²GETHER NHS FOUNDATION TRUST

BOARD MEETING

THURSDAY 30 NOVEMBER 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 28 September 2017**	**PAPER A**
	4	**Action Points and Matters Arising**	
	5	**Questions from the Public**	
IMPROVING QUALITY			
10.10	6	**Patient Story Presentation**	**VERBAL**
10.40	7	**Performance Dashboard Report – September 2017**	**PAPER B**
10.50	8	**Mortality Review Report**	**PAPER C**
11.00	9	**Service Experience Report – Quarter 2 2017/18**	**PAPER D**
11.10	10	**Quality Report – Quarter 2 2017/18**	**PAPER E**
11.20	11	**Non-Executive Director Audit of Complaints – Quarter 2 17/18**	**PAPER F**
11.30	12	**CQC National Patient Survey Results**	**PAPER G**
BREAK – 11.40AM			
IMPROVING ENGAGEMENT			
11.50	13	**Chief Executive's Report**	**PAPER H**
IMPROVING SUSTAINABILITY			
12.00	14	**Summary Financial Report**	**PAPER I**
12.10	15	**Board Assurance Map**	**PAPER J**
12.20	16	**Board Committee Summaries** • Development Committee - October • Delivery Committee – October and November (Verbal) • Governance Committee – October • MHLS Committee – November • Audit Committee - November • Charitable Funds Committee – November	 **PAPER K1** **PAPER K2** **PAPER K3** **PAPER K4** **PAPER K5** **PAPER K6**
INFORMATION SHARING (TO NOTE ONLY)			
12.35	17	**Chair's Report**	**PAPER L**
	18	**Council of Governor Minutes – September and October 2017**	**PAPER M**
	19	**Use of the Trust Seal – Quarter 2 2017/18**	**PAPER N**
12.45	20	**Any Other Business**	
	21	**Date of Next Meeting** Tuesday 30 January 2018 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
TRUST HQ, RIKENEL
28 SEPTEMBER 2017

PRESENT

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

IN ATTENDANCE

Kate Atkinson, Trust Governor
Hilary Bowen, Trust Governor
Mervyn Dawe, Trust Governor
Anna Hilditch, Assistant Trust Secretary
Frances Martin, Director of Transformation
John McIlveen, Trust Secretary
Philippa Moore, Joint Director of Infection and Prevention Control (Item 11)
Kate Nelmes, Head of Communications
Dr Ross Runciman, CT3 (Item 6)
Dr Amjad Uppal, Medical Director Designate
Dr Brenda Wasunna-Smith, ST4 (Item 6)

1. WELCOMES, APOLOGIES AND INTRODUCTIONS

1.1 Apologies were received from Nikki Richardson.

2. DECLARATIONS OF INTERESTS

2.1 The Chief Executive had been appointed as Vice Chair of the Health Education England Leadership Academy.

2.2 The Director of OD had been appointed as Chair of the South West HR Directors Network.

3. MINUTES OF THE MEETING HELD ON 27 JULY 2017

3.1 The minutes of the meeting held on 27 July 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.

5. QUESTIONS FROM THE PUBLIC

5.1 There were no questions received from members of the public.

6. SERVICE PRESENTATION – RAPID TRANQUILISATION

6.1 The Board welcomed Dr Ross Runciman and Dr Brenda Wasunna-Smith to the meeting to give a presentation on Rapid Tranquilisation.

Rapid tranquillisation (RT) is the reactive administration of medication (IMI or oral) to manage unanticipated agitation or disturbance with the intended purpose of tranquilising the patient. RT occurs when medication is administered for the purpose of calming acute disturbance in circumstances where the clinical decision has been reached that receiving the prescribed medication is essential and should be seen as part of a measured and proportionate approach to de-escalation. (2gether definition)

6.2 The Board noted that a process of change began approximately 5 years ago when Dr Wasunna-Smith was an F2 and needed to administer RT for the first time. In the acute situation, she found it difficult to find the algorithm on the intranet for guidance. Dr Wasunna-Smith arranged for policy to be more easily accessible on the intranet and this has been especially useful when searching out of hours for the correct way to prescribe RT. It was noted that the Trust lead pharmacist approached the authors of the policy with concerns about what RT was being prescribed and a discrepancy between used medicine and documented RT administration. Colleagues then approached the local Drug and Therapeutics Committee to explore how to tackle this issue. NICE updated their guidance on RT (NG10) and this document outlined both behavioural approaches as well as medications. The Committee was conscious that trust policy differed significantly therefore from NICE guidance and to this end; it began the process of updating our local policy incorporating the NICE guidance.

6.3 Dr Runciman advised that the new policy went live in March 2017 and since then new drug cards and NEWS charts have been rolled out, quick guidance has been sent out to all clinicians, monthly training is delivered (coinciding with rotations of doctors) and RT training is now mandatory for all doctors and nurses.

6.4 The Board noted that the first full audit of RT was carried out in September 2017 and focused on undocumented RT, senior reviews obtained, drug cards correctly completed, completion of physical observations and deviations from RT documented. Audits would be carried out annually to monitor compliance with the new policy.

6.5 Dr Runciman highlighted a number of areas which could have been improved throughout the policy development process, including service user involvement, having a consistent team early on and the time it took: five years.

6.6 The Chief Executive thanked Ross and Brenda for the presentation, noting that whilst there was good assurance around the processes now in place there was a lot of learning to take on board and a lot that the Trust could do to improve systems in the future.

6.7 The Director of Quality said that she was disappointed that it had taken to so long to develop this policy. She was not aware that the Executive Team knew about the struggles that were happening and there was therefore an issue around communication and escalating such matters to enable the Executive to step in and assist. The Director of Quality also raised the importance of communication with service users due to the potential impact of RT on the patient.

6.8 Maria Bond firstly congratulated Ross and Brenda on their perseverance and for continuing to push this work through. In terms of the involvement of patients, Dr Runciman advised

that service users had not been involved in the development of the policy, which was something that in hindsight he wished had happened. However, more work would be carried out to engage with patients to speak to them after the use of RT and getting their views and feedback. The Director of E&I said that she would be happy to connect Ross and Brenda with patients who would be happy to share their experiences.

6.9 The Board noted that RT was only carried out in inpatient settings, occurring at least daily in adult inpatient settings, and less frequently within older people's services.

6.10 The Medical Director informed the Board that RT was safe; however, it could be traumatic. He said that the use of RT had historically increased on wards with less experienced clinicians and it was therefore important to ensure that the training was robust, and include links with PMVA and Breakaway training.

6.11 Mervyn Dawe expressed his thanks to the Board for taking such a presentation at its public Board meeting and for sharing good practice and learning so openly. He said that RT could be traumatic for the patient but suggested that there could also be an impact on fellow services users and the staff involved and asked that this be considered.

6.12 Ruth FitzJohn once again thanked Ross and Brenda for attending the meeting, and for their commitment, dedication and quality of thinking in bringing this policy and practice to fruition. The presentation had offered the Board good assurance about the care provided; however, one of the key messages from this was the need for a clear process or mechanism for people to escalate issues to the Board for resolution. Taking 5 years to fully implement a revised Rapid Tranquilisation policy was not good enough and could have been done much quicker with Board intervention. The involvement of service users and using their experiences to feedback into clinical practice was also something that needed to be considered. The Board agreed that the presentation had given much to think about as well as highlighting a lot of reflective practice.

7. PERFORMANCE DASHBOARD

7.1 The Board received the performance dashboard report which set out the performance of the Trust's Clinical Services for the period to the end of July 2017 (month 4) of the 2017/18 contract period, against our NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

7.2 Of the 154 performance indicators, 86 were reportable in July with 79 being compliant and 7 non-compliant at the end of the reporting period. The Board noted that this report had not been received in full at the Delivery Committee in advance due to no meeting taking place in August. However, the August dashboard had been scrutinised in detail at the September Delivery Committee meeting.

7.3 The Board noted that indicator *5.13: Attendances at ED have access to Mental Health Liaison Team within 2 hours* was non-compliant in July. There were 4 cases recorded in July that had not met the performance threshold. 1 case was believed to be non-compliant due to mis-recording and this would be removed once RiO has been updated. This update would make the indicator compliant at 81%.

7.4 Jonathan Vickers made reference to the number of indicators within the dashboard that were still "Not Yet Agreed" or "Not Yet Required", noting that the Trust was now 5 months in to the contracting year. The Director of Service Delivery advised that the delay in agreeing these sat with the commissioners, not 2gether. He noted that if the indicators were not

agreed by next month, there was agreement with commissioners via the Contract Board that these would be moved forward into the 2018/19 contract year.

7.5 Mervyn Dawe asked what 2gether was doing in relation to Under 18 admissions. The Director of Service Delivery said that the Trust continued to carry out a lot of work to try to address this and was in no way complacent. There were robust policies and safeguards in place before, during and after admission. The admission of under 18s to adult inpatient units was a national issue and more work was needed at a national level around the provision of suitable young people's inpatient beds.

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

8. QUALITY REPORT – QUARTER 1 2017/18

8.1 The Director of Quality reported that this was the first review of the Quality Report priorities for 2017/18. The report showed the progress being made towards achieving targets, objectives and initiatives identified in the Annual Quality Report. The Board noted that the report had been scrutinised in detail by the Governance Committee.

8.2 The Board noted that the following 4 targets were not currently being met:

- 1.2 – Personalised discharge care planning
- 2.1 – Numbers of service users being involved in their care
- 3.1 – Suicide reduction
- 3.3 – Reduction in the use of prone restraint.

8.3 The Director of Quality advised that the data presented related to Quarter 1 and would be subject to change as the supportive evidence base grew throughout the year. The Board noted that sustained focus would be needed, particularly on discharge care planning as completion of the necessary documentation was within the gift of staff to accomplish. The Trust scored 82% against a stretch target of 92% for the number of service users being involved in their care. More work was being carried out to increase engagement and it was hoped that an increase in compliance with this indicator would be seen in the next Quarter's report.

8.4 The Board noted that the target for reduction of the use of prone restraint had not been met at the end of Quarter 1. The Director of Quality advised that discussions had been taking place at the Executive Committee about training and the auditing of prone restraint use. The Trust's Positive and Safe Sub-Committee had been asked to focus on this in more detail.

8.5 The Governance Committee would continue to monitor the 4 targets not currently being met, via the QCR Sub-Committee.

8.6 The Board noted the good progress made to date and supported the recommendation that the Quarter 1 Quality Report update be shared with partner organisations, commissioners and governors.

9. SERVICE EXPERIENCE REPORT – QUARTER 1 2017/18

9.1 The Director of Engagement and Integration presented the Service Experience Report for Quarter 1 2017/18. The Board noted that the report had been scrutinised by the Governance Committee in August 2017.

9.2 This report provided the Board with a high level overview of feedback received from service users and carers and provided assurance that service experience information had been reviewed, scrutinised for themes, and considered for both service-specific and general learning across the organisation.

9.3 It was noted that information gathered across all domains of feedback including complaints, concerns, comments and compliments had been triangulated to understand service experience. The Board was significantly assured that the organisation had listened to, heard and understood service user and carer experience of 2gether's services.

9.4 The Board noted that during Quarter 1, 87% of people who completed the Friends and Family Test said that they would recommend 2gether's services. The Trust continued to maintain a high percentage of people who would recommend our services, with results exceeding national scores. This provided significant assurance that service users valued the service being offered and would recommend it to others. However, there was limited assurance that people were participating in the local survey of quality in sufficient numbers. It was anticipated that response rates would rise during Quarter 2 as the new system was embedded. The Director of E&I added that the results from the National CQC Patient Survey were expected in the coming weeks.

9.5 The Board was significantly assured that services were reporting details of compliments they had received. There was full Assurance that complaints were acknowledged within required timescales, there was significant assurance that all people who complained had their complaint dealt with by the initially agreed timescale and that all complainants received regular updates on any potential delays in the response being provided.

9.6 The Board was assured that the Trust continued to seek feedback about service experience from multiple sources on a continuous basis. This quarter, concerns and complaint themes had focused on communication issues with service users and/or their carers. Other themes which had been identified included the need to fully involve people when making decisions about their care and explain the reasons behind why we do the things we do.

9.7 The Director of E&I informed the Board that the Governance Committee had requested that work be carried out to look at producing a more streamlined report in future. There was a great deal of information contained in this report and consideration would be given to what should be reported in future, how often the report should be received and whether the report should focus more on those areas of limited assurance.

9.8 Quinton Quayle made reference to the You Said, We Did example at Table 11 within the report. He noted the complaint "I was unable to access the disabled parking bay when visiting your building due to a car blocking the space" and the Trust's response to this. However, he said that "adding additional spaces" and "introducing a system for staff and visitors to leave contact details in their cars to ease any required moving of vehicles" did not seem to respond to the individual's complaint, noting that disabled parking spaces should not be blocked at any time and should be easily accessible. Quinton asked whether a further look into this issue could be carried out as there were regulations that the Trust was required to meet.

ACTION: Director of E&I to investigate further the concern raised in the SE Report about cars blocking disabled parking spaces to ensure that 2gether was operating in line with regulations

9.9 Ruth FitzJohn noted that the Trust had only received one piece of feedback from Healthwatch Gloucestershire and Herefordshire during the Quarter and suggested that more needed to be done to encourage feedback to be collected.

10. SAFE STAFFING 6 MONTHLY UPDATE

10.1 The Board is mandated to receive a 6 monthly report outlining the requirements of the NHS National Quality Board (NQB) guidance on safe staffing levels. The Board noted that the Governance Committee continues to receive a monthly report detailing staffing levels across all inpatient sites.

10.2 The Director of Quality noted that this 6 monthly update outlined:

- An update on all the expectations within the new guidance – including sample quality dashboards
- National reporting requirements, latest developments and the latest data in the required format
- Local Trust exception reporting
- Update of agency use across wards

10.3 The Board noted that the Trust had made much progress and was in a good position regarding compliance with this guidance. This report detailed two 'sample' quality dashboards in relation to inpatient wards. The quality dashboard is currently being refined to ensure it includes workforce data and any other relevant quality information for triangulation. A full dashboard for all wards will be reported on at the next 6 monthly update. It was noted that the quality dashboard would also form part of the team accounts which the Trust is currently working on for all services.

10.4 National reporting with regards to fill rates continues to be uploaded monthly and reported to the Governance Committee on behalf of the Board. The Trust continues to have high compliance with planned vs actual fill rates - over 96% for July 2017. Use of agency continues with a significant reduction in the use of nursing agency spend during 2017/18.

10.5 In summary for July 2017:

- No staffing issues were escalated to the Director of Quality or the Deputy Director
- Where staffing levels dipped below the planned fill rates of 100% for qualified nurses this was usually offset by increasing staffing numbers of unqualified nurses based on ward acuity and dependency and the professional judgement of the nurse in charge of the shift
- 96.3% of the hours exactly complied with the planned staffing levels
- 2.9% of the hours during July had a different staff skill mix than planned staffing however overall the staffing numbers were compliant and the needs of patients were met
- 0.8% of the hours during July had a lower number of staff on duty than the planned levels, however this met the needs of the patients on the ward at the time

10.6 The Director of Quality advised that 2gether was one of 23 Trusts participating in the Carter review for Mental health and Community Trusts and is repeating the last data collection during September on the Care Hours Per Patient Day (CHPPD). Acute Trusts are currently mandated to collect this data monthly. This will become mandatory for Mental Health and Community Trusts for all inpatient units from April 2018.

10.7 The Board noted the content of the Safe Staffing report and the assurance it offered regarding staffing within inpatient units.

11. INFECTION CONTROL ANNUAL REPORT 2016/17

11.1 Philippa Moore presented the Annual Infection Prevention and Control report 2016/17 to the Board. She reported that the Trust remained compliant with the Health and Social Care Act: Code of Practice for Health and Adult Social Care on the prevention and control of infections and related guidance (The Hygiene Code). Risks for healthcare associated infection remained low in the Trust.

11.2 The Board was assured that the Trust was committed to providing high standards of infection prevention and control across all services. Evidence was also provided of infection control related activity, monitoring and governance during 2016/17.

11.3 The Board noted that during August 2016, 2 patients on Willow ward were found to be colonised with MRSA. Over the course of the next 6 months a further 6 patients were detected with MRSA colonisation with the same isolate indicating cross-infection on the unit. The likely underlying cause was the fact that the initial 2 patients did not receive MRSA suppression therapy due to a misunderstanding of the preferred infection control management of these patients by the infection control team. This likely led to some environmental contamination, despite enhanced cleaning being in place, and cross-infection to other patients. A full outbreak was declared in December 2016 at the time a further cluster of patients was identified and the ward closed. A full review of the incident was subsequently undertaken and highlighted good practice by the ward but a need for further education which has been addressed. Admission screening for MRSA was put in place for all wards in Charlton Lane and this will now continue.

11.4 During 2016/17 there were three cases of Clostridium difficile toxin positive infection in the trust. One case was detected 48 hours after admission for 2gether Gloucestershire to report. This case occurred at Wotton Lawn and a Root Cause Analysis was undertaken. Antibiotic prescribing was appropriate, no significant issues were identified and this case was considered unavoidable. In Herefordshire a patient who had previously been in the Stonebow unit was found to be C. difficile toxin positive from a sample taken in Hereford County Hospital A&E in July 2016. Investigations within the Stonebow unit highlighted environmental and commode cleanliness issues which were rectified at the time. In September 2016 there was another unrelated case detected in the Stonebow unit. Cleanliness was again highlighted as an issue on auditing the ward. In November 2016 a multidisciplinary meeting reviewed cases of C. difficile in the Stonebow unit. Training was also identified as an issue for the clinical teams and the Wye Valley infection control team provided additional education sessions around C. difficile for staff. Cleanliness was highlighted as an issue twice during the year around these 2 cases, and the trust has taken action in that hotel services provision is no longer being managed by Sodexo and is now under the supervision of 2gether. Since this transfer of responsibility improvements in cleanliness have been noted by staff.

11.5 During 2016/17 the trust achieved its target of vaccinating more than 75% of front line clinical staff against flu. This was an excellent achievement.

11.6 The Board noted that a comprehensive infection control audit programme was in place was significant assurance was given in relation to compliance. All areas of non-compliance in audits resulting in low scores are followed up. Action plans to remedy problems are

monitored and the areas are rechecked during subsequent clinical visits by the infection prevention and control nurses.

11.7 Hand hygiene is considered the most important part of preventing healthcare associated infections. Mental health organisations are different from acute trust hospitals in that many of the WHO hand hygiene 'moments' (opportunities for hand hygiene) are patient initiated rather than staff initiated. Given this, 2gether aims to ensure compliance with hand hygiene that protects patients and has a compliance target of 90%. Audits are performed quarterly and reported 6 monthly. During 2016/17 the compliance for the 2 periods was 94% and 95% and therefore good compliance was maintained. The Board agreed that this was an excellent achievement.

11.8 Significant assurance was received around infection control training. During 2016/17 infection control education was delivered principally by both face to face training and by e-learning and training figures had improved compared to 2015/16 with Non-clinical staff achieving 70% compliance and Clinical staff 81%.

11.9 The Director of Finance made reference to the earlier point about the change in hotel services provision in Herefordshire, noting that this was no longer being managed by Sodexo and was now under the supervision of 2gether. He said that there had been positive feedback from staff in Herefordshire about these changes and although this may not be apparent in the figures, he suggested that this positive feedback could be captured in the narrative of future reports.

11.10 The Director of Finance noted the reference in the report to the discretionary spend freeze on Estates Maintenance. He offered the Board assurance that the Trust would always action any infection control requirements immediately.

11.11 The Board noted the Annual Infection Prevention and Control report and continued to support the infection prevention and control programme to minimise the risks of healthcare associated infection, as required by the Health and Social Care Act.

12. NON-EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS

12.1 The Board received the Non-Executive Director Audit of Complaints that was conducted by Duncan Sutherland. This audit covered three complaints that had been closed between 1 April and 31 July 2017 (Quarter 1 2017/18).

12.2 Duncan Sutherland said that he had found carrying out the audit an excellent learning experience.

12.3 It was noted that the 3 complaints that Duncan had audited had been complex cases. However, given their complexity and the number of investigators involved, he advised that the investigations were carried out in a very open and honest way and he wished to show appreciation for this to the individual investigators and the overall co-ordinating investigator. The Director of E&I agreed to pass these positive comments back to the relevant people.

ACTION: Director of E&I to pass thanks on to the complaints investigators highlighted in the NED Audit of complaints

12.4 The Board noted the content of this report and the assurances provided. The Director of E&I provided additional assurance that the report and its findings would be shared with the Service Experience Team for learning and action where required.

13. SMOKING CESSATION REPORT

13.1 The purpose of this paper was to update the Trust Board on the progress of the implementation of the smoke free guidance that was introduced in April 2017 across the Gloucestershire 2gether sites and with a planned implementation for Herefordshire sites.

13.2 The National Institute for Health and Care Excellence - NICE (2013) PH 48 – published guidance in November 2013 for smoking cessation in secondary care: acute, maternity and mental health services. At that time there was no nationally mandated date for completion of this guidance; however the Trust implemented a planned approach to take this recommendation forward to successful implementation which commenced in April 2017. New guidance from NHS England now requires smoke free to be implemented in all mental health Trusts by 2018.

13.3 The project board has a number of work streams including training; staff engagement; estates and treatments. Largely implementation of smoke free with a robust policy has been well accepted and positively received. The nature of such a culture shift is that it is best described as a 'journey' to smoke free – as advised by the SW Public Health England (PHE) lead. The Director of Quality advised that work was progressing well and the Trust continued to engage with staff and service users and have a number of service users on the project board.

13.4 The Director of Quality noted that the Trust had seen no significant rise in aggression or violence related to the smoke free implementation. However, there were still a number of risks and challenges which continued to be addressed, which included:

- staff accessing training
- culture shift for staff and service users
- Implementation of smoke free within Herefordshire (date now set for Jan 2018)

13.5 Jonathan Vickers asked about the use of vaping and whether there were any long term plans around this. The Director of Quality advised that Public Health England had endorsed the use of vapes and e-cigarettes and 2gether would be carrying out a pilot on the wards at Wotton Lawn to see how this would work.

13.6 The Board agreed that it was impressive how well and efficiently this had been implemented, and congratulated all those who had been involved in achieving this.

14. LEARNING FROM DEATHS POLICY

14.1 The Medical Director presented the draft Learning from Deaths in the NHS Policy. In accordance with national guidance and legislation, the Trust currently reported all incidents and near misses, irrespective of the outcome, which affected one or more persons, related to service users, staff, students, contractors or visitors to Trust premises; or involving equipment, buildings or property. This arrangement was set out in the Trust policy on reporting and managing incidents. Further guidance was published by the National Quality Board in March 2017 setting out mandatory standards for organisations in the collecting of data, review and investigation, and publication of information relating to the deaths of all patients under their care. This information was to be reported and published on a quarterly basis through the Trust Board, commencing quarter three 2017/18.

14.2 The Board noted that the draft Policy had been developed and widely consulted upon over the past 4 months. However, in September 2017 NHSE published a template for Learning from Deaths policies. The Board noted that the Medical Director and Non-Executive

Director responsible for this piece of work have discussed and reviewed this template and concluded that all requirements are covered by the 2gether's draft policy as it stands.

14.3 Jonathan Vickers referred to the creation of a Mortality Review Committee which it was proposed would meet monthly, at which all data on patients who fall within the scope of this policy will be considered, categorised and reviewed. He noted that a NED would be in attendance at this Committee and therefore queried current capacity to manage this new "Board" Committee. The Medical Director advised that a sub-Committee of Governance had already been set up and had been carrying out this work for a year. More work was needed around the governance of setting up a formal Board Committee but it was agreed that it was important for the Trust to send the right messages about the importance of this work.

14.4 The Board ratified this local policy, noting that this would be reviewed in the light of further guidance by September 2018.

15. MEDICAL APPRAISAL ANNUAL REPORT

15.1 The Board received the Annual Medical Appraisal Report, noting that the appraisal process had continued to be instituted within 2gether aligned with national policy. Investment in SARD JV and the transfer to that system was supporting effective monitoring, recording and review of the quantity, quality and uptake of appraisal. The Medical Appraisal Committee has instituted a work plan that will further deliver assurance annually and sustain quality.

15.2 The Board was assured that recruitment processes provided appropriate safety and quality checks aligned with national policy and best practice, and the use of locum practitioners was being monitored and used to sustain service commitments and activity appropriately.

15.3 The Board noted that at the end of March 2017 90.9% of doctors had a currently valid appraisal; 7.8% of those non-compliant were explained by exclusion criteria such as long term sick leave. This left 1.3% (one case) who at that point was classified as non-compliant. A further review of this case indicated that it was a short term delay and the annual appraisal had since been completed. The Board noted that there was a clear escalation process in place and new appraisals were reviewed along with a random sample of all appraisals. Compliance was high and the quality of appraisals was good.

15.4 The Board accepted and endorsed the Medical Appraisal Annual Report which provided significant assurance around delivery of appraisals. The Board noted that appraisal levels had been maintained without significant additional funding and recognised that effective appraisal had supported timely and appropriate revalidation for all Doctors to date. The Board agreed to submit the appropriate Statement of Compliance to NHS England.

15.5 Quinton Quayle said that he welcomed the approach of carrying out appraisals for medical staff, noting that the system was very robust. He asked whether there was any learning from this that could be taken on board and used to improve the appraisal process for all Trust staff, not just medics. The Director of OD was asked to think about this further as part of the wider work taking place to improve compliance with appraisals and training.

16. CHIEF EXECUTIVE'S REPORT

16.1 The Chief Executive presented his 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.

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

16.3 The Chief Executive advised that the Council of Governors had received and endorsed the proposal to progress the strategic intention to acquire Gloucestershire Care Services via an FT Chain. Governors had been overall positive about this proposal. Following this endorsement, the process of setting up the interviews for the Joint Chair and Joint Chief Executive posts had commenced.

16.4 The Board noted the Chief Executive's report.

17. SUMMARY FINANCIAL REPORT

17.1 The Board received the Finance Report that provided information up to the end of August 2017. The month 5 position was a surplus of £286k in line with the planned surplus. The month 5 forecast outturn is a £884k surplus in line with the Trust's control total. The Trust has an Oversight Framework segment of 2 and a Finance and Use of Resources metric of 2. The Director of Finance asked the Board to note that whilst the Trust was on target to achieve its forecast outturn, there was no flexibility for movement and the Trust therefore needed to remain cautious during what was going to be a very challenging year ahead if it was to meet its control total by the end of the financial year.

17.2 The 2017/18 contracts with Gloucestershire CCG, Herefordshire CCG, NHS England and Worcestershire Joint Commissioning Unit have been signed. The Trust has agreement in principle with Aneurin Bevan Health Board and is just awaiting contract paperwork to finalise the contract.

17.3 Agency spend at the end of August was £1.821m. On a straight line basis the forecast for the year would be £4.372m, which would be a reduction of £1.12m on last year's expenditure level, but above the agency control total by £0.968m. It is estimated however that with a number of initiatives currently being implemented to reduce agency usage further the year end forecast will be £3.712m.

17.4 The Trust was in the process of undertaking a mid-year review of its financial position. There are a number of cost pressures the Trust is managing and the review is identifying the mitigations and deliverables required to ensure the Trust meets its control total. Revenue budgets, capital expenditure, savings schemes, cash, balance sheet provisions and potential risks and opportunities are all being reviewed. This review will come to the October Board meeting.

17.5 The Board noted the summary Finance Report for the period ending 31st August 2017 and agreed that based upon the month 5 position it was content for the Q2 position to be submitted to NHSI in mid-October showing a forecast that will achieve our Finance Control Total, subject to any significant changes arising as the month 6 position is finalised, although such changes are not expected.

18. CORPORATE STRATEGY

18.1 The Board received the updated Corporate Strategy, noting that this had been approved at both the Executive Committee and the Development Committee in August.

18.2 Since the production and agreement of the existing Corporate Strategy there has been the advent of Sustainability and Transformation Partnerships (STPs), and so the strategy references the original environmental context for its production and then brings in a section on STPs.

18.3 The Board approved the revised Corporate Strategy, noting that this updated overarching strategy was key to the delivery of the Trust's Strategic and Operational Plans.

19. FINANCE STRATEGY

19.1 The Board received the updated Finance Strategy, being an enabling strategy to the delivery of the Trust's Strategic and Operational Plans. The Finance Strategy covered a number of key areas, including Quality & Finance, the Annual Financial Plan, Planning Assumptions, Budget Setting, Service Planning & Contracting, Cost Improvement Plans, Financial Management and Cash & Investments.

19.2 The Board noted that a draft of this strategy was considered at the Development Committee meetings in February and May, with a number of amendments suggested all of which have been incorporated into this final version. The August Development Committee then approved this strategy. This version has also been widely circulated for comment among senior managers both within and outside of the finance function and was also considered at the Executive Committee in May.

19.3 Marcia Gallagher queried the timescales in relation to 12.4 of the Finance Strategy which stated "During 2017/18 we expect the outputs of SLR and PLICS to start to be built into the monthly Board Finance Report as standard." The Director of Finance advised that it was planned that this would be in place by the end of Quarter 3 this year.

19.4 The Board approved the revised Finance Strategy.

20. AUDIT COMMITTEE ANNUAL REPORT

20.1 Marcia Gallagher presented the annual report of the Audit Committee which provided an overview of the Committee's work during 2016/17. The report was structured in sections reflecting each of the headings in the Committee's Terms of Reference, and set out the Committee's activities in overseeing the internal control mechanisms in the Trust in support of the Annual Governance Statement.

20.2 The Board noted the Audit Committee Annual Report 2016/17. Marcia Gallagher expressed her thanks to Board, finance and audit colleagues for their significant contributions over the past year, noting that the Trust's Audit Committee operated very smoothly and efficiently.

21. BOARD COMMITTEE REPORTS – APPOINTMENTS AND TERMS OF SERVICE

21.1 The Director of OD presented the annual summary report from the Appointments and Terms of Service Committee. The Committee's purpose is to determine and decide on appointments, appropriate remuneration and terms of service for the Chief Executive and

Executive Directors. This includes deciding all aspects of salary and the provision of any other appropriate benefits and contractual terms.

21.2 The Committee met on five occasions in the past year and has achieved good attendance at meetings ensuring a range of differing views are heard and challenges have been taken into account for the decisions made. The Committee has received papers and wider benchmarking providing detailed information to inform the debates and decisions made. Significant assurance is given as to the Committee's ability to meet its specified purpose.

21.3 The Committee will continue to meet as and when required to continue its work, particularly in light of the recent agreements relating to the formation of a Foundation Trust Chain and the intent to work with Gloucestershire Care Services to become a single provider of physical care, mental health and learning disabilities.

22. BOARD COMMITTEE REPORTS – DELIVERY COMMITTEE

22.1 Maria Bond provided a verbal report from the Delivery Committee meeting held on 27 September. A full written report would be presented at the next Board meeting. Key items received and discussed at the meeting included:

- The Committee was assured that all reports for Q1 2017/18 had been submitted within agreed timescales. The CQUINS for Gloucestershire and Low Secure had been deemed compliant and the results from Herefordshire were awaited. Significant assurance was provided at this stage of the year in relation to the delivery of the 17/18 CQUINs.
- The Herefordshire Locality exceptions report highlighted the significant work that continued to take place locally to reduce agency spend through attempts to increase recruitment options, review recruitment processes, bank deployment models and staff bank recruitment.
- In Herefordshire the new Mental Health Veterans Support Worker was due to start in post on 18th September. The Learning Disability Music Group had now recorded their CD of the music they had written in the music workshops.
- Received a locality presentation from the Gloucestershire South Locality and a presentation on Dementia Services in Gloucestershire and Herefordshire
- Noted the positive results and endorsed the findings of the 11th Staff Friends and Family Test for Quarter 2 of 2017/18
- Endorsed the recommendation from the Governance Committee to centralise the monitoring of security activity and compliance within one core committee.

23. BOARD COMMITTEE REPORTS – DEVELOPMENT COMMITTEE

23.1 Jonathan Vickers presented the summary report from the Development Committee meeting held on 16 August. This report and the assurances provided were noted.

24. BOARD COMMITTEE REPORTS – GOVERNANCE COMMITTEE

24.1 The Board received the summary report from the Governance Committee meeting that had taken place on 18 August. The Board noted the key points discussed at this meeting and the assurance received by the Committee.

25. INFORMATION SHARING REPORTS

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

- Chair's Report

- Council of Governors Minutes – July 2017

25.2 The Board noted the full assurance regarding engagement activities provided by the Chair's report

26. ANY OTHER BUSINESS

26.1 There was no other business.

27. DATE OF THE NEXT MEETING

27.1 The next Board meeting would take place on Thursday 30 November 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
	9.8	Director of E&I to investigate further the concern raised in the SE Report about cars blocking disabled parking spaces to ensure that 2gether was operating in line with regulations	Jane Melton	Nov	**Complete**
	12.3	Director of E&I to pass thanks on to the complaints investigators highlighted in the NED Audit of complaints	Jane Melton	Nov	**Complete**

Agenda item 7 **Enclosure Paper B**

Report to: 2gether NHS Foundation Trust Board Meeting – 30th November 2017
Author: Chris Woon, Head of Information Management and Clinical Systems
Presented by: Colin Merker, Director of Service Delivery

SUBJECT: **Performance Dashboard Report for the period to the end of September 2017 (month 6)**

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

EXECUTIVE SUMMARY:

Overview

This month's report sets out the performance of the Trust's Clinical Services for the period to the end of September 2017 (month 6) of the 2017/18 contract period, against our NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

Of the 154 performance indicators, 109 are reportable in September with 101 being compliant and 8 non-compliant at the end of the reporting period.

Please note that not all Gloucestershire CCG Contractual Indicators (Schedule 4) have been finalised with Commissioners. This report reflects the 16/17 contract plus those new indicators that have been agreed at the time of reporting.

New indicators for the 2017/18 contract period have been added at the end of each of the specific Schedule 4 reporting sections.

Where performance is not compliant, Service Directors are taking the lead to address issues with a particular focus continuing to be on IAPT service measures:

Work is ongoing in accordance with our agreed Service Delivery Improvement Plans to address the underlying issues affecting this performance.

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

A column has been added to indicate whether the indicator is forecast to be compliant at the end of the financial year.

Compliant

Non Compliant

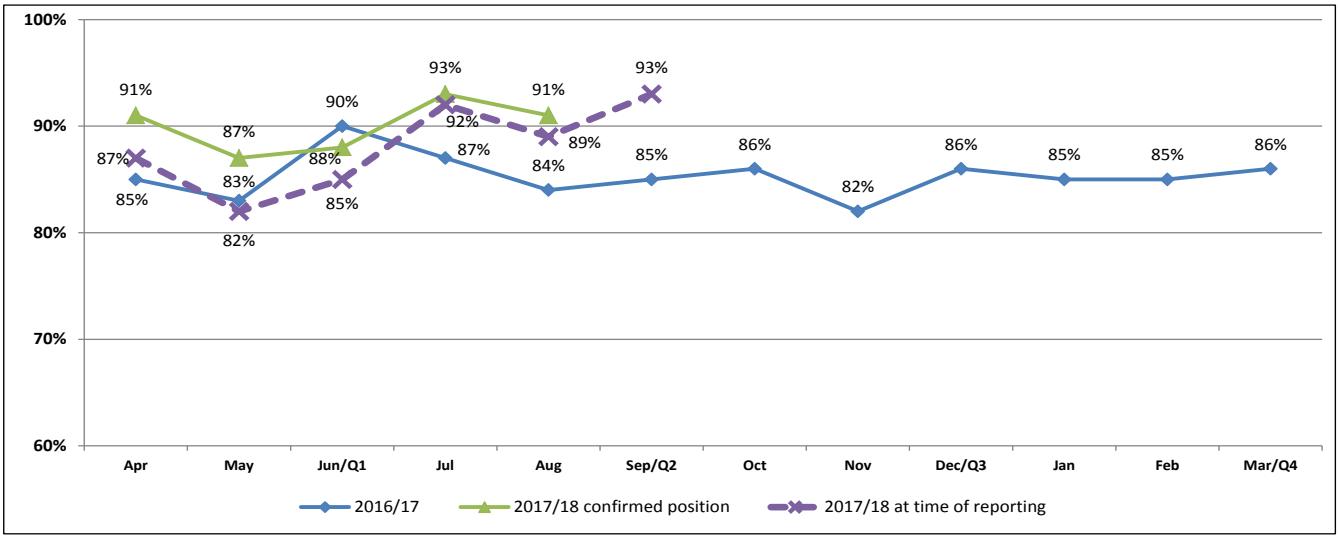
Unknown

No performance threshold

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

Indicators Reported in Month and Levels of Compliance							
Indicator Type	**Total Measures**	**Reported in Month**	**Compliant**	**Non Compliant**	**% non-compliance**	**Not Yet Required**	**NYA / UR**
NHSi Requirements	**13**	**13**	**11**	**2**	**15**	**0**	**0**
Never Events	**17**	**17**	**17**	**0**	**0**	**0**	**0**
Department of Health	**10**	**8**	**7**	**1**	**13**	**2**	**0**
Gloucestershire CCG Contract	**52**	**26**	**25**	**1**	**4**	**22**	**4**
Social Care	**15**	**13**	**12**	**1**	**8**	**2**	**0**
Herefordshire CCG Contract	**22**	**15**	**12**	**3**	**20**	**3**	**4**
CQUINS	**25**	**17**	**17**	**0**	**0**	**8**	**0**
Overall	**154**	**109**	**101**	**8**	**7**	**37**	**8**

The following graph shows our percentage compliance by month and the previous year's compliance for comparison. The line "2017/18 confirmed position" shows the position of our performance reported a month in arrears to enable late data entry and late data validation to be taken into account.



The confirmed position for August has increased from 89% to 91% due to:

- (3.46) Alexandra Wellbeing House dataset now being made available to commissioners
- (4.07) Improvements in the recording of the number of carers that have been offered a carer's assessment.

Summary Exception Reporting

The following 8 key performance thresholds were not met for the Trust for September 2017:

NHS Improvement Requirements

- 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 – No children under 18 admitted to adult inpatient wards

Gloucestershire CCG Contract Measures

- 3.19 – IAPT Access rate : Access to psychological therapies should be improved

Social Care –Gloucestershire CCG Contract Measures

- 4.02 – Percentage of people receiving long-term services in a residential or community care setting reviewed/re-assessed within a year

Herefordshire CCG Contract Measures

- 5.09 – IAPT maintain 15% of patients entering the service against prevalence
- 5.12 – All admitted patients aged 65+ should have a completed MUST assessment
- 5.13 – Attendances at Emergency Departments should have an assessment within 2 hours

RECOMMENDATIONS

The Board is asked to:

- Note the Performance Dashboard Report for September 2017.
- Accept the report as a significant level of assurance that our contract and regulatory 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	October 2017

Where in the Trust has this been discussed before?		
Delivery Committee	Date	25 October 2017

What consultation has there been?		
Not applicable.	Date	

Explanation of acronyms used:	
	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 DNA Did not Attend ED Emergency Department EI Early Intervention EWS Early warning score HoNoS Health of the Nation Outcome Scale IAPT Improving Access to Psychological Therapies IST Intensive Support Team (National IAPT Team) KPI Key Performance Indicator LD Learning Disabilities MHICT Mental Health Intermediate Care Team MHL Mental Health Liaison MRSA Methicillin-resistant Staphylococcus aureus MUST Malnutrition Universal Screening Tool NHSI NHS Improvement NICE National Institute for Health and Care Excellence SI Serious Incident SUS Secondary Uses Service VTE Venous thromboembolism YOS Youth Offender's Service

1. CONTEXT

This report sets out the performance Dashboard for the Trust for the period to the end of September 2017, month six of the 2017/18 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 end of September 2017. Where indicators have not been met during the reporting period, an explanation is provided relating to the non-achievement of the Performance Threshold and the action being taken to rectify the position.

2.2 Where stated, 'Cumulative Compliance' refers to compliance recorded from the start of this contractual year April 2017 to the current reporting month, as a whole.

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

	=	**Target not met**
	=	**Target met**
NYA	=	**Not Yet Available from Systems**
NYR	=	**Not Yet Required by Contract**
UR	=	**Under Review**
N/A	=	**Not Applicable**
Baseline	=	**2017/18 data reporting to inform 2018/19**

DASHBOARD CATEGORY - NHSI REQUIREMENTS

NHS Improvement Requirements				
	In month Compliance			Cumulative Compliance
	Jul	Aug	Sep	
Total Measures	13	13	13	13
🔴	2	3	2	2
🟢	11	10	11	11
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):

1.09: 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

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

As above

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

As above

Changes to Previously Reported Figures

1.08: New Psychosis (EI) cases treated within 2 weeks of referral (Gloucestershire)
It was reported in July that 1 client had been recorded as a new case but is in fact an ongoing case of psychosis. This has now been amended on RiO and within the KPI methodology and compliance for July is now reported at 67%.

Early Warnings / Notes

None

Note in relation to year end compliance predictions (forecast outturn)

1.07: New Psychosis (EI) cases as per contract (Gloucestershire):
These services are subject to development in line with the Mental Health 5 Year Forward View (MH5YFV). The development is underpinned with a new performance modelling tool and so this indicator will be considered as part of that modelling and any revisions agreed with Commissioners. The forecast is non-compliant until the review is complete (likely Q3).

1.09 & 1.10: IAPT: Waiting times - Referral to Treatment within 6 & 18 weeks
This forecast position will be reviewed when Commissioners discussions around investment and methodology are resolved.

NHS Improvement Requirements

ID	Performance Measure (PM)		2016/17Outturn	July-2017	August-2017	September-2017	(Apr to Sep) Cumulative Compliance	Forecast 17/18 Outturn
1								
1.01	Number of MRSA Bacteraemias	PM	0	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	0
		Gloucestershire	0	0	0	0	0	
		Herefordshire	3	0	0	0	0	
		Combined Actual	3	0	0	0	0	
1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	98%	98%	99%	100%	99%	
		Herefordshire	99%	100%	97%	95%	98%	
		Combined Actual	98%	99%	98%	99%	99%	
1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	99%	98%	97%	96%	97%	
		Herefordshire	99%	98%	99%	98%	97%	
		Combined Actual	99%	98%	97%	96%	97%	
1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Gloucestershire	1.6%	2.5%	6.6%	3.8%	2.6%	
		Herefordshire	2.2%	2.7%	2.7%	2.4%	1.9%	
		Combined Actual	1.8%	2.5%	5.6%	3.5%	2.4%	
1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	99%	100%	100%	100%	100%	
		Herefordshire	100%	100%	100%	100%	100%	
		Combined Actual	99%	100%	100%	100%	100%	
1.07	New psychosis (EI) cases as per contract	PM	72	24	30	36	36	72
		Gloucestershire	67	21	28	39	39	
		PM	24	8	10	12	12	24
		Herefordshire	20	16	16	19	19	
		PM	96	32	40	48	48	96
		Combined Actual	87	37	44	58	58	
1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	72%	67%	43%	82%	74%	
		Herefordshire	70%	100%	N/A	67%	68%	
		Combined Actual	71%	83%	43%	79%	72%	

NHS Improvement Requirements

ID	Performance Measure (PM)		2016/17Outturn	July-2017	August-2017	September-2017	(Apr to Sep) Cumulative Compliance	Forecast 17/18 Outturn
1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Gloucestershire	35%	70%	72%	67%	66%	
		Herefordshire	49%	65%	58%	62%	55%	
		Combined Actual	38%	69%	69%	66%	64%	
1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	86%	87%	88%	88%	87%	
		Herefordshire	85%	78%	73%	72%	78%	
		Combined Actual	86%	85%	85%	85%	86%	
1.11	**MENTAL HEALTH SERVICES DATA SET PART 1 DATA COMPLETENESS: OVERALL**	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%	
1.11a	Mental Health Services Data Set Part 1 Data completeness: DOB	PM	97%	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%	97%
		Gloucestershire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%	
1.11c	Mental Health Services Data Set Part 1 Data completeness: NHS Number	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%	
1.11d	Mental Health Services Data Set Part 1 Data completeness: Organisation code of commissioner	PM	97%	97%	97%	97%	97%	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%	
1.11e	Mental Health Services Data Set Part 1 Data completeness: Postcode	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.8%	99.8%	99.8%	99.8%	99.8%	
		Herefordshire	99.8%	99.9%	99.9%	99.9%	99.9%	
		Combined Actual	99.8%	99.8%	99.8%	99.9%	99.8%	
1.11f	Mental Health Services Data Set Part 1 Data completeness: GP Practice	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.4%	99.5%	99.6%	99.9%	99.6%	
		Herefordshire	99.7%	99.7%	99.7%	99.7%	99.6%	
		Combined Actual	99.5%	99.6%	99.6%	99.9%	99.6%	

NHS Improvement Requirements

ID	Performance Measure (PM)		2016/17Outturn	July-2017	August-2017	September-2017	(Apr to Sep) Cumulative Compliance	Forecast 17/18 Outturn
1.12	**MENTAL HEALTH SERVICES DATA SET PART 2 DATA COMPLETENESS : OVERALL**	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	95.7%	95.2%	95.2%	95.0%	95.2%	
		Herefordshire	92.5%	90.3%	90.5%	90.8%	90.5%	
		Combined Actual	95.1%	94.2%	94.2%	94.2%	94.3%	
1.12a	Mental Health Services Data Set Part 2 Data completeness: CPA Employment status last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	90.0%	90.6%	90.3%	90.1%	90.7%	
		Herefordshire	89.2%	86.4%	86.4%	86.7%	86.4%	
		Combined Actual	89.9%	89.7%	89.5%	89.4%	89.8%	
1.12b	Mental Health Services Data Set Part 2 Data completeness: CPA Accommodation Status in last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	97.3%	96.8%	96.8%	96.6%	96.8%	
		Herefordshire	89.6%	87.0%	87.1%	87.4%	87.1%	
		Combined Actual	95.9%	94.9%	94.9%	94.8%	94.9%	
1.12c	Mental Health Services Data Set Part 2 Data completeness: CPA HoNOS assessment in last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	99.6%	98.2%	98.4%	98.3%	98.3%	
		Herefordshire	98.5%	97.6%	98.0%	98.3%	98.2%	
		Combined Actual	99.4%	98.0%	98.3%	98.3%	98.3%	
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	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
	Jul	Aug	Sep	
Total Measures	27	27	27	27
🔴	0	1	1	1
🟢	25	24	24	25
NYA	0	0	0	0
NYR	1	1	1	0
UR	0	0	0	0
N/A	1	1	1	1

Performance Thresholds not being achieved in Month

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

A 17 year old, presenting with psychosis and exhibiting aggressive behaviour to others and of risk to self, was admitted to Kingsholm Ward under section 2. They were discharged to an age appropriate bed 5 days later.

Cumulative Performance Thresholds Not being Met

2.21: No children under 18 admitted to adult inpatient wards
To date there have been 6 under 18s admitted to adult inpatient wards, 3 in Gloucestershire and 3 in Herefordshire.

Changes to Previously Reported Figures

None

Early Warnings

None

Note in relation to year end compliance predictions (forecast outturn)

2.21: No children under 18 admitted to adult inpatient wards

Unfortunately the annual performance threshold is zero and it has not been met therefore the performance for the year will be none compliant. Historic performance indicates that without changes in the tier 4 services arrangements - outside of the remit of ^{2}gether - we will not be able to meet this indicator.

DOH Never Events

ID	Performance Measure (PM)		2016/17Outturn	July-2017	August-2017	September-2017	(Apr to Sep) Cumulative Compliance	Forecast 17/18 Outturn
2								
2.01	Wrongly prepared high risk injectable medications	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.02	Maladministration of potassium containing solutions	PM	0	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	0
		Actual	0	0	0	0	0	
2.04	Intravenous administration of epidural medication	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.05	Maladministration of insulin	PM	0	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	0
		Actual	0	0	0	0	0	
2.07	Opioid overdose in opioid naive patient	PM	0	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	0
		Actual	0	0	0	0	0	
2.09	Suicide using non collapsible rails	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.10	Falls from unrestricted windows	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.11	Entrapment in bedrails	PM	0	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	0
		Actual	0	0	0	0	0	
2.13	Wrong gas administered	PM	0	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	0
		Actual	0	0	0	0	0	
2.15	Air embolism	PM	0	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	0
		Actual	0	0	0	0	0	
2.17	Mis-identification of patients	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	

DOH Requirements

ID	Performance Measure (PM)		2016/17Outturn	July-2017	August-2017	September-2017	(Apr to Sep) Cumulative Compliance	Forecast 17/18 Outturn
2.18	Mixed Sex Accommodation - Sleeping Accommodation Breaches	PM	0	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	0
		Gloucestershire	10	0	0	1	3	
		Herefordshire	8	0	1	0	3	
		Combined	18	0	1	1	6	
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 (PM)		2016/17Outturn	July-2017	August-2017	September-2017	(Apr to Sep) Cumulative Compliance	Forecast 17/18 Outturn
2.24	Serious Incident Reporting (SI)	Glos	35	3	3	2	17	
		Hereford	8	4	1	0	12	
2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	100%	100%	100%	100%	100%	
		Herefordshire	100%	100%	100%	N/A	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%	100%	100%
		Gloucestershire	91%	100%	100%	100%	100%	
		Herefordshire	78%	100%	100%	N/A	100%	
2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	100%	NYR	NYR	NYR	100%	
		Herefordshire	100%	NYR	NYR	NYR	100%	
2.28	SI Report Level 3 - Independent investigations - 6 months from investigation commissioned date	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	N/A	N/A	N/A	N/A	N/A	
		Herefordshire	N/A	N/A	N/A	N/A	N/A	
2.29	SI Final Reports outstanding but not due	Gloucestershire	2	3	2	2	7	
		Herefordshire	1	4	1	0	5	

DASHBOARD CATEGORY – GLOUCESTERSHIRE CCG CONTRACTUAL REQUIREMENTS

Gloucestershire Contract				
	In month Compliance			Cumulative Compliance
	Jul	Aug	Sep	
Total Measures	52	52	52	52
	1	1	1	2
	18	18	25	27
NYA	0	0	4	1
NYR	28	28	15	15
UR	0	0	0	0
N/A	5	5	7	7

Performance Thresholds not being achieved in Month

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.

Cumulative Performance Thresholds Not being Met

3.08: Reduce the number of detained patients absconding from inpatient units
There were 37 occasions recorded in quarter 1 against a threshold of 36. In the first quarter of 2016/17 there were 21 incidents and therefore this will be closely monitored throughout the year.

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

Changes to Previously Reported Figure

None

Early Warnings/Notes

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
It is recognised that this indicator no longer gives a meaningful indication of performance within the new pathway model and is therefore now excluded from reporting requirements, while discussions continue with our commissioner.

3.50- 3:53: Adolescent Eating Disorder treatment waiting times
These indicators are reported as "not yet available" for September. The service has only just begun to record interventions which allow the "clock stop" for the wait to be calculated. There are currently data quality issues with recording and there is on-going work with the service to correct these. .

Note in relation to year end compliance predictions (forecast outturn)

3.18 & 3.19: IAPT Recovery rate and IAPT Access rate:
See earlier note on Page 7.

3.38: Transition- Joint discharge/ CPA reviews meeting within 4 weeks of Adult MH services accepting:
This is a new indicator which still needs to be reported/agreed so outliers need to be considered when available. Only 1 young person was transitioned during Quarter 1.

3.39: Number and % of crisis assessments undertaken by the MHARS team on CYP age 16-25 with agreed timescales of 4 hours:
This is a new indicator which still needs to be reported/agreed so outliers need to be considered when available.

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	July-2017	August-2017	September-2017	(Apr to Sep) Cumulative Compliance	Forecast 17/18 Outturn
	B. NATIONAL QUALITY REQUIREMENT							
3.01	Zero tolerance MRSA	PM	0	0	0	0	0	0
		Unavoidable	1	0	0	0	0	
3.02	Minimise rates of Clostridium difficile	PM	0	0	0	0	0	0
		Unavoidable	1	0	0	0	0	
3.03	Duty of candour	PM	Report	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%	99%
		Actual	99%	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%	90%
		Actual	99%	100%	97%	98%	99%	
3.06	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	PM	90%	90%	90%	90%	90%	90%
		Actual	99%	100%	100%	100%	99%	
	C. Local Quality Requirements							
	Domain 1: Preventing People dying prematurely							
3.07	Increased focus on suicide prevention and reduction in the number of reported suicides in the community and inpatient units	PM	Report			Q2 Report	Q2 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	< 144			< 36	< 36	< 144
		Actual	96			NYA	37	
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	Report				Annual	Annual
		Actual	Compliant				NYR	
3.10	Minimum of 5% increase in uptake of flu vaccination (15/16 55.3%	PM	>55.3%				Annual	Annual
		Actual	77.2%				NYR	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	July-2017	August-2017	September-2017	(Apr to Sep) Cumulative Compliance	Forecast 17/18 Outturn
	Domain 2: Enhancing the quality of life of people with long-term conditions							
3.11	2G bed occupancy for Gloucestershire CCG patients	PM	> 91%	> 91%	> 91%	> 91%	> 91%	> 91%
		Actual	93%	92%	95%	92%	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%	95%
		Actual	99%	100%	100%	100%	100%	
3.13	CPA Review - 95% of those on CPA to be reviewed within 1 month (Review within 13 months)	PM	95%	95%	95%	95%	95%	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	95%			95%	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%	85%	85%
		Actual	95%			96%	96%	
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%	85%
		Actual	95%	98%	92%	96%	92%	
3.17	AKI (previous CQUIN 1516) 95% of pts to have EWS score within 12 hours	PM	95%			95%	95%	95%
		Actual	99%			95%	98%	
	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%	50%
		Actual	47%	51%	57%	53%	52%	
3.19	IAPT access rate: Access to psychological therapies for adults should be improved	PM	15.00%	1.25%	1.25%	1.25%	15.00%	15.00%
		Actual	8.20%	0.96%	1.24%	1.15%	13.80%	
3.20	IAPT reliable improvement rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%	50%
		Actual	73%	71%	73%	74%	72%	
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%	95%
		Actual	100%	NA	NA	NA	100%	
3.22	To send :Inpatient and day case discharge summaries electronically, within 24 hours to GP	PM	Report			TBC	TBC	Report
		Actual	Compliant			NYA	73%	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	July-2017	August-2017	September-2017	(Apr to Sep) Cumulative Compliance	Forecast 17/18 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	Report				Annual	Annual
		Actual	Compliant				NYR	
	CYPS							
3.24	Number of children that received support within 24 hours of referral, for crisis home treatment (CYPS)	PM	95%			95%	95%	95%
		Actual	N/A			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%	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%	95%
		Actual	99%			98%	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%	80%
		Actual	89%			93%	94%	
3.28	Level 2 and 3 – Referral to treatment within 10 weeks (excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	90%			95%	95%	95%
		Actual	96%			98%	98%	
3.29	Adults of working age - 100% of MDT assessments to have been completed within 4 weeks (or in the case of a comprehensive	PM	85%	85%	85%	85%	85%	85%
		Actual	94%	88%	91%	89%	91%	
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%	85%
		Actual	65%					

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	July-2017	August-2017	September-2017	(Apr to Sep) Cumulative Compliance	Forecast 17/18 Outturn
	Vocational Services (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%	98%
		Actual	100%			NYA	NYA	
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	52%				NYR	
3.33	The number of people retaining employment at 3/6/9/12+ months (measured as a percentage of individuals placed into employment retaining employment) (IPS)	PM	50%				50%	50%
		Actual	66%				NYR	
3.34	The number of people supported to retain employment at 3/6/9/12+ months	PM	50%				50%	50%
		Actual	88%				NYR	
3.35	Fidelity to the IPS model	PM	Report				90%	90%
		Actual	Compliant				NYR	
	General Quality Requirements							
3.36	GP practices will have an individual annual (MH) ICT service meeting to review delivery and identify priorities for future.	PM	Annual				Annual	Annual
		Actual	NYA				NYR	
3.37	Care plan audit to show : All dependent Children and YP <18 living with adults know to Recovery, MAHRS, Eating Disorder and Assertive Outreach Services. Recorded evidence in care plans of impact of the mental health disorder on those under 18s plus steps put in place to support.(Think family)	PM	Qtr 4			TBC	TBC	Report
		Actual	Compliant			NYA	52%	
3.38	Transition- Joint discharge/CPA review meeting within 4 weeks of adult MH services accepting :working diagnosis to be agreed, adult MH care coordinator allocated and care cluster and risk levels agreed as well as CYPS discharge date.	PM	100%			100%	100%	100%
		Actual	0%			N/A	100%	
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%	90%
		Actual	NYR				NYR	
3.40	MHARS wait time to assessment (4 hours)	PM	TBC				TBC	TBC
		Actual	NYR				NYR	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	July-2017	August-2017	September-2017	(Apr to Sep) Cumulative Compliance	Forecast 17/18 Outturn
	New KPIs for 2017/18							
3.41	LD: To deliver specialist support to people with learning disabilities in accordance with specifically developed pathways	PM					95%	95%
		Actual					NYR	
3.42	LD: To demonstrate a reduction in an individual's health inequalities thanks to the clinical intervention provided by 2gether learning disability services.	PM					TBC	TBC
		Actual					NYR	
3.43	LD: People with learning disabilities and their families report high levels of satisfaction with specialist learning disability services	PM					75%	75%
		Actual					NYR	
3.44	LD: To ensure all published clinical pathways accessed by people with learning disabilities are available in easy read versions	PM					95%	95%
		Actual					NYR	
3.45	LD: The CLDT will take a proactive and supportive role in ensuring the % uptake of Annual Health Checks for people with learning disabilities on their caseload is high	PM					75%	75%
		Actual					NYR	
3.46	Gloucestershire Sanctuary (Alexandra Road Wellbeing House) dataset available for Commissioners	PM		Report	Report	Report	Report	Report
		Actual		Compliant	Compliant	Compliant	Compliant	
3.47	IAPT DNA rate	PM		<16%	<16%	<16%	<16%	<16%
		Actual		13%	13%	13%	13%	
3.48	CPI: Referral to Assessment within 4 weeks	PM		80%	80%	80%	80%	80%
		Actual		87%	83%	94%	88%	
3.49	CPI: Assessment to Treatment within 16 weeks	PM		80%	80%	80%	80%	80%
		Actual		100%	100%	98%	98%	
3.50	Adolesecent Eating Disorders - Urgent referral to NICE treatment start within 1 week	PM		TBC	TBC	TBC	TBC	TBC
		Actual		N/A	NYA	NYA	50%	
3.51	Adolesecent Eating Disorders - Urgent referral to non-NICE treatment start within 1 week	PM		TBC	TBC	TBC	TBC	TBC
		Actual		N/A	NYA	NYA	N/A	
3.52	Adolesecent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	PM		TBC	TBC	TBC	TBC	TBC
		Actual		29%	NYA	NYA	32%	
3.53	Adolesecent Eating Disorders - Routine referral to non-NICE treatment start within 4 weeks	PM		TBC	TBC	TBC	TBC	TBC
		Actual		N/A	NYA	NYA	0%	

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

2.21 – No children under 18 admitted to adult inpatient wards
There was 1 admission of an under 18 to an adult ward during September in Gloucestershire.

A 17 year old, presenting with psychosis and exhibiting aggressive behaviour to others and of risk to self, was admitted to Kingsholm Ward under section 2. They were discharged to an age appropriate bed 5 days later.

Changes to Previously Reported Figures

None

Note in relation to year end compliance predictions (forecast outturn)

1.09 & 1.10: IAPT: Waiting times - Referral to Treatment within 6 & 18 weeks
See earlier note on Page7.

2.21: No children under 18 admitted to adult inpatient wards
See earlier note on Page 12.

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

ID	Performance Measure (PM)		2016/17Outturn	July-2017	August-2017	September-2017	(Apr to Sep) Cumulative Compliance	Forecast 17/18 Outturn
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	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	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%	95%
		Actual	98%	98%	99%	100%	99%	
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	1.6%	2.5%	7%	4%	2.6%	
NHSI 1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	100%	100%	100%	100%	
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%	50%
		Actual	72%	67%	43%	82%	74%	
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Actual	35%	70%	72%	67%	66%	
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Actual	86%	87%	88%	88%	87%	
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	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	0
		Actual	10	0	0	1	3	
DoH 2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%	100%
		Actual	100%	100%	100%	100%	100%	
DoH 2.26	Interim report for all SIs received within 5 working days of identification (unless extension granted by CCG)	PM	100%	100%	100%	N/A	100%	100%
		Actual	91%	100%	100%	100%	100%	
DoH 2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM	91%	100%	100%	100%	100%	100%
		Actual	100%	NYR	NYR	NYR	100%	

DASHBOARD CATEGORY – GLOUCESTERSHIRE SOCIAL CARE

Gloucestershire Social Care				
	In month Compliance			Cumulative Compliance
	Jul	Aug	Sep	
Total Measures	15	15	15	15
	1	1	1	1
	12	12	12	12
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

4.02 – Percentage of people receiving long-term services in a residential or community care setting reviewed/re-assessed within a year
There are 13 cases that are not recorded as having been reviewed/ re-assessed. The majority of these (8) were due to late data entry and will be updated by service delivery colleagues. Once RiO has been updated, performance will be compliant at 97%.

Cumulative Performance Thresholds Not being Met

4.03 – Ensure that reviews of new packages take place within 12 weeks
Previous data quality and reporting issues in earlier months has led to this indicator being cumulatively non-compliant. These issues are now being addressed and performance is reported as 100% for September.

Changes to Previously Reported Figures

4.07 – Percentage with a carer that have been offered a carer's assessment
Improvements in the recording of the number of carers that have been offered a carer's assessment has meant that the reported performance for August has risen from 79% (non-compliant) to 90% (compliant) thanks to the focused work of service delivery teams.

Early Warnings/Notes
None

Note in relation to year end compliance predictions (forecast outturn)

4.03 – Ensure that reviews of new packages take place within 12 weeks
Data quality and reporting issues need to be reviewed for several months before we know what this year-end performance can be forecast as.

Gloucestershire Social Care

ID	Performance Measure		2016/17 outturn	July-2017	August-2017	September-2017	(Apr to Sep) Cumulative Compliance	Forecast 17/18 Outturn
4.01	The percentage of people who have a Cluster recorded on their record	PM	90%	TBC	TBC	TBC	90%	90%
		Actual	96%	97%	98%	97%	98%	
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%	95%
		Actual	95%	97%	95%	93%	97%	
4.03	Ensure that reviews of new packages take place within 12 weeks of commencement	PM	95%	80%	95%	95%	80%	80%
		Actual	22%	90%	75%	100%	71%	
4.04	Current placements aged 18-64 to residential and nursing care homes per 100,000 population	PM	13	13	13	13	13	13
		Actual	12.90	9.36	9.36	9.10	9.36	
4.05	Current placements aged 65+ to residential and nursing care homes per 100,000 population	PM	22	22	22	22	22	22
		Actual	16.55	14.78	14.78	15.56	14.91	
4.06	% of WA & OP service users on caseload asked if they have a carer	PM	100%	80%	80%	80%	80%	100%
			86%	82%	82%	82%	82%	
4.07	% of WA & OP service users on the caseload who have a carer, who have been offered a carer's assessment	PM	100%	90%	90%	90%	90%	100%
		Actual	75%	89%	90%	92%	92%	
4.08a	% of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC	TBC
		Actual	39%	41%	42%	42%	42%	
4.08b	Number of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC	TBC
		Actual	244	387	418	440	440	
4.09	% of eligible service users with Personal budgets	PM	80%	80%	80%	80%	80%	80%
		Actual	100%	93%	93%	93%	92%	

Gloucestershire Social Care

ID	Performance Measure		2016/17 outturn	July-2017	August-2017	September-2017	(Apr to Sep) Cumulative Compliance	Forecast 17/18 Outturn
4.10	% of eligible service users with Personal Budget receiving Direct Payments (ASCOF 1C pt2)	PM	15%	15%	15%	15%	15%	15%
		Actual	18%	21%	20%	20%	20%	
4.11	Adults subject to CPA in contact with secondary mental health services in settled accommodation (ASCOF 1H)	PM	80%	80%	80%	80%	80%	80%
		Actual	89%	88%	89%	88%	88%	
4.12	Adults not subject to CPA in contact with secondary mental health service in settled accommodation	PM	90%	90%	90%	90%	90%	90%
		Actual	96%	96%	96%	96%	96%	
4.13	Adults subject to CPA receiving secondary mental health service in employment (ASCOF 1F)	PM	13%	13%	13%	13%	13%	13%
		Actual	16%	15%	16%	15%	15%	
4.14	Adults not subject to CPA receiving secondary mental health service in employment	PM	20%	20%	20%	20%	20%	20%
		Actual	24%	22%	22%	23%	23%	

DASHBOARD CATEGORY – HEREFORDSHIRE CCG CONTRACTUAL REQUIREMENTS

Herefordshire Contract				
	In month Compliance			Cumulative Compliance
	Jul	Aug	Sep	
Total Measures	22	22	22	22
	2	2	3	3
	15	13	12	14
NYA	0	0	4	0
NYR	0	0	0	0
UR	0	0	0	0
N/A	5	7	3	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.

5.12: All admitted patients aged 65+ should have a completed MUST assessment
There was 1 patient in September that did not have a completed MUST assessment recorded within the clinical system RiO. This was due to late data entry and it has been confirmed that it was complete. Once RiO is updated this indicator will be 100% compliant.

5.13: Attendances at Emergency Departments should have an assessment within 2 hours
There were 6 non-compliant cases in September:

Five were due to staff shortages within the team due to a vacancy and sick leave. Each of the five cases has been reviewed and there has been no known untoward clinical impact from the breach.

The other client absconded before they were able to be assessed. Discussions are on-going as to whether this should have been recorded as a DNA (did not attend) and thereby excluded from the indicator.

Cumulative Performance Thresholds Not being

5.08: IAPT: Recovery rate
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

5.17: CYP Eating Disorders: Treatment waiting times for urgent referrals within 1 week – NICE treatments
There was 1 treatment started in June. The client's family were contacted on day 7 with an offer to be seen that day however the service were unable to get a response. When the family did respond an appointment was agreed for the following week and treatment was started at that appointment.

Changes to Previously Reported Figures

None

Early Warnings / Notes

None

Note in relation to year end compliance predictions (forecast outturn)

5.09: IAPT roll-out (access rate) – IAPT maintain 15% of patient entering the service against prevalence:
See earlier note on Page 7.

5.15 & 5.16: CYP Eating Disorders: Treatment waiting time for patient referrals within 4 weeks: Discussions with Commissioners around whether the service has resources to meet this target need to be resolved before year end forecast can be confirmed

5.17 & 5.18: CYP Eating Disorders: Treatment waiting time for patient referrals within 1 week: Discussions with Commissioners around whether the service has resources to meet this target need to be resolved before year end forecast can be confirmed

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 Outturn	July-2017	August-2017	September-2017	(Apr to Sep) Cumulative Compliance	Forecast 17/18 Outturn
5.01	Duty of Candour	Plan	Report	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant	Compliant	Compliant	
5.02	Completion of a valid NHS number field in metal health and acute commissioning data sets submitted via SUS.	Plan	99%	99%	99%	99%	99%	99%
		Actual	99%	99%	99%	99%	99%	
5.03	Completion of Mental Health Services Data Set ethnicity coding for all service users	Plan	90%	90%	90%	90%	90%	90%
		Actual	100%	100%	98%	96%	98%	
5.04	Completion of IAPT Minimum Data Set outcome data for all appropriate service users	Plan	90%	90%	90%	90%	90%	90%
		Actual	99%	100%	100%	100%	100%	
5.05	Zero tolerance MRSA	Plan	0	0	0	0	0	0
		Unavoidable	0	0	0	0	0	
5.06	Minimise rates of Clostridium difficile	Plan	0	0	0	0	0	0
		Unavoidable	1	0	0	0	0	
5.07	VTE risk assessment: all inpatient service users to undergo risk assessment for VTE	Plan	95%	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%	50%
		Actual	43%	52%	39%	55%	49%	
5.09	IAPT Roll-out (Access Rate) - IAPT maintain 15% of patient entering the service against prevalence	Plan	2178	726	908	1,089	1089	2178
		Actual	1,191	616	827	1,010	1,010	

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 Outturn	July-2017	August-2017	September-2017	(Apr to Sep) Cumulative Compliance	Forecast 17/18 Outturn
5.10a	Dementia Service - number of new patients aged 65 years and over receiving an assessment	Plan	540	45	45	45	270	540
		Actual	572	56	67	47	310	
5.10b	Dementia Service - total number of new patients receiving an assessment	Plan						
		Actual	610	63	69	52	330	
5.11	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%	80%
		Actual	100%	100%	100%	100%	100%	
5.12	All admitted patients aged 65 years of age and over must have a completed MUST assessment	Plan	95%	95%	95%	95%	95%	95%
		Actual	98%	100%	100%	75%	97%	
5.13	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%	80%	80%
		Actual	88%	75%	91%	73%	87%	
5.14	Attendances at ED, wards and clinics for self-harm receive a mental health assessment	Plan	85%	85%	85%	85%	85%	85%
		Actual	98%	92%	100%	86%	95%	

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 Outturn	July-2017	August-2017	September-2017	(Apr to Sep) Cumulative Compliance	Forecast 17/18 Outturn
New KPIs for 2017/18								
5.15	CYP Eating Disorders: Treatment waiting time for routine referrals within 4 weeks - NICE treatments	Plan		95%	95%	95%	95%	95%
		Actual		100%	100%	100%	100%	
5.16	CYP Eating Disorders: Treatment waiting time for routine referrals within 4 weeks - non-NICE treatments	Plan		95%	95%	95%	95%	95%
		Actual		N/A	N/A	N/A	N/A	
5.17	CYP Eating Disorders: Treatment waiting time for urgent referrals within 1 week - NICE treatments	Plan		95%	95%	95%	95%	95%
		Actual		100%	N/A	NYA	50%	
5.18	CYP Eating Disorders: Treatment waiting time for urgent referrals within 1 week - non-NICE treatments	Plan		95%	95%	95%	95%	95%
		Actual		100%	N/A	NYA	100%	

Herefordshire Carers Information

ID	Performance Measure		2016/17 Outturn	July-2016	August-2016	September-2016 / Quarter 2	(Apr to Sep) Cumulative Compliance	Forecast 17/18 Outturn
5.19	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	41%	54%	56%	57%	57%	
5.20	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	58%	62%	62%	61%	61%	
5.21	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	35%	38%	36%	36%	36%	

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.

Note in relation to year end compliance predictions (forecast outturn)

1.09 & 1.10: IAPT: Waiting times - Referral to Treatment within 6 & 18 weeks
See earlier note on Page 7.

2.21: No children under 18 admitted to adult inpatient wards
See earlier note on Page 12.

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

ID	Performance Measure (PM)		2016/17Outturn	July-2017	August-2017	September-2017	(Apr to Sep) Cumulative Compliance	Forecast 17/18 Outturn
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	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	0
		Actual	3	0	0	0	0	
NHSI 1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	100%	97%	95%	98%	
NHSI 1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	98%	99%	98%	97%	
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	2.2%	2.7%	2.7%	2.4%	1.9%	
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%	50%
		Actual	70%	100%	N/A	67%	68%	
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Actual	49%	65%	58%	62%	55%	
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Actual	85%	78%	73%	72%	78%	
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	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	0
		Actual	8	0	1	0	3	

DASHBOARD CATEGORY – GLOUCESTERSHIRE CQUINS

Gloucestershire CQUINS				
	In month Compliance			Cumulative Compliance
	Jul	Aug	Sep	
Total Measures	12	12	12	12
	0	0	0	0
	0	0	8	9
NYA	0	0	0	0
NYR	12	12	4	3
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 (PM)		2016/17Outturn	July-2017	August-2017	September-2017	(Apr to Sep) Cumulative Compliance	Forecast 17/18 Outturn
	CQUIN 1							
7.01a	Improvement of health and wellbeing of NHS Staff	PM				Report	Report	Report
		Actual				NYR	NYR	
7.01b	Healthy food for NHS staff, visitors and patients	PM				Report	Report	Report
		Actual				NYR	NYR	
7.01c	Improving the update of flu vaccinations for frontline clinical staff	PM				Report	Report	Report
		Actual				NYR	NYR	
	CQUIN 2							
7.02a	Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with psychoses	PM				Report	Qtr 1	Report
		Actual				NYR	Awarded	
7.02b	Improving Physical healthcare to reduce premature mortality in people with SMI: Collaboration with primary care clinicians	PM				Report	Qtr 2	Report
		Actual				Compliant	Compliant	
	CQUIN 3							
7.03	Improving services for people with mental health needs who present to A&E	PM				Report	Qtr 2	Report
		Actual				Compliant	Compliant	
	CQUIN 4							
7.04	Transition from Young People's Service to Adult Mental Health Services	PM	Qtr 4			Report	Qtr 2	Report
		Actual	Compliant			Compliant	Compliant	
	CQUIN 5							
7.05a	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco screening	PM				Report	Qtr 2	Report
		Actual				Compliant	Compliant	
7.05b	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco brief advice	PM				Report	Qtr 2	Report
		Actual				Compliant	Compliant	
7.05c	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco referral and medication	PM				Report	Qtr 2	Report
		Actual				Compliant	Compliant	
7.05d	Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol screening	PM				Report	Qtr 2	Report
		Actual				Compliant	Compliant	
7.05e	Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol brief advice or referral	PM				Report	Qtr 2	Report
		Actual				Compliant	Compliant	

DASHBOARD CATEGORY – LOW SECURE CQUINS

Low Secure CQUINS				
	In month Compliance			Cumulative Compliance
	Jul	Aug	Sep	
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 (PM)		2016/17Outturn	July-2017	August-2017	September-2017	(Apr to Sep) Cumulative Compliance	Forecast 17/18 Outturn
	CQUIN 1							
8.01	Reducing the length of stay in specialised MH services	PM	Qtr 4			Report	Qtr 2	Report
		Actual	Compliant			Compliant	Compliant	

DASHBOARD CATEGORY – HEREFORDSHIRE CQUINS

Herefordshire CQUINS				
	In month Compliance			Cumulative Compliance
	Jul	Aug	Sep	
Total Measures	12	12	12	12
🔴	0	0	0	0
🟢	0	0	8	9
NYA	0	0	0	0
NYR	12	12	4	3
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
None

Early Warnings
None

Herefordshire CQUINS

ID	Performance Measure (PM)		2016/17Outturn	July-2017	August-2017	September-2017	(Apr to Aug) Cumulative Compliance	Forecast 17/18 Outturn
	CQUIN 1							
9.01a	Improvement of health and wellbeing of NHS Staff	PM	Qtr 4			Report	Report	Report
		Actual	Compliant			NYR	NYR	
9.01b	Healthy food for NHS Staff, Visitors and Patients	PM	Qtr 4			Report	Report	Report
		Actual	Compliant			NYR	NYR	
9.01c	Improving the uptake of Flu vaccinations for Front Line Clinical Staff	PM	Qtr 4			Report	Report	Report
		Actual	Compliant			NYR	NYR	
	CQUIN 2							
9.02a	Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with psychoses	PM	Qtr 3			Report	Report	Report
		Actual	Compliant			NYR	Awarded	
9.02b	Improving Physical healthcare to reduce premature mortality in people with SMI: Collaborating with primary care clinicians	PM				Report	Qtr 2	Report
		Actual				Compliant	Compliant	
	CQUIN 3							
9.03	Improving services for people with mental health needs who present to A&E	PM				Report	Qtr 2	Report
		Actual				Compliant	Compliant	
	CQUIN 4							
9.04	Transition from Young People's Service to Adult Mental Health Services	PM				Report	Qtr 2	Report
		Actual				Compliant	Compliant	
	CQUIN 5							
9.05a	Tobacco screening	PM				Report	Qtr 2	Report
		Actual				Compliant	Compliant	
9.05b	Tobacco brief advice	PM				Report	Qtr 2	Report
		Actual				Compliant	Compliant	
9.05c	Tobacco referral and medication offer	PM				Report	Qtr 2	Report
		Actual				Compliant	Compliant	
9.05d	Alcohol screening	PM				Report	Qtr 2	Report
		Actual				Compliant	Compliant	
9.05e	Alcohol brief advice or referral	PM				Report	Qtr 2	Report
		Actual				Compliant	Compliant	

Agenda item 8 **Enclosure Paper C**

Report to: Trust Board, 30th November 2017
Author: Dr Chris Fear, Medical Director and Paul Ryder, Patient Safety Manager
Presented by: Dr Chris Fear, Medical Director

SUBJECT: **Mortality Review 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**

EXECUTIVE SUMMARY

The data presented below represent the first draft of those available for the period April to August 2017. During this period there were 161 patient deaths recorded, of which 129 (80.1%) required table-top review only, 20 (12.5%) were closed after a case record review and 12 (7.5%) were notified as Serious Incidents.

No deaths were considered to have involved problems in care either within this or partner organisations.

This, the first iteration of mortality review data under the Learning from Deaths policy provides some assurance about the progress of this process within 2gether. A further paper, due in 3 months, will be expanded to provide further information as required by the policy.

The Board is asked to note the contents for information and to recognise that this is at an early stage and that processes in partner organisations, and in primary care are less developed to date. A work-stream is being developed by the Strategic Transformation Partnership.

RECOMMENDATIONS

The Board is asked to note the contents of this first Mortality Review Report which covers quarter 1 of 17-18.

Corporate Considerations	
Quality implications	Required by National Guidance to support system learning
Resource implications:	Significant time commitment from clinical and administrative staff
Equalities implications:	None
Risk implications:	None

WHICH TRUST STRATEGIC OBJECTIVE(S) DOES THIS PAPER PROGRESS OR CHALLENGE?	
Continuously Improving Quality	Yes
Increasing Engagement	No
Ensuring Sustainability	No

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

Reviewed by:		
Dr Chris Fear	Date	19th November 2017

Where in the Trust has this been discussed before?		
Mortality Review Committee	Date	Q1 17-18

What consultation has there been?		
	Date	

Explanation of acronyms used:	

1. INTRODUCTION

1.1 In accordance with national guidance and legislation, the Trust currently reports all incidents and near misses, irrespective of the outcome, which affect one or more persons, related to service users, staff, students, contractors or visitors to Trust premises; or involve equipment, buildings or property. This arrangement is set out in the Trust policy on reporting and managing incidents.

1.2 In March 2017, the National Quality Board published its *National Guidance on Learning from Deaths: a Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care*. This guidance sets out mandatory standards for organisations in the collecting of data, review and investigation, and publication of information relating to the deaths of patients under their care.

1.3 From Quarter 3 2017, the Trust Board will receive a quarterly (or as prescribed nationally) dashboard report to a public meeting, following the format of Appendix D, including:

- number of deaths
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework (and declared as serious incidents)
- number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care
- themes and issues identified from review and investigation (including examples of good practice)
- actions taken in response, actions planned and an assessment of the impact of actions taken.

1.4 From June 2018, the Trust will publish an annual overview of this information in Quality Accounts, including a more detailed narrative account of the learning from reviews/investigations, actions taken in the preceding year, an assessment of their impact and actions planned for the next year

1.5 This paper offers the first iteration of data for the period April to August 2017.

2. PROCESS

2.1 All 2gether Trust staff are required to notify, using the Datix process, the deaths of any Trust patients. This comprises anyone who dies within 30 days of receiving care from 2gether. Deaths recorded on Datix are collated for discussion at the monthly Mortality Review Meeting chaired by the lead Clinical Directors. The Trust's Information Department also provides a monthly report detailing any patients discharged from inpatient care who have died within a 30 day period after discharge. These data are compiled from RiO and provided to the Mortality Review Meeting.

2.2 For each reported death, a table-top review is conducted, identifying the following information: cause of death (from e.g. GP or Coroner), location of death, who certified death, any family concerns, any known details of health deterioration immediately prior to death.

2.3 Based upon the information provided, patient deaths are assigned to one of the six categories developed by the Mazars report into Southern Health NHS Foundation Trust (2015).

2.4 Expected Natural deaths (EN1 & EN2) are sorted into those where there may be concerns and those where no possible concerns are identified. Unexpected Natural deaths (UN1 & UN2) are subjected to a case record review and sorted into those where there may be concerns and those where no possible concerns are identified.

Type	Description
Expected Natural (EN1)	A group of deaths that were expected to occur in an expected time frame. E.g. people with terminal illness or in palliative care services. These deaths would not be investigated but could be included in a mortality review of early deaths amongst service users.
Expected Natural (EN2)	A group of deaths that were expected but were not expected to happen in that timeframe. E.g. someone with cancer but who dies much earlier than anticipated These deaths should be reviewed and in some cases would benefit from further investigation
Expected Unnatural (EU)	A group of deaths that are expected but not from the cause expected or timescale E.g. some people on drugs or dependent on alcohol or with an eating disorder These deaths should be investigated.
Unexpected Natural (UN1	Unexpected deaths which are from a natural cause e.g. a sudden cardiac condition or stroke These deaths should be reviewed and some may need an investigation.
Unexpected Natural (UN2)	Unexpected deaths which are from a natural cause but which didn't need to be e.g. some alcohol dependency and where there may have been care concerns These deaths should all be reviewed and a proportion will need to be investigated
Unexpected Unnatural (UU)	Unexpected deaths which are from unnatural causes e.g. suicide, homicide, abuse or neglect These deaths are likely to need investigating

2.5 All Unnatural deaths (EU & UU) are discussed, individually with the Patient Safety manager to identify those that fall into the category of serious incidents requiring investigation, within statute, and according to the relevant Trust policy. Where there appears to be further information required or learning to be derived, incidents that do not require a serious incident review are notified to the relevant team manager for a clinical incident review. The remaining incidents are sorted into those where there may be concerns and those where no possible concerns are identified.

2.6 Where no concerns are identified, the datix incident is closed without further action.

2.7 Where concerns are raised, the case is be elevated to the clinical leads for review and, depending upon the outcome, can be treated as a serious incident, referred for multiagency review or notified to the relevant team manager for a clinical incident review.

2.8 The data obtained will be subjected to a modified version of the structured judgement review methodology defined by the Royal College of Physicians and assigned to one of three categories:

Category 1: "not due to problems in care"

Category 2: "possibly due to problems in care within ^{2}gether"

Category 3: "possibly due to problems in care within an external organisation"

2.9 For those deaths that fall into Category 2, learning is collated and an action plan developed to be progressed through operational and clinical leads and reported to Governance Committee. For Category 3, the issues identified are escalated to local partner organisations through the relevant Clinical Commissioning Group lead for mortality review. For distant organisations, issues will be shared with the local lead for learning from deaths within the organisation.

2.10 All deaths of patients with a learning disability will be also reported through the appropriate Learning Disabilities Mortality Review Program (LeDeR) process, and deaths of people under the age of 18 will be reported through the current child death reporting methodology.

3. DATA

3.1 The data presented below represent the first draft of those available for the period April to August 2017. During this period there were 161 patient deaths recorded, of which 129 (80.1%) required table-top review only, 20 (12.5%) were closed after a case record review and 12 (7.5%) were notified as Serious Incidents.

3.2 No deaths were considered to have involved problems in care either within this or partner organisations.

4. CONCLUSION

4.1 This, the first iteration of mortality review data under the Learning from Deaths policy provide some assurance about the progress of this process within 2gether. A further paper, due in 3 months, will be expanded to provide further information as required by the policy.

4.2 The Board is asked to note the contents for information and to recognise that this is at an early stage and that processes in partner organisations, and in primary care are less developed to date. A work-stream is being developed by the Strategic Transformation Partnership.

Closed Mortality Reviews											
Month	Closed Following Table-Top Review Only			Closed Following Care Record Review			Closed Following Serious Incident Review			Total	Quarterly Total
	Category 1: Not Due to Problems in Care	Category 2: Possibly Due to Problems in Care within 2gether	Category 3: Possibly Due to Problems in Care Within an External Organisation	Category 1: Not Due to Problems in Care	Category 2: Possibly Due to Problems in Care within 2gether	Category 3: Possibly Due to Problems in Care Within an External Organisation	Category 1: Not Due to Problems in Care	Category 2: Possibly Due to Problems in Care within 2gether	Category 3: Possibly Due to Problems in Care Within an External Organisation		
Apr-17	31	0	0	10	0	0	4	0	0	**45**	**140**
May-17	46	0	0	7	0	0	3	0	0	**56**	
Jun-17	36	0	0	1	0	0	2	0	0	**39**	
Jul-17	15	0	0	2	0	0	2	0	0	**19**	**21**
Aug-17	1	0	0	0	0	0	1	0	0	**2**	
Sep-17										**0**	
Oct-17										**0**	**0**
Nov-17										**0**	
Dec-17										**0**	
Jan-18										**0**	**0**
Feb-18										**0**	
Mar-18										**0**	
	129	**0**	**0**	**20**	**0**	**0**	**12**	**0**	**0**	**161**	

Agenda Item: 9 **Enclosure Number:** D

Report to: [2]gether NHS Foundation Trust Board – 30 November 2017
Author: Angie Fletcher, Service Experience Clinical Manager
Presented by: Jane Melton, Director of Engagement and Integration

Subject: **Service Experience Report Quarter 2 2017/18**

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 2 2017/18. Learning from people's experiences is the key purpose of this paper. Assurance is offered that service experience information has been reviewed, scrutinised for themes, and considered for both service-specific and general learning across the organisation.

Significant assurance that the organisation has listened to, heard and understood Service User and carer experience of [2]gether'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 2, 88% of people who completed the Friends and Family Test said that they would recommend [2]gether's services. The Trust continues to maintain a high percentage of people who would recommend our services, with results generally exceeding national scores.

Limited assurance that people are participating in the local survey of quality in sufficient numbers.
The new **How did we do?** Survey was launched during Quarter 1 of this year. Whilst feedback given by respondents has generally been positive, response rates remain low than hoped for. It is anticipated that response rates will rise due to the implementation of the SMS survey during Quarter 3.

Significant assurance that services are consistently reporting details of compliments they have received.
Compliments continue to be reported to the Service Experience Department.

Numbers have increased during Quarter 2 and work continues to increase reporting by colleagues throughout the Trust.

<u>Full Assurance</u> that complaints have been acknowledged in required timescale
During Quarter 2 100% 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.
93% of complaints were closed within timescales agreed with the complainant. This is continued good progress from the past two quarters: Quarter 1 (17/18) n=81% and Quarter 4 (16/17) n=78%.

<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 and complaint themes continue to focus on communication issues by our services with service users and/or their carers. Colleagues across the Trust are working hard to develop practice in this area – the continued implementation of the Triangle of Care being an example of this.

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

- We must get in touch with people when we say we will.
- We must tell people when the staff they usually see are away from work. We must tell them who they will see instead

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

RECOMMENDATIONS

The 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 ^{2}gether's services in Q2 2017/18 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	09/10/17

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

Explanation of acronyms used:	
NHS	National Health Service
PALS	Patient Advice and Liaison Service
CYPS	Children and Young People Service
HR	Human Resources
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
CAMHS	Child and Adolescent Mental Health Service
MHA	Mental Health Act
MCA	Mental Capacity Act
CCG	Clinical Commissioning Group
Q1	Quarter 1 (previous quarter 2017/18)
FFT	Friends and Family Test (survey)

2gether
Making life better

2gether
NHS Foundation Trust

Service Experience Report

Quarter 2

1st July 2017 to 30th September 2017

"I really felt the counsellor made every effort to understand my particular difficulty and made an insightful observation about mine and other's behaviours. CBT techniques were much more helpful this time in breaking down and tracking difficult problems so now I feel confident and continue using their methods myself.**"**

Let's Talk, Herefordshire

"Helped me a lot being able to talk to someone independently about what I was going through and how to self soothe. The staff member was very easy to talk to.**"**

Let's Talk, Gloucestershire

Contents

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1.2 Strategic context

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2.3 Compliments
2.4 Parliamentary and Health Service Ombudsman (PHSO)
2.5 Surveys
- 2.5.1 How did we do? survey
- 2.5.2 How did we do? - Friends and Family Test (FFT) Service User/ Carer feedback
- 2.5.3 How did we do? - Friends and Family Test (FFT) Staff feedback
- 2.5.4 How did we do? - Quality Survey questions
- 2.5.5 Improving Access to Psychological Therapies Patient Experience Questionnaire (IAPT PEQ)
- 2.5.6 Children and Young People Services

Section 3 – Learning from reported Service Experience
3.1 Learning themes emerging from individual complaints
3.2 Aggregated learning themes emerging from feedback from this quarter
3.3 Aggregated learning themes emerging from feedback from last quarter

Key

NHS	National Health Service
PALS	Patient Advice and Liaison Service
CYPS	Children and Young People Service
HR	Human Resources
CEO	Chief Executive Officer
BME	Black and Minority Ethnic Groups
IAPT	Improving access to psychological therapies
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Q1	Quarter 1 (previous quarter 2017/18)
FFT	Friends and Family Test (survey)

Service Experience Report – Quarter 2

1st July 2017 to 30th September 2017

Complaints 	**19** complaints (65 separate issues) were made this quarter. This is more than last time (n=16). We want people to tell us about any worries about their care. This means we can make it better.	↑
Concerns 	**44** concerns were raised through PALS. This is less than last time (n=55).	↓
Compliments 	**449** people told us they were pleased with our service. This is more than last time (n=420). We want teams to tell us about every compliment they get.	↑
FFT 	**88%** of people said they would recommend our service to their family or friends. This is nearly the same as last time (90%).	↔
Quality Survey 	Gloucestershire: **28 people told us what they thought** Herefordshire: **50 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 replies)
We must listen 	We must get in touch with people when we say we will. We must tell people when the staff they usually see are away. We must tell them who they will see instead.	

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 [2]gether NHS Foundation Trust's services between **1st July 2017 and 30th September 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 [2]gether NHS Trust
- Patient Advice and Liaison Service (PALS)
- Meetings with stakeholders
- [2]gether quality surveys
- National Friends and Family Test (FFT) responses

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]), 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.

You said – We did

A shared goal to listen to, respond to, and improve service experience; through a continuous cycle of learning from experience we will provide the best quality service experience and care.

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.

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

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

Section 2 – Emerging Themes about Service Experience

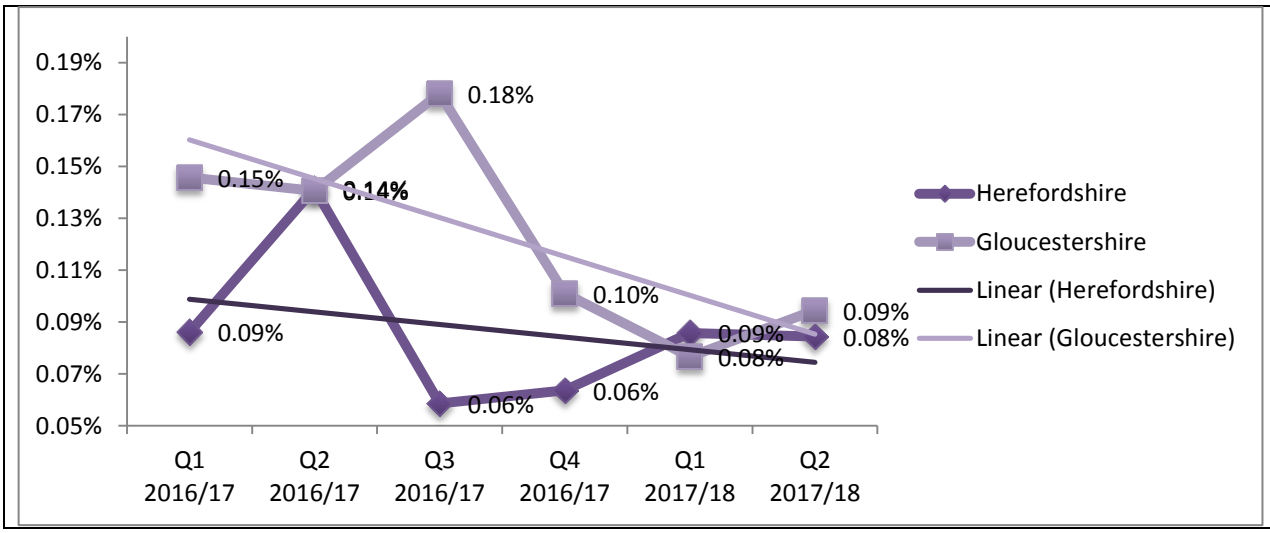
2.1 Complaints

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). We value feedback from those in contact with our services as this enables us to make services even more responsive and supportive. We encourage people to let us know if they are concerned so that we can resolve at the earliest possible opportunity.

Table 1: Number of complaints received this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	16	↑	An increase in the number of complaints has been reported in Gloucestershire in Q2 (Q1 n=13)	Significant
Herefordshire	3	↔	The same number of complaints has been reported in Herefordshire in Q2 (Q1 n=3).	Significant
Total	19	↑	The total number of complaints received is higher than the previous quarter (Q1 n=16)	Significant

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



The proportion of complaints to contacts has fluctuated minimally over time, remaining low and relatively consistent.

Table 2: Responsiveness

Target	Number (numerical direction)		Interpretation	Assurance
Acknowledged with three days	100%	↔	**All** complaints were acknowledged within target timeframes (Q1=100%)	Full
Complaint closed within agreed timescales	93%	↑	This is higher than last quarter (Q1=81%). Only one complaint investigation was overdue in this time period.	Significant
Concerns escalated to complaint	11%	↑	Of 44 concerns received (Q1=54), five were escalated; this is higher than last quarter (*Q1=4%) * SED Q1 report incorrectly reported this as Q1= 0%	Significant

The Service Experience Department (SED) acknowledged all complaints within the national standards for response times for this quarter.

The rate of complaints closed within the initially agreed timescale continues to increase for the fourth consecutive quarter to 93%. The Service Experience Department will continue to carefully monitor closure rates to ensure a continued high rate of timely closures.

Table 3: Satisfaction with complaint process

Measure	Number (numerical direction)		Interpretation	Assurance
Reopened complaints	1		This figure is lower than the previous quarter (Q1 n=4)	Significant
Local Resolution Meetings	4		This figure is higher than the previous quarter (Q1 n=2).	Significant
Referrals to PHSO	2		Two complaints have been referred to the PHSO this quarter. (Q1 n=0).	Significant

Quarter 2 has seen a continued decrease in the number of complaints reopened following receipt of the Trusts response detailing investigation findings. This suggests that the complaint investigation process continues to be robust and that response letters explain and answer the queries raised without the need to reopen the complaint.

Table 4: Outcome of complaints closed this quarter

Outcome	No.	%	
Not upheld *No element of the complaint was upheld*	4	21%	Following feedback from complainants and Experts by Experience, the Trust no longer uses the terms upheld/partially upheld/not upheld within response letters. However, these categories are required to be recorded for formal reporting purposes. In total 19 complaints were closed this quarter, a slight increase on Q1 where n=16. 74% of the complaints closed this quarter had the issues within the complaint partially upheld. No complaints were fully upheld. This differs slightly to the previous quarter (63% partially upheld, 6% upheld).
Partially upheld *Some elements of the whole complaint were upheld*	14	74%	
Upheld *All elements of the whole complaint were upheld*	0	0%	
Withdrawn *Complaint was withdrawn*	1	5%	

**Individual issues within each formal complaint are either upheld or not upheld. Partially upheld is not used for individual issues. Percentages rounded to nearest whole number*

Table 5: Breakdown of closed complaints by staff group for this quarter

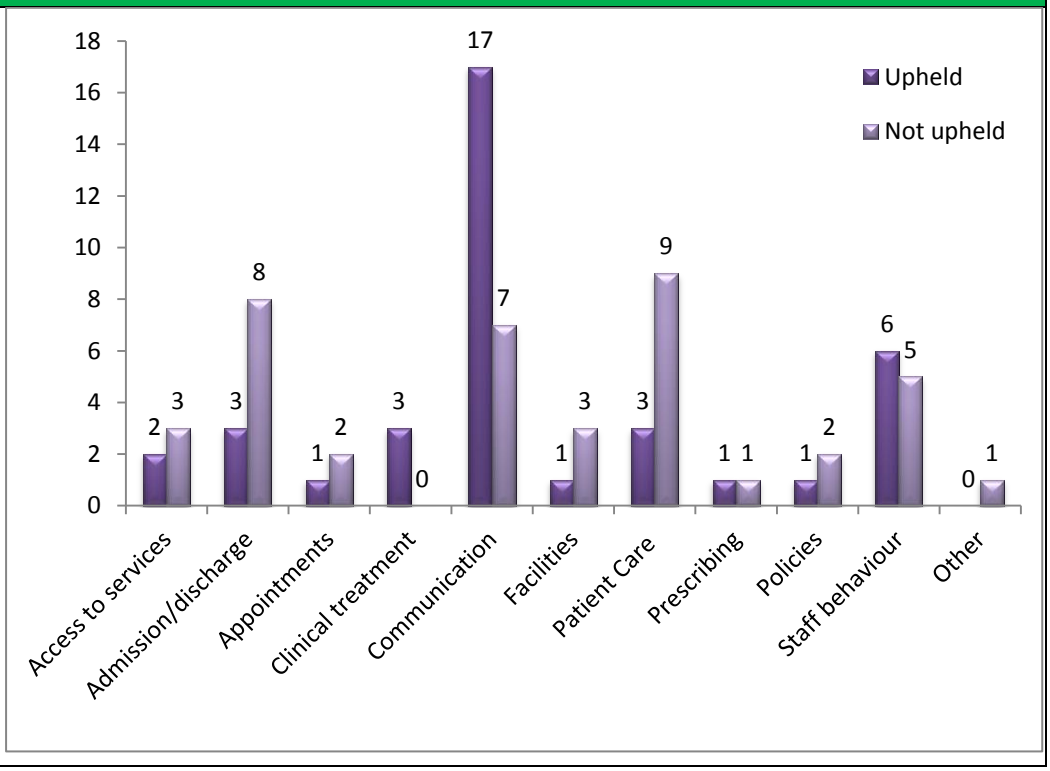
Outcome	Total No.*	Upheld	Not upheld	
Medical	4	2	2	The number of complaint issues involving different disciplines and staff groups is recorded for *NHS Digital*. It has been possible to categorise the complaint issues by staff group and the Quarter 2 data is presented in Table 5. Quarter 2 figures show Nursing as the main staff group identified within complaints. This has increased from (n=40) the previous quarter and is likely to be reflective of increased number of complaints closed in Quarter 2.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
Nursing	50	26	24	
Social Worker	3	2	1	
Psychology	1	0	1	
PWP (Psychological Wellbeing Practitioner)	11	5	6	
Estates staff	4	1	3	
HCA	1	1	0	
Other	3	1	2	

No staff identified	2	0	2	ensure that professional leads are aware of any themes relating to professional groups.

**The numbers represented in these data relate to a breakdown of individual complaint issues following investigation*

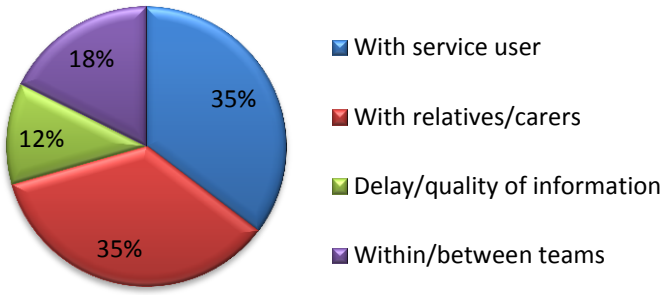
Analysis of data is undertaken by the Service Experience Department in order to identify any patterns or themes. Analysis is shown in table 6.

Table 6: Overarching closed complaint themes

Theme	Chart showing number of issues raised and their outcome
Access to services *Access to treatment or drugs*	
Admission/discharge *Poor planning*	
Appointments *Waiting for / at an appointment*	
Clinical treatment *e.g. diagnosis, medication*	
Communication *Internal and external*	
Facilities *Fixtures/fabric of buildings*	
Patient Care *e.g. observation, support*	
Prescribing *e.g. lack of prescription*	
Policies *e.g. not followed*	
Staff behaviour *Values and attitude*	
Other *Any other issue*	

Thematic analysis shows an increase in areas of complaint that is reflective of the higher number of complaints closed during Quarter 2. The ratio of upheld: not upheld complaint issues remain stable.

Table 7: Review of identified complaint themes

Breakdown of upheld complaint issues relating to theme of Communication	
The Trust takes all issues within individual complaints very seriously. The themes reflected in Table 7 demonstrate the outcomes of complaint issues that have been investigated and closed. The main complaint theme is about ***communication*** and is shown in greater detail as in the chart show to the right:	

Communication continues to dominate complaint thematic data. Colleagues across the Trust are working hard to develop and improve practice in this area.

Table 8: Examples of complaints and action taken

Example	You said	We did	Assurance
Communication	You telephoned the team when you were distressed and were told they would call you back. You were not contacted by them until the following day.	A system is now in place to ensure that when a person is identified as distressed or needing a same day response the team are alerted to this for timely follow up.	Significant
Assessment process	You told us that it was difficult to answer emotional questions over the telephone	We apologised for this and have placed a note on your records to say that you would prefer face to face appointments.	Significant
Recording of information	You told us that your clinical records contained inaccurate information.	We apologised for this and offered to amend and update your clinical records to be factually accurate	Significant

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 and a corresponding increase in the number of PALS contacts. **DatixWeb**, a service experience recording and reporting system, has continued to be used for Quarter 2.Themes and trends have been analysed for Quarter 2 and are reflected below:

Table 9: Number of concerns received this quarter

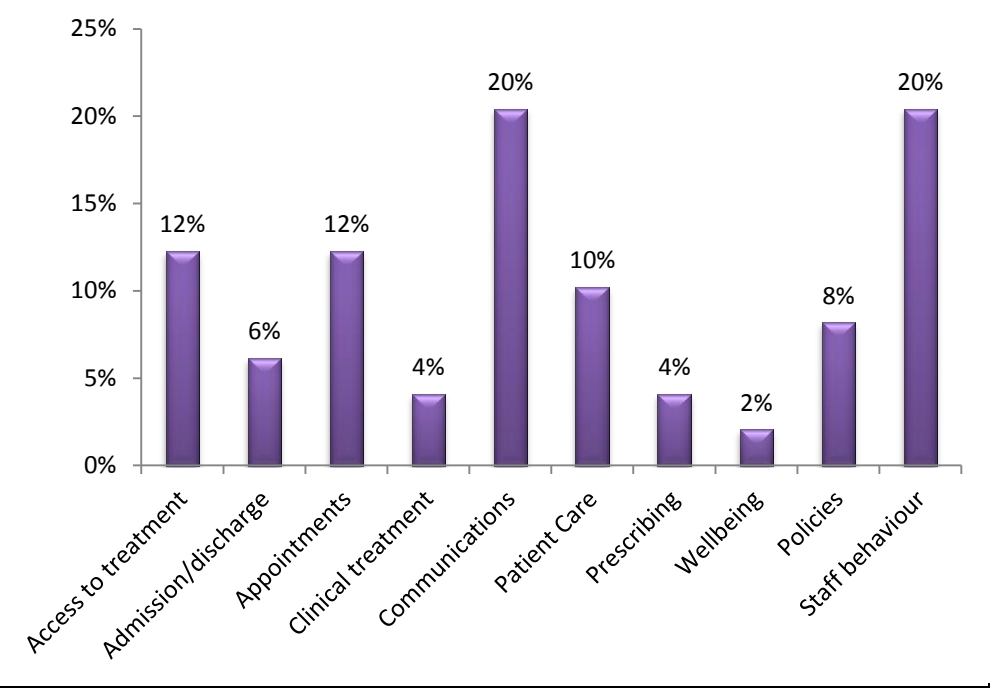
County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	38	↓	There are fewer Gloucestershire concerns compared to last quarter (Q1 n=41)	Significant
Herefordshire	3	↓	There are fewer Herefordshire concerns compared to last quarter (Q1 n=9)	Significant
Corporate	3	↓	There are fewer Corporate concerns compared to last quarter (Q1 n=5)	Significant
Total	44	↓	There are fewer concerns compared to last quarter (Q1 n=55)	Significant

The number of concerns remains relatively consistent with previous quarters. The number of contacts with the SED PALS for “signposting and advice” has increased this quarter and this suggests that the majority of queries raised are being resolved locally in a timely way.

Table 10: Overarching concern themes this quarter

**The numbers represented in this data relate to a breakdown of individual issues and do not equal the number of concerns*

Theme	No.*	Chart showing percentages
Access to treatment *Treatment or medication*	6	
Admission/discharge *Community or inpatient*	3	
Appointments *e.g. cancelled, staff DNA*	6	
Clinical treatment *e.g. diagnosis, medication*	2	
Communication *Internal and external*	10	
Patient Care *e.g. observation, support*	5	
Prescribing *e.g. lack of prescription*	2	
Wellbeing *e.g. privacy and dignity*	1	
Policies *e.g. Health Records, MHA*	4	
Staff Behaviour *Attitude and actions*	10	



The main themes identified from concerns raised are "Communication" and "Staff Behaviour"; this is consistent with the main theme reported from formal complaints. Learning points and actions will be captured in Section 3 of this report.

Table 11: Breakdown of concerns by staff group for this quarter

Outcome	No	%
Admin	3	6
Medical	8	16
HCA	2	4
Nursing	21	43
PWP (Psychological Wellbeing Practitioner)	4	8
Psychology	1	2
Other	2	4
No staff identified	8	16

As previously reflected in complaint analysis, nursing represents the largest staff group in the Trust and has the greatest number of contacts and so it is to be expected that this professional group features most frequently within feedback data. The percentage of Nurses identified within concerns raised remains stable n=47%. Work is ongoing to ensure that professional leads are made aware of any themes relating to their staffing group.

There were 79 other contacts with the Service Experience Department (Q1 = 39) covering a range of topics: people asking advice about our services, requesting contact from their team, and concerns about funding for placements.

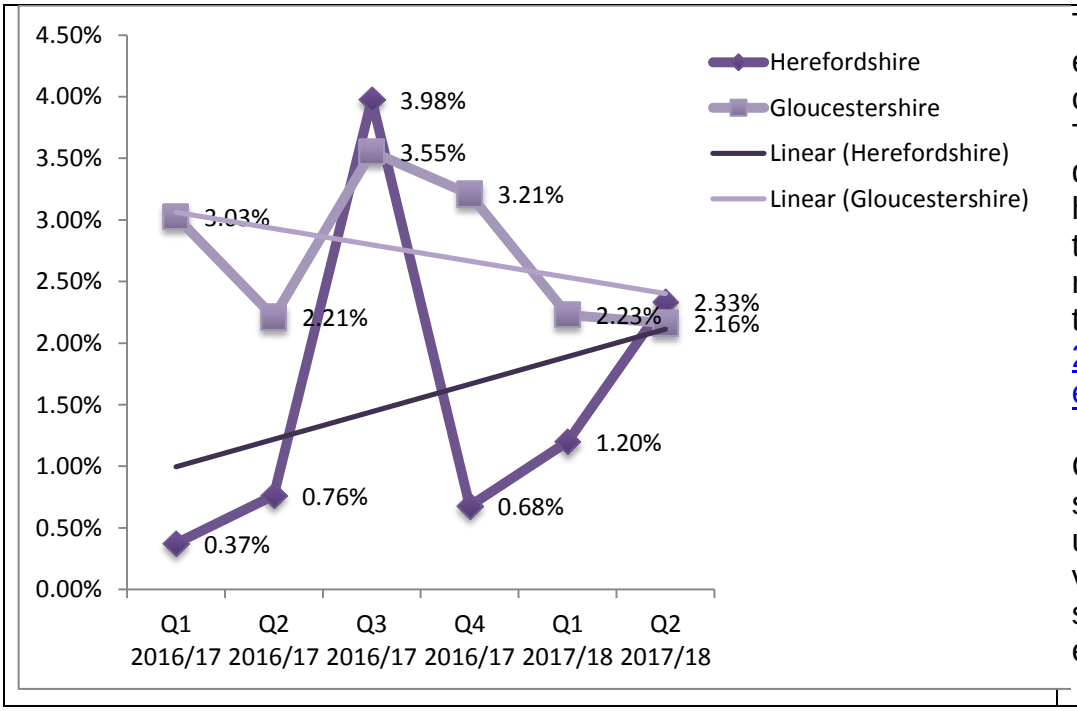
Table 12 Examples of concerns and action taken:

Example	You said	We did	Assurance
Assessment processes	You wrote to us to say that a telephone assessment had been arranged for you. You told PALS that you experience anxiety when using the telephone.	The team apologised and were unaware that your anxiety was related to using the telephone. A face to face assessment was arranged by the assessing team	**Significant**

Example	You said	We did	Assurance
Availability of bicycle parking at one of our buildings	You asked us to put bicycle stands near the main entrance and for all NHS facilities to have secure places to lock bicycles to reduce reliance on cars	We were able to inform you of the arrangements to secure your bicycle at this site and resolve your issue.	Significant
Care and Treatment	You told us that your Care Co-ordinator had not been in touch with you for months and that you needed some support	We offered a change of Care Co-ordinator along with an explanation and an apology.	Significant
Referral process	You told us that you were referred to non-NHS services but they have said they could not help you. You said you needed some help and asked what you could do.	We helped you to contact CRHTT who completed an assessment, offered home treatment and an onward referral to a Recovery Team.	Significant

2.3 Compliments

Figure 2: Graph showing proportion of compliments to number of contacts with services:



The SED continues to encourage the reporting of compliments received by Trust services. A dedicated email address has 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 2:

Facilitators were amazing and worked so well together which made me feel so safe and understood. *Gloucestershire Recovery College*

I rang a mess and ended the call laughing. Pretty surreal. I've tucked myself in bed and going to sleep. Thank you so much. *CRHTT, Gloucestershire*

Thank you for all your help and support over the past 18 months. We are so grateful that we have been able to access such an excellent service here in Hereford. *CAMHS, Herefordshire*

OTs help you to do things to get better. *Wotton Lawn, Gloucestershire*

Thank you for the time and effort you have given to supporting our son and ourselves…progress is being made. *LD, Herefordshire*

I am incredibly grateful for the work that has been done…life has changed completely. *Recovery North, Gloucestershire*

2.4 – Parliamentary and Health Service Ombudsman (PHSO)

There have been two referrals to the PHSO this quarter. The PHSO have confirmed that they are investigating one referral. The other has been signposted by the PHSO to the CQC as it relates to the application of the Mental Health Act.

2.5Surveys

2.5.1 How did we do? Survey

The Service Experience Department (SED) continues to implement the plan for the Trust's **How did we do?** survey. Surveys used in 2016/17, the "Friends and Family Test" and "Quality Survey" are combined in this new approach and are used for all Trust services apart from IAPT and CYPS/CAMHS, where alternative service experience feedback systems are in place.

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.

The two elements of the **How did we do?** survey will continue to be reported separately as Friends and Family Test and Quality Survey responses.

2.5.2 Friends and Family Test (FFT) Service User/ Carer feedback

Service users are asked "*How likely are you to recommend our service to your friends and family if they needed similar care or treatment?*"
Our Trust has played a key role in the development of an Easy Read version of the FFT. Roll out of this version ensures that everybody is supported to provide feedback.
Table 13 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 13: Returns and responses to Friends and Family Test

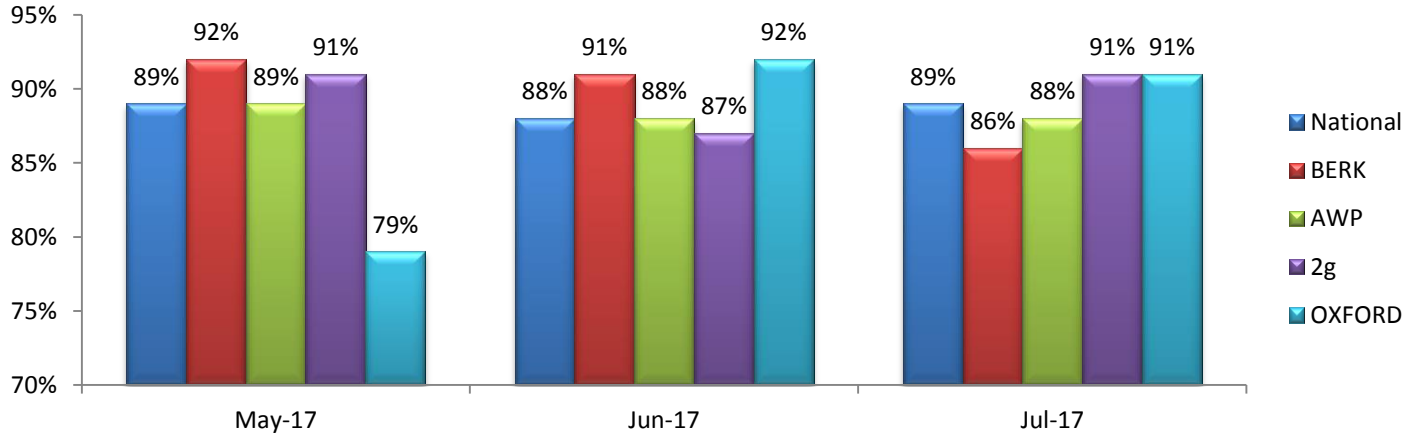
	Number of responses	FFT Score (%)
July 2017	135	91%
August 2017	116	86%
September 2017	215	88%
Total	**466 (Q1 = 531)**	**88% (Q1 = 90%)**

The Quarter 2 response rates are lower than the previous quarter. It is expected that responses will increase as the new system continues to be embedded along with the introduction of SMS surveys in Quarter 3 2017/18.

The FFT score for Quarter 2 has remained consistent with that received in 2016/17, this is encouraging news. The Trust continues to maintain a high percentage of people who would recommend our services.

Figure 3 shows the FFT Scores for May, June and July 2017 (the most recent data available) compared to other Mental Health Trusts in our region, and the average of Mental Health Trusts in England. Our Trust consistently receives a high percentage of recommendation in line with other Mental Health Trusts in the region. (*August and September 2017 data is not yet available*)

Figure 3: Friends and Family Test Scores – comparison between the 2gether Trust, other Mental Health Trusts in the NHS England South Central region, and the Mental Health Trusts' average



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

Friends and Family Test Comments

What was good about the visit?

Help there when I needed it.

MHLT, Gloucester

Everything was explained thoroughly and the team were very understanding, sympathetic, and supportive.

IHOT, Gloucestershire

The support during my mental health crisis was excellent.

CAHTT, Herefordshire

It was a quiet and relaxing room.

CLDT, Gloucester

Very helpful and supportive.

MHICT, Stroud/Cirencester

Listened and gave constructive discussion in relation to my problems.

Recovery South, Herefordshire

Gave some good advice and made others aware of the support required.

CYPS, Gloucestershire

Good all round service. Great food

Mortimer Ward, Stonebow

What would have made the visit better?

Extremely long waiting list. Telephone appointments were not enough to make a difference.

Let's Talk, Gloucestershire

It is a stressful and semi-dubious thing to have to go through.

Wotton Lawn

It would be better if the sessions weren't so long.

CYPS, Gloucestershire

I would like more and longer contact with my Care Co-ordinator.

Recovery South, Herefordshire

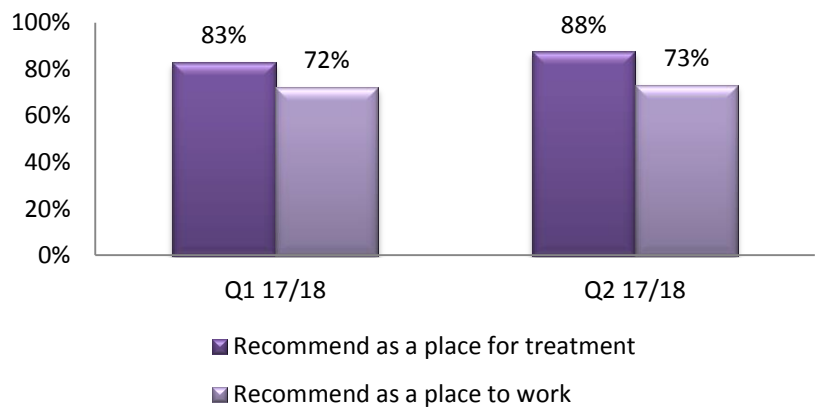
2.5.3 Friends and Family Test (FFT) 2gether Staff feedback

Our staff are asked about their experience of working for our Trust on a quarterly basis. Two questions are asked:

- *How likely are you to recommend 2gether to friends and family if they needed care or treatment?*
- *How likely are you to recommend 2gether to friends and family as a place to work?*

The results of the staff Friends and Family test for Quarters 1 and 2 2017/18 are shown in figure 4:

Figure 4 Staff Friends and Family Test Scores



The results of the Staff FFT continue to reflect that of service user feedback. Feedback shows that the majority of staff respondents would recommend 2gether NHS Foundation Trust as an employer. The high percentage of staff who would recommend Trust Services to those close to them shows a reasonable level of correlation between staff experience and service user experience of care, with service user feedback being slightly more positive

.

2.5.4 How did we do?

The How Did We Do? survey (Quality Survey questions) provides people with an opportunity to comment on key aspects of the quality of their treatment.
Table 14 shows responses in relation to set targets for this quarter:

Table 14: How Did We Do? Quality survey questions and responses

Question	County	No. of responses	Target Met?
Were you involved as much as you wanted to be in agreeing the care you receive?	Gloucestershire	28 (22 positive)	**88%** **TARGET 92%**
	Herefordshire	50 (47 positive)	
Have you been given information about who to contact outside of office hours if you have a crisis?	Gloucestershire	27 (20 positive)	**86%** **TARGET 74%**
	Herefordshire	50 (46 positive)	
Have you had help and advice about taking part in activities that are important to you?	Gloucestershire	26 (20 positive)	**89%** **TARGET 69%**
	Herefordshire	47 (43 positive)	
Have you had help and advice to find support for physical health needs if you have needed it?	Gloucestershire	24 (21 positive)	**89%** **TARGET 76%**
	Herefordshire	39 (35 positive)	

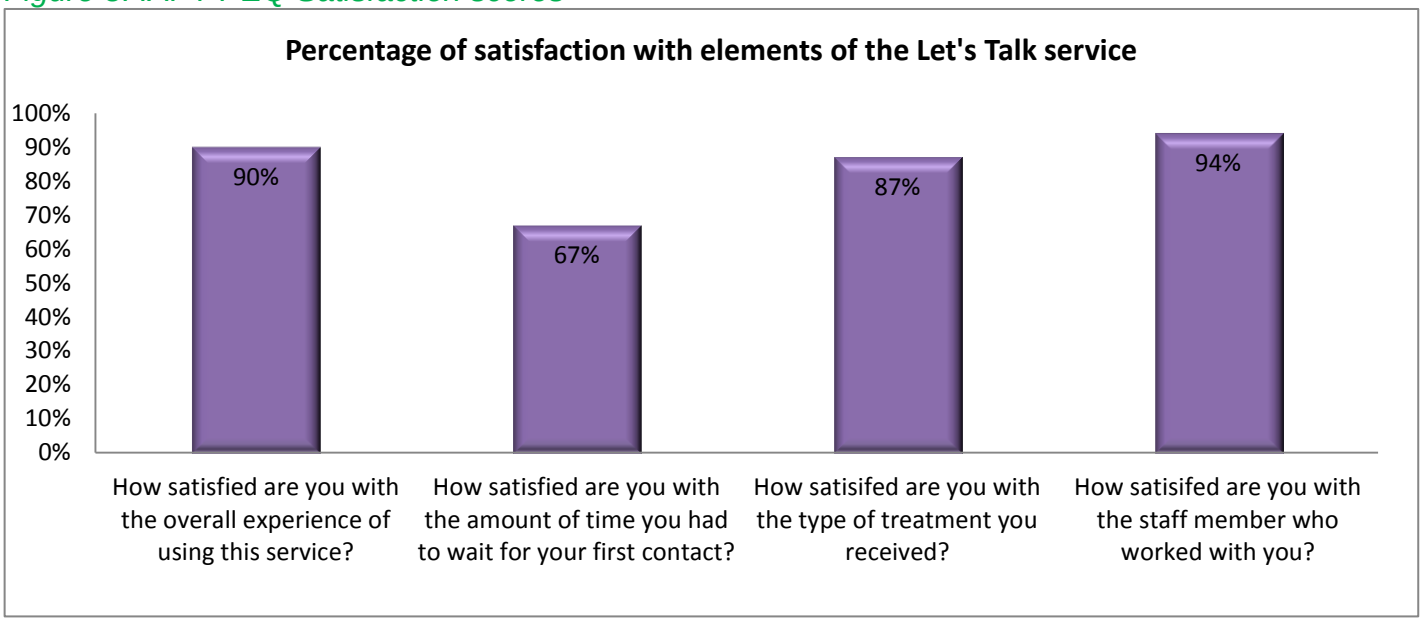
Quality survey targets were reviewed and refreshed to reflect in line with the launch of the **How did we do?** survey. Three out of the four targets set have been exceeded. This is good news and suggests that, of those people who responded to the survey, most are feeling supported to meet their needs and explore other activities. The one target that hasn't been fully achieved this quarter continues to receive a high percentage of positive responses. It is important to acknowledge that this target for 2016/17 was 78% and that this was consistently exceeded during this time. The increase in

the target set for 2017/18 is demonstrative of our desire to consistently improve our services and although the target has not yet been met, the responses are more positive than the previous quarter.

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

Our IAPT Let's Talk services use a nationally agreed survey to gain feedback and measure levels of satisfaction with the service. The current IAPT PEQ has been reviewed by SED and service leads and two new IAPT questionnaires are planned to be launched during Quarter 3 2017/18.
The feedback from a selection of questions currently asked within the IAPT PEQ about satisfaction is included below. All data and feedback shown in figure 5 is based on responses processed within Quarter 2 2017/18.

Figure 5: IAPT PEQ Satisfaction scores



The Quarter 2 feedback shows that largely people are satisfied with these elements of the Lets Talk service.

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

Appointments made sooner but I understand the pressures with NHS.

Speedier access time but I expect that is down to 'the cuts'.

Nothing you are very helpful from start to finish

I don't really have anything to add here as the service worked as I needed it to.

Really not my place to say. Feeling overwhelmed with gratitude. Personal thanks to Therapist.

Just keep understanding and being so kind.

Name badges for all the clients on a course.

Possibly all the information in the presentations during the sessions being printed and included in the booklet/set of papers given to each participant

2.5.6 Children and Young People service (CYPS)

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.

They are three versions of the CHI-ESQ survey used, these are identified by age and role type as follows: CHI-ESQ Age 9 -11 yrs, CHI-ESQ Age 12 -18 yrs and CHI-ESQ Adult &Carer. All the surveys ask questions based upon the same theme but are presented differently in age appropriate format.

Table 15 reflects responses across all three surveys asking if people felt listened to by the CYPS/CAMHS Services during Quarter 2**: 90%** of adults and carers said that they felt listened to and **94%** of 12-18 year olds. **100%** of 9-11 years respondents felt that they had been listened to.

Table 15: CHI-ESQ responses by age group

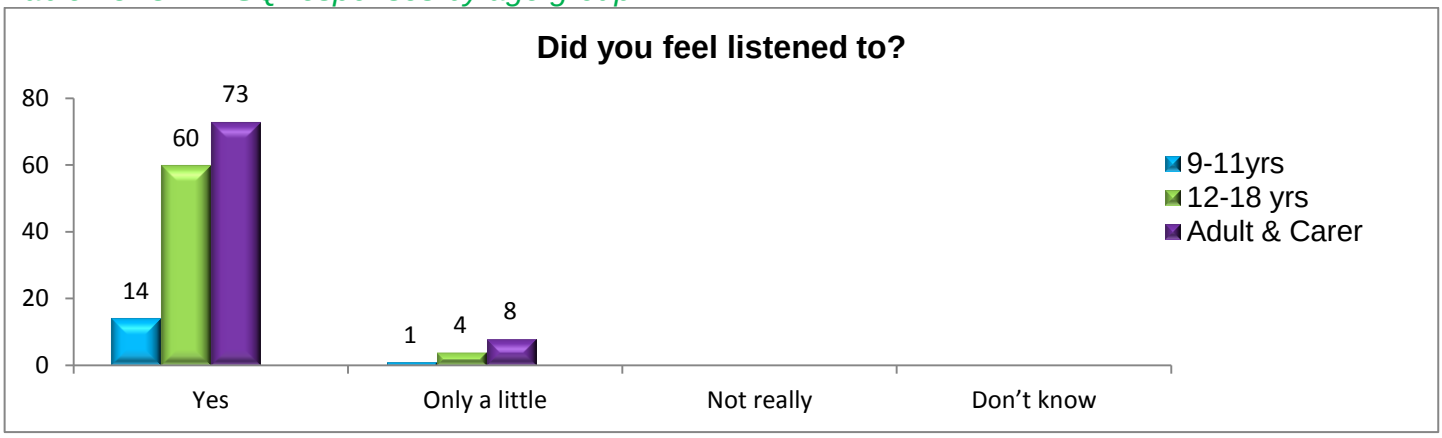


Table 16: Adapted Friends and Family Test

	Number of responses	FFT Score (%)
Age 9-11	15 (12 positive)	80%
Age 12-18	65 (61 positive)	94%
Parent/Carer	78 (77 positive)	99%
Total	**158** (150 positive) **(77 last quarter)**	**95% (94% last quarter)**

Examples of some feedback given:

People have said they've seen a big difference in me so I think having this has helped a lot.

It helped my daughter deal with her feelings in a safe way.

Was listened to an my information was safe.

I found the individual that worked mostly with my son to be very kind and patient with all of us as a family.

Listening to my child and not being judgemental. I wish we had come a long time ago.

It helped me through the tough times.

The person listened to my child's needs and dealt with them.

The person that saw me was really supportive, I never felt scared to tell her about my problems

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 15 illustrates the lessons learnt from **individual** complaints and concerns. 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.

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 17 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 17: Points of learning from Service Experience feedback Q1 closed complaints– action plan to be sought from locality leads

Organisational Learning	Action Plan (to be sought)
When a member of staff is absent at short notice a system should be in place to ensure their caseload/workload is reviewed and a plan made to manage existing commitments.	
When a person is discharged from a ward or a team it is essential that they are involved in the discharge planning process and plans are shared with family/carers involved whenever possible.	

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. Table 18 below illustrates the assurance that services have provided around actions that have been completed as a result of previous aggregated lessons learnt.

Table 18: Points of learning from Service Experience feedback Q4 2016/17 – action plan has been completed

Organisational Learning	Action Plan	Date assurance received
Service users and/or carers must be consulted about whom they wish to attend their review meetings and this should be documented in the progress notes. This is in line with	**Herefordshire:** This will be highlighted alongside the requirements of the assessment and care management policy will be in the Triangle of care meetings/ briefings.	
	CYPS: The Assessment and Care Management Policy is identified with the CYPS and CAMHS Operational policies. Children and young people and their families and carers are consulted about who should attend reviews as appropriate. This information will be re enforced via the CYPS/CAMHS Governance Committee and cascaded to Team Managers to share with their teams and read by all staff.	**September**

Organisational Learning	Action Plan	Date assurance received
the Assessment and Care Management Policy.	**Countywide:** Staff will be reminded via their team meetings requirements regarding consultation with service users and carers and attendance at review meetings. Teams will be asked to minute the discussion with Team members so that there is an audit trail for the purposes of assurance.	**2017**
	Gloucestershire Localities Community Services Managers to take to forums and ensure Clinicians are aware of the organisational learning identified in the Q1 SED report	
Where clinically appropriate service users and/or carers must be kept updated following conversations about potential safeguarding referrals, to minimise anxiety and distress and ensure they are aware of what will happen next.	**Herefordshire:** The process of how to keep people informed and aware of next steps when considering or raising safeguarding referrals will also be included in the Triangle of care meetings/ briefings.	**September 2017**
	CYPS: It is good practice to discuss with children, young people and families and keep them informed when a safeguarding referral is indicated. It is not always possible to know what will happen next when a referral is made but staff should remain in touch to provide support if appropriate. Staff will refer to the Trust safeguarding processes	
	Countywide: Staff to be reminded to keep service users and carers involved in the safeguarding process as detailed within the current Safeguarding Adults Policy, whilst always reviewing individual circumstances to ensure involvement will not impact upon the risks identified within the Safeguarding concerns.	
	Gloucestershire Localities Community Services Managers to take to forums and ensure Clinicians are aware of the organisational learning identified in the Q1 SED report	
Where staff seek safeguarding advice from an external agency and do not agree with the outcome/ decision made the escalation policy must be followed.	**Herefordshire:** The escalation policy has been circulated to team managers via Herefordshire clinical governance meetings who will cascade amongst staff.	**September 2017**
	CYPS: CYPS/CAMHS staff have regular reflective and dedicated safeguarding supervision and would be expected to discuss disagreements between agencies with their managers, in team meetings, with the safeguarding team and within safeguarding supervision. It is important to share safeguarding concerns and seek specialist advice and supervision. Any discussion around safeguarding will be documented on RiO.	
	Countywide: Matrons, and Team Managers will be reminded that they must use the Trust escalation policy when there is a disagreement with external agencies regarding decisions pertaining to safeguarding This will also be shared with Teams via the team briefings and recorded in the notes of the team meeting that the discussion took place.	
	Gloucestershire Localities Community Services Managers to take to forums and ensure Clinicians are aware of the organisational learning identified in the Q1 SED report	

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

Report to: Trust Board – 30 November 2017
Author: Gordon Benson, Assistant Director of Governance & Compliance
Presented by: Marie Crofts, Director of Quality

SUBJECT: **Quality Report: Report for 2nd Quarter 2017/18**

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

EXECUTIVE SUMMARY

This is the second review of the Quality Report priorities for 2017/18. The quarterly report is in the format of the annual Quality Report format.

Assurance

- The report shows the progress made towards achieving targets, objectives and initiatives identified in the Annual Quality Report.

- Overall, there are 3 targets which are not currently being met:
    1. 1.2 – Personalised discharge care planning
    2. 2.1 – Numbers of service users being involved in their care
    3. 3.3 – Reduction in the use of prone restraint.

Improvements

- The data within relates to Quarter 2 and will, therefore, be subject to change as the supportive evidence base grows throughout the year.

- There must be a sustained focus, particularly in discharge care planning as completion of the necessary documentation is within the gift of staff to accomplish. This target has been referred to the Delivery Committee and Locality Management Boards for action.

- In the Quarter 3 report, there will be greater breakdown of information by county, and also in 3.3 – Prone restraint, an analysis of the numbers of supine restraint being used.

RECOMMENDATIONS

The Board is asked to:

- Note the progress made to date and actions in place to improve/sustain performance where possible;
- Agree that the Quarter 2 Quality Report update be shared with the Board, partner organisations, commissioners and governors.

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:		
	Date	

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
	Date	

Explanation of acronyms used:	

1. CONTEXT

1.1 Every year the Trust is 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 NHS Improvement (incorporating the Department of Health Guidance for Quality Accounts) and the Quality Report checked for consistency against the defined regulations.

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Quality Report 2017/18

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Part 1: Statement on Quality from the Chief Executive

Introduction

This will be included at year-end

Part 2.1: Looking ahead to 2018/19

Quality Priorities for Improvement 2018/19

These will be developed during Quarter 4 under the following domains.

Effectiveness

User Experience

Safety

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

Review of Services

This will be included at year-end

Participation in Clinical Audits and National Confidential Enquiries

This will be included at year-end

Participation in Clinical Research

This will be included at year-end

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

A proportion of 2gether NHS Foundation Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between 2gether 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 2017/18 and for the following 12 month period are available electronically at http://www.2gether.nhs.uk/cquin

2017/18 CQUIN Goals

Gloucestershire

Gloucestershire Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
1a (a) National CQUIN – Staff health and wellbeing	To achieve a 5 percentage point improvement in 2 of the 3 NHS annual staff survey questions on Health and Wellbeing	0.3	£72261	Effectiveness
1b National CQUIN – Staff health and wellbeing	Healthy food for NHS staff, visitors and patients		£72261	Effectiveness
1c National CQUIN - Staff health and wellbeing	Improving the uptake of flu vaccinations for front line staff		£72261	Safety
2 National CQUIN - Improving Physical Healthcare 3a	- To reduce premature mortality by demonstrating cardio metabolic assessment and treatment for patients with psychoses.	0.3	£173426	Effectiveness
2 National CQUIN - Improving Physical Healthcare 3b	- To reduce premature mortality - Improved communication with GPs		£43357	Effectiveness
3. Improving Services for people with mental health needs who present to A & E.	Care and management for frequent attenders to Accident and Emergency	0.3	£216783	Safety
4. Transitions out of Children and Young People's Mental Health Services.	To improve the experience and outcomes for young people as they transition out of (CYPMHS)	0.3	£216783	Effectiveness
5.Preventing ill health by risky behaviours – Alcohol and Tobacco	To offer advice and interventions aimed at reducing risky behaviour in admitted patients	0.3	£216783	Effectiveness

Herefordshire

Herefordshire Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
1a (a) National CQUIN – Staff health and wellbeing	To achieve a 5 percentage point improvement in 2 of the 3 NHS annual staff survey questions on Health and Wellbeing	0.3	£17231	Effectiveness
1b National CQUIN – Staff health and wellbeing	Healthy food for NHS staff, visitors and patients		£17231	Effectiveness
1c National CQUIN - Staff health and wellbeing	Improving the uptake of flu vaccinations for front line staff		£17231	Safety
2 National CQUIN - Improving Physical Healthcare 3a	- To reduce premature mortality by demonstrating cardio metabolic assessment and treatment for patients with psychoses.	0.3	£41354	Effectiveness
2 National CQUIN - Improving Physical Healthcare 3b	- To reduce premature mortality - Improved communication with GPs		£10339	Effectiveness
3. Improving Services for people with mental health needs who present to A & E.	Care and management for frequent attenders to Accident and Emergency	0.3	£51693	Safety
4. Transitions out of Children and Young People's Mental Health Services.	To improve the experience and outcomes for young people as they transition out of (CYPMHS)	0.3	£51693	Effectiveness
5.Preventing ill health by risky behaviours – Alcohol and Tobacco	To offer advice and interventions aimed at reducing risky behaviour in admitted patients	0.3	£51693	Effectiveness

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.

2018/19 CQUIN Goals

These will be added at year-end.

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.

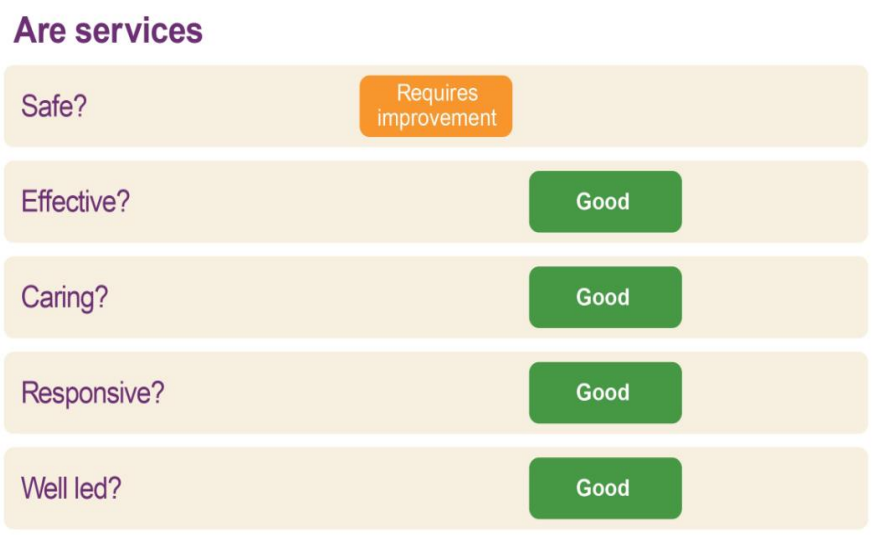
[2]gether NHS Foundation Trust has no conditions on its registration.

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 2017/18

This will be included at year-end.

Quality of Data

This will be included at year-end.

Part 2.3: Mandated Core Indicators 2017/18

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 1 2016-17	Quarter 2 2016-17	Quarter 3 2016-17	Quarter 4 2016-17	Quarter 1* 2017-18
[2]gether NHS Foundation Trust	97.1%	97.2%	98.3%	99.2%	99.2%
National Average	96.2%	96.8%	96.8%	96.8%	96.7%
Lowest Trust	28.6%	76.9%	73.3%	84.6%	71.4%
Highest Trust	100%	100%	100%	99.4%	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 1 2016-17	Quarter 2 2016-17	Quarter 3 2016-17	Quarter 4 2016-17	Quarter 1* 2017-18
[2]gether NHS Foundation Trust	98.9%	98.9%	99.4%	100%	100%
National Average	98.1%	98.4%	98.7%	98.8%	98.7%
Lowest Trust	78.9%	76%	88.3%	90%	88.9%
Highest Trust	100%	100%	100%	100%	100%

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

- 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 Quarter 1 2017/18 has not yet been revised and may change. Quarter 2 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 1 2016-17	Quarter 2 2016-17	Quarter 3 2016-17	Quarter 4 2016-17	Quarter 1 2017-18
[2]gether NHS Foundation Trust 0-15	0%	0%	0%	0%	0%
[2]gether NHS Foundation Trust 16 +	7%	5%	8%	6%	6.3%
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 April 2016 – 30 September 2016				1 October 2016 – 31 March 2017			
	Number	Rate*	Severe	Death	Number	Rate*	Severe	Death
[2]gether NHS Foundation Trust	1,900	54.85	4	30	2,474	72.05	2	17
National	162,954	-	562	1240	157,141	-	538	1233
Lowest Trust	40	10.28	0	0	68	11.17	0	0
Highest Trust	6,349	88.97	50	84	6,447	88.21	72	100

* 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 commenced in 2017/18.

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

Introduction

The 2017/18 quality priorities were agreed in May 2017.

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

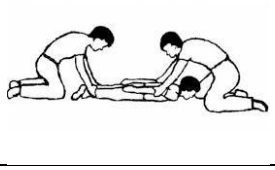
The table below provides a summary of our progress against these individual priorities. Each are subsequently explained in more detail throughout Part 3.

Summary Report on Quality Measures for 2016/2017

		2016 - 2017	2017 -2018
Effectiveness			
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.	**Achieved**	**Achieved**
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.	**Achieved**	**Not 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**	**Achieved**
User Experience			
2.1	Were you involved as much as you wanted to be in agreeing what care you will receive? **> 92%**	**83%**	**88%**
2.2	Do you know who to contact out of office hours if you have a crisis? **>74%**	**74%**	**86%**
2.3	Has someone given you advice about taking part in activities that are important to you? **> 69%**	**69%**	**89%**
2.4	Have you had help and advice to find support to meet your physical health needs if you needed it? **> 76%**	**76%**	**89%**
Safety			
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.	**-**	**Achieved**
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)	**-**	**Achieved**
3.3	To reduce the number of prone restraints by 5% year on year (on all adult wards & PICU) based on 2016/17 data.	**211**	**134**

Easy Read Report on Quality Measures for 2017/2018

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 	Less people had all parts of their discharge care plan completed at the end of the quarter than previously.	↓
Care (CPA) Review 	Everyone moving from children's to adult services had a care review. We met the target.	↑
Care Plans 	82% of people said they felt involved in their care plan. This is less than the target (92%). We have not met the target. We are doing lots of work to get better at this.	↓
Crisis 	88% of people said they know who to contact if they have a crisis. This is more than the target (74%). We met the target.	↑
Activity 	81% of people said they had advice about taking part in activities. This is more than the target (69%). We met the target.	↑
Physical Health 	79% of people said they had advice about their physical health This is more than the target (76%). We met the target.	↑

Suicide 	There have been less suicides compared to this time last year. We have met the target. We are working hard to keep people safe.	↑
AWOL 	Inpatients who were absent without leave did not come to serious harm or death. We met the target.	↑
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.	↓

Key

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

Effectiveness

In 2017/18 we remained committed to ensure that our services are as effective as possible for the people that we support. For the second consecutive year 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

A two year Physical Health CQUIN was announced for 2017/19. This CQUIN includes all service users with an active diagnosis of psychosis (using the CQUIN specified ICD-10 codes) who were either an inpatient or who had accessed community services including; Assertive Outreach Team (AOT), Recovery Teams, Community Learning Disability Teams (CLDT's), Older Age Services (OP's) and Children and Young Persons Services (CYPS). The sample group has now been extended to include service users from both counties.

Following on from the Lester Tool training and implementation for staff in quarter one, the Trust has been able to provide ongoing support from the physical health facilitators. The cardio metabolic health screening is now embedded in practice for community and inpatient service users, local compliance audits are encouraging.

The quarter two target looked at collaboration with primary care clinicians with an aim to improve the flow of useful clinical information between secondary and primary care. The Trust was asked to identify and develop clear plans for aligning and cross checking SMI QOF and CPA registers.

We have identified key leads within both Herefordshire and Gloucestershire CCG's to help with this liaison. We are working closely with them to provide us with guidance on our next steps.

Within Herefordshire, we will aim to email all Practice Managers to raise the profile of the purpose of cross referencing the SMI QOF with CPA registers. This will be the first stage of creating links with primary care to facilitate this information sharing opportunity. We have liaised with Taurus Healthcare in order to gain support and understanding for the rationale of this CQUIN, and how we anticipate this will improve patient care and collaboration between primary and secondary care.

Within Gloucestershire the CCG's Locality Development and Primary Care Directorate has kindly offered to email all Practice Managers to raise the profile of the purpose of cross referencing the SMI QOF with CPA registers. This will be the first stage of creating links with primary care to facilitate this information sharing opportunity.

Alongside the CQUIN work, the Trust continues to increase access to physical health treatment for its' service users. Following the successful secondment of a general trained nurse working within the inpatient units in Gloucestershire, the matron is planning to advertise a substantive position for this role to continue. This will ensure patients to access services normally only available from a practice nurse at a GP surgery.

In April 2017 the Trust became “Smoke-Free”, and the benefit of this to both staff and service users continues to be evident. The Trust plans to hold a “Smoke free” event for the South West in February 2018.

We are currently meeting this target.

Target 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.

Discharge from inpatient units to the community can pose a time of increased risk to service users. During 2016/17 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. 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 will also be looking to ensure that discharges summaries and medication information for service users discharged from hospital are sent to their GP within 48 hours of Discharge.

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)	Quarter 1 Compliance (2017/18)	Quarter 1 Compliance (2017/18)
Overall Average Compliance	**69%**	**72%**	**73%**	**71%**
Chestnut Ward	84%	85%	**81%**	**87%**
Mulberry Ward	75%	79%	**73%**	**76%**
Willow Ward	59%	71%	**69%**	**65%**
Abbey Ward	72%	75%	**78%**	**83%**
Dean Ward	79%	73%	**69%**	**71%**
Greyfriars PICU	50%	62%	**62%**	**59%**
Kingsholm Ward	75%	72%	**69%**	**74%**
Priory Ward	80%	80%	**87%**	**76%**
Montpellier Unit	50%	57%	**67%**	**50%**
Honeybourne	N/A	70%	**70%**	**60%**
Laurel House	N/A	65%	**75%**	**80%**

* 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.

Quarter 2 overall average compliance in Gloucester for these standards during this year is **71%** which is a **2%** reduction from the end of Quarter 1, it is noted that several inpatient areas have reduced in this area. There will be an increased focus on ensuring that these standards are met throughout the year.

Herefordshire Services

Criterion	Year End compliance (2015/16)	Year End Compliance 2016/17)	Quarter 1 Compliance (2017/18)	Quarter 2 Compliance (2017/18)
Overall Average Compliance	**N/A**	**74%**	**70%**	**66%**
Cantilupe Ward	**N/A**	85%	**78%**	**77%**
Jenny Lind Ward	**N/A**	71%	**71%**	**62%**
Mortimer Ward	**N/A**	69%	**64%**	**58%**
Oak House	**N/A**	70%	**67%**	**67%**

Quarter 2 overall average compliance in Herefordshire for these standards during this year is **66%** which is a **4%** reduction from the end of Quarter 2 , noting that three of the inpatient areas have further reduced in this area. There will be an increased focus on ensuring that these standards are met throughout the year.

Trustwide compliance for each of the individual criteria assessed is outlined in the table below. For future audits, services will focus on the criteria scoring an **AMBER** or **RED** RAG rating to promote improvement.

		%
1.	Has a Risk Summary been completed?	100%
2.	Has the Clustering Assessment and Allocation been completed?	81%
3.	Has the Pre-Discharge Planning Form been completed?	32%
4.	Have the inpatient care plans been closed within 7 days of discharge?	21%
5.	Has the patient been discharged from bed?	100%
6.	Has the Nursing Discharge Summary Letter to Client/GP been sent within 24 hours of discharge?	79%
7.	Has the 48 hour follow up been completed if the Community Team are not doing it?	93%

This target has not 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 every time a young person transitions to adult services.

Results from 2016-17 transitions are also included below so that historical comparative information is available.

Gloucestershire Services

2016-17 Results

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

2017-18 Results

During Quarter 2, there were 2 young people who transitioned into adult services, they had a joint CPA review.

Criterion	Compliance Quarter 1 (2017/18)	Compliance Quarter 2 (2017/18)	Compliance Quarter 3 (2017/18)	Compliance Quarter 4 (2017/18)
Joint CPA Review	100%	100%		

Herefordshire Services

2016-17 Results

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%

2017-18 Results

Criterion	Compliance Quarter 1 (2017/18)	Compliance Quarter 2 (2017/18)	Compliance Quarter 3 (2017/18)	Compliance Quarter 4 (2017/18)
Joint CPA Review	100%	100%		

During Quarter 2, there were 2 transitions of young people into adult services, all of these had a joint CPA review.

To improve our practice and documentation in relation to this target, a number of measures were developed during 2016-17 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.

We are currently meeting 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 Trust's **How did we do?** survey combines the NHS Friends and Family Test and the Quality Survey. The Quality Survey questions encourage people to provide feedback on key aspects of their care and treatment.

The two elements of the **How did we do?** survey will continue to be reported separately as Friends and Family Test and Quality Survey responses by county. A combined total percentage for both counties is also provided to mirror the methodology used by the CQC Community Mental Health Survey.

Data for Quality Survey (Quarter 1 - July to September 2017) results:

Target 2.1 Were you involved as much as you wanted to be in agreeing the care you will receive? > 92%

Question	County	Number of responses	Target Met?
Were you involved as much as you wanted to be in agreeing the care you receive?	Gloucestershire	28 (22 positive)	88% TARGET 92%
	Herefordshire	50 (47 positive)	
	Total	78 (69 positive)	

This target has not been met but response rates and outcomes have improved compared to Quarter 1 (82%).

Target 2.2 Have you been given information about who to contact outside of office hours if you have a crisis? > 74%

Question	County	Number of responses	Target Met?
Have you been given information about who to contact outside of office hours if you have a crisis?	Gloucestershire	27 (20 positive)	86% TARGET 74%
	Herefordshire	50 (46 positive)	
	Total	77 (66 positive)	

This target has been met.

Target 2.3 Have you had help and advice about taking part in activities that are important to you? >69%

Question	County	Number of responses	Target Met?
Have you had help and advice about taking part in activities that are important to you?	Gloucestershire	26 (20 positive)	89% TARGET 69%
	Herefordshire	47 (43 positive)	
	Total	73 (63 positive)	

This target has been met.

Target 2.4 Have you had help and advice to find support for physical health needs if you have needed it? > 76%

Question	County	Number of responses	Target Met?
Have you had help and advice to find support for physical health needs if you have needed it?	Gloucestershire	24 (21 positive)	89% TARGET 76%
	Herefordshire	39 (35 positive)	
	Total	63 (56 positive)	

This target has been met.

Quality survey targets were reviewed and refreshed in line with the launch of the **How did we do?** Survey. Three out of the four targets set have been exceeded. This is positive and suggests that, of those people who responded to the survey, most are feeling supported to meet their needs and explore other activities.

The one target that has not been fully achieved (Target 2.1) continues to receive a high percentage of positive responses. It is important to acknowledge that this target for 2016/17 was 78% and that this was consistently exceeded during this time. The increase in the target set for 2017/18 is demonstrative of our desire to consistently improve our services and although the target has not yet been met, the responses are more positive than the previous quarter

Friends and Family Test (FFT)

FFT responses and scores for Quarter 2

The FFT involves service users being asked "*How likely are you to recommend our service to your friends and family if they needed similar care or treatment?*"

Our Trust played a key role in the development of an Easy Read version of the FFT. Roll out of this version ensures that everybody is supported to provide feedback.

The table below details the number of combined total responses received by the Trust each month in quarter 2. The FFT score is the percentage of people who stated that they would be 'extremely likely' or 'likely' to recommend our services. These figures are submitted for national reporting.

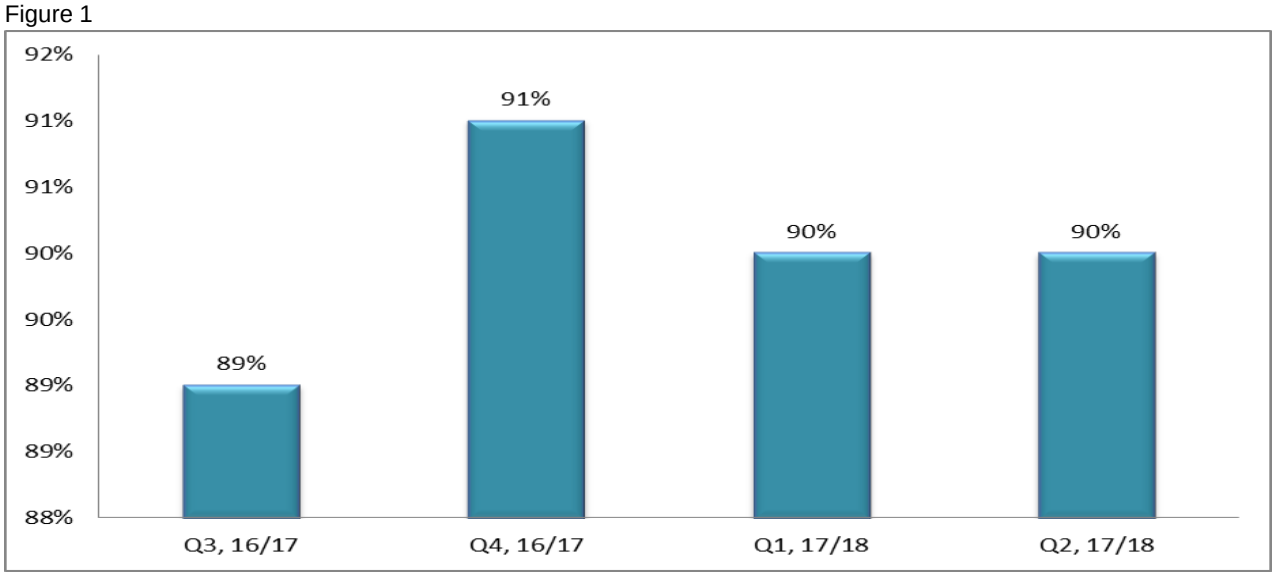
	Number of responses	FFT Score (%)
July 2017	152 (137 positive)	90%
August 2017	134 (117 positive)	87%
September 2017	337 (308 positive)	91%
Total	**623** (562 positive) **(last quarter = 617)**	**90% (last quarter = 90%)**

The Quarter 2 response rates are slightly higher than the previous quarter. This is encouraging news, it is expected that this increase will continue as the new system continues to be embedded along with the planned introduction of SMS surveys in Quarter 3 2017/18.

The FFT score for Quarter 2 has remained consistent with that received in 2016/17.The Trust continues to maintain a high percentage of people who would recommend our services.

FFT Scores for ^{2}gether NHS Foundation 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.

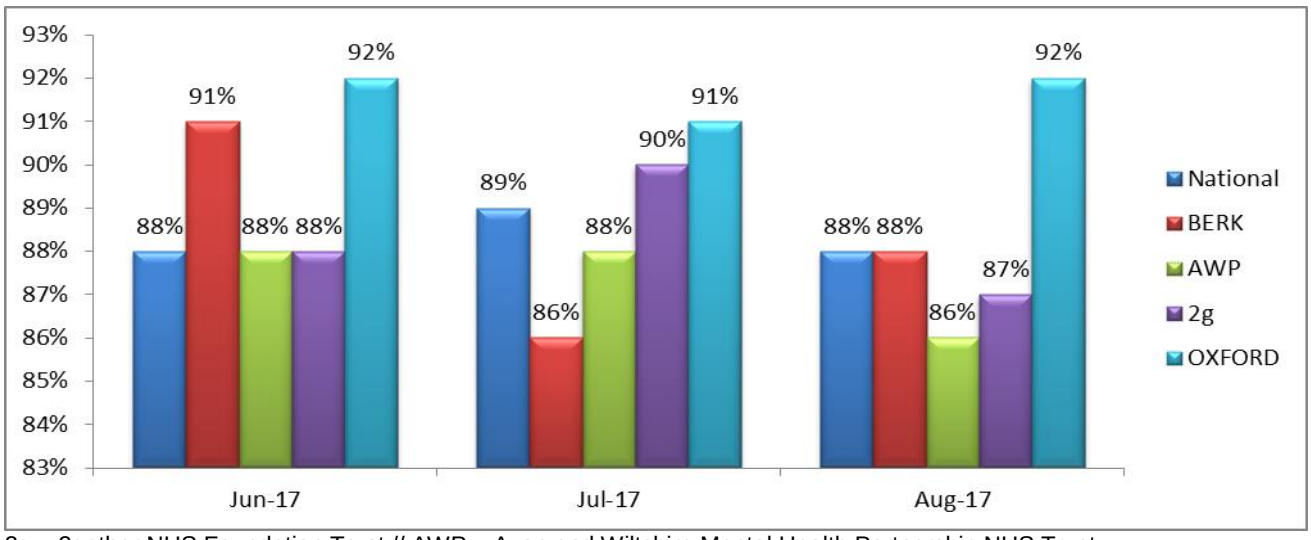
Figure 1



The FFT score for Quarter 2 has remained consistent with previous quarters. The Trust continues to maintain a high percentage of people who would recommend our services.

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

The chart below shows the FFT scores for June, July, and August 2017 (the most recent data available) compared to other Mental Health Trusts in our region and the national average. Our Trust consistently receives a high percentage of recommendation in line with other Mental Health Trusts in the region (September 2017 data is not yet available).



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

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 3 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:

There are 3 associated targets.

Target 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**.

We aim to minimise the risk of suicide amongst those with mental disorders through systematic implementation of sound risk management principles. In 2013/14, during which year we reported **22** suspected suicides, 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. Sadly the number increased and during 2016/17 we reported **26** suspected suicides. At the end of Quarter 2 2017/18 the number of reported suspected suicides was **14,** 3 less than at the end of the same quarter last year. This is seen in Figure 4.

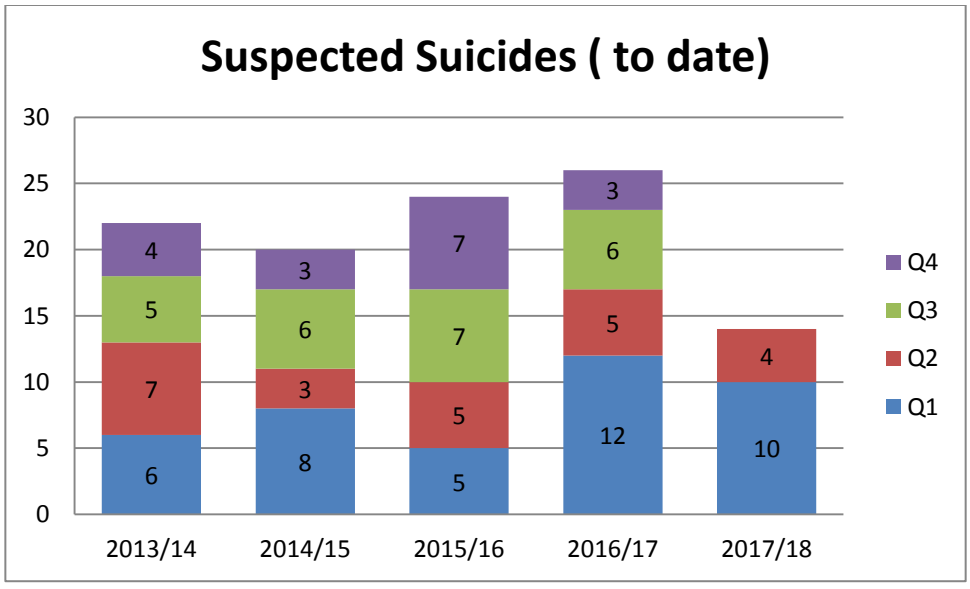


Figure 4

What we also know is that we are seeing more and more service users on our caseload year on year, so we are going measure this important target differently this year. This will be as reported as a rate per 1000 service users on the Trust caseload. The graph in Figure 5 shows this rate from 2014/15 onwards for all Trust services covering Herefordshire and Gloucestershire, and we are aiming to see the median value (green line) get smaller. During both 2015/16 and 2016/17 the median value was 0.09. At the end of Quarter 2 2017/18, the median value remains at 0.09.

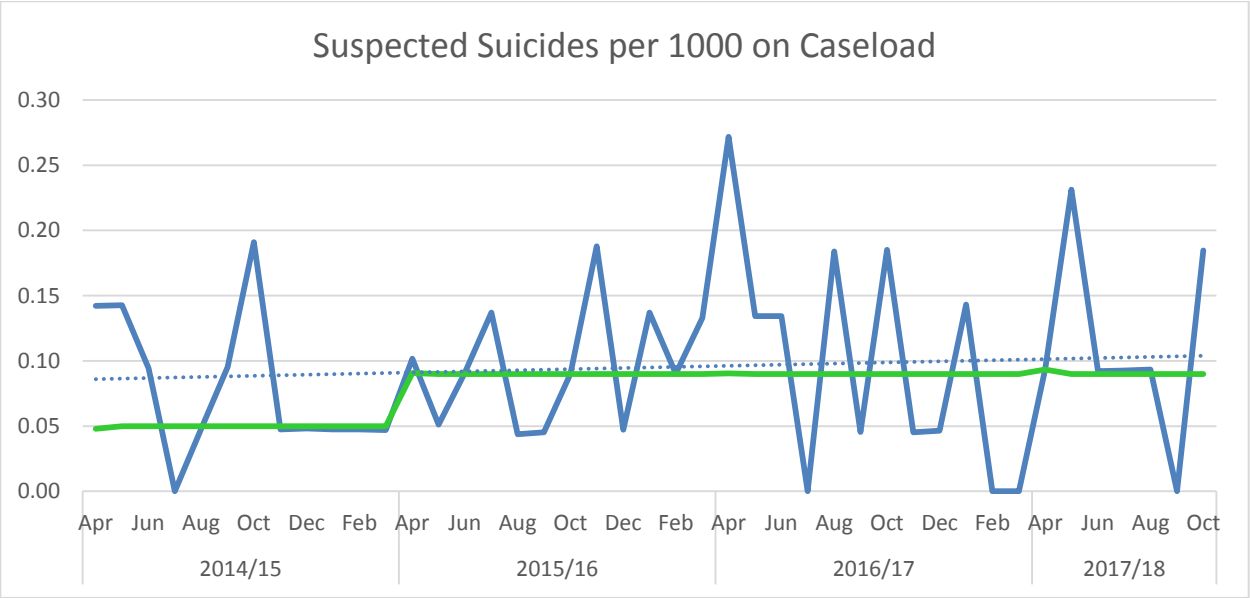


Figure 4

In terms of the inquest conclusions, these are shown in Figure 6 below. It is seen that the majority of reported suspected suicides are determined as such by the Coroner.

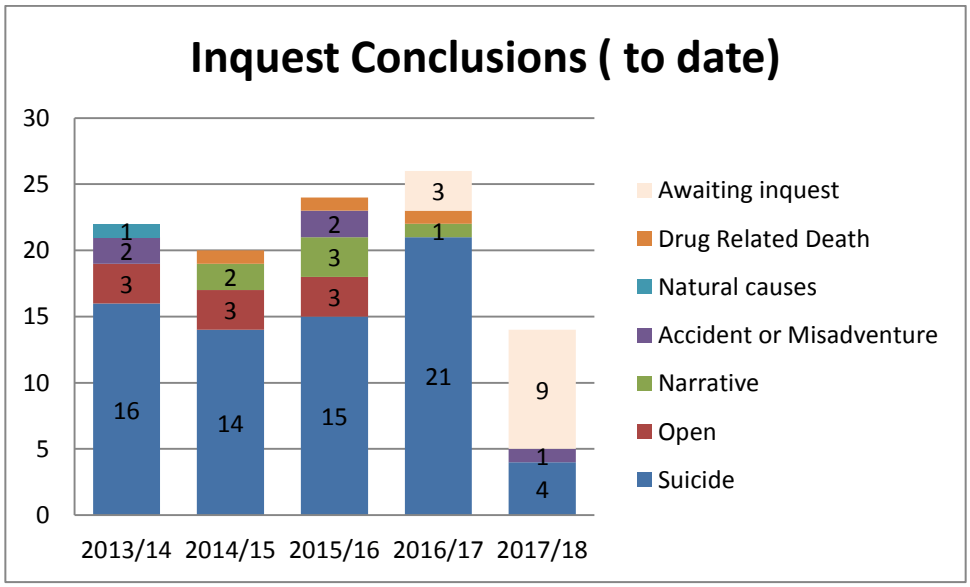


Figure 6

We are currently meeting this target.

Target 3.2 Detained service users who are absent without leave (AWOL) will not come to serious harm or death.

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.

In 2015/16 we reported **114** occurrences of AWOL (83 in Gloucestershire and 31 in Herefordshire. Last year we reported **211** occurrences of AWOL (162 in Gloucestershire and 49 in Herefordshire) so there has been a considerable increase in the numbers of people who are AWOL year on year. There are a number of factors which influence this, including open wards, increased numbers of detained patients in our inpatient units, increased acuity, and on occasion, service users who leave the hospital without permission multiple times.

What we want to ensure is that no service users who are AWOL come to serious harm or death, so this year we are measuring the level of harm that people come to when absent. The charts below show the levels of harm from our reported AWOLs for each year from 2015/16 onwards.

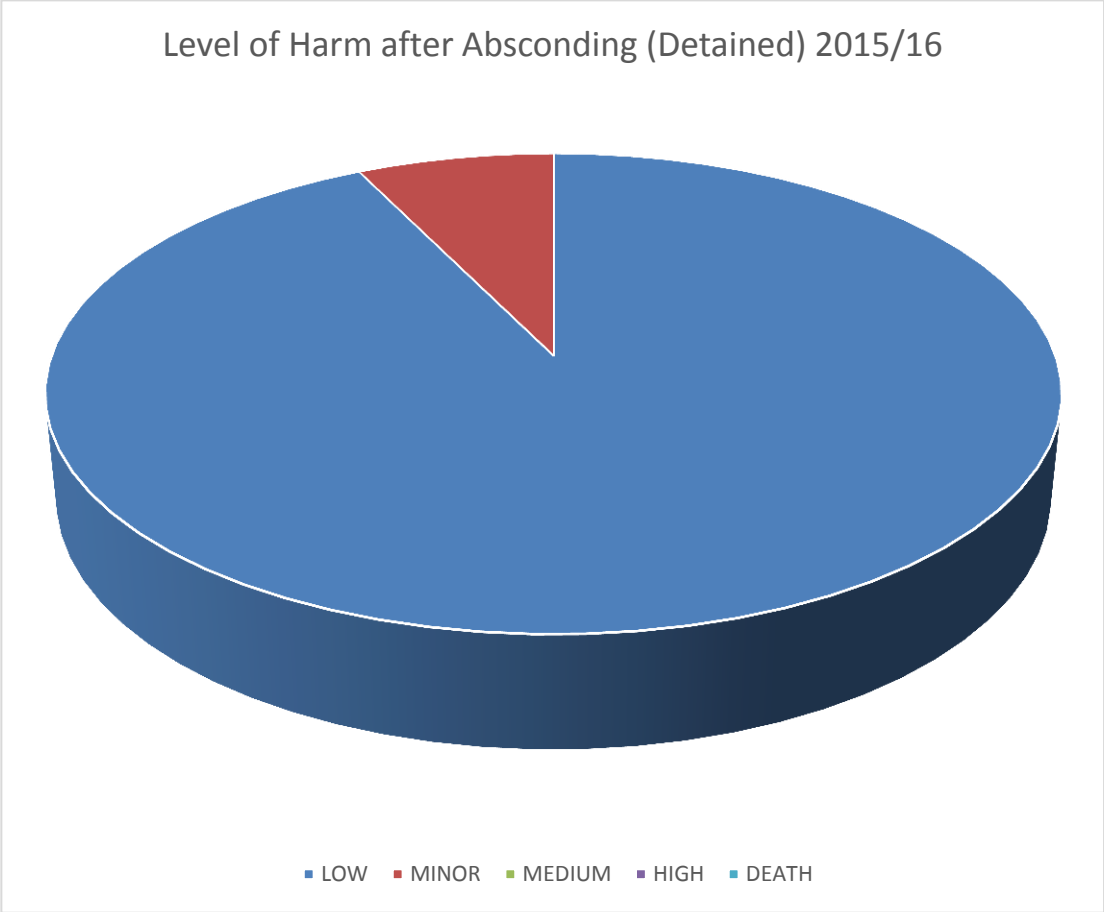


Figure 7

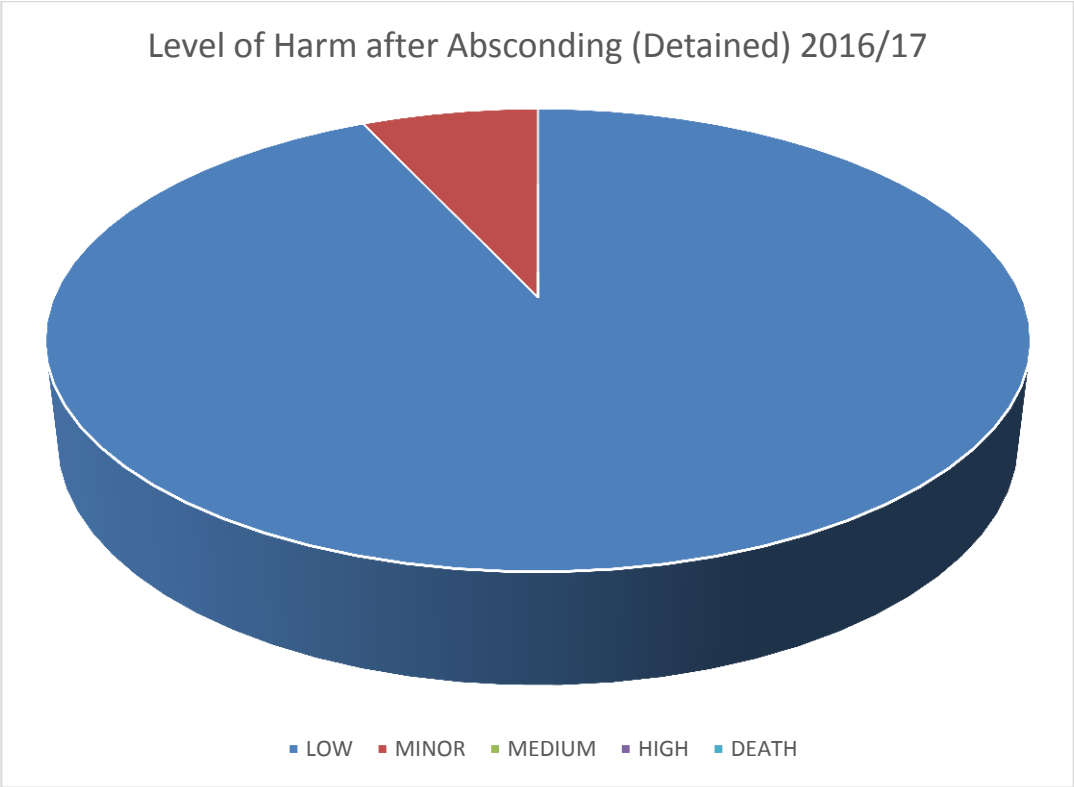


Figure 8

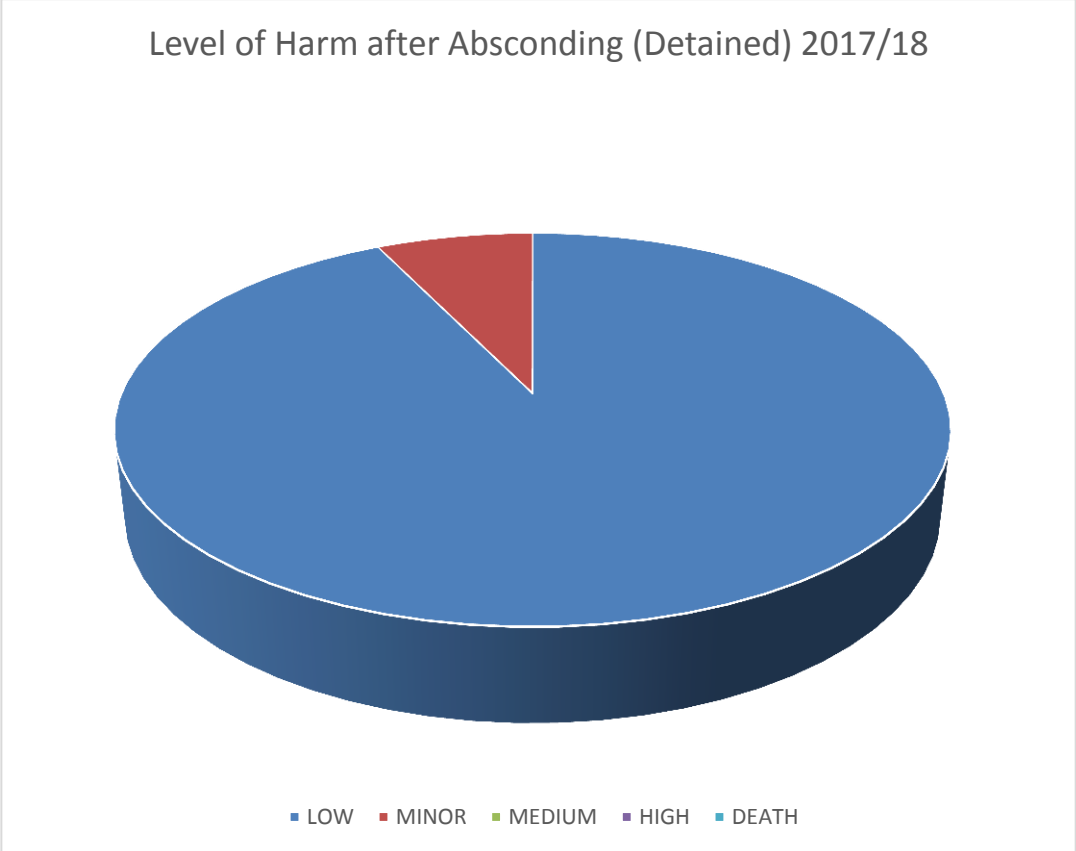


Figure 9

We are meeting this target.

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

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.

At the end of 2016/17, **211** instances of prone restraint were used as seen in Figure 8 which was an overall increase.

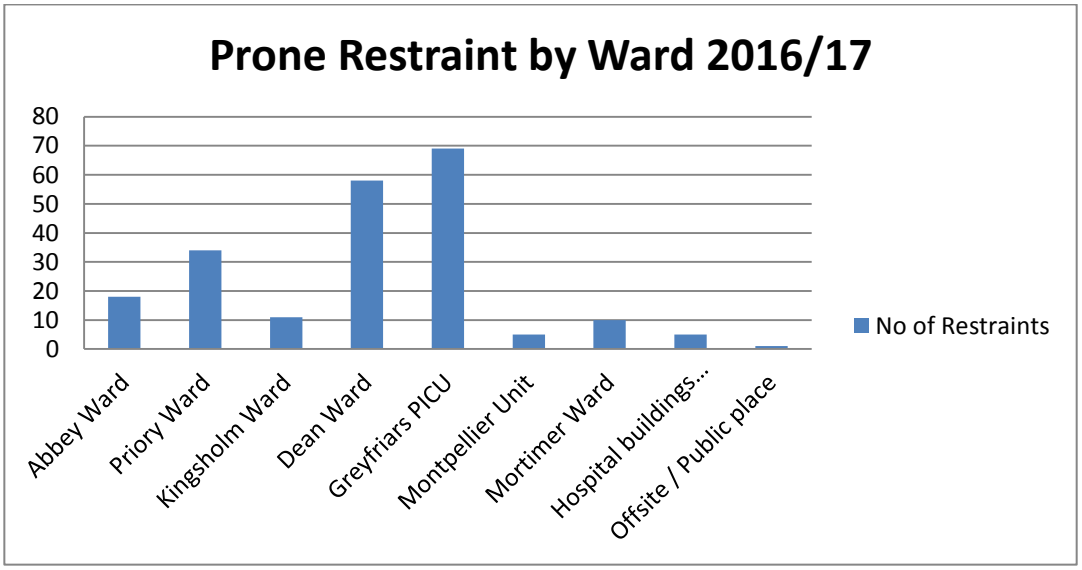
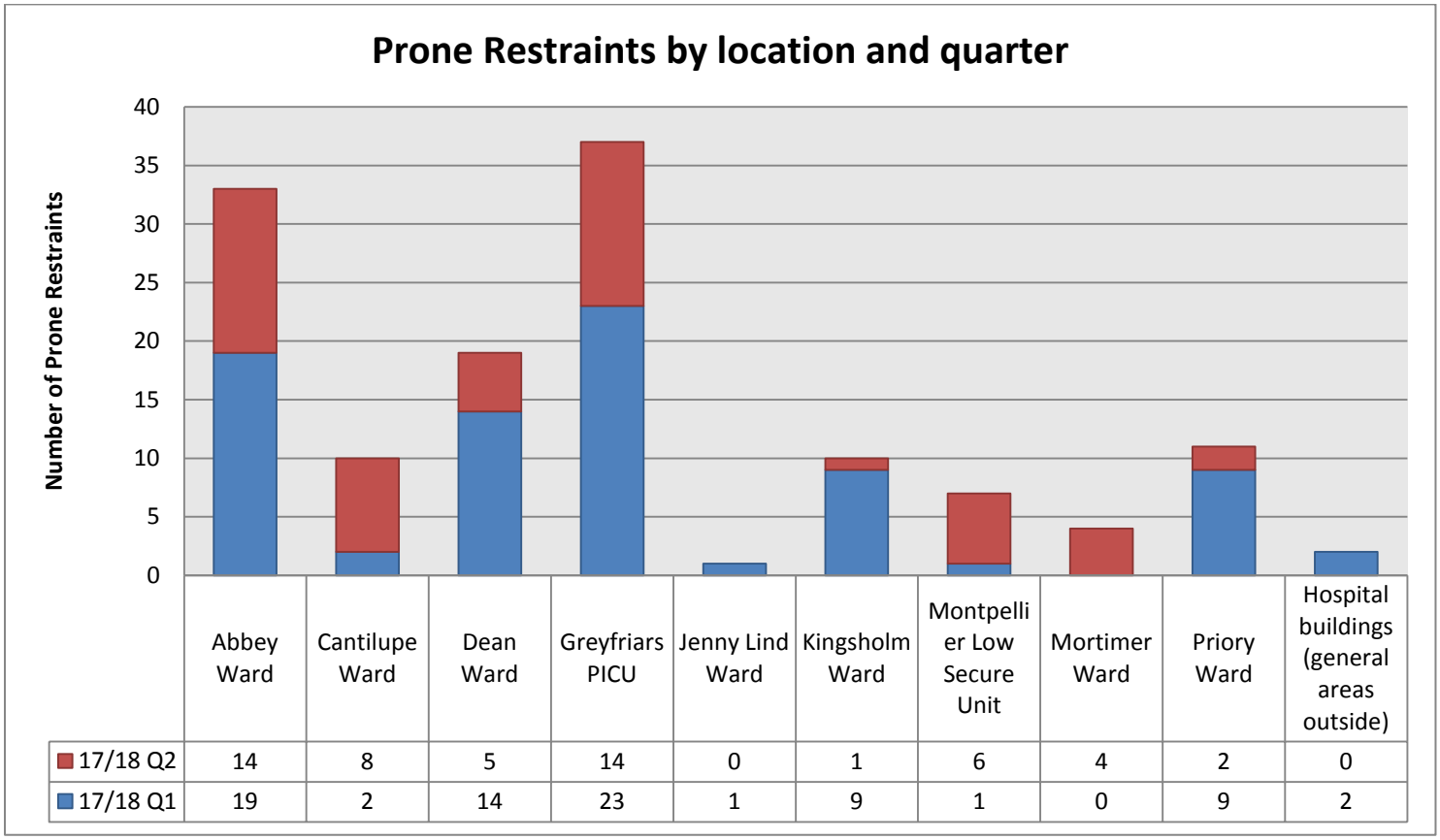


Figure 10

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 are being implemented during 2017/18 and it is anticipated that we will ultimately see a corresponding reduction in the use of prone restraint.

At the end of Quarter 1, **80** instances of prone restraint were used which saw a further increase, however, **54** prone restraints were reported in Quarter 2 which is 26 occurrences less than the previous quarter.



	Abbey Ward	Cantilupe Ward	Dean Ward	Greyfriars PICU	Jenny Lind Ward	Kingsholm Ward	Montpellier Low Secure Unit	Mortimer Ward	Priory Ward	Hospital buildings (general areas outside)
17/18 Q2	14	8	5	14	0	1	6	4	2	0
17/18 Q1	19	2	14	23	1	9	1	0	9	2

Figure 11

We have not yet met this target.

Serious Incidents reported during 2017/18

By the end of Quarter 2 2017/18, **28** serious incidents were reported by the Trust, **3** of which were subsequently declassified; the types of these incidents reported are seen below in Figure 10.

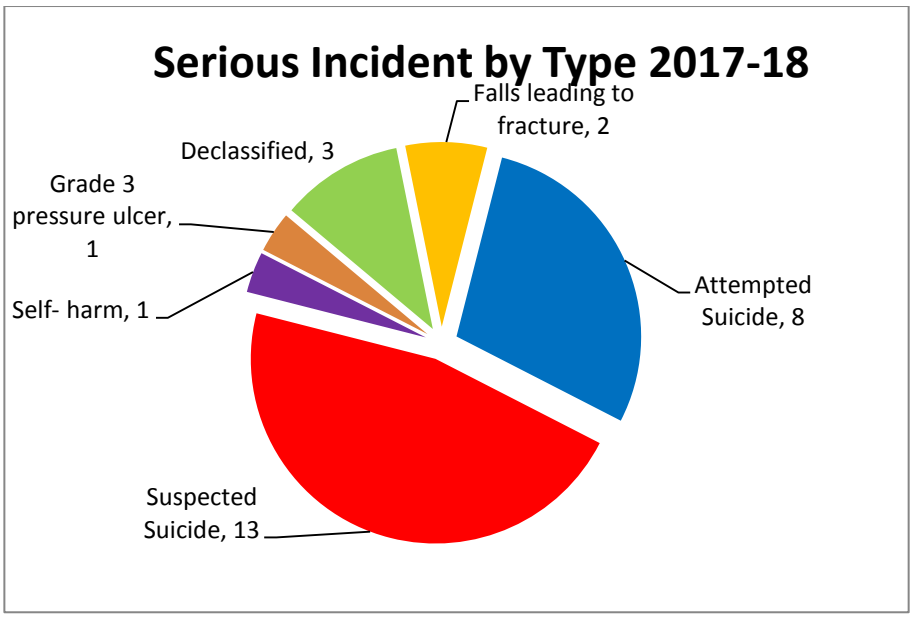


Figure 10

Figure 11 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 commenced this important work in May 2017, and a further dedicated Investigating Officer is now available via the Trust's Staff Bank. This arrangement will be reviewed during Quarter 4 2017/18.

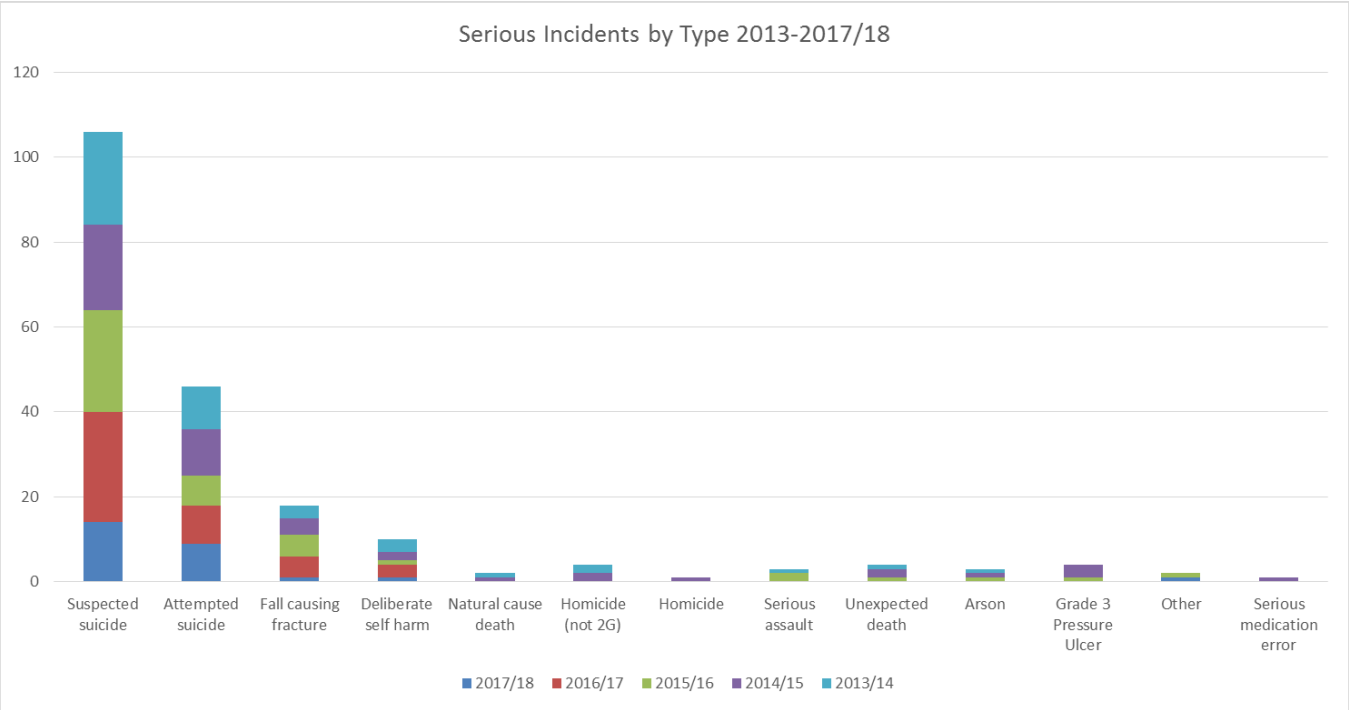


Figure 11

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. During 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 2017/18. 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.

The 'active' review of patient information commenced from 1 April 2017 and our 'Learning from Deaths Policy' was approved by the Board and published in September 2017 in line with the requirements of the "National Guidance on Learning from Deaths". We will be publishing our mortality review data 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 2017/2018

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

		2015-2016 Actual	2016-2017 Actual	National Threshold	2017-2018 Actual
1	Clostridium Difficile objective	0	**3**	0	**0**
2	MRSA bacteraemia objective	0	**0**	0	**0**
3	7 day CPA follow-up after discharge	95.63%	**98%**	95%	**99%**
4	CPA formal review within 12 months	99.35%	**99%**	95%	**97%**
5	Delayed transfer of care	1.02%	**1.7%**	≤7.5%	**0.7%**
6	Admissions gate kept by Crisis resolution/home treatment services	99.74%	**99%**	95%	**100%**
7	Serving new psychosis cases by early intervention teams	63.56%	**71%**	50%	**74%**
8	MHMDS data completeness: identifiers	99.57%	**99.9%**	97%	**99.9%**
9	MHMDS data completeness: CPA outcomes	97.42%	**94.7%**	50%	**94.6%**
10	Learning Disability – six criteria	6	**6**	6	**6**
11	EIP: Receipt of NICE approved care within 2 weeks	-	**71.3%**	50%	**tbc**
12	Improving access to psychological therapies - treated within 6 weeks of referral - treated within 18 weeks of referral		**37.8%**	75% 95%	**58%** **86%**

Commissioner Agreed Developments

This will be included at year-end.

Community Survey 2016

This will be included at year-end.

Staff Survey 2016

This will be included at year-end.

PLACE Assessment 2016

This will be included at year-end.

Annex 1: Statements from our partners on the Quality Report

This will be included at year-end.

The Royal College of Psychiatrists

This will be included at year-end.

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

This will be included at year-end.

Annex 3: Glossary

ADHD	Attention Deficit Hyperactivity Disorder
BMI	Body Mass Index
CAMHS	Child & Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
CPA	Care Programme Approach: a system of delivering community service to those with mental illness
CQC	Care Quality Commission – the Government body that regulates the quality of services from all providers of NHS care.

CQUIN	Commissioning for Quality & Innovation: this is a way of incentivising NHS organisations by making part of their payments dependent on achieving specific quality goals and targets
CYPS	Children and Young Peoples Service
DATIX	This is the risk management software the Trust uses to report and analyse incidents, complaints and claims as well as documenting the risk register.
GriP	Gloucestershire Recovery in Psychosis (GriP) is ^{2}gether's specialist early intervention team working with people aged 14-35 who have first episode psychosis.
HoNOS	Health of the Nation Outcome Scales – this is the most widely used routine Measure of clinical outcome used by English mental health services.
IAPT	Improving Access to Psychological Therapies
Information Governance (IG) Toolkit	The IG Toolkit is an online system that allows NHS organisations and partners to assess themselves against a list of 45 Department of Health Information Governance policies and standards.
MCA	Mental Capacity Act
MHMDS	The Mental Health Minimum Data Set is a series of key personal information that should be recorded on the records of every service user
Monitor	Monitor is the independent regulator of NHS foundation trusts. They are independent of central government and directly accountable to Parliament.
MRSA	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. It is also called multidrug-resistant
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 – 30 November 2017
Author: Quinton Quayle, Non-Executive Director
Presented by: Quinton Quayle, Non-Executive Director

SUBJECT: **NON EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS QUARTER 2 2017/18**

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 August and 31 October 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 audit 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.

2. SUMMARY OF FINDINGS

2.1 Case 1

2.1.1 This case involved a complaint by the son of a service user who suffered a number of falls after being prescribed Lithium. The complainant said that the

possible side effects of the medication were not explained to the family. In addition, the son complained that medical staff did not take his mother's symptoms sufficiently seriously when she contracted pneumonia.

2.1.2 The investigation covers in appropriate detail the number and circumstances of the service user's falls, the way that they were reviewed and recorded and corrective action taken (she was issued with Zimmer frame). All this is well reflected in the CEO's letter which also addresses the circumstances in which the complainant's mother contracted pneumonia and the admission of the service user to A&E when her condition deteriorated significantly.

2.1.3 The CEO's letter acknowledges that the possible side effects of the medication were not explained to the service user's family before it was prescribed and he apologises for this in his letter. However, in neither the CEO's letter nor the investigation report is it clear whether the aspect of the complaint about the possible side effects of prescribing lithium was correct and, if so, what corrective action is being taken (the implication is that lithium was a contributory factor to the falls as the investigation report records that the GP stopped the prescription "in the hope that this would improve mobility").

2.1.4 I therefore offer significant assurance about the way that the complaint was handled but limited assurance on the "learning aspects".

2.2 Case 2

2.2.1 This complaint was made by a neighbour, friend and relative of a service user with long term mental health issues. The key issue was the delay in carrying out a mental health assessment of the service user when she appeared to be at risk. The three complainants also felt that their concerns were not taken sufficiently seriously when they contacted the Crisis and Resolution Home Treatment Team (CRHTT) and the police.

2.2.2 It is clear from the investigation report and the CEO's letter that the concerns raised by the complainants were not acted on sufficiently expeditiously and that this resulted in a delay in the admission of the service user to Wotton Lawn. The CEO's letter adopts an appropriately apologetic tone in acknowledging these failures. It is also clear from the investigation report and the CEO's letter that a key issue is the difficulty that the CRHTT have in communicating with the Emergency Duty Team, who are managed by Gloucestershire County Council (GCC) and who are responsible for carrying out the out of hours Mental Health Act assessments. The CEO's letter says the issues raised will be fed back to the CRHTT and reviewed with GCC.

2.2.3 I thought that this complaint, which was clearly articulated by the complainants, was well handled both in the investigation and the CEO's letter. I therefore offer full assurance on this complaint.

2.3 Case 3

2.3.1 This complaint is made directly by a service user who expresses frustration at the delays she encountered in accessing mental health services. She originally saw her GP who advised her that it would take her a long time to

access the services of a psychiatrist on the NHS. She therefore paid to see one privately but then suffered a series of delays and mishaps in attempting to re-engage with NHS services via her GP and a mental health nurse. The file details a litany of unreturned calls, cancelled appointments and generally unsatisfactory engagement by the NHS with the service user, fully justifying her frustration and ultimately prompting her to make a formal complaint.

2.3.2 The service user originally wrote to Gloucester Royal Hospital (GRH) on 3 February; the complaint was passed by GRH to 2gether on 17 March but it was not acknowledged and acted on by 2gether until 25 April. The investigation report is dated 30 May but the CEO's final response letter was not issued until 6 July. Neither the investigation report nor the CEO's letter explains why the complaint took so long to deal with.

2.3.3 The investigation of this complaint has been complicated by the fact that the mental health nurse who had seen the complainant was off work and does not seem to have left very complete records of her inter-actions with the service user. Even allowing for this, I did not find the investigation report at all sympathetic towards an understandably anxious service user who seems to have gone from pillar to post in trying to access the help she needed from the NHS. An example of this is a letter which the service user thought was very distressing saying that "the nursing team are discharging you back to the GP". The investigation report comments on this "the patient appears to have been adequately communicated with, but was still confused about her care".

2.3.4 The CEO's letter strikes a much better tone and is appropriately apologetic. He also makes it clear that this complaint represents a learning experience for the staff and services involved. However, his letter does not explain the delay in first acknowledging and then dealing with the complaint. It also repeats the phrase "discharging you" which might have been more sensitively put.

2.3.5 I can therefore offer only limited assurance about the handling of this complaint.

3 RECOMMENDATIONS

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

Agenda item 12 **Enclosure No Paper G**

Report to:	[2]gether NHS Foundation Trust Board – 30 November 2017
Author:	Lauren Wardman, Deputy Director for Engagement
Presented by:	Jane Melton, Director for Engagement and Integration
SUBJECT:	**CQC Survey of people who use community mental health services - 2017 Results**

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

EXECUTIVE SUMMARY

- Enabling people to have positive experiences of NHS services which meet their needs and expectations is a key national strategic goal and an underpinning core value of [2]gether NHS Foundation Trust.
- Quality Health has been commissioned by [2]gether NHS Foundation Trust to undertake the 2017 national Community Mental Health Survey, which is a requirement of the Care Quality Commission.
- This paper outlines the Care Quality Commission's published results of the data analysis of the survey sample of people who use [2]gether's services. The CQC makes comparison with all other English mental health Trust results of the same survey. Some qualitative data are used to illustrate areas for development.
- The sample of participants was drawn randomly from Herefordshire and Gloucestershire using a prescribed national formula.
- Results were published on 15th November 2017 on the CQC website.

Assurance

- Three mental health Trusts in England were classed as 'better than expected' across the entire survey - [2]gether was named as one of these 3 Trusts.
- These results **represent a further improvement** when compared with our results from last years' service user feedback in the same survey.
- [2]gether is categorised as performing 'better' than the majority of other mental health Trusts in 5 of the 10 domains:

- ²gether is categorised as performing 'about the same' as the majority of other mental health Trusts in the remaining 5 domains:

- ²gether has demonstrated a statistically significant improvement compared to the 2016 score for the question: 'In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work?'. (2016: 3.6/10, 2017 5.5/10)

- ²gether is not categorised as performing 'worse' than the majority of other mental health Trusts for any of the domains or any of the specific questions.

- The development of an action plan will be undertaken with Locality Directors by January 2017.

Areas for development include:

1. Supporting people at times of crisis

2. Involving people in planning and reviewing their care

3. Involving family members or someone close, as much as the person would like

4. Giving people information about getting support from people with experience of the same mental health needs as them

5. Helping people with their physical health needs and to take part in an activity locally

6. Providing help and advice for finding support with finances, benefits and employment

RECOMMENDATIONS

The Board is asked to:

- Note the contents of this report

Corporate Considerations	
Quality implications:	Service Experience Feedback through survey methodology provides one element of quality information and assurance. This information needs to be triangulated with other forms of service experience feedback including that presented in the quarterly Service Experience Report.
Resource implications:	Taking action to develop positive service experience in the areas where scores are lower may require additional or a realignment of resources
Equalities implications:	The demographic results of the survey show that a very small proportion of respondents were from Black, Asian and minority ethnic (BAME) groups. Work will continue to encourage people from our BAME communities to take part in the survey.

	A higher percentage of people over 65 years of age completed the ²gether survey (54%) compared with many other Trusts (national average 40%). This has occurred for several years and reflects the population demographic of Gloucestershire and Herefordshire. It is also understood that older people are more likely to complete a survey request of this nature.
Risk implications:	Feedback from service experience offers an insight into how services are received. The results will be publically available and it is important to offer assurance that the organisation is taking appropriate action to effect positive practice development. The reputation of the organisation, which may impact on uptake of services, could be at risk particularly where results are 'worse than other trusts'. However, it should be noted that the results suggest 'low risk' in this area.

WHICH TRUST KEY STRATEGIC OBJECTIVES DOES THIS PAPER PROGRESS OR CHALLENGE?			
Quality and Safety	P	Skilled workforce	P
Getting the basics right	P	Using better information	P
Social inclusion	P	Growth and Financial Efficiency	
Seeking involvement	P	Legislation and Governance	P
WHICH TRUST VALUES DOES THIS PAPER PROGRESS OR CHALLENGE?			
Seeing from a service user perspective			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 for Engagement and Integration	Date	Nov 2017

Where in the Trust has this been discussed before?		
Senior leaders were engaged in a presentation of preliminary results from Quality Health.		September 2017
Pre-publication notification of results at Executive Committee		November 2017
Notification of and link to the published results has been circulated for to all staff with acknowledgement of the dedicated effort to deliver best service experience.		November 15th 2017
Notification of and link to the published results has been Trust Governors.		November 15th 2017

What consultation has there been?		
	Date	

Explanation of acronyms used:	Care Quality Commission (CQC) Quality Health (QH) Red, Amber, Green (RAG)

2017 CQC survey of people who use community mental health services

The CQC survey	The CQC checks whether mental health services are doing a good job. They send surveys to people who use community mental health services. The survey is sent to a sample of people from all over England. Not everyone who uses community mental health services will get a survey.	
This report 	Every year some of ²gether's service users are sent a survey. The survey asks what they think about ²gether's community mental health services. This report tells you what the results were for ²gether	
Overall 	²gether's community mental health services were classed as 'better than expected'. Only 2 other Trusts in England performed as well as ²gether. This is a very good result and is better than last year.	
Things we do well 	²gether is better than most other Trusts for: - Organising people's care - Managing changes in who people see - Managing medicines - Helping with support and wellbeing - Overall care and services	
Things we are quite good at 	²gether is about the same as other Trusts for: - The quality of its staff - Planning care - Reviewing care - Crisis care - People's overall experience	
Things we can do better 	²gether will work hard to get better at: - Supporting people when they are in crisis - Involving people in planning and reviewing their care - Involving family members or someone close - Helping people to find support from people with the same problems - Helping people with their physical health and taking part in local activities - Giving help and advice with money and work	

	Full assurance		Limited assurance
	Significant assurance		Negative assurance

CQC 2017 Survey of people who use community mental health service

RESULTS FOR GLOUCESTERSHIRE AND HEREFORDSHIRE

1. Background

1.1 The Care Quality Commission (CQC) requires that all mental health Trusts in England undertake an annual survey of patient feedback. 2gether NHS Foundation Trust has, for several years, commissioned Quality Health to undertake this work.

1.2 The 2017 survey of people who use community mental health services involved 56 providers in England, including combined mental health and social care trusts, Foundation Trusts and community healthcare social enterprises that provide mental health services.

1.3 The data collection was undertaken between February and June 2017 using a standard postal survey method. The sample was generated at random using the agreed national protocol for all clients on the CPA and Non-CPA Register seen between 1st September and 30th November 2016.

1.4 This year 2gether NHS Foundation Trust received one of the highest percentage response rates at 33% (national average of 26%).

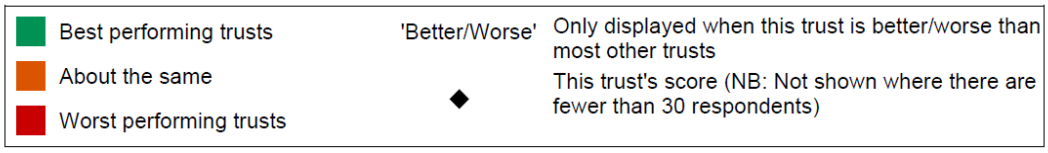
1.5 Full details of this survey questions and results can be found on the following website: http://nhssurveys.org/Filestore/MH17_bmk_reports/MH17_RTQ.pdf

2. Scores for 2gether NHS Foundation Trust in 2017

2.1 The CQC results for the 2017 survey of people who use community mental health services were published on the 15th November 2017. 2gether's overall results are summarised in Table 1 below.

Table 1 – 2gether NHS Foundation Trust scores for the 2017 survey of people who use community mental health services

Key to Table 1



2.2 ²gether is categorised as performing 'better' than the majority of other mental health Trusts in 5 of the 10 domains:

- *Organising care*
- *Changes in who people see*
- *Treatments (medicines)*
- *Support and wellbeing*
- *Overall views of care and services*

2.3 ²gether is categorised as performing 'about the same' as the majority of other mental health Trusts in the remaining 5 domains:

- *Health and social care workers*
- *Planning care*
- *Reviewing care*
- *Crisis care*
- *Overall experience*

2.4 ²gether obtained the highest score achieved by any Trust on 5 of the 32 evaluative questions:

- *Have you agreed with someone from NHS mental health services what care you will receive?*
- *Were these treatments or therapies explained to you in a way that you could understand?*
- *Do the people you see through NHS mental health services help you with what is important to you?*
- *In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?*
- *Overall experience*

2.5 ²gether has demonstrated a statistically significant improvement compared to the 2016 score for the question: 'In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work?' (2016: 3.6/10, 2017 5.5/10). This suggests that actions which have been put in place to improve our performance in this area are having a positive impact on service user experience.

2.6 ²gether is not categorised as performing 'worse' than the majority of other mental health Trusts for any of the domains or any of the evaluative questions.

2.7 An infographic has been developed to share the results in a more accessible format for local stakeholders (Appendix 1).

3. Top areas for priority further development include:

3.1 ²gether scored well this year overall by comparison to other Trusts, being one of only three English mental health Trusts classed as 'better than expected'. However, there continue to be areas where further development and continued effort would enhance

the experience of people in contact with 2gether's services. For example, the results in the crisis care domain suggest that further work is required in this area.

3.2 It would appear from the CQC 2017 scores and information from a range of other service experience information (reported to Board quarterly) that actions being taken to enhance service experience over recent years are having a positive impact. However, areas for further development are evident and these will be reflected in the Action Plan (to follow).

3.3 The priority areas to undertake further work have been identified by considering where the scores suggest a lower degree of satisfaction overall. As such the following areas for further practice development are proposed:

- Supporting people at times of crisis

'Unfortunately I found crisis care very poor, on several occasions they forgot to phone me when they were meant to. On home visits they turned up extremely late and they didn't visit for very long.'

- Involving people in planning and reviewing their care

'My care was textbook. It didn't take in to account my personal needs at all.'

- Involving family members or someone close, as much as the person would like

'It would be nice for my daughter to be updated a little more regularly than she is, as they don't update her at all.'

- Giving people information about getting support from people with experience of the same mental health needs as them

'Finding someone to talk to is sometimes difficult.'

- Helping people with their physical health needs and to take part in an activity locally

'I have kidney failure from taking lithium in my youth. I was also taking dosulepin, which was not being removed because of the kidney failure. It did not show on any blood tests and was missed by the kidney specialist and the psychiatrist and many other specialists.'
'Maybe link with local activity centres/organisations that could help with social/physical improvements e.g. climbing centre/GL1.'

- Providing help and advice for finding support with finances, benefits and employment

'Being diagnosed with a psychiatric illness is very confusing. There should be a welcome pack explaining services and processes available and also covering things like benefit entitlement.''

4. Next Steps

4.1 These results represent a further improvement when compared to our results from last years' service user feedback in the same survey. The results are a testament to the expert and dedicated effort that colleagues are making to understand need, involve and respond well to people who use our services and their carers.

4.2 There is a need to sustain the effort made to develop practice in the areas identified in previous years.

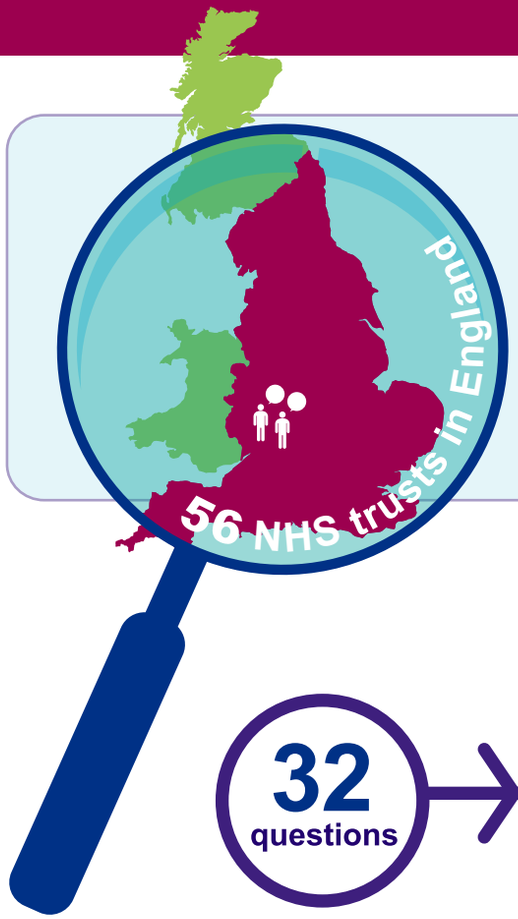
4.3 The development of an action plan will be undertaken with Locality Directors and Heads of Professions by January 2018.

4.4 The 2017 results have already been provided for all colleagues through a global email which celebrates our successes and thanks them for their dedication. Further cascade will be undertaken through Team Talk across Herefordshire and Gloucestershire. The results will be cascaded to Service Directors for sharing with Teams and for generating ideas for continued practice development. An infographic has been developed to share the local results in a more accessible format (Appendix 1)

'I am so extremely grateful for MH services, they saved my life'

2017 CQC Survey of people who use community mental health services
Gloucestershire and Herefordshire

²gether NHS Foundation Trust



822 people were sent the survey

271 people returned the survey

18 years plus

National response rate

Trust response rate

32 questions → **10** domains → **²gether's results:** In the top 20% of Trusts in 5 out of the 10 domains. 'About the same' as other Trusts in 5 domains.

Results of 10 domains

Each domain compared to other trusts

Better | About the same | Worse

Health and social care workers	8.0/10
Organising care	8.9/10
Planning care	7.3/10
Reviewing Care	7.8/10
Changes in who people see	7.3/10
Crisis care	6.5/10
Treatments	7.9/10
Support and well-being	5.7/10
Overall views of care and services	7.9/10
Overall experience	7.5/10

Rated nationally as amongst the highest performing trusts for:

- Organising people's care
- Involving people in agreeing what care they will receive
- Formally meeting with people every 12 months to discuss how their care is working
- Managing changes in who people see
- Clearly explaining and reviewing treatments or therapies
- Helping people with what is important to them
- Seeing people enough to meet their needs
- People's overall experience

Areas for further focus:

- Supporting people at times of crisis
- Involving people in planning and reviewing their care
- Involving family members or someone close, as much as the person would like
- Giving people information about getting support from people with experience of the same mental health needs as them
- Helping people with their physical health needs and to take part in an activity locally
- Providing help and advice for finding support with finances, benefits and employment

2017 CQC Survey of people who use community mental health services
Gloucestershire and Herefordshire

2gether NHS Foundation Trust

Results for 32 questions

Each domain includes a number of questions. These are each compared to other trusts using this key:

Better | About the same | Worse

Health and social care workers	8.0/10
Listen carefully	8.3/10
Enough time to discuss needs	8.0/10
Understand how mental health affects life	7.7/10
Organising Care	**8.9/10**
Kept informed of who organises care	8.4/10
Know how to contact Care Co-ordinator	9.8/10
Care organised well	8.7/10
Planning care	**7.3/10**
Agreeing the care received	6.7/10
Involvement in care planning	7.6/10
Personal circumstances considered	7.8/10
Reviewing care	**7.8/10**
Discussed how care is working	8.0/10
Involvement in care review	7.7/10
Decisions made together	7.6/10
Changes in who people see	**7.3/10**
Explanations given for change in care	7.0/10
Impact of change in care	8.0/10
Aware who was in charge of care	6.9/10
Crisis care	**6.5/10**
Know who to contact out of hours	7.4/10
Support during a crisis	5.6/10
Treatment	**7.9/10**
Involved in decisions	7.4/10
Understandable medicines information	7.4/10
Medicines reviewed	8.2/10
Treatments or therapies explained	8.9/10
Involved in deciding therapies to use	7.7/10
Support and well-being	**5.7/10**
Help finding physical health needs support	5.7/10
Help finding financial advice/benefits support	5.5/10
Help finding or keeping work	5.5/10
Support to take part in local activities	4.9/10
Involving family or friends	7.1/10
Information about support from others with similar experiences	4.4/10
Help to achieve what is important to the service user	7.0/10
Overall view and experience of services	**7.9/10**
Enough contact with services	7.1/10
Treated with respect and dignity	8.7/10
Overall experience	**7.5/10**
Overall experience of services	7.5/10

Agenda item 13 **Paper H**

Report to: 2gether NHS Foundation Trust Board - 30th November 2017
Author: Colin Merker – Deputy Chief Executive
Presented by: Colin Merker – Deputy 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:	As Noted
Resource implications:	As Noted
Equalities implications:	As Noted
Risk implications:	As Notes

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	*November 2017*

Where in the Trust has this been discussed before?		
CEO	Date	*November 2017*

What consultation has there been?		
N/A	Date	

Explanation of acronyms used:	

1. CONTEXT

1.1 Delivering our Three Strategic Priorities

1.2.1 Continuously Improving Quality

Our focus on continuous improvement continues via:

- Ongoing engagement and leadership of the South of England Mental Health Safety Collaborative, which has been shortlisted for a Health Service Journal award,
- Quality Service Improvement Redesign – both Damian Gardner and Zoe Scott-Lewis have passed the reaccreditation process and are accredited trainers until November 2018.
    - Gloucestershire – Just started training cohort 3. Once complete, over 90 colleagues will have completed the QSIR Practitioner course. Two Fundamentals courses have been run with another scheduled for December. In Gloucestershire, over 10 organisations and 30 projects will have been supported by the QSIR process after cohort 3 is complete. Hein Le Roux, the CCG Older Peoples GP Lead, has just been accredited as a QSIR associate, and will be joining the Gloucestershire training group, which will hopefully increase engagement from/with primary care. A fourth cohort is scheduled to start in Q4 with recruitment currently open. Executive colleagues are nominating Trust staff.

    - Herefordshire – Just started training cohort 2. Once complete, 45 colleagues from across Herefordshire & Worcestershire will have completed the QSIR Practitioner course from across all NHS organisations. Two more colleagues (one from Wye Valley Trust and

one from Worcestershire Health & Care NHS Trust) have been accredited, bringing the total number of trainers to five.

- 2gether-specific – A Fundamentals Day targeting psychologists and medics took place on 13th October 2017. This was very well-received and there is interest for further sessions, with wider staff groups.

- Our engagement with NHSI on a number of Rapid Improvement Projects associated with; continuity of staffing further reducing dependency on temporary staffing; and Observation and Engagement.

2.0 Engagement

2.1 Internal Board Engagement

01.09.17 The Chief Executive attended the Medical Staffing Committee

01.09.17 The Director of Organisational Development participated on the panel for an Appeal against Dismissal hearing.

04.09.17 The Chief Executive welcomed new colleagues at Corporate Induction

04.09.17 The Director of Service Delivery delivered Team Talk

04.09.17 The Director of Service Delivery attended the Senior Leadership Forum

04.09.17 The Director of Organisational Development led the Team Talk session at Weavers Croft, Stroud

04.09.17 The Director of Finance and Commerce attended Senior Leadership Forum

04.09.17 The Director of Engagement and Integration greeted new recruits at Corporate Induction at Collingwood House

04.09.17 The Director of Engagement and Integration attended the Trust's Senior Leadership Forum

04.09.17 The Director of Organisational Development attended Senior Leadership Forum

06.09.17 The Director of Service Delivery attended a Patient Safety visit at Stonebow Unit and Jenny Lind Ward

11.09.17 The Chief Executive chaired the Executive Business Committee

11.09.17 The Director of Service Delivery attended an Executive Business meeting

13.09.17 The Director of Organisational Development chaired the People Sub-Committee

14.09.17 The Director of Finance and Commerce attended IT Partnership Review Board

15.09.17 The Medical Director attended a Junior Doctors meeting.

15.09.17 The Director of Engagement and Integration chaired the Trust's Quality and Clinical Risk Sub-Committee

19.09.17 The Chief Executive attended the Council of Governors

19.09.17 The Director of Engagement and Integration chaired the Triangle of Care Project Board

19.09.17 The Director of Engagement and Integration attended the Trust's Council of Governors meeting

19.09.17 The Director of Organisational Development attended Council of Governors meeting

19.09.17 The Director of Service Delivery attended a Council of Governors meeting

20.09.17 The Director of Service Delivery attended an ad-hoc Team Talk

20.09.17 The Director of Organisational Development joint led the Special Team Talk session at Rikenel

20.09.17 The Director of Engagement and Integration co-led a special Team Talk meeting at Park House

20.09.17 The director of Finance and Commerce attended Team Talk

22.09.17 The Director of Organisational Development attended a joint Board/Patient Safety Visit at Abbey Ward, Wotton Lawn Hospital

22.09.17 The Director of Organisational Development attended a Board Visit at Greyfriars Ward, Wotton Lawn Hospital

25.09.17 The Chief Executive chaired the Executive Business Committee

25.09.17 The Director of Service Delivery attended an Executive Business Meeting

26.09.17 The Director of Finance and Commerce attended Capital Review Group

27.09.17 The Director of Finance and Commerce attended Transformation (CIP) Project Board

27.09.17 The Director of Service Delivery took part in the recruitment panel of a consultant

27.09.17 The Director of Service Delivery took part in the recruitment of a Medicines Optimisations post

28.09.17 The Director of Service Delivery attended the Trust Board meeting

28.09.17 The Director of Service Delivery attended the Appointments and Terms of Service Committee meeting

28.09.17 The Director of Engagement and Integration attended the Trust's Board meeting

28.09.17 The Director of Organisational Development attended the Trust Board meeting

02.10.17 The Chief Executive hosted Team Talk at Weavers Croft

02.10.17 The Chief Executive visited Pullman Place

02.10.17 The Chief Executive chaired the Senior leadership Forum

02.10.17 The Director of Finance and Commerce attended Corporate Induction on behalf of the CEO

02.10.17 The Director of Finance and Commerce attended Senior Leadership Forum

02.10.17 The Director of Organisational Development led Team Talk at Rikenel

02.10.17 The Director of Organisational Development attended Senior Leadership Forum

02.10.17 The Medical Director delivered Team Talk in Hereford.

03.10.17 The Chief Executive attended the interviews for Joint Chair.

03.10.17 The Director of Finance and Commerce attended Appointment of Joint Chair – Board Discussion Group

03.10.17 The Medical Director Designate participated in the Focus Groups for the Chair's post.

03.10.17 The Director of Service Delivery participated in the Chairs appointment process

04.10.17 The Director of Service Delivery attended a meeting regarding Oak House costs.

04.10.17 The Director of Service Delivery attended a MH ICT progression meeting

06.10.17 The Medical Director attended MSC.

09.10.17 The Director of Service Delivery attended the Executive Business meeting

10.10.17 The Chief Executive attended a board visit to Mulberry Ward

10.10.17 The Director of Service Delivery attended a AMHP Paper feedback and presentation

11.10.17 The Director of Service Delivery attended an Inpatient Services meeting

11.10.17 The Director of Service Delivery attended a Developing On-call arrangements meeting

11.10.17	The Director of Organisational Development attended a Board Visit to Laurel House, Swindon Road, Cheltenham
12.10.17	The Director of Finance and Commerce attended Senior Manager Team Meeting
12.10.17	The Director of Service Delivery conducted a Board visit to Herefordshire Primary MH Care Team
13.10.17	The Director of Service Delivery attended a Social Care/Commissioner meeting
16.10.17	The Chief Executive welcomed new colleagues at Corporate induction
16.10.17	The Director of Service Delivery attended the Executive Development meeting.
16.10.17	The Director of Service Delivery attended an Inpatient Medics Meeting
17.10.17	The Chief Executive attended JNCC
17.10.17	The Director of Service Delivery attended JNCC
17.10.17	The Director of Organisational Development attended the Joint Negotiating & Consultative Committee (JNCC) meeting
18.10.17	The Director of Finance and Commerce attended Development Committee
18.10.17	The Director of Finance and Commerce attended Development Committee
18.10.17	The Director of Service Delivery attended an Executive meeting regarding the CQC preliminary review
19.10.17	The Director of Service Delivery attended a Primary Care MH Nurse Pilot meeting
19.10.17	The Director of Finance and Commerce attended Audit Committee
20.10.17	The Director of Organisational Development attended the Local Negotiating Committee (LNC) meeting
20.10.17	The Director of Engagement and Integration attended the Quality and Clinical Risk Sub-Committee
20.10.17	The Director of Engagement and Integration attended the Trust's Governance Committee
23.10.17	The Director of Service Delivery attended the Executive Business meeting
24.10.17	The Director of Engagement and Integration led a Patient Safety Visit at Laurel House in Cheltenham

24.10.17 The Director of Finance and Commerce chaired Gloucester Hub Gateway Update

24.10.17 The Director of Finance and Commerce chaired Capital Review Group

24.10.17 The Director of Finance and Commerce attended Transformation (CIP) Project Board

25.10.17 The Director of Engagement and Integration facilitated a Board Visit with the Assertive Outreach Team at Charlton Lane Hospital in Cheltenham

25.10.17 The Director of Organisational Development attended the Temporary Staffing Demand Project Board meeting

25.10.17 The Director of Service Delivery attended the Delivery Committee meeting

26.10.17 The Director of Organisational Development attended the Trust Board meeting

26.10.17 The Director of Engagement and Integration attended the Trust's Board meeting

26.10.17 The Director of Service Delivery attended Trust Board

30.10.17 The Director of Service Delivery attended the Executive Development meeting.

30.10.17 The Director of Engagement and Integration met with the Chief Executive Officer of Gloucestershire Care Services

30.10.17 The Medical Director Designate attended the Corporate Induction Welcome slot.

31.10.17 The Director of Engagement and Integration attended an AHP STP Meeting

2.2 Board Stakeholder Engagement

01.09.17 The Medical Director attended the West of England NHS Genomics Medicine Centre 2017 Annual Event

01.09.17 The Director of Service Delivery attended a meeting with the CEO of Gloucester Care Services

04.09.17 The Director of Engagement and Integration attended an AHP Gloucestershire STP meeting at Ambrose House

05.09.17 The Director of Service Delivery attended a meeting with the Accountable Officer at CCG

05.09.17 The Director of Engagement and Integration attended the Mental Health and Wellbeing Partnership Board

05.09.17	The Director of Engagement and Integration chaired a quarterly strategic partnership meeting between colleagues at 2gether and Swindon Mind
05.09.17	The Director of Finance and Commerce attended Swindon Mind & 2gether Strategic Partnership Meeting
06.09.17	The Chief Executive attended the West of England AHSN Board meeting
06.09.17	The Chief Executive Chaired the HR and OD workstream meeting
06.09.17	The Director of Service Delivery attended a Mental Health and Urgent Care meeting
06.09.17	The Director of Service Delivery attended a EPRR Assurance meeting
07.09.17	The Chief Executive attended the Gloucestershire STP delivery Board
07.09.1 7	The Director of Service Delivery attended a Gloucestershire Urgent Care Partners Joint Governance meeting
07.09.17	The Director of Organisational Development attended the Gloucestershire STP Social Partnership Forum
07.09.17	The Director of Organisational Development chaired the Gloucestershire STP Capability Thematic Group
07.09.17	The Director of Engagement and Integration attended a presentation of the GRiP service users
12.09.17	The Chief Executive attended the Gloucestershire HSOSC meeting
12.09.17	The Director of Engagement and Integration attended a meeting to discuss the Recovery College with commissioners at Gloucestershire CCG
12.09.17	The Director of Engagement and Integration attended the Gloucestershire Health and Care Overview and Scrutiny Committee meeting at Shire Hall
12.09.17	The Director of Engagement and Integration attended the Gloucestershire STP Clinical Reference Group at Sanger House
13.09.17	The Chief Executive attended the Herefordshire and Worcestershire STP Q2 stocktake meeting
13.09.17	The Medical Director attended the West of England Collaborative Learning From Deaths Meeting
13.09.17	The Director of Finance and Commerce attended Gloucester Hub Gateway Update
13.09.17	The Director of Finance and Commerce attended 2gether Contract Board (Gloucestershire)
13.09.17	The Director of Service Delivery attended the Gloucestershire Contract Board meeting

13.09.17	The Director of Service Delivery attended a Budgetary Discussion with Gloucester County Council and Gloucestershire Clinical Commissioning Group
14.09.17	The Director of Service Delivery attended the IT Partnership Review Board
14.09.17	The Director of Service Delivery attended the New Models of Care Board
18.09.17	The Director of Engagement and Integration attended a Time to Change Hub meeting at Shire Hall
18.09.17	The Director of Service Delivery attended the A&E Delivery Board
19.09.17	The Director of Service Delivery attended the Gloucester Place Based Pilot Board
21.09.17	The Director of Service Delivery attended the Stroud and Berkeley Vale Board meeting
21.09.17	The Director of Service Delivery attended an Interface meeting with Gloucestershire County Council
21.09.17	The Director of Finance and Commerce attended 2gether Contract Board (Herefordshire)
22.09.17	The Director of Service Delivery attended a Delivery Committee
29.09.17	The Director of Organisational Development attended the Gloucestershire STP Planning Meeting
03.10.17	The Director of Organisational Development participated in a teleconference interview regarding a Health Foundation Bid for the Advancing Applied Analytics Programme
03.10.17	The Director of Service Delivery attended a Gloucestershire Countywide IM&T Steering Group
04.10.17	The Chief Executive chaired the Gloucestershire HR and OD workforce Committee
04.10.17	The Director of Service Delivery participated in a conference call regarding STP Human Resources & Organisational Development Stock Take
05.10.17	The Chief Executive attended the Gloucestershire STP Delivery Board
05.10.17	The Director of Service Delivery attended One Place Business Case Discussion at STP Delivery Board meeting
05.10.17	The Director of Service Delivery attended a meeting regarding Learning Difficulty services in Herefordshire
05.10.17	The Director of Finance and Commerce attended IT Partnership Review Board

05.10.17	The Director of Organisational Development chaired the STP Gloucestershire Capability Thematic Group meeting
06.10.17	The Chief Executive attended the Allied Health Professionals and Psychological Professionals Conference
06.10.17	The Medical Director attend the Annual Deanery Visit to the Trust.
06.10.17	The Director of Engagement and Integration hosted 2gether's Allied Health Professionals and Psychological Professionals Conference
06.10.17	The Director of Service Delivery attended a Gloucestershire STP Stocktake meeting with NHS England colleagues
10.10.17	The Director of Service Delivery attended an A&E Delivery Board with Hereford CCG
10.10.17	The Director of Service Delivery attended a Joining Up Your Information Project Board and Clinical Information Sharing Projects Group Meeting
10.10.17	The Director of Finance and Commerce attended Joint RSG and PDG Meeting
11.10.17	The Chief Executive attended the One Herefordshire Health and Care alliance meeting
11.10.17	The Director of Finance and Commerce attended Gloucestershire 2gether Contract Board Meeting
11.10.17	The Director of Service Delivery attended a 2gether Contract Board Meeting with commissioners
12.10.17	The Director of Service Delivery attended a 2gether MH Housing Support meeting
13.10.17	The Director of Service Delivery attended a AMPH Discussion meeting with Clinical Commissioning Group
16.10.17	The Director of Service Delivery attended a Q2 Assurance Meeting-Gloucestershire CCG
17.10.17	The Director of Service Delivery attended a meeting regarding Miller Court Discussions with the Chief Executive of Herefordshire Mind
17.10.17	The Director of Engagement and Integration presented at an engagement session and tour with local Councillors at Wotton Lawn Hospital in Gloucester
18.10.17	The Chief Executive attended the Herefordshire and Worcestershire STP Mental Health Workstream
18.10.17	The Director of Engagement and Integration presented to the Rotary Club in Stonehouse
18.10.17	The Director of Service Delivery attended a meeting regarding Potential Development of Health Facilities in Stroud

18.10.17 The Director of Service Delivery attended a STP Mental Health Workstream meeting

19.10.17 The Director of Service Delivery attended a Stroud & Berkley Vale Pilot Board

19.10.17 The Director of Organisational Development attended the Herefordshire & Worcestershire Local Workforce Action Board (LWAB) meeting

19.10.17 The Director of Finance and Commerce attended Herefordshire 2gether Contract Board Meeting

27.10.17 The Director of Engagement and Integration hosted a visit and tours from the Chair of the Cornwall Partnership NHS Foundation Trust at Rikenel, Wotton Lawn Hospital and Charlton Lane Hospital

27.10.17 The Director of Service Delivery attended a CYPS Tier 4 bid meeting

27.10.17 The Director of Service Delivery attended a meeting regarding MH Commissioning and Provider Issues with Clinical Commissioning Group

31.10.17 The Director of Service Delivery attended a meeting regarding Oak House

31.10.17 The Director of Engagement and Integration Chaired the Gloucestershire Tackling Mental Health Stigma Group at Sanger House

2.3 National Engagement

14.09.17 The Chief Executive attended the South of England HEE LETB meeting

14.09.17 The Director of Organisational Development attended the South West HR Director Network meeting

15.09.17 The Director of Organisational Development attended the West Midlands HR Director Network meeting

18.09.17 The Director of Organisational Development was filmed for a Speak in Confidence Customer Video Case Study

19.09.17 The Chief Executive attended the NHS Benchmarking steering group AGM

22.09.17 The Director of Service Delivery participated in a telephone call with the Department of Health

22.09.17 The Medical Director attended the SW Responsible Officer Network Meeting

25.09.17 The Medical Director attended a Higher level Responsible Officer Quality Review

27.09.17 The Chief Executive attended the South West Leadership Academy AGM & STP Meeting

27.09.17 The Director of Organisational Development attended the South West Leadership Academy AGM & STP Meeting

03.10.17 The Director of Engagement and Integration presented alongside the Director of Quality at the NHS Improvement Community and Mental Health Operational Productivity Review Engagement Event in Reading

04.10.17 The Chief Executive attended the South West Chief Executives Forum

04.10.17 The Director of Engagement and Integration undertook a visiting lecture at the Queen Margaret University, Edinburgh

10.10.17 The Director of Engagement and Integration attended an event for World Mental Health Day at Buckingham Palace in London

3. Sustainability

3.1 Triangle of Care Quality/Engagement

Triangle of Care is progressing to plan and 2 star accreditation will be sought in Spring 2018. All community teams have completed self-assessments and are busy working on their action plans and presenting details to their locality boards. Jo Denney recently attended a Herefordshire & Worcestershire STP event to present details of our activities and the difference it already makes to carers. The CCG bus will be in Cheltenham town centre on Carers Rights Day (24th November 2017) with displays and information on triangle of care and carers within the Trust.

3.2 Crisis Resolution Service (MHARS) Quality/Sustainability

The contract for the 'Mental Health Matters' helpline has been finalised and will be operational from November 2017. This service will provide support to people who would normally access our Crisis teams, but whose needs do not require an acute response. Callers can be escalated to our Crisis Team for an urgent response if required.

The S136 Triage service 'Mental Health Nurse in a Police Car' has increased to 4 days per week from 2pm until midnight, Tuesday through to Friday. The service has resulted in a significant reduction of S136 detentions. The pilot will be reviewed in conjunction with the police in December 2017, before formalising a decision around future service provision.

A briefing document has been provided to the CCG for circulation to GP's updating them on progress with the development of our Crisis services,

advising them of the new helpline and confirming the referral process and contact details.

3.3 Smoking Cessation Sustainability

Monday 8th January 2018 has been set as the date for implementing smoking cessation in Herefordshire. Implementation planning meetings have been scheduled with an emphasis on providing Level 1 (Brief Awareness & Nicotine Replacement Therapy - NRT) training to inpatient staff within the county. Level 2 (Quit Advisor) training has also taken place for Herefordshire staff.

A flyer has been created to promote the implementation date, and staff/service user/carer events have been held across Herefordshire. Signs and banners are being prepared to promote this initiative at our Herefordshire sites.

Level 1 and Level 2 training continues in Gloucestershire, primarily aimed at inpatient staff, but planning is underway to train Community teams.

'Stoptober' (an NHS campaign to encourage people to stop smoking throughout the month of October) was supported with a a number of events to provide people with information about quitting smoking were organised at Wotton Lawn, Charlton Lane and Stonebow.

It's now been six months since we started our smokefree journey in Gloucestershire, and to find out how staff feel about the introduction of our smokefree policy, a survey has been launched via our intranet. The findings of the survey will assist in the implementation of smoking cessation in Herefordshire.

3.4 CIP 2017/18 sustainability

Through 20 recurrent savings work-streams, and 2 non-recurrent savings work-streams, the CIP savings for 2017/18 are on track to deliver £2.996m. Each saving stream is monitored monthly, progress is challenged by a project board, and additional saving streams are identified. By the end of month 6, £1.977m (66%) of the targeted savings had been made, and plans are in place to deliver the remaining saving.

Work is already underway to assure delivery of £2.671m savings in 2018/19. To provide financial and quality assurance, all proposed work-stream savings must be quality impact assessed, and the detail of how the savings will be achieved must be specified and viability checked prior to 2018/19. On 11th December 2017 the work-stream leads and the Executive Directors responsible for approving the quality impact assessments are meeting to challenge and approve all the 2018/19 savings work-streams. If any risks or issues are identified, solutions and alternative options will be developed in the 3 months prior to the commencement of the financial year 2018/19, to ensure full savings are achieved in-year.

3.5 Temporary Staffing Demand quality/sustainability

Our cumulative agency spend for the first seven months of 2017/18 (£2.6m) is below the same period for 2016/17 (£3.1m). Based upon our planned actions the financial agency spend forecast for 2017/18 is £4.1m, which compares with a 2016/17 agency spend of £5.49m.

Planned actions in the final 5 months of 2017/18 should see our agency spend on admin, IAPT and locums reduce, but it is unlikely that the NHSI ceilings for those services will be achieved this year.

Nursing Services have already seen a significant reduction in agency spend through a series of initiatives around, for example, peripatetic teams, e-rostering, substantive recruitment, and the growth in bank staff numbers. By month 7 our 2016/17 nursing agency spend was £1.35m, while for 2017/18 it has fallen to £0.85m. The nursing agency straight-line forecast for 2017/18 is £1.46m against a ceiling of £1.47m, but, as our actions roll forward, our likely agency spend is predicted to be £1.3m.

Agenda item 14 **Enclosure No Paper I**

Report to: 2gether NHS Foundation Trust Board 30th November 2017
Author: Becky Amos, Lead Management Accountant
Presented by: Stephen Andrews, Acting Director of Finance and Commerce

SUBJECT: **Finance report for period ending 31st October 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 7 position is a surplus of £430k in line with the planned surplus before impairments. The Trust has had a revaluation of its asset base conducted which has resulted in a £1.032m impairment.
- The month 7 forecast outturn is an £884k surplus before the impairment, in line with the Trust's control total.
- The Trust has an Oversight Framework segment of 2 and a Finance and Use of Resources metric of 2.
- Agency spend at the end of October is £2.626m. On a straight line basis the forecast for the year would be £4.501m, which would be a reduction of £0.991m on last year's expenditure level, but above the agency control total by £1.097m. It is estimated however that with a number of initiatives currently being implemented to reduce agency usage further the year end forecast will be £4.084m (a worsening of £104k from last month).
- The Trust has completed a mid-year review of its financial position. Revenue budgets, capital expenditure, savings schemes, cash, balance sheet provisions and potential risks and opportunities have all been reviewed. The actions identified in the review are being implemented and the Trust remains on track to meet the control total. There remain a significant number of risks in the Trusts financial position.
- The Trust has agreed funding support with Gloucestershire CCG for the delayed implementation of the reconfigured Learning Disability service.

RECOMMENDATIONS

It is recommended that the Board:

- note the month 7 position
- note the reasons for variances from budget

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	x	Using better information	
Social inclusion		Growth and financial efficiency	x
Seeking involvement		Legislation and governance	x

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

Reviewed by: Stephen Andrews, Acting Director of Finance and Commerce		
	Date	15th November 2017

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
	Date	

Explanation of acronyms used:	

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	
Income	FOT vs FT Plan	102.3%	
Operating Expenditure	FOT vs FT Plan	102.4%	
Year end Cash position	£m	10.3	
PSPP	%age of invoices paid within 30 days	98.0%	90% paid in 10 days
Capital Income	Monthly vs FT Plan	100.3%	
Capital Expenditure	Monthly vs FT Plan	66.7%	£4,039k expenditure.

The parameters for the traffic light dashboard are detailed below:

INDICATOR	RED 	AMBER 	GREEN 
NHS Improvement FOT segment score	>3	2.5 - 3	<2.5
INCOME FOT vs FT Plan	<99%	99% - 100%	>100%
Expenditure FOT vs FT Plan	>100%	99% - 100%	<99%
CASH	<£8m	£8-£10m	>£10m
Public Sector Payment Policy - YTD	<80%	80% - 95%	>95%
Capital Income - Monthly vs FT Plan	<90%	90% - 100%	>100%
Capital Expenditure - Monthly vs FT Pla	>115% or <85%	110% - 115% or 85% to 90%	>90% to <110%

- The financial position of the Trust at month 7 is a surplus of £430k before impairments which is £3k above the plan (see appendices 1 & 8). Including the impairment the Trust has a year to date deficit of £603k.
- Income is £1,986k over recovered against budget and operational expenditure is £2,010k over spent, and non-operational items are £27k 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	(4,878)	(2,836)	(2,885)	(49)	(4,967)	(89)
Stroud & S Cots Locality	(4,581)	(2,672)	(2,741)	(69)	(4,848)	(267)
Gloucester & Forest Locality	(4,213)	(2,457)	(2,415)	42	(4,125)	87
Social Care Management	(3,801)	(2,217)	(3,022)	(805)	(5,171)	(1,370)
Entry Level	(6,261)	(3,655)	(3,929)	(274)	(6,496)	(235)
Countywide	(31,299)	(18,307)	(18,418)	(111)	(31,412)	(113)
Children & Young People's Service	(6,488)	(3,771)	(3,577)	193	(6,239)	249
Herefordshire Services	(13,038)	(7,630)	(7,783)	(153)	(13,313)	(275)
Medical	(15,272)	(8,909)	(9,301)	(393)	(15,913)	(641)
Board	(1,641)	(957)	(948)	9	(1,929)	(288)
Internal Customer Services	(1,833)	(1,069)	(1,009)	60	(1,841)	(8)
Finance & Commerce	(6,107)	(3,573)	(3,806)	(233)	(6,540)	(433)
HR & Organisational Development	(3,110)	(1,814)	(1,900)	(85)	(3,401)	(290)
Quality & Performance	(2,906)	(1,696)	(1,718)	(22)	(3,079)	(172)
Engagement & Integration	(1,334)	(778)	(827)	(49)	(1,435)	(101)
Operations Directorate	(1,124)	(656)	(721)	(66)	(1,247)	(122)
Other (incl. provisional / savings / dep'r	(4,612)	(2,757)	(3,751)	(993)	(4,222)	390
Income	113,379	66,182	68,149	1,967	116,027	2,648
TOTAL	**883**	**427**	**(603)**	**(1,030)**	**(148)**	**(1,031)**

The key points are summarised below;

In month

- The Social Care Management over spend relates to Community Care and is offset by additional income
- The Entry Level over spend relates to the IAPT service, agency staff and additional leadership and administration time
- Herefordshire is over spent due to ward staffing costs but a proportion of this is due to specialling and will be offset by additional income
- The Medical over spend has been caused by agency expenditure - £1,172k in the year to date
- Finance and Commerce is overspent due mainly to additional maintenance costs. This has risen in the month due to an increased number of unavoidable works. The Estates team continue to try and drive costs down and there is a rigorous process in place to review all requests.
- Income is over recovered due to additional income for activity related Community Care work and additional development funds which weren't budgeted
- There is limited slippage against the savings programme

Forecast

There are significant cost pressures within Directorates including

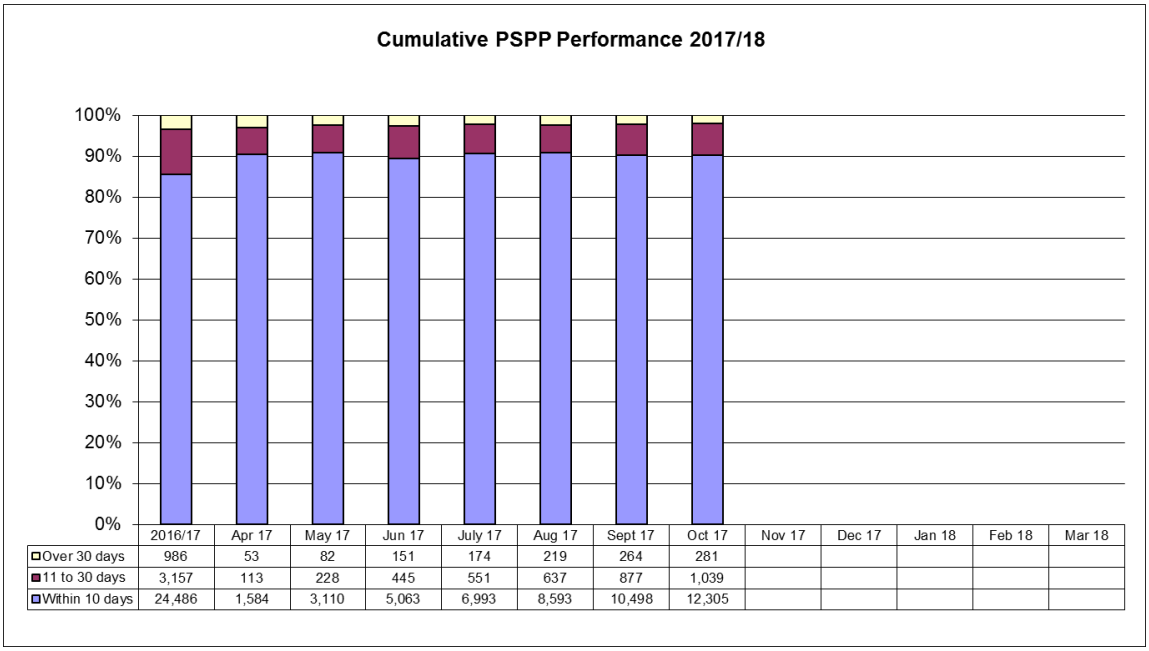
- Agency costs for Medical and Inpatients are still expected to be significant, even after the effect of actions being taken to reduce this usage
- The apprenticeship levy of £310k, against which there is currently little offset of training costs

- Despite some success in bringing placements back into county the forecast for Complex Care remains £472k over spend due to the effect of new high cost placements. This assumes a £250k reduction on a straight line cost projection as it is anticipated people will be brought back into Gloucestershire for treatment.
- The use of agency staff in IAPT will reduce but is expected to continue until December. No further agency is expected after this time although there is a risk that targets will not be met if there is no cover for posts which become vacant.

  These are offset by under spends in other areas and additional income expected.

PUBLIC SECTOR PAYMENT POLICY (PSPP)

The cumulative Public Sector Payment Policy (PSPP) performance for month 7 remains at 90% of invoices paid in 10 days and 98% paid in 30 days. The cumulative performance to date is depicted in the chart below and compared with last year's position. The Trust has a strong cash position which enables it to continue to consistently pay suppliers promptly.



	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	82	151	174	219	264	281					
11 to 30 days	3,157	113	228	445	551	637	877	1,039					
Within 10 days	24,486	1,584	3,110	5,063	6,993	8,593	10,498	12,305					

	10 days		30 days	
	In month	**YTD**	**In month**	**YTD**
Number paid	1,803	12,305	1,970	13,344
Total Paid	1,986	13,625	1,986	13,625
%age performance	**91%**	**90%**	**99%**	**98%**
Value paid (£000)	5,980	41,900	6,202	45,330
Total value (£000)	6,355	46,357	6,355	46,357
%age performance	**94%**	**90%**	**98%**	**98%**

Agenda item 15 **PAPER J**

Report to: Trust Board, 30 November 2017
Author: John McIlveen, Trust Secretary
Presented by: John McIlveen, Trust Secretary

SUBJECT: BOARD ASSURANCE MAP

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

EXECUTIVE SUMMARY

The assurance map is attached for its biannual review by the Board, as recommended by the Trust's Well Led Review of Governance completed in 2015. The assurance map was last reviewed by the Audit Committee on 1 November 2017.

The assurance map:

- Is a dynamic document, comprising strategic risks to the achievement of the Trust's strategy
- Contains those risks in the corporate risk register scoring 12 or more.
- Identifies 'Top 5' risks, regardless of risk score.
- Indicates overall assurance levels.
- Identifies Committee 'ownership' of risks, along with lead Executive Director.

Risks on the risk register have been subject to routine review by Executive leads and risk owners prior to collation of this assurance map, which contains 11 risks. In addition to regular review by the Audit Committee, the assurance map is reviewed on a regular basis by the Executive Committee.

A number of risks have been added or removed from the assurance map since its last review by the Board in April, as existing risk scores change as a result of mitigation, or new risks are identified. In addition, some risks have been reworded in order more accurately to reflect the risk posed.

One risk has been added since papers were issued for the Audit Committee's review of the assurance map on 1 November. This is risk AM21, and relates to the recruitment of qualified inpatient nursing staff. The Executive Committee reviewed the assurance map on 9 October, and agreed changes to the 'top 5' risks in the light of a changing risk environment. Risks regarding IAPT services and the use of the mortality review framework have been removed from the Top 5 list. These risks remain on the assurance map as their scores are above the threshold for inclusion. Two new risks have been designated as 'Top 5' risks; these are risk AM20 (junior doctor recruitment) and risk AM21 regarding the recruitment of qualified inpatient nursing staff.

Consideration is being given to the format of the assurance map to assess whether the document can provide detail as to the role of each Committee in reviewing risks. This was an action raised at the meeting of the Audit Committee in August.

This report offers **significant assurance** regarding the process of identification, mitigation and regular review of risks which may affect the quality or safety of services provided by the Trust. Assurance offered in respect of individual risks varies as shown in the assurance map.

RECOMMENDATIONS

The Board is asked to:

- Note the assurances provided within this report

Corporate Considerations	
Quality implications:	None other than those identified in this report
Resource implications:	None other than those identified in this report
Equalities implications:	None other than those identified in this report
Risk implications:	None other than those identified in this report. Risks are identified within the risk register and presented to the relevant Committee for regular review.

WHICH TRUST VALUESIVES DOES THIS PAPER PROGRESS OR CHALLENGE?			
Supporting clinical care	P	Skilled workforce	
Getting the basics right	P	Using better information	
Social inclusion		Financial efficiency	P
Seeking involvement		Legislation	P

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

Reviewed by:		
Neil Savage	Date	2 November 2017

Where in the Trust has this been discussed before?		
Executive Committee Audit Committee	Date	October 2017 November 2017

What consultation has there been?		
Updates obtained from Risk Manager/Datix	Date	October 2017

Explanation of acronyms used:	

ASSURANCE MAP - NOVEMBER 2017

Assurance Map Reference	Risk Register reference	High scoring risks	Top 5 Risk	Corporate Objective	Primary Assurance Committee	Lead executive	1st Line of Defence **Management Control**			2nd Line of Defence **Corporate Oversight**									3rd Line of Defence **Independent Verification**							**Corrective Action**			**Risk and Assurance Analysis**			
							Management Oversight	Project Team Oversight	Sub-Committee	Clinical Audit/Peer review	Governance Committee	Audit Committee	MHL Scrutiny Committee	Development Committee	Executive Committee	Ratings and formal declarations	Delivery Committee	Board	Internal Audit	External Audit	Expert Review/Accreditation	External Review	CCG	NHS Improvement	CQC/HSE	Action Plan	Validate Assurance	Add to IA Plan	**Overall Assurance Level** (From Risk Register)	**Maximum Acceptable Risk** (Target Risk Score)	**Current Risk Score** (Risk After Control) Likelihood x Impact Extreme risk: date identified	**Risk Trend** (versus last report)
Governance Risk																															
AM13	121	If Trust fails to ensure that RiO records are accurate and complete (regarding safeguarding) then this may result in a serious incident.		1	G	MC	●				●	●			●											✓			LTD	8	3x4 = 12	↔
AM19	157	If the Trust fails to ensure that deceased patients are identified and reviewed using a national mortality review framework then this may lead to significant reputational risk (loss of faith in services by service users and public) and possible regulatory action.		1	G	CF	●				●	●			●			●								✓			LTD	4	3x4 = 12	↔
People Risk																															
Safety/Clinical Risk																															
AM5	13	Risk of injury to staff, patients and others from patients being violent and aggressive		1	G	CM	●				●	●			●		●							●	✓			LTD	8	3x4 = 12	↔
AM6	20	There is evidence to show that crisis contingency/relapse plans are not consistently recorded in the appropriate section of RiO, and that these, where evident, are not being reviewed regularly, leading to an increased clinical/safety risk for service users.		1	G	CM	●	●		●	●	●			●										✓			LTD	8	3x4 = 12	↔
AM7	112	If the Trust IAPT Services (Gloucestershire & Herefordshire) fails to meet national performance standards and/or Commissioners fail to agree the necessary investments in our IAPT Service then patients will not have access to appropriate services.		1	Del	CM	●	●				●			●		●	●				●			●	✓			LTD	9	3x4 = 12	↔
AM17	133	Current LD and CYPS service medical rotas are too frequent to be sustainable and are impeding recruitment. Lack of consistency filling junior doctor places compromosis ability to provide medical on call rota in inpatient areas		1	Del	CF	●					●			●			●								✓			LTD	8	4x3 = 12	↔
AM20	173	If trainee doctors are not successfully recruited then this will have a significant effect on the ability to deliver services within inpatient units.	✓	1	G	CF	●					●			●			●								✓			LTD	4	3x4 = 12	↔
AM21	195	A failure to recruit appropriate qualified inpatient nursing staff may adversely impact on patient safety and user experience.	✓	1	G	MC	●				●	●			●											✓			LTD	6	3x4 = 12	
Strategic Risk																															
AM4	48	That we fail to secure the workforce and evolve the organisational culture necessary to deliver our strategic objectives. (Appropriately skilled, engaged, equipped and led).	✓	1	Del	NS	●	●				●			●		●		●							✓			LTD	8	3x4 = 12	↔
Financial Risk																															
AM18	177	If Cost Improvement Plan is not delivered there is a significant risk that the Trust will not meet its financial control total.	✓	3	E	AL	●					●			●			●	●	●						✓			SIG	9	3x4 = 12	↔
AM12	116	If the Trust spends above its agency control total set by NHS Improvement (NHS I) this will impact both on services and on the Trust's overall financial control total.	✓	3	G	MC	●	●			●	●			●			●						●		✓			LTD	4	3x4 = 12	↔

ASSURANCE MAP - NOVEMBER 2017

Assurance Map Reference	Risk Register reference	High scoring risks	Top 5 Risk	Corporate Objective	Primary Assurance Committee	Lead executive	1st Line of Defence **Management Control**			2nd Line of Defence **Corporate Oversight**									3rd Line of Defence **Independent Verification**							**Corrective Action**			**Risk and Assurance Analysis**			
							Management Oversight	Project Team Oversight	Sub-Committee	Clinical Audit/Peer review	Governance Committee	Audit Committee	MHL Scrutiny Committee	Development Committee	Executive Committee	Ratings and formal declarations	Delivery Committee	Board	Internal Audit	External Audit	Expert Review/Accreditation	External Review	CCG	NHS Improvement	CQC/HSE	Action Plan	Validate Assurance	Add to IA Plan	**Overall Assurance Level** (From Risk Register)	**Maximum Acceptable Risk** (Target Risk Score)	**Current Risk Score** (Risk After Control) Likelihood x Impact Extreme risk: date identified	**Risk Trend** (versus last report)

Key to Bullets and Assurance Levels

●	**Negative 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
●	**Limited Assurance** gaps in the application of controls as designed by management put the achievement of objectives at risk
●	**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
◊	**Full assurance**: a sound system of controls has been effectively applied and manages the risks to the achievement of objectives.

Key to Corporate Objectives

1	Continuous quality improvements
2	Engagement to support delivery of a challenging agenda
3	Transformation to support internal and external sustainability

Key to Primary Assurance Committees

G	Governance Committee
Del	Delivery Committee
Dev	Development Committee
MHL	Mental Health Legislation Scrutiny Committee
E	Executive Committee

Key to Risk Scores

Low
Moderate
High
Extreme

Key to Risk Trend

↓	Improving
↔	Static
↑	Worsening

Risk Score Matrix

Likelihood	Impact				
	1 Negligible	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
5 Almost Certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Development Committee

DATE OF COMMITTEE MEETING: 18 October 2017

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

ENGAGEMENT AND COMMUNICATION IMPLEMENTATION PLAN

The Committee received an update on the progress being made against the Engagement and Communication Strategy implementation plan for 2017/18 Quarter 2 and the priorities for the next quarter.

Some examples of recent engagement activities included;

- Presentations had been made to NHS Improvement, to Local Councillors in Gloucestershire and Herefordshire and to the Rotary Club.
- Conversations were taking place with Public Health Gloucestershire about extending the scope of the Tackling Stigma work through a bid to Time to Change.
- The Director of E&I had represented 2gether and other local agencies working in Mental Health at a reception at Buckingham Palace on World Mental Health Day. The prestigious event was held to acknowledge significant campaign work undertaken to tackle the stigma around mental illness.

The Committee noted one red action in the implementation plan which related to the development of a system of measuring engagement with the Trust's internal newsletter, ByteSize, and increase readership through the year. The introduction of an audit tool was being planned which would enable the Communications Team to measure 'clicks'.

RESEARCH SUB-COMMITTEE

The Committee noted that the Head of Research and Development was in the process of setting up an engagement event with the CEO at Cobalt; this was to be aimed at staff involvement in dementia care research. An AHPP Conference was held on 6th October and this had been well attended with presentations from the Trust's Head of Research and Development, from Professor Crone at the University of Gloucestershire and from a Speech and Language Therapist from GCS who was also a research fellow with National Institute for Health Research.

The capacity of the Trust's small research team was queried and it was noted that regular meetings with the Head of Research and Development were held to discuss priorities. A number of research studies and commercial clinical trials were being currently being discussed. Interviews were being set up to recruit a part time Clinical Director on a 1 year contract pilot.

BUSINESS CASE PROCEDURES

The Committee received the updated "Procedure for Business Cases" which was a recommendation arising from the Pullman Place Review. This updated procedure had been previously presented at both the Executive Committee and the Development Committee, where it was approved subject to a couple of minor amendments which had all been actioned.

The Executive Committee would be asked to approve all Business Cases for Capital and Revenue projects; and these decisions would then be reported through the Development Committee.

OTHER ITEMS

The Development Committee also:

- Received and endorsed the Development Committee Annual Report 2016/17 for onward reporting to the Board for assurance

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Jonathan Vickers **ROLE: Committee Chair**

DATE: 17 November 2017

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Delivery Committee

DATE OF COMMITTEE MEETING: 25 October 2017

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PERFORMANCE DASHBOARD

The Committee received the performance dashboard report for the period to the end of September 2017. Of the 154 performance indicators, 109 were reportable with 101 being compliant and 8 non-compliant at the end of the reporting period. Where performance was not compliant, Service Directors were taking the lead to address issues with a particular focus continuing to be on IAPT service measures which accounted for 4 of the non-compliant indicators.

Improvements in the recording of the number of carers that have been offered a carer's assessment (indicator 4.07) has meant that the reported performance for August had risen from 79% (non-compliant) to 90% (compliant) thanks to the focused work of service delivery teams.

At the July Board meeting, the Board noted that indicator *5.07: All inpatients to undergo risk assessment for VTE* was non-compliant during June, and two patients were not assessed within the required time. This was the first time that this indicator had been reported as non-compliant and the Board had asked the Delivery Committee to review this to ensure that there were no underlying issues of concern. It was noted that staff were being reminded that when patients are transferred from wards within the unit another VTE assessment needs to take place. This indicator was now compliant; however, a revised policy on VTE assessments was being developed, which would be presented to and signed off by the Governance Committee.

IAPT

The Delivery Committee received an overview of the key issues relating to the progress made within our IAPT Services for both Gloucestershire and Herefordshire.

A huge amount of work and effort had been carried out in developing IAPT services over the past year; however, it was felt that the report did not demonstrate this achievement in the narrative and it was therefore suggested that the future format of the reports be changed to clearly reflect the success story that IAPT was.

LOCALITY EXCEPTION REPORTS

The Committee received reports from the Gloucestershire Localities and Countywide, which set out financial positions and compliance against HR targets such as training and appraisals.

Countywide was reporting sickness absence of 5.57% against the current target of 6% compliance. Countywide had been set a different target for sickness absence and it was agreed that a review be carried out to look at this in more detail, looking at trends and types of sickness to ascertain whether the level of sickness absence was reasonable. A more detailed review of sickness absence within the locality would be received at the January 2018 meeting.

BENCHMARKING

This report highlighted the current performance of the Trust against agreed indicators captured as part of the Benchmarking exercise against other Mental Health Trusts. The report focussed on 7 key performance areas, including Emergency Readmission Rates within 30 days of discharge, Mean Lengths of Stay (LoS), Delayed Transfers of Care (DToC), Occupied bed days clustering 1- 4, Crisis response times and the % of contacts delivered to cluster 17 patients.

The Committee noted that issues of poor data quality and reliability had been raised within this benchmarking report and in the earlier performance dashboard. Service Directors needed to keep a real focus on this, with clinicians and other staff members needing to take ownership of the data and inputting correctly into the clinical systems. It was agreed that a presentation would be given at the January Committee meeting, presented jointly by Service Directors and the Information Team setting out how the Trust was dealing with data quality.

STAFF SURVEY ACTION PLAN UPDATE

The Committee received an update on the action plan developed from the 2016 NHS National Staff Survey. Progress had been made against the objectives and although work remains to be done, some initiatives have already been well received by staff and good assurance was received. Ultimately the measure of success would be whether the Staff Survey scores for 2017 show an improvement in the areas covered by the action plan. The 2017 Staff Survey would run until 1st December 2017 with the initial report due in December. The full report including the Key Findings was expected in February 2018, at which time it would be presented to the Delivery Committee.

It was noted that the Trust had seen a low level of returns so far from the 2017 Survey. There were 5-6 weeks to go and work was taking place to remind staff to complete the survey. Feedback from staff was that there were still some concerns about being identified from the survey and some staff were refusing to complete the survey on that basis. It was suggested that the next email reminder to staff include a clear statement that returns were treated completely confidentially and individual members of staff could not be identified.

TELEPHONY ANNUAL ASSURANCE STATEMENT

The Committee received and noted the contents of this report and the assurances that were provided around cost saving programmes and future telephony developments.

Mobile telephony has been relied upon for many years to support clinicians working in the community. Since the introduction of Digital Dictation and Transcription, clinicians have received a smartphone, equipped with a mobile data contract by default and this has resulted in a large increase in the trust's monthly mobile phone bill. A working group was established to enable cost savings in this area and some trust mobile device accounts have had their associated data contracts ceased, so that they will function as mobile phones but will only be able to access internet functions when connected to Wi-Fi. This change would reduce costs substantially; however, some staff members had expressed concern about losing their data packages and these concerns were being worked through.

CYPS/CAMHS LOCALITY REVIEW

The Committee received a detailed and informative locality presentation from the CYPS and CAMHS services. There was a lot of great work being carried out and this was reflected in the presentation.

OTHER ITEMS

The Delivery Committee also:

- Noted the updated/new HR policies that had been approved
- Received an update on the current housing situation within Gloucestershire for service users requiring accommodation
- Received a written report setting out the proposals for improving recording on RiO for Safeguarding, Household & Family and Dependent Children Care Planning.
- Received the IT Annual Assurance Statement

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Maria Bond **ROLE: Chair**

DATE: 17 November 2017

2gether Making life better

2gether NHS Foundation Trust

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Governance Committee

DATE OF COMMITTEE MEETING: 20 October 2017

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

MEDICINES MANAGEMENT ANNUAL REPORT

The Committee was assured that the appropriate medicine management arrangements were in place within the Trust. Increased assurance was provided with the development of Service Specifications for the clinical pharmacy and supply services from Gloucestershire Hospitals NHS Foundation Trust (GHT) and Wye Valley NHS Trust (WVT). The Committee noted that the contract with WVT finished at the end of September and GHT was now supplying pharmacy services to 2Gether Hereford.

PATIENT SAFETY AND SERIOUS INCIDENT REPORT

There had been 3 new serious incidents (SIs) reported during August and 2 during September. No Never Events had occurred within Trust services. The Trust was 'Green' for Serious Incident reporting to Commissioners; however, it was noted that it was a challenge to provide these reports within the timescales as investigations needed to be undertaken as well as meetings with families in order to ensure that the information was right. This report provided the Committee with significant assurance that the Trust had robust processes in place to report and learn from serious incidents.

Work had been carried out to review the way in which overdue actions were presented and a revised format was provided. There were fewer actions now overdue; however, it was important that the QCR Sub-Committee be used to provide assurance and updates to the Governance Committee around these actions.

An External Review was underway of the 2014 Homicide at Montpellier. The internal investigation had been accessed and found to be thorough; therefore staff would not need to be re-interviewed. Evidence was to be reviewed and meetings would be held with current staff to ensure that learning had been embedded. The Committee welcomed this review as a good opportunity for the Board to receive independent assurance of Trust processes.

LIBRARY SERVICES ANNUAL REPORT

The Committee received the Library Services Annual Report for 2016/17 and was assured around the Trust's compliance with NHS Library Quality Assurance Framework. Current priorities for the service included developing services for Recovery College students, to work more closely with research and training teams and to promote KnowledgeShare; a new service that provided evidence updates, tailored to individual areas of interest. The Library Service continued to collaborate with Herefordshire County Hospital library to increase resource sharing for Trust staff. The Library Service in Hereford was now more accessible and was being better utilised. The Governance Committee endorsed the Library Service annual report. Further discussions around the Funding process for Library services would be carried out and reported back to the Committee at the next meeting.

RESEARCH AND DEVELOPMENT ANNUAL REVIEW

The Committee received an overview of assurance for research governance and performance activity at the Trust during 2016/17. The Committee was significantly assured that a comprehensive level of research governance was applied to all research activities undertaken. Research activity was monitored across Gloucestershire and Herefordshire services and there was clinical oversight and risks relating to research activity were identified and monitored. Significant assurance was provided that the research portfolio offered equity of access to participation in research to service users and carers and they valued their involvement in research.

The Committee received significant assurance that the Research team had achieved targets set by commissioners in 2016/17. The Committee noted a number of developments currently taking place including the appointment of a Clinical Director for Research and opportunities for Service Users and Carers involvement were being further strengthened. Clinical governance oversight was being strengthened as commercial drug trials took place and preparation for a likely inspection by the Medicines and Healthcare Products Regulatory Agency (MHPR) was to be undertaken.

Limited assurance was provided on the dissemination of activity to ensure the adoption of research findings into practice in a timely way and more work would be carried out to ensure that research was embedded in practice.

ASSESSMENT AND CARE MANAGEMENT – AUDIT (INTERIM REPORT)

The Committee received the outcome of an audit measuring compliance against the Trust's Assessment and Care Management Policy, which was carried out in July 2017. Previous Audits had found that quantitative data had remained largely static at around 50%; however this interim audit, had found a very slight improvement in the rate of compliance. A further qualitative and quantitative audit of the Assessment and Care Management policy would be provided at Governance in December 2017.

PROFESSIONAL REGULATION – HEALTH AND SOCIAL CARE ANNUAL REPORT

A high level overview of specific professional areas of development was provided and the Committee was fully assured that the Trust's Heads of Profession were sighted to and engaged in professional regulation and in practice development with their respective professional groups. All professional groups had provided full or significant assurance of robust clinical supervision opportunities and uptake. Work was being undertaken to implement the Trust's Allied Health and Psychological Professions Strategy 2016-2020 and a new national strategy for AHPs, "AHPs into Action" was launched this year. Attention was being paid to ensure the consistent delivery of clinical supervision across all disciplines and Heads of Profession were seeking ways to mitigate the impact of challenges with recruitment in order to maintain high standards of practice.

WHISTLEBLOWING ANNUAL REPORT

The Committee was assured that the Trust had instigated a suite of options supported by appropriate policies and procedures which provided guidance and advice, enabling pragmatic methods of raising and managing issues and concerns. The Trust had also embedded "Speak in Confidence" as a secure and anonymous on-line method to enable staff to raise issues. A Freedom to Speak Up Guardian had also been appointed. The Committee noted that in the past year, 2 concerns had been raised and these were currently being worked through.

The 2016 Staff Survey showed a slight improvement on the previous year and ranked the Trust higher than average compared with other Mental Health Trusts; indicating that the majority of staff would feel safe to report unsafe practices.

VOLUNTEER STRATEGY – IMPLEMENTATION AND GOVERNANCE

The Volunteer Strategy was endorsed in September 2013 and a range of actions designed to modernise the volunteer recruitment process and to support teams were put in place in the form of a 3 year implementation plan. The Social Inclusion (SI) Team had led this work and the Committee was assured that robust governance arrangements were in place for the volunteer programme.

Significant assurance was received that robust pre-employment checks were undertaken for all volunteers and that adequate training supervision was provided. New recruitment and registration processes were being followed and a mechanism was in place to validate and celebrate the contribution of volunteers, with an annual event hosted by the Trust Chair. Currently there was limited assurance that a mechanism was in place to measure the quality of experience and impact of volunteer roles, however, a plan to implement this in Q3 2017-18 was noted.

The following developments were in place:

- A new Volunteer Strategy had been drafted, engagement was to be undertaken with clinical teams prior to launch in Q1 2018-19.
- Sustained effort would continue in order to increase the number and type of volunteer placements available. Implementation of a Volunteer Friends and Family Test in Quarter 3 2017-18.
- The Volunteer Impact Assessment Tool (VIAT) was to be undertaken in Quarter 4 2017-18.

OTHER ITEMS

The Governance Committee at its October meeting also:

- Received the Service Experience Report Q1 2017/18.
- Received and ratified the revised Serious Incidents Policy and Procedure.
- Noted the significant assurance received regards to the QIA and CIP savings scheme Governance Process
- Noted the Safe Staffing and temporary staffing demand report
- Reviewed the Governance Committee risks, noting that the process for reviewing risk was now clearer and more dynamic. The Committee noted the 'top 5' risks currently allocated to the Governance Committee and the update on actions/mitigations in place. Two new risks had been added:
  - Recruitment – Core Trainee Doctors (Limited assurance)
  - Recruitment – Qualified Nursing Staff (Inpatient) (Limited assurance)

  A report on the Recruitment of Core Trainee Doctors would be prepared for the February Governance Committee for assurance and assurance around the recruitment of Qualified Nursing Staff (Inpatient) would be provided in the next Safe Staffing report.
- Received an update on progress regarding specific Patient Safety and Quality Improvement implementation within the organisation

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Nikki Richardson **ROLE: Chair**

DATE: 17 November 2017

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Mental Health Legislation Scrutiny Committee

DATE OF COMMITTEE MEETING: 8 November 2017

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

REVIEW OF MHA COMMISSIONER (CQC) VISITS

The annual unannounced CQC monitoring visits provided a source of information on how well the Trust was performing in relation to meeting the requirements of the MHA and its supporting Code of Practice. From 1 May to 23 October 2017 there had been 7 CQC annual monitoring visits to Trust sites. Of the twenty five action statements submitted to the CQC:

- 16 reports had been closed with all actions completed.
- 3 reports remained open with original target dates having been missed and revised dates set
- 6 reports remain open and were within their original target dates

One previously reportable exception area remained open and related to the use of CCTV in inpatient areas to capture images of those patients that go AWOL. CCTV had been put into all sites where this was possible and other sites were using digital cameras; however, it was agreed that this issue would be referred to the Operations Group to monitor progress.
Significant assurance was received that systems and processes were in place to review, measure, analyse, improve and monitor the Trust's compliance with CQC monitoring framework.

REVIEW OF ISSUES ARISING AT MHA REVIEWS

The Committee received good assurance on the processes, responses and actions undertaken to address MHA Managers issues that arose during hearings. Three MHA Managers Hearing issue forms had been received between July and October 2017 and the issues raised, included:

- Availability of an interpreter
- Social circumstances report and attendance of Care Coordinator
- Availability of advocacy to support a service user during their hearing.

All of the issues raised had been reviewed and investigated and actions to address shortfalls or improvements in processes or lines of accountability were documented. .

REVIEW OF DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

This year there had been 15 DoLS applications of which 8 were authorised. Over the last 3 months no DoLS applications had been submitted, indicating a change in practice by consultants to use the MHA for non-compliant patients who lacked capacity to consent to admission.

It was noted that the Trust had been criticised for not providing enough evidence of capacity to consent in the RiO record. Work was currently being carried out to provide some examples of capacity which could be used as prompts, however evidence must be provided for each individual; standard statements were not acceptable.

REVIEW OF MHA/MCA/DOLS TRAINING

Following an inspection visit in October 2015, the CQC raised a concern that 2gether Trust staff had a lack of knowledge around the new Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA) (2005), including the Code of Practice. A number of actions were agreed, including the introduction of a mandatory read briefing document, followed by the development and implementation of a bespoke e-learning course. This programme was now on staff training profiles and completed by relevant staff as part of their Corporate Induction.

Training compliance figures had been steadily increasing since the introduction of the course and current training compliance by Locality/Service areas stood at between 88% and 100%. The only exception was for bank staff at 70% (a significant improvement from the previous figure) .

KEY PERFORMANCE INDICATORS

The Committee was significantly assured around the Trust's compliance with the Mental Health Act and Code of Practice.

A number of trends were noted including a small rise in the use of Sections 2&3 in relation to BME. Trends were generally static or downwards, except for section 3 in Herefordshire. The use of Section 136 had increased in both counties, with a consistently higher proportionate use in Gloucestershire.

AUDIT OF DETAINED PATIENTS AND THE REMINDER OF THEIR RIGHTS

An audit of the recording of the provision of rights to patients subject to the Mental Health Act had been carried out. There was a significant level of assurance of the provision/reminder of rights to detained inpatients but a more limited level of assurance in relation to Community Treatment Order patients.

Compliance rates for both detained and CTO patients showed an upward trend. Within inpatient units there was a record of 96% of detained patients having been informed of their rights. 86% of detained inpatients were recorded as having received/been reminded of these rights within Trust policy timescales. Within community teams there was a record of 65% of CTO patients having been informed of their rights; however, overall only 29% of these were recorded as having received/been reminded of their rights within Trust policy timescales.

The recording of information provision remained poor/non-compliant for CTO patients. Reminders had gone to Operational Managers to ensure that this information was up to date as it was believed that rights may be given but not recorded.

INTERNAL AUDIT REPORTS - Section 17 Leave Arrangements

The aim of this audit was to assess the level of Trust compliance with the Code of Practice guidance as it related to Section 17 of the of the Mental Health Act (1983). The previous audit was conducted in May 2016 and the re-audit was carried out in July/August 2017.

The audit was carried out on a random sample of 40 patients from Gloucestershire and Herefordshire detained under section 2, section 3 or section 37 of the Mental Health Act for whom section 17 leave had been authorised. Overall average compliance was 80%, which was an increase on last year's aggregate of 73%.

OTHER ITEMS

The MHLS Committee also:

- Received an update on AMHP cover
- Received an update and the minutes from the Operational Group which had met 3 times since the last meeting of the MHLSC. The Chair thanked the Group for the work it had been undertaking on behalf of the Committee, noting that meetings were effectively chaired and that the Group was proving to be a useful forum for discussing and resolving issues in a business-like way.
- Endorsed revisions to the "Policy for the Receipt, Scrutiny and Rectification of Mental Health Act Documents" and the "Renewal of Detention & Extension of Community Treatment Order Policy".

ACTIONS REQUIRED BY THE BOARD

The Board is asked to note the contents of this summary.

SUMMARY PREPARED BY: Quinton Quayle ROLE: Committee Chair

DATE: 21 November 2017

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Audit Committee

DATE OF COMMITTEE MEETING: 1 November 2017

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

INTERNAL AUDIT PROGRESS REPORT
The Committee received an update on progress against the Internal Audit Plan. One final report was received by the Committee at this meeting. A further report on Data Quality had been issued in draft form to management. Three reviews remained on the plan for Q4. The Committee reviewed the recommendations tracker and noted the good progress in timely closure of actions and recommendations.

Financial Shared Services Contract Management
This review produced a medium risk rating overall, with 4 medium risk and 2 low risk findings. Medium risk findings related to out of date key performance indicators and service level agreement; sporadic reporting against KPIs; infrequent meetings of the Partnership Board, and the SLA historically being signed some time after the start of the relevant financial year. However in respect of this last point the Committee noted that while the 2017/18 SLA had been signed late, the value of that SLA had been agreed prior to the start of the financial year. The Committee noted that a substantive Director of Finance had been appointed at Gloucestershire Hospitals NHS Foundation Trust, who would bring new focus to the Partnership Board and to the oversight of Financial Shared Services generally, Additionally, Deputy Directors of Finance from both GHT and 2g had been tasked withdrawing up improved KPIs which would bring FSS to a satisfactory standard of performance. The Committee asked that draft KPIs be presented for assurance to the April meeting of the Committee, along with the agreed SLA. The Committee noted that a further review would take place in 2018/19 as per the Internal Audit plan. This review would help to provide further clarity about which matters within FSS were dealt with at an operational level, and which were the remit of the Partnership Board. The Committee also agreed to receive for information audit reports produced for FSS.

EXTERNAL AUDIT REPORT
The Committee received a brief report setting out preparatory work undertaken in respect of the 2017/18 audit. The report also provided an update on key technical issues that had occurred in the NHS since the last meeting of the Audit Committee in August.

COUNTER FRAUD
The Committee received and noted the draft counter fraud progress report for the period April to October 2017 and associated Work Plan and noted the proactive report. The report offered significant assurance on the Counter Fraud activity being undertaken. The Committee noted that the updated Counter Fraud Bribery and Corruption Policy was now live and available on the intranet. The Local Counter Fraud Specialist would provide a summary of the changes contained in this policy to the Committee for assurance. An anti-bribery statement had been agreed by the Chief Executive and was available on the Trust's website. A counter fraud survey was due to be issued shortly to test staff understanding of counter fraud and bribery issues. The Trust's self-review tool had two amber ratings which were expected to be green by the end of the year; both were process issues.

LOSSES AND SPECIAL PAYMENTS
The Committee noted that 2 special payments had been made during Q2, totaling £20k. These related to an Employment Tribunal judgement, and settlement of a personal injury claim. There had been no losses reporting during the period.

ASSURANCE MAP

The Committee received an updated Assurance Map report and noted the assurance provided. While no new risks had been added to the Assurance Map since its last review by the Audit Committee in August, changes had been made to the Trust's Top 5 risks following review by the Executive Committee. Risks relating to IAPT and the use of the national mortality review framework and to CYPS Tier 4 services have been replaced on the list of Top 5 risks by junior doctor recruitment and qualified nursing staff recruitment. The nursing staff risk had been scored as 12, and would therefore appear in the Assurance Map presented to the Board in November.

CONFLICT OF INTEREST POLICY

The Committee received a draft Conflicts of Interest Policy, noting that it had been reviewed and endorsed both by the Executive Committee and JNCC. The Head of Counter Fraud had been consulted during the drafting process. The Committee noted that the provisions in the policy enacted requirements issued to Trusts by NHS England earlier in the year. Some provisions within the policy were more stringent than those recommended by NHS England, for example in stipulating a lower value at which gifts must be declared, and in extending the definition of 'senior manager' to Band 8a, rather than remaining at Band 8d as recommended by NHS E. This would mean that a wider cohort of 2g staff would be asked to complete annual conflicts of interest declarations. The Committee noted that elements of the policy, which will replace the existing Business Conduct, Gifts and Hospitality policy, had already been enacted by virtue of being included in constitutional changes approved by the Board and the Council of Governors earlier in the year. The Committee approved the Conflicts of Interest policy, which would now be publicized to staff.

OTHER ITEMS

The Audit Committee also:

- Received an update on the Internal Auditor procurement
- Received a summary of all 2gether waivers over £25,000 for orders raised during Q2 2017/18. The report included entries where waivers were not in fact required, for example due to there being a contract in place. These entries would be omitted from future reports. The Committee asked that future reports clarify that the reasons given in the report for waiving the tender process are as set out in Standing Financial Instructions.
- Received a verbal update on progress regarding Pullman Place. The Committee noted that the first teams were moving in this week. The top floor of the building contained a meeting room which might be suitable for Board or Committee meetings.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to note the contents of this summary.

SUMMARY PREPARED BY: Marcia Gallagher ROLE: Committee Chair

DATE: 1 November 2017

2gether
Making life better

2gether NHS Foundation Trust

BOARD OF TRUSTEES COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Charitable Funds Committee

DATE OF COMMITTEE MEETING: 1 November 2017

KEY POINTS TO DRAW TO THE BOARD OF TRUSTEES' ATTENTION

Countywide Services Spending Report
The Committee received a report outlining charitable funds spending in Countywide services during 2016. Charitable funds had helped to provide a range of activities over and above those funded by commissioners. These included the annual Big Health Check Day, the Christmas party at Charlton Lane, refurbishment of the garden at Honeybourne, and a number of regular activities such as dance, music in hospitals, and visits to Gloucester Rugby. The Committee noted and welcomed the beneficial effect which such activities have on service users.

Annual Accounts and Statement of Financial Activities 2016/17
The Committee noted that at the end of March 2017, the fund balance stood at just under £140k, some £5k below the start of year balance. Due to the level of annual income and expenditure, formal annual accounts need not be submitted to the Charity Commission. An audit of the Charitable Fund was not required for the same reason. The Committee agreed that formal accounts should not be produced, and noted that the required annual return had been submitted to the Charity Commission.

Financial Activities Report Q1-2
The Committee received a report setting out the balances and movements within funds and of approvals over £1,000 taken under delegated powers for the period 1st April 2017 to 30th September 2017. Income during the period totalled £2k, with £31k of expenditure committed (including four approvals over £1k), leaving the fund balance at £109k. No donations or legacies over £100 were received for the period.

Charitable Fund Strategy
The Committee received a draft Charitable Fund Strategy which proposed a number of initiatives in order to generate funds for the Trust Charity, including appointing a temporary fundraiser who will pilot a fundraising strategy for a minimum of 18 months. The Committee discussed the draft strategy at length, and considered the relative merits of targeted appeals versus fundraising for general activities and smaller projects, which could benefit a greater number of people. The Committee was conscious of the need only to use charitable funds to provide 'additional' services and to meet any gaps in funding while not using charitable funds for services or facilities which could or should be provided by commissioners. The Committee also felt that capturing the views of service users as to what charitable funds should be spent on would be helpful in informing a charitable fund strategy and providing a wider range of potential projects which might be funded via this route.

The Committee also noted that Gloucestershire Care Services had employed a fundraiser on a short term contract (now ended). The Committee felt it would be sensible to understand GCS's position regarding charitable funds strategy and fundraising, given the intention to integrate 2g and GCS during the next year. It would also be helpful to understand Gloucestershire Hospitals NHS Foundation Trust's experience of charitable funds strategy and fundraising, in order to

inform 2g's own strategy, and to understand what gaps existed in respect of commissioned services which might be filled through charitable funds investment. The Committee therefore asked for a summary report at its next meeting in February 2018 in order to consider these issues further.

Use of Professional Fundraiser

The Committee received a proposal to recruit a professional fundraiser for a period of up to 2 years. The proposal envisaged that this professional would cover his/her own costs during the first year, and raise a further £100k in the second year. The Committee heard that there were a limited number of fundraising professionals available, and that it would be possible to test the market by going out to advert to ask any interested parties to submit a proposal. While such a proposal would not commit the Trust to recruitment of a fundraiser it would identify the anticipated investment required and the methodology to be used to generate the anticipated funding. The Committee considered the proposal in the light of its previous discussion regarding a charitable funds strategy, and came to the view that before agreeing to incur any costs, there should be greater clarity on the priorities for charitable funds, the costs involved in recruiting this professional and identification of the risks associated with that recruitment, input from service users on how charitable funds should be used, and an understanding of the experience of GCS and GHT in terms of fundraising. The Committee therefore felt unable to approve the proposal at this stage, but requested a report to its February meeting which would address the issues described above and help inform a decision by the Committee.

ACTIONS REQUIRED BY THE BOARD OF TRUSTEES

The Board of Trustees is asked to note the contents of this summary.

SUMMARY PREPARED BY: Duncan Sutherland ROLE: Committee Chair

DATE: 1 November 2017

Agenda item 17 **Enclosure Paper L**

Report to: Trust Board, 30th November 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 September – 16 November 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 two Board meetings in Gloucestershire
- Chairing two Appointment and Terms of Services Committees
- Chairing two Councils of Governors
- Chairing two Appointment and Terms of Service Committees
- Chairing a Nomination and Remuneration Committee
- Attending Gloucestershire Care Service NHS Trust's Annual General Meeting
- Attending Gloucestershire's Clinical Commissioning Group's Annual General Meeting
- Attending two meetings of the Gloucestershire Strategic Forum

- Chairing the recruitment process for the appointment of the Joint Chief Executive
- Participating in a series of communications relating to the announcement of the joint strategic intent with Gloucestershire Care Services NHS Trust
- Several meetings with ²gether NHS Foundation Trust's Chief Executive
- Working with colleagues on very many occasions to further the joint strategic intent with Gloucestershire Care Services NHS Trust
- Participating in several telephone meetings with NHS Improvement related to the joint strategic intent with Gloucestershire Care Services NHS Trust
- Meeting with the Chair of Gloucestershire Hospital NHS Foundation Trust's Governance Committee
- Meeting several times with the Chair of Gloucestershire Care Services NHS Trust
- Meeting with the Chief Executive of Gloucestershire Care Services NHS Trust
- Meeting with the Chair of Gloucestershire Hospital NHS Foundation Trust
- Participating in an event at Stonebow to which all Herefordshire Councillors were invited
- Participating in an event at Wotton Lawn to which all Gloucestershire County Councillors were invited
- Attending the Bishop's Breakfast meeting at Emmaus in Gloucester
- Meeting with a Non-Executive Director of several local health and housing organisations
- Meeting with the previous Chair of Wye Valley NHS Trust
- Meeting with the Chair of Cornwall Partnership NHS Foundation Trust
- Attending an event at the Nelson Trust
- Visiting Beaufort Academy to talk to aspirational students
- Meeting with a Tribunal Judge interested in mental health in the workplace
- Being interviewed by BBC Radio Gloucestershire
- Attending the Trust's Care and Compassion conference at Bowden Hall in Gloucester
- Attending the Trust's Tea Party for carers, experts by experience and volunteers
- Attending the Licensing Ceremony for the newly appointed Trust Chaplain undertaken by the Bishop of Gloucester

- Meeting with one of the Trust's Clinical Psychologists
- Holding an informal meeting with Non-Executive Directors
- Having my influenza jab
- 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

- Prepared for and attended a board meeting
- Prepared for and attended a meeting of the ATOS committee
- Held discussions with colleagues about Development Committee business
- Prepared for and chaired a meeting of the Development Committee
- Participated in two board conference calls
- Prepared for and participated in an audit committee conference call
- Discussed 2g matters with the CEO of GCS
- Prepared for and attended meetings of the audit committee, the charitable funds committee, and the New Highways board
- Prepared for and attended a Council meeting
- Prepared for and participated in a board members panel for CEO recruitment

Nikki Richardson

<u>October activity</u>

- Meeting to discuss process for interview panel for appointment of Trust Chair
- Participated in the interview panel for the Trust Board Chair's appointment
- Attended Nomination and Remuneration Committee
- Attended a Council of Governors meeting
- Panel member for Appeals Hearing Meeting to discuss NED complaints process
- Meeting to discuss Governance Committee
- Gave welcome address at AHPP Conference
- Board visit to Laurel House
- Board visit to Cantilupe Ward
- Meeting with GCS SID
- Meeting with Director of Quality
- Preparation and attendance at extra ordinary meeting of the Audit Committee
- Attended the Gloucestershire LD Partnership Board
- Meeting to discuss Soroptimist learning event
- Panel member for Director of Medical Education interviews
- Prepared for and attended Board of Directors
- Panel member for CEO shortlisting interviews
- Telephone conversation with GCS CEO
- Acting up for Trust Chair during her annual leave

<u>November activity</u>

- Prepared for and attended Audit Committee
- Prepared for and attended Charitable Funds Committee

- Preparation for CEO interviews
- Meetings with Deputy CEO
- Board visit to CRHT team
- Preparation for and attendance at MHLS Committee
- Meeting with Director of OD
- Meeting with Joint Chair designate
- Prepared for and Chaired CoG
- Meetings with the Director of OD
- Meeting with the Secretary of State for Health
- Prepared for and member of disciplinary appeal panel
- Member of CEO shortlisting panel
- Attended Gloucestershire HCOSC
- Meeting with members of the Council of Governors
- Panel member for CEO interviews
- Attended an ATOS Committee
- Attended a Board discussion meeting
- Attended a meeting with GCS
- Attended a meeting of the merger Joint Working Group
- Chaired a meeting for the Soroptimist Association

Marcia Gallagher

October

- Participated in a focus group re recruitment process for the appointment of the joint Chair
- Attended an Appointment and Terms of Service Committee
- Met privately with Internal Auditors- PWC
- Attended a Governors visit at Alexandra wellbeing house Gloucester
- Meeting with Finance Director to discuss the mid-year review of the financial position
- Met privately with the External Auditors - KPMG
- Prepared for and attended the Governance Committee
- Attended a visit to the Cheltenham Assertive outreach team
- Prepared for and attended the October Board meeting
- Meeting with Finance Director in preparation for the November Audit Committee meeting

November

- Prepared for and Chaired the November Audit Committee
- Prepared for and attended the Charitable Funds Committee
- Undertook initial evaluations of Internal Audit Tenders with the Deputy and Director of Finance
- Attended the Internal Audit Tender presentations in Swindon and participated in the final evaluations
- Participated in two Mental Health Act Panels
- Had a meeting with the Chair Designate of 2GFT
- Prepared for and attended the Governors Committee
- Attended a meeting with the Director of HR and OD at Weavers Croft Stroud
- Had a booked call with the Deputy Director of Finance re the monthly Board Finance report
- Prepared for and attended the November Board meeting

Duncan Sutherland
A verbal report will be provided at the meeting

Quinton Quayle

- Prepared for and attended a board meeting
- Prepared for and attended a meeting of the Appointments and Terms of Service Committee
- Prepared for and attended an Audit Committee meeting
- Prepared for and attended a meeting of New Highways
- Prepared for and attended a meeting of the Charitable Funds Committee
- Had a one-to-one meeting with the Deputy Chief Executive
- Prepared for and chaired a meeting of the Mental Health Legislation Scrutiny Committee
- Participated in an informal board discussion by telephone conference
- Conducted an NED audit of complaints
- Prepared for and attended a Governors' meeting
- Prepared for an attended a Mental Health Act Managers Hearing
- Prepared for and attended a meeting of the Delivery Committee

Maria Bond

<u>October</u>

- Met with Exec. Director and another NED to discuss format of Complaints Audit
- Met with Exec. Director and Chair of Governance to review the effectiveness of Governance Committee
- Prepared for and dialled in to ATOS meeting
- Carried out a MHA Review at Charlton Lane
- Joined the joint Chair appointment discussion group
- Prepared for and dialled in to Audit Committee
- Prepared for and attended Governance Committee
- Met with deputy CEO prior to Delivery Committee
- Prepared for and Chaired Delivery Committee
- Prepared for and attended ATOS meeting
- Prepared for and attended a Board meeting
- Had my flu injection

<u>November</u>

- Prepared for and attended Audit Committee
- Prepared for and attended Charitable Funds Committee
- Met with new Joint Chair
- Prepared a holding to account presentation for Governors
- Attended a Council of Governors meeting
- Attended the joint CEO appointment discussion group
- Dialled in to informal board meeting
- Dialled in to ATOS meeting
- Prepared for and Chaired a Delivery Committee
- Met with deputy CEO prior to the Delivery Committee
- Prepared for and attended a Board meeting

4. OTHER MATTERS TO REPORT

The appointment process for the Joint Chief Executive of ²gether NHS Foundation Trust and Gloucestershire Care Service NHS Trust is continuing to plan.

In the light of the continuing ill health of the current Chief Executive, I will update the meeting on recent decisions putting in place interim leadership arrangements.

This is the last Board meeting of our Medical Director Dr Chris Fear who is retiring. I know the Board will join me in offering grateful thanks to him for a long career of care to our community, service to this Trust and contribution to this Board.

Dr Amjad Uppal takes up the Medical Director post in December, and so will become a substantive Board Director.

[2]GETHER NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING
TUESDAY 19 SEPTEMBER 2017
BUSINESS CONTINUITY ROOM, RIKENEL, GLOUCESTER

PRESENT:	Ruth FitzJohn *(Chair)*	Rob Blagden	Jenny Bartlett
	Vic Godding	Jo Smith	Katie Clark
	Cherry Newton	Mervyn Dawe	Jennifer Thomson
	Said Hansdot	Amjad Uppal	Ann Elias
	Svetlin Vrabtchev	Vanessa Ball	Xin Zhao
	Mike Scott	Euan McPherson	Kate Atkinson

IN ATTENDANCE: Shaun Clee, Chief Executive
Marcia Gallagher, Non-Executive Director
Anna Hilditch, Assistant Trust Secretary
John McIlveen, Trust Secretary
Jane Melton, Director of Engagement and Integration
Colin Merker, Director of Service Delivery
Kate Nelmes, Head of Communications
Nikki Richardson, Non-Executive Director
Neil Savage, Director of OD
Jonathan Vickers, Non-Executive Director

1. WELCOMES AND APOLOGIES

1.1 Apologies for the meeting had been received from Hazel Braund, Lawrence Fielder and Hilary Bowen.

2. DECLARATION OF INTERESTS

2.1 Jo Smith informed the Council that she was now a member of the Gloucestershire Hospital's NHSFT Learning Disabilities Steering Group.

2.2 Cherry Newton was a member of the Royal College of Psychiatry's Steering Group focussing on depression and anxiety.

3. COUNCIL OF GOVERNOR MINUTES

3.1 The minutes of the Council meeting held on 13 July 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 At the July Council meeting, Governors had agreed to end the tenure of a staff Governor due to non-attendance. A query was raised as to what the Trust was

currently doing to recruit to the vacant Governor positions. The Assistant Trust Secretary informed the Council that the Trust had 4 vacant staff Governor positions and 2 public Governor vacancies. Work had already commenced with the Electoral Reform Service to set up an election process for these positions at the beginning of October. With regard to the staff Governor vacancies, the Assistant Trust Secretary had spoken to members of the Executive Team about the need to promote these throughout the Trust and to seek ways of getting interest from staff. Assurance was received that the staff Governor posts were Trust wide positions and therefore staff in both Gloucestershire and Herefordshire would have the opportunity to put themselves forward.

5. CHIEF EXECUTIVE'S REPORT

5.1 The Council noted 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.

5.2 This briefing provided the Council of Governors with an update in relation to a number of issues since the Council meeting in July 2017, including:

- Fire Assurance Processes
- South of England Mental Health Collaborative
- Mental Health Acute Response Service (MHARS)
- Gloucester Hub Update
- Accountable Care Systems
- Perinatal Mental Health Awards

5.3 In relation to Fire Assurance Processes, and Oak House in Hereford in particular, Shaun Clee advised that discussions and meetings with relevant partners had taken place and he set out some of the key areas for assurance for the Governors. Shaun noted that whilst the report outlined appropriate fire safety protection, Oak House did not currently offer the standard of accommodation that 2gether would wish to offer, both for service users and members of staff. Two potential alternative solutions were therefore being explored with commissioning colleagues and further updates would be provided to the Governors on progress with this.

5.4 Rob Blagden thanked Shaun Clee for producing his written report in advance of the meeting, noting that Governors found it very helpful to receive this in advance to be able to read it and think about any questions they may wish to ask.

6. ELECTION OF LEAD GOVERNOR

6.1 The Lead Governor is elected by the Council for a period of up to two years, and any Governor – Public, Staff or Appointed – may apply. This tenure period was agreed by the Council at its meeting in March 2017.

6.2 A nomination form and the Lead Governor role description were sent out to all Governors via email on 25 August, with a return date for interested Governors of close of play on Wednesday 13 September.

6.3 One nomination was received from the existing Lead Governor Rob Blagden (Staff Governor, Management and Administration). The Council was therefore asked to approve the re-appointment of Rob Blagden for a period of up to 2 years with effect from 1 October 2017.

6.4 The Council of Governors agreed that Rob had done an outstanding job as Lead Governor and were therefore fully supportive of him continuing in this role for a further term.

7. TENURE OF A GOVERNOR

Ann Elias left the meeting at this point

7.1 The Trust's constitution contains a provision regarding attendance at meetings of the Council of Governors which states that if a governor fails to attend three consecutive general meetings of the Council of Governors his/her tenure of office is to be terminated at the next meeting unless the other governors (by a simple majority) are satisfied that:-

a) the absence was due to a reasonable cause; and
b) he/she will be able to start attending meetings of the Council of Governors again within such a period as they consider reasonable.

7.2 Ann Elias was elected as a Public Governor for Stroud in July 2016. Although Ann had been involved in other activities in her capacity as a Governor, such as Governor visits and attendance at engagement events, she had not attended the last 3 consecutive meetings of the Council of Governors, in March, May or July 2017.

7.3 The Assistant Trust Secretary discussed the matter with Ann Elias prior to compiling this report and received assurance that the absence was due to last minute, unforeseen personal circumstances. It was reported that Ann was keen to continue in her role as a Governor, and had every intention of attending future Council of Governors meetings. Ann said that she was also very keen to get more involved with membership and would like to work closely with the Trust's Communications Team to arrange events in local colleges and schools in the Stroud area.

7.4 A number of Governors noted that they had attended the Gloucestershire Police Open Day the previous Saturday and Ann Elias had been there participating. Those Governors had spoken to Ann and received good assurance from her about her commitment to the role and her regret at having been unable to attend the last 3 Council meetings.

7.5 Given the assurances received regarding future attendance, the Council of Governors agreed that Ann Elias's tenure as a Public Governor should not be terminated at this time.

Ann Elias returned to the meeting at this point

8. NOMINATIONS AND REMUNERATION COMMITTEE MEMBERSHIP

8.1 The Nominations and Remuneration Committee is a formal Committee of the Council of Governors and its purpose is to advise the Council on the appointment, dismissal, remuneration and terms of service of the Chair and Non-Executive Directors of the Board. The Committee has delegated authority to manage and oversee the appointment and appraisal processes for the Chair and Non-Executive Directors on behalf of the Council. The Committee also acts as a task and finish group of the Council of Governors in order to consider corporate governance matters affecting the Council.

8.2 With the exception of the Lead Governor, Governor members of the Committee will be elected by the Council of Governors for a period of 1 year. At the end of their initial term, members of the Committee may stand for re-election. Committee membership will be conditional upon continued membership of the Council of Governors.

8.3 An email was sent out to all Governors on 25th August 2017 asking people to nominate themselves to sit on the Nominations and Remuneration Committee. Following receipt of these expressions of interest, it is suggested that the membership of the Committee be confirmed, as follows:

- Trust Chair (Ruth FitzJohn)
- Trust Deputy Chair (Nikki Richardson)
- Lead Governor (Rob Blagden)
- Named Governors (Vic Godding, Mervyn Dawe and Mike Scott)

8.4 The Council of Governors agreed the proposed membership of the Nominations and Remuneration Committee, and agreed that a refresh of Committee membership would take place in a year's time, in line with the Committee's Terms of Reference.

9. BOARD COMMITTEE OBSERVATION – GOVERNOR PARTICIPATION

9.1 A programme of Governor observation of key Board Committees has been developed to support Governors in their statutory duty to hold the Non-Executive Directors to account for the performance of the Board. The programme covers five Committees – Audit, Delivery, Development, Governance and Mental Health Legislation Scrutiny. By observing Committee proceedings, Governors are able to take assurance that the Non-Executive Directors are effectively leading and controlling the Trust, and report that assurance back to the Council as part of the holding to account process.

9.2 An email was sent out to all Governors on 25th August 2017 asking people to express an interest in participating in the observation programme. Two Governors are nominated to attend each Board Committee; however, people may choose to attend alternate meetings.

9.3 Following receipt of these expressions of interest, it was agreed that the observation of the Board Committees be confirmed, as follows:

Committee		
Audit	Ann Elias	Mike Scott
Delivery	Xin Zhao	Kate Atkinson
Development	Said Hansdot	Euan McPherson
Governance	Vic Godding	Jo Smith
Mental Health Legislation Scrutiny	Cherry Newton	Jennifer Thomson

9.4 The Council of Governors agreed the proposed Governor involvement with the Board Committee observation process, and agreed that a refresh of Governor involvement take place in a year's time, to enable all Governors to have the opportunity to take part if they wish.

10. KEY ISSUES FOR DISCUSSION FROM THE GOVERNOR PRE-MEETING

10.1 Rob Blagden advised that all issues discussed at the Governor pre-meeting had already been covered by items on the agenda.

11. GOVERNOR ACTIVITY

11.1 The Trust had participated in the Gloucestershire Police Open Day and a number of Governors had attended and helped to host an information stand at the event. All those who took part said that it had been a fantastic day.

11.2 Jennifer Thomson informed the Council that the Forest of Dean Membership Engagement event planned for 10th October had been postponed. Jennifer was working with the Trust's Communications Team to seek an alternative date for this event.

11.3 Vic Godding had participated in the Governor visit to Charlton Lane in Cheltenham and said that this was a superb unit. He encouraged those new Governors to take up the opportunity to visit the Trust's units as part of the rolling programme. Vic advised that he had also been invited by the Matron Manager at Charlton Lane to attend a presentation on digital reminiscing equipment which he said was excellent.

11.4 Mike Scott had also attended the visit to Charlton Lane. Mike said that it was his first time visiting an older people's mental health inpatient facility and he had some pre-conceived ideas of what to expect. However, he was blown away by what he had seen in terms of the quality of the team, the atmosphere, environment and the attitudes of the staff. He said that it had been an amazing experience and reiterated Vic Godding's encouragement to fellow Governors to take part in the visiting programme.

12. ANY OTHER BUSINESS

12.1 Vic Godding informed the Council that he was a member of the Gloucester Dementia Alliance and asked whether one of the Gloucester Governors, or members might be interested in attending meetings. Kate Nelmes agreed to advertise this opportunity.

13. DATE OF NEXT MEETINGS

Council of Governor Meetings

Business Continuity Room, Trust HQ, Rikenel		
Date	**Governor Pre-meeting**	**Council Meeting**
2017		
Thursday 9 November	1.30 – 2.30pm	3.00 – 5.00pm
2018		
Tuesday 16 January	9.00 – 10.00am	10.30 – 12.30pm
Thursday 8 March	1.30 – 2.30pm	3.00 – 5.00pm
Tuesday 8 May	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 12 July	9.00 – 10.00am	10.30 – 12.30pm
Tuesday 11 September	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 8 November	1.30 – 2.30pm	3.00 – 5.00pm

Public Board Meetings

2017		
Thursday 30 November	10.00 – 1.00pm	Hereford
2018		
Tuesday 30 January	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 29 March	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 31 May	10.00 – 1.00pm	Hereford
Thursday 26 July	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 27 September	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 29 November	10.00 – 1.00pm	Hereford

THE FOLLOWING SECTION OF THE MEETING WAS TAKEN IN CLOSED SESSION DUE TO THE COMMERCIAL TIMING OF THE ITEMS. INFORMATION DISCUSSED HAS SINCE BEEN RELEASED IN THE PUBLIC DOMAIN

COUNCIL OF GOVERNORS MEETING
TUESDAY 19 SEPTEMBER 2017

14. PROGRESSING OUR ORGANISATIONAL STRATEGY

14.1 The purpose of this paper was to update the Council of Governors on progress in implementing our organisational strategy and to seek the Council of Governors support in implementing an "FT Community based Mental and Physical Health Care Services Chain " during 2017/18, with the intention of consulting on developing an integrated physical and mental health offer for Gloucestershire during 2018/19. This report was accompanied by a comprehensive presentation given by Shaun Clee.

14.2 In May 2017 the Council of Governors engaged with the Board in a "Strategic Stocktake" during which it was agreed to test the feasibility of preferred options for delivering our strategic intention (to be a provider of high quality mental health and community physical health care) and in particular to pursue discussions with partners and progress evaluation of, and deliverability of, a preferred option.

14.3 Over the last 4 months the Board has held Board level discussions with provision and commissioning partners and has jointly concluded with Gloucestershire Care Services NHS Trust that there is significant alignment of both organisations' strategic priorities, to the extent that a "blended offer" through a single organisation, would best support both of our individual and collective organisational ambitions and accelerate local Strategic Transformation Partnership plans.

14.4 Shaun Clee provided assurance to the Council of Governors that:

1) Appropriate engagement with, and advice from, professional advisors and regulators has been sought, received and considered in order to assist the Board in its evaluation of strategic options.
2) Appropriate risks have been identified and risk mitigation put in place, including an exit strategy in the event that the Strategic Outline Case (SoC) insufficiently supported acquisition.
3) A set of documentation comprising of a Heads of Terms, a Memorandum of Understanding and a "Strategic Intent" have been co-developed with Gloucestershire Care Services NHS Trust, with NHSI and with our lawyers and that these documents have been endorsed and signed by both Boards
4) A communication plan has been produced in conjunction with NHSI to ensure positive stakeholder relationships are maintained.
5) Stage one (establishing an FT Community based Mental and Physical Health Care Services Chain) is not a Material or Significant Transaction and that should the SoC be approved by NHSI, that formal approval by the Governors would be required to support the Acquisition at Full Business Case stage.

14.5 Shaun Clee offered the Council further assurance that arrangements were in place to ensure continuity of performance alongside establishing the FT Chain and progressing the Strategic Outline Case and Full business Case. The Trust would not be "taking its eye off the ball" and the Council of Governors would continue to receive full updates.

14.6 Rob Blagden advised that the Governors had discussed this report and its implications in depth at the Governor pre-meeting. He said that there was an overall positive feeling about the proposals; however, some areas were raised that Governors wanted to know more about, including the impact on staff and assurances that MH services would continue to be front and centre. Shaun Clee advised that all Board and executive appointments, other than the Chair and Chief Executive, would continue as normal, until the full business case had been approved by NHS Improvement. Discussions had taken place with Staffside colleagues and a clear message would go out to staff as part of the detailed "Frequently Asked Questions" being developed as part of the communications plan.

14.7 Mervyn Dawe said that he was supportive of the proposals, but asked that reference to Learning Disability services was made more prominent as these were important services that 2gether provided. This was agreed as a helpful suggestion.

14.8 In terms of what impact this acquisition would have on the Council of Governors, Shaun Clee advised that the Council would still exist in its current form, but work would take place to expand membership to cover Physical Health services as well. Shaun Clee also offered assurance that the Governors would have no accountability in relation to the governance of Gloucestershire Care Services whilst it was part of the Chain, only 2gether.

14.9 With regard to Herefordshire services, the Council was advised that focus was not being lost and it was hoped that the changes taking place in Gloucestershire would be looked at with interest in Herefordshire. Non-Executive Directors present at the meeting offered their assurance that the challenge around Herefordshire services had already been made and they had been assured by the response received.

14.10 The Council of Governors unanimously supported and endorsed the Board to proceed with pace and purpose the opportunity to bring [2]g NHS Foundation Trust ([2]g) and Gloucestershire Care Services NHS Trust (GCS) together, initially within an FT Community Chain.

15. APPOINTMENT OF A JOINT CHAIR

15.1 The purpose of this paper was to present a proposal to the Council of Governors for the appointment of a Joint Chair to deliver the implementation of our organisational strategy particularly in terms of implementing a "Foundation Trust Community based Mental and Physical Health Care Services Chain" during 2017. This appointment was also against the context of the previously notified planned retirement of the existing Chair, Ruth FitzJohn, at the end of this calendar year.

15.2 The appointment of the Chair is the responsibility of the Council of Governors in line with the roles and responsibilities of Governors as set out in the Health and Social Care Act 2012. To this end, in light of the agreements reached between both Trusts and NHS Improvement in terms of future strategy and the chain, the Council of Governors considered and supported the following appointment process:-

a. The Council of Governors accepted one ring-fenced candidate – the Chair of the chain partner trust, Gloucestershire Care Services - into the process, interviewing on 3 October 2017

b. It was agreed that the interview panel be made up of Rob Blagden, Vic Godding, and Mervyn Dawe, who are the current members of the Nominations and Remuneration Committee and have been appropriately trained in recruitment processes. The Non-Executive team would also provide a member for the interview panel to support the Governors. Both the Chief Executive and a representative of NHS Improvement would be available to advise the panel.

c. The Nominations and Remuneration Committee will bring back an appointment recommendation in relation to the appointment to a full Council of Governors meeting for final decision, at a proposed exceptional meeting to be planned for October 2017 (Thursday 5 October).

15.3 The Council of Governors noted that the Nominations and Remuneration Committee would be meeting prior to the interviews to formally agree the Chair Job description and person specification, taking into account any changes required to this in light of the joint appointment.

16. CHANGES TO THE TRUST CONSTITUTION

16.1 The Board and the Council of Governors approved changes to the Trust constitution in July 2017. Those changes enacted guidance from NHS England designed to strengthen the Trust's procedures for managing conflicts of interests.

16.2 This report set out two further proposed changes to the Trust constitution which were intended to refine and strengthen further the previously agreed change while facilitating the delivery of the Trust's corporate strategy and closer working with partner organisations.

16.3 Accordingly, the proposed change amends clause 32.1.14 which previously excluded from being a director of the Trust anyone who is a director of an NHS trust or another foundation trust. The proposed amendment adds a rider to this clause, namely that 'This exclusion shall not apply in the context of the establishment of formal relationships with other healthcare organisations, as agreed by the Board.'

16.4 To complement this change, a further amendment was proposed to clause 35.9 which currently states "The duty to avoid a conflict of interest is not infringed if the matter has been authorised in accordance with the constitution". Currently however, the constitution does not specify how such conflicts would be resolved.

Accordingly an amendment was proposed so that this clause would read "authorised in advance by the Trust Board". This clarifies the original clause and enables the Trust to place a Director with another organisation in order to further the Trust's strategy.

16.5 The Council of Governors agreed the proposed changes to the constitution. It was noted that these changes had also been agreed by the Board at its meeting on 31 August and would therefore take immediate effect.

17. ANY OTHER BUSINESS

17.1 There was no other business.

Council of Governors
Action Points

Item	Action	Lead	Progress
13 July 2017			
12.1	Kate Nelmes was asked to consider whether some form of briefing note could be developed to assist Governors in carrying out the key role of meeting with and engaging with constituents.	Kate Nelmes	**Complete** A briefing note is attached as Paper A3 for Governor information.

²GETHER NHS FOUNDATION TRUST

EXTRAORDINARY COUNCIL OF GOVERNORS MEETING
THURSDAY 5 OCTOBER 2017
BOARD ROOM, RIKENEL, GLOUCESTER

PRESENT:	Ruth FitzJohn *(Chair)*	Rob Blagden	Kate Atkinson
	Vic Godding	Jo Smith	Mervyn Dawe
	Jennifer Thomson	Said Hansdot	Ann Elias
	Svetlin Vrabtchev	Xin Zhao	Mike Scott
VIA PHONE:	Euan McPherson	Katie Clark	Cherry Newton

IN ATTENDANCE: Shaun Clee, Chief Executive
Anna Hilditch, Assistant Trust Secretary
Nikki Richardson, Non-Executive Director
Neil Savage, Director of OD

1. WELCOMES AND APOLOGIES

1.1 Apologies for the meeting had been received from Hazel Braund, Lawrence Fielder, Jenny Bartlett, Hilary Bowen and Vanessa Ball.

2. DECLARATION OF INTERESTS

2.1 There were no changes to Governor's declarations of interest and no conflicts arising from the business to be conducted.

3. APPOINTMENT OF A JOINT CHAIR

3.1 At its meeting on 19 September 2017, the Council of Governors supported and endorsed the Board to proceed with pace and purpose the opportunity to bring ²gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust together, initially within an FT Chain. As part of this opportunity, the Governors endorsed the proposal to establish a joint Chair across both Trusts, with the appointment of the new Chair of ²gether NHS Foundation Trust initially being ring-fenced to the current Chair of GCS and subject to an appropriate selection process. The appointment of the Chair is the responsibility of the Council of Governors in line with the roles and responsibilities of Governors as set out in the Health and Social Care Act 2012.

3.2 The Nominations and Remuneration Committee met on 27 September to review the job description and person specification for the Joint Chair to ensure that this reflected the necessary role, responsibilities, skills, experience and values.

3.3 A selection process was conducted which mirrored the process conducted for previous Chair and Non-Executive Director appointments. Discussion groups (Governors, Experts By Experience, local stakeholders and Board members) met with this one candidate on the morning of Tuesday 3rd October, and a formal interview took place that day. Governors formed the majority on the interview panel, alongside the Deputy Trust Chair and an Expert by Experience.

The Chief Executive of ²gether and a representative from NHS Improvement participated in the interview in an advisory capacity.

3.4 Following the formal interview, which lasted 90 minutes, the panel deliberated and the recommendation regarding the appointment was presented to a meeting of the Nominations and Remuneration Committee.

3.5 The Nominations and Remuneration Committee received the following assurances:

- The panel unanimously supported the appointment of the candidate, Ingrid Barker
- Involvement in both the discussion groups and the interview panel had been extensive
- The candidate had the required skills and competencies to carry out the role
- Any areas for development were noted and would be addressed as part of the agreed appraisal process of setting objectives and development plans e.g. experience of working in a Foundation Trust
- The interview panel gave particular attention to the importance of Herefordshire and was suitably assured by the responses received
- The candidate has a suitable background in mental health, community services and the wider NHS
- References received for the candidate were excellent

3.6 Having taken into account the feedback from the discussion groups and undertaken a rigorous interview, the recommendation to the Council of Governors was the appointment of Ingrid Barker as Joint Trust Chair for a three year term commencing on 1 January 2018.

3.7 Rob Blagden, who had chaired the interview panel, informed the Council that the feedback received from the discussion groups had been very helpful and this had been used to re-form some of the questioning in the formal interview. The questions were robust and covered areas such as culture, joint working and partnerships.

3.8 One of the areas identified for development related to Ingrid's lack of experience working in a Foundation Trust. Shaun Clee advised that the Foundation Trust environment was very different in relation to regulators and accountability. However, the interview panel were in agreement that Ingrid had the necessary skills and capabilities to take this new challenge in her stride.

3.9 Nikki Richardson had sat on the interview panel and she informed the Council that she felt very comfortable with Ingrid's values, her approach and her excitement at working with the Governors. Nikki noted that Ingrid would be a good fit on the Board; however, it needed to be recognised that she was a different person and time would be needed to build up the necessary relationships.

3.10 Cherry Newton asked about Ingrid's commitment to Herefordshire services. Rob Blagden said that the interview panel had been well assured by her responses to this line of questioning. Mervyn Dawe added that Ingrid had raised Herefordshire in advance of any questions by the panel which demonstrated her pro-active approach.

3.11 Shaun Clee advised that Ingrid was fully up to speed with the STP work being carried out in the county and she was passionate about partnership working. Ingrid also showed real commitment to making the merger of mental and physical health work.

3.12 Euan McPherson expressed his thanks to those Governors who had contributed to what looked to have been a very robust recruitment process. He said that the Trust was fortunate to have a person of such quality and experience as Ingrid who was ready to step into the post.

3.13 Ruth FitzJohn informed the Council that she had purposefully not involved herself in the recruitment process so as not to create any potential conflicts of interest or bias to the process. She said that she had known Ingrid personally for over 10 years, first as a Non-Executive at NHS Gloucestershire and then as Chair of GSC. Ruth said that Ingrid was a very hard worker and in her personal opinion, if appointed, would be an excellent Joint Chair.

3.14 Mike Scott asked about the time commitment for the Joint Chair, querying whether the 3 days a week would be sustainable whilst covering both 2gether and GCS. Ruth FitzJohn said that it would take time to get this right, and added that a Chair shouldn't be in the office 5 days a week as it would mean that they were doing the wrong thing. However, this pressure had already been recognised and there would be a greater reliance on other NEDs, in particular the Senior Independent Director and Deputy Chair. Ruth added that the Nominations and Remuneration Committee had recently approved the recruitment process for a 7th NED on this basis. Nikki Richardson assured the Council that all NEDs were aware of this and had been consulted in advance of making this proposal to the N&R Committee.

3.15 Rob Blagden asked the Council of Governors to note that the appointment would be made for an initial term of three years. When the Council had endorsed the proposal for a Joint Chair at the September meeting, it had been proposed that the appointment be for an initial term of 2 years. He advised that discussions had taken place since then and it was suggested that reverting to the standard 3 year term would offer more stability and continuity. This had been agreed by the N&R Committee. The Council of Governors approved this.

3.16 Having taken into account all of the feedback from the interview panel and the Nominations and Remuneration Committee, and the added assurances received at the meeting, the Council of Governors unanimously approved the appointment of Ingrid Barker as Joint Trust Chair for a three year term commencing on 1 January 2018.

3.17 In terms of process, Shaun Clee advised that the communication of this appointment would be embargoed until Monday 9th October, at which time briefings for staff and the press would be issued. Governors were therefore asked to ensure that the outcome of this meeting remained confidential until such time as they were advised that it could be made publically available.

4. ANY OTHER BUSINESS

4.1 Ruth FitzJohn informed the Council that the recruitment process for a Joint Chief Executive would be commencing in October. As with the Chair post, there would be ring-fenced candidates, with the existing Chief Executives of 2gether and GCS being part of the process. This process would also involve Governors; however, it would be a Board appointment. Governors would be required to approve the appointment. Timescales for this recruitment had been moved forward and it was now envisaged that the interviews would take place before the end of October, which would therefore mean that a further extraordinary Council meeting would be required. The date and arrangements for this would be confirmed ASAP.

5. DATE OF NEXT MEETINGS

Council of Governor Meetings

Business Continuity Room, Trust HQ, Rikenel		
Date	**Governor Pre-meeting**	**Council Meeting**
2017		
Thursday 9 November	1.30 – 2.30pm	3.00 – 5.00pm
2018		
Tuesday 16 January	9.00 – 10.00am	10.30 – 12.30pm
Thursday 8 March	1.30 – 2.30pm	3.00 – 5.00pm
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Tuesday 11 September	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 8 November	1.30 – 2.30pm	3.00 – 5.00pm

Public Board Meetings

2017		
Thursday 30 November	10.00 – 1.00pm	Hereford
2018		
Tuesday 30 January	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 29 March	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 31 May	10.00 – 1.00pm	Hereford
Thursday 26 July	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 27 September	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 29 November	10.00 – 1.00pm	Hereford

Agenda item **19** **Enclosure** **Paper N**

Report to: Trust Board, 30 November 2017
Author: John McIlveen, Trust Secretary
Presented by: John McIlveen, Trust Secretary

SUBJECT: **USE OF THE TRUST SEAL**

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

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

PURPOSE

To present the Board with a report on the use of the Trust Seal for the period July - September 2017 (Q2 2017/18).

SUMMARY OF KEY POINTS

Section 10.3 of the Trust's Standing Orders requires that use of the Trust Seal is reported to the Board on a quarterly basis.

"10.3 Register of Sealing - The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document. Use of the seal will be reported to the Board quarterly."

During Quarter 2 2017/18, the Seal was not used.

RECOMMENDATIONS

The Board is asked to note the use of the Trust seal for the reporting period.