2gether
Making life better

2gether
NHS Foundation Trust

BOARD MEETING

THURSDAY 29 NOVEMBER 2018
AT 10.00AM

THE MAIN HALL, THE KINDLE CENTRE
HEREFORD

Our Core Values

Seeing from a service user perspective
Excelling and improving
Responsive
Valuing and respectful
Inclusive, open and honest
Can do
Efficient, effective, economic and equitable

[2]GETHER NHS FOUNDATION TRUST
BOARD MEETING
THURSDAY 29 NOVEMBER 2018 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 26 September 2018**	**PAPER A**
	4	**Action Points and Matters Arising**	
10.10	5	**Questions from the Public**	
IMPROVING QUALITY			
10.15	6	**Patient Experience Story**	**PRESENTATION**
10.40	7	**Performance Dashboard Report – September 2018**	**PAPER B**
10.50	8	**Learning from Deaths Q2**	**PAPER C**
11.00	9	**Guardian of Safe Working Q1**	**PAPER D**
11.10	10	**Quality Report Q2**	**PAPER E**
BREAK – 11.20AM			
11.30	11	**Service Experience Report Q2**	**PAPER F**
11.40	12	**NED Audit of Complaints Q2**	**PAPER G**
11.50	13	**National Patient Survey Report (Jane)**	**PAPER H**
IMPROVING ENGAGEMENT			
12.00	14	**Chief Executive's Report**	**PAPER I**
IMPROVING SUSTAINABILITY			
12.10	15	**Summary Financial Report**	**PAPER J**
12.20	16	**Board Assurance Map Report**	**PAPER K**
12.30	17	**Board Committee Summaries**	
		• Appointments and TOS Committee Annual Report	**PAPER L1**
		• Development Committee - October	**PAPER L2**
		• Delivery Committee – Sept, October and November (Verbal)	**PAPER L3**
		• Governance Committee – October	**PAPER L4**
		• Audit Committee - November	**PAPER L5**
INFORMATION SHARING (TO NOTE ONLY)			
12.45	18	**Chair's Activity Report**	**PAPER M**
	19	**Council of Governor Minutes – September 2018**	**PAPER N**
	20	**Use of the Trust Seal Q2**	**PAPER O**
12.50	21	**Any Other Business**	
	22	**Date of Next Meeting** Wednesday 30th January 2019 in Gloucester. Venue TBC	

PUBLIC QUESTIONS PROTOCOL

Written questions for the Board Meeting

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

A question under this protocol may be asked in writing to the Trust Secretary by 10am, 4 clear working days before the date of the Board meeting.

A written answer will be provided to a written question and will also be read out at the meeting by the Chair or other Trust Board member to whom it was addressed.

If the questioner is unable to attend the meeting in person, the question and response will still be read out and a formal written response will be sent following the meeting.

A record of all questions asked, and the Trust's response, will be included in the minutes from the Board meeting for public record.

Oral Questions without Notice

A member of the public who has put a written question may, with the consent of the Chair, ask an additional oral question on the same subject.

Public Board meetings also have time allocated at the start of each agenda for the receipt of oral questions from members of the public present, 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.

Exclusions

Written questions may be rejected and oral questions need not be answered when the Chair 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 Trust Secretary/Assistant Trust Secretary on 01452 894165. Public questions can be submitted for Trust Board meetings by emailing: anna.hilditch@nhs.net

[2]GETHER NHS FOUNDATION TRUST

BOARD MEETING
TRUST HQ, RIKENEL
26 SEPTEMBER 2018

PRESENT

Ingrid Barker, Joint Trust Chair
Maria Bond, Non-Executive Director
John Campbell, Director of Service Delivery
Marie Crofts, Director of Quality
Marcia Gallagher, Non-Executive Director
Andrew Lee, Director of Finance
Jane Melton, Director of Engagement and Integration
Colin Merker, Deputy Chief Executive
Nikki Richardson, Non-Executive Director
Paul Roberts, Joint Chief Executive
Neil Savage, Joint Director of Organisational Development
Dominique Thompson, Non-Executive Director
Dr Amjad Uppal, Medical Director

IN ATTENDANCE

Kate Atkinson, Trust Governor (until Item 10)
Anna Hilditch, Assistant Trust Secretary
John McIlveen, Trust Secretary
Dr Philippa Moore, Joint Director of Infection Prevention and Control (Item 9)
Kate Nelmes, Head of Communications
Rob Newman, Freedom to Speak Up Guardian (Item 13)
Anna Walters, Advanced Junior Doctor Trainee (Shadowing Amjad Uppal)

1. WELCOMES, APOLOGIES AND INTRODUCTIONS

1.1 Apologies were received from Jonathan Vickers and Duncan Sutherland.

2. DECLARATIONS OF INTERESTS

2.1 No new interests were declared.

3. MINUTES OF THE PREVIOUS MEETING HELD ON 26 JULY 2018

3.1 The minutes of the meeting held on 26 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 The Board had not received any questions in advance of the meeting.

6. PERFORMANCE DASHBOARD

6.1 The Board received the performance dashboard outturn report which set out the performance of the Trust's Clinical Services for the period to the end of July 2018, against our NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

6.2 The Board noted that of the 194 performance indicators, 91 were reportable in July with 85 being compliant and 6 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. A review of Schedule 4 of the Gloucestershire CCG Contractual requirements had been carried out and a number of outcome based KPIs had been removed from the dashboard.

6.3 The Board noted that there had been no Under 18 admissions to adult inpatient units during June and July which was excellent to see.

6.4 Dominique Thompson noted that one of the current non-compliant indicators was "Adolescent Eating Disorders: Routine referral to non-NICE treatment within 4 weeks". Dominique asked why the Trust would be making referrals for treatment that were not NICE recommended. The Director of Service Delivery agreed to speak with the Eating Disorder Team Lead Clinician to establish what this KPI related to and would feedback to the Board.

ACTION: Director of Service Delivery to speak with the Eating Disorder Team Lead Clinician to establish what the Adolescent Eating Disorders: Routine referral to non-NICE treatment within 4 weeks KPI related to and would feedback to the Board

6.5 The Board noted that some new indicators had been included for the first time this month relating to Patients with Dementia having weight assessments. It was noted that in July, only 55% of patients with dementia were recorded as being weighed on admission, against a target of 85%. Issues around nutrition and hydration were key for this group of patients and this was therefore concerning. The Director of Quality said that she had not been made aware of any concerns; however, she agreed to investigate this and establish whether there was a gap in practice or whether this was simply a data quality glitch relating to a newly reported KPI.

ACTION: Director of Quality to investigate the position with Patients with Dementia having weight assessments on admission to see whether there was a gap in practice or it was a data glitch

6.6 The Board noted the dashboard report for Month 4 of 2018/19, and the assurance that this provided.

7. QUALITY REPORT – QUARTER 1 2018/19

7.1 The Director of Quality presented the first review of the Quality Report priorities for 2018/19. The report showed progress made towards achieving targets, objectives and initiatives identified in the Annual Quality Report. The Board noted that there were 2 targets which were consistently not being met:

- 1.2 – Personalised discharge care planning
- 2.1 – Numbers of service users being involved in their care

7.2 There continued to be a sustained focus on the unmet targets, particularly on Personalised discharge care planning. In August 2018 the QCR sub-committee agreed that the required standards within the Assessment and Care Management Policy would be reviewed. Until this work was concluded, Localities would report on performance against this target at each monthly QCR and a task and finish group had been asked to look at the 7 indictors which made up this overall quality indicator.

7.3 In terms of the local patient Quality Survey, whilst the target for being involved in care had not been met this quarter, the result was encouraging and currently on trajectory for being met by year end (currently 80% against a target of 84%).

7.4 The Board noted the progress made to date and the actions in place to improve/sustain performance where possible. This was a positive picture, with much improved performance being seen from this point last year against the key quality indicators.

7.5 Marcia Gallagher recalled that the Board had received an update on the outcome of the recent CQC inspection at the last meeting and it had been agreed that a Board discussion on the Learning Disability service and the CQC action plan to address the "requires improvement" areas identified would take place. She said that she had heard nothing further about this and expressed some concern that the Board as a whole was not fully sighted on the work taking place. The Director of Quality advised that the CQC action plan had been presented at the Executive Committee the previous week, and was scheduled for the October Governance Committee. A monthly CQC Planning meeting was also taking place to progress the recommendations and actions. In the interim, Executive safety walk arounds had also been taking place, with 2 visits carried out at Berkeley House over the past month. The CQC Action Plan would be shared with the CQC tomorrow for information. The Board agreed that assurance on the actions taking place and progress needed to come back to the whole Board for oversight. It was suggested that a separate section be included on future Governance Committee summary reports to the Board specifically to receive feedback on progress.

8. PATIENT EXPERIENCE PRESENTATION

8.1 The Board welcomed Beth to the meeting who had come along to share her recovery story and experience of using mental health services.

8.2 Beth spoke to the Board about her difficult childhood, teenage years and the defining relationships in her life, including her mother and ex-partner, both of which had been abusive relationships. Beth had gone to university, had achieved a degree in English and Music, and subsequently moved to Ireland to study for an MA in Music Therapy. Beth was a trained Music Therapist.

8.3 Beth was first referred to MH services in 2006 suffering with an eating disorder and after going through a difficult divorce, was admitted to the Stonebow Unit in 2013 following 2 suicide attempts.

8.4 The Board heard how Beth had now "graduated" from MH services and was active in the community having joined a number of groups, despite this initially being very difficult for her. Beth continued to volunteer at the Stonebow Unit and was an active Expert by Experience for the Trust which she said that she valued.

8.5 Beth had two young children and the Board asked whether she felt that she had received enough support both for herself and for her children during the periods when she was unwell. Beth said that she had received the necessary support.

8.6 The Director of Service Delivery asked Beth as an Expert by Experience whether there was anything about the Stonebow Unit that she would change. Beth said that she had been anxious on entering the unit as she did not know what to expect. During her admission, Beth said that she spent most of the time in her room, rather than communal areas. However, she said that one of the things that she valued the most was taking part in the Art and Music Therapy sessions at the unit which had been very beneficial.

8.7 Ingrid Barker thanked Beth for attending the meeting and for speaking so powerfully and honestly about her experiences. She said that it had been a humbling and poignant experience listening to her story and her courageous journey on the road to recovery.

9. INFECTION CONTROL ANNUAL REPORT 2017/18

9.1 The Board welcomed Dr Philippa Moore to the meeting to present the Infection Control Annual Report 2017/18. The report provided evidence for assurance that the Trust is committed to maintaining high standards of infection prevention and control across all its services.

9.2 The Trust remains 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) and risks for healthcare associated infection remain low in the Trust.

9.3 Philippa was asked whether the flu vaccination would be offered to patients, as well as Trust staff. It was noted that patients were usually referred to their GPs to receive the flu jab; however, those "long stay" inpatients in Trust units at the time would be offered the vaccination.

9.4 The Joint Chief Executive noted the reference to antibiotic stewardship and the "need to update" the current Antibiotic guideline booklets. Philippa Moore advised that the guidelines were based on the national Public Health England guidelines; however, this was a local issue and updates would be made over the next few months. She noted that the updates would only involve some minor tweaks.

9.5 PLACE is now in its sixth year and the 2018 assessments took place between April and May this year. The aim of PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient care experience. The assessment looks at 6 domains: Cleanliness; Food and Hydration; Privacy, Dignity and Wellbeing; Condition, Appearance and Maintenance; Dementia; and Disability. National results were analysed and released by NHS Digital on 16th August and the Trust has achieved very positive results placing us above the UK national average for Mental Health and Learning Disability settings in all of the six domains for the first time since PLACE began. The national average score for Cleanliness in Mental Health and Learning Disabilities is 98.4%. The Trust's overall score this year is 99.64% which is over 1% higher than the national average and an increase on last year's score of 97.21%. All sites scored above the national average which is an excellent achievement. In addition, Berkeley House, Charlton Lane, Laurel House and Oak House all scored 100%. The Board offered its huge congratulations to the Team for this fantastic achievement.

9.6 There were poor cleaning results for Stonebow last year with a drop in over 10% compared to the previous year. However this year there was an increase of almost 9% on 2017's score placing Stonebow above the national average. It was anticipated that this would be the case now that 2gether has control and influence over schedules, frequencies and standards following the TUPE of all Sodexo staff into an in-house service. There were poor cleaning results for Oak House last year with a score of 79.87%, however this year Oak House scored a resounding 100% which is a remarkable achievement. The Director of Finance informed the Board that the Trust did have to invest some money into the provision of cleaning services in Herefordshire; however, there had been huge payback in terms of quality and improvements which was excellent to see.

9.7 The Board thanked Philippa Moore for attending and presenting the Infection Control Annual Report which offered significant levels of assurance for all areas covered by the infection prevention and control programme.

10. SERVICE EXPERIENCE REPORT - QUARTER 1 2018/19

10.1 The Board received the Service Experience report for Quarter 1 of 2018/19.

10.2 The Director of Engagement and Integration provided assurance that service experience information about Trust activity in Quarter 1 2018/19 had been reviewed in depth, scrutinised for themes and considered for both individual team and general learning across the organisation. The full report had been discussed in detail at the Governance Committee in August.

10.3 The Board received significant assurance that the organisation had listened to, heard and understood patient and carer experience of 2gether's services. This assurance was provided across all domains of feedback including complaints, concerns, comments and compliments. The Board also received significant assurance that service users valued the service being offered by [2]gether and would recommend it to others. During quarter 1, 81% of people who completed the Friends and Family Test said that they would recommend 2gether's services. This score is a slight dip from the previous quarter but relatively consistent with the previous scores from 2017/18. However, the Board was asked to note the limited assurance in relation to the number of people taking part in the local 'How Did We Do?' survey of quality. Whilst the feedback given by respondents has generally been positive, response rates remain lower than hoped for. Changes to the systems used to capture and analyse survey feedback are underway to be implemented in Quarter 3 2018/19 with the aim to increase the number of responses received. Work has also been undertaken with Gloucestershire Care Services colleagues to learn from alternative methods and increase response rates.

10.4 Significant assurance was received that services are consistently reporting details of compliments they have received. Compliments continue to be reported to the Service Experience Department and vastly outnumber the rate of complaints received. Numbers decreased during Quarter 1 and work continues to increase reporting by colleagues throughout the Trust.

10.5 The Board received Full Assurance that complaints have been acknowledged in required timescales, noting that during Quarter 1, 100% of complaints received were acknowledged within 3 days. There was also Significant assurance that all people who complain have their complaint dealt with by the initially agreed timescale and 90% of complaints received a response to their complaint within the agreed timescales.

10.6 The Board noted that there continued to be a sustained focus on sharing and embedding learning from service experience feedback. The Service Experience Department and locality governance leads have developed new systems during Quarter 1 to share learning and recommendations from complaints using practice notes that are cascaded from Locality Management Boards to Trust colleagues. Work continues on our intranet site to detail learning from service experience feedback ensuring that it is freely available to all Trust colleagues. The Non-Executive Director audits of complaints continue on a quarterly basis giving us feedback and assurance about the way we investigate and respond to the complaints we receive.

10.7 Nikki Richardson said that the Governance Committee had monitored the development of this report on a quarterly basis throughout the year, and had been pleased to see improvements taking place. She said that this was an excellent informative report that offered good levels of assurance.

10.8 The Director of E&I informed the Board that the results of the National Patient Survey would be received over the coming weeks and a session had been organised to review the results with Quality Health, who conducted the survey on the Trust's behalf.

10.9 The Board noted that the Service Experience Report was already shared with certain partners and forums and it was queried whether there would be any merit in sharing the report with the Chair of the HOSC and the Health & Wellbeing Board. This was supported.

10.10 In terms of staff engagement, the Director of OD noted that this was an excellent feel good report and suggested that more communication of the content be made out to staff. The Director of E&I agreed the importance of sharing the report with staff, but there was a need to ensure that the systems currently in place to do exactly this (disseminating the information within the report via Locality Governance Leads) was actually working. The Director of E&I would raise this at the next meeting of the QCR sub-Committee.

ACTION: Director of E&I to investigate at the next QCR committee whether current communication channels to disseminate information from the SE Report to staff via the Locality Governance Leads were working

10.11 The Board noted the Quarter 1 Service experience report and expressed their thanks to the Team for their continued efforts.

11. NON-EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS – QUARTER 1 2018/19

11.1 A Non-Executive Director Audit of Complaints was conducted covering three complaints that have been closed between 1 April and 30 June 2018.

11.2 Jonathan Vickers had conducted the audit and overall, he reported that it was noticeable that the quality and timeliness of our handling of complaints had continued to improve, as had the tone of our response letters. The Board noted that the identification of learning points was also more systematic, and it seemed that the learning was now being taken seriously and widely disseminated.

11.3 The Board welcomed this report and the audit process as a whole which it was agreed was a valuable assurance tool. Ingrid Barker reported that Gloucestershire Care Services had now put a programme of NED audits of complaints in place as a matter of good practice.

12. SAFE STAFFING 6 MONTHLY UPDATE

12.1 The Board received the six monthly update report on safe staffing arrangements within the Trust. This paper offered significant assurance on the current progress and monthly reporting.

12.2 This 6 monthly update included:

- Quality dashboard for inpatient units
- National reporting requirements, latest developments and the latest data in their required format
- Local Trust exception reporting

- Update of agency use across wards
- Confirmation of achievement of the NQB expectations

12.3 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 v actual fill rates - over 96% compliant for July 2018.

12.4 With regard to temporary staff, the Trust continues to use high levels of agency locum medics and agency IAPT workers. There are many actions which will seek to address this moving forward this year. The current predicted forecast for agency spend for 2018/19 is above the control total.

12.5 The Board received an updated quality dashboard for the inpatient wards, ensuring triangulation of both staffing; workforce indicators and patient experience. This indicates some wards have higher rates of sickness and turnover and other indicators which are RAG rated red. The wards and Matrons will be asked to review their units and sites and work with the Director of Quality and the Director of Organisational Development to explore this further. It was noted that the Quality dashboard would be developed to include all services over the next 6-12 months. The Board agreed that this dashboard provided a very useful snapshot and welcomed the roll out to all teams.

13. FREEDOM TO SPEAK UP (FTSU) SELF ASSESSMENT

13.1 Effective Freedom to Speak Up arrangements help to protect service users, carers, staff, the public and the Trust, improving the quality of service provision and employment experiences. Having a healthy speaking up culture which is embedded in a culture of continuous improvement is a required indicator of the Care Quality Commission Well-led domain.

13.2 In line with national regulatory requirements, the Trust has recently undertaken a self-assessment process. The Freedom to Speak Up Guardian and Director of Organisational Development have reviewed this with Staff Side input and the endorsement of the Executive Committee. The outcomes of the self-assessment will be submitted to NHS Improvement at the end of September.

13.3 The Board noted that out of the 69 assessment criteria the Trust rated itself: Green – 37 and Amber – 32. There were no red ratings. Rob Newman informed the Board that this was a similar rating to the outcomes of the Gloucestershire Care Services self-assessment. It was proposed that this self-assessment process would be a dynamic on-going requirement which will be tested out by NHSI, the CQC and staff themselves.

13.4 Rob Newman reported that it was strongly believed that 2gether's approach to FTSU activities is the right one as there has been a positive impact and FTSU visibility across the Trust is good with positive staff feedback.

13.5 Marcia Gallagher asked whether there was more that the Trust could do to publicise the FTSU arrangements, such as posters, mandatory reads on the intranet and information on PC home screens. The Board noted that a number of tools had already been put in place to make the arrangements clear to staff but initiatives would continue as the importance of this was recognised.

13.6 Maria Bond challenged the FTSU process and suggested that the organisation could be seen as failing in its duty if staff were using this route. She said that staff should feel

comfortable to speak to managers within their own teams about any concerns, rather than feeling the need to report them via the FTSU route. Rob Newman advised that a lot of work to feed into the upcoming Values Week was taking place as it was key to develop this alongside the culture of the new organisation.

13.7 The Joint Chief Executive said that it was vital for any organisation to have these communication channels available to ensure that staff felt safe and able to report their concerns.

13.8 With regard to the self-assessment tool, the Joint Chief Executive said that there was a need to ensure that all necessary actions had been identified, along with timescales. The Director of OD advised that a FTSU National Strategy was due to be published in the autumn and this would be presented to the Governance Committee, alongside a worked up action plan.

13.9 The Director of Quality said that there was evidence nationally about the difficulty in re-employing staff who had been involved in whistleblowing incidents. She suggested that this could make for a strong Staff Story at a future Board meeting.

13.10 The Deputy Chief Executive said that the CQC had made some recommendations following their recent inspection around the need for further investment for the FTSU guardian role. The Board noted that Rob Newman had subsequently spoken to the CQC and reassured them that he had sufficient time to carry out this role and had no issues about the support and flexibility given to him in this role. However, despite this the CQC had still made reference to no allocated time given to the FTSU guardian to carry out this role.

13.11 The Board expressed their thanks to Rob Newman for his leadership of the FTSU arrangements.

14. NURSING STRATEGY/FRAMEWORK

14.1 The Director of Quality presented the Nursing Framework to the Board.

14.2 The Chief Nursing Officer for England produced the 'Leading Change, Adding Value' strategy / framework in 2016 for all Nurses, Midwives and Care staff. Using this as a driver the Director of Quality had led a piece of work over the last 12 months with the 2gether nursing workforce (at all levels) to produce a strategy/ framework document for 2018-20.

14.3 This document focuses on key achievements and key improvements over the next 2 years; ensuring alignment of this work with the Triple Aims and the Integrated Care System approach to health care. Going forward and following the merger with GCS there will be further opportunities for improvements for our service users and their families.

14.4 The Board noted that the framework had been reviewed at the Executive Committee and by the NEDs represented on the Development Committee. All feedback has been taken into account to produce this final version.

14.5 The Director of Quality advised that the senior nurses within the Trust were keen to have this framework for action signed off as they had put much effort into its development. An implementation plan will be developed to identify specific outcomes to be measured.

14.6 The Board agreed that this was a comprehensive, easy to read document and it was therefore happy to endorse the Nursing Framework / Strategy for 2018-2020.

15. LEARNING FROM DEATHS – QUARTER 1 2018/19

15.1 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.

15.2 This report included data for the period April to June 2018 (Q1 2018/19). It was noted that 18 deaths had been closed without further review due to being referred into services, assessed and either not offered a service following assessment, or declined the service offered. A further 68 deaths had been closed without further review due to being open to solely ACI-Monitoring caseloads. Additional processing of those deaths remaining open will increase both of these figures. The Board was asked to note that no deaths had raised a cause for concern either within 2gether or with partner organisations during Q1 2018/19.

15.3 The Medical Director advised that this Q1 report could only offer the Board limited assurance at this time due to the recent departure of the Mortality Review Administrator. This had caused additional delays in appropriately processing Datix incident reports and in obtaining basic cause of death information from GP surgeries, local partner NHS providers' PALS offices and the Coroner's Office. It was noted that recruitment to the Administrator post was currently held whilst the Learning from Deaths Policy was reviewed and revised during its annual review cycle. In the interim, a Bank Administrator had been identified and will provide some support to the Patient Safety Team until a more permanent solution is identified.

15.4 The Board agreed that more needed to be done to secure appropriate administration for the Learning from Deaths process. This was a national requirement and there were significant resource implications. The Joint CEO advised that he had already raised this issue with commissioners as there was a need to consider system wide funding for this function. In the meantime it was suggested that further discussion take place at the Executive Committee to consider a way forward.

ACTION: Executive Committee to discuss further the resource requirements for the Learning from Deaths process

16. MEDICAL APPRAISAL ANNUAL REPORT 2017/18

16.1 The Board received the Medical Appraisal Annual Report 2017/18. The Medical Director reported that Medical Appraisal had continued to be instituted within the Trust aligned with national policy. Investment in SARD JV and transfer to that system was supporting effective monitoring, recording and review of the quantity, quality and uptake of appraisal. The Medical Appraisal Committee had instituted a work plan to further deliver assurance annually and sustain quality.

16.2 The Board noted that at the end of March 2018 88.6% of Doctors had a valid appraisal. 10.1% non-compliant were explained by exclusion criteria such as being a new starter or long term sick leave. There were 1.3% (equivalent to 1 doctor) who at that point was classified as being non-compliant; this was accounted for by short term delay but it was noted that this doctor had since completed an annual appraisal.

16.3 The Medical Director reported that recruitment processes provided appropriate safety and quality checks aligned with national policy and best practice. Use of locum practitioners was being monitored and used to sustain service commitments and activity appropriately.

16.4 The Board accepted and endorsed the Medical Appraisal Annual Report which provided significant assurance around delivery of appraisals. It was noted that appraisal levels had been maintained without significant additional funding, and it was recognised that effective appraisal had supported timely and appropriate revalidation for all Doctors to date. Ingrid Barker agreed to sign the annual declaration of compliance on behalf of the Board.

17. CHIEF EXECUTIVE'S REPORT

17.1 The Chief Executive presented his report to the Board which provided an update on key national communications and a summary of progress against local developments and initiatives. The key headings included:

- Progress on the strategic intent to merge with Gloucestershire Care Services NHS Trust (GCS)
- "One Gloucestershire" Integrated Care System
- Herefordshire and Worcestershire STP – Integrated Care System Development

17.2 The Board noted that the adverts had now been published for 12 senior positions at NHSE/NHSi, including the South West regional Director post. The Board was asked to be mindful of the changes underway and the potential implications of this.

17.3 The Joint Chief Executive said that he would be attending the NHS70 Awards at Cheltenham Racecourse the following evening. In total 19 teams from 2gether and GCS had been shortlisted in the award categories which was excellent. A full report from the event would be produced.

17.4 The Joint Chief Executive advised that he would soon be coming to the end of his "first 100 days" in post. The coming months would be very busy progressing the merger with GCS; however, he said that he also planned to carry out some more immersive visits across the Trust.

17.5 The Board noted that the Transformation workstream of the merger had now been branded the "Better Care Together" programme. Hazel Braund from Herefordshire CCG had been seconded in as the Project Director for this programme.

17.6 The Board also 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 report offered the Board significant assurance that the Executive Team was undertaking wide engagement.

18. SUMMARY FINANCIAL REPORT

18.1 The Board received the summary Finance Report that provided information up to the end of August 2018. The month 5 position was a surplus of £405k which was in line with the planned surplus. The month 5 forecast outturn was an £834k surplus in line with the Trust's control total. The Trust had an Oversight Framework segment of 2 and a Finance and Use of Resources metric of 1 which is the best achievable. The Trust has signed 2018/19 contracts with Gloucestershire CCG, Herefordshire CCG, and NHS England and Worcestershire Joint Commissioning Unit. The Trust has identified £767k of recurring

savings up to August 2018, which is ahead of plan. The Trust's current year end cash projection is £13.5m which is £3.7m greater than plan.

18.2 The agency cost forecast is £4.182m, a decrease of £0.211m on last month's projection. This would be £1.048m above the Agency Control Total, due largely to the need to support the IAPT service and medical staffing. The Director of Finance advised that the Trust would not hit its Agency Control Total; however, the Trust had recently been successful in recruiting to two Consultant posts which would assist greatly in reducing medical locum agency costs.

18.3 The Board was asked to note that the backdated element of the national pay award for April to June was paid to staff in August. A budget of £1.229m has been added to income and pay to match the funding received from the Department of Health and Social Care. The Trust has calculated that the pay award funding is £55k below the level required and is an additional cost pressure to the Trust. Funding arrangements for the Medical staff pay award have not yet been announced and this could lead to an additional cost pressure too.

18.4 The Trust was in the process of commencing its mid-year financial review. This would be presented at both the Executive Committee and the Delivery Committee in October, before being received at the Board in November. The Director of Finance advised that there were some risks to the Trust's financial position that the Board needed to be aware of, however, he said that the mid-year review was unlikely to generate any major changes.

19. CHANGE TO THE TRUST CONSTITUTION

19.1 As a Foundation Trust, 2gether has a constitution which sets out its governance framework. The Trust's constitution may be amended with the agreement of both the Council of Governors and the Board. Currently the constitution limits the term of office for Non-Executive Directors to two terms of up to three years each. Non-Executive Directors of an NHS Trust are appointed by NHS Improvement, and would normally serve for eight years in total.

19.2 The Trust Secretary informed the Board that this would mean that when appointments are made to the Shadow Board, existing 2gether NEDs in their second term of office may be disadvantaged, as Governors would not be able to offer terms of office which took those NEDs beyond the current six year maximum.

19.3 Accordingly a change to the constitution is proposed which would allow NEDs appointed to the Shadow Board to serve up to three terms, each of up to three years. As required by the Foundation Trust Code of Governance, any term beyond six years in total would be subject to annual review and reappointment. This would provide more of a level playing field for NEDs from both Trusts, and will ensure continuity by retaining valuable expertise, experience and organisational memory through the transition period.

19.4 The Board noted that the proposed amendment had been agreed by the Trust's legal advisers, Bevan Brittan and was presented to and subsequently agreed by the Council of Governors at its meeting on 11 September.

19.5 The Board approved the proposed amendment to the constitution, which would take effect immediately.

20. BOARD COMMITTEE REPORTS - AUDIT COMMITTEE (INC ANNUAL REPORT)

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

20.2 The Board also received the Audit Committee Annual Report 2017/18 which set out the activity of the Committee over the past year. Marcia Gallagher said that she was pleased to see the clear triangulation between the Board Committees that had been demonstrated.

21. BOARD COMMITTEE REPORTS – DELIVERY COMMITTEE

21.1 The Board received the summary reports from the Delivery Committee meetings held on 25 July and 29 August. These reports and the assurances provided were noted.

22. BOARD COMMITTEE REPORTS – DEVELOPMENT COMMITTEE

22.1 The Board received the summary report from the Development Committee meeting held on 8 August. This report and the assurances provided were noted.

23. BOARD COMMITTEE REPORTS – GOVERNANCE COMMITTEE

23.1 Nikki Richardson presented the summary report from the Governance Committee meeting that had taken place on 31 August. The Board noted the summary report and the assurances provided.

23.2 Nikki Richardson expressed her thanks to Marie Crofts, Director of Quality for her Executive leadership of the Governance Committee over the past years. The Committee had undergone a real transformation in that time, with the introduction of the QCR sub-Committee and was in a good, strong place going forward.

24. INFORMATION SHARING REPORTS

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

- Chair's Report
- Council of Governors Minutes – July 2018

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

25. ANY OTHER BUSINESS

Reappointment of MHAM

25.1 Lay MHA Managers act on behalf of the Trust Board. A term of office lasts for three years, with the possibility of 3 renewals. The renewal process is that the Chair of the MHAM Forum meets the Manager for a personal development review and then asks the Board to endorse the re-appointment if deemed satisfactory. Duncan Sutherland, as Chair of the Mental Health Legislation Scrutiny Committee was unable to attend today's meeting; however, he was seeking the Board's endorsement for the reappointment of 7 MHA Managers.

25.2 A query was raised about the process to enable people to feed in comments and feedback on MHAMs as part of their personal development review. A concern had been raised

recently regarding the ability of a Manager to carry out their role effectively and it was queried how this had been fed through the system. The Board agreed that there were a number of issues in relation to the role of the MHAMs that required further clarification, such as performance, time commitments, terms of appointment and resources. The Director of Service Delivery agreed to liaise with Les Trewin, Chair of the MHAM Forum to address these matters and provide feedback back to the Board as appropriate.

ACTION: Director of Service Delivery to liaise with Les Trewin, Chair of the MHAM Forum to address the issues raised re: MHAM appraisals and reappointments and provide feedback back to the Board as appropriate.

26. DATE OF THE NEXT MEETING

26.1 The next Board meeting would take place on Thursday 29 November 2018 at The Kindle Centre, Hereford

Signed: …….. **Date: …….**
Ingrid Barker, Chair

BOARD MEETING
ACTION POINTS

Date of Mtg	Item ref	Action	Lead	Date due	Status/Progress
26 July 2018	6.5	Medical Director to schedule a training session for junior doctors on eating disorders	Amjad Uppal	September	Session scheduled for January 2019
26 Sept 2018	6.4	Director of Service Delivery to speak with the Eating Disorder Team Lead Clinician to establish what the Adolescent Eating Disorders: Routine referral to non-NICE treatment within 4 weeks KPI related to and would feedback to the Board	John Campbell	November	"Non-NICE treatment" is a locally defined term used to transparently present all intervention activity within our Eating Disorder (ED) services such as Avoidant/ Restrictive Food Intake Disorder (ARFID). Due to the lack of NICE treatment codes for certain interventions this activity would otherwise be lost or incorrectly impact our NICE performance indicators. There are low incidences of non-NICE treatments (hence the common recording of Not Applicable).
	6.5	Director of Quality to investigate the position with Patients with Dementia having weight assessments on admission to see whether there was a gap in practice or it was a data glitch	Director of Quality	November	Action being taken forward via the Delivery Committee
	10.10	Director of E&I to investigate at the next QCR committee whether current communication channels to disseminate information from the SE Report to staff via the Locality Governance Leads were working	Jane Melton	November	Complete
	15.4	Executive Committee to discuss further the resource requirements for the Learning from Deaths process		15 November	Discussion scheduled for Executive Committee on 6 December
	25.2	Director of Service Delivery to liaise with Les Trewin, Chair of the MHAM Forum to address the issues raised re: MHAM appraisals and reappointments and provide feedback back to the Board as appropriate.	John Campbell	November	John Campbell to email NEDs to get specific feedback re: MHAMs for meeting with Les Trewin. This will be fed into a broader MHAM Appraisal Process paper to be presented to MHLS Committee on the new year.

Agenda Item 7 **Enclosure Paper B**

Report to:	Trust Board, 29th November 2018
Author:	Chris Woon, Head of Information Management and Clinical Systems
Presented by:	John Campbell, Director of Service Delivery
SUBJECT:	**Performance Dashboard Report for the period to the end of September 2018 (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 2018 (month 6) of the 2018/19 contract period, against our NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

Of the 194 performance indicators, 125 are reportable in September with 112 being compliant and 13 non-compliant at the end of the reporting period.

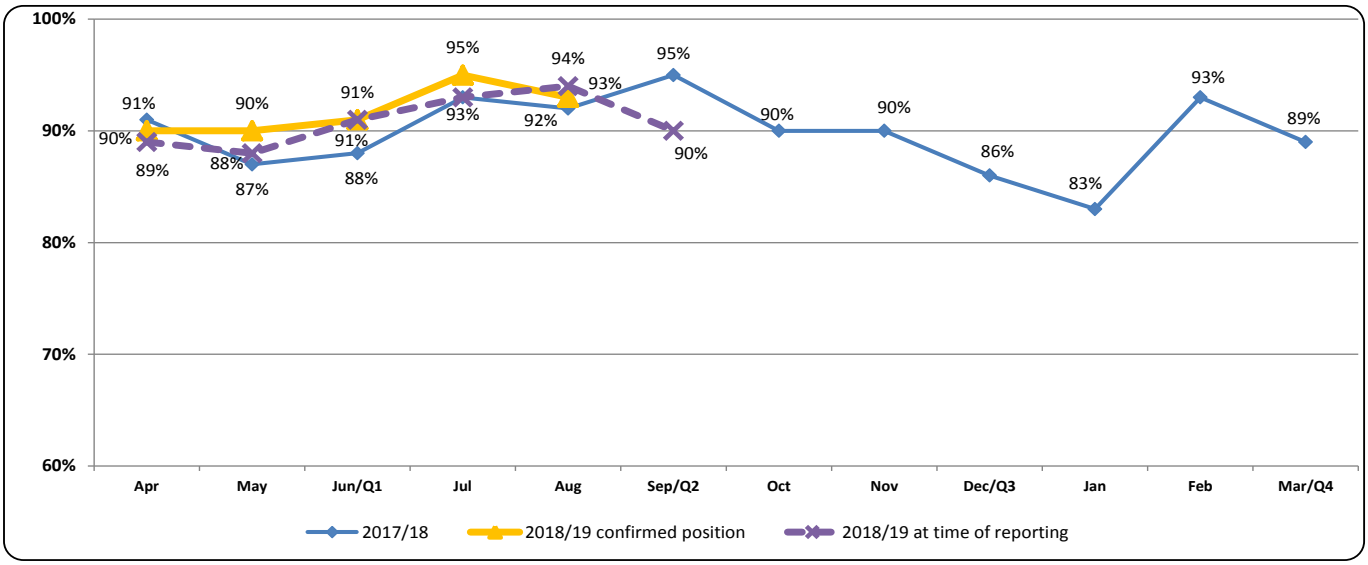
Where performance is not compliant, Service Directors are taking the lead to address issues and work is ongoing in accordance with our agreed Service Delivery Improvement Plans to address the underlying issues affecting this performance.

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

The following table summarises our performance position as at the end of September 2018 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 or N/A	NYA
NHSi Requirements	14	13	13	0	0	1	0
Never Events	17	17	17	0	0	0	0
Department of Health	10	6	6	0	0	4	0
Gloucestershire CCG Contract	89	44	32	12	27	24	21
Social Care	15	13	13	0	0	2	0
Herefordshire CCG Contract	24	15	14	1	6	9	0
CQUINS	25	17	17	0	0	8	0
Overall	194	125	112	13	10	48	21

The following graph shows our percentage compliance by month and the previous year's compliance for comparison. The "2018/19 confirmed position" line 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.



Confirmed positions for July and August have been updated as follows:

July: Increase of 2% to 95%:

- **3.18: IAPT access rate in Gloucestershire**
  - Updated information has now shown this indicator to be compliant for July.

August: Decrease of 1% to 93%:

- **3.63 &3.64: Adolescent Eating disorders: treatment within 4 weeks**
  - Updated information has shown 3.63 (NICE treatment) to now be non-compliant and 3.64 (Non-Nice treatments) to be reported as not applicable

- **5.12: All admitted patients age 65+ to have a MUST assessment**
  - Reported in August as compliant, updated information shows that there was 1 non-compliant case.

The following key performance areas remain a priority for the Trust as they have the potential to carry contractual, financial, reputational or quality risk;

- Under 18 admissions to Adult Inpatient Wards (2.21)
- Improving Access to Psychological Therapies (IAPT)

- Recovery (3.17, 5.08), Access (3.18, 5.09a) & Waiting times (1.09 & 1.10)
- CYPS/ CAMHS Level 2 and 3 Referral to Treatment waiting times (3.26 & 3.27)
- Eating Disorders (ED) Waiting times (3.63, 3.64, 3.65 & 3.67)

Summary Exception Reporting

The following 13 key performance thresholds were not met for the Trust for September 2018:

Gloucestershire CCG Contract Measures

- 3.18 – IAPT: Access rate
- 3.23 – Children urgently referred by CYPS, receive support within 24 hours from Crisis
- 3.25 – CYPS: Referral to assessment within 4 weeks
- 3.26 – CYPS Level 2 and 3: Referral to treatment within 8 weeks
- 3.27 – CYPS Level 2 and 3: Referral to treatment within 10 weeks
- 3.36 – CYPS Transition to Adult (Recovery) Service
- 3.54 – Patients with Dementia have a weight assessment at weekly intervals
- 3.55 – Patients with Dementia have a weight assessment near discharge
- 3.63 – Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks
- 3.65 – Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week
- 3.67 – Adult Eating Disorders: Wait time for assessments will be 4 weeks
- 3.80 – Perinatal: Preconception advice: Referral to assessment within 8 weeks

Herefordshire CCG Contract Measures

- 5.19 – CYPs Access: Percentage of CYP entering treatment

RECOMMENDATIONS

The Board is asked to:

- Note the Performance Dashboard Report for September 2018.
- 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:		
John Campbell	Date	October 2018

Where in the Trust has this been discussed before?		
Delivery Committee	Date	October 2018

What consultation has there been?		
Not applicable.	Date	

Explanation of acronyms used:	
	AKI Acute kidney injury
	ARFID Avoidant restrictive food intake disorder
	ASCOF Adult Social Care Outcomes Framework
	CAMHS Child and Adolescent Mental health Services
	C-Diff Clostridium difficile
	CLDT Community Learning Disability Teams
	CPA Care Programme Approach
	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
	GARAS Gloucestershire Action for Refugees and Asylum Seekers
	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
	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 2018, month six of the 2018/19 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 2018. 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 Performance indicators include all relevant Trust activity allocated between Gloucestershire and Herefordshire based on locality of the service.

2.3 Where stated, 'Cumulative Compliance' refers to compliance recorded from the start of this contractual year April 2018 to the current reporting month, as a whole.

	=	**Target not met**
	=	**Target met**
NYA	=	**Not yet available**
NYR	=	**Not yet required**
N/A	=	**Not applicable: No data to report or baseline data to inform 2018/19**

DASHBOARD CATEGORY - NHSI REQUIREMENTS

NHS Improvement Requirements				
	In month Compliance			Cumulative Compliance
	Jul	Aug	Sep	
Total Measures	14	14	14	14
	0	0	0	0
	13	13	13	13
NYA	0	0	0	0
NYR	0	0	0	0
N/A	1	1	1	1

Performance Thresholds not being achieved in Month

None

Cumulative Performance Thresholds Not being Met

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

Changes to Previously Reported Figures

None

Early Warnings / Notes

None

NHS Improvement Requirements

ID	Performance Measure (PM)		2017/18 Outturn	July-2018	August-2018	September-2018	(Apr-Sep) Cumulative Compliance	Forecast 18/19 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	<3	0
		Gloucestershire	0	0	0	0	0	
		Herefordshire	0	0	0	0	0	
		Combined Actual	0	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	99%	100%	97%	98%	98%	
		Herefordshire	99%	95%	97%	100%	99%	
		Combined Actual	99%	99%	96%	99%	98%	
1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	98%	98%	98%	97%	98%	
		Herefordshire	98%	97%	96%	97%	98%	
		Combined Actual	98%	98%	98%	97%	98%	
1.05	Nationally reported - Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Gloucestershire	3.2%	1.7%	2.7%	3.7%	2.2%	
		Herefordshire	2.4%	3.6%	0.6%	0.5%	1.4%	
		Combined Actual	3.0%	2.1%	2.3%	2.9%	2.0%	
1.05b	- Delayed Discharges - Outliers	PM						
		Gloucestershire	10.1%	7.4%	8.0%	9.6%	7.6%	
		Herefordshire	12.5%	9.5%	0.1%	3.2%	2.7%	
		Combined Actual	10.7%	7.9%	6.1%	8.0%	6.4%	
1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	99%	98%	100%	100%	99%	
		Herefordshire	100%	100%	100%	100%	100%	
		Combined Actual	99%	98%	100%	100%	99%	
1.07	New psychosis (EI) cases as per contract	PM	72	24	30	36	36	72
		Gloucestershire	80	28	35	45	45	
		PM	24	8	10	12	12	24
		Herefordshire	31	9	12	12	12	
		PM	96	32	40	48	48	96
		Combined Actual	111	37	47	57	57	
1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	53%	53%	53%	53%	53%
		Gloucestershire	71%	73%	43%	70%	69%	
		Herefordshire	68%	100%	100%	N/A	83%	
		Combined Actual	70%	77%	60%	70%	72%	

NHS Improvement Requirements

ID	Performance Measure (PM)		2017/18 Outturn	July-2018	August-2018	September-2018	(Apr-Sep) Cumulative Compliance	Forecast 18/19 Outturn
1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Gloucestershire	69%	96%	98%	99%	95%	
		Herefordshire	59%	91%	94%	96%	89%	
		Combined Actual	67%	95%	98%	98%	94%	
1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	88%	98%	99%	99%	98%	
		Herefordshire	75%	94%	96%	96%	91%	
		Combined Actual	85%	98%	99%	99%	96%	
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%	99.8%	99.9%	
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Combined Actual	99.9%	99.9%	99.9%	99.8%	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%	100.0%	99.9%	
		Herefordshire	99.9%	100.0%	100.0%	100.0%	100.0%	
		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%	99.5%	99.7%	
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Combined Actual	99.8%	99.8%	99.8%	99.5%	99.8%	
1.11f	Mental Health Services Data Set Part 1 Data completeness: GP Practice	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.6%	99.6%	99.6%	99.6%	99.6%	
		Herefordshire	99.7%	99.8%	99.9%	99.9%	99.9%	
		Combined Actual	99.7%	99.7%	99.7%	99.6%	99.7%	

NHS Improvement Requirements

ID	Performance Measure (PM)		2017/18 Outturn	July-2018	August-2018	September-2018	(Apr-Sep) Cumulative Compliance	Forecast 18/19 Outturn
1.12	**MENTAL HEALTH SERVICES DATA SET PART 2 DATA COMPLETENESS : OVERALL**	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	94.7%	96.5%	96.7%	96.5%	96.7%	
		Herefordshire	90.9%	89.3%	88.8%	89.6%	89.1%	
		Combined Actual	94.1%	95.4%	95.5%	95.4%	95.5%	
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	89.4%	94.7%	94.8%	94.6%	94.9%	
		Herefordshire	86.4%	84.6%	83.6%	84.6%	83.9%	
		Combined Actual	88.9%	93.1%	93.1%	93.1%	93.2%	
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	96.6%	96.3%	96.5%	96.4%	96.6%	
		Herefordshire	87.1%	85.5%	84.6%	85.5%	84.9%	
		Combined Actual	94.9%	94.6%	94.7%	94.7%	94.8%	
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	98.2%	98.5%	98.7%	98.5%	98.7%	
		Herefordshire	99.2%	97.8%	98.2%	98.6%	98.6%	
		Combined Actual	98.4%	98.4%	98.6%	98.5%	98.7%	
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	0	0	0
🟢	25	25	23	26
NYA	0	0	0	0
NYR	1	1	0	0
N/A	1	1	4	1

Performance Thresholds not being achieved in Month

None

Cumulative Performance Thresholds Not being Met

2.21: No children under 18 admitted to adult inpatient wards
To date there have been 2 admissions of under 18s to adult wards 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 non-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)		2017/18 Outturn	July-2018	August-2018	September-2018	(Apr-Sep) Cumulative Compliance	Forecast 18/19 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)		2017/18 Outturn	July-2018	August-2018	September-2018	(Apr-Sep) Cumulative Compliance	Forecast 18/19 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	6	0	0	0	0	
		Herefordshire	5	0	0	0	2	
		Combined	11	0	0	0	2	
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)		2017/18 Outturn	July-2018	August-2018	September-2018	(Apr-Sep) Cumulative Compliance	Forecast 18/19 Outturn
2.24	Serious Incident Reporting (SI)	Glos	33	2	1	0	10	
		Hereford	18	0	0	0	4	
2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	100%	100%	100%	N/A	100%	
		Herefordshire	100%	N/A	N/A	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	100%	100%	100%	N/A	100%	
		Herefordshire	100%	N/A	N/A	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	N/A	100%	
		Herefordshire	100%	N/A	N/A	N/A	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	5	1	1	0	2	
		Herefordshire	2	0	0	0	0	

DASHBOARD CATEGORY – GLOUCESTERSHIRE CCG CONTRACTUAL REQUIREMENTS

Gloucestershire Contract				
	In month Compliance			Cumulative Compliance
	Jul	Aug	Sep	
Total Measures	89	89	89	89
🔴	4	2	12	14
🟢	19	19	32	32
NYA	5	5	21	17
NYR	59	59	16	20
N/A	2	4	8	6

Performance Thresholds not being achieved in Month

3.18: IAPT access rate: Access to psychological therapies for adults should be improved

Services in Gloucestershire have a stepped target across the 2018/19 financial year:

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Access Target	1.25%	1.29%	1.33%	1.40%	1.42%	1.46%	1.50%	1.54%	1.56%	1.58%	1.58%	1.58%
Actual	1.29%	1.33%	1.30%	1.41%	1.44%	1.45%						
Access Target year	15.00%	15.50%	16.00%	16.80%	17.00%	17.50%	18.00%	18.50%	18.75%	19.00%	19.00%	19.00%
Actual	15.36%	15.96%	15.36%	16.78%	17.28%	17.37%						

3.23: Children urgently referred by CYPS, receive support within 24 hours from Crisis

There is currently 1 non-compliant case recorded. The client was seen within 24 hours; however this has not yet been recorded on RiO. Once updated this indicator will be reported as compliant.

3.25: CYPS: Referral to assessment within 4 weeks

Please see narrative below.

3.26 & 3.27: CYPS: Referral to treatment within 8 & 10 weeks

We are non-compliant for Quarter 2 of this financial year. Work is ongoing to identify capacity and demand issues and produce a trajectory to assist with future planning.

3.36: **CYPS Transition to Adult (Recovery) Service**
There is 1 non-compliant case for Quarter 2. This is being investigated by the service as it is believed to be a recording error.

3.54 - 3.55: Patients with Dementia have weight assessments at weekly intervals and near discharge.
Work is on-going with the clinical systems and information team to capture the instances when it has not been clinically appropriate to weigh a patient.

3.63: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks
A responsive implementation plan has been developed to improve wait times. The recruitment element of this is complete and staff are currently going through their induction. When fully initiated, the extra capacity will start to ease waiting times as more patients will be assessed and treated. Priority is being given to CYP to ensure they are assessed and treated in line with national expectation.

3.65: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week
There are 2 non-compliant cases recorded in September. Both cases have been investigated.

One client started treatment within 11 days of referral. The other started treatment within 7 days but this has not yet been entered on RiO. Once updated performance, although still non-compliant, will be reported at 83%.

The service has since implemented a new team for dealing with urgent cases

The service believes that further work can be done to improve clinical data recording therefore performance and progress will continue to be monitored closely so that data quality is improved

3.67: Adult Eating Disorders: Wait time for assessments will be 4 weeks
Work is ongoing to remodel the Adult pathway and understand the increase in demand on the service

3.80: Perinatal Preconception advice: Referral to assessment within 8 weeks
Due to shortage of staff a client was not seen within the required 8 weeks. The client is under the care of the Recovery service and so was not at risk. They were seen within 9 weeks.

Cumulative Performance Thresholds Not being Met

3.18: IAPT access rate: Access to psychological therapies for adults should be improved
As above

3.21: To send Inpatient discharge summaries electronically within 24 hours to GP
The current level of compliance (93%) falls below the target of 100%. Quarterly compliance will continue to be monitored through regular audits and where necessary appropriate action will be taken to address this. Additionally, a process has been initiated to manually audit records to

ensure that discharge summaries have been sent and within the timescale set. The results of this current audit will be shared with Matrons to ensure that there is ongoing communication regarding the importance of sending the discharge summaries in a timely manner.

3.23: Children urgently referred by CYPS, receive support within 24 hours from Crisis
As above

3.26 & 3.27 CYPS: Referral to treatment within 8 & 10 weeks
As above

3.36: **CYPS Transition to Adult (Recovery) Service**
As above

3.53 - 3.55: Patients with Dementia have weight assessments on admission, at weekly intervals and near discharge.
As above

3.63: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks
3.64: Adolescent Eating Disorders: Routine referral to Non-NICE treatment within 4 weeks
3.65: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week
As above

3.67: Adult Eating Disorders: Wait time for assessments will be 4 weeks
As above

3.80: Perinatal Preconception advice: Referral to assessment within 8 weeks
As above

Changes to Previously Reported Figure

3.18: IAPT access rate: Access to psychological therapies for adults should be improved
Previously reported for July as non-compliant, information has been updated and this indicator is now reported as compliant for July.

3.63 &3.64: Adolescent Eating disorders: treatment within 4 weeks
Further data quality work has shown 3.63 (NICE treatments) to be non-compliant for August due to 1 treatment starting outside the required 4 week.

3.64 (Non-Nice treatments) is reported for August as “not applicable” as there were, in fact, no new ARFID (Avoidant restrictive food intake disorder) cases in August.

Early Warnings/Notes
None

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

3.18 IAPT Access rate:
The performance threshold for 2018/19 has increased from 15% to 19% and although we are compliant for August it is too early in the period to determine whether we will be able to meet 19% by the end of the financial year.

3.21: To send Inpatient discharge summaries electronically within 24 hours to GP
The performance threshold is 100% and as not met in Quarter 1; performance for 2018/19 will be non-compliant.

3.26 & 3.27 CYPS: Referral to treatment within 8 & 10 weeks
We were below the performance threshold for 2017/18 and although work is ongoing and issues being addressed it is too early in the period to determine whether we will be compliant by the end of the financial year.

3.53 - 3.55: Patients with Dementia have weight assessments on admission, at weekly intervals and near discharge.
This is the first time this indicator has been reported therefore, too early to say whether we will be compliant at the end of the Financial Year.

3.63 – 3.65: Adolescent Eating Disorders Waiting Times
See note on page 15

3.67: Adult Eating Disorders: Wait time for assessments will be 4 weeks
Work is ongoing to remodel the pathway and understand the increase in demand on the service. It is too early in the financial year to determine whether we will be compliant by the end of the financial year.

.

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	July-2018	August-2018	September-2018	(Apr-Sep) Cumulative Compliance	Forecast 18/19 Outturn
	B. NATIONAL QUALITY REQUIREMENTS							
3.01	Zero tolerance MRSA	PM	0	0	0	0	0	0
		Unavoidable	0	0	0	0	0	
3.02	Minimise rates of Clostridium difficile	PM	0	0	0	0	<3	<3
		Unavoidable	0	0	0	0	1	
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	100%	99%	100%	100%	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%	98%	98%	97%	98%	
3.06	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	PM	90%	90%	90%	90%	90%	90%
		Actual	99%	99%	99%	99%	99%	
	C. Local Quality Requirements							
	Domain 1: Preventing People dying prematurely							
3.07	Increased focus on suicide prevention and reduction in the number of reported suicides in the community and inpatient units	PM	Report				Annual	Report
		Actual	28				NYR	
3.08	To reduce the numbers of detained patients absconding from inpatient units where leave has not been granted	PM	< 144			< 36	<72	< 144
		Actual	122			23	58	
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	N/A				NYR	
	Domain 2: Enhancing the quality of life of people with long-term conditions							
3.10	2G bed occupancy for Gloucestershire CCG patients	PM	> 91%	> 91%	> 91%	> 91%	> 91%	> 91%
		Actual	93%	95%	93%	93%	95%	
3.11	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	100%	100%	100%	100%	100%	
3.12	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%	100%	99%	99%	99%	
3.13	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%	
3.14	Assessment of risk: All 2g service users (excluding those on CPA) to have a documented risk assessment	PM	85%			85%	85%	85%
		Actual	97%			96%	96%	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	July-2018	August-2018	September-2018	(Apr-Sep) Cumulative Compliance	Forecast 18/19 Outturn
3.15	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	93%	98%	95%	94%	94%	
3.16	AKI (previous CQUIN 1516) 95% of pts to have EWS score within 12 hours	PM	95%			95%	95%	95%
		Actual	98%			100%	98%	
	Domain 3: Helping people to recover from episodes of ill-health or following injury							
3.17	IAPT recovery rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%	50%
		Actual	51%	52%	51%	51%	52%	
3.18	IAPT access rate: Access to psychological therapies for adults should be improved	PM	15.00%	1.40%	1.42%	1.46%	19.00%	19.00%
		Actual	13.32%	1.41%	1.44%	1.45%	17.37%	
3.19	IAPT reliable improvement rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%	50%
		Actual	70%	64%	65%	67%	66%	
3.20	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	NA	
3.21	To send :Inpatient and day case discharge summaries electronically, within 24 hours to GP	PM	Report			100%	100%	Report
		Actual	93%			NYA	97%	
	Domain 4: Ensuring that people have a positive experience of care							
3.22	To demonstrate improvements in staff experience following any national and local surveys	PM	Report				Annual	Annual
		Actual	Compliant				NYR	
3.23	Number of children in crisis urgently referred that receive support within 24 hours of referral by CYPS	PM	95%			95%	95%	95%
		Actual	100%			75%	88%	
3.24	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%	98%	98%	98%	99%	
3.25	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	98%			94.9%	96%	
3.26	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	78%			43%	45%	
3.27	Level 2 and 3 – Referral to treatment within 10 weeks (excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	95%			95%	95%	95%
		Actual	86%			57%	51%	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	July-2018	August-2018	September-2018	(Apr-Sep) Cumulative Compliance	Forecast 18/19 Outturn
3.28	Adults of working age - 100% of MDT assessments to have been completed within 4 weeks (or in the case of a comprehensive assessment commenced within 4 weeks)	PM	85%	85%	85%	85%	85%	85%
		Actual	90%	93%	91%	94%	91%	
	Vocational Services (Individual Placement and Support)							
3.29	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	
3.30	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	NYA				NYR	
3.31	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%	50%
		Actual	NYA			NYA	NYR	
3.32	The number of people supported to retain employment at 3/6/9/12+ months	PM	50%			50%	50%	50%
		Actual	NYA			NYA	NYR	
3.33	Fidelity to the IPS model	PM	90%				90%	90%
		Actual	100%				NYR	
	General Quality Requirements							
3.34	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	
3.35	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			75%	75%	75%
		Actual	82%			NYA	NYA	
3.36	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%			0%	50%	
3.37	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%	90%	90%	90%
		Actual	NYR	NYA	NYA	NYA	NYA	
3.38	MHARS Wait time to Assessment: Triage wait time 1 hour (Emergency assessments within 1 hour of triage)	PM		TBC	TBC	TBC	TBC	TBC
		Actual		NYA	NYA	NYA	NYA	
3.39	MHARS Wait time to Assessment: Full Assessment 4 hours (Urgent assessments within 4 hours of triage)	PM	90%	TBC	TBC	TBC	TBC	TBC
		Actual	NYR	NYA	NYA	NYA	NYA	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	July-2018	August-2018	September-2018	(Apr-Sep) Cumulative Compliance	Forecast 18/19 Outturn
	New KPIs for 2017/18							
3.40	LD: To deliver specialist support to people with learning disabilities in accordance with specifically developed pathways	PM	95%			33%	33%	95%
		Actual	100%			45%	45%	
3.41	LD: To demonstrate a reduction in an individual's health inequalities thanks to the clinical intervention provided by 2gether learning disability services.	PM	Report			TBC	TBC	TBC
		Actual	Compliant			Compliant	Compliant	
3.42	LD: People with learning disabilities and their families report high levels of satisfaction with specialist learning disability services	PM	75%			75%	75%	75%
		Actual	Compliant			100%	100%	
3.43	LD: To ensure all published clinical pathways accessed by people with learning disabilities are available in easy read versions	PM	95%				95%	95%
		Actual	100%				NYR	
3.44	LD: The CLDT, IHOT & LDISS 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%	75%
		Actual	80%				NYR	
3.45	Of those supported by 2g to access AHC 100% are then further supported with their Health Action Plans & screening	PM					100%	75%
		Actual					NYR	
3.46	IAPT DNA rate	PM	<16%	<16%	<16%	<16%	<16%	<16%
		Actual	13%	15%	15.5%	13%	14%	
3.47	IAPT Equity of Access for Service Users: aged 65 and over on the caseload					TBC	TBC	TBC
		Actual				6%	8%	
3.48	IAPT Equity of Access for Service Users: Numbers of BAME on the caseload					TBC	TBC	TBC
		Actual				143	284	
3.49	IAPT Clinical productivity by Groups and 1:1 sessions for: Hi Intensity					> 18 per week	> 18 per week	> 18 per week
		Actual				N/A	N/A	
3.50	IAPT Clinical productivity by Groups and 1:1 sessions for: Lo Intensity					> 18 per week	> 18 per week	> 18 per week
		Actual				N/A	N/A	
3.51	IAPT treatment outcomes: Women in the Perinatal period showing reliable improvement in outcomes between pre and post treatment	PM	50%	50%	50%	50%	50%	85%
		Actual	75%	84%	61%	69%	72%	
3.52	% of CYP entering partnership in CYPS have pre and post treatment outcomes and measures recorded					TBC	TBC	TBC
		Actual				NYA	NYA	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	July-2018	August-2018	September-2018	(Apr-Sep) Cumulative Compliance	Forecast 18/19 Outturn
3.53	Patients with Dementia have weight assessments on admission	PM				85%	85%	85%
		Actual				88%	68%	
3.54	Patients with Dementia have weight assessments at weekly intervals	PM				85%	85%	85%
		Actual				67%	68%	
3.55	Patients with Dementia have weight assessments near discharge	PM				85%	85%	85%
		Actual				30%	55%	
3.56	Patients with Dementia have delirium screening on admission	PM				85%	85%	85%
		Actual				NYA	NYA	
3.57	Patients with Dementia have delirium screening at weekly intervals	PM				85%	85%	85%
		Actual				NYA	NYA	
3.58	Patients with Dementia have delirium screening near discharge	PM				85%	85%	85%
		Actual				NYA	NYA	
3.59	CPI: Referral to Assessment within 4 weeks	PM	85%	85%	85%	85%	85%	85%
		Actual	91%	97%	94%	91%	94%	
3.60	CPI: Assessment to Treatment within 16 weeks	PM	85%	85%	85%	85%	85%	85%
		Actual	99%	95%	93%	100%	97%	
3.61	Comprehensive audit in relation to timeliness and quality of discharge communication (non-medical)					Report	Report	
		Actual				NYA	NYA	
3.62	Daily submission of information to inform the daily escalation level	PM		Report	Report	Report	Report	Report
		Actual		NYA	NYA	NYA	NYA	
3.63	Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	PM	95%	95%	95%	95%	95%	95%
		Actual	29%	33%	50%	0%	23%	
3.64	Adolescent Eating Disorders - Routine referral to non-NICE treatment start within 4 weeks	PM	95%	95%	95%	95%	95%	95%
		Actual	9%	0%	N/A	N/A	0%	
3.65	Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week	PM	95%	95%	95%	95%	95%	95%
		Actual	64%	0%	N/A	67%	59%	
3.66	Adolescent Eating Disorders - Urgent referral to non-NICE treatment start within 1 week	PM	95%	95%	95%	95%	95%	95%
		Actual	N/A	N/A	N/A	N/A	N/A	
3.67	Eating Disorders - Wait time for adult assessments will be 4 weeks	PM	95%	95%	95%	95%	95%	95%
		Actual	36%	71%	70%	68%	63%	
3.68	Eating Disorders - Wait time for adult psychological interventions will be 16 weeks	PM		95%	95%	95%	95%	95%
		Actual		NYA	NYA	NYA	NYA	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	July-2018	August-2018	September-2018	(Apr-Sep) Cumulative Compliance	Forecast 18/19 Outturn
3.69	LD Health facilitation - awareness and support for all stakeholders including reasonable adjustments support to reduce health inequalities						Annual	
		Actual					NYR	
3.70	LD: Patients on the LD challenging behaviour pathway have a single positive behaviour support plan (containing primary, secondary and reactive interventions) completed within 30 days of allocation to clinician (CLDTs: 60 days)	PM				33%	33%	95%
		Actual				33%	33%	
3.71	LD: Active involvement in Care and Treatment Reviews & Blue Light protocol meetings to prevent admission and actively support and plan for integration/discharge in the community: 100% completion of the CTR Provider Checklist prior to CTR meetings	PM				100%	100%	100%
		Actual				NYA	NYA	
3.72	LD: Active involvement in Care and Treatment Reviews & Blue Light protocol meetings to prevent admission and actively support and plan for integration/discharge in the community: 75% CTRs being completed within 10 days of admission to Berkeley House	PM				75%	75%	75%
		Actual				NYA	NYA	
3.73	CYP report being satisfied or more than satisfied with service experience	PM					Report	Report
		Actual					NYR	
3.74	CYP report being satisfied or more than satisfied following Transition to Adult services	PM					Report	Report
		Actual					NYR	
3.75	CYP report being satisfied or more than satisfied with Transition to Adult Services: 95% of CYP asked to complete Service Questionnaire	PM					95%	95%
		Actual					NYR	
3.76	Perinatal: Urgent Referral to Assessment within 4 - 6 hours - During working hours (unless otherwise negotiated with referrer or patient) in conjunction with Crisis Team	PM				95%	95%	95%
		Actual				NYA	NYA	
3.77	Perinatal: Out of hours emergencies assessed by MHARS to be discussed with the Specialist Perinatal Service the next working day	PM					95%	95%
		Actual					NYR	
3.78	Perinatal: Urgent referrals with High risk indicators (following telephone screening) will be seen with 48 working hours	PM				95%	95%	95%
		Actual				N/A	100%	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	July-2018	August-2018	September-2018	(Apr-Sep) Cumulative Compliance	Forecast 18/19 Outturn
3.79	Perinatal: Preconception advice - Referral to assessment within 6 weeks	PM				50%	50%	95%
		Actual				71%	78%	
3.80	Perinatal: Preconception advice - Referral to assessment within 8 weeks	PM				90%	90%	90%
		Actual				86%	89%	
3.81	Perinatal: Routine referral to assessment within 2 weeks	PM				50%	50%	95%
		Actual				76%	75%	
3.82	Perinatal: Routine referral to assessment within 6 weeks	PM				95%	95%	95%
		Actual				98%	98%	
3.83	Perinatal: Number of women asked if they have a carer	PM	80%			80%	80%	80%
		Actual	82%			85%	85%	
3.84	Perinatal: Number of women with a carer offered carer's assessment	PM	90%			90%	90%	90%
		Actual	90%			92%	92%	
3.85	Perinatal: Women and families views inform the development of the service via a service user forum	PM					Report	Annual
		Actual					NYR	
3.86	Perinatal: all perinatal care plans to be reviewed within 3 months	PM				95%	95%	95%
		Actual				NYA	NYA	
3.87	Perinatal: Reduction in number of episodes of Crisis	PM					Report	Report
		Actual					NYR	
3.88	GARAS: Accepted referrals receive an initial assessment appointment within 6 weeks	PM				95%	95%	95%
		Actual				NYA	NYA	
3.89	GARAS: percentage of referrals completing the course of therapy	PM				90%	90%	90%
		Actual				NYA	NYA	

Schedule 4 Specific Measures that are reported Nationally

Performance Thresholds not being achieved in Month
None

Changes to Previously Reported Figures
None

Early Warnings / Notes
None

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

2.21: No children under 18 admitted to adult inpatient wards
Although there were no admissions in Gloucestershire in April or May we are anticipating that there will be some during 2018/19.

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

ID	Performance Measure (PM)		2017/18 Outturn	July-2018	August-2018	September-2018	(Apr-Sep) Cumulative Compliance	Forecast 18/19 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	<3	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	99%	100%	97%	98%	98%	
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	3.2%	1.7%	2.7%	3.7%	2.2%	
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%	98%	100%	100%	99%	
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	53%	53%	53%	53%	53%
		Actual	71%	73%	43%	70%	69%	
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Actual	69%	96%	98%	99%	95%	
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Actual	88%	98%	99%	99%	98%	
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	6	0	0	0	0	
DoH 2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%	100%
		Actual	100%	100%	100%	N/A	100%	
DoH 2.26	Interim report for all SIs received within 5 working days of identification (unless extension granted by CCG)	PM	100%	N/A	N/A	N/A	100%	100%
		Actual	100%	100%	100%	N/A	100%	
DoH 2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM	100%	100%	100%	N/A	100%	100%
		Actual	100%	NYR	NYR	N/A	100%	

DASHBOARD CATEGORY – GLOUCESTERSHIRE SOCIAL CARE

Gloucestershire Social Care				
	In month Compliance			Cumulative Compliance
	Jul	Aug	Sep	
Total Measures	15	15	15	15
	0	0	0	0
	13	13	13	13
NYA	0	0	0	0
NYR	0	0	0	0
N/A	2	2	2	2

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
None

Early Warnings/Notes
None

Gloucestershire Social Care

ID	Performance Measure		2017/18 outturn	July-2018	August-2018	September-2018	(Apr-Sep) Cumulative Compliance	Forecast 18/19 Outturn
4.01	The percentage of people who have a Cluster recorded on their record	PM	95%	90%	90%	90%	95%	95%
		Actual	98%	99%	99%	99%	99%	
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	97%	97%	96%	97%	96%	
4.03	Ensure that reviews of new packages take place within 12 weeks of commencement	PM	80%	80%	80%	80%	80%	80%
		Actual	74%	100%	100%	100%	100%	
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	9.44	8.35	8.60	8.85	9.10	
4.05	Current placements aged 65+ to residential and nursing care homes per 100,000 population	PM	22	22	22	22	22	22
		Actual	16.54	21.01	21.01	21.01	19.45	
4.06	% of WA & OP service users on caseload asked if they have a carer	PM	80%	80%	80%	80%	80%	80%
			88%	85%	86%	86%	86%	
4.07	% of WA & OP service users on the caseload who have a carer, who have been offered a carer's assessment	PM	90%	90%	90%	90%	90%	90%
		Actual	91%	91%	91%	92%	91%	
4.08a	% of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC	TBC
		Actual	43%	41%	42%	41%	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	521	554	579	584	584	
4.09	% of eligible service users with Personal budgets	PM	80%	80%	80%	80%	80%	80%
		Actual	95%	98%	99%	98%	98%	

Gloucestershire Social Care

ID	Performance Measure		2017/18 outturn	July-2018	August-2018	September-2018	(Apr-Sep) Cumulative Compliance	Forecast 18/19 Outturn
4.10	% of eligible service users with Personal Budget receiving Direct Payments (ASCOF 1C pt2)	PM	15%	15%	15%	15%	15%	15%
		Actual	19%	16%	16%	15%	17%	
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	87%	87%	87%	87%	87%	
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%	93%	93%	
4.13	Adults subject to CPA receiving secondary mental health service in employment (ASCOF 1F)	PM	13%	13%	13%	13%	13%	13%
		Actual	18%	16%	16%	16%	16%	
4.14	Adults not subject to CPA receiving secondary mental health service in employment	PM	20%	20%	20%	20%	20%	20%
		Actual	21%	21%	21%	21%	21%	

DASHBOARD CATEGORY – HEREFORDSHIRE CCG CONTRACTUAL REQUIREMENTS

Herefordshire Contract				
	In month Compliance			Cumulative Compliance
	Jul	Aug	Sep	
Total Measures	24	24	24	24
	1	4	1	3
	17	11	14	15
NYA	0	0	0	0
NYR	0	0	0	0
N/A	6	9	9	6

Performance Thresholds not being achieved in Month

5.19: CYP Access: percentage of CYP in treatment against prevalence
We are 34 below the projected number of young people accessing treatment in September that was suggested by our Commissioners.

Cumulative Performance Thresholds Not being

5.09a: 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. Trajectory plans and an associated investment envelope has been agreed with Herefordshire CCG in order to meet the 19% access target by quarter 4 2018/19. A service improvement development plan is being produced.

5.15: CYP Eating Disorders: Routine referral to NICE treatment within 4 weeks
There were 2 cases in April and both started treatment outside of the required 4 weeks.

One case was due to the initial appointment, which was within 4 weeks, being cancelled by the family. The second case was as a result of unprecedented caseload activity and the need to manage deteriorating presentations in existing cases.

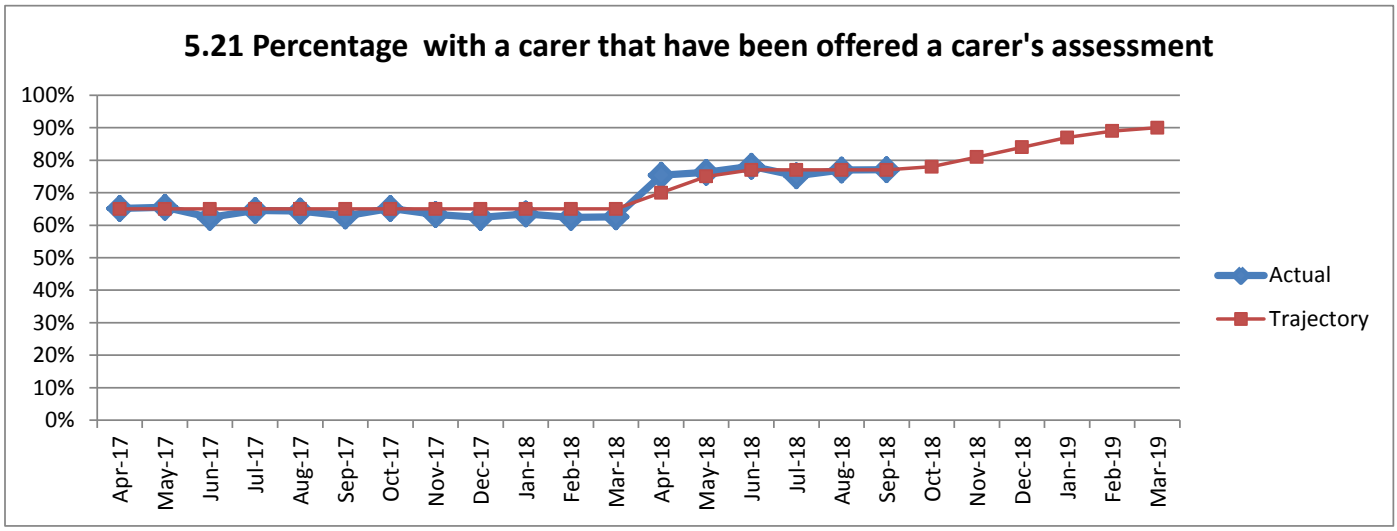
5.19: CYP Access: percentage of CYP in treatment against prevalence
The performance threshold for 2018/19 is 30% of prevalence, which equates to 973 young people having accessed treatment during 2018/19. We are currently 81 below the anticipated number required to achieve this at the end of September.

Changes to Previously Reported Figures

5.12: All admitted patients age 65+ to have a MUST assessment
Reported in August as compliant, updated information shows that there was 1 non-compliant case due to the patient refusing to engage.

Early Warnings / Notes

5.21: Percentage with a carer that have been offered a carer's assessment
The following chart monitors progress against a trajectory to reach 90% by March 2019.



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

5.09a: IAPT roll-out (access rate) – IAPT maintain 15% of patient entering the service against prevalence:
See earlier note on Page 30.

5.15: 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: 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.

5.19: CYP Access: Percentage of CYP in treatment against prevalence
This is the first year this indicator has been reported and it is currently too early in the period to say whether we will be compliant at the end of the Financial Year.

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 Outturn	July-2018	August-2018	September-2018	(Apr-Sept) Cumulative Compliance	Forecast 18/19 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	100%	100%	100%	100%	100%	
5.03	Completion of Mental Health Services Data Set ethnicity coding for all service users	Plan	90%	90%	90%	90%	90%	90%
		Actual	100%	97%	100%	100%	99%	
5.04	Completion of IAPT Minimum Data Set outcome data for all appropriate service users	Plan	90%	90%	90%	90%	90%	90%
		Actual	100%	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	0	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	98%	100%	100%	96%	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	49%	60%	52%	54%	53%	
5.09a	IAPT Roll-out (Access Rate) - IAPT maintain 15% of patient entering the service against prevalence	Plan		1.13%	1.25%	1.25%	19.00%	19.00%
				1.26%	1.23%	1.29%	15.48%	
5.09b	IAPT Roll-out (Access Rate) - Number accessing service	Plan	2,178	640	822	1,003	1,003	2190
		Actual	1,977	676	855	1,042	1,042	

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 Outturn	July-2018	August-2018	September-2018	(Apr-Sept) Cumulative Compliance	Forecast 18/19 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	667	70	41	71	379	
5.10b	Dementia Service - total number of new patients receiving an assessment	Plan						
		Actual	711	77	48	75	408	
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	100%	100%	90%	100%	98%	
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	89%	82%	88%	92%	89%	
5.14	Attendances at ED, wards and clinics for self-harm receive a mental health assessment (Mental Health Liaison Service)	Plan	85%	85%	85%	85%	85%	85%
		Actual	96%	96%	98%	97%	97%	
5.15	CYP Eating Disorders: Treatment waiting time for routine referrals within 4 weeks - NICE treatments	Plan	95%	95%	95%	95%	95%	95%
		Actual	96%	100%	N/A	N/A	71%	
5.16	CYP Eating Disorders: Treatment waiting time for routine referrals within 4 weeks - non-NICE treatments	Plan	95%	95%	95%	95%	95%	95%
		Actual	N/A	100%	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%	95%
		Actual	80%	N/A	N/A	N/A	100%	
5.18	CYP Eating Disorders: Treatment waiting time for urgent referrals within 1 week - non-NICE treatments	Plan	95%	95%	95%	95%	95%	95%
		Actual	N/A	100%	N/A	N/A	100%	
5.19	CYP Access: Number and percentage of CYP entering treatment (30% of prevalence)	Plan - %		8.5%	8.5%	8.5%	63.0%	100%
		Actual %		8.1%	7.6%	5.0%	54.7%	
		Plan - numbers		83	83	83	613	973
		Actual - numbers		79	74	49	532	

Herefordshire Carers Information

ID	Performance Measure		2017/18 Outturn	July-2018	August-2018	September-2018	(Apr-Sept) Cumulative Compliance	Forecast 18/19 Outturn
5.20	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	67%	85%	85%	86%	86%	○
5.21	Working Age and Older People service users on the caseload who have a carer who have been offered a carer's assessment. (Includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan						
		Actual	63%	75%	77%	77%	77%	○
5.22	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	28%	26%	25%	25%	25%	○

Schedule 4 Specific Measures that are reported Nationally

Performance Thresholds not being achieved in Month
None

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

2.21: No children under 18 admitted to adult inpatient wards
See earlier note on Page 10.

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

ID	Performance Measure (PM)		2017/18 Outturn	July-2018	August-2018	September-2018	(Apr-Sep) Cumulative Compliance	Forecast 18/19 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	<3	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	99%	95%	97%	100%	99%	
NHSI 1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%	95%
		Actual	98%	97%	96%	97%	98%	
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	2.4%	3.6%	0.6%	0.5%	1.4%	
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	53%	53%	53%	53%	53%
		Actual	68%	100%	100%	N/A	83%	
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Actual	59%	91%	94%	96%	89%	
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Actual	75%	94%	96%	96%	91%	
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	5	0	0	0	2	

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
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)		2017/18 Outturn	July-2018	August-2018	September-2018	(Apr-Sep) Cumulative Compliance	Forecast 18/19 Outturn
	CQUIN 1							
7.01a	Improvement of health and wellbeing of NHS Staff	PM	Qtr 4			Report	Report	Report
		Actual	Awarded			NYR	NYR	
7.01b	Healthy food for NHS staff, visitors and patients	PM	Qtr 4			Report	Report	Report
		Actual	Awarded			NYR	NYR	
7.01c	Improving the update of flu vaccinations for frontline clinical staff	PM	Qtr 4			Report	Report	Report
		Actual	Awarded			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	Qtr 4			Report	Qtr 1	Report
		Actual	Awarded			NYR	Awarded	
7.02b	Improving Physical healthcare to reduce premature mortality in people with SMI: Collaboration with primary care clinicians	PM	Qtr 4			Report	Qtr 2	Report
		Actual	Awarded			Compliant	Compliant	
	CQUIN 3							
7.03	Improving services for people with mental health needs who present to A&E	PM	Qtr 4			Report	Qtr 2	Report
		Actual	Awarded			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	Awarded			Compliant	Compliant	
	CQUIN 5							
7.05a	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco screening	PM	Qtr 4			Report	Qtr 2	Report
		Actual	Awarded			Compliant	Compliant	
7.05b	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco brief advice	PM	Qtr 4			Report	Qtr 2	Report
		Actual	Awarded			Compliant	Compliant	
7.05c	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco referral and medication	PM	Qtr 4			Report	Qtr 2	Report
		Actual	Awarded			Compliant	Compliant	
7.05d	Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol screening	PM	Qtr 4			Report	Qtr 2	Report
		Actual	Awarded			Compliant	Compliant	
7.05e	Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol brief advice or referral	PM	Qtr 4			Report	Qtr 2	Report
		Actual	Awarded			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
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)		2017/18 Outturn	July-2018	August-2018	September-2018	(Apr-Sep) Cumulative Compliance	Forecast 18/19 Outturn
	CQUIN 1							
8.01	Reducing the length of stay in specialised MH services	PM	Qtr 4			Report	Qtr 2	Report
		Actual	Awarded			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
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)		2017/18 Outturn	July-2018	August-2018	September-2018	(Apr-Sep) Cumulative Compliance	Forecast 18/19 Outturn
7								
	CQUIN 1							
9.01a	Improvement of health and wellbeing of NHS Staff	PM	Qtr 4			Report	Report	Report
		Actual	Awarded			NYR	NYR	
9.01b	Healthy food for NHS Staff, Visitors and Patients	PM	Qtr 4			Report	Report	Report
		Actual	Awarded			NYR	NYR	
9.01c	Improving the uptake of Flu vaccinations for Front Line Clinical Staff	PM	Qtr 4			Report	Report	Report
		Actual	Awarded			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 4			Report	Qtr 1	Report
		Actual	Awarded			NYR	Awarded	
9.02b	Improving Physical healthcare to reduce premature mortality in people with SMI: Collaborating with primary care clinicians	PM	Qtr 4			Report	Qtr 1	Report
		Actual	Awarded			Compliant	Compliant	
	CQUIN 3							
9.03	Improving services for people with mental health needs who present to A&E	PM	Qtr 4			Report	Qtr 2	Report
		Actual	Awarded			Compliant	Compliant	
	CQUIN 4							
9.04	Transition from Young People's Service to Adult Mental Health Services	PM	Qtr 4			Report	Qtr 2	Report
		Actual	Awarded			Compliant	Compliant	
	CQUIN 5							
9.05a	Tobacco screening	PM	Qtr 4			Report	Qtr 2	Report
		Actual	Awarded			Compliant	Compliant	
9.05b	Tobacco brief advice	PM	Qtr 4			Report	Qtr 2	Report
		Actual	Awarded			Compliant	Compliant	
9.05c	Tobacco referral and medication offer	PM	Qtr 4			Report	Qtr 2	Report
		Actual	Awarded			Compliant	Compliant	
9.05d	Alcohol screening	PM	Qtr 4			Report	Qtr 2	Report
		Actual	Awarded			Compliant	Compliant	
9.05e	Alcohol brief advice or referral	PM	Qtr 4			Report	Qtr 2	Report
		Actual	Awarded			Compliant	Compliant	

Agenda item 8 **Enclosure Paper C**

Report to: Trust Board, 29 November 2018
Author: Dr Amjad Uppal, Medical Director and Paul Ryder, Patient Safety Manager
Presented by: Dr Amjad Uppal, Medical Director

SUBJECT: **Learning from Deaths 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 represents those available for the period July to September 2018 (Q2 2018/19).

121 deaths have been closed without further review due to being open to solely ACI-Monitoring caseloads.

No deaths have raised a cause for concern either within 2gether or with partner organisations during Q2 2018/19.

There has been a key post vacant since August 2018 and a suitable appointment is made, presently limited to Bank Staff, and a substantive appointment is anticipated.

The Board is asked to note the contents for information and to recognise that remedial work continues to improve the unsatisfactory position currently observed.

RECOMMENDATIONS

The Board is asked to note the contents of this Mortality Review Report which covers Quarter 2 of 2018/19.

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	Yes	Can do	
Valuing and respectful	Yes	Efficient	

Reviewed by:		
	Date	

Where in the Trust has this been discussed before?		
Mortality Review Committee (MoReC)	Date	16 November 2018

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 Since Quarter 3 2017/18, the Trust Board has received 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 subsequent iteration of data for the period July to September 2018.

2. PROCESS

2.1 All 2gether Trust staff are required to notify, using the Datix system, the deaths of all Trust patients. This comprises anyone open to a Trust caseload at the time of their death and who dies within 30 days of receiving care from 2gether. Deaths recorded on Datix are collated for discussion at the monthly Mortality Review Committee 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 Committee (MoReC).

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, and 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.

2.11 During the first year of implementation, the process has proven to have a demonstrably high administrative burden. The quality of the output from a large proportion of Mortality Reviews indicated that, within that large proportion, the care afforded to the patient during their End of Life Care was not provided by 2gether teams, but often from 3rd sector providers (care homes) and GP practices. There has been limited learning produced from reviewing these cases.

2.12 It has been agreed by County Steering Groups in Gloucestershire and Herefordshire, and subsequently discussed with the Royal Colleges also involved in Mortality Review work, to modify the process for those patients who die whilst receiving an annual review only from the ACI-Monitoring Teams. These deaths amounted to over 50% of the total reported during 2017/18 and yet they produced very limited learning. Since November 2017, these deaths continue to be recorded within Datix, but no further active review will take place unless obvious concerns are raised by the clinical teams and/or carers and relatives.

3. DATA

3.1 The data presented below represents those available for the period July to September 2018.

3.2 121 deaths have been closed without further review due to being open to solely ACI-Monitoring caseloads.

3.3 No deaths have raised a cause for concern either within 2gether or with partner organisations during Q2 2018/19.

4. CONCLUSION

4.1 This, the Q2 report for 2018/19 of mortality review data under the Learning from Deaths policy, is limited following the unexpected departure from the Patient Safety Team of the Mortality Review Administrator. This has caused additional delays in appropriately processing Datix incident reports and in obtaining basic cause of death information from GP surgeries, local partner NHS providers' PALS offices and the Coroner's Office.

4.2 Recruitment to the Administrator post is currently held whilst the Learning from Deaths Policy is reviewed and revised during its annual review cycle. In the interim, a Bank B4 Administrator has been identified and will provide some support to the Patient Safety Team until a more permanent solution is identified.

4.3 A new Mortality Review Administrator, Zoë Lewis, has joined the team 29 October 2018, following a period of a vacant post for August 2018. Since joining the team, Zoë has concentrated on data cleansing in order to focus on incidents that do require either a table top or care record review. She has also picked up the backlog from Q3-Q4 2017/18. In 3 ½ weeks, Zoë has able closed 140 death incidents and rejected a further 9.

4.4 From w/c 19/11/18, there has been a focus on deaths from Q1-Q2 2018/19. We have now introduced a range of new reports that serve to identify deaths of service users under the age of 65 years, in order that any learning from these deaths is maximised by prioritising these reviews. By Q3 2018/19, it is projected that significant progress will be made regarding the number of Q1-Q2 2018/19 death incidents being reviewed. Additionally, in order to assist in clearing of the backlog, additional recruiting is in progress for an additional part-time Bank Administrator. An appropriate candidate has been identified, and we hope that she will have completed the recruitment process and be in post before Christmas.

4.5 The data provided is acknowledged to be incomplete and provides limited assurance. The last Mortality Review Committee (MoReC) was held on 20 July 2018 prior to the departure of the Mortality Review Administrator.

4.6 The learning derived from Q2 2018/19 is limited to Serious Incidents. MoReC meetings has not produced significant learning during Q2 2018/19. July, August and September 2018 deaths recorded within Datix have been partially processed. The Datix Mortality Review Dashboard indicates there are 182 deaths yet to be processed for this period.

4.7 The Lessons Learned documents produced following completion of Serious Incident Final Reports are attached for

- SI-08-19
- SI-09-19
- SI-10-19
- SI-11-19
- SI-12-19

This learning is published to the 2getherNet intranet and the documents have been distributed through locality governance committees for cascade to wards, teams and bases.

Financial Year 2018-2019

September MoReC Figures - correct up to 30 September 2018

Closed Mortality Reviews

Month	Closed ACI Caseload Deaths	Closed Following Table-Top Review Only			Closed Following Care Record Review			Closed Following Serious Incident Review			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-18	33	0	0	0	2	2	0	3	0	0	40
May-18	27	0	0	0	0	0	0	3	0	0	30
Jun-18	31	0	0	0	1	1	0	1	0	0	34
Jul-18	10	0	0	0	0	0	0	1	0	0	11
Aug-18	13	0	0	0	0	0	0	0	0	0	13
Sep-18	7	0	0	0	0	0	0	0	0	0	7
Oct-18											0
Nov-18											0
Dec-18											0
Jan-19											0
Feb-19											0
Mar-19											0
	121	0	0	0	3	3	0	8	0	0	135

Open Mortality Reviews

Month	Awaiting Information to Complete Table-Top Review	Awaiting Table Top Review	Awaiting Care Record Review (MoReC)	Awaiting Clinical Review (SI's)	Total	Quarterly Total
Apr-18	34	0	0	0	34	
May-18	31	0	0	0	31	88
Jun-18	23	0	0	0	23	
Jul-18	28	0	0	1	29	
Aug-18	33	0	0	0	33	96
Sep-18	33	0	0	1	34	
Oct-18					0	
Nov-18					0	0
Dec-18					0	
Jan-19					0	
Feb-19					0	0
Mar-19					0	
	182	0	0	2	184	

2gether Making life better

2gether NHS Foundation Trust NHS

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-09-19

Incident Category:

Non-Compliant Disposal of Medication Waste

What happened? ***(Describe the incident)***

- **An unsealed Biobin (medication waste) was collected as part of a general waste by a waste management company from a hospital site. It was then baled and incinerated.**
- **This was a Near Miss in terms of patient harm and environmental damage.**

What did the Investigation find? ***(What was done well? Did anything go wrong?)***

- **The correct procedure for the disposal of medication waste was not followed. There was no porter.**
- **There was an error made on the day of collection by the waste management company. Waste was collected as general waste instead of recycling. It was fortunate that the waste was incinerated rather than recycled.**
- **The red wheelie bins that the Biobins sit within in the clinical areas are too small, which causes difficulties when closing the lid and can cause damage to the Biobins themselves.**
- **There was uncertainty regarding whose responsibility it is to dispose the Biobins into the external clinical waste wheelie bin in the waste compound.**
- **A practice notice was sent to all clinical staff within the Trust immediately after the incident was discovered highlighting the correct process to follow, although some clinicians remained unclear of the disposal processes.**

What can we learn from this incident? ***(What does this remind us about good practice? What can we change?)***

- **Appropriate recruitment for a porter vacancy should be progressed immediately.**
- **All wards will have a key to access the external clinical waste bins in the waste compound. All staff will be notified of where the key is located.**
- **Medicine leads on each ward can assist with disseminating information to other staff.**
- **The methods for training waste management processes should be reviewed and amended as appropriate with suitable consideration given to the practical 'hands-on' nature of this process (e-learning might not be the best option).**
- **The on-going use of the red wheelie bins within the clinical areas will be reviewed to ensure that they are fit for purpose.**

2gether Making life better

2gether NHS Foundation Trust

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-10-19

Incident Category:

Patient Death

What happened? ***(Describe the incident)***

- **The patient died at home after taking an overdose of medication.**

What did the Investigation find? ***(What was done well? Did anything go wrong?)***

- **The patient's risks were impacted by a complex dual diagnosis of Paranoid Schizophrenia and their long term use of alcohol and illicit substances, alongside unstable Epilepsy, due to the patient being non-concordant with medication.**
- **The treating team provided an intensive and flexible service and endeavoured to engage the patient with appropriate services and treatments to mitigate the presenting mental health and physical health risks and improve the patient's quality of life.**
- **There was evidence of good communication and joint working across teams within the Trust and outside organisations, including the Neurology department and Police.**

What can we learn from this incident? ***(What does this remind us about good practice? What can we change?)***

- **There were no Care Delivery Problems identified which impacted on the quality of the service delivered to the patient, nor were there any changes which could have been made to prevent the very sad death of the patient but the following improvements were noted:**
- **When a patient is assessed as HIGH risk a separate HIGH Risk Care Plan will be completed and up loaded onto the RiO Risk section and shared with patient and relevant Care Agencies and family members, consistent with the Assessing & Managing Clinical Risk and Safety Policy.**
- **With the patient's consent, all agencies involved in the patient's care are invited to be part of the patient's Care Programme Approach reviews, or their view sought.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-11-19

Incident Category:

Patient harm: Death

What happened? ***(Describe the incident)***

- **The patient found at home by their family, hanged.**

What did the Investigation find? ***(What was done well? Did anything go wrong?)***

- **The patient was diagnosed with Recurrent Depressive Disorder and presented with distressing fixed beliefs, which did not improve with medication, psychological intervention and daily support from the Crisis Resolution & Home Treatment Team.**
- **The patient was identified as requiring an inpatient admission and despite being on the waiting list, the Trust had not been able to arrange a hospital admission to the patient's preferred location prior to the patient's death.**
- **Staff worked flexibly with the patient, acknowledging their preferences for treatment, and included their partner in discussions, both individually and with the patient, in line with best practice as set out by the Triangle of Care.**

What can we learn from this incident? ***(What does this remind us about good practice? What can we change?)***

- **A system will be developed to refer delayed admissions to Mental Health Acute Response Service manager**
- **There will be a review of and improvements to the system for notifying teams of availability of beds outside of office hours and for teams to have in place a system to ensure the Bed State is checked regularly when they supporting patients who are awaiting inpatient admissions.**
- **The Bed Management Role is being expanded to provide additional support out of hours.**

2gether Making life better

2gether NHS Foundation Trust NHS

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-12-19

Incident Category:

Patient harm

What happened? ***(Describe the incident)***

- **The patient jumped from the first floor of a multi-storey car park, which resulted in non-life-changing injuries.**

What did the Investigation find? ***(What was done well? Did anything go wrong?)***

- **The patient had a complex presentation, did not engage with mental health services consistently and used illicit substances, which made diagnosis difficult.**
- **The patient received a flexible, responsive and patient-centred package of care from all of the mental health services that they came into contact with and there was excellent communication with outside agencies who were also supporting the patient.**
- **The patient's level of engagement was very sporadic, choosing not to engage or work towards longer term goals.**
- **Due to persistent non-engagement, the patient had been reluctantly discharged from her community team 13 days before the incident.**
- **The Care Coordinator provided a high level of input and support despite the patient residing in a different locality.**

What can we learn from this incident? ***(What does this remind us about good practice? What can we change?)***

- **When a team and patient are based in different geographical localities, a transfer to the most appropriate locality team should be considered.**
- **When a patient is referred for assessments from private providers, it is critical that we receive written copies of outcome reports.**
- **There needs to be clarity around the process of referring a patient to the Complex Care Panel.**
- **Clinicians should only undertake assessments (in this case the Hare Psychopathy Test) if they have received the appropriate training to do so.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-13-19

Incident Category:

Patient death

What happened? ***(Describe the incident)***

- **The patient was found deceased at their home address by police after they did not meet a family member at a lunch engagement.**

What did the Investigation find? ***(What was done well? Did anything go wrong?)***

- **The patient had a long history of mental health difficulties including depression, anxiety, substance misuse and a chronic bulimic eating disorder.**
- **The patient had been offered a range of services, but had a history of disengagement from the services provided.**
- **At the time of the patients death, anti-depressants had been re-started, the clinical presentation was improving and the risk of suicide was assessed as low.**
- **There was a longer than normal waiting time to be seen by the Eating Disorder Service due to a high number of referrals into the team.**
- **The Eating Disorders Team are only able to offer appointments at their base in Cheltenham and the patient was unable to travel to that base.**
- **Although risks and onward referral to other teams were considered, it was not always documented within the patients clinical notes.**
- **There was good evidence of consistent, notable practice in care throughout a period of three years.**

What can we learn from this incident? ***(What does this remind us about good practice? What can we change?)***

- **All assessment of risk and clinical decisions around referring on to other teams should be documented within the patient's clinical notes.**
- **Offering appointments at different localities may enhance the availability of a service.**

Agenda item 9 **Enclosure Paper D**

Report to:	Trust Board, 29 November 2018
Author:	Dr Nader Abbasi, Consultant & Guardian of Safe Working Hours
Presented by:	Dr Amjad Uppal, Medical Director
SUBJECT:	**Guardian of Safe Working Hours Quarterly Report covering February, March , April 2018**

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

All new Psychiatry Trainees, Foundation Trainees and GP Trainees rotating into a Psychiatry placement are now on the new 2016 Terms and Conditions of Service with occasional exceptions. There are currently 36 junior doctors working in the 2gether NHS Foundation Trust, all on the new Terms and Conditions of Service on different sites.

The 'exception' reporting process, which is part of the new Juniors Doctors Contract enables them to raise and resolve issues with their working hours and training. The trainees can raise 'exception reports' for excessive hours worked, missed breaks, or missed educational opportunities and this system is well established in the Trust. These 'exception reports' where possible have been resolved by the preferred option of time off in lieu (TOIL); those where TOIL will impact on colleagues' workload or educational opportunities have received payments. Exception reports may also trigger work schedule reviews and if necessary fines can be imposed on the Trust by the Guardian of Safe Working if issues remain unresolved. Exception reporting rates are variable between different sites.

The Quarterly Board report from the Guardian which summarises all exception reports, work schedule reviews and rota gaps, and provides assurance on compliance with safe working hours by both the employer and doctors in approved training programs, will be considered by CQC, GMC, and NHS employers as key data during reviews. The purpose of the report is to give assurance to the Board that the doctors in training are safely rostered and their working hours are complaint with the TCS.

RECOMMENDATIONS

1) The Board is asked to note the content of this paper, in particular in regard to challenges within Hereford junior doctors' rota and how it relies on locum cover.

2) Monitoring progress of remedial actions to improve the junior doctor Rota in Hereford with a specific concern and focus on the on-call average working hours is the key recommendation of this report.

Corporate Considerations	
Quality implications	Implementing the new contract is a DoH requirement justified by a need to ensure consistent quality care and working conditions for junior doctors
Resource implications:	The cost of implementing this contract is being progressed through Execs. It is also important to make sure our rotas are compliant to avoid fines.
Equalities implications:	Nil
Risk implications:	Financial risk if the Trust breaches, a number of issues have been identified in the implementation phase which are identified in the report, together with the plans to resolve them.

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

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

Reviewed by:		
Dr Amjad Uppal	Date	8th November 2018

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
	Date	

Explanation of acronyms used:	CQC – Care Quality Commission DME – Director of Medical Education HEE – Health Education England

1. CONTEXT

1.1 The safety of patients is of paramount importance for the NHS and significant staff fatigue is a hazard both to patients and to the staff themselves. The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours. It was agreed during negotiations with the BMA that a 'Guardian of Safe Working Hours' will be appointed in all NHS Trusts employing of hosting junior doctors to ensure safe working practice.

1.2 The role of 'Guardian of Safe Working Hours' is independent of the Trust management structure, with a primary aim to represent and resolve issues related to working hours for the junior doctors employed by it. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and /or employer, as appropriate; and will provide assurance to the Trust Board or equivalent body that doctors' working hours are safe.

1.3 The work of Guardian will be subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by the continued scrutiny of the quality of training by Health Education England (HEE). These measures should ensure the safety of doctors and therefore of patients.

1.4 The system in the new junior doctors' contract for monitoring safe working practices is relatively new and will require Trust-wide cultural and administrative changes. The Trust has invested in relevant software to help monitor the 'Exception Reports' in line with national guidance

1.5 The Guardian's Quarterly Report, as required by the junior doctor's contract, is intended to provide the Board with an evidence based report on the working hours and practices of junior doctors within the Trust, confirming safe working practices and highlighting any areas of concern.

2. THE GUARDIAN OF SAFE WORKING HOURS REPORT

2.1 Exception Reporting

The Trust uses 'Allocate' as the reporting software system, which appears to function reasonably well for this purpose.

Since beginning of February 2018 till end of April 2018, 16 exception reports have been generated and a break down has been provided in following tables.

2.2 The table below shows the number of trainee posts available and filled by junior doctors in training.

Grade	Trainees	Glos	Hereford	New Contract	Old Contract
F1	5	4	1	5	0
F2	5	3	2	5	0
GP	6	4	2	6	0
CT	9	8	1	9	0
ST	11	10	1	11	0
Total	**36**	**29**	**7**	**36**	**0**

Exception reports by site	
Gloucester	5
Hereford	11
Total	16

Exception reports by grade						
Grade	F1	F2	GP	CT	ST	Total
	3	2	5	5	1	16

Exception reports, response time					
	Addressed within 48 hrs	Addressed within 7 days	Addressed in longer than 7 days	Addressed by Guardian	Still open
F1	0	1	0	0	2
F2	2	0	0	0	0
GP	5	0	0	0	0
CT	3	0	2	0	0
ST	0	0	1	0	0
Total	10	1	3	0	2

2.3 Out of 16 reports in this period, 12 have been related to hours, 1 related to service support and 2 in relation to educational opportunities. We had 14 resolutions and 2 are still open at the time one pending a meeting and outcome and the other one need to be closed by trainee.

Resolutions have included:

- 3/16 No further action
- 2/16 time in lieu agreed
- 10/16 overtime payment agreed
- 1/16 pending meeting with Educational Supervisor
- 7/16 required work schedule reviews in this period, which needs to be considered designing next rota.

There are some historical reports remained open from previous periods and we are in discussion with the software provider Allocate to find a way to solve this problem in future. These reports have not been closed down by trainees who have left the Trust.

2.4 **Work Schedule reviews**

Seven out of sixteen reports recommended a work schedule review during this period, which has been noted through the discussions of Guardian with medical staffing and Director of Medical Education. These are mainly related to the Hereford rota and have been taken into account designing the new rota. We are in discussion with medical staffing to increase the average time allocated to on calls during weekdays and weekends.

2.5 **Locum Booking and Vacancies**

2.5.1 There were two Trust locum doctors working within Hereford rota to fill the gap created by colleague sickness and 12 on call shifts were covered on the same rota by locums. There was one trainee on the rota on long-term sick leave.

2.5.2 There were 8 on-call shifts within Gloucestershire rota covered by agency locum. There were 3 trainees; one CT, one GP and one F2 on the same rota who could not complete any on calls.

2.6 **Fines**

2.6.1 At this stage no fines have as yet been levied against Trust, there are ongoing discussions around amendment to the Hereford rota. We are in the process of collecting more data to implement changes within the rota to cover time worked during the on calls.

3. CHALLENGES:

3.1 **Completion of Exception Reports / Knowledge of the System:** Both junior doctors and their supervisors need to be more disciplined in meeting and resolving issues highlighted through the exception reports. A number of reports are not attended to in a timely manner. The Guardian will continue to support junior doctors and supervisors in resolving these issues as soon as possible.

3.2 **Software System:** The Trust uses a nationally procured system for medical staff rotas called 'Allocate Software System', which is the system now used for Exception reporting. All our junior doctors and educational supervisors are registered with the system. There still are some issues with the system, which has been highlighted to the software company. Other Trusts have also highlighted similar issues with the software and I was assured by the developers at a recent Conference I attended that these were being looked into.

3.3 **Junior doctor rota:** Since changing rota in Gloucestershire to working waking nights there has been significant decline in number of exception reports from the rota. There are concerns regarding times allocated to average working hours during on calls in Hereford. It seems that this is the main reason behind the numbers of exception reports raised from Hereford. We are gathering information from junior doctors through junior doctors' forum.

3.4 **Workload:** The new contract does have workload implications for the Guardian, administrator, DME, Educational and Clinical supervisors when a trainee submits an exception report. The amount of time spent depends on the number of exception reports submitted and it is too early to make a judgment about this currently.

3.5 **Administrative support for the Guardian role:** The Guardian is being assisted by admin from medical staffing and they have been very supportive in introducing the new system and answering queries from users.

3.6 **Junior Doctors Forum:** Our Junior Doctors Forum predates the introduction of the new contract and has been further strengthened by the Guardian and the DME meeting quarterly. The attendance by junior doctors has been variable despite a proactive approach by the current junior doctors' rep to engage colleagues.

4. EXCEPTION REPORTS AND FINES

4.1 There have been 16 exception reports during this period with 2 still open and need addressing by junior doctors and supervisors. There has been a consistent reduction in number of exception reports on both sites due to training and amendment to rotas. There are still a number of exception reports raised from Hereford site, which remain a concern and need further changes and alteration to rota. Around 70% of our reports were raised in Hereford, which has 20% of our junior doctors.

4.2 There has been no breach of contract to initiate any fines against the Trust yet.

5. NETWORKING

5.1 The Guardian has attended the annual national training and is a member of the regional forum of Safe Working Guardians as well as having email contact with a number of other Guardians in the region to share updates and experience. Intelligence from this network suggests that the level of exception reporting has been similar across Trusts within the region. The Guardian also regularly meets with the Director of Medical Education.

5.2 There is a national view that there is a surge of exception reports in February and August when new junior doctors start in post. This usually settles when junior doctors become familiar with the system and their work schedules. We have included a presentation by Guardian in all Induction Programs of Trust to address this issue.

6. CONCLUSION

6.1 All of our junior doctors now are on the new contract and they are mostly have embraced the system and are genuinely committed to Exception Reporting and maintaining a professional work-life balance, promoting safe working. Information gleaned from the exception reports enables the DME to keep informed of the challenges and threats to the provision of quality Trainee placements at the Trust.

6.2 The Exception Reporting process allows Trainees to give the Guardian notice of working unsafe hours. However, it remains a concern that despite known understanding in the Trust and comments regarding the respond time it still remains a problem. The challenge increases in the area of educational supervisors and junior doctors engagement and improving the response to their contractual duties although some improvement has noticed.

6.3 The Guardian of Safe Working Quarterly Report provides assurance that trust is positively engaged with its junior doctors via a number of routes and meetings. Since the implementation of the junior doctors' contract, there were initially more exception reports then regular induction programme presentations and involvement through the junior doctors' forum resulted in improved trainee feedback and a significant reduction in exception reports. No fines have been made since introduction of the new junior doctors' contract.

6.4 There are concern regarding the number of exception reports produced by Hereford trainees which is due to insufficient average hours allocated to on calls and shortage of trainees. We are gathering information with help from HR and trainees along data gathered through exception reports to solve this problem

7. RECOMMENDATION

7.1 The Board is asked to read and note of this report from the Guardian of Safe Working.

7.2 Hereford remains a challenge due to the long standing shortage of trainees in the region and non-adequate time allocated to on calls.

Agenda Item 10 **Enclosure Paper E**

Report to: Trust Board – 29 November 2018
Author: Gordon Benson, Assistant Director of Governance & Compliance
Presented by: John Trevains, Director of Quality

SUBJECT: **Quality Report: Report for 2nd Quarter 2018/19**

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

EXECUTIVE SUMMARY

This is the second review of the Quality Report priorities for 2018/19. 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 2 targets which are consistently not being met:

    1. 1.2 – Personalised discharge care planning
    2. 2.1 – Numbers of service users being involved in their care

Improvements/developments

- There continues to be a sustained focus on the unmet targets, particularly in discharge care planning as the target remains consistently unmet. It was agreed at QCR on 17 August 2018 that the required standards within the ACM Policy would be reviewed to establish the value and impact of the 8 defined criteria and, if indicated, agree revised and more effective criteria. This review is nearing completion.

- In terms of the local patient Quality Survey, whilst the target for being involved in care has not been met this quarter, the result is encouraging and currently on trajectory for being met by year end.

- Target 3.3, to reduce prone restraint is showing considerable improvement over time and is anticipated to improve as there is demonstrable evidence of a cultural shift in moving to the use of supine restraint, supported by training and positive practice.

RECOMMENDATIONS

The Board is asked to:

- Note the progress made to date and actions in place to improve/sustain performance where possible.
- Agree to share the Quarter Two Quality Report with stakeholders.

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:		
John Trevains, Director of Quality	Date	20 November 2018

Where in the Trust has this been discussed before?		
QCR	Date	16 November 2018
	Date	

What consultation has there been?		
	Date	

Explanation of acronyms used:	ACM – Assessment & Care Management Policy

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

Quality Report 2018/19

Quarter 2

CONTENTS

Part 1: Statement on Quality from the Chief Executive

Introduction

To be completed at year-end

Part 2.1: Looking ahead to 2019/20

Quality Priorities for Improvement 2018/19

To be completed at year-end

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

Review of Services

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

During 2018/2019, the 2gether NHS Foundation Trust provided and/or sub-contracted the following NHS services:

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

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

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

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

The [2]gether NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the NHS services reviewed in 2018/19 represents (To be completed at year-end) % of the total income generated from the provision of NHS services by the [2]gether NHS Foundation Trust for 2017/18.

Participation in Clinical Audits and National Confidential Enquiries

To be completed at year-end

Participation in Clinical Research

To be completed at year-end

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

A proportion of [2]gether NHS Foundation Trust's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between [2]gether NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at http://www.2gether.nhs.uk/cquin

2018/19 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	£75133	Effectiveness
1b National CQUIN – Staff health and wellbeing	Healthy food for NHS staff, visitors and patients		£75133	Effectiveness
1c National CQUIN - Staff health and wellbeing	Improving the uptake of flu vaccinations for front line staff		£75133	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	£180320	Effectiveness
2 National CQUIN - Improving Physical Healthcare 3b	- To reduce premature mortality - Improved communication with GPs		£45080	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	£225400	Safety
4. Transitions out of Children and Young	To improve the experience and outcomes for young people as they	0.3	£225400	Effectiveness

People's Mental Health Services.	transition out of (CYPMHS)			
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	£225400	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	£19066	Effectiveness
1b National CQUIN – Staff health and wellbeing	Healthy food for NHS staff, visitors and patients		£19066	Effectiveness
1c National CQUIN - Staff health and wellbeing	Improving the uptake of flu vaccinations for front line staff		£19066	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	£45760	Effectiveness
2 National CQUIN - Improving Physical Healthcare 3b	- To reduce premature mortality - Improved communication with GPs		£11440	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	£57201	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	£57201	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	£57201	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 2018/19 is £2,390,000.

In 2017/18, the total potential value of the income conditional on reaching the targets within the CQUINs was £2,282,000 of which £2,282,000 was achieved.

2019/20 CQUIN Goals

To be completed when this information becomes available

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 2018/19 or the previous year 2017/18.

[2]gether NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

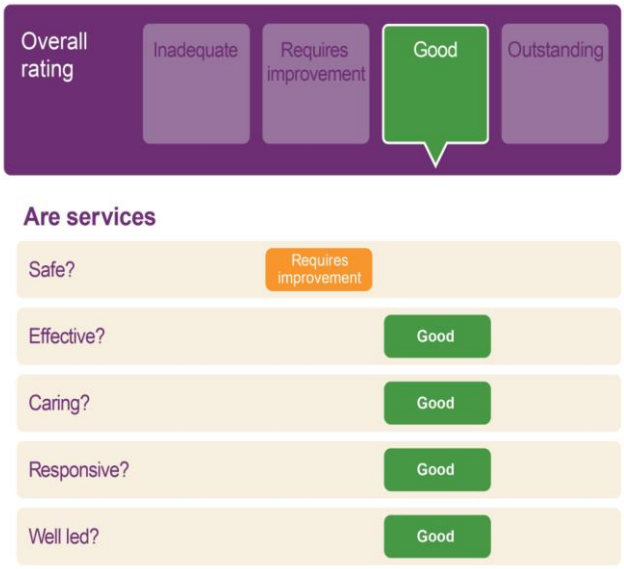
CQC Inspections of our services

The CQC have moved away from the previous Comprehensive Inspection model to one which consists of an annual Well Led review which is announced, and unannounced inspections of specific services. The CQC undertook the following inspections during the period: 12th February to 29th March 2018.

1. Unannounced inspection of community based mental health services for older people
2. Unannounced inspection of wards for older people with mental health problems
3. Unannounced inspection of wards for people with learning disabilities or autism
4. Unannounced inspection of specialist community mental health services for children and young people
5. Well Led Review,

New Ratings from latest review.

The overall Trust rating remains at GOOD and the CQC recognised that there have been many improvements made since the last inspection in 2015.



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 has developed an action plan in response to the 11 “must do” recommendations, and the 23 “should do” recommendations identified by the inspection and is managing the actions through to their completion.

	Safe	Effective	Caring	Responsive	Well led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Outstanding ★	Good	Good	Good	Outstanding ★	Outstanding ★
Long-stay or rehabilitation mental health wards for working age adults	Requires Improvement	Good	Good	Good	Good	Good
Forensic inpatient or secure wards	Good	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Good	Good	Outstanding ★	Good	Good	Good
Wards for people with a learning disability or autism	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Community-based mental health services for adults of working age	Requires Improvement	Good	Good	Good	Good	Good

Mental health crisis services and health-based places of safety	Good	Good	Outstanding 	Outstanding 	Good	Outstanding 
Specialist community mental health services for children and young people	Good	Good	Good	Good	Good	Good
Community-based mental health services for older people	Good	Good	Good	Good	Good	Good
Community mental health services for people with a learning disability or autism	Good	Good	Good	Good	Requires Improvement	Good

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

.

Quality of Data

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

To be completed at year-end

Information Governance

To be completed at year-end

Clinical Coding

To be completed at year-end

Learning from Deaths

To be completed at year end.

Part 2.3: Mandated Core Indicators 2018/19

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 2017-18	Quarter 2 2017-18	Quarter 3 2017-18	Quarter 4 2017-18	Quarter 1 2018-19
[2]gether NHS Foundation Trust	99.2%	98.5%	99.6%	98.4%	97.6%
National Average	96.7%	96.7%	95.4%	95.5%	95.8%
Lowest Trust	71.4%	87.5%	69.2%	87.2%	73.4%
Highest Trust	100%	100%	100%	100%	100%

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

- During 2015/16 we reviewed our practices and policies associated with both our 7 day and 48 hour follow up of patients discharged from our inpatient services, the changes were introduced in 2016/17. This has strengthened the patient safety aspects of our follow up contacts.

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

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

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

	Quarter 1 2017-18	Quarter 2 2017-18	Quarter 3 2017-18	Quarter 4 2017-18	Quarter 1 2018-19
[2]gether NHS Foundation Trust	100%	100%	99.5%	98.6%	99.4%
National Average	98.7%	98.6%	98.5%	98.7%	98.1%
Lowest Trust	88.9%	94%	84.3%	93.7%	85.1%
Highest Trust	100%	100%	100%	100%	100.00%

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.

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 2 2017-18	Quarter 3 2017-18	Quarter 4 2017-18	Quarter 1 2018-19	Quarter 2 2018-19
[2]gether NHS Foundation Trust 0-15	0%	0%	0%	0%	0%
[2]gether NHS Foundation Trust 16 +	7.3%	10.4%	5.8%	6.2%	6.1%
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 2014	NHS Staff Survey 2015	NHS Staff Survey 2016	NHS Staff Survey 2017
[2]gether NHS Foundation Trust Score	3.61	3.75	3.84	3.86
National Median Score	3.57	3.63	3.62	3.67
Lowest Trust Score	3.01	3.11	3.20	3.26
Highest Trust Score	4.15	4.04	3.96	4.14

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

- For the second year running, all staff in post were invited to take part in the survey. Previously the survey had only been sent to a random sample of staff.

The overall response rate in the most recent survey was **45%** (improved from 40% the previous year). This equated with **921** staff taking the time to contribute their views (up from 777 the previous year). The 2017 survey has arguably provided the richest and most accurate picture of the staff views in the Trust to date.

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

Taking steps to

- Improve Staff Health and Well-being;
- Improve Reporting of Incidents;
- Make more effective use of patient and service user feedback.

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 2014	NHS Community Mental Health Survey 2015	NHS Community Mental Health Survey 2016	NHS Community Mental Health Survey 2017
[2]gether NHS Foundation Trust Score	8.2	7.9	8.0	8.0
National Average Score	Not available	Not available	Not available	Not available
Lowest Score	7.3	6.8	6.9	6.4
Highest Score	8.4	8.2	8.1	8.1

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

- [2]gether is categorised as performing 'better' than the majority of other mental health Trusts in 5 of the 10 domains and 'about the same' as the majority of other mental health Trusts in the remaining 5 domains.

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

- 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.

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 2017 – 30 September 2017				1 October 2017-31 March 2018			
	Number	Rate*	Severe	Death	Number	Rate*	Severe	Death
[2]gether NHS Foundation Trust	2585	73.19	2	20	2901	83.69	2	28
National	167,477	-	532	1212	166787	-	569	1331
Lowest Trust	68	16	0	0	1	14.88	0	0
Highest Trust	6447	126.4	89	83	8134	96.72	121	138

* 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:

- Establishing a Datix User Group to improve the processes in place for the timely review, approval of, response to and learning from 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 2017/18

Introduction

The 2018/19 quality priorities were agreed in May 2018.

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 2018/2019

Effectiveness		2016 - 2017	2017 - 2018	2018- 2019
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).	**Achieved**	**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**	**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**	**Not achieved**	**Achieved**
User Experience				
2.1	Were you involved as much as you wanted to be in agreeing what care you will receive? **> 84%**	**Achieved**	**Not achieved**	**Not achieved**
2.2	Do you know who to contact out of office hours if you have a crisis? **>71%**	**Achieved**	**Achieved**	**Achieved**
2.3	Has someone given you advice about taking part in activities that are important to you? **> 64%**	**Achieved**	**Achieved**	**Achieved**
2.4	Have you had help and advice to find support to meet your physical health needs if you needed it? **> 73%**	**Achieved**	**Achieved**	**Achieved**
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.	**Not achieved**	**Not achieved**	**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)	Not measured	**Achieved**	**Achieved**
3.3	To increase the use of supine restraint as an alternative to prone restraint	**Not achieved**	**Not achieved**	**On Target**
3.4	To ensure that 100% of service users within Berkeley House have a bespoke restrictive intervention care plan tailored to their individual need.	Not measured	Not measured	**Achieved**

Easy Read Report on Quality Measures for 2018/2019

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. We have not met the target. We are doing lots of work to get better at this.	↓
Care (CPA) Review 	All people moving from children's to adult services had a care review. We met the target.	↑
Care Plans 	80% of people said they felt involved in their care plan. This is less than the target (84%). We have not met the target. We are doing lots of work to get better at this.	↓
Crisis 	87% of people said they know who to contact if they have a crisis. This is more than the target (71%). We met the target.	↑
Activity 	88% of people said they had advice about taking part in activities. This is more than the target (64%). We met the target.	↑
Physical Health 	84% of people said they had advice about their physical health This is more than the target (73%). We met the target.	↑

Suicide 	There were fewer suicides compared to this time last year. We met the target	↑
AWOL 	In patients who were absent without leave did not come to serious harm or death. We met the target.	↑
Face down restraint 	We have reduced the number of face-down restraints this year. We are doing lots of work to get better at this and may meet the target at the end of the year.	↔
Physical Intervention Care Plans 	Everyone at Berkley House has one of these We met the target	↑

Effectiveness

In 2018/19 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

The 2018/19 Physical Health CQUIN includes all service users with an active diagnosis of psychosis (using the CQUIN specified ICD-10 codes) who are either an inpatient or who have access to 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 for this year will include patients from both counties.

Within quarter two, we have reviewed the positive progress made in the last year to establish a clear shared care protocol between secondary care provider and primary care regarding physical health checks for people with Serious Mental Illness, and the appropriate follow up.

It was agreed last year, the responsibility for completing the annual physical health checks for patients who meet the CQUIN criteria, will remain with ^{2}gether staff. All patients subject to the Care Programme Approach within the community will be invited for a physical health check at the time of their annual CPA review; these results will then be shared with their GP electronically by email. Additionally, every inpatient will have the same screening offered on admission, and results shared with their GP electronically on discharge. This process is now embedded in practice and timescales adhered to.

Our successful physical health clinics continue to run at Pullman Place and 27a St Owen Street, providing service users in the community access to physical health checks in an environment with staff who are familiar to them. Attendance at these clinics is growing and it is hoped to provide a similar service at Leckhampton Lodge in Cheltenham soon.

Several of our Health and Exercise practitioners recently attended a study day looking at tackling obesity for our service users in the community. This has been particularly useful as these colleagues are working hard to achieve the Early Intervention CQUIN targets which look at minimising weight gain when commencing anti-psychotic medication.

Alongside the CQUIN work, [2]gether continues to increase access to physical health treatment for service users. Following the successful secondment of a general trained nurse working within Wotton Lawn Hospital in Gloucestershire, a second general nurse has been appointed to provide a similar service for inpatients at Stonebow Unit in Hereford.

[2]gether was invited to attend the project launch of "Equally Well" which is a new national collaborative to support the physical health of people with a mental illness. It aims to bring together health and care providers, commissioners, professional bodies, service user and carer organisations, charities and many more, working nationally or locally, to form a collaborative in the UK to bring about equal physical health for people with a mental illness.

The inaugural meeting for the collaborative was held at the Royal College of Nursing in London in September, where we signed The **Charter for Equal Health** which offers a vision for improved physical health support for anyone living in the UK with a severe mental illness. We look forward to working collaboratively with Equally Well in the coming year.

We have met this target.

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

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

The following 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 HEF been completed? (LD only)
4. Has the Pre-Discharge Planning Form been completed?
5. Have the inpatient care plans been closed within 7 days of discharge?
6. Has the patient been discharged from the bed?
7. Has the Nursing Discharge Summary Letter to Client/GP been sent within 24 hours of discharge?
8. Has the 48 hour follow up been completed?

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

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

Gloucestershire Services

Criterion	Year End Compliance (2015/16)	Year End Compliance (2016/17)	Year End Compliance (2017/18)	Compliance Quarter 1 (2018/19)	Compliance Quarter 2 (2018/19)
Overall Average Compliance	**69%**	**72%**	**73%**	**71%**	**65%**
Chestnut Ward	84%	85%	**83%**	**84%**	**86%**
Mulberry Ward	75%	79%	**73%**	**72%**	**65%**
Willow Ward	59%	71%	**69%**	**69%**	**65%**
Abbey Ward	72%	75%	**78%**	**74%**	**64%**
Dean Ward	79%	73%	**73%**	**73%**	**64%**
Greyfriars PICU	50%	62%	**64%**	**53%**	**56%**
Kingsholm Ward	75%	72%	**72%**	**73%**	**68%**
Priory Ward	80%	80%	**80%**	**73%**	**67%**
Montpellier Unit	50%	57%	**64%**	**71%**	**57%**
Honeybourne	N/A	70%	**65%**	**58%**	**54%**
Laurel House	N/A	65%	**81%**	**83%**	**71%**

*Berkeley House was not included in the audit as there were no discharges in Q2 2018-19.

Herefordshire Services

Criterion	Year End compliance (2015/16)	Year End Compliance 2016/17)	Year End Compliance (2017/18)	Compliance Quarter 1 (2018/19)	Compliance Quarter 2 (2018/19)
Overall Average Compliance	**N/A**	**74%**	**71%**	**71%**	**70%**
Cantilupe Ward	**N/A**	85%	**82%**	**79%**	**81%**
Jenny Lind Ward	**N/A**	71%	**68%**	**69%**	**63%**
Mortimer Ward	**N/A**	69%	**65%**	**67%**	**65%**
Oak House	**N/A**	70%	**68%**	**67%**	**NA**

*Oak House did not have any discharges during Q2 2018-19.

Overall compliance for the Trust (Gloucestershire and Herefordshire) for Quarter 2 was 68% compared to 71% in Quarter 1, this means there has been a 3% decrease in compliance. Overall compliance for Gloucestershire only for Quarter 2 was 65% compared to 71% in Quarter 1, this means there has been a 6% decrease in compliance. Overall compliance for Herefordshire only for Quarter 2 was 70% compared to 71% in Quarter 1, this means there has been a 1% decrease in compliance.

During Quarter 2 of 2018/19 there were 76 discharges from Herefordshire and 190 from Gloucestershire. The total number of discharges across the Trust was 266.

Trust wide 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.

		Current compliance (Q2)	Direction of travel and previous compliance (Q1)
1.	Has a Risk Summary been completed?	100%	⇔100%
2.	Has the Clustering Assessment and Allocation been completed?	92%	⇧85%
3.	Has HEF been completed? (LD only)	N/A	N/A
4.	Has the Pre-Discharge Planning Form been completed?	27%	⇧25%
5.	Have the inpatient care plans been closed within 7 days of discharge?	11%	⇩20%
6.	Has the patient been discharged from bed?	99%	⇩100%
7.	Has the Nursing Discharge Summary Letter to Client/GP been sent within 24 hours of discharge?	87%	⇧83%
8.	Has the 48 hour follow up been completed if the Community Team are not doing it?	51%	⇩74%

Of the seven individual criteria assessed, compliance has increased for 3 criteria, remained the same for 1 criterion, and decreased for 3 criteria.

It has been noted by the data collector that more often than not, the patient care plans are not being closed within 7 days of discharge and this is often the case each quarter.

3. Has HEF been completed (LD only)
There were no applicable patients recorded as having a Learning Disability.

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 2017-18 transitions are also included below so that historical comparative information is available.

2017-18 Results

Gloucestershire Services.

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%	100%	75%

Herefordshire Services

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%	Not applicable	Not applicable

2018-19 Results

Gloucestershire Services

Criterion	Compliance Quarter 1 (2018/19)	Compliance Quarter 2 (2018/19)	Compliance Quarter 3 (2018/19)	Compliance Quarter 4 (2018/19)
Joint CPA Review	100%	100%		

Herefordshire Services

Criterion	Compliance Quarter 1 (2018/19)	Compliance Quarter 2 (2018/19)	Compliance Quarter 3 (2018/19)	Compliance Quarter 4 (2018/19)
Joint CPA Review	100%	NA		

During Quarter 1 all young people who transitioned into adult services had a joint CPA review. .

To improve our practice and documentation in relation to this target, a number of measures were developed during 2017-18 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 teams. Team Managers will monitor those who are coming up to transition discuss them with care coordinators in caseload management to see whether transition is clinically indicated.

These measures will continue to be used to promote good practice and as the target was not achieved last year and we will maintain this as a quality priority in 2018/19.

We met this target.

User Experience

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

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

The 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 2 2018/19 – July to September 2018) results:

Target 2.1 Were you involved as much as you wanted to be in agreeing the care you will receive? < 84%

Question	County	Number of responses	Target Met?
Were you involved as much as you wanted to be in agreeing the care you receive?	Gloucestershire	51 (38 positive)	75% TARGET 84%
	Herefordshire	18 (14 positive)	
	Total	62 (47 positive)	

This target has not been met.

Target 2.2 Have you been given information about who to contact outside of office hours if you have a crisis? > 71%

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	54 (46 positive)	86% TARGET 71%
	Herefordshire	17 (15 positive)	
	Total	71 (61 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? > 64%

Question	County	Number of responses	Target Met?
Have you had help and advice about taking part in activities that are important to you?	Gloucestershire	51 (41 positive)	**81%** **TARGET 64%**
	Herefordshire	16 (13 positive)	
	Total	67 (54 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? > 73%

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	46 (34 positive)	**76%** **TARGET 73%**
	Herefordshire	16 (13 positive)	
	Total	62 (47 positive)	

This target has been met.

Feedback from the Quality survey along with the National Community Mental Health survey results helped us to identify the need to increase the involvement of people in the development of their care plans. This is the focus of our work to implement an Always Event as part of the NHS England campaign.

Although response rates for the survey have increased over time the level of response continues to be lower than we would like. The introduction of new systems in Quarter 4 2018/19 to capture survey feedback aims to increase the number of response we receive to both aspects of the How did we do? survey

Friends and Family Test (FFT)

FFT responses and scores for Quarter 2, 2018/19

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.

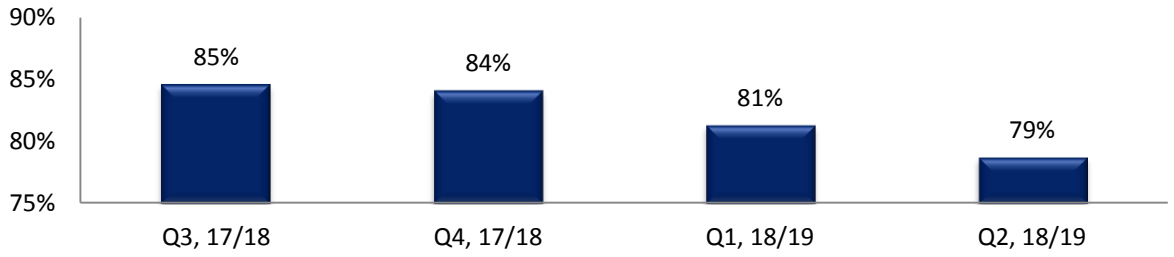
The table below details the number of combined total responses received by the Trust each month in Quarter 2. The FFT score is the percentage of people who stated that they would be 'extremely likely' or 'likely' to recommend our services. These figures are submitted for national reporting.

	Number of responses	FFT Score (%)
July 2018	365 (287 positive)	79%
August 2018	362 (289 positive)	80%
September 2018	293 (227 positive)	77%
Total	**1020** (803 positive) **(last quarter = 953)**	**79%** **(last quarter = 81%)**

The FFT score for our Trust this quarter has continued to decrease in line with an observed drop during previous quarters. This is disappointing when compared with our national survey results and compliments which suggest a high level of satisfaction with the services that we provide.

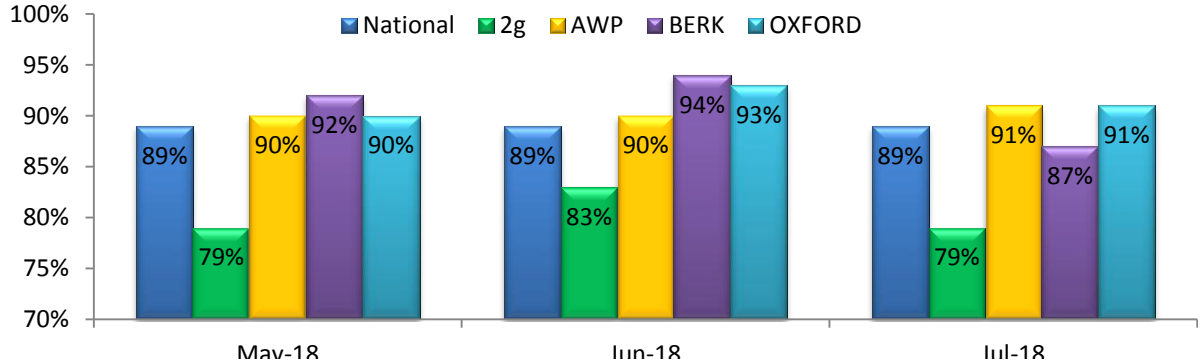
SED have undertaken further analysis of this quarter's FFT scores to review for any areas that are influencing decreased scores and are sharing with operational colleagues for further follow up and action.

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 generally receives mostly positive feedback.



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 May, June, and July 2018 (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 although we have achieved lower scores than other Trusts in our region in recent quarters. This is a reversal from previous years and does not triangulate with our positive National Survey scores (August and September 2018 data are 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 Trus

Complaints

To be completed at year-end

Safety

Protecting service users from further harm whilst they are in our care is a fundamental requirement. We seek to ensure 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 and last year the number of reported suspected suicides was **28.** By the end of Quarter 2 2018/19 we reported **10** suspected suicides which is lowest number reported since Quarter 2 2015/16. This is seen in Figure 4.

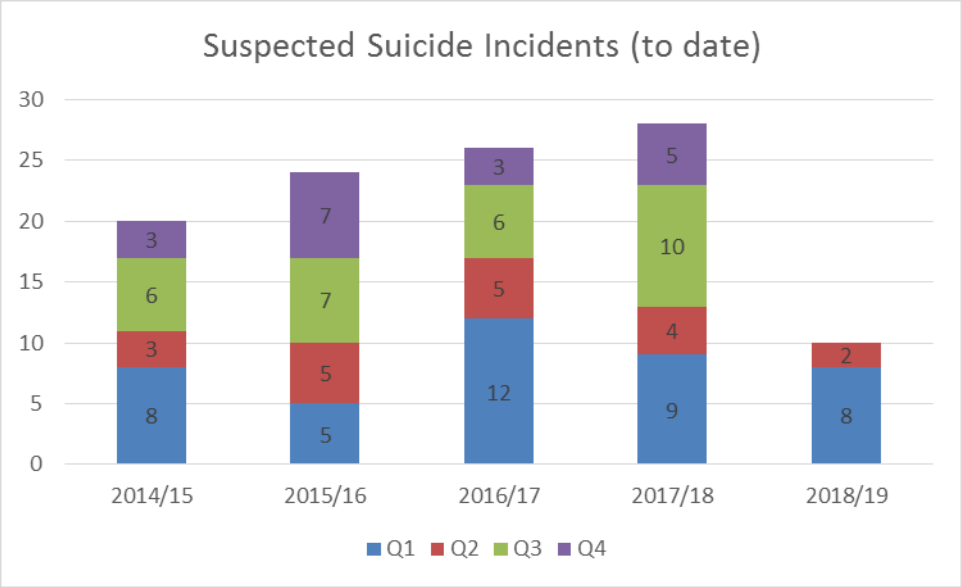


Figure 4

What we also know is that we are seeing more and more service users on our caseload year on year, so we measured this important target differently this year. This is also 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 2015/16, 2016/17 and 2017/18 the median value was 0.09. By the end of Quarter 2 2018/19 the median value remained has fallen to 0.06.

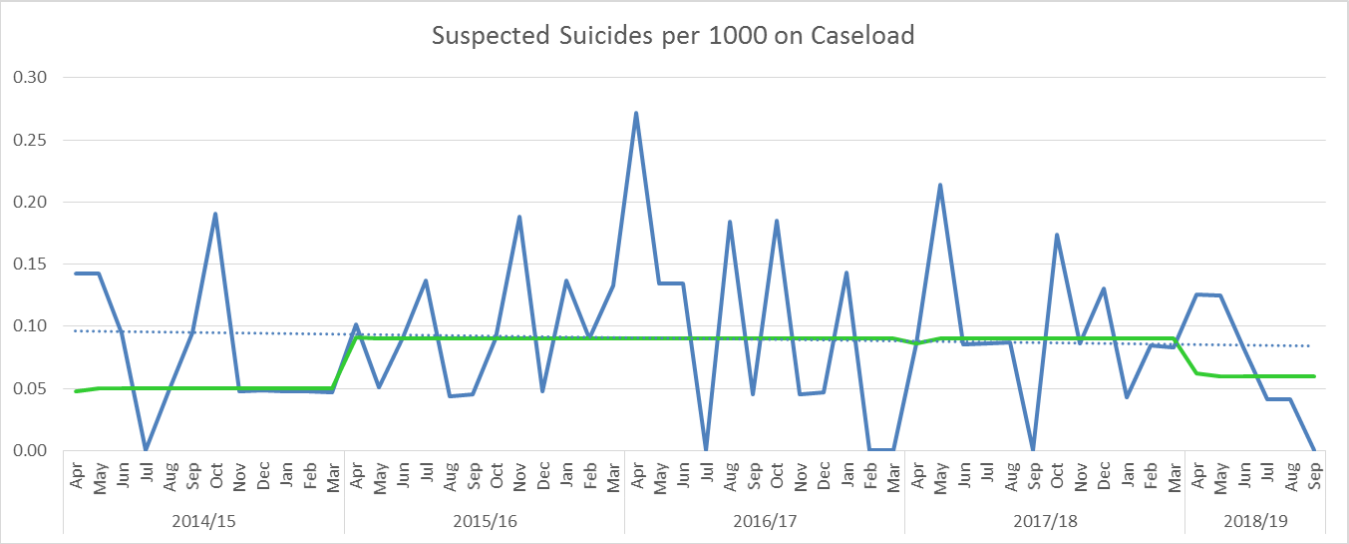


Figure 5

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.

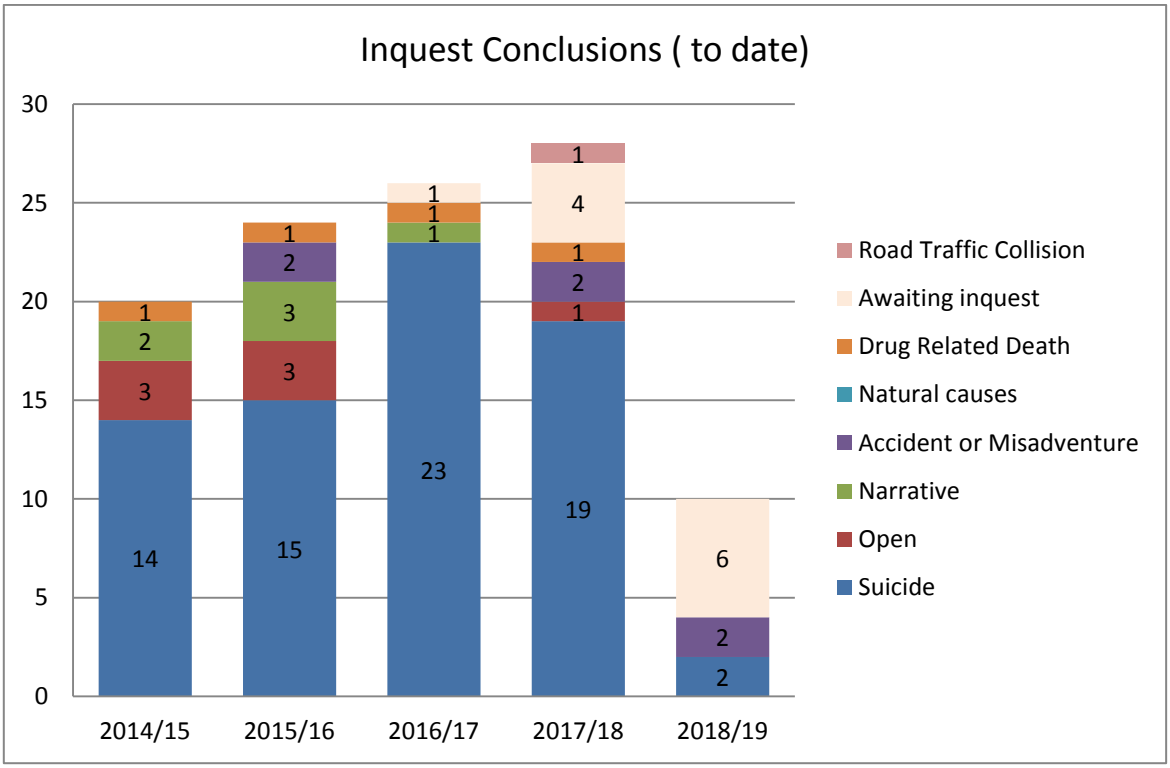


Figure 6

Information is provided below in Figures 7 & 8 for both Gloucestershire and Herefordshire services separately. It is seen that greater numbers of suspected suicides are reported in Gloucestershire services. There is no clear indication of why the difference between the two counties is so marked, but it is noted that the population of people in contact with mental

health services in Gloucestershire is greater, and the overall population of Gloucestershire is a little over three times that of Herefordshire (based on mid -2015 population estimates).

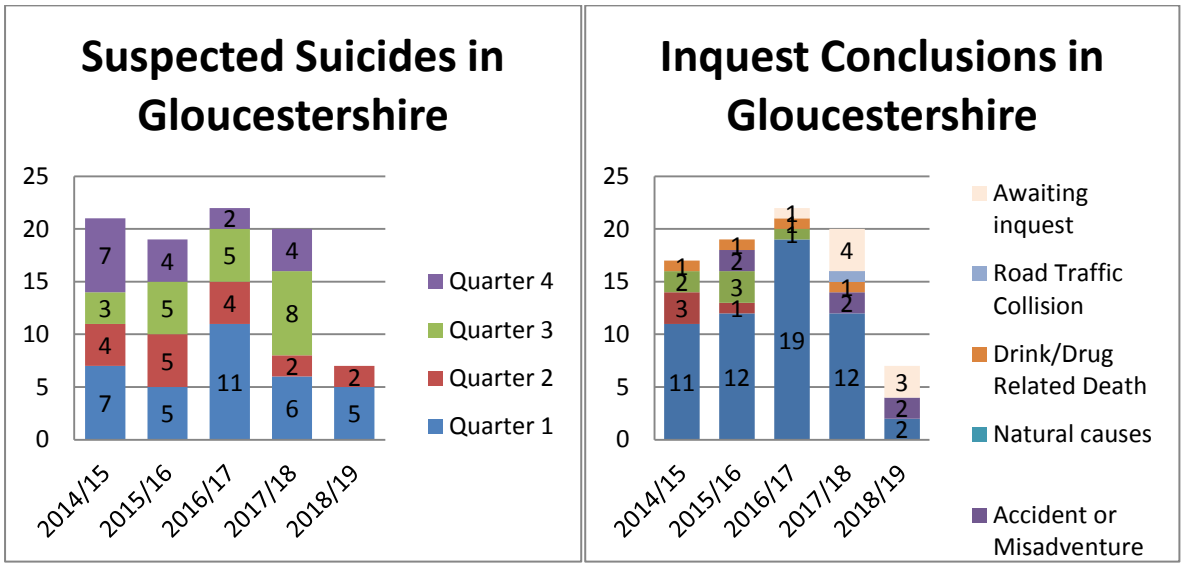


Figure 7

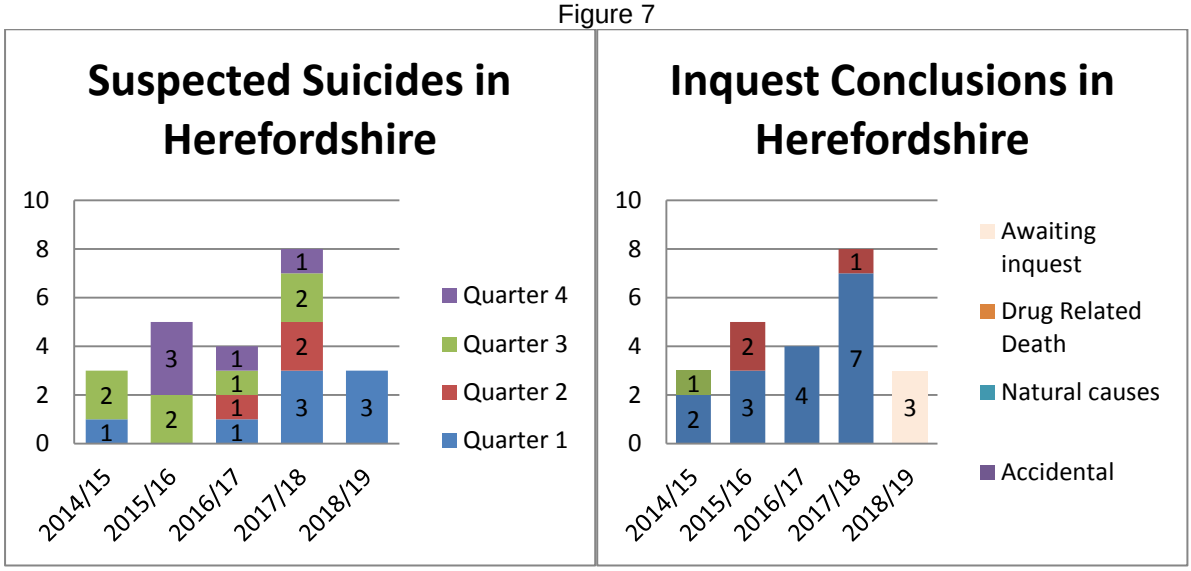


Figure 8

We will continue to work hard to identify and support those people experiencing suicidal ideation and aim to establish the interventions that will make the most impact for individuals. We launched the StayAlive App during 2017/18; this is a pocket suicide prevention resource for both people who are having thoughts of suicide and those who are concerned about someone else who may be considering suicide. This is available on AppStore and Google Play.

GRASSROOTS SUICIDE PREVENTION
Thinking about suicide? #StayAlive
prevent-suicide.org.uk

2gether Making life better

We are 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.

What we want to ensure is that no detained 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.

In **2015/16** we reported **114** occurrences of AWOL (83 in Gloucestershire and 31 in Herefordshire as seen in the table below.

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	55	19	9	**83**
Herefordshire	23	4	4	**31**
Total	**78**	**23**	**13**	**114**

None of these incidents led to serious harm or death.

In **2016/17** we reported **211** occurrences of AWOL (162 in Gloucestershire and 49 in Herefordshire detailed in the table below) so there was a considerable increase in the numbers of people who were AWOL. 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. **170** occurrences were reported during **2017/18.**

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	95	49	18	**162**
Herefordshire	40	4	5	**49**
Total	**135**	**53**	**23**	**211**

None of these incidents led to serious harm or death.

At the end of **2017/18** the following occurrences of AWOL were reported

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	72	59	11	**142**
Herefordshire	20	3	5	**28**
Total	**92**	**62**	**16**	**170**

None of these incidents led to serious harm or death.

At the end of **Quarter 1 2018/19** the following occurrences of AWOL have been reported.

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	19	13	3	**35**
Herefordshire	10	0	0	**10**
Total	**Q1 29**	**Q1 13**	**3**	**45**

None of these incidents led to serious harm or death.

At the end of **Quarter 2 2018/19** the following occurrences of AWOL have been reported.

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	16	15	1	**32**
Herefordshire	18	0	1	**19**
Total	**Q2 34**	**Q2 15**	**2**	**51**

None of these incidents led to serious harm or death

We are meeting this target

Target 3.3 To increase the use of supine restraint as an alternative to prone restraint (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. Overall, we wished to reduce the use of prone restraint by 5% year on year.

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 Behavior 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 Behavioral 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 which was an overall increase and by the end of 2017/18, **229** instances of prone restraint were used so we did not see a 5% reduction by year end.

In reviewing our restraint data in detail over the past 2 years, we have, however, seen an encouraging increase in the use of supine restraint as an appropriate less risky alternative to prone restraint. In 2018/19 our aim is, therefore, be to see an increase in the use of supine restraint as an alternative to prone restraint. Our target will be to see a greater percentage of supine restraints compared to prone.

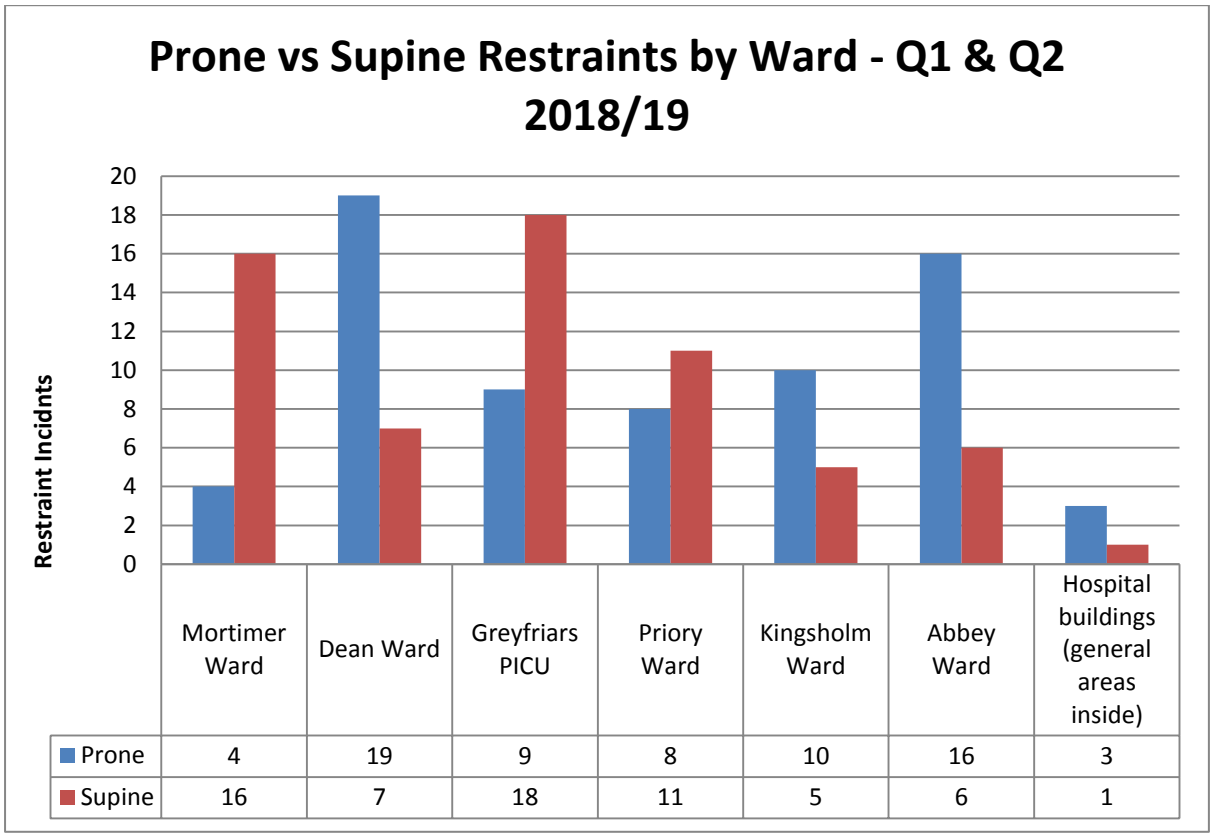


Figure 9

Figure 9 shows that during Quarters 1 & 2 **69** instances of prone restraint were used compared to **64** instances of supine. Figure 10 below compares 2017/18 and 2018/19 prone restraint data and from this analysis it is clear that the use of prone restraint has reduced by greater than 5% this year.

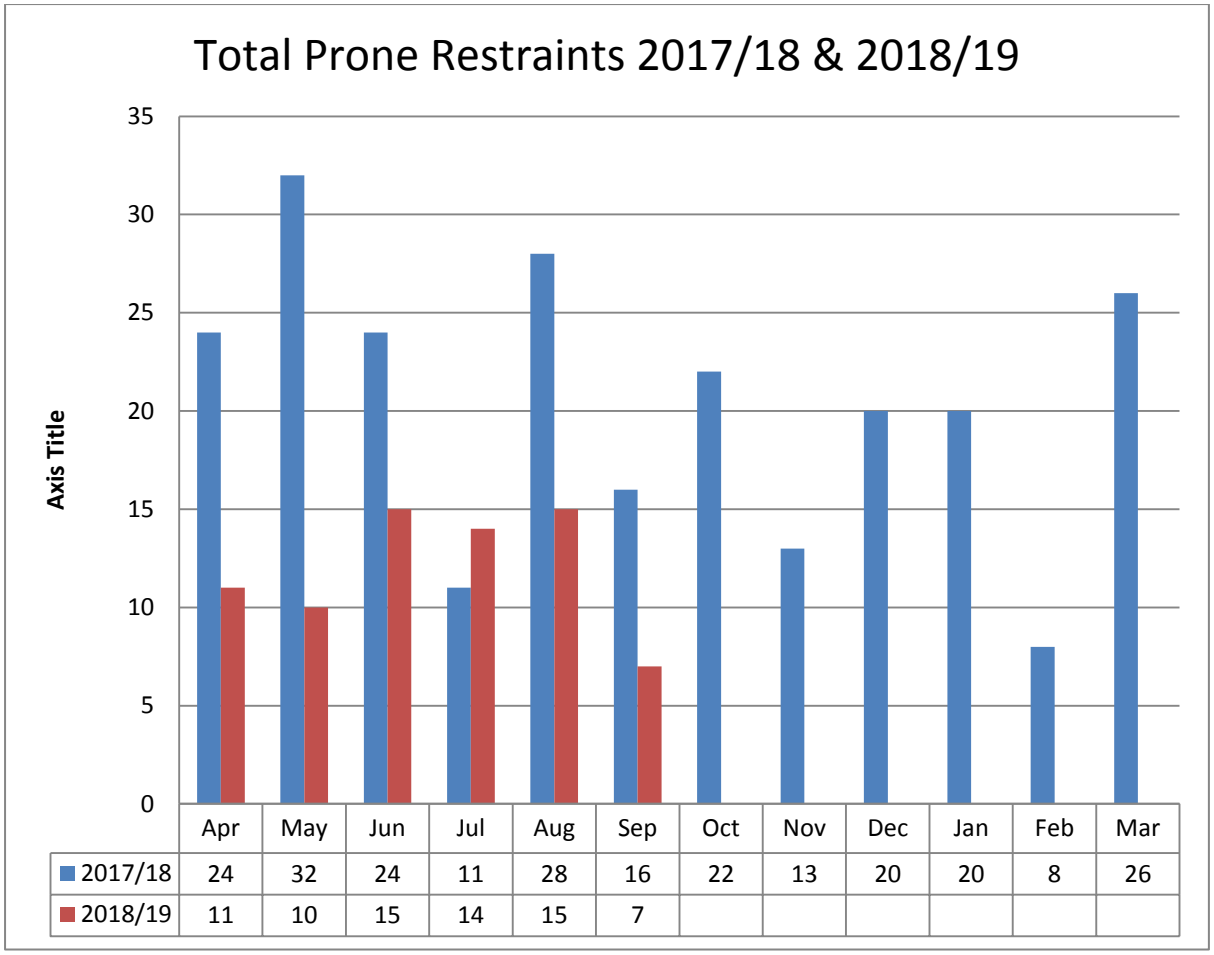


Figure 10

We are on trajectory to meet this target.

Target 3.4 To ensure that 100% of service users within Berkeley House have a bespoke restrictive intervention care plan tailored to their individual need.

Berkeley House currently has 6 patients all of whom have specific care plans for Positive Behaviour Management (PBM) interventions, these care plans are on RiO and a copy of an accessible care plan is available for the patient.

They also have Positive Behavioural Support (PBS) plans which contain detailed information regarding primary, secondary and tertiary strategies for each person. Within these plans are functional assessments of behaviours that individuals may display. These also include what a good day looks like and individualised strategies to manage behaviours when a patient begins to show signs of distress.

Primary prevention strategies aim to enhance the service users' quality of life and meet their unique needs thereby reducing the likelihood of behavioural disturbances.

Secondary prevention strategies focus on the recognition of early warning signs of impending behavioural disturbance and how to respond in order to encourage the patient to be calm.

Tertiary strategies guide the responses required to manage behavioural disturbance and acknowledge that the use of proportionate restrictive interventions may be required to minimise harm.

Alongside these patients have activity care plans providing information on preferred activities, likes and dislikes and implementation of activities for each individual. All patients also have a Health Action Plan and health and wellbeing care plan that gives information on health issues thus minimising possible influences pain may have an individual's behaviour.

All these plans are written following assessment and advice obtained from PBM trainers about any patient specific interventions (2 staff at Berkeley House are also PBM trainers). Also included in these plans are sensory interventions formulated by an occupational therapist which are implemented at associated primary and secondary phases appropriate for each individual.

All patients have a bespoke PBM assessment and care plan, this is written in conjunction with the Behaviour Support & Training Team, the two PBM trainers we have within the staffing establishment at Berkeley House and the wider Multidisciplinary team. These plans include sensory interventions formulated by an occupational therapist. The PBM assessment (Individual Patient Physical Intervention Technique Checklist) clearly identifies techniques to be implemented for each individual as and when proportional to the risk to self and others.

Patients are physically monitored following all physical interventions to ensure that any concerns of physical harm or distress are acted upon within a timely manner. Where appropriate debriefs would be offered to patients post incident.

There are staff debriefs after any incidents of intervention, during which they are able to reassess and evaluate interactions and change care plans accordingly to better meet patient needs. Incidents are logged and discussed at MDT each week and interventions reviewed.

We have met this target.

Serious Incidents reported during 2018/19

By the end of Quarter 2 2018/19, **14** serious incidents were reported by the Trust; the types of these incidents reported are seen below in Figure 12.

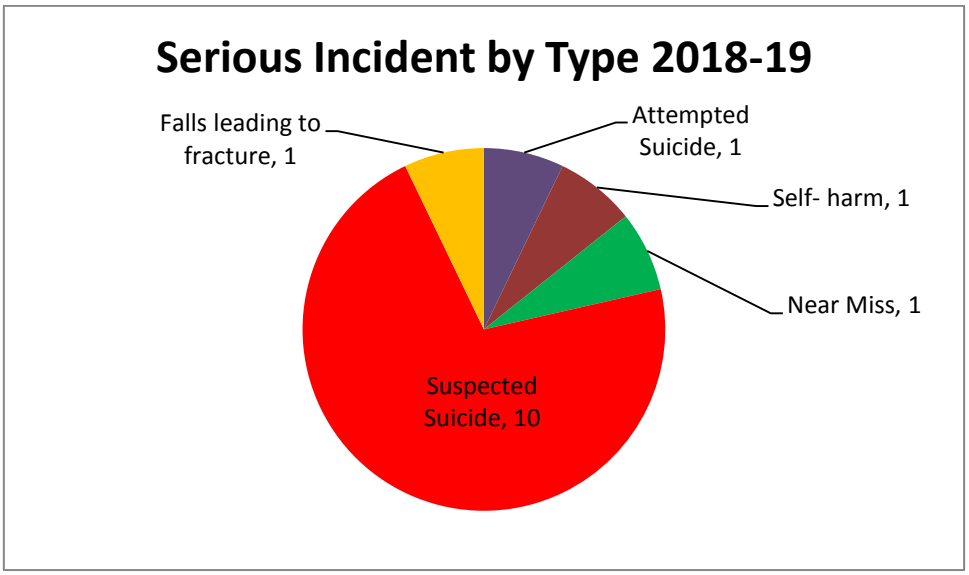


Figure 11

Figure 13 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 appointed a whole time equivalent Lead Investigator commenced this important work in May 2017, and 2 further dedicated Investigating Officers are now available via the Trust’s Staff Bank.

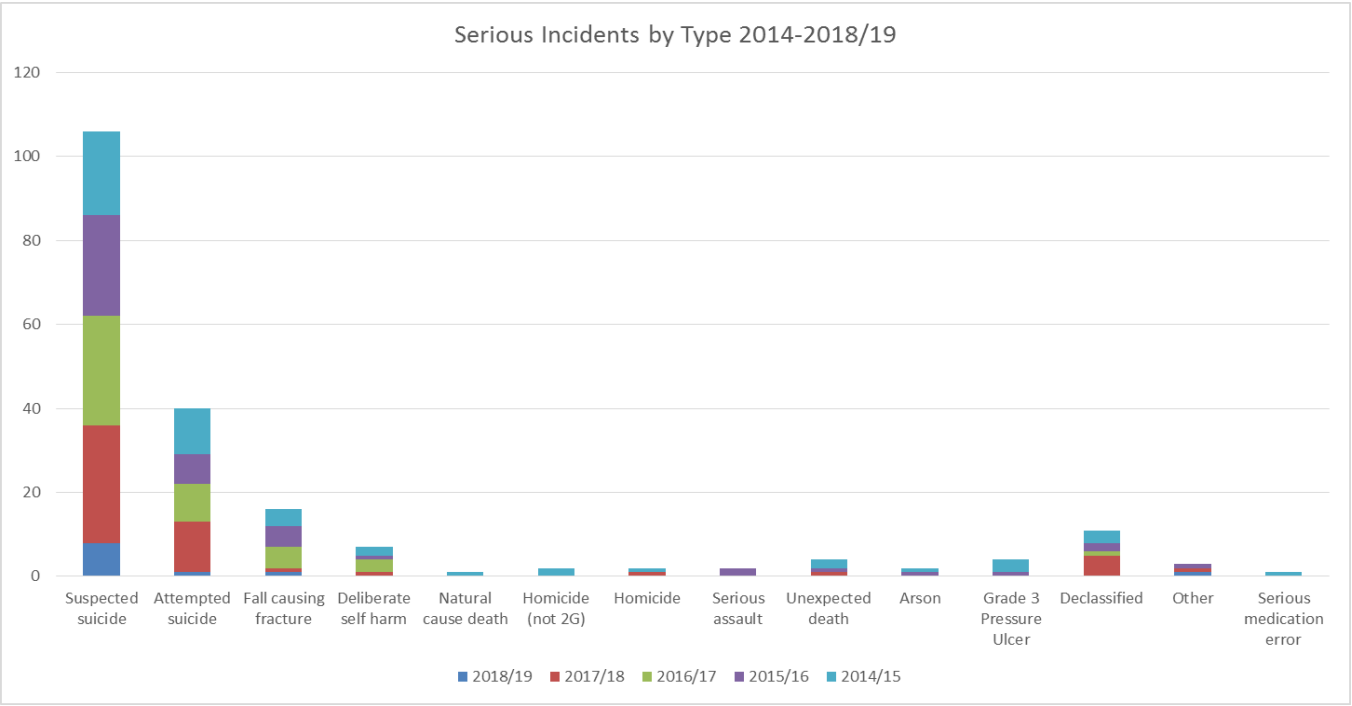


Figure 12

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 and copies of our investigation reports. 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 a further 20 staff attended an additional Hundred Families workshop regarding 'Involving Families in Serious Incidents' in November 2017. During 2018/19 we will also be developing processes to provide improved support to people bereaved by suicide and in May 2018 18 staff were trained in Postvention techniques by the charity Suicide Bereavement UK.

The Trust also 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 2018/19. 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 in 2015, 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.

We are aware that further work is required to ensure that all incidents of moderate harm are appropriately reported and that the service user experiencing this harm is fully informed and

supported. This will be a key area of further development and consolidation throughout 2018/19.

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.

NHSI Indicators 2018/2019

The following table shows the NHSI mental health metrics that were monitored by the Trust during 2018/19.

		2016-2017 Actual	National Threshold	2017-2018 Actual	2018-2019 Actual
1	Early Intervention in psychosis EIP: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	**71.3%**	50%	**70%**	**72%**
2	Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered routinely in the following service areas: -inpatient wards -early intervention in psychosis services -community mental health services (people on CPA)	 - - -		 **95%** **92%** **90%**	**YE**
3	Improving access to psychological therapies (IAPT): Proportion or people completing treatment who move to recovery (from IAPT database) Waiting time to begin treatment (from IAPT minimum dataset - treated within 6 weeks of referral - treated within 18 weeks of referral	**-** **37.8%**	50% 75% 95%	**50%** **67%** **85%**	**52%** **94%** **96%**
4	Admissions to adult facilities of patients under 16 years old.	**-**		**1**	**0**
5	Inappropriate out-of area placements for adult mental health services	**-**		**24**	**22**

Community Survey 2018

To be completed at year-end

Staff Survey 2018

To be completed at year-end

PLACE Assessment 2018

Site Name	Cleanliness	Food Overall	Organisational Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Overall 2gether Trust Score: (taken from Organisation Average)	**99.64%**	**94.60%**	**92.43%**	**98.37%**	**93.11%**	**99.20%**	**90.18%**	**91.19%**
BERKELEY HOUSE	**100.00%**	**94.66%**	**90.79%**	**99.45%**	**100.00%**	**99.45%**	**N/A**	**93.77%**
CHARLTON LANE	**100.00%**	**96.55%**	**94.51%**	**100.00%**	**94.53%**	**99.84%**	**99.02%**	**92.69%**
WOTTON LAWN	**99.94%**	**95.04%**	**92.80%**	**100.00%**	**93.75%**	**99.88%**	**N/A**	**89.52%**
HONEYBOURNE	**99.13%**	**94.89%**	**91.10%**	**100.00%**	**94.53%**	**99.59%**	**N/A**	**92.43%**
LAUREL HOUSE	**100.00%**	**94.34%**	**88.87%**	**100.00%**	**94.53%**	**99.64%**	**N/A**	**95.92%**
STONEBOW UNIT	**98.62%**	**91.93%**	**91.20%**	**92.93%**	**89.49%**	**97.59%**	**81.53%**	**91.77%**
OAK HOUSE	**100.00%**	**N/A**	**N/A**	**N/A**	**90.32%**	**96.88%**	**N/A**	**86.67%**
National Average MH/LD	98.40%	90.60%	88.80%	92.30%	91.00%	95.40%	88.30%	87.70%
National Average	98.50%	90.20%	90.00%	90.50%	84.20%	94.30%	78.90%	84.20%
lowest	74.80%	60.70%	49.50%	48.10%	53.90%	68.80%	45.60%	50.20%
highest	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Key

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

These results are very positive and for the first time since PLACE began the Trust is above the national average for Mental Health and Learning Disability settings in all six domains. The overall results clearly demonstrate how as a Trust we are improving the quality of the non-clinical services provided to our patients.

Cleanliness performed really well this year and the Trust overall score was over 1% higher than the National average, with four of the seven sites assessed scoring 100%.

The Food assessment scored well this year and the Trust overall score was 4% higher than the National average. The ward 'food tasting' scored particularly well this year with four out of six sites scoring 100% for taste, texture, temperature and appearance.

In comparison with our local healthcare partners in Gloucestershire we achieved a higher average domain score than GCS and GHT in all domains.

In terms of individual site ranking Charlton Lane achieved the highest site average score of 97.14 followed closely by Berkeley House who achieved 96.87%

Annex 1: Statements from our partners on the Quality Report

To be completed at year-end

The Royal College of Psychiatrists

To be completed at year-end

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

To be completed at year-end

Annex 3: Glossary

ADHD	Attention Deficit Hyperactivity Disorder
BMI	Body Mass Index
CAMHS	Child & Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
CPA	Care Programme Approach: a system of delivering community service to those with mental illness
CQC	Care Quality Commission – the Government body that regulates the quality of services from all providers of NHS care.
CQUIN	Commissioning for Quality & Innovation: this is a way of incentivising NHS organisations by making part of their payments dependent on achieving specific quality goals and targets
CYPS	Children and Young Peoples Service
DATIX	This is the risk management software the Trust uses to report and analyse incidents, complaints and claims as well as documenting the risk register.
GriP	Gloucestershire Recovery in Psychosis (GriP) is ^{2}gether's specialist early intervention team working with people aged 14-35 who have first episode psychosis.

HoNOS	Health of the Nation Outcome Scales – this is the most widely used routine Measure of clinical outcome used by English mental health services.
IAPT	Improving Access to Psychological Therapies
Information Governance (IG) Toolkit	The IG Toolkit is an online system that allows NHS organisations and partners to assess themselves against a list of 45 Department of Health Information Governance policies and standards.
MCA	Mental Capacity Act
MHMDS	The Mental Health Minimum Data Set is a series of key personal information that should be recorded on the records of every service user
Monitor	Monitor is the independent regulator of NHS foundation trusts. They are independent of central government and directly accountable to Parliament.
MRSA	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. It is also called multidrug-resistant
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:

Paul Roberts
Chief Executive
2gether NHS Foundation Trust
Rikenel
Montpellier
Gloucester
GL1 1LY

Or email him at: paul.roberts@glos-care.nhs.uk

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: [2]gether NHS Foundation Trust Board November 2018
Author: Angie Fletcher, Service Experience Clinical Manager
Presented by: Jane Melton, Director of Engagement and Integration
Subject: **Service Experience Report Quarter 2 2018/19**

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 2018/19. Learning from people's experiences is the key purpose of this paper, which provides assurance that service experience information has been reviewed, scrutinised for themes, and considered for both 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, 79% of people who completed the Friends and Family Test said that they would recommend [2]gether's services. Response rates have continued to increase this quarter meaning that more feedback was received and this may have an impact on the overall FFT score.

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 2017/18. Whilst feedback given by respondents has generally been positive, response rates remain lower than hoped for. Quarter 2 2018/19 has seen a consistency in the numbers of responses received. The SED are working to implement a new system to receive collate and analyse feedback to encourage more responses to our surveys. This system is hoped to be implemented by Q4 2018/19.

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 again 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.
92% of complaints were closed within timescales agreed with the complainant. This is an increase from previous Quarters (90%). The SED are working hard with Trust colleagues to ensure that future complaints are closed in a timely way.

<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.

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

- We must explain who is doing what in a person's care.
- We must think carefully about the words that we use when talking with people.

An update on complaints referred for external review following investigation by our Trust is included within this report.

RECOMMENDATIONS

The Trust Board is asked to:

- Note the contents of this report

Corporate Considerations	
Quality Implications	Patient and carer experience is a key component of the delivery of best quality of care. The report outlines what is known about experience of ^{2}gether's services in Q2 2018/19 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. This paper offers limited assurance on 1 aspect covered by the report. The SED are working with operational and clinical colleagues in order to identify and mitigate any risks associated with this. The SED closely monitor performance indicators relating to areas of limited assurance and regularly review the mitigating actions accordingly.

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:		
Lauren Edwards, Deputy Director of Integration	Date	11th October 2018

Where in the Trust has this been discussed before?		
Quality and Clinical Risk Sub-committee	Date	19th October 2018
Governance Committee		26th October 2018

Explanation of acronyms used:	
NHS	National Health Service
PALS	Patient Advice and Liaison Service
CYPS	Children and Young People Service
SED	Service Experience Department
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
CQC	Care Quality Commission
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
Q2	Quarter 1 (previous quarter (2018/19)
FFT	Friends and Family Test (survey)

2gether
Making life better

2gether
NHS Foundation Trust

Service Experience Report

Quarter 2

1st July 2018 to 30th September 2018

"Thank you for…this morning's racquetball session. The guys just love it and it brings out all this positive energy, thanks for your motivating skills and ability to make it such fun!"

Adult Learning Disabilities Service, Herefordshire

"Thank you CLDT – you listen when I am worried about my sister, and I appreciate the support."

Community Learning Disabilities Team, Gloucestershire

Contents

Key

NHS	National Health Service
PALS	Patient Advice and Liaison Service
CYPS	Children and Young People Service
SED	Service Experience Department
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
CQC	Care Quality Commission
CHI ESQ	Children's Experience of Service Questionnaire
CAMHS	Child and Adolescent Mental Health Service
Mental Health Act	Mental Health Act
MCA	Mental Capacity Act
CCG	Clinical Commissioning Group
Q1	Quarter 1 (previous quarter 2018/19)
FFT	Friends and Family Test (survey)

Service Experience Report

1st July 2018 to 30th September 2018

Complaints 	**14** complaints were made this quarter. This is less than last time (Q1=17). We want people to tell us about any worries about their care. This way we can help to make things better.	↓
Concerns 	**89** concerns were raised through PALS. This is a lot more than last time (Q1=61).	↑
Compliments 	**479** people told us they were pleased with our service. This is more than last time (Q1=396). We want teams to tell us about every compliment they get.	↑
FFT 	**79%** of people said they would recommend our service to their family or friends. This is about the same as last time (Q1=81%).	↔
Quality Survey 	Gloucestershire: **54** people told us what they thought. This is a more than last time (Q1=41) Herefordshire: **18** people told us what they thought. This is less than last time (Q1=25) We want more people to tell us what they think.	↔ (number of replies)
We must listen 	We must explain who is doing what in a person's care We must think carefully about the words that we use when talking with people.	

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 2018 and 30th September 2018**. 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 identified through analysis of reported service experience and the 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) (see below). The Service Experience Strategy will be reviewed and updated during 2018/19 in collaboration with our stakeholders.

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:

Our vision for best Service Expereince: *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

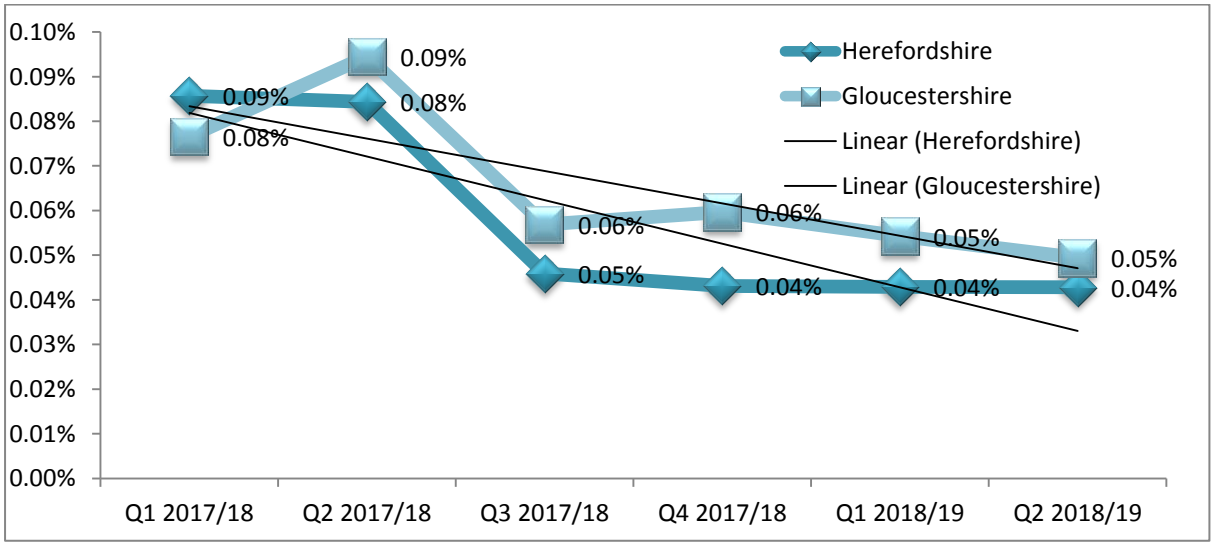
2.1 Complaints

2.1.1 Formal complaints to NHS service providers are highly governed and responses must follow specific procedures (for more information, please see the Trust's Policy and Procedure on Handling and Resolving Complaints and Concerns). 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 issues at the earliest possible opportunity.

Table 1: Number of complaints received this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	12	↓	The number of complaints reported in Gloucestershire has decreased from the previous quarter (Q1=15)	Significant
Herefordshire	2	↔	The number of complaints reported in Herefordshire is consistent with the previous quarter (Q1=2)	Significant
Total	14	↓	The total number of complaints received has decreased from the previous quarter (Q1=17)	Significant

Figure 1: Percentage of complaints received (calculated by the number of individual service user contacts) per quarter plus the associated trend line over time.



2.1.2 Figure 1 shows the percentage of complaints received in relation to the number of individual contacts made with our services during each quarterly period since Q1 2017/18. Whilst there have been minor fluctuations quarter by quarter, a continual low level of complaints to contacts has been observed with a gradual downwards trend over time.

2.1.3 Table 2 summarises our responsiveness. This quarter has seen an improvement in the percentage of complaint responses received by complainants within the agreed timescale.

Table 2: Responsiveness

Target	% Number	Direction compared with Q3	Interpretation	Assurance
Acknowledged with three days	100%	⟷	**All** complaints were acknowledged within target timeframes (Q1=100%)	**Full**
Response received within agreed timescales	92%	↑	This is higher than last quarter (Q1=90%). Two letters of response were not received by the complainant within the timescale agreed.	**Significant**
Concerns escalated to complaint	2%	↓	Of 86 concerns closed (Q1=60 closed), 2 were escalated to a formal complaint; this is less than last quarter (Q1=3%)	**Significant**

2.1.4 Two complaint responses were not received within agreed timescales. One was overdue by two days due to delay within quality review processes. The other was delayed due to the complexity of the complaint meaning that further investigation was required. On both occasions the complainant was contacted in order to provide an explanation, an apology, and an expected date that our response would be sent to them

2.1.5 The SED continue to monitor delayed response rates carefully, working closely with operational and corporate colleagues to ensure that the complaints policy is adhered to in relation to all aspects of complaint handling.

Table 3: Satisfaction with complaint process

Measure	Number (numerical direction)		Interpretation	Assurance
Reopened complaints	3	↓	This figure is less than the previous quarter (Q1=6)	**Significant**
Local Resolution Meetings	1	⟷	This figure is the same as the previous quarter (Q1=1)	**Significant**
Referrals to external review bodies	0	↓	No complaints were referred for external review (Q1=2). See Table 13 for more detail.	**Full**

2.1.6 In Quarter 2 a total of three complaints were reopened. Two of those were complaints that closed during Quarter 2 2018/19 (total closed Q2=24) and were closed again after follow-up action taken by SED. The remaining complaint was closed in Quarter 1 and remains open whilst resolution work is being undertaken. One local resolution meeting occurred and the complaint was closed following this. No new referrals were made to external bodies during this time period.

2.1.7 Analysis of data is undertaken by the SED in order to identify any patterns or themes. Analysis of complaint themes from complaints closed during Quarter

2 is shown by the status of complaint outcome (Table 4) and by staff group involved in individual issues of complaint (Table 5).

Table 4: Outcome of complaints closed this quarter

Outcome	No.	%
Not upheld *No element of the complaint was upheld*	11	46%
Partially upheld *Some elements of the whole complaint were upheld*	11	46%
Upheld *All elements of the whole complaint were upheld*	2	8%
Withdrawn *Complaint was withdrawn*	0	0%

Following feedback from complainants and stakeholders, the Trust no longer uses the terms upheld/partially upheld/not upheld within our response letters. However, these categories are required to be recorded for national reporting purposes.

In total, 24 complaints were closed this quarter. This is double the amount closed in Quarter 1 (n=12).

54% of the complaints closed this quarter had at least some or all issues of complaint upheld. This is similar to Quarter 1 (58% upheld/partially upheld).

**Individual issues within each formal complaint are either upheld or not upheld. Partially upheld is not used for individual issues, the term is used to classify the overarching complaint where some but not all of the issues were found to have been upheld. Percentages rounded to nearest whole number*

Table 5: Breakdown of closed complaint issues by staff group for Quarter 2

Outcome	Total No.*	Upheld	Not upheld	Withdrawn
Medical	18	0	18	0
Nursing	75	17	58	0
Psychology	10	0	10	0
HCA	6	2	4	0
Admin	2	1	1	0
Physiotherapy	1	1	0	0
Occupational Therapy	2	0	2	0
Psychological Wellbeing Practitioner	2	2	0	0
Social Work	3	0	3	0
No staff group	3	2	1	0

The number of complaint issues involving different disciplines and staff groups is recorded for *NHS Digital*. The SED have continued to refine Datix inputting in order to capture all disciplines identified within issues of complaints.

Quarter 2 figures continue to show nursing as the main staff group identified within complaints. Nursing represents the largest staff group in the Trust and has the greatest number of individual contacts with service users and carers. Further analysis of this data undertaken by SED has identified the themes from these upheld complaints to be communication with carers and relatives and accuracy of information contained within health records.

Out of a total of 75 issues identifying nurses, 17 of these concerns were upheld following investigation (23%).

Work is ongoing to 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*

2.1.8 Table 6 provides an overview of the issues of complaint in the context of the investigation outcome (upheld or not upheld). Analysis of this information shows that the main theme emerging from the Q2 issues of complaint that were upheld following investigation, related to aspects of the reported experience of **communication**.

2.1.9 Further analysis of upheld issues relating to **communication** is shown in Figure 2.

Table 6: Overarching closed complaint themes

Theme	Chart showing number of issues raised and their outcome
Access to services *Incl. treatment/drugs*	
Admission/discharge *Discharge planning*	
Appointments *Waiting times, referrals*	
Clinical treatment *e.g. observation, support*	
Communication *Internal and external*	
Facilities *Accessibility*	
Other *Home visits*	
Patient care *e.g. not followed*	
Prescribing *All aspects of prescribing*	
Privacy *Incl. dignity and wellbeing*	
Trust policy *e.g. not followed*	
Staff attitude *Values and attitude*	
Waiting times *Waiting times*	

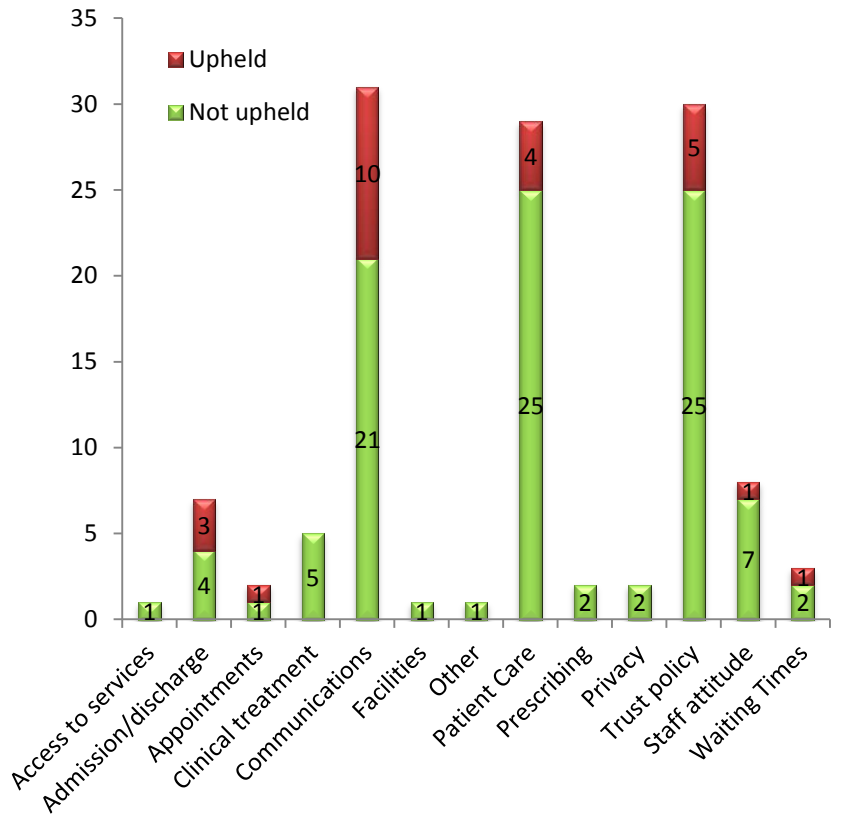
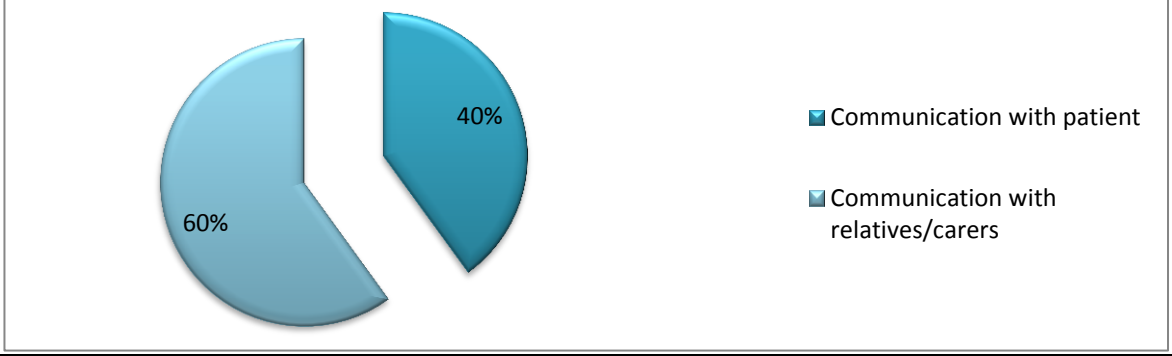


Figure 2: Review of identified complaint themes

Breakdown of upheld complaint issues

Our Trust takes all concerns very seriously. The themes reflected below demonstrate the outcomes of complaint issues that have been investigated and upheld. The main upheld complaint theme relates to ***communication*** and is analysed further below:



2.1.10 Communication is a recurrent theme found following the investigation of complaints. Further analysis of this theme shows that the areas that were upheld following investigation are the accuracy of health records and relatives and carers having the plan of care and/or the next steps to be taken shared with and explained to them.

The SED have continued to work with operational colleagues throughout Quarter 2 to implement new systems of learning from service experience feedback. Practice notes detailing learning from complaints are now produced monthly and disseminated throughout our locality governance boards for onward review and discussion by our teams and services. The learning detailed in Figure 2 has been included in this quarter's practice notes.

Individual examples of actions taken by Trust colleagues linked to the thematic data are detailed further in Table 8.

Table 8: Examples of complaints closed and action taken

Example	You said	We did	Assurance
Care and treatment	A number of my son's appointments have been cancelled by the team, leaving us with no support.	We apologised and explained that to cover staff absence we had arranged for staff from other teams to provide support instead. We agreed to monitor appointments cancelled by our staff in the same way we monitor "Did Not Attend" rates.	**Significant**
Access to services	My team ignored recommendations made by another of your Trust's teams and did not offer me the support I needed	We apologised that the recommendations made by another team were not within the remit of services that our Trust provides. We agreed that this led to you feeling let down and have shared the feedback and learning with colleagues to help prevent future similar occurrences.	**Significant**
Communication	I found out that I had been discharged from services when I received a Friends and Family Test survey via text message.	We apologised for this and explained that the discharge process involves a discharge letter being sent to you and your GP. Our staff also note the discharge on a person's electronic health care record which automatically triggers a text message to be sent requesting feedback. On this occasion the electronic process was implemented faster than the postal notification. Adjustments have been made to the notification system for text messages to help prevent this happening again.	**Significant**

2.2 Concerns

2.2.1 Our Trust 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 this quarter. Data regarding the concerns received by our SED have been analysed and are reflected in Table 9.

Table 9: Number of concerns received this quarter

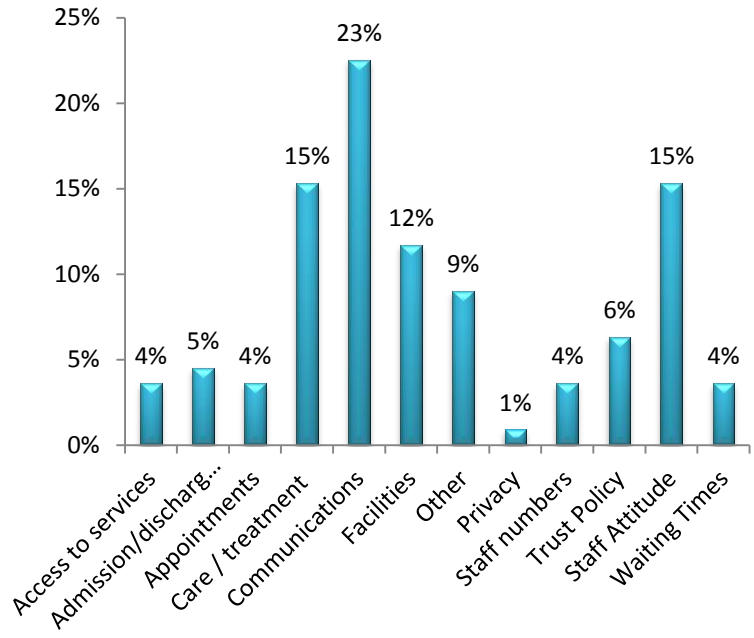
County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	63	↑	The number of concerns raised in Gloucestershire is higher than the last quarter (Q1=46)	Significant
Herefordshire	16	↑	The number of concerns raised in Herefordshire is higher than the last quarter (Q1=10)	Significant
Corporate	10	↑	There are more concerns relating to corporate services compared to last quarter (Q1=4)	Significant
Total	89	↑	The number of concerns raised is higher than last quarter (Q1=60)	Significant

2.2.2 The number of concerns raised remains relatively consistent with previous quarters but has risen slightly by comparison to last quarter. The increase is mainly due to the ongoing programme of PALS visits to our inpatient services in order to seek feedback from those who use our services.

There were also 103 other contacts with our Service Experience Department during Quarter 2 (Q1=53) covering a range of topics. This provides us with the assurance that more people are contacting the SED with queries although the number of complaints and concerns received remain consistently low compared to the number of clinical contacts.

Table 10: Overarching concern themes this quarter

Theme	No.*	Chart showing percentages
Access to services *Treatment or medication*	4	
Admission/discharge *Community or inpatient*	5	
Appointments *e.g. cancelled, staff DNA*	4	
Care and treatment *e.g. observation, support*	17	
Communication *Internal and external*	**25**	
Facilities *e.g. temperature*	13	
Other *e.g. loss of belongings*	10	
Privacy *e.g. dignity and wellbeing*	1	
Staff numbers *e.g. short staffing*	4	
Trust policy *e.g. Health Records, MHA*	7	
Staff attitude *Behaviour and actions*	17	
Waiting times *e.g. waiting list*	4	



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

2.2.3 Table 10 outlines the themes of concerns that have been closed this quarter. The main theme identified is ***Communication***, and this is consistent with the main theme of our formal complaints.

2.2.4 Table 11 demonstrates the staff groups referred to in individual concerns.

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

Outcome	No	%
Admin	7	7%
Medical	**31**	**29%**
Domestics / Catering Staff	1	1%
Executive Director	1	1%
Manager (non-clinician)	2	2%
Nursing	**26**	**25%**
Psychologist	2	2%
Social Worker	4	4%
None	14	13%
Other	18	17%

As outlined in Table 5, nursing represents the largest staff group in the Trust and has the greatest number of contacts with service users and carers.

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

2.2.5 Examples of concerns and actions taken during Quarter 1 are shown below in Table12.

Table 12 Examples of concerns and action taken:

Example	You said	We did	Assurance
Food hygiene	I think the food on my ward is left out too long before serving.	Our Facilities department reviewed the process of how food is served on the wards and found that hotplates were not always switched on – this has now been remedied.	**Significant**
Access to services or treatment	I have been waiting for several months for an ADHD assessment. Every time I ring I get told something different.	We apologised for the varying information you received, clarified how referrals are being managed, and explained our expected timeframes.	**Significant**
Communication	I am unhappy with the content of my discharge letter – can it be amended?	We contacted the author of the letter who listened to your concerns and made amendments where possible.	**Significant**
Access to services or treatment	I have some concerns about my neighbour's behaviour as he seems to be becoming unwell – what can I do?	We explained that we would check if your neighbour has a mental health team and if so alert them to your concerns.	**Significant**

2.2.5 PALS Visits

2.2.5.1 Patient Advice and Liaison Service (PALS) visits are undertaken in our clinical services to ensure that people's concerns are heard and resolved as soon as possible. Visits to Wotton Lawn Hospital and Charlton Lane Hospital in Gloucestershire, and Stonebow Unit in Herefordshire, were undertaken during Quarter 2.

2.2.5.2 During each visit the SED PALS Officers visited the designated wards and spoke with service users and families/carers.

2.2.5.3 PALS provided the following types of support and assistance during visits undertaken in Quarter 2:

- Assisting service users to resolve queries relating to the ward environment.
- Providing support about how to give feedback about Trust services.
- Receiving compliments about the ward and our staff from both service users and members of their families.
- Listening to service users' and carers' experiences of our wards.
- Responding to concerns and queries by liaison with staff and ward managers

2.2.5.4 The majority of feedback given has been positive and any issues raised were reported directly to the ward for timely resolution wherever possible. A summary report of each visit is sent by the PALS Officers to the Ward Manager, Modern Matron, Deputy Director of Nursing, and Locality Governance Lead. SED have successfully recruited a PALS volunteer to support ongoing PALS visits throughout the Trust.

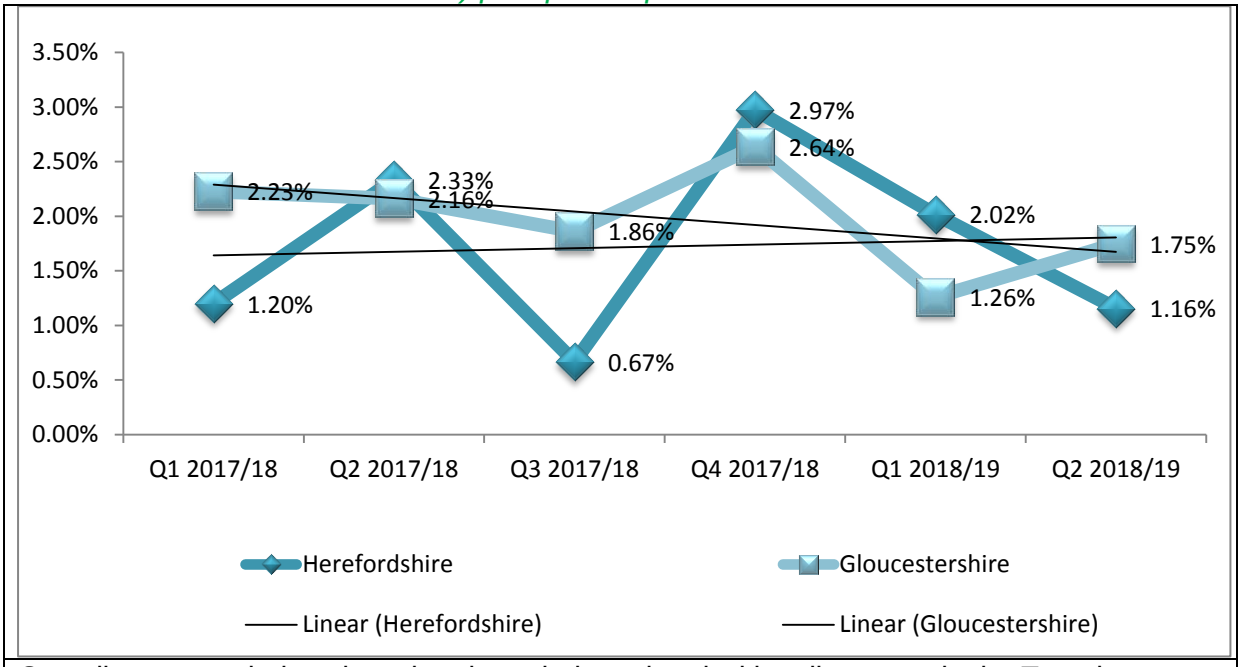
2.2.5.5 The following **emerging themes** have been identified from analysis of PALS reports following visits to our inpatient services across our Trust:

- Feedback about food served on the wards – both positive and negative reports given
- Mixed views about the ward environment – comments ranged from wards being very clean, and whilst some found the wards a bit boring, others enjoyed it.
- Differing feelings regarding detention under the Mental Health Act – some felt it beneficial, others did not agree with it
- Feedback about the ward staff – this has been mainly positive in nature with descriptions such as "good", "marvellous", and "excellent"

2.3 Compliments

2.3.1 The SED continues to encourage the reporting of compliments received by Trust services. **479** compliments were received this quarter. This is an increase when compared to Quarter 1 (n=396). A dedicated email address is set up to simplify the process for colleagues to report compliments that they have received: 2gnft.compliments@nhs.net. Figure 3 shows the percentage of compliments to contacts as reported during Quarter 2.

Figure 3: Percentage of compliments received (calculated by the number of individual service user contacts) per quarter plus the associated trend line over time



Compliments are being shared and regularly updated with colleagues via the Trust intranet system to further encourage reporting.

Examples of compliments received during Quarter 2:

Thanks again, for your very prompt response. I am grateful to you and to your colleagues. You go beyond the call of duty to help me and I shall make sure people know how impressed I am.

Communication Team, Corporate

My husband has spent months in Willow Ward and has been fortunate enough to have been cared for by a wonderful team of carers and nurses.

Willow Ward, Charlton Lane Hospital

I wanted to tell you that the treatment I have received has literally saved my life, just as if I had been given medication for a life-threatening illness…I would not have made it during the difficult times without the constant insight, understanding, and encouragement.

Eating Disorders Team, Gloucestershire

I was helped to stop/reduce self-harm and shown tools that I will continue to use. I was also shown tools to help my OCD which has been beneficial.

CYPS, Gloucestershire

2.4 – Complaints referred for external review following investigation by our Trust

2.4.1 Current open referrals for external review:

Table 13: current open referrals for external review

Reviewing organisation	Date of first contact from reviewing organisation	Date official investigation confirmed	Current status of referral
PHSO	25/01/2017	07/08/2017	Investigation ongoing – draft findings released.
LGO	23/01/2018	03/04/2018	Investigation ongoing
PHSO	06/06/2017	30/04/2018	Investigation ongoing
PHSO	04/09/2018	-	Awaiting contact from PHSO
LGO*	-	23/08/2017	Officially closed on 27/07/2018 with no actions for our Trust

PHSO - Parliamentary and Health Service Ombudsman, LGO - Local Government Ombudsman

2.4.2 Referrals made for external review of complaint this quarter

None.

2.4.3 Completed external complaint investigations

PHSO: The PHSO have released draft findings to us regarding their investigation of a complaint previously investigated by our Trust. At this stage their findings do not indicate any recommendations or actions for our Trust. A final report is due in Quarter 3 for wider circulation.

LGO: The LGO closed an investigation in July 2018 of a complaint that was not previously investigated by our Trust. The LGO investigation concluded with no recommendations or actions for our Trust and agreed with the reasons we provided regarding why we did not investigate this complaint.

**This was closed in Quarter 1 but not reported in the Q1 SED report due to difficulties with reporting systems that have since been resolved.*

2.5 Surveys

2.5.1 'How did we do?' Survey

2.5.1.1 The Trust continues to implement the Trust's **How did we do?** survey. This survey combines the "Friends and Family Test" and "Quality Survey" and is used for all Trust services apart from IAPT and CYPS/CAMHS, where alternative service experience feedback systems are in place.

2.5.1.2 Survey results are reported internally, locally to our Commissioners, and nationally to NHS Benchmarking. It is important that colleagues encourage and support people who use our services to make their views and experiences known so we can learn from feedback and make improvements where needed.

2.5.1.3 For the past 3 years we have utilised an external provider to input and manage our survey feedback. Following a review of our processes and a desire to seek more feedback, a new system to manage Trust feedback has

been commissioned to commence in Quarter 4 2018/19. Our preferred provider will bring us in line with processes used by Gloucestershire Care Services NHS Trust. Existing arrangements will continue until the end of December 2018.

2.5.1.3 The two elements of the **How did we do?** survey are reported separately below as Friends and Family Test and Quality Survey responses.

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

2.5.2.1 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.

2.5.2.2 Table 14 details the Trust-wide 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. The FFT questionnaire is available in all Trust services.

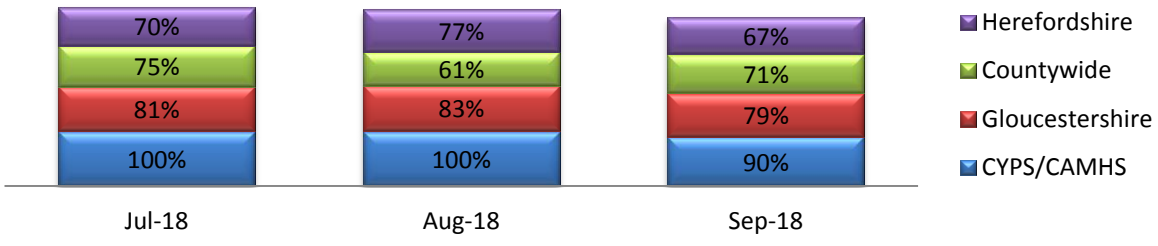
Table 14: Returns and responses to Friends and Family Test in Q2

	Number of responses	FFT Score (%)
July 2018	365 (287 positive)	79%
August 2018	362 (289 positive)	80%
September 2018	293 (227 positive)	77%
Total	**1020** (803 positive) **(last quarter = 958)**	**79%** **(last quarter = 81%)**

2.5.2.3 As reported during 2017/18 some difficulties have continued when sending text messages to people due to the recording of telephone numbers on RiO. Work continues to raise colleagues' awareness of how to record mobile telephone numbers within RiO. The response rate to the text messages that were sent successfully during Quarter 2 has been encouraging, with a response rate of 29% (Q1=25%).

2.5.2.4 Quarter 2 FFT response rates have slightly increased, continuing the quarterly rise seen during 2017/18. However response rates continue to be lower than we would like to allow robust statistical analysis of emerging themes or trends.

Figure 4: FFT percentage of respondents recommending our services by month and locality



2.5.2.5 The FFT score for our Trust this quarter has continued to decrease in line with an observed drop during previous quarters. This is disappointing when compared with our national survey results and compliments which suggest a high level of satisfaction with the services that we provide.

SED have undertaken further analysis of this quarter's FFT scores to review for any areas that are influencing decreased scores.

Further analysis has shown that we continue to receive a relatively low number of responses to the FFT survey. The responses are widely spread amongst our services meaning that statistical significance is impacted, for example a service that receives only one response in total that does not recommend the service has a score of 0% recommendation. This in turn impacts our Trusts overarching FFT score.

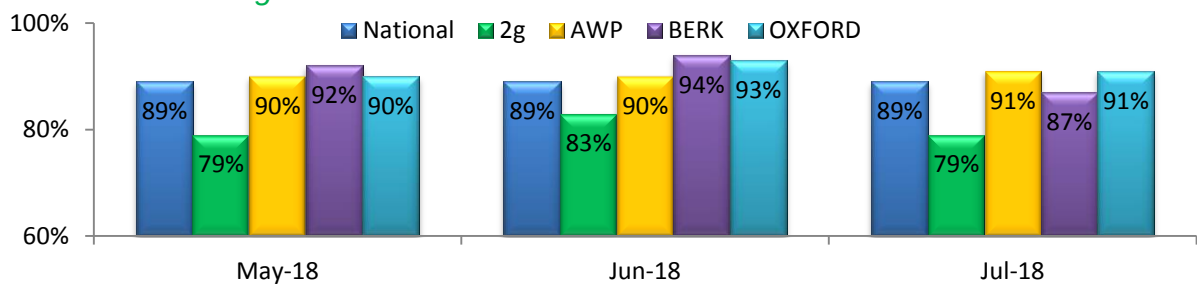
Since our introduction of seeking FFT feedback by text messaging we have had more feedback from our inpatient and liaison services across the Trust. The scores received for these areas do contribute to a low level of recommendation of Trust services. Comments when given alongside these ratings have been analysed for any emerging themes and indicate that often people do not feel that they needed intervention by these services and therefore would not recommend them.

Our Let's Talk services in both Gloucestershire and Herefordshire receive a high proportion of responses that contribute to our FFT scores, whilst the majority of feedback from these services is positive, those who would not recommend it comment that it is due to the waiting time for an appointment. This information is fed back to our locality managers who have been working to improve waiting times in this area.

It is hoped that the implementation of our new system to seek FFT feedback in January 2019 will enable us to increase our response rates to allow statistical significance when analysing scores and responses.

2.5.2.6 Figure 5 shows the FFT Scores for May, June, and July 2018 (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 although we haveachieved lower scores than other Trusts in our region in recent quarters. This is a reversal from previous years and does not triangulate with our positive National Survey scores (*August and September 2018 data are not yet available*)

Figure 5: Friends and Family Test Scores – comparison between the regional data and national averages



Friends and Family Test Comments

Comments are fed back to services in order that they can be shared with team members and for appropriate actions to be taken as a result of the valuable learning. Figure 6 demonstrates that more positive feedback is left about our services than negative feedback.

Figure 6: Comments taken from FFT responses during Quarter 2

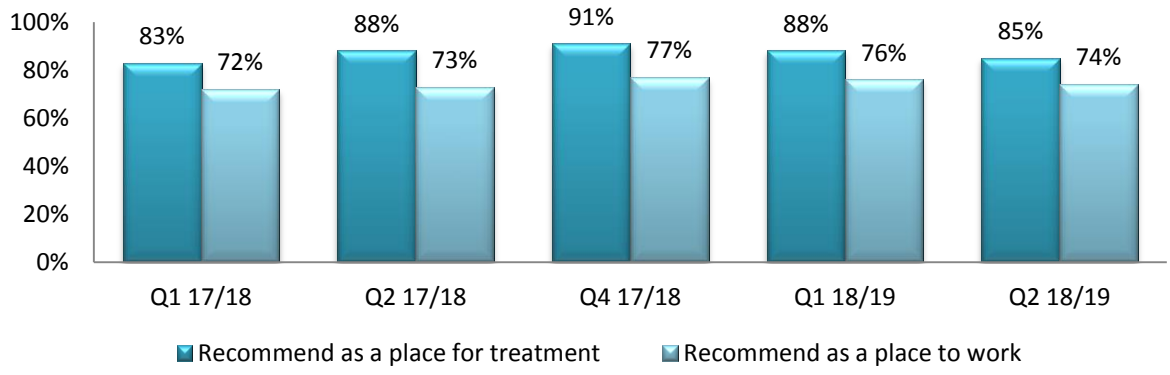
Negative comments:

Positive Comments:

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

Our staff are asked about their experience of working for our Trust during quarters 1, 2 and 4 each year. In quarter 3 the FFT is replaced by the annual Staff Survey. Figure 6 shows the latest staff FFT scores along with previous quarters.

Figure 6: Staff Friends and Family Test Scores



2.5.3.1 For the past two quarters the results of the Staff FFT continue to align closely with the observed trend seen from service user feedback. Comparison of the two FFT scores suggests that over the past year, our staff are slightly more likely to recommend Trust services than service users.

2.5.4 How did we do?

2.5.4.1 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. It was initially launched as a paper-based survey in April 2017. From 1st November 2017 the survey was distributed via text message to people who were discharged from our community and inpatient services. The text message asks the FFT questions and provides a link for people to complete additional Trust Quality survey questions.

2.5.4.2 Quality survey targets were reviewed and refreshed for the commencement of Quarter 1 2018/19. Three out of the four targets set have been exceeded. This 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 level of positive responses. Table 15 shows responses in relation to set targets for this quarter.

Table 15: 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	51 (38 positive)	75% TARGET 84%
	Herefordshire	18 (14 positive)	
Have you been given information about who to contact outside of office hours if you have a crisis?	Gloucestershire	54 (46 positive)	86% TARGET 71%
	Herefordshire	15 (15 positive)	
Have you had help and advice about taking part in activities that are important to you?	Gloucestershire	51 (41 positive)	81% TARGET 64%
	Herefordshire	16 (13 positive)	
Have you had help and advice to find support for physical health needs if you have needed it?	Gloucestershire	46 (34 positive)	76% TARGET 73%
	Herefordshire	16 (13 positive)	

2.5.4.3 Feedback from the Quality survey along with the National Community Mental Health survey results helped us to identify the need to increase the involvement of people in the development of their care plans. This is the focus of our work to implement an Always Event as part of the NHS England campaign.

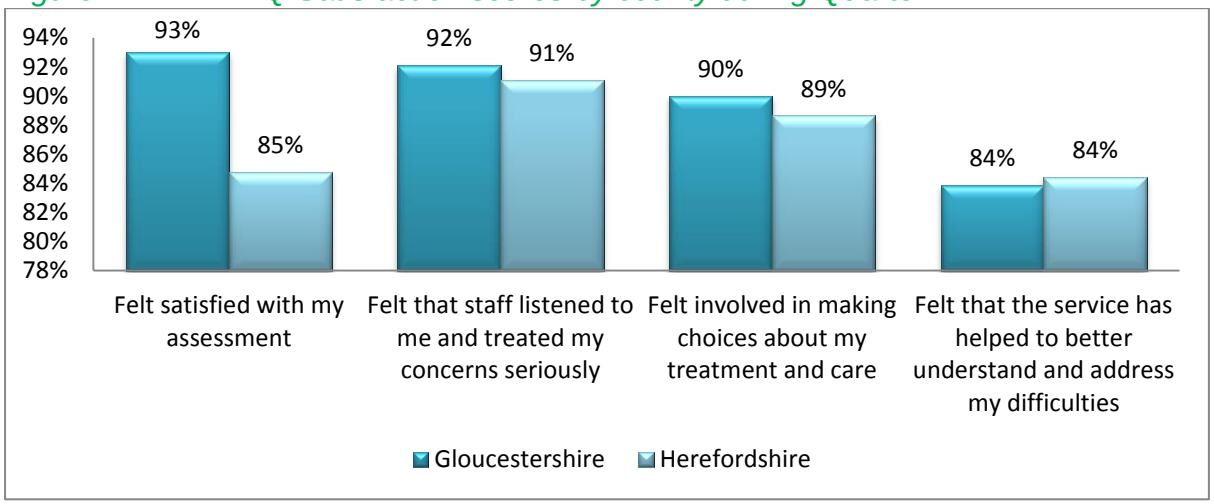
2.5.4.4 Although response rates for the survey have increased over time the level of response continues to be lower than we would like. The introduction of new systems in Quarter 4 2018/19 to capture survey feedback aims to increase the number of response we receive to both aspects of the How did we do? survey.

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

2.5.5.1 Our IAPT Let's Talk services use a nationally agreed survey to gain feedback and measure levels of satisfaction with the service.

2.5.5.2 Feedback questionnaires are sent to people following the initial assessment and after discharge from the service. Quarter 2 feedback (figure 7) shows that people are largely satisfied with these elements of the Let's Talk service.

Figure 7: IAPT PEQ Satisfaction scores by county during Quarter 2



2.5.5.3 This information is shared with colleagues from IAPT Let's Talk so that it can be used by them to deliver service improvements. The free text comments from surveys received during Q2 have been reviewed and analysed by SED to look for possible contributory factors to those scores that are less than 90%. The majority of comments received are extremely positive about our Let's Talk services, the remainder of comments refer to length of waiting time to access the service.

2.5.5.4 The IAPT PEQ seeks comments from people about the service that they have received. A selection of comments for Q2 responses are shared below:

I feel that I have made progress and I will continue to utilise what I have been taught.

Only complaint - Had to wait so long to get the help I needed. I think 5 months. It would have made me feel a lot better a lot quicker if I had been given an appointment much sooner

I found the online CBT very good but sometimes felt I needed one to one. I would use Let's Talk again

It was made easy for me to attend locally as I had lost the confidence to drive and use public transport.

I never imagined it would be so successful - I was only willing to try anything that might help improve my situation.

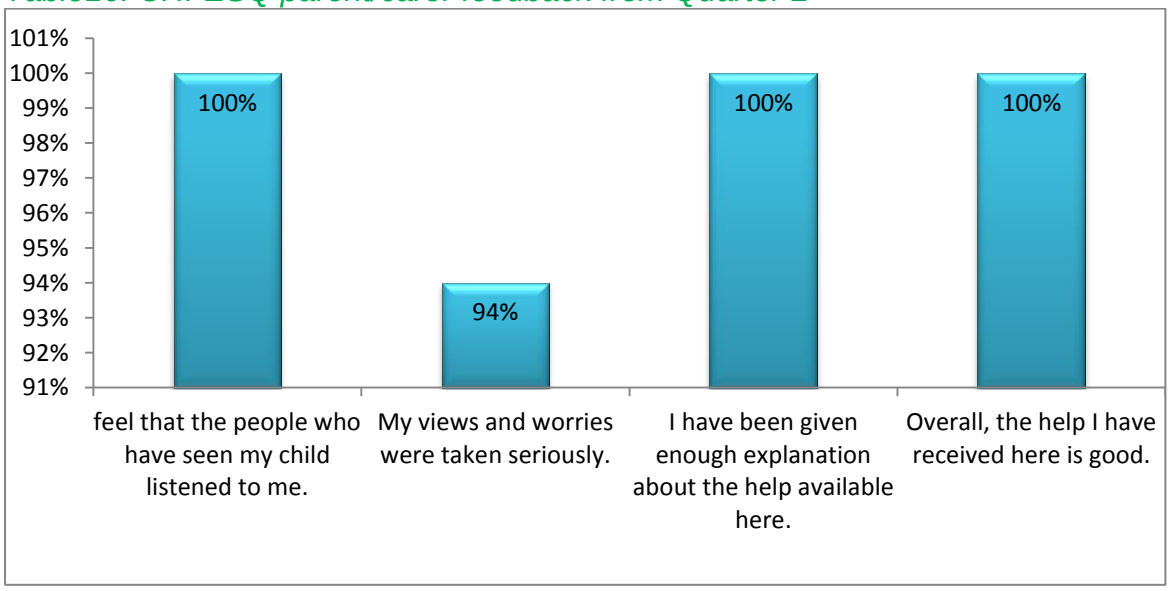
All very good but took very long to get to the actual therapy session

2.5.6 Children and Young People service (CYPS)

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

2.5.6.2 Tables 16 and 17 reflect responses to questions asked to the differing groups of respondents during Quarter 2.

Table16: CHI-ESQ parent/carer feedback from Quarter 2



Examples of some feedback given by Carers & Parents:

My son was able to see the same person for most of his appointments. We always felt listened to and treated like individuals..

Good pace, chance to try different techniques/ideas and then discuss the following week.

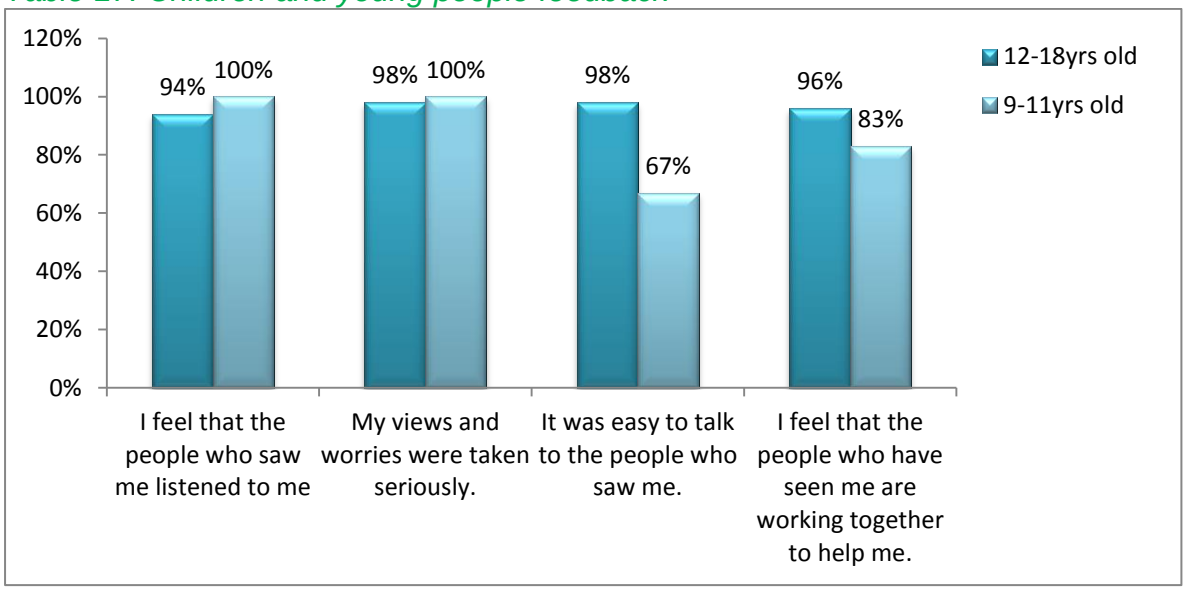
Difficult as a single parent working and all appointments in the day

Great to know that if help needed within 6 months if things decline again that the help is here. Very reassuring.

After 4 years of different approaches and being told the system did not provide for our difficulties. It was great to have people try to understand our needs rather than fit him us a box.

Sometimes I felt I needed more support to talk through things as a parent caring for a child that needed support

Table 17: Children and young people feedback



2.5.6.3 This information is shared with CYPS colleagues so that it can be used by them to deliver service improvements. The lower scores for 9-11 year olds will be flagged to operational managers.

Examples of some feedback given by children and young people:

I was very glad that CYPS and another service were able to communicate to each other so I that I didn't have to repeat anything in my different therapy sessions.

It wasn't too formal and didn't make me uncomfortable.

My sessions were fun

I felt as though I was listened to and the help I received was good since coming here my mental health has been improving dramatically.

Section 3 – Learning from Service Experience Feedback

Section 3.1 – learning themes emerging from individual complaints

The SED, in partnership with Service Managers, routinely record, report and take actions based upon the valuable feedback from complaints, concerns, compliments and comments.

Reporting of local service experience activity and learning from feedback continues on a monthly and quarterly basis at each locality governance meeting. The SED is also attending these meetings regularly to discuss local themes, trends and learning and disseminate practice notes regarding elements of Trust wide learning, detailed in Table 18.

Table 18 illustrates points of learning from Service Experience feedback. Localities, in partnership with corporate services, are asked to disseminate local and Trustwide learning and embed in practice to ensure that it informs quality improvement nof our services and shapes future practice

Table 18: Trust wide points of learning from Service Experience feedback Q2 closed complaints disseminated to localities via Practice Notes– assurance of actions be sought from locality leads

Practice Note number	Organisational Learning
1610	Work should be undertaken to improve communication between the acute hospital and mental health services regarding joint working and discharge arrangements. Should a planned mental health review not occur before discharge, teams should consider liaising with the service user by telephone, or passing this to a community team to complete following discharge. It was suggested that a standard timescale be developed for mental health teams to complete a discharge letter, along with review processes to ensure this happens.
1620	Appointments that are cancelled by our staff should be monitored in the same way as “Did Not Attend” rates.
1573	Staff should adhere to the guidance and protocols in place regarding the follow up and sharing of blood test results. Staff should carefully observe how they use quotation marks when recording information on RiO, and be mindful about the language and terminology used.
1723	Where making recommendations to other services thought and consideration should be given to remit of the service and any resource implications.
1729	We should review the timescales between our systems registering a discharge from our services and the trigger point for a feedback text message to be sent.
1739	There should be clear direction and delegation of task in communicating with relatives after incidents, both informing them of what has happened and what the Trust will do next. The delegated person should maintain regular contact for the purpose of support and give feedback regarding the Trust processes taking place.

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. Service Experience feedback has contributed to the *Learning ²gether from Incidents, Complaints and Claims* report issued within the Trust on 1st December 2017.

Section 3.3 – Assurance of learning and action from aggregated learning themes from Quarter 1

The learning shown in Table 18 is shared with localities on a monthly basis who disseminate amongst colleagues and feedback learning and actions through our Quality & Clinical Risk Committee (QCR) where aggregated learning themes are identified and compiled to be included in the Learning ²gether from Incidents, Complaints and Claims reports. The process by which learning is embedded within the organisation is described our *Policy for Continuous Improvement (Aggregated Learning Policy).*

Agenda Item	**12**	**Enclosure**	**Paper G**

Report to: 2gether NHS Foundation Trust Board – 29 November 2018
Author: Marcia Gallagher, Non-Executive Director
Presented by: Marcia Gallagher, Non-Executive Director

SUBJECT: **NON EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS QUARTER 2 2018/19**

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

EXECUTIVE SUMMARY

A Non-Executive Director Audit of Complaints was conducted covering three complaints that have been closed between 1 July and 30 September 2018.

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

2. PREPARATION

2.1 In accordance with standard procedure, three cases were chosen at random for review.

2.2 The documentation was properly prepared and easy to follow. The introduction of a checklist for learning sign-off is a welcome innovation.

2.3 It should be noted that the sharing and follow-up on learning is handled outside the complaints process, and as such is not included in the documentation provided for the audit. Assurance under aspect 4 is therefore limited to consideration of what has been identified in the complaint process, and does not extend to subsequent actions taken.

3. SUMMARY OF FINDINGS

3.1 Case 1

3.1.1 Summary of complaint.

This complaint concerned the discharge of a patient from a Gloucestershire-based Recovery Team for not attending appointments with the Care Co-ordinator. It was brought to the attention of the Trust by the patient's parents.

The complainants view was that the service offered had not met their expectations to meet their daughter or her needs. The targets set by the Care Co-ordinator were also considered to be too ambitious. Their view was the service user remained at risk and that there needed to be a reassessment and re-engagement of services.

Additionally the complaint included an issue in relation to the collection of a prescription for a change in medication when this would have been difficult for their daughter to do as she was not able on occasions to go out.

3.1.2 Audit findings

The various elements of the complaint were thoroughly investigated. The investigation concluded that the goals set had not been unrealistic and that a number of amendments including location changes had been made.
There was evidence that the investigator had tried on a number of occasions to contact the complainant to arrange a meeting but was unable to obtain a response.

The tone of the CEO letter was apologetic whilst being clear that the reasons for discharge had been appropriate. The letter also made clear the process of how to obtain a potential future reassessment by contacting her GP but also that if the GP referral was accepted any re-engagement with services would require set boundaries to be adhered to and that regular attendance at appointments and demonstrable progress would be required.

Organisational learning from the complaint was clear in that the process for discharge should be reviewed to ensure that a text containing a satisfaction questionnaire post discharge (sent by a third party organisation) should never be received before a letter of discharge had been sent to avoid un-necessary distress being caused .However one criticism I have is that it did not say who was responsible for taking this forward and by when.

3.1.3 Conclusion of auditor

I would offer *full* assurance against the timeliness aspect, and significant assurance against the other three audit aims.

3.2 Case 2

3.2.1 Summary of complaint

This was a complaint via the Patient Advice and Liaison Service on behalf of a patient from a protected characteristic group. The individual had been discharged from Recovery services in Gloucester when in her view she was still unwell. She accepted that having moved house she should have notified

Recovery Services but she did not understand why she was being discharged and not transferred to a new local team.

3.2.2 Audit findings

The Investigating officer met with the complainant.

The CEO letter was apologetic with an informative style outlining that whilst the investigation had found that the discharge had been appropriate that other organisations could be accessed to support her going forward outside of Mental Health Services.

If in a discussion with her GP it was agreed that there was a need for Mental Health services in the future, then either the patients GP could refer her to 2gether NHS Foundation Trust services or contact could be made directly by the individual to 2gether's "Let's Talk" service. An information leaflet was enclosed in the letter of reply.

3.2.3 Conclusion of Auditor

I would offer *full* assurance against all aspects of this investigation. There was no learning identified as being required on this occasion.

3.3 Case 3

3.3.1 Summary of complaint

This case came to the attention of the Trust from an Advocacy organisation. The case related to a period in May to July 2017 when the complainant was a patient within an inpatient unit. The individual had also accessed Accident and Emergency (A&E) services. The complaint consisted of three issues.

The patient claimed they had been unable to access showering or bathing facilities; that there had been communication issues regarding medication and that the Trust did not seem to be aware that complainant received support from a third party organisation which could have supported care planning and discharge.

3.3.2 Audit findings

The investigation was thorough. The complaint was partially upheld.
The Trust apologised for the confusion with regards to discharge paperwork and rightly acknowledged some learning which included medication input into Datix. The investigation also identified that there was no evidence on RIO of reports back from the acute hospital after the patient was transferred to A&E for an assessment.

The learning identified was a need for a discussion to be held with the Modern Matron to ensure hospital transfer notes after an A&E admission are received. This issue was also included in the CEO response letter.
An additional point of learning was that a review of notes would have revealed involvement of a third sector organisation in its support to the complainant.

The CEO letter was apologetic. The letter stated that the team had been asked to look at the process and communications when significant changes in historic practices occur.

An offer was made to the complainant that a meeting with appropriate clinical colleagues was available if that was seen as being helpful.
An apology was given around third party support and that colleagues in Inpatient Services will be reminded to ask patients on admission if there is a third party involved in their care in the hope that this action will reduce likelihood of this type of issue being overlooked in future.

3.3.3 Auditor conclusion

Again, I would offer *full* assurance against all four NED Audit aims.

4. SUMMARY

4.1 Overall, it is noticeable that the quality and timeliness of our handling of complaints has continued to improve, as has the tone of our response letters and additional information being supplied. There was a delay in the last case which was at a period of change in the senior leadership within the Trust.

4.2 The identification of learning points is also more systematic, and it seems that the learning is now being taken seriously and widely disseminated, though this is not something that the audit process covers. It was pleasing to note in Case 3 especially the benefits of RIO in supporting the investigation.

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

Report to:	[2]gether NHS Foundation Trust Board – November 2018
Author:	Lauren Edwards, Deputy Director for Engagement
Presented by:	Jane Melton, Director for Engagement and Integration
SUBJECT:	**CQC Survey of people who use community mental health service - 2018 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 was commissioned by [2]gether NHS Foundation Trust to undertake the 2018 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 22nd November 2018 on the CQC website.
- Service users from 56 mental health Trusts in England that took part in the survey. Four Trusts were classed as 'better than expected' across the entire survey - ²gether was named as one of these 4 Trusts. ²gether was the only Trust in England to achieve a 'better than expected' rating for the survey results in both 2017 and 2018.
- ²gether's results are '*better*' than most Trusts for 10 of the 28 questions (36%) and '*about the same*' as other Trusts for the remaining 18 questions (64%) These results **represent a further improvement** when compared with our results from last years' service user feedback in the same survey (Better = 25%, about the same = 75%).

- ²gether is categorised as performing 'better' than the majority of other mental health Trusts in 5 of the 11 domains:

- ²gether is categorised as performing 'about the same' as the majority of other mental health Trusts in the remaining 6 domains:

- 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.

Assurance

- These survey results offer **significant assurance** that the Trust's strategic focus and dedicated activity to deliver best service experience is having a positive effect over time.

Areas for development include:

- Helping people to find support for their physical health needs

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

- Supporting people to join a group or take part in an activity

- Providing help and advice with finding support with finances or benefits

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

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 (50%) compared with many other Trusts (national average 39%). 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 2018

Where in the Trust has this been discussed before?		
Senior leaders were engaged in a presentation of preliminary results from Quality Health.		October 2018
Pre-publication notification of results		October 2018
Preliminary results were presented at Quality and Clinical Risk Sub-Committee		October 2018
Trust Governance Committee were advised of the assurances in the preliminary results		October 2018

What consultation has there been?		
	Date	

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

2018 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 in 2018	
Overall 	Many parts of ²gether's community mental health services were classed as **better** than most other Trusts. This is a very good result and is better than last year.	
Things we do well 	²gether is better than most other Trusts for: - The quality of our staff - Organising people's care - Planning people's care - People's overall view of our care and service - Overall	
Things we are quite good at 	²gether is about the same as other Trusts for: - Reviewing care - Managing changes in who people see - Crisis care - Medicines - NHS therapies - Support and wellbeing	
Things we can do better 	²gether will work hard to get better at: - Involving family members or someone close - Helping people to find support from people with the same problems - Helping people to find help for their physical health needs - Helping people to join a group or take part in an activity - Helping people to find advice about money and benefits	

	Full assurance		Limited assurance
	Significant assurance		Negative assurance

CQC 2018 Survey of people who use community mental health services

RESULTS FOR HEREFORDSHIRE AND GLOUCESTERSHIRE

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 2018 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 2018 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 2018.

1.4 This year 2gether NHS Foundation Trust received the **highest percentage response rate** of all the 56 Trusts involved (2gether response rate was 36%; national average of 28%). 296 service users (36% of those sampled) responded to the 2gether survey.

1.5 Full details of this survey questions and results can be found on the following website: http://nhssurveys.org/Filestore/MH18/MH18_RTQ.pdf

2. Scores for 2gether NHS Foundation Trust in 2015

2.1 The CQC results for the 2018 survey of people who use community mental health services were published on the 22nd November 2018[1]. 2gether's overall results are summarised in Table 1 below.

2.2 An additional domain has been added to the 2018 version of the survey (NHS Therapies) and the number of evaluative questions has reduced from 32 in 2017 to 28 in 2018. Five questions were modified for 2018 and it is therefore not possible to compare these with previous years (questions 19, 22. 27, 28, and 34). Question 7 was modified which caused questions 8 and 9 to not be comparable with previous years.

[1] https://www.cqc.org.uk/provider/RTQ/survey/6

Table 1

Survey of people who use community mental health services 2018
2gether NHS Foundation Trust

Section scores

Key to Table 1

Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

2.3 ²gether is categorised as performing 'better' than the majority of other mental health Trusts in 5 of the 11 domains:

- *Health and social care workers*
- *Organising care*
- *Planning care*
- *Overall views of care and services*
- *Overall*

2.4 ²gether is categorised as performing 'about the same' as the majority of other mental health Trusts in the remaining 6 domains:

- *Reviewing care*
- *Changes in who people see*

- *Crisis care*
- *Medicines*
- *NHS therapies*
- *Support and wellbeing*

2.5 ²gether obtained the **highest Trust scores in England** on 3 of the 28 evaluative questions:
- *Were you given enough time to discuss your needs and treatment?*
- *In the last 12 months, did NHS mental health services give you any help or advice with finding or keeping work?*
- *In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?*

2.6 ²gether obtained the **highest Trust scores in England** on 2 of the 11 domains:
- *Health and social care workers*
- *Support and wellbeing*

2.7 ²gether's results are 'better' than most Trusts for 10 of the 28 questions (36%) and 'about the same' as other Trusts for the remaining 18 questions (64%) These results suggest a further improvement when compared with our results from last years' service user feedback in this broadly similar survey (Better = 25%, about the same = 75%).

2.8 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.

2.9 An infographic of 2gether's results 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 four 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 support and wellbeing domain suggest that further work is required in this area.

3.2 It would appear from the CQC 2018 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 and that learning from feedback is being embedded into practice. However, areas for further development are evident and these will be reflected in the Action Plan which is currently being developed.

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:

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

'Find support groups to help people with mental health problems'

- Helping people to find support for their physical health needs

'Very poor support for my…physical related disabilities which render me housebound…for most of the week'

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

'I have been able to remain at home because my wife is my carer, but she needs help'

- Helping people to join a group or take part in an activity

'No therapeutic/group activities provided'

- Providing help or advice for finding support with finances or benefits

'I would have welcomed any information on claiming benefits while I was in hospital and when I'd been too ill to do my job'

4. Conclusion and summary 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 Further detail will be sought from the data to explore additional question, for example whether there are differences between Herefordshire and Gloucestershire Services.

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

4.4 Where other organisations have scored well in particular areas we will collaborate and seek ideas to further develop local practice.

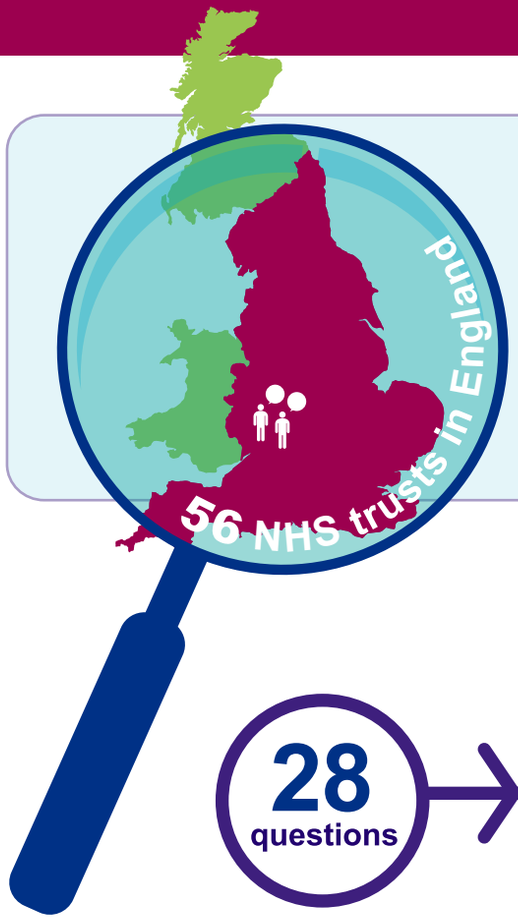
4.5 An action plan will be co-developed with Locality Directors and Heads of Professions by January 2019 and presented at Trust Governance Committee for assurance of action.

4.6 The 2018 results have 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 truly appreciative of the help I am getting. Just having someone to listen, without judging and you making them uncomfortable, is such a relief. I feel I can take bigger breaths of air having spoken to these health workers! Thank you.'

2018 CQC Survey of people who use community mental health services
Gloucestershire and Herefordshire

2gether NHS Foundation Trust



822 people were sent the survey

296 people returned the survey

18 years plus

National response rate

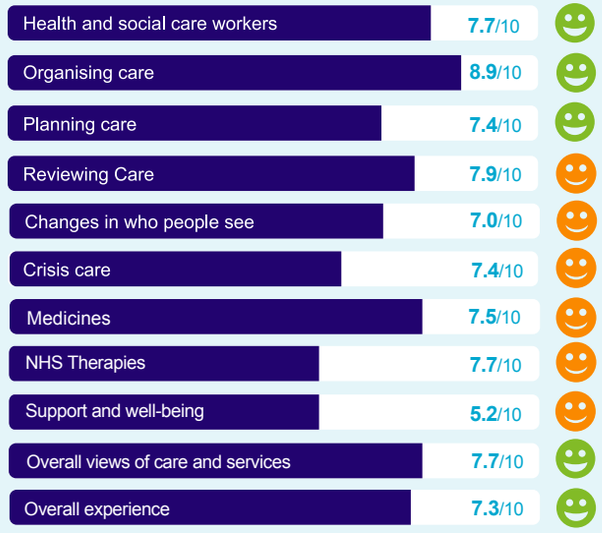
Trust response rate

28 questions → **11** domains → **2gether's results:** In the top 20% of Trusts in 5 out of the 11 domains. 'About the same' as other Trusts in 6 domains.

Results of 11 domains

Each domain compared to other trusts

Better | About the same | Worse



Rated nationally as amongst the highest performing trusts for:

- Health and social care workers
- 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
- Out of hours services providing the help that people need
- Seeing people enough to meet their needs
- People's overall experience
- Giving people time to discuss their needs and treatment

Areas for further focus:

- 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 to find support for their physical health needs
- Helping people to join a group or take part in an activity
- Providing help or advice for finding support with finances or benefits.

2018 CQC Survey of people who use community mental health services
Gloucestershire and Herefordshire

2gether NHS Foundation Trust

Results for 28 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	7.7/10
Enough time to discuss needs	8.0/10
Understand how mental health affects life	7.4/10
Organising Care	**8.9/10**
Kept informed of who organises care	8.5/10
Able to contact Care Co-ordinator	9.7/10
Care organised well	8.6/10
Planning care	**7.4/10**
Agreeing the care received	6.5/10
Involvement in care planning	7.9/10
Personal circumstances considered	7.7/10
Reviewing care	**7.9/10**
Discussed how care is working	8.2/10
Decisions made together	7.6/10
Changes in who people see	**7.0/10**
Explanations given for change in care	7.0/10
Impact of change in care	7.1/10
Crisis care	**7.4/10**
Know who to contact out of hours	7.4/10
Get the care needed out of hours	7.4/10
Medicines	**7.5/10**
Involved in decisions	7.2/10
Understandable medicines information	7.0/10
Medicines reviewed	8.4/10
Therapies	**7.7/10**
Therapies explained	8.0/10
Involved in deciding therapies to use	7.3/10
Support and well-being	**5.2/10**
Help finding physical health needs support	5.1/10
Help finding financial advice/benefits support	4.9/10
Help finding or keeping work	5.1/10
Support to take part in local activities	5.6/10
Involving family or friends	6.9/10
Information about support from others with similar experiences	3.6/10
Overall view and experience of services	**7.7/10**
Enough contact with services	6.8/10
Treated with respect and dignity	8.5/10
Overall experience	**7.3/10**
Overall good experience of services	7.3/10

Agenda item 14 **Enclosure Paper I**

Report to: 2gether NHS Foundation Trust Board – 29th November 2018
Author: Paul Roberts, Joint Chief Executive
Presented by: Paul Roberts, Joint 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

Recognising the Strategic Intent work and my role as both Chief Executive of 2gether and Gloucestershire Care Services, this report reflects the breadth of my activity across both Trusts. I remain accountable separately for the performance of each of these roles.

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 Noted

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:		
Chief Executive	Date	*November 2018*

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
N/A	Date	

Explanation of acronyms used:	

1. CHIEF EXECUTIVE ENGAGEMENT

I remain committed to spending a significant proportion of my time visiting front-line services in both organisations and continue to be impressed and heartened by the professionalism and commitment of colleagues across the organisations and in the pride that they take in the delivery of, in many cases, outstanding services.

Services I have visited in recent weeks include:

[2]gether Services

- **Afternoon Tea in Celebration of Contributions made by Volunteers and Experts by Experience** –. An educational and inspiring afternoon where we heard from experts by lived experience about their own recovery journeys and were able to thank the many, many people who give their time freely to support people using our services. Mental health services are frequently ahead of the rest of the NHS world in truly appreciating the major contribution of those who use our services to designing and delivering them better.
- **QI Inspiring and Driving Group**. This is a 2gether group, which has invited GCS colleagues to join it (an excellent thing to do and to reciprocate), which focusses on using QI (Quality Improvement) methodology to improve services. The group was not set up by Trust management and is a true community of interest. We discussed how we would join their work up with our emerging "Better Care Together" plan
- **Corporate Departments** – as part of getting to know these key teams, who help support our clinical colleagues in getting on with their day job, I have had a number of walk arounds and informal visits in Rikenel. (This mirrors the walk arounds I have previously done at Edward Jenner Court, GCS).
- **Recovery Services, Leominster –** It was great to get out and meet colleagues at this key service and hear more about how they are supporting service users at challenging times in their lives.

Gloucestershire Care Services

- **North Cotswold Hospital** – I met with colleagues and service users to understand how it is on the ground before we move to winter pressures..
- **George Moore Clinic** – I enjoyed seeing the services provided at the Clinic and to find out more about how we work with the GPs and Great Western Hospital in this area.
- **Cirencester Hospital –** to host Team Talk, one of our mechanisms for two way communication with colleagues from both Trusts, where some helpful questions were asked which will be taken forward to shape our future thinking and also an "Open Door session which volunteers and paid colleagues attended. Both sessions were well attended and proved a great opportunity to understand local challenges.
- **Cheltenham integrated care team**, to listen to their particular concerns and challenges which are now being considered by the Executive – as updated within the services update element of this report.

As the strategic intent progresses it becomes increasingly difficult to separate into the services of each Trust – with colleagues from both trusts now regularly engaging together – as demonstrated within the QI update above.

2 PROGRESS ON THE STRATEGIC INTENT TO MERGE ^{2}GETHER NHS FOUNDATION TRUST WITH GLOUCESTERSHIRE CARE SERVICES NHS TRUST (GCS)

In the foreword to the 'Strategic Case' for our merger, which both Boards approved for submission, Ingrid and I called the joining up of mental and physical healthcare a social justice issue. This is because we understand the evidence that those with a mental illness live shorter, less healthy lives and those with long-term physical illnesses frequently suffer mental health consequences, which are often untreated. If you have a learning disability then these factors are likely to be even more pronounced. One of the most rewarding parts of my role is finding that my colleagues feel strongly about these issues too.

We are in the process of developing a summary of the Strategic Case which we will be able to share with colleagues and stakeholders

The development of the Strategic Case has been a thorough and comprehensive process which keeps at its heart the difference to service users we are working to achieve. It has involved colleagues from both Trusts working together to test the premise within the Strategic Intent and ensure that it delivers for our communities.

Following submission of the Strategic Case NHSI Improvement have held an interview process with a number of Board level colleagues from both Trusts, both individually and a wider Executive Challenge Team to test out the Strategic Case – with the focus on ensuring clinical safety and sustainability in the proposed new organisation. We await formal feedback from these sessions which will inform the development of the Full Business Case.

This work will continue to involve clinical colleagues and further develop involvement of service users. **Values Week** was a clear demonstration of this with over 1,400

colleagues and over 50 service users providing valuable input into the values that we need as the bedrock of our new organisation.

I was pleased to see colleagues from GCS and 2gether engaging with such openness and honesty. This willingness to see things from each other's' perspectives will be very valuable as we take forward the transformation of services. The feedback from this week, which was mixed, gives us a clear message that we need to do even more to involve and communicate with colleagues as we proceed. This is a message we as Boards will reflect on as we take forward the valuable output from the sessions to put in place the foundations required for the new organisation, and recognising the good practice in the two Trusts.

Work is ongoing to put in place the appointment processes for the shadow Board which is another key next step in the merger process. The Non-Executive appointment process is scheduled for the end of November/beginning of December and the Executive appointment process for January. We will of course be including colleagues, stakeholders, service users, experts by experience from both Trusts in both these processes, with the ^{2}gether Council of Governors fully engaged in line with their key responsibilities.

Trust Name

Board members may recall that a 'Name that Trust' survey has been circulated within both organisations – primarily during Values Week – to consult colleagues on what our new organisation should be called.

We have now received more than 1,440 responses and the survey remains open on the intranets, should colleagues who were unable to attend Values Week wish to have their say.

Our next priority is to consult with the public members of 2gether. To achieve this, a short article and the survey link will be printed in the next membership newsletter, due to be published in the first week of December.

We propose closing that survey on December 28, at which point all responses will be analysed by our respective communication teams. There is a need to share the most popular names with NHS England, which governs NHS identity guidelines. NHS England will advise us on the suitability of our shortlisted names.

We can then prepare an update paper for 2gether's Council of Governors, when it meets on January 15.

We will then need to consult with our closest partners, such as the CCGs, partner providers, local authorities and Healthwatch, to ensure our proposed name/s does not cause any confusion or concern.

Finally, we will present papers to the Shadow Board once appointed, before a final name proposal is presented to 2gether's Council of Governors, as the name will require a change to 2gether's constitution.

It is possible that the chosen name will include Gloucestershire, please note we have the option of choosing a separate name for the services provided in Herefordshire something that we would clearly wish to do. Within the NHS England brand guidelines, there is guidance on NHS 'service logos' being used where NHS

organisations are delivering services outside of their 'geographical area', and where a name could confuse patients and the public. The guidance explains that organisations should include a textual statement which explains that our NHS organisation is responsible for delivering the service.

3 "ONE GLOUCESTERSHIRE" INTEGRATED CARE SYSTEM (ICS)

3.1 Developing Integrated Working

Mary Hutton (the CCG accountable officer) and I were privileged to attend the last session of the One Gloucestershire Leadership Development Programme. This programme has been specifically designed to mix leaders from the three NHS Trusts in the county together and to promote an ethos of integrated working across organisational boundaries. Around 50 people have taken part so far and those from 2g and GCS who have spoken to me say it is a really effective programme. I am therefore hoping that now we have our Gloucestershire Integrated Care System in place we will expand this programme to include CCG, primary and social care colleagues too.

3.2 CEO Leadership

I have been asked to take up the CEO leadership of three programmes within the Integrated Care System: Diagnostics, Urgent Treatment Centres and Quality Improvement. These strands are key to both Trusts and taking the helm within these programmes will enable me to ensure we are at the centre to shape them to the needs of the community, reflecting our knowledge and experience.

3.3 King's Fund

I attended informative sessions from the King's Fund Future of Regulation and ICS Community of Practice which were as thought provoking as their sessions normally are – it is good to get the opportunity to be stimulated to think outside the box.

4. NHS70 AWARDS - GLOUCESTERSHIRE

Although this event took place on the evening of our last Board this is the first opportunity for me to formally report to Board on the outcome of this latest celebration of the NHS 70th birthday milestone. The event was organised by Gloucestershire Live and the Gloucestershire Clinical Commissioning Group to celebrate the achievements of those working in the NHS and social care with 2gether and GCS nominees being judged by the panel with colleagues from other Trusts.

I am delighted therefore that, between them, 2gether and GCS won 6 of the 13 awards. Kevin Garraway-Pitts, the Macmillan Next Steps Cancer Rehabilitation Team, the Abbey Ward (Wotton Lawn) Healthcare Assistants, the Homeless Healthcare Team, Aoife Price, and Tina Kukstas all won awards.

We also dominated the finalists with the Criminal Justice Liaison Service, the Physiotherapy, Health and Exercise Team, the Complex Leg Wound service, Mulberry Ward (Charlton Lane), Brian Mountford, Lisa Davis, Angela Cooper, Helen Wilson, Rhondda May, Gloucestershire Self-Management Programme Volunteers, the Community Diabetes Service, the Social Inclusion Team, Kelly Williams and,

shortlisted for a lifetime achievement award, Lisa Davis, the Recovery Team Secretary - a fantastic recognition of colleagues who on a daily basis go the extra mile to support the users of our services – and each other. A highlight for me was a recent breast cancer patient, Victoria Newland, telling us her story and singing the praises of, amongst other services, the MacMillan Next Steps Cancer Rehabilitation Team.

5. DIRECTOR OF WRES IMPLEMENTATION AT NHS ENGLAND VISITS THE TRUST

Yvonne Coghill OBE, Director of Workforce Race Equality Standard (WRES) Implementation at NHS England visited the Trust in September and met with colleagues from both ^{2}gether and GCS to consider opportunities to further develop, and then embed, Race Equality and further the inclusion agenda within the organisation.

Yvonne was awarded an OBE for services to healthcare in 2010 and was appointed as Director for WRES Implementation in June 2015 and last week it was announced she has been elected as deputy Chair of the Royal College of Nurses

As part of her visit to the Trust, there was an opportunity for Yvonne to meet our Black and Minority Ethnic colleagues from across both organisations, to understand their experiences of working in the Trusts.

6. NATIONAL GUARDIAN FOR THE NHS VISITS THE TRUST

As also updated within the Chair's report Dr Henrietta Hughes, National Guardian for the NHS, visited in October to meet colleagues from the Trust and representatives from all Trusts in the South West. This coincided with the national *Speak Up Month* campaign.

Every Trust in England has a Freedom to Speak Up Guardian, so that colleagues are able to share issues or concerns which may ultimately affect patient safety or staff experience.

Dr Hughes met with members of the Boards and colleagues from both Trusts, sharing her thoughts and insight on why it's so important for workers to be able to speak up in a supportive environment. She emphasised this was particularly important during a period of organisational transition - feedback which we will ensure we keep central to our working and thinking as the transformation agenda is progressed.

7. LEARNING FROM AND SHARING GOOD PRACTICE

Since the last Board I have attended a range of events to share and benefit from good practice in the sector, including:

- A meeting with the CEO of the Royal College of Occupational Therapists
- The NHS National Providers Conference
- Continuous Improvement Communities Workshop
- NHSP Community Network
- King's Fund – Future of Regulation
- King's Fund ICS Community of Practice

.

I am keen to ensure that the Trusts are not inventing their own wheels and are benefitting from testing and good practice that other areas have developed to ensure that we move as quickly as possible to develop the best possible services for our communities, and make best use of resources.

8. EXECUTIVE DIRECTOR ENGAGEMENT ACTIVITY

Since the last Board, our Executive Team have attended a huge range of meetings and events. This activity is listed below for information:

Internal Board Engagement

03.09.18	Members of the Executive Team conducted Team Talk sessions across the Trust sites
	The Director of Engagement and Integration and Deputy chief Executive lead the executive presentation induction for new staff
	The Executive Directors attended a Herefordshire Staffing Issues meeting
04.09.18	The Director of Finance and Commerce conducted a Board Visit to a Community Learning Disability Team (CLDT) at Charlton Lane
	The Director of Engagement and Integration met with Trust Head of Professions
	The Director of Service Delivery attended a Shaping our Culture Steering Group with colleagues from GCS
05.09.18	The Director of Service Delivery conducted a patient safety visit to Kingsholm and Dean Ward at Wotton Lawn Hospital.
	The Director of Service Delivery attended a Liaison Psychiatry meeting with 2gether colleagues
06.09.18	The Director of Quality attended NPAC.
07.09.18	The Medical Director attended the Mental Health Commissioning Meeting.
	The Medical Director attended the Medical Staffing Committee.
10.09.18	The Executive Team attended a Programme Management Executive Workshop with colleagues from Gloucester Care Services
11.09.18	The Director of Service Delivery attended a Board visit to the Clinical Systems Team.
	The Executive Directors attended Council of Governor's meeting.

12.09.18 The Director of Engagement and Integration conducted a Patient Safety Visit to the Crisis Resolution and Home Treatment Team, and Assertive Outreach teams in Stroud

The Director of Service Delivery attended Mental Health Legislation Scrutiny Committee Informal meeting.

13.09.18 The Deputy Chief Executive presented a ROSCA award to a staff member for Best Supporting colleague.

The Director of Service Delivery attended a meeting regarding sustained change at Stonebow Unit.

14.09.18 The Director of Engagement and Integration met with senior colleagues from the Engagement and Integration Directorate

The Medical Director attended an Associate Medical Director/Clinical Director away day.

17.09.18 The Executive Directors attended an Executive Development meeting

The Director of Service Delivery lead the corporate induction presentation for new members of staff.

18.09.18 The Director of Service Delivery presented ROSCA award certificates to nominees.

The Director of Service Delivery attended an IAPT Planning meeting for 2019/20

20.09.18 The Director of Finance and Commerce chaired the Transformation (CIP) Project Board

The Executive Directors attended an Executive Committee meeting

The Executive Directors attended a Joint Business Executive Team meeting

21.09.18 The Director of Service Delivery attended a Shaping Our Culture Steering Group with GCS

The Director of Quality attended the Quality and Clinical Risk Sub-Committee.

24.09.18 The Executive Directors attended an NHSI / 2gether Oversight Meeting

The Director of Service Delivery attended a Transformation Programme Board meeting

25.09.18 The Executive Team attended a Senior Leadership Networks meeting

	The Director of Finance and Commerce and the Director of Service Delivery attended the Capital Review Group meeting
	The Director of Organisational Development chaired a JNCC meeting
26.09.18	The Executive Team attended a Trust Board meeting
27.09.18	The Director of Service Delivery attended Trust Delivery Committee
	The Director of Quality met with the CQC provider Representatives.
28.09.18	The Deputy Chief Executive attended an Extraordinary joint JNCC/JNCF meeting
01.10.18	Members of the Executive Team conducted Team Talk sessions across the Trust sites
	The Director of Finance and Commerce chaired an Estates Discretionary Spend Meeting with senior members of the Finance and Commerce Directorate
	The Director of Organisational Development attended Corporate Induction
	The Director of Engagement and Integration hosted and the Director of Service Delivery attended a presentation by Quality Health on the results of the CQC Patient Experience Survey 2018
	The Director of Service Delivery attended a Liaison Psychiatry meeting
02.10.18	The Director of Engagement and Integration met with the Clinical Director of Herefordshire ^{2}gether services
	The Director of Engagement and Integration, The Director of Service Delivery and the Director of Organisational Development attended the Trusts Volunteer Tea party to acknowledge and celebrate the contribution of volunteers
03.10.18	The Executive Directors attended a Joint Business Executive Team meeting
04.10.18	The Director of Organisational Development chaired a Safety, Health & Environment Committee meeting
	The Director of Organisational Development and Medical Director attended an LNC meeting
	The Department of Engagement and Integration undertook a clinical visit to Occupational Therapists at Pullman Place
05.10.18	The Medical Director attended the Medical Staffing Committee.

08.10.18 The Director of Service Delivery attended an Occupational Therapy: Embracing a New Frontier workshop

09.10.18 The Director of Engagement and Integration met with senior colleagues from the Engagement and Integration Directorate

11.10.18 The Director of Engagement and Integration, Director of Service Delivery and Medical Director attended part of the Shaping our Culture Steering Group meeting with representatives from ^{2}gether and GCS

The Medical Director had a interview with NHSI about oversight of the merger with the GCS.

12.10.18 The Director of Engagement and Integration met with the new Chair of Research 4 Gloucestershire

15.10.18 The Director of Organisational Development attended a meet and greet induction for new staff

The Executive Directors attended an Executive Development meeting

The Medical Director attended the Vision and Values Workshop at Kingsholm Stadium.

16.10.18 The Director of Organisational Development and Deputy Chief Executive attended the Strategic Intent Leadership Group with colleagues from Gloucester Care Services

The Director of Engagement and Integration opened an In Our Shoes presentation as part of the Visions and Values week

The Director of Engagement and Integration attended a Joint Board Seminar as part of the Visions and Values week

17.10.18 The Director of Organisational Development attended an In Our Shoes presentation as part of the Visions and Values week

The Director of Organisational Development and Director of Engagement and Integration attended Development Committee

18.10.18 The Director of Finance and Commerce and the Director of Service Delivery attended an In Our Shoes presentation as part of the Visions and Values week

The Executive Directors attended an Executive Committee meeting

The Executive Directors attended a Joint Business Executive Meeting

19.10.18 The Director of Organisational Development conducted a Patient Safety Visit to the Jenny Lind and Cantilupe wards at Stonebow Unit

	The Director of Engagement and Integration chaired a QCR Sub-Committee meeting
	The Deputy Chief Executive attended an In Our Shoes presentation as part of the Visions and Values week
22.10.18	The Director of Quality attended the Herefordshire Management Meeting.
24.10.18	The Director of Finance and Commerce and the Director of Service Delivery attended the Delivery Committee
	The Director of Organisational Development attended an Integrated Delivery Board
	The Deputy Chief Executive conducted a patient safety visit to Gloucester Crisis Team.
25.10.18	The Executive Team attended a Joint Board Development meeting along with colleagues from Gloucester Care Services
26.10.18	The Director of Organisational Development, Director of Quality and Director of Engagement and Integration attended Governance Committee
29.10.18	The Deputy Chief Executive lead the presentation at corporate induction.
30.10.18	The Director of Finance and Commerce chaired the Capital Review Group meeting
	The Director of Organisational Development chaired a Safety, Health & Environment Committee meeting
31.10.18	The Director of Finance and Commerce chaired an SLR/PLICS meeting with senior members of the Finance and Commerce Directorate as well as representatives from Gloucester Care Services
	The Medical Director held a meeting with relatives following a serious incident review.

Board Stakeholder Engagement

03.09.18	The Director of Finance and Commerce took part in a bi-monthly update call with PwC
	The Director of Organisational Development attended a Senior Management Team meeting with GCS

The Director of Engagement and Integration met with the Chief Officer for Gloucestershire CCG

The Deputy Chief Executive attended a Cheltenham Integrated Locality Board meeting.

The Director of Service Delivery attended an EPRR Assurance meeting with colleges from Gloucestershire CCG

04.09.18 The Director of Organisational Development attended an STP Social Partnership Forum with GCS and GHT

The Director of Engagement and Integration attended a Mental Health & Wellbeing Partnership Board meeting at Gloucestershire CCG

The Deputy Chief Executive attended an EMIS Community and STP IT meeting with Herefordshire CCG.

05.09.18 The Director of Engagement and Integration and the Deputy Chief Executive attended a Forest of Dean Integrated Locality Board

The Deputy Chief Executive attended an IRIS Project Board meeting with Gloucestershire CCG.

06.09.18 The Director of Organisational Development and the Director of Finance and Commerce attended a meeting with GHT regarding a Working Well Contract

The Director of Engagement and Integration and Director of Service Delivery attended a strategic partnership meeting with Swindon and Gloucestershire Mind

The Deputy Chief Executive attended a STP Delivery Board with Gloucestershire CCG.

The Deputy Chief Executive attended a New Models of Care Board.

The Director of Quality attended the Gloucestershire Safeguarding Adults Board at Shire Hall.

07.09.18 The Director of Service Delivery attended a LMC CCG meeting to discuss Mental Health Issues.

The Deputy Chief Executive attended a Mental Health Commissioning meeting with colleagues from Gloucestershire CCG

The Deputy Chief Executive and Director of Service Delivery attended a presentation on S12 Solutions.

10.09.18 The Director of Finance Commerce attended the Transaction Leadership Group at Gloucester Care Services

The Director of Engagement and Integration chaired Gloucestershire Tackling Mental Health Stigma Group

The Deputy Chief Executive meet with colleagues from South Worcestershire CCG.

11.09.18 The Director of Finance and Commerce attended a Partnership Board Meeting with Gloucestershire Hospitals Trust

The Director of Engagement and Integration attended a Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC)

The Director of Engagement and Integration had a conversation with Healthwatch Gloucestershire

The Deputy Chief Executive attended a Integrated Care Alliance Programme Board with Herefordshire CCG

12.09.18 The Director of Engagement and Integration met with the Chair of Research4Gloucestershire

13.09.18 The Director of Finance and Commerce and Director of Engagement and Integration attended a Swindon Mind & 2gether Quarterly Strategic Partnership meeting

The Director of Finance and Commerce attended a discussion meeting with NHSI and counter-parts at Gloucester Care Services to review the merger strategic case

The Director of Engagement and Integration attended a 2gether Annual Business Review meeting with members from the National Institute for Health Research (NIHR) local Clinical Research Network West of England

14.09.18 The Director of Organisational Development chaired an ICS Workforce Steering Group meeting

The Deputy Chief Executive participated in a call regarding a review of the Gloucestershire ‘One Place’ Scheme.

The Deputy Chief Executive attended a One Hereford Next Steps meeting the colleagues from Herefordshire CCG.

The Deputy Chief Executive attended a DoF and DoS meeting in Malvern

18.09.18 The Director of Finance and Commerce attended a meeting with British Gas in Oxford

	The Deputy Chief Executive attended a Gloucester City Place Based Pilot Board
	The Deputy Chief Executive attended the Herefordshire and Worcestershire STP Partnership Board
19.09.18	The Director of Finance and Director of Service Delivery attended a Hereford Contract Management Board meeting
	The Director of Finance attended a RSG One Place meeting reviewing costs with staff from GCCG and Gloucester Care Services
20.09.18	The Deputy Chief Executive attended a STP CEO's meeting with colleagues from Gloucestershire CCG
21.09.18	The Deputy Chief Executive attended a Stakeholder Workshop for Mental Health Practitioner Pilot.
	The Deputy Chief Executive attended a Cheltenham ILB Data Sub-group meeting
24.09.18	The Director of Engagement and Integration attended a Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC) planning meeting
25.09.18	The Director of Engagement and Integration chaired an AHP meeting for Gloucestershire ICS
	The Director of Engagement and Integration attended an event at the University of Gloucester
	The Deputy Chief Executive attended the Gloucestershire Strategic Forum with colleagues from GCCG
	The Deputy Chief Executive attended the Herefordshire CCG AGM
27.09.18	The Director of Engagement and Integration attended in a meeting with colleagues from Gloucestershire County Council regarding Military Covenant
	The Director of Organisational Development and the Director of Engagement and Integration attended an NHS 70 Awards event in Cheltenham
	The Deputy Chief Executive attended a STP Clinical Reference Group meeting.
	The Deputy Chief Executive attended a CCG Launch Event at Cheltenham Racecourse.

28.09.18 The Director of Organisational Development met with the Director of the WRES Implementation Team

The Director of Engagement and Integration met with Healthwatch Herefordshire for an engagement meeting

01.10.18 The Director of Finance and Commerce chaired a meeting with Stroud Alarms regarding CCTV at Pullman Place

The Director of Organisational Development attended a Strategic Workforce Development Partnership Board at the University of Gloucestershire

The Director of Organisational Development attended a Senior Management Team Business meeting with GCS

The Director of Engagement and Integration met with the Associate Director of R&D at Gloucestershire Hospitals Trust

The Deputy Chief Executive attended a Health and Wellbeing Board.

The Deputy Chief Executive attended a Cheltenham Integrated Locality Board meeting.

02.10.18 The Director of Organisational Development met with the National Guardian

The Director of Engagement and Integration attended a Herefordshire Adults & Wellbeing Scrutiny Committee at Shire Hall in Hereford

03.10.18 The Director of Finance and Commerce met with the Director of Finance of Wye Valley Trust to discuss Herefordshire Telephony

04.10.18 The Director of Finance and Commerce and the Director of Service Delivery met with counter-parts from Gloucester Care Services regarding an Estates Maintenance Shortlist

The Director of Engagement and Integration chaired cross system STP Allied Health Professionals meeting

The Director of Engagement and Integration chaired a meeting of AHPs leaders across One Gloucestershire system.

The Director of Service Delivery attended the Dementia CPG Board with colleagues from Gloucestershire CCG

The Deputy Chief Executive attended an Integrated Care System Delivery Board

05.10.18 The Deputy Chief Executive attended a STP Partnership Board Quarterly Workshop.

The Director of Service Delivery attended a Mental Health Workshop hosted by Gloucestershire CCG

07.10.18 The Director of Engagement and Integration attended HM Lord Lieutenant's Awards Ceremony at HQ Allied Rapid Reactions Corps, Imjin Barracks

08.10.18 The Executive Team attended the Programme Management Executive Workshop at Gloucester Care Services regarding IM&T strategy

The Director of Finance and Commerce attended the Transaction Leadership Group at Gloucester Care Services

The Deputy Chief Executive, Director of Service Delivery and Director of Finance and Commerce attended an IAPT Performance Plan meeting with Gloucestershire CCG

The Director of Organisational Development chaired an ICS Workforce Steering Group meeting

The Director of Engagement and Integration presented a keynote on Occupational Therapy: Embracing New Frontiers workshop event with colleagues from ^{2}gether and GCS

The Director of Service Delivery attended a Learning Disabilities Away Day.

09.10.18 The Director of Finance and Commerce met with the Business Development Manager from DisabledGo

The Director of Finance and Commerce attended a Resources Steering Group meeting with Gloucestershire CCG at Sanger House

The Director of Engagement and Integration provided a lecture on The Future of Health and Social Care with Faculty members of the University of the West of England, AHP and Health Science program

The Director of Service Delivery attended a Safer Gloucestershire event at Police HQ

The Deputy Chief Executive attended an Integrated Care Alliance Programme Board with Herefordshire CCG.

10.10.18 The Deputy Chief Executive and Director of Finance and Commerce attended the Local Digital Roadmap refresh meeting with Gloucestershire CCG

The Deputy Chief Executive attended a Forest of Dean Integrated Locality Board.

	The Director of Service Delivery attended a Mental Health Open day to provide a presentation and participate in a questions and answers panel.
11.10.18	The Deputy Chief Executive attended a STP Health Estates meeting with colleagues from Gloucestershire CCG
15.10.18	The Director of Organisational Development attended a Three Counties Medical School Partnership Group committee involving the University of Worcester and representatives from local NHS bodies
	The Director of Service Delivery attended an “In your Shoes” Values Session
16.10.18	The Director of Finance and Commerce and Director of Organisational Development met with representatives from Liaison regarding Contract Renewal Options
	The Director of Service Delivery met with PWC regarding Internal Audit
16.10.18	The Director of Engagement and Integration met with the Chair of the Development Committee
17.10.18	The Director of Finance and Commerce and the Director of Service Delivery attended a Trust Contract Management Board meeting with Herefordshire CCG
	Members of the Executive Team attended a Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC) informal meeting with colleagues from ^{2}gether and GCS
	The Deputy Chief Executive attended a STP Mental Health Workstream meeting.
18.10.18	The Director of Engagement and Integration met with the Chief Executive of Cobalt Health with the Director of Clinical Research
19.10.18	The Director of Engagement and Integration presented an evening session at the Frampton on Severn Patient Participation Group
	The Director of Service Delivery attended a meeting with Gloucestershire CCG regarding Mental Health Accommodation Based Support
	The Deputy Chief Executive met with the Member of Parliament representing Hereford
22.10.18	The Director of Engagement and Integration held a meeting with Herefordshire CCG regarding AHP developments

The Director of Service Delivery visited the Team at Alexandra Wellbeing House.

23.10.18 The Director of Finance and Commerce met with PWC for a monthly catch up

The Director of Engagement and Integration met with colleagues from Healthwatch Gloucestershire

The Director of Engagement and Integration attended an STP Clinical Reference Group meeting

The Deputy Chief Executive and Director of Service Delivery attended a Dementia CPG Board.

The Director of Service Delivery attended a Better Care Together Transformation Meeting

24.10.18 The Deputy Chief Executive and Director of Finance and Commerce met with representatives from Greenway Properties regarding Cleeve House

The Director of Engagement and Integration opened a Research Showcase event held by Worcester University for ^{2}gether staff in Herefordshire

The Deputy Chief Executive attended a ICP/PCN Working group with colleagues from Gloucestershire CCG

25.10.18 The Director of Engagement and Integration held a teleconference with the West of England Academic Health Science Network

The Director of Service Delivery attended a Young Carers workshop

26.10.18 The Deputy Chief Executive and Director of Service Delivery participated in a conference call regarding Mother and Baby Units with Gloucestershire CCG

The Director of Service Delivery attended an IRIS Strategy meeting.

The Deputy Chief Executive attended a Cheltenham Integrated Locality Board Data Sub-Group meeting.

29.10.18 The Director of Organisational Development and the Director of Finance and Commerce took part in a conference call with Liaison regarding Contract Renewal Options

30.10.18 The Deputy Chief Executive and Director of Finance and Commerce attended an LDR refresh meeting with GCS, GHT and Gloucestershire County Council

	The Director of Engagement and Integration attended an event held by Gloucestershire Young Carers
31.10.18	The Director of Finance and Commerce met with representatives from KPMG
	The Director of Finance and Commerce attended a Resources Steering Group meeting with Gloucestershire CCG at Sanger House
	The Director of Organisational Development attended the Gloucestershire Local Workforce Advisory Board (LWAB) meeting
	The Deputy Chief Executive meet with colleagues in Herefordshire regarding Community Outcomes Framework

National Engagement

12.09.18	The Director of Finance and Commerce attended a webinar regarding Mental Health Finances of the NHS Long Term Plan
13.09.18	The Director of Organisational Development chaired a South West HR Directors Network Forum in Taunton
17.09.18	The Director of Finance and Commerce attended a Directorate of Finance and Directorate of Services meeting with staff from several other local NHS organisations
18.09.18	The Director of Organisational Development chaired a Building Relationships Across the South West conference in Cheltenham
27.09.18	The Director of Finance and Commerce attended an Annual Mental Health Finance Conference in London
03.10.18	The Director of Organisational Development attended the 'Let's Talk: The Future for Integrated Social Care' presentation at the University of Gloucestershire
05.10.18	The Director of Organisational Development attended a presentation on Eliminating the Gender Pay Gap in London
09.10.18 & 10.10.18	The Director of Organisational Development attended an NHS Providers annual conference in Manchester
24.10.18	The Director of Quality attended a NHS England Learning into Action Meeting in London
31.10.18	The Director of Engagement and Integration attended a National Institute for Health Research (NIHR) Nursing Times Awards finalist event with members of the ^{2}gether Research Team.
	The Director of Quality attended the Nursing Times Awards on behalf of 2gether NHS Foundation Trust.

Agenda item 15 **Enclosure No Paper J**

Report to: 2gether NHS Foundation Trust Board 29th November 2018
Author: Stephen Andrews, Deputy Director of Finance
Presented by: Andrew Lee, Director of Finance and Commerce

SUBJECT: **Summary Finance report for period ending 31st October 2018**

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 £533k which is £11k above the planned surplus.
- The month 7 forecast outturn is an £834k surplus in line with the Trust's control total.
- The Trust currently has an Oversight Framework segment of 2, and a Finance and Use of Resources metric of 2.
- The agency cost forecast is £4.455m, an increase of £0.182m on last month's projection and £1.321m above the Agency Control Total. This is due to increased IAPT agency spend (£130k in October) to reduce waiting lists and is matched by additional income from Gloucestershire CCG.
- The Trust has identified £866k of recurring savings up to October 2018 which is £137k behind plan.
- The Trust has a year end cash projection of £15.2m which is £5.4m greater than the plan.
- 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. There are a number of cost pressures the Trust is managing and the review has identified the mitigations and deliverables required to ensure the Trust meets its control total at year end.

RECOMMENDATIONS

It is recommended that the Committee:

- note the month 7 position
- note the risks inherent in the financial projections

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: Andrew Lee, Director of Finance and Commerce		
	Date	15th November 2018

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
	Date	

Explanation of acronyms used:	See footnotes

1. CONTEXT

The Board has a responsibility to monitor and manage the performance of the Trust. This report presents the financial position and forecasts for consideration by the Board.

2. EXECUTIVE SUMMARY

The following table details headline financial performance indicators for the Trust in a traffic light format driven by the parameters detailed below. Red indicates that significant variance from plan, amber that performance is close to plan and green that performance is in line with plan or better.

Indicator	**Measure**		**Comments**
NHS I Oversight	Single Oversight Framework Segment	2.0	as at June 2018
Use of Resources	Financial Risk rating	2.0	as at Oct 2018
Income	FOT vs FT Plan	102.5%	
Operating Expenditure	FOT vs FT Plan	102.6%	
Year end Cash position	£m	15.2	
PSPP	%age of invoices paid within 30 days	96.0%	90% paid in 10 days
Capital Income	Monthly vs FT Plan	199.8%	sale of Fieldview, Coleford House & London Rd
Capital Expenditure	Monthly vs FT Plan	74.9%	£1,080k expenditure.

The parameters for the traffic light dashboard are as follows;

Indicator	RED 	AMBER 	GREEN 
NHS I FOT segment score	>3	2.5 - 3	<2.5
Use of Resources Score	>3	2.5 - 3	<2.5
INCOME FOT vs FT Plan	<99%	99% - <100%	=>100%
Expenditure FOT vs FT Plan	>101%	>100% - 101%	=<100%
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 Spend - Monthly vs FT Plan	>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 £533k which is slightly better than the planned surplus (see appendices 1 & 8).
- Income is £1,239k over recovered against budget and operational expenditure is £1,276k over spent, and non-operational items are £53k 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	(5,309)	(3,076)	(2,959)	117	(5,180)	129
Stroud & S Cots Locality	(6,129)	(3,540)	(3,478)	62	(6,074)	55
Gloucester & Forest Locality	(4,484)	(2,616)	(2,592)	24	(4,461)	23
Social Care Management	(5,034)	(2,946)	(3,572)	(626)	(6,192)	(1,159)
Entry Level	(5,927)	(3,576)	(3,500)	76	(6,458)	(531)
Countywide	(32,124)	(18,771)	(18,639)	132	(32,270)	(146)
Children & Young People's Service	(6,827)	(3,997)	(3,693)	304	(6,366)	461
Herefordshire Services	(13,659)	(7,942)	(7,929)	12	(13,771)	(111)
Medical	(15,472)	(8,922)	(9,472)	(550)	(16,145)	(673)
Board	(1,425)	(831)	(1,407)	(575)	(2,530)	(1,105)
Internal Customer Services	(1,864)	(1,087)	(1,073)	14	(1,891)	(27)
Finance & Commerce	(6,460)	(3,840)	(4,141)	(301)	(6,517)	(57)
HR & Organisational Development	(3,530)	(2,059)	(1,886)	173	(3,359)	171
Quality & Performance	(3,172)	(1,850)	(1,830)	20	(3,314)	(142)
Engagement & Integration	(1,490)	(869)	(876)	(7)	(1,516)	(26)
Operations Directorate	(1,048)	(612)	(670)	(58)	(1,194)	(146)
Other (incl. provisional / savings / dep'r	(4,860)	(2,723)	(2,796)	(73)	(4,565)	295
Income	119,647	69,773	71,045	1,387	122,636	2,989
TOTAL	**834**	**518**	**533**	**131**	**834**	**0**

The key points are summarised below;

In month

- The Social Care Management over spend relates to Community Care and is offset by additional income
- The Childrens Services under spend relates to vacancies and project expenditure not yet fully committed
- The Medical over spend has been caused by agency expenditure - £1.073m year-to-date
- The over spend on Board relates to Improving Patient Safety spend, merger costs and STP OD project spend for which there is some income to cover all three issues
- Finance and Commerce is over spent on telephony and COIN although some is offset by income
- Other expenditure is overspent due to increased depreciation costs
- Income is over recovered due to additional income for activity related Community Care work and additional development funds which weren't budgeted

Forecast

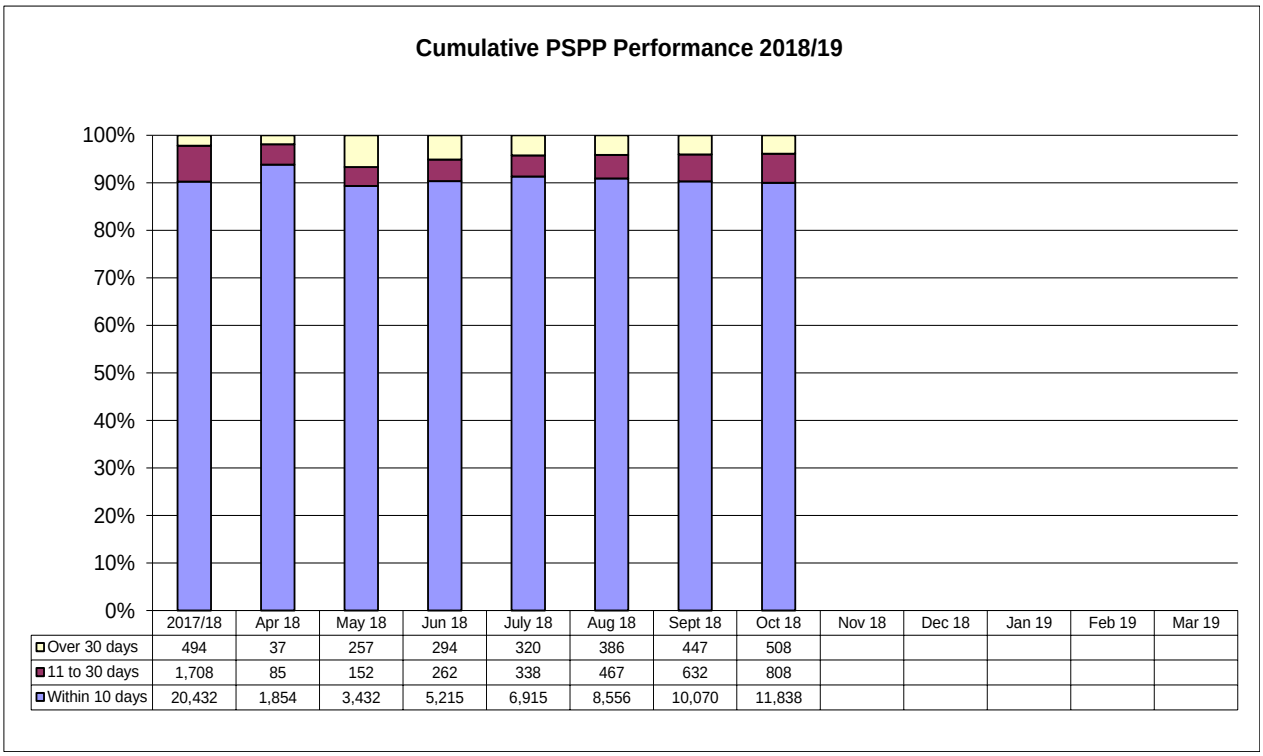
- The Social Care Management forecast over spend relates to Community Care and is offset by additional income
- The Herefordshire services forecast over spend is due to specialling costs and

cost pressures caused by difficulties in recruiting to the wards. The specialling costs are matched with additional income of £180k

- The Medical forecast over spend is due to anticipated continuing usage of agency during 2018/19
- The forecast over spend on Board is linked to expenditure on STP OD projects for which there is some budget in reserves.

PUBLIC SECTOR PAYMENT POLICY (PSPP)

The cumulative Public Sector Payment Policy (PSPP) performance for month 7 is 90% of invoices paid in 10 days and 96% paid in 30 days. The cumulative performance to date is depicted in the chart below and compared with last year's position:



	2017/18	Apr 18	May 18	Jun 18	July 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Over 30 days	494	37	257	294	320	386	447	508					
11 to 30 days	1,708	85	152	262	338	467	632	808					
Within 10 days	20,432	1,854	3,432	5,215	6,915	8,556	10,070	11,838					

	10 days		30 days	
	In month	**YTD**	**In month**	**YTD**
Number paid	1,781	11,838	1,951	12,646
Total Paid	2,006	13,154	2,006	13,154
%age performance	**89%**	**90%**	**97%**	**96%**
Value paid (£000)	6,315	38,009	6,416	39,317
Total value (£000)	6,465	41,087	6,465	41,087
%age performance	**98%**	**93%**	**99%**	**96%**

Agenda item 16 **PAPER K**

Report to: Trust Board, 29 November 2018
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. The assurance map was last reviewed by the Board in April 2018. The Audit Committee reviewed this iteration of the assurance map on 7 November 2018.

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. In addition to regular review by the Audit Committee, the assurance map is reviewed on a regular basis by the Executive Committee.

This iteration of the assurance map contains 10 risks, compared to 11 risks at the time of the Board's last review of the document in April. While the overall number of risks on the assurance map has decreased by 1, a number of risks have been added or removed from the assurance map in the interim, 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, and a number of presentational changes have been made to improve clarity.

At its meeting on 7 November, the Audit Committee noted several changes to the content of the assurance map compared to its previous review which took place in August. One risk (AM 18 – delivery of 2018/19 cost improvement plan) has been reinstated to the assurance map for this iteration, and has also been reinstated as one of the Trust's top 5 risks following mitigation of another risk which had previously been assigned a top 5 designation by the Audit Committee. At its meeting on 7 November the Audit Committee asked that the Executive Committee inform Non-Executive Directors promptly of any changes to the top 5 risks, rather than wait until a formal Board and Committee meeting which, given current scheduling, might

not take place for some time.

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:		
Executive Committee	Date	18 October 2018

Where in the Trust has this been discussed before?		
Executive Committee Audit Committee	Date	October 2018 November 2018

What consultation has there been?		
Updates obtained from Risk Manager/Datix	Date	October 2018

Explanation of acronyms used:	

ASSURANCE MAP - NOVEMBER 2018

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 *Quality & safety issues*	Audit Committee *Internal control issues*	MHL Scrutiny Committee *MHS/MCA compliance issues*	Development Committee *Development & engagement issues*	Executive Committee *Enacts strategic priorities*	Ratings and formal declarations	Delivery Committee *Performance & improvement issues*	Board	Internal Audit Plan	External Audit	External Review/Accreditation	Action Plan	Add to IA Plan for further review	**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 the Trust fails to ensure that RiO records (Child in household) are accurate and complete then this may result in poor multi-agency communication which may result in a failure to protect children.		1	G	JT	●		●		●	●			●							✓		LTD	8	3x4 = 12	↔
AM23	31	If Information provided by key electronic health record systems (i.e. RiO, IAPTUS) is not accurate or complete then this may adversely affect key business decisions, our services, Trust reputation and may also result in a regulatory breach.		1	Del	JC	●								●		●		●			✓		LTD	6	4x3 = 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	AU	●				●	●			●			●				✓		SIG	4	3x4 = 12	↔
People Risk																											
AM20	173	Our inability to recruit successfully in the Trust can lead to serious issues with service delivery during and after hours [i.e Medical and Non-Medical Staff]	✓	1	G	AU, JT	●				●	●			●			●				✓		LTD	4	3x4 = 12	↔
AM26	232	Limited availability of Section 12 Appproved Doctors out of hours can lead to delays in Mental Health Act assessments and treatment		1	MHL	AU, JC	●						●		●									LTD	4	3x4=12	↔
Safety/Clinical Risk																											
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	JC	●	●				●			●		●					✓		LTD	9	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	G	NS	●	●				●			●		●		●			✓		LTD	8	3x4 = 12	↔
AM24	216	The process necessary to achieve authorisation for merger may impact on: The Trust financial position The Trusts ability to deliver its commissioner responsibilities Relationships with wider system partners Reputation	✓	3	E	JC	*SILG*	*PME*	*AUDIT CTEE*						●			●	●			✓		LTD	4	3x4 = 12	↔
Financial Risk																											
AM18	177	If the 2018/19 Cost Improvement Plan is not delivered there is a significant risk that the Trust will not meet its financial control total.	✓	3	E	AL	●	●				●			●			●	●	●		✓		LTD	9	3x4 = 12	↑
AM12	116	If Agency management control is not effective then this may impact both on quality and safety of services as well as the Trust's overall financial control total.	✓	3	G	JT	●	●			●	●			●			●	●			✓		LTD	4	3x4 = 12	↔

ASSURANCE MAP - NOVEMBER 2018

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 *Quality & safety issues*	Audit Committee *Internal control issues*	MHL Scrutiny Committee *MHS/MCA compliance issues*	Development Committee *Development & engagement issues*	Executive Committee *Enacts strategic priorities*	Ratings and formal declarations	Delivery Committee *Performance & improvement issues*	Board	Internal Audit Plan	External Audit	External Review/Accreditation	Action Plan	Add to IA Plan for further review	**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** Oversight of quality and patient safety issues
Del	**Delivery Committee** Oversight of training/development, performance and im provement issues
Dev	**Development Committee** Oversight of service development and engagement issues
MHL	**Mental Health Legislation Scrutiny Committee** Oversight of MHA/MCA compliance issues
E	**Executive Committee** Overight of finance and risk issues generally

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

Risk levels

- Extreme
- High
- Moderate
- Low

2gether Making life better

2gether NHS Foundation Trust

PAPER L1

BOARD COMMITTEE SUMMARY SHEET

COMMITTEE NAME: Appointments and Terms of Service Committee (ATOS)

DATES OF COMMITTEE MEETINGS: 28th September 2017, 10th October 2017, 23rd & 30th November 2017, 21st December 2017, 12th & 30th January 2018, 22nd February 2018, 26th April 2018, 31st May 2018 and 30th August 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

SUMMARY

This report presents a summary of the Appointments and Terms of Service Committee's meetings and work in the 12 months following its last Board summary report.

The Committee's prime purpose is to determine and decide on appointments, appropriate remuneration, terms and conditions of service for the Chief Executive and Executive Directors. This includes deciding all aspects of salary and the provision of any other benefits and contractual terms. It is also responsible for overseeing and approving the award of Consultant Clinical Excellence awards.

The Committee met on eleven occasions over this period between September 2017 and August 2018. Each meeting has been quorate with the participation of not less than four Non-Executive Directors plus the Trust Chair. The Chief Executive (and/or Deputy Chief Executive) and the Director of Organisational Development were either in attendance or available for each meeting.

September 2017

The Committee received a paper outlining the recommended approach for the appointment of a Joint Chair and Joint Chief Executive. It approved the approach to be taken for the appointment of a Joint Chief Executive and noted the approach proposed for Council of Governors to appoint the Joint Chair. An update report was provided by the Deputy Chief Executive on finalising resolution for an Executive Director on matters relating to Sections 5.15 of the NHS Standard Contract on "Employment or engagement following NHS Redundancy."

October 2017

The Committee received a draft Management Services Contract for the provision of potential joint management services with Gloucestershire Care Services NHS Trust. The Committee endorsed the approach and noted that a final revised agreement would be considered at Audit Committee. An update was provided confirming the progress with enacting the appointments of a Joint Chair and a Joint CEO. It was noted that Ingrid Barker had been

successful in being appointed to the role of Joint Chair following the recruitment process, group discussions and interview panel the previous week on the 3rd of October. An update was also provided on the next steps in the appointment process for the Joint CEO, with an internal assessment process and interview scheduled for November 2017. The Committee reviewed and approved the finalisation of the job description and person specification for the Joint CEO subject to Gloucestershire Care Services NHS Trust's agreement. Finally, the Committee received an update and endorsed Chair's Action taken since the previous meeting in relation to the remuneration offer including the award of 3 Clinical Excellence Awards for a new Consultant.

23rd November 2017

The Committee received a paper and endorsed arrangements for securing continuity of executive leadership during the transition towards the proposed merger. It noted that the internal Joint CEO process had not concluded with an appointment and that the external recruitment process was underway with a view to the assessment process and interviews concluding in January 2018. An agreed approach was reached on interim Acting arrangements in light of the prolonged absence of the CEO due to ill health. Contractual termination and notice provisions for an Executive post were considered alongside mechanisms to ensure the uptake of Executive Annual Leave. Finally, the Committee noted the planned retirement of the Director of Service Delivery in 2018 and approved the job description, person specification, remuneration and recruitment process for replacing this role.

30th November 2017

The Committee received a paper on Progressing the Trust's Strategic Intent. Through this the Committee considered the Accounting Officer's Memorandum of Understanding and agreed that it was necessary to put into place temporary arrangements in the prolonged absence of the Accounting Officer. The Committee endorsed the appointment of the Deputy CEO into the Accounting Officer role and the extension of the Acting CEO arrangements.

21st December 2017

The Committee received further updates on Progressing the Trust's Strategic Intent. This included an update and agreement on interim Executive leadership arrangements, including the appointment process for an interim Deputy CEO. A proposal was received and endorsed on the proposed remuneration of the Joint Chief Executive role based on national and benchmarking alongside consideration of the NHS Foundation Trust Network Remuneration and NHS Improvement VSM Guidance. The Committee noted that under the current rules, the final pay arrangements may be subject to NHS Improvement "opinion". Finally, a proposal was received on securing the services on a fixed term basis of the retiring Director of Service Delivery through the Trust's "Retire and Return "provisions. This was agreed for an initial period of up to 30th September 2018.

12th January 2018

The Committee considered a paper on progress with Executive Director roles and leadership within the Trust. This included an update on the appointment process for the Joint Chief Executive and agreement of the next steps. Consideration was also made and support given on appointment into the Director of Service Delivery role on a fixed term basis in view of the planned merger. Finally, the Committee considered written legal advice from Mills and Reeve and associated recommendations relating to the potential termination contractual

arrangements for an Executive Director in the event of an appointment of the new Joint CEO.

30th January 2018

The Committee received an update that NHS Improvement had been briefed on the potential contractual termination arrangements discussed at the meeting of the 12th of January and had advised the Trust there were no issues. A Partner from Mills and Reeve attended and advised the Committee on related contractual requirements and obligations.

22nd February 2018

The Committee received a report on the conclusions of the Joint CEO appointment process. It endorsed the appointment of Paul Roberts to the post from April 2018 and agreed his associated remuneration and associated terms subject to satisfactory receipt of NHS Improvement "opinion". The Committee agreed to the Deputy Chair and the Director of OD progressing and concluding contractual termination arrangements of and Executive Director following the successful joint CEO appointment. The Committee received an update and endorsed the interim appointment of John Campbell to the Director of Service Delivery post. Finally, the Committee considered and approved a recruitment process and terms for a merger Programme Director.

26th April 2018

The Committee received and approved the outcome of the 2017 Clinical Excellence Awards (CEA) round. It noted that two CEA meetings had taken place in March 2018, following the usual Trust policy and process in line with national guidance. 34 Consultants had been eligible to apply, with 10 of these applying and a further one candidate undergoing a five-year review. The Committee supported the recommendation for candidates for the five-year review to retain their existing CEAs. It also supported the recommendation to make one award of 2 CEAs and six awards of a single CEA each, with one award being carried forward to the following year's round. 2017/18.

31st May 2018

The Committee received an update on the resignation of the Director of Quality who had secured a new role for geographical reasons. Consideration was given to the process and options to replace the current post holder in advance of her leaving date in September 2018. The Committee considered and approved the appointment of the Director of OD into an interim Joint Director role covering both ²gether and Gloucestershire Care Services subject to the latter organisation's own Remuneration Committee. Agreement was reached on the portfolio and extension of the Deputy CEO's fixed term contract to March 2019 and necessary amendments to executive voting rights for this period.

30th August 2018

The Committee approved the appointment of John Trevains into the role of Director of Quality on an interim basis. An extension of the interim Director of Service Delivery's fixed term contract was approved until the 31st March 2020. A paper was considered and supported on the appointment arrangements of Executive Directors into the Shadow Board of the proposed merged organisation. A proposal for the future appointment of a new Director of Strategy and Partnerships was considered and approved alongside the job description, person specification and remuneration for the role.

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Neil Savage, Director of Organisational Development

SUMMARY PRESENTED BY: Ingrid Barker **ROLE: Joint Chair**

DATE: 20th November 2018

2gether Making life better

2gether NHS Foundation Trust

PAPER L2

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Development Committee

DATE OF COMMITTEE MEETING: 17 October 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

POLICY/STRATEGY ALIGNMENT REPORT

This report offered assurance that a programme and schedule to align enabling strategies for 2gether and GCS was underway. Co-ordination of strategy alignment was being progressed via the Governance work stream of the Merger Transition programme. A review of the Clinical Policies had also now commenced.

OCCUPATIONAL HEALTH SERVICE UPDATE

The Committee received an update on the progress regarding appropriate longer term accommodation for Working Well, alongside a progress update on the Occupational Health contracts for clients of 2gether's Working Well service.

ENGAGEMENT AND COMMUNICATION TACTICAL PLAN (Q1 & Q2)

The Committee received and noted the progress against the Engagement and Communication Strategy Tactical Plan for 2018/19 and the suggested areas of key focus for the remainder of 2018/19. Key achievements included:

- communication on the merger,
- a system had been introduced and piloted to assess whether engagement with the Trust at community events had increased knowledge and understanding of mental health and MH services. The pilot demonstrated 98.7% of respondents had found engagement enhanced knowledge and understanding.
- Progress had been made on embedding organisational learning from feedback received via complaints, compliments and PALS visits.
- Trust Executives had attended 16 Integrated Locality Board meetings to ensure improvements in Gloucestershire and Herefordshire place-based developments and made 21 board visits.

The key focus in Q3 and Q4 would be to; increase Trust membership in Herefordshire and the Cotswolds, and for young people; To increase the percentage of Staff Friends and Family Test respondents who would recommend the Trust as a place to work; and further efforts were also required to meet targets for enhanced social media engagement.

STAKEHOLDER SUB-COMMITTEE SUMMARY REPORT

The Committee noted the summary report from the Stakeholder Sub-Committee Meeting held on 16th October. The two key areas of discussion were the development of volunteers and the NHS Improvement Always Event project.

RESEARCH OVERVIEW COMMITTEE – SUMMARY OF MEETINGS

The Committee noted the summary report from the Research Overview Sub-Committee Meeting held on 15th August. Key areas of discussion included the very positive and supportive relationship with Cobalt, connections with the University of Gloucestershire, a planned research

engagement event, the Trust Research Policy and Standard Operating Procedures. The Count Me In Policy was discussed and updates on Research 4 Gloucestershire.

The Committee noted that the Director of Clinical Research had been appointed and this post would be shared by Dr Tarun Kuruvilla specialising in Dementia and Dr Rob Macpherson specialising in Working Age Recovery and Assertive Outreach.

The Research Team had been shortlisted for a Nursing Times Award. The team would be making a presentation to the National Research Group and the Committee wished them all the best.

REVIEW OF THE CAPITAL PROGRAMME

The Committee received a review of the Capital Programme at month 6 of the financial year 2018/19. At month 6 capital expenditure was £842k; an under spend of £164k against the NHS Improvement Plan of £1,006k and an under spend of £101k against the Trust's Revised Budget Plan of £943k. Following an Executive review of the major capital schemes the M12 forecast capital expenditure was £3,969k with £1,651k of forecast spend being re-profiled to 2019/20.

Over 30 schemes had been approved by the Capital Control Group and improved attendance at these meetings continued. It was noted that a number of projects were deferred while alternative options were sought, however, the Committee was assured that operational colleagues were in attendance at CRG meetings and discussions around the impact on service users of delaying projects was considered.

The Committee received an update on current and proposed estate disposals. From November 2018 the disposals update was to be included on the standing agenda for the Capital Review Group.

RECOVERY COLLEGE ANNUAL REPORT

The Recovery College was commissioned by Gloucestershire CCG to run on a co-production and co-delivery ethos to empower people recovering from a mental health problem and those who support them to take charge of their own wellbeing.

Some of the key activity over the last academic year 2017-2018 included:

- 208 separate students (a 7% increase) attended at least one Recovery College session in 2017-2018.
- 34 Recovery College courses were delivered in 2017-2018 which consisted of a diverse programme of education and validation of achievement. There is significant assurance that the Recovery College met the service specification set by Gloucestershire CCG.
- Service experience feedback and outcome measures indicate that the majority of students benefitted from the Recovery College.
- Significant assurance is provided that the educational model delivered through the Recovery College offers value, effectiveness of outcome and best service experience.

The Recovery College had been a really successful project and was very cost effective and it agreed that work would be carried out to further publicise the Recovery College and to share this good news.

ACTIONS REQUIRED BY THE BOARD

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

PAPER L3a

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Delivery Committee

DATE OF COMMITTEE MEETING: 27 September 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PERFORMANCE DASHBOARD

The Committee received the Performance Dashboard setting out the performance of the Trust for the period to the end of August 2018. Of the 194 performance indicators, 88 were reportable in August with 83 being compliant and 5 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.

The confirmed positions for May, June and July had been updated since the previous month's report. This meant that the position in May had increased by 1% to 90%, June had seen a decrease of 1% to 91% and July had increased by 1% to 94%.

The following key performance areas remained a priority for the Trust as they had the potential to carry contractual, financial, reputational or quality risk;

- Under 18 admissions to Adult Inpatient Wards (2.21)
- Improving Access to Psychological Therapies (IAPT)
  - Recovery (3.17, 5.08), Access (3.18, 5.09a) & Waiting times (1.09 & 1.10)
- CYPS/ CAMHS Level 2 and 3 Referral to Treatment waiting times (3.26 & 3.27)
- Eating Disorders (ED) Waiting times (3.63, 3.64, 3.65 & 3.67)

IRIS – CURRENT POSITION

The Committee was presented with an overview of the Business Case for Gloucestershire's Intensive Recovery & Intervention Service (IRIS), the CYPS role within IRIS and the current risks and challenges to the service. The Committee also received an overview of the investment offer by NHS England regarding bed days and the proposed model of clinical delivery within a social care setting.

The IRIS Business Case provided an innovative and integrated approach between the NHS and social care (including education) to ensure young people over 11 years old, with complex needs, received joined up assessments and ongoing care. A formal IRIS Project Board with membership from all partner agencies had been established to provide oversight of IRIS.

OD ANNUAL ASSURANCE STATEMENT - ACTIONS

The Delivery Committee was presented with assurance that the Organisational Development strategy and its underpinning action plan were being progressed. The 3-year Organisational Development strategy was approved by the Board of Directors in the summer of 2015. The content of the strategy was aligned to the Trust's three strategic objectives.

The Committee was significantly assured that the Organisational Development action plan was being monitored through and supported by the People Committee and had been progressed during 2017/18 and in the first two quarters of 2018/2019. The Committee was significantly

assured that the strategy and underpinning plan was connected with other strategies and action plans and formed part of an integrated approach to organisational development. There was on-going engagement with key stakeholders including a programme of Staff Focus Groups, and a review by the People Committee.

A new strategy was in the process of being formulated for quarter 4 as part of the preparation for the merger.

STAFF SURVEY – RESULTS AND ACTION PLAN

The Committee received an update on the NHS Annual Staff Survey and on progress with the associated action plan. The 2018 Annual Staff Survey would be launched in October.

The Committee received an update on the most recent Staff Friends and Family score and noted a rating of significant assurance on staff experience within the Trust. It was pleasing to note that there had been an improvement in the number of people recommending the Trust as a place to work. The Quarter 2 Staff Friends and Family score would be reportable in October 2018.

BENCHMARKING REPORT

The Committee noted that the national average was still based on 2016/17 as 2017/18 national figures would not be available until later in the year.

Challenges with in-patient length of stay were noted, associated with several factors including Delayed Transfers of Care (DTOC's), with social worker provision, variations in ward performance and increase in patient acuity. Actions had been identified within the report to address declining performance and bring about improvement. Community Services demonstrated a static or improving picture against the national average however there was still more to do. The Committee noted that the outcome of this analysis would be included in the next Performance Dashboard report.

IAPT SERVICE IMPROVEMENT PLAN

The Committee received an overview of the key issues relating to the progress made within IAPT Services for both Gloucestershire and Herefordshire. The report updated the Committee on all aspects of the IAPT recovery plans.

The key issues for the Committee to be aware of this month were:

- In stage waiting list backlog clearance:
  - For Gloucestershire the plan required additional investment which had been requested via our Commissioners. Additionally, a revised Access trajectory had been agreed, which would enable the backlog to be reduced earlier.
  - For Herefordshire a revised Access trajectory had been discussed and agreed with Commissioners in principle. Formal agreement was anticipated in September.
- Access rates for August 2018 were marginally below recovery plan target for Herefordshire (14.73% against a 15% target) and above recovery plan target for Gloucestershire at 17.32% (against a 17% target)
- Recovery rates for August 2018 were above the national 50% target for Gloucestershire and Herefordshire.
- Waiting time thresholds – Nationally, waiting time thresholds were reported against 2 measures – 6 and 18 week referral to treatment.

REVIEW OF DELIVERY COMMITTEE RISKS

There were no Top 5 risks currently allocated for the Delivery Committee. However, a new risk was identified – Cyber Risk – GP Surgeries but since highlighting this risk, assurance had been received that adequate mitigation was in place and that the risk owner planned to recommend to the Executive Committee that the risk be removed from the Top 5. The Committee was

concerned that they were not being sighted on new risks in a timely way and asked if a process could be developed to ensure that Executives and Chairs of the relevant Committee were informed as soon as possible.

The Committee noted that Data Quality and IAPT Services (Performance Standards) were Delivery Committee risks with limited assurance.

OTHER ITEMS

- The Committee received a presentation which provided an overview of Dementia Services for Herefordshire and Gloucestershire
- Locality exception reports were received and noted for the Gloucestershire localities and Countywide. In Countywide, good progress had been made in addressing the recommendations from the recent CQC inspection at Berkeley House, which had been rated as "requiring improvement". An update on the position with the outstanding requirements would be provided in the next Locality Exception Report.
- A review of Countywide sickness absence had been carried out. Sickness absence of 3.8% was reported, this was made up of 89% short term sickness and 11% long term. Close work was being undertaken with HR to make improvements.
- The Committee noted the Trust's current position against the Emergency Preparedness, Resilience and Response (EPRR) Core Standards. The format of the 2018/19 core standards reporting had been modified making a direct comparison with last year's report not feasible.
- There was currently full assurance on all security policies and procedures. The Violence and Aggression risk was now rated as providing significant assurance. Policies and procedures were in place and these had been examined during a recent PWC internal audit at the request of the Executive Committee.

ACTIONS REQUIRED BY THE BOARD

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

PAPER L3b

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Delivery Committee

DATE OF COMMITTEE MEETING: 24 October 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PERFORMANCE DASHBOARD

The Committee received the Performance Dashboard setting out the performance of the Trust for the period to the end of September 2018. Of the 194 performance indicators, 125 were reportable in September with 112 being compliant and 13 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.

The confirmed positions for July and August had been updated since the previous month's report. This meant that the position in July had increased by 2% to 95%; August had seen a decrease of 1% to 93%.

The following key performance areas remained a priority for the Trust as they had the potential to carry contractual, financial, reputational or quality risk;

- Under 18 admissions to Adult Inpatient Wards (2.21)
- Improving Access to Psychological Therapies (IAPT)
  - Recovery (3.17, 5.08), Access (3.18, 5.09a) & Waiting times (1.09 & 1.10)
- CYPS/ CAMHS Level 2 and 3 Referral to Treatment waiting times (3.26 & 3.27)
- Eating Disorders (ED) Waiting times (3.63, 3.64, 3.65 & 3.67)

IAPT SERVICE IMPROVEMENT PLAN

The Committee received an overview of the key issues relating to the progress made within IAPT Services for both Gloucestershire and Herefordshire. The report updated the Committee on all aspects of the IAPT recovery plans.

The key issues for the Committee to be aware of this month were:

- In stage waiting list backlog clearance - in both Counties, the backlog waiting list was the most significant concern:
  - For Gloucestershire the plan required additional investment which had been requested via Commissioners. Additionally, a revised Access trajectory had been agreed with Commissioners. The Service would continue to review the backlog plan monthly.
  - For Herefordshire a revised Access trajectory had been discussed and agreed with Commissioners.
- Access rates for September 2018 were above the recovery plan target for Herefordshire at 15.45% (against a 15% target) and also above recovery plan target for Gloucestershire at 17.37% (against a 17% target)
- Recovery rates for September 2018 were above the national 50% target for Gloucestershire and Herefordshire.
- Waiting time thresholds – Nationally, waiting time thresholds were reported against 2 measures – 6 and 18 week referral to treatment. Tables 3 - 6 detail performance against

these targets in September 2018.

The Committee agreed that good progress was being made and was pleased that additional funding had been achieved.

PROCUREMENT ½ YEARLY REVIEW

The Committee received an update on the work undertaken on behalf of the Trust by the Procurement Shared Services. The number of invoices paid against a PO had improved on the previous year. However, the number of automated POs had fallen slightly from 32% last year to 29.1%. A new manager had been appointed and was targeting this area of work as a priority. The Audit Committee was concerned with the number of retrospective orders made and it was agreed that this issue would be raised at the Executive Committee for consideration.

The Committee noted that contract renewals were being worked on. 21 were overdue although there were reasons for each of these delays and some contracts had been extended due to the merger. The contracts database was being reviewed as part of the merger work and a report would be brought to future meeting. The Committee noted that there had been previous poor performance on Trust contract work and it was agreed that the Procurement Shared Services performance against the KPIs incorporated in the Service Level Agreement would be provided to the Committee.

OTHER ITEMS

- The Committee received and noted the Herefordshire Locality Review.
- The Committee received and noted the mid-year financial review position and the risks and assumptions that underpinned the financial projections and confirmed they were content with the assumptions and supported the actions proposed. This report had also been presented to the Executive Committee and would be received at the November Trust Board meeting
- The Committee received an overview of progress to date with the CYPS LD Business Plan (2016). Analysis of waiting list for Referral-Partnership was also provided along with an overview of preliminary demand and capacity modelling alongside outline trajectory estimations.
- The Committee received the Locality exception reports from CYPS, CAMHS and Herefordshire
- The Committee received and noted the Capacity and Demand Reports for Eating Disorders, the CYPS Service and Gloucestershire Localities Adult and Community MH Teams (Recovery).

ACTIONS REQUIRED BY THE BOARD

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

PAPER L4

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Governance Committee

DATE OF COMMITTEE MEETING: 26 October 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

CQC INSPECTION UPDATE /BERKELEY HOUSE UPDATE

Following the last CQC visit a Trust Wide Action Plan had been developed in response to the 11 "Must do" actions and the 23 "should do" actions. 9 of the 11 "Must do" actions had been completed and 13 of the 23 "Should do" actions were now complete. Quarterly project meetings were taking place and regular face to face meetings with the CQC continued where progress was reported and any problematic issues were discussed. Work continued across the Trust to raise ratings to "outstanding" and focus remained on the two red actions.

The action plan had been discussed with the CQC on the 27 September and provided assurance that all issues identified had already been, or would be rectified within identified timescales. The plan was continually updated and discussed with the CQC at each meeting and the CQC had confirmed that they were happy with the methodology and progress made to date.

The Committee was significantly assured that the Trust was meeting the standards expected of the organisation by the CQC.

Berkeley House

Following the 2018 CQC inspection, Berkeley House LD in-patient service obtained a further 'good' domain (responsive) but retained its overall rating as 'requires improvement'. In total there were 6 'must do' and 17 'should do' recommendations identified. All actions had now been completed apart from one 'should do' action which was nearing completion associated with training. There was full assurance on the 'must do's' with 14 'should do's' still to be ratified.

The Committee noted that the general environment of Berkeley House was not highlighted as an issue in the CQC report; however feedback from visitors suggested that first impressions of the building were of an estate that was tired and run down, with patient environments having been described as stark and lacking in individuality. It was noted that a report would be presented to the Capital Review Group in the coming month to request funding to progress the patient environment works.

PATIENT SAFETY AND SERIOUS INCIDENT REPORT

The Governance Committee received an overview and analysis of serious incident reporting to commissioners and high level monthly trend analysis, including Never Events. 0 new SIs were reported during September and the Committee was very pleased to note that it had been over seven weeks since the last SI was reported; longer than ever before. No Never Events had occurred within Trust Services and the Committee was significantly assured that the Trust had robust processes in place to report and learn from serious incidents.

The Open Actions Report demonstrated overdue actions from the 2017/18 SI Action Plans at the request of the Committee. The Action Plan for 2016/17 was fully complete and the Committee was pleased with this progress.

LIBRARY SERVICE ANNUAL REPORT

The Committee was provided with a summary of library service activity for the year 2017/18 for 2gether and Gloucestershire Care Services. The Committee was assured around 2gether's compliance with the NHS Library Quality Assurance Framework (LQAF); this was a requirement of the Learning & Development Agreement (LDA) which the Trust had signed up to and which ensured continued funding from Health Education England for the library service. Trusts had to evidence 90% compliance and 2g's current level was 93%.

The Governance Committee endorsed the annual report and noted the priorities for 2018 – 2019. These included more promotion of the library service across the Trust, getting more people signed up to Knowledgeshare and work on streamlining resources for 2gether and Gloucestershire Care Services staff.

WORKFORCE ASSURANCE PROGRAMME

Workforce remained a top risk across provider Trusts in the NHS and was currently a "Top 5" Risk for 2gether. The Committee noted the current and planned actions in place to mitigate the Workforce Risk.

The Committee noted that while the Trust was clearly improving its focus and resultant successes with many aspects of workforce, evidence suggested that, at the moment, the Trust continued to experience higher levels of risk with workforce, particularly with medics, registered nurses, IAPT and some AHPs. The key elements of many of the solutions to recruitment and retention were outside the Trust's immediate control and it was noted that there was still limited assurance on this risk despite all the work taking place. The Committee was assured that a great deal of work was taking place and some of this would take time to come to fruition. Work on the development of a joint 5 year Recruitment and Retention Strategy had commenced.

ASSESSMENT AND CARE MANAGEMENT PROCESSES – AUDIT

An audit measuring compliance against the Trust's Assessment and Care Management Policy was carried out in October 2018. As with the previous Assessment and Care Management (ACM) audits the quantitative data included represented a 100% sample of service users on open caseload.

The Committee noted that this Audit found a modest improvement generally in the rate of quantitative compliance (All care levels). Both Herefordshire and Gloucestershire had made comparable gains in compliance since the last audit although Gloucestershire remained behind Herefordshire in regard to overall compliance.

Overall there had been a further 4% rise in compliance in the quantitative data entered in the correct place within the record since the last audit. The Committee agreed that in order to allow the adjustments to the Core assessment to become fully embedded and to monitor the levels of compliance within the record, a further ACM audit would be repeated in 6 months and reported to the committee.

PROFESSIONAL REGULATION – HEALTH AND SOCIAL CARE PROFESSIONALS

The Committee was provided with information about and assurance of professional regulation for the Dietetics, Nursing, Occupational Therapy, Physiotherapy, Psychological Services, Social Work and Speech and Language Therapy. The Committee was fully assured that the Trust's Heads of Profession were sighted to and engaged in professional regulation and engaged in practice development with their respective professional groups. The Committee also noted that all professional groups had described full or significant assurance of robust clinical supervision opportunities and uptake.

The Trust's Allied Health and Psychological Professions Strategy continued to be implemented and a system-wide conference was being organised in Gloucestershire in December 2018 on behalf of the Integrated Care System.

RESEARCH GOVERNANCE

The Committee received an overview of assurance for research governance activity at the Trust in 2017/18. Significant assurance was received that a comprehensive level of research governance was applied to all research activities undertaken by 2gether and that research activity was monitored across Gloucestershire and Herefordshire services.

Significant assurance of clinical oversight of research activity was received along with assurance that risks relating to undertaking research activity were identified and monitored. The Committee was also significantly assured that the Trust's research portfolio offered equity of access to participation in research to service users and carers in line with the NHS Constitution within allocated resources.

The Committee was significantly assured that the Research team had achieved (and exceeded) the target set by commissioners and was on target to meet research recruitment figures for the forthcoming year. There was also significant assurance that Year 1 performance objectives of the Trust's Research Strategy had been achieved and Year 2 were in progress.

OTHER ITEMS

- The Committee received the Quarter 2 Service Experience Report. This would be presented in full to the Trust Board in September.
- The Committee received the Safe Staffing data for August and September 2018 and significant assurance was received regarding the levels of staffing on all wards during this time.
- The Committee was updated on progress to date regarding specific Patient Safety and Quality Improvement activity within the organisation. The Committee received significant assurance that improvements had been made in both mental and physical health care. A number of new and developing Quality Improvements and Learning themes were noted, these demonstrated the Trust's commitment to continuous clinical improvement. The appointment of a Physical Health nurse at Stonebow was noted.
- The Committee received a summary of the work that had taken place on the collection and collation of outcome measures across the services provided by the Trust. A number of planned developments around these outcome measures were noted.
- The Committee received assurance that the governance of the Cost Improvement Programme (CIP) savings and Quality Impact Assessment (QIA) process was effective. To reflect the Trust's quality values, all saving schemes required an authorised Quality Impact Assessment (QIA) detailing the potential quality risks and mitigating actions. The CIP Project Board continued to meet regularly throughout the year, chaired by the Director of Finance, and comprised the Director of Quality and senior managers from quality, clinical, and support services. The CIP Project Board aimed to challenge the delivery of the savings to ensure the quality and efficiency of the services is maintained to Trust standards.
- The Committee received an update on the Trust's Risk Register, with particular focus on those risks allocated to the Governance Committee for oversight.
- The Committee received an update on the use of temporary staffing (agency) during 2018/19. The predicted forecast was that agency spend would be slightly above the 2017/18 outturn, and above the 2018/19 control total. In order to mitigate the agency spend, particularly in the high agency spend areas of Medics, IAPT, and Nursing, a number of actions were underway and planned with the objective both to ensure the 2018/19 outturn was in line with or better than 2017/18, and to prepare for a positive start to 2019/20.
- The Committee received the results of the quantitative and qualitative audit for quarters 1 and 2 2018/19 against the Trust-wide policy on Assessing and Managing Risk and Safety. Compliance for both Herefordshire and Gloucestershire, as well as the overall Trust compliance was noted. The audit of this policy was now part of the Trust's audit cycle and findings were reported to the Governance Committee on a six monthly basis.
- The Committee received the Annual Whistleblowing Review and was significantly assured around the Trust's overall approach to Whistleblowing and noted the policies, procedures, processes and guidance in place; alongside the related actions and activities taken.
- The Committee was assured that on the 2018/19 clinical audit programme, there were 5 audits completed with a RAG rating of green, 1 audit was completed with a RAG rating of amber and 6

audits were completed with a RAG rating of red. 24% of Audits were completed in line with the 2018/19 programme, 26% were progressing as per the programme, 9% of Audits were running behind schedule but with evidence of progress and 3% were running behind plan with no evidence of progress. 24% of audits were not yet due to be started and 14% had been removed from the programme.

ACTIONS REQUIRED BY THE BOARD

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

2gether Making life better

2gether NHS Foundation Trust

PAPER L5

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Audit Committee

DATE OF COMMITTEE MEETING: 7 November 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

INTERNAL AUDIT

Internal Audit Progress Report

The Committee received report outlining progress against the Internal Audit plan. Three final reports were received by the Committee and a verbal update was provided on a fourth review, with the review report being circulated to Committee members after the meeting. The Committee also noted continuing good progress in closing actions from previous reviews. The Committee noted two actions due in respect of ligature audits, and was assured that these were low risk issues relating to information sharing and did not constitute an enhanced risk to patients. Arrangements were in hand to put information sharing measures in place, and the matter would continue to be monitored by the Governance Committee.

Internal Audit – Financial Budgeting and Monitoring (Low Risk)

The Committee received the final financial monitoring review report, which was given an overall classification of low risk. The report identified two low risk findings, regarding a lack of consistency in documentation of outcomes for budget variance meetings held with budget holders, and documentation on the budget setting approach not being shared with budget holders. The Committee welcomed the positive outcome of this review, and noted that the equivalent review in Gloucestershire Care Services had produced similar results.

Internal Audit – Consultant Underpayments (High Risk)

The Committee received the final review report on consultant underpayments, which received an overall classification of high risk. There were two high risk findings, concerning the manual process used for progressing consultants and speciality doctors through pay thresholds which relied on a spreadsheet being monitored and updated, and the process in place to implement changes to the Programmed Activities of consultants and speciality doctors which was not deemed sufficiently robust. There were a further two medium risk findings, relating to a lack of processes being in place for the medical staffing officer role, and in terms of compliance with the policy requirement that underpayments must be repaid to the employee as soon as they are confirmed. The Committee was assured that issues raised in the review were now being corrected, and an improved approvals process was being implemented. All outstanding payments had now been made to the relevant employees. The Committee noted that the high risk findings in this review would be referenced in the Trust's Annual Governance Statement, in line with the Trust's usual practice.

Internal Audit – Learning from Service Experience (Low Risk)

The Committee received the final review report on learning from service experience, which received an overall classification of low risk. There was one medium risk finding, relating to learning from complaints and compliments not being effectively disseminated to localities. There was a further low risk finding regarding the time allocation for conducting investigations. The Committee welcomed the overall conclusions of the report, which showed a process which had drastically improved over the past 18 months, with all staff members surveyed as part of the field work for the review being aware of the Trust's complaints policy. The Committee also noted that learning from service experience was a topic which had been discussed in several of the Trust's Committees, and was therefore a good example of information being triangulated to achieve a positive outcome.

Internal Audit – Transaction Governance (Low Risk)

The Committee received a verbal report on transaction governance in relation to the merger process.

The Committee noted that the review had received an overall classification of medium risk. There were two medium risk findings, relating to resource availability and the potential impact of additional workload on business as usual, and the process in place to manage benefits. Two low risk findings related to potential enhancement of the Transaction Governance & Programme Management Plan, and conflict of interest declarations processes. The Committee noted that in comparison with comparable transactions, this merger was considerably less well resourced. However, the Committee heard that current outputs remained satisfactory in terms of business as usual, and that during oversight meetings with NHS I, no concerns had been expressed by the regulator. The Committee was clear that business as usual must be safeguarded during the merger process, and asked that the Audit Report be shared with the Strategic Intent Leadership Group for consideration at its next meeting.

COUNTER FRAUD REPORT

The Committee received the Counter Fraud progress report, summarising the key counter fraud activity undertaken between April-October 2018, including:

- 9 fraud awareness presentations
- 16 corporate induction sessions,
- 2 workshops undertaken by the Competition & Markets Authority aimed at countywide staff involved in the procurement process
- Discussions on piloting national counter fraud e-learning

The Committee received the Counter Fraud update, and noted the activity undertaken. The Committee noted that the risk of fraud might increase during a time of change, and was assured that extra proactive work was being undertaken to mitigate that risk. The Committee asked that the next Counter Fraud report set out what actions had been taken respect of preventing fraud during the merger process.

MERGER ISSUES

The Committee discussed, at a pre meeting, a report regarding due diligence and the appointment of a reporting accountant, in respect of the ongoing merger process. Richard Cryer, Chair of Gloucestershire Care Services NHS Trust's Audit Committee was present for this discussion, and the remainder of the Audit Committee meeting. The Committee was content with the process outlined in the report, but raised a number of points about where and in what sequence the final due diligence report should be received.

AUDIT COMMITTEE PERFORMANCE REVIEW

The Committee received a report setting out the results of its annual self-assessment of its performance and effectiveness. The self-assessment used a questionnaire from the Healthcare Financial Management Association's Audit Committee Handbook. This questionnaire is issued to all members of the Committee, as well as to Internal Audit, External Audit, and Counter Fraud. This year, the Committee's Governor observer also completed the questionnaire. The outcome of the self-assessment was very positive, with a clear majority of respondents agreeing or strongly agreeing with 30 of the 31 assessment statements. The Committee welcomed the assessment result, and noted that the free text comments accompanying the assessment gave useful context and assurance regarding the Committee's effectiveness.

OTHER ITEMS

The Audit Committee also:

- Received the standing report on waivers over £25k, and noted the waivers in the reporting period.
- Received the External Audit progress report, technical update, and benchmarking report which provided a comparison of 2gether's performance compared with other trusts
- Received a verbal update on a matter being considered by the Delivery Committee relating to retrospective purchase orders, and agreed to receive a further update from the Delivery Committee at the next Audit Committee meeting
- Discussed Financial Shared Services KPIs and asked that these be received and reviewed quarterly by the Delivery Committee
- Received and noted the Losses and Special Payments report
- Reviewed and noted the Board Assurance Map.

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: 7 November 2018

Agenda item 18 **Enclosure Paper M**

Report to: Trust Board, 29 November 2018
Author: Ingrid Barker, Trust Chair
Presented by: Ingrid Barker, Trust Chair

SUBJECT: JOINT 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**

INTRODUCTION AND PURPOSE

Recognising the Strategic Intent work and my role as both Chair of ²gether and Gloucestershire Care Services this report format has been revised to reflect the breadth of my activities across both Trusts. The production of a joint report does not impact on my existing accountability as the appointed Chair of each Trust.

The Report also provides an overview of 2gether Non-Executive Director (NED) activity.

RECOMMENDATIONS

This report is for information and the Board is invited to note the report.

1. INTRODUCTION AND PURPOSE

This report seeks to provide an update to both Boards on Chair and Non-Executive Director activities in the following areas:

- Strategic Intent
- Board Development
- Working with our partners
- Working with our colleagues
- National and Regional Meetings attended and any issues highlighted

1.1 Strategic Intent Update – Moving Towards Developing an integrated Physical and Mental Health Care Offer with Gloucestershire Care Services NHS Trust

The work in the two Trusts to move forward the Strategic Intent continues, with progress and overall monitoring being maintained through the agreed governance processes.

As advised at the September Board, both Trusts agreed the submission of the Strategic Case to NHSI by 30th September. As part of the review of the submission NHSI have held a number of meetings with key colleagues within both Trusts, including Non-Executives and also held an Executive Challenge meeting. Formal feedback from these processes and on the Strategic Case document is expected at the end of December 2018.

The Strategic Intent Leadership Group, which is made up of Non-Executives and Executives from both Trusts, has moved to monitoring progress against the next stages of the proposed merger.

The Council of Governors at 2gether NHS Foundation Trust, in line with their statutory responsibility in relation to "significant transactions" continue to be engaged in the merger process. As the Trusts work together we keep at the heart of all our work the needs of service users – ensuring we are looking after today's users but also thinking about how we can improve services for the future. This ambition was central to the important work begun in October to develop the vision and values for the merged organisation. This work involved significant numbers of colleagues and service users and while logistically challenging really helped to build understanding between colleagues and with service users – I would like to thank those who attended for their open and honest contribution. Other mechanisms to ensure service users remain central to our transformation work are continuing to be developed.

1.2 Board Development

A Joint Board Development session took place on 25th October 2018. This was a session supported by The King's Fund, a respected think tank that shapes health and social care policy and practice. On this occasion we heard from Andrew Cash, Chief Executive for the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS). This ICS includes five Clinical Commissioning Groups, 12 provider organisations, including acute trusts, mental health trusts, children's trust and ambulance trusts and six Local Authorities. Andrew's commentary, informed by his previous role as Chief Executive of the Sheffield Teaching Hospitals NHS Foundation Trust, was insightful and should be helpful in informing our considerations as the One Gloucestershire ICS develops. The processes SYB ICS has in place to provide wider accountability to communities struck a particular resonance – as a Chair of provider organisations within the One Gloucestershire ICS I am keen to ensure we consider these important issues.

We also heard from Anna Charles, Senior Policy Adviser, The King's Fund, who was a key part of the review by the King's Fund "A year of Integrated Care Systems – reviewing the journey so far." Again this session helped to deepen understanding of how Integrated Care Systems are operating and the good practice which we can learn from.

A full programme of Board development is planned. These sessions are an important part of the work we are doing to bring our two Trusts together, ensuring that our shared values stay at the heart of what we are working to achieve and that best practice in both organisations is maintained and enriches our work.

Work to appoint the shadow Board for the new merged organisation is now underway. An appointment process for Non-Executives will start in late November/early December with colleagues and stakeholders from both organisations and, of course, led by the Council of Governors.

1.3 Working with our Partners

Maintaining **business as usual** remains a priority across both organisations. As part of this I have continued my regular meetings with key stakeholders including:

- The Chair of the Gloucestershire Hospitals NHS Foundation Trust
- Meeting with Jesse Norman MP
- Meeting with NHSI to discuss the merger plans

In October we were delighted to host Dr Henrietta Hughes, National Guardian for Freedom to Speak Up in a Regional session with colleagues from both Trusts, including Jan Marriott and Maria Bond who are the Non-Executive Freedom to Speak Up leads for GCS and 2gether respectively. The session updated on national issues, further raised the profile of this important work, and was an opportunity to celebrate how both Trusts have embraced this agenda, most recently with the development of Freedom to Speak Up Advocates.

In November, several Board members from both Trusts and I were pleased to attend the first ever '**More than ACEs** *[Adverse Childhood Experiences]* **Conference'** with over 250 professionals from a range of organisations, to hear from local, national and international speakers on this area of significant concern to both ^{2}gether and GCS. Julian Moss, Assistant Chief Constable at Gloucestershire Constabulary, explained that "ACEs are specified traumatic events which happen before the age of 18 years. Research shows frequent exposure to ACEs, without the support of a trusted adult can lead to toxic stress. Some traumatic events can be avoided if we can spot the signs and intervene, and by working together we can all help to improve the lives of children who may have faced difficult circumstances. We are seeking to build a social movement in Gloucestershire where individuals, communities, businesses, and the public sector all make a difference by taking action on ACEs". The impact of ACEs on both physical and mental ill health in adult life is well documented and this is a vital preventive theme being pursued by the health and Wellbeing board.

2gether and GCS are committed to supporting the Action on ACEs Gloucestershire strategy, launched at the event, which outlines how the County as a whole can protect children from the things that harm them, break the cycle of ACEs by making sure that children have supportive, trusted adults and the life skills they need to thrive and flourish.

The **NHS Provider Annual Conference** in Manchester in October was a great opportunity to meet with colleagues and consider the national context and share good practice on how as providers we can respond to challenges such as recruitment. A number of colleagues from both Boards - Executive and Non-

Executive attended. We were particularly inspired by the ambition set out by Andy Burnham in his speech "Messages from Place-Based Integration and Whole Person Support: the Greater Manchester Model". The Joint Board development session in December will have an opportunity to review this work.

I attended the **NHS Providers Board** on 7th November. Board have been briefed separately on this.

The **South West Chairs Meeting** enabled focus on more regional issues and consideration of how we are responding to the changes in the health system.

I attended the **Gloucestershire Health and Wellbeing Board** in November which considered the Director Public Health's Annual Report which focussed on mental wellbeing; an update on Self Harm; deep dives on the proposal for loneliness/isolation and air quality and health; an update on the Joint Health and Wellbeing Strategy and a general report on Activity on Health and Wellbeing matters in Gloucestershire.

Duncan Sutherland, Non-Executive Director for 2gether NHSFT, attended the **Herefordshire Health & Wellbeing Board** in October which considered the quarter 1 report for the Better Care Fund; the Children and Young People's Plan for 2018-2023 and the Director of Public Health Annual Report for 2017.

I took part in a telephone conference with the **Chair of Hereford & Worcester STP,** Charles Waddicor, in October.

I have attended two half-day workshops of the **Gloucestershire Strategic Forum** in October and November. A further half-day workshop is planned for December. These are helpful session which will inform the governance of the Integrated Care System going forward.

A r**egular meeting of the Health Care Overview and Scrutiny Committee (HCOSC)** took place in November. I attended the meeting with executives from both Trusts - Candace Plouffe and Jane Melton. The meeting focused on ongoing developments and pressures in the health system, including the challenges relating to radiology currently and a proposed pilot to reconfigure general surgery across the two acute hospitals.

We continue to build our relationship with the Health Care Overview and Scrutiny Committee and were delighted to host our yearly informal session for Scrutiny members at Pullman Court where GCS and 2gether were able to provide an overview of our services and the merger to help inform the more formal meetings. This is the first time 2gether and GCS have met jointly with the HCOSC Committee members in this way and it was a lively and engaging session.

The county's **Health Chairs** also met for our regularly quarterly meeting in November.

A recent important event was a meeting of eight Community Trust Chairs with **Dido Harding, Chair of NHSI,** organised by the Community Network which is jointly supported by NHS Providers and the NHS Confederation. The network comprised providers (including social enterprises spun out from PCTs) who provide community services, sometimes in standalone community trusts, some in

mental health / community and some acute/ community. The Chairs at the meeting were representative of this diversity. Our aim was to raise the profile of community services with Dido and highlight issues and celebrate the role that community services play in the wider system. Board colleagues have been briefed separately on the detail of this meeting.

2. WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

The Chief Executive and I held our regular quarterly meeting on 27th November with the Chairs of Leagues of Friends and updated them on the work the Trust, and the wider Integrated Care System, including how this is progressing in their locality with the piloting of Integrated Locality Boards in some areas. Whilst there is of course particular focus on the work of the community hospitals, Leagues of Friends also updated on how they are, in a number of cases, supporting wider community services.

I have also met with Tim Poole, Chief Executive of Carers' Gloucestershire for a briefing on latest developments with this important partner.

3. ENGAGING WITH OUR TRUST COLLEAGUES

I continue to meet regularly with Trust colleagues at 2gether and GCS and visit services at both Trusts to inform my triangulation of information.

I engaged in a number of sessions at the Trusts' Values Week and enjoyed meeting colleagues and service users and learning more about what makes a good day and a bad day and considering how we, as Boards, can help ensure that the features of good days are the basis of how we work.

I had an introductory meeting with newly elected staff Governor for 2gether – Alison Feher – who is excited to be joining the Council of Governors at such a key time and keen to play a full part in helping to ensure that the best possible services are provided to the community. I also met with Governors Mervyn Dawe and Nic Matthews. These individual meetings reinforce to me the role of the Council of Governors in providing accountability to the wider community – a core responsibility which all of them are committed to achieve and which I saw reflected at the latest Council of Governors meeting. In addition I was 'shadowed' for two days by a colleague from Herefordshire 2gether services, Janine Soffe-Caswell as part of her development programme.

On 11th October I visited the Maxwell Suite at Wotton Lawn and attended a meeting of Trust colleagues responsible for organising the work of the Mental Health Act Managers.

I was delighted to attend a 2gether Trust Volunteers Tea Party celebrating the contribution that Volunteers make every day to help provide additional support to service users and their families.

I am pleased to be continuing to develop my knowledge of the 2gether and GCS teams and their challenges, more recently at the SAS Doctors Away Day which was a great opportunity for two way communication – both about the merger but also their day to day work.

4. NED ACTIVITY

Activities undertaken by the 2gether NEDs are listed below.

NED'S KEY ACTIVITIES (October and November 2018)

Jonathan Vickers (Chair of Development Committee)
Since his last report Jonathan has;

- Attended the launch of a new homeless charity
- Prepared for and attended two meetings of the SILG
- Attended a values workshop
- Prepared for and chaired a meeting of the development committee
- Prepared for and attended a joint board development session
- Prepared for and attended a meeting of the ATOS committee
- Prepared for and attended a joint NED meeting
- Prepared for and attended a meeting of 2g NED's
- Prepared for and attended a meeting of the audit committee
- Prepared for and attended a meeting of the Council of Governors
- Prepared for and attended a board meeting
- Held conversations with executive and non-executive colleagues on board and development matters

Nikki Richardson (Deputy Trust Chair/SID/Chair of Governance Committee)
Since her last report Nikki has;

- Prepared for and attended Board meeting
- Prepared for and attended closed Board meeting
- Attended an NHS Awards event
- Attended In Your Shoes Workshop
- Visited Berkeley House
- Attended preparation for NHSi interview x2
- Attended NHSi interview
- Met with the Lead Governor
- Attended a NED meeting
- Attended a Joint Board Development session
- Prepared for and Chaired Governance Committee
- Visited the Stroud ICT Team
- Met with the Trust Governor Governance Committee observer
- Met with the Trust Chair
- Prepared for and attended a Joint ATOS meeting
- Met with the Joint CEO
- Met with the Deputy CEO
- Prepared for and attended a Council of Governors meeting
- Visited CLDT Herefordshire
- Visited CLDT Forest of Dean
- Visited CLDT North
- Visited CYPS CLDT
- Visited Dental Services Stroud
- Visited MIIU, Stroud
- Prepared for and attended SILG
- Prepared for and attended MHLS Committee
- Attended a joint NED meeting

- Visited Homeless Services

Marcia Gallagher (Chair of Audit Committee)
Since her last report Marcia has;
October
- Prepared and attended a joint Audit Chairs meeting with the Directors of Finance, Internal Audit
- Attended the two day NHS Providers Conference in Manchester.
- Attended In our shoes and in your shows sessions at Kingsholm Rugby Club.
- Attended the Board in your shoes session at Bowden Hall.
- Prepared for and attended a meeting with the Director of Finance to discuss the Month 6 finance report and mid-year financial review.
- Attended 2GFT NEDs meeting with the Chair.
- Prepared for and attended the Delivery Committee
- Prepared for and attended a joint Board development session.

November
- Prepared for and attended ATOS Committee.
- Prepared for and Chaired the Audit Committee with a pre meeting Due Diligence briefing.
- Undertook an audit of three random Complaints.
- Dialled in to a joint GCS/2GFT NEDs meeting.
- Undertook a visit to the George Whitfield Centre in Great Western Rd Gloucester.
- Participated in a MHAM hearing.
- Prepared for and attended the Delivery Committee.
- Prepared for and attended the 2GFT Board meeting in Hereford .

Duncan Sutherland (Chair of MH Legislation Scrutiny Committee/Charitable Funds)
No update this month.

Maria Bond (Chair of Delivery Committee)
Since her last report, Maria has:
October
- Prepared for and attended a Freedom to Speak-up meeting with the National Representative
- Attended a Tea Party with the Governors and Volunteers
- Attended an 'In our Shoes' Values Workshop
- Prepared for and attended the Joint Board Seminar
- Sat on a MHAM Review at Charlton Lane
- Prepared for and attended a NED's meeting at GCS
- Prepared for and Chaired Delivery Committee
- Prepared for and attended a Joint Board Development Seminar
- Prepared for and attended Governance Committee

November
- Prepared for and dialled-in to a Joint ATOS meeting
- Prepared for and attended Audit Committee
- Attended an ACE Conference in Cheltenham
- Met with 2g Governor
- Prepared for and Chaired ACC Panel for Old age Psychiatry
- Prepared for and attended Joint NED's meeting at GCS
- Prepared for and attended Focus group meetings
- Attended Capital Review Group meeting

- Prepared for and Chaired Delivery Committee
- Prepared for and attended a Board meeting

Dominique Thompson
Since her last report, Dominique has;

- Prepared for and attended an Audit Committee meeting
- Prepared for and attended a Delivery Committee
- Prepared for and attended a Joint Board Development Meeting
- Prepared for and attended a Governance Committee meeting

[2]GETHER NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING
TUESDAY 11 SEPTEMBER 2018
BUSINESS CONTINUITY ROOM, RIKENEL, GLOUCESTER

PRESENT:	Ingrid Barker (Chair)	Rob Blagden	Vic Godding
	Jan Furniaux	Mike Scott	Alison Feher
	Anneka Rose	Cherry Newton	Miles Goodwin
	Hilary Bowen	Carole Allaway-Martin	Nic Matthews
	Ann Elias	Graham Adams	

IN ATTENDANCE: Philip Baillie, Integration Programme Director
Sandra Betney, Deputy CEO and Director of Finance (GCS)
Anna Hilditch, Assistant Trust Secretary
John McIlveen, Trust Secretary
Colin Merker, Deputy Chief Executive
Nikki Richardson, Non-Executive Director
Neil Savage, Director of Organisational Development
Dave Smith, Programme Director – Transition (GCS)
Dominique Thompson, Non-Executive Director
Jonathan Vickers, Non-Executive Director

1. WELCOMES AND APOLOGIES

1.1 Apologies for the meeting had been received from Bren McInerney, Said Hansdot, Katie Clark, Jo Smith, Mervyn Dawe, Kate Atkinson, Jenny Bartlett, and Lawrence Fielder. Xin Zhao, Stephen McDonnell and Faisal Khan did not attend the meeting.

1.2 Ingrid Barker welcomed Graham Adams, Mile Goodwin, Alison Feher and Dr Anneka Rose to their first meeting of the Council of Governors since being appointed.

1.3 The Council noted that Hazel Braund, Appointed Governor for Herefordshire CCG had recently moved into a secondment to 2g/GCS as Director of the Better Care Together Transformation Programme. It had therefore been necessary for Hazel to resign from her Governor position. The Trust would commence the process to seek a new Herefordshire CCG nominee.

2. DECLARATION OF INTERESTS

2.1 There were no new declarations of interest.

3. COUNCIL OF GOVERNOR MINUTES

3.1 At the previous meeting, Bren McInerney had asked that the Strategic Case for the merger be explicit about how it would address health and social care inequalities in the county. This suggestion had been omitted from the minutes.

3.2 Subject to this addition, the minutes of the Council meeting held on 12 July 2018 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 these were now complete or progressing to plan.

4.2 An electronic copy of the "Governor Engagement with the Joint Working process" pack had been circulated to all Governors. It was noted that some comments had been received from Governors on this and once these changes had been incorporated, the pack would be re-issued and would also be made available to all Governors in hard copy, on request. The final version would also be uploaded onto the Governor portal.

4.3 The Council received and noted the Meeting Evaluation feedback from the last meeting in May.

5. STAFF SURVEY PRESENTATION

5.1 Neil Savage, Director of Organisational Development was in attendance to give the Council a presentation on the 2017 National Staff Survey Results. A copy of the full presentation would be circulated to Governors for information.

ACTION: National Staff Survey presentation to be circulated to Governors electronically for information

5.2 The Staff Survey has been running for 15 years since 2003 and is one of the biggest ongoing healthcare staff surveys in the world. The results are published in March of the following year (i.e. 2018 for the 2017 survey) and are used by the Trust Board, NHS England, the CQC, NHS Improvement and the CCGs to assess performance.

5.3 Prior to 2016, the survey had been sent to a random sample of 750 staff, however, the Council noted that for the past 2 years the Survey had been sent out to all 2gether staff. If a person was a substantive member of staff in post from 1st September of said year, then they would be invited to participate in the survey. The number of respondents rose from 777 in 2016 to 921 in 2017, equating to a response rate of 45% which was an improvement over last year's 40%.

5.4 Some of the key highlights from the 2017 Survey included:

- 2g was better than average in 17 out of 32 Key Findings (53%)
- Better than average or average in 27 (84%) when compared with all other MH/LD Trusts
- Better on our Key Finding scores compared with other Gloucestershire, Herefordshire & Worcestershire Trusts
- The Staff Engagement score was steady at 3.88 compared to a national MH/LD score of 3.78 (out of 5)
- The Staff Engagement score is in the top 25% of all NHS organisations
- Staff recommendation of the Trust as a place to work/receive treatment rose (3.86) & is well above the average for MH/LD Trusts (3.67)

5.5 2gether's Top 5 Scores were:

- % Staff Experiencing Discrimination at Work (low)
- % Staff experiencing physical violence from staff (low)
- Effective Team Working (high)
- Staff satisfaction with resourcing & support (high)
- % Staff experiencing physical violence from patients, relative, public (low)

The Bottom 5 Scores were:

- % Staff reporting errors, near misses or incidents in the last month (lower)
- Effective use of patient/service user feedback (lower)
- % Staff attending work in last 3 months despite feeling unwell because they felt pressure from manager, colleagues or self (higher)
- % Staff reporting most recent experience of harassment, bullying or abuse (lower – but higher score the better)
- % Staff working extra hours (higher)

5.6 Neil Savage advised that the 2018 Staff Survey would be issued to staff during quarter 3 (October-November). The 2017 Survey results were published in March, and since that time the Trust has developed a focussed action plan, with the key priorities including: Improving Staff Health and Well-being, Improving Reporting of Incidents, Making more effective use of patient & service user feedback and Locality & team engagement with local priorities from the survey. The Council received a summary of just some of the work on engagement and staff health and wellbeing that had taken place as a result.

5.7 Nic Matthews asked whether the Trust had the ability to "live track" certain areas of the Trust which were demonstrating high levels of sickness absence or turnover. Neil Savage advised that 2gether did not have a dynamic system that was updated daily; however, all HR data such as sickness, appraisals and training compliance was reviewed and made available to service directors and team managers monthly to enable them to monitor any areas of concern. The Trust's Delivery Committee also receive monthly reports from services which included performance against HR KPIs and a quarterly "HR Indicators" report was also received by the Committee, which included benchmarking against other similar organisations.

5.8 Mike Scott asked whether it would still be possible to look at the results of the Survey for individual Trusts following the merger, as it would be interesting to see if there had been an impact. Neil Savage said that this would be possible, with the Survey results being broken down by staff group and service area.

5.9 The Council thanked Neil Savage for attending the meeting and presenting the results of the Staff Survey.

6. JOINT WORKING – VALUES DEVELOPMENT PROGRAMME

6.1 The purpose of this report was to ensure that the Council of Governors were fully briefed on the forthcoming Values Development Programme, taking place as part of the merger/joint working and outlining how they could participate and support the programme.

6.2 Dave Smith set out the context and methodology of the programme, noting that much of this focussed around "Values Week" which would be taking place from 15-19 October. A number of sessions would be taking place that week for staff from both 2gether and GCS to attend, with the aim of getting people to think about the future and culture of the new organisation proactively. Dave said that this was an ambitious project but setting out and agreeing a joint culture from the start was vital for the new organisation to succeed. Spaces on the sessions were available for up to 2000 staff members, allocated equally between GCS and 2gether. Governors were also encouraged to participate and were asked to contact Anna Hilditch if they wished to attend a session.

6.3 Cherry Newton noted that all of the sessions would be taking place in Gloucestershire and suggested that this would make it difficult for staff in Herefordshire to be able to participate. Dave Smith informed the Council that the venues for the sessions were chosen partly due to capacity and availability, but also to ensure that staff from both organisations had equal access. He said that feedback would be taken on board and if it was felt that Herefordshire staff had not been properly engaged then further sessions may be considered.

6.4 Mike Scott said that he was keen to see the outputs from the Values development work, including the numbers of staff who had participated and from which Trusts. He asked when this output was likely to be made available. Dave Smith advised that a presentation on the outcome from the values week work was scheduled to be given to the Joint Executive Team in mid-November.

6.5 The Council noted that both Trust Boards had enthusiastically supported this report and the overall development programme. The importance of developing a jointly owned and agreed culture from the outset was paramount.

7. NED RECRUITMENT PROCESS TO SHADOW BOARD

Nikki Richardson, Jonathan Vickers and Dominique Thompson left the meeting at this point

7.1 This report sought approval of the Council of Governors in respect of proposals for the recruitment of Non-Executive Directors (NED) to the Shadow Board of the new Trust, ahead of the completion of the proposed merger process. These proposals were reviewed and endorsed by the Nominations and Remuneration Committee at its meeting on 29th August.

7.2 The Shadow Board will become the Board of the new Trust following completion of the merger transaction. The proposed size of the new Board will be the same as now, comprising 7 NEDs plus the Trust Chair. The recommendation is that of the 7 NED vacancies, at least 6 would be recruited from the existing pool of NEDs from both Trusts. This would be an open process, with all NEDs eligible to apply. This ring-fenced recruitment process is envisaged to take place in November/December 2018 and will broadly be in line with previous selection processes.

7.3 Alongside this ring-fenced process, it is proposed to use a national process to appoint one NED. In terms of visible diversity, neither the 2gether Board nor the Gloucestershire Care Services Board is fully representative of its community. As

2gether has an existing NED vacancy, there is an opportunity to address this relative lack of diversity by using a national open process which would not only seek candidates who meet the person specification criteria, but particularly those suitably qualified and experienced candidates from a Black, Asian and Minority Ethnic (BAME) background. If a preferred candidate is identified through this national recruitment process, their appointment would not be confirmed until the selection process involving the existing 2gether and GCS NEDs takes place, so as to allow the appointment panel to consider the skills and experience of all candidates (internal and external) in the round when making its decision on appointments to the Shadow Board. The preferred candidate identified through this national process would not be required to be re-interviewed. Should no suitable candidate be identified through this national route, then all NED posts would be selected to through the ring-fenced process from existing NEDs of both organisations. This ring-fenced process would seek to achieve an appropriate mix of both ²g and GCS NEDs on the Shadow Board while equipping it with the necessary skills and experience to take the new Trust forward. For both processes it will be important to ensure appropriate representation from GCS colleagues on the interview panel, in an advisory capacity and in discussion / focus groups.

7.4 Rob Blagden confirmed that the Nominations and Remuneration Committee had carried out a good and robust discussion about these proposals. Further discussion had taken place at the Governor pre-meeting and Governors were happy to approve the recommendations within the report. Rob Blagden noted that Governors were keen to ensure that there was a fair process for appointing the NEDs and that there was equal representation as part of the recruitment process from both 2gether and GCS, noting that these would ultimately be 2gether Governor appointments. It had also been suggested that the appointment terms be made on a staggered basis to ensure that people did not come to the end of their terms at the same time. Jan Furniaux added that the Council was very supportive of the proposal to seek appointment from the BAME community.

7.5 Ingrid Barker informed the Council that in preparation for the appointment process, a session had been arranged for Governors to meet with the GCS NEDs by way of a meet and greet session. This would be taking place on 18th October and all Governors were encouraged to attend the session.

7.6 The Council of Governors approved the proposals for the recruitment of Non-Executive Directors to the Shadow Board of the new Trust.

8. CHANGE TO THE TRUST CONSTITUTION – NED TERMS OF OFFICE

8.1 As a foundation trust, 2gether has a constitution which sets out its governance framework. The Trust's constitution may be amended with the agreement of both the Council of Governors and the Board. To guarantee continuity as the new organisation is formed, it is proposed that the Constitution be amended to allow NEDs appointed to the Shadow Board to serve up to three terms of up to three years each, with any term beyond six years in total being subject to annual reappointment, as required by the regulator's Code of Governance. This will enable ²gether NEDs approaching the end of their terms of office to remain with

the new Trust for a period of time, and ensure that knowledge, skills and business as usual are maintained during the transition.

8.2 The Council of Governors approved this change to the constitution. The Trust Board would also be asked to consider this amendment to the constitution at its meeting on 26 September, and if approved, the amendment would take effect immediately.

Nikki Richardson, Jonathan Vickers and Dominique Thompson returned to the meeting at this point

9. FEEDBACK FROM GOVERNOR OBSERVATION AT BOARD COMMITTEES

9.1 A number of Board and Board Committee meetings had taken place since the Council of Governors last met in July 2018 and Governors had been present in an observation capacity at some of these meetings.

- Audit Committee – 1 August
  Mike Scott and Ann Elias had attended this meeting and said that they felt very assured by the business conducted. Mike Scott said that KPMG, the Trust's External Auditors had stated at the meeting that they planned to attend and present their progress report to the Council of Governors at the September meeting and he therefore queried whether this was scheduled to take place. The Council noted that this item had been deferred to the next meeting in November due to the amount of business to be conducted at this meeting.
- Development Committee – 8 August
  There had been no Governor attendance at this meeting
- Delivery Committee – 25 July and 29 August
  Kate Atkinson had attended the Committee meeting on 25 July but was not present at the Council meeting to provide feedback.
- Governance Committee – 31 August
  Jo Smith had been in attendance at this meeting but was not present at the Council meeting to provide feedback.

10. GOVERNOR OBSERVERS AT BOARD COMMITTEES – ANNUAL REVIEW

10.1 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.

10.2 Two Governors are nominated to attend each Board Committee and it was previously agreed that a refresh of Governor involvement would take place annually, to enable all Governors to have the opportunity to take part if they wish.

10.3 Rob Blagden said that the Governors had discussed this at their pre-meeting. One vacant position existed on the MH Legislation Scrutiny Committee and it was agreed that Carole Allaway Martin would take up this role.

10.4 As a large number of apologies had been received for this meeting, it was suggested the Rob work with Anna Hilditch to contact Governors outside the meeting to seek expressions of interest for taking part in the Committee observation process. A report would then be brought back to the Council in November. In the meantime, it was agreed that all Governors would receive information about the role and description of each of the Committees and to get in touch if they wished to put their name forward to participate.

ACTION: All Governors to receive information about the Board Committees, including future meeting dates to enable people to express an interest in participating as part of the Committee observation process

11. GOVERNOR ACTIVITY

11.1 Cherry Newton and Vic Godding had attended a Dementia Education Evening on Thursday 26 July. The event highlighted the collaborative work between 2gether and Cobalt, aimed at improving research and diagnosis of dementia to benefit local patients and their families. Both agreed that this had been a very interesting event.

11.2 Nic Matthews informed the Council that he had been invited to sit on the joint working Vision and Values Core Team, as a Governor representative. He said that he had been happy to have been invited to participate.

11.3 Vic Godding said that he had participated in the recent Governor visit to the Trust's Recovery Units in Cheltenham. He said that he was disappointed to see the lack of Governor attendance at these visits, which had been set up especially for Governors to see the Trust's units and have the opportunity to speak to staff and patients. He encouraged all Governors to consider attending future visits and also to carry out repeat visits as this would enable Governors to hear about new developments and improvements to services.

11.4 Cherry Newton had attended the Horse Trials at Much Marcle, Herefordshire and had helped man a 2gether information stand at the event, signing up new Trust Members.

11.5 The Council was reminded that the Gloucestershire Police Open Day would be taking place on Saturday 15th September. A number of Governors had already volunteered to help at this event and had been contacted directly by the Communications Team to confirm a time slot to attend. Any other Governors who wished to come along and help were asked to let Anna Hilditch know.

12. ANY OTHER BUSINESS

12.1 There was no other business.

13. DATE OF NEXT MEETING

Business Continuity Room, Trust HQ, Rikenel		
Date	**Governor Pre-meeting**	**Council Meeting**
2018		
Thursday 8 November	1.30 – 2.30pm	3.00 – 5.00pm
2019		
Tuesday 15 January	1.30 – 2.30pm	3.00 – 5.00pm
Thursday 14 March	9.00 – 10.00am	10.30 – 12.30pm
Tuesday 14 May	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 11 July	1.30 – 2.30pm	3.00 – 5.00pm
Tuesday 10 September	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 14 November	9.00 – 10.00am	10.30 – 12.30pm

Council of Governors
Action Points

Item	Action	Lead	Progress
11 September 2018			
5.1	National Staff Survey presentation to be circulated to Governors electronically for information	Anna Hilditch	**Complete**
10.4	All Governors to receive information about the Board Committees, to enable people to express an interest in participating as part of the Committee observation process	Anna Hilditch / Rob Blagden	**One Development Committee observer post still vacant. Expressions of interest from Governors invited.** **Review of Observation process and Governor involvement to be carried out annually in September.**

Agenda item **20** **Enclosure** **Paper O**

Report to: Trust Board, 29 November 2018
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 (Q2 2018/19).

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 2018/19, the Seal was used on four occasions, as follows:

Seal 1
Bupa Recognition – confirmation form of a Consultant Post
Signed: Sandra Beresford, Medical Staffing
Date: 4 July 2018

Seal 2
GMC Registration for Overseas Doctor
Signed: Karen Small, Medical Directorate
Date: 24 July 2018

Seal 3
Licence for alterations at Belmont, Rucknall Lane
Signed by: Director of Finance and Director of Service Delivery
Date: 7 August 2018

Seal 4
Sale of 44 London Road, Gloucester to Perrick Farm Estates Ltd for £566,000.
Signed by: Director of OD and Deputy Chief Executive
Date: 15 August 2018

RECOMMENDATIONS

The Board is asked to note the use of the Trust seal for the reporting period.