[2]GETHER NHS FOUNDATION TRUST
BOARD MEETING
THURSDAY 28 SEPTEMBER 2017 AT 10.00AM
TRUST HQ, RIKENEL

AGENDA

10.00	1	**Apologies**	
	2	**Declaration of Members Interests**	
10.05	3	**Minutes of the Board meeting held on 27 July 2017**	**PAPER A**
	4	**Action Points and Matters Arising**	
	5	**Questions from the Public**	
IMPROVING QUALITY			
10.10	6	**'Rapidly Failing, Slowly Tranquilising' Presentation**	**PRESENTATION**
10.35	7	**Performance Dashboard Report – July 2017**	**PAPER B**
10.40	8	**Quality Report Quarter 1 2017/18**	**PAPER C**
10.50	9	**Service Experience Report Quarter 1 2017/18**	**PAPER D**
11.00	10	**NED Audit of Complaints Q1 2017/18**	**PAPER E**
11.10	11	**Safe Staffing 6 Monthly Update**	**PAPER F**
BREAK – 11.20AM			
11.30	12	**Infection Control Annual Report**	**PAPER G**
11.40	13	**Smoking Cessation Update**	**PAPER H**
11.50	14	**Learning from Deaths Policy**	**PAPER I**
12.00	15	**Medical Revalidation Annual Report**	**PAPER J**
IMPROVING ENGAGEMENT			
12.10	16	**Chief Executive's Report**	**PAPER K**
IMPROVING SUSTAINABILITY			
12.20	17	**Summary Financial Report**	**PAPER L**
12.25	18	**Corporate Strategy**	**PAPER M**
12.35	19	**Financial Strategy**	**PAPER N**
12.45	20	**Audit Committee Annual Report**	**PAPER O**
12.50	21	**Board Committee Summaries** • Appointments and TOS Annual Committee Summary • Delivery Committee – Sept (Verbal) • Development Committee – August • Governance Committee – August	 **PAPER P1** **VERBAL** **PAPER P2** **PAPER P3**
INFORMATION SHARING (TO NOTE ONLY)			
13.05	22 23	**Chair's Report** **Council of Governor Minutes – July 2017**	**PAPER Q** **PAPER R**
13.10	24	**Any Other Business**	
	25	**Date of Next Meeting** Thursday 30 November 2017 at The Kindle Centre, Hereford	

QUESTIONS FROM THE PUBLIC

Written questions for the Board Meeting

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

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

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

Notice of questions

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

Response

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

Additional Questions or Oral Questions without Notice

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

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

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

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

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

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

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

[2]GETHER NHS FOUNDATION TRUST

BOARD MEETING
BUSINESS CONTINUITY ROOM, RIKENEL
27 JULY 2017

PRESENT

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

IN ATTENDANCE

Hilary Bowen, Trust Governor
Rhian Edwards, Sunovion
Anna Hilditch, Assistant Trust Secretary
Bren McInerney, Member of the Public
John McIlveen, Trust Secretary
Kate Nelmes, Head of Communications
Cherry Newton, Trust Governor
Lorraine Peters, Health Facilitation Team Coordinator
Mike Scott, Member of the Public
Jennifer Thomson, Trust Governor
Dr Anna Walters, ST5 (Shadowing Shaun Clee)

1. WELCOMES, APOLOGIES AND INTRODUCTIONS

1.1 Apologies were received from Duncan Sutherland and Frances Martin.

2. DECLARATIONS OF INTERESTS

2.1 There were no changes to the declaration of interests and no conflicts arising from those items on the agenda for this meeting.

3. MINUTES OF THE MEETING HELD ON 25 MAY 2017

3.1 The minutes of the meeting held on 25 May were agreed as a correct record, subject to 2 minor typos.

4. MATTERS ARISING AND ACTION POINTS

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

5. QUESTIONS FROM THE PUBLIC

5.1 Bren McInerney expressed his thanks to the Director of Quality for accommodating a visit with Jane Cummings from NHS England. He said that the Trust had received an excellent write up on her blog following her time here.

6. PATIENT STORY PRESENTATION

6.1 The Board viewed a short film showcasing the 9th Learning Disability Annual Big Health Check Day that had taken place in May. The event took place at Oxstalls Tennis Centre and welcomed over 1000 attendees. Those Board members who had attended the event said that this had been an amazing day and an excellent opportunity for networking and to learn more about the services and support available for people with learning disabilities in Gloucestershire. It had been a genuinely fun and inspiring day for all who had attended. A copy of the link to the video, which could be viewed via YouTube, would be shared with all Governors.

ACTION: The link to the YouTube video of the 9thLD Big Health Check Day would be shared with all Governors.

6.2 Lorraine Peters informed the Board that the next Big Health Check Day would be taking place on 22 May 2018 and plans had already started to organise the day and to make this extra special by way of celebrating its 10th anniversary.

6.3 Hilary Bowen asked about the advertising of the event, noting that calling it a Big Health Check Day could give some people the impression that it was for people to go and get blood pressure checks, rather than a day filled with sport and activities. Lorraine Peters advised that the name of the event had been changed last year to include reference to the launch of the Special Olympics so it was hoped that this would assist in people's understanding of the event.

6.4 The Board noted that despite the huge number of attendees there had been a relatively low level of feedback received following the event and Lorraine Peters advised that further work was being carried out to look at alternative ways of seeking feedback in future. However, feedback points were available to people at the event to receive on the spot feedback and this had been a helpful tool.

6.5 The Director of Service Delivery reflected on the progress that had been made from the first event to the most recent, noting that it was phenomenal how much it had developed and how popular and well supported it was.

6.6 In terms of people with a learning disability getting equal access to general health services, the Board noted that this was improving; however, the Chief Executive said that more was needed to work alongside partners and commissioners to ensure that this remained a top priority.

6.7 The Board thanked Lorraine Peters for attending the Board meeting. It was agreed that watching the film had been such an inspiring and uplifting experience.

7. PERFORMANCE DASHBOARD

7.1 The Board received the performance dashboard report which set out the performance of the Trust up to the end of May 2017 against the Trust's NHS Improvement, Department of Health, and Contractual and CQUINS key performance indicators. This report had been received and scrutinised in detail at the Delivery Committee meeting in June.

7.2 Of the 145 reportable indicators, 78 were reported in May with 64 being compliant and 14 non-compliant at the end of the reporting period. The Director of Service Delivery advised however, that the May dashboard report had been reviewed since it was produced and it

was reported that there were 13 non-compliant indicators, not 14. The Board noted that 7 out of the 13 non-compliant indicators concerned Let's Talk services, and work was ongoing with commissioners to bring about improvements to the service.

7.3 The Director of Service Delivery noted that Trust performance was currently in line with plan. An additional column had been added to the dashboard to provide a RAG rated forecast outturn for 2017/18 which was welcomed. The Board noted that the year-end forecast compliance was likely to be 85-90%. This was due to some indicators, such as Under 18 admissions and SI reporting, that once one incident was reported, the target had been missed and the indicator would therefore remain Red for the remainder of the year.

7.4 Jonathan Vickers asked about current performance against the HR indicators such as sickness, training and appraisals. The Board noted that the Workforce KPI report was received at the Delivery Committee meeting the previous day. The Chief Executive informed the Board that Workforce was key for the NHS right now and he had confidence that the Delivery Committee was monitoring this appropriately; however, there was a question about how often the full Board should receive an update. It was agreed that the Workforce KPIs report would be shared with all Board members for information and more thought would be given as to how the full Board could be regularly kept informed of these key HR targets and indicators.

ACTION: Workforce KPI report received at the Delivery Committee in July to be shared with all Board members for information.

ACTION: Director of OD to consider how best for the full Board to be kept up to date and informed on progress with achieving HR indicators

7.5 The Director of Service Delivery updated the Board on the current position with IAPT services, noting that 2gether was in line with trajectories and proposed progress. A lot of work continued with commissioners and there had been some recent changes to clinical practice and recording proposed, which could impact positively on access rates.

7.6 Ruth FitzJohn made reference to the statements within the dashboard report around resources, noting that a number of the target indicators were still in discussion with commissioners around whether the service had the necessary resources to achieve the targets that had been set. 2gether was not funded to provide the level of services required given an increase in demand; and this in turn could have a negative impact on service users and an increase in waiting times.

7.7 The Board noted the report and the assurance offered. The Chief Executive said that 2gether's Performance was holding static whilst demand for services had increased and resources had stayed the same. The performance dashboard should be seen as a positive picture in these circumstances, and the huge efforts of staff in meeting the targets should be congratulated.

8. DELIVERY COMMITTEE ANNUAL REPORT 2016/17

8.1 The Board received the Delivery Committee Annual Report which provided an overview of the Committee's activities against its Terms of Reference during 2016/17. This report had been endorsed by the Delivery Committee at its meeting the previous day.

8.2 The Board was pleased to note this annual report, and thanks were expressed to all those who had contributed to the work of the Delivery Committee over the past year.

9. CHIEF EXECUTIVE'S REPORT

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

9.2 The Board noted the extensive engagement activities that had taken place during the past month, and the importance of these activities in order to inform strategic thinking, raise awareness of mental health, build relationships and influence the strategic thinking of others.

9.3 Following a request from a member of the public the Chief Executive agreed to ensure that his report was reviewed thoroughly in relation to the use of acronyms and a glossary included where possible.

ACTION: Chief Executive to ensure that his report was reviewed thoroughly in relation to the use of acronyms and a glossary included where possible.

9.4 Jonathan Vickers highlighted the section in the report relating to smoking cessation, noting that the Trust became smoke free on 3rd April 2017. The Board had held a number of discussions over the past year about the implications of implementing a Smokefree environment, with specific concerns being raised around a potential increase in AWOL incidents or an increase in Sections. The Director of Quality informed the Board that none of these concerns had been realised. Jonathan Vickers said that a lot of work had been carried out to get to this point and it was excellent therefore that this appeared to have been a success and was now being classed as "Business as Usual". The Board noted that a full update on Smoking Cessation would be presented to the Board in September.

10. CHANGES TO THE TRUST CONSTITUTION

10.1 The Board received this report which set out some proposed changes to the Trust constitution. These changes deal largely with matters concerning conflicts of interest, and reflect policy guidance from NHS England, published in spring this year, requiring NHS trusts and foundation trusts to adopt strengthened policies to deal with actual and potential conflicts. The Board noted that this was "guidance" however, Trusts were expected to comply.

10.2 Accordingly, a number of changes were proposed which would affect both governors and directors. A number of existing provisions which hitherto applied only to governors have been expanded to include directors. In respect of governors, the proposal incorporates provisions which would prevent a governor taking up or continuing in office if she/he were concurrently a governor of another trust, given that this would clearly constitute a conflict of interest. This provision is already included in the constitutions of many other trusts, and the proposed change brings 2gether into line with what is now standard practice across many parts of the NHS. The Board was asked to note that whilst this change would not affect any governor in office currently, it would affect one governor joining the council from 1 August. The Trust Chair has attempted to arrange a meeting with that person to discuss the changes and their implications for the prospective governor's tenure.

10.3 Previous versions of the constitution incorporated Standing Orders for both the Council of Governors and the Board, meaning that Standing Orders formed part of the constitution. Each set of Standing Orders included provisions about conflicts of interest. In order to provide clarity, those conflicts of interest provisions in Standing Orders have been relocated

into the main body of the constitution. As a result, Standing Orders now deal solely with procedural matters for meetings of the Council and the Board, and the proposal in this report would decouple Standing Orders from the constitution, and enable the Council and the Board to amend and approve their own Standing Orders. A copy of the revised Standing Orders was attached for the Board's approval.

10.4 Additionally, the proposed changes remove the position of Learning Disability Partnership governor; the Trust has been unable to secure a nomination from the Learning Disability Partnership for this position, which has been vacant since December 2015. This change would reduce the size of the Council to 26 governors. Following discussion at the July Council of Governors a provision has been added for the Council to co-opt a LD advisor should it wish to do so.

10.5 It was noted that the Council of Governors had discussed the proposed changes in depth at its meeting on 13 July, and proposed a number of changes which have been incorporated. The Council agreed the changes to the constitution subject to the incorporation of those suggested amendments, and subject to approval by the Trust Board.

10.6 The Board thanked the Trust Secretary for the work carried out and for preparing a very clear and comprehensive report for consideration. The Board fully supported the changes to the Trust constitution, to take effect immediately.

11. SUMMARY FINANCE REPORT

11.1 The Board received the Finance Report that provided information up to the end of June 2017. The month 3 position was a surplus of £156k in line with the planned surplus. The month 3 forecast outturn is a £885k surplus in line with the Trust's control total. The Trust has an Oversight Framework segment of 2 and a Finance and Use of Resources metric of 2. The Director of Finance asked the Board to note that whilst the Trust was on target to achieve its forecast outturn, there was no flexibility for movement and the Trust therefore needed to remain cautious during what was going to be a very challenging year ahead if it was to meet its control total by the end of the financial year.

11.2 The Board noted that the agency cost forecast is a reduction of £1.049m on last year's expenditure level. This would leave the Trust £1.039m above the Agency Control Total.

11.3 Nikki Richardson asked whether the 2017/18 inpatient services budgets had been adjusted to take into account vacancies and agency expenditure. The Director of Finance confirmed that these budgets had been adjusted to ensure that services were able to operate within their financial control totals; however, it was noted that the agency factor was still a big pressure on operational services. The Director of Quality added however, that nursing agency usage was currently below the Trust's control total which was excellent.

11.4 The Board noted the Trust's Cash position. The number of creditor days was 25 with a current cash position of £10.6m. The year-end forecast was £12m and the Trust was closely monitoring this. The Director of Finance advised that he was not currently concerned about this indicator, however, the threshold was £10m and it was agreed that focus was needed on this and a review of the target parameters to ensure that the Trust did not slip into a Red position. It was suggested that 2gether could look at potentially setting its own local indicator for this target which could help provide this additional focus. The Director of Finance agreed to look at this further.

ACTION: Director of Finance to look at the development of a local indicator to provide additional focus on the Trust's Cash position

11.5 Discussions took place at the last meeting around cost pressures in the maintenance budgets, particularly in relation to the Reactive Maintenance budget (fixing broken items). The Chief Executive assured the Board that the Executive Committee was reviewing and monitoring this position.

11.6 The Board noted the summary Finance Report for the period ending June 2017.

12. SELF ASSESSMENT ON FINANCIAL GOVERNANCE

12.1 As part of our established governance processes the Board scans the operating environment for recommendations from relevant independent governance reviews. The Board utilises findings and recommendations from those reports to self assess or commission independent assessment of our governance arrangements. Such assessments assist in identifying either gaps in our current governance arrangements or opportunities for further strengthening assurance processes.

12.2 In July 2017 an independent review by Deloitte of financial governance arrangements within an NHS Foundation Trust reviewed how the drivers of deterioration in the Trusts financial position arose. Within 24 hours of the report being published the Chief Executive of 2gether had reviewed the report and commissioned the Trust Secretary and Director of Finance to review and summarise current corporate and financial governance arrangements within 2gether against the report's conclusions and recommendations.

12.3 On 17 July the Executive Committee received and debated the draft self-assessment produced by the Trust Secretary. Each recommendation from the report was reviewed and the self-assessment statements pulled together by the Trust Secretary and the supporting evidence were challenged and either accepted or rejected. Against the 32 areas self assessed, the Executive Committee:

- Accepted all (with some minor additional references to evidence)
- Rejected none
- Identified 8 opportunities to further strengthen internal assurance processes.

12.4 The Board was asked to debate the recommendations and if supportive endorse the proposed changes to process. It was noted that a draft of the report had not been shared with Non-Executive Directors in advance to enable good discussion and debate at this meeting.

12.5 The Chief Executive said that the review offered the Board good assurance that the appropriate mechanisms were in place around financial governance. However, the second level of assurance was how the Trust could ensure that those mechanisms were having the necessary impact. The Chief Executive advised that this was a very important report and it was good practice for 2gether to carry out such a review/self-assessment against it. 2gether could rely on national indicators, CQC ratings, NHSi performance but good Boards needed to continue detailed discussion and scrutiny of key risks in year – if risks did exist then we needed to know about them.

12.6 It was agreed that the self-assessment had highlighted a number of process issues which still needed to be worked through. Overall this self-assessment offered the Board good assurance and the direction of travel was endorsed. Board members were invited to

feedback comments to the Chief Executive, and a fuller report would be presented back to the Board in October.

ACTION: Board members to provide comments on the self-assessment of financial governance to the Chief Executive

ACTION: A follow up report on the self-assessment of financial governance to be presented back to the Board in October

12.7 Bren McInerney said that the culture at 2gether was excellent and the presentation of such self-assessment reports at Board meetings was a good demonstration of its open and transparent nature.

13. HEREFORDSHIRE & WORCESTERSHIRE SUSTAINABILITY AND TRANSFORMATION PLAN

13.1 On 22 December 2015, NHS England published the NHS Planning Guidance 2016/17-2020/21, setting out the mandatory planning requirements for all NHS organisations. This included a requirement for NHS organisations to come together across defined geographical areas to prepare a local health and social care system Sustainability and Transformation Plan (STP). The basic philosophy of the plan is that long-term sustainability can be secured only through simultaneous achievement of the triple aim of (i) population well-being (ii) high quality service delivery, and (iii) efficient use of resources.

13.2 At the meeting of the STP Partnership Board on 20th June 2017, the Board endorsed the final version of the plan and commended it to CCG Governing Bodies and NHS Provider Boards for approval and publication.

13.3 The Chief Executive informed the Board that 2gether had had good representation and involvement in the development of the Herefordshire and Worcestershire STP work.

13.4 The Board:

- Approved the refreshed Sustainability and Transformation Plan (STP) for publication dated the 5th July 2017 and agreed to review the plan at least annually.
- Noted that STP delivery plans will now be developed to underpin delivery of the plan and that it is expected these plans will be coordinated through the STP Programme Office
- Over the coming months, would consider the how the role of the Trust Board will need to evolve in the light of the emerging Accountable Care environment that is being encouraged through national policy formulation.

14. BOARD COMMITTEE REPORTS – MH LEGISLATION SCRUTINY COMMITTEE

14.1 The Board received the summary reports from the MH Legislation Scrutiny Committee meetings held on 12 June and 12 July 2017. The Board noted the key points discussed at the meetings and the assurance received by the Committee.

15. BOARD COMMITTEE REPORT – GOVERNANCE COMMITTEE

15.1 The Board received the summary report from the Governance Committee meeting held on 16 June 2017 and noted the key points discussed at the meeting and the assurance received by the Committee.

16. BOARD COMMITTEE REPORTS – DELIVERY COMMITTEE

16.1 The Board received the summary report from the Delivery Committee meeting held on 28 June 2017 and noted the key points discussed at the meeting and the assurance received by the Committee.

16.2 Maria Bond provided a verbal report from the Delivery Committee meeting held on 26 July. A full written report from the July Committee would be presented at the next Board meeting.

17. INFORMATION SHARING REPORTS

17.1 The Board received the following reports for information and to note:

- Chair's Report.
- Use of the Trust Seal – Q4 2016/17 and Q1 2017/18
- Council of Governors minutes – May 2017

17.2 The Chair informed the Board that Chris Creswick had been appointed as the Gloucestershire STP Chair.

18. ANY OTHER BUSINESS

18.1 There was no other business.

18.2 Bren McInerney asked whether the Trust could consider further ways of promoting the Trust Board meetings via social media. Kate Nelmes agreed to take this as an action.

19. DATE OF THE NEXT MEETING

19.1 The next Board meeting would take place on Thursday 28 September 2017 at Trust HQ, Rikenel, Gloucester.

Signed: …….. **Date: …….**

Ruth FitzJohn, Chair

BOARD MEETING
ACTION POINTS

Date of Mtg	Item ref	Action	Lead	Date due	Status/Progress
27 July 2017	6.1	The link to the YouTube video of the 9th LD Big Health Check Day would be shared with all Governors.	Anna Hilditch	August	**Complete**
	7.4 (1)	Workforce KPI report received at the Delivery Committee in July to be shared with all Board members for information.	Anna Hilditch	August	**Complete**
	7.4 (2)	Director of OD to consider how best for the full Board to be kept up to date and informed on progress with achieving HR indicators	Neil Savage	September	
	9.3	Chief Executive to ensure that his report was reviewed thoroughly in relation to the use of acronyms and a glossary included where possible.	Shaun Clee	September	
	11.4	Director of Finance to look at the development of a local indicator to provide additional focus on the Trust's Cash position	Andrew Lee	September	**Complete** Included in Finance Report
	12.6	Board members to provide comments on the self-assessment of financial governance to the Chief Executive	ALL	September	**Complete**
	12.6	A follow up report on the self-assessment of financial governance to be presented back to the Board in October	Shaun Clee / Trust Secretariat	October	**Complete** Scheduled on Board work plan for October

Agenda item 7 **Paper** B

Report to: 2gether Trust Board – 28 September 2017
Author: Chris Woon, Head of Information Management and Clinical Systems
Presented by: Colin Merker, Director of Service Delivery

SUBJECT: **Performance Dashboard Report for the period to the end of July 2017 (month 4)**

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 July 2017 (month 4) of the 2017/18 contract period, against our NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

Of the 154 performance indicators, 86 are reportable in July with 79 being compliant and 7 non-compliant at the end of the reporting period.

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

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

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

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

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

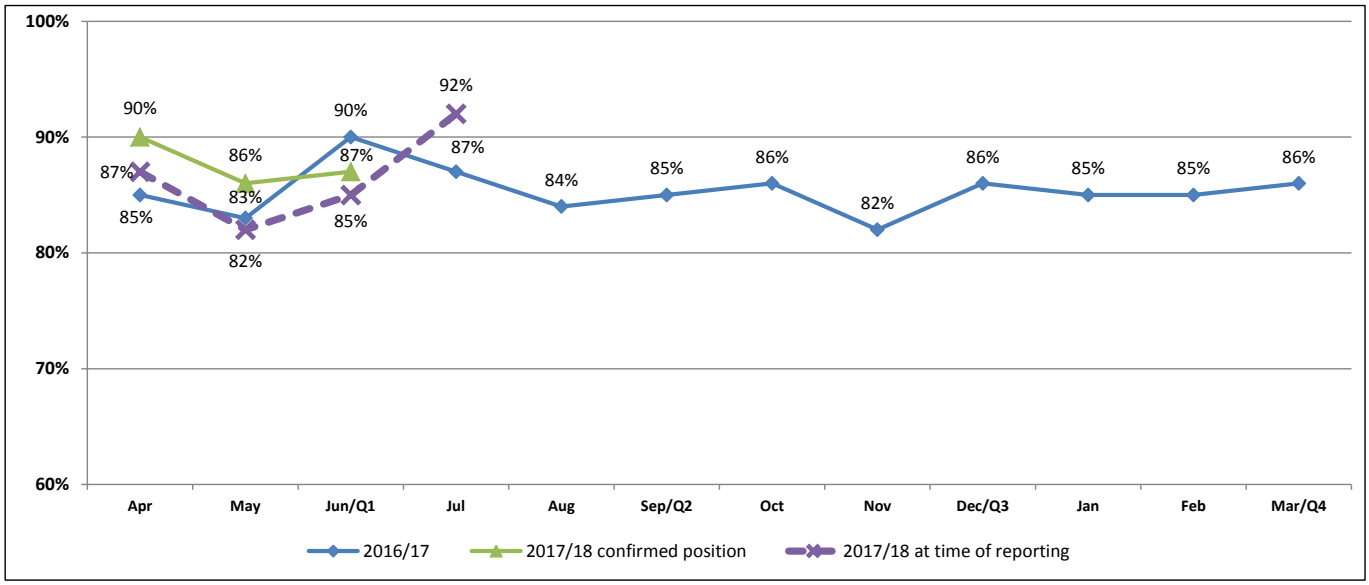
A column has been added to indicate whether the indicator is forecast to be compliant at the end of the financial year.

- Compliant
- Non Compliant
- Unknown
- No performance threshold

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

Indicators Reported in Month and Levels of Compliance							
Indicator Type	**Total Measures**	**Reported in Month**	**Compliant**	**Non Compliant**	**% non-compliance**	**Not Yet Required**	**NYA / UR**
NHSi Requirements	**13**	**13**	**11**	**2**	**15**	**0**	**0**
Never Events	**17**	**17**	**17**	**0**	**0**	**0**	**0**
Department of Health	**10**	**8**	**8**	**0**	**0**	**2**	**0**
Gloucestershire CCG Contract	**52**	**18**	**17**	**1**	**6**	**33**	**1**
Social Care	**15**	**13**	**11**	**2**	**15**	**2**	**0**
Herefordshire CCG Contract	**22**	**17**	**15**	**2**	**12**	**5**	**0**
CQUINS	**25**	**0**	**0**	**0**	**0**	**25**	**0**
Overall	**154**	**86**	**79**	**7**	**8**	**67**	**1**

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



June's confirmed position is 87% compared to 85% previously reported. This is due to 16 compliant CQUIN indicators which we were unable to report last month as the information was not available.

Summary Exception Reporting

The following 7 key performance thresholds were not met for the Trust for July 2017:

NHS Improvement Requirements

- 1.09 – IAPT: Waiting times - Referral to Treatment within 6 weeks
- 1.10 – IAPT: Waiting times - Referral to Treatment within 18 weeks

Gloucestershire CCG Contract Measures

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

Social Care –Gloucestershire CCG Contract Measures

- 4.06 – Percentage of service users asked if they have a carer
- 4.07 – Percentage with a carer that have been offered a carer's assessment

Herefordshire CCG Contract Measures

- 5.09 – IAPT maintain 15% of patients entering the service against prevalence
- 5.13 – Attendances at ED have access to Mental Health Liaison Team within 2 hours

RECOMMENDATIONS

The Board is asked to:

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

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

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

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

Reviewed by:		
Colin Merker	Date	August 2017

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

What consultation has there been?		
Not applicable.	Date	

Explanation of acronyms used:	
	AKI Acute kidney injury
	ASCOF Adult Social Care Outcomes Framework
	CAMHS Child and Adolescent Mental health Services
	C-Diff Clostridium difficile
	CIRG Clinical Information Reference Group
	CPA Care Programme Approach
	CPDG Contract Performance and Development Group
	CQUIN Commissioning for Quality and Innovation
	CRHT Crisis Home Treatment
	CSM Community Services Manager
	CYPS Children and Young People's Services
	DNA Did not Attend
	ED Emergency Department
	EI Early Intervention
	EWS Early warning score
	HoNoS Health of the Nation Outcome Scale
	IAPT Improving Access to Psychological Therapies
	IST Intensive Support Team (National IAPT Team)
	KPI Key Performance Indicator
	LD Learning Disabilities
	MHICT Mental Health Intermediate Care Team
	MHL Mental Health Liaison
	MRSA Methicillin-resistant Staphylococcus aureus
	MUST Malnutrition Universal Screening Tool
	NHSI NHS Improvement
	NICE National Institute for Health and Care Excellence
	SI Serious Incident
	SUS Secondary Uses Service
	VTE Venous thromboembolism
	YOS Youth Offender's Service

1. CONTEXT

This report sets out the performance Dashboard for the Trust for the period to the end of July 2017, month four of the 2017/18 contract period.

1.1 The following sections of the report include:

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

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

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

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

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

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

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

DASHBOARD CATEGORY - NHSI REQUIREMENTS

NHS Improvement Requirements				
	In month Compliance			Cumulative Compliance
	May	Jun	Jul	
Total Measures	13	13	13	13
🔴	2	2	2	2
🟢	11	11	11	11
NYA	0	0	0	0
NYR	0	0	0	0
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month

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

1.07: New Psychosis (EI) cases as per contract (Gloucestershire):
Although overall the Trust is compliant with 36 new cases at the end of July against an expected threshold of 32, Gloucestershire have reported 21 new cases which is 3 short of the anticipated year to date total of 24 for this locality.

1.08: New Psychosis (EI) cases treated within 2 weeks of referral (Gloucestershire):
Although overall the Trust is compliant with 60% of new cases treated within 2 weeks at the end of July, Gloucestershire is currently reporting 33% against a performance threshold of 50%.

There are 2 non-compliant cases, one of which is where the client has been reported as a new case but is in fact being treated as an ongoing case of psychosis. (The client having been diagnosed by another Trust but currently residing in Gloucestershire). The system will be updated to record a referral reason of on-going psychosis and the methodology revised to exclude this referral reason. Once this has been completed revised performance will be compliant at 66%.

🚩 **1.09: IAPT: Waiting times - Referral to Treatment within 6 weeks**
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

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

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

Cumulative Performance Thresholds Not being Met

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

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

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

Changes to Previously Reported Figures

None

Early Warnings / Notes

None

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

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

1.09 & 1.10: IAPT: Waiting times - Referral to Treatment within 6 & 18 weeks
The position us unlikely to be recoverable until additional investment is agreed with Commissioners to address deficits in the service modelling relating to referrals fluctuations and extended staff absences.

This forecast position will be reviewed when Commissioners discussions are resolved in Q2.

NHS Improvement Requirements

ID	Performance Measure (PM)		2016/17Outturn	May-2017	June-2017	July-2017	(Apr to Jul) Cumulative Compliance	Forecast 17/18 Outturn
1								
1.01	Number of MRSA Bacteraemias	PM	0	0	0	0	0	0
		Gloucestershire	0	0	0	0	0	
		Herefordshire	0	0	0	0	0	
		Combined Actual	0	0	0	0	0	
1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	0	0
		Gloucestershire	0	0	0	0	0	
		Herefordshire	3	0	0	0	0	
		Combined Actual	3	0	0	0	0	
1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	98%	100%	98%	98%	99%	
		Herefordshire	99%	100%	97%	100%	99%	
		Combined Actual	98%	100%	98%	99%	99%	
1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	99%	98%	97%	97%	97%	
		Herefordshire	99%	98%	94%	98%	97%	
		Combined Actual	99%	98%	96%	97%	97%	
1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Gloucestershire	1.6%	1.2%	1.0%	2.5%	1.3%	
		Herefordshire	2.2%	0.0%	3.8%	2.7%	1.6%	
		Combined Actual	1.8%	0.9%	1.7%	2.5%	1.4%	
1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	99%	100%	100%	100%	100%	
		Herefordshire	100%	100%	100%	100%	100%	
		Combined Actual	99%	100%	100%	100%	100%	
1.07	New psychosis (EI) cases as per contract	PM	72	12	18	24	24	72
		Gloucestershire	67	10	18	21	21	
		PM	24	4	6	8	8	24
		Herefordshire	20	10	13	15	15	
		PM	96	16	24	32	32	96
		Combined Actual	87	20	31	36	36	
1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	72%	100%	75%	33%	76%	
		Herefordshire	70%	75%	67%	100%	67%	
		Combined Actual	71%	89%	73%	60%	72%	

NHS Improvement Requirements

ID	Performance Measure (PM)		2016/17Outturn	May-2017	June-2017	July-2017	(Apr to Jul) Cumulative Compliance	Forecast 17/18 Outturn
1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Gloucestershire	35%	62%	64%	68%	62%	
		Herefordshire	49%	43%	59%	66%	52%	
		Combined Actual	38%	58%	63%	68%	61%	
1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	86%	88%	85%	87%	87%	
		Herefordshire	85%	80%	83%	77%	81%	
		Combined Actual	86%	87%	84%	86%	86%	
1.11	**MENTAL HEALTH SERVICES DATA SET PART 1 DATA COMPLETENESS: OVERALL**	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%	
1.11a	Mental Health Services Data Set Part 1 Data completeness: DOB	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	100.0%	100.0%	100.0%	100.0%	100.0%	
		Herefordshire	100.0%	100.0%	100.0%	100.0%	100.0%	
		Combined Actual	100.0%	100.0%	100.0%	100.0%	100.0%	
1.11b	Mental Health Services Data Set Part 1 Data completeness: Gender	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Herefordshire	99.9%	100.0%	100.0%	99.9%	99.9%	
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%	
1.11c	Mental Health Services Data Set Part 1 Data completeness: NHS Number	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%	
1.11d	Mental Health Services Data Set Part 1 Data completeness: Organisation code of commissioner	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	100.0%	100.0%	100.0%	100.0%	100.0%	
		Herefordshire	100.0%	100.0%	100.0%	100.0%	100.0%	
		Combined Actual	100.0%	100.0%	100.0%	100.0%	100.0%	
1.11e	Mental Health Services Data Set Part 1 Data completeness: Postcode	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.8%	99.9%	99.8%	99.8%	99.9%	
		Herefordshire	99.8%	99.8%	99.8%	99.8%	99.8%	
		Combined Actual	99.8%	99.8%	99.8%	99.8%	99.8%	
1.11f	Mental Health Services Data Set Part 1 Data completeness: GP Practice	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.4%	99.6%	99.6%	99.6%	99.6%	
		Herefordshire	99.7%	99.6%	99.6%	99.6%	99.6%	
		Combined Actual	99.5%	99.6%	99.6%	99.6%	99.6%	

NHS Improvement Requirements

ID	Performance Measure (PM)		2016/17Outturn	May-2017	June-2017	July-2017	(Apr to Jul) Cumulative Compliance	Forecast 17/18 Outturn
1.12	MENTAL HEALTH SERVICES DATA SET PART 2 DATA COMPLETENESS : OVERALL	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	95.7%	95.2%	95.2%	95.3%	95.2%	
		Herefordshire	92.5%	90.3%	90.6%	89.9%	90.3%	
		Combined Actual	95.1%	94.3%	94.3%	94.2%	94.3%	
1.12a	Mental Health Services Data Set Part 2 Data completeness: CPA Employment status last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	90.0%	90.5%	90.4%	90.1%	90.3%	
		Herefordshire	89.2%	86.0%	86.4%	85.7%	86.0%	
		Combined Actual	89.9%	89.6%	89.6%	89.2%	89.5%	
1.12b	Mental Health Services Data Set Part 2 Data completeness: CPA Accommodation Status in last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	97.3%	96.9%	97.1%	97.3%	97.0%	
		Herefordshire	89.6%	86.6%	87.0%	86.4%	86.7%	
		Combined Actual	95.9%	94.9%	95.1%	95.1%	94.9%	
1.12c	Mental Health Services Data Set Part 2 Data completeness: CPA HoNOS assessment in last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	99.6%	98.3%	98.3%	98.5%	98.4%	
		Herefordshire	98.5%	98.3%	98.3%	97.6%	98.2%	
		Combined Actual	99.4%	98.3%	98.3%	98.3%	98.3%	
1.13	Learning Disability Services: 6 indicators: identification of people with a LD, provision of information, support to family carers, training for staff, representation of people with LD; audit of practice and publication of findings	PM	6	6	6	6	6	6
		Gloucestershire	6	6	6	6	6	
		Herefordshire	6	6	6	6	6	
		Combined Actual	6	6	6	6	6	

DASHBOARD CATEGORY – DEPARTMENT OF HEALTH PERFORMANCE

DoH Performance				
	In month Compliance			Cumulative Compliance
	May	Jun	Jul	
Total Measures	27	27	27	27
	1	1	0	1
	24	24	25	24
NYA	0	0	0	0
NYR	1	1	1	1
UR	0	0	0	0
N/A	1	1	1	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 4 under 18s admitted to adult inpatient wards, 2 in Gloucestershire and 2 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)		2016/17Outturn	May-2017	June-2017	July-2017	(Apr to Jul) Cumulative Compliance	Forecast 17/18 Outturn
2								
2.01	Wrongly prepared high risk injectable medications	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.02	Maladministration of potassium containing solutions	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.03	Wrong route administration of oral/enteral treatment	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.04	Intravenous administration of epidural medication	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.05	Maladministration of insulin	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.06	Overdose of midazolam during conscious sedation	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.07	Opioid overdose in opioid naive patient	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.08	Inappropriate administration of daily oral methotrexate	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.09	Suicide using non collapsible rails	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.10	Falls from unrestricted windows	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.11	Entrapment in bedrails	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.12	Misplaced naso - or oro-gastric tubes	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.13	Wrong gas administered	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.14	Failure to monitor and respond to oxygen saturation - conscious sedation	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.15	Air embolism	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.16	Severe scalding from water for washing/bathing	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.17	Mis-identification of patients	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	

DOH Requirements

ID	Performance Measure (PM)		2016/17Outturn	May-2017	June-2017	July-2017	(Apr to Jul) Cumulative Compliance	Forecast 17/18 Outturn
2.18	Mixed Sex Accommodation - Sleeping Accommodation Breaches	PM	0	0	0	0	0	0
		Gloucestershire	0	0	0	0	0	
		Herefordshire	0	0	0	0	0	
		Combined	0	0	0	0	0	
2.19	Mixed Sex Accommodation - Bathrooms	Gloucestershire	Yes	Yes	Yes	Yes	Yes	
		Herefordshire	Yes	Yes	Yes	Yes	Yes	
		Combined	Yes	Yes	Yes	Yes	Yes	
2.20	Mixed Sex Accommodation - Women Only Day areas	Gloucestershire	Yes	Yes	Yes	Yes	Yes	
		Herefordshire	Yes	Yes	Yes	Yes	Yes	
		Combined	Yes	Yes	Yes	Yes	Yes	
2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0	0
		Gloucestershire	10	2	0	0	2	
		Herefordshire	8	0	1	0	2	
		Combined	18	2	1	0	4	
2.22	Failure to publish Declaration of Compliance or Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	Gloucestershire	Yes	Yes	Yes	Yes	Yes	
		Herefordshire	Yes	Yes	Yes	Yes	Yes	
		Combined	Yes	Yes	Yes	Yes	Yes	
2.23	Publishing a Declaration of Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	Gloucestershire	Yes	Yes	Yes	Yes	Yes	
		Herefordshire	Yes	Yes	Yes	Yes	Yes	

DOH Requirements

ID	Performance Measure (PM)		2016/17Outturn	May-2017	June-2017	July-2017	(Apr to Jul) Cumulative Compliance	Forecast 17/18 Outturn
2.24	Serious Incident Reporting (SI)	Glos	35	6	1	3	12	
		Hereford	8	2	4	4	11	
2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	100%	100%	100%	100%	100%	
		Herefordshire	100%	100%	100%	100%	100%	
2.26	Interim report for all SIs received within 5 working days of identification (unless extension granted by CCG)	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	91%	100%	100%	100%	100%	
		Herefordshire	78%	100%	100%	100%	100%	
2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	100%	NYR	NYR	NYR	NYR	
		Herefordshire	100%	NYR	NYR	NYR	NYR	
2.28	SI Report Level 3 - Independent investigations - 6 months from investigation commissioned date	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	N/A	N/A	N/A	N/A	N/A	
		Herefordshire	N/A	N/A	N/A	N/A	N/A	
2.29	SI Final Reports outstanding but not due	Gloucestershire	2	1	1	3	5	
		Herefordshire	1	1	4	4	9	

DASHBOARD CATEGORY – GLOUCESTERSHIRE CCG CONTRACTUAL REQUIREMENTS

Gloucestershire Contract				
	In month Compliance			Cumulative Compliance
	May	Jun	Jul	
Total Measures	52	52	52	52
	3	4	1	3
	16	23	17	25
NYA	0	1	1	1
NYR	28	16	28	16
UR	0	0	0	0
N/A	5	8	5	7

Performance Thresholds not being achieved in Month

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

Cumulative Performance Thresholds Not being Met

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

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

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

Changes to Previously Reported Figure

3.37: Care plan audit - dependent children living with adults known to the Trust
Previously reported as not yet available for June, this is now reported with performance at 52%.

3.38: Alexandra Wellbeing house dataset available for Commissioners
This dataset has now been made available for May and June and this indicator is now reported as compliant for these two months

Early Warnings/Notes

3.11: 2g Bed Occupancy for Gloucestershire patients
We will be reviewing the current method of measurement with Commissioners to examine whether measuring against 'available' bed days rather than 'occupied' bed days would be more appropriate.

3.30: Adult Mental Health Intermediate Care Teams (IAPT/Nursing Integrated Service): Wait times from referral to screening assessment within 14 days of receiving referral
It is recognised that this indicator no longer gives a meaningful indication of performance within the new pathway model and is therefore now excluded from reporting requirements, while discussions continue with our commissioner.

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

3.18 & 3.19: IAPT Recovery rate and IAPT Access rate:
The position is unlikely to be recoverable until additional investment is agreed with Commissioners to address deficits in the service modelling relating to referral fluctuations and extended staff absences.

This forecast position will be reviewed when Commissioners discussions are resolved in Q2.

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

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

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	May-2017	June-2017	July-2017	(Apr to Jul) Cumulative Compliance	Forecast 17/18 Outturn
	B. NATIONAL QUALITY REQUIREMENT							
3.01	Zero tolerance MRSA	PM	0	0	0	0	0	0
		Unavoidable	1	0	0	0	0	
3.02	Minimise rates of Clostridium difficile	PM	0	0	0	0	0	0
		Unavoidable	1	0	0	0	0	
3.03	Duty of candour	PM	Report	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant	Compliant	Compliant	
3.04	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS,	PM	99%	99%	99%	99%	99%	99%
		Actual	99%	99%	99%	99%	99%	
3.05	Completion of Mental Health Services Data Set ethnicity coding for all detained and informal Service Users	PM	90%	90%	90%	90%	90%	90%
		Actual	99%	97%	100%	100%	99%	
3.06	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	PM	90%	90%	90%	90%	90%	90%
		Actual	99%	99%	100%	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	Annual
		Actual	Complete				NYR	
3.08	To reduce the numbers of detained patients absconding from inpatient units where leave has not been granted	PM	< 144		< 36		< 36	< 144
		Actual	96		37		37	
3.09	Compliance with NICE Technology appraisals within 90 days of their publication and ability to demonstrate compliance through completion of implementation plans and costing templates.	PM	Report				Annual	Annual
		Actual	Compliant				NYR	
3.10	Minimum of 5% increase in uptake of flu vaccination (15/16 55.3%	PM	>55.3%				Annual	Annual
		Actual	77.2%				NYR	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	April-2017	May-2017	June-2017	July-2017	(Apr to Jul) Cumulative Compliance	Forecast 17/18 Outturn
	Domain 2: Enhancing the quality of life of people with long-term conditions								
3.11	2G bed occupancy for Gloucestershire CCG patients	PM	> 91%	> 91%	> 91%	> 91%	> 91%	> 91%	> 91%
		Actual	93%	94%	94%	90%	92%	93%	
3.12	Care Programme Approach: 95% of CPAs should have a record of the mental health worker who is responsible for their care	PM	95%	95%	95%	95%	95%	95%	95%
		Actual	99%	100%	100%	100%	100%	100%	
3.13	CPA Review - 95% of those on CPA to be reviewed within 1 month (Review within 13 months)	PM	95%	95%	95%	95%	95%	95%	95%
		Actual	99%	99%	99%	99%	99%	99%	
3.14	Assessment of risk: % of those 2g service users on CPA to have a documented risk assessment	PM	95%			95%		95%	95%
		Actual	99%			99%		99%	
3.15	Assessment of risk: All 2g service users (excluding those on CPA) to have a documented risk assessment	PM	85%			85%		85%	85%
		Actual	95%			96%		96%	
3.16	Dementia should be diagnosed as early in the illness as possible: People within the memory assessment service with a working diagnosis of dementia to have a care plan within 4 weeks of diagnosis	PM	85%	85%	85%	85%	85%	85%	85%
		Actual	95%	93%	83%	92%	100%	92%	
3.17	AKI (previous CQUIN 1516) 95% of pts to have EWS score within 12 hours	PM	95%			95%		95%	95%
		Actual	99%			100%		100%	
	Domain 3: Helping people to recover from episodes of ill-health or following injury								
3.18	IAPT recovery rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%	50%	50%
		Actual	47%	50%	48%	49%	50%	49%	
3.19	IAPT access rate: Access to psychological therapies for adults should be improved	PM	15.00%	1.25%	1.25%	1.25%	1.25%	15.00%	15.00%
		Actual	8.20%	1.00%	1.03%	0.91%	0.92%	11.04%	
3.20	IAPT reliable improvement rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%	50%	50%
		Actual	73%	72%	69%	71%	71%	71%	
3.21	Care Programme Approach (CPA): The percentage of people with learning disabilities in inpatient care on CPA who were followed up within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%	95%
		Actual	100%	100%	NA	NA	NA	100%	
3.22	To send :Inpatient and day case discharge summaries electronically, within 24 hours to GP	PM	Report			TBC		TBC	Report
		Actual	Compliant			73%		73%	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	May-2017	June-2017	July-2017	(Apr to Jul) Cumulative Compliance	Forecast 17/18 Outturn
	Domain 4: Ensuring that people have a positive experience of care							
3.23	To demonstrate improvements in staff experience following any national and local surveys	PM	Report				Annual	Annual
		Actual	Compliant				NYR	
	CYPS							
3.24	Number of children that received support within 24 hours of referral, for crisis home treatment (CYPS)	PM	95%		95%		95%	95%
		Actual	N/A		N/A		N/A	
3.25	Children and young people who enter a treatment programme to have a care coordinator - (Level 3 Services) (CYPS)	PM	98%	98%	98%	98%	98%	98%
		Actual	99%	99%	99%	99%	99%	
3.26	95% accepted referrals receiving initial appointment within 4 weeks (excludes YOS, substance misuse, inpatient and crisis/home treatment and complex engagement) (CYPS)	PM	95%		95%		95%	95%
		Actual	99%		99%		99%	
3.27	Level 2 and 3 – Referral to treatment within 8 weeks , excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	80%		80%		80%	80%
		Actual	89%		94%		94%	
3.28	Level 2 and 3 – Referral to treatment within 10 weeks (excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	90%		95%		95%	95%
		Actual	96%		98%		98%	
3.29	Adults of working age - 100% of MDT assessments to have been completed within 4 weeks (or in the case of a comprehensive	PM	85%	85%	85%	85%	85%	85%
		Actual	94%	92%	93%	88%	92%	
3.30	Adults Mental Health Intermediate Care Teams (New Integrated service) Wait times from referral to screening assessment within 14 days of receiving referral	PM	85%	85%	85%	85%	85%	85%
		Actual	65%					

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	May-2017	June-2017	July-2017	(Apr to Jul) Cumulative Compliance	Forecast 17/18 Outturn
	Vocational Services (Individual Placement and Support)							
3.31	100% of Service Users in vocational services will be supported to formulate their vocational goals through individual plans (IPS)	PM	98%		98%		98%	98%
		Actual	100%		NYA		NYA	
3.32	The number of people on the caseload during the year finding paid employment or self-employment (measured as a percentage against accepted referrals into the (IPS) Excluding those in employment at time of referral - Annual	PM	50%				50%	50%
		Actual	52%				NYR	
3.33	The number of people retaining employment at 3/6/9/12+ months (measured as a percentage of individuals placed into employment retaining employment) (IPS)	PM	50%				50%	50%
		Actual	66%				NYR	
3.34	The number of people supported to retain employment at 3/6/9/12+ months	PM	50%				50%	50%
		Actual	88%				NYR	
3.35	Fidelity to the IPS model	PM	Report				90%	90%
		Actual	Compliant				NYR	
	General Quality Requirements							
3.36	GP practices will have an individual annual (MH) ICT service meeting to review delivery and identify priorities for future.	PM	Annual				Annual	Annual
		Actual	NYA				NYR	
3.37	Care plan audit to show : All dependent Children and YP <18 living with adults know to Recovery, MAHRS, Eating Disorder and Assertive Outreach Services. Recorded evidence in care plans of impact of the mental health disorder on those under 18s plus steps put in place to support.(Think family)	PM	Qtr 4		TBC		TBC	Report
		Actual	Compliant		52%		52%	
3.38	Transition- Joint discharge/CPA review meeting within 4 weeks of adult MH services accepting :working diagnosis to be agreed, adult MH care coordinator allocated and care cluster and risk levels agreed as well as CYPS discharge date.	PM	100%		100%		100%	100%
		Actual	0%		100%		100%	
3.39	Number and % of crisis assessments undertaken by the MHARS team on CYP age 16-25 within agreed timescales of 4 hours	PM	90%				90%	90%
		Actual	NYR				NYR	
3.40	MHARS wait time to assessment (4 hours)	PM	TBC				TBC	TBC
		Actual	NYR				NYR	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	May-2017	June-2017	July-2017	(Apr to Jul) Cumulative Compliance	Forecast 17/18 Outturn
	New KPIs for 2017/18							
3.41	LD: To deliver specialist support to people with learning disabilities in accordance with specifically developed pathways	PM					95%	95%
		Actual					NYR	
3.42	LD: To demonstrate a reduction in an individual's health inequalities thanks to the clinical intervention provided by 2gether learning disability services.	PM					TBC	TBC
		Actual					NYR	
3.43	LD: People with learning disabilities and their families report high levels of satisfaction with specialist learning disability services	PM					75%	75%
		Actual					NYR	
3.44	LD: To ensure all published clinical pathways accessed by people with learning disabilities are available in easy read versions	PM					95%	95%
		Actual					NYR	
3.45	LD: The CLDT will take a proactive and supportive role in ensuring the % uptake of Annual Health Checks for people with learning disabilities on their caseload is high	PM					75%	75%
		Actual					NYR	
3.46	Gloucestershire Sanctuary (Alexandra Road Wellbeing House) dataset available for Commissioners	PM		Report	Report	Report	Report	Report
		Actual		Compliant	Compliant	NYA	Compliant	
3.47	IAPT DNA rate	PM		<16%	<16%	<16%	<16%	<16%
		Actual		14%	13%	13%	14%	
3.48	CPI: Referral to Assessment within 4 weeks	PM		80%	80%	80%	80%	80%
		Actual		81%	92%	87%	87%	
3.49	CPI: Assessment to Treatment within 16 weeks	PM		80%	80%	80%	80%	80%
		Actual		92%	100%	100%	96%	
3.50	Adolesecent Eating Disorders - Urgent referral to NICE treatment start within 1 week	PM		TBC	TBC	TBC	TBC	TBC
		Actual		N/A	50%	N/A	50%	
3.51	Adolesecent Eating Disorders - Urgent referral to non-NICE treatment start within 1 week	PM		TBC	TBC	TBC	TBC	TBC
		Actual		N/A	N/A	N/A	N/A	
3.52	Adolesecent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	PM		TBC	TBC	TBC	TBC	TBC
		Actual		25%	33%	29%	32%	
3.53	Adolesecent Eating Disorders - Routine referral to non-NICE treatment start within 4 weeks	PM		TBC	TBC	TBC	TBC	TBC
		Actual		N/A	0%	N/A	0%	

Schedule 4 Specific Measures that are reported Nationally

Performance Thresholds not being achieved in Month

NHS Improvement

1.08: New Psychosis (EI) cases treated within 2 weeks of referral (Gloucestershire):
Gloucestershire is currently reported at 33% against a performance threshold of 50%.

There are 2 non-compliant cases, one of which is where the client has been reported as a new case but is in fact being treated as an ongoing case of psychosis. (The client having been diagnosed by another Trust but currently residing in Gloucestershire). The system will be updated to record a referral reason of on-going psychosis and the methodology revised to exclude this referral reason. Once this has been completed revised performance will be compliant at 66%.

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

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

Changes to Previously Reported Figures

None

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

1.09 & 1.10: IAPT: Waiting times - Referral to Treatment within 6 & 18 weeks
See earlier note on Page 8.

2.21: No children under 18 admitted to adult inpatient wards
See earlier note on Page 11.

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

ID	Performance Measure (PM)		2016/17Outturn	May-2017	June-2017	July-2017	(Apr to Jul) Cumulative Compliance	Forecast 17/18 Outturn
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
NHSI 1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
NHSI 1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Actual	98%	100%	98%	98%	99%	
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	1.6%	1.2%	1.0%	2.5%	1.3%	
NHSI 1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	100%	100%	100%	100%	
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%	50%
		Actual	72%	100%	75%	33%	76%	
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Actual	35%	62%	64%	68%	62%	
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Actual	86%	88%	85%	87%	87%	
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
DoH 2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0	0
		Actual	10	2	0	0	2	
DoH 2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%	100%
		Actual	100%	100%	100%	100%	100%	
DoH 2.26	Interim report for all SIs received within 5 working days of identification (unless extension granted by CCG)	PM	100%	100%	100%	100%	100%	100%
		Actual	91%	100%	100%	100%	100%	
DoH 2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM	91%	100%	100%	100%	100%	100%
		Actual	100%	NYR	NYR	NYR	NYR	

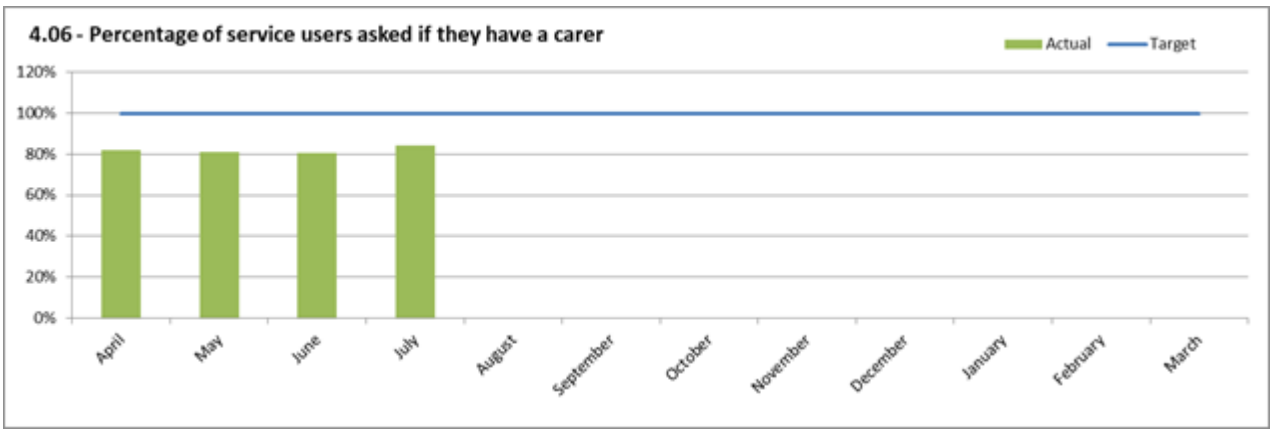
DASHBOARD CATEGORY – GLOUCESTERSHIRE SOCIAL CARE

Gloucestershire Social Care				
	In month Compliance			Cumulative Compliance
	May	Jun	Jul	
Total Measures	15	15	15	15
	3	3	2	3
	10	10	11	10
NYA	0	0	0	0
NYR	0	0	0	0
UR	0	0	0	0
N/A	2	2	2	2

Performance Thresholds not being achieved in Month

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

Focused work continues with Community Service Managers to improve compliance. Weekly progress reports are supplied to managers however ongoing staffing and recruitment issues in some locality Recovery Teams may be impacting performance. There is discussion with Commissioners regarding an 80% compliance threshold.



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

Work continues alongside indicator 4.06 to improve compliance further. There is discussion with Commissioners regarding a 90% compliance threshold.

Cumulative Performance Thresholds Not being Met

4.03 – Ensure that reviews of new packages take place within 12 weeks
Further analysis and work has been undertaken to improve monitoring and this indicator is now reported as compliant for the month of July. Work will continue to embed the recording process.

This indicator is being reviewed by our internal auditors to provide further reassurance around the recording and reporting of the data to support this indicator.

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

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

Changes to Previously Reported Figures

None

Early Warnings/Notes

None

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

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

4.06 & 4.07 – Percentage of service users asked if they have a carer and Percentage with a carer that have been offered a carer's assessment
Performance threshold negotiations need to be resolved before this year end forecast can be confirmed.

Gloucestershire Social Care

ID	Performance Measure		2016/17 outturn	May-2017	June-2017	July-2017	(Apr to Jul) Cumulative Compliance	Forecast 17/18 Outturn
4.01	The percentage of people who have a Cluster recorded on their record	PM	90%	90%	90%	TBC	90%	90%
		Actual	96%	97%	99%	97%	97%	
4.02	Percentage of people getting long term services, in a residential or community care reviewed/re-assessed in last year	PM	95%	95%	95%	95%	95%	95%
		Actual	95%	99%	97%	97%	99%	
4.03	Ensure that reviews of new packages take place within 12 weeks of commencement	PM	95%	80%	80%	80%	80%	80%
		Actual	22%	33%	57%	90%	53%	
4.04	Current placements aged 18-64 to residential and nursing care homes per 100,000 population	PM	13	13	13	TBC	13	13
		Actual	12.90	9.61	9.36	9.36	9.61	
4.05	Current placements aged 65+ to residential and nursing care homes per 100,000 population	PM	22	22	22	TBC	22	22
		Actual	16.55	14.78	14.78	14.78	14.78	
4.06	% of WA & OP service users on caseload asked if they have a carer	PM	100%	100%	100%	100%	100%	100%
			86%	81%	81%	84%	84%	
4.07	% of WA & OP service users on the caseload who have a carer, who have been offered a carer's assessment	PM	100%	100%	100%	100%	100%	100%
		Actual	75%	80%	80%	78%	78%	
4.08a	% of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC	TBC
		Actual	39%	38%	38%	40%	40%	
4.08b	Number of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC	TBC
		Actual	244	291	292	316	273	
4.09	% of eligible service users with Personal budgets	PM	80%	80%	80%	80%	80%	80%
		Actual	100%	90%	92%	93%	90%	

Gloucestershire Social Care

ID	Performance Measure		2016/17 outturn	May-2017	June-2017	July-2017	(Apr to Jul) Cumulative Compliance	Forecast 17/18 Outturn
4.10	% of eligible service users with Personal Budget receiving Direct Payments (ASCOF 1C pt2)	PM	15%	15%	15%	15%	15%	15%
		Actual	18%	19%	20%	21%	19%	
4.11	Adults subject to CPA in contact with secondary mental health services in settled accommodation (ASCOF 1H)	PM	80%	80%	80%	80%	80%	80%
		Actual	89%	88%	88%	88%	88%	
4.12	Adults not subject to CPA in contact with secondary mental health service in settled accommodation	PM	90%	90%	90%	90%	90%	90%
		Actual	96%	96%	96%	96%	96%	
4.13	Adults subject to CPA receiving secondary mental health service in employment (ASCOF 1F)	PM	13%	13%	13%	13%	13%	13%
		Actual	16%	15%	15%	15%	15%	
4.14	Adults not subject to CPA receiving secondary mental health service in employment	PM	20%	20%	20%	20%	20%	20%
		Actual	24%	21%	23%	22%	22%	

DASHBOARD CATEGORY – HEREFORDSHIRE CCG CONTRACTUAL REQUIREMENTS

Herefordshire Contract				
	In month Compliance			Cumulative Compliance
	May	Jun	Jul	
Total Measures	25	16	16	16
	3	4	2	2
	12	12	15	15
NYA	0	0	0	0
NYR	0	0	0	0
UR	0	0	0	0
N/A	7	6	5	5

Performance Thresholds not being achieved in Month

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

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

One patient was not seen within 2 hours as there was only 1 member of the team in the department and they were with another patient

One patient is a frequent attender at the Emergency department and has a care plan in place with the team. The impact of not being seen within 2 hours was minor.

One patient was seen after 2 hours and fifteen minutes and then was transported home.

Cumulative Performance Thresholds Not being

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

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

Changes to Previously Reported Figures

None

Early Warnings / Notes

None

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

5.09: IAPT roll-out (access rate) – IAPT maintain 15% of patient entering the service against prevalence:
Negotiations with commissioners around resource issues associated with this service need to be resolved before year end forecast can be confirmed.

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

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

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 Outturn	May-2017	June-2017	July-2017	(Apr to Jul) Cumulative Compliance	Forecast 17/18 Outturn
5.01	Duty of Candour	Plan	Report	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant	Compliant	Compliant	
5.02	Completion of a valid NHS number field in metal health and acute commissioning data sets submitted via SUS.	Plan	99%	99%	99%	99%	99%	99%
		Actual	99%	99%	99%	99%	99%	
5.03	Completion of Mental Health Services Data Set ethnicity coding for all service users	Plan	90%	90%	90%	90%	90%	90%
		Actual	100%	100%	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	99%	100%	100%	100%	100%	
5.05	Zero tolerance MRSA	Plan	0	0	0	0	0	0
		Unavoidable	0	0	0	0	0	
5.06	Minimise rates of Clostridium difficile	Plan	0	0	0	0	0	0
		Unavoidable	1	0	0	0	0	
5.07	VTE risk assessment: all inpatient service users to undergo risk assessment for VTE	Plan	95%	95%	95%	95%	95%	95%
		Actual	99%	100%	94%	100%	98%	
5.08	IAPT Recovery Rate: The number of people who are below the caseness threshold at treatment end	Plan	50%	50%	50%	50%	50%	50%
		Actual	43%	47%	48%	51%	51%	
5.09	IAPT Roll-out (Access Rate) - IAPT maintain 15% of patient entering the service against prevalence	Plan	2178	363	545	726	726	2178
		Actual	1,191	312	465	611	611	

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 Outturn	May-2017	June-2017	July-2017	(Apr to Jul) Cumulative Compliance	Forecast 17/18 Outturn
5.10a	Dementia Service - number of new patients aged 65 years and over receiving an assessment	Plan	540	45	45	45	180	540
		Actual	572	40	56	54	194	
5.10b	Dementia Service - total number of new patients receiving an assessment	Plan						
		Actual	610	42	58	61	207	
5.11	Patients are to be discharged from local rehab within 2 years of admission (Oak House). Based on patients on w ard at end of month.	Plan	80%	80%	80%	80%	80%	80%
		Actual	100%	100%	100%	100%	100%	
5.12	All admitted patients aged 65 years of age and over must have a completed MUST assessment	Plan	95%	95%	95%	95%	95%	95%
		Actual	98%	100%	100%	100%	100%	
5.13	Any attendances at ED with mental health needs should have rapid access to mental health assessment within 2 hours of the MHL team being notified.	Plan	80%	80%	80%	80%	80%	80%
		Actual	88%	96%	100%	75%	91%	
5.14	Attendances at ED, wards and clinics for self-harm receive a mental health assessment	Plan	85%	85%	85%	85%	85%	85%
		Actual	98%	100%	100%	92%	97%	

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 Outturn	May-2017	June-2017	July-2017	(Apr to Jul) Cumulative Compliance	Forecast 17/18 Outturn
New KPIs for 2017/18								
5.15	CYP Eating Disorders: Treatment waiting time for routine referrals within 4 weeks - NICE treatments	Plan		95%	95%	95%	95%	95%
		Actual		100%	100%	100%	100%	
5.16	CYP Eating Disorders: Treatment waiting time for routine referrals within 4 weeks - non-NICE treatments	Plan		95%	95%	95%	95%	95%
		Actual		N/A	N/A	NYA	N/A	
5.17	CYP Eating Disorders: Treatment waiting time for urgent referrals within 1 week - NICE treatments	Plan		95%	95%	95%	95%	95%
		Actual		N/A	0%	100%	50%	
5.18	CYP Eating Disorders: Treatment waiting time for urgent referrals within 1 week - non-NICE treatments	Plan		95%	95%	95%	95%	95%
		Actual		N/A	N/A	100%	100%	

Herefordshire Carers Information

ID	Performance Measure		2016/17 Outturn	May-2016	June-2016 / Quarter 1	July-2016	(Apr to Jul) Cumulative Compliance	Forecast 17/18 Outturn
5.19	Working Age and Older People service users on the caseload asked if they have a carer. (Only includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan						
		Actual	41%	49%	53%	54%	54%	
5.20	Working Age and Older People service users on the caseload who have a carer who have been offered a carer's assessment. (Only includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan						
		Actual	58%	62%	59%	62%	62%	
5.21	Working Age and Older People service users/carers who have accepted a carers assessment. (Only includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan						
		Actual	35%	40%	40%	39%	39%	

Schedule 4 Specific Measures that are reported Nationally

Performance Thresholds not being achieved in Month

NHS Improvement

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

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

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

1.09 & 1.10: IAPT: Waiting times - Referral to Treatment within 6 & 18 weeks
See earlier note on Page 8.

2.21: No children under 18 admitted to adult inpatient wards
See earlier note on Page 11.

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

ID	Performance Measure (PM)		2016/17Outturn	May-2017	June-2017	July-2017	(Apr to Jul) Cumulative Compliance	Forecast 17/18 Outturn
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
NHSI 1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	0	0
		Actual	3	0	0	0	0	
NHSI 1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	100%	97%	100%	99%	
NHSI 1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	98%	94%	98%	97%	
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	2.2%	0.0%	3.8%	2.7%	1.6%	
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%	50%
		Actual	70%	75%	67%	100%	67%	
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Actual	49%	43%	59%	66%	52%	
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Actual	85%	80%	83%	77%	81%	
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
DoH 2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0	0
		Actual	8	0	1	0	2	

DASHBOARD CATEGORY – GLOUCESTERSHIRE CQUINS

Gloucestershire CQUINS				
	In month Compliance			Cumulative Compliance
	May	Jun	Jul	
Total Measures	12	12	12	12
🔴	0	0	0	0
🟢	0	8	0	8
NYA	0	0	0	0
NYR	12	4	12	4
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
8 CQUIN measures for quarter 1 can now be reported as compliant and have been awarded.

Early Warnings
None

Gloucestershire CQUINS

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

DASHBOARD CATEGORY – LOW SECURE CQUINS

Low Secure CQUINS				
	In month Compliance			Cumulative Compliance
	May	Jun	Jul	
Total Measures	1	1	1	1
🔴	0	0	0	0
🟢	0	1	0	1
NYA	0	0	0	0
NYR	1	0	1	0
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
The CQUIN measure for quarter 1 can now be reported as compliant and has been awarded.

Early Warnings
None

Low Secure CQUINS

ID	Performance Measure (PM)		2016/17Outturn	May-2017	June-2017	July-2017	(Apr to Jul) Cumulative Compliance	Forecast 17/18 Outturn
	CQUIN 1							
8.01	Reducing the length of stay in specialised MH services	PM	Qtr 4		Report		Report	Report
		Actual	Compliant		Awarded		Awarded	

DASHBOARD CATEGORY – HEREFORDSHIRE CQUINS

Herefordshire CQUINS				
	In month Compliance			Cumulative Compliance
	May	Jun	Jul	
Total Measures	12	12	12	12
🔴	0	0	0	0
🟢	0	7	0	7
NYA	0	0	0	0
NYR	12	5	12	5
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
7 CQUIN measures for quarter 1 can now be reported as compliant of which 1 has been awarded.

Early Warnings
None

Herefordshire CQUINS

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

Agenda Item 8 **Enclosure Paper C**

Report to: Trust Board – 28 September 2017
Author: Gordon Benson, Assistant Director of Governance & Compliance
Presented by: Marie Crofts, Director of Quality

SUBJECT: **Quality Report: Report for 1st Quarter 2017/18**

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

EXECUTIVE SUMMARY

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

Assurance

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

- Overall, there are 4 targets which are not currently being met:
    1. 1.2 – Personalised discharge care planning
    2. 2.1 – Numbers of service users being involved in their care
    3. 3.1 – Suicide reduction
    4. 3.1 – Reduction in the use of prone restraint.

Improvements

- The data within relates to Quarter 1 and will, therefore, be subject to change as the supportive evidence base grows throughout the year.

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

- In the Quarter 2 report, there will be greater breakdown of information by county, and also in 3.3 – Prone restraint, an analysis of the numbers of supine restraint being used.

RECOMMENDATIONS

The Board is asked to note the progress made to date and the actions in place to improve/sustain performance where possible.

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

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

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

Reviewed by:		
Marie Crofts, Director of Quality	Date	11 August 2017

Where in the Trust has this been discussed before?		
Governance Committee	Date	18 August 2017

What consultation has there been?		
	Date	

Explanation of acronyms used:	

1. CONTEXT

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

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Quality Report 2017/18

CONTENTS

Part 1: Statement on Quality from the Chief Executive

Introduction

This will be included at year-end

Part 2.1: Looking ahead to 2018/19

Quality Priorities for Improvement 2018/19

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

Effectiveness

User Experience

Safety

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

Review of Services

This will be included at year-end

Participation in Clinical Audits and National Confidential Enquiries

This will be included at year-end

Participation in Clinical Research

This will be included at year-end

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

A proportion of 2gether NHS Foundation Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between 2gether NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at *http://www.2gether.nhs.uk/cquin*

2017/18 CQUIN Goals

Gloucestershire

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

Herefordshire

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

Low Secure Services

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

The total potential value of the income conditional on reaching the targets within the CQUINs during 2016/17 is £2,219,300 of which we anticipate £2,219,300 will be achieved.

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

2018/19 CQUIN Goals

These will be added at year-end.

Statements from the Care Quality Commission

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

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

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

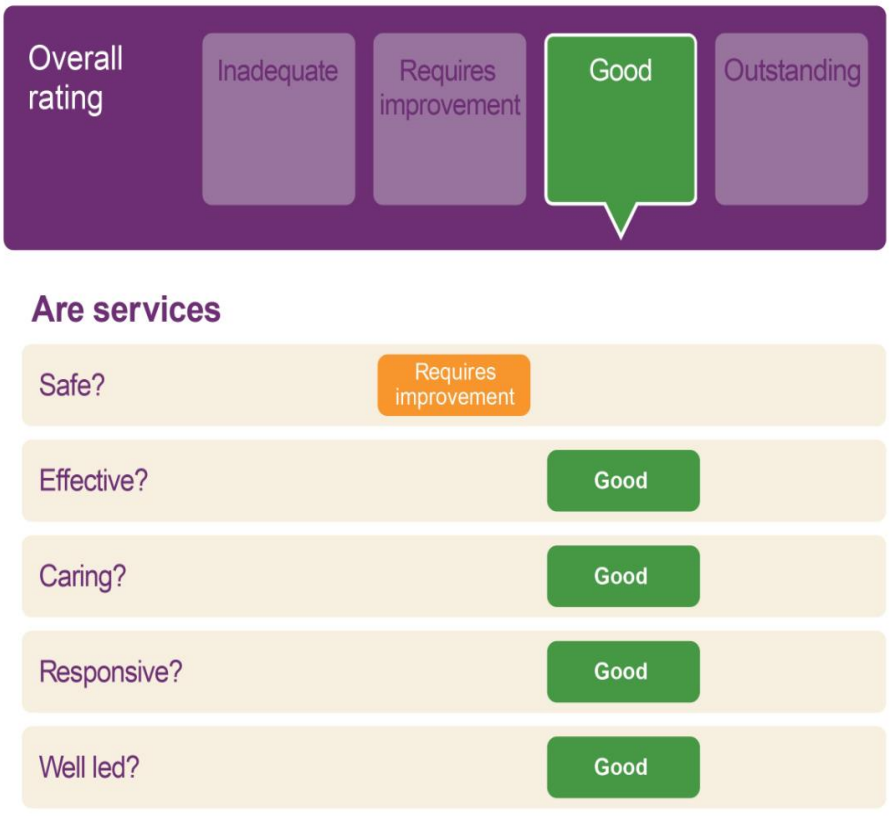
[2]gether NHS Foundation Trust has no conditions on its registration.

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

CQC Inspections of our services

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

The Care Quality Commission last undertook a planned comprehensive inspection of the Trust week commencing 26 October 2015 and published its findings on 28 January 2016. The CQC rated our services as GOOD, rating **2** of the **10** core services as "outstanding" overall and **6** "good" overall.



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

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

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

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

Changes in service registration with Care Quality Commission for 2017/18

This will be included at year-end.

Quality of Data

This will be included at year-end.

Part 2.3: Mandated Core Indicators 2017/18

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

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

	Quarter 3 2015-16	Quarter 4 2015-16	Quarter 1* 2016-17	Quarter 2* 2016-17	Quarter 3* 2016-17
[2]gether NHS Foundation Trust	97.2%	98.10%	97.1%	97.2%	98.3%
National Average	96.9%	97.2%	96.2%	96.8%	96.7%
Lowest Trust	50%	80%	28.6%	76.9%	73.3%
Highest Trust	100%	100%	100%	100%	100%

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

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

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

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

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

	Quarter 3 2015-16	Quarter 4 2015-16	Quarter 1* 2016-17	Quarter 2* 2016-17	Quarter 3* 2016-17
[2]gether NHS Foundation Trust	100%	98.4%	98.9%	98.9%	99.4%
National Average	97.5%	98.2%	98.1%	98.4%	98.7%
Lowest Trust	61.9%	84.3%	78.9%	76%	88.3%
Highest Trust	100%	100%	100%	100%	100%

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

- Staff respond to individual service user need and help to support them at home wherever possible unless admission is clearly indicated;

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

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

* Activity published on NHS England website via the NHS IC Portal is revised throughout the year following data quality checks. Activity shown for Quarters 1, 2 & 3 2016/17 has not yet been revised and may change. Quarter 4 data has not been published.

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

	Quarter 1 2016-17	Quarter 2 2016-17	Quarter 3 2016-17	Quarter 4 2016-17	Quarter 1 2017-18
[2]gether NHS Foundation Trust 0-15	0%	0%	0%	0%	0%
[2]gether NHS Foundation Trust 16 +	7%	5%	8%	6%	6.3%
National Average	Not available	Not available	Not available	Not available	Not available
Lowest Trust	Not available	Not available	Not available	Not available	Not available
Highest Trust	Not available	Not available	Not available	Not available	Not available

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

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

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

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

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

	NHS Staff Survey 2013	NHS Staff Survey 2014	NHS Staff Survey 2015	NHS Staff Survey 2016
[2]gether NHS Foundation Trust Score	3.46	3.61	3.75	3.84
National Median Score	3.55	3.57	3.63	3.62
Lowest Trust Score	3.01	3.01	3.11	3.20
Highest Trust Score	4.04	4.15	4.04	3.96

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

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

- Staff have reported an increase in the level of motivation at work. Whilst the improved level of staff satisfaction is encouraging, the trust is very careful to also take note of feedback from colleagues who are less satisfied and where possible to address these concerns.

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

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

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

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

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

- Across six of the ten domains in the survey our scores were reported as 'About the Same' as other trusts. In the other four domains people scored [2]gether's service as 'Better than Others', which is in the top 20% of similar organisations.

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

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

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

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

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

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

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

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

- Re-auditing its Incident Reporting Systems (DATIX) to improve the processes in place for the timely review, approval of, and response to reported patient safety incidents;

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

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

Introduction

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

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

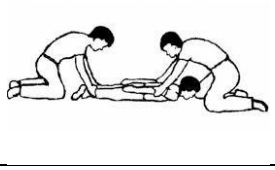
The table below provides a summary of our progress against these individual priorities. Each are subsequently explained in more detail throughout Part 3.

Summary Report on Quality Measures for 2016/2017

		2016 - 2017	2017 -2018
Effectiveness			
1.1	To improve the physical health of patients with a serious mental illness on CPA by a positive cardio metabolic health resource (Lester Tool). This will be used on all patients who meet the criteria within the inpatient setting and all community mental health teams. In accordance with national CQUIN targets we aim to achieve 90% compliance for inpatients and early intervention teams and 65% compliance for all other community mental health teams.	**Achieved**	**Achieved**
1.2	To further improve personalised discharge care planning in adult and older peoples wards, including the provision of discharge information to primary care services within 24hrs of discharge.	**Achieved**	**Not achieved**
1.3	To ensure that joint Care Programme Approach reviews occur for **all** service users who make the transition from children's to adult services.	**Not achieved**	**Achieved**
User Experience			
2.1	Were you involved as much as you wanted to be in agreeing what care you will receive? **> 92%**	**83%**	**82%**
2.2	Do you know who to contact out of office hours if you have a crisis? **>74%**	**74%**	**88%**
2.3	Has someone given you advice about taking part in activities that are important to you? **> 69%**	**69%**	**81%**
2.4	Have you had help and advice to find support to meet your physical health needs if you needed it? **> 76%**	**76%**	**79%**
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**
3.2	Detained service users who are absent without leave (AWOL) will not come to serious harm or death. We will report against 3 categories of AWOL as follows; harm as a consequence of: 1. Absconded from escort 2. Failure to return from leave 3. Left the hospital (escaped)	**-**	**Achieved**
3.3	To reduce the number of prone restraints by 5% year on year (on all adult wards & PICU) based on 2016/17 data.	**211**	**79**

Easy Read Report on Quality Measures for 2017/2018

Quality Report 	This report looks at the quality of [2]gether's services. We agreed with our Commissioners the areas that would be looked at.	
Physical health 	We increased physical health tests and treatment for people using our services. We met the target.	
Discharge Care Plans 	More people had a discharge care plan at the end of the year than previously.	
Care (CPA) Review 	Everyone moving from children's to adult services had a care review. We met the target.	
Care Plans 	82% of people said they felt involved in their care plan. This is less than the target (92%). We have not met the target. We are doing lots of work to get better at this.	
Crisis 	88% of people said they know who to contact if they have a crisis. This is more than the target (74%). We met the target.	
Activity 	81% of people said they had advice about taking part in activities. This is more than the target (69%). We met the target.	
Physical Health 	79% of people said they had advice about their physical health This is more than the target (76%). We met the target.	

Suicide 	Sadly there have not been less suicides compared to this time last year. We have not met the target. We are working hard to keep people safe.	
AWOL 	In patients who were absent without leave did not come to serious harm or death. We met the target.	
Face down restraint 	We have not reduced the number of face-down restraints this year. We have not met the target. We are doing lots of work to get better at this.	

Key

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

Effectiveness

In 2017/18 we remained committed to ensure that our services are as effective as possible for the people that we support. For the second consecutive year we set ourselves 3 targets against the goals of:

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

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

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

Quarter one targets meant we needed to ensure a sustainable and high quality training programme was in place for all relevant staff. We have created a dual approach that directs training at the specific disciplines – one for the Medical Staff and then one for Qualified/Unqualified Nursing and AHP teams. The details of our approach are as follows:

We continue to use the model used in previous years to train the medical teams. We have received support from the medical directorate to embed the training as part of the Medical Academic Programme.

All staff within the community mental health teams and on the inpatient wards have been offered a face to face training to introduce the need for increased physical health awareness and the Lester tool. This included the rationale for the CQUIN, processes for assessing, documenting and acting on cardio metabolic risk factors. Evidence based care pathways were discussed and shown to all staff.

To date, we have successfully trained over 225 members of staff from the above specified teams in the community and within the inpatient services. Any staff who were not able to attend these sessions have been provided with a booklet to read which details the need for screening and information about the Lester tool. If they feel they require further training they have been asked to contact either of the Physical Health Facilitators.

In addition to above, we have worked with the Clinical Skills Department at Gloucester Royal Hospital to facilitate two additional venepuncture training sessions for ^{2}gether staff to equip them with this skill. This will ensure that we have sufficient numbers of staff equipped to complete the requirements for screening for glucose regulation and blood lipids.

We have also worked with Healthy Lifestyles Gloucestershire to complete Making Every Contact Count (MECC) training, which was aimed to support the clinicians on how to offer brief advice to patients. This was available for all clinical staff.

A further target for Quarter one was to ensure clear pathways for interventions and signposting for all cardio-metabolic risk factors, this was completed for each of the identified risk areas and has been distributed Trust-wide and is available on the intranet for all staff to access.

The final target set for quarter one involved ensuring our electronic care record system is being used effectively for the collection of physical health data. Therefore, during Quarter One we have been working closely with our RiO Systems team to develop a specific assessment form to streamline it and include all of the CQUIN cardiovascular checks needed. This will make management of the Lester tool assessment more straight forward for the Care Co-ordinators and Named Nurses. Interventions completed can now be recorded in the same location as the screening detail.

Alongside the CQUIN work, the Trust continues to increase access to physical health treatment for its' service users. The secondment of a general trained nurse working within the inpatient units in Gloucestershire, has enabled patients to access services normally only available from a practice nurse at a GP surgery. Data is currently being collected as to the services accessed and it is hoped this position will become permanent.

In April 2017 the Trust became "Smoke-Free", and the benefit of this to both staff and service users is already evident. It is hoped to use the outside area within Wotton Lawn Hospital (previously used as the designated smoking area), into an outside Gym area. Work is ongoing to the feasibility of this.

We are currently meeting this target.

Target 1.2 To further improve personalised discharge care planning in adult and older peoples wards, including the provision of discharge information to primary care services within 24hrs of discharge.

Discharge from inpatient units to the community can pose a time of increased risk to service users. During 2016/17 we focused on making improvements to discharge care planning to ensure that service users are actively involved in shared decision making for their discharge and the self-management care planning process. Identical criteria are being used in the services across both counties as follows:

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

We will also be looking to ensure that discharges summaries and medication information for service users discharged from hospital are sent to their GP within 48 hours of Discharge.

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

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

Gloucestershire Services

Criterion	Year End Compliance (2015/16)	Year End Compliance (2016/17)	Quarter 1 Compliance (2017/18)
Overall Average Compliance	**69%**	**72%**	**73%**
Chestnut Ward	84%	85%	**81%**
Mulberry Ward	75%	79%	**73%**
Willow Ward	59%	71%	**69%**
Abbey Ward	72%	75%	**78%**
Dean Ward	79%	73%	**69%**
Greyfriars PICU	50%	62%	**62%**
Kingsholm Ward	75%	72%	**69%**
Priory Ward	80%	80%	**87%**
Montpellier Unit	50%	57%	**67%**
Honeybourne	N/A	70%	**70%**
Laurel House	N/A	65%	**75%**

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

Quarter 1 overall average compliance in Gloucester for these standards during this year is **73%** which is a **1%** improvement from the end of last year, however it is noted that several inpatient areas have reduced in this area. There will be an increased focus on ensuring that these standards are met throughout the year.

Herefordshire Services

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

Quarter 1 overall average compliance in Herefordshire for these standards during this year is **70%** which is a **4%** reduction from the end of last year, noting that three of the inpatient areas have reduced in this area. There will be an increased focus on ensuring that these standards are met throughout the year.

An initial audit in June 2017 (from a sample of 62 cases) to determine if all clients discharged from inpatient wards/units in Gloucestershire had copies of their nursing discharge summaries and TTO's emailed to their GP within 24 hours of discharge showed a cumulative compliance of **20%**, therefore this target is not yet being achieved.

This target has not been met.

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

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

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

Gloucestershire Services

2016-17 Results

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

2017-18 Results

During Quarter 1, there was 1 young people who transitioned into adult services, they had a joint CPA review.

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

Herefordshire Services

2016-17 Results

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

2017-18 Results

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

During Quarter 1, there were 4 transitions of young people into adult services, all of these had a joint CPA review.

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

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

We are currently meeting this target.

User Experience

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

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

The Trusts **"How did we do?"** service experience survey combines the NHS Friends and Family Test and the Quality Survey questions about peoples quality of care. The Quality Survey questions provide people with an opportunity to comment on key aspects of the quality of their care and treatment. The responses for the Quality Survey questions and Friends and Family Test will continued to be reported separately by county.

A combined total percentage for both counties is also provided for these questions to mirror the methodology used by the CQC Community Mental Health Survey, as this does not differentiate by county.

Data for Quality Survey (Quarter 1 - April to June 2017) results:

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

Question	County	Number of responses	Target Met?
Were you involved as much as you wanted to be in agreeing the care you receive?	Gloucestershire	26 (21 positive)	82% TARGET 92%
	Herefordshire	2 (2 positive)	
	Total	28 (23 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? > 74%

Question	County	Number of responses	Target Met?
Have you been given information about who to contact outside of office hours if you have a crisis?	Gloucestershire	23 (20 positive)	88% TARGET 74%
	Herefordshire	2 (2 positive)	
	Total	25 (22 positive)	

This target has been met.

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

Question	County	Number of responses	Target Met?
Have you had help and advice about taking part in activities that are important to you?	Gloucestershire	25 (21 positive)	**81%** **TARGET 69%**
	Herefordshire	2 (1 positive)	
	Total	27 (22 positive)	

This target has been met.

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

Question	County	Number of responses	Target Met?
Have you had help and advice to find support for physical health needs if you have needed it?	Gloucestershire	19 (15 positive)	**79%** **TARGET 76%**
	Herefordshire	0 (0 positive)	
	Total	19 (15 positive)	

This target has been met.

In line with the launch of the **"How did we do?"** survey Quality Survey response targets have been reviewed and refreshed to reflect our Trust's aims and aspirations. Three out of the four targets set have been exceeded. This is good news and demonstrates that those people who responded to the survey, are feeling supported to meet their needs and explore other activities.

The one target (2.1) that has not been achieved this quarter did receive a high percentage of people who responded that they did feel satisfied with their involvement in care they received. It is important to acknowledge that this target during 2016-17 was 78%. This was consistently exceeded throughout that year. The increase in the target set for 2017-18 is demonstrative of our Trust's desire to improve our services to the highest standard.

Friends and Family Test (FFT)

FFT responses and scores for Quarter 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?", and have six options from which to choose:

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

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

	Number of responses	FFT Score (%)
April 2017	176 (160 positive)	91%
May 2017	187 (170 positive)	91%
June 2017	168 (146 positive)	87%
Total	**531** (476 positive) **(last quarter = 740)**	**90% (last quarter = 91%)**

FFT Scores for 2gether NHS Foundation Trust for the past year

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

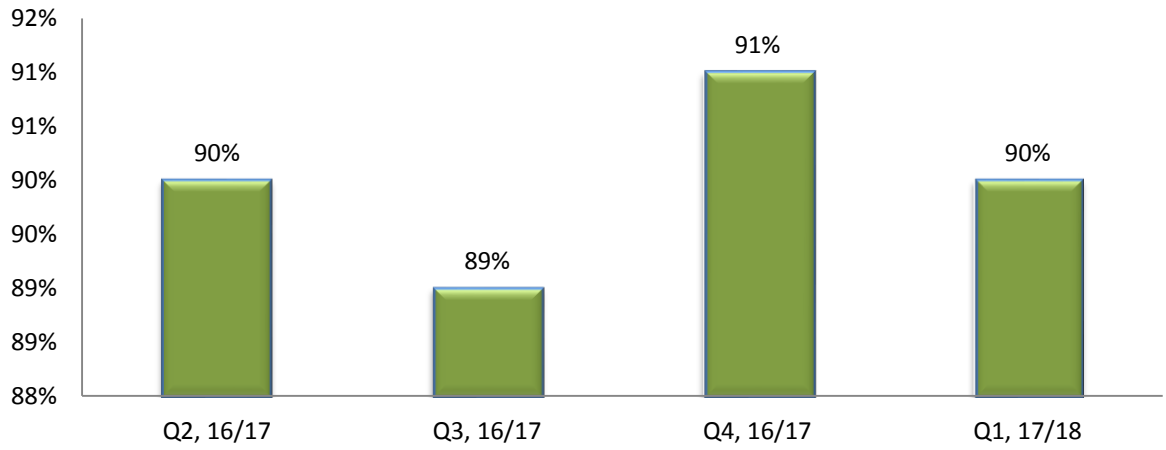


Figure 1

The FFT score for Quarter 1 has remained relatively consistent with that received in previous quarters 2016-17. The Trust continues to maintain a high percentage of people who would recommend our services.

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

Figure 2 shows the FFT Scores for the past six months, including this quarter. The Trust receives a consistently high percentage of recommendation scores (*June 2017 data for England is not yet available*).

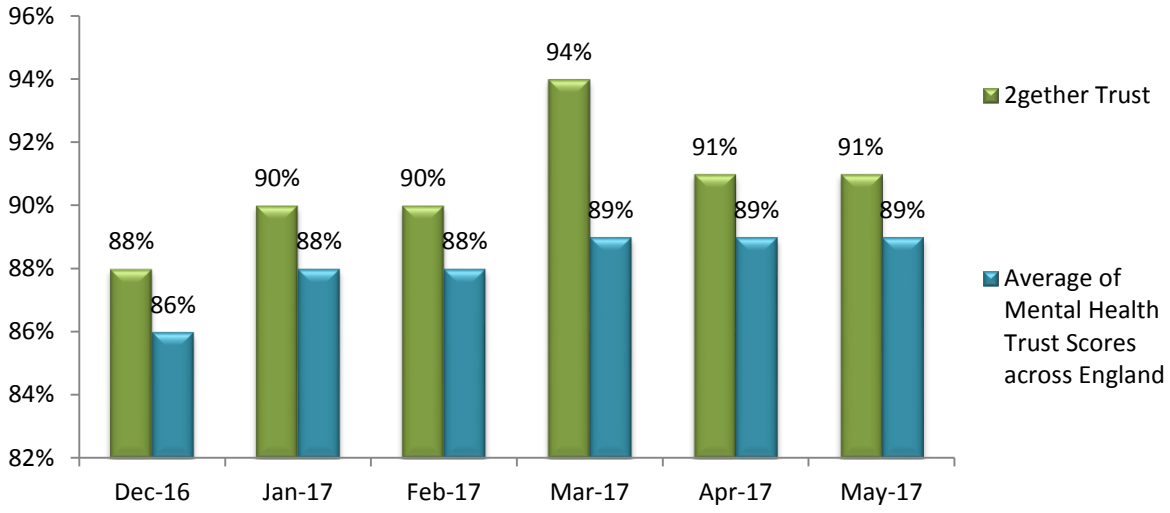


Figure 2

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

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

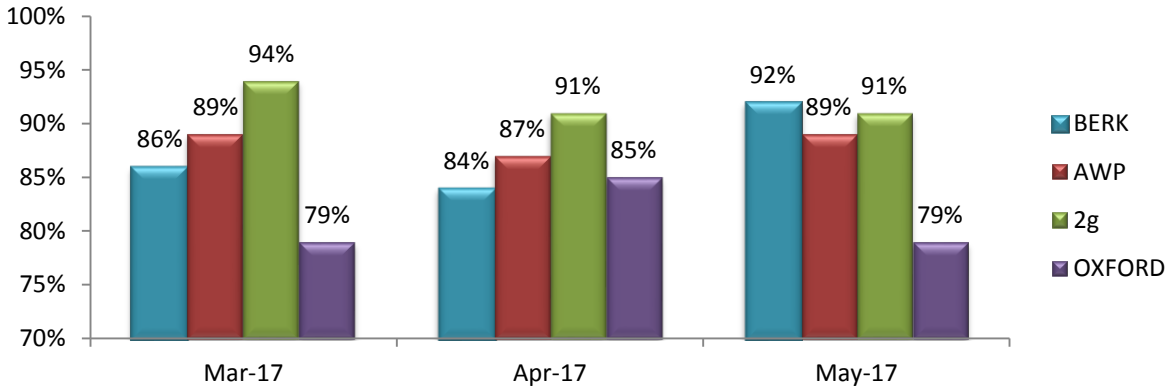


Figure 3

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

Safety

Protecting service users from further harm whilst they are in our care is a fundamental requirement. We seek to ensure that we assess the safety of those who use our services as well as providing a safe environment for service users, staff and everyone else that comes into contact with us. In this domain, we have set ourselves 3 goals to:

- Minimise the risk of suicide of people who use our services;
- Ensure the safety of people detained under the Mental Health Act;
- Reduce the number of prone restraints used in our adult inpatient services:

There are 3 associated targets.

Target 3.1 **Reduce the proportion of patients in touch with services who die by suspected suicide when compared with data from previous years. This will be expressed as a rate per 1000 service users on the Trust's caseload**.

We aim to minimise the risk of suicide amongst those with mental disorders through systematic implementation of sound risk management principles. In 2013/14, during which year we reported **22** suspected suicides, we set ourselves a specific quality target for there to be fewer deaths by suicide of patients in contact with teams and we have continued with this important target each year. Sadly the number has increased and during 2016/17 we reported **26** suspected suicides.

What we also know is that we are seeing more and more service users on our caseload year on year, so we are going measure this important target differently this year. This will be as reported as a rate per 1000 service users on the Trust caseload. The graph below shows this rate from 2014/15 onwards for all Trust services covering Herefordshire and Gloucestershire, and we are aiming to see the median value (green line) get smaller. During both 2015/16 and 2016/17 the median value was 0.09. At the end of Quarter 1 2017/18, the median value remains at 0.09.

At the end of Quarter 2 we will start reporting this for each separate county.

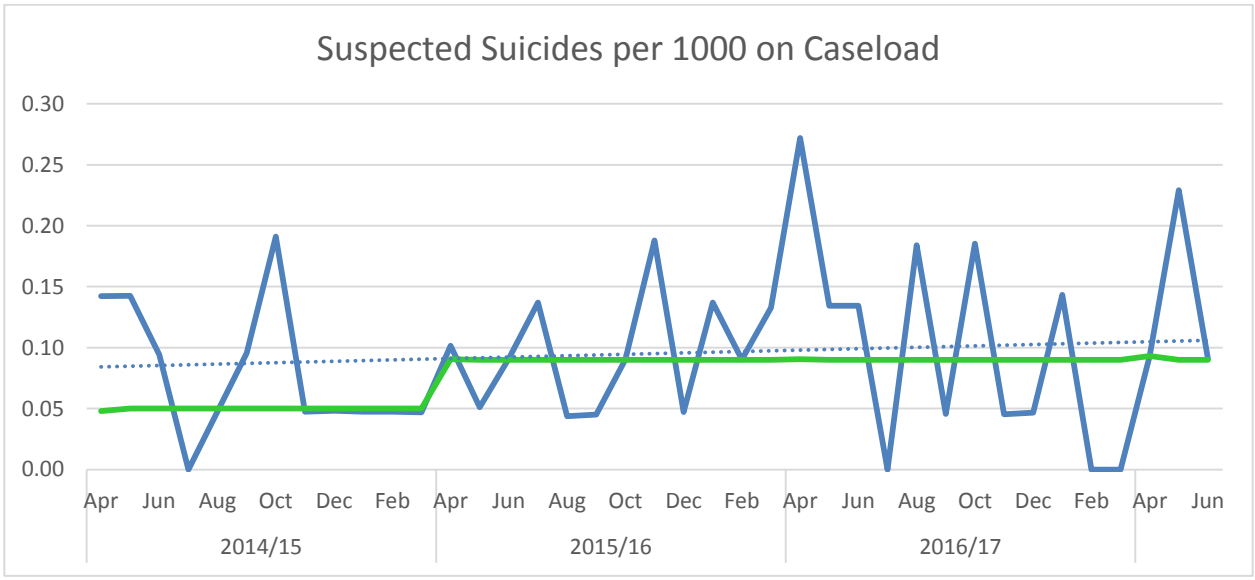


Figure 4

We have not met this target.

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

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

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

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

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

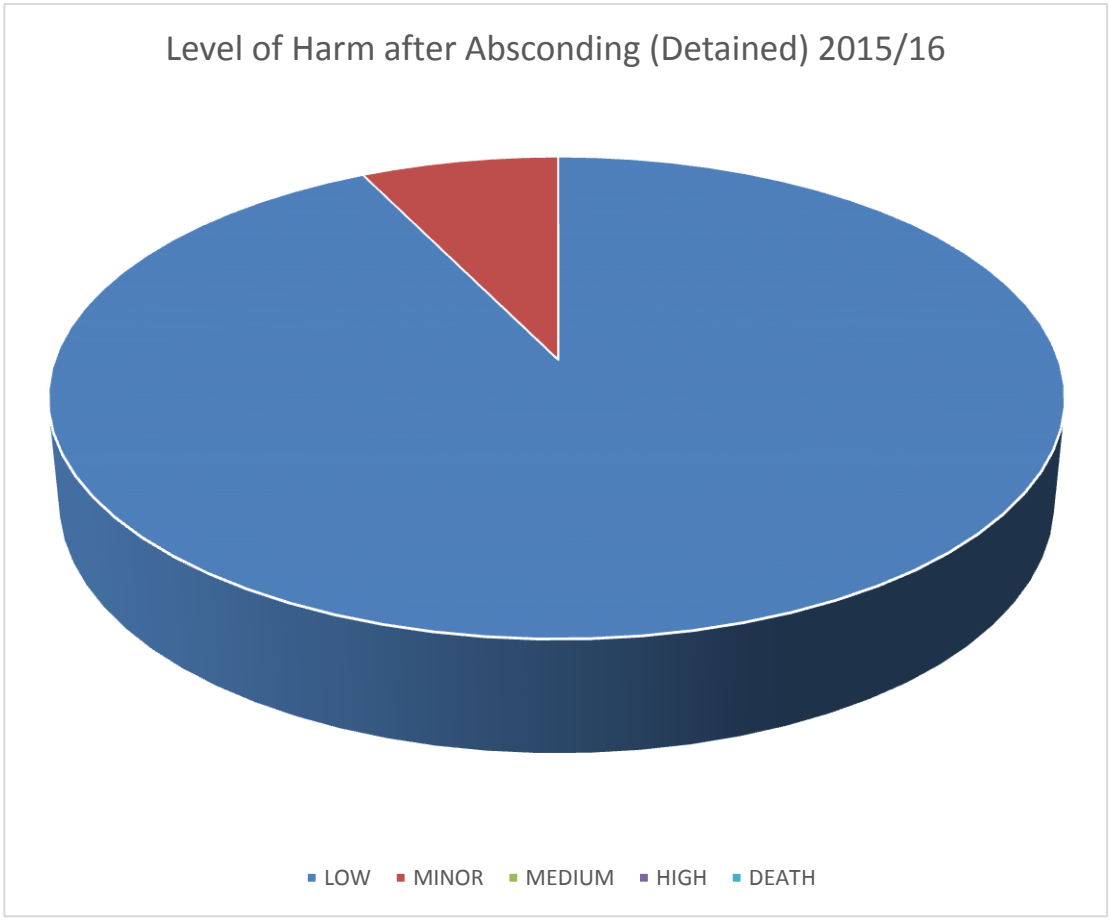


Figure 5

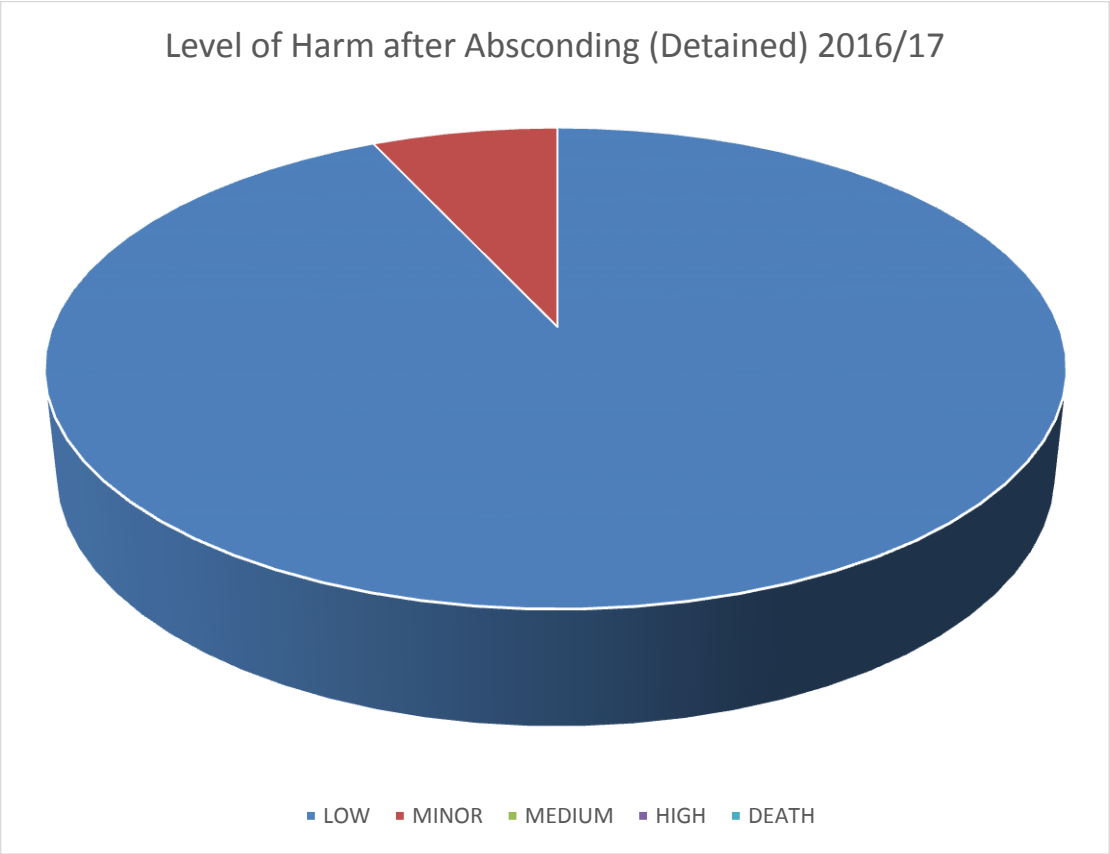


Figure 6

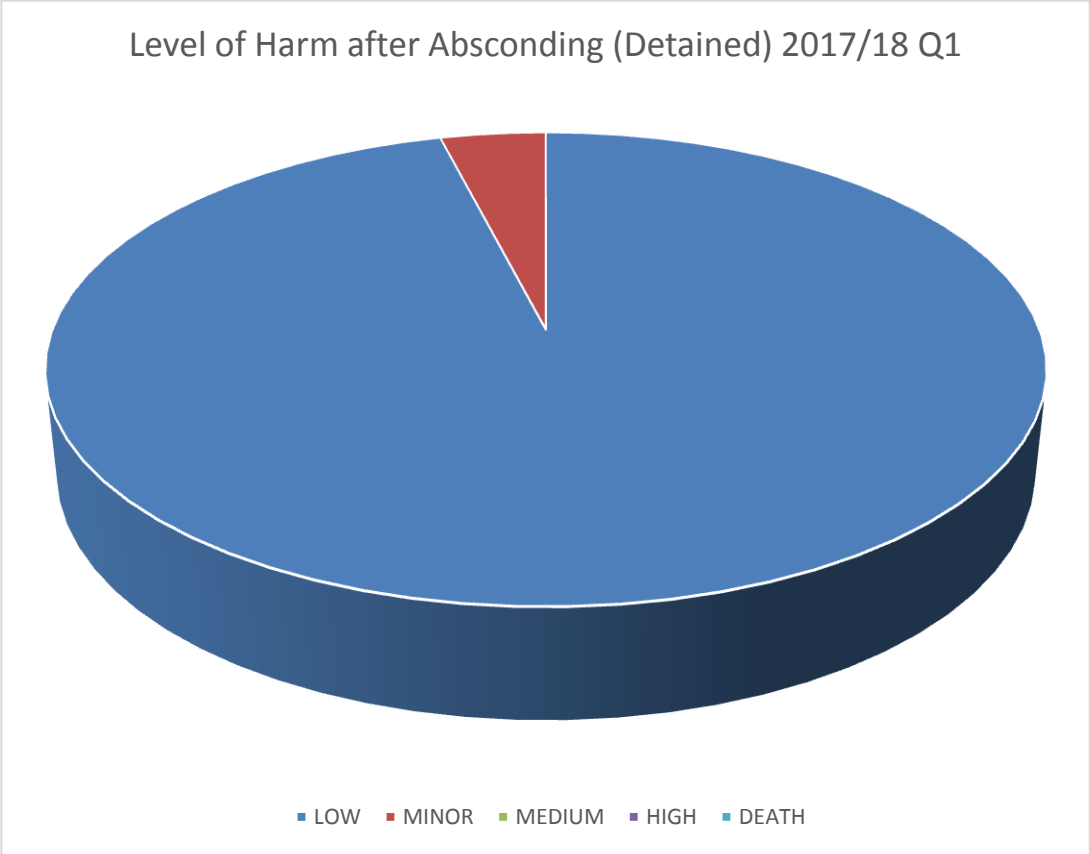


Figure 7

We are meeting this target.

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

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

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

- Support the reduction of all forms of restrictive practice;
- Promote an organisational culture that is committed to developing therapeutic environments where physical interventions are a last resort;
- Ensure organisational compliance with the revised Mental Health Act 1983 Code of Practice (2015) and NICE Guidance for Violence and Aggression;
- Oversee and assure a robust training programme and assurance system for both Prevention & Management of Violence & Aggression (PMVA) and Positive Behaviour Management (PBM);
- Develop and inform incident reporting systems to improve data quality and reliability;
- Improve transparency of reporting, management and governance;
- Lead on the development and introduction of a Trust wide RiO Physical Intervention Care Plan/Positive Behavioural Support.

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

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

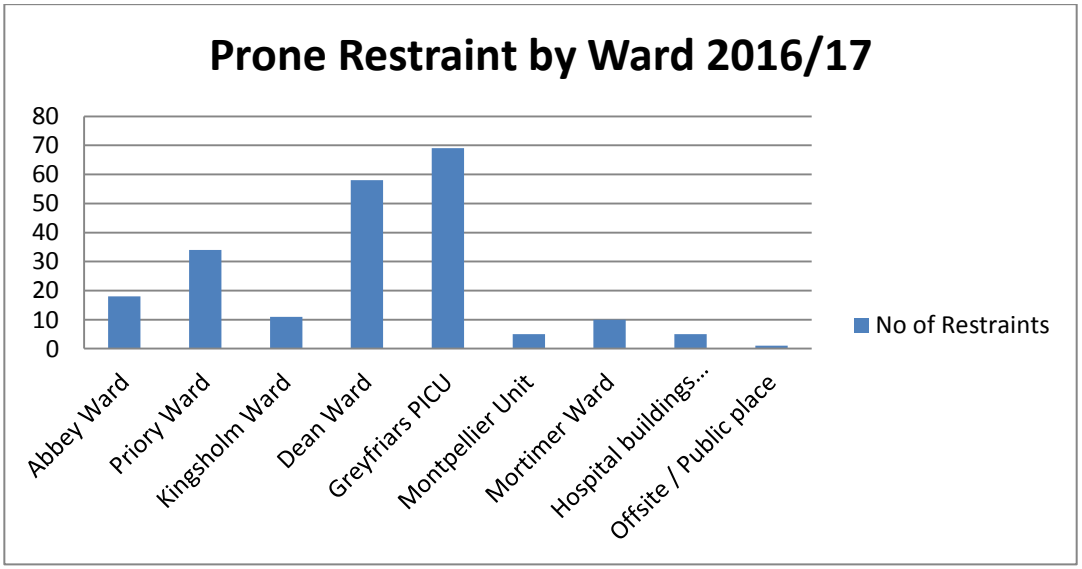


Figure 8

In terms of further developments to minimise the use of prone restraint, injection sites for the purpose of rapid tranquillisation have been reviewed. Historically staff have been trained to provide rapid tranquillisation intramuscularly via the gluteal muscles, this necessitates the patient being placed into the prone restraint position if they are resistant to the intervention. New training is in the process of being rolled out to all inpatient nursing and medical staff to be able to inject via the quadriceps muscles. This requires the patient to be placed in the supine position which poses less risk. These important changes are being implemented during 2017/18 and it is anticipated that we will ultimately see a corresponding reduction in the use of prone restraint.

At the end of Quarter 1, **79** instances of prone restraint were used as seen in Figure 9 which sees a further increase.

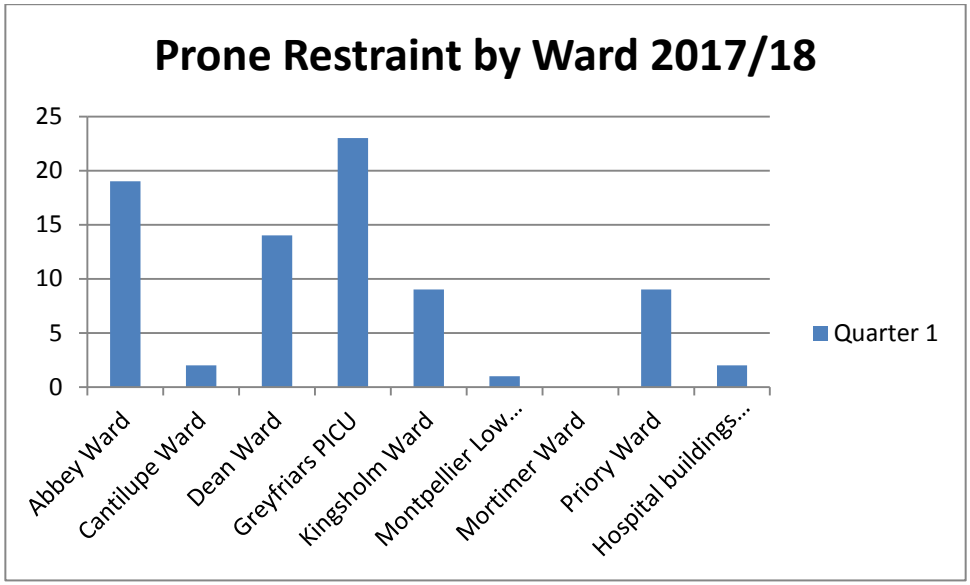


Figure 9

We have not met this target.

Serious Incidents reported during 2017/18

By the end of Quarter 1 2017/18, **16** serious incidents were reported by the Trust, **2** of which were subsequently declassified; the types of these incidents reported are seen below in Figure 10.

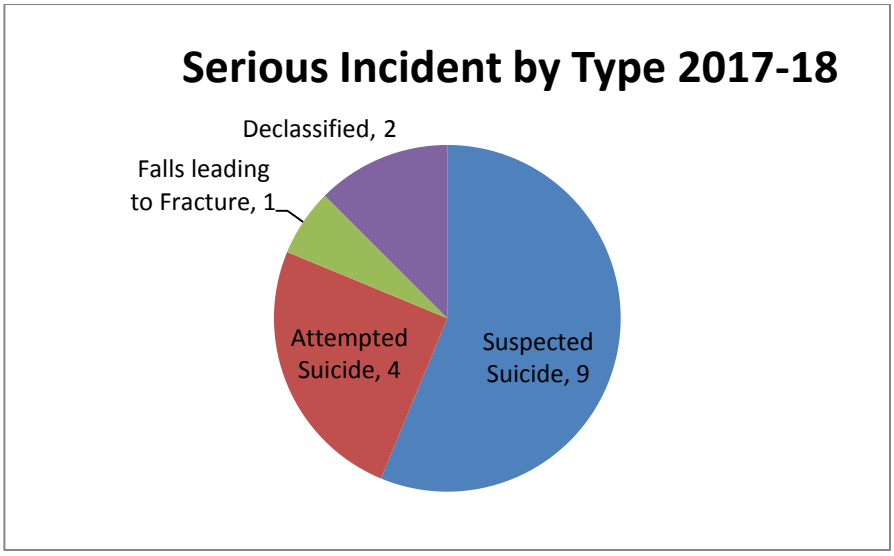


Figure 10

Figure 11 shows a 4 year comparison of reported serious incidents. The most frequently reported serious incidents are "suspected suicide" and attempted suicide which is why we continue to focus on suicide prevention activities in partnership with stakeholders. All serious incidents were investigated by senior members of staff, all of whom have been trained in root cause analysis techniques. To further improve consistency of our serious incident investigations we have seconded a whole time equivalent Lead Investigator for 12 months who commenced this important work in May 2017, and a further dedicated Investigating Officer is now available via the Trust's Staff Bank. This arrangement will be reviewed during Quarter 4 2017/18.

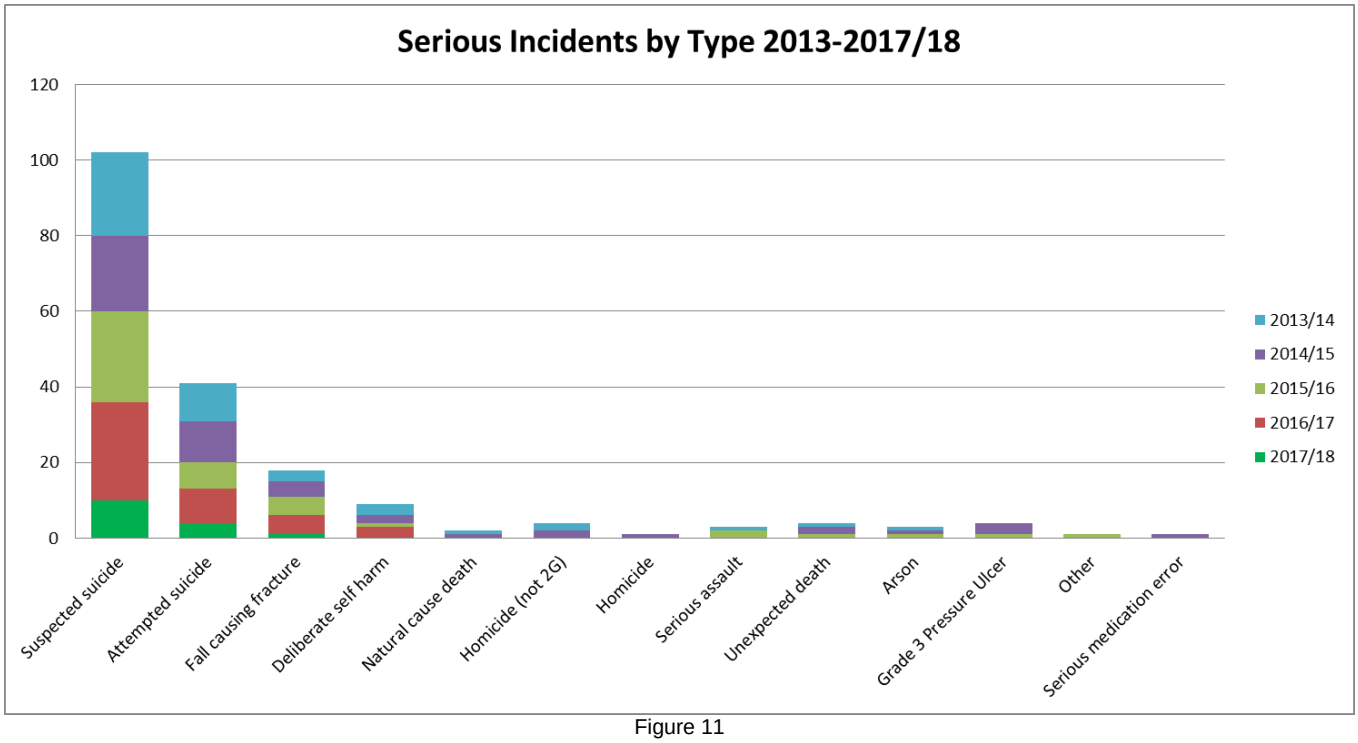


Figure 11

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

There have been no Department of Health defined "Never Events" within the Trust during 2017/18. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Duty of Candour

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

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

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

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

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

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

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

Mortality Reviews

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

An administrator has been employed in a full-time capacity from October 2016 to begin to complete initial screening of the reported patient death information and the categorisation of patient deaths within the Mazars categories of Expected Natural 1, Expected Natural 2, Expected Unnatural, Unexpected Natural 1, Unexpected Natural 2, and Unexpected Unnatural. The pro-forma review tool based on the Learning Disabilities Mortality Review Programme (LeDer) format will be utilised within the Datix system to assist with desktop reviews of healthcare records, and red flag indicators are being developed by the Clinical Directors involved with the mortality work to identify deaths which should be more closely investigated. An unused Datix module is being developed to contain this work.

The 'active' review of patient commenced from 1 April 2017 and it is anticipated that we will be meeting the requirements of the "National Guidance on Learning from Deaths", by having a policy developed and published by the end of Quarter 2 2017/18 and publishing our mortality review data by Quarter 3 2017/18.

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

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

Indicators & Thresholds for 2017/2018

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

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

Commissioner Agreed Developments

This will be included at year-end.

Community Survey 2016

This will be included at year-end.

Staff Survey 2016

This will be included at year-end.

PLACE Assessment 2016

This will be included at year-end.

Annex 1: Statements from our partners on the Quality Report

This will be included at year-end.

The Royal College of Psychiatrists

This will be included at year-end.

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

This will be included at year-end.

Annex 3: Glossary

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

CQUIN	Commissioning for Quality & Innovation: this is a way of incentivising NHS organisations by making part of their payments dependent on achieving specific quality goals and targets
CYPS	Children and Young Peoples Service
DATIX	This is the risk management software the Trust uses to report and analyse incidents, complaints and claims as well as documenting the risk register.
GriP	Gloucestershire Recovery in Psychosis (GriP) is ^{2}gether's specialist early intervention team working with people aged 14-35 who have first episode psychosis.
HoNOS	Health of the Nation Outcome Scales – this is the most widely used routine Measure of clinical outcome used by English mental health services.
IAPT	Improving Access to Psychological Therapies
Information Governance (IG) Toolkit	The IG Toolkit is an online system that allows NHS organisations and partners to assess themselves against a list of 45 Department of Health Information Governance policies and standards.
MCA	Mental Capacity Act
MHMDS	The Mental Health Minimum Data Set is a series of key personal information that should be recorded on the records of every service user
Monitor	Monitor is the independent regulator of NHS foundation trusts. They are independent of central government and directly accountable to Parliament.
MRSA	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. It is also called multidrug-resistant
MUST	The Malnutrition Universal Screening Tool is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.
NHS	The National Health Service refers to one or more of the four publicly funded healthcare systems within the United Kingdom. The systems are primarily funded through general taxation rather than requiring private insurance payments. The services provide a comprehensive range of health services, the vast majority of which are free at the point of use for residents of the United Kingdom.
NICE	The National Institute for Health and Care Excellence (previously National Institute for Health and Clinical Excellence) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.
NIHR	The National Institute for Health Research supports a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.

NPSA	The National Patient Safety Agency is a body that leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector.
PBM	Positive Behaviour Management
PHSO	Parliamentary Health Service Ombudsman
PICU	Psychiatric Intensive Care Unit
PLACE	Patient-Led Assessments of the Care Environment
PROM	Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective.
PMVA	Prevention and Management of Violence and Aggression
RiO	This is the name of the electronic system for recording service user care notes and related information within ^{2}gether NHS Foundation Trust.
ROMs	Routine Outcome Monitoring (ROMs)
SIRI	Serious Incident Requiring Investigation, previously known as a “Serious Untoward Incident”. A serious incident is essentially an incident that occurred resulting in serious harm, avoidable death, abuse or serious damage to the reputation of the trust or NHS. In the context of the Quality Report, we use the standard definition of a Serious Incident given by the NPSA
SMI	Serious mental illness
VTE	Venous thromboembolism is a potentially fatal condition caused when a blood clot (thrombus) forms in a vein. In certain circumstances it is known as Deep Vein Thrombosis.

Annex 4: How to Contact Us

About this report

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

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

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

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

Other Comments, Concerns, Complaints and Compliments

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

You can give us feedback about our services by:

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

Alternative Formats

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

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

Report to: [2]gether Trust Board – 28 September 2017
Author: Angie Fletcher, Service Experience Clinical Manager
Presented by: Jane Melton, Director of Engagement and Integration

Subject: **Service Experience Report Quarter 1 2017/18**

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

EXECUTIVE SUMMARY

(1) Assurance

This Service Experience Report provides a high level overview of feedback received from service users and carers in Quarter 1 2017/18. 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 1, **90%** of people who completed the Friends and Family Test said that they would recommend [2]gether's services. The Trust continues to maintain a high percentage of people who would recommend our services, with results exceeding national average scores. **94%** of those responding to the Children and Young People's Survey Friends and Family Test said that they would recommend our service (page 24)

Limited assurance that people are participating in the local survey of quality in sufficient numbers.

The new '**How did we do?'** survey was launched during Quarter 1 of this year. Whilst feedback given by respondents has generally been positive, response rates remain low. It is anticipated that response rates will rise during Quarter 2 as more time has allowed the new system to be embedded and responses to be returned.

<u>Significant assurance</u> that services are consistently reporting details of compliments they have received.

Compliments continue to be reported to the Service Experience Department. Numbers are slightly lower this quarter and continued work is underway to increase reporting by colleagues throughout the Trust.

<u>Full Assurance that complaints have been acknowledged in required timescale</u>
During Quarter 1 100% 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.

81% of complaints were closed within timescales agreed with the complainant. This is continued good progress from the past two quarters: Quarter 4 n=78%, Quarter 3 n=65%.

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

(2) Recommended learning and improvement

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

This quarter concerns and complaint themes have focused on communication issues either with service users and/or their carers. Colleagues across the Trust are working hard to develop practice in this area – the continued implementation of the Triangle of Care being an example of this.

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

- We must fully involve people when making decisions about their care
- We must explain the reasons behind why we do the things we do.

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

RECOMMENDATIONS

The Board is asked to:

- Note the contents of this report

Corporate Considerations	
Quality Implications	Patient and carer experience is a key component of the delivery of best quality of care. The report outlines what is known about experience of ^{2}gether's services in Q1 2017/18 and makes key recommendations for actions to enhance quality.
Resource Implications	The Service Experience Report offers assurance to the Trust that resources are being used to support best service experience.
Equalities Implications	The Service Experience Report offers assurance that the Trust is attending to its responsibilities regarding equalities for service users and carers.
Risk Implications	Feedback on service experience offers an insight into how services are received. The information provides a mechanism for identifying performance, reputational and clinical risks.

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

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

Reviewed by:		
Jane Melton, Director of Engagement and Integration	Date	September 6th 2017

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

What consultation has there been?		
Service Experience Committee members	Date	July 2017
Lauren Wardman, Deputy Director of Engagement		July 2017

Explanation of acronyms used:	NHS – National Health Service FFT – Friends and Family Test HW – Healthwatch PALS – Patient Advise and Liaison Service GP – General Practitioner MP – Member of Parliament

	OPS – Older Peoples Service LD – Learning Disabilities CYPS – Children and Young People's Service GRIP – Gloucestershire Recovery in Psychosis Team MHA- Mental Health Act GHNHSFT – Gloucestershire Hospitals NHS Foundation Trust CCG – Clinical Commissioning Group BME – Black and Minority Ethnic Groups IAPT – Improving Access to Psychological Therapies PHSO – Parliamentary Health Services Ombudsman CAMHS – Child and Adolescent Mental Health Service CRHTT – Crisis Resolution and Home Treatment Team

2gether
Making life better

2gether
NHS Foundation Trust

Service Experience Report

Quarter 1

1st April 2017 to 30th June 2017

"Excellent CPN and a sensitive consultant who is a good listener. Grateful for the support I received after a very difficult and frightening time."

Recovery South, Gloucestershire

"I was made to feel that I have seen the right person for what I wanted and the person was very helpful for my recovery."

Recovery South, Herefordshire

Contents

Key

NHS	National Health Service
HW	HealthWatch
PALS	Patient Advice and Liaison Service
GP	General Practitioner
MP	Member of Parliament
OPS	Older People's Service
LD	Learning Disabilities
CYPS	Children and Young People Service
GRIP	Gloucestershire Recovery in Psychosis
HR	Human Resources
CEO	Chief Executive Officer
BME	Black and Minority Ethnic Groups
IAPT	Improving access to psychological therapies
PHSO	Parliamentary and Health Service Ombudsman
CHI ESQ	Children's Experience of Service Questionnaire
DMHOP	Department of Mental Health for Older People
CAMHS	Child and Adolescent Mental Health Service
CRHTT	Crisis Resolution and Home Treatment Team
MHA	Mental Health Act
MCA	Mental Capacity Act
CCG	Clinical Commissioning Group
GHNHSFT	Gloucestershire Hospitals NHS Foundation Trust
Q4	Quarter 4 (previous quarter 2016/17)
FFT	Friends and Family Test (survey)

Service Experience Report – Quarter 1

1st April 2017 to 30th June 2017

Complaints 	**16** complaints (81 separate issues) were made this quarter. This is less than last time (n=20). We want people to tell us about any worries about their care. This means we can make it better.	↓
Concerns 	**55** concerns were raised through PALS. This is almost the same as last time (n=56).	↔
Compliments 	**420** people told us they were pleased with our service. This is less than last time (n=572). We want teams to tell us about every compliment they get.	↓
FFT 	**90%** of people said they would recommend our service to their family or friends. This is nearly the same as last time (91%).	↔
Quality Survey 	April 2017 – June 2017 feedback: Gloucestershire: **26 people told us what they thought** Herefordshire: **2 people told us what they thought** Some people are telling us what they think about their care. We need to ask more people for their thoughts and views.	↓ (number of replies)
We must listen 	We must fully involve people when making decisions about their care.	
We must listen 	We must explain the reasons behind why we do the things we do.	

Key

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

Section 1 – Introduction

1.1 Overview of the paper

1.1.1 This paper provides an overview of people's reported experience of ²gether NHS Foundation Trust's services between **1st April 2017 and 30th June 2017**. It provides examples of the learning that has been achieved through service experience reporting, and an update on activity to enhance service experience.

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

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

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

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

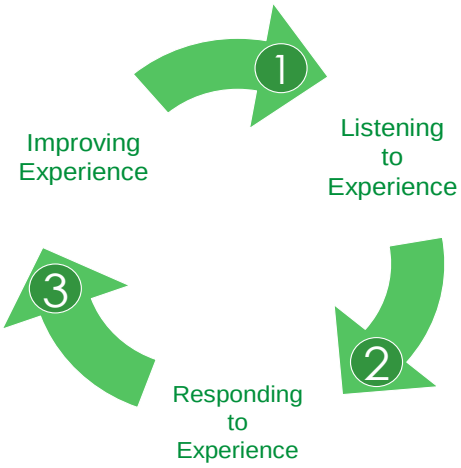
1.2 Strategic Context

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

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

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

You said – We did



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

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

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

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

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

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

Section 2 – Emerging Themes about Service Experience

2.1 Complaints

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

Table 1a: Number of complaints received this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	13		A decrease in the number of complaints has been reported in Gloucestershire in Q1 (Q4 n=17)	Significant
Herefordshire	3		No change in the number of complaints has been reported in Herefordshire in Q1 (Q4 n=3).	Significant
Total	16		The total number of complaints received is lower than the previous quarter (Q1 n=20)	Significant

Table 1b: Number of complaints received this quarter by locality and team

	Countywide Locality	Gloucestershire Localities	Herefordshire Locality	CYPS and CAMHS	Total
Crisis	2		1		3
CYPS				2	2
Wotton Lawn	2				2
Stonebow			2		2
MHICT (Nursing / IAPT)		5	0		5
Charlton Lane	1				1
Recovery (One Stop)		1	0		1
Total	5	6	3	2	16

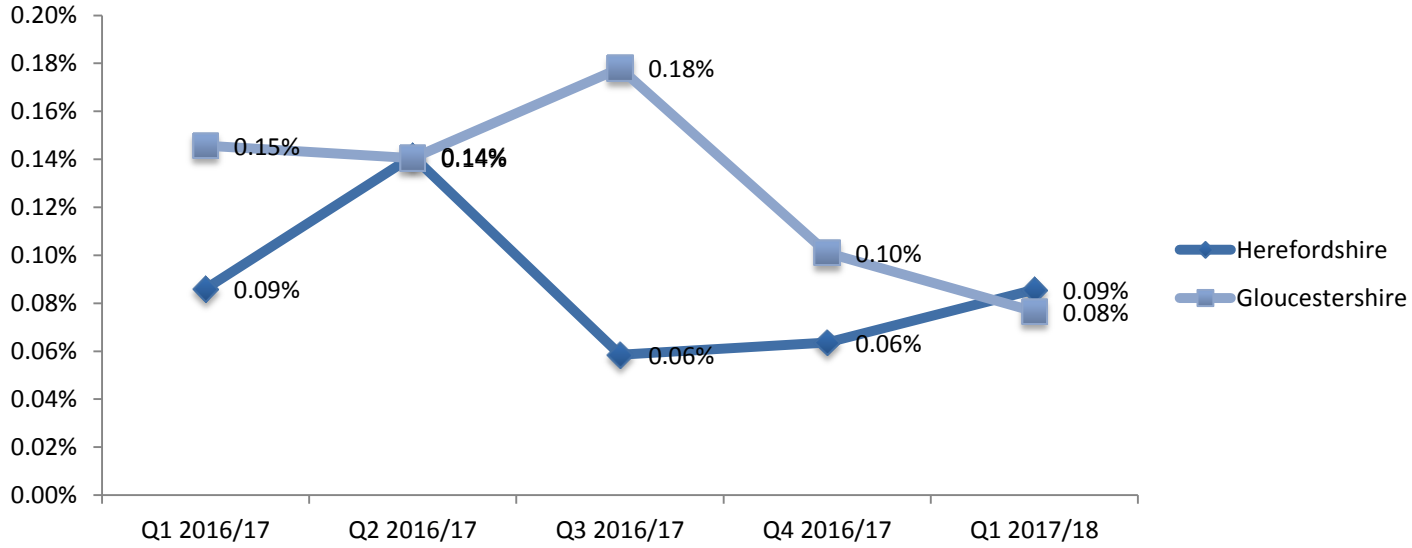
The number of formal complaints received during Quarter 1 is lower than that of previous quarters. When analysing Service Experience activity it can be seen that the number of people contacting the department has remained in line with previous quarters. Enquiries to the department are initially responded to using the "concern" or "signposting and advice" pathway. The reduction in complaints but consistency in numbers of people contacting the Service Experience Department suggests that increased resolution is being achieved locally without the need for instigating the formal complaints process. Complaints continue to be complex and frequently contain multiple issues within each individual complaint. This means we are seeing an increase in both the depth and breadth of individual complaints leading to wider and more complex investigations

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

	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18
Gloucestershire complaints	23	29	17	13
Gloucestershire contacts	16,373	16,288	16,829	16,966
Herefordshire complaints	5	2	3	3
Herefordshire contacts	3,538	3,418	4,716	3,501

**contact numbers differ from previous quarterly reports due to primary care contacts now being included. This has been backdated for previous quarters shown in the table above.*

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



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

Table 3a: Number of complaints closed this quarter

County	Number (Numerical direction)		Interpretation	Assurance
Gloucestershire	13	↓	The number of complaints closed for Gloucestershire is significantly lower than last quarter (Q4 n=25)	Significant
Herefordshire	3	↑	The number of complaints closed for Herefordshire is slightly higher than last quarter (Q4 n=2)	Significant
Total	16	↓	The overall number of complaints closed is significantly lower than the previous quarter (Q4 n=27)	Significant

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

Table 3b: Number of complaints closed this quarter by locality and team

	Countywide Locality	Gloucestershire Localities	Herefordshire Locality	CYPS and CAMHS	Total
Crisis	0		1		1
CYPS				1	1
Wotton Lawn	3				3
Stonebow			1		1
CLDT		1	0		1
MHICT (Nursing / IAPT)		6	0		6
Charlton Lane	2				2
Recovery Team		0	1		1
Total	5	7	3	1	16

Table 4: Responsiveness

Target	Number (numerical direction)		Interpretation	Assurance
Acknowledged with three days	100%	↑	**All** complaints were acknowledged within target timeframes (Q4=95%)	**Full**
Complaint closed within agreed timescales	81%	↑	This is higher than last quarter (Q4=78%) and is due to delays in the investigation process (100%)	**Significant**
Concerns escalated to complaint	0%	↓	Of 55 concerns received (Q4=56), none were escalated; this is lower than last quarter (Q4=4%).	**Significant**

The Service Experience Department (SED) acknowledged all complaints within the national standards for response times for Quarter 1 2017/18.

The rate of complaints closed within the initially agreed timescale continues to increase for the third consecutive quarter to 81%. This is encouraging news. The Service Experience Department will continue to carefully monitor closure rates to ensure a continued high rate of timely closures.

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

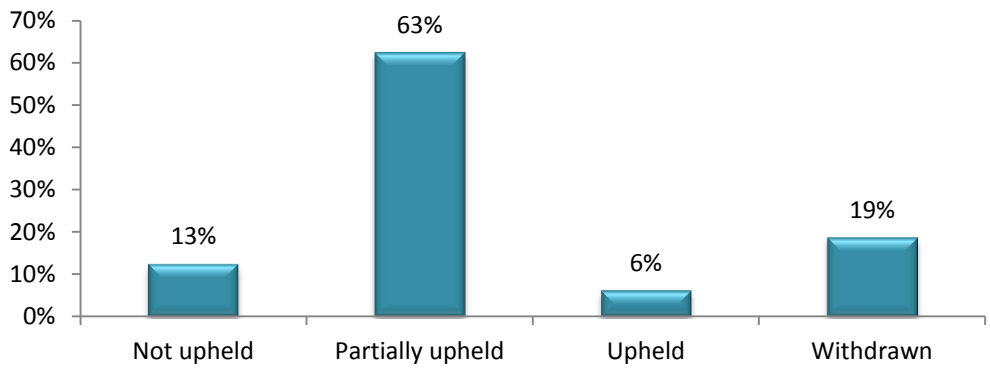
Table 5: Satisfaction with complaint process

Measure	Number (numerical direction)		Interpretation	Assurance
Reopened complaints	4	↓	This figure is lower than the previous quarter (Q4 n=6)	**Significant**
Local Resolution Meetings	2	↓	This figure is much lower than the previous quarter (Q4 n=7).	**Significant**
Referrals to PHSO	0	↓	No complaints have been referred to the PHSO this quarter. (Q4 n=4).	**Significant**

Quarter 1 has seen a slight decrease in the number of complaints reopened following a complainant being informed of the findings of the complaint investigation. This demonstrates that the complaint investigation process is robust and that response letters explain and answer the queries raised without the need to reopen the complaint.

There have been no referrals to the PHSO this quarter, again another indicator that people are largely satisfied with the management of their complaint.

Table 6: Outcome of complaints closed this quarter

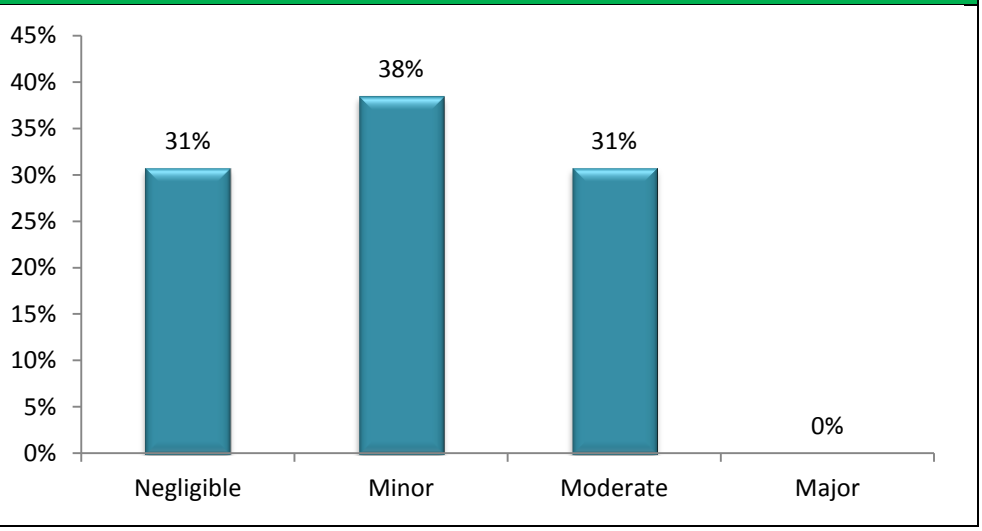
Outcome	No.	Chart showing percentages
Not upheld *No element of the complaint was upheld*	2	
Partially upheld *Some elements of the complaint were upheld*	10	
Upheld *All elements of the complaint were upheld*	1	
Withdrawn *Complaint was withdrawn*	3	

Percentages rounded up to nearest whole number

Following feedback from complainants and Experts by Experience, the Trust no longer uses the terms upheld/partially upheld/not upheld within response letters. However, these categories are used for formal reporting purposes.

69% of the complaints closed this quarter had their concerns upheld or partially upheld. This is lower than the previous quarter (59% partially upheld, 15% upheld). Reporting overarching complaint outcomes continues as established during Quarter 4 2016/17, where a single issue or more within an individual complaint is categorised as upheld, the overarching status is that the complaint is upheld.

Table 7: Risk rating of complaints closed this quarter

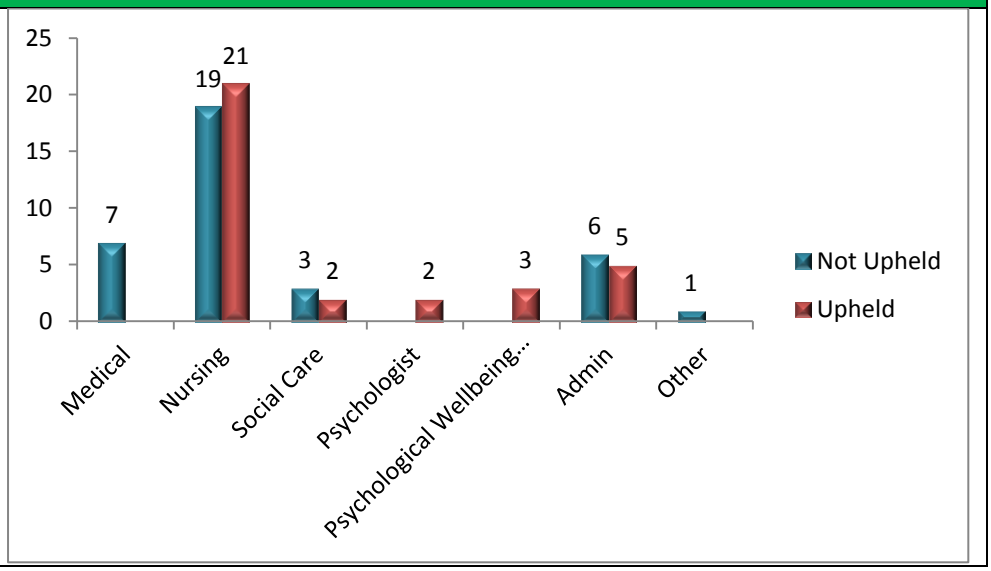
Rating	No.	Chart showing percentages
Negligible *Minimal impact on individual or organisation*	4	
Minor *Minor implications, reduced performance, single failure*	5	
Moderate *Significantly reduced effectiveness, failure to meet internal standards*	4	
Major *Complaint regarding serious harm or death*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

Three closed complaints have not been included as they were withdrawn

69% of the complaints received were classified as negligible or minor in terms of their impact on the individual or the organisation. This is lower than the previous quarter (Q4=80%). The number of complaints meeting the “moderate” threshold remains stable (Q4 n=4) although they do account for a higher percentage of the total complaints closed when compared to last quarter (Q4 n=20%).

All complaints are regarded as important for individuals and resolution and learning are the key aims.

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

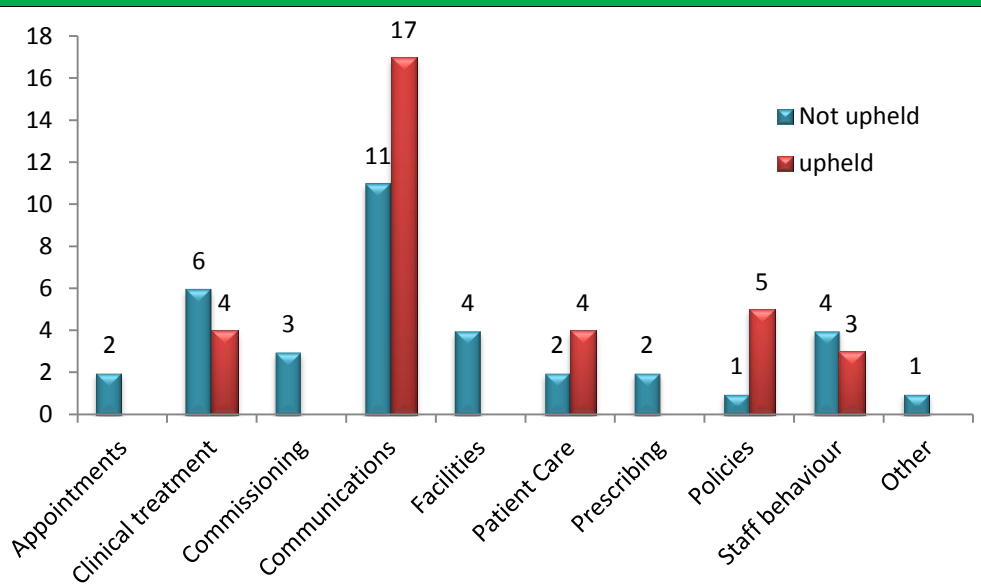
Outcome	No.*	Chart showing percentages of outcomes
Medical	7	
Nursing	40	
Social Care	5	
Psychology	2	
PWP (Psychological Wellbeing Practitioners)	3	
Admin	11	
Other	1	

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

The number of complaint issues involving different disciplines and staff groups continues to be recorded for *NHS Digital* (previously known as Health and Social Care Information Centre (HSCIC)) this year. It has been possible to categorise the complaint issues by staff group and the Quarter 1 data is presented in Table 8, above.

Quarter 1 figures continue in line with the trend shown during 2016/17, showing Nursing as the dominant staff group identified within complaints. Nursing continues to represent the largest staff group in the Trust and has the greatest number of individual contacts with service users and carers. Work is ongoing to ensure that professional leads are made aware of any themes relating to their professional group.

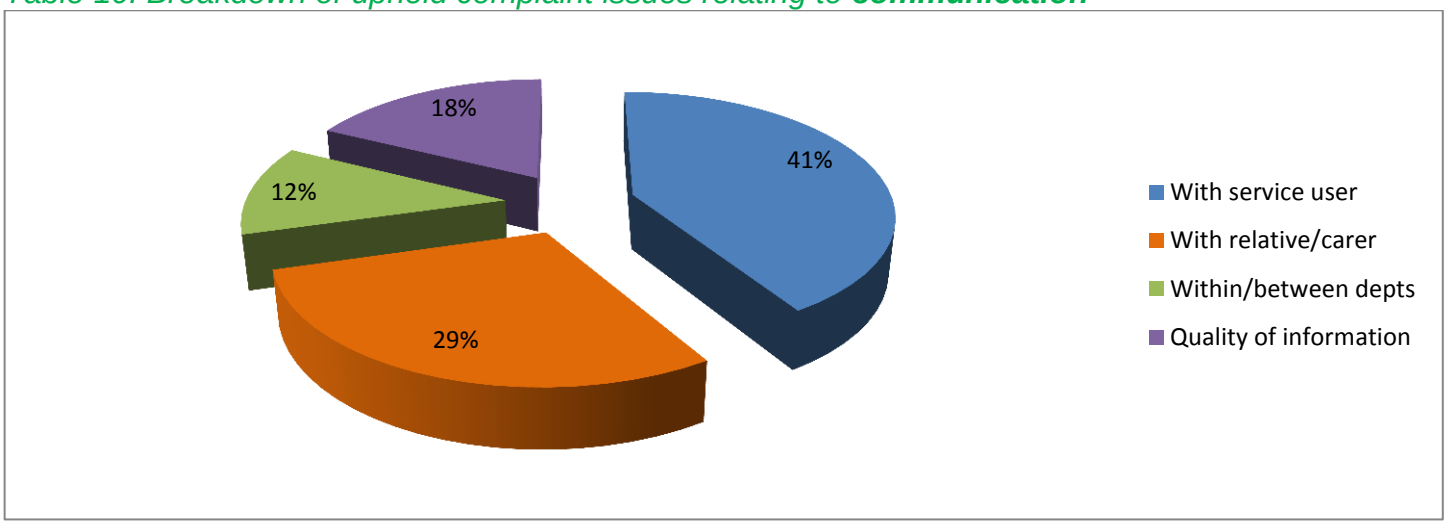
Table 9: Overarching closed complaint themes

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

The Trust takes all issues within individual complaints very seriously. The themes reflected in Table 9 demonstrate the outcomes of complaint issues that have been investigated and closed.

The main complaint theme is about ***communication*** and this has been reviewed in greater detail below.

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



Analysis of data is undertaken by the Service Experience Department in order to identify any patterns or themes. Communication continues to dominate complaint thematic data. Colleagues across the Trust are working hard to develop practice in this area – the continued implementation of the Triangle of Care being an example of this.
A current theme emerging is that the Let's Talk service and Mental Health Intermediate Care Team (MHICT) are receiving the highest numbers of complaints. Due to the significantly higher volume of referrals and appointments compared to other Trust services (these services account for over a third of ALL Trust total contacts) a higher percentage of service feedback is expected. This is also reflected in the numbers of compliments received.

Table 11: Examples of complaints and action taken

Example	You said	We did
Care and Treatment	I wouldn't have started therapy sessions if I had known they were time limited.	We apologised that you were not informed at the commencement of your contact with our service about the timescales for therapy. We have updated our staff to ensure this is explained at the very beginning of contact with people.
Availability of parking at a community site	I was unable to access the disabled parking bay when visiting your building due to a car blocking the space.	We reviewed our site and added additional spaces. We introduced a system for staff and visitors to leave contact details in their cars to ease any required moving of vehicles.
Communication with relatives/carers	My daughter was moved to another hospital in the early hours of the morning – this was very distressing for us all and we didn't know why.	We explained the reasons why it was necessary on this occasion and apologised we had not explained sooner. We gave you assurance that we had issued further advice to staff about night time transfers.

2.2 Concerns

The Service Experience Department endeavours to be responsive to feedback and to resolve concerns with people at the point at which they are raised. This has resulted in complaint numbers being maintained at a lower level this quarter and a corresponding increase in the number of contacts for PALS to raise concerns or for signposting with the SED, meaning a stable level of overall contacts for the same time period.

DatixWeb, a service experience recording and reporting system, has continued to be used for Quarter 1. The system has been refined by the Service Experience Department to allow greater data interrogation and improved opportunities for learning from feedback. Themes and trends have been analysed for Quarter 1 and are reflected in the tables below.

Table 12a: Number of concerns received this quarter

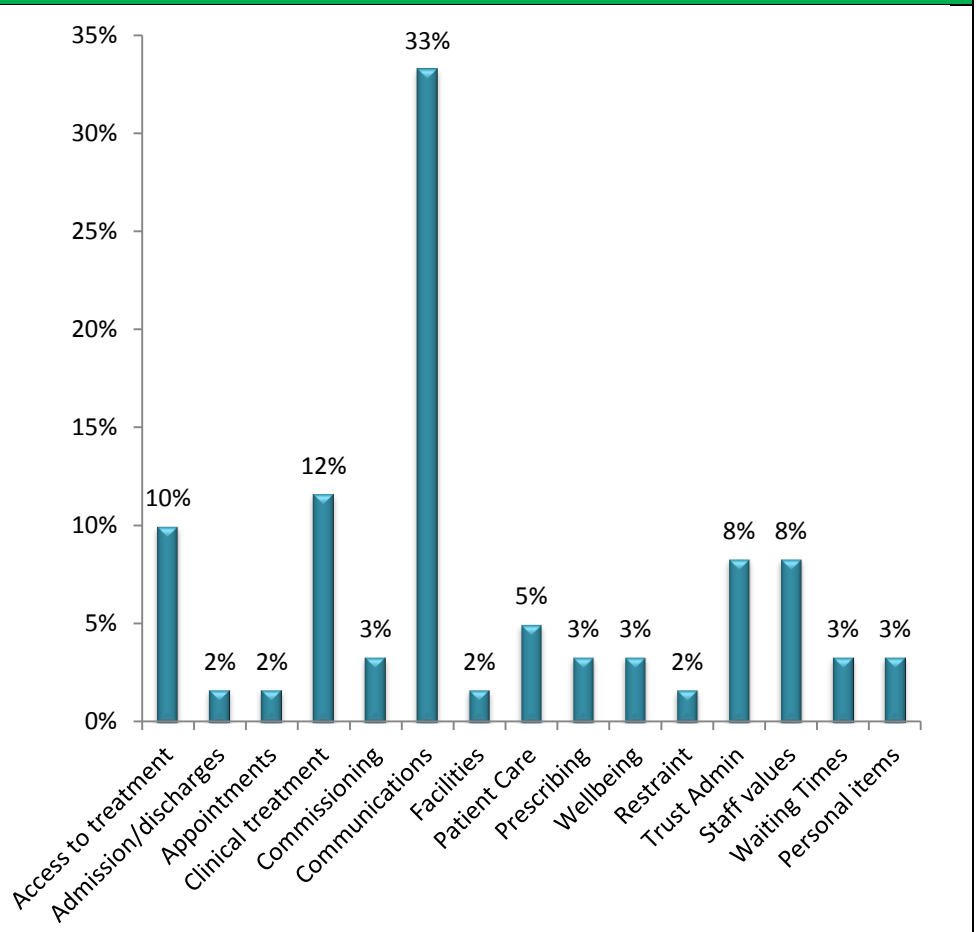
County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	41		There has been a decrease in the number of Gloucestershire concerns (Q4 n=46)	Significant
Herefordshire	9		There has been a slight increase in the number of Herefordshire concerns (Q4 n=6)	Significant
Corporate	5		There were a similar number of Corporate concerns (Q4 n=4)	Significant
Total	55		The overall number of concerns received is similar (Q4 n=56)	Significant

The number of concerns remains consistent with Quarter 4 2016/17 and is balanced by the decrease in complaints for this quarter. The number of contacts with the SED for “signposting and advice” has increased this quarter and continues to demonstrate that the majority of queries raised by people are being resolved locally in a timely way.

Table 12b: Number of concerns received this quarter by locality and team

	Countywide	Gloucestershire	Herefordshire	CYPS/CAMHS	Corporate	Total
AOT		1	1			2
ASC		1				1
CAMHS				2		2
CRHTT	1					1
CYPS				4		4
Eat. Disorders	1					1
Health Records					1	1
CLDT		1	1			2
Acute Inpatient	9		3			12
Later Life Teams		1				1
Berkeley House	1					1
Managing Memory		2				2
MHICT		9				9
Charlton Lane	1					1
Liaison Service			1			1
Recovery		7	3			10
Chief Exec's office					1	1
Communications					1	1
Service Delivery					1	1
Service Experience					1	1
Total	13	22	9	6	5	55

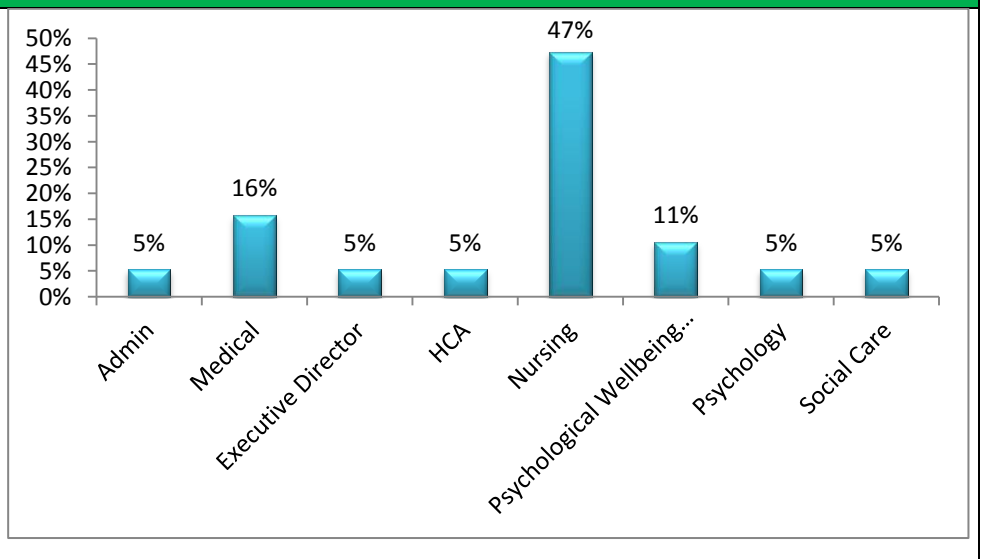
Table 13: Overarching concern themes this quarter

Theme	No.	Chart showing percentages
Access to treatment *Treatment or medication*	6	
Admission/discharge *Community or inpatient*	1	
Appointments *e.g. cancelled, staff DNA*	1	
Clinical treatment *e.g. diagnosis, medication*	7	
Commissioning *Services not available*	2	
Communication *Internal and external*	20	
Facilities *e.g. food or environment*	1	
Patient Care *e.g. observation, support*	3	
Prescribing *e.g. lack of prescription*	2	
Wellbeing *e.g. privacy and dignity*	2	
Restraint *All issues relating to restraint*	1	
Trust Admin *e.g. Health Records, MHA*	5	
Staff Values *Attitude and actions*	5	
Personal items *e.g. loss or damage*	2	

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

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

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

Outcome	No	Chart showing percentages
Admin	1	
Medical	3	
Executive Director	1	
HCA	1	
Nursing	9	
Psychological Wellbeing Practitioner (PWP)	2	
Psychology	1	
Social Care	1	

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

Table 15a: Number of concerns closed this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	41		This is similar to the last quarter (Q4 n=40)	Significant
Herefordshire	8		This is slightly more than the last quarter (Q4 n=6)	Significant
Corporate	2		This is more than the last quarter (Q4 n=1)	Significant
Total	51		The overall number of concerns closed has increased (Q4 n=47)	Significant

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

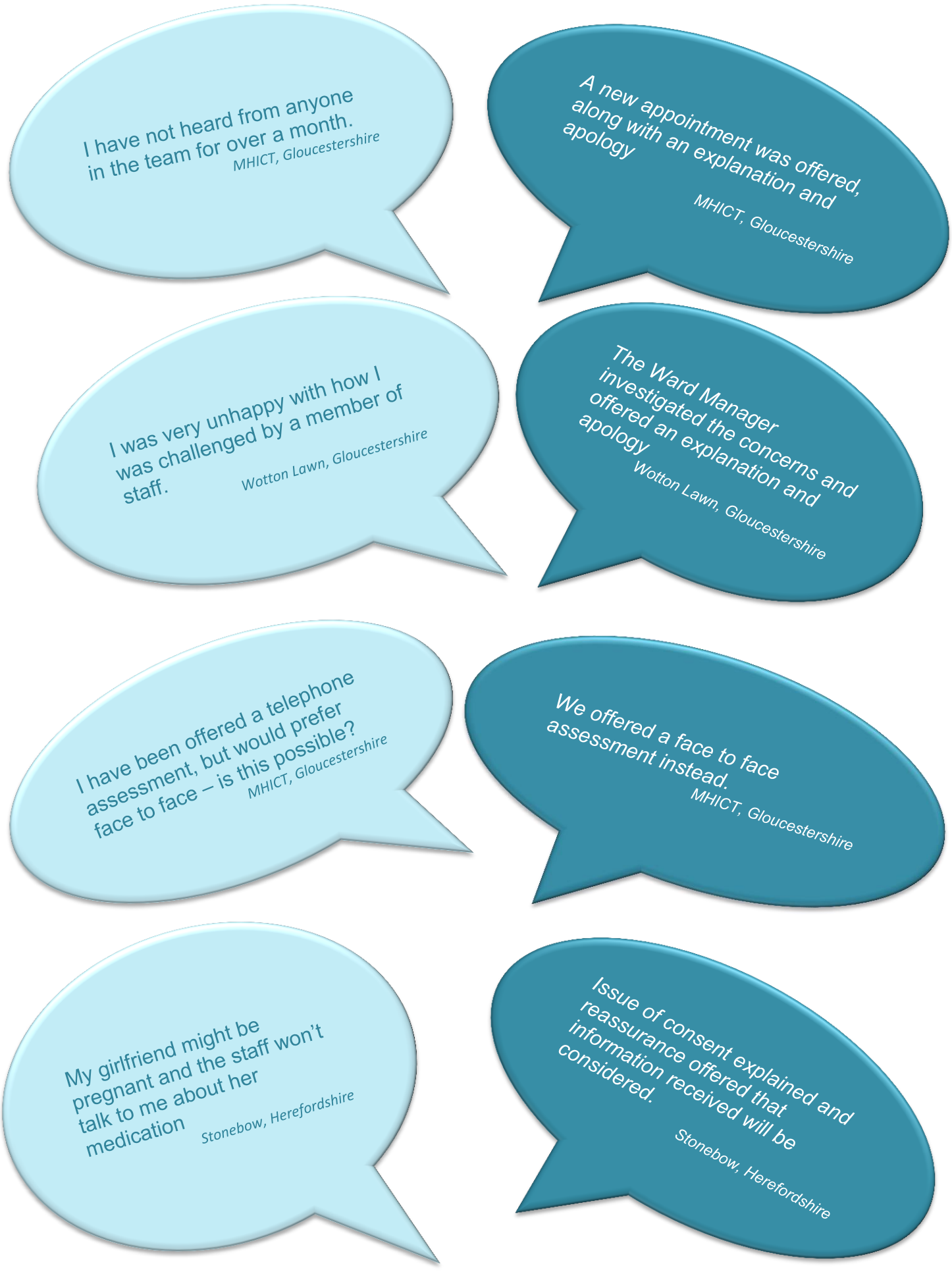
Table 15b: closed concerns by locality and team

	Countywide	Gloucestershire	Herefordshire	CYPS/CAMHS	Corporate	Total
AOT		1				1
ASC		1				1
CAMHS				2		2
CRHTT	1					1
CYPS				5		5
Eating Disorders	1					1
Health Records					1	1
CLDT		1	1			2
Acute Inpatient	6		3			9
Later Life Teams		1				1
Berkeley House	1					1
Managing Memory		1				1
MHICT		14				14
Charlton Lane	1					1
Liaison Service			1			1
Recovery		7	1			8
Service Delivery					1	1
Total	10	26	6	7	2	51

Table 16: Other contacts and activity

Advice
There were 22 episodes of advice offered this quarter by the PALS Service: 16 episodes related to information about our services, 4 were general advice, and 2 episodes related to the complaints process
Signposting
There were 17 episodes of signposting by the PALS Service: 14 to internal teams and 3 to external organisations

Examples of concerns and action taken:



2.3 Compliments

Table 17: Number of compliments received

County	This quarter		Last quarter	Assurance
Gloucestershire	368	↓	534	Significant
Herefordshire	42	↑	32	Significant
Corporate	10	↑	6	Significant
Total	420	↓	572	Significant

The SED continues to encourage the reporting of compliments throughout our Trust. The SED will continue to work with services to raise the profile of compliment reporting. A dedicated email address has been set up to simplify the process for staff to report compliments that they have received – 2gnft.compliments@nhs.net .Compliments are being shared and regularly updated with colleagues via the Trust intranet system to further encourage reporting.

Sample compliments from Quarter 1:

2.4 Comments received via HealthWatch

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

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

HealthWatch Gloucestershire has gathered 1 piece of feedback relating to [2]gether Trust this quarter. This related to work between our Trust and partner agencies.

HealthWatch Herefordshire referred a service user and their carer to us to discuss their experiences and this was subsequently progressed as a formal complaint.

2.5 – Parliamentary and Health Service Ombudsman (PHSO)

There have been no new cases referred to the PHSO for review this quarter –this is an encouraging indicator that people are largely satisfied with the management and findings of the complaint investigation and response.

2.6 Surveys

2.6.1 How did we do? Survey

The Service Experience Department (SED) continues to implement the plan for our new **How did we do?** survey. The **How did we do?** survey combines the surveys we used in 2016/17 known as the "Friends and Family Test" and "Quality Survey" and are now used for all Trust services apart from IAPT and CYPS/CAMHS, where alternative service experience feedback systems are in place. The surveys are available solely in paper formats at present. Disappointingly, the expected rollout of the use of SMS (text messaging) surveys has been significantly delayed due to issues relating to Trust IT works. The SMS messaging was expected to be the main source of feedback about our services as demonstrated in the high response received during a previous pilot.

As a Trust we report our survey results internally, locally to our Commissioners, and nationally to NHS Benchmarking data. It is important that colleagues encourage and support people who use our services to make their views and experiences known so we can learn from feedback and make improvements where needed.

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

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

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

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

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

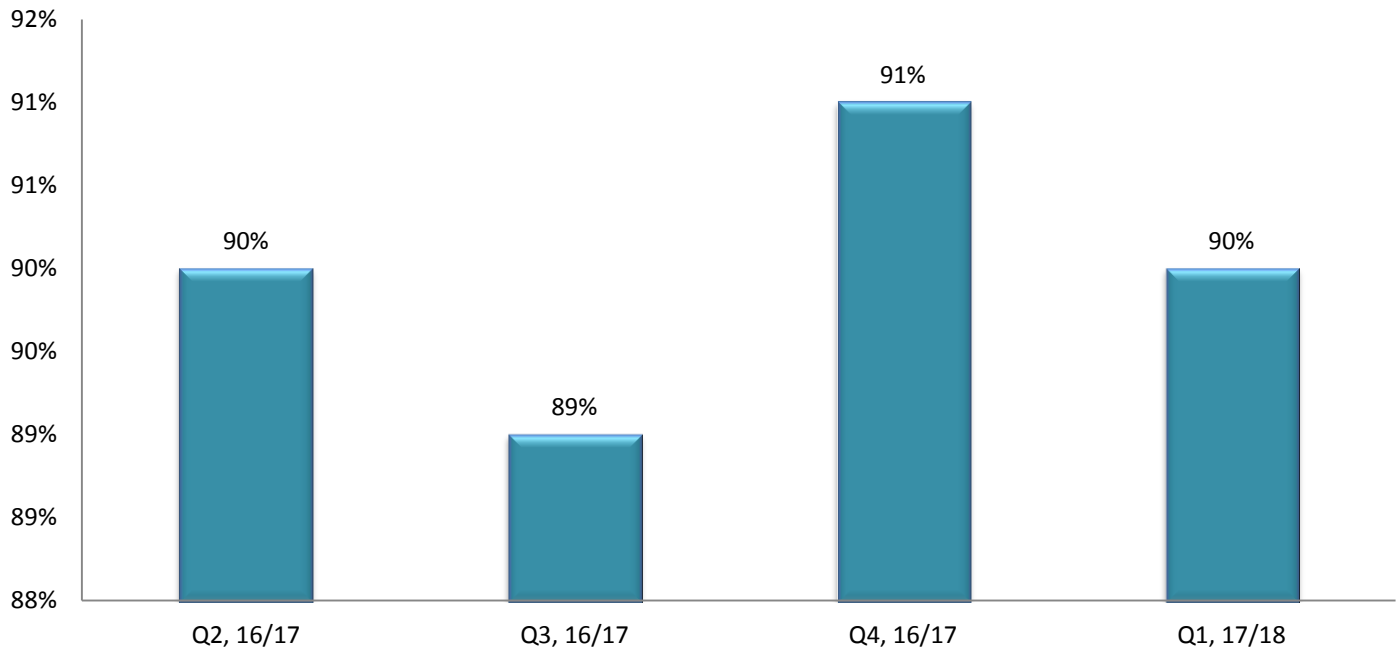
The table below details the number of responses received each month. The “FFT score” is the percentage of people who stated that they would be ‘extremely likely’ or ‘likely’ to recommend our services

Table 18: Returns and responses to Friends and Family Test

	Number of responses	FFT Score (%)
April 2017	176 (160 positive)	91%
May 2017	187 (170 positive)	91%
June 2017	168 (146 positive)	87%
Total	**531** (476 positive) **(last quarter = 740)**	**90% (last quarter = 91%)**

The Quarter 1 response rates are lower than the previous quarter and this is largely thought to be due to the roll out during April 2017 of the use of the new How **did we do?** survey forms. It is expected that Quarter 2 results will increase as more time has allowed the new system to be embedded and responses to be returned.
The percentage of those who would recommend our services has remained stable – this is encouraging news. The **How did we do?** survey will build upon last year’s good progress. Service Managers are given local feedback on a monthly basis about the FFT results and responses relating to the services they manage.

Figure 2: Friends and Family Test Scores for [2]gether Trust for the past year
The following chart shows the FFT Scores for the past rolling year, including this quarter. The Trust has received consistently positive feedback.



The FFT score for Quarter 1 has remained relatively consistent with that received in previous quarters 2016/17. The Trust continues to maintain a high percentage of people who would recommend our services.

Friends and Family Test Comments

What was good about the visit?

It helped my mind. I enjoyed relaxed me.
Recovery College, Glos

Very interesting and informative. I will remember a lot of the information to help me throughout this journey.
Managing Memory, Gloucestershire

The staff were very welcoming and the place had a nice environment. I thought that the visit was all good.
ASC Service, Gloucestershire

Excellent care/service. Feels like they actively care.
MHICT, Gloucestershire

This is my second stay on Mortimer Ward. On both occasions I have received excellent support and care. The team are very friendly and helpful. Fantastic support with continuous conversations with the nursing team.
Mortimer Ward, Stonebow

Very positive outcome. The patient heard some hard hitting to messages that she needed to hear from someone independent of the family.
Eating Disorders Team, Glos

Talking and kind.
CLDT, Glos

Staff available 24 hours a day when needed at a time I need.
CAHTT, Herefordshire

Excellent care, sensitivity and understanding about my mental health issues. Really sympathetic and understanding.
MHLT, Gloucestershire

What would have made the visit better?

No communication with family. Unhelpful 'passing of the buck' for information.
MHLT, Gloucester

I was discharged without my consent or agreement and had very little support from the team.
MHICT, Gloucester

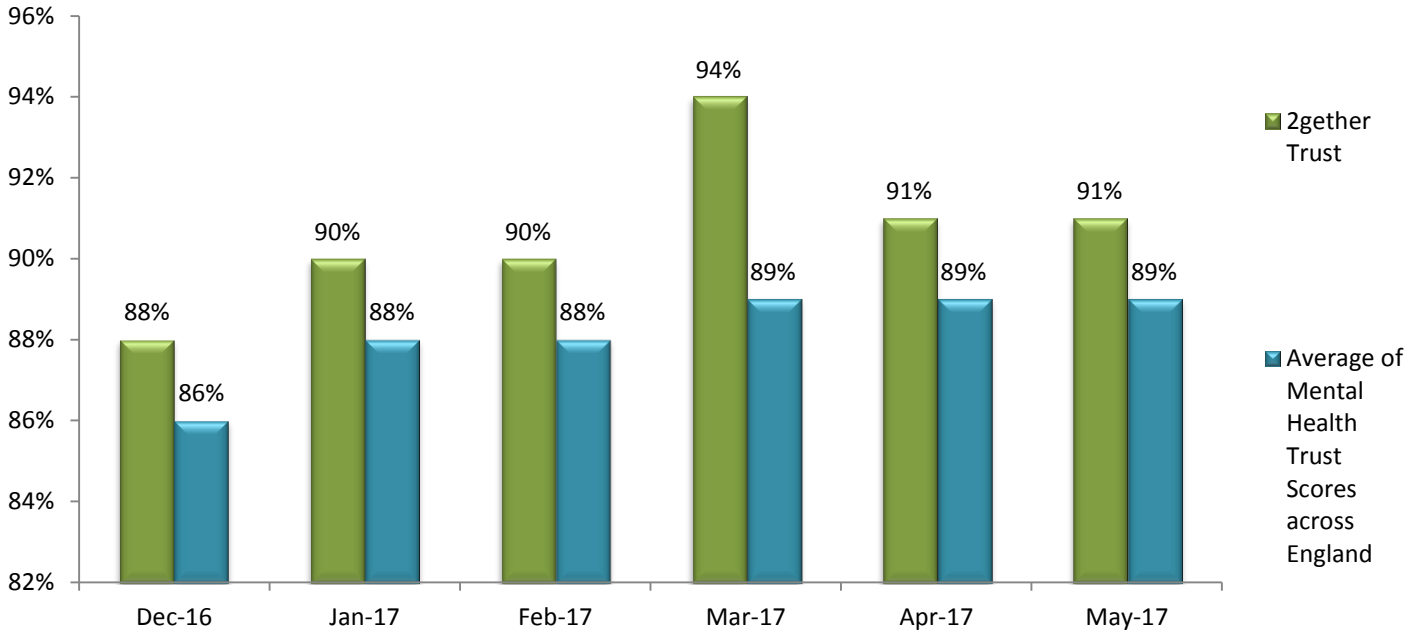
Made to feel like a waste of resources.
Eating Disorders Team, Gloucestershire

Was constantly lied to. If I was listened to.
CYPS, Gloucestershire

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

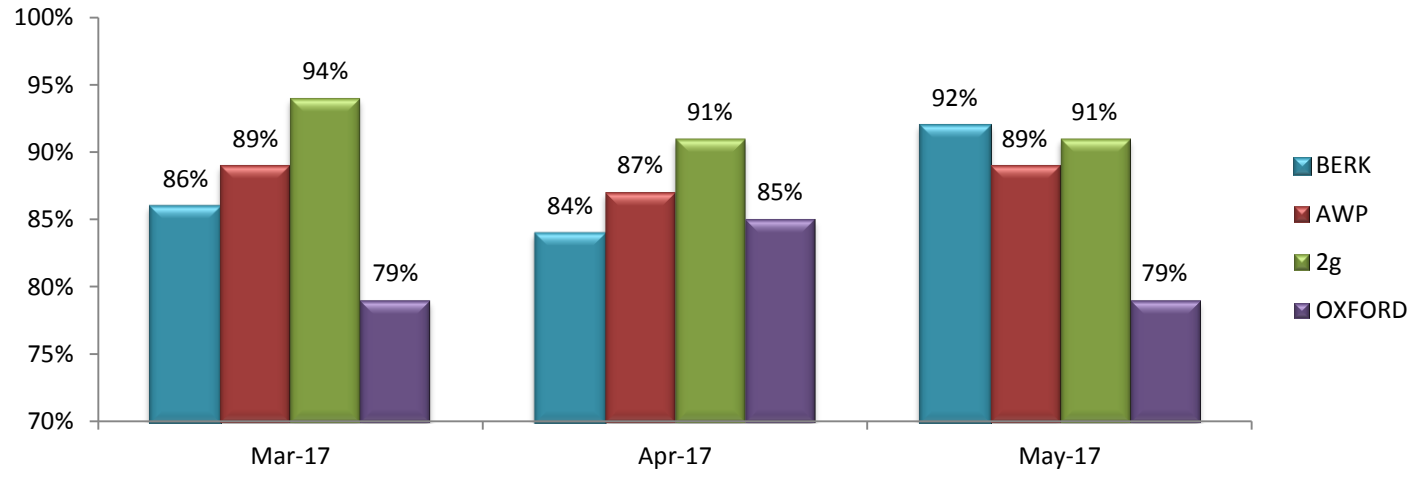
The following graph (Figure 3) shows the FFT Scores for the most recent six months of this year. Our Trust continues to receive a high percentage of recommendation that is typically higher or the same other Mental Health Trusts in England. (*June 2017 national data is not yet available*)

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



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

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



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

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

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

- *We would like you to think about your recent experience of working in 2gether. How likely are you to recommend 2gether to friends and family if they needed care or treatment?*

- *How likely are you to recommend 2gether to friends and family as a place to work?*

With six choices of response:

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

This is the first time results from our Staff Friends and Family Test have been reported within the Service Experience Quarterly reports. The results will demonstrate staff experience of working for our Trust by those who responded as well as if staff would recommend Trust services to their friends or family. The results may also be an indicator that satisfied and happy staff offer a good and high quality service.

The results of the staff Friends and Family test for Quarter 1 2017/18 are shown below

1. We would like you to think about your recent experience of working in 2gether. How likely are you to recommend 2gether to friends and family if they needed care or treatment?

		Response Percent	Response Total
1	Extremely likely	40.25%	97
2	Likely	42.74%	103
3	Neither likely nor unlikely	13.69%	33
4	Unlikely	1.24%	3
5	Extremely unlikely	0.83%	2
6	Don't know	1.24%	3
		answered	241

2. How likely are you to recommend 2gether to friends and family as a place to work?

		Response Percent	Response Total
1	Extremely likely	29.88%	72
2	Likely	42.32%	102
3	Neither likely nor unlikely	16.60%	40
4	Unlikely	7.47%	18
5	Extremely unlikely	3.32%	8
6	Don't know	0.41%	1
		answered	241

The results of the Staff FFT are reflective of the FFT results from service user feedback showing that a high majority of people would recommend 2getherNHS Foundation Trust as an employer and

would recommend working for 2gether to others. The high percentage of staff who would recommend Trust Services to those close to them shows a correlation between staff experience and service user experience of care.

2.6.4 How did we do?

The How Did We Do? (Quality Survey questions) provides people with an opportunity to comment on key aspects of the quality of their treatment

The following table shows responses from the Quality Survey questions for this quarter:

Table 19: How Did We Do? Quality survey questions and responses

Question	County	Number of responses	Target Met?
Were you involved as much as you wanted to be in agreeing the care you receive?	Gloucestershire	26 (21 positive)	82% TARGET 92%
	Herefordshire	2 (2 positive)	
	Total	28 (23 positive)	
Have you been given information about who to contact outside of office hours if you have a crisis?	Gloucestershire	23 (20 positive)	88% TARGET 74%
	Herefordshire	2 (2 positive)	
	Total	25 (22 positive)	
Have you had help and advice about taking part in activities that are important to you?	Gloucestershire	25 (21 positive)	81% TARGET 69%
	Herefordshire	2 (1 positive)	
	Total	27 (22 positive)	
Have you had help and advice to find support for physical health needs if you have needed it?	Gloucestershire	19 (15 positive)	79% TARGET 76%
	Herefordshire	0 (0 positive)	
	Total	19 (15 positive)	

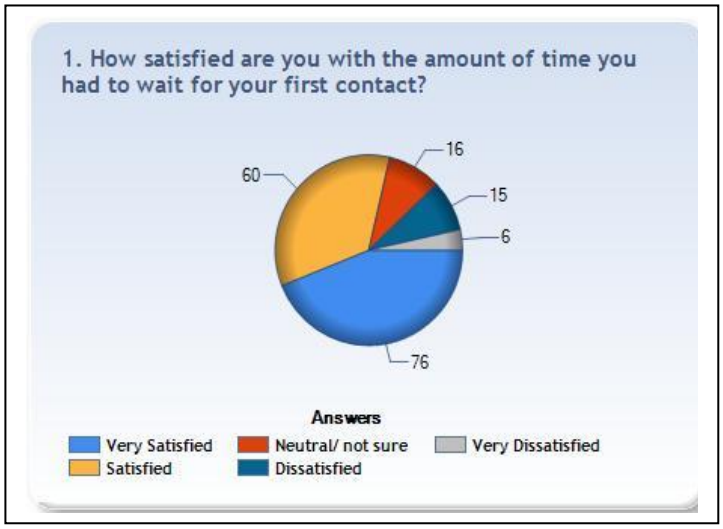
In line with the launch of the **How did we do?** survey the targets were reviewed and refreshed to reflect our Trust's aims and aspirations. Three out of the four targets set have been exceeded. This is good news and demonstrates that, of those people who responded to the survey, most are feeling supported to meet their needs and explore other activities. The one target that hasn't been fully achieved this quarter has still received a high percentage of positive responses regarding feeling involved in the care they received. It is important to acknowledge that this target for 2016/17 was 78% and that this was consistently exceeded during this time. The increase in the target set for 2017/18 is demonstrative of our desire to consistently improve our services.

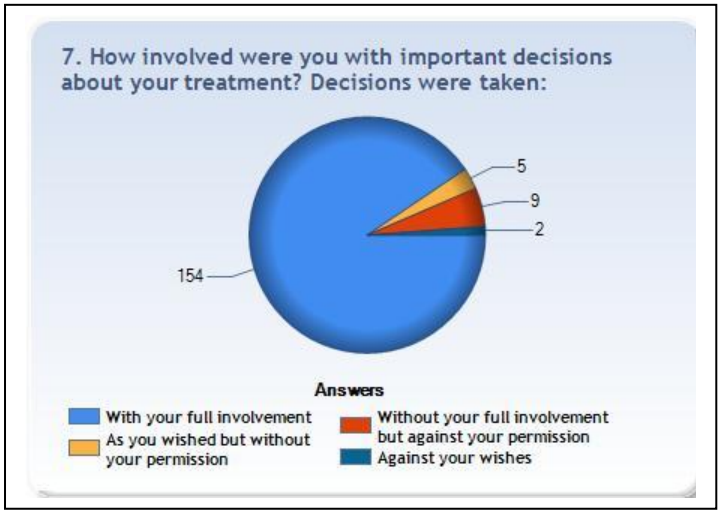
2.6.5 Improving Access to Psychological Therapies – Patient Experience Questionnaire (IAPT PEQ)

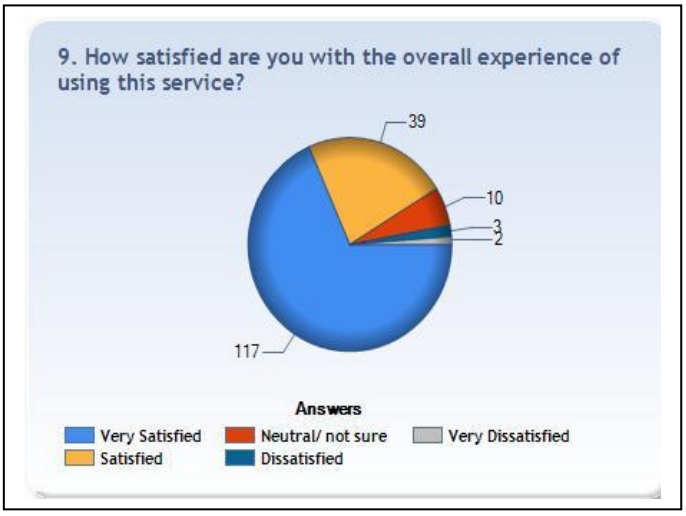
Our IAPT Let's Talk services use a survey that has been nationally agreed to gain particular feedback and measure people's level of satisfaction with the service. The current IAPT PEQ has been reviewed by SED and service leads and two new IAPT questionnaires each focusing on an area of

assessment and discharge are planned to be launched during Quarter 2 2017/18. The two new IAPT PEQ's will bring the service in line with nationally required reporting requirements.

The IAPT PEQ asks a variety of questions for feedback about the service people have received. As the current questionnaire is under review, the feedback from a selection of questions currently asked about "satisfaction" is included below. All data and feedback shown is based on responses processed within Quarter 1 2017/18. The sample size (total number of responses) for feedback shown in the pie charts is 183. This is a slight decrease on the 213 responses for Quarter 4 2016/17.







The Quarter 1 feedback from the four questions shows that largely people are either "very satisfied" or "satisfied" with these elements of the Lets Talk service.

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

- To be able to have ongoing treatment, not just a limited amount.
- I felt lucky to have heard about the service.
- More funding so help can be provided sooner.
- I found your service to be first rate. I cannot suggest any improvements.
- Really not my place to say. Feeling overwhelmed with gratitude. Personal thanks to Therapist.
- Switch to email comms and allow text replies.
- Some people might prefer to meet their counsellor face to face initially. I was a little uncertain about receiving counselling, over the phone and would have preferred to meet in person. However having experienced this type of counselling I would have no qualms about doing so again, or about the recommending this service to others.

2.6.6 Children and Young People service (CYPS)

CYPS do not use the “How did we do?” survey. CYPS gather service feedback using the Experience of Service Questionnaire, known as CHI-ESQ. CHI-ESQ is a nationally designed survey to gain feedback from children, young people and their parents/carers. CYPS also use age appropriate versions of the Friends and Family Test.

Adapted Friends and Family Test

	Number of responses	FFT Score (%)
Age 9-11	12 (8 positive)	67%
Age 12-18	28 (27 positive)	96%
Parent/Carer	37 (37 positive)	100%
Total	**77** (72 positive) **(169 last quarter)**	**94% (96% last quarter)**

Examples of some feedback given:

Section 3 – Learning from Service Experience Feedback

Section 3.1 – learning themes emerging from individual complaints

The Service Experience Department, in partnership with Service Managers, routinely record, report and take actions based upon the valuable feedback from complaints, concerns, compliments and comments. Table 20 illustrates the lessons learnt from **individual** complaints and concerns. This includes learning when a complaint or concern has been upheld or not upheld.
Reporting of local service experience activity on a monthly and quarterly basis at each locality governance meeting continues to be embedded. The SED is also attending these meetings regularly to discuss local themes, trends and learning.

*Table 20: Lessons learnt from **individual** complaints and concerns closed Quarter 1*

Learning	Action taken	Assurance of action
You told us that moving your relative to another hospital in the early hours of the morning was distressing for all of you.	We apologised to you that this happened and that we did not fully explain the reasons why this was necessary.	Significant
	We have advised our staff to ensure all transfers to other hospitals should happen as early as possible to avoid night time transfers.	
You told us you were not given information about your relative's diagnosis.	We apologised that we did not explain this to you and your relative.	Significant
	We have fed back to the team involved about your experience and the importance of clear and consistent communications with service user and their families regarding all aspects of diagnosis, care and treatment.	
You told us you were concerned some information relating to your personal life was not kept confidential.	We apologised and reviewed this matter with the staff involved. The staff member refreshed their Information Governance training.	Significant
You told us you were concerned you had been discharged from a service without any onward referral.	We reviewed your care plan and found you had been referred to another team and an appointment had been made.	Significant
	We learnt that we must always explain what is going to happen next and why about care and treatment with the people involved.	
You told us that the showers in our inpatient ward did not stay on long enough.	We took time to explain to you that our showers operate by a timed push button system. This is for safety reasons and unfortunately we would not be able to change it.	Significant

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

Effective dissemination of learning across the organisation is vital to ensure [2]gether's services are responsive to people's needs and that services continue to improve. Table 21 illustrates points of learning from Service Experience feedback. Localities, in partnership with corporate services, are asked to develop action plans to ensure that the learning is incorporated into future practice.

Table 21: Points of learning from Service Experience feedback Q1 closed complaints– action plan to be sought from locality leads

Organisational Learning	Action Plan (to be sought)
Service users and/or carers must be consulted about whom they wish to attend their review meetings and this should be documented in the progress notes. This is in line with the Assessment and Care Management Policy.	
Service users and/or carers must be kept updated following conversations about potential safeguarding referrals, to minimise anxiety and distress and ensure they are aware of what will happen next.	
Where staff seek safeguarding advice from an external agency and do not agree with the outcome/ decision made the escalation policy must be followed.  Safeguarding Newsletter May 2017	

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

Effective dissemination of learning across the organisation is vital to ensure we are responsive to people's needs and that services continue to improve. Table 22 below illustrates the assurance that services have provided around actions that have been completed as a result of previous aggregated lessons learnt.

Table 22: Points of learning from Service Experience feedback Q4 2016/17 – action plan has been completed

Organisational Learning	Action Plan (to be sought)	Date assurance received
Where a clinician is a new member of a service user's care team it is essential to establish a good rapport/relationship with the service user and family and they explain their role and their responsibilities along with establishing the expectations of the service user and the family. *All staff to give clear communication at first contact with service users and family.*	**CYPS/CAMHS:** Complaints & Service Experience feedback are reported and discussed at CYPS/CAMHS Governance. Learning and recommendations are disseminated via CYPS/CAMHS Delivery Committee to Team Managers. Team Managers share the information with their teams and it is stored in the team folder for future reference. An example would be the need for good information and communication at the first point of contact with a family	May 2017
	Herefordshire Localities: Reiterated at governance meeting. Community Services Manager is also pulling together all of the actions regarding fully implementing Triangle of Care in Herefordshire	July 2017
	Gloucestershire Localities: Via Delivery & Governance Committee & Locality Forums, Community Service Managers to ensure that all Team Managers/teams are familiar with their Service Specifications and Operational Policies and that these are made available to new staff as part of their induction.	May 2017
	Countywide Localities: Staff to be made aware of the requirement within team meetings. This will be initially discussed at Board. Staff to be reminded of the importance of explaining who they are, what their name is and their role in the care.	July 2017
Where a person's needs cross multiple services and /or geographical boundaries of our Trust it is important that we work together as an organisation to focus on meeting the service users' needs rather than request multiple assessments	**CYPS/CAMHS:** Complaints & Service Experience feedback are reported and discussed at CYPS/CAMHS Governance. Learning and recommendations are disseminated via CYPS/CAMHS Delivery Committee to Team Managers. Team Managers share the information with their teams and it is stored in the team folder for future reference. An example of improvements to the navigation of service boundaries can be seen in the improved transitions protocol within 2G for transitions from CYPS to Adult Services	May 2017

Organisational Learning	Action Plan (to be sought)	Date assurance received
and/or referrals to different teams in different geographical locations. *All staff to be aware of service user's care that may cross our internal Trust service and/or geographical boundaries and the impact this has in terms of service availability and experience of our Trust services as an organisation*.	**Herefordshire Localities:** All out of county patients are discussed at the Wednesday morning delay prevention meeting attended by ward staff and Community team managers, This seeks to ensure seamless care.	July 2017
	Gloucestershire Localities: Via Delivery & Governance Committee & Locality Forums, Community Service Managers (CSMs) to ensure that all Team Managers/teams are aware of the role of the Care Coordinator (via the Assessment + Care Management Policy and the Interface Policy which guides helpful working between teams	May 2017
	Countywide Localities: Discussed in Locality Board Team meetings to remind staff of the importance of communicating effectively with fellow teams. All staff to be reminded of the effect this can have on clients	July 2017
It is important that service users and carers are informed of the next steps to be taken in relation to their care and service provision. Quarter 4 feedback shows several occasions where people were unaware of what would happen next following contact with our services. *All staff to give clear communication about the next steps to be taken following contact with service users and/or carer.*	**CYPS/CAMHS:** Complaints & Service Experience feedback are reported and discussed at CYPS/CAMHS Governance. Learning and recommendations are disseminated via CYPS/CAMHS Delivery Committee to Team Managers. Team Managers share the information with their teams and it is stored in the team folder for future reference. An example is the improvement to Care Plans to make them more accessible CYP.	May 2017
	Herefordshire Localities: Community Services Manager is monitoring and reporting monthly on compliance with the Assessment and Care Management policy	July 2017
	Gloucestershire Localities: Via Delivery & Governance Committee + Locality Forums, CSMs to ensure that all Team Managers/teams discuss the importance of next steps discussions/inclusion of next steps within all correspondence.	May 2017
	Countywide Localities: Discussed in Locality Board All staff to be reminded of the importance of explaining clearly the future plans and expectations. Where possible to explain who else may or will be involved in continued care.	July 2017

Agenda Item 10 **Enclosure Paper E**

Report to: 2gether NHS Foundation Trust Board – 28 September 2017
Author: Duncan Sutherland, Non-Executive Director
Presented by: Duncan Sutherland, Non-Executive Director

SUBJECT: **NON EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS QUARTER 1 2017/18**

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

EXECUTIVE SUMMARY

A Non-Executive Director Audit of Complaints was conducted covering three complaints that had been closed between 1 April and 31 July 2017.

RECOMMENDATIONS

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

1. INTRODUCTION

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

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

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

1.3 The changes introduced represented a significant improvement on the previous process. I felt, however, there were two areas which would be worth looking at in future reports. The first is the upheld/not upheld decision. There were several issues in the complaints viewed that did not lend themselves to this conclusion. In terms of these particular issues I felt that the decision reached was weak and did not adequately deal with the complainants issue.

The second is related to the 'learning' aspect of the reports. I did feel that, where learning was identified, this was not specific enough, both in the actions to be taken and in who and how it was to be monitored and reported.

2. SUMMARY OF FINDINGS

2.1 The documentation was properly prepared and easy to follow. In one case, the most complex, the numbering of the issues differed between the letter confirming the issues to the complainant and those in the investigation reports. This was the result of the investigation having several investigators for different parts of the complaint.

2.2 Case 1

2.2.1 This case was somewhat different than most as it dealt with a non-patient complaint by a neighbour of one of the Trust's facilities.

2.2.2 This issue started with a simple issue of lack of consultation by the Trust of work it was undertaking and escalated into a more worrying problem involving patients, staff and the police. The investigation was hampered by the fact that the staff involved in the initial issue had left the Trust's employment.

2.2.3 The complainant had a just complaint which was dealt sensitively in the CEO's response letter. The investigation missed some aspects of detail given that staff were no longer employed by the trust.

2.2.4 I felt that the learning actions in the complaint response needed more detail particularly on how we consult externally before we carry out work affecting neighbours. I would offer ***limited*** **assurance** on this case.

2.3 Case 2

2.3.1 This case involved a patient who had been assaulted by a family member and felt that the advice received from the Trust was confused and not correct. The patient's interaction with the Trust was with various departments and the patient felt that it was not co-ordinated or joined up. There were 10 issues of complaint in all many of which were based on what was said to the patient or a misunderstanding of the conversations.

2.3.2 This was a complex complaint from someone who a lot of the time was in high anxiety. All of the complaints were based largely on verbal conversations. The majority of this was documented in RIO. The biggest issue was one of interpretation and understanding on both sides. The investigation was both thorough and honest throughout and the CEO struck the right balance of apology and sensitivity.

2.3.3 It might also be said that the learning could have been more clearly stated in the CEO's letter.

2.3.4 I would offer ***significant assurance*** overall on the approach to investigating and responding to this complaint

2.4 Case 3

2.4.1 This was an incredibly complex complaint that dealt with the non-performance by the Trust of a previous complaint. The essence of this complaint was that the actions of a Local Resolution meeting (LRM) held in January 16 were not followed up on and despite the complainant contacting various people in the Trust, there was no response for a year. This resulted in a lack of trust in the ability of 2gether to deal with the real issues of the patient and therefore a whole series of further complaint issues in the way the patient has been dealt with. Core to this was that the Service Experience Team were not invited to the LRM.

2.4.2 The investigation was very complex involving several investigators including clinical and corporate. Various points come out of this:

i) Given its complexity and the number of investigators involved this investigation was carried out in a very open and honest way. I would wish to show appreciation for this to the individual investigators and the overall co-ordinating investigator.

ii) The administrative numbering was confusing between the issues letter to the complainant and the investigation report.

iii) I felt there should have been more definitive conclusions in the upheld/not upheld section particularly for those issues that did not easily fit into this classification.

iv) The Deputy CEO letter was excellent upholding the main complaint while sensitively dealing with the many other complex issues which sometimes were difficult to grasp. A separate letter was sent form the CEO giving his personal apologies which again was very sensitive to the patient's complaints.

2.4.3 This investigation and upheld core complaint raises some important strategic issues of communication and overall care at various levels. I would like to see a more structured strategy for learning following on from this complaint.

2.4.4 I would offer ***full assurance*** on the way in which this complaint has been dealt with through the Complaints Team although ***limited assurance*** on the 'learning' aspects.

3 RECOMMENDATIONS

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

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

Report to: Trust Board – 28th September 2017
Author: Marie Crofts, Director of Quality
Presented by: Marie Crofts, Director of Quality

SUBJECT: **6 Monthly Safe Staffing Update**

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

EXECUTIVE SUMMARY

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

This 6 monthly update outlines :

- An update on all the expectations within the new guidance (see Appendix 1) – including sample quality dashboards
- National reporting requirements, latest developments and the latest data in their required format
- Local Trust exception reporting
- Update of agency use across wards

Appendix 1 details any significant updates from the previous 6 monthly update to Board in March 2017. The Trust has made much progress and is in a good position regarding compliance with this guidance. This paper (Appendix 3) details two 'sample' quality dashboards in relation to inpatient wards. This quality dashboard is currently being refined to ensure it includes workforce data and any other relevant quality information for triangulation. A full dashboard for all wards will be reported on at the next 6 monthly update.

The quality dashboard will form part of the team accounts which the Trust is currently working on for all services.

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% for July 2017. Appendix 2 details the latest figures presented at the Governance Committee in August 2017. Use of agency continues with a significant reduction in the use of nursing agency spend during 2017/18.

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

ASSURANCE

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

RECOMMENDATIONS

The Board is asked to:

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

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

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

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

Reviewed by:		
Marie Crofts, Director of Quality	Date	28th September 2017

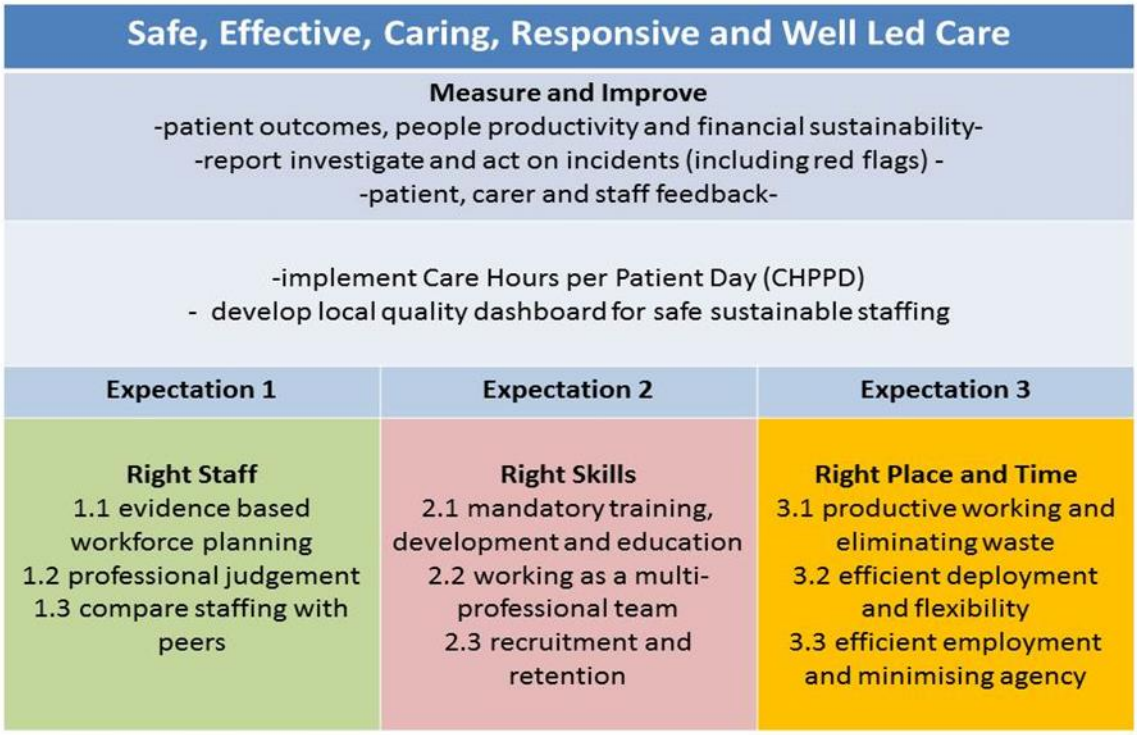
Where in the Trust has this been discussed before?		
Every 6 months at Board	Date	March 2017

What consultation has there been?		
N/A	Date	

Explanation of acronyms used:	
NQB	National Quality Board
CHPPD	Care Hours Per Patient Day
NHSI	NHS Improvement
HCA	Health Care Assistant
HEI	Higher Education Institution
HEE	Health Education England

1. CONTEXT

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



The Trust Board received the last 6 monthly update in March 2017. The Governance Committee continues to receive bi-monthly reports detailing staffing levels across all inpatient sites as well as updates regarding the use of temporary staffing.

This six monthly update paper outlines :

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

2. PROGRESS ON THE NQB REVISED KEY EXPECTATIONS

Appendix 1 attached to this report details each expectation and progress to date. In summary the Trust has made significant progress against each expectation. The Director of Quality is leading a piece of work ensuring that the triangulation of the data from the three expectations above is co-ordinated and any further improvement progressed. The sample quality dashboard highlights how key quality indictors will be brought together from each ward to ensure triangulation of information at a local level. This will also include workforce indicators; agency use and further service experience information.

The quality team are working closely with the information team to ensure progress with 'team accounts' ties in with the developing quality dashboards and forms part of this reporting.

3. NATIONAL GUIDANCE

The National Quality Board (NQB) and NHSI are leading on a number of toolkits in relation to safe staffing for both inpatient and community services. The guidance for mental health (both community and inpatient) will be published shortly. There has been no confirmed date as yet.

In addition the Trust is participating in the Carter Review for mental health and community Trusts and will be repeating the data collection regarding 'Care Hours Per Patient Day' (CHPPD) during September. The collection of the CHPPD data was mandated to be reported by acute Trusts from last July. Mental Health and Community Trusts will be mandated to report this monthly from April 2018.

Currently the Trust continues to publish the fill rates as directed by the previous national guidance. This is uploaded on to Unify and the Trust website. Appendix 2 outlines the national safe staffing requirement for July 2017. Actual fill rates continue to remain high and over 96% compliant against planned levels.

4. LOCAL TRUST EXCEPTION REPORTING

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

4.1 Ward specific information

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

- Increase in staff on duty to provide one to one care for patients (specialling);

- Decrease in staff, if the patient need does not require it e.g. patients on leave, or staff supporting other wards where the need is higher;
- The planned staffing numbers are based on pre-empted activity and dependency levels. This is determined by the nurse in charge for a set time frame and these may vary, for example; decisions may be made to replace a qualified nursing staff member with a health care assistant who knows the patients and the ward, rather than a bank or agency nurse who may not. National Quality Board guidance states that the nurse in charge must use their professional judgement alongside the planned staffing requirements to meet the needs of the patients on the ward at any particular time.
- The reasons for internal exceptions will only be reported where they are significantly high in number

In summary for July 2017:

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

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

4.2 Wotton Lawn:
Priory Ward
The Code 1 exceptions are owing to band 5 vacancy and use of regular band 2/3 HCA rather than using agency for RMN. This has a positive effect on the use of agency and the associated cost and in addition has consistency of staff for service users.

4.3 Stonebow:
Issues regarding the additional qualified staff on nights remain - this has no impact on patient safety. The high average fill rate relates to the additional use of bank and agency HCAs due to the level of acuity across the ward with increased observation through day and night for some patients.

4.4 Learning Disability Unit
Berkeley House:
The exceptions relate to the use of Brandon staff working alongside Trust staff.

Exception reporting in hours – all wards July 2017

			Exception Code 1	Exception Code 2	Exception Code 3	Exception Code 4	Exception Code 5
Ward	Bed number	Number of required staff hours in the month	Minimum staff numbers met – skill mix non-compliant but met needs of patients	Minimum staff numbers not compliant but met needs of patients	Minimum staff numbers met – skill mix non-compliant and did not meet needs of patients	Minimum staff numbers not compliant and did not meet needs of patients	Minimum staffing nos and skill mix not met. Resulting in clinical incident / harm to patient or other
Dean	14	3255 monthly hours	10	0	0	0	0
Abbey	18	3255 monthly hours	82.5	22.5	0	0	0
Priory	22	3255 monthly hours	187.5	0	0	0	0
Kingsholm	15	3255 monthly hours	47.5	0	0	0	0
Montpellier	12	3565 monthly hours	45	0	0	0	0
Greyfriars	10	4030 monthly hours	232.5	0	0	0	0
Willow	16	4495 monthly hours	0	15	0	0	0
Chestnut	14	3022.5 monthly hours	0	30	0	0	0
Mulberry	18	3255 monthly hours	0	0	0	0	0
Laurel	12	2015 monthly hours	105	0	0	0	0
Honeybourne	10	2015 monthly hours	150	0	0	0	0
Berkeley House	8	9135 monthly hours	360	382.5	0	0	0
Mortimer	21	3208.5 monthly hours	11.5	0	0	0	0
Cantilupe	8	2991.5 monthly hours	317	0	0	0	0
Jenny Lind	12	1782.5 monthly hours	11.5	0	0	0	0
Oak House	10	1782.5 monthly hours	0	0	0	0	0
Total		54317.5 monthly hrs	1560	450	0	0	0

5. USE OF TEMPORARY NURSING STAFFING

To ensure the wards are safe and to achieve the current level of fill rates temporary staff, both bank and agency staff, is used. This is monitored through Trust Governance Committee and through the monthly Temporary Staffing Project Board. In addition the Executive Committee is regularly updated with the current positon with regards to the use and spend of agency staff across all professional groups.

The Director of Quality is ensuring that at ward level staff are aware of their use and cost of agency staff each month. This will ensure local ownership and understanding. Once the quality dashboards are fully established this will include use of agency staff as one indicator. Currently the use of nursing agency during 2017/18 has reduced when compared with 2016/17 and on target to achieve the control total from NHSI. This equates to around £1m reduction from last year. This is very positive and is the result of much work and commitment by the Matrons and ward managers.

The Trust has established a 'peripatetic' HCA workforce across our three main inpatient sites. This has seen a significant reduction in the use of agency particularly in Herefordshire inpatient services (this being this first established team) However, both Mortimer and Cantilupe wards are the highest uses of agency year to date. This is largely owing to increase acuity and registered nurse vacancies within these wards. This is being monitored on a regular basis within the locality and through the Trust Governance structures.

The Trust is participating in two 90 day rapid improvement programmes led by NHSI. These should impact on the use of temporary staffing and ensure increased efficiencies'. The programmes cover e-rostering and observation levels. Frontline clinical staff are fully engaged in these work-streams and we are receiving regular feedback from NHSI through improvement events and Trust visits.

6. CONCLUSION:

In summary the Trust is progressing well with all of the expectations within the revised NQB guidance. The Quality dashboards will form a clear way of triangulating all indicators going forward.

7. RECOMMENDATIONS

The Board is asked to:

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

Appendix 1 - Updated NQB Expectations (Sept 2017)

Expectation 1: Right staff (8 standards)

The organisation uses evidence-based guidance such as that produced by NICE, Royal Colleges and other national bodies to inform workforce planning, within the wider triangulated approach in this NQB resource.

The Trust has established planned ward staffing levels which have been reviewed on a number of occasions since the initial guidance in 2013. These were based upon the RCN and other relevant guidance. When the new mental health NQB guidance is published all wards will be reviewed using this guidance. The Trust is part of two STP footprints and the associated workforce groups which are currently developing local workforce plans

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

We are currently working with HEE West Midlands and Keith Hurst to develop an appropriate MH acuity and dependency tool.

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

Workforce plans for the wards contain provision for leave; sickness and training. This is currency being reviewed in light of what actually is necessary against what is currently planned for and has been discussed within the 90 day rapid improvement programmes . Ensuring supervision within our Herefordshire services remains a challenge and we are working with staff to support all nurses get

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

Ensuring the nurse in charge of the shift has ultimately the responsibility to ensure there is sufficient numbers and skills of staff on duty on every shift. The 90 day rapid improvement programmes (e-rostering and observations) will also impact this positively.

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

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

As part of our participation in the Carter Review the Trust has collected CHPPD during May and is in the process of doing so in September. Feedback from NHSI following the initial data collection was positive in terms of staffing levels within our wards. Where acuity has increased and cannot be safely managed with the numbers and skills of staff on any shift the nurse in charge will seek to gain additional staff for that shift. This is part of our internal escalation process for access to temporary staffing.

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

The Director of Quality is part of a MH and LD directors of nursing forum where work-force issues are discussed; including sharing good practice. Nationally there have been recent publications related to the mental health workforce which we will take account of in the coming weeks and months. The CHPPD work will inform staffing levels on inpatient units.

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

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

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

Currently the Trust has no locally held quality dashboard however quality and performance KPI's are reported to Board. This is correlated and triangulated with the safe staffing report for any inconsistencies or concerns. This report highlights a sample quality dashboard which needs further work to capture all relevant quality indicators and will form part of the 'team accounts'.

Expectation 2: Right skills (13 standards)

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

Clinical leaders and local managers using the escalation process actively manage their staffing levels using the triangulated approach described. Matrons make decisions regarding staffing at their sites and if additional staffing is required that will be discussed at a local level. At a locality directorate level senior management teams review and monitor all quality indictors and performance KPI's . Significant concerns are raised through the Governance structures and v the risk register.

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

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

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

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

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

This work is continuing through the STP workforce structures and internally through the development of new roles such as Advanced Nurse Practitioners; Physicians Assistants etc. In addition the Director of Integration and Engagement and the Director of Quality are reviewing how the contribution of AHPs could be further progressed on the wards and could potentially benefit patient engagement and impact the use of agency further. The Head of Occupational Therapy is helpfully engaged in the 90 day rapid improvement programme for observations.

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

This work continues to deliver the national CQUINs in relation to improving physical health of our service users. In particular, our smoking cessation and making every contact count work. In addition working across the STP footprint will be helpful to consider all aspects of a person's mental and physical health.

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

The workforce changes which will take place over the coming years will need additional or changed competencies and skills. Hs work is currently underway as part of the STP work-stream. New and alternative roles for staff are being developed to ensure we have the workforce fit for the future.

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

In addition to the last update a review of the supervision policy for AHPPs and nurses has taken place and led by the appropriate Heads of Profession. Leadership development is a priority of the STP footprint ensuring clinical leaders are at the front and centre of this. All professional groups continue to have profession specific best practice and networking groups in addition to Multi-disciplinary meetings and discussion.

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

We are currently part of the Trainee Nurse Associate (TNA) pilots in both Counties. IN addition we are working to establish new and innovative roles including physicians assistants and advanced nurse practitioners.

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

A multi professional approach is evident from Board to ward. The Trust Board has three clinical executives and actively promotes an MDT approach in all teams. This is highlighted in our Assessment and Care Management policy in terms of care co-ordination.

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

Work continues across the health and social care economy through the STP in both Counties. This has given more impetus to collaborative working which was taking place within both patches.

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

More work needs to be done on this in relation to actively ensuring those from BAME groups have appropriate access to developments to promote their leadership across all Bands.

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

As part of the STP (in both Counties) the Trust is engaged in workforce planning including recruitment and retention. Some innovation approaches such as paying bursaries for pre-registered nurse training and additional funding in respect of bank shifts to be worked are now in place. In addition we have in place a ‘peripatetic’ HCA workforce at 3 of our inpatient sites now which will significantly impact positively on our agency use and spend.

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

In addition to the STP workforce planning internally we have written to all medics who are due to retires offering a range of options post retirement. This is being replicated for other professional groups.

Expectation 3: Right Place (16 standards)

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

The organisation has quality improvement at its heart and continues to embed the principles and methodologies of this within all that it does. In addition the Quality Service Improvement and Re-design (QSIR) national roll out and our previous patient safety collaborative work are in place. We are also part of the Carter Review for Mental Health and Community Trusts.

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

Our extended bed management team is in place and works closely with our staff bank and e-rostering team. A weekly bed management meeting takes place and a twice daily sit-rep now takes place.

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

Matrons have continued their work to ensure they get the best efficiencies across their hospital sites. In addition the Trust is participating in two 90 day rapid improvement programmes which will impact on this. In addition our peripatetic team will be used flexibly across all wards on a site

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

We continue to participate in the Carter review for mental health and Community Trusts. This work will inform future practices and appropriately increase productivity. Our Governance structures monitor and challenge all aspects of patients safety and effectiveness. In addition we have a number of initiatives which support compassionate care.

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

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

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

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

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

Clinical and professional leaders participate in the Senior Leadership forum and the Clinical Directors sit alongside the service Directors managing and leading their localities.

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

Clinical capacity and skill mix are reviewed team by team and by the Matrons within the hospital sites. This work will need a further review following publication of the MH safe staffing toolkits later in this year.

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

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

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

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

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

We have now implemented an e-rostering system and as part of the Carter review are using the improvement methodology to inform our practice alongside 22 other Trusts. Positive feedback from NHSI has been received in terms of our progress given we only commenced in April with e-rostering.

The annual strategic staffing assessment gives boards a clear medium-term view of the likely temporary staffing requirements. It also ensures discussions take place with service leaders and temporary workforce suppliers to give best value for money in deploying this option. This includes an assessment to maximise flexibility of the existing workforce and use of bank staff (rather than agency), as reflected by NHS Improvement guidance.

The Trust currently has a monthly Temporary staffing Project Board and reports on safe staffing within nursing to the Governance Committee and 6 monthly updates to the Board. We have a lot of detailed information now relating to our temporary staffing needs and have put in place the peripatetic teams on the back of this knowledge. We are currently engaging in a number of initiatives regarding registered nurses (both shorter term and longer term)

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

Following the previous 6 monthly update agency spend on nursing has reduced significantly and is in now line with NHSI control total. A number of initiatives have been put in place to support this. The monthly temporary staffing board continues to be in place chaired by the Director of Quality. The current risks to non-achievement of the NHSI control total is AHPP (IAPT) and medical agency spend.

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

Our CEO continues as the chair of both STP workforce work streams and as such is fully engaged with this work. The Trust has embarked on a number of initiatives re new roles including being a fast follower site for the Nursing Associate role and Physicians assistants. We are working with the local Universities to develop further advanced practice roles.

The organisation works closely with commissioners and with Health Education England, and submits the workforce plans they develop as part of the STP, using the defined process, to inform supply and demand modelling

The Trust works closely with both CCGs and HEE through the STP workforce work stream to map supply and demand. Additional work is being planned in terms of new skills needed to deliver the Five Year Forward View and 5 Year Forward View for MH

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

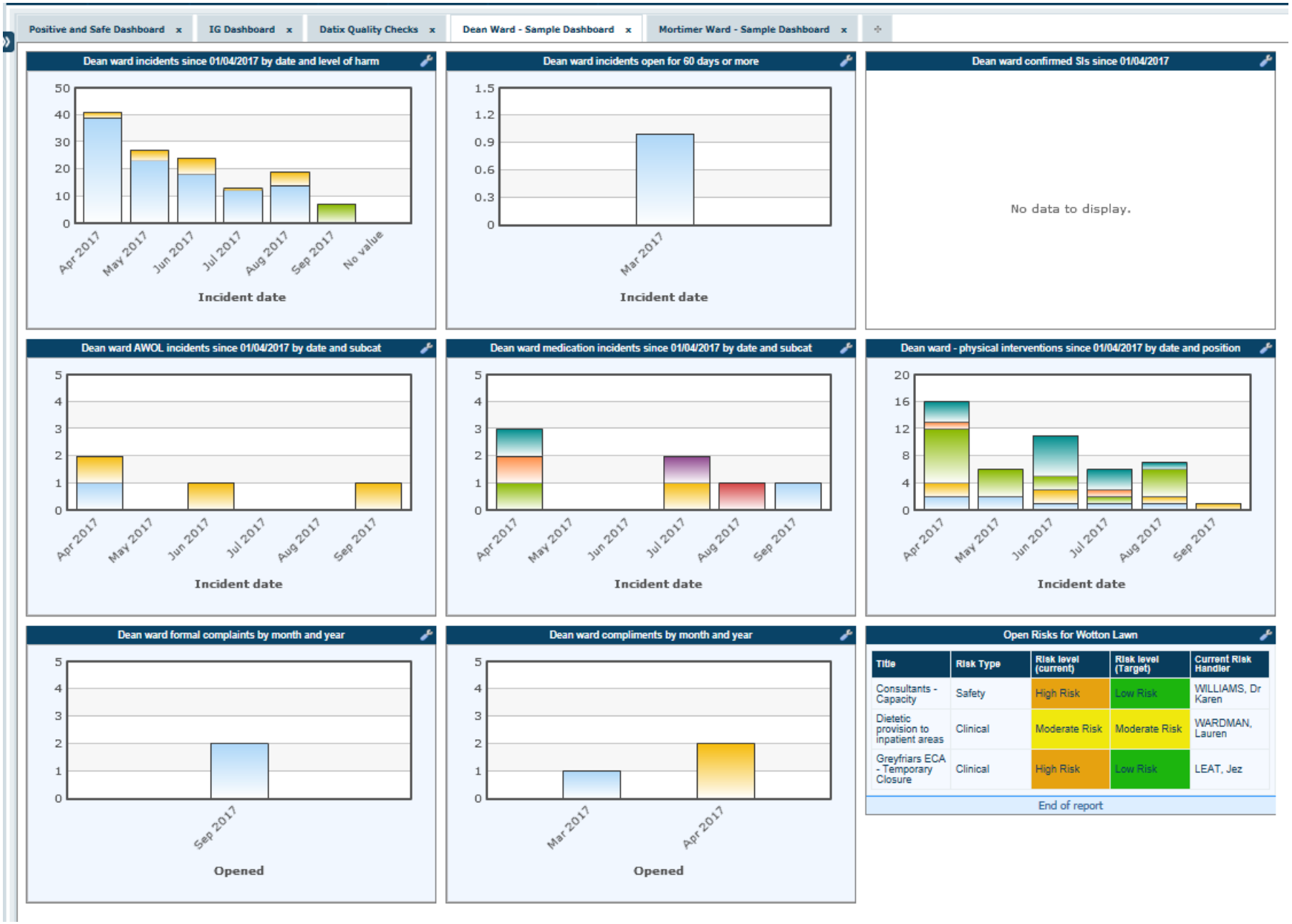
The Trust continues to work with a number of HEI's and alongside HEE to ensure the placement experience within our Trust is the best it can be. We continue to receive positive feedback across professional groups.

Appendix 2 JULY 2017

Hospital Site Details		Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
RTQ02	WOTTON LAWN HOSPITAL	Dean	710 - ADULT MENTAL ILLNESS		930	945	1395	1402.5	620	610	310	340	101.6%	100.5%	98.4%	109.7%
RTQ02	WOTTON LAWN HOSPITAL	Abbey	710 - ADULT MENTAL ILLNESS		1395	1312.5	930	1455	620	640	310	600	94.1%	156.5%	103.2%	193.5%
RTQ02	WOTTON LAWN HOSPITAL	Priory	710 - ADULT MENTAL ILLNESS		1395	1185	930	1207.5	620	632.5	310	315	84.9%	129.8%	102.0%	101.6%
RTQ02	WOTTON LAWN HOSPITAL	Kingsholm	710 - ADULT MENTAL ILLNESS		930	937.5	1395	1357.5	620	610	310	310	100.8%	97.3%	98.4%	100.0%
RTQ02	WOTTON LAWN HOSPITAL	Montpelier	710 - ADULT MENTAL ILLNESS		930	967.5	1395	1312.5	620	590	620	650	104.0%	94.1%	95.2%	104.8%
RTQ02	WOTTON LAWN HOSPITAL	Greyfriars	710 - ADULT MENTAL ILLNESS		1395	1192.5	1395	1665	620	620	620	880	85.5%	119.4%	100.0%	141.9%
RTQ01	CHARLTON LANE HOSPITAL	Willow	715 - OLD AGE PSYCHIATRY		930	975	2325	2287.5	310	340	930	900	104.8%	98.4%	109.7%	96.8%
RTQ01	CHARLTON LANE HOSPITAL	Chestnut	715 - OLD AGE PSYCHIATRY		930	930	1162.5	1170	310	310	620	620	100.0%	100.6%	100.0%	100.0%
RTQ01	CHARLTON LANE HOSPITAL	Mulberry	715 - OLD AGE PSYCHIATRY		930	1012.5	1395	1627.5	310	310	620	620	108.9%	116.7%	100.0%	100.0%
RTQ11	LAUREL HOUSE CHELT	Laurel	710 - ADULT MENTAL ILLNESS		697.5	660	697.5	765	310	310	310	310	94.6%	109.7%	100.0%	100.0%
RTQ13	HONEYBOURE	Honeybourne	710 - ADULT MENTAL ILLNESS		697.5	667.5	697.5	735	310	310	310	310	95.7%	105.4%	100.0%	100.0%
RTQ54	BERKELEY HOUSE	Berkeley	700- LEARNING DISABILITY		930	1552.5	5115	3930	310	410	2780	2500	166.9%	76.8%	132.3%	89.9%
RTQHJ	STONEBOW UNIT	Mortimer	710 - ADULT MENTAL ILLNESS		1069.5	1056.5	713	989	713	724.5	713	989	98.8%	138.7%	101.6%	138.7%
RTQHJ	STONEBOW UNIT	Cantilupe	715 - OLD AGE PSYCHIATRY		713	764	1069.5	1947.5	713	425.5	496	1894.5	107.2%	182.1%	59.7%	382.0%
RTQHJ	STONEBOW UNIT	Jenny Lind	710 - ADULT MENTAL ILLNESS		713	759	356.5	422	356.5	356.5	356.5	448.5	106.5%	118.4%	100.0%	125.8%
RTQHM	OAK HOUSE	Oak House	710 - ADULT MENTAL ILLNESS		713	736	356.5	368	356.5	356.5	356.5	379.5	103.2%	103.2%	100.0%	106.5%

APPENDIX 3 SAMPLE DASHBOARD

APPENDIX 3 SAMPLE DASHBOARD



Agenda item 12 **Enclosure** **Paper G**

Report to: [2]gether Board Meeting – 28 September 2017
Author: Philippa Moore, Joint Director of Infection Prevention and Control
Marie Crofts, Director of Quality and Joint Director of Infection Prevention and Control
Presented by: Philippa Moore, Joint Director of Infection Prevention and Control

SUBJECT: **Annual Infection Prevention and Control Report 2016/17**

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

EXECUTIVE SUMMARY

- 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).

- Risks for healthcare associated infection remain low in the Trust.

Assurance

The paper provides evidence for assurance that the Trust is committed to maintaining high standards of infection prevention and control across all its services. This paper provides evidence of infection control related activity, monitoring and governance during 2016/17.

RECOMMENDATIONS

The Board is asked to:

- Note the Annual Infection Prevention and Control report
- Continue to support the infection prevention and control programme to minimise the risks of healthcare associated infection, as required by the Health and Social Care Act.

Corporate Considerations	
Quality implications:	Included in the body of the report
Resource implications:	External expertise in infection control is purchased from GHNHSFT and Gloucestershire Care Services NHS Trust. Provision of infection control services from Herefordshire is purchased from Wye Valley Trust.
Equalities implications:	None
Risk implications:	Low risk with continued support of the agenda

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

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

Reviewed by:		
A Curson	Date	

Where in the Trust has this been discussed before?		
IC Committee QCR Committee Governance Committee	Date	August 2017

What consultation has there been?		
Open to discussion with ICC members from	Date	

Explanation of acronyms used:	GHNHSFT – Gloucestershire Hospitals NHS Foundation Trust DIPC - Director of Infection Prevention and Control ATP - adenosine triphosphate MRSA – Meticillin Resistant Staphylococcus aureus MSSA – Meticillin Sensitive Staphylococcus aureus GRE – Glycopeptide Resistant Enterococci PLACE – Patient Led Assessments of the Care Environment WVT – Wye Valley Trust WEEB – Water, Environment, Equipment and Buildings group

1. INTRODUCTION

[2]gether NHS Foundation Trust ([2]gether) has a comprehensive programme of infection prevention and control which has supported declaration of full compliance with the Health and Social Care Act 2012: Code of Practice for health and adult social care on the prevention and control of infections and related guidance. This annual report from the joint Directors of Infection Prevention and Control (DIPC) provides documentation of how [2]gether has sought to prevent and control infection during 2016/17.

2. OVERVIEW OF INFECTION CONTROL ACTIVITIES DURING 2016/17

The 2016/17 year presented some infection prevention and control challenges, particularly around the MRSA outbreak on Willow ward (see section 4.4.3). In addition, three cases of C. difficile infection were detected during the year, two of which were reported to Herefordshire CCG as lapses in care due to concurrent audit findings of cleanliness issues on the Stonebow unit. However the Trust was particularly successful in achieving its target of over 75% of front line staff vaccinated against influenza.

3. DESCRIPTION OF INFECTION CONTROL ARRANGEMENTS

3.1 The infection prevention and control team

The role of Director of Infection Prevention and Control (DIPC) in [2]gether remains shared between the Director of Quality, Marie Crofts, as board lead, and Dr Philippa Moore, Consultant Microbiologist and Infection Prevention and Control Doctor. Louise Forrester continues as nursing lead within [2]gether for infection control. She is supported by specialist infection control nurses contracted from Gloucestershire Care Services and from Wye Valley Trust. There were no significant concerns during the year around service provision from contracted providers, (compared to previous years). Inpatient wards are visited regularly in both Herefordshire and Gloucestershire supplemented by regular telephone calls in order to proactively detect and act on any infection prevention and control issues.

The infection control agenda is delivered within the trust with the help and engagement of many infection control link practitioners and hand hygiene champions. There are well established good working relationships with inpatient units and estates and facilities, and community links continue to grow.

3.2 Reporting to the Trust Board

Infection Control has been at a low level of risk for some years and therefore there is exception reporting rather than regular formal reports. No formal reports were required to be submitted during the year 2016/17. The annual report for 2015/16 was presented to the Governance Committee and Trust Board in September 2016.

3.3 Infection Prevention and Control and Decontamination Committee

The infection prevention and control and decontamination committee (ICC) meets quarterly. Committee membership includes the Director of Quality, and Directors of Infection Prevention and Control, the Deputy Director of Nursing, the [2]gether infection control lead, the infection control teams from both Gloucestershire and Herefordshire. Representatives from Hotel Services and Estates and Facilities are regular attenders and other representatives attend according to the agenda. The committee monitors and oversees infection prevention and control and decontamination work in the trust providing assurance for the organisation that standards are being met for compliance with the Health and Social Care Act. The Water, Environment, Equipment and Buildings group (WEEB) reports to the Infection Prevention and Control and Decontamination Committee, as does the Infection Control Focus Group. There are countywide infection prevention and control forums in both Gloucestershire and

Herefordshire that provide links with infection prevention and control activities with other trusts in these counties.

3.4 Infection Control Focus Group

The infection control focus group is a subcommittee of the Infection Control Committee and meets monthly during those months when there is no infection control committee. This group is chaired by the 2gether infection control lead, Louise Forrester. The group is a forum in which staff can discuss any infection control concerns. This group is the main action group for infection control that presents the solutions to issues to the infection control committee or highlights where issues require further input to achieve resolution. Its agenda overlaps with that of the WEEB committee to provide efficiency of discussions on joint subjects such as cleaning, catering, waste disposal and other Estates related issues.

4. HEALTHCARE ASSOCIATED INFECTIONS Level of Assurance: Significant

4.1 MRSA

2gether participates in the national mandatory surveillance of MRSA bacteraemias (blood stream infections). During 2016/17 there were no MRSA bacteraemias detected from patients in Gloucestershire or Herefordshire.

Selective screening has previously been undertaken to detect MRSA colonisation of the nose or groin in susceptible individuals. Following an MRSA colonisation outbreak in Willow ward, this has now been changed to admission screening for all inpatients entering Charlton Lane Hospital and the Stonebow unit. An audit was undertaken 2016/17 to test compliance with policy elsewhere in the Trust inpatient units and this demonstrated some issues with a missed screen in the Montpellier unit but no undetected circulation of MRSA on the unit. Further audits on compliance with new policy are planned for the 2017/18 work plan year.

4.2 Clostridium difficile

2gether participates in the mandatory surveillance scheme for C. difficile infections.

During 2016/17 there were three cases of Clostridium difficile toxin positive infection in the trust. One case was detected 48 hours after admission for 2gether Gloucestershire to report. This case occurred at Wotton Lawn and a Root Cause Analysis was undertaken. Antibiotic prescribing was appropriate, no significant issues were identified and this case was considered unavoidable.

In Herefordshire a patient who had previously been in the Stonebow unit was found to be C. difficile toxin positive from a sample taken in Hereford County Hospital A&E in July 2016. Investigations within the Stonebow unit highlighted environmental and commode cleanliness issues which were rectified at the time. In view of the cleanliness issues this was reported to the CCG as a lapse in care (as per the Herefordshire CCG reporting requirements). In September 2016 there was another unrelated case detected in the Stonebow unit. Cleanliness was again highlighted as an issue on auditing the ward and this case was also reported as a lapse in care. In November 2016 a multidisciplinary meeting reviewed cases of C. difficile in the Stonebow unit. Training was also identified as an issue for the clinical teams and the Wye Valley infection control team provided additional education sessions around C. difficile for staff. Although cleanliness was highlighted as an issue twice during the year around these 2 cases, the trust has taken action in that hotel services provision is no longer being managed by Sodexo and is now under the supervision of 2gether. Since this transfer of responsibility improvements in cleanliness have been noted by staff.

4.3 Other bacteraemia surveillance (GRE, E. coli, MSSA)

In addition to MRSA there is established mandatory reporting of other organisms that cause bacteraemias, including E. coli and MSSA. There were no cases in Gloucestershire or Herefordshire during 2016/17.

4.4 Outbreaks and Incidents

4.4.1 Influenza

An Influenza outbreak occurred at Laurel House in January 2017. Initially a patient became unwell and was admitted to the acute trust with respiratory symptoms. Within 48 hours another inpatient became unwell with a flu-like illness. Over the following seven days a further 2 patients and 3 staff became unwell with influenza. The unit was closed for seven days with the loss of 3 bed days and the single confirmed patient case made a full recovery.

Eligible long term inpatients received an influenza vaccine if they had not received it from their General Practitioner.

During 2016/17 the trust achieved its target of vaccinating more than 75% of front line clinical staff.

4.4.2 Viral Gastroenteritis outbreaks

During 2016/17 there were 4 outbreaks of diarrhoeal illness requiring ward closure reported to the Gloucestershire infection prevention and control team, all proven to be due to Norovirus. Strict infection prevention and control measures were put in place.

HOSPITAL / UNIT	ORGANISM	DATE REPORTED	START DATE (first symptoms)	FINISH DATE (ward open)	DURATION	BED DAYS LOST	PATIENTS AFFECTED	STAFF AFFECTED
Willow Ward	Norovirus (proven)	04/04/16	03/04/16	12/04/16	8 days	8	9	7
Dean Ward	Norovirus (proven)	07/11/16	04/11/16	16/11/16	10 days	9	8	7
Dean Ward	Norovirus (proven)	06/03/17	05/03/17	17/03/17	10 days	9	7	4
Kingsholm	Norovirus (proven)	07/03/17	06/03/17	15/03/17	9 days	49	6	2
Total 2016/17					**37**	**75**	**30**	**20**
Total 2015/16					**14**	**3**	**10**	**9**
Total 2014/15					**25**	**24**	**28**	**32**

There were no outbreaks in ^{2}gether Herefordshire sites during 2016/17.

4.4.3. MRSA outbreak Willow ward

During August 2016 2 patients on Willow ward were found to be colonised with MRSA. Although control measures were put in place there was some debate over the advice given by the infection control team to staff. Over the course of the next 6 months a further 6 patients were detected with MRSA colonisation with the same isolate indicating cross-infection on the unit. The likely underlying cause was the fact that the initial 2 patients did not receive MRSA suppression therapy due to a misunderstanding of the preferred infection control management of these patients by the infection control team. This likely led to some environmental contamination, despite enhanced cleaning being in place, and cross-infection to other patients. A full outbreak was declared in December 16 at the time a further cluster of patients was identified and the ward closed. A full review of the incident was subsequently undertaken and highlighted good practice by the ward but a need for further education which has been addressed. Admission screening for MRSA was put in place for all wards in Charlton Lane and this will now continue.

HOSPITAL/UNIT	ORGANISM	DATE REPORTED	FINISH DATE	DURATION	BED DAYS LOST	PATIENTS AFFECTED
Willow Ward	MRSA	13/12/16	03/02/17	52 days	94	8

4.4.4 Other

During 2016/17 the Infection Control teams also gave advice for individual patients and issues on a wide variety of topics including: scarlet fever, glandular fever, gastroenteritis, C. difficile infection, hepatitis B, wound infections, influenza, shingles, ESBL urine infection, MRSA colonisation, as well as general enquiries related to estates and facilities such as environmental sewage contamination due to a leaking toilet in the Stonebow unit, cleaning, dishwasher breakdowns and equipment decontamination.

5. AUDIT

Level of Assurance: Significant

5.1 Inpatient area audits: Gloucestershire

The audit programme uses the Infection Prevention Society (IPS) Quality Improvement Tool (QIT) which states that scores of 85% or more are green, 84% or less red, with no intermediate category.

Location/Audit Scores	2013/14	2014/15	2015/16	2016/17
Honeybourne	93%	91%	96%	89%
Laurel House	Deferred	90%	97%	95%
Westridge	92%	80%	91%	95%
Hollybrook	92%	86%	93%	97%
Abbey Ward, Wotton Lawn	86%	91%	92%	90%
Dean Ward, Wotton Lawn	85%	91%	93%	85%
Greyfriars, Wotton Lawn	95%	97%	89%	90%
Kingsholm Ward, Wotton Lawn	91%	85%	93%	89%
Priory Ward, Wotton Lawn	88%	85%	95%	89%
Montpellier Ward, Wotton Lawn	92%	92%	88%	82%
Maxwell 136 Suite	84%	90%	89%	86%
Wotton Lawn Therapies (OT/Physio)	OT: 86% Physio: 87%	For 2015/16	OT 88% Physio: 89%	89%
ECT	96%	For 2015/16	97%	96%
Chestnut ward, Charlton Lane	81%	88%	90%	91%
Mulberry ward, Charlton Lane	85%	92%	93%	92%
Willow ward, Charlton Lane	82%	86%	92%	90%
Charlton Lane therapies (OT/Physio)			85%	92%

The issues identified on Montpellier unit included issues around training, cleaning, furniture replacement, and estates related repairs. The ward has taken action around all issues identified.

All areas of non-compliance in all audits resulting in low scores are followed up. Action plans to remedy problems are monitored and the areas are rechecked during subsequent clinical visits by the infection prevention and control nurses.

5.2 Outpatient Area Audits: Gloucestershire

Location/Audit Score	2013/14	2014/15	2015/16	2016/17
Albion Chambers	63%	86%	81%	
Park House	64%		87%	85%
Avon House	80%		86%	
Weavers Croft	64%	97%	90%	90%
Cirencester Memorial Centre		66%		79%
Denmark Road		86%	77%	
Brownhills		74%	88%	85%
London Road			73%	90%
Tyndale Centre			46%	70%
Colliers Court				95%
Field View				75%
Evergreen House				87%
Leckhampton Lodge				73%
Fritchie Centre				92%
Acorn House				84%
Stanway centre				80%
Lexham Pavilion				58%

The 2016/17 audit programme of community centres was the most comprehensive to date. As has been noted in previous years, units audited for the first time tend to have lower scores until they work up to the required standards.

Specific reasons for any falls in audit scores and the necessary rectification work were identified by the infection prevention and control team.

The infection control focus group and, where appropriate, WEEB (Water, Environment, Equipment and Buildings) group or infection prevention and control and decontamination committee oversees actions taken to ensure infection control compliance.

5.3 Audits: Herefordshire

The Herefordshire audit tool is also based on the IPS audit tool.

Location	Audit Frequency	2014/15	2015/16	2016/17
Jenny Lind- Ward	Annual	76%	87%	74%, re-audit 94%
Mortimer- Ward	Annual	84%	84%	91%
Cantilupe - Ward	Annual	66%	87%	93%
Day care	Annual	90%	88%	87%
ECT	Annual		87%	98%
Oak House	Annual	84%	90%	86%

Other community sites are audited 2 yearly and next due audit in 2017/18.

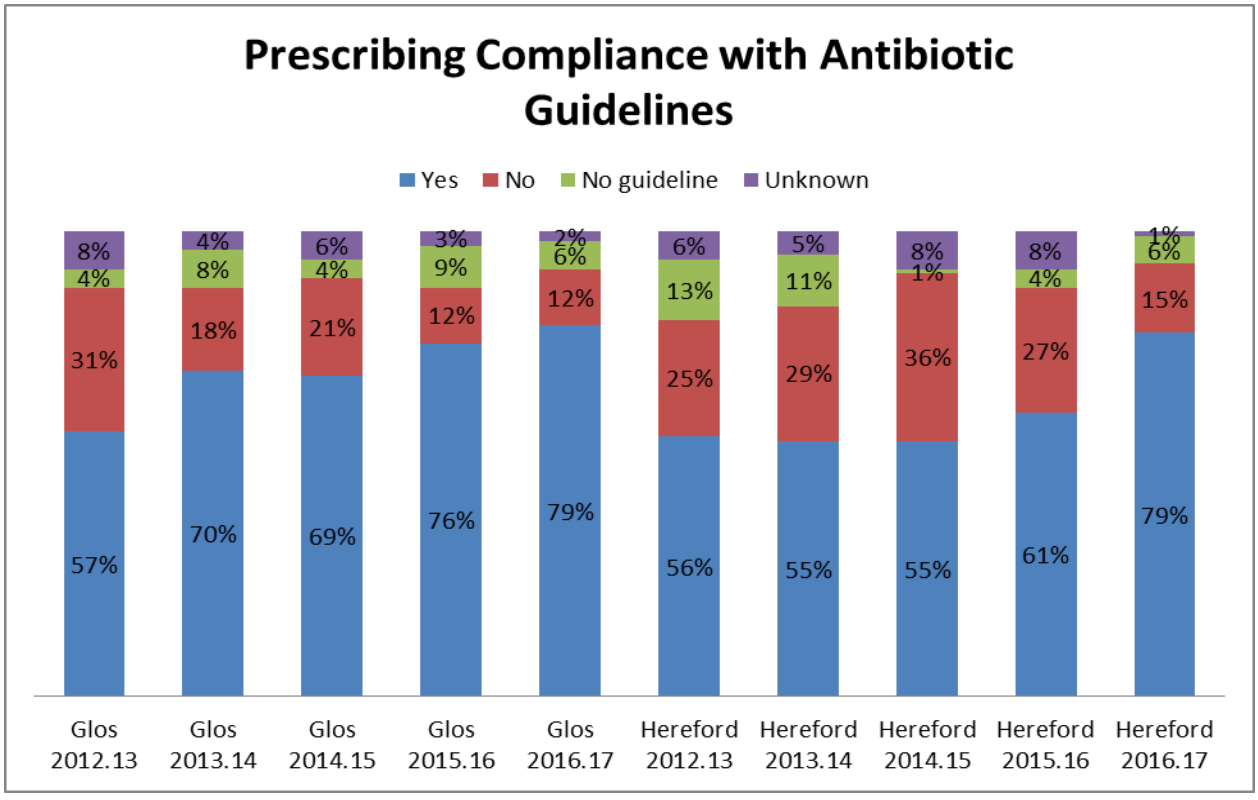
6. HAND HYGIENE **Level of Assurance: Significant**

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

7. ANTIBIOTIC STEWARDSHIP **Level of Assurance: Significant**

[2]gether keeps a database of all antibiotics prescribed for inpatients, established in July 2010 for Gloucestershire and in October 2011 for Herefordshire. Antibiotic guideline booklets are distributed to junior doctors and are available on line and provide prescribing advice for most common conditions.

Compliance is defined as the correct antibiotic choice for the indication, given via the correct route, at the correct dose for the correct duration. All elements must be correct before considering the prescription to be compliant. Compliance is also considered to be 'yes' if there is documentation of a reasonable rationale for prescribing off guideline, or prescribing on Microbiologist advice that might otherwise be different from the guidelines. Prescribing compliance has improved compared to last year, particularly in Herefordshire.



8. INFECTION PREVENTION & CONTROL EDUCATION **Level of Assurance: Significant**

During 2016/17 infection control education was delivered principally by both face to face training and by e-learning. Training figures improved compared to 2015/16.

December 2016 Non-clinical	**70%**
Clinical staff	**81%**

A more in –depth focus on compliance with training was examined more recently.

Training Compliance figures May 17

Wotton Lawn Hospital	
Ward	**Compliance**
Abbey	100%
Priory	77.3%
Kingsholm	100%
Greyfriars	97.2%
Montpellier	89.5%
Dean	90.5%
Charlton Lane Hospital	
Ward	**Compliance**
Willow	89.2%
Mulberry	95.8%
Chestnut	100%
Recovery Inpatients	
Ward	**Compliance**
Laurel House	92%
Honeybourne	100%
LD Inpatients	
Ward	**Compliance**
Berkeley House	89.4%
Stonebow Unit	
Ward	**Compliance**
Jenny Lind	100%
Mortimer	91.7%
Cantilupe	91.3%
Oak House	100%

Mandatory training is now being delivered with additional face to face training sessions given by specially trained ^{2}gether staff. The content of the sessions has been developed with infection control team input.

An infection control study half day was provided on 21st September 2016. Staff from both Herefordshire and Gloucestershire attended.

9. INFECTION CONTROL & ESTATES AND FACILITIES Level of Assurance: <u>Significant</u>

9.1 Departmental Structure

The Estates and Facilities Department, headed by Adrian Eggleton, Deputy Director of Estates and Facilities is structured into the following areas, each area under a specialist manager: Facilities; Estates; and Estates Project Management (2 x part time); The Department is under the overall leadership of the Director of Finance

The Estates and Facilities Department is responsible for the management of all catering and cleaning in the Trust, apart from two of the three recovery units and the one learning disability unit. Up to 30th June 2017 this included the oversight of the Sodexo Contract in Herefordshire, but this contract has now been brought in-house to more effectively manage quality and service change.

The Department reports to: Infection Prevention and Control and Decontamination Committee, Delivery Committee, Development Committee, Governance Committee, Health and Safety Committee, Capital Review Group, Patient Environment Action Groups (PEAG) and the Water, Environment, Equipment and Buildings (WEEB) Group. The latter is an operational group that covers the business areas of the Department, with strong representation from the Infection Prevention and Control professionals.

Estates and Facilities Information is available on a sharepoint site available through the Trust Intranet. This site is the repository for all plans, risk assessments, cleaning schedules, chemical safety data sheets and servicing, testing and inspection records. It is available to all staff. The quality and extent of the data available is constantly improving; in collaboration with users and contractors. It is proposed to reduce the information available on this site that commonly used, to improve its usefulness, whilst leaving servicing, testing and inspection records within the Lorne Stewart electronic web format and Wye Valley on-site log books.

Since Sumer 2016 there has been a discretionary spend freeze on Estates Maintenance, which has impacted on redecoration and re-flooring; unless they are part of a Capital Scheme. This discretionary spend Freeze extended to Site Department Estates budgets from January 2017; which has impacted on small estates projects and furniture replacement. This financial constraint is anticipated to continue; with an expectation that there will be deterioration in the décor of Trust premises.

9.2 Performance

PLACE is now in its fifth year and the 2017 assessments took place between March 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 are not yet publically available and therefore at the time of writing it was not possible to benchmark against like for like organisations, however comparison against the 2016 national average for Mental Health & Learning Disability units is shown in table 9.2a below.

Table 9.2a

2016	Cleanliness	Food	Privacy, Dignity and Wellbeing	Estates – Condition, Appearance & Maintenance	Dementia	Disability
2016 **National** Average	97.80%	89.70%	89.70%	94.50%	82.90%	84.50%
2017 **Trust** Average	97.21%	88.69%	97.55%	97.93%	97.53%	95.31%
Gain or Loss	Loss 0.59%	Loss 1.01%	Gain 7.85%	Gain 3.43%	Gain 14.63%	Gain 10.81%

Westridge was not assessed this year as the Trust leased the property to the Brandon Trust before the assessments began and will be selling the property late 2017. Of the six domains the Trust has improved on last year with some significant gains in Privacy, Dignity and Wellbeing and Condition, Appearance and Maintenance. This year there were marginal losses in Cleanliness and Food. The tartan rug (table 9.2b) below scores sites against the 2016 national benchmarks (green if the trust is above the score for the upper quartile and

amber if the trust scores between the national average and the upper quartile, red if the trust scores below the national average for 2016:

Table 9.2b

Site Code	PLACE Site Type	Cleanliness		Food		Privacy, Dignity and Wellbeing		Facilities	
WOTTON LAWN	Mental Health Only	2013	98.83%	2013	86.40%	2013	90.93%	2013	95.34%
		2014	99.28%	2014	96.38%	2014	97.55%	2014	96.84%
		2015	99.28%	2015	96.66%	2015	99.01%	2015	98.92%
		2016	100.00%	2016	94.14%	2016	96.91%	2016	98.17%
		2017	100.00%	2017	93.26%	2017	98.99%	2017	99.54%
CHARLTON LANE	Mental Health Only	2013	98.02%	2013	90.77%	2013	90.15%	2013	91.59%
		2014	99.33%	2014	95.85%	2014	98.51%	2014	99.17%
		2015	95.98%	2015	95.94%	2015	98.53%	2015	99.35%
		2016	99.72%	2016	93.16%	2016	93.15%	2016	99.28%
		2017	100.00%	2017	91.57%	2017	98.41%	2017	99.41%
LAUREL HOUSE	Mental Health Only	2013	98.84%	2013	85.47%	2013	88.89%	2013	89.00%
		2014	97.22%	2014	97.04%	2014	93.33%	2014	96.55%
		2015	99.82%	2015	93.40%	2015	94.44%	2015	96.32%
		2016	100.00%	2016	95.17%	2016	100.00%	2016	100.00%
		2017	100.00%	2017	94.00%	2017	100.00%	2017	99.63%
HONEYBOURNE, CHELTENHAM	Mental Health Only	2013	99.44%	2013	82.70%	2013	83.33%	2013	93.00%
		2014	100.00%	2014	96.59%	2014	89.66%	2014	99.18%
		2015	100.00%	2015	97.70%	2015	82.86%	2015	100.00%
		2016	99.21%	2016	91.58%	2016	96.55%	2016	99.58%
		2017	100.00%	2017	94.23%	2017	100.00%		100.00%
STONEBOW UNIT	Mental Health Only	2013	98.49%	2013	84.19%	2013	87.78%	2017	90.18%
		2014	97.51%	2014	90.03%	2014	97.35%	2014	99.21%
		2015	98.32%	2015	90.04%	2015	93.75%	2015	97.54%
		2016	99.89%	2016	79.76%	2016	95.89%	2016	93.82%
		2017	89.78%	2017	71.30%	2017	93.67%	2017	96.06%
OAK HOUSE	Mental Health Only	2013	97.30%	2013	n/a	2013	78.06%	2013	57.14%
		2014	100.00%	2014	n/a	2014	87.10%	2014	86.89%
		2015	93.16%	2015	n/a	2015	88.10%	2015	87.29%
		2016	92.26%	2016	n/a	2016	86.49%	2016	91.12%
		2017	79.87%	2017	n/a	2017	88.57%	2017	78.46%
HOLLYBROOK	Learning Disabilities Only	2013	93.79%	2013	76.67%	2013	92.80%	2013	89.62%
		2014	98.94%	2014	93.71%	2014	100.00%	2014	98.31%
		2015	100.00%	2015	83.41%	2015	86.90%	2015	96.92%
		2016	100.00%	2016	95.11%	2016	100.00%	2016	99.58%
		2017	100.00%	2017	90.72%	2017	100.00%	2017	99.59%
WESTRIDGE	Learning Disabilities Only	2013	96.07%	2013	91.56%	2013	84.17%	2013	87.04%
		2014	99.51%	2014	96.40%	2014	90.33%	2014	97.50%
		2015	99.90%	2015	95.04%	2015	94.59%	2015	100.00%
		2016	100.00%	2016	82.73%	2016	94.12%	2016	100.00%
		2017	closed	2017	closed	2017	closed	2017	closed

There were poor cleaning results for Stonebow this year with a drop in over 10% compared to last year. Whilst it is far from satisfactory it was expected as the PLACE assessment period coincided with the approach to the end of the contract with Sodexo which expired 30th June 2017. From 1st July 2017 all cleaning and catering services are now provided in house with the majority of existing Sodexo employees who are now 2gether employees following a TUPE process. 2gether now has control and influence over schedules, frequencies and standards and a higher cleaning score is expected next year. There were poor cleaning results for Oak House this year with a drop in over 12% compared to last year. The assessors reported that high dusting consistently failed in most areas of the building. This was due in part to an equipment issue which has now been resolved. An additional contributing factor is that the age of the internal and external decorations in this property makes it more difficult for cleanliness to be maintained without causing damage to the fabric of the walls, painted woodwork and carpets. On a site by site basis, five out of the seven sites achieved 100% for cleanliness which is a tremendous achievement. Overall as a Trust we performed well in the Cleaning domain achieving 97.2%, a 2.3% fall on last year's 99.5% which is due in part to the low cleaning scores at Oak House and Stonebow this year.

The Facilities score has been poor at Oak House for the past 5 years and the score this year is lower than last year by 12.6%. This is hoped to be addressed through capital resources secured by NHS Property Services; and the resultant revenue consequences financed by Herefordshire CCG, subject to resolution of the tenancy arrangements.

Disability was a new domain added in 2016. Overall as a Trust 2gether scored well achieving 95.31% which is a 4% improvement on last year. Honeybourne and Laurel House scored 100% with Hollybrook at 99%.

9.3 Catering and Cleaning

In the last 12 months the quality and performance of Sodexo has continued to fall significantly with recurrent issues highlighted within Infection Control audits. The decline in performance worsened towards the end of the contract. The contract with Sodexo was due to end on 30th March 2017 however a 3 month extension was requested by WVT to allow them to complete a tendering process. 2gether gave notice to WVT and Sodexo with no extension beyond 30th June 2017. An options paper was submitted to the Development Committee in September 2016 indicating options for the future of the catering and cleaning services in Herefordshire. The preferred option was to TUPE 11.07 WTE existing Sodexo staff into the Trust and manage them directly. 2gether also recommended the recruitment of an additional 4.89 WTE staff to manage seven day working, sickness, absence and shortfalls in the service. The paper was subsequently approved and a new Facilities Manager was successfully recruited in March 2017 to lead the transfer and implementation of the services in Herefordshire. This new post will manage and monitor the services at Stonebow, 27a St Owen Street, Widemarsh Street, Linden Centre, 62 Etnam Street, Rose Cottage, The Knoll and Oak House.

The Facilities department has commented on several Infection Control policies which has initiated an action to develop a post outbreak deep clean checklist which is now in use across all sites.

The Facilities department have an aspiration to switch to using microfibre flat mops as a means of cleaning floors in order to improve the patient environment and overall cleanliness. As part of the review stage there will be a trial at Charlton Lane hospital and the ATP swabbing system will be used to provide evidence based data for assessment of the system.

Cleaning and swabbing audits continue to take place on a monthly basis. A particular challenge around the collection of cleaning audits using the Credits for Cleaning (C4C) software has been the persistent software and Wi-Fi issues that have led to intermittent results; however sites have reverted to manual collection of results in the interim. [2]gether have served 12 months' notice on Pierce Management Services who own the rights to C4C and the trust is working with our partner NHS organisations in Gloucestershire to seek an alternative system. Sodexo were tasked with swabbing the ward areas at Stonebow but despite efforts have failed to deliver a full years collection of results as they were not contracted to perform this task. [2]gether ward staff have now taken over this function from Sodexo.

In Herefordshire Sodexo reports cleanliness audit scores:

MONTHLY AUDITS STONEBOW	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2013/14	96%	98%	99%	97%	99%	99%	96%	99%	98%	95%	98%	99%
2014/15	99%	99%	99%	99%	99%	99%	99%	99%	99%	98%	99%	99%
2015/16	99%	98%	98%	99%	98%	99%	99%	95%	98%	96%	90%	88%
2016/17	94%	95%	92%	93%	91%	92%	93%	96%	nil	nil	nil	nil

TWO MONTHLY AUDITS	**Apr-15**	**Apr-16**	**Jun-15**	**Jun - 16**	**Aug-15**	**Aug -16**	**Oct-15**	**Oct-16**	**Dec-15**	**Dec -16**	**Feb -15**	**Feb -16**
ETNAM ST	100%	98%	100 %	96%	100 %	100 %	96%	98%	100%	nil	92 %	nil
ST OWEN'S STREET	97%	98%	100 %	95%	100 %	98%	94%	97%	93%	nil	94 %	nil
THE KNOLL	100%	100 %	100 %	100 %	100 %	98%	100 %	100 %	100%	nil	100 %	nil
ROSE COTTAGE	100%	100 %	100 %	97%	100 %	100 %	97%	97%	97%	nil	98 %	nil

Cleaning audit scores for Gloucestershire are as follows and data collection this year has improved from last year's 58% of data returned to a 97% return.

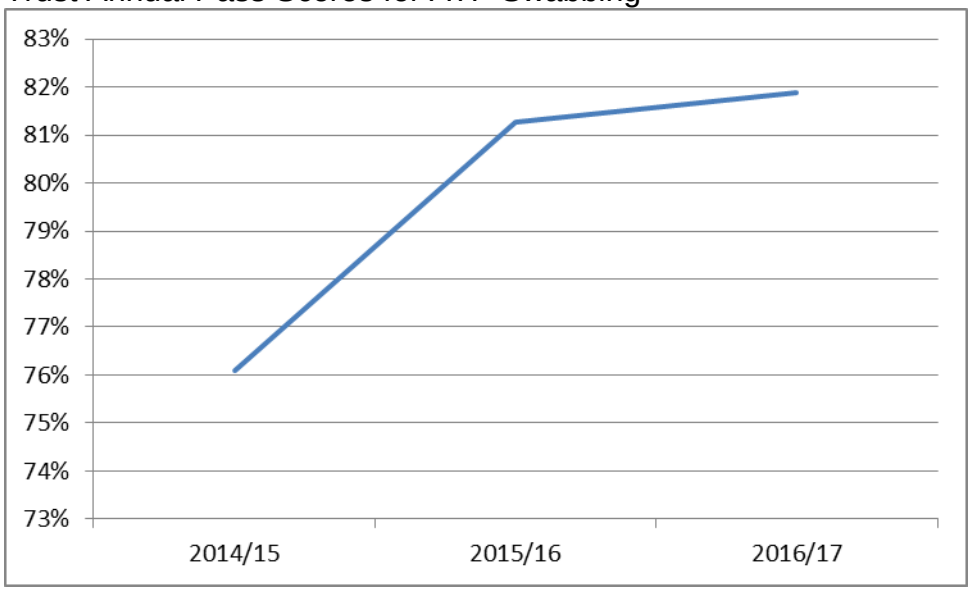
MONTHLY AUDITS	**Apr 15**	**May 15**	**Jun 15**	**Jul 15**	**Aug 15**	**Sep 15**	**Oct 15**	**Nov 15**	**Dec 15**	**Jan 16**	**Feb 16**	**Mar 16**
CHARLTON LANE 2015/16	nil	nil	93%	90%	94%	92%	94%	94%	92%	94%	nil	nil
CHARLTON LANE 2016/17	nil	96%	94%	95%	97%	96%	95%	96%	98%	97%	96%	96%

MONTHLY AUDITS	**Apr 15**	**May 15**	**Jun 15**	**Jul 15**	**Aug 15**	**Sep 15**	**Oct 15**	**Nov 15**	**Dec 15**	**Jan 16**	**Feb 16**	**Mar 16**
WOTTON LAWN 2015/16	nil	nil	96%	98%	97%	97%	nil	96%	93%	96%	98%	99%
WOTTON LAWN 2016/17	96%	94%	94%	97%	97%	99%	97%	100 %	99%	95%	95%	96%

Data from ATP swabbing supplements assurance around cleaning processes.

ATP swabbing has improved this year and is becoming more embedded as training has been rolled out and refreshed. On a quarter by quarter basis an improvement in pass rates from 88% in Q1 to 90% in Q2 was seen. The results in Q3 88% and Q4 81% are lower than anticipated but can be explained in part due to the low scores at Stonebow, thought to be a timing issue. The newly trained ward staff did not fully appreciate that in order for the surface test to be effective it must be done as close to the time of cleaning as possible. Freeing up HCA time to swab after cleaning has taken place has proved to be difficult, and this function will therefore be moved to the Facilities team once they are at full establishment. The appropriate staff group is notified of all areas or items that fail ATP swabbing to ensure feed back to the staff who clean, and so that the area or item is recleaned. The data below includes both the environment and patient equipment for all inpatient sites.

Trust Annual Pass Scores for ATP Swabbing



Food Hygiene – Apart from Oak House and Hollybrook, all Trust sites were subject to unannounced visits this year by their respective Environmental Health Officers (EHO) and all sites were awarded the maximum of '5' on the six tier food hygiene rating scheme. Of particular importance this year was the fact that Honeybourne succeeded in maintaining their food hygiene rating at the same high level.

In addition to the EHO inspections, the Trust commissions an external annual audit of all catering premises, which is to a higher standard than EHO inspections. Those audits were due in July this year however the company have decided to discontinue this service and revert to their core business so an alternative provider is being sought.

[2]gether NHS FT Food Hygiene Ratings as at 21st June 2017

Site	Latest Food Hygiene Rating	Date Of last Inspection	Inspection Risk Category	Inspection Frequency
Honeybourne	5	16/06/2017	C	Every 18 Months
Wotton Lawn Greyfriars Ward	5	10/01/2017	D	Every 2 Years
Brownhills Centre	5	02/11/2016	D	Every 2 Years
Westridge	5	15/09/2016	D	Every 2 Years
Wotton Lawn Hospital	5	12/07/2016	D	Every 2 Years
Charlton Lane Hospital	5	19/05/2016	D	Every 2 Years
Laurel House	5	25/04/2016	D	Every 2 Years
Stonebow Unit	5	22/03/2016		
Oak House	5 (AES)*	27/05/2015	E	Every 3 Years
Hollybrook	5	24/04/2015	E	Every 3 Years

*AES – **A**lternate **E**nforcement **S**trategy – the FSA national code of practice identifies Oak House as 'low risk' which allows local authorities to adopt alternative methods. Future inspections are not guaranteed.

9.4 Estates and Maintenance

In Herefordshire all planned and reactive maintenance is managed by Wye Valley NHS Trust except for work at Oak House, Belmont, and Widemarsh Street; these premises are maintained by Mitie, under contract to NHS Property Services.

In Gloucestershire all planned and reactive maintenance is managed operationally by Lorne Stewart.

Both Wye Valley Trust and Lorne Stewart have achieved 100% compliance on Statutory and Mandatory maintenance throughout 2016/17.

The Mitie / NHS Property Services Ltd arrangement commenced on 1st April 2016. Unfortunately up to the 30th June 2017 they had not demonstrated that they were undertaking any maintenance. Consequently a step-in intervention, in agreement with the Trust's Authorised Engineer - Water Management took place at the end of August 2016 to provide compliance. On the 30th June 2017 NHS Property Services Ltd were able to demonstrate

compliance had been taking place since January 2017, and the temporary arrangement was ceased.

9.5 Building Improvements

During 2016/17 the Trust's spent £7,193,220 of its Capital Programme on the Trust Estate, which is a £2,515,960 increase on the previous year. The Programme areas of expenditure are outlined in the following table:

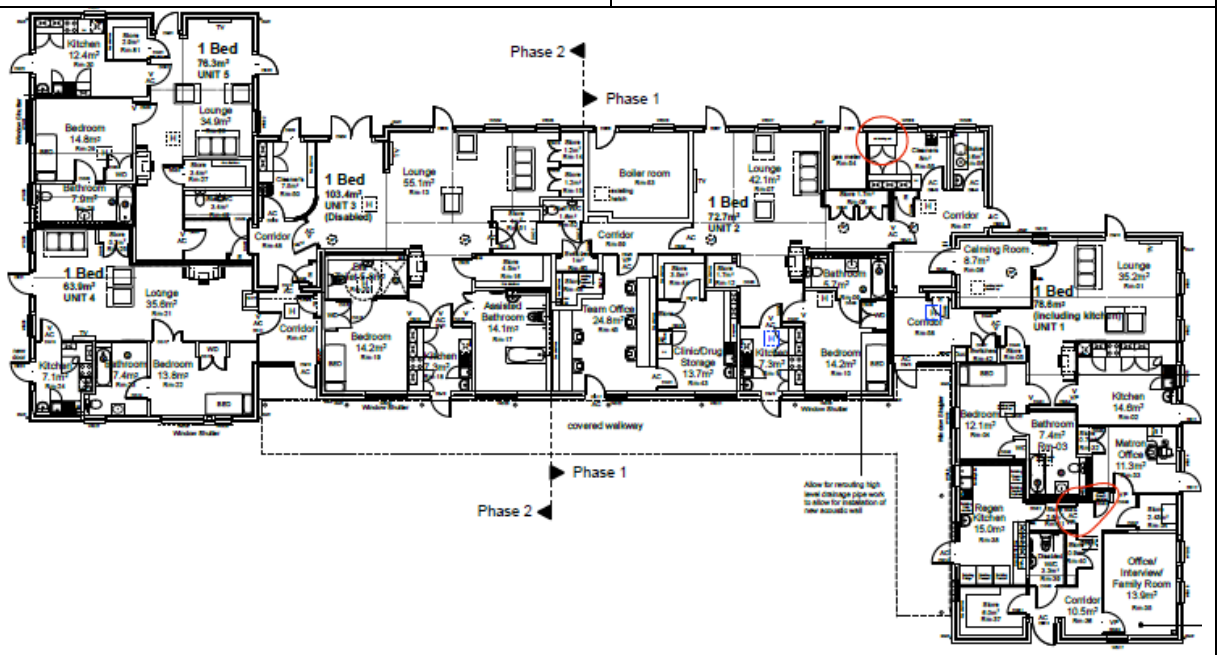
Programme	**2016/17 Spend on the Estate**
Gloucestershire Major Capital	£6,075,310
Herefordshire Major Capital	£112,320
Minor Capital Improvements	£402,570
Fire Precautions	£18,170
Health and Safety	£58,590
Security	£30,230
Patient Safety	£65,070
Estate Infrastructure	£296,820
Miscellaneous	£133,880
Total	**£7,193,220**

Capital funding is only available if it meets one or more of the following criteria:

- How it Improves the Clinical Environment or Safety
- How it Addresses Capital Asset end of life
- How it leads to financial savings

Infection Control advice is sought on capital projects, with some projects arising as a consequence of Infection Control inspections and in some cases Infection Control inspections brought forward to inform an upcoming project. The following projects illustrate some which had an Infection Control component:

Project	
Pullman Place The purchase and refurbishment of Pullman Place, leading to the closure of inappropriate and poor accommodation in 44 London Road, 18 Denmark Road, Albion Chambers, Burleigh House and Fieldview. The project is underway and programmed to be fully operational towards the end of 2017.	

<table>
<tr><td>  </td><td>  </td></tr>
<tr><td>LD inpatients Hollybrook</td><td>Conversion of four, two-bed flats into five one bed units; leading to the closure of Westridge as an inpatient unit.</td></tr>
<tr><td colspan="2"> 
</td></tr>
<tr><td>Tyndale Infection Control Works

Wall repairs, re-flooring and redecoration works to improve control of infection</td><td>  </td></tr>
</table>

Stonebow De-escalation suite

The creation of an additional en-suite bedroom and a de-escalation suite on Mortimer Ward

Montpellier Unit Showers & Bath

The only remaining non en-suite inpatient bedrooms in Gloucestershire are the 12 beds in the Montpellier unit. This project is on hold awaiting a decision by the commissioner on Low Secure units. However it was possible to increase the provision from 1 bath and 2 showers to 1 bath and 4 showers in the location that en-suites could be provided in the future, enhancing the washing and toilet facilities available for long stay patients.

9.6 Water Management

The Trust's independent Authorising Engineer for water management undertook audits of the water management systems during July 2016 and February 2017.

The Trust is in the process of monitoring bacterial and microbial population of the Charlton Lane water system. 6 months monitoring has been undertaken with the chlorine dioxide plant on, and now the effectiveness with the system turned off is being monitored in order to

minimise micro dosing of potable water. The schedule was agreed with the DIPC and the Authorising Engineer.

A new flushing record has been developed following the Authorising Engineer's recent audit which will be launched in Q2 of 2017/18. All Water Risk Assessments across the Trust are up to date.

All persons within the Trust water management hierarchy have been formally appointed in writing and accepted; except for the Approved Person in NHS Property Services (confirmation of identity awaited). This is in line with the Recommendations of the HSE Approved Code of Practice (ACOP) L8 and Health Technical Memorandum (HTM) 04 – Safe Water in Healthcare Premises.

10. CONCLUSIONS

[2]gether NHS Foundation Trust continues to control the risk of healthcare associated infections, and is improving antibiotic stewardship. Patients, visitors and the Trust can be confident that appropriate work is ongoing to minimise the risk of healthcare associated infection in [2]gether and that the risk of acquisition of a healthcare associated infection within the Trust remains low. This provides details significant levels of assurance for all areas covered by the infection prevention and control programme.

Dr Philippa Moore and Marie Crofts
Joint Directors of Infection Prevention and Control
10th August 2017

Agenda item 13 **Paper H**

Report to: Trust Board – 28 September 2017
Author: Alison Curson, Deputy Director of Nursing &
Louise Forrester, Lead Nurse & Marie Crofts Director of Quality
Presented by: Marie Crofts, Director of Quality

SUBJECT: **NICE (2013) PH 48 Smoking Cessation in Secondary care: acute, maternity and mental health services – implementation update**

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

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

EXECUTIVE SUMMARY

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

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

The project board has a number of work streams including training; staff engagement; estates and treatments. Largely implementation of smoke free with a robust policy has been well accepted and positively received. The nature of such a culture shift is that it is best described as a 'journey' to smoke free – as advised by the SW Public Health England (PHE) lead.
Currently work is progressing well. We continue to engage with staff and service users and have a number of service users on the project board. We have seen no significant rise in aggression /violence related to smoke free implementation. There are a number of risks and challenges which include:

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

RECOMMENDATIONS

The Trust Board:

- notes the progress to date with smoke free implementation
- notes and endorses the implementation date of January 2018 within Herefordshire services
- notes the current risks and challenges and mitigation in place

Corporate Considerations	
Quality implications:	Implementation of NICE guidance is a quality and contractual requirement of NHS organisations.
Resource implications:	No resource requirement is stated within this paper. However additional capacity may be needed to support implementation.
Equalities implications:	The implementation of this guidance will be subject to an equality impact assessment – related work is fully inclusive of all demographic groups.
Risk implications:	A range of risk and issues are stated within the paper.

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	

Reviewed by:		
Marie Crofts, Director of Quality	Date	*18th Sept 2017*

Where in the Trust has this been discussed before?		
	Date	
Smoking Cessation Project Board		Monthly

What consultation has there been?		
	Date	

Abbreviations	
BMJ	British Medical Journal
CQUIN	Commissioning for Quality & Innovation
DH	Department of Health
JNCC	Joint Negotiating and Consultative Committee

Abbreviations	
NICE	National Institute for Health and Care Excellence
NRT	Nicotine Replacement Therapies
PHE	Public Health England
QI	Quality Improvement
CNO	Chief Nursing Officer
NHSE	NHS England

1. Introduction

1.1. The Trust has previously agreed the implementation of NICE (2013) PH48 Smoking Cessation in Secondary care: acute, maternity and mental health services, which we began implementing from 3 April 2017. 2gether sites within Gloucestershire became smoke free with the launch of the revised smoke free policy from that date. This report provides an overview of the smoke free implementation to date including milestones achieved, together with current challenges and risks.

1.2. To support our implementation the Trust was asked to participate in a national NHSE and PHE forum looking at sharing good practice and overseeing smoke free implementation across mental health Trusts. This is part of the Chief Nursing Officer's (CNO) 'Lead to Add Value' framework.

2. Context

2.1. Smoking levels within the UK general population currently stand at 15.5 %; the lowest since records began. However over 200 deaths every day are still caused by smoking. For those that use mental health services, the prevalence remains at over 40 %. These high rates of smoking exacerbate the health inequality already experienced by those with mental illness. The largest positive impact on the health of people with mental health problems will come from increasing the focus on their smoking behaviour and through the routine provision of smoking cessation support.

2.2. The previous Trust systems and practices did not promote and support smoking cessation, harm reduction or temporary abstinence adequately. The NICE guidance requires a comprehensive structure to be in place to support smoking cessation.

2.3. The Department of Health publication in July 2017, 'Towards a smoke free Generation – A Tobacco Control Plan for England' states:

'*People with mental health conditions have an equal right to be asked whether they smoke. They need to be offered effective methods to quit smoking or reduce harm as part of their care plan and there is an urgent clinical need to improve the support they receive. In some instances, healthcare staff will escort patients on and away from hospital grounds to smoke. This practice is outdated. It reduces the resources available to deliver clinical care and causes direct harm to patients'.*

2.4. The guidance aims to support smoking cessation, temporary abstinence from smoking and smoke free policies in all secondary care settings.

2.5. Public Health England published a document in 2016 entitled: 'Smoke free mental health services in England: Implementation for providers of mental health services' and recent government guidance to support implementation has been developed providing information and lessons learnt from those Mental Health Trusts who have fully implemented NICE PH48. Reports state:

'As with all projects of this scale and importance, a well-defined and tested project management approach is crucial. Realistic timescales, identification of key milestones, communication, monitoring and evaluation are all crucial to ensure that, "Smoke free policy implementation is a process not an event".'

2.6. The Trust's smoke free implementation date was initially set for October 2016; however following information and feedback from other mental health Trusts this was postponed until April 2017.

2.7. A paper outlining the costs associated with this project was presented at the Executive Committee in October and November 2016 and the costs associated with potential NRT use and training were acknowledged. Close liaison with PHE in Gloucestershire has been taking place in order to support access to NRT via community quit smoking services. There has been no progress regarding resources from PHE to access NRT for our inpatients. Discussion between the Trust and PH Gloucestershire are continuing.

2.8. This paper details the specific work and achievements to date of the Smoking Cessation Project and identifies the main risks and issues to the project.

3. Project Work Streams

3.1. The self-assessment tool which supports the NICE guidance on smoking cessation in secondary care (PH48) provides a framework to help mental health trusts to develop local actions to reduce smoking prevalence and the use of tobacco within secondary care settings. This framework provided the project with areas in which to form work streams and the basis on which to form the project.

3.2. Initially the project was divided into 5 work streams, with leads, as shown below:

	Work Stream
1	Communication
2	Staff Engagement
3	Support Systems
4	Training
5	Treatments

3.3. Following implementation of smoking cessation in Gloucestershire in April 2017, the project was reviewed and two additional work streams were identified and have been formed to ensure the efficient implementation for Phase 2:

	Work Stream
1.	Estates
2.	Herefordshire

3.4. Each of the work streams is documented in the sections below; detailing milestones achieved since the last Trust Board report in January 2017, together with on-going and future work required to fully achieving smoke free status within the Trust.

4. Communication Work stream

4.1. The purpose of this work stream is to contribute to the creation of a smoke free environment within the Trust by communicating to staff, service users and all stakeholders the work of the project, together with the benefits of becoming a smoke free organisation. Work stream milestones achieved within this reporting period include:

Smoke Free Signage & Banners

4.1.1. The smoke free signage on the entrances to all site buildings in Gloucestershire is almost complete. (Cirencester Memorial site is a listed building, so signage has been delayed whilst planning approval has been agreed.)

4.1.2. Large smoke free banners have been erected outside Wotton Lawn and Charlton Lane Hospitals.

Literature

4.1.3. Staff received a smoke free information leaflet, together with their salary advice slips, at the beginning of the year. Information leaflets aimed at service users and carers were distributed across all sites within Gloucestershire in preparation for the smoke free implementation. A new A5 flyer has recently been distributed Trust wide, giving the key facts about smoking and advice on how to quit.

Smoke Free Lanyards

4.1.4. All smoke free champions within the Trust have been provided with a lanyard to promote their position and to ensure they are easily recognisable to support staff during an attempt to quit smoking.

Good News Stories

4.1.5. We are encouraging anyone who has good news stories to post them on the intranet site for others to see and share. This has had a positive response.

On-going work

4.1.6. A plan for Herefordshire signage is currently being developed as the implementation date for smoke free in the County has now been agreed as January 2017. This date is behind the launch in Gloucestershire owing to access to NRT and community 'quit' resources. Colleagues within our Herefordshire services have still taken every opportunity to support people to quit as part of the 'Making Every Contact Count' agenda.

4.1.7. On-going communication will be provided to staff, service users and carers via the Trust's intranet and Internet sites.

5. Staff Engagement

5.1. The main purpose of this work stream is to contribute to the creation of a smoke free environment within the Trust by implementing a strategy and plan to support staff and develop smoke free culture

5.2. Prior to the smoke free implementation in April, a range of staff engagement exercises were undertaken which included staff surveys and staff engagement forums. Staff were able to share their concerns and issues. The main concerns raised were how staff could access support to quit smoking and how to clinically manage patients who smoke and who may present a challenge if stopped.

5.3. To alleviate staff concerns in these areas, the Trust undertook the following initiatives.

5.3.1. The revised policy included clear guidance around the use of unofficial smoking breaks, which had become routinely accepted across the Trust. The policy states that all staff should adhere to the 'Working Time Directive' which includes regulation on staff breaks. This is a change in culture for staff who smoke and the project team have been supporting staff alongside HR and staff side.

5.3.2. The Trust has trained a number of staff to become Level 2 Quit Advisors and it has been agreed at a local level that these advisors can support staff as well as service users in a smoke free quit attempt. This includes providing a voucher which can be used as a prescription to obtain NRT products from local pharmacists.

5.3.3. The Level 2 Quit Advisors have supported a considerable number of staff who wish to quit smoking. (Anecdotally, there has been 12 staff at Charlton Lane Hospital who participated in a quit attempt with the support of a Level 2 Quit Advisor.) .

5.3.4. Staff concerns about managing any incidents of violence and aggression relating to smoking have been addressed and discussed in training, team meetings and ward managers' meetings. The message from PHE SW lead directly to our staff suggested that smoke free implementation needs to be viewed as a 'journey' for staff and service users. As such we need to keep influencing the culture and moving slowly in the direction of travel we want to achieve. This means for instance that there may be some service users who continue to smoke within the grounds during the early days of implementation. We are not in any way advocating using any form of restraint to stop a service user smoking. Our approach is one of working with people to support improving their physical health by quitting smoking.

5.3.5. Any smoking-related incidents are reported on 'Datix' (incident reporting system) and these reports are reviewed and monitored by the Project Board on a monthly basis. To date, we have not seen any significant increase in the number of incidences of violence and aggression that directly relate to the smoke free implementation. .

5.3.6. Training and increased knowledge of nicotine addiction and withdrawal will assist staff in understanding and managing challenging situations.

5.3.7. Since the introduction of the Smoke Free Policy, the project lead, together with the Staff Engagement work stream lead, has visited a number of inpatient sites to engage with staff at all levels and to discuss the challenges and impact of the smoke free implementation.

5.3.8. The project lead, together with members from the Staff Engagement Work Stream plan to conduct staff focus groups as another opportunity for staff to feedback directly their experiences of the first six months of the smoke free implementation. It is hoped that this information will then help shape further training and future development of the smoke free implementation.

5.3.9. The membership of the Project Board was revised in April 2017 and now includes a staff side representative, and a wider representation of services users which has been welcomed.

5.4. Our focus to date has been primarily to direct staff engagement within inpatient units; however moving forward we will now expand this to community staff.

6. Support Systems

6.1. The Support Systems Work Stream focussed initially on the development of the smoke free policy which was ratified by the JNCC in March 2017 and formally adopted in April 2017. National guidance relating to smoke free within mental health services is being reviewed on a regular basis and will be incorporated in the Trust's policy on an on-going basis and as soon as it becomes available. This work stream seeks to now support outcome measurement of smoke free implementation.

6.2. Work Stream milestones achieved to date include:

6.2.1. **CQUINS** - There are two national CQUINS (2017/18 and 2018/19) which target physical health within mental health which encompasses smoking cessation which have a number of measures attached to each payment of the CQUIN. We have achieved all requirements for Quarter 1 and are well placed for full achievement of these CQUIN's during 2017/18.

6.2.2. The Physical Health recording form on RiO was modified in July 2017. The most recent data audited for Quarter 2 of the CQUIN demonstrated that 91% of admissions had their smoking status recorded, with 40 % of those admissions being smokers. (49 % of admissions to Wotton Lawn were identified as smokers.)

6.2.3. **Mental Health Act Detentions** - The Project Board is monitoring the number of monthly Mental Health Act detentions to ascertain if there is any increase compared to last year's number of detentions and what if any impact the smoke free policy has had on detentions.

Datix Reports

6.2.4. Although from the current data we believe that the number of smoking related incidents is not increasing (when compared to last year) we are closely monitoring these at the project board each month. Each incident is analysed to determine the exact nature and ensure the incident has been recorded correctly i.e we have had some incidents recorded as 'smoking - related' when this was not a result of implementation of the smoke free policy.

6.2.5. A recent article in the British Medical Journal (BMJ) analysing violence and aggression within a smoke free mental health hospital showed a no change and in some cases a decrease in physical violence after the implementation of a smoke free policy which is in accordance with most previous studies.

Experts by Experience

6.2.6. During the initiation stage of the project, two 'experts by experience' worked closely with the project team, took part in project meetings and appeared in our video made to promote the Trust's smoke free status. Now, in Phase 2, the project will benefit from having three new 'experts by experience' who have recently joined the team (one person recently attended a Project Board meeting).

6.3. Although we have some resource in terms of project management and a designated lead for implementation of the smoke free plan there is still a significant amount of work to

keep on track. Some Trusts have a full time dedicated smoke free lead and we may need to determine any additional resource required in the coming months.

7. Training

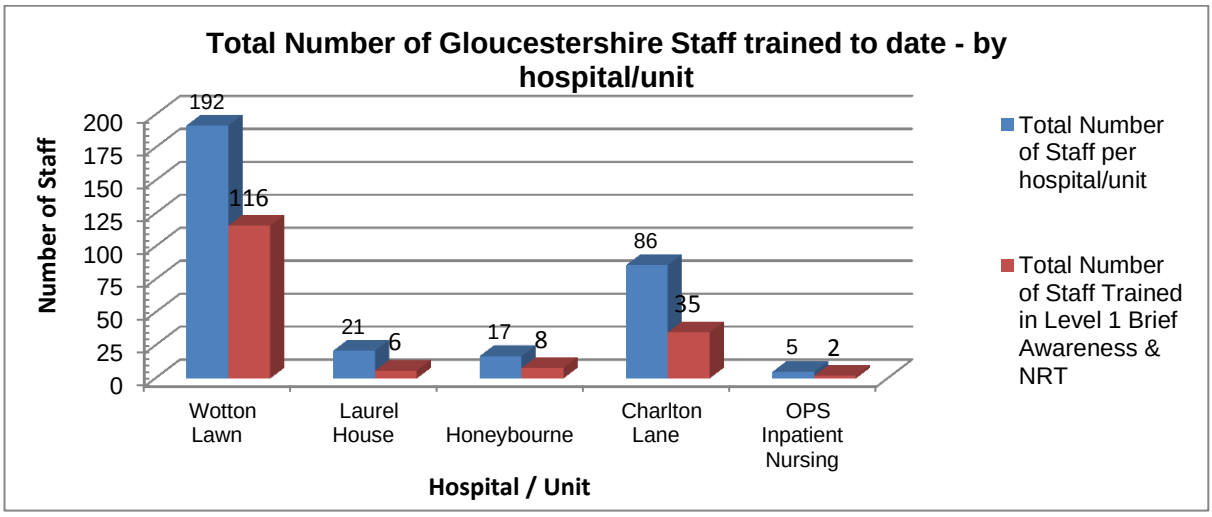
7.1. The purpose of this work stream is to deliver a training strategy and plan that equips all staff to manage and support the creation and delivery of a smoke free environment.

7.2. Prior to the implementation date of smoke free, it was identified and agreed that:

- All inpatient clinical staff with patient contact would have training at Level 1 smoking cessation. This training was to take 1 hour and provide staff with brief interventions and signposting for those who wish to quit.
- All registered nurses within the inpatient units would then need to undertake an additional 1 hour training relating to NRT which would give them the knowledge to assess and administer NRT within 30 minutes of a patient's admission.

7.3. This training commenced in January 2017 within Gloucestershire, focussing on Wotton Lawn, Charlton Lane and the Recovery Units. Following feedback from attendees and the trainer, it was decided to incorporate both the Level 1 training and NRT training into one training session which all clinical staff would attend. Staff who had attended the training believed that knowledge around NRT products was important to all clinical staff. Unfortunately, wards are struggling to release staff for training and numbers are not where we initially forecasted. However the work-stream lead has worked with ward managers to determine the most appropriate delivery method to increase training uptake.

7.4. To date, the total number of Gloucestershire clinical staff across our inpatient units, trained in Level 1 (Brief Awareness and NRT) is **167** (52%), against the training trajectory forecast of 225. The following chart shows the total number of Gloucestershire staff trained to date, split by hospital/unit.



7.5. As a result of the latest Smoke Free Project Board, a decision has been made to implement smoke free in Herefordshire from 8 January 2018 and a training programme is being scheduled from September 2017.

Level 2 Training

7.5.1. It is recommended that all inpatient clinical areas have a minimum of two Level 2 trained staff. The Level 2 advisors' role is to offer additional support to those who do want to quit smoking. The Level 2 advisors provide the ongoing behavioural support and ensure the continuing provision of NRT.

7.5.2. In total there are **24** Level 2 Quit Advisors across the Trust to date, although some of these staff received the training in 2015 and require refresher training now as this is recommended annually. There are challenges in staff receiving the refresher training owing to the providers who allocate places. The Director of Quality is discussing this with Public Health Gloucestershire who commission this service.

7.6. The training programme has been monitored and reviewed, and a number of alternative training methods have been recommended. These include providing training:

- At ward/unit 'Away Days'
- At shift handover sessions
- As part of the Local Induction process
- As E-learning

7.7. Future work will include the use of additional training models and methods following on from work undertaken by the Project Team using the quality improvement (QI) approaches and methodologies. Driver diagrams have been developed to aid implementation which will be reviewed through the Project Board.

8. Treatments

8.1. This workstream will produce guidelines for the management of related medicines. It includes the creation of decision algorithms to assist in the selection of appropriate medicines.

8.2. Work Stream milestones achieved to date include:

Guidelines for the management of related medicines

8.2.1. The UK Medicines Information document 'Which Medicines need dose adjustment when a patient stops smoking' was circulated by the Head of Profession for Medicines Management for 2gether to all wards, non-medical prescribers and community services managers and medics. It details cigarette smoking and interactions with medication and appropriate management.

Algorithm: 'Achieving a hospital non-smoking environment'

8.2.2. A decision algorithm has been created as part of the smoke free policy for achieving a hospital non-smoking environment. The algorithm focusses on the pathway from patient admission through to discharge and includes NRT guidance.

NRT

8.2.3. Patients who are admitted to the inpatient units are to be assessed and offered NRT products within 30 minutes of admission. Registered nursing staff can administer NRT under 'homely remedies' for 48 hours and then this requires prescribing by medics. To

ensure that patients do not have to wait for NRT products these are stock items across wards within Gloucestershire. From October 2017, NRT products will also be available as stock items within Herefordshire.

8.2.4. Initial costings of NRT products were estimated based on the number of patients who smoked. This was estimated to be in excess of £170K. The uptake of NRT to date has been very low (this has also been the experience of other MH trusts that have become smoke free).

8.2.5. It is believed that the uptake of NRT is low as this is the beginning of our smoke free journey and that the culture of smoke free needs to be further embedded and not just badged as banning smoking within the hospital and its grounds. In addition several patients are already vaping or choosing this method of reducing cigarette smoking rather than NRT.

Vaporisers and E-cigarettes

8.2.6. Stopping smoking is not easy and many smokers are turning to e-cigarettes to help them in their quit attempts. In 2016 it was estimated that 2 million consumers in England had used these products and completely stopped smoking and a further 470,000 were using them as an aid to stop smoking.

8.2.7. The latest evidence published by Public Health England (PHE) in 2015 found that, based on the international peer-reviewed evidence, vaping is around 95% safer for users than smoking.

8.2.8. The Department of Health continue to monitor the impact of regulation and policy and will continue to provide smokers and the public with clear evidence based and accurate information on e-cigarettes. This year's Stoptober campaign will feature e-cigarettes as a way to support this. www.bbc.co.uk/news/health-41339790

8.2.9. Currently patients can vape outside but not within Trust buildings. There appears to be no standardisation across mental health hospitals who are already smoke free about the use of vapes - with some Trusts advocating their use and even providing e-cigarettes on admission, to other Trusts condoning their use. As part of the national reference group it will be helpful to share experiences and challenges across organisations.

8.2.10 Currently there is only one Vape available on prescription and feedback is that this is of a poorer quality than newer models current so users are not keen to use this. Therefore at this time, the Trust will not be recommending this on prescription, although it is envisaged that this will change in the near future.

8.2.11 The Trust is looking to develop a pilot project in one ward /unit which will seek to introduce funded vaping for a short period of time to support service users to quit and demonstrate this improves not only their health but their wealth.

8.2.12 It appears that nationally the issue of vapes and e-cigarettes is the most asked question among mental health Trusts suggesting clear guidance required would be helpful.

9 Estates

9.2 An estates work stream has recently been established given the focus needed on the built environment to support the smoke free journey.

9.3 The historic image of mental health services is strongly associated with smoking. Following the smoking ban in 2007 when patients were no longer allowed to smoke, outside smoking areas were created. At Wotton Lawn, any structures deemed to be used for smoking have been dismantled. Ideally, we want to provide a healthy environment to work in and create outside spaces which are conductive to wellbeing. Examples of this from other Trusts include: sensory gardens and outdoor gyms - thus promoting health and wellbeing. Transforming these outdoor areas re-enforces the culture change needed to embed smoke free implementation.

9.4 A number of charitable organisations are being approached to support the transformation of the area around Wotton Lawn. This may include an outside gym area.

10 Herefordshire

10.2 With confirmation of the implementation date for Herefordshire in January 2018, a separate work stream has been formed which is focussing on the development of a detailed project plan, which will incorporate all work streams involved in Phase 1 of the project.

11 Risk and Issues:

11.2 Staff accessing appropriate training: This is crucial to the success of the programme. We are working with wards to determine alternative ways to train staff. In addition we need to turn to community teams to enable colleagues to support service users in the community to quit smoking

11.3 Changing Culture: This applies to service users and staff and we are working with all stakeholders to ensure we support both our staff and our service users to quit smoking and understand the rationale for this. In addition the approval of the smoke free policy and the support for staff to take their correct breaks (not smoking breaks) has been a positive step forward.

12 Recommendations

The Trust Board:
- notes the progress to date with smoke free implementation
- supports the work of the project team as detailed in this paper
-notes and endorses the implementation date of January 2018 within Herefordshire services
- notes the current risks and challenges and mitigation in place

Agenda item 14 **Enclosure Paper I**

Report to: Trust Board, 28th September 2017
Author: Dr Chris Fear, Medical Director
Presented by: Dr Chris Fear, Medical Director

SUBJECT: **Learning from Deaths Policy**

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

National guidance, dated 17th March 2017 requires the Board to receive and ratify the completed Learning From Deaths policy at a public board meeting.

In September 2017 NHSE published a template for Learning From Deaths policies. The West of England Steering Group was circulated this following it's meeting on 13th September 2017, too late for the organisations present who were already in the process of Board ratification of their policies before the end of quarter 2, as required by the guidance of 17th March 2017. The Medical Director and Non-Executive Director responsible for this piece of work have discussed and reviewed this template and concluded that all requirements highlighted within red type are covered by the 2gether draft policy as it stands.

It is proposed that the Board ratify this local policy which has been developed and consulted upon over the past 4 months, and that this be reviewed in the light of further guidance by September 2018.

RECOMMENDATIONS

The Trust Board is asked to ratify the policy.

Corporate Considerations	
Quality implications	Organisational learning in an essential component of quality.
Resource implications:	No further requirements.
Equalities implications:	Nil.
Risk implications:	This addresses risk to patients and learning.

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

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

Reviewed by:		
Dr Chris Fear	Date	13th September 2017

Where in the Trust has this been discussed before?		
Trust Board	Date	28th Feb 2017, 30th March 2017, 27th April 2017, 27th July 2017
Governance Committee	Date	21st April 2017, 16th June 2017, 18th August 2017
Mortality Review Group	Date	14th July 2017

What consultation has there been?		
	Date	

Explanation of acronyms used:	See glossary in policy

Policy on Learning from Deaths

Version number:	1
Consultation:	Governance Committee Board Committee Director of Quality Assistant Director of Governance & Compliance Patient Safety Manager
Ratified by:	Dr Chris Fear
Date ratified:	
Name & Title of originator/author:	Dr Chris Fear, Medical Director
Date issued:	
Review date:	
Audience:	All Trust Employees

Version History

Version	Date	Reason for Change
1	June 2017	New Policy

Contents

1. POLICY STATEMENT

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 Further guidance was published by the National Quality Board in March 2017 setting out mandatory standards for organisations in the collecting of data, review and investigation, and publication of information relating to the deaths of all patients under their care. This information is to be reported and published on a quarterly basis through the Trust Board, commencing quarter three 2017/2018.

2. EQUALITY STATEMENT

2.1 This policy applies to all employed Trust employees irrespective of age, race, colour, religion, disability, nationality, ethnic origin, gender, sexual orientation or marital status, domestic circumstances, social and employment status, HIV status, gender reassignment, political affiliation or trade union membership.

2.2 ²gether NHS Foundation Trust will ensure that this policy and procedure is monitored and evaluated on a regular basis.

3. INTRODUCTION AND PURPOSE

3.1 This policy relates to the collection, recording, investigating and reporting procedures which are to be adopted in respect of the deaths of people who are, or have been within a specified period, patients of 2gether NHS Foundation Trust. The data generated is likely to provide an overview of the health outcomes for all patients with mental health difficulties and learning disabilities who have been seen or treated by providers within the Gloucestershire and Herefordshire health and social care systems. The information will be used to inform internal quality and safety reports, but is intended also to engage with a wider systemic review of patient deaths across all providers, the scope and function of which is yet to be directed either locally or nationally.

3.2 While these data will include information concerning cases that have been reviewed through the serious incident process; that process will continue to run alongside the learning from deaths process and this policy will not affect the scope or purpose of the existing policy on reporting and managing incidents.

3.3 2gether NHS Foundation Trust recognises the need for prompt review and, where necessary, investigation, and reporting in respect of all deaths of people who have been patients of the organisation. The Trust has, for some years, provided a robust and comprehensive approach to the investigation and reporting of serious incidents, including patient deaths, but recognises the importance of widening this review to provide better understanding of the issues relating to quality of care and patient safety within the organisation.

3.4 The Trust supports an active approach to reviewing patient deaths and places an emphasis on lessons learned, both internally, and within the wider NHS and social care systems in which it operates. The Trust recognises that the majority of deaths are likely to relate to episodes of physical health care over which it has limited, or no, control and it is therefore essential that a system-wide approach is developed to give consideration to these data, and derive learning. This issue has been raised with commissioners. Since all NHS providers are required to adopt a methodology of learning from deaths, there is likely to be a local approach across partner organisations and it will be necessary for this policy to be adjusted and to adapt to a system-wide approach.

3.5 2gether NHS Foundation Trust is mindful of its obligations to people with mental health problems and learning disabilities and recognises the considerable epidemiological information indicating that such people often find disadvantage within the wider health and social care community, leading to their premature deaths, for a variety of reasons.

3.6 This policy sets out the approach to be followed in publishing data relating to patient deaths, deriving and publishing learning, and reporting the information publicly through board meetings.

4. SCOPE

This policy and procedure applies to all 2gether NHS foundation Trust staff, patients and carers. There are no limitations on its circulation within the Trust and the wider NHS community, and it can be made available to service users, their families and the public on request.

5. CONTEXT

5.1 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.

5.2 To date, the serious incident review process has been the standard by which Trusts are required to work in investigating the deaths of patients within a statutory framework that dictates timescales and reporting. However, concerns arising from Southern Health led to the publication of an audit by Mazars LLP, in November 2015, which suggested that the serious incident review process discriminated against patients with learning disability and elderly patients where their deaths were considered to be due to natural causes. This led to a review by the care quality commission and a recognition of the need to understand and publish mortality data for all patients in contact with a provider.

5.3 The guidance specifies standards of governance and organisational capability to ensure that governance arrangements and processes include, facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care. They are required to ensure that they act upon any learning. Providers are also required to review and, if necessary, enhance skills and training to support the agenda. Providers should also have a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one.

5.4 Trusts are required to ensure that their governance arrangements and processes "include, facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care". In respect of this, Trust boards are required to ensure that their organisation pays particular attention to the processes required in the guidance and that an appropriate policy and reporting arrangements are in place and acted upon. The requirements for Board leadership are set out in Annex A of the National guidance.

5.5 The Board is required to ensure that their organisation has an existing Board level leader acting as Patient Safety Director to take responsibility for the learning from deaths agenda, and an existing Non-Executive Director to take oversight of the process.

5.6 In respect of governance and process, the Board is expected to have oversight of a systematic organisational approach to identifying deaths requiring review, effective methodology for case record reviews to ensure that these are carried out to a high quality, receive regular reports in relation to deaths, reviews investigations and learning, ensure that learning is acted upon and shared across the organisation, that families are appropriately engaged in a timely compassionate and meaningful way, that nominated staff have appropriate skills in respect of reviewing and investigating deaths, works with commissioners to review and improve their local approaches, and recognises the benefit of independent investigation in a small number of cases.

5.7 Trusts are expected to have a cohort of staff who have received training to develop specialist skills in the investigation and review of deaths. Provider Trusts are also expected to have a clear policy for engagement with bereaved families and carers.

5.8 The responsibility of Non-Executive Directors are set out in Annex B of the National guidance. This reinforces the guidance with regard to necessary board oversight and sets out the roles and responsibility of non-executive directors, including:

a) Understand the process: ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support
b) Champion and support learning and quality improvement
c) Assure published information; ensure that information published is a fair and accurate reflection of the provider's achievements and challenges.

6. DUTIES

6.1 All Members of Staff

- Take initial corrective actions (where safe) to prevent re-occurrence of any accident/incident leading to the death of a patient.
- Report all patient deaths, including those believed to arise from "natural causes", in a timely manner using the designated procedure via Datix.
- Ensure incident forms (in the event that Datix is unavailable) are given to the line manager as soon as possible after the incident is discovered (within 72 hours).
- Follow the procedure set out in the Policy on Reporting and Managing Incidents in respect of any suspected serious incidents.

6.2 Managers

- Review incident received and check the details for completeness.
- Authorise the Datix record (or countersign the completed paper form) and forward it, together with any supplementary documentation, to the safety department within five days.
- Escalate the incident immediately if it is serious or potentially serious or suspected to meet the criteria for a formal serious incident review.
- In respect of suspected serious incidents follow the procedure set out in the policy on reporting etc.

6.3 Director of Quality and Medical Director

- Have joint Board level responsibility for the development of this document and may delegate the authority to a subordinate.
- Provide the Governance committee with quarterly reports of all data relating to learning from deaths prior to their submission to a public Board meeting.

6.4 The Executive Team

- The Chief Executive has overall responsibility to ensure the Trust has a robust coordinated response to publishing data and learning from deaths. The Chief Executive is supported in this role by all Executive Directors.
- The Medical Director, Director of Quality and the Director of Service Delivery have responsibility for ensuring that the policy in respect of serious incidents is followed and that appropriate processes are in place to review, where necessary investigate, and publish data relating to learning from deaths across the organisation.

6.5 The Board

- Take responsibility for receiving and reviewing information in respect of the deaths of patients through its public board meetings.
- Take responsibility for overseeing the measures in place and ensuring that these are understood and monitored at a board level.
- Nominate a non-executive director to take responsibility for oversight of the learning from deaths/mortality review process.
- Have an existing board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda and an existing non-executive director to take oversight of progress.
- Pay particular attention to the care of patients with a learning disability or mental health needs.
- Have a systemic approach to identifying those deaths requiring review and selecting other patients whose care they will review.
- Adopt a robust and effective methodology for case record reviews of all selected deaths (including engagement with the LeDeR programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for involvement, with the outcome documented.
- Ensure case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that general occur.
- Ensure that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board in order that the executives remain aware and non-

executives can provide appropriate challenge. The reporting should be discussed at the public section of the board level with data suitably anonymised.

- Ensure that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and reported in annual quality accounts.
- Share relevant learning across the organisation and with other services where the insight gained could be useful.
- Ensure sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths.
- Offer timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death.
- Acknowledge that an independent investigation (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in some circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved.
- Work with commissioners to review and improve their respective local approaches following the death of people receiving care from their services. Commissioners should use information from providers from across all deaths, including serious incidents, mortality reviews and other monitoring, to inform their commissioning of services. This should include looking at approaches by providers to involving bereaved families and carers and using information from the actions identified following reviews and investigation to inform quality improvement and contracts etc.

6.6 Clinical Director Leads for Learning From Deaths

- Two clinical directors to have joint lead for reviewing the data in relation to learning from deaths.
- Chair a “Mortality Review Committee” meeting monthly at which all data on patients who fall within the scope of this policy will be considered, categorised and reviewed. For terms of reference for the review meeting see Appendix A.
- Decide which cases require investigation and at what level (table top review, clinical case review or full investigation per Serious Incident Policy, see Appendix B).
- Using trigger tool methodology, look at 10% of the table top reviews to ensure adverse events/deficits in care are being picked up.
- Together with the Assistant Director of Governance and Compliance and/or the Patient Safety Manager, prepare a report to be submitted quarterly to the Trust Governance Committee prior to consideration at a public Board meeting.

6.7 Assistant Director of Governance and Compliance and/or Patient Safety Manager

- Produce the learning from deaths report, in conjunction with the clinical director leads for learning from deaths, and submitting this to the Governance committee and Board as appropriate.
- Collate data relating to patient deaths from datix, RiO, and any other appropriate sources.
- Responsible, with the Clinical Director leads for learning from deaths, for commissioning and reviewing any investigations considered to be appropriate.

7. DEFINITIONS

Table Top Review	a review by the care co-ordinator or mortality review administrator, gives a Mazars classification and identifies some “red flags” that warrant further clinical review.
Case Record Review	the application of a case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened.
Investigation	The act of all process of investigating; a systemic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.
Death due to a problem in care	A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in health care and therefore to have been potentially avoidable.
Clinical incident	An event or circumstance which could have resulted, or did result in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public which does not meet threshold associated with serious incidents requiring investigation.
Datix	The computer system used by the Trust to record and manage incidents.
NQB	National Quality board
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
DOH	Department of Health
Learning Disabilities Mortality Review (LeDeR) Program	A programme commissioned by the health care quality improvement partnership for NHS England to receive notification of all deaths of people with learning disabilities, and support local areas to conduct standardised, independent reviews following the deaths of people with learning disabilities aged 4 to 74 years of age.
National Child Mortality Program	A national review of child mortality review processes conducted by NHS England both in the hospital and community. A key aim is to make the process easier for families to navigate at a very difficult time in their life.
National Child Mortality Database	A national database central to the national child mortality programme.

8. OWNERSHIP AND CONSULTATION

8.1 The Medical Director and Director of Quality have joint Board level responsibility for the development of this document, and may delegate the authority to a subordinate.

8.2 The Board, Associate Medical Directors and Trust Localities must be consulted with, prior to ratification.

9. RATIFICATION DETAILS

9.1 This document will be ratified by the Trust Board.

10. RELEASE DETAILS

10.1 This document will be made available to all staff and managers via the Trust's policy section on the intranet.

10.2 The ratification and release of this document will be highlighted to managers and all staff via the weekly electronic news bulletin.

11. REVIEW ARRANGEMENTS

11.1 This document will be reviewed as determined by changes in:

- Legislation
- National guidance
- Local Trust and system needs

11.2 An annual review is required.

12. PROCESS FOR MONITORING COMPLIANCE

12.1 This policy requires approval by the Trust Board. It will be reviewed at least annually, and sooner if needed. The Trust Board is responsible for ensuring that compliance against the standards defined by the National Quality Board within the National Guidance is upheld by receiving a quarterly report from the Assistant Director of Governance and Compliance, together with the Clinical Directors responsible for learning from deaths (for details see Appendix C).

12.2 An audit of the implementation of the policy will be undertaken every two years, commissioned by the Director of Quality. The other criteria will include assessing compliance against the following standards:

- Duties of individuals and committees
- Process for obtaining notification of deaths through Datix, RiO and from other sources
- The process for reporting the data internally and publishing publicly
- Engagement and ownership from commissioners and partner organisations

12.3 It is expected that the implementation of these elements will comply with this guidance. The results of the audit will be presented to the Governance Committee who will be

responsible for the development of monitoring of any identified actions within the scope of the audit.

13. TRAINING

Staff receive training in incident reporting as part of the health & safety programme in corporate induction. Additional training is provided through Datix sessions run by the Datix Systems Manager.

14. LEARNING

Process by which learning from the data generated in the Datix analysis, and from investigation, is embedded within the organisation as described in the Trust Policy for Continuous Improvement (Aggregated Learning Policy). Learning will be disseminated through the same process as for the serious incident reviews.

15. MAIN BODY OF POLICY/GUIDELINE

Identifying Patient Deaths for Review

15.1 All 2gether NHS Trust staff will be required to notify, using the Datix process, the deaths of any Trust patients. This comprises anyone who dies within 30 days of receiving care from 2gether. Deaths recorded on Datix will be collated by the Assistant Director of Governance & Compliance and/or Patient Safety Manager for discussion at the monthly Mortality Review Meeting chaired by the lead Clinical Directors.

15.2 The Trust's Information Department will provide, to the Assistant Director of Governance & Compliance, a monthly report detailing details of any patients discharged from inpatient care who have died within a 30 day period after discharge. These data will be compiled from RiO and provided to the Mortality Review Meeting.

15.3 The Patient Safety Administrator will complete a table-top review including the following information: cause of death (from e.g. GP or Coroner), location of death, who certified death, any family concerns, any known details of health deterioration immediately prior to death.

15.3 Based upon the information provided, patient deaths will be assigned to one of the six categories developed by the Mazars report into Southern Health NHS Foundation Trust (2015) as detailed in the table below.

15.4 Deaths falling into the categories of Expected Natural deaths (EN1 & EN2) will, following from the table-top review, be sorted into those where there may be concerns and those where no possible concerns are identified.

15.5 Unexpected Natural deaths (UN1 & UN2) will be subjected to a case record review and will also 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

15.6 All Unnatural deaths (EU & UU) will be 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 be further information required or learning to be derived, incidents that do not require a serious incident review will be notified to the relevant team manager for a clinical incident review. The remaining incidents will be sorted into those where there may be concerns and those where no possible concerns are identified.

15.7 Where no concerns are identified, the datix will be closed without further action.

15.8 Where concerns are raised, the case will 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.

15.9 Global Trigger Tools Methodology (The Health Foundation, April 2010) will be used as a sampling method to support the random audit of cases to ensure the methodology is robust.

15.10 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”

15.11 For those deaths that fall into Category 2, learning will be collated and an action plan developed that will be progressed through operational and clinical leads and reported to Governance committee.

15.12 Where deaths are identified in Category 3, the issues identified will be 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.

15.13 The data will be presented to the Trust Board in the format prescribed by the learning from deaths dashboard, at least annually, and more often if prescribed by National Guidance (see Appendix D).

15.14 All deaths of patients with a learning disability will be also reported through the appropriate LeDeR process, and deaths of people under the age of 18 will be reported through the current child death reporting methodology.

15.15 The Mortality Review Meeting will, through the Assistant Director of Governance & Compliance, the Director of Quality and the Medical Director, provide a report using the format of the Learning from Deaths Dashboard to the Governance Committee and thence to the Trust Board on a quarterly basis.

Supporting staff

15.16 Staff will be offered debriefing and support around incidents within their team and professional network. The availability of support for staff will be highlighted through the process, and staff will be reminded of their access to Freedom to Speak Up Guardians and the Raising Concerns Protocols.

16. INVOLVING FAMILIES

16.1 The Trust will endeavour to:

- provide a clear, honest and sensitive response to bereavement in a sympathetic environment
- offer a high standard of bereavement care, including support, information and guidance
- ensure families and carers know they can raise concerns and these will be considered when determining whether or not to review or investigate a death
- involve families and carers from the start and throughout any investigation as far as they want to be
- offer to involve families and carers in learning and quality improvement as relevant.

16.2 The process for involvement of families in the investigation following serious incidents is well tested within this organisation and will continue as set out in the Serious Incident Policy. This provision will be extended to provide a family liaison worker and full involvement, to the extent the family wishes, in any clinical incident investigation into the

death of a patient.

17. PUBLICATION OF FINDINGS

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

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

17.2 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

18. REFERENCES

- Implementing the Learning from Deaths framework: key requirements for trust boards (NHS Improvement, July 2017)

- National Guidance on Learning from Deaths (National Quality Board, March 2017).

- Mazars LLP. Independent review of deaths of people with a learning disability or mental health problem in contact with Southern health NHS Foundation Trust April 2011 to March 2015 (2015).

- 2gether NHS Foundation Trust Documents:
  - Policy on Reporting and Managing Incidents
  - Policy for Continuous Improvement (Aggregated Learning Policy).
  - Serious Incident Policy
  - Raising Concerns Protocols

- Reference Royal College of physicians. Using the structured judgement review method. A clinical governance guide to mortality case record reviews (2016).

19. RESOURCES (correct to September 2017)

- *National guidance on Learning from Deaths* https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf
- *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*

https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

- Learning from deaths dashboard https://improvement.nhs.uk/resources/learning-deaths-nhs-national-guidance
- Resources from the national patient safety team; https://improvement.nhs.uk/resources/patient-safety-alerts
- The Improvement Hub https://improvement.nhs.uk/improvement-hub/
- *Developing people – improving care: A Framework for leadership and improvement* https://improvement.nhs.uk/resources/developing-people-improving-care/
- Royal College of Physicians mortality review materials https://www.rcplondon.ac.uk/projects/national-mortality-case-record-review-programme
- Learning disabilities mortality review programme http://www.bristol.ac.uk/sps/leder/
- Hogan et al Research on mortality review http://www.bmj.com/content/351/bmj.h3239 http://qualitysafety.bmj.com/content/early/2012/07/06/bmjqs-2012-001159
- Serious incident framework https://improvement.nhs.uk/resources/serious-incident-framework/
- Root cause analysis tools and resources http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/
- Duty of candour http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf
- Being open guidance http://www.nrls.npsa.nhs.uk/beingopen/

Appendix A

[2]gether NHS Foundation Trust
Mortality Review Committee

Terms of Reference

CONSTITUTION

The Board hereby resolves to establish a committee of the Board to be known as the Mortality Review Committee (MoReC). The MoReC has no executive powers other than those delegated by these terms of reference. The Chair of the MoReC will be shared between the two Clinical Directors.

MEMBERSHIP

- Two Clinical Directors (CD) with lead responsibility for Leaning from Deaths (joint chair), or nominated deputy
- Assistant Director of Governance and Compliance
- Patient Safety Manager
- Patient Safety Administrator (administrative support)

In Attendance (as required)

- Medical Director
- Director of Quality
- Non-Executive Director with Board responsibility for Learning from Deaths oversight
- Clinical Directors

QUORUM

One CD (chair), Assistant Director of Governance and Compliance and Patient Safety Manager.

FREQUENCY OF MEETINGS

The Committee will meet on a monthly basis and be supported by the administrator to the mortality review process.

AUTHORITY

The committee is authorised by the Board to review and consider any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any reasonable request made by the committee. On behalf of the Board, the Committee is authorised to review and analyse mortality data from the Trust and to prepare quarterly reports for the Board.

DUTIES OF THE MORTALITY REVIEW COMMITTEE

- To advise the Trust on national policies and standards and the requirements for learning from deaths.
- To receive and analyse information concerning the deaths of people who are, or have been, patients of the Trust during the prescribed period.
- To advise on the Datix standards for report patient deaths.
- To advise on the RiO standards for recording and reporting patient deaths.
- To provide quarterly reports to the Trust Board public meetings using the prescribed data dashboard.
- To manage the referrals, applying relevant standards derived from the Trigger Tools Technology to initiate and provide assurance through sampling, table top review, case notes review, or investigation as required.
- To liaise with partner organisations to share and promote learning from data.
- To liaise with the LeDer and Child Deaths programme.
- Liaise with the leader of the multiagency Patient Safety Group.

REPORTING

The MoReC will submit a report to the Trust Board on a quarterly basis.

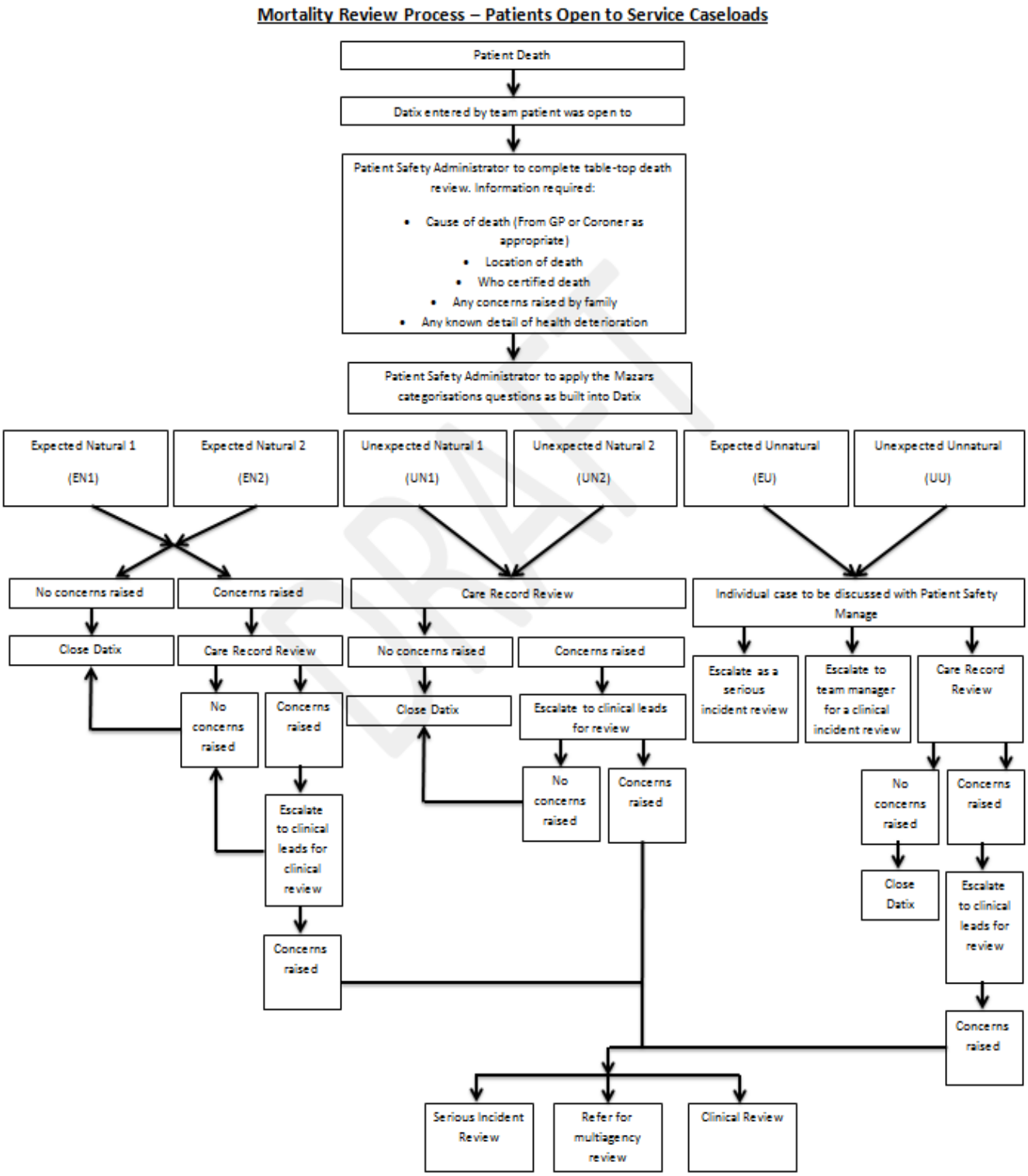
REVIEW

The Terms of Reference will be reviewed on an annual basis.

September 2017

Appendix B

Mortality Review Process – Pathway



Appendix C - Learning from Deaths Quarterly Report: Board Assurance Framework

Do we identify and report deaths correctly?	**Do we investigate unexpected deaths properly and without delay?**
• How many deaths were there amongst our service users? • How many of our inpatients die? • Where and how do our service users die? • How do we identify unexpected deaths correctly? • How do we report unexpected deaths as incidents?	• How do we know we are making the right decisions at IMA stage? • How do we know we are investigating the right cases? • What is the quality of our investigations? • How do we know our quality review processes are adequate? • How do we know if we have any delays in completing investigations? • How do we know if we are working with other agencies well? • How do we know we are informing other agencies when we are concerned about a case in their care?
Do we meet our obligations to others?	**Do we learn from deaths?**
• How do we know how many of our service users in detention die? • Have we reported and investigated all deaths in detention and how do we know this is accurate? • Have we reported appropriate deaths to NRLS in line with Trust policy and best practice and how do we know this is accurate? • How many deaths require our involvement with the Coroner and are we meeting accepted standards? • How many deaths require an inquest? • How do we know we are providing the right information to the inquest? • How many SIRIs are being signed off? How many are outstanding? How do we know? • Have we met our obligations to inquests and are we reporting our deaths in accordance with guidance? • Are we meeting our safeguarding obligations? How do we know?	• What are the causes of deaths? • What do our investigations tell us about our services? • What themes are arising and are we refining our services as a result? • What learning is there? • How is it monitored?
Are we being transparent and open in our reporting and investigating?	
• Are we involving families in the right way? How do we know? • Why are families not involved in our investigations? How can we improve involvement? • What is best practice for family involvement and do we meet it? • Has the Coroner commented on our services or our investigations? How do we know we've responded properly? • Is it clear when we report unexpected deaths in our annual report what we mean?	

Appendix D

Learning from Deaths Dashboard

2gether NHS Foundation Trust: Learning from Deaths Dashboard Totals - 2017/2018									
Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology									
Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable									
	Total Number of Deaths			Total Number of Deaths Subject to Case Record Review			Number of Deaths Investigated Under Serious Incident Framework		
	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
Older People	0	0	0	0	0	0	0	0	0
Working Age Adults	0	0	0	0	0	0	0	0	0
Learning Disabilities	0	0	0	0	0	0	0	0	0
Children and Young People	0	0	0	0	0	0	0	0	0
Totals	0	0	0	0	0	0	0	0	0
	0			0			0		

2gether NHS Foundation Trust: Learning from Deaths Dashboard
Quarter 1 - 2017/2018

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable

	Total Number of Deaths			Total Number of Deaths Subject to Case Record Review			Number of Deaths Investigated Under Serious Incident Framework		
	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
Older People	0	0	0						
Working Age Adults	0	0	0						
Learning Disabilities	0	0	0						
Children and Young People	0	0	0						
Totals	0	0	0	0	0	0	0	0	0
		0			0			0	

Themes and Issues Identified:

Actions Arising:

Appendix E

CARE RECORD REVIEW

Mortality Review Reference: MR- -

PART ONE	
This section focuses on the detail of the team responsible for the patient's care within 2gether NHS Foundation Trust and the reporting of the death	
Was the Patient Open to Services at the time of death	
If Yes Which Team	
If No what was the date of discharge	
Who was the patient's care co-ordinator	
Datix Reference Number	
Date Datix Entered	
If there was a delay in the Datix being completed why?	
PART TWO	
This section focuses on the patient's demographic information	
Name	
NHS Number	
Date of Birth	
Gender	
Age at time of Death	
Ethnic Group	
Marital Status	
GP Surgery	
Living Arrangement	
Was the patient placed out of county?	
Diagnosis	
If there is a Learning Disability Diagnosis, what degree?	
Is there co-morbidity?	
Who informed the trust of the patient's death?	Name: Relationship:
Did the patient have any restrictive legislation in place? *i.e. DOLs, Section of the Mental Health Act, Detention in police custody, imprisonment*	

PART THREE				
This section focuses on details of the death and the patients general health care				
Date of death *(dd/mm/yy)*				
Place of death				
Cause of death from death certificate				
Was the death expected *(i.e. did the patient die from an expected cause within an expected time)*	Yes		No	
Will there be a post mortem	Yes		No	
Will there be a Coroner's inquest	Yes		No	
Does the death meet the SI criteria	Yes		No	
Date of last GP health check *(dd/m/yy)*				
Did the deceased have any health screens prior to their death? *(if yes provide details)*				
Name of Local Authority/Health Commissioner				
Did the deceased have contact with the following: *(If yes please provide details)*				
Family/Relative				
Friend				
An attorney under Lasting Power of Attorney direction				
A deputy agreed/appointed by the Court of Protection				
An advocate				
Other *(Please state)*				

Did the deceased received support from the following:	**If yes, frequency:**			
	Day Time Only	**Night Time Only**	**Day and Night (Sleeping)**	**Day and Night (Waking)**
Paid services				
Voluntary services				
Informal carers				

In the 6 months prior to their death did the patient receive any changes to: *(If yes please provide details)*	
Service Provision	
Service Provider	

PART FOUR				
This section focuses on areas that would raise concerns around the care the deceased was provided. If any concerns are highlighted the information will need to escalated to the trust's mortality review groups.				
Has anyone expressed a concern about the patient's death? *(If yes please provide details)*				
Did the patient have a DNAR in place at the time of their death?				
If a DNAR was in place was the correct process followed to record a DNAR on the patient's notes?				
In terms of health care provision, did the patient have a Mental Capacity Assessment?	Yes		No	
If the patient had a Mental Capacity Assessment have the best interests been documents?				
If the patient did not have a Mental Capacity Assessment did they consent to their treatment?				
As the patient's care co-ordinator, do you think that the person experienced standards of care or risks that were unmitigated? *(If yes please provide details)*				
From the evidence you have, do you think this death might be attributable to abuse or neglect in any setting? *(If yes please provide details)*				
Do there appear to be any gaps in service provision that might have contributed in any way to the patient's death? *(If yes please provide details)*				
At the time of their death was the patient subject to an adult or child protection plan?				
If there were current adult or child protection plans in place, was there a failure that contributed to their death?				
Had the patient been subject to any historical safeguarding concerns? *(If yes please provide details)*				
Following the review of the patient's death are you surprised that the patient died from this cause at this time? *(If yes please provide details)*				
Do you think that there is any further learning to be gained from a multiagency review of the patient's death that would contribute to improving practice? *(If yes please provide details)*				

Agenda item **15** **Enclosure** **Paper J**

Report to: Trust Board, 28th September 2017
Author: Dr B Major, Clinical Director & Dr C Fear, Medical Director
Presented by: Dr C Fear, Medical Director

SUBJECT: **Medical Appraisal Annual 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

- Medical Appraisal has continued to be instituted within 2gether NHSFT aligned with national policy.
- Investment in SARD JV and transfer to that system is supporting effective monitoring, recording and review of the quantity, quality and uptake of appraisal.
- The Medical Appraisal Committee has instituted a work plan that will further deliver assurance annually and sustain quality.
- Headline figures at the end of March 2017 demonstrate that at that time 90.9% of Doctors had a currently valid appraisal. 7.8% non-compliant are explained by exclusion criteria such as long term sick leave. There are 1.3% who at that point were classified as being non-compliant. A further review of this one case indicates that it is accounted for by short term delay and that doctor has since completed an annual appraisal.
- Recruitment processes provide appropriate safety and quality checks aligned with national policy and best practice.
- Use of locum practitioners is being monitored and used to sustain service commitments and activity appropriately.
- Medical Appraisal and Revalidation whilst being proportionately resourced and supported in 2gether NHSFT has a significant cost associated with the support and engagement that is inescapable.
- To note Appendix F that indicates the current compliance rates.

RECOMMENDATIONS

1) That the Trust Board accept and endorse the Medical Appraisal Annual Report and:

- Recognise that levels have been maintained in the application of appraisal, recording and quality assuring is recognised and that this has occurred without significant additional funding.
- Recognise that the figures for engagement in appraisal reflect a snap shot at one point in the year and that the Trust will continue to achieve appraisal consistent with the provision of safe medical services on an annual basis supported by the Revalidation statistics provided.
- Recognise that there are a number of exceptions / reasons for non-compliance that contribute to a compliance point of less than 100%.
- Recognise that effective appraisal has supported timely and appropriate Revalidation for all Doctors to date.
- Recognise the good employment practice with regard to recruitment is supporting safe practice.
- That locum use remains necessary for the safe provision of clinical services but that this is monitored appropriately.

2) That the Board agrees the content and submission of the Statement of Compliance to NHS England (Appendix G).

Corporate Considerations	
Quality implications	Appraisal contributes to patient safety.
Resource implications:	Continuing use of administrative and managerial time with clinician input to revalidation process.
Equalities implications:	The annual appraisal monitoring process addresses equalities issues. This process is a particular issue for people on part time contracts.
Risk implications:	There are significant risks both to quality, safety and reputation of failure to implement Revalidation and annual appraisal effectively.

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

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

Reviewed by:		
Dr Chris Fear	Date	6th September 2017

Where in the Trust has this been discussed before?		
Governance Committee	Date	18th August 2017
Medical Appraisal Committee	Date	26th April 2017

What consultation has there been?		
	Date	

Explanation of acronyms used:	SARD - Strengthened Appraisal & Revalidation Database MAC – Medical Appraisal Committee

1. CONTEXT

1.1 The Medical Appraisal and Revalidation Report provides a summary of the work that has been undertaken within the Trust to support the safe provision of clinical services through the medical practitioners working to this Designated Body aligned with national policy.

1.2 It provides assurance as to the application of national policy with regard to the regulation and Revalidation of Medical Practitioners and insight into the processes and resources that are required to undertake this work.

Annual Medical Appraisal Board Report

Appraisal year:	**1st April 2016 – 31st March 2017**
Author:	**Dr Barnaby Major (Chair of Medical Appraisal Committee)** ***On behalf of Medical Appraisal Committee***
Prepared for:	**Trust Board via Trust Governance Committee**

1. Executive summary

Of the 77 doctors requiring appraisal during the last year 70 (90.9%) were compliant as at 1st April 2017; this demonstrates that the high rate of compliance achieved in the previous year (90.9% end of 2016) has been maintained; and represents sustained improvement compared to earlier years (75% end of 2014, 89.5% end of 2015).

When the Medical Appraisal Committee (MAC) was set up in 2013 the focus was on developing and implementing the basics required to ensure doctors engaged in and completed a standardised medical appraisal. Since then the MAC have focussed on improving the quality of medical appraisals undertaken in the organisation.

In July 2015 the Trust's appraisal and revalidation systems were scrutinised by the NHS England Independent Verification Review Team; overall the trust was highly commended and scored at least 5 out of 6 (equating to 'Excellence') in all of the core standards. Verification Visits are expected on a 5 year cycle. No required actions were recommended and many areas of good practice were noted. Each year a quality assurance audit of appraisal outputs is conducted; which to date has demonstrated year-on-year improvement in quality. These outcomes provide significant validation and assurance to the Governance Committee and Board that the organisation is fulfilling its statutory obligations.

2. Purpose of the Paper

The purpose of this paper is to report on the state of medical appraisal and revalidation to the Trust Board over the preceding appraisal year. It is also to report on progress made towards further developing and refining systems and procedures to support

medical appraisal and to improve the quality of medical appraisals taking place in the organisation. In addressing these two issues the paper provides assurance to the Trust regarding both the quality of the medical workforce and its sustainability.

3. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. The strengthened annual appraisal process is the primary supporting mechanism by which revalidation recommendations are made to the General Medical Council (GMC) for the re-licensing of doctors.

All non-training grade doctors in an organisation relate to a senior doctor, the Responsible Officer (usually the Medical Director). Completion of satisfactory annual appraisal over a five year period is a crucial factor in enabling the Responsible Officer (RO) to make a positive affirmation of fitness to practice to the GMC.

4. Governance Arrangements

The Trust Medical Appraisal Committee (MAC) was set up in 2013. The aim and objectives of the committee are; to oversee the process of appraisal of all licensed doctors employed within the trust; to develop robust systems for the recruitment, training, support & performance review of all medical appraisers within the organisation; and to review and quality assure the standard of appraisals conducted within the trust.

The MAC comprises of the Medical Director/RO, a separate chair, the director of medical education, at least 2 consultant representatives/lead appraisers (selected to represent the geographical & sub-specialty spread of consultants within the Trust) and at least 1 SAS doctor representative (currently 2; representing both counties).

The MAC convenes quarterly; including holding an appraisal year-end away day to review the results of the quality assurance audit and to scrutinise the end of year appraisal compliance figures. The committee review the annual work plan and the progress made against the Terms of Reference developed at inception of the committee.

Key outputs from the MAC during the last year include:

- Review and update of the trust medical appraisal policy with tighter RO scrutiny of appraisees who refuse to consent to their appraisal outputs being audited for quality assurance
- Review and informal benchmarking of our appraisal and revalidation systems against both NHSE position statements and the recently published Pearson review (and the GMC's subsequent response)
- Further refinement of the user-friendly guide for completion of appraisal portfolios (including how to obtain, and what, supporting information to include)

- Development of a new appraisal & revalidation leaflet for patients
- Further refinement and development of the 6-monthly medical appraiser support forums
- Review of the membership of the MAC (including proactive turnover of members) to ensure compliance with aimed 3 year terms
- Completion of the annual quality assurance audit and further improvement in systems for disseminating learning from this
- Proactive removal of 8 previous appraisers from the currently active list due to non-compliance with minimum numbers of appraisals completed
- Further improvement in systems for performance review of newly qualified medical appraisers
- The Chair of MAC appointed as a Regional RO appraiser with a view to bringing learning and experience back into the Trust from regional organisations

Alongside these new developments the MAC continues to regularly monitor appraisal compliance rates and engagement in the process; provide approved baseline & refresher training for medical appraisers (provision is determined by current need); monitor training compliance & output of approved appraisers; enforce required minimum and maximum numbers of completed appraisals conducted by each approved appraiser within a 2 year cycle; and regularly review appraisee feedback.

The Strengthened Appraisal and Revalidation Database (SARD JV) was introduced in 2013 and training made available for all users. All appraisals and job planning are completed and documented in this software package. Use of SARD JV contributes significantly to the process of compliance monitoring and hence maintaining the overall high compliance rates seen since its introduction.

Administrative support for the MAC, and for the use of SARD JV, is provided by the Medical Director's office. Additional technical support is also provided by SARD JV staff. All doctors requiring appraisal are sent email reminders 3 months and 6 weeks before their appraisal due dates. Weekly emails and correspondence are then undertaken from the due date onwards. If a doctor becomes non-compliant the Medical Director sends an assertive reminder. If the doctor remains non-compliant after 1 month and no appraisal meeting date has been set, a face to face meeting with the Medical Director is arranged. A process for escalation to the GMC if non-engagement continues beyond this is also in place.

Priorities for the MAC for the next year include further consideration of ways to improve patient and public involvement in appraisal and revalidation processes (not as much progress as hoped had been made in relation to this to date; partly due to the difficulty in identifying a fit-for-purpose process); further refinement of the number and nature of active qualified medical appraisers within the organisation; and focus on moving beyond compliance towards further quality improvement.

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

Of the 77 doctors requiring appraisal during the last year 70 (90.9%) were compliant as at 1st April 2017; this demonstrates that the high rate of compliance achieved in the previous year (90.9% end of 2016) has been maintained; and represents sustained improvement compared to earlier years (75% end of 2014, 89.5% end of 2015).

Sub-group numbers were insufficient to conduct any meaningful statistical analyses; however general trends in the data reviewed suggest that there were no significant differences in compliance rates between different grades of doctor, or locality or specialty worked. Notably compliance remains reasonable within trust locums (currently 70%; and of those non-compliant all had an acceptable reason); typically a group in which engagement and compliance is hard to establish and maintain.

Of the 7 doctors which were non-compliant; 6 (85.7%) had acceptable reasons (4 being new starters; 1 on or returning from long term sickness; and 1 on or returning from maternity leave). The 1 (14.3%) without a reason was overdue by less than 1 month.

The system for monitoring compliance (SARD JV) does not allow for any flexibility around the appraisal due date. Once the due date has passed (even by a day) the appraisee is deemed non-compliant. This is at odds with the Trust policy which allows for one month before or after the due date for completion of appraisal. Compliance rates are therefore never likely to regularly reach 100% and will fluctuate monthly throughout the appraisal year.

To account for this, and given that at any one time there are likely to be a small proportion of doctors who are currently non-compliant with a reason, the MAC recently agreed that overall compliance rates maintained above 75% should provide adequate assurance of engagement in the process and completion of medical appraisals within the medical workforce.

For further details see appendix A.

b. Appraisers

There are currently 21 trained medical appraisers within the establishment of non-training grade doctors; this is significantly less than the previous year (when there were 34); this reduction has been intentional (see further below). A significant number of appraisers have been removed from the current list and no new appraisers have been appointed by the MAC this year. All consultants and SAS doctors continue to be offered access to training though in order to both provide a cohort of appraisers and increase awareness and knowledge of appraisal for appraisers and appraisees alike.

The previous number of approved appraisers within the Trust was not sustainable; there were too many active appraisers available (and insufficient numbers of appraisals required) to ensure that each appraiser was conducting a minimum number per year to ensure that those approved were able to maintain their skills. The MAC set and have

enforced minimum numbers of completed appraisals required in a 2 year period. These standards were introduced in October 2014 and enforced at the end of the first 2 year cycle in October 2016, at which point 8 appraisers were removed from the active list. Other appraisers have been lost due to other reasons such as retirement.

The MAC have developed a formal recruitment process and set minimum baseline and refresher training requirements. The MAC continue to encourage SAS doctors to become trained and practising appraisers.

Appraiser refresher training was not provided by the Trust in the last year as it was not required. Previous and future training however is delivered by a recognised leader in the field. The training has been reviewed and further developed to bring it more in line with Trust policy and use of SARD JV.

Not all appraisals undertaken by appraisers are captured by SARD JV or relate to doctors with whom 2gether has a prescribed connection. Some appraisals are undertaken for colleagues working outside 2gether, in retirement or within other roles such as the Deanery.

c. Quality Assurance

In July 2015 the Trust was visited and scrutinised by the NHS England Independent Verification Review Team; the purpose of which is to assess and validate the status of appraisal and revalidation systems within all designated bodies. The process is designed to provide independent assurance to trust boards that the organisation is fulfilling its statutory obligations in respect of the RO's statutory responsibilities.

Overall the trust was highly commended and scored at least 5 out of 6 (equating to 'Excellence') in all of the core standards; with the highest score achieved for 'Engagement & Enthusiasm'. No required actions were recommended by the scrutiny panel, and only a few suggestions made for improvement mainly in relation to HR procedures (which have since been enacted). Many areas of good practice were noted including the overriding focus on the quality of medical appraisals taking place within the organisation, use of SARD JV as a tool to support quality and compliance, automatic inclusion of complaints and serious incidents within individual appraisal portfolios, and the processes to support learning and quality improvement from the annual quality assurance audits. Independent Verification visits are expected every 5 years.

In addition the MAC have reviewed all 27 of NHS England's medical appraisal position statements (designed to represent current opinion on a variety of appraisal/revalidation issues and, where relevant, state current best practice). The statements are however not designed to be prescriptive. This process was akin to an (albeit informal) benchmarking exercise; the outcome was reassuring that our current practices and policy are consistent with the majority of the position statements. The recent publication of the Pearson Review ('Taking Revalidation Forward'), and the subsequent GMC response, was also reviewed and considered by the MAC and has helped to inform further priorities for the MAC over the coming year.

As RO the Medical Director is required to individually review all completed appraisals for both completion and quality. The MAC has developed additional assurance processes to support this, discussed below.

Alongside ensuring robust recruitment and training processes for medical appraisers, regular support and review of the role takes place within 6 monthly appraiser support forums, existing consultant CPD peer groups, as part of appraisers' own appraisals and via informal support offered by members of the MAC itself.

Appraisee feedback forms are automatically generated by SARD JV and sent to individual appraisees after all completed appraisals. Once completed these are screened by the medical director's office and then reviewed quarterly at MAC meetings. Collated (anonymised) feedback covering the entire appraisal year is circulated to all appraisers; it was also recently agreed to provide individualised (anonymised) feedback to appraisers as well. Summarised feedback has previously been benchmarked against feedback collated from other similar organisations (and has been considered comparable).

The Medical Director's office automatically populates individual doctor's SARD JV portfolios with anonymised complaints and anonymised serious incident reports. The expectation is that these will then be referred to and reflected on as part of appraisal.

The annual medical appraisal quality assurance re-audit was recently conducted by all members of the MAC; 14 (18% of all) completed appraisal summaries were audited for completeness and quality; 8 were automatically audited because they were done by new appraisers; 6 were randomly selected. Consent was sought from individual appraisees. A nationally recognised medical appraisal QA tool was used. Results were reviewed at an away day and an action plan subsequently developed; including dissemination of key learning points to all appraisers and appraisees and individualised feedback provided to appraisers in relation to the specific cases audited. The results demonstrated further improvement (year-on-year) in the quality of appraisal outputs. A separate audit report has been completed. The audit will be repeated annually.

Please refer to appendix B.

d. Access, security and confidentiality

Appraisees are advised to only upload anonymised documents to their appraisal portfolios so that no patient identifiable information is included. The Medical Director's office has administrative access to SARD portfolios in order to support appraisees and upload information with the agreement and knowledge of appraisees.

e. Clinical Governance

The Medical Director's office automatically populates individual doctor's SARD JV portfolios with anonymised complaints and anonymised serious incident reports. The expectation is that these will be readily available to both appraiser and appraisee so that

they can be discussed and reflected on in the course of the pre-appraisal preparation and appraisal meeting.

The MAC has set an expectation of 2 completed multi-source feedback (MSF) exercises within each 5 year revalidation cycle. This is greater than the national minimum standard but provides opportunity to gain more frequent and appropriate feedback allowing the identification, addressing and review of any issues highlighted. Provided the national standard is achieved and there is appropriate consideration in appraisal of one MSF this does not prevent recommendation for revalidation being made. NHS England has a position statement on when to repeat MSF exercises following a change of role which the trust adheres to.

6. Revalidation Recommendations

During the last year only 7 revalidation recommendations were due; for 5 of the 7 (71%) positive recommendations were made; the remaining 2 (29%) were recommended for deferral; 1 within 2016/17 (since recommended) and 1 for deferral to 2017/18. The GMC are clear that deferral should not be considered as a negative outcome; rather acknowledgement that doctors require more time (for a variety of valid reasons) to gather sufficient evidence for appraisal to take place and revalidation recommendations to be made.

Deferrals are typically recommended either due to long term sickness or to provide additional time in order to gather further evidence required; such as Statutory and Mandatory training compliance or completion of a multi-source feedback exercise.

See appendix C for further details.

7. Recruitment and engagement background checks

Recruitment and engagement checks are completed when doctors are first employed at the 2gether NHS Foundation Trust; they are in line with the Trust's Pre-Employment Checks Policy. These checks include:

- Occupational Health Clearance, including any night working
- Identity Verification
- Qualifications
- Right to Work
- DBS - Disclosure and Barring Service - Enhanced Level checks
- References from two line managers over the last two years
- Medical Practice Transfer Form - information from previous medical director

All pre-employment checks for substantive doctors are completed before employment is started.

Please see Appendix E.

8. Monitoring Performance

The performance of Doctors is monitored through the combination of perspectives provided by the following source materials and processes:-

- Initial design of Job Description and Person Specification
- Effective recruitment and selection processes
- Job planning
- Peer Group membership and attendance
- Appraisal
- Monitoring of Serious Incidents, Complaints and Compliments
- Participation in Supervision
- Activity data
- Participation in Continuing Professional Development
- Completion of Statutory and Mandatory Training
- Diary Monitoring Exercises
- Attendance / sickness absence

These perspectives are available through a combination of routine reports and intermittent reviews reporting to the RO, Clinical Directors, Clinicians and Managers. Most also constitute areas that are considered as part of the Appraisal process.

Please refer to appendix D.

9. Responding to Concerns and Remediation

The Policy on the Management and Remediation for Concerns about the Professional Conduct and Clinical Performance of Medical Practitioners provides a framework that interprets national policy and best practice for local delivery.

One doctor is currently in receipt of input within the framework provided by this policy.

Please refer to appendix D.

10. Risk and Issues

Overall engagement in and compliance with appraisal has remained high throughout the last appraisal year. This is largely due to the improved engagement of doctors achieved over recent years and also to the ongoing work of the Medical Director's team in monitoring compliance and providing prompting and support. This has been possible due to the universal use of the SARD JV software.

However the sensitivity of the monitoring system which allows no latitude in completion date before being non-compliant is recorded, combined with the limited range of exceptions, mean that the rolling compliance rates vary from month to month without

appraisal uptake having altered markedly. Exceptions this year are accounted for mostly by new starters.

There is a significant time and therefore cost associated with both completion of appraisals as an appraisee (estimate 16-36 data collection hours per annum) and appraiser (4-6 hours per appraisal). This does not take account of the activity associated with populating appraisal documentation or undertaking multi-source feedback, audits, peer groups, supervision and training. This is having an impact on the availability of retired doctors to undertake locum and part time work and will create a particular pressure in Mental Health service provision in the future.

Recruits from outside the UK have not been taking part in this process and thus for the first year of any practice will not have undertaken appraisal whilst they are collecting data. This group provide a further exception for periods. This is nationally recognised issue and one further expanded on in the recent Pearson review.

The scope of work that a doctor can undertake is determined by and determines their CPD and CME requirements. There is a raised expectation that any activities have an associated CME/CPD function. This does limit practitioner flexibility and cover to specialist areas, a particular issue in relation to on-call rotas and 7 day working.

11. Corrective Actions, Improvement Plan and Next Steps

The MAC will continue to review its work plan against the terms of reference annually. The Trust medical appraisal policy was reviewed in October 2016. Priorities for the MAC for the next year include further consideration of ways to improve patient and public involvement in appraisal and revalidation processes (not as much progress as hoped had been made in relation to this to date; partly due to the difficulty in identifying a fit-for-purpose process); further refinement of the number and nature of active qualified medical appraisers within the organisation; and focus on moving beyond compliance towards further quality improvement.

The MAC will investigate individual cases where appraisal has not been completed (without reason) within a reasonable time frame. Subsequent investigation reports will be submitted to the Medical Director/Responsible Officer who will decide on further action. Doctors who have not completed an annual appraisal will not be eligible for routine pay progression or local clinical excellence awards; ²gether NHS Foundation Trust has the right to terminate the contract of a doctor if they do not undergo an annual appraisal without having good reason.

Workforce planning will need to take account of the possible limitations to the scope of practice and perhaps the limited workforce that may be available due to retirement.

12. Recommendations

The Board is asked to accept the Annual Report on Medical Revalidation and Appraisal and:

- Recognise the progress that has been made in the support provided to Appraisal and Revalidation within 2gether NHSFT through the use of SARD JV and the engagement of clinicians in this.
- Recognise the work that has been undertaken and is planned by the Medical Appraisal Committee to support the work of the Medical Secretariat and Responsible Officer in providing, maintaining and developing sustainable recording, reporting and assurance systems.
- Recognise that snap shot compliance figures do not reflect the annual uptake of appraisal but are primarily a function of the way in which data is collected. In any year the expected outturn will be for 100% of doctors with a prescribed connection to this Designated Body to be appraised; however there will be exceptions which will reduce the overall figure.
- Appropriate processes are in place for the review of Appraisals, Appraiser performance, maintenance of Appraisal capacity and the quality of appraisals.
- Employment checks are undertaken consistent with national standards and best practice.
- Locum use whilst significant is reviewed and regulated, aimed at maintaining clinical provision to cover mostly medium to long term absence including long term sickness and recruitment.

Annual Report Appendix A

Audit of all missed or incomplete appraisals

Doctor factors (total)	**7**
Maternity leave during the majority of the 'appraisal due window'	1
Sickness absence during the majority of the 'appraisal due window'	1
Prolonged leave during the majority of the 'appraisal due window'	0
Suspension during the majority of the 'appraisal due window'	0
New starter within 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	4
Postponed due to incomplete portfolio/insufficient supporting information	0
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	1
Lack of engagement of doctor	0
Other doctor factors	0
Appraiser factors	
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	0
Other appraiser factors (describe)	0
(describe)	
Organisational factors	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

Annual Report Appendix B

Quality assurance audit of appraisal inputs and outputs

Excellence audit tool

		Number (Percentage)		
Number	**Criterion**	absent	room for improvement	well done
1	Includes whole scope of work?	1 (7)	4 (29)	9 (64)
2	Free from bias?	0	2 (14)	12 (86)
3	Challenging & supportive?	1 (7)	1 (7)	12 (86)
4	Exceptions explained?	0	0	14 (100)
5	Reviews & reflects?	1 (7)	0	13 (93)
6	Review of previous PDP?	4 (29)	2 (14)	8 (57)
7	Encourages excellence?	4 (29)	0	10 (71)
8	Gaps identified?	1 (7)	2 (14)	11 (79)
9	SMART PDP?	1 (7)	7 (50)	6 (43)
10	Relevant PDP?	1 (7)	3 (21)	10 (71)

Annual Report Template Appendix C

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2016 to 31 March 2017	
Recommendations completed on time (within the GMC recommendation window)	6 (Positive) 1 (Deferral)
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	6 (Positive) 1 (Deferral)
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	0
Describe other – Trust was in negotiations with Doctor and GMC	0
TOTAL [sum of (late) + (missed)]	0

Annual Report Appendix D

Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level[1]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	1		2	
Capability concerns (as the primary category) in the last 12 months	Concerns cover all areas		1	
Conduct concerns (as the primary category) in the last 12 months			1	
Health concerns (as the primary category) in the last 12 months				
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2015 who have undergone formal remediation between 1 April 2014 and 31 March 2015 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*				
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				1
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				0
General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0
Temporary or short-term contract holders (temporary employed staff including				0

[1] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies	
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	0
TOTALS	1
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	0
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	0
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	0
GMC Actions: Number of doctors who:	
Were referred by the designated body to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	0
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	1
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	
Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment	1
Number of NCAS assessments performed	0

Annual Report Appendix E

Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	3
Temporary employed doctors	8
Locums brought in to the designated body through a locum agency	46
Locums brought in to the designated body through 'Staff Bank' arrangements	0
Doctors on Performers Lists	0
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	0
TOTAL	0

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	Disclosure and Barring Service (DBS)	2 recent references	Name of last responsible officer	Reference from last responsible officer	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Permanent employed doctors	3	3				3	3					3				
Temporary employed doctors	8	8				8	8					8				
Locums brought in to the designated body through	46	46				46	46					46				

a locum agency																
Locums brought in to the designated body through 'Staff Bank' arrangements																
Doctors on Performers Lists																
Other (independent contractors, practising privileges, members, registrants, etc)																
Total	57	57				57	57					57				

For Providers of healthcare i.e. hospital trusts – use of locum doctors:

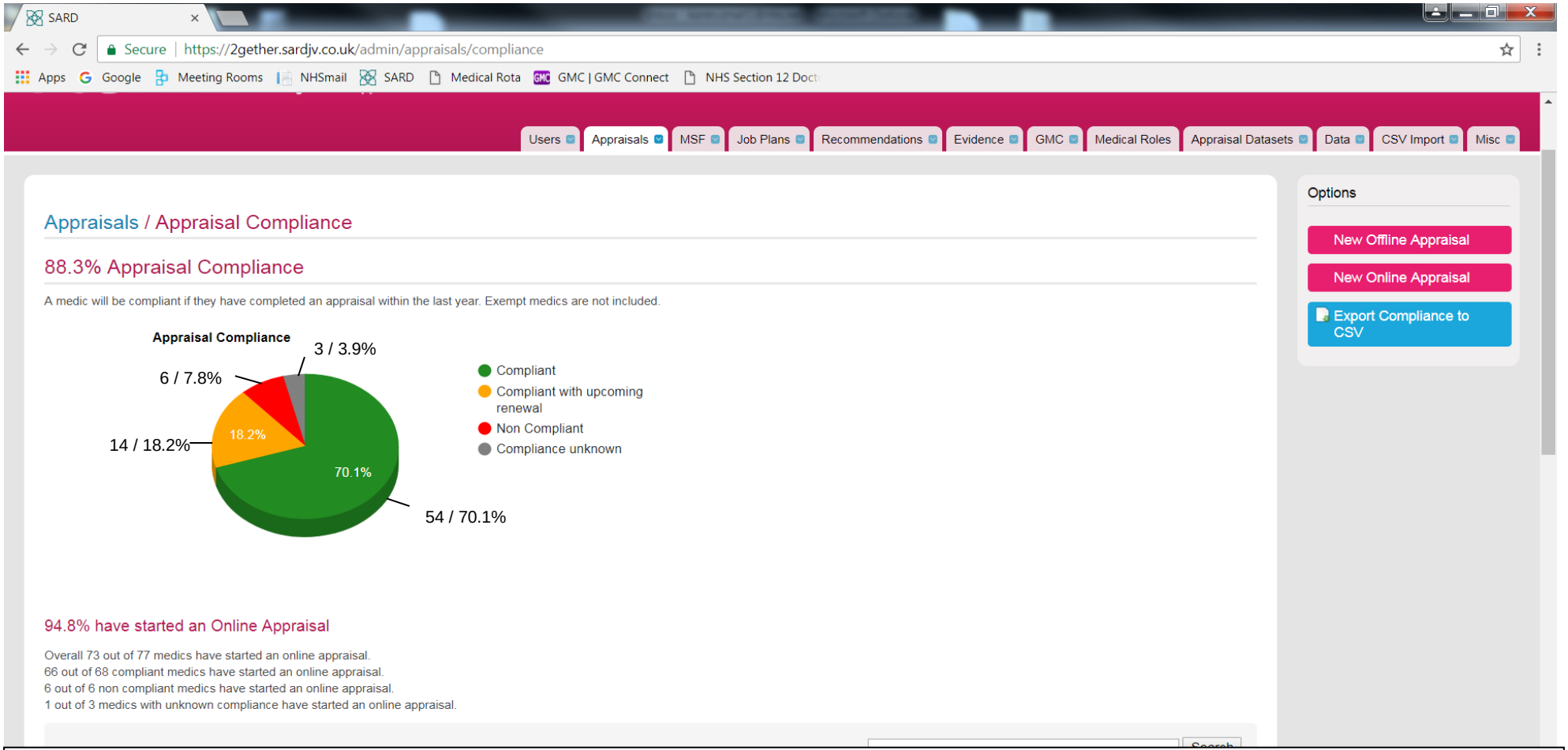
Explanatory note: Number of locum sessions used (days) as a proportion of total medical establishment (days)

The total WTE headcount is included to show the proportion of the posts in each specialty that are covered by locum doctors

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum days used
Surgery					
Medicine					
Psychiatry	24	12	8	4	
Obstetrics/Gynaecology					
Accident and Emergency					

Anaesthetics					
Radiology					
Pathology					
Other – Occ Health	0.2				
Total in designated body (This includes all doctors not just those with a prescribed connection)		1635	707	335	
Number of individual locum attachments by duration of attachment (each contract is a separate 'attachment' even if the same doctor fills more than one contract)	Total	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less	12	12	12		
3 days to one week	11	11	11		
1 week to 1 month	8	8	8		
1-3 months	5	5	5		
3-6 months	4	4	4		
6-12 months	4	4	4		
More than 12 months	2	2	2		
Total	46	46	46		0

Appendix F



SARD does not show doctors that are currently classed as exempt from appraisal due to maternity, long term sick, new starters etc. of which there are 6 doctors (in the graph above these are included in the non-compliant and compliance unknown categories). This reduces the total non-compliant figure to 4% / 3 doctors and increases the total compliance figure to 96% / 74 doctors.

Figures as of 13th September 2017

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Statement of Compliance

Version number: 2.0

First published: 4 April 2014

Updated: 22 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Publications Gateway Reference: 03432

NB: The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Designated Body Statement of Compliance

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: Yes

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

   Comments: Yes

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

   Comments: Yes

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Comments: Yes

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

   Comments: Yes

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;

   Comments: Yes

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

    Comments: Yes

Signed on behalf of the designated body

Official name of designated body: 2gether NHS Foundation Trust

Name: Ruth FitzJohn Signed: _ _ _ _ _ _ _ _ _ _

Role: Chair

Date: 28th September 2017

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Agenda item **16** **Paper** **K**

Report to: 2gether NHS Foundation Trust Board - 28th September 2017
Author: Shaun Clee – Chief Executive
Presented by: Shaun Clee – Chief Executive

SUBJECT: **Chief Executive's Report**

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

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

EXECUTIVE SUMMARY

This paper provides the Board with:

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

RECOMMENDATIONS

The Board is asked to note the contents of this report

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

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

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

Reviewed by:		
Executive Team	Date	

Where in the Trust has this been discussed before?		
CEO	Date	*08.09.17*

What consultation has there been?		
N/A	Date	

Explanation of acronyms used:	CCG – Clinical Commissioning Group AHPP – Allied Health Psychological Professionals CQC – Care Quality Commission CQR – Quality and Clinical Risk Committee CQRG – Clinical Quality Review Group GCS – Gloucestershire Care Services HCA – Health Care Assistant IAPT – Improved Access to Psychological Therapies LDISS – Learning Disability Intensive Support Service MHARS – Mental Health Acute Response Service NPAC – Nurse Professional Advisory Committee NHSI – NHS Improvement OD – Organisational Development QSIR – Quality Service Improvement and Redesign STP – Sustainability and Transformation Plan WVT - Wye Valley Trust

1. CONTEXT

1.1 Delivering our Three Strategic Priorities

1.2.1 Continuously Improving Quality

Our focus on continuous improvement continues via:

- Ongoing engagement and leadership of the South of England Mental Health Safety Collaborative, which has been shortlisted for a Health Service Journal award,
- QSIR
    - Gloucestershire – Just started training cohort 3. Once complete, over 90 colleagues will have completed the QSIR Practitioner course. Two Fundamentals courses have been run with another scheduled for December. In Gloucestershire, over 10 organisations and 30 projects

will have been supported by the QSIR process after cohort 3 is complete. Hein Le Roux has just been accredited as a QSIR associate, and will be joining the Gloucestershire training group, which will hopefully increase engagement from primary care.

- Herefordshire – Just started training cohort 2. Once complete, 45 colleagues from across Herefordshire & Worcestershire will have completed the QSIR Practitioner course from across all NHS organisations. Two more colleagues (one from WVT and one from Worcestershire Health & Care NHS Trust) have been accredited, bringing the total number of trainers to five.

- 2gether-specific – Damian Gardner has arranged a Fundamentals training day for Trust psychologists and medics on 13th October. So far, 37 colleagues have signed up to attend from across both counties.

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

2.0 Ensuring Engagement

Internal Board Engagement

03.07.17 The Director of Service Delivery attended an Executive Business Meeting

03.07. 17 The Director of Service Delivery attended Senior Leadership Forum

03.07.17 The Director of Service Delivery attended a Hereford Nursing Summit meeting

03.07.17 The Director of Quality attended the Executive Business Meeting

03.07.17 The Director of Quality attended Senior Leadership Forum

03.07.17 The Director of Organisational Development attended Senior Leadership Forum

04.07.17 The Director of Organisational Development attended the Gloucestershire STP Improvement Academy Workshop

04.07.17 The Director of Quality attended the Social Care Professionals Development Group

04.07. 17 The Director of Service Delivery attended a Revenue Consequences meeting

06.07.17 The Director of Quality attended NPAC

07.07. 17 The Director of Service Delivery attended a meeting to discuss Digital Dictation

07.07.17 The Chief Executive attended the Medical Staffing Committee

07.07.17 The Medical Director attended the Medical Staffing Committee.

07.07. 17 The Director of Service Delivery attended a Management Structures meeting

10.07. 17 The Director of Service Delivery attended a Team Talk meeting in Hereford

10.07. 17 The Director of Service Delivery attended an Executive Development meeting

10.07.17 The Medical Director attended a Junior Doctors Peer Group meeting.

10.07.17 The Director of Engagement and Integration hosted the Team Talk at Weavers Croft in Stroud

11.07.17 The Director of Quality attended the Smoking Cessation Project Board

12.07. 17 The Director of Service Delivery attended the Mental Health Legislation Scrutiny Committee meeting

13.07. 17 The Director of Service Delivery attended a meeting regarding Bank Staff, Agency Staff and 1:1's in the Peri Team at Hereford

14.07.17 The Director of Engagement and Integration met with the Senior Leaders in the Engagement and Integration Directorate

14.07.17 The Director of Quality attended the Quality & Clinical Risk Sub-Committee

17.07.17 The Chief Executive chaired the Executive Business committee meeting

17.07. 17 The Director of Service Delivery attended an Executive Business Meeting

17.07.17 The Director of Quality attended the Executive Business Meeting

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

17.07. 17 The Director of Service Delivery attended a Carers Assessment meeting

18.07. 17 The Director of Service Delivery attended a Joint Negotiating and Consultative Committee meeting

20.07. 17 The Director of Service Delivery attended a Complex Care Follow Up meeting

20.07. 17 The Director of Service Delivery attended an IAPT Shadow Tariff Proposals meeting

20.07. 17 The Director of Service Delivery attended the 2gehter NHS Foundation Trust Annual General Meeting

21.07.17 The Director of Engagement and Integration met with the Associate Medical Director for Herefordshire

21.07.17 The Director of Engagement and Integration met with the Lead Psychologist for Older People Services in Herefordshire

24.07. 17 The Director of Service Delivery attended an Executive Development meeting

24.07. 17 The Director of Service Delivery attended an 'On Call Issues' Meeting

24.07.17 The Director of Quality attended the Executive Development Leadership Development Options Meeting

25.07. 17 The Director of Service Delivery attended a meeting regarding Berkeley House/LDISS Budget Settings

25.07.17 The Director of Organisational Development chaired the Safety, Health & Environment Sub-Committee

26.07. 17 The Director of Service Delivery attended a Delivery Committee Meeting

26.07.17 The Director of Engagement and Integration facilitated a patient safety visit at the Cantilupe Ward at Stonebow

26.07.17 The Director of Engagement and Integration facilitated a patient safety visit with the Therapy Department at Stonebow

27.07.17 The Director of Engagement and Integration attended the Trust Board meeting

27.07. 17 The Director of Service Delivery attended a Trust Board Meeting

27.07.17 The Director of Organisational Development attended Trust Board

27.07.17 The Director of Quality attended the Trust open Board

31.07.17 The Medical Director attended a Junior Doctors meeting.

31.07.17 The Director of Quality attended the Executive Business Meeting

31.07.17 The Chief Executive chaired a meeting of the Executive Business Committee

02.08.17 The Director of Finance and Commerce attended the Audit Committee.

02.08.17 The Director of Quality attended a clinical shift at Oak House

03.08.17 The Director of quality worked alongside the Matron of Charlton Lane for the day

03.08.17 The Director of Quality attended the NPAC

03.08.17 The Medical Director attended a MH Nurse Pilot Review Meeting

03.08.17 The Director of Finance and Commerce conducted a board visit at the managing memory team at the Fritchie Centre.

04.08.17 The Chief Executive met with colleagues from Charlton Lane Hotel Services

07.08.17 The Director of Finance and Commerce met with the senior managers within the Finance and Commerce directorate.

07.08.17 The Director of Finance and Commerce attended the Senior Leadership Forum.

07.08.17 The Director of Organisational Development attended Senior Leadership Forum

07.08.17 The Director of Quality attended Executive Development meeting

07.08.17 The Director of Quality attended the Senior Leadership forum

07.08.17 The Director of Engagement and Integration attended Corporate Induction to meet new recruits

08.08.17 The Director of Organisational Development participated in Patient Safety Visits at Kingsholm and Dean Wards, Wotton Lawn Hospital

08.08.17 The Director of Finance and Commerce chaired the Gloucester Hub Gateway Update Meeting.

09.08.17 The Director of Service Delivery undertook a Board visit to Field View

09.08.17 The Director of Quality met with the CQC to handover to the new local inspection leads

10.08.17 The Director of Service Delivery attended the Worcestershire STP Mental Health Workstream meeting

14.08.17 The Chief Executive chaired the Executive Business Committee meeting

14.08.17 The Director of Service Delivery attended the Executive Business Meeting

14.08.17 The Director of Quality attended the Executive Business Meeting

15.08.17 The Director of Quality chaired the Task & Finish group around Crisis Contingency Plans

15.08.17 The Director of Organisational Development chaired the inaugural meeting of People Sub-Committee

16.08.17 The Director of Engagement and Integration attended the Trust Development Committee

17.08.17 The Director of Engagement and Integration met with the Clinical Director for Older People's Services

17.08.17 The Director of Quality visited Staff Bank

18.08.17 The Director of Quality chaired QCR Subcommittee

18.08.17 The Director of Quality attended Trust Governance

18.08.17 The Director of Engagement and Integration attended the Quality and Clinical Risk Sub-Committee for Governance

18.08.17 The Director of Engagement and Integration attended the Trust Governance Committee

18.08.17 The Director of Engagement and Integration held a meeting with the Senior Leaders of the Engagement and Integration Directorate

21.08.17 The Chief Executive welcomed new colleagues at Corporate Induction

21.08.17 The Director of Quality attended Executive Development meeting

22.08.17 The Director of Quality attended a patient safety visit at Montpellier & Greyfriars

22.08.17 The Director of Engagement and Integration chaired the Trust Research Overview Sub-Committee

23.08.17 The Director of Engagement and Integration conducted a Patient Safety Visit with the Hereford Crisis Team at the Stonebow Unit

31.08.17 The Director of Organisational Development attended Appointments & Terms of Service Committee

29.08.17 The Director of Quality chaired the Temporary staffing demand board

31.08.17 The Chief Executive attended Trust Board

31.08.17 The Chief Executive attended the new Governor Induction Session

31.08.17 The Director of Quality attended Trust Board

31.08.17 The Director of Organisational Development attended Trust Board

31.08.17 The Director of Finance and Commerce attended the Trust Board Meeting.

Board Stakeholder Engagement

04.07.17 The Chief Executive hosted the Patient Safety Collaborative Event

04.07.17 The Director of Service Delivery attended an Internal Digital Technology Deep Dive meeting

04.07. 17 The Director of Service Delivery attended a Joining Up Your Information Project Board and Clinical Information Sharing Projects Group Meeting

04.07. 17 The Director of Service Delivery attended a Regulation 28 Report meeting with Gloucestershire Clinical Commissioning Group

05.07. 17 The Director of Service Delivery attended a Service Strategy meeting at Redwood House, Stroud.

05.07. 17 The Director of Service Delivery participated in a workshop at the Acute Care Pathway Away Day in Ross on Why

05.07.17 The Director of Quality attended the Royal visit to open 2 new locations across 2gether – Wotton Lawn Family Room & Berkley House

05.07.17 The Director of Quality attended the Acute Care Pathway Away Day in Ross on Wye

05.07.17 The Director of Engagement and Integration attended the Royal Visit to the opening of the Family Room at Wotton Lawn Hospital

05.07.17 The Director of Engagement and Integration attended the Royal Visit to the opening of the Alexandra Wellbeing House

05.07.17 The Director of Organisational Development attended the opening of the Pied Piper Room at Wotton Lawn by the Countess of Wessex

05.07.17 The Director of Organisational Development attended Herefordshire & Worcestershire STP HR Directors Working Group

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

06.07.17 The Medical Director attended the CQRG meeting at the CCG.

06.07.17 The Medical Director attended the STP Clinical Reference Group at the CCG.

06.07.17 The Director of Engagement and Integration met with colleagues from the West of England Clinical Research Network at the Fritchie Centre

06.07.17 The Director of Engagement and Integration attended a partnership meeting with the CEO at Cobalt

06.07.17 The Director of Engagement and Integration attended the Sustainability Transformation Partnership Clinical Reference Group at Sanger House

06.07. 17 The Director of Service Delivery attended a Gloucestershire Stage 1 Assurance Meeting with Gloucestershire Clinical Commissioning Group

06.07. 17 The Director of Service Delivery attended a PC Pilot Steering Group meeting

07.07.17 The Chief Executive attended the Wye Valley Trust Annual Public Meeting

07.07.17 The Chief Executive chaired the Dementia Partnership Board

07.07. 17 The Director of Service Delivery attended a Police & Crime Bill meeting with Herefordshire CCG

07.07. 17 The Director of Service Delivery met with a DCI from Gloucestershire Police

10.07. 17 The Director of Service Delivery attended an A & E Delivery Board meeting

10.07.17 The Director of Quality attended the Gloucestershire Safeguarding Children's Board Improvement Task & Finish Group

10.07.17 The Director of Quality attended the Gloucestershire Care Services Joint Meeting with 2gether Trust

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

11.07. 17 The Director of Service Delivery attended a meeting with a representative from "Big Hand"

12.07.17 The Medical Director attended a Suicide Audit Meeting with GCC.

13.07. 17 The Director of Service Delivery attended a New Models of Care Board meeting

13.07.17 The Director of Engagement and Integration facilitated a meeting between Local NHS Chief Executive Officers, AHP Leads and the Chief AHP Officer for NHS England

13.07.17 The Director of Engagement and Integration hosted a visit from the Chief AHP Officer for NHS England with ^{2}gether AHP Leads to discuss the services that the Trust provides and innovation

14.07. 17 The Director of Service Delivery attended a Review of Mental Health ICT with Gloucestershire Clinical Commissioning Group

17.07. 17 The Director of Service Delivery attended an Introductory meeting with the CEO of Herefordshire Mind

18.07.17 The Chief Executive attended a meeting of the Clinical Senate

18.07. 17 The Director of Service Delivery attended a meeting regarding Oak House works with Herefordshire CCG

19.07. 17 The Director of Service Delivery attended a Networking Transformation Project Board Meeting at Gloucester Royal Hospital

20.07.17 The Chief Executive chaired the Improvement Academy Steering Group

20.07.17 The Chief Executive attended the Herefordshire and Worcestershire LWAB meeting

20.07. 17 The Director of Service Delivery attended a Stroud and Berkley Vale Pilot Board meeting

20.07.17 The Director of Quality attended 2gether Contracting Monitoring Board and CQRF with the CCG in Hereford

20.07.17 The Director of Engagement and Integration attended the Trust's Annual General Meeting

20.07.17 The Director of Quality attended the Trust AGM

21.07.17 The Chief Executive attended the STP BI Strategy Development Day

21.07. 17 The Director of Service Delivery attended STP BI Strategy Development Day

24.07. 17 The Director of Service Delivery attended a Mental Health Act Group meeting

24.07.17 The Medical Director attended a Site Visit and Meeting with ROCHE regarding CREAD2 (Research & Development).

25.07.17 The Director of Organisational Development attended Strategic Workforce Development Partnership Board

25.07.17 The Director of Quality attended the Strategic Workforce Development Partnership board in Cheltenham

25.07.17 The Director of Engagement and Integration met with the CEO of Carers Gloucestershire

26.07. 17 The Director of Service Delivery attended a WAN/LAN Costings meeting

27.07. 17 The Director of Service Delivery attended a Mental Health Housing Support Update meeting with Gloucester Council

28.07.17 The Director of Engagement and Integration attended a partnership meeting with colleagues from Cobalt

28.07.17 The Medical Director held a meeting with relatives following a serious incident.

28.07.17 The Director of Quality attended the Chief Nursing Officer Stakeholder Panel for Hereford CCG.

01.08.17 The Chief Executive attended the Gloucestershire Countywide IM&T meeting

02.08.17 The Director of Finance and Commerce attended the Quarterly Meeting with Price Water House Coopers.

02.08.17 The Director of Engagement and Integration attended the Forest of Dean Community Services Review Steering Group meeting at Sanger House

03.08.17 The Director of Engagement and Integration attended the Gloucestershire Health and Care Overview and Scrutiny Committee Work Planning Meeting at Shire Hall

04.08.17 The Chief Executive chaired the Dementia Board

07.08.17 The Director of Engagement and Integration met with the Strategic Stakeholder Lead of Pluss

08.08.17 The Chief Executive attended a Primary Healthcare Workshop with Gloucestershire Care Services

08.08.17 The Director of Service Delivery attended a Primary Healthcare Workshop with Gloucestershire Care Services

08.08.17 The Director of Engagement and Integration attended the Gloucestershire Care Services and 2gether Clinical Workshop at the Gloucestershire Deaf Association Centre for Deaf People

08.08.17 The Director of Quality attended the Primary Health Workshop with Gloucestershire Care Services

09.08.17 The Chief Executive attended the One Herefordshire Health and Care Shadow Alliance meeting

09.08.17 The Medical Director held a meeting with relatives following a serious incident.

09.08.17 The Director of Organisational Development attended Integrated Care Alliance – Workforce Group

10.08.17 The Chief Executive attended the Worcestershire STP Mental Health Workstream meeting

10.08.17 The Director of Organisational Development attended Joint STP Hfds&Worc Workforce & OD Action Group and HR Directors meeting

11.08.17 The Director of Service Delivery attended the MHARS Service meeting

15.08.17 The Director of Engagement and Integration attended a private viewing for 'Mindscape' at the Nature in Art Centre

16.08.17 The Chief Executive attended the Gloucestershire STP Digital deep dive meeting

16.08.17 The Director of Engagement and Integration met with a the family of a service user to discuss the Experts by Experience programme

17.08.17 The Chief Executive attended the Gloucestershire STP CEO's meeting

17.08.17 The Director of Engagement and Integration met with the Director of 'Look Again'

18.08.17 The Director of Organisational Development met with colleagues from University of Worcester to discuss the new Nurse Degree Apprenticeship standard.

21.08.17 The Director of Engagement and Integration met with the Lead Commissioner (Public Health) and the Project Manager for Mental Health/ End of Life (CCG) to discuss 'Time to Change'

22.08.17 The Director of Engagement and Integration attended the Tackling Mental Health Stigma Group

22.08.17 The Chief Executive attended the Worcestershire STP Partnership Board

22.08.17 The Chief Executive met with Colleagues from Herefordshire Mind

23.08.17 The Chief Executive attended the Herefordshire AO's meeting

23.08.17 The Director of Engagement and Integration attended the Herefordshire Adults and Wellbeing Overview Scrutiny Committee at Shire Hall

24.08.17 The Chief Executive attended the Gloucestershire STP Extraordinary Delivery Board

Board National Engagement

06.07.17 The Director of Quality attended the Patient Safety Collaborative in Bristol

19.07.17 The Director of Engagement and Integration attended the CHCR Summer Seminar at the University of the West of England in Bristol

22.07.17 The Director of Quality attended the NHSI 90 Day Rapid Improvement Programme around the MH Observations Programme in London

01.08.17 The Director of Finance and Commerce attended the Powys LHB & 2g Intro and Update Meeting in Powys.

01.08.17 The Director of Quality attended the NHSI 90 day rapid improvement programme site visit to Wotton Lawn Hospital

02.08.17 The Director of Engagement and Integration met with NHS England's National Nursing Lead for Mental Health and Learning Disabilities

03.08.17 The Director of Organisational Development chaired Gloucestershire STP Capability Thematic Group

09.08.17 The Director of Engagement and Integration took part in a teleconference with International Partners building a new practice assessment

15.08.17 The Director of Engagement and Integration had an introductory phone conversation with Dr Barbara Vann, Chair of Cornwall NHSFT

22.08.17 The Director of Engagement and Integration hosted a meeting with AHPP colleagues from Aneurin Bevan University Health Board Wales

30.08.17 The Director of Finance and Commerce attended the Aneurin Bevan & 2gether Intro & Update Meeting in Newport.

3. Sustainability

Temporary Staffing Demand quality/sustainability

Cumulative agency spend for the first four months of 2017/18 (£1.48m) is below the same period 2016/17 (£1.68m), and the aim this year is to deliver an agency spend that is within 25% of the NHSI ceiling.

Nursing spend is on track to deliver to the NHSI ceiling (around £1m below 2016/17 spend), and work continues to sustain that performance – the peripatetic HCA team in Herefordshire has significantly reduced agency spend, and the Gloucestershire peripatetic HCA teams will roll-out between September and November 2017.
Medical spend remains above the 2016/17 level, but work to increase the number of direct engagement locums and move locums to Trust contract is underway. Although the AHPP spend remains high due to the IAPT improvement programme, the underlying AHPP agency spend is in line with the NHSI ceiling.

Gloucester City Hub sustainability/quality

The project is currently on programme for the building to be occupied in November.

Much of the work to the exterior of the building is now complete with the exception of the construction of the new entrance lobby. Inside, much of the work has also been completed but a detailed fire prevention survey, conducted following the Grenfell Tower fire, has revealed that some additional fire stopping work is required. These works will be completed before occupation.

Staff and service users continue to be involved in the development of the internal design and operational processes, with service users stressing the importance of the welcome they receive when entering the building. Good progress is being made with preparation work (e.g. disposal of unwanted items and paperwork) for staff to vacate existing buildings and move to Pullman Place.

Agenda item 17 **Enclosure No** **Paper L**

Report to: 2gether NHS Foundation Trust Board 28th September 2017
Author: Stephen Andrews, Deputy Director of Finance
Presented by: Andrew Lee, Director of Finance and Commerce

SUBJECT: **Finance Summary report for period ending 31st August 2017**

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

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

EXECUTIVE SUMMARY

- The month 5 position is a surplus of £286k in line with the planned surplus.
- The month 5 forecast outturn is an £884k surplus in line with the Trust's control total.
- The Trust has an Oversight Framework segment of 2 and a Finance and Use of Resources metric of 2.
- The 2017/18 contracts with Gloucestershire CCG, Herefordshire CCG, NHS England and Worcestershire Joint Commissioning Unit have been signed. The Trust has agreement in principle with Aneurin Bevan Health Board and is just awaiting contract paperwork to finalise the contract.
- Agency spend at the end of August is £1.821m. On a straight line basis the forecast for the year would be £4.372m, which would be a reduction of £1.12m on last year's expenditure level, but above the agency control total by £0.968m. It is estimated however that with a number of initiatives currently being implemented to reduce agency usage further the year end forecast will be £3.712m.
- The Trust is in the process of undertaking a mid year review of its financial position. There are a number of cost pressures the Trust is managing and the review is identifying the mitigations and deliverables required to ensure the Trust meets its control total. Revenue budgets, capital expenditure, savings schemes, cash, balance sheet provisions and potential risks and opportunities are all being reviewed. This review will come to the October Board meeting.

RECOMMENDATIONS

It is recommended that the Board:

- note the month 5 position

- agree that based upon the month 5 position it is content for the Q2 position to be submitted to NHS I in mid-October showing a forecast that will achieve our Finance Control Total, subject to any significant changes arising as the month 6 position is finalised, although such changes are not expected.

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 September 2017

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
	Date	

Explanation of acronyms used:	See footnotes

1. CONTEXT

The Board has a responsibility to monitor and manage the performance of the Trust. This report presents the financial position and forecasts for consideration by the Board.

2. EXECUTIVE SUMMARY

The following table details headline financial performance indicators for the Trust in a traffic light format driven by the parameters detailed below. Red indicates that significant variance from plan, amber that performance is close to plan and green that performance is in line with plan or better.

Indicator	**Measure**		
Year End I&E	Single Oversight Framework Segment	2.00	
Income	FOT vs FT Plan	102.9%	
Operating Expenditure	FOT vs FT Plan	103.2%	
Year end Cash position	£m	13.6	Forecast balance of £13.6m (including investments)
PSPP	%age of invoices paid within 30 days	98.0%	91% paid in 10 days
Capital Income	Monthly vs FT Plan	101.8%	
Capital Expenditure	Monthly vs FT Plan	76.6%	£3,164k expenditure.

The parameters for the traffic light dashboard are detailed below:

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

Nb. The RAG rating for cash has been amended above as requested at the last Board meeting.

- The financial position of the Trust at month 5 is a surplus of £286k which is in line with the plan (see appendices 1 & 8).
- Income is £1,769k over recovered against budget and operational expenditure is £2,078k over spent, and non-operational items are £313k under spent.

The table below highlights the performance against expenditure budgets for all localities and directorates for the year to date, plus the total income position.

Trust Summary	Annual Budget £000	Budget to Date £000	Actuals to Date £000	Variance to Date £000	Year End Forecast £000	Year End Variance £000
Cheltenham & N Cots Locality	(4,849)	(2,020)	(2,082)	(61)	(4,998)	(149)
Stroud & S Cots Locality	(4,552)	(1,897)	(1,941)	(45)	(4,887)	(335)
Gloucester & Forest Locality	(4,221)	(1,759)	(1,745)	14	(4,204)	17
Social Care Management	(3,801)	(1,584)	(2,113)	(529)	(5,068)	(1,267)
Entry Level	(6,263)	(2,610)	(2,826)	(216)	(6,513)	(249)
Countywide	(31,082)	(12,936)	(13,190)	(255)	(31,431)	(349)
Children & Young People's Service	(6,490)	(2,680)	(2,544)	136	(6,401)	88
Herefordshire Services	(12,714)	(5,311)	(5,523)	(212)	(13,224)	(510)
Medical	(15,396)	(6,415)	(6,667)	(252)	(15,932)	(536)
Board	(1,642)	(684)	(675)	9	(1,855)	(214)
Internal Customer Services	(1,833)	(764)	(754)	10	(1,838)	(5)
Finance & Commerce	(6,113)	(2,552)	(2,685)	(132)	(6,416)	(303)
HR & Organisational Development	(3,111)	(1,296)	(1,325)	(28)	(3,351)	(240)
Quality & Performance	(2,900)	(1,209)	(1,210)	(1)	(2,978)	(78)
Engagement & Integration	(1,335)	(556)	(602)	(46)	(1,433)	(98)
Operations Directorate	(1,125)	(469)	(509)	(41)	(1,246)	(122)
Other (incl. provisional / savings / dep't	(4,022)	(1,804)	(1,906)	(103)	(2,929)	1,093
Income	112,331	46,827	48,582	1,756	115,589	3,258
TOTAL	**883**	**282**	**286**	**4**	**884**	**2**

The key points are summarised below;

In month

- The Social Care Management over spend relates to Community Care and is offset by additional income
- The Entry Level over spend relates to the IAPT service, agency staff and additional leadership and administration time
- Herefordshire is over spent due to ward staffing costs but a proportion of this is due to specialling and will be offset by additional income
- The Medical over spend has been caused by agency expenditure - £767k in the first five months.
- Finance and Commerce is overspent due mainly to additional maintenance costs although these have started to reduce. Estates are reviewing the work done to date and drawing up a list of key priorities
- Income is over recovered due to additional income for activity related Community Care work and additional development funds which weren't budgeted
- There is limited slippage against the savings programme

Forecast

There are significant cost pressures within Directorates including

- Agency costs for Medical and Inpatients are still expected to be significant, even after the effect of actions being taken to reduce this usage
- The apprenticeship levy of £310k, against which there is currently little offset of training costs
- Despite some success in bringing placements back into county the forecast for

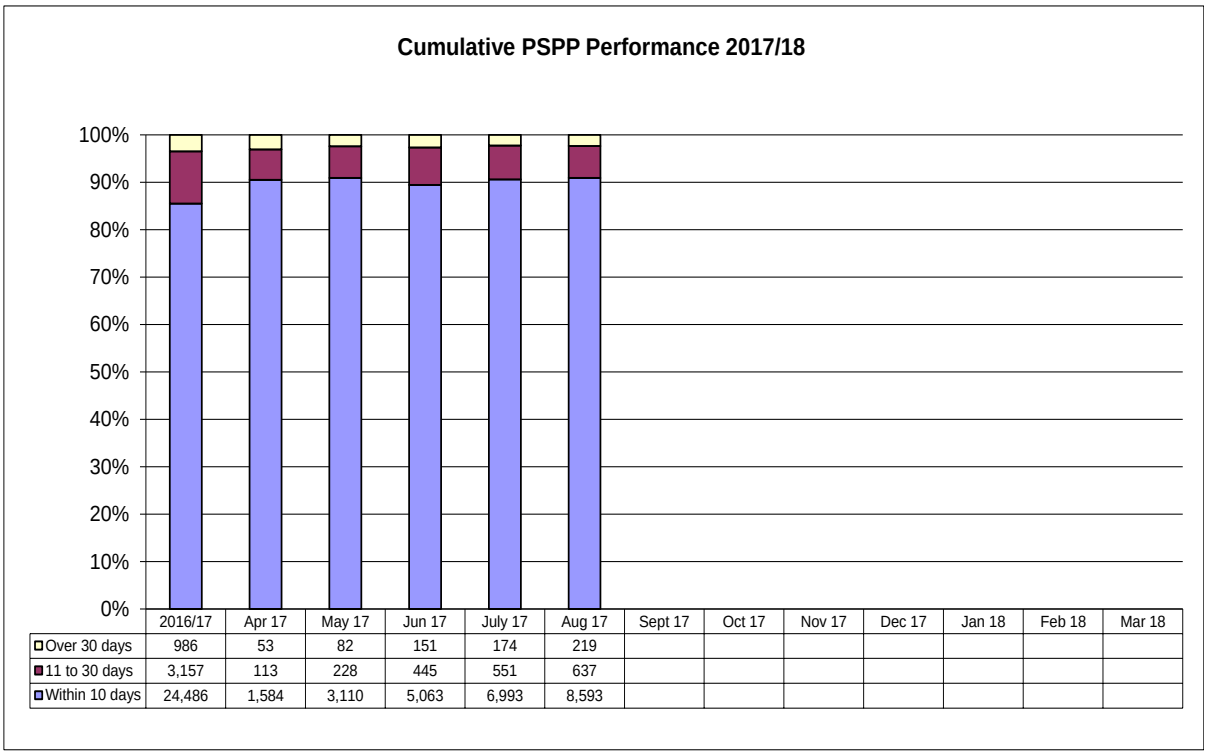
Complex Care has risen to £458k over spend due to the effect of new high cost placements. This assumes a £250k reduction on a straight line cost projection as it is anticipated people will be brought back into Gloucestershire for treatment.

- The use of agency staff in IAPT will reduce but is expected to continue until December. No further agency is expected after this time although there is a risk that targets will not be met if there is no cover for posts which become vacant.

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

PUBLIC SECTOR PAYMENT POLICY (PSPP)

The cumulative Public Sector Payment Policy (PSPP) performance for month 5 is 91% of invoices paid in 10 days and 98% paid in 30 days. The cumulative performance to date is depicted in the chart below and compared with last year's position. The Trust has a strong cash position which enables it to continue to consistently pay suppliers promptly.



	2016/17	Apr 17	May 17	Jun 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Over 30 days	986	53	82	151	174	219							
11 to 30 days	3,157	113	228	445	551	637							
Within 10 days	24,486	1,584	3,110	5,063	6,993	8,593							

	10 days		30 days	
	In month	**YTD**	**In month**	**YTD**
Number paid	1,603	8,593	1,694	9,230
Total Paid	1,731	9,449	1,731	9,449
%age performance	**93%**	**91%**	**98%**	**98%**
Value paid (£000)	5,148	28,062	6,071	31,001
Total value (£000)	6,111	31,784	6,111	31,784
%age performance	**84%**	**88%**	**99%**	**98%**

Agenda item 18 **Enclosure Paper M**

Report to: Trust Board - 28th September 2017
Author: Andrew Lee, Director of Finance & Commerce
Presented by: Andrew Lee, Director of Finance & Commerce

SUBJECT: **Corporate Strategy**

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

EXECUTIVE SUMMARY

1. Attached is the updated Corporate Strategy, which has been approved at both the Executive Committee and the Development Committee in August.

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

3. This updated overarching strategy is key to the delivery of our Strategic and Operational Plans.

RECOMMENDATION

That the Board reviews and approves this updated Corporate Strategy.

Corporate Considerations	
Quality implications:	None
Resource implications:	None
Equalities implications:	None
Risk implications:	None

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

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

Reviewed by:		
	Date	

Where in the Trust has this been discussed before?		
Executive Committee & Development Committee	Date	August 2017

What consultation has there been?		
	Date	

Explanation of acronyms used:	

CORPORATE STRATEGY

1. Introduction

1.1 The Trust has a suite of enabling strategies in place that are consistent with and facilitate delivery of our Strategic Plan 2014-2019

1.2 This Corporate Strategy is an overarching strategy, and is of particular importance, as it aims to set out how we will seek to sustain and improve the provision of high quality care and support services; reduce inequalities; achieve financial growth and, therefore, remain sustainable as an organisation in the long term.

2. Original Environmental Context

2.1 A number of key strands were considered when arriving at our 5 year Strategic Plan. Many of these would appear relevant to our Corporate Strategy too, along with how we seek to progress it, and are set out below.

2.2 Firstly, that our operating environment indicates that in the advent of Sustainability and Transformation partnerships and emerging guidance with regard to the creation of ACS/ACO pathway redesign is inevitable and with it associated challenges to the artificial silos created by organisational boundaries. This could significantly affect the financial viability of our of small standalone organisations in the medium to longer term. This is in the context and light of current planning assumptions for health and social care demand, overall health funding going forward, the need to continue to deliver cash releasing efficiencies year on year, and evolving social and political policy.

2.3 Secondly, that our analysis revealed that whilst assessment by patients, service users, carers and regulators indicates that many of our services are rated as good or outstanding:-

(i) We are currently at the lower end of critical mass for a sustainable Foundation Trust.

(ii) We are constantly under pressure to reduce the cost of the services we provide.

(iii) Elements of our business are at risk of being “cherry picked” by lower cost providers.

2.4 Thirdly, that where commissioners tender services these are usually at a reduced contract sum than the current cost, thereby providing less

opportunity to deliver realistic contributions to overhead costs and a level of margin. In addition, this can call into question service quality levels.

2.5 Fourthly, that to tender for services comes at a cost that can typically run into hundreds of thousands for larger tenders, and requires significant senior clinical and executive level input.

2.6 Fifthly, that the supply of tenders to the market appears to be significantly reduced.

2.7 Sixthly, that we are, however, well placed to respond to tenders and other opportunities that present themselves, as we have a strong liquidity position that can provide pump priming funds.

2.8 Further environmental context has arisen since the production of our strategic plan, in the light of the Dalton Review and the 5 Year Forward View and their vision for integrated service provision.

3. Sustainability and Transformation Partnerships (STP's)

3.1 The environmental context has significantly changed since our initial Corporate Strategy was agreed, via the introduction of STP's.

3.2 STP's are the vehicle to promote whole system integrated working in a particular area, and seek to promote joint working between different NHS providers, commissioners, primary care, local authorities and the voluntary sector. STP's are to drive integrated working as opposed to organisational change, but they could nevertheless lead to organisational change.

3.3 There are 44 STP's throughout England, and we participate in two STP's, being Gloucestershire and Herefordshire & Worcestershire, as we provide and deliver services throughout the counties of both Gloucestershire and Herefordshire.

3.4 STP's may develop into Accountable Care Systems (ACS) to cover service provision for an entire area, and within an ACS you could have one or more Accountable Care Organisation (ACO). An ACO will be made up of one or more organisation in an area (either as a result of joint pathway working or organisational acquisition or merger), who would then take on the lead provider role for that area, and hold sub contracts with other providers as necessary.

3.5 As a result of STP working commissioners are rarely tendering services any more, as it is now felt that better outcomes can be achieved through integrated place based partnership working. There are, however, smaller

specific areas where tenders are still put to the market, e.g. for Occupational Health services.

3.6 Therefore, financial growth and sustainability is now more likely to be achieved via acquisition or merger, rather than successful tendering.

4. Strategic Plan Direction

4.1 Our 5 year Strategic Plan – submitted to NHS Improvement (previously Monitor) in June 2014 and subsequently rated as Green by NHSI – set out a clear ambition for growth, with this growth to be achieved as a result of maintaining and strengthening our expertise in mental health services, while seeking to develop and move into the provision of community health services. This ambition, although stated before the release of the Dalton Review, the 5 Year Forward View and the 5 Year Forward View for Mental Health, fits with the vision of more integrated place based services contained within these documents and the subsequent STP ethos, and seeks to ensure more effective alignment of mental and physical well-being.

4.2 The detailed but separate Commercial Strategy sets out a range of options, tools and processes that could be followed in pursuance of our strategic ambition for growth. However, there is a real danger that the organisation could seek to follow too many options for growth at the same time, resulting in a lack of capacity and capability to respond well and potentially leading to an inability to deliver our growth ambition.

4.3 Therefore, this Corporate Strategy sets out below the options that the Board has determined that 2gether will follow in order to deliver our growth ambition.

5. Options

5.1 The options agreed are:-

5.2 **Protect existing business and respond to opportunities to develop further.** This option seeks to protect and retain existing business (but in doing so would discern whether or not it was financially and/or strategically sound to do so), but also looks to pick up new business in line with our strategic direction. Under this option we would need to develop strategic partnerships in order to be successful. However, this option rejects pursuing significant growth opportunities that present themselves in Wales, and also rejects pursuing growth opportunities that are not geographically contiguous with our current service delivery area (but please note that these rejections do not apply to Occupational Health opportunities). This option is consistent with the STP ethos, as the best way to achieve it is through integrated partnership working.

5.3 **Progress big step change.** Under this option we would seek to identify and progress opportunities to acquire or merge with other NHS organisations, in order to more closely align mental and physical well being and deliver a step change in our service offer and opportunities to reduce inequalities and long term financial sustainability. This option is also consistent with the STP ethos, as it would lead to improved pathway working and greater service integration. The current possibilities against this option would appear to be threefold as below:-

(i) Continue to progress integration options in Gloucestershire, via an acquisition of or merger with Gloucestershire Care Services, to provide a joint offering for mental and physical health and well being.

(ii) Consider integration options within Herefordshire, in conjunction with the CCG, Wye Valley NHS Trust, Taurus and Herefordshire Council.

(iii) Be ready to be proactive in progressing a three counties option covering service provision in Gloucestershire, Herefordshire and Worcestershire.

Agenda item 19 **Enclosure Paper N**

Report to: Trust Board - 28th September 2017
Author: Andrew Lee, Director of Finance & Commerce
Presented by: Andrew Lee, Director of Finance & Commerce

SUBJECT: **Finance Strategy**

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

EXECUTIVE SUMMARY

1. Attached is the updated Finance Strategy, being an enabling strategy to the delivery of our Strategic and Operational Plans.

2. The Finance Strategy covers the following areas:-
   - (i) Introduction.
   - (ii) General Objectives.
   - (iii) Quality & Finance.
   - (iv) Overall Aim.
   - (v) Specific Aims.
   - (vi) The Annual Financial Plan.
   - (vii) Planning Assumptions.
   - (viii) Budget Setting, Service Planning & Contracting.
   - (ix) Cost Improvement Plans.
   - (x) Benchmarking and Carter Review.
   - (xi) Financial Management.
   - (xii) Key Cost Drivers, Service Line Reporting & Patient Budgeting.
   - (xiii) Capital.
   - (xiv) Cash & Investments.
   - (xv) Annual Accounts.
   - (xvi) Innovation.
   - (xvii) Charitable Funds.
   - (xviii) Finance Department.
   - (xix) Financial Shared Services.
   - (xx) Other Shared Services.
   - (xxi) Internal Audit, External Audit & Counter Fraud.

3. A draft of this strategy was considered at the Development Committee in February, with a number of amendments suggested all of which have been incorporated into this final version.

4. This version has also been widely circulated for comment among senior managers both within and outside of the finance function.

5. This strategy was also considered at the Executive Committee of 8th May, where it was approved subject to some minor changes all of which have been made.

6. The May Development Committee the considered this strategy again and requested a small number of further changes, which have all been actioned.

7. The August Development Committee then approved this strategy subject to one minor amendment which has been made.

RECOMMENDATION

That the Board reviews and approves this Finance Strategy.

Corporate Considerations	
Quality implications:	None
Resource implications:	None
Equalities implications:	None
Risk implications:	None

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

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

Reviewed by:		
	Date	

Where in the Trust has this been discussed before?		
Executive Committee and Development Committee	Date	Various

What consultation has there been?		
	Date	

Explanation of acronyms used:	

FINANCE STRATEGY

CONTENTS

1. Introduction

1.1 This document sets out the overall Finance Strategy for 2gether NHS Foundation Trust.

1.2 It will be used as the basis to complete the relevant financial sections of Strategic and Operational Plans, as well as the basis upon which we provide finance input to both the Gloucestershire and the Herefordshire & Worcestershire Sustainability and Transformation Plans (STP's).

1.3 It will also be used as the basis to complete the specific annual draft and final Financial Plan for each year.

1.4 This strategy should be read in conjunction with the following other Trust enabling strategies:-

(i) Corporate
(ii) Commercial
(iii) Partnerships
(iv) Marketing
(v) Engagement and Communication
(vi) Research
(vii) Allied Health Professions Practice Development
(viii) Nursing
(ix) Organisational Development
(x) Workforce
(xi) Training
(xii) Technology
(xiii) Clinical Services
(xiv) Estates
(xv) Information and Performance Management
(xvi) Quality Strategy

1.5 The Executive Committee approves all the above strategies and in doing so ensures there is appropriate alignment between them.

2. General Objectives

2.1 The Finance Strategy is consistent with our Strategic Plan submission of June 2014 to cover the period from 2014 to 2019, and is one of the enabling strategies to seek to deliver this plan. It is also consistent with our two year Operational Plan to cover the period from April 2017 to March 2019.

2.2 It also fits entirely with our key priorities of Quality, Engagement and Sustainability, as indicated below:-

(i) The strategy must be a high quality document in and of itself, and must also create a financial picture which facilitates the delivery of high quality services to all service users.
(ii) The strategy sets out processes that seek to ensure excellent engagement in the production of annual financial plans.
(iii) The strategy sets out what is needed from the financial perspective to seek to deliver sustainability in the short, medium and longer term, and underpins the Declaration of Sustainability in the Strategic Plan.

2.3 It is also consistent with our desire to continuously seek to improve both our services, and the delivery of our services, to our service users.

3. Quality & Finance

3.1 It is of vital importance that the delivery of the quality agenda and the finance agenda progress side by side on a "hand in glove" basis. The organisation cannot be successful by delivering one without the other.

3.2 Therefore, we work to the maxim of "Quality without Finance is unsustainable while Finance without Quality is unthinkable".

3.3 An example of this "hand in glove" working can be found in the Quality Impact Assessment (QIA) process around Cost Improvement Programme (CIP) schemes, as under normal circumstances a scheme will not progress unless it has a QIA in place that the Director of Quality, the Medical Director, the Director of Engagement & Integration, and the Director of Finance have all signed off.

4. Overall Aim

4.1 The overall aim of the Finance Strategy is to ensure that ^{2}gether NHS Foundation Trust always has sufficient funds available to enable it to meet its liabilities as they fall due, and to invest in the future needs of the Trust.

5. Specific Aims

5.1 The specific aims of the Finance Strategy are:-
(i) To set out and put in place those processes and systems necessary to seek to deliver financial sustainability in the short term through efficiency plus the appropriate use of the Trust's strong liquidity position, and in the medium to longer term through further efficiency and income growth.

(ii) To provide all information necessary to budget holders, and to fully support them throughout the year, to enable them to deliver the target year end revenue financial positions as per our Strategic Plan, our Operational Plan and our revenue Control Totals as set by NHS Improvement (NHSI).

(iii) To provide all information necessary to capital scheme owners to assist them in the delivery of capital schemes to the required specification in a timely manner.

(iv) To ensure that the Trust's cash is managed as effectively as possible within NHSI's guidelines, maximising the opportunity to earn interest within these guidelines.

(v) To seek to deliver a Use of Resources rating within the NHSI's Single Oversight Framework of at least a 2 (with 1 being the best and 4 the worst score), and support the Trust in obtaining an overall Segment score of at least a 2.

(vi) To support innovation in service delivery to improve access, treatment and recovery for service users, but also to assist in the delivery of required efficiency savings.

(vii) To seek to generate additional income through appropriate developments that are in-line with the Trust's strategic objectives.

(viii) To deliver a high quality set of annual accounts with a clean audit opinion, and within the required timescale.

(ix) To deliver a greater understanding of our key cost drivers, plus report on the contribution or loss of each of our service areas, as a result of significantly developing the use of Service Line Reporting (SLR) plus the implementation of a Patient Level Information Costing System (PLICS).

6. The Annual Financial Plan

6.1 Each year a specific draft and then final Financial Plan will be produced to deal with the particular circumstances of the year in question.

6.2 The draft plan will be produced between November and January of the year before it covers, and will be presented to the Executive and Development Committees (and also the Board if there are particular issues that require this).

6.3 The final plan will be prepared and finalised based upon the outcomes of contract negotiations with commissioners, and will be presented to the Board in either March or April.

7. Planning Assumptions

7.1 In order to forward plan in the most effective way possible it is necessary to make assumptions in a number of key areas, as outlined below.

7.2 Inflation – These need to cover the following (but could be set at zero or even be negative in certain cases):-

(i) Tariff Deflator (the difference between required commissioner efficiency and their uplift for inflation).
(ii) Pay (ie pay awards and incremental drift).
(iii) Non Pay – Drugs.
(iv) Non Pay – Utilities.
(v) Non Pay – Rent and Rates.
(vi) Non Pay – Other.

7.3 Cost Pressures – These need to cover the following:-

(i) General (ie a provision against as yet unknown pressures, knowing that there will be some).
(ii) Specific (ie a provision against a known cost pressure).
(iii) Capital Programme related.

7.4 Enabling Budgets – As a minimum these need to support the following:-

(i) CQUIN achievement.
(ii) Organisational Development.

7.5 The organisation does not currently hold a General Contingency Reserve or a specific CIP Delivery Contingency Reserve, with this position being reviewed on an annual basis dependant upon the outcome of contract negotiations with commissioners.

8. Budget Setting, Service Planning & Contracting

8.1 Budget setting, service planning and contracting all need to be taken together, and must not be seen in isolation. Completion of these generally runs between October and February of the year before that which they relate to.

8.2 They all flow from the Strategic and Operational Plans, with budgets set needing to be sufficient to deliver the agreed service plans, and the outcomes of the contracting round needing to be sufficient to underpin the budgets set. Should contracting outcomes be insufficient to do so, then there will either be a need for additional CIP schemes to make up the shortfall or service plans will need to be revisited.

8.3 The process for budget setting is as follows:-

(i) Planning guidance issued to budget holders in early October.

(ii) Management accountants then meet with budget holders through October and November to identify draft budgets for the following year.

(iii) During these meetings cost pressures are identified, with tactical decisions made with regard to the delivery of any general budget reductions required as part of our CIP.

(iv) Vacancy factor is also applied, currently at the overall Trust level of 2%. However, this is not uniformally applied to all staff budgets as it is recognised that certain areas cannot deliver vacancy savings (eg inpatient wards), while others can deliver greater than 2% (eg community budgets).

(v) Draft budgets are then finalised including those cost pressures supported plus the effect of any general savings required, and these will be compared to the Financial Control Totals (FCT's) maintained by the Deputy Director of Finance in order to identify how close we are to achieving our agreed target financial position at that point.

(vi) During the period of January to March the following then occurs:-

- Draft budgets are updated for any unresolved issues (likely to be very few).
- Draft budgets are reduced to remove the following year's scheme specific CIP's.
- Draft budgets are updated for any changes arising from the contracting process and/or as a result of the issuing of the Allocation Letter.

(vii) Final budgets are now agreed, with budget holders physically signing for them and a signed copy retained in the Finance Department as the master copy.

8.4 The above process results in budget holders knowing their full annual budget to manage within for the year on 1st April, as all CIP impacts will have already been removed. This position is significantly more straightforward for budget holders to manage than providing them with an allocation, but saying that we need to remove an as yet unspecified amount in year for CIP delivery.

8.5 Pay and non pay budgets are set on the following bases:-

(i) Pay (in post) – Based upon the actual point of scale that an individual is at and taking account of in year pay inflation and incremental rises.

(ii) Pay (vacant) – Based on the minimum point of the scale, but taking account of in year pay inflation.

(iii) Non Pay – Based upon expenditure trends, but adjusted for known changes. However, in doing so care is taken to avoid creating a perverse incentive to reward overspending budgets, with any budget increases requiring full justification.

8.6 The process for service planning is as follows:-

(i) Planning guidance issued to managers at the same time as the budget setting planning guidance.

(ii) A requirement for a limited number (usually 3 to 5 but can vary) of service area specific objectives, plus a limited number of organisation wide objectives.

(iii) All objectives must be SMART in nature.

(iv) Objectives to be agreed during the period of October to March, and then delivery reported upon during the year in question.

8.7 Once objectives are agreed then a “plan on a page” will be completed for each area, in order to circulate to all staff in the area to assist with ownership and delivery of the agreed objectives.

8.8 The process for contracting is as follows:-

(i) Commissioners issue Commissioning Intentions during October or November, which indicate those services they wish to invest in, those they wish to maintain as are, those they wish to transform, and those they wish to disinvest in.

(ii) These Commissioning Intentions will also set out any tendering plans that commissioners have.

(iii) As a provider we then need to respond to these Commissioning Intentions. However, provided we have good commissioner relationships in place, there should not be any surprises in the Commissioning Intentions and we should already be working with commissioners on any issues for us.

(iv) During November we will then agree our contract negotiation stance (ensuring escalation processes exist) and negotiations will begin.

(v) Senior Executive meetings will also normally take place in November or December to set the frame for contract negotiations and/or unblock any issues where necessary.

(vi) Examples of key areas to address during contract negotiations are the tariff deflator, changes to non financial service targets, cost pressures, changes in government policy, CQUIN funding and demographic population changes.

(vii) The aim is always to reach financial agreement by the end of January (and be in a position to sign a Heads of Terms if required), with all other contractual issues and terms agreed in time to enable contract

sign off by the end of February (unless these deadlines are changed centrally).

(viii) Should contract sign off not be achieved within the required timescale, then regulators (NHSI and NHS England) will initiate arbitration processes.

8.9 The Trust currently remains largely on block contract arrangements, but with shadow service user activity arrangements in place with commissioners. However, the Trust is working towards making these arrangements real over the next 2 to 3 years, but with appropriate gain and risk share arrangements with commissioners.

8.10 The outputs from the budget setting, service planning and contracting processes then enable us to complete our annual operational planning return and pro formas for NHSI.

9. Cost Improvement Plans (CIP)

9.1 CIP's are an ongoing requirement on us as a Trust in order to seek to continually be more efficient, and in order to deliver the efficiency savings element of the tariff deflator plus any surplus required.

9.2 Wherever possible we seek to keep our CIP target below 3%, and always seek to keep it below 5% as above that level is regarded as high risk.

9.3 Our CIP strategy also seeks to identify schemes to cover the full CIP value (ie leave nothing as unidentified) by the end of September in the financial year prior to that in which the savings are to be delivered (eg so for 2018/19 CIP schemes we aim to have the CIP plan fully scheme specific by 30th September 2017).

9.4 In order to achieve this we require Executive Directors, Service Directors, Senior Managers and Heads of Professions to be examining their areas for potential efficiencies, and then owning and driving forward, supported by finance and other staff, those savings plans that are agreed to progress.

9.5 We then move on to identify a Project Initiation Document (PID) and Quality Impact Assessment (QIA) for each scheme, and aim to have them both signed off by 31st March ready for removal from budgets prior to the start of the next year.

9.6 Despite having signed off PID's and QIA's in place, as these are completed and signed in advance of the necessary actions taking place and are based upon assumptions or expectations, unforeseen events or issues can occur which can compromise scheme delivery. Therefore, and as a safety mechanism, every four months there will be an in year review of schemes to seek to ensure no such unforeseen events have occurred. Should unforeseen events occur which result in a scheme being delayed or not delivering at all, then removed funding will need to be reinstated and additional replacement schemes sought.

9.7 However, where a scheme is not delivering as expected due to a lack of focus on delivery (rather than the occurance of an unforeseen event), then the budget will not be reinstated and an overspend will occur which will need to be made good in other ways.

9.8 Our CIP strategy also has a Transformation Board in place to seek to ensure effective scheme identification and delivery. This is chaired by the Director of Finance and made up of a range of senior managers from across the organisation. Its purpose is to identify sufficient CIP schemes prior to the year starting, ensure PID's and QIA's are in place, and then monitor progress on delivery in year.

9.9 The Finance Strategy also has safeguards to ensure a "common truth" around CIP scheme rag rating and delivery. This is achieved through monthly meetings of the Director of Finance, the Deputy Director of Finance and the PMO Project Manager leading on CIP delivery, with the output of these meetings being collated onto a single reporting template which is used for all reporting (whether it to be to Transformation Board, as part of the Finance Report to the Board, NHSI reporting or for whatever purpose).

10. Benchmarking and the Carter Review

10.1 Increasingly benchmarking is being used as an essential tool to understand both performance and cost.

10.2 The Trust receives benchmarking information from a number of areas including NHS Improvement, the national Mental Health Benchmarking Club, and STP analyses, and will also shortly have significant further benchmarking information available internally from its SLR/PLICS system.

10.3 This benchmarking information identifies whether or not the Trust is an outlier in any particular area, thereby enabling us to review costs and/or performance to understand why this may be and does it present an efficiency gain that could become part of our CIP plans.

10.4 Lord Carter has undertaken a benchmarking/efficiency review of acute trusts which has identified potential savings areas and targets for them. His review has now extended to mental health and community services, and we are part of the pilot group for this extension and expect to identify potential areas to consider for efficiency or effectiveness as a result.

11. Financial Management

11.1 Financial management covers a range of areas, but for the purposes of the Finance Strategy this will cover Budgetary Control and Financial Reporting.

11.2 Budgetary control is the process whereby managers and budget holders manage their expenditure levels within their budget levels. In order to assist budget holders to do so there is specific management accountant support by service area, with the relevant management accountant working closely with all budget holders in their area.

11.3 This management accountant support assists budget holders to quickly identify any areas of concern within their area, plus a relevant action plan to recover wherever possible any overspending areas. Management accountants also contribute to the monthly Board Finance Report, and provide position statements for their areas along with explanations for any significant in year or forecast year end variances. They also ensure that underspends against budget are withdrawn non recurrently in year where appropriate in order to avoid them being spent in an unplanned manner.

11.4 This support enables budget holders and managers to have a good understanding of their budgets and what impacts upon their budgetary position. To facilitate this regular finance training to non finance managers and staff is provided.

11.5 With regard to Financial Reporting, a comprehensive Finance Report is prepared and presented to each private Board meeting (with a summary report going to each public Board meeting). This report covers the in year and forecast year end financial position with variance analysis for key areas, the position against capital spend, the position with regard to CIP achievement, the position against cash, performance against the NHSI Segmentation, forecast CQUIN achievement, and an assessment of key risks to the forecast year end position. Various appendices and graphs are attached to assist the reader in understanding the report.

11.6 On an annual basis the Board Finance Report format is reviewed to ensure it continues to provide the level and clarity of information that the Board requires and that NHSI requires the Board to have considered.

11.7 Financial reporting on specific areas is also provided to both the Delivery and Development sub committees of the Board, as required by their agendas and terms of reference.

11.8 Financial reporting is also submitted to NHSI in the required format and to the required frequency and standard, in order for NHSI to assess performance and Segment the Trust.

12. Key Cost Drivers, Service Line Reporting (SLR) & Patient Level Costing (PLICS)

12.1 In order to seek to deliver the most effective services to service users, to gain a better understanding of those actions that are key cost drivers, to better understand the profitability of our different service delivery areas, and to seek to effectively benchmark our costs both internally and externally, we are developing Service Line Reporting (SLR) via the utilisation of a Patient Level Information Costing System (PLICS).

12.2 This system will also enable us to drill down to individual patient costing information, in readiness for the potential introduction of individual patient budgets to sit with patients rather than with commissioners.

12.3 Once fully up and running SLR and the PLICS system will enable us to:-

(i) Understand those costs which really drive other costs, and over which we need to exercise as much control as possible.

(ii) Understand and report upon the relative contribution or loss to the Trust's financial bottom line that each service area provides.

(iii) Benchmark our performance by service area against other like organisations.

(iv) Benchmark our performance down to the level of individual clinical delivery.

(v) Be in a position to compete and cope should individual patient budgeting be introduced.

12.4 During 2017/18 we expect the outputs of SLR and PLICS to start to be built into the monthly Board Finance Report as standard.

13. Capital

13.1 The Finance Strategy requires the Trust to have a capital plan in place that facilitates Strategic Plan delivery, along with processes to facilitate in year delivery and review of the capital plan.

13.2 As part of its Strategic and Operational Plan submissions the Trust set out a clear 5 year capital programme specifically aimed at delivering the aims of these Plans. These submissions remains the basis for capital expenditure, but will be refreshed as part of the specific yearly Financial Strategy.

13.3 A Capital Review Group (CRG) exists with authority to approve amendments to the plan within delegated limits, but also to monitor in year progress against plan delivery taking action as necessary where progress is off target. In addition, the CRG proposes the following year's refreshed plan to the Executive Committee and on to the Development Committee and full Board for approval.

13.4 As part of identifying the capital programme, the split of funding in year for the programme between depreciation, disposals and utilisation of liquidity (cash) is clearly set out.

13.5 A surplus asset disposal plan is also part of the overall Capital Programme.

14. Cash & Investments

14.1 The Trust must at all times ensure its cash balances are wisely utilised and maximised.

14.2 To facilitate this an annual cash plan is determined and monitored, with significant variances from plan reported as part of the Board Finance Report.

14.3 The Finance Strategy enables surplus cash (ie cash not needed to meet existing liabilities) to be utilised in any way permitted by NHSI. This includes:-

(i) Investment in commercial short or longer term investments where the risk and return of such investments justifies this.

(ii) Underpinning financial sustainability in the short term (ie to manage an agreed in year deficit position) while transformational change is being enacted.

(iii) Pump prime in a non recurrent manner savings or service development initiatives.

(iv) Strategically support non recurrent tender production costs to seek to gain or maintain areas of service delivery.

(v) Strategically support non recurrent costs of implementing new ways of working with a partner or range of partners, which will be of benefit to service users.

(vi) Support increased capital expenditure to seek to deliver Strategic Plan or other corporate aims.

(vii) Investment in other NHS or non NHS bodies, where to do so is in the interest of strengthening, transforming or modernising service delivery.

14.4 All cash investments do, however, have to be in line with the REID manual.

14.5 In addition, all cash investments have to be consistent with the Treasury Management Policy, which covers areas such as level of risk, ethical investing, and income versus capital growth.

15. Annual Accounts

15.1 The Finance Strategy requires the production and submission of a high quality set of annual accounts within the NHSI timescale.

15.2 These accounts are also to achieve a clean audit opinion.

15.3 Annual accounts are not only required to be completed as at the year end (31st March), but interim sets of accounts are required by NHSI at the end of quarter 2 and also and more fully at the end of quarter 3.

15.4 All required disclosures and notes must be completed and submitted with the year end set of accounts, which must also comply with all regulator and legislative requirements.

15.5 Where the Trust sets up any subsidiary companies then these will also need to be consolidated into the Trust's annual accounts.

15.6 The draft year end accounts usually require completion and submission by around two thirds of the way through April. External audit of these draft accounts is then carried out, with the final audited Accounts submitted in late May following a special meeting of the Audit Committee to consider and sign them off.

16. Innovation

16.1 The Finance Strategy fully supports innovative ways of service delivery and innovative ways of funding service delivery.

16.2 However, where such innovation takes the Trust into new territory where expertise does not specifically exist, then it is essential that it obtains the necessary expert advice before progressing.

16.3 Before progressing a financial model would, therefore, need to be created and signed off by the Executive Committee.

16.4 Alternatively, the Trust may at some future point consider investing into a joint venture of some kind to benefit service delivery. In such cases financial due diligence must be undertaken on all partners, with the level of diligence dependant upon the value of the venture and/or the level of involvement of the partner.

17. Charitable Funds

17.1 Although there is a separate Charitable Funds Policy and process to set the direction for Charitable Funds transactions, the Finance Strategy supports the principle of active but targeted fundraising.

18. Finance Department

18.1 The ethos of the finance department is that of ensuring it provides best value and is thereby supporting service delivery to service users.

18.2 The finance department is a service department and, therefore, supports others in the delivery of their budgets and targets. It does not of itself deliver any of the Trust's financial obligations, but seeks to ensure that those who are delivering on financial targets have all the tools and support necessary to do so.

18.3 The exception to point 18.2 above is the production of the annual accounts, where the finance department does ensure these are produced on time and to a high standard with a clean audit opinion.

18.4 The finance department is split into three sections, as indicated below:-

(i) Management Accounting – where support is provided to managers and budget holders to deliver their financial responsibilities.

(ii) Financial Accounting – where the Annual Accounts are produced (but supported significantly by management accounting with regard to the data for the accounts), and from where regulatory financial issues support is provided.

(iii) Contracting – where contract negotiation with commissioners and its subsequent monitoring is facilitated, support is provided to Heads of Service and Directors on contract actions to enable effective contract monitoring to take place, and a library of contracts is held and maintained for reference.

19. Financial Shared Services

19.1 In order to seek to be as cost effective as possible the finance department does not directly provide all functions itself, but is part of a shared services arrangement with Gloucestershire Hospitals NHS Foundation Trust.

19.2 The following services are currently provided under this arrangement:-

(i) Counter Fraud.
(ii) Procurement.
(iii) Financial Accounts (ledger maintenance, control account reconciliations, etc.).
(iv) Payroll.
(v) FAPS (Fixed Assets).
(vi) Creditors.
(vii) Pensions.
(viii) Staff Payments (Expenses).

19.3 The Finance Strategy requires the Trust to ensure that this arrangement remains competitive, and in order to do so there is a service level agreement in place.

19.4 This arrangement will be periodically reviewed to see if it is more cost effective to do more directly ourselves, or to do less directly ourselves and put more under the shared services umbrella, or indeed to examine a more fuller outsourcing arrangement.

20. Other Shared Services

20.1 Other services are also provided on a shared services basis, and in conjunction or partnership with different organisations (eg IT Services are provided by CITS).

20.2 As per points 19.3 and 19.4 above relating to financial shared services, all other shared services will also be expected to remain competitive and be periodically reviewed for effectiveness and efficiency.

20.3 As we work ever closer with our local partners as part of progressing jointly agreed STP's, it is expected that a greater level of shared services will emerge for consideration, but these will need to be competitively advantageous for the Trust to pursue them.

21. Internal Audit, External Audit & Counter Fraud

21.1 Internal audit, external audit and counter fraud are all functions that exist to provide confidence as to the robustness and integrity of our financial and other systems of operation.

21.2 It is essential for all to be in place, and all will have an annual plan agreed by the Audit Committee.

21.3 Internal audit and counter fraud are more focused upon internal assurance, while external audit provides both internal and external assurance.

21.4 All are different and it is important to ensure they work “hand in glove” to avoid duplication. Internal audit will audit or investigate areas identified by Trust management (and will often be directed to areas of known problems in an attempt to highlight and then resolve them), whereas counter fraud will carry out proactive work agreed with Trust management but will also investigate potential issues of fraud and corruption that they may receive from a range of different sources (including anonymously). External audit will focus their work on that needed to be able to provide the various audit opinions required, and the assurance that comes with these opinions.

21.5 All completed reports will be received at and reported to the Audit Committee.

22. Recommendation

22.1 That the Board reviews and approves this Finance Strategy.

Andrew Lee

Director of Finance & Commerce

11th September 2017

Agenda item **20** **Enclosure** **Paper O**

Report to: Trust Board – 28 September 2017
Author: John McIlveen, Trust Secretary
Presented by: Marcia Gallagher, Audit Committee Chair

SUBJECT: **AUDIT COMMITTEE ANNUAL REPORT 2016/17**

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

EXECUTIVE SUMMARY

The Committee's terms of reference require that it reports to the Board, at least annually, on its performance against its terms of reference, and on its work in support of the Annual Governance Statement.

The attached report provides an overview of the Committee's work in the last financial year, in sections which reflect the headings in the Committee's terms of reference. The report also provides an overview of the work of the Committee in overseeing internal control mechanisms in the Trust, in support of the Annual Governance Statement.

RECOMMENDATIONS

The Board is asked to note the Audit Committee's Annual Report 2016/17.

Corporate Considerations	
Quality implications:	Effective management of risk provides assurance that patient services are being delivered safely
Resource implications:	None other than those identified in the report
Equalities implications:	None other than those identified in the report
Risk implications:	Failure to identify and mitigate corporate and strategic risks may adversely affect the Trust's strategic goals of engagement, quality and sustainability.

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

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

Reviewed by:		
Andrew Lee	Date	

Where in the Trust has this been discussed before?		
Audit Committee	Date	August 2017

What consultation has there been?		
Audit Committee Chair Director of Finance		

Explanation of acronyms used:	

²gether NHS Foundation Trust

Audit Committee Annual Report 2016/17

1 Introduction

1.1 The Audit Committee was established in its current form under Board delegation in late 2010 following a review of Board Committee structures. Its terms of reference are aligned with the Audit Committee Handbook, published by HFMA and the Department of Health.

1.2 All Non-Executive Directors are members of the Committee, with the exception of the Trust Chair. A number of officers are in regular attendance in accordance with the Committee's Terms of Reference. These include the Director of Finance & Commerce, the Trust Secretary, Internal and External Auditors, and the Local Counter Fraud Specialist. Other Directors and Managers attended at the request of the Committee. After each meeting of the Committee, the Audit Committee Chair provides a summary report of the Committee's deliberations and decisions to the next Board meeting.

1.3 The Committee met 5 times during the period 1 April 2016 to 31 March 2017, and has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the Trust's business through self-assessment and review, and by requesting assurances from Trust Officers. Each meeting was quorate.

1.4 Attendance by members at the Committee during the period was as follows:

	13/04/2016	25/05/2016	03/08/2016	02/11/2016	01/02/2017
Richard Szadziewski (Chair)[1]	✓				
Charlotte Hitchings[2]	✓		✓	✓	
Martin Freeman[3]	✓	✓	✓		
Jonathan Vickers	✓	✓	✓	✓	✓
Nikki Richardson	✓	✓	✓	✓	✓
Marcia Gallagher (Chair)[4]	✓	✓	✓	✓	✓
Duncan Sutherland		✓		✓	✓
Quinton Quayle[5]			✓		✓
Maria Bond[6]				✓	✓

1.5 The following were in attendance at the Committee during the period:

	13/04/2016	25/05/2016	03/08/2016	02/11/2016	01/02/2017
Andrew Lee, Director of Finance & Commerce		✓	✓	✓	✓
Stephen Andrews, Deputy Director of Finance	✓	✓	✓	✓	✓
Lee Sheridan, Local Counter Fraud Specialist	✓	✓		✓	✓
Lisa Evans, Board Committee Secretary	✓			✓	✓
Marie Crofts, Director of Quality	✓		✓		

[1] Left the Trust on 30/04/2016
[2] Left the Trust on 30/11/2016
[3] Left the Trust on 31/10/2016
[4] Chair from 01/05/2016
[5] From 01/06/2016
[6] From 30/11/2016

John McIlveen, Trust Secretary	✓	✓		✓	✓
Efe Ayeni, PWC				✓	
Peter Stephenson, PWC					
Michelle Hopton, Deloitte		✓		✓	
Ian Howse, Deloitte		✓	✓		
Gordon Benson, Asst Director of Governance		✓			
Shaun Clee, Chief Executive		✓			
Ruth FitzJohn, Trust Chair[7]		✓			
Tanya Hartley, Asst Director of Finance		✓			
Anna Hilditch, Asst Trust Secretary			✓		
Lynn Pamment, PWC	✓				✓
Claire Edge, Deloitte	✓				✓
Paul Kerrod, Counter Fraud Support Officer		✓			
Natalie Tarr, PWC		✓	✓	✓	✓
Alan Bourne-Jones, Risk Manager					✓
Carol Sparks, Director of Organisational Development[8]			✓		

1.6 Each meeting of the Committee except that on 1 February 2017 was observed by a Governor, who provides onward assurance to the Council of Governors regarding the performance of Committee members.

2 Principal Review Areas

2.1 This annual report is divided into five sections, reflecting the five key duties of the Committee as set out in its terms of reference.

2.2 Governance, Risk Management and Internal Control

2.3 The Committee has reviewed relevant disclosure statements, in particular the Annual Governance Statement together with the Head of Internal Audit Opinion, external audit opinion and other appropriate independent assurances.

2.4 The Head of Internal Audit Opinion was based on the audit work carried out during the year in line with the plan approved by the Committee, together with regard to the Trust's Board Assurance Framework, Risk Register, and other control mechanisms. This opinion contributed to the Committee's assessment of the effectiveness of the Trust's system of internal control, and to the completion of its Annual Governance Statement.

2.5 The Committee reviewed the Board Assurance Framework at regular intervals. The format of the Board Assurance Framework was amended during the year to provide a review based on an 'assurance map' approach, which the Committee found helpful.

2.6 The Committee reviewed the Corporate Risk Register at regular intervals, and received summary reports from other Board Committees in order to provide challenge and receive assurance that strategic and corporate risks assigned to those Committees are being adequately monitored.

[7] The Trust Chair is not a member of the Audit Committee, but may attend a meeting of the Committee by invitation

[8] Left the Board on 27/11/2016

2.7 The Committee reviewed both the draft and final versions of the Annual Governance Statement which set out the systems and processes for internal control and formed part of the Trust's 2015/16 Annual Report.

2.8 The Committee reviewed the Register of Directors' Interests, and the Register of Gifts and Hospitality.

2.9 The Committee has reviewed the completeness of the risk management system and the extent to which it is embedded within the organisation. The Committee believes that while adequate systems for risk management are in place, continued management focus is required to ensure that risk management continues to be embedded within the trust and in particular to address outstanding issues concerning Incident Reporting systems.

2.10 Internal Audit

2.11 In completing its work, the Committee places considerable reliance on the work of Internal Auditors. Throughout the year the Committee has worked effectively with internal audit to strengthen the Trust's internal control processes and during the year the Committee:

- Reviewed and approved the internal audit plan for 2016/17
- Considered the findings of internal audit in relation to work on the following issues

  - Human Resources – Bank and Agency
  - Contracting
  - CQC Implementation Plan
  - Procurement
  - Estates and Capital
  - Data Quality
  - Core Financial Systems
  - HR- Mandatory Training Follow Up
  - Incident Reporting
  - Risk Management
  - Information Governance
  - Procurement – Finance Shared Services

2.12 A number of these audits were undertaken at the Committee's request in order to examine areas where known areas of risk exist. The audits produced a total of 43 findings (4 more than the previous year). There were 20 Low, 21 medium and 2 high risk-rated findings, and a further 3 advisory findings were reported. In respect of each of these findings the Committee sought and received assurance on the mitigating actions being taken, following up outstanding actions as necessary, and referring issues to other Committees as appropriate in order for progress with action plans to be monitored.

2.13 All audit reports were classified as either Medium or Low risk, with the exception of the Procurement – Finance Shared Services report which received a high risk classification and 2 individually rated high risk findings. The Committee has requested assurance on a number of mitigating actions in respect of this review, which will be delivered during 2017/18.

2.14 The Committee has been pleased to note during the year a marked improvement in the timely completion of management actions arising from Internal Audit Reviews, as evidenced by the IA recommendations tracker which the Committee receives and reviews at each meeting.

2.14 **External Audit**

- The Committee received and noted the final audit in respect of the 2015/16 Financial Accounts and the 2015/16 Quality Report, and approved the Financial Accounts and the Quality Report on behalf of the Trust Board.
- The Committee reviewed and agreed the external audit plan for 2016/17.
- The Committee reviewed and commented on the reports prepared by external audit which have kept the Committee apprised of progress against the External Audit Plan.
- The Committee also received regular Sector Development Reports which proved a useful source of intelligence on key national issues and developments.

2.15 The Committee supported the Council of Governors' External Audit Working Group in appointing an External Auditor ahead of the expiry of Deloitte's contract on 31 March 2017. Following a tender exercise, KPMG was appointed as the Trust's External Auditor from 1 April 2017.

2.16 **Private Meeting with the Auditors**

2.17 The Committee Chair met privately with internal and external auditors in April 2016. No concerns were raised by either auditor, and both gave positive feedback about the reputation of the Trust and the working relationships that had been established.

2.18 Other Assurance Functions

2.19 The Committee has reviewed the findings of other significant assurance functions, and has considered any governance implications for the Trust. For example, the Committee received a report on an audit of the Trust's 7 day and 48 hour Quality Report indicator, a matter which had been referred to the Committee by the Delivery Committee following a review by Deloitte.

2.20 The Committee received regular Counter Fraud updates, and received the Counter Fraud Annual Report for 2015/16 and the Counter Fraud action plan for 2016/17. The planned total of 145 days of counter fraud activity was provided during 2016/17 across the 4 generic areas of Counter Fraud activity as defined by NHS Protect. This compares to 95 days in 2015/16. The areas of activity for 2016/17 were apportioned thus: 15 to 'Strategic Governance', 25 to 'Inform and Involve', 45 to 'Prevent and Deter' and 60 to 'Hold to Account'.

2.21 The NHS Protect self-review tool provided assurance that the Trust has a robust and effective Counter Fraud Service, with the overall level of risk being rated as 'Green' the same rating as for 2015/16, and there were no further quality assessment recommendations from NHS Protect arising from this self-assessment.

2.22 Management

2.23 The Committee has challenged the assurance process when appropriate, and has requested and received assurance reports from Trust management and various other sources both internally and externally throughout the year. The Committee has, for example, requested and received

- further assurance regarding the technical aspects of procedures in respect of staff leaving the Trust;

- further assurance on measures to ensure that staff are familiar with the Trust's procurement policy;
- visibility at each meeting on any waivers which may have been applied in the preceding period

2.24 The Committee works to an annual plan of scheduled agenda topics. In setting this annual plan, the Committee considers items currently on the Risk Register, items of current interest, and items raised by the auditors and the Executive Team. In addition the Committee follows up risk items previously identified to ensure that it remains informed of progress against previously agreed actions. A rolling programme of actions is maintained and monitored accordingly for all Committee meetings.

2.25 Financial Reporting

2.26 The Committee received Losses and Special Payments reports at various points through the year, as required by the Trust's Standing Financial Instructions. The Committee sought assurance in each case as to the processes in place to recover these amounts, and prevent recurrence.

2.27 The Committee reviewed the 2015/16 financial statements and annual report at the May 2016 meeting prior to recommending the final accounts for Accounting Officer signature, in line with authority delegated by the Board.

2.28 The Committee was pleased to note the external audit report which indicated that an unqualified audit opinion was to be given to the accounts, and that the auditors had not identified any significant weaknesses in systems of accounting and financial control.

3 Other matters

3.1 The Committee reviewed its own effectiveness during the year using the checklist contained in the Healthcare Finance Management Association's Audit Committee Handbook. The assessment provided broadly positive assurance that the Committee was effectively undertaking the duties required of it, and an action plan was implemented to address areas for improvement.

3.2 The Committee compiled an Annual Report on its activities which was received by the September 2016 Board.

3.3 The Committee reviewed its terms of reference during the year.

4 Conclusion

4.1 The Committee's primary contribution to the achievement of the Trust's strategic objectives is to ensure that Governance, Control, Risk Management and Audit systems are sound, reliable, and robust. This report gives an overview of the work of the Committee in the last financial year, which has enabled the Committee to conclude that the Trust's systems are in the main sound, reliable and robust.

Marcia Gallagher
Chair, Audit Committee

BOARD COMMITTEE SUMMARY SHEET

COMMITTEE NAME: Appointments and Terms of Service Committee

DATES OF COMMITTEE MEETINGS: 2nd November 2016, 10th January 2017, 30th March, 29th June and 31st August 2017

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

SUMMARY

The Appointments and Terms of Service Committee has met on five occasions in the past year.

The Committee's purpose is to determine and decide on appointments, appropriate remuneration and terms of service for the Chief Executive and Executive Directors. This includes deciding all aspects of salary and the provision of any other appropriate benefits and contractual terms.

At each meeting there have been not less than four Non-Executive Directors present plus the Trust Chair. Both the Chief Executive and the Director of Organisational Development were in attendance in person or via telephone at each meeting.

November 2016

The Committee reviewed actions taken to review and ensure equality and diversity relating to the local Clinical Excellence Award. It also debated and agreed the terms and conditions for the appointment into the post of Director of Organisational Development. Finally, the Committee requested a formal review of the current Executive pay framework and ranges in line with Hay's previous recommendation.

January 2017

The Committee received confirmation that the local Clinical Excellence Award policy and procedure had been reviewed and updated in light of recent learning, with alignment to the most recent national guidance for local Employer Based Awards. It also reviewed and approved a recommendation on the pay progression of two Executive Directors following consideration of their respective appraisals.

March 2017

Following the Committee's previous request and recommendations from Hays for a benchmarking review, the Committee considered and approved options for the Executive pay framework and related band ranges. The paper presented the most recent national NHS

Providers remuneration survey, the new NHS Improvement VSM guidance and additional local benchmarking, labour market research and national guidance. The Committee also considered and approved a similar paper outlining options for the Chief Executive in light of the same data. In line with national guidance, regulator opinion was sought in relation to the Chief Executive's remuneration. Approval was also given to an explicit appeal process for Executives, something which had previously been absent in the framework. The Committee was mindful of ensuring that the Trust maintained a reward strategy that represented best value for public money, recognised and rewarded the talent of the Executives in a manner commensurate with their roles, and ensured the ability to attract and retain the capability to deliver the Trust's strategy. This was felt to be increasingly important given the significant operational and financial challenges facing the Trust, the labour market for Executives and the need for stability.

June 2017

The Committee considered and supported the recommendations for the appointment of a Medical Director to replace the present incumbent when he retires later in the year. It also received and approved the recommendations from the 2015/16 Clinical Excellence Award round which had completed in March 2017. Ten consultant staff were awarded eleven local Employer Based Clinical Excellence Awards, with nine staff receiving an award each and one receiving two. Support was given to scoping additional equal opportunities training and guidance to members for the following year's award round. It was also agreed that, subject to any national requirements, the 2016/17 round should commence in Quarter 3.

August 2017

The Committee finalised the appointment terms of the incoming Medical Director. It also considered and supported recommendations for the implementation of a Payment In Lieu of Notice clause in Executive Contracts following a review of legal advice and good practice. The Committee agreed the principles for a satisfactory resolution of issues relating to Sections 5.15 of the NHS Standard Contract on "Employment or engagement following NHS Redundancy." Approval was also given to recommendations for an interim Executive role pending the satisfactory conclusion of Board discussions and Council of Governors support on the proposed strategic intent of the Trust in relation to the formation of a Foundation Trust chain and an integrated physical, mental health and learning disabilities offer.

RISKS

There is a risk that the Trust will not make robust appointments or be able to retain Executive Directors with the requisite skills, values, knowledge and experience to deliver the organisation's strategy if the Committee does not have in place clearly understood and agreed processes for recruitment, remuneration and terms of service, or does not have thorough and comprehensive discussions and challenge about those processes.

ASSURANCES

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

FURTHER ACTIONS

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

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: Ruth FitzJohn **ROLE: Sub-Committee Chair**

DATE: 21st September 2017

2gether
Making life better

2gether NHS Foundation Trust

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Development Committee

DATE OF COMMITTEE MEETING: 16 August 2017

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

FINANCE STRATEGY

The Committee received an updated Finance Strategy which had been considered by the Executive Committee, where a small number of amendments had been suggested. These amendments had been made, and addressed issues such as future needs in terms of income generation, and made clear the Finance Strategy's relationship to other corporate strategies. The Development Committee suggested one further amendment, namely the inclusion of the Quality Strategy which had been omitted from the enabling strategies listed. With that inclusion, the Development Committee endorsed the Finance Strategy for consideration by the Board.

STRATEGY REVIEWS

The Committee received a verbal update on reviews in relation to the Trust's Commercial, Marketing and Partnership strategies. The Committee was assured that work on these reviews was progressing, and that revisions would address the changing local health economy environment in terms of Sustainability and Transformation Partnerships, as well as ensuring consistency with the Trust's other enabling strategies. The Commercial Strategy would examine ways in which the Trust could maintain and increase its income stream, given the changing health service environment. The Committee noted that work on these strategies would be complete by October, and that the Commercial, Marketing and Partnership may at that point be combined in some form. The Committee agreed to receive the revised strategies at its October meeting, and also requested a short glossary in order to explain, on a single document, the purpose of each of the Trust's enabling strategies.

The Committee also considered the latest iteration of the Corporate Strategy, noting that this had also been discussed at the Executive Committee earlier in the week. Additional sections had been added to the Corporate Strategy to reference the development of STP's, and to provide further reference to the quality of services. The Committee noted the strategic options contained within the strategy, and agreed that while these were not mutually exclusive, option 2 (big step change) was the most appropriate option to pursue at the moment. The Committee suggested that the Corporate Strategy be deemed an overarching strategy, rather than a key enabling strategy as described in the document. The Committee endorsed the Corporate Strategy for consideration by the Board.

SOCIAL INCLUSION ANNUAL REPORT/ENGAGEMENT TACTICAL PLAN

The Committee received the Social Inclusion Annual Report for 2016/17 and noted the work undertaken to raise awareness of the Trust and its work and the significant assurance provided in most areas. The Committee noted that where assurance was limited (for example in respect of the involvement of volunteers) these would remain areas of focus during 2017/18. A number of new volunteer roles had already been identified and would shortly be advertised. The Committee noted the action plan for 2017/18, and agreed that the Social Inclusion Annual Report be shared with the Council of Governors.

The Committee received the Engagement and Communication Strategy Tactical Plan Q1 update, and noted the significant work underway in 2017/18, both through the Social Inclusion team and more widely within the Trust. The tactical plan focussed where possible on measurable engagement indicators, although some indicators were more difficult to measure (e.g. engagement through the Bytesize staff newsletter). The Committee noted that priorities for Q2 would be those indicators such as increasing Trust membership and the availability of volunteer roles, where performance was below target.

RECOVERY COLLEGE ANNUAL REPORT 2016/17

The Committee received the Recovery College Annual Report which provided significant assurance that the Recovery College was meeting its service specification and providing good experiences and outcomes for its students. The Committee noted that the Trust has secured an additional Health Foundation grant to produce a Recovery College Digital Workbook and Manual, which would be produced during 2017/18 to extend the reach of the Recovery College's intervention principles.

RESEARCH DEVELOPMENTS

The Committee received a report on research developments, and noted that the Trust had signed contracts to conduct two clinical trials, and had expressed an interest in participating in a number of other research studies. The Committee received assurance that work had been done to ensure that principal investigators were in place for these trials, and also that analysis had been undertaken to understand the financial impact of participation. The Committee agreed to receive a research update every quarter. The Committee also reviewed and approved revised terms of reference for the Research Overview Committee. It was agreed that the Chair and Deputy Chair of the Development Committee should be listed as ex officio members of this Committee, in order to receive papers and to attend the meeting on a periodic basis.

STAKEHOLDER COMMITTEE TERMS OF REFERENCE

The Committee received TOR for the Stakeholder Committee (formerly the Service Experience Committee). The Chair and Deputy Chair of the Development Committee are ex officio members of the Stakeholder Committee, and it was agreed that it would be useful for both to attend a meeting of the Stakeholder Committee on an approximately annual basis, once the Committee was well established.

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Jonathan Vickers ROLE: Committee Chair
DATE: 16 August 2017

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Governance Committee

DATE OF COMMITTEE MEETING: 18 August 2017

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PATIENT SAFETY

There had been 5 new serious incidents reported during June 2017; 1 serious incident was reported for Gloucestershire - 1 incident was subsequently de-classified by commissioners and 4 serious incidents were reported for Herefordshire. There were 7 new SIs reported during July; 3 for Gloucestershire and 4 for Herefordshire. No Never Events had occurred within Trust services since the NRLS devised the original list of 8 Never Events in 2009. The SI rate per 1000 caseload was 0.32 for July and 0.23 for June. The Governance Committee agreed that this report provided significant assurance that the Trust had robust processes in place to report and learn from serious incidents.

LEARNING FROM DEATHS IN THE NHS DRAFT POLICY

The Committee received the draft Learning from Deaths in the NHS Policy which had been developed by the Medical Director. In accordance with national guidance and legislation, the Trust currently reported all incidents and near misses, irrespective of the outcome, which affected one or more persons, related to service users, staff, students, contractors or visitors to Trust premises; or involving equipment, buildings or property. This arrangement was set out in the Trust policy on reporting and managing incidents. The Committee had noted that this Policy would be taken to Board in September and provided feedback on the final version.

MEDICAL APPRAISAL ANNUAL REPORT

The Committee received the Medical Appraisal Annual Report. Medical Appraisals had continued to be instituted 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 that would further deliver assurance annually and sustain quality. At the end of March 2017 90.9% of Doctors had a valid appraisal; 7.8% of those non-compliant were explained by exclusion criteria such as long term sick leave. This left 1.3% (one case) who at that point was classified as non-compliant. A further review of this case indicated that it was a short term delay and the annual appraisal had since been completed. The Committee was assured that there was a clear escalation process in place; new appraisals were reviewed along with a random sample of all appraisals. Compliance was high and the quality of appraisals was good.

SAFE STAFFING LEVELS

The Committee received the safe staffing levels report for June and July, noting the consistently high fill levels of over 96% for shifts within the 2 reporting periods. The Committee noted a number of occasions where planned staffing levels in certain wards had not been met and received assurance that these exceptions had presented no patient safety concerns.

The Committee also received an update on temporary staffing. The first Quarter the Trust had seen a significant reduction in the cost of agency nursing (at NHSI control total) however there had been a substantial increase in the cost of agency relating to medics and the control total for Medics was not on course to be met. The Committee asked that additional information on actions and timescales regarding medical agency use be included in the next report.

SAFEGUARDING (ADULTS AND CHILDREN) ANNUAL REPORT

The Committee received the first annual Safeguarding report; this provided a summary of the key issues and activities associated with Safeguarding Children and Adults in Herefordshire and Gloucestershire for the financial year 2016/17. More work was being undertaken around assurance that could be given and objectives that could be set to demonstrate activity that is appropriate. The Committee was significantly assured that safeguarding was a Priority function of the Trust and was being delivered as per the 4 Safeguarding Strategic Boards across Gloucestershire and Herefordshire. The Committee noted the report and agreed that it would be forwarded to Herefordshire and Gloucestershire Clinical Commissioning Groups.

QUALITY REPORT (Q1 SUMMARY)

The Committee received the first review of the Quality Report priorities for 2017/18.
Progress made towards achieving targets, objectives and initiatives identified in the Annual Quality Report was noted; 4 targets were not currently being met:

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

Target 1.2 was referred to the Delivery Committee for action and the QCR Sub-Committee was asked to monitor the 4 targets not currently being met. An update would be provided to the Governance Committee at the next meeting on the actions being undertaken.

OTHER ITEMS

The Governance Committee at its June meeting also received and noted the assurance provided by the Security Monitoring and Reporting and the Service Experience Report.

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Nikki Richardson ROLE: Chair

DATE: 12 September 2017

Agenda item 22 **Enclosure Paper Q**

Report to: Trust Board, 28th September 2017
Author: Ruth FitzJohn, Trust Chair
Presented by: Ruth FitzJohn, Trust Chair

SUBJECT: **CHAIR'S REPORT**

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

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

1. PURPOSE, ASSURANCE AND RECOMENDATION

This report sets out the key activities of the Trust Chair and Non-Executive Directors for the period 17 July 2017 – 16 September 2017.

The report offers full assurance that regular, targeted and purposeful engagement is being undertaken by the Chair and Non-Executive Directors aiming to support the strategic goals of the Trust.

This report is for information only and the Board is invited to note the report.

2. CHAIR'S KEY ACTIVITIES

- Chairing the Trust's Annual General Meeting in Gloucester
- Chairing two Board meetings in Gloucestershire
- Chairing two Appointment and Terms of Services Committees
- Attending the Gloucestershire Health and Wellbeing Committee
- Meeting with the Lead Governor
- Charing the Governor induction workshop
- Together with the Deputy Chair, attending a meeting with the Chair and Deputy Chair of Gloucestershire Care Services NHS Trust

- Undertaking substantial interaction with NHS Improvement about our strategic plans
- Participating in telephone meetings with the Chair of Gloucestershire Care Services NHS Trust
- Meeting with the Chair of Gloucestershire Care Services NHS Trust several times
- Meeting several times with the Deputy Chair and CEO
- Participating in several meetings and teleconferences with Non-Executive Directors
- Attending the regular informal meeting with Non-Executive Directors
- Meeting with the Trust's newly appointed Chaplain
- Meeting with the Medical Director Designate
- Meeting with a colleague from the Trust's psychology team
- Attending a Trust colleague's funeral in Cheltenham
- Attending the Weavers Croft Gardening Group in Stroud
- Visiting the Stonebow Unit in Hereford
- Visiting Charlton Lane in Cheltenham
- Visiting Wotton Lawn in Gloucester
- Participating in a telephone meeting with the Chair of Gloucestershire Hospitals NHS Foundation Services NHS Trust
- Meeting with the newly appointed Gloucestershire Strategic Transformation Partnership Independent Chair
- Meeting with the Assistant Chief Constable for Gloucestershire Police
- Meeting with the Gloucestershire Police and Crime Commissioner
- Meeting with the Deputy Police and Crime Commissioner
- Meeting with a community activist
- Participating as a panel member in Gloucestershire Hospitals NHS Foundation Trust's League of Friends public Question Time panel
- Participating in and presenting at a Leavers Ceremony at the National Star College in Ullenwood
- Attending an event at Bishopscourt at the request of the Bishop of Gloucester
- Being interviewed by Victoria Derbyshire on BBC2 as the Chair of a good mental

health services provider

- Meeting with the Chair of Avon and Wiltshire Partnership NHS Trust
- Visiting the Nelson Trust with the Deputy Chair
- Participating in appraisal discussions with Executive Directors
- Meeting with the Director of Organisational Development to discuss Appointment and Terms of Service issues
- Additional regular background activities include:
    - attending and planning for smaller ad hoc or informal meetings
    - dealing with letters and e-mails
    - reading many background papers and other documents.

3. NON-EXECUTIVE DIRECTORS' ACTIVITIES

Jonathan Vickers

Since his last report Jonathan has;

- Prepared for and attended two board meetings
- Prepared for and attended a meeting of the appointments committee
- Prepared for and chaired a meeting of the development committee
- Prepared for and attended a Council meeting
- Attended a chair/NED's informal meeting
- Attended a strategic governance meeting
- Held discussions with the chair and other colleagues on trust business
- Held discussions with colleagues on the development committee

Nikki Richardson

Since her last report Nikki has;

<u>August</u>

- Prepared for and attended Board of Directors
- Attended meeting with Chair and CEO
- Attended Chairs/Vice Chairs meeting with Gloucester Community Services
- Prepared for and attended Audit Committee
- Met with 2g Freedom to Speak Up Guardian
- Meeting with Chair and CEO
- Telephone call with CEO
- Prepared for and Chaired Governance Committee
- Visit to Children and Young People's Service
- Governance meeting with Executives
- Deputised for Chair during annual leave
- Visit to the Nelson Trust
- Teleconference re Suicide Conference
- Prepared for and attended Appointments and Terms of Service Committee
- Prepared for and attended Board of Directors

<u>September</u>

- Attendance at Suicide Conference
- Attendance at Regional Learning from Deaths meeting
- Meeting with Chair of GCS

- Prepared for and attended Council of Governors
- Meeting with CEO regarding a complaint and follow up action with the complainant

Marcia Gallagher
Since her last report Marcia has;
August
- Prepared for and Chaired the Audit Committee
- Attended a NEDs meeting with the Chair
- Prepared for and attended a Serious Incident Review meeting
- Led a Governors visit to Charlton Lane re Dementia Services
- Attended a visit to Evergreen House Cheltenham re CYPS and LD
- Prepared for and attended a Committee Chairs Governance meeting with the Chief Executive

September
- Attended a World Suicide Prevention service at Gloucester Cathedral
- Prepared for and attended a Council of Governors meeting
- Prepared for and attended the Delivery Committee
- Prepared for and attended the Appointment and Terms of Service Committee
- Prepared for and attended the September Board meeting

Duncan Sutherland
A verbal report will be provided at the meeting

Quinton Quayle
A verbal report will be provided at the meeting

Maria Bond
Since her last report, Maria has:
August
- Prepared for and attended an Audit Committee
- Prepared for and attended a Committee Chairs Governance meeting with the Chief Executive
- Prepared for and attended a Governance Committee
- Carried out a visit to CYPS at Evergreen House, Cheltenham
- Attended an Appointments and TOS Committee
- Attended Trust Board

September
- Met with the GRIP Early Intervention Team in Gloucester
- Attended a MHAM Hearing at Wotton Lawn
- Carried out a MHA Review at Charlton Lane
- Participated in a Serious Incident Review meeting
- Met with Director of Service Delivery
- Prepared for and Chaired a Delivery Committee meeting
- Attended an Appointments and TOS Committee
- Attended Trust Board

4. OTHER MATTERS TO REPORT

There are no specific matters to be drawn to the attention of the Board at the time of writing.

[2]GETHER NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING
THURSDAY 13 JULY 2017
BUSINESS CONTINUITY ROOM, RIKENEL, GLOUCESTER

PRESENT:	Ruth FitzJohn *(Chair)*	Paul Toleman	Vic Godding
	Jo Smith	Katie Clark	Cherry Newton
	Mervyn Dawe	Jennifer Thomson	Hilary Bowen
	Svetlin Vrabtchev	Pat Ayres	

IN ATTENDANCE: Shaun Clee, Chief Executive
Marcia Gallagher, Non-Executive Director
Anna Hilditch, Assistant Trust Secretary
John McIlveen, Trust Secretary
Kate Nelmes, Head of Communications
Nikki Richardson, Non-Executive Director
Jonathan Vickers, Non-Executive Director

1. WELCOMES AND APOLOGIES

1.1 Apologies for the meeting had been received from Rob Blagden, Paul Grimer, Jenny Bartlett, Hazel Braund, Said Hansdot and Amjad Uppal. Elaine Davies and Ann Elias did not attend the meeting.

2. DECLARATION OF INTERESTS

2.1 There were no changes to the declaration of interests.

2.2 Shaun Clee advised of a potential conflict of interest in relation to the item on the agenda for the meeting around Benchmarking. He informed the Council that he was currently an Ambassador for the National Benchmarking Network. This was noted.

3. COUNCIL OF GOVERNOR MINUTES

3.1 The minutes of the Council meeting held on 9 May 2017 were agreed as a correct record.

4. MATTERS ARISING, ACTION POINTS AND EVALUATION FORM

4.1 The Council reviewed the actions arising from the previous meeting and noted that the majority of actions had been completed, or were progressing to plan. The inclusion of more detail against “completed” actions was helpful by way of tracking progress and adding additional assurance of completion.

4.2 The Trust had recently launched a new website, and work had been ongoing to transfer the Governor portal to the new site. During this time the portal had been unavailable to Governors. However, work was now complete and a “relaunch” was planned for 1 August 2017. The Assistant Trust Secretary would be preparing guidance for all Governors advising how to access the site and this would be sent out and support offered for people wishing to access the portal. It

was agreed that this would remain on the actions list until the September meeting to ensure that this was completed.

4.3 An action from the last meeting was to arrange a visit for Governors to the new Alexandra Wellbeing House. The Assistant Trust Secretary advised that the official opening of the unit had taken place the previous week and once the unit had been fully operational for a period of time a visit would be arranged. The date for this visit would be sought and shared with Governors ASAP. It was agreed that this would remain on the actions list until the September meeting to ensure that this was completed.

4.4 The Governors noted the comments and feedback received via the Meeting Evaluation Forms from the last meeting. Ruth FitzJohn said that this had been a complex and challenging meeting; however, she was pleased to see the positive feedback from Governors and the sense that people were all trying to work together. Mervyn Dawe highlighted the positive comments made about the chairing of the meeting, reiterating that Ruth FitzJohn had chaired the meeting admirably.

5. TENURE OF A GOVERNOR

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

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

5.2 Elaine Davies was elected as a Staff Governor in July 2013 and re-elected in July 2016 for a second term. Elaine has not attended the last 4 consecutive meetings of the Council of Governors. Since her initial election in 2013 Elaine has attended 5 out of 26 Council meetings. The Council received a similar report in November 2014 regarding Elaine's attendance, and determined at that time that she should remain a member of the Council of Governors.

5.3 The Council of Governors was asked to note this report and consider whether Elaine Davies's tenure as a Staff Governor be terminated in accordance with the constitution.

5.4 The Council noted that Elaine was the representative for Clinical, Social Care and Support Staff and this covered all staff working for the Trust in both Gloucestershire and Herefordshire.

5.5 Pat Ayres said that Governors were made aware of meeting dates a year in advance and if people did not think that they could commit to the time required then they needed to consider their position before becoming a Governor.

5.6 The Council noted that this post represented a large staff group which included Allied Health Professionals, Support workers and healthcare assistants. It was

therefore important that the necessary commitment could be given to carrying out the role.

5.7 The Council acknowledged the current work pressures within Elaine's service; however, it was agreed that Elaine Davies's tenure as a Staff Governor be terminated. The Council all agreed that a warm letter of thanks be sent to Elaine from Ruth FitzJohn setting out the Council's decision.

ACTION: Ruth FitzJohn to send a warm letter of thanks to Elaine Davies setting out the Council's decision in relation to the termination of tenure.

6. CHANGES TO THE TRUST CONSTITUTION

6.1 The Trust Secretary presented this report to the Council, setting out proposed changes to the Trust constitution. These changes deal largely with matters concerning conflicts of interest, and reflect policy guidance from NHS England, published in spring this year, requiring NHS trusts and foundation trusts to adopt strengthened policies to deal with actual and potential conflicts.

6.2 A number of changes have been proposed which affect both governors and directors. A number of existing provisions which hitherto applied only to governors have been expanded to include directors. In respect of governors, the proposal incorporates provisions which would prevent a governor taking up or continuing in office if she/he were concurrently a governor of another trust, given that this would clearly constitute a conflict of interest. This provision is already included in the constitutions of many other trusts, including University Hospitals Birmingham FT, Essex Partnership University FT, East London FT, and Cambridge and Peterborough FT, and the proposed change brings 2gether into line with what is now standard practice across many parts of the NHS.

6.3 Previous versions of the constitution incorporated Standing Orders for both the Council of Governors and the Board, meaning that Standing Orders formed part of the constitution. Each set of Standing Orders included provisions about conflicts of interest. In order to provide clarity, those conflicts of interest provisions in Standing Orders have been relocated into the main body of the constitution. As a result, Standing Orders now deal solely with procedural matters for meetings of the Council and the Board, and the proposal in this report would decouple Standing Orders from the constitution, and enable the Council and the Board to amend and approve their own Standing Orders.

6.4 Additionally, the proposed changes remove the position of a Learning Disability Partnership governor; the Trust has been unable to secure a nomination from the Learning Disability Partnership for this position, which has been vacant for over two years. This would reduce the size of the Council to 26 governors.

6.5 A small number of other changes had been made to update the constitution (for example, updating organisational names) and the changes were summarised, and new inclusions (i.e. those which were not previously part of the constitution of Standing Orders) were highlighted for Governors to review.

6.6 The Council of Governors were asked to note that whilst these changes would not affect any governor in office at the time of the July Council meeting, it could affect governors joining the council after this meeting.

6.7 At 29.4, a request was made that it be made clear that this referred to NEDs of "2gether". The Trust Secretary informed the Council that this provision also meant that a NED of 2gether who had served 2 consecutive terms could not stand as the Trust Chair or as a Governor within 3 years due to matters of independence.

6.8 At 16.4, Hilary Bowen suggested the addition of a co-opted advisor for Learning Disability services, given the proposed removal of the LD Partnership Board post. This was agreed.

6.9 The Council agreed that the report was very clear about the changes being proposed to the Constitution and Standing Orders. The Council therefore gave their full support and agreement to the changes, subject to the incorporation of those suggested amendments, and subject to approval by the Trust Board at its meeting on 27 July.

7. NHS BENCHMARKING

7.1 Chris Woon, Head of Information Management Services was in attendance at the meeting to provide an annual update to the Council on NHS Benchmarking.

7.2 The Benchmarking Network is the in-house benchmarking service of the NHS. The Network works with over 340 members to understand the wide variation in demand, capacity and outcomes evident within the NHS and define what 'good' looks like. This supports providers in delivering optimal services within resource constraints, whilst also allowing commissioners to achieve the best balance from available commissioning resources. Examples of the data received from the Network include benchmarks around Bed Occupancy, Serious Incident rates, Lengths of Stay and Patient Experience scores.

7.3 The Council was informed that the NHS Benchmarking exercise is an annual activity and the full report was received at the Delivery Committee for scrutiny. The Committee reviews the results and identifies keys areas of focus where further detailed reports would be prepared. The Council of Governors was offered good assurance that 2gether had the mechanisms in place to measure performance, with monthly scrutiny of its national and local target indicators via the Performance Dashboard. The dashboard was a public document and was also uploaded onto the Governor Portal.

7.4 The document received provided a summary for Gloucestershire; however, Chris Woon advised that the same report was produced for Herefordshire services as well and this could be made available for Governors to see.

7.5 The Council noted the benchmarking report. It was agreed that a more in depth look at the performance of the Trust, in particular via the Performance Dashboard would be helpful and the Governors therefore requested that the Chair of the Delivery Committee be invited to the next meeting in September for the Holding to Account session.

ACTION: The Chair of the Delivery Committee to be invited to the next Council meeting in September for the Holding to Account session, focussing on the Performance Dashboard

8. CHIEF EXECUTIVE'S REPORT

8.1 The Council noted the Chief Executive's report to the Council of Governors, which was intended to draw Governors' attention to key areas for awareness, information or for exploring further if of sufficient interest.

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

- Friends and Family Test
- Appointment of a New Medical Director
- Accountable Care Systems
- Fire Assurance Processes
- Formal opening of Alexandra Wellbeing House

8.3 The Chief Executive informed the Council that discussions were continuing locally around Accountable Care Systems and Accountable Care Organisations. NHS England Guidance was available which explained all about the proposed changes.

8.4 The Council congratulated Dr Amjad Uppal, current staff Governor who had been successfully appointed as the Trust's new Medical Director. Amjad's term as a Governor would come to an end in October, before taking up this new appointment.

8.5 The Governors agreed that it was excellent to see the fire safety response that had been provided by the Trust in light of the London tower block tragedy. In summary, assurance was received that:

- We have no estate which is high rise (classified as above 5 storey)
- We have no bedded estate which has cladding of the type on Grenfell Tower
- We have no bedded facilities which are unstaffed at night – with the exception of the Wellbeing House which is operated by Swindon Mind
- We have established processes for regular fire surveys
- We have established fire procedures informed by site specific risk assessments/surveys
- We have acceptable levels of staff trained in fire procedures

The Chief Executive advised however, that in the course of the review, 2gether has one property, Oak House in Hereford, where some of our assurance can only be considered as partial at the current time and as a consequence urgent additional information is being sought to support further additional decision making. It was noted that the issues and key risks had been escalated with NHS Property Services, who owned the building, and Herefordshire commissioners. The suitability of the environment at Oak House generally was currently being reviewed. The Chief Executive assured the Council that the safety and quality of services provided to those people located at Oak House was paramount. It was agreed that Governors would be kept up to date with the outcome of the review of Oak House.

ACTION: Chief Executive to ensure that Governors were kept up to date with the outcome of the review of Oak House.

9. MEMBERSHIP REPORT

9.1 Kate Nelmes was in attendance to present this report which provided a brief membership update to inform the Council of Governors about information for members, Governor Engagement Events and information about membership (year to date).

9.2 The last Membership newsletter (published in May) contained a survey, asking members why they joined, what they feel they gain from membership and inviting suggestions for ways in which we could improve membership and make it more meaningful. Some useful comments and feedback was received and a full analysis of the survey is being undertaken and recommendations for action will be reported as soon as possible.

9.3 The survey also invited members to join the newly established 'Membership Advisory Group', and five members volunteered to join. The first meeting took place on June 4, however only one member was able to attend. The group will meet again in September.

9.4 Plans are underway to hold a Governor Engagement event in the Forest of Dean on 10 October – World Mental Health Day. This event will take place at the Royal Forest of Dean College and will focus on children and young people's mental health.

9.5 Hilary Bowen noted the Membership statistics, making particular reference to the analysis of Membership characteristics. She asked whether it would be appropriate to include provision on membership forms for people to declare if they were transgender, noting that the risk of developing a mental illness within that group was particularly high. Ruth FitzJohn suggested that this could be a helpful item for discussion at the next Membership Advisory Group. Kate Nelmes would provide Anna Hilditch with the date of the next meeting to enable Governors to be invited. In the meantime, Kate Nelmes also agreed to seek advice around best practice for recording such membership characteristics from Stonewall.

ACTION: Date of next Membership Advisory Group (MAG) meeting to be sent out to Governors inviting attendance

ACTION: Kate Nelmes to seek advice around best practice for recording certain membership characteristics from Stonewall, for further discussion at the next MAG meeting

9.6 The Governors agreed that it would be helpful to receive a membership "pack" to enable them to go to events and promote membership. This pack would contain items such as membership forms, wristbands and useful website links for Governors to hand out. Kate Nelmes advised that such packs had already been made available to all Governors but agreed to liaise with Anna Hilditch to ensure that Governors had sufficient supplies.

ACTION: Kate Nelmes to liaise with Anna Hilditch to ensure that Governors had sufficient membership pack supplies and information about who to contact if they required more

9.7 Kate Nelmes agreed to check the membership database to ensure that all Governors received the Membership Newsletter. Some staff Governors noted that they had not received a copy.

ACTION: Kate Nelmes to check the membership database to ensure that all Governors received the Membership Newsletter

10. HOLDING TO ACCOUNT

10.1 Ruth FitzJohn said that she wanted to add a Holding to Account discussion at this meeting for people to have the opportunity to think about how they wished to carry out the role of HTA and what information they may want to receive. Feedback from recently resigning Governors had been that the HTA function of the Council was still not working as effectively as it could be and Ruth was therefore keen to get this right.

10.2 The Council was updated on a recent review carried out at another NHS Foundation Trust around a failure in financial governance. Some examples of the recommendations for improvement from this review were discussed and the Council was pleased to note that 2gether already had mechanisms in place for the majority of the areas where improvement was suggested. However, the key issue to consider around HTA was how the Council of Governors could carry out their role effectively to prevent such failings happening in the first place.

10.3 A HTA session had taken place at the November Council meeting around Finance, with Marcia Gallagher as Chair of the Audit Committee in attendance along with the Director of Finance. This session had looked at Marcia's skill set, and had asked challenging questions around how Marcia could assure herself that the Trust was operating effectively and whether she had any concerns about the Trust's financial position. This session had been widely praised by those Governors in attendance as an excellent way of seeking assurance.

10.4 Svetlin Vrabtchev said that HTA was difficult; however, 2gether had definitely improved and it was now about building on existing processes. He added that the HTA process should be seen as a positive occurrence and an opportunity for Governors to speak to and constructively challenge the Non-Executive Directors. Mervyn Dawe said that it had been his experience that 2gether was very open and willing to share and discuss issues with Governors. Ruth FitzJohn added that HTA did not always need to come from a formal session, but from Governor observation at Board Committee meetings and informal contact with the NEDs at events and visits.

10.5 The Council agreed to continue holding a "Holding to Account" slot on each meeting agenda. As requested earlier in the meeting the Chair of the Delivery Committee would be invited to the next meeting in September for a

Holding to Account session looking at Trust performance via the Performance Dashboard report.

11. BOARD COMMITTEE OBSERVATION FEEDBACK

11.1 Those Governors who had attended the recent Board Committee meetings provided feedback to the Council. Jennifer Thomson had attended the MH Legislation Scrutiny Committee meeting on 12 July. She said that this had been very interesting and she had been impressed with the Chairing and NED presence at the Committee.

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

12.1 Cherry Newton noted that one of the Governors key duties was to *"Represent the interests of the people within their constituency or partner organisation, report feedback on our services and, wherever possible, how they could be improved".* Cherry said that she would welcome more guidance around how she could fulfil this role of meeting and engaging with members of the public. All Governors at the meeting agreed that some form of guidance would be helpful. Kate Nelmes was asked to consider this further and whether some form of briefing note could be developed to assist Governors in carrying out this key role.

ACTION: Kate Nelmes was asked to consider whether some form of briefing note could be developed to assist Governors in carrying out the key role of meeting with and engaging with constituents.

13. ANNUAL REPORT 2016/17

13.1 The Council of Governors formally received the Annual Report 2016/17. Hard copies of the report were made available at the meeting.

14. COUNCIL OF GOVERNOR ELECTION RESULTS

Ruth FitzJohn asked Vic Godding to leave the meeting at this point

14.1 The Trust has recently completed a round of elections to the Council of Governors. This report provided the Council with an update of the successful candidates, as well as providing information about those Governors who will be leaving the Trust and where vacant positions remain.

14.2 Discussions had taken place earlier in the meeting about changes to the Trust's Constitution, changes of which were approved by the Council. Approval of these changes now meant that one of the recently elected Governors was no longer eligible to become a Governor of 2gether. The Council of Governors noted this position and agreed that it was appropriate that this new Governor not be appointed due to a conflict of interest (already a sitting Governor on another local Foundation Trust Council). On this basis, the candidate who had come in second place at the recent election would take up the post. The Council of Governors was happy to endorse that Vic Godding be re-elected as a Public Governor for Cheltenham, to serve out his

second term, subject to the final sign off of the Constitutional changes by the Board on 27 July.

14.3 *Newly Elected Governors – Appointments to commence 1 August 2017*

- Kate Atkinson (Cotswolds) – elected unopposed
- Vanessa Ball (Cheltenham) – elected
- Xin Sheen Zhao (Gloucester) – elected
- Mike Scott (Greater England) – elected
- Euan McPherson (Herefordshire) – elected

14.3 *Re-elected Governors*

- Rob Blagden (Management and Administration/Lead Governor) – re-elected unopposed
- Vic Godding (Cheltenham) – re-elected

14.4 *Outgoing Governors*

End of Term – 30 June 2017

- Dawn Lewis (Herefordshire) – served 1 term, did not re-stand for election

End of Term – 31 July 2017

- Pat Ayres (Cotswolds) – served 2 full terms
- Paul Toleman (Gloucester) – served 1 term, did not re-stand for election

Vic Godding re-joined the meeting at this point

14.5 Ruth FitzJohn informed Vic Godding of the discussion that had just taken place. Vic advised that he would be honoured to continue as a Governor, subject to final confirmation by the Trust Chair.

14.6 Ruth FitzJohn expressed her sincerest thanks to Pat Ayres who had supported the Trust and represented the Cotswolds as a Public Governor for the past 6 years. Thanks were also given to Paul Toleman who had served one term as a Public Governor. Ruth said that bringing together such a diverse group of people into a functioning Council had been a challenging but rewarding experience and that the Council would benefit from both Pat and Paul's contributions going forward.

15. ANY OTHER BUSINESS

15.1 Mervyn Dawe recommended the Radio 4 programme "All in the Mind" to the Governors, which explored the themes of mental health and was very insightful.

16. DATE OF NEXT MEETINGS

Council of Governor Meetings

Business Continuity Room, Trust HQ, Rikenel		
Date	**Governor Pre-meeting**	**Council Meeting**
2017		
Tuesday **19** September	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 9 November	1.30 – 2.30pm	3.00 – 5.00pm
2018		
Tuesday 16 January	9.00 – 10.00am	10.30 – 12.30pm
Thursday 8 March	1.30 – 2.30pm	3.00 – 5.00pm
Tuesday 8 May	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 12 July	9.00 – 10.00am	10.30 – 12.30pm
Tuesday 11 September	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 8 November	1.30 – 2.30pm	3.00 – 5.00pm

Public Board Meetings

2017		
Thursday 28 September	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 30 November	10.00 – 1.00pm	Hereford
2018		
Tuesday 30 January	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 29 March	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 31 May	10.00 – 1.00pm	Hereford
Thursday 26 July	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 27 September	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 29 November	10.00 – 1.00pm	Hereford

Council of Governors
Action Points

Item	Action	Lead	Progress
9 March 2017			
4.3	Regular monthly updates to the Governor Portal to be diarised by the Trust Secretariat and notification sent out to all Governors advising of those documents uploaded	Anna Hilditch	**Complete.** Re-launch of Governor Portal took place on 18 September 2017. Monthly updates to Governors programmed in to ATS calendar
9 May 2017			
5.4	Trust Secretariat to liaise with Director of Engagement and Integration to arrange a Governor visit to Alexandra Wellbeing House	Anna Hilditch	**Complete.** Visit to Alexandra Wellbeing House arranged for Thursday 12 October at 9.30 – 11am
13 July 2017			
5.7	Ruth FitzJohn to send a warm letter of thanks to Elaine Davies setting out the Council's decision in relation to the termination of tenure.	Ruth FitzJohn	**Complete** Letter sent on 20 July 2017
7.5	The Chair of the Delivery Committee to be invited to the next Council meeting in September for the Holding to Account session, focussing on the Performance Dashboard	Anna Hilditch	**Complete** Chair of Delivery unable to attend the September meeting however, she has confirmed attendance for the November 2017 meeting.
8.5	Chief Executive to ensure that Governors were kept up to date with the outcome of the review of Oak House.	Shaun Clee	To be included as part of the CEO Briefing for Governors at the September meeting
9.5	Date of next Membership Advisory Group (MAG) meeting to be sent out to Governors inviting attendance	Kate Nelmes / Anna Hilditch	**Complete** Next meeting to take place on 27 September. Date emailed to Governors on 24 August
9.5	Kate Nelmes to seek advice around best practice for recording certain membership characteristics from Stonewall, for further discussion at the next MAG meeting	Kate Nelmes	**Complete** Stonewall has published a number of papers on the importance of capturing LGBT monitoring information within the NHS. Capturing such information is seen as an important way of monitoring inclusivity, and improving engagement where required. This will be reported when the Membership Advisory Group meets on September 27, when the membership form is being reviewed.
9.6	Kate Nelmes to liaise with Anna Hilditch to ensure that Governors had sufficient membership pack supplies and information about who to contact if they required more	Kate Nelmes / Anna Hilditch	**Complete** All Governors have been issued with a membership pack/folder. If supplies are running low, please contact Anna Hilditch
9.7	Kate Nelmes to check the membership database and circulation to ensure that all Governors were on the mailing to receive the Membership Newsletter	Kate Nelmes	**Complete** Governors are on the mailing list so should receive newsletters in the future.

12.1	Kate Nelmes was asked to consider whether some form of briefing note could be developed to assist Governors in carrying out the key role of meeting with and engaging with constituents.	Kate Nelmes	**In progress** A briefing note is being drafted and will be circulated as soon as possible.