2GETHER NHS FOUNDATION TRUST

BOARD MEETING

THURSDAY 25 MAY 2017 AT 10.00AM
THE KINDLE CENTRE, HEREFORD

AGENDA

10.00	1	**Apologies**	
	2	**Declaration of Members Interests**	
10.05	3	**Minutes of the Board meeting held on 30 March 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 – Outturn 2016/17**	**PAPER B**
10.50	8	**Service Experience Report – Quarter 4**	**PAPER C**
11.00	9	**Complaints Annual Report 2016/17**	**PAPER D**
11.10	10	**Quality Report 2016/17**	**PAPER E**
11.20	11	**Non-Executive Director Audit of Complaints – Quarter 4**	**PAPER F**
11.30	12	**Annual Mental Health Legislation Scrutiny Committee Report**	**PAPER G**
BREAK – 11.40AM			
IMPROVING ENGAGEMENT			
11.50	13	**Chief Executive's Report**	**PAPER H**
12.00	14	**Annual Membership Report 2016/17**	**PAPER I**
IMPROVING SUSTAINABILITY			
12.10	15	**Summary Financial Report**	**PAPER J**
12.20	16	**Provider Licence Declarations**	**PAPER K**
12.30	17	**Board Committee Summaries** • Governance Committee – 21 April • Development Committee – 17 May • Audit Committee – 24 May • Delivery Committee – 24 May	 **PAPER L** **VERBAL** **VERBAL** **VERBAL**
INFORMATION SHARING (TO NOTE ONLY)			
12.45	18 19	**Chair's Report** **Council of Governor Minutes – March 2017**	**PAPER M** **PAPER N**
12.55	20	**Any Other Business**	
	21	**Date of Next Meeting** Thursday 27 July 2017 at Trust HQ, Rikenel, Gloucester	

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
30 MARCH 2017

PRESENT

Ruth FitzJohn, Trust Chair
Maria Bond, Non-Executive Director
Shaun Clee, Chief Executive
Dr Chris Fear, Medical Director
Marcia Gallagher, Non-Executive Director
Andrew Lee, Director of Finance and Commerce
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
Alison Curson, Deputy Director of Nursing
Anna Hilditch, Assistant Trust Secretary
Frances Martin, Director of Transformation
Bren McInerney, Member of the Public
Kate Nelmes, Head of Communications
Cherry Newton, Trust Governor
Mike Scott, Member of the Public
Carol Sparks, Director of Special Projects
Ian Stead, Healthwatch Herefordshire
Lauren Wardman, Deputy Director of Engagement

1. WELCOMES, APOLOGIES AND INTRODUCTIONS

1.1 Apologies were received from Marie Crofts, Jane Melton and Colin Merker.

2. DECLARATIONS OF INTERESTS

2.1 The Chief Executive informed the Board that he had been appointed as Chair of the LWAB Board in Herefordshire and Gloucestershire.

3. MINUTES OF THE MEETING HELD ON 26 JANUARY 2017

3.1 The minutes of the meeting held on 26 January 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 There were no questions from the public.

6. PATIENT STORY PRESENTATION

6.1 The Board welcomed colleagues from the Children and Young People's Service (CYPS) and Helen Phillips from Action for Children to the meeting who presented 2 voice recordings from current service users talking about their experience of services. The Board was also pleased to welcome Nicola to the meeting, who had provided one of the recordings.

6.2 The first recording was from a young person who had been referred to CYPS between 2013-15 for the treatment of depression and anxiety. This was a positive story, with the key points including:

- 2g referral to Action for Children was helpful and there was whole family support
- Short waiting time when self-referred back in to service
- Anxiety now reduced and seeing care-co-ordinator fortnightly
- Effective CBT: flexible to needs and has had a big impact on self-esteem
- Team: all friendly and approachable so happy to open up to them
- Positive overall experience, grown as a person, planning for future

However, there were some areas for improvement suggested, and these included:

- Limited knowledge of service and what to expect in advance
- Could have been more focus on strategies for coping with anxiety
- Would like to see care co-ordinator more frequently and for this to be goal-focused

6.3 The second recording was from a young person suffering with depression and anxiety, and psychotic symptoms whose main input with CYPS was between 2013-14. The one key positive message from this story was that the CYPS Psychiatrist really listened to her.

A number of challenges were identified from this young person's experience, as follows:

- Seen at site away from home to be seen more quickly (Cheltenham but lived in Forest of Dean)
- Limited knowledge of the service and role of care co-ordinator
- Would've liked more information about her diagnosis and strategies
- Didn't engage with care co-ordinator and only recently found out that she could change
- Would be good to have 24/7 cover from CYPS for times of crisis
- Perceived little communication between psychiatrist and endocrinologist
- Only received support from Tier 3.5 service 10 days after disclosed suicide attempt
- Felt 3.5 contact was limited
- No cover for 1month when care co-ordinator was on leave

6.4 Mel Harrison, CYPS Service Manager informed the Board that a number of developments had been put in place to improve the experience of young people accessing the service. These included:

- The development of the CYPS website as a result of feedback from young people to increase ease of access to information about conditions and services
- Have a system in place to ensure young people are aware of their ability to change care co-ordinator if they are not feeling properly engaged
- The introduction of 'what to do in a crisis' cards with necessary contact details
- Improvement of feedback channels for young people to enable them to feel comfortable about proving feedback on services and suggested improvements

6.5 The Board expressed their thanks for the time, effort and courage taken to provide the recordings at the meeting, both of which had been powerful to listen to. There were a number of themes arising from the experiences, with the key theme relating to communication. There was a need to improve communication, to tailor communications to appropriate age ranges and to ensure that young people had all the necessary information to hand to help understand what the service was, who a "care co-ordinator" was and their role, and to be able to learn more about their condition.

6.6 Marcia Gallagher raised the issue of geography and asked whether signposting had been improved as one of the young people had been unaware of a clinic in the Forest of Dean.

Mel Harrison advised that waiting lists were much longer in 2013 and the service was trying to manage this, hence the appointment had been made in Cheltenham. However, she noted that a clinic was now in place at Colliers Court.

6.7 Mel Harrison informed the Board that funding had been received from the CCG to enable services to be provided in schools, which was a very positive new development as it meant that young people could be seen at school and not need to miss lessons.

6.8 Nicola said that she agreed with the need to improve communication, such as tailoring questionnaires to appropriate age ranges and suggested using mobile apps and the website rather than letters to get in touch with people. Information should be made available to people in a way that it didn't make it feel as though they were being talked down to.

6.9 The Chief Executive thanked Nicola and Trust colleagues for attending the meeting. He said that communication had been identified as a key challenge but added that there was more to be done to look at internal processes, such as contact with the Tier 3.5 service and reallocation of caseloads during periods of sickness absence. More also needed to be done to continue to tackle the stigma of mental health services and making information available about the consequences of accessing services. The Chief Executive assured colleagues that Board members would have the opportunity to reflect further on the key points raised in the confidential Board meeting later in the day and to drill down into the themes and identify any immediate actions to be carried out.

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 January 2017 against NHSI, Department of Health, Contractual and CQUIN key performance indicators. Of the 147 performance indicators, 87 were reportable in January with 74 being compliant and 13 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 7 of the 13 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 noted the dashboard report and the assurance that this provided.

8. SAFE STAFFING 6 MONTHLY UPDATE REPORT

8.1 The purpose of this report was to update the Trust Board on the revised safe staffing guidance issued by the National Quality Board (NQB) in July 2016. This 6 monthly update provided the full update on all the expectations within the new guidance, national reporting requirements, latest developments and the latest data, and local Trust exception reporting.

8.2 The Deputy Director of Nursing advised that although the Trust had made good progress and was in a good position regarding this guidance, more work needed to be undertaken to ensure triangulation of all data.

8.3 National reporting with regards to fill rates continues to be uploaded monthly and reported to the Governance Committee on behalf of Board. The Trust continues to have high compliance with planned versus actual fill rates.

8.4 The Board noted that there were shifts where the core actual staffing hours did not exactly reflect the core planned staffing levels. One of the reasons for this was that 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.

8.5 It was agreed that this update paper offered significant assurance to the Board on current progress and monthly reporting against the revised NQB guidance. Further assurance was offered that monthly update reports on safe staffing levels were received and scrutinised at the Governance Committee.

9. SERVICE EXPERIENCE REPORT QUARTER 3

9.1 The Board received the Service Experience Report which provided a high level overview of feedback received from service users and carers in Quarter 3 2016/2017.

9.2 Significant assurance was received that the organisation had listened to, heard and understood Service User and carer experience of 2gether's services. This assurance was 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.

9.3 Significant assurance was received 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.

9.4 Limited assurance was currently being offered that people were 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.

9.5 Significant assurance was received that services were 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.

9.6 The Board was offered Full Assurance that complaints have been acknowledged in the required timescale. During Quarter 3, 100% of complaints received were acknowledged within 3 days. Limited assurance was received 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. However, this was 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 but currently this remained Limited assurance. There was significant assurance that all complainants received regular updates on any potential delays in the response being provided.

9.7 This quarter there had 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 include 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.

10. QUALITY REPORT QUARTER 3

10.1 The Board received the Quarter 3 Quality Report for 2016/17. The report showed the progress made towards achieving targets, objectives and initiatives identified in the Annual Quality Report.

10.2 Overall, there were 3 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
3.3 – Reduction in the use of prone restraint.

10.3 There was limited assurance that target 3.1 – Reduction in the numbers of reported deaths by suspected suicide and target 1.2 – Improved personalised discharge planning would be met. These targets continue to receive considerable focus by Service Directors and their operational management systems.

10.4 There have been sustained improvements across all User Experience targets, 48hr follow up and Joint CPA reviews for young people transitioning into adult services 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 year. Duncan Sutherland said that he would find it helpful to receive a more detailed briefing setting out the process for young people transitioning into adult services. It was agreed that a briefing for Board members would be prepared and shared for information.

ACTION: Briefing setting out the process for young people transitioning into adult services to be prepared and shared with Board members for information.

10.5 The Board noted the progress made to date and noted the actions in place to improve/sustain performance where possible. Additional assurance was provided that the Quality Report was received and reviewed in detail at the Governance Committee.

11. NON EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS QUARTER 3

11.1 Jonathan Vickers presented his Audit of Complaints report to the Board which was conducted covering three complaints that had been closed between 1 October and 31 December 2016.

11.2 The Board noted that the agreed aim of the audits was 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

11.3 Jonathan Vickers advised that the changes introduced to the NED Audit represented a significant improvement on the previous process; however, he suggested a number of further improvements including:

- A clear statement of the three key dates (i.e. those of the three documents provided), and the timeliness standards to be met.
- 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

11.4 The report included some positive comments about the complaints investigators, with one case suggesting that the investigator should be congratulated on having conducted a very thorough investigation into the specific incidents referenced in the complaint. The Board agreed that this could sometimes be a difficult role to carry out and asked therefore that the congratulations and positive comments be fed back to the necessary people.

ACTION: Congratulations and positive comments to be fed back to those complaints investigators recognised within the NED audit of complaints

11.5 Jonathan Vickers had highlighted some examples of language used within his audit report that it was thought might be regarded as provocative ("this complaint is not upheld"). The Chief Executive asked the Board to note that this was the language used on guidance from the Health service ombudsman.

11.6 The Board noted the content of this report and the assurances provided. Assurance was also received that the Service Experience Team had received this report for consideration of those recommendations for improvement.

12. CHIEF EXECUTIVE'S REPORT

12.1 The 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.

12.2 The Board noted that 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.

12.3 The rollout of e-rostering commenced on 6 March 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.

12.4 The Board received a briefing on the new HM Revenue and Customs rules for the payment of tax and National Insurance contributions. 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.

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.

12.5 The Board noted the Chief Executive's report

13. NHS STAFF SURVEY RESULTS 2016

13.1 The Director of OD provided an overview and analysis of the 2016 NHS Annual Staff Survey. The Board noted that the 2016 Survey was sent to all staff (1950) in post on 1st September 2016; previously the survey had been sent to a random sample of 750 staff. 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 was below the average response rate of 45% for all Mental Health/Learning Disability Trusts.

13.2 The Board noted that the Trust scored better than average or average in 28 (86%) of the 32 Key Findings when compared with other Mental Health/Learning Disability Trusts. Although some Key Findings had improved and some had worsened; there were no statistically significant changes to any of the Key Findings when compared with the 2015 survey.

13.3 It was reported that "staff engagement" was above average, with the overall score for staff engagement nationally being 3.79 (out of 5) compared with the Trust's score of 3.89. The Board noted that the vast majority of staff (97%) would report errors or incidents and there was a slight improvement in staff confidence in reporting unsafe working practice.

13.4 The Board noted that the Staff recommendation of the Trust as a place to work or to receive treatment had increased and was above average for MH/LD Trusts. Again this indicator was above average when compared with the All Trusts.

13.5 The Board noted that recommendations for improvements included focussed actions on encouraging colleagues to report bullying, harassment, abuse and physical violence, effective use of patient feedback and the promotion of the health and wellbeing of staff. The Director of OD reported that this year Service Directors and locality management boards had been asked to engage with staff locally to highlight three priorities from the survey and develop an appropriate local action plan; HR would be providing Locality Directors with area specific data in the next week.

13.6 The Board was pleased to receive this excellent report, which continued to show steady improvements year on year. Those areas for development were noted. The Board expressed their thanks to the current and former Director of OD for leading this work.

14. SUMMARY FINANCIAL REPORT

14.1 The Board received the month 11 position which was a surplus of £425k in line with the planned position. The budgets had been revised to include the £650k Sustainability and Transformation Fund monies that have been allocated to the Trust. Three quarters of this fund had been included up to 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.

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

14.3 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. Taking into account all the actions in train or planned the Trust expects to meet its 2017/18 agency control total of £3.404m.

14.4 The Board noted the Finance Report for the period ending February 2017 and the assurances received around the continuing work on reducing bank and agency expenditure, the capital programme and the materialisation of risks to the forecast outturn.

15. BOARD COMMITTEE REPORT – AUDIT COMMITTEE

15.1 Marcia Gallagher presented the summary report from the Audit Committee meeting held on 1 February. The Board noted the key points raised at this meeting and the assurance received by the Committee.

16. BOARD COMMITTEE REPORTS – DELIVERY COMMITTEE

16.1 Maria Bond presented the summary report from the Delivery Committee meeting held on 22 February. The Board noted the key points raised at this meeting and the assurance received by the Committee.

16.2 Maria provided a verbal report from the Delivery Committee meeting held on 24 March. A full written report would be presented at the next Board meeting.

17. BOARD COMMITTEE REPORT – GOVERNANCE COMMITTEE

17.1 Nikki Richardson presented the summary report from the Governance Committee meeting held on 17 February. The Board noted the key points raised at this meetings and the assurance received by the Committee.

18. BOARD COMMITTEE REPORT – MH LEGISLATION SCRUTINY COMMITTEE

18.1 Quinton Quayle presented the summary report from the MHLS Committee meeting that had taken place on 8 March. The Board noted the key points raised at this meeting and the assurance received by the Committee.

19. BOARD COMMITTEE REPORTS – CHARITABLE FUNDS COMMITTEE

19.1 Duncan Sutherland presented the summary report from the Charitable Funds Committee meeting held on 1 February. Acting in the capacity of the Board of Trustees, the key points raised at this meeting and the assurance received by the Committee was noted.

20. INFORMATION SHARING REPORTS

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

- Chair's Report
- Council of Governors Minutes – January 2017

21. ANY OTHER BUSINESS

21.1 Ruth FitzJohn, on behalf of the Board, presented Carol Sparks with an Outstanding Contribution commendation award. Carol had resigned as Director of OD in November 2016 but had continued with the Trust, leading special projects including particular focus on temporary staffing requirements. Carol would leave the Trust at the end of March. The Board expressed their thanks and best wishes to Carol.

22. DATE OF THE NEXT MEETING

22.1 The next Board meeting would take place on Thursday 25 May 2017 at The Kindle Centre, Hereford

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

BOARD MEETING
ACTION POINTS

Date of Mtg	Item ref	Action	Lead	Date due	Status/Progress
30 March 2017	10.4	Briefing setting out the process for young people transitioning into adult services to be prepared and shared with Board members for information.	Colin Merker	May	
	11.4	Congratulations and positive comments to be fed back to those complaints investigators recognised within the NED audit of complaints	Lauren Wardman / Jane Melton	May	

Agenda item 7 **PAPER B**

Report to: Trust Board – 25th May 2017
Author: Chris Woon, Head of Information Management and Clinical Systems
Presented by: Chris Woon, Head of Information Management and Clinical Systems

SUBJECT: **Performance Dashboard Report for the contract year 2016-2017**

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

EXECUTIVE SUMMARY:

Overview

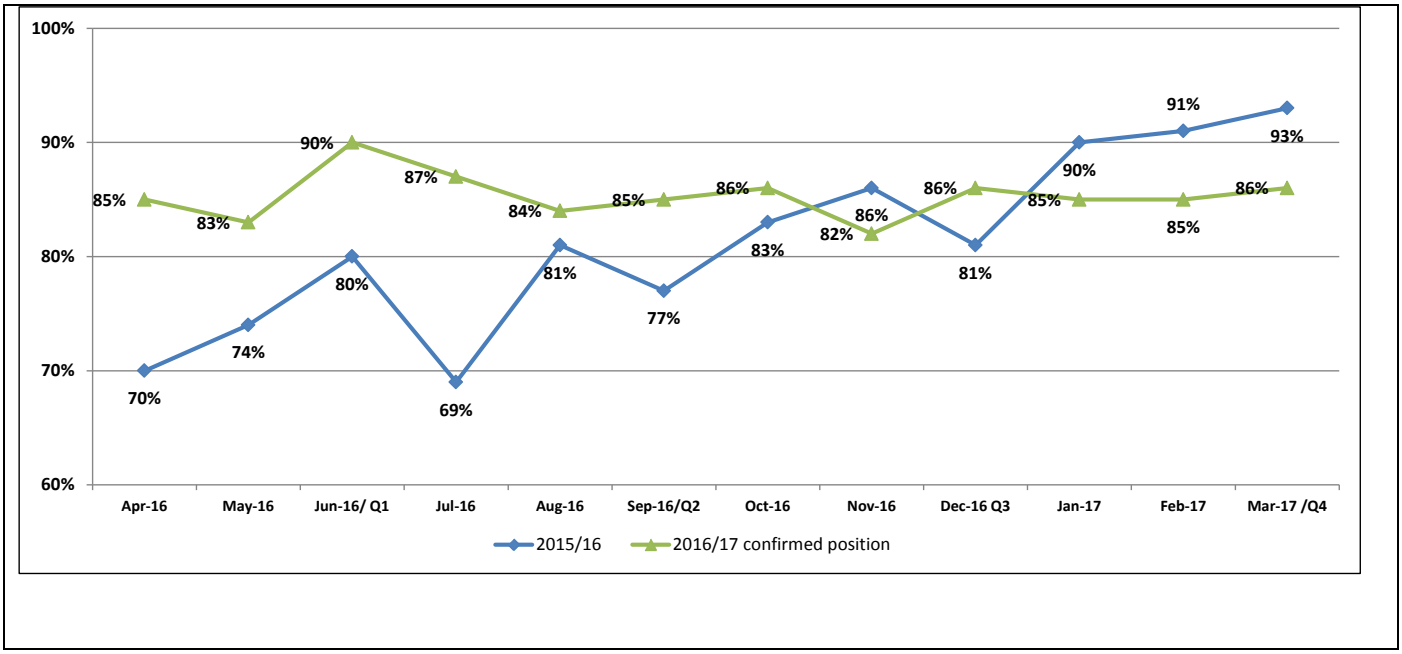
This outturn report sets out the performance of the Trust for the full 2016/2017 contract period against our NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

Of the 132 reportable measures, 113 are compliant and 19 are non-compliant. Of the remaining 15 indicators, 1 is not yet available, 7 are for baseline information to inform future reporting and 7 have had either no activity or insufficient activity recorded against them during the year to support reliable performance reporting.

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

Indicators Reported in 2016/17 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	9	4	23	0	0
Never Events	17	17	17	0	0	0	0
Department of Health	10	9	7	2	25	1	1
Gloucestershire CCG Contract	56	49	42	7	11	6	0
Social Care	15	13	10	3	23	2	0
Herefordshire CCG Contract	25	20	17	3	10	5	0
CQUINS	11	11	11	0	0	0	0
Overall	147	132	113	19	14	14	1

The following graph shows our percentage compliance by month and the previous year's compliance for comparison.



Summary Exception Reporting

The following 19 key performance thresholds were not met either by the end of the reporting period or at some time during the reporting period:

NHS Improvement Requirements

- 1.02 – Number of CDiff cases - avoidable
- 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

Gloucestershire CCG Contract Measures

- 3.01 – Zero tolerance MRSA
- 3.02 –Minimise rates of CDiff (unavoidable)
- 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.
- 3.38 – Transition of young people to adult recovery service
- 3.43 – LD: Annual health check – notification to GP and offer of support

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

- 5.06 – Minimise rates of Clostridium difficile – avoidable
- 5.08 – IAPT Recovery rate
- 5.09 – IAPT maintain 15% of patients entering the service against prevalence

There is currently 1 measure labelled as Not Yet Available to report

- 3.36 - GP Practices will have an individual (MH) ICT service meeting to review delivery and identify priorities

Where non-compliance has highlighted issues within a service, Service Directors have taken the lead to address issues and indicators have been "red flagged" to show where further analysis and work has been undertaken to fully scope data quality and performance issues.

Section 2 of this report provides a detailed commentary on indicators which did not meet the required performance threshold level during the final month of the year and also cumulatively for the 2017-17 reporting period.

RECOMMENDATIONS

The Board is asked to:

- Note the Performance Dashboard Report for the full 2016-17 contract period
- 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	May 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 AHC Annual Health Check 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 complete 2016-17 contract period.

1.1 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 completion of the 2016-17 contract period. 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 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
	Jan	Feb	Mar	
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

Gloucestershire have reported 67 new cases against an expected threshold of 72 new cases and Herefordshire 20 new cases against an expected threshold of 24 new cases. In total the Trust is 9 cases below the 96 new cases anticipated by the end of March.

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
There were 3 unavoidable incidents in Herefordshire during 2016/17. Although non-contributory, issues relating to cleanliness were identified as part of the investigation and have been addressed.

There were 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
None

Early Warnings / Notes
None

NHS Improvement Requirements

ID	Performance Measure (PM)		2015/16 Outturn	January-2017	February-2017	March-2017	2016/17 Outturn
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%	99%	98%	100%	98%
		Herefordshire	96%	100%	100%	100%	99%
		Combined Actual	96%	99%	99%	100%	98%
1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%
		Gloucestershire	99%	99%	99%	99%	99%
		Herefordshire	98%	99%	99%	99%	99%
		Combined Actual	99%	99%	99%	99%	99%
1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%
		Gloucestershire	1.0%	1.4%	1.4%	0.0%	1.6%
		Herefordshire	1.2%	2.1%	2.7%	0.6%	2.2%
		Combined Actual	1.0%	1.5%	1.7%	0.2%	1.8%
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	60	66	72	72
		Gloucestershire	76	54	61	67	67
		PM	24	20	22	24	24
		Herefordshire	41	19	19	20	20
		PM	92	80	88	96	96
		Combined Actual	117	73	80	87	87
1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%
		Gloucestershire	66%	100%	71%	50%	72%
		Herefordshire	61%	N/A	N/A	100%	70%
		Combined Actual	64%	100%	71%	57%	71%

NHS Improvement Requirements

ID	Performance Measure		2015/16 Outturn	January-2017	February-2017	March-2017	2016/17 Outturn
1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%
		Gloucestershire	87%	36%	40%	45%	35%
		Herefordshire	95%	29%	34%	34%	49%
		Combined Actual	89%	34%	39%	43%	38%
1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%
		Gloucestershire	99%	86%	90%	94%	86%
		Herefordshire	99%	73%	72%	79%	85%
		Combined Actual	99%	83%	88%	92%	86%
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%	99.9%	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%	100.0%	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%	99.8%	99.8%
		Herefordshire	99.6%	99.9%	99.9%	100.0%	99.8%
		Combined Actual	99.5%	99.9%	99.9%	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%	99.6%	99.5%	99.4%
		Herefordshire	99.5%	99.6%	99.6%	99.7%	99.7%
		Combined Actual	99.2%	99.5%	99.6%	99.6%	99.5%

NHS Improvement Requirements

ID	Performance Measure		2015/16 Outturn	January-2017	February-2017	March-2017		2016/17 Outturn
1.12	**MENTAL HEALTH SERVICES DATA SET PART 2 DATA COMPLETENESS : OVERALL**	PM	50%	50%	50%	50%		50%
		Gloucestershire	97.9%	95.6%	95.5%	95.7%		95.7%
		Herefordshire	95.3%	91.6%	91.8%	91.1%		92.5%
		Combined Actual	97.4%	94.9%	94.8%	94.8%		95.1%
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%	90.0%	90.0%	90.3%		90.0%
		Herefordshire	93.7%	88.0%	88.3%	87.0%		89.2%
		Combined Actual	96.4%	89.6%	89.7%	89.7%		89.9%
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%	97.1%	97.0%	97.2%		97.3%
		Herefordshire	93.8%	88.3%	88.6%	87.3%		89.6%
		Combined Actual	96.5%	95.5%	95.4%	95.3%		95.9%
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%	99.7%	99.5%	99.6%		99.6%
		Herefordshire	98.5%	98.6%	98.6%	98.9%		98.5%
		Combined Actual	99.4%	99.5%	99.3%	99.5%		99.4%
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
	Jan	Feb	Mar	
Total Measures	27	27	27	27
	2	1	2	2
	24	24	23	24
NYA	0	0	0	0
NYR	0	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 during March, 1 in Gloucestershire and 1 in Herefordshire.

In Gloucestershire a 17 year old, presenting with acute psychotic episode was admitted to Wotton Lawn under section 2 of the Mental Health Act. The patient was admitted 11 days prior to turning 18 and at the time of reporting remains on Priory ward.

In Herefordshire a 15 year old with suicidal ideation was admitted to Stonebow Unit and put on leave to Wye Valley Trust's children's ward under section 2 of the Mental Health Act. The patient was moved to a Tier 4 provision the next day.

2.26: Interim report for all SIs received within 5 working days
During March there was one late *interim* report submission for Herefordshire due to human error. Commissioners are informed of all SI report delays and the Trust maintains a priority to submit all *final* reports on time. To manage the high SI workload and mitigate this issue the patient safety team is expanding its investigator and administration resourcing which will add the capacity to monitor interim SI report deadlines more closely and avoid reoccurrences in 2017/18.

Cumulative Performance Thresholds Not being Met

2.21: No children under 18 admitted to adult inpatient wards
During 2016-17 there were 18 admissions, 10 admissions in Gloucestershire and 8 in Herefordshire. This is 3 more admissions than reported for 2015/16.

2.26: Interim report for all SIs received within 5 working days of identification
There were 5 late submissions during 2016-17, 3 for Gloucestershire and 2 for Herefordshire.

Changes to Previously Reported Figures

None

Early Warnings

None

DOH Never Events

ID	Performance Measure		2015/16 Outturn	January-2017	February-2017	March-2017	2016/17 Outturn
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	January-2017	February-2017	March-2017	2016/17 Outturn
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	1	1	1	10
		Herefordshire	4	1	0	1	8
		Combined	15	2	1	2	18
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	January-2017	February-2017	March-2017	2016/17 Outturn
2.24	Serious Incident Reporting (SI)	Glos	32	5	2	0	35
		Hereford	11	1	0	1	8
2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%
		Gloucestershire	100%	100%	100%	N/A	100%
		Herefordshire	100%	100%	N/A	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		80%	100%	N/A	91%
		Herefordshire		100%	N/A	0%	78%
2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM		100%	100%	100%	100%
		Gloucestershire		100%	NYR	NYR	100%
		Herefordshire		100%	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	2	0	2
		Herefordshire	0	0	0	1	1

DASHBOARD CATEGORY – GLOUCESTERSHIRE CCG CONTRACTUAL REQUIREMENTS

Gloucestershire Contract				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	56	56	56	56
	3	3	5	7
	13	13	44	42
NYA	0	0	1	1
NYR	39	39	0	0
UR	0	0	0	0
N/A	1	1	6	6

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
During quarter 4 of 2016-17 contract period it was recognised that this indicator no longer gave a meaningful indication of performance within the new pathway model. However for consistency of reporting performance, we continued to include it for the remainder of the 2016/17 financial year. Negotiations are being held with Commissioners to remove this indicator for 2017/18.

3.38: Transition of young people to adult recovery service.
This is a new indicator in 2016/17 and to ensure compliance against the 100% performance threshold, each of the following must be carried out and captured within 28 days of the Recovery service accepting a referral from CYPS.

- Joint CPA Review
- Risk Assessment
- Confirmed diagnosis
- Allocated adult Care Coordinator
- Care plan uploaded with cluster recorded

Processes for measurement were only in place during the 4th quarter of the year and during this period there were 3 transitions. For each of these cases a different part of the procedure was not captured in a timely manner.

Work is ongoing in both the CYPS service and the Recovery service to ensure that all stages are carried out and recorded within the required 28 days.

3.43: LD: Annual health check – notification to GP and offer of support
This is an annual indicator with an audit process to ascertain compliance. Of the 10 random cases that were audited, 65% contained a date of the last Annual Health Check (AHC) or indicated that a prompt had been given. Recent measures to increase recording on RiO have included:

- Easy read summary care plans for new referrals with a prompt regarding AHCs
- Team Managers being reminded of the need to record
- Road Shows have been facilitated which include reminding clinicians where to record.
- Consultant Psychiatrists are now recording the date of the last AHC in their clinical letters.

Consideration is also being given on how to electronically audit the data.

<u>Cumulative Performance Thresholds Not being Met</u>

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 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 was applied and it was recorded as unavoidable. Routine screening for all admissions across Charlton Lane has been introduced.

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

3.38: Transition of young people to adult recovery service.
As above

3.43: LD: Annual health check – notification to GP and offer of support
As above

Changes to Previously Reported Figure
None

Early Warnings/Notes
None

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	January-2017	February-2017	March-2017	2016/17 Outturn
	B. NATIONAL QUALITY REQUIREMENT						
3.01	Zero tolerance MRSA	PM	0	0	0	0	0
		Unavoidable	0	0	0	0	1
3.02	Minimise rates of Clostridium difficile	PM	0	0	0	0	0
		Unavoidable	0	0	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%	99%	99%
3.06	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	PM	90%	90%	90%	90%	90%
		Actual	85%	99%	97%	99%	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			Report	Report
		Actual	Complete			Complete	Complete
3.08	To reduce the numbers of detained patients absconding from inpatient units where leave has not been granted	PM				<36	<144
		Actual				15	96
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	PM
		Actual				Compliant	Compliant
3.10	Minimum of 5% increase in uptake of flu vaccination (15/16 55.3%)	PM				>55.3%	>55.3%
		Actual				77.2%	77.2%

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	January-2017	February-2017	March-2017	2016/17 Outturn
	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%	95%	93%	93%	93%
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%	100%	99%
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%	99%	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				85%	85%
		Actual				95%	95%
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%	100%	89%	87%	95%
3.17	AKI (previous CQUIN 1516) 95% of pts to have EWS score within 12 hours	PM				95%	95%
						100%	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%	47%	45%	49%	47%
3.19	IAPT access rate: Access to psychological therapies for adults should be improved	PM		12.50%	13.75%	15.00%	15.00%
		Actual		6.45%	7.29%	8.20%	8.20%
3.20	IAPT reliable improvement rate: Access to psychological therapies for adults should be improved	PM	N/A	50%	50%	50%	50%
		Actual	55%	84%	72%	73%	73%
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	100%	100%
3.22	To send :Inpatient and day case discharge summaries electronically, within 24 hours to GP	PM				Report	Report
		Actual				Compliant	Compliant

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	January-2017	February-2017	March-2017	2016/17 Outturn
	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	Annual
		Actual	Compliant			Compliant	Compliant
	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%	89%
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%	96%
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%	96%	93%	94%	94%
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%	65%	70%	69%	65%

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	January-2017	February-2017	March-2017	2016/17 Outturn
	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 on the caseload during the year 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%**	50%
		Actual	45%			52%	52%
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%	50%
		Actual	65%			66%	66%
3.34	The number of people supported to retain employment at 3/6/9/12+ months	PM	50%			50%	50%
		Actual	73%			88%	88%
3.35	Fidelity to the IPS model	PM	Annual			Report	Report
		Actual	NYA			Compliant	Compliant
	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	Annual
		Actual	NYA			NYA	NYA
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 4
		Actual				Compliant	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				0%	0%
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%	90%
		Actual				N/A	N/A
3.40	MHARS wait time to assessment (4 hours)	PM				TBC	TBC
		Actual				N/A	N/A

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	January-2017	February-2017	March-2017	2016/17 Outturn
	New KPIs for 2016/17 LD						
3.41	To define LD clearly and the route into specialist LD service	PM				Annual	Annual
		Actual				Compliant	Compliant
3.42	LD: To implement Pathways for work within specialist service with easy read supporting information	PM				Annual	Annual
		Actual				Compliant	Compliant
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%	80%
		Actual				65%	65%
3.44	LD: All clients referred will have a risk assessment completed when core assessment is completed	PM				80%	80%
		Actual				83%	83%
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%	80%
		Actual				N/A	N/A
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%	80%
		Actual				N/A	N/A
3.47	LD: All new patients have a risk assessment completed within 48 hours of admission	PM				80%	80%
		Actual				100%	100%
3.48	LD: All new patients have a psychological assessment and formulation of behaviours and emotions completed within 28 days of admission.	PM				80%	80%
		Actual				100%	100%
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%	80%
		Actual				100%	100%

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	January-2017	February-2017	March-2017	2016/17 Outturn
3.50	LD: All new patients receive a health check within 48 hours of admission.	PM				95%	95%
		Actual				100%	100%
3.51	LD: All new patients have a Health Action Plan completed within 3 days of admission	PM				95%	95%
		Actual				100%	100%
3.52	LD: All new patients requiring a health screening are supported to access screenings where appropriate.	PM				95%	95%
		Actual				N/A	N/A
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%	80%
		Actual				85%	85%
3.54	LD: All clients have a functional assessment / formulation of behaviours completed within 28 days on completion of assessment	PM				80%	80%
		Actual				100%	100%
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%	80%
		Actual				80%	80%
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%	80%
		Actual				100%	100%

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 during March in Gloucestershire.

In Gloucestershire a 17 year old, presenting with acute psychotic episode was admitted to Wotton Lawn under section 2 of the Mental Health Act. The patient was admitted 11 days prior to turning 18 and at the time of reporting remains on Priory ward.

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

ID	Performance Measure		2015/16 outturn	January-2017	February-2017	March-2017 / Quarter 4	2016/17 Outturn
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%	99%	98%	100%	98%
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	1.0%	1.4%	1.4%	0.0%	1.6%
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%	71%	50%	72%
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%
		Actual	87%	36%	40%	45%	35%
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%
		Actual	99%	86%	90%	94%	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	11	1	1	1	10
DoH 2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%
		Actual	100%	100%	100%	N/A	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		80%	100%	N/A	91%
DoH 2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM		100%	100%	100%	100%
		Actual		100%	NYR	NYR	100%

DASHBOARD CATEGORY – GLOUCESTERSHIRE SOCIAL CARE

Gloucestershire Social Care				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	15	15	15	15
	3	3	3	3
	10	10	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. There were 9 new social care placement reviews due in March and currently only 2 are presenting within the clinical system as compliant. A manual audit of the 7 cases that have not met the threshold shows;

- 4 cases were incorrectly recorded as a *new* package where they should have been recorded as *review* cases (accountable to a 12 month review).
- 1 review was completed but not appropriately recorded in the clinical system RiO.
- 1 review was deferred by 3 months and referred to the GCC Joint Complex Panel as authorised by the Community Care Panel.
- 1 new case was authorised by the Community Care Panel for a review at 12 months not the usual 3 months.

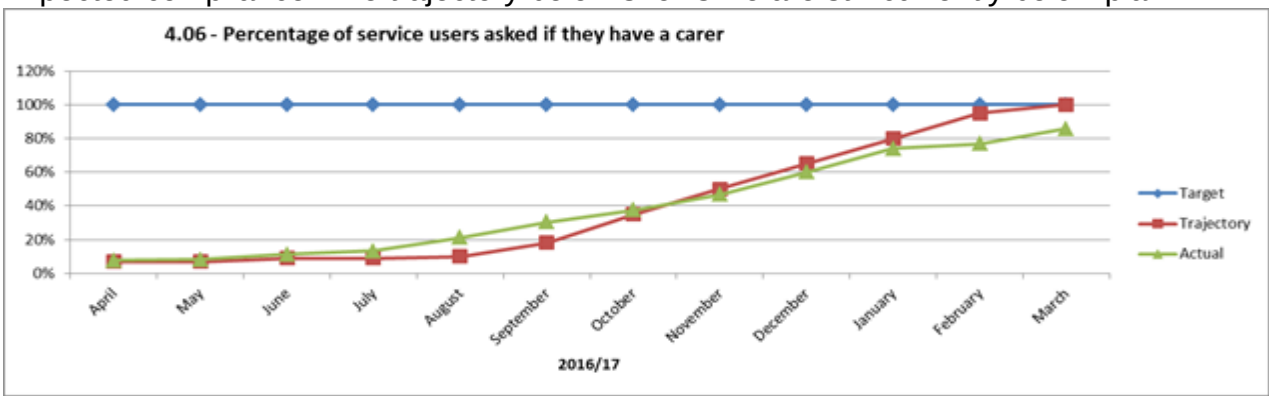
This manual audit would revise the compliance level to 50%; 2 of 4 cases had been reviewed within 3 months. The 2 non-compliant cases were authorised exceptions by the Community Care Panel.

This indicator has been red flagged as it requires further analysis to fully understand the data inputting and methodology issues and introduce further remedial steps to improve monitoring.

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. There has been a significant improvement to 86% in March compared to February's performance of 77%.

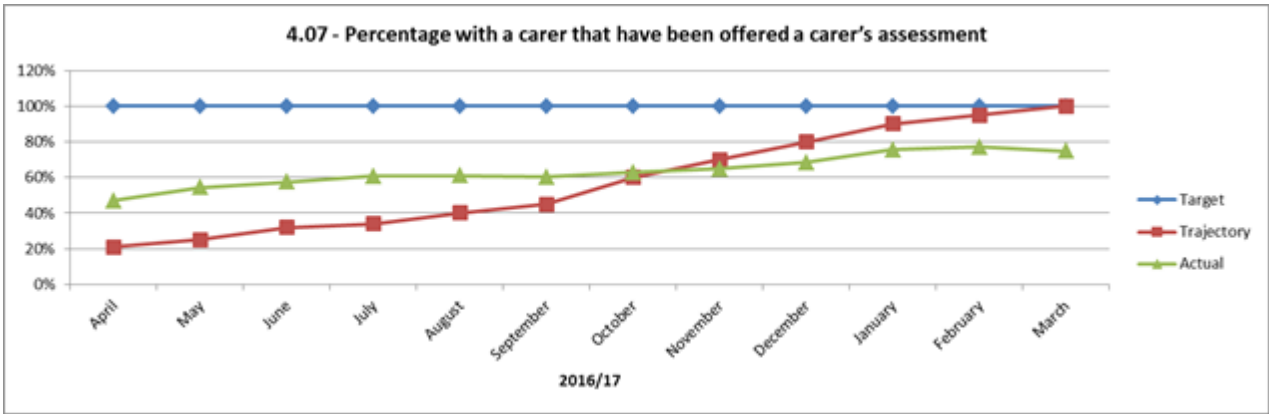
Expected compliance: The trajectory below shows we are still currently below plan.



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	January-2017	February-2017	March-2017	2016/17 Outturn
4.01	The percentage of people who have a Cluster recorded on their record	PM	TBC	90%	90%	90%	90%
		Actual	96%	95%	96%	97%	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%	98%	96%	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%	33%	80%	22%	22%
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	12.83
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	16.55
4.06	% of WA & OP service users on caseload asked if they have a carer	PM		100%	100%	100%	100%
				74%	77%	86%	86%
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		76%	77%	75%	75%
4.08a	% of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC
		Actual	NYA	38%	38%	39%	39%
4.08b	Number of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC
		Actual	NYA	192	217	244	244
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	January-2017	February-2017	March-2017	2016/17 Outturn
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%	88%	88%	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%	95%	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%	15%	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%	23%	25%	22%	24%

DASHBOARD CATEGORY – HEREFORDSHIRE CCG CONTRACTUAL REQUIREMENTS

Herefordshire Contract				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	25	25	25	25
	2	3	2	3
	18	16	18	17
NYA	0	0	0	0
NYR	0	0	0	0
UR	0	0	0	0
N/A	5	6	5	5

Performance Thresholds not being achieved in Month

 **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.

5.11 – IAPT High Intensity: Number of clients receiving step 3 treatment
The performance threshold for this indicator is an annual figure of 351 and although we did not meet the expected number for March, cumulatively we are compliant.

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"**
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
As above

Changes to Previously Reported Figures

5.13a – Dementia service: Number aged 65 and over receiving an assessment
The number of assessments in March was reported as 44 against a performance threshold of 45. RiO has been updated with another case and therefore this indicator is now reported as compliant for March.

Early Warnings / Notes

None

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 Outturn	January-2017	February-2017	March-2017 / Quarter 4	2016/17 Outturn
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%	100%	100%	100%	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%	99%	100%	100%	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%	100%	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%	41%	47%	51%	43%
5.09	IAPT Roll-out (Access Rate) - IAPT maintain 15% of patient entering the service against prevalence	Plan	2,178	1815	1997	2178	2178
		Actual	2,005	1,009	1,101	1,191	1,191
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		43%	37%	34%	44%
5.11	IAPT High Intensity - Number of discharged patients that received step 3 treatment	Plan	350	29	29	29	351
		Actual	356	54	12	15	379

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 Outturn	January-2017	February-2017	March-2017 / Quarter 4	2016/17 Outturn
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%	N/A	100%	100%
5.13a	Dementia Service - number of new patients aged 65 years and over receiving an assessment	Plan		45	45	45	540
		Actual		68	55	45	572
5.13b	Dementia Service - total number of new patients receiving an assessment	Plan					
		Actual		70	58	46	610
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%	96%	100%	100%	99%
5.15	Reduce those people readmitted to inpatient care within 30 days following discharge.	Plan	<8%	<8%	<8%	<8%	<8%
		Actual	6%	5%	7%	6%	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		98%	98%	99%	99%
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%	100%	100%	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%	89%	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		94%	94%	92%	88%
5.21	Attendances at ED for self-harm receive a mental health assessment	Plan		85%	85%	85%	85%
		Actual		100%	100%	100%	98%

Herefordshire Carers Information

ID	Performance Measure		2015/16 Outturn	January-2017	February-2017	March-2017 / Quarter 4	2016/17 Outturn
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		30%	33%	41%	41%
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		50%	54%	58%	58%
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		43%	39%	35%	35%

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 during March in Herefordshire.

A 15 year old with suicidal ideation was admitted to Stonebow Unit and put on leave to Wye Valley Trust's children's ward under section 2 of the Mental Health Act. The patient was moved to a Tier 4 provision the next day.

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

ID	Performance Measure		2015/16 outturn	January-2017	February-2017	March-2017 / Quarter 4	2016/17 Outturn
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%	99%	99%	99%	99%
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	1.2%	2.1%	2.7%	0.6%	2.2%
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%
		Actual	61%	N/A	N/A	100%	70%
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%
		Actual	95%	29%	34%	34%	49%
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%
		Actual	99%	73%	72%	79%	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	4	1	0	1	8

DASHBOARD CATEGORY – GLOUCESTERSHIRE CQUINS

Gloucestershire CQUINS				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	2	2	2	2
	0	0	0	0
	0	0	2	2
NYA	0	0	0	0
NYR	2	2	0	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 4		2016/17 Outturn
	Local CQUINs					
	CQUIN 1					
7.01	Transition from Young People's Service to Adult Mental Health Services	PM	Qtr 4		Report	Qtr 4
		Actual	Compliant		Compliant	Compliant
	CQUIN 2					
7.02	Perinatal Mental Health	PM	Qtr 4		Report	Qtr 4
		Actual	Compliant		Compliant	Compliant

DASHBOARD CATEGORY – LOW SECURE CQUINS

Low Secure CQUINS				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	1	1	1	1
	0	0	0	0
	0	0	1	1
NYA	0	0	0	0
NYR	1	1	0	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 4		2016/17 Outturn
	Local CQUINs					
	CQUIN 1					
8.01	Reducing the length of stay in specialised MH services	PM			Report	Qtr 4
		Actual			Compliant	Compliant

DASHBOARD CATEGORY – HEREFORDSHIRE CQUINS

Herefordshire CQUINS				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	8	8	8	8
	0	0	0	0
	0	0	7	8
NYA	0	0	0	0
NYR	8	8	0	0
UR	0	0	0	0
N/A	0	0	1	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 4		2016/17 Outturn
	National CQUINs					
	CQUIN 1					
9.01a	(b) Introduction of Health and Wellbeing Initiatives	PM			Report	Qtr 4
		Actual			Compliant	Compliant
9.01b	Healthy food for NHS Staff, Visitors and Patients	PM			Report	Qtr 4
		Actual			Compliant	Compliant
9.01c	Improving the uptake of Flu vaccinations for Front Line Clinical Staff	PM			Report	Qtr 4
		Actual			Compliant	Compliant
9.02a	Improving physical healthcare: Cardio Metabolic Assessment for patients with psychoses	PM	Qtr 4		Report	Qtr 4
		Actual	Compliant		Compliant	Compliant
9.02b	Improving physical healthcare: Communication with GPs	PM	Qtr 2			Qtr 3
		Actual	Awarded			Awarded
	Local CQUINs					
	CQUIN 2					
9.03	Personalised relapse prevention plans for adults accessing and using 2G Mental Health Services	PM			Report	Qtr 4
		Actual			Compliant	Compliant
	CQUIN 3					
9.04	Personalised relapse prevention plans for children and young people accessing and using MH services				Report	Qtr 4
					Compliant	Compliant
	CQUIN 4					
9.05	Appropriate care and management for frequent attenders to WVT A&E dept				Report	Qtr 4
					Compliant	Compliant

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

Report to: Trust Board – 25 May 2017
Author: Angie Fletcher, Interim Service Experience Clinical Manager
Presented by: Jane Melton, Director of Engagement and Integration

Subject: **Service Experience Report Quarter 4 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 4 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 been triangulated to understand service experience.

Significant assurance that service users value the service being offered and would recommend it to others.

During Quarter 4, 91% 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 with results exceeding national scores.

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 being delivered to relaunch the surveys used within our Trust during Quarter 1 2017/18. Despite response rates being lower that we would want, the responses received reflect positively on services.

<u>Significant assurance</u> 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 is generally increasing. Compliments reported in Quarter 2 – 389, Quarter 3 – 715, Quarter 4 – 572. Continued work is underway to build upon this progress.

<u>Significant Assurance that complaints have been acknowledged in required timescale</u>
During Quarter 4, 95% of complaints received were acknowledged within 3 days.

<u>Significant assurance</u> that all people who complain have their complaint dealt with by the initially agreed timescale.

78% of complaints were closed within timescales agreed with the complainant. This is encouraging news and reflects the effectiveness of the action plan created in response to the disappointing closure rate during Quarter 2 (n=41%) Quarter 3 (n=65%).

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

(2) Recommended learning and improvement

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

This Quarter concerns have been raised by service users about being advised of the next steps to be taken in relation to their care and treatment following contact with our services.

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

- We must introduce ourselves fully to people. We must check they understand our role and how we can help.
- We must work together as a Trust to meet people's needs regardless of the geographical and/or service boundaries.

An update on Parliamentary and Health Service Ombudsman activity is included within this report.

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 outlines what is known about experience of 2gether's services in Q4 2016/17 and makes key recommendations for actions to enhance quality.
Resource Implications	The 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 on 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	11th April 2017

Where in the Trust has this been discussed before?		
Quality and Clinical Risk Sub-committee Trust Governance Committee	Date	April 2017 April 2017

What consultation has there been?		
Service Experience Committee members	Date	April 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 4

1st January 2017 to 31st March 2017

"I feel so supported and the team are lovely."

CRHTT, Gloucestershire

"Following an overdose, my daughter has received first rate care and support. The on-going follow up has been so thorough and supportive. Thank you all so much."

CAHTT, 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 4

1st January 2017 to 31st March 2017

Complaints 	**20** complaints (103 separate issues) were made this quarter. This is less than last time (n=31). We want people to tell us about any concerns about their care. This means we can make it better.	↓
Concerns 	**56** concerns were raised through PALS. This is more than last time (n=35).	↑
Compliments 	**572** people told us they were pleased with our service. This is less than last time (n=715). We want teams to tell us about every compliment they get.	↓
FFT 	**91%** of people said they would recommend our service to their family or friends. This is nearly the same as last time (89%).	↔
Quality Survey 	April 2016 – March 2017 feedback combined: Gloucestershire: **150 people told us what they thought** Herefordshire: **62 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.	↓ (number of participants)
We must listen 	We must introduce ourselves fully to people. We must check they understand our role and how we can help.	
We must listen 	We must explain the next steps after people make contact with our services.	

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 January 2017 and 31st March 2017**. 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.

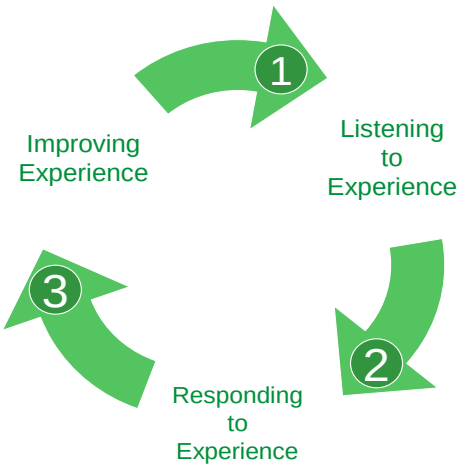
1.2 Strategic Context

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.

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

You said – We did



As we serve patients and their carers, we will go beyond what people expect of us to ensure that we earn their trust, confidence, and foster hope for the future.

[2]gether NHS Foundation Trust is a learning organisation. We want to learn from people who use our services **('you said')**, and take action to develop our services accordingly **('we did')**.

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	17		A marked decrease in the number of complaints has been reported in Gloucestershire in Q4 (Q3 n=29)	Significant
Herefordshire	3		A minor increase in the number of complaints has been reported in Herefordshire in Q4 (Q3 n=2).	Significant
Total	20		The total number of complaints received is much lower than the previous quarter (Q3 n=31)	Significant

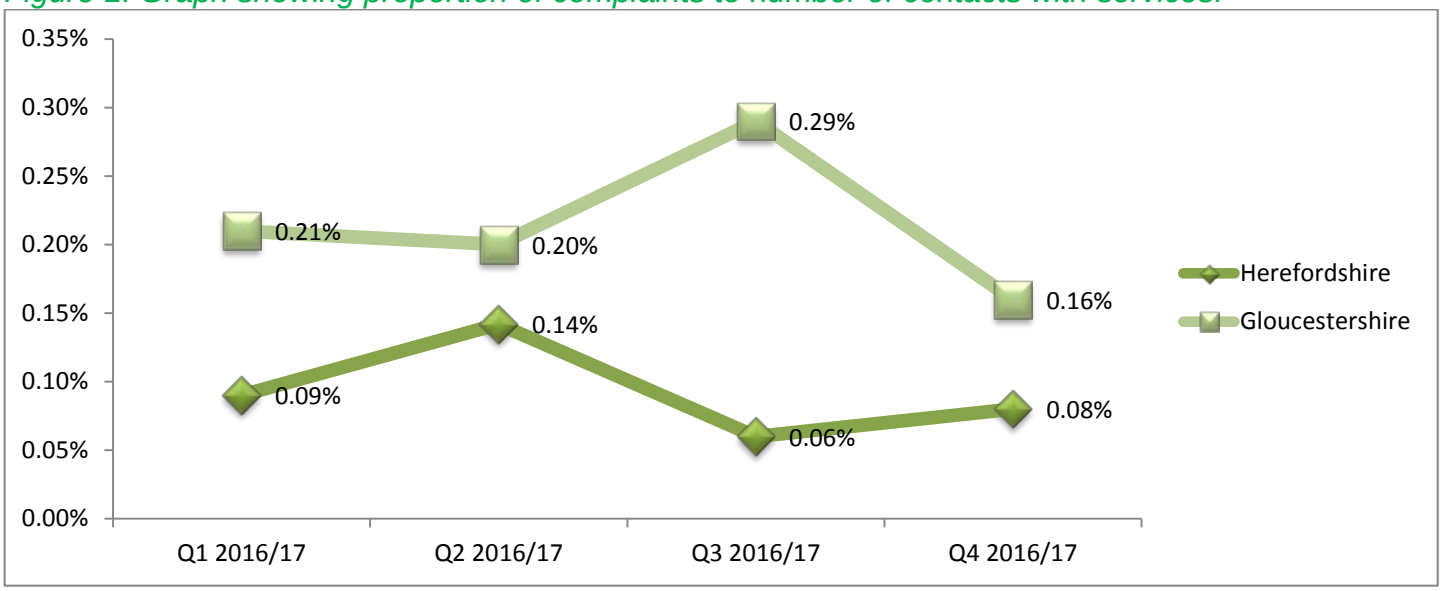
The numbers of individual complaints has remained relatively stable throughout this year ranging from 20 – 31 individual complaints each quarter. Quarter 4 sees the lowest level of formal complaints recorded for this year however, the number of concerns received during this time increased. This demonstrates that resolution is being achieved locally without the need for the formal complaints process. 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:

	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
Gloucestershire complaints	24	23	29	17
Gloucestershire contacts	10,219	10,067	9,998	10,410
Herefordshire complaints	3	5	2	3
Herefordshire contacts	3,477	3,525	3,409	3,557

**this does not include primary care contacts*

Figure 1: Graph showing proportion of complaints to number of contacts with services:



**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	25	↑	The number of complaints closed for Gloucestershire is slightly higher than last quarter (Q3 n=23)	Significant
Herefordshire	2	↓	The number of complaints closed for Herefordshire is slightly lower than last quarter (Q3 n=3)	Significant
Total	27	↔	The overall number of complaints closed is similar to the previous quarter (Q3 n=26)	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	95%	↓	**One** complaint was not acknowledged within target timeframes (Q3=100%)	Significant
Complaint closed within agreed timescales	78%	↑	This is higher than last quarter (Q3=65%) and is predominantly due to delays in the investigation process (50%)	Significant
Concerns escalated to complaint	4%	↓	Of 56 concerns received (Q3=35), 2 were not resolved and were escalated; this is lower last quarter (Q3=6%).	Significant

The Service Experience Department (SED) acknowledged all complaints within the national standards for response times for Quarters 1 to 3, 2016/17. In Quarter 4 one complaint was not formally acknowledged within the response timeframe. Investigation into this incident has identified that the person was an inpatient at the time the complaint was made. The Service Experience

department did contact the ward within 3 working days however the service user was not available. The department liaised with the Care Coordinator who confirmed that a message would be given to the service user regarding acknowledgement of their complaint. The Service Experience Department followed this up formally in writing, achieving this after the target of responding within 3 working days.

The rate of complaints closed within the initially agreed timescale has again increased during Quarter 4. This is encouraging news. Quarter 2 closure rates were disappointing. The SED worked closely with Service Directors to identify the areas that contributed to the delays and formulated an action plan in response. Continued implementation and embedding of the action plan has resulted in the closure rate continuing to improve. The closure rate is now consistent with that at the start of this financial year. The Service Experience Department will continue to carefully monitor closure rates to ensure sustained improvement.

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.

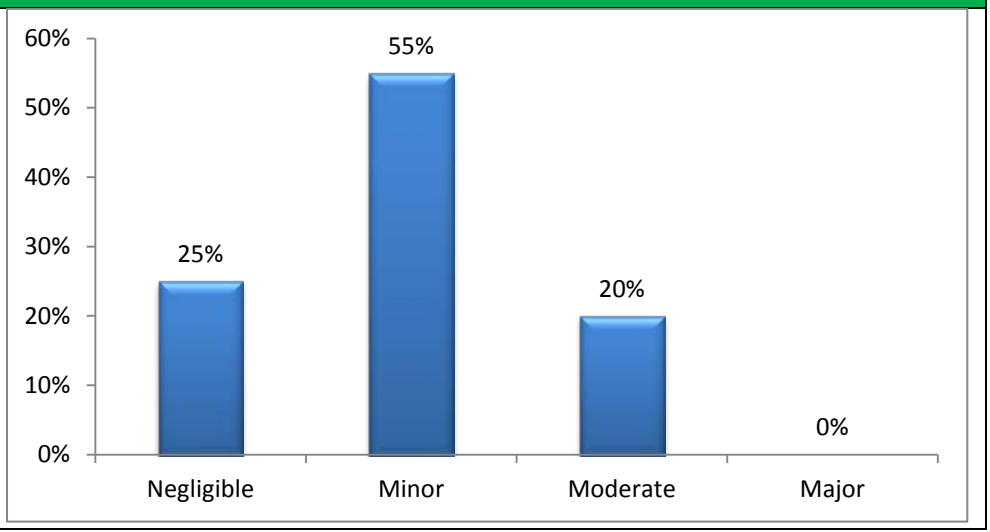
Table 5: Satisfaction with complaint process

Measure	Number (numerical direction)		Interpretation	Assurance
Reopened complaints	6		This figure is slightly lower than the previous quarter (Q3 n=7)	Significant
Local Resolution Meetings	7		This figure is higher than the previous quarter (Q3 n=4).	Significant
Referrals to PHSO	4		Four complaints have been referred to the PHSO this quarter. (Q3 n=1).	Significant

Quarter 4 has seen a slight decrease in the number of complaints reopened following a complainant being informed of the findings of the complaint investigation. The SED has continued to offer Local Resolution Meetings to meet with complainants who remain dissatisfied with the outcome of the complaint investigation. This means reopening a previously closed complaint – this may influence the number of complaints being reopened.

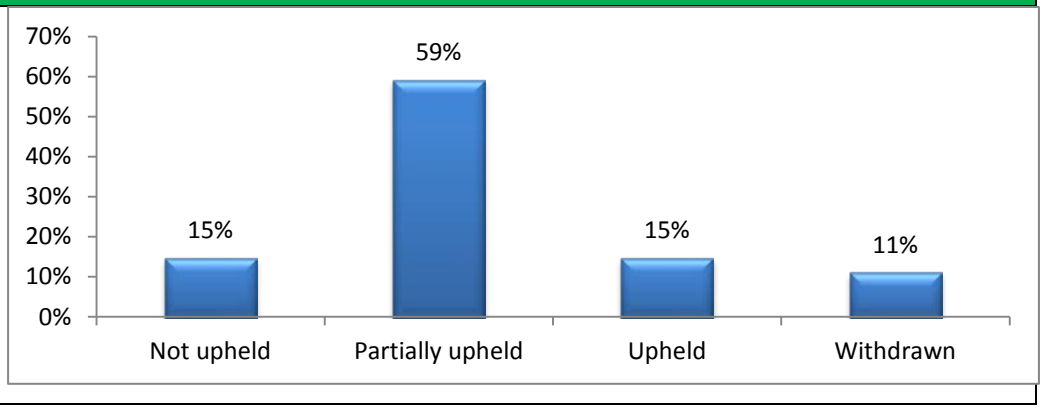
There have been four referrals to the PHSO this quarter. As yet we have not been informed as to whether the PHSO intend to investigate any of these referrals.

Table 6: Risk rating of complaints received this quarter

Rating	No.	Chart showing percentages
Negligible *Minimal impact on individual or organisation*	5	
Minor *Minor implications, reduced performance, single failure*	11	
Moderate *Significantly reduced effectiveness, failure to meet internal standards*	4	
Major *Complaint regarding serious harm or death*	0	

80% of the complaints received were classified as negligible or minor in terms of their impact on the individual or the organisation. This is lower than the previous quarter (Q3=94%), with an increase in complaints meeting the “moderate” threshold (Q3 n=6%). The 4 complaints within this category relate to incidents where harm has been sustained by individuals.
All complaints are regarded as important for individuals and resolution is the key aim.

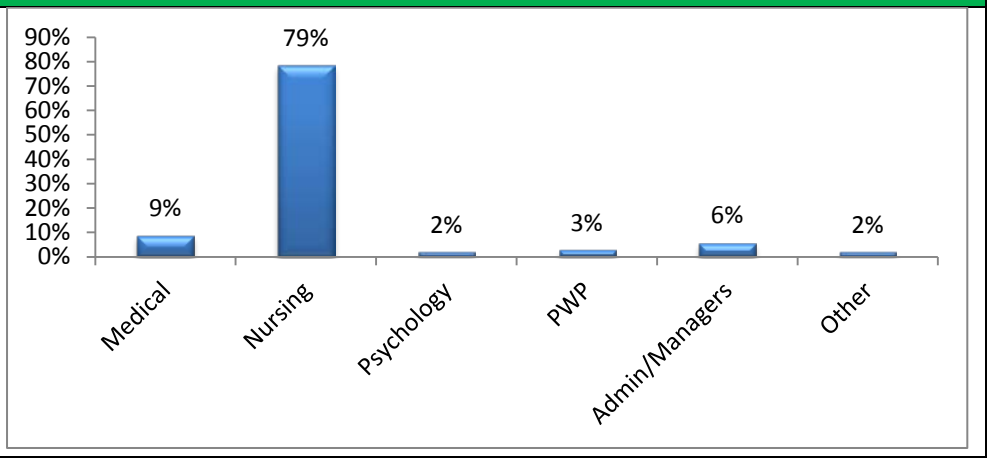
Table 7: Outcome of complaints closed this quarter

Outcome	No.	Chart showing percentages
Not upheld *No element of the complaint was upheld*	4	
Partially upheld *Some elements of the complaint were upheld*	16	
Upheld *All elements of the complaint were upheld*	4	
Withdrawn *Complaint was withdrawn*	3	

74% of the complaints closed this quarter had their concerns upheld or partially upheld. This is higher than the previous quarter (54% partially upheld, 15% upheld). SED have revised the way complaint outcomes are classified during Quarter 4. Where a single issue or more within an individual complaint is categorised as upheld, the overarching status will now be that the complaint is upheld. Previously the classification of outcome was based upon the “majority rule” between upheld and not upheld. This new way of formulating the overarching outcome for complaints further increases the openness and transparency of reporting. Reporting overarching complaint outcomes will continue in this way for 2017/18.

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

Outcome	No.*	Chart showing percentages
Medical	9	
Nursing	81	
Psychology	2	
PWP (Psychological Wellbeing Practitioners)	3	
Admin	6	
Other	2	



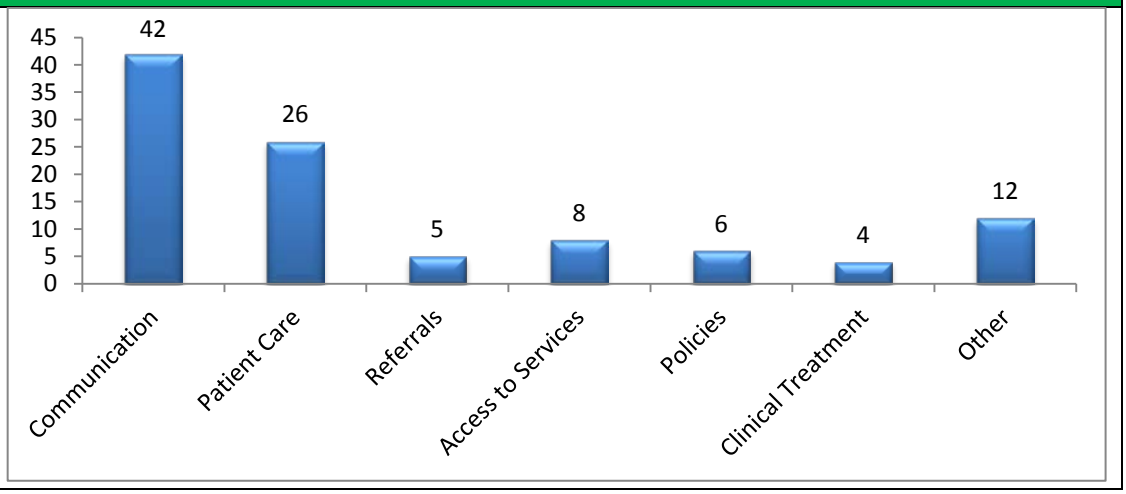
**The numbers represented in these data relate to a breakdown of individual complaint issues and relate to different staff groups.*

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 4 data is presented in Table 8, above.

Quarter 4 figures continue in line with the first three 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 with service users and carers. Work is ongoing to ensure that professional leads are made aware of any themes relating to their professional group.

Table 9: Overarching complaint themes in Quarter 4

Theme	Chart showing number of issues raised
Communication *Internal and external*	
Patient Care *e.g. observation, support*	
Referrals *Includes appointments*	
Access to Services *Inc. Admission/Discharge*	
Policies *e.g. not followed*	
Clinical treatment *e.g. diagnosis, medication*	
Other *Any other issue*	



The main complaint themes are ***communication*** and ***patient care.*** These themes have been reviewed in greater detail on the following page.

*Table 10: Breakdown of complaint issues relating to **communication** and **patient care***

Top 3 areas of communication identified in Q4 complaints
Communication with relatives and carers
Communication with Service Users
Inaccurate/ inaccurate interpretation of written clinical records and/or reports

Top 3 areas of patient care identified in Q4 complaints:
Inadequate support provided
Inappropriate treatment
Incorrect procedure

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

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 people feeling they are "bounced" between teams, needing to give the same information multiple times before being referred/ accepted by the team best placed to meet their needs. This highlights the importance of colleagues working together to ensure care is continuous. 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
Assessment processes	I was concerned with the level of detail I was asked for during an initial assessment.	We apologised and reviewed and updated our assessment template to guide clinicians during initial assessments.
Communication of information about our services	Details of who could access and how to access Crisis Teams are not clear on your website.	We reviewed our website and updated the details making information about our Crisis Teams more prominent.
Communication with relatives/carers	My daughter was assessed several times by different teams before she was admitted to hospital	We apologised and assured you we had reviewed our admission policy to streamline admission processes.

2.2 Concerns

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

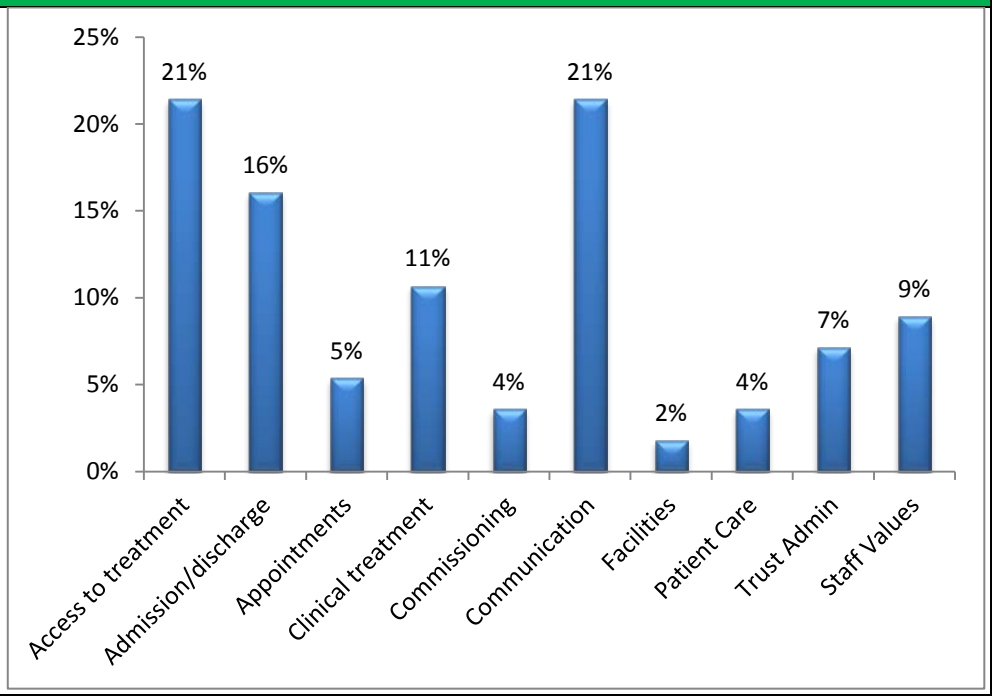
DatixWeb, a service experience recording and reporting system, has continued to be used for Quarter 4. The information gathered allows greater data interrogation and improved opportunities for learning from feedback. Themes and trends have been analysed for Quarter 4 and are reflected in the tables below.

Table 12: Number of concerns received this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	46	↑	There has been a marked increase in the number of Gloucestershire concerns (Q3 n=24)	Significant
Herefordshire	6	↓	There has been a slight decrease in the number of Herefordshire concerns (Q3 n=8)	Significant
Corporate	4	↔	There were a similar number of Corporate concerns (Q3 n=3)	Significant
Total	56	↑	The overall number of concerns received has increased (Q3 n=35)	Significant

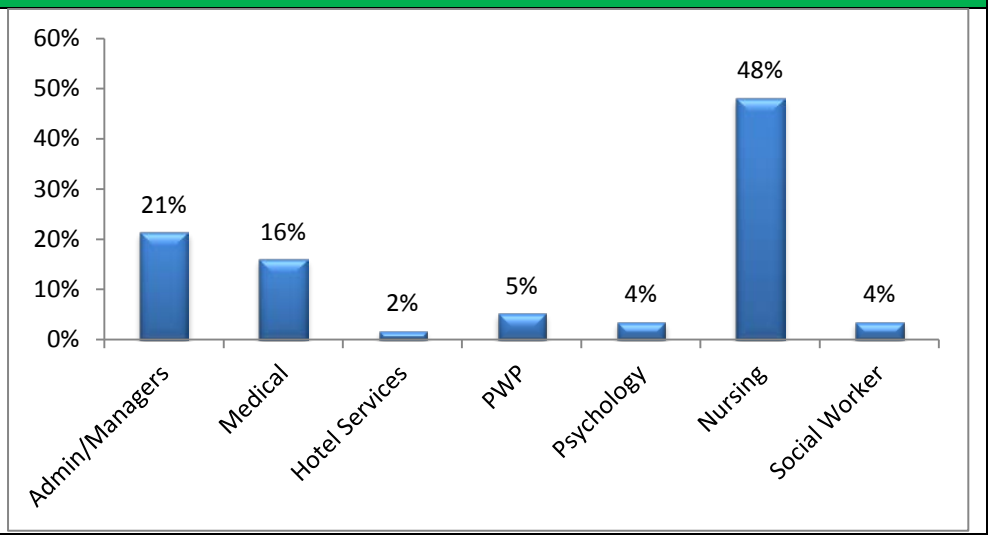
The increase in numbers of concerns is balanced by the decrease in complaints for this quarter. This demonstrates that people are continuing to raise their concerns and that the majority of these are being resolved locally in a timely way.

Table 13: Overarching concern themes this quarter

Theme	No.	Chart showing percentages
Access to treatment *Treatment or medication*	12	
Admission/discharge *Community or inpatient*	9	
Appointments *e.g. cancelled, staff DNA*	3	
Clinical treatment *e.g. diagnosis, medication*	6	
Commissioning *Services not available*	2	
Communication *Internal and external*	12	
Facilities *e.g. food or environment*	1	
Patient Care *e.g. observation, support*	2	
Trust Admin *e.g. Health Records, MHA*	4	
Staff Values *Attitude and actions*	5	

The two main themes identified from concerns raised are “Access to treatment or medication” and “Communication”. These themes differ slightly from the main themes reported from formal complaints and are demonstrative of the type of issues that can be resolved locally. 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/Managers	12	
Medical	9	
Hotel Services	1	
Psychological Wellbeing Practitioners (PWP)	3	
Psychology	2	
Nursing	27	
Social Worker	2	

As previously reflected in complaint analysis, nursing represents the largest staff group in the Trust and has the greatest number of contacts. Work is ongoing to ensure that leads are made aware of any themes relating to their staffing group.

Table 15: Number of concerns closed this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	40	↑	This is more than the last quarter (Q3 n=31)	Significant
Herefordshire	6	↓	This is fewer than the last quarter (Q3 n=10)	Significant
Corporate	1	↓	This is fewer than the last quarter (Q3 n=4)	Significant
Total	47	↔	The overall number of concerns closed is similar (Q3 n=45)	Significant

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

Table 16: Other contacts and activity

Advice
There were 26 episodes of advice offered this quarter by the PALS Service
22 episodes related to information about our services, and 3 were general advice on other services
1 episode related to making a complaint

Signposting
There were 26 episodes of signposting by the PALS Service
21 episodes were signposting to internal teams such as wards, Communications Department, the Research Team and various clinical teams
5 were signposting to external teams, such as the CCG and advocacy

Examples of concerns and action taken:

2.3 Compliments

Table 17: Number of compliments received

County	This quarter		Last quarter	Assurance
Gloucestershire	534	↓	553	Significant
Herefordshire	32	↓	136	Significant
Corporate	6	↓	26	Significant
Total	572	↓	715	Significant

The SED continues to encourage the reporting of compliments throughout our Trust. Following a peak of reporting in Quarter 3, reporting levels in Quarter 4 are relatively consistent with the rest of this year. The SED will continue to work with our 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 4:

2.4 Comments received via HealthWatch

HealthWatch 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 15 pieces of feedback relating to [2]gether Trust this quarter. HealthWatch Herefordshire has provided 7 pieces of feedback. The feedback can be broadly broken down into the following feedback areas:

- Difficulty accessing services, particularly those for people with an Autism Spectrum Condition (n=8)
- Lack of support from services (n=10)
- Tackling stigma (n=2)
- Receiving good support from services (n=2)

A selection of the comments can be seen below:

2.5 – Parliamentary and Health Service Ombudsman (PHSO)

Four cases have been referred to the PHSO for review this quarter – this means four people have contacted the PHSO as they remain unhappy with the outcome of their complaint. As yet a decision has not been made by the PHSO about whether any of these four will be investigated by them.

2.6 Surveys

2.6.1 Survey re-launch plan

The Service Experience Department (SED) continue to implement the plan for our new **"How did we do?"** survey. The **"How did we do?"** survey will combine the current surveys we use known as the "Friends and Family Test" and "Quality Survey" and 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), with an implementation plan throughout Quarter 1 2017/18.

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

As a Trust we report our survey results internally, 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.

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 service users 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 4 returns and responses to Friends and Family Test

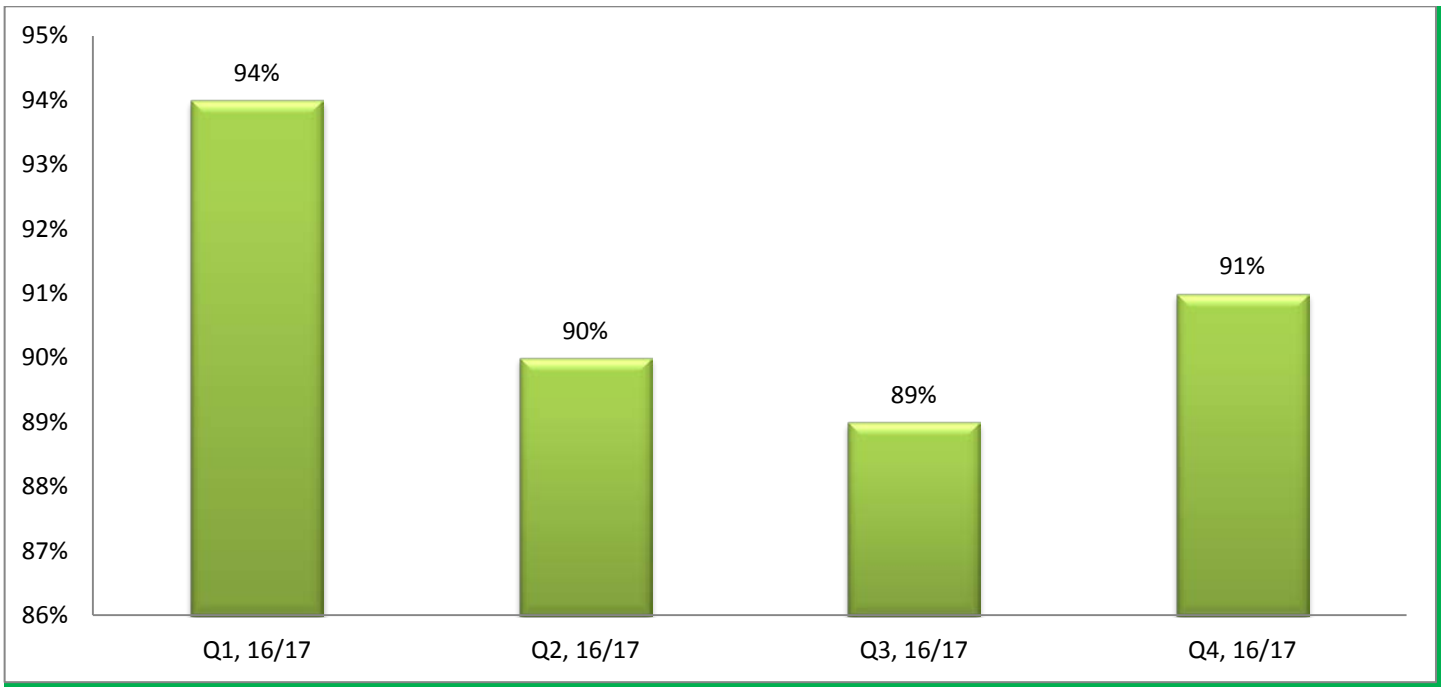
	Number of responses	FFT Score (%)
January 2017	312	90%
February 2017	228	90%
March 2017	200	95%
Total	**740 (last quarter = 1,100)**	**91% (last quarter = 89%)**

The Quarter 4 response rates are lower than the previous quarter however the percentage of those who would recommend our services has increased – this is encouraging news. The **"How did we do?"** survey, will build upon this year's good progress. Service Managers are given local feedback

on a weekly and monthly basis about the FFT results and responses relating to the services they manage.

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

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



The FFT score for Quarter 4 has remained relatively consistent with that received in Quarter 3. The Trust continues to maintain a high percentage of people who would recommend our services.

Friends and Family Test Comments

What was good about the visit?

Empathy and kindness of staff.
Mulberry Ward, Charlton Lane

Meeting other people who are caring for relatives with dementia and learning about the different kinds of dementia.
Managing Memory, Gloucestershire

Friendly receptionist, nice building, staff I saw were really nice and understanding.
ASC Service, Gloucestershire

Very professional, clear, approachable, understanding.
CYPS, Gloucestershire

The swiftness of the initial response to my cry for help was excellent. The support I received throughout was excellent.
DMHOP North, Herefordshire

Compassionate and caring.
IHOT, Gloucestershire

You have helped me regain my life. Supported and enabling me to grow positive.
Eating Disorders Team, Glos

The time taken to fully explain and the genuine care shown, follow ups and progress. Sharing of hope!
Primary Mental Health Team, Herefordshire

The care and compassion I received during my recent stay have me faith in the NHS. I felt part of a family rather than a patient with a mental health problem.
Mulberry Ward, Wotton Lawn

What would have made the visit better?

Delayed appointments and muddled opinions.
Working Well, Gloucestershire

Nothing was good - most horrendous experience of my life. Staff condescending and patronising - all overworked and underpaid so no time for the individual.
Mortimer Ward. Stonebow

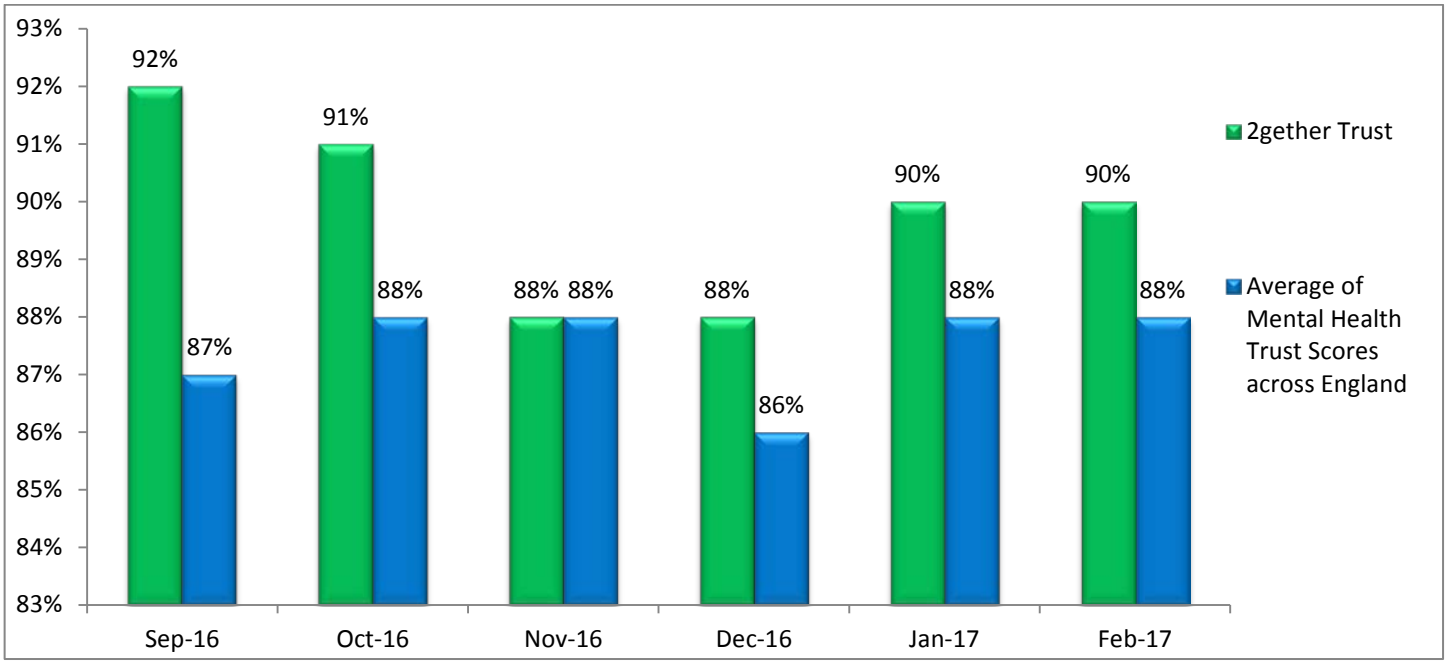
Poor service, no information about care plan for relative, unhelpful and just giving platitudes over the phone.
CRHTT, Gloucestershire

Time and detail of appointment not very clear and not written down for patients. Therefore two hour wait expecting an important meeting with a key worker. No refreshments at all on site.
Recovery Team, Gloucestershire

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

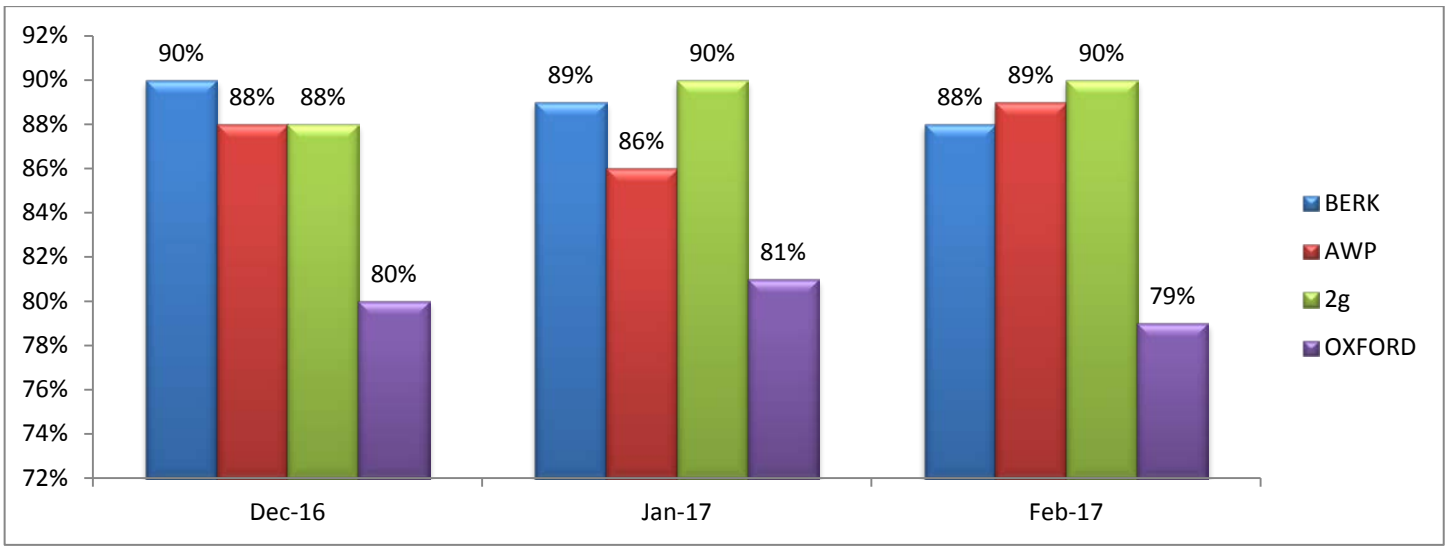
The following graph (Figure 3) shows the FFT Scores for the most recent six months of this year. Our Trust continues to receive a high percentage of recommendation that is typically higher or the same other Mental Health Trusts in England. (*March 2017 national data is not yet available*)

Figure 3: Friends and Family Test Scores – comparison between 2gether Trust and other Mental Health Trusts across England



The chart below (Figure 4) shows the FFT Scores for December 2016, January and February 2017 (the most recent data available) when compared to other Mental Health Trusts in our region. Our Trust consistently receives a high percentage of recommendation in line with other Mental Health Trusts in the region. (*March 2017 data for the region is not yet available*)

Figure 4: Friends and Family Test Scores – comparison between the 2gether Trust and other Mental Health Trusts in the NHS England South Central region



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 "How did we do?" survey relaunch, 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 1-4, 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	32	25	17	13	83% TARGET 78%
		Community	118	95	45	43	
		Total Responses	150	120	62	56	

	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	32	23	17	13	77% TARGET 73%
		Community	96	73	41	34	
		Total Responses	128	96	58	47	

	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	24	19	16	11	81% TARGET 71%
		Community	110	86	44	42	
		Total Responses	134	105	60	53	

	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	31	25	17	14	83% TARGET 48%
		Community	77	59	42	37	
		Total Responses	108	84	59	54	

	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	31	26	13	7	79% TARGET NONE SET
		Community	63	48	29	26	
		Total Responses	94	74	42	33	

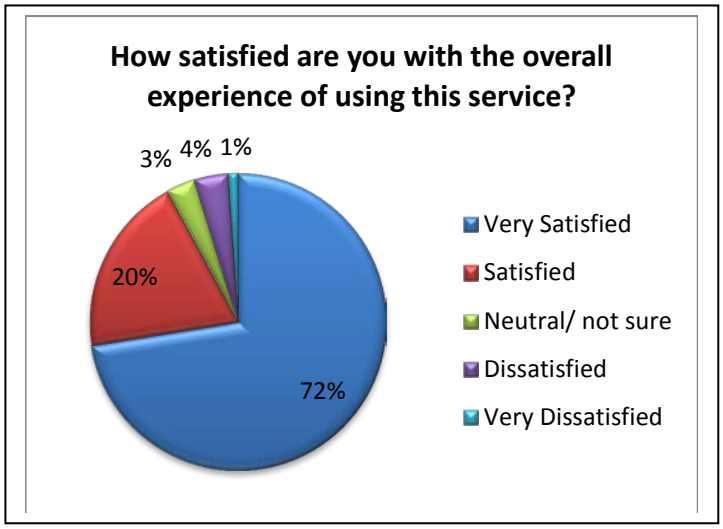
	Question	Treatment setting	Sample size (Gloucestershire)	Number 'yes' (Gloucestershire)	Sample size (Herefordshire)	Number 'yes' (Herefordshire)	Total % giving 'yes' answer
6	Do you feel safe in our services?	Inpatient	31	25	17	13	87% TARGET NONE SET
		Community	85	76	45	41	
		Total Responses	116	101	62	54	

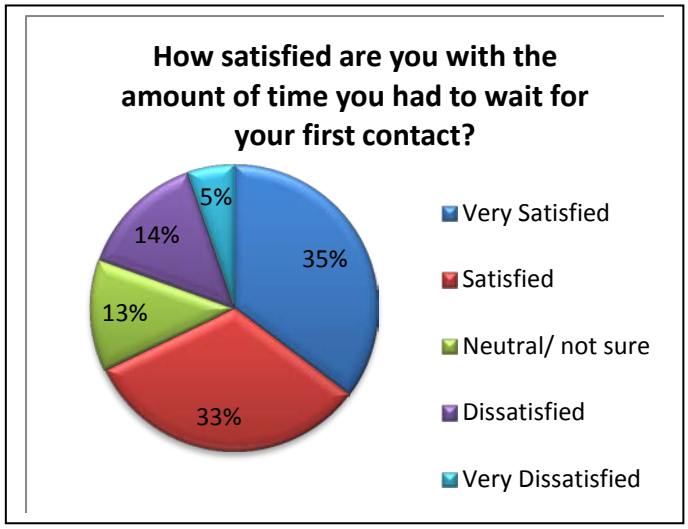
Where set, targets have been exceeded in all areas for feedback. This is good news and demonstrates that, of those people who responded to the survey, they are not only being involved in their care but are also feeling supported to meet their needs and explore other activities. This is a positive reflection of the work undertaken within the Trust to improve performance in these key areas. Targets have been set for all questions in 2017/18 'How did we do?' survey questions.

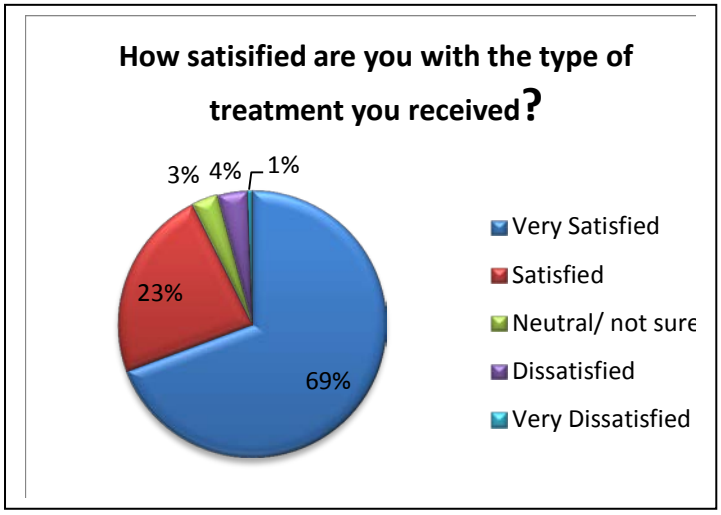
2.6.4 Improving Access to Psychological Therapies – Patient Experience Questionnaire (IAPT PEQ)

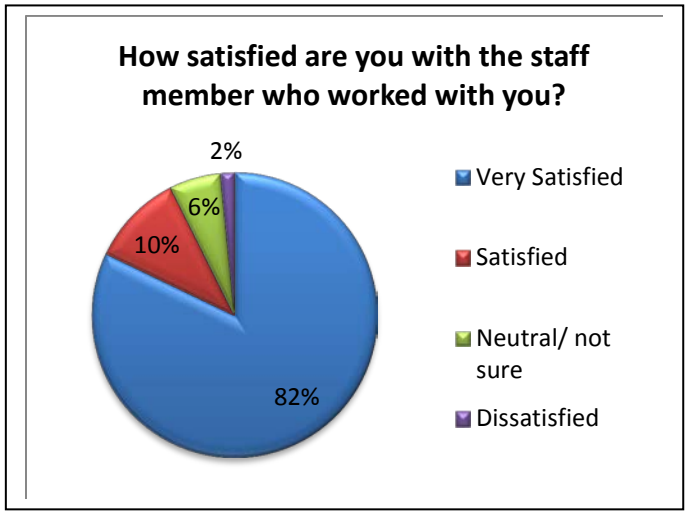
Our IAPT services, including Mental Health Intermediate Care Teams and Let's Talk services, use a survey that has been nationally agreed to gain particular feedback and measure people's level of satisfaction with the IAPT service. The current IAPT PEQ is under review by SED and service leads

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 can be seen below the charts. All data and feedback shown is based on responses processed within Quarter 4 2016/17, the sample (total number of responses) size for feedback shown in the pie charts is 213. This is an increase on the 189 responses for Quarter 3 of this year.









The Quarter 4 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.
The IAPT PEQ includes the following question: "Please tell us anything that you think would improve this service". A selection of comments is shared below:

- Very helpful nurse and very friendly.
- Helpful to discuss problems. Nothing would have made visit better.
- More understanding of my problems and help on things. A cup of tea would have made visit better.
- The time taken to fully explain and the genuine care shown, follow ups and progress. Sharing of hope!
- Telephone support was easier than traveling. A very perceptive listener who helped me see life differently.
- Practical advice, clearly delivered. A longer course would be better.
- Always leave feeling better and positive that things will and are changing. This is really working for me.
- Even though the waiting time takes nearly a year, I'm glad I saw the great people and team.

2.6.5 Children and Young People service (CYPS)

CYPS do not use the Trust's 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.

Adapted Friends and Family Test – Quarter 4 2016/17

	Number of responses	FFT Score (%)
Age 9-11	31	81%
Age 12-18	80	100%
Parent/Carer	58	96%
Total	**169 (not previously reported)**	**96% (not previously reported)**

Some feedback:

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. Table 20 illustrates the lessons learnt from **individual** complaints and concerns. This includes learning when a complaint or concern has been upheld or not upheld.
Reporting of local service experience activity on a monthly and quarterly basis at each locality governance meeting continues to be embedded. The SED is also attending these meetings regularly to discuss local themes, trends and learning.

*Table 20: Lessons learnt from **individual** complaints and concerns closed Quarter 4*

Learning	Action taken	Assurance of action
You told us you were concerned that you were asked to give detailed information about a trauma at a first assessment and then left for several weeks before your first appointment.	We updated our assessment template and gave guidance to our staff to not discuss traumatic experiences in detail during an initial assessment	Significant
	We apologised and assured you we had learnt from your feedback and changed the systems we use.	
You told us it was not clear on our website who could contact and how to contact our Crisis Teams	We apologised and updated our website with the relevant details making sure the Crisis Team information was prominent.	Significant
	We will ensure that our newly revised website is reviewed so that contact details are clearly detailed.	
You told us your relative needed multiple assessments and had to repeat the same information several times to different teams in order to be admitted to one of our inpatient units.	We said we were sorry and informed you that we had reviewed our admission policy.	Significant
You received a letter saying you had been discharged from a service – you had no prior knowledge of this.	We apologised and contacted the team who promptly reopened your access to their services.	Significant
	We learnt that we must be clear and ensure people understand the next steps to be taken in relation to their care and treatment.	
You told us that vegetarian food was not available during an inpatient admission.	We apologised and explained this to you in the context of the individual clinical needs.	Significant
	We reviewed our policy relating to dietary needs in the context of clinical care and treatment.	

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. Table 21 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 Q4 closed complaints– action plan to be sought from locality leads

Organisational Learning	Action Plan (to be sought)
Where a clinician is a new member of a service users care team it is essential to establish a good rapport/relationship with the service user and family and they explain their role and their responsibilities along with establishing the expectations of the service user and the family. *All staff to give clear communication at first contact with service users and family.*	
Where a person's needs cross multiple services and /or geographical boundaries of our Trust it is important that we work together as an organisation to focus on meeting the service users' needs rather than request multiple assessments and/or referrals to different teams in different geographical locations. *All staff to be aware of service user's care that may cross our internal Trust service and/or geographical boundaries and the impact this has in terms of service availability and experience of our Trust services as an organisation*.	
It is important that service users and carers are informed of the "next steps" to be taken in relation to their care and service provision. Quarter 4 feedback shows several occasions where people were unaware of what would happen next following contact with our services. *All staff to give clear communication about the next steps to be taken following contact with service users and/or carer.*	

Section 3.3 – Assurance of learning and action from aggregated learning themes from Quarter 3

Effective dissemination of learning across the organisation is vital to ensure we are responsive to people's needs and that services continue to improve. The following 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 Q3 – action plan has been completed

Organisational Learning	Locality Directorate Plan	Date Assurance provided
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.*	**Children's Services across both counties** The Learning will be cascaded through CYPS/CAMHS Governance Committee and down to Team Managers who will discuss in their Team meetings.	March 2017
	Gloucestershire Localities have a robust process of Team Operational Policy review via the Board. A review would occur at a pre-set date (usually annually / bi-annually or sooner if changes to team form or function occur). The Communications Team enable the upload of these policies to the intranet. The Board will ensure that the Communications team are asked to make any associated website changes at the same time.	March 2017
	Countywide Initial discussion to take place at Countywide Locality Board (CLMB) in April 2017. Directive to be cascaded to team managers for discussion with teams and recorded in team meeting minutes. Item to be placed on May CLMB agenda to confirm information has indeed been cascaded	April 2017
	Herefordshire The Service operational managers have been briefed to ensure that all changes to service and contact details are updated on the central system , Likewise communication will be made with key external agencies	March 2017
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*)	**Children's Services across both counties** The Learning will be cascaded through CYPS/CAMHS Governance Committee and down to Team Managers who will discuss in their Team meetings.	March 2017
	Gloucestershire Staff will be reminded of the importance of this via Gloucestershire Localities Delivery and Governance Committee and then via Forums in each Locality	March 2017
	Countywide Initial discussion to take place at Countywide Locality Board (CLMB) in April 2017. Directive to be cascaded to team managers for discussion with teams and recorded in team meeting minutes. Item to be placed on May CLMB agenda to confirm information has indeed been cascaded.	April 2017
	Herefordshire Team managers have been requested to brief team members at staff meetings.	March 2017

Organisational Learning	Locality Directorate Plan	Date Assurance provided
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.*	**Children's Services across both counties** The Learning will be cascaded through CYPS/CAMHS Governance Committee and down to Team Managers who will discuss in their Team meetings.	March 2017
	Gloucestershire Staff will be reminded of the importance of this via Gloucestershire Localities Delivery and Governance Committee and then via Forums in each Locality	March 2017
	Countywide Initial discussion to take place at Countywide Locality Board (CLMB) in April 2017. Directive to be cascaded to team managers for discussion with teams and recorded in team meeting minutes. Item to be placed on May CLMB agenda to confirm information has indeed been cascaded.	April 2017
	Herefordshire Team managers have been requested to brief team members at staff meetings.	March 2017

Agenda Item 9 **Enclosure Paper D**

Report to:	Trust Board, 25 May 2017
Author:	Angie Fletcher, Service Experience Clinical Manager
Presented by:	Jane Melton, Director of Engagement and Integration
SUBJECT:	**Complaints: Annual Report 2016-2017**

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

EXECUTIVE SUMMARY

(1) Assurance

This report provides s**ignificant assurance** that the Trust has made considerable effort to listen to, understand and resolve complaints over the past year. The themes of complaints received during the period 2016-17 have been reviewed and comparisons made with information from previous years. Data has been recorded and analysed in an effort to understand and ensure that complaints and concerns from individuals are responded to promptly and effectively. Methods of disseminating learning across the Trust continue to be refined and developed.

The number of complaints received during 2016-17 (n=106) is lower than the previous year (n=131). Whilst the numbers of formal complaints has reduced there is **significant assurance** that individuals are increasingly prepared to share concerns. This is evidenced by the increased number of concerns resolved without the formality of the NHS complaints process.

(2) Improvement – practice developments

A number of practice developments are planned for the coming year including:

- To further implement and evaluate the revised Non-Executive Director Complaints Audit to enable review of national best practice in investigation and complaint management.
- To ensure reasonable adjustments are made to the complaints process to increase awareness to further assure its accessibility to everyone using our services, particularly older people, children, and people with a learning disability.
- To review and update the Trust's Complaints Policy to reflect changes in local practice and national guidance.

- To work with colleagues across the Trust to review and improve dissemination of learning from complaints and to ensure that service user feedback is considered and embedded in practice.

- To provide training and support to investigators to ensure they are confident in applying national and local best practice for complaint investigation.

- To continue to triangulate complaints with concerns, comments, compliments and survey information to gain rich information to inform practice and service development.

- To embed the new Datix web data collection system in practice and utilise the additional functionality to develop and share information with Locality Boards and Clinical Teams.

- To continue the development of the style and tone of Final Response Letters.

- To ensure that people who use our services are aware of how to make a complaint.

RECOMMENDATIONS

The Trust Board is asked to note the contents of this report and the assurance that it provides.

Corporate Considerations	
Quality implications:	The Complaints Annual Report offers assurance that the Trust continues to enable continuous improvement to the quality of services by implementing learning from service experience.
Resource implications:	The Complaints Annual Report offers assurance to the Trust that resources are being used to support the best service experience for service users and carers.
Equalities implications:	The Complaints Annual 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 our 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	11th April 2017

Where in the Trust has this been discussed before?		
Trust Governance Committee	Date	April 2017

What consultation has there been?		
Quality and Clinical Risk Sub-Committee	Date	April 2017

Explanation of acronyms used:	NHS – National Health Service PALS – Patient Advise and Liaison Service GP – General Practitioner OPS – Older Peoples Service CYPS – Children and Young People's Service CAMHS – Child and Adolescent Mental Health Services PHSO – Parliamentary Health Services Ombudsman HSCIC - Health and Social Care Information Centre NED – Non Executive Director

Complaints Annual Report
1st April 2016 – 31st March 2017

This report 	This report gives information about the complaints that 2gether Trust gets. It also looks at people's concerns. Concerns are like complaints but are usually managed less formally and more quickly.	
Complaints 	106 people complained. This is less than last year (131). This is less than most other mental health Trusts.	
Concerns 	195 people told us their concerns. This is more than last year (149).	
Overall 	8% more people told us they were unhappy with their experience. We want people to tell us what they think. This helps us to make services even better.	
Ombudsman 	The ombudsman checks if we manage complaints properly. 5% of complaints were passed to the ombudsman. This is the same as last year. 1 complaint was partially upheld. This is less than other Trusts.	
Next steps 	Next we will: - review and update the Complaints Policy - carry on making sure we learn from complaints and concerns - train more staff to look into complaints - carry on making our response letters better	

Key

			Full assurance
↑	Higher/more activity		Significant assurance
↔	Activity remains similar		Limited assurance
↓	Lower/less activity		Negative assurance

Annual Report: Complaints

1st April 2016 – 31st March 2017

CONTENT

[2]gether NHS Foundation Trust
Complaints Annual Report – 2016/17

1. INTRODUCTION

1.1 This report presents information regarding complaints received by the Trust between 1st April 2016 and 31st March 2017.

1.2 The Complaints Annual Report is an external audit requirement as part of the assurance processes for the Quality Report/Account. This report is a summary of complaints received during the year, which are more routinely reported in the quarterly Service Experience Reports. The Service Experience Reports provide aggregated information gained from an in-depth analysis of service user and carer experience information from a variety of sources, including complaints. This process allows our Trust to understand how services are experienced, to take action to improve the experience of those who use our services, and to learn from both positive and challenging feedback.

1.3 The Complaints Annual Report provides a broad overview of the national and local context to explain the background to the report. It goes on to provide specific information about the number of complaints received throughout the year, emerging themes from complaints, a summary analysis of the issues that have arisen, and the lessons learned by the organisation. Comparative data is provided with previous years and where available, with other healthcare organisations. Some examples of individual experiences are also highlighted in vignettes to provide insight into individual complaints and context to the report. The report concludes with recommendations for developments in complaint handling, recording and reporting.

2. CONTEXT

2.1 National context

Nationally and locally, the experience of service users and carers remains essential to allow evaluation and improvement of our services. Practice experience coupled with current national guidance[1] has informed developments within the Service Experience Department and the complaints process. Key actions and areas for development include:

- Raising awareness of the importance of service user feedback about our services and making sure people know how to complain.

- Ensuring that people who raise concerns feel confident that their complaint will be dealt with seriously.

[1] https://www.ombudsman.org.uk/publications/learning-mistakes-0

https://www.ombudsman.org.uk/publications/review-quality-nhs-complaints-investigations-where-serious-or-avoidable-harm-has

- Assurance that complaints will be investigated consistently and transparently using a robust framework.

- Responding to complaints with open, honest and sensitive feedback regarding the findings of complaint investigations, highlighting opportunities for learning and actions taken.

2.2 Local context

In their comprehensive inspection of the Trust in October 2015, the Care Quality Commission (CQC) reviewed complaints information and interviewed key staff involved in complaints resolution. They noted that the Trust detailed the nature of complaints and a summary of actions taken in response. They found that complaints had been appropriately investigated by the Trust and included recommendations for learning.

In their published report about [2]gether NHS Foundation Trust, the CQC noted that:

The *Trust operates an effective complaints system. Information relating to complaints past and present were orderly and up to date. The complaints staff were able to speak with knowledge, confidence and transparency of past and present complaints.*

The CQC also noted that:

Staff felt confident in handling complaints from patients. All staff we spoke to about complaints said they would make efforts to resolve any complaint before it became formal. Staff were also happy to support patients in making formal complaints. The complaints service fed back the outcome of complaints to the relevant team manager.

Building on developments from 2015/16, the Service Experience Department have continued to focus on and progress complaint resolution this year in the following areas:

- Review and triage of complaints at the point of contact from complainants to attempt to resolve concerns in a timely and responsive way.

- Tailored training sessions led by the Complaints Manager to support staff to carry out quality, impartial and transparent complaint investigations.

- Sustained embedding and adjustment to the Datix information system used to record all complaint data and activity. This ensures that all relevant service experience information and data is captured, allowing themes and trends to be monitored.

- Review of the standards for the quarterly audit of complaints from our Trusts Non-Executive Directors (NEDs), to ensure an impartial review of best practice.

- Continued review, development and implementation of processes to resolve complaints wherever possible.

- Development work with directorate leads to ensure that learning from complaints and concerns is shared and embedded in practice.

- Review and development of Final Response Letters (FRL) sent to complainants to ensure responses explain the findings from complaint investigations in a clear, transparent and compassionate way.

2.3 Service Experience Committee

The Service Experience Committee uses a collaborative approach to enable ²gether to be a learning organisation, to address any areas for improvement, to provide evidence of service experience outcomes and to acknowledge best practice. ²gether's Service Experience Committee is held on a quarterly basis and membership is drawn from people who use Trust services, carers, partner organisations and senior members of operational staff.

2.4 Quarterly Service Experience Reports

Quarterly reports about service experience activity are presented to the Trust Board and reflect the importance placed on striving for positive service experience for all. The Trust's culture is to welcome feedback including complaints, concerns, comments and compliments from any service user, carer and/or their representative. ²gether's aim is to resolve people's complaints or concerns, learning and taking action whenever possible.

Learning from complaints is shared through the Trust's governance structures in order to disseminate learning and to inform practice. Key themes are highlighted and assurance is sought from Locality Directors regarding local implementation. Work has commenced to provide quarterly analysis of themes and trends and to learn from service users and carers experiences across each locality.

2.5 Service Experience Department

The Service Experience Department aims to deliver a robust, clinically led approach to the management of all aspects of the Trust's Service Experience processes, in partnership with operational colleagues across services.

The Service Experience Department has a dedicated Complaints Manager who has extensive clinical experience and who works alongside a Complaints Officer. In addition, the Patient Advice and Liaison Service (PALS) role has continued to develop to support the triage of complaints at first contact and to facilitate the timely resolution of concerns raised by service users and carers. Service user feedback continues to be coordinated by the department, including the Friends and Family Test and Quality Survey. An extensive review of the processes used to gather survey feedback within our Trust has been undertaken by the Service Experience Clinical Manager. The outcome of the review led to the development of a new combined survey called "How did we do?" This survey combines the Friends and Family Test and Quality Survey with the aim of making it simpler to complete and to encourage people to feedback about their experiences of our services.

Work is underway with operational colleagues for PALS team members to have a routine and regular presence in inpatient environments to support people to have their views heard, resolve any concerns, and to obtain feedback about service user experience.

2.6 Training and practice development to resolve complaints

Training at Corporate Induction includes a session led by the Service Experience Department informing all new [2]gether colleagues about the functions of the department, advising about local complaint handling processes, and sharing examples of service user feedback.

Combined Serious Incident investigation and Complaint investigation training for senior staff continues to be offered regularly by our training department, along with a senior member of the Service Experience Department, to support colleagues to develop the appropriate skills for complaint resolution.

Additional training led by our Complaints Manager to support complaint investigators is underway. Training will be held on a quarterly basis throughout 2017/18 as well as ad hoc sessions arranged as requested. The aim of the training is to support and equip colleagues with the knowledge and confidence to carry out high quality complaint investigations. The training also informs staff about current best practise, national guidance and local implementation.

2.7 Audit of complaints

The Trust continues the good practice of commissioning regular audits of the complaints handling process by Non-Executive Directors (NED) of the Trust Board.

Revisions were made to the audit process and template and a new format was approved in 2016. The new format was implemented for the Quarter 3 audit (October – December) 2016/17. The NED audit monitors if the Trust is meeting current standards for complaint management and will provide greater emphasis on the rigour of the investigation, the openness and candour of communication and the efficacy of the organisation in learning from complaints and concerns.

Audits undertaken by the NED continue to provide assurance that the Trust continues to use current evidence-based practice in line with the values of the organisation.

2.8 Teamwork across the Trust

The Service Experience Department works closely with colleagues across all services and with corporate departments. Regular meetings have taken place with Service and Locality leads and Team Managers. Some examples of action taken as a result of liaison and feedback from operational colleagues include:

- Development of the PALS service within the inpatient environments.
- Advancements in the way service experience activity and data are shared with the localities on a monthly basis.
- Improvement in the way learning is identified and shared throughout the Trust, demonstrating listening, responding and learning.
- Creation of supportive training sessions for colleagues to enhance the reliability and quality of the complaint investigation process.

The Service Experience Department will continue to work closely with colleagues to support effective complaint resolution and dissemination of all learning identified during the complaint handling process.

3. COMPLAINT INFORMATION 2016 -17

Data collection and analysis

The complaints and PALS data is entered into a database and analysed using the Datix computer software system. As well as recording the number of formal complaints and PALS contacts, a vast amount of qualitative data is entered into Datix. This includes:

- The nature of the complaints and concerns regarding [2]gether NHS Foundation Trust.
- The number and nature of compliments forwarded directly to the SED.
- Categorisation of all concerns and complaints to enable detailed analysis of themes.

The data is analysed to show the total number of complaints and/or concerns by ward, department or service.

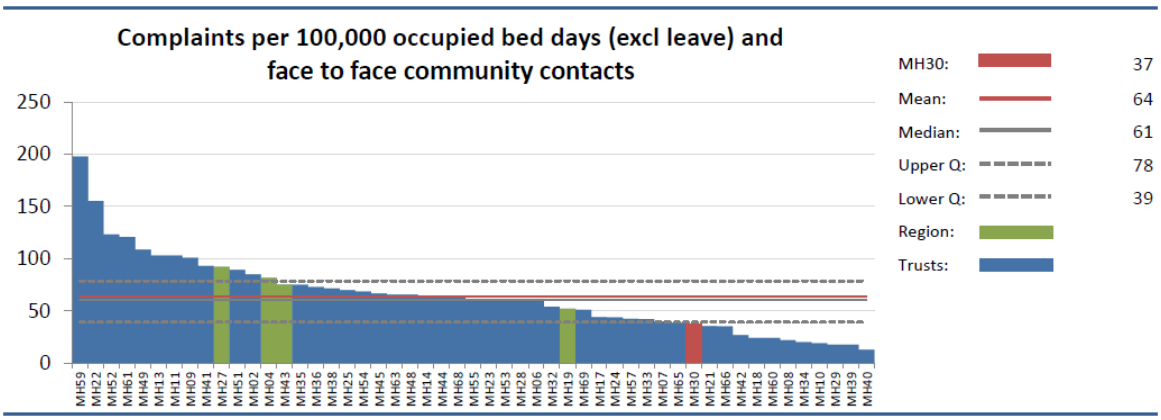
The categorisation of concerns and complaints is a somewhat subjective process. During 2016/17 the data inputting has been undertaken by four different staff. Following a review in early 2016/17 the inputting and categorising of information has been overseen by the Clinical Manager for Service Experience in order to minimise variation.

3.1 National complaint data

In 2015/16 the Health and Social Care Information Centre (HSCIC), now known as *NHS Digital,* started collecting additional information about complaints raised with NHS organisations. Aggregated quarterly reports are emerging[2]. NHS Digital comment that the results are provisional and experimental and so care should be taken when interpreting the results.

[2]gether NHS Trust takes part in a separate national NHS benchmarking process for Mental Health Services. The number of complaints reported across health care organisations in relation to the number of people our services have contact with is shown in Figure 1. In this calculation, [2]gether NHS Foundation Trust shown in red as MH30 is significantly lower than the national average as shown in Figure 1 on the next page.

Figure 1 – Benchmarking data of reported formal complaints



[2] http://content.digital.nhs.uk/catalogue/PUB23365/data-writ-comp-nhs-2016-2017-Q3-rep.pdf

Whilst the number of formal complaints received by ²gether is significantly lower than the average shown within the national benchmarking data, it is important to note that the number of concerns processed by the Service Experience Department has risen. This demonstrates that the Service Experience Department, along with operational colleagues, is working hard to listen and respond to people in a timely way to resolve concerns raised by people who use our services.

The leadership from the Service Experience Clinical Manager, along with the Complaints Manager and continued development of the PALS service has meant that responses to people's feedback are often undertaken in a way that enables timely action and local resolution without the need for a formal complaint process.

3.2 ²gether NHS Foundation Trust complaints

Every person who raises a new complaint or concern is contacted by a member of the Service Experience Department. This individualised process enables the key issues that the person wishes to raise are identified and the desired outcomes are clearly established. It is also an opportunity for the NHS complaints process to be explained and for a less formal approach to resolution to be explored. The priority is early resolution of people's concerns and difficulties especially when they relate to current care or treatment.

Where a concern and a complaint are reported within the same contact the issues are logged separately for transparency. This is done in order to capture all issues and to ensure robust the data for analysis.

3.2.1 Numbers of reported formal complaints

All NHS complaints are logged nationally in line with the KO41, NHS Digital categories used to record and collect NHS complaint information and data. Our Trust has continued to comply with the requirement to provide quarterly data for the KO41 submission

Between the 1st April 2016 and the 31st March 2017 our Trust recorded **106** formal complaints, a 19% reduction on the previous year (n=131 complaints). A quarterly breakdown is in Table 1, detailing numbers for Gloucestershire and Herefordshire.

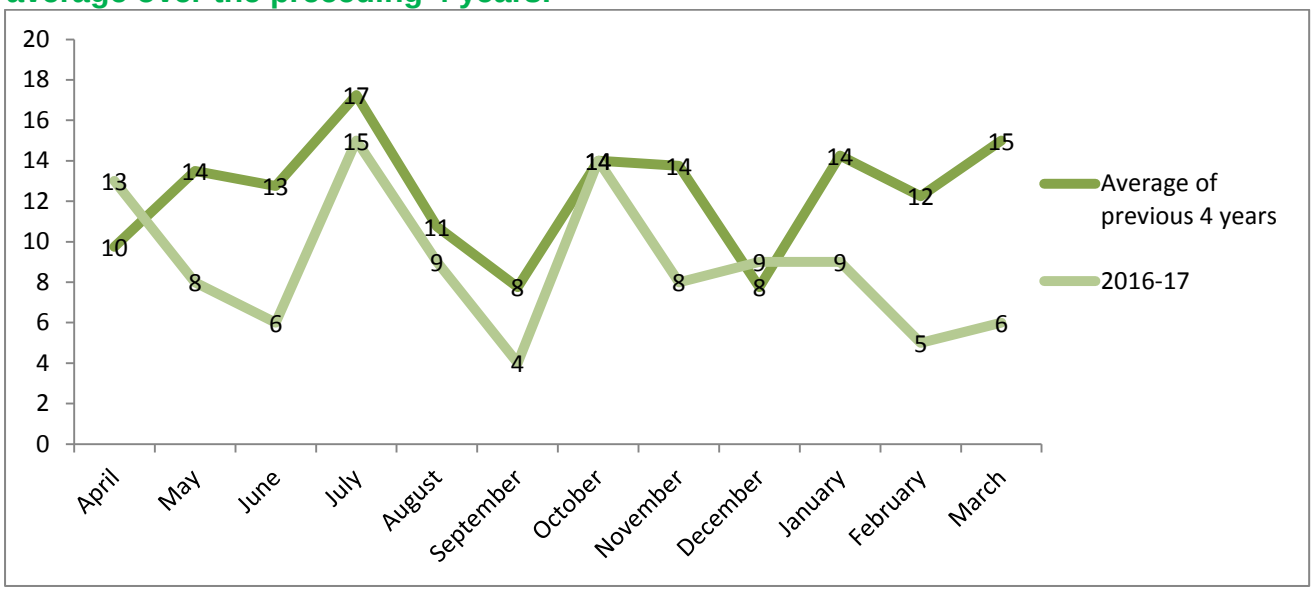
Table 1: Quarterly number of complaints by county

	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
Gloucestershire complaints	24	23	29	17
Herefordshire complaints	3	5	2	3

It is important to note that NHS Digital (formerly Health and Social Care Information Centre (HSCIC)) report by the number of individual complaint *issues* that are contained within each individual formal complaint. The number of complaint issues reported to NHS Digital this year by ²gether was **583** and these were contained within the **106** individual complaints. The number of complaint issues within each complaint ranged between **1** and **29**. The outcome of investigations, that is whether aspects of complaints were Upheld, Partially Upheld or Not Upheld, were also reported this way to NHS Digital this year.

The pattern of complaint numbers received month by month over the previous 4 years is relatively consistent; with peaks in reported complaints in July, October and March (see Figure 2). This information is important for workforce considerations to ensure that individuals receive a timely response to their complaints.

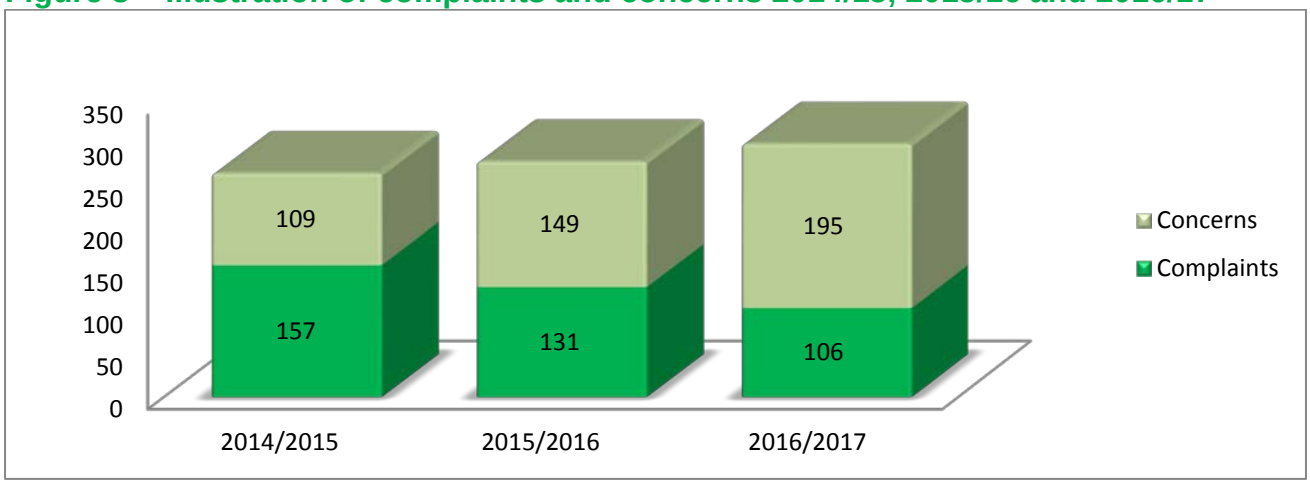
Figure 2 – The monthly number of complaints received in 2016/17, compared to the average over the preceding 4 years.



3.2.2 Comparison of formal complaints and concerns 2015/16 and 2016/17

During 2016-17 a greater proportion of concerns raised with the Service Experience Department were supported through the management of 'concerns' process (Figure 3).

Figure 3 – Illustration of complaints and concerns 2014/15, 2015/16 and 2016/17



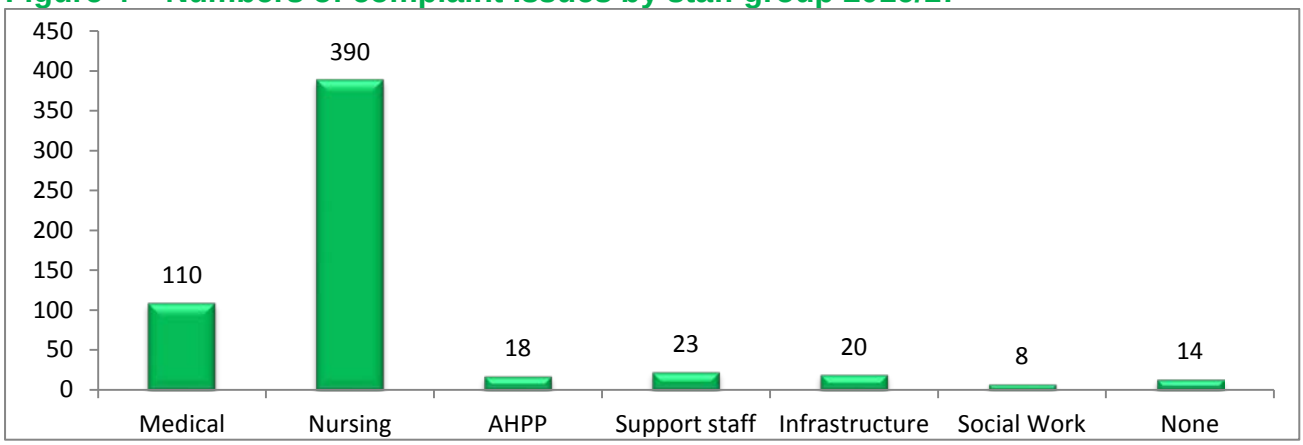
Analysis of this information shows that there has been a 19% reduction in the number of formal complaints (n=106), with a corresponding 31% increase in the number of concerns (n=195) (Figure 3). Managing issues via the concerns process ensures an emphasis on swift and local resolution through negotiation between operational staff, the complainant, and other service areas and organisations. The data suggests that this has had an impact on the number of formal complaints the Trust has recorded this year.

There is an 8% increase in the combined number of complaints and concerns reported to the Service Experience Department 2016/17. As a Trust we view this positively as we actively encourage people to engage with us, share views of experience and seek resolution where concerns are raised, enabling opportunity to learn and improve our services.

3.2.3 Complaints by staff group

The number of complaint *issues* involving different disciplines and staff groups has been recorded for NHS Digital this year. The majority of complaint issues reported relate to the nursing staff group, data is presented in Figure 4. Nursing is the largest staff group in the Trust and has the highest numbers of contacts with service users and carers. This is especially the case within inpatient services and at times when people are cared for within legal frameworks. This combination of facts helps to account for this professional group featuring most frequently in complaint information.

Figure 4 – Numbers of complaint issues by staff group 2016/17



Work is ongoing to ensure that professional leads are made aware of any themes relating to their professional group

Figure 5 –Percentage of complaint issues by staff group compared to staff group as a percentage of the workforce.

	% of complaint issues relating to staff group	% total workforce figures by staff group
Medical	**19%** (n=110)	**3%**
Nursing	**66.5%** (n=390)	**31%**
AHPP	**3%** (n=18)	**12%**
Support staff	**4%** (n=23)	**27%**
Infrastructure staff	**3%** (n=20)	**24%**
Social Care	**1.5%** (n=8)	**3%**
Non-attributable	**3%** (n=14)	

A total of 583 individual complaint issues were contained within the 106 complaints received during the reporting period. This data shows that that the highest proportion of complaint issues relate to medical and qualified nursing colleagues**.** This remains

consistent from our Trust's previous year's data and that reported in analysis of national NHS complaint data.

Workforce configuration information has been sourced from Human Resources and was correct as at 06/04/17. Staff group clusters have been amended slightly for this reporting period as a result of more detailed categorisation within the Datix system. These groupings will remain moving forward but this means that it is not possible to draw direct comparisons with last year's data.

3.2.4 Complaints by locality and service type

The Datix system allows more information to be recorded and subsequently analysed in relation to complaint data. For the first time in 2016/17 it has been possible to use technology to breakdown complaints data not only for each locality but also by service type within each locality.

The number of complaints by locality is shown in Figure 6. Levels of complaints by county are consistent when compared to the number of service user contacts shown later in this report (Figure 10).

Figure 6 – Complaints by locality 2016/17

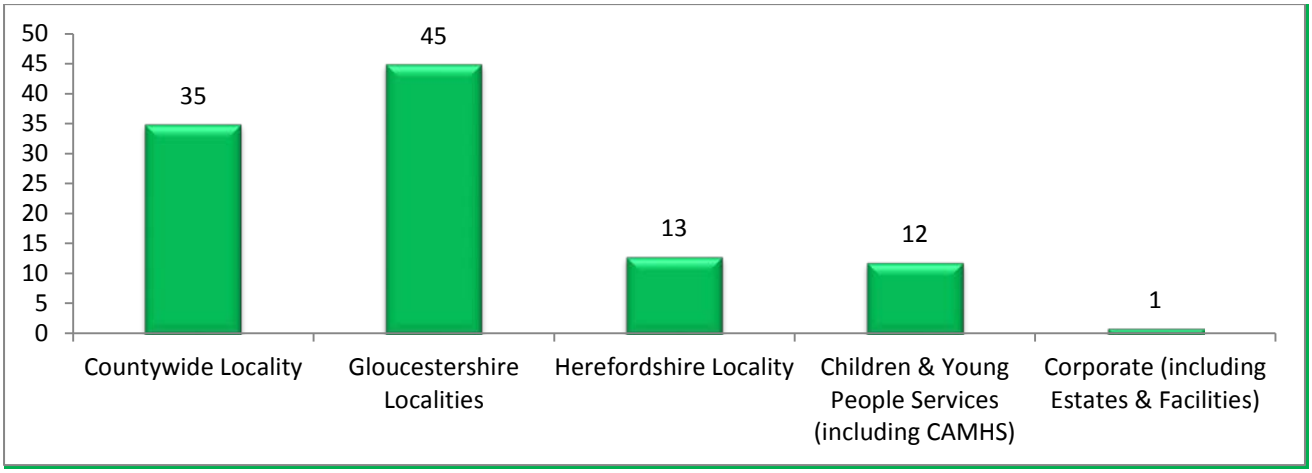


Figure 7 shows numbers of complaints broken-down by service type within each locality. This information is shared on a monthly basis with localities in order to allow each service to discuss trends and implement learning.

Figure 7– Complaint numbers by locality and service type

	Countywide Locality	Gloucestershire Localities	Herefordshire Locality	Children & Young People Services (including CAMHS)	Corporate (including Estates & Facilities)	Total
Assertive Outreach Teams	0	1	0	0	0	1
Crisis Resolution and Home Treatment Teams	10	0	2	0	0	12
CYPS	0	0	0	13	0	13
CAMHS	0	0	0	0		0
Eating Disorders Service	3	0	0	0	0	3
Inpatient Adult Acute	15	0	4	0	0	19
Inpatient Low Secure	1	0	0	0	0	1
Inpatient Psychiatric Intensive Care Unit	2	0	0	0	0	2
Inpatient Rehabilitation	1	0	1	0	0	2
Later Life Teams	0	1	0	0	0	1
Learning Disabilities Community Teams	0	1	0	0	0	1
Memory Management	0	1	1	0	0	2
Mental Health Intermediate Care	0	20	0	0	0	20
Mental Health Liaison Teams	2	0	0	0	0	2
Older People's Organic	1	0	0	0	0	1
Older People's Functional	0	0	1	0	0	1
Recovery	0	21	4	0	0	25
Executive	0	0	0	0	1	1
Total	35	45	13	12	1	106

3.3 Time taken to acknowledge complaints

Best practice standards suggest that people contacting the Service Experience Department to raise a concern should receive a response within three working days. Service Experience staff will seek to resolve any concerns in the most timely and proportionate manner. Service users who wish to pursue a formal complaint will have their complaint issues clarified and sent to them in writing for confirmation.

In 2016/17, 99% (n=105) of complainants were contacted within 3 days or less to acknowledge and further clarify their concerns. One person did not receive an acknowledgement within 3 working days. Investigation has identified that the person was an inpatient at the time the complaint was made. The Service Experience Department contacted the ward within 3 working days but the service user was not available. The department liaised with the Care Coordinator who confirmed that a message would be given to the service user regarding acknowledgement of their complaint. The Service Experience Department followed this up formally in writing outside of 3 day target.

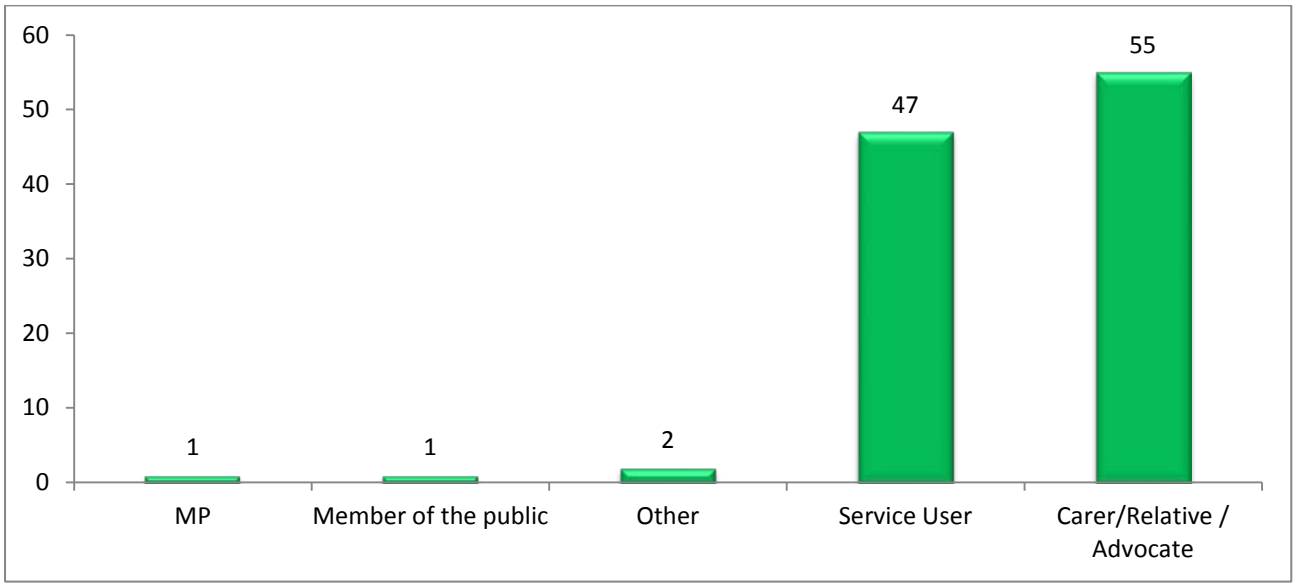
3.4 Complaints closed within agreed timescales

Quarter	% closed within agreed timescale	Comments
1	78%	Not previously reported
2	41%	The rate of complaints closed within the agreed timescale decreased significantly in Quarter 2. A review was undertaken and the main contributory factors identified as: • Investigation process – allocation of investigators, complexity of investigations and lack of protected time to complete investigations. • Delay in the final review process. An action plan was created by the Service Experience Department and operational leads. Actions included: • Increased availability of training sessions for complaint investigators, a new approach to support and coach investigators throughout the process, and robust management of allocation of investigators. • A new system was implemented to ensure a final review of complaint responses is now available every week via the Chief Executive's office.
3	65%	The rate of complaints closed within the agreed timescale increased during Quarter 3. This is reflective of the implementation of the action plan following the disappointing closure rates in Quarter 2. Embedding of the action plan to continue throughout Quarter 3.
4	78%	Continued implementation and embedding of the action plan has resulted in the closure rate continuing to improve. The closure rate now remains consistent with performance at the start of this year. The Service Experience Department will continue to monitor closure rates carefully to ensure sustained improvement.

3.5 Sources of complaints

The source of complaints remains similar to previous years. Figure 8 illustrates that 47% of people who complained contacted us themselves to raise concerns, which is 5% higher than 2015/16. This year a similar proportion of complaints were made by family members or carers compared to 2015/16. In total 88% of complaints were made by service users, their partners or carers and relatives.

Figure 8 – Complaints received by source 2016/17



3.6 Methods used to raise complaints

The trends for submitting complaints electronically or by telephone both continue to grow. This year 32% of complaints were submitted electronically, an increase on the 22% received via this method in 2015/16. Similarly complaints made by telephone call increased from 28% 2015/16 to 34% this year.

People writing to the Trust (including using the complaints leaflet) remains the main method used to raise concerns. (Figure 9)

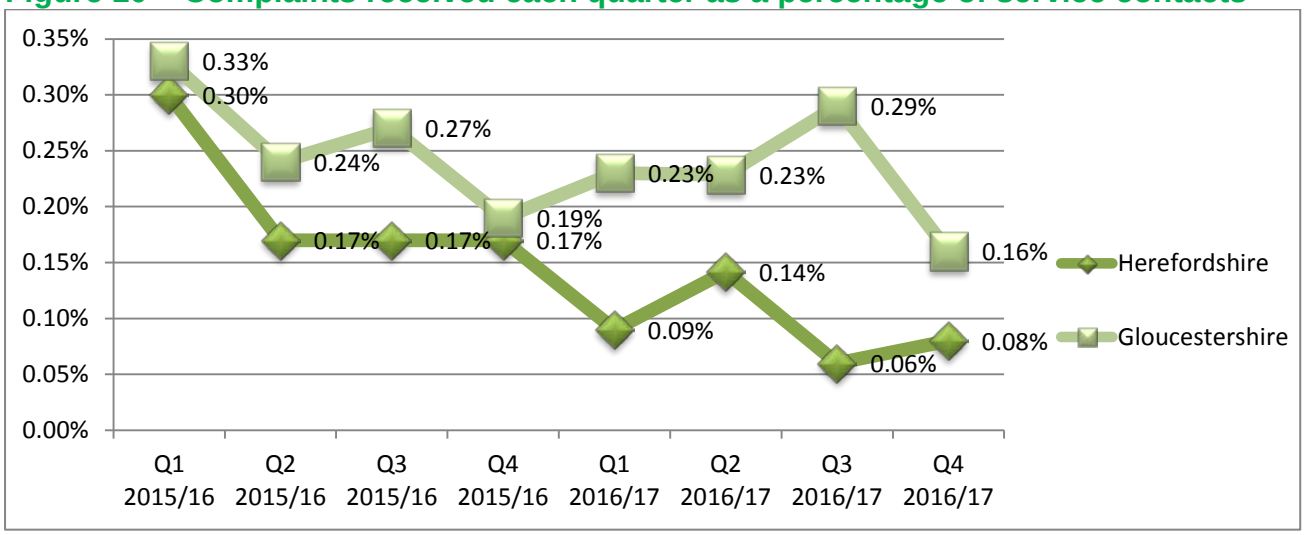
Figure 9

Method of complaint	Total
Email	32
In person	1
Letter	39
Telephone	34

3.7 Complaints received each quarter as a percentage of service contacts

The number of service user contacts each quarter in relation to the number of complaints raised has remained relatively consistent over recent years (see Figure 10). This could suggest that the vast majority of contacts with services result in people being satisfied with the care and treatment they receive. However, it is important to continue to encourage a culture of listening to feedback so that people who use our service can feel confident to raise any concerns in a timely way.

Figure 10 – Complaints received each quarter as a percentage of service contacts



3.8 Complaints by type and sub-type

The types of formal complaints submitted to our Trust over the last 12 months are presented in Figure 11. When combined, complaints about clinical treatment and patient care form the most frequent type of complaint reported during 2016 -17. Complaints detailing issues with communication form the largest single type. Dissatisfaction with staff attitude and discharge arrangements are similar to previous years.

A new theme has emerged this year involving complaints relating to service user health care records. Factual accuracy, administration issues and factors relating to confidentiality were featured within this theme.

Figure 11 – Complaints by area of concern

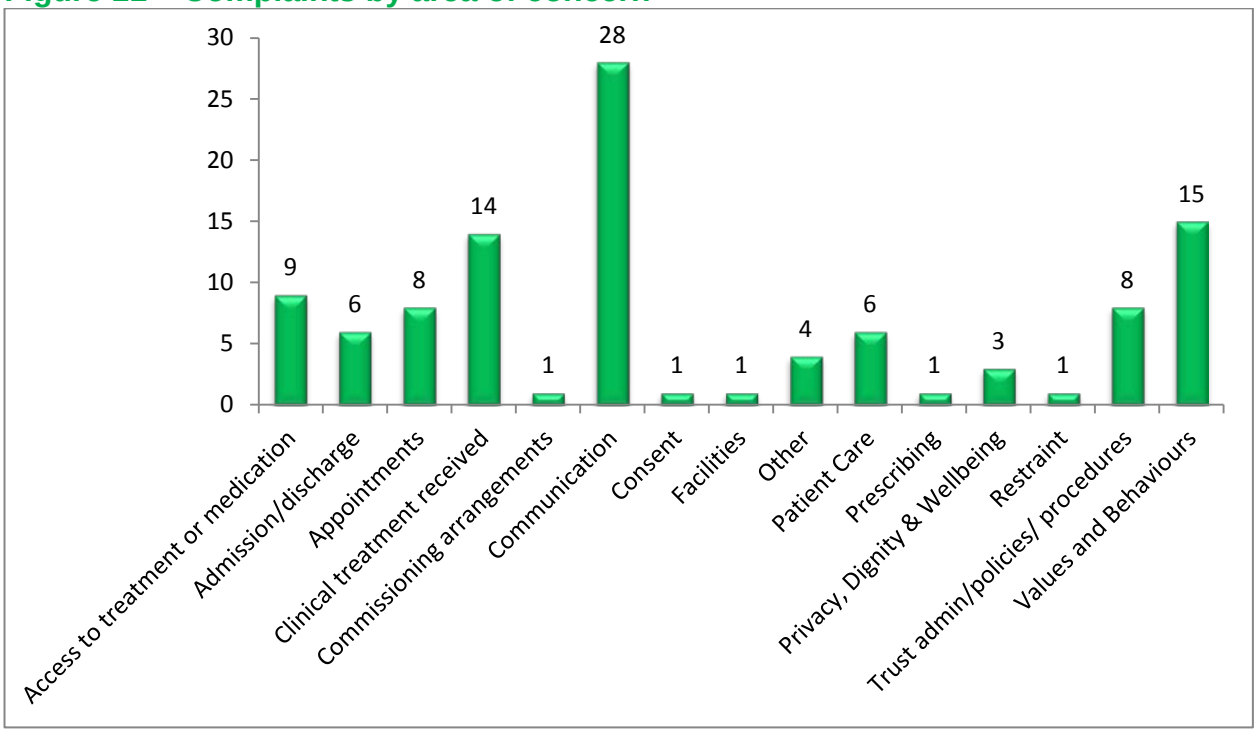
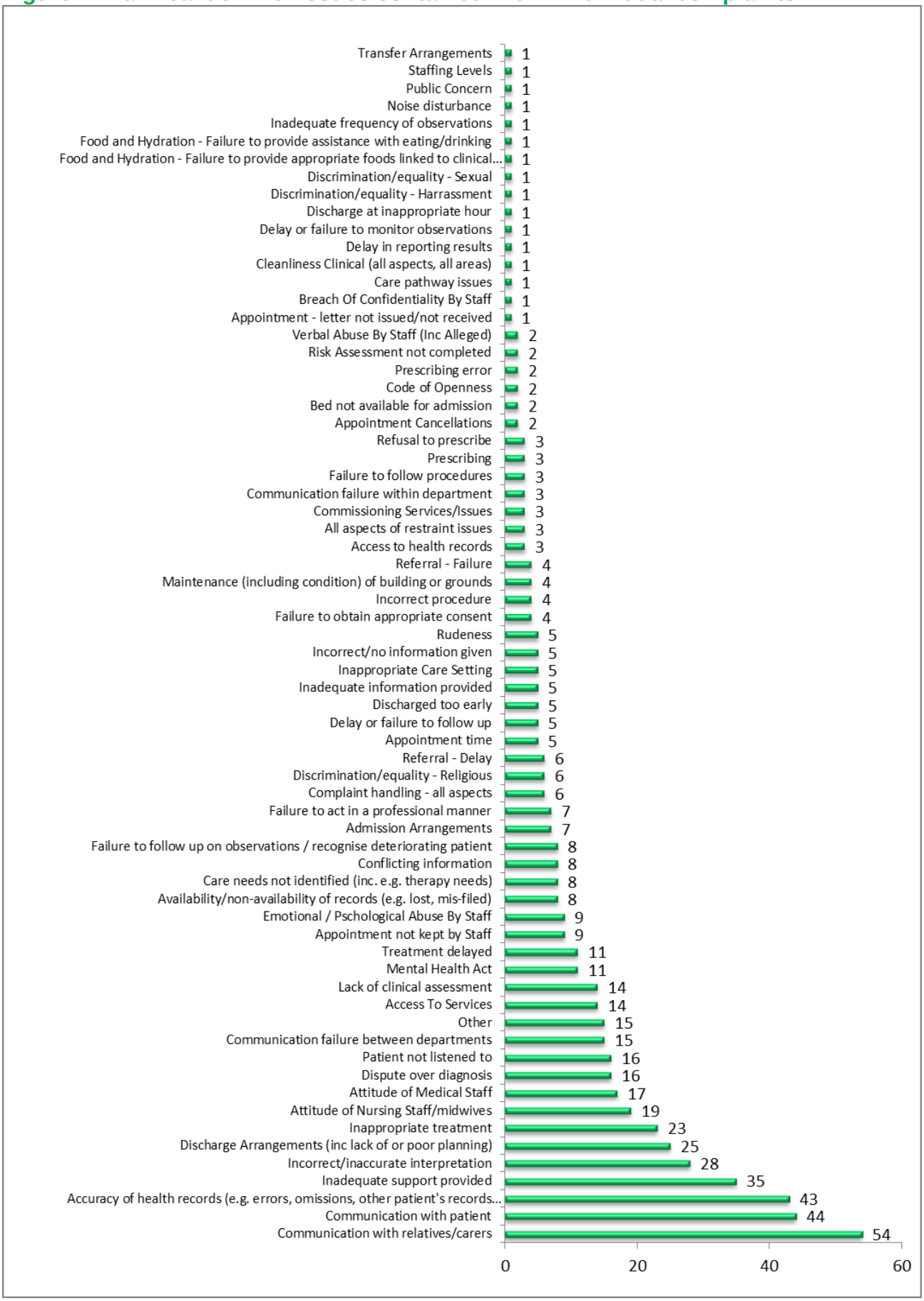


Figure – 11a Breakdown of issues contained within individual complaints



The breakdown of the issues shown in Figure 11a provides the detail within each of the themes noted in Figure 11. Issues related to clinical care and treatment are spread over several types of issues. Communication however, is shown to be particularly related to Trust communication with relatives and carers.

As a Trust we are delivering practice developments in partnership with carers and families via implementation of the Triangle of Care project. This project encourages clinicians to have increased consideration and communication with carers and families, alongside the person receiving care.

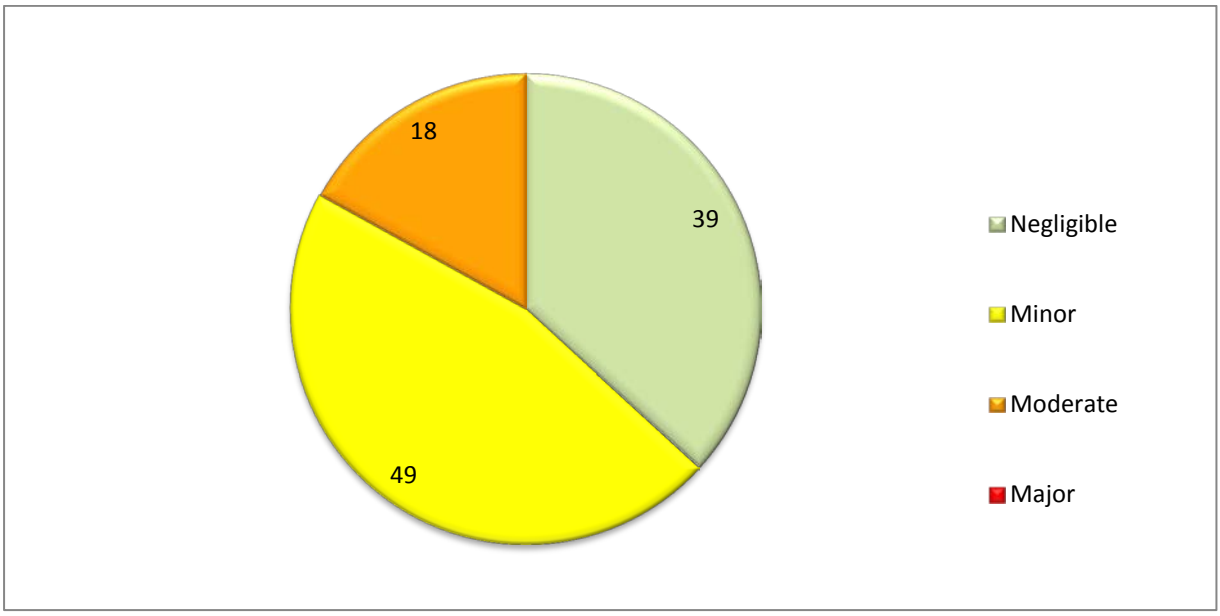
3.9 Level of organisational risk of complaints

Each complaint submitted for investigation is risk assessed by a clinical member of the Service Experience Department. The categorisation of risk is based on the National Patient Safety Agency format which considers the likelihood of an issue recurring and the potential consequences if it did. As such, each complaint is evaluated and allocated a category:

- **Negligible** – simple, non-complex issues
- **Minor** – several issues relating to a short period of care
- **Moderate** – multiple issues relating to longer period of care/involving other organisations
- **Major** – multiple issues relating to serious failures, causing serious harm

3.9.1 This year's complaints risk ratings are consistent with those reported in previous years. The majority of complaints were assessed as being negligible or minor. The number of risks assessed as major this year is zero, compared to 3% of total complaints meeting these criteria in 2015/16. Figure 12 shows the breakdown of risk ratings of complaints for 2016/17.

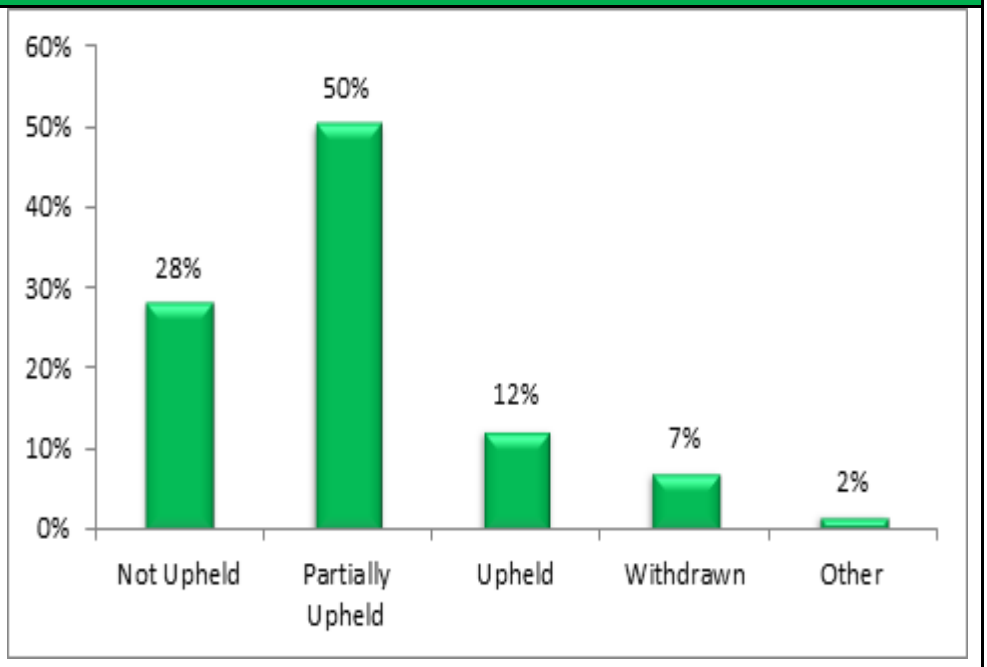
Figure 12 – Complaint numbers by level of organisational risk 2016/17



4. OUTCOME OF COMPLAINTS

A total of 113 complaints were closed during 2016/17. The Service Experience Department record the outcome of each individual complaint issue using Datix. By combining the issue outcomes in each individual complaint an overarching complaint status is reached. Figure 13 shows the overarching status of the 113 complaints closed by the Trust in 2016/17. Partially upheld complaints dominated complaints outcomes for this year.

Figure 13 – Overall outcomes of individual complaints 2016/17

Outcome	No.	Chart showing percentages
Not upheld *No element of the complaint was upheld*	32	
Partially upheld *Some elements of the complaint were upheld*	57	
Upheld *All elements of the complaint were upheld*	14	
Withdrawn *Complaint was withdrawn*	8	
Other *Complaint issues did not relate to 2gether Trust*	2	

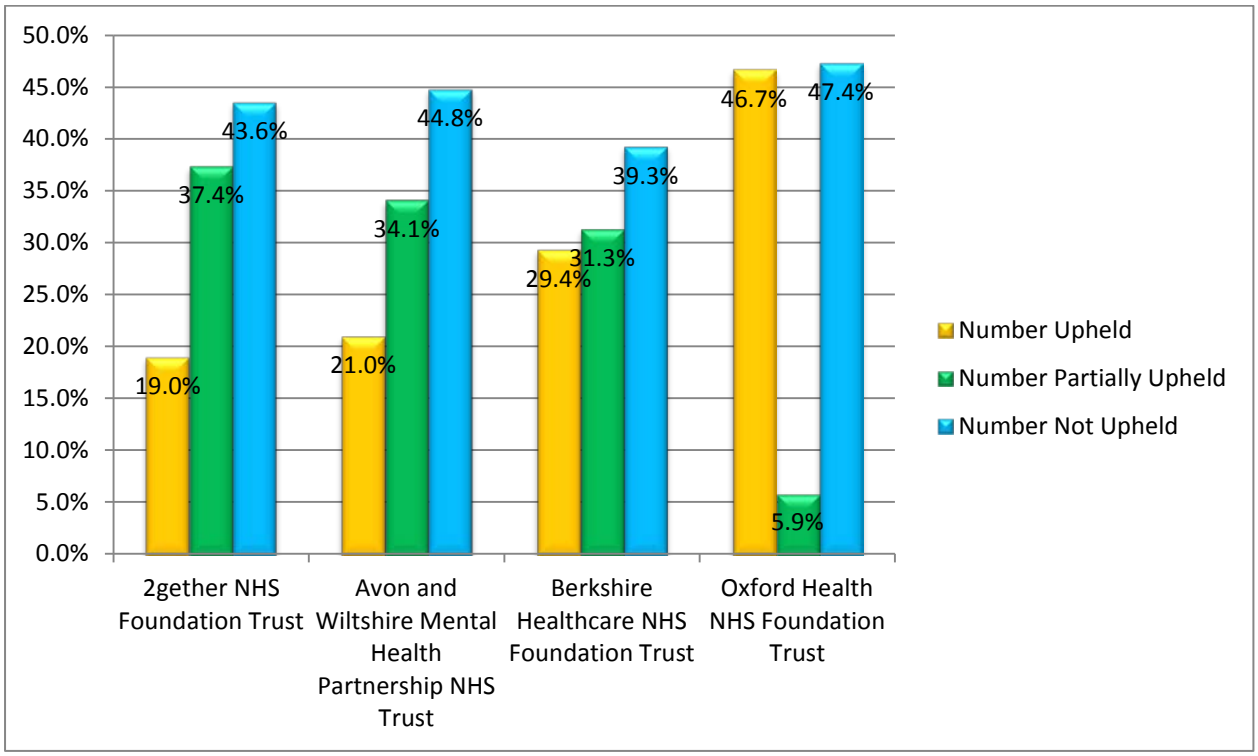
4.1 National complaint outcome data

Section 3.2.1 discusses the new national data collection system being used across NHS organisations regarding the outcome of complaint investigations. 2015/16 was the first year this data was collected and analysed in this way nationally.

The information collected allows comparisons to be made regarding complaint investigation outcomes across organisations. The first full year's comparison has been published for 2015/16 and quarterly data collection continues for 2016/17. Yearly comparison for 2015/16 is shown in Figure 14.

NHS Digital has advised that the results are provisional and experimental and caution that care should be taken when interpreting the results. NHS Digital has highlighted that Trusts have different approaches to reporting complaint outcome data. For example some Trusts regard every complaint they receive as "upheld" due to the fact the issues have been raised so are reflective of someone's experience. Currently there is no single nationally agreed way of reporting outcomes of complaints as the data collection is in its infancy. The Service Experience Department will continue to review guidelines for data submission in order to remain fully compliant with NHS Digital reporting.

Figure 14 – Complaint outcomes across mental health organisations in the South West.



5. SATISFACTION WITH THE COMPLAINT RESOLUTION PROCESS

Resolving complaints to the satisfaction of people who complain remains the key focus for the Trust. Service users and carers who have raised concerns or complaints are routinely offered the opportunity to meet with clinical and service experience staff in order to attempt to achieve local resolution.

5.1 Resolution meetings in 2016/17

Of the 106 complaints received this year 13 Local Resolution Meetings were held, representing 10% of the formal complaints received. This suggests that at least 10% of people who complained were not completely satisfied with the findings presented to them. Findings are presented to complainants in the letter of response from the Chief Executive following a completed investigation. One element that complainants within this 10% commented upon was that they were unhappy with was the Final Response Letter that they received. People reported that the tone and perceived lack of sensitivity within the letter was unsatisfactory.
During Quarters 3 and 4 the Service Experience Department have placed a focus on improving the way response letters are constructed. The Quarter 3 2016-17 Non-Executive Director audit of complaints found response letters to be greatly improved from previous audit findings and reported that they were personal, open, honest and demonstrated empathy and candour to complainants.

5.2 Referrals to the Parliamentary and Health Service Ombudsman (PHSO)

People are encouraged to seek an independent review of their complaint via the Parliamentary and Health Service Ombudsman if they are dissatisfied with the complaint outcome or if they feel that their concern remains unresolved. On average the PHSO uphold a third of cases referred from NHS organisations across the country.

5.2.1 The PHSO have requested information relating to 7 complaints over the last 12 months. The Ombudsman has taken 5 of these cases forward for review and investigation.

5.2.2 This is fewer than last year, although it represents 5% of complaints received during 2016/17, which is the same percentage as last year.

5.2.3 Five cases remain open with the PHSO (one from 2014/15) and four have been closed.

5.2.4 One complaint, which was received in 2013/14, was partially upheld by the PHSO this year. An action plan was created by the Trust to address the areas of the complaint that were upheld. The action plan was implemented and completed in November 2016. The complaint was then closed.

6. LEARNING FROM COMPLAINTS

The Service Experience Department has continued to work in partnership with colleagues across the Trust to develop and implement systems to share learning and improve our services. Monthly and quarterly reports detailing Service Experience activity, themes and learning for each locality have been developed by the Service Experience Department and are shared with service leads.

Figure 15 outlines some examples of complaints and the actions taken in response to people's reported experiences.

Figure 15 – Examples of complaints made and the actions taken as a result of learning during 2016/17

Example	You said	We did
Clinical Records	*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
Access to care and treatment	*My appointments were scheduled with little notice which meant I could not gain the support of a mental health advocate.*	We agreed that that your CPA been scheduled with little notice and we apologised. We gave assurance that the team will learn from your experience to ensure this does not happen again.

Example	You said	We did
Confidentiality	*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.
Communication	*I made five separate requests for a face to face or telephone conversation with a clinician about my relative over a two week period before somebody responded.*	We apologised for the breakdown in communication. We explained why there was a delay in responding to you. We assured you it was not intentional but an error in internal processes.
Admission	*A planned admission to hospital was delayed. My relative experienced a rapid deterioration in mental state and required an admission to hospital under the Mental Health Act.*	We apologised and assured you that we constantly review our bed management processes and will continue to do so in relation to planned admissions.
Information	*I was unhappy that the Trust did not listen to a recording I had made of a meeting with a member of staff.*	We apologised and informed you at this time the Trust did not have a policy in place regarding recording meetings. We assured you that in response to your experience and national guidance the trust is currently in the process of developing a policy to address the issue of recording.

7. AREAS FOR DEVELOPMENT

A number of practice developments are planned for the coming year including:

- To implement and evaluate the revised Non-Executive Director Complaints Audit to enable review of national best practice in investigation and complaint management.
- To ensure reasonable adjustments are made to the complaints process to increase awareness and accessibility to everyone using our services, particularly older people, children, and people with a learning disability
- To review and update the Trust's Complaints Policy to reflect changes in local practice and national guidance.
- To work with colleagues across the Trust to review and improve dissemination of learning from complaints and to ensure that service user feedback is considered and embedded in practice

- To provide training and support to investigators to ensure they are confident in applying national and local best practice for complaint investigation.

- To continue to triangulate complaints with concerns, comments, compliments and survey information to gain rich information to inform practice and service development.

- To embed the new Datix web data collection system in practice and utilise the additional functionality to develop and share information with Locality Boards and Clinical Teams.

- To continue the development of the style and tone of Final Response Letters.

- To ensure that people who use our services are aware of how to make a complaint.

8. CONCLUSION

[2]gether NHS Foundation Trust is committed to learning from people's experiences of our services obtained through feedback from surveys, concerns, complaints, comments and compliments. In this way we will provide the best quality service experience and care in line with our Service Experience Strategy.

The Service Experience Department will continue to work with service users, carers, operational colleagues and the wider community to develop robust systems for complaint handling and to ensure that learning from feedback is used to inform practice and service developments.

Agenda item 10 **Enclosure Paper E**

Report to: [2]gether NHS Foundation Trust Board – 25 May 2017
Author: Gordon Benson, Assistant Director of Governance & Compliance
Presented by: Gordon Benson, Assistant Director of Governance & Compliance

SUBJECT: **Draft Quality Report for 2016-17**

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

2016-17 Draft Quality Report

- This final draft of the Annual Quality Report summarises the progress made in achieving targets, objectives and initiatives identified, and has been collated following an extensive review of all associated information received from a variety of sources throughout the year.

- The priorities for improvement during 2017-18 have been agreed in consultation with both internal and external stakeholders. These priorities were categorised under the three key dimensions of effectiveness; user experience and safety.

- Final CQUIN payment confirmation has not yet been received but the anticipated amount is included within the report. Should this be confirmed before 25 May 2017, then this will be included within the Quality Report and tabled accordingly.

- The Council of Governors at its meeting on 17 January 2017 chose one of the local indicators for our external auditor to audit as part of the external audit process of the Quality Report.

- The draft Quality Report has been shared with commissioners in Herefordshire and Gloucestershire, and also both Healthwatch organisations and the Health and Community Care Overview and Scrutiny Committees (HCOSCs) in the two counties, in order for them to provide formal feedback which is published as part of the final report.

- The Committee should note the requirement that External Assurance on the Quality Report (provided by Deloitte) must provide a limited assurance report on the content of Quality Reports produced by Foundation Trusts. In providing this assurance, Deloitte have reviewed the draft report for consistency with the following:

1. Papers relating to the Quality Report reported to the Board over the year;
2. Feedback from commissioners;
3. Feedback from governors;
4. Feedback from Healthwatch organisations;
5. The trust" complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
6. Feedback from other named stakeholder(s) involved in the sign off of the Quality Report;
7. Latest national and local patient survey;
8. Latest national and local staff survey;
9. The Head of Internal Audit "annual opinion over the trust" control environment; and
10. Care Quality Commission quality and risk profiles.

Deloitte have also tested the following mandated indicators:

1. *Delayed Transfers of Care*
2. *Admissions to inpatient services has access to crisis resolution home treatment teams;*

   And the local indicator

3. *Suicide reduction.*

Deloitte have indicated that they anticipate issuing an unmodified opinion in their public report and have identified a number of recommendations following testing of these indicators. They will issue their report on conclusion which will be received by the Audit Committee

- Formal ratification of the Quality Report is required at the Board. Part 1 on Page 4 (Statement on Quality from the Chief Executive) must be signed off by the Chief Executive and Annex 2 of the Quality Report describes director's responsibilities in respect of the Quality Report and must be signed off formally by the Chair and Chief Executive at Board on 25 May 2017.

- The Quality Report must be included as part of the Trust Annual Report and be submitted to NHSI by the end of May.

RECOMMENDATIONS

The Board is asked to:

1. Note that the Audit Committee will approve the Quality Report on 24 May 2017.
2. Approve the Quality Report for submission to NHSI and wider publication.

Corporate Considerations	
Quality implications:	By the setting and monitoring of quality targets, the quality of the service we provide will improve.
Resource implications:	Collating the information does have resources implications for those providing the information and putting it into an accessible format
Equalities implications:	This is referenced in the report
Risk implications:	Specific initiatives that are not being achieved are highlighted in the report.

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:		
Marie Crofts, Director of Quality & Performance	Date	18 May 2017

Where in the Trust has this been discussed before?		
Governance Committee	Date	Quarterly
Council of Governors		Quarterly
Trust Board		Quarterly

What consultation has there been?		
Ongoing liaison with internal & external stakeholders, in particular commissioners, Healthwatch organisations & HCOSCs	Date	Quarterly

Explanation of acronyms used:	**HCOSC** = Health and Care Overview and Scrutiny Committee

1. CONTEXT

Every year the Trust is obliged by statute to produce a Quality Report, reporting on activities and targets from the previous year's Account, and setting new objectives for the following year. Guidance regarding the publication of the Quality Report is issued by Monitor (incorporating the Department of Health Guidance for Quality Accounts) and the Quality Report checked for consistency against the defined regulations.

The Board is required to approve the areas for quality improvement in the forthcoming year following the period of consultation with stakeholders, and to approve the content of the Quality Report in its entirety.

2gether
Making life better

2gether
NHS Foundation Trust

Quality Report 2016/17

CONTENTS

Part 1: Statement on Quality from the Chief Executive

Introduction

Our Trust has a clear focus on three strategic priorities. The first and most important to my colleagues and I is 'Continuous Quality Improvement'.

Quality and the pursuit of providing high quality services runs throughout everything we do on a daily basis, for every team, department and service. It is only by focussing on quality that we can achieve our overall purpose of Making Life Better for our communities, service users and carers.

This report outlines the quality standards either set nationally or that we have set for ourselves, how we monitor performance against those standards, our main quality achievements during 2016/17 and the priorities we will focus upon in the coming 12 months.

In summary, our main quality initiatives this year included:

- measures focussed on improving the physical health of our service users;
- improving care planning, discharge and transition processes;
- enhancing the perinatal mental health care pathway;
- risk reduction (in the form of improving transitions from children's' to adult services, reducing opportunity for detained patients to be absent without leave, suicide prevention activities and improved inpatient discharge planning); and
- including and involving service users and carers.

Whilst we have continued to make strong progress, we have not achieved every target we set out to and the reasons for that are many, varied and complex. These priorities will continue to be the focus of our attention in 2017/18, as we recognise their importance for the health and wellbeing of our communities.

One of our main initiatives for 2017/18 is our move to becoming 'Smokefree'. This will go a long way towards helping service users, carers and staff to quit smoking and improve their physical health. We also hope to build on our most successful flu vaccination programme, in which 77 per cent of staff and service users were vaccinated for the 2016/17 flu season.

To improve engagement with service users and carers, we will continue to build upon our commitment to the 'Triangle of Care' programme. We are also introducing a new method of gathering service user and carer feedback.

For safety, we have a number of initiatives planned for the coming year. These include the continued embedding of our new Mental Health Acute Response Service, work with the media to encourage responsible reporting of suicides or suspected suicides and awareness raising of a new 'app' to help people at risk of suicide.

Our comprehensive CQC inspection in October 2015 continues to inform many of our quality initiatives. Our overall outcome was 'good', however we are ambitious and there were some areas for further development. While the vast majority of these areas have been fully addressed, there are still some issues we continue to work on, with the aim of improving still further.

The content of this report has been reviewed by the people who pay for our services (our commissioners), the Health and Care Scrutiny Committees of our local authorities and Healthwatch. Their views on this report are included on page 56. The report is also subject to review by our external auditor.

In preparing our Quality Report, we have used 'best endeavours' to ensure that the information presented is accurate and provides a fair reflection of our performance during the year. The Trust is not

responsible, and does not have direct control for all of the systems from which the information is derived and collated. The provision of information by third parties introduces the possibility that there is some degree of error in our performance, although we have taken all reasonable steps to verify and validate such information.

As Chief Executive, I confirm that to the best of my knowledge the information within this document is accurate.

On behalf of our Trust, I am privileged to present this Quality Report, containing many significant achievements and an outline of our areas of focus for the coming year. I will work with my colleagues, Board, Governors, communities and partner organisations to strive for continued quality improvements during 2017/18.

Shaun Clee
Chief Executive
[2]gether NHS Foundation Trust

Part 2.1: Looking ahead to 2017/18

Quality Priorities for Improvement 2017/18

This section of the report looks ahead to our priorities for quality improvement in 2017/18. We have developed our quality priorities under the three key dimensions of **effectiveness, user experience and safety** and these have been approved by the Trust Board following discussions with our key stakeholders.

Following feedback from service users, carers and staff, our Governors and commissioners as well as Herefordshire and Gloucestershire Healthwatch, we have identified **7** goals and **10** associated targets for 2017/18. These targets will be measured and monitored through reporting to the Trust Governance Committee with the period of time varying from monthly, quarterly or annually dependent upon what we measure, and the frequency of data collection.

How we prioritised our quality improvement initiatives

The quality improvements in each area were chosen by considering the requirements and recommendations from the following sources:

Documents and organisations:

- Our 2017/18 Business Plan;
- The 2017/18 NHS England Mandate;
- NHS England: Five Year Forward View:
- NHS England: Next Steps on the NHS Five Year Forward View. March 2017;
- Care Quality Commission (via CQC Comprehensive Inspection at our sites in October 2015);
- NHS Outcomes Framework 2016-17;
- Department of Health, with specific reference to 'No health, without mental health' (2011) and 'Mental health: priorities for change (January 2014);
- Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing. Department of Health 2015;
- NHS England: Commissioning for Quality & Innovation (CQUIN) Guidance for 2017-2019. November 2016;
- NHS Improvement;
- National Institute for Health & Care Excellence publications including their quality standards;
- Preventing suicide in England: Third annual report on the cross-government outcomes strategy to save lives. Department of Health 2016;
- National Confidential Inquiry into Suicide & Homicide by People with Mental Illness: Making Mental Health Care Safer, Annual Report and 20-year Review October 2016;
- Gloucestershire Sustainability Transformation Plan (STP);
- Herefordshire & Worcestershire STP.

The feedback and contributions have come from:

- Healthwatch Gloucestershire;
- Healthwatch Herefordshire;
- Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC) and Council colleagues;
- Herefordshire Overview and Scrutiny Committee and Council colleagues;
- Gloucestershire Clinical Commissioning Group;
- Herefordshire Clinical Commissioning Group;
- Internal assurance and Internal Audit reports;
- NHS South of England Mental Health Patient Safety Improvement Programme;
- Trust Governors;
- Trust clinicians and managers.

Effectiveness

Goal	Target	Drivers
Improving the physical health care for people with serious mental illness.	1.1 To improve the physical health of patients with a serious mental illness on CPA by a positive cardio metabolic health resource (Lester Tool). This will be used on all patients who meet the criteria within the inpatient setting and all community mental health teams. In accordance with national CQUIN targets we aim to achieve 90% compliance for inpatients and early intervention teams and 65% compliance for all other community mental health teams.	To support NHS England's commitment to reduce the 15-20 year premature mortality in people with psychosis and improve their safety through improved assessment, treatment and communication between clinicians. We wish to continue to improve the physical health for those people in contact with our services. There is historical data available for year on year comparison.
Ensure that people are discharged from hospital with personalised care plans.	1.2 To further improve personalised discharge care planning in adult and older peoples wards, including the provision of discharge information to primary care services within 24hrs of discharge.	To ensure effective discharge from our inpatient services and enhance communication with both service users and primary care services. There is historical data available for year on year comparison.
Improve transition processes for child and young people who move into adult mental health services.	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.	As we did not achieve this in 2016/17 we wish to continue to support this as a key quality priority during 2017/18 to further improve our transition processes.

User Experience

Goal	Target	Drivers
Improving the experience of service user in key areas. This will be measured though defined survey questions for both people in the community and inpatients.	2.1 Were you involved as much as you wanted to be in agreeing the care you receive? > 92% **Target :** To achieve a response 'Yes' for more than **92%** of the people surveyed.	Questions 2.2 – 2.4 are areas relating to patient experience where we wish to improve following the 2016 Care Quality Commission (CQC) national community mental health survey results.
	2.2 Have you had help and advice to find support to meet your physical health needs if you have needed it? > 76% **Target :** To achieve a response 'Yes' for more than **76%** of the people surveyed.	
	2.3 Do you know who to contact out of office hours if you have a crisis? >74% **Target :** To achieve a response of 'Yes' for more than **74%** of the people surveyed.	
	2.4 Has someone given you advice about taking part in activities that are important to you? > 69% **Target :** To achieve a response of 'Yes' for more than **69%** of the people surveyed.	

Safety

Goal	Target	Drivers
Minimise the risk of suicide of people who use our services.	3.1 Reduce the proportion of patients in touch with services who die by suspected suicide when compared with data from previous years. This will be expressed as a rate per 1000 service users on the Trust's caseload.	Gloucestershire Suicide Prevention Strategy and Action Plan Preventing suicide in England: Third annual report on the cross-government outcomes strategy to save lives. We have historical data available for year on year comparison. This is a variation on our previous suicide reduction indicator.
Ensure the safety of people detained under the Mental Health Act.	3.2 Detained service users who are absent without leave (AWOL) will not come to serious harm or death. We will report against 3 categories of AWOL as follows; harm as a consequence of: 1. Absconded from escort 2. Failure to return from leave 3. Left the hospital (escaped)	NHS South of England Patient Safety Improvement Programme It is a high risk area with historical data available for year on year comparison. We have historical data available for year on year comparison. This is a variation on our previous AWOL indicator.
Minimise the risk of harm to service users within our inpatient services when we need to use physical interventions	3.3 To reduce the number of prone restraints by 5% year on year (on all adult wards & PICU) based on 2016/17 data. During 2016/17 we reported **211** such incidents.	Positive and safe: reducing the need for restrictive interventions. April 2014 As we did not achieve this in 2016/17 we wish to continue to support this as a key quality priority during 2017/18 to promote restraint reduction. There is historical data available for year on year comparison.

Part 2.2: Statements relating to the Quality of NHS Services Provided

Review of Services

The purpose of this section of the report is to ensure we have considered the quality of care across all our services which we undertake through comprehensive reports on all services to the Governance Committee (a sub-committee of the Board).

During 2016/2017, the [2]gether NHS Foundation Trust provided and/or sub-contracted the following NHS services:

Gloucestershire
Our services are delivered through multidisciplinary and specialist teams. They are:

- One stop teams providing care to adults with mental health problems and those with a learning disability;
- Intermediate Care Mental Health Services (Primary Mental Health Services & Improving Access to Psychological Therapies);
- Specialist services including Early Intervention, Crisis Resolution and Home Treatment, Assertive Outreach, Managing Memory, Children and Young People Services; Eating Disorders, Intensive Health Outcome Team and the Learning Disability Intensive Support Service;
- Inpatient care.

Herefordshire
We provide a comprehensive range of integrated mental health and social care services across the county. Our services include:

- Providing care to adults with mental health problems in Primary Care Mental Health Teams, Recovery Teams and Older People's Teams;
- Children and Adolescent Mental Health care;
- Specialist services including Early Intervention, Assertive Outreach and Crisis Resolution and Home Treatment;
- Inpatient care;
- Community Learning Disability Services;
- Improving Access to Psychological Therapies.

The [2]gether NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these NHS services through a systematic plan of quality reporting and assurance that is considered by the Trust's Governance Committee and the Board.

The income generated by the NHS services reviewed in 2016/17 represents 93.3% of the total income generated from the provision of NHS services by the [2]gether NHS Foundation Trust for 2016/17.

Participation in Clinical Audits and National Confidential Enquiries

During 2016/17 two national clinical audits and three national confidential enquiries covered NHS services that [2]gether NHS Foundation Trust provides.

During that period**,** [2]gether NHS Foundation Trust participated in 50% national clinical audits and 100% of confidential enquiries of the national clinical audits and national confidential enquiries which we were eligible to participate in.

The national clinical audits and national confidential enquiries that [2]gether NHS Foundation Trust was eligible and participated in during 2016/17 are as follows:

National Clinical Audits

Clinical Audits	Participated Yes/No	Reason for no participation
Prescribing Observatory for Mental Health	No	The Trust is not a member of the Observatory.
Early Intervention in Psychosis audit	Yes	N/A

National Confidential Enquiries

National Confidential Enquiries	Participated Yes/No	Reason for no participation
Confidential Enquiry into Maternal and Child Health	Yes	N/A
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	Yes	N/A
Sudden Unexplained Death Study	Yes	N/A

The national clinical audits and national confidential enquiries that [2]gether NHS Foundation Trust participated in, and for which data collection was completed during 2016/2017 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Topic	Trust Participation		National Participation	
	Teams	Submissions	Teams	Submissions
Early Intervention in Psychosis	Early Intervention Service	Information not available*	Information not available*	Information not available*

*This information has not been provided by the Royal College of Psychiatrists

The report of 1 national clinical audit was reviewed in 2016/17 and [2]gether NHS Foundation Trust intends to take the following action to improve the quality of healthcare provided.

- Continued focus on the physical health of people diagnosed with schizophrenia via Target 1.1 2016/17 - to increase the number of service users with a LESTER tool alongside increased access to physical health treatment**.**

Participation in National Confidential Enquiries

Confidential Enquiries	% cases submitted [2]gether	National Average
Confidential Enquiry into Maternal and Child Health	Information not published	Information Unavailable
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	99%	98%
Sudden Unexplained Death Study	Information unavailable	Information unavailable

Local Clinical Audit Activity

Within our services there is a high level of clinical participation in local clinical audits, demonstrating our commitment to quality across the organisation. All clinically led local audits are reported to the Quality & Clinical Risk Committee in summary form to ensure that actions are taken forward and learning is shared widely. The table below shows the status of the audit plan at the end of the year. During this process we internally identified a significant number of recommendations to further improve our practice as part of our commitment to continuous improvement.

Clinical Audits	2015/16 audit programme	2016/17 audit programme
Total number of audits on the audit programme	168	168
Audits completed (at year end)	75	95
Audits that are progressing and will carry forward	49	31
Audits taken off the programme for specific reasons	44	42

The reports of **95** local clinical audits were reviewed by the provider in 2016/17 and [2]gether NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Building on the review of key clinical policies ***Assessment and Care Management CPA*** and ***Assessing and Managing Clinical Risk and Safety*** undertaken in 2016, the Trust has continued to implement and embed these principles into policies and practice. There have been a number of audits carried out throughout the year to provide assurance and actions plan were developed to support improvements in compliance throughout the year. This action continues from last year;

- The Trust has continued to review and develop its training programme to all staff (clinical and non-clinical) in line with the learning that is established from the clinical audit programme. This has, and will continue, to drive the constant review and evaluation of training modules and their contents. This action also continues from last year.

Specific examples of change in practice that have resulted from clinical audits are:

- The [2]gether Trust no longer considers the use of 'PO/IM' (Oral/Intramuscular) prescriptions, in which the professional dispensing or administering a drug is given discretion about which route to use from a single prescription, acceptable. This is due to the risk of mishaps, and as such, this prescription should no longer be accepted. In February 2016 an audit was carried out looking specifically at the prescription of PRN sedative medication. The key finding of the initial audit was that 39% of prescriptions for PRN sedative medication took the form of 'PO/IM', giving a compliance of only 61% prescribed in line with new expectations. A re-audit was then carried out in May 2016, again making a cross-sectional analysis of prescription charts in Wotton Lawn and Charlton Lane Hospitals, with the audit criterion being that no prescription for PRN sedative medication should be prescribed as 'PO/IM'. The key finding of the re-audit was that only 10% of prescriptions for PRN sedative medication now take the form of 'PO/IM', giving a much improved compliance of 90% prescribed in line with new expectations.

- CG43 Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults re audit. This re-audit was conducted as part of the Trusts rolling programme of Quality Assurance 2015 – 2016 in order to assess how the organisation is performing against the NICE guidance CG43. Data collection took place during April to June 2016 and was carried out by a health and exercise practitioner across inpatient services in the Trust. A total of 203 patients were included in the audit. The compliance increased from 74% to 85% since the previous audit carried out in 2015 and provided assurance that:

    - Patients had undergone a physical examination

- That an Essence of Care screening tool had been used
- A MUST screening Tool assessment had been completed
- Service users with a BMI greater than 30 had received a health and exercise or physiotherapy intervention.

A re-audit will occur in July 2017 to monitor ongoing compliance with this guidance.

Participation in Clinical Research

Research Activity in 2gether in 2016-17

The number of patients receiving relevant health services provided or subcontracted by 2gether NHS Foundation Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee **308**.

This participation was from across **23** different studies[1] . This level of recruitment is slightly less than the previous year's total of **354** participants, and reflects a drop in the number of research studies that have been registered and opened to recruit participants in Trust services.

In 2016/17, the Trust registered and approved **27** studies. Of these studies, **19** were based in mental health services and **1** in dementia services. The remaining studies were made up from **5** "generic and cross-cutting themes" studies (often academic studies involving staff participants) and **2** neurological studies. This also included **8** National Institute for Health Research (NIHR) portfolio studies and **5** of the studies were service evaluations.

Growing 2gether Research

Our research team has performed well in a national key performance indicator of recruiting to time and target for open research studies, as well as supporting a number of activities that help to grow research across the counties of Gloucestershire and Herefordshire. We continue to seek new ways to expand our service, and have recently received funding from the Clinical Research Network West Midlands to fund a full-time Research Nurse post for Herefordshire in 2017/18, and plan to expand our activity across this region.

In August 2016 we held an official opening for the Fritchie Centre; a new development for the organisation to expand our research activity to include commercial and academic research for clinical trials involving medicines. The Research Centre is a team base for both the Research Team and the Managing Memory Service, and we are working towards an integrated service where researchers work collaboratively with clinicians, offering research opportunities to service users and carers.

Alongside our research centre, a new partnership has been formed to carry out research into Alzheimer's disease and dementia. The pioneering programme, between our Trust and the Cheltenham-based charity Cobalt Health, will ensure that research into the illness is undertaken in Gloucestershire and Herefordshire. The research results will contribute towards improving standards of care and treatment locally, and also to the wider research environment nationally and internationally. Cobalt has also undertaken to fund Research Nurse posts at the centre to exclusively support the development and opening of clinical trials for dementia.

We have had additional funding from the Clinical Research Network West of England for a Research Nurse to deliver a development project to integrate the secondary care and primary care interface for research studies. We are working closely with three GP surgeries as part of a pilot to increase opportunities for patients to take part in dementia research and the Join Dementia Research database, a national register for people wanting to be part of dementia research.

[1] Data reported by the West of England Comprehensive Research Network, WoE CRN, from 1 April 2016 to 27 March 2017)

Seeking new research opportunities

The availability of research through the National Institute of Health Research (NIHR) and local portfolios fluctuated throughout 2016/17. We are pleased to report a partnership with Queen Mary University, London, who have now received a 5 year NIHR programme grant for a research study aiming to help people with chronic depression. We continue to work collaboratively with partners through the Clinical Research Network West of England to support programme grant applications in other areas of interest.

Currently we have **23** approved NIHR studies recruiting or active in Gloucestershire and Herefordshire, an increase on the **2** open at this time last year. We continue to develop a rolling programme of studies open across the range of our services, as new studies come on to the NIHR portfolio.

Research ^{2}gether strategy

Our Research ^{2}gether Strategy 2016 – 2020 enters its second year and continues to work towards our vision to be a world class centre of practice-based research and development to help make life better. One development from this strategy will be the adoption and roll out of an 'opt-out' research programme that will enable us to offer research opportunities to more people using our services so that they are routinely offered information about research studies.

We are also developing a pipeline of Principle Investigators for research studies to work both commercially and academically, which involves training and supporting staff to recruit participants to trials.

Research Studies

Examples of the portfolio of activity for 2016/17 are listed below.

Mental Health

- SCIMITAR - Smoking Cessation Intervention for Severe Mental Ill Health Trial: a definitive randomised evaluation of a bespoke smoking cessation service;
- The MILESTONE Study: Improving Transition from Child to Adult Mental Health Care;
- PPiP – Prevalence of neuronal cell surface antibodies in patients with psychotic illness;
- DPIM Polymorphisms in Mental Illness: investigating genetic factors involved in schizophrenia, bipolar disorder, alcoholism and autism and exploring possible treatment options;
- Molecular Genetics – Bipolar Disorder Research Network;
- REACT – An online randomised controlled trial to evaluate the clinical and cost effectiveness of a peer supported self-management intervention for relatives of people with psychosis or bipolar disorder: Relatives Education And Coping Toolkit (REACT);
- Autism Cohort - Learning about the lives of adults on the autism spectrum;
- ESMI - The Effectiveness and cost-effectiveness of Mother and Baby Units versus general psychiatric Inpatient wards and Crisis Resolution Team services (ESMI).

Dementias and Neurodegenerative Disease

- DAPA – Dementia and Physical Activity research programme;
- VALID - Valuing Active Life in Dementia: a randomised controlled trial of Community Occupational Therapy in Dementia (COTiD-UK);
- IDEAL: Improving the experience of dementia and enhancing active life; the IDEAL longitudinal research study;
- MADE: Minocycline in Alzheimer's Disease Efficacy, a clinical trial;
- MAS: Using Patient Reported Outcome Measures (PROMs) to Improve Dementia Services: Evaluation of Memory Assessment Services;
- MS PAIPMS – Primary progressive multiple sclerosis survey;
- Caregiving HOPE: How obligations, preparedness and eagerness influence wellbeing.

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 goals for 2016/17 and for the following 12 month period 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
3 National CQUIN - Improving Physical Healthcare	- To reduce premature mortality - Improved communication with GPs	.25	£41100	Effectiveness
Local CQUIN 1 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 2 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 2016/17 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

CQUIN goals for 2017/18 reflect the nationally agreed two year scheme and are intended to deliver clinical quality improvements and drive transformational change in line with the Five Year Forward View and NHS Mandate. These include:

National CQUINs applicable to Gloucestershire and Herefordshire mental health services

- CQUIN 1 – NHS Staff Health and Wellbeing;
- CQUIN 2 - Improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI);
- CQUIN 3 – Improving Services for people with mental health needs who present to A & E;
- CQUIN 4 – Transitions out of Children and Young People's Mental Health Services;
- CQUIN 5 – Preventing ill health by risky behaviors – alcohol and tobacco.

Low Secure Services

- Reduction in Length of stay.

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.

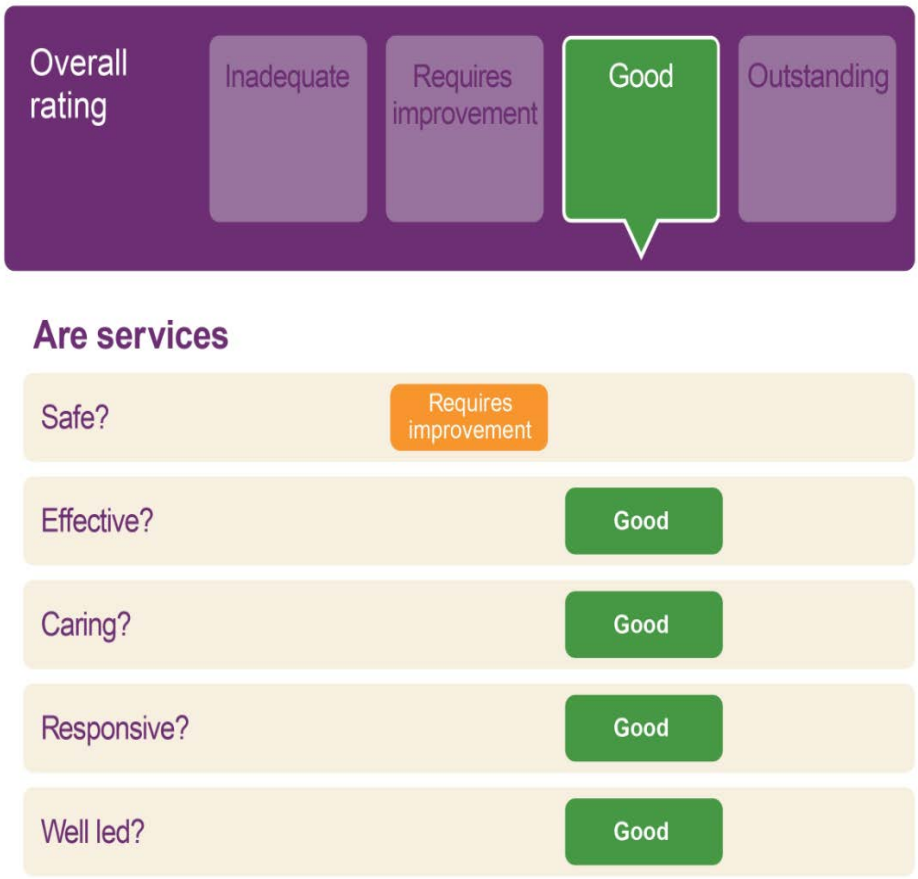
[2]gether NHS Foundation Trust has no conditions on its registration.

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 not participated in any special reviews or investigations by the CQC during the reporting period.

The Care Quality Commission last 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.



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.

The Trust developed an action plan in response to the **15** "must do" recommendations, and the **58** "should do" recommendations identified by the inspection and is managing the actions through to their completion.

	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.

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

Good quality data underpins the effective provision of care and treatment and is essential to enabling improvements in care. [2]gether NHS Foundation Trust submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data (Month 11 data is reported below, as this was the only available information at the date of publication).

- The patient's valid NHS number was: **99.7%** for admitted patient care (**99.3%** national); and **99.9**% for outpatient care (**99.5**% national);
- The patient's valid General Practitioner Registration Code was: **100%** for admitted patient care (**99.9%** national); and **100%** for outpatient care (**99.8%** national).

[2]gether NHS Foundation Trust has taken the following action to improve data quality building on its existing clinical data quality arrangements:

- During 2016/17 the Trust has continued to progress data quality improvement. Based on the work undertaken in previous years to provide automated reports, we have continued the early warning report for Senior Managers so they are alerted to any identified gaps;

- "Masterclasses" have continued to take place across all areas of the Trust. These have focused on educating staff how to use the new Assessment and Care Management clinical audit dashboard which ensures the right data is entered, at the right time. This method enables effective management of data quality through awareness, training and support and moves away from the labor intensive data quality management through list generation;

- As a result of the Masterclass series and the successful pilot of more intuitive "Team Sites" a platform that brings many data sources together into one place, teams can manage their individual and team data quality more effectively. The Trust is continuing to roll this out across all areas with full implementation completed by June 2017;

- Once the rollout has completed a series of 'deep dives' throughout 2017/18 and the following years will be completed, reviewing all aspects of service performance and data quality focusing on Service Specific Reporting" and "Demand and Capacity".

Information Governance Toolkit

Ensuring that patient data is held securely is essential, as such the Trust complies with the NHS requirements on Information Governance and assesses itself annually against the national standards set out in the Information Governance Toolkit which is available on the Health & Social Care Information Centre website:

http://systems.hscic.gov.uk/infogov

[2]gether NHS Foundation Trust Information Governance Assessment Report overall score for 2016/17 was **85%** and was graded green. The Trust scored 84% in 2015/16.

The Toolkit has been the focus of regular review throughout the year by the Information Governance and Health Records Committee, and the Information Governance Advisory Committee. In this year's assessment of **45** key indicators:

- **25** key indicators were at level **3**;
- **19** key indicators were at level **2**;
- **1** key indicator was deemed not relevant.

The Toolkit has been the subject of an audit by the Trust's Internal Auditor, which produced a classification of low risk.

The Trust's efforts will remain focussed on maintaining the current level of compliance during 2017/18 and ensuring that the relevant evidence is up to date and reflective of best practice as currently understood, and that good information governance is promoted and embedded in the Trust through the work of the Information Governance and Health Records Committee, the IG Advisory Committee and Trust managers and staff.

Clinical Coding Error Rate

[2]gether NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2016/2017 by the Audit Commission.

Part 2.3: Mandated Core Indicators 2016/17

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 3 2015-16	Quarter 4 2015-16	Quarter 1* 2016-17	Quarter 2* 2016-17	Quarter 3* 2016-17
[2]gether NHS Foundation Trust	97.2%	98.10%	97.1%	97.2%	98.3%
National Average	96.9%	97.2%	96.2%	96.8%	96.7%
Lowest Trust	50%	80%	28.6%	76.9%	73.3%
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 reviewed our practices and policies associated with both our 7 day and 48 hour follow up of patients discharged from our inpatient services, the changes were introduced in 2016/17. This has strengthened the patient safety aspects of our follow up contacts.

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;
- Continuing to ensure that service users are followed up within 48 hours of discharge from an inpatient unit whenever possible.

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

	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	100%	98.4%	98.9%	98.9%	99.4%
National Average	97.5%	98.2%	98.1%	98.4%	98.7%
Lowest Trust	61.9%	84.3%	78.9%	76%	88.3%
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;

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 both complete the 'Method of Admission' field with the appropriate option when admissions are made via the Crisis Team and 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 & 3 2016/17 has not yet been revised and may change. Quarter 4 data has not been published.

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 4 2015-16	Quarter 1 2016-17	Quarter 2 2016-17	Quarter 3 2016-17	Quarter 4 2016-17
[2]gether NHS Foundation Trust 0-15	0%	0%	0%	0%	0%
[2]gether NHS Foundation Trust 16 +	6%	7%	5%	8%	6%
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 2013	NHS Staff Survey 2014	NHS Staff Survey 2015	NHS Staff Survey 2016
[2]gether NHS Foundation Trust Score	3.46	3.61	3.75	3.84
National Median Score	3.55	3.57	3.63	3.62
Lowest Trust Score	3.01	3.01	3.11	3.20
Highest Trust Score	4.04	4.15	4.04	3.96

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

- For the first time, all staff in post on 1 September 2016 were invited to take part in the survey, confidentially online. Previously the survey had only been sent to a random sample of **750** staff. The overall response rate was **40%,** equal to the previous year but **777** staff took the time to respond and give their views, a significant increase on the **298** responses in the previous year. The 2016 survey has provided the most accurate picture of the Trust obtained to-date.

- 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:

- Encouraging staff to report any incidents which affect patient and staff safety or morale in the workplace;
- Acting to make the best use of service user feedback and highlighting how this feedback is used;
- Promoting the health and wellbeing of Trust staff.

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:

- 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 [2]gether's service as 'Better than Others', which is in the top 20% of similar organisations.

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

- 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.

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 October 2015 – 31 March 2016				1 April 2016 – 30 September 2016			
	Number	Rate*	Severe	Death	Number	Rate*	Severe	Death
[2]gether NHS Foundation Trust	1,371	39.01	1	5	1,900	54.85	4	30
National	146,325	-	501	1167	162,954	-	562	1240
Lowest Trust	25	14.01	0	0	40	10.28	0	0
Highest Trust	5,572	85.06	51	91	6,349	88.97	50	84

* 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;

- Creating an additional part time DATIX Administrator post to enhance data quality checks and further promote timeliness of reporting. This post will commence in 2017/18.

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	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**	**Achieved**
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%**	**83%**
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%**	**81%**
2.4	Has someone given you advice about taking part in activities that are important to you? **> 48%**	**48%**	**83%**
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**	**26**
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**	**23** **53** **135** **211 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**	**211**
3.4	**95%** of adults will be followed up by our services within 48 hours of discharge from psychiatric inpatient care.	**90%**	**95%**

Easy Read Report on Quality Measures for 2016/2017

Quality Report 	This report looks at the quality of [2]gether's services. We agreed with our Commissioners the areas that would be looked at.	
Physical health 	We increased physical health tests and treatment for people using our services. We met the target.	↑
Discharge Care Plans 	More people had a discharge care plan at the end of the year than previously. We met the target.	↑
Care (CPA) Review 	Not everyone moving from children's to adult services had a care review. We have not met the target. We are working on this and are getting better.	↓
Care Plans 	83% of people said they felt involved in their care plan. This is more than last time (78%). We met the target.	↑
Medicines 	77% of people said they felt involved in choosing their medications. This is more than last time (73%). We met the target.	↑
Crisis 	81% of people said they know who to contact if they have a crisis. This is more than last time (71%). We met the target.	↑
Activity 	83% of people said they had advice about taking part in activities. This is more than last time (48%). We met the target.	↑

Suicide 	Sadly there have not been less suicides compared to this time last year. We have not met the target. We are working hard to keep people safe.	↓
AWOL 	The number of inpatients who were absent without leave has increased. We have not met the target. We are doing lots of work to get better at this.	↓
Face down restraint 	We have not reduced the number of face-down restraints this year. We have not met the target. We are doing lots of work to get better at this.	↓
Follow up 	We saw 95% of people within 48 hours of discharge from hospital. This is more than last time (90%).	↑

Key

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

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 implementing 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)

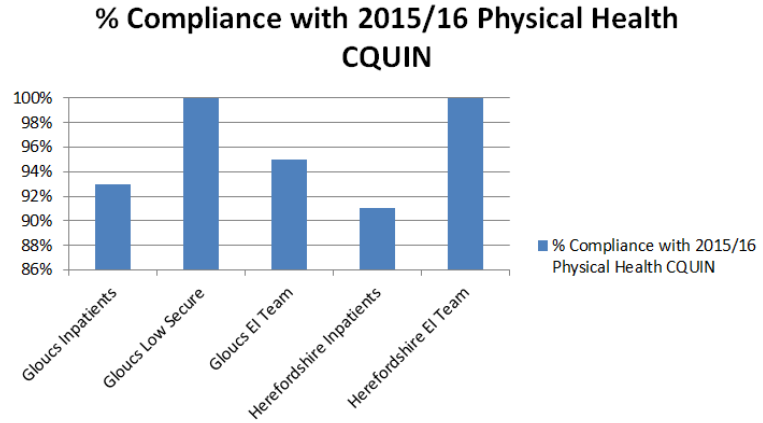


Figure 1

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 ensured that the clinical training plan was fully rolled out to all necessary medical, inpatient and community teams. The medical doctor's induction programme also included a section on the Lester tool. 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 "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 us to make changes to the Electronic Patient Record. Work has taken place to streamline where Physical Health information is recorded within the 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.

We are currently awaiting the results of the National audit of inpatients, early intervention and community mental health teams. These results are due to be published later this month; however we are confident that we will have met the threshold needed for 100% payment for this CQUIN.

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.

A Physical Health Awareness Day was held for both patients and staff in February 2017. This was considered to be a huge success with over a hundred people attending and leaving positive feedback. Plans are being made to combine this event next year with a similar event held in Gloucester for people with learning difficulties.

To support the improvement in service user's physical health, the Trust will become "Smoke Free" in April 2017, and plans are in place to ensure this transition takes place smoothly, enabling service users to both quit and abstain from smoking across all Trust sites. 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.

This target has been met.

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 at this time due to audit criteria being influenced by the West Midlands Quality Review which resulted in 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)	Year End Compliance (2016/17)
Overall Average Compliance	**69%**	**72%**
Chestnut Ward	84%	85%
Mulberry Ward	75%	79%
Willow Ward	59%	71%
Abbey Ward	72%	75%
Dean Ward	79%	73%
Greyfriars PICU	50%	62%
Kingsholm Ward	75%	72%
Priory Ward	80%	80%
Montpellier Unit	50%	57%
Honeybourne	N/A	70%
Laurel House	N/A	65%

* 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 average compliance in Gloucester for these standards during this year is **72%** which is a **3%** improvement from last year.

Herefordshire Services

Criterion	Year End compliance (2015/16)	Compliance Quarter 1 2016/17)	Year End Compliance 2016/17)
Overall Average Compliance	**N/A**	**70%**	**74%**
Cantilupe Ward	**N/A**	77%	85%
Jenny Lind Ward	**N/A**	65%	71%
Mortimer Ward	**N/A**	72%	69%
Oak House	**N/A**	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. 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. Quarter 1 data therefore provided the baseline information and it is seen that year end average compliance increased from **70%** to **74%.**

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 next year.

This target has been met.

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 was the second successive quarter with 100% compliance which needs to be maintained.

During Quarter 4 there were no transitions of young people into adult services.

Criterion	Compliance Quarter 1 2016/17)	Compliance Quarter 2 (2016/17)	Compliance Quarter 3 (2016/17)	Compliance Quarter 4 (2016/17)
Joint CPA Review	86%	100%	100%	N/A

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 2 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 was the first quarter with 100% compliance which now needs to be maintained.

During Quarter 4 there were 4 transitions of young people into adult services, all of these had a joint CPA review.

Criterion	Compliance Quarter 1 2016/17)	Compliance Quarter 2 (2016/17)	Compliance Quarter 3 (2016/17)	Compliance Quarter 4 (2016/17)
Joint CPA Review	33%	50%	100%	100%

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

- Transition to adult services for any young person will be included as a 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 those young people who are 17.5 years open to CYPS. Team Managers will monitor those who are coming up to transition and discuss in supervision.

As the target was not met, this will continue as a quality priority during 2017/18.

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.

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. In order to encourage more feedback and increase response rates our Trust is launching a new survey for 2017/18 known as **"How did we do?"** The Quality survey and Friends and Family Test will be combined in this survey to streamline feedback. The responses for the Quality Survey and Friends and Family Test will continued to be reported separately.

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.

Cumulative data for Quality survey 2016/17 results:

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

Questions	Treatment Setting	Sample Size Glos	Number 'yes' Glos	Sample size Hereford	Number 'yes' Hereford	Total % giving 'yes' answer
Question 1 Were you involved as much as you wanted to be in agreeing what care you will receive? > 78%	Inpatient	32	25	17	13	**83%**
	Community	118	95	45	43	
	Total Responses	150	120	62	56	

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%

Questions	Treatment Setting	Sample Size Glos	Number 'yes' Glos	Sample size Hereford	Number 'yes' Hereford	Total % giving 'yes' answer
Question 2 Were you involved as much as you wanted to be in decisions about which medicines to take? **> 73%**	Inpatient	32	23	17	13	**77%**
	Community	96	73	41	34	
	Total Responses	128	96	58	47	

This target has been met.

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

Questions	Treatment Setting	Sample Size **Glos**	Number 'yes' **Glos**	Sample size **Hereford**	Number 'yes' **Hereford**	**Total %** giving 'yes' answer
Question 3 Do you know who to contact out of office hours if you have a crisis? **>71%**	Inpatient	24	19	16	11	**81%**
	Community	110	86	44	42	
	Total Responses	134	105	60	53	

This target has been met.

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

Questions	Treatment Setting	Sample Size **Glos**	Number 'yes' **Glos**	Sample size **Hereford**	Number 'yes' **Hereford**	**Total %** giving 'yes' answer
Question 4 Has someone given you advice about taking part in activities that are important to you? **> 48%**	Inpatient	31	25	17	17	**83%**
	Community	77	59	42	37	
	Total Responses	108	84	59	54	

This target has been met.

Friends and Family Test (FFT)

<u>FFT responses and scores for Quarter 4</u>

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 below details the number of responses received 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 (%)
January 2017	312	90%
February 2017	228	90%
March 2017	200	95%
Total	**740 (Q3 = 1,100)**	**91% (Q3 = 89%)**

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.

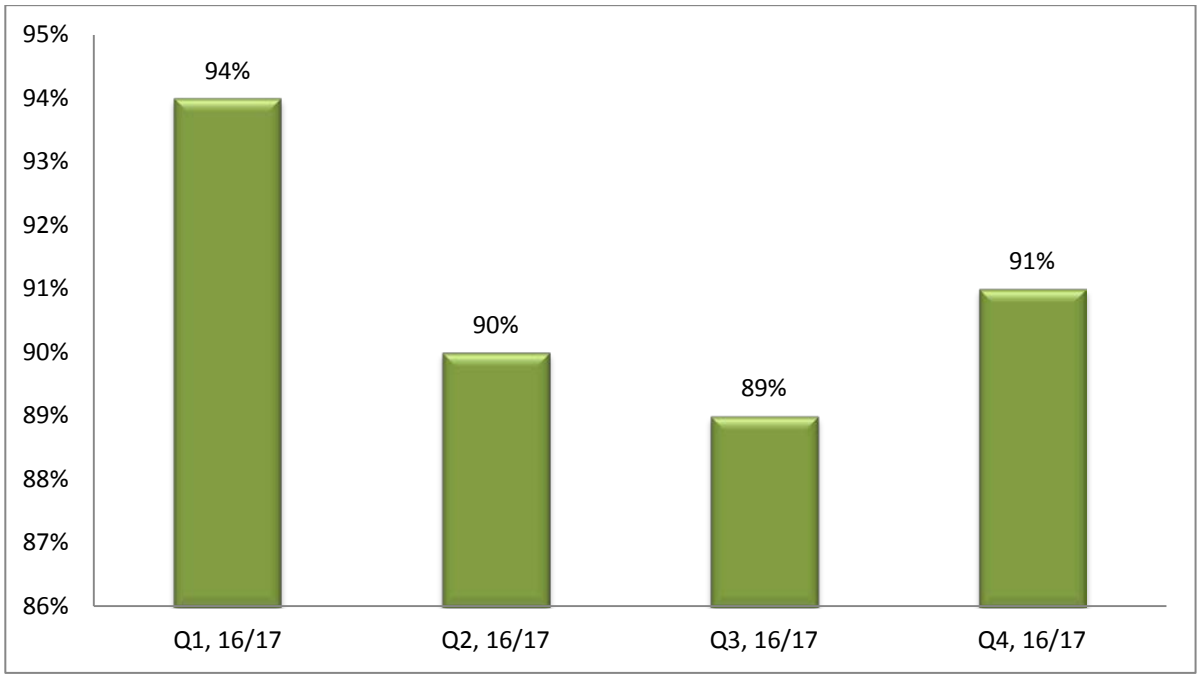


Figure 2

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

Figure 3 shows the FFT Scores for the past six months, including this quarter. The Trust receives a consistently high percentage of recommendation scores (*March 2017 data for England is not yet available*).

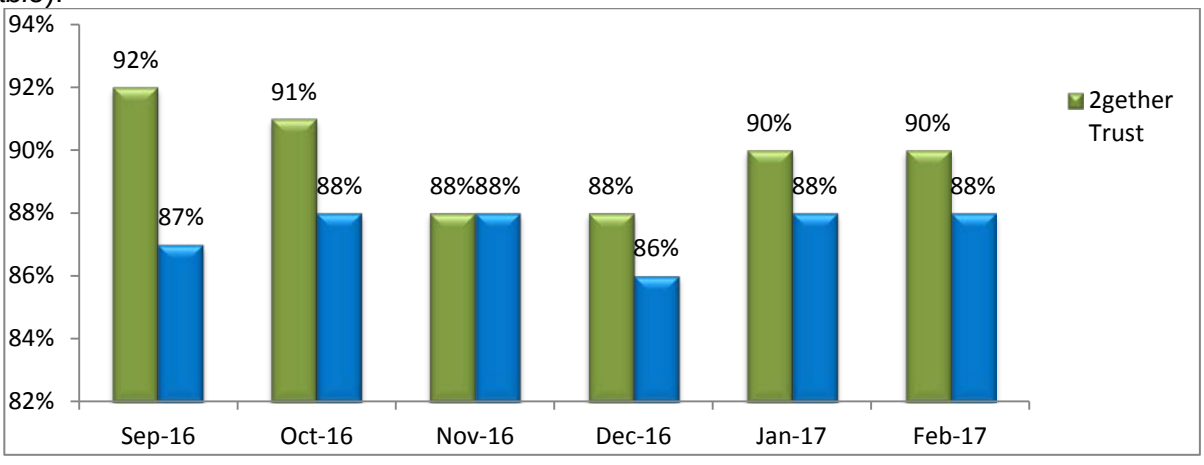


Figure 3

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 December 2016, January and February 2017 (the most recent data available). The Trust receives a consistently high percentage of feedback. (*March 2017 data for the region is not yet available*)

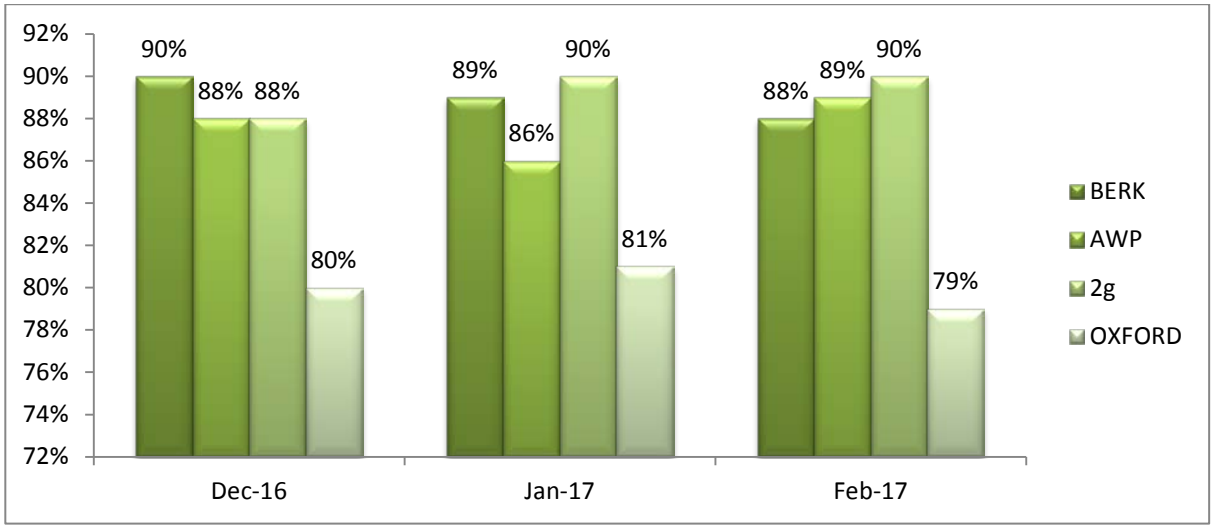


Figure 4

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

Between 1 April 2016 and 31 March 2017 the Trust received **106** formal complaints, a reduction in actual number from the previous year. However, Figure 5 below (The numbers of complaints received by 2gether in 2016/17 by month compared to the average over preceding 4 years) provides a trend line suggesting that the numbers of complaints received has been relatively consistent in relation to the number of people seen over a period of three years.

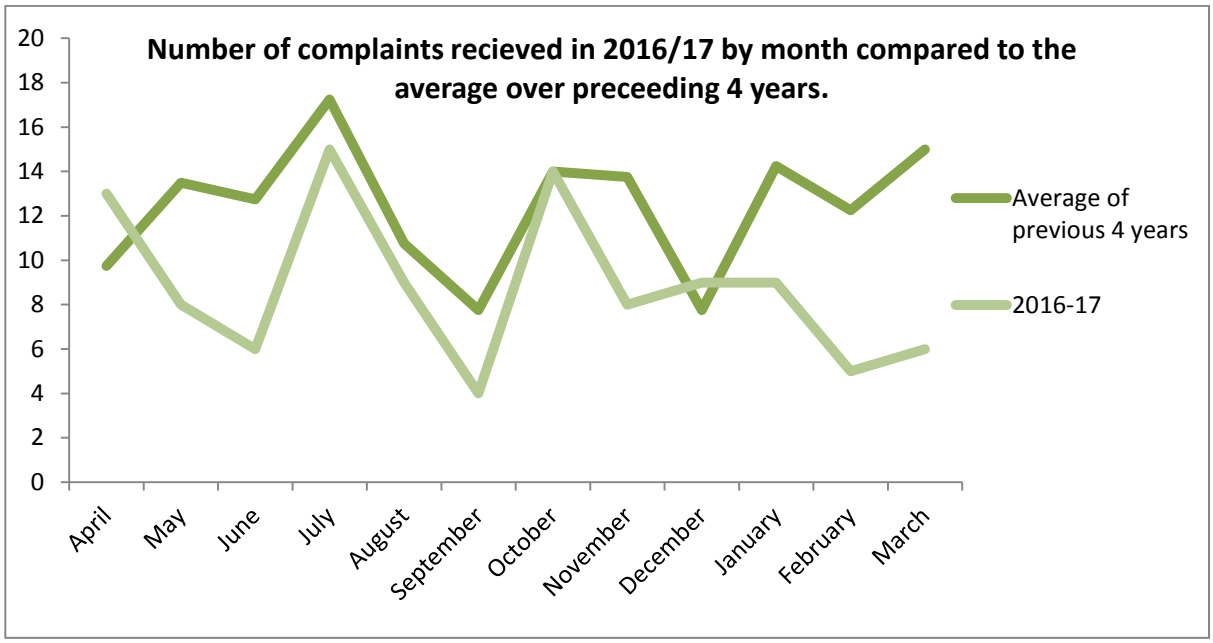


Figure 5

When the numbers of complaints are measured against the number of individual contacts within our services the percentage of complaints is very low (trend line shown for 2015/16 and 2016/17 in Figure 6).

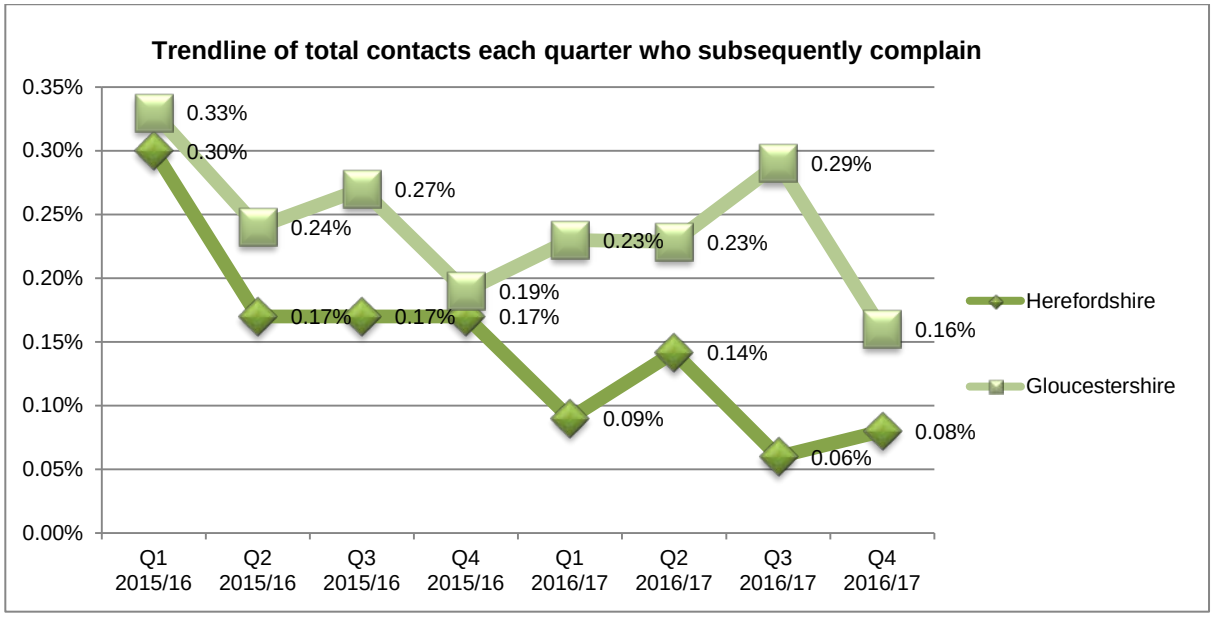


Figure 6

People who raise concerns or complain about [2]gether NHS Foundation Trust are contacted by our Service Experience Department. The aim of this is to clarify issues with people and to identify the outcomes being sought from the complaint. The complaint process is explained and the opportunities for informal resolution are also explored. This year increasing numbers of concerns were dealt with by local resolution in a timely manner reducing the need for the formal complaints process.

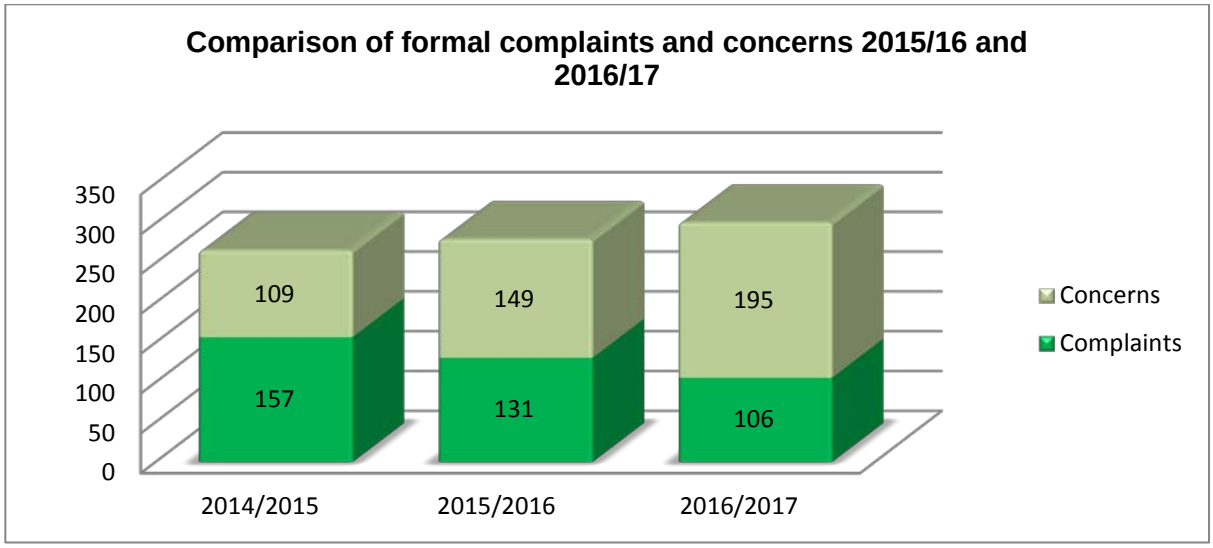


Figure 7

A continuous year on year improvement in written acknowledgement of complaints within the expected three day timeframe has been demonstrated. **99%** (**105**) of complaints were acknowledged within the three day time standard this year.

People are encouraged to seek an independent investigation of their complaint via the Parliamentary Health Services Ombudsman (PHSO) if they are not satisfied with the outcome of [2]gether's investigation or if they feel that their concern remains unresolved. On average the PHSO uphold a third of cases referred from organisations across the country.

This year the PHSO requested information about **7** complaints, a reduction from the 11 requested the previous year. The Ombudsman took **5** of these cases forward for review and investigation. This is fewer than last year, although it represents 5% of complaints received during 2016/17, which is the same percentage as last year. Five cases remain open with the PHSO (one from 2014/15) and four have been closed. Of the latter, one related to a complaint received in 2013/14 and this was partially upheld by the PHSO. An action plan was created by our Trust to address the areas of the complaint that were upheld. The action plan was implemented and completed in November 2016, the complaint was then closed.

Building on developments from 2015/16, the Service Experience Department have continued to focus on and progress complaint resolution this year in the following areas:

- Review and triage of the complaint at point of contact from complainants to attempt to resolve concerns in a timely and responsive way;

- Tailored training sessions lead by our Complaints Manager to support our staff to carry out quality, impartial and transparent complaint investigations;

- Sustained embedding and adjustment to the Datix information system used to record all Complaint data and activity. This ensures that all relevant service experience information and data is captured allowing themes and trends to be monitored;

- Review of the standards for quarterly audit of complaints from our Trusts Non- Executive Directors (NEDS) to ensure impartial review of best practice used;

- Continued review, development and implementation of the processes to resolve complaints;

- Development work with directorate leads to assure that learning from complaints and concerns is shared and embedded in practice.

The quarterly Service Experience Report to the Trust Board outlines in detail the themes of complaints, the learning and the actions that have been taken. Learning from complaints, concerns, compliments and comments is essential to the continuous improvement of our services.

Safety

Protecting service users from further harm whilst they are in our care is a fundamental requirement. We seek to ensure that 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, this year has seen a further rise in these tragic incidents and at the end of the year we reported **26** suspected suicides. It is not clear why higher numbers of suspected suicides were reported in Quarter 1.

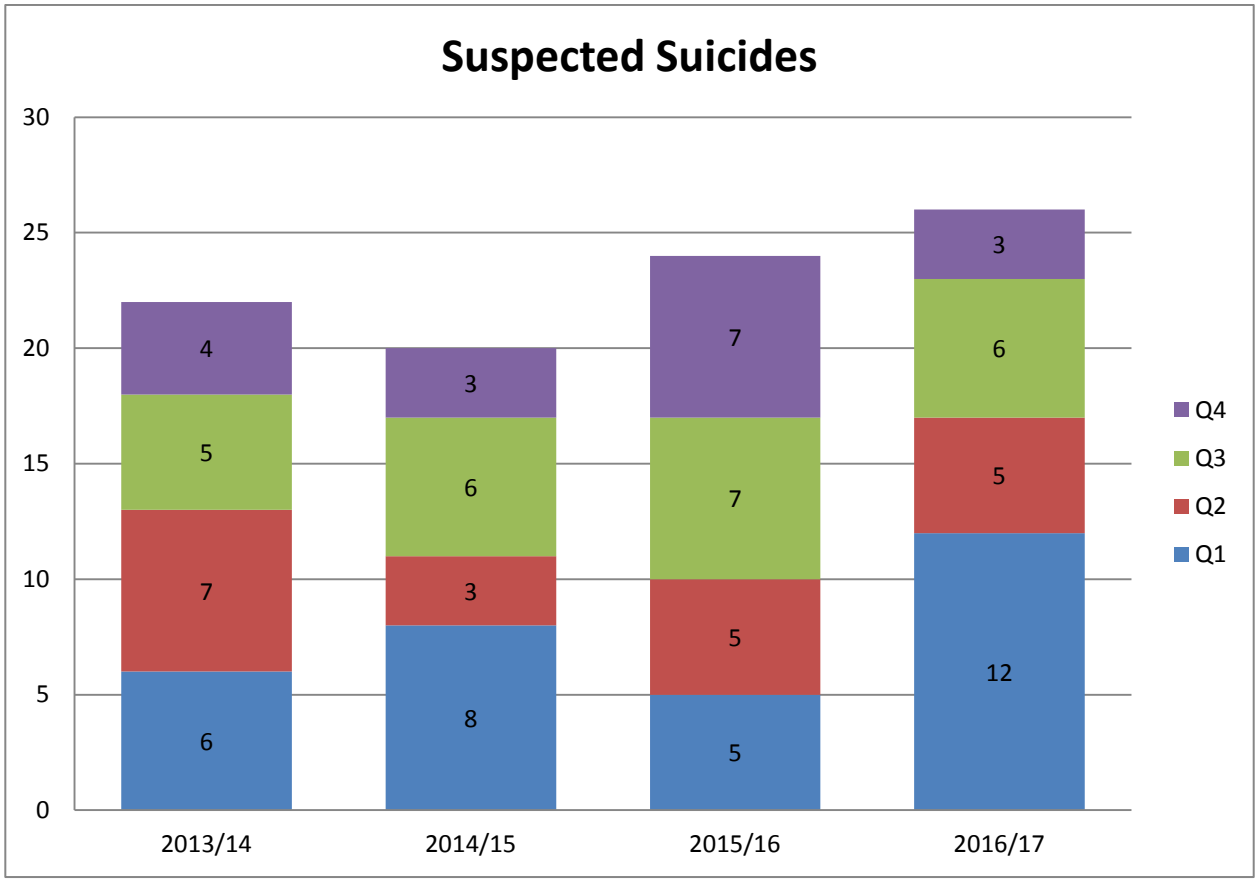


Figure 8

This information is provided below in Figures 9 & 10 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 overall population of Gloucestershire is a little over three times that of Herefordshire (based on mid -2015 population estimates).

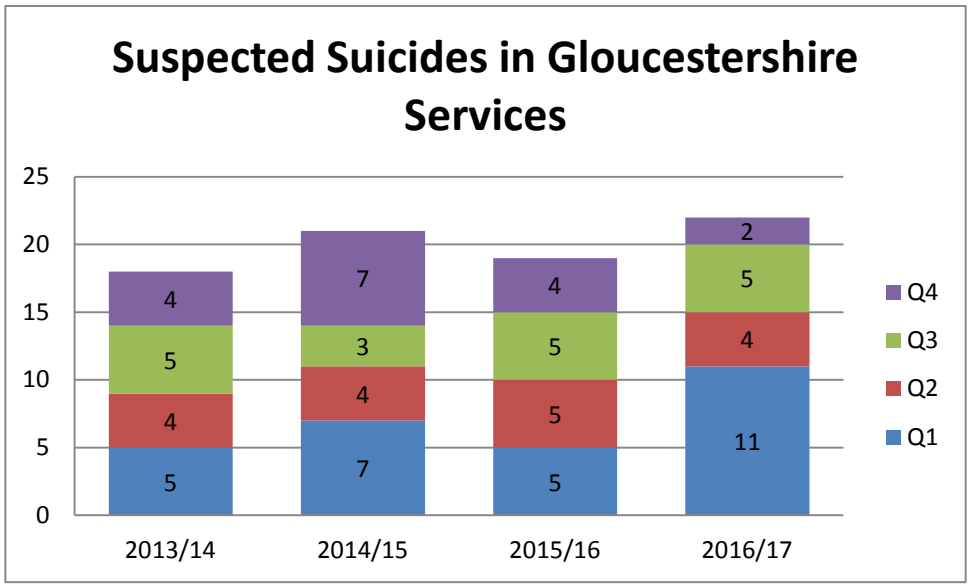


Figure 9

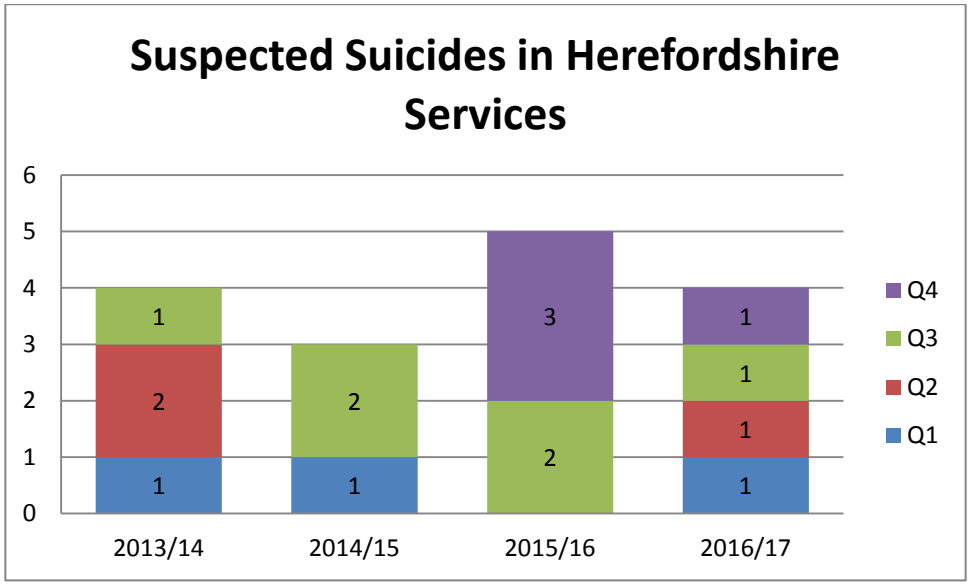


Figure 10

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 11 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 12 & 13.

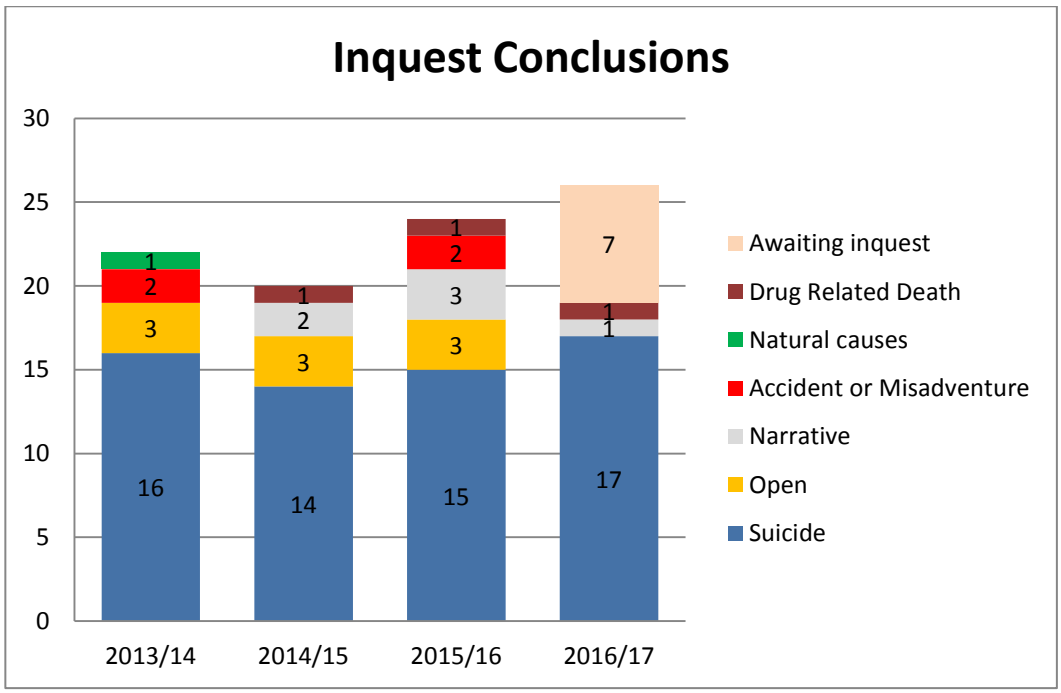


Figure 11

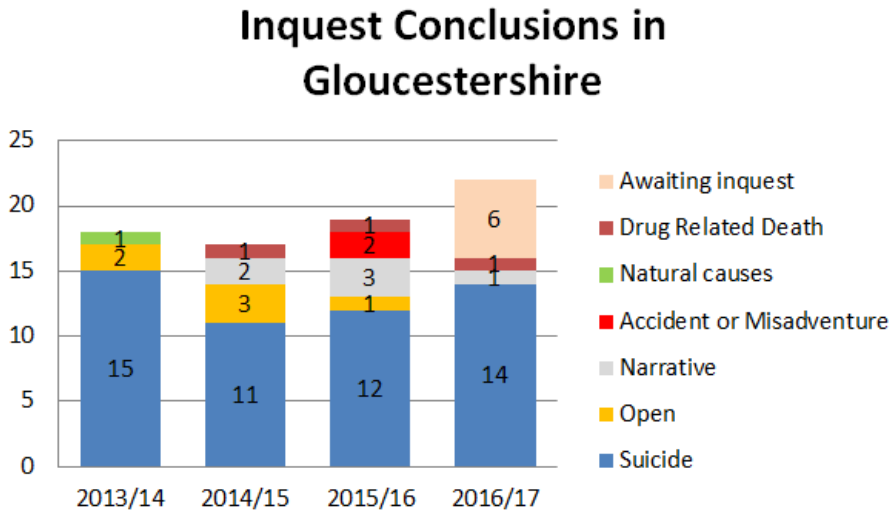


Figure 12

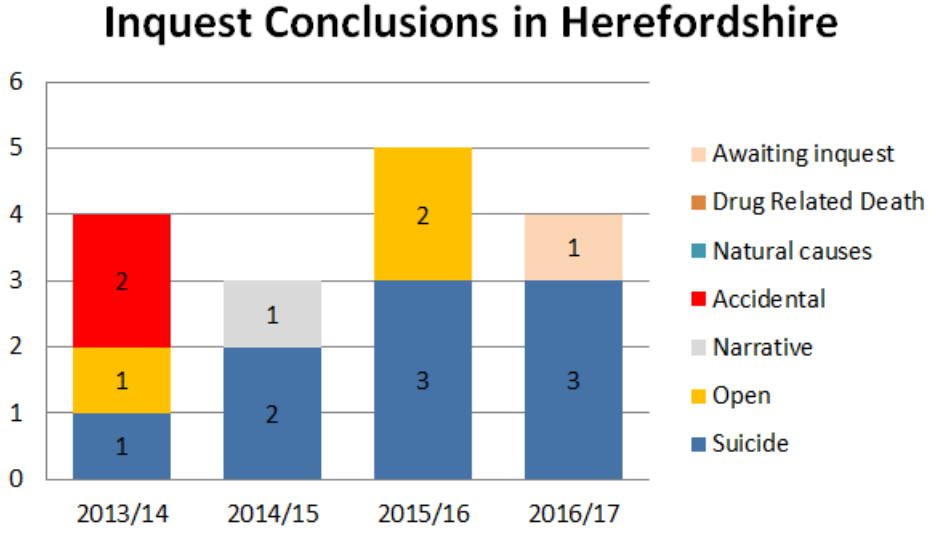


Figure 13

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. There were 2 consecutive months when the North Recovery Team did not complete the toolkit due to staffing issues; all other areas undertook the exercise.

Additionally, inpatient units undertake annual ligature audits to identify and remove, where possible, potential ligature points. This occurred on each inpatient unit except Hollybrook who did not undertake the audit due to the building work occurring on the site throughout the year. Hollybrook will be renamed Berkeley House from April 2017 and a ligature audit will be undertaken during 2017/18.

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;

- Leadership of Gloucestershire wide, multi-agency forum to tackle stigma;

- 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 have not met this target.

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 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 quarterly 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	9
Did not return from leave	4	2	1	1	0
Absconded from an escort	4	2	0	2	1
Totals for year	**31**	**49**			

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	15
Did not return from leave	19	9	16	14	10
Absconded from an escort	9	3	9	3	3
Totals for year	**83**	**162**			

A total of **211** episodes of AWOL were reported during 2016/17.

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.

- 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. Leaving a hospital is reported more than other categories. The detail of absences from the Wotton Lawn Hospital has been reviewed closely by the Hospital Matron during Quarter 4 and it has been identified that Priory Ward which hosts local people from Gloucester city, reports higher levels of absconding around meal times and bed times implying that people who are much nearer their home leave the hospital around their customary daily habits. Increased vigilance has been implemented on this ward around these times.

- Throughout the year, no reported AWOLS have resulted in 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 has been increased receptionist cover at the Stonebow Unit since September 2016 to include week day evenings and weekend/bank holiday cover in addition to office hours. Staff report this as being helpful. A time delay on reception doors is also being considered.

There will be a continued focus on positive engagement within our inpatient services to reduce the number of occasions where detained patients abscond from the ward environment. We will use coproduction to understand in more detail why patients abscond from the ward and what we can put in place to support them.

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 14 below.

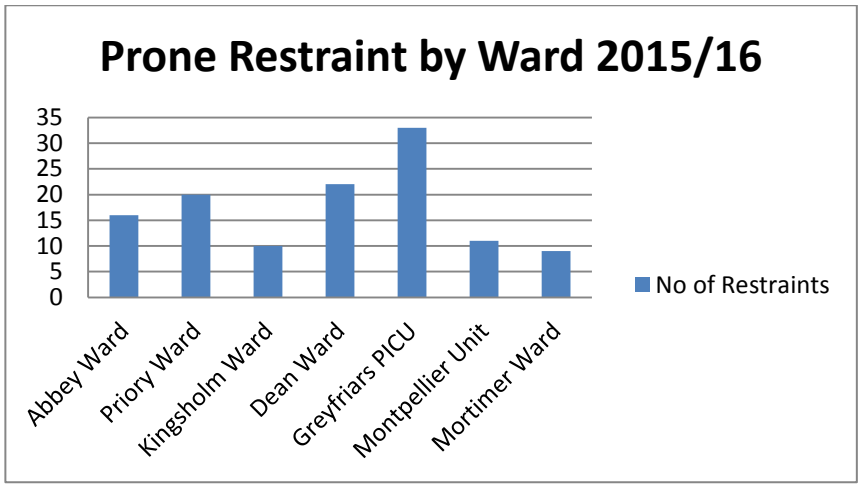


Figure 14

At the end of 2016/17, **211** instances of prone restraint were used as seen in Figure 15 which is an overall increase this year.

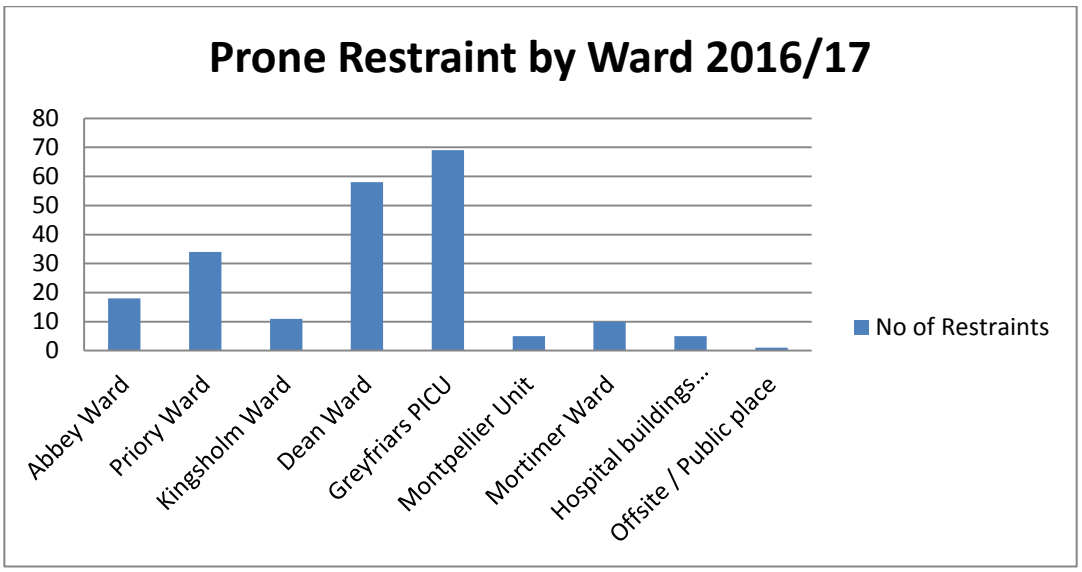


Figure 15

Analysis of the data during April – September 2016 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" was, therefore, added to DATIX for more accurate reporting.

In terms of further developments to minimise the use of prone restraint, injection sites for the purpose of rapid tranquillisation have been reviewed. Historically staff have been 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. These important changes will be implemented during 2017/18 and 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 16 below shows that the Trust reports incidences of prone restraint slightly above the national average.

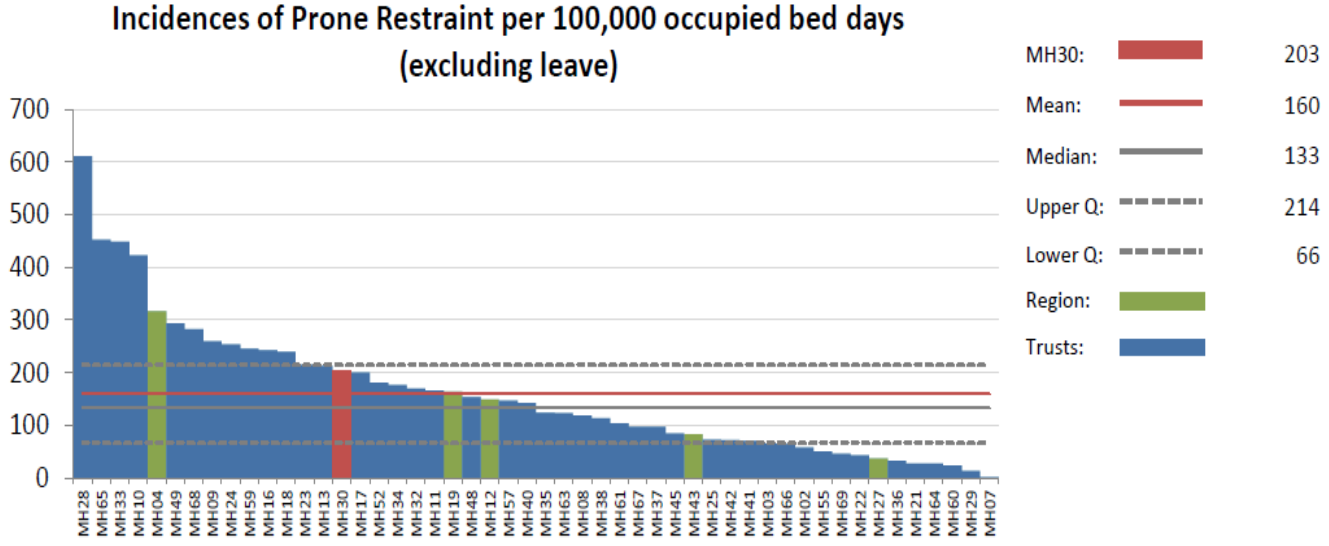


Figure 16

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 introduced in 2012/13. The national target is that 95% of CPA service users receive follow up within 7 days[2].

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[3] 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 many years, and the cumulative figures for each year end are seen in the table below.

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 2016/17, Herefordshire services followed up **96%** (**11** breaches) of people discharged from inpatient care and Gloucestershire services followed up **95%** (**39** breaches). This gives an overall organisational compliance of **95%.** Each of these breaches were reviewed to establish if there were 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
Gloucestershire Services	>95%	89%	95%	95%	90%	95%
Herefordshire Services	>95%	70%	95%	92%	91%	96%

This target has been met.

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

Serious Incidents reported during 2016/17

By the end of 2016/17, **43** serious incidents were reported by the Trust, **1** of which was subsequently declassified; the types of these incidents reported are seen below in Figure 17.

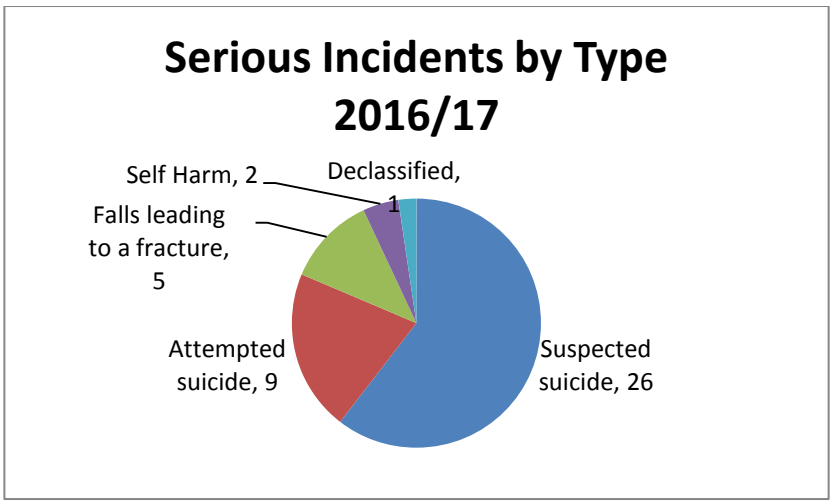


Figure 17

Figure 18 shows a 4 year comparison of reported serious incidents. The most frequently reported serious incidents are "suspected suicide" and attempted suicide which is why we continue to focus on suicide prevention activities in partnership with stakeholders. All serious incidents were investigated by senior members of staff, all of whom have been trained in root cause analysis techniques. To further improve consistency of our serious incident investigations we have seconded a whole time equivalent Lead Investigator for 12 months who will commence this important work in May 2017, and we are in the process of appointing further dedicated Investigating Officers via the Trust's Staff Bank. This arrangement will be reviewed during Quarter 4 2017/18.

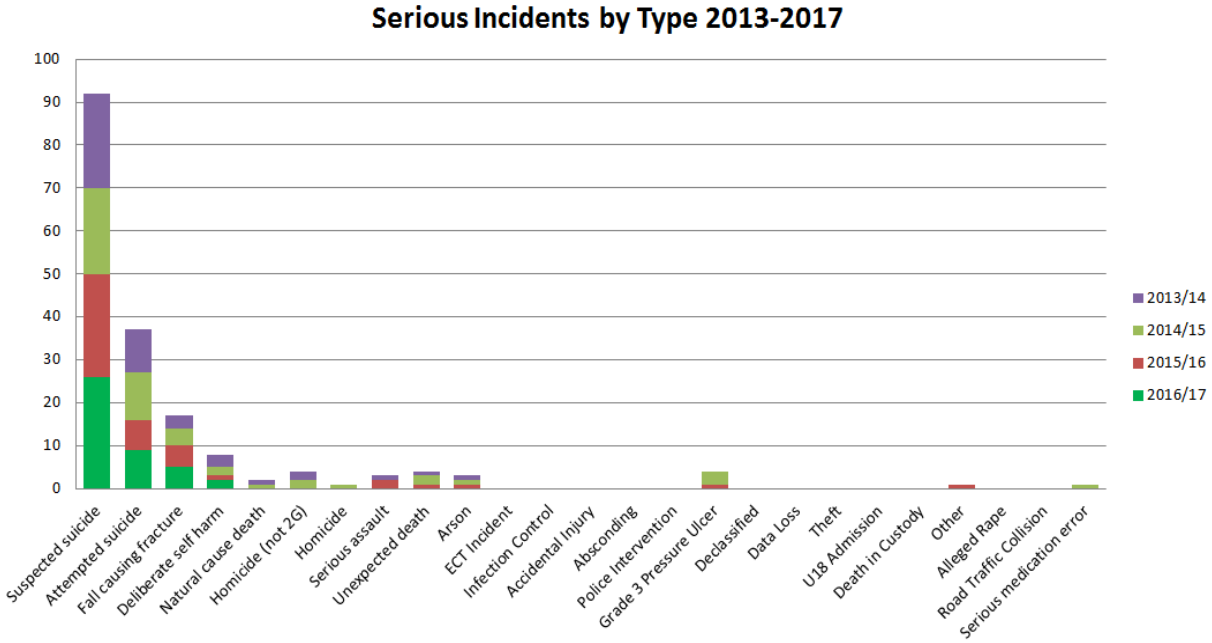


Figure 18

Wherever possible, we include service users and their families/carers to ensure that their views are central to the investigation, we then provide feedback to them on conclusion. During 2016/17 we engaged the Hundred Families organisation to deliver 'Making Families Count' training to 51 staff to improve our involvement of families and this will be explored further next year. In 2017/18 we will also be developing processes to provide improved support to people bereaved by suicide. The Trust shares

copies of our 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.

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 historically 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 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.

Mortality Reviews

From 1 April 2016 the Trust has collected detailed information regarding the deaths of patients open to our services, and deaths within 6 months of their discharge from services in preparation for the "Single Framework for Reviewing Deaths in the NHS" requirement which was published in March 2017. To date, there is limited assurance that the data collected is of good quality. However, several improvements have been made to both Datix and the technology available for collecting information relating to patient deaths.

An administrator has been employed in a full-time capacity from October 2016 to begin to complete initial screening of the reported patient death information and the categorisation of patient deaths within the Mazars categories of Expected Natural 1, Expected Natural 2, Expected Unnatural, Unexpected Natural 1, Unexpected Natural 2, and Unexpected Unnatural. The pro-forma review tool based on the

Learning Disabilities Mortality Review Programme (LeDer) format will be utilised within the Datix system to assist with desktop reviews of healthcare records, and red flag indicators are being developed by the Clinical Directors involved with the mortality work to identify deaths which should be more closely investigated. An unused Datix module is being developed to contain this work.

The 'active' review of patient deaths will commence from 1 April 2017 and it is anticipated that we will be reporting to Board within the requirements of the "National Guidance on Learning from Deaths", with policy development and publication by Quarter 2 2017/18 and data publication by Quarter 3 2017/18.

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 metrics that were monitored by the Trust during 2016/17. These are the indicators and thresholds from NHS Improvement.

		2014-2015 Actual	2015-2016 Actual	National Threshold	2016-2017 Actual
1	Clostridium Difficile objective	3	0	0	**3**
2	MRSA bacteraemia objective	0	0	0	**0**
3	7 day CPA follow-up after discharge	97.73%	95.63%	95%	**98%**
4	CPA formal review within 12 months	97.1%	99.35%	95%	**99%**
5	Delayed transfer of care	0.06%	1.02%	≤7.5%	**1.7%**
6	Admissions gate kept by Crisis resolution/home treatment services	99.57%	99.74%	95%	**99%**
7	Serving new psychosis cases by early intervention teams	100%	63.56%	50%	**71%**
8	MHMDS data completeness: identifiers	99.71%	99.57%	97%	**99.9%**
9	MHMDS data completeness: CPA outcomes	97.06%	97.42%	50%	**94.7%**
10	Learning Disability – six criteria	6	6	6	**6**
11	EIP: Receipt of NICE approved care within 2 weeks	-	-	50%	**71.3%**
12	Improving access to psychological therapies - treated within 6 weeks of referral - treated within 18 weeks of referral			75% 95%	**37.8%** **86.1%**

Commissioner Agreed Developments

There have been a number of innovative developments during the year which now form part of our commissioned services, these include:

- **Gloucestershire Mental Health Acute Response Service (MHARS).** The Urgent Response Team is located with, and works alongside the emergency services to advise on and respond to incidents taking place anywhere in the county, where it is suspected that mental health has played a part. The intention is to provide a quicker service for people experiencing mental health crisis or distress so they can get the right response at the right time in the right place.

- **Wellbeing House.** Alexandra Wellbeing House opened in spring 2017. This is a partnership venture between [2]gether, Swindon MIND and Gloucestershire CCG, and provides an alternative to an inpatient admission for when a person is feeling overwhelmed and needs somewhere peaceful and away from everyday life to recover from an episode of distress.

- **Gloucestershire Perinatal Service.** The team is in the process of being formed following a successful bid for £1.5million of Government funding during 2016/17. This will see improved care and outcomes for women with mental health problems during pregnancy and in the postnatal period.

- **Community Dementia Nurse Pilot.** We are working collaboratively with primary care and Gloucestershire Care Services colleagues to enable one of our Community Dementia Nurses to create better working relationships throughout the healthcare system and achieve better outcomes for people with dementia. This forms part of the work being carried out through the Sustainability and Transformation Plan agenda.

- **Gloucester City Primary Mental Health (PMH) Specialist Nurse Pilot.** We are working with Gloucester City GPs to pilot two specialist PMH nurse posts to work alongside GPs in practices. This is a developmental role exploring the opportunities and benefits that can be offered from a Mental Health Nurse working at a GP Practice level.

Community Survey 2016

The CQC published results of an independent survey taken in 2016 that tested the experience of service users who use Trust community services. The published results compare ratings about [2]gether NHS Foundation Trust'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 Trust's service as 'Better than Others' which is in the top 20% of similar organisations. The results are tabulated below together with the scores out of 10 for [2]gether NHS Foundation 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 NHS Foundation Trust 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

High levels of staff engagement and satisfaction are priorities for [2]gether NHS Foundation Trust. As part of this, each year the Trust is able to use information from the annual NHS Staff Survey to improve this. Although staff have a variety of ways to feedback on their experiences at work, the NHS Staff Survey provides the most in-depth analysis of how our staff view the Trust as an employer and as a provider of mental health and learning disability services. The responses to each of the questions asked are grouped into 32 Key findings, progress against which can be measured year on year.

For the first time, all staff in post on 1 September 2016 were invited to take part in the survey, confidentially online. Previously the survey had only been sent to a random sample of **750** staff. The overall response rate was **40%,** equal to the previous year but **777** staff took the time to respond and give their views, a significant increase on the **298** responses in the previous year. The 2016 survey has provided the most accurate picture of the Trust obtained to-date.

Overall staff engagement has again increased with the result being derived from three 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 towards improvements at work.

The Trust score was **3.89** (from a possible **5**) and was higher than the national average for Mental Health/Learning Disability Trusts.

The results of the 2016 Survey showed the Trust to be ***better than average*** in **18** Key Findings***, average*** in **10** Key Findings ***and worse than average*** in **4** Key Findings when compared with the national average. This represents a favourable comparison with the previous year when the Trust was reported to be better than average in 18, Key Findings, average in 13 and worse than average in one Key Finding.

There were ***no statistically significant changes*** to any of the Key Findings but there were improvements show in **19** of them, **12** worsened slightly and one Key finding showed no change.

It has been encouraging to note that the number of staff recommending the organisation as a place to work or receive treatment had increased and was higher than the national average. Staff motivation at work also remains above the national average. After a disappointing score last year, the percentage of staff reporting good communication between senior managers and staff had improved although remains slightly below the national average. It has however been disappointing to see that whilst the reporting of near misses and incidents have been diligently reported, colleagues have been less likely to report incidences of bullying and harassment.

The Staff Survey results are also used to inform progress against the Workforce Race Equality Standard (WRES), introduced in 2014. Four of the nine WRES indicators are taken from the survey. An average of **88%** of staff reported that there were equal opportunities for career progression and promotion, slightly above the national average.

It is not possible to compare responses from Black and Minority Ethnic (BME) staff with last year's results as the response rate from BME colleagues last year was too low to include. However for 2016, the results from BME and White staff were broadly similar. **30%** of white and **30%** of BME staff reported experiencing harassment from patients and members of the public, both below the national average but still of concern. **25%** of white staff experienced harassment from other staff while **21%** of BME staff reported the same.

Nationally, levels of bullying and harassment remain unacceptably high but as a Trust we continue to work to eliminate this kind of behaviour. Over the last 12 months we have increased the number of

Dignity at Work Officers and we continue to promote our confidential online dialogue system known as Speak in Confidence as part of the range of measures introduced to offer support to staff.

Following analysis and discussion of the survey outcomes, the Trust's resultant action plan will be focussing on encouraging staff to report such incidences as these are unacceptable and against our values. Emphasis will also be put on making the best use of service user feedback and highlighting how such feedback is used. The third element of the action plan will focus on promoting the health and wellbeing of our staff. To complement the Trust actions, our service localities will utilise the survey to define priorities that will be addressed locally.

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

Gloucestershire Health and Care Overview and Scrutiny Committee

On behalf of the Health and Care Overview and Scrutiny Committee I welcome the opportunity to comment on the 2gether NHS Foundation Trust Quality Account 2016/17.

Members from the HCOSC and the Children and Families Overview and Scrutiny Committee (CFOSC) share concerns with regard to the provision of mental health services to children and young people in the county. Members believe that early intervention is important, and can better support health and wellbeing outcomes. Members therefore welcome the willingness of the Trust to engage with and support the scrutiny workshops on this matter. Elected members have found these sessions to be very beneficial and will be following up on this work in the new council.

The committee notes that the Trust has still not met the targets relating to the numbers of deaths by suspected suicide (pending inquest) of people in contact with services when comparing data from previous years. Elected members are aware that the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness is investigating suicide by children and young people in England. This work is being undertaken in two phases. The second phase of this work is due to be published in 2017, and will include recommendations for services. The county council's Student Mental Health Task Group has asked the Gloucestershire Suicide Prevention Partnership Forum (GSPPF) to consider the recommendations from this report and inform the HCOSC and CFOSC of their findings. I anticipate that these committees will wish to discuss this work with the Trust as part of the work to review the Gloucestershire Suicide Prevention Strategy.

The committee congratulates the 2gether NHS Foundation Trust on being rated as one of the top two mental health trusts in the country, based on service user's ratings in the National Community Mental Health Patient Survey (Adults) 2016.

Members welcome the opening of the Wellbeing House and look forward to hearing, in due course, if this facility is making a difference.

Members particularly welcome the productive partnership working with the Emergency Services on the delivery of the Mental Health Acute Response Service (MHARS); and the successful bid for funding to provide a perinatal service in Gloucestershire.

I would like to thank the Trust for its continued willingness to work with and inform committee members, in particular, Jane Melton, Ruth FitzJohn and Shaun Clee.

Iain Dobie, Chairman Gloucestershire Health Overview and Scrutiny Committee

Healthwatch Herefordshire Response to [2]gether NHS Foundation Trust Annual Quality Accounts 2016-17

Healthwatch Herefordshire is pleased to have been a partner of [2]gether over the past year. We still strongly support the Triangle of Care initiative and with our partner organisation HCS continue working with [2]gether to ensure that this is implemented throughout the Herefordshire services as soon as possible. Regular board reports tracking this progress would be helpful.

Another initiative we strongly support is the need to tackle higher than expected suicide rates in the county, we look forward to plans being rapidly developed and implemented in Herefordshire.

Disappointing progress with access to and the effectiveness of IAPT is an area which needs serious and urgent attention. Early intervention services are strongly supported and we look forward to improvement in this.

Once again Healthwatch Herefordshire thanks [2]gether Trust for its open and supportive culture and its continued collaboration with Healthwatch in working towards delivering excellent mental health services for the people of Herefordshire.

Ian Stead
Healthwatch Herefordshire

Healthwatch Gloucestershire's Response to 2gether NHS Foundation Trust's Quality Statement 2016/17

Healthwatch Gloucestershire welcomes the opportunity to comment on 2gether NHS Foundation Trust's quality account for 2016/17. Healthwatch Gloucestershire exists to promote the voice of patients and the wider public with respect to health and social care services. As of April 1st 2017 Healthwatch Gloucestershire came under a new provider and we are therefore unable to comment on the previous year's activity as it relates to work carried out under the previous Healthwatch Gloucestershire contract. However, we look forward to developing relationships with the Trust over the coming year and working with them to ensure the patient voice is heard.

It is good to see that the Trust has a clear focus on continuous quality improvement with a view to making life better for communities, service users and unpaid carers. In addition, the input of service user experience into the priorities for the coming year is welcomed and ensures that the Trust remain user-focused.

We are pleased to see the ongoing commitment of the Trust to improve the physical health of patients under their care and note that a health awareness event for patients and staff is to be held in Gloucestershire in the coming year.

Last year The Trust set a target to improve the process for children and young people who transition from child to adult mental health services. In particular, they aimed to ensure that joint care programme approach reviews were carried out for all of those who were transitioning. The Trust did not achieve this aim so we are pleased to see that this remains a priority and we will be monitoring progress over the coming year.

We welcome the prioritisation of user experience by the Trust and note the positive results achieved by the Trust on the CQC national community mental health survey and the proposed introduction of the 'How did we do?' survey. Healthwatch Gloucestershire would be happy to work with the Trust over the coming year to ensure that the voice of service users continues to be used to improve services provided by the Trust.

We are concerned to see that a greater number of suspected suicides are reported within Gloucestershire compared with Herefordshire. We acknowledge however that the population of people in contact with services is higher in Gloucestershire and that the service is configured differently to reflect commissioning requirements. We also note the work being carried out by the Trust to improve outcomes for patients including their continued partnerships working with external agencies.

The Trust's target to reduce prone restraints by 5% year on year was not met; in fact, there was a significant increase in reported incidents. The Trust established a baseline for its target based on the number of instances of prone restraint it had recorded in 2015/16 We note that analysis of the data for 2016/17 identified that a proportion of the incidents recorded as prone restraint were in fact the application of fleeting, precautionary holds for individuals who hold themselves face down, and that consequently a new category of "precautionary non-standard hold" has been added to the incident reporting system. We note the work being carried out by the Trust to reduce the instances of prone restraint and would like to see a reduction in recorded incidents (from baseline) during 2017/18.

Work by the Healthwatch network has shown that people often find the complaints process stressful we are therefore pleased to see that an increasing number of concerns raised by patients are dealt with by

local resolution without need for a formal complaints process. We acknowledge also the work being carried out to improve the consistency of serious incident investigations. We welcome the involvement of service users in these investigations and welcome the plans to provide improved support for those bereaved by suicide.

Healthwatch Gloucestershire look forward to developing the relationship with The Trust over the coming year and working with them to ensure that the experiences of patients, their families and unpaid carers are heard and taken seriously.

Dr. Sara Nelson
Healthwatch Gloucestershire

NHS
Herefordshire
Clinical Commissioning Group

Herefordshire CCG response to 2gether NHS Foundation Trust Quality Accounts

Herefordshire Clinical Commissioning Group (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by 2g NHS Foundation Trust (2gNHSFT) for 2016/17. The report is easy to read and understandable given that it has to be considered by a range of stakeholders.

Within the past year Herefordshire Health and Social Care partnerships have faced varied challenges, 2gNHSFT has worked together with partnership organisations, including the CCG to face the challenges whilst striving to deliver improved quality of care and outcomes for the residents of Herefordshire.

The 2016/17 Quality Report demonstrates some of the challenges, concerns and opportunities that the Trust has faced. Herefordshire CCG continues to regularly attend the Trust Quality Committee meetings and contribute constructively at the Contract Quality Review Forum.

The CCG acknowledge 2gNHSFT's continuing focus on patient and carer experience and the delivery of high quality of care, which underpins all clinical work delivered by the Trust, the results of this focus is demonstrated in the outcomes from the Friends and Family test with over 90% of respondents reporting they would recommend 2gNHSFT and the increasing number of staff who would do the same. The links between poor mental health and poor physical health have been long established, The work 2gNHSFT has undertaken to improve the physical health of their patients is to be commended and also contributes to improving the patient's experience of services provided by the Trust.

The CCG notes that the Trust did not reach its targets of:

- Ensuring that all services users making the transition from childhood to adulthood had joint Care Programme Approach reviews.
- Reducing the number of patients who were Absent without Leave (AWOL)
- Reducing the number of prone restraints

The CCG will monitor these aspects of care to ensure that the practice changes undertaken by the Trust support improved outcomes.

We were pleased to note there continues to be a high level of 2gNHSFT engagement in both national and local clinical audits and research as well as participation in national confidential enquiries.

The CCG reviews 2gNHSFT's incident responses on a regular basis and find robust systems and processes in place with evidence of duty of candour has been undertaken in each report and evidence that learning is embedded within the wider Trust workforce.

We are aware that 2gNHSFT are actively engaged in partnership working with the Local Authority, other statutory partners and voluntary sector bodies in Herefordshire through many fora. We are confident that this engagement will continue throughout 2017/18.

The CCG endorses all 2gNHSFT's priorities for improvement as contained in this report in the expectation that they will lead to improved delivery against effectiveness, service user experience and safety, supporting improved outcomes for service users.

Following a review of the information presented within this report, coupled with commissioner led reviews of quality across all providers, the CCG is satisfied with the accuracy of the report. This recognises the Trust commitment to quality and demonstrates transparency, honest assessment and further development which mirror the aspirations of commissioners.

Lynne Renton, Deputy Chief Nurse, Herefordshire CCG

NHS Gloucestershire CCG Comments in Response to 2gether NHS Foundation Trust Quality Report 2016/17

NHS Gloucestershire Clinical Commissioning Group (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by [2]gether NHS Foundation Trust (2gNHSFT) for 2016/17 in line with NHS Improvement guidance '*Detailed requirements for quality reports for foundation trusts 2016/17*' published February 2017.

The past year has continued to present major challenges across both Health and Social care in Gloucestershire and we are pleased that 2gNHSFT have worked jointly with partnership organisations, including the CCG during 2016/17 to deliver a system wide approach to maintain, further develop and improve the quality of commissioned services and outcomes for service users and carers. We wish to acknowledge the Trust's contribution and commitment to the development of the Sustainability and Transformation Plan for Gloucestershire (STP).

Following the comprehensive CQC inspection during October 2015, where the overall outcome was rated as 'good', the CCG has continued to work with the Trust to monitor the implementation of the CQC action plan developed to address areas identified for further improvement. We were pleased to note the good progress in closing down these actions and recognise the focus and commitment of management and staff in addressing the necessary quality improvements. However we note there remain some areas for further development and improvement, and the CCG will continue to work with the Trust to address these in 2017/18.

The 2016/17 Quality Report is easy to read and understandable given that it has to be considered by a range of stakeholders with varying levels of understanding. The report clearly identifies how the Trust performed against the agreed quality priorities for improvement for 2016/17 and also outlines their priorities for improvement in 2017/18.

The CCG endorses the quality priorities included in the report whilst acknowledging the very difficult financial and partnership challenges 2gNHSFT have to address in the future, particularly in the implementation and delivery of the Gloucestershire STP. We are pleased to note progress and achievement against these quality priorities, and will continue to work with the Trust where targets have not been met.

We commend the Trust for good progress and achievement against the mandated core indicators 2016/17. The CCG were pleased to note the continued improvement of physical healthcare for people with schizophrenia and other serious mental illnesses in 2016/17, whilst recognising the commitment of staff to further improve the physical health and wellbeing outcomes for patients in 2017/18. We recognise the challenges for the Trust in becoming "Smoke Free" in April 2017, and also the extensive work undertaken to successfully roll out the annual Flu vaccination programme across the Trust whilst achieving 77% of staff and patients immunised.

Given the local CQUIN in relation to Young Peoples Transitions 2016/17, we were disappointed that the target to ensure that joint Care Programme Approach reviews occur for all service users who make the transition from children's to adult services was not met and will continue to work with the Trust on this quality priority for 2017/18. We acknowledge the extensive work undertaken by the Trust and progress to date against the Gloucestershire Improving Access to Psychological Therapies (IAPT) recovery plans. This remains a high priority for the CCG, and we will continue to work with 2gNHSFT in 2017/18 to improving access to IAPT services to meet national targets.

2gNHSFT did not achieve the target for reducing the number of deaths relating to identified risk factors of people in contact with services in 2016/17 when compared to data from previous years. We recognise that the number of suicides reported was in line with national reporting trends and that

minimising the risk of suicide continues to be a priority for the Trust in 2017/18. The CCG note the Trust continues to be an active member of the Gloucestershire Suicide Prevention Partnership Forum (GSPPF) and is working in partnership with other key stakeholders in Gloucestershire to reducing stigma around suicide and self-harm.

The Trust also failed to meet the target to reduce the number of people who are absent without leave (AWOL) from inpatient units who are formally detained. However the CCG recognise that the Trust has undertaken a great deal of work to understand the context in which detained service users are AWOL via the NHS South of England Patient Safety & Quality Improvement Mental Health Collaborative. We welcome that the Trust will have a continued focus in 2017/18 on positive engagement within their inpatient services to try and reduce the number of occasions where detained patients abscond from the ward environment.

The Trust has demonstrated continued improvement in service user and carer experience of mental health services provided, and we welcome the focus on improvement of the experience of service users in transition from children and young people's mental health service to adults. We also note a reduction in the actual number of complaints from the previous year. However the Trust has demonstrated that the numbers of complaints received has been relatively consistent in relation to the numbers of people seen over a period of three years, and report a continuous year on year improvement in written acknowledgement of complaints within the expected three day timeframe.

The CCG are pleased to note the Trust's focus on continuing improvement in identified priorities for effectiveness, service user experience and safety in 2017/18. We note achievement of targets in 2016/17, and whilst there are a number of areas where targets were partially or not achieved, the CCG are content that the Quality Report provides a balanced view.

The CCG also acknowledge the Trust's commitment to the 'Sign up to Safety Campaign' and all the patient safety initiatives such as the continued involvement in the NHS South of England Improving Patient Safety and Quality in Mental Health Collaborative, the NHS Safety Thermometer, Safewards interventions and Reducing Physical Interventions project to focus improvement on ways of working, and thereby improving the patient's experience of services provided by the Trust. We welcome the development of the Trust's Safety Improvement Plan and will continue to work with the Trust to improve the safety of patients.

The CCG acknowledge 2g's continued strong focus on service user and carer experience and quality of caring, which demonstrates a joint commitment to delivering high quality, compassionate care, and also dignity and respect with which service users are treated. This is demonstrated in the results of the CQC Community Survey 2016 where 2gNHSFT received particularly favourable results compared with other Trusts rated in the CQC Survey. We are pleased to note that the Trust are continuing to improve engagement with service users and carers and will continue to build upon their commitment to the 'Triangle of Care' programme.

The CCG also wish to acknowledge the Trust has achieved very positive results in the Patient Led Assessments of the Care Environment (PLACE) 2016 and were placed above the national average for Mental Health and Learning Disability settings in all six domains.

We recognise that the Trust's response rate to the Staff Survey 2016 saw an increase from 298 responses in 2015 to 777 staff responses in 2016, and overall staff engagement has again increased. We note the Trust score was higher than the nation average when compared to other Mental Health and Learning Disabilities Trusts.

We were pleased to note there continues to be a high level of clinical participation in local clinical audits, and also a positive increase in activity in relation to Clinical Research.

The CCG note that from 1 April 2016 the Trust was required to collect detailed information regarding the deaths of patients open to their services, and deaths within six months of their discharge from services in preparation for the 'Single Framework for Reviewing Deaths in the NHS' requirement published

March 2017. However there is limited assurance in relation to data quality and we note several improvements have been made in both Datix and available technology for collecting information relating to patient deaths. The CCG will work with the Trust to monitor progress against these requirements in 2017/18.

2gNHSFT need to be in a strong position to manage both present and future challenges. The CCG will continue to work with the trust to deliver mental health and learning disabilities services that provide best value with a clear focus on providing high quality, safe and effective care for the people of Gloucestershire.

Gloucestershire CCG wish to confirm that to the best of our knowledge we consider that the 2016/17 Quality Report contains accurate information in relation to the quality of services provided by 2gNHSFT. During 2017/18 the CCG wish to work with 2gNHSFT, all stakeholders and the people of Gloucestershire to further develop ways of receiving the most comprehensive reassurance we can regarding the quality of the mental health and learning disability services provided to the residents of Gloucestershire and beyond.

Dr Marion Andrews-Evans
Executive Nurse & Quality Lead
NHS Gloucestershire CCG

Herefordshire Health and Social Care Overview and Scrutiny Committee

I have noted the report and commend you for the successes over the past year.

The report raises a number of points that I would welcome further information on in relation to Herefordshire and to see improvements on meeting targets in the next quality report as described below:

- You'll be aware that the Herefordshire HSCOSC recently heard the outcomes of a task and finish review of mental health services for children and young people. One of the points that came up was regarding the transition from children's to adult services and in particular a recommendation that the upper age limit for children' services to be 25. I also note that targets for transition described on pages 30 and 31 have not been met. I would like to know more about developments to ease the transition and to align age groups with other services for children and young people.

- Page 7, point 2.2 refers to help and advice around physical health. How does this relate to age groups?

- Initiatives to support smoking cessation are commendable in terms of over-all physical health of services users and health outcomes, but it should be recognised within this that smoking can be a source of comfort or a handrail for some people with emotional difficulties during recover and to attempt smoking cessation during this time may be a big ask.

- Page 23 points 1.3, 2.4, where there are under achievements, why are they so, and how are they being addressed. How does quality compare between Herefordshire and Gloucestershire?

- Regarding complaints – I would like to see more information about the nature of complaints and comparisons between Herefordshire and Gloucestershire. I am not convinced by the friends and family test as there is one provider and therefore no choice!

- Regarding safety (Page 38) goals could also include a longer period of support beyond 48 hours, and as well as follow-ups, include a goal about ensuring people know who to contact if they feel they need support when they leave inpatient services. Page 46 gives a target of 95% follow-ups within 48 hours and I'd like to see this set at 100%. I'd like to understand why it wasn't clear why there were high numbers of suspected suicides in quarter 1.

- I'd welcome development of a suicide prevention forum for Herefordshire, and to see an update on the trial of the "stay alive" app

- P49 indicators regarding IAPT show an improvement is required, and shown separately for both counties, although this is a good example of how the split data is helpful to see

- P49 references to service developments and pilots for Gloucestershire would be welcomed as equivalents in Herefordshire if they prove successful in Gloucestershire

As services within Herefordshire develop and become more embedded I would welcome more detail in relation to Herefordshire services and for some of the statistics to be more defined for Herefordshire for the next quality report.

I would like to take this opportunity to thank you and your colleagues for your engagement with the health and social care overview and scrutiny committee. The council adopts constitutional arrangements this month which will include a change to the scrutiny arrangements to better align to our service structure and forward plan. I hope that we will see your continued contact with the two new scrutiny committees for adults and children's services in the coming year.

Councillor PA Andrews
Chair, Herefordshire Health and Social Care Overview and Scrutiny Committee

The Royal College of Psychiatrists

Statement of Participation in National Quality Improvement Projects managed by The Royal College of Psychiatrists' Centre for Quality Improvement

[2]gether NHS Foundation Trust			
Programmes	Participating services in the Trust	Accreditation Status	Number of Services Participating Nationally
MSNAP: Memory Services National Accreditation Project	Gloucester Memory Service	Accredited	107
PLAN: Psychiatric Liaison Accreditation Network	None	N/A	74
QNCC ED: Quality Network for Community CAMHS (Child and Adolescent Community Mental Health Services) Eating Disorders	Eating Disorder Service	Participating but not yet undergoing accreditation	18
QNLD: Quality Network for Learning Disability Wards	None	N/A	40
QNOAMHS: Quality Network Older Adults Mental Health Services	Chestnut Ward	Accreditation deferred	67
	Willow Ward	Accreditation deferred	
	Cantilupe Ward	Accredited	
	Jenny Lind Ward	Accredited as excellent	
	Mulberry Ward	Participating but not yet undergoing accreditation	
AIMS-WA: Working Age Adult Wards	Mortimer Ward, Stonebow Unit	Accreditation suspended for this service	136
	Abbey Ward, Wotton Lawn Hospital	Accredited	
	Dean Ward, Wotton Lawn Hospital	Accredited as excellent	
	Kingsholm Ward, Wotton Lawn Hospital	Accredited as excellent	
	Priory Ward, Wotton Lawn Hospital	Accredited as excellent	
ECTAS: Electro Convulsive Therapy Accreditation Service	Stonebow (Hereford)	Accredited	101
	Wotton Lawn (Gloucester)	Accredited as excellent	
EIP Self-Assessment (English Teams only): EIP GRIP (Gloucestershire) N/A Self-Assessment (English Teams only)	GRIP (Gloucestershire)	N/A	153
	Herefordshire Early Intervention Service	N/A	
Perinatal: Perinatal In-Patient & Community Settings	None	N/A	43

Programmes	Participating services in the Trust	Accreditation Status	Number of Services Participating Nationally
QNCC: Quality Network for Community CAMHS (Child and Adolescent Community Mental Health Services)	None	N/A	32
QNFMHS: Quality Network for Forensic Mental Health Services	The Montpellier Unit (LSU)	Accreditation not offered by this network	125
QNIC: Quality Network for Inpatient CAMHS (Child and Adolescent Community Mental Health Services)	None	N/A	127
QNPMHS (Prison): Quality Network for Prison Mental Health Services	None	N/A	40
AIMS PICU: Psychiatric Intensive Care Units	Greyfriars PICU	Accredited as excellent	38
AIMS Rehab: Rehabilitation Wards	Honeybourne Recovery Unit	Accredited as excellent	65
	Laurel House	Accredited as excellent	
HTAS: Home Treatment Accreditation Service	Cheltenham Crisis Resolution and Home Treatment Team	Accredited	49
	Gloucester Crisis Resolution and Home Treatment Team	Accredited	
	Stroud and Cirencester Crisis Resolution and Home Treatment Team	Accredited	
QED: Quality Network for Eating Disorder Services	None	N/A	32
APPTS: Accreditation Project for Psychological Therapy Services	None	N/A	22
CofC: Community of Communities	None	N/A	8
MS-AT: Assessment Triage	None	N/A	5
EIPN: Early Intervention in Psychosis Network	None	N/A	5
QNLD : Quality Network for Learning Disability Wards	None	N/A	1
ACOMHS: Accreditation for Community Mental Health Services	None	N/A	12

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

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2016 to April 2017
    - papers relating to Quality reported to the Board over the period April 2016 to April 2017
    - feedback from Gloucestershire commissioners dated 15 May 2017
    - feedback from Herefordshire commissioners dated 15 May 2017
    - feedback Governors dated 17 January 2017
    - feedback from Herefordshire Healthwatch dated 2 May 2017
    - feedback from Gloucestershire Healthwatch dated 15 May 2017
    - feedback from Gloucestershire Overview and Scrutiny Committee dated 28 April 2017
    - feedback from Herefordshire Overview and Scrutiny Committee dated 15 May 2017
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2017
    - the 2016 national patient survey
    - the 2016 national staff survey
    - the Head of Internal Audit's annual opinion over the trust's control environment dated 17 April 2017
    - CQC inspection report dated 28 January 2016

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with MHs Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

….....Date.....Chair

.....Date.....Chief Executive

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

MUST	The Malnutrition Universal Screening Tool is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.
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 – 25 May 2017
Author:	Marcia Gallagher, Non-Executive Director
Presented by:	Marcia Gallagher, Non-Executive Director

SUBJECT: **NON EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS QUARTER 4 2016/17 – January to March 2017**

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 January and 31 March 2017.

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 recommended after the first NED audit to documentation to be made available to those undertaking the audit represents a significant improvement. However the unhelpful formality of language is still evident in terms of the use of upheld/not upheld within the CEO response letter. Early consideration needs to be given to a more appropriate response in future.

2. SUMMARY OF FINDINGS

2.1 The documentation was well prepared and easy to follow .The documentation helpfully included the following post the recommendations of the first NED audit:-

- The checklist.
- Consent details.
- The acknowledgement letter detailing issues and timescales.
- A holding letter if required.

2.1.2 My observations were that:

- The investigations seemed open, honest, detailed and transparent.
- The outcome of each issue of complaint was identified in the investigators report.
- Where there was a difference of opinion the investigator made a judgment about the available evidence and suggested which opinion may be more reasonable.
- Investigations and responses were undertaken in a timely manner.
- File numbers matched the number on the investigation report.
- The name of the investigator(s) was clear.
- The reports were countersigned by the service director.
- Apologies were given where it was seen as appropriate.

2.2 Case 1

2.2.1 The nature of this complaint was very clear and consisted of perceived communication and alleged attitudinal issues. A holding letter was required as there were difficulties making contact with the complainant. The investigation was very thorough.

2.2.2 The report contained some examples of a formality of language that may be unhelpful when dealing with complaints (“this complaint is not upheld”)

2.2.3 The tone of the CEO letter was apologetic which may have helped to mitigate the formality of some of the language in the response to the complainant.

2.2.4 There was limited learning identified due to the nature of the complaint but none the less clearly identified.

2.2.5 I would offer full assurance in respect of this investigation.

2.3 Case 2

2.3.1 This complaint consisted of ten areas of complaint .The complaints were brought by the parent of a young adult and centred round their concerns regarding the communication, care and treatment that had been provided.

2.3.2 The investigation was thorough .Apologies were given where the trust agreed that they were required. Only two of the ten complaints were upheld and apologies then given. Regarding one area of complaint there appeared to be no evidence on RIO to substantiate either way .Additionally of those interviewed as part of the investigation they were not aware of the facts relating to that complaint. The investigation concluded that as no recorded evidence of what allegedly had been communicated to the parent or witnesses

of what was said the conclusion reached was therefore the complaint was not upheld.

2.3.3 The tone of the CEO letter was good and where the apologies were given these were “sincere apologies” ,”truly sorry” and regarding the complaint where there was a lack of information the letter expressed “deep regret” that such a comment may have been made. The report concluded that the investigation found several aspects of communication fell below the expected standards expected by the Trust.

2.3.4 Learning was identified as part of the complaint and the action identified centred around improvements required in communication.

2.3.5 I would offer full assurance in respect of this complaint but state the importance of input into RiO in supporting investigations.

2.4 Case 3

2.4.1 A complex complaint contained within an eight page letter with eight areas of complaints. The complaint involved two NHS organisations .The complainant was supported by an advocacy company. The complainant had previously had private sector mental health assessments and the complaint made numerous references to the comparison of previous diagnosis and treatment. A very good and honest acknowledgement letter was sent from the Trust to explain that as some complaints related to events more than twelve months previously that given the time lapse some staff may have left 2g FT and some staff may not be able to recall all the facts.

2.4.2 This complaint was the oldest of the three I reviewed and the defensive style of the investigation was noticeable.

2.4.3 The complainant declined to meet as part of the investigation and this caused delay.

2.4.4 None of the eight areas of complaint were ultimately upheld. However the CEO response letter commenced empathetically with “I am sorry to her of your experiences and the impact that this had on you”.

2.4.5 There was no specific learning identified other than the outcome of the investigation to be shared with the operational manager.

2.4.6 This complaint resulted in a local resolution meeting and is now closed.

2.4.7 I would offer full assurance in respect of this complaint.

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.

Agenda item 12 **PAPER G**

Report to: Trust Board – 25 May 2017
Author: Leigh Clarke, Assistant Director of Service Continuity
Presented by: Colin Merker, Director of Service Delivery

SUBJECT: **Mental Health Legislation and Scrutiny Committee – Annual Report 2016/17**

Can this report be discussed at a public Board meeting?	Yes

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

EXECUTIVE SUMMARY

The Mental Health Legislation and Scrutiny Committee (the Committee) Annual Report outlines the activities of the Committee between April 2016 and March 2017.

Section 2 of the report sets out a number of requirements linked to the Committee's Terms of Reference in which both evidence and a level of assurance are provided. While the majority of requirements are listed as significant or full assurance, several areas have been deemed to be limited, including;

- Comply with the Mental Capacity Act (MCA) and Deprivation of Liberty Standards (DOLS): The limited assurance rating relates to 'Capacity to consent to treatment', which has been deemed internally (audit) and externally (CQC monitoring visits) as requiring additional improvement.
- Procedures are in place and operating satisfactorily to inform detained patients and their nearest relatives about applicable provisions of the MHA and of their rights: The limited assurance rating has been applied as new audit data is awaited to determine whether or not a new automated reminder system has improved both the giving and recording of Section 132 rights.
- Review issues raised through the CQC annual monitoring visits and actions plans resulting from them: The limited assurance rating has been applied due to both slipped timeframes for actions to be achieved and for those aspects of the MHA Code of Practice that are continually flagged by the CQC.

The Committee is able to provide significant assurance on the controls it has in place for ensuring the Trust monitors and sustains compliance with the MHA, MCA, HRA (and their associated codes of practice) and where necessary takes action to address non-conformities.

RECOMMENDATIONS

1. The Board is asked to note:
   - The contents of this report and the current level of assurance.
2. The Board is asked to approve:
   - The Mental Health Legislation and Scrutiny Committee priorities for 2017/18.
   - This Annual Report.

Corporate Considerations	
Quality implications	Appropriate compliance with the MHA, MCA and HRA is a fundamental requirement of a competent Mental Health Service provider. Addressing the actions highlighted by the regulator is a priority to ensure that we meet the necessary standards consistently.
Resource implications:	None identified outside of currently agreed budgets.
Equalities implications:	Ensuring people with mental health needs are treated equitably within the framework of the various legislation is a fundamental requirement of the Trust.
Risk implications:	Legal, reputational and safety as they relate to individuals patients, carers, staff and the organisation.

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	Inclusive open and honest	P
Excelling and improving	P	Can do	P
Responsive	P	Efficient	P
Valuing and respectful	P		

Where in the Trust has this been discussed before?		
MHA Legislation and Scrutiny Committee	Date	08 March 2017

Reviewed by:		
Colin Merker (Executive Director of Service Delivery)	Date	24 February 2017

What consultation has there been?		
Philip Southam	Date	24 February 2017

Explanation of acronyms used:	AMHP	Approved Mental Health Practitioner
	CoP	Code of Practice
	CTO	Community Treatment Orders
	CQC	Care Quality Commission
	DoLS	Deprivation of Liberty Standards
	HRA	Human Rights Act
	MCA	Mental Capacity Act
	MHA	Mental Health Act

1 INTRODUCTION

1.1 Purpose Statement

1.1.1 [2]gether NHS Foundation Trust as a provider of Mental Health and Community Services is required to demonstrate that its systems, structures and controls for how it provides services are compliant with; the Mental Health Act (MHA), Mental Capacity Act (MCA), Human Rights Act (HRA) and associated codes of practice.

1.1.2 The Mental Health Legislation and Scrutiny Committee is the Committee responsible for ensuring compliance on behalf of the Trust Board by holding the Executive to account and providing assurance to the Trust Board that appropriate integrated; systems, processes and reporting arrangements are established, monitored and maintained.

1.2 Scope of report

1.2.1 This report covers the structures, systems and activities that are in operation across the Trust to ensure [2]gether NHS Foundation Trust's continued compliance with; the Mental Health Act (MHA), Mental Capacity Act (MCA), Human Rights Act and associated codes of practice. Internal and external monitoring mechanisms that support the provision of assurance are included in table 1 below.

Table 1: Internal and external monitoring mechanisms

Internal Monitoring	External Monitoring
• MHA Legislation and Scrutiny Committee meetings - Minutes - reviewed Terms of Reference • Mental Health Act Managers Forum (including issues reports) • Policy/Procedure submissions and approvals • Key Performance Indicators • Audits • Training • MHA Operational Group (New)	• CQC Monitoring visits • CQC Inspection • Bevan Brittan advice and guidance

1.3 Mental Health Legislation Scrutiny Committee members attendance

Date / Core Member	11/05/16	06/07/17	16/09/17	09/11/16	11/01/17
Martin Freeman (until 16/09/16)	✓	✓	✓	-	-
Quinton Quayle (from the 06/07/16)	-	✓	✓	✓	✓
Colin Merker	✓	✓	✓	✓	✓
Nikki Richardson	o	o	✓	✓	✓
STATUS	Quorate	Quorate	Quorate	Quorate	Quorate

1.4 The following officers were in attendance at the Committee;

Role	Date / Officer	11/05/16	06/07/17	16/09/17	09/11/16	11/01/17
Section 12 approved doctor – Gloucester	Kelwyn Williams	✓	✓	o	✓	✓
Section 12 approved doctor – Hereford	Dr Ramandeep Dargan	✓	o	✓	o	o
Deputy Director of Nursing	Alison Curson	o	o	✓	o	o
Head of Profession for Social	Sarah Bennion	o	✓	✓	o	✓
Head of Health	Philip Southam	✓	✓	✓	✓	✓

Role	Date / Officer	11/05/16	06/07/17	16/09/17	09/11/16	11/01/17
Records/MHA Practice Policy Lead						
MCA/DOLS Organisational Lead	Tina Kukstas	✓	✓	✓	o	o
Senior Operations Lead - Gloucester	Marieanne Bubb-McGhee	✓	o	o	o	✓
Senior Operations Lead - Hereford	Sally Simmonds	✓	✓	✓	✓	✓
Community Services Manager - Gloucester	Jonathan Thomas	o	o	✓	o	o
Assistant Director of Service Continuity	Leigh Clarke	✓	✓	✓	o	✓
Trust Secretary	John Mcilveen	o	o	o	o	o

2 Developments in 2016/17

- MHA Operational Group – Established in January 2017 the Group was formed to focus on those operational aspects of the MHA and CoP that are identified (through a variety of data sources) as requiring additional attention due to the frequency and/or the degree of difficulty in finding solutions to address a particular issue(s)/challenge(s).

- **CQC Monitoring Report Formats** – Significant changes to the way in which CQC monitoring visit reports and their corresponding action statements are received, analysed, completed and monitored has provided for a more informed MHA Legislation and Scrutiny Committee and a means to actively address reoccurring issues operationally.

- **Human Rights Act Self-Assessment** – The development and introduction of a Human Rights Act (HRA) framework to support the gathering and assessment of evidence to ensure the Trust meets its statutory and legal requirements as they pertain to the HRA.

3 Overall level of Assurance

3.0.1 The Committee is able to provide **Significant Assurance** based on the controls it has put in place and its continued action in directing the activities of the Trust where non-conformities with the MHA, MCA, HRA and their associated codes of practice are identified.

4 KEY STRATEGIC RISKS 2016/17

During 2016/17 the Committee has highlighted a number of key strategic risks which will help to inform the work programme for the Committee into 2017/18. These risks include;

- AMHP Service provision
- Compliance with legislative requirements including; the Mental Health Act, Mental Capacity Act, Deprivation of Liberty Standards and the Human Rights Act.

5 MENTAL HEALTH LEGISLATION SCRUTINY COMMITTEE ACTIVITY 2016/17

5.1 Activity Summary

Key:	
	Full assurance - A sound system of controls has been effectively applied and manages the risks to the achievement of the objectives.
	Significant assurance - A sound system of controls has, for the most part, been consistently applied, minor inconsistencies have occurred but there is no evidence to suggest that the system's objectives have been put at risk.
	Limited assurance - Gaps in the application of controls as designed by management put the achievement of objectives at risk.
	No assurance - Gaps in the application of controls as designed by management have opened the system to risk of significant failure to achieve its objectives and left it open to abuse or error.

Ref	Assurance requirements	Evidence	Level of assurance	Direction of improvement	Commentary
2.1.1	Comply with the Mental Health and Human Rights Acts and any associated codes of practice.	Key Performance Indicators MHA Legislation & Scrutiny Committee Minutes; 11/05/16 – Use of seclusion audit 06/07/16 – T2/T3 Compliance audit 06/07/16 – SOAD related consultations audit 21/09/16 – Detained patients and rights audit 09/11/16 – Section 17 leave audit 09/11/16 – 06/07/16 T2/T3 Compliance audit 11/01/17 – Human Rights Report CQC Monitoring Visit Ward Reports	**Significant assurance**	↑	No comments
2.1.2	Comply with the Mental Capacity Act (MCA) and Deprivation of Liberty Standards (DOLS).	MHA Legislation and Scrutiny Committee Minutes; 11/05/16 – Capacity & Consent audit 11/05/16 – Section 58 and 63 audit Review of DOLS applications reports CQC Monitoring Visit Ward Reports	**Limited assurance**	↑	The limited assurance rating relates to 'Capacity to consent to treatment', which has been deemed internally (audit) and externally (CQC monitoring visits) as requiring additional improvement.
2.1.3	Provide a robust performance and compliance framework and effective arrangements for ongoing review and monitoring of statistical information on MHA activity.	Key Performance Indicators	**Significant assurance**	↑	No comments

Ref	Assurance requirements	Evidence	Level of assurance	Direction of improvement	Commentary
2.1.4	Staff acting on the Hospital Managers' behalf under the Scheme of Delegation are competent to undertake their delegated tasks and to monitor their performance.	MHA Legislation and Scrutiny Committee Minutes; 06/07/16 – MHA Responsibilities letter sent to Clinicians.	**Significant assurance**	↑	No comments
2.1.5	Arrangements are in place and are operating satisfactorily for the completion and review of relevant legal documentation relating to compulsory admission and detention of patients.	MHA Legislation and Scrutiny Committee Minutes; 11/05/16 – AMHP Application Audit Deprivation of Liberty Standards (DoLS) Applications	**Full Assurance**	↔	No comments
2.1.6	Procedures are in place and operating satisfactorily to inform detained patients and their nearest relatives about applicable provisions of the MHA and of their rights.	MHA Legislation and Scrutiny Committee Minutes; 21/09/16 – Detained patients and rights audit CQC Monitoring Visit Ward Reports	**Limited assurance**	↑	The limited assurance rating has been applied as new audit data is awaited to determine whether or not a new automated reminder system has improved both the giving and recording of Section 132 rights.
2.1.7	Policies and procedures relating to the MHA are reviewed and ratified.	Amendments to guidance of Section 135 warrants 11/05/16 CTO concerns of the family Policy- Audit 09/11/16 CTO concerns of the family Policy- Audit	**Significant assurance**	↑	Two policies are currently being reviewed; Policy for the Receipt, Scrutiny and Rectification of Mental Health Act Documents Renewal of Detention and SCT Policy
2.1.8	To consider any matters referred from the MHA Managers' Forum	Review of MHA Managers Forum minutes and questions	**Full Assurance**	↔	No comments
2.1.9	To review issues raised through the CQC annual monitoring visits and actions plans resulting from them.	MHA Legislation and Scrutiny Committee Minutes Quarterly CQC Monitoring Visit Reports Ward Action Statements CQC Monitoring Visit monitoring spreadsheet Quarterly Operational CQC Compliance updates	**Limited assurance**	↑	During 2016/17 systems and processes have been put in place to; support the review of CQC observations, to identify suitable actions and to monitor their implementation. Although progress has been made in developing structures and systems a number of issues remain that appear to have not progressed significantly enough to provide significant assurance. Issues raised by the CQC in 2016/17 include; • **Staff training** (with a particular focus on MHA and MCA)

Ref	Assurance requirements	Evidence	Level of assurance	Direction of improvement	Commentary
					– this has been an improving picture throughout the year with an E-Learning Course adding to the current MHA and MCA face to face training courses on offer. Uptake of the training has on the whole been very good, with a few areas reporting challenges in releasing staff to complete e.g. inpatient areas and staff bank. • **Section 17 Leave** (primarily related to an administrative issue with forms not showing whether the patient and nearest relative have received copies) – being reviewed by the newly formed MHA Operational Group. • **Section 132 rights** (regular recording and giving of rights) – A new automated reminder system on RiO was introduced in the latter part of 2016 to support staff in remembering to give and record S132 rights to patients on a regular basis. Data is yet to be made available to determine the effectiveness of this system to support the Trust in complying with the MHA Code of Practice. • N**o evidence of advance decisions or statements** – Resolution identified and being taken forward by Tina Kukstas and Judith Boniface. • **Assessment of capacity to consent to treatment** – being reviewed by the newly formed MHA Operational Group. • **Insufficient evidence of patients' views and wishes being recorded in their care plans on RiO** – being reviewed by the newly formed MHA Operational Group.
2.1.10	To review issues arising from Managers' Hearings.	MHA Legislation and Scrutiny Committee Minutes MHA Managers issues reports (including investigations) Review of MHA Managers Hearing issues reports	**Significant assurance**	↑	Requirement to confirm that MHA Managers are satisfied with the current arrangements for raising issues from hearings and the subsequent process for investigating the causes and reporting the findings.
2.1.11	To ensure appropriate training programmes are in place for staff and MHA Managers	MHA and MCA full day courses New MHA E-Learning Package Training completion statistics	**Significant assurance**	↑	No comments

6 PRIORITIES FOR 2017/18

6.1 To support the growth and development of the MHA Operational Group in supporting the activities and responsibilities of the MHA Legislation and Scrutiny Committee.

6.2 To define, measure, analyse and improve aspects of the MHA/MCA/HRA that the Committee believes the Trust is not compliant with (e.g. Policies, practice, process, structures and/or lines of accountability).

6.3 To review the range of data sources available to the Committee to help build a picture of good practice and areas requiring additional improvement.

6.4 Continue to provide a robust forum to ensure the Trust's continuing compliance with MHA, MCA, HRA and their associated codes of practice.

6.5 Continue to meet its requirements as set out in the MHA Scrutiny Committee Terms of Reference.

6.6 Overseeing where necessary the implementation and monitoring of actions and activities from the CQC comprehensive inspection and subsequent monitoring visits.

6.7 To ensure consistency and standardisation (where appropriate) of systems, structures and processes that support compliance across Gloucestershire and Herefordshire.

6.8 To progress work associated with the key strategic risks identified in section 3 of this paper.

7 RECOMMENDATIONS

7.1 The Mental Health Legislation and Scrutiny Committee is asked to note:

- The contents of this report; and
- The current level of assurance

7.2 The Mental Health Legislation and Scrutiny Committee is asked to approve:

- the Mental Health Legislation and Scrutiny Committee priorities for 2017/18.
- This Annual Report

Agenda item **13** **Paper** **H**

Report to: 2gether NHS Foundation Trust Board on 25th May 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	*19.05.2017*

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

01.03.17 The Director of Organisational Development attended the NHS Improvement Sector Development Cohort Visit

03.03.17 The Chief Executive attended Hosted the ROSCA's

03.03.17 The Director of Organisational Development attended the ROSCA Award Event at Hatherley Manor

03.03.17 The Medical Director attended the Medical Staffing Committee

03.03.17 The Medical Director attended the ROSCAs awards

06.03.17 The Director of Engagement and Integration facilitated the monthly Team Talk event at Weavers Croft in Stroud.

06.03.17 The Director of Engagement and Integration attended the Senior Leadership Forum.

06.03.17 The Director of Organisational Development attended Corporate Induction to meet with new Trust employees

06.03.17 The Director of Organisational Development attended Senior Leadership Forum

06.03.17 The Medical Director presented Team Talk

09. 03. 17 The Director of Engagement and Integration chaired a Research Overview meeting.

09.03.17 The Medical Director did a presentation at the Council of Governors meeting

17.03.17 The Director of Engagement and Integration attended the Quality and Clinical Risk Committee meeting.

17.03.17 The Medical Director attended the Junior Doctors Forum

21.03.17 The Chief Executive attended JNCC

28.03.17 The Director of Organisational Development chaired the Workforce and Organisational Development Sub Committee

29.03.17 The Director of Organisational Development chaired the inaugural meeting of the short life Apprenticeship Working Group

29.03.17 The Medical Director was on the interview panel for Consultant interviews

30.03.17 The Chief Executive attended Trust Board

30.03.17 The Director of Organisational Development attended the Trust Board meeting

03.04.17 The Chief Executive hosted Team Talk at Rikenel

03.04.17 The Director of Engagement and Integration attended Corporate Induction.

03.04.17 The Director of Engagement and Integration attended the Senior Leadership Forum.

03.04.17 The Director of Organisational Development attended Senior Leadership Forum

03/04/17 The Director of Finance and Commerce delivered the Corporate Induction Presentation on behalf of Shaun Clee

03.04.17 The Medical Director attended an extraordinary LNC meeting

03/04/17 The Director of Finance and Commerce attended Senior Leadership Forum

04.04.17 The Chief Executive hosted the Herefordshire Roadshow

04.04.17 The Director of Organisational Development attended a Board Meeting of the Gloucestershire CYPS team

05.04.17 The Director of Engagement and Integration held a Board Visit with Children and Young People Service Colleagues at Acorn House, Gloucester.

05.04.17 The Director of Organisational Development attended a Patient Safety Visit to the Stroud Assertive Outreach Team

07.04.17 The Chief Executive chaired the Dementia Board

07.04.17 The Chief Executive attended MSC

07.04.17 The Medical Director attended the Medical Staffing Committee

11.04.17 The Chief Executive hosted the Herefordshire Roadshow

11.04.17 The Director of Organisational Development chaired a meeting of the Apprenticeship Working Group

12.04.17 The Director of Organisational Development attended a Team Meeting of the Gloucestershire CYPS team

12/04/17 The Director of Finance and Commerce attended Audit Committee

12.04.17 The Director of Engagement and Integration took part in a Patient Safety Visit at Mortimer Ward in Hereford.

13.04.17 The Director of Engagement and Integration attended a Board Strategy Session.

13.04.17 The Medical Director attended the Board Strategy Session

13/04/ 17 The Director of Finance and Commerce attended a Board Strategy Session

19/04/17 The Director of Finance and Commerce attended a BCF Planning Meeting at Hereford CCG Office

20/04/17 The Director of Finance and Commerce attended a 2gether Contract Monitoring Board Meeting with Herefordshire CCG

24/04/17 The Director of Finance and Commerce attended a Joint Exec's Meeting at Gloucester Farmers Club

25.04.17 The Director of Organisational Development chaired the Workforce and Organisational Development Sub Committee

25.04.17 The Director of Organisational Development chaired the Safety Health and Environment Sub Committee

26.04.17 The Director of Engagement and Integration presented colleagues in the Service Experience Department with ROSCA certificates.

27.04.17 The Director of Engagement and Integration attended the Board Meeting.

27.04.17 The Director of Organisational Development attended the Trust Board meeting

27/04/17 The Director of Finance and Commerce attended 2g Board Meeting

27/04/17 The Director of Finance and Commerce attended an additional Exec Session

Board Stakeholder engagement

01.03.17 The Director of Engagement and Integration attended a Forest of Dean Community Services Steering Group meeting at Sanger House.

02.03.17 The Chief Executive attended the Gloucestershire STP Delivery Board

02.03.17 The Director of Engagement and Integration chaired an international steering group teleconference re Occupational Therapy Research.

02.03.17 The Director of Organisational Development chaired the STP Gloucestershire Capability Thematic Group

03.03.17 The Chief Executive chaired the Herefordshire MH Workstream Meeting

03.03.17 The Chief Executive attended the One Herefordshire Summit

04.04.17 The Chief Executive attended the Gloucestershire service reconfiguration meeting

06.04.17 The Director of Organisational Development chaired the STP Gloucestershire Capability Thematic Group

07.03.17 The Director of Organisational Development attended the STP Hfd&Worc Integrated Care Alliance

07.03.17 The Director of Organisational Development attended a lunch event organised by the Wessex Reserve Forces & Cadets Association – "Filling the Skills Gap"

07.03.17 The Director of Engagement and Integration attended the Gloucestershire Health Care Overview and Scrutiny Committee at Shire Hall.

07.03.17 The Medical Director attended the Herefordshire Clinical Reference Group Meeting along with the Herefordshire Clinical Director

07.03.17 The Director of Engagement and Integration met with the CEO of Stroud Valley's Project in Stroud 09.03.17 The Director of Organisational Development attended the South West HR Directors Group

13.03.17 The Medical Director was on the interview panel for the Practice Based Adult MH Nurse Specialist Pilot

16.03.17 The Medical Director attended the Clinical Programmes Board Meeting with the CCG

16.03.17 The Director of Engagement and Integration chaired the Swindon Mind and 2gether Strategic Partnership Meeting at Cirencester Memorial Centre.

16.03.17 The Director of Organisational Development participated in a teleconference meeting of the STP Hfd&Worc Workforce & OD Working Group

21.03.17 The Chief Executive attended The Herefordshire STP Programme Board

22.03.17 The Chief Executive attended The One Herefordshire health and care shadow alliance meeting

24.03.17 The Chief Executive attended the Forest of Dean Provider Forum

24.03.17 The Director of Organisational Development participated in a webex meeting regarding the Trust's application to provide placements for the national Graduate Management Trainee Scheme

22.03.17 The Director of Organisational Development attended the STP Hfd&Worc HR Director's Working Group

28.03.17 The Chief Executive attended the Gloucestershire Strategic Forum

28.03.17 The Chief Executive attended the Gloucestershire STP Advisory Group

28.03.17 The Director of Organisational Development participated in a teleconference meeting of the STP Hfd&Worc Workforce & OD Working Group

28.03.17 The Director of Organisational Development attended a meeting of the Gloucestershire STP Social Partnership Forum

03.04.17 The Medical Director took part in the induction programme for the Practice Based Adult MH Nurse Specialist Pilot

04/04/17 The Director of Finance and Commerce attended a Resources Steering Group Meeting at Gloucestershire CCG

04.04.17 The Director of Engagement and Integration chaired the Tackling Mental Health Stigma Group at Sanger House on behalf of the CCG.

05.04.17 The Director of Engagement and Integration attended the Forest of Dean Community Services Review Steering Group meeting at Sanger House.

05/04/17	The Director of Finance and Commerce attended a Patient Safety Visit with Sally Ashton to the AOT/EI Team at 27a St Owens Street, Hereford HR1 2JB
06.04.17	The Chief Executive attended the Gloucestershire STP Delivery Board
06.04.17	The Chief Executive attended the GSF away Day
06/04/17	The Director of Finance and Commerce attended a Charitable Funds Donation from Mr Burfield on behalf of the Mason's
07.04.17	The Director of Engagement and Integration co-facilitated a Mental Health Conversation at the Bishop's Breakfast at The University of Gloucestershire.
10.04.17	The Medical Director attended the 2gether CQRG meeting
11.04.17	The Medical Director attended a meeting at WVT to meet the Medical Director and Deputy Medical Director
12.04.17	The Chief Executive attended the One Herefordshire Health and care shadow alliance meeting
13.04.17	The Chief Executive chaired the Improvement Academy Steering Group
13.04.17	The Director of Organisational Development attended the Herefordshire Integrated Care Alliance
13.04.17	The Director of Organisational Development attended the STP Gloucestershire Improvement Academy Steering Group
20.04.17	The Chief Executive chaired the Herefordshire and Worcestershire LWAB board
20.04.17	The Director of Engagement and Integration met with the CEO of Carers Gloucestershire.
24.04.17	The Director of Organisational Development attended a joint meeting with Board members of Gloucestershire Care Services
26.04.17	The Chief Executive attended the FoD alliance meeting
26/04/17	The Director of Finance and Commerce met with Duncan Laird of KPMG
27.04.17	The Director of Organisational Development attended a meeting of the Gloucestershire STP Social Partnership Forum
28.04.17	The Medical Director attended an inquest

28.04.17 The Director of Engagement and Integration attended the Herefordshire Health and Social Care Overview and Scrutiny Committee meeting at Shire Hall.

Board National engagement

01.03.17 The Director of Engagement and Integration took part in a Carter Review Site Visit with NHS Improvement.

31.03.17 The Director of Engagement and Integration attended a Forces In Mind briefing at Andover.

21.03.17 The Medical Director attending the national NHS England Learning from Deaths Conference in London

05.04.17 The Chief Executive attended the SWLA Board as representative for Gloucestershire STP

25.04.17 The Director of Engagement and Integration co-hosted a clinical visit for NHS Improvement with the Director of Quality.

25.04.17 The Director of Engagement and Integration chaired an international steering group teleconference re Occupational Therapy research.

1.2.3 Sustainability

Major Project Update – April 2017

SLR/PLICS 2016/17 quality

The reworks requested by the Executive Team on income apportionment methods have been concluded, and subsequently the 2015/16 figures have now been completed and work on the 2016/17 figures will be achieved in line with the timescales set by the Executive Team.

The Business Rules & Assumption Manual has been signed off, the review and approval of the cost apportionment methods used in PLICS will take place on Tuesday 18th April 2017, and to allow the Qlikview roll out, a presentation will take place as part of the final executive sign off.

In readiness for roll out, a number of papers have been drawn up, e.g. an SLR training paper and training manual and a Qlikview policy on use and reporting - these papers have already been presented to the SLR Project Board and signed off

As part of an NHS England initiative, Ernst Young LLP carried out a review on the costing systems/processes, which includes PLICS. Excellent feedback was received and has been given a “Moderate Assurance” rating.

A need to review the SQL processes was identified and work will be commissioned around the “Pscal, ETL database” with the objective of simplifying the input processes, which will facilitate a move towards monthly reporting.

Improving Care Through Technology **sustainability**

During February and March 132 laptops were deployed and the majority of corporate users were successfully moved onto the new system. Because of the end of year accounting pressures, the Finance team will move to the new system on 15th May. The operation to move our corporate users to the new system was extremely complex and time consuming because of the various pieces of bespoke software required. Work is ongoing work to replace older desktop computers with newer machines recovered during the laptop replacement exercise, and should complete by the beginning of October.

The Team is now working with colleagues in Training & Education to provide new starters with laptops during Corporate Induction, and has so far attended four inductions.

By the end of June all server infrastructure will have been moved from the glos domain to the 2gether domain, all disaster recovery elements will be in place, and all 2gether owned active directory objects will be deleted from the glos domain.

Although the IT systems and hardware upgrades have largely been delivered, the major project risk is that the benefits of this project can only be achieved through cultural and working practice changes. Clinical Practice Development and HR/OD are responsible for delivering those changes.

Gloucester City Hub **sustainability/quality**

Good progress is being made on the refurbishment of Pullman Place, Gloucester, to provide a single service delivery Hub for the city. The contract delivery is on programme and design work is concentrating on finalising the colour schemes and furnishing details. To support this work, a stakeholder event was held on 18 April in the Guildhall to provide information about the new Hub and seek the views of service users, carers and visitors. Invitations were sent to a wide range of organisations and individuals from which a group will be formed to assist with the design. Consultation events continue to be held with staff to ensure that their views are obtained and to support them in preparing for the move to the Hub in November 2017.

Smoking Cessation **quality**

On 03 April 2017, the Trust began its journey to becoming smoke free and has taken steps to provide staff and service users with support to stop or abstain from smoking while using or working in our services.

The ‘Smoke Free’ Policy has been ratified and uploaded to the Trust’s intranet, and staff and user engagement to support the considerable cultural change has been undertaken. Posters, banners, and leaflets to acknowledge the smoke free status of the Trust and to reinforce the benefits of being smoke free have been distributed to Trust sites.

The implementation of our smoke free policy relies upon a strong network of smoke free champions and smoking cessation advisers. Approximately 40% of nursing staff in Gloucestershire have received training in providing smoking cessation advice, and more smoking cessation advisers will be trained in the next 3 months. In Herefordshire the network of smoke free champions and advisers is smaller, but training dates for the combined Level 1 and NRT training for inpatient staff will soon be available. Discussions are

taking place with Public Health regarding Level 2 quit advisor training, with the expectation that there will be a minimum of two Level 2 trained staff per ward.

In the first 2 weeks of the Trust becoming smoke free, positive feedback has been received from both staff and service users.

E-rostering **sustainability/quality**

E-rostering training has been completed in 14 Units (Hereford x6, Wotton Lawn x6, Cheltenham x2), and the average auto-roster percentage for those wards exceeds 50%. All remaining wards will be completed by 19 May. Further to the JNCC meeting on 21 March, ward managers now have the autonomy to proactively manage annual leave and have been provided with clarity on overtime allocation.

In the next quarter:

- A Roster Policy will be drafted and reviewed by Staffside
- The Benchmarking and Benefits Realisation Methodology will be defined
- An initial KPI Report will be created using the Roster Perform Module
- The w/c 19 June roster will be reviewed to ensure the auto-roster percentage remains above 50%

Agenda item 14 **Enclosure No** **Paper I**

Report to:	Trust Board - 25th May 2017
Author:	Kate Nelmes, Head of Communications
Presented by:	Jane Melton, Director of Engagement and Integration

SUBJECT: **Annual Report of Membership Data 2016/17**

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

EXECUTIVE SUMMARY

- This paper provides an analysis of the 2016/17 financial year membership data for 2gether NHS Foundation Trust.
- In September 2016, the Council of Governors agreed the Trust's new Membership Strategy. Our focus is on retaining members and recruiting new members, with a specific emphasis on recruiting young members, members from black and minority ethnic backgrounds and men, who are all under-represented.
- An annual report on membership was requested by the Council of Governors to provide a year-on-year comparison of membership data.
- There are **7443** members of our Trust at the end of the 2016/17 financial year. This represents a decrease of 30 members over the year. This decrease is attributable to cleansing our membership database of out of date records and previous flaws in the reporting of staff membership figures.

RECOMMENDATIONS

The Trust Board is asked to note the 2016/17 financial year-end membership data and analysis.

Corporate Considerations	
Quality Implications:	An active and representative group of members will assist the organisation to enhance understanding of service experience and provide link with the important constituencies of Herefordshire and Gloucestershire.
Resource implications:	Further membership activity may require further resource to utilise membership resource to best effect.

Equalities implications:	Understanding the diversity of membership will assist to target recruitment and retention resources to best effect. Ensuring diversity in membership will offer a range of important views and participation to influence 2gethers work.
Risk implications:	There are risks of marginalising certain groups within the local community if attention is not paid to membership demographics.

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:		
Jane Melton, Director of Engagement and Integration	Date	14 April 2017

Where in the Trust has this been discussed before?		
The Council of Governors have received membership report updates throughout the year	Date	Throughout the year
What consultation has there been?		
	Date	

Explanation of acronyms used:	

1. Context

1.1. A new membership strategy was agreed by Governors in September 2016. Our focus is on those groups currently under-represented within our membership base, including men, younger people (under 19) and people from a black and minority ethnic background. Our membership base in Herefordshire is also far lower than it is in Gloucestershire, so this is another area of priority.

1.2. So far work on implementing the strategy has included the recruitment of a new membership volunteer, the use of iPads to recruit members at events, and conversations with young people and members of the black and minority ethnic community about what would encourage them to join the Trust.

1.3. Work has also been taking place to cleanse our membership data, to ensure we are accurately reporting and have a clear starting point for increased

recruitment. This work has included removing members who are no longer engaging with us, including those who have moved without leaving a forwarding postal or email address, and ensuring that we are only counting staff members who are within the relevant categories for membership. This has led to an overall decrease in membership, but more accurately reflects our true membership figures.

1.4. We are consulting with our members through our April membership newsletter, to gain feedback on our membership strategy and tactics. We will also be seeking volunteers to join a new Membership Advisory Group to help guide and implement our new membership strategy.

1.5. We are also reviewing our membership application form, including producing an 'Easy Read' version, which should make membership meaningful to a wider range of constituents.

1.6. The actions presented here also seek to compliment the tactical plan of the Trust's Engagement and Communication Strategy 2016 -2020 which is structured to influence more people in our community to become champions of the services that we deliver to make life better.

1.7. The membership data in this paper will help to inform the appropriate focus and tactics to enable recruitment, retention and engagement of members. This report will focus on overall change within membership data.

2. Membership figures

2.1 Membership data, at 31st March 2017, is as follows:

- There are **7443** members of our Trust **(**representing a **total decrease of 30** members overall**)**
- **5355** are Public Members and **2088** are Staff Members
- Our public membership increased by **200** over the year
- Our staff membership reduced by **230** due to data cleansing
- **250 public membership** records were removed with **178** members removed due to 'no forwarding address'
- On average, **24** members of the public joined the Trust every month, which is a decrease on the rate for 2015/16, when an average of **34** members joined each month. Our target for 2017/18 will be to recruit an average of 40 new members each month.
- New members are sometimes recruited at Governor Membership Events although the results of this method of recruitment are currently modest. Most new members recruited are through other public events, such as stands during awareness weeks and at organised events. Our most successful member recruitment event in 2016/17 was the open day at Gloucestershire Police Headquarters, when we recruited almost 100 new members.

2.2 Number of Public Members at 31 March 2017

Table 1 represents the actual numbers of members per constituency. However, the actual numbers do not provide information about the relative

numbers of members in relation to the size of the associated constituency. This is considered in the additional tables below. Information regarding the demographics of ethnicity, disability, age and gender are also provided.

Table 1 Public Membership Numbers by Constituency at 31st March 2017

Cheltenham	Cotswolds	Forest of Dean
884	376	557
Gloucester	**Stroud**	**Tewkesbury**
1406	816	596
Greater England	**Herefordshire**	
365	355	

Figure 2 provides the percentage spread of membership by constituency whilst Table 2 shows the relative percentage of membership. This data suggests that membership in Herefordshire is significantly lower than in Gloucestershire. However, the number of members in Herefordshire has risen from 315 to 355 in the last 12 months (an increase of 13%). Gloucester City has the largest proportion of Trust members and the largest population.

Figure 2 Membership data by constituency as at 31 March 2017

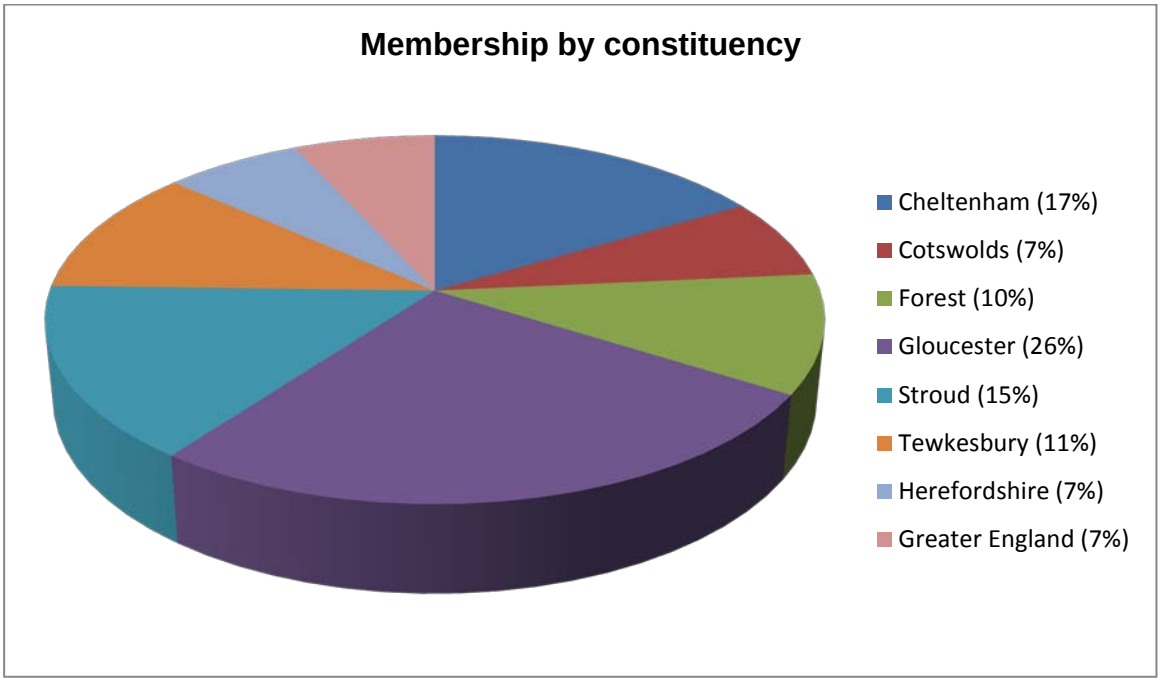


Table 2 **Public Membership as a total percentage of constituent population**

Constituency	Members	Population	%
Cheltenham	884	115,732	0.71
Cotswolds	376	82,881	0.45
Forest of Dean	557	81,961	0.67
Gloucester	1406	121,688	1.15
Stroud	816	112,779	0.72
Tewkesbury	596	81,943	0.73
Herefordshire	355	183,477	0.19

2.3 Ethnicity of Trust Members

Tables 3 and 4 suggest that the Trust has successfully recruited a reasonably representative group of people by ethnicity. This is particularly the case in Gloucestershire, although in both counties there is more work to undertake.

Table 3

Ethnicity - Gloucestershire		
	White British/White Other	**Black and Minority Ethnic**
Gloucestershire Census 2011	92% (596,984 people)	5% (27,337 people)
2g Public membership	93%	7%

Table 4

Ethnicity - Herefordshire		
	White British/White Other	**Black and Minority Ethnic**
Herefordshire Census 2011	94% (183,477 people)	2% (3,308 people)
2g Public membership	97%	3%

Table 5 **Ethnicity of members in relation to the associated populations of Gloucestershire and Herefordshire**

Ethnicity	Gloucestershire	Glos Members	%	Herefordshire	Hfd members	%
White British	546,599	4288	0.78	171,922	344	0.20
Mixed	8,661	49	0.57	1,270	2	0.16
Black/Black British	5,150	64	1.24	331	0	0.00
Asian/Asian British	10,522	100	0.95	1,162	0	0.00
White Other	23,048	122	0.52	8,247	8	0.11
Chinese/Other	3,004	12	0.39	545	1	0.18
Total	**596,984**	**4635**		**183,477**	**355**	

2.4 Disability status of Trust Members

In relation to members' self-report of their disability status, a much larger proportion of Trust members report a disability than do the general population of Gloucestershire and Herefordshire. These figures are represented in Table 6 with 14% of Trust members in Gloucestershire reporting disability and 15% of people in Herefordshire.

Table 6 Disability status of members in relation to the associated population of Gloucestershire and Herefordshire

Disability – Gloucestershire	
Census data 2011	0.5%
Public membership (Glos)	14% (651 of 4635 members)

Disability – Herefordshire	
Herefordshire Census 2011	0.2%
Public membership (Hfd)	15% (55 of 355 members)

2.5 Age Distribution of Trust members

A wide distribution of membership age range is reported in Table 7. Whilst the largest number of members are between the ages of 20 and 64, in relation to the population size for adults who are older than 65, the Trust reports a higher percentage. Work is required to increase membership representation from younger people.

Table 7 Age group of members in relation to the associated population of Gloucestershire and Herefordshire

Age	Total Hfd & Glos	% of people in age group	Total Public Membership	% of membership (disclosed)
10 – 15	54,528	8%	10*[1]	1%
16 – 19	38,260	6%	51*	1%
20 – 44	236,952	34%	1,495	28%
45 – 64	216,612	31%	1,812	34%
65 – 74	78,706	11%	761	14%
75+	71,665	10%	718	13%
Did not disclose			**508**	**9%**
Total	**696,723**	**100%**	**5355**	**100%**

[1] * Please note that the 2011 Census age groups differ to how we currently collate membership data. The age range noted against the census age group 10 – 15 for members is 11 – 16; and the age range noted against the census age group 16 – 19 for members is 17 – 19.

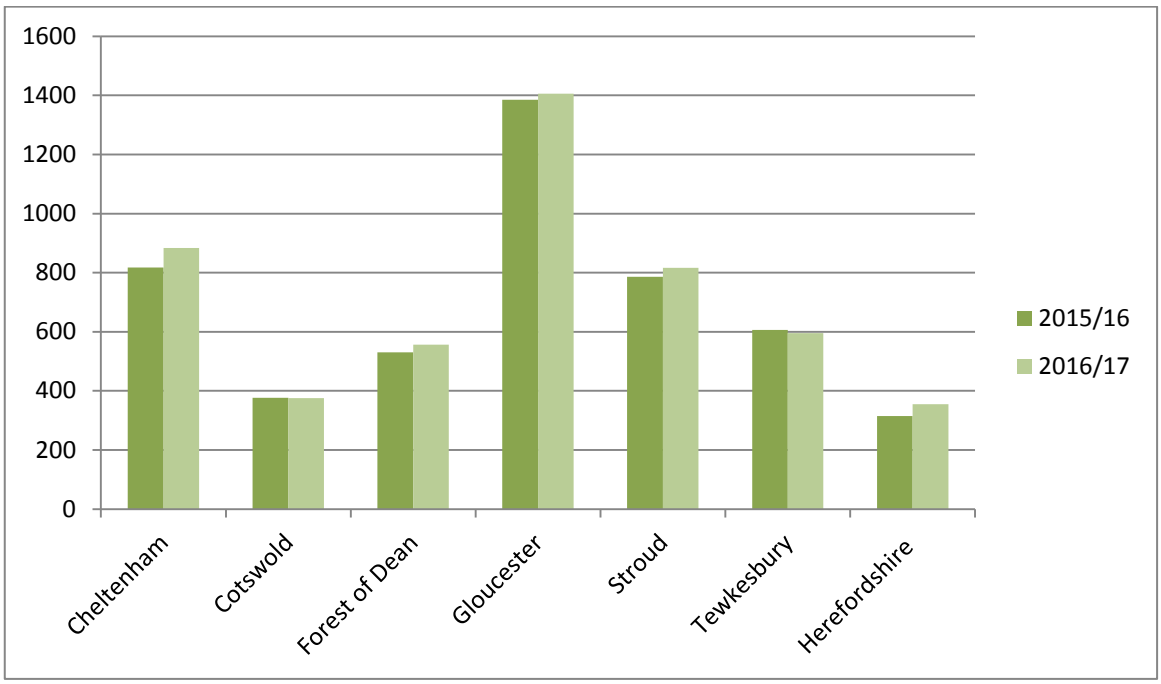
Table 8 Gender of Trust members

Gender – total public membership	
Male	1867
Female	3488

2. Comparison of Annual Public Membership Data (2016/17)

The following chart (Figure 3) shows a modest overall increase in public membership between 31st March 2016 and 31st March 2017. The graph indicates that overall, membership has been relatively constant in each constituency but with our largest constituency increases by population in Cheltenham and Herefordshire.

Figure 3 Comparison of membership between 2015/16 and 2016/17



3. Conclusion

Analysis of the membership data suggests that:

- Membership currently appeals more to women than men, to people aged between 20 and 65 and to those with self-reported disability.
- Further tactics need to be developed to encourage membership from males, younger people, people from minority ethnic groups and from people who are without disability in order to reflect an accurate representation of the constituents of Gloucestershire and Herefordshire.
- The number of members from Herefordshire remains significantly lower than in Gloucestershire. Gloucester City has the largest proportion of Trust members.

Agenda item 15 **Enclosure No Paper J**

Report to: 2gether NHS Foundation Trust Board 25th May 2017
Author: Stephen Andrews, Deputy Director of Finance
Presented by: Andrew Lee, Director of Finance & Commerce

SUBJECT: **Finance report for period ending 30th April 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 1 position is a surplus of £53k in line with the planned surplus.
- The month 1 forecast outturn is an £883k surplus in line with the Trust's control total.
- The Trust has a Oversight Framework segment of 2.
- The 2017/18 contracts with Gloucestershire CCG, Herefordshire CCG, NHS England and Worcestershire Joint Commissioning Unit have been signed.
- Budgets were approved by the Board in March for 2017/18.
- An update on the 2016/17 final accounts position is included.

RECOMMENDATIONS

It is recommended that the Board:

- note the month 1 position

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?			
Quality and Safety		Skilled workforce	
Getting the basics right		Using better information	
Social inclusion		Growth and financial efficiency	
Seeking involvement		Legislation and governance	

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

Reviewed by: Stephen Andrews, Deputy Director of Finance		
	Date	19th May 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	100.0%	
Operating Expenditure	FOT vs FT Plan	100.0%	
Cash	Number of creditor days	25	Balance of £10.6m (including investments) which equates to 25 creditor days.
PSPP	%age of invoices paid within 30 days	97.0%	91% paid in 10 days

The parameters for the traffic light dashboard are detailed below:

INDICATOR	RED 	AMBER 	GREEN 
Monitor FOT Financial Risk Rating	<2.5	2.5 - 3	>3
INCOME FOT vs FT Plan	<99%	99% - 100%	>100%
Expenditure FOT vs FT Plan	>100%	99% - 100%	<99%
CASH	<=50 days	51-60	>60 days
Public Sector Payment Policy - YTD	<80%	80% - 95%	>95%
Capital Income - Monthly vs FT Plan	<99%	99% - 100%	>100%
Capital Expenditure - Monthly vs FT Plan	>115% or <85%	110% - 115% or 85% to 89%	90% to 109%

- The financial position of the Trust at month 1 is a surplus of £53k which is in line with the plan (see appendicies 1 & 8).
- Income is £221k over recovered against budget and operational expenditure is £284k over spent, and non-operational items are £63k under 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	(4,848)	(404)	(403)	1	(4,848)	0
Stroud & S Cots Locality	(4,545)	(379)	(391)	(12)	(4,545)	0
Gloucester & Forest Locality	(4,300)	(358)	(334)	24	(4,300)	0
Social Care Management	(3,801)	(317)	(409)	(92)	(3,801)	0
Entry Level	(5,285)	(440)	(545)	(104)	(5,285)	0
Countywide	(30,695)	(2,558)	(2,611)	(53)	(30,695)	0
Children & Young People's Service	(6,333)	(528)	(502)	26	(6,333)	0
Herefordshire Services	(12,679)	(1,060)	(1,076)	(17)	(12,679)	0
Medical	(15,355)	(1,280)	(1,366)	(87)	(15,355)	(0)
Board	(1,428)	(119)	(137)	(18)	(1,428)	0
Internal Customer Services	(1,822)	(152)	(121)	31	(1,822)	0
Finance & Commerce	(6,256)	(521)	(508)	13	(6,256)	0
HR & Organisational Development	(3,149)	(262)	(256)	7	(3,149)	0
Quality & Performance	(2,836)	(236)	(267)	(30)	(2,836)	0
Engagement & Integration	(1,335)	(111)	(113)	(2)	(1,335)	0
Operations Directorate	(1,125)	(94)	(92)	1	(1,125)	0
Other (incl. provisional / savings / dep'n / PDC)	(5,950)	(517)	(421)	96	(5,950)	0
Income	112,623	9,388	9,606	217	112,623	0
TOTAL	**883**	**53**	**53**	**0**	**882**	**(0)**

The key points are summarised below;

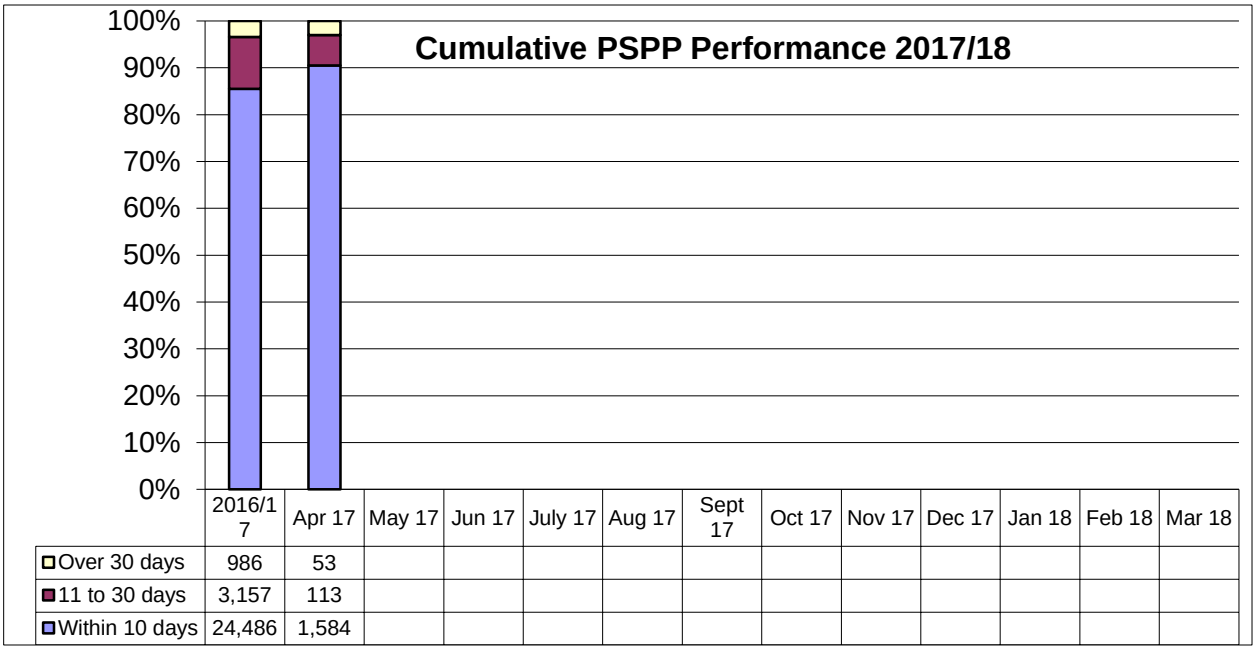
In month

- The Social Care Management over spend relates to Community Care and is offset by additional income
- Funding for the IAPT development has not yet been allocated from the developments budget, which accounts for much of the Entry level over spend
- The Medical over spend has been caused by agency expenditure - £200k in month 1

Forecast

- All budgets are forecasting they will meet their budget at year end as no significant risks have arisen in month 1.

The cumulative Public Sector Payment Policy (PSPP) performance for month 1 is 91% 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:



	2016/17	Apr 17	May 17	Jun 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Over 30 days	986	53											
11 to 30 days	3,157	113											
Within 10 days	24,486	1,584											

Agenda item 16 **Paper K**

Report to: [2]gether NHS Foundation Trust Board – 25 May 2017
Author: John McIlveen, Trust Secretary
Presented by: John McIlveen, Trust Secretary

SUBJECT: **PROVIDER LICENCE DECLARATIONS**

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

The Trust Board is required each year to self-certify regarding compliance with the conditions of its provider licence and the systems and processes for ensuring such compliance. Formerly these declarations had to be submitted to Monitor. However, there is now no requirement to submit these to NHS Improvement, however, the Board is required to publish one of its declarations. NHS I will contact a select number of Trusts from July to ask for evidence that they have self-certified. This evidence will normally be the relevant Board minutes and papers, or a declaration template supplied by NHS I.

1. Corporate Governance Statement

It is a requirement of the governance condition of the Trust's licence that the Board signs off a Corporate Governance Statement within three months of the end of each financial year.

The Corporate Governance Statement requires the Trust Board to confirm:

- Compliance with the governance condition **at the date of the statement**; and
- **Forward compliance** with the governance condition for the current financial year, specifying (i) and risks to compliance and (ii) any actions proposed to manage such risks

The governance condition of the licence concerns the Trust's internal systems and processes. Hence, the references to risks within the corporate governance statement relate to risks to those systems and processes, rather than wider risks to the Trust or the achievement of the Trust's objectives.

In making its Corporate Governance Statement declaration, the Board can rely on a range of evidence which is summarised in Appendix 1 of this report. The Board is asked to confirm **compliance at the date of the statement** and **forward compliance**, for each section of the Corporate Governance Statement.

2. Training of Governors

The Board is required to make a declaration regarding the provision of necessary training to Governors, pursuant to Section 151(5) of the Health and Social Care Act 2012. The joint Board/Governor engagement work undertaken during the year has produced a number of outputs intended to support Governors to undertake their role. The Board is therefore recommended to make a declaration of 'Confirmed' in respect of the provision of Governor training.

3. Compliance with Licence conditions

Foundation Trusts are also required to make an annual declaration that they have their systems and processes for compliance with provider licence conditions (General Condition G6). Appendix 2 provides evidence which the Board may rely on to make this declaration which is in two parts, with part 1 referring to the financial year just ended, and part 2 referring to continuing to meet the criteria for holding a licence. The Board is invited to make a declaration of 'Confirmed' in respect of both parts of this declaration.

The Board must sign off this self-certification by 31 May, and must publish its self-certification declaration by 30 June 2017.

All declarations must be made *having regard to* the views of Governors. The Board is therefore asked to note that the Council of Governors received a report at its meeting on 9 May to provide assurance regarding the process for making these declarations. The appendices to this Board report were provided to Governors as background information alongside the summary report. Governors noted the report and no concerns were raised in respect of systems and processes for compliance with licence conditions.

A declaration regarding the availability of resources (CoS7) relates only to foundation trusts designated as providing 'Commissioner Requested Services'. The Trust is not designated as a provider of CRS, and therefore a separate declaration in respect of CoS7 is not required.

RECOMMENDATIONS

It is recommended that the Board:

a) Have regard to feedback received from Governors in respect of these declarations

b) Agree to make a declaration confirming compliance in respect of each of the statements listed in the Corporate Governance Statement.

c) Agree to make a declaration of 'Confirmed' in relation to the Governor training declaration.

d) Agree to make a declaration of 'Confirmed' by the due date of 31 May in respect of systems for compliance with licence conditions for the financial year just ended

e) Agree to make a declaration confirming that the Trust continues to meet the criteria for holding a licence.

f) Agree to publish on the Trust website the declaration in respect of systems for

compliance with licence conditions by 30 June.

Corporate Considerations	
Quality implications	None identified
Resource implications:	None identified
Equalities implications:	None identified
Risk implications:	Should risks to compliance with the governance condition of the Trust's licence be identified, NHS I may require other actions or assurance, or may choose to maintain a watching brief.

WHICH TRUST STRATEGIC OBJECTIVE(S) DOES THIS PAPER PROGRESS OR CHALLENGE?	
Continuously Improving Quality	P
Increasing Engagement	
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:		
Executive Committee	Date	April 2017

Where in the Trust has this been discussed before?		
Executive Committee	Date	April 2017

What consultation has there been?		
Council of Governors		9 May 2017

Explanation of acronyms used:	CQC – Care Quality Commission CCG – Clinical Commissioning Group NHS I – NHS Improvement

1. INTRODUCTION

1.1 It is a condition of the Trust's licence that the Trust makes certain self-certification declarations at the end of each financial year regarding its corporate governance systems and processes.

1.2 Declarations must be made by the Board, having regard to the views of Governors.

2. CORPORATE GOVERNANCE STATEMENT

2.1 The Corporate Governance self-certification refers to the provisions within the governance condition of the Trust's provider licence. The self-certification requires Trust Boards to confirm

- Compliance with the governance condition at the date of the statement; and
- Forward compliance with the governance condition for the current financial year, specifying
    (i) and risks to compliance and
    (ii) any actions proposed to manage such risks

2.2 The governance condition of the licence concerns the Trust's internal systems and processes. Hence, the reference to risks within the Corporate Governance declaration relate to risks to those systems and processes, rather than wider risks to the achievement of the Trust's objectives.

2.3 Where a statement in the declaration indicates a risk to compliance with the governance condition of the Trust's provider licence, NHS I will consider whether any actions or other assurances are required at the time of the declaration, or whether it is more appropriate to maintain a watching brief.

2.4 The Board has during the course of the year received a number of documents which provide evidence of compliance. Appendix 1 provides a summary of the available evidence to support the Board in making its declaration.

2.5 Accordingly, the Board is recommended to make a declaration of 'Confirmed' in respect of each element of the Corporate Governance statement, as shown at Appendix 2.

3. GOVERNOR TRAINING DECLARATION

3.1 Additionally, the Board is required to make a declaration that it has provided Governors with the necessary training, pursuant to Section 151 (5) of the Health and Social Care Act 2012, to enable Governors to fulfil their roles. The Act does not specify the nature or content of training to be provided.

3.2 A number of training and development opportunities are provided to Governors, including an induction to each new Governor, a range of material made available to Governors through a website portal, making available a number of places on training and development events organised by third parties such as GovernWell, service presentations to the Council of Governors, and a programme of Governor visits to Trust sites. The joint Board/Governor development programme concluded recently, and the outputs from that programme include a number of actions around induction, team charter, the role of the Governor, and collaborative working designed to help Governors undertake their role. The development programme is scheduled for a review later in the current year.

3.3 The Board is therefore asked to confirm that it is satisfied that the Trust has provided the necessary training to Governors to ensure they are equipped with the skills and knowledge they need to undertake their role.

4. GENERAL CONDITION G6 – SYSTEMS FOR COMPLIANCE WITH LICENCE CONDITIONS

4.1 General Condition 6 requires that the Trust against the risk of failure to comply with the conditions of its licence, any requirements imposed by the NHS Acts, and the requirement to have regard to the NHS Constitution in providing health care services for the purpose of the NHS.

4.2 The licence condition states that the steps the Trust must take should include:

'*the establishment and implementation of processes and systems to identify risks and guard against their occurrence'*, and

'regular review of whether those processes and systems have been implemented and of their effectiveness'.

4.3 The declaration asks the Board having reviewed the evidence, to confirm (or otherwise) by the due date of 31 May that:

PART 1 '*Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that,* ***in the Financial Year most recently ended****, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.'*

AND

PART 2 *'The Board declares that the Licensee continues to meet the criteria for holding a licence'*

4.4 An overview of the provider licence conditions is given at Appendix 2. Much of the evidence given in support of the Corporate Governance Statement (listed at Appendix 1) may also be relied upon by the Board in order to make the declaration regarding the processes and systems in place to comply with the Trust's licence conditions and general obligations. Significantly for this declaration, during the year the Board has received a positive Well-Led Framework for Governance external review report, and a CQC inspection which produced an overall rating of 'Good.

4.5 The Board is therefore recommended to respond 'Confirmed' in respect of both parts of the declaration above.

5. HAVING REGARD TO THE VIEWS OF GOVERNORS

5.1 The Board is required to make the above declarations "having regard to the views of Governors". As agreed by the Council of Governors last year, a separate report has been made available to Governors providing assurance regarding the process for the Board to make these declarations. The appendices to this Board report have also been made available to Governors alongside the summary assurance report. Governors noted the report and at their Council meeting on 9 May and no concerns were raised in respect of systems and processes for compliance with licence conditions.

5.2 The Board is therefore asked to have regard to the views of Governors regarding these declarations.

6. RECOMMENDATIONS

6.1 The Board is asked to:

a) Have regard to feedback received from Governors in respect of these declarations

b) Agree to make a declaration confirming compliance with each of the statements listed in the Corporate Governance Statement.

c) Agree to make a declaration of 'Confirmed' in relation to the Governor training declaration.

d) Agree to make a declaration of 'Confirmed' by the due date of 31 May in respect of systems for compliance with licence conditions for the financial year just ended

e) Agree to make a declaration confirming that the Trust continues to meet the criteria for holding a licence.

f) Agree to publish on the Trust website the declaration in respect of systems for compliance with licence conditions by 30 June.

APPENDICES

The appendices provide the following information:

Appendix 1: **Corporate Governance Declaration - Evidence**

Appendix 2: **Provider Licence conditions - Overview and Additional Evidence**

Governance Statement	Evidence for current compliance	Risks to future compliance and mitigating actions, or supporting information	Suggested declaration
The Board is satisfied that [2]gether NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	• Organisational leadership through Board • Local accountability through Council of Governors • Engagement programme with stakeholders • Scheduled Board meetings including public meetings • Committee structure and Committee meeting programme • Committee structure reviewed and realigned with strategic priorities during the year • Establishment of Quality and Clinical Risk Committee, a sub-Committee of Governance Committee, to provide focus and challenge on quality and clinical risk issues • Performance dashboards to Delivery Committee • Performance exception reports to Board • Quality monitoring and reporting to Governance Committee • CCG observers at Governance Committee/QCR sub-committee • Quality Strategy aims translate into service planning objectives • Quality Report and indicators • Financial reporting monthly to Board • Financial control systems in place • Information Governance function and reporting • Risk management framework and reports to Board and Committees • Assignment of key risks to relevant Committees and ongoing risk identification • Quarterly update and review of risk register • Implementation of new incident reporting system • Risk reporting to Board and Committees • Council of Governors statutory roles in holding NEDs to account • Service experience function and reports to Board	No risks identified	Confirmed

	• Patient safety reports to Board and Governance Committee • Patient Stories agenda item at public Board meetings • Quality checklist used at each Board meeting • Mental Health Legislation Scrutiny Committee and Managers' Forum • Whistleblowing and other organisational policies and procedures in place • External auditors appointed • Internal audit programme • Clinical audit programme • Compliance with FT Code of Governance • Trust Constitution • Trust vision and values • Annual Governance Statement • Mandatory disclosures in Annual Report • Statutory and mandatory training • Corporate induction for all new starters • Fit and proper person test for Board appointments • Declarations of Interests • Single Oversight Framework segmentation of 2 • 'Good' rating in Openness and Learning From Mistakes league table		
The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	• Monthly CEO Reports to Board highlight relevant new publications/guidance • Policy and guidance standing agenda item at Development Committee • External Auditor Sector development report • FT Bulletins to Board members • Annual Reporting Manual guidance	No risks identified	Confirmed
The Board is satisfied that [2]gether NHS Foundation Trust	• Committee structures reviewed in year. • Committee membership streamlined	No risks identified	Confirmed

implements effective board and committee structures	• Good clinical presence on Board • Committee summary reports to Board • Committee annual reports to Board • Audit Committee annual effectiveness review • Locality Governance structures		
The Board is satisfied that [2]gether NHS Foundation Trust implements clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees	• Constitution sets out Board responsibilities • Committee duties reviewed and realigned to strategic priorities • Committee Terms of Reference reviewed annually and substantive changes approved by the Board • Committee agenda planners refreshed at each meeting • Scheme of Delegation in place setting out delegated responsibilities and powers reserved to Board • Revised Standing Financial Instructions in place	No risks identified	Confirmed
The Board is satisfied that [2]gether NHS Foundation Trust implements clear reporting lines and accountabilities throughout its organisation	• Clear Executive portfolios • Defined management and committee structure • Chief Executive is Accounting Officer • Director of Quality and Medical Director lead on quality matters • Lead Executive for each Committee • Committees reviewed in year • Assignment of organisational risks to appropriate Committees • Committees are accountable and report regularly to the Board • Reporting lines agreed for Localities, Expert reference Groups and sub-committees • Staff appraisals and objectives linked to organisational objectives	No risks identified	Confirmed
The Board is satisfied that [2]gether NHS Foundation Trust effectively implements systems and/or	• Going concern report to Audit Committee • Board Finance Reports • Savings Plans in place • Quality Impact Assessments process in place, overseen by Governance Committee	No risks identified	Confirmed

processes to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively	• Budget setting process • Strategic Plan • Capital Programme • Performance dashboard reports to Delivery Committee • Performance exceptions reports to Board • Quality reports to Governance Committee/QCR • Outcomes reporting • Clinical audit programme • Internal audit programme • External auditor • CQC registration • Aggregated Learning Reports to Governance Committee • Single Oversight Framework segment 2 rating • Service/business planning process • Service plans include actions for 5 Year Forward View		
The Board is satisfied that [2]gether NHS Foundation Trust effectively implements systems and/or processes to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively	• Executive Committee meetings • NED oversight on Board and Committees • MHLS Committee meeting • Delivery Committee meetings • Governance Committee meetings • Audit Committee meetings • Board and Committee agenda planners • Monthly performance dashboards and exception reports • Locality reviews at Delivery, Development and Governance Committees • Service performance focus reports to Delivery Committee • Executive Safety walkabouts • Board visits • CQC compliance quarterly reports to Governance Committee	No risks identified	Confirmed
The Board is satisfied	• Performance dashboard reports to Delivery Committee	No risks identified	Confirmed

that [2]gether NHS Foundation Trust effectively implements systems and/or processes to ensure compliance with health care standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions	• Safety/quality oversight by Governance Committee • Expert Reference Groups • Board performance exception reports • CQC compliance reports • CQC inspection report • Medical revalidation programme • Mental Health Legislation Scrutiny Committee oversight • Executive safety walkabouts • Board visits • Clinical audit programme • Statutory and mandatory training requirements • Clinical policies • Mental Health Act/Mental Capacity Act policies • Mental health Act Managers in place • Quality Report • Francis action plans • Regulatory inspection reports/action planning • Inquest reports/action planning • Quality Impact Assessments for efficiency and transformation proposals • QIAs reviewed by Medical Director, Director of Quality and Director of Engagement & Integration • Practice Development Strategy and Triangle of Care implementation • Nursing Strategy and action plan • Social care strategy • Organisation Development Strategy and implementation plan • Staff Survey action plan		
The Board is satisfied that [2]gether NHS Foundation Trust	• Budget setting process • Savings and transformational change programmes • Fully funded capital programme	No risks identified	Confirmed

effectively implements systems and/or processes for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern)	• Surpluses in previous years to achieve strong liquidity position • Use of liquidity position for strategic plan transformation • Monthly finance reports to Delivery Committee and Board • Standing Financial Instructions • Authorised signatory lists • Scheme of Delegation • Audit Committee Going Concern reports • Audit Committee Losses/Special Payments reports • Counter Fraud Service and annual action plan • Development Committee oversight of development opportunities and business cases • Tender submission procedures • Governor approval process for significant transactions • Organisation Development Strategy and implementation plan • NHSLA Clinical Negligence Scheme for Trusts • NHSLA Risk Pooling Scheme for Trusts • Annual financial plan approved by Board before the start of the year		
The Board is satisfied that [2]gether NHS Foundation Trust effectively implements systems and/or processes to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making	• Board/Committee agenda planners • Monthly Finance and Performance reports • Performance Point system to provide up to date high quality data • Clinical audit programme provides assurance on data quality • Data quality policy • Data quality requirement in Information Governance Toolkit • Finance and performance reporting aligned to Board/Committee cycle • Chief Executive's Reports to Board	No risks identified	Confirmed

The Board is satisfied that [2]gether NHS Foundation Trust effectively implements systems and/or processes to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence	• Risk register reviews by 'owning' Committees and overseen by Audit Committees and Board • Board Assurance Map review by Executive Committee, Audit Committee and Board • Performance early warning reports to Delivery Committee • Internal audit programme • Clinical audit programme • Risk identification as standing Committee agenda item • Incident Reporting policy and culture • Whistleblowing policy and procedure • Quality Impact Assessments process	No risks identified	Confirmed
The Board is satisfied that [2]gether NHS Foundation Trust effectively implements systems and/or processes to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery	• Annual operational planning process • Service planning process involves service users and Governors • Annual plan/operational plan submission to NHS I • Alignment of service planning wheel and organisational objectives • Plans aligned to commissioners' stated intentions • Development Committee oversight • Executive Committee oversight • Governor consultation on business plan • Quarterly monitoring reports to Delivery Committee • Performance reports • Finance reports • Quality report – external consultation • External auditors report on Quality report	No risks identified	Confirmed
The Board is satisfied that [2]gether NHS Foundation Trust effectively implements	• Access to retained lawyers • Internal auditors • External auditors	No risks identified	Confirmed

systems and/or processes to ensure compliance with all applicable legal requirements	• Executive leads for each key area of business • Trust Secretariat responsible for constitutional and corporate governance matters/updates • Legal briefings/updates received from a variety of sources • Executive Committee oversight • Audit Committee • Charitable Funds Committee • Information Governance policies and procedures • Clinical policies and procedures • Mental Health Legislation Scrutiny Committee and MHA Managers • Directors' fit and proper person tests on recruitment • FT Code of Governance compliance reports		
The Board is satisfied that systems and processes in place ensure that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided	• Medical Director, Director of Quality and Director for Engagement & Integration are clinicians • Non-Executive Director engagement and review provides rigorous quality challenge	No risks identified	Confirmed
The Board is satisfied that systems and processes in place ensure that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations	• Quality Impact Assessments for savings plans • Quality Strategy • Quality Report is key element of organisational vision and values • Quality Report defines key quality themes for the coming year • Service Plan includes specific element on Quality, Service Users and carers, Staff and Volunteers • Quality Strategy aims translate into Service Planning Wheel requirements for staff • Burdett principles and exception checklist applied at each Board meeting • Evaluation of each Board meeting covers Patient Experience,	No risks identified	Confirmed

	Quality and Risk		
The Board is satisfied that systems and processes in place ensure the collection of accurate, comprehensive, timely and up to date information on quality of care	• Monthly performance dashboard to Delivery Committee • Performance Exception reports to Board • Quarterly update reports on Quality Report • Monthly Patient Safety report to Board • Data Quality assurance processes in place	No risks identified	Confirmed
The Board is satisfied that systems and processes in place ensure that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care	• Monthly performance dashboard to Delivery Committee • Performance Exception reports to Board • Quarterly update reports on Quality Report • Monthly Patient Safety report to Board • Monthly performance reports to Delivery Committee and Board • Data Quality assurance processes in place	No risks identified	Confirmed
The Board is satisfied that systems and processes in place ensure that [2]gether NHS foundation trust including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and	• Quality Report consultation • Quarterly update reports on Quality Report shared with stakeholders including CCGs, Health Watch and Overview and Scrutiny Committees, and feedback encouraged • Governors select local indicator for Quality Report audit • Patient survey • Staff Survey • Complaints and Comments process • Patient and Staff Friends & Family Tests • Patient Story is regular agenda item at public Board meetings • Service Experience function and reports to Board • Quality Outcomes published through public Board papers and in	No risks identified	Confirmed

information from these sources	Annual report • Joint Negotiating and Consultative Committee • Local Negotiating Committee and Medical Staff Committee • "One Gloucestershire" STP Clinical and non-clinical workstreams		
The Board is satisfied that systems and processes in place ensure that there is clear accountability for quality of care throughout [2]gether NHS foundation trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate	• Quality Governance assigned to Exec Directors • Non-Exec Director oversight of Quality • Clinical Directors • Service Directors • Heads of Profession • Lead Nurses • Board Committee and sub-committee structure • Locality Governance Committees have reporting line to Board through the Governance Committee	No risks identified	Confirmed
The Board of [2]gether NHS foundation trust effectively implements systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licence holder's organisation who are sufficient in number and	• Board recruitment processes • Governor appointment of Non Exec Directors • Appointment & Terms of Service Committee for Executive recruitment • Budgeted establishment • Delegated recruitment processes • Recruitment and selection policy • Appraisal and revalidation policies • Ward staffing levels information	No risks identified	Confirmed

appropriately qualified to ensure compliance with the Conditions of this Licence.			

Appendix 2

PROVIDER LICENCE CONDITIONS – OVERVIEW AND ADDITIONAL EVIDENCE

	Licence Condition	Condition summary	Evidence for compliance
General Conditions			
G1	Provision of Information	Provision of information to NHS I	Operating plan Strategic plan submission Ad hoc submissions to NHS I via portal
G2	Publication of information	Publish information as directed by NHS I	Information on website eg Board profiles
G3	Payment of fees to Monitor	Pay fees to NHS I as required	Not applicable - no fees requested to date
G4	Fit and Proper Persons	Not to appoint unfit persons as Directors or Governors	Exclusion criteria in constitution for Directors and Governors Directors' recruitment procedures Governor election rules *'Fit & Proper Persons: Directors'* test incorporated into Board recruitment
G5	NHS I guidance	Have regard to NHS I guidance	Code of Governance compliance Single Oversight Framework compliance
G6	Systems for compliance with licence conditions	Have systems in place to comply with licence conditions	Outlined in the appendices to this report
G7	CQC registration	Be registered with the CQC	CQC registration in place
G8	Patient eligibility & selection criteria	Set and apply transparent criteria to determine who can receive health care	Commissioner service specifications
G9	Application of Section 5 – Continuity of Services	States that the Continuity of Services conditions apply where commissioner-requested services are provided	Not applicable
Pricing			
P1	Recording of Information	Record pricing information if required by NHS I	Not required to date.
P2	Provision of Information	Provide information to NHS I	Provision of information via portal
P3	Assurance report on submissions to NHS I	Provide an assurance report re Condition P2 if required by NHS I	Not required to date
P4	Compliance with the National Tariff	Comply with national tariff	There is no national tariff in place for mental health PbR
P5	Constructive	Engage with local	Agreements in in place with both

	Licence Condition	Condition summary	Evidence for compliance
	engagement re local tariff modifications	commissioners re tariff modifications	Gloucestershire CCG and Herefordshire CCG re price tariff. Regular monthly meetings take place where performance reports are presented and discussed.
Choice & competition			
C1	Patients' right of choice	Patient notified of choice of provider	Not applicable to Mental health Services
C2	Competition oversight	Not to restrict or distort competition	Legal advice obtained where appropriate when bidding for services/entering partnerships
Integrated care			
IC1	Provision of integrated care	Not to act detrimentally to the provision of integrated care	Local Health Economy 'Better Care Fund' proposals IAPT/primary care services integration Collaborative approach in Herefordshire
Continuity of services			
CoS1	Continuing provision of Commissioner Requested Services	Continue to provide CRS as specified except in certain circumstances eg with Commissioner agreement	Not applicable as Trust does not provide Commissioner Requested Services
CoS2	Restriction on the disposal of assets	Not to dispose of any asset without written consent from NHS I	No assets disposed of that provide Commissioner Requested Services
CoS3	Standards of corporate governance and financial management	Apply suitable systems of corporate and financial governance	See evidence in Appendix 1 of this report
CoS4	Undertaking from the ultimate controller	Undertaking from any parent company not to cause a breach of the provider licence	Not applicable
CoS5	Risk pool levy	To pay a risk pool levy to NHS I	Not applicable
CoS6	Cooperation in the event of financial stress	To cooperate with NHS I and others in the event of financial stress	Not applicable
CoS7	Availability of resources	Ensure and certify the availability of financial, physical and human resources for the next 12 months	Not applicable as Trust does not provide Commissioner Requested Services
NHS Foundation Trust Conditions			
FT1	Information to	Provision of certain	Provision of annual accounts and

	Licence Condition	Condition summary	Evidence for compliance
	update the register of FT's	documents to NHS I	annual report Provision of current version of the constitution Updates regarding Board and Lead Governor changes
FT2	Payment to NHS I in respect of registration and related costs	Payment of a licence fee to NHS I	Not applicable
FT3	Provision of information to advisory panel	Provision of any information requested by an advisory panel	Not applicable – no information requested
FT4	NHS FT governance arrangements	Apply and certify appropriate systems and processes for good corporate governance	Internal Audit reports Head of Internal Audit opinion External Audit

2gether Making life better

2gether NHS Foundation Trust

PAPER L

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Governance Committee

DATE OF COMMITTEE MEETING: 21 April 2017

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PATIENT SAFETY

There had been 1 new serious incident reported during March 2017, with the SI rate per 1000 caseload presenting at 0.05. The 2016/17 year ended with the same number of SIs as in 2015/16. There had been an increase of 2 in the number of suspected suicides for 2016/17 compared to the previous year, which was consistent with the national trend.

The Committee noted that 2 red external actions remained outstanding from the 2015/16 SI Action Plan, and received assurance that these actions would be addressed through the ongoing countywide multi-agency suicide audit. The Committee noted good progress in relation to the 2016/17 SI Action Plan, with several of the 46 actions due to be closed by the end of April 2017.

The Committee welcomed the appointment of a full time SI investigator who was due to take up the post on 15 May. The Committee asked the Patient Safety Manager to consider potential KPIs for this post, and to report back to the Committee in 6 months on how the difference made by the post could be measured. The Committee requested, in view of its now bi-monthly meeting schedule, that future meetings receive both the current and previous month's Patient Safety reports.

LEARNING FROM DEATHS IN THE NHS

The Committee received a report, also be presented to the April meeting of the Board, summarising the expectations placed upon Trusts by the new Learning From Deaths guidance issued by the Department of Health. A number of measures were already in place, and further actions would need to be completed in the next 6 months. Data would need to be presented at a public Board meeting from November. The Committee requested that a proposed policy on this issue be presented to the June meeting of the Committee prior to consideration at Board later in the year.

JUNIOR DOCTOR CONTRACT

The Committee received a verbal update on the implementation of the Junior Doctor contract. While there were no issues relating specifically to contract implementation, the Committee noted ongoing recruitment difficulties, particularly in Herefordshire, which created problems in terms of shift and on-call cover. The Committee noted that the position in Gloucestershire was less problematic than in Herefordshire.

SAFE STAFFING LEVELS

The Committee received the safe staffing levels report for February and March, noting the consistently high fill levels of over 97% for shifts within the 2 reporting periods. The Committee noted a number of occasions where planned staffing levels in certain wards had not been met and the Committee received assurance that these exceptions had presented no patient safety concerns.

The Committee discussed the use of agency staff, noting that 2gether was not currently compliant with its control total. The Committee noted actions already in place to control agency expenditure, and noted that 2gether staff had visited Devon Partnership Trust in order to learn lessons from that Trust about the successful reduction of agency spend. The Governance Committee agreed to receive a report on the outcome of that learning at a meeting in the near future, and asked that this report also consider wider quality issues around the use of temporary staffing.

QUALITATIVE AND QUANTITATIVE AUDIT – ASSESSING AND MANAGING RISK
The Committee received a report for Q3 and Q4 setting out the results of an audit against the Trust's policy on Assessing and Managing Risk. The quantitative audit showed 100% overall compliance with the risk assessment policy in terms of inpatients, and 95% compliance in terms of community services. The Committee commented on the assurance provided in respect of 7 day risk assessments for inpatients and noted that recorded figures suggested that overall, 47% of risk assessments had not been updated within the past 7 days. The Committee noted that while it is important that risk assessments are completed upon admission and kept up to date, it is equally important that risk assessments are reviewed every 7 days and that this review is recorded in Rio. The Committee asked that the format of future reports be amended to provide clear assurance to the Committee in respect of the completion, review and recording of risk assessments, both in terms of inpatients and community patients.

ASSESMENT AND CARE MANAGEMENT PROCESSES AUDIT
The Committee received the outcome of an audit assessing compliance against the Trust's Assessment and Care Management Policy, and noted that while there had been some improvement in compliance, this improvement was very small (51% overall compliance from 50% at the previous audit in November 2016). The Committee noted that Assessment & Care Management information is being gathered but often is being recorded in the wrong section of RiO. A number of initiatives are underway to try and address this problem, including the establishment of a RiO core assessment implementation group tasked with identifying, in conjunction with clinical colleagues, new ways of enabling clinicians to populate the record in a manner that demonstrates compliance. The Governance Committee expressed concern regarding the information recording issues raised both by this and by the previous report, and asked that the matter be raised with the Executive Committee for further consideration.

QUALITY REPORT 2016/17
The Committee reviewed the draft Quality Report 2016/17, and discussed performance in respect of quality measures for the year. Where quality targets had not been achieved, these measures would roll forward to 2017/18. In some cases, measures would be adjusted, for example to show a suicide rate rather than numbers of suicides, and to measure levels of harm associated with Absences Without Leave rather than just AWOL figures alone. The Committee was confident that work was ongoing to address these issues. The Committee noted that the final Quality Report would be signed off by the Audit Committee and Board in May.

REVALIDATION OF NURSING STAFF
The Committee received the annual report on revalidation of nursing staff which offered full assurance that all registered nurses have renewed their nursing registration over the past 12 months. The Committee commended the work done to achieve this outcome, which was a good example of the proactive management of an issue.

OTHER ITEMS
Amongst other reports the Governance Committee at its April meeting also received and noted the assurance provided by the Quarter 4 Service Experience Report and the Complaints Annual Report (to be received at the Board in May), the Physical Health Annual Report, and a report on Quality Improvement in Mental Health.

ACTIONS REQUIRED BY THE BOARD
The Board is asked to note the content of this report.

SUMMARY PREPARED BY: Nikki Richardson ROLE: Chair
DATE: 21 April 2017

Agenda item 18 **Enclosure Paper M**

Report to: Trust Board, 25th May 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 March 2017 – 16 May 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 an Appointments and Terms of Service Committee of the Board
- Charing a Council of Governors
- Attending a Nomination and Remuneration Committee of the Council of Governors
- Attending a Board Strategy seminar
- Attending the Gloucestershire Strategic Forum
- Attending a Gloucestershire Strategic Forum strategic seminar in Cheltenham

- Meeting with the Independent Chair of the Gloucestershire Sustainability and Transformation Partnership to discuss strategic direction
- Meeting the Chair of Gloucestershire Care Services NHS Trust several times to discuss strategic direction
- Together with the Chief Executive, attending meetings with Chair and Chief Executive of Gloucestershire Care Services NHS Trust
- Attending a development event of the Gloucestershire Health and Well Being Board at Shire Hall
- Attending the Gloucestershire Annual Legal Service and Declaration of Office as High Sheriff
- Attending a meeting of the Aston Project in Cheltenham
- Leading a Bishops Breakfast together with the Director of Integration and Engagement at the University of Gloucestershire which focussed on young peoples' mental health during their education and employment
- Visiting ²gether NHS Foundation Trust teams based in Belmont in Herefordshire
- Visiting the inpatient wards in Stonebow in Hereford
- Participating in the International Nurses Day celebrations at Charlton Lane Hospital
- Visiting Beaufort Academy in Tuffley
- Attending the Secrets and Lies exhibition in Tewkesbury focussing on young peoples' mental wellbeing during Mental Health Awareness Week
- Participating in the interview and selection panel for the new Deputy Chief Constable for Gloucestershire Constabulary
- Meeting with the Gloucestershire Constabulary to discuss a support event for families to be held in Churchdown
- Meeting with the Deputy Police and Crime Commissioner for Gloucestershire to discuss opportunities to reshape police commissioning to support mental wellbeing
- Meeting with the National Star College in Ullenwood to discuss their 50th anniversary celebrations and being an ambassador for their work
- Meeting with the Director of the Cheltenham Town Community Trust to discuss their mental wellbeing work
- Meeting with the Hate Crime Co-ordinator for the Gloucestershire Constabulary to share approaches
- Supporting an NHS Foundation Trust in their chair appointment process
- Participating in a radio show at BBC Radio Gloucestershire

- Hosting a Governors' visit to Charlton Lane Hospital

- Meeting with an exiting Mental Health Nurse at their request and following up appropriately

- Meeting with a former member of staff from Wotton Lawn at their request and following up appropriately

- Participating in Non-Executive Directors' appraisals

- Meeting with several Governors separately as part of their ongoing induction at their six-month anniversary

- Meeting with the Director of Organisational Development to discuss Non-Executive Director induction

- Participating in my annual appraisal with the Senior Independent Director

- 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:

- Prepared for and attended the April Board meeting
- Prepared for his annual appraisal
- Prepared for and attended the May Board meeting
- Prepared for and chaired a meeting of the development committee
- Held discussions with the chair of delivery committee
- Held discussions with the chair of governance committee
- Prepared for and attended a meeting of the audit committee

Nikki Richardson

Since her last report Nikki has:

- Prepared for and attended a Board meeting
- Prepared for and attended the Appointments and Terms of Service Committee
- Attended the Treasure Seekers Spring Show
- Attended a meeting between lead NEDs and Executives regarding the Governance Committee
- Prepared for and attended the Audit Committee
- Attended an Audit Committee discussion meeting
- Prepared for and conducted the Chair's appraisal
- Prepared for and attended the Board's strategy session
- Prepared for and chaired the Governance Committee
- Prepared for and attended her annual appraisal with the Chair

Marcia Gallagher
Since her last report Marcia has:

- Visited the Stonebow Unit, Hereford
- Attended a Mental Health Act Managers hearing at Wotton Lawn
- Met with the Director of Finance
- Held a private meeting with the Internal and External Auditors
- Prepared for and chaired the Audit Committee
- Prepared for and attended her annual appraisal with the Chair
- Prepared for and attended the Board Strategy session
- Undertaken a NED audit of complaints and produced a report
- Prepared for and attended the April and May Board meeting
- Prepared for and attended the Council of Governors meeting
- Met with the Director of Finance.
- Held a Private meeting with the Internal and External Auditors.
- Prepared for and Chaired the Audit Committee as part of the Annual Accounts process.

Duncan Sutherland
Since his last report Duncan has:

- Prepared for and attended a Board meeting
- Prepared for and attended the Audit Committee
- Visited the Stonebow Unit, Hereford
- Prepared for and attended the Appointments and Terms of Service Committee

Quinton Quayle
Since his last report, Quinton has:

- Prepared for and attended a board strategy meeting
- Attended an Audit Committee lunch
- Prepared for and attended an Audit Committee meeting
- Prepared for and attended a Board meeting
- Prepared for and attended an Appointments and Terms of Service Committee meeting
- 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:

- Prepared for and attended the April and May Board meetings
- Prepared for and attended the Audit Committee
- Visited the Stonebow Unit, Hereford
- Attended a NED lunch
- Attended a meeting between lead NEDs and Executives regarding the Governance Committee
- Attended a Mental Health Act Managers hearing
- Prepared for and attended a meeting of the Delivery Committee
- Attended a meeting with the Director of Service Delivery
- Attended a Serious Incident Review meeting
- Attended a Later Life Team meeting at Weavers Croft
- Attended a MHAM Conference in Birmingham

4. OTHER MATTERS TO REPORT

As the Board is aware, when I was reappointed as Chair in 2016 I informed the Council of Governors that I would not be serving the full three years of my second term. At the Council of Governors meeting in May, I informed the Council that I will be stepping down with effect from 1 January 2018. The Council agreed to commence a recruitment process at the appropriate time and appointed Nikki Richardson to act up as Trust Chair from 1 January to 31 March 2018 to ensure stability.

[2]GETHER NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING
THURSDAY 9 MARCH 2017
BUSINESS CONTINUITY ROOM, RIKENEL, GLOUCESTER

PRESENT:

Nikki Richardson *(Deputy Chair)*		Alan Thomas
Vic Godding	Jo Smith	Jenny Bartlett
Rob Blagden	Katie Clark	Cherry Newton
Jennifer Thomson	Hilary Bowen	Svetlin Vrabtchev
Richard Butt-Evans	Said Hansdot	Dawn Lewis
Pat Ayres	Amjad Uppal	

IN ATTENDANCE: Maria Bond, Non-Executive Director
Dr Chris Fear, Medical Director (Item 8)
Marcia Gallagher, Non-Executive Director
Anna Hilditch, Assistant Trust Secretary
John McIlveen, Trust Secretary
Colin Merker, Deputy Chief Executive
Mike Scott, Member of the Public

1. WELCOMES AND APOLOGIES

1.1 Apologies for the meeting had been received from Ruth FitzJohn, Ann Elias, Hazel Braund, Roger Wilson, Paul Grimer, Paul Toleman, Mervyn Dawe, Elaine Davies and Tristan Lench. Shaun Clee had also sent his apologies, and Colin Merker would deputise for Shaun at the meeting.

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 17th January 2017 were agreed as a correct record.

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 Colin Merker had agreed to produce a briefing note for Governors regarding Out of Area Placements and any associated costs to the Trust. This was marked on the actions list as “carried forward”; however, it was noted that the briefing had been sent out to Governors since the papers had been circulated so this action was now complete. Hard copies of the briefing were made available at the meeting.

4.3 Al Thomas made reference to the Performance Dashboard report and said that the Governor Portal had not been updated to include the previous 2 reports. He said that as this action had previously been marked as "complete" on the actions list he would expect this to be updated automatically each month, without needing to provide a reminder. This oversight was acknowledged and the Portal would be updated accordingly, as well as ensuring that routine monthly updates were programmed in to the diary. It was agreed that Governors would also be informed when the portal was updated to ensure everyone was aware of what information was available.

ACTION: Regular monthly updates to the Governor Portal to be diarised by the Trust Secretariat and notification sent out to all Governors advising of those documents uploaded

5. LEAD GOVERNOR ELECTIONS

Rob Blagden left the meeting at this point

5.1 The Council of Governors elects someone to be Lead Governor. In addition to the duties of a Foundation Trust Governor, the Lead Governor acts as a means of direct communication between NHSI and the Council of Governors, and between the Council of Governors and the Chief Executive. The statutory role of the Lead Governor is to, in exceptional circumstances, provide a channel of communication between NHSI and the Council on matters that it would be inappropriate to channel via the Board or Chair, and to provide a means of raising concerns with the Chief Executive, where it would be inappropriate to make such contact via the Board or the Chair.

5.2 The role of the Lead Governor has developed over the past 6 years and some other key duties include:

- To be available to members of the Council to discuss concerns that may arise in the discharge of their duties, where discussion with the Chair is inappropriate
- To bring collective concerns to the attention of the Chair and (if appropriate) the Board, informally or formally
- To assist Governors to understand the work of the Board, and the Board's responsibility for the management of the Trust
- To act as a link between NHS Providers (GovernWell) and the Council
- To present the Governors' Report at the Trust's Annual General Meeting
- To work closely with the Chair as required to develop the work and agenda of Council

5.3 Previously the Trust has held elections for the Lead Governor post on an annual basis. The sitting Lead Governor, Rob Blagden was appointed for a first term in March 2016. The Trust is mindful that a large Council of Governor election process will be commencing in April, with the potential that 10 new Governors could be elected during June/July. By way of ensuring fairness, but also a level of continuity during the period, it was proposed that Rob Blagden's tenure as Lead Governor be extended until September 2017, subject to his reappointment as a Governor, at which point any changes in Governor personnel will have taken place.

5.4 The current role description states that the Lead Governor will be elected by the Council for a period of 1 year and Governors can be reappointed as the Lead Governor for a maximum of 3 years. However, it was also proposed for continuity purposes that the tenure for all future Lead Governor appointments be changed to 2 years, rather than one, with the option of standing for further terms.

5.5 The Council of Governors fully supported the recommendation to extend Rob Blagden's tenure as Lead Governor until 30 September 2017.

5.6 Discussion took place about the period of appointment for the Lead Governor, with some Governors feeling that there should be no limit on how long someone could stand as Lead Governor if they were performing well. The Council of Governors agreed that well performing Lead Governors should have an opportunity to re-stand and John McIlveen said that there was no reason why people could not seek re-election as Lead Governor, subject to their continued membership of the Council of Governors. He advised however, that it was good practice to have a defined period of appointment, at the end of which an open nomination process could take place which would enable any other interested Governors to put themselves forward. If a Governor putting himself forward for Lead Governor only had one year of their term left to stand this would be considered and the future years' nomination process brought forward to accommodate.

ACTION: Lead Governor role description to be updated to reflect the change in tenure from 1 year to up to 2 years, with the ability to seek re-election, subject to their continued membership of the Council of Governors

5.7 The Council discussed the possibility of shadowing for those Governors who may wish to put themselves forward for the Lead Governor position in future. It was agreed that the Nominations and Remuneration Committee would be asked to consider this further at their next meeting in May, reporting the outcome back to the Council.

ACTION: Nominations and Remuneration Committee to consider the potential opportunity to provide shadowing for the Lead Governor at their next meeting in May, reporting the outcome back to the Council.

Rob Blagden returned to the meeting at this point

6. REVIEW OF NON-EXECUTIVE DIRECTOR RECRUITMENT PROCESS

6.1 The purpose of this paper was to provide the Council of Governors with details of recommendations arising out of a recent Governor working group reviewing the appointment process for Non-Executive Directors.

6.2 The group was asked to review governance, membership, process and support for the Nominations and Remuneration Committee and future process for appointing and reappointing Non-Executive Directors or the Chair. All Governors were encouraged to feed comments or queries about the process or make-up of the Nominations and Remuneration Committee into the Lead Governor or Trust Secretariat so as they could be considered by the working group.

6.3 The working group met twice – on 30th January and then again on 21st February. The membership of the working group was Rob Blagden, Alan Thomas, Vic Godding and Richard Butt-Evans, with support and advice provided by the Trust Secretariat team, Nikki Richardson (Deputy Chair) and Neil Savage (Director of Organisation Development).

6.4 The review was now complete and two key recommendations were presented to the Council of Governors for consideration and support:-

- The first recommendation related to the proposed future process for NED and Chair Appointments and Reappointments. This provides a refresh and update of the previous arrangements and adds further clarity about process, respective responsibilities and ideal timeframes within the process. The Council of Governors approved the revised process flowchart.

- The second recommendation related to the proposed revised Terms of Reference for the Nominations and Remuneration Committee. This has focussed on providing a Committee with added clarity of purpose, strengthened membership and duties. It also offers the opportunity for Council to use the Committee as a task and finish group to consider relevant governance matters referred to it by the Council. Importantly, it is also proposed that the Committee will now be formally scheduled to meet 6 times a year with these dates being set a year in advance. The Council of Governors approved the revised TOR.

6.5 One further issue discussed by the Working Group related to the membership of the Nominations and Remuneration Committee. As noted earlier in the meeting, there was some concern around continuity and the potential turnover of Governors during June/July. On this basis it was proposed that those Governors who had participated in the Working Group would become the named members of the Nominations and Remuneration Committee, with a review of membership taking place at the September Council meeting when all potential changes to Governor personnel would have taken place. The Council of Governors agreed that this was a sensible way forward.

7. CHIEF EXECUTIVE'S REPORT

7.1 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.

7.2 This briefing provided the Council of Governors with an update in relation to a number of issues since the Council meeting in January 2017, including:

- Dispatches programme on Channel 4 – 1st March 2017
- New Chief Executive Officer at Gloucestershire Care Services
- Mental Health Five-Year Forward View Investment Standard
- Our 2017/18 Financial Position
- HSE investigation into Montpellier incident
- National Implementation Plan for the Overall NHS Five-Year Forward View

- Sustainability and transformation plans – national bids for IAPT services and learning disability transforming care developments
- Learning from Deaths/Mortality Reviews
- Staffing/Recruitment Pressures
- Approved Mental Health Practitioner (AMHP) issues within Gloucestershire

7.3 The Council noted that 2gether was commissioned to provide AMHP services within Gloucestershire between the hours of 9.00am to 5.00pm Monday to Friday. Outside of these hours AMHP services are provided through the Gloucestershire County Council Emergency Duty Team (EDT). We have been undertaking a piece of work with our Gloucestershire Commissioner to review issues associated with the 9-5 AMHP arrangements, as these have been becoming unsustainable due to the number of AMHPs available to support the current rotas and working practices. In parallel with this, the EDT service has been experiencing issues of being unable to fully staff their out of hours rotas.

Gloucestershire County Council has agreed additional funding to support the development of AMHP services and we are now working to look at the options available to us to reconfiguring the daytime AMHP services provided by the Trust and how these could link to improve the Out of Hours AMHP services provided by EDT. The work being progressed looks at formalising cover arrangements from the 2gether AMHPs to the EDT rotas as a backup to minimise potential further instances of non-availability of an AMHP, while longer-term arrangements are considered further and a preferred option agreed. In conjunction with these cross cover arrangements, contingency plans for how the Trust's Section 136 Suite and other services would operate during any period of no AMHP being available have been agreed and are being discussed and finalised with system partners such as the Police.

The Deputy Chief Executive provided the Council with assurance that this matter had been discussed in detail at the Mental Health Legislation Scrutiny Committee and this Committee would take the lead in ensuring that actions were progressed.

8. SUICIDE: COMPARISON OF LOCAL AGAINST NATIONAL DATA

8.1 Dr Chris Fear, the Trust's Medical Director was in attendance to give a verbal presentation to the Governors, which provided an analysis of local data on suicide during the period 2011-2014, compared with the findings of the 2014 National Confidential Inquiry report. The Governors were asked to note that this analysis was based on small numbers but had highlighted a number of key findings. These included:

- 2gether patient suicides comprised 27% of all suicides over the study period, 8.6% of suicides were of inpatients and 14.8% were of crisis team patients: the figures are consistent with national data.
- The rise in male patient suicide nationally has not been reflected in 2gether where rates for both genders have remained steady and below national rates.
- There has been a rise in male suicides aged over 25 with a trend towards a fall in female suicides aged 25-44.
- Hanging/asphyxia was the most common method locally, at a rate 1.5 times the national average. It was more likely in males aged 25-64 and females

aged 25-44. The rate was 1.5 times higher in Gloucestershire than Herefordshire.
- Self-poisoning and jumping/multiple injuries was half the national rate.
- Herefordshire patients were twice as likely to die by drowning, which was more common in males aged 45-64 (but small numbers).
- 71% of the small number of inpatient deaths (n=7) were by hanging/asphyxia compared with 26.7% nationally.
- Over four years, only one patient died within 7 days of discharge from hospital (3%), half the national rate.
- 14% of patients who died by suicide during 2012-2014 had never been referred to crisis teams, but this more than doubled to 33% in 2015. The reason for this is not clear and this needs further investigation.
- Most suicides were of recovery team patients but the number of patients who are managed by MHICT has risen from 1 in 2012 to 9 in 2015. This merits further investigation since suicides in MHICT appear to have made up 56% of all Gloucestershire patient suicides in 2015/16.

8.2 Chris Fear advised that more themed work to review the role of the Mental Health Intermediate Care Team (MHICT) was needed as there were currently some concerns about how this service was running and how it worked alongside the recovery and crisis teams.

8.3 The Council received additional assurance about the Trust's performance in the form of the National Confidential Inquiry into Suicide and Homicide (NCISH) Safety Scorecard.

8.4 The Council was asked to note that only 27% of those people who had ended their lives had been known to 2gether which highlighted the importance of raising the profile of suicide prevention within primary care services. A Suicide Prevention Strategy for Gloucestershire was in place and was making good progress but continued efforts were needed.

8.5 As previously noted, hanging/asphyxia was the most common method of suicide locally; at a rate 1.5 times the national average and Chris Fear advised that a themed review of this was planned. This review would also look in more detail at the act itself and whether the incidents were deemed to have been impulsive or carefully planned.

8.6 The Council agreed that this was a very informative presentation on a difficult and distressing subject and thanked Chris Fear for attending and presenting. It was noted that the Trust Board would receive a suicide analysis report annually, both for information and to receive an update on progress with the recommended actions.

8.7 Rob Blagden made reference to the target within the Quality Report for "Reduction in the numbers of reported deaths by suspected suicide". It was noted that this target would not be achieved in 2016/17 and he therefore queried whether this was a realistic and sensible target to be monitored against. Chris Fear agreed that it was difficult to have a target which the Trust was somewhat powerless to control; however, he said that the Trust welcomed having it as it meant that continued focus would be placed on it.

9. MEMBERSHIP REPORT

9.1 The Council of Governors received the Membership activity report which set out details of membership activity, the membership development plan and Governor Engagement Events.

9.2 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 February, the Trust had a total of 7781 members – 5331 Public members and 2450 Staff members.

9.3 The latest Governor Engagement event took place at Gloucestershire College's Cheltenham campus on Time to Talk Day – 2 February. The event was attended by approximately 60 people, and focussed on children and young people's mental health. The feedback on the event was overwhelmingly positive, with a number of Governors attending. Vic Godding and Al Thomas, who had organised the event with the Communications Team said that they felt it had been a very successful event; however, they were slightly disappointed that the event hadn't been attended by more teachers from the local area. It was agreed that Kate Nelmes would be asked to provide the invitation list for the event to see who was invited, in case some learning could be gained for next time.

ACTION: Kate Nelmes to be asked to provide the invitation list for the Cheltenham Governor event to Vic and Al to see who had been invited, in case some learning could be gained for next time.

9.4 It was noted that further Governor Engagement events were planned during 2017 and any Governors who wished to hold an event within their constituencies were encouraged to contact Kate Nelmes, Head of Communications who would assist in the organisation of these.

10. KEY ISSUES FOR DISCUSSION FROM THE GOVERNOR PRE-MEETING

10.1 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.

10.2 One item discussed related to the agenda item on the Board Committee agendas for "Items to be referred to Governors" and whether those things that are referred at the meeting were actually shared. It was noted that anything raised at the meetings to be shared with Governors were usually recorded as a formal action as part of the minutes from the meeting. Examples of completed referrals were given and it was agreed that the current process was appropriate; however, Governors would be informed when certain documents were uploaded to the Governor portal.

10.3 An observation template for those Governors attending the Board Committees was currently being developed and this would be shared with Governors once complete.

11. GOVERNOR ACTIVITY

11.1 Governors updated the Council about activities they had undertaken in their role as a Governor. Some of these included attendance at the Governor Engagement event on CYPS in Cheltenham, and observation at Board Committee meetings.

11.2 Pat Ayres had attended the Stroud Youth Day, and events at Cirencester College and the Royal Agricultural College where she provided information about Eating Disorder Services in the county.

11.3 Jennifer Thomson informed the Council that she had met with colleagues from the local Foodbank in the Forest of Dean and had given them information about 2gether for them to hand out.

12. COUNCIL OF GOVERNOR WORK PLAN 2017

12.1 A draft Annual Work plan was tabled at the meeting and comments were welcomed. Changes would be made to this as per the conversations at today's meeting. The work plan would be sent out as a standard agenda item for all future meetings.

13. ANY OTHER BUSINESS

13.1 There was no other business.

14. DATE OF NEXT MEETINGS

Council of Governor Meetings

Business Continuity Room, Trust HQ, Rikenel		
Date	**Governor Pre-meeting**	**Council Meeting**
2017		
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 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

Council of Governors
Action Points

Item	Action	Lead	Progress
17 January 2017			
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 July 2017 Council meeting. Governors interested in receiving a briefing on the survey results to notify Anna Hilditch,
9 March 2017			
4.3	Regular monthly updates to the Governor Portal to be diarised by the Trust Secretariat and notification sent out to all Governors advising of those documents uploaded	Anna Hilditch	New Trust website has been launched and work is still in progress to transfer the Governor Portal to the new site. Work is taking place with the Communications Team to migrate this ASAP
5.6	Lead Governor role description to be updated to reflect the change in tenure from 1 year to up to 2 years, with the ability to seek re-election, subject to their continued membership of the Council of Governors	John McIlveen	**Complete** Lead Governor role description included in May papers for information
5.7	Nominations and Remuneration Committee to consider the potential opportunity to provide shadowing for the Lead Governor at their next meeting in May, reporting the outcome back to the Council.	Anna Hilditch (N&R Agenda)	**Complete** On agenda for N&R Committee meeting on 3 May
9.3	Kate Nelmes to be asked to provide the invitation list for the Cheltenham Governor event to Vic and Al to see who had been invited, in case some learning could be gained for next time.	Kate Nelmes	