with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION

Thursday 30 November 2023

10:00 – 13:00

Forest of Dean District Council Offices, Belle Vue Centre, Cinderford

AGENDA

TIME	Agenda Item	Title	Purpose		Presenter
Opening Business					
10.00	01/1123	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/1123	Declarations of interest	Assurance	Verbal	Chair
10.05	03/1123	Service Story Presentation	Assurance	Verbal	DoNTQ
10.30	04/1123	Draft Minutes of the meeting held on 28 September 2023	Approve	**Paper**	Chair
	05/1123	Matters arising and Action Log	Assurance	**Paper**	Chair
10.35	06/1123	Questions from the Public	Assurance	Verbal	Chair
Performance and Patient Experience					
10.45	07/1123	Quality Dashboard Report	Assurance	**Paper**	DoNTQ
11.10	08/1123	Performance Report	Assurance	**Paper**	DoF
11.30	09/1123	Finance Report	Approve	**Paper**	DoF
11.40 – BREAK - 10 Minutes					
Strategic Issues					
11.50	10/1123	Report from the Chair	Assurance	**Paper**	Chair
12.00	11/1123	Report from Chief Executive	Assurance	**Paper**	CEO
12.10	12/1123	Freedom to Speak Up Report	Assurance	**Paper**	FTSU Gdn
12.25	13/1123	Annual Sustainability Report	Assurance	**Paper**	DoSP
12.35	14/1123	Board Assurance Framework	Approve	**Paper**	DoCG
Governance					
12.45	15/1123	Use of the Trust Seal – Q1 and Q2	Assurance	**Paper**	DoCG
TO NOTE	16/1123	Council of Governor Minutes – Sept	Information	**Paper**	DoCG
Board Committee Summary Assurance Reports (Reporting by Exception)					
TO NOTE	17/1123	Great Place to Work Committee (5 October)	Information	**Paper**	GPTW Chair
TO NOTE	18/1123	Mental Health Legislation Scrutiny Committee (18 October)	Information	**Paper**	MHLS Chair

TIME	Agenda Item	Title	Purpose		Presenter
TO NOTE	19/1123	Working Together Advisory Committee (19 October)	Information	**Paper**	WTAG Chair
TO NOTE	20/1123	Resources Committee (1 November)	Information	**Paper**	Resources Chair
TO NOTE	21/1123	Quality Committee (2 November)	Information	**Paper**	Quality Chair
TO NOTE	22/1123	Appointments and Terms of Service Committee (8 November)	Information	**Paper**	Trust Chair
TO NOTE	23/1123	Audit and Assurance Committee (9 November)	Information	**Paper**	Audit Chair
Closing Business					
12.55	24/1123	Any other business	Note	Verbal	Chair
	25/1123	**Date of Next Meetings** **<u>Board Meetings 2024</u>** Thursday 25th January Thursday 28th March Thursday 30th May Thursday 25th July Thursday 26th September Thursday 28th November	Note	Verbal	All

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AGENDA ITEM: 04/1123

MINUTES OF THE TRUST BOARD MEETING

Thursday, 28 September 2023
Meeting Space, Salvation Army, Acre Street, Stroud

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

IN ATTENDANCE:
Anthony Burton, Member of the Public
Jacqui Cooper, CQC
Andrew Cotterill, Appointed Governor (Inclusion Gloucestershire)
Anna Hilditch, Assistant Trust Secretary
Fran Hill, Junior Doctor (Observing)
Bren McInerney, Members of the Public
Lavinia Rowsell, Director of Corporate Governance/Trust Secretary

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting. Apologies had been received from Marcia Gallagher, Vicci Livingstone-Thompson, and Helen Goodey.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. SERVICE STORY PRESENTATION

3.1 The Board welcomed Pippa Mileham to the meeting who was in attendance to speak to the Board about her experiences and her role as Lead Peer Support worker for GHC.

3.2 Peer support workers are the only staff within the NHS employed specifically to use their lived experience to support people practically and emotionally. GHC currently employs 19 Peer Support Workers / Lived Experience Practitioners, working in 6 different teams.

3.3 As Lead Peer Support Worker, Pippa informed the Board that she was on a Band 5 secondment until March 2024. She provided training, supervision and support to PSWs across the Trust and helped to prepare teams for peer support, helping them to recognise the opportunities this brings and working through any challenges. Pippa said that the Trust

was moving in the right direction in increasing the number of PSWs employed, but suggested that as the workforce grows, more structure and leadership would be needed for these roles.

3.4 In terms of looking at the future, Pippa said that she would like to see lived experience workers embedded across the Trust, with PSWs in all mental health teams, services and wards and more focus on moving into physical health services. There would need to be a more developed support and leadership structure in place, and career development opportunities for staff.

3.5 Pippa Mileham said that more was needed to increase the awareness of PSWs especially within corporate teams, noting that on the ESR system, PSWs are listed as 'Administrators' and there seemed to be no recognition or understanding of the role.

3.6 Steve Alvis said that discussions about the importance of PSWs had taken place at a recent Mental Health Act Managers' training day, and he asked about the barriers to having PSWs in physical health services. Pippa suggested that more promotion was needed within physical health services as colleagues did not think about using PSWs. However, there were some services where their experiences and insights would be extremely valuable such as maternity services, diabetes and long-term conditions.

3.7 Sumita Hutchison said that the work done by PSWs was hugely impressive, powerful and impactful in supporting the mainstream therapies available.

3.8 Neil Savage thanked Pippa Mileham for presenting to the Board with such energy and enthusiasm. He noted that the Trust's People Strategy made a commitment to increasing the number of PSWs within the Trust but did not go into the granular detail so it would be important to re-visit this.

3.9 Neil Savage asked Pippa if she could change one thing, what would it be. Pippa said that she would like her post to be a permanent position and to have more structure. Jan Marriott noted that the Quality Committee had requested a report for a future meeting focussing on Peer Support Workers and the structure. She said it was so important to get that right.

3.10 Angela Potter noted the read across with Experts by Experience and the cultural change that was required within the Trust for colleagues to have people with lived experience working with them and working alongside their teams. A clear plan was needed to ensure that the rest of the workforce was on board as there were lots of misconceptions about the role of the Experts and PSWs. Douglas Blair agreed that creating the framework and addressing the barriers was an important first step. He said that training was key for PSWs, noting that they were sharing their unique experiences with other potentially vulnerable people, and it was therefore important that this was done in an appropriate and skilled way.

3.11 The Board thanked Pippa Mileham for attending and talking about her personal experience, and the broader role of Peer Support Workers. The Board fully supported the use of PSWs within the Trust and welcomed the setting up of further meetings to discuss this important area further.

4. MINUTES OF THE PREVIOUS BOARD MEETING

4.1 The Board received the minutes from the previous Board meeting held on 27 July 2023. The minutes were accepted as a true and accurate record of the meeting.

5. MATTERS ARISING AND ACTION LOG

5.1 An action had been identified at the July meeting asking that further consideration be given as to how to provide information to the Board around waiting lists, looking at how the lists were managed, prioritised, patient profiles, and identifying people that should be on a waiting list but weren't. Sandra Betney informed the Board that an initial discussion had taken place at the Business Intelligence Management Group (BIMG) on 17 August and further actions were agreed. Sandra Betney suggested that this be closed down as a Board action, noting that updates would be presented through the Resources Committee. This was agreed.

5.2 There were no further 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. The question was "What assurance and reassurance does Gloucestershire Health & Care NHS Foundation Trust have that the mental health services provided by the Trust to people from the Gypsy, Roma and Traveller community meet their needs and are positive experiences for this community". A verbal response was provided at the meeting from David Noyes. A full written response would be sent to Bren McInerney following the meeting. and the question and response would be included as an annex to the meeting minutes for future record.

6.2 Anthony Burton offered his congratulations to the Trust on the very successful Big Health Day that took place on 16th June. Anthony asked about the progress on the STOMP programme and available statistics, and also asked about the availability of online or telephone-help lines for getting information and guidance for people and their families wishing to undertake a staged safe withdrawal of prescribed psychotropic medicines. David Noyes thanked Anthony Burton for his questions, and it was agreed that a full written response would be provided following the meeting.

6.3 The full questions and responses received would be included as an annex to the meeting minutes for future record. **ACTION**

6.4 A short film from the Big Health Day had now been produced and was available on the Trust's website. A link to this would be emailed out to all Board members and Governors. **ACTION**

7. QUALITY DASHBOARD REPORT

7.1 This report provided an overview of the Trust's quality activities for August 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. This month's report also included additional information regarding: Learning from Deaths, Non-Executive Director Quality Visits and an Overview of the changes from the NHS Complaint Standards.

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:

- 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 and 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.

7.4 Those areas showing a positive improvement this month included:

- 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.

7.5 Ingrid Barker made reference to the data around ensuring that cardio-metabolic assessment & treatment for people with psychosis is delivered. Currently, the Trust was achieving 72% in inpatient settings (95% target) and 41% in the community (90% target). One of the main drivers for the Trust's merger in 2019 was to ensure joined up physical and mental health care and this needed further work. John Trevains noted that there had been a steady improvement which reflected the input from two Physical Health Nurses within Wotton Lawn and Charlton Lane, and increased governance and oversight. The planned training had commenced, and sessions were booked for the Recovery units in order to further improve the compliance rates and thus impact upon patient safety and experience. The Board noted that one of the Community Mental Health Transformation workstreams was looking at this specific area and the need to improve the completion of health checks for people with Serious Mental Illness (SMI).

7.6 Steve Alvis offered his congratulations to the PCET Team for their continued improvement in performance around the management of complaints.

7.7 The Board noted the long length of stay data for patients in community hospitals. A significant number of bed days had been lost throughout August due to housing delays. John Trevains

informed the Board that this increase had been noted across the system and escalated to the ICB. An initial meeting had now taken place to clarify the Housing discharge processes and to ensure parity across the system.

7.8 Douglas Blair noted the incident data and graphs around the use of restraint and suggested that it would be helpful to make clear within this the type of restraint being used. It was noted that the Positive & Safe Meeting reviewed all activity monthly 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. Seated restraints and clinical holds remain the highest categories and reflect the ongoing training programme and approaches to reducing prone restraint.

7.9 Jan Marriott referred to the themes arising from complaints and queried the process that would be put in place if a complaint was upheld that related to poor staff attitude. John Trevains said that the actions put in place would be dependent on the response received from the member of staff in relation to the complaint; however, the Trust would look to address this through reflective learning with their line manager, and evidence of this taking place would need to be recorded.

7.10 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 August 2023 (Month 5 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 A Workforce KPI and Performance report was included in this month's report. This would be reported and discussed at the October Great Place To Work Committee, with additional detailed data on nursing and HCSW recruitment, turnover and vacancies being shared with the Committee. It was noted that the future format and content would be influenced by the expected launch in 2024 of the new national People KPI data suite and reporting requirements. Progress with the Workforce KPIs would continue to be monitored by the Great Place to Work Committee and within the *Education matters* theme of Measuring what matters.

8.3 David Noyes presented the Chief Operating Officer report to the Board. This provided an update on system flow challenges, and it was noted that 25% of GHC community hospital beds were currently occupied by patients no longer requiring a hospital bed, or No Criteria to Reside (NCTR). Positively, David Noyes reported that GHC had managed to reduce the average length of stay in the community hospitals to 32.4days, the first time this has been within SPC limits in 2 years.

8.4 It was noted that operational planning for the decommissioning of Lydney and Dilke Hospitals, and migration to the new Forest of Dean Community Hospital continued to gain momentum and is necessarily an increasing focus for the Operational Teams. A bed reduction was

planned as part of the scheduled transition and a query was raised about the management of beds especially over the winter months and the pressures that this would bring. David Noyes advised that the modelling was now complete as part of the transition, but he acknowledged that there would be pressures and the Trust would need to be prepared to manage these.

8.5 In core CAMHS, while there remains much to do and a long road ahead, David Noyes reported that there were some encouraging signs. The Trust was able to offer first assessments following referrals at around 21 days. There were 605 people 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.

8.6 The Board was also updated on current performance within Children's Occupational Therapy, Children's Physiotherapy, Podiatry and MSK Physiotherapy services.

8.7 It was noted that good progress continued with the recovery of Dental Services. The waiting list had reduced from 507 in March to 127 in August. The number of patients waiting over 18 weeks has reduced from 166 in March to 11 in August. Assurance was given that anyone waiting to be seen was subject to clinical triage.

8.8 Steve Brittan welcomed the receipt and oversight of the workforce KPIs within the Performance Dashboard, noting that there had been some significant improvements. The Board was asked to note that further work to develop the workforce KPIs was taking place. For example, data reported around Length of Service currently looked at a member of staff's length of service in a specific post, not necessarily their length of service for the Trust. It was important to distinguish this and make clear for future iterations.

8.9 The Board noted the assurance provided and thanked colleagues for this detailed and informative report.

9. FINANCE REPORT

9.1 The current system plan is break even and the Trust's plan is break even. At month 5 the Trust had a surplus of £0.241m compared with a plan of £0.242m. The 2023/24 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.

9.2 The Cost improvement programme has delivered £3.362m of recurring savings against a plan of £3.615m. Non-recurring savings have been delivered to date of £1.781m compared with the plan of £1.85m.

9.3 The Better Payment Policy shows 98.7% of invoices by value paid within 30 days against the 95% national target. The Board noted that the Trust had received a letter from the National NHS Finance Director congratulating us on our sustained PSPP performance.

9.4 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%. The Board noted that this was a key area of focus for the Trust. Sandra Betney advised that bank staff spend was going up, but agency spend was reducing which was positive. The Trust's recent focussed recruitment drives into hot spot areas had been successful with a number of vacancies now being filled.

9.5 The System position at month 5 is a £2.774m overspend which reflects a number of cost pressures at GHFT, and a prescribing cost pressure at the ICB. The system forecast remains break even.

9.6 The Trust Board received and approved 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.

10. MEDICAL APPRAISAL ANNUAL REPORT

10.1 The Medical Appraisal and Revalidation Report provides a summary of the work that has been undertaken within the Trust to support the safe provision of clinical services 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.

10.2 Amjad Uppal provided a summary of the key points to note from the report. 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 continue to 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.

10.3 The Board noted that the Medical Appraisal Committee (MAC) membership included 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.

10.4 Sandra Betney congratulated Amjad Uppal on his management of locum doctors, noting that the Trust was an outlier due to having very low usage of locums which was positive.

10.5 The Board accepted and endorsed this report, and it was agreed that the Chair would sign the Statement of Compliance on behalf of the Board, for onward submission to NHS England.

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 July. 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 informed the Board that following a recent round of Council of Governor elections, she was pleased to welcome David Summers representing Greater England & Wales, Lisa Crooks representing Cheltenham and Peter Gardner representing the Cotswolds. Andrew Cotterill had also joined the Council as an Appointed Governor representing Inclusion Gloucestershire. It was noted that there were three vacant Public

Governor positions, one in Gloucester, one in Tewkesbury and one in Cheltenham and these roles would be advertised later in the autumn.

11.3 On 22nd September, Mark Harper MP for the Forest of Dean made his first visit to the new Forest Community hospital site where he met with Trust colleagues. Ingrid Barker said that it was a pleasure to share with Mark the ongoing progress and plans to date. It was noted that during the autumn, Town Councils will also be invited to visit the site and plans for this were underway`.

11.4 The Trust welcomed members of the HOSC who carried out a visit to Wotton Lawn on 26th September. This visit had offered colleagues good assurance and was a positive meeting for both HOSC members and colleagues at Wotton Lawn.

11.5 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 March 2024 deadline, noting that some elements would take effect from 30 September 2023.

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

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 July.

12.2 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. Douglas Blair said that he was acting as sponsor for the 'Hospital Flow and Decision Making' workstream and had been part of 'kick off' sessions in the last month to agree the scope and priorities within this stream.

12.3 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 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.

12.4 Douglas Blair said that he was pleased to announce that 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, Douglas expressed thanks to all our colleagues who have contributed to this achievement.

12.5 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. The Board noted that 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 background on 'Right Care Right Person' (RCRP) was presented within the report. Douglas Blair advised that 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.

12.6 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 Reinforced Autoclaved Aerated Concrete (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. Sandra Betney advised that 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.

12.7 The Board noted that a Gloucestershire ICB Board Development session took place the previous day, 27th September which was attended by the Chair, Ingrid Barker, Vice-Chair, Graham Russell, and Douglas Blair. Key individuals from our operational services and experts by experience were also in attendance at the session which focussed on Children and Young People services in Gloucestershire. This was 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.

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

13. RISK APPETITE STATEMENT

13.1 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.

13.2 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.

13.3 The Board approved the revised Risk Appetite Statement for the Trust.

14. COUNCIL OF GOVERNOR MINUTES

14.1 The Board received and noted the minutes from the Council of Governor meeting held on 12 July 2023.

15. BOARD COMMITTEE SUMMARY REPORTS

15.1 **Great Place to Work Committee**

The Board received and noted the summary report from the Great Place to Work Committee meeting held on 3 August 2023. Graham Russell noted that the Committee had received a powerful Staff Story from a colleague who shared her experience of violence and aggression whilst working for the Trust. The Committee had thanked her for sharing her story and commended her dedication to the role, and her hard work and resilience. The Committee followed this up by carrying out a deep dive into violence and aggression, looking at the trends, drivers and training and education.

15.2 **Audit and Assurance Committee**

The Board received and noted the summary report from the Audit & Assurance Committee meeting held on 11 August 2023.

15.3 **Resources Committee**

The Board received and noted the summary report from the Resources Committee meeting held on 31 August 2023. A review of the Committee's Terms of Reference had been carried out to include enhanced governance and reporting routes and frequency for the Sustainability Programme. The Board received the revised TOR and approved the amendment.

15.4 **Forest of Dean Assurance Committee**

The Board received and noted the summary report from the Forest of Dean Assurance Committee meeting held on 4 September 2023. Steve Brittan advised that the project remained on track. Discussions had taken place on the workforce transition plan and the ongoing processes of engagement with colleagues across both existing hospital sites. Jan Marriott informed the Board that she had carried out a recent visit to Lydney Hospital and said that colleagues there had reported good engagement with the senior team around the move to the new hospital. She said that she felt assured by this. The Board noted that the transition plan, setting out the timescales and phasing of the moves, had been presented at a recent meeting of the Forest of Dean Health Forum and this had been well received.

15.5 **Charitable Funds Committee**

The Board received and noted the summary report from the Charitable Funds Committee. It was noted that this meeting, scheduled to take place on 6 September had taken place via correspondence. The summary report provided an update on those items presented seeking Committee approval. The Committee approved the Gloucestershire Health & Care NHS Foundation Trust Charities Annual Accounts and Annual Report of the Trustees for the financial year ending 31 March 2023.

15.6 **Quality Committee**

The Board received and noted the summary report from the Quality Committee meeting held on 7 September 2023. The Committee had 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.

16. ANY OTHER BUSINESS

16.1 There was no other business.

17. DATE OF NEXT MEETING

17.1 The next meeting would take place on Thursday, 30 November 2023.

APPENDIX 1

Questions from the Public

Question 1

What assurance and re assurance does Gloucestershire Health & Care NHS Foundation Trust have that the mental health services provided by the Trust to people from the Gypsy, Roma and Traveller community meet their needs and are positive experiences for this community. What evidence does the Trust have to demonstrate this is the case for this community.

Bren McInerney
(This question was originally asked at the Trust's AGM on 13 September 2023)

Trust Response

Thanks so much for your question. Currently we do not have separate mechanisms to gather information for this specific group; our main experience measure – Friends and Family Test do offer respondents the opportunity to identify themselves as White/Irish/Traveller community and this feedback is regularly reported on but not necessarily through the lens of seldom heard groups or ethnic/cultural minorities.

There is significant ongoing work around the Patient Level Information and Costing Systems programme however these datasets are currently aligned with the 2001 ethnicity census categories which aggregate the traveller community into British/Irish/Any other white background. Gypsy/Roma/Irish Traveller have been introduced in the 2021 census and we are waiting on the NHS Datasets being updated. Once this is done we will be much better able to interrogate and interpret our data for this purpose, and indeed to focus attention on a much wider range of groups who may have health inequalities. There are also significant workstreams ongoing within the Patient and Carer Race Equality Framework which will also improve the structures which allow services to monitor feedback and outcomes from racialised and minority groups.

David Noyes, Chief Operating Officer

Question 2

I would like to attend the meeting and hope that there maybe an opportunity to mention the following items:

1. Congratulations on the very successful BIG HEALTH DAY for the learning disabled on the 16th June
2. An indication about progress on the STOMP programme - with any available statistics
3. What on-line or telephone-help lines are available for getting information and guidance for people and their families wishing to undertake a staged safe withdrawal of prescribed psychotropic medicines

Tony Burton, Carer Member of the Health Action Group

Trust Response

Dear Anthony, very many thanks for your questions that you presented to our Board on 28 September 2023.

We are also delighted with the reach and impact of the Big Health Day, and see great value in such events. You can be assured that as long as GHC are involved in the delivery of LD Services, we will continue to support such events into the future on at least an annual basis.

Regarding your question about the statistics and data around our monitoring of the issue of stopping the over-medication of people with a learning disability, autism, or both, (STOMP) the numbers of applicable patients considered and percentages of outcomes so far, we are not in a position that would give us a detailed picture.

As you are aware, the STOMP programme is not mandated, but GHC are fully signed up to the approach and agree with the underlying principles. We have supported the programme since its inception, however, as data collection isn't a mandated element of the approach currently, we are unable to say how many patients are affected or how many have had their medication changed as a result of this.

What we can say, however, is that we ensure that our medical staff communicate with all who are managing patients (GP's, families, paid carers), and in that communication we very clearly set out the diagnosis and set out the prescription of any particular drugs (for mental health and physical health) prescribed. These are usually prescribed by the GP. Where there is a psychotropic drug prescribed, we will make a recommendation regarding clinical review and timeframes for such. This information is updated at any clinical review. When STOMP was initiated, and we signed up to this, we added a section in our clinical letters to note that there was an antipsychotic drug prescribed, and that this was for a reason that was not for psychosis or mental illness.

It is also noteworthy that we are not the sole provider with oversight of this important community; our GP colleagues are of course able to prescribe if they consider it appropriate, and people with LD from outside the county can remain under the care of providers other than GHC.

So while we aren't able to provide you with accurate data for this across the county we can reassure you of our approach, the supportive stance our clinicians have to this important initiative, and that we have set up our communication to ensure regular review of appropriateness for all those under our care. Dr Mark Scheepers said "we acknowledge those patients that are prescribed an antipsychotic for behaviour through the STOMP section of our letters. We do not discharge these patients and will keep them on our caseload with a minimum expectation that these patients are reviewed annually. An audit that we recently completed, we had 30 patients that were on an antipsychotic drug and the STOMP section, and giving a reason for the medication being in place was appropriately completed in 29/30 (97%) letters. This was an increase from 84% from the previous audit completed 18 months earlier. We continue to endeavour to ensure that people with LD have medication appropriately prescribed and that this is reviewed on a regular basis."

There are no specific online or telephone advice lines or on-line guidance provided on the safe withdrawal of antipsychotic medication. There is a general medication advice line 'NHS Choice' which provides general medicines information. Reducing psychotropic medicines is very specific to an individual and should be discussed with the patient and their psychiatrist if open to secondary care Mental Health Services or with their GP if not.

David Noyes, Chief Operating Officer

TRUST BOARD PUBLIC SESSION: Matters Arising and Action Log – 30 November 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
28 Sept 2023	6.3	The full questions and responses received as Questions from the Public would be included as an annex to the meeting minutes for future record.	Trust Secretariat	Nov 2023	**Complete.** Included as annex to Sept meeting minutes	
	6.4	Short video from Big Health Day to be emailed round to Trust Board members and Governors	Trust Secretariat	Nov 2023	**Complete.**	

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AGENDA ITEM: 07

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 NOVEMBER 2023**

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

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

SUBJECT: **QUALITY DASHBOARD REPORT – OCTOBER 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 is asked to:
Receive, note and d**iscuss** the October 2023 Quality Dashboard

Executive summary

This report provides an overview of the Trust's quality activities for October 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 Q2
- Non-Executive Director Audit of complaints Q1 and Q2

Quality issues showing positive improvement:

- Detail provided this month reports good achievement against the Trust Quality Priorities and Commissioning for Quality and Innovation (CQUIN) activity
- Increased number of embedded learning events taking place across the Trust
- Continued improving recruitment position at WLH with a trajectory to be fully established at Band 5 level, for the entire WLH site, by end of November 2023
- To date 92% 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.
- 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:

- Continued focus 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 inclusive of improved recording of clinical supervision and independent advocacy activity.
- 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 current 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 63%) and recording of household contact details.

Are our Services SAFE?

During October the Patient Safety Team (PST) 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 1414 patient incidents reported in October. 1281 were reported as No and Low harm incidents and 133 Moderate, Severe or Catastrophic incidents. The top four overall categories of incident were skin integrity, self-harm, falls and Clinical care. 1 serious incident was confirmed and reported in October. The team continue to support clinical reviews and huddles as

part of the PSIRF pilot and, during October, the team have facilitated 4 After Action Reviews and learning was shared with clinical teams. Following a number of sustained improvements, within staffing and use of agency, shift fill ratios, length of stay, readmission rates, patient safety data, patient experience and good practice initiatives, Wotton Lawn Hospital (WLH) has formally been stood down from "Enhanced Surveillance" by the ICB. The closed culture update provides insight to advocacy services provided at the Montpellier Unit and notes highlights from Greyfriars, Laurel House and Charlton Lane.

Are our services EFFECTIVE?

This month we have provided an overview of the 7 CQUIN's that have been agreed with Gloucestershire ICB. 1 CQUIN, in relation to MUST screening, has scored below the required standard of 70%. A review identified the main factor was the timing of the use of the tool rather than results obtained, remedial actions have been agreed and commenced. The business intelligence team are developing a clinical system to automatically report safeguarding referrals to the local authority, in the interim the team continue to monitor this manually for assurance. Throughout 2023 there has been an increase in MASH activity due to the introduction of the new Police Daily Vulnerability Meeting (PDVM). This is impacting on the team's ability to meet MASH timescales and new appointments have been made to expand the team to successfully manage the increased demand. A full summary of Safeguarding key performance data is provided in Appendix 1. Included this month, in summary on slide 5 and in detail at Appendix 3, are the slides relating to the Organisational Quality Priorities for improvement which are contained within the Quality Account. The Quality Priorities cover a two-year time frame. All of the priorities support local and national agendas around personalisation, co-production and shared decision making. Safer staffing data acknowledges the continuing challenges and progress for inpatient teams and the ratios between registered and non-registered staff. There has been an increase in the vacancy rate for Healthcare Support Workers (HCSW) with Berkeley House still recording the highest HCSW vacancy rate across the Trust. Overall, vacancy rates have increased within MH settings but reduced in PH settings. There is an improving position at WLH 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 by creating 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, Fire Safety & 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. Baseline clinical supervision recording rates are recorded in month and follows development with the Training, BI team and NTQ. The current rate of 35.59% represents those captured in the new reporting system. It is expected this rate will continue to improve as the sessions being recorded on the Care 2 Learn system is embedded and performance managed.

Are our services CARING?

The new PCET process launched on 1st August 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 decreased this month with the % of respondents reporting having had a positive experience reducing to below target again at 94% (target 95%). In September, there were 23 formal complaints which incorporates the changes in process and classifications. 80**%** of complaints were closed within three months (target 50%) and 92**%** closed within six months (80%). There are currently 2 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. The Non-Executive Director audit of complaints for Q1 and Q2 shows assurance that the Trust is investigating and responding to complaints appropriately.

CQC Update

We are progressing actions from the recent CQC inspection at Berkeley House. We are awaiting the final inspection report and have been holding regular meetings with the CQC, ICB and NHSE to update them on progress. The actions arising from the CQC core inspection remain at 98% complete. A final audit of case notes in January will complete all actions on the WLH Action Plan. Current compliance for physical health monitoring post rapid tranquillisation stands at 96%. All self-assessments have now been completed for those services not inspected in the 2022 programme. Further peer reviews are planned in December. Overall, there is good assurance for preparedness for any CQC unannounced inspection with teams being able demonstrate concordance with the CQC domain areas.

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 - October 2023 Data

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

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Quality Dashboard 2023/24

Physical Health, Mental Health and Learning Disability Services

Data covering October 2023

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

Executive Summary

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?
Following a number of sustained improvements within; staffing and use of agency, shift fill ratios, length of stay, readmission rates, patient safety data, patient experience and good practice initiatives, Wotton Lawn Hospital (WLH) has formally been stood down from "Enhanced Surveillance" by the ICB. In line with NHSE PU reporting standards we have removed the **acquired** and **inherited** label from the dashboard and are preparing to adopt the new national PU data system to replace the National Safety Thermometer which supports quality improvement rather than traditional data collection. GHC PU reporting is line with regional and national community Trusts recognising that a)PU prevention and management is a system issue rather than a single provider issue and b) a significant proportion of GHC patients enter our services with a PU developed outside of the Trusts services**.** There are three key factors that are driving an increase in number and severity of pressure ulcers: circulatory changes following Covid-19 infection; deconditioning of patients who live at home and have become more socially isolated; and physical immobility during/following Covid-19 or other infections and illnesses. We have commenced a thematic review of skin integrity incidents across 2 ICT's. The thematic review will report early findings to the ICT's and Improving Care Group. Importantly, the themes will inform the workplan of the ICS wide PU workstream. There were a total of 1414 patient incidents reported in October. 1281 were reported as No and Low harm incidents and 133 as Moderate, Severe or Catastrophic incidents. The top four overall categories of incident were skin integrity, self-harm, falls and clinical care. 1 serious incident was reported in October. Four After Action Reviews took place in October and learning shared with clinical teams and governance forum. The closed culture update provides insight to advocacy services provided at the Montpellier Unit and notes highlights from Greyfriars, Laurel House and Charlton Lane. This month we include the Q2 Guardian of Safe Working Hours update which highlights the challenges in filling on call shifts generally and, in particular, during the strikes.

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. 1 CQUIN, in relation to MUST screening, has scored below the required minimum standard of 70%. A review identified the main factor was the timing of the use of the tool rather than results obtained, remedial actions have been agreed and an improved position is expected. The business intelligence team have developed a clinical system to automatically report safeguarding referrals to the local authority. Throughout 2023, there has been a significant increase in MASH activity due to the introduction of the new Police Daily Vulnerability Meeting (PDVM). This is impacting on the team's ability to meet MASH timescales and new appointments have been made to expand the team to absorb the increased activity safely and effectively. **Appendix 2** summarises wider key operational performance data. We note improvement within therapies with four of the six reported measures showing a positive improvement over September data which is attributable to increased oversight and the realisation of recovery plans. Included this month, in summary on slide 5 and in detail at **Appendix 3,** are the slides relating to the Trusts Quality Priorities for improvement which are contained within the Quality Account. The Quality Priorities cover a two-year time frame. All of the priorities support local and national agendas around personalisation, co-production and shared decision making. Safer staffing data acknowledges the continuing challenges and progress for inpatient teams and the ratios between registered and non-registered staff. There is an improving recruitment position at WLH 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 by creating an international recruitment supply route for mental health nurses. We have included a wider set of Statutory and Mandatory Training figures this month. Resus Level 3, Fire Safety & Safeguarding training compliance continue to be the focus for teams and improvements have been seen in these areas. 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 which will be included in future Dashboards. Baseline clinical supervision recording rates have increased to 35.59% in October and this figure is expected to continue to increase on a monthly basis - analysis of data shows that Operational areas have highest compliance rates. Sickness levels have risen slightly this month to 5.3% and respiratory illness continues to be prevalent.

Are our services CARING?
This month we present the NED audit of complaints for Q1 and Q2 which provides assurance that, overall, the Trust is investigating and responding to complaints appropriately. The new PCET process launched on 1st August 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 increasing to 94%, noting that the target is 95%. In October, the number of formal complaints reduced to 13. 80**%** of complaints were closed within three months, target (50%) and 92**%** closed within six months, target (80%). There are currently 2 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
We are working on actions arising from the recent CQC inspection visit to Berkeley House . We are awaiting the final inspection report and have been holding regular meetings with the CQC, ICB and NHSE to update them on progress. The actions arising from the Trust wide CQC core inspection remain at 98% complete. A final audit of case notes in January will complete all actions on the WLH Action Plan. Current compliance for physical health monitoring post rapid tranquillisation stands at 96%. All self-assessments have now been completed for those services not inspected in the 2022 programme. Further peer reviews are planned in December. Overall, there is good assurance for preparedness for any CQC unannounced inspection with teams being able demonstrate concordance with the CQC domain areas.

Learning from Deaths Summary Q2 2023/24

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 2 2023/24. It includes learning from 'expected' and 'unexpected' End of Life care incidents, concerns, queries and compliments and local 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.

Quarter 2 2023/24 Learning from Deaths Summary:

- No concerning trends or themes have been identified.
- 138 patients died whilst under the care of the Trust in Q2, the deaths reviewed during Q2 were judged not to be due to problems in the care provided.
- Learning from End-of-Life care incidents, concerns, queries and compliments shows that there needs to be continued focus on medicines management, both within GHC and across the wider care community. Also, discharge and transfer between hospitals across the Gloucestershire system needs to be appropriate and in the best interests of the patient.
- 'Learning on a Page' documents are generated where novel learning has been identified, 5 learning summaries were generated in Q2. These have been shared with operational services, Pan-Ops Governance Group, through display on the Patient Safety Notice Boards within IPU's and with doctors. Outputs this month include understanding the decision-making processes regarding potential transfer to ED for head injuries to incapacitious patients following falls, promotion of bowel care and the importance of family inclusion in end of life care.
- The inpatient death rate for Community Hospitals (CoHo) and Charlton Lane (CLH) is consistent with historical data although it has been observed that more patients are being transferred from the acute trust who require end of life care. Current activity shows that death rates are highest on Mondays and Fridays, this is new data and admission and transfer data will be overlaid in subsequent reports to establish if there is any correlation.
- Cancer, frailty of old age, respiratory and cardiovascular illness remain the most prevalent causes of death for CoHo and CLH patients. Respiratory infections remain the most prevalent cause of death of people with a learning disability and Community Mental Health patients. Data regarding natural cause of deaths for Community Mental Health patients has been reported for the first time. This identified 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 SMI.

Learning from Deaths Summary Q2 2023/24

Quarter 2 2023/24 Learning from Deaths Summary (Continued):

- The mean age of patients at date of death for Community Mental Health patients is younger than the mean age of patients who died in CoHo/CLH. This is consistent with accepted research indicating that people with mental health illness die on average at an earlier age than those without. This information continues to inform the physical health work stream for the Community Mental Health Teams redesign and transformation.

- There were 3 deaths of patients open to Trust Learning Disability services in Q2 and all deaths have been referred to LeDER for review. The mean age at date of death is almost 20 years younger than the mean age of patients who died in Coho/CLH.

- Feedback from the Medical Examiner service continues to provide significant assurance that that the care provided to inpatients at the time of their death was of a good standard, that families were appreciative of the ME service input and were happy with the cause of death given, and gladly gave feedback about care when asked. The ME was involved with 52 deaths in Q2.

- 13 inquests were heard in Q2 and it is clear from the outcome of these inquests that suicide prevention remains a key priority for the Trust and is a key Quality Priority in 2023/24.

- During Q2 there were 7 deaths by suspected suicide, all patients were open to Community Mental Health teams. 4 patients were male, 3 were female and ages were evenly distributed across the age ranges (from 20-29 through to 60-69). There was a range of mental health diagnoses for these patients, the most common were Anxiety and depression and Depression (3 patients)

- The University of Manchester produces a National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) Safety Scorecard for Trusts on behalf of the Healthcare Quality Improvement Partnership (HQIP). This provides benchmarking data to support quality improvement. The Trust benchmarks as follows:
    - Suicide rate of 3.72 per 10,000 people under mental health care (2018-2020), national average is a rate of 4.83
    - Non-medical staff turnover rate was 18% (between Oct 2021 and Oct 2022), national average was 17%

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

The National CQUINs applicable to GHC for 2023-24 are tabled in summary below, progress reporting commences at the close of H1. (Q3 for Flu) . Agreement reached with commissioners that reporting will be for information purposes only with no financial penalties linked to thresholds.

SUMMARY CQUIN INITIATIVES 2023-2024

CCG Ref	Description	Mental Health	Physical Health	Reporting Process	Status
CCG1	**Flu vaccinations for frontline healthcare workers, (70%-90% compliance)**	✓	✓	Established process via Immform to continue as per previous years.	Flu and Covid-19 vaccination programme is underway. Clinic locations and times are publicised on the Intranet. Good take up from staff has been evident in these early clinics, targeted work is planned for areas of low uptake.
CCG12	**Assessment and documentation of pressure ulcer risk** Achieving 70% (min) 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	H1 results show 75% compliance, CQUIN Requirements for H1 have been achieved. Manual audits planned for H2.
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 to 2023-24 by the implementation of the tissue viability quality priority.
CCG14	**Malnutrition screening in the community - applicable to inpatients in community settings** . Achieving 70% (min) 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	H1 results show 44% compliance, CQUIN requirements for H1 have not been achieved. A review identified the main factor was the timing of the use of the tool rather than results obtained. Remedial actions are under way and we confident of being fully compliant .
CCG15a	**Achieving 50% of adults and older adults accessing select Community Mental Health Services (CMHS's), having their outcomes measure recorded at least twice**. Separately, achieving 10% of adults and older adults accessing select Community Mental Health Services, having their patient-reported outcomes measure (PROM) recorded at least twice.	✓		Routine submission (via MHSDS)	At present paired outcomes are not consistently recorded. As part of the Community Mental Health Transformation work, DIALOG+, which is a self assessment and Patient Rated Outcome Measure (PROM), is being trialled. This will give an opportunity for outcomes to be assessed. Engagement and training is underway with the remainder of the Recovery Teams. Teams have been informed that the use of the template is now compulsory.
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)	Being scoped. 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)	Being scoped. 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.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

Quality Priorities 2023-2025:

A summary of quality priority activity in H1 2023-24 is provided below. This is a 2 year work programme and a definitive compliant/non compliant rating will be issued at the end of Q8.
Progress against plan for each priority is provided in more detail in Appendix 3.

SUMMARY QUALITY PRIORITIES 2023-2025

Priority	Description	Status 23/24
1	• Tissue Viability (TVN) - with a focus on reducing performance through improvement in the recognition, reporting, and clinical management of chronic wounds.	In progress no significant barriers to achievement reported
2	• Dementia Education - with focus on Increase staff awareness of dementia through training and education, to improve the care and support that is delivered to people living with dementia and their supporters across Gloucestershire.	In progress no significant barriers to achievement reported
3	• Falls prevention – with a focus on reduction in medium to high harm falls within all inpatient environments based on 2021/22 data.	In progress no significant barriers to achievement reported
4	• End of Life Care (EoLC) – with a focus on patient centered decisions, including the extent by which the patient wishes to be involved in the End of Life Care decisions.	In progress no significant barriers to achievement reported
5	• Friends and Family Test (FFT) – with a focus of building upon the findings of the 22/23 CQC Adult Community Mental Health Survey action plan.	In progress no significant barriers to achievement reported
6	• Reducing suicides – with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services.	In progress no significant barriers to achievement reported
7	• Reducing Restrictive Practice – with a focus on continuing our strategy in line with the Southwest Patient Safety Strategy to include restraint and rapid tranqulisation.	In progress no significant barriers to achievement reported
8	• Learning disabilities – with a focus on developing a consistent approach to training and delivering *trauma informed* Positive Behavioral Support (PBS) Plans in line with National Learning Disability Improvement Standards. This includes training all learning disability staff in PBS by April 2025.	In progress no significant barriers to achievement reported
9	• Children's services – with a focus on the implementation of the SEND and alternative provision improvement plan.	In progress no significant barriers to achievement reported
10	• Embedding learning following patient safety incidents – with a focus on the implementation of the Patient Safety Improvement Plan.	In progress no significant barriers to achievement reported
11	• Carers – with a focus on achieving the Triangle of Care Stage 3 accreditation.	In progress no significant barriers to achievement reported

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	2,476	2,683						18,974	
% of respondents indicating a positive experience of our services	N - T	95%	94%	94%	94%	94%	94%	95%	93%	94%						94%	
Number of compliments received in month	L - R		2081	202	160	256	306	205	205	244						1578	
Number of enquiries (other contacts) received in month	L - R		619	44	75	82	87	99	102	116						605	This includes feedback that may previously have been categorised as a *concern*
Number of concerns received in month	L - R		692	66	65	48	40	0	0	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	23	13						109	
Of complaints received in month, how many were early resolution complaints	L - R			0	0	0	0	33	23	13						69	
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	58	46							This includes feedback that may previously have been categorised as a *concern*
Percentage of complaints acknowledged within 3 working days	N - T	100%	100%	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	15	25						104	Additionally, there was 1 concern closed this month (opened under the old process)
Number of complaints closed within 3 months	L - I			5	9	8	4	13	12	20						71	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	4	2							
Number of external reviews (not all opened within month)	L - R			2	4	4	5	6	7	7							This includes 3 x complaints we have referred to the PHSO to investigate

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 - T	National measure/standard with target	L – I	Locally agreed measure for the Trust (internal target)
N - R	Nationally reported measure but without a formal target	L – R	Locally reported (no target/threshold) agreed
L – C	Locally contracted measure (target/threshold agreed with GCCG)	N – R/L – C	Measure that is treated differently at national and local level, e.g. nationally reported/local target

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

Key Highlights:.

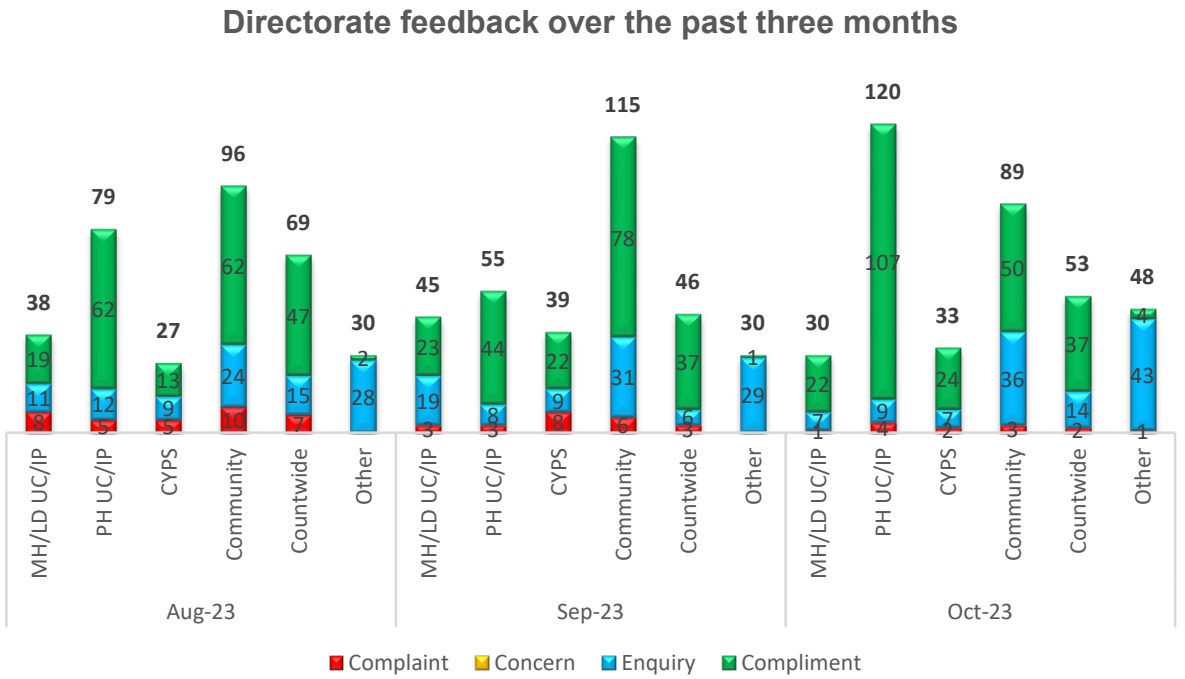
- The new PCET process launched on 1st August 2023 in line with the NHS Complaints Standards.
- The Standards are designed to ensure that the right structures and systems are in place to capture and act on feedback, provide timely resolutions and deliver better patient and carer (and staff) experience. 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	1	Early resolution:	**1**	7	22
		Closer look:	**0**		
PH urgent care and inpatient	4	Early resolution:	**4**	9	107
		Closer look:	**0**		
CYPS	2	Early resolution:	**2**	7	24
		Closer look:	**0**		
PH/MH/LD Community	3	Early resolution:	**3**	36	50
		Closer look:	**0**		
Countywide	2	Early resolution:	**2**	14	37
		Closer look:	**0**		
Other	1	Early resolution:	**1**	43	4
		Closer look:	**0**		
Totals	13	Early resolution:	**13**	116	244
		Closer look:	**0**		

Examples of complaints [as reported] for each directorate:

- **MH UC/IP**: Patient's wife felt excluded from discussions about discharge plan.
- **PH UC/IP**: Patient had no inpatient physio, fell after discharge and was readmitted.
- **CYPS**: Patient's father unhappy with reports stating our therapist said some upsetting things about him.
- **Community**: Patient unhappy with medication which resulted in side effects.
- **Countywide**: Patient complained that urgent referral was delayed due to staff sickness;.



The above graph shows feedback by type and directorate over the past three months.
Whilst there have been complaints across each directorate, there have been significantly more compliments. Moving forward, we want to start shifting our focus to learning from excellence too.

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.

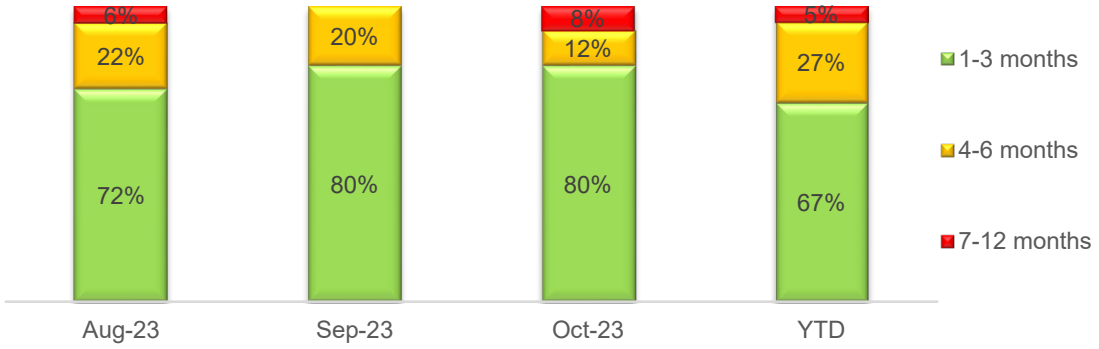
Directorate	Upheld	Partially upheld	Not upheld	Other	Total
MH/LD urgent care, inpatient	0	3	3	0	6
PH urgent care, inpatient	0	1	0	0	1
CYPS	1	1	3	1	6
PH/MH/LD Community	0	1	4	0	5
Countywide	2	2	2	0	6
Other	0	1	0	0	1
Totals	**3**	**9**	**12**	**1**	**25**

The below table shows upheld COMPLAINT THEMES this month.
These include closer look and early resolution complaints.

Directorate	Upheld themes for complaints closed this month
MH/LD urgent care, inpatient	**Care and treatment**: patient able to abscond; notes on how to support patient not read **Communication and attitude**: staff did not knock before entering a bedroom
PH urgent care, inpatient	**Communication**: miscommunication around patient's expectations
CYPS	**Communication**: inaccurate information contained in clinic letter; letter sent to wrong address
PH/MH/LD Community	**Communication**: voicemails not returned
Countywide	**Communication**: children discharged and parent not informed; wrong test result given to patient; inadequate information provided regarding treatment **Care and treatment**: wrong procedure undertaken;
Other	**Trust admin**: health records not supplied upon request; appropriate action not taken

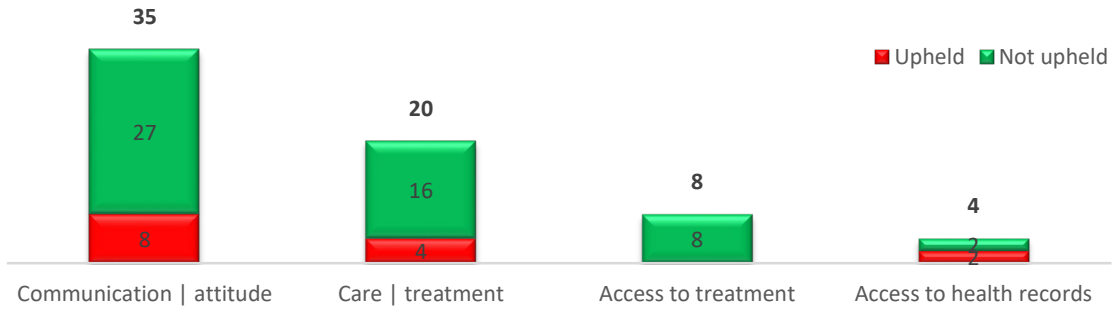
The below graph shows improvements in the length of time taken to close complaints.

- We have updated our local KPIs in line with the new national targets
- This month, **80%** were closed within three months (target = 50%), **92%** closed within six months (target = 80%)
- YTD, **95%** 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 or attitude– upheld in **4** directorates
- Care and treatment – upheld in **3** directorates
- Access to health records – upheld in **1** directorate

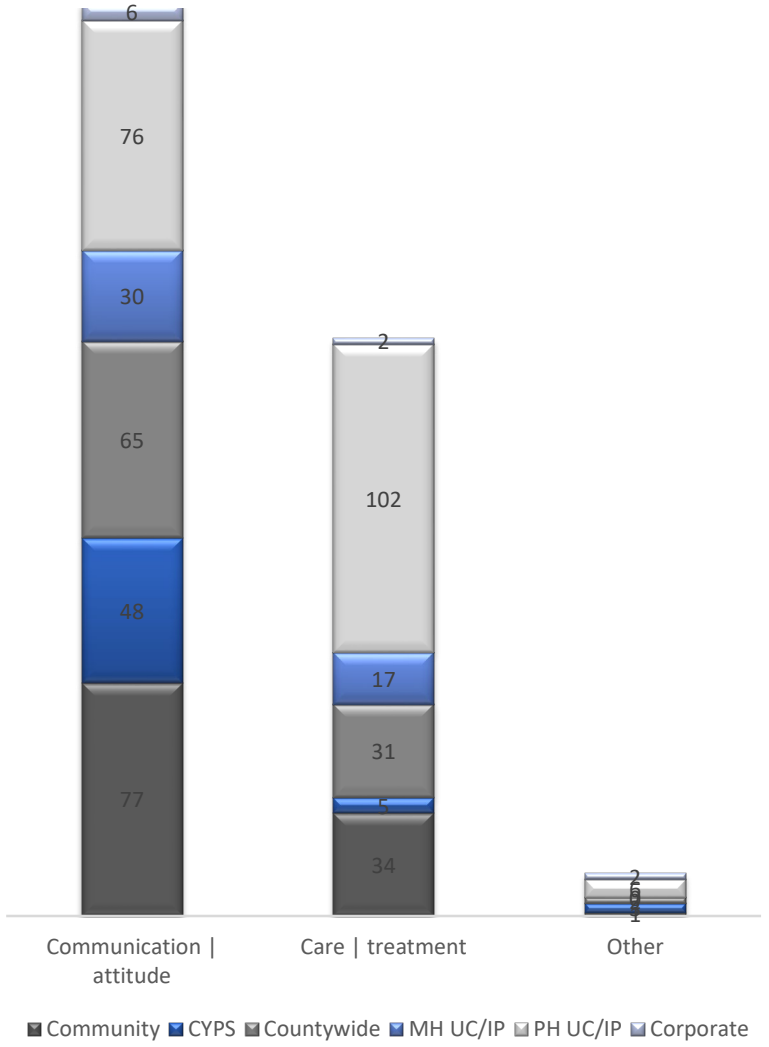


CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

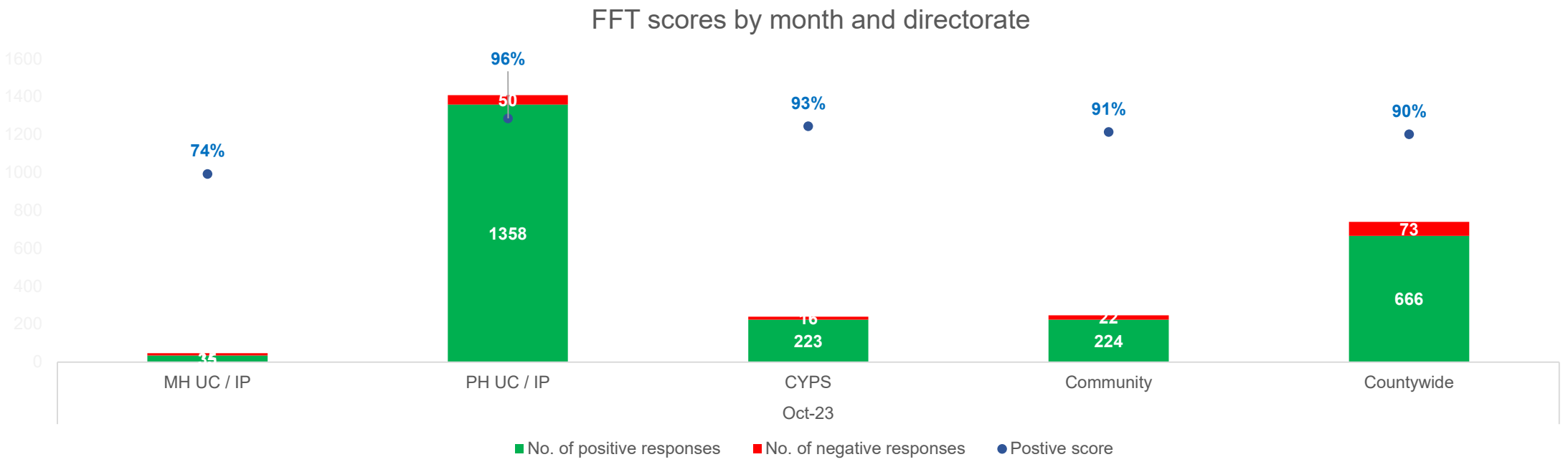
The table below is a sample of compliments received this month, and the chart opposite shows all COMPLIMENTS received this month by theme and directorate.

The **244** 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
02/10/2023	11301	ICT Stroud Physio	To say much thanks from the family of * for our time and the things we put in to his home He died very recently but * said they asked her to pass on their thanks to us
31/10/2023	11651	Later Life North	I have had such a positive experience with all the support I have received whilst in the community as well as the inpatient service, I do not believe I would be here if it were not for you all, thank you.
19/10/2023	11509	SALT Adults Physical Health	Gifted a box of chocolates to say thank you for all the care and help he has received since having life saving / changing surgery.
19/10/2023	11504	Community Equipment Service	The lady I asked advice for has got the Maxx heel protectors and they are working really well. Nothing else we have tried has helped. Thank you.
02/10/2023	11318	CYPS/PH- Children's SALT	Email received from parent thanking the therapist for being kind and patient with their child.
09/10/2023	11557	CAMHS Core	Thank you for this and the autism information. We were able to show the letter to X's SENDCO and she is putting some things in place which means he can be with his friends more, plus have the twice weekly mentoring. Thank you so much for such a thorough summary of X's needs.
09/10/2023	11386	Dilke Hosp- Forest Ward	A big thank you for all the care, support, patience and kindness you have shown Mum and myself during her time at the Dilke. I am grateful for all the valued time you have given….you are a marvellous team.
05/10/2023	11347	MIiU- Forest of Dean	Sore eyes for nearly 1/52 got worse – told to go to MIiU. MIiU contacted GP antibiotics prescribed - Patient was very thankful and got the team a lovely box of chocs and a card
10/10/2023	11399	CRHT Chelt & Tewks	Patient wanted to thank the team for being 'the most fantastic team in the world - and the recovery team!' and that if she could she would buy us all sweeties and biscuits
10/10/2023	11402	Charlton Lane- Mulberry Ward	Thank you SO much for all your help and advice over the recent weeks and facilitating our visits. You have really helped us to help **** in our small way. Thank you.



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



Highlights for this month:

- The FFT response continues to be at a high level in line with recent months.
- The overall positive experience rating has increased to **94%**, 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).
- **8** requests for contact have generated further action/investigation through the new 'open' question.

Overview of the new PCET process (from 1st August 2023)

How we manage and respond to patient feedback (complaints)

Gloucestershire Health and Care NHS Foundation Trust

Complaints can be made in person, by phone, by email or in writing.

PCET will **triage all complaints** and consider how best to provide a resolution.

We will always try to **deal with complaints quickly if we can**, however, it is sometimes that case that a detailed investigation is required. We will discuss this with the complainant.

Early resolution

Overseen by DSD (c.c. SD) who appoints a Local Lead* to look into the issues

We will always try to resolve complaints quickly, if we can.

A written response will be shared with Local Lead for comments and the DSD for approval (to ensure any learning is appropriate/achievable).

The response will be sent from the DSD.*

*The Local Lead should not be directly involved in the patient's care but can be someone from the same team/service.

A closer look/full investigation

Overseen by SD (c.c. DSD) who appoints an investigator* to look into the issues

If the matters raised cannot be resolved quickly, are serious, complex or need detailed investigation, we will take a closer look at the complaint.

A full investigation will be undertaken, with a report and learning shared with PCET.

A response will be sent from the DoN.

*Wherever possible, the investigator should not be from the same team/service.

Local Resolution

If the complainant is unhappy with our response, we can look at our findings again.

We will always try and resolve complaints to the satisfaction of patients and carers before signposting to the PHSO.

The Parliamentary and Health Services Ombudsman

If we are unable to resolve a complaint, the Ombudsman can be asked to consider it.

PCET will explain how to do this once all other options have been exhausted and we are satisfied that the outcome will not be affected by further review.

*Signatory for early resolution complaints to be discussed and agreed at SDs. PCET to use DSD signatures for the time being unless directed otherwise by SDs (who are always kept copied in).

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.

ARE SERVICES SAFE? Non-Executive Director audit of complaints Q1 and Q2 2023/24

INTRODUCTION

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

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

PROCESS

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

SUMMARY OF FINDINGS

- Audit findings are summarized within the table on the following slides
- The Q1 and Q2 2023/24 audit provide good assurance that, overall, the Trust is investigating and responding to complaints appropriately
- The Trust's responsiveness to complaints is monitored via the monthly Quality Dashboard

FUTURE AUDITS

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

RECOMMENDATIONS

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

ARE SERVICES SAFE? Non-Executive Director audit of complaints Q1 2023/24

	Time scale of response	Quality of investigation	Accessibility, style and tone of letter	Learning actions identified	Comments
Complaint 1 • Mother raised concerns about levels of care provided to the patient who has been able to significantly self-harm, as well as absconding from the ward.	**PARTIAL ASSURANCE** • Appropriate acknowledgement and clarification of issues • This was the investigator's first complaint and they required additional support/oversight, which delayed the response letter • Evidence of updates regarding delay but these could have been more frequent	**PARTIAL ASSURANCE** • Feedback reviewed by Patient Safety Team • Initial investigation was not thought to be sufficiently robust; another member of staff was asked to review the investigation	**FULL ASSURANCE** • Letter addressed the individual issues raised • Appropriate apologies were offered	**FULL ASSURANCE** • Learning was identified and actions agreed	• Initial issues raised in respect of the patient accessing vodka on approved leave not addressed (discussed with PCET but mother did not want this investigated).
Complaint 2 • Patient reported that a mental health nurse failed to recognise the severity of his symptoms and an opportunity for an early referral to GRiP was missed which subsequently delayed his treatment.	**FULL ASSURANCE** • Appropriate acknowledgement/contact considering patient's autism disclosure • Response outside initial timeframe but good evidence of updates/engagement	**PARTIAL ASSURANCE** • Given the condition of the patient, some elements of the complaint are inevitably subjective	**PARTIAL ASSURANCE** • Highly subjective in light of patient's condition	**FULL ASSURANCE** • Generally in support of the clinicians, but noting that some of the communication could have been better	
Complaint 3 • Joint complaint (led by GHFT and including SWAST) where patient is unhappy that she was not given a brace as she had fractured her C2 vertebrae.	**FULL ASSURANCE** • Good evidence of system-wide collaboration to provide required information quickly	**PARTIAL ASSURANCE** • Unsure that an adequate explanation has been given as to why Stroud MIIU missed that the patient had a fracture and why neck bracing wasn't used	**FULL ASSURANCE** • Response to GHC issue only (to be dropped in to GHFT letter)	**FULL ASSURANCE** • Although no learning was identified, response noted GHC's commitment to working with GHFT to improve system-wide learning	

ARE SERVICES SAFE? Non-Executive Director audit of complaints Q2 2023/24

	Time scale of response	Quality of investigation	Accessibility, style and tone of letter	Learning actions identified	Comments
Complaint 1 • Mother complained that the patient was given access to a razor blade which was not handed in after use; the patient then used the razor to self-harm.	**PARTIAL ASSURANCE** • Long delay in responding – should have been April 2023, was issued August 2023. • Current care issues requiring attention caused some delays in the complaint process.	**FULL ASSURANCE** • Initial investigation was not significantly robust and included information and policies not relevant to GHC. • Investigation was subsequently reviewed by senior colleague • Initial investigation appeared as bit confused on some key policy and practice issues.	**FULL ASSURANCE** • Letter addressed the individual issues raised. • Appropriate apologies were offered.	**PARTIAL ASSURANCE** • The Experience Complaint Learning summary could be more detailed, would prefer to see something more expansive, plus how the learning is delivered / received beyond naming a responsible person. • Reads as if it needed some 'deep reflection and learning'.	PCET launched a new process launched on 1st August 2023 in line with the NHS Complaints Standards. The Standards are designed to provide timely resolutions and deliver better patient and carer (and staff) experience. Learning summaries are to be read in conjunction with the response letter.
Complaint 2 • Patient unhappy about being detained under the Mental Health Act for the fifth time.	**PARTIAL ASSURANCE** • Delays in process due to time taken to appoint an investigator. • One month delay in response due to annual leave which could have been foreseen.	**FULL ASSURANCE** • Investigation was honest and transparent with the outcome of each issue clearly indicated.	**PARTIAL ASSURANCE** • Letter offers apologies but less about lessons learnt.	**FULL ASSURANCE** • Experience Complaint Learning Summary is very summary and question mark whether captures the real learning.	As above.
Complaint 3 GHFT joint complaint: • Consultant refused to see a patient who was late due to pre-planned road closures. Patient rang ahead to inform consultant that they would be late, but consultant still refused to see them.	**FULL ASSURANCE** • Response was sent within three weeks of receipt of complaint.	**FULL ASSURANCE** • Investigation was open and transparent.	**FULL ASSURANCE** • Letter was written by GHFT with comments from GHC which seemed fair and appropriate.	**FULL ASSURANCE** • Not applicable.	NED queried whether a conversation with GCC Highways had been initiated as this could be serious if it were a critically ill person.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

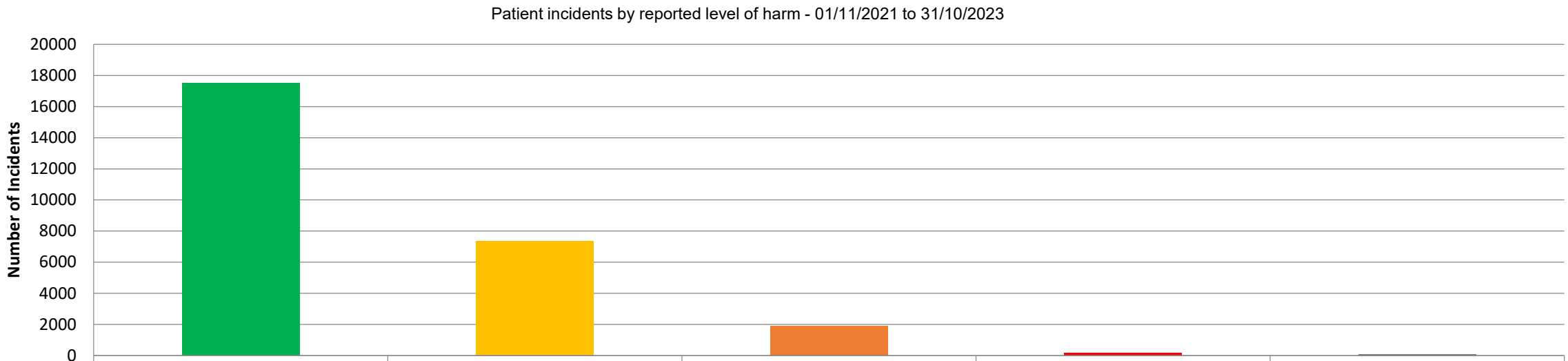
CQC DOMAIN - ARE SERVICES SAFE? INCIDENTS (Whole Trust data)

	Reporting Level	Threshold	22-23 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023-24 YTD	R / A / G	Exception Report?	Benchmarking Report
Number of Never Events	N - T	0	1	0	0	0	0	0	0	0						0			N/A
Number of Serious Incidents Requiring Investigation (SIRI)	N - R		39	5	2	2	3	3	1	1						18			N/A
No of overdue SI actions (incomplete by more than I month)	L - R		N/A	0	0	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	0	0						3			N/A
Number of Serious Incidents Requiring Investigation (SIRI) regarding self harm or attempted suicide	N - R		5	0	0	0	0	1	0	0						1			N/A
Number of Learning and Engagement Sessions meetings taking place	L - R		9	2	6	4	2	0	10	27						51			N/A
Total number of Patient Safety Incidents reported	L - R		13029	1057	1111	1317	1237	1329	1209	1414						8674			N/A
Number of incidents reported resulting in low or no harm	L - R		11967	964	1007	1209	1145	1233	1118	1281						7957			N/A
Number of incidents reported resulting in moderate harm, severe harm or death	L - R		1062	93	104	108	92	96	91	133						717			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	1	0						8			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	2	0						6			N/A
Total number of sexual safety incidents reported	L- R		129	7	5	10	13	13	4	13						65			N/A
Total number of Rapid Tranquilisations reported	N - R		981	46	30	61	37	71	48	52						345			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



None (no harm caused by the incident)	Low (minor harm, e.g. takes up to 1 month to rectify)	Moderate (significant but not permanent harm e.g. takes up to 1 year to rectify)	Severe (permanent or long term harm caused)	Death
17519	7347	1884	188	99

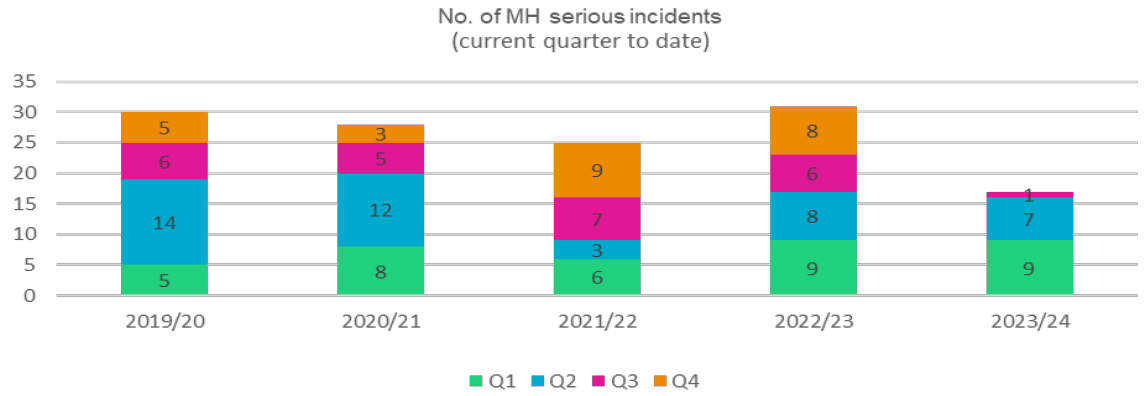
Key highlights:

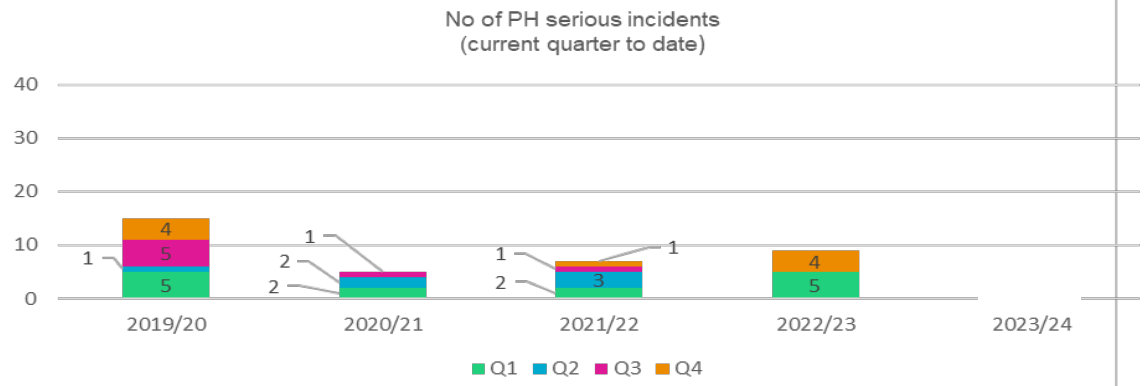
We have included in this dashboard a summary of patient safety incidents reported over the last 2 years and seek to present data that can identify patterns requiring deeper analysis.

In October there were 1414 patient incidents reported in Datix (205 more than September). 1281 were reported as No and Low harm incidents (163 more than September) and 133 as Moderate or Severe harm or Death (42 more than September).

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 into 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. Mortality data and themes also drive the QI process. The legal services team have joined this forum to share learning from claims and other legal processes.

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





Key Highlights

In October the Trust reported 1 new serious incident relating to a patient of the Cheltenham CRHTT

PST and the ICB have agreed renewed timescales for the submission of a number of SI reports, the position will be fully recovered by the end of January 2024.

Four After Action Reviews (AAR) took place in October as part of the PSIRF pilot. These are reported in Datix and shared with the clinical team and governance forums. The AAR reports will form part of our Duty of Candour response to patients and families.

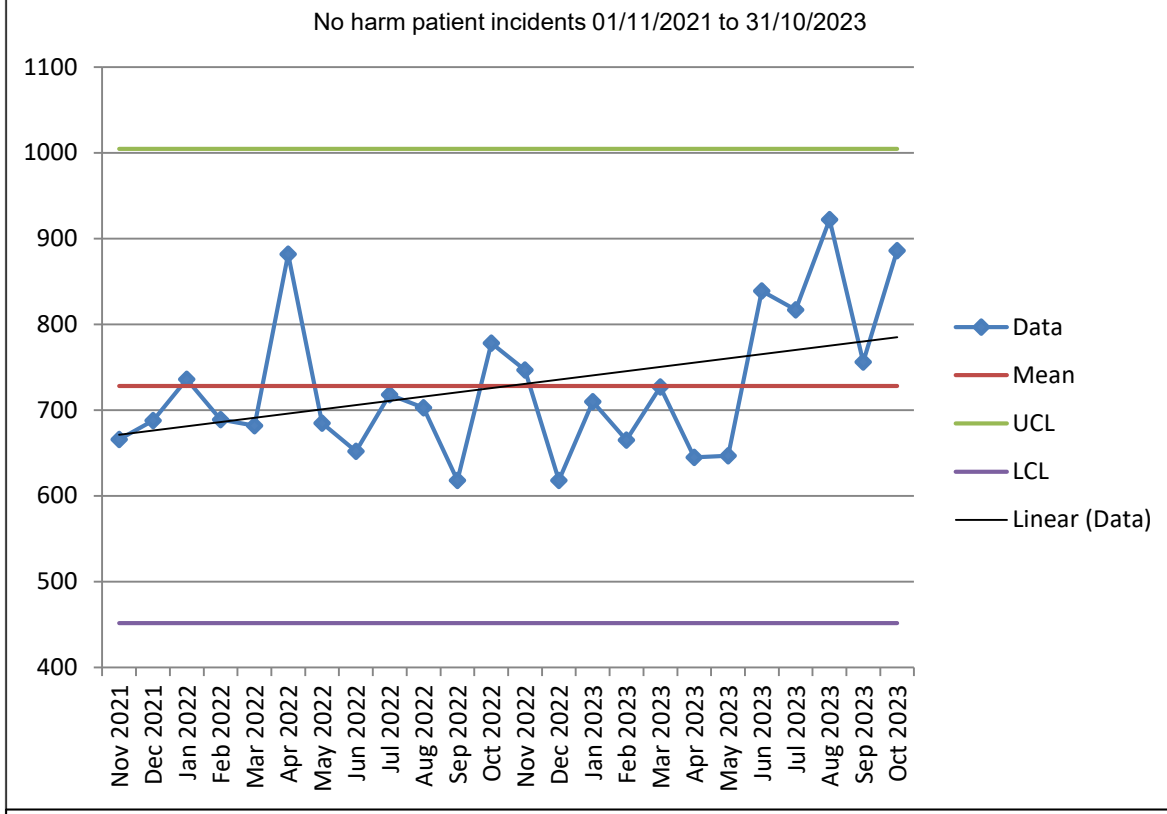
Learning Assurance Activity

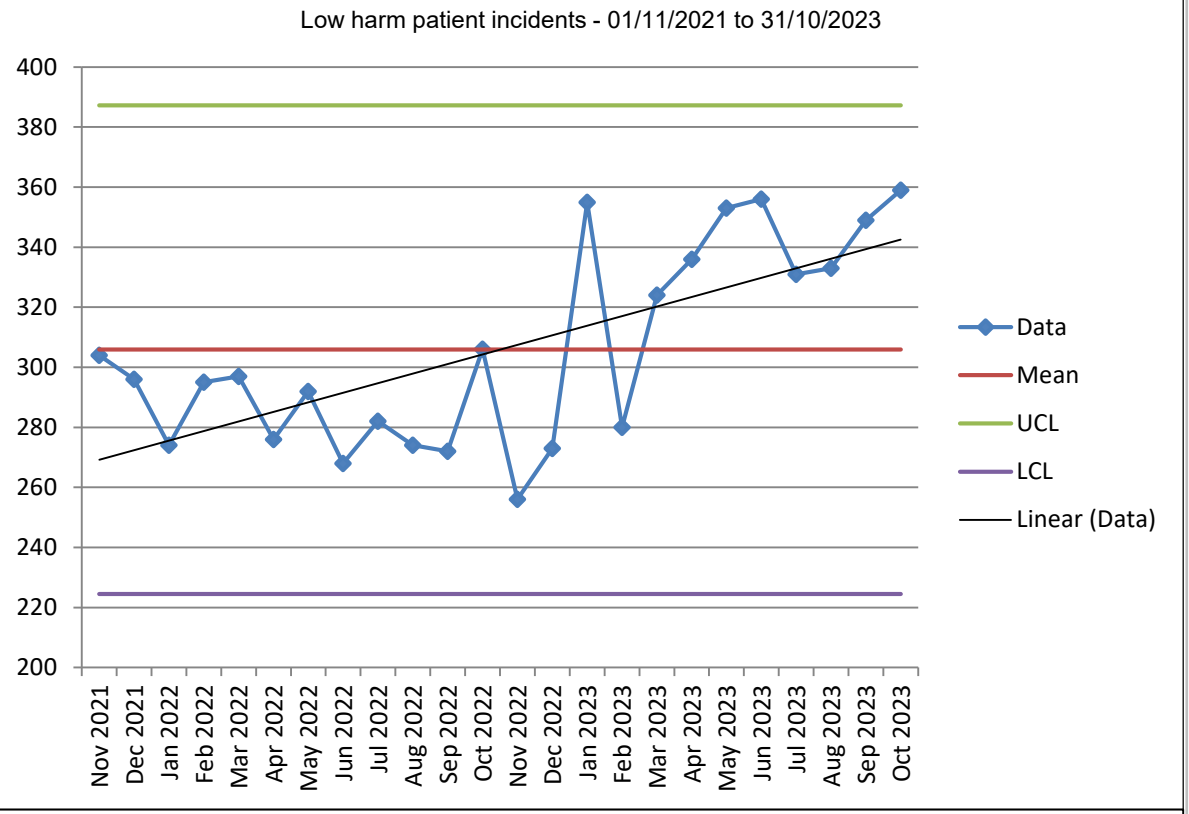
- The Patient Safety Bulletin has been launched and shared via the intranet. The bulletin shares news, learning and improvements from incidents of harm, practice reminders, updates on PSIRF and any national patient safety communications. A new Patient Safety Bulletin will be published every six weeks.
- The Learning Assurance team met with the ICB to discuss learning assurance from past incidents. The team now also attend both the mental health and physical health mortality review meetings to support triangulation of learning. The team attended a number of drop-in national meetings of the Patient Safety Managers Network (sharing experience and good practice).
- 2 further sites now have a Patient Safety and Quality of Care (PS&Q) Noticeboard and were visited to gain feedback from staff on their effectiveness. There are currently 45 noticeboards in use across the trust.

Ongoing learning assurance has been supported through:

- Regular meetings with: the Matrons at Wotton Lawn Hospital / Charlton Lane Hospital, together with the Clinical Development Manager and Duty of Candour Lead, to support with learning assurance work in the Hospitals; the homicide action plan working group; and colleagues in PCET, QI and CQC Quality to share updates (weekly)
- Attendance at the bimonthly falls group. We are also part of the Observation and Engagement Task and Finish Group which has come from the homicide action plan.

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





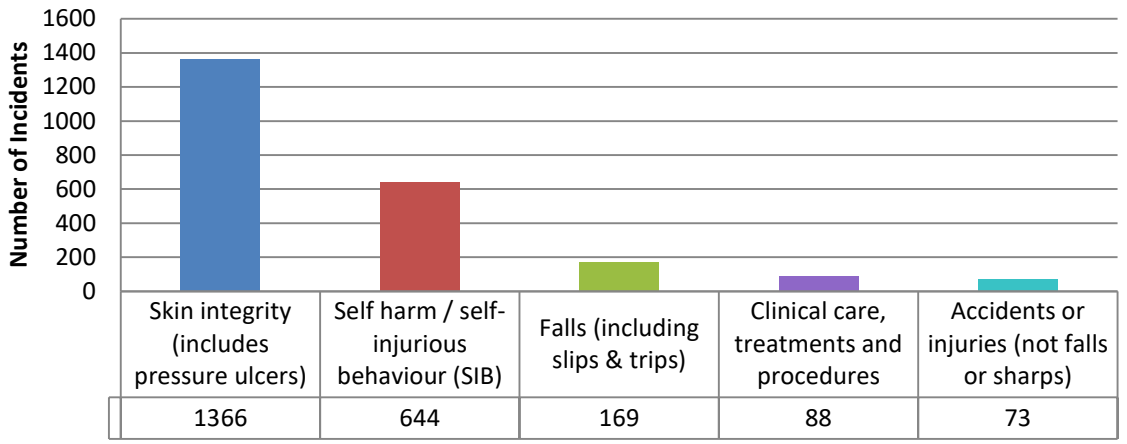
Key Highlights:

- **No Harm Incidents** – the increase from May to October is attributed to no harm restraints at Berkley House, no harm falls at Charlton Lane Hospital and no harm restraints in LD IHOT who are supporting seasonal Covid and Flu vaccinations.
- **Low Harm Incidents over time** - The PST continue to support staff to correctly assess and grade incidents. The 8 data points above the mean are being monitored and were due to an increase in the reporting of skin integrity (including pressure ulcers) and falls incidents. This is shown in more detail on the next slide.

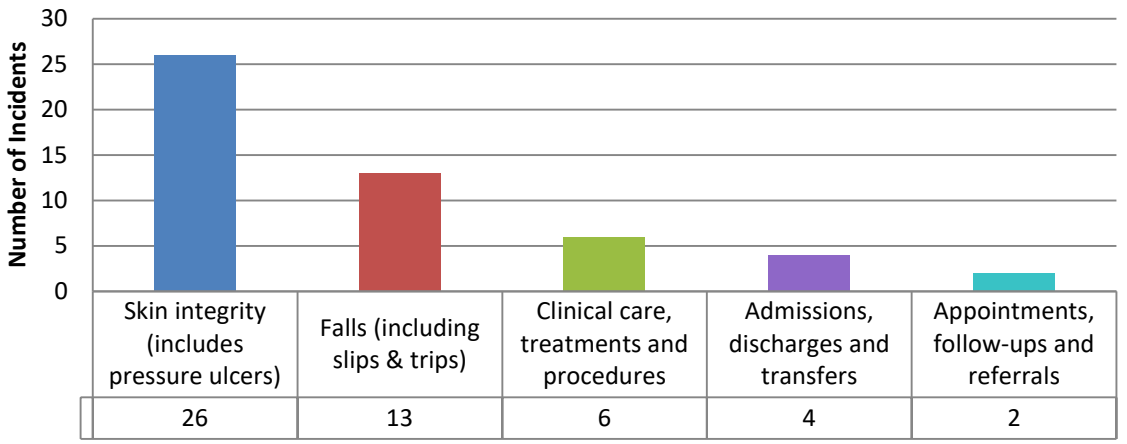
A high level of incident reporting is positive and patterns observed in these increases will be monitored and reported through services and QAG.

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

Top 5 low harm patient incident categories – (excluding restraint) 01/03/2023 to 31/10/2023



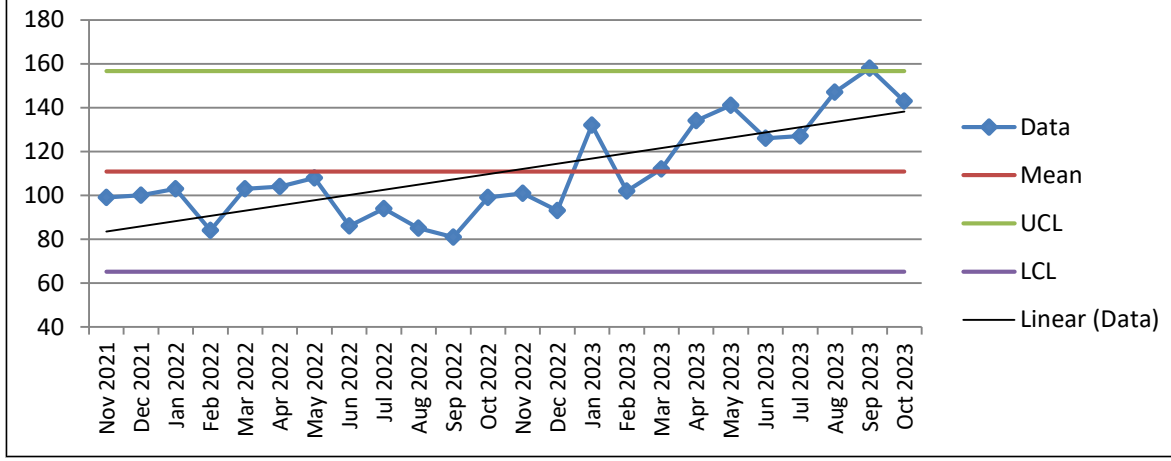
Increase in low harm patient safety incidents, top 5 categories – (excluding restraint) March 2023 vs October 2023



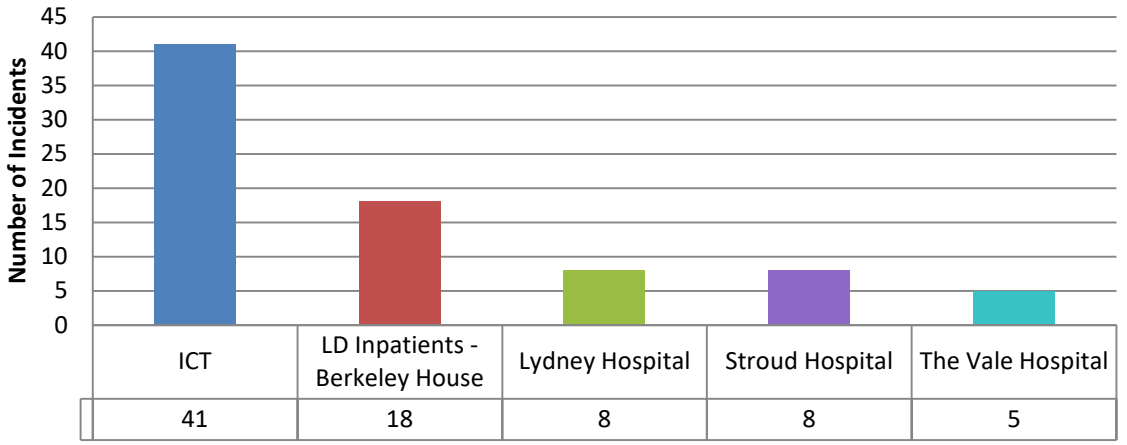
Increase in low harm patient safety incidents

As shown on the previous slide, there has been an increase in the number of low harm patient safety incidents reported, with 8 data points above the mean since March 2023. The largest increases in low harm incidents reported have been skin integrity (including pressure ulcers), up 26 from March to October 2023, and falls, up 13 from March to October 2023. The majority of the increase in low harm patient incident reporting has been in ICTs. The SPC chart below shows the increase in low harm skin integrity incidents since March 2023 reported in ICTs (8 data points above the mean), which correlates with the overall increase in low harm incident reporting over the same period.

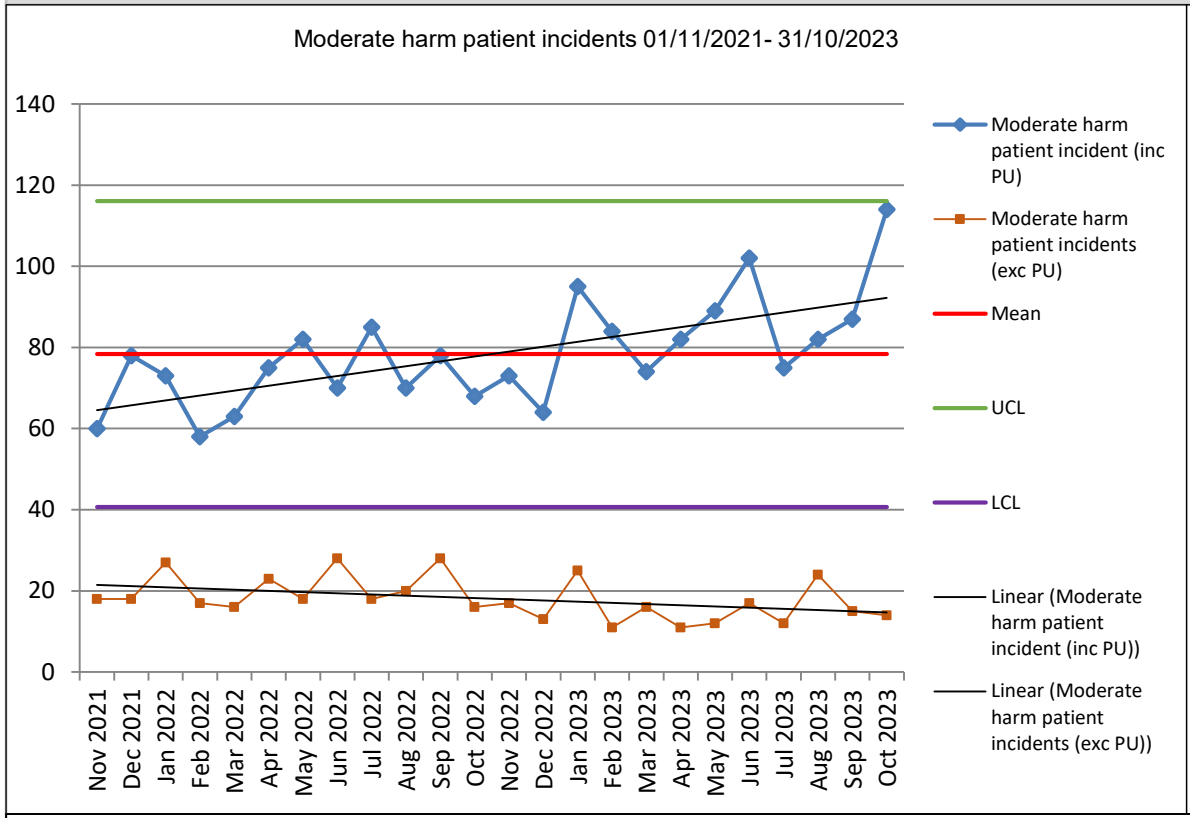
Low harm skin integrity (including PU) incidents across ICTs 01/11/2021- 31/10/2023

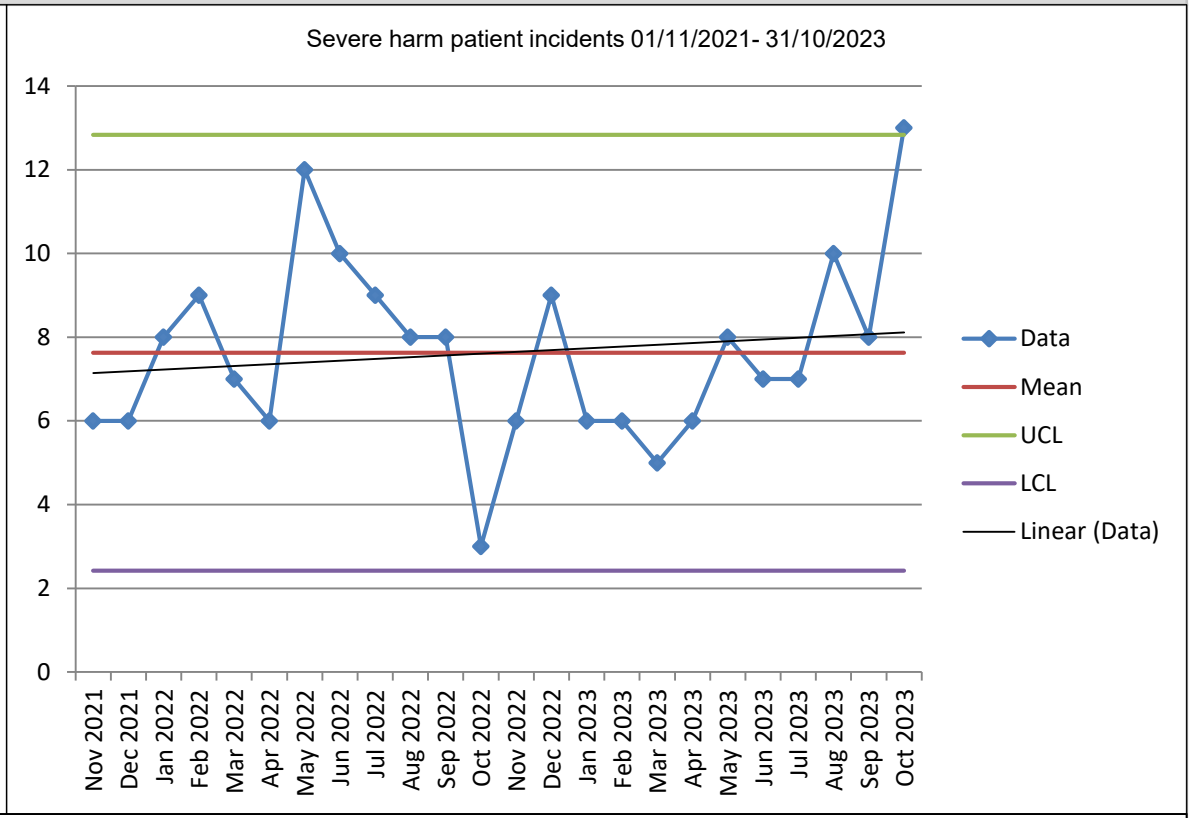


Increase in low harm patient safety incidents, top 5 services – (excluding restraint) March 2023 vs October 2023



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





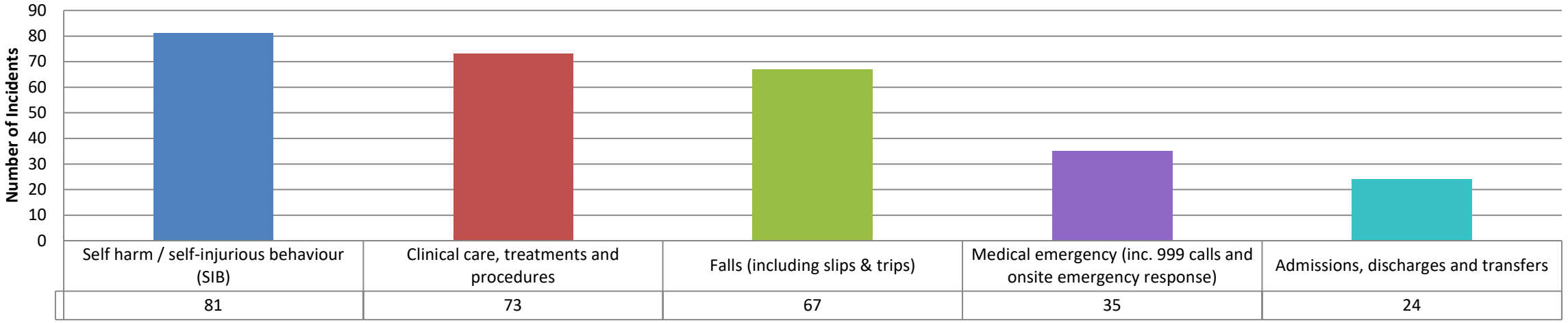
Moderate Harm Incidents over time - The picture emerging here, despite the mean not altering at present, is a rise in the number of reported moderate harm incidents. Currently 8 data points emerge on or above the mean. There is an increase in skin integrity incidents and a general reduction in all other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

The PST monitor these routinely and capture these on a team tracker which are reviewed at regular points in the working week. In October, 100 of the 114 moderate harm incidents reported were related to skin integrity, the majority of which are reported by ICT's. There are three key factors that are driving an increase in number and severity of pressure ulcers; circulatory changes following Covid-19 infection, deconditioning of patients who live at home and have become more socially isolated and physical immobility during and following Covid-19 infection. The PST have commenced a thematic review of skin integrity incidents across 2 ICT's. The thematic review will report early findings to ICT's and ICG. Importantly, the themes will form the workplan of the ICS wide PU workstream as prevention and early identification is often outside of the Trusts remit and requires a system approach which is outside the influence of any one organisation.

Severe Harm Incidents over time - Following a largely static picture in 2023, there has been an increase in severe harm pressure ulcer incidents in October, it is highly likely that these are directly linked to those patients who are approaching end of life. This picture is mirrored regionally and nationally.

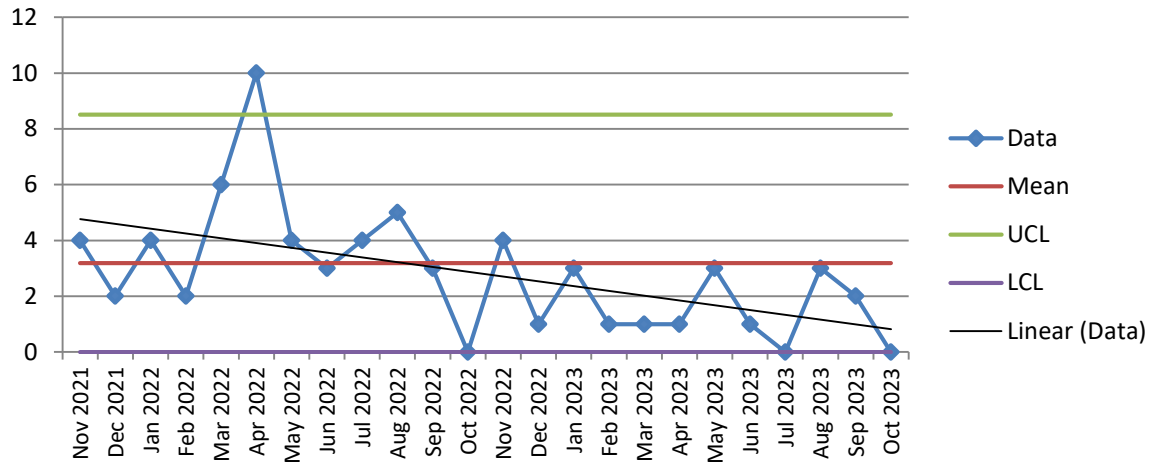
CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Incident Data

Top 5 moderate harm (as reported) patient incident categories (excluding skin integrity) 01/11/2021 to 31/10/2023

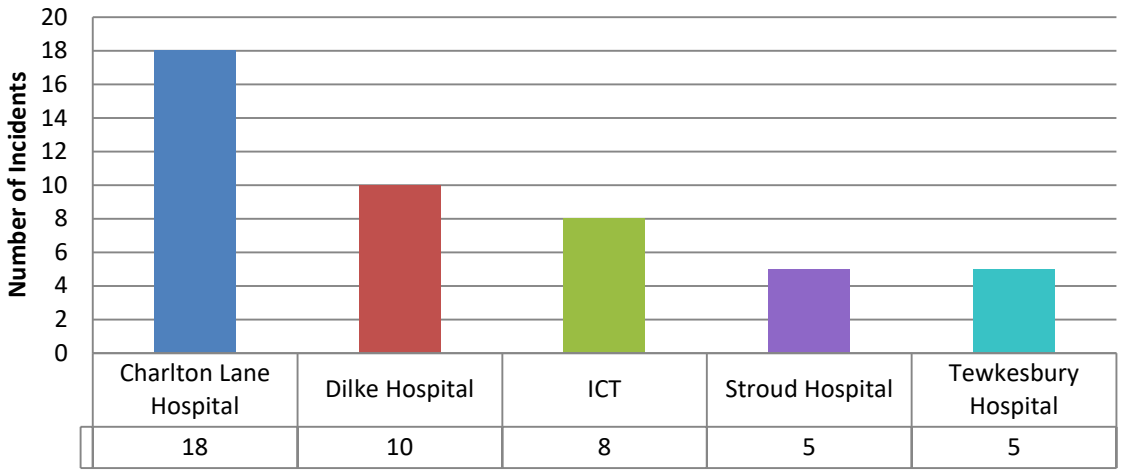


Moderate harm patient incidents (excluding skin integrity)
The chart above shows the 5 highest categories of reported moderate harm patient incidents (excluding skin integrity) over 24 months. Moderate and severe harm self injury and ligatures activity is monitored on a weekly basis and is shared with Matrons, Team Managers, Heads of Profession and NTQ. There are 4 new SOP's to support the safe management for those that self injure and care plans are assessed against these standards on a weekly basis.
The charts below provide a breakdown of moderate harm patient falls incidents over the same period. There were no moderate harm patient falls incidents in October 2023.

Moderate harm patient falls 01/11/2021- 31/10/2023



Moderate harm patient falls – 5 highest reporting services 01/11/2021 to 31/10/2023



Quality Dashboard

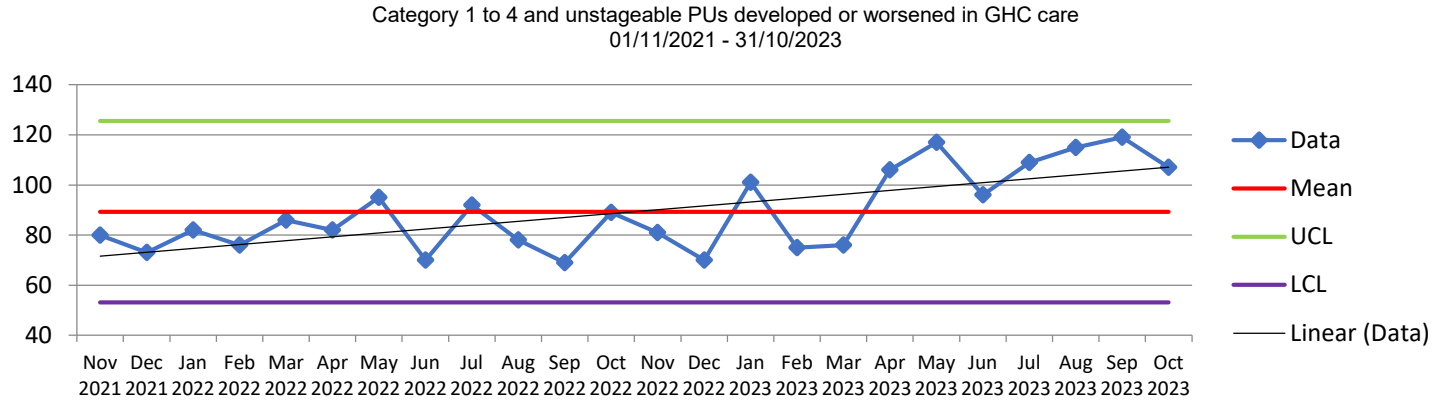
Gloucestershire Health and Care NHS Foundation Trust

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%	98%	98%						99%	G		
Number of HODA Clostridium Difficile Infections (C Diff)	N	16	10	3	0	0	0	2	0	0						5	G		
Number of C Diff cases (days of admission plus 2 days = 72 hrs) - avoidable	N	0	0	0	0	0	0	0	0	0						0	N/A		
Number of MRSA Bacteraemia	N	0	0	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		978	106	117	96	109	115	119	107*						769			
Number of Category 1 & 2 pressure ulcers developed or worsened within our care.	L - R		735	82	91	73	85	90	93	68*						582			
Number of Category 3 pressure ulcers developed or worsened within our care.	L - R		33	5	5	3	5	2	2	12*						34			
Number of Category 4 pressure ulcers developed or worsened within our care.	L - R		18	1	1	1	1	1	1	1*						7			
Number of unstageable pressure ulcers developed or worsened within our care.	L - R		192	18	20	19	18	22	23	26*						146			

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

HCAI: There were 0 post 48-hour Clostridium Difficile in September (C. Diff), and no MRSA infections recorded in October Note our ICB threshold has been set at 16 for the year.



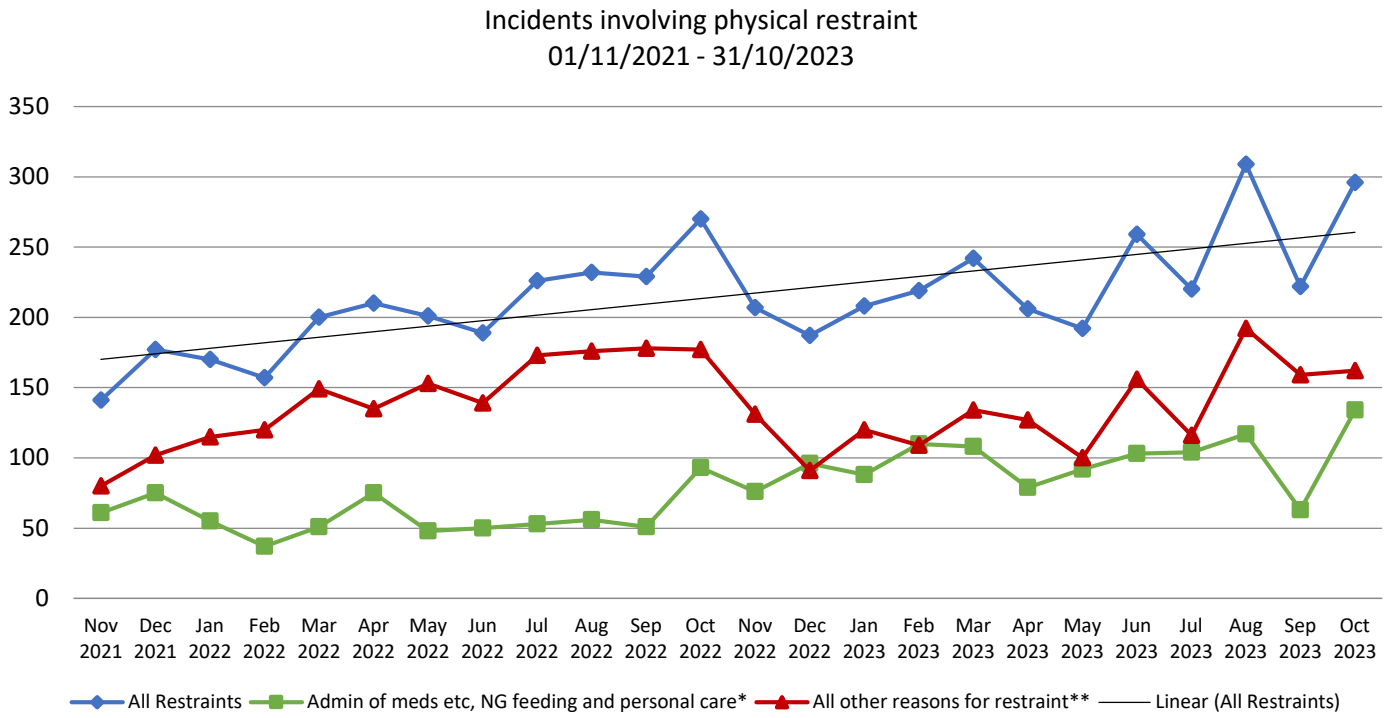
Pressure Ulcers:

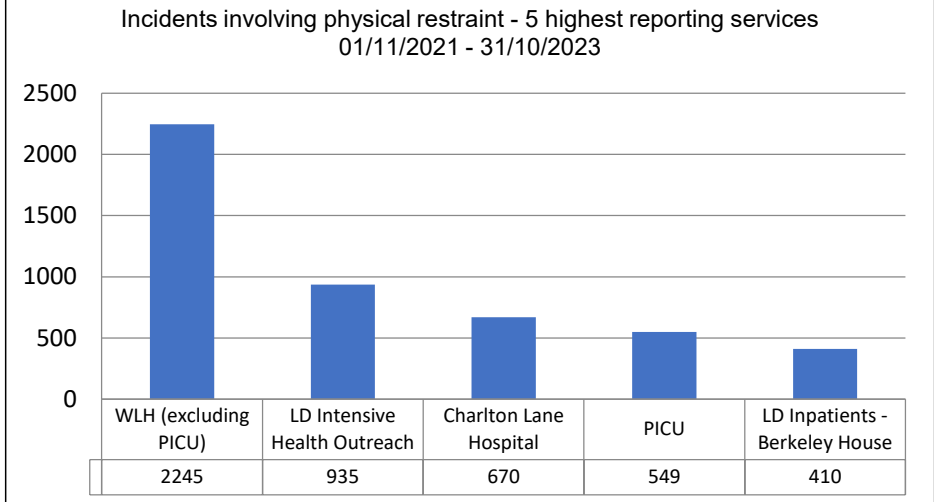
All cat 3, 4 and unstageable pressure ulcers each month are subject to senior clinical review as part of our validation process.

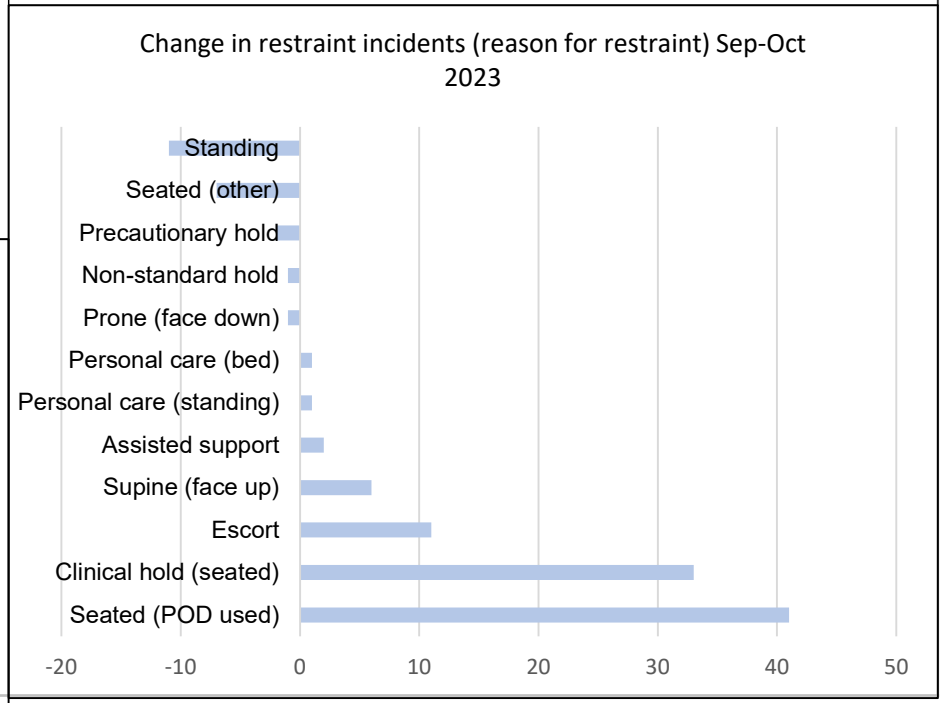
***October data has not been fully validated so PU classification is likely to alter due to duplication of reporting etc. 76% of skin integrity incidents from October have been reviewed and closed**

The SPC chart to the left shows data, from 2021 to date, of moderate harm pressure ulcers that have developed or worsened in our care. This is a useful visual representation of incidence over time and compliments the tabled month by month detailed analysis.

Incidents involving restraint







*Lawfully administer medicines or other medical treatment, facilitate nasogastric (NG) feeding and facilitate personal care

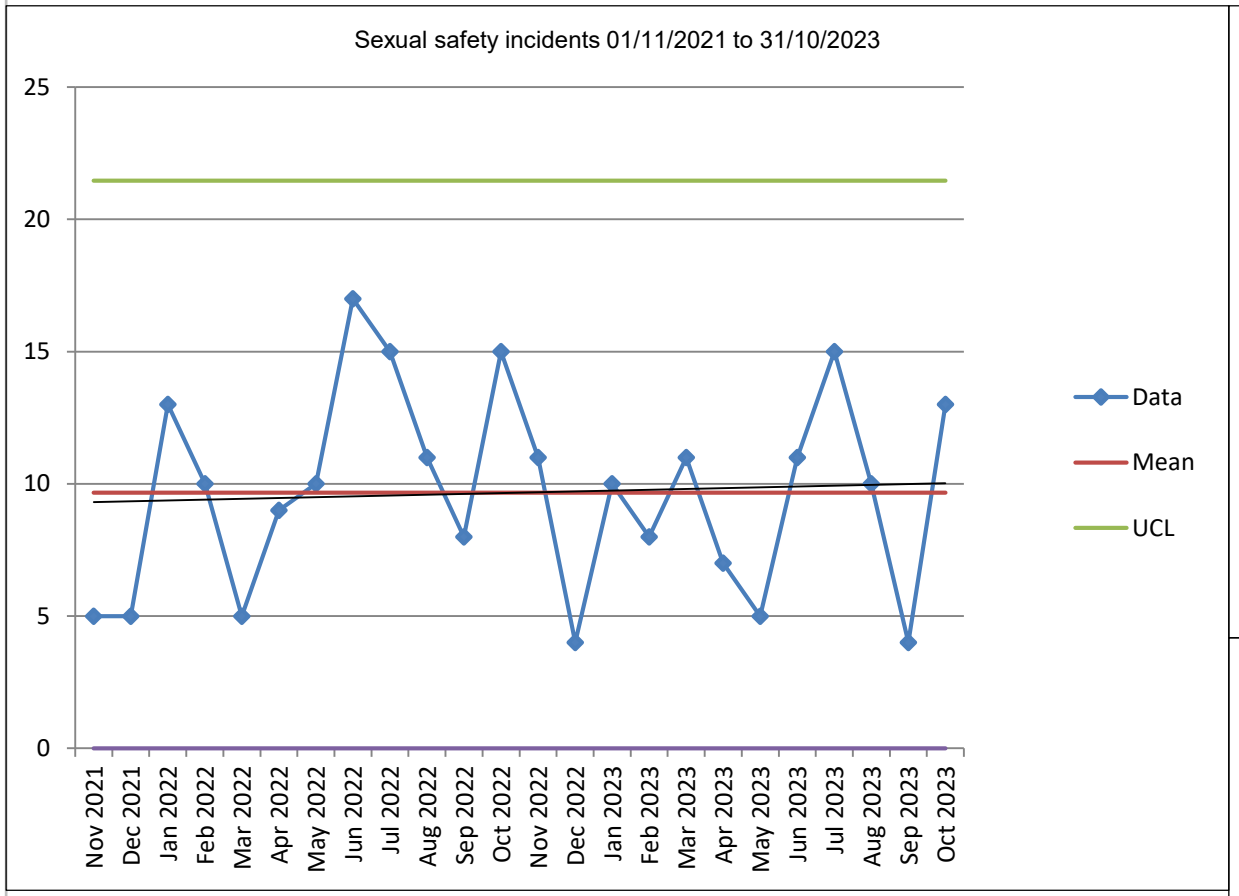
**Prevent a patient being violent to others, prevent a patient causing serious intentional harm to themselves, prevent a patient causing serious physical injury to themselves by accident, prevent the patient exhibiting extreme and prolonged over-activity, prevent the patient exhibiting otherwise dangerous behaviour, undertake a search of the patient's clothing or property to ensure the safety of others, prevent the patient absconding from lawful custody and other/not known.

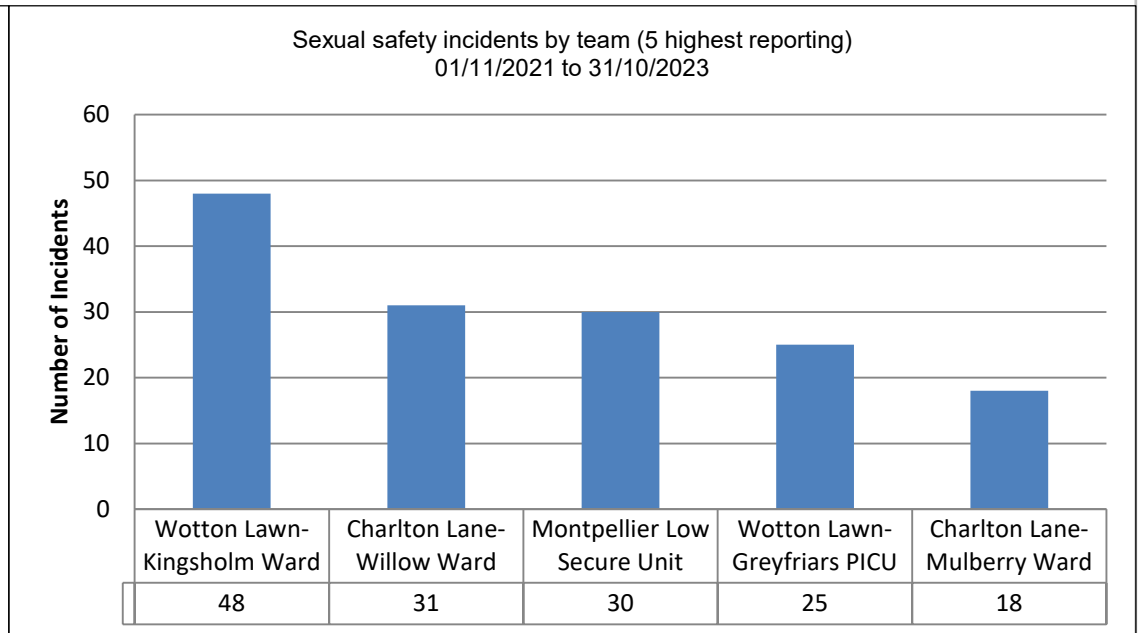
The Positive and Safe meeting continues to review all activity on a monthly basis and a weekly summary is provided to all team managers to ensure we have regular oversight of restraint and can take action to support teams. There have been no moderate harm restraint incidents reported in the Trust since April 2020.

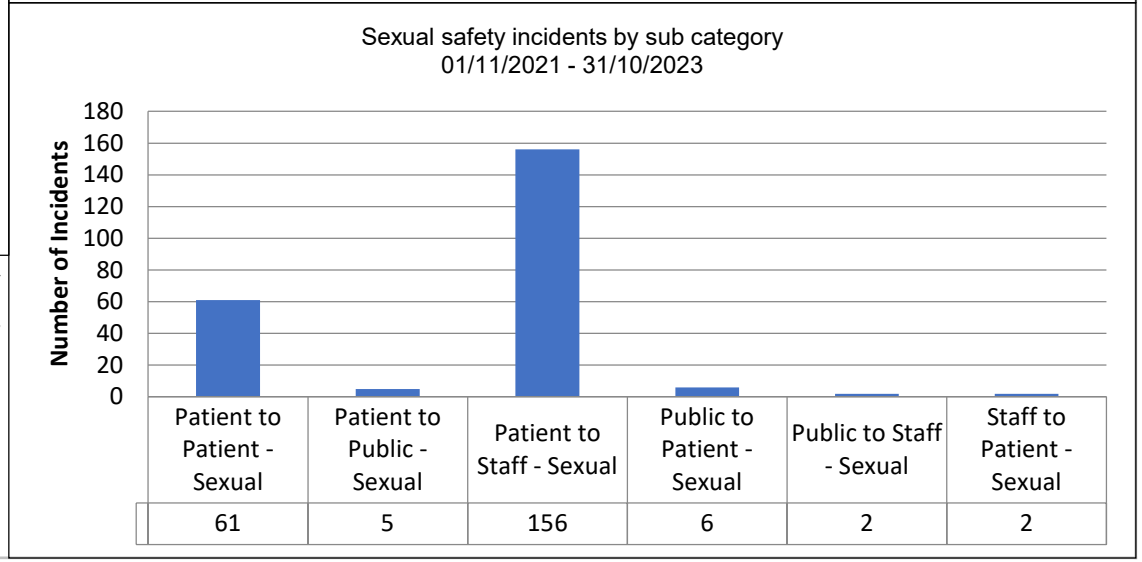
There has been an increase in the use of seated restraint in October, following a fall in September. The increase is mainly due to two areas:

- IHOT facilitate clinical holding to enable phlebotomy and vaccinations; it is projected that both the influenza and Covid-19 booster vaccination programmes will account for increased interventions throughout Q3
- The therapeutic interventions to support a female patient requiring NG feeding have not been as effective in October as they were in September

Sexual Safety Incidents







NHS England have developed a toolkit designed to support colleagues to discuss and tackle unwanted, inappropriate and/or harmful sexual behaviour in the workplace. GHC have a local plan, ongoing work continues regarding reducing sexual behaviour harms and incidents and data collection is more robust due to improved sexual safety incident reporting. Policy alignment is taking place currently to strengthen sexual safety and connect practices..

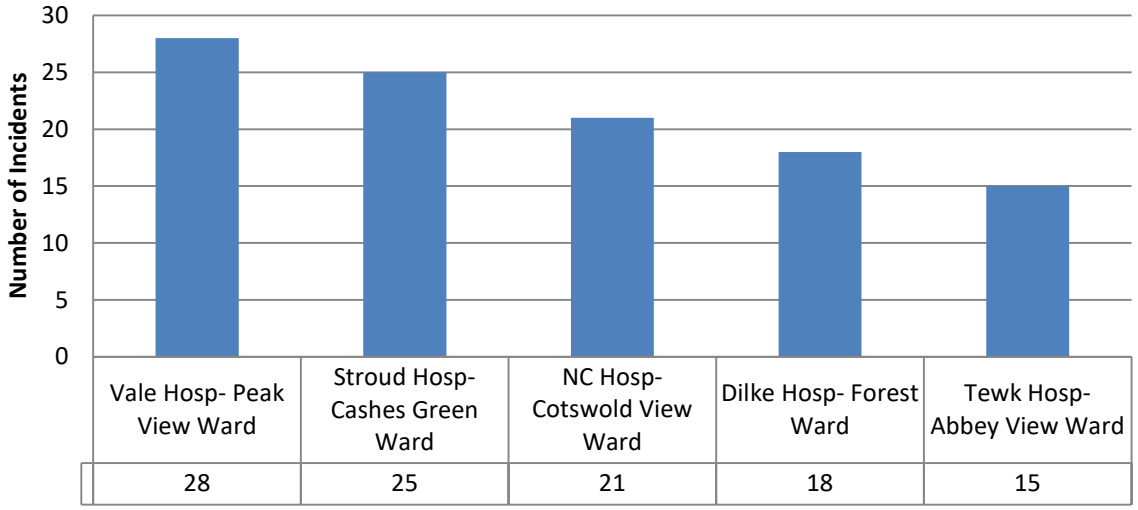
During October, mental health inpatient areas reported most sexual safety incidents of disinhibition and harassment. 6 'other' incidents were reported, the detail of 4 of these shows they could be recategorised as sexual assault and harassment and a review of these are in progress.

93% of incidents reported were patient to staff with the majority being male service user to female colleague. This is being addressed via an OD/HR project to promote the Sexual Safety Charter through the Violence and Harm Reduction workstream..

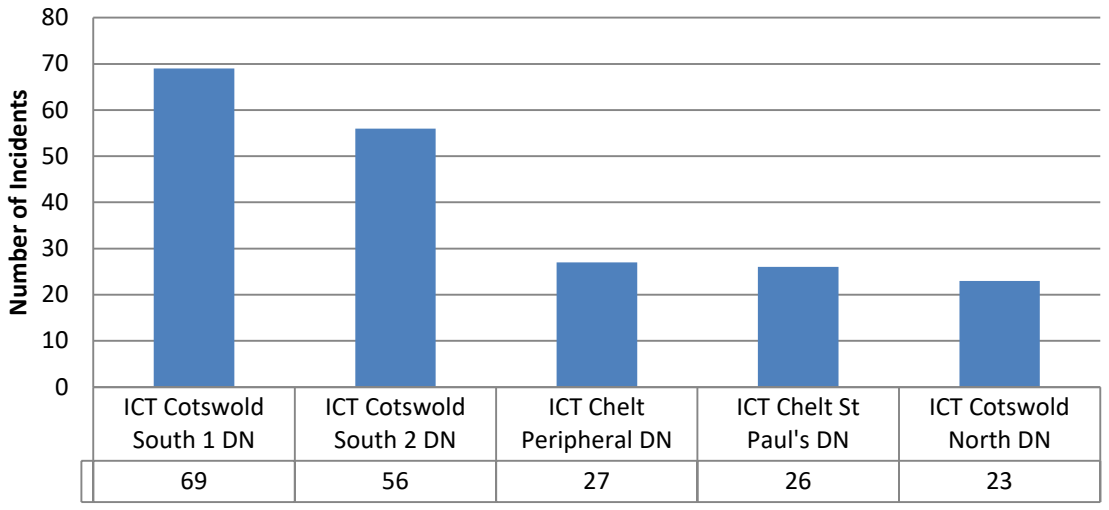
Incidents awaiting review and confirmation of level of harm: data priority areas and actions underway

MH inpatient wards/units (Top 5) –
Open incidents (awaiting review / being reviewed) as of 07/11/2023

Community hospital wards (Top 5) –
Open incidents (awaiting review / being reviewed) as of 07/11/2023



ICT teams (Top 5) –
Open incidents (awaiting review / being reviewed) as of 07/11/2023



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

The number of open incidents, excluding serious incidents, that have yet to be reviewed by Managers has decreased by 2094 since 8 March 2023, **representing a 59.3% decrease in open incidents across the Trust.**

The PST will continue to work with managers to ensure Datix are reviewed and closed in a timely manner in order that any learning is identified in a timely manner.

Quality Dashboard

NHS
Gloucestershire Health and Care
NHS Foundation Trust

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

Closed cultures – identification and risk factors

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 delivered a Board development session on the report's findings and we are constantly seeking to improve Trust protective activity in this area of practice .

November 2023 update

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

All Wards are working on improvement plans for recording Clinical Supervision via the new electronic recording system. This system now enables daily monitoring of all supervision taken place within the 40 day period Trust mandated standard. All of the wards subject to additional monitoring for closed culture risks are showing good levels of supervision taking place.

The Trust has been actively encouraging colleagues in inpatient mental health and learning disability services to complete the national Trust Staff survey. Historically these areas have been lower reporters despite the Trust overall having relatively high levels of response rates amongst peer NHS Trusts.

Independent advocacy – how it works at the Montpellier Unit

Our independent advocate attends the Unit every Tuesday They are visible and available for all patients during Tuesday morning.

Every patient is offered a referral to advocacy when their section rights are read and we have posters displaying how to access advocacy (contact details or simply talk to a member of staff who can make a referral).

Our advocate also introduces themselves at the point of admission for every new patient .A referral to advocacy is also part of our admission checklist – It is offered within 24 hours.

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Trust safeguards against closed culture risks

- Trust culture and values
- Clinical supervision
- Staff wellbeing support
- Physical restraint monitoring – weekly dashboard and scrutiny
- Freedom to Speak Up activity
- 2023/24 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
- My Care and Treatment Review activity

Promoting an open culture

Greyfriars Ward

The Ward promotes carers attending ward rounds for their families and offer alternative ways of attending, such as Teams invites.

Staff continue to send out the carers leaflets and regularly review the Engagement, Activity and Physical Health (EAP) team agenda to ensure they are facilitating varied activities, taking into account patients' suggestions made during community meetings.

Montpellier Ward

The use of advocacy and connecting feedback to South West NHSE commissioners is being undertaken by the ward manager

The team are developing how they write care plans collaboratively with patients. A focus on formulation and health outcomes will allow patients and staff to write care plans more effectively and collaboratively.

Berkley House

The Trust is working with commissioners to develop new reporting for the Independent Supporters who meet regularly with the patients

Commissioners are in the process of supplying additional independent advocacy support at the unit

Charlton Lane Hospital (incl Willow Ward)

Feedback from a family following their mother's discharge

Thank you ever so much to each and everyone in the Willow Ward who is doing a fantastic job looking after elderly people with mental health.

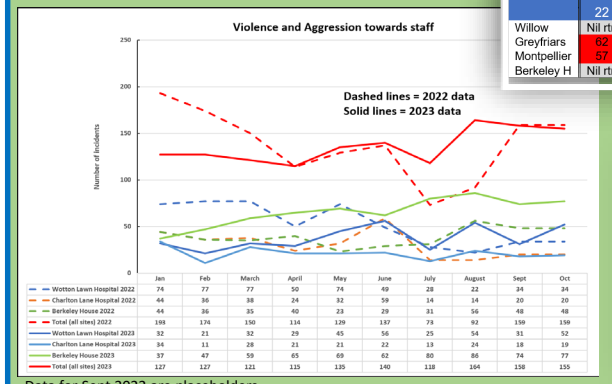
Thank you is a very small word for the love and affection people get from each and every staff on Willow Ward. We always felt that my mother was in safe hands and very well looked after. Thank you.

Visit	Site	Patients seen	
		Gave feedback	Declined
9/11/23	CLH	13	–
12/10/23	WLH	9	–

Patient and Carer Experience Team

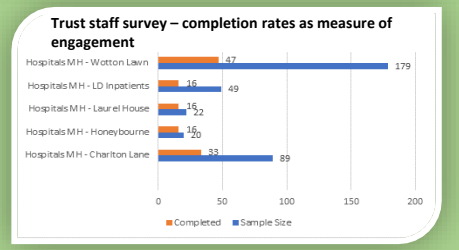
The team regularly visit our hospitals to speak directly to patients and carers during visits to actively seek feedback and support people with complaints. CLH, Charlton Lane Hospital; WLH, Wotton Lawn Hospital.

Supportive Trust datasets and monitoring metrics



Data for Sept 2022 are placeholders.

	Breakaway (%)						Full PBM (%)						Full PVMA (%)					
	Jan 22	June	Aug	Sept	Oct	Nov	Jan 22	June	Aug	Sept	Oct	Nov	Jan 22	June	Aug	Sept	Oct	Nov
Willow	Nil rtn	91	77	71	68	100	92	92	89	97	91	97	n/a	n/a	n/a	n/a	n/a	n/a
Greyfriars	62	82	96	76	79	76	n/a	n/a	n/a	n/a	n/a	n/a	90	83	88	85	85	85
Montpellier	57	68	100	73	71	70	n/a	n/a	n/a	n/a	n/a	n/a	60	93	93	93	93	91.5
Berkeley H	Nil rtn	100	100	100	100	100	98	90	88	86	86	80.5	n/a	n/a	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.

All data are 2023 apart from Jan 22; PBM and PVMA are physical interventions training. Snapshot dates: 27/1/22, 27/6/23, 2/8/23, 4/9/23, 6/10/23, 6/11/23.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES SAFE?- Mandatory Training **Development Slide – Training and supervision – Please note this is a new slide and subject to further development**

Service – data as at 19/10/23	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	99.0%	100%	99.0%	99.6%	94.4%	96.3%	94.4%	98.10%	98.5%	88.4%	100%	N/A
Dilke Hospital	100%	100%	91.2%	100%	98.2%	94.7%	100%	100%	100%	94.6%	100%	N/A
Lydney Hospital	100%	100%	85.4%	100%	95.0%	97.5%	100%	100%	100%	95.4%	100%	N/A
MIIU's	98.9%	100%	97.9%	100%	96.9%	100%	100%	99.3%	100%	87.8%	98.9%	N/A
North Cotswold Hospital	96.3%	100%	92.7%	98.1%	90.9%	89%	89.0.%	100%	89.0%	90.9%	97. 8%	N/A
Stroud Hospital	97.5%	98.3%	86.6%	97.5%	97.5%	97.5%	94.1%	100%	94.1%	85.0%	96.9%	N/A
Tewkesbury Hospital	100%	100%	91.4%	100%	98.7%	98.7%	98.7%	100%	98.7%	93.3%	100%	N/A
The Vale Hospital	98%	100%	76.9%	96.1%	98.0%	98.0%	98%	100%	98.0%	94.4%	100%	N/A
AMHP	100%	100%	100%	100%	100%	100%	100%	100%	100%	97.2%	100%	N/A
Charlton lane Hospital	100%	100%	91.2%	100%	98.9%	98.9%	95.6%	95.8%	89.7%	95.26	98.9%	79%
Community Forensics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	N/A
Criminal Justice Liaison	100%	100%	100%	98.7%	100%	100%	100%	100%	N/A	95.8%	100%	N/A
Crisis Resolution HT	100%	100%	97.5%	100%	97.5%	98.7%	98.7%	99.1%	81.8%	88.3%	98.6%	N/A
Honeybourne	95.0%	100%	85.0%	100%	90.0%	95%	100%	100%	73.6%	85.7%	100%	N/A
Laurel	100%	100%	82.6%	100%	100%	100%	95.6%	100%	95.4%	90.1%	100%	N/A
Berkeley House	100%	100%	83.3%	100%	90..4%	100%	97.6%	100%	76.7%	91.9%	100%	80%
Psychiatric Liaison	100%	100%	93.7%	100%	90.6%	100%	100%	100%	100%	94.4%	100%	N/A
Wotton Lawn Hospital	98.8%	98.2%	86.7%	99.4%	93.7%	94.8%	95.4%	100%	86.7%	88.5%	98.8%	70%

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 October figure is 85% which remains the same as previous month and is being impacted by higher sickness levels.

Sickness - The October figure is 5.3% - which is an increase of 0.4% over last month

Clinical Supervision – The October figure has increased to 35.59% 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 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 - October 2023

- There has been an average of 39.75 patients that have Not Met the Criteria to Reside (nCTR) in a community hospital in October 2023
- There has been an average of 5.25 patients in total Not Meeting the Criteria to Reside (nCTR) for over 30 days in October 2023

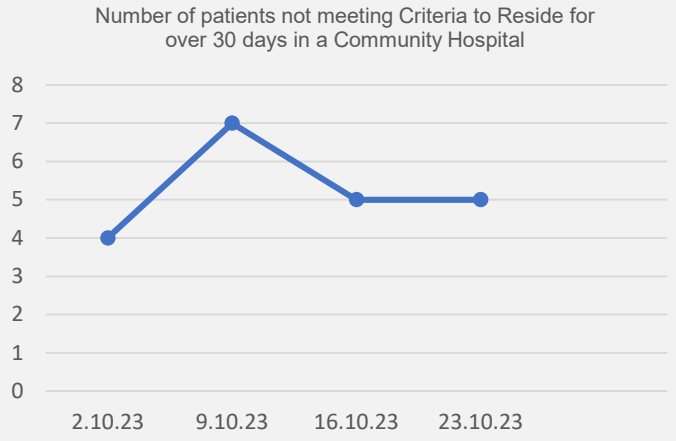
- Overall, there has been a slight increase in the number of patients that have Not Met the Criteria to Reside.
- The number of patients waiting has reduced, partly supported by the reduction in the number of people awaiting progression from the service, which has enabled flow, but also the implementation of the hybrid model with Homefirst, brokerage and reablement.
- Bed days lost due to housing remain significant and are the main reason for delays in 5 out of 7 patients who currently have not met CTR for more than 30 days. Issues have been escalated to ICS Frailty Housing Officer and ICB.

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

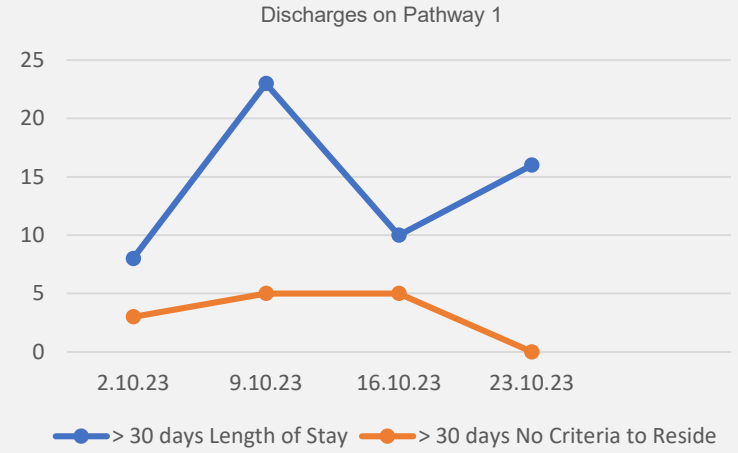
Pathway One 'Homefirst' – Return Home with additional Support 1
Homefirst principle with support to recovery or pre-existing Domiciliary Care that needs to be increased

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 2.10.23 – 29.10.23. Pathway 1 can be defined as discharge home with support from Home first, a self-funding care package or a care package sourced by Social Care.



Showing the number of patients **discharges** on Pathway 1 who did not meet the criteria to reside for > 30 days. Date range: w/commencing 2.10.23 – 29.10.23.

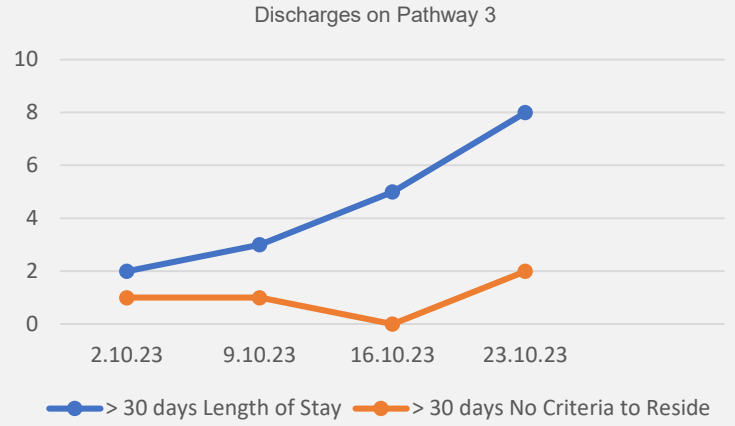


Chart 3 - Showing the number of patients delayed on Pathway 3 for over 30 days. Date range: week commencing 2.10..23 – 29..10.23. Pathway 3 is defined as discharge to a Care home, either funded by the individual or through Social Care funding.

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

Long Length of Stay Patients- MH Hospitals.

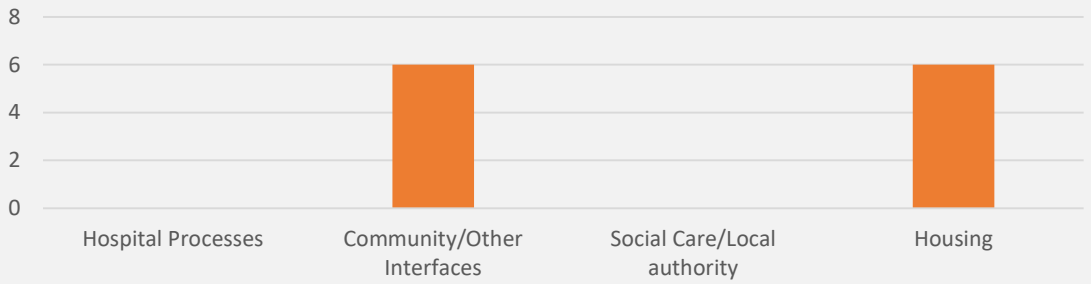
Clinically Ready for Discharge, formally known as DTOC, is the new terminology for reporting delays in MH since January 2023. "Clinically Ready" does not indicate complete recovery, it is the point at which a person could be safely assessed, cared for and treated at home or in a less restrictive setting.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

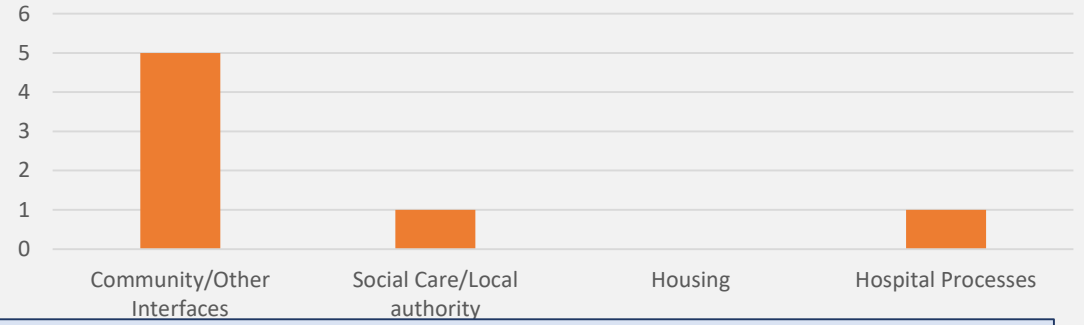
Headline Data - October 2023: Total of patients across WLH, CLH, Recovery, LD = 23 WLH = 12 CLH = 7 Recovery Units = 3 Learning Disability = **1**

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



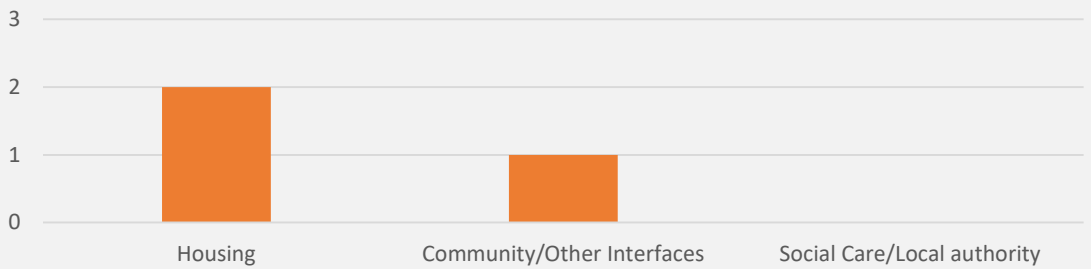
Themes related to delays:-
Community/Other Interfaces – lack of specialist health care provision.
Social Care/Local Authority – lack of Social care provision to support assessment/discharge.
Housing – homelessness; lack of appropriate supported accommodation

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

- = Developing a FCP Occupational therapist in Primary Care
- + CYPS Public Health Liaison Nursing
- = Inappropriate referrals into therapies (OT) from care homes

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

- + Smartcard use for RIO by bank and agency workers MH and LD inpatients
- = Staff retention - itchy feet
- = Improving Access & Delivery of Family Interventions with Psychosis & bi-polar within the Early Interventions Team
- = Toilet training - improving outcomes for children
- = Improving the number of patients receiving their depots in primary care
- + Ensuring meaningful appraisals and assuring completion levels
- + Increasing number of sustainability champions
- * Reducing restrictive practice in Dean Ward, WLH
- * Reducing restrictive practice in Greyfriars, WLH
- ↑ School nursing mental health pathway and resources
- ↑ Reducing School Nursing waiting list for primary school aged children

3. Improvement idea initiated

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

- = Sexual health specimen mis-labelling
- = (s) Leadership opportunities for AHP students
- = CYPS SLT waiting list
- = Increasing service user and carer involvement in QI
- = (s) Paired ROMs compliance – CAMHS
- = Reducing medication errors in CLH
- = Health checks for those with SMI
- = CYPS physio service flow
- = (s) Improve communication and liaison between maternity service and health visiting service
- =Patchwork project Infection Prevention Control
- = Decreasing laxative use CLH
- ↑ Improving access to ECT in WLH and community

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
- = (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
- = School nursing duty system
- + Improving standard of observations on Abbey Ward, WLH
- + Improving standard of observations on Dean Ward, WLH
- ↑ Antipsychotic monitoring CAMHS
- ↑ Substance misuse in CAMHS

5. Improvement idea sustained & implemented

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

- ↑ Improving standard of observations on Priory Ward, WLH

Directorate	No of Projects
Countywide	4
MH Hospitals and UC	11
PH Hospitals and UC	2
Adult MH/PH/LD Community	7
CYPs	14
Corporate	9
Total:47	

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

Training data October 2023:
26 Silver – 0.4% workforce
584 Bronze - 13% workforce
528 Pocket QI – 11.7% workforce

Supervision

Childrens: Group Supervision Compliance **63%**

Integrated Group Supervision Sessions: **27**

One to One Supervision Sessions: **4**

Adults Group Supervision Sessions **2**

Training

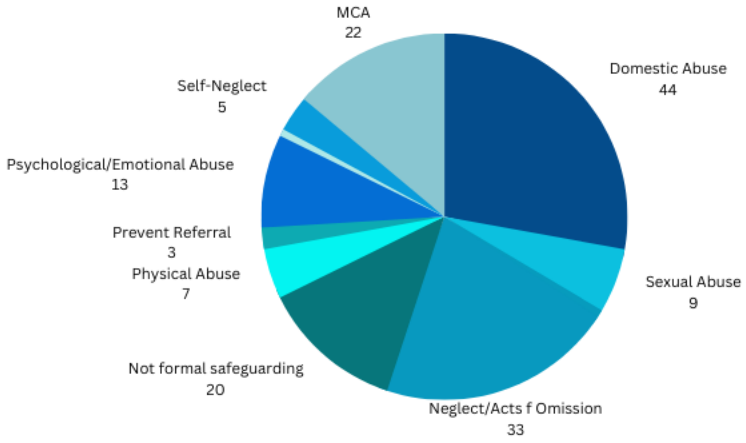
97%	89%	89%	78%	85%
LEVEL 1: INDUCTION	**LEVEL 2: THINK FAMILY**	**LEVEL 3: CHILD PROTECTION**	**LEVEL 3: ADULT PROTECTION**	**LEVEL 4: ADULT PROTECTION**
Sep 23:97%	Sep 23: 97%	Sep 23: 89%	Sep 23: 76%	Sep 23: 85%
Aug 23: 97%	Aug 23: 91%	Aug 23:85%	Aug 23: 88%	Aug 23: 85%
Jul 23: 96%	Jul 23: 91%	Jul 23: 88%	Jul 23: 72%	Jul 23: 74%

Referrals and Advice Line

182 OCT Contacts to Advice Line (adults and children combined)
Jul 23: 133 Aug 23: 132 Sep 23: 132

38 OCT Referrals made to GCC (adults and children combined)
Jul 23: 39 Aug 23: 39 Sep 23: 30

Referral Themes



Summary information

The Safeguarding Dashboard provides assurance that:

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

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

The Safeguarding Dashboard is presented in 3 sections:

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

Summary

Highlights

- In October, The Head of Safeguarding and Named Nurse for Safeguarding Children left GHC. The safeguarding team has a new management structure which is in the process of being filled. A new Head of Safeguarding has been appointed and will start on 18th December 2023. The new Named Nurse for Safeguarding Children started on 30th October, and the new Named Lead for Safeguarding Adults joined the Trust on 6th November.
- The current children's supervision offer is being reviewed so that GHC practitioners who work with Children and Young People will be able to choose from a menu of safeguarding sessions and select which one they would like to attend according to their need. The safeguarding team are currently offering group supervision sessions for multidisciplinary staff, 121 sessions, management sessions and Team sessions which include the Children in Care, Learning Disabilities, Vulnerable Children's Service and Sexual Health. In October, face to face supervision sessions started with good feedback. The full new supervision offer is expecting to be introduced in March 2024.
- The October Safeguarding Learning Lunch was attended by approximately 35 Trust Staff accessing the session on 'The role of the advocacy in safeguarding'. Discussions took place about different cases, and Power of attorney. The next Learning Lunch is on 28th November about 'Safeguarding Children with Learning Disabilities'.
- The MASH team is expanding and has recently employed 3 x Band 6 nurses, and about to interview for 2 x Band 4 administration staff who are all expected to start early in the new year. This is to support with the new strategy meeting process in which all strategy meetings for all of health within Gloucestershire now is requested and managed by MASH health.

Challenges/Risks

- As already highlighted, the safeguarding team has a new management structure. The new Head of Safeguarding will be joining the team on 18th December. Until then, this position is currently empty with the safeguarding team being supported by the Deputy Director of Nursing. With the management structure changing, it is acknowledged that the efficiency may be affected whilst staff settle into new roles.
- 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. The target date for completion was this month (Nov 2023) but maybe delayed whilst roles in the safeguarding team are changing. The Children's safeguarding template is a priority and will be pushed forward to meet timescales.
- 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. In Q2 the MCA Lead has delivered 24 bespoke MCA training sessions to Teams.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES SAFE

Safe Staffing Inpatient data October – 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	7.5	1	0	0	0	0	0	0
Abbey	127.5	14	15	2	0	0	0	0	0	0
Priory	22.5	3	0	0	0	0	0	0	0	0
Kingsholm	0	0	0	0	0	0	0	0	0	0
Montpellier	0	0	7.5	1	0	0	0	0	0	0
Greyfriars	37.5	5	0	0	0	0	0	0	0	0
Willow	0	0	22.5	3	0	0	0	0	0	0
Chestnut	35	4	22.5	3	0	0	0	0	0	0
Mulberry	7.5	1	7.5	1	0	0	0	0	0	0
Laurel	285	29	52.5	4	0	0	0	0	0	0
Honeybourne	22.5	3	0	0	0	0	0	0	0	0
Berkeley House	45	6	312.5	41	0	0	0	0	0	0
Total In Hours/Exceptions	582.5	65	447.5	56	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 November 2023. We have cross referenced highest exceptions with patient safety and experience data. Laurel House have reported the highest code 1 exception levels, followed by Abbey Ward. The Matrons report no adverse impact on care delivery or patient experience. Code 1 exceptions at Laurel House were attributable to HCA vacancies on early and late shifts, this has presented the opportunity to have 2 RMN's on duty at one time. Code 2 exceptions at Berkeley were attributable to all shifts (RN and HCA) apart from RN nights. The increasing sickness and vacancy rates have contributed to this increase, they are at the highest rate since November 2022. 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	125.16%	5.7	-2.0
Abbey Ward	104.62%	0.9	6.5
Priory Ward	136.94%	9.8	5.2
Kingsholm Ward	119.73%	4.0	-1.2
Montpellier	118.23%	7.6	14.1
PICU Greyfriars Ward	134.54%	8.7	23.6
Willow Ward	107.09%	9.6	8.4
Chestnut Ward	106.45%	15.4	-3.4
Mulberry Ward	106.67%	7.0	9.5
Laurel House	101.88%	5.4	0.8
Honeybourne Unit	103.76%	6.0	-2.1
Berkeley House	96.33%	8.9	29.1
MHH Totals Avg (Oct 2023)	**110.52%**	**7.6**	**10.9**
Previous Month Totals	110.50%	7.1	9.2

Physical Health			
Ward	**Average Fill Rate %**	**Sickness %**	**Vacancy %**
Coln (Cirencester)	97.24%	4.9	14.9
Windrush (Cirencester)	98.37%	6.2	17.9
The Dilke	99.59%	3.8	17.6
Lydney	96.08%	6.6	15.1
North Cotswolds	100.43%	8.0	4.6
Cashes Green (Stroud)	96.05%	1.3	4.4
Jubilee (Stroud)	97.66%	4.5	12.3
Abbey View (Tewkesbury)	108.64%	5.4	4.5
Peak View (Vale)	92.12%	11.4	13.9
PHH Totals Avg (Oct 23)	**98.47%**	**6.1**	**10.6**
Previous Month Totals	103.20%	5.8	12.9

NHSE Zero HCSW Vacancy Commitment Inc. bank – 3 month report	
Aug	94.39
Sept	100.8
Oct	99.99

	FTE Budgeted	FTE Actual	FTE Variance
Grand Total	**608.63**	**508.64**	**-99.99**
327 E11850 LD Inpatients - Berkeley House	49	32.4	-16.6
327 B11200 Ciren Hosp- Windrush Ward	17.06	8.07	-8.99
327 B11201 Ciren Hosp- Coln Ward	20.16	13	-7.16
327 E11802 Vale Hosp- Peak View Ward	18.63	12.63	-6
327 G12308 Children Complex Care	11.59	6.8	-4.79
327 G13693 Physical Health Checks	6	2.72	-3.28
327 E11701 Stroud Hosp- Jubilee Ward	14.34	11.07	-3.27
327 D11602 Wotton Lawn- Dean Ward	12.5	9.4	-3.1

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 31 people in recruitment pipeline and in October there were 27 new recruits and 18 leavers. The table opposite is a breakdown of the current HCSW vacancy hotspots.
IR/Recruitment: 1 AHP and 10 International Educated Nurses (IEN) are in the pipeline for 2023. 89 international colleagues have been recruited (from Jan 2021).We received the NHS Pastoral Care Quality Award in September for the high level of care and support we provide to our IEN's. It is presented by NHS England and recognises the Trust's commitment to supporting the pastoral needs of IEN's. 2 IEN's have received promotion to band 6, showing their dedication and professionalism. Our IEN council meets on 15th November. To note that one of our IENs had the pleasure of representing the Trust at the Kings Birthday Celebrations.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN – ARE SERVICES SAFE - Quarter 2 - 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: July 2023 – Sept 2023	**Guardian of Safe Working Hours: Dr Sally Morgan**	
Number of doctors in training (all on 2016 contract)	**In Quarter 2 2023/24 (July) there were 34 MH doctors in training posts.** • 8 Higher Trainees • 3 CT3s • 5 CT2s • 6 CT1s • 5 GP Trainees • 4 FY2s • 3 FY1s	**In Quarter 2 2023/24 (August – September) there were 33 MH doctors in training posts** • 9 Higher Trainees • 5 CT3s • 3 CT2s • 2 CT1s • 5 GP Trainees • 3 FY2s • 6FY1s
Exceptions in this period	• **33 on call shifts had a junior doctor gap mainly due to sickness and a member of staff being taken off on call on Occupational Health advice** • 32 on call shifts were covered by doctors in our bank • 1 was covered by by an Advanced Trainee stepping down • Due to strike action in July, August and September there were a further 26 on call gaps (not including any daily normal working hours cover required) • **9 exception reports in this time period, all at WLH or CLH. One exception resulted in GOSWH issuing a fine (£600), overtime payments agreed in 6 exceptions with 2 exceptions still outstanding.** • **The Junior Doctors Forum was held via Teams on 21st August 2023 and was well attended.** • **GOSWH met with the Modern Matrons from WLH and CLH** to review junior doctor office and rest spaces at both sites to ensure working conditions are adequate and meet the requirements of the trainees particularly in light of the planned increase in foundation trainees. • There are **2 Trainee Wellbeing Reps** who are helping develop the next **Wellbeing Days** planned for next year. • **GOSWH has established contact with the Guardian at GHNHSFT** with plans to meet to improve communication between the organisations.	

Appendix One

Safeguarding Information - October 2023

with you, for you

Summary
Trust Safeguarding Data

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Summary information:

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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.

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Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

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

	Q1	Q2	Oct-23	Nov-23	Dec-23	Additional Information
SAFEGUARDING ACTIVITY						
Advice Line Calls	181	166	77			Good use of the Safeguarding Advice Line continues.
Multi-Agency Request for Service Forms submitted to MASH	55	61	25			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 however this is likely to be delayed). Monthly dip sampling of safeguarding record keeping and the quality of referral is taking place.
Number of Safeguarding Escalations	3	4	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	3	6	4			Expected deaths are infants with known life limiting conditions or cases of extreme neonatal prematurity.
Unexpected	6	0	1			Gloucestershire Child Death Overview Process is followed for each unexpected death. Cause of each death in Q1 has not yet been formally reported. 1 child deaths in October.
RAPID REVIEWS/LCSPR'S						
Number of Serious Incident notifications made by LA	1	1	0			No Serious Incident Notifications submitted to the National Safeguarding Review Panel by the LA in October.
Number of Rapid Reviews attended	1	0	1			1 multi-agency rapid review undertaken in October relating to a large family of 12 children who had minimal GHC involvement. The outcome was that it would not be going onto a LCSPR because the majority of the multiagency practitioners felt that the learning had been identified. However, all of the health representatives - GHC, ICB and GHT all disagreed with this outcome and challenged the decision not for it to progress to a LCSPR.
Number of LCSPR's in progress	1	1	1			1 Gloucestershire LCSPR's in progress, recommendations have been made and approved multiagency action plan is underway. This review is relating to a CIC, considerable GHC involvement. Publication of the report is now expected early December 2023.
MASH HEALTH TEAM ACTIVITY						
Children researched/info shared	2,126	2, 940	1,439			Significant increase in MASH activity/number of children researched in throughout 2023. 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	319	182	102			Q2 saw a significant drop in the number of adults researched for MASH enquires but this has increased in October. The MASH team are only researching adults where there is a clear need to do so. This is not a negative position, in demonstrates appropriate information sharing.
MASH strategy meetings attended	68	115	20			Expected variation in month as expected with MASH activity. The MASH team reported the increase in MASH strategy meetings seen in September is related to physical chastisement.
Demographic information sharing	684	980	221			MASH health are frequently asked for demographic data from multiagency partners - this is due to referral data quality and incomplete data. Q2 saw a huge increase in requests in Q2 due to the new PDVM, where multi-agency partners have incomplete demographic data, so are requesting missing data from health. These requests have reduced in October.
AUDITS						
Single Agency	3	1	1			Monthly Safeguarding Children dip sample audit
Multi-Agency sub group activity	3	0	0			
UNDER 18'S ADMISSIONS						
Number of under 18's admitted to Adult MH Wards	1	0	0			0 children admitted in October.
Number of under 18's assessed under S.136 of the MHA 83/07	7	1	1			1 child assessed in October.
OTHER WORKSTREAMS						
Allegations management – number of referrals to/from the LADO	6	1	0			0 referral made to the LADO in October.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

GHC - Safeguarding Dashboard 2023/24 Adults safeguarding Data	Q1	Q2	Oct-23	Nov-23	Dec-23	Additional Information
SAFEGUARDING ACTIVITY						
Contacts to GHC advice Line	200	231	105			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 in October.
Safeguarding Referrals made to GCC	24	38	13			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	56%	57%	56%			Linked to Risk 107 – recording of household members. Household & Family form completion (MH/ LD Current caseload) – added as new 2023/24 Performance indicator - Threshold: 100%
CASE REVIEWS						
New Safeguarding Adult Reviews/Domestic Homicide Reviews	1	0	0			0 new reviews in October.
Number of Reviews ongoing	15	15	13			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	7	7	7			This includes single and multi agency action plans
MAPPA						
Level 2 Meetings Held	15	15	*	*	*	
Level 2 Meetings Attended	15	15	*	*	*	100% attendance at MAPPA 2 Meetings
Level 3 Meetings Held	6	5	*	*	*	
Level 3 Meetings Attended	6	4	*	*	*	Excellent Level of attendance at MAPPA 3 Meetings
PREVENT						
Number of Prevent Referrals Made	0	0	1			1 Prevent concern raised with the police
Information requests received & completed from Police/Channel	4	8	3			100% response to all police and channel panel information sharing requests, supportive effective planning and decision making.
MARAC						
Families screened/researched	408	435	167			Continued high level of MARAC activity. Minor variation in month.
No.of children open to MH Services	57	36	6			Number of children open to mental health service highlights the emotional impact of domestic abuse on children. Expected minor variation in month.
No.of victims open to MH Services	76	49	20			Highlights the link between the impact of domestic abuse on victims mental health. Expected minor variation in month.
No.of perpetrators open to MH Services	55	61	20			Identifies the number of perpetrators open to MH services. Expected minor variation in month.
Un-uploaded MARAC Action Plans	59	43	0			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	12	9	1			Continued pattern of DOLS applications
Mental Health Services Authorised	5	5	0			Minor variation in month
Physical Health Services Total	39	40	23			Physical health urgent applications (not requiring LA authorisation)
Physical Health Services Authorised	0	0	0			
AUDITS						
Single Agency - Safeguarding Related	1	1	1			Monthly Safeguarding Adults dip sample auditing commenced in November 2022 and continues each month.
Multi Agency Sub - Group Related	1	1	0			
OTHER WORKSTREAMS						
Allegations management - use of PiPoT guidance	3	3	0			0 new allegations in relating to a member of GHC staff in October.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

GHC - Safeguarding Dashboard 2023/24 Training and Supervision Data

	Q1	Q2	Oct-23	Nov-23	Dec-23	Additional Information
TRAINING						
Level 1 – Induction	96%	97%	97%			Consistent month on month compliance level
Level 2 – Think Family	91%	91%	89%			Overall a minor variation in month
Level 3 – Multi-Agency Child Protection	88%	87%	89%			Overall a minor variation in month. Training compliance review being undertaken to identify specific Teams to target to improve compliance.
Level 3 Adult Protection	84%	79%	78%			Overall a minor variation in month. Training compliance review being undertaken to identify specific Teams to target to improve compliance.
Level 4 Adult Protection	75%	81%	85%			Overall a minor variation in month. Training compliance review being undertaken to identify specific Teams to target to improve compliance.
PREVENT:						
Level 1	98%	98%	95%			Continued high level of compliance with Level 1 Prevent Training
Level 2	84%	86%	89%			Training compliance review being undertaken to identify specific Teams to target to improve compliance.
Level 3	92%	97%	98%			Improving picture of compliance with Level 3 PREVENT training
MENTAL CAPACITY ACT:						
Level 1	90%	92%	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	66%	56%	48%			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	*	24	12			Excellent uptake of bespoke team MCA training. Sessions offered has increased month on month.
SAFEGUARDING SUPERVISION						
CHILDREN:						
Group Supervision Sessions	67	66	27			Clinical staff working with children need to attend this supervision 3 x per year. 5 x sessions are delivered per week. Attendance at sessions is excellent, with a maximum of 8 participants per session. Feedback is sought and captured following every session via a Snap Survey – feedback helps to shape future sessions.
Group Supervision Compliance	55%	61%	63%			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	6	4	4			121 Supervision is available to all upon request.
ADULTS:						
Group Supervision Sessions	4	5	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	5	12	3			
One to One Supervision Sessions	2	0	0			121 Supervision is available to all upon request.

Appendix Two
Trust Operational Data Extract – October 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%	61%	56%						47%	R		
	ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	63.93%	78%	68%	65%	80%	80%	76%	78%						72%	R		
	ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	72.81%	78%	78%	80%	75%	77%	72%	73%						77%	R		
	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	50.59%	45%	41%	43%	39%	32%	20%	24%						38%	R		
	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	90.16%	89%	89%	85%	81%	63%	64%	79%						78%	R		
	Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	14.35%	11.0%	13.0%	8%	31%	14%	10%	6%						13%	R		
	Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R	3,279	13437	1241	1415	1447	1167	1374	1490							8134			
	Wheelchair Services Adults : New referrals assessed within 8 weeks	L - C	90%	83.24%	86%	85%	90%	81%	96%	96%	97%						90%	G		
	Wheelchair Services : Under 18's new referrals assessed within 8 weeks	L - C	90%	84.66%	94.0%	83.0%	94%	100%	84%	100%	95%						93%	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%	No longer reported	No longer reported						95%	G		
	Adolescent Eating Disorder - routine referral to NICE treatment start within 4 weeks %		95%	46.95 %	30.0%	30.0%	67%	75%	70%	79%	52%						58%	R		
	Adolescent Eating Disorder - Urgent referral to NICE treatment start within 1 week %		95%	45.1%	87%	100%	82%	83%	100%	100%	100%						90%	G		
	Eating disorders - Wait time for adult assessments will be 4 weeks %		95%	47.04%	37%	53%	85%	84%	87%	78%	81%						74%	R		
	Eating disorders - Wait time for adult psychological interventions will be 16 weeks %	N – T	95%	68.96%	85.0%	100%	100%	96%	85%	86%	78%						92%	A		

Additional information

Therapies: Improvements are being seen in ICT Physio, ICT OT, Paediatric SLT and Paediatric Physio which are as a result of increased oversight and initiatives being in place.
Podiatry: The 8 week RTT is 55.8% with 429 out of 972 referrals seen outside 8 weeks. The waiting list is currently showing as 1934 compared to 2186 6 months ago. Although performance has dropped, the number of patients seen has risen by 32% from last month and the waiting list has dropped by 6%. There has been an increase in F2F follow up and new patient appointments in the Core podiatry clinics. A new Band 5 is running the clinics and wait times are reducing. The longest waits are with the MSK new patient appointments, there was a sharp increase in MSK specific referrals in September and this also increased into October. extra new patient slots have been added to the MSK clinics and the service has also added Saturday clinics as overtime to help with the waits. These initiatives have started to see an impact on this waiting list. There are plans to add Sunday clinics in the Kingstreet clinic, Stroud, and the service is liaising with MSKAPS regarding further support. Work is under way to assess the impact of the proposed threshold move from 8 to 18 weeks.
Paediatric Occupational Therapy: In October 47 out of 52 referrals were seen outside the 8-week target timeframe of RTT. The following Improvement priorities have been established:
•Second stage of telephone wait list review to be completed with the aim of reducing the list from 114 to 0. A review of the telephone assessment will then take place to establish a more streamlined offer.
•Focus on flow of appointments and allocation to continue with the support of our new Data Administrator. Anticipating wait times to reduce further through this process.
•1WTE Band 6 and 0.2WTE Band 7 post advertised internally. We anticipate full establishment on appointment to these roles which will be impactful in relation to our recovery and service delivery.
It is recognised that the 8 week (RTT) target is too ambitious and unattainable. The Children's Commissioners and operational leads support revision of the service KPI, replacing it with more meaningful and achievable treatment thresholds: Urgent Referrals – 4 weeks wait ,Non-Urgent Referrals – 18 weeks wait (Aligning with National waiting time standards for non – urgent care.
Wheelchair Services: The clinical team is now fully established and the service has met target for both indicators since September this year and expects to continue with a positive trajectory in the coming year with adult new referrals now at 96%. The compliance rate for equipment delivered within 18 weeks of referral is at 100% for October.

Eating Disorders: RRT to NICE treatment within 4 weeks shows 14 non compliant cases. 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. A waiting list model has been produced giving an indication of capacity required to address the routine assessment and treatment waiting list backlog. The service is reviewing the process for adult and adolescent routine assessments with the Quality Team and are planning to implement a sub assessment team to solely concentrate on routine assessments. The service continues to work with BEAT and continues to refer parents and carers to the Developing Dolphins programme. To date 104 referrals have been made and 66 spaces remain. Recent appointments to hard to fill posts include a band 4 assistant Clinician.

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%	98%	98%						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%	87%	100%	75%	74%						71%	G		
Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered																				
Inpatient Wards		N - T	95%	68%	72%	63%	69%	71%	72%	80%	66%						66%	R		
Community		N - T	90%	70.2%	76%	9.0%	25%	31%	41%	87%	66%						66%	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%	52%	54%						53.0%	G		
Admissions to adult facility of patient under 16yrs		N - R		0	0	0	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	3	5						26	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% 43.%	70% 69%	80% 70%	85% 71	90% 73%								90% 73%	A		.
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% 82.5%	85.0% 91.9.%	95% 96.9%	95% 97.1%	95% 97.1%								97.1%	G		
Percentage of children in Year 6 with height and weight recorded		N - T	95%*	96.1%	75% 89.7%	87% 94.0%	95.0% 96.4%	95% 96.6	95% 96.6%								96.6%	G		

Additional Information

OOA: This month we are reporting 5 OOA bed days which is a slight increase on the previous month and indicative of the demand on beds in October. 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. Data collection re commences in November.
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. Following the improvements seen last month there is a reduction in compliance in October which is being addressed with Matrons and Team leaders. However, an improving overall trajectory from the reported May position remains.

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	56	54	62	66	67	71	84						460	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%	94%	94%						94%	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%	97%						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%	87.0%	86%						88.%	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%	94%	93%						93%	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%	87%	87%						89%	A	Y	
Percentage of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence).			58%	53.73%	55%	59%	57%	56%	54%	53%	57%						56%	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%	80%	81%						79%	A	Y	

Additional Information

Health Visiting:

- **NBV and Child reviews**: October performance (NBV – 7-14 days) was marginally below threshold at 94.5% with 30 out of 488 infants not being seen within timeframe. Exceptions were due to babies being in NICU, staffing capacity (all now have booked appointments) parental choice to delay the visit, plus movements in and out of county .October performance (9-12 month review) was 85.9% with 74 out of 526 children not being seen within timeframe, 33% of exceptions were due to lack of staff capacity (all children now have booked appointments) others were attributable to parental delay/decline, DNA's and recording errors. 2-2.5.review non compliance was mainly due to parental declines and DNAs, plans are in place to address these issues: the service is considering closer working with nurseries as declines are frequently due to parents working full time. Triggers are being introduced when DNAs occur such as introducing automatic home visits post DNA.

- **% of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks**: October performance was 56.7% (September was 53%) compared to a threshold of 80.0%, early indicators for this data show recovery to above target status being sustained going forward.

- **% of infants being totally or partially breastfed at 6-8wks (breastfeeding prevalence) –** October performance was 56.7%, with 209 out of 483 infants recorded as totally or partially breastfed. The Midwifery Service continues to be understaffed, which impacts on the specialist feeding service / tongue tie service waiting lists. Infant Feeding Lead Health Visitor has set up weekly meetings to address needs identified with plans to improve feeding status and has been invited to Post Natal Care Pathway meetings with the Midwifery service. Infant Feeding Assessment Clinics have been introduced as Pilots in the targeted areas of Gloucester and The forest of Dean. Early intervention is key as attrition rates are highest between 0 and 2 weeks

Appendix Three

Organisational Quality Priorities – October 2023

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

QUALITY PRIORITIES 2023-2025

Standard	**Tissue Viability (TVN) - with a focus on reducing through improvement, the recognition, reporting, and clinical management of chronic wounds.**
Performance	**Target** – To include recognition of the importance of prevention which has received wide coverage within clinical areas and to align workstreams with the national Wound Care Strategy.
Commentary	
Lead NF	

Work Stream	Q1	Q2	Q3	Q4
Implementation of the National Wound Care Strategy (2 year initiative)	Link with TVN colleagues across nearby Community Trusts: Oxford & Bristol	Review learning content on NWCS platform	Scope strategy requirements	Set SMART objectives and achievable timelines
Refresh and evaluate the delivery of training education and support available.	Meet with TVN colleagues, noting current vacancy in CLWS/TVN Professional Lead role will delay progress.	HOP & Operational Lead for Wound and lower limb services to map current education offer from GHC. Identify any gaps; produce an action plan.	Allocate identified gaps in training to clinical specialists to progress. (Professional Lead role commencing mid Oct.)	Update Care to learn with new training. Ensure colleagues are aware of complete TV training offer using professional & operational managerial cascade routes. Publicise using the Trust's weekly communications update: Indigo.
Evaluate and produce business case for the implementation of a wound care app.	Contact companies approved by NWC strategy and identify the ap most suited to community care	Invite community based clinicians & TVN colleagues to review the ap & comment on its application to supporting patient care.	Identify a community nurse team to trial the use of the ap. Request a quote from the company. Identify business planning colleagues to progress on a "go no go basis "	Identify if funding is available to proceed on a go no go basis.
Evaluate and strengthen links with dietetic services other services both within GHC and across the system to improve holistic support to patients..	Identify colleagues within GHC	Meet with colleagues and invite comment on the production of improvement and collaboration work.	Participate in systemwide approach to wound care strategy led by ICB.	In partnership with system colleagues scope how to strengthen links to support improved patient care and outcomes

Quarter 2 Progress	
Implementation of Strategy	Links have been established and NWCS platform has been evaluated
Training	Current offer from GHC evaluated and training gaps identified with action plan containing corrective measures being completed.
Wound Care App	Evaluation of Aps has taken place and the most suitable is one called Healthy 10 which been evaluated and reviewed by clinicians.

Next steps : Work continues to complete action plan and develop Q3 expectations. Question as to whether funding is available to pursue the application of the App .

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

QUALITY PRIORITIES 2023-2025

Standard	**Dementia Education - with focus on Increasing staff awareness of dementia through training and education, to improve the care and support that is delivered to people living with dementia and their supporters across Gloucestershire.**
Performance	**Target** – To be established.in Q2 following scoping in Q1

Commentary

Work stream Plans	Q1	Q2	Q3	Q4
• **Training** • Establish the baseline for T1, T2 and T3 dementia training and Undertake evaluation of future requirements. • Plan and facilitate the implementation of Essential to Role Training at Charlton Lane Hospital, including plan profile and journey updates.	Scoping	• Gather baseline training data providing a breakdown across services / teams. • Identify training audience and agree training thresholds	• Q2 data to be reported to the ICS Dementia Training and Education Strategy Network.	• Q3 data to be reported to the ICS Dementia Training and Education Strategy Network.
• **Gloucestershire 5 Step approach.** • Progress across Community Hospitals.	Scoping	• Ensure training module is uploaded to Care2Learn. • Establish network with Training and Development Sisters across Community Hospital's and aim to share and evidence distribution of training resources. Add to GCC Dementia Education website for use across ICS. • Develop training targets	• Report training uptake of GHC staff via Care2Learn. • Report upon how many GHC staff the Training and Development Sisters have trained.	• Report training uptake of GHC staff via Care2learn. • Report upon how many GHC staff the Training and Development Sisters have trained.
• **Patient /Carer Experience** • To establish and evaluate any themes and trends relating to dementia arising from complaints and compliments received via the Patient Experience Team and to ensure learning from these events is shared throughout the organisation.	Scoping		• To meet with Patient Experience Team in order to identify themes and trends from compliments and complaints and begin evaluation. • Complete evaluation and report on these findings via Improving Care Group, evaluate how these can feed into workstreams .	• Share learning
• **System working with GP practices** • Targeted work within GP practice staff to include ARRS roles around early onset dementia and identification.	Scoping	• Evaluate ARRS team training needs. • Develop education session along side EBE.	• Finalise education session with EBE and deliver with EBE. Consider session for social prescribers (non GHC colleagues). Discuss best way to engage with GP's	• Develop GP session – (video resource – Webinar)?
• **Communication** • Develop Comms plan with a profile of workstream to be on current agendas and team meetings	Scoping	• NA	• NA	• Update Complete comms and add to Bitesize

Quarter 2 Progress	
Training	Training audience and thresholds agreed.
5 Step Approach	Update on C2L in progress, networks established, additions made to website and training targets ongoing
System Working/PCET	Sessions /invites planned for February 2024 with GP practice nurses - . Lead chairs Dementia education within ICS Cultural and Diversity Dementia Network and Public Engagement sessions.

SAFE : QUALITY PRIORITIES 2023-2025	
Standard	**3 Falls prevention with a focus on reduction in medium to high harm falls based on 2021/22 data .**
Performance	**Target** – an overall reduction in the number of medium and high harm falls within inpatient units.
Commentary	• The Trust wide Falls group ensures consistency of practice, and strong focus on evidence based falls prevention in all areas of GHC. The group is looking to produce and implement a framework with the ambition of: • A reduction in the number, and impact of falls in both **community and inpatient** settings, (hence widening the reach of the indicator) • Improving both staff **and patient awareness** of falls risks, • Reduce the variation of practice in falls prevention. • The focus is to promote a culture in which falls prevention, risk assessments and interventions are everybody's business.
Lead	HW

Workstream - Plans	Q1	Q2	Q3	Q4
Community falls Establish a baseline for falls at home to measure improvements made. Inpatient Falls To produce a countywide Falls Reduction Action Plan for Inpatient Units	Scoping Scoping –Decision made to trial at CLH	Data gathering and process map to be produced. Roll out Falls reduction plan at CLH	Review data and depending on results, decide how and if these falls can be reduced Review data and plan. Share best practice with CoHo's to implement where appropriate Introduce an inpatient Falls Reduction Awareness Training programme for Inpatient Staff. Target 80%	Evaluation and plan of roll out Audit number of falls within inpatient units since introduction of action plan Audit number of staff who have attended Falls awareness training
Falls Policy Revise and refresh policy to meet NICE standards for both Community and Inpatient	Scoping	Draft policy to be produced and circulated to Trust Falls group for comment.	New Trust wide Policy to be ratified by GHC Policy Group. Undertake Roll out Trust wide and implement changes.	Audit compliance with revised policy.
Trust wide Inpatient falls leaflet to be produced.	Scoping	Draft version to be produced and circulated within Falls Group	New Falls Prevention Leaflet to be agreed and circulated to Inpatients Trust wide	Ask for staff/patient feedback on Leaflet, make changes if needed

Quarter 2 Progress	
Community Falls:	Being re evaluated as wider discussions are taking place relating to scoping of data and the validity/accuracy and effectiveness of the data evidenced thus far.
Inpatient Falls	Successful trial completed at CLH with presentation prepared to share results.
Falls Policy	Has been redrafted and has been circulated for wider consultation reporting back to the policy group to be ratified as per normal process..
Falls leaflet	Has been redrafted is out for consultation.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

SAFE : QUALITY PRIORITIES 2023-2025

Standard	**End of Life Care (EoLC) – with a focus on patient centered decision, including the extent by which the patient, their carers and families, wish to be involved in the End of Life Care decisions.**				
Performance	**Target** – To be fully assured that patients, their carers and families, are being involved as much as they want to be in end of life care decisions. To Be fully assured that all appropriate staff are identified and have received essential to role training with systems in place for ongoing compliance and monitoring of training provision. To maximise training availability, and ensure identification of additional resource where required.				
	Quality Priority Plan	**Q1**	**Q2**	**Q3**	**Q4**
Commentary	**GHC EoLc priorities align with NICE Quality Standards for care at the end of life and NHSE personalised care approach. Our aim is to enable all our staff to be compassionate, confident and competent in delivering personalised end of life care in our hospitals and in the community.**	• Identify training needs baseline across the organisation – (Essential to Role) including which staff are trained to what level. • Identify targets • Devise training plan • Audits to evidence personalised care	• Evidence 90% or better attendance at Essential to Role Masterclass sessions • Identify the number/% of instances where care was/was not personalised (identified through Datix, concerns, compliments, case reviews, bereavement surveys)	• Evidence 90% or better attendance at Essential to Role Masterclass sessions • NICE QS144 (Care of Dying Adults in Last Few Days of Life) Audit on care at end of life for community and in-patients • Identify number/%of instances where care was/was not personalised (identified through Datix, concerns, compliments, case reviews, bereavement surveys)	• Evidence 90% or better attendance at Essential to Role Masterclass sessions • Number/% of instances where care was/was not personalised (identified through Datix, concerns, compliments, case reviews, bereavement surveys) • Undertake review of documentation (Shared Care Plan for Expected Last Few Days of Life/S1 template)
Lead	DW				

To be fully assured that patients, their carers and families, are being involved as much as they want to be in end of life care decisions.	National Care at End of Life 2023 Pilot Audit in Sept 2023 (20 case notes reviewed). Evidence of good compliance that patients, their carers and families are being involved in end of life care decisions as much as they wanted to be. Community Nursing Care at End of Life Audit in October is being analysed currently. Community Hospital Bereavement Surveys to next of kin ask "During the last few days, how involved were you with the decisions about their care and treatment?" H1 – 19 surveys returned, 18 (95%) responded "As involved as I needed or wanted to be" Complaints raised. H1 – 3 complaints. For a patient who died in the community there was a learning point around ensuring next of kin are as informed about care and decisions as the patient. Datix reported. H1 – 98 Datix (excl. falls and skin integrity). Communication and lack of accurate documentation about care at end of life are a common theme. There will be a review of Shared Care Plan and templates used to document end of life care on S1 in H2 to better capture personalised care at end of life	**Next steps - To re evaluate the training needs baseline and match to available resource/increase resource.**
To Be fully assured that all appropriate staff are identified and have received essential to role training with systems in place for ongoing compliance and monitoring of training provision.	A training needs baseline has been identified and 13 Masterclasses have been assigned as Essential to Role for certain staff groups. Work undertaken has shown that the trajectories for staff completing E2R training are not realistic or achievable during the 2 years expected in the End of Life Quality Priority. Further work is required to refine what is E2R and the End of Life Lead is looking at what the mandatory end of life training offer is in other NHS Trusts. The number of Masterclasses that are classed as E2R and/or staff groups needs to reduce and/or a different way of delivering the training needs to be introduced in order to deliver within the 2 years.	
To maximise training availability, and ensure identification of additional resource where required.	30 spaces are available at Masterclass (with the exception of Having Difficult Conversations which is face to face and 15 max). Q1 – 69% and Q2 – 58% of available Masterclass spaces were taken up. Overall 64% take-up of Masterclasses. We allow these sessions to be overbooked on C2L as there are always No Shows on the day. (In total, Q1 – 125 staff, Q2 – 95 staff trained). We are increasing the number of places that can be overbooked for the next run of Masterclasses. Need identified for Difficult Conversations at End of Life training for call handlers/ward clerks in hospitals, ICT Referral Centres etc. 1 session in September (17 attendees), 2 further sessions planned October. Training aimed at HCA's has been rolled out to Training and Development sisters at Community Hospitals, Charlton Lane Hospital and Professional Leads in ICT's for them to train HCA's in their hospitals/localities. 47 attendees in H1.	

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

QUALITY PRIORITIES 2023-2025

Standard	**1. Increasing the visibility of the Friends and Family Test (FFT) feedback to staff and patients and their families** **2. Embedding the actions of the 2022 CQC Adult Community Mental Health Survey action plan**
Performance	**Target** **To deliver greater value for the data collected through patient surveys and demonstrate increased awareness of patient and carer feedback**

Commentary

Work Stream	Q1	Q2	Q3	Q4
Silver QI FFT project	Complete Silver QI training / Project scoping/ Development	Work with services to implement agreed changes and scoping further developments within remit of project. Draft FFT toolkit with QI project group	Finalise FFT toolkit and distribute to services – undertake implementation training with services where required	Evaluate project success and potential further development
CQC Community MH Survey Action Plan	Agree actions from 2022 MH Community Survey	Work with services to implement agreed actions	Evaluate action outcomes	Report on 2023 MH Community Survey and develop action Plan (Q1 2024/25)

Lead KB

Action	Update Q2 (H1)
Silver QI project	Community services are now using a variety of methods for collecting FFT responses, including electronic, paper and QR codes. This has resulted in an increased number of responses across most areas. Staff are encouraging patients to complete the FFT using these new methods. The project team have considered different options on how to share the outcomes more widely with staff and patients through the use of feedback boards in clinical settings and social media. New 'You said, we did' feedback boards to be trialled in Q3.
CQC Community MH Survey Action Plan	**Crisis Care:** ensuring people have access to crisis care at the time of need and they receive the help they need when contacting the Crisis Team. Action: reviewing patient information regarding access to the service through a review of the Service specific website and patient information leaflet **Talking Therapies:** ensuring talking therapies is explained in an understandable way and service users are involved in decision making. Action: reviewing patient information regarding access to the service through a review of the Service specific website and patient information leaflet We asked both the services how we could best help the address the action areas and both agreed that a review of the information currently provided to patients via leaflets and websites would be a helpful start. The review with the Crisis Team has been completed (Q1) and the Talking Therapies review has been started but some further development being considered.

Next steps : To continue with agreed workstreams through to Q4.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

QUALITY PRIORITIES 2023-2025								
Standard	**Suicide Prevention – with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services.**							
Performance	**Target** – To Reduce Restrictive Interventions within Mental Health & Learning Disability Inpatient Services.							
Commentary	Progress will be measured through the implementation of 4 key elements							
		Priority	**Q2 23/24**	**Q3 23/24**	**Q4 23/24**	**Q1 24/25**	**Q2 24/25**	**Q3 24/25**	**Q4 24/25**
	1.	MHC Project Reducing the incidence of reactive restrictive practice in inpatient mental health and learning disability services by 10% by March 2025	Refresh project objectives & support for participating wards	Engage with hospital/unit managers. Identify participating wards & establish new baseline.	Wards/units to run PDSA Cycles Data collection ongoing. Monitor impact via SPC charts	Wards/units to run PDSA Cycles Data collection ongoing. Monitor impact via SPC charts. Extend Project to March 2025	Wards/units to run PDSA Cycles Data collection ongoing. Monitor impact via SPC charts	Wards/units to run PDSA PDSA Cycles	Wards/units to run PDSA Cycles
	2.	CQUIN 17 Achieving 90% of restrictive interventions in adult and older adult inpatient mental health settings recorded with all mandatory and required data fields completed.	Business Intelligence to develop the event lines that can be used to monitor the records reportable as Restrictive Interventions in the MHSDS.	Report on compliance, establish baseline & promote improvements in reporting where identified.	Monitor compliance – target 90%	IMPLEMENT NEXT PHASE OF CQUIN – details awaited			
	3.	Reduce Blanket Restrictions	Agree template for identifying restrictions	Pilot draft template on identified ward.	Evaluate Pilot and agree process for spread.	Implement template across all wards WLH	Implement trust wide across relevant sites	Trust wide register of blanket restrictions to be established	Embed ongoing review of blanket restrictions throughout relevant GHC sites
	4.	Develop Post Restraint Debrief Process	Map out current practice	Establish potential options and framework for debrief	Pilot draft model on identified ward	Evaluate Pilot	Draft Standard Operating Procedure (SOP) and consult	Approve & Implement SOP	Embed SOP in practice

Update Q2 Progress	
MHC Project	1.Project refreshed and objective amended to exclude planned restrictive interventions. Target agreed as a 10% reduction
CQUIN 17	Currently in phase 2 of the KPI Portfolio development process
Blanket Restrictions	Template approved
Develop Post Restraint Debrief Process	Work ongoing

QUALITY PRIORITIES 2023-2025

Standard	**Suicide Prevention– with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services.**
Performance	**Target** – To Improve The Safety Of Mental Health Services Through Implementing Measures Known to Reduce Patient Suicide
Commentary	The National Confidential Inquiry into Suicide & Safety In Mental Health (NCISH) identifies 10 key elements for safer care of patients

- NCISH have produced a toolkit (revised March 23) intended to be used as a basis for annual self-assessment by mental health care providers. NCISH | Resources (manchester.ac.uk)
- The Trust will review its practice and performance against each element of the self-assessment toolkit and implement improvements where there is an identified need.
- This activity will be supported by findings from ongoing activity such as ligature audits, the clinical audit programme, KPIs and feedback from service users, carers and families.

	Priority	Q2 23/24	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
5.	Suicide Prevention Implementation of the NCISH self-audit Toolkit for mental health services.	Identify Leads for each of the 10 key elements for safer care	Leads to complete the self-audit	Develop and implement action plan where improvements have been identified.	Establish compliance with action plans.	Annual cycle of re-audit against the toolkit to recommence.	Develop and implement action plan where improvements have been identified.	Establish compliance with action plans.

Lead	Gordon Benson, Quality Lead (Mortality, Engagement & Development)

Update Q2 progress	
Implementation of the NCISH self-audit Toolkit for mental health services.	Leads identified and confirmed

QUALITY PRIORITIES 2023-2025

Standard	**Learning disabilities – with a focus on developing a consistent approach to training and delivering *trauma informed* Positive Behavioral Support (PBS) Plans in line with National Learning Disability Improvement Standards. This includes training all learning disability staff in PBS by April 2025.**				
Performance	**Target** – To **train all GHC Learning Disability staff in PBS by April 2025.**				
Commentary	**Workstream Plans**	**Q1**	**Q2**	**Q3**	**Q4**
	• Develop training matrix to identify the baseline no of staff who require a consistent approach to training.	• Scoping	• Establish and report upon the identified staff numbers who require training at team level. • Develop training plan		
	• Develop a bespoke Trauma Informed Positive Behaviour Support Training Pack (TIPBSTP) to form core foundation of the delivery of this programme.	• Scoping	• Collaboratively produce training pack.	• Training pack to be available .	
	• Deliver Trauma Informed Positive Behaviour Support Training to ALL staff working in learning disability services			• Pilot training pack	• Commence delivery of training
Lead KA					

Q2 Progress Update	
Matrix and Training Pack	Q2 training numbers have been evaluated to be in the region of 180 staff members with the training plan remaining as work in progress due to changes in leadership structure, the training pack development has commenced and an initial trial of parts of the presentation has been run . A full day pilot is planned during Q3 .As the workstream covers 2 years the delivery plan is being evaluated to ensure that the actual requirements are realistic.

QUALITY PRIORITIES 2023-2025

Narrative	**The KPI will be further enhanced by the continuation of the separate Oliver McGowan Training with the ambition that all staff will have an increased awareness of the unique needs of people with a learning disability and autistic people, with a focus on reasonable adjustments, diagnostic overshadowing and tackling health inequalities with the baseline from 22-23 being evaluated and increases delivered.**
Performance	**Target** – To **continuing the roll out of the Oliver McGowan Mandatory Training in Learning Disabilities and Autism across the Trust and monitoring it's impact.**

Commentary

Workstream Plans	Q1	Q2	Q3	Q4
• Tier One of The Oliver McGowan Mandatory Training package co-designed by GHC, Inclusion Gloucestershire and Family Partnership Solutions in Gloucestershire was chosen last year to be the national training package to be s rolled out nationally. • Plan further roll out organisationally at tier 1 and 2 with the ambition of improving last years figures of 82.15% T1 and 355 members of staff T2.	• Re-commence delivery of T1 webinars • ICB to lead on training needs analysis	• ICB to lead on developing work plan for rollout of the training • Review T2 materials and train trainers for T2. • T1 webinars available	• Pilot T2 locally • T1 webinars available	• T1 webinars and T2 training available across the Trust & ICB
• Develop measures to assess impact of training		Report upon levels of training achieved H2	• Collaboratively Identify and document measures to assess direct and indirect outcomes from training that can be shared.	• Establish and report upon the effectiveness of Oliver McGowan Mandatory Training.

Lead

Quarter 2 Update

Tier One Training	Tier 1 Webinars, facilitated by Inclusion Gloucestershire IG), are now available to staff in GHC. These are also being made available to staff across the ICS, including Gloucestershire Hospitals Trust, Primary Care and Social Care staff. The capacity of IG to deliver training is restricted by the number of Experts with Lived Experience available to help co-deliver the Webinars, so many of the available sessions are fully booked. IG are taking steps to recruit more trainers to help overcome this issue. Work is underway to assess the total number of staff across the ICS who need training, including the numbers for Tier 1 and Tier 2.
Roll Out	Plans are underway to deliver Gloucestershire's Tier 2 'Train the Trainer' session, ready for the roll out of Tier 2 training. Currently 80.1% of required staff have completed the Tier 1 training (this slight reduction from the previous figure is due to staff changes and the recent restrictions on Tier 1 availability). 496 people have completed the Tier 2 training.

Quality Dashboard

NHS
Gloucestershire Health and Care
NHS Foundation Trust

SAFE : QUALITY PRIORITIES 2023-2025

Standard	**Children's services – with a focus on the implementation of the SEND and alternative provision improvement plan.**				
Performance	**Target** – To improve the outcomes and experiences of children with SEND by developing system relationships and the knowledge and skills of healthcare staff supporting these children and their families.				
Commentary	**Quality Priority Plan**	**Q1**	**Q2**	**Q3**	**Q4**
	Digital reporting Implement performance reporting of SEND related data to inform service provision by reviewing the SystmOne modules and RiO data capturing capabilities by 1st October 2023	• Take a proposal/request paper to the relevant clinical system working group, highlighting the needs and the recording/ reporting capabilities required. • To have an agreed plan to develop digital reporting for SEND.	• Work with CST to build recording capability within the clinical systems.	• Work with BI to ensure data flows through the data warehouse and performance reports and dashboards can be developed.	• To have robust reporting capability that demonstrates activity, demand and compliance against statutory EHCP timeframes.
	Training Develop a SEND Training Assurance Framework by 1st April 2024 to enhance knowledge and understanding of the SEND process focusing on inclusion co-production, participation, engagement, personalisation and advocacy. This will include CPD opportunities for all patient facing staff in CYPS to complete the Council for Disabled Children SEND Basic Awareness E-Learning Level 1 and Level 2.	• Work with the Learning & Development Team to get SEND Basic Awareness Training Levels 1 & 2 added to Care2Learn. • Early adopters in CYPS leadership to start completing training to ensure it works.	• For all CYPS staff to have completed Level 1 & 2 SEND Basic Awareness Training on Care2Learn. This training is delivered by the Council for Disabled Children (CDC).	• SEND Leads and Training Team to develop EHCP Contents Awareness Training that is informed by the outcome of the audits.	• To have a SEND Training Assurance Framework ratified by CYPS Governance forums by April 2024.
	Feedback Complete survey of CYP who have transitioned to adult care in order to improve the experiences of young people and inform future practice. This will include 3 patient cohorts (MH/PH and LD)and their carer/family's.	• Scope engagement opportunities with service users and young people with SEND to better understand needs, hear their voices and coproduce development work.	• SEND Leads to engage with the Engagement Officer for Future Me Gloucestershire (GCC). • SEND Leads to join the ICB-led Transition to Adulthood group that is reviewing transition processes, tools and frameworks across health services and the wider system.	• SEND Leads to join Future Me Glos forums to work alongside young people.	• Work with Communications team to develop transition surveys that can be shared with parent/ carers and young people to understand their experience and quality of transition. • Work with the Young Adults Team and Adult services to share this survey with young people and families who have recently transitioned from children's services to adulthood.
	Electronic EHCP Portal For all new referrals received through the electronic portal to be actioned electronically in the portal by 1st August 2023 in CYPS Physical health services, and by 1st January 2024 for CYPS Mental Health Services.	• SEND Leads to work with the Portal development team to get health services set up on the new platform. • Offer teaching and training for CYPS staff on how to use the portal.	• All CYPS PH services to be using the EHCP portal by the end of Q1.	• CAMHS and LD Services to prepare to use the EHCP portal – set up, training sessions and testing.	• For all CYPS Services will be using the EHCP portal.

Q2 Updates

Gloucestershire Health and Care NHS Foundation Trust

Digital Reporting Q2 Update	No solution has been found for adequate SEND recording or reporting from the clinical systems with SEND data being captured across both SystmOne and RiO in children's and young people's services. Further discussions have taken place with CST and BI to explore what options are available, but there does not appear to be the system capability to enable satisfactory solutions. Workaround options include: - physical health services continue to register and report upon EHCP requests within the CYPS SALT unit. This data is reportable and features on the Tableau performance dashboard. This helps services recognise the and understand EHCP demands. - The EHCP portal is also growing with more schools now using this platform. Once this is fully operational it is expected that compliance measures against statutory targets for EHCP reports will be available across the system. The ICB's Designated Clinical Officer is also asking the Local Authority for reports of any EHCPs that with outstanding health reports. - In terms of visibility, reports are now available showing CYPs known to more than 1 children's health service, which will support joined up working and care planning. - The Health Visiting Team continue to add a notification to clinical records for children with SEND. This report is available and shared with the Local Authority. It is not possible to add this notification to all CYPS clinical system units due to the capability of the clinical system itself and the risks involved in managing notifications effectively across multiple units and records. Next steps: BI and CST are considering whether SEND notifications can be configured just within the CYPS SALT unit where EHCPs are registered. Whilst this is not a solution, it will give an indication of the scale of SEND across school-aged children accessing community services.
Training Q2 Update	Learning: All CYPS staff have access to the CDC Level 1 & 2 SEND Basic Awareness Training on Care2Learn. This training has also been shared with all colleagues who work with young adults with SEND (up to the age of 25). Robust recording and reporting on the Care2Learn system is not yet available, so we are unable to provide full assurance of training completion or compliance rates. Service-level feedback suggests that staff have completed this training. Multi-Agency Audit: MH and PH SEND Leads involved in the Gloucestershire multi-agency audit and reviews with SEND Leads reviewing audit results, agreeing action plans and progressing actions locally. The DSD has requested that this audit be added to the CYPS Directorate Audit planner for 23-24 for oversight and support. GHC EHCP Quality Audit: An audit has been completed for physical health services and actions are progressing across both PH and MH/ LD services. The SEND Lead for CAMHS and LD is working with the Audit Team to complete this in CAMHS/ LD Services. The ambition is to do an integrated this audit into a whole CYPS Services Audit in the future.
Feedback Q2 Update	Service Users/ Experts: SEND Leads are working with the Engagement Officer for Future Me Glos at the County Council. They are attending some forums with young people with SEND to capture their voice and hear their thoughts and contributions. System Partners: Preparing for Adulthood Practitioner Forum. SEND Lead (PH) and Sally Powell attending and supporting workstream. The CYPS Directorate PfA group has now been established and is working to review our internal transition processes, tools and outcomes for service users.
Electronic EHCP Portal Q2 Update	CAMHS: Working with the DCO in ICB to prepare CAMHS and LD services to use the EHCP portal. This is still expected to be adopted in January 24. PH Services: The portal is in use by all PH services, but not all notifications are coming through the portal yet – services are still receiving a combination of Portal and email comms as not all schools have started using the portal yet. The DCO is asking for additional PID to be added to records for robust governance. SEND Leads: Continue to complete monthly Datix for any requests with inadequate timelines for report submission.

QUALITY PRIORITIES 2023-2025

Standard	**Embedding learning following patient safety incidents – with a focus on the implementation of the Patient Safety Incident Response Framework**
Performance	**Target** – To develop a framework which details how the trust will support the development of clear, measurable actions from areas for improvement, how we will schedule longer-term monitoring, define markers of benefit for patients/service users, families and carers and disseminate learning across services and professions.

Commentary: The approach of the PSIRF seeks to shift our response away from individuals and root cause analysis to exploring and understanding systemic issues.

There will be renewed focus upon the impact of and the part that psychological safety plays in learning from incidents in enabling staff to speak up, participate and learn.

Workstream Actions	Q1	Q2	Q3	Q4
Review Incident Reporting Policy	Scoping	Policy draft	Policy published on Intranet	
Development and Implementation of Learning Assurance Framework	Scoping	Draft Framework to be produced which details how the trust will support the development of clear, measurable actions from areas for improvement, how we will schedule longer-term monitoring, define markers of benefit for patients/service users, families and carers and disseminate learning across services and professions.	The framework will be completed and agreed in Q3 .	Implementation of framework
Fidelity Testing	Scoping	Fidelity testing template , process and tracker to be developed.	Review of results and learning	
Civility saves lives.	This is an Ongoing workstream: Harm from disrespect has been identified as a key element in patient safety efforts and fostering a culture of civility and respect within our Trust further supports the delivery of our values and behaviours. Civility and respect sit behind a positive workplace culture and our Trust values. **Civility** describes a behaviour: treating someone politely or with courtesy. **Respect** involves valuing other people's experience and feelings. The two are closely linked, as people show their respect for someone by acting with civility. In health and care, civility and respect involve supporting, valuing and respecting each other for what we do and showing kindness, compassion and professionalism towards our colleagues, patients and service users. It also means ensuring that people are civil in their digital communications, avoiding sharp, harsh or insulting comments on email or social media. Civility saves lives is intended to be entwined into all that we do and we have a four module course available on C2L which we aim to report uptake of over the 2 years.			

Lead PBM and SP

Q2 Update	
LAF Framework and Incidents Policy	The LAF and Incidents policy will be presented to Quality Assurance Group in November.
Fidelity Testing:	**T**he process established ,template and tracker developed and in use
Civility Saves Lives	Ongoing workstream, highlights in Q2 include webinars from external prominent speakers which were well attended and received

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

Standard	**Carers –** with a focus on achieving and maintaining the Triangle of Care Stage 3 accreditation.
Performance	**Target** – To revalidate the organisational Stage 2 accreditation in 23-24 and then achieve Stage 3 accreditation in 24-25.
Commentary	• As a Trust we need to feel confident that the principles held within the Triangle of Care mirror our Organisational values and beliefs, and should be undertaken and embraced by teams as part of their core activities forming business as usual. Prior to merger, 2gether NHS Foundation Trust was accredited at Level 2 having established Triangle of Care within both the Mental Health inpatient and community teams, and therefore prior to undertaking assessment enabling our journey to Level 3 to progress we are required to demonstrate that the merged organisation retains and can evidence competency with each requirement of the accreditation.
Lead	CN

Workstream	Q1	Q2	Q3	Q4
Mission and vison Develop and launch an Organisational plan that communicates the mission and vision of the project.	Scoping	Work to re-engage connections with all Mental Health and Learning Disability Community and Inpatient teams, to review their position within the Triangle of Care Self Assessments and develop plans to progress RAG ratings as a result	Work continuing to re-engage remainder of all Mental Health and Learning Disability Community and Inpatient teams who have yet to review their position with Triangle of Care Self Assessments and to define their progress accordingly	Work to finalise engagement with the remaining teams within Mental Health and Learning Disability Community and Inpatient teams who have yet to undertake or complete a review of their position with Triangle of Care Self Assessments
Mapping Develop a map of all teams and establish their current compliance status with level 2 requirements by using a self assessment methodology.	Scoping	Development of a matrix map to begin detailing the Trusts current position with teams self assessment within the Triangle of Care covering all Mental Health, Learning Disability Community and Inpatient teams	Continuing progressing the matrix detailing all teams self assessment compliance with Triangle of Care	Work to finalise the self assessments within all MH & LD teams and to have this detailed within the matrix thus providing clear and succinct position within all MH & LD inpatient and community teams
Engagement Engage with stakeholders	Scoping	Engagement with teams and carer champions to work towards completion of the Triangle of Care self assessment. Carer Ambassador undertakes work alongside to support teams	To continue process and encourage Team Managers and Carer Champions to advance any remedial work required to positively progress the RAG ratings within the Self assessment	Trust is assured that 80% of its MH and LD teams (both community and inpatient) are complaint with the Triangle of Care Self assessment process and teams remain positively engaged to continue to make progress within their RAG ratings
Planning Develop plan on a page and project control methodology.	Scoping	Team Managers and Carer Champions are enabled to become positively engaged within this process	Evidence that Team Managers and Carer Champions are enabled to become constructively engaged with the Carer Ambassador to positively progress the Triangle of Care self assessment	Teams are able to successfully take ownership of their onward progression within the Triangle of Care self assessment process

Update Q2
Plans and engagement work are progressing with the workstream being positively viewed by teams.
Work underway with Matrix map – completion planned for Q3

with you, for you

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AGENDA ITEM: 08/1123

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 November 2023**

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

AUTHOR: Chris Woon, Deputy Director of Business Intelligence

SUBJECT: **PERFORMANCE REPORT (MONTH 7)**

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 October (Month 7 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 operational governance forums and more widely account for performance indicators in exception and outline service-level improvement plans.

Recommendations and decisions required

The Board is asked to:

- Note the Performance Dashboard Report for October 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 Deputy 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)

Adolescent Eating Disorders routine referral to treatment within 4 weeks was the only indicator under threshold for the period. However, the adolescent assessment and treatment waiting lists have both reduced.

- **Specialised & directly commissioned domain** (under threshold)

In addition, attention is drawn to 4 health visiting indicators which were slightly behind their thresholds for the period.

- **ICS Agreed domain** (under threshold & outside of statistical control rules)

The Core CAMHS 4-week wait indicator is in exception but presents a significantly improved position for October, just behind threshold. The Social Care review indicator is in exception for this period due to a range of factors such as delayed record keeping, data quality, staff capacity and challenging patient engagement.

- **Board focus domain** (under threshold & outside of statistical control rules)

Bed Occupancy levels remains high for October across Physical and Mental Health.

The **Operational domain** is presented to Resources Committee and not the Trust Board.

- **Indicators not in exception**

There are sometimes indicators that are not formally highlighted for exception but it is useful for Board to note. These are routinely monitored by operational and support services within the online Tableau reporting server.

This month Adult Eating Disorders Wait Times are highlighted to add context to the adult waiting list numbers which, although reducing will unlikely impact the waiting time indicator until the waiting list is reduced.

Appraisals are noted as performance is above the upper Statistical Process Control limit suggesting a sustained level of improvement over the year.

Although, still over desired levels Turnover has improved, relative to recent performance.

- **Workforce KPIs**

Once again, attached as an appendix is the Workforce KPI and Performance report which will (as routine) be reported and discussed in detail at the December 2023 Great Place To Work Committee. Further integration of Workforce reporting such as recruitment and workforce profiling into the Performance Dashboard will be further considered and developed in 2024 through the Measuring What Matters

work stream. This is because future format and content will be influenced by the expected launch in 2024 of the new national People KPI data suite and reporting requirements. An initial scoping meeting is being held in December 2023 between BI and HR & OD Directorate colleagues. The Performance Dashboard already monitors Vacancy, Turnover, Annual Leave, Appraisal, Training, and Sickness Absence by exception.

A review of exception criteria for aggregated indicator performance within the Performance Management Framework has begun. Alongside consideration for highlighting further sensitivity of localised performance, this work will lead to a trial of a new approach for Workforce data in the November Performance Dashboard for December's Resources Committee.

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 developed and being introduced in 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?
Director of Finance Review 20/11/2023

Appendices:	Performance Report – Month 7

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

Gloucestershire Health and Care NHS Foundation Trust

Snapshot Month
October

Performance Dashboard Report & BI Update

Aligned for the period to the end October 2023 (month 7)

In line with the planned Performance Indicator Portfolio reconfiguration, this report presents performance indicators across four domains including **Nationally measured**, **Specialised & Direct Commissioning**, **ICS Agreed** (formally Locally contracted) and **Board focus**. Indicators within the **Operational domain** are not presented to Board but are presented to the Resources Committee.

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.

Performance Dashboard Summary

An Executive level observation of operational performance for the period is provided through the Deputy 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 section 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

MH/ LD Service Line Dashboard development continues across Perinatal, EI, ED, CRHTT, ADHD&ASC and MAS before a wider rollout. Essential to Role Training reports have been published in November with a new Dental Patient Tracking List sprint (6-week project cycle) starting in November. There are a number of new project activities that are redirecting BI capacity through Q3 such as Working as One (with NewtonEurope), GCC Statutory Delegated Function reporting and the GP OOHrs, NHS111 and Clinical Assessment Service (CAS) tender opportunity. Although these may delay plans slightly, progress continues in all areas and there are no major delivery risks to report.

There are currently 263 indicators across all domains within the new 2023/24 Performance Indicator Portfolio although this is a dynamic position. Around 155 legacy indicators (59%) remain unchanged from the 2022/23 portfolio. 67 indicators (25%) are in Phase 1 of development and 41 (15%) in phase 2. 35 (52%) of indicators within Phase 1 are already complete and deployed, whilst a further 32 are in various stages of analysis, development and testing. Once Phase 1 is complete the position will be 223 (85%) active. The second phase of development just begun, but these items require more extensive evaluation of definitions and/ or thresholds. They are planned through 2023/24 and completion will run into 2024/25.

Chief Operating Officer's Report Sharon Buckley, Deputy Chief Operating Officer (COO)

As expected, while the system has never not been busy, the tempo of operations has ticked up as we transition from late autumn and into winter. Similar to last year we have generated and mobilised a number of additional beds across our estate to enable earlier in the day transfer from the Acute across to the community hospitals, a process which proved effective last winter. Our offer to the system does remain pretty consistent and strong; our average length of stay in community hospitals is sitting at 35.3 days and bed occupancy rate at 97.88%, giving a slight rise in both metrics which may be attributable to a recent change in the inclusion/ exclusion criteria for the beds to reflect the national discharge to assess definitions, so we are monitoring this closely. MiiU continue to deliver very strongly, and we continue to do pretty well with Rapid Response activity, albeit further improvements could be achieved here as we refine the process for referrals from the ambulance service with colleagues from SWAST (noting that already in terms of ambulance referrals to community urgent care services we achieve more than others in the SW region). This is being worked through in the system's urgent and emergency care transformation programme.

Homefirst performance has remained on an upward trajectory, clearly underpinned by recruitment (where our targets have been met, and we are now just managing top ups when colleagues choose to leave the service). Over recent weeks we have experienced good out flow from the service which allows the achievement of at least 50 starts a week, which is starting to be more consistently achieved.

Planning for the mobilisation of the new Forest of Dean Hospital continues, and is understandably taking an ever growing focus for us, with the plan to start to adapt to the new bed base in the Forest due to start in early December.

Board are aware that we have now established a task and finish group co-chaired by DCOO and Deputy HR Director looking at the growing issue we are seeing with workforce challenges in community nursing, with the Cheltenham team in particular struggling to match their demand and capacity. This work will look at a range of measures and potential solutions, including agency, international recruitment, examine retention positive measures, bespoke recruitment events and campaigns.

The pressure on Acute Mental Health beds has remained high, although pleasingly over the past few weeks we have restored some balance and have no longer had people waiting for admission. There remain some positive long lead signs that we are starting to impact on Length of Stay here, and the very recent mobilisation of a red-to-green database should help catalyse some actions we have been long planning. But progress here is slower than hoped and hence I have directed a re-set day to re-examine and remind the teams of all the work we did earlier in the year and seek to re-galvanise this area. As Board colleagues are aware, we are now in a much-improved position for recruitment at B5 across the Acute wards, which is very encouraging; B6 vacancy within PICU is the next area to focus on.

Of note, in core CAMHS, steady, but nonetheless encouraging progress is being made. We are now offering first assessments following referrals at around 2 weeks (note we lose c10-12% of capacity with cancellations or non-attendance) which is an improving position (was 5 weeks at the time of the last report), and the waiting list has reduced again slightly to 503 currently (from 513 but was over 800 this time last year). Clinicians continually review the list and prioritise/triage and try to match resource to the greatest need. Our longest waiter is at 109 weeks, however they have declined an offer to attend and are now considering an alternative offer we have put forward to support them.

The CYPS OT service remains challenged and recovery actions continue, and whilst the average wait time is not 16.5 weeks, it has improved since the beginning of the year when is was 33.5 weeks. The longest wait times are: Telephone appt – 1.5 months, Clinic - 8 months, Community - 11 months. Urgent referrals are being seen within 4 weeks. Waiting list management continues and in October, In October, 128 referrals were received of which approximately 66 (51%) were unsuitable and required onwards referral, signposting and management. Recruitment continues.

In CYPS Physio compared to previous months, performance is improving with reducing waiting times with the current average wait for a 1st contact is 8.3 weeks which means that the average wait is almost in line with the local 8 week Refer to treatment KPI (national metrics are set at 18 weeks). 245 new patients were seen in October and 974 patient contacts were completed overall. 75% of these new patients were seen within 8 weeks of referral.

In CYPS SLT, there are 958 on the waiting list with an average wait of 10 weeks, and the service continues to have clinical contact with the majority of patients within 0-18 weeks of referral. Currently, 159 patients have waited longer than 18 weeks to be seen; however there has been reduced capacity in the SLT team to review the PTL and cleanse the list. There is assurance though that the majority if longer waiters are in the mainstream and special schools cohort – they are safer to wait as in a supportive setting, although urgent cases are being prioritised by clinicians. Job plans are being reviewed to ensure that clinical time is optimised.

Continued on next page...

Continued from last page...

In Podiatry, the October 8 week RTT is currently showing as 55.8% compared to the 95% target with 429 out of 972 referrals seen outside 8 weeks, this is a decrease from 61.4% last month. Whilst performance has dropped, the number of patients seen has risen by 32% from last month and the waiting list has dropped by 6%. We have increased face to face follow up and new patient appointments in core podiatry clinics due to our new B5s now running their own clinics. The longest waits are for Podiatry MSK new patient appointments as there was a significant increase in MSK specific referrals in September and October. We have added extra new patient slots to our MSK clinics going forward and we have also added Saturday clinics as overtime to help with the waits. We have now started to see an impact on this waiting list. There are plans to add Sunday clinics in the coming weeks and the Service Director is also liaising with MSKAPS regarding further support.

In MSK Physio The October 8 week RTT is currently showing as 60.5% compared to the 95% target with 639 out of 1620 referrals seen outside 8 weeks. This is a slight increase from 60.0% last month. Data cleansing continues and the longest waits are being targeted. Demand for the service remains consistently high at 2200 referrals a month which outstrips current capacity. Recruitment continues to address the cycles of vacancy normal for the service. Waiting List initiatives have been implemented and additional clinics are scheduled for weekend work. In summary the service remains relatively stable.

In MSKAPS, the October 8 week RTT is currently showing as 70.9% compared to the 95% target with 168 out of 579 referrals seen outside 8 weeks, this is an increase from 69.9% last month. Data cleansing continues to ensure accuracy. There are some long waits on the PTL as a consequence of patients cancelling appointments and rebooking. This data does not include the Specialist Triage Activity and subsequent e-RS processes involved prior to the patients booking. At the point the patient chooses to book an appointment the scheduled appointment automatically pulls through to S1 with the original date of referral. This ‘triage to booking process’ can take a number of weeks and is dependent on patients booking an appointment as recent analysis demonstrated that there are plenty of appointments to book into.

Progress continues with recovery of our Dental Service, patients waiting more than 18 weeks have reduced from 166 in March to 6 this month in domiciliary care although there has been an increase in referrals this month. Waits for children in care and those with protection plans continue to reduce as per are target at risk plan.

Performance Dashboard: *National Contract Domain*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Compliant Non Compliant

National Contract Domain

Performance Thresholds not being achieved in Month - *Note this indicator has been in exception previously in the last twelve months.*

N11 - Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks

October performance is reported at 51.7% against a performance threshold of 95%. There were 14 non-compliant cases in October. 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 adolescent assessment waiting list has significantly reduced to 29 at the end of October, from 78 at the start of the year. The adolescent treatment waiting list has significantly reduced to 48 from 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 has adopted a new triage process, and all new patients receive an initial call within 24-72 hours of the service receiving the referral. Self Help guidance is provided as appropriate and recorded as a treatment start in line with relevant SNOMED coding. The service is also reviewing the process for adult and adolescent routine assessments with the Quality Team and are planning to implement a sub assessment team to solely concentrate on routine assessments.

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 104 referrals have been made and 66 spaces remain. The Service continue to work with TIC+ to refer patients to a counselling programme and then discharge from the caseload. Over 170 patients have now been referred 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 87 referrals have been made of which the ORRI have started to treat 59 patients.

Establishment WTE and skill mix have been reviewed to increase recruitment into hard-to-fill posts. Recent appointments: 1.0 x Band 4 Assistant Clinicians, Vacancies: 1.0 Band 7 ED Clinician, 1 x Band 4 assistant clinician, 1 x Band 5 ED Clinician and 1 x Band 6 Senior 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 Performance Governance Tracker. This is on the risk register ID 149 (Score 16)

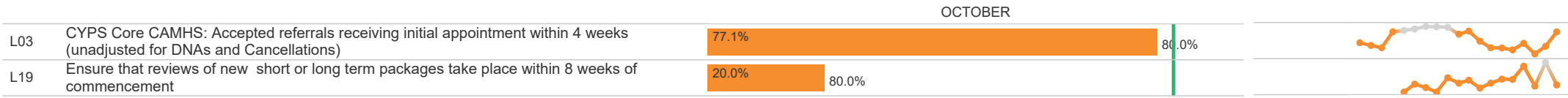
Performance Dashboard: *ICS Agreed Domain*

Gloucestershire Health and Care NHS Foundation Trust

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)
October performance is reported at 77.1% (64/83) against a performance threshold of 80%. There were 19 non-compliant cases reported in October. This is an improvement in performance compared to September (36.4%). A review of SPC limits for this indicator will take place for 2024/25 when sufficient data will be available.

The service attribute this improvement to additional clinics over the past few months that were arranged to reduce the waiting times.

To note, the denominator in October is lower than in previous months (80 compared to an average of 119 for the past 6 months). Of the total 132 slots available for first appointments in the month, 41 (31%) were lost due to a mixture of reasons including staff illness, moving telephone to face to face appointments, training, and slots for urgent referrals not being needed. Of the 98 appointments that were booked, 32.7% were not attended or cancelled. This is slightly higher than the 6 month average of 30.0%.

The service is piloting a new gateway assessment model from 7 November 2023 with Core CAMHS. The service will be evaluating the pilot to see how it affects the waiting time to first assessment. It is anticipated that the new model will increase the number of slots available each month. Trajectory work has been undertaken by the service to look at the average days to first assessment for 2 scenarios. One based on the new gateway rota and one based the new gateway rota plus a catch up clinic. The trajectory includes referral demand based on the previous year's figures, a 60% referral acceptance rate, and a 12% DNA / late cancellation rate. It is projected that the average days to assessment for November will be 27 days in the first scenario and 22 days in the second one.

L19 - Ensure that reviews of new short or long term packages take place within 8 weeks of commencement
October performance is reported at 20.0% against an 80% performance threshold. There were 4 non-compliant cases reported in October.

One patient was reviewed within the required 8 weeks; however the clinical system has not yet been updated. One case is showing as non-compliant due to recording and data capture issues, this is currently being investigated. Two patients are still awaiting a review, 1 due to staffing capacity and 1 due to the patient not attending their booked review and continuing to be difficult to engage with.

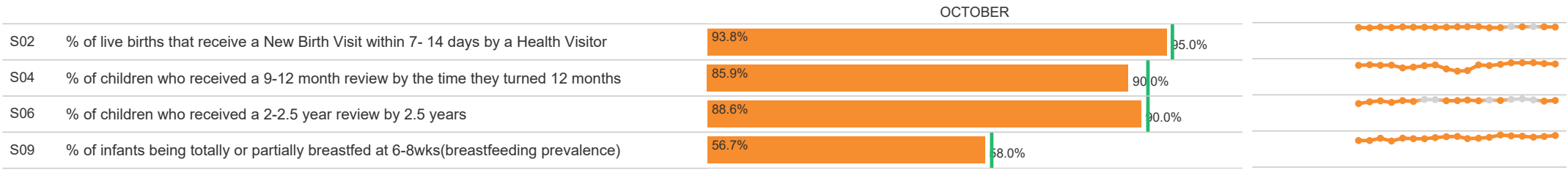
Performance Dashboard: *Specialised Commissioning Domain*

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*.

S02 - % of live births that receive a New Birth Visit within 7- 14 days by a Health Visitor
October performance was 93.8% (September was 94.5%) compared to a threshold of 95.0%, with 30 out of 488 infants showing as not seen within the 14 day target timeframe. Performance is within the SPC chart upper and lower control limits.

Exceptions were due to 15 babies being in NICU (Neonatal Intensive Care Unit), 6 out of timeframe due to staffing capacity (all have booked appointments), 4 parental choice to delay the visit, plus movements in and out of county and admission of mother to hospital. 1 was due to a lack of translator availability and 1 was due to a recording error which has now been rectified putting performance at 94.0%.

The service is seeing an increase in babies admitted to NICU and babies being readmitted to hospital – this may be due to maternity services pressures and early discharges.

There has been some reduction in staff availability due to sickness, which was 5.9% in Ootober.

Team Leaders will be using the Health Visiting service decision making matrix to ensure mandatory contacts and safeguarding are prioritised.

Locality Team leads are being informed when staff book outside timescales to support compliance. Where possible all NBV should be covered if illness occurs.

All children apart from Movements out and those still in NICU have now been seen by the service.

S04 - % of children who received a 9-12 month review by the time they turned 12 months
October performance was 85.9% (September was 87.0%) compared to a threshold of 90%, with 74 out of 526 children 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.

A third of exceptions were due to staff capacity. All have booked appointments. The remaining were due to parents either declining or delaying the review, DNAs for appointments or recording errors.

Action Plan
Out of timeframe – staffing capacity. Team Leaders are meeting on weekly basis to forecast any issues raised by sickness absence or staffing issues to try and ensure cover from other areas. ASQ (Ages and Stages Questionnaire) clinics are not to be cancelled unless all other staffing options have been exhausted. There has been a rise in staff respiratory illness over the last 2 months, sickness in October was 5.9%. There is ongoing recruitment for staff with 7.6WTE live on TRAC in stages of shortlisting and post interview. The October vacancy rate was 4.0%.

DNAs – Localities who have a particularly high DNA rate are being looked at to trial alternative offer. E.g. where DNA x 1 then triggers an automatic home visit to complete the ASQ (Ages and Stages Questionnaire).

Declined Review – The service is considering working closer with local Nurseries to access those children whose parents decline due to working full time.

Record errors – these were not corrected in timeframe to show for this monthly snapshot however they have now been corrected and performance for October is currently showing as 87.0%.

S06 - % of children who received a 2-2.5 year review by 2.5 years
October performance was 88.6% (September was 86.7%) compared to a threshold of 90.0%, with 54 out of 474 children showing as not having had a 2-2.5 year review by the time they turned 2.5 years. Performance is within the SPC chart control limits.

The majority of exceptions were due to parents either declining the review or DNAs for appointments. 4 exceptions were due to recording errors.

Action Plan
Declines – The service locality leads are looking at how to support lowering the decline rate in 2 year ASQ (Ages and Stages Questionnaire). This is likely linked to parents in work and unable to attend appointments. The service is considering working with Nurseries to complete check with parental consent.

DNAs – Localities which have a particularly high DNA rate are being looked at to trial alternative offer. E.g. where DNA x 1 then triggers an automatic home visit to complete the ASQ.

Record Errors - There was some sickness in the team that completes exceptions and they were not able to be corrected in timeframe before the final refresh. Team lead overseeing will ensure that the allocated day to complete Data is more flexible in future. October recording errors have now been amended and performance is showing as 89.4%.

S09 - % of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence)
October performance was 56.7% (September was 55.0%) compared to a threshold of 58%, with 209 out of 483 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 their specialist feeding service / tongue tie service waiting lists. Infant Feeding Lead Health Visitor has set up weekly meetings to address needs identified with plans to improve feeding status and has now been invited to the Postnatal Care Pathway meetings with the Midwifery Service. The Midwifery Infant Feeding Leads have introduced Infant Feeding Assessment/Support Clinics, as pilots in target areas of Gloucester & Forest of Dean.

Increasingly, more babies are born prematurely and require long NICU (Neonatal Intensive Care Unit) stays/re-admission for complex needs when they are discharged early. Health Visiting staff will ensure they are using the NICU template to ensure feeding status can be captured.

Importantly the service is above threshold in October for the percentage of babies continuing to breastfeed at 6 weeks that were at 2 weeks, showing good retention of referrals onto from Midwifery.

Action Plan
Joint Health Visiting and Midwifery Service Training/Updates have re-commenced and will review all training & policies with new Hospital Infant Feeding Team to ensure consistency with Health Visiting.

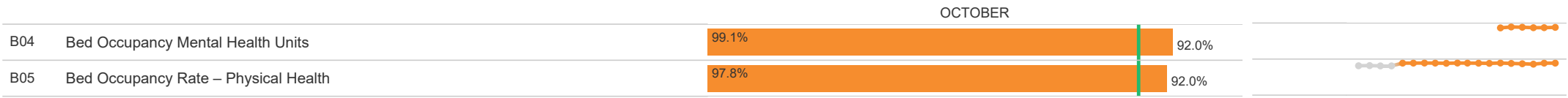
The Service will continue to promote the referral to specialist to local breastfeeding groups, Infant Feeding Keyworkers and the Infant feed Lead/Tongue tie Service, along with multi-agency Training/updates to maintain/ improve the figures.

Meeting held with Business Intelligence to refining the demographic information for specific target locations to focus on for improving breastfeeding rates. The Infant Feeding Lead is reviewing/updating the Infant Feeding Strategy Plan as part of the Infant Feeding Strategic Partnership Board Meetings. A business case is currently being formulated to allocate available funding to establish new Breastfeeding Support Groups where the rates are lowest (Gloucester, Forest of Dean).

Performance Dashboard: *Board Focus Domain*

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.*

B04 - Bed Occupancy Rate - Adult and Older Persons Mental Health

Bed occupancy excluding leave for Wotton Lawn (excluding Low Secure) and Charlton Lane for October was 99.1% (September was 98.3%) against a threshold of 92%.
All wards were above the 92% threshold:
Charlton Lane – Chestnut Ward: 121.2%
Charlton Lane – Mulberry Ward: 97.8%
Charlton Lane – Willow Ward: 99.7%
Wotton Lawn – Abbey Ward: 98.2%
Wotton Lawn Dean Ward: 98.3%
Wotton Lawn – Kingsholm Ward: 98.7%
Wotton Lawn – Priory Ward: 97.4%

B05 - Bed Occupancy Rate – Physical Health
Bed occupancy for October is 97.8% (September was 97.7%) against a threshold of 92% and is above the SPC control limits.
The following wards were above the 92% threshold:
Cirencester Hospital – Windrush Ward (97.8%)
Cirencester Hospital – Coln Ward (98.6%)
North Cotswold Hospital (98.8%)
Dilke Hospital (96.8%)
Lydney Hospital (96.4%)
Stroud Hospital – Cashes Green Ward (96.7%)
Stroud Hospital – Jubilee Ward (98.3%)
Vale Hospital (97.9%)
Tewkesbury Hospital (97.8%)
This means that no site was below the threshold for October.

Non-Exception highlights

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

- **L07 - Eating Disorders - Wait time for adult assessments will be 4 weeks**

October performance is reported at 80.7% against a 95% performance threshold and is within SPC limits, however, is being highlighted due to concerns around the waiting list numbers. There were 5 non-compliant cases reported in October

All 5 cases were referred prior to the new triage system with follow up calls and each patient had remained on the waiting list until an assessment became available. The number of adults waiting for assessment at the end of October 2023 was at 280 compared to 517 at its highest peak in August 2022.

- **L08 - Eating Disorders - Wait time for adult psychological interventions will be 16 weeks**

October performance is reported at 78.5% against a 95% performance threshold and is within SPC limits however, is being highlighted due to concerns around the waiting list numbers variation. There were 6 non-compliant cases reported in October.

The service continues to focus on reducing waiting times and allocating patients to clinicians for treatment as soon as capacity becomes available.

- **Additional commentary for L08 & L09**

Both of these indicators are being highlighted to offer oversight to the waiting list numbers and to provide early context that performance will likely remain in exception for a period whilst the tail of longest waiters is reduced.

The service has adopted a new triage process, and all new patients receive an initial call within 24-72 hours of the service receiving the referral. Self Help guidance is provided as appropriate and is 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 is currently reviewing the process for adult and adolescent routine assessments with the Quality Team with the aim to ensure that all routine adults and adolescents are assessed and offered an initial treatment start. The service is planning to implement a sub assessment team to solely concentrate on routine assessments service.

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 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: 1.0 x Band 4 Assistant Clinicians, Vacancies: 1.0 Band 7 ED Clinician, 1 x Band 4 assistant clinician, 1 x Band 5 ED Clinician and 1 x Band 6 Senior 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 Performance Governance Tracker. This is on the risk register ID 149 (Score 16).

- **B28 - % of Staff with completed Personal Development Reviews (Appraisal)**

Performance for October was 81.2%, (September was 81.2%) compared to a threshold of 90%. Performance is above the upper SPC chart control limit which shows a sustained level of improvement over the year. This appraisal performance figure includes Bank Staff.

Also see notes for KPI B29 below.

- **B29 - % of Staff with completed Personal Development Reviews (Appraisal) Exclusions Applied**

Performance for October is 85.8 % against a performance threshold of 90% and is above the upper SPC control limit (September performance: 84%). This shows a sustained level of improvement over the year. Excluding Bank staff, compliance has however dipped slightly from 87% last month.

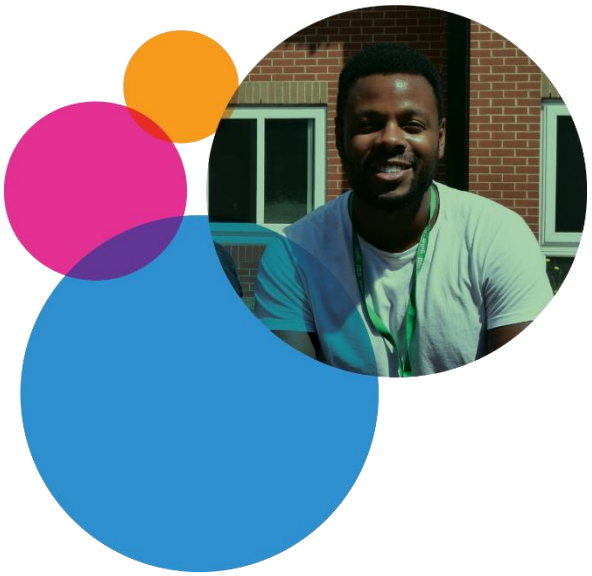
The Executive Directorate remains the highest performing Directorate at 97% , followed by Operations at 86% and then Finance (84%). The lowest performing areas continue to be Strategy and Partnerships Directorate and Nursing, Therapy and Quality Directorate

- **B31 - Turnover (12 month rolling)**

Turnover FTE (LTR) was 11.9% in October (for the 12 months 1 November 2022 – 31 October 2023) compared to a threshold of 11%. (September was 12%). This is within the SPC control limits. 11.9% is the best position Turnover has been since March 2021 (12%).

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust



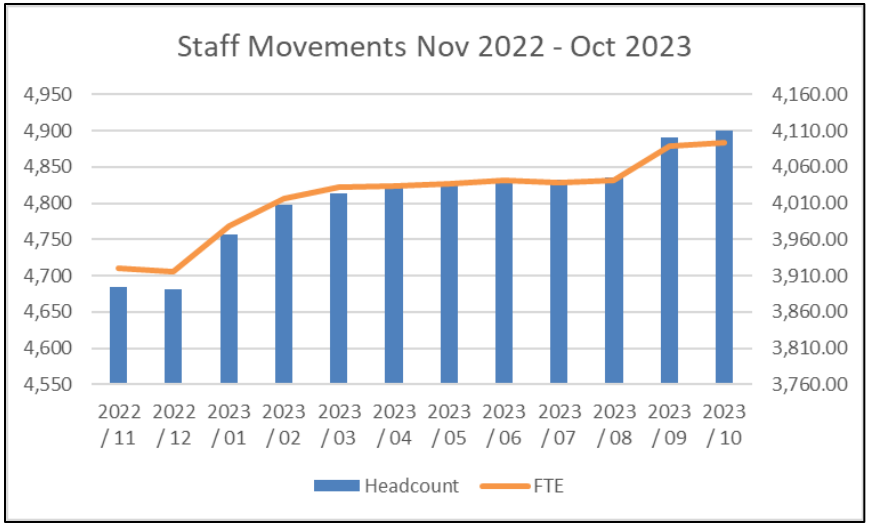
Workforce KPIs & Performance Report Month 7 – October 2023

Board Update

November 2023

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

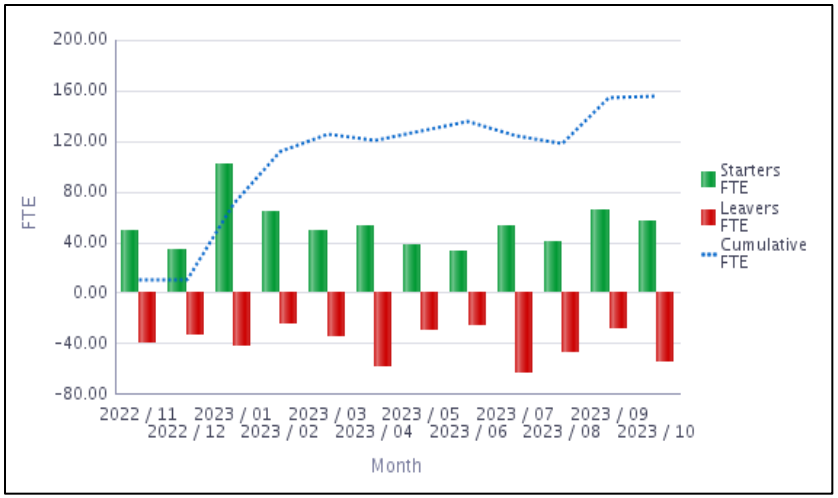
Workforce Establishment



Workforce Establishment:
The Trust's staff in post establishment trend Nov 22 – Oct 23, shows workforce increases over the 12-month period and an increase of FTE (full time equivalence) from 3914.02 to 4094.20 (+4.40%)

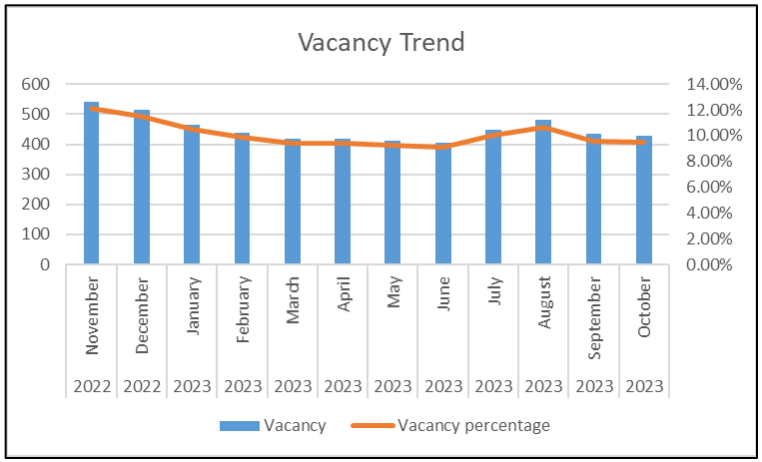
Starters & Leaver

Starters & Leaver
Net gain of 146.7 WTE (whole time equivalent) (156 headcount) over the last 12 months.



Vacancies

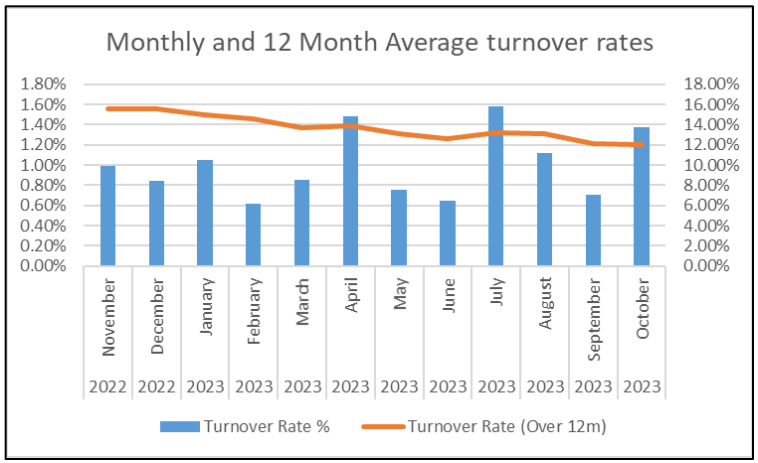
Gloucestershire Health and Care
NHS Foundation Trust



Year	Month	Vacancy	Vacancy percentage
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	449.29	10.01%
2023	August	482.75	10.66%
2023	September	435.52	9.60%
2023	October	428.90	9.47%

Vacancies
The Vacancy FTE & %s have remained relatively stable over the last few months, there continues to be challenges 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. A Task & Finish group has been established to tackle this issue & additional regional funding sourced to support. .

Turnover



Year	Month	Turnover Rate %	Turnover Rate (Over 12m)
2022	November	0.99%	15.55%
2022	December	0.85%	15.58%
2023	January	1.05%	14.98%
2023	February	0.61%	14.56%
2023	March	0.86%	13.69%
2023	April	1.48%	13.94%
2023	May	0.75%	13.14%
2023	June	0.64%	12.60%
2023	July	1.58%	13.20%
2023	August	1.12%	13.08%
2023	September	0.71%	12.11%
2023	October	1.38%	12.01%

Turnover
Turnover was 12.01% in October (for the 12 months Nov 22 – Oct 23) against an 11% target KPI, comparing to last year's 15.55%.

Benchmarking
Oxford Health – 15.1% turnover/15.9% vacancies. Herefordshire & Worcestershire - 12.72% turnover/11% vacancies. Avon Wiltshire Partnership 13.8% turnover/14.35% vacancies. Devon PT 7.6% vacancies/12.8% turnover Gloucs ICS turnover rate 13.8%. Cornwall PT Model Hospital Peer turnover rate 16.8% & 10.6% for vacancies.

Vacancies

Gloucestershire Health and Care
NHS Foundation Trust

As of 31 October 2023 there were 426.83 Trust vacancies & a vacancy rate of **9.5%**. 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	465.07	-89.70	-16.17%
327 Community Hospitals PH	507.65	448.73	-58.92	-11.61%
327 Inpatients Mental Health	475.46	420.90	-54.56	-11.48%
327 CYPS Mental Health	195.55	147.84	-47.71	-24.40%
327 Urgent Care Physical Health	176.85	141.56	-35.29	-19.95%
327 Facilities	181.48	149.58	-31.90	-17.58%
327 Urgent Care MH	144.35	122.01	-22.34	-15.47%
327 Adult Community Mental Health	341.46	320.76	-20.70	-6.06%
327 CYPS Physical Health	316.13	296.61	-19.52	-6.17%
327 Therapies & Spec Equip	232.48	217.97	-14.51	-6.24%
327 Adult Community LD	64.32	54.09	-10.23	-15.90%
327 CYPS Management & Admin	83.34	75.90	-7.44	-8.93%
327 Business Intelligence 1	24.67	17.57	-7.10	-28.77%
327 Operational Flow	30.22	23.23	-6.99	-23.12%
327 Governance & Compliance 1	36.52	30.25	-6.27	-17.18%
327 Medical 3	160.24	154.19	-6.05	-3.77%
327 NTQ Management 1	36.91	30.89	-6.02	-16.30%
327 Performance & Governance	16.09	12.09	-4.00	-24.84%

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.

An ICT Task and Finish Group is in place to tackle particular challenges recruiting to community nursing.

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

Turnover rates

Gloucestershire Health and Care
NHS Foundation Trust

Directorate & Staff group – higher areas

Org L6	Avg FTE	Starters FTE	Leavers FTE	LTR FTE %
327 Business Intelligence 1	19.37	3.49	6.99	36.10%
327 Adult Community Social Care	8.37	4.91	2.00	23.89%
327 IT & Clinical Systems 1	78.93	30.01	15.17	19.22%
327 Performance & Governance	10.79	2.00	2.00	18.53%
327 Learning & Development 1	43.63	5.61	7.81	17.91%
327 Contracts & Planning 1	6.00	1.00	1.00	16.67%
327 Community Hospitals PH	463.57	64.03	74.22	16.01%
327 Adult Community LD	54.98	4.20	8.16	14.84%
327 Adult Comm Physical Health	443.87	87.39	62.42	14.06%
327 Operational Flow	22.43	4.00	3.00	13.37%
327 Research & Development	7.63	0.40	1.00	13.11%
327 Estates	54.29	8.53	6.80	12.53%
327 Financial Management	32.09	4.00	4.00	12.47%
327 Therapies & Spec Equip	212.02	37.47	26.30	12.40%
327 CYPS Physical Health	286.59	50.65	34.80	12.14%
327 CW Specialist Services	219.67	33.79	26.64	12.13%
327 Facilities	151.39	16.63	17.46	11.53%
327 CYPS Management & Admin	73.07	6.30	8.42	11.52%
327 Temporary Staffing	8.71	1.80	1.00	11.48%
327 Corporate Governance	39.50	12.20	4.49	11.37%
327 Adult Community Entry Services	211.52	24.90	23.40	11.06%
327 Adult Community Mental Health	319.07	34.36	35.21	11.04%

Turnover rates

Turnover rates include colleagues leaving the Trust **and** those moving internally to other jobs.

Breakdown of turnover for Directorates with higher rates of >11% and by staff group (below) over the last 12 months, Nov 2022 to Oct 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. Additionally, funding has been sourced from the regional team to support retention projects.

Leavers

Gloucestershire Health and Care
NHS Foundation Trust

Unlike Turnover, Leavers are those colleagues wholly leaving the Trust. Rolling leaver numbers continue to steadily reduce **over the 12-month periods measured**, this partially aligns with the lower turnover rates.

Month	Leaver Rolling 12m
2022 / 11	-746
2022 / 12	-754
2023 / 01	-731
2023 / 02	-714
2023 / 03	-670
2023 / 04	-679
2023 / 05	-644
2023 / 06	-621
2023 / 07	-644
2023 / 08	-639
2023 / 09	-596
2023 / 10	-594

Leaving Reason	2022 Nov	2022 Dec	2023 Jan	2023 Feb	2023 Mar	2023 Apr	2023 May	2023 Jun	2023 Jul	2023 Aug	2023 Sep	2023 Oct	Grand Total
Death in Service				1									1
Dismissal - Capability						1				1		1	3
Dismissal - Conduct											1		1
End of Fixed Term Contract	1	3	1			6	1	3	6	3	1		25
End of Fixed Term Contract - Completion of Training Scheme			1							4			5
End of Fixed Term Contract - End of Work Requirement		1											1
Flexi Retirement				1		1	1	3	9	1	1	2	19
Mutually Agreed Resignation - Local Scheme with Repayment				1								1	2
Mutually Agreed Resignation - National Scheme with Repayment												1	1
Retirement - Ill Health	1		1	1	1			1	1	2	1		9
Retirement Age	5	6	14	2	3	29	3	4	9	5	2	2	84
Voluntary Early Retirement - no Actuarial Reduction			3			1			1	1		1	7
Voluntary Resignation - Adult Dependants					1				1			1	3
Voluntary Resignation - Better Reward Package	3	1	2	4	2		1		1	2		2	18
Voluntary Resignation - Child Dependants		1	1	1	2	2	2	1	1	3		1	15
Voluntary Resignation - Health	2	5	2		3	2	3		4	1	2	2	26
Voluntary Resignation - Incompatible Working Relationships	1		1			1			1		1		5
Voluntary Resignation - Lack of Opportunities	1	2	3		1	1	2	1	2	3	1	1	18
Voluntary Resignation - Other/Not Known	7	7	11	7	8	11	11	5	9	12	9	10	107
Voluntary Resignation - Promotion	5	7	2	4	4	4	2	4	4	4	7	5	52
Voluntary Resignation - Relocation	4	2	3	2	3	4	4	1	7	5	3	7	45
Voluntary Resignation - To undertake further education or training	2	3	2	1	1	1			8	5	2	2	27
Voluntary Resignation - Work Life Balance	17	6	4	6	12	10	7	9	13	4	4	7	99
Grand Total	**49**	**44**	**51**	**31**	**41**	**74**	**37**	**32**	**77**	**56**	**35**	**46**	**573**

Leavers Detail

Gloucestershire Health and Care
NHS Foundation Trust

Examples of reasons for leaving and examples of feedback

Leaving Reason	Comments
Retirement - Ill Health	
Retirement Age	A new back!
Voluntary Resignation - Adult Dependants	Feel last few years have been draining and now with waiting lists and referrals feels relentless. Thankful I can retire as could not keep going. Increasing mobility difficulties have made it difficult to continue working
Voluntary Resignation - Child Dependants	not sure really, possible more flexible hours.
Voluntary Resignation - Other/Not Known	No work life balance.
Voluntary Resignation - Promotion	Car parking/parking permit Career progression. Access to higher education modules. Better engagement from managers. Better involvement For changes to service. More compassionate towards mental health. No, my reasons for leaving are more based on my personal circumstances and wanting to change to full time elsewhere. Not at this point in time, if i was offered a career break or sabbatical I may not have left the trust completely.
Voluntary Resignation - Relocation	Being able to work more clinically as a manager as I have a lot of experience and this did not always seem to be valued. If there was a part time band 5/6 static role in my locality. No B7 non-clinical roles no B5 for B4 Admin staff. There is service need for B5 MMT Office Manager current OM is B4 which is underpaid for the need
Voluntary Resignation - Work Life Balance	A clearly defined plan with definite timelines N/A - I am leaving due to having to relocate rather than dissatisfaction with job role/Trust Progression job title be as I trained and be valued reduction in waiting list The ability to work remotely would have enabled me to keep my job despite moving house.
	It was a personal choice for me to leave my position to suit my life. I enjoyed working for the trust.

International Nursing Leavers

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NHS Foundation Trust

There are 82 International Nurses working for the Trust at present, 22 have already served with us for over 2 years, 26 over 1 year and 34 less than 1 year. Leavers and Turnover rates since 2021 have remained low.

Leaving Reason	Start Date	Termination Date	FTE	Length of Service (Years)	Length of Service (Months)
Voluntary Resignation - Relocation	**21/02/2022**	25/09/2022	1.00	0.00	7.00
Voluntary Resignation - Relocation	**03/08/2022**	30/10/2022	1.00	0.00	2.00
Voluntary Resignation - Relocation	**02/10/2021**	01/10/2023	1.00	1.00	11.00
Voluntary Resignation - Health	**11/08/2022**	09/05/2023	1.00	0.00	8.00
Voluntary Resignation - Other/Not Known	02/09/2022	26/11/2023	1.00	1.00	2.00
Voluntary Resignation - Other/Not Known	08/08/2022	18/10/2023	1.00	1.00	2.00

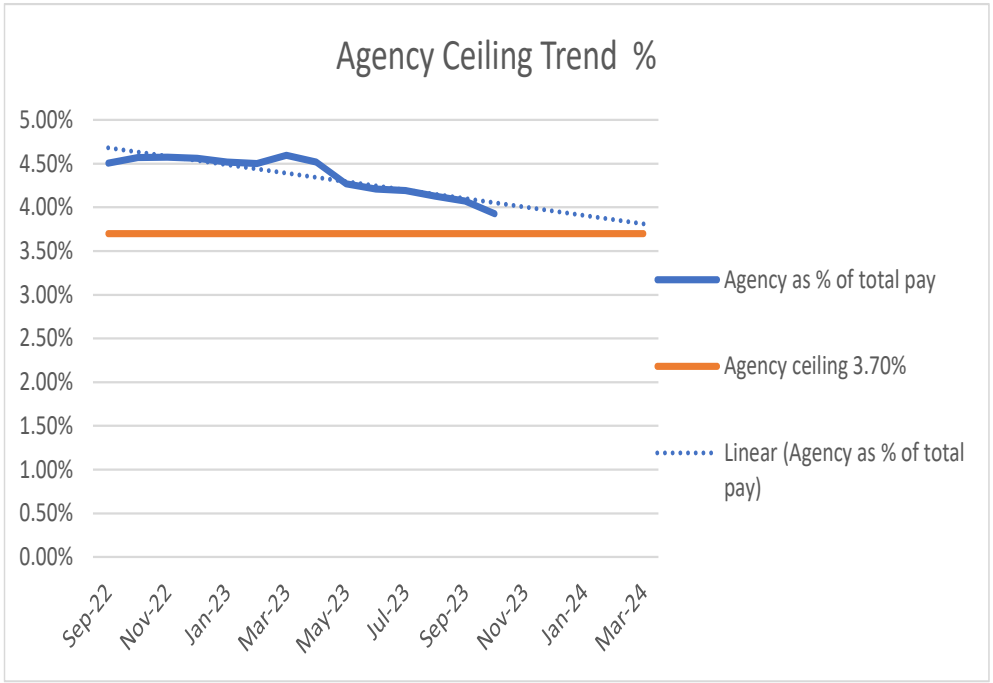
Length of Service (Years)	FTE
0	34.00
1	26.00
2	21.87
Grand Total	**81.87**

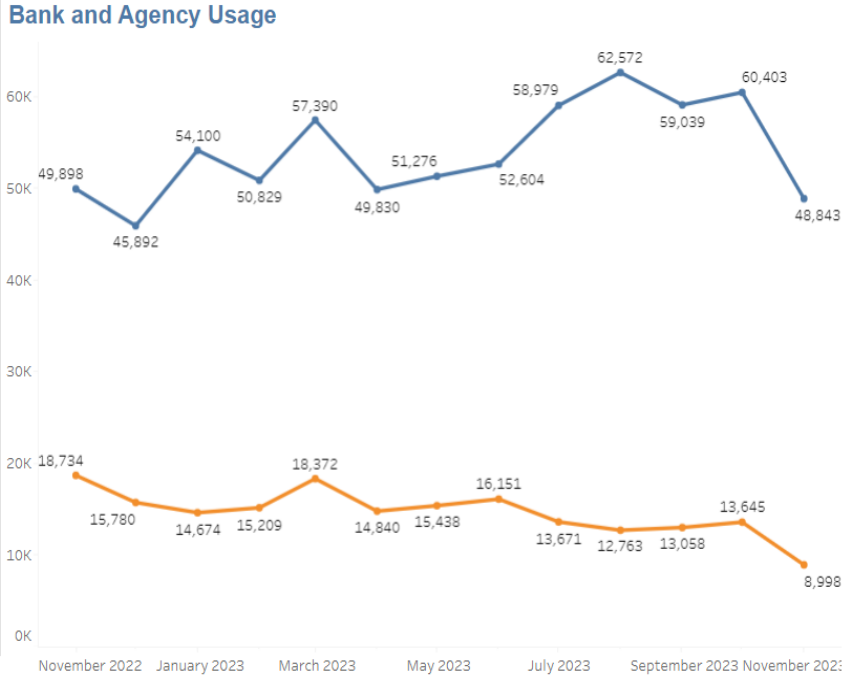
Temporary Staffing – Agency Ceiling

Gloucestershire Health and Care
NHS Foundation Trust

Month	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Medical Agency spend	125,874	131,607	180,995	176,320	194,859	91,624	91,520
Nursing & HCA Agency spend	679,899	572,455	543,980	529,002	460,066	600,718	390,601
Other Agency spend	19,057	26,614	23,538	18,313	44,261	20,160	43,065
	824,830	730,676	748,513	723,635	699,187	712,501	525,186
YTD spend	824,830	1,555,506	2,304,019	3,027,654	3,726,841	4,439,342	4,964,528

Agency Spend Ceiling
The plan in year is to achieve an agency spend of 3.7% of gross staff costs. At the end of **M7 it was 3.93%** of gross staff costs, but supported by the mitigation plans outlined below, we aim to achieve this by the start of the 2024/25 financial year.
The Trust has an NHSE set agency ceiling of £6.9 (8?)million. As of M7 2023/24, the Trust's NHSE agency ceiling trend analysis was as follows:

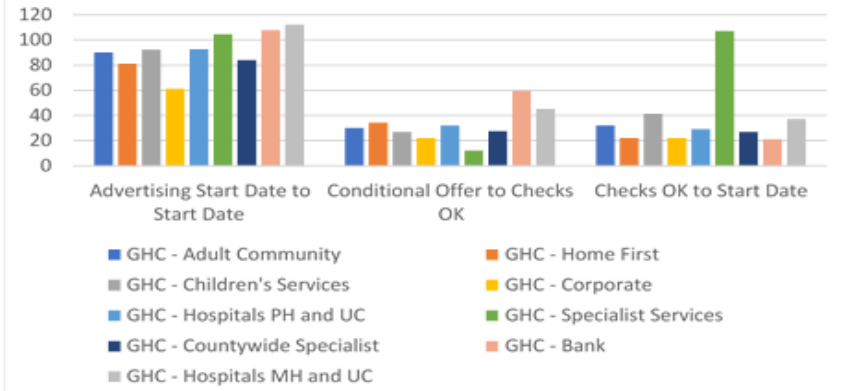


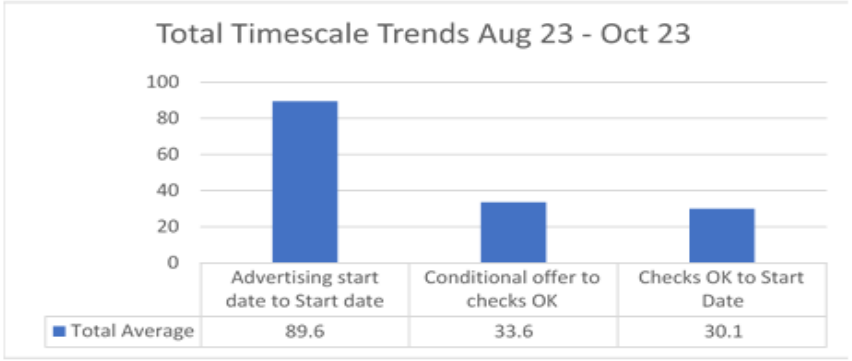


Recruitment

Gloucestershire Health and Care
NHS Foundation Trust

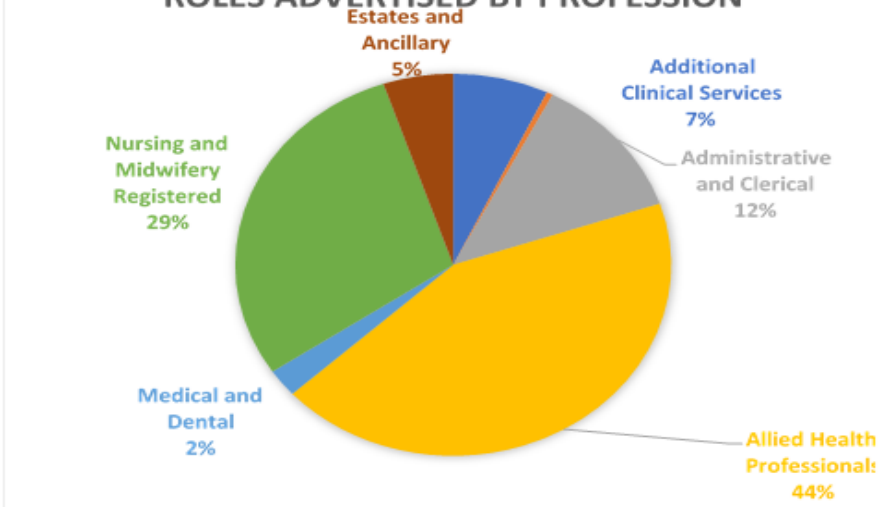
Timescale Data by Directorate and Totals





Timescale trend	1	2	3
Movement (since last report (Jul – Sept 23)	Increase from 85 to 89.6	Increase from 31.8 to 33.6	Increase 29.6 to 30.1

Vacancies and Applicants October 2023



Total vacancies advertised = 212 (15.22% increase on September 2023 and 1.40% decrease on October 2022)

Application Statistics	October 2023
Total Number of Applicants	2421
Shortlisted Applicants	341
% of applicants shortlisted	14.09%
Conditional Offer's made	138
Applicants in Pipeline (effective 02/11/2023)	222
Total "Started" during October	138

HCSW Recruitment

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HCSW Recruitment Dashboard

Recruitment Activity

	Starters			Leavers			
	Aug 2023	Sep 2023	Oct 2023	Aug 2023	Sep 2023	Oct 2023	In Pipeline Currently
MH & LD Urgent Care and Inpatient	3	2	2		3	2	2
PH Urgent Care and Inpatient	1	4	13	5	3	10	11
Community PH, MH & LD	1	3	10	2	1	3	16
CYPS Directorate	1		1	1	1	3	1
Countywide Services		5	1				1
Total	6	14	27	8	8	18	31

October 23:

Conditional Offers	9.38
Current Vacancy Rate (WTE)	-99.99

Vacancy Hotspots:

	FTE Budgeted	FTE Actual	FTE Variance
Grand Total	**608.63**	**508.64**	**-99.99**
327 E11850 LD Inpatients - Berkeley House	49	32.4	-16.6
327 B11200 Ciren Hosp- Windrush Ward	17.06	8.07	-8.99
327 B11201 Ciren Hosp- Coln Ward	20.16	13	-7.16
327 E11802 Vale Hosp- Peak View Ward	18.63	12.63	-6
327 G12308 Children Complex Care	11.59	6.8	-4.79
327 G13693 Physical Health Checks	6	2.72	-3.28
327 E11701 Stroud Hosp- Jubilee Ward	14.34	11.07	-3.27
327 D11602 Wotton Lawn- Dean Ward	12.5	9.4	-3.1

Project Workstream Highlights

Attraction

- Creating people profiles with development stories of existing HCSWs.

Innovative Recruitment

- Focus on HCSW recruitment to reduce time to hire
- Assistance from Recruitment Team in filtering applications for shortlisting for vacancies with lots of applicants
- Several recruitment events planned for 2023 (NHS Bus, Kingsholm Stadium, One Glos Event, UOG…etc.)
- Potential ICB event in Feb/March 2024 – on hold due to vast spread of HCSW vacancies
- Rolling adverts for vacancy hotspots and focusing more on offering apprenticeships
- Taster days in vacancy hotspots
- Creating values-based recruitment guidance and question bank.
- We're setting up a HCSW Talent Pool on Trac.

Learning and Development

- The Apprenticeships Team are attending several upcoming HCSW Council meetings to present on the development opportunities and career pathways available to them.
- Career conversation form and sessions.

Recognition and Value

- HCSW Shared Decision-Making Council

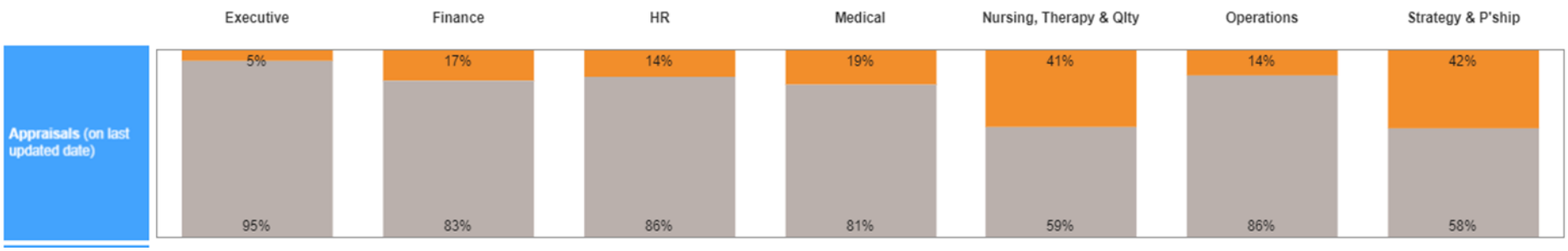
Retention

- Pastoral Care Assistant touching base with new ICB HCSWs to see how they're getting on, and to see what learning we can take away from onboarding process.
- Understanding vacancy hotspots.
- Investigating exit trends and themes (contacting leavers).
- Investigating demographics of applicants.
- Analysing HCSW engagement data – looking at NHS Staff Survey results for last year.
- Reviewing and setting standards with regards to local induction.
- Pastoral support sessions / listening events in vacancy hotspots/areas of high turnover.
- Reviewing Trust exit process.
- Promoting Band 4 roles to current HCSWs across services throughout the Trust

Appraisals / Personal Development Reviews

Gloucestershire Health and Care
NHS Foundation Trust

Whole Trust		
Appraisals (on last updated date) - **Target 90%**		
Appraisals Not Completed	15%	696
Appraisals Completed	85%	3,962



Benchmarking
Gloucestershire Hospitals 81%, Avon Partnership Trust 88%, Cornwall Partnership Trust 62%, Devon Partnership 70%, Dorset Health Care (MH) 83%, Herefordshire & Worcestershire 86%, Oxford Health 92%, Somerset NHSFT 61%

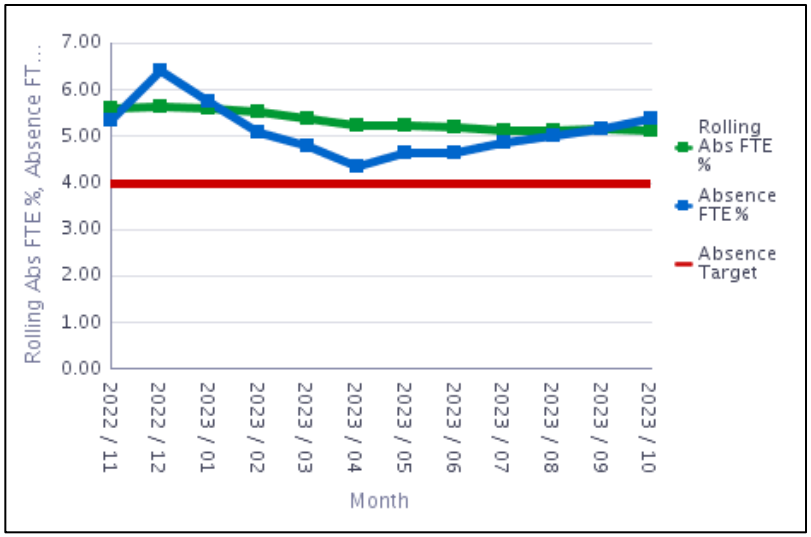
KPI Breakdown: Trust Wide Requirements

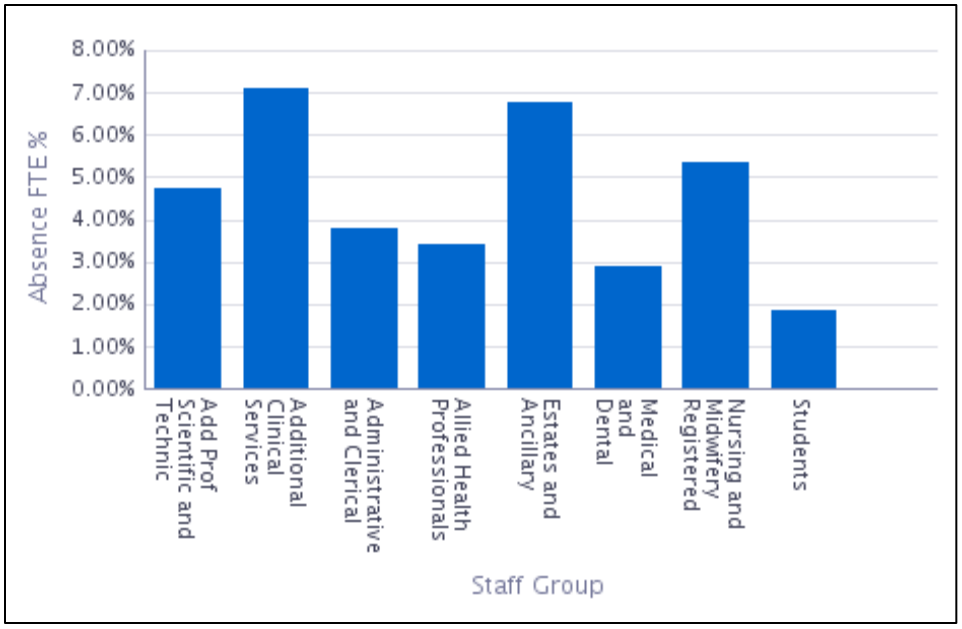
Gloucestershire Health and Care
NHS Foundation Trust

Sickness absence data shows a rise over the past few months due to increased cold/flu, MSK and stress related reasons being recorded, the rate is now at **5.37%** for October against a KPI target of 4%. The rise over the last few months is related to an increase in cold/flu reporting. More details on the next slide.

Rolling absence (green line) now sits at 5.12%.

The two highest staff groups are Additional Clinical Services workers (HCSW) at 7.09% & Estates and Facilities at 6.75%. Nursing is at 5.35%.





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%.

KPI Breakdown: Trust Wide Requirements

Gloucestershire Health and Care
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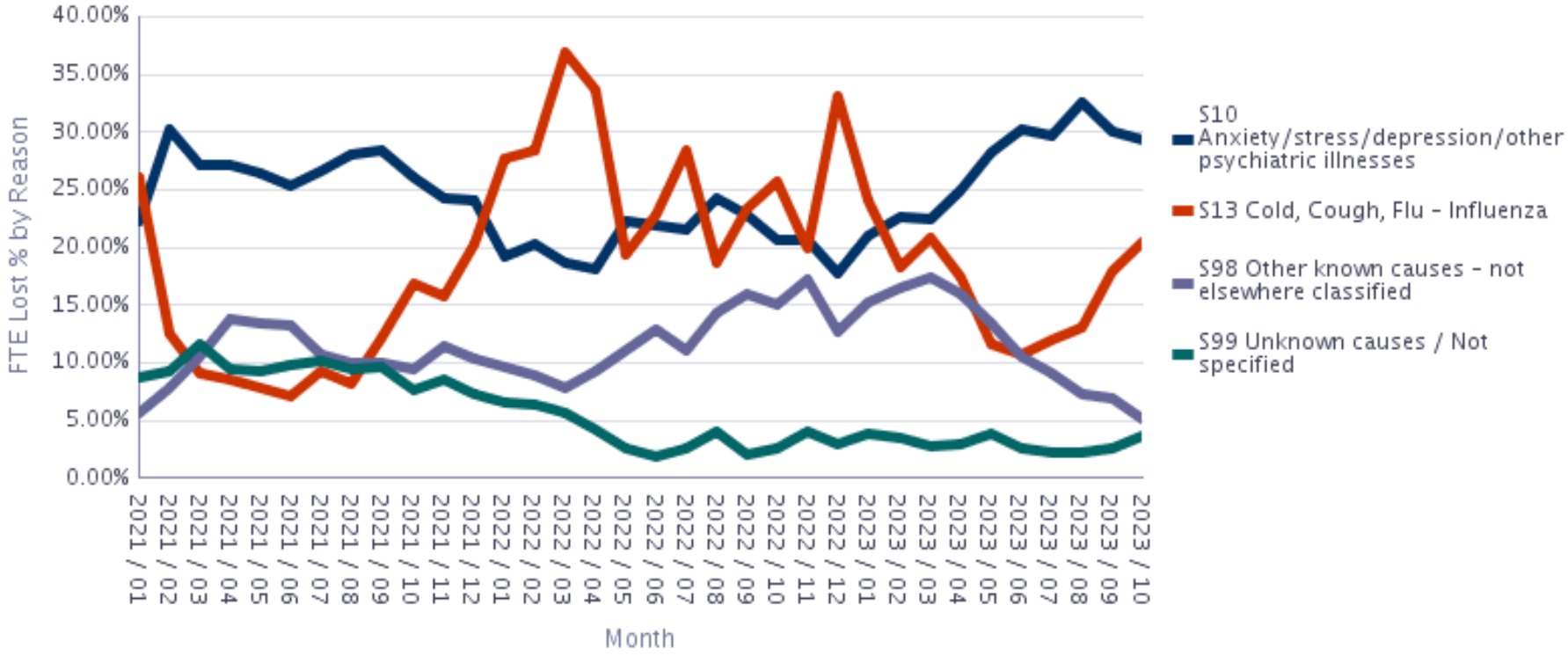
Slide included to highlight two factors:

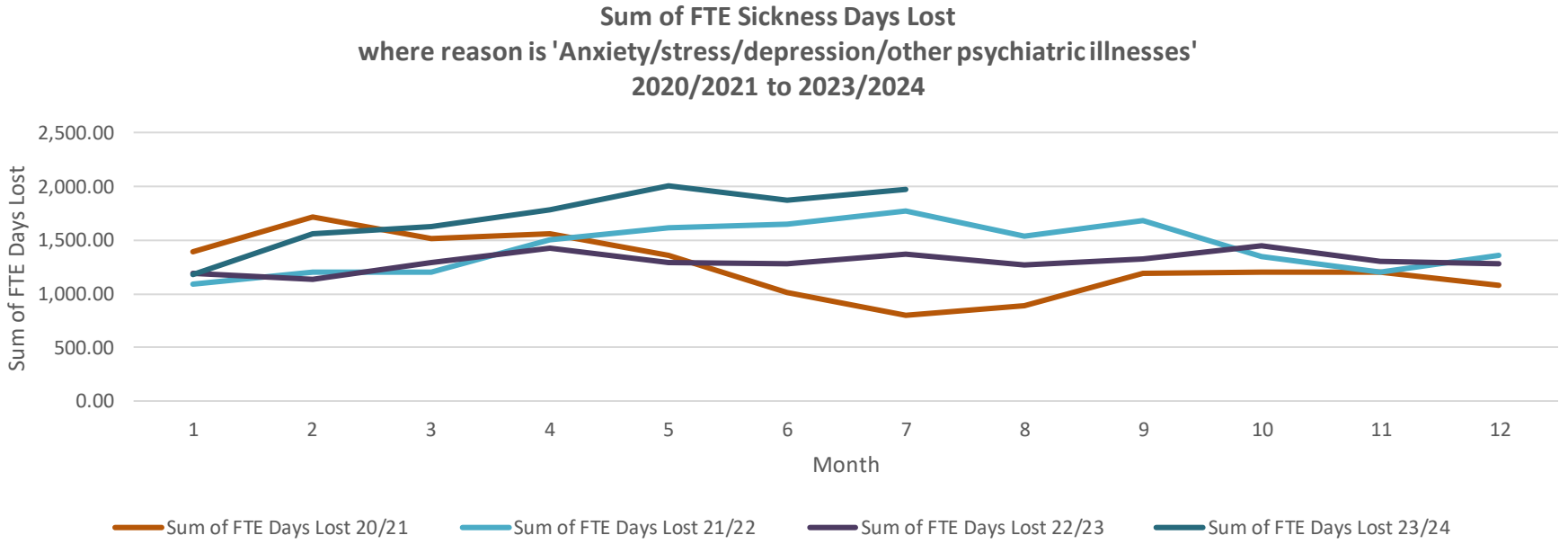
- Impact of the removal of S98 'Other' from our roster system and the relative increase in S10 Anxiety reporting
- Illustrate the recent increase in S13 Cold/Flu cases reported.



KPI Breakdown: Trust Wide Requirements

Gloucestershire Health and Care
NHS Foundation Trust

Anxiety/stress/depression/other psychiatric illnesses remains the top reasons for sickness absence within the Trust. The recent increase in this category is reflective of the removal of the "Unknown" sickness reason category implemented to improve reporting accuracy. It is believed that stress related illness has been higher historically but reported as "unknown" previously.



The Trust continues to support colleagues with MSK problems via the Self Referral Physiotherapy service. For anxiety/stress/depression/other psychiatric illnesses, additional resources have been put into the Well-being Line for all health & care colleagues, the internal GHC counselling resourcing is widely utilised, as well as the VIVUP 24/7 EAP.

Sickness absence performance at service / departmental level is available on Tableau &7 is operationally managed via the monthly Directorate Governance Forums with the Senior Operations Team, Service Directors & invited HR, BI and Finance partners, with oversight by the Senior Operations Pan Directorate Operational Governance Meeting.

KPI Breakdown: Trust Wide Requirements

Gloucestershire Health and Care
NHS Foundation Trust

Staff Training

Average Compliance	Total Staff	Total Staff with Outstanding Courses
95.90%	4,511	3,291

Total Compliance Percentage by Directorate for All Courses

Use + to open each area detail

Average Compliance	Total Staff	Total Staff with Outstanding Courses
82.20%	727	603

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 95.90%, 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%. There has also been a considerable effort from the temporary staffing team to increase Bank training compliance, the bank worker compliance rate is steadily rising and now sits at 82.20%.

Benchmarking
Avon Wiltshire Partnership 85%, Cornwall Partnership 89%, Devon Partnership 90%, Dorset Healthcare 93%, Gloucestershire Hospitals 85%, Herefordshire & Worcestershire 93%, Oxford Health 87%, Somerset NHSFT 65%.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 09/1123

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 November 2023**

PRESENTED BY: Sandra Betney, Director of Finance

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT – MONTH 7**

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 7 financial position

Executive summary

- The current system plan is break even and the Trust's plan is break even
- At month 7 the Trust has a surplus of £1.425m compared with a plan of £0.249m
- 23/24 Capital plan is £17.785m and spend to month 7 is £7.124m against a plan of £11.562m
- Cash at the end of month 7 is £40.400m
- Cost improvement programme has delivered £3.661m of recurring savings against a plan of £4.137m
- Non recurring savings delivered to date of £2.985m compared with the plan of £2.59m
- Additional non recurring financial support has been announced for the NHS in 23/24. Gloucestershire ICS must submit a revised forecast outturn by the 22nd November, and an extraordinary Board meeting has been set for the 21st November to discuss the Trust and system positions.

Risks associated with meeting the Trust's values
Risks included within the paper

Corporate considerations	
Quality Implications	
Resource Implications	
Equality Implications	

Where has this issue been discussed before?

Appendices:	Finance Report – Month 7

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

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Gloucestershire Health and Care
NHS Foundation Trust

Finance Report
Month 7

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Overview

- The current system plan is break even and the Trust's plan is break even
- At month 7 the Trust has a surplus of £1.425m compared with a plan of £0.249m
- 23/24 Capital plan is £17.785m and spend to month 7 is £7.124m against a plan of £11.562m
- Cash at the end of month 7 is £40.400m
- Cost improvement programme has delivered £3.661m of recurring savings against a ytd plan of £4.137m. Forecast is £5.443m against plan of £5.443m.
- Non recurring savings delivered to date of £2.985m compared with the plan of £2.59m. Forecast is £4.440m against plan of £4.440m.
- The Trust spent £4.965m on agency staff up to month 7. This equates to 3.9% ytd of total pay, excluding centrally funded employers contribution to pensions of 6.3%, compared to the agency expenditure ceiling of 3.7%.
- October agency spend continued on a downward trend of previous months at 3.03% of total pay
- System position at month 7 is a £4.031m variance to plan, an improvement of £1.564m on last month. The reported system forecast currently remains break even.
- Additional non recurring financial support has been announced for the NHS in 23/24. Gloucestershire ICS must submit a revised forecast outturn by the 22nd November, and an extraordinary Board meeting has been set for the 21st November to discuss the Trust and system positions.

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	271,858	158,584	157,055
Other operating income	12,792	11,409	17,292	10,387	11,034
Employee expenses - substantive	(184,330)	(201,415)	(218,476)	(127,444)	(111,015)
Bank	(11,698)	(1,704)	(4,040)	(2,357)	(10,407)
Agency	(7,952)	(863)	(1,387)	(809)	(4,965)
Operating expenses excluding employee expenses	(59,034)	(59,076)	(64,721)	(37,754)	(40,274)
PDC dividends payable/refundable	(2,580)	(2,590)	(2,590)	(1,511)	(1,511)
Finance Income	1,383	1,383	2,110	931	1,579
Finance expenses	(153)	(153)	(153)	(89)	(114)
Surplus/(deficit) before impairments & transfers	**(108)**	**(94)**	**(108)**	**(63)**	**1,383**
Remove central PPE stock impact					
Remove capital donations/grants I&E impact	108	94	108	63	42
Surplus/(deficit)	**0**	**0**	**0**	**0**	**1,425**
WTEs	4433	4405	4489	4489	4547

GHC I & E Forecasts

Gloucestershire Health and Care
NHS Foundation Trust

Statement of comprehensive income £000	2023/24	2024/25	2025/26	2026/27	2027/28
	Forecast £000s	Forecast £000s	Forecast £000s	Forecast £000s	Forecast £000s
Operating income from patient care activities	270,619	260,491	263,176	264,815	266,155
Other operating income	17,959	15,278	14,409	14,599	15,101
Employee expenses - substantive	(194,660)	(190,501)	(188,852)	(189,364)	(189,145)
Bank	(17,316)	(18,676)	(19,050)	(19,431)	(19,819)
Agency	(8,268)	(7,740)	(7,692)	(7,725)	(7,732)
Operating expenses excluding employee expenses	(68,194)	(58,739)	(61,771)	(62,567)	(64,131)
PDC dividends payable/refundable	(2,800)	(2,624)	(2,724)	(2,824)	(2,924)
Finance Income	2,759	2,565	2,565	2,565	2,565
Finance expenses	(191)	(160)	(164)	(165)	(169)
Surplus/(deficit) before impairments & transfers	**(92)**	**(106)**	**(103)**	**(98)**	**(98)**
Remove central PPE stock impact					
Remove capital donations/grants I&E impact	92	106	103	98	98
Surplus/(deficit)	**0**	**(0)**	**0**	**0**	**0**
Recurring savings		**(6,517)**	**(6,543)**	**(6,561)**	**(6,577)**
Savings as % of budget		**2.5%**	**2.5%**	**2.5%**	**2.5%**
Non recurring savings		**(7,676)**	**(5,254)**	**(4,401)**	**(3,427)**
Savings as % of budget		**2.9%**	**2.0%**	**1.7%**	**1.3%**

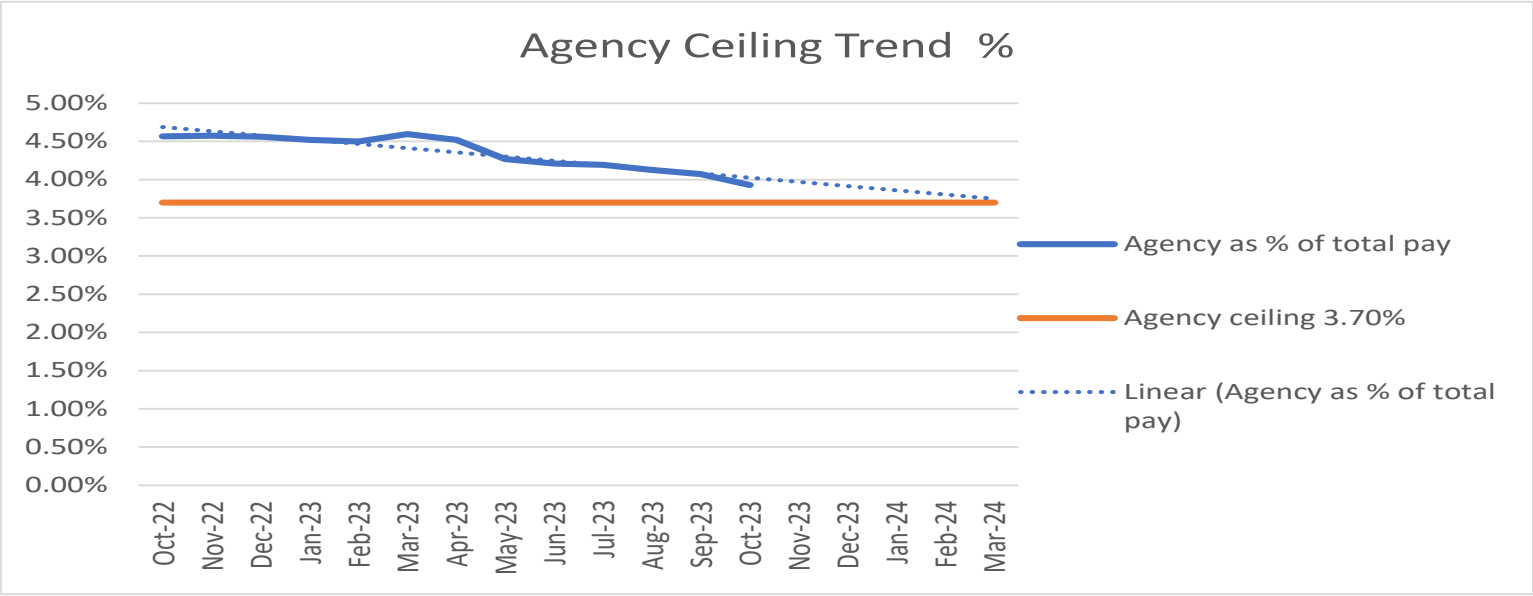
Future years forecasts based on recurrent budgets with inflation, savings assumptions applied. Non recurrent income and costs are excluded.

Pay analysis

Gloucestershire Health and Care
NHS Foundation Trust

Pay analysis month 7					
	Budget WTE year to date	Actual WTE year to date	Budget year to date £000s	Actual year to date £000s	Actual ytd as % of Total
Substantive	4,466	4,096	127,444	111,015	87.8%
Bank	14	377	2,357	10,407	8.2%
Agency	3	79	809	4,965	**3.9%**
Total	**4,483**	**4,552**	**130,610**	**126,387**	**100.0%**

Comments
- substantive costs exclude employers contribution of nationally funded pension costs of 6.3%
- A4C and Medical pay awards lead to recurring cost pressure of c.£0.77m
- Agency spend £200k lower in October than the average monthly spend April to September
- 3.9% of pay bill spent on agency year to date. System agency ceiling 3.7%
- We are £300k above agency ceiling



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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	936	1,161	226	1,074	786	502	230	0
	Property, plant and equipment: other	113,537	143,163	137,787	114,472	(23,315)	120,616	120,901	124,890	124,431	123,977
	Right of use assets*	17,715	19,028	19,638	16,686	(2,952)	17,241	16,577	16,005	14,444	12,883
	Receivables	1,085	511	512	1,084	573	826	901	901	901	901
	Total non-current assets	**133,707**	**163,522**	**158,872**	**133,403**	**(25,469)**	**139,757**	**139,165**	**142,298**	**140,006**	**137,761**
Current assets	Inventories	406	494	494	398	(95)	398	398	398	398	398
	NHS receivables	14,538	4,300	4,270	14,451	10,181	8,451	8,770	8,720	8,690	8,660
	Non-NHS receivables	7,165	8,738	8,738	7,092	(1,645)	7,092	6,085	5,985	5,935	5,885
	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	5,954	5,954	2,565				
	Cash and cash equivalents:	48,836	42,044	43,721	40,400	(3,321)	40,653	46,102	44,378	46,441	48,566
	Total current assets	**72,480**	**53,412**	**55,059**	**66,161**	**11,101**	**57,025**	**59,220**	**57,346**	**59,329**	**61,374**
Current liabilities	Trade and other payables: capital	(4,343)	(5,594)	(2,594)	(1,984)	610	(3,984)	(4,220)	(4,220)	(4,220)	(4,220)
	Trade and other payables: non-capital	(38,870)	(25,865)	(28,169)	(29,558)	(1,388)	(27,854)	(30,204)	(30,204)	(30,204)	(30,204)
	Borrowings*	(1,446)	(1,345)	(1,480)	(1,328)	151	(1,277)	(1,345)	(1,345)	(1,345)	(1,345)
	Provisions	(7,882)	(6,511)	(5,561)	(8,865)	(3,305)	(7,594)	(6,558)	(6,558)	(6,558)	(6,558)
	Other liabilities: deferred income including contract liabilities	(1,107)	(2,478)	(2,478)	(4,830)	(2,351)	(2,830)	(2,400)	(2,400)	(2,400)	(2,400)
	Total current liabilities	**(53,649)**	**(41,793)**	**(40,282)**	**(46,565)**	**(6,283)**	**(43,539)**	**(44,727)**	**(44,727)**	**(44,727)**	**(44,727)**
Non-current liabilities	Borrowings	(15,298)	(18,265)	(18,320)	(14,377)	3,943	(15,189)	(14,684)	(14,549)	(14,419)	(14,294)
	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**	**152,791**	**136,142**	**(16,649)**	**135,574**	**136,494**	**137,888**	**137,709**	**137,634**
Taxpayers Equity	Public dividend capital	130,166	132,056	130,215	130,166	(49)	131,072	132,285	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)	(4,602)	(4,771)	(4,950)	(5,025)
	Income and expenditure reserve (current	(14,950)	(108)	186	1,382	1,196	(92)				
	Total taxpayers' and others' equity	**134,761**	**154,338**	**152,791**	**136,142**	**(16,649)**	**135,574**	**136,494**	**137,888**	**137,709**	**137,634**

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**	**40,653**	**44,440**	**42,716**	**44,779**
Cash flows from operating activities										
Operating surplus/(deficit)	(13,138)		1,427		140		**1,734**	**1,967**	**2,058**	**2,266**
Add back: Depreciation on donated assets	84		42		92		0	0	0	0
Adjusted Operating surplus/(deficit) per I&E	**(13,054)**		**1,469**		**232**		**1,734**	**1,967**	**2,058**	**2,266**
Add back: Depreciation on Right of use assets	7,918						8,228	8,431	8,804	8,757
Add back: Depreciation on owned assets			4,722		8,562		1,561	1,561	1,561	1,561
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)		133		6,390		650	150	80	80
Increase/(Decrease) in provisions	3,576		983		(288)		(500)	0	0	0
Increase/(Decrease) in trade and other payables	10,119		(9,943)		(11,019)		0	0	0	0
Increase/(Decrease) in other liabilities	(1,301)		3,722		1,722		0	0	0	0
Net cash generated from / (used in) operations		**14,362**		**1,094**	**0**	**5,608**	**11,673**	**12,109**	**12,503**	**12,664**
Cash flows from investing activities										
Interest received	1,144		1,578		2,759		825	825	825	825
Interest paid			(5)		(13)		0	(7)	(7)	(7)
Asset Held for Sale					3,389		2,233	5,500	500	0
Purchase of property, plant and equipment	(22,650)		(9,221)		(17,122)		(9,164)	(18,625)	(8,573)	(8,073)
Sale of Property	0				0				0	0
Net cash generated used in investing activities		**(21,506)**		**(7,648)**	**0**	**(10,987)**	**(6,106)**	**(12,307)**	**(7,255)**	**(7,255)**
Cash flows from financing activities										
PDC Dividend Received	1,886				906		**1,213**	**1,563**	**0**	**0**
PDC Dividend (Paid)	(3,217)		(899)		(2,194)		**(2,690)**	**(2,790)**	**(2,890)**	**(2,990)**
Finance lease receipts - Rent			129		221					
Finance lease receipts - Interest	216		(1)		(2)					
Finance Lease Rental Payments	(1,632)		(1,004)		(1,557)		**(162)**	**(164)**	**(165)**	**(169)**
Finance Lease Rental Interest	(169)		(107)		(178)		**(141)**	**(135)**	**(130)**	**(125)**
		(2,916)		**(1,882)**	**0**	**(2,804)**	**(1,780)**	**(1,526)**	**(3,185)**	**(3,284)**
Cash and cash equivalents at end of period		**48,836**		**40,400**	**0**	**40,653**	**44,440**	**42,716**	**44,779**	**46,904**

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	850	46	1,202	1,000	3,000	3,000	3,000
Backlog Maintenance	1,045	580	441	1,938	1,250	1,393	1,393	1,393
Buildings - Finance Leases	784	227	0	1,241	712	989	0	0
Vehicle - Finance Leases	384	224	0	459	239	0		0
Net Zero Carbon	500	400	0	262	500	500	500	500
LD Assessment & Treatment Unit						2,000	0	
Cirencester Scheme						5,000	0	
Medical Equipment	500	278	14	531	1,030	1,030	1,030	1,030
Xray				267	0			
Endoscopy				0	0			
IT								
IT Device and software upgrade			0		600	600	600	600
IT Infrastructure	1,130	1,169	32	1,130	1,300	1,300	1,300	1,300
Clinical Systems Vision	2,191	210	298	1,256	2,533	2,813	250	250
Unallocated				103			500	
Sub Total	**8,934**	**3,938**	**831**	**8,389**	**9,164**	**18,625**	**8,573**	**8,073**
Forest of Dean	8,851	7,624	6,031	8,951	0	0	0	0
Total of Original Programme	**17,785**	**11,562**	**6,862**	**17,340**	**9,164**	**18,625**	**8,573**	**8,073**
Disposals	(3,749)			(3,700)	(2,233)	(500)	0	0
Donation - Cirencester Scheme	**0**					(5,000)	0	0
Total CDEL	**14,036**	**11,562**	**6,862**	**13,640**	**6,931**	**13,125**	**8,573**	**8,073**

FoD projected total spend £25.9m

Risks

Gloucestershire Health and Care
NHS Foundation Trust

Potential risks are as set out below:
23/24 Pay award pressure, ICS Risk share mechanism, Dental dispute, and Section 117 cost share risk all removed as they are now issues rather than risks

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 Inpatients	700	3,400	-2,700	3	2	6
Recurring savings without a plan don't deliver	359	359	0	3	2	6
Utility, fuel, waste costs rise due to inflationary pressures	300	300	0	3	2	6
Capital cost inflation leads to capital programme being reduced	0	1,000	-1,000	0	0	0
Mental Health Act White paper reforms	0	1,000	-1,000	0	0	0
Microsoft Licenses cost pressure from national deal	0	283	-283	0	0	0
Total of all risks	**1,359**	**6,342**	**-4,983**			

System position

Gloucestershire Health and Care
NHS Foundation Trust

Draft System Position Month 7 23/24	Plan 31/10/2023 YTD	Actual 31/10/2023 YTD	Variance 31/10/2023 YTD	31/03/2024 Forecast
Organisation	£'000	£'000	£'000	£'000
Gloucestershire ICB	0	(2,788)	(2,788)	0
Gloucestershire Health And Care NHS Foundation Trust	249	1,425	1,176	0
Gloucestershire Hospitals NHS Foundation Trust	(9,204)	(11,622)	(2,418)	0
TOTAL	(8,955)	(12,985)	(4,030)	0

System risk share position

Gloucestershire Health and Care
NHS Foundation Trust

Organisation	Measure	Target	Delivery on track?
ICB	Deliver Financial Plan	Break even	**Yes**
ICB	Deliver system ERF	Delivery of system ERF target (Independent sector providers and out of county providers)	**Yes**
ICB	Increased flow	Increased flow through discharge to assess beds – 5 day reduction in LOS by 31st March 2024 from a baseline of 38.4 days average.	**Yes**
GHFT	Deliver Financial Plan	Break even	**No**
GHFT	Deliver ERF target	Delivery of the Elective Recovery target for 23/24 of 109% of 19/20 baseline (Trusts' element of Gloucestershire target which is NOW 103% activity recovery rate).	**maybe**
GHFT	Deliver Ambulance handover trajectory	Delivery of the ambulance handover trajectory in the Operational Plan (using average handover time as the measure).	**No**
GHC	Deliver Financial Plan	Break even	**Yes**
GHC	Improve rapid response demand and capacity by 3%	Have 3900 starts annually	**No**
GHC	Improved mental health liaision response	1115 Routine referrals responded to in 24 hours, 476 Urgent referrals responded to in 2 hours	**Yes**

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NHS Foundation Trust

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

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 NOVEMBER 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 – September and October 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 October and 21st November. Due to a commitment in my calendar, I was unable to join the meeting which took place on 21st November and Graham Russell Chaired the meeting on my behalf. 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.

- 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 eight visits across the breadth of Trust services including the Cotswolds District Nursing Team, Gloucester District Nursing Team, Clinical Flow and Single Point of Clinical Access Team, Stroke Early Discharge Service, Dementia Nursing Service, Gloucestershire Health and Wellbeing Recovery College, Vale Hospital Inpatients and the CAMHS Multi Agency Hub. 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. We look forward to receiving an annual report on the impact of these visits at our next Board meeting.

- 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.

- At the July Board meeting, I advised the Trust was participating as a sponsor organisation in GatenbySanderson's **Insight South West Programme** for aspiring Non-Executive Directors. I am pleased to confirm that our first

placement, Mohammed Rashid, has now commenced with us and I had the pleasure of an introductory meeting with Mo on 26th October. Mo will be attending a number of our Board and Board Committee meetings during his placement which is due to end in April 2024 and will participate in a wider development programme including mentoring and support from myself and other members of the Board.

2.2 **Trust Board Meetings:**

- 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.

- Since the last Board meeting we have held two **Board Development Sessions** facilitated by The Value Circle in October and November where we reflected on progress made since our Strategic Away Day in July, and specifically how we move forward our strategic planning agenda.

- On 16th October, a **Board Briefing** was held on the CQC inspection of Berkeley House.

- Following receipt of the **operational guidance from NHS England** addressing the significant financial challenges created by industrial action in 2023/24 and the immediate actions to be taken, an **Extraordinary Board** session took place on 21st November where Board met to approve a revised system plan for 2023/24.

3. GOVERNOR UPDATES

- We were saddened to hear of the passing of Mervyn Dawe. Mervyn served as a Public Governor representing Stroud for six years, coming to the end of his term in June 2022. However, many colleagues will have worked with Mervyn over many years in both his Nursing and Unison roles. Mervyn was a qualified psychiatric nurse, training and working in Gloucestershire until his retirement in 2011. He was also elected trade union lead for the joint trade unions for the last fifteen years of his career. Mervyn first joined our Council of Governors in 2008 as a Staff Governor representing Nursing colleagues, so we were lucky to have his expertise, advice and guidance on not just one, but two occasions. Mervyn will be sadly missed. On behalf of the Trust I have expressed our sincerest condolences to his wife Karen, and his family and attended Mervyn's funeral which took place on 1st November.

- I continue to meet on a regular basis with the **Lead Governor Chris Witham**, to discuss matters relating to our Council of Governors including agenda planning, governor elections and matters relating to membership engagement.

- A **Council of Governors** meeting took place on 22nd November where the Council received a presentation from Dawn Allen, Service Director on 'community hospitals as community assets'. Graham Russell, NED gave a

presentation on his role as Chair of the Great Place to Work Committee as part of the Governor role in holding the Non-Executive Directors to account. The Council also received a verbal update on key developments and news from our Chief Executive, Douglas Blair, updates on membership activity and a progress update following our recent round of Governor elections.

- I attended the **Quarterly Staff Governor** meeting with NEDs on 7th November. A number of topics were discussed at this meeting, including equality, diversity and inclusion and the support available for colleagues in reporting incidents, the revision and strengthening of holding NEDs to account at Governor meetings and following initial discussion at a previous Staff Governor meeting, Management of Change.

- Our **programme of visits to sites for Trust Governors** continues to progress. These visits offer Governors the opportunity to see our sites, speak to colleagues and to gain a better understanding of the services we provide. Non-Executive colleagues accompany Governors on each of the visits. A new schedule is in development for the new year and we hope to share this with Governors in the coming weeks.

- At our September **Council of Governors meeting**, it was reported that the Trust had 3 vacant Public Governor positions (Tewkesbury, Cheltenham and Gloucester). An election process was scheduled for later in the autumn for one Public Governor position (Tewkesbury) and one Staff Governor position (Medical, Dental & Nursing) as both existing Governors would be coming to the end of their first terms. This process commenced on 30 October 2023 and all 5 positions were advertised to eligible Members. The nominations phase closed on Tuesday 14th November. We will be required to hold an election for the Gloucester constituency which will commence at the end of November. However, I am delighted to welcome two new Governors to the Council – Chas Townley (Tewkesbury) and Roger Stewart (Cheltenham) who will join us from 1st January 2024. I am equally delighted to welcome back two returning Governors, Laura Bailey (Tewkesbury) and Kizzy Kukreja (Staff: MDN), who will both join us for a second term. Sadly, for us, Jacob Arnold has tendered his resignation, having secured a new post. We wish Jacob well and thank him for his contribution as a public governor and deputy lead governor. We will be seeking a new governor for the Forest of dean through the usual election process by our members in that constituency.

- A **new Governor Induction session** took place on 5th October for those Governors who had joined us early in September. This was followed up by 1:1 introductory meetings with Lisa Crooks, (Public Governor for Cheltenham) on 17th October and Peter Gardner (Public Governor for Cotswolds) on 31st October.

- A meeting of the **Nominations and Remuneration Committee** took place on 2nd November. The Committee noted the update on the process and timeline for the recruitment of the Trust Chair and the process to recruit to the post of Non-Executive Director in light of Steve Brittan's resignation.

4. NATIONAL AND REGIONAL MEETINGS

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

- **NHS Confederation Mental Health Chairs' Network** – Meetings take place weekly and I attend when my diary permits. On **26th October**, we were joined by Ian Trenholm, Chief Executive and Chris Dzikiti, Director for Mental Health from the Care Quality Commission to discuss the CQC's recent state of care report, new single assessment framework and received feedback from Chairs. On **2nd November**, Claire Murdoch the National Director for Mental Health at NHS England and Matthew Taylor, Chief Executive of the NHS Confederation joined the meeting. Claire and Matthew shared a national perspective and update on the political landscape.

- On 30th October, I joined the **NHS Confederation Chairs Meeting** - The focus of the meeting was the regulation of NHS Managers and we were joined by Matthew Taylor, Chief Executive of the NHS Confederation and Danny Mortimer, Chief Executive of NHS Employers and Deputy Chief Executive of the NHS Confederation.

- **NHS Providers Annual Conference** - 14th and 15th November. This year's theme was ***Vital!***, representing the essential care the provider sector delivers, the deep commitment of staff, and the importance of ensuring our health service is sustainable for the future. I was joined at the conference by the Chief Executive and Graham Russell, Vice Chair.

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 **Matt Lennard, Chief Officer of Gloucestershire VCS Alliance** on 20th October and **Chair of Forest of Dean District Council, Councillor Di Martin** on 23rd October where we discussed matters of mutual interest.

- **Dame Gill Morgan, Chair of the NHS Gloucestershire Integrated Care Board, Deborah Evans, Chair of the Gloucestershire Hospitals NHS Foundation Trust** and I circulated a joint statement as Chairs of the NHS organisations in Gloucestershire following the recent national media reporting on equality, diversity and inclusion in the NHS. Equality, diversity and inclusion plays a critical part within the NHS, from staff on the frontline to the boardroom and it is incumbent on each and every one of us, to champion this vital work. We must build on the evidence-based advice from experts and our community networks to improve outcomes, access to health care and ensure the NHS is an inclusive employer. This is a key strategic priority and a key feature of our plans across the One Gloucestershire Integrated Care System. Equality, diversity and inclusion is very much a health matter and we are determined to make the continued progress that our communities rightly expect

- On 25th October an **ICB Board Development Session** took place where we received updates on Health Economics following the June Board Development session and Community/Neighbourhood Transformation. The Chief Executive, Vice-Chair, Graham Russell and I were in attendance.

- A meeting of the **Integrated Care Board** took place on 29th November where a number of important operational and strategic issues were discussed.

- The Chief Executive, Director of Strategy and Partnerships and I attended the County Council's **Health Overview and Scrutiny Committee** on 28th November. The meeting primarily focused on the Long-Term Workforce Plan from NHS England and community services delegated to the ICB particularly on GP services, community Pharmacy and Dentistry. Reports were also received from the Gloucestershire Integrated Care System and NHS Gloucestershire Integrated Care Board. The meeting on 10 October was attended by the Chief Executive at which the NHS Gloucestershire Winter Sustainability Plan for 2023-2024 was considered.

- 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.

- I continue to meet 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 I met on **3rd October** and **Deborah Evans, Chair of the Gloucestershire Hospitals NHS Foundation Trust** on 21st November.

- The Chief Executive and I met with **Chris Nelson, Police and Crime Commissioner** and **Nick Evans, Deputy Police and Crime Commissioner** on 21st November**.** The meeting was an opportunity to discuss matters of mutual interest.

6. WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

- Regular briefings with the county's MPs continue. I met with **Laurence Robertson, MP for Tewkesbury** on 17th October and **Richard Graham, MP for Gloucester** on 17th November. A meeting with **Siobhan Baillie, MP for Stroud** will take place on 1st December.

- It was a pleasure to meet with David Hindle on 17th October following his attendance at the Trust AGM. Amongst other things, David and I discussed his involvement in volunteering and I provided David with contact details for various organisations across Gloucestershire including our own Trust and the ICB.

7. ENGAGING WITH OUR TRUST COLLEAGUES

- As part of **Freedom to Speak Up Month**, I joined part of the session facilitated by Helene Donnelly OBE on 18th October. Helene was the Ambassador for Cultural Change & Lead Freedom to Speak Up Guardian at Midlands Partnership NHS Foundation Trust and is now Head of Safety Culture at Nuffield Hospital.

- On 8th November we celebrated the long service of colleagues who have worked in the NHS for 20, 30 and 40 years. Our annual **Long Service Recognition event** was held at Churchdown Community Centre and I had the pleasure of celebrating with colleagues and presenting recipients a certificate to commemorate their service. It was a lovely occasion and a great opportunity to thank our colleagues. Volunteers and experts by experience were also recognised alongside substantive employees.

- As part of the interview panel for the recruitment to the post of Director of Nursing, Therapies & Quality, I attended the **Fair & Equitable Recruitment training** on 22nd November.

- On 23rd November, the Trust was presented with the prestigious **Armed Forces Covenant Gold Award**. The Award was presented by Jon Beake, Regional Employer Engagement Defence, Defence Relationship Management in the South West. This award is testament to our continued dedication and support for the Armed Forces community and reflects our commitment to upholding the principles of the Armed Forces Covenant. I and the Trust were honoured to receive this recognition. It is a wonderful achievement which the Trust can be proud of. My thanks to Andy Collins-Mills, Associate Director Workforce Systems, Planning & Temporary Staffing and the team who have led on this.

- I carried out a very interesting **quality visit** on the 9th November to the Cotswolds District Nursing Service. I met and spent time with Louise Westerman, Interim Community Manager and Melanie Richmond, Community Manager of the Cotswolds Integrated Community Teams and members of their team who are based on Baunton Ward at Cirencester Community Hospital.

- I continue to attend the Trust's Committees on a rotational basis and I regularly attend the **Working Together Advisory Committee**. At the last meeting which took place on 19th October, I chaired the meeting on behalf of Jan Marriott. I attended the **Great Place to Work Committee** on 5th October, **Mental Health Legislation Scrutiny Committee** on 18th October and **Quality Committee** on 2nd November.

- I chaired a meeting of the **Appointments and Terms of Service Committee** on 8th November where we received an update on the progress and timeline for the recruitment of the Director of Nursing, Therapies and Quality role and Executive Succession Planning arrangements.

- Following receipt of the **operational guidance from NHS England** addressing the significant financial challenges created by industrial action in 2023/24 and the immediate actions to be taken, an **Extraordinary Board** session took place on 21st November where Board met to approve a revised system plan for 2023/24.

- As part of my regular activities, I continue to have a range of virtual and face to face **1:1 meetings with Executive colleagues**, including a weekly meeting with the Chief Executive. At our meeting on 5th October, the Chief Executive and I discussed mid-year performance objectives.

- I attended the **Senior Leadership Network** meeting on 26th October.

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. 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 September and October 2023.

9. CONCLUSION AND RECOMMENDATIONS

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

Appendix 1

Non-Executive Director – Summary of Activity 1st September – 31st October 2023

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Dr Stephen Alvis	4 x ICB NED Candidate groups NEDs meeting Council of Governors Meeting Staff Governor Meeting Children's Physiotherapy Service Quality Visit NEDs Meeting 1:1 with Chair Mental Health Act Managers' Forum 5 x individual meetings with ICB CMO candidates	GGI Webcast MHAM Regional Training Day GGI Webinar GGI Webinar	Trust Board: Private Trust Board: Public Extraordinary ATOS Committee via correspondence Forest of Dean Assurance Committee Quality Committee Board Session: MTFP Board Seminar: Edenfield/Learning from Incidents Trust AGM ATOS Committee Council of Governors Meeting Trust Board: Private Trust Board: Private
Steve Brittan	Gloucestershire ICS: System Resources Committee Introduction meeting with Chief Executive MTFP catch up meeting Resources Committee agenda planning Plics submission overview		Forest of Dean Assurance Committee Trust Board: Private Trust Board: Public Extraordinary ATOS Committee via correspondence CQC Board Briefing
Marcia Gallagher	Quality Assurance Group Meeting NEDs Meeting Chair of League of Friends Meeting 1:1 with Chair NEDs/Lay Members Meeting Staff Governors Meeting Seminar re Information Governance and Cyber Meeting with Head of Counter Fraud ICB Audit Committee		Charitable Funds Committee – via correspondence Governors Nomination and Remuneration Committee Quality Committee Board Session: MTFP Board Seminar: Edenfield/Learning from Incidents ATOS Committee Trust AGM

	Chair recruitment meeting with Director of HR & OD, Director of Corporate Governance and Trust Secretary and Assistant Trust Secretary 1:1 with Chair ICB Informal Drop in with Chair NEDs Meeting Chair recruitment meeting with Director of HR & OD, Director of Corporate Governance and Trust Secretary and Assistant Trust Secretary		Extraordinary ATOS Committee via correspondence Board Development: Follow up Strategy Session with The Value Circle CQC Board Briefing
Sumita Hutchison	Staff Governors Meeting Pre-meet with Vicci Livingstone-Thompson 1:1 with Chair Quality visit to Art Psychotherapy Service NEDs Meeting GHC Diversity Network Meeting NEDs Meeting Senior Leadership Meeting		Board Session: MTFP Board Seminar: Edenfield/Learning from Incidents ATOS Committee Charitable Funds Committee – via correspondence Extraordinary ATOS Committee via correspondence Trust Board: Private Trust Board: Public Board Development: Follow up Strategy Session with The Value Circle GPTW Committee
Nicola de Iongh	ICS NED Informal NED Drop In 1:1 with Chair NEDs Meeting Introduction meeting with Chief Executive Governor Visit to Wotton Lawn Hospital ICS NEDs Network Meeting Council of Governors Meeting Quality visit to School Nursing Service ICB Board Development Session		Extraordinary ATOS Committee via correspondence GPTW Committee CQC Board Briefing Board Session: MTFP ATOS Committee Trust Board: Public Trust Board: Private Extraordinary ATOS Committee via correspondence Trust AGM

Jan Marriott	Staff Governor Meeting Experts by Experience and Volunteers Celebration Tea Party FTSU Champions Meeting Quality Advisory Meeting NEDs Meeting Council of Governors Meeting Quality visit to Lydney Hospital ICB Children and Young People Seminar ICB System Quality Committee Quality Assurance Group NEDs Meeting 1:1 with DoNTQ Quality Committee pre-meet w DoNTQ and Associate NED	GGI Seminar: Freedom to Speak Up	Quality Committee Board Session: MTFP Board Seminar: Edenfield/Learning from Incidents Trust AGM ATOS Committee Trust Board: Private Trust Board: Public Extraordinary ATOS Committee via correspondence CQC Board Briefing
Graham Russell	ICB Neighbourhood Transformation Committee Council of Governors Meeting ICB Board Staff Governors Meeting Experts by Experience and Volunteers Celebration Tea Party 1:1 with Chair NEDs Meeting Meeting with Jane Cummings, ICB NED and Helen Goodey ICB Development Session ICB Neighbourhood Transformation Committee NEDs Meeting 1:1 with Chair ICB Board Development Meeting		FoD Hospital Assurance Committee Governors Nomination and Remuneration Committee Board Session: MTFP Board Seminar: Edenfield/Learning from Incidents Trust AGM ATOS Committee Council of Governors Meeting Trust Board: Public Trust Board: Private Extraordinary ATOS Committee via correspondence GPTW Committee CQC Board Briefing Board Development: Follow up Strategy Session with The Value Circle
Vicci Livingstone-Thompson	ICS Volunteering Network Meeting NEDs Meeting ICS NEDS Network Meeting Council of Governors Meeting Informal visit to Homeless Healthcare Team	Chair and NED Welcome Introduction session with NHS England	Board Session: MTFP Board Seminar: Edenfield/Learning from Incidents Trust AGM ATOS Committee

	NEDs Meeting Quality Committee pre-meet w DoNTQ and Jan Marriott		Trust Board: Private Extraordinary ATOS Committee via correspondence Board Development: Follow up Strategy Session with The Value Circle CQC Board Briefing

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 11/1123

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 November 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
- Sexual Charter
- Patient and Carer Race Equality Framework

Risks associated with meeting the Trust's values
None identified

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

Where has this issue been discussed before?
N/A

Appendices:	

Report 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. Since the last Board meeting, locations I have visited have included:

- Acorn House, Gloucester
- Wotton Lawn Hospital
- Pullman Place
- Springbank Resource Centre, Cheltenham
- Rikenel
- Eastgate House
- Tewkesbury Hospital
- Avon House, Tewkesbury
- Lexham Lodge, Cheltenham
- The Pavilion, Cheltenham
- Quedgeley Clinic
- Young Adults Team (16-25 years)

1.2 Update on industrial action

In response to industrial action by Junior Doctors and Senior Doctors (Consultants) of the British Medical Association in October (2nd to 5th October), Gloucestershire NHS implemented contingency plans to ensure essential services remained available and continued to operate in a safe and resilient way.

Following careful consideration of the cover arrangements announced by the BMA, Cheltenham A&E remained open during the period of industrial action with Doctors providing emergency cover (Christmas Day level of service). However, services experienced significant pressure and residents were therefore strongly advised to only attend A&E or call 999 if their condition was serious or life-threatening. Those with an urgent care need, but unsure of which service to use, were asked to visit 111.nhs.uk in the first instance or call 111 for advice.

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 Flu and Covid Vaccination Clinics

To give colleagues the maximum level of protection, the Trust has been offering both Flu and Covid vaccinations in one-stop drop-in clinics across our sites. The team delivering the vaccinations have been delivering an excellent service and have experience a good uptake from colleagues across the Trust.

1.4 Launch of the Hardship Fund

The Trustees of our Charitable Funds have agreed to offer a new Hardship Fund to help colleagues who may be experiencing exceptional financial difficulties, particularly during the current cost of living crisis.

We launched a similar fund in October 2022 and 80 colleagues and people who use our services were supported as a result, with over £20,000 being distributed to those in exceptional need.

The fund has a simple application process and colleagues experiencing genuine financial hardship can apply for grants of up to £500, for support with urgent and unexpected expenses they are struggling to meet. Similarly, colleagues who become aware of someone needing urgent support during the course of their work may also apply on behalf of people who use our services.

The fund is limited and will only be granted to those who can evidence that they are in an “in extremis” circumstance. Once the fund is spent, we will close applications pending any further donations to the Trust’s Charitable Funds.

1.5 Chair Recruitment

Recruitment is underway to find a new Chair for the Trust. Ingrid Barker has been our Chair since October 2019, having been the Joint Chair for Gloucestershire Care Services NHS Trust and 2gether NHS Foundation Trust since January 2018. Prior to that she was the Chair of Gloucestershire Care Services from April 2011 and previously a Non-Executive Director on the Board of NHS Gloucestershire Primary Care Trust for five years.

Ingrid’s term of office is due to end in April 2024, so the process of recruiting a new Chair has now begun. Recruitment to the Chair’s position is the responsibility of the Council of Governors, guided by our Senior Independent Director, Marcia Gallagher.

1.6 Stakeholder Engagement

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

2.0 SYSTEM UPDATES

2.1 Right Care Right Person Conference

On 16th November I attended the Right Care Right Person (‘RCRP’) Conference, hosted by Gloucestershire Constabulary. Right Care Right Person is a nationally agreed strategy to change the way police and health partners respond to mental health emergencies in the future and aims 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

The in-person event was convened to determine the best collegiate approach to implementing RCRP in our county. Key stakeholders from across the system attended the event to ensure system partners, including health and care agencies, emergency services and social care, continue to provide services in a collaborative and productive way. The NHS in Gloucestershire is committed to continue to work alongside the emergency services to make sure anyone with urgent and emergency mental health needs can be treated safely and compassionately. The agreed approach in Gloucestershire will be based on a strong partnership approach, a phased approach to change, with implications worked through before any changes are made.

2.2 Community Mental Health Transformation

The CMHT programme continues to make good progress with the Locality Community Partnerships embedded now in Forest of Dean/Tewkesbury and Gloucester City. We are on track to commence shortly in both Cheltenham and Stroud, with Cotswolds later in the new year.

We have just completed a successful round of small grant applications from our Voluntary Sector partners with over 24 applications received amounting to bids significantly over the original fund that we had allocated. We are in the process of reviewing all of these and determine the allocation of funds and will be feeding back to organisations shortly. We had made provision to a launch a second round of grant applications which, based on the success of this initial round, we will move to commence in early December.

2.3 Urgent Care Transformation Programme – Working as One

The Trust continues to play an active role in the urgent and emergency care work which is now in its delivery phase, supported by our partners Newton Europe, to help implement service improvement and change identified during the system-wide review.

The formal launch event for this programme was held on 26th September. The Trust has commenced work to implement and introduce change across our services in response, perhaps most notably in Home First and Rapid Response, where performance benefits are already being realised. We remain committed to this programme of work and colleagues across the trust will be engaged and involved in this programme of change as we strive to improve the service we can provide for our patients.

The delivery phase will be structured across five main workstreams:

- Prevention
- Community Urgent Response and Hospital Front Door

- Hospital Flow and Decision Making
- Intermediate Care and Reablement
- Access to Care Packages

Each workstream has a senior responsible leader. Angela Potter, our Director of Strategy and Partnerships, is leading on 'Access to Care Packages' and I am leading on 'Hospital Flow and Decision Making'.

The entire programme of work is of such size and scale that we envisage this next delivery phase taking us around 18 months to implement in full. However, we will continue to provide updates on progress as we move through the programme.

2.4 ICB Board Meetings

Gloucestershire ICB held a Board Development session on 25th October which was attended by the Chair, Ingrid Barker, Vice-Chair, Graham Russell, and I. The session focussed on a number of important issues including Leading for inclusion (Equality and Diversity), Gloucestershire ICB's response to proposed legislation on smoking and vaping, Health Economics and an update on Community / Neighbourhood Transformation.

The NHS Gloucestershire ICB Confidential and Public Board Meetings are being held on 29th November. The papers for the Public Board meeting can be located on their website - Board Meetings: NHS Gloucestershire ICB (nhsglos.nhs.uk)

2.5 New Forest of Dean Hospital

The new Forest of Dean Community Hospital is due to open in Spring 2024 and we have recently published our transition plans.

The transition will begin within the next few months, with teams and services gradually moving out of the former hospitals to the new site. We had previously planned to move the existing X ray machine from Lydney hospital to the new hospital, meaning there would be a disruption to X ray services. However, having now agreed funding, we are in the process of moving forward with the purchase and installation of a new machine, which should provide a smoother transition for X ray services in the Forest.

We have notified the Forest of Dean District Council that we will first market Lydney Hospital for sale (marketed by Alder King), followed by the Dilke Hospital at a later date. One part of the Lydney Hospital site (Stonebury House) will be retained by the Trust as it will continue to be occupied by several teams for the foreseeable future.

Both sites have been registered as Assets of Community Value and we are working with Lydney Town Council who have resolved to trigger the full moratorium period and therefore have until the 2nd April to develop a community based proposal to put forward for consideration developing the site. As an NHS organisation we must follow strict guidelines while disposing of sites that have become surplus to requirements. This includes generating best value – both financial and social – so

that any capital can be invested in enhancing patient care while releasing public land for new use.

Skatepark

Work is underway on a new skatepark in the Miner's Field in Cinderford, which forms part of the wider new hospital project. Re-provision of the former skatepark in Steam Mills Road, now the site of the new Forest of Dean Community Hospital, formed part of the plan when the hospital proposal was agreed in March 2022.

The skatepark is being built by Mavericks, and designed in collaboration with a Skatepark User Group which has included skateboarders, and BMX and scooter enthusiasts. The design incorporates features for each group, in a graded layout which provides easier obstacles at the top and more complex terrain further down. Work is underway with the project on track to be completed by the end of the year.

2.6 Partnership updates

Gloucestershire Healthwatch is undertaking a survey to understand people's experiences of using urgent and emergency health care services, having had many people contact them informally who have used the various urgent care services across the county. The work will combine a survey and community discussion groups, to build a fuller picture of how people are using services locally, assess public knowledge and understanding of the different urgent care services available across the county, and to provide recommendations on how the NHS can continue to improve patient experience and confidence in the care being provided.

The survey is open until the 22nd December 2023 via smartsurvey.co.uk/s/GloucestershireUEC or call **0800 652 5193** (Freephone) to request a paper copy of the survey/share your views over the phone, or find out about joining a group discussion.

3.0 EVENTS

3.1 National Speak Up Month - October

October was Freedom to Speak Up month, an opportunity to raise awareness of the difference Freedom to Speak Up is making and to pay a little extra attention to the importance of ensuring everyone within the NHS feels safe and confident to speak up. This year the theme was **Breaking Barriers**, focusing on removing the barriers that can stop people from speaking up.

'Freedom to Speak Up' is both a statement and a process. The statement is that everyone should feel free to say what they think and ask for help in resolving concerns. It is also a process, with a Freedom to Speak Guardian and Freedom to Speak Up champions, who can be contacted with any concern. The month provided a valuable opportunity to remind colleagues of all the different ways that concerns can be raised - directly with team leaders, at team meetings, with other members of the team, with the safeguarding team, the quality team or through the Direct to

Douglas app. All of which are also supplemented by the Freedom to Speak Up process.

The main barriers to speaking up are either worry about what will happen or a sense that it won't be worth it because nothing will happen. We have a large number of FTSU champions in our Trust from across our services, role types and locations and part of their role is to let people know that they should neither fear speaking up or worry that it won't make a difference.

Throughout the month Trust colleagues had an opportunity to hear from two notable speakers, Bernie Rochford MBE and Helene Donnelly OBE, who presented insightful talks on their experiences of Speaking Up and provided further information to colleagues wishing to learn more about the Freedom to Speak Up process.

At the end of the month, the Trust also launched a new Freedom to Speak Up Guardian App to give colleagues another route to speaking up in a safe confidential or anonymous way.

3.2 Black History Month – October

Black History Month takes place annually in October and throughout the month, the Trust celebrated the diverse heritage and cultures within our organisation and county, and in particular those of African and Caribbean heritage.

This year the national theme of **Saluting our Sisters** highlighted the crucial role that black women have played in shaping history, inspiring change and building communities. Events were held across the county to showcase pioneering black women who have made remarkable contributions to literature, music, fashion, sport, business, politics, academia, social and health care and more.

It was an excellent opportunity to learn about, and reflect on, the struggles and contributions our black colleagues make, empowering us to continue to drive equity and inclusion forward. Colleagues were invited to show their support of Black History Month by reading highlighted articles and/or joining in with any of the events taking place across the country (many of which were accessible online).

3.3 International Infection Prevention Week: 15 to 21 October

This year International Infection Prevention Week celebrated the **'Fundamentals of Infection Prevention'** and going **'Back to Basics'**.

During the week I joined colleagues from our Infection Prevention and Control team at Edward Jenner Court for a hand hygiene demonstration. It was an opportunity to raise awareness of infection prevention control and the important work the team do. Everyone has a role in prevention and control of infections in healthcare and simple actions and awareness, such as hand hygiene, PPE, respiratory cough hygiene, cleaning and occupational safety, can make a big difference.

3.4 Long Service Awards

The GHC Long Service Awards were held on 8th November at Churchdown Community Centre. It was an excellent event which highlighted just how fortunate we are to have colleagues, volunteers and Experts by Experience with such vast experience within our Trust. The colleagues honoured during the event have worked in services for 20, 30 and 40 years - a total of more than 1,000 years between them. Thanking them for their service to the NHS and our communities was an honour and a privilege.

3.5 NHS Providers Conference

The Chair, Ingrid Barker, Vice-Chair, Graham Russell, and I attended the NHS Providers Annual Conference on 14th and 15th November in Liverpool. The conference provided a useful opportunity to explore key issues impacting the healthcare sector and an opportunity to network and attend sessions delivered by expert speakers over the course of two days.

4.0 ACHIEVEMENTS / AWARDS

4.1 Colleagues' commitment recognised with Queen's Nurse title

Seven nursing professionals working within our Trust have been recognised with the Queen's Nurse title for their commitment to high standards of person-centred care and nursing practice.

A Queen's Nurse demonstrates integrity, honesty and compassion while delivering the highest quality care to the benefit of individuals, carers, families, communities and peers. All seven nursing professionals will be presented with their Queen's Nurse badge and certificate at the Queen's Nursing Institute Annual Awards Ceremony held in London in December.

The QN title is a formal recognition of their commitment to improving care for patients and provides further learning and leadership opportunities, as well as access to developmental programmes, bursaries and networking.

Established 132 years ago, the Queen's Nursing Institute (QNI) is the oldest professional nursing organisation in the UK and believed to be the oldest nursing charity in the world. The charity provides a variety of services, including funding nurses' plans to improve patient care, publishing research on nursing practice and education, and campaigning for investment into nursing services.

4.2 Working Well receives full SEQOHS accreditation

Our Occupational Health team at Working Well are pleased to announce that they have received full SEQOHS (Safe Effective Quality Occupational Health Service) accreditation following their recent annual renewal application. They are among the minority of occupational health services in the UK to hold full accreditation.

Congratulations to the team on their continuing commitment to maintaining SEQOHS standards.

4.3 Cavell Star Award

Congratulations to Abbeyview Ward Sister Lou Williams who picked up a prestigious Cavell Star Award for her work to develop a tool to help improve dementia care at our Trust.

The CARE Tool is a document that can be used as a checklist to help ward staff to ensure they are doing all they can to help support patients with dementia. Lou developed this document for folders on the ward as part of the project work she undertook for completing the Gloucestershire Dementia Lead Award, which helps to promote and improve patient-centred care.

The Cavell Star Award is named after Edith Cavell, a British nurse celebrated for saving the lives of soldiers from both sides and for helping some 200 Allied men escape from German-occupied Belgium during the First World War, for which she was sentenced to death. Despite international pressure for mercy, she was shot by a German firing squad on October 12, 1915. Her execution received worldwide condemnation.

4.4 Admitted to Order of St John by HRH King Charles III

In recognition of his contribution to clinical development within the South West, Emergency Care Practitioner and Independent Prescriber, Gavin Harrison MStJ, has been admitted to The Order of St John by sanction of HRH King Charles III.

Gavin has volunteered for St John Ambulance since 2010, and for the last few years has been in a management role for the organisation's volunteer healthcare professionals, which include, amongst others, doctors, nurses, paramedics and physiotherapists. Using his advanced nursing and prescriber training, he also volunteers by crewing ambulances for 999 work to help support the NHS.

St John International

5.0 SEXUAL SAFETY CHARTER

On 4th September NHS England launched its first ever sexual safety charter in collaboration with key partners across the healthcare system. The charter requires organisations to commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to implement ten core principles and actions by July 2024 to help achieve this.

GHC have signed up to the charter to demonstrate our commitment to ensuring that our staff and patients feel safe and supported when at work and under our care. We are dedicated to continuing to strengthen our position on tackling domestic abuse and sexual violence (DASV) to identify, safeguard and care for individuals who have been or are being sexually assaulted or abused.

NHS England will use the new network of NHS DASV leads across the system to help share and promote good practice, identify issues and develop practical solutions in relation to implementation of the charter as quickly and effectively as possible.

As a signatory to this charter, we have committed to the following principles and actions:

1) We will actively work to eradicate sexual harassment and abuse in the workplace.
2) We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.
3) We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.
4) We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.
5) We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.
6) We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
7) We will ensure appropriate, specific, and clear training is in place.
8) We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.
9) We will take all reports seriously and appropriate and timely action will be taken in all cases.

10) We will capture and share data on prevalence and staff experience transparently.

A review of our policies, support and training for staff has been undertaken against the ten core principles to identify and strengthen those practices already in place. We will work to ensure any areas highlighted as requiring further action are addressed as quickly as possible and in any event before the July 2024 deadline.

6.0 PATIENT AND CARER RACE EQUALITY FRAMEWORK

Following the publication of NHS England's first ever anti-racism framework, the Patient and Carer Race Equality Framework (PCREF), the Trust is taking further steps in our commitment to reduce inequality and inequity.

The PCREF has therefore been co-designed with services, patients and carers to improve the experiences of care for people from ethnically and culturally diverse communities. This mandatory framework will become part of Care Quality Commission (CQC) inspections.

The PCREF will support improvement in three main domains:

- Leadership and governance: trusts' boards will be leading on establishing and monitoring concrete plans of action to reduce health inequalities
- Data: new data set on improvements in reducing health inequalities will need to be published, as well as details on ethnicity in all existing core data sets.
- Feedback mechanisms: visible and effective ways for patients and carers to feedback will be established, as well as clear processes to act and report on that feedback.

Our Trust is starting work to implement the framework, with the view to embed it fully by the end of the financial year 2024/25. The PCREF will become part of our Trust's business as usual planning and will be developed and implemented in partnership with our communities.

We are strongly committed to ensuring the framework is implemented within our Trust as soon as possible to improve access, experiences and outcomes of service users and carers that come from ethnically and culturally diverse backgrounds.

7.0 CONCLUSION AND RECOMMENDATIONS

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

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AGENDA ITEM: 12/1123

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 30 November 2023**
PRESENTED BY:	Sonia Pearcey, Ambassador for Cultural Change & Freedom to Speak Up Guardian
AUTHOR:	Sonia Pearcey, Ambassador for Cultural Change & Freedom to Speak Up Guardian
SUBJECT:	**FREEDOM TO SPEAK UP GUARDIAN SIX MONTHLY UPDATE 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:

Provide assurance to the group:

- That speaking up processes are in place and remain open for colleagues to speak up, be listened to and follow up action occurs
- That speaking up processes are in line with national guidance
- That continued progress in raising the bar in embedding our positive speaking up culture

Recommendations and decisions required:

The Board is asked to:

- **Receive, review** and **note** information for assurance relating to Freedom to Speak Up activity in Q1 & Q2 2023-24.

Executive summary

This report for Q1 & Q2 2023-24 gives an overview of the cases, some national and regional updates and the proactive work undertaken by the Freedom to Speak Up Guardian.

There have been 40 cases raised to the Freedom to Speak Up Guardian in the first

two quarters of 2023-24. Last year there were 77 cases raised to the GHC Freedom to Speak Up Guardian over the year a slight increase on the previous year, compared to 54 cases 2021-22, 120 cases in 2020-21 and 60 in 2019-20.

On a quarterly basis, Freedom to Speak Up Guardians are expected to share non-identifiable information with the National Guardian's Office (NGO) about the speaking up cases raised with them. This information provides invaluable insight into the implementation of Freedom to Speak Up. The National Speak Up data from Q1 2023-24 is now available to view on the NGO website.

Feedback continues to be positive from colleagues who have accessed the Freedom to Speak Up Guardian service, to including the growing network of Freedom to Speak Up Champions.

A new Freedom to Speak Up in-house application went live on the 30th October and colleagues are also now speaking up also through this route.

In July 2023, BDO our external auditors report concluded a substantial opinion across both the design and effectiveness of the controls in place.

In October 2023, the sixth National Speak Up Month we focused on removing the barriers that can stop people from speaking up and an opportunity to further raise awareness and the difference which Freedom to Speak Up is making.

Three new Guardians have been appointed within Gloucestershire at the Integrated Care Board, Local Medical Committee and Gloucestershire Hospitals NHS Foundation Trust, which is a positive move for the system.

Since my last report various National reports have been published and as Trust this is a further opportunity to reflect and capture some learning. In July 2023, the National Guardian's Office published its annual data report 'Summary of Speaking Up to Freedom to Speak Up Guardians' 2022-2023.

Risks associated with meeting the Trust's values
All risks are clearly identified within the paper.

Corporate considerations	
Quality Implications	Processes are aligned to the guidance NHE/I and the National Guardian's Office embedded in the NHS Contract. A positive speaking up culture within our workforce will ensure that patient safety matters are heard and that colleagues are supported.
Resource Implications	Continued monitoring of the workload and demand on the Freedom to Speak Up service and look to determine

	whether further resourcing would be available to support the work of the Guardian.
Equality Implications	No issues identified within this report.

Where has this issue been discussed before?
PowerPoint presentation to the Workforce Management Group 13th September 2023 PowerPoint presentation to the Great Place to Work Committee 5th October 2023 PowerPoint presentation to the Quality Assurance Group 20th October 2023

Appendices:	Nil

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

FREEDOM TO SPEAK UP REPORT

1. INTRODUCTION

1.1 This bi-annual report is to give assurance to that speaking up processes are in place and remain open for colleagues to speak up, be listened to and follow up action occurs. Colleagues are feedback with outcomes where appropriate.

1.2 Celebrate our progress in continuing to raise the bar in embedding our positive speaking up culture.

2. ASSESSMENT OF FTSU CASES

This report covers the period of April 2023 - September 2023. It highlights the continued use of Freedom to Speak Up as an as an alternative route for colleagues either through the Guardian, the Executive and Non-Executive Leads, champions or the previous anonymous portal and now a new App.

There have been 40 cases raised to the Freedom to Speak Up Guardian in the first two quarters of 2023-24. Last year there were 77 cases in total raised to the Freedom to Speak Up Guardian a slight increase on the previous year, compared to 54 cases 2021-22, 120 cases in 2020-21 and 60 in 2019-20.

The main concerns raised are themed as colleague safety/wellbeing 35% with patient safety/quality and inappropriate attitude/behaviours at 23% each. Bullying and harassment and anonymous reporting have both declined to 12% and 5% although 13% of colleagues have reported suffering detriment from speaking up. Anonymous reporting remains low at 5%.

From a professional perspective, Registered Nurses as a group accounted for 41% of speaking up followed by administrative and clerical at 20%, additional clinical services at 18% and Allied Health Professionals also at 18%. Dental and medical, and estates and facilities colleagues have also accessed the Guardian. Those colleagues working at band 5 have accessed the Guardian the most.

Those colleagues that have declared a protected characteristic is at 26%, of those speaking up 5% are from our temporary workforce and signposted on from a champion is at 8%.

There are often elements of culture associated with cases and the Guardian has observed an increase in colleagues needing to take sick leave and experiencing wellbeing issues, therefore are signposted onto to gain that further more specialised support.

3. COLLEAGUE EXPERIENCE FEEDBACK

Feedback is requested from all colleagues and qualitative feedback is shared from colleagues as below. Of the 40 colleagues that accessed the Guardian in the first two quarters, 22 shared feedback. 21 said that ‘Yes they would speak up again’ and 1 said ‘Maybe they would speak up again’.

‘If it wasn’t for the Guardian I wouldn’t have stayed in the Trust or recognised

that I needed some time out'

'Speaking Up felt like the simplest bit although difficult. I am known as a whistleblower, although I did the right thing'

'Thank you as you gave me a voice when I didn't know what to do with the information I had'

'Thank you, Sonia, for allowing me to speak up, for listening and sharing your feedback of which I am truly grateful. I most certainly feel I can in future speak up again and the reason for this, is I feel our voices are heard in confidence and acted upon without any repercussions'

Yes, I would definitely speak up again – in fact, because it was such a positive experience, I would be more likely to err on the side of speaking up than not in the future. The issue I needed to speak up about related to an individual's actions outside of work that I believed could impact their work or reputation within the Trust. As such, I wasn't sure whether the issues would be considered relevant, so wasn't sure whether to speak up. Once I decided to speak up, I contacted the FTSU guardian and it was quick and easy to arrange a meeting in which she listened and made sure she had understood the issue being raised and why. She then negotiated and agreed a course of action with me (I wished to remain anonymous, and this was accommodated). The FTSU guardian carried out the agreed actions and provided regular updates without compromising the confidentiality of the person about whom the issues were raised. I felt that the issues I raised were seriously listened to, and then escalated to relevant senior staff for their consideration and awareness. Thank you for your support – you made a difficult situation much easier!

4. WORK IN CONFIDENCE

This contract was terminated on 30th September with Work in Confidence, an external anonymous reporting portal. We acknowledged that colleagues speaking up through this anonymous portal was at a very low point and none of the contacts were patient safety critical. Conversations for the preceding years had declined 2021-22 - 12 contacts, 2022-23 - 7 contacts and to September 2023-24 - 4 contacts.

A new Freedom to Speak Up in-house application went live on the 30th October and colleagues are also now speaking up also through this route.

5. OUTCOME OF FREEDOM TO SPEAK UP AUDIT

In July 2023, BDO our external auditors report concluded a substantial opinion across both the design and effectiveness of the controls in place. 'Overall, the Trust has a robust Freedom to Speak Up service in place. Responses to concerns raised are timely and effective, and there are several proactive measures in place to address barriers and promote a positive speaking up culture across the Trust'. Below are some highlights from the report.

The areas of strength and good practice were recognised as;

- **Policy** - The current 'Speaking Up at Work' policy and the latest national guidance to ensure these were operating effectively.

- **Training** - The GHC Guardian has been active in the network and was Chair of the South West FTSU Guardian Regional Network for five years, recently stepping down in May 2023. They also act as a National Mentor for newly appointed FTSU Guardians and have been involved in national projects, demonstrating an expert level of experience and knowledge to carry out the role for the Trust. General training for colleagues across the Trust is available on the e-learning system.

- **Reporting tool for speaking up** - the Trust currently uses the Work in Confidence system which allows colleagues to anonymously raise concerns directly with the Guardian. It is also used as a secure system to document cases and retains a log of all communications and outcomes. The Trust is looking to update the system to an in-house case management system going forward.

- **Network of Champions** - the Trust has a network of 46 FTSU Champions (as at July 2023). This is a voluntary role through which colleagues can apply to support FTSU through involvement in promoting the service and acting as a local representative in their area. Champions do not handle cases but are able to signpost to the Guardian for further support.

- **Detailed sample testing** - a non-identifiable random review of 18 cases, and in all cases where the Guardian was available initial concerns were responded to within one working day (against a target of 72 hours, to allow for weekends). The Guardian offered comprehensive advice and signposting (where appropriate), offering colleagues multiple options for further support. Where applicable and agreed to by the colleague, further enquiries were carried out in order to establish further facts and determine a suitable resolution. The Guardian contacted the colleague to debrief them on the results of any agreed enquiries and agree a resolution. Regular contact was made and colleagues were kept informed of progress and findings at each stage of the process. The time from initial contact to case closure took on average 36 days, with a range from 0 to 135 days. In our sample 14 cases had been closed and feedback had been received for six of these (43% response rate), which in all cases was positive.

- **CQC & NHS Staff Survey** - The latest CQC inspection concluded that FTSU was operating effectively, including a focus on cultural changes within the Trust. The 2022 Staff Survey results showed that in all four questions relating to speaking up the Trust scored above average against comparators and nationally.

- **Governance** - the Guardian reports to the NGO on a quarterly basis and we confirmed to the national data set that GHC figures had been reported. A FTSU report is prepared by the Guardian and shared bi-annually with the Quality Assurance Group, Great Place to Work Committee and Trust Board. We obtained copies of these reports and meeting minutes to evidence that they had been reviewed and discussed by the Board. The Guardian advised they have a high level of support from the Trust Board and their dedicated Executive Lead.
- **Culture and barriers proactive work** - Several proactive projects and initiatives which incorporate FTSU and aim to create a culture of psychological safety to benefit both staff and patients). Alongside the policy, the Trust is introducing a FTSU Strategy. This will be a three-year strategy to feed into the quality and people strategies. The Guardian attends various events across the Trust to deliver relevant sessions related to FTSU, behaviour and cultural change.

  Through our sample testing we observed a recent case where an agency worker on a one-off shift was able to contact FTSU after seeing a poster on the ward.

  Communications - the Trust has various methods of advertising FTSU across the Trust, including the intranet site, notice boards, posters and contact cards. These have recently been revised to include pronouns and QR codes for easy links to the intranet and contact information.

  Demographic data – This is collected which may be a specific characteristic is raised as part of the concern. The Trust further triangulates FTSU data with results from the staff survey to effectively analyse barriers and accessibility.

  An example observed during our detailed testing highlighted that the reach of the GHC Guardian operates not only in GHC but staff from other NHS organisations had also made contact and received support and sign posting. Positive feedback was received from this example which was reflected in the May 2023 report to the Trust Board.

The review did not raise any key findings as areas of concern, although it noted four low priority findings as areas for improvement as below.

1. A process for sharing FTSU cases across the Trust should be designed and introduced.

   We will showcase the stories of speaking up and how these are contributing to making it business as usual. This will be adopted as ‘100 Voices’ to show the difference which Freedom to Speak Up makes highlighting impact that has led to positive change to people. ‘100 Voices’ is a campaign led by the National Guardian’s Office. These will be shared through communications routes such as the Trust intranet, patient safety notice boards, champions and staff networks.

Action: October 2023 (to coincide with National Speak Up month to aid promotion).

2. The Trust should ensure the Freedom to Speak Up training modules are accessible and promoted to those in senior leadership and Board roles as part of the recommended training. Also continue to promote the training modules and encourage all workers to complete the training on a voluntary basis.

   We will continue to utilise the existing national training on Care 2 Learn aimed at senior leaders (band 8a) and above. We will further encourage take up, monitor these levels and consider whether to make it mandatory if needed.

   Action: Work continues and further targeted commenced October 2023 in line with National Speak Up Month.

3. The Trust should review the current role description and application process for FTSU Champions to ensure this is accessible and inclusive of all worker groups. The recommendation in Finding 2 should be completed to ensure there is an awareness of the FTSU Champion role and the benefits of this at senior leadership level, to enable a supportive environment with ring fenced time for Champions.

   Action: In the recent Champion sessions, we have reviewed the accessibility and inclusivity to be a FTSU Champion for all workers. Following engagement with current champions we will now share with our staff networks for further engagement.

4. The Trust should continue to monitor the workload and demand on the FTSU service and look to determine whether further resourcing would be available to support the work of the Guardian. This could include an additional Guardian to support with promotional activity, case handling and/or admin support. Also, to establish a contingency plan when considering resourcing, for example appointing a deputy Guardian that can be mentored to enable them to take on the Guardian role.

   Action: A business case is being developed for consideration focusing on patient and staff safety, closed culture work, business continuity, and succession planning for completion by the end of Q3 2023-24.

6. LEARNING AND FURTHER PROACTIVE WORK

- NHS England in June 2022 published its new and updated national Freedom to Speak Up policy, which is applicable to primary care, secondary care and integrated care systems.

  Action: Completion by Q3 2023 (NHS England requirement by January 2024). Draft policy with various colleagues and networks for comment.

- Together with NHS England, the National Guardian's Office also published new and updated Freedom to Speak Up guidance and a Freedom to Speak Up reflection and planning tool. This tool was included in a call to action with the Trust Board Development session in November 2022. And all trust boards are to be able to evidence this by the end of January 2024.

  Action: The Board to review self-reflection tool by January **2023,** to be shared with comments by the Freedom to Speak Up Guardian.

- Our Champion Network continues to grow with 55 colleagues now awareness raising, signposting on and promoting a positive speaking up culture by supporting the organisation to welcome and celebrate speaking up. The network meets on a monthly basis for peer support and development.

  This month the National Guardian's Office published its revised Champion and Ambassador guidance, which provides a clear distinction between the roles of a Champion and Guardian. As part of the national working group, the updated Champions Guidance is to provide greater clarity on expectations of this vital role. Only Freedom to Speak Up Guardians, having received National Guardian's Office training and registered on the NGO's public directory, should handle speaking up cases. This ensures quality and consistency in how colleagues are supported when speaking up.

  Action: Reflection with the Champion Network is in progress and further discussions regarding, *Champions must not record or report identifying details of the workers who contact them* (P7).

- The Freedom to Speak Up Strategic Framework (2024-2026) - An initial draft, updated following the BDO audit, is being shared with colleagues through networks and team sessions. This framework will also align with the themed strategic framework of four core pillars of support: workers; Freedom to Speak Up guardians; leadership; and the healthcare system (National Guardian's Office). Linked to this the Annual Report of the National Guardian for the NHS was laid before Parliament (16 November 2023), highlighting the work of Freedom to Speak Up Guardians and the National Guardian's Office. The report also shares learning which indicates that more work is needed for speaking up to be described as business as usual in the healthcare sector in England.

  Action: Draft Freedom to Speak Up Strategic Framework to be presented to the Workforce Management Committee in Q4.

- Civility Saves Lives and 'Speaking Up in a Culture of Civility and Respect' continues with teams

- Staff Networks - The Freedom to Speak Up Guardian is an integral member of all the network and offers guidance, support and leadership to the Chair of the Race and Cultural Awareness Network. More recently supporting the Internationally Educated Nurses Council.

- National Mentor for Freedom to Speak Up Guardians following stepping down as Chair of the South West Guardian Network in May 2023 (5-year term).

- Cultural work continues alongside OD, HR and EDI colleagues, also supporting the 'Thrive' Leadership programme delivering 'Creating Psychological Safety'.

- Collaboration continues with the University of Gloucestershire to share Freedom to Speak Up to learners within health.

- October 2023 was the sixth National Speak Up Month. Our theme was Breaking Barriers and we focused on removing the barriers that can stop people from speaking up. It was also an opportunity to raise awareness, through increased visibility and the difference which Freedom to Speak Up is making, 'What speaking up means to them' and colleagues also making speak up pledges. Colleagues also heard from two notable speakers, Bernie Rochford MBE and Helene Donnelly OBE on the theme of barriers to speaking up, reflecting on their own journeys following speaking up and how far the speaking up agenda has come. If we are to have speaking up as business as usual we must continue to address the fear and futility of speaking up.

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AGENDA ITEM: 13/1123

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 November 2023**

PRESENTED BY: Angela Potter, Director of Strategy and Partnerships

AUTHOR: James Powell, Head of Sustainability

SUBJECT: **ANNUAL SUSTAINABILITY REPORT**

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

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

The purpose of this report is to:

To update the Trust Board on the latest carbon footprint metrics (relating to FY22/23) and delivery to date of Gloucestershire Health and Care (GHC)'s Green Plan which was approved in January 2022.

The Green Plan is the Trust's three-year sustainability strategy to deliver on national Net Zero requirements, as well as recognising the wider role we play in enabling sustainability across our Trust as well as the Integrated Care Board and wider system.

Recommendations and decisions required

The Trust Board is asked to note the positive progress with delivery of the Green Plan and Carbon Footprint reductions in line with the NHS net zero targets.

Executive Summary

This paper provides an update on progress with Carbon Footprint reduction in line with NHS net zero targets. The latest carbon report from 2022-23 indicates that there has been a 14% decrease in emissions from the previous year, and a **33% decrease compared to the baseline year 2019-20**.

The report also provides an update on the positive progress with delivery of the Trust's Green Plan from 2023-24 and the way in which this plan is supporting the delivery of our sustainability goals, with linked nationally and locally defined targets.

The Green Plan is presented with four sustainability priorities: • Net Zero • Sustainable Models of Care • Equity and Procurement • Workforce and Systems Leadership

Risks associated with meeting the Trust's values The risks to delivery are the ability to deliver at pace within the available resources whilst the organisation continues to focus on planning and recovery. There are risks to people's experience and the reputation of the Trust should our sustainability aims not be fully realised.

Corporate considerations	
Resource Implications	To deliver the remainder of the Green Plan there are resource requirements, beyond the existing capacity and budget of the Sustainability team which must be considered in order to achieve the targets set out. There will be opportunities to seek grant funding to support this, however capital requirements and Trust wide resources must also be considered.

Where has this issue been discussed before?
Green Plan Dashboard was reported to Resources Committee in October

Appendices:	Appended documents to this report include: Sustainability Programme Tracker (PowerPoint) Green Plan update (Presentation)

Report authorised by:	**Title:**
Angela Potter	Director of Strategy & Partnerships

UPDATE ON DELIVERY OF THE CARBON REDUCTION STANDARDS AND THE TRUST'S GREEN PLAN

1. Introduction

This paper provides an update on progress with Carbon Footprint reduction in line with NHS net zero targets. The latest carbon report from 2022-23 indicates that there has been a 14% decrease in emissions from the previous year, and a **33% decrease compared to the baseline year 2019-20**.

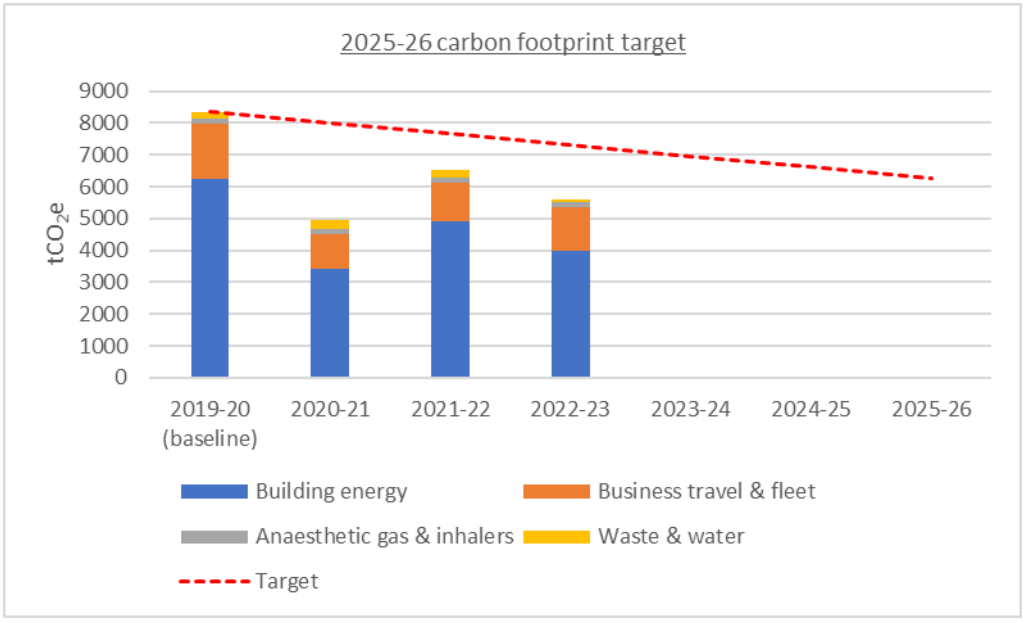
The report also provides an update on the positive progress with delivery of the Trust's Green Plan from 2023-24 and the way in which this plan is supporting the delivery of our sustainability goals, with linked nationally and locally defined targets.

2. Carbon Footprint Reduction

This report provides an overview of Gloucestershire Health and Care NHS Foundation Trust's carbon footprint and carbon footprint (plus) for 2022-23. The Trust's carbon footprint covers emissions within the organisations' direct control including building energy, waste, water, business travel, fleet, inhalers, and anaesthetic gases. The Trust's carbon footprint (plus) includes the carbon footprint of the organisations indirect emissions which include the supply chain, staff commuting, and patient and visitor travel.

Gloucestershire Health and Care NHS Foundation Trusts (GHC) carbon footprint plus for 2022-23 was estimated to be 20,469 tCO_2e, the equivalent of a person flying a return journey from London to Hong Kong 5,848 times.

GHC's Carbon Footprint 2022-23



In 2020-21 carbon emissions were 42% lower than the 2019 baseline. This decrease was from a combination of reduced emissions from business mileage, electricity and gas use during the COVID-19 pandemic when most outpatient services and buildings were closed. In 2021-22 the Trust's buildings and services resumed normal operation and emissions increased by 34% from the previous year, however the overall emissions in 2021-22 were still 22% lower than the 2019-20 baseline. The latest carbon report from 2022-23 indicates that there has been a 14% decrease in emissions from the previous year, and a **33% decrease compared to the baseline year 2019-20**.

A significant contribution to this overall reduction has been from installing LED lighting and roof mounted Solar PV at Charlton Lane, and a continuation of LED lighting projects across all of the community hospitals. MS Teams was also introduced during 2020-21 to reduce meetings held face-to-face and continued to be a prevalent and effective platform for a high proportion of Trust meetings. This has enabled a 24% reduction in emissions from business travel against the baseline year.

Emissions associated with water are relatively small and were 72% lower in 2022-23 compared to the baseline year, this is due to having more accurate data provided by a new supplier and the roll out of smart meters and leak detection devices.

Gas and heating oil are the largest contributor towards emissions, these emissions however will be reduced once the new Forest of Dean Hospital (FoD) replaces the Dilke Memorial and Lydney Hospital where both buildings depend on heating oil and gas as the main fuel source. The (FoD) has been designed to meet net zero standards and is on target to achieve BREEAM Excellence, the building will have air source heat pumps, LED lighting, Solar PV and electric vehicle charging points.

In November 2023, the Trust applied for £1.1m to the Public Sector Decarbonisation Scheme (PSDS), if successful then this funding will be utilised to replace the existing gas boilers at Charlton Lane Hospital with more energy efficient air source heat pumps, this project will effectively the hospital to a net zero standard through retrofit.

The Trust currently has 2 electric vehicles within the pool car fleet and there is a Green Plan target to introduce a further 6 electric vehicles, this equates to 10% of pool car fleet being EV by 2025-26. The Trust has 18 electric vehicle charging points which are evenly dispersed across 5 sites and there are new plans in place to install another 18 charge points in locations where pool car fleet is based, this will enable a steady transition of EV fleet and support the Trust to go beyond the existing 10% target.

Carbon emissions from waste were significantly lower in 2022-23, this is because COVID waste streams had ceased operation during this period. During the pandemic, most of the clinical waste produced was orange bag (infectious waste) which is sent to landfill and clinical sharps which are sent for high temperature incineration, these waste streams carry a much higher carbon footprint than alternative clinical waste streams such as tiger bag (offensive waste).

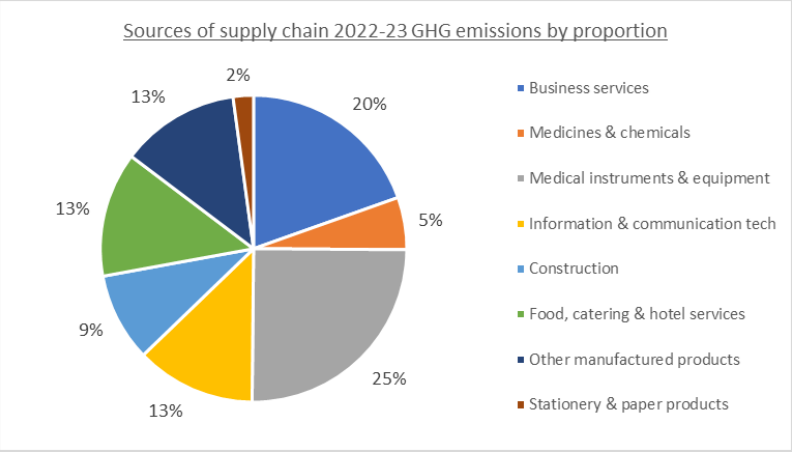
Emissions category	Emissions sub-category	tCO_2e				2022-23 change from baseline
		2019-20	2020-21	2021-22	2022-23	
Core carbon footprint	Building energy (fossil fuels)	4,166	2,014	3,166	2,644	-37%
	Electricity	2,090	1,423	1,758	1,358	-35%
	Anaesthetic gases	*162	**162	**162	**162	0%
	Inhalers	*7	*6	*5	***5	-33%
	Trust fleet	269	214	256	250	-7%
	Water	106	114	43	30	-72%
	Waste	117	141	195	60	-49%
	Business travel	1,433	867	941	1,090	-24%
Total core carbon footprint		**8,350**	**4,940**	**6,526**	**5,598**	**-33%**

*data taken from Greener NHS dashboard

2.1 Update on GHC's Carbon Footprint (Plus) 2022-23

The NHS Carbon Footprint (Plus) is derived from supply chain emissions which are split and measured in different categories, these account for 53% of the total GHC carbon footprint. Medical instruments & equipment at 25%, is the largest contribution, coming from laboratory equipment and tests, general and disposable medical equipment, disposable PPE and dressings.

The Infection Control Team are developing a new QI project for repairing vinyl coverings on coaches, hospital beds and chairs. The repair consists of patching vinyl covered equipment which may have been accidently damaged during treatment involving the use of scalpels or blades. The project will significantly improve carbon reduction and financial sustainability by avoiding the cost of replacement medical equipment.



In 2022-23, GHC consumed 7,164,609 items of single-use PPE, contributing 360 tonnes of CO_2e and 13% of total medical instruments and equipment emissions. Previously, emissions associated with PPE have not been included within the Trusts supply chain carbon footprint analysis due to PPE being centrally procured and funded and excluded from Trusts procurement costs. Therefore, it can only be assumed that

previously, the consumption of PPE items would have been significantly higher during the pandemic years of 2020-21 and 2021-22.

*Item	Quantity	GHG emissions (tCO_2e)	Contribution (tCO2e)
Non-sterile gloves (pairs)	5,188,710	270	75%
Apron	685,000	45	12%
Type 2R mask	1,206,020	24	7%
Gown	11,541	10	-10%
FFP3 cup fit mask	44,061	6	2%
Face shield	21,711	5	1%
FFP3 duckbill fit mask	7,566	1	0.2%
Total	**7,164,609**	**360**	

2022-23 saw a 7% increase in supply chain emissions compared to the previous year, with all procurement categories increasing except medicines and chemicals and business services which decreased by 13%, and 12% respectively. Other manufactured products, stationery and paper products and food and catering saw the largest increase in 2022-23. The increase in medical instruments and equipment is likely due to additional emissions associated with Personal Protective Equipment (PPE) which has previously been excluded.

Emission category	tCO_2e			Change since 2021-22
	2020-21	2021-22	2022-23	
Medical instruments & equipment	2,590	2,498	2,739	10%
Business services	2,604	2,434	2,142	-12%
Information & communication tech	1,297	1,380	1,383	0.2%
Food, catering & hotel services	1,305	1,107	1,439	30%
Construction	1,352	965	1,020	6%
Other manufactured products	900	931	1,374	48%
Medicines & chemicals	534	694	604	-13%
Stationery & paper products	135	174	235	35%
Total	***10,717**	***10,182**	**10,935**	**7%**

Procurement data was collected using 2022-23-year end accounts. The costs are used to estimate the GHC emissions, and an Environmentally Extended Input Output Analysis (EEIOA) was the methodology used. In EEIOA, financial spend in a sector is directly converted into CO2e. The annual spend of each procurement category was multiplied with its associated sector specific emissions factor. Emissions factors used were taken from the Greener NHS database.

3. Delivery of the GHC Green Plan

The GHC green plan defines a number of areas of focused work to support the Trust's sustainability objectives and the delivery of carbon footprint reduction. Green plan deliverables are all linked to clear sustainability goals, including those measurable in terms of the Trust's Carbon Footprint.

Progress with delivery of the Green Plan continues to be positive, and a comprehensive view of this across the different themes is provided in the Green Plan delivery dashboard at Appendix 1 to this paper.

4. Alignment with the One Gloucestershire ICS Green Plan

The Integrated Care Board (ICB) has worked alongside the Sustainability Teams at GHC and GHT to ensure that individual Trust Green Plans are fully aligned with the goals and objectives set out in the One Gloucestershire ICS Green Plan so the goals and objectives to reach net zero across Gloucestershire ICS are consistent with the national NHS targets.

5. Recommendations

The Trust Board is asked to **note** the positive progress with delivery of the Green Plan and Carbon Footprint reductions in line with the NHS net zero targets.

Appendix 1 - Green Plan linked Goals Dashboard

Net Zero

					Baseline		Green Plan Target		Annual Progress against baseline				
Green Plan Theme	**Green Plan Goal**	**Target Type**	**Carbon Footprint category**	**Metric**	**Year**	**Value**	**Target**	**Goal Date (end of FY)**	**20/21**	**21/22**	**22/23**	**RAG**	**Comments**
Net Zero	Decarbonise our estate by reducing emissions from building energy use	NHS Mandatory	NHS Carbon Footprint	% reduction in emissions	19/20	6256 tco2e	**25%**	24/25	-82%	-21%	-36%		Target already exceeded – focus on sustaining and further reduction through heat decarbonisation
	inclusion of low, ultra-low or zero emission vehicles in fleet.	NHS Mandatory	NHS Carbon Footprint	% of overall fleet	19/20	0% (98 vehicles)	**10%**	24/25	1% (1/93 vehicles)	18% (18/104 vehicles)	22% (24/106 vehicles)		Target reached but 99% of the vehicles are hybrid and therefore we haven't reduced our carbon footprint from Trust Fleet - still accounts for 7% of direct emissions.
	Reduce Trust business mileage	NHS Mandatory	NHS Carbon Footprint	% reduction	19/20	1422 tco2e	**20%**	24/25	-39%	-34%	-24%		Exceeded target but percentage reductions are decreasing annually.
	Develop and construct our first net zero community hospital in the Forest of Dean by 2024/25.	NHS Mandatory	NHS Carbon Footprint	new builds to meet Net Zero Carbon Hospital Standards	19/20			23/24					Formal NHS standard not yet developed by NHSE, but on track to deliver planned, sustainable design meeting BREEAM excellence standard.
	To increase our resilience against climate-related severe weather events	ICS	NHS Carbon Footprint	County wide Climate Change Adaptation Plan in place				25/26					We are supporting this by ensuring the new FoD hospital is built to a net zero standard to prepare for extreme weather events.
	To develop sustainability and net zero principles into all new, existing, and decommissioning projects.	NHS Mandatory	NHS Carbon Footprint	Development of a Net Zero Building design standard				22/23					we have missed the target due to external delays in NHS England producing the Net Zero building standard - no penalties associated with us missing this target.

Equity and Procurement

					Baseline		Green Plan Target		Annual Progress against baseline				
Green Plan Theme	**Green Plan Goal**	**Target Type**	**Carbon Footprint category**	**Metric**	**Year**	**Value**	**Target**	**Goal Date (FY)**	**20/21**	**21/22**	**22/23**	**RAG**	**Comments**
Equity and Procurement	increase waste recycling rate	NHS Recommended	NHS Carbon Footprint Plus	% increase in recycling rate	20/21	TBC	**50%**	24/25	TBC	TBC	TBC		new waste contract in place with clearer KPIs - will have data on this in April 2024 report
	Embed a 10% sustainability and social value into the weightings criteria of all procurement contracts	NHS Mandatory	NHS Carbon Footprint Plus	Compliance to NHS England Social Value.									Completed 23/24 FY - mandated via NHS England.
	increase procurement spend with local businesses spend where financially viable	NHS Recommended	NHS Carbon Footprint Plus	% increase in spend with local businesses	22/23	TBC	**TBC**	24/25	TBC	TBC	TBC		need to confirm definition of local with procurement team (could be county/neighbouring counties or Regional). Once this is confirmed will be measured and reported.
	to reduce the use of single-use plastics used within the organisation where financially feasible	NHS Mandatory	NHS Carbon Footprint Plus	% reduction	18/19		**10%**		NA	NA	-25%		No data available for financial years 20/21 and 21/22, data was available for 22/23 and indicates that we are exceeding our 10% target.

Sustainable Models of Care

					Baseline		Green Plan Target		Annual Progress against baseline				
Green Plan Theme	**Green Plan Goal**	**Target Type**	**Carbon Footprint category**	**Metric**	**Year**	**Value**	**Target**	**Goal Date (FY)**	**20/21**	**21/22**	**22/23**	**RAG**	**Comments**
Sustainable Models of Care	Reduce Meter Dose Inhalers	NHS Mandatory	NHS Carbon Footprint Plus	% reduction in Meter Dose inhalers	19/20	7 tco2e	**25%**	25/26	-14%	-29%	-29%		Target already exceeded.
	reduce the use of pharmaceuticals and harmful medical gases	NHS Mandatory	NHS Carbon Footprint	% reduction in co2e of anaesthetic gases	19/20	162 tco2e	**No target set**	25/26					Data is currently unavailable but anaesthetic gases only account for 1% of our total carbon footprint therefore limited scope for change/low carbon impact.
	Empower people across the organisation to make sustainable and nutritious food choices.	NHS Recommended	NHS Carbon Footprint Plus	% reduction in emissions from low carbon menu choices	19/20	22kgco2e	**No target set**	25/26		-27%			27% reduction in carbon emissions from menu choices and a 22% reduction in carbon emissions by portion.
	Increase the amount of sustainable and active travel facilities across the Trust to contribute towards improved air quality, health and wellbeing.	NHS Mandatory	NHS Carbon Footprint	Number of cycle spaces and number of EV charging points	19/20	TBC	**No target set**	23/24					Purchased EV charging points and waiting installation. Data on active travel measures forms part of the Healthy Travel Strategy. New FOD will increase the amount of cycle spaces across GHC.
	reduction in food waste	NHS Recommended	NHS Carbon Footprint Plus	% reduction in food waste	20/21	TBC	**60%**	25/26					Digital meal ordering system will significantly assist in this reduction when it goes live in 24/25

					Baseline		Green Plan Target		Annual Progress against baseline				
Green Plan Theme	**Green Plan Goal**	**Target Type**	**Carbon Footprint category**	**Metric**	**Year**	**Value**	**Target**	**Goal Date (FY)**	**20/21**	**21/22**	**22/23**	**RAG**	**Comments**
Sustainable Models of Care	**Increased impacts of digitally enabled care through a reduction in face-to-face appointments**	NHS Mandatory	NHS Carbon Footprint Plus	% reduction in face-to-face appoint-ments	**19/20**	**TBC**	**25%**	**25/26**					NHS mandatory target - need to establish baseline value and progress
	Understand opportunities that biodiversity and, greenspace offer in order to promote a more sustainable model of care	NHS Mandatory	NHS Carbon Footprint Plus	Develop-ment of Greensp ace and Biodivers ity Strategy	**19/20**			**23/24**					Various schemes in progress – including new FoD hospital. Strategy to be complete by end of 23/24 financial year.

Workforce and System Leadership

					Baseline		Green Plan Target		annual Progress against baseline				
Green Plan Theme	**Green Plan Goal**	**Target Type**	**Carbon Footprint category**	**Metric**	**Year**	**Value**	**Target reduction**	**Goal Date (FY)**	**20/21**	**21/22**	**22/23**	**RA G**	**Comments**
Workforce and Systems Leadership	Improve the awareness of Sustainability agenda across the organisation	NHS Recommended	NHS Carbon Footprint Plus	Development of sustainability behaviour change campaign	20/21			23/24					
	Embed sustainability into Trust transformational, learning & development and quality improvement programmes of work.	NHS Recommended	NHS Carbon Footprint Plus	Sustainability Embedded into stated services	20/21			23/24					Embedded in QI, further work to embed in Transformation and L&D

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Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 14/1123

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 30 November 2023**
PRESENTED BY:	Lavinia Rowsell, Director of Corporate Governance & Trust Secretary
AUTHOR:	Gillian Steels, Governance Advisor
SUBJECT:	**PROPOSED BOARD ASSURANCE FRAMEWORK (BAF) NOVEMBER 2023 - MARCH 2025**

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

This report is provided for:

Decision ☐ Endorsement ☒ Assurance ☒ Information ☐

The purpose of this report is to:

To provide assurance to the Board on the management of strategic risks and present the Board Assurance Framework (BAF) for Nov 2023-March 2025.

Recommendations and decisions required

The Board is asked to:

- **Receive** and **endorse** the proposed BAF for 2023/2025
- **Note** the overarching risk profile for the Trust at end Q2 **(Page 1 BAF) 1)**

Executive summary

Along with the Corporate Risk Register the Board Assurance Framework (BAF) supports the creation of a culture which allows the organisation to anticipate and respond to adverse events, unwelcome trends and significant business and clinical opportunities. It helps to clarify what risks are likely to compromise the trust's strategic and operational objectives and assists the executive team in identifying where to make the most efficient use of their resources in order to improve the quality and safety of care.

The BAF for 2023/25 reflects the Trust's Strategic Aims and Objectives and has been updated in light of discussions at the Board Risk Seminar held in June 2023. The current BAF has been subject to a detailed review, with feedback sought on current risks, but also reflecting on new risks that should be incorporated given changed circumstances since the last BAF was developed.

Areas that have been of particular consideration during the review are ensuring Health Inequalities are effectively incorporated; reflecting on system and national issues, both in funding and in practice; considering where the Board's focus should be for the next 18 months.

The risks on the revised BAF have been confirmed by the Executive and reviewed by the Board Governance Committees. It is recognised that it is a living document that will evolve as circumstances change. A particular area of focus over the next quarter will be to ensure that appropriate deadlines are assigned to all mitigating actions.

- *Changes since last review:* The entire BAF has been subject to review.
- *Strategic risks added or removed:* The following three risks have been added to the register.

Risk	Description	Score
10	*System Operation*	**9**
11	*Closed Culture*	**12**
12	*Workforce Transformation*	**9**

- *Movements in risk ratings:*

7	*Sustainability (environment):* Risk score decreased to reflect overall progress against plan and carbon reduction targets.	**12 to 9**

Note: Risk 8 – *Cyber* had been redacted due to commercial sensitives. The full version of this risk is reviewed at each meeting of the Audit and Assurance Committee. There are currently no issues to be escalated to Board at this stage.

Risks associated with meeting the Trust's values
Report is focused on ensuring the Board is targeting the appropriate key strategic risks.

Corporate considerations	
Quality Implications	Incorporated within proposed risks
Resource Implications	Incorporated within proposed risks
Equality Implications	Incorporated within proposed risks

Where has this issue been discussed before?
The BAF is regularly reviewed by the Executive and Board Committees.

Appendices:	**Appendix 1:** Proposed BAF

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

BOARD ASSURANCE FRAMEWORK (Draft)

November 2023- March 2025

Risk No	Strategic Risk Description	Strategic Aim				Risk Type(s)							Lead Committee	Tolerance	Initial Risk Score	Target Risk Score	Risk Score					Lead Exec	Last Exec Review	Last Comm Review	Issue to be raised By Exec /Comm.(Y/N)
		High Quality Care	Better Health	Great Place to Work	Sustainability	Quality/Outcomes	Compliance / Regulatory	Reputational	Innovation	Partnerships	Workforce	Finance Inc. VFM					Target Date Aim By When	Qtr 1	Qtr 2	Qtr 3	Qtr 4				
1	Quality Standards	✓	✓			✓	✓	✓					Qual.	10	12	8	April 2025	12	12			Dir NTQ	Oct 23	Nov 2023	N
2	Services Not meet Pop Need	✓	✓			✓	✓	✓	✓	✓		✓	Res.	10	16	12	April 2025	16	16			COO	Oct 23	Nov 2023	N
3	Recruitment & Retention	✓	✓	✓		✓	✓	✓			✓	✓	GPTW	12	12	12	April 2025	16	16			DIR HR& OD	Oct 23	Nov 2023	N
4	Inclusive Culture (Internal)		✓	✓				✓					GPTW	6	9	4	April 2025	6	6			DIR HR& OD	Oct 2023	Nov 2023	N
5	Partnership Culture		✓			✓		✓		✓			Board	12	9	6	April 2025	9	9			Dir S&P	Oct 2023	Nov 2023	N
6	Level & Prioritisation of Funding	✓	✓			✓	✓	✓	✓			✓	Board	10	16	8	April 2025	12	12			DoF/ COO	Oct 2023	Nov 2023	N
7	Sustainability (environment)				✓		✓		✓	✓			Res.	6	12	6	April 2025	12	9			Dir S&P	Oct 2023	Nov 2023	N
8	Cyber	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	Audit	6	20	8	April 2025	12	12			DoF	Oct 2023	Nov 2023	N
9	Strategic Focus	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Board	10	9	6	April 2025	9	9			Dir S&P	Oct 2023	Nov 2023	N
10	System Operation	✓	✓	✓		✓	✓	✓			✓	✓	Audit	6	12	6	April 2025		9			DoF/ CEO	Oct 2023	Nov 2023	N
11	Closed Culture	✓	✓	✓		✓	✓	✓		✓	✓		Board	6	12	6	April 2025		12			DNTQ /DHR	Oct 2023	Nov 2023	N
12	Workforce Transformation	✓	✓	✓	✓	✓		✓		✓	✓	✓	GPTW	10	12	12	April 2025		9			COO/ DHR	Oct 2023	Nov 2023	N

<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health</td><td>Exec Risk Owner</td><td>John Trevains, Dir NTQ</td><td>Date of review:</td><td>Oct 23</td></tr>
<tr><td>Risk ID:</td><td>01</td><td>Description:</td><td colspan="3" rowspan="2">Quality Standards:

There is a risk that failure to:
(i) monitor & meet consistent quality standards for care and support;
(ii) address variability across quality standards;
(iii) embed learning when things go wrong;
(iv) monitor and respond to trends in complaints and concerns, serious clinical incidents and mortality;
(v) ensure continuous learning and improvement,
(vi) ensure the appropriate timings of interventions

will result in poorer outcomes for patients / service user and carers and poorer patient safety and experience.</td><td>Lead Committee</td><td>Quality</td><td>Date of next review:</td><td>Nov 23</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td>Updated Oct 2023 (Ongoing BAF Risk from 2019)</td><td colspan="3" rowspan="6">• Number of Complaints (and trends – including by site and service)
• Number of concerns and trends including by site & service)
• Timeliness of reviews into Concerns
• Patient Safety Incidents
• Friends & Family Test measures
• Safe Staffing Levels
• Embedding learning /Quality Improvement activity reporting
• Waiting times
• Vacancy rates – aggregate position</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Target Score</td><td>2</td><td>4</td><td>8</td></tr>
<tr><td>Date to Achieve Target Score</td><td>1st April 2025</td><td>Tolerance</td><td>10</td></tr>
<tr><td colspan="4">Potential or actual origin of the risk:</td><td colspan="6">Recognising its core importance to the work of the Trust this has been confirmed as an area for ongoing monitoring on the BAF since 2019, confirmed 2023.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">The work of the Quality Committee and their reviews of the Quality Indicators provides ongoing assurance. The development, implementation and monitoring of the Quality Strategy/Framework, approved by the Board in July 2021, ensure this risk is effectively managed and continues to be central to our ways of working. The majority of KPIs identified to inform the scoring of this risk are within agreed parameters excluding waiting times/access. Safe staffing levels are improving, however there is an increase in the vacancy rate of Healthcare Support Workers (HCSW), with Berkeley House recording the highest HCSW rate. Increased focus on inpatient settings including WL Assurance Group. Anti-closed culture activity progressing such as reducing restrictive practice, improving clinical supervision and independent advocacy reporting to Quality Committee.</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10">273: Eating Disorders, 165/320: Core CAMHS Waiting List/Medical Vacancies, ~~180: Mental Health Act Changes~~, 196 Demand and Capacity MH Inpatient Beds. ~~114: Acquired Pressure Ulcers~~; 109 Safeguarding. 107: Ligatures, 160: Patient Doc Storage, 247: Agency and Bank Reliance, 232/~~243~~: CYPS. 280: Out of Area Placements, 294 C&YP with SEND, ~~293: ADHD/ASC Waiting List~~, 326: Social work capacity; 346: Estate Berkeley House, 356/355: PSIRF/LFPSE, 295 VOIP Infrastructure {Telephony] 372 Building works for accreditation,373 GHC Theatre STOP activity, 323 General Anaesthetic Provision for Community Dental Services referrals</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1.	Quality Dashboard	Monthly	2023/24	Dir NTQ/ Quality Committee / Board	Implementation and embedding of Quality Strategy. Work in progress on embedding this
2.	Patient Safety Controls – including Freedom to Speak Up mechanisms	As above	As above	Dir NTQ	Quality Dashboard and patient safety, experience and Freedom to speak up reports consistently produced – to maintain.
3.	Patient Experience Controls	As above	As above	As above	As above
4.	Workforce Controls	As above	As above	Dir NTQ	Ongoing monitoring. Safe staffing report in quality dashboard, community services staffing data being developed. Recovery reporting in performance report.

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Reports on Quality Standards/Performance	L2	Rec'd each Mtg	Qual/Res Comm or Board	Satisfactory	KPIs within Monthly reports and regularly review to ensure measures being used are the most appropriate and timely.
2	Reports on Service User Experience	Includes L3	monthly reports	Qual Comm/Board	Satisfactory	Complaints waiting times closely monitored and improving To date 94% complaints have been closed within 6 months, this compares to 87% last year (Sept 23)
3	Internal Audit Reports on Freedom to Speak Up	L3	Aug 2023	Audit Committee	Satisfactory	Revised FTSU policy and reporting process to be implemented by 2024. Outcome of FTSU internal audit – substantial assurance
4	Reports on Freedom to Speak up actions & issues raised	L2	6 monthly Reports	Board	Satisfactory	None highlighted since recommendations within Internal Audit Report implemented. Roll out of civility saves lives programme
5	Service Experience Stories to Board	L3	Every other month	Board	Satisfactory	Feedback loop from service user stories built into Quality Committee agenda cycle.

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Freedom to Speak Up revised Policy - 2024 requirement	To be discussed at Board	FSUG	Jan 24 – in progress
2	Measuring What Matters Work Phase 2 to be progressed	Ongoing – Board Dev Session Aug 23	DoF	Priorities & focus to be agreed
3	Quality Strategy/Framework implementation to be reviewed	Biannual implementation update to Quality Comm – 09 22, 09 24	DoNTQ	In Progress
4	Quality mechanism processes KPIs to be kept under review	Quality Committee to Monitor for timeliness of actions	DoNTQ	Dashboard being updated
5	CQC action-planning and review in response to improvement plans	Quality Committee review in Feb and March Board.	DoNTQ	In Progress
6	Ongoing review and prioritisation for recruitment focus of safer staffing hotspots	See Risk 3 (Colleague Recruitment and Retention) – progressing well international nursing,	DoNTQ / DHR&OD	In Progress
7	Development of service heat maps, triangulating data and scoring mechanism as early warning and detection.	Rec. arising from well led review and considered further at quality seminar. Further development required.	DoNTQ / MD	In Progress
8	Anti-closed culture activity	Progress in activities such as reducing restrictive practice, improving clinical supervision and independent advocacy reporting to Quality Committee.	DoNTQ	In progress

Return to Summary Page

Strategic Aim:			**High Quality Care** **Better Health**	**Exec Risk Owner**	David Noyes, COO	**Date of review:**	Oct 23
Risk ID:	**2**	**Description:**	**Services not Meeting Population Need** There is a risk of demand out stripping supply for services and/or that services operate in a way which does not meet the needs of the population, potentially reinforcing health inequalities.	**Lead Committee**	Resources	**Date of next review:**	Nov 23

Risk Rating: (Consequence x Likelihood):			
Date Risk Identified/ confirmed	Oct 2023 (Refocused from 2022 BAF risk)		
	Likelihood	**Impact**	**Overall**
Inherent Risk Score:	**5**	**4**	**20**
Current Risk Score:	**4**	**4**	**16**
Target Score:	**2**	**4**	**8**
Date to Achieve Target Score	**1st April 2025**	**Tolerance**	**10**

Relevant Key Performance Indicators: (taken from the Performance Report)

- Waiting times
- Referral and Access Reports
- Length of Stay
- No. Complaints and Compliments (also Trends – access, timeliness, E&D focus)
- Out of Area Placements
- Increased number of individuals with long term conditions – once available
- Health Inequalities key metrics
- User Satisfaction – by service, E&D characteristics
- Quality Data

Potential or actual origin of the risk: Oct 2023 – Demand for Services Risk substantially revised and refocused to reinforce link to health inequalities and ensure reflects on way services delivered as well as demand.

Rationale for current score: (What is the justification for the current risk score)

Demand for our services remains high and monitoring to reflect service operation meets the needs of the population continues to be in development. The Newton Europe/Working as One diagnostic intervention identified areas for improvement which are currently being prioritised; the next phase of implementation is being mobilised at system level in qtr2/3 2023 (actions under our direct control are being taken forward and monitored through physical health transformation board). To date relationships with Commissioners remain supportive, but we need to ensure clear understanding of the volumes we are dealing with and how we are supporting Health & Care across the County through different services and different communities. We maintain a full suite of service improvement plans which are regularly reviewed at operational and governance level. Project to resolve data quality issues relating to physical health and the information held in the clinical system completed. We have developed a plan to reconfigure service around local partnerships considered by Board August 2023. Data monitoring of services against diversity characteristics to ensure needs of different communities being met requires further development.

Links to Risk Register

273: Eating Disorders, 165/320: Core CAMHS Waiting List/Medical Vacancies, 196 Demand & Capacity MH Inpatient Beds~~.~~ 247: Agency & Bank Reliance, 232/~~243~~: CYPS, 280: Out of Area Placements, 294 C&YP with SEND, ~~293:~~ ~~302~~: Clinical Records syncing to Spine; 321: Springbank Performance, 346 Estate – Berkeley House; 326 Social worker capacity across MH services, 359 Specialist Allocation Service Demand, 344 Dental Provision - Out Of Hours 372 Building works for accreditation, 373 GHC Theatre STOP activity, 323 General Anaesthetic Provision for Community Dental Services referrals

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Contract Management Board	Monthly		DoF	
2	ICS Board	Monthly		CEO	
3	Board and Committee Monitoring	Monthly		Board	
4	Business plan – process & monitoring	Annual		CEO/Chair	
5	Relationship GCC and GCCG	Ongoing		CEO/Chair/Board	GCC not formal member ICS

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 – Operational L2 – Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Performance Report	L2	Monthly	Res Comm/Board	Satisfactory	Improved integrated reporting
2	ICS Operating Plan	L2	Annual	Board	Limited	ICS Control Total will impact funds available to meet demand
3	Business Plan monitoring	L2	6 monthly	Board	Satisfactory	Delays in provision guidance business plan & budget mean 6-month review planned.
4	Quality Account – including stakeholder feedback	L2/L3	Annual	Board	Satisfactory	
5	HoSC feedback	L3	Every other month	Chair/CEO/	Satisfactory	
6	Service User Feedback	L3	Annual	Board/Qual	Limited	National issue impacts, ensure comms effective
7	Quality Report	L2	Monthly	Qual Comm/Board	Satisfactory	
8	Quality Dashboard	L2	Monthly	Qual Comm/Board	Satisfactory	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1.	Continue work to build capacity and understanding of self-care and develop more admission avoidance schemes.	To be built into service reviews & developments. Focus on co-production for service developments to continue	COO DS&P	In progress –incremental adoption in conjunction with ILPs
2	Continue work to improve joined up working across the county to make best use of Gloucestershire pound	Ongoing work across ICS	Exec	Ongoing
3	Continue performance report monitoring & deep dives to focus on patient outcomes.	Established within agenda cycles	COO	Ongoing
4	Consider further how health inequalities can be measured and targeted as a system (links to item 6).	Localisation plan to be discussed by Board. Links to PLICS project being explored.	Exec/ICS	In progress
5	Integrated reporting in newly configured performance report	Executive objective for 23/24. Service profile reports in the interim.	Exec	In progress
6	Quality Improvement Hub operation to be further developed to enable project consideration in relation to services meeting population needs	Resource and focus of QIH to be considered in line with meeting population needs.	DSP	In progress
7	Further work to develop integration of Working Together Advisory Committee within quality improvement processes	Regular meeting cycle to be put in place	DSP	In progress

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Strategic Aim:				**Great place to work** **Better Health** **High Quality Care**	**Exec Risk Owner**	N Savage D of HR & OD	**Date of review:** Oct23
Risk ID:	**3**	**Description:**		**Colleague Recruitment & Retention** There is a risk that we fail to recruit, retain and plan for a sustainable workforce to deliver services in line with our strategic objectives.	**Lead Committee**	GPTW	**Date of next review:** Nov 23
Risk Rating: (Consequence x Likelihood):					**Relevant Key Performance Indicators:**		
Date Risk Identified/confirmed	October 23 (Updated from 2022)				• Staff Turnover – including wellbeing metrics • Annual Staff and Pulse Surveys • Staff Friends and Family FFT scores • Vacancy Rates • Bank and Agency Usage • Recruitment & Retention Report – exit trends • Education & Development Report • Appraisals • Probationary periods • Statutory & Mandatory Training Update • Sickness Absence KPI • Health & Wellbeing Report		
	Likelihood	**Impact**	**Overall**				
Inherent Risk Score:	**4**	**4**	**16**				
Current Risk Score:	**4**	**4**	**16**				
Target Score:	**3**	**4**	**12**				
Date to Achieve Target Score	**1st April 2025**	**Tolerance**	**12**				
Potential or actual origin of the risk:				Confirmed to be retained 2033-2025 BAF, now broadened to include workforce wellbeing.			

Rationale for current score: (What is the justification for the current risk score)

A range of revised processes have been developed and are being embedded and further developed. This work is now overseen by the Great Place to Work Committee, Executive Team Meeting and the Sustainable Staffing Oversight Group. The risk has been refocused to incorporate workforce and wellbeing metrics to ensure holistic oversight of recruitment and retention. It is recognised that many aspects of supply, terms, conditions and competitive remuneration remain outside the Trust's immediate control. There is a continuing national shortage of staff, and timescales to resolve are long term, (for example the workforce supply pipeline for degree level registered medical, AHP and nursing roles has between a 3 and 10 year tenure with, our local RNLD degree programme only having commenced in September 2022 and the 3 Counties Medical School opening delayed to Sept 2023, which initially is not able to enrol UK students). Due to these factors recruitment and retention will remain a significant risk, with delays in the current registered staff pipeline continuing to significantly impact our ability to reduce this risk in the short or medium term.

Links to Risk Register

165: Core CAMHS Waiting List, 247/~~310~~: Agency and Bank Reliance, 232/~~243:~~ CYPS, 280: Out of Area Placements, ~~285: Cost of Living Crisis~~, 294 C&YP with SEND, ~~293: ADHD/ASC Waiting List~~, ~~245 GPTW – Model Recruitment & Retention~~, 320 CAMHS – Medical Workforce Vacancies

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1.	International Recruitment Programme for RMN, RGN and AHP	July 23	July 24	Exec	Update paper to July Board
2.	Relationships with a number of universities to build supply New Programmes developed Uni of Glos – LD Nursing, Established RGN, RMN & Physiotherapy Degrees and student placement UoG. Three Counties Medical School – local medical supply line	Ongoing	Quarterly	Exec	Lead time for RN LD degree training to complete i.e 2025.
3.	Recruitment Policy in place to fast track recruitment	1/9/23	1/1/24	Exec	Impact of changes to be reviewed.
4.	ICS Workforce Steering Group	01/09/23	Quarterly	Exec	ICS people strategy and recruitment and retention plan to be finalised and agreed.
5.	Health Care Support Worker Recruitment and Retention Project	ongoing	Quarterly	Exec	Retention focus through targeting Health Care Support Worker interventions. Analysis of leaver data – winter 2023
6.	Recruitment and Retention Framework Impact Review	01/06/23	01/04/24	Exec and GPTW	To include consideration of how we recruit from under represented communities (geographic, demographic, & protected characteristics) and potential links to voluntary sector.
7.	Health & Wellbeing Strategic Framework & Budget Funding in place	Quarterly	Quarterly	Exec and GPTW	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Monthly Recruitment Activity Reports to SSOG	L1	Monthly	Exec	Work in progress	To consider recruitment from underrepresented communities.
2	Staff Survey and Staff FFT	Ls 1,2 and 3	August 2022	GPTW	Satisfactory	Includes wellbeing metrics
3	Retention Data	Ls 1 and 2	Ongoing	GPTW	Satisfactory	
4	Sickness Data	Ls 1 and 2	Ongoing	GPTW	Work in progress	Concern level remains above target
4	Turnover Data	Ls 1 and 2	Ongoing	GPTW	Satisfactory	
5	Annual Working Well Assurance Report	L2	June 2023	GPTW	Satisfactory	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	International Recruitment – additional partnering for RMNs	35 RMNs are now in post and are working through the support and development pathway to gain NMC registration. Recruitment into a further 10 RMN posts in planned for Q3-4.	D HR&OD	In progress – Q4
2	Return to practice	Review opportunities to increase RTP recruits for 2023, 2024 cohort	D HR&OD	In progress
3	Remuneration Review	2022 pay review paid at end Sept. Work to calculate the implications of paying the Living Wage underway. Will require ICS and regional consultation.	D HR&OD	In progress
4	ICS Providers Cost of Living Support review	ICS wide Cost of Living support review commended in July 22, with further recommendations expected in year.	D HR&OD	In progress
5	Launch International AHP Recruitment	Yet to secure a pipeline of suitable candidates, despite help from a number of international agencies.	DHR&OD/DNTQ	Q4

6	Improved long term nursing workforce supply modelling	Part 2 of a "Supply Scenario Modelling (Optioneering) Tool Scoping Workshop" run with Health Education England assistance in Q2	DHR&OD	In progress
7	Implementation of the Nursing and Midwifery Self-Assessment Tool and action plan	New work stream commenced in Q3. Quarterly updates provided to GPTW. Latest update is Oct 2023.	DHR&OD	In Progress
8.	Review Recruitment & Retention Framework impact	To include consideration of how we recruit from under represented communities (geographic, demographic, & protected characteristics) and potential links to voluntary sector.	DHR&OD	Timeline to be considered.
9	Increase careers, widening access and apprenticeship engagement	GHC Careers and Engagement Officer connecting with schools, DQP, communities and diversity groups including recruitment to apprenticeship talent pool	DHR&OD	In Progress
10	Agreement for use of Section 256 monies to run a series of 2023/24 ICS wide recruitment campaigns	Work is underway with an external company supporting the ICS to build a system wide campaign to attract future workforce into health and social care roles within the county	DHRD&OD	Q 1-4
11	Submission of a bid to NHSE to support IR recruitment for social care in GCC and GHC	Bid submitted - outcome outstanding	DHRD&OD	TBC
12	Launch International Educated Nurse Council	Feedback from IENs gained through the May IEN celebration event, Terms of Reference are currently being scoped with a view to a Sept-Oct 2023 launch.	DDHR&OD	Q3
13	Renewal of funding for the system-wide Mental Health and Wellbeing service (The Wellbeing Line - TWBL), (which is funded through the ICS until March 24) to be identified as priority with ICS.	Data on impact to be used to support. If ongoing funding not received actions to close/ alternative options for provision to be considered.	DDHR&OD	Dec 2023.
14	Retention within Trust – facilitation of movement between Teams/services opportunities to be supported.	Consideration of how to equip staff to move between teams	DDHR&OD	In Progress
15	Violence and Aggression Strategic Plan	Discussion at GPTW Committee and colleague engagement workshops held	DDHROD	In Progress – Q4 report
16	Industrial Relations /Staff Engagement Activities	Comms processes to be reviewed	Exec	Not started

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">Great Place to Work

Better Health</td><td>Exec Risk Owner</td><td>N Savage, DHR&OD</td><td>Date of review:</td><td>Oct 23</td></tr>
<tr><td>Risk ID:</td><td>4</td><td>Description:</td><td colspan="3" rowspan="2">Inclusive Culture (Internal)

There is a risk that we fail to deliver our commitment to having a fully inclusive and engaging culture with kind and compassionate leadership, strong values and behaviours which negatively impacts on retention and recruitment, colleagues experience and engagement and on our ability to address inequalities in service delivery (access, experience and outcomes).</td><td>Lead Committee</td><td>GPTW</td><td>Date of next review:</td><td>Nov 23</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed</td><td colspan="3">Oct 2023 (Updated from 2022)</td><td colspan="4" rowspan="6">• Staff Survey and Pulse Surveys
• HR Formal Casework report
• Just & Learning Culture e-learning
• Diversity levels at Band 8 and above – area of ongoing work
• Freedom to Speaking up Data
• WRES Data
• WDES Data
• Gender Pay Gap Data
• Service User Equality Access Data – when available
• Recruitment metrics from underrepresented communities</td></tr>
<tr><td colspan="3"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="3">Inherent Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="3">Current Risk Score:</td><td>3</td><td>2</td><td>6</td></tr>
<tr><td colspan="3">Target Score:</td><td>3</td><td>2</td><td>6</td></tr>
<tr><td>Date to Achieve Target Score</td><td>1st April 2025</td><td colspan="2">Tolerance</td><td>6</td></tr>
<tr><td colspan="5">Potential or actual origin of the risk:</td><td colspan="5">Updated format for 2023-25 BAF (previously in 2021 BAF)</td></tr>
<tr><td colspan="10">Rationale for current score: (What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">The organisation Values & Behaviours work was co-developed, agreed and is now embedded within key policies, reward/award process, recruitment, inductions and appraisals to help ensure the culture reflects Trust and Board commitments. The Speaking Up at Work and Freedom to Speak Up Policies plus the developing Diversity Networks are used to inform and develop practice provide assurance that the values and behaviours are being lived throughout the organisation. The Civility Saves Lives programme is now being implemented alongside a Restorative, Just & Learning Culture approach. A new Freedom To Speak Up Policy is in the final stages of development following a new national template policy. The Trust received positive compliments on its Freedom To Speak Up approach and culture in the 2022 Care Quality Commission report, noting however that more publicity was still needed. Leadership Development Programme (Thrive) and ICS Flourish Programme (positive action/stepping up programme) in place. The 2022 Staff Survey results were used for action plans to address areas of concern and help mitigate the risk. The 2022 Staff Survey indicators for ‘compassionate and inclusive culture’ place our Trust above the average score for all trust wide indicators, with 69.8% of colleagues stating they would recommend the organisation as a place to work. However feedback indicators continue to show less good experience for some colleagues related to protected characteristics so this remains an area of ongoing focus.</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10"></td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Co-developed Values & Behaviours organisational values	01/06/23	01/11/23	Board	Post-merger review with UoG of effectiveness of values and behaviours. Complete Q1 23/24
2	Just culture and appreciative enquiry processes included in performance management & Disciplinary Processes	01/09/23	01/12/23	Executive	Learning from HR casework event and wider benchmarking
3	Valuing Difference Leadership Strategy in place	1/06/23	01/12/23	Executive	
4	Freedom to Speak Up, Speaking up at work policies	01/06/23	01/12/23	Board	Policy under review
5	Co-production commitment to service design	Ongoing		Board	
6	Learning and Development Strategic Framework	01/06/23	01/12/23	GPTW	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 – Operational L2 – Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Feedback from appraisals and reward award processes	L1	Ongoing	Exec	Satisfactory	Gap between colleagues reported uptake and internal ESR records. Reported usefulness.
2	Disability Confident Leader Accreditation	L3	Aug 2023	Exec	Satisfactory	
3	Annual Workforce Race Equality Scheme & Action Plan	Ls 2 and 3	July 2023	Board	Satisfactory	
4	Annual Disability Equality Scheme & Action Plan	Ls 2 and 3	July 2023	Board	Satisfactory	
5	Patient & Staff Surveys	Ls 1,2 and 3	Mar 2023	Board	Satisfactory	
6	Freedom to Speak Up 6 monthly report	Ls 2 and L3	May 2023	Board	Satisfactory	
7	Diversity Network (sub groups women, LGBTQ+, Disabled, RCAN) with Lead NED in place	L2	Ongoing	Board/Exec	Satisfactory	
8	Gender Pay Gap Reporting	Ls 2 and 3	Mar 2023	Board	Satisfactory	
9	Work in Confidence in place	L2	Ongoing	Exec	Satisfactory	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1.	Senior management diversity – Bands 8 and above to be developed.	Reciprocal Mentoring and Flourish Leadership Development programmes in place and ongoing. Flourish review scheduled.	D HR&OD	In progress
2	Equality &Diversity Training to be updated.	New ED focussed 'safer recruitment' training implemented. Updated E&D Training to be implemented to reflect "Dignity at Work practice review - Just and Learning Culture"	D HR&OD	Delayed - within 23/24 business planning objectives
3	Annual EDI action plan formalised, which includes key statutory requirements and stretch milestones.	Currently in development	D HR&OD	In Progress
4	Values and Behaviours Review survey	Scoping work with UoG commenced delivery through Qs 3 and 4.	D HR & OD	In progress
5	Review of Apprenticeship (widening access) policy and pay	Commenced Q4 – delayed due to prioritisation of b2/3 project	ADELD	In progress
6	Recruitment metrics to be reviewed	Focus on underrepresented communities – geography, demographics & protected characteristics	D HR&OD	Not Started -to be considered

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">Better Health</td><td>Exec Risk Owner</td><td>Angela Potter, Dir of Strategy & Partnerships</td><td>Date of review:</td><td>Oct 23</td></tr>
<tr><td>Risk ID:</td><td>5</td><td>Description:</td><td colspan="3" rowspan="7">Partnership Culture

There is a risk that the Trust is not seen as, and does not maintain focus on being, an organisation which actively engages with its patients, staff and wider community partners impacting on our ability to deliver co-produced, personalised, high-quality services and address inequalities in health service delivery (access, experience and outcomes).</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>Nov 23</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report)</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td>Oct 2023 (updated from 2022)</td><td colspan="4" rowspan="5">• Number of Engagement Partners
• Number of services redesigned using co production
• Number and breadth of services covered by Experts by Experience?
• Staff Diversity data reflects our community
• Patient Diversity Data reflects our community – available but needs to be more widely promoted and used
• Working Together Advisory Committee feedback</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Target Score:</td><td>2</td><td>3</td><td>6</td></tr>
<tr><td>Date to Achieve Target Score</td><td>1st April 2024</td><td colspan="2">Tolerance</td><td>12</td></tr>
<tr><td colspan="5">Potential or actual origin of the risk:</td><td colspan="5">Similar risk on BAF since 2019. Refined Oct 2023.</td></tr>
<tr><td colspan="10">Rationale for current score: (What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">Partnership working, co-production and personalised care are central to the Trust's ways of working. There is clear leadership around the personalisation agenda through the Quality Improvement Team and the Partnership Team providing a consistent approach to how the Trust is taking forward co-production and working with stakeholders to achieve this. The Working Together Advisory Group is in place, providing strong oversight, and engagement with system partners. CMHT programme has strong partner engagement throughout. All actions proposed have now been completed and the experts by experience cohort is growing. However, work is required to further embed co-production within the organisation.</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10"></td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Directorate for Strategy and Partnership with engaged team embedded in the communities we serve	Agreed as part merger	-	Board	
2	Joint Director with GCCG to support working with GP Network	Agreed as part merger	-	Board	
3	Expert by Experience Programme	21/22	22/23	D S&P	
4	Governor Membership & Engagement Strategy	31/3/21	June 23	Council of Governors/Board	Action Plan to be implemented
5	Walk in My Shoes Programme	Ongoing	June 23	Exec/Board	To be reviewed for impact

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Friends and Family Test Patient Feedback Report	L2	Monthly (in quality report)	Quality Comm/Board	Satisfactory	
2	Compliments & Complaints Report	L2	Monthly (in quality report)	Quality Comm/Board	Satisfactory	
3	Staff Diversity Data	L2	Annual	Resources	Satisfactory	
4	Patient Diversity Data	L2	Ad hoc		Low	Reporting to be enhanced

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high-level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Personalisation of Care to be confirmed element of co-production and service review	The April 23 Better Together event focus on personalised care was very positively received. A clear work plan is now in place with a focus on What Matters to Me folders being piloted and a roll out plan developed. Updates to Quality Committee (last in June 23).	D S&P	In progress
2	Experts by Experience Review	EBE numbers continue to increase – focus on recruiting young experts and those with physical health conditions	D S&P	In progress
3	Governor Membership & Engagement Action Plan	To be implemented – partners and members to be put in place	H CG&TS	In Progress
4	Walk in My Shoes Programme	To be reviewed for impact – application to Charity Commission to register WIMS as a CIO submitted. Discussions with ICB underway.	CEO	In Progress – Dec 2023
5	Patient Access and Involvement Data to be developed	BI have developed a range of data tools to enable understanding of our cohorts at team and patient level and demographic data is being introduced into reporting. Building into Measuring What Matters Phase 2 to raise profile and utilisation across ops teams. Plan for roll out to be developed.	DD of BI	In Progress

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health
Great Place to Work</td><td>Exec Risk Owner</td><td>Sandra Betney D of F</td><td>Date of review:</td><td>Oct 23</td></tr>
<tr><td>Risk ID:</td><td>6</td><td>Description:</td><td colspan="3" rowspan="6">Level & Prioritisation of Funding
There is a risk that National and System Funding is insufficient, and does not effectively balance and prioritise the breadth and range of NHS provision, resulting in an inability to meet demand and delays in individuals being seen.</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>Nov 23</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="5">Relevant Key Performance Indicators:
• NHS Funding Settlement
• ICS Funding Settlement
• Access waiting times</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed</td><td colspan="3">2023</td></tr>
<tr><td colspan="3"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="3">Inherent Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td colspan="3">Current Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="3">Tolerable Risk:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Date to Achieve Target Score</td><td>March 2025</td><td>Tolerance</td><td colspan="2">10</td></tr>
<tr><td colspan="4">Potential or actual origin of the risk:</td><td colspan="6">2023 (national and system funding risks brought together from 2022 BAF)</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">The Trust's ability to directly impact on national funding is limited, but the Trust is active nationally in NHS Providers, the ICS and in community and mental health networks to support understanding of the roles of these services in supporting the population of the community and recognition of the need for their distinct funding. Whilst Gloucestershire has been able to submit a balanced plan for 23/24 following additional inflation pressures, there are still considerable risks to delivery and although the national pay award has been mostly funded there appears to be a recurrent unfunded cost pressure to the system arising from the pay awards. Whilst it will be difficult to achieve this level of efficiency and deal with the inflationary pressures and underfunded pay award it does not appear as if the national economic position has had a disproportionate effect on NHS funding, although the cost of living crisis for our workforce is leading to significant workforce issues. The medium-term financial outlook for the system and the Trust is however challenging.</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10"></td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Active Member NHS Providers	Ongoing	Each Board	Board	
2	Membership ICS Strategic Executive Meetings	Ongoing	Exec	Exec	
3	Membership of System Resources Committee	Ongoing	Exec	Exec	
4	Communication Plan and objective.	Annual – Bus Plan	Mar Board	CEO – ongoing	
5	Business & Financial Planning & Budget Setting processes	Annual & 6 monthly review	Sept Board	Board	These reflect internal processes to support sustainability, which are within the parameters of any funding settlement achieved by both the NHS and the local authority.
6	Financial Management processes	Monthly	April	Resources & Board	As above
7	Monitoring of Access and Waiting Times	Ongoing	Each Board	Board	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 – Operational L2 – Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Management Accounts	L2	Monthly	Resources/ Board	Satisfactory	
2	Performance Reports	L2	Monthly	Resources/ Board	Satisfactory	
3	Staff recruitment & Retention data	L2	Monthly	GPTW/ Board	Satisfactory	
4	Funding allocations achieved with commissioners	L2	Annual – Jan- Mar	Exec/Board	Satisfactory	
5	Updates on relationships – commissioners, GCC, GCCG, MPs, Councillors.	L2	Every other month	Board	Satisfactory	
6	ICS System Reporting	L2	Every other month	Board	Satisfactory	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Continue to provide information to NHS Providers to demonstrate wider impact of the NHS settlement in keeping individuals able to return to work/self-care.	Ongoing	CEO/DoF	Ongoing
2	Continue to work with community and mental health networks	Ongoing	CEO/COO	Ongoing
3	Continue to be active ICS Partner making best use of Gloucestershire pound	Ongoing	CEO/DoF	Ongoing

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Strategic Aim:			**Sustainability**		**Exec Risk Owner**	Angela Potter, Director of S&P	**Date of review:** Oct 23
Risk ID:	**7**	**Description:**	**Sustainability (environment)** There is a risk that responding to the climate emergency is not prioritised resulting in the failure to transform and deliver the Green Plan.		**Lead Committee**	Resources	**Date of next review:** Nov 23
Risk Rating: (Consequence x Likelihood):					**Relevant Key Performance Indicators:**		
Date Risk Identified/confirmed	2023 Reviewed & 2022 Risk maintained				• Green Plan in Place on track2 • Green Plan Targets/KPIs		
	Likelihood	**Impact**	**Overall**				
Inherent Risk Score:	4	**3**	**12**				
Current Risk Score:	3	3	**9**				
Target Score:	2	**3**	**6**				
Date to Achieve Target Score	**March 2025**	**Tolerance**	**6**				
Potential or actual origin of the risk:			Recognition of need to keep a holistic oversight on Trust's approach to sustainability which helps drive change.				

Rationale for current score:
(What is the justification for the current risk score)

Sustainability (environment) has been identified as an area of ongoing focus for the Trust. A Green Plan, with Board input, was developed to support this work. (Green Plan Guidance (*A three-year strategy towards net zero)* has been issued by NHSE/I with Trust plans required by January 2022 and system-wide plans by end March 2022). The focus of the risk has moved from set up to taking forward of breadth of actions. Progress is being made in overall carbon reduction and the Sustainability Steering Group in place to bring together a wider Trust wide focus to the broader issues of sustainability development including workforce, procurement, anchor institution work. External funding bid for the works to upgrade the Charlton Lane boilers is now scheduled to be resubmitted in Nov 23 and therefore remains a risk however, the overall plan is ahead of its carbon reduction targets and therefore this scheme is not critical to the delivery of the current performance.

Links to Risk Register

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Estates Environment Measures monitoring	Ongoing	Mar 24	Head of Sustainability	Annual Monitoring in Place
2	Management structure to support sustainability in place – Directorate responsibility DSP and Head of Resources in Place	Nov 2020	-	DSP	
3	Relationships in place to support joint working on this issue	Ongoing	-	DSP	
4	Commitment to sustainability within Trust Business Plan	Mar 22	Mar 24	Board	Need to embed the sustainability culture further
5	Commitment to sustainability within Trust Strategy	Mar 22	Mar 24	Board	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Estates Reporting on environmental measures within annual report	L2 L3	May 22	Board	Environmental maturity assessment completed by BDO as a developmental audit.	Environmental maturity assessment completed – 1 domain assessed as mature, 3 as defined and 1 Amber – all actions being taken forward
2	Procurement processes in place which include high level consideration of sustainability	L1	2020	Resources	Satisfactory	Embed sustainability within procurement at all levels.
3	Sustainability at Board level to contextualise this work.	L2	2020	Board	Reporting processes now agreed	Bi-annual reporting to Resources Comm & Annual to Board

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Embed sustainability considerations into Trust Procurement processes	Work ongoing to further develop sustainability considerations into Trust wide procurement processes – beyond estates procurement	DSP	**In progress**
2	Consider future reporting mechanisms for sustainability to ensure impact is recognised and built upon	Dashboard has been developed for wider monitoring of sustainability to be considered as part of the green plan development	H of Sustainability	**In progress** – discussions with BI
3	Explore external funding sources and grant applications	Government PSDS funding bid successful for Charlton lane boiler replacement. Low Carbon Skills fund bid made but unsuccessful. Grant applications being progressed for 'Green Health' projects including gardens at Charlton Lane and consideration of external space at new FoD	DSP	**Not Started** - Ongoing applications to be made to next tranche of funding

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health</td><td>Exec Risk Owner</td><td>Sandra Betney DofF</td><td>Date of review:</td><td>Oct 23</td></tr>
<tr><td>Risk ID:</td><td>8</td><td>Description:</td><td colspan="3" rowspan="6">Cyber
There is a risk that we do not adequately maintain and protect the breadth of our IT infrastructure and software resulting in a failure to protect continuity/ quality of patient care, safeguard the integrity of service user and colleague data and performance/monitoring data.

[redacted version]</td><td>Lead Committee</td><td>Audit</td><td>Date of next review:</td><td>Nov 23</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="2">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)
Cyber Essentials Plus Certification
Colleague Cyber Training</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed</td><td colspan="3">2023 (originated 2022)</td></tr>
<tr><td colspan="3"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="3">Inherent Risk Score:</td><td>4</td><td>5</td><td>20</td></tr>
<tr><td colspan="3">Current Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="3">Target Score:</td><td>2</td><td>4</td><td>8</td></tr>
<tr><td>Date to Achieve Target Score</td><td>1 April 2025</td><td>Tolerance</td><td>6</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Risk identified at Board Risk Seminar March 2022, informed by the growing risks in the corporate risk register relating to cyber security. Confirmed ongoing 2023 with additional recognition of risks to service user and colleague data and performance monitoring data.</td></tr>
<tr><td colspan="10">Rationale for current score: (What is the justification for the current risk score)</td></tr>
<tr><td colspan="10"></td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10"></td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1.	Information Governance/ Digital policies and procedures	At review date		Information Governance Group/ Digital Group	
2.	Continued staff awareness through communication	Ongoing			Regular updating to reflect latest risks
3.	Anti Virus & Advanced Threat Protection	Ongoing			Regular updating to reflect latest risks
4.	Email Scanning	Ongoing			
5.	Secure Boundary	Ongoing			
6.	Cyber Tools			ICS Cyber Group	Work in progress with ICS Cyber Team
7.	Cyber Security Operations alert actions	Annual			
8.	Cyber Essentials Plus certification	Annual	Annual	Digital Group	
9.	Information Governance Training and Testing	Ongoing			Needs regular updating to reflect latest risks
10	Information Governance requirements built into system development processes	Ongoing			
11	Multi-factorial authentication implemented	Complete			

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Internal Audit of DSPT	L3	May 23	Audit and Assurance Committee	Satisfactory	
2	Digital Group Reporting including phishing testing and tracking of cyber operational risks	L1	Quarterly	Resources Committee	Satisfactory	ICS Cyber Reporting to understand system risk as well as organisational risk – in progress
3	ICS Cyber reporting	L1	Regular	ICS Digital Execs	Satisfactory	
4	Annual SIRO Report	L2	Annual – May 23	Board	Satisfactory	
5	Information Governance Group Reporting	L1	Quarterly	Audit and Assurance Committee	Satisfactory	
6	Ad hoc cyber reports	L2	As required	Audit and Assurance Committee		In place.

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1.				
2.				
3.				

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<table>
<tr><td colspan="4">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health

Great Place to Work</td><td>Exec Risk Owner</td><td>DoSP COO</td><td>Date of review:</td><td>Oct 23</td></tr>
<tr><td>Risk ID:</td><td>9</td><td colspan="2">Description:</td><td colspan="3" rowspan="6">Strategic Focus
There is a risk that operational challenges and the constrained financial challenges to meet system imperatives mean that Board and Executive focus is not sufficiently strategic and holistic, resulting in a failure to achieve transformation and the agreed Board Strategic Aims.</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>Nov 23</td></tr>
<tr><td colspan="4">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)</td></tr>
<tr><td colspan="2">Date Risk
Identified/confirmed</td><td colspan="2">2023</td><td colspan="4" rowspan="4">It is recognised that there is an inter relation of this risk and risks 5 – Partnership Culture, Risk 3 Colleague Recruitment and Retention and that if risk 9 increases in likelihood that risks 3 and 5 are also likely to increase.</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>3</td><td>2</td><td>6</td><td colspan="4"></td></tr>
<tr><td>Date to Achieve Target Score</td><td>March 2025</td><td>Tolerance</td><td>6</td><td colspan="7"></td></tr>
<tr><td colspan="4">Potential or actual origin of the risk:</td><td colspan="7">Builds on previous risk relating to diversion of time due to system demands.</td></tr>
<tr><td colspan="11">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="11">Recognition that ongoing operational demands, at both Trust and system level can divert time and focus from transformational activity. There is a need to invest adequately to fund transformation.</td></tr>
<tr><td colspan="11">Links to Risk Register</td></tr>
<tr><td colspan="11"></td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1.	Executive Review of Transformation Programme	Bi monthly	Sept 23	Exec	
2.	Exec Prioritisation of transformation Programme	Annually	Feb 24	Exec	
3.	Strategic Oversight Group	Ongoing	Ongoing	Exec/Board	
4.	Board Development Time – review of Strategy Progress	March	Annual	Board	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Board Strategy Reporting	L2	Every other month	Board	Satisfactory	Incorporated into the CEO report as BAU
2	Enabling Strategies Reporting	L2	6 monthly	Relevant Committees	Satisfactory	
3	Overarching Board Strategy Reviews	L2	Annual (July 23)	Board	Satisfactory	
4	Core Strategies Reviews	L2	6 monthly	Relevant Committees	Satisfactory	
5	Urgent care transformation programme	L1	Monthly	Board/Comm		Clear governance and reporting process for the system wide urgent care transformation is in development. CEO & DS&P members of the Programme Steering Board. Not yet fully able to estimate time commitments required.

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Ensure that performance reporting is considered against impact on achieving long term strategic goals	Ongoing	Exec	Ongoing
2	Ensure that overarching Strategy achievement progress is considered to identify if performance is impacting on this risk and remedial action considered.	Strategic oversight group mapping the organisational programmes of work with the ICS clinical programme groups and ensuring alignment and attendance.	Execs	**In progress**
3	Annual strategy review took place to reconfirm overarching direction of travel and impacts of ICS strategy	Board Development session took place January & July 2023 and further sessions planned for 2024	DS&P	**In progress**
4	Full participation in the urgent care transformation programme	Newton Europe reported to Trust Board in March 23. Trust input into the delivery and governance structure now clearer.	Execs	**In progress**
5	Ensure Board Development Programme – sessions and seminars has long term strategic as well as operational focus.	Board Seminar and Development Programme Cycle for 2023/24 to be finalised and outline for 2024-25 to be developed.	DoG	**In progress**

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health
Great Place to Work</td><td>Exec Risk Owner</td><td>DoF/ CEO</td><td>Date of review:</td><td>Oct 23</td></tr>
<tr><td>Risk ID:</td><td>10</td><td>Description:</td><td colspan="3" rowspan="6">System Operation
There is a risk that controls, practices and processes are inconsistent across the ICS resulting in the Trust being impacted by risks which are not within its direct control.</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>Nov 23</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td>2023</td><td colspan="4">ICS Updates to Board.</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>3</td><td>2</td><td>6</td></tr>
<tr><td>Date to Achieve Target Score</td><td>March 2025</td><td>Tolerance</td><td colspan="3">6</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">2023 – recognises ICS Working requires best practice common systems and practices to be in place.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">There is a need for best practice common controls, practices and processes across the ICS. At this stage an understanding of this is broadly understood but actions have not been put in place to review and implement.</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10"></td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1.	Membership of ICS Board	Every other month	Sept 23	Board	
2.	Membership of ICS Strategic Executive Meetings	Ongoing	Ongoing	Exec	
3.	Finance Directors Meetings	Ongoing	Ongoing	Exec/Board	
4.	ICS Risk Reporting	Every other month	Sept 23	Board	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	ICS Reports to Board	L2	Every other month	Board		
2	Common Internal Auditors for system	L3	Ongoing	Audit Comm	Satisfactory	
3	ICS Exec Level Meetings	L1	Ongoing	Exec Level ICS Mtngs		

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Review governance controls, processes and practices for the system to ensure fully compatible	System approach to be reinforced by GHC exec & Board	CEO/DoF	**In progress**
2	Continue to monitor and promote commonality of finance controls for system	All organisations using NHSE Grip and Control checklist, Investment control mechanism in place	DoF	**In progress**
3	Continue to monitor and promote implementation of cyber controls across the system	Cyber exercise review planned cross system	DoF	**In progress**
4	Continue to monitor and promote implementation of system approach to workforce management.	Safer staffing review across ICS commenced. Commonalities across e-rostering and job planning being explored	DHR	**In progress**

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health
Great Place to Work</td><td>Exec Risk Owner</td><td>DNTQ/ DHR</td><td>Date of review:</td><td>Oct 23</td></tr>
<tr><td>Risk ID:</td><td>11</td><td>Description:</td><td colspan="3" rowspan="6">Closed Culture
There is a risk of closed cultures existing within the organisation, where problems and concerns are not openly shared and acted on, either locally and/or at a Trust level, resulting in vulnerable and isolated patient groups being at risk of harm.</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>Nov 23</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="5">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)</td></tr>
<tr><td colspan="2">Date Risk
Identified/confirmed</td><td>2023</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Target Score:</td><td>2</td><td>3</td><td>6</td></tr>
<tr><td>Date to Achieve Target Score</td><td>March 2025</td><td>Tolerance</td><td colspan="2">6</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Identified following reflection on Edenfield case, issues identified within the Trust and at other Trusts.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">The Trust has in place a range of processes to support an open culture, such as Freedom to Speak Up, Civility at Work, options to raise concerns confidentiality or via CEO or Board member, however it recognises this is an area where vigilance is required where supporting vulnerable and/or isolated patient groups.</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10">387 – Berkeley House Closed Culture</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1.	Quality Report	Aug	Monthly	Qual Comm/Board	
2.	Quality Dashboard	Aug	Monthly	Qual Comm/Board	
3.	Freedom to Speak up Policy and Processes	6 Monthly	Dec	Board	
4.	SIRI and Complaint Reporting Processes	Ongoing	Ongoing	Qual Comm/Board	
5.	Leadership Training, including reflection on mechanisms to avoid closed culture	Ongoing	Ongoing	GPTW Comm	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Safeguarding Reports	L1	Annual	Annual	Satisfactory	
2	Safeguarding Internal Audit Report	L1	Ongoing	Ongoing	Satisfactory	
3	Non-Exec Quality Visits	L2	Ongoing	Ongoing	Satisfactory	
4	Internal Audit FSU	L3	Aug 23	Audit Comm/Qual Comm	Satisfactory	
5	Clinical Issues Report	L2	Sept 23	Board	Some Concerns	Further reporting ongoing
6	Internal Audit Closed Culture	L3	Nov 23	Board	TBC	Draft to be considered by Board

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Ensure robust processes in place relating to Closed Culture at Wotton Lawn Hospital following provision of 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.	Assurance being provided through additional reporting to Quality Committee and ICB. Gloucestershire Healthwatch to complete a series of "Enter and View" to provide additional external assurance visits at WLH, seven sessions are planned to take place in October and November 2023. A range of good practice initiatives are running at WLH. A new women's garden project, recent appointment of ward-based exercise and activity practitioners, ongoing development of advanced nurse practitioners and additional psychology input; and additional training regarding reducing absconding, personalised care planning and improving therapeutic observations	DNTQ	**In progress**
2	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	Ongoing	DNTQ	**In progress**
3	Improvement Plan Berkeley House following management reviews and CQC unannounced inspection Sept 23	Review & Development of improvement plan with focus on culture ongoing.	DNTQ	**In progress**
4	Reviews of practice ongoing to identify improved ways of working & options to identify & then share good practice.		DNTQ	**In progress**
5	Ensure workforce data: clinical supervision, T&D, appraisal, length of service in one area, staff vacancies and safety incidents and complaints/concerns for areas with vulnerable or isolated patient groups regularly triangulated.	Appropriate frequency and reporting mechanism to Board committee/operational groups to be considered – potential for regular deep dives focused on closed culture risks to be assessed	Exec	
6	Action plan in place against internal audit recommendations	Internal audit in draft and under review	DoNTQ	TBC

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health
Great Place to Work</td><td>Exec Risk Owner</td><td>COO/ DHR</td><td>Date of review:</td><td>Oct 23</td></tr>
<tr><td>Risk ID:</td><td>12</td><td>Description:</td><td colspan="3" rowspan="6">Workforce Transformation – Skill Mix & New Roles
There is a risk the Trust does not invest strategically and sufficiently in colleague's development, meaning that colleagues do not develop the new skills or have the ability to undertake the transformational roles needed for the future, do not have a long-term relationship with the trust and that productivity is below target.</td><td>Lead Committee</td><td>GPTW</td><td>Date of next review:</td><td>Nov 23</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)</td></tr>
<tr><td colspan="2">Date Risk
Identified/confirmed</td><td>2023</td><td colspan="4" rowspan="4">Staff Development Budget %
Digital Budget % transformation related</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>3</td><td>2</td><td>6</td><td colspan="4"></td></tr>
<tr><td>Date to Achieve Target Score</td><td>March 2025</td><td>Tolerance</td><td>6</td><td colspan="6"></td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Reflection of need to ensure focus on transformation of staffing roles and practice.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">Recognition of need to equip colleagues for transformed ways of working to support the Trust's long term operation. Recruitment and retention challenges can potentially reduce the focus on this risk.</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10"></td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1.	Executive Review of Transformation Programme	Bi monthly	Sept 23	Exec	
2.	Exec Prioritisation of transformation Programme	Annually	Feb 24	Exec	
3.	Strategic Oversight Group	Ongoing	Ongoing	Exec/Board	
4.	Board Development Time – review of Strategy Progress	March	Annual	Board	
5.	Staffing Structure Reporting	Ongoing	Ongoing	GPTW	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Board Strategy Reporting	L2	Every other month	Board	Satisfactory	Incorporated into the CEO report as BAU
2	Quality, Finance & Workforce Reporting	L2	Monthly	Board/Related Committee	Satisfactory	Exception Reporting in place and any significant changes in performance to be considered to identify if they are being impacted by this risk.
3	Digital Strategy	L2	Annual	Board	Satisfactory	Ensure colleagues provided with best digital tools.
4						
5						

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Ensure that colleague T&D planning and budget commitment is considered through this lens to ensure there is appropriate balance between funding for statutory training and preparing colleagues for future working practice.	Reports to GPTW Committee	DNTQ DHR&OD	**In progress**
2	Ensure mechanisms in place to identify and fund the best digital tools to future proof practice. – regular best practice review in relation to digital innovation	Consider best mechanism to ensure regular review of innovative practice being developed at similar Trusts.	DNTQ DHR&OD	**Not started**
3	Consider mechanism to ensure supervision and appraisal discussions include reflection on wider opportunities within the Trust and development for future roles		DHR&OD	**Not started**

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Agreed Risk Appetite Table for Nov 2023- Mar 2025 BAF (following Risk Seminar)

Risk Theme	Appetite Level	Tolerance	Reporting Impact
Research and Innovation	High (Open)	12	Risks scored 13 and up reported
Partnership and Collaboration	High (Open)	12	Risks scored 13 and up reported
Workforce	High (Open)	12	Risks scored 13 and up reported
Quality of Care and Service User Experience	Moderate (Cautious)	10	Risks scored 11 and up reported
Meeting Population Needs	Moderate (Cautious)	10	Risks scored 11 and up reported
Finance	Moderate (Cautious)	10	Risks scored 11 and up reported
Compliance and Regulation	Low (Minimalist)	6	Risks scored 7 and up reported
Information Security (Cyber and Information Governance)	Low (Minimalist)	6	Risks scored 7 and up reported

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RISK MATRIX		LIKELIHOOD				
CONSEQUENCE		1	2	3	4	5
		Rare	Unlikely	Possible	Likely	Almost certain
5	Catastrophic	5	10	**15**	**20**	**25**
4	Major	4	8	12	**16**	**20**
3	Moderate	3	6	9	12	**15**
2	Minor	2	4	6	8	10
1	Negligible	1	2	3	4	5

KEY:	1 – 3 LOW RISK	4-6 MODERATE RISK	8-12 SIGNIFICANT RISK	15 and over HIGH RISK

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WHO	ROLE	WHEN
Audit and Assurance Committee	To ensure that overall risk management framework is in place and working effectively. For the BAF the Committee ensures that the process of identifying, naming, managing and mitigating the risks works well, and ensures Committee challenge. The Audit & Assurance Committee will consider scoring consistency.	Quarterly (each regular Meeting)
Executive Leads	Executive Leads to update the area of the BAF which they lead on in discussion with the Trust Secretary who will own the document. Updates will be kept at high level, recognising the detailed work ongoing in the Committees which is reflected, but not duplicated in the BAF.	Quarterly – as a minimum – if there is a significant change to a risk score or a new strategic risk proposed this would be brought to the next Executive meeting.
Executive Meeting	Executive to review updates within the BAF to ensure it is considered holistically and that to review and challenge scorings, particularly when a score changes or has not changed beyond the timeframe where target score was anticipated to be achieved. Overall Executive to: (i) confirm the Qtr. Risk Score (ii) to confirm whether the Risk needs to be highlighted to the Committee. (iii) Review any proposed new risks and agree proposed addition	Quarterly
Quality/Resources/ GPTW Committee	Committees to consider the Board Assurance Framework as last item on their meeting agendas to: (i) Challenge Current Risk Scores and mitigations and controls (ii) Confirm whether the Risk needs to be highlighted to the Board or whether there is sufficient assurance on ongoing work to mitigate the risk. (iii) Review any proposed new risks and agree proposed addition (iv) Confirm the risks as set out reflect relevant issues (v) Hold the Executive Lead to account for actions and progress.	Quarterly
Board	Board to consider Board Assurance Framework to confirm (i) continues to cover all risks, or agree any proposed new risks. (ii) Note progress towards mitigating strategic risks (iii) Note current position and highlight if any further action required (iv) Ensure BAF reflects current risks – informed by horizon scanning work.	6 monthly

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with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 15/1123

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 November 2023**

PRESENTED BY: Lavinia Rowsell, Director of Corporate Governance/Trust Secretary

AUTHOR: Anna Hilditch, Deputy Trust Secretary

SUBJECT: **USE OF THE TRUST SEAL – Q1 & Q2 2023/24**

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

The purpose of this report is to:

To provide information to the Trust Board on the use of the Trust Seal, as required by the Trust's Standing Orders, reference section 7.3.

Recommendations and decisions required

The Board is asked to note the use of the Trust seal for the reporting period – Quarter 1 & 2 2023/24 (1st April – 30th September 2023).

Executive summary

The Trust's Standing Orders require that the use of the Trust's Seal, be reported to the Trust Board at regular intervals. The common Seal of the Trust is primarily used to seal legal documents such as transfers of land, and lease agreements. Since the last report to the Board on the 25 May 2023, the seal has been used five times during Q1 & Q2 (1st April 2023 – 31 September 2023).

Risks associated with meeting the Trust's values

All actions have been taken in accordance with the Trust Board's Scheme of Delegation and no inherent risks are to be reported to the Trust Board in the application of the Corporate Seal.

Corporate considerations	
Quality Implications	Nil
Resource Implications	Nil
Equality Implications	Nil

Where has this issue been discussed before?

Appendices:	Appendix 1: Register of Seals (Q1 & Q2 April 2023 - September 2023)

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

APPENDIX 1

Gloucestershire Health and Care NHS Foundation Trust
Register of Seals (Q1: 1st April – 30 June 2023 – Q2: 1st July – 31 September 2023)

Seal No.	Date of Sealing	Document Description	No. of Copies	Document Signatory (1)	Document Signatory (2)	Attested by	Attested Date
34/2023 Q1	25 April 2023	**Deed of Surrender of Part and Variation** Between Invista Textiles (UK) Ltd and GHCNHSFT ***Background:*** *The deed refers to GHC's occupancy of Invista management block where the trust has agreed to surrender part of its demise. The lease will continue on mostly the same terms as those agreed in August 2019 except for the following:* • *The Trust will be giving up possession of Invista's security office which is hatched blue on Plan 2.* • *The rent has been reduced from £229,154.40 to £216,911.40.* • *The Trust has a right of entry to the security office for the purposes of complying with its obligations under the lease.*	1	David Noyes COO	Angela Potter Director of Strategy & Partnerships	Lavinia Rowsell Trust Secretary	25 April 2023
35/2023	09 May 2023	**Underlease** Between MD Morgan, SW Heginbotham, AP Gillett & CA Fisher and GHCNHSFT *relating to part second floor, St Paul's Medical Centre, 121 Swindon Rd, Cheltenham, GL50 4DP*	1	Douglas Blair CEO	Angela Potter Director of Strategy & Partnerships	Lavinia Rowsell Trust Secretary	09 May 2023
36/2023	09 May 2023	**Licence to carry out Alterations** Between Assura Properties UK Ltd and GHCNHSFT	1	Douglas Blair CEO	Angela Potter Director of Strategy & Partnerships	Lavinia Rowsell Trust Secretary	09 May 2023

Seal No.	Date of Sealing	Document Description	No. of Copies	Document Signatory (1)	Document Signatory (2)	Attested by	Attested Date
		relating to St Paul's Medical Centre, 121 Swindon Rd, Cheltenham, GL50 4DP re installation of new LED lighting					
37/2023 Q2	15 August 2023	**LEASE** of offices at Oakley Community Resource Centre, Clyde Crescent, Whaddon, Cheltenham between Cheltenham Borough Council and GHCNHSFT.	1	David Noyes COO	Neil Savage Director of HR & OD	Anna Hilditch Deputy Trust Sec	15 August 2023
38/2023	08 Sept 2023	**HM Land Registry TP1** – Title No. GR154951 Engrossment SOSH Transfer 168520 re Land at West Lodge Drive, Gloucester being part of the former Coney Hill Hospital Site (Holly House).	1	Douglas Blair CEO	John Trevains Director of Nursing, Quality & Therapies	Louise Moss Deputy Head of Corporate Governance	08 Sept 2023

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING

Wednesday 20 September 2023
Held at Brockworth Community Centre

PRESENT:	Ingrid Barker (Chair)	Chris Witham	Kizzy Kukreja
	Mick Gibbons	Jacob Arnold	Bob Lloyd-Smith
	Sarah Nicholson	Steve Lydon	Cath Fern
	Paul Winterbottom	Peter Gardner	Lisa Crooks
	David Summers	Andrew Cotterill	

IN ATTENDANCE: Steve Alvis, Non-Executive Director
Douglas Blair, Chief Executive
Nicola de Iongh, Non-Executive Director
Vicci Livingstone-Thompson, Associate Non-Executive Director
Jan Marriott, 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: Jenny Hincks, Alicia Wynn, Alison Hartless, Nic Matthews, Erin Murray, Ismail Surty, Rebecca Halifax and Laura Bailey. Apologies had also been received from Sumita Hutchison, Marcia Gallagher and Steve Brittan, Non-Executive Directors.

1.3 The Council welcomed 4 newly appointed Governors to the meeting. Lisa Crooks (Cheltenham), David Summers (Greater England & Wales) and Peter Gardner (Cotswolds) had joined the Council from 7 September. The Governors also welcomed Andrew Cotterill who joined the Council on 1 September as an Appointed Governor representing Inclusion Gloucestershire.

1.4 Ingrid Barker informed the Council that the resignation of Alan Cole (Tewkesbury) had been received earlier in the day. Alan had suffered from ill health over the past year, and he had made the decision to tender his resignation as he was unable to engage as fully as he would have wished. Colleagues wished Alan well for the future.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes from the previous meeting held on 12 July 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. There were no other matters arising. It was noted that a copy of the draft One Gloucestershire People Strategy had been circulated to Governors with the papers,

following a request at the July meeting. Any comments from Governors on the plan should be submitted to Anna Hilditch who would collate and share with the ICB.

5. GOVERNOR PRE-MEETING UPDATE

5.1 The main points covered at the pre-meeting would be picked up as part of other items on the agenda for the meeting.

6. CHAIR'S REPORT

6.1 The Council received the Chair's Report, which outlined the key activities of the Trust Chair and Non-Executive Directors up to the end of July 2023. It was noted that this report had been presented in full to the Trust Board at its meeting on 27 July.

6.2 The Council noted that it continued to be a very busy time, but the Chair's report demonstrated that some great work was taking place, both within GHC and with wider system partners.

6.3 The Chair highlighted a number of important Board development sessions that had been held in recent months including sessions on;

- *Measuring What Matters* where the importance of robust data quality and digital integration were considered.
- *Localisation* focusing on the development of a shared vision for what the role the Trust will be across the neighbourhood and locality agenda
- *Learning from Edenfield* where the Board reviewed the work the Trust was undertaking to address the risks of closed culture and reducing the use of restrictive practices.

6.4 The Chair reported that she had undertaken a joint visit with the Chair of the Acute Trust, Deborah Evans and Professor Jane Cummings, ICB Non-Executive Director to the inpatient wards treating patients with eating disorders at Gloucester Royal Hospital.

6.5 Chris Witham reported on the recent Volunteer and Expert by Experience Thank You Tea Party Celebration. The event was hosted by Ingrid Barker, and provided an opportunity to mark the NHS75 anniversary, celebrate together and to look forward to the new opportunities and ways in which people can get involved in our Trust. Colleagues had also heard some inspirational reflections on the impact that volunteers, experts by experience and peer support workers are having.

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

7. CHIEF EXECUTIVE'S REPORT

7.1 Douglas Blair provided a verbal update to the Council highlighting a number of recent developments.

7.2 Due to industrial action by junior doctors and consultants of the British Medical Association during August and September, the Trust and wider system partners had been operating a number of contingency arrangements to ensure that we are able to continue to operate safe and resilient services. Whilst the medial workforce at the Trust was limited to specific sites, ensuring appropriate medical cover during industrial action was becoming increasingly difficult but was under control.

7.3 Douglas Blair highlighted the work that the Trust had done in response to the verdict in the trial of Lucy Letby. The Department of Health and Social Care had announced an independent inquiry into the events at the Countess of Chester Hospital. Whilst waiting for the outcome of this, reviews and reflections by the Trust Board and leadership team

have commenced to address the immediate lessons with a focus on speaking up routes within the Trust. All colleagues had been reminded of these. David Summers noted the pressure that colleagues were under and asked how senior management were responding to this noting that this could impact on the likelihood of individuals raising concerns. Steve Lydon highlighted the importance of a wider understanding in relation to Equality and Diversity as an individual's background could also impact on their approach to speaking up. Douglas Blair agreed that it was important to avoid assumptions being made and that all leaders needed to continue to challenge themselves and each other to ensure that speaking up was embedded in the culture of the Trust. He assured the Council that there was an established Freedom to Speak up Guardian in place and regular reporting and oversight by the Trust Executive and Board. Jan Marriott, Non-Executive Director, highlighted her role as Speaking Up Champion for the Board.

7.4 Lisa Crooks asked how service KPIs were reviewed noting that data indicating issues at the Countess of Chester had been 'explained away'. Douglas Blair responded that this had been a topic for discussion at the recent Board development sessions on *Measuring What Matters*. Whilst data and the outcomes of serious incidents were regularly reviewed within the Trust and at Board level, this was a continuing journey to ensure that patterns of concern are spotted in a timely manner.

7.5 An update on the media coverage relating to Wotton Lawn Hospital was received. Recent coverage had focussed on the introduction of the new policing approach to attending mental health incidents – Right Care, Right Person. Douglas Blair informed the Council that discussions were ongoing between Gloucestershire Police and local health partners and any changes would be fully agreed by all partners to ensure a safe transition into any new arrangements. There were currently no changes to the arrangements in Gloucestershire. Paul Winterbottom noted that when introduced, the changes would impact on colleague workload, and workforce modelling in advance of the introduction would help to better understand this and mitigate any potential risks.

7.6 Vicci Livingstone-Thompson asked whether there would be any additional funding available to the NHS to reflect the increased workload that would result from the changes proposed. Douglas Blair responded that at this stage, no additional funding had been confirmed but this would be considered at a national level. David Summers asked how the spend of allocated mental health funding was monitored across different partners. It was noted that the Integrated Care Board would be accountable for this rather than the Trust.

8. MEMBERSHIP ACTVITY AND STATISTICS REPORT

8.1 The Council received this report which provided an update on Trust membership activity and statistics for the period up to 15 September 2023.

8.2 At the last Council meeting, an update was presented on our proposals for developing an engaged membership. The first element of this was a membership engagement exercise which took place in July. This involved writing out to all Public Members who had joined as a Member prior to March 2020, and who received communication from the Trust via post. With the assistance of the Trust's election provider, people who wished to remain as a Public Member were asked to complete and return a form to the Trust. A full breakdown of the outcome of this exercise was attached as an appendix to this report. As a result of this exercise, the Trust reduced its Public Membership from 5779 (at 27 June) to 3158 (at 2 August), a reduction of 2625 Members. It is hoped that we are a step closer to better understanding who our Public Members are, and to having Members who wish to be involved in the work of the Trust. Regular reviews of Public Membership will be carried out each year to ensure our database remains up to date and accurate.

8.3 An overview of Trust membership was presented and included a breakdown of public members by constituency, ethnicity, disability and age profile. As of 15 September, the Trust had 3182 Public members. Of these public members, 2919 receive communication from the Trust via Email.

8.4 Andrew Cotterill requested that future reports include information on how the membership ethnicity compares with that of the County. This could be useful in informing more targeted membership recruitment drives.

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

9. SERVICE PRESENTATION: FALLS REDUCTION

9.1 The Council welcomed Naymond Campbell (Lead Physio) and Brad Watkins (Matron, Charlton Lane) to the meeting.

9.2 Naymond shared that he started working at Charlton Lane hospital in September 2021 and at the time the hospital had the highest fall rates in the Trust, approx. 75 per month, despite being only a 48-bed unit. A project had been set up to better understand the reasons behind this, engaging with colleagues, reviewing policies and guidelines and benchmarking with other Trusts.

9.3 Brad shared what had been done and implemented to reduce the fall rate at Charlton Lane Hospital, highlighting the different project works streams. As a result, a 65 point action plan had been developed for Charlton Lane Hospital, which involved a monthly falls action plan review. A number of audits were also undertaken with alignment to the overall action plan. A review of the Trust Falls Policy was underway.

9.4 Since October 2021, there had been a sustained improvement in the number of falls at Charlton Lane, noting a slight uptick in mid-23 which was under review. Monthly data reviews were undertaken in which the number of falls and the level of harm were reviewed, alongside any patterns or themes occurring. Any findings were communicated with colleagues.

9.5 During discussion a number of points were raised, as follows:

- The use of artificial technology and falls technology was being considered as part of the project.

- A number of Governors highlighted the benefits of sharing the learning from this project with partners across the system including the domiciliary care market, ambulatory and fire services. Naymond confirmed that learning had been shared and links were being made via the Falls Group.

- Governors asked how colleagues from across the Trust can be encouraged to undertake quality improvement projects/activity of this nature when often very busy with business as usual activity. Naymond stressed the importance of early engagement, understanding what matters to them (this tended to be seeing improvements in patient care) and demonstrating value.

9.6 On behalf of the Council, the Chair thanked Naymond and Brad for their informative presentation. The Council was impressed with the amount of work achieved and congratulated Naymond Campbell and Brad Watkins on the progress and achievements in reducing the falls rate at Charlton Lane Hospital.

10. NOMINATIONS AND REMUNERATION COMMITTEE SUMMARY

Ingrid Barker left the meeting at this point

10.1 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 6 September 2023. Chris Witham presented this item.

10.2 Initial discussion had taken place at the Nominations and Remuneration Committee in May and June 2023, and support was given to the proposed timeline for the recruitment of a new Trust Chair, noting that Ingrid Barker's term of office as Trust Chair would come to an end in April 2024.

10.3 Since the last meeting, an Executive Search partner, Finegreen, had been selected to undertake the recruitment process on behalf of the Trust and a revised timeline had been developed. David Summers challenged the use of recruitment consultants. Graham Russell reported on the rationale for the Committee's decision is this regard and provided assurance regarding value for money for this important appointment.

10.4 The Senior Independent Director had undertaken a series of engagement events with key stakeholders and board members and their feedback had helped inform the development of the job description and person specification which was being finalised, noting that there was a national template for this.

10.5 The Nominations and Remuneration Committee received a paper which provided an update on the recruitment process and the outcome of discussions with stakeholders. Following a review of the paper and subsequent discussions, the Committee:

- noted the update provided on the recruitment process and timeline for the recruitment of the Chair
- received the feedback from the Board and Stakeholder Engagement discussions
- noted that the final job description, person specification and welcome pack were under development with the Executive Search partner, taking into account the comments and feedback received as part of the engagement process
- considered the composition of the interview panel and planned focus groups
- considered the use of psychometric testing as part of the selection process
- considered the training requirements for those Governors and colleagues participating on the formal interview panel

10.6 The Council of Governors noted this update.

Ingrid Barker rejoined the meeting at this point

11. GOVERNOR DASHBOARD

11.1 The Governors received the Governor Dashboard, presenting data up to 31 July 2023. The purpose of this dashboard was to provide a high-level overview on the performance of the Trust through the work of the Board and Committees, with particular focus on the core responsibilities of governors in holding the NEDs to account for the performance of the Board.

11.2 Following previous discussions at the Council meeting, additional information had been included within the dashboard, notably the Chief Operating Officer Report from the public Performance Dashboard which it was hoped would provide a helpful operational overview for Governors. A different "focus" piece would also be included in each future report and this dashboard included information about the important

closed culture work taking place within the Trust. Governors supported this approach.

11.3 Chris Witham noted that the number of individuals with performance plans fluctuated and was below target. The importance of individual development plans was noted and it was agreed that it was important that the Trust understand the barriers to this. It was agreed that assurance would be sought via the Great Place to Work (GPTW) Committee, and this may be a future topic for discussion as part of the Governors role in holding to account.

11.4 Kizzy Kukreja reported that she was aware, within her service, of an increase in verbal abuse directed towards colleagues. Graham Russell reported that this had been discussed in a focussed session on violence and aggression at the last GPTW Committee and an action plan was being developed.

11.5 The Governors welcomed the dashboard report.

12. HOLDING TO ACCOUNT PRESENTATION

12.1 The Council welcomed Steve Alvis, Non-Executive Director and Chair of the Mental Health Act Managers' (MHAM) Forum.

12.2 Steve Alvis informed the Council that the Forum met quarterly and reported to the Mental Health Legislation Scrutiny (MHLS) Committee which was Chaired by Sumita Hutchison, Non-Executive Director.

12.3 The role of the Mental Health Act Managers was defined in the Mental Health Act and was independent of the Trust. Managers were appointed based on their commitment, insight and empathy and understanding of how mental ill health affects daily living. MHA managers will participate in panels – these may be held as a part of a statutory review to renew a detention, section or community treatment order or a review can also be requested by an individual subject to detention. Unlike Tribunals, hearings are not judicial.

12.4 Paul Winterbottom noted the important role that MHA Managers play by providing external scrutiny and thoughtful enquiry. This was an important additional layer of assurance. Bob Lloyd-Smith shared his experience as a MHA Manager.

12.5 Steve Alvis informed the Council that recruitment for new MHA Managers was underway and that he would be happy to discuss the role further if any Governors were interested.

12.6 The Council of Governors thanked Steve Alvis for his presentation and for providing assurance on the role of the Mental Health Act Managers Forum.

13. COUNCIL OF GOVERNOR MEMBERSHIP AND ELECTION UPDATE

13.1 The Council received and noted this report which provided an update on changes to the membership of the Council of Governors and an update on progress with upcoming Governor elections.

13.2 As highlighted earlier in the meeting the Council had welcomed a number of new Governors during September. An updated membership list of the Council of Governors was included within the report for reference.

13.3 Following the resignation earlier in the day from Alan Cole, the Trust now had 3 vacant Public Governor positions. Two Governor positions would be coming to the end of their first terms in January and a nomination/election process would be set up.

These 3 vacant positions would be included in that next round commencing later in the autumn.

13.4 A new Governor Induction session had been scheduled to take place on 5th October at 4pm via MS Teams. All new Governors had already received an invitation to attend the session, however, it was noted that all Governors were welcome to attend and should contact the Assistant Trust Secretary for further details.

14. GOVERNOR QUESTIONS LOG

14.1 The Governor Questions Log is presented at each Council meeting, and any questions received between meetings would be presented in full, alongside the response for Governors' information. It was noted that no new questions had been received since the last meeting.

15. GOVERNOR ACTIVITY UPDATE

15.1 Mick Gibbons reported on the recent Governor visit to Wotton Lawn Hospital that had taken place on 15 September. Steve Lydon and Nicola de Iongh had also attended the visit. Mick Gibbons informed the Council that this visit had been a very positive experience and was timely given the media interest in the hospital which had impacted on colleagues working there. Wotton Lawn colleagues had been very welcoming and had a clear focus on patient care. The only negative point raised related to staff seniority with colleagues indicating that they would like more senior presence.

15.2 Bob Lloyd-Smith reported on his attendance at the recent NHS Providers Governor Workshop. Alicia Wynn had also attended this online workshop and a further session would be held later in the month.

15.3 Sarah Nicholson reported on a helpful Staff Governor meeting with Non-Executive Directors where the development of the dashboard had been discussed and how this might be developed to support the Governors holding to account role.

15.4 Jacob Arnold reported that he had represented the Council on the Gloucestershire Patient Participation Network. A tender exercise for a patient portal was being undertaken.

16. ANY OTHER BUSINESS

16.1 Governors were informed that a survey would be sent out to seek views on the preferred times for Council of Governor meetings in 2024. The Trust wanted to ensure that all Governors had equal opportunity to attend meetings.

16.2 The Chair reported that John Trevains, Director of Nursing, Therapies and Quality had recently tendered his resigned and a recruitment process would commence shortly for his replacement.

17. DATE OF NEXT MEETING

17.1 The next meeting would take place on Wednesday 22 November 2023 at 10.30 – 1.00pm via MS Teams.

GPTW COMMITTEE SUMMARY REPORT
DATE OF MEETING: 5 OCTOBER 2023

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

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

STAFF STORY: VIOLENCE & AGGRESSION

The Committee welcomed Val to the meeting who shared his journey of becoming an Internationally Recruited Nurse within the Trust. Val was from Zimbabwe and had always dreamed of living in the UK and becoming a nurse, however the journey to achieve this was a roller-coaster, and took a lot of hard work and persistence. Val shared the costs and commitments which were involved in achieving the necessary qualifications; and the support he had received along the way. Val spoke about when he had first joined the Trust and the experiences and challenges he encountered, which included cultural differences within the workplace. Val felt more mentorship should be available to international nurses, and shared that once he had requested a mentor he found this made life easier and was able to adjust to cultural working differences. Val asked for consideration to be given to the ongoing support of internationally recruited nurses and recommended managers attend workshops teaching how to manage the cohort and their requirements and expectations.
Val thanked the Trust for giving him the opportunity to work in the UK and shared that he was very happy to have his family with him and work and live in Gloucestershire, and his future goals were to advance further with his career and remain working for GHC. The Committee thanked Val for his inspirational story and wished him well with his future endeavours.

DEEP DIVE: EDI – WRES & WDES ACTION PLANS

The Committee received the EDI (Equality Diversity & Inclusion) WRES and WDES Action Plans, which provided an update on the Trust's planned publication of its 2023-24 Action Plan; and focussed its data return of the 2023 Workforce Equality Standard Data as follows:

- 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 the WDES was a set of ten 'metrics' plus 29 disability related survey questions. The data enabled NHS organisations to compare and contrast the workplace and career experiences of disabled and non-disabled colleagues. The WRES was a set of 9 'indicators' where the Trust; along with the NHS nationally, was mandated to show progress against these indicators.
It was highlighted the WDES and WRES key actions included growing the EDI section on the Trust intranet, links with NHS EDI Improvement Plan 2023 and the Equality Delivery System (EDS22) being created and linked with the ICB's EDI strategy at the system-wide Organisational Development Steering Group. Board members would also be required to include EDI objectives within their appraisals.

The Committee divided in to two break-out groups to discuss and consider:

1. Ensuring the Trust has a strong and clear statement on the importance of EDI for the organisation, and that this is well communicated.
2. Ensuring the agenda is embedded on each page on the Trust's strategy
3. Does the Board have a clear set of indicators and metrics in order to evidence performance was going in the right direction.
4. Whether the Board required any additional EDI training.

The Committee **noted** the report, its data and the recommended actions and **approved** the required national data upload.

ALLIED HEALTH PROFESSIONAL (AHP) STRATEGIC FRAMEWORK

The Committee welcomed Sarah Birmingham to the meeting who shared the Allied Health Professional Strategic Framework for review and endorsement.

The AHP Strategic Framework proposed 12 ambitions and 30 deliverables. These were structured within the Trust's strategic aims; High Quality Care, Better Health, Great Place to Work and Sustainability. Incorporating the framework within the Trust's structural aims would enable the Trust to be the organisation it inspires to become, with clear deliverables included to help achieve better health for the Trust's communities.

The Committee **noted** the information included within the report and **endorsed** the proposed ambitions and deliverables within the strategic framework.

FREEDOM TO SPEAK UP 6 MONTHLY REPORT

The Committee received the Freedom to Speak Up 6 Monthly Report and informed the Committee there had been 77 cases raised to the Freedom to Speak Up Guardian in 2022-23, which was a slight increase from the previous year (which was 54 cases). Three new guardians had been appointed within the ICS.

The Committee was informed the BDO internal audit on the Freedom to Speak Up, received a *substantial* opinion for both the design and effectiveness of controls in place; and that overall, there were robust Freedom to Speak Up services in place. The audit further concluded that responses to concerns raised were timely and effective, and there were several proactive measures in place to address barriers and promote a positive speaking up culture across the Trust. The Committee congratulated Sonia Pearcey for the excellent internal audit outcome. A recommendation from the internal audit was to appoint another Freedom to Speak Up Guardian, and it was reported that the business case for this was being progressed and would be received by the Executive in the upcoming months for review.

OTHER ITEMS RECEIVED

The Committee:

Received and **noted** the Colleague Engagement Update Report
Received and **noted** the Performance Report
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

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **NOTE** the contents of the report.

DATE OF NEXT MEETING	7 December 2023

MHLS COMMITTEE SUMMARY REPORT
DATE OF MEETING: 18 OCTOBER 2023

COMMITTEE GOVERNANCE	• Committee Chair – Sumita Hutchison, Non-Executive Director • Attendance (membership) – 75% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PATIENT AND CARERS RACE EQUALITY FRAMEWORK UPDATE

The Committee received an update on the Patient and Carers Race Equality Framework (PCREF). The PCREF was a recommendation following the National Mental Health Act Review in 2018; and the PCREF was the NHSE accountability framework to eliminate the unacceptable racial disparity in the Access, Experience and Outcomes (AEO) of Diverse Ethnic communities and to significantly improve their trust and confidence in mental health services. The PCREF was comprised of three components of statutory and regulatory obligations, these were:

- PCREF Part 1: Leadership and Governance
- PCREF Part 2: National Organisational Competencies
- PCREF Part 3: Patient and Carers Feedback Mechanism

The Committee was informed the PCREF would be formally launched nationally on Friday 3 November, via an NHSE webinar. The next steps of the PCREF project were shared with the Committee, and these included further cultural training and engagement mapping. A steering group was in the process of being established to ensure the alignment of workstreams to the Trust's strategic objectives; improving experiences of care for ethnic minority communities across mental health services.

CQC MENTAL HEALTH REGISTRATION IN COMMUNITY HOSPITALS TO ENABLE THE USE OF SECTION 5(2)

The Committee received the CQC Mental Health Registration in Community Hospitals to Enable the use of Section 5(2) Report, which explained why it would be helpful to be able to use section 5(2) (doctor's holding power) within the Trust's community hospitals. It was noted that this would require an addition to those hospitals' CQC registration. The Committee supported in principle and requested the report be referred to the Executives to further discuss why this had not been done before, the resource requirements and what the unintended consequences could be. The Committee **considered** whether the Trust should seek to extend the CQC registration of its community hospitals to include mental health and agreed the paper would be brought back to the next meeting for further discussion.

MENTAL HEALTH ACT MANAGERS' (MHAM) FORUM UPDATE

It was reported that six Mental Health Act Managers were in their final term of office; with five due to stand down in 2024. The Committee was referred to the current Appointment of MHA Managers policy which stated "*MHA appointments were for a fixed period of three years, and may be renewed for a maximum of three consecutive occasions, providing for a total of 12 years in the role.*" The Committee was asked to approve extending to a period

of four consecutive periods of three years, rather than the three (in the current policy). It was noted that GHC was the only Trust that had the current limitations within the policy.
The Committee supported and **approved** the proposal to extend the time in post to a period of four consecutive periods, with the caveat of annual appraisal being held to monitor performance.

REVIEW OF MCA PRACTICE, DOLS APPLICATIONS AND LPS UPDATE

The Committee received this report, which provided an update in relation to activities being undertaken within the Trust to ensure practice in relation to the Mental Capacity Act (MCA); and to provide an update of the current situation in relation to Deprivation of Liberty Safeguards (DoLS) and Liberty Protection Safeguards (LPS), in terms of current practice within the Trust, and also national developments.
An audit on MCA practice within community hospitals identified that the practice was not where it was required to be with compliance and that there was a lack of understanding of the MCA and DoLS process. Work was underway to improve this and colleagues had visited all community hospital wards and spoken about the MCA and training available. A re-audit had been carried out and the compliance had increased by 38%.
The Committee was informed of the audit of MCA and best interest forms, which looked at forms from both physical health and mental health settings. The sample was relatively small, but highlighted issues which had been observed by the MCA/LPS lead in other assessment documents she had viewed, and the overall compliance was 27%. As a result, it was reported that MCA compliance had been re-added to the Trust's risk register. A Practice Improvement Plan had been developed and was detailed in the report.
MCA level 2 training was now being rolled out to all band 6 and band 7 staff. Following the completion of band 6 staff, this would also be rolled out further to include band 5 staff.
The Committee agreed issues relating to MCA compliance would be escalated to the Executive.

OTHER ITEMS RECEIVED

The Committee:
Received and **noted** the Review of CQC Monitoring Visits
Received and **noted** the Mental Health Legislation Operational Group Update Report
Received and **noted** the AMHP Service Update Report
Received and **noted** the Receipt and Scrutiny Policy of MHA documents policy.
Received and **noted** the Renewal of Detention and Extension of CTO, policy.
Received and **noted** the Corporate Risk Register

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **NOTE** the contents of the report.

DATE OF NEXT MEETING	24 January 2023

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

COMMITTEE GOVERNANCE	• Chair – Ingrid Barker

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

This WTAC discussion-based workshop meeting took place in Walls Club, Gloucester. In addition to the members of the Committee, a further 12 Experts by Experience were invited to the attend and contributed to discussion. Outputs from the meeting were captured as themes to inform further implementation of our GHC Working Together Strategic Framework and shape our maturity matrix.

NATIONAL STANDARDS & ICS APPROACH UPDATE

Becky Parish, Associate Director, Engagement and Experience for Gloucestershire Integrated Care Board (ICB) attended the meeting to provide an overview of NHSE national guidance and standards, working with people and communities' strategy update, which included discussion on: One Gloucestershire People Panel, Insight Library, Get Involved Gloucestershire platform and engagement work with communities.

GHC WORKING TOGETHER UPDATE

Dominika Lipska-Rosecka and Julie Mackie provided an update on the GHC Working Together Strategic Plan goals and objectives, highlighting progress made. This led into the first workshop session to discuss whether we needed to change information included in the Plan to align with NHSE national guidance changes in spectrum of the involvement, ICS10 Principles and consider our next steps to implement the aims for our Plan. 3 break out groups with facilitators were provided with relevant information to allow detailed discussions and indicative voting to indicate preference for outcomes:

- Do we need to align our plan to the new diagram for the NHSE spectrum and the 10 ICS principles? Voting on Yes, No or blended model.
- What challenges might there be to progress on our goals? How can we overcome the challenges?

The presentation provoked discussion around the language and model used in the WTP spectrum of involvement. Voting indicated a preference for blending the national model and language of the WTP. It was agreed that a draft model will be developed collaboratively and presented back to the committee for approval. It was agreed that the WTP 10 step principles and ICS 10 step model provided different information that did not support blending or replacement. It was agreed that further work was required to understand change requirements. Members and Experts by Experience acknowledged progress made by the Trust Working Together objectives. Future priorities that were identified included: continued focus building relationship with communities and system partners, particularly in the VCSE sector; increasing and embedding Experts by Experience programme across services with a focus on physical health service users; and setting key objectives to build

relationships and understand needs of people and communities who are marginalised, under-represented and not accessing our services.

The Chair thanked Julie and Dominika for their presentation and the good work taking place in this area.

WORKING TOGETHER - DEVELOPING & TESTING THE MATURITY MATRIX FOR GHC

Julie Mackie (Head of Partnership) provided a short presentation about the GHC approach to self-assess and measure progress in our working together co-production objectives. There is currently no 'off the shelf provider co-production tool', the development of the GHC coproduction maturity matrix therefore represents innovative practice that has interest and support from NHSE South West Engagement Network. The GHC Maturity Matrix aims to be a practical tool to help people, teams and services reflect on their journey to meaningful co-production with people and communities, can support and identify which areas need more attention and can support teams and services to share good practice across the Trust. The draft Maturity Matrix v.1 tool presented was co-produced involving the partnership team, an expert by experience and a member of the QI Hub. Workshop session 2 involved facilitated break out groups to test, review and consider if and how the maturity matrix should be developed and implemented. Questions posed included:

- Does the matrix make sense?
- Are the maturity matrix factor the right ones?
- What evidence would you want to see to meet a level?

WTAC members and Experts by Experience welcomed the opportunity to review the maturity matrix. All agreed that further work is required to complete it, factors and dimensions were good and slight suggestion and changes were noted. Further discussion took place on what evidence will be required to meet certain levels and where and how we can trail matrix. The Chair thanked colleagues for their contributions and asked for the maturity matrix to come back to the Committee when reviewed.

ANY OTHER BUSINESS

The question was raised on how we can make sure the Experts by Experience work with people who use our services and our Colleagues can be supported and championed by our Senior Leaders. The Chair agreed to further explore how we can amplify the benefits and contributions at Exec level. The Chair thanked the Partnership team and Becky Parish (Associate Director, Engagement and Experience, ICB Gloucestershire) for the quality of the presentations, workshop format and interesting discussion that was stimulated.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

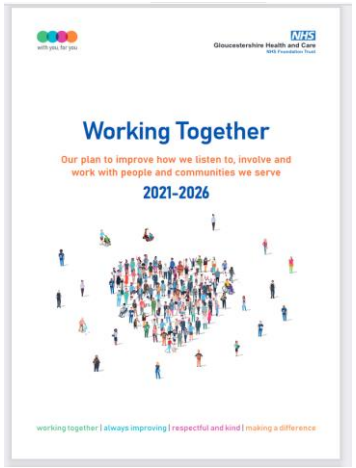
- **NOTE** the contents of the summary and to look at the themes from the workshop and asked to endorse further work on maturity matrix and alignments with line of the NHSE guidance.

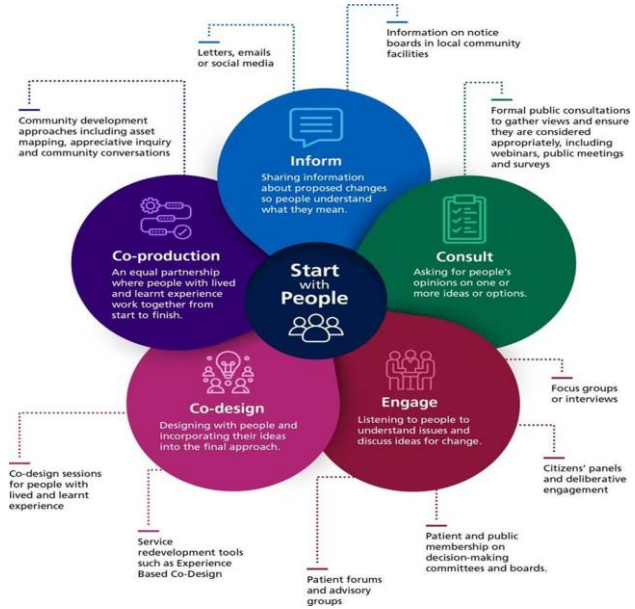
DATE OF NEXT MEETING	10 January 2024

with you, for you

Spectrum of the involvement

NHS
Gloucestershire Health and Care
NHS Foundation Trust





Main themes from workshop

- Models: very similar but different style and majority liked the flower NHSE model (start with people, suggestion that we can have 'with you for you' in centre).
- Terminology: to have a clear description for co-production, co-design, collaboration.
- Graphic: could benefit from aligning with GHC values colours.
- Examples: to include key examples for each of the part for All people to understand the spectrum.
- **Majority of the people voted for blended approach, using NHSE model and incorporating some of the language from WTP model.**

NHS

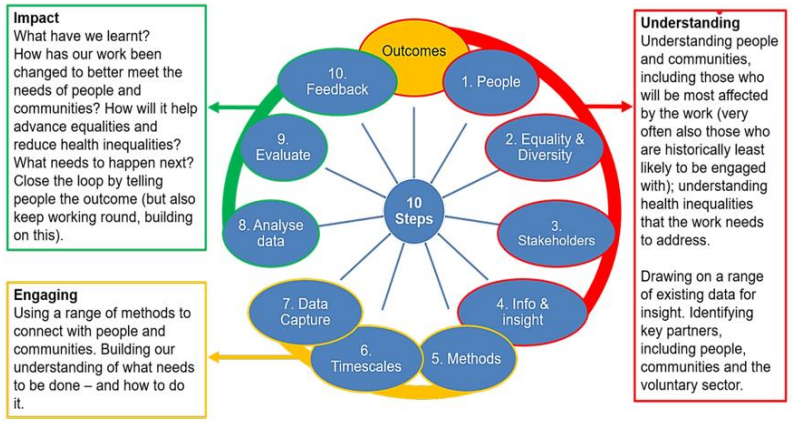
with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

10 Steps for working with people and communities

Ten ICS principles for working with people and communities[3] :

1. Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.
2. Start engagement early when developing plans and feedback to people and communities on how their engagement has influenced activities and decisions.
3. Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.
4. Build relationships with excluded groups, especially those affected by inequalities.
5. Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.
6. Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.
7. Use community development approaches that empower people and communities, making connections to social action.
8. Use co-production insights and engagement to achieve accountable health and care services.
9. Co-produce and redesign services and tackle system priorities in partnership with people and communitities.
10. Learn from what works and build on the assets of all ICS partners - networks, relationships, activity in local places.



Main themes from workshop

- Graphic: people suggested to align 10 steps model with GHC Values colours and make that more accessible.
- Language and description: people liked ICS 10 steps; logical process, just need to be clear about language and description required for each step.
- Language: people agreed that principles are must to have along with 10 steps model.
- **Voting indicated a preference for blending the national model and our model/principles for Working Together Plan.**

	MATURITY MATRIX: 6 lenses of Working Together					
	VISION	**COMMUNICATES**	**LISTENS**	**INCLUDES**	**COLLABORATES**	**EMPOWERS**
Behaviour we want to see	Everyone understands and promotes working together.	Our communication is always clear and inclusive.	We are always open and honest.	We are always open and honest.	We always involve people to enable change.	We always involve people to enable change.
Attributes	We have a culture of working together that is embedded at every level and in everything we do. We involve people and communities early when developing plans and feedback to people and communities on how their engagement has influenced activities and decisions.	We share information and communicate in a variety of different formats and languages to increase accessibility and inclusion. We provide clear and accessible public information about our vision, plans and progress.	A range of approaches are used to understand individual and community needs, experiences, ideas and aspirations for health and care. We explore learning through clear, open and honest communication. We have a “we said, we did” approach, acting collaboratively to make improvement and feedback to find out if change is working.	We build relationships with individuals and communities based on trust. We actively seek out and involve people who do not use our services, experience inequity or are marginalised to understand how we can better meet their health and care needs.	We co-produce and redesign services that are big and small, from improving letters to tackling system priorities. We work with a range of health and care sector organisations, Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.	A Personalised Care approach and a culture of partnership working is embedded in every aspect of health and care provision. We use strength-based community-centred approaches that empower people and communities. There are a range of mechanisms in place to ensure people and communities are at the centre and involved in decision making and governance.
Excelling						
Achieving						
Developing						
Exploring						

Maturity matrix feedback from workshop

The GHC Maturity Matrix aims to be a practical tool to help people, teams and services reflect on their journey to meaningful co-production with people and communities, can support and identify which areas need more attention and can support teams and services to share good practice across the Trust.

Main feedback received:

- Majority of the people agreed that factors and dimensions were good.
- People suggested that vison should be an overarching key element in matrix with 5 lenses.
- Lots of examples of potential evidence for each dimension was provided and we will explore that further.
- It was suggested that all service areas and teams should complete Maturity Matrix.
- People agreed that Maturity Matrix ensures a consistent process for assessing with clear recognition of services requiring improvement and support with the journey.
- This toolkit provides a platform for Trust to showcase and share exemplary practices and support development of Working Together champions across our organisation.

RESOURCES COMMITTEE SUMMARY REPORT
DATE OF MEETING: 1 NOVEMBER 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 6

The Committee received the Finance Report for month 6, which provided an update of the financial position of the Trust. At month 6, the surplus was £1.131m compared to a plan of £0.246m. Income from the ICB had been confirmed and there was some slippage against income in terms of expenditure received. The forecast remained break-even, and this was in line with national guidelines. The Capital Plan was £17.823m and spend at month 6 was £5.853 against a plan of £10.11m. Amendments were highlighted within the Capital Plan and it was reported maintenance schemes, x-ray equipment and the lease renewal for Avon House all were proposed to be brought forward a year. The Cost Improvement Programme had delivered £3.29m of recurring savings against a plan of £3.876m, and £2.287m of non-recurring savings compared with the plan of £2.22m.

System Risk Share slides were shared with the Committee and provided an update on the System deficit risk share. System partners had been engaged with discussions on this. Each organisation [within the System] had been set three objectives, which included two operational objectives and one relating to the financial plan. The allocation of risk share was dependent on the number of objectives delivered by each organisation. The current delivery status for each organisations objectives was noted and the Committee was informed GHC had delivered two out of three of its objectives to date.

PERFORMANCE REPORT – MONTH 6

The Committee received the Performance Report, which provided a high-level view of the key performance indicators in exception across the organization. Continued improved performance for eating disorders referral to treatment in four weeks was highlighted. It was noted that this indicator was under the threshold for the period, however consistent positive performance was seen. The Core CAMHS and CYPS LD four week wait indicators were under threshold areas in exception for the period. Bed occupancy remained high across all of the Trust's services, and this was in exception for the period. The Chief Operating Officer's Report was received and this highlighted that System pressures had increased moving in to winter and the position remained difficult to predict. Good flow through community hospitals had enabled a good number of beds, however, bed occupancy had risen to 97.9% from 94.7% in the previous month.

NATIONAL COST COLLECTION SUBMISSION

The Committee was informed the National Cost Collection had previously been referred to as Reference Costs. It is also referred to as Patient Level Information Costing System (PLICS) and is mandated as part of the NHS provider license.
The purpose of the National Cost Collection was to understand costs in detail, as the BI Team was able to generate a national average cost for different activities. This could also

be used to benchmark against national average and peers. An overview of the National Cost Collection Submission was shared, which outlined the process that takes place. The next steps were shared with the Committee, and it was reported that analysis and service engagement would take place ahead of submission and the national results would be available in April 2024. The results would be received by the Resources Committee and wider stakeholders.

EPRR CORE STANDARDS, WINTER PREPAREDNESS & RISK

The Committee received an update on the Trust's compliance against the NHSE Core Standards for Emergency Preparedness Resilience and Response for 2023/24, Winter preparedness and the EPRR risk review. This year's *confirm and challenge* session with the ICB rated the Trust as substantially compliant against the Core Standards Assurance for the 2023/24 period. The Committee noted the letter received which evidenced this. The Committee noted the content of the report and the current declared level of assurance provided.

CLINICAL SYSTEMS VISION UPDATE

The Director of Strategy and Partnerships provided a verbal update on Clinical System Visions and informed the Committee, following conversations at the Trust Board it was agreed to progress option 1B, which was to look at working with the existing two clinical systems. It had been agreed to keep the patient at the centre of the Clinical System Vision and further consensus relating to mobile working and clinical productivity.
The Committee was informed the next steps would be to develop a clear timeframe, however, it was noted that it remained unknown as to whether funding would be received.

OTHER ITEMS RECEIVED

The Committee:
Received and **noted** the Medium-Term Financial Plan update
Received and **noted** the Service Development Report
Received and **noted** the Business Planning Report
Received and **noted** the Green Plan Update
Received and **noted** the Corporate Risk Register
Received and **noted** the Board Assurance Framework
Received and **noted** the Summary Reports from the Capital Management Group, Business Intelligence Management Group, the Strategic Oversight Group and the Community Mental Health Transformation Programme

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **NOTE** the contents of the report.

DATE OF NEXT MEETING	20 December 2023

QUALITY COMMITTEE SUMMARY REPORT
DATE OF MEETING: 2 NOVEMBER 2023

COMMITTEE GOVERNANCE	• Committee Chair – Jan Marriott, Non-Executive Director • Attendance (membership) – 88% • 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. Wotton Lawn Hospital had now been formally stepped down from its period of enhanced surveillance by the ICB, and it was reported work had progressed well with patient safety, and further work was ongoing. There had been an increase in the number of Mental Capacity Act training sessions available to teams where compliance was required. The Trust had been awarded the NHSE Pastoral Care Quality award in recognition of the care and support provided to Internationally educated colleagues of the Trust. Further work was being developed to provide further assurance regarding moderate harm pressure ulcer area harms. A deep dive on pressure ulcers would be scheduled to be received by the Committee in early 2024. The Committee was informed of issues delivering the CQUIN in relation to MUST (Malnutrition Universal Screening Tool) screening in Community Hospitals and it was reported that additional support from NTQ colleagues would be provided to support this.

BERKELEY HOUSE UPDATE

The Director of NTQ provided a verbal update and informed the Committee of concerns which had been raised following an unannounced CQC inspection to Berkeley House. The Committee was informed of actions underway and was assured that concerns had been responded to rapidly. The issues identified were shared and discussed with the Committee.

GLOUCESTERSHIRE LeDeR ANNUAL REPORT

The Committee welcomed Althia Lyn, Commissioning Officer, Gloucestershire County Council to the meeting who shared the Gloucestershire LeDeR Annual Report. 52% of LeDeR reviews had been completed as of 31 March 2023. This was compared to 53% the previous year. A total of 48 reviews were reported for the LeDeR programme from 2020 to 2023. Gloucestershire had completed 83% of all reviews since the beginning of the LeDeR programme in 2017. Any reviews that were outstanding were reviews which were awaiting outcomes from other processes; including safeguarding inquiries, child death review process, coroners court or police investigations and these were placed on hold until the outcome of those investigations have taken place. The quality of the LeDeR reviews was highlighted, with 72% graded as receiving excellent or good care, and a further 20% as satisfactory. Experts by Experience were involved in the creation of learning templates, videos and webinars, ensuring resources were co-produced and inclusive. A video had been commissioned and produced by Inclusion Gloucestershire and Teach Health Citation team called *Understanding respect with a terminal diagnosis.*
The Committee was informed that a piece of work would be undertaken to have a better understanding of the national age of death being 34 years old for people with learning disabilities in minority ethnicities.

RESEARCH & DEVELOPMENT ANNUAL REPORT

The Committee received the Research and Development Annual Report, which provided an update on activity across the Trust for 2022/23, and consideration of future impacts on the team.

For 2023/24 and 2024/25 part of the budget for research and development would be funded by the commercial budget. Work had begun to develop outcomes and plans for the new strategy and to build a core research team within the Trust to support the non NIHR work. The Committee was informed of project work currently being undertaken by the Research and Development team, which included developing a service evaluation of friends and families of people with emotional complex needs and their experiences using the Trust services. Other projects included supporting people with severe mental health issues in becoming more active and also working with the ICS and the University of Glos. to develop the team's portfolio. The Committee congratulated Mark Walker and the Team for the work achieved.

MEDICINES OPTIMISATION ANNUAL REPORT

The Committee received the Medicines Optimisation Annual Report, which provided an update on medicines optimisation and medicine governance across the Trust; outlining progress made in year and also areas of development for 2023-24. As part of the 2022 CQC Trust inspection, the medicines management criteria was inspected with a focus on safety, effectiveness and leadership. The inspection report included no 'must do' actions in relation to medicines optimisation and all 'should do' actions had been addressed through the wider Trust action plan.

CHILDREN IN CARE ANNUAL REPORT

The Committee received the Children in Care Annual Report, which outlined how the children's health and care system promotes and protects the health and well-being of our children in care, in line with statutory guidance in Gloucestershire. The Permanence (adoption) Medical team had been transferred from GHFT to GHC Trust in May 2023, which provided the CAMHS team with specialist nurses and medics. Work planned to be undertaken was shared. Capacity issues were highlighted and it was reported case-loads should be 100 children per nurse, however this was currently 136 children per nurse. It was noted the main constraint was the resource to fill new posts. The Committee agreed this would be raised and discussed further at the ICB Quality Committee.

QUALITY IMPROVEMENT (QI) ACTIVITY ANNUAL REPORT

The Committee received the Quality Improvement (QI) Activity Annual Report, which provided an update on the improvement activity across the Trust during 2022/23. A huge amount of progress had been made with embedding a QI culture and approach across the organisation. The Strategic Implementation Plan would be published week commencing 9 November and this would include commitments relating to; capability, alignment, speed and control and the importance of aligning the foundational aspects of data and co-production. It was noted this mirrored the NHS England improvement approach. The Committee noted the contents of the report and key recommendations for continuing to build an embedded culture of QI.

OTHER ITEMS RECEIVED

The Committee:
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	11 January 2023

APPOINTMENTS AND TERMS OF SERVICE COMMITTEE SUMMARY REPORT

DATE OF MEETING: 8 NOVEMBER 2023

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

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

DIRECTOR OF NURSING THERAPIES AND QUALITY RECRUITMENT UPDATE

The purpose of this report was to provide an update on progress with the recruitment to the post of Director of Nursing, Therapies and Quality following the resignation of John Trevains.

At its September meeting, the Committee reviewed and supported the recommendations relating to the recruitment process, the Executive Search partner and remuneration range. Subsequent approval was also received for the job description and person specification. The vacancy and search went live w/c 9th October and closed on 5th November.

The Committee received an update following the longlisting process that had taken place the previous day. Candidates had a broad spread of backgrounds and experience which was welcomed. In terms of next steps, the Executive Search Partner would now carry out in depth candidate interviews and due diligence, and the Trust had fed in those key areas it wished to be explored further with candidates.

The Committee noted this update and the good progress that made been made in preparing a healthy longlist of candidates.

EXECUTIVE SUCCESSION PLANNING

The Appointments and Terms of Service Committee is responsible for ensuring due consideration is given, and, where possible, appropriate arrangements are in place for Executive Director succession planning. It was noted that the ATOS Committee last reviewed the Trust's Executive succession planning in July 2022. Since that time, the internal succession planning position had improved due, in part to a focus on professional development and support for senior colleagues.

The Committee reviewed and **approved** the revised Executive Succession Planning arrangements for the Trust.

EXECUTIVE PERFORMANCE REVIEW - TIMELINE

The purpose of this report was to provide an outline of the timetable for the remuneration and performance reporting to the AToS Committee for the periods 2023/24 and 2024/25 for the Executive Directors. Due to the CEO transition in April 2023, the 2023/24 schedule for the completion and reporting of reviews was adjusted to provide continuity and support an effective handover between the previous and current Chief Executive. The 2024/25 timeline sees a return to 'reporting as usual'. The mid-year Executive Director performance reviews for 2023/24 would therefore be presented to the January 2024 ATOS Committee.

EXECUTIVE REMUNERATION AND VSM GUIDANCE 2023/24

The purpose of this report was to provide an update on the most recent national very senior managers (VSMs) pay award guidance from NHS England for 2023/24 and to make a recommendation that this be applied for Executive Directors.

The Committee discussed the report and approved the national VSM recommendation for a 5% consolidated uplift to be provided to the Executives backdated to 1st April 2023, for the 23/24 financial year. The Committee also considered and agreed the recommendation that no further actions were needed with the 0.5% quantum to address pay anomalies.

CHIEF EXECUTIVE INTERIM PERFORMANCE REVIEW

The purpose of this report was to provide a summary of the performance of the Chief Executive following an interim appraisal for 2023/24 undertaken by the Chair. The review covered the period from mid-April to end September. The outcome of the discussion and progress against objectives (as agreed by ATOS in July), were set out in the report. Ingrid Barker reported that the report demonstrated a very positive first few months in the role with significant progress being evidenced against all objectives. The Committee welcomed this positive mid-year appraisal report.

CHIEF EXECUTIVE REMUNERATION

The purpose of this report was for the Committee to consider the remuneration of the Chief Executive in line with the summary of the 2023/24 VSM pay guidance as presented as an earlier item on the agenda. The Committee discussed this report and approved the recommendations set out.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

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

DATE OF NEXT MEETING	16 January 2024

AUDIT & ASSURANCE COMMITTEE SUMMARY REPORT
DATE OF MEETING: 9 NOVEMBER 2023

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

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

INTERNAL AUDIT – BDO

The Committee **noted** the Internal Audit Progress Report, which detailed the progress made towards the 2023/24 internal audit plan. No issues were raised.

The Committee **received** and considered the following internal audit reports:

- Consultant Job Planning - this was scored moderate for both design opinion and design effectiveness; with three medium and one low recommendations.
- E-Rostering - this was scored moderate for both design opinion and design effectiveness; with three medium and one low recommendations.
- Business Planning - this was scored moderate for both design opinion and design effectiveness; with three medium and one low risk finding.

Assurance was received from Executive Leads (of the internal audits undertaken) that recommendations were being actioned and work was being progressed.

The Committee **noted** the progress made by the Trust in implementing prior year recommendations. 24 recommendations were due and nine recommendations across five different audits had been signed off as complete.

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 August 2023, it was reported work was progressing well. Four new allegations of fraud had been received since the previous meeting of the Committee.

The Committee **received** the Conflict of Interest Report, which provided a review of compliance of with the Trust's Conflict of Interest Policy, and the accuracy of the returns. The report was classified as medium risk; however, assurance was provided that the Trust had a made significant progress and was in a positive position in relation to peers.

The Committee **received** the Single Tender Waiver Report, which provided benchmarking against 55 other healthcare organisations; a 20% reduction in waivers used since 2021/22 and also a 33.5% reduction in total spend authorised via single tender waivers since 2021/22 was highlighted.

The Committee **noted** the contents of the reports provided.

FINANCE COMPLIANCE REPORT

The Committee received the Finance Compliance Report and it was reported debtors had increased from £1.05m in June to £7.4m. The Committee was informed that regular

discussions were taking place to resolve this. There had been two SFI breaches since the last meeting of the Committee.

CYBER SECURITY ASSURANCE REPORT

The Committee **received** and **noted** the Cyber Security Assurance Report, which provided an update on the latest position for Cyber Security for the Trust and wider system. Ongoing cyber projects were highlighted to the Committee. The results of the recent Trust-wide phishing test were highlighted noting a slight improvement in compliance rates. Further targeted training was being provided

AUDIT & ASSURANCE COMMITTEE ANNUAL EFFECTIVENESS REVIEW & TERMS OF REFERENCE

The Committee **received** and **noted** the positive outcome of the annual evaluation process. Minor changes to the terms of reference were agreed. The Committee agreed areas of focus for 2023/24 would include cyber security and mental health services.

REVIEW OF EXTERNAL AUDITOR EFFECTIVENESS

The Committee **received** the outcome of the annual internal assessment of the performance of the external auditors – KPMG. Responses received from showed strong levels of satisfaction with KPMGs performance, and overall, the Committee was satisfied with the service provided.

OTHER ITEMS RECEIVED

The Committee **received** and **noted** the following reports:

- External Audit Progress Update and Technical Update Report
- Corporate Risk Register
- Board Assurance Framework
- Summary Report of the Information Governance Group
- Buildings Environment & Medical Equipment (BEME)
- Summary Report of the Health & Safety & Security Management Group

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **NOTE** the contents of the report.

DATE OF NEXT MEETING	8 February 2024