilised. Could we do more as an organisation to promote the availability of the sessions? Please could we do more to support them in promoting their sessions to ensure good attendances?	The team manager has collated a variety of feedback and following successful conversations with system partners the following have been actioned: • Continue to publicise sessions on NHS Glos website Continue to update local GP practices about outreach sessions in the local area including posters with date and venue details • Advertise our clinics on the NHS website when people search for local walk-in sessions • Share clinic details with local district councils • Share with 111 • Social media push • Share details of vaccination clinics with Inclusion Gloucestershire and partner organisations who support people with learning difficulties, neurodiversity and experiencing issues with their mental health. • Updated our intranet page which includes the link to the NHS Gloucestershire website where our outreach sessions are published.	**Closed**

Visit Outcomes Update – completed visits Q1 (2)

Service	Recommendations/questions	Progress	Status
CAMHS	Issues raised in this report are reported on to Execs frequently. There were 6 specific aspects discussed during the visit: 1. Waiting List 2. Interface with Social Care 3. CIPs 4. How is CAMHS addressing health inequalities and meeting the needs of underserved communities? 5. Preventative work with young people regarding their mental health. 6. Retention of staff perspective	1. A key priority within our project plan is review and support of those waiting. There is currently a focus on those waiting over a year who have not had a contact with our service in that time. We are reviewed the Core CAMHS Skill Mix of staff in June to ensure we match staff skills to areas of greatest CYP need and then recruit accordingly as vacancies occur. We are in touch with a number of other services locally and nationally to share ideas on how they have reduced waiting lists. CAMHS waiting list management is now BAU 2. Our CAMHS Service Director continues to enhance the relationships with social care. Within CAMHS we are currently meeting monthly to share ideas about how we can embed sustained change for the better across the 2 agencies. 3. Reduction in posts can reduce the capacity of the workforce and creates a major challenge to the prospect of addressing the backlog of children and young people who are waiting. All CIP proposals are accompanied by an QIA/EQIA and subject to scrutiny within established Trust governance routes.	**Closed** **Partially completed** **Closed**

Visit Outcomes Update – completed visits Q1 (3)

Service	Recommendations/questions	Progress	Status
CAMHS ***continued***	Issues raised in this report are reported on to Execs frequently. There were 6 specific aspects discussed during the visit: 1. Waiting List 2. Interface with Social Care 3. CIPs 4. How is CAMHS addressing health inequalities and meeting the needs of underserved communities? 5. Preventative work with young people regarding their mental health. 6. Retention of staff perspective	4. There are a number of teams within CAMHS specifically set up to address the needs of children and young people whose vulnerability or challenges accessing services warrant a more tailored approach e.g. Complex Engagement, CAMHS Youth Support, Young Adults. The Child in Care team recently undertook some training around health inequalities experienced by vulnerable young people. Experts by Experience, both CYP and parents, have been recruited to the team to help inform other team members. 5. There is a growing 'Young Minds Matter' mental health support team available within schools, with a focus on earlier intervention. There is also a pilot under way for a multiagency Mental Health Navigation Hub to ensure children and young people get access to the right help as swiftly as possible. A Children's summit with the ICB in the autumn aims to promote and understand how CYP mental health needs are addressed across the whole system. This whole system approach is aimed to have impact on all levels of need alongside partner agencies. 6. A CAMHS Academy is in development to help support the growth of existing staff, recruitment and retention, including a 'Career Development Framework .There is significant focus on staff health and wellbeing with a programme of staff forums and a monthly newsletter.	**Closed** **Partially completed** **Partially completed**

Visit Outcomes Update – completed visits Q1 (4)

Service	Recommendations/questions	Progress	Status
Complex Leg Wound Service	1. There is a Band 7 vacancy which the service has yet to fill. The establishment is for two Band 7's so this is putting pressure on the team and other Band 7.	1. This post has now been recruited to and the post holder will join the team in October. Additional support to the remaining band 7 and the wider team is being provided by the Band 8a and Director of Nursing, ensuring staff have clinical support and a route of escalation	**Closed**
	2. Hearing how practice nurses have become de-skilled is a concern.	2. This is a concern, however practice managers seek to rectify and the service can provide training and single issue clinical guidance. The ICB have convened a workshop in October to explore expanding the current prevision to cover the whole county and explore primary care education needs.	**Closed**
	3. Frustration still exists re IT and glitches and lost data especially if it relates to a three-hour assessment and also managing the pressure in the appointment service.	3. 'Lost data' refers to instances where IT has 'crashed' during data collection/entry. This is mainly due to intermittent Wi-Fi issues across the county. Staff do have an option to work 'offline' to mitigate data loss and the service lead is supporting staff to understand how they can do this.	**Closed**

Visit Outcomes Update – completed visits Q1 (5)

Service	Recommendations/questions	Progress	Status
Gloucester Recovery Team	1. Is there any potential to introduce more training facilitator resource to increase clinical learning and development? Constantly improving and learning enables people to feel they are making a difference which a major contributor to staff satisfaction and morale. 2. More support for introducing Structured Clinical Management to provide much better outcomes and lives for people with personality disorders/complex emotional needs. This investment should reduce admissions and provide far better outcomes as hospital is not the best place for most people with these needs. 3. Estates solutions so the team can see more people as outpatients rather than having to visit them in their own homes – thus freeing up valuable time and supporting recovery.	1. Discussions to progress this have been initiated. In addition the team has been connected with the Trusts Head of Practice Education and Widening Access skills and expertise to explore CPD funded opportunities and longer term advance practice opportunities. 2. Development of a local SCM pathway with the involvement of CPI (Complex Psychological Interventions) team has commenced. There is an identified need for training within this and opportunities are currently being explored recognising the need to prioritise some staffing groups. 3. Discussions are being held with GL1, a community space, to explore using their wellbeing hub for appointments, recognising the need to ensure confidentiality. Service leads are mindful that some patients feel the space at Pullman is 'too clinical' and have begun to explore additional community spaces as home visits are not always indicated and can be counterproductive in terms of encouraging leaving the home and being more connected to the local community.	**Closed** **Closed** **Closed**

Visit Outcomes Update – completed visits Q1 (6)

Service	Recommendations/questions	Progress	Status
Gloucester Recovery Team ***continued***	4. Continue to develop more housing options and rehabilitative approaches so people can move on from more institutionalised settings. Support the initiatives to skill up housing officers to feel confident to provide more support to patients.	4. Currently we are unable to discharge patients who are in supported accommodation managed by the Accommodation Team. There is a cohort of patients whose mental health is stable and there is no active treatment role required for who due to this arrangement continue to require the monitoring and adjunct paperwork of being on the caseload. Service leads are actively working with system partners to explore more innovative housing options, recognising the well documented housing issues nationally and locally.	**Closed**
	5. Ensure that resources match demand/need/demographic differences so that we can demonstrate we are reducing inequalities at least regarding access to services.	5. Specific and wider issues relating to increasing current and future demand are regularly shared at appropriate system boards. Within GHC service leads continue to work in partnership with communities to improve access to our services.	**Closed**
	6. Do our pay structures recognise the value/expertise of specialist generalists which often requires a broader range of expertise and experience than a narrower specialist role?	6. All pay structures are aligned to national agenda for change arrangements	**Closed**
	7. Is there more that can be done to influence GP practices re Depo injections through primary care commissioners	7. A QI project is in progress looking at how we transfer (where clinically appropriate) depot injections into primary care.	**Closed**

Visit Outcomes Update – completed visits Q1 (7)

Service	Recommendations/questions	Progress -	Status
Adult Speech and Language Therapy	No particular concerns but I was left with a question about how we can better support joint working across GHT and GHC in this service.	With a new SLT Head of Profession in post for GHC and a new AHP lead in post for GHFT, communication across the Trusts regarding the acute SLT service has significantly improved in recent weeks. The main issue we have with working across Trusts is related to IT. Our current GHT contract is a legacy contract and would benefit from updating to reflect current need and demand and capacity requirements. There is scope to widen access opportunities to video fluoroscopy at GHFT and develop Fibreoptic Evaluation of Swallowing, both of which the team felt would also improve patient outcomes, this is being explored by the Head of Profession.	**Closed**

Visit Outcomes Update – completed visits Q1 (8)

Service	Recommendations/questions	Progress	Status
Children's Speech and Language Therapy	AWAITING REPORT	1. N/A	
GRiP	AWAITING REPORT	1. N/A	

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Appendix One

Safeguarding Information - August 2023

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Summary
Trust Safeguarding Data

NHS
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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:

- Joint Area Targeted Inspection (JATI) took place from 12-16th June 2023. The inspection looked at the multi-agency response to identification of initial need and risk in Gloucestershire. The inspection over all was incredibly positive and successful and demonstrated mature multi-agency partnership. Headline finding – "Most children living in Gloucestershire who are initially identified to be in need of help and protection receive a swift and appropriate multi-agency response from the 'front door'. Senior leaders' strategic partnership is strong, and this mature relationship is supported by effective governance in the Gloucestershire Safeguarding Children's Partnership (GSCP). Areas for improvement, relevant to GHC, align to our on-going work on clinical system template development, MASH Health team and function expansion, and the review of our current adult and children's safeguarding supervision offer.
- On Thursday 7th September the Gloucestershire LADO service delivered a Allegations Management Awareness Session to the GHC Safeguarding Team, senior HR managers, and CYPS directorate colleagues. Transferable risk, eligibility criterial, referral pathways and LADO outcomes were key areas of learning.
- 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.

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 to find solutions that mitigate and 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. Comms and training are currently being developed in preparation for the template launch.
- Staff engagement with safeguarding supervision is a concern. A review of our current supervision model is underway with a staff consultation, we are exploring the viability of the re-introduction 121 supervision for safeguarding case holders, as well as a move to some face-to-face supervision sessions and 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

	Apr-23	May-23	Jun-23	Q1	Jul-23	Aug-23	Additional Information
SAFEGUARDING ACTIVITY							
Advice Line Calls	47	57	77	181	62	55	Operational colleagues continue to make good use of the Safeguarding Advice Line.
Multi-Agency Request for Service Forms submitted to MASH	8	17	30	55	25	20	The Local Authority are unable to provide referral data and current GHC clinical systems are unable to accurately capture referral figures. 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). In July & August we have seen an 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	0	1	2	3	2	1	This information is currently obtained from our Safeguarding Advice Line data. It 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	1	2	0	3	1	3	Expected deaths are infants with known life limiting conditions or cases of extreme neonatal prematurity.
Unexpected	3	3	0	6	0	0	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 August.
RAPID REVIEWS/LCSPR'S							
Number of Serious Incident notifications made by LA	0	1	0	1	0	0	No Serious Incident Notifications submitted to the National Safeguarding Review Panel by the LA in July.
Number of Rapid Reviews attended	0	1	0	1	0	0	No multi-agency rapid reviews undertaken in July.
Number of LCSPR's in progress	2	2	1	1	1	1	1 Gloucestershire LCSPR's in progress, it nearing its conclusion and development of recommendations – this review is relating to a CIC, considerable GHC involvement. Publication of the report is now expected to be late September 2023.
MASH HEALTH TEAM ACTIVITY							
Children researched/info shared	477	782	867	2,126	956	930	Significant increase in MASH activity/number of children researched throughout June/July/August. Increase is due to the introduction of the new Police Daily Vulnerability Meeting (PDVM), bringing a high number of cases through the multi-agency information sharing triage process.
Adults researched/info shared	99	123	97	319	82	48	July and August has seen a slight drop in the number of adults researched, this may be due to the introduction of the PDVM has reduced the number of MASH enquiries taking place. Adults are not currently routinely researched for the PDVM.
MASH strategy meetings attended	10	25	33	68	30	28	Expected variation in month as expected with MASH activity. Number of Strategy meetings in April was lower than usual, we now see a return to usual activity levels.
Demographic information sharing	197	230	257	684	424	372	MASH health are frequently asked for demographic data from multiagency partners - this is due to referral data quality and incomplete data. Huge increase in requests in July & August, almost double the number of requests in previous months. Increase is due to the new PDVM, where multi-agency partners have incomplete demographic data, so are requesting missing data from health.
AUDITS							
Single Agency	1	1	1	3	1	1	Monthly Safeguarding Children dip sample audit
Multi-Agency sub group activity	1	1	1	3	1	1	Monthly MASH multi-agency audit
UNDER 18'S ADMISSIONS							
Number of under 18's admitted to Adult MH Wards	0	0	1	1	0	0	0 children admitted in August
Number of under 18's assessed under S.136 of the MHA 83/07	0	4	3	7	0	0	0 children assessed in August
OTHER WORKSTREAMS							
Allegations management – number of referrals to/from the LADO	2	4	0	6	0	1	1 referral made to the LADO in August

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

GHC - Safeguarding Dashboard 2023/24 Adults safeguarding Data

	Apr-23	May-23	Jun-23	Q1	Jul-23	Aug-23	Additional Information
SAFEGUARDING ACTIVITY							
Contacts to GHC advice Line	64	65	71	200	71	77	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 July.
Safeguarding Referrals made to GCC	6	13	5	24	14	10	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%	57%	57%	Linked to Risk 107 – recording of household members. Household & Family form completion (MH/ LD Current caseload) – added as new 2023/24 Performance indicator - Threshold: 100%
CASE REVIEWS							
New Safeguarding Adult Reviews/Domestic Homicide Reviews	0	0	1	1	0	0	0 new reviews in July.
Number of Reviews ongoing	14	14	15	15	15	15	Consistently high number of safeguarding reviews relating to adults (DHR's DARDR's and SARs). Several reviews are in the final stages of sign off.
Action Plans Ongoing	6	6	7	7	7	7	This includes single and multi agency action plans
MAPPA							
Level 2 Meetings Held	*	*	*	15	*	*	
Level 2 Meetings Attended	*	*	*	15	*	*	
Level 3 Meetings Held	*	*	*	6	*	*	
Level 3 Meetings Attended	*	*	*	6	*	*	
PREVENT							
Number of Prevent Referrals Made	0	0	0	0	0	0	No Prevent concerns raised with the police
Information requests received & completed from Police/Channel	1	2	1	4	3	0	100% response to all police and channel panel information sharing requests, supportive effective planning and decision making.
MARAC							
Families screened/researched	106	139	163	408	135	150	Continued high level of MARAC activity. Expected variation in month.
No.of children open to MH Services	19	20	18	57	9	18	Number of children open to mental health service highlights the emotional impact of domestic abuse on children. Expected variation in month.
No.of victims open to MH Services	13	21	23	76	19	16	Highlights the link between the impact of domestic abuse on victims mental health. Expected variation in month.
No.of perpetrators open to MH Services	10	22	23	55	24	18	Identifies the number of perpetrators open to MH services. Expected variation in month.
Un-uploaded MARAC Action Plans	132	48	59	59	31	28	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	2	4	6	12	5	2	Continued pattern of DOLS applications
Mental Health Services Authorised	1	1	3	5	1	2	Minor variation in month
Physical Health Services Total	14	15	10	39	11	17	Physical health urgent applications (not requiring LA authorisation)
Physical Health Services Authorised	0	0	0	0	0	0	
AUDITS							
Single Agency - Safeguarding Related	1	1	1	1	1	1	Monthly Safeguarding Adults dip sample auditing commenced in November 2022 and continues each month.
Multi Agency Sub - Group Related	0	0	1	1	0	0	Multi Agency GSAB Audit Group meeting in Sept 2024
OTHER WORKSTREAMS							
Allegations management - use of PiPoT guidance	2	1	0	3	1	2	2 new allegations in relating to a member of GHC staff in August.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

GHC - Safeguarding Dashboard 2023/24 Training and Supervision Data

	Apr-23	May-23	Jun-23	Q1	Jul-23	Aug-23	Additional Information
TRAINING							
Level 1 – Induction	96%	96%	96%	96%	96%	97%	Consistent month on month compliance level
Level 2 – Think Family	90%	91%	91%	91%	91%	91%	Overall a minor variation in month
Level 3 – Multi-Agency Child Protection	87%	88%	88%	88%	88%	85%	Overall a minor variation in month. Training compliance review being undertaken to identify specific Teams to target to improve compliance.
Level 3 Adult Protection	88%	82%	82%	84%	72%	88%	Overall a minor variation in month. Training compliance review being undertaken to identify specific Teams to target to improve compliance. 16% rise in compliance in August.
Level 4 Adult Protection	77%	74%	74%	75%	74%	85%	Overall a minor variation in month. Training compliance review being undertaken to identify specific Teams to target to improve compliance. 11% rise in compliance in August.
PREVENT:							
Level 1	97%	97%	99%	98%	99%	97%	Continued high level of compliance with Level 1 Prevent Training
Level 2	84%	84%	84%	84%	84%	86%	Training compliance review being undertaken to identify specific Teams to target to improve compliance.
Level 3	90%	91%	96%	92%	96%	97%	Improving picture of compliance with Level 3 PREVENT training
MENTAL CAPACITY ACT:							
Level 1	*	89%	90%	90%	91%	94%	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%	54%	57%	New item to dashboard. During the Covid 19 Pandemic, Level 2 MCA training was put on hold. Training recommenced in July 2022.
Bespoke MCA Training	*	*	*	*	3	9	Excellent uptake of bespoke team MCA training
SAFEGUARDING SUPERVISION							
CHILDREN:							
Group Supervision Sessions	20	22	25	67	21	26	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	56%	52%	56%	55%	61%	62%	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. Alongside this a scoping activity is underway to consider developing a new model of Safeguarding Supervision, development will include consultation with operational teams and a review of the different supervision needs of the target audience.
One to One Supervision Sessions	3	1	2	6	1	2	121 Supervision is available to all upon request.
ADULTS:							
Group Supervision Sessions	0	2	2	4	3	2	A new offer/model of Adult Safeguarding Supervision has been developed to address poor attendance and engagement with supervision. This is now beginning to be rolled out across teams and localities
Number of Staff who attended Supervision	0	2	3	5	6	6	
One to One Supervision Sessions	1	1	0	2	0	0	121 Supervision is available to all upon request.

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Appendix Two

Trust Operational Data Extract – August 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%	46%	44%								44%	R		
	ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	63.93%	78%	68%	65%	80%	80%								73%	R		
	ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	72.81%	78%	78%	80%	74%	77%								78%	R		
	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	50.59%	45%	41%	43%	39%	32%								41%	R		
	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	90.16%	89%	88%	85%	81%	63.2%								86%	R		
	Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	14.35%	11.0%	13.0%	8%	31%	14%								16%	R		
	Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R	3,279	13437	1241	1415	1447	1167	1374								6644			
	Wheelchair Services Adults : New referrals assessed within 8 weeks	L - C	90%	83.24%	86%	85%	90%	81%	96%								88%	A		
	Wheelchair Services : Under 18's new referrals assessed within 8 weeks	L - C	90%	84.66%	94.0%	83.0%	94%	100%	84%								91%	G		
Mental Health Services (CPA and Eating Disorders)																				
	CPA Follow up contact within 7 days of discharge. %	N - T	95%	95%	95%	98%	93%	96%	95%								95%	G		
	Adolescent Eating Disorder - routine referral to NICE treatment start within 4 weeks %		95%	46.95 %	30.0%	30.0%	65%	74%	78%								60%	R		
	Adolescent Eating Disorder - Urgent referral to NICE treatment start within 1 week %		95%	45.1%	87%	100%	82%	83%	100%								86%	A		
	Eating disorders - Wait time for adult assessments will be 4 weeks %		95%	47.04%	37%	53%	85%	84%	87%								73%	R		
	Eating disorders - Wait time for adult psychological interventions will be 16 weeks %	N – T	95%	68.96%	85.0%	100%	100%	96%	92%								95%	G		

Additional information

Paediatric Speech and Language Therapy: The service is in a position where demand continues to outstrip capacity and the added complexity of cases is impacting upon service delivery, the majority of patients are assessed within 18 weeks, The service continues to offer and explore initiatives to manage demand and hold safe waiting lists.
Podiatry: The service is carrying high vacancy levels , there are issues with recruitment to the B6 role but mitigating plans in place, high risk patients are prioritised.
Paediatric Occupational Therapy: Targeted measures being introduced to reduce wait times. (Blitz clinics and EHCP sessions). This operational KPI is being revised and will be replaced with a 4 week wait for urgent referrals and an 18 week wait for routine referrals in line with national waiting time targets. There are some recording errors which service leads are working to rectify.
Wheelchair Services: The clinical team is now fully established and the service expects to continue with a positive trajectory in the coming year with adult new referrals now at 90%, caseload is currently 530 and this month the wait target for under 18s reduced from 100% to 84% which represents 3 patients. The compliance rate for equipment delivered within 18 weeks of referral is at 84.6% for August.

Mental Health: The CPA 7 day follow up indicator has been included as rates for 12 month reviews (previously shown) received focus and achieved/exceeded target for the past 10 months. This is a safety measure with the majority of follow up within 48 hours after admission.
Eating Disorders:. August performance shows overall improvement within the indicators against a performance threshold of 95.0%. The adult caseload was 582 (Aug) compared to 526 (April). The adolescent case load was 448 (Aug) compared to 462 (April) Within the "adult wait time will be 4 weeks" target the number of non compliant cases was 4 out of 32 cases . The service continues to work through the assessment waiting list. 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. 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. The Demand and Capacity Model has been created to give an indication of the capacity required to address the routine assessment waiting list backlog. This set of indicators has a Service Improvement Plan and is on the risk register ID 149 Score 16).

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%	97%	98%	97%	96%	95%								97.%			
*** 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%	67%	100%	70%	50%								70%	G		
Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered																				
Inpatient Wards		N - T	95%	68%	72%	63%	69%	71%	72%								72%	R		
Community		N - T	90%	70.2%	76%	9.0%	25%	31%	41%								41%	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%	57%	53%	54%								54.0%	G		
Admissions to adult facility of patient under 16yrs		N - R		0	0	0	0	0	0									N/A		
Inappropriate out of area placements for adult mental health services		N - R	Occupied bed days	950	0	0	5	7	6								12	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%								90%	A		.
					43.%	69%	70%	71	73%								73%			
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%								97.1%	G		
					82.5%	91.9.%	96.9%	97.1%	97.1%											
Percentage of children in Year 6 with height and weight recorded		N - T	95%*	96.1%	75%	87%	95.0%	95%	95%								96.6%	G		
					89.7%	94.0%	96.4%	96.6	96.6%											

Additional Information

OOA: This month we are reporting 6 OOA bed days which is indicative of the continued demand on beds in August. All patients were monitored by the Bed Management Team through a virtual ward approach.
HPV 2: 73% of the estimated cohort of children eligible for HPV 2nd dose in the 2022/23 academic year had been immunised at the end of August 2023. This is cumulative performance compared to August threshold of 90%. Overall national target at the end of the programme is 90%. The ability to meet the 90% target is impacted by the ongoing recovery of 1st Doses as a result of the Covid pandemic and the requirement to have a 5 month gap between 1st and 2nd dose. The announcement of a 1 dose schedule effective from September 2023, is also impacting on uptake
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. There is steady improvement which reflects the input from two Physical Health Nurses within WLH and CLH and increased governance and oversight. The planned training has commenced in CLH/WLH and we have sessions booked for Recovery units in order to further improve the compliance rates and thus impact upon patient safety and experience.

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%	95%								95%	G	N	
					85%	94%	98%	99%	99%								99%			
Number of Antenatal visits carried out				505	54	53	60	66	66								299	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%	95%								95%	G	Y	
Percentage of children who received a face to face, telephone or video 6-8 weeks review.			95%	93.1%	96%	96%	96%	97%	96%								96%	G	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%	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%	92%	91%								91%	A	Y	
Percentage of children who received a 2-2.5 year review by 2.5 years.			95%	81.06%	90%	89%	92%	93%	90%								90%	A	Y	
Percentage of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence).			58%	53.73%	55%	59%	57%	56%	54%								54%	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%	79%								78%	A	Y	

Additional Information

Health Visiting:

- **NBV and Child reviews**: August performance maintained the expected threshold of 95% with 467 out of 491 children seen within the 12 month target timeframe. Performance is above the SPC chart upper control limit. The majority of breaches were due to staffing issues and DNAs. Team Leaders are meeting on a weekly basis to forecast any issues raised by sickness absence or staffing issues to try and ensure cover from other areas. ASQ clinics are not to be cancelled unless all other staffing has been exhausted. The service is gathering data from S1 and from the Children's Centres to look at their DNA demographics and identify trends so they can put in area specific interventions to engage communities that may not be fully accessing the service.

- **% of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks** : August performance was 79% (July was 83%) compared to a threshold of 80.0%, early indicators for this data show recovery to above target status being achieved going forward.

- **% of infants being totally or partially breastfed at 6-8wks (breastfeeding prevalence) –** August performance was 54% (July was 56%) compared toto a threshold of 58%, with 246 out of 540 infants recorded as totally or partially breastfed. Performance is within the SPC chart upper and lower control limits. The Midwifery Service continues 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 Health Visitor has set up weekly meetings to address needs identified with plans to improve feeding status. Early intervention is key as attrition rates are highest between 0 and 2 weeks

AGENDA ITEM: 08/0923

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 September 2023**

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

AUTHOR: Chris Woon, Deputy Director of Business Intelligence

SUBJECT: **PERFORMANCE DASHBOARD AUGUST 2023/24 (MONTH 5)**

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 August (Month 5 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 August 2023/24 as a **significant level of assurance** that the Trust's performance measures are being met, or appropriate service action plans are being developed or are in place to address areas requiring improvement.

Executive summary

Business Intelligence Update

2022/23 Business Intelligence business planning highlights are presented on page 1.

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 five domain format:

- **Nationally measured domain** (under threshold)
  Clostridium Difficile rates, Care Programme Approach (CPA) follow-up, Early Intervention wait to treatment and Adolescent Eating Disorder indicators were under threshold for the period.
- **Specialised & directly commissioned domain** (under threshold)
  In addition, attention is drawn to 3 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)
  The Core CAMHS 4-week wait indicator, 2 Eating Disorders indicators and a Social Care review indicator were the areas in exception for this period.
- **Board focus domain** (under threshold & outside of statistical control rules)
  GHT diagnostic tests and acquired pressure ulcers were the only two areas in exception for the period.
- The **Operational domain** is presented to Resources Committee and not the Trust Board.
- **Indicators not in exception**
  As noted above, 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, this month some items are presented as potential areas for closer awareness and monitoring (such as bed occupancy within PH and MH).
- **Workforce KPIs**
  A Workforce KPI and Performance report is included in this month's report. This will be reported and discussed at the October Great Place To Work Committee, with additional detailed data on nursing & HCSW recruitment, turnover and vacancies being shared with the committee. Future format and content will also be influenced by the expected launch in 2024 of the new national People KPI data suite and reporting requirements. The report's last two slides provide further detail on this. Progress will be monitored by the Great Place to Work Committee and within the *Education matters* theme of Measuring what matters

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 on the 21 September 2023

Appendices:	None

Report authorised by:	**Title:**
Stephen Andrews	Deputy Director of Finance

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Snapshot Month
August

Performance Dashboard Report & BI Update

Aligned for the period to the end August 2023 (month 5)

In line with the planned Performance Indicator Portfolio reconfiguration, this report presents performance indicators across five 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 but not to Board.

In support of these metrics a monthly Operational Performance & Governance report (with action plans) is routinely presented to the Business Intelligence Management Group (BIMG). An operationally led Quality Forum will also 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. Around 147 legacy indicators (57%) remain unchanged from the 2022/23 portfolio. 73 indicators (28%) are in Phase 1 of development. 36 of these indicators within Phase 1 are already complete and deployed (an increase from 31 in July), whilst a further 37 are in various stages of analysis, development and testing. This puts the total portfolio position at the end of July at 184 indicators (71%) active. Once Phase 1 is complete (extended to the end of September due to a Clinical Systems Upgrade that had a detrimental impact on reporting) the position will be 220 (85%) active. The remaining 40 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 needs 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**'. Indicators within this section are 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

All the 41 planned Physical health Service Line Dashboards (some services do not require one or they have been amalgamated into existing reports) have been published. Key finance and training measures are being introduced into the Service Line dashboards and these will all be complete by the end of September, a slight delay due to wider priorities. MH/ LD Service Line Dashboard needs are now 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 has now begun.

Workforce KPIs

As requested by the CEO this month, attached as an appendix is the Workforce KPI and Performance report which will be reported and discussed at the October Great Place To Work Committee, with additional detailed data on nursing & HCSW recruitment, turnover and vacancies. This remains in development between BI and Workforce colleagues through the Measuring What Matters work stream. Future format and content will also be influenced by the expected launch in 2024 of the new national People KPI data suite and reporting requirements. The report's last two slides provide further detail on this.

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

Since the last report (to Resources Committee in August) the brief period of stability appears to have finished; possibly as a result of some extremely hot weather. Our Acute partners have been consistently under pressure and struggling to cope with demand, and this has had consequent knock on across the system. We have managed to maintain a good offer of flow into the community hospitals, notwithstanding the consistently stubborn figure of c25% of our beds being occupied by patients who no longer need to be in our hospitals. But the result of the uptick in pressure does mean that we are again back to unrelenting high levels of bed occupancy. Occupancy rates in August were lower at 94.7%, and haven't been below 90% since Aug 21, but we are now back to beds being filled almost as soon as they are vacated. That said, notwithstanding the pressures I'm really pleased to report that we have managed to reduce the average length of stay in our community hospitals to 32.4 days, the first time this has been within SPC limits in 2 years. MiiUs have also seen some extremely busy days, on occasion exceeding 400 contacts a day; we are consistently achieving our 2-hour urgent response target. Home First performance hasn't been as consistent as I would like to see, albeit we have all but achieved our recruitment targets if those being processed by HR mature into joining us (at time of writing just 3 B2 below full establishment), we quite often now have more capacity deployed looking after patients at the back door of the service than we would need to clear the front door. We continue to manage the ongoing industrial action, which is becoming more challenging as dates for action by junior doctors and consultants are starting to coincide. Operational planning for the decommissioning of Lydney and Dilke and migration to the brand-new Forest of Dean Hospital continues to gain momentum and is necessarily an increasing focus for the Ops team.

Unfortunately, we have (rather similar to the Acute pressures in GHFT for physical health) recently experienced a significant up tick in demand for Mental Health acute beds. While there is no clear causation for this, the situation is such that we have had to resort unfortunately to some out of area beds to manage through the pressure. Naturally clinical colleagues are at the forefront in reviewing both patients within our Acute beds and those waiting, and while there remain some early signs of progress in reducing the average Length of Stay within our hospitals (the data is showing progress in reducing the number of very long waiters ie those over 180 days), that work hasn't yet reached the maturity to deliver the benefits in flow that ultimately is the answer here.

A notably strong position for Talking Therapy (formally IAPT), where we are delivering strongly in terms of access, recovery and referral times. Within the ICTs, both physio and OT remain under some pressure, most notably due to the ongoing high numbers of referrals.

In core CAMHS, while there remains much to do and a long road ahead there are some encouraging signs. At the time of writing we were able to offer first assessments following referrals at around 21 days. There are 605 on the list waiting for treatment, compared to over 800 this time last year. Clinicians continually review the list and prioritise/triage and try to match resource to the greatest need. As the board are aware I had set an interim internal target of no waiters over 2 years, and accordingly the "top 50" (ie those who have been waiting the longest and are approaching the 2 year point) are now assessed by the team alongside the urgent referrals, and those have now been allocated (may not yet have attended) a group therapy, some CBT or have an appointment with a clinician.

A less good month in terms of Childrens OT, although heavily impacted by leave during August within this small team. There are at time of writing 453 referrals waiting on first contact (of which 4 are urgent), with the average wait for routine referrals sitting at 22 weeks. The trend lines (with the exception of August) are showing a steady improvement with waiting times reducing month on month. Recruitment is starting to deliver with new colleagues either on induction or due to commence work within the next few weeks, so we should continue to see improvement and growing momentum towards the end of the year.

In other therapy areas we are also struggling to achieve the current 8-week RTT targets but ongoing dialogue, with support from commissioners indicates a shift to what is felt to be a more meaningful target set of a 4 week wait for urgent referrals and 18 for routine. Currently in children's Physio some workforce shortfall coupled with steadily rising demand (up to 400 referrals a month) has seen compliance with the 8 week target deteriorating, with current achievement 63.2%; The average wait for physio is 12 weeks, with 374 on the list at the time of writing. To mitigate the issues, we are naturally seeking to recruit, triaging the lists, piloting a patient initiated follow up to reduce DNAs, and hosting drop-in clinics. We are also encouraging use of Physio Direct to provide advice and guidance, often via a video call.

In Speech and Language therapy, while the majority of patients are assessed within 18 weeks, there are some long waits in certain pathways, for example in stammering, up to 16 months for 1:1 treatment intervention. Positively in recruitment terms we have done well and now have no vacancies (national average vacancy is 23%). We are also offering drop ins, and patient initiated follow ups in this area, offering training to staff at special schools and seeking to pilot the use of digital platforms.

While earlier in the year the recruitment profile for Podiatry looked promising, sadly due to some resignations and some putative candidates withdrawing it again looks a challenge, and so I am reviewing the recovery plan and trajectory for this service again, since recovery projections to achievement of 95% 8-week RTT have slipped to March 24. 8-week RTT Performance in August was 43.5% (July was 45.9%). Part of the recovery will include an apprenticeship pathway and a B5 to B6 development framework; I have also asked the professional lead to review the caseload and investigate whether it might be appropriate for some long-standing patients on the caseload be discharged.

In MSK Physio the 8 week RTT is 59.3% (target 95%) with 686 out of 1687 referrals seen outside 8 weeks; this is an improvement from 55.4% last month. The waiting list has reduced to 4386, down from 5164 6 months ago. Demand for the service remains consistently high at 2200 referrals a month. The service remains relatively stable, but we are working on new capacity modelling to inform a proposal to the ICB as there appears to be an enduring demand/capacity mismatch.

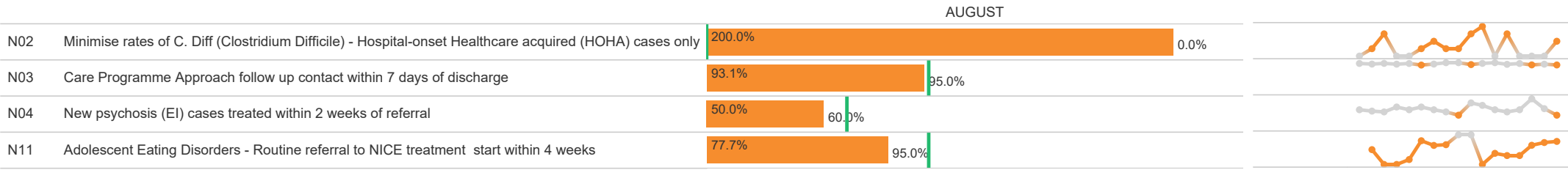
Good progress continues with recovery of our Dental Service, although the August leave period meant we were offering fewer slots than normal, so while last month I reported the waiting list reduced from 507 in March to 127, during August it has slipped back a little to 186. Patients waiting more than 18 weeks have reduced from 166 in March to 11 (naturally anyone waiting is subjected to clinical triage). I reported to Resources Committee my growing concerns about the pressure our people were coming under when operating the emergency triage line, attributable to the very low capacity across the system for emergency appointments; since then the ICB have helpfully implemented some incentives, and pleasingly Gloucester Dental Care have added 3 new dentists working a day each solely for emergencies, which provides the ability to send up to 20 patients a day, which is very welcome.

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*.

N02 - Minimise rates of C. Diff (Clostridium Difficile) - Hospital-onset Healthcare acquired (HOHA) cases only
There were 2 post 48 hours cases reported in August compared to a threshold of 1. One occurred at Dean Ward in Wotton Lawn Hospital and one on Windrush Ward at Cirencester Hospital.

Wotton Lawn - Dean Ward
Transfer from GHT following admission to Department of Critical Care - Sample taken and treatment given whilst in GHT. C.diff gene detected. Went on to develop further symptoms on return to Dean ward sample sent and C.diff toxin detected confirmed.

Cirencester Hosp - Windrush
Transfer from GHT to Windrush ward for rehabilitation, developed symptoms and sample taken. C.diff toxin confirmed.

N03 - Care Programme Approach follow up contact within 7 days of discharge
August is reported at 93.1% against a performance threshold of 95% and is within SPC (Statistical Process Control) limits. There were 3 non-compliant cases reported in August.
Two of these patients were followed up within the required 7 days but have not been entered as attendances on the clinical system. The final patient DNA'd their appointment but has subsequently been followed up. Once the 2 late data entry cases have been updated August performance will be reported at 95.1% which would be deemed compliant. However, as a Nationally monitored indicator the current performance is presented for awareness. Services have been reminded about the importance of timely data capture.

From next month the performance threshold for this indicator will be shown as 72 hours, this is to come into line with new National reporting requirements. The national threshold is 80% but the threshold for internal reporting will remain at 95% to align to the Trust's 48hour (internal stretch) performance threshold which is also at 95%.

To note, performance for August against the new 72 hour threshold would be 90.9% and once the 2 corrections mentioned above have been made performance will be 95.4% with 2 non-compliant case).

N04 - New psychosis (EI) cases treated within 2 weeks of referral
August performance is reported at 50.0% against a performance threshold of 95%. There was 1 non-compliant case reported in August. The patient was assessed and had a care-coordinator allocated within the required 2 weeks, however the clinical system needs to be updated to show the care coordinator is an "EI" care coordinator (in line with national guidance) . This will ensure the case is recorded as compliant. The service have worked with the clinical systems team to update RIO.

Since the August data freeze date, there have been 2 more non-compliant cases . Both cases again appear to be due to the clinical system needing a care coordinator update. All changes have now been made to RIO and this indicator can be reported for August at 100%. As a National indicator the point in time position of 50% is however reported for audit.

N11 - Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks
August performance is reported at 77.7% against a performance threshold of 95%. There were 2 non-compliant cases in August.

Achieving expected performance levels remains a challenge and the service continues to offer assessments to patients that have been waiting for an extended period based on a clinical decision of non-urgency. The improvement in August is due to the recently introduced triage system and follow up calls to patients which has allowed for guided self-help to be implemented sooner in the pathway.

At the beginning of August there were 44 routine adolescent clients on the assessment waiting lists, compared to 201 at its highest peak in June 2022. The Business Intelligence service has produced a waiting list model which provides an indication of capacity required to address the routine assessment and treatment waiting list backlog.

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 80 referrals have been made and 40 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 145 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 34 patients.

Establishment WTE and skill mix have been reviewed to increase recruitment into hard-to-fill posts. Recent appointments: 1 x Band 7 RHED team Lead, 2 x Band 6 ED Clinicians, 4.8 x Band 4 Assistant Clinicians, 1 x Band 5 ED Clinician. Vacancies: 1.0 Band 7 ED Clinician.

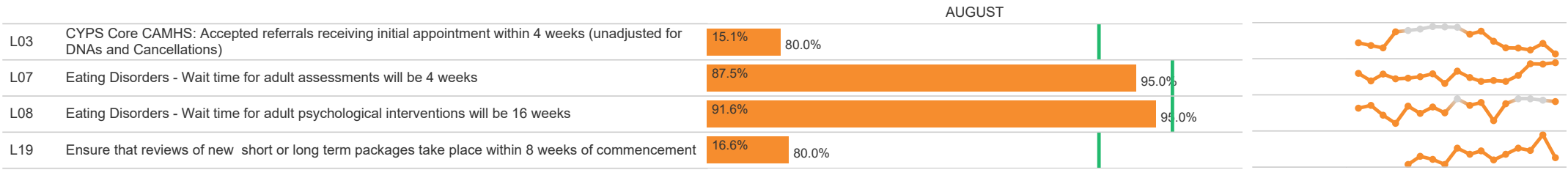
The service is working through the challenges of the potential long wait between initial assessment and subsequent treatment sessions and continues to rely on bank staff and staff from the wider trust offering additional hours. The service continues to accept routine referrals, which are triaged and placed on a waiting list. This set of indicators has a Service Improvement Plan and is on the risk register ID 149 (Score 16).

Performance Dashboard: *ICS Agreed Domain*

KPI Breakdown

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.*

L03 - CYPS Core CAMHS: Accepted referrals receiving initial appointment within 4 weeks (unadjusted for DNAs and Cancellations)
August's performance is reported at 15.1% against a performance threshold of 80%. There were 84 non-compliant cases reported in August. This is a decrease in performance compared to July (44.8%) and is the lowest value reported in the past 17 months. A review of SPC limits for this indicator will take place for 2024/25 when sufficient data will be available.

The service reports that performance is below threshold due to reduced staffing capacity for assessments at the CAMHS Front Door. This is partly due to CAMHS diploma training and staff annual leave in August. The percentage of appointments offered in 6 weeks was 80.7% (81 out of 98) in August, compared to 80.6% (133 out of 165) in July. Additional Saturday Clinics took place in August, and more are being planned for September and October. Within the CAMHS Development Plan the “Gateway into CAMHS” (i.e. model of screening/ triage/ assessment) is being reviewed, in-line with the learning from the Navigation Hub Pilot. The Gateway into CAMHS work will develop the recovery detail required for achieving this KPI. This new assessment process will be operationalised in November 2023 and rotas are currently being drafted.

Navigation hub pilot: Between 20 March and 23 June 2023 a pilot was undertaken to use a multidisciplinary navigation hub to direct children requiring support to the most appropriate service. The result was expected to be a reduction of referrals to the CAMHS service and an increase in the percentage of referrals being accepted for assessment. An analysis of the likelihood of a referral being accepted between intervention and control schools and GP practice was undertaken by the BI team. The analysis found that there was no evidence to support an increase in the percentage of referrals being accepted when the Navigation hub was used compared to the established route. However, the sample size was small and further data would need to be collected to confirm the finding. The navigation hub is being expanded to primary schools from September 2023.

L07 - Eating Disorders - Wait time for adult assessment"August performance is reported at 87.5% against a 95% performance threshold. There were 4 non-compliant cases reported in August.
The service continues to focus on reducing waiting times and allocating patients to clinicians for treatment as soon as capacity becomes available. The number of adults waiting for assessment at the end of August 2023 was at 275 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 24-72 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 Business Intelligence service has produced a waiting list model which provides an indication of capacity required to address the routine assessment and treatment 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: 1 x Band 7 RHED team Lead, 2 x Band 6 ED Clinicians, 4.8 x Band 4 Assistant Clinicians, 1 x Band 5 ED Clinician. Vacancies: 1.0 Band 7 ED Clinician. 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.

The service continues to accept routine referrals, which are triaged and placed on a waiting list. This set of indicators has a Service Improvement Plan and is on the risk register ID 149 (Score 16)."s will be 4 weeks

L08 - Eating Disorders - Wait time for adult psychological interventions will be 16 weeks
August performance is reported at 91.6% against a 95% performance threshold. There were 2 non-compliant cases reported in August.

The service continues to focus reducing waiting times and allocating patients to clinicians for treatment as soon as capacity becomes available. The service has recently adopted a new triage process and

all new patients will receive an initial call within 24-72 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 Business Intelligence service has produced a waiting list model which provides an indication of capacity required to address the routine assessment and treatment 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: 1 x Band 7 RHED team Lead, 2 x Band 6 ED Clinicians, 4.8 x Band 4 Assistant Clinicians, 1 x Band 5 ED Clinician. Vacancies: 1.0 Band 7 ED Clinician. 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 risk register ID 149 (Score 16).

L19 - Ensure that reviews of new short or long term packages take place within 8 weeks of commencement
Performance is reported at 16.6% against a performance threshold of 80%. There were 10 non-compliant cases in August. Three cases are due to entries not yet made on the clinical system, once these have been made performance will be reported at 41.7%.

Three non-compliance cases are due to staffing capacity, two due to unavailability of the service user, one due to the service user not turning up for their review and one case was reviewed outside of the required 8 weeks due to the need for a joint review and availability of all staff that needed to be present.

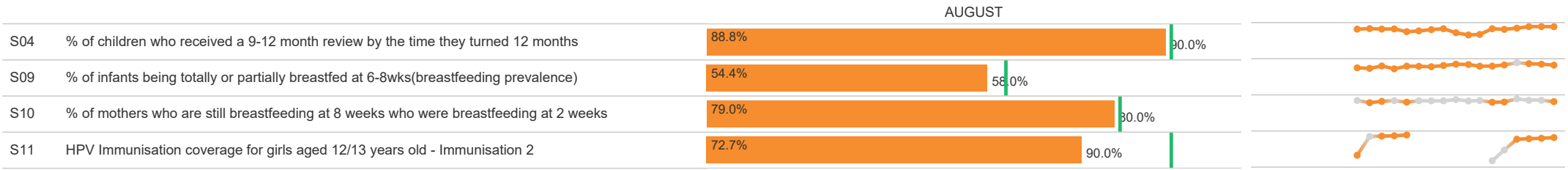
Performance Dashboard: *Specialised Commissioning Domain*

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 - % of children who received a 9-12 month review by the time they turned 12 months
August performance was 88.2% (July was 89.2%) compared to a threshold of 90%, with 56 out of 502 children re showing as not having received a 9-12 month review by the time they turned 12 months. Performance is within the SPC chart control limits.

The majority of breaches were due to staffing capacity and DNAs.
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 Questionnaire) clinics are not to be cancelled unless all other staffing has been exhausted.

For DNAs the service is 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.
If out of timeframe by one DNA'd visit then this can indicate the visit had been booked too late originally if missing the 3-month timeframe. The service is considering a model from Birmingham where DNA x 1 then triggers an automatic home visit to complete the ASQ.
For declined visits, the service is considering working closer with local Nurseries to access those children whose parents decline due to working full time.
For visits that are not possible due to a child's medical diagnosis – The ASQ Champion team new pathway, and offer for children with medical needs, is being rolled out countywide from September.

S09 - % of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence)
August performance was 54.4% (July was 56.1%) compared to a threshold of 58%, with 246 out of 540 infants recorded as not being totally or partially breastfed. Performance is within the 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. For new staff in place from April, the Infant Feeding Lead Health Visitor has set up weekly meetings to address needs identified with plans (including Referral Pathways, Training, Policy/G-Care Reviews) to improve feeding status.
Early intervention is key as attrition rates are highest between 0 and 2 weeks. From KPI 8 below it is evident that the service is maintaining breastfeeding rates well once they reach 2 weeks. Antenatal group education could be a way for HV to influence this.

Action Plan
Joint Health Visiting & Midwifery training/updates have re-commenced & Reviewing all training & policies with new Hospital Infant Feeding Team to ensure consistency with Health Visiting Infant Feeding Team.

S10 - % of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks
72.8% of the estimated cohort of children eligible for HPV 2nd dose in the 2022/23 academic year had been immunised at the end of August 2023. This is cumulative performance compared to August threshold of 90%. Overall national target at the end of the programme is 90%.

The service held 21 follow up clinics in August for children who could not be vaccinated at school visits.

The ability to meet the 90% target is impacted by the ongoing recovery of 1st Doses as a result of the covid pandemic and the requirement to have a 5 month gap between 1st and 2nd dose.

The announcement of a 1 dose schedule effective from September 2023, is also impacting on uptake.

S11 - HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 2
72.8% of the estimated cohort of children eligible for HPV 2nd dose in the 2022/23 academic year had been immunised at the end of August 2023. This is cumulative performance compared to August threshold of 90%. Overall national target at the end of the programme is 90%.

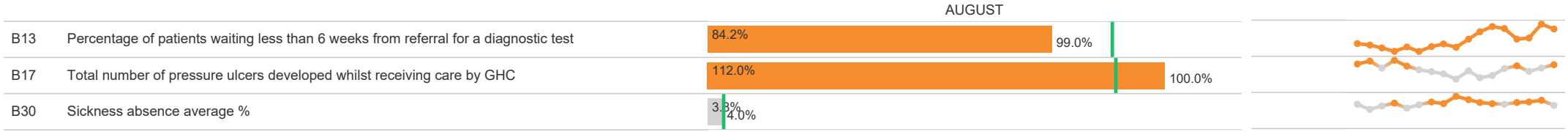
The service held 21 follow up clinics in August for children who could not be vaccinated at school visits.

The ability to meet the 90% target is impacted by the ongoing recovery of 1st Doses as a result of the covid pandemic and the requirement to have a 5 month gap between 1st and 2nd dose.

The announcement of a 1 dose schedule effective from September 2023, is also impacting on uptake.

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.*

B13 - Percentage of patients waiting less than 6 weeks from referral for a diagnostic test
GHC is no longer responsible for the national submission for this activity which is now made by Gloucestershire Hospitals NHS Foundation Trust.

Submitted data (by GHNHSFT) for GHC patients in Aug 2023 indicates a performance of 84.2% (compared with 98.9% in Aug) 23 out of 146 patients referred for an echocardiogram had been waiting 6 weeks or more for the scan at the end of Aug 2023. 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 13th September 2023, 48 patients are on the Priority Echo waiting list for an echocardiogram, and 157 patients on the Routine Echo Waiting list, which has decreased from 219 at the end of July. 19 patients are still to be triaged for Echo which includes awaiting GPSI opinion. There is often a reduction in Echocardiograms in peak annual leave weeks.

B17 - Total number of Acquired pressure ulcers (PU)
In August there were 102 acquired pressure ulcers (in July there were 90) compared to a threshold of 91. This is above the SPC chart upper control limit.

The increase in reported category 1 & 2 pressure ulcers in May and August developed by patients whilst receiving care by the Trust has been acknowledged and discussed across the organisations governance routes.

It is understood that whilst the category 3,4, DTI (deep tissue injury) and unstageable PU's are clinician reviewed and validated category 1 & 2 are not. As low harm incidents they are reviewed by the handler who will feedback learning points to the reporter and close the incident. PU incidence has increased across the country with neighbouring community trusts reporting increases.

To further understand and explore what may be contributing to these two data points the organisation is planning to:

- Conduct a thematic review of 20 PU incidents in an ICT locality to further understand the themes impacting on incidence. The new patient safety incident response framework (PSIRF) supports this approach.
- Promote the resources available from the National Wound care Strategy (NWCS) are free and available to all clinical colleagues and have focused PU education offer.
- Join system partners and clinical colleagues from all sectors in Gloucestershire to share, review and discuss challenges and the increase in reported incidence of PU across Gloucestershire.

B30 - Sickness Absence Average %
Although (at the time of reporting) the Sickness absence rate in August 2023 was 3.8% compared to a threshold of 4%, this position does not include data from the e-rostering system (Allocate). With Allocate data it is expected to increase to around 4.9%. By comparison, the reported sickness absence rate in July (with Allocate) was 4.6%. July performance was within the SPC chart control limits. 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 were required. Adjustments to the methodology have been included in this month's reporting and work is ongoing reconciling the data with workforce.

Sickness rates remain high in certain areas due to the increased level of cold/ flu cases that are being reported.

Operations Directorate sickness absence was 5.3% in July compared to 6.9% reported in June. Areas above 4% include:
- Adult Community PH, MH & LD (5.3%)
- CYPS (4.2%)
- MH Urgent Care & IP (5.6%)

- Operational Management (11%)
- PH Urgent Care & IP (4.9%)

Nursing, Therapies and Quality Directorate sickness absence was 4.7% in July compared to 6.7 reported in June. Areas above 4% include:
- Governance and Compliance (4.1%)
- NTO Management (5.4%)
- Quality Assurance (17.5%)

Executive Directorate sickness absence was 3.2% in July

Finance Directorate sickness absence was 4.2% in July compared to 4.4% reported in June. Areas above 4% include:
- Estates (6.1%)
- Facilities (4.9%)

This reflects the sickness absence information on Tableau on 13/09/2023.

Non-Exception highlights

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

- **B04 - Bed occupancy - Mental Health**

The automated methodology behind this indicator line is not yet available, therefore as an interim a manual presentation is shown below.

Bed occupancy for August was 96.8% (July 98.1%) against a threshold of 92%. The following wards were above the 92% threshold:

- Charlton Lane – Chestnut Ward: 98.2%
- Charlton Lane – Mulberry Ward: 97.7%
- Charlton Lane – Willow Ward: 98.6%
- LD Inpatients – Berkeley House: 100.0%
- Rehab – Honeybourne: 97.1%
- Wotton Lawn – Montpellier LSU: 95.2%
- Wotton Lawn – Abbey Ward: 100.4%
- Wotton Lawn Dean Ward: 93.8%
- Wotton Lawn – Kingsholm Ward: 99.4%
- Wotton Lawn – Priory Ward: 99.3%

Wards below the threshold were Laurel House (Rehab) at 91.3% and Greyfriars PICU (Wotton Lawn) at 87.1%.

- **B05 - Bed Occupancy Rate – Physical Health**

The automated methodology behind this indicator line within the dashboard has not yet been updated to include all patients. It currently captures Gloucestershire patients only (legacy 2gether methodology) therefore as an interim a manual presentation including all patients is shown below.

Bed occupancy for August is 94.7% (July was 95.9%) against a threshold of 92% and is within the SPC limits. The following wards were above the 92% threshold:

- Cirencester Hospital – Coln Ward (93.1%)
- Cirencester Hospital – Windrush Ward (96.0%)
- Dilke Hospital (97.2%)
- Lydney Hospital (92.9%)
- North Cotswold Hospital (94.0%)
- Stroud Hospital – Jubilee Ward (94.2%)
- Stroud Hospital – Cashes Green Ward (94.7%)
- Vale Hospital (98.2%)

Only Tewkesbury Hospital was below the threshold at 91.7%

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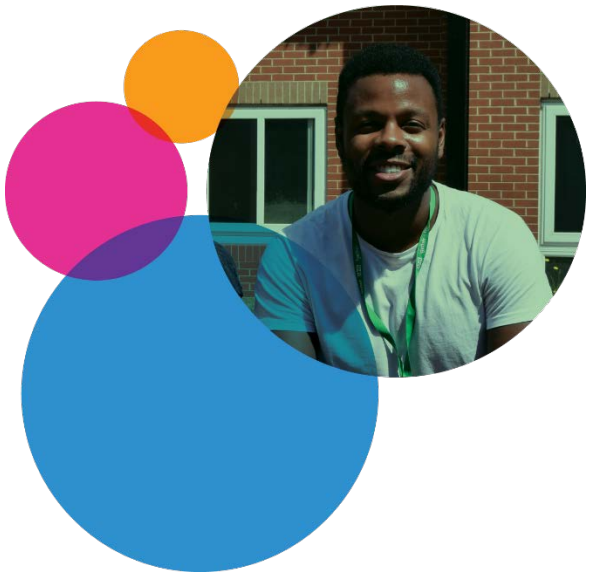
NHS Foundation Trust

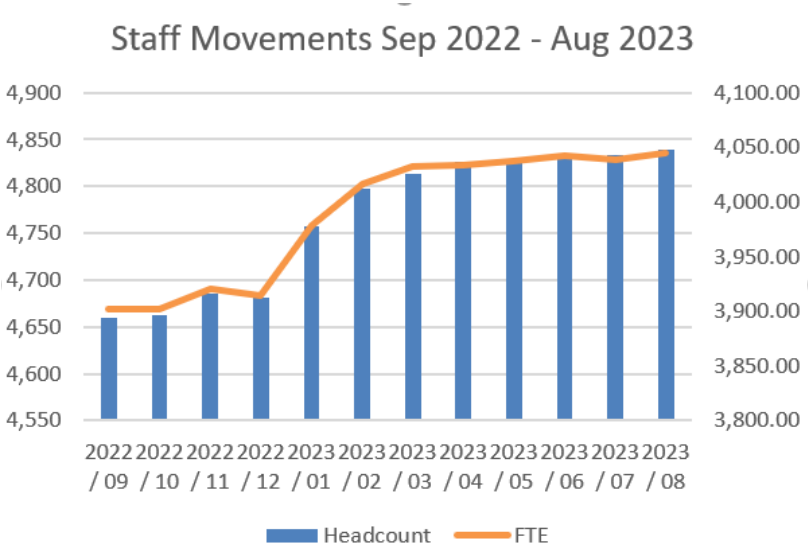


Workforce KPIs & Performance Report Month 5 – August 2023

Board of Directors

September 2023

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



Workforce Establishment

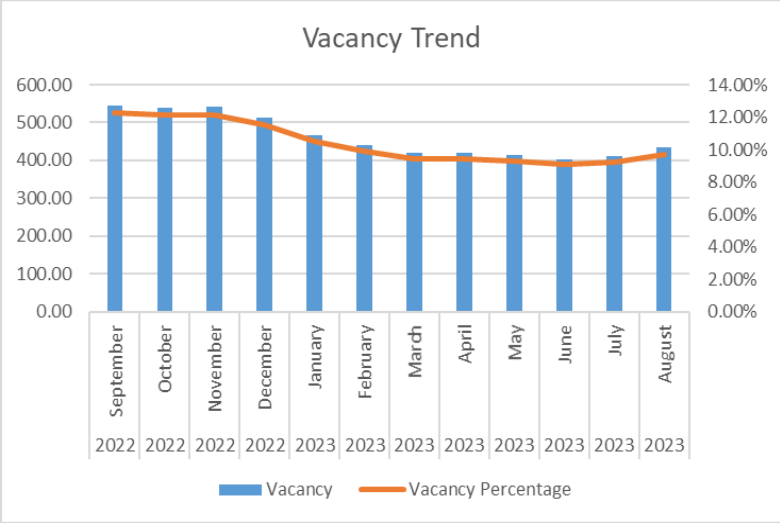
Workforce Establishment:
The Trust's staff in post establishment trend Sep 22 – Aug 23, shows workforce increases over the 12-month period and an increase of FTE (full time equivalence) from 3901.82 to 4044.76 (+3.66%)

Starters & Leavers

Starters & Leaver
Net gain of 142.04 WTE (whole time equivalent) (179 headcount) over the last 12 months.

Vacancies

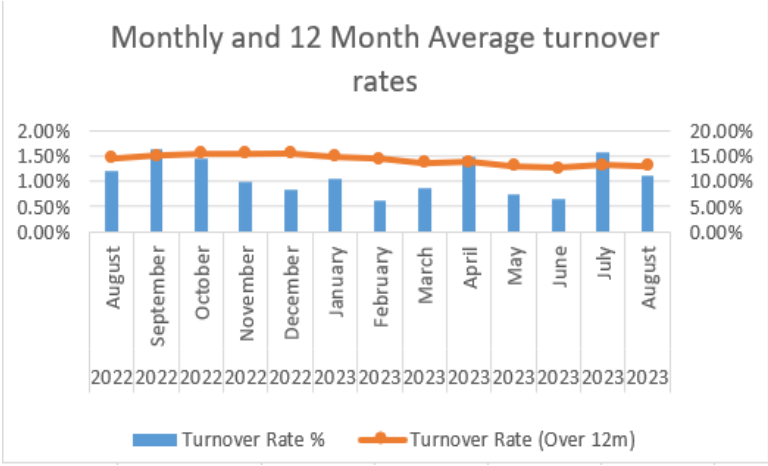
Gloucestershire Health and Care
NHS Foundation Trust



Year	Month	Vacancy	Vacancy Percentage
2022	September	543.90	12.24%
2022	October	538.25	12.12%
2022	November	540.74	12.15%
2022	December	513.40	11.50%
2023	January	466.10	10.50%
2023	February	439.30	9.90%
2023	March	418.92	9.41%
2023	April	419.92	9.44%
2023	May	412.86	9.28%
2023	June	403.88	9.08%
2023	July	412.65	9.20%
2023	August	433.40	9.70%

Vacancies
The Vacancy FTE & %s have increased over the last two months due to increased accuracy of funded establishment data in ESR, but there is also an ongoing challenge around those in the Additional Clinical Staff group (HCSWs). Whilst HCSW starter numbers continue to exceed leavers, their career pathway often moves them from HCSW roles & into other roles.

Turnover



Year	Month	Turnover Rate %	Turnover Rate (Over 12m)
2022	September	1.67%	15.66%
2022	October	1.50%	16.00%
2022	November	1.03%	16.01%
2022	December	0.93%	16.14%
2023	January	1.06%	15.52%
2023	February	0.63%	15.11%
2023	March	0.87%	14.19%
2023	April	1.56%	14.37%
2023	May	0.78%	13.64%
2023	June	0.68%	13.13%
2023	July	1.60%	13.57%
2023	August	1.10%	13.37%

Turnover
Turnover was 13.37% in August (for the 12 months Sep 22 – Aug 23) against an 11% target KPI. This compares to 15.66% a year ago. The in-month turnover rate is steady at 1.08%.

Benchmarking
Most recently available data includes Oxford Health – 16% turnover / 13.6% vacancies. Herefordshire & Worcestershire - 13.48% turnover /16% vacancies. Avon Wiltshire Partnership 16% turnover / 15.12% vacancies. Gloucestershire ICS turnover rate 13.8%. Model Hospital Peer turnover rate 16.8% & 10.6% for vacancies.

FTE - 12 month and current FY trends

Gloucestershire Health and Care
NHS Foundation Trust

Data below shows that our in-post FTE continues to grow but there are some areas that continue to provide challenges to recruitment. A particular area is the Additional Clinical staff group (HCSWs) which has a net loss over the last 5 months despite positive recruitment numbers. The HCSW project targeted recruitment, alongside the work of the HCSW Council & the Trust rebanding exercise, whereby the majority of band 2 HCSWs will be rebanded to band 3, is expected to improve both recruitment & retention for this staff group later in 2023/24.

	FTE by Month												12 month	
Staff Group	**2022 / 09**	**2022 / 10**	**2022 / 11**	**2022 / 12**	**2023 / 01**	**2023 / 02**	**2023 / 03**	**2023 / 04**	**2023 / 05**	**2023 / 06**	**2023 / 07**	**2023 / 08**	Increase change	Change from April
Add Prof Scientific and Technic	180.70	181.87	181.25	178.43	183.91	182.31	180.43	180.51	181.44	184.84	186.88	186.42	5.72	5.91
Additional Clinical Services	923.91	928.91	925.02	911.94	924.26	933.29	941.28	944.77	943.07	949.71	945.00	928.75	4.83	-16.02
Administrative and Clerical	854.65	855.60	862.66	865.36	882.69	896.70	900.11	905.66	901.61	900.31	898.55	898.57	43.92	-7.10
Allied Health Professionals	467.50	467.73	469.73	469.78	472.01	473.82	475.43	474.46	476.57	476.60	475.79	483.38	15.88	8.92
Estates and Ancillary	159.29	161.66	163.01	162.46	162.87	159.77	156.13	155.77	156.65	157.40	159.11	159.70	0.41	3.93
Medical and Dental	108.66	109.76	111.27	111.37	113.07	116.30	117.30	118.91	119.46	119.26	120.56	124.80	16.14	5.89
Nursing and Midwifery Registered	1,200.11	1,189.10	1,199.38	1,205.81	1,227.35	1,231.63	1,239.26	1,236.25	1,239.68	1,238.48	1,235.87	1,246.05	45.93	9.79
Students	7.00	8.00	8.00	10.00	13.00	23.00	23.00	18.00	18.80	15.60	16.60	16.20	9.20	-1.80
Grand Total	**3,901.82**	**3,902.62**	**3,920.32**	**3,915.15**	**3,979.16**	**4,016.82**	**4,032.94**	**4,034.34**	**4,037.29**	**4,042.20**	**4,038.37**	**4,043.86**	142.04	9.52

Turnover

Gloucestershire Health and Care
NHS Foundation Trust

Higher service areas

Org L6	Avg FTE	Starters FTE	Leavers FTE	LTR FTE %
327 Business Intelligence 1	18.87	3.49	7.99	42.35%
327 Performance & Governance	10.79	2.00	3.00	27.79%
327 Adult Community Social Care	8.37	3.91	2.00	23.89%
327 Contracts & Planning 1	5.50	0.00	1.00	18.18%
327 Learning & Development 1	42.08	4.21	7.41	17.62%
327 Community Hospitals PH	460.17	75.13	79.11	17.19%
327 Adult Community LD	54.88	3.20	9.15	16.67%
327 Corporate Governance	39.74	12.20	6.43	16.17%
327 CYPS Physical Health	287.11	54.10	44.83	15.61%
327 IT & Clinical Systems 1	77.91	28.01	12.00	15.40%
327 Therapies & Spec Equip	203.00	31.95	30.61	15.08%
327 Adult Comm Physical Health	437.88	79.85	63.49	14.50%
327 CW Specialist Services	216.37	35.35	31.17	14.41%
327 Adult Community Entry Services	203.91	35.30	27.58	13.53%
327 Facilities	150.22	22.28	19.94	13.27%
327 Temporary Staffing	7.73	1.80	1.00	12.94%
327 Estates	53.29	7.53	6.80	12.76%
327 Financial Management	32.12	2.00	4.00	12.45%
327 CYPS Management & Admin	72.59	5.30	9.02	12.43%
327 HR Operations 1	58.02	12.61	7.20	12.41%
327 Nursing 1	23.50	1.53	2.90	12.34%
327 Countywide Services	8.63	1.00	1.00	11.59%
327 Research & Development	8.63	0.40	1.00	11.59%
327 Urgent Care Physical Health	139.30	17.69	15.58	11.18%

Turnover rates
Breakdown of turnover for Directorates with higher rates of >11% and by staff group (below) over the last 12 months, Aug 2022 to Sep 2023.

Targeted recruitment & retention support & interventions are provided to key hot spot areas where agreed (including itchy feet, exit questionnaires / interviews, & widening access / apprenticeships support, alongside recruitment & retention financial incentives).

Clinical teams with sustained challenges include Community Hospitals, Social Care, Community Learning Disabilities, CYPS, Community Physical Health & Specialist Services.

Corporate teams such as BI, Performance & Governance (NTQ), Contracts & Planning, Facilities, Finance, Learning & Development, Corporate Governance, HR Operations plus IT & Clinical Systems remain challenged by particularly competitive labour markets both inside & outside the NHS.

An ICB mapping project is underway with system partners to help identify good practice & gaps in the provision of career support & signposting. This will inform an action plan later in 2023 to develop further improvements to aid retention.

Vacancies

Gloucestershire Health and Care
NHS Foundation Trust

As of 31 August 2023 there were 443.20 Trust vacancies & a vacancy rate of **9.7%**. Current / recent benchmarking is included on slide 3.

Current vacancy factor challenges for key selected service areas are highlighted below:

Org L6	FTE Budgeted	FTE Actual	FTE Variance	Percentage
327 Adult Comm Physical Health	554.77	461.56	-93.21	-17%
327 Community Hospitals PH	507.65	450.84	-56.81	-11%
327 Inpatients Mental Health	476.46	421.66	-54.80	-12%
327 CYPS Mental Health	197.65	153.12	-44.53	-23%
327 Urgent Care Physical Health	176.85	143.24	-33.61	-19%
327 Facilities	181.48	153.29	-28.19	-16%
327 Urgent Care MH	144.35	120.41	-23.94	-17%
327 CYPS Physical Health	316.13	292.67	-23.46	-7%
327 Therapies & Spec Equip	232.48	209.93	-22.55	-10%
327 Adult Community Mental Health	342.06	319.62	-22.44	-7%
327 Adult Community LD	64.32	52.25	-12.07	-19%
327 Medical 3	160.24	151.99	-8.25	-5%
327 CYPS Management & Admin	83.34	75.17	-8.17	-10%
327 Business Intelligence 1	24.67	16.57	-8.10	-33%
327 NTQ Management 1	44.70	37.61	-7.09	-16%
327 Governance & Compliance 1	36.52	30.45	-6.07	-17%
327 Operational Flow	30.22	24.23	-5.99	-20%
327 Performance & Governance	16.09	11.09	-5.00	-31%

Particular hot spots continue to include registered nursing, particularly community nursing (ICTs), community & mental health inpatients. Facilities & CYPS (particularly MH).

A range of focussed support is being provided to hot spots, but with particular focus on RNs, HCSWs, Facilities, Homefirst, International Recruitment & medical recruitment. This includes recruitment & retention incentives in targeted areas.

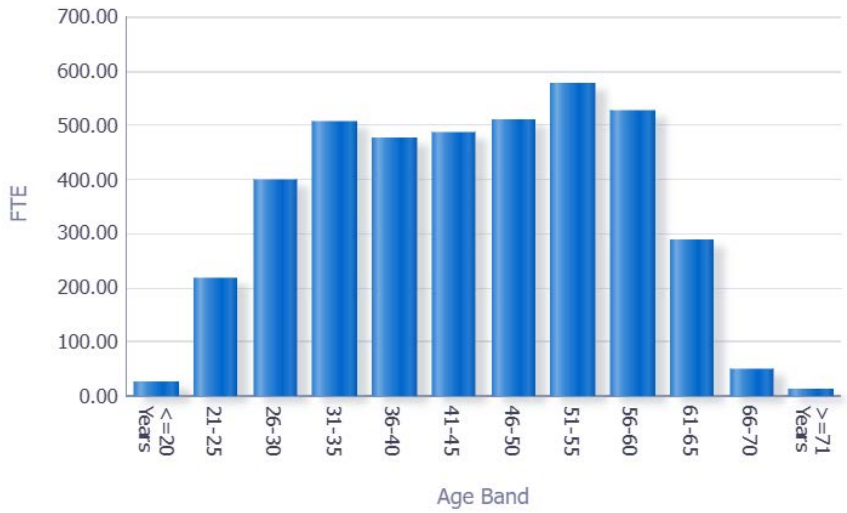
A cross-partner ICS stakeholder group is scoping additional collaborative interventions to improve CYPS recruitment.

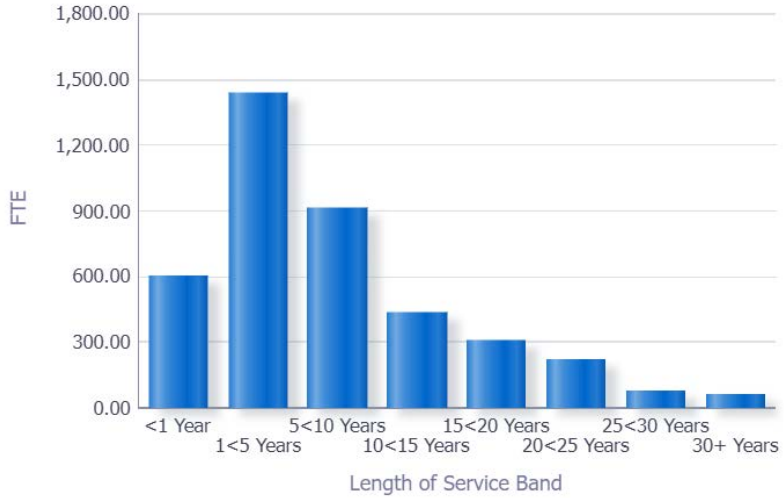
For Adult Community Physical Health, ICT band 5 & 6 recruitment and FTE has continued to improve since June, from 138.88 to 144.77, with a further 18 new band 5 & 6 starters expected in the September & October pipeline

Age profiles & Length of Service

Gloucestershire Health and Care
NHS Foundation Trust

Staff in Post





Age Band	FTE	FTE
<=20 Years	28.45	28.45
21-25	219.76	219.76
26-30	400.22	400.22
31-35	506.50	506.50
36-40	474.99	474.99
41-45	485.47	485.47
46-50	511.56	511.56
51-55	576.48	576.48
56-60	525.02	525.02
61-65	287.72	287.72
66-70	51.42	51.42
>=71 Years	12.82	12.82
Grand Total	**4,080.42**	**4,080.42**

Length of Service Band	FTE
<1 Year	604.38
1<5 Years	1,435.71
5<10 Years	916.72
10<15 Years	437.77
15<20 Years	313.71
20<25 Years	226.37
25<30 Years	78.86
30+ Years	66.91
	4,080.42

Retirement is reported as the main reason for leaving.

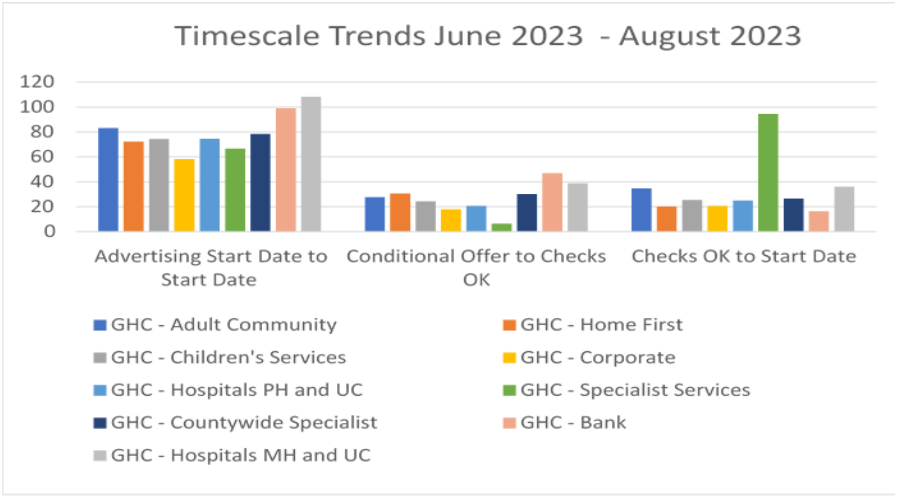
Detailed additional leaver commentary & learning from exit processes will be shared at the October GPTWC.

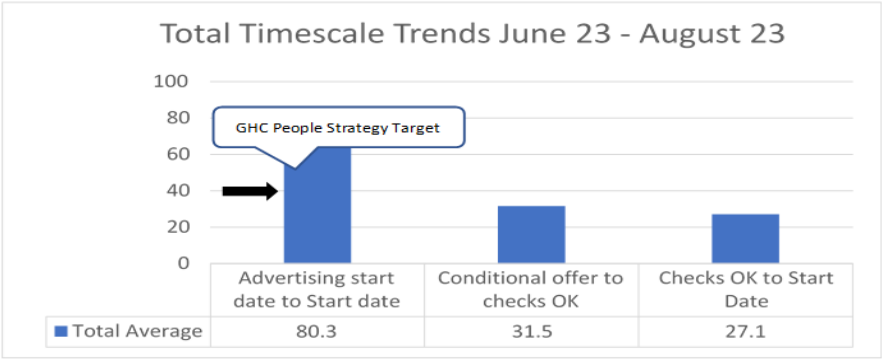
Actions to support retention include a review of the retire & return employment options with the LNC, publicity on the new pension scheme flexibilities & the revised flexible working policy. Good practice examples are being sought for wider good practice sharing.

Recruitment

Gloucestershire Health and Care
NHS Foundation Trust

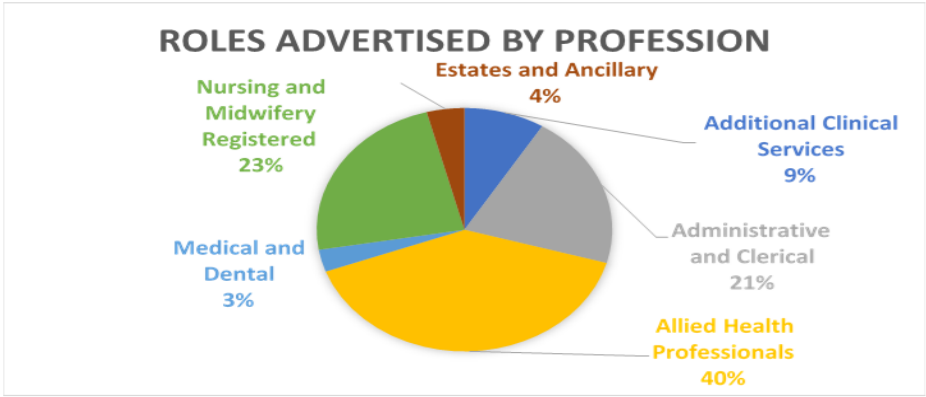
Timescale Data by Directorate and Totals





Timescale trend	1	2	3
Movement (since last report (May 23 – Jul 23)	Increase from 75 to 80.3	Increase from 28.9 to 31.5	Increase from 23 to 27.1

Vacancies and Applicants August 2023



Total vacancies advertised = 170 (18.66% decrease on July 2023 and 39.29% decrease on August 2022)

Application Statistics	
	August 2023
Total Number of Applicants	2101
Shortlisted Applicants	276
% of applicants shortlisted	13.13%
Conditional Offer's made	154
Applicants in Pipeline (effective 04/09/2023)	322
Total "Started" during August	110

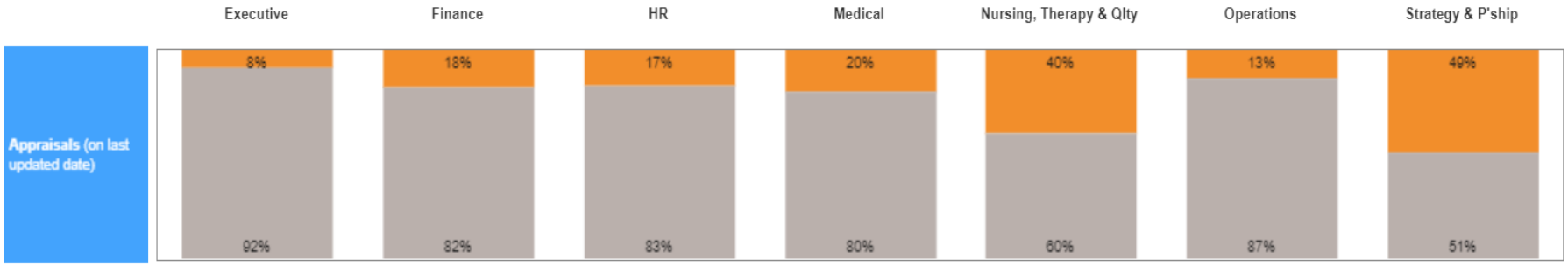
Additional detailed data on HCSW recruitment & the HCSW project work stream action plan will be shared at the October 2023 GPTWC.

National TRAC supply issues & unplanned downtime over an intermittent 2-week period have impacted timescale trend performance

Appraisals / Personal Development Reviews

Gloucestershire Health and Care
NHS Foundation Trust

Whole Trust		
Appraisals (on last updated date) - **Target 90%**		
Appraisals Not Completed	15%	702
Appraisals Completed	85%	3,936



Benchmarking
Gloucestershire Hospitals 81%, Avon Partnership Trust 88.2%, Cornwall Partnership Trust 61.83%, Devon Partnership 69.92%, Dorset Health Care (MH) 83.03%, Herefordshire & Worcestershire 85.6%, Oxford Health 31.0%, Somerset NHSFT 61.25%

Sickness Absence

Gloucestershire Health and Care
NHS Foundation Trust

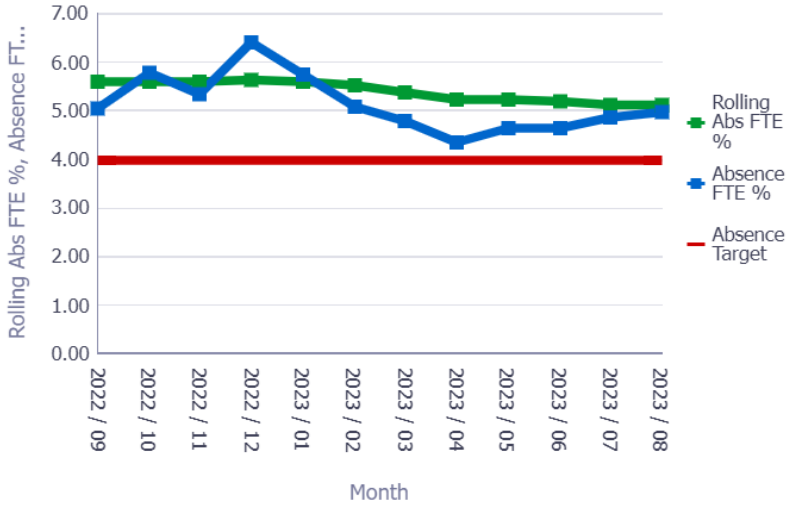
Sickness absence data shows a reduction over the past few months, now at **4.97%** for August against a KPI target of 4%.

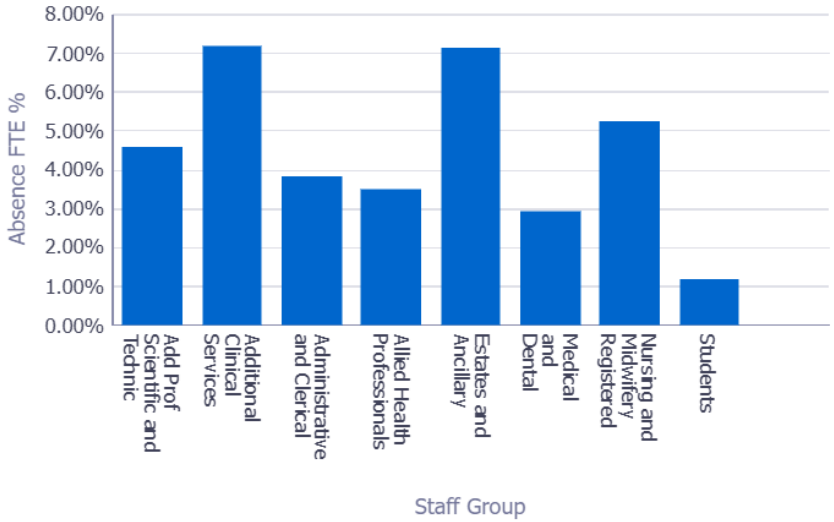
Rolling absence continues to dip & now sits at 5.14%.

The two highest staff groups are Additional Clinical Services workers (HCSW) at 7.15% & Estates and Facilities at 7.14%. Nursing is at 5.25%.

An internal audit will be completed in Qs 3 & 4 to include an assessment against good practice & the national sickness absence toolkit.

Additional detail on reasons & improvement interventions will be shared at the GPTWC in October 2023.





Benchmarking
Avon Wiltshire Partnership is 5.19%. Cornwall Partnership 5.34%. Devon Partnership 5.45%. Dorset Healthcare 5.08%. Herefordshire & Worcestershire 5.13%, Oxford Health 5.1%, Somerset NHSFT 4.65%. Gloucestershire ICS health & social care average sickness is 4.1%. Gloucestershire Hospitals sickness rate is 3.87%.

Statutory & Mandatory Training

Gloucestershire Health and Care
NHS Foundation Trust

Total Compliance Percentage by Directorate for All Courses

Use + to open each area detail

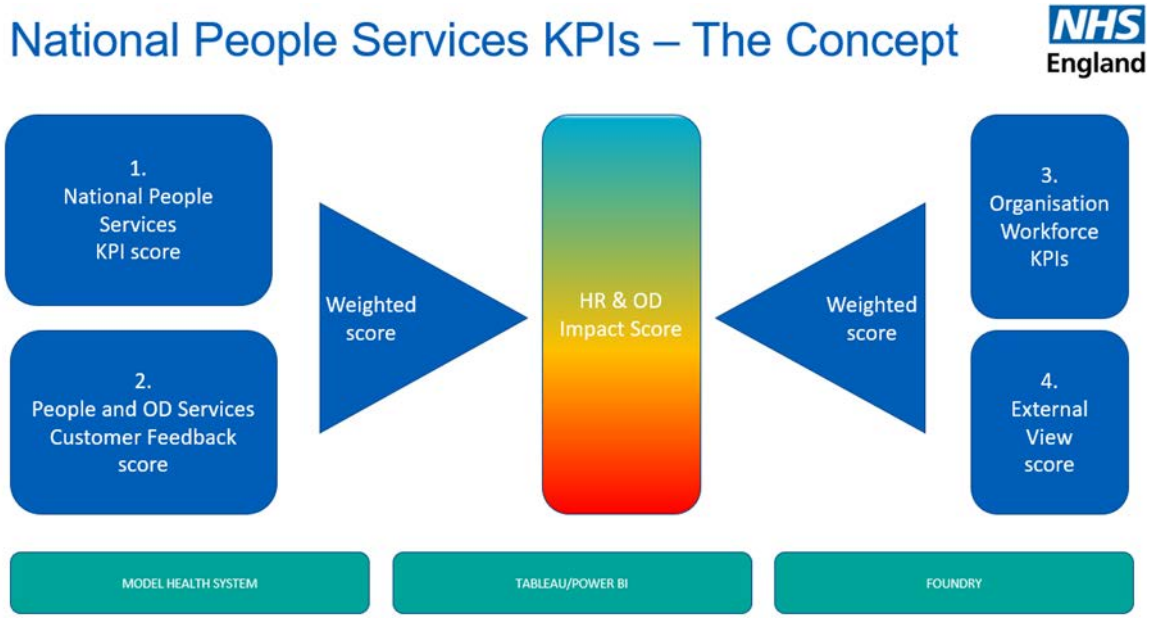
The Trust training compliance figures, for statutory and mandatory training is currently 93.70%, above the target. Detailed performance data is available on Tableau and Care 2 Learn.

All service areas (as reported on the Trust's dashboard) achieved at least 90% training compliance other than HR & OD Directorate, the underperformance due to Staff Bank section compliance. Work is ongoing to engage with bank workers directly to address this.

Benchmarking
Avon Wiltshire Partnership 85%, Cornwall Partnership 89%, Devon Partnership 90.28%, Dorset Healthcare 92.58%, Gloucestershire Hospitals 85%, Herefordshire & Worcestershire 93.71%, Oxford Health 87.1%, Somerset NHSFT 65.3%.

Update - New National People KPI Scorecard (1)

Gloucestershire Health and Care
NHS Foundation Trust



Customer feedback framework roll-out started in May 2023 with 13 pilot organisations onboard & 150 users providing test feedback.

Training material & implementation guidance will be made available through the Futures collaboration website at: https://future.nhs.uk/

Finalised dynamic customer service feedback dashboard (which includes interactive maps & word clouds) will be available.

The draft list & taxonomy of People metrics and indicators has now been agreed.

KPIs engagement starts from October 2023 with a view to roll out by February / March 2024.

Benefits & Timeline

Simplified, standardised & automated collection, analysis & reporting of core people services metrics, measuring the unique contribution of people services on organisational performance by March 2024.

Draft set of national people indicators to inform decision making, cultural & behavioural change has been agreed. Provider engagement & concept testing due to start from October 2023.

Customer feedback framework to support improvement in service delivery has been developed & is being rolled-out across providers.

Evidence baseline to support & measure innovation, consistency, improvement & value added by the people profession & ensure alignment with the Long-Term Workforce Plan & Promise by January 2024.

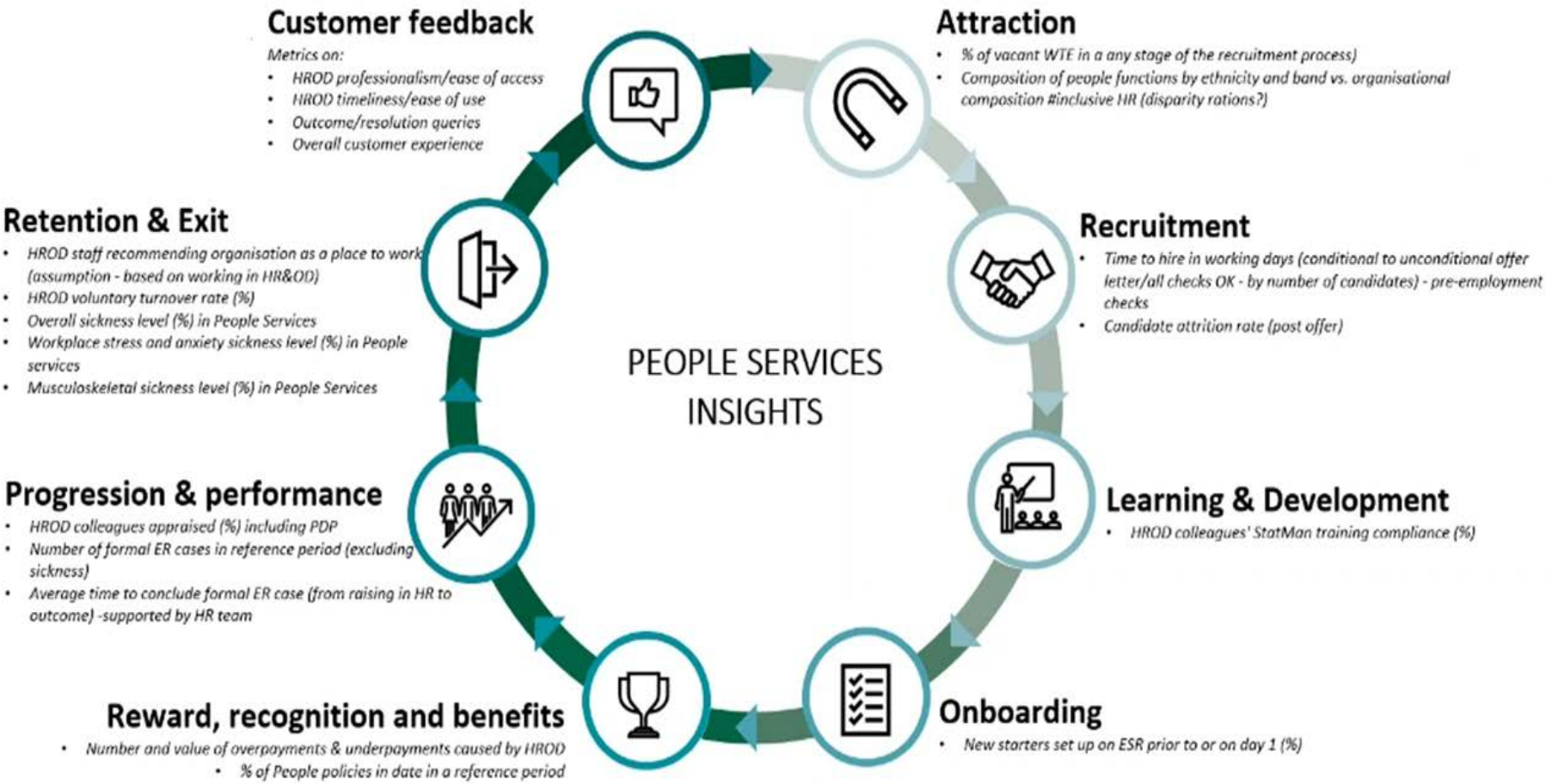
Automated, centralised & standardised dynamic national KPIs dashboards providing real-time data relating to People Services performance by March 2024.

Reduced (& eventually eliminated) duplicate requests for data made to systems & providers from national teams by March 2024.

Update - New National People KPI Scorecard (2)

Gloucestershire Health and Care
NHS Foundation Trust

The proposed final national People KPI Scorecard is expected to cover metrics outlined in the below infographic. The aim is that by collecting & benchmarking metrics aligned with the employee life cycle, organisations will be better able to best serve the Trust's People Strategy delivery.



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AGENDA ITEM: 09/0923

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 September 2023**

PRESENTED BY: Sandra Betney, Director of Finance

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 31st August 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 5 position
- To **APPROVE** the updates to the capital programme

Executive summary

- The current system plan is break even and the Trust's plan is break even
- At month 5 the Trust has a surplus of £0.241m compared with a plan of £0.242m
- 23/24 Capital plan is £17.785m and spend to month 5 is £4.071m against a plan of £8.292m
- Cash at the end of month 5 is £43.652m
- Cost improvement programme has delivered £3.362m of recurring savings against a plan of £3.615m
- Non-recurring savings delivered to date of £1.781m compared with the plan of £1.85m
- Trust Board are asked to approve the revised capital programme with changes to the phasing of both the Clinical Systems Vision Project and the disposals, and rephasing between 24/25 and 25/26

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?
Presented monthly to Trust Board and Resources Committee.

Appendices:	Finance Report

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

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NHS Foundation Trust

AGENDA ITEM: 09/0923

Finance Report Month 5

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

Overview

Gloucestershire Health and Care
NHS Foundation Trust

- The current system plan is break even and the Trust's plan is break even
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- 23/24 Capital plan is £17.785m and spend to month 5 is £4.071m against a plan of £8.292m
- Cash at the end of month 5 is £43.652m
- Cost improvement programme has delivered £3.362m of recurring savings against a plan of £3.615m
- Non recurring savings delivered to date of £1.781m compared with the plan of £1.85m
- The Trust spent £3.727m on agency staff up to month 5. This equates to 4.1% of total pay compared to the agency salary ceiling of 3.7%.
- Better Payment Policy shows 98.7% of invoices by value paid within 30 days against 95% target
- System position at month 5 is a £2.774m over spend which reflects a number of cost pressures at GHFT, and a prescribing cost pressure at the ICB. The system forecast remains break even.
- Trust Board are asked to approve the revised capital programme with changes made to the phasing of both the Clinical Systems Vision Project and the disposals, and rephasing between 24/25 and 25/26.

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	259,837	108,265	109,044
Other operating income	12,792	11,409	17,087	7,120	7,810
Employee expenses - substantive	(184,330)	(201,415)	(209,063)	(87,109)	(79,201)
Bank	(11,698)	(1,704)	(3,588)	(1,495)	(7,376)
Agency	(7,952)	(863)	(912)	(380)	(3,727)
Operating expenses excluding employee expenses	(59,034)	(59,076)	(61,551)	(25,646)	(26,282)
PDC dividends payable/refundable	(2,580)	(2,590)	(2,590)	(1,079)	(1,079)
Finance Income	1,383	1,383	825	344	1,103
Finance expenses	(153)	(153)	(153)	(64)	(81)
Surplus/(deficit) before impairments & transfers	**(108)**	**(94)**	**(108)**	**(45)**	**211**
Remove central PPE stock impact					
Remove capital donations/grants I&E impact	108	94	108	45	30
Surplus/(deficit)	**0**	**0**	**0**	**0**	**241**
Adjust (gains)/losses on transfers by absorption/impairments		0		0	**0**
Remove net impact of consumables donated from other DHSC bodies					
Revised Surplus/(deficit)		**0**		**0**	**241**
WTEs	4433	4405	4451	4451	4521

GHC I & E Forecasts

Gloucestershire Health and Care
NHS Foundation Trust

Statement of comprehensive income £000	2023/24 Forecast £000s	2024/25 Forecast £000s	2025/26 Forecast £000s	2026/27 Forecast £000s	2027/28 Forecast £000s
Operating income from patient care activities	260,296	253,667	256,842	258,908	260,682
Other operating income	19,292	15,278	14,409	14,599	15,101
Employee expenses - substantive	(191,275)	(186,075)	(185,143)	(186,185)	(187,176)
Bank	(16,646)	(18,676)	(19,050)	(19,431)	(19,819)
Agency	(8,253)	(7,576)	(7,555)	(7,608)	(7,659)
Operating expenses excluding employee expenses	(63,373)	(56,506)	(59,333)	(60,007)	(60,749)
PDC dividends payable/refundable	(2,590)	(2,624)	(2,674)	(2,774)	(2,874)
Finance Income	2,625	2,565	2,565	2,565	2,565
Finance expenses	(167)	(160)	(164)	(165)	(169)
Surplus/(deficit) before impairments & transfers	**(91)**	**(106)**	**(103)**	**(98)**	**(98)**
Remove central PPE stock impact					
Remove capital donations/grants I&E impact	91	106	103	98	98
Surplus/(deficit)	**0**	**(0)**	**0**	**0**	**0**
Recurring savings		**(6,459)**	**(5,424)**	**(5,354)**	**(5,394)**
Savings as % of turnover		**2.4%**	**2.0%**	**1.9%**	**1.9%**
Non recurring savings		**(6,156)**	**(4,021)**	**(3,099)**	**(2,551)**
Savings as % of turnover		**2.3%**	**1.5%**	**1.1%**	**0.9%**

Pay Analysis

Gloucestershire Health and Care
NHS Foundation Trust

Pay analysis month 5					
	Budget WTE year to date	Actual WTE year to date	Budget year to date £000s	Actual £000s	Actual as % of Total
Substantive	4,433	4,075	87,109	79,201	87.7%
Bank	15	372	1,495	7,376	8.2%
Agency	3	74	380	3,727	**4.1%**
Total	**4,451**	**4,521**	**88,984**	**90,304**	**100.0%**

Comments

- Budgets not yet included for developments while contract is finalised with Glos ICB c.£4.4m
- A4C and Medical pay awards lead to potential recurring cost pressure of c. £0.77m (subject to confirmed ICB funding)
- 4.1% of pay bill spent on agency year to date. System agency ceiling 3.7%
- We are £400k above agency ceiling

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	982	1,220	238	1,075	832	589	346	103
	Property, plant and equipment: other	113,537	143,163	137,850	115,003	(22,846)	122,859	131,118	131,390	131,112	130,896
	Right of use assets*	17,715	19,028	19,882	16,868	(3,014)	17,187	17,707	16,157	14,607	13,057
	Receivables	1,085	511	513	994	482	990	820	796	772	748
	Total non-current assets	**133,707**	**163,522**	**159,226**	**134,085**	**(25,141)**	**142,111**	**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	4,250	8,360	4,109	8,960	13,174	13,124	13,094	13,064
	Non-NHS receivables	7,165	8,738	8,738	8,000	(738)	6,500	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	(3)				
	Cash and cash equivalents:	48,836	42,044	43,867	43,652	(215)	41,884	39,435	40,898	42,836	44,821
	Total current assets	**72,480**	**53,412**	**55,185**	**61,972**	**6,787**	**55,604**	**57,318**	**58,631**	**60,489**	**62,394**
Current liabilities	Trade and other payables: capital	(4,343)	(5,594)	(2,594)	(1,844)	751	(4,344)	(4,049)	(4,049)	(4,049)	(4,049)
	Trade and other payables: non-capital	(38,870)	(25,865)	(28,344)	(30,812)	(2,468)	(30,128)	(36,918)	(36,918)	(36,918)	(36,918)
	Borrowings*	(1,446)	(1,345)	(1,532)	0	1,532	(1,345)	(1,345)	(1,345)	(1,345)	(1,345)
	Provisions	(7,882)	(6,511)	(5,779)	(7,061)	(1,282)	(7,061)	(7,349)	(7,349)	(7,349)	(7,349)
	Other liabilities: deferred income including contract liabilities	(1,107)	(2,478)	(2,478)	(3,012)	(534)	(2,412)	(1,115)	(1,115)	(1,115)	(1,115)
	Total current liabilities	**(53,649)**	**(41,793)**	**(40,727)**	**(42,729)**	**(2,002)**	**(45,290)**	**(50,776)**	**(50,776)**	**(50,776)**	**(50,776)**
Non-current liabilities	Borrowings	(15,298)	(18,265)	(18,343)	(15,877)	2,466	(14,371)	(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**	**152,803**	**134,971**	**(17,832)**	**135,574**	**138,113**	**138,016**	**137,909**	**137,906**
Taxpayers Equity	Public dividend capital	130,166	132,056	130,215	130,166	(49)	131,072	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	(14,950)	(108)	198	211	13	(92)	(115)	6	(9)	95
	Total taxpayers' and others' equity	**134,761**	**154,338**	**152,803**	**134,971**	**(17,832)**	**135,574**	**138,113**	**138,016**	**137,909**	**137,906**

PPE variance due to 22/23 revaluation, and transfer to Assets Held for Sale

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**	**41,884**	**37,715**	**39,178**	**41,116**
Cash flows from operating activities										
Operating surplus/(deficit)	(13,138)		270		(272)		**1,806**	**2,039**	**2,130**	**2,338**
Add back: Depreciation on donated assets	84		30		92		0	0		0
Adjusted Operating surplus/(deficit) per I&E	**(13,054)**		**300**		**(180)**		**1,806**	**2,039**	**2,130**	**2,338**
Add back: Depreciation on owned assets	7,918		3,362		8,538		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)		5,436		6,311		650	174	104	104
Increase/(Decrease) in provisions	3,576		(821)		(821)		(500)	0	0	0
Increase/(Decrease) in trade and other payables	10,119		(9,124)		(8,744)		(2,649)	0	0	0
Increase/(Decrease) in other liabilities	(1,301)		1,905		1,305		0	0	0	0
Net cash generated from / (used in) operations		**14,362**		**1,065**	**0**	**6,416**	**8,912**	**12,052**	**12,378**	**12,524**
Cash flows from investing activities										
Interest received	1,144		1,100		2,780		825	825	825	825
Interest paid			(4)		(9)		0	(7)	(7)	(7)
					3,697					
Purchase of property, plant and equipment	(22,650)		(6,570)		(16,819)		(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)**		**(5,474)**	**0**	**(10,351)**	**(11,930)**	**(7,500)**	**(7,255)**	**(7,255)**
Cash flows from financing activities										
PDC Dividend Received	1,886				906		**1,841**	**0**	**0**	**0**
PDC Dividend (Paid)	(3,217)				(2,194)		**(2,690)**	**(2,790)**	**(2,890)**	**(2,990)**
Finance lease receipts - Rent			2		5					
Finance lease receipts - Interest	216		2		5					
Finance Lease Rental Payments	(1,632)		(702)		(1,556)		**(162)**	**(164)**	**(165)**	**(169)**
Finance Lease Rental Interest	(169)		(76)		(182)		**(141)**	**(135)**	**(130)**	**(125)**
		(2,916)		**(774)**	**0**	**(3,017)**	**(1,152)**	**(3,089)**	**(3,185)**	**(3,284)**
Cash and cash equivalents at end of period		**48,836**		**43,653**	**0**	**41,884**	**37,715**	**39,178**	**41,116**	**43,101**

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	2023/24	2023/24	2023/24	2024/25	2025/26	2026/27	2027/28
Land and Buildings								
Buildings	2,400	375	(25)	2,400	1,000	3,000	3,000	3,000
Backlog Maintenance	1,045	340	242	1,045	1,250	1,393	1,393	1,393
Buildings - Finance Leases	784	162	0	784	712	989	0	0
Vehicle - Finance Leases	384	160	0	384	239	0		0
Net Zero Carbon	500	200	0	500	500	500	500	500
LD Assessment & Treatment Unit						2,000	0	
Cirencester Scheme						5,000	0	
							0	
Medical Equipment	500	153	3	500	1,030	1,030	1,030	1,030
Xray				267	0			
Endoscopy				600	0			
IT								
IT Device and software upgrade			0		600	600	600	600
IT Infrastructure	1,130	684	(0)	1,130	1,300	1,300	1,300	1,300
Clinical Systems Vision	2,191	140	211	1,256	2,533	2,813	250	250
Unallocated				128			500	
Sub Total	**8,934**	**2,214**	**430**	**8,994**	**9,164**	**18,625**	**8,573**	**8,073**
Forest of Dean	8,851	6,078	3,641	8,851	0	0	0	0
Total of Original Programme	**17,785**	**8,292**	**4,071**	**17,845**	**9,164**	**18,625**	**8,573**	**8,073**
Disposals	(3,749)			(3,700)	(2,233)	(500)	(500)	0
Donation - Cirencester Scheme	**0**					(5,000)	0	0
Total CDEL	**14,036**	**8,292**	**4,071**	**14,145**	**6,931**	**13,125**	**8,073**	**8,073**

Phasing of CSVP altered. Funding and spend from 23/24, moved into 24/25 and 25/26
Property sale moved from 23/24 to 24/25. New Property sale added to 23/24
FoD projected total spend £25.9m

Risks

Gloucestershire Health and Care
NHS Foundation Trust

Potential risks are as set out below:

- Risk of loss from disposal of land and building sale removed as system CDEL received

Risks	Risks	Made up of: Recurring	Made up of: Non Recurring	Likelihood	Impact	RISK SCORE
Staffing above establishment is not able to be reduced in Inpatie	3,400	3,400	0	4	4	16
Cost share changes for Section 117 patients leads to additional costs not reimbursed by ICB	1,400	2,000	-600	2	3	6
ICS risk share mechanism will lead to financial impact on GHC	2,720		2,720	3	4	12
Recurring savings without a plan don't deliver	1,337	1,337	0	3	3	9
Maintenance costs rise due to inflationary pressures	848	848	0	3	3	9
Utility, fuel, waste costs rise due to inflationary pressures	300	300	0	3	2	6
23/24 pay award under funded (incl. Medical and non A4C)	190	840	-650	4	3	12
Capital cost inflation leads to capital programme being reduced	0	1,000	-1,000	3	2	6
Mental Health Act White paper reforms	0	1,000	-1,000	4	2	8
Microsoft Licenses cost pressure from national deal	0	283	-283	4	2	8
Total of all risks	**10,195**	**11,008**	**-813**			

System position

Gloucestershire Health and Care
NHS Foundation Trust

Draft System Position Month 5 23/24		Net I & E Plan 31/07/2023 YTD	Net I & E Actual 31/07/2023 YTD	Net I & E Variance 31/07/2023 YTD	Net I & E Variance 31/03/2024 Forecast
Organisation		**£'000**	**£'000**	**£'000**	**£'000**
Gloucestershire ICB		**0**	**(335)**	**(335)**	**0**
Provider 1 - Gloucestershire Health And Care NHS Foundation Trust		**242**	**241**	**(1)**	**0**
Provider 2 - Gloucestershire Hospitals NHS Foundation Trust		**(8,432)**	**(10,870)**	**(2,438)**	**0**
TOTAL		**(8,190)**	**(10,964)**	**(2,774)**	**0**

System risk share position

NHS
Gloucestershire Health and Care

Deficit Risk Share - Operational Measures				
Organisation	**Measure**	**Target**	**Delivery on track?**	**Comments**
ICB	Deliver Financial Plan	Break even	**No**	Prescribing cost pressure £2m
ICB	Deliver system ERF	Delivery of system ERF target (Independent sector providers and out of county providers)	**Yes**	Likely to achieve as ERF targets reduced due to industrial action
ICB	Increased flow	Increased flow through discharge to assess beds – 5 day reduction in LOS by 31st March 2024 from a baseline	**n/k**	
GHFT	Deliver Financial Plan	Break even	**No**	Overspend £1.73m ytd due to a number of factors
GHFT	Deliver ERF target	Delivery of the Elective Recovery target for 23/24 of 109% of 19/20	**No**	Currently not hitting the target
GHFT	Deliver Ambulance handover trajectory	delivery of the ambulance handover trajectory in the Operational Plan (using average handover time as the measure).	**Yes**	good performance on ambulance handover recently
GHC	Deliver Financial Plan	Break even	**Yes**	On track. Ytd position and forecast indicate break even at year endy
GHC	Improve rapid response demand and capacity by 3%	Have 3900 starts annually	**Yes**	1200 in June/July. Assume On track.
GHC	Improved mental health liaision response	1115 Routine referrals responded to in 24 hours, 476 Urgent referrals responded to in 2 hours	**Yes**	On track. 998 routine referrals responded to in 24 hours upto end of Aug, and 384 urgent responded to within 2 hours at end of August
GHC risk is c.16% share of **externally driven** system cost pressures				£443,840

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Gloucestershire Health and Care

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REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 September 2023**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Dr Hannah Leng, Specialty Doctor

SUBJECT: **MEDICAL APPRAISAL ANNUAL 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 Medical Appraisal and Revalidation Report provides a summary of the work that has been undertaken within the Trust to support the safe provision of clinical services by medical practitioners with a connection to this designated body.

It provides assurance as to the application of national policy with regard to the regulation and revalidation of medical practitioners and insight into the processes and resources that are required to undertake this work.

Recommendations and decisions required:

1) That the Board **ACCEPT** and **ENDORSE** the Medical Appraisal Annual Report and:
   - **Recognise** that levels have been maintained in the application of appraisal, recording and quality assuring and that this has occurred without significant additional funding.
   - **Recognise** that the figures for engagement in appraisal reflect a snap shot at one point in the year and that the Trust will continue to achieve appraisal consistent with the provision of safe medical services on an annual basis supported by the revalidation statistics provided.
   - **Recognise** that there are a number of exceptions/reasons for non-compliance that contribute to a compliance point of less than 100%.
   - **Recognise** that effective appraisal has supported timely and appropriate revalidation for all doctors to date.
   - **Recognise** that good employment practice with regard to recruitment is supporting safe practice.
   - **Recognise** that locum use remains necessary for the safe provision of clinical services but that this is monitored appropriately.
   - To **note** in particular the assurance for NHS England in section 13 that the Trust meets requirements.

2) That the Board **AGREES** to the content and submission of the Statement of Compliance to NHS England and that this is signed by the Chair on behalf of the Trust (section 13 page 9-14).

Executive summary

- Medical Appraisal has continued to be instituted within Gloucestershire Health and Care NHSFT aligned with national policy.
- The Medical Appraisal Committee has instituted a work plan that will further deliver assurance annually and sustain quality.
- Headline figures demonstrate that of the 106 doctors requiring appraisal during the 2022-23 appraisal year 86 (81.1%) were compliant as at 1st April 2023. Of the 20 doctors who were non-compliant; 15 (14.2%) had acceptable reasons (11 being new starters; 1 on long term sickness; 1 on a career break and 2 having an agreed extension). The 5 (4.7%) without a reason were overdue by two months or less.
- Doctors revalidation was effectively managed with no non-engagement referrals.
- Recruitment processes provide appropriate safety and quality checks aligned with national policy and best practice.
- Use of locum practitioners is being monitored and is necessary to sustain service commitments and activity appropriately.
- The MAC membership includes a range of subspecialties, including non-psychiatry, and both consultant and SAS level doctors. Ivars Reynolds, a long-established MH Act Manager was welcomed to the Committee in 2019 in order to provide lay oversight for the work of the Committee.

Risks associated with meeting the Trust's values

There are significant risks both to quality, safety and reputation of failure to implement revalidation and annual appraisal effectively.

Corporate considerations	
Quality Implications	Appraisal contributes to patient safety.
Resource Implications	Continuing use of administrative and managerial time with clinician input to revalidation process.
Equality Implications	The annual appraisal monitoring process addresses equalities issues.

Where in the Trust has this been discussed before?

Medical Appraisal Committee, 3rd May 2023
Quality Assurance Group, 18th August 2023
Quality Committee, 7th September 2023

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

Appendices:	None.

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

ANNUAL MEDICAL APPRAISAL BOARD REPORT

Appraisal year:	1st April 2022 – 31st March 2023
Author:	Dr Hannah Leng *On behalf of Medical Appraisal Committee*
Prepared for:	Trust Board via Trust Quality Committee and Quality Assurance Group

1. Executive summary

Of the 106 doctors requiring appraisal during the 2022-23 appraisal year, 86 (81.1%) were compliant as at 1st April 2023; this is down on the previous year (89% at end of Q4 2022).–10 of the 106 doctors are employed by GHC but not under our designated body.

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

Each year a quality assurance audit of appraisal outputs is conducted; to date this has demonstrated sustained improvement in quality, providing significant validation and assurance to the Trust Board through the Quality Committee and the Quality Assurance Group that the organisation is fulfilling its statutory obligations. The most recent verification visit by NHS England was in June 2019, with future visits expected on a 5-year cycle.

2. Purpose of the paper

The purpose of this paper is to report on the state of medical appraisal and revalidation to the Trust Board through the Quality Committee and the Quality Assurance Group over the preceding appraisal year. It is also to report on progress made towards further developing and refining systems and procedures to support medical appraisal and to improve the quality of medical appraisals taking place in the organisation. In addressing these two issues the paper provides assurance to the Trust regarding both the quality of the medical workforce and its sustainability.

3. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical

system. The strengthened annual appraisal process is the primary supporting mechanism by which revalidation recommendations are made to the General Medical Council (GMC) for the re-licensing of doctors.

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

4. Governance arrangements

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

The MAC comprises of the Medical Director/Responsible Officer, Revalidation Officer, a separate chair, the Director of Medical Education, at least 2 consultant representatives/lead appraisers (selected to represent the geographical and sub-specialty spread of consultants within the Trust) and at least 1 SAS doctor representative.

The MAC convenes quarterly; this includes a year-end half-day to review the results of the quality assurance audit and to scrutinise the end of year appraisal compliance figures. The committee reviews the annual work plan and the progress made against the Terms of Reference developed at inception of the committee.

Key outputs from the MAC during the last year include:

- Review of the current terms of reference for the MAC
- Review of the membership of the MAC
- Completion of the annual quality assurance audit. The April 2023 audit covered all appraisals completed from 1st April 2022 to 31st March 2023
- Continued review of the currently active medical appraisers list
- Performance review of newly qualified medical appraisers
- Ensuring the continuation of high-quality appraisals

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

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

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

Priorities for the MAC for the next year include further refinement of the number and nature of active qualified medical appraisers within the organisation and further consideration of ways to improve patient and public involvement in appraisal and revalidation processes. The committee have sourced an easy read patient feedback form for 360-degree feedback as clinicians from certain sub-specialities had previously identified this as being a barrier to collecting patient feedback.

5. Medical appraisal

5.1. Appraisal and revalidation performance data

Of the 106 doctors requiring appraisal during the 2022-23 appraisal year 86 (81.1%) were compliant as at 1st April 2023; this is down on the previous year (89% at end of Q4 2022).

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

Of the 20 doctors who were non-compliant; 15 (14.2%) had acceptable reasons (11 being new starters; 1 on long term sickness; 1 on a career break and 2 having an agreed extension). The 5 (4.7%) without a reason were overdue by two months or less.

The SARD JV system for monitoring compliance does not allow for any flexibility around the appraisal due date. Once the due date has passed (even by a day) the appraisee is deemed non-compliant. This is at odds with the Trust policy which allows for one month before or after the due date for completion of appraisal. Compliance rates are therefore unlikely to regularly reach 100% and will fluctuate monthly throughout the appraisal year.

To account for this, and given that at any time there will be a small number of doctors currently non-compliant with a reason, the MAC agreed in 2018 that overall compliance rates maintained above 75% should provide adequate assurance of engagement in the process and completion of medical appraisals within the medical workforce.

For further details see **Appendix A.**

5.2. Appraisers

There are currently 19 trained medical appraisers within the establishment of non-training grade doctors. All consultants and SAS doctors continue to be offered access to training in order to both provide a cohort of appraisers and increase awareness and knowledge of appraisal for appraisers and appraisees alike.

The MAC have set minimum numbers of completed appraisals required in a 2-year period by an appraiser. These standards were introduced in 2014 and enforced in 2016; 8 appraisers were then removed from the active list, and this review of activity has continued annually. Appraisers who consistently do small numbers are asked whether they wish to continue in this role.

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

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

5.3. Quality assurance

In July 2015 the Trust was visited and scrutinised by the NHS England Independent Verification Review Team; whose purpose is to assess and validate the status of appraisal and revalidation systems within all designated bodies. The process is designed to provide independent assurance to trust boards that the organisation is fulfilling its statutory obligations in respect of the RO's statutory responsibilities. A comparator report is received each year from NHS England, which allows the Trust to benchmark itself against other trusts. As GHC is small compared to other trusts, a small number of doctors can make a significant difference to percentages quoted.

Overall the Trust was highly commended and scored at least 5 out of 6 (equating to 'Excellence') in all core standards; scoring highest for 'Engagement & Enthusiasm'. No required actions were recommended by the scrutiny panel, and few suggestions made for improvement, mainly concerning HR procedures (since enacted). Many areas of good practice were noted including the overriding focus on quality of medical appraisals, use of SARD JV as a tool to support quality and compliance, automatic inclusion of complaints and serious incidents within

individual appraisal portfolios, and the processes to support learning and quality improvement which result from the annual quality assurance audit. An Independent Verification Visit by NHS England took place in June 2019 and found no further actions required.

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

5.3.1. Support for appraisers

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

5.3.2. Feedback from appraisees

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

5.3.3. Automatic uploading of complaints and anonymised SI reports

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

5.3.4. Annual quality assurance audit

The annual medical appraisal quality assurance audit was conducted in April 2023 by all members of the MAC, using a nationally recognised medical appraisal QA tool (the Excellence Tool). New appraisers were audited at the time of completion to avoid delay in scrutiny.

9 (11 % of all) completed appraisal summaries were randomly selected for audit for completeness and quality; 1 appraisal done by a new appraiser was also audited. Consent was sought from individual appraisees; none declined. 10 appraisals were audited in total. Results were reviewed and an action plan developed, including:

- Preparation of a comprehensive audit report
- Dissemination of key learning points to all appraisers and appraisees and
- Individualised feedback provided to appraisers

The results demonstrated maintenance of quality of appraisal outputs. This year the average score from the Excellence Tool was higher compared to last year (average score 20/22) indicating a sustained high standard of appraisal documentation.

SARD JV has informed the MAC of its intention to develop its own audit tool, based on the ASPAT, which will be able to automate a lot of the data gathering currently done by this audit. The committee will consider this once it is available, a previous trial of the ASPAT tool in 2019 found that the Excellence Tool still provided better scrutiny of appraisal than ASPAT.

The audit will be repeated annually.

Please refer to **Appendix B.**

5.4. Access, security and confidentiality

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

5.5. Lay participation in medical appraisal

Ivars Reynolds, an experienced member of the Mental Health Managers Review Panels serves as a lay member of the MAC. His background is in social work and performance management.

5.6. Clinical governance

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

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

a position statement on when to repeat MSF exercises following a change of role which the Trust adheres to.

6. Revalidation recommendations

During the last year 10 revalidation recommendations were due; positive recommendations were made for 9 of these (90%), and 1 was deferred (10%).

Deferrals are typically recommended either due to long term sickness or to provide additional time in order to gather further evidence required; such as statutory and mandatory training compliance or completion of a multi-source feedback exercise.

See **Appendix C** for further details.

7. Recruitment and engagement background checks

Recruitment and engagement checks are completed when doctors are first employed at Gloucestershire Health and Care NHS Foundation Trust; they are in line with the Trust's Pre-Employment Checks Policy. All pre-employment checks for substantive doctors are completed before employment is started. These checks include:

- Occupational health clearance, including any night working
- Identity verification
- Qualifications
- Right to work
- Disclosure and Barring Service (DBS) enhanced level checks
- References from two line-managers over the last two years
- Medical Practice Transfer Form (information from previous Medical Director)

Please see **Appendix E**.

8. Monitoring performance

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

- Initial design of job description and person specification
- Effective recruitment and selection processes
- Job planning
- Peer group membership and attendance
- Appraisal
- Monitoring of serious incidents, complaints and compliments
- Participation in supervision
- Activity data
- Participation in continuing professional development (CPD)
- Completion of statutory and mandatory training
- Diary monitoring exercises

- Attendance/sickness absence

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

Please refer to **Appendix D**.

9. Responding to concerns and remediation

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

No doctors are currently in receipt of input within the framework provided by this policy.

Please refer to **Appendix D**.

10. Risk and issues

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

However, the sensitivity of the monitoring system, which allows no latitude in completion date before a doctor is flagged as non-compliant, combined with the limited range of exceptions, mean that rolling compliance rates vary from month to month without appraisal uptake having altered markedly. Exceptions this year are again accounted for mostly by new starters.

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

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

The scope of work that a doctor can undertake is determined by and determines their CPD and continuing medical education (CME) requirements. This does limit practitioner flexibility and cover to specialist areas, a particular issue in relation to on-call rotas and 7 day working.

11. Corrective actions, improvement plan and next steps

The MAC will continue to review its work plan against the terms of reference annually. The Trust Medical Appraisal Policy was reviewed during the appraisal year 21-22. Priorities for the MAC for the next year include ongoing consideration of ways to improve patient and public involvement in appraisal and revalidation processes; further refinement of the number and nature of active qualified medical appraisers within the organisation; and continuing focus on moving beyond compliance towards further quality improvement.

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

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

12. Recommendations

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

- Recognise the support provided to Appraisal and Revalidation within GHC through the use of SARD JV and the engagement of clinicians in this.
- Recognise the work undertaken and planned by the Medical Appraisal Committee to support the work of the Medical Secretariat and Responsible Officer in providing, maintaining and developing sustainable recording, reporting and assurance systems.
- Recognise that snapshot compliance figures do not reflect annual uptake of appraisal but are primarily a function of the way data is collected. In any year the expected outturn is for 100% of doctors with a prescribed connection to this designated body to be appraised; however, there will be exceptions which will reduce the overall figure.
- Appropriate processes are in place for the review of appraisals, appraiser performance, maintenance of appraisal capacity and the quality of appraisals.
- Employment checks are undertaken consistent with national standards and best practice.
- Locum use, whilst significant, is reviewed and regulated, aimed at maintaining clinical provision to cover mostly medium to long term absence.
- To note in particular the assurance in section 13 and for the Chair of the Trust to complete the Statement of Compliance on behalf of the Trust.

13. NHSE Statement of compliance

Section 1 – General

The board/executive management team of Gloucestershire Health and Care NHS Foundation Trust can confirm that:

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

Action from last year: None Comments: Dr Uppal is appointed as Responsible Officer Action for next year: None

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

Action from last year: None Comments: Yes Action for next year: None

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

Action from last year: None Comments: Yes, this is maintained by Medical Director's office Action for next year: None

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

Action from last year: None Comments: The Medical Appraisal Policy was reviewed and aligned for the new merged organisation during appraisal year 21-22 Action for next year: None

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

Action from last year: None Comments: The annual medical appraisal quality assurance audit was conducted in April 2023 for the appraisal year 22-23 by the Medical Appraisal Committee (MAC) Action for next year: The audit is repeated annually by the MAC

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

Action from last year: None Comments: A process is in place and this is actively monitored by the Medical Secretariat Action for next year: Continue with current provision

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: None Comments: Except those where there is an accepted reason agreed by the RO Action for next year: Continue with current practice

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

Action from last year: None Comments: Yes, a full record of non-compliance and reasons for exemption is maintained by the Medical Secretariat Action for next year: Continue with current practice

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

Action from last year: None Comments: Submitted to the board annually Action for next year: Continue with current practice

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

Action from last year: None Comments: Appraiser numbers are regularly monitored by the MAC, and a minimum and maximum number of appraisals per year stipulated for appraisers Action for next year: Continue with current practice

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

Action from last year: None Comments: 10% appraisals audited annually for quality control, plus the first 3 appraisals by any new appraiser. Appraisers are monitored for attendance at update training. Feedback is sought from appraisees and followed up by the MAC chair Action for next year: Continue with current practice

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

Action from last year: None Comments: Annual audit of 10% appraisals, and the first 3 appraisals done by each new appraiser. This considers whether the appraisal has covered (at appropriate depth) scope of work, progress towards previous year's PDP, and a SMART PDP for next year which reflects the trust's aims and objectives. It considers whether appropriate challenge and support has been present, and whether the doctor is on course for successful revalidation. Action for next year: Continue with current practice

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

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	GHC
Total number of doctors with a prescribed connection as at 31 March 2023	106
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	86
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	20
Total number of agreed exceptions	15

Section 3 – Recommendations to the GMC

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

Action from last year: None

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

Action for next year: Continue with current practice

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

Action from last year: None

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

Action for next year: Continue with current practice

Section 4 – Medical governance

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

Action from last year: None

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

Action for next year: Continue with current practice

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

Action from last year: None Comments: A thorough system is in place with the Medical Secretariat Action for next year: Continue with current practice

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

Action from last year: None Comments: A thorough system is in place with the Medical Secretariat and supported by a current responding to concerns policy Action for next year: Continue with current practice

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

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

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

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

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

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

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

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

Section 5 – Employment Checks

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

Action from last year: None Comments: A thorough process is in place within Medical Staffing and HR Action for next year: Continue with current practice

Section 6 – Summary of comments, and overall conclusion

The Medical Appraisal Committee supports the RO and his office by ensuring high quality appraisals for all doctors within the Trust. These systems are now established and repeated annually; they ensure medical governance. Data collection is possible via the SARD JV software, with all doctors using this for appraisal to ensure immediate knowledge of poor compliance. There are no actions outstanding for this report, as the annual reviews will continue to ensure the provision of high-quality appraisals for Trust doctors.

Section 7 – Statement of Compliance:

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

Signed on behalf of the designated body

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

Official name of designated body: Gloucestershire Health and Care NHS Foundation Trust

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

Role: Chair Date: _ _ _ _ _ _ _ _ _ _

Appendix A - Audit of all missed or incomplete appraisals (as of 1st April 2023)

Doctor factors (total)	
Maternity leave during the majority of the 'appraisal due window'	
Sickness absence during the majority of the 'appraisal due window'	2
Prolonged leave during the majority of the 'appraisal due window'	1
Suspension during the majority of the 'appraisal due window'	
New starter within 3 month of appraisal due date	9
New starter more than 3 months from appraisal due date	1
Postponed due to incomplete portfolio/insufficient supporting information	
Appraisal outputs not signed off by doctor within 28 days	
Lack of time of doctor	4
Lack of engagement of doctor	
Other doctor factors	1
Appraiser factors	
Unplanned absence of appraiser	
Appraisal outputs not signed off by appraiser within 28 days	
Lack of time of appraiser	
Other appraiser factors (not known)	
Organisational factors	
Administration or management factors	
Failure of electronic information systems	1
Insufficient numbers of trained appraisers	
Other organisational factors (describe) Waiting for appraisal to be undertaken by different designated body and evidence provided.	1
Total	20
NB. Dentists employed by the Trust are currently subject to different monitoring arrangements and not included in the figures on this page.	

Appendix B - Quality assurance audit of appraisal outputs using the Excellence Tool

		Frequency (% in brackets)		
Number	**Criterion** (following scrutiny of the appraisal summary, score 0-2 for each criteria)	absent	room for improvement	well done
1	Includes whole scope of work?	0	3 (30%)	7 (70%)
2	Free from bias?	0	0	10 (100%)
3	Challenging & supportive?	0	1 (10%)	9 (90%)
4	Exceptions explained?	0	0	10 (100%)
5	Reviews & reflects?	0	0	10 (100%)
6	Review of previous PDP?	1 (10%)	0	9 (90%)
7	Encourages excellence?	0	0	10 (100%)
8	Gaps identified?	0	0	10 (100%)
9	SMART PDP?	0	0	10 (100%)
10	Relevant PDP?	0	0	10 (100%)
11	Form A	8 (80%)	0	2 (20%)

Appendix C - Audit of revalidation recommendations

Revalidation recommendations between 1st April 2022 to 31st March 2023	
Recommendations completed on time (within the GMC recommendation window)	9 (Positive) 1 (Deferral)
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	9 (Positive) 1 (Deferral)
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other – (late due to Staff unplanned absence)	0
Describe other – Trust was in negotiations with Doctor and GMC	0
TOTAL [sum of (late) + (missed)]	0

Appendix D - Audit of concerns about a doctor's practice (1st April 22 to 31st March 23)

Please note this does not include information about dentists.

Concerns about a doctor's practice	High level[4]	Medium level[4]	Low level[4]	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	2	3	0	5
Capability concerns (as the primary category) in the last 12 months	2 - Concerns cover all areas			2 - Concerns cover all areas 3 - Conduct
Conduct concerns (as the primary category) in the last 12 months		3		
Health concerns (as the primary category) in the last 12 months				
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2023 who have undergone formal remediation between 1 April 2022 and 31 March 2023 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*				0
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				2
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				3

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

General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)	0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)	0
Doctors with practising privileges (this is usually for independent healthcare providers; however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)	0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies	0
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	0
TOTALS	5
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	0
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	0
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	0
GMC Actions: Number of doctors who:	
Were referred by the designated body to the GMC between 1 April and 31 March	0

	Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	(1x pre-existing undertakings from 17/18)
	Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
	Had their registration/licence suspended by the GMC between 1 April and 31 March	0
	Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:		
Number of doctors about whom the NHS Resolution (previously NCAS) has been contacted between 1 April and 31 March for advice or for assessment		3
Number of NHS Resolution assessments performed		0

Appendix E - Audit of recruitment and engagement background checks (1st April 2022 to 31st March 2023)

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	10
Temporary employed doctors	7
Temporary employed doctors who became substantive	1
Locums brought in to the designated body through a locum agency	0
Locums brought in to the designated body through 'Staff Bank' arrangements	13
Doctors on Performers Lists	0
Other: Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	0
TOTAL	31

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

NB. MPIT forms from previous designated body

These forms provide information from previous Responsible Officer. We have experienced huge difficulty getting responses to these requests for MPIT forms especially within 1 month of starting; the GMC have been made aware. Plus, this form is not required for all new doctors employed, i.e. trainees who are then appointed, bank staff, those under a different designated body etc.

	Total	Identity check	GMC issues	GMC conditions or	On-going investigatio	DBS	2 references	Last RO	Reference from last	Language competenc	Local conditions or	Qualificatio n check	Revalidatio n due date	Appraisal due date	Unresolved performanc e concerns
Permanent employed doctors	10	10	2	2	2	10	10	10	2	10	2	10	10	2	2
Temporary employed doctors	7	7	1	1	1	7	7	7	1	7	1	7	7	1	1
Temporary employed doctors who became substantive	1	1	1	1	1	1	1	1	n/a	1	1	1	1	1	1
Locums brought in to the designated body through a locum agency	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Locums brought in to the designated body through 'Staff Bank' arrangements	13	13	n/a	n/a	n/a	13	13	n/a	n/a	13	n/a	13	n/a	n/a	n/a

Doctors on Performers Lists	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other (independent contractors, practising privileges, members, registrants, etc.)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	31	31	4	4	4	31	31	18	3	31	4	31	18	4	4

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

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

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

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum days used
Surgery					
Medicine					
Psychiatry	107.7	671	807	0	1498
Obstetrics/Gynaecology					
Accident and Emergency					
Anaesthetics					

Radiology					
Pathology					
Total in designated body (Includes all doctors, not just those with a prescribed connection)	107.7	671	807	0	1498

Number of individual locum attachments by duration of attachment (each contract is a separate 'attachment' even if the same doctor fills more than one contract)	Total	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less	1	1	1	0	0
3 days to one week	2	2	2	0 (remain available for on call shifts)	
1 week to 1 month	0	0	0	0	0
1-3 months	1	1	1	0	0
3-6 months	2	2	2	0 (1 still here)	0
6-12 months	3	3	2	0	0
More than 12 months	5	5	Previously completed	0 (still here)	0
Total	14	14	8	0	0

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28th September 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

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 development – 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 – July and August 2023

Report authorised by: Ingrid Barker	Title: 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 meetings took place on 24th August and 19th September. 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 meeting on 24th August we discussed the verdict in the trial of Lucy Letby and the letter received from NHS England following the trial requesting that NHS Leaders and Boards ensure appropriate oversight and implementation of mechanisms to ensure access to Speaking Up mechanisms and that Boards are regularly reporting, reviewing and acting on available data. Further information on this is provided in the CEOs report.

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

- 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 seven visits across the breadth of Trust services including GRiP Team (Early Intervention in Psychosis), Psychology and Art Therapy, Children's Physiotherapy Service, Diabetes Service, Falls Assessment and Education Service, Assertive Outreach Service, and the School Nursing 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.

- Another crucial part of activity undertaken by Non-Executive Directors is an **audit of complaints** received into the Trust. Audits take place on a quarterly basis and the results are presented within our Quality Dashboard reports received at Trust Board Meetings.

2.2 Trust Board Meetings:

Board Development:

- 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.

- On 24th August we met for a Board Development session focussing on **Measuring What Matters**. This was the follow up to a foundation building Board Development session held in the Summer of 2021. The session re-emphasised the importance of 'Measuring What Matters' to the organisation and the people that may use our services, acknowledging that effective measurement is truly *everyone's business*. Board members discussed the benefits that could be driven from robust data quality, data integration, and digital education. The session explored the opportunities of effective measurement across the organisation, but also discussed the challenges that we may collectively need to overcome.

- On 30th August, a Board seminar took place on **Localisation.** The session, led by the Director of Strategy and Partnerships focussed on the development of a shared vision around the strategic approach the Trust will play across the neighbourhood and locality agenda and the operational delivery model associated with our community physical and mental health teams.

- Following the BBC Panorama Programme on the Edenfield Centre in Prestwich, a Board seminar on **Learning from Edenfield** took place on 12th September. The seminar was led by the Director of Nursing, Therapies & Quality and NTQ colleagues working within the Trust who are actively and positively addressing Closed Culture risks. The seminar focussed on the Trusts work in reducing restrictive practices.

- Following discussion at Trust Board on 27th July, a Board session to discuss the **submission of the system wide Medium-Term Financial Plan (MTFP)** took place on 12th September. This will be further discussed at the Board's private meeting in September for final decision.

3. GOVERNOR UPDATES

- I continue to meet on a regular basis with the **Lead Governor Chris Witham**, and we met on 23rd August along with Director of Corporate Governance & Trust Secretary, Lavinia Rowsell, to discuss agenda planning for the Council of Governors meeting on 20th September.

- A **Council of Governors** meeting took place on 20th September where the Council received an update on the Letby Case. The Council also received updates on the Trust Chair recruitment process, industrial action and a briefing on the Wotton Lawn Hospital Quality Review. Dr Steve Alvis, NED gave a presentation on his role as Chair for the Mental Health Act Managers' Forum as part of the Governor role in Holding the Non-Executive Directors to account. Colleagues from Charlton Lane were also in attendance to provide an update

to our Council on some of the innovative work taking place to reduce Falls across the Trust.

- I attended the Quarterly Staff Governor meeting with NEDs on 5th September and the topic for discussion was the routes in place for receiving and managing patient feedback and concerns within services and the scrutiny of patient experience data. The meeting was well attended by Staff Governors and NEDs.

- Our **programme of visits to sites for Trust Governors** is progressing well with a visit to Wotton Lawn Inpatient Unit taking place on 15th September. 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.

- **Governor changes:** The Terms of Office as **Public Governors** for Dan Brookes and Juanita Paris representing Cheltenham and Tracey Thomas representing Gloucester ended on 6th September after serving three years. The term of Graham Hewitt representing the Cotswolds ended on 31st July after also serving three years. Graham, Dan, Juanita and Tracey were thanked for their contributions to the Council. All four had made a significant contribution, linking us effectively to their community.

- The Trust commenced its **nomination process** for six Public Governor positions on 11th July and following recent elections I am very pleased to welcome David Summers representing Greater England & Wales, Lisa Crooks representing Cheltenham and Peter Gardner representing the Cotswolds. Andrew Cotterill has also joined the Council as an Appointed Governor representing Inclusion Gloucestershire.

  There are two vacant Public Governor positions, one in Gloucester and one in Cheltenham and these roles will be readvertised later in the year.

  I am delighted to advise that **Chris Witham**, Lead Governor, Forest has been successfully re-elected for a second term.

- Although unable to attend myself due to a prior commitment, a meeting of the **Nominations and Remuneration Committee** took place on 6th September. The Committee noted the update on the process and timeline for the recruitment of the Trust Chair.

4. NATIONAL AND REGIONAL MEETINGS

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

- **NHS Confederation Mental Health Chairs' Network** – due to the summer break, meetings were suspended during August and recommenced on 7th September. Meetings take place weekly and I attend when my diary permits which I was able to on 21st September. At this meeting we were joined by the Director of Partnerships and Equality from NHS Confederation who led a session on their anti-racism strategy. Additionally, we were also joined by the Confederation's Head of EDI Communications where we discussed their campaign to address anti-EDI rhetoric.

- On 6th September, at the invitation of **Richard Meddings**, **Chair at NHS England**, the Chief Executive and I attended the NHS England Leadership event in London. Following the verdict in the trial of Lucy Letby, it was an opportunity for Chairs' and Chief Executives' to discuss NHS patient safety strategy priorities and current NHS context on leadership and culture.

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:

- I met with **Matthew Fellows, Chief Executive of Age UK** on 14th August, **Mark Yates, Chair of Herefordshire and Worcestershire Health and Care NHS Trust**, on 15th August and **Gloucestershire Constabulary Deputy Chief Constable Shaun West** on 19th September where we discussed matters of mutual interest.

- On 23rd August, Jan Marriott and I were delighted to accompany **Cllr Allaway-Martin** on a visit to the Forest of Dean hospital site where steady and exciting progress continues. On 22nd September, **Mark Harper MP for the Forest of Dean** made his first visit to the hospital site where he met with Trust colleagues. It was a pleasure to share with Mark ongoing progress and plans to date. During the autumn, Town Councils will also be invited to visit the site and plans are currently in place.

- A meeting of the **Integrated Care Board** took place on 27th September where a number of important operational and strategic issues were discussed. Prior to this, an **ICB Board Development Session** took place which focussed on Children and Young People. The Chief Executive, Vice-Chair, Graham Russell and I were in attendance. Non-Executive Directors were also invited to join the session. A Board Development Session also took place on 30th August.

- On 21st September I joined the virtual **Herefordshire and Worcestershire Health and Care NHS Trust's Annual General Meeting** and on 27th

September I attended the face to face **NHS Gloucestershire Annual General Meeting**.

- As you will see from the NEDs activity report, they continue to represent the Trust on a variety of **ICB Committees** including; the System Audit Committee, System Resources Committee and System Quality Committee. On 15th August I attended the **ICB Remuneration Committee**.

- I continue to meet the with the Chairs of System Partner organisations on a quarterly basis, and individually, to discuss matters of mutual interest. **Dame Gill Morgan, Chair of the NHS Gloucestershire Integrated Care Board** and **Deborah Evans, Chair of the Gloucestershire Hospitals NHS Foundation Trust** met on 17th August.

- On 5th September, Deborah Evans, Professor Jane Cummings, ICB Non-Executive Director and I visited the **Inpatient Wards treating patients with an eating disorder** at Gloucestershire Royal Hospital. We had the opportunity to meet with staff from Paediatrics, Renal and Safeguarding and it was good to understand more about eating disorders and self harm being managed on the wards. We also had the opportunity to meet with the porters who were very impressive in their caring outlook. The visit was facilitated by Matt Holdaway, Chief Nurse and Director of Quality.

- The Trust's **Annual Informal meeting with Gloucestershire County Council's Health Overview Scrutiny Committee (HOSC)** took place in person on 26th September at Wotton Lawn Hospital and was an opportunity to focus on the delivery of mental health services and to respond to member questions.

6. WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

- As the development of the new Forest of Dean hospital continues to take shape, the Chief Executive, Director of Strategy and Partnerships and I attended the **Forest Health Forum** on 5th September where we shared information on the next steps in the transition plan to the new hospital. More information can be found in the Chief Executive's report.

- On 13th September, the Director of Strategy and Partnerships and I met with **John Thurston**, **Chair of Lydney Hospital League of Friends** where we discussed x-ray provision at the new Forest of Dean hospital.

- Marcia Gallagher, Non-Executive Director and the Director of Finance and Deputy Chief Executive held a quarterly meeting with the **Chairs of the County's Leagues of Friends** on 6th September. 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. The next meeting will be held in December.

- I had the pleasure of attending the **Volunteer and Experts by Experience Thank You Tea Party Celebration** on 7th September. The tea party was an

opportunity to thank our dedicated Volunteers and Experts by Experience for the valuable contribution they make to our services.

- Regular briefings with the county's MPs continue. I met with **Sir Geoffrey Clifton Brown, MP for the Cotswolds** on 1 September, **Alex Chalk, MP for Cheltenham** on 8th September and **Mark Harper, MP for the Forest of Dean** on 22nd September.

- The **Trust's AGM** took place on 13th September. This was a virtual event which provided a review of last year and an account of our quality and financial position as well as a review by our Lead Governor, Chris Witham. There was an opportunity to ask questions of the Council of Governors and the Board.

7. ENGAGING WITH OUR TRUST COLLEAGUES

- On 24th August I met with the Director of Strategy and Partnerships where I received an update on **Community Mental Health Transformation Programme**.

- I met informally with **Brad Watkins**, **Modern Matron** at **Charlton Lane Hospital** on 31st August and visited Willow Ward. It was a pleasure to meet Brad and Trust colleagues and talk with some of our patients.

- I carried out a very interesting **quality visit** on 20th September with Cathie Hole, Community Services Manager and Clinical Lead for the south locality from the Assertive Outreach Team. I spent time in discussion with Cathie and her team who are based at Weavers Croft in Stroud.

- On 13th September, I met with **Hannah Williams, Deputy Director of Nursing Therapies and Quality** where we discussed Non-Executive Director quality visits and also arrangements for the joint Chair's visit on End of Life Care which is scheduled to take place in December.

- I continue to attend the Trust's Committees on a rotational basis and I regularly attend the **Working Together Advisory Committee**. I attended the **Resources Committee** on 31st August, and the **Quality Committee** on 7th September.

- I chaired a meeting of the **Appointments and Terms of Service Committee** which took place on 19th September to agree on next steps in recruiting to the Director of Nursing, Therapies and Quality role in the light of John Trevains' resignation.

- 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.

- I attended the **Mental Health Act Managers' Forum** on 26th September.

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

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

8. GOVERNANCE CHANGES

- **Fit and Proper Person Regulations**
  In August, NHS England published a new Fit and Proper Persons Test (FPPT) Framework and associated guidance. The framework sets out new checks and balances required by NHS organisations to ensure board members are fit and proper to be NHS directors. It applies to both executive and non-executive directors.

  NHS provider trust chairs are responsible for ensuring this framework is implemented effectively. We will be working through this to ensure the full framework is implemented by the 21 March 2024 deadline noting that some elements take effect from 30 September

  While the FPPT checks that are currently required remain in place, the new framework introduces a standardised board member reference and the recording of FPPT checks as part of an individual's Electronic Staff Record (ESR).

  Other key points include:
  - The FPPT is now clearly situated within the range of measures organisations take to assure themselves of their board members' ongoing effectiveness, including appraisal processes, effective recruitment, and board development
  - ICB, CQC and NHSE board members are now also required to comply with FPPT for the first time
  - New data processing and internal processes for dispute resolution may be required

  NHSE says the impact of the new framework will be reviewed in 18 months and we would encourage you to share any questions or concerns with us in the interim to pass on to NHSE.

9. 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 July and August 2023.

10. CONCLUSION AND RECOMMENDATIONS

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

Appendix 1

Non-Executive Director – Summary of Activity 1st July – 31st August 2023

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Dr Stephen Alvis	1:1 with CEO Council of Governors Development Session Meeting with Hannah Williams and Marcia Gallagher regarding quality visit to Complex Leg Wound Service Non-Executive Directors Meeting Non-Executive Directors Meeting Senior Leadership Network Meeting	Good Governance Institute Webinar NHS Confederation Chairs Group Meeting	ATOS Committee Board Development Strategic Away Day Board Development: Measuring What Matters Board Discussion: Chair Recruitment Process Board Seminar: Localisation MHLS Committee Quality Committee Trust Board: Private Trust Board: Public
Steve Brittan	Clinical System Vision preparation Clinical System Vision Programme meeting Council of Governors Meeting Development Session NEDs Meeting NEDs visit to new FoD hospital Non-Executive Directors Meeting Quality visit to CYPS Speech and Language Service Resources Committee Agenda Planning Meeting Senior Leadership Network Meeting		ATOS Committee Audit and Assurance Committee Board Development: Measuring What Matters Board Discussion: Chair Recruitment Process Resources Committee Trust Board: Private Trust Board: Public

Marcia Gallagher	1:1 with Chair Chair Recruitment – County Council CEO Meeting Chair Recruitment – Director of HR & OD/Director of Corporate Governance Chair Recruitment – GHNHSFT Chair Meeting Chair Recruitment – ICB Chair Meeting Chair Recruitment – Regional Director Meeting Council of Governors Development Session H&S and Security Management Team Meeting Introduction meeting with CEO Meeting with Chair and Vice Chair Meeting with Cllr Andrew Gravells regarding Chair recruitment Meeting with Dr Atkinson regarding Chair recruitment Meeting with GDoc Chair regarding Chair recruitment Meeting with Hannah Williams and Dr Steve Alvis regarding quality visit to Complex Leg Wound Service Meeting with Head of Counter Fraud Meeting with Matt Lenard VCS regarding Chair recruitment NEDs visit to new FoD hospital Non-Executive Directors Meeting Non-Executive Directors Meeting Quality visit to Falls Assessment Service Women's Leadership Network	NHS 75th Opening ParkRun at Mallards Pike	ATOS Committee Audit and Assurance Committee Board Development Strategic Away Day Board Development: Measuring What Matters Board Discussion: Chair Recruitment Process Board Seminar: Localisation Quality Committee Trust Board: Private Trust Board: Public

Sumita Hutchison	Diversity Network Agenda discussion Introduction meeting with CEO Non-Executive Directors Meeting		Board Development Strategic Away Day Board Development: Measuring What Matters Board Discussion: Chair Recruitment Process Board Seminar: Localisation Great Place to Work Committee Trust Board: Private Trust Board: Public
Jan Marriott	1:1 FTSU Guardian 1:1 with CEO 1:1 with Chair 1:1 with Colleague 1:1 with Director of Nursing, Therapies & Quality 1:1 with Lee Charlton Governors Visit ICB CNO Interview Focus Group ICB System Quality Committee Workshop New FoD Hospital Site Visit Non-Executive Directors Meeting Non-Executive Directors Meeting Quality Assurance Group		ATOS Committee Board Development Strategic Away Day Board Development: Measuring What Matters Board Discussion: Chair Recruitment Process Board Seminar: Localisation Quality Committee Working Together Advisory Committee

Graham Russell	1:1 with Chair 1:1 with Chair 1:1 with Neil Savage 1:1 with Vicci Livingstone Thompson Council of Governors Development Session ICB Board ICB Neighbourhood Transformation Committee ICB Neighbourhood Transformation Committee Pre-Meet ICB Public Board Meeting ICB Transforming Neighbourhoods meet Introduction meeting with CEO Meeting with Chair and Vice Chair Meeting with Matt Lennard and Vicci Livingstone-Thompson NEDs Meeting NEDs visit to new FoD hospital Non-Executive Directors Meeting Quality Visit to Diabetes Service Visit to SW Ambulance Trust Working together Advisory committee		ATOS Committee Audit & Assurance Committee Board Development Strategic Away Day Board Development: Measuring What Matters Board Discussion: Chair Recruitment Process Board Seminar: Localisation Great Place to Work Committee Trust Board: Private Trust Board: Public
Nicola de longh	Council of Governors Development session Interview panel for Consultant Inpatient Recovery post NEDs visit to new FoD hospital Non-Executive Directors Meeting Pre-meet for Consultant Interview Inpatient Recovery Quality visit to GRiP Team (Early Intervention in Psychosis) Quarterly 1:1 with Chair		Board Development Strategic Away Day Board Discussion: Chair Recruitment Process Board Seminar: Localisation Great Place to Work Committee Resources Committee Trust Board: Private Trust Board: Public

Vicci Livingstone-Thompson	Council of Governors Meeting ICS Volunteer Network Meeting Informal visit to Dental Services Informal visits to Charlton Lane Hospital, Dental Services and CLDT Introduction meeting with Amjad Uppal Introduction Meeting with CEO Introduction meeting with David Noyes Introduction meeting with Helen Goodey Introduction Meeting with John Trevains Introduction meeting with Lavinia Rowsell Introduction meeting with Neil Savage Meeting with Anna Hilditch regarding Appointed Governor role NEDs visit to new FoD hospital Non-Executive Directors Meeting Pre-meet with Graham Russell ahead of GPTW Committee Quality visit to CYPS Speech and Language Service		Board Development Strategic Away Day Board Discussion: Chair Recruitment Process Great Place to Work Committee Resources Committee Trust Board: Private Trust Board: Public

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NHS Foundation Trust

AGENDA ITEM: 13/0923

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 September 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
- Verdict in the Trial of Lucy Letby
- Right Care, Right Person
- RAAC

Risks associated with meeting the Trust's values

None identified

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

Where has this issue been discussed before?
N/A

Appendices:	Report attached

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

CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM REPORT

1.0 CHIEF EXECUTIVE OVERVIEW

1.1 Chief Executive – Service/Team Visits

I have continued to carry out service visits, team meetings and to 'hot desk' from different sites. I have welcomed the opportunity to meet with colleagues, learn about their roles and understand any of the challenges facing their service areas. My visits since the last Board meeting have included:

- Southgate Moorings
- Lydney Hospital
- Vale Community Hospital
- New Forest of Dean Hospital
- Colliers Court

1.2 Update on industrial action

Due to industrial action by junior doctors and consultants of the British Medical Association during August and September, 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.

The BMA industrial action from 19th to 21st September (Consultant Doctors) and 20th to 23rd September (Junior Doctors) resulted in a lengthy closure of Cheltenham Emergency Department from 8pm on Monday 18th until 8am on Saturday 23rd. Emergency care services (A&E) were centralised at Gloucestershire Royal Hospital during this period.

Through periods of industrial action, the public were strongly advised only to attend A&E at Gloucester if their condition was serious or life-threatening and were encouraged to use alternative provision such as 111.nhs.uk in the first instance or call NHS 111.

Whilst the Gloucestershire NHS implemented contingency plans to ensure essential services remained available, regrettably the strikes caused unavoidable disruption and patients experienced cancellations to planned outpatient appointments, procedures and operations. GP practices and other Community Minor Injury and Illness Units across the county continued to provide services throughout the periods of industrial action.

Thank you to everyone involved in helping to plan our contingencies, as well as all those working additional shifts or working hard to rearrange appointments.

1.3 Director of Nursing, Therapies and Quality

Our Director of Nursing, Therapies and Quality, John Trevains, has taken the decision to leave the Trust next year. We will begin the process to recruit a replacement in the near future and will provide further updates in due course.

On behalf of the Board, I would like to thank John for his hard work and dedication over the last five years and his huge contribution not only to our Trust but also to the NHS in Gloucestershire.

1.4 Wotton Lawn Media Reports

Since the last Board meeting there has been further media coverage relating to Wotton Lawn Hospital and in particular the introduction of the new policing approach to attending mental health incidents – Right Care, Right Person. Both BBC online and BBC Radio Gloucestershire featured a patient who expressed concerns about the new policing approach, and how this may compromise safety for people in mental health crisis.

John Trevains took part in an interview for BBC Radio Gloucestershire and we issued a statement, which explained that we are working with the police on Right Care, Right Person and that patient safety and wellbeing was paramount in any discussions. Further information can be found at paragraph 6 of this report.

1.5 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 Know Your Numbers Week – 4th to 10th September

The NHS in Gloucestershire supported **Know Your Numbers! Week** from 4th to 10th September, an annual campaign led by charity Blood Pressure UK, with a series of health check drop-in events where people can get their blood pressure checked.

One Gloucestershire's Information Bus and the Outreach Vaccination and Health Team, with support from Gloucestershire's Healthy Lifestyles Service, was out and about every day at locations across the county offering blood pressure and simple health checks at community venues. I was pleased to be able to pay a visit to the info bus in Gloucester City Centre to have my blood pressure checked. The team were on hand to chat with members of the public about how to make positive changes to their health or wellbeing and get further support if needed.

2.2 Community Mental Health Transformation

The Locality Community Partnership forums have now commenced in the Forest of Dean, Tewkesbury and Gloucester City and discussions are taking place across the Integrated Locality Partnerships for the roll out into the remaining 3 localities to meet the anticipated timeline below. We therefore remain on track to achieve countywide coverage by the end of the financial year, but there will still be considerable work to do to embed and transition the new models into our business as usual service delivery across 2024/25.

LCP	LCP Go Live	Transition to BAU
FoD & TWNS	May 2023	December 2023
Glos City	August 2023	March 2024
Stroud	December 2023	April 2024
Cheltenham	February 2024	July 2024
Cotswolds	March 2024	September 2024

2.3 Urgent Care Transformation Programme – Working as One

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. It will be called the 'Working as One' programme.

The UEC transformation programme has commenced soft launch, with workstreams initially focussing on gathering up to date data, setting up governance and identifying the programme leadership resources. Cross system representation is in place on all key workstreams to ensure a joined-up approach, with senior sponsorship provided by system Chief Executives. I am acting as sponsor for the 'Hospital Flow and Decision Making' workstream, and have been part of 'kick off' sessions in the last month to agree the scope and priorities within this stream.

2.4 ICB Board Meetings

Gloucestershire ICB is holding a Board Development session on 27th September which will be attended by the Chair, Ingrid Barker, Vice-Chair, Graham Russell, and I along with key individuals from our operational services and experts by experience. The session is focusing on Children and Young People services in Gloucestershire. Feedback will be given at the Board meeting itself, as it should be a useful opportunity for system partners, including education, social care, voluntary sector and NHS organisations, to discuss and agree the strategic priorities for children and young people over the coming years.

The NHS Gloucestershire ICB Confidential and Public Board Meeting and Annual General Meeting are being held on the same day. The papers for the

Public Board meeting can be located on their website - Board Meetings: NHS Gloucestershire ICB (nhsglos.nhs.uk)

2.5 Gloucestershire Children's Safeguarding Joint Inspection

Inspectors from Ofsted, the Care Quality Commission (CQC) and His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) have completed their report relating to a Joint inspection conducted of the county council, police and NHS in June 2023. It considered the county's response to the identification of initial need and risk (often referred to as the 'front door') and praised the strength of Gloucestershire's strategic partnership between all agencies and the mature relationships and effective governance in the Gloucestershire Safeguarding Children's Partnership (GSCP).

The Trust plays an active role in the Multi-Agency Safeguarding Hub (MASH), or 'front door,' an area which was highlighted as a key strength of the partnership. This forum promotes effective partnership working where information on the current impact of risks to children is shared and next steps are identified and considered, including who is best to work with children and their families.

It is recognised that steps are being taken to make progress in the areas that inspectors found needed improvement including the efficiency of partner recording systems, the consistent use of police vulnerability screening tools and making sure children's voices are used to inform decisions across all partner agencies.

2.6 New Forest of Dean Hospital

With building work on the new Forest of Dean Community Hospital nearing completion we are now preparing for the relocation of colleagues and their services from Lydney and Dilke Hospitals to the new site in Cinderford.

This is a complex move and there will be unavoidable disruption to each of our services, although we will do all we can to minimise the impact on patients and service users.

We expect handover of the new building from the contractor in January 2024. It will take around eight weeks for cleaning, IT installation and other work. We will then take a phased approach to transitioning and moving services into the new building which will include the reduction of inpatient beds from 47 to the planned 24 with the beds consolidating at the Dilke Hospital for a short period of time prior to moving into the new hospital. We

expect the hospital to begin to open to patients around 10 weeks after handover and for the majority of moves to be complete after 14 weeks.

3.0 EVENTS

3.1 Inclusion Month Bring and Share

On 12th September our Race and Cultural Awareness Network members held a **Bring and Share lunch** at Edward Jenner Court to mark **Inclusion Month** and in preparation for Black History Month, celebrated in October.

The lunch was open to all colleagues to join and everyone was invited to bring hot and cold snacks, cakes, drinks, bakes and other local and international speciality food to celebrate the diverse cultures working within our Trust. It provided an excellent opportunity to meet with colleagues and hear more about individual's stories, backgrounds and cultures. I particularly enjoyed the opportunity to 'graze' on wide variety of different foods.

The aim of the lunch was to raise awareness of how diverse our organisation is, the importance of belonging, inclusion, and get to know each other and the celebrations of the many cultures that exist in GHC.

3.2 Volunteer and Expert by Experience Thank You Tea Party Celebration

On 7th September a Tea Party Celebration was held at Bowden Hall Hotel to thank our Volunteers and Experts by Experience for their continued support to patients, carers, GHC Colleagues and visitors. They support our services in a wide range of roles, from patient befrienders to volunteer gardeners, quality improvement to transformation projects.

The event was hosted by our Chair, Ingrid Barker, and provided an opportunity for to mark the NHS75 anniversary, celebrate together and to look forward to the new opportunities and way people can be involved in our Trust. We also heard some inspirational reflections on the impact that volunteers, experts by experience and peer support workers are having.

It was a real privilege to meet the people who give up their time freely to help our Trust and the people we serve - they deserve all the thanks they were given during the afternoon. We are very grateful and proud to have them as part of our team.

3.3 National Trust Chairs and Chief Executives Event

On 6th September the Chair, Ingrid Barker, and I attended an **NHS England Trust Chairs and Chief Executives Event** in London. The event, which was originally scheduled for ICB and Trust Chairs, was refocussed by Amanda Pritchard, NHS Chief Executive, to allow a collective discussion, with Chairs and Chief Executives, following the recent **Lucy Letby verdict** and the complex issues it raises. It was a welcome opportunity to reflect on the potential implications and impact of this case and the forthcoming inquiry, together**.**

Further information on the Lucy Letby verdict is provided at paragraph 5 of this report.

4.0 ACHIEVEMENTS / AWARDS

4.1 Apprenticeships

Congratulations to the following learners who have all recently completed their Level 3 Healthcare Support Worker apprenticeships with **distinction**:

- Lucy Minshall
- Sharon Smith
- Simmone Peart
- Nicola Pollart
- Nicky Pollard

Congratulations to the following learners who have recently completed their Podiatry Degree apprentices with a **2:1**:

- Faith Cox
- Rebekah Sutton

4.2 Electronic Document Management System

The Trust is in the process of implementing a new electronic document management system (EDMS). The first phase of this process involved the digitising of RiO (our electronic health records system) documents and paper mental health records. This has required the scanning and digitising of more than 300,000 paper mental health records, for storage within the CITO health records management system. For the past 19 months the EDMS team, based at Rikenel, has been busy scanning 15,000 boxes of records and they are pleased to report they have now finished. Well done and thank you to the team for all their hard work.

4.3 Health Service Journal (HSJ) Awards

NHS Race Equality Award

A joint NHS community project in Gloucestershire to tackle health inequalities has been shortlisted for a national award. The project is a partnership between Gloucestershire Hospitals NHS Foundation Trust (GHFT) Community Outreach Team and our Complex Care at Home Team, and funded by the Cheltenham and Gloucester Hospitals Charity.

The team has been shortlisted for the NHS Race Equality Award, one of HSJ's 2023 awards, because of their work in tackling health inequalities within ethnic communities and in promoting equality and inclusion.

Within the first 12 months, almost 17,000 local people have been engaged by the community outreach team, including health and wellbeing checks, signposting services, providing information in a range of languages, identifying barriers to accessing care and helping to reduce the number of people needed to access emergency services. Nine outreach workers have been funded by the charity through the project, all from ethnic minority backgrounds who speak languages including Gujarati, Urdu, Malayalam, Tamil, Sinhala and Spanish allowing them to communicate and build strong links with the community in and around Gloucestershire.

Deteriorating Patients and Rapid Response Initiative

A trust project received a high commendation in the annual HSJ Patient Safety awards. The team was shortlisted in the Deteriorating Patients and Rapid Response Initiative of the Year category for their project titled "Integrated community team therapists identifying the deteriorating patient in the home setting".

Therapists in ICTs were taught how to take baseline clinical observations during their community visits to patients at home using appropriate clinical equipment and then to communicate findings to their medical colleagues across the system including Rapid Response and GPs.

Results showed a huge increase in the confidence of therapists visiting deteriorating patients at home following competence-based training and patients now have less time to wait at home when they are deteriorating waiting for a clinical decision to be made in support of their onward care. Appropriate patients can now get the medical care they need in a timelier fashion and better patient outcomes and safety have been achieved as a result.

Last year the project group was asked to present at the prestigious Bristol Patient Safety Conference before being submitted for HSJ Awards this year.

4.4 Clinical Research Network Annual 2023 Awards

The Stroke team at Vale Hospital and research colleagues at GHC and GHFT were joint-winners at last night's Clinical Research Network Annual 2023 Awards in the Collaboration in Research category for ensuring stroke patients along the whole of their pathway can contribute and benefit from research.

The RECREATE Team was recognised for breaking down barriers between two organisations so that research mirrors the patient pathway and ensures that more Stroke patients have the opportunity to take part in the study. It was a shared award with the West of England Regional Team's Harmony Study.

By embodying an ethos of collaboration and team-working, team members were able to gain significant development opportunities with the support of the depth of experience across both organisations. This purposeful collaborative endeavour led to the recruitment of 37 patients and 15 carers, making Gloucestershire the top recruitment site for two months in a row.

4.5 Internationally Educated Nurses (IEN)

Congratulations to all the Internationally Educated Nurses (IENs) who have passed the Nursing and Midwifery Council's test of competence (called the OSCE) to become a registered nurse.

A special well done to Edith Damptey on being our Trust's first IEN to receive the IEN Working Together Award and to Achilles Dadole, an IEN who has recently been promoted to a band 6 role within the Trust.

NHS Pastoral Care Quality Award

We are pleased to announce the Trust has been awarded the NHS Pastoral Care Quality Award. This award recognises our trust's work in international recruitment and our commitment to providing high-quality pastoral care to internationally educated nurses and midwives during recruitment processes and their employment.

On behalf of the Board, I would like to thank all our colleagues who have contributed to this achievement.

5.0 NHS OVERSIGHT FRAMEWORK QUARTER 1 – 2023/24 SEGMENTATION REVIEW

During August NHS England and the ICB undertook a detailed Quarter 1 review against the six themes in the framework, with the findings and recommendations being presented to NHS England's South West Regional Support Group (RSG).

GHC was assessed as being in segment 2 for Quarter 1 2023/24. It was reported that overall, the Trust has demonstrated a strong position across several metrics, particularly Quality, Finance (except agency spend) and Workforce. The mental health challenges identified in Quarter 4 have also improved significantly, with all three metrics now considered as individual segment 1.

Work continues between NHS England and the ICB, in collaboration with the Trust, to identify steps required to move towards an overall segment 1 position.

6.0 VERDICT IN THE TRIAL OF LUCY LETBY

Everyone has been shocked and deeply saddened by the appalling crimes committed by Lucy Letby. Our thoughts are with all of those who have been directly affected by these crimes.

The Department of Health and Social Care has announced an independent inquiry into the events at the Countess of Chester. Whilst waiting for the outcome of this, reviews and reflections in the Trust Board and leadership team have commenced to address the immediate lessons. The Trust has reinforced messages about the importance of everyone feeling able to raise concerns and for concerns to be listened to and understood, as well as the fact that everyone has a part to play in helping to ensure that these types of situations do not occur.

In our Trust we have a number of ways in which staff are supported to do this:

- Freedom to Speak Up Guardian, Sonia Pearcey, can provide an independent, confidential space to talk about unsafe patient care, unsafe working conditions, bullying and harassment, cultural concerns, dignity at work and a lack of, or poor, response to a reported patient safety incident.
- Safeguarding Team can offer supervision, training and advice via the safeguarding advice line.
- Chief Executive, anonymously if preferred, can be contacted through the Direct to Douglas app.
- Trust managers, including line managers and Service Directors, as well as other senior leaders such as Trust Executives
- Professional bodies and/or unions
- Care Quality Commission - Report a concern if you are a member of staff (cqc.org.uk)

NHS England have written to all NHS organisations to request that leaders and Boards have ensured:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.
4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

The Trust is committed to continually seeking to improve patient safety and to have as many ways of preventing and detecting issues of concern. Our Trust Board and Executive team have reviewed and implemented the requirements to date and will respond to the findings of the independent inquiry to ensure every possible lesson is learned.

7.0 RIGHT CARE, RIGHT PERSON

At the end of August, NHS Gloucestershire, Gloucestershire Health and Care and Gloucestershire Constabulary issued a joint briefing on the new initiative, **Right Care, Right Person,** which will change the way police and health partners respond to mental health emergencies in the future.

Right Care, Right Person started as an initiative in Humberside to reduce policing time spent responding to:

- Concerns for Welfare
- Walkout of Health Care facilities
- Transport to Mental Health provision (i.e. s136 Place of Safety Facilities)
- Absent Without Leave from Mental Health units

'Right Care Right Person' (RCRP) has now developed into a national strategy. Gloucestershire Constabulary have indicated they will be adopting RCRP, working in close partnership with health and care agencies to create a joint approach.

The NHS in Gloucestershire is committed to working alongside the emergency services to make sure anyone with urgent and emergency mental health needs can be treated safely and compassionately. Ensuring those suffering from acute (sudden and serious) mental illness and crisis in Gloucestershire can access the care they need promptly and in the right place is the focus of our approach which is supported by teams across healthcare and partner organisations.

Working in partnership with Gloucestershire Constabulary is an important part of the way we support different types of mental health crisis or emergency need. Patients and their families can access emergency support in a number of ways including:

- Crisis line – 0800 169 0398 open 24 hours a day, seven days a week
- Visit www.ghc.nhs.uk/crisis
- If there is an immediate danger to life dial 999 or attend A&E.

Gloucestershire already has a strong track record of joint working between police and NHS services, to support those facing a mental health crisis or who need acute emergency care. This includes:

- A joint working group (Inter-Agency Monitoring Group) which involves professionals from mental health services, the police, the voluntary and community sector, local councils and other areas of the NHS. This group oversees some of the joint projects aimed at supporting those in crisis.
- A specialist NHS mental health team operating out of Gloucestershire Constabulary's Waterwells HQ and a Mental Health Rapid Respond

vehicle. This allows health professionals to treat those in crisis quickly and means those in need of emergency care can access it in a safe environment.

- A mental health response desk, staffed by South Western Ambulance Service and funded by NHS Gloucestershire to take mental health calls and ensure those in crisis can access treatment quickly.

The police are sometimes called to attend incidents where a person is experiencing an acute mental health crisis. This is often to protect public safety, or the safety of the person themselves, or to prevent a crime. For example, someone may be at risk of coming to physical harm, property may be damaged or access to an area needs to be restricted. Officers work alongside paramedics and medical professionals to ensure the safety of the public and the person in crisis.

In certain circumstances it may be necessary for the police to detain a person under the Mental Health Act (section 136) if they meet certain criteria. The purpose of this is for the person to be assessed. This assessment is carried out by an Approved Mental Health professional and two Doctors who are approved under Section 12 of the Mental Health Act. In Gloucestershire this is normally carried out at the Maxwell Centre which is on the Wotton Lawn Hospital site.

What will change with the introduction of Right Care, Right Person?
At the moment, discussions are still ongoing between Gloucestershire Police and local health partners. Any changes will be fully agreed by all partners to ensure a safe transition into any new arrangements and these will be shared in due course.

Our commitment to providing joined up support for those in need of crisis care will not change and we will continue to treat people in a safe, compassionate and appropriate way.

8.0 REINFORCED AUTOCLAVED AERATED CONCRETE (RAAC)

NHS England have written to Trusts following the new guidance published earlier this month by the Department for Education regarding the approach to the presence of RAAC in the school estate, which has also generated heightened public interest in the presence of RAAC in the NHS estate. NHS England have asked Trusts to assess their estate again based on this updated guidance.

Initial assessments undertaken by our Estates & Facilities team have found no evidence of RAAC in any of our premises.

For further assurance, the Trust has appointed a structural engineer to undertake building surveys where deemed necessary and has contacted the relevant landlords to seek their assurance (where the buildings are not our direct responsibility). NHS Property Services, our landlord for a number of properties, have already provided assurance that RAAC is not present in any of their Gloucestershire estate.

9.0 CONCLUSION AND RECOMMENDATIONS

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

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AGENDA ITEM: 14/0923

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 September 2023**

PRESENTED BY: Lavinia Rowsell – Director of Corporate Governance

AUTHOR: Lavinia Rowsell – Director of Corporate Governance

SUBJECT: **PROPOSED RISK APPETITE STATEMENT**

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 present to the Board for approval the Trust's Risk Appetite Statement which has been updated following the Board Risk Appetite session held on 7 June 2023.

Recommendations and decisions required

On the recommendation of the Audit and Assurance Committee, the Board is asked to a**pprove** the revised Risk Appetite Statement for the Trust.

Executive summary

Risk appetite can be summarised as the amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategic objectives.

The revised Risk Appetite statement for the Trust has been produced to reflect the outcome of discussions at the Board Risk session held on 7 June 2023. It reflects a more simplified approach to previous statements that should allow it to be more easily applied throughout the organisation. The statement has been reviewed by the Executive Team and endorsed by the Audit and Assurance Committee at its meeting in August for presentation to the Board.

Risks associated with meeting the Trust's values
Report is focused on all elements of strategic risk and the risk management process.

Corporate Considerations	
Quality Implications	Set out within the detail of the BAF actions and mitigations
Resource Implications	Set out within the detail of the BAF actions and mitigations
Equality Implications	Set out within the detail of the BAF actions and mitigations

Where has this issue been discussed before?
Board Risk Session – June 20223 Executive Team – July 2023 Audit and Assurance Committee – August 2023

Appendices:	**Appendix 1** (Page 5) Draft risk appetite statement, tolerance levels and definitions

Report authorised by:	Title:
Lavinia Rowell	Director of Corporate Governance and Trust Secretary

PROPOSED TRUST RISK APPETITE STATEMENT

1.0 INTRODUCTION

Risk Management provides a holistic way for an organisation to consider the challenges and opportunities it faces and supports the Board in considering them strategically and avoiding being drawn into operational issues. It also allows a Board to consider where it will expend more focus to achieve its strategic goals. It should be seen as a key enabler to support a Board in achieving its purpose.

The Board had an externally facilitated Risk Appetite session on 7th June 2023 which considered a risk appetite and risk tolerance level for each of the Trust's existing strategic risks. Initial consideration was also given to feedback from questionnaires completed prior to the event in relation to the current and future strategic risks facing the Trust and the appropriate oversight, reporting and decision making in relation to strategic risks.

The Risk Appetite Statement is a core driver of the Risk Management process within an organisation, enabling the Board to assess where focus should be applied, and enabling a Board to reflect on the appropriate timing for review of risks, recognising some risks are more critical than others, and that for some risks an organisation will have more control over the mitigations which can be put in place to manage impact.

The session involved consideration of a framework which used different terminology to describe the appetite level that currently in use in the Trust. It was agreed that the process rather than the language was key and therefore in the draft Risk Appetite Statement the terminology continues to be the terminology which has been used at the Trust since merger. Recognising that a key element of the risk appetite process was to support colleagues in assessing risk through the organisation it was considered that the current terminology was well known and that there would not be a significant benefit in changing it, particularly as the suggested alternative terminology was not felt by Board members to be sufficiently clear. Within **Appendix 1 - Appetite Level Descriptors** the current terminology is used, with the terminology used within the session provided in brackets.

2. NEXT STEPS

Governance reporting arrangements will be updated to reflect the revised appetite and tolerance levels for each of the risk themes as set out in **Appendix 1** (Table 2). Committees will continue to see those risks with a risk score of 12 but in addition will see those risks which are outside their agreed risk appetite.

The main change will be that there will be increased Governance Committee oversight of those risks relating to *Compliance and Regulation* and *Information Security (Cyber and Info Gov)* where the Board had a lower appetite and tolerance for risks in these areas. These risks are overseen by the Audit and Assurance Committee.

The Trust's risk management framework will be updated to reflect the revised statement which will then be disseminated throughout the organisation.

The revised risk appetite statement will be taken into account when updating the Board Assurance Framework (BAF).

3. RECOMMENDATIONS

The Board is asked to **APPROVE** the revised Risk Appetite Statement for the Trust.

APPENDIX 1

RISK APPETITE STATEMENT AND DESCRIPTORS

1. RISK APPETITE STATEMENT 2023

The purpose of the Risk Appetite Statement is to inform all those responsible for identifying and managing risk at GHC of the context to use when assessing how a risk should be evaluated.

The risk appetite, set by the Board of Gloucestershire Health and Care NHS Foundation Trust is necessarily more open than in previous years. This reflects the unprecedented challenges that the NHS has, and is, experiencing, the healthcare reforms taking place at national and local levels, the pace of societal and technological changes and the ongoing climate emergency. During this time of change and uncertainty we will continue to protect the Quality and Safety of Care and minimise risks that may have a detrimental effect on the Service User Experience and the experience of those supporting them (classified as a moderate risk appetite).

In relation to Meeting Population Needs and Finance we will continue to have a moderate risk appetite, enabling us to explore opportunities whilst ensuring the breadth and importance of these areas is subject to sufficient oversight.

We acknowledge that service capacity continues to be a challenge across our healthcare system. Transforming services to ensure their future sustainability will require changes in staffing models and an agile, resilient workforce. We will support our people to adapt and thrive during change. Investment decisions will reflect our ambition to provide outstanding physical and mental health care services for the people of Gloucestershire, putting the person at the heart of our services focusing on *personalised care* from the perspective of '*what matters to you'* rather than '*what is the matter with you'*.

To achieve our aims of providing outstanding physical and mental health care, we have a high-risk appetite in our approach to Innovation; Partnership and Collaborative Working and Workforce. We will seek the opportunities that healthcare reform may present; we have a keen desire to take a leading role in the collaborative arena and implement new ways of working through a range of partnerships. The digital agenda will underpin innovation and the transformation of services to become more efficient and effective. Whilst we are prepared to accept higher levels of risk to implement changes for longer term benefit, we have a low appetite in relation to Information Security and Compliance.

The Risk Appetite Statement provides the Board's appetite for risk taking and tolerances and is mapped against the Strategic Priorities. This clear understanding of

the Board's tolerances and appetite for risk taking is necessary to steer and influence the development of appropriate risk mitigation controls.

The Risk Appetite Statement does not negate the opportunity to potentially make decisions that result in risk taking that is outside of the risk appetite. Where this is the case, it is proposed that these decisions will be referred to the Board.

The Risk Appetite Statement was approved by the Board on 29 September 2023 (TBC).

2. Proposed Risk Appetite Table

Risk Theme	Appetite Level	Tolerance	Reporting Impact
Quality and Safety of Care & Service User Experience	Moderate	10	11 and up
Research and Innovation	High	12	13 and up
Meeting Population Needs	Moderate	10	11 and up
Partnership and Collaboration	High	12	13 and up
Workforce	High	12	13 and up
Finance	Moderate	10	11 and up
Compliance and Regulation	Low	6	7 and up
Information Security (Cyber & Info Gov)	Low	6	7 and up

3. Risk Appetite Descriptors

Appetite Level	Description	Upper Tolerance	Reporting
None (Averse)	Prepared to accept only the very lowest levels of risk, with the performance being ultra-safe delivery options, while recognising that these will have little or no potential for reward/return.		1 and above
Low (Minimalist)	Willing to accept some low risks, while maintain an overall performance for safe delivery options despite the probability of these having mostly restricted potential for reward/return	6	7 and above
Moderate (Cautious)	Tending towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	10	11 and above
High (Open)	Willing to be innovative and prepared to consider all potential delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.	12	13 and above
Significant (Seek)	Eager to seek original/innovative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return because of controls, forward scanning and robust systems	16	17 and above

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GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING

Wednesday 12 July 2023
Held via Microsoft Teams

PRESENT:	Ingrid Barker (Chair)	Chris Witham	Alicia Wynn
	Mick Gibbons	Jacob Arnold	Bob Lloyd-Smith
	Sarah Nicholson	Steve Lydon	Paul Winterbottom
	Nic Matthews	Jenny Hincks	

IN ATTENDANCE: Steve Alvis, Non-Executive Director
Steve Brittan, Non-Executive Director
Nicola de Iongh, Non-Executive Director
Marcia Gallagher, Non-Executive Director
Anna Hilditch, Assistant Trust Secretary
Vicci Livingstone-Thompson, Associate Non-Executive Director
Lavinia Rowsell, Director of Corporate Governance / Trust Secretary
Graham Russell, Non-Executive Director/Deputy Chair

1. WELCOMES AND APOLOGIES

1.1 Ingrid Barker welcomed colleagues to the meeting.

1.2 Apologies had been received from the following Governors: Kizzy Kukreja, Cath Fern, Tracey Thomas, Alan Cole, Dan Brookes, Alison Hartless, Rebecca Halifax, Erin Murray, Ismail Surty, Juanita Paris, Graham Hewitt and Laura Bailey. Apologies had also been received from Sumita Hutchison and Jan Marriott, Non-Executive Directors.

2. DECLARATIONS OF INTEREST

2.1 Nic Matthews informed the Council that he was now the Chair of Staffside, having commenced in this role from 1 July 2023.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes from the previous meeting held on 17 May 2023 were agreed as a correct record.

4. MATTERS ARISING AND ACTION POINTS

4.1 The actions from the previous meeting were either complete or progressing to plan.

4.2 Governors had received a special briefing session on 30 May to discuss the press coverage concerning the care provided at Wotton Lawn. Since that time, a Rapid Quality Review had been undertaken at Wotton Lawn by the ICB, with CQC involvement. This review had been broadly positive, and some specific actions had been identified. Wotton Lawn was now under a period of enhanced surveillance by the ICB whereby regular data would be collected and monitored around patient experience, AWOL, incidents etc. The Governors noted that the Trust had been successful in its recruitment efforts at Wotton Lawn which was positive news as this would mean less reliance on agency staffing. The Council of Governors noted that an update on the work taking place would be presented at the Public Board meeting on 27 July.

4.3 Paul Winterbottom asked about progress with the development of an ICS wide workforce strategy/plan. It was agreed that an update would be sought and provided back to the Council. **ACTION**

4.4 The Council noted that a further period of industrial action had been scheduled involving junior doctors and consultants. It was noted that the Trust continued to work alongside system partners and was assured that robust plans were in place to maintain safe services during this period.

5. NOMINATIONS AND REMUNERATION COMMITTEE SUMMARY

5.1 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 29 June 2023. Chris Witham presented this item.

5.2 The Committee received a report setting out a recommendation for the reappointment of Steve Alvis, Non-Executive Director for a further term of 3 years. Steve Alvis's first term of office would come to an end on 19 November 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 a good attendance record. As part of its considerations, the Committee also received and noted the positive outcome of Steve Alvis's most recent appraisal for 22/23.The Nominations and Remuneration Committee recommended that the Council of Governors approve the reappointment of Steve Alvis, Non-Executive Director for a further term of 3 years, commencing on 19 November 2023. This reappointment was **approved**.

5.3 The Committee received the summary of the 2022/23 appraisals of the Trust Non-Executive Directors, which had been conducted in accordance with guidance issued by NHSE. Appraisals were completed for Marcia Gallagher, Graham Russell, Sumita Hutchison, Jan Marriott, Dr Stephen Alvis, Steve Brittan and Nicola de Iongh. Appraisal meetings for all NEDs took place during April, May and June 2023. In advance of each meeting, NEDs were asked to undertake a self-review focusing on their achievements over the past year and previously agreed objectives. Following the meeting, a summary of the discussion, proposed objectives and development plans were shared with each NED and signed off by both parties. The Committee thanked Ingrid Barker for providing such a comprehensive report. Committee members agreed that the NEDs were performing well individually, but more importantly they were working well as a strong and cohesive team and the Trust was blessed to have such a diverse yet well-established NED team in place, who brought their individual styles, experiences and approaches to the table. The Council of Governors noted that this report had been received and noted the positive outcome of the 2022/23 NED appraisals.

5.4 The N&R Committee received and noted a report which provided clarification from NHSE around the provisions within the new Code of Governance for NHS Provider Trusts relating to chair and non-executive independence and reappointments, particularly where individuals have already served 6 or more years with an organisation. The Committee noted this report and was assured that the Trust would ensure that the new guidance is taken on board for future Chair and NED appointments and reappointments.

5.5 The Committee received this report which set out the process 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. The Nominations and Remuneration Committee has delegated

authority to manage and oversee the appointment and appraisal processes for the Chair and Non-Executive Directors on behalf of the Council. The Chair recruitment process timeline was noted, which included key tasks, milestones and indicative dates. Work was underway to appoint an executive search partner, and additional support would also be provided by the Non-executive Talent and Appointments Team at NHS England. As part of their submissions, the potential providers would be asked to explicitly confirm how they would approach the need for diversity on the Board. The Committee noted and supported the proposed remuneration range for the Chair, which was in line with national guidance and benchmarking provided by the NHS Providers Remuneration Survey. The Committee discussed and supported the proposed role description, noting that this had been produced using the NHSE Trust Chair recruitment template as good practice. A series of engagement meetings had been set up in July for the Senior Independent Director to meet with system partners (GHT, GCC, ICB) and with the Trust's Regional NHSE Director to provide them with the opportunity to consider the role description and to provide their input into this and the proposed recruitment process. Following the engagement period, it was planned that the role description, remuneration and recruitment pack would come back to the Committee in September for approval. Discussions would also take place to agree the composition of the interview panel and any training requirements for panel members.

6. ANNUAL REPORT AND ACCOUNTS 2022/23

6.1 The purpose of this item was to present the Council of Governors with the final draft Annual Report and Accounts 2022/23, to meet their statutory duty to "Receive the Trust's Annual Accounts and any report of the Auditor on them".

6.2 It was noted that the Annual Report would be Laid before parliament later in July and would be formally presented to the AGM taking place on Wednesday 13th September 2023.

6.3 Marcia Gallagher informed the Council that the Trust had once again produced a clean set of financial accounts and she said that the work and effort in achieving this should not be underestimated. Huge thanks were given to the Director of Finance and the wider Finance Team for this great achievement.

7. GOVERNOR ACTIVITY UPDATE

7.1 Bob Lloyd-Smith and Jacob Arnold had both attended a recent Gloucestershire Patient Participation Group Network meeting. Bob Lloyd-Smith said that this was a well-attended and interesting meeting, noting that there was a drive to get GP surgeries to identify veterans.

7.2 Jacob Arnold had attended the NHSP Governor Focus Annual Conference in London. He said that this had been a good event and it was pleasing to see that GHC was already focussed on those areas of good practice and learning identified. Jacob had also attended the recent Governor visit to Charlton Lane and the Forest of Dean Health Forum.

7.3 Chris Witham had attended the centenary celebrations at the Dilke Hospital which had been a great event and highlighted the benefit of the League of Friends. Jacob Arnold said that the Matron at Charlton Lane had discussed the value of the League of Friends and community involvement in terms of supporting the community hospitals and Jacob queried whether something similar could be put in place to support the mental health units (Charlton Lane and Wotton Lawn). It was agreed that this was a helpful reflection,

and the matter would be referred to the Trust's Charitable Funds Committee for further consideration. **ACTION**

7.4 Steve Brittan informed the Council that a Governor visit to Tewkesbury Hospital had also taken place in June and the Governors had been able to visit the Community Assessment and Treatment Unit (CATU) and had been enthusiastic about the work taking place there. He said it was hoped that the CATU model would be expanded to other areas across the Trust.

8. ANY OTHER BUSINESS

8.1 Ingrid Barker informed the Council that this was the final meeting for Dan Brookes (Cheltenham), Graham Hewitt (Cotswolds) and Tracey Thomas (Gloucester) who would be coming to the end of their first terms as Public Governors. She expressed her thanks to each of them for their contributions over the past 3 years.

9. DATE OF NEXT MEETING

9.1 The next meeting would take place on Wednesday, 20 September 2023.

ACTIONS 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.	**Keep on action log for reference** Business Planning discussions to commence in autumn, will be built into considerations at that time.
12 July	4.3	An update on progress with the development of an ICS wide workforce strategy/plan would be sought and provided back to the Council.	**Complete** Draft "One Gloucestershire People Strategy" (July 2023) circulated to Governors alongside papers for September meeting.
	7.3	Discussion about League of Friends and/or community involvement with the Trust's MH units to be referred to the Trust's Charitable Funds Committee for further consideration.	**Closed** On agenda for discussion at next CF Committee. .

GPTW COMMITTEE SUMMARY REPORT
DATE OF MEETING: 3 AUGUST 2023

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

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

STAFF STORY: VIOLENCE & AGGRESSION

The Committee welcomed a colleague who worked as a Clinical Lead Specialist to the meeting, who shared her personal story and experience of violence and aggression whilst working for the Trust.

The colleague informed the Committee that she had worked as a Registered Mental Health Nurse at Wotton Lawn Hospital within the Greyfriars psychiatric intensive care unit (PICU). She shared details of some of the incidents that had occurred, which had resulted in injury, harm, and wider impact of the attacks. She shared that one incident had resulted in facial injuries, scarring and long-term nerve damage. The incident had also had an effect on her family and her young children were worried about her returning to work.

The Committee was informed that aggressive behaviour was sometimes a common occurrence on the wards of Wotton Lawn Hospital and when working with mental health patients. The behaviour was not solely physical, but verbal too, which was hard for some less resilient staff members to deal with.

She said that she had received good support from her line manager throughout and suggested that it could be valuable for a support group to be established to provide support to colleagues who had experienced violence and aggression within the workplace.
The Committee thanked the colleague for sharing her story and commended her dedication to the role, and her hard work and resilience.

DEEP DIVE: VIOLENCE & AGGRESSION

The Committee undertook a deep dive into Violence and Aggression, facilitated by Ali Koeltgen, Deputy Director of HR and OD, in which the following areas were of focus:

1. Trends and colleague experience indicators
2. Training and education
3. Colleague support
4. National Drivers
   - National Violence Prevention Reduction Standards
   - Health and Safety Executive requirements
5. Engagement on Violence and Aggression Strategic Framework development

The number of physical assaults against staff during 2022-23 was shared with the Committee and it was noted the highest number of incidents occurred in Berkeley House and Wotton Lawn, Greyfriars PICU. The Trust mandatory training was shared with the

Committee, and it was reported conflict resolution was a key prevention tool, which provided staff with important de-escalation, communication and calming skills to help prevent and manage violent situations. The Committee was informed that Conflict Resolution training was applied to all staff profiles, and not just those who worked in mental health areas.

The Committee was also informed of the Essential to Role training, specifically for staff working within mental health and learning disabilities services within the Trust. This included Breakaway training and provided skills to deal with one-to-one situations when confronted with distressed, and potentially aggressive behaviour, but also emphasised the importance of proactive skills for prevention and de-escalation. Other physical invention training available was shared with the Committee, including Prevention and Management of Violence and Aggression (PMVA) and Positive Behaviour Management (PBM).

The Violence Prevention and Reduction (VPR) standards were shared with the Committee, and it was reported this was a risk-based framework to support the prevention of violence and aggression.

The Committee was informed that all trusts had received a letter from HSE in March 2023, with recommendations for managing violence and aggression and MSK Disorders in the NHS. The letter identified four categories where failings had been identified, following a series of inspections between 2018-22. The Committee was informed that a short-term task and finish group had been established to address the specific areas of concern raised and evidence compliance.

2023 STAFF SURVEY & PEOPLE PULSE SURVEY UPDATE

The Committee received an update on the preparation of the 2023 Staff Survey and People Pulse Survey. The Committee was informed that a key area of focus from the staff survey was to review the Annual Appraisals to make them more meaningful. A small cross directorate working party had met to review and identify changes to be achieved. The Committee was informed the agreed changes would be implemented by March 2024.

ANNUAL WRES/ WDES REPORT

The Committee received the Annual WRES / WDES Report, which provided an update on the Trust's annual data return on the 2023 Workforce Equality Standards, the results of which would inform the 2023/24 Workforce Equality Standard Action Plans:

- Workforce Disability Equality Standard (WDES)
- Workforce Race Equality Standard (WRES)
- Bank Workforce Race Equality Standard (BWRES)
- Medical Workforce Race Equality Standard (MWRES)

The Committee was informed that the data for the WRES and WDES submissions would be published on 31 October 2024. The Committee would review ahead of the publication. It was highlighted that 100% of returns had been received from the Trust Board.

ANNUAL EQUALITIES REPORT

The Committee received the Annual Equalities Report, which provided an update and assurance on the Trust's Annual Report and current EDI activities, in the light of the 2023 NHSE EDI Improvement Plan and how the current activities would inform the plan and address our public sector duty. The NHS EDI Improvement Plan, published in June 2023,

included six high impact actions. These would be built in to the existing EDI action plan which would be shared and monitored at the quarterly diversity network meetings, chaired by Sumita Hutchison. The recommendations from the recent BDO EDI Internal Audit would also be built into the EDI action plan. The new requirement for all Executive and Non-Executive Directors to have equality related objectives included within their annual objectives was highlighted.

M2 AGENCY STAFFING CAP

The Committee received the M2 Agency Staffing Cap, which ensured the Committee was aware of the requirement to comply with the NHSE agency cap, and the assured areas for future focus and development.

The key recommendation in the report was to ensure the Committee had sight of the information relating to compliance with the agency rules, specifically with the spending cap. This would be included in the KPIs Performance Report going forward. Discussions had been held by Board members about the balance between safe staffing and agency usage, and asked for consideration how to express that safe staffing would prioritise over compliance. The balance agreed by the Committee would be reported to the Trust Board. The Committee **noted** the information and progress highlighted within the report, and **endorsed** the recommendation for the inclusion of specific agency rules reporting within the regular suite of KPI's presented to the Committee.

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. Highlights included:

- A net gain of 184 WTE was reported over the last 12 months, which was a 4.79% increase from July 2022 to June 2023.
- The vacancy rate was currently 9.2%. Turnover rates were reducing, which evidenced improved staff retention.
- Appraisal rates were improving, with 86% complete, against the target of 90%.
- The Trust's training compliance for statutory and mandatory training was 92.8%.
- 27 colleagues had requested an "Itchy Feet" meeting, and 24 had decided to stay within the Trust following discussions and support.

OTHER ITEMS RECEIVED

The Committee:
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 NHS Long Term Workforce Plan
Received and **noted** the Workforce Management Group
Received and **noted** the Joint Negotiating & Consultative Forum
Received and **noted** the ICS People Function

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **NOTE** the contents of the report.

DATE OF NEXT MEETING	5 October 2023

AUDIT & ASSURANCE COMMITTEE SUMMARY REPORT
DATE OF MEETING: 10 AUGUST 2023

COMMITTEE GOVERNANCE	• Committee Chair – Marcia Gallagher, Non-Executive Director • Attendance (membership) – 75% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

INTERNAL AUDIT (BDO)

The Committee received the Internal Audit Progress Report and it was reported that good engagement had been received from colleagues and good progress had been made.

The Committee received the Recruitment internal audit report for consideration and noted this was scored moderate for both design opinion and design effectiveness; with two medium, and two low findings.

The Committee received the Freedom to Speak Up internal audit report for consideration and noted this was scored substantial for both design opinion and design effectiveness; with four low findings.

The Committee received the Internal Audit Follow Up Report, which detailed the progress made by the Trust against recommendations made in audits undertaken by PwC in 2020/21 and 2021/22. The report also included recommendations that were falling due from the audits completed in 2022/23. The Committee was informed BDO had followed up on 22 recommendations, which had fallen due, and seven recommendations across four different audits had been signed off as complete. The Committee was informed three recommendations from two audits completed in 2020/21 remained overdue. It was reported work to progress the recommendations relating to cyber security and the Data Security Protection Toolkit was underway.

The Committee **noted** the progress report, including the timings of audit reviews, and **noted** the progress made by the Trust in implementing prior year recommendations.

COUNTER FRAUD, BRIBERY & CORRUPTION

The Committee received the Counter Fraud, Bribery and Corruption Progress Report, which provided an update on the counter fraud work undertaken since May 2023. The benchmarking against referral rates was highlighted, and it was reported out of 25 organisations, the Trust rated the fourth highest in terms of referral rates. This evidenced Counter Fraud being highly visible in the organisation and that the service was embedded in the organisation.

The Committee **received** the Counter Fraud, Bribery and Corruption Annual Report 2022/23 and the Counter Fraud Functional Standard Return for 2022/23 and **noted** the overall rating was green.

The Committee received the Counter Fraud, Bribery and Corruption Policy and noted the revised policy had been reviewed to ensure it remained aligned to the NHS Counter Fraud Authority 3-Year Strategy. Changes made to the policy were merely cosmetic, and the policy had been seen and agreed by Staffside. The Committee **ratified** the revised Counter Fraud, Bribery and Corruption Policy.

The Committee received and **noted** the Summary of Investigations.

CYBER SECURITY ASSURANCE REPORT

The Committee received the Cyber Security Assurance Report, which provided an update on the latest position for Cyber Security for the Trust. Lee Charlton highlighted the summary of the objectives and the findings of the ICS Cyber incident desktop exercise, and shared there were a number of lessons learned and actions that the ICS and individual organisations were required to follow up with the Cyber team to improve its position in this area. It was noted that an internal audit on Cyber would commence shortly. This would be looked at as an ICS.

The Committee received and considered the current Trust cyber risks in the context of the cyber risk environment.

FINANCE COMPLIANCE REPORT

The Committee received the Finance Compliance Report, which provided an update on actions taken under delegated powers. The Committee was informed that six waivers had been approved for the period and no losses had been recorded.

It was reported the Trust had made five special payments during the period, which totalled £696 and that the debtors' position had increased by £1m since March and was at £6.37m. It was reported a working group had been established with Gloucester County Council to resolve both the delays and difficulties in making payments, along with the management of the flow of information received.

The Committee was informed that there had been two SFI breaches since the previous report

RISK APPETITE STATEMENT

The Committee considered and agreed to **recommend to the Board** for approval the draft Trust Risk Appetite Statement that had been prepared following the Board session in June.

OTHER ITEMS RECEIVED

The Committee **received** and **noted** the following reports:

- External Audit Progress Report
- Board Assurance Framework and Corporate Risk Register
- Annual Reports from Health & Safety and Security Management
- NHS Pension Scheme Year End 2023 Heat Map
- Summary reports from Management Groups

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **NOTE** the contents of the report.
- **APPROVE** the Risk Appetite Statement

DATE OF NEXT MEETING	9 November 2023

RESOURCES COMMITTEE SUMMARY REPORT
DATE OF MEETING: 31 AUGUST 2023

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

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

FINANCE REPORT – MONTH 4

The Committee received the Finance Report for month 4, which provided an update of the financial position of the Trust. The Trust had a surplus of £0.127m, compared to a plan £0.194m for month 4. It was reported the 2023/24 Capital plan was £17.785m and spend to month 4 was £3.352m, against a plan of £6.799m.

The Committee was informed that the delivery of savings was progressing well and the Cost Improvement Programme (CIP) had delivered £3.262m of recurring savings against a plan of £3.354m. The non-recurring savings delivered to date were £1.41m against a plan of £1.48m. Additional non-recurrent saving had been identified and schemes had been identified to deliver the next tranche of savings.

The System position was shared and it was reported this was a deficit of £3.6m. It was noted, the Trust had contributed £127k to the surplus. The ICB had been working on prescribing costs with GHFT, which contributed to a significant number of pressures.

PERFORMANCE REPORT – MONTH 4

The Committee received the Performance Report, which provided a high-level view of the key performance indicators in exception across the organisation for month 4. The nationally measured indicators were highlighted and it was reported challenges remained in the Adolescent Eating Disorders Service, which remained below the threshold. It was reported this was, however, progressing and moving in the right direction. The Committee was informed that the thresholds of a further six health visiting and school aged immunization indicators were not met for the period.

Five indicators (under the operational domain) were reported in exception. These were; Podiatry wait, MSK Physiotherapy wait, Paediatric SaLT, Paediatric Physio and Paediatric OT wait.

The Committee was informed MiiUs had continued to perform well and continued to achieve the 2-hour urgent community response target in Rapid Response.

It was reported no patients had been placed out of area, in the past month, despite the demand on mental health beds.

The improvement plans for Wotton Lawn and Berkeley House were reviewed at a monthly assurance oversight group. The Committee was informed that progress had been made in both areas; however, further concerns had been raised by staff at Berkeley House.

Significant improvement in Echo performance was highlighted, in which 98.9% patients were seen within 6 weeks following conversations with GHFT colleagues. It was noted this was a significant improvement from 57 in the prior month.

Issues had been raised regarding the lack of urgent dental appointments available, and the Committee was informed the ICB were aware; and a scheme would be discussed to resolve this.

SYSTEM FINANCE POSITION & DEFICIT RISK SHARE UPDATE

The System Finance Position and Deficit Risk Share presentation was shared with the Committee.

The month 4 recurring and non-recurring Income and Expenditure financial position was shared, which included the 2024/25 underlying position and the 2023/24 forecast outturn. The forecast outturn income was a lot higher when compared to the previous underlying budgets. It was reported the Trust was working with the ICB to agree the final figure, and a revised contract schedule had not yet been received.

The Director of Finance informed the Committee the 2024/25 underlying position was the amount that the Trust was putting in to the system position and highlighted this was £8.26m deficit.

The ICS faced significant financial pressures and there was a high risk of non-recurring delivery of an overall system breakeven position. It was noted the main financial pressures in the ICB were due to prescribing cost price increases. GHFT's main cost pressures were due to workforce pressures leading to high agency and locum expenditure.

The next steps were shared, and the Committee was informed that further discussions would be held with the ICB and a system approach to funding would be agreed. Forecast projects were being progressed and the ICB income position would be reviewed.

ICS MEDIUM TERM FINANCIAL PLAN

The ICS Medium Term Financial Plan (MTFP) was shared with the Committee, and the Director of Finance reported Systems had the flexibility they needed to develop medium term financial plans which satisfy local requirements, one of the key aims is to demonstrate medium term financial stability for the system. Systems were free to set their own priorities, which reflected on the national priorities for the current year as an indication of the direction of travel. Systems were also free to make their own assumptions regarding inflation, population changes, pay growth, allocations etc.

The Committee was informed that the decision had been made for the Trust to not make its own assumptions, and instead a set of assumptions which had been developed across the South West would be used. The Committee was informed the first draft of the MTFP would be submitted on 8 September, and the final submission was scheduled for 29 September 2023. The Committee endorsed the approach to working with system partners. The MTFP would be received by the Trust Board for further discussion.

GREEN PLAN STRATEGY

The Committee received the Green Plan Strategy, which provided an update on the delivery of the Trust's Green Plan, approved by the Board January 2022. It was reported that progress made towards net zero goals was positive and progressing well. There were no project areas

that were currently Red in a delivery RAG rating, and those rated amber by the Sustainability team were deliverable within the planned period.

The Committee **noted** the positive progress with the delivery of the Green Plan and **endorsed** an amendment to the Committee's TOR to include enhanced governance and reporting routes and frequency for the Sustainability Programme.

OTHER ITEMS RECEIVED

The Committee:
Received and **noted** the Service Development Report
Received and **noted** the Business Planning Report
Received and **noted** the Corporate Risk Register
Received and **noted** the Board Assurance Framework
Received and **noted** the summary report of the Digital Group.
Received and **noted** the summary report of the Capital Management Group.
Received and **noted** the summary report of the Business Intelligence Management Group.
Received and **noted** the summary report of the Strategic Oversight Group.
Received and **noted** the summary report of the Community Mental Health Transformation Programme.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **NOTE** the contents of the report.
- **APPROVE** an amendment to the Committee TOR (attached) to strengthen governance and reporting around sustainability and the Green Plan

DATE OF NEXT MEETING	1 November 2023

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

TERMS OF REFERENCE

Resources Committee

Version 5

1.	**Purpose**
1.1	The Resources Committee will be a crucial part of developing a sustainable, transformative, innovative and forward-looking organisation.
1.2	The Resources Committee will be responsible for making recommendations to the Trust Board in respect of business development opportunities, in addition to major business cases that require capital investment.
1.3	The Resources Committee will ensure relevant Strategies are in place, ensuring the Trust has an appropriate: • Finance Strategy • Estates Strategy • Green Plan • Communication and Engagement Strategic Framework • Digital Strategy The Committee will maintain an overview of procedures for and performance in respect of business planning, sustainability, performance, investment and capital expenditure procedures, and transformation. Maintain robust oversight of the implementation of the strategies and where performance or activities are not in line with proposed timescales or budgets, oversee the development and discharge of action plans to ensure improvement.
1.4	Undertake high-level, exception-based monitoring of the delivery of financial and operating performance to ensure that the Trust is operating in line with its annual plan objectives Business Planning.
2.	**Membership**
2.1	Three Non-Executive Directors, one of whom will be appointed Chair (the Chair may not be the same person as the Chair of the Audit and Assurance Committee) Director of Finance (Executive Lead) Director HR & OD Chief Operating Officer Director of Strategy & Partnerships **<u>In attendance:</u>** Deputy Director of Finance Associate Director, Business Intelligence Associate Director, Contracts and Planning Deputy COO Director of Corporate Governance /Assistant Trust Secretary

2.2	Other Officers of the Trust may attend at the discretion of the Committee Chair. Any other Trust Board Member may attend the meetings and will count towards the quorum.
3.	**Quorum**
3.1	Three members, at least two of whom should be Non-Executive Directors. 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.	**Reporting Arrangements**
4.1	The Resources 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 which require consideration by another Governance Committee.
5.	**Powers**
5.1	The Trust's Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation shall apply to the Resources Committee.
5.2	The Committee is authorised to establish sub-groups, to which it can delegate specific tasks or functions, whose activities it will monitor through the groups minutes or reports depending on the tasks or functions undertaken. The Committee will approve the terms of reference of the sub groups.
6	**Responsibilities**
6.1	<u>Annual Plan Delivery and Future Development</u> To oversee the Trust's business planning process and agree principles and approach for internal budget setting and the development of directorate business plans, linked to the Trust's strategic aims. To review the Trust's Annual Plan, including medium and long term plans required by NHS Improvement Gloucestershire System Plans, to confirm that the financial plan supports the Trust's wider strategy; to scrutinise assumptions underpinning the financial modelling and advise the Trust Board accordingly. To take an overview of the Trust's performance against financial and performance objectives ensuring that resources are being appropriately managed to deliver effective and efficient services, receiving advice regarding remedial action being taken as necessary by the Executive Team and ensure regular reports are provided to the Trust Board. Assure that the Trust's Cost Improvement Programme (CIP) Schemes are delivering to time, and therefore that all necessary efficiencies are being achieved and reflected within financial reports.

	To monitor key financial ratios against current and strategic plans, particularly those required by NHS Improvement, and agree any appropriate action. To monitor Trust Reference Costs, PLICS and SLR and report any significant implications from variances against national averages or historical trends to the Trust Board. To oversee and consider market share analysis reports and business development opportunities and assess any identified business risks. To confirm that the Trust manages its asset base efficiently and effectively and to confirm capital projects of significant value, whether related to property or other assets, are properly identified, managed and controlled. This definition relates equally to both the acquisition of assets and to their disposal.
6.2	Estates Strategy: To review the Trust's Estates Strategy, its formulation, development and implementation, its links to service and financial strategies and compliance with all legislative duties, system strategies and national targets and thus ensure that the Trust's capital assets are properly and effectively utilised. To seek assurance on behalf of the Board of Directors that the Estates Strategy is linked to the delivery of the Trust's financial and clinical service objectives; that there is an up to date asset register linked to service provision; there is effective space utilisation and a robust disposal policy for redundant estate.
6.3	Green Plan and Sustainability To seek assurance on behalf of the Board of Directors that the Trust has appropriate strategies relating to the environment and sustainability and policies are effectively implemented and monitored. To include review of bi-annual updates of delivery progress against the four key themes embodied in the Trust's Green Plan. A full sustainability update, including the output from our carbon footprint reporting and progress against Net Zero targets will be provided to the Board once a year.
6.4	Investment Strategy: To scrutinise business cases for all major capital investments (all material and significant investments) to provide assurance to the Board of Directors that in reaching its decision on the business case it has complied with the independent regulator's requirements and that it has considered any other factors which the Committee feels is relevant to the decision. To approve to progression of ITT stage of strategically significant tenders or tenders requiring the commitment of resources above a limit set in the Trust's Scheme of Delegation.

	To recommend to the Board of Directors, and, on approval, oversee and regularly review all Trust policies and procedures with respect to investment strategy in line with current NHS guidance and relevant accounting standards to ensure the delivery of agreed financial objectives. To agree principles and approach for substantial or material contracts and be a point of referral in negotiations if required. To agree principles and approach for lease arrangements. To review all business cases to confirm Trust resources are focussed on relevant areas
6.5	Business Development Consider, review and advise the Trust Board, in respect of any proposals for significant new business development opportunities, including tender submissions and bid status, ensuring that these will minimise financial and clinical risk, and increase service effectiveness and efficiency. Undertake a regular review of provider competition and potential business partners in the county and wider health economy and maximise business opportunities. Review the Trust's business development plans and all underlying principles. Review any market analysis undertaken by, or on behalf of, the Trust.
6.6	Governance Ensure that the indicators and outcomes used to evaluate financial performance are appropriate to enable the Board to monitor the organisation's adherence to its vision, values and strategic objectives. Ensure that all risks as appropriate to the Committee are captured and recorded, and that salient risks are escalated to the Board Assurance Framework: moreover, identify and enact all mitigations as may be relevant.
6.7	Engagement Ensure effective on-going engagement and communication with all relevant internal and external stakeholders, including staff, service users, the public, the Integrated Care Board and other professional partners, as appropriate to the Committee's duties and remit.
7.	**Frequency and Review of Meetings**
7.1	The Committee will usually meet 6 times a year. 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 for approval following approval by the Resources Committee. This review will include a self-assessment of the Committee's effectiveness in discharging its responsibilities as set out.
8.	**Administration**
8.1	The Trust Secretary will ensure appropriate support is provided to the Committee.
8.2	The Committee will agree an annual plan which will outline the business to be discussed at each meeting. This will include the content and frequency of reports from sub-groups.

Version:	**Date:**	**Approved by:**
Version 1	24/10/19	Approved by Resource Committee
Version 1	28/11/19	Approved by Trust Board
Version 2 (Draft)	17/12/20	Draft received by Resources Committee
Version 2	25/02/21	Approved by Resources Committee
Version 2	31/03/21	Approved by Trust Board
Version 3	25/10/21	Approved by Resources Committee
Version 4	22/12/22	Approved by Resources Committee
Version 4	26/01/23	Approved by Trust Board
Version 5	31/08/23	Resources Committee
Version 5	28/09/23	Trust Board

FOD ASSURANCE COMMITTEE SUMMARY REPORT
DATE OF MEETING: 4 SEPTEMBER 2023

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

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

FINANCIAL UPDATE

The Committee received the Financial Update, which provided an update on the project programme, finances, forecast outturn and the associated risks. The Committee was informed that expenditure was on track from a construction perspective.

It was reported the Mechanical & Engineering (M&E) works were slightly delayed, with Speller Metcalfe's planned completion date being 23 January, against the contract completion date of 5 January. It was not yet known if this would result in an early warning notice. The Committee was assured that the M&E works would be able to run parallel with other works and was not likely to impact the programme.

The Committee was informed that the total expenditure against the overall programme was £21m, as of 31 July 2023. It was reported that excess costs were currently anticipated to be incurred due to the nature of commissioning works with the forecast spend reported to be £26.7m.

The Committee was informed of one early warning notice received. The early warning notice related to the IPS material and was not anticipated to cause any issues.

X-RAY POSITION & ONGOING RISK MANAGEMENT

The Committee received the X-Ray Position and Ongoing Risk Management Report, which provided a list of the associated risks pertaining to the transition of the current x-ray equipment to the new FoD hospital and to provide options for x-ray activity during the transition period.

The Committee noted that there is still ongoing discussion as to whether a new x-ray machine could be purchased as part of the x-ray upgrade programme and this would be discussed further at the Capital Management Group the following day. The Director of Finance had contacted the ICB about the desire to develop such a plan and that ongoing updates would be provided shortly.

COMMISSIONING PLANS – UPDATE

The Committee received the Commissioning Plans Update, which provided an update on the phased approach plan to transition all services from the current two FoD hospitals to the new hospital, including sequencing and beds reduction which would enable the safe and efficient transfer of patients and services. The paper outlined the proposed phased approach, which included five phases. Phase one of the approach was highlighted, which involved the closure of Lydney inpatient beds first and that the main reason for this was to

have the kitchen operational onsite ahead of the inpatient transfer. This was expected to take between three to four weeks. It was highlighted the move was happening during the winter, and that transferring goods to the new hospital may be impacted by ice and/or snow.

The Committee:

- **Noted** the proposed plan for reducing beds and transferring the inpatient wards to the new FoD hospital.
- **Noted** the proposed phased approach to transition from the current two sites to the new hospital.

DISPOSAL OF LYDNEY HOSPITAL SITE

The Committee received the Disposal of Lydney Hospital Site Report, which provided an update on the timeline and outlined the approach for the disposal of Lydney & District Hospital. The report also provided an update on plans of the disposal of The Dilke Memorial Hospital.

The Committee **endorsed** the disposal of Lydney Hospital as detailed within the report.

OTHER ITEMS RECEIVED

The Committee:

Received and **noted** the Communication Plan.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **NOTE** the contents of the report.

DATE OF NEXT MEETING	TBC

CHARITABLE FUNDS COMMITTEE SUMMARY REPORT
DATE OF MEETING: 6 SEPTEMBER 2023

COMMITTEE GOVERNANCE	• Committee Chair – Sumita Hutchison, 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

ANNUAL ACCOUNTS 2022/23 APPROVAL

The Committee received the Annual Accounts 2022/23, which provided Gloucestershire Health & Care NHS Foundation Trust Charities Annual Accounts and Annual Report of the Trustees for the financial year ending 31 March 2023.

The Committee **reviewed** and **approved** the Annual Accounts and Trustee's Report subject to completion of the independent review which was currently underway.

OTHER ITEMS RECEIVED

The Committee:
Received and **noted** Hardship Funds Update & Future Proposal.
Received and **noted** FoD Fundraising Update.
Received and **noted** Fundraising Strategy Progress Update.
Received and **noted** Tap and Donate – Options for Consideration.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **NOTE** the contents of the report.

DATE OF NEXT MEETING	7 December 2023

QUALITY COMMITTEE SUMMARY REPORT
DATE OF MEETING: 7 SEPTEMBER 2023

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

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

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.

Quality issues showing improvement were highlighted and it was reported that 94% of complaints had been closed within 6 months, compared to 87% in the previous year.
The Committee noted a significant reduction over time in moderate harm falls incidents and John Trevains shared that the falls reduction work at Charlton Lane and Community Hospitals had contributed to this position.

The Committee was informed that an internal audit had been undertaken by BDO to review the systems and process relating to the Trust's Freedom to Speak Up process. The report provided good assurance that the Trust had a robust Freedom to Speak Up service in place.

Progress had been made in providing more detailed reporting of Statutory and Mandatory training and Clinical Supervision, however more work was required to use the data for full assurance.

The Committee was informed of the development work against closed culture risks in response to the enhanced surveillance applied following the recent rapid review of Wotton Lawn Hospital. The Committee was assured that support was provided to colleagues at Berkeley House who had raised closed culture type challenges in their practice area. It was noted that this was being addressed through Trust processes. The Committee was assured that patients were safe at Berkeley House, and that work was underway to address the concerns raised.

The Committee discussed how concerns were raised and assurance sought following the Letby case in the media. John Trevains requested the Committee's consideration on the future reporting of Learning from Deaths, given the increased scrutiny from NHS England following the Letby case.

PRIORY WARD HOMICIDE ACTION PLAN UPDATE

The Committee received the Priory Ward Homicide Action Plan Update, which provided an update of the current status of work relating to the Wotton Lawn Homicide Action Plan.
The Committee was informed that the investigation report and action plan had been shared with the ICB and NHSE Mental Health Homicide Investigation Team, who both approved the

14 recommendations and the associated actions that were identified as a result of the investigation.
The Committee was informed that the action plan was progressing well, with significant progress made on 11 actions, and further focus was with required in three areas.
The Committee:

- **Noted** and discussed the report and the action plan detail
- **Supported** the associated actions outlined to address the areas of learning and development related to the tragic Mental Health Homicide on Priory Ward.

WOTTON LAWN HOSPITAL ICB ENHANCED SURVEILLANCE REPORTING UPDATE

The Committee received the Wotton Lawn Hospital ICB Enhanced Surveillance Reporting Update, which provided an update on the Enhanced Surveillance Review report for Wotton Lawn Hospital (WLH) – July 2023 data.

The staffing and agency usage was highlighted and it was reported the plan was on track to achieve close to 100% to be fully established at band 5 level in Wotton Lawn by the end of September 2023.

Bed occupancy, length of stay and readmission rates had been reviewed and it was found all wards, apart from PICU; were significantly over Royal College recommendations. A mixture of increasing demand, demographic increases, delayed Transfers of Care (DTOC) and a variation in length of stay (LOS) were noted as significant drivers. Work was being undertaken to explore the pathways and length of stay, and this was progressing well.
John Trevains highlighted the issues relating to climbing, which were included in the report, and noted that this mainly related to one individual and multi occurrences, and was not a common issue. This was balanced by the restrictive measure of the building. Ongoing anti-climb and building work was continuously in play and additional funding had recently been agreed to progress further works across the site.

The allegations of staff sleeping were highlighted, and John Trevains noted the Trust had not received any evidence of this, despite requests. It was reported any instances where staff were found sleeping would be reported and dealt with accordingly, as this was not tolerated. Unannounced night time visiting programmes had been introduced to provide further assurance, which had found good practice and proved to be valuable for staff engagement.

The Committee was reassured that the PCET regularly visited Wotton Lawn under the PALs function, which involved talking and engaging with patients.

The Committee **noted** and discussed the report and **supported** the associated actions to maintain and/or improve quality related matters at WLH

ALLIED HEALTH PROFESSIONAL ANNUAL REPORT

The Committee received the Allied Health Professional (AHP) Annual Report, which provided a reflective approach highlighting the profile of the Trust's Allied Health Professional workforce, outlining key developments and the ambition for the next 12 months. The Committee welcomed this report as an excellent example of clinical leadership.

OTHER ITEMS RECEIVED

The Committee:

Received an **noted** the Medical Staffing verbal update
Received and **noted** the Corporate Risk Register
Received and **noted** the Board Assurance Framework
Noted and e**ndorsed** the Infection Prevention Control Annual Report 2022/23
Accepted and **Endorsed** the Medical Appraisal Annual Report *(to be presented to Sept Board)*
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	2 November 2023