2GETHER NHS FOUNDATION TRUST

BOARD MEETING

THURSDAY 30 MARCH 2017 AT 10.00AM

BUSINESS CONTINUITY ROOM, RIKENEL

AGENDA

10.00	1	**Apologies**	
	2	**Declaration of Members Interests**	
10.05	3	**Minutes of the Board meeting held on 26 January 2017**	**PAPER A**
	4	**Action Points and Matters Arising**	
10.10	5	**Questions from the Public**	
IMPROVING QUALITY			
10.15	6	**Patient Story Presentation**	**VERBAL**
10.45	7	**Performance Dashboard Report – January 2017**	**PAPER B**
10.50	8	**Safe Staffing 6 Monthly Update**	**PAPER C**
11.00	9	**Service Experience Report – Quarter 3**	**PAPER D**
11.10	10	**Quality Report – Quarter 3**	**PAPER E**
11.20	11	**Non-Executive Director Audit of Complaints – Quarter 3**	**PAPER F**
BREAK – 11.30AM			
IMPROVING ENGAGEMENT			
11.40	12	**Chief Executive's Report**	**PAPER G**
11.50	13	**Annual Staff Survey Results**	**PAPER H**
IMPROVING SUSTAINABILITY			
12.00	14	**Summary Financial Report**	**PAPER I**
12.05	15	**Board Committee Summaries** • Audit Committee – 1 February • Charitable Funds Committee – 1 February • Delivery Committee – 22 February and 24 March (Verbal) • Governance Committee – 17 February • MHLS Committee – 8 March	 **PAPER J1** **PAPER J2** **PAPER J3** **PAPER J4** **PAPER J5**
INFORMATION SHARING (TO NOTE ONLY)			
12.25	16 17	**Chair's Report** **Council of Governor Minutes – January 2017**	**PAPER K** **PAPER L**
12.30	18	**Any Other Business**	
	19	**Date of Next Meeting** Thursday 25 May 2017 at The Kindle Centre, Hereford	

QUESTIONS FROM THE PUBLIC

Written questions for the Board Meeting

People who live or work in the county or are affected by the work of the Trust may ask:

- the Chairperson of the Trust Board;
- the Chief Executive of the Trust;
- a Director of the Trust with responsibility; or
- a chairperson of any other Trust Board committee, whose remit covers the subject matter in question;

a question on any matter which is within the powers and duties of the Trust.

Notice of questions

A question under this procedural standing order may be asked in writing to the Chief Executive by 10 a.m. 4 clear working days before the date of the meeting.

Response

A written answer will be provided to a written question and will be given to the questioner and to members of the Trust Board before being read out at the meeting by the Chairperson or other Trust Board member to whom it was addressed.

Additional Questions or Oral Questions without Notice

A member of the public who has put a written question may, with the consent of the Chairperson, ask an additional oral question on the same subject. The Chairperson may also permit an oral question to be asked at a meeting of the Trust Board without notice having been given.

An answer to an oral question under this procedural standing order will take the form of either:

- a direct oral answer; or
- if the information required is not easily available a written answer will be sent to the questioner and circulated to all members of the Trust Board.

Unless the Chairperson decides otherwise there will not be discussion on any public question.

Written questions may be rejected and oral questions need not be answered when the Chairperson considers that they:

- are not on any matter that is within the powers and duties of the Trust;
- are defamatory, frivolous or offensive;
- are substantially the same as a question that has been put to a meeting of the Trust Board in the past six months; or
- would require the disclosure of confidential or exempt information.

For further information, please contact the Assistant Trust Secretary on 01452 894165

[2]GETHER NHS FOUNDATION TRUST

BOARD MEETING
BUSINESS CONTINUITY ROOM, RIKENEL
26 JANUARY 2017

PRESENT

Ruth FitzJohn, Trust Chair
Maria Bond, Non-Executive Director
Marie Crofts, Director of Quality
Dr Chris Fear, Medical Director
Marcia Gallagher, Non-Executive Director
Andrew Lee, Director of Finance and Commerce
Jane Melton, Director of Engagement and Integration
Colin Merker, Director of Service Delivery/Deputy Chief Executive
Quinton Quayle, Non-Executive Director
Nikki Richardson, Non-Executive Director
Neil Savage, Director of Organisational Development
Duncan Sutherland, Non-Executive Director
Jonathan Vickers, Non-Executive Director

IN ATTENDANCE

Ron Allen, Tewkesbury Borough Council
Hilary Bowen, Trust Governor
Anna Hilditch, Assistant Trust Secretary
Frances Martin, Director of Transformation
John McIlveen, Trust Secretary
Bren McInerney, Member of the Public
Helen Munro, Member of the Public
Kate Nelmes, Acting Head of Communications
Carol Sparks, Director of Special Projects
Ian Stead, Healthwatch Herefordshire

1. WELCOMES, APOLOGIES AND INTRODUCTIONS

1.1 Apologies were received from Shaun Clee.

2. DECLARATIONS OF INTERESTS

2.1 There were no new declarations of interests.

3. MINUTES OF THE MEETING HELD ON 24 NOVEMBER 2016

3.1 The minutes of the meeting held on 24 November were agreed as a correct record.

4. MATTERS ARISING AND ACTION POINTS

4.1 The Board reviewed the action points, noting that these were now complete or progressing to plan. There were no matters arising.

5. QUESTIONS FROM THE PUBLIC

5.1 Bren McInerney said that he was not always able to attend the Trust Board meetings but he always read the papers and he said that he was proud of Board members for always responding to key questions and never being defensive. Ruth FitzJohn thanked Bren for his kind comments.

6. PATIENT STORY PRESENTATION

6.1 At the start of each Board meeting it was tradition for a service user or carer to attend and to speak to Board members about their personal experiences of Trust services. The Director of Engagement and Integration informed the Board that it had not been possible on

this occasion to get someone to attend the meeting; however, discussions were currently taking place to develop further ways of hearing from people who use Trust services at the start of the Board meeting. An alternative format was proposed for this meeting whereby the Board would hear about some actual complaints that had been received by the Trust. The Director of E&I said that it was important to hear about those areas where the Trust was not doing as well and it was vital to learn from complaints.

6.2 The Board was asked to note that each of the complaints contained no personal information and the individuals involved could not be identified. The complaints would also be read out verbatim using the complainants own words.

6.3 The first complaint related to someone being "forced to go into a mental health unit in the wrong town". The Board noted that the circumstances into this complaint had been fully investigated. There had been a need to detain the person under the MHA and at the time there had been no bed available in their hometown. However, after a few weeks the patient was transferred to a local unit when a bed became available, despite the patient stating that they did not want to be moved to a different unit. The decision to transfer the patient to a local unit was made to ensure that the Trust could provide required care and support locally.

6.4 The second complaint was received from the wife of a patient who stated that they had been very grateful for the care that they had received; however, on returning to hospital after planned leave, the patient's room, perceived as a safe haven, had been given to someone else. The complaint made clear that this had been a big setback in the patient's recovery and urged the Trust to ensure that advance notice was given in such circumstances in future.

6.5 The final complaint came from a service user who had contacted Let's Talk asking for help. They did not know what help they needed and wanted guidance from the member of staff. The patient had not felt guided by the member of staff and they reported that the contact had made them feel worse.

6.6 Board members were given some time to reflect on the key messages from these complaints and then it was opened up for discussion.

6.7 In terms of the Let's Talk complaint, the Deputy Chief Executive assured the Board that the complaint was fully investigated and the service user was contacted, received an apology and was given the necessary support. It was noted that the screening process for IAPT services aims to work with people with mild to moderate anxiety and depression. The screening will take place over the phone but there are a number of different options that people can chose including online courses and books on prescription. It was acknowledged that some people could find making decisions difficult and the Deputy CEO advised that a lot of work was taking place to look at IAPT services currently and a number of changes had been made to the care pathway in terms of the screening and assessment process.

6.8 Jonathan Vickers said that he was surprised and concerned about the complaint regarding the return from leave only to find the patients room had been used for another patient. The Director of Quality advised that in times where bed occupancy levels are high, this can occur. However, she said that the key issue related to the communication and the failure here which led to the returning patient and his carer not being told of the situation before coming back to the unit.

6.9 Quinton Quayle suggested that all three of the complaints involved "softer" issues and demonstrated a failure to communicate properly with our service users in these instances.

This raised the importance of communication and engaging with people as individuals, providing personalised communication and not treating all people as part of a script, the need to listen to patients and to remember the underlying feelings of that person, to make people feel valued.

6.10 Maria Bond suggested that this exercise had been very valuable and asked that consideration be given to including a similar session at each corporate induction session for new staff. The Board agreed that this would be a very helpful development and asked for this to be considered further.

ACTION: Consideration to be given to including a patient focused/summary of complaints session at each Corporate Induction

6.11 Bren McInerney said that he had found this session to be very powerful and agreed that the key message that had arisen related to effective communication. He added that there was more work to be done to identify and seek feedback from those people who didn't complain.

6.12 Ruth FitzJohn thanked the Director of E&I for leading the session and noted that Board members would have the opportunity to reflect further on the key points raised in the confidential Board meeting later in the day.

7. PERFORMANCE DASHBOARD

7.1 The Board received the performance dashboard report which set out the performance of the Trust for the period to the end of November 2016 against NHSI, Department of Health, Contractual and CQUIN key performance indicators. Of the 147 performance indicators, 87 were reportable in November with 71 being compliant and 16 non-compliant at the end of the reporting period. Where performance was not compliant, Service Directors are taking the lead to address issues with a particular focus continuing to be on IAPT services which account for 8 of the 16 non-compliant indicators. Maria Bond assured the Board that work was ongoing in accordance with the agreed Service Delivery Improvement Plans to address the underlying issues affecting this IAPT performance and detailed reports continue to be received and scrutinised at monthly Delivery Committees.

7.2 Maria Bond informed the Board that she was very pleased to see that everything not being achieved in the performance dashboard had a plan of action and was being actively challenged.

7.3 The Board was informed that the Delivery Committee the previous day had received the quarterly CYPS waiting list management report. Much progress had been made on managing the waiting lists, with focused reports being presented over the last 2 years and performance was now being achieved. It was excellent to note therefore that the Committee had closed down this report and had congratulated the CYPS team for this achievement.

7.4 The Board noted the dashboard report and the assurance that this provided.

8. SMOKEFREE IMPLEMENTATION UPDATE

8.1 The purpose of this report was to update the Trust Board on the progress of the implementation of the smoke free guidance that was proposed to be introduced in April 2017 across 2gether Trust sites.

8.2 The Director of Quality advised that the Trust remained on plan to implement a smoke free environment from April 2017 and continued to gain intelligence from other Trusts who have already implemented this guidance. A number of work streams continue to deliver outputs and key risks and issues have been identified and mitigated against.

8.3 The Board was asked to note the three main risks within the implementation process:

- Training – Training, especially for in-patient staff, is crucial to the success of the implementation of the project. A trainer to deliver the training has now been identified and training dates have been advertised (within Gloucestershire). However release of staff from clinical duties to attend training remains a risk and the Deputy Director of Nursing is now directly managing the overall implementation of the programme and closely monitoring delivery of the training plan. Mental Health Trusts who have been successful with smoke free implementation have stressed the importance of training and in some cases the implementation has failed due to the lack of training.

- Culture – Smoking within the mental health community is much greater than within the general population. Mental Health Trusts who have successfully implemented smoking cessation all report that this is challenging to the long-standing culture. Therefore the Trust has acknowledged this and is putting in place ways of supporting our staff and service users who smoke. This is the start of the Trust's smoke free journey, and we will continue to work with staff and service users to help them to quit smoking. The Chief Nursing Officers (CNO) office has approached the Trust to take part in a national programme to support us with our smoke free journey which we are now pursuing with NHSE.

- Costs – There are potentially significant cost implications with the supply of Nicotine Replacement Therapy (NRT). The Executive team has been tasked with modelling this further based on up to date information from other Trusts and further data from within our own inpatient units.

8.4 Ruth FitzJohn informed the Board that 2gether would not receive any funding from Gloucestershire County Council's Public Health Smoking Cessation work for its inpatient units. She said that this was very disappointing and was a stark example of disadvantaging and discriminating against mental health service users. The Board noted that the Director of Finance would be writing to both Gloucestershire and Herefordshire County Councils about funding for inpatient services and asking them to reconsider their position. Bren McInerney said that he was very disappointed to hear of this decision by Gloucestershire CC and he agreed to contact Health England to raise this matter with them.

8.5 Quinton Quayle asked whether the implementation of smokefree had received staff support. He had carried out a recent visit to Wotton Lawn and members of staff had expressed a number of concerns to him, including fire risks of patient smoking in their rooms, an increase in the number of absconsions and fewer self-referrals. The Director of Quality said that she had spoken to staff about these concerns but agreed that more was needed to step up this engagement with staff, including the presentation of research and learning from other Trusts. The Director of Quality assured the Board that the Head of Estates was fully involved with the Smokefree work and had been focusing on fire alarms and smoke alarms, using the learning from elsewhere of what worked well.

8.6 The Medical Director informed the Board that he agreed with the implementation of smokefree environments; however, he said that there were a number of clinical issues that needed to be considered which he was aware were being addressed by the project group.

These included a possible increase in MHA detentions due to people not wishing to be admitted as they would be unable to smoke and the effect of smoking on the metabolism and the potential impact on patients taking tablets. He also suggested that some studies had indicated that nicotine had a positive effect on people with schizophrenia.

8.7 The Board noted the report and the associated risks highlighted with the implementation of Smokefree. Work continued and the Board supported the ongoing implementation of the smoke free guidance.

9. COMPLIANCE WITH STATUTORY AND MANDATORY TRAINING

9.1 The Director of Organisational Development presented this report which provided an update on progress towards delivering improved compliance for staff statutory and mandatory training.

9.2 Training compliance was 80% in December 2016. Reported compliance tallied with the draft results from the 2016 Staff Survey, which suggested that 80% of staff had received training, learning or development in the previous 12 months. Additionally, 86% of staff felt that this had helped them to do their jobs more effectively.

9.3 As a key part of the Trust's delivery strategy, we have focused on implementing the Learn2gether system to deliver, record and report on compliance.

9.4 Additional work has been identified to improve compliance going forwards. This includes:

- the further development of Learn2gether functionality and use
- a review with external benchmarking on our future approach to compliance targets
- the option to develop a new governance mechanism for overseeing, challenging and confirming the inclusion of training as either statutory or mandatory, its content, delivery methodology, duration, frequency and its on-going review.

9.5 Quinton Quayle noted the issues around low training compliance by bank staff. The Director of OD assured the Board that there was a workstream focusing on this and the work that needed to be put in place to increase this compliance. Carol Sparks informed the Board that all Trust staff received the necessary statutory and mandatory training at Corporate Induction. The issue with compliance related more to staff receiving refresher training, rather than never having received the training at all. The Director of OD added that the Trust was unlikely to be fully compliant as clinical responsibilities would always take priority over training. However, he assured the Board that all staff had the necessary competencies to carry out their roles.

9.6 As part of the STP work, the Board noted a proposal for 'Passports' for staff which would list all training and when a member of staff moved from one NHS organisation to another, their training compliance would move with them.

9.7 Nikki Richardson said that the Delivery Committee had received increased assurance around the accuracy of data held in the Learn2gether system. This was excellent news. The Delivery Committee and the Service Directors in particular would continue to focus on the 'hot spots' at each meeting, such as fire training and Positive Behavioural Management (PBM). Maria Bond added that there was good ownership of training and appraisal compliance within the localities and great progress had been seen.

9.8 The Board noted the progress being made towards improving compliance with statutory and mandatory training and supported the further work identified, noting that this would continue to be monitored at the Delivery Committee.

10. CHIEF EXECUTIVE'S REPORT

10.1 The Deputy Chief Executive presented this report to the Board which provided an update on key national communications via the NHS England NHS News and a summary of key progress against organisational major projects.

10.2 The Board noted the extensive engagement activities that had taken place during the past month, and the importance of these activities in order to inform strategic thinking, raise awareness of mental health, build relationships and influence the strategic thinking of others. The Deputy Chief Executive advised that this report offered the Board significant assurance that the Executive Team was undertaking wide engagement; however, it only offered limited assurance on the effectiveness of that engagement.

10.3 In terms of the Improving Care through Technology (ICTT) project, the Board noted that activity in Herefordshire had now transitioned out of project and into 'Business As Usual' and were being managed by Countywide IT Services' operational teams. In Gloucestershire, the project team has been deploying laptops to colleagues since the beginning of December, in a similar fashion to the approach taken in Herefordshire. These sessions will continue until the end of January, after which time up to date computers will have been deployed to the majority of Gloucestershire based colleagues.

10.4 Progress with the development of the Gloucester City Hub continues, with the project having now reached the stage where tenders have been invited from a list of selected contractors. This stage will be completed by mid-February and, following a period of time to analyse the tenders, a contractor should be appointed in early March. The overall project programme and the budget have been reviewed in the light of emerging information and the works are now programmed for completion in autumn 2017.

10.5 The Board noted that 2gether had been working with NHSE and the University of Gloucestershire on the development of Nurse Associate roles. These would be registered roles following a 2 year qualification. There had been some good collaborative working and adverts for 5 posts in Herefordshire and 10 in Gloucestershire had been published.

10.6 The Director of OD informed the Board that a new Gloucestershire Social Partnership Forum (SPF) had been launched, with employers and trade union representatives meeting to drive forward key workforce issues. This would be a monthly meeting and the Director of OD noted that there was a good level of energy and enthusiasm for this. An SPF was already in place in the West Midlands.

10.7 The Board noted the Chief Executive's report

11. SUMMARY FINANCIAL REPORT

11.1 The Board received the month 9 position which was a surplus of £293k in line with the planned position. The budgets have been revised to include the £650k Sustainability and Transformation Fund monies that have been allocated to the Trust. Three quarters of this fund have been included at the month 9 position. The Trust was allocated £650k from the Sustainability and Transformation Fund (STF) by NHS Improvement. The Trust also had its 2016/17 control total of a surplus of £4k adjusted upward by £650k to a revised 2016/17

revenue control total of £654k surplus. Despite a number of cost pressures arising in recent weeks the Trust anticipates it will still meet its financial control total. The Trust has recently introduced tight controls on discretionary spend for the remainder of the financial year. The month 9 forecast outturn is a £654k surplus, excluding impairments, as per the revised revenue control total and Trust budgets. The Trust is anticipating it will meet its targets and receive the full allocation from the STF.

11.2 NHS Improvement introduced a new Oversight Framework from the 1st October 2016. Under this framework the Trust has been informed that our segment is a 2, with 1 being the highest score, 4 being the lowest.

11.3 The Trust has a revised forecast agency spend taking into account the impact of the considerable number of actions taken of £4.812m at month 9, which is above the £3.404m control in 2015/16. This equates to achievement of 33% of NHS I's required reduction in agency spend in 2016/17. The Trust has seen a recent increase in agency spend due to the need to recruit additional staff to meet IAPT targets and in order to cover medical staffing vacancies.

11.4 The Trust has nearly completed budget setting for next year following submission of the Operational Plan in December, and has updated its financial projections for the next five years in this report. The Trust has signed two year contracts with its three main commissioners for 2017 to 2019.

12. BOARD COMMITTEE REPORTS – DELIVERY COMMITTEE

12.1 Maria Bond presented the summary report from the Delivery Committee meeting held on 23 November. The Board noted the key points raised at this meeting and the assurance received by the Committee.

12.2 Maria provided a verbal report from the Delivery Committee meeting held on 25 January. A full written report would be presented at the next Board meeting. Some of the key highlights from the meeting included:

- 77% of staff had received the flu vaccination against the 61% national target which was excellent
- The Committee had signed off the CYPS waiting list management report, noting the huge progress made in this area
- A benchmarking report was received and a further report focusing on some key indicators would be presented back to the Committee in March
- The Locality budgets had not been adjusted during 2016/17 as agreed; however, the Committee received assurance that this would be taking place from April onwards.
- The Committee received a focused report looking at the workforce pressures in Herefordshire, and it had been agreed to add this to the Corporate Risk Register

13. BOARD COMMITTEE REPORTS – GOVERNANCE COMMITTEE

13.1 Nikki Richardson presented the summary reports from the Governance Committee meetings that had taken place on 18 November and 16 December 2016. The Board noted the key points raised during these meetings and the assurance received by the Committee.

13.2 Nikki Richardson advised that a Quality and Clinical Risk Sub-committee (QCR) would be established from January 2017. This would further strengthen the clinical governance structure for the Trust and provide opportunity for locality governance leads to have a more in depth debate about issues or concerns. In addition it would allow for scrutiny and

challenge with all exceptions reported to the Governance Committee. Meetings of the QCR Sub-Committee would take place monthly, with the Governance Committee meetings held bi-monthly from February to follow the QCR meetings. These new arrangements would be reviewed in 6 months' time to determine whether they were adding value and to ensure that robust quality and clinical risk mechanisms were in place.

14. BOARD COMMITTEE REPORT – MH LEGISLATION SCRUTINY COMMITTEE

14.1 Quinton Quayle presented the summary reports from the MHLS Committee meetings that had taken place on 9 November and 11 January. The Board noted the key points raised during these meetings and the assurance received by the Committee.

14.2 The Board noted that an Operational Group composed of key staff dealing with MHLS issues had been set up. It would meet bi-monthly between the MHLSC meetings and it was hoped that the Group would resolve outstanding points on the Action Log. The Group would look at what CQC inspectors were focusing on and how the Trust could prepare better for inspections. The Committee decided that it was not necessary at this stage to establish formal terms of reference for the Operational Group, though it would look again at this if necessary.

15. INFORMATION SHARING REPORTS

15.1 The Board received and noted the following reports for information:

- Chair's Report
- Council of Governors Minutes – November 2016
- Use of the Trust Seal Q3 2016/17

16. ANY OTHER BUSINESS

16.1 There was no other business.

17. DATE OF THE NEXT MEETING

17.1 The next Board meeting would take place on Thursday 30 March 2017 at Trust HQ, Rikenel, Gloucester.

Signed: …….. **Date: …….**
Ruth FitzJohn, Chair

BOARD MEETING
ACTION POINTS

Date of Mtg	Item ref	Action	Lead	Date due	Status/Progress
26 Jan 2017	6.10	Consideration to be given to including a patient focused/summary of complaints session at each Corporate Induction	Neil Savage	March	**Complete** We have revised the corporate induction to include this. The Service Experience and Social Inclusion teams are finalising the new session over the next fortnight and the new content will be launched at the first induction session in May.

Agenda item 7 **Enclosure Paper B**

Report to:	2gether NHS Foundation Trust Board – 30 March 2017
Author:	Chris Woon, Head of Information Management and Clinical Systems/Colin Merker Director of Service Delivery
Presented by:	Colin Merker Director of Service Delivery
SUBJECT:	**Performance Dashboard Report for the period to the end of January 2017**

This Report is provided for:

Decision Endorsement **Assurance** **To Note**

EXECUTIVE SUMMARY:

Overview

This month's report sets out the performance of the Trust for the period to the end of January 2017 against our NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

Of the 147 performance indicators, 87 are reportable in January with 74 being compliant and 13 non-compliant at the end of the reporting period.

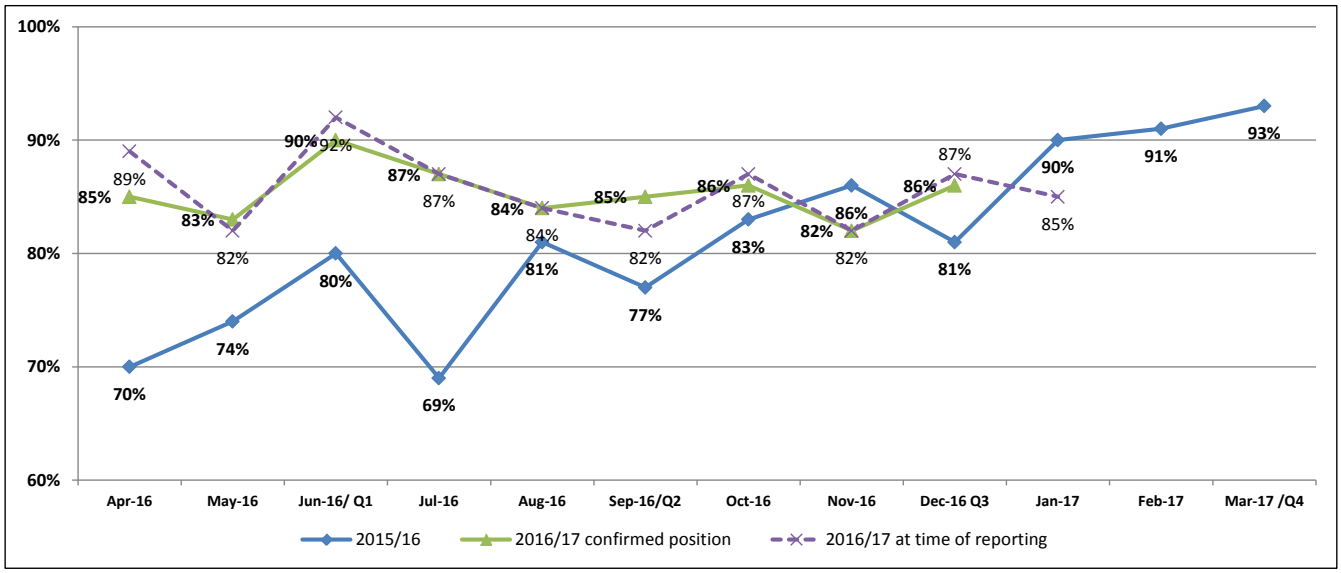
Where performance is not compliant, Service Directors are taking the lead to address issues with a particular focus continuing to be on IAPT services which account for 7 of the 13 non-compliant indicators (1.09, 1.10, 3.18, 3.19, 3.30, 5.08 and 5.09). Work is ongoing in accordance with our agreed Service Delivery Improvement Plans to address the underlying issues affecting this performance.

A red flag '⚑' continues to be placed next to indicators where further analysis and work is required or ongoing to fully scope potential data quality or performance issues.

The following table summarises our performance position as at the end of January 2017 for each of the KPIs within each of the reporting categories.

Indicators Reported in Month and Levels of Compliance							
Indicator Type	Total Measures	Reported in Month	Compliant	Non Compliant	% non-compliance	Not Yet Required	NYA / UR
NHSi Requirements	13	13	10	3	23	0	0
Never Events	17	17	17	0	0	0	0
Department of Health	10	8	6	2	25	2	0
Gloucestershire CCG Contract	56	16	13	3	19	40	0
Social Care	15	13	10	3	23	2	0
Herefordshire CCG Contract	25	20	18	2	10	5	0
CQUINS	11	0	0	0	0	11	0
Overall	147	87	74	13	15	60	0

The following graph shows our percentage compliance by month and the previous year's compliance for comparison. The line "2016/17 confirmed position" has been added to show the confirmed position of our performance. This is reported a month in arrears to enable late data entry/late data validation to be taken into account.



The confirmed position for December is 86% which has fallen from 87% due to the MRSA incident on Willow Ward of which details are given in the Gloucestershire CCG Contractual section of this report.

Summary Exception Reporting

The following 13 key performance thresholds were not met for January 2017:

NHS Improvement Requirements

- 1.07 – New psychosis (EI) cases as per contract
- 1.09 – IAPT: Waiting times - Referral to Treatment within 6 weeks
- 1.10 – IAPT: Waiting times - Referral to Treatment within 18 weeks

Department of Health Requirements

- 2.21 – Number of under 18s admitted to adult inpatient wards
- 2.26 – Interim report for all SIs received within 5 working days of identification

Gloucestershire CCG Contract Measures

- 3.18 – IAPT recovery rate : Access to psychological therapies should be improved
- 3.19 – IAPT Access rate : Access to psychological therapies should be improved
- 3.30 – MHICT (IAPT/Nursing Integrated service): 14 days from referral to screening assessment.

Social Care –Gloucestershire CCG Contract Measures

- 4.03 – Ensure that reviews of new packages take place within 12 weeks
- 4.06 – Percentage of service users asked if they have a carer
- 4.07 – Percentage with a carer that have been offered a carer's assessment

Herefordshire CCG Contract Measures

- 5.08 – IAPT Recovery rate – those who have completed treatment and have "caseness"
- 5.09 – IAPT maintain 15% of patients entering the service against prevalence

RECOMMENDATIONS

The Board is asked to:

- Note the Performance Dashboard Report for January 2017.
- Accept the report as a significant level of assurance that our contract and regulator performance measures are being met or that appropriate action plans are in place to address areas requiring improvement.
- Be assured that there is ongoing work to review all of the indicators not meeting the required performance threshold. This includes a review of the measurement and data quality processes as well as clinical delivery and clinical practice issues.

Corporate Considerations	
Quality implications:	The information provided in this report is an indicator into the quality of care patients and service users receive. Where services are not meeting performance thresholds this may also indicate an impact on the quality of the service / care we provide.
Resource implications:	The Information Team provides the support to operational services to ensure the robust review of performance data and co-ordination of the Dashboard
Equalities implications:	Equality information is included as part of performance reporting
Risk implications:	There is an assessment of risk on areas where performance is not at the required level.

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

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

Reviewed by:		
Colin Merker	Date	January 2017

Where in the Trust has this been discussed before?		
Not applicable.	Date	

What consultation has there been?		
Not applicable.	Date	

Explanation of acronyms used:	
	AOT Assertive Outreach Team AKI Acute kidney injury ASCOF Adult Social Care Outcomes Framework CAMHS Child and Adolescent Mental health Services C-Diff Clostridium difficile CIRG Clinical Information Reference Group CPA Care Programme Approach CPDG Contract Performance and Development Group CQUIN Commissioning for Quality and Innovation CRHT Crisis Home Treatment CSM Community Services Manager CYPS Children and Young People's Services ED Emergency Department EI Early Intervention EWS Early warning score HoNoS Health of the Nation Outcome Scale IAPT Improving Access to Psychological Therapies IST Intensive Support Team (National IAPT Team) KPI Key Performance Indicator LD Learning Disabilities MHICT Mental Health Intermediate Care Team MHL Mental Health Liaison MRSA Methicillin-resistant Staphylococcus aureus MUST Malnutrition Universal Screening Tool NHSI NHS Improvement NICE National Institute for Health and Care Excellence SI Serious Incident SUS Secondary Uses Service VTE Venous thromboembolism YOS Youth Offender's Service

1. CONTEXT

This report sets out the performance Dashboard for the Trust for the period to the end of January 2017, month ten of the 2016/17 contract period.

The following sections of the report include:

- An aggregated overview of all indicators in each section with exception reports for non-compliant indicators supported by the relevant Scorecard containing detailed information on all performance measures. These appear in the following sequence.

    - NHSI Requirements
    - Never Events
    - Department of Health requirements
    - NHS Gloucestershire Contract – Schedule 4 Specific Performance Measures
    - Social Care Indicators
    - NHS Herefordshire Contract – Schedule 4 Specific Performance Measures
    - NHS Gloucestershire CQUINS
    - Low Secure CQUINS
    - NHS Herefordshire CQUINS

2. AGGREGATED OVERVIEW OF ALL INDICATORS WITH EXCEPTION REPORTS ON NON-COMPLIANT INDICATORS

2.1 The following tables outline the performance in each of the performance categories within the Dashboard as at the end of January 2017. Where indicators have not been met during the reporting period, an explanation is provided relating to the non-achievement of the Performance Threshold and the action being taken to rectify the position.

2.2 Where stated, 'Cumulative Compliance' refers to compliance recorded from the start of this contractual year April 2016 to the current reporting month, as a whole.

2.3 Indicator IDs has been colour coded in the tables to indicate whether a performance measure is a national or local requirement. Blue indicates the performance measure is national, while lilac means the measure is local.

	=	**Target not met**
	=	**Target met**
NYA	=	**Not Yet Available from Systems**
NYR	=	**Not Yet Required by Contract**
UR	=	**Under Review**
N/A	=	**Not Applicable**
Baseline	=	**2016/17 data reporting to inform 2017/18**

DASHBOARD CATEGORY - NHSI REQUIREMENTS

NHS Improvement Requirements				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	13	13	13	13
	3	3	3	4
	10	10	10	9
NYA	0	0	0	0
NYR	0	0	0	0
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month

(Reference number relates to the number of the indicator within the scorecard):

 **1.07: New psychosis (EI) cases as per contract**

Year to date Gloucestershire have reported 54 new cases against an expected threshold of 60 new cases and Herefordshire 19 new cases against an expected threshold of 20 new cases. In total the Trust is 7 cases below the 80 new cases required by the end of January.

Work continues to understand what an accurate threshold looks like for both the Gloucestershire and Herefordshire counties. The Committee will be updated once work in this area has been completed.

This indicator has been red flagged as it requires further analysis to fully understand the issues and identify the actions required.

 **1.09: IAPT: Waiting times - Referral to Treatment within 6 weeks**

This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

 **1.10: IAPT: Waiting times - Referral to Treatment within 18 weeks**

This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

Cumulative Performance Thresholds Not being Met

1.02: Number of C Diff cases
To date, there have been 3 unavoidable incidents in Herefordshire and issues relating to cleanliness, which were non-contributory, but identified as part of the investigation have been addressed.

There have been 2 unavoidable incidents, 1 in Herefordshire in October and 1 in Gloucestershire in November. All unavoidable incidents are not required to be reported under NHS Improvement Measures but are reported within each local Schedule 4 specific contract performance measures.

1.07: New psychosis (EI) cases as per contract
As above

1.09: IAPT: Waiting times - Referral to Treatment within 6 weeks
As above

1.10: IAPT: Waiting times - Referral to Treatment within 18 weeks
As above

Changes to Previously Reported Figures

1.02: Number of C Diff cases
Previously only 1 case was reported for September. Further information from our infection control team shows that as well as this case, there was a further incident in September for the same patient involved in the reported August case. Although the same individual, these were different strains of C Diff therefore it has been confirmed that they need to be reported separately. Therefore 2 cases are now reported as avoidable during September.

Early Warnings / Notes

None

NHS Improvement Requirements

ID	Performance Measure (PM)		2015/16 Outturn	November-2016	December-2016	January-2017	(Apr to Jan) Cumulative Compliance
1							
1.01	Number of MRSA Bacteraemias	PM	0	0	0	0	0
		Gloucestershire	0	0	0	0	0
		Herefordshire	0	0	0	0	0
		Combined Actual	0	0	0	0	0
1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	0
		Gloucestershire	0	0	0	0	0
		Herefordshire	0	0	0	0	3
		Combined Actual	0	0	0	0	3
1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%
		Gloucestershire	95%	98%	96%	99%	98%
		Herefordshire	96%	100%	100%	100%	99%
		Combined Actual	96%	99%	97%	99%	98%
1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%
		Gloucestershire	99%	98%	95%	98%	99%
		Herefordshire	98%	100%	99%	96%	99%
		Combined Actual	99%	98%	96%	97%	99%
1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%
		Gloucestershire	1.0%	1.1%	1.4%	1.2%	1.7%
		Herefordshire	1.2%	4.1%	2.7%	0.9%	2.2%
		Combined Actual	1.0%	1.8%	1.7%	1.1%	1.9%
1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%
		Gloucestershire	99%	100%	100%	100%	99%
		Herefordshire	100%	100%	100%	100%	100%
		Combined Actual	99%	100%	100%	100%	99%
1.07	New psychosis (EI) cases as per contract	PM	72	48	54	60	60
		Gloucestershire	76	41	48	54	54
		PM	24	16	18	20	20
		Herefordshire	41	18	19	19	19
		PM	92	64	72	80	80
		Combined Actual	117	59	67	73	73
1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%
		Gloucestershire	66%	100%	57%	100%	76%
		Herefordshire	61%	0%	100%	N/A	68%
		Combined Actual	64%	71%	63%	100%	74%

NHS Improvement Requirements

ID	Performance Measure		2015/16 Outturn	November-2016	December-2016	January-2017	(Apr to Jan) Cumulative Compliance
1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%
		Gloucestershire	87%	35%	31%	35%	33%
		Herefordshire	95%	52%	49%	29%	50%
		Combined Actual	89%	38%	33%	34%	37%
1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%
		Gloucestershire	99%	82%	83%	86%	85%
		Herefordshire	99%	86%	81%	73%	86%
		Combined Actual	99%	83%	83%	83%	85%
1.11	**MENTAL HEALTH SERVICES DATA SET PART 1 DATA COMPLETENESS: OVERALL**	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.6%	99.9%	99.9%	99.9%	99.9%
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%
		Combined Actual	99.6%	99.9%	99.9%	99.9%	99.9%
1.11a	Mental Health Services Data Set Part 1 Data completeness: DOB	PM	97%	97%	97%	97%	97%
		Gloucestershire	100.0%	100.0%	100.0%	100.0%	100.0%
		Herefordshire	100.0%	100.0%	100.0%	100.0%	100.0%
		Combined Actual	100.0%	100.0%	100.0%	100.0%	100.0%
1.11b	Mental Health Services Data Set Part 1 Data completeness: Gender	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	99.9%	100.0%	99.9%	99.9%
		Herefordshire	100.0%	99.9%	99.9%	99.9%	99.9%
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%
1.11c	Mental Health Services Data Set Part 1 Data completeness: NHS Number	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	99.9%	99.9%	99.9%	99.9%
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%
1.11d	Mental Health Services Data Set Part 1 Data completeness: Organisation code of commissioner	PM	97%	97%	97%	97%	97%
		Gloucestershire	98.8%	100.0%	100.0%	100.0%	100.0%
		Herefordshire	99.9%	100.0%	100.0%	100.0%	100.0%
		Combined Actual	99.1%	100.0%	100.0%	100.0%	100.0%
1.11e	Mental Health Services Data Set Part 1 Data completeness: Postcode	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.5%	99.9%	99.9%	99.9%	99.8%
		Herefordshire	99.6%	99.9%	99.8%	99.9%	99.8%
		Combined Actual	99.5%	99.9%	99.8%	99.9%	99.8%
1.11f	Mental Health Services Data Set Part 1 Data completeness: GP Practice	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.1%	99.5%	99.5%	99.5%	99.4%
		Herefordshire	99.5%	99.7%	99.8%	99.7%	99.7%
		Combined Actual	99.2%	99.5%	99.6%	99.5%	99.5%

NHS Improvement Requirements

ID	Performance Measure		2015/16 Outturn	November-2016	December-2016	January-2017	(Apr to Jan) Cumulative Compliance
1.12	MENTAL HEALTH SERVICES DATA SET PART 2 DATA COMPLETENESS : OVERALL	PM	50%	50%	50%	50%	50%
		Gloucestershire	97.9%	94.7%	94.7%	94.7%	96.5%
		Herefordshire	95.3%	92.5%	92.1%	91.7%	92.5%
		Combined Actual	97.4%	94.3%	94.2%	94.2%	95.8%
1.12a	Mental Health Services Data Set Part 2 Data completeness: CPA Employment status last 12 months	PM	50%	50%	50%	50%	50%
		Gloucestershire	97.2%	87.5%	87.7%	87.7%	93.1%
		Herefordshire	93.7%	89.5%	88.7%	88.1%	89.4%
		Combined Actual	96.4%	87.9%	87.9%	87.8%	88.1%
1.12b	Mental Health Services Data Set Part 2 Data completeness: CPA Accommodation Status in last 12 months	PM	50%	50%	50%	50%	50%
		Gloucestershire	97.1%	97.3%	97.1%	97.0%	97.0%
		Herefordshire	93.8%	89.8%	89.1%	88.5%	89.9%
		Combined Actual	96.5%	96.0%	95.6%	95.5%	95.7%
1.12c	Mental Health Services Data Set Part 2 Data completeness: CPA HoNOS assessment in last 12 months	PM	50%	50%	50%	50%	50%
		Gloucestershire	99.6%	99.2%	99.2%	99.4%	99.4%
		Herefordshire	98.5%	98.2%	98.6%	98.5%	98.2%
		Combined Actual	99.4%	99.0%	99.1%	99.2%	99.2%
1.13	Learning Disability Services: 6 indicators: identification of people with a LD, provision of information, support to family carers, training for staff, representation of people with LD; audit of practice and publication of findings	PM	6	6	6	6	6
		Gloucestershire	6	6	6	6	6
		Herefordshire	6	6	6	6	6
		Combined Actual	6	6	6	6	6

DASHBOARD CATEGORY – DEPARTMENT OF HEALTH PERFORMANCE

DoH Performance				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	27	27	27	27
🔴	1	1	2	2
🟢	24	24	23	24
NYA	0	0	0	0
NYR	1	1	1	0
UR	0	0	0	0
N/A	1	1	1	1

Performance Thresholds not being achieved in Month

2.21: No children under 18 admitted to adult inpatient wards
There were 2 admissions of under 18s to adult wards in January, 1 in Gloucestershire and 1 in Herefordshire.

In Gloucestershire, a 16 year was admitted to Dean Ward on Section 2 from the 136 Suite and was discharged the next day to a tier 4 unit.

In Herefordshire, a young person was admitted to Wye Valley Trust (WVT) Paediatric Ward following an act of self-harm. Due to the lack of an age appropriate Tier 4 bed, WVT not holding a licence for section patients and the expiry of the S5(2); the consultant responsible (with authority from the Trust on-call clinical manager and on-call executive) placed the young person on a section 2 to the Stonebow Unit and immediately sanctioned S17 leave to the paediatric ward as the least restrictive option.

The young person was transferred to an age appropriate Psychiatric Intensive Care Unit (PICU) two days later.

2.26: Interim report for all SIs received within 5 working days of identification
1 initial report for Gloucestershire was submitted late in January. The submission process has been reviewed to ensure future compliance.

Cumulative Performance Thresholds Not being Met

2.21: No children under 18 admitted to adult inpatient wards
Year to date there have been 15 admissions, 8 admissions in Gloucestershire and 7 in Herefordshire.

2.26: Interim report for all SIs received within 5 working days of identification
There have been 4 late submissions year to date, 3 for Gloucestershire and 1 for Herefordshire.

Changes to Previously Reported Figures
None

Early Warnings
None

DOH Never Events

ID	Performance Measure		2015/16 Outturn	November-2016	December-2016	January-2017	(Apr to Jan) Cumulative Compliance
2							
2.01	Wrongly prepared high risk injectable medications	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.02	Maladministration of potassium containing solutions	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.03	Wrong route administration of oral/enteral treatment	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.04	Intravenous administration of epidural medication	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.05	Maladministration of insulin	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.06	Overdose of midazolam during conscious sedation	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.07	Opioid overdose in opioid naive patient	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.08	Inappropriate administration of daily oral methotrexate	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.09	Suicide using non collapsible rails	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.10	Falls from unrestricted windows	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.11	Entrapment in bedrails	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.12	Misplaced naso - or oro-gastric tubes	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.13	Wrong gas administered	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.14	Failure to monitor and respond to oxygen saturation - conscious sedation	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.15	Air embolism	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.16	Severe scalding from water for washing/bathing	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.17	Mis-identification of patients	PM	0	0	0	0	0
		Actual	0	0	0	0	0

DOH Requirements

ID	Performance Measure		2015/16 Outturn	November-2016	December-2016	January-2017	(Apr to Jan) Cumulative Compliance
2.18	Mixed Sex Accommodation - Sleeping Accommodation Breaches	PM	0	0	0	0	0
		Gloucestershire	0	0	0	0	0
		Herefordshire	0	0	0	0	0
		Combined	0	0	0	0	0
2.19	Mixed Sex Accommodation - Bathrooms	Gloucestershire	Yes	Yes	Yes	Yes	Yes
		Herefordshire	Yes	Yes	Yes	Yes	Yes
		Combined	Yes	Yes	Yes	Yes	Yes
2.20	Mixed Sex Accommodation - Women Only Day areas	Gloucestershire	Yes	Yes	Yes	Yes	Yes
		Herefordshire	Yes	Yes	Yes	Yes	Yes
		Combined	Yes	Yes	Yes	Yes	Yes
2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0
		Gloucestershire	11	2	1	1	8
		Herefordshire	4	1	1	1	7
		Combined	15	3	2	2	15
2.22	Failure to publish Declaration of Compliance or Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	Gloucestershire	Yes	Yes	Yes	Yes	Yes
		Herefordshire	Yes	Yes	Yes	Yes	Yes
		Combined	Yes	Yes	Yes	Yes	Yes
2.23	Publishing a Declaration of Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	Gloucestershire	Yes	Yes	Yes	Yes	Yes
		Herefordshire	Yes	Yes	Yes	Yes	Yes

DOH Requirements

ID	Performance Measure		2015/16 Outturn	November-2016	December-2016	January-2017	(Apr to Jan) Cumulative Compliance
2.24	Serious Incident Reporting (SI)	Glos	32	0	3	5	33
		Hereford	11	1	1	1	8
2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%
		Gloucestershire	100%	N/A	100%	100%	100%
		Herefordshire	100%	100%	100%	100%	100%
2.26	Interim report for all SIs received within 5 working days of identification (unless extension granted by CCG)	PM		100%	100%	100%	100%
		Gloucestershire		N/A	100%	80%	91%
		Herefordshire		100%	100%	100%	88%
2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM		100%	100%	100%	100%
		Gloucestershire		N/A	NYR	NYR	100%
		Herefordshire		NYR	NYR	NYR	100%
2.28	SI Report Level 3 - Independent investigations - 6 months from investigation commissioned date	PM		100%	100%	100%	100%
		Gloucestershire		N/A	N/A	N/A	N/A
		Herefordshire		N/A	N/A	N/A	N/A
2.29	SI Final Reports outstanding but not due	Gloucestershire	3	0	3	5	8
		Herefordshire	0	1	1	1	3

DASHBOARD CATEGORY – GLOUCESTERSHIRE CCG CONTRACTUAL REQUIREMENTS

Gloucestershire Contract				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	56	56	56	56
	4	4	3	6
	12	21	13	21
NYA	0	2	0	2
NYR	39	27	39	25
UR	0	0	0	0
N/A	1	2	1	2

Performance Thresholds not being achieved in Month

 **3.18: IAPT Recovery rate: Access to psychological therapies should be improved**
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

 **3.19: IAPT Access rate: Access to psychological therapies should be improved**
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

 **3.30: Adult Mental Health Intermediate Care Teams (IAPT/Nursing Integrated Service): Wait times from referral to screening assessment within 14 days of receiving referral**

Expected compliance: The new MHICT Service Specification is currently under review, which includes a review of clinical capacity. Once this is complete and a contract variation is finalised this indicator will change to report on Nursing activity only. This indicator is unlikely to be compliant until that piece of work is complete

This indicator has been red flagged as it requires further analysis to fully understand the issues and identify the actions required.

Cumulative Performance Thresholds Not being Met

3.01: Zero tolerance MRSA
Due to an MRSA case Willow Ward was closed to admissions from 13th December 2016 to 24th January 2017 but the original case dated back to May 2016. It was an unusual and complex outbreak and overall there were eight patients with positive results for MRSA but importantly no MRSA bacteraemia.

The Commissioner has confirmed that the national quality requirement (E.A.S.4) only applies to MRSA bacteraemia which is not relevant in this instance as the service user had a skin infection. Therefore no penalty will be applied and it is recorded as unavoidable. The CCG has been informed and we are holding a clinical review. Additionally we have introduced routine screening for all admissions across Charlton Lane

3.02: Minimise rates of CDiff
There was one case on Priory Ward in November which has been confirmed as unavoidable.

3.18: IAPT Recovery rate: Access to psychological therapies should be improved
As above

3.19: IAPT Access rate: Access to psychological therapies should be improved
As above

3.30: Adults Mental Health Intermediate Care Teams (New Integrated Service): Wait times from referral to screening assessment within 14 days of receiving referral
As above

3.37: Care plan audit: Dependent children and young people
One of the Gloucestershire CCG Schedule 4 Quality requirements for 2016-17 is for a care plan audit to show:

- All dependent children and young people under the age of 18 living with adults known to the Recovery, MAHRS, Eating Disorder and Assertive Outreach Services.
- Recorded evidence in care plans of the impact of the mental health disorder on those under 18s plus steps put in place to support (Think family).

Compliance at quarter 1 was 61%, quarter 2 and quarter 3 was 56% although we are still awaiting the validated quarter 3 audit report from the Quality Department. Teams have been asked to ensure that the information has been recorded in the correct place on RiO. The quarter 4 audit will be run in April 2017.

Changes to Previously Reported Figure

3.01: Zero tolerance MRSA
There has been an MRSA incident on Willow Ward of which details are given above.

Early Warnings

None

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	November-2016	December-2016	January-2017	(Apr to Jan) Cumulative Compliance
	B. NATIONAL QUALITY REQUIREMENT						
3.01	Zero tolerance MRSA	PM	0	0	0	0	0
		Unavoidable	0	0	1	0	1
3.02	Minimise rates of Clostridium difficile	PM	0	0	0	0	0
		Unavoidable	0	1	0	0	1
3.03	Duty of candour	PM	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant	Compliant	Compliant
3.04	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS,	PM	99%	99%	99%	99%	99%
		Actual	100%	99%	99%	99%	99%
3.05	Completion of Mental Health Services Data Set ethnicity coding for all detained and informal Service Users	PM	90%	90%	90%	90%	90%
		Actual	97%	100%	100%	97%	100%
3.06	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	PM	90%	90%	90%	90%	90%
		Actual	85%	100%	99%	100%	99%
	C. Local Quality Requirements						
	Domain 1: Preventing People dying prematurely						
3.07	Increased focus on suicide prevention and reduction in the number of reported suicides in the community and inpatient units	PM	Report				Annual
		Actual	Complete				NYR
3.08	To reduce the numbers of detained patients absconding from inpatient units where leave has not been granted	PM	N/A		<36		<108
		Actual	55		24		81
3.09	Compliance with NICE Technology appraisals within 90 days of their publication and ability to demonstrate compliance through completion of implementation plans and costing templates.	PM					PM
		Actual					NYR
3.10	Minimum of 5% increase in uptake of flu vaccination (15/16 55.3%)	PM					Annual
		Actual					NYR

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	November-2016	December-2016	January-2017	(Apr to Jan) Cumulative Compliance
	Domain 2: Enhancing the quality of life of people with long-term conditions						
3.11	2G bed occupancy for Gloucestershire CCG patients	PM	N/A	>91%	>91%	>91%	>91%
		Actual	92%	93%	93%	95%	92%
3.12	Care Programme Approach: 95% of CPAs should have a record of the mental health worker who is responsible for their care	PM	95%	95%	95%	95%	95%
		Actual	100%	99%	99%	99%	100%
3.13	CPA Review - 95% of those on CPA to be reviewed within 1 month (Review within 13 months)	PM	95%	95%	95%	95%	95%
		Actual	99%	99%	98%	99%	99%
3.14	Assessment of risk: % of those 2g service users on CPA to have a documented risk assessment	PM	85%		95%		95%
		Actual	99%		99%		99%
3.15	Assessment of risk: All 2g service users (excluding those on CPA) to have a documented risk assessment	PM			95%		85%
		Actual			94%		94%
3.16	Dementia should be diagnosed as early in the illness as possible: People within the memory assessment service with a working diagnosis of dementia to have a care plan within 4 weeks of diagnosis	PM	85%	85%	85%	85%	85%
		Actual	89%	96%	100%	100%	96%
3.17	AKI (previous CQUIN 1516) 95% of pts to have EWS score within 12 hours	PM			95%		95%
					98%		99%
	Domain 3: Helping people to recover from episodes of ill-health or following injury						
3.18	IAPT recovery rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%
		Actual	35%	44%	50%	47%	47%
3.19	IAPT access rate: Access to psychological therapies for adults should be improved	PM		10.00%	11.25%	12.50%	12.50%
		Actual		5.12%	5.48%	6.15%	6.15%
3.20	IAPT reliable improvement rate: Access to psychological therapies for adults should be improved	PM	N/A	50%	50%	50%	50%
		Actual	55%	68%	74%	85%	74%
3.21	Care Programme Approach (CPA): The percentage of people with learning disabilities in inpatient care on CPA who were followed up within 7 days of discharge	PM	95%	95%	95%	95%	95%
		Actual	100%	N/A	N/A	N/A	N/A
3.22	To send :Inpatient and day case discharge summaries electronically, within 24 hours to GP	PM			Report		Report
		Actual			NYA		NYA

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	November-2016	December-2016	January-2017	(Apr to Jan) Cumulative Compliance
	Domain 4: Ensuring that people have a positive experience of care						
3.23	To demonstrate improvements in staff experience following any national and local surveys	PM	Annual				Annual
		Actual	Compliant				NYR
	CYPS						
3.24	Number of children that received support within 24 hours of referral, for crisis home treatment (CYPS)	PM	95%		95%		95%
		Actual	97%		N/A		N/A
3.25	Children and young people who enter a treatment programme to have a care coordinator - (Level 3 Services) (CYPS)	PM	98%	98%	98%	98%	98%
		Actual	99%	99%	99%	99%	99%
3.26	95% accepted referrals receiving initial appointment within 4 weeks (excludes YOS, substance misuse, inpatient and crisis/home treatment and complex engagement) (CYPS)	PM	95%		95%		95%
		Actual	98%		99%		99%
3.27	Level 2 and 3 – Referral to treatment within 8 weeks , excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	80%		80%		80%
		Actual	65%		98%		85%
3.28	Level 2 and 3 – Referral to treatment within 10 weeks (excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	95%		95%		90%
		Actual	78%		99%		95%
3.29	Adults of working age - 100% of MDT assessments to have been completed within 4 weeks (or in the case of a comprehensive assessment commenced within 4 weeks)	PM	85%	85%	85%	85%	85%
		Actual	94%	97%	92%	96%	95%
3.30	Adults Mental Health Intermediate Care Teams (New Integrated service) Wait times from referral to screening assessment within 14 days of receiving referral	PM	85%	85%	85%	85%	85%
		Actual	70%	67%	60%	66%	64%

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	November-2016	December-2016	January-2017	(Apr to Jan) Cumulative Compliance
	Vocational Service (Individual Placement and Support)						
3.31	100% of Service Users in vocational services will be supported to formulate their vocational goals through individual plans (IPS)	PM	98%		98%		98%
		Actual	100%		100%		100%
3.32	The number of people finding paid employment or self-employment (measured as a percentage against accepted referrals into the (IPS) Excluding those in employment at time of referral - Annual	PM	50%				50%
		Actual	45%				NYR
3.33	The number of people retaining employment at 3/6/9/12+ months (measured as a percentage of individuals placed into employment retaining employment) (IPS)	PM	50%				50%
		Actual	65%				67%
3.34	The number of people supported to retain employment at 3/6/9/12+ months	PM	50%				50%
		Actual	73%				82%
3.35	Fidelity to the IPS model	PM	Annual				90%
		Actual	NYA				NYR
	General Quality Requirements						
3.36	GP practices will have an individual annual (MH) ICT service meeting to review delivery and identify priorities for future.	PM	Annual				Annual
		Actual	NYA				NYR
3.37	Care plan audit to show : All dependent Children and YP <18 living with adults know to Recovery, MAHRS, Eating Disorder and Assertive Outreach Services. Recorded evidence in care plans of impact of the mental health disorder on those under 18s plus steps put in place to support.(Think family)	PM			Report		Qtr 3
		Actual			Non-compliant		Non-compliant
	New KPIs for 2016/17						
3.38	Transition- Joint discharge/CPA review meeting to be held within 4 weeks of acceptance into adult MH services during which a working diagnosis to be agreed, adult MH care coordinator allocated and care cluster and risk levels agreed as well as CYPS discharge date. The meeting will be recorded on RIO.	PM			100%		100%
		Actual			NYA		NYA
3.39	Number and % of crisis assessments undertaken by the MHARS team on CYP age 16-25 within agreed timescales of 4 hours	PM					90%
		Actual					NYR
3.40	MHARS wait time to assessment (4 hours)	PM					TBC
		Actual					NYR

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	November-2016	December-2016	January-2017	(Apr to Jan) Cumulative Compliance
	New KPIs for 2016/17 LD						
3.41	To define LD clearly and the route into specialist LD service	PM					Annual
		Actual					NYR
3.42	LD: To implement Pathways for work within specialist service with easy read supporting information	PM					Annual
		Actual					NYR
3.43	The CLDT will ask when an annual health check is due and will notify GP where one is needed, and offer support regarding reasonable adjustments.	PM					80%
		Actual					NYR
3.44	LD: All clients referred will have a risk assessment completed when core assessment is completed	PM					80%
		Actual					NYR
3.45	LD:All clients referred for difficulties they are expressing through their behaviour will have an assessment and formulation completed within 56 days of case being opened by the relevant clinician	PM					80%
		Actual					NYR
3.46	LD: All clients referred for difficulties they are expressing through their behaviour will have single support plan, containing (as appropriate) changes within the person, changes external to the person (systems), and reactive interventions completed within 56 days of case being opened by the relevant clinician	PM					80%
		Actual					NYR
3.47	LD: All new patients have a risk assessment completed within 48 hours of admission	PM					80%
		Actual					NYR
3.48	LD: All new patients have a psychological assessment and formulation of behaviours and emotions completed within 28 days of admission.	PM					80%
		Actual					NYR
3.49	LD: All new patients have a single support plan to support their behavioural and emotional presentation completed within 28 days of admission. This will contain, as appropriate, goals targeting changes within the person, changes external to the person, and reactive interventions.	PM					80%
		Actual					NYR

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	November-2016	December-2016	January-2017	(Apr to Jan) Cumulative Compliance
3.50	LD: All new patients receive a health check within 48 hours of admission.	PM					95%
		Actual					NYR
3.51	LD: All new patients have a Health Action Plan completed within 3 days of admission	PM					95%
		Actual					NYR
3.52	LD: All new patients requiring a health screening are supported to access screenings where appropriate.	PM					95%
		Actual					NYR
3.53	LD: All clients referred for challenging behaviour will have a risk assessment completed within five days of case being allocated to clinician	PM					80%
		Actual					NYR
3.54	LD: All clients have a functional assessment / formulation of behaviours completed within 28 days on completion of assessment	PM					80%
		Actual					NYR
3.55	LD: All clients referred for challenging behaviours will have a single plan describing how their behaviour will be supported positively. It will contain primary, secondary and reactive interventions. Goals for the person and the wider system will be clear. The plan will be completed within 30 days of case being opened by the clinician.	PM					80%
		Actual					NYR
3.56	LD: All clients being admitted for challenging behaviour to Learning Disability Assessment and Treatment services will have a blue light meeting where feasible. This will be notified to Commissioners for Commissioners or their designee to Chair	PM					80%
		Actual					NYR

Schedule 4 Specific Measures that are reported Nationally

Performance Thresholds not being achieved in Month

NHS Improvement

1.09 IAPT Waiting times: Referral to Treatment within 6 weeks (based on discharges)
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

1.10 IAPT Waiting times: Referral to Treatment within 18 weeks (based on discharges)
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

Department of Health Requirements

2.21: No children under 18 admitted to adult inpatient wards
There were 1 admissions of under 18 to an adult wards in January, 1 in Gloucestershire

A 16 year was admitted to Dean Ward on Section 2 from the 136 Suite and was discharged the next day to a tier 4 provision unit.

2.26: Interim report for all SIs received within 5 working days of identification
1 initial report for Gloucestershire was submitted late in January. The submission process has been reviewed to ensure future compliance.

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures - National Indicators

ID	Performance Measure		2015/16 outturn	November-2016	December-2016 / Quarter 3	January-2017	(Apr to Jan) Cumulative Compliance
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	0	0	0	0
		Actual	0	0	0	0	0
NHSI 1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	0
		Actual	0	0	0	0	0
NHSI 1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%
		Actual	95%	98%	96%	99%	98%
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	1.0%	1.1%	1.4%	1.2%	1.7%
NHSI 1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%
		Actual	99%	100%	100%	100%	99%
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%
		Actual	66%	100%	57%	100%	76%
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%
		Actual	87%	35%	31%	35%	33%
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%
		Actual	99%	82%	83%	86%	85%
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	0	0	0	0
		Actual	0	0	0	0	0
DoH 2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0
		Actual	11	2	1	1	8
DoH 2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%
		Actual	100%	N/A	100%	100%	100%
DoH 2.26	Interim report for all SIs received within 5 working days of identification (unless extension granted by CCG)	PM		100%	100%	100%	100%
		Actual		N/A	100%	80%	91%
DoH 2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM		100%	100%	100%	100%
		Actual		N/A	NYR	NYR	100%

DASHBOARD CATEGORY – GLOUCESTERSHIRE SOCIAL CARE

Gloucestershire Social Care				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	15	15	15	15
🔴	4	4	3	3
🟢	9	9	10	10
NYA	0	0	0	0
NYR	0	0	0	0
UR	0	0	0	0
N/A	2	2	2	2

Performance Thresholds not being achieved in Month

4.03 – Ensure that reviews of new packages take place within 12 weeks

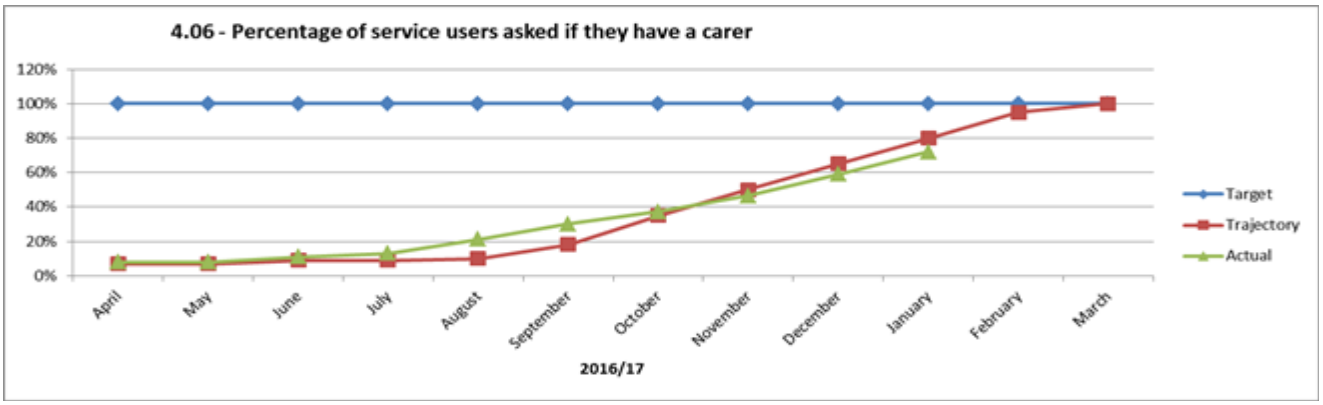
This is a newly reported indicator. At the time of reporting there were 5 cases recorded as not having been reviewed within 12 weeks. A manual audit has confirmed that only 1 case was not seen within 12 weeks. It was reviewed 3 days after the due date. The other cases were not breaches but were related to our reporting methodology.

This indicator has been red flagged as it requires further analysis to fully understand the methodology issues and identify the actions required.

4.06 – Percentage of service users asked if they have a carer

The new data collection form went "live" in RiO in June 2016 and work is on-going to inform staff about the new way to record carer information.

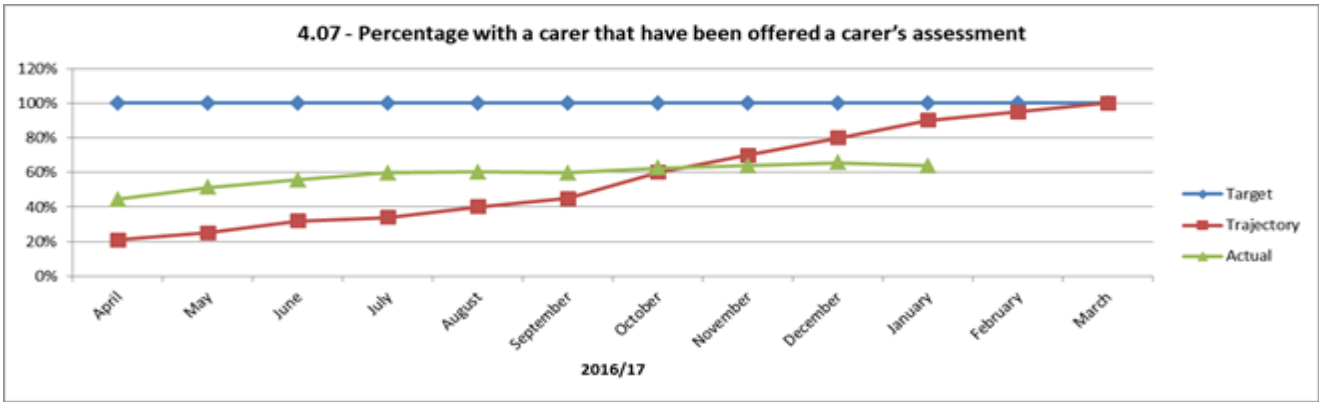
Expected compliance: The trajectory below shows that although recording is improving we are still currently below plan.



4.07– Percentage with a carer that have been offered a carer's assessment

The new data collection form went "live" in RiO in June 2016 and work is needed to ensure all staff are aware that it is available and that information is collected at the right time in the pathway.

Expected compliance: The trajectory below shows we are below our planned trajectory



Cumulative Performance Thresholds Not being Met

4.03 – Ensure that reviews of new packages take place within 12 weeks
As above

4.06 – Percentage of service users asked if they have a carer
As above

4.07– Percentage with a carer that have been offered a carer's assessment
As above

Changes to Previously Reported Figures

None

Early Warnings/Notes

None

Gloucestershire Social Care

ID	Performance Measure		2015/16 outturn	November-2016	December-2016	January-2017	(Apr to Jan) Cumulative Compliance
4.01	The percentage of people who have a Cluster recorded on their record	PM	TBC	90%	90%	90%	90%
		Actual	96%	95%	96%	95%	96%
4.02	Percentage of people getting long term services, in a residential or community care reviewed/re-assessed in last year	PM	95%	95%	95%	95%	95%
		Actual	96%	94%	93%	98%	95%
4.03	Ensure that reviews of new packages take place within 12 weeks of commencement	PM	95%	95%	95%	95%	95%
		Actual	96%	0%	0%	38%	38%
4.04	Current placements aged 18-64 to residential and nursing care homes per 100,000 population	PM	TBC	13	13	13	13
		Actual	13.01	12.90	12.90	12.90	12.82
4.05	Current placements aged 65+ to residential and nursing care homes per 100,000 population	PM	TBC	22	22	22	22
		Actual	21.21	16.34	16.34	16.34	16.57
4.06	% of WA & OP service users on caseload asked if they have a carer	PM		100%	100%	100%	100%
				46%	59%	72%	72%
4.07	% of WA & OP service users on the caseload who have a carer, who have been offered a carer's assessment	PM		100%	100%	100%	100%
		Actual		64%	66%	64%	64%
4.08a	% of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC
		Actual	NYA	41%	40%	38%	38%
4.08b	Number of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC
		Actual	NYA	100	124	166	166
4.09	% of eligible service users with Personal budgets	PM	80%	80%	80%	80%	80%
		Actual	97%	100%	100%	100%	100%

Gloucestershire Social Care

ID	Performance Measure		2015/16 outturn	November-2016	December-2016	January-2017	(Apr to Jan) Cumulative Compliance
4.10	% of eligible service users with Personal Budget receiving Direct Payments (ASCOF 1C pt2)	PM	15%	15%	15%	15%	15%
		Actual	19%	18%	19%	18%	19%
4.11	Adults subject to CPA in contact with secondary mental health services in settled accommodation (ASCOF 1H)	PM	80%	80%	80%	80%	80%
		Actual	86%	87%	87%	89%	89%
4.12	Adults not subject to CPA in contact with secondary mental health service in settled accommodation	PM	TBC	90%	90%	90%	90%
		Actual	91%	96%	96%	96%	96%
4.13	Adults subject to CPA receiving secondary mental health service in employment (ASCOF 1F)	PM	13%	13%	13%	13%	13%
		Actual	14%	16%	15%	16%	16%
4.14	Adults not subject to CPA receiving secondary mental health service in employment	PM	TBC	20%	20%	20%	20%
		Actual	23%	24%	23%	24%	24%

DASHBOARD CATEGORY – HEREFORDSHIRE CCG CONTRACTUAL REQUIREMENTS

Herefordshire Contract				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	25	25	25	25
	4	3	2	3
	16	17	18	17
NYA	0	0	0	0
NYR	0	0	0	0
UR	0	0	0	0
N/A	5	5	5	5

Performance Thresholds not being achieved in Month

 **5.08: IAPT Recovery rate – those who have completed treatment and have "caseness"**
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

 **5.09: IAPT achieve 15% of patients entering the service against prevalence**
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

Cumulative Performance Thresholds Not being

5.06: Minimise rates of CDiff
There was one case in October which has been confirmed as unavoidable.

 **5.08: IAPT Recovery rate – those who have completed treatment and have "caseness"**
As above

5.09: IAPT achieve 15% of patients entering the service against prevalence
As above

Changes to Previously Reported Figures
None

Early Warnings / Notes
None

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 Outturn	November-2016	December-2016 / Quarter 3	January-2017	(Apr to Jan) Cumulative Compliance
5.01	Duty of candour	Plan	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant	Compliant	Compliant
5.02	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS	Plan	99%	99%	99%	99%	99%
		Actual	100%	99%	99%	99%	99%
5.03	Completion of Mental Health Services Data Set ethnicity coding for all detained and informal Service Users	Plan	90%	90%	90%	90%	90%
		Actual	100%	100%	100%	100%	100%
5.04	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	Plan	90%	90%	90%	90%	90%
		Actual	96%	96%	100%	99%	99%
5.05	Zero tolerance MRSA	Plan	0	0	0	0	0
		Unavoidable	0	0	0	0	0
5.06	Minimise rates of Clostridium difficile	Plan	0	0	0	0	0
		Unavoidable	0	0	0	0	1
5.07	VTE risk assessment: all inpatient service users to undergo risk assessment for VTE	Plan	95%	95%	95%	95%	95%
		Actual	99%	97%	100%	100%	99%
5.08	IAPT Recovery Rate: The number of people who are below the caseness threshold at treatment end	Plan	50%	50%	50%	50%	50%
		Actual	33%	29%	48%	41%	43%
5.09	IAPT Roll-out (Access Rate) - IAPT maintain 15% of patient entering the service against prevalence	Plan	2,178	1452	1634	1815	1815
		Actual	2,005	879	937	1,008	1,008
5.10	IAPT waiting times and completed treatments - Number of ended referrals in the reporting period that received a course of treatment against the number of ended referrals that received a single treatment appt	Plan	N/A	TBC	TBC	TBC	TBC
		Actual		42%	41%	43%	46%
5.11	IAPT High Intensity - Number of discharged patients that received step 3 treatment	Plan	350	30	29	29	292
		Actual	356	23	32	54	352

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 Outturn	November-2016	December-2016 / Quarter 3	January-2017	(Apr to Jan) Cumulative Compliance
5.12	Emergency referrals to Crisis Resolution Home Treatment Team seen within 4 hours of referral (8am-6pm)	Plan	98%	95%	95%	95%	95%
		Actual	99%	100%	100%	100%	100%
5.13a	Dementia Service - number of new patients aged 65 years and over receiving an assessment	Plan		45	45	45	450
		Actual		49	29	70	473
5.13b	Dementia Service - total number of new patients receiving an assessment	Plan					
		Actual		54	32	71	506
5.14	Waiting times - Specialist Memory Service: All patients are offered a first appointment within 4 weeks of referral	Plan	100%	95%	95%	95%	95%
		Actual	97%	100%	100%	96%	99%
5.15	Reduce those people readmitted to inpatient care within 30 days following discharge.	Plan	<8%	<8%	<8%	<8%	<8%
		Actual	6%	20%	6%	5%	6%
5.16	Number of service users on the caseload who have been seen (face to face) within the previous 90 days (Recovery Service). Excludes service users with a medic as Lead HCP.	Plan	100%	98%	98%	98%	98%
		Actual		99%	99%	98%	98%
5.17	Patients are to be discharged from local rehab within 2 years of admission (Oak House). Based on patients on ward at end of month.	Plan	80%	80%	80%	80%	80%
		Actual	86%	89%	90%	100%	100%
5.18	CYPS IAPTOutcomes - Consistent with the data specification for CYP-IAPT CAMHS V2 (Dec 2012).(Caseload at month end for CYPS IAPT trained staff with a CYPS IAPT outcome recorded).	Plan		60%	60%	60%	60%
		Actual		91%	85%	87%	87%
5.19	All admitted patients aged 65 years of age and over must have a completed MUST assessment	Plan		95%	95%	95%	95%
		Actual		100%	100%	100%	98%
5.20	Any attendances at ED with mental health needs should have rapid access to mental health assessment within 2 hours of the MHL team being notified.	Plan		80%	80%	80%	80%
		Actual		83%	89%	90%	82%
5.21	Attendances at ED for self-harm receive a mental health assessment	Plan		85%	85%	85%	85%
		Actual		90%	93%	95%	96%

Herefordshire Carers Information

ID	Performance Measure		2015/16 Outturn	November-2016	December-2016 / Quarter 3	January-2017		Cumulative Compliance
5.22	Working Age and Older People service users on the caseload asked if they have a carer. (Only includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan						
		Actual		21%	24%	26%		26%
5.23	Working Age and Older People service users on the caseload who have a carer who have been offered a carer's assessment. (Only includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan						
		Actual		36%	35%	38%		38%
5.24	Working Age and Older People service users/carers who have accepted a carers assessment. (Only includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan						
		Actual		55%	51%	45%		45%

Schedule 4 Specific Measures that are reported Nationally

Performance Thresholds not being achieved in Month

NHS Improvement

1.09: IAPT Waiting times: Referral to Treatment within 6 weeks (based on discharges)
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

1.10: IAPT Waiting times: Referral to Treatment within 18 weeks (based on discharges)
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

Department of Health Requirements

2.21: No children under 18 admitted to adult inpatient wards
There was 1 admission of an under 18 to an adult ward in January in Herefordshire.

A young person was admitted to Wye Valley Trust (WVT) Paediatric Ward following an act of self-harm. Due to the lack of an age appropriate Tier 4 bed, WVT not holding a licence for section patients and the expiry of the S5(2); the consultant responsible (with authority from the Trust on-call clinical manager and on-call executive) placed the young person on a section 2 to the Stonebow Unit and immediately sanctioned S17 leave to the paediatric ward as the least restrictive option.

The young person was transferred to an age appropriate Psychiatric Intensive Care Unit (PICU) two days later.

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures - National Indicators

ID	Performance Measure		2015/16 outturn	November-2016	December-2016 / Quarter 3	January-2017	(Apr to Jan) Cumulative Compliance
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	0	0	0	0
		Actual	0	0	0	0	0
NHSI 1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	0
		Actual	0	0	0	0	3
NHSI 1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%
		Actual	96%	100%	100%	100%	99%
NHSI 1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%
		Actual	98%	100%	99%	96%	99%
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	1.2%	4.1%	2.7%	0.9%	2.2%
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%
		Actual	61%	0%	100%	N/A	68%
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%
		Actual	95%	52%	49%	29%	50%
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%
		Actual	99%	86%	81%	73%	86%
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	0	0	0	0
		Actual	0	0	0	0	0
DoH 2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0
		Actual	4	1	1	1	7

DASHBOARD CATEGORY – GLOUCESTERSHIRE CQUINS

Gloucestershire CQUINS				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	2	2	2	2
🔴	0	0	0	0
🟢	0	2	0	2
NYA	0	0	0	0
NYR	2	0	2	0
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
None

Early Warnings
None

Gloucestershire CQUINS

ID	Performance Measure		2015/16 Outturn	Quarter 3			(Apr to Jan) Cumulative Compliance
	Local CQUINs						
	CQUIN 1						
7.01	Transition from Young People's Service to Adult Mental Health Services	PM	Qtr 4	Report			Qtr 3
		Actual	Compliant	Compliant			Compliant
	CQUIN 2						
7.02	Perinatal Mental Health	PM	Qtr 4	Report			Qtr 3
		Actual	Compliant	Compliant			Compliant

DASHBOARD CATEGORY – LOW SECURE CQUINS

Low Secure CQUINS				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	1	1	1	1
	0	0	0	0
	0	1	0	1
NYA	0	0	0	0
NYR	1	0	1	0
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
None

Early Warnings
None

Low Secure CQUINS

ID	Performance Measure		2015/16 Outturn	Quarter 3			(Apr to Jan) Cumulative Compliance
	Local CQUINs						
	CQUIN 1						
8.01	Reducing the length of stay in specialised MH services	PM		Report			Qtr 3
		Actual		Compliant			Compliant

DASHBOARD CATEGORY – HEREFORDSHIRE CQUINS

Herefordshire CQUINS				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	8	8	8	8
	0	0	0	0
	0	5	0	8
NYA	0	3	0	0
NYR	8	0	8	0
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
None

Early Warnings
None

Herefordshire CQUINS

ID	Performance Measure		2015/16 Outturn	Quarter 3			(Apr to Jan) Cumulative Compliance
	National CQUINs						
	CQUIN 1						
9.01a	(b) Introduction of Health and Wellbeing Initiatives	PM		Report			Qtr 1
		Actual		NYA	NYA		Awarded
9.01b	Healthy food for NHS Staff, Visitors and Patients	PM		Report			Qtr 1
		Actual		NYA	NYA		Awarded
9.01c	Improving the uptake of Flu vaccinations for Front Line Clinical Staff	PM		Report			Qtr 1
		Actual		NYA	NYA		Awarded
9.02a	Improving physical healthcare: Cardio Metabolic Assessment for patients with psychoses	PM	Qtr 4	Report			Qtr 3
		Actual	Compliant	Compliant			Compliant
9.02b	Improving physical healthcare: Communication with GPs	PM	Qtr 2	Report			Qtr 3
		Actual	Awarded	Compliant			Compliant
	Local CQUINs						
	CQUIN 2						
9.03	Personalised relapse prevention plans for adults accessing and using 2G Mental Health Services	PM		Report			Qtr 3
		Actual		Compliant			Compliant
	CQUIN 3						
9.04	Personalised relapse prevention plans for children and young people accessing and using MH services			Report			Qtr 3
				Compliant			Compliant
	CQUIN 4						
9.05	Appropriate care and management for frequent attenders to WVT A&E dept			Report			Qtr 3
				Compliant			Compliant

Agenda Item **8** **Enclosure** **Paper C**

Report to: Trust Board – 29th March 2017
Author: Marie Crofts, Director of Quality
Presented by: Alison Curson, Deputy Director of Nursing

SUBJECT: **6 Monthly Safe Staffing Update**

This Report is provided for:			
Decision	Endorsement	**Assurance**	**To note**

EXECUTIVE SUMMARY

This paper will give an update on the revised safe staffing guidance issued by the National Quality Board (NQB) in July 2016.

This 6 monthly update outlines :

- The full update on all the expectations within the new guidance (see Appendix 1)
- National reporting requirements, latest developments and the latest data in their required format
- Local Trust exception reporting

Appendix 1 details in full all expectations giving an update on Trust progress. Although the Trust has made much progress and in a good position regarding this guidance some work needs to be undertaken to ensure triangulation of all data.

National reporting with regards to fill rates continues to be uploaded monthly and reported to Governance Committee on behalf of Board. The Trust continues to have high compliance with planned v actual fill rates. Appendix 2 details the latest figures for Februarys 2017.

ASSURANCE

This update paper gives significant assurance on current progress and monthly reporting.

RECOMMENDATIONS

The Board is asked to:

- Note the current progress and assurance against the revised NQB guidance
- Note monthly reporting and compliance with fill rates

Corporate Considerations	
Quality implications	Safe staffing is fundamental to ensuring high quality safe services are delivered. This guidance ensures that all relevant triangulation regarding safe services is highlighted and noted for the Board
Resource implications:	No resource implications currently have been identified
Equalities implications:	No equalities implications as this guidance applies to all population groups
Risk implications:	If all the expectations are not met fully their may be some level of risk regarding delivery of safe and effective services.

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

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

Reviewed by:		
Marie Crofts, Director of Quality	Date	26th March 2017

Where in the Trust has this been discussed before?		
Every 6 month at Board	Date	September 2016

What consultation has there been?		
N/A	Date	

Explanation of acronyms used:	
NQB	National Quality Board
CHPPD	Care Hours Per Patient Day
CLDT's	Community Learning Disability Teams

1. CONTEXT

The Trust Board is mandated to receive a 6 monthly report outlining the requirements of the NHS National Quality Board (NQB) guidance on safe staffing levels (2013). This guidance has been updated in July 2016 *"Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time"* and outlines three main expectations below:

<table>
<tr><th colspan="3">Safe, Effective, Caring, Responsive and Well Led Care</th></tr>
<tr><td colspan="3">Measure and Improve
-patient outcomes, people productivity and financial sustainability-
-report investigate and act on incidents (including red flags) -
-patient, carer and staff feedback-</td></tr>
<tr><td colspan="3">-implement Care Hours per Patient Day (CHPPD)
- develop local quality dashboard for safe sustainable staffing</td></tr>
<tr><th>Expectation 1</th><th>Expectation 2</th><th>Expectation 3</th></tr>
<tr><td>Right Staff
1.1 evidence based workforce planning
1.2 professional judgement
1.3 compare staffing with peers</td><td>Right Skills
2.1 mandatory training, development and education
2.2 working as a multi-professional team
2.3 recruitment and retention</td><td>Right Place and Time
3.1 productive working and eliminating waste
3.2 efficient deployment and flexibility
3.3 efficient employment and minimising agency</td></tr>
</table>

The Trust Board received the last 6 monthly update in September 2016. The Governance Committee continues to receive bi-monthly reports detailing staffing levels across all inpatient sites as well as the use of temporary staffing updates.

This six monthly update paper outlines :

- The full update on all the expectations within the new guidance (see Appendix 1)
- National reporting requirements, latest developments and the latest data in their required format
- Local Trust exception reporting

2. PROGRESS ON THE NQB REVISED KEY EXPECTATIONS

See Appendix 1 attached to this report where the detail regarding each expectation is noted as well as progress to date. In summary the Trust has made significant progress against each expectation however the Director of Quality will lead a piece of work ensuring that the triangulation of the data from the 3 expectations above is co-ordinated and any further improvement progressed.

3. NATIONAL GUIDANCE

The National Quality Board (NQB) and NHSI are leading on a number of toolkits in relation to safe staffing for both inpatient and community services. The Learning Disability toolkit was published in December 2016 and the Trust has been considering this in relation to the CLDT's. Alongside this the Trust Head of Psychology has been piloting a weighing tool for CLDT's. The mental health toolkit is currently out for consultation and circulated widely for comments amongst our nursing staff.

In addition the Trust has chosen to be part of the Carter Review for mental health and community Trusts and has been undertaking an initial benchmarking exercise regarding collation of 'Care Hours Per Patient Day' (CHPPD) as well as corporate costs. The collection of the CHPPD data has been mandated to be reported by acute Trusts from last July however mental health Trusts were not mandated to do so. The next stage of the Carter Review will see this piloted and information benchmarked with the other 22 Trusts taking part.

Currently the Trust continues to publish the fill rates as directed by the previous national guidance. This is uploaded on to Unify and the Trust website. Appendix 2 outlines the national safe staffing requirement for February 2017. Planned fill rates continue to remain high and over 95% compliant against planned levels.

4. LOCAL TRUST EXCEPTION REPORTING

In line with previous internal Trust reporting, we have continued to collect and collate the reasons where core planned staffing levels have not been met through the internal exception codes. It is important to note that these are relatively rare events (in terms of percentages of overall fill rates). This local reporting is in addition to the national reporting and supports analysis of any issues which may arise regarding skill mix within the units and how the nurse in charge mitigates these risks.

Ward specific information

There are shifts where the core actual staffing hours may not exactly reflect the core planned staffing levels - the main reasons are outlined below:

- Increase in staff on duty to provide one to one care for patients (specialling);
- Decrease in staff, if the patient need does not require it e.g. patients on leave, or staff supporting other wards where the need is higher;
- The planned staffing numbers are based on pre-empted activity and dependency levels. This is determined by the nurse in charge for a set time frame and these may vary, for example; decisions may be made to replace a qualified nursing shift with a health care assistant who knows the patients and the ward, rather than a bank or agency nurse who may not. National Quality Board guidance states that the nurse in charge must use their professional judgement alongside the planned

staffing requirements to meet the needs of the patients on the ward at any particular time.

- The reasons for internal exceptions will only be reported where they are significantly high in number

In summary for February 2017:

- No staffing issues were escalated to the Director of Quality or the Deputy Director
- Where staffing levels dipped below the planned fill rates of 100% for qualified nurses this was usually offset by increasing staffing numbers of unqualified nurses based on ward acuity and dependency and the professional judgement of the nurse in charge of the shift
- **97%** of the hours exactly complied with the planned staffing levels
- **2.4%** of the hours during February had a different staff skill mix than planned staffing however overall the staffing numbers were compliant and the needs of patients were met
- **0.6%** of the hours during February had a lower number of staff on duty than the planned levels, however this met the needs of the patients on the ward at the time

Exception reporting per unit: (only those reporting high levels)

<u>Wotton Lawn:</u>

Greyfriars – the Code 1 exceptions were due to a band 5 vacancy and some sickness during the month.

<u>Learning Disability:</u>

Hollybrook – The Code 2's were in relation to a number of issues but the unit was safely managed on reduced numbers on all occasions.

<u>Stonebow:</u>

Cantilupe – the Code 1 exceptions are owing to the reduced number of qualified on at night. The Director of Quality and the Service Director and matron will review this as the Unit safely manage on one qualified member of staff and has done so for a number of years.

Exception reporting – February 2017

			Exception Code 1	Exception Code 2	Exception Code 3	Exception Code 4	Exception Code 5
Ward	***Bed number***	**Number of required staff hours in the month**	**Minimum staff numbers met – skill mix non-compliant but met needs of patients**	**Minimum staff numbers not compliant but met needs of patients**	**Minimum staff numbers met – skill mix non-compliant and did not meet needs of patients**	**Minimum staff numbers not compliant and did not meet needs of patients**	**Minimum staffing nos and skill mix not met. Resulting in clinical incident / harm to patient or other**
Dean	***14***	**2940 monthly hours**	**15**	**0**	**0**	**0**	**0**
Abbey	***18***	**2940 monthly hours**	**45**	**0**	**0**	**0**	**0**
Priory	***22***	**2940 monthly hours**	**70**	**0**	**0**	**0**	**0**
Kingsholm	***15***	**2940 monthly hours**	**15**	**0**	**0**	**0**	**0**
Montpellier	***12***	**3220 monthly hours**	**22.5**	**0**	**0**	**0**	**0**
Greyfriars	***10***	**3640 monthly hours**	**290**	**0**	**0**	**0**	**0**
Willow	***16***	**4060 monthly hours**	**60**	**0**	**0**	**0**	**0**
Chestnut	***14***	**2730 monthly hours**	**45**	**7.5**	**0**	**0**	**0**
Mulberry	***18***	**2940 monthly hours**	**7.5**	**0**	**0**	**0**	**0**
Laurel	***12***	**1820 monthly hours**	**135**	**0**	**0**	**0**	**0**
Honeybourne	***10***	**1820 monthly hours**	**97.5**	**0**	**0**	**0**	**0**
Westridge	***8***	**3220 monthly hours**	**0**	**0**	**0**	**0**	**0**
Hollybrook	***8***	**5040 monthly hours**	**0**	**265**	**0**	**0**	**0**
Mortimer	***21***	**2772 monthly hours**	**11.5**	**0**	**0**	**0**	**0**
Cantilupe	***8***	**2590 monthly hours**	**366.5**	**0**	**0**	**0**	**0**
Jenny Lind	***12***	**1540 monthly hours**	**1.5**	**0**	**0**	**0**	**0**
Oak House	***10***	**1540 monthly hours**	**0**	**0**	**0**	**0**	**0**
Total		**48692 monthly hrs**	**1182**	**272.5**	**0**	**0**	**0**

5. CONCLUSION

In summary the Trust has progressed a number of the detailed expectations within the revise NQB guidance however more work is needed to fully ensure triangulation of all factors relating to right skills; right time and right place within our teams and ward environments.

Appendix 1 - Updates NQB Expectations

Expectation 1: Right staff (8 standards)

The organisation uses evidence-based guidance such as that produced by NICE, Royal Colleges and other national bodies to inform workforce planning, within the wider triangulated approach in this NQB resource (see Appendix 4 for list of evidence-based guidance for nursing and midwifery care staffing).

The Trust has established planned ward staffing levels which have been reviewed on a number of occasions since the initial guidance in 2013. These were based upon the RCN and other relevant guidance. The mental health safe staffing guidance when published was a further opportunity to review staffing levels. All Matrons reported appropriate levels of staffing at that time. A further piece of work regarding triangulation will commence over the next 6 months.

The organisation uses workforce tools in accordance with their guidance and does not permit local modifications, to maintain the reliability and validity of the tool and allow benchmarking with peers.

The Keith Hurst tool was used initially as well as the guidance issues by the RCN. Following publication of the updated mental health and LD safer staffing tools in 2017staffing will be reviewed against this new guidance. Use of the Shelford model within older people's inpatient services was attempted but this was too acute hospital focused to be of any value.

Workforce plans contain sufficient provision for planned and unplanned leave, eg sickness, parental leave, annual leave, training and supervision requirements.

Workforce plans for the wards contain provision for leave; sickness and training. This is currency being reviewed in light of what actually is necessary against what is currently planned for. Ensuring supervision within our Herefordshire services remains a challenge and we are working with staff to support all nurses get appropriate and relevant supervision.

Clinical and managerial professional judgement and scrutiny are a crucial element of workforce planning and are used to interpret the results from evidence-based tools, taking account of the local context and patient needs. This element of a triangulated approach is key to bringing together the outcomes from evidence-based tools alongside comparisons with peers in a meaningful way.

Ensuring the nurse in charge of the shift has ultimately the responsibility to ensure there is sufficient numbers and skills of staff on duty on every shift. Although the Trust has benchmarked staffing levels some time ago it would be prudent to repeat this over the next 6 months.

Professional judgement and knowledge are used to inform the skill mix of staff. They are also used at all levels to inform real-time decisions about staffing taken to reflect changes in case mix, acuity/dependency and activity.

Case load supervision and management decision making with each team and ward are key to ensuring appropriate real-time decisions are made. Where acuity has increased and cannot be safely managed with the numbers and skills of staff on any shift the nurse in charge will seek to gain additional staff for that shift. This is part of our internal escalation process for access to temporary staffing.

The organisation compares local staffing with staffing provided by peers, where appropriate peer groups exist, taking account of any underlying differences.

The Trust has not recently compared itself with peers and will undertake to do this work over the next 6 months and provide an update in the next report to Board.

The organisation reviews comparative data on actual staffing alongside data that provides context for differences in staffing requirements, such as case mix (eg length of stay, occupancy rates, caseload), patient movement (admissions, discharges and transfers), ward design, and patient acuity and dependency.

As part of the daily recording planned against actual numbers of staff on shift- including skill mix ay exceptions with regards to increased acuity or dependence or any additional risk factor are noted using our exception reporting process. This forms part of the monthly safe staffing report to Governance Committee. Any patient safety issues are highlighted immediately through our internal escalation process to the Director of Quality. Our PICU and low secure services have developed planned levels based n additional levels of acuity.

The organisation has an agreed local quality dashboard that triangulates comparative data on staffing and skill mix with other efficiency

Currently the Trust has no locally held quality dashboard however quality and performance KPI's are reported to Board. This is correlated and triangulated with the safe staffing report for any inconsistencies or concerns. The next 6 months will see the production of a quality dashboard at ward level to highlight any local triangulation.

Expectation 2: Right skills (13 standards)

Frontline clinical leaders and managers are empowered and have the necessary skills to make judgements about staffing and assess their impact, using the triangulated approach outlined in this document.

Clinical leaders and managers actively manage their staffing levels using the triangulated approach described. Issues are escalated such as within our Herefordshire inpatient services where concerns emerge regarding recruitment and retention of staff. Here there are concerns additional staffing is considered through our temporary staffing process and escalation to Matron and ultimately the Director of Quality and Director of Service Delivery.

Staffing establishments take account of the need to allow clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship and supervision roles, including the support of preregistration and undergraduate students.

Numbers of days required to undertake all training has been scoped and staffing rotas are constructed in a way that enables staff to be released to undertake training without impacting clinical numbers. This will be further reviewed through benchmarking with other Trusts.

Those with line management responsibilities ensure that staff are managed effectively, with clear objectives, constructive appraisals, and support to revalidate and maintain professional registration.

The Trust has in place a number of policies supporting this. These include the appraisal policy; Supervision policy and revalidation policy. Compliance against these policies is closely monitored through both our Delivery and Governance Committees.

The organisation analyses training needs and uses this analysis to help identify, build and maximise the skills of staff. This forms part of the organisation's training and development strategy, which also aligns with Health Education England's quality framework.

The Head of training at Collingwood house undertakes annual training needs analysis with support from professional leads and annual education report created. As part of the STP in both our Counties the Trust is heavily involved in workforce planning and our CEO Shaun Clee is chairing both these work streams. We are always reviewing training needs and delivery and seeking innovative ways to recruit and retain staff. The Director of Quality has delivered a series of 'Care and Compassion' workshops which sought to re-energise and value staff for their contribution. The Trust is using new roles to sustain the workforce such as Nursing Associates and Physicians Assistants.

The organisation develops its staff's skills, underpinned by knowledge and understanding of public health and prevention, and supports behavioural change work with patients, including self-care, wellbeing and an ethos of patients as partners in their care.

The Trust is committed to self care and prevention which includes improving the physical health of our service users. Through the national physical health CQUIN and the Trust going smoke-free in April 2017 we hope to build on the great progress made during the last two years. This work is led at a senior level by the Deputy Director of Nursing.

Service user and carer involvement and co-production is a key strategic objective for the organisation and the Director of Engagement and Integration leads a strong social inclusion and service experience department which includes a recovery college and other ways of co-production with service users.

The workforce has the right competencies to support new models of care. Staff receive appropriate education and training to enable them to work more effectively in different care settings and in different ways. The organisation makes realistic assessments of the time commitment required to undertake the necessary education and training to support changes in models of care.

The workforce changes which will take place over the coming years will need additional or changed competencies and skills. Hs work is currently underway as part of the STP workstream. Current CPD has been identified by all of the Nurse Directors across our Glos health community and will be commissioned on the basis of 5 strategic areas including mental health; EOL and others linked to the STP and national drivers. This will enable the workforce to be able to support new models of care in the future.

The organisation recognises that delivery of high quality care depends upon strong and clear clinical leadership and well-led and motivated staff. The organisation allocates significant time for team leaders, professional leads and lead sisters/charge nurses/ward managers to discharge their supervisory responsibilities and have sufficient time to coordinate activity in the care environment, manage and support staff, and ensure standards are maintained.

There is strong clinical leadership at all levels. The Trust Board has three clinician executives including a nurse; a medic and an AHP. This ensures all debates are clinically focused where appropriate. A Nursing Professional Advisory group convenes on a monthly basis led by the Deputy Director of Nursing (and attended by the Director of Quality). The CEO has established both a senior leadership and a leadership forum which meet regularly. More locally all team leaders and ward managers have time for reflection and supervision which is highly regarded and encouraged via the trust supervision policy.

The organisation demonstrates a commitment to investing in new roles and skill mix that will enable nursing and midwifery staff to spend more time using their specialist training to focus on clinical duties and decisions about patient care.

The Trust demonstrates such a commitment through active engagement with local partners and HEE with regard to the nursing associate 'fast follower' course plus x6 support workers seconded to undertake pre-registration RMN training. In addition the Trust has invested and supported nurse medical prescribers and AMHP'S from a range of professions.

The organisation recognises the unique contribution of nurses, midwives and all care professionals in the wider workforce. Professional judgement is used to ensure that the team has the skills and knowledge required to provide high-quality care to patients. This stronger multi-professional approach avoids placing demands solely on any one profession and supports improvements in quality and productivity, as shown in the literature.

A multi professional approach is evident from Board to ward. The Trust Board has three clinical executives and actively promotes an MDT approach in all teams. All teams have access to a range of professionals. Care coordination is the responsibility of a range of disciplines in community teams and in our inpatient Glos services service users have access to a 7 day a week therapy service.

The organisation works collaboratively with others in the local health and care system. It supports the development of future care models by developing an adaptable and flexible workforce (including AHPs and others), which is responsive to changing demand and able to work across care settings, care teams and care boundaries.

The STP in both Counties has given impetus to collaborative working which was taking place within both patches. Within Glos the DoN's have commissioned the CPD for nurses and AHP's to be aligned to the STP priorities which will support the development of new models of care. In addition the increasing focus on physical health within the mental health user population is an area we are focusing on. This will encourage cross organisational and cross boundary working.

The organisation has clear plans to promote equality and diversity and has leadership that closely resembles the communities it serves. The research outlined in the NHS provider roadmap[42] demonstrates the scale and persistence of discrimination at a time when the evidence demonstrates the links between staff satisfaction and patient outcomes.

The staff survey this year demonstrates an improvement with staff from BME backgrounds feeling bullied or stating they are discriminated against from previous years results. Although this is good progress we need to ensure we actively make opportunities for BME staff. Within nursing this will be actively encouraging staff from these groups to have robust CPD plans and access to specific leadership training where possible.

The organisation has effective strategies to recruit, retain and develop their staff, as well as managing and planning for predicted loss of staff to avoid over-reliance on temporary staff.

Within the Trust part time workers are facilitated as per service demands as are flexible working contracts in alignment with our flexible working lives policy. 2gether is committed to ensuring equitable access to education for the whole workforce and we encourage support workers to advance their skills and knowledge via NAP courses as well as returners via return to practice programmes.

In planning the future workforce, the organisation is mindful of the differing generational needs of the workforce. Clinical leaders ensure workforce plans address how to support staff from a range of generations, through developing flexible approaches to recruitment, retention and career development

The Trust will be working on how we can best retain staff who are due to retire and best use their expertise in a flexible way. In addition we will be using the research evidence 'Mind the Gap' to identify what other things we can put in place for the different generational groups (particularly the younger groups) to ensure they come and work for us.

Expectation 3 : Right place and time. (16 standards)

The organisation uses 'lean' working principles, such as the productive ward, as a way of eliminating waste.

Productive ward techniques are employed by all wards. Strategies have included white boards to improve efficiency in clinical handovers, de-cluttering clinics to reduce waste and over-ordering and speed in locating items as well as strategies for handovers including 'SBARD' (Situation; Background; Assessment; Recommendation/ Response and Decision). SBARD is not embedded into practice and this will be reviewed over the next 6 months.

The organisation designs pathways to optimise patient flow and improve outcomes and efficiency eg by reducing queueing.

The bed management structure has been reviewed recently and has now been improved including increasing the resources for this. A bed management and discharge planning meeting is held twice weekly which includes all inpatient areas across both Counties. The Trust has a dedicated complex care team which holds the budget and resources for out of County placements and moving people to the most appropriate placements as soon as possible. Our Lead nurses and the current ERG's are supporting defining pathways through their expertise and through the STP workstreams.

Systems are in place for managing and deploying staff across a range of care settings, ensuring flexible working to meet patient needs and making best use of available resources.

Our Matrons ensure that nurses are deployed appropriately across our inpatient units. Team managers ensure their local teams can operate effectively re community staffing. The Trust has a staff bank which has been expanded to more actively include our Herefordshire services however this does need strengthening. Work on recruiting the use of agency across all professions has taken place during 2016/17 however this has not yet impacted significantly on the control total position. More focus on this during 2017/18 will take place including learning from other Trusts who are doing well.

The organisation focuses on improving productivity, providing the appropriate care to patients, safely, effectively and with compassion, using the most appropriate staff.

The Trust is currently one of the pilot Trusts within the Carter review for mental health Trusts. This work will inform future practices and appropriately increase productivity. The Trust is part of the South of England patient safety / Quality Improvement Collaborative with our CEO as Chair of this. Many QI initiatives to improve patient safety have been embed within practice including falls bundles; reduction in medication errors / blank boxes and reducing harm form AWOLs. In addition our 'harm free' indicators are either above or same as the national average and over 90% compliant with little or no harm. The Director of Quality has led a series of 'Care and Compassion' events for all staff across the organisation (clinical and non-clinical) to support staff in terms of their resilience and value their contribution. The feedback was overwhelmingly positive. Following the publication of the safe staffing toolkits for MH and LD we will review both inpatient and community teams .

The organisation supports staff to use their time to care in a meaningful way, providing direct or relevant care or care support. Reducing time wasted is a key priority.

The Trust has embarked on an 'Improving Care through Technology' programme of work which it has brought forward to enable all clinicians to have the technology they need to support their practice in a more efficient way. This includes the use of including digital dictation and mobile devices (phones, tablets and laptops). This will improve productively as staff will no longer need to return to a base to update records etc.

Systems for managing staff use responsive risk management processes, from frontline services through to board level, which clearly demonstrate how staffing risks are identified and managed.

Safe staffing levels are reported monthly to QCR and Governance bi-monthly and subsequently to Board as well as uploaded onto Unify. Actual fill rates are over 96% compliant against planned levels. Our escalation process is clear and there is a line of sight through to the Director of Quality where any issues result in potential increased risk or patient safety concerns. Each locality has a full risk register which is discussed at the monthly QCR subcommittee led by the executive clinicians. Workforce is one of the top 5 risks for the organisation and is continually discussed at executive and Board level.

Organisational processes ensure that local clinical leaders have a clear role in determining flexible approaches to staffing with a line of professional oversight, that staffing decisions are supported and understood by the wider organisation, and that they are implemented with fairness and equity for staff.

Clinical leaders are engaged in ongoing discussions with clinical teams regarding clinical challenges and staffing level needs. Within the senior leadership forum and the wider leadership forum these issues are discussed. The Clinical Directors alongside the profession leads are encouraged to engage flexible and innovative approaches to this.

Clinical capacity and skill mix are aligned to the needs of patients as they progress on individual pathways and to patterns of demand, thus making the best use of staffing resource and facilitating effective patient flow.

Clinical capacity and skill mix are reviewed team by team and by the Matrons within the hospital sites. This work will need a further review following publication of the MH and LD safe staffing toolkits later in this year. Within LD services some work has progressed with the piloting of a caseload management/ weighting tool.

Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet patients' needs.

The staffing levels within inpatient settings are reviewed on a shift by shift basis by the nurse in charge of the shift and overseen by the Matron for the hospital site. Any change from planned levels will be discussed by the ward manger and the Matron. Consideration will be made as to the best appropriate action should acuity increase or the planned levels of staffing cannot be met. Our internal exception reporting will note any change from planned levels.

Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective and compassionate care, and staff are aware of the steps to take where capacity problems cannot be resolved.

We have an escalation policy and business contingency policy which are enacted if this becomes relevant. In addition our observation policy cross references to the escalation policy for completeness.

Meaningful application of effective e-rostering policies is evident, and the organisation uses available best practice from NHS Employers[46] and the Carter Review Rostering Good Practice Guidance (2016).

From April 2017 we will be implementing e-rostering. We have a e-rostering manager now in post who will lead on this as well as some temporary resource to ensure robust initial implementation of this system. In addition we are one of the pilot sites for the mh Carter review process which has just recently commenced.

The annual strategic staffing assessment gives boards a clear medium-term view of the likely temporary staffing requirements. It also ensures discussions take place with service leaders and temporary workforce suppliers to give best value for money in

deploying this option. This includes an assessment to maximise flexibility of the existing workforce and use of bank staff (rather than agency), as reflected by NHS Improvement guidance.

The Trust currently has a monthly Temporary staffing Project Board and reports on safe staffing within nursing to the Governance Committee and 6 monthly updates to the Board. Over the coming months the executive team will work together to identify what longer team plans need to be put in place to ensure greater flexibility of the workforce and reduced reliance on temporary staffing solutions – in particular agency use.

The organisation is actively working to reduce significantly and, in time, eradicate the use of agency staff in line with NHS Improvement's nursing agency rules, supplementary guidance and timescales.

The Trust has a monthly temporary staffing board chaired by the Director of Quality. Additional actions during 2017/18 have been identified to ensure a full grip and focus on the use of agency is taken including having an effective and responsive staff bank which can respond quickly to cover shifts. The reduction in the use of medical locums is also being tackled by the Medical Director.

The organisation's workforce plan is based on the local Sustainability and Transformation Plan (STP), the place-based, multi-year plan built around the needs of the local population.

Our CEO is the chair of both STP workforce work streams and as such is fully engaged with this work. In addition several other executive colleagues are part of the STP work streams which impact on the workforce development. The Trust has embarked on a number of initiatives re new roles including being a fast follower site for the Nursing Associate role. Both the Director of HR and OD and the Director of Quality work closely with commissioners to inform the workforce plans for the Counties in which we operate.

The organisation supports Health Education England by ensuring that high quality clinical placements are available within the organisation and across patient pathways, and actively seeks and acts on feedback from trainees/students, involving

The Trust works with a number of HEI's and alongside HEE to ensure the placement experience within our Trust is the best it can be. We actively encourage and use all feedback form the HEI's to improve our Clinical placements and through 2016/17 have had a number of innovative placements put in place especially for third year nursing students. The placements for junior doctors are deemed as high quality and the survey has resulted in the Trust being one of the top Trusts for positive feedback. We have a very active Practice Education Facilitator for nursing students who works closely with the HEI's. In addition we are one of the sites for the HEE national RePAIR project looking at attrition of student nurses and how we improve support to them in their student placements as well as in the first year of qualifying.

Appendix 2: Safe staffing fill rates February 2017

Only complete sites your organisation is accountable for			Day				Night				Day		Night	
Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
Dean	710 - ADULT MENTAL ILLNESS		840	840	1260	1365	560	580	280	350	100.0%	108.3%	103.6%	125.0%
Abbey	710 - ADULT MENTAL ILLNESS		1260	1230	840	870	560	560	280	280	97.6%	103.6%	100.0%	100.0%
Priory	710 - ADULT MENTAL ILLNESS		1260	1237.5	840	915	560	550	280	300	98.2%	108.9%	98.2%	107.1%
Kingsholm	710 - ADULT MENTAL ILLNESS		840	832.5	1260	1297.5	560	570	280	330	99.1%	103.0%	101.8%	117.9%
Montpellier	710 - ADULT MENTAL ILLNESS		840	877.5	1260	1245	560	560	560	560	104.5%	98.8%	100.0%	100.0%
Greyfriars	710 - ADULT MENTAL ILLNESS		1260	1027.5	1260	1515	560	510	560	840	81.5%	120.2%	91.1%	150.0%
Willow	715 - OLD AGE PSYCHIATRY		840	802.2	2100	2152.5	280	290	840	850	95.5%	102.5%	103.6%	101.2%
Chestnut	715 - OLD AGE PSYCHIATRY		840	832.5	1050	1057.5	280	280	560	570	99.1%	100.7%	100.0%	101.8%
Mulberry	715 - OLD AGE PSYCHIATRY		840	855	1260	1492.5	280	280	560	560	101.8%	118.5%	100.0%	100.0%
Laurel	710 - ADULT MENTAL ILLNESS		630	510	630	802.5	280	280	280	280	81.0%	127.4%	100.0%	100.0%
honeybourne	710 - ADULT MENTAL ILLNESS		630	562.5	630	735	280	280	280	280	89.3%	116.7%	100.0%	100.0%
Westridge	700- LEARNING DISABILITY		420	487.5	1680	1545	280	300	840	840	116.1%	92.0%	107.1%	100.0%
Hollybrook	700- LEARNING DISABILITY		420	645	2940	2625	280	300	1400	1370	153.6%	89.3%	107.1%	97.9%
Mortimer	710 - ADULT MENTAL ILLNESS		924	984	616	1128.25	616	644	616	1012	106.5%	183.2%	104.5%	164.3%
Cantilupe	715 - OLD AGE PSYCHIATRY		616	630	924	1443.5	616	322	434	1221.5	102.3%	156.2%	52.3%	281.5%
Jenny Lind	715 - OLD AGE PSYCHIATRY		616	642.5	308	701.5	308	322	308	678.5	104.3%	227.8%	104.5%	220.3%
Oak House	710 - ADULT MENTAL ILLNESS		616	678.5	308	425.5	308	322	308	322	110.1%	138.1%	104.5%	104.5%

Agenda Item: 9 **Enclosure:** Paper D

Report to: Trust Board – 30 March 2017
Author: Angie Fletcher, Interim Service Experience Clinical Manager
Presented by: Jane Melton, Director of Engagement and Integration

Subject: **Service Experience Report Quarter 3 2016/17**

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

EXECUTIVE SUMMARY

(1) Assurance

This Service Experience Report provides a high level overview of feedback received from service users and carers in Quarter 3 2016/2017. Learning from people's experiences is the key purpose of this paper which provides assurance that service experience information has been reviewed, scrutinised for themes and considered for both individual team and general learning across the organisation.

Significant assurance that the organisation has listened to, heard and understood Service User and carer experience of 2gether's services.
This assurance is offered from a triangulation of information gathered across all domains of feedback including complaints, concerns, comments and compliments. Survey information has also been triangulated to understand service experience.

Significant assurance that service users value the service being offered and would recommend it to others.
During Quarter 3, 89% of people who completed the Friends and Family Test said that they would recommend 2gether's services. The Trust continues to maintain a high percentage of people who would recommend our services.

Limited assurance that people are participating in the local survey of quality in sufficient numbers.
An in-depth review has been undertaken and a targeted action plan is now underway to refresh and relaunch the surveys used within our Trust from April 2017.

Significant assurance that services are consistently reporting details of compliments they have received.
Following a review and refresh of existing systems to collect compliment information by the Service Experience Department the amount of compliments reported has significantly increased. Compliments reported in Quarter 2 – 389, compliments received in Quarter 3 – 715.

Full Assurance that complaints have been acknowledged in required timescale
During Quarter 3 100% of complaints received were acknowledged within 3 days.

Limited assurance that all people who complain have their complaint dealt with by the initially agreed timescale.
65% of complaints were closed within timescales agreed with the complainant. This is encouraging news as the Quarter 2 closure rate was a disappointing 41%. The Service Experience Department have worked with Service Directors to implement plans to respond to the areas contributing to delays with good effect.

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

(2) Learning and Improvement recommended

The Trust continues to seek feedback about service experience from multiple sources on a continuous basis.

This Quarter there have been concerns raised by Service Users about being updated about changes in service contact details when a service moves location or changes telephone numbers.

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

- We must explain our referral and assessment process clearly to people their carers and families. We should tell people about the next steps that will be taken.
- People are unhappy that reports about them are not accurate. We should write entries in clinical records to mirror how things happened or how they were talked about.

An update on referrals to and responses from the Parliamentary and Health Service Ombudsman activity is included within this report and offers assurance that the Trusts approach to complaint resolution is good.

RECOMMENDATIONS

The Trust Board is asked to:

- Note the contents of this report

Corporate Considerations	
Quality Implications	Patient and carer experience is a key component of the delivery of best quality of care. The report aims to outline what is known about service experience of ^{2}gether's services in Q3 2016/17 and to make key recommendations for action to enhance quality.

Resource Implications	A service experience report offers assurance to the Trust that resources are being used to support best service experience.
Equalities Implications	The Service Experience Report offers assurance that the Trust is attending to its responsibilities regarding equalities for service users and carers.
Risk Implications	Feedback from service experience offers an insight into how services are received. The information provides a mechanism for identifying performance, reputational and clinical risks.

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

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

Reviewed by:		
Jane Melton, Director of Engagement and Integration	Date	16th March 2017

Where in the Trust has this been discussed before?		
Quality and Clinical Risk Committee Trust Governance Committee	Date	17th February 2017 17th February 2017

What consultation has there been?		
Service Experience Committee members	Date	January 2017

Explanation of acronyms used:	NHS – National Health Service HW – Healthwatch PALS – Patient Advise and Liaison Service GP – General Practitioner MP – Member of Parliament OPS – Older Peoples Service LD – Learning Disabilities CYPS – Children and Young People's Service GRIP – Gloucestershire Recovery in Psychosis Team MHA- Mental Health Act GHNHSFT – Gloucestershire Hospitals NHS Foundation Trust

	CCG – Clinical Commissioning Group BME – Black and Minority Ethnic Groups IAPT – Improving Access to Psychological Therapies PHSO – Parliamentary Health Services Ombudsman CAMHS – Child and Adolescent Mental Health Service CRHTT – Crisis Resolution and Home Treatment Team

2gether
Making life better

2gether
NHS Foundation Trust

Service Experience Report

Quarter 3

1st October 2016 – 31st December 2016

"As always, supportive, funny and kind. Made the visit enjoyable."

CYPS, Gloucestershire

"Was listened to and given the help I needed and the environment was friendly."

CAMHS, Herefordshire

Contents

Key

NHS	National Health Service
HW	HealthWatch
PALS	Patient Advice and Liaison Service
GP	General Practitioner
MP	Member of Parliament
OPS	Older People's Service
LD	Learning Disabilities
CYPS	Children and Young People Service
GRIP	Gloucestershire Recovery in Psychosis
HR	Human Resources
SIDW	Social Inclusion Development Worker
CEO	Chief Executive Officer
BME	Black and Minority Ethnic Groups
IAPT	Improving access to psychological therapies
PHSO	Parliamentary and Health Service Ombudsman
CHI ESQ	Children's Experience of Service Questionnaire
DMHOP	Department of Mental Health for Older People
CAMHS	Child and Adolescent Mental Health Service
CRHTT	Crisis Resolution and Home Treatment Team
MHA	Mental Health Act
MCA	Mental Capacity Act
CCG	Clinical Commissioning Group
GHNHSFT	Gloucestershire Hospitals NHS Foundation Trust
Q2	Quarter 2 (previous quarter)
FFT	Friends and Family Test (survey)

Service Experience Report – Quarter 3

1st October 2016 – 31st December 2016

Complaints 	**31** complaints (164 separate issues) were made this quarter. This is more than last time (n=28). We want people to tell us about any concerns about their care. This means we can make it better.	↑
Concerns 	**35** concerns were raised through PALS. This is less than last time (n=48).	↓
Compliment 	**715** people told us they were pleased with our service. This is more than last time (n=389). We want teams to tell us about every compliment they get.	↑
FFT 	**89%** of people said they would recommend our service to their family or friends. This is nearly the same as last time (90%).	↔
Quality Survey 	April 2016 – December 2016 feedback combined: Gloucestershire: **127 people told us what they thought** Herefordshire: **59 people told us what they thought** Some people are telling us what they think about their care. We need to ask more people for their thoughts and views.	↓ (numbers of participants)
We must listen 	We must explain our referral and assessment process clearly to people, their carers and families. We should tell people about the next steps that will be taken.	
We must listen 	People are unhappy that reports about them are not accurate. We should write entries in clinical records to mirror how things happened or how they were talked about.	

Key

			Full assurance
↑	Increased performance/activity		Significant assurance
↔	Performance/activity remains similar		Limited assurance
↓	Reduced performance/activity		Negative assurance

Section 1 – Introduction

1.1 Overview of the paper

1.1.1 This paper provides an overview of people's reported experience of ²gether NHS Foundation Trust's services between **1st October 2016 and 31st December 2016**. It provides examples of the learning that has been achieved through service experience reporting, and an update on activity to enhance service experience.

1.1.2 **Section 1** provides an introduction to give context to the report.

1.1.3 **Section 2** provides information on emerging themes from reported experience of Trust services. It includes complaints, concerns, comments, compliments and survey information. Conclusions have been drawn via triangulation of information provided from:

- A synthesis of service experience reported to ²gether NHS Trust (complaints, concerns, comments, compliments)
- Patient Advice and Liaison Service (PALS)
- Narrative reports made by members of the Service Experience Committee
- Meetings with stakeholders
- ²gether meetings with patients in the ward environment
- ²gether quality surveys
- National Friends and Family Test (FFT) responses
- ²gether Carer focus groups
- HealthWatch Gloucestershire reports and engagement events
- HealthWatch Herefordshire reports and engagement events

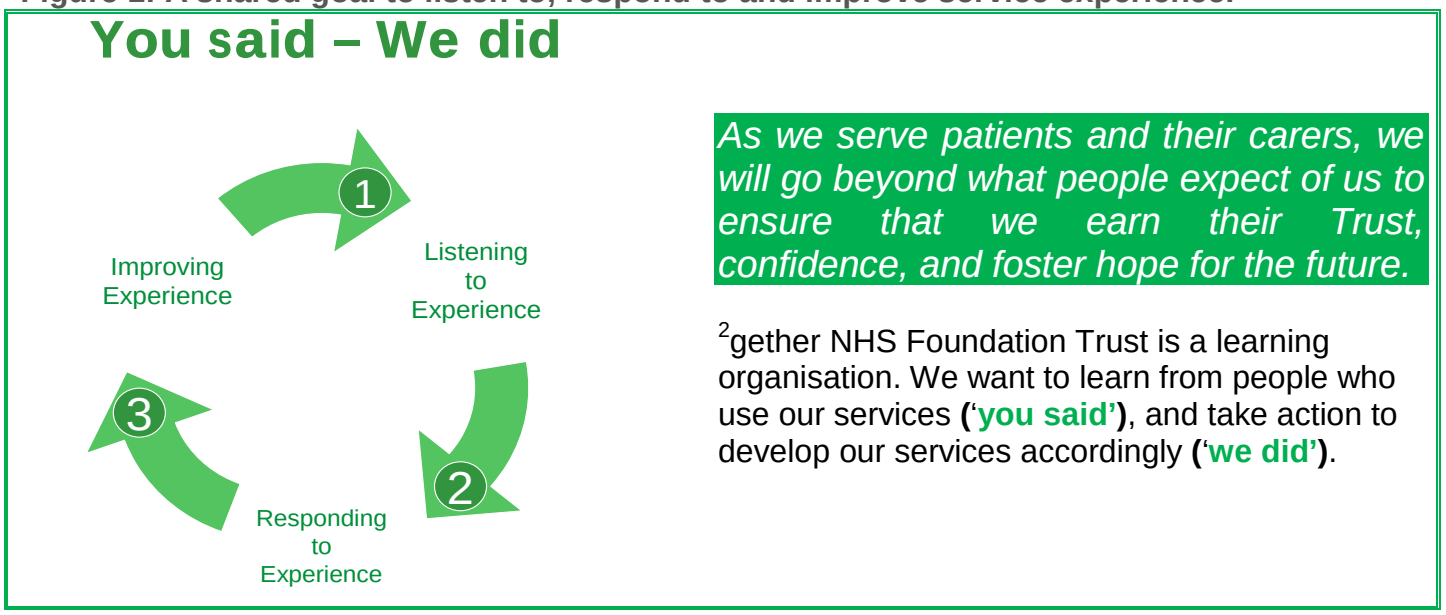
1.1.4 **Section 3** provides examples of the learning that has been brought together through service experience reporting and subsequent action planning.

1.2 Strategic Context

1.2.1 Listening and responding to comments, concerns and complaints and being proactive about the development of inclusive, quality services is of great importance to [2]gether. This is underpinned by the NHS Constitution (2015[1]) and is a key component of the Trust's core values.

1.2.2 [2]gether NHS Trust's Service User Charter, Carer Charter and Staff Charter outline the commitment to delivering our values and this is supported by active implementation of [2]gether's Service Experience Strategy (2013). The Service Experience Strategy will be reviewed and updated during 2017/18 in collaboration with our stakeholders.

Figure 1: A shared goal to listen to, respond to and improve service experience.



1.2.3 **The overarching vision for service experience is that:**

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

Through a continuous cycle of learning from experience we will provide the best quality service experience and care.

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

Section 2 – Emerging Themes about Service Experience

2.1 Complaints

Formal complaints to NHS service providers are highly governed and responses must follow specific procedures (for more information, please see the Trust's Complaints Policy). Complaints are welcomed by the Trust. We value feedback from service users and those close to them relating to the services they receive as this enables us to make services even more responsive and supportive.

Table 1: Number of complaints received this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	29		An increased number of complaints has been reported in Gloucestershire in quarter 3 (Q2 n=23)	Significant
Herefordshire	2		A slightly decreased number of complaints has been reported in Herefordshire in quarter 3 (Q2 n=5).	Significant
Total	31		The total number of complaints received is similar to the previous quarter (Q2 n=28)	Significant

The numbers of individual complaints has continued to remain stable throughout the first three quarters of this year. Complaints continue to be more complex and have many issues within each individual complaint. This means we are seeing an increase in both the depth and breadth of individual complaints leading to wider and more complex investigations

Table 2: Number of complaints by individual contacts made with our services:

	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17
Gloucestershire complaints	17	21	20	20
Gloucestershire contacts	10,230	10,219	10,067	9,998
% complaints to contacts (Glos)	0.17%	0.21%	0.20%	0.20%
Herefordshire complaints	6	3	5	2
Herefordshire contacts	3,527	3,477	3,525	3,409
% complaints to contacts (Hfd)	0.17%	0.09%	0.14%	0.06%

**this does not include primary care contacts*

The proportion of complaints to contacts remains low and relatively consistent.

Table 3: Number of complaints closed this quarter

County	Number (Numerical direction)		Interpretation	Assurance
Gloucestershire	23		The number of complaints closed for Gloucestershire is similar to last quarter (Q2 n=22)	Significant
Herefordshire	3		The number of complaints closed for Herefordshire is slightly lower than last quarter (Q2 n=5)	Significant
Total	26		The overall number of complaints closed is similar to the previous quarter (Q2 n=27)	Significant

The closure rate continues to reflect the number of complaints raised in the previous quarter – this shows timely completion of complaints processes.

Table 4: Responsiveness

Target	Number (numerical direction)		Interpretation	Assurance
Acknowledged with three days	100%		**All** complaints were acknowledged within target timeframes	Full
Complaint closed within agreed timescales	65%		This is higher than last quarter (Q2 = 41%) and is predominantly due to delays in the investigation process (78%)	Limited
Concerns escalated to complaint	6%		Of 35 concerns received (Q2 = 48), 2 were not resolved and so were escalated; this is much lower than Quarter 2. (Q2= 13%).	Significant

The Service Experience Department (SED) has continued to acknowledge all complaints within the national standards for response times for Quarters 1 -3 2016/17.

The rate of complaints closed within the agreed timescale has increased during Quarter 3. This is encouraging news. Quarter 2 closure rates were disappointing and so the SED along with Service Directors have worked to identify areas of difficulty within the existing complaints process that have contributed to the delays identified. Plans have been developed and implemented along with the refresh of existing systems. The Service Experience Department have continued to increase the availability of training sessions for complaint investigators and have adopted a new approach to support and coach investigators throughout the process.

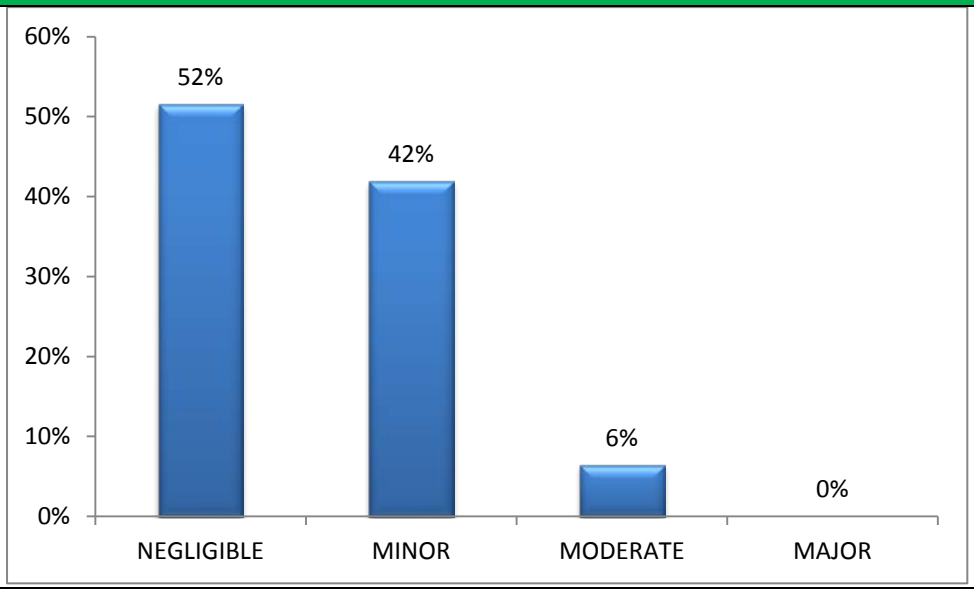
The continued implementation of a triage process at the point of initial contact with complainants has resulted in achieving more local resolutions to issues raised. This has resulted in a timely and less formal response to the issues raised. The relatively low number of concerns being escalated to complaints suggests that people are largely satisfied with this approach.

Table 5: Satisfaction with complaint process

Measure	Number (numerical direction)		Interpretation	Assurance
Reopened complaints	7	↑	This figure is slightly higher than the previous quarter (Q2 n=4)	Significant
Local Resolution Meetings	4	↔	This figure is similar to that reported in the previous quarter (Q2 n=5) suggesting continued satisfaction with the complaint process in most cases.	Significant
Referrals to PHSO	1	↑	One complaint has been referred to the PHSO this quarter. (Q2 n=2).	Significant

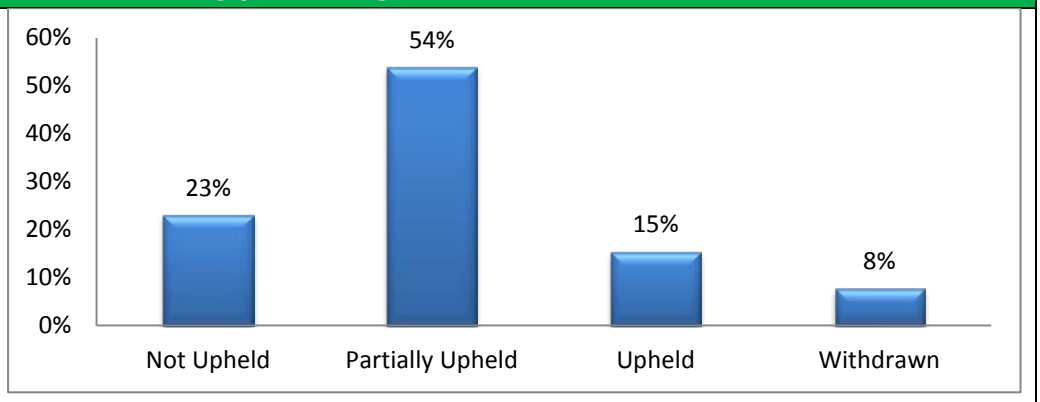
Quarter 3 has seen a slight increase in the number of complaints reopened following a complainant being informed of the findings of the complaint investigation. Our SED have routinely been offering Local Resolution Meetings to meet with complainants who remain dissatisfied with the outcome of a complaints investigation. This means reopening a previously closed complaint – this has may influence the number of complaints being reopened.
There has been one referral to the PHSO this quarter. As yet we have not been informed if the PHSO intend to investigate this referral.

Table 6: Risk rating of complaints received this quarter

Rating	No.	Chart showing percentages
Negligible *Minimal impact on individual or organisation*	10	
Minor *Minor implications, reduced performance, single failure*	11	
Moderate *Significantly reduced effectiveness, failure to meet internal standards*	6	
Major *Complaint regarding serious harm or death*	0	

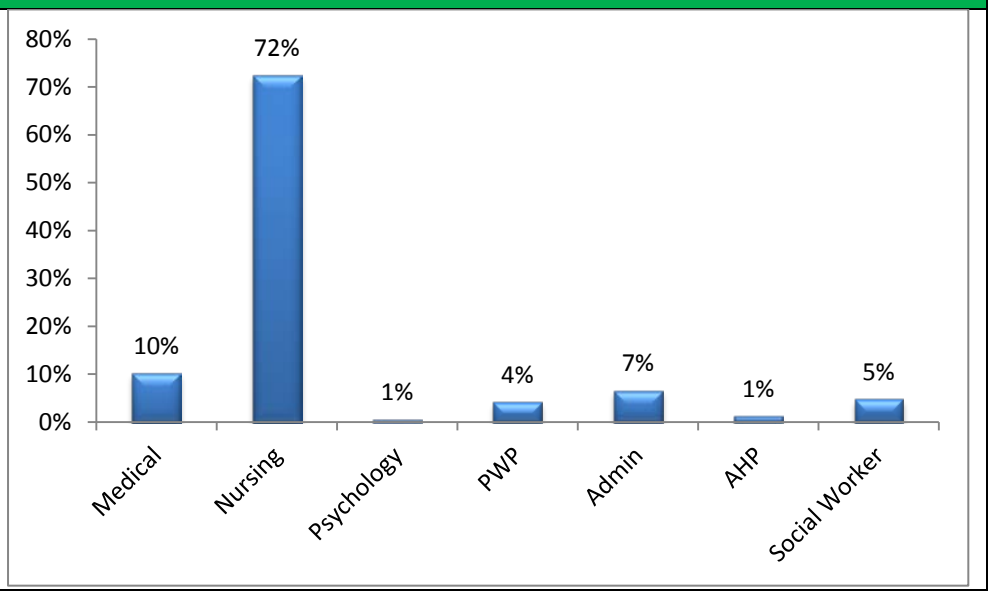
94% of the complaints received were classified as negligible or minor in terms of their impact on the individual or the organisation. This is higher than last quarter (Q2 = 75%) showing a reduction of complaints in Quarter 3 meeting the “moderate” threshold. All complaints are regarded as important for individuals and resolution is a key aim.

Table 7: Outcome of complaints closed this quarter

Outcome	No.	Chart showing percentages
Not upheld *No element of the complaint was upheld*	6	
Partially upheld *Some elements of the complaint were upheld*	14	
Upheld *All elements of the complaint were upheld*	4	
Withdrawn *Complaint was withdrawn*	2	

69% of the complaints closed this quarter had their concerns upheld or partially upheld. This is higher than the previous quarter (33% partially upheld, 15% upheld). A contributory factor to this slight increase is thought to be linked to the increased number of issues within individual complaints.

Table 8: Breakdown of complaints by staff group for this quarter

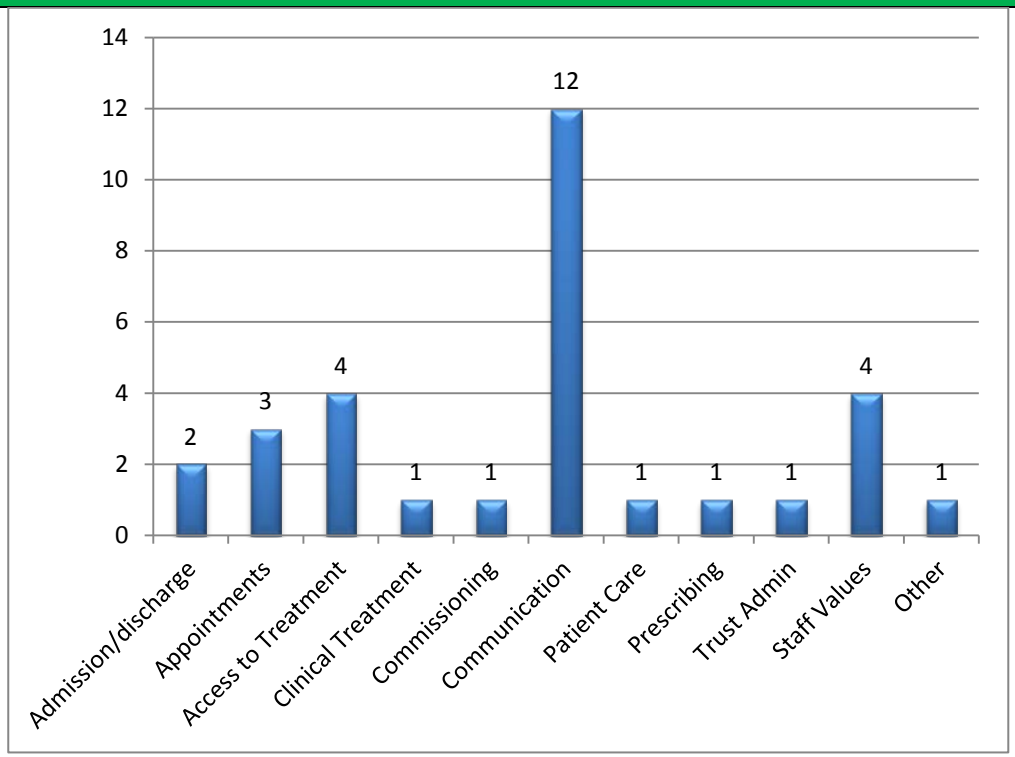
Outcome	No.*	Chart showing percentages
Medical	17	
Nursing	121	
Psychology	1	
PWP (Psychological Wellbeing Practitioners)	7	
Admin	11	
Allied Health Professionals (AHP)	2	
Social Work	8	

**The numbers represented in these data relate to a breakdown of individual complaint issues and relate to different staff groups.*

The number of complaint issues involving different disciplines and staff groups has been recorded for NHS Digital (previously known as Health and Social Care Information Centre (HSCIC) this year. It has been possible to categorise the complaint issues by staff group and the Quarter 3 data is presented in the table above.

Quarter 3 figures continue in line with the first two quarters of this year showing Nursing as the dominant staff group identified within complaints. Nursing continues to represent the largest staff group in the Trust and has the greatest number of individual contacts. Work is ongoing to ensure that professional leads are made aware of any themes relating to their professional group.

Table 9: Overarching complaint themes this quarter

Theme	Chart showing themes of complaints
Admission/discharge *Community or inpatient*	
Appointments *e.g. cancelled, staff DNA*	
Access to treatment *Treatment or medication*	
Clinical treatment *e.g. diagnosis, medication*	
Commissioning *e.g. specific services*	
Communication *Internal and external*	
Patient Care *e.g. observation, support*	
Prescribing *e.g. prescription issues*	
Trust Admin *e.g. Health Records, MHA*	
Staff Values *Attitude and action*	
Other *Any other issue*	

The main complaint theme is ***communication***. The theme of "communication" has been reviewed in greater detail; areas of communication are identified in the chart below.

The Trust takes all issues detailed within individual complaints very seriously. The issues reflected in Table 9 are subject to ongoing investigation and conclusions have not yet been reached in relation to outcomes.

*Table 10: Breakdown of complaint issues relating to **communication***

Top 3 areas of communication identified in Q3 complaints:
Communication with relatives and carers
Communication with Service Users
Inaccurate/ inaccurate interpretation of written clinical records and/or reports.

Analysis of data is undertaken by the Service Experience Department in order to identify any patterns of clinical concern e.g. similar issues being raised regarding the same service or practitioner. A current theme emerging from complaint investigations relates to entries made within clinical records being inaccurate or not a true reflection of a situation. This highlights the importance of colleagues keeping contemporaneous and accurate clinical records. This has been identified as a theme for our services to learn from and will be addressed later within this report.

Table 11: Examples of complaints and action taken

Example	You said	We did
Incorrect or inaccurate interpretation	My health records give a misleading representation of what was said in my appointments	We apologised and said you could include an addendum to the relevant parts of the health records
Communication with patient	My appointments were scheduled with little notice which meant I could not gain the support of a mental health advocate.	We agreed that one of the CPAs had been scheduled with little notice and we apologised. The team will make every effort to learn from your experience to ensure this does not happen again.
Communication with relatives/carers	My daughter was taken into hospital and the staff there would not give me any information, even to let me know she was safe.	We apologised and explained that our staff work hard to ensure people's confidentiality is maintained and take this very seriously. We agreed with you that it did not make sense to not give you information at this time. We have revisited our guidance to staff about common-sense and confidentiality.

2.2 Concerns

The Service Experience Department endeavour to be responsive to feedback and to resolve concerns with people at the point they are raised. This has resulted in complaint numbers being maintained at a lower level for the first three quarters of this year and a corresponding increase in the number of concerns for the same time period.

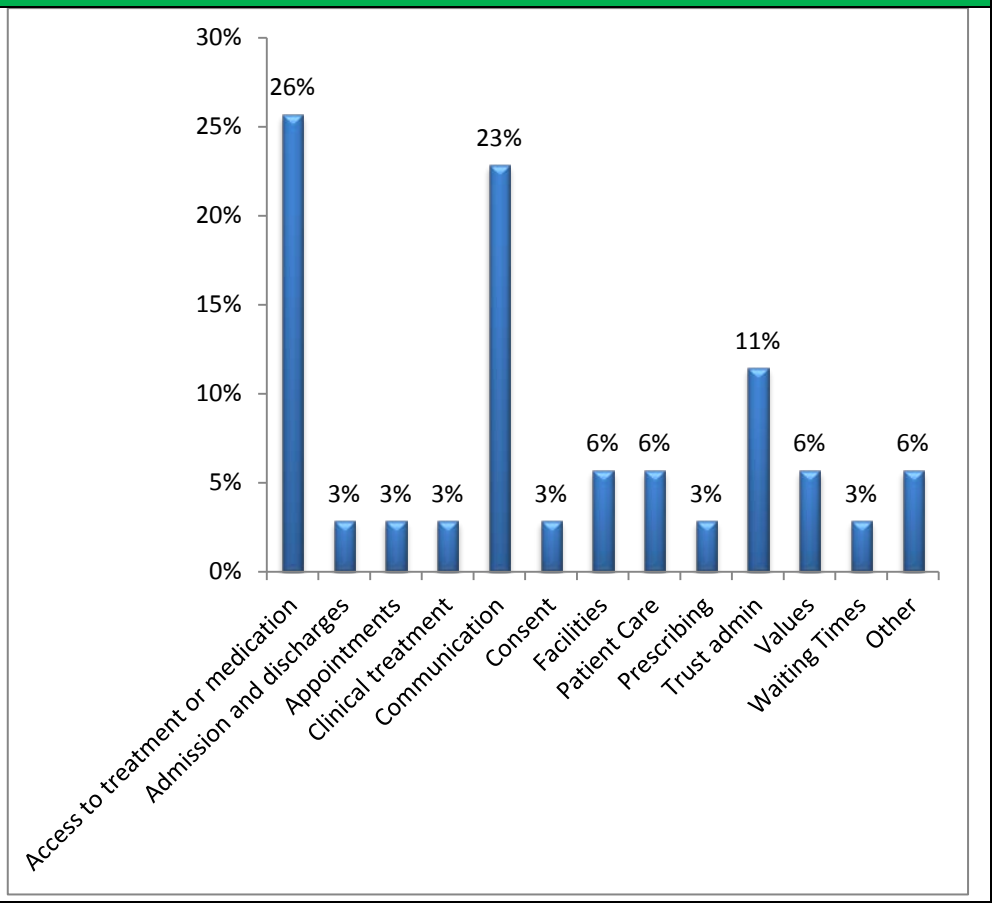
DatixWeb, a complaints and concerns recording and reporting system, has continued to be used for Quarter 3. The information gathered allows greater data interrogation and improved opportunities for learning from feedback. Themes and trends have been analysed for Quarter 3 and are reflected in the tables on the next page.

Table 12: Number of concerns received this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	24		There has been a decrease in the number of Gloucestershire concerns (Q2 n=35)	Significant
Herefordshire	8		There has been a slight decrease in the number of Herefordshire concerns (Q2 n=10)	Significant
Corporate	3		There were the same number of Corporate concerns (Q2 n=3)	Significant
Total	35		The overall number of concerns received has decreased (Q2 n=48)	Significant

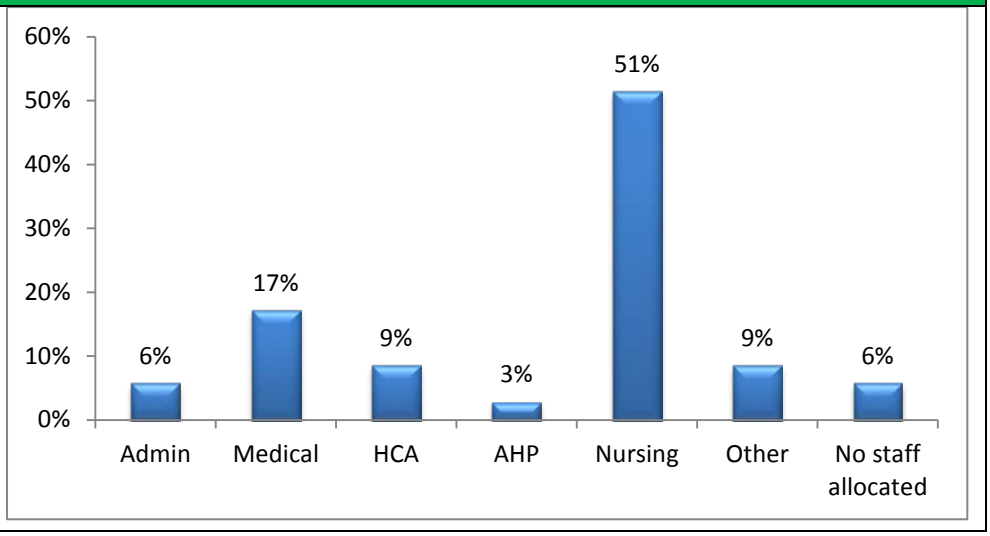
The reduction in numbers of concerns raised in Quarter 3 is balanced by the reported increase in complaints for this quarter. This demonstrates that people are continuing to raise issues using the formal complaints process more often in Quarter 3.

Table 13: Overarching concern themes this quarter

Theme	No.	Chart showing percentages
Access to treatment *Treatment or medication*	9	
Admission/discharge *Community or inpatient*	1	
Appointments *e.g. cancelled, staff DNA*	1	
Clinical treatment *e.g. diagnosis, medication*	1	
Communication *Internal and external*	8	
Consent *e.g. to share information*	1	
Facilities *e.g. food or environment*	2	
Patient Care *e.g. observation, support*	2	
Prescribing *e.g. prescription issues*	1	
Trust Admin *e.g. Health Records, MHA*	4	
Staff Values *Attitude and actions*	2	
Waiting Times *e.g. at or for appointments*	1	
Other *Any other issue*	2	

The two main themes identified from concerns raised are “Access to treatment or medication” and “Communication”. These themes follow those identified in the complaints analysis. Learning points and actions will be captured in Section 3 of this report.

Table 14: Breakdown of concerns by staff group for this quarter

Outcome	No.*	Chart showing percentages
Admin	2	
Medical	6	
HCA	3	
Allied Health Professionals (AHP)	1	
Nursing	18	
Other	3	
No staff allocated	2	

As previously reflected in complaint analysis, nursing represents the largest staff group in the Trust and has the greatest number of contacts.

Table 15: Number of concerns closed this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	31	⇔	This is about the same as last quarter (Q2 n=32)	Significant
Herefordshire	10	⇔	This is the same as last quarter (Q2 n=10)	Significant
Corporate	4	⇔	This is the same as last quarter (Q2 n=4)	Significant
Total	45	⇔	The overall number of concerns closed is similar (Q2 n=46)	Significant

The reduction in the number of concerns closed reflects the number of concerns received this quarter.

Table 16: Other contacts and activity

Advice
There were 17 episodes of advice offered this quarter by the PALS Service
9 episodes related to how to access services
6 episodes were queries about staff or how to make a complaint
Signposting
There were 29 episodes of signposting this quarter by the PALS Service
20 episodes were signposting to internal teams such as wards, Communication department, Crisis Teams, and Let's Talk
9 were signposting to external teams, such as the police, Addaction, and advocacy

Examples of concerns and action taken:

2.3 Compliments

Table 17: Number of compliments received

County	This quarter		Last quarter	Assurance
Gloucestershire	553	↑	347	Significant
Herefordshire	136	↑	27	Significant
Corporate	26	↑	15	Significant
Total	715	↑	389	Significant

**this does not include primary care contacts*

Following a review by our SED resulting from low reporting of compliments in Quarter 2, it is encouraging to see the numbers of compliments have more than doubled in Quarter 3. Our SED have worked with services to raise the profile of compliment reporting throughout the Trust. A dedicated email address has now been set up to simplify the process for staff to report compliments that they have received – 2gnft.compliments@nhs.net .Compliments are being shared and regularly updated with colleagues via the Trust intranet system to further encourage reporting.

Sample compliments from Quarter 3:

2.4 Comments received via HealthWatch

HealthWatch Gloucestershire gathers people's experiences and tries to understand people's needs in a variety of ways including:

- Supermarket information stands
- Events
- Working with Parish or Town Councils
- Working with specific groups, such as young people, BME communities, and people in the military

HealthWatch Gloucestershire has gathered 9 separate pieces of feedback relating to [2]gether Trust this quarter. The feedback can be broadly broken down into the following feedback areas:

- Unsure what to expect from staff or services (n=1)
- Insufficient or inconsistent support offered by services (n=4)
- Using services currently (n=2)
- Miscellaneous (n=2)

A selection of the comments can be seen below:

2.5 – Parliamentary and Health Service Ombudsman (PHSO)

One new case has been referred to the PHSO for review this quarter. As yet a decision has not been made by the PHSO whether this will be investigated by them.

During Quarter 3 we have received feedback on five existing open PHSO referrals. The PHSO confirmed that in four cases, they have reviewed the Trust's investigation and responses to each individual complaint. The outcome of each review is that they are satisfied with the processes followed and responses from our Trust and will not be investigating the cases further. In the fifth case the PHSO did undertake an investigation. Following investigation the PHSO did not make any recommendations for our Trust and were satisfied with our processes. This is encouraging news and reflects that our investigations and complaints processes are working well to address issues thoroughly.

A previous review by the PHSO made several recommendations for service developments within the Trust. The review related to issues raised by a complainant between 2010 and 2013. The action plan developed in response to the recommendations has been implemented in full. The action plan was completed and closed in November 2016.

2.6 Surveys

2.6.1 Survey re-launch plan

The Service Experience Department (SED) has undertaken an extensive review of the surveys used to gain service user views and feedback within our Trust. These surveys are currently known as the "Friends and Family Test" and "Quality Survey".

As a Trust we report our survey results not only internally but also locally to our Commissioners and nationally to NHS Benchmarking data. It is important that colleagues encourage and support people who use our services to make their views and experiences known so we can learn from feedback and make improvements where needed.

The SED have work under way with service leads to refresh and relaunch our service user feedback surveys for 2017/18. The process will be streamlined to encourage increased amounts of feedback informing our learning about people's experience of our services. The surveys will be merged into one format and be known as the **"How did we do?"** survey. The "How did we do?" survey will be used for all Trust services apart from IAPT and CYPS/CAMHS where separate review processes are in action. The surveys will be accessible in the following formats: Paper, Online and SMS (text message). Updates to the developments and re launch of "How did we do?" will be available to colleagues via ByteSize, Team Talk, intranet and SED representation at locality governance meetings.

The Friends and Family Test and Quality survey responses will be continued to be reported separately.

2.6.2 Friends and Family Test (FFT)

Service users are asked "*How likely are you to recommend our service to your friends and family if they needed similar care or treatment?*", and have six options from which to choose:

1. Extremely likely
2. Likely
3. Neither likely nor unlikely
4. Unlikely
5. Extremely unlikely
6. Don't know

Our Trust has played a key role in the development of an Easy Read version of the FFT. Roll out of this version across our services ensures that all client groups are supported to provide feedback.

The table below details the number of responses received each month. The "FFT score" is the percentage of people who stated that they would be 'extremely likely' or 'likely' to recommend our services

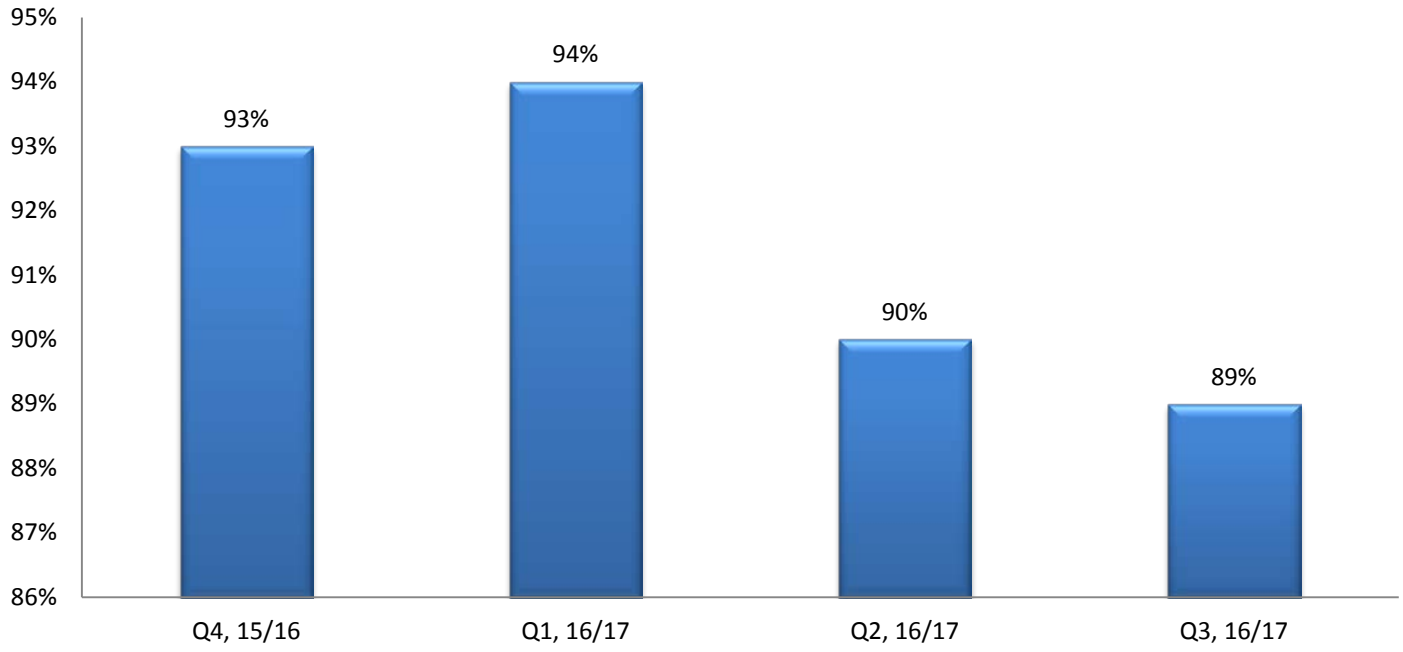
Table 18: Quarter 3 returns and responses to Friends and Family Test

	Number of responses	FFT Score (%)
October 2016	554	91%
November 2016	307	88%
December 2016	239	88%
Total	**1,100 (last quarter = 1,087)**	**89% (last quarter = 90%)**

It is encouraging to see increased response rates maintained in Quarter 3. This, combined with the launch of the "How did we do?" survey, aims to build upon the good progress. Service Managers are given feedback on a weekly and monthly basis about the FFT results and responses relating to the services they manage. Feedback pathways are being reviewed and refreshed as part of the survey relaunch to ensure learning reaches all colleagues.

Figure 2: Friends and Family Test Scores for [2]gether Trust for the past year

The following graph shows the FFT Scores for the past rolling year, including this quarter. The Trust has received consistently positive feedback.



The FFT score for Quarter 3 has remained relatively consistent with that received in Quarter 2. The Trust continues to maintain a high percentage of people who would recommend our services.

Friends and Family Test

Positive comments about 2gether's service

Very calm and caring atmosphere
Chestnut Ward, Charlton Lane

Kind and understanding staff. Made to feel comfortable and reassured.
ASC Service, Gloucestershire

I would like to express my sincere thanks to you all for the loving care you gave my brother whilst he was with you and the kindness you showed to us, his family
Willow Ward, Charlton Lane

I feel so supported and the team are lovely.
CRHTT, Gloucestershi

They always respond whenever myself or my mother phone up.
North Cots Recovery, Gloucestershire

They gave good care.
IHOT, Gloucestershire

Talking with knowledgeable staff who listen and offer practical advice.
Primary Care, Herefordshire

I've been taught some great coping skills and understand my depression and anxiety better. One bad day does not undo everything!
IAPT, Herefordshire

It has been brilliant having the time and support and the information from an understanding and caring person.
Memory Service, Herefordshire

Examples of comments and concerns expressed and ideas for development

Don't have appointments in school time.
CAMHS, Herefordshire

I did not feel that the course was suited to my mental health problems.
Let's Talk, Gloucestershire

Lack of empathy and care from staff. Lack of communication between doctors, staff, patient, and family.
Abbey Ward, Wotton Lawn

Rooms cold, not good when you are trying to get well.
CAMHS, Herefordshire

Written feedback from surveys is analysed to ensure any themes are identified and is used to inform organisational learning.

Figure 4: Friends and Family Test Scores – comparison between 2gether Trust and other Mental Health Trusts across England

The following graph shows the FFT Scores for the most recent six months of this year. The Trust continues to receive a high percentage of recommendation that is typically higher or the same other Mental Health Trusts in England. (*December 2016 national data is not yet available*)

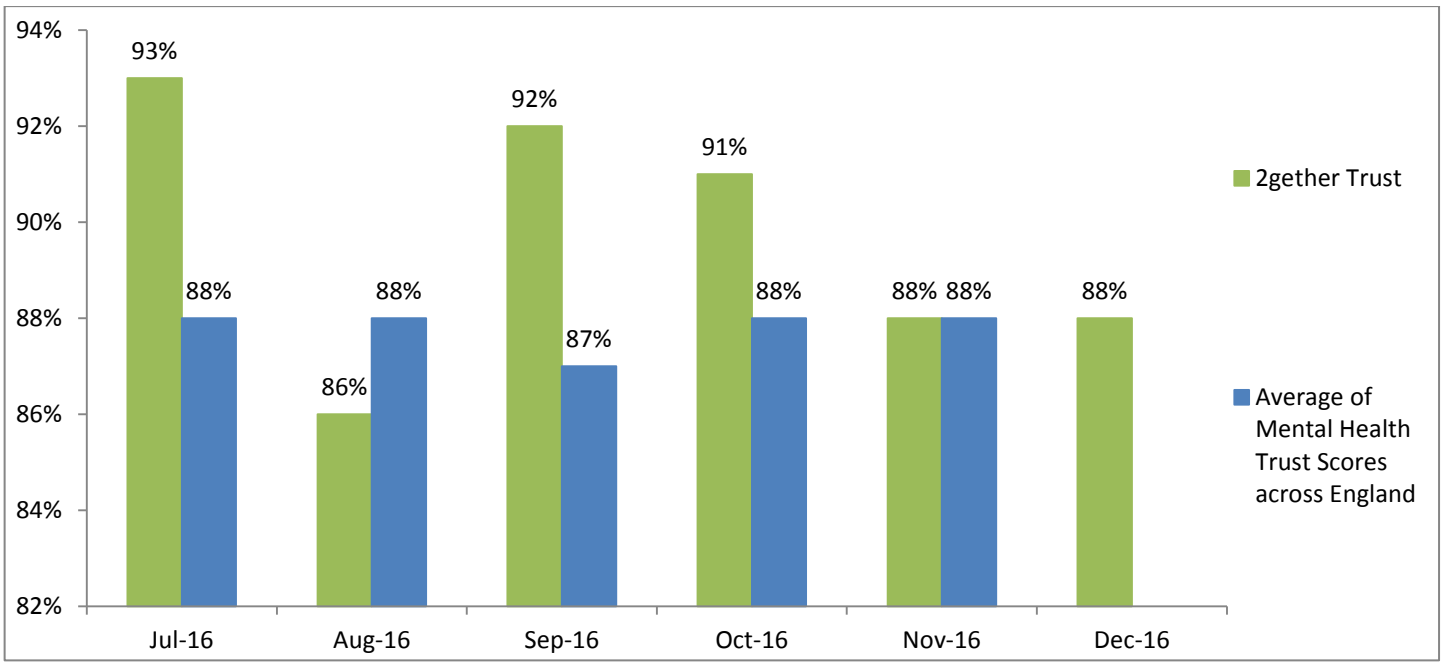
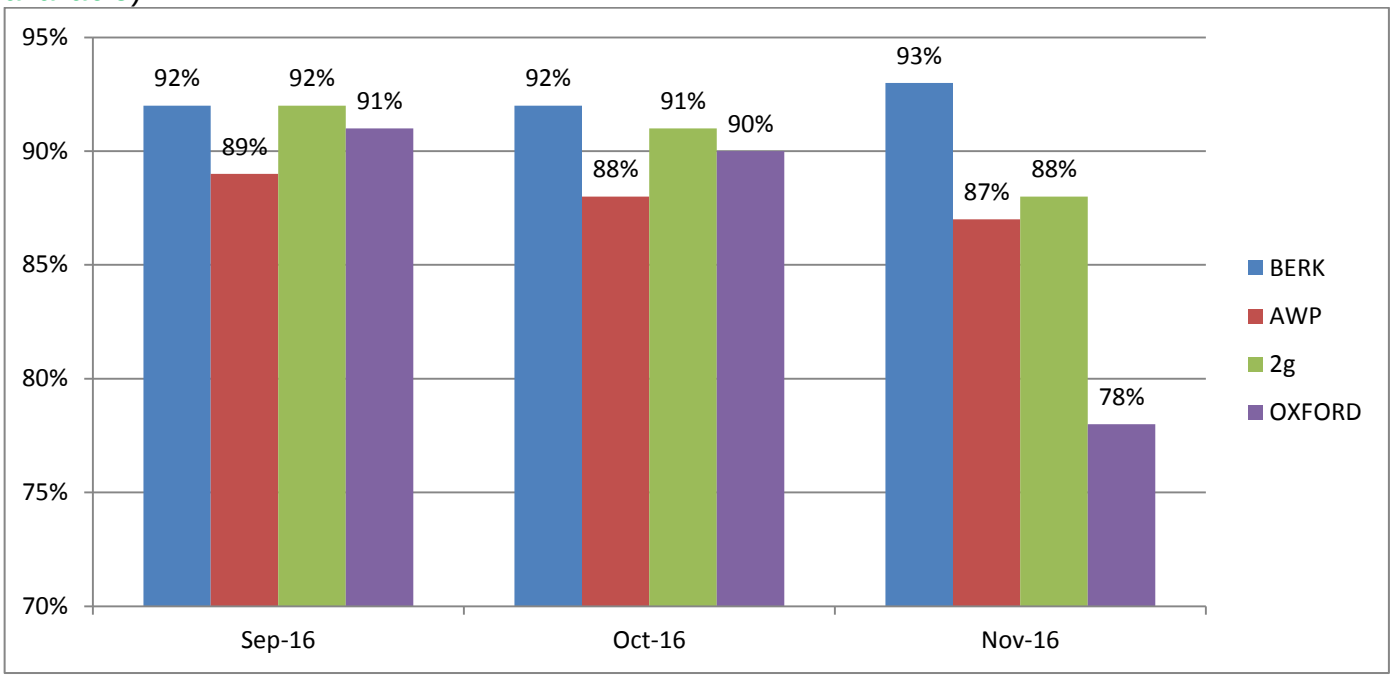


Figure 5: Friends and Family Test Scores – comparison between the 2gether Trust and other Mental Health Trusts in the NHS England South Central region

The following graph shows the FFT Scores for the September, October, and November 2016 (the most recent data available). Our Trust consistently receives a high percentage of recommendation in line with other Mental Health Trusts in the region. (*December 2016 data for the region is not yet available*)



2g – 2gether NHS Foundation Trust // AWP – Avon and Wiltshire Mental Health Partnership NHS Trust
BERK – Berkshire Healthcare NHS Foundation Trust // OXFORD – Oxford Health NHS Foundation Trust

2.6.3 Quality Survey

The Quality Survey provides people with an opportunity to comment on key aspects of the quality of their treatment. It is available as a paper questionnaire and an online survey. The Quality survey is part of the planned survey relaunch. The Quality survey questions will be included within the new combined "How did we do?" survey and responses will continued to be reported separately from the Friends and Family Test feedback.

The following tables show responses from the Quality Survey for Quarters 1-3, 2016/17 combined:

Table 19: Quality Survey questions and responses

	Question	Treatment setting	Sample size (Gloucestershire)	Number 'yes' (Gloucestershire)	Sample size (Herefordshire)	Number 'yes' (Herefordshire)	Total % giving 'yes' answer
1	Were you involved as much as you wanted to be in agreeing what care you will receive?	Inpatient	30	22	17	13	82% TARGET 78%
		Community	92	74	42	40	
		Total Responses	122	96	59	53	

	Question	Treatment setting	Sample size (Gloucestershire)	Number 'yes' (Gloucestershire)	Sample size (Herefordshire)	Number 'yes' (Herefordshire)	Total % giving 'yes' answer
2	Were you involved as much as you wanted to be in decisions about which medicines to take?	Inpatient	30	21	17	13	77% TARGET 73%
		Community	77	59	38	31	
		Total Responses	107	80	55	44	

	Question	Treatment setting	Sample size (Gloucestershire)	Number 'yes' (Gloucestershire)	Sample size (Herefordshire)	Number 'yes' (Herefordshire)	Total % giving 'yes' answer
3	Do you know who to contact out of office hours if you have a crisis?	Inpatient	22	17	16	11	80% TARGET 71%
		Community	87	65	41	39	
		Total Responses	109	82	57	50	

	Question	Treatment setting	Sample size (Gloucestershire)	Number 'yes' (Gloucestershire)	Sample size (Herefordshire)	Number 'yes' (Herefordshire)	Total % giving 'yes' answer
4	Has someone given you advice about taking part in activities that are important to you?	Inpatient	29	23	17	14	75% TARGET 48%
		Community	85	57	39	34	
		Total Responses	114	80	56	48	

	Question	Treatment setting	Sample size (Gloucestershire)	Number 'yes' (Gloucestershire)	Sample size (Herefordshire)	Number 'yes' (Herefordshire)	Total % giving 'yes' answer
5	Has someone given you help or advice with finding support for physical needs?	Inpatient	29	24	13	7	72% TARGET NONE SET
		Community	67	42	26	24	
		Total Responses	96	66	39	31	

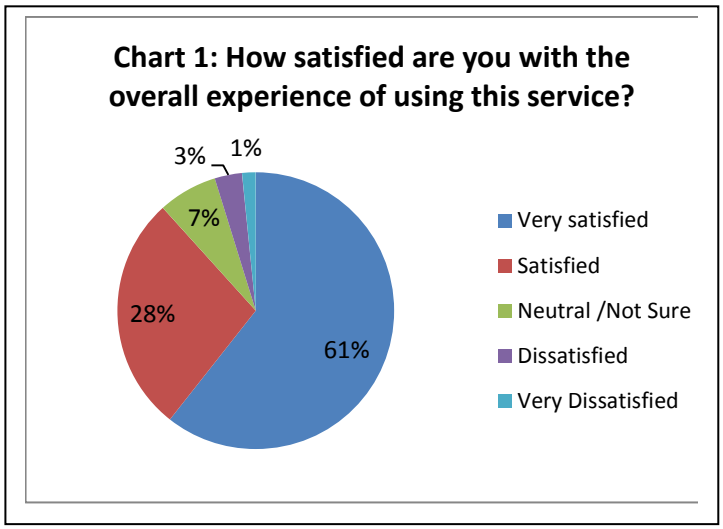
	Question	Treatment setting	Sample size (Gloucestershire)	Number 'yes' (Gloucestershire)	Sample size (Herefordshire)	Number 'yes' (Herefordshire)	Total % giving 'yes' answer
6	Do you feel safe in our services?	Inpatient	29	23	17	13	87% TARGET NONE SET
		Community	92	82	42	38	
		Total Responses	121	105	59	51	

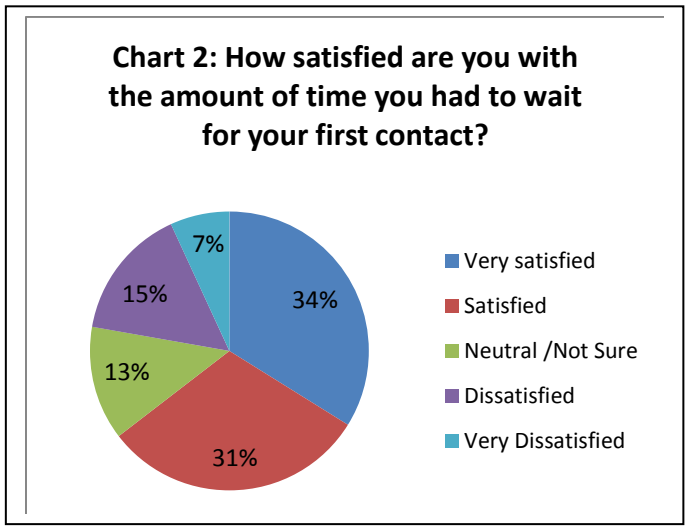
Where set, targets have been exceeded in all areas for feedback. In questions 5 and 6 where targets were not set the feedback percentage remains high in both areas. This is good news and demonstrates that, of those people who responded to the survey, they are not only being involved in their care but are also feeling supported to meet their needs and explore other activities. This is a positive reflection of the work undertaken within the Trust to improve performance in these key areas. Targets will be set for all questions in 2017/18 quality survey questions.

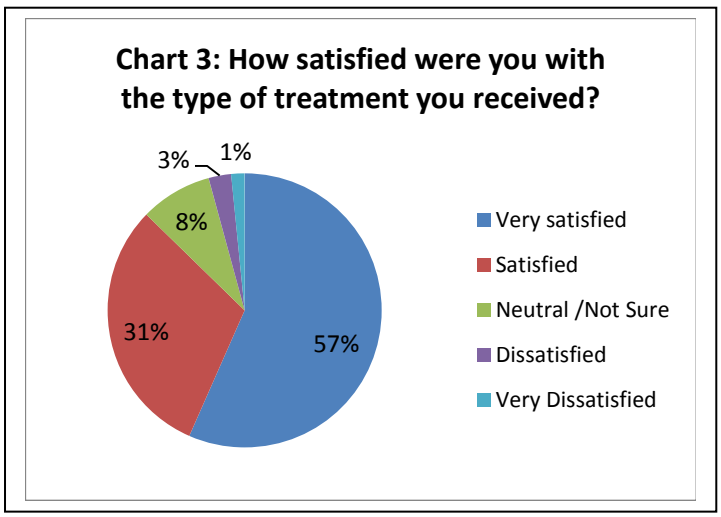
2.6.4 Improving Access to Psychological Therapies – Patient Experience Questionnaire (IAPT PEQ)

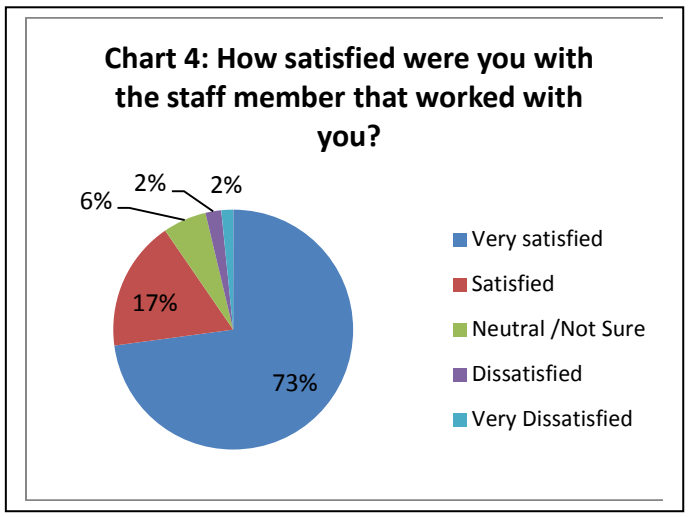
Our IAPT services, including Mental Health Intermediate Care Teams and Let's Talk services, use a survey that has been nationally agreed to gain particular feedback and measure people's level of satisfaction with the IAPT service. The current IAPT PEQ is under review by SED and service leads to ensure we are in line with the nationally set guidance as well as having a system in place to share feedback and learning.

The IAPT PEQ asks a variety of questions for feedback about the service people have received. As the questionnaire is currently under review, the feedback from a selection of questions asking about "satisfaction" is included below. A selection of comments people have included in the feedback is also included. All data and feedback shown is based on responses processed within Quarter 3 2016/17, the sample (total number of responses) size for feedback shown in charts 1-4 =189.









The Quarter 3 feedback from the four questions asking about people's satisfaction with the IAPT service show that largely people are either "Very Satisfied" or "Satisfied" with these elements of the service. Feedback from the IAPT PEQ has not been reported before in the SED quarterly reports but future responses and feedback will be included going forward.

People are asked for comments for the following question as part of the IAPT PEQ – "Please tell us anything that you think would improve this service". A Selection of comments is shared below:

- Identifying client needs earlier and ensuring they get help when they need it.
- Less time waiting for appointments.
- Quicker response when you first phone up.

- More therapists to help reduce the huge waiting lists for such treatments.
- Waiting room could be made more relaxing.
- Course materials to follow course delivered.
- More flexible to book on e.g. online rather than only telephone.
- A shorter waiting list (I know NHS is over stretched however).
- More sessions would be good.
- The waiting time, the service itself was brilliant.
- Probably a little more time than ½ hour each session.

2.6.5 Children and Young People service (CYPS)

During Quarter 3 our CYPS services used an innovative way to gain feedback from the people who use their services. The service launched the "Magic Wand Takeover Challenge Event". Displays were put in waiting rooms encouraging people to think how they would make CYPS better if they could wave a magic wand. Magic wands were made out of paper for children and young people to write their wishes on, decorate and enter into a competition with the opportunity to win a £20 voucher. Over sixty wands were collected. Some wands had no suggestion, but had been coloured in to enter the "Best looking wand competition". Young people, staff and board members came together to look through the magic wand suggestions that had been received in waiting rooms during the competition.

The top four suggestions were explored with ideas of how to take forward, these were:

- Having Skype appointments
- Having groups for young people to meet other young people
- Having more information during waiting times
- Improve the outdoor area at Evergreen House

Some suggestions written on the Magic Wands:

CYPS do not use the Trusts Quality Survey. CYPS gather service feedback using the Experience of Service Questionnaire, known as “CHI –ESQ”. CHI-ESQ is a nationally designed survey to gain feedback from children, young people and their parents/ carers. CYPS also use age appropriate versions of the Friends and Family Test. The SED quarterly report will report on feedback gained from these surveys going forward.

Section 3 – Learning from Service Experience Feedback

Section 3.1 – learning themes emerging from individual complaints

The Service Experience Department, in partnership with Service Managers, routinely record, report and take actions based upon the valuable feedback from complaints, concerns, compliments and comments. This table illustrates the lessons learnt from **individual** complaints and concerns. This includes learning when a complaint or concern has been upheld or not upheld.

A new system is being embedded to report back service experience activity on a monthly and quarterly basis to each locality governance meeting. A member of the SED is also attending these meetings regularly to discuss themes, trends and learning.

*Table 20: Lessons learnt from **individual** complaints and concerns closed Quarter 3*

Learning	Action taken	Assurance of action
You told us you were concerned that your clinical records held on our electronic system could be “hacked”.	We explained our Clinical Records policy, including the security of your electronic records. We sent you a form to complete if you wished to opt out of your records being held electronically.	Significant
	We will ensure that we explain to people at first contact how we hold information and give the opportunity to opt out.	
You told us a telephone number on our website was incorrect and you were unable to contact the service you needed.	We apologised and gave you the correct telephone number to contact. We updated our website with the relevant details.	Significant
	We will ensure that when team/service contact details are changed we will update our systems in a timely way.	
You were requested to attend for a health check and but were not told why.	We said we were sorry and the team contacted you to explain why you had been asked to have a health check.	Significant
You received an email where you could see all the recipient names – this should have been “blind copied”.	We said we were sorry that people’s details had not been protected. We reported this as an incident.	Significant
	We learnt that emails to multiple people must be used carefully and with caution to ensure people’s confidentiality is protected.	

Learning	Action taken	Assurance of action
You arrived for your appointment only to be told it had been rearranged for another date	We apologised for your experience and acknowledged that an administrative error had occurred.	Significant
	We reviewed and discussed this incident with the staff member involved.	
You reported to us that the team you were contacting were not listening to your concerns	The team contacted you to apologise for your experience. They listened to your concerns and took action in response.	Significant

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

Effective dissemination of learning across the organisation is vital to ensure [2]gether's services are responsive to people's needs and that services continue to improve. The table illustrates points of learning from Service Experience feedback. Localities, in partnership with corporate services, are asked to develop action plans to ensure that the learning is incorporated into future practice.

Table 21: Points of learning from Service Experience feedback Q3 closed complaints– action plan to be sought from locality leads

Organisational Learning	Action Plan (to be sought)
When any contact details for a team/service change the team/ service(s) involved will check to confirm that the new contact details have been updated on the Trust website. A plan will be made of how to best inform service users and/ or their carers directly when contact details change. *Team/service managers to be aware to include these checks in any change to service contact details.*	
When compiling a report detailing a person's care, treatment and background history colleagues are reminded to ensure that report remains reflective of the original entries in the clinical records and that events remain in chronological order. *All staff to ensure that written reports are based on clinical/ professional judgement and any summaries of information reflect the original clinical entries.* (*Health and Social Care Policy March 2015*)	.
It is essential that our referral and assessment processes are clearly explained to service users and carers/ families at first contact with our services, so that everyone is aware of the next steps and likely timescales. *All staff to be reminded to inform people of processes and next steps at point of contact with our services.*	

Section 3.3 – Assurance of learning and action from aggregated learning themes from Quarter 2

Effective dissemination of learning across the organisation is vital to ensure we are responsive to people's needs and that services continue to improve. This table illustrates the assurance that services have provided around actions that have been completed as a result of previous aggregated lessons learnt.

Table 22: Points of learning from Service Experience feedback Q2 – action plan has been completed

Organisational Learning	Locality Directorate Plan	Date Assurance provided
Requests for staff to supply reports for court submission need to be requested via a court order or a solicitor. Staff should not submit reports when requested to do so by service users and or carers/ relatives. *All staff to be informed of this requirement whilst Policy is being drafted for further direction.*	**Children's Services across both counties** Staff in Gloucestershire CYPS and Herefordshire CAMHS are aware that they should not provide court reports unless requested by the court or via a solicitor. Also they are aware that they need to inform their line manager if such a request is made and seek advice from the Trust Solicitors so that reports can be checked appropriately. A reminder will be sent via the CYPS/CAMHS Governance Committee	December 2016
	Gloucestershire Community Service Managers and matrons will cascade information to teams/forums and ensure that colleagues understand the requirements as outlined	December 2016
	Herefordshire Circulated through team managers to team members via MDTs	December 2016
Clear and accurate communication must be made between our services, families and service users. All communication should be recorded so that any actions, verbal advice or support provided to families and service users is recorded with clinical notes.	**Children's Services across both counties** This is expected of all CYPS and CAMHS staff. This learning will be referred to CYPS/CAMHS Governance to ensure the a review of clinical notes is undertaken	December 2016
	Gloucestershire The expected standards have been discussed with managers. An audit will be completed in 3 months' time to ascertain what improvements have been made. Also being monitored through Triangle of Care Project.	December 2016
	Herefordshire An audit of inpatient and crisis notes completed. Communication with carers / family recorded.	December 2016
A person felt they had not been treated with dignity and respect, and experienced discrimination based upon their religion. To ensure compliance with Equality and Diversity training requirements for all staff.	**Children's Services across both counties** CYPS/CAMHS has had a robust expectation that staff will attend Equality & Diversity training and have been involved with the Service Experience Department in the review of training with reference to CYP to ensure it is relevant to clinicians.	December 2016
	Gloucestershire Equality and Diversity training is undertaken by all staff as part of their induction to the Trust.	December 2016
	Herefordshire December 2016 All staff attend the Trust induction. This is also considered in risk assessment updates.	December 2016

Agenda Item 10 **Enclosure** **Paper E**

Report to: 2gether Board Meeting - 30 March 2017
Author: Gordon Benson, Assistant Director of Governance & Compliance
Presented by: Gordon Benson, Assistant Director of Governance & Compliance

SUBJECT: **Quality Report Process**

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

EXECUTIVE SUMMARY

Quarter 3 Quality Report

This is the Quarter 3 review of the Quality Report priorities for 2016/17. The quarterly report is in the format of the annual Quality Report format.

Assurance

- The report shows the progress made towards achieving targets, objectives and initiatives identified in the Annual Quality Report.
- Overall, there are 3 confirmed targets which will not be met by year end:
    1. 1.3 – Joint CPA reviews for young people transitioning to adult services
    2. 3.2 – Reduction in the number of detained patients who are AWOL
    3. 3.3 – Reduction in the use of prone restraint.
- There is limited assurance that target 3.1 – Reduction in the numbers of reported deaths by suspected suicide will be met.
- There is also a risk that target 1.2 – Improved personalized discharge planning will not be met. This target will continue to receive considerable focus by Service Directors and their operational management systems.
- At their January 2017 Council meeting, Governors indicated that they would like the following priorities subject to external audit:
    1. Delayed Transfers of Care (mandated indicator).
    2. Local indicator 3.1 - Reduction in the numbers of reported deaths by suspected suicide subject to the statutory external assurance audit.

3. In addition, the Executive Team indicated that the remaining mandated indicator for auditing will be Crisis Team Gatekeeping admissions. Deloitte commenced sample testing for these indicators on 28 February 2017 for the period up end of month 10.

Year-end testing of the indicators will commence 18 April 2017.

Improvements

- The data within relates to Quarter 3 and will, therefore, be subject to change as the supportive evidence base grows during Quarter 4.

- There have been sustained improvements across all User Experience targets, 48hr follow up and Joint CPA reviews for young people transitioning in adult service which demonstrate that measures put in place to improve performance in these areas by Service Directors have been effective. These will continue to receive focus throughout the remainder of the year.

RECOMMENDATIONS

The Board is asked to note the progress made to date.

Corporate Considerations	
Resource implications:	Collating the information has resources implications regarding collation and presentation of information.
Equalities implications:	This is referenced in the report
Risk implications:	Specific initiatives that are not being achieved are highlighted in the report.

WHICH TRUST KEY STRATEGIC OBJECTIVES DOES THIS PAPER PROGRESS OR CHALLENGE?			
Quality and Safety	P	Skilled workforce	P
Getting the basics right	P	Using better information	P
Social inclusion	P	Growth and financial efficiency	
Seeking involvement	P	Legislation and governance	P

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

Reviewed by:		
Marie Crofts, Director of Quality	Date	2 March 2017

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
	Date	

Explanation of acronyms used:	

1. CONTEXT

1.1 Every year the Trust is required by statute to produce a Quality Report, reporting on activities and targets from the previous year's Report, and setting new objectives for the following year.

To ensure appropriate oversight of the Quality Report, we produce an update for the Governance Committee & Board every quarter, identifying progress or otherwise against the Report. The Quality Report is also reviewed by the Council of Governors.

By carrying out this exercise on a regular basis, any deviation from the objectives, actual or potential, can be identified and wherever possible rectified at an early stage rather than at the year's end.

2. AUDIT PROCESS

2.1 The external audit process commenced in February 2017 with onsite testing to be completed mid-April 2017.

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NHS Foundation Trust

Quality Report 2016/17

Quarter 3

CONTENTS

Part 1: Statement on Quality from the Chief Executive

Introduction

This will be completed at year end.

Part 2a: Looking ahead to 2017/18

Quality Priorities for Improvement 2017/18

This will be completed at year end.

Effectiveness

These will be developed during Quarter 4

User Experience

These will be developed during Quarter 4

Safety

These will be developed during Quarter 4

Part 2b: Statements relating to the Quality of NHS Services Provided

This will be completed at year end.

Participation in Clinical Audits and National Confidential Enquiries

This will be completed at year end.

Participation in Clinical Research

This will be completed at year end.

Use of the Commissioning for Quality & Innovation (CQUIN) framework

A proportion of [2]gether NHS Foundation Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between [2]gether NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed CQUIN goals for 2016/17 are available electronically at http://www.2gether.nhs.uk/cquin

2016/17 CQUIN Goals

Gloucestershire

Gloucestershire Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
Young Peoples Transitions	This CQUIN will improve outcomes in young people transitioning from [2]gether Young People's Services to Adult Mental Health Services.	.80	£564256	Effectiveness
Perinatal Mental Health	This CQUIN will focus on quality improvement across the perinatal mental health pathway to promote integration, knowledge and skills of staff and improve outcomes for women and families.	1.7	£1199044	Effectiveness

Herefordshire

Herefordshire Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
1a (b) National CQUIN – Staff health and wellbeing	The introduction of health and wellbeing initiatives covering physical activity, mental health and improving access to physiotherapy for people with MSK issues	.25	£41100	Effectiveness
1b National CQUIN – Staff health and wellbeing	Healthy food for NHS staff, visitors and patients	.25	£41100	Effectiveness
1c National CQUIN - Staff health and wellbeing	Improving the uptake of flu vaccinations for front line staff	.25	£41100	Safety
Improving Physical Healthcare	The purpose of this CQUIN is twofold. Firstly, to improve the physical health of service users who	.25	£41100	Effectiveness
Local CQUIN personalised relapse prevention plans for adults	Personalised relapse prevention plans for adults accessing services, specifically Assertive Outreach Team and Early Intervention Service	0.52	£85488	Safety
Local CQUIN personalised relapse prevention plans for Children and Young People	Personalised relapse prevention plans for young people accessing services, specifically children and young people accessing and using CAMHS services	0.52	£85488	Safety
Local CQUIN 3 – Frequent attenders	Care and management for frequent attenders to WVT Accident and Emergency	0.46	£75624	Safety

Low Secure Services

Low Secure Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
Reduction in length of stay	Aim to reduce lengths of stay of inpatient episodes and to optimise the care pathway. Providers to plan for discharge at the point of admission and to ensure mechanisms are in place to oversee the care pathway against estimated discharge dates.	2.5	£45000	Effectiveness

The total potential value of the income conditional on reaching the targets within the CQUINs during 2016/16 is £2,219,300 of which we anticipate £2,219,300 will be achieved.

In 2015/16, the total potential value of the income conditional on reaching the targets within the CQUINs was £2,107,995 of which £2,107,153 was achieved.

2017/18 CQUIN Goals

These will be developed during Quarter 4.

Statements from the Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. From April 2010, all NHS trusts have been legally required to register with the CQC. Registration is the licence to operate and to be registered, providers must, by law, demonstrate compliance with the requirements of the CQC (Registration) Regulations 2009.

[2]gether NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is to provide the following regulated activities:

- Assessment or medical treatment to persons detained under the Mental Health act 1983;
- Diagnostic and screening procedures;
- Treatment of disease, disorder or injury.

[2]gether NHS Foundation Trust has no conditions on its registration.

The CQC has not taken enforcement action against [2]gether NHS Foundation during 2016/17 or the previous year 2015/16.

CQC Inspections of our services

[2]gether NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2015/16. The Care Quality Commission undertook a planned comprehensive inspection of the Trust week commencing 26 October 2015 and published its findings on 28 January 2016. The CQC rated our services as GOOD, rating **2** of the **10** core services as "outstanding" overall and **6** "good" overall.

Are services

Safe?	Requires improvement
Effective?	Good
Caring?	Good
Responsive?	Good
Well led?	Good

The inspection found that there were some aspects of care and treatment in some services that needed improvements to be made to ensure patients were kept safe. However, the vast majority of services were delivering effective care and treatment.

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

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

[2]gether NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

- The Trust has developed an action plan in response to the **15** "must do" recommendations, and the **58** "should do" recommendations identified by the inspection.

[2]gether NHS Foundation Trust has made the following progress by 31st December 2016 in taking such action:

- Setting up a Project Group to manage all actions through to their conclusion;
- Progressing and monitoring the associated actions with reporting to both the CQC and local CCGs

Changes in service registration with Care Quality Commission for 2016/17

There have been no requests to change our registration with the CQC this year.

Quality of Data

Statement on relevance of Data Quality and actions to improve Data Quality

This will be completed at year end.

Information Governance Toolkit

This will be completed at year end.

Clinical Coding Error Rate

This will be completed at year end.

Part 3: Looking Back: A Review of Quality during 2016/17

Introduction

The 2016/17 quality priorities were agreed in May 2016.

The quality priorities were grouped under the three areas of Effectiveness, User Experience and Safety.

The table below provides a summary of our progress against these individual priorities. Each are subsequently explained in more detail throughout Part 3.

Summary Report on Quality Measures for 2016/2017

		2015 - 2016	Quarter 3 2016 - 2017
Effectiveness			
1.1	To increase the number of service users (all inpatients and all SMI/CPA service users in the community, inclusive of Early Intervention Service, Assertive Outreach and Recovery) with a LESTER tool intervention (a specialist cardio metabolic assessment tool) alongside increased access to physical health treatment**.**	**Achieved**	**Achieved**
1.2	To improve personalised discharge care planning in: a) Adult inpatient wards and; b) Older people's wards.	**Achieved**	**Risk of non-achievement**
1.3	To ensure that joint Care Programme Approach reviews occur for **all** service users who make the transition from children's to adult services.	**-**	**Not achieved**
User Experience			
2.1	Were you involved as much as you wanted to be in agreeing what care you will receive? **> 78%**	**78%**	**82%**
2.2	Were you involved as much as you wanted to be in decisions about which medicines to take? **> 73%**	**73%**	**77%**
2.3	Do you know who to contact out of office hours if you have a crisis? **>71%**	**71%**	**80%**
2.4	Has someone given you advice about taking part in activities that are important to you? **> 48%**	**48%**	**75%**
Safety			
3.1	Reduce the numbers of deaths by suspected suicide (pending inquest) of people in contact with services when comparing data from previous years.	**24**	**23**
3.2	Reduce the number of detained patients who are absent without leave (AWOL) when comparing data from previous years. Reported against 3 categories of AWOL as follows: 1. Absconded from an escort 2. Did not return from leave 3. Absconded from a ward	**13** **23** **78** **114 total**	**19** **43** **111** **122 total**
3.3	To reduce the number of prone restraints by 5% year on year (on all adult wards & PICU) based on 2015/16 data.	**121**	**173**
3.4	**95%** of adults will be followed up by our services within 48 hours of discharge from psychiatric inpatient care.	**90%**	**97%**

Effectiveness

In 2016/17 we remained committed to ensure that our services are as effective as possible for the people that we support. We set ourselves 3 targets against the goals of:

- Improving the physical health care for people with schizophrenia and other serious mental illnesses;
- Ensuring that people are discharged from hospital with personalised care plans;
- Improving transition processes for child and young people who move into adult mental health services.

Target 1.1 **To increase the number of service users (all inpatients and all SMI/CPA service users in the community, inclusive of Early Intervention Service, Assertive Outreach and Recovery) with a LESTER tool intervention (a specialist cardio metabolic assessment tool) alongside increased access to physical health treatment**

There is a long established association between physical comorbidity (the presence of multiple illnesses) and mental ill health. People with severe and enduring mental health conditions experience reduced life expectancy compared to the general population. People with Schizophrenia and Bipolar disorder die on average, 20 to 25 years earlier than the general population, largely because of physical health problems. These include coronary heart disease, diabetes, respiratory disease, greater levels of obesity and metabolic syndrome.

In 2014/15 the Trust introduced the LESTER screening tool within the inpatient services, as part of the National Physical Health Commissioning for Quality and Innovation (CQUIN) payment framework. The LESTER tool is a way of identifying service users at risk of cardiovascular disease and to implement interventions to reduce any risk factors identified. Specific areas covered in the tool are, diabetes, high cholesterol, high blood pressure, increased body mass index, smoking, diet and exercise levels, and substance and alcohol misuse.

In 2015/16 the National Physical Health CQUIN was repeated within the inpatient services and was extended to include the Early Intervention teams within Herefordshire and Gloucestershire. We successfully achieved full compliance with this CQUIN and using the same methodology for both the inpatients and community teams, the Trust achieved overall 93% compliance (see Figure 1)

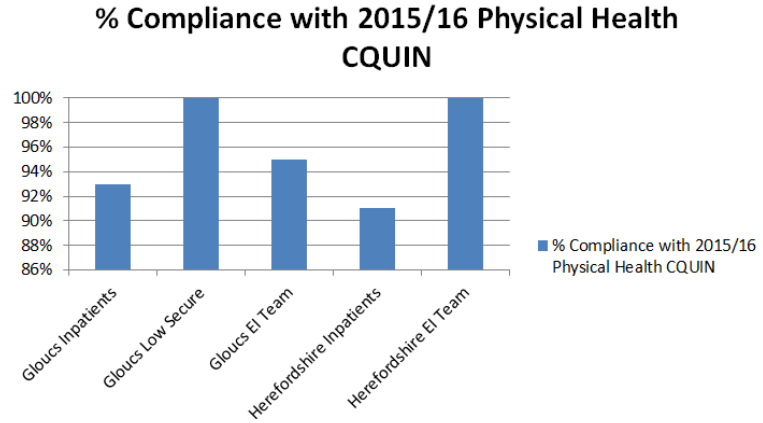


Figure 1

This year 2016/17 the Physical Health CQUIN has been adapted slightly to continue to build on the good work already in place. The sample group has now been extended to include both inpatients and patients from all community mental health teams who have a diagnosis of psychosis and are on CPA. (This year the CQUIN only relates to Herefordshire, however internal audits continue within Gloucestershire to ensure standards are maintained trust wide).

In order to support this work a substantial Lester Tool training programme for both inpatient areas and community mental health teams has been undertaken by the Physical Health Facilitator. The training department have also facilitated a one day Physical Health Awareness course, designed to complement the Lester tool training and increase staff awareness of coronary heart disease, chronic obstructive pulmonary disease and diabetes. All teams currently working with the Lester tool have an allocated 'lead' professional who receives regular feedback regarding progress in implementing and completing the Lester tool.

Within quarter three, the Trust has ensured the clinical training plan has been successfully fully rolled out to all necessary medical, inpatient and community teams. The medical doctor's induction programme includes a section on the Lester tool. This training focuses on the role of the medical teams to support the Lester tool as well as an overview of the need for increased physical health screening for patients with serious mental illnesses. Lester Tool Training for both inpatient and community nursing teams has been well received and has ensured all staff are confident and competent in their roles regarding Lester Tool screening and providing access to physical health treatment.

The roll out of the screening programme within the community teams highlighted the need for a standardisation of physical health equipment needed as a minimum to undertake the screening. A set stock list is now available for community teams to access and the training team have offered a clinical skills training package for staff that are unfamiliar with how to use the equipment. Lack of staff trained in venepuncture skills again was highlighted as a potential barrier to completing the Lester tool and a group of staff have now received this training and are competent to take the blood samples needed.

A "Physical Health Clinic" has been established at the community base in Hereford to enable staff to complete the Lester tool in a suitable environment; however staff are also able to screen patients at home if they are unable to attend the clinic.

Documentation has been highlighted as an issue nationwide, in that physical health information (screening details and interventions offered) are currently documented in multiple locations within the Electronic Patient Record RiO. The Trust received access to 'open RiO' in May 2015 which enabled the Trust to make changes to the Electronic Patient Record. Work has taken place to streamline where Physical Health information is recorded within the Electronic Patient Record RiO system. This will improve the way in which information can be audited and fed back to the clinicians. This system has now gone live and staff are now familiar with the new pages within RiO. Feedback from staff so far has been positive and appears to reduce the need for duplication of data.

Work continues to revise and update the Physical Health information pages within the Trust intranet. It is hoped to be a central point for obtaining information regarding the Lester tool, along with general physical health information, updates, audits and quality improvement projects.

Following the success of the Physical Health Day for staff and patients at Wotton Lawn hospital in January 2016, a second similar event is planned for February 2017. External providers invited to attend include; The Independence Trust, Stop Smoking Service, Slimming World, Sexual Health clinic and Dental Access Centres. The Trust's Working Well team, dietician and health and exercise practitioners will also be represented.

The Trust will become "Smoke Free" in April 2017, and plans are well underway to ensure this transition takes place smoothly. The annual Flu vaccination programme was successfully rolled out across the Trust, with the Trust obtaining 77% of staff and patients immunised this year. A ten month secondment for one of our physical health facilitators to provide support for staff and patients at Wotton lawn hospital has been approved. It is hoped this will improve standards of care with regards to wound care, diabetes and health screening.

We are currently meeting this target.

Target 1.2 To improve personalised discharge care planning in: a) Adult inpatient wards and; b) Older people's wards.

Discharge from inpatient units to the community can pose a time of increased risk to service users. During 2015/16 we focused on making improvements to discharge care planning to ensure that service users are actively involved in shared decision making for their discharge and the self-management care planning process. There were different criteria in use across Gloucestershire and Herefordshire due to audit criteria changing from the original set of questions which were influenced by the West Midlands Quality Review which agreed a differing set of standards within Herefordshire.

This year identical criteria are being used in the services across both counties as follows:

1. Has a Risk Summary been completed?
2. Has the Clustering Assessment and Allocation been completed?
3. Has the Pre-Discharge Planning Form been completed?
4. Have the inpatient care plans been closed within 7 days of discharge?
5. Has the patient been discharged from the bed?
6. Has the Nursing Discharge Summary Letter to Client/GP been sent within 24 hours of discharge?
7. Has the 48 hour follow up been completed?

We are also including discharge care planning information from within our Recovery Units, as they too discharge people back into the community.

Results from the quarterly audit against these standards are seen below.

Gloucestershire Services

Criterion	Year End Compliance (2015/16)	Compliance Quarter 1 (2016/17)	Compliance Quarter 2 (2016/17)	Compliance Quarter 3 (2016/17)	Cumulative Compliance 2016/17)
Overall Average Compliance	**75%**	**73%**	**77%**	**75%**	**75%**
Chestnut Ward	84%	83%	88%	83%	85%
Mulberry Ward	75%	77%	86%	78%	80%
Willow Ward	59%	66%	68%	71%	68%
Abbey Ward	72%	73%	75%	72%	73%
Dean Ward	79%	73%	76%	73%	74%
Greyfriars PICU	50%	64%	71%	52%	62%
Kingsholm Ward	75%	72%	72%	71%	72%
Priory Ward	80%	77%	81%	82%	80%
Montpellier Unit	50%	42%	50%	64%	52%
Honeybourne	N/A	68%	78%	67%	71%
Laurel House	N/A	56%	67%	67%	63%

* Data for Honeybourne and Laurel House (Recovery Units) was not collected in 2015/16 – only hospital wards were audited to reflect comparable data across both Gloucestershire and Herefordshire.

Overall cumulative compliance in Gloucester with these standards in Quarter 3 is at 75% which is the same as at year end 2015/16, and a reduction from the 77% compliance rate at the end of Quarter 2. There will be an increased focus on this important work during Quarter 4.

Herefordshire Services

Criterion	Year End compliance (2015/16)	Compliance Quarter 1 2016/17)	Compliance Quarter 2 (2016/17)	Compliance Quarter 3 (2016/17)	Cumulative Compliance 2016/17)
Overall Average Compliance	**N/A**	**73%**	**74%**	**74%**	**74%**
Cantilupe Ward	**N/A**	77%	85%	79%	80%
Jenny Lind Ward	**N/A**	65%	76%	72%	71%
Mortimer Ward	**N/A**	72%	70%	68%	70%
Oak House	**N/A**	67%	78%	67%	70%

There is no 2015/16 data for Herefordshire. This is due to the audit criteria changing from the original set of questions which were influenced by the West Midlands Quality Review which agreed a differing set of standards within Herefordshire. As the audit widened to the whole Trust across two counties, the criteria within the audit changed to reflect the standards outlined within the clinical system in relation to discharge care planning. It is seen that overall cumulative compliance has remained at 74% at the end of Quarter 3, which remains an improvement compared to Quarter 1 data.

Of the seven individual criteria assessed, overall compliance has improved in both counties in all areas except in the following:

1. Has the Pre-Discharge Planning Form been completed?
2. Have the inpatient care plans been closed within 7 days of discharge?

Services will, therefore, be focusing on these elements to promote improvement.

We are currently meeting this target in our Herefordshire services, but there is a risk the target may not be met in our Gloucestershire services.

Target 1.3 To ensure that joint Care Programme Approach reviews occur for all service users who make the transition from children's to adult services.

The period of transition from children and young people's services (CYPS) to adult mental health services is often daunting for both the young person involved and their family or carers. We want to ensure that this experience is as positive as it can be by undertaking joint Care Programme Approach (CPA) reviews between children's and adult services.

Gloucestershire Services

During Quarter 1, there were 7 young people who transitioned into adult services, of these 7, 6 (86%) had a joint CPA review. All young people received input from the relevant services but this is not clearly documented within RiO.

Compliance improved in Quarter 2, 5 young people were transitioned from CYPS to adult services. All of these (100%) had a joint CPA review with CYPS and adult services staff present.

In Quarter 3, there were 4 young people who transitioned from children's to adult services. All of these (100%) had a joint CPA review with CYPS and adult staff present. This is the second successive quarter with 100% compliance which needs to be maintained.

Criterion	Compliance Quarter 1 2016/17)	Compliance Quarter 2 (2016/17)	Compliance Quarter 3 (2016/17)
Joint CPA Review	86%	100%	100%

Compliance has been maintained at 100% for Quarters 2 & 3 and needs to be maintained at this level.

Herefordshire Services

During Quarter 1, there were 3 young people who transitioned into adult services, of these 3, 1 (33%) had a joint CPA review. All young people received input from the relevant services but this is not clearly documented within RiO.

In Quarter 2, there were 2 young people who transitioned into adult services, of these 1 (50%) had a joint CPA review. The one young person who did not receive a joint CPA review was having their care coordinated by a new member of staff who was unfamiliar with process.

In Quarter 3, there were 2young people who transitioned from children's to adult services. All of these (100%) had a joint CPA review with CYPS and adult staff present. This is the first quarter with 100% compliance which now needs to be maintained.

Criterion	Compliance Quarter 1 2016/17)	Compliance Quarter 2 (2016/17)	Compliance Quarter 3 (2016/17)
Joint CPA Review	33%	50%	100%

To improve our practice and documentation in relation to this target a number of measures have been developed as follows:

- Transition will be included as standard agenda item for teams, to provide the opportunity to discuss transition cases;
- Transition will be included as a standard agenda item in caseload management to identify emerging cases;
- Teams are encouraged to contact adult mental health services to discuss potential referrals;
- There is a data base which identifies cases for transition;
- SharePoint report identifies 17.5 years open to CYPS. Team Managers will monitor those who are coming up to transition and discuss in supervision.

We have not met this target.

User Experience

In this domain, we have set ourselves 1 goal of improving service user experience and carer experience with 4 associated targets.

- Improving the experience of service users in key areas. This was measured though defined survey questions for both people in community and inpatient settings.

Quality surveys using the same questions have been implemented in our community and inpatient settings using a paper based survey method. This has been across the Trust in both Gloucestershire and Herefordshire, and below are the cumulative responses to the returned service user questionnaires at year end. A combined total percentage for both counties is provided for these questions to mirror the methodology used by the CQC Community Mental Health Survey, as this does not differentiate by county.

The following tables show the combined results of Quarters 1,2 and 3 for this current year 2016/17 (April 2016 – December 2016) to allow an overview of feedback given and to evaluate our progress against the set targets in these important areas.

Target 2.1 Were you involved as much as you wanted to be in agreeing what care you will receive? > 78%

Question	Treatment setting	Sample size (Glos)	Number 'yes' (Glos)	Sample size (Hereford)	Number 'yes' (Hereford)	Total % giving 'yes' answer
Were you involved as much as you wanted to be in agreeing what care you will receive?	Inpatient	30	22	17	13	**82%**
	Community	92	74	42	40	
	Total Responses	122	96	59	53	

This target has been met.

Target 2.2 Were you involved as much as you wanted to be in decisions about which medicines to take? > 73%

Question	Treatment setting	Sample size (Glos)	Number 'yes' (Glos)	Sample size (Hereford)	Number 'yes' (Hereford	Total % giving 'yes' answer
Were you involved as much as you wanted to be in decisions about which medicines to take?	Inpatient	30	21	17	13	**77%**
	Community	77	59	38	31	
	Total Responses	107	80	55	44	

This target has been met.

Target 2.3 Do you know who to contact out of office hours if you have a crisis? >71%

Question	Treatment setting	Sample size (Glos)	Number 'yes' (Glos)	Sample size (Hereford)	Number 'yes' (Hereford)	Total % giving 'yes' answer
Do you know who to contact out of office hours if you have a crisis?	Inpatient	22	17	16	11	**80%**
	Community	87	65	41	39	
	Total Responses	109	82	57	50	

This target has been met.

Target 2.4 Has someone given you advice about taking part in activities that are important to you? > 48%

Question	Treatment setting	Sample size (Glos)	Number 'yes' (Glos)	Sample size (Hereford)	Number 'yes' (Hereford)	Total % giving 'yes' answer
Has someone given you advice about taking part in activities that are important to you?	Inpatient	29	23	17	14	**75%**
	Community	85	57	39	34	
	Total Responses	114	80	56	48	

This target has been met.

Friends and Family Test (FFT)

FFT responses and scores for Quarter 3

Service users are asked “How likely are you to recommend our service to your friends and family if they needed similar care or treatment?”, and have six options from which to choose:

1. Extremely likely
2. Likely
3. Neither likely nor unlikely
4. Unlikely
5. Extremely unlikely
6. Don’t know

The table overleaf details the number of responses processed each month; the FFT score is the percentage of people who chose either option 1 or 2 – they would be extremely likely/likely to recommend our services.

	Number of responses	FFT Score (%)
October 2016	554	91%
November 2016	307	88%
December 2016	239	88%
Total	**1,100 (Q1 = 643)**	**89% (Q1 = 94%)**

Friends and Family Test Scores for 2gether Trust for the past year

The following graph shows the FFT Scores for the past rolling year, including this quarter. The Trust receives consistently positive feedback.

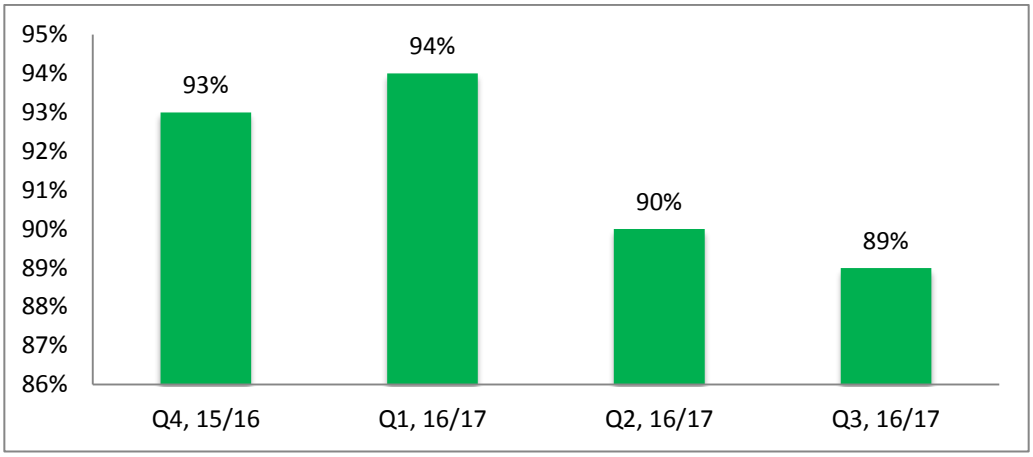


Figure 2

Friends and Family Test Scores – comparison between 2gether Trust and other Mental Health Trusts across England

The following graph shows the FFT Scores for the past six months, including this quarter. The Trust receives a consistently high percentage of recommendation scores (December *2016 data for England is not yet available*).

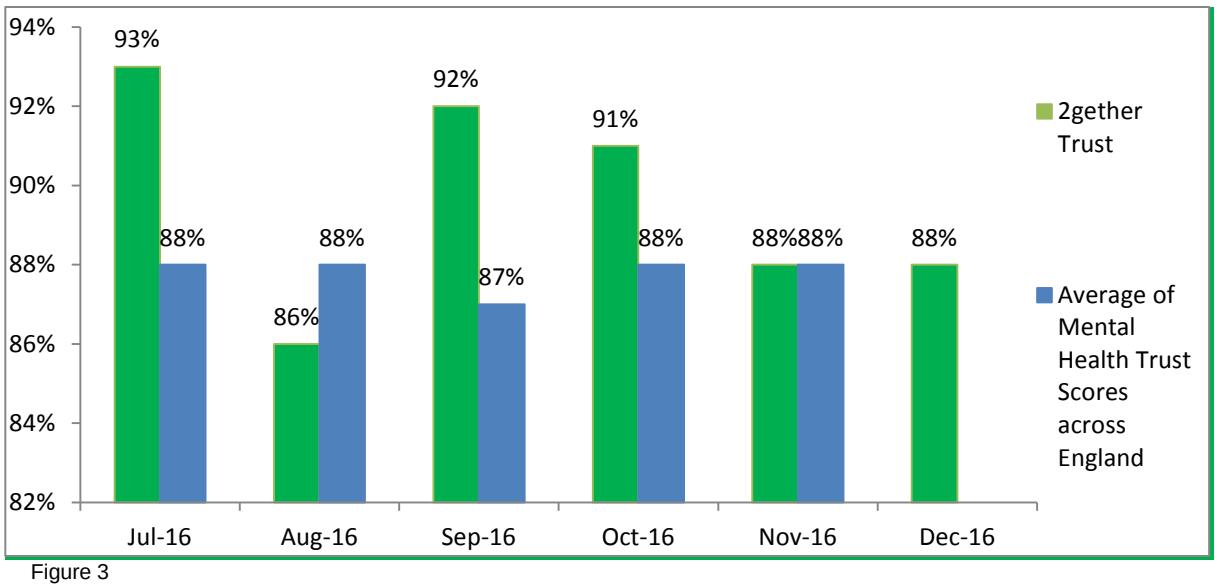


Figure 3

Friends and Family Test Scores – comparison between 2gether Trust and other Mental Health Trusts in the NHSE South Central Region

The following graph shows the FFT Scores for September, October and November 2016 (the most recent data available). The Trust receives a consistently high percentage of feedback. (*December 2016 data for the region is not yet available*)

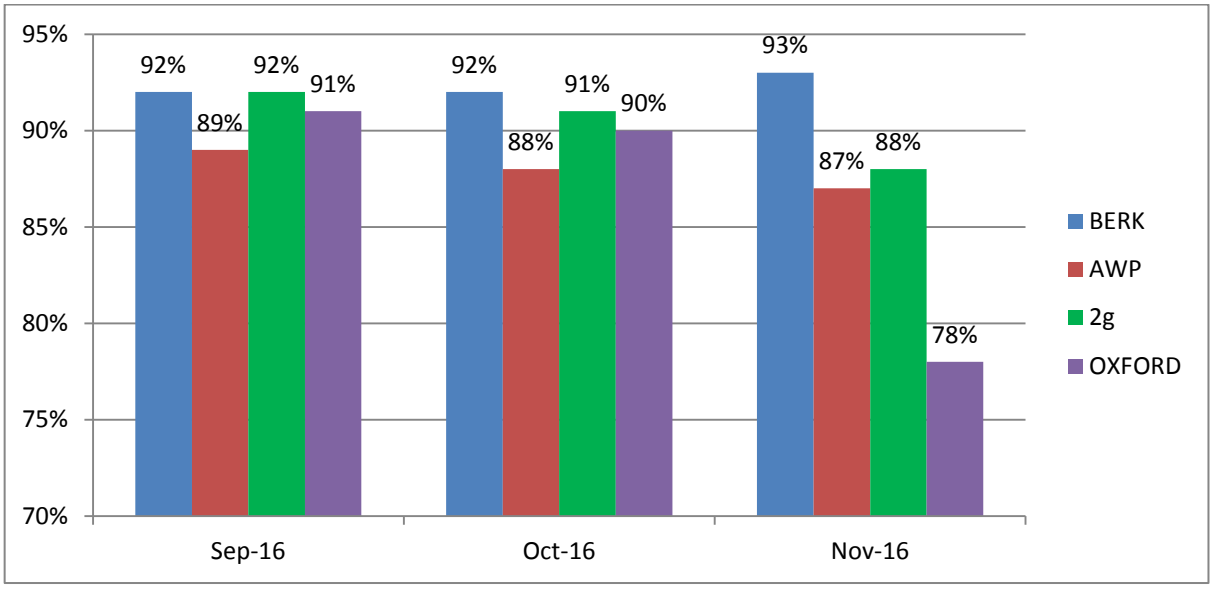


Figure 4

2g – 2gether NHS Foundation Trust, AWP – Avon and Wiltshire Mental Health Partnership NHS Trust
BERK – Berkshire Healthcare NHS Foundation Trust, OXFORD – Oxford Health NHS Foundation Trust

Complaints

This will be completed at year end.

Safety

Protecting service users from further harm whilst they are in our care is a fundamental requirement. We seek to ensure we assess the safety of those who use our services as well as providing a safe environment for service users, staff and everyone else that comes into contact with us. In this domain, we have set ourselves 4 goals to:

- Minimise the risk of suicide of people who use our services;
- Ensure the safety of people detained under the Mental Health Act;
- Reduce the number of prone restraints used in our adult inpatient services:
- Ensure we follow people up when they leave our inpatient units within 48 hours to reduce risk of harm.

There are 4 associated targets.

Target 3.1 Reduce the numbers of deaths relating to identified risk factors of people in contact with services when compared data from previous years.

We aim to minimise the risk of suicide amongst those with mental disorders through systematic implementation of sound risk management principles. In 2013/14 we set ourselves a specific quality target for there to be fewer deaths by suicide of patients in contact with teams and we have continued with this important target each year. Last year we reported **24** suspected suicides, **4** more than last year, therefore we did not meet the target. This year has seen a further rise in these tragic incidents at the end of Quarter 3 we have reported **23** suspected suicides over the year.

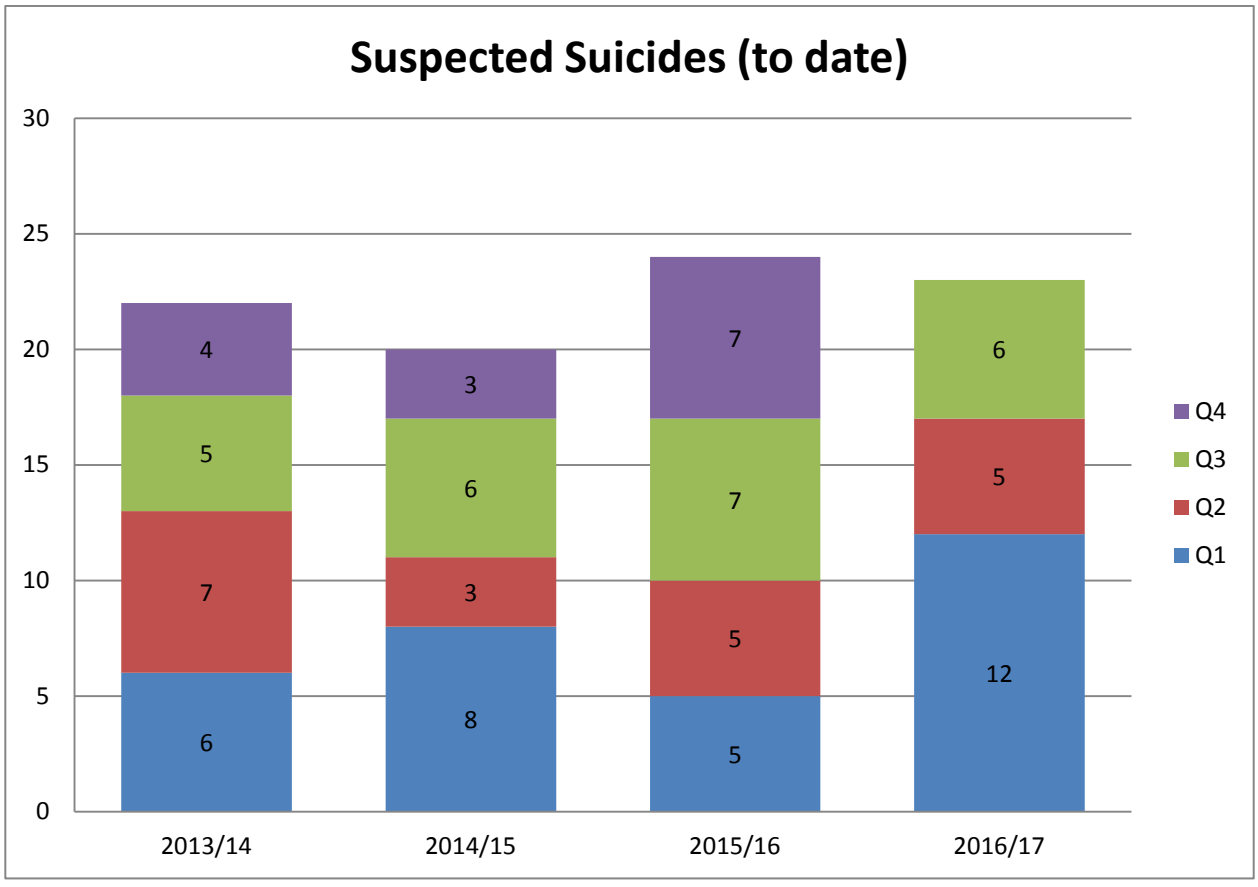


Figure 5

This information is provided below in Figures 6 & 7 for both Gloucestershire and Herefordshire services separately. It is seen that greater numbers of suspected suicides are reported in Gloucestershire services. There is no clear indication of why the difference between the two counties is so marked, but it is noted that the population of people in contact with mental health services in Gloucestershire is greater, and the services in each county are configured differently to reflect individual commissioning requirements.

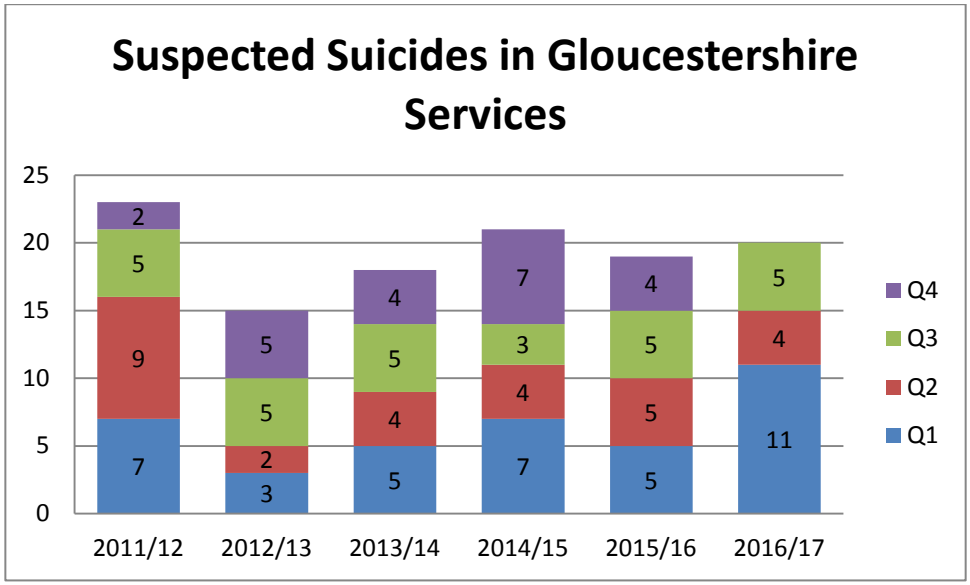


Figure 6

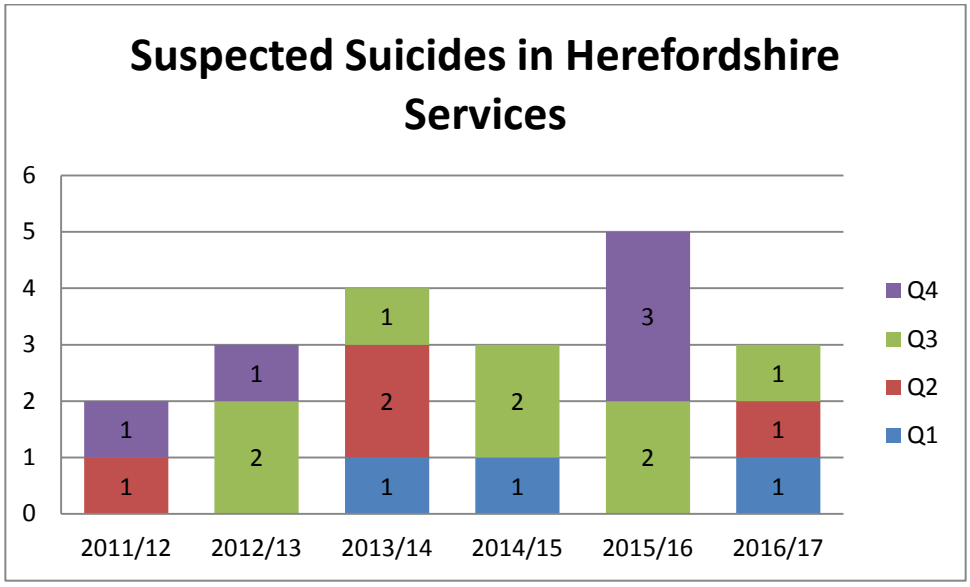


Figure 7

Whilst we report all deaths which appear to be as a consequence of self-harm as suspected suicide, ultimately it is the coroner who determines how a person came by their death. Figure 8 provides the number of suicide, open and narrative conclusions following an inquest being heard for the same cohort of service users. The outcome of inquests for each county is subsequently provided in Figures 9 & 10.

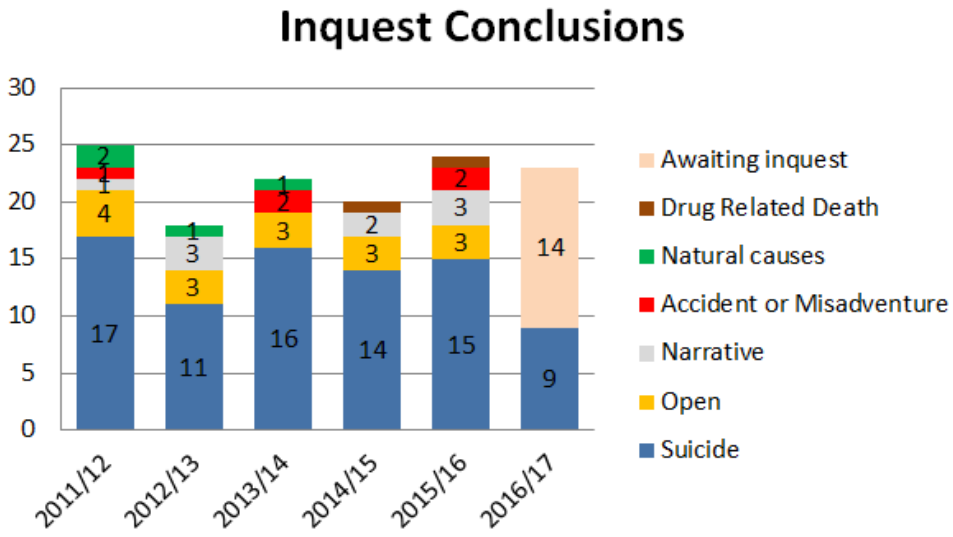


Figure 8

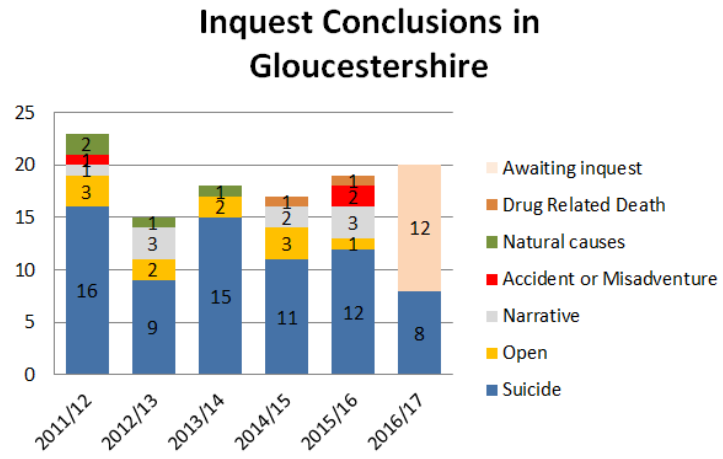


Figure 9

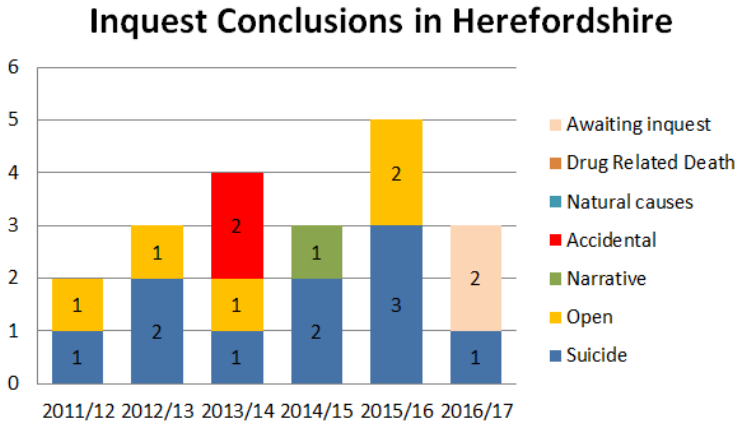


Figure 10

As well as clinical risk assessment training for frontline staff, the Trust also implements the nationally developed Suicide Prevention Toolkit on a monthly basis within all its inpatient units and within the community teams which report the most suspected suicides, these being Recovery and Crisis Teams. Additionally, Inpatient units undertake annual ligature audits to identify and remove, where possible, potential ligature points.

The Trust has active input into the Gloucestershire Suicide Prevention Partnership Forum, which works to improve the lives of people and carers in Gloucestershire, by focussing action on suicide and self-harm prevention. The Gloucestershire Suicide Prevention Strategy can be accessed via the following hyperlink.

http://www.gloucestershire.gov.uk/suicide-prevention

A number of "Task and Finish" groups are operational, these consider:

- Suicide Hotspots
- Self-Harm
- Media reporting
- Suicide and self-harm in children and young people

Whilst there is currently no similar forum in Herefordshire, Herefordshire CCG are in discussion with Herefordshire Public Health regarding the need to formalize countywide arrangements for a suicide prevention strategy.

This year has seen the continuation of number of interagency activities including the following:

- Joint annual [2]gether/SOBS Conference in June 2016, this year focusing on children and young people's mental health issues;

- Continued joint working between [2]gether and Gloucester Constabulary in supporting people in the aftermath of being bereaved by suicide, this model is being adopted by an increased number of trusts and constabularies nationally. [2]gether and Gloucestershire Constabulary presented the model at the Zero Suicide Collaborative annual conference;

- ASIST training for both statutory and voluntary sector organisations being funded via Public Health Gloucestershire;

- Continued delivery of Mental Health First Aid Training;

- Continued multi-agency working regarding frequent attenders (self-harm) at Emergency Departments in both Herefordshire & Gloucestershire;

- Continuation of the Gloucestershire Rethink Mental Illness Self harm helpline to 7 evenings per week from 5-10pm and launch of the associated website in September 2016;

- Implementation of the Mental Health Acute Response Service;

- 48 Hour follow up from an inpatient unit remains a key quality target;

- Research poster developed and presented at a Royal College of Psychiatrists event in response to the local hypothesis that the suicide rate reduced during the Olympics;

- An initial comparison of both local and [2]gether suicide data against the National Confidential Inquiry 20 Year Review. This will inform further suicide prevention work in the Trust during 2017/18;

- Development and launch in January 2017 of the "Stay Alive" app (Gloucestershire & Herefordshire) for iPhone & Android smartphones. This will be trialed by small number of services initially using small "tests of change" in line with improvement methodology. As further

improvements are made these can be added to the app on a quarterly basis. General awareness raising of the app will be scheduled for April 2017 following local trials;

- An additional "task & finish" group of the Gloucestershire Suicide Prevention Partnership Forum was set up in January 2017 to progress establishing a Suspected Suicide Early Alert System similar to that developed in County Durham. This group consists of representatives from Public Health Gloucester, Gloucestershire Constabulary, [2]gether, HM Coroner for Gloucester and Gloucestershire SOBS;

We are currently meeting this target as the total number remains below 24; however we have reported more suspected suicides in Quarters 1 & 2 this year than in the previous 4 years and there is a high risk that this target will not be met.

Target 3.2 Reduce the number of people who are absent without leave from inpatient units who are formally detained.

Much work has been done to understand the context in which detained service users are absent without leave (AWOL) via the NHS South of England Patient Safety and Quality Improvement Mental Health Collaborative. AWOL reporting includes those service users who:

1. Abscond from a ward,
2. Do not return from a period of agreed leave,
3. Abscond from an escort.

During 2015/16 **114** episodes of AWOL were been reported with the overall target being met, but there was an increase of **9** incidents where service users absconded from a ward. Therefore, we want to continue with this indicator as a quality priority during 2016/17. A breakdown of the 3 categories of AWOL for each county showing the year-end figures for 2015/16 and the Quarter 1 figures for 2016/17 are seen below.

Herefordshire

	Total 2015/16	Quarter 1 2016/17	Quarter 2 2016/17	Quarter 3 2016/17	Quarter 4 2016/17
Absconded from a ward	23	15	9	7	
Did not return from leave	4	2	1	1	
Absconded from an escort	4	2	0	2	
Totals for year	**31**	**39**			

Gloucestershire

	Total 2015/16	Quarter 1 2016/17	Quarter 2 2016/17	Quarter 3 2016/17	Quarter 4 2016/17
Absconded from a ward	55	20	36	24	
Did not return from leave	19	9	16	14	
Absconded from an escort	9	3	9	3	
Totals for year	**83**	**134**			

A total of **173** episodes of AWOL for Quarters 1, 2 & 3 which now exceeds the total number of AWOL for the year 2015/16.

The increase in reported AWOL incidents has prompted a local review to better understand the context and detail about this increase. Several sources of data have been requested and explored and the findings are summarised below:

- Revisions to the Trust's incident reporting system (Datix) were implemented from 1 April 2016 meaning that the reporting of AWOL is quicker and easier than previously, and this may have impacted as "better reporting". Data quality has also improved as a result.

- Inpatient areas are challenged in the recruitment and retention of Registered Nurses, as is the current national picture. This may impact on time available for engagement with inpatients.

- The number of people who are formally detained in inpatient units has increased slightly by 3% overall across the Trust this year. Whilst this is not significant, it is noteworthy.

- There are no significant changes reported as modes of absconding.

- Between Quarters 1 & 2 an small increase in minor harm (taking one month to rectify) as a result of AWOL was reported and this may coincide with changes to Datix. In Quarter 3, no harm as a result of an AWOL incident occurred. Throughout the year, no reported AWOLS have resulted in moderate or severe harm, or death.

- As part of the NHS South of England Patient Safety and Quality Improvement Mental Health Collaborative, it was reported that one other Trust had identified that reduced length of stay correlates with reduced reported AWOLS. This has been explored using data from our information team and although some minor changes in length of stay were noted, overall this is largely unchanged.

We will continue to promote the use of "leave cards". These are cards given to patients, along with a conversation on what the expectations of returning from leave are as agreed. For example, planned leave arrangements can be documented on the back of the credit card sized "leave card", explicitly showing the time due to return and a prompt to contact the ward team if unable to return by the agreed time. The hospital/ward contact numbers are provided on the other side of the cards also.

There will be a continued focus on positive engagement within our inpatient services to try to reduce the number of occasions where detained patients abscond from the ward environment.

We have not met this target.

Target 3.3 To reduce the number of prone restraints by 5% year on year (on all adult wards & PICU)

This is a new target for 2016/17. During 2015/16, the Trust developed an action plan to reduce the use of restrictive interventions, in line with the 2 year strategy – Positive & Safe: developed from the guidance Positive and Proactive Care: reducing the need for restrictive interventions. This strategy offered clarity on what models and practice need to be undertaken to support sustainable reduction in harm and restrictive approaches, with guidance and leadership by the Trust Board and a nominated lead.

The Trust developed its own Positive & Safe Sub-Committee during 2015/16 which is a sub–committee of the Governance Committee. The role of this body is to:

- Support the reduction of all forms of restrictive practice;
- Promote an organisational culture that is committed to developing therapeutic environments where physical interventions are a last resort;
- Ensure organisational compliance with the revised Mental Health Act 1983 Code of Practice (2015) and NICE Guidance for Violence and Aggression;
- Oversee and assure a robust training programme and assurance system for both Prevention & Management of Violence & Aggression (PMVA) and Positive Behaviour Management (PBM);
- Develop and inform incident reporting systems to improve data quality and reliability;

- Improve transparency of reporting, management and governance;
- Lead on the development and introduction of a Trust wide RiO Physical Intervention Care Plan/Positive Behavioural Support.

As use of prone restraint (face down) is sometimes necessary to manage and contain escalating violent behaviour, it is also the response most likely to cause harm to an individual. Therefore, we want to minimise the use of this wherever possible through effective engagement and occupation in the inpatient environment. All instances of prone restraint are recorded and this information was used to establish a baseline in 2015/16. Overall, there were **121** occasions when prone restraint was used in our acute adult wards and PICU and the breakdown of this information by month is shown in Figure 9 below.

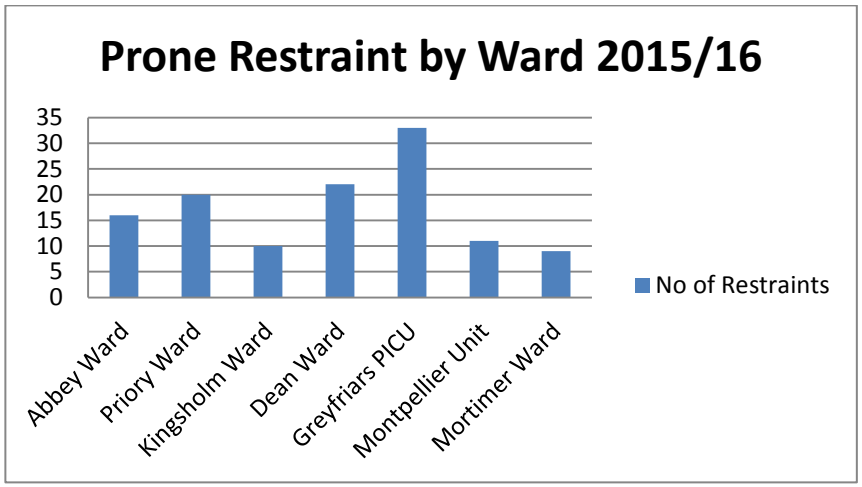


Figure 9

At the end of Quarter 3 2016/17, **154** instances of prone restraint were used as seen in Figure 10 which is an overall increase this year.

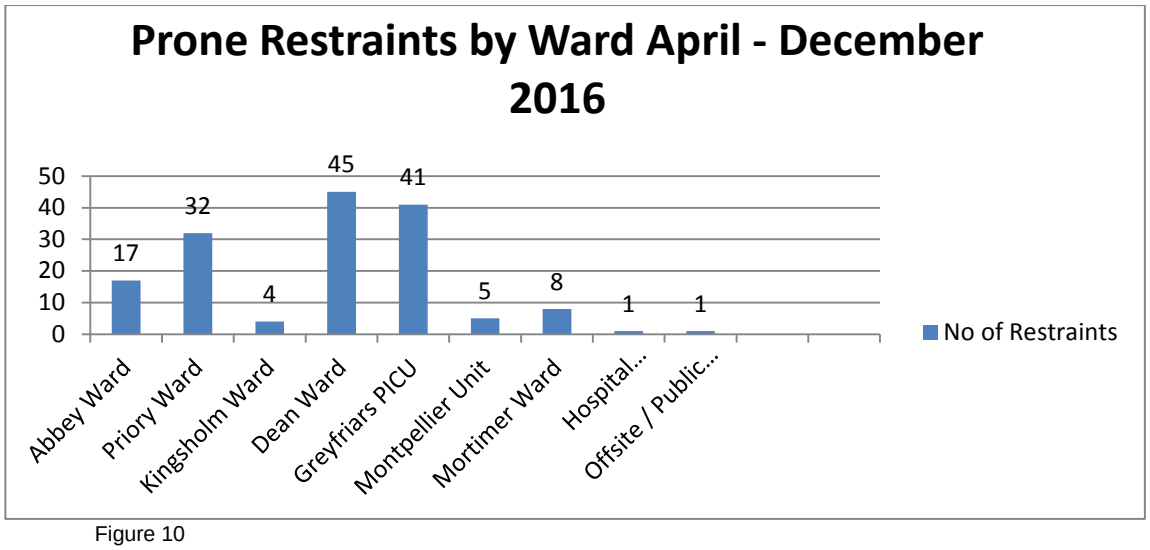


Figure 10

Analysis of the data during Quarters 1 & 2 identified that not all of these incidents are, in fact, episodes of prone restraint, rather the application of precautionary holds for individuals who place themselves face down whilst holding items being used for the purpose of self-harm. These precautionary holds are fleeting and the person is released as soon as the item has been safely removed. A new category of "Precautionary/Non-Standard Hold" has, therefore, been added to DATIX and the wards advised of this. In Quarter 3, 50 incidents of prone restraint overall were reported.

In terms of further developments to minimise the use of prone restraint, injection sites for the purpose of rapid tranquillisation have been reviewed. Currently staff are trained to provide rapid tranquillisation

intramuscularly via the gluteal muscles, this necessitates the patient being placed into the prone restraint position if they are resistant to the intervention. New training is in the process of being rolled out to all inpatient nursing and medical staff to be able to inject via the quadriceps muscles. This requires the patient to be placed in the supine position which poses less risk. When the workforce is in a position to implement this change, it is anticipated that we will see a corresponding reduction in the use of prone restraint.

Each year, the Trust engages in the NHS Mental Health Benchmarking exercise, which all English NHS Trusts who are providers of secondary mental health services participate in. This enables individual organisations to compare trends and benchmark themselves against the national data. Figure 11 below shows that the Trust reports incidences of prone restraint slightly above the national average.

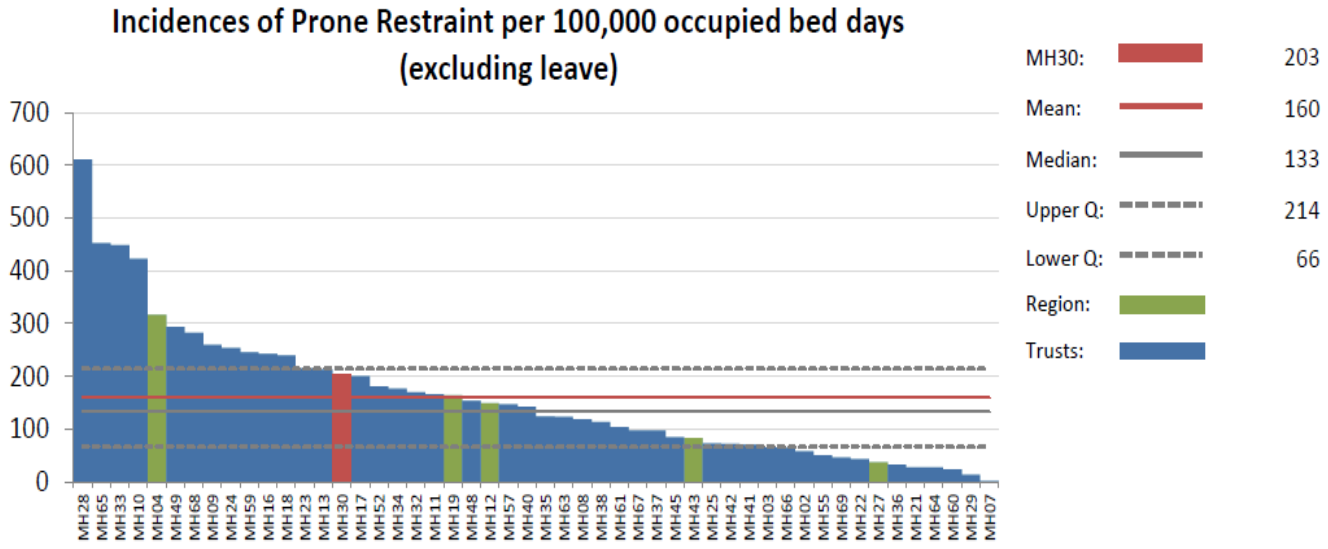


Figure 11

We have not met this target.

Target 3.4 95% of adults will be followed up by our services within 48 hours of discharge from psychiatric inpatient care

This is a local target and one which we first established as a quality target in 2012/13. The national target is that 95% of CPA service users receive follow up within 7 days[1].

Discharge from inpatient units to community settings can pose a time of increased risk of self-harm for service users. The National Confidential Inquiry into Suicides and Homicides[2] recommended that *'All discharged service users who have severe mental illness or a recent (less than three months) history of self-harm should be followed up within one week'*

One of the particular requirements for preventing suicide among people suffering severe mental illness is to ensure that follow up of those discharged from inpatient care is treated as a priority and that care plans include follow up on discharge. Although the national target for following up service users on CPA is within 7 days, in recognition that people may be at their most vulnerable within the first 48 hours, we aim to follow up 95% of people within these 2 days. This has been an organisational target for two years, and the cumulative figures for each year end are seen in the table below.

[1] Detailed requirements for quality reports 2014/15: Monitor, February 2015
[2] Five year report of National Confidential Inquiry into Suicide and Homicide by people with mental illness Department of Health – 2001

During 2015/16 we took the opportunity to review our practices and policies associated with both our 7 day and 48 hour follow up of patients discharged from our inpatient services. Whilst the adjustments we have undertaken have strengthened the patient safety aspects of our follow up contacts, introducing these changes have led to an impact on our in year performance, in comparison to our previous year's performance against these performance standards. In the case of our 48 hour local stretch target, our 2015/16 organisational performance fell to **90% (**Herefordshire services followed up **91%** (**25** breaches) of people discharged from inpatient care and Gloucestershire services have followed up **90%** (**83** breaches) which is below our stretch target.

We are confident that the practice changes we introduced have strengthened the patient safety aspects of this measure and that our performance in both our 7 day and 48 hour follow ups will ultimately return to being well above the national performance requirement and our local stretch target.

At the end of Quarter 3, Herefordshire services followed up **100%** of people discharged from inpatient care and Gloucestershire services followed up **95%** (**8** breaches). This gives an overall organisational compliance of **97%.** Each of these breaches will be reviewed to establish if there are any themes and trends, and the learning from this review will be used to promote practice.

	Target	2012-13	2013-14	2014-15	2015-16	2016-17 Q3
Gloucestershire Services	>95%	89%	95%	95%	90%	95%
Herefordshire Services	>95%	70%	95%	92%	91%	100%

We are currently meeting this target.

Serious Incidents reported during 2016/17

By the end of Quarter 3 2016/17, **34** serious incidents were reported by the Trust in the year, and the types of incidents reported are seen in Figure 12.

Figure 13 overleaf shows a 6 year comparison of reported serious incidents. The most frequently reported serious incidents are "suspected suicide" and attempted suicide which is why we have continued this year with a target to reduce suicide of people in contact with services. All serious incidents are investigated by a senior member of staff who has been trained in root cause analysis techniques. Wherever possible, we include service users and their families/carers in this process to ensure their perspective is taken into account, and we provide feedback to them on conclusion of an investigation. We also share copies of our trust investigation reports regarding "suspected suicides" with the Coroners in both Herefordshire and Gloucestershire to assist with the Coronial investigations.

There have been no Department of Health defined "Never Events" within the Trust during 2016/17. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

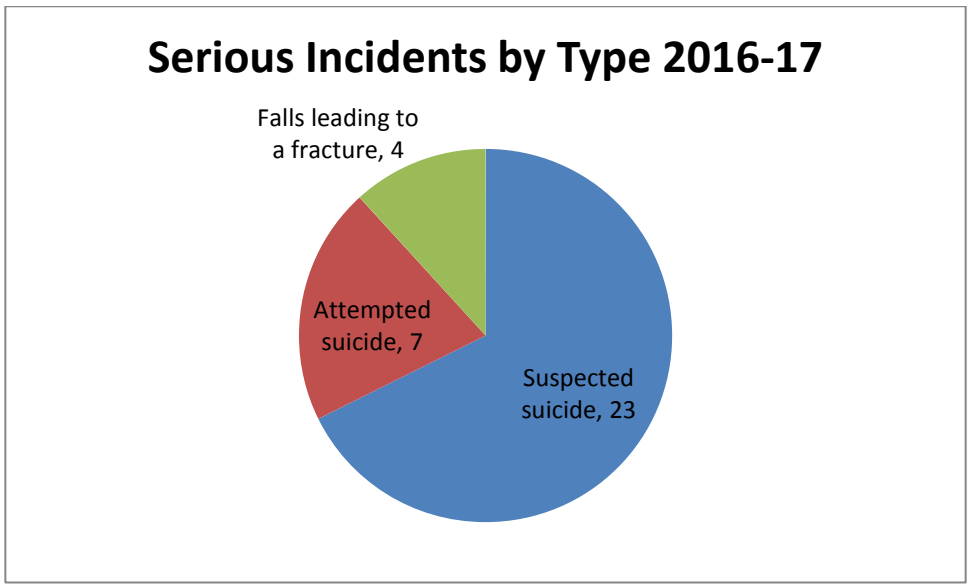


Figure 12

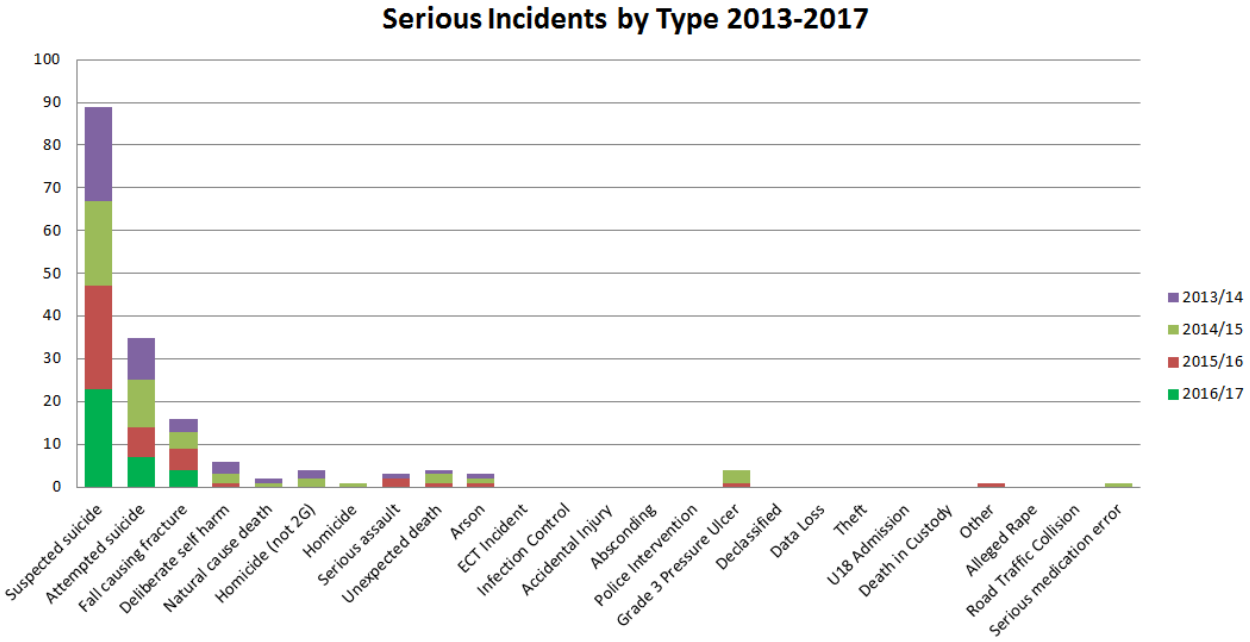


Figure 13

Duty of Candour

The Duty of Candour is a statutory regulation to ensure that providers of healthcare are open and honest with services users when things go wrong with their care and treatment. The Duty of Candour was one of the recommendations made by Robert Francis to help ensure that NHS organisations report and investigate incidents (that have led to moderate harm or death) properly and ensure that service users are told about this.

The Duty of Candour is considered in all our serious incident investigations, and as indicated in our section above regarding serious incidents, we include service users and their families/carers in this process to ensure their perspective is taken into account, and we provide feedback to them on conclusion of an investigation. Additionally, we review all reported incidents in our Datix System (incident reporting system) to ensure that any incidents of moderate harm or death are identified and appropriately investigated.

To support staff in understanding the Duty of Candour, we have provided training sessions through our Quality Forums and given all staff leaflets regarding this. There is also a poster regarding this on every staff notice board.

During the CQC comprehensive inspection of our services, they reviewed how the Duty of Candour was being implemented in across the Trust and provided the following comments in their report dated 27 January 2016.

"Staff across the trust understood the importance of being candid when things went wrong including the need to explain errors, apologise to patients and to keep patients informed."

"We saw how duty of candour considerations had been incorporated into relevant processes such as the serious investigation framework and complaints procedures. Staff across the trust were aware of the duty of candour requirements in relation to their role."

Our upgraded Incident Reporting System (Datix) has been configured to ensure that any incidents graded moderate or above are flagged to the relevant senior manager/clinician, who in turn can investigate the incident and identify if the Duty of Candour has been triggered. Only the designated senior manager/clinician can "sign off" these incidents.

Sign up to Safety Campaign – Listen, Learn and Act (SUP2S)

[2]gether NHS Foundation Trust signed up to this campaign from the outset and was one of the first 12 organisations to do so. Within the Trust the campaign is being used as an umbrella under which to sit all patient safety initiatives such as the NHS South of England Patient Safety and Quality Improvement Mental Health Collaborative, the NHS Safety Thermometer, Safewards interventions and the Reducing Physical Interventions project. Participation in SUP2S webinars has occurred, and webinar recordings are shared with colleagues. A Safety Improvement Plan has been developed, submitted and approved. Monitoring of progress as a whole is completed every 6 months via the Trust Governance Committee, but each work stream has its own regular forum and reporting mechanisms.

Indicators & Thresholds for 2016/2017

The following table shows the 10 metrics that were monitored during 2016/17. These are the indicators and thresholds from NHS Improvement (NHSI) and follow the standard Department of Health national definitions. Note that some are also the Trust Quality targets, and some may have more stretching targets than Monitor require as a threshold.

		2013-2014 Actual	2014-2015 Actual	2015-2016 Actual	National Threshold	2016-2017 YTD
1	Clostridium Difficile objective	1	3	0	0	**3**
2	MRSA bacteraemia objective	0	0	0	0	**0**
3	7 day CPA follow-up after discharge	99.1%	97.73%	95.63%	95%	**98%**
4	CPA formal review within 12 months	96.4%	97.1%	99.35%	95%	**99%**
5	Delayed transfer of care	0.12%	0.06%	1.02%	≤7.5%	**1.9%**
6	Admissions gate kept by Crisis resolution/home treatment services	99.1%	99.57%	99.74%	95%	**99%**
7	Serving new psychosis cases by early intervention teams	100%	100%	63.56%	50%	**71%**
8	MHMDS data completeness: identifiers	99.7%	99.71%	99.57%	97%	**99.9%**
9	MHMDS data completeness: CPA outcomes	80.6%	97.06%	97.42%	50%	**96.7%**
10	Learning Disability – six criteria	6	6	6	6	**6**

Mandated Quality Indicators 2016 -2017

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

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

	Quarter 2 2015-16	Quarter 3 2015-16	Quarter 4 2015-16	Quarter 1* 2015-16	Quarter 2* 2015-16
[2]gether NHS Foundation Trust	97%	97.2%	98.10%	97.1%	97.2%
National Average	96.8%	96.9%	97.2%	96.2%	96.8%
Lowest Trust	83.4%	50%	80%	28.6%	76.9%
Highest Trust	100%	100%	100%	100%	100%

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

- During 2015/16 we have taken the opportunity to review our practices and policies associated with both our 7 day and 48 hour follow up of patients discharged from our inpatient services. Whilst the adjustments we have undertaken have strengthened the patient safety aspects of our follow up contacts, introducing these changes have led to an impact on our in year performance, in comparison to our previous year's performance against these performance standards. Our 7 day performance has fallen to just over 95% in Gloucestershire and just over 96% in Herefordshire which are lower than our previous year's performance, but still above the national performance requirement of 95 %. We are confident that the practice changes we have introduced have strengthened the patient safety aspects of this measure and that our future years performance in both our 7 day and 48 hour follow ups will return to being well above the national performance requirement and our local stretch target as in previous years.

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

- Clearly documenting follow up arrangements from Day 1 post discharge in RiO;
- Ensuring that service users are followed up within 48 hours of discharge from an inpatient unit whenever possible.

* Activity published on NHS England website via the NHS IC Portal is revised throughout the year following data quality checks. Activity shown for Quarters 1 & 2 2016/17 has not yet been revised and may change.

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

	Quarter 2 2015-16	Quarter 3 2015-16	Quarter 4 2015-16	Quarter 1* 2016-17	Quarter 2* 2016-17
[2]gether NHS Foundation Trust	98.6%	100%	98.4%	98.9%	98.9%
National Average	97%	97.5%	98.2%	98.1%	98.4%
Lowest Trust	48.5%	61.9%	84.3%	78.9%	76%
Highest Trust	100%	100%	100%	100%	100%

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

- Staff respond to individual service user need and help to support them at home wherever possible unless admission is clearly indicated;
- During 2015/16, crisis teams also gate kept admissions to older people's services beds within Gloucestershire.

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

- Continuing to remind clinicians who input information into the clinical system (RiO) to complete the 'Method of Admission' field with the appropriate option when admissions are made via the Crisis Team;
- Continuing to remind clinicians who input information into RiO to ensure that all clinical interventions are recorded appropriately in RiO within the client diary.

* Activity published on NHS England website via the NHS IC Portal is revised throughout the year following data quality checks. Activity shown for Quarters 1 & 2 2016/17 has not yet been revised and may change.

3. The percentage of patients aged 0-15 & 16 and over, readmitted to hospital, which forms part of the Trust, within 28 days of being discharged from a hospital which forms part of the trust, during the reporting period

	Quarter 3 2015-16	Quarter 4 2015-16	Quarter 1 2016-17	Quarter 2 2016-17	Quarter 3 2016-17
[2]gether NHS Foundation Trust 0-15	0%	0%	0%	0%	0%
[2]gether NHS Foundation Trust 16 +	10%	6%	7%	6%	8%
National Average	Not available	Not available	Not available	Not available	Not available
Lowest Trust	Not available	Not available	Not available	Not available	Not available
Highest Trust	Not available	Not available	Not available	Not available	Not available

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

- The Trust does not have child and adolescent inpatient beds;
- Service users with serious mental illness are readmitted hospital to maximize their safety and promote recovery;
- Service users on Community Treatment Orders (CTOs) can recalled to hospital if there is deterioration in their presentation.

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

- Continuing to promote a recovery model for people in contact with services;
- Supporting people at home wherever possible by the Crisis Resolution and Home Treatment Teams.

4. The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends

	NHS Staff Survey 2012	NHS Staff Survey 2013	NHS Staff Survey 2014	NHS Staff Survey 2015
[2]gether NHS Foundation Trust Score	3.19	3.46	3.61	3.75
National Median Score	3.54	3.55	3.57	3.63
Lowest Trust Score	3.06	3.01	3.01	3.11
Highest Trust Score	4.06	4.04	4.15	4.04

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

- The National Staff Survey does not report directly on this question but does report on 'Staff recommendation of the trust as a place to work or receive treatment'. This key finding is derived from the responses to three linked questions relating to care of patients, recommending the organization as a place to work and being happy with the standard of care provided by the organisation. The response to the component questions was more positive in 2015 than in the previous three surveys indicating increasing satisfaction with the trust as a place to receive treatment and to work as perceived by staff. The 2015 survey also shows the trust score continues to move ahead of the median score for other like-type trusts;
- The National Staff Survey results continues to be complemented by the introduction of the Staff Friends and Family Test that has now been in operation since April 2014 giving staff the opportunity to voice their opinion on the trust as an employer and provider of care, confidentially in three questionnaires during the year. In the most recent survey held in March 2016, 85% of respondents said they would be likely or extremely likely to recommend the trust to friends and family as a place to receive care or treatment;
- The staff survey showed an increase in the percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver;
- Staff have reported an increase in the level of motivation at work. Whilst the improved level of staff satisfaction is encouraging, the trust is very careful to also take note of feedback from colleagues who are less satisfied and where possible to address these concerns.

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

- Administering the National Staff Survey entirely online in 2015 in response to staff feedback;
- Publicizing the Staff Friends and Family Test results widely in each quarter (excluding Quarter 3 which corresponds with the National Staff Survey). This has continued to prove to be a popular medium for staff to feedback how they perceive the trust as an employer and provider of care. Close monitoring of feedback from these regular surveys highlight areas where not only improvements can be made but also to celebrate success;
- Using the Trust's intranet, known as [2]getherNet to provide a more accessible resource for staff. This is the main method of communication throughout the Trust and development continues with feedback from staff. Work is continuing to ensure easy access to information relating to support available for the health and wellbeing of staff and of a range of benefits available locally for colleagues;
- Increasing the visibility of senior managers including a regular programme of site visits by Executive and Non-Executive Directors.

5. **"Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.**

	NHS Community Mental Health Survey 2013	NHS Community Mental Health Survey 2014	NHS Community Mental Health Survey 2015	NHS Community Mental Health Survey 2016
[2]gether NHS Foundation Trust Score	8.7	8.2	7.9	8.0
National Average Score	Not available	Not available	Not available	Not available
Lowest Score	8.0	7.3	6.8	6.9
Highest Score	9.0	8.4	8.2	8.1

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

- The survey results for this set of questions are broadly similar to the previous three years when compared with the national scores. In fact, in relation to previous years, [2]gether's scores are nearer the higher scores nationally. There is still work to do to enhance service experience and some of the actions being taken are reflected in the points below.

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

- Ensuring that people are involved in the development and review of their plan of care including decisions about their medication
- Understanding people's individual interests and circumstances beyond health care.
- Signposting and supporting individuals to other agencies for social engagement
- Ensuring that service users are provided with information about who can be contacted out of office hours should they need support in a crisis.
- Providing information about getting support from people who have experience of similar mental health needs.

6. **The number and rate* of patient safety incidents reported within the Trust during the reporting period and the number and percentage of such patient safety incidents that resulted in severe harm or death.**

	1 April 2015 – 30 September 2015				1 October 2015 – 31 March 2016			
	Number	Rate*	Severe	Death	Number	Rate*	Severe	Death
[2]gether NHS Foundation Trust	1,464	39.61	1	6	1,371	39.01	1	5
National	144,850	-	492	992	146,325	-	501	1167
Lowest Trust	8	6.46	0	0	25	14.01	0	0
Highest Trust	6,723	83.72	74	95	5,572	85.06	51	91

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

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

- NRLS data is published 6 months in arrears; therefore data for severe harm and death will not correspond with the serious incident information shown in the Quality Report.

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

- Re-auditing its Incident Reporting Systems (DATIX) to improve the processes in place for the timely review, approval of, and response to reported patient safety incidents.
- Appointing a Datix Systems Manager, upgrading the Trust's DATIX system and making the Incident Reporting Form more "user friendly";
- Setting up a DATIX User Group.

Community Survey 2016

The CQC published results of an independent survey taken in 2016 that tested the experience of service users who use [2]gether's community services. The published results compare ratings about [2]gether's services with the results of other mental health trusts.

[2]gether NHS Foundation Trust received a relatively high percentage response rate (compared with others in the country) to the questionnaire at 33% returned. Full details of this survey questions and results can be found on the CQC website http://www.cqc.org.uk/provider/RTQ/survey/6. No significant differences were noted between the results for Herefordshire and Gloucestershire. Across six of the ten domains in the survey our scores were reported as 'About the Same' as other trusts. In the other four domains people scored 2gether's service as 'Better than Others' that is in the top 20% of similar organisations. The results are tabulated below together with the scores out of 10 for [2]gether Trust calculated by the CQC.

[2]gether's scores compared with scores of other trusts

Score (out of 10)	Domain of questions	How the score relates to other trusts
8.0	Health and Social Care workers	Same as others
9.0	Organising Care	Better than others
7.5	Planning care	Same as others
8.1	Reviewing Care	Better than others
6.9	Changes in who people see	Same as others
6.8	Crisis care	Same as others
7.9	Treatment	Better than others
5.3	Support and Wellbeing	Same as others
7.9	Overall view of care and services	Better than others
7.3	Overall	Same as others

In 12 out of the **32** evaluative questions, [2]gether received particularly favourable results compared with other Trusts rated in the CQC Survey. These questions are illustrated in the infographic.

The results have been considered further for areas where improvements will be sought. These include:

- Helping people with a focus on their physical health needs
- Providing people with signposting, support and advice on finances and benefits
- Help people with finding support for gaining or keeping employment
- Signposting and supporting people to take part in activities of interest
- Helping people to access peer support from others with experience of the same mental health needs
- Ensure knowledge of contacts in time of crisis
- Provision of information about new medicines

The Trust has also produced an infographic summarising the key messages from the CQC Survey and this can be seen overleaf

National Mental Health Community Patient Survey Results 2016
Gloucestershire and Herefordshire

²gether NHS Foundation Trust

850 people sent the survey

270 people returned the survey

18 years plus

28% National response rate

33% Trust response rate

32 questions → **10** domains → **²gether's results:** In the top 20% of Trusts in 4 out of the 10 domains. 'About the same' as other Trusts in 6 domains

Results of 10 domains

Each domain compared to other Trusts

Above | About the same | Below

Health and social care workers	8.0/10
Organising care	9.0/10
Planning care	7.5/10
Reviewing care	8.1/10
Changes in who people see	6.9/10
Crisis care	6.8/10
Treatments	7.9/10
Support and well-being	5.3/10
Overall views of care and services	7.9/10
Overall experience	7.3/10

Highlighted nationally as among the highest Trusts rated:

- Keeping service users informed about who is organising their care
- Knowing who to contact with concerns about care
- Involving service users in planning care, reviewing care and sharing decisions
- Giving enough time to discuss needs and treatment
- Supporting service users to achieve what is important to them
- Treating service users with respect and dignity

Areas for further focus:

- Helping with physical health needs
- Providing support and advice on finances and benefits
- Help with finding support on gaining or keeping employment
- Support in taking part in a local activity
- Helping with support from others with experience of the same mental health needs
- Contact in time of crisis
- Information about new medicines

Staff Survey 2016

This will be added following publication of the results.

PLACE Assessment 2016

In April 2013, Patient Led Assessments of the Care Environment (PLACE) were introduced in England. PLACE are self-assessments carried out voluntarily that involve local people who go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness, general building maintenance, Dementia friendly environments and for the first time this year a disability domain has been added. PLACE focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job. It is only concerned about the non-clinical activities.

PLACE is now in its fourth year and the 2016 assessments took place between February and June 2016 with the results being seen in the tables below.

Domain:	**1**	**2**			**3**	**4**	**5**	**6**
Site Name	**Cleanliness**	**Food Overall**	Organisational Food	Ward Food	**Privacy, Dignity and Wellbeing**	**Condition Appearance and Maintenance**	**Dementia**	**Disability** new domain for 2016
Overall 2gether Trust Score:	**99.54%**	**90.85%**	90.34%	90.65%	**95.63%**	**97.62%**	**95.43%**	**91.04%**
HOLLYBROOK	**100.00%**	**95.11%**	92.13%	100.00%	**100.00%**	**99.58%**	**N/A**	**100.00%**
WESTRIDGE	**100.00%**	**82.73%**	91.53%	55.56%	**94.12%**	**100.00%**	**N/A**	**93.65%**
CHARLTON LANE	**99.72%**	**93.16%**	93.37%	92.88%	**93.15%**	**99.28%**	**98.07%**	**93.92%**
WOTTON LAWN	**100.00%**	**94.14%**	89.18%	99.49%	**96.91%**	**98.17%**	**N/A**	**87.23%**
HONEYBOURNE	**99.21%**	**91.58%**	94.31%	88.28%	**96.55%**	**99.58%**	**N/A**	**100.00%**
LAUREL HOUSE	**100.00%**	**95.17%**	91.53%	100.00%	**100.00%**	**100.00%**	**N/A**	**100.00%**
STONEBOW UNIT	**99.89%**	**79.76%**	87.21%	70.72%	**95.89%**	**93.82%**	**92.17%**	**90.10%**
OAK HOUSE	**92.26%**	**N/A**	N/A	N/A	**86.49%**	**91.12%**	**N/A**	**84.62%**
National Average MH/LD	97.80%	89.70%	86.60%	91.90%	89.70%	94.50%	82.90%	84.50%

Key

At or above MH/LD National Average	
Below England MH/LD average	

The Trust has achieved very positive results placing us above the national average for Mental Health and Learning Disability settings in all six domains. This demonstrates how we are improving the quality of the non-clinical services to our patients.

A Disability domain has been added for the first time this year, with the Trust scoring above the upper interquartile (top 25%) compared with other UK Healthcare establishments.

Cleanliness has improved to 99.54% this year which places us above the UK national average for all healthcare establishments.

As a result of the PLACE outcomes and scores, the Trust has developed a comprehensive action plan for each unit, highlighting areas for improvement and resolution; owned by the unit managers under the Matrons. Progress against these action plans is monitored by the Patient Environment Action Groups (PEAG) and supported by the Estates and Facilities Department.

Annex 1: Statements from our partners on the Quality Report

These will be provided at year end.

Annex 2: Statement of Directors' Responsibilities in respect of the Quality Report

This will be completed at year end.

Annex 3: Glossary

ADHD	Attention Deficit Hyperactivity Disorder
BMI	Body Mass Index
CAMHS	Child & Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
CPA	Care Programme Approach: a system of delivering community service to those with mental illness
CQC	Care Quality Commission – the Government body that regulates the quality of services from all providers of NHS care.
CQUIN	Commissioning for Quality & Innovation: this is a way of incentivising NHS organisations by making part of their payments dependent on achieving specific quality goals and targets
CYPS	Children and Young Peoples Service
DATIX	This is the risk management software the Trust uses to report and analyse incidents, complaints and claims as well as documenting the risk register.
GriP	Gloucestershire Recovery in Psychosis (GriP) is ^{2}gether's specialist early intervention team working with people aged 14-35 who have first episode psychosis.
HoNOS	Health of the Nation Outcome Scales – this is the most widely used routine Measure of clinical outcome used by English mental health services.
IAPT	Improving Access to Psychological Therapies
Information Governance (IG) Toolkit	The IG Toolkit is an online system that allows NHS organisations and partners to assess themselves against a list of 45 Department of Health Information Governance policies and standards.
MCA	Mental Capacity Act
MHMDS	The Mental Health Minimum Data Set is a series of key personal information that should be recorded on the records of every service user
Monitor	Monitor is the independent regulator of NHS foundation trusts. They are independent of central government and directly accountable to Parliament.
MRSA	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. It is also called multidrug-resistant

NHS	The National Health Service refers to one or more of the four publicly funded healthcare systems within the United Kingdom. The systems are primarily funded through general taxation rather than requiring private insurance payments. The services provide a comprehensive range of health services, the vast majority of which are free at the point of use for residents of the United Kingdom.
NICE	The National Institute for Health and Care Excellence (previously National Institute for Health and Clinical Excellence) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.
NIHR	The National Institute for Health Research supports a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.
NPSA	The National Patient Safety Agency is a body that leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector.
PBM	Positive Behaviour Management
PHSO	Parliamentary Health Service Ombudsman
PICU	Psychiatric Intensive Care Unit
PLACE	Patient-Led Assessments of the Care Environment
PROM	Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective.
PMVA	Prevention and Management of Violence and Aggression
RiO	This is the name of the electronic system for recording service user care notes and related information within ^{2}gether NHS Foundation Trust.
ROMs	Routine Outcome Monitoring (ROMs)
SIRI	Serious Incident Requiring Investigation, previously known as a “Serious Untoward Incident”. A serious incident is essentially an incident that occurred resulting in serious harm, avoidable death, abuse or serious damage to the reputation of the trust or NHS. In the context of the Quality Report, we use the standard definition of a Serious Incident given by the NPSA
SMI	Serious mental illness
VTE	Venous thromboembolism is a potentially fatal condition caused when a blood clot (thrombus) forms in a vein. In certain circumstances it is known as Deep Vein Thrombosis.

Annex 4: How to Contact Us

About this report

If you have any questions or comments concerning the contents of this report or have any other questions about the Trust and how it operates, please write to:

Mr Shaun Clee
Chief Executive Officer
2gether NHS Foundation Trust
Rikenel
Montpellier
Gloucester
GL1 1LY

Or email him at: shaun.clee@nhs.net

Alternatively, you may telephone on 01452 894000 or fax on 01452 894001.

Other Comments, Concerns, Complaints and Compliments

Your views and suggestions are important us. They help us to improve the services we provide.

You can give us feedback about our services by:

- Speaking to a member of staff directly
- Telephoning us on 01452 894673
- Completing our Online Feedback Form at www.2gether.nhs.uk
- Completing our Comment, Concern, Complaint, Compliment Leaflet, available from any of our Trust sites or from our website www.2gether.nhs.uk
- Using one of the feedback screens at selected Trust sites
- Contacting the Patient Advice and Liaison Service (PALS) Advisor on 01452 894072
- Writing to the appropriate service manager or the Trust's Chief Executive

Alternative Formats

If you would like a copy of this report in large print, Braille, audio cassette tape or another language, please telephone us on 01452 894000 or fax on 01452 894001.

Agenda Item	**11**	**Enclosure**	**Paper F**

Report to: 2gether NHS Foundation Trust Board – 30 March 2017
Author: Jonathan Vickers, Non-Executive Director
Presented by: Jonathan Vickers, Non-Executive Director

SUBJECT: **NON EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS QUARTER 3 2016/17**

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

EXECUTIVE SUMMARY

A Non-Executive Director Audit of Complaints was conducted covering three complaints that had been closed between 1 October and 31 December 2016.

RECOMMENDATIONS

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

1. INTRODUCTION

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

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

1.2 Under the new system agreed in November 2016, following the random selection of three files, the Service Experience Department completes section 1 of the template, and provides the auditor with copies of the initial complaint letter, the investigation report and the final response letter. Having studied the files, the auditor then completes sections 2-4.

1.3 The changes introduced represented a significant improvement on the previous process, but could in my view be improved still further by the inclusion in the documentation of:

- A clear statement of the three key dates (i.e. those of the three documents provided), and the timeliness standards to be met. This would facilitate an assessment against aspect 1

- The statement of issues of complaint to be investigated, as agreed with the complainant. This is particularly important where the original letter lacks clarity.
- The date of birth of the service user. This may be important when issues of consent arise.
- Clear signposting in the template of the four aspects. For example, timeliness does not appear in the template; and the headings of sections 2-4 should be reviewed.

2. SUMMARY OF FINDINGS

2.1 The documentation was properly prepared and easy to follow. There were some very minor corrections to be made:

- In one case, the number of the file did not match the number on the investigation report.
- In one case, the name of the investigator was missing from the report.
- In two cases, the report had not been countersigned by the service director

2.2 Case 1

2.2.1 This was a complex case, with a complaint letter that was in some respects difficult to understand. The investigator should be congratulated on having conducted a very thorough investigation into the specific incidents referenced in this complicated complaint. However, it was not clear that the fundamental issues had actually been addressed.

2.2.2 There were some examples of language that might be regarded as provocative ("this complaint is not upheld"; "there is no evidence that…"), and it would be difficult to imagine the complainant being satisfied with the outcome.

2.2.3 The learning identified was non-specific.

2.2.4 I would offer *limited* assurance against all four aspects of this case.

2.3 Case 2

2.3.1 This was a simpler case, involving a parent complaining about the treatment of her teenage daughter. In many respects, it was a model example of a complete and balanced investigation, with a clear and sympathetic response letter. Where the trust agreed with the complaint, a suitable apology was offered; where not, it was made clear why this was the case, and acknowledged that this response might not be well received.

2.3.2 One element that might have been more clearly explained was the extent of the young person's rights to refuse for her mother to be informed. On a detailed point of language, it is worth reflecting on the distinction between "I am sorry that…" and "I apologise for…" (and, in this particular letter, one case of "I am truly sorry…").

2.3.3 It might also be said that the learning could have been more clearly stated.

2.3.4 However, whilst I would offer only *limited* assurance on timeliness, I would offer *significant* assurance on the third aspect, and *full* assurance on the other two.

2.4 Case 3

2.4.1 Whilst in some respects the simplest of the three cases, this one involved other agencies and other parts of the NHS. The report was thorough, and the response clear and well-expressed.

2.4.2 Again, whilst I would offer only *limited* assurance on timeliness, I would offer *full* assurance on the other three aspects.

3 RECOMMENDATIONS

3.1 The Board is asked to note the content of this report and the assurances provided. The Service Experience Team has received this report for consideration of those recommendations for improvement listed at 1.3.

Agenda item 12 **Enclosure Paper G**

Report to: 2gether NHS Foundation Trust Board on 30th March 2017
Author: Shaun Clee – Chief Executive
Presented by: Shaun Clee – Chief Executive

SUBJECT: **Chief Executive's Report**

Can this report be discussed at a public Board meeting?	***Yes***
If not, explain why	

This Report is provided for:
Decision Endorsement Assurance **To Note**

EXECUTIVE SUMMARY

This paper provides the Board with:

1. An update on key national communications via the NHS England NHS News
2. A summary of key progress against organisational major projects

RECOMMENDATIONS

The Board is asked to note the contents of this report

Corporate Considerations	
Quality implications:	
Resource implications:	
Equalities implications:	
Risk implications:	

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

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

Reviewed by:		
Executive Team	Date	

Where in the Trust has this been discussed before?		
CEO	Date	*24.03.2017*

What consultation has there been?		
N/A	Date	

Explanation of acronyms used:	

1. CONTEXT

1.1 National Context

1.1.1 Children and Young People's Mental Health Research Campaign

As part of Children's Mental Health Week the National Institute for Health Research (NIHR) has launched a Children and Young People's Mental Health Research Campaign to highlight that children and young people have the right to take part in research. Mental health research offers children and young people the opportunity to access cutting-edge treatments and to have a say in how new treatments are developed.

1.1.2 One year on from Future in Mind - Vision to Implementation,

In March 2016 it will have been a year since the publication of Future in Mind, setting the direction of travel for children and young people's mental health. The focus of this event will be how to move forward from the vision of a joined up system to implementation. It is aimed at all partners helping to improve children and young people's mental health, whether within the NHS, a local authority, education or the third sector.

1.1.3 NHS commits to major transformation of mental health care with help for a million more people

The Mental Health Taskforce has published its Five Year Forward View with recommendations for changing and developing mental health care across the NHS. It calls for £1 billion investment to help over a million more people to access the services they need.

1.1.4 New training to support mental health professionals to tackle stigma and discrimination within services

A new training pack has been launched to help reduce the stigma and discrimination sometimes experienced by people when using mental health services. Insight from research, focus groups and individual interviews, demonstrated that a high number of people using mental health services felt they experienced stigma and discrimination. This helped Time To Change to work with mental health professionals and service users to identify examples of good practice as well as the barriers which can sometimes stand in the way of positive interactions. The resulting training pack focuses on the positive changes which can improve both team culture and working practices.

1.1.5 Inspiring leaders in learning disability services

Health Education England has launched a new campaign, to encourage leadership in learning disability services across health and social care. Strong leadership is vital for the delivery of change needed to achieve the aims of the Transforming Care Programme. Be inspired by Daniel Marsden's story and take a look at the leadership training courses available to you. You can also join the conversation on Twitter using #inspiringleadersinLD and say thank you to great leaders who've influenced your practice

1.2 Delivering our Three Strategic Priorities

1.2.1 Continuously Improving Quality

Temporary Staffing Demand

The Executive Team continues to monitor, on a weekly basis, the use of agency (agency spend and shifts covered by bank staff and agency), and the effectiveness of the improvement actions. In addition, the project board meets monthly, and the matrons meet fortnightly to pursue improvements and actions.

Although the forecast is that the cost of agency in nursing, admin, and management will be lower in 2016/17 when compared with 2015/16, the medical costs will be higher, and AHPP costs (due to the IAPT improvement work) will also be higher. The predicted overall agency spend for 2016/17 will be comparable to 2015/16.

A 'direct engagement' scheme was introduced on 13 March which will result in significant savings on the use of medical locums. In 2017/18, e-rostering will help reduce nursing costs through improved and more transparent rostering. Additionally, as many nursing agency shifts (qualified and unqualified) result from demands that occur within 24 hours of a shift commencing, small peripatetic teams are being introduced into Herefordshire and Gloucestershire inpatient units with a remit to cover those urgent requests. Around 40% of all shift cover demand comes from vacancies, and therefore recruitment continues to be a focus.

E-rostering

Rollout commenced 6 March 2017 and included drop-in sessions and engagement with all relevant departments including Staff Bank. Roll-out has

been completed in Herefordshire inpatient, liaison and crisis units, and roll-out has commenced in Gloucestershire.

A decision on the use of 'SafeCare' (a system provided by the e-rostering provider which allows the comparison of staffing levels and skill mix to the actual patient demand/acuity) will be deferred to September 2017 to allow time to investigate the experiences other trusts have had with the system.

E-rostering will go live in June/July, and before then the Roster Policy will be completed and reviewed by staff-side, and the ESR interface (Time & Attendance + Absence) will be readiness tested.

1.2.2 Building Engagement

Internal Board Engagement

01/02/17 The Director of Finance and Commerce attended Audit Committee

01/02/17 The Director of Finance and Commerce attended Charitable Funds Committee

01/02/17 The Director of Finance and Commerce attended New Highway Charity Trustee Board Meeting

02/02/17 The Deputy Director of Finance attended 2g Contract Performance and Information Meeting with Herefordshire CCG

06.02.17 The Chief Executive welcomed new colleagues at Corporate Induction

06.02.17 The Chief Executive hosted the Leadership Forum

06/02/17 The Deputy Director of Finance attended Leadership Forum at Hatherley Manor Hotel

06.02.17 The Director of Engagement and Integration attended the Leadership Forum at Hatherley Manor.

06.02.17 The Director of Service Delivery attended the Executive Development Meeting

06.02.17 The Director of Service Delivery attended the Leadership Forum

06.02.17 The Director of Organisational Development attended Corporate Induction to welcome new colleagues to the Trust

06.02.17 The Director of Organisational Development attended Team Talk at Charlton Lane Hospital, Cheltenham

06.02.17 The Director of Organisational Development attended Leadership Forum

08.02.17 The Director of Engagement and Integration met with the newly appointed Head of Contracts.

12.02.17 The Medical Director attended the On-Call Task and Finish Groups with Medical Staff

13.02.17 The Chief Executive attended the Herefordshire Consultants meeting

13.02.17 The Director of Service Delivery attended the Executive Business Meeting

15/02/17 The Deputy Director of Finance attended Development Committee

16.02.17 The Chief Executive attended a patient safety visit to Mulberry Ward

16/02/17 The Deputy Director of Finance attended Shared Services Partnership Board

17.02.17 The Director of Engagement and Integration chaired the Quality and Clinical Risk Sub-Committee.

17.02.17 The Director of Engagement and Integration attended the Governance Committee.

20.02.17 The Director of Service Delivery attended the Executive Development Meeting

21.02.17 The Director of Organisational Development attended a meeting with Trust Governors to review the NED recruitment process

22.02.17 The Director of Service Delivery attended the Delivery Committee Meeting

22.02.17 The Medical Director attended the On-Call Task and Finish Groups with Medical Staff

23.02.17 The Director of Organisational Development chaired the Workforce & Organisational Development Sub Committee

24.02.17 The Medical Director attended LNC

27.02.17 The Director of Service Delivery attended the Executive Business Meeting

27.02.17 The Director of Service Delivery attended the Executive Priorities Business Meeting

28.02.17 The Director of Service Delivery attended the Board Development Session on AWOL

28.02.17 The Director of Organisational Development attended Trust Board

28/02/17 The Deputy Director of Finance attended 2g Board Meeting

28.02.17 The Director of Engagement and Integration attended the Trust Board meeting.

Board Stakeholder Engagement

01.02.17 The Director of Service Delivery attended the CCG Interface Meeting

01.02.17 The Director of Service Delivery attended the New Highway Charity Trust Board Meeting (Bevan Brittan)

01.02.17 The Director of Service Delivery attended the Gloucester/Hereford Contract Meeting

01.02.17 The Director of Service Delivery attended a meeting with relative of a Service user

01.02.17 The Director of Organisational Development attended the STP Hfds & Worcs Workforce & OD Planning Group meeting with NHS Elect

01.02.17 The Director of Engagement and Integration attended the Forest of Dean Community Review Steering Group at Sanger House.

02.02.17 The Director of Engagement and Integration attended at CYPS Participation Event at Acorn House

02.02.17 The Director of Engagement and Integration attended a 2gether Governors Event at Cheltenham College

02.02.17 The Director of Organisational Development attended the STP Gloucestershire Staff Engagement Tools/Frameworks engagement event

02.02.17 The Director of Organisational Development attended the Time to Talk Governors' Event at Gloucestershire College

02.02.17 The Director of Service Delivery attended a Governors Event as part of National Time to Talk Day

02.02.17 The Director of Service Delivery attended the STP Strategic Networking Awayday

03.02.17 The Chief Executive chaired the Dementia Board.

03.02.17 The Director of Service Delivery attended the Dementia Board Meeting

03.02.17 The Director of Service Delivery attended a Development of Step Down House from Montpellier Meeting

06.02.17 The Director of Service Delivery attended the Gloucester Team Talk

07.02.17 The Director of Service Delivery attended the Gloucestershire Network Project Meeting

08.02.17 The Director of Service Delivery attended the MH Liaison Pathways Meeting

09.02.17 The Director of Service Delivery attended the Hereford Single Sex Accommodation Meeting

09.02.17	The Director of Service Delivery attended the Gloucester City Place-based Model Pilot Board
10.02.17	The Director of Service Delivery attended the updated LDR and Ongoing Reporting Meeting
13.02.17	The Director of Service Delivery attended the Gloucester City MH Pilot Discussion
14.02.17	The Director of Service Delivery attended the Joint RSG & PDG Meeting
14.02.17	The Director of Organisational Development participated in a conference call of the STP Hfds & Worcs Workforce & OD Planning Group
14/02/17	The Deputy Director of Finance attended a Joint Resources Steering Group and PDG Meeting at Gloucestershire CCG
15.02.17	The Director of Service Delivery attended the IT Partnership Review Board
15.02.17	The Director of Service Delivery attended the STP Programme Development Group
16.02.17	The Medical Director attended a Mental Health Pilot Scheme at Hadwen Medical Practice
16.02.17	The Director of Service Delivery attended a Contract Management Board meeting in Hereford
16.02.17	The Director of Service Delivery attended an On-call Task & Finish Group Meeting
16.02.17	The Director of Organisational Development chaired the STP Glos introductory meeting of the Capability Thematic Group
17.02.17	The Director of Service Delivery attended the Psychotherapy Support to Junior Doctors' Programme Meeting
20.02.17	The Director of Service Delivery attended the Urgent Care Programme Board
21.02.17	The Chief Executive attended the Worcestershire STP Programme Board
21.02.17	The Director of Service Delivery attended the Senior Managers' Team Meeting
21.02.17	The Director of Service Delivery attended the LDR Infrastructure Delivery Group
21.02.17	The Director of Service Delivery attended the Network Replacement Capital Expenditure Meeting

22.02.17 The Chief Executive attended the Gloucestershire STP event for HR and OD

22.02.17 The Chief Executive attended the Gloucestershire Strategic Forum

22/02/17 The Deputy Director of Finance attended a Community Finance Meeting at Herefordshire CCG

22.02.17 The Director of Service Delivery attended the On-Call Task & Finish Group Meeting

22.02.17 The Director of Organisational Development attended the STP Glos event for HR, OD and Learning & Development colleagues

23.02.17 The Director of Organisational Development attended the STP Glos Social Partnership Forum

23.02.17 The Director of Service Delivery attended the S&BV Pilot Board Meeting

23.02.17 The Director of Service Delivery attended the MH in Primary Care Meeting

28.02.17 The Director of Service Delivery attended the Herefordshire 17/18 SDIP & DQIP Framework Meeting

07.02.17 The Director of Engagement and Integration met with senior leaders in her Directorate.

10.02.17 The Director of Engagement and Integration took part in the Time to Change Facilitator Meeting at Ambrose House.

10.02.17 The Director of Engagement and Integration took part in a meeting about services for veterans of the Armed Forces.

16.02.17 The Director of Engagement and Integration attended the HCOSC Working Planning Meeting in Gloucester.

28.02.17 The Director of Engagement and Integration attended the Launch of Strategic Plan hosted by the University of Gloucestershire.

<u>Board National Engagement</u>

02.02.17 The Chief Executive attended the NHS Confederation Board of Trustees meeting

07/02/17 The Deputy Director of Finance attended NHSI in London to discuss Carter Review with Frances Martin

06.02.17 The Director of Engagement and Integration hosted the Team Talk meeting at Park House in Stroud.

15.02.17 The Director of Engagement and Integration was part of an examination interview panel for a PhD viva at London Southbank University.

24.02.17 The Chief Executive chaired the South West Mental Health CEO's Meeting

1.2.3 Sustainability

Gloucester City Hub

Work has commenced on the remodelling and refurbishment of Pullman Place to provide a service delivery hub for Gloucester. The site on Great Western Road (behind the rail station) is conveniently located near to other NHS establishments and the city centre, with good communication links.

The contractor, E.G.Carter & Co. Ltd, a Gloucester based company, took possession of the site and started work on Monday 20 March. Following completion all the clinical mental health teams, currently working from a range of sites dispersed around the city, will move into the Hub during November 2017.

New HM Revenue and Customs rules for the payment of tax and National Insurance contributions

Background

New draft legislation was included in the Finance Bill 2017 outlining changes to be made to the intermediaries' legislation (IR35) which will apply where the services of a person are provided through an intermediary to a "public authority". These new rules will apply to payments made on or after 6 April 2017. This includes payments in respect of contracts entered into before 6 April 2017 which continue in force after this date (and also payments made after this date in respect of work undertaken prior to then).

What is IR35?

Introduced in 2000, IR35 purpose is to ensure that people who work off-payroll through their own company (or other intermediary), who would have been taxed as employees had they been directly paid, pay appropriate employment taxes on their income. Under these rules the limited company is currently required to assess whether IR35 applies and, if so, to then account for income tax and national insurance on the payments that it receives for the engagement.

Why is it changing?

The UK government estimated that only one in ten Personal Service Companies (PSCs) who should be operating the rules on at least part of their income were actually doing so. The government held that public sector bodies should be doing much more to ensure that those who work for them off-payroll pay the right amount of tax.

What are the effects of the new rules?

Under the new rules, where the client receiving the person's services is a public authority, responsibility for determining whether IR35 applies moves from the

intermediary to the public authority, or, if agencies or third parties are in the contractual chain between the public authority and the intermediary, to the party closest to the intermediary in the chain. Additionally, where the legislation does apply, the responsibility for operating PAYE and accounting for Income Tax and National Insurance will fall on the public authority (or relevant third party).

Where public authorities fail to comply with the new rules they may be liable to interest and penalties from HMRC.

Does it affect the Trust?

Yes. “Public authority” is defined as:

- Any NHS body
- All local authorities
- Police forces
- All government departments
- Educational establishments including universities and FE colleges

Significantly it does not apply to private companies delivering public services, including charities, or to registered housing providers.

What sort of workers will it impact in the Trust?

There are three types of workers the Trust currently use who will be affected by the new IR35 rules:-

1. Liaison - Workers coming to the Trust who have been provided through Liaison which is an intermediary organisation which assists us in sourcing medical locums. Liaison have confirmed that their processes and locum medics are and will continue to be compliant.
2. Agency Workers
   - Bookings made by our Staff Bank or Medical Staffing
   - Bookings managers have themselves directly with an agency

   The Trust has written to all agencies seeking assurance of IR35 compliance.
3. P2P Workers - Workers who are engaged and paid via P2P on receipt of an invoice.
   The Trust has written to workers explaining its approach that invoices will be paid less tax and National insurance.

What is the expected impact?

The changes are expected to have a significant impact on all public authorities. It will be particularly felt within the NHS where a number of long established arrangements for clinical and non-clinical temporary staffing will be impacted. As a result, all organisations have been working on putting in place new systems for checking the status of any off-payroll engagements. HMRC has only just issued its online digital tool in the past couple of weeks. This is the tool which enables individuals or employers to assess whether engagements fall within IR35 scope. It also provides downloadable evidence of the process taken to reach conclusions.

Payments to intermediaries will now need to be processed by the Trust (and all other public authorities) through payroll under real time information. This will increase our administrative requirements on a range of fronts. Where intermediaries are provided through a third party such as a locum doctor agency or nursing agency, the new rules require the Trust to inform the third party whether or not it considers the IR35 legislation applies.

To date the Trust has identified circa 20 directly employed and 13 PCS through its processes, for example, in medical locum, nursing and clinical supervisory roles. Identified workers to whom IR35 applies have the option to be employed directly, have tax and National Insurance deducted through payroll, to seek alternative engagement elsewhere or to leave the market. There is a risk which will become apparent after the rules come in to place that some workers may attempt to increase their chargeable rates to offset the loss of earnings or may dispute the Trust's assessment. These will be worked through on an individual basis.

<u>What has the Trust has done to ensure compliance going forwards?</u>

Human Resources, Finance and Shared Services colleagues have been working in partnership to ensure compliance. We have: -

- Accessed the new HMRC toolkit
- Developed and issued internal guidance notes and related flow charts for staff and managers
- Written to agencies and vendors about the new requirements and the Trust's assessment of their status
- Put into place a new process to provide suitable governance. This includes two identified IR35 assessment validators (one in Finance and one in Staff Bank)
- Put into place Executive level approval of PSCs.

Progress will be closely overseen by the Executive team going forwards.

Agenda item 13 **Enclosure Paper H**

Report to: Trust Board – 30 March 2017
Author: Nick Grubb - Assistant HR Director
Presented by: Neil Savage, Director of Organisational Development

SUBJECT: **2016 NHS National Staff Survey**

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

EXECUTIVE SUMMARY

This report provides the Board of Directors with an overview and analysis of the 2016 NHS Annual Staff Survey.

- For 2016 the Survey was sent to all staff in post on 1st September 2016.Previously the survey had been sent to a random sample of 750 staff. 1950 staff were invited to take part.
- The Trust's response rate was 40%, equal on a percentage basis to the previous year. However, the number of respondents rose from 298 in 2015 to 777 in 2016. This is below the average response rate of 45% for all Mental Health/Learning Disability Trusts but numerically provides an extensive survey population.
- In the NHS across England, 982,000 staff were invited to take part in the survey and there was a response rate of 44%, up from 41% in 2015.
- The nationally determined "Comparator groups" changed in 2016. 2gether is included in the Mental Health/Learning Disabilities comparator group. Overall there are 28 trusts in this group.
- There are 32 Key Findings, the same number as last year although 2 have been changed and are not directly comparable.
- Encouragingly, the Trust was better than average or average in 28 (86%) of the 32 Key Findings when compared with other MH/LD Trusts. The Trust also did very well in comparison with other Trusts in Gloucestershire.
- While some Key Findings scores have increased and some have reduced, there were no statistically significant changes to any of the Key Findings when compared with the 2015 survey.
- Trust staff engagement rose over 2015's score. It is above average for MH/LD Trusts. It is also above average when compared with the All Trusts, Acute Trusts, Combined Mental Health/Learning Disabilities and Community Trusts and the Community Trusts

comparator group averages.

- The overall score for staff engagement nationally was 3.79 (out of 5) compared with the Trust's score of 3.89.

- Staff recommendation of the Trust as a place to work or receive treatment rose and is above average for MH/LD Trusts. Again this indicator is above average when compared with the All Trusts, Acute Trusts, Combined Mental Health/Learning Disabilities and Community Trusts and the Community Trusts comparator group averages.

Recommendations

- Ensure effective use of patient feedback
- Promote the health and wellbeing of staff
- Focus actions on encouraging colleagues to report bullying, harassment, abuse and physical violence

Additionally, this year we have asked the Service Directors and locality management boards engage with staff locally and then to highlight three priorities from the survey within their area and then develop an appropriate local action plan.

RECOMMENDATIONS

The Board of Directors is asked to note the Trust's strong position, areas for development and to endorse the recommended priority areas for the action plan.

Corporate Considerations	
Quality implications	The results are part of a range of feedback mechanisms that reflect how staff view the Trust, including the quality of the services it provides and of the Trust as an employer.
Resource implications:	The delivery of the action plan is managed within existing resources.
Equalities implications:	The Survey's lack of equalities monitoring across all protected characteristics reduces the usefulness of the evidence to support actions to reduce barriers and improve staff experience particularly regarding race.
Risk implications:	The results of the Annual Staff Survey are published nationally and locally. Poor or negative results may impact upon the view of service users and carers and other stakeholders and the care the Trust provides. In addition poor results can impact upon the Trust's ability to demonstrate that we are an employer of choice when recruiting and Commissioners may choose not to commission services from a Trust that has poor Staff Survey results.

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

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

Reviewed by:		
Neil Savage, Director of Organisational Development	Date	15.03.17 & 23.03.17

Where in the Trust has this been discussed before?		
Executive Committee	Date	13.03.17
Senior HR Team Meeting	Date	14.03.17
What consultation has there been?		
JNCC	Date	22.03.17

Explanation of acronyms used:	MHLDT – Mental Health/Learning Disability Trusts QH – Quality Health ESR – Electronic Staff Record NHSE – NHS England

1. Introduction

1.1 The Trust participates in the NHS Annual Staff Survey, a requirement of the Department of Health.

1.2 The Survey is carried out by our independent contractor Quality Health (QH). The Trust provided a full staff listing extracted from the Electronic Staff Record (ESR).

1.3 Previous surveys were sent to a random sample of 750 staff. In 2016 for the first time, all staff in post on 1st September 2016 were invited to take part online.

1.3 All responses are returned directly to QH, the Trust does not know who responded to the survey.

2. Response to the Survey

2.1 The response rate for the 2016 survey was 40%. This is equal to the 2015 response rate. This rate is below average for Mental Health and Learning Disability Trusts being 42%. The lowest response rate for an MHLDT was 30.4%, the highest being 60.5%. This refers to the Trusts for whom Quality Health administer the survey

2.2 It should be noted that although the overall response rate remained at 40%, 777 staff responded to the survey, it is a considerable increase in numbers over the 298 that responded to the previous survey. This larger sample has produced a robust and accurate picture of the Trust as seen by staff and given there were no statistically significant changes to any of the Key Findings, it is consistent with previous years and shows the smaller samples were also an accurate reflection of the Trust.

3. Key Findings

3.1 For the 2016 survey, there are still 32 key Findings but they have been grouped differently that in the previous year. The groupings are:

- Appraisals and Support for Development
- Equality and Diversity
- Errors and Incidents
- Health and Wellbeing
- Job Satisfaction
- Managers
- Patient Care and Experience
- Violence, Harassment and Bullying
- Working Patterns

3.2 As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions
- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5.

3.3 Each year the Trust's results are compared with a group of like/type trusts. In 2016 the comparator groups were adjusted. ^{2}gether resides with the Mental Health and Learning Disability Trusts. The group consists of 28 Trusts in England.

3.4 The 2016 Survey took place between September and December 2016.

3.5 The Survey was run online and a number of reminders were sent to staff from Quality Health to those who had not responded. Global email reminders were also issued to encourage staff to complete the survey.

3.6 To reassure colleagues that the Survey was completely confidential, QH's Statement of Confidentiality was published on ^{2}getherNet, the Trust's intranet.

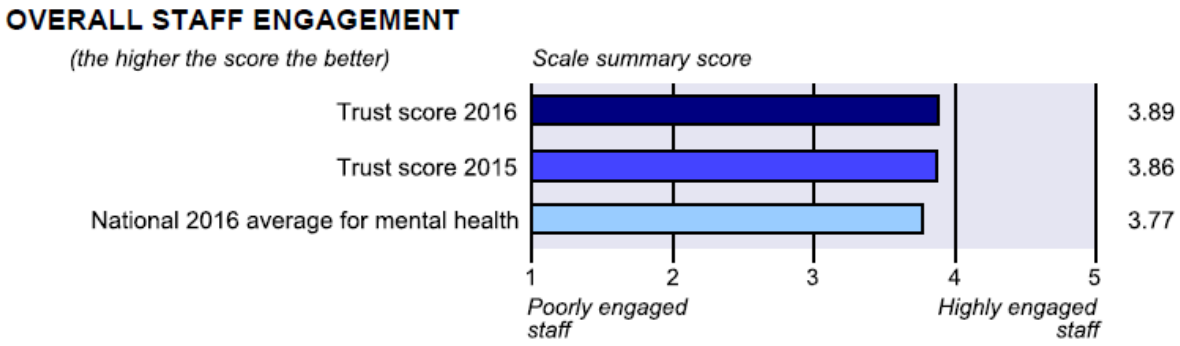
3.7 The summary report is attached. The full Survey report, available here, provides not just the Key Findings but also the raw data from which the Key Findings are determined. Demographic information to view responses by profession, locality etc., is also included.

4. Headline Results

4.1 The first result to look at is that of overall staff engagement. This result is combined from the following Key Findings:

- *KF1 – Staff recommendation of the Trust as a place to work or receive treatment*
- *KF4 – Staff motivation at work*
- *KF7- Staff ability to contribute toward improvements at work*

Table 1 – Overall Staff Engagement



4.2 Table 2 shows that staff engagement within the Trust has improved and is better than average for MHLDT. All of the three Key Findings that constitute this outcome, KF1 showed no change on the previous year but were ‘better than average’.

4.3 Table 2 below presents the Key Findings in which the Trust compares most favourably with other MHLDT. All of these Key Findings are ‘better than average’.

Table 2 – Top Five Ranking Scores

4.4 Table 2 shows that the vast majority of staff reported errors or incidents in the month preceding the survey, although 3% of staff did not.

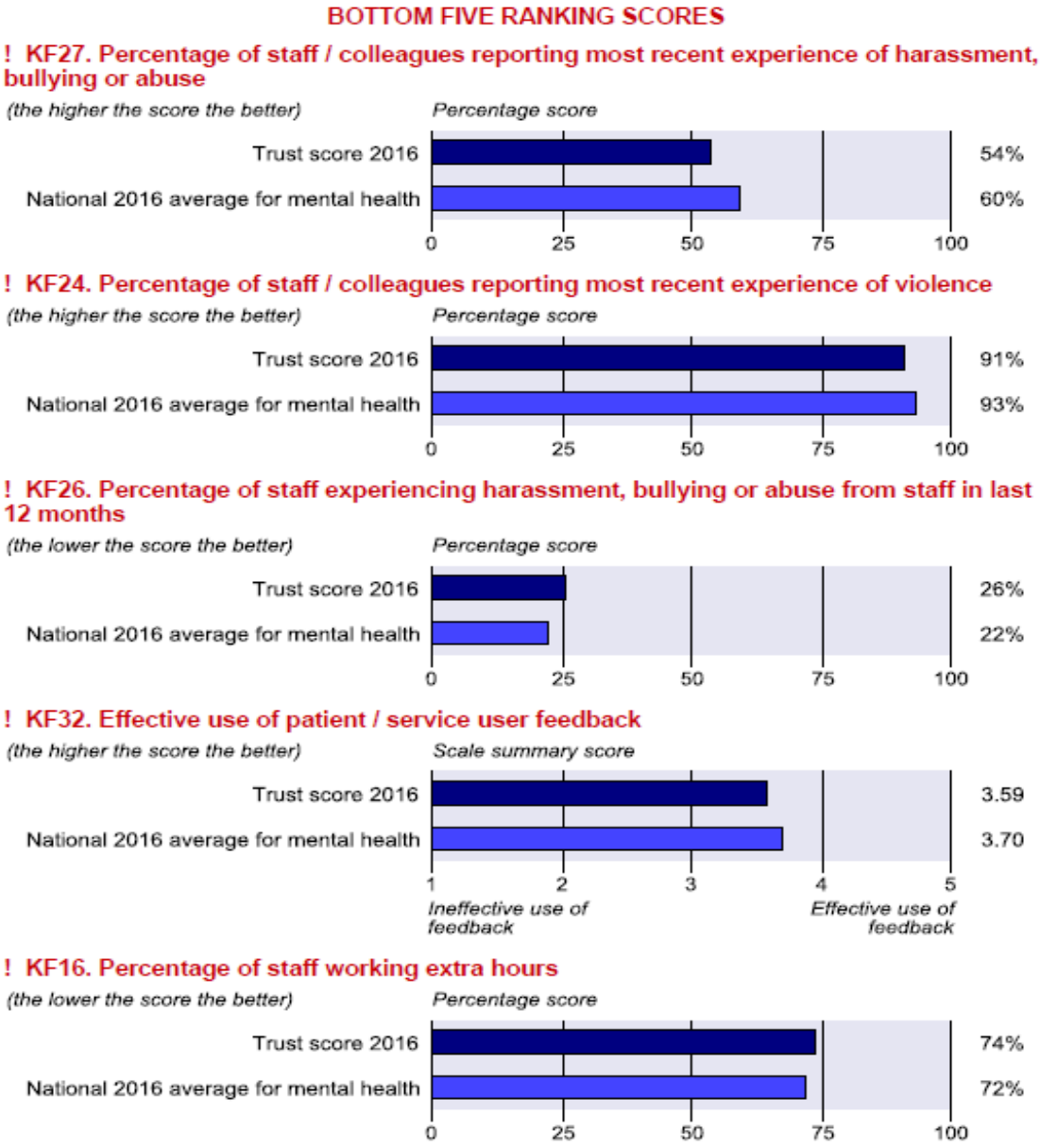
4.5 More staff than ever feel they are able to contribute to improvements at work.

4.6 The percentage of staff experiencing discrimination at work is significantly lower than the national average.

4.7 Less staff are saying that they have witnessed potentially harmful errors or incidents.

4.8 Although the trust is able to show statistically 0% of staff have experienced violence, a small number of staff have still reported this but as in previous years there is no evidence to support it.

Table 3 – Bottom 5 Ranking Scores



4.9 Table 3 shows the 5 bottom ranked scores and it appears that staff may be somewhat reluctant to ***report*** issues of harassment, violence or bullying.

4.10 Staff also believe that the Trust does not make the most effective use of service user feedback.

4.11Nearly three quarters of staff work over and above their contracted hours. This score is 1% above the national All Trust average.

5. Key Findings

5.1 Although there were no statistically significant changes between Key Findings from 2016 and 2015, 19 of the 32 Key Findings showed some improvement, 12

worsened and 1 showed no change. It should be noted that the changes were usually a few percentage points either way. Briefly looking at each of the groupings;

5.2 Appraisals, support and development

5.2.1 Most respondents had an appraisal, up 2% to 90% of all staff and the quality had improved although a slight worsening of the quality of statutory and mandatory training was reported.

5.3 Equality and Diversity

5.3.1 8% of staff experienced discrimination at work, down from 10% and considerably lower than the national average of 14%. Although fewer people said they had experienced discrimination, the percentage of people who believe there was equality of opportunity for career progression fell by 4% to 88% although this is slightly higher than the national average.

5.4 Errors and Incidents

5.4.1 The four Key Findings in this section have all shown slight improvements with most staff having reported any errors or incidents in the month preceding the survey. There is also a slight improvement in staff confidence in reporting unsafe practice.

5.5 Health and wellbeing

5.5.1Three key findings constitute this section. The number of people feeling unwell due to stress and those attending work despite feeling unwell have fallen very slightly. The percentage of staff who believe the Trust is interested in and takes action on health and wellbeing has increased and is above the national average.

5.6 Working patterns

5.6.1Although still above average, fewer staff are satisfied with flexible working patterns. (The least satisfied staff are Nursing and HCAs). Slightly more staff (74%) are working extra hours than last year and this is worse than the national average.

5.7 Job satisfaction

5.7.1Three of the key Findings in this section show small improvements and three show slight deterioration although as mentioned above, none of the changes are regarded as statistically significant. The biggest improvement is in the percentage of staff who would recommend the Trust as a place to work or receive treatment with a score of 3.84, up from 3.75 and above the national average of 3.62.

5.8 Managers

5.8.1 Recognition and value of staff by managers has improved, as has the level of support from immediate managers. After a disappointing result last year, communications between senior managers and staff has shown a 5% improvement reflecting the amount of work that has gone in to improving communications. Clearly there is some way to go but it is moving in the right direction.

5.9 Patient care and experience

5.9.1 Satisfaction with the quality of work and making a difference to patients remain constant but the effective use of patient/service user feedback is one of our lowest ranked scores. 90% of respondents agree that their role makes a difference to patients.

5.10 Violence, bullying and harassment

5.10.1 Although fewer staff have experienced physical violence from patient or the public, the number of staff experiencing harassment, bullying and abuse from patients, the public and staff has increased. The percentage of staff reporting unacceptable behaviour has fallen. Three of the 5 worst scores for 2016 centre on staff experiencing harassment from staff and reporting both harassment and violence.

5.10.2 Our two lowest scores was for the non-reporting of harassment, bullying and abuse, and of violence which could indicate that either people view this as part and parcel of the job or that they feel that nothing will come of it if they do report it.

5.10.3 The Directorates that have the highest percentage of staff reporting bullying, harassment and abuse from patients and the public are Countywide Inpatient Services (46% or 69 people) and the Medical Directorate (48% or 36 people). 42% or 63 people reported experiencing physical violence from patients and the public in Countywide Inpatients Services.

6. Workforce Race Equality Standard

6.1 The Staff Survey provides the data for four of the WRES indicators. In 2016 the first national WRES report was published based on data from the 2014 survey. The Trust was shown as a very clear outlier when looking at the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public with 54% of BME staff reporting these experiences.

6.2 The 2016 survey shows that 30% of white staff (216 staff) and 30% of BME staff (10 staff) have experienced this type of behaviour, both below the national average. The discrepancy was likely to be due to the very small number of BME staff responding to the survey in 2014 (18). For 2016, 33 BME staff responded or 4% of the workforce, slightly below the overall figure of 6% of staff who have declared themselves to be from a BME background.

7. Staff Comments

7.1 The survey provides a ‘free text’ section for staff to add comments. These comments are anonymised and provided back to the Trust. This year the Trust received 146 comments from staff. This is considerably higher than the previous year but perhaps to be expected given the significant increase in respondents.

7.2 The comments are personal to those who wrote them and are often contradictory. For instance, people have differing views on the application of the Sickness absence policy – too severe, not severe enough.

7.3 It is important to note that although there are negative comments there are also a large number of staff who are clearly happy with their job and pleased to be working for the Trust, a fact that should not be overlooked and is a clear indication that there is can be no ‘one size fits all’ approach to staff engagement.

7.4 A number of themes run through the comments. It is not possible to categorise every comment but many people have expressed concerns about limited resources and staffing levels. However, Key Finding 14 of the survey shows that staff were more satisfied with resourcing and support that in the previous year. Many people also refer to targets and data recording and how they sometimes perceive that this at times seems to take priority over other things.

7.5 There is some expressed dissatisfaction regarding career progression opportunities although people feel that terms and conditions remain good despite minimal national pay awards in recent years.

7.6 Bullying features in some of the comments. One comment refers to managers needing more support in how they speak and organise staff so that it is not construed as bullying. Through the use of Speak in Confidence, Dignity at Work Officers and other media, more people are beginning to come forward to challenge unacceptable behaviour.

7.7 There are also comments about senior management, some complimentary, others less so, although the survey itself shows that there has been an improvement in communications between staff and senior management and we benchmark well across local NHS organisations in Gloucestershire and the wider comparator groups.

8. The Survey on a National Level

8.1 For the 2016 Staff Survey, NHS England have launched a new website enabling comparison with all other Trust results.

8.2 Nationally the average response rate was 44%, an increase on the previous year (41%). The overall score for staff engagement was 3.79 (from 5, higher score better).

8.3 Table 4 shows the Trusts in the MHLD comparator group. The table shows the response rate and number of staff at each Trust. The final two columns show the response to Key finding 1 – Staff recommendation of the organisation as a place to work or receive treatment.

8.4 Although the Trust had one of the lower response rates, overall, the score for recommending the Trust as a place to work or to receive treatment compares favourably with the others in the group.

Table 4 – The MHLDT comparator group

Trust	Response	No of staff	Score	No of respondents
2Gether NHS Foundation Trust	40	1,924	3.85	763
Avon And Wiltshire Mental Health Partnership NHS Trust	51	3,844	3.46	1,879
Birmingham and Solihull Mental Health NHS Foundation Trust	39	3,766	3.58	1,441
Camden and Islington NHS Foundation Trust	55	1,495	3.65	805
Central and North West London NHS Foundation Trust	41	5,534	3.74	2,218
Devon Partnership NHS Trust	62	2,309	3.60	1,382
Dudley And Walsall Mental Health Partnership NHS Trust	51	986	3.76	493
Greater Manchester West Mental Health NHS Foundation Trust	42	3,051	3.87	1,272
Hertfordshire Partnership University NHS Foundation Trust	42	1,207	3.84	489
Isle of Wight NHS Trust (mental health sector)	45	377	3.44	167
Kent And Medway NHS And Social Care Partnership Trust	53	3,311	3.51	1,721
Leeds and York Partnership NHS Foundation Trust	53	2,368	3.59	1,246
Lincolnshire Partnership NHS Foundation Trust	59	1,718	3.58	979
Manchester Mental Health and Social Care Trust	39	1,482	3.19	557
Mersey Care NHS Foundation Trust	60	4,354	3.64	2,555
Norfolk and Suffolk NHS Foundation Trust	58	3,723	3.37	2,062
North Essex Partnership University NHS Foundation Trust	44	1,754	3.29	725
North Staffordshire Combined Healthcare NHS Trust	51	1,342	3.56	680
Northumberland, Tyne and Wear NHS Foundation Trust	45	5,873	3.87	2,599
Sheffield Health & Social Care NHS Foundation Trust	40	2,594	3.69	1,034
South London and Maudsley NHS Foundation Trust	40	4,537	3.67	1,756
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	60	3,197	3.81	1,858
South West London And St George's Mental Health NHS Trust	50	2,023	3.53	976
Surrey and Borders Partnership NHS Foundation Trust	65	2,315	3.69	1,479
Sussex Partnership NHS Foundation Trust	53	4,306	3.62	2,102
Tavistock and Portman NHS Foundation Trust	58	556	3.97	306
Tees, Esk and Wear Valleys NHS Foundation Trust	49	5,952	3.83	2,828
West London Mental Health NHS Trust	47	3,183	3.57	1,462

8.5 The NHSE website enables comparisons such as the one above for all the Key Findings of the survey.

8.6 Table 5 shows the extent of staff engagement within the MHLD comparator group. [2]gether is clearly one of the highest performing Trusts reflecting the amount of work that has been undertaken in recent years to improve engagement.

Table 5 - Staff Engagement for MHLD Trusts

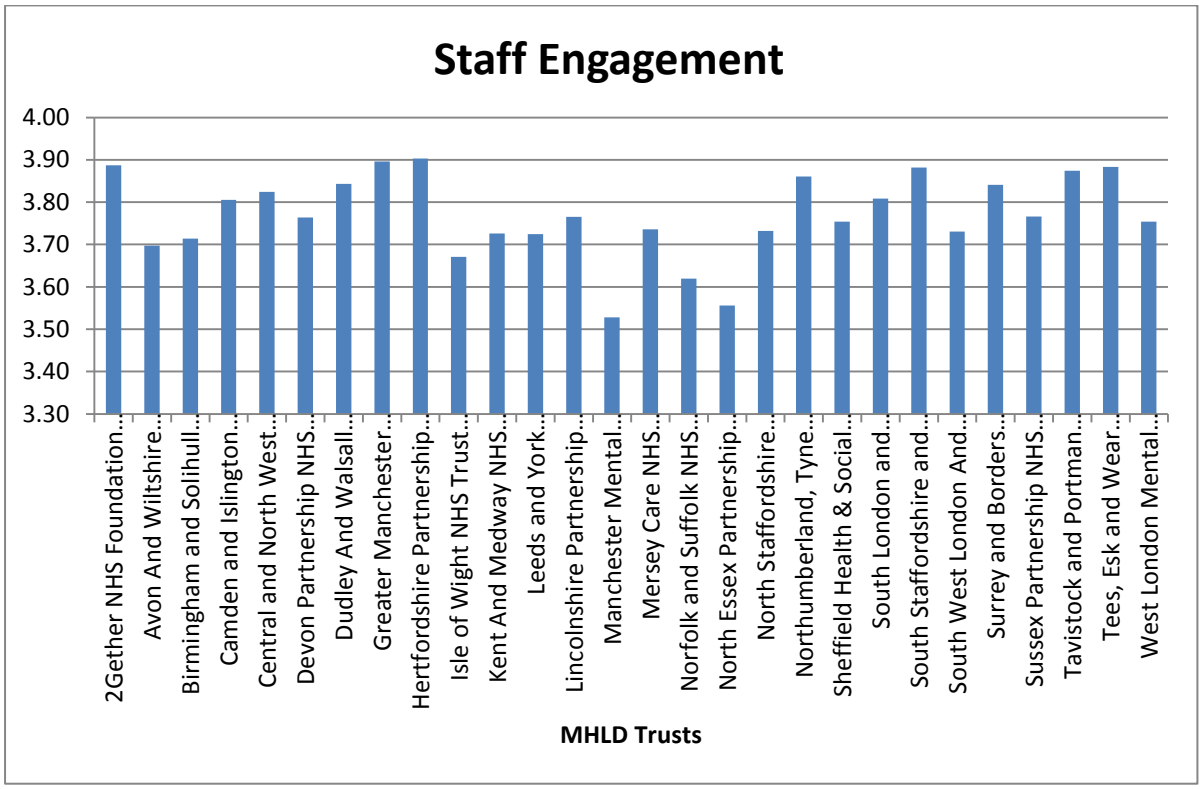


Table 6 Comparison with Gloucestershire and Herefordshire NHS Community

Trust	Staff Engagement	Recommendation of the Trust as a place to work or receive treatment.
[2]gether	**3.89 (3.86)**	**3.84 (3.75)**
Gloucestershire Care Services	**3.78 (3.78)**	**3.72 (3.73)**
Gloucestershire Hospitals Trust	**3.71 (3.71)**	**3.64 (3.62)**
Wye Valley Trust	**3.8 (3.82)**	**3.66 (3.72)**

8.7 Table 6 shows that [2]gether is the leading employer as far as staff opinion is concerned within the Gloucestershire NHS community and when compared with the Wye Valley Trust that provides health services in Herefordshire.

9. Workforce Profile

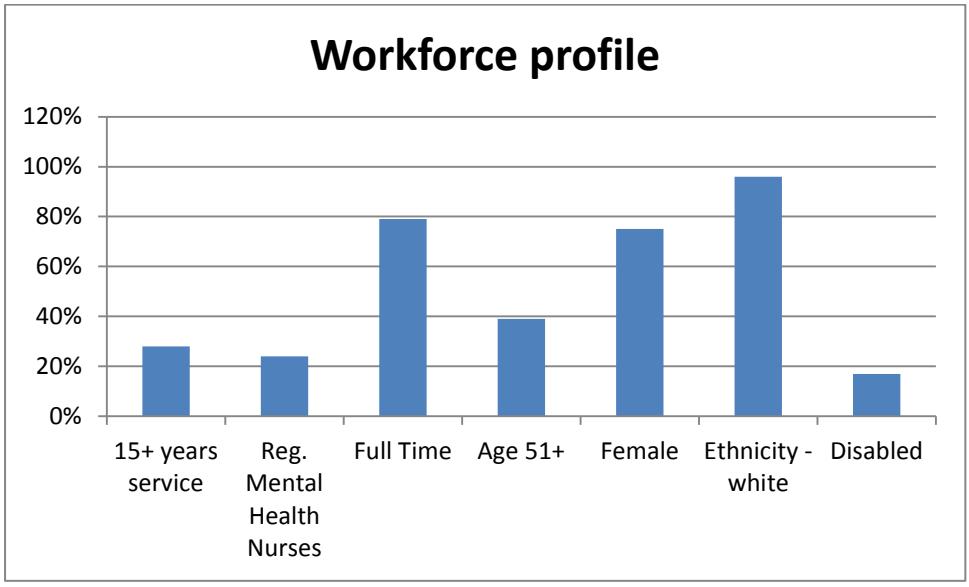
9.1 Table 7 highlights the profile of respondents to the survey.

- 39% of respondents were over 51

- 20% of respondents had more than 15 years' service
- 24% of respondents were Registered Mental Health Nurses
- 79% were full time
- 75% were female
- 96% were white
- 17% said they had a disability

This broadly reflects the profile of the Trust except in the area of disability. The Trust figure for staff declaring a disability is in the area of 5%. This is something that will be explored in the soon to be introduced Workforce Disability Equality Standard.

Table 7 – Workforce profile



10. Recommended Actions

10.1 Overarching actions recommended are based on 3 of the 5 worst scores for the Trust in the 2016 survey.

10.2 Although the survey shows that our staff have been very diligent in reporting errors, near misses or incidents, they have been less so in reporting incidents of bullying and harassment. It would be appropriate to **focus actions on encouraging colleagues to report bullying, harassment, abuse and physical violence**. It should not be acceptable to see this type of behaviour as part and parcel of the job. If incidences are accurately reported, appropriate actions can be taken, both preventative and reactive. By linking with the Communications Department and other stakeholders, consideration should be given to a campaign to remind service users, carers and members of the public that our staff do not have to tolerate this behaviour. Actions such as these will demonstrate a commitment to improving Key Findings 27, 24 and 26.

10.3 The percentage of staff who believe the Trust makes **effective use of patient feedback** has fallen since last year and remains below average. Looking at the key Finding, it does not necessarily mean that use of patient feedback is ineffective as a

score of 3.59 out of a possible 5 was achieved so it would be desirable to highlight how feedback has been used. As an example, feedback, both positive and negative could be presented to new recruits at induction to highlight the patient experience. Similar examples could be shared at Team Talk so non clinical as well as clinical colleagues can learn about the patient experience. Other options also need explored.

10.4 A third recommended action can be centred on **health and wellbeing** which is also the subject of a national CQUIN. Although not expressed as a Key Finding, the CQUIN is based upon answers to 3 of the survey questions:

- 9a - % saying their organisation definitely takes positive action on health and well-being.
- 9b - % saying they have experienced musculoskeletal problems (MSK) in the last 12 months as a result of work activities
- 9c - % saying they have felt unwell in the last 12 months as a result of work related stress.

10.5 The CQUIN requires a 5% improvement on 2 out of the three scores over the next two years. In association with Working Well, opportunities for increasing support for staff with MSK problems, either preventative or by providing treatment should be explored. This could include closer working with other local health care providers. We will also continue to highlight the full range of health and wellbeing support that the Trust is able to provide.

10.6 In addition, the full Survey report will be provided to the Service Directors of Countywide Inpatients Services, Gloucestershire Localities, Herefordshire Localities and CYPS with the aim that each Directorate will review the Survey findings with staff and select three priorities and develop **local action plans** to address them.

10.7 Utilising the Senior Leadership Forum, the Survey findings will also be shared with the Heads of Professions for them to identify their priorities using the demographic information provided as part of the full Survey report, identifying feedback from the various staff groups.

10.8 The Survey has been shared with the Joint Negotiation and Consultation Committee (JNCC) to enable our Staffside representatives to fully discuss the survey and its implications with the Trust's senior management. Similarly, the Gloucestershire Social Partnership Forum is looking at options for a One Gloucestershire approach to harassment and bullying in the workplace too.

10.9 The newly refreshed Team Talk will be used to brief colleagues about the survey headlines and the report will be made available to all staff via the Trust's intranet.

10.11 The Board is asked to note the findings of the 2016 Staff Survey and to endorse the related priority areas highlighted above.

2016 National NHS staff survey

Brief summary of results from 2Gether NHS Foundation Trust

Table of Contents

1. Introduction to this report

This report presents the findings of the 2016 national NHS staff survey conducted in 2Gether NHS Foundation Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3 and 4 of this report, the findings of the questionnaire have been summarised and presented in the form of 32 Key Findings.

These sections of the report have been structured thematically so that Key Findings are grouped appropriately. There are nine themes within this report:

- Appraisals & support for development
- Equality & diversity
- Errors & incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care & experience
- Violence, harassment & bullying

Please note, two Key Findings have had their calculation changed and there have been minor changes to the benchmarking groups for social enterprises since last year. For more detail on these changes, please see the ***Making sense of your staff survey data*** document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

A longer and more detailed report of the 2016 survey results for 2Gether NHS Foundation Trust can be downloaded from: www.nhsstaffsurveys.com. This report provides detailed breakdowns of the Key Finding scores by directorate, occupational groups and demographic groups, and details of each question included in the core questionnaire.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q21a, Q21b, Q21c and Q21d and the un-weighted score for Key Finding 1. The percentages for Q21a – Q21d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

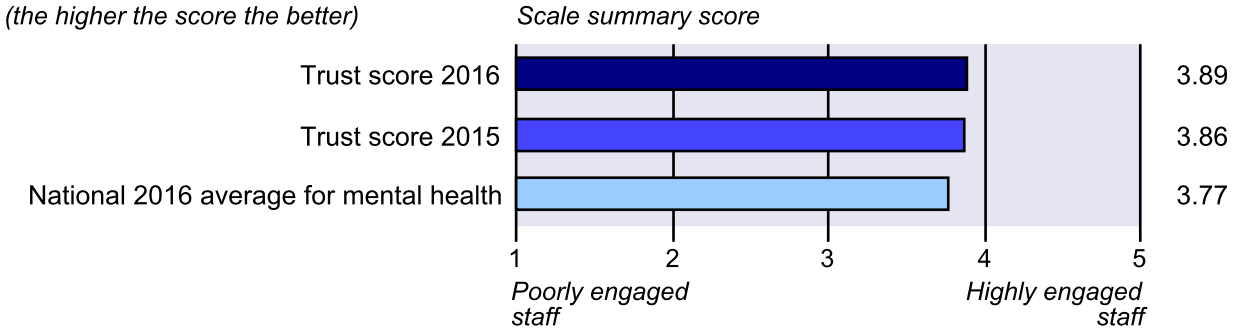
Q21a, Q21c and Q21d feed into Key Finding 1 “Staff recommendation of the organisation as a place to work or receive treatment”.

		Your Trust in 2016	Average (median) for mental health	Your Trust in 2015
Q21a	"Care of patients / service users is my organisation's top priority"	78%	72%	75%
Q21b	"My organisation acts on concerns raised by patients / service users"	78%	74%	78%
Q21c	"I would recommend my organisation as a place to work"	68%	56%	64%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	73%	59%	67%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.85	3.63	3.75

2. Overall indicator of staff engagement for 2Gether NHS Foundation Trust

The figure below shows how 2Gether NHS Foundation Trust compares with other mental health / learning disability trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.89 was above (better than) average when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4).

The table below shows how 2Gether NHS Foundation Trust compares with other mental health / learning disability trusts on each of the sub-dimensions of staff engagement, and whether there has been a significant change since the 2015 survey.

	Change since 2015 survey	Ranking, compared with all mental health
OVERALL STAFF ENGAGEMENT	• No change	✓ Above (better than) average
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	• No change	✓ Above (better than) average
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	✓ Above (better than) average
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	✓ Above (better than) average

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

3. Summary of 2016 Key Findings for 2Gether NHS Foundation Trust

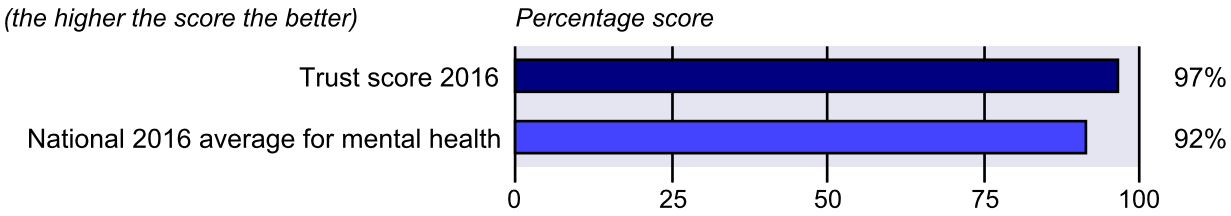
3.1 Top and Bottom Ranking Scores

This page highlights the five Key Findings for which 2Gether NHS Foundation Trust compares most favourably with other mental health / learning disability trusts in England.

TOP FIVE RANKING SCORES

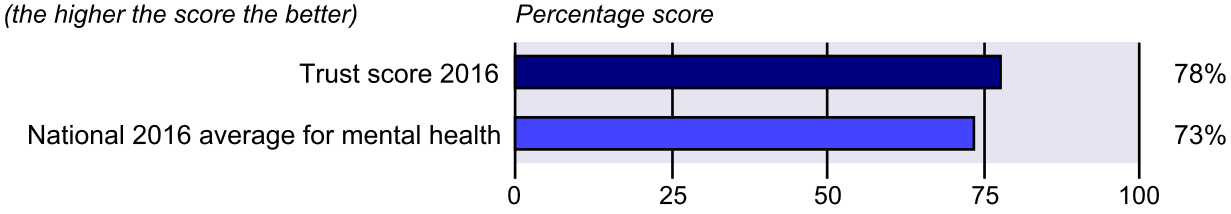
✓KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



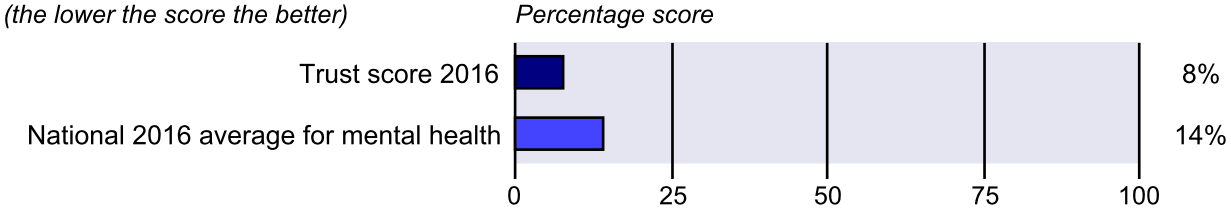
✓KF7. Percentage of staff able to contribute towards improvements at work

(the higher the score the better)



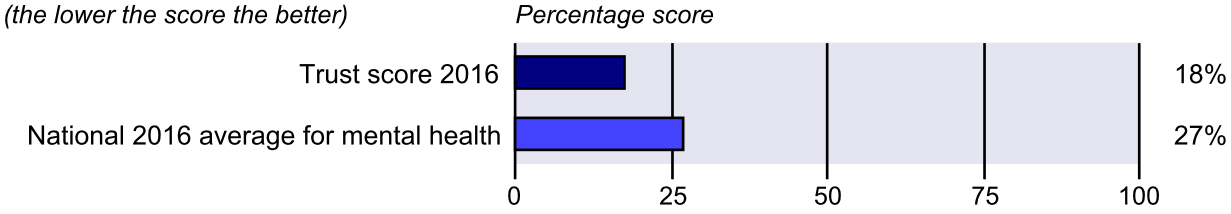
✓KF20. Percentage of staff experiencing discrimination at work in the last 12 months

(the lower the score the better)



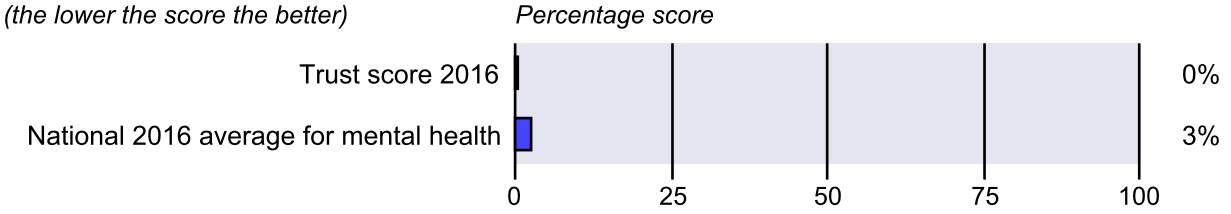
✓KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



✓KF23. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



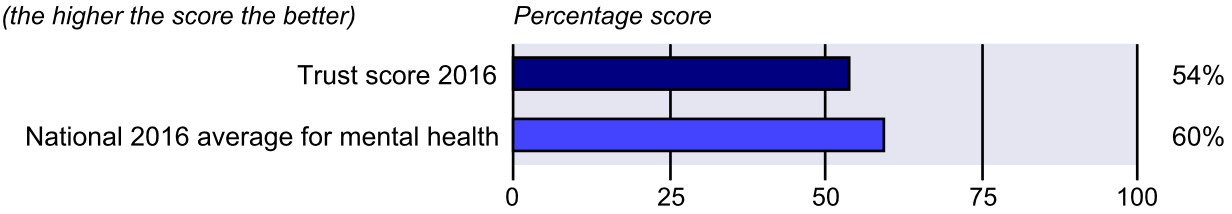
For each of the 32 Key Findings, the mental health / learning disability trusts in England were placed in order from 1 (the top ranking score) to 28 (the bottom ranking score). 2Gether NHS Foundation Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the five Key Findings for which 2Gether NHS Foundation Trust compares least favourably with other mental health / learning disability trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

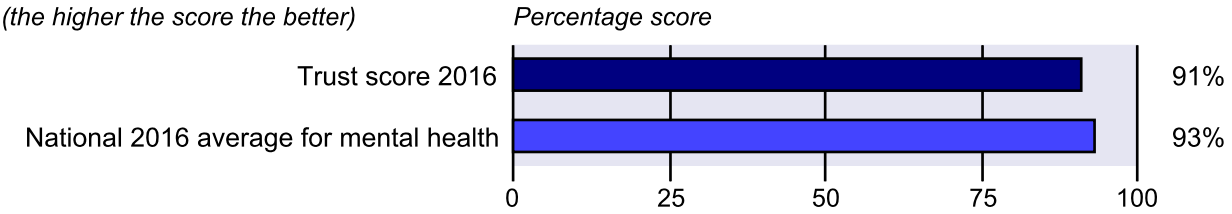
! KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

(the higher the score the better)



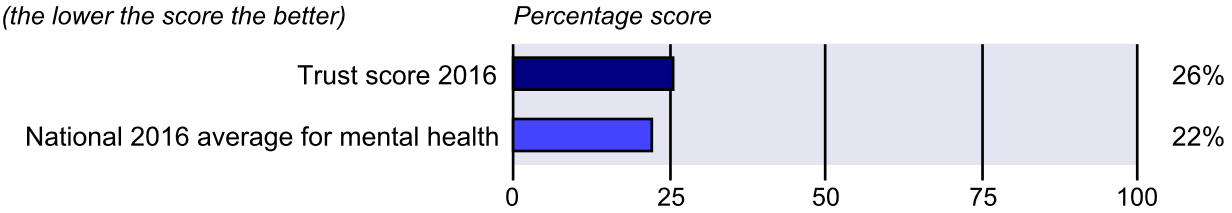
! KF24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



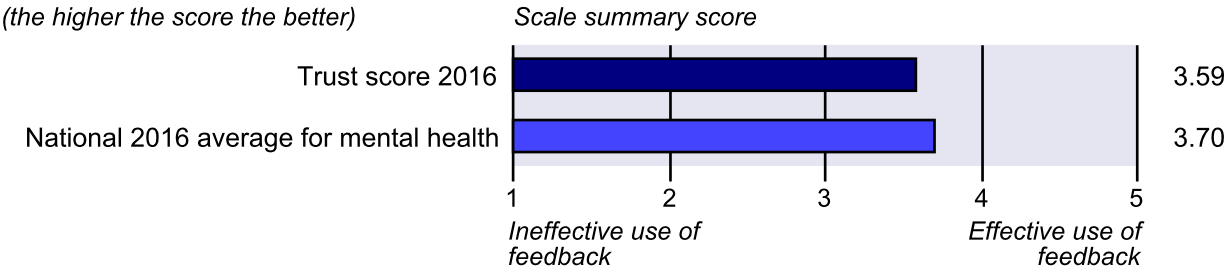
! KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



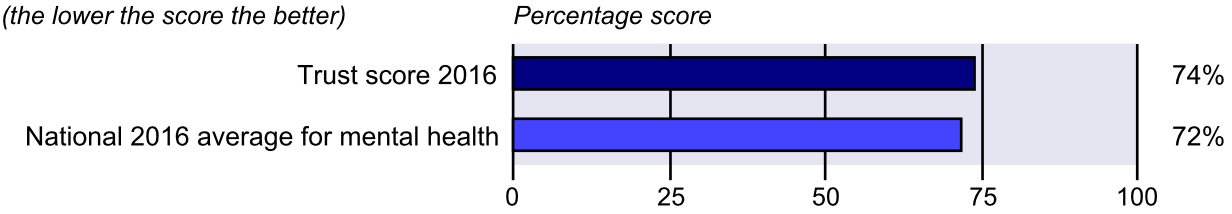
! KF32. Effective use of patient / service user feedback

(the higher the score the better)



! KF16. Percentage of staff working extra hours

(the lower the score the better)



For each of the 32 Key Findings, the mental health / learning disability trusts in England were placed in order from 1 (the top ranking score) to 28 (the bottom ranking score). 2Gether NHS Foundation Trust's five lowest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 28. Further details about this can be found in the document ***Making sense of your staff survey data***.

3.2. Summary of all Key Findings for 2Gether NHS Foundation Trust

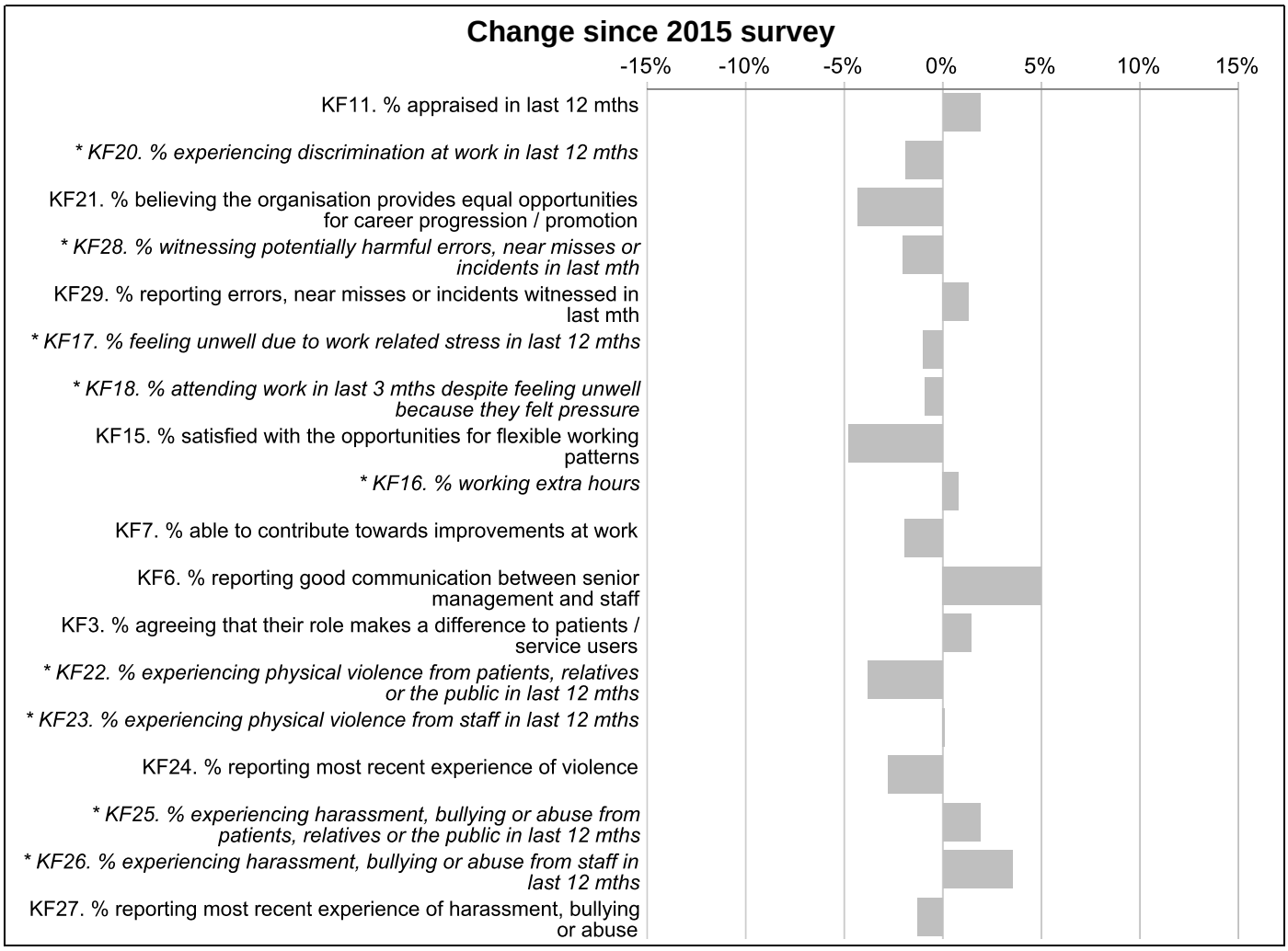
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2015 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2015 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2015 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



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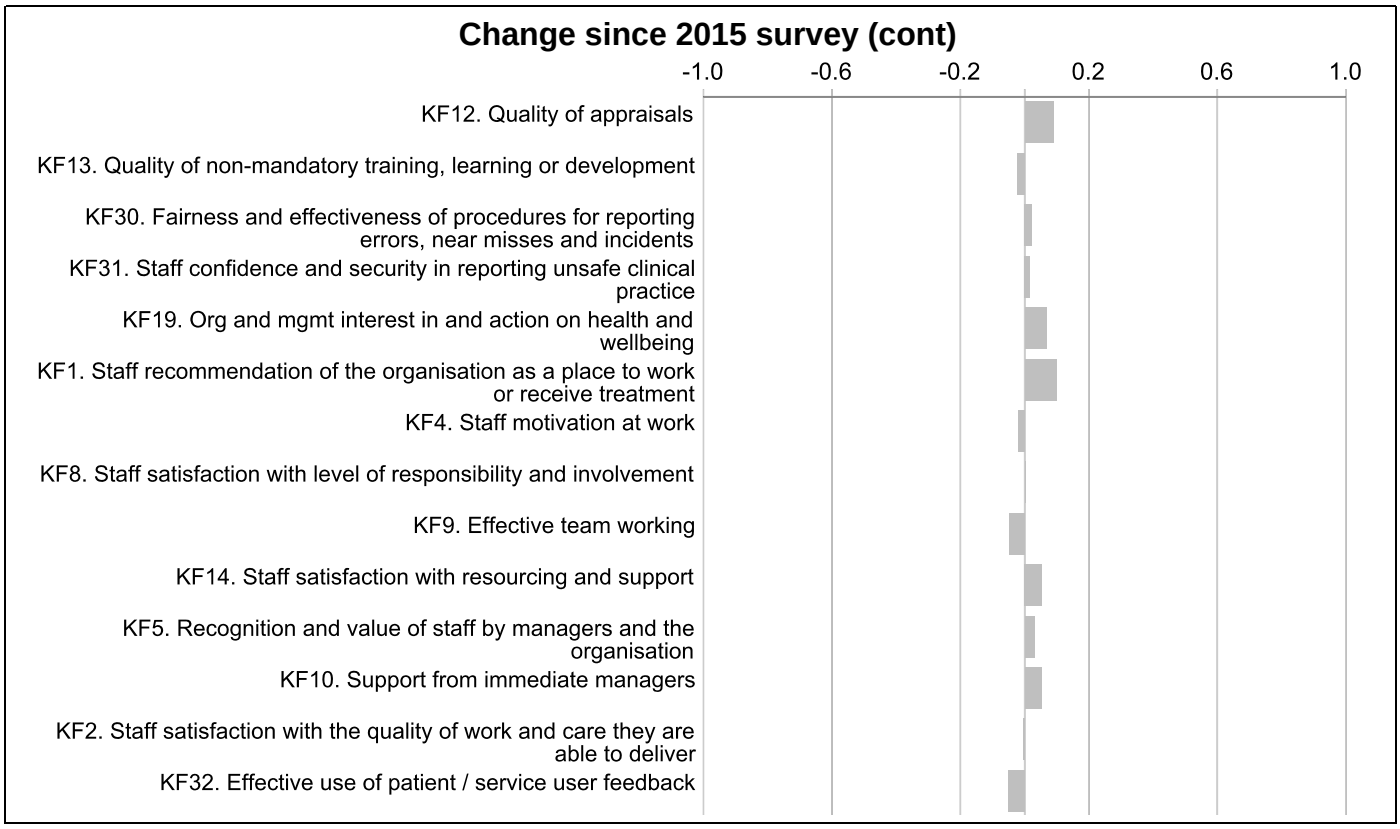

3.2. Summary of all Key Findings for 2Gether NHS Foundation Trust

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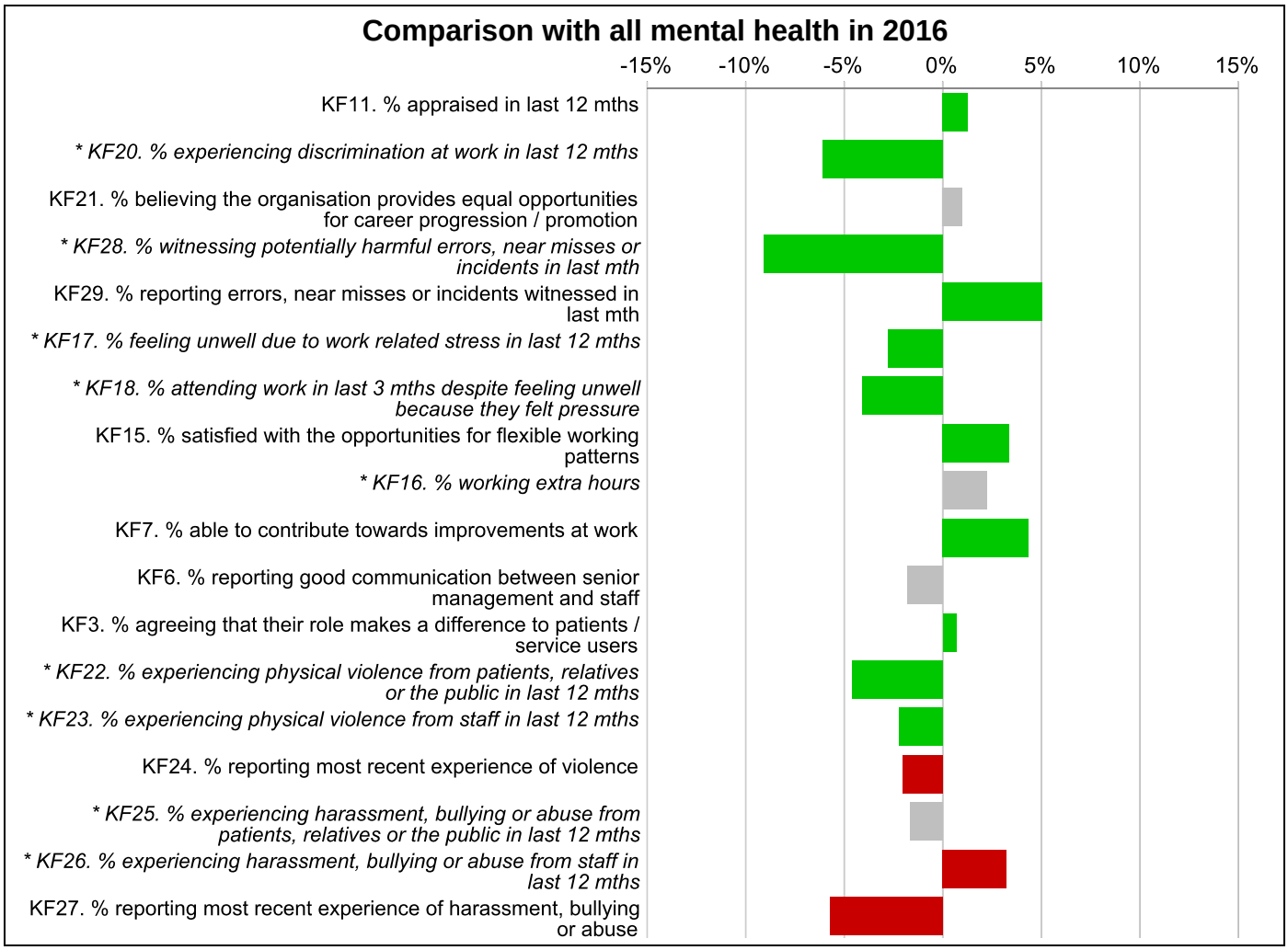
Green = Positive finding, e.g. better than average.

Red = Negative finding, i.e. worse than average.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



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Green = Positive finding, e.g. better than average.

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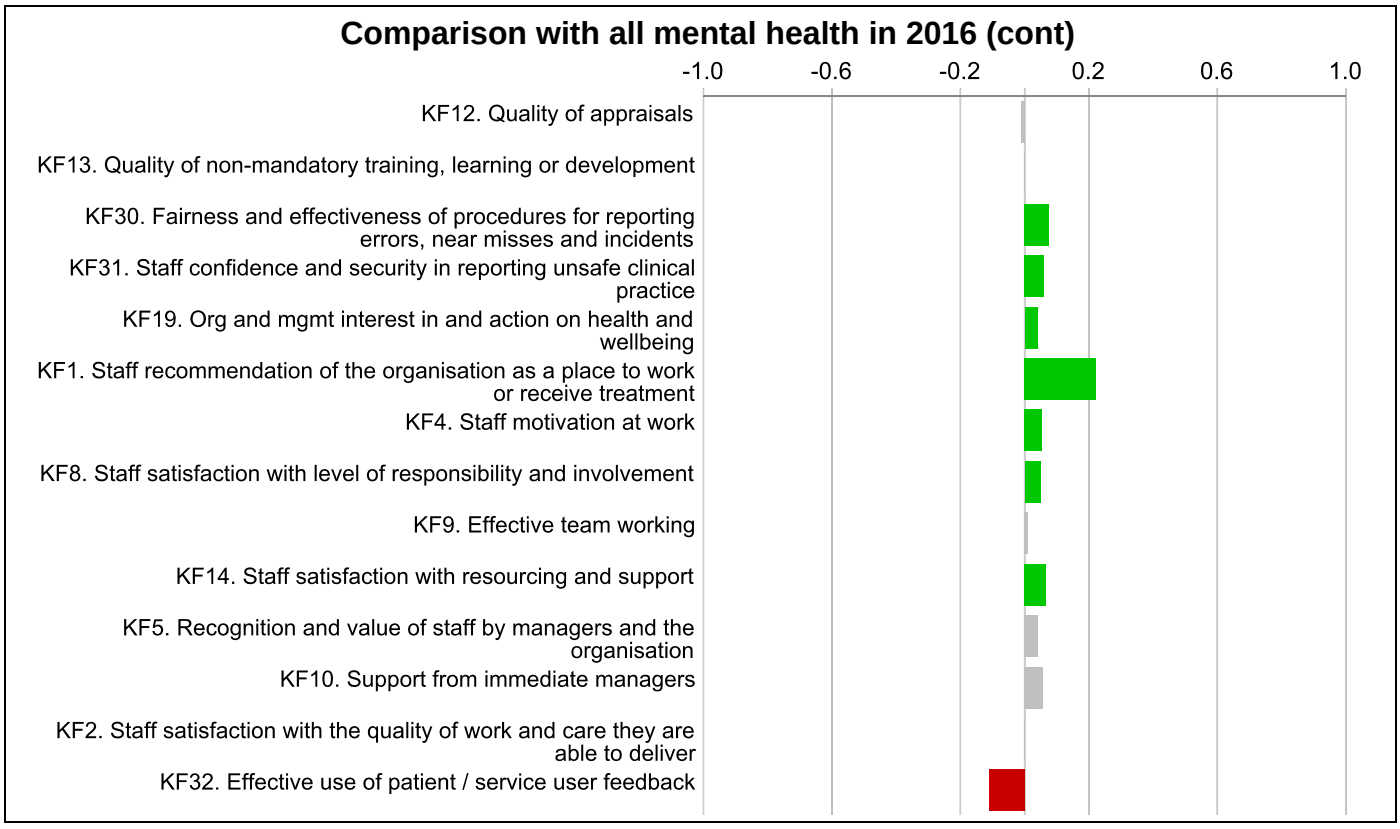
For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for 2Gether NHS Foundation Trust

KEY

✓ Green = Positive finding, e.g. better than average, better than 2015.

! Red = Negative finding, e.g. worse than average, worse than 2015.

'Change since 2015 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2015 survey.

-- Because of changes to the format of the survey questions this year, comparisons with the 2015 score are not possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

	Change since 2015 survey	Ranking, compared with all mental health in 2016
Appraisals & support for development		
KF11. % appraised in last 12 mths	• No change	✓ Above (better than) average
KF12. Quality of appraisals	• No change	• Average
KF13. Quality of non-mandatory training, learning or development	• No change	• Average
Equality & diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	• No change	✓ Below (better than) average
KF21. % believing the organisation provides equal opportunities for career progression / promotion	• No change	• Average
Errors & incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	✓ Below (better than) average
KF29. % reporting errors, near misses or incidents witnessed in last mth	• No change	✓ Above (better than) average
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	• No change	✓ Above (better than) average
KF31. Staff confidence and security in reporting unsafe clinical practice	• No change	✓ Above (better than) average
Health and wellbeing		
* *KF17. % feeling unwell due to work related stress in last 12 mths*	• No change	✓ Below (better than) average
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	• No change	✓ Below (better than) average
KF19. Org and mgmt interest in and action on health and wellbeing	• No change	✓ Above (better than) average
Working patterns		
KF15. % satisfied with the opportunities for flexible working patterns	• No change	✓ Above (better than) average
* *KF16. % working extra hours*	• No change	• Average

3.3. Summary of all Key Findings for 2Gether NHS Foundation Trust (cont)

	Change since 2015 survey	Ranking, compared with all mental health in 2016
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	• No change	✓ Above (better than) average
KF4. Staff motivation at work	• No change	✓ Above (better than) average
KF7. % able to contribute towards improvements at work	• No change	✓ Above (better than) average
KF8. Staff satisfaction with level of responsibility and involvement	• No change	✓ Above (better than) average
KF9. Effective team working	• No change	• Average
KF14. Staff satisfaction with resourcing and support	• No change	✓ Above (better than) average
Managers		
KF5. Recognition and value of staff by managers and the organisation	• No change	• Average
KF6. % reporting good communication between senior management and staff	• No change	• Average
KF10. Support from immediate managers	• No change	• Average
Patient care & experience		
KF2. Staff satisfaction with the quality of work and care they are able to deliver	• No change	• Average
KF3. % agreeing that their role makes a difference to patients / service users	• No change	✓ Above (better than) average
KF32. Effective use of patient / service user feedback	• No change	! Below (worse than) average
Violence, harassment & bullying		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	✓ Below (better than) average
* *KF23. % experiencing physical violence from staff in last 12 mths*	• No change	✓ Below (better than) average
KF24. % reporting most recent experience of violence	• No change	! Below (worse than) average
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	• Average
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	! Above (worse than) average
KF27. % reporting most recent experience of harassment, bullying or abuse	• No change	! Below (worse than) average

4. Key Findings for 2Gether NHS Foundation Trust

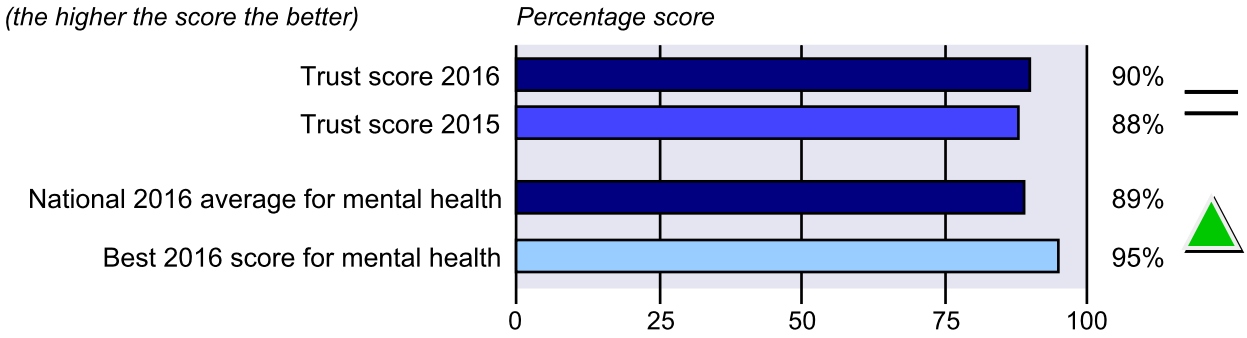
2Gether NHS Foundation Trust had 777 staff take part in this survey. This is a response rate of 40%[1] which is below average for mental health / learning disability trusts in England, and compares with a response rate of 40% in this trust in the 2015 survey.

This section presents each of the 32 Key Findings, using data from the trust's 2016 survey, and compares these to other mental health / learning disability trusts in England and to the trust's performance in the 2015 survey. The findings are arranged under seven headings – the four staff pledges from the NHS Constitution, and the three additional themes of equality and diversity, errors and incidents, and patient experience measures.

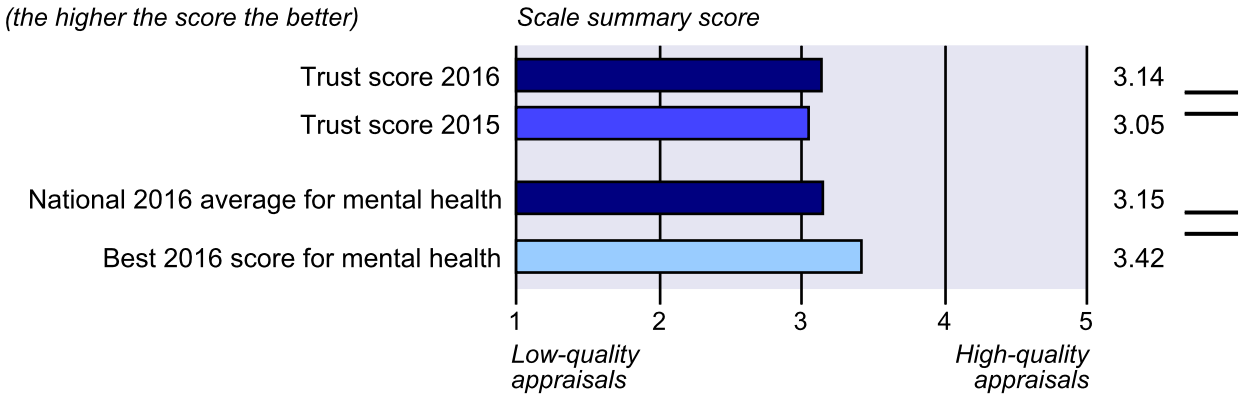
Positive findings are indicated with a green arrow (e.g. where the trust is better than average, or where the score has improved since 2015). Negative findings are highlighted with a red arrow (e.g. where the trust's score is worse than average, or where the score is not as good as 2015). An equals sign indicates that there has been no change.

Appraisals & support for development

KEY FINDING 11. Percentage of staff appraised in last 12 months



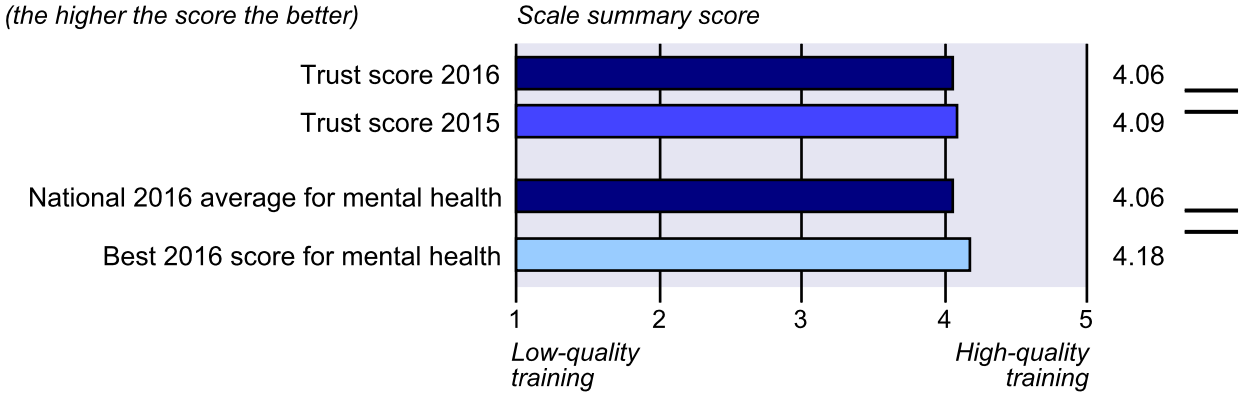
KEY FINDING 12. Quality of appraisals



[1]Questionnaires were sent to all 1924 staff eligible to receive the survey. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

KEY FINDING 13. Quality of non-mandatory training, learning or development

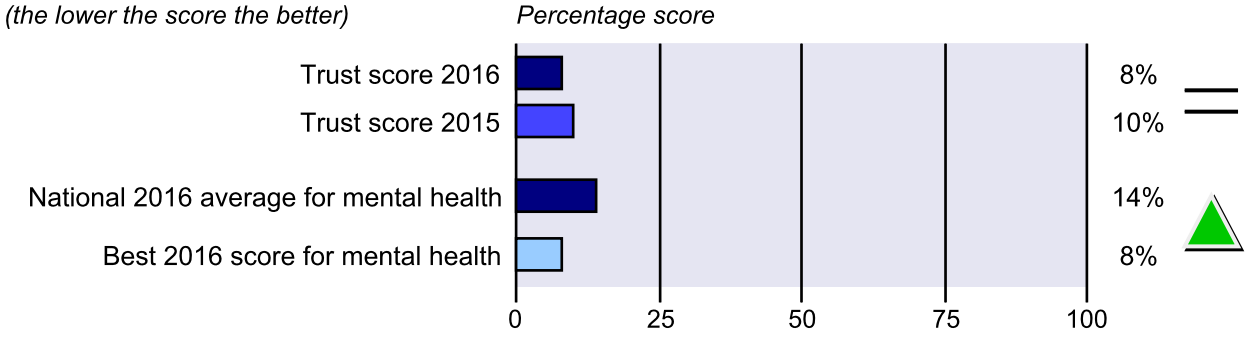
(the higher the score the better)



Equality & diversity

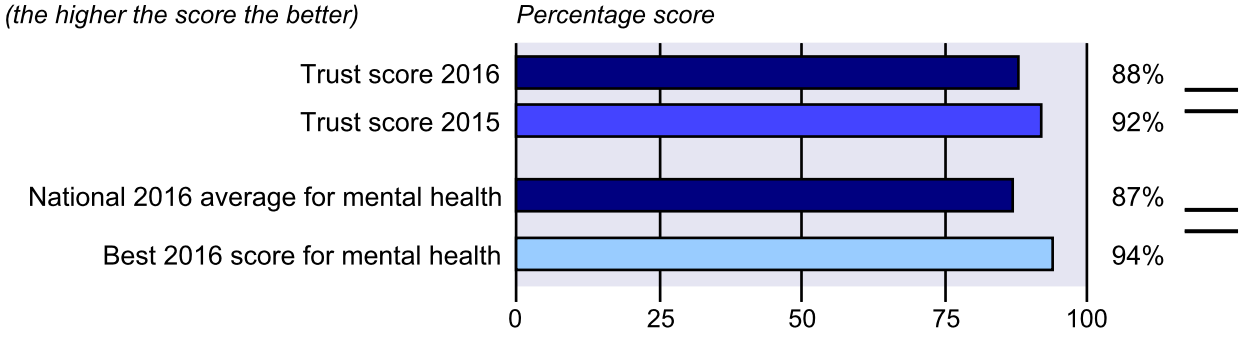
KEY FINDING 20. Percentage of staff experiencing discrimination at work in the last 12 months

(the lower the score the better)



KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

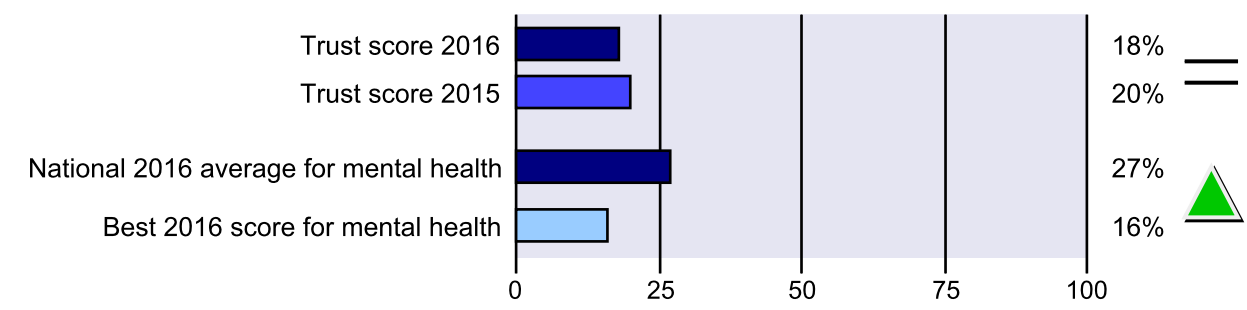
(the higher the score the better)



Errors & incidents

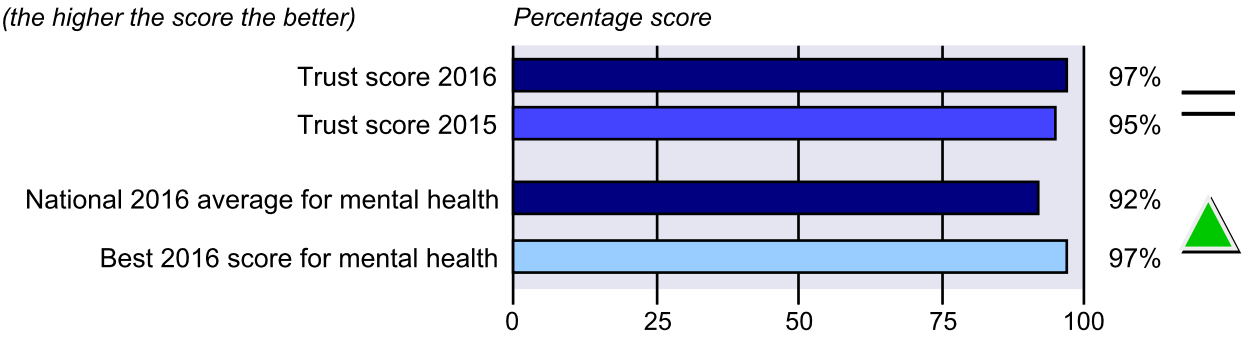
KEY FINDING 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



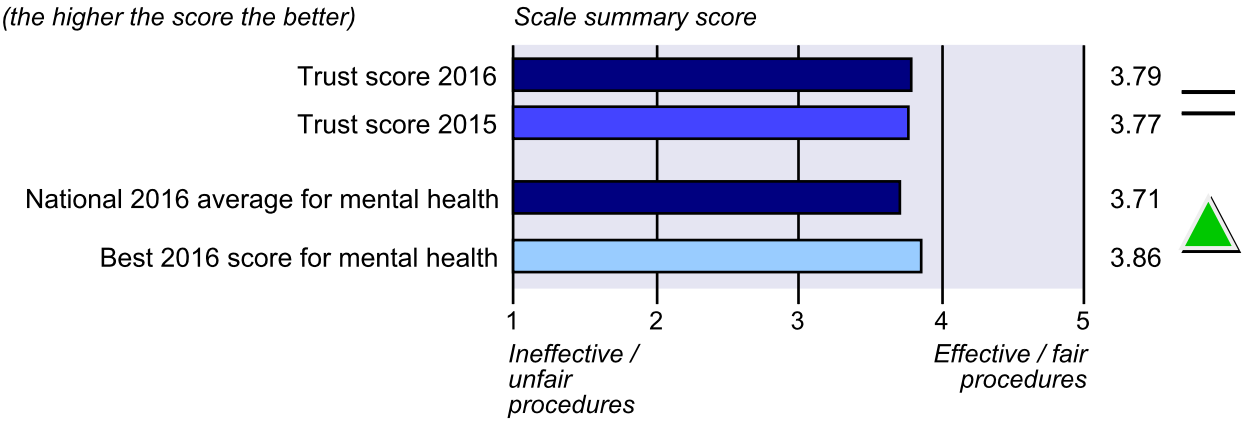
KEY FINDING 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



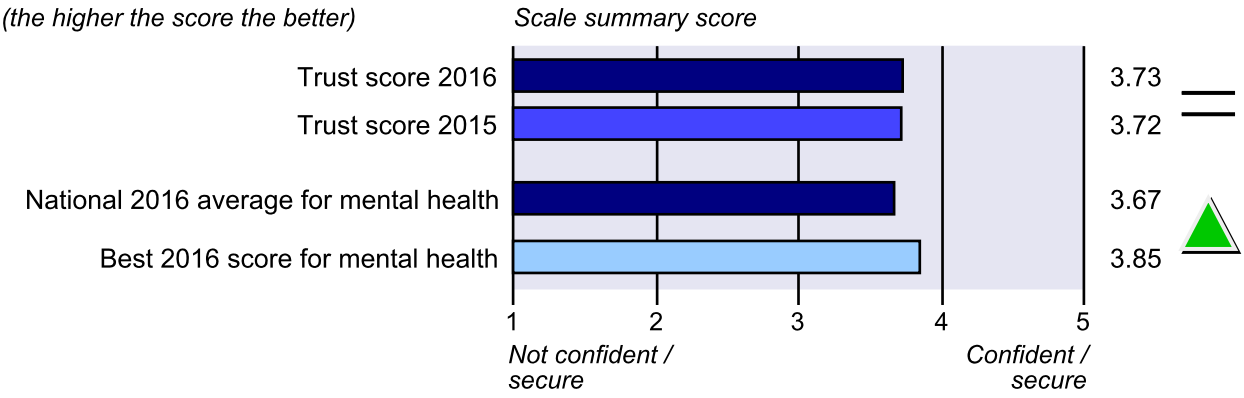
KEY FINDING 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

(the higher the score the better)



KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice

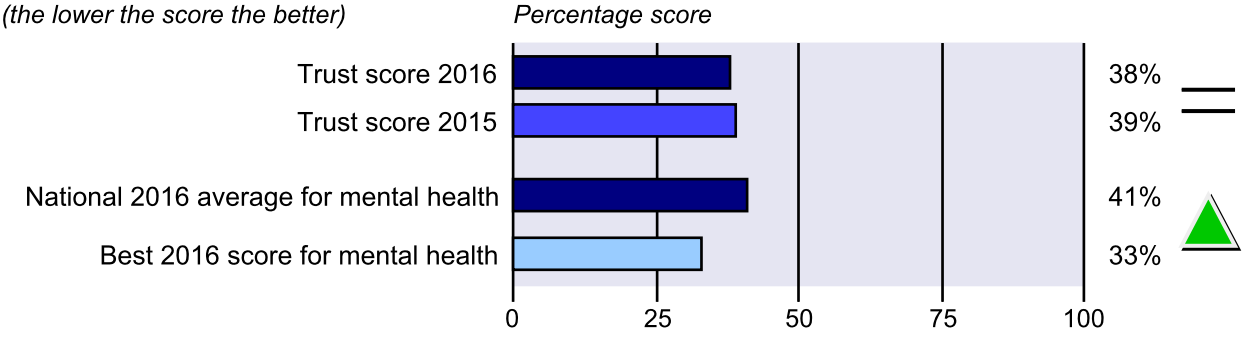
(the higher the score the better)



Health and wellbeing

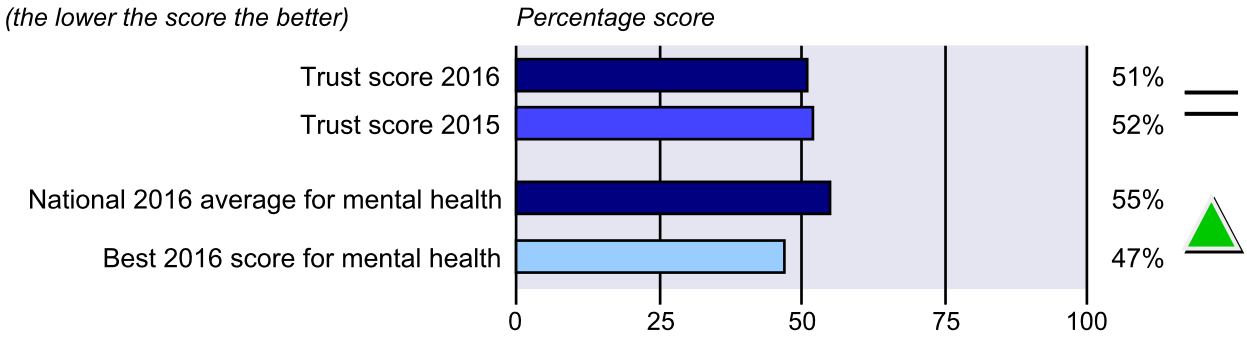
KEY FINDING 17. Percentage of staff feeling unwell due to work related stress in the last 12 months

(the lower the score the better)



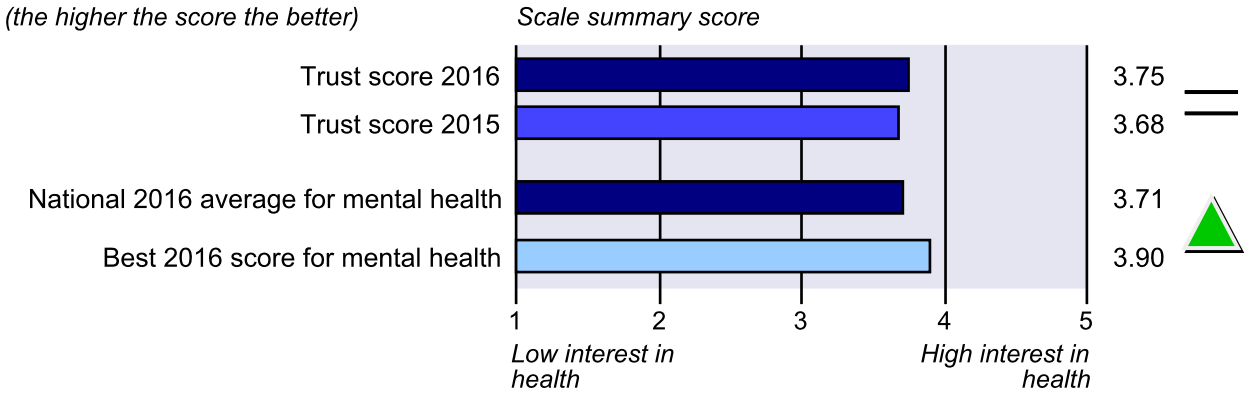
KEY FINDING 18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

(the lower the score the better)



KEY FINDING 19. Organisation and management interest in and action on health and wellbeing

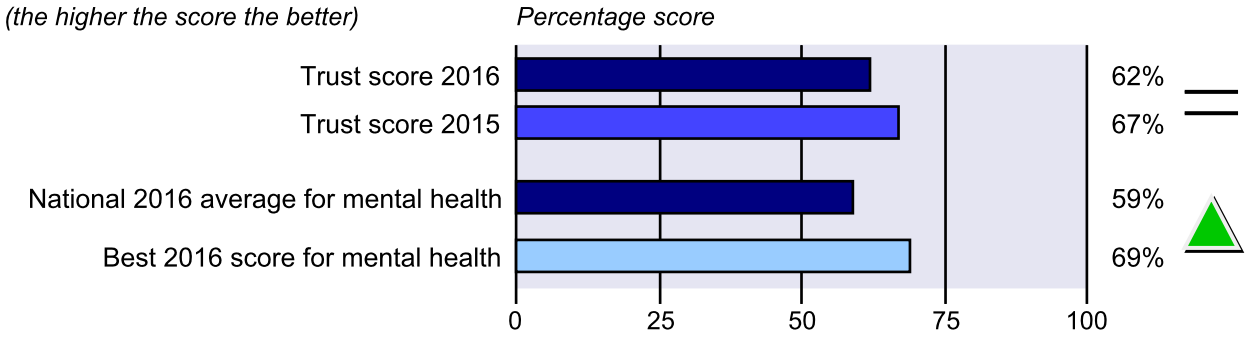
(the higher the score the better)



Working patterns

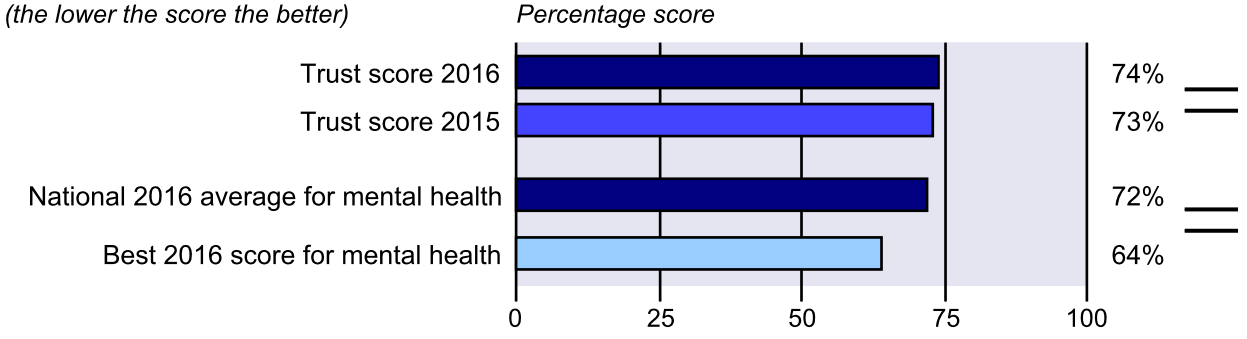
KEY FINDING 15. Percentage of staff satisfied with the opportunities for flexible working patterns

(the higher the score the better)



KEY FINDING 16. Percentage of staff working extra hours

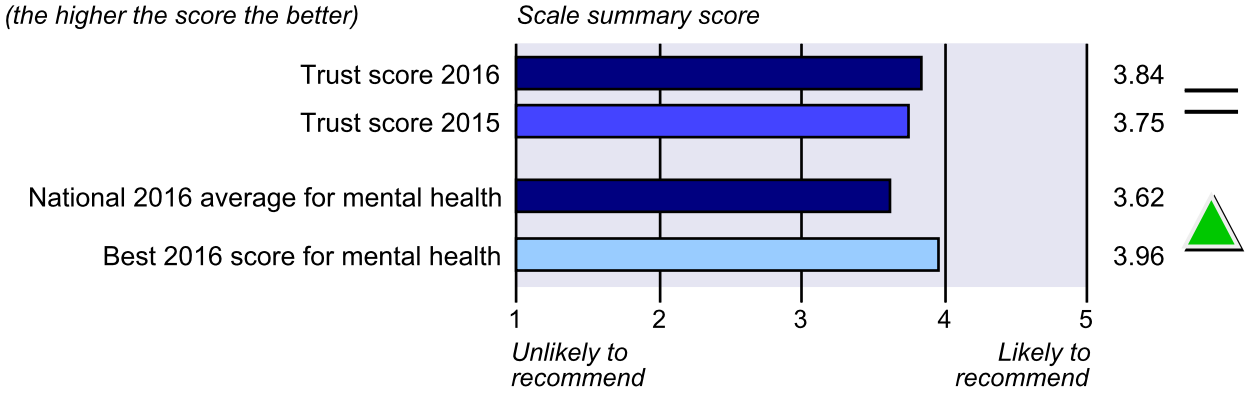
(the lower the score the better)



Job satisfaction

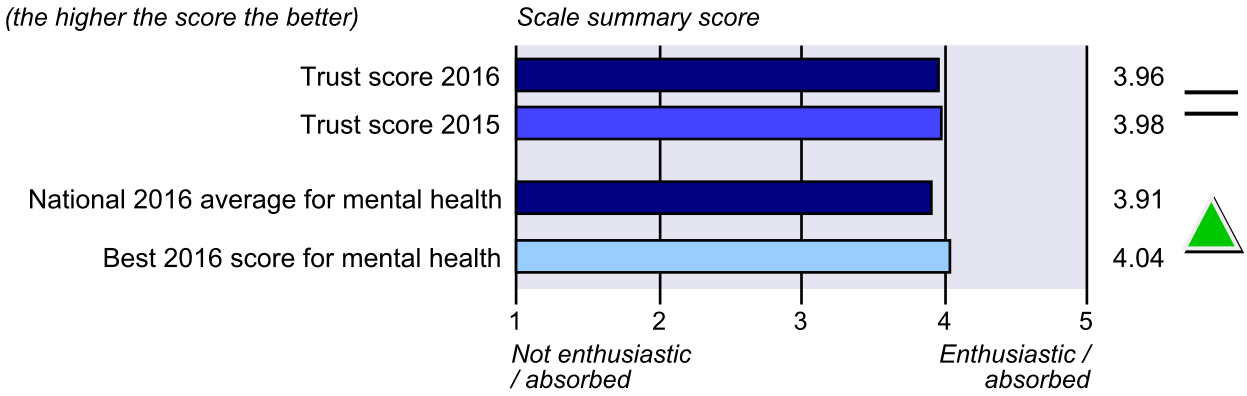
KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment

(the higher the score the better)



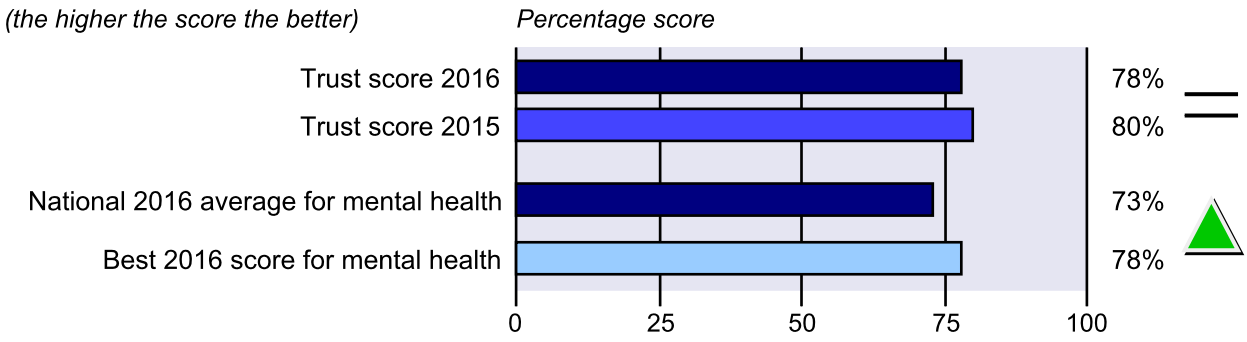
KEY FINDING 4. Staff motivation at work

(the higher the score the better)



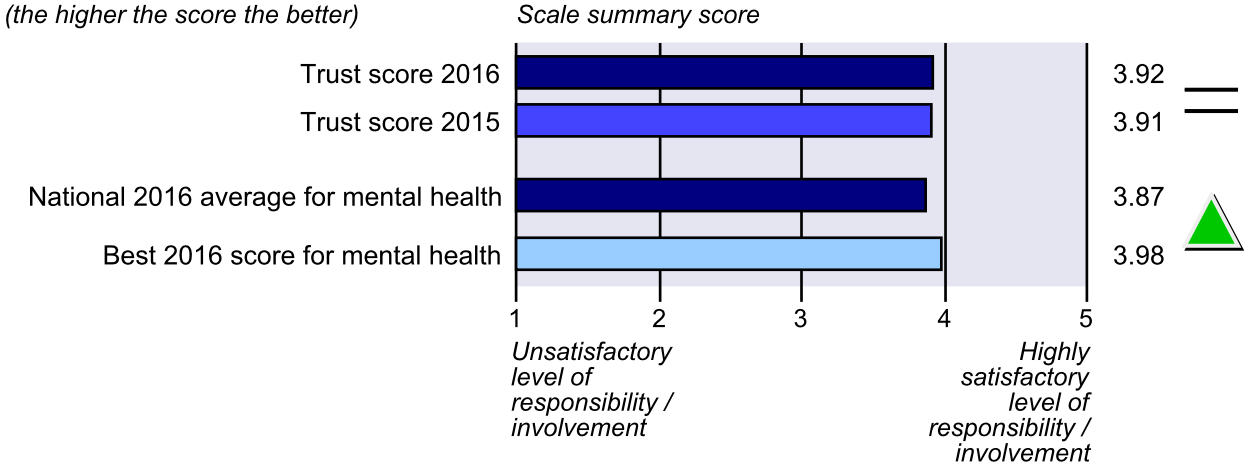
KEY FINDING 7. Percentage of staff able to contribute towards improvements at work

(the higher the score the better)



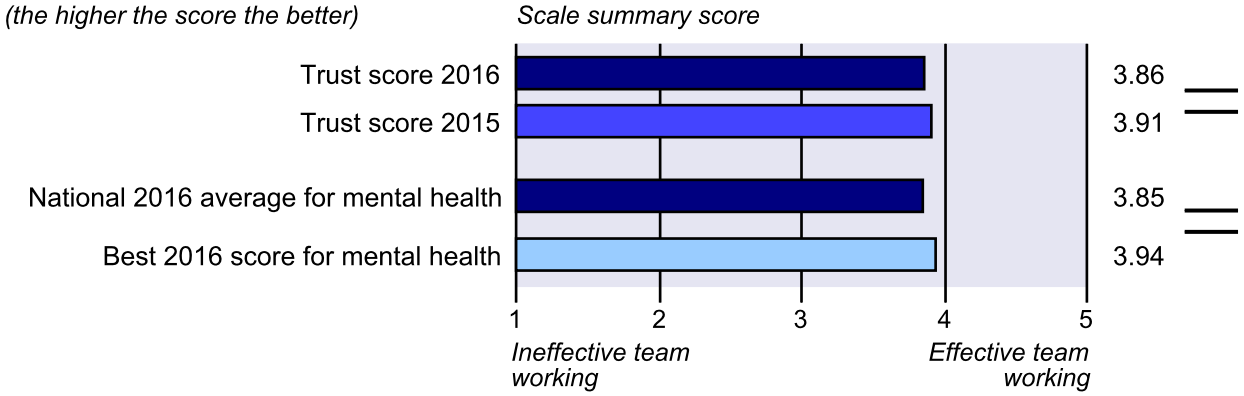
KEY FINDING 8. Staff satisfaction with level of responsibility and involvement

(the higher the score the better)



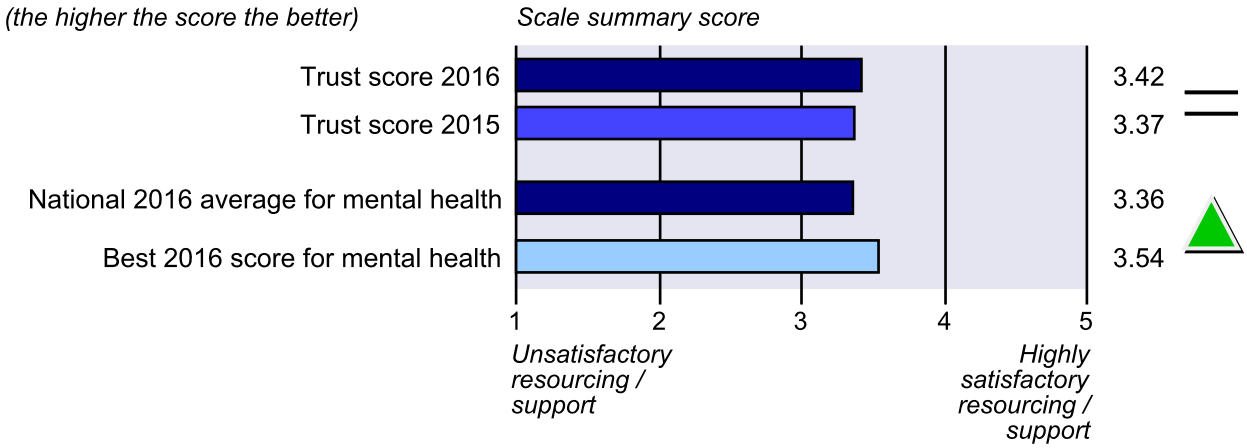
KEY FINDING 9. Effective team working

(the higher the score the better)



KEY FINDING 14. Staff satisfaction with resourcing and support

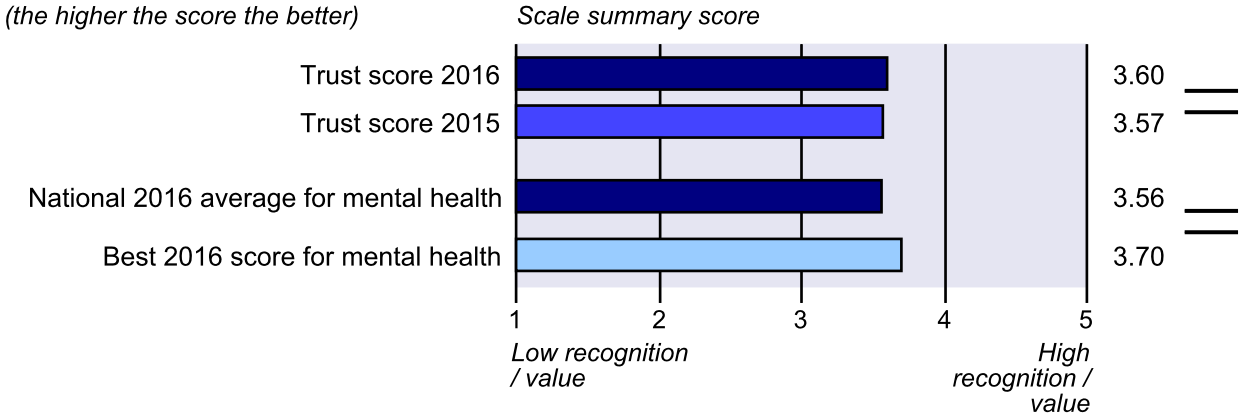
(the higher the score the better)



Managers

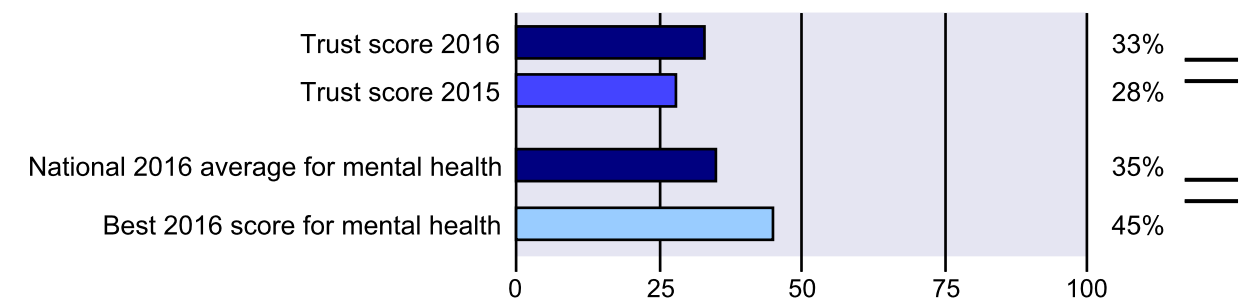
KEY FINDING 5. Recognition and value of staff by managers and the organisation

(the higher the score the better)



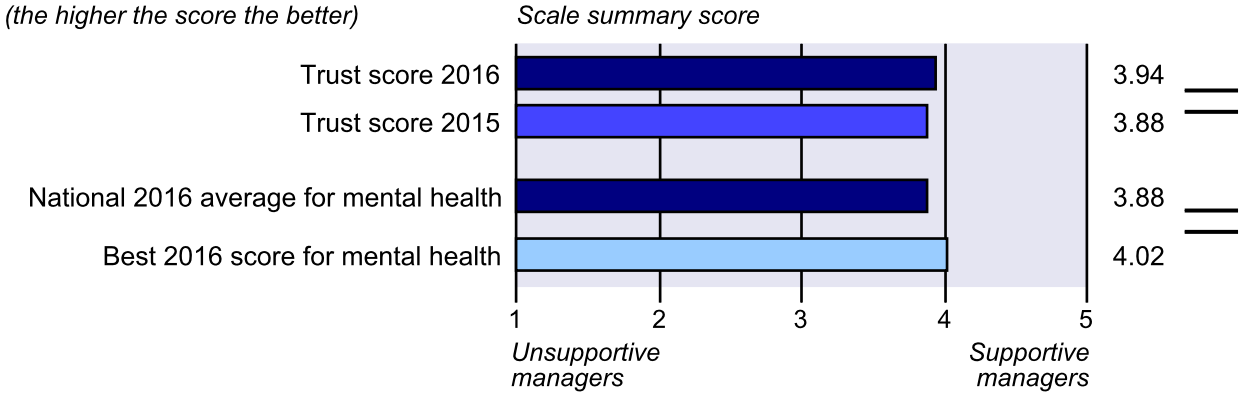
KEY FINDING 6. Percentage of staff reporting good communication between senior management and staff

(the higher the score the better)



KEY FINDING 10. Support from immediate managers

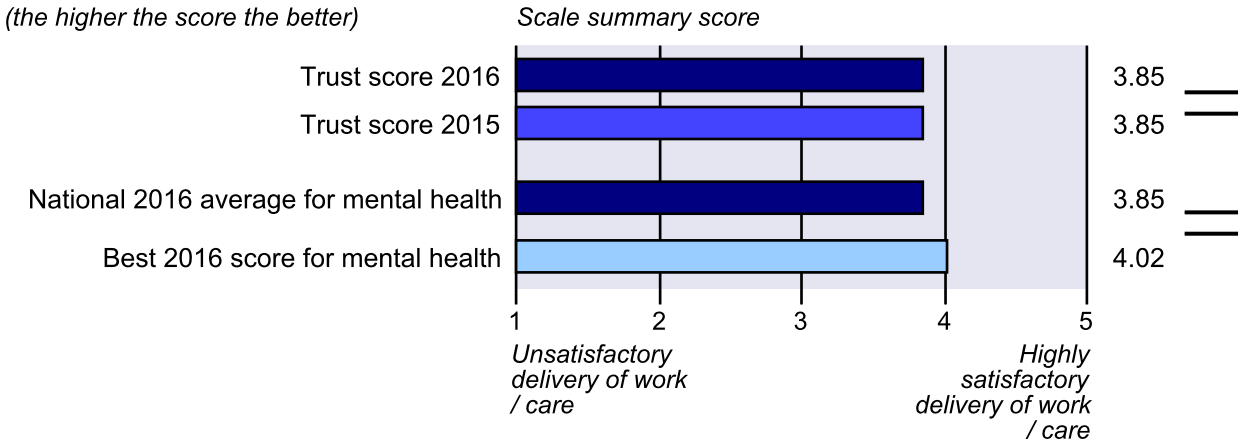
(the higher the score the better)



Patient care & experience

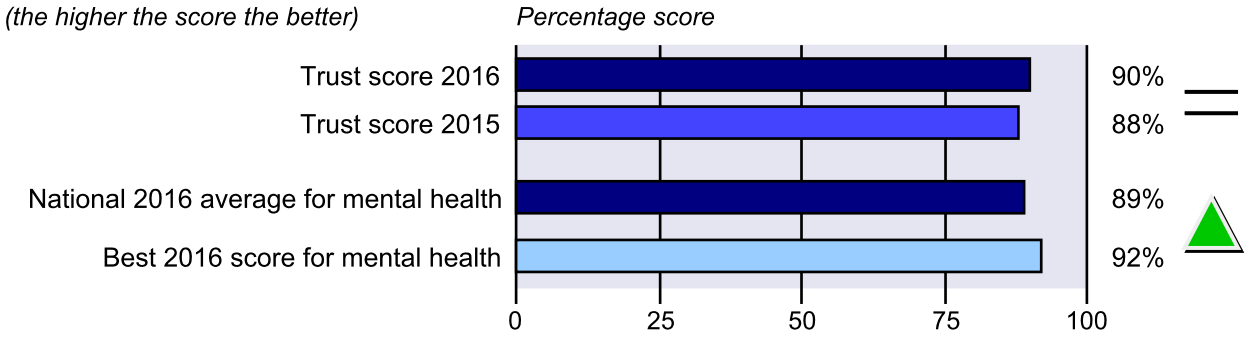
KEY FINDING 2. Staff satisfaction with the quality of work and care they are able to deliver

(the higher the score the better)



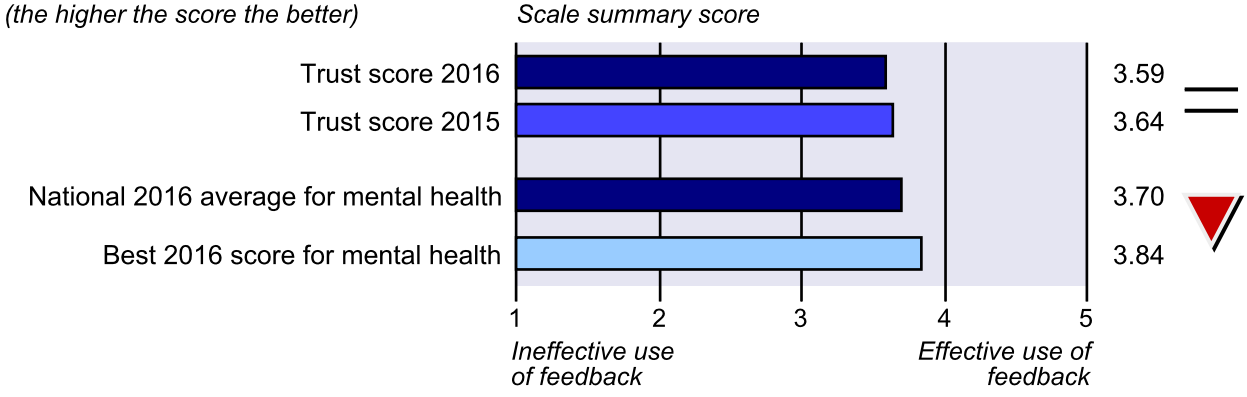
KEY FINDING 3. Percentage of staff agreeing that their role makes a difference to patients / service users

(the higher the score the better)



KEY FINDING 32. Effective use of patient / service user feedback

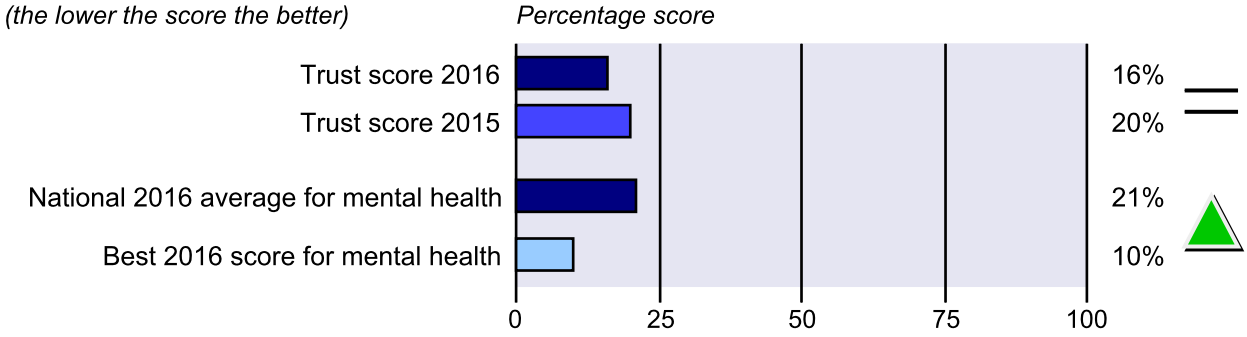
(the higher the score the better)



Violence, harassment & bullying

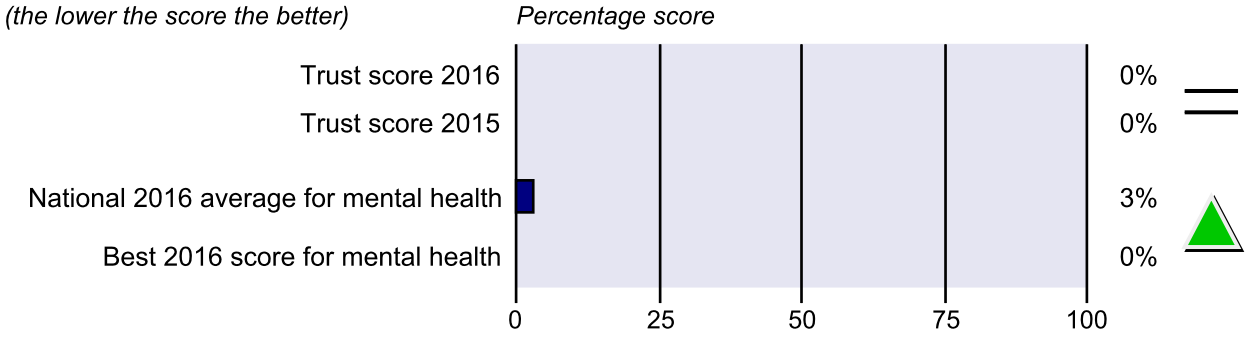
KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



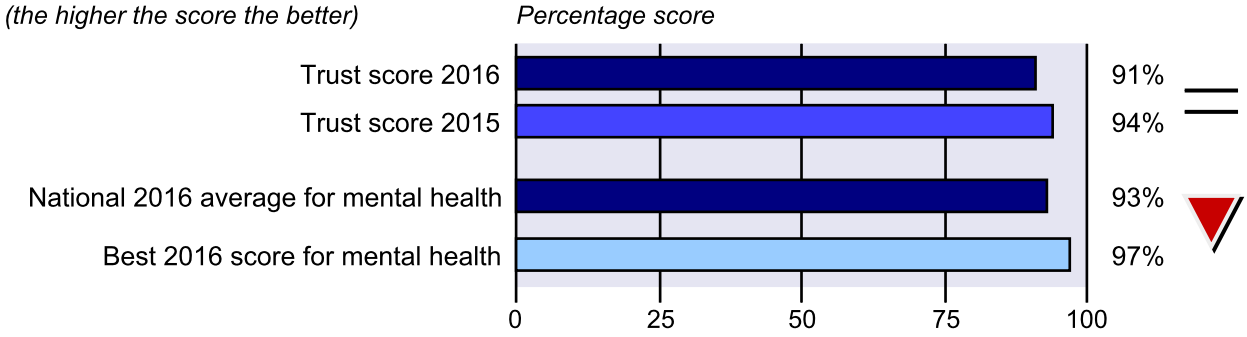
KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



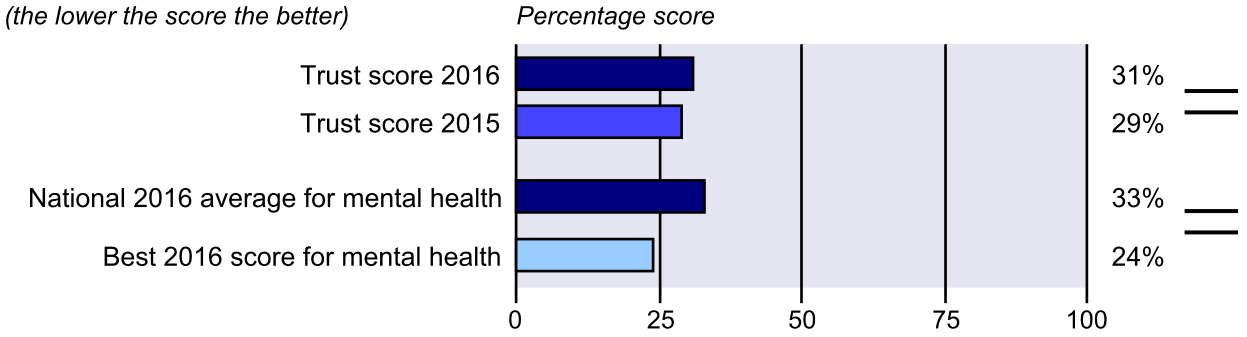
KEY FINDING 24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



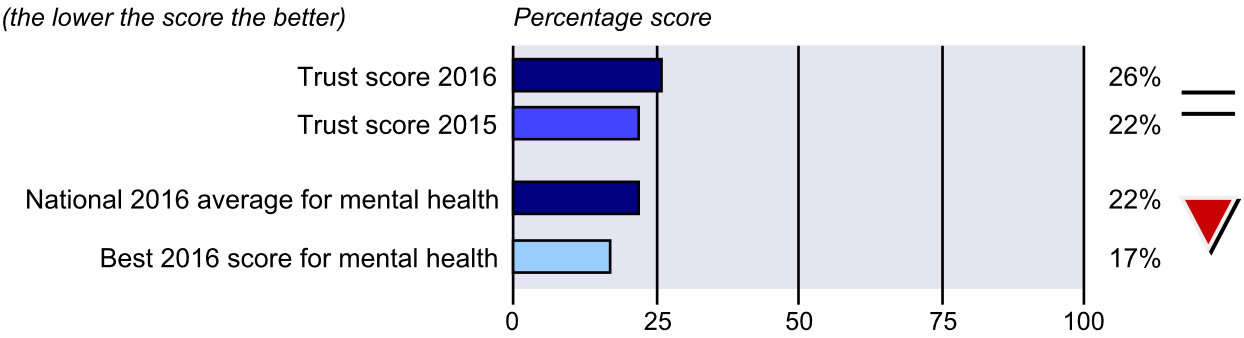
KEY FINDING 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



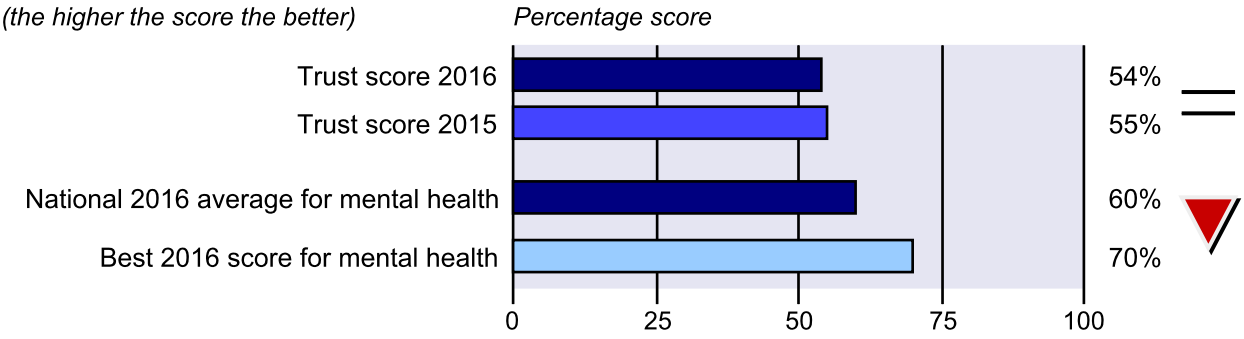
KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



KEY FINDING 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

(the higher the score the better)



Agenda item 14 **Enclosure No** **Paper I**

Report to: 2gether NHS Foundation Trust Board 30th March 2017
Author: Stephen Andrews, Deputy Director of Finance
Presented by: Andrew Lee, Director of Finance and Commerce

SUBJECT: **Finance report for period ending 28th February 2017**

Can this report be discussed at a public Board meeting?	Yes
If not, explain why	

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

EXECUTIVE SUMMARY

- The month 11 position is a surplus of £425k in line with the planned position. The budgets have been revised to include the £650k Sustainability and Transformation Fund monies that have been allocated to the Trust. Three quarters of this fund have been included upto the month 11 position.
- The Trust was allocated £650k from the Sustainability and Transformation Fund (STF) by NHS Improvement. The Trust also had its 2016/17 control total of a surplus of £4k adjusted upward by £650k to a revised 2016/17 revenue control total of £654k surplus.
- Despite a number of cost pressures arising in recent weeks the Trust anticipates it will still meet its financial control total. The Trust has recently introduced tight controls on discretionary spend for the remainder of the financial year. The Trust has released a number of provisions from the balance sheet in order to ensure it meets its control total. The month 11 forecast outturn is a £654k surplus, excluding impairments, as per the revised revenue control total and Trust budgets. The Trust is anticipating it will meet its targets and receive the full allocation from the STF.
- NHS Improvement introduced a new Oversight Framework from the 1st October. Under this framework the Trust has been informed that our current segment is a 2, with 1 being the highest score, 4 being the lowest.
- The Trust has a revised forecast agency spend for the year end, excluding the cost of agency specialling shifts recharged to commissioners, of £5.044m at month 11, which is above the £3.404m control in 2015/16. The forecast has reduced by £0.1m and has been helped by nursing off-framework and above price cap shifts being at their lowest levels for some time. The Trust is shortly introducing a peripatetic nursing team into Herefordshire to undertake shifts that would otherwise have been given to an agency, and is expecting to have an e-rostering system operational in April. These actions will further reduce off framework and above price cap agency shifts.
- The Trust is working with Liaison to change arrangements for the recruitment of agency and locum doctors and move to a direct engagement model. This is will commence on the

13th March 2017. It is anticipated this will help the Trust to meet the requirements of IR35.

- Taking into account all the actions in train or planned the Trust expects to meet its 2017/18 agency control total of £3.404m.
- The Trust has completed budget setting for next year following submission of the Operational Plan in December, and has updated its financial projections for the next five years.
- The Trust has received feedback from NHS Improvement that we are not required to resubmit our Operational Plan.
- The Trust has signed two year contracts with its three main commissioners for 2017 to 2019.

RECOMMENDATIONS

It is recommended that the Board:

- note the month 11 position
- note the reasons for variances from budget and risks to delivery of the financial plans

Corporate Considerations	
Quality implications:	None identified
Resource implications:	Identified in the report
Equalities implications:	None
Risk implications:	Identified in the report

WHICH TRUST KEY STRATEGIC OBJECTIVES DOES THIS PAPER PROGRESS OR CHALLENGE?	
Continuously Improving Quality	
Increasing Engagement	
Ensuring Sustainability	P

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

Reviewed by: Andrew Lee, Director of Finance and Commerce		
	Date	15th March 2017
Where in the Trust has this been discussed before?		
	Date	
What consultation has there been?		
	Date	

Explanation of acronyms used:	See footnotes

1. CONTEXT

The Board has a responsibility to monitor and manage the performance of the Trust. This report presents the financial position and forecasts for consideration by the Board.

2. EXECUTIVE SUMMARY

The following table details headline financial performance indicators for the Trust in a traffic light format driven by the parameters detailed below. Red indicates that significant variance from plan, amber that performance is close to plan and green that performance is in line with plan or better.

Indicator	**Measure**		
Year End I&E	Single Oversight Framework Segment	2.00	Confirmed by NHS I at quarter 2
Income	FOT vs FT Plan	101.9%	
Operating Expenditure	FOT vs FT Plan	101.3%	
Cash	Number of creditor days	24	Balance of £11.3m (including investments) which equates to 24 creditor days.
PSPP	%age of invoices paid within 30 days	97.0%	85% paid in 10 days
Capital Income	Monthly vs FT Plan	100.4%	
Capital Expenditure	Monthly vs FT Plan	99.7%	£9,162k expenditure.

The parameters for the traffic light dashboard are detailed below:

INDICATOR	RED 	AMBER 	GREEN 
NHS Improvement FOT segment score	>3	2.5 - 3	<2.5
INCOME FOT vs FT Plan	<99%	99% - 100%	>100%
Expenditure FOT vs FT Plan	>100%	99% - 100%	<99%
CASH	<15 days	15-40	>40 days
Public Sector Payment Policy - YTD	<80%	80% - 95%	>95%
Capital Income - Monthly vs FT Plan	<90%	90% - 100%	>100%
Capital Expenditure - Monthly vs FT Pla	>115% or <85%	110% - 115% or 85% to 90%	>90% to <110%

- The financial position of the Trust at month 11 is a surplus of £425k which is in line with the plan.
- Income is £1,665k over recovered against budget and operational expenditure is £965k over spent, and non-operational items are £700k over spent.

The table below highlights the performance against expenditure budgets for all localities and directorates for the year to date, plus the total income position.

Trust Summary	Annual Budget £000	Budget to Date £000	Actuals to Date £000	Variance to Date £000	Year End Forecast £000	Year End Variance £000
Cheltenham & N Cots Locality	(4,854)	(4,450)	(4,474)	(24)	(4,893)	(39)
Stroud & S Cots Locality	(4,179)	(3,777)	(3,987)	(210)	(4,376)	(198)
Gloucester & Forest Locality	(4,203)	(3,854)	(3,846)	8	(4,192)	11
Social Care Management	(3,802)	(3,486)	(4,463)	(977)	(4,905)	(1,102)
Entry Level	(5,907)	(5,373)	(5,323)	50	(5,843)	64
Countywide	(29,992)	(27,468)	(27,671)	(203)	(30,283)	(291)
Children & Young People's Service	(6,216)	(5,694)	(5,127)	567	(5,613)	603
Herefordshire Services	(12,475)	(11,427)	(11,986)	(559)	(13,097)	(621)
Medical	(14,880)	(13,640)	(14,391)	(750)	(15,841)	(961)
Board	(1,658)	(1,520)	(1,565)	(45)	(1,835)	(177)
Internal Customer Services	(1,781)	(1,634)	(1,581)	53	(1,783)	(2)
Finance & Commerce	(6,517)	(5,941)	(5,714)	227	(6,269)	249
HR & Organisational Development	(3,134)	(2,873)	(3,003)	(130)	(3,275)	(141)
Quality & Performance	(2,721)	(2,488)	(2,591)	(103)	(2,834)	(113)
Engagement & Integration	(1,345)	(1,232)	(1,228)	4	(1,362)	(17)
Operations Directorate	(1,197)	(1,086)	(1,110)	(24)	(1,209)	(12)
Other (incl. provisional / savings / dep'n / PDC)	(4,495)	(4,223)	(3,719)	504	(3,771)	724
Income	110,011	100,590	102,203	1,613	112,035	2,024
TOTAL	**654**	**425**	**425**	**(0)**	**654**	**(0)**

The key points are summarised below;

In month

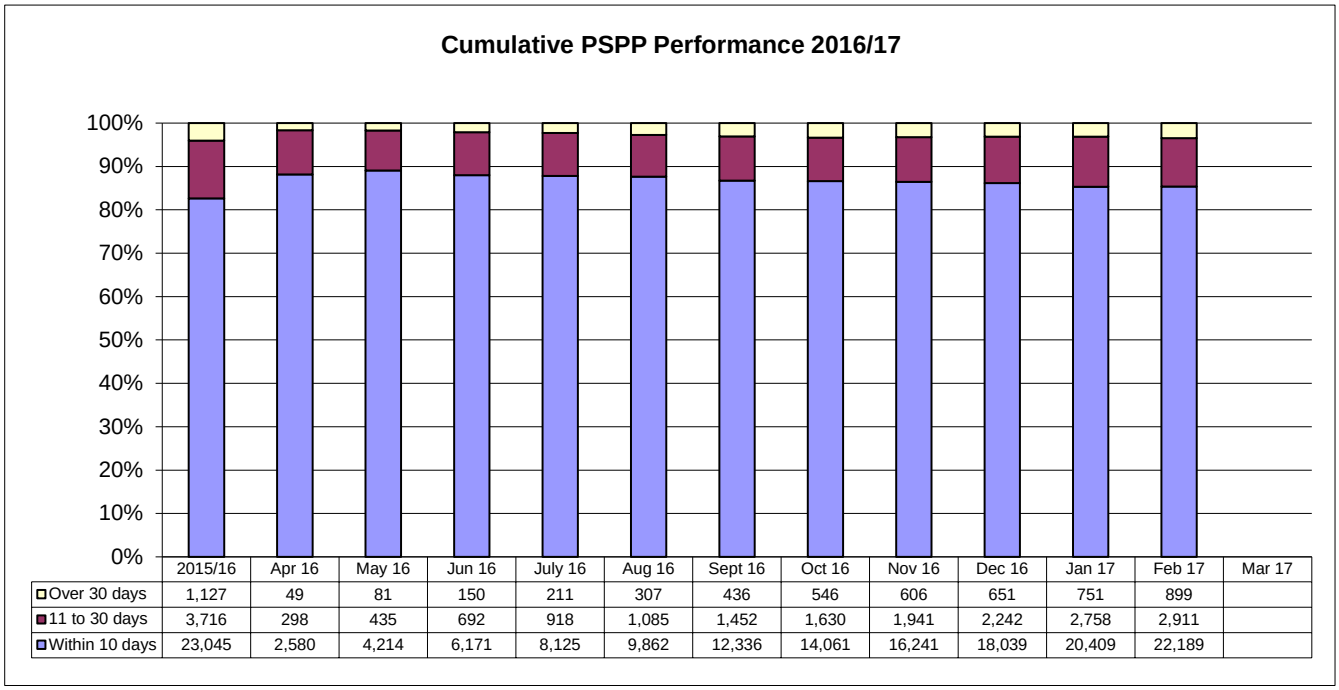
- Stroud locality was over spent due to higher than budgeted Supporting People costs. This is matched by additional income.
- Social Care Management was over spent due to over performance against the funded level for Community Care, which is offset by additional income. Expenditure is being
- Herefordshire was over spent due to agency costs to cover specialling costs on Mortimer and Cantilupe wards, and significant vacancies across the wards.
- CYPs was under spent due to a number of vacancies across many services.
- Medical budgets over spent due to agency usage in Countywide, Children and Young People, Herefordshire, Occupational Health, Localities and Learning Disabilities to cover vacancies, sickness and maternity leave.
- Countywide was over spent due to increased complex care costs from a number of new high cost placements.
- Human Resources was over spent due to nursing, admin and medical agency costs in Occupational Health and unbudgeted employment tribunal costs.
- Other was under spent due to development funds not being utilised.
- Income is over recovered due to additional funds from Supporting People, Community Care and development income.

Forecast Outturn

- Stroud locality is forecast to be over spent due to higher than budgeted Supporting People costs. This is matched by additional income.
- Social Care Management is forecast to be over spent due to over performance against the funded level for Community Care, which is offset by additional income.
- Countywide is forecast to be over spent due to complex care costs from new high cost placements and additional inpatient costs covering vacancies and clinical need.
- Herefordshire is forecast to be over spent due to agency costs to cover specialling and vacancies across all wards.
- Medical is forecast to over spend due to high significant requirements for agency usage.
- Human Resources is forecasting an over spend due to agency costs within Occupational Health.
- Income will over recover due to additional funds for Supporting People, Community Care, Improving Patient Safety and development income.

A review of the financial position was undertaken during the financial year and is reflected in the report. As part of the review the financial plans and assumptions for 2017/18 were updated to reflect the latest assumptions on income, expenditure, capital, savings and reserves in light of the work on the Sustainability and Transformation Plans process, and the proposed control totals for 2017-19.

The cumulative Public Sector Payment Policy (PSPP) performance up to month 11 is 85% of invoices paid in 10 days and 97% paid in 30 days. The cumulative performance to date is depicted in the chart below and compared with last year's position. It highlights that the Trust has a strong balance sheet and has the cash available to consistently pay its invoices promptly and meet the Public Sector Payment Policy target of 95% of invoices paid within 30 days.



	2015/16	Apr 16	May 16	Jun 16	July 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Over 30 days	1,127	49	81	150	211	307	436	546	606	651	751	899	
11 to 30 days	3,716	298	435	692	918	1,085	1,452	1,630	1,941	2,242	2,758	2,911	
Within 10 days	23,045	2,580	4,214	6,171	8,125	9,862	12,336	14,061	16,241	18,039	20,409	22,189	

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Audit Committee

DATE OF COMMITTEE MEETING: 1 February 2017

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

Internal Audit Progress Report
The Committee received an update on progress against the Internal Audit Plan. Five reviews had been scoped and the Committee was assured that these were on track to be completed in Q4. Four final reports were received by the Committee at this meeting.

Contracting Review Phase 2
A Phase 1 report had previously been presented to the Committee in November 2016, and had produced 1 low risk finding. This Phase 2 review had produced 1 additional low risk finding relating to requirements which should not have been included in the Trust's contract with Gloucestershire CCG. Current contracts had already been amended to take account of this finding. The combined Phase 1 and Phase 2 report produced a low risk classification, compared to a medium risk classification in the equivalent review last year.

Estates and Capital
This review produced an overall classification of low risk, the same classification as the previous audit report. The audit report highlighted a number of areas of good practice. There was 1 medium risk finding regarding insufficient evidence to demonstrate that anticipated benefits and outcomes are being tracked. There was also 1 low risk finding regarding one instance where a variance from the capital expenditure report had not been included in the variance report. One advisory finding concerned poor attendance by Service Directors at the Capital review Group.

Core Financial Systems
This review produced an overall classification of low risk, the same as the previous audit report. There was 1 medium risk finding and 2 low risk findings. The medium risk finding referred to a lack of reporting against agreed Procurement and Finance Shared Service Key Performance Indicators, and non-attendance by Procurement staff at meeting. Two low risks related to journal and ledger entries. The Committee was assured that in the main, there was good assurance in relation to core financial systems. However the Committee had previously expressed concern about performance in terms of procurement, and relevant issues referred to in the audit report had already been raised in writing with the Director of Finance at Gloucestershire Hospitals NHS Foundation Trust. A further audit of Procurement Shared Services was due to be completed by the end of the financial year, and would be presented to the Audit Committee's April meeting. The Committee agreed to consider this report in April, and to request that the Finance Head of Shared Services attend a subsequent meeting to present a report on the overall performance of Financial Shared Services. The Director of Finance would liaise with the Committee Chair if necessary to agree whether any changing circumstances necessitated bringing that report to the Committee earlier.

Data Quality
This review produced an overall classification of medium risk. There were 2 medium risk

findings and 2 low risk findings. Medium findings related to discrepancies in data recorded on RiO versus data reported to NHS I, in respect of Care Programme Approach and Delayed Transfers of Care indicators. Low risk findings related to the incorrect reporting of one patient who was transferred to another ward, and to the reasons for delayed discharge not being recorded. A number of areas of good practice were also recorded. The Committee noted the impact which recording issues has on clinicians, and stressed the importance of addressing those issues. It was agreed that data quality would remain on the audit plan for the 2017/18 financial year.

The Committee noted that the Trust had received no high or critical risk findings from the audit reviews conducted to date during 2016/17.

Internal Audit Recommendations Tracker
The Committee received the recommendations tracker and noted 1 outstanding recommendation from the 2014/15 review on E-Expenses which was due to delays with the supplier, but which would be completed by the end of March. In respect of the 2015/16 recommendations, 1 action was outstanding which was due for completion in March. All actions from the 2016/17 programme were either complete or on track, and the Committee noted and welcomed the good progress made by the Trust in completing these audit actions, and agreed that the tracker offered significant assurance that audit recommendations are being addressed in a timely way.

External Audit Report
The Committee received the plan for the 2016/17 audit, and noted the scope and areas of focus for the audit. The audit would consider a number of significant risks including recognition of NHS revenue, accounting for property valuations, and management override of controls. The Committee noted that these were generic risks considered as part of the audit process, and did not imply any specific risk in relation to 2gether.

The Committee received the Sector Developments report providing intelligence on a number of items and agreed to make it available to Governors for information.

Counter Fraud
The Committee noted that all activity was progressing and it was anticipated that all actions within the Counter Fraud Action Plan would be completed by year end. For the period April – January 2017, Counter Fraud had participated in all Trust inductions and provided fraud awareness to 381 staff. Thirteen counter fraud presentations had been given, above the target of 10 agreed in the Counter Fraud action plan. Three Counter Fraud newsletters and four Counter Fraud bulletins had been published and were now accessible to staff via the Trust's intranet. Counter Fraud material including posters had been distributed and displayed in staff areas, and a new Counter Fraud website was being developed. Discussions are underway with a third party Counter Fraud service to allow access additional support in times of exceptional pressure.

The Committee received and noted a verbal update on current Counter Fraud investigative activity. The Committee agreed that the report offered significant assurance on the Counter Fraud activity being undertaken.

Accounting Policies Report
The Committee received a report the accounting policies which are disclosed in the Statutory Accounts. Guidance for accounting policies had not yet been published but little if any change was expected from the current wording, which was provided for information to the Committee,

and the report. The Committee agreed the accounting policy wording as presented, and agreed that should significant changes become apparent when the guidance is published, this would be agreed by the Committee Chair and the Director of Finance, and brought to the Committee's attention.

Valuation of Intangible Assets
The Committee received a report outlining current book values of intangible assets such as computer software. The Committee agreed that the values set out in the report represented a fair value for accounting purposes, and that the stated remaining asset lives are realistic and reasonable.

Going Concern Report
The Committee received the Going Concern report and noted the International Financial Reporting Standards requirement that in making an assessment of whether the Trust is a going concern when preparing its annual financial statements, the presumption should be that the organisation remains a going concern unless there is an expectation to the contrary. The Committee noted that the Trust had reviewed its financial performance and its future plans, and had negotiated two year rolling contracts with its two main commissioners. These contracts provide assurance that the Trust will continue to deliver services across Herefordshire and Gloucestershire in 2017/18. The Trust has continued to perform well and is projecting a year end surplus of £654k for 2016/17, which is in line with its plans. The Committee agreed that this report offered significant assurance and agreed that the annual accounts should be prepared on a going concern basis.

Review of the Risk Register
The Committee reviewed the Trust's Corporate Risk Register as at quarter 3 (2016/17) which contained those risks scoring 12 or more, and noted new risk management arrangements which are currently being embedded in the Trust. The Committee noted the risks contained within the report, and queried whether a risk relating to potential loss of business in Herefordshire ought to be included in the risk register. The Committee also noted that in respect of one risk, an action was overdue, and asked that the Governance Committee seek assurance from the action owner to ensure that this action was completed. The Committee also discussed the format of the risk register, and asked that the Executive Committee consider whether the levels of assurance shown were commensurate with the risk likelihood score, and also whether the register should show risk scores both pre and post mitigation.

Assurance Map
The Committee received an updated Assurance Map report and noted the assurance provided. The Committee discussed the top 5 risks as stated in the report, and noted that in respect of the risk around agency staffing, this had been designated a top 5 risk due to the combination of financial, quality and reputational risk which a failure to meet agency staffing targets might pose. The Committee requested that the wording of the agency staffing risk be reviewed to make these potential consequences clearer.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to note the contents of this summary.

SUMMARY PREPARED BY: Marcia Gallagher ROLE: Committee Chair
DATE: 1 February 2017

BOARD OF TRUSTEES COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Charitable Funds Committee

DATE OF COMMITTEE MEETING: 1 February 2017

KEY POINTS TO DRAW TO THE BOARD OF TRUSTEES' ATTENTION

Financial Activities Report

The Charitable Funds Committee received a report setting out the balances and movements within funds and of approvals over £1,000 taken under delegated powers for the period 1st April 2016 to 31st December 2016. There had been four approvals over £1,000 taken under delegated powers between the period 1st October and 31st December. No donations or legacies over £100 were received for the period 1st October 2016 to 31st December 2016.

The Committee was apprised of the spending plans and approved commitments and received assurance that projected spending plans and approved commitments on the funds did not lead to any potential overspends. The anticipated fund balances were reviewed in accordance with the charity's reserve policy and the Committee noted that the charity's reserves were adequate. The total fund balance now stood at £141,240.

There had been no expenditure requests received since the Committee's last meeting in November 2016.

Due to time pressures, a presentation on expenditure from the Countywide fund was deferred until the next meeting.

ACTIONS REQUIRED BY THE BOARD OF TRUSTEES

The Board of Trustees is asked to note the contents of this summary.

SUMMARY PREPARED BY: Duncan Sutherland **ROLE: Committee Chair**

DATE: 1 February 2017

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Delivery Committee

DATE OF COMMITTEE MEETING: 22 February 2017

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PERFORMANCE DASHBOARD

At the end of January, of the 147 performance indicators, 87 were reportable with 74 being compliant and 13 non-compliant at the end of the reporting period. Particular focus continued to be on IAPT services which accounted for 7 of the 13 non-compliant indicators. Work was ongoing in accordance with agreed Service Delivery Improvement Plans to address the underlying issues affecting this performance.

The Committee was assured that there was ongoing work to review all of the indicators not meeting the required performance threshold. This included a review of the measurement and data quality processes as well as clinical delivery and clinical practice issues. Work would be undertaken to include a quarterly red/green performance compliance forecaster for each performance indicator to support proactive monitoring/improvement.

The Trust was reporting compliance against two new carers Key Performance Indicators (set as 100% targets):

- Indicator: 4.06 and 5.22 - patients asked if they have a carer
- Indicator: 4.07 and 5.23 - patients offered a carers assessment

Staff were required to complete the new Carer Information contained in the Core assessment on RiO. This applied to referrals after the 1st March 2016. In Gloucestershire, a trajectory had been set to monitor progress to achieve 100% compliance. As of 13th February 2017 the level of compliance was 74% for Indicator 4.06 and 65% for Indicator 4.07. Gloucestershire Localities was aiming for 95% compliance for both Key Performance Indicators by March 2017, but anticipated 80-85%. Herefordshire had set no trajectory at the present time although work was ongoing to improve the compliance. As of 13th February 2017 the level of compliance in Herefordshire was 38.7% for Indicator 5.22 and 61.4% for Indicator 5.23. 45% compliance for Indicator 5.22 and 70% for Indicator 5.23 was likely to be achievable by March 2017 and the Committee asked for recovery trajectories to be provided in the next focus report.

CQUIN IMPLEMENTATION

The Committee received a report providing an update on progress with achieving the 2016/17 CQUIN targets. It was reported that the Q1, Q2 and Q3 reports had all been submitted on time and had all been confirmed as being fully compliant.

CQC NATIONAL PATIENT SURVEY ACTION PLAN

The Committee received a report presenting the findings of the CQC National Community Mental Health Survey 2016. The Trust had achieved a response rate of 33%; this compared favourably to the national average of 28%. The results of the survey put 2gether in a very favourable position as the Trust was rated in the top 20% of Trusts in 4 out of the 10 domains on the survey and ranked 2nd in the country.

An action plan had been developed in collaboration with Gloucestershire Localities Services, Gloucestershire Countywide Services, Herefordshire Services and Professional Leads. This would ensure a sustained effort to build on the work identified in previous years. A detailed analysis of the data in relation to the Gloucestershire and Herefordshire sample results had been undertaken and while the sample numbers were small, no significant differences could be drawn between the 2 counties.

The Delivery Committee noted the significant assurance of continuous improvements in service experience provided by the survey results and action plan.

COUNTYWIDE LOCALITY REVIEW

Westridge was to close in 2017 and Hollybrook would become the Learning Disability Services Inpatient facility/service for the Trust. The new service was to be re-named Berkeley House. Work had already been completed to convert the Hollybrook bungalow from six beds to two individualised flats with a shared kitchen and in converting the main building from four two bedded flats to five individualised flats. All seven flats had been built to a robust specification, while maintaining a homely feel. Each had their own front doors, comfortable lounge, kitchen, bedroom en-suite and garden. This would provide a patient experience that did not feel institutionalised and afforded people dignity and privacy while working towards discharge to the community.

The LDISS service was for Adults and children with a Learning Disability whose behaviour challenged the 'system' and caused significant impact on the individual themselves, their family or the services supporting them. The LDISS service aimed to prevent hospital admissions and breakdown in home circumstances. The Committee noted the achievements to date and the continued challenges facing the service.

The Committee noted that the Mental Health Acute Response Service (MHARS) service now had an operation base within the joint Tri Service control room at Waterwells and was available from 12 until 8pm, seven days a week. MHARS staff worked alongside the emergency services to advise on and respond to incidents that could be taking place anywhere in the county and which involved mental health needs. Recruitment continued to be a challenge and the service needed to recruit a substantial number of new posts before it could become fully operational within the new service model proposals. Since 2013/14 the MHARS service had increased attendances from 9082 to 10,760.

LEARN2GETHER PROGRESS REPORT

The Committee noted the improvements being made with the Learn2gether system and the accuracy of the information held. Appraisals would be included on the system from April 2017 and discussions would take place to see whether there was a need for both systems to be run in tandem for the first quarter.

LOCAL SECURITY MANAGEMENT UPDATE

The Committee noted the reported levels of violence and aggression. There were no physical assaults without clinical factor reported during the period 1 October – 31 December 2016; 58 were reported where Mental Health was found to be a clinical factor and 68 where severe Learning Disability was a clinical factor. There were no non–physical assaults without clinical factors (including abuse/attempted assaults) during that period; 14 were reported where Mental Health was a clinical factor and 26 where severe learning disability was a factor. The Committee asked for a breakdown of the number of individual patients these assaults related to in the next report. Reported physical assaults with mental health as a factor were down by 38.30% and reported physical assaults with severe learning disability as a factor were down by 26.09%. Some explanation on why the numbers of physical assaults had fallen was requested for the next report. The Committee was significantly assured that all relevant security policies and procedures were current and in place, and that all Security related Datix reports were accurate and correctly reported.

OTHER ITEMS

The Delivery Committee also received:

- Locality Exception reports
- IAPT Service Improvement summary
- A review of Delivery Committee risks
- Revised Committee terms of reference

ACTIONS REQUIRED BY THE BOARD

Nothing to report.

SUMMARY PREPARED BY: Maria Bond **ROLE: Committee Chair**
DATE: 24 February 2017

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Governance Committee

DATE OF COMMITTEE MEETING: 17 February 2017

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PATIENT SAFETY

There had been 6 new serious incidents reported during January 2017, with the SI rate per 1000 caseload presenting at 0.29. There continued to be an increase in the number of suspected suicides and there was a trend of more fatalities from incidents, which was sadly in line with national reporting.

The SI Action Plan 2015/16 contained 2 outstanding amber actions which required some additional assurance before full closure (4 previously when last reported in January 2017). The SI Action Plan 2016/17 contained 11 (11 previously) amber actions plus 25 (7 previously) red actions which were overdue for completion. There were 16 (36 previously) further actions that were not yet due. The newly formed QCR Committee had agreed a process for challenging action owners, with a themed meeting planned. Action owners would be asked to challenge and refine their own actions if they did not fully understand them. There was concern that the number of outstanding SI actions had increased; however, there was good assurance that a process to review this was in place.

The Committee noted that discussions had taken place with the Coroner about the timing of inquests and the issues in relation to the ability to share preliminary reports with families in advance. This had been a very helpful discussion and the Trust would be working together with the Coroner's office to facilitate this.

The Committee received the Quarterly Patient Safety & Near Miss Report for quarters 2 and 3 2016/17, which clearly demonstrated an increased reporting culture, and importantly, greatly improved capture of mortality incidents to inform the required mortality review processes from April 2017. The Committee was assured that the majority of incidents reported were classed as "low/no harm" incidents.

The Committee was significantly assured that the Trust had robust processes in place to report and learn from serious incidents. Going forward, the quarterly patient safety report would be presented at the QCR Committee to enable more time to be given to drilling down into the detail and action required.

SAFE STAFFING LEVELS

The Committee received the safe staffing levels report for December and January, noting that there was a significant level of assurance that this continued to be monitored and safe staffing levels were being maintained. There was discussion about the use of agency staff, noting that 2gether was not currently compliant with its control total.

The Committee received assurance that the Executive Committee remained focussed on the use of bank and agency staffing and received regular monitoring reports; however, the Committee requested a detailed report on agency usage and the actions in place to reduce this, to be included in the next temporary staffing report. Despite the concerns about agency usage, the Committee noted that 2gether was consistently in the right place in relation to the provision of safe staffing which was excellent.

SUICIDE PREVENTION

This report provided an overview of the implementation of both inpatient and community suicide prevention toolkits and an overview of the undertaking of ligature assessments within inpatient areas. The report also included an overview of suicide prevention activities being carried out alongside partner

agencies, noting that 2gether was an active member of the Gloucestershire Suicide Prevention Partnership Forum.

The Committee received good assurance that the Suicide Prevention Toolkits continued to be utilised in acute inpatient areas and within the community teams which reported the highest numbers of serious incidents. Annual ligature audits had been undertaken within inpatient environments and all community team bases updated their ligature audits within 2016/17.

The Gloucester City Plan was currently out for consultation and Gloucester City Council was proposing a suite of health and wellbeing policies and have included a specific policy (Policy D15) requiring developers of tall buildings to include suicide prevention measures. This was a real step forward and had happened as a direct result of the influence of the Gloucestershire Suicide Prevention Partnership Forum.

STAFF INCIDENTS REPORTS

In Quarter 3 there were 33 Health and Safety incidents recorded. These are incidents to staff, visitors and contractors. Eight Health & Safety incidents that had occurred during the quarter had not been closed by handlers. Gloucestershire Countywide Services have the greatest proportion of incidents reported across all types of Health and Safety incidents however, this reflects the nature of the services provided. There were 2 RIDDOR reportable incidents in Quarter 3. Both were currently "under review" by their respective handlers.

The Committee received significant assurance for the accuracy of the 'grade of harm' or 'level of seriousness' as assessed by handlers. However, limited assurance was currently given as to whether all Health and Safety incidents had been fully reported for Quarter 3, given the significant reduction in overall numbers when compared with the previous 2 quarters. It remained unclear if this was an issue of underreporting or if incidents were being reported but not categorised as Health and Safety. More analysis was underway and the Committee stressed the importance of resolving this issue, given the implications of non-reporting of RIDDOR incidents. Future reports would include the current training compliance with H&S training, both for staff and Managers.

The Committee were pleased to note significant improvement with fire training compliance. At the end of January 2017, overall Inpatient Fire Training compliance stood at 84% (97% in Herefordshire and 81% in Gloucestershire). Generic Fire Training compliance was at 91% overall (97% in Herefordshire and 91% in Gloucestershire). Proactive work was underway to ensure a continued increase with compliance.

CLINICAL SUPERVISION OF NURSING AND OCCUPATIONAL THERAPY STAFF

The Governance Committee was offered good assurance that the structure and processes for the delivery of Clinical Supervision for the Nursing and Occupational Therapy professions were in place. However, significant assurance could not yet be provided until an improvement in compliance could be seen. A further update on this compliance would be included in the next quarter Professional Regulation report. It was also agreed that compliance would be audited in Quarter 3 of next year's audit programme, with the results reported back at the Governance Committee.

OTHER ITEMS

The Governance Committee at its February meeting also received and noted the Quarter 3 Service Experience Report (to be received at the Board in March), the Quarter 3 Quality Report (March Board), an update on Datix, the Clinical Audit Programme 2017/18, a Medical Appraisal report, a Junior Doctor contract update, a CIP Savings and Quality Impact Assessments report and an update on progress with the CQC Action Plan.

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Nikki Richardson ROLE: Chair
DATE: 22 February 2017

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Mental Health Legislation Scrutiny Committee

DATE OF COMMITTEE MEETING: 8 March 2017

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

ROLLING AUDIT OF DETAINED PATIENTS AND REMINDER OF THEIR RIGHTS

Section 132 of the Mental Health Act requires the managers of a hospital to inform a detained patient of his or her legal position and rights, and information should be given both orally and in writing. For patients subject to hospital detention, the total % of rights recorded in February stood at 93%. The % advised of the availability of an Independent MH Advocate (IMHA) stood at 91% and the % of reminders which were up to date for the same period was 84%. For patients subject to Community Treatment Orders, the total % of rights recorded in February stood at 53%. The % advised of the availability of an Independent MH Advocate stood at 45% and the % of reminders which were up to date for the same period was 15%.

Performance had not got worse; however, results were now more accurate and the RiO User Group were investigating the details. It was agreed that the Operational Group would look at instances of poor performance and how this could be improved. The Committee was significantly assured of the provision/reminder of rights to detained inpatients but noted there was only very limited assurance in relation to Community Treatment Order patients.

REPORTS OF ISSUES ARISING AT MHA REVIEWS

Five MHA Hearing Issue forms had been received by the MHA Administration Team between the 1 November 2016 and the 21 February 2017. The causes of the issues raised, included;

- Availability of historical service notes from another Mental Health Trust
- Care Coordinator not present
- Nursing report presenter not deemed prepared enough for the hearing.

All of the issues raised had been reviewed and investigated and actions to address shortfalls or improvements in processes, structures, procedures, practice or lines of accountability had been documented.

The Committee was significantly assured on the processes and structures in place to manage and monitor MHA Manager issues. However it was agreed that at the next MHA Managers Forum, the MHA Managers would be asked for their views on the process and the Committee's responses to any issues raised.

ANNUAL BOARD REPORT

The Committee received the draft MHLS Committee Annual Report outlining the activities of the Committee between April 2016 and March 2017. The report set out a number of requirements linked to the Committee's Terms of Reference in which both evidence and a level of assurance were provided. A final version of the report would be presented to the Trust Board in May.

UPDATE ON APPROVED MENTAL HEALTH PRACTITIONER (AMHP) COVER

The Committee received an update on the current issues and concerns around AMHP cover. The Local Authority had identified £500k of additional funding to reconfigure the service to make it more robust. There would be a dedicated AMHP service and the service would extend to cover the Emergency Duty Team. A revised framework for Trust services was being

developed and AMHPs were being asked to consider how they could provide support in the interim. Contingency plans were being put in place and discussions were taking place with partners including the police. A further update would be provided at the next meeting.

HEALTH BASED PLACE OF SAFETY IN GLOUCESTERSHIRE

The Committee received a report which highlighted the increased activity within the Maxwell Centre Place of Safety (PoS) between 2014–2016, and gave further analysis of activity throughout 2016. The number of S136 detentions had almost doubled and the length of time people remained within the PoS had also increased from 3.18 hrs to 4.07 hrs. 28 (5%) detentions were under the age of 18yrs, 11 of which were admitted to Wotton Lawn for a brief time.

In 2016, 222 (37%) of detentions had a dominant Mental Health condition of F60-F69 Disorders of Adult Behaviour & Personality. In the last 6 months, a total of 18 people had accounted for 103 detentions. Further work was being undertaken to understand if there was a correlation between these high intensity users and those accessing services at the Acute Hospitals Trust. A review of the 18 people suggested that the majority of these had an emotionally unstable personality disorder and were open to Recovery Teams.

Over the last 3 years, there had been an increase in S136 detentions presented to the Maxwell Suite. This had been anticipated as the new Police and Crime Act placed more pressure on the Police to seek advice from Mental Health professionals before initiating a detention. The move away from using police cells as a PoS for individuals suspected of having a mental health issue had seen a significant upward trend especially in 2016. Work continued via the Interagency Monitoring Group to try to understand this particular surge and whether this was associated with the mental health of the county or a change in policing behaviour.

The number of detentions to the Maxwell Suite was currently being triangulated with the number of contacts from police to seek advice from the Crisis Urgent Response Team based in the police control room before initiating a detention. The Committee agreed to establish a Task and Finish Group to monitor this increase in activity and terms of reference would be developed for this group.

OTHER ITEMS

Other reports received by the Committee included:

- Key Performance Indicators
- Themes of the National Review of the Application of the Mental Health Act
- Review of legal updates
- Review of the Committee terms of reference
- Receipt of the Responsible Clinician SOAD documentation audit
- Review of DOLS applications/update report

ACTIONS REQUIRED BY THE COMMITTEE

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

SUMMARY PREPARED BY: Quinton Quayle **ROLE: Committee Chair**

DATE: 11 March 2017

Agenda item 16 **Enclosure Paper K**

Report to: Trust Board - 30 March 2017
Author: Ruth FitzJohn, Trust Chair
Presented by: Ruth FitzJohn, Trust Chair

SUBJECT: **CHAIR'S REPORT**

Can this report be discussed at a public Board meeting?	**Yes**
If not, explain why	

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

1. PURPOSE, ASSURANCE AND RECOMENDATION

This report sets out the key activities of the Trust Chair and Non-Executive Directors for the period 17 January 2017 – 16 March 2017.

The report offers full assurance that regular, targeted and purposeful engagement is being undertaken by the Chair and Non-Executive Directors aiming to support the strategic goals of the Trust.

This report is for information only and the Board is invited to note the report.

2. CHAIR'S KEY ACTIVITIES

- Chairing a Board meeting in Gloucestershire
- Chairing a Council of Governors meeting
- Attending a development event of the Gloucestershire Health and Well Being Board at Shire Hall
- Meeting with the Director of Integration and Engagement
- Meeting with the Deputy Chair
- Meeting with the Chair Executive and Chairs of Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Care Services NHS Trust
- Meeting with the Police and Crime Commissioner for Gloucestershire and his deputy

- Meeting with our former Appointments Commissioner
- Attending an Aston Project Stakeholder meeting in Cheltenham
- Participating in an Aston Project interview and promotional video
- Participating in the public engagement event led by the Council of Governors on Time to Talk day at Gloucestershire College in Cheltenham
- Meeting with community activists
- Meeting with the new Chair of Gloucestershire Hospitals NHS Foundation Trust as part of his induction
- Meeting with the Trust's Lead Management Accountant to discuss a project review
- Attending a Holocaust Memorial Day Commemorative Service in Gloucester
- Meeting with BBC Radio Gloucestershire
- Hosting an informal meeting with the Non-Executive Directors
- Additional regular background activities include:
    - attending and planning for smaller ad hoc or informal meetings
    - dealing with letters and e-mails
    - reading many background papers and other documents.

3. NON-EXECUTIVE DIRECTORS' ACTIVITIES

Jonathan Vickers

Since his last report Jonathan has;

February

- Prepared for and attended a board meeting
- Held discussions with colleagues on the terms of reference of the Development Committee
- Prepared for and attended a meeting of the Audit Committee
- Prepared for and chaired a meeting of the Development Committee

March

- Prepared for and attended a board meeting
- Held discussions with fellow NED's on appraisals
- Prepared for and conducted an audit of complaints, and provided feedback
- Held discussions with the Director of Finance on development committee matters
- Prepared for and chaired a meeting of the development committee
- Held discussions with the chair

Nikki Richardson

Since her last report Nikki has;

February

- Prepared for and attended a Board Meeting
- Prepared for and attended the Audit Committee
- Prepared for and attended the Charitable Funds Committee
- Attended a Gloucestershire STP event
- Prepared for and Chaired the Governance Committee
- Attended a NED informal meeting
- Attended 2 Council of Governors Working Groups

- Attended the Gloucestershire Strategic Forum
- Met with the Director of OD
- Attended a Workshop re Recovery to Sustainable Transformation
- Deputised for the Trust Chair

March

- Prepared for and chaired Board of Directors Meeting
- Completion of NED Appraisal Feedback
- Preparation and attendance at MHLS Committee
- Prepared for and chaired Council of Governors meeting
- Attended "Learning from Deaths in the NHS" Conference
- Completed assessments for and attended meeting regarding Clinical Excellence Awards for Consultants
- Attended Gloucestershire STP Advisory Group
- Member of Consultant Psychiatrist interview panel

Marcia Gallagher

Since her last report Marcia has;

February

- Prepared for and chaired the February Audit Committee
- Attended the Chair /NED lunch meeting
- Undertook a visit to Wotton Lawn
- Teleconference with the Director of Finance re Board report.
- Follow up meeting with Head of Art therapy and undertook a short observation of an Art therapy session
- Prepared for and attended the January Board meeting.

March

- Prepared for and attended the Council of Governors meeting
- Prepared for and attended the March Board meeting
- Attended the Appointments and Terms of Service Committee

Duncan Sutherland

Since his last report Duncan has;

February

- Prepared for and attended a Board Meeting
- Prepared for and attended the Audit Committee
- Prepared for and chaired the Charitable Funds and New Highways Committees
- Prepared for and attended the Development Committee
- Held various discussions re property issues through February

March

Verbal update at the meeting

Quinton Quayle

Since his last report, Quinton has:

February

- Prepared for and attended a Mental Health Act Managers Forum
- Participated in a Governors' visit to Wotton Lawn
- Observed two Mental Health Act Managers' Meetings
- Prepared for and attended two board meetings
- Prepared for and attended an Appointments and Service Committee
- Prepared for and chaired a Mental Health Legislation Scrutiny Committee
- Prepared for and attended a meeting of the Governors

- Prepared for and attended a meeting of the Audit Committee
- Prepared for and attended a meeting of the Charitable Trust Committee
- Prepared for and attended a meeting of New Highways
- Prepared for and attended a Mental Health Act and Mental Capacity Act Training Day
- Visited Wotton Lawn and held a discussion with the Matron
- Prepared for and attended a Serious Incident Review Meeting
- Prepared for and attended a meeting of the Delivery Committee

March

- Prepared for and attended a Serious Incident Review Meeting in Gloucester
- Prepared for and attended a board meeting
- Prepared for and attended a Serious Incident Review Meeting in Hereford
- Had a 1:1 with the Deputy Chief Executive
- Prepared for and chaired the Mental Health Legislation Scrutiny Committee
- Prepared for attended by teleconference a Mental Health Act Managers Forum
- Attended an Audit Committee lunch
- Prepared for and attended a meeting of the Delivery Committee
- Prepared for and attended interviews for 2gether Consultant Psychiatrists

Maria Bond

Since her last report, Maria has:

February

- Prepared for and attended the Audit Committee
- Attended a Bevan Brittan Training session on 'Trustees' role and legal responsibilities'
- Attended Training on 'Mental Health Act' and 'Mental Capacity Act'.
- Held a 1:1 Meeting with Marie Crofts
- Held a 1:1 Meeting with Jane Melton
- Attended a NED Lunch
- Carried out a visit to Wotton Lawn
- Prepared for and attended the Governance Committee
- Met with Colin Merker prior to Delivery Committee
- Prepared for and Chaired the Delivery Committee
- Met with the Executive Director lead and NED regarding Governance Committee
- Observed a MHAM hearing at Charlton Lane
- Prepared for and attended the Board.

March

- Attended the staff ROSCA awards
- Prepared for and attended a Council of Governors meeting
- Observed a MHAM hearing at Charlton Lane
- Sat on a MHAM hearing panel at Charlton Lane
- Prepared for and Chaired a Delivery Committee
- Met with Colin Merker ahead of Delivery Committee
- Prepared for and attended a Board meeting
- Attended an NHS Conference

4. OTHER MATTERS TO REPORT

There are no specific matters to be drawn to the attention of the Board at the time of writing.

[2]GETHER NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING
TUESDAY 17 JANUARY 2017
BUSINESS CONTINUITY ROOM, RIKENEL, GLOUCESTER

PRESENT:	Ruth FitzJohn *(Chair)*	Hazel Braund	Alan Thomas
	Vic Godding	Jo Smith	Paul Grimer
	Rob Blagden	Paul Toleman	Cherry Newton
	Jennifer Thomson	Hilary Bowen	Ann Elias
	Richard Butt-Evans	Said Hansdot	Svetlin Vrabtchev
	Pat Ayres		

IN ATTENDANCE: Colin Merker, Deputy Chief Executive
Gordon Benson, Assist Director of Governance (Item 5)
Maria Bond, Non-Executive Director
Anna Hilditch, Assistant Trust Secretary
John McIlveen, Trust Secretary
Quinton Quayle, Non-Executive Director
Neil Savage, Director of Organisational Development
Jane Melton, Director of Engagement and Integration
Kate Nelmes, Communications Manager (Item 10)
Nikki Taylor, Contracts Manager (Item 8)

1. WELCOMES AND APOLOGIES

1.1 Apologies for the meeting had been received from Dawn Lewis, Roger Wilson, Jenny Bartlett, Mervyn Dawe, Katie Clark, Amjad Uppal, Elaine Davies and Tristan Lench. Shaun Clee had also sent his apologies, and Colin Merker would deputise for Shaun at the meeting.

1.2 Governors were asked to welcome Neil Savage to his first meeting of the Council. Neil was appointed as the Trust's new Director of Organisational Development from 28 November 2016.

2. DECLARATION OF INTERESTS

2.1 There were no changes to the declaration of interests and no conflicts of interest with those items scheduled for discussion at the meeting.

3. COUNCIL OF GOVERNOR MINUTES

3.1 The minutes of the Council meeting held on 10th November were agreed as a correct record, subject to a change in the attendance list to include Maria Bond as 'in attendance' and to record Elaine Davies' apologies.

4. MATTERS ARISING, ACTION POINTS AND EVALUATION FORM

4.1 The Council reviewed the actions arising from the previous meeting and noted that the majority of actions had been completed, or were progressing to plan. The inclusion of more detail against "completed" actions was helpful by way of tracking progress and adding additional assurance of completion.

4.2 Action 13.2 - A request was made that information about key media issues could be shared with Governors as appropriate. Colin Merker noted that this action had arisen in relation to the STP process and he advised that the Head of Communications had emailed all Governors following the last meeting with copies of both the Gloucestershire and the Herefordshire & Worcestershire STP. Rob Blagden suggested that it would be helpful to have a process in place to ensure that Governors were kept up to date with all potential media stories. It was acknowledged that it is not always easy to predict which of the Trust's thousands of daily activities will appear in the media. Jane Melton agreed to follow up this request and aim to ensure that all Governors were briefed and informed in advance of any media stories that could appear in the local press.

ACTION: Jane Melton will aim to ensure that all Governors were briefed and informed in advance of any media stories that could appear in the local press.

4.3 Action 15.2 – Colin Merker had agreed to produce a briefing note for Governors regarding Out Of County Placements and any associated costs to the Trust. Colin expressed his apologies that this had not yet been completed and it was agreed that this action would be carried forward to the next meeting.

5. QUALITY REPORT 2016/17 AND QUALITY PRIORITIES 2017/18

Quality Report Quarter 2 2016/17

5.1 The Council received the 2016/17 Quarter 2 Quality Report, which showed the progress made towards achieving targets, objectives and initiatives identified in the Annual Quality Report.

5.2 Gordon Benson advised that at the end of Quarter 2, there were two confirmed targets which would not be met by year end:
1.3 – Joint CPA reviews for young people transitioning to adult services
3.2 – Reduction in the number of detained patients who are AWOL

As at the end of Quarter 3, Gordon informed the Council that two further targets had not been achieved:
3.1 – Reduction in the numbers of reported deaths by suspected suicide,
3.3 – 5% reduction in the number of prone restraints on adult wards/PICU.

5.3 Gordon Benson assured the Governors that all targets would continue to receive considerable focus through operational management systems, wider work streams such as the Patient Safety Improvement Programme, and sub-committees such as the Positive & Safe Sub-Committee. It was confirmed that these targets did not have any links to the Trust's CQUINs and there would be no financial penalties for non-achievement.

Quality Report 2016/17 Audit Process

5.4 The Council was informed that NHS Improvement guidance was currently unavailable for the external assurance report which will be provided by Deloitte; however, Deloitte understand that it is unlikely there will be significant changes in the Quality Report assurance requirements. Therefore, in keeping with

previous guidance the Trust was working on the assumption that one locally chosen Governor indicator would still be required in addition to two mandated indicators. On this basis the Council was presented with the potential options for auditing under the set domain headings of effectiveness, user experience and safety.

5.5 Rob Blagden said that the Governors had discussed this report at its pre-meeting and it was agreed that it would have been helpful to have received this paper much earlier to give Governors the opportunity to think about the appropriate indicators to audit. This useful feedback would be taken on board for future years.

5.6 On review of the indicators, the Council asked that 2 of the mandated indicators be reviewed, to include Minimising delayed transfers of care and/or either of the remaining two - Admissions to inpatient services that had access to crisis resolution home treatment teams; and 100% enhanced Care Programme Approach (CPA) patients receive follow-up contact within seven days of discharge from hospital. The Governors agreed that their locally selected indicator for auditing this year would be to "Reduce the numbers of deaths by suicide of people in contact with services".

2017/18 Quality Report Development

5.7 Gordon Benson advised that the Trust was currently considering quality priorities for inclusion in the 2017/18 Quality Report, working with colleagues within the organisation and externally. The Governors were invited to provide suggestions for potential indicators, to be submitted to the Assistant Director of Governance & Compliance no later than 31 January 2017.

6. NON-EXECUTIVE DIRECTOR RECRUITMENT

6.1 Neil Savage presented this report to the Council of Governors, outlining the process that had been followed for the recent recruitment of a new Non-Executive Director.

6.2 The Council had received a report at its November 2016 meeting regarding the appointment process for a new Non-Executive Director, which was required to bring the Board up to its full complement following Charlotte Hitchings' resignation. Following the last NED recruitment exercise in May 2016, a number of potentially suitable candidates had come forward to enquire about additional NED vacancies, leading to a view from the Trust that a full national search campaign may not be needed to produce a satisfactory field of candidates. It was felt that a locally focused recruitment process could be successful and also achieve a cost saving. The Council had agreed that should the local recruitment campaign prove unsuccessful, a full national recruitment process would be undertaken in partnership with Gatenby Sanderson.

6.3 By the closing date, 5 applications had been received and the long listing discussion took place on 14 December with Gatenby Sanderson and the Trust. The long listing recommendations were that there were only two applicants who fully met the role specification. The proposal was put forward to the governor members of the interview panel that the Trust put both candidates forward to

interview without the need of the originally scheduled shortlisting meeting. Copies of the candidates' CVs and applications were shared at this point, with governor members being asked to confirm that they were happy with this approach. Despite initial agreement to this approach, subsequent discussions took place about the suitability of the candidates and it was agreed that a formal shortlisting meeting would be arranged. This meeting took place on 4 January 2017 and was attended by all members of the interview panel. Following a review of Gatenby Sanderson's longlisting recommendations, the Chair then asked the Governors individually for their views on the applicants' match to the role specification and whether or not they should be put forward to full interview stage. Following careful debate it was agreed that none of the applicants should be put forward to interview. Having concluded this it was agreed that the discussion groups and interviews scheduled for 6 January would be cancelled.

6.4 A Nominations and Remuneration Committee meeting was held on 10 January, and the Committee agreed to inform the Council that the current recruitment cycle had been completed without appointment, and to recommend that a short-life working group be convened, supported by the Director of OD, to review the process and make recommendations for the future provision of NED appointments to the full Council meeting in March 2017. This would look particularly at membership, process and support for the Nominations and Remuneration Committee and the governor interview panel.

6.5 It was also agreed that the Council would be apprised of the following specific learning points from the most recent local recruitment campaign:-

- The specific skills requirement for Human Resources / Organisational Development expertise for the 7th NED appointment had not been discussed and agreed with Governors in advance of the advertising.
- There was some avoidable ambiguity around the use and role of the Trust's contracted search agency Gatenby Sanderson for this recruitment campaign. Some governors had assumed that the use of a local recruitment campaign would mean that the agency wouldn't be used for any advertising or other elements of the process.
- The meeting agreed that the long listing which had been managed by Gatenby Sanderson and reported back to the Trust, should have involved a representative from the governors' interview panel.
- It was also agreed that the governors' interview panel should have had access to all applications, not just the long listing recommendations, prior to the discussion about shortlisting.
- In hindsight, the governors on the interview panel felt they should not have accepted the long listing recommendations. However, it was acknowledged that the governors and the Trust had worked quickly and appropriately to review and remedy this.
- The meeting concluded that the current approach of an ad hoc Nominations and Remuneration Committee appeared to have led to a situation where the process did not feel as owned by the Council as it should be.
- Finally, there was a discussion on respective roles in the NED appointment process. This discussion confirmed that the Nominations and Remuneration Committee leads and controls the appointment process on the behalf of the Council of Governors. In support of this the Trust provides administrative support and advice to both the Committee and the interview panel.

6.6 Ruth FitzJohn said that on reviewing the agreed process, 95% had been followed; however, she acknowledged that there were some mistakes, namely the proposal to cancel the planned shortlisting meeting and the lack of involvement of Governors in the longlisting. Al Thomas said that he did not believe that the Trust had a proper process in place for NED recruitment and he reiterated the need for Governors to be involved in all steps of the process from the beginning, including the agreement of the job description, advert and interviews.

6.7 There was agreement all round that the recruitment of the Chair and NEDs was the responsibility of the Governors and it was important that whatever process was agreed ensured that the Governors had this involvement and ownership at every level.

6.8 The Council approved the convening of a short-life working group to review, develop options and make recommendations for the future provision of NED appointments to the full Council meeting in March 2017. A meeting of the group would be set up ASAP with the view of getting a draft report for consideration by the end of February. The following Governors volunteered to participate in this group: Rob Blagden, Vic Godding, Al Thomas, Cherry Newton, Hilary Bowen, Richard Butt-Evans and Jennifer Thomson. All Governors were invited to feed in any comments or queries about the process that could be considered by the working group. Neil Savage agreed to contact those interested Governors about dates.

ACTION: Neil Savage to contact those Governors who had volunteered to take part in a short life working group on NED recruitment to arrange a meeting, with the aim of producing a draft process paper by the end of February.

7. GOVERNOR OBSERVATION AT BOARD COMMITTEES

7.1 In May 2016, the Council supported a proposal to trial Governor observation at Board Committees by way of supporting Governors in their statutory duty to hold the Non-Executive Directors to account for the performance of the Board. This trial covered four additional Committees - Delivery, Development, Governance and Mental Health Legislation Scrutiny, as well as the Audit Committee where observation had been taking place for some time.

7.2 It was agreed that a review of the Observation trial would be carried out in January 2017 to see whether this was working effectively and whether those Governors participating in the trial had felt that this had been of benefit to them.

7.3 The Governors had discussed this item at the pre-meeting and it was agreed that all Governors who had participated in the observation trial had found this of huge benefit. One area which it was felt required further consideration was how to get better feedback from Governors on the process. There was a suggestion that an item be added to future meeting agendas to provide feedback to the full Council on the meetings that had been attended. Ruth FitzJohn agreed that it was important to be able to provide feedback but she asked the Governors to ensure that they were clear that any feedback about their observations related only to the performance and assurances around the NEDs, and not on the

content of the meetings as this was not the intention. A summary of the content of Board Committee meetings was already provided at each Board meeting, the papers for which were available to all Governors.

7.4 Jo Smith attended meetings of the Governance Committee with Vic Godding and she said that she had welcomed the opportunity and had a much better understanding of Trust business because of it. She advised that if there was anything raised at the meetings that was of any concern then she would raise this with the Trust straight away, rather than waiting for a scheduled feedback session. Vic Godding agreed, noting that the process currently in place worked well.

7.5 Ruth FitzJohn welcomed the views of Governors. It was noted that it was a Trust decision as to whether or not Governors continued with this observation process and given the preference of Governors to continue, she agreed to contact all Board Committee Chairs following the meeting to ensure that people were happy for this to continue.

7.6 The Council agreed that the protocol for Committee observation would be updated slightly to state that each Committee could have 2 Governor observers in attendance at each meeting.

ACTION: Ruth FitzJohn to contact all Board Committee Chairs to ensure that they were content for the observation of Board Committees to continue and for both nominated Governor observers to be present at any given Committee

ACTION: Protocol for Committee observation to be updated to state that each Committee could have 2 Governor observers in attendance at each meeting.

7.7 The Assistant Trust Secretary would contact all Governors to canvass people's interest in participating. A list of all future meeting dates would be included in the information and Governors were asked to consider their availability for these meetings before putting themselves forward. A Committee description for the Audit Committee would also be included. A review of the observation process would be scheduled annually.

ACTION: Anna Hilditch to contact all Governors asking for expressions of interest in attending and observing the Board Committees during 2017

ACTION: Audit Committee to be included in the Committee description and dates information before circulating to Governors

8. DRAFT SERVICE PLANNING OBJECTIVES 2017/18

8.1 Every year the Trust develops service plans for the forthcoming financial year (April – March.) The service plans contain objectives to provide continuous quality of care to service users, carers, staff and volunteers within financial constraints. These service plans are an integral part of the Trusts Strategy and Operational plans. This report provided the Council with details of the service

planning process and timescales for 2017/18, and provided an update on completed and planned activities.

8.2 The Council of Governors was pleased to receive the opportunity to comment on this early iteration of the service plan, noting that there was still time to incorporate key comments and reflections.

8.3 Rob Blagden had received some comments from Jenny Bartlett in her absence which he asked to be considered. These included:

- Can we include a reference to the direction of travel – where are we now and where do we want to get to? Can we benchmark?
- Not all of the objectives are measurable or SMART
- There is a need to ensure that the service objectives and the corporate objectives are presented in a like for like format with the same headings
- It would be helpful to include a RAG rating for visual presentation

Other comments received from the Governors included:

- The heading of the tables should read "2017/18", not 2016/17 as currently stated
- A review of the wording of some objectives would be helpful e.g. sickness absence "we will achieve 4%". If possible we would like to achieve better than 4%

8.4 Nikki Taylor welcomed these comments and would go back to the Director of Finance to ensure that these were incorporated where appropriate. She noted that timelines for the achievement of objectives had not yet been included but assured the Council that these would be included in the final version of the plan.

8.5 Governors were invited to provide further comment on the draft service plans and to send these to Nikki via Anna Hilditch, by close of play on 27th January.

9. CHIEF EXECUTIVE'S REPORT

9.1 Colin Merker provided the Chief Executive's report to the Council of Governors, which was intended to draw Governors' attention to key areas for awareness, information or for exploring further if of sufficient interest. Colin expressed his apologies for the late circulation of the report to Governors; however, the Council fully appreciated the current pressures within the Executive team.

9.2 This briefing provided the Council of Governors with an update in relation to a number of issues since the Council meeting on 10th November 2016, including:

- Sustainability and transformation plans – Herefordshire & Worcestershire and Gloucestershire
- Local Contract Positions
- Our 2016/17 Financial Position
- IAPT recovery plan
- Children and Young People's Services (CYPS/CAMHS) update
- Alexandra Well-being House – Gloucestershire
- Extension of Liaison and Diversion Services in Gloucestershire
- National Patient Survey Results 2016
- National staff survey 2016

9.3 The Council noted that the Trust had recently received its CQC National Community Mental Health Patients Survey results (adults) 2016, for Herefordshire and Gloucestershire. The 2016 National Staff Survey results were expected by the end of February 2017. Governors were asked to consider whether they wished to receive combined feedback on the Staff Survey and Patient Survey results, to either a full meeting of the Council and/or via a small Task and Finish Group. Following discussion it was agreed that a presentation on both should be presented at a full Council meeting; however, a number of Governors expressed an interest in looking at the results of the surveys in more detail in advance of such a presentation taking place and this would be facilitated.

ACTION: A presentation on both the Patient Survey and the Staff Survey would be scheduled for presentation at a full Council meeting

ACTION: A session would be set up for interested Governors to look at the results of the Patient and Staff surveys in more detail in advance of being presented at a Council meeting

9.4 Hilary Bowen thanked Colin Merker for his report and noted the huge amount of time and effort currently being put in by members of the Executive Team. She asked whether this high volume of workload was sustainable. Colin Merker informed the Council that there were always peaks in demand, with increased requirements around performance management and it could be very challenging. He assured the Council that 2gether voiced its concerns where appropriate but the team was committed to getting on with it and continuing to provide safe and quality services.

9.5 Al Thomas noted the updates in relation to IAPT and Hospital Liaison services and he asked what the impact of not receiving additional funding would have on these services. Colin Merker confirmed that the services would continue to be provided but the level of the service could be affected. He said that this was a whole system issue, with huge pressure currently on the acute Trust so 2gether would continue to work with and support commissioners.

10. MEMBERSHIP REPORT

10.1 Jane Melton provided an update for the Council of Governors about membership activity, the membership development plan and Governor Engagement Events.

10.2 In terms of membership statistics, the Council noted that there continued to be a steady increase in the number of members, including in respect of under-represented groups. At the end of December, the Trust had a total of 7737 members – 5300 Public members and 2437 Staff members. However, it was noted that a recent review of the membership database has highlighted a large number of 'undeliverable' newsletters, sent either by post or via email. It is estimated that cleansing the database of these members (many of whom have moved without leaving a forwarding address) could lead to a loss of approximately 100 members.

10.3 Plans were being made for Governor engagement events, including an event at Gloucestershire College's Cheltenham Campus on 2 February 2017, and a

possible event at Stroud College soon after. Governors who wished to hold an event within their constituencies were encouraged to contact Kate Nelmes, Communications Manager who would assist in the organisation of these.

11. KEY ISSUES FOR DISCUSSION FROM THE GOVERNOR PRE-MEETING

11.1 Rob Blagden said that a number of the key discussion points from the pre-meeting had already been raised and responded to elsewhere in the meeting.

11.2 One item discussed related to a forward work plan for the Council of Governor meetings. It was agreed that it would be helpful for the Governors to see future agenda items in advance to enable them to prepare; as currently Governors were only informed of the items to be presented at each meeting when they received the papers. Ruth FitzJohn agreed that this was a very sensible development and asked that all future papers include a forward work plan for the coming year.

ACTION: Future Council papers to include a forward work plan for the Council of Governors for the coming year.

12. GOVERNOR ACTIVITY

12.1 Governors updated the Council about activities they had undertaken in their role as a Governor. Some of these included participating in a visit to Wotton Lawn in Gloucester, a visit to IAPT services in Herefordshire, the opening of Alexandra Well-being House and attendance at the November Board meeting in Hereford. Ann Elias had also taken part in this year's ROSCAs judging panel and would be attending the awards evening.

12.2 Paul Toleman advised that the Gloucestershire Health Overview and Scrutiny Committee would be undertaking a review of homelessness and it was agreed that it would be helpful for the final report from this review to be shared with the Trust for information.

13. HOLDING TO ACCOUNT – ENGAGEMENT

13.1 Jane Melton and Ruth FitzJohn gave the Council a presentation focussing on Engagement, looking at examples of engagement carried out within the Trust, and specifically by Board members.

Who do we engage with?	How do we know how we're doing?
Customers Patients, Carers	• 2016 CQC survey results; FFT; • Service Experience Reports; Pt Story • Triangle of Care survey; 15 Steps
Contributors Staff members, Volunteers, students	• Staff survey results; • Volunteer FFT; • University feedback

Commissioners CCG, GCC, GPs, Universities, Research Funders	• Cooperation with developments • Funding for new research (Cobalt) • Partnership agreements
Collaborators Strategic partners / Other NHS Private bodies, Voluntary sector, Religious Groups, Criminal Justice / Police	• Co-location with police for MHARS • Swindon Mind development • Tackling stigma – over 100 organisations • Bishops breakfast
Commentators Healthwatch, Governors, Members, Press, Public, NHSI, Care Quality Commission, Council	• Regular connections with some commentators • More members, reaching more people • Proactive with press - +positive stories • 'Good' from CQC • HCOSC interest in scrutiny of MH

13.2 Ruth FitzJohn advised that engagement was explicitly part of the Non-Executive and Executive Director roles and gave the Council a number of examples of the type of engagement that took place, whether this is attendance at national events or softer measures such as simply having a cup of coffee and a chat with someone.

13.3 Hilary Bowen said that she had spoken to one of the Governors from the Gloucestershire Hospital's Trust who had held a Members Surgery in the Forest of Dean. She asked whether it would be appropriate for her to join them and hold a joint session. Ruth FitzJohn said that this would need thinking through and asked Jane Melton to follow this opportunity up with Hilary to discuss the details.

ACTION: Jane Melton to speak to Hilary Bowen about the opportunity of joining GHT Governors at a Members Surgery in the Forest

14. ANY OTHER BUSINESS

14.1 There was no other business.

15. DATE OF NEXT MEETINGS

Council of Governor Meetings

Business Continuity Room, Trust HQ, Rikenel		
Date	**Governor Pre-meeting**	**Council Meeting**
2017		
Thursday 9 March	1.30 – 2.30pm	3.00 – 5.00pm
Tuesday 9 May	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 13 July	9.00 – 10.00am	10.30 - 12.30pm
Tuesday 12 September	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 9 November	1.30 – 2.30pm	3.00 – 5.00pm

Board Meetings

2017		
Thursday 26 January	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 30 March	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 25 May	10.00 – 1.00pm	Kindle Centre, Hereford
Thursday 27 July	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 28 September	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 30 November	10.00 – 1.00pm	Kindle Centre, Hereford

Joint Board and Governor Development Session - Thursday 29th June at 2.00 – 5.00pm

Council of Governors
Action Points

Item	Action	Lead	Progress
10 November 2016			
15.2	Colin Merker to produce a briefing note for Governors regarding Out Of County Placements and any associated costs to the Trust	Colin Merker	**Complete**
17 January 2017			
4.2	Jane Melton will aim to ensure that all Governors were briefed and informed in advance of any media stories that could appear in the local press.	Jane Melton / Communications Team	Noted and Communications Team to be mindful of the need to brief Governors where necessary
6.8	Neil Savage to contact those Governors who had volunteered to take part in a short life working group on NED recruitment to arrange a meeting, with the aim of producing a draft process paper by the end of February.	Neil Savage	**Complete** Two meetings held and a report is scheduled on the agenda for the March Council meeting
7.6 (i)	Ruth FitzJohn to contact all Board Committee Chairs to ensure that they were content for the observation of Board Committees to continue and for both nominated Governor observers to be present at any given Committee	Ruth FitzJohn	**Complete**
7.6 (ii)	Protocol for Committee observation to be updated to state that each Committee could have 2 Governor observers in attendance at each meeting.	Anna Hilditch	**Complete** Emailed out on 31 January
7.7	Anna Hilditch to contact all Governors asking for expressions of interest in attending and observing the Board Committees in 2017 Audit Committee to be included in the Committee description and dates information before circulating to Governors	Anna Hilditch Anna Hilditch	**Complete** Emailed out on 31 January **Complete** Emailed out on 31 January
9.3	A presentation on both the Patient Survey and the Staff Survey would be scheduled for presentation at a full Council meeting A session would be set up for interested Governors to look at the results of the Patient and Staff surveys in more detail in advance of being presented at a Council meeting	Anna Hilditch	Update on Staff Survey and Patient Survey Results to be scheduled for May 2017 Council meeting. Governors interested in receiving a briefing on the survey results to notify Anna Hilditch, who will arrange a session in advance on the May meeting
11.2	Future Council papers to include a forward work plan for the Council of Governors for the coming year.	Anna Hilditch	**Complete** Included in papers for the meeting
13.3	Jane Melton to speak to Hilary Bowen about the opportunity of joining GHT Governors at a Members Surgery in the Forest	Jane Melton	**Complete** Discussion held after the January CoG Meeting