[2]GETHER NHS FOUNDATION TRUST

BOARD MEETING

WEDNESDAY 26 SEPTEMBER 2018 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 26 July 2018**	**PAPER A**
	4	**Action Points and Matters Arising**	
	5	**Questions from the Public**	
IMPROVING QUALITY			
10.10	6	**Performance Dashboard Report – July 2018**	**PAPER B**
10.15	7	**Quality Report Quarter 1 2018/19**	**PAPER C**
10.25	8	**Service Experience Report Quarter 1 2018/19**	**PAPER D**
10.35	9	**Patient Experience Presentation**	**PRESENTATION**
11.00	10	**NED Audit of Complaints Q1 2018/19**	**PAPER E**
11.05	11	**Safe Staffing 6 Monthly Update**	**PAPER F**
11.10	12	**Nursing Strategy/Framework**	**PAPER G**
BREAK – 11.20AM			
11.30	13	**Infection Control Annual Report 2017/18**	**PAPER H**
11.40	14	**Learning from Deaths Quarter 1 Update**	**PAPER I**
11.50	15	**Medical Appraisal Annual Report**	**PAPER J**
12.00	16	**Freedom to Speak Up Self-Assessment**	**PAPER K**
IMPROVING ENGAGEMENT			
12.10	17	**Chief Executive's Report**	**PAPER L**
IMPROVING SUSTAINABILITY			
12.20	18	**Summary Financial Report**	**PAPER M**
12.25	19	**Change to the Trust Constitution**	**PAPER N**
12.35	20	**Board Committee Summaries**	
		• Audit Committee & Committee Annual Report 2017/18	**PAPER O1**
		• Delivery Committee – July and August	**PAPER O2**
		• Development Committee – August	**PAPER O3**
		• Governance Committee – August	**PAPER O4**
INFORMATION SHARING (TO NOTE ONLY)			
12.50	21	**Chair's Report**	**PAPER P**
	22	**Council of Governor Minutes – July 2018**	**PAPER Q**
13.00	23	**Any Other Business** • MHAM Appointments	
	24	**Date of Next Meeting** Thursday 29 November 2018 at The Kindle Centre, Hereford	

PUBLIC QUESTIONS PROTOCOL

Written questions for the Board Meeting

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

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

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

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

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

Oral Questions without Notice

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

Public Board meetings also have time allocated at the start of each agenda for the receipt of oral questions from members of the public present, without notice having been given.

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

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

Exclusions

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

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

For further information, please contact the Trust Secretary/Assistant Trust Secretary on 01452 894165. Public questions can be submitted for Trust Board meetings by emailing: anna.hilditch@nhs.net

[2]GETHER NHS FOUNDATION TRUST

BOARD MEETING
TRUST HQ, RIKENEL
26 JULY 2018

PRESENT

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

IN ATTENDANCE

John McIlveen, Trust Secretary
Kate Nelmes, Head of Communications
Graham Russell, Non-Executive Director, Gloucestershire Care Services

1. WELCOMES, APOLOGIES AND INTRODUCTIONS

1.1 Apologies were received from Neil Savage and Duncan Sutherland.

1.2 The Board welcomed Graham Russell, Non-Executive Director Gloucestershire Care Services, to the meeting.

2. DECLARATIONS OF INTERESTS

2.1 No new interests were declared.

3. MINUTES OF THE PREVIOUS MEETING HELD ON 31 MAY 2018

3.1 The minutes of the meeting held on 31 May were agreed as a correct record.

4. MATTERS ARISING AND ACTION POINTS

4.1 The Board reviewed the action points, noting that these were now complete or progressing to plan. An update on finance reporting in months when the Board did not meet would be given as part of the Delivery Committee summary report.

5. QUESTIONS FROM THE PUBLIC

5.1 The Board had not received any questions in advance of the meeting.

6. PATIENT EXPERIENCE PRESENTATION

6.1 The Board welcomed Zoe Hepburn to the meeting to share her story of using mental health services. Zoe is also a senior clinician within 2gether's Eating Disorders service and recently presented at a Gloucestershire based Maternal Mental Health conference about her experience.

6.2 Zoe told the Board that she had developed an eating disorder at the age of 14. Although she continued to do well academically and socially, and in terms of her career, she was

desperate to be better but shame had prevented her from seeking help. When Zoe became pregnant while still suffering from the eating disorder, she hoped that the midwife would ask her about her eating habits and thus allow Zoe to start the process of getting help with her disorder. However, that specific question was not forthcoming as it was not included in the national form for midwives, and Zoe felt unable to volunteer the information herself. After her second pregnancy Zoe had reluctantly entered treatment because her own physical health had deteriorated, and because she wanted her children's lives to be different from her own.

6.3 Zoe received cognitive behavioural therapy which dismantled and rebuilt her perspective on life, and allowed Zoe to begin to hope that she could get better. Her therapist had been helpful and non-judgmental. While still receiving treatment, Zoe began campaigning on eating disorders so as to help other people who might be in a similar situation. Zoe now worked as a senior clinician in the eating disorder service which had helped her to recover, and she continues to campaign and learn about mental health. She has completed a number of qualitative studies, 2 of which have been published in the Mental Health review Journal. The Director of Engagement and Integration agreed to circulate copies of these papers to the Board.

ACTION: Zoe's published papers to be circulated to the Board for information.

6.4 Zoe told the Board that shame and guilt had initially prevented her own recovery, but her message to service users now is that their own health and happiness is the best gift they could possibly give to their own family and loved ones. She stressed the importance of fighting stigma, and helps to dispel that stigma every time she speaks about her own history.

6.5 The Director of Quality asked what could be done to encourage midwives to ask their clients about eating disorders. Zoe told the Board that the Trust's perinatal team was campaigning for a specific question about eating habits to be included in the national form. Zoe told the Board that a dentist had asked about this due to the damage caused to Zoe's teeth. The dentist had been very compassionate and non-judgmental, and this had led to a referral to a specialist dental hospital for treatment. The Deputy Chief Executive agreed that more general awareness was required. Zoe replied that she always asks her own clients whether there was anything that they were expecting her to ask, or that she ought to know. Dominique Thompson told the Board that a short online training film about eating disorders and pregnancy was available at http://www.eatingdisordersandpregnancy.co.uk/ . At the request of the Medical Director, Zoe agreed to take part in a training session for junior doctors.

ACTION: Medical Director to schedule a training session for junior doctors on eating disorders

6.6 The Director of Service Delivery asked whether Zoe's husband had received all the support he needed during Zoe's illness. Zoe replied that as she had done everything she could to hide her illness, and had not always been underweight, it had been difficult for her husband to know that she was ill. The Director of Service Delivery asked about the challenges in engaging people early. Zoe replied that initially she didn't know about the eating disorders service, but that the service was now much better known and there were many self-referrals into the service. The 'Freed' project, developed by the South London and Maudsley Trust provided good signposting and support for people aged 16-24, but it would be good to extend that programme across all ages.

6.7 Ingrid Barker thanked Zoe for attending the meeting and for speaking so powerfully about her experiences.

7. PERFORMANCE DASHBOARD

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

7.2 The Board noted that of the 202 performance measures, 90 were reportable at Month 2, with 80 of those being compliant and 10 non-compliant at the end of the reporting period. Of the 10 non-compliant indicators, 3 related to IAPT and 4 to the Eating Disorder Service. The Board noted that additional investment had been agreed with the CCG to address staffing issues contributing to non-compliance in the ED Service. The Board was assured that staff numbers would be up to full complement by the end of the month, meaning that emergency referrals would be seen within 2 days, and urgent referrals seen within 4 weeks. The Board noted one admission of an under-18 patient to an adult ward, and was assured that this admission took place only after an exhaustive national search for an age-appropriate bed, and alongside rigorous safeguarding measures.

7.3 The Board noted that where performance is not compliant, Service Directors are taking the lead to address issues, with a continuing focus on IAPT service measures. Work is ongoing to address the underlying issues affecting this performance, in line with the Trust's agreed Service Delivery Improvement Plans, and the Board noted that achievement of the 19% access target would be dependent on the increasing use of digital access to therapy. The Board noted the continuing oversight by the Delivery Committee regarding IAPT, alongside quarterly reviews of performance and action plans by the Executive Committee.

7.4 The Board noted the dashboard report for Month 2 of 2018/19, and the assurance that this provided.

8. SERVICE EXPERIENCE REPORT QUARTER 4

8.1 The Board received the Service Experience report for Quarter 4 of 2017/18.

8.2 The Director of Engagement and Integration provided assurance that service experience information about Trust activity in Quarter 4 2017/18 had been reviewed in depth, scrutinised for themes and considered for both individual team and general learning across the organisation. The full report had been discussed in detail at the Governance Committee in June. The Board welcomed the Easy Read version of the report which had been produced alongside the main report.

8.3 The Board received significant assurance that the organisation had listened to, heard and understood patient and carer experience of 2gether's services. This assurance was provided across all domains of feedback including complaints, concerns, comments and compliments. The Board also received significant assurance that service users valued the service being offered by [2]gether and would recommend it to others. During quarter 4, 84% of people who responded to the invitation to complete the Friends and Family Test said that they would recommend [2]gether's services. However, the Board was asked to note the limited assurance in relation to the number of people taking part in the local 'How Did We Do?' survey of quality; although the responses received reflect positively on services, the response rates remain lower than was hoped for. However, response rates had risen in Q4,

and the Service Experience team is working with operational colleagues to try and increase response rates still further.

8.3 The Board noted that a number of broad themes and learning had been identified for learning and dissemination. This Quarter those concerns continued to relate to communication issues by our services with service users and/or their carers. Other learning themes included:

- The need to explain the reasons for the decisions we make.
- The need to include everyone involved when planning care

8.4 Nikki Richardson said that the Governance Committee had monitored the development of this report on a quarterly basis throughout the year, and had been pleased to see improvements taking place. However, more work was required on embedding learning from feedback, and the Governance Committee would be inviting Service Directors to tell the Committee what services were doing to embed learning from feedback.

8.5 Jonathan Vickers sought clarification on the trend line showing the proportion of complaints to individual services. The Director of Engagement and Integration confirmed that the trend for complaints is downwards, with other methods such as raising concerns becoming more widely used to resolve matters. The Chief Executive questioned whether a trend line was the most appropriate way to show this data, and the Director of Engagement and Integration agreed to look at how the data might be better presented for the next report.

ACTION: Director of E & I to review presentation of 'proportion of complaints' trend data

8.6 The Board noted the report.

9. NON-EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS ANNUAL REPORT

9.1 The Board received a report setting out common themes and analysis of Non-Executive Director (NED) reviews of complaints throughout the year. Four NEDs had completed reviews of three complaints each during the reporting year, making a total of 12 reviews in all. All of these reviews had been reported to the Board.

9.2 The Board noted that in relation to the assurance offered by each of these reviews, 7 out of 12 rated the assurance regarding the approach to investigating the complaint as either full or significant. 9 out of 12 rated the assurance regarding the style of the CEO's letter as either full or significant. 6 out of 12 rated the assurance regarding learning from feedback as either full or significant. Significant assurance was reported on progress being made to further develop investigation practice, respond to complaints with sensitivity, and embed learning from complaints into practice.

9.3 The report offered limited assurance in some of the cases reviewed by NEDs, and the report set out actions intended to raise assurance levels to significant. These included:

- A review of the investigators' training programme
- A review of processes to achieve more timely responses
- Collaboration with Gloucestershire Care Services colleagues to share and learn from good practice in complaints resolution
- Leadership workshops to build a culture of learning through feedback from ward to Board

- Dissemination of learning points to Locality Boards

9.4 A number of further developments were planned to improve the capture and embedding of learning from feedback, including complaints. These include the issue of practice notes to share learning, capturing evidence that actions have been completed following learning from complaints, and the presentation of examples of learning from complaints to the Governance Committee by Locality leads.

9.5 Marcia Gallagher noted the big improvement in the way that complaints were handled which was evident in the audits she had undertaken. However, accurate and consistent documentation in RiO was essential for complaints to be fully and fairly resolved, and such information was not consistently recorded. Nikki Richardson replied that the Governance Committee sees a number of audits where RiO entry is an issue, but that an improvement in compliance was being seen, and the compliance level at the last such audit had been good. Marcia Gallagher noted that Service Directors were now incorporating feedback information into their reports to the Delivery Committee.

9.6 Ingrid Barker reported that Gloucestershire Care Services had now put in place a programme of NED audits of complaints as a matter of good practice. The Board noted the report.

10. GUARDIAN OF SAFE WORKING HOURS REPORT

10.1 The Board received a report from the Guardian of Safe Working Hours covering the period November 2017 to January 2018.

10.2 All new Psychiatry Trainees, Foundation Trainees and GP Trainees rotating into a Psychiatry placement from 1st February and 2nd August 2017 are now on the new 2016 Terms and Conditions of Service. There are currently 34 trainees working in 2gether on the new Terms and Conditions of Service on different sites.

10.3 The exception reporting process, allowing variations from the trainees contractually agreed service requirements and training opportunities to be resolved is now in place. The trainees can raise exception reports for hours worked, missed breaks, or missed educational opportunities. The reports where possible have been resolved by the preferred option of time off in lieu (TOIL); those where TOIL will impact on colleagues workload or educational opportunities have received payments. Exception reports may also trigger work schedule reviews and if necessary fines can be raised against the directorates by the Guardian. The Board noted that of the 21 reports in the period, 19 related to hours, 1 to service support, and 1 to training. The Medical Director informed the Board that there are also 10 historical 'open' reports. These are mainly from trainees who have now left the Trust, but did not close the report before doing so. As only the trainee raising the report can close it, the Medical Director is ensuring that junior doctors are aware of the importance of closing any reports they raise once an outcome has been agreed.

10.4 Nikki Richardson noted that the use of overtime was the most common resolution in terms of reports raised regarding hours, and questioned whether this was good practice. The Medical Director agreed to provide the Governance Committee with a more detailed analysis should the next report continue to show a high figure in respect of overtime.

10.5 Marcia Gallagher commented on the relatively high proportion of exception reports from Herefordshire trainees. The Medical Director agreed that there has been a long-standing

staffing issue in Herefordshire, and efforts are being made to increase recruitment and retention and to make Herefordshire a more attractive location for prospective trainees.

10.6 The Board noted the contents of the Guardian of Safe Working Hours Report for November 2017 to January 2018.

11. CHIEF EXECUTIVE'S REPORT

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

- Progress on the strategic intent to merge with Gloucestershire Care Services NHS Trust (GCS)
- Carter Mental Health Community Services Work
- "One Gloucestershire" Integrated Care System
- Herefordshire and Worcestershire STP – Integrated Care System Development Programme
- The NHS Funding Settlement

11.2 The Board also noted the extensive engagement activities that had taken place during the past month, and the importance of these activities in order to inform strategic thinking, raise awareness of mental health, build relationships and influence the strategic thinking of others. The report offered the Board significant assurance that the Executive Team was undertaking wide engagement.

11.3 The Chief Executive noted the outcome of the recent CQC inspection of the Trust, which had seen the retention of the Trust's 'Good' rating, and an improvement in the rating of several domains. One core service – wards for people with learning disabilities – remained as 'Requires Improvement' overall. However, this service had seen its 'responsive' rating increase to 'Good'. An action plan had been drawn up to address the required improvements identified by the CQC. A number of peer reviews were planned to take place at the end of 2018 to test both areas where particular issues had been identified at this inspection, and also to review areas identified by the CQC as 'Outstanding' at the previous inspection. It was agreed that a Board discussion on the Learning Disability service would be scheduled once the action plan had been considered by the Governance Committee.

ACTION: Board discussion on LD service to be scheduled after Governance Committee has considered the CQC action plan

11.4 The Chief Executive informed the Board that interviews would take place on Monday 30 July for the Interim Director of Quality post.

12. SUMMARY FINANCIAL REPORT

12.1 The Board received the summary Finance Report that provided information up to the end of June 2018. The month 3 position was a surplus of £263k which was in line with the planned surplus. The month 3 forecast outturn was an £834k surplus in line with the Trust's control total. The Trust had an Oversight Framework segment of 2 at the end of June 2018. The Trust has signed 2018/19 contracts with Gloucestershire CCG, Herefordshire CCG, and NHS England and Worcestershire Joint Commissioning Unit. Agency cost forecast is £4.17m, an increase of £0.021m on last year's expenditure; this would be £1.036 above the Agency Control Total, due largely to the need to support the IAPT service. The Trust has

identified £691k of recurring savings up to June 2018, which is ahead of plan. The Trust's current year end cash projection is £16.2m, £6.4m ahead of plan.

12.2 The Director of Finance highlighted a number of key risks around potential slippage regarding Cost Improvement Plans, potential funding gaps in terms of the pay award, and agency spend, which the Trust will need to monitor through the year. However, the Director of Finance believed that the Trust would still hit its overall control total at the end of the year.

12.3 The Board noted the sale of Field View, which had been bought by a nursing home company which provides learning disability and mental health accommodation. Another company had bid slightly more for the property, but the Trust had accepted the lower offer given the potential benefits to the Trust in the future. The Board welcomed this decision, and noted the summary finance report for June 2018.

13. OPERATIONAL PLAN FEEDBACK FROM NHS IMPROVEMENT

13.1 The Director of Finance updated the Board on feedback received from NHS Improvement on the Trust's 2018/19 Operational Plan. The letter from NHS I was circulated with the report, and highlighted the following points:

- Concern about the deliverability of the IAPT recovery plan, given current recruitment difficulties
- The need for a continued focus on agency expenditure

13.2 The Director of Finance assured the Board that the Executive Team continued to manage IAPT very closely, and all possible steps were being taken to support performance. Additional recurrent funding had been obtained from both CCGs to support performance. However, recruitment remains difficult, particularly in Herefordshire. The Delivery Committee maintained a focus on IAPT performance and the progress of the recovery plan.

13.3 In respect of agency expenditure, while there remained a real focus on reducing these costs, the need to recruit agency staff to support IAPT performance means that at present the Trust is not forecast to reduce agency costs beyond the 2017/18 level. This would result in not meeting the agency control total, but the Trust remains on track to deliver its overall control total.

13.4 The Board noted that the Trust had confirmed to NHS I that appropriate demand and capacity planning had taken place alongside the agreement of 2018/19 contracts, and hence had been built into the Trust's Operational Plan refresh.

13.5 Maria Bond noted that the feedback letter referred to an increasing number of 12 hour breaches declared by A & E Departments which related to mental health patients waiting to access mental health beds or other mental health services, and asked how the Board would know about such breaches. The Deputy Chief Executive replied that the mental health liaison team would be aware of such breaches and would report these into the Trust. The Director of Service Delivery would provide the Delivery Committee with information to quantify the scale of the issue.

ACTION: Director of Service Delivery to provide a report to the Delivery Committee on 12 hour A & E breaches relating to mental health patients

13.6 The Chief Executive commented that it would be helpful if a formal method could be agreed with the acute Trust to notify 2gether of such breaches. The Director of Service Delivery was asked to take this up with the acute Trust.

ACTION: Director of Service Delivery to establish a formal reporting mechanism with the acute Trust regarding 12 hour A & E breaches relating to mental health patients

14. BOARD COMMITTEE REPORTS – CHARITABLE FUNDS COMMITTEE

14.1 The Board, in its capacity as the Board of Trustees, received and noted the summary report from the Charitable Funds Committee meeting held on 11 July.

14.2 The Committee had received 2 funding requests relating to the garden and gym equipment for Wotton Lawn, and the inner courtyard garden and Chestnut Ward garden at Charlton Lane. These requests, totaling c £74k, were supported in principle by the Committee. However, the Committee felt that some elements of the request did not fall within the remit of charitable funds, and the Committee therefore asked the Capital Review Group to separate out these non-charitable works. The Committee delegated authority to the Committee Chair to approve the request once the funding split had been agreed.

14.3 The Committee received an update on the proposal to recruit a professional fundraiser. No formal responses had been received for this post, and the Committee asked for further feedback at its next meeting as to what may have put off potential applicants. The Committee had some concerns about offering the post as a fixed term contract, and the Executive Committee had been asked to reconsider options and make further recommendations.

15. BOARD COMMITTEE REPORTS - AUDIT COMMITTEE

15.1 Marcia Gallagher presented the summary report from the Audit Committee meeting held on 25 May. This report had been presented verbally to the Board in May. The Board noted the key points raised at this meeting and the assurance received by the Committee.

16. BOARD COMMITTEE REPORTS – DEVELOPMENT COMMITTEE INCLUDING DEVELOPMENT COMMITTEE ANNUAL REPORT

16.1 Jonathan Vickers presented the summary report from the Development Committee meeting held on 19 June. This report and the assurances provided were noted.

16.2 The Committee had also received its annual report at this meeting, setting out the Committee's activities during the year in delivering against its terms of reference. This had been the Committee's first full year under its revised terms of reference, and matters considered included

- Research developments, and in particular the research partnership with the Cobalt Institute
- Strategy review, in particular, oversight of the Trust's enabling strategies
- Engagement activities, including oversight of the Engagement & Communications Strategy tactical plan, and approval of the terms of reference for the Stakeholder Committee

16.3 The Board noted the summary report and the Development Committee annual report

17. BOARD COMMITTEE REPORTS – DELIVERY COMMITTEE

17.1 The Board received the summary reports from the Delivery Committee meetings held on 23 May and 27 June. These reports and the assurances provided were noted.

17.2 The Board received a verbal update on matters discussed at the Delivery Committee meeting on 25 July, and Maria Bond reported a pleasing improvement in the quality of reports coming to the Committee. A written summary of the meeting would be presented at the next meeting of the Board.

17.3 Marcia Gallagher reported that as there had been no Board meeting in June, the Delivery Committee had trialled a process to receive a verbal update on the Trust's financial position at month 2. This review was referenced in the Committee's summary report to the Board. The update to the Committee was informed by Marcia Gallagher's meeting with the Director of Finance where the content of the update was agreed. An escalation procedure was in place should Marcia have any concerns about the information or assurances received during her meeting with the Director of Finance. The Board agreed that this arrangement should continue and that the Delivery Committee should continue to receive verbal Finance updates via Marcia Gallagher in months when there is no formal Board meeting, and forward assurance to the Board via the Committee's summary report. The Director of Finance assured the Board that Finance reports were being prepared on a monthly basis, regardless of whether a Board meeting was scheduled.

18. BOARD COMMITTEE REPORTS – GOVERNANCE COMMITTEE

18.1 Nikki Richardson presented the summary report from the Governance Committee meeting that had taken place on 29 June. The Committee had in particular looked at aggregated learning reports and the approach to risk management, and had agreed to revisit the approach to this information to see if improvements were merited. The Board noted the summary report and the assurances provided.

19. BOARD COMMITTEE REPORTS – MH LEGISLATION SCRUTINY COMMITTEE

19.1 The Board received the summary report from the Mental Health Legislation Scrutiny Committee meeting that had taken place on 11 July. Nikki Richardson reported that the Committee had considered embedding of learning, and had received an update on a new out of hours Approved Mental Health Professional support service provided by the Local Authority's Emergency Duty Team. The Board noted that the AMHP hub was now active, and provided AMHP cover between 9am and 11pm. It was hoped to extend the service to a full 24 hour cover. The summary report and the assurances provided were noted.

20. INFORMATION SHARING REPORTS

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

- Chair's Report
- Council of Governors Minutes – May 2018
- Use of the Trust Seal – Quarter 1 2018/19

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

26. ANY OTHER BUSINESS

26.1 Ingrid Barker thanked all those involved in the joint Annual General Meeting held on 19 July, which had been very positively received. She also congratulated everyone involved in this year's ROSCA awards, which had been a very slick and well-organised event.

27. DATE OF THE NEXT MEETING

27.1 The next Board meeting would take place on Wednesday 26 September 2018 at Trust HQ, Rikenel, Gloucester

Signed: …….. **Date: …….**

Ingrid Barker, Chair

BOARD MEETING
ACTION POINTS

Date of Mtg	Item ref	Action	Lead	Date due	Status/Progress
26 July 2018	6.4	Zoe's published papers to be circulated to the Board for information	Jane Melton	July	**Complete**
	6.5	Medical Director to schedule a training session for junior doctors on eating disorders	Amjad Uppal	September	
	8.5	Director of E & I to review presentation of 'proportion of complaints' trend data	Jane Melton	September	
	11.3	Board discussion on LD service to be scheduled after Governance Committee has considered the CQC action plan	Anna Hilditch		**Action plan scheduled for Governance in October**
	13.5	Director of Service Delivery to provide a report to the Delivery Committee on 12 hour A & E breaches relating to mental health patients	John Campbell	September	
	13.6	Director of Service Delivery to establish a formal reporting mechanism with the acute Trust regarding 12 hour A & E breaches relating to mental health patients	John Campbell	September	

Agenda item 6 **Paper B**

Report to:	2gether Board Meeting – 26th September 2018
Author:	Chris Woon, Head of Information Management and Clinical Systems
Presented by:	John Campbell, Director of Service Delivery
SUBJECT:	**Performance Dashboard Report for the period to the end of July 2018 (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 2018 (month 4) of the 2018/19 contract period, against our NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

Of the 194 performance indicators, 91 are reportable in July with 85 being compliant and 6 non-compliant at the end of the reporting period.

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

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

We have received an update to Schedule 4 of Gloucestershire CCG Contractual requirements and the following changes have been made:

Removal of the following CYPS indicators:

- CYP report being satisfied or more than satisfied with Service Experience: Satisfaction rate of 75% (annual).
- CYP report being satisfied or more than satisfied with Transition to Adult Services: Satisfaction rate of 75% (annual).
- CYPS Youth Support Mental Health Workers: Practioner feedback demonstrating access to MH consultation and support: 95% of CYP asked to complete Questionnaire (annual).
- CYPS Youth Support Mental Health Workers: Practioner feedback demonstrating access to MH consultation and support: Satisfaction rate of 75% (annual).
- YP Substance Misuse: Referral to be offered appointment within 5 working days (monthly).

Removal of the following GARAS indicators:
(Gloucestershire Action for Refugees and Asylum Seekers)

- 3.94: GARAS: Pre and Post outcome measures: Number reported to have decreased symptoms of distress
- 3.95: GARAS: Pre and Post outcome measures: Number reported to have improved quality of life
- 3.96: GARAS: Pre and Post outcome measures: Number reported to have improved functional ability
- 3.97: GARAS: Pre and Post outcome measures: Number reported to have improved mental health

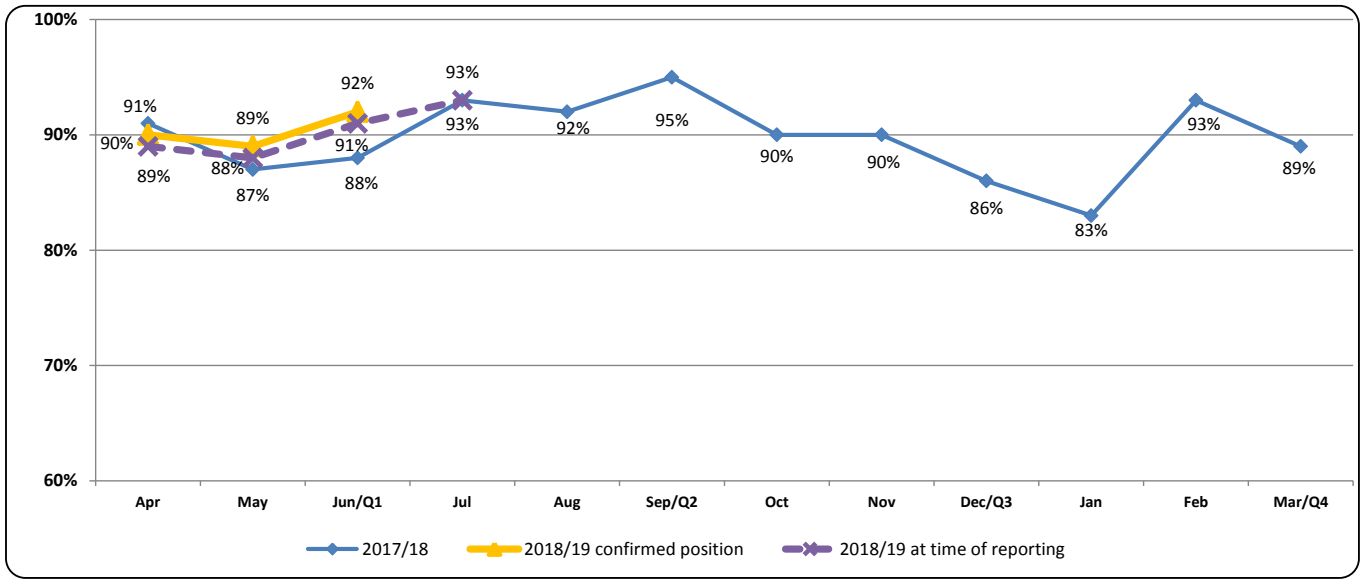
Addition of the following GARAS indicator:

- 3.89: GARAS: Percentage of referrals completing the course of therapy

The following table summarises our performance position as at the end of July 2018 for each of the KPIs within each of the reporting categories.

Indicators Reported in Month and Levels of Compliance							
Indicator Type	**Total Measures**	**Reported in Month**	**Compliant**	**Non Compliant**	**% non-compliance**	**Not Yet Required or N/A**	**NYA**
NHSi Requirements	**14**	**13**	**13**	**0**	**0**	**1**	**0**
Never Events	**17**	**17**	**17**	**0**	**0**	**0**	**0**
Department of Health	**10**	**8**	**8**	**0**	**0**	**2**	**0**
Gloucestershire CCG Contract	**89**	**23**	**18**	**5**	**22**	**61**	**5**
Social Care	**15**	**13**	**13**	**0**	**0**	**2**	**0**
Herefordshire CCG Contract	**24**	**17**	**16**	**1**	**6**	**7**	**0**
CQUINS	**25**	**0**	**0**	**0**	**0**	**25**	**0**
Overall	**194**	**91**	**85**	**6**	**7**	**98**	**5**

The following graph shows our percentage compliance by month and the previous year's compliance for comparison. The "2018/19 confirmed position" line shows the position of our performance reported a month in arrears to enable late data entry and late data validation to be taken into account.



The confirmed positions for April, May and June have all risen by 1%. Following negotiations with Herefordshire Commissioners, the IAPT Access trajectory (5.09a) has been updated and we are now reporting this indicator as compliant across all months, to date, in 2018/19.

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

- Under 18 admissions to Adult Inpatient Wards (2.21)
- Improving Access to Psychological Therapies (IAPT)
    - Recovery (3.17, 5.08), Access (3.18, 5.09a) & Waiting times (1.09 & 1.10)
- CYPS/ CAMHS Level 2 and 3 Referral to Treatment waiting times (3.26 & 3.27)
- Eating Disorders (ED) Waiting times (3.63, 6.64, 6.65 & 3.67)

Summary Exception Reporting

The following 6 key performance thresholds were not met for the Trust for July 2018:

Gloucestershire CCG Contract Measures

- 3.18 – IAPT access rate
- 3.63 – Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks
- 3.64 – Adolescent Eating Disorders: Routine referral to non-NICE treatment within 4 weeks
- 3.65 – Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week
- 3.67 – Adult Eating Disorders: Wait time for assessments will be 4 weeks

Herefordshire CCG Contract Measures

- 5.19: – CYPs Access: Percentage of CYP entering treatment

RECOMMENDATIONS

The Board is asked to:

- Note the Performance Dashboard Report for July 2018.
- Accept the report as a significant level of assurance that our contract and regulatory performance measures are being met or that appropriate action plans are in place to address areas requiring improvement.
- Be assured that there is ongoing work to review all of the indicators not meeting the required performance threshold. This includes a review of the measurement and data quality processes as well as clinical delivery and clinical practice issues.

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

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

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

Reviewed by:		
John Campbell	Date	August 2018

Where in the Trust has this been discussed before?		
Delivery Committee	Date	29 August 2018

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 CLDT Community Learning Disability Teams CPA Care Programme Approach CQUIN Commissioning for Quality and Innovation CRHT Crisis Home Treatment CSM Community Services Manager CYPS Children and Young People's Services DNA Did not Attend ED Emergency Department EI Early Intervention EWS Early warning score GARAS Gloucestershire Action for Refugees and Asylum Seekers HoNoS Health of the Nation Outcome Scale IAPT Improving Access to Psychological Therapies IST Intensive Support Team (National IAPT Team) KPI Key Performance Indicator LD Learning Disabilities MHL Mental Health Liaison MRSA Methicillin-resistant Staphylococcus aureus MUST Malnutrition Universal Screening Tool NHSI NHS Improvement NICE National Institute for Health and Care Excellence SI Serious Incident SUS Secondary Uses Service VTE Venous thromboembolism YOS Youth Offender's Service

1. CONTEXT

This report sets out the performance Dashboard for the Trust for the period to the end of July 2018, month four of the 2018/19 contract period.

1.1 The following sections of the report include:

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

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

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

2.1 The following tables outline the performance in each of the performance categories within the Dashboard as at the end of July 2018. Where indicators have not been met during the reporting period, an explanation is provided relating to the non-achievement of the Performance Threshold and the action being taken to rectify the position.

2.2 Performance indicators include all relevant Trust activity allocated between Gloucestershire and Herefordshire based on locality of the service.

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

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

DASHBOARD CATEGORY - NHSI REQUIREMENTS

NHS Improvement Requirements				
	In month Compliance			Cumulative Compliance
	May	Jun	Jul	
Total Measures	14	14	14	14
	3	0	0	0
	10	13	13	13
NYA	0	0	0	0
NYR	0	0	0	0
N/A	1	1	1	1

Performance Thresholds not being achieved in Month

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

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

Cumulative Performance Thresholds Not being Met

1.10: IAPT Waiting times: Referral to treatment within 18 weeks (Herefordshire)
As above

Changes to Previously Reported Figures

1.03: CPA Approach: Follow-up contact within 7 days of discharge (Gloucestershire)
There were 3 cases in June that were recorded as not followed up within 7 days of discharge from Wotton Lawn. Further investigation has shown 2 of these to be recording errors. RiO has been updated and this indicator is now reported as compliant for June.

Early Warnings / Notes

1.02: Number of C Diff cases – avoidable
A patient on Willow Ward, Charlton Lane tested positive for C diff in May 2018. A root cause analysis was undertaken at the end of June. The outcome of this, being that the case was unavoidable; however, it still needs to be taken to the countywide CDiff assurance group for final confirmation.

For transparency the case is assumed to be avoidable until final confirmation is received.

Although we are showing this indicator as non-compliant for May. The performance threshold for the whole financial year is less than 3 cases; therefore we have shown the cumulative total as compliant.

NHS Improvement Requirements

ID	Performance Measure (PM)		2017/18 Outturn	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
1								
1.01	Number of MRSA Bacteraemias	PM	0	0	0	0	0	0
		Gloucestershire	0	0	0	0	0	
		Herefordshire	0	0	0	0	0	
		Combined Actual	0	0	0	0	0	
1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	<3	0
		Gloucestershire	0	1	0	0	1	
		Herefordshire	0	0	0	0	0	
		Combined Actual	0	1	0	0	1	
1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	99%	96%	96%	97%	97%	
		Herefordshire	99%	100%	100%	95%	99%	
		Combined Actual	99%	98%	97%	96%	98%	
1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	98%	98%	98%	97%	98%	
		Herefordshire	98%	98%	98%	96%	97%	
		Combined Actual	98%	98%	98%	97%	98%	
1.05	Nationally reported - Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Gloucestershire	3.2%	0.8%	1.7%	1.7%	1.7%	
		Herefordshire	2.4%	2.1%	1.6%	3.6%	1.8%	
		Combined Actual	3.0%	1.1%	1.7%	2.1%	1.7%	
1.05b	- Delayed Discharges - Outliers	PM						
		Gloucestershire	10.1%	6.7%	6.4%	7.4%	7.0%	
		Herefordshire	12.5%	1.8%	2.4%	9.5%	3.3%	
		Combined Actual	10.7%	5.5%	5.5%	7.9%	6.1%	
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%	97%	98%	99%	
		Herefordshire	100%	100%	100%	100%	100%	
		Combined Actual	99%	100%	98%	98%	99%	
1.07	New psychosis (EI) cases as per contract	PM	72	12	18	24	24	72
		Gloucestershire	80	12	17	27	27	
		PM	24	4	6	8	8	24
		Herefordshire	31	6	7	9	9	
		PM	96	16	24	32	32	96
		Combined Actual	111	18	24	36	36	
1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	53%	53%	53%	53%	53%
		Gloucestershire	71%	33%	80%	70%	74%	
		Herefordshire	68%	67%	100%	100%	78%	
		Combined Actual	70%	50%	83%	75%	75%	

NHS Improvement Requirements

ID	Performance Measure (PM)		2017/18 Outturn	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Gloucestershire	69%	93%	93%	96%	93%	
		Herefordshire	59%	83%	94%	90%	86%	
		Combined Actual	67%	91%	93%	95%	92%	
1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	88%	97%	97%	98%	97%	
		Herefordshire	75%	84%	97%	93%	89%	
		Combined Actual	85%	94%	97%	98%	95%	
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%	100.0%	99.9%	99.9%	
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%	
1.11c	Mental Health Services Data Set Part 1 Data completeness: NHS Number	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	100.0%	100.0%	99.9%	99.9%	
		Herefordshire	99.9%	100.0%	100.0%	100.0%	100.0%	
		Combined Actual	99.9%	100.0%	100.0%	99.9%	99.9%	
1.11d	Mental Health Services Data Set Part 1 Data completeness: Organisation code of commissioner	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	100.0%	100.0%	100.0%	100.0%	100.0%	
		Herefordshire	100.0%	100.0%	100.0%	100.0%	100.0%	
		Combined Actual	100.0%	100.0%	100.0%	100.0%	100.0%	
1.11e	Mental Health Services Data Set Part 1 Data completeness: Postcode	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.8%	99.8%	99.8%	99.8%	99.8%	
		Herefordshire	99.9%	99.9%	99.9%	99.8%	99.9%	
		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	99.6%	99.7%	99.6%	99.6%	99.6%	
		Herefordshire	99.7%	99.8%	99.9%	99.9%	99.9%	
		Combined Actual	99.7%	99.7%	99.7%	99.7%	99.7%	

NHS Improvement Requirements

ID	Performance Measure (PM)		2017/18 Outturn	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
1.12	MENTAL HEALTH SERVICES DATA SET PART 2 DATA COMPLETENESS : OVERALL	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	94.7%	96.4%	96.3%	96.0%	96.3%	
		Herefordshire	90.9%	87.9%	87.6%	88.2%	87.8%	
		Combined Actual	94.1%	95.1%	94.9%	94.8%	95.0%	
1.12a	Mental Health Services Data Set Part 2 Data completeness: CPA Employment status last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	89.4%	94.2%	94.2%	94.0%	94.2%	
		Herefordshire	86.4%	81.5%	81.5%	82.2%	81.6%	
		Combined Actual	88.9%	92.1%	94.5%	92.1%	92.2%	
1.12b	Mental Health Services Data Set Part 2 Data completeness: CPA Accommodation Status in last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	96.6%	96.4%	96.1%	95.9%	96.2%	
		Herefordshire	87.1%	83.2%	82.7%	83.6%	83.0%	
		Combined Actual	94.9%	94.3%	94.0%	94.0%	94.1%	
1.12c	Mental Health Services Data Set Part 2 Data completeness: CPA HoNOS assessment in last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	98.2%	98.7%	98.5%	98.2%	98.5%	
		Herefordshire	99.2%	99.1%	98.7%	98.7%	98.9%	
		Combined Actual	98.4%	98.8%	98.5%	98.3%	98.5%	
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	0	0	1
	25	25	25	25
NYA	0	0	0	0
NYR	0	1	1	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 2 admissions of under 18s to adult wards in Herefordshire.

Changes to Previously Reported Figures

None

Early Warnings

None

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

2.21: No children under 18 admitted to adult inpatient wards
Unfortunately the annual performance threshold is zero and it has not been met therefore the performance for the year will be none compliant. Historic performance indicates that without changes in the tier 4 services arrangements - outside of the remit of ^{2}gether - we will not be able to meet this indicator.

DOH Never Events

ID	Performance Measure (PM)		2017/18 Outturn	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
2								
2.01	Wrongly prepared high risk injectable medications	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.02	Maladministration of potassium containing solutions	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.03	Wrong route administration of oral/enteral treatment	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.04	Intravenous administration of epidural medication	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.05	Maladministration of insulin	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.06	Overdose of midazolam during conscious sedation	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.07	Opioid overdose in opioid naive patient	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.08	Inappropriate administration of daily oral methotrexate	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.09	Suicide using non collapsible rails	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.10	Falls from unrestricted windows	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.11	Entrapment in bedrails	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.12	Misplaced naso - or oro-gastric tubes	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.13	Wrong gas administered	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.14	Failure to monitor and respond to oxygen saturation - conscious sedation	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.15	Air embolism	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.16	Severe scalding from water for washing/bathing	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.17	Mis-identification of patients	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	

DOH Requirements

ID	Performance Measure (PM)		2017/18 Outturn	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
2.18	Mixed Sex Accommodation - Sleeping Accommodation Breaches	PM	0	0	0	0	0	0
		Gloucestershire	0	0	0	0	0	
		Herefordshire	0	0	0	0	0	
		Combined	0	0	0	0	0	
2.19	Mixed Sex Accommodation - Bathrooms	Gloucestershire	Yes	Yes	Yes	Yes	Yes	
		Herefordshire	Yes	Yes	Yes	Yes	Yes	
		Combined	Yes	Yes	Yes	Yes	Yes	
2.20	Mixed Sex Accommodation - Women Only Day areas	Gloucestershire	Yes	Yes	Yes	Yes	Yes	
		Herefordshire	Yes	Yes	Yes	Yes	Yes	
		Combined	Yes	Yes	Yes	Yes	Yes	
2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0	0
		Gloucestershire	6	0	0	0	0	
		Herefordshire	5	1	0	0	2	
		Combined	11	1	0	0	2	
2.22	Failure to publish Declaration of Compliance or Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	Gloucestershire	Yes	Yes	Yes	Yes	Yes	
		Herefordshire	Yes	Yes	Yes	Yes	Yes	
		Combined	Yes	Yes	Yes	Yes	Yes	
2.23	Publishing a Declaration of Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	Gloucestershire	Yes	Yes	Yes	Yes	Yes	
		Herefordshire	Yes	Yes	Yes	Yes	Yes	

DOH Requirements

ID	Performance Measure (PM)		2017/18 Outturn	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
2.24	Serious Incident Reporting (SI)	Glos	33	3	1	2	9	
		Hereford	18	1	2	0	4	
2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	100%	100%	100%	100%	100%	
		Herefordshire	100%	100%	100%	N/A	100%	
2.26	Interim report for all SIs received within 5 working days of identification (unless extension granted by CCG)	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	100%	100%	100%	100%	100%	
		Herefordshire	100%	100%	100%	N/A	100%	
2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	100%	100%	NYR	NYR	100%	
		Herefordshire	100%	100%	NYR	NYR	100%	
2.28	SI Report Level 3 - Independent investigations - 6 months from investigation commissioned date	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	N/A	N/A	N/A	N/A	N/A	
		Herefordshire	N/A	N/A	N/A	N/A	N/A	
2.29	SI Final Reports outstanding but not due	Gloucestershire	5	0	1	2	3	
		Herefordshire	2	0	2	0	2	

DASHBOARD CATEGORY – GLOUCESTERSHIRE CCG CONTRACTUAL REQUIREMENTS

Gloucestershire Contract				
	In month Compliance			Cumulative Compliance
	May	Jun	Jul	
Total Measures	89	89	89	89
	4	10	5	11
	19	32	18	32
NYA	5	21	5	21
NYR	59	19	59	19
N/A	2	7	2	6

Performance Thresholds not being achieved in Month

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


3.63: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks


3.64: Adolescent Eating Disorders: Routine referral to non-NICE treatment within 4 weeks


3.65: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week
In response to current performance, a responsive implementation plan has been developed to improve wait times. This plan outlines the timeframe for staff recruitment which will, when initiated, start to ease waiting times as patients are assessed and treated. Priority is being given to CYP to ensure they are assessed and treated in line with national expectation. No child currently requiring emergency treatment waits more than a week from assessment to treatment in line with national KPI's. By end of August 2018 additional staff will have been appointed so that the assessment to treatment for urgent cases can occur within 1 week. Performance and progress will continue to be monitored closely.


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

Cumulative Performance Thresholds Not being Met

3.18: IAPT access rate: Access to psychological therapies for adults should be improved
Services in Gloucestershire have a stepped target across the 2018/19 financial year:

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Access Target	1.25%	1.29%	1.33%	1.40%	1.42%	1.46%	1.50%	1.54%	1.56%	1.58%	1.58%	1.58%
Actual	1.28%	1.33%	1.28%	1.398%								
Access Target year	15.00%	15.50%	16.00%	16.80%	17.00%	17.50%	18.00%	18.50%	18.75%	19.00%	19.00%	19.00%
Actual	15.36%	15.96%	15.36%	16.78%								

We are reporting this indicator as cumulatively non-compliant as we are not yet at 19%

3.21: To send Inpatient discharge summaries electronically within 24 hours to GP
The current level of compliance (93%) falls below the target of 100%. Quarterly compliance will continue to be monitored through regular audits and where necessary appropriate action will be taken to address this. Additionally, a process has been initiated to manually audit records to ensure that discharge summaries have been sent and within the timescale set. The results of this current audit will be shared with Matrons to ensure that there is ongoing communication regarding the importance of sending the discharge summaries in a timely manner.

3.26 & 3.27 CYPS: Referral to treatment within 8 & 10 weeks
We are non-compliant for Quarter 1 of this financial year. Work is ongoing to identify capacity and demand issues and produce a trajectory to assist with future planning.

3.53 - 3.55: Patients with Dementia have weight assessments on admission, at weekly intervals and near discharge.
Quarter 1 was the first time this indicator has been reported and work is on-going to investigate the reasons for non-compliance.

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

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

Changes to Previously Reported Figure

3.21: To send Inpatient discharge summaries electronically within 24 hours to GP
Previously reported as Not Yet Available, the report has now been completed. This indicator is reported for Quarter 1 as non-compliant. See above for commentary.

3.36: CYPS Transition to Adult (Recovery) Services
Previously reported in June with 1 non-compliant case recorded due to an erroneous entry on RIO which has now been corrected. This indicator is now reported as compliant

Early Warnings/Notes

None

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

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

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

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

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

3.63 – 3.65: Adolescent Eating Disorders Waiting Times
See note on page 16

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

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Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
	B. NATIONAL QUALITY REQUIREMENTS							
3.01	Zero tolerance MRSA	PM	0	0	0	0	0	0
		Unavoidable	0	0	0	0	0	
3.02	Minimise rates of Clostridium difficile	PM	0	0	0	0	0	0
		Unavoidable	0	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	100%	100%	100%	99%	99%	
3.05	Completion of Mental Health Services Data Set ethnicity coding for all detained and informal Service Users	PM	90%	90%	90%	90%	90%	90%
		Actual	99%	100%	98%	98%	99%	
3.06	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	PM	90%	90%	90%	90%	90%	90%
		Actual	99%	99%	99%	99%	99%	
	C. Local Quality Requirements							
	Domain 1: Preventing People dying prematurely							
3.07	Increased focus on suicide prevention and reduction in the number of reported suicides in the community and inpatient units	PM	Report				Annual	Report
		Actual	28				NYR	
3.08	To reduce the numbers of detained patients absconding from inpatient units where leave has not been granted	PM	< 144		< 36		<36	< 144
		Actual	122		35		35	
3.09	Compliance with NICE Technology appraisals within 90 days of their publication and ability to demonstrate compliance through completion of implementation plans and costing templates.	PM	Report				Annual	Annual
		Actual	N/A				NYR	
	Domain 2: Enhancing the quality of life of people with long-term conditions							
3.10	2G bed occupancy for Gloucestershire CCG patients	PM	> 91%	> 91%	> 91%	> 91%	> 91%	> 91%
		Actual	93%	97%	97%	95%	96%	
3.11	Care Programme Approach: 95% of CPAs should have a record of the mental health worker who is responsible for their care	PM	95%	95%	95%	95%	95%	95%
		Actual	100%	100%	100%	100%	100%	
3.12	CPA Review - 95% of those on CPA to be reviewed within 1 month (Review within 13 months)	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	100%	99%	99%	99%	
3.13	Assessment of risk: % of those 2g service users on CPA to have a documented risk assessment	PM	95%		95%		95%	95%
		Actual	99%		99%		99%	
3.14	Assessment of risk: All 2g service users (excluding those on CPA) to have a documented risk assessment	PM	85%		85%		85%	85%
		Actual	97%		96%		96%	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
3.15	People within the memory assessment service with a working diagnosis of dementia to have a care plan within 4 weeks of diagnosis	PM	85%	85%	85%	85%	85%	85%
		Actual	93%	90%	98%	98%	93%	
3.16	AKI (previous CQUIN 1516) 95% of pts to have EWS score within 12 hours	PM	95%		95%		95%	95%
		Actual	98%		97%		97%	
	Domain 3: Helping people to recover from episodes of ill-health or following injury							
3.17	IAPT recovery rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%	50%
		Actual	51%	55%	52%	52%	53%	
3.18	IAPT access rate: Access to psychological therapies for adults should be improved	PM	15.00%	1.30%	1.34%	1.40%	19.00%	19.00%
		Actual	13.32%	1.33%	1.28%	1.398%	16.78%	
3.19	IAPT reliable improvement rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%	50%
		Actual	70%	68%	69%	66%	67%	
3.20	Care Programme Approach (CPA): The percentage of people with learning disabilities in inpatient care on CPA who were followed up within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Actual	100%	NA	NA	NA	NA	
3.21	To send :Inpatient and day case discharge summaries electronically, within 24 hours to GP	PM	Report		100%		100%	Report
		Actual	93%		97%		97%	
	Domain 4: Ensuring that people have a positive experience of care							
3.22	To demonstrate improvements in staff experience following any national and local surveys	PM	Report				Annual	Annual
		Actual	Compliant				NYR	
3.23	Number of children in crisis urgently referred that receive support within 24 hours of referral by CYPS	PM	95%		95%		95%	95%
		Actual	100%		100%		100%	
3.24	Children and young people who enter a treatment programme to have a care coordinator - (Level 3 Services) (CYPS)	PM	98%	98%	98%	98%	98%	98%
		Actual	99%	99%	99%	98%	99%	
3.25	95% accepted referrals receiving initial appointment within 4 weeks (excludes YOS, substance misuse, inpatient and crisis/home treatment and complex engagement) (CYPS)	PM	95%		95%		95%	95%
		Actual	98%		96%		96%	
3.26	Level 2 and 3 – Referral to treatment within 8 weeks , excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	80%		80%		80%	80%
		Actual	78%		39%		39%	
3.27	Level 2 and 3 – Referral to treatment within 10 weeks (excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	95%		95%		95%	95%
		Actual	86%		45%		45%	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
3.28	Adults of working age - 100% of MDT assessments to have been completed within 4 weeks (or in the case of a comprehensive assessment commenced within 4 weeks)	PM	85%	85%	85%	85%	85%	85%
		Actual	90%	88%	93%	93%	91%	
	Vocational Services (Individual Placement and Support)							
3.29	100% of Service Users in vocational services will be supported to formulate their vocational goals through individual plans (IPS)	PM	98%		98%		98%	98%
		Actual	100%		NYA		NYA	
3.30	The number of people on the caseload during the year finding paid employment or self-employment (measured as a percentage against accepted referrals into the (IPS) Excluding those in employment at time of referral - Annual	PM	50%				50%	50%
		Actual	NYA				NYR	
3.31	The number of people retaining employment at 3/6/9/12+ months (measured as a percentage of individuals placed into employment retaining employment) (IPS)	PM	50%				50%	50%
		Actual	NYA				NYR	
3.32	The number of people supported to retain employment at 3/6/9/12+ months	PM	50%				50%	50%
		Actual	NYA				NYR	
3.33	Fidelity to the IPS model	PM	90%				90%	90%
		Actual	100%				NYR	
	General Quality Requirements							
3.34	GP practices will have an individual annual (MH) ICT service meeting to review delivery and identify priorities for future.	PM	Annual				Annual	Annual
		Actual	NYA				NYR	
3.35	Care plan audit to show : All dependent Children and YP <18 living with adults know to Recovery, MAHRS, Eating Disorder and Assertive Outreach Services. Recorded evidence in care plans of impact of the mental health disorder on those under 18s plus steps put in place to support.(Think family)	PM	Qtr 4		75%		75%	75%
		Actual	82%		NYA		NYA	
3.36	Transition- Joint discharge/CPA review meeting within 4 weeks of adult MH services accepting :working diagnosis to be agreed, adult MH care coordinator allocated and care cluster and risk levels agreed as well as CYPS discharge date.	PM	100%		100%		100%	100%
		Actual	0%		100%		100%	
3.37	Number and % of crisis assessments undertaken by the MHARS team on CYP age 16-25 within agreed timescales of 4 hours	PM	90%	90%	90%	90%	90%	90%
		Actual	NYR	NYA	NYA	NYA	NYA	
3.38	MHARS Wait time to Assessment: Triage wait time 1 hour (Emergency assessments within 1 hour of triage)	PM		TBC	TBC	TBC	TBC	TBC
		Actual		NYA	NYA	NYA	NYA	
3.39	MHARS Wait time to Assessment: Full Assessment 4 hours (Urgent assessments within 4 hours of triage)	PM	90%	TBC	TBC	TBC	TBC	TBC
		Actual	NYR	NYA	NYA	NYA	NYA	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
	New KPIs for 2017/18							
3.40	LD: To deliver specialist support to people with learning disabilities in accordance with specifically developed pathways	PM	95%		25%		95%	95%
		Actual	100%		NYA		NYA	
3.41	LD: To demonstrate a reduction in an individual's health inequalities thanks to the clinical intervention provided by 2gether learning disability services.	PM	Report		TBC		TBC	TBC
		Actual	Compliant		NYA		NYA	
3.42	LD: People with learning disabilities and their families report high levels of satisfaction with specialist learning disability services	PM	75%		75%		75%	75%
		Actual	Compliant		NYA		NYA	
3.43	LD: To ensure all published clinical pathways accessed by people with learning disabilities are available in easy read versions	PM	95%				95%	95%
		Actual	100%				NYR	
3.44	LD: The CLDT, IHOT & LDISS will take a proactive and supportive role in ensuring the % uptake of Annual Health Checks for people with learning disabilities on their caseload is high	PM	75%				75%	75%
		Actual	80%				NYR	
3.45	Of those supported by 2g to access AHC 100% are then further supported with their Health Action Plans & screening	PM					100%	75%
		Actual					NYR	
3.46	IAPT DNA rate	PM	<16%	<16%	<16%	<16%	<16%	<16%
		Actual	13%	13%	13%	15%	14%	
3.47	IAPT Equity of Access for Service Users: aged 65 and over on the caseload				TBC		TBC	TBC
		Actual			9%		9%	
3.48	IAPT Equity of Access for Service Users: Numbers of BAME on the caseload				TBC		TBC	TBC
		Actual			414		414	
3.49	IAPT Clinical productivity by Groups and 1:1 sessions for: Hi Intensity				> 18 per week		> 18 per week	> 18 per week
		Actual			N/A		N/A	
3.50	IAPT Clinical productivity by Groups and 1:1 sessions for: Lo Intensity				> 18 per week		> 18 per week	> 18 per week
		Actual			N/A		N/A	
3.51	IAPT treatment outcomes: Women in the Perinatal period showing reliable improvement in outcomes between pre and post treatment	PM	50%	50%	50%	50%	50%	85%
		Actual	75%	74%	73%	84%	74%	
3.52	% of CYP entering partnership in CYPS have pre and post treatment outcomes and measures recorded				TBC		TBC	TBC
		Actual			NYA		NYA	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
3.53	Patients with Dementia have weight assessments on admission	PM			85%		85%	85%
		Actual			55%		55%	
3.54	Patients with Dementia have weight assessments at weekly intervals	PM			85%		85%	85%
		Actual			70%		70%	
3.55	Patients with Dementia have weight assessments near discharge	PM			85%		85%	85%
		Actual			67%		67%	
3.56	Patients with Dementia have delirium screening on admission	PM			85%		85%	85%
		Actual			NYA		NYA	
3.57	Patients with Dementia have delirium screening at weekly intervals	PM			85%		85%	85%
		Actual			NYA		NYA	
3.58	Patients with Dementia have delirium screening near discharge	PM			85%		85%	85%
		Actual			NYA		NYA	
3.59	CPI: Referral to Assessment within 4 weeks	PM	85%	85%	85%	85%	85%	85%
		Actual	91%	91%	100%	97%	95%	
3.60	CPI: Assessment to Treatment within 16 weeks	PM	85%	85%	85%	85%	85%	85%
		Actual	99%	94%	100%	95%	97%	
3.61	Comprehensive audit in relation to timeliness and quality of discharge communication (non-medical)						Report	
		Actual					NYR	
3.62	Daily submission of information to inform the daily escalation level	PM		Report	Report	Report	Report	Report
		Actual		NYA	NYA	NYA	NYA	
3.63	Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	PM	95%	95%	95%	95%	95%	95%
		Actual	29%	33%	33%	33%	30%	
3.64	Adolescent Eating Disorders - Routine referral to non-NICE treatment start within 4 weeks	PM	95%	95%	95%	95%	95%	95%
		Actual	9%	0%	N/A	0%	0%	
3.65	Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week	PM	95%	95%	95%	95%	95%	95%
		Actual	64%	75%	50%	0%	50%	
3.66	Adolescent Eating Disorders - Urgent referral to non-NICE treatment start within 1 week	PM	95%	95%	95%	95%	95%	95%
		Actual	N/A	N/A	N/A	N/A	N/A	
3.67	Eating Disorders - Wait time for adult assessments will be 4 weeks	PM	95%	95%	95%	95%	95%	95%
		Actual	36%	53%	56%	71%	59%	
3.68	Eating Disorders - Wait time for adult psychological interventions will be 16 weeks	PM		95%	95%	95%	95%	95%
		Actual		NYA	NYA	NYA	NYA	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
3.69	LD Health facilitation - awareness and support for all stakeholders including reasonable adjustments support to reduce health inequalities						Annual	
		Actual					NYR	
3.70	LD: Patients on the LD challenging behaviour pathway have a single positive behaviour support plan (containing primary, secondary and reactive interventions) completed within 30 days of allocation to clinician	PM			25%		95%	95%
		Actual			NYA		NYA	
3.71	LD: Active involvement in Care and Treatment Reviews & Blue Light protocol meetings to prevent admission and actively support and plan for integration/discharge in the community: 100% completion of the CTR Provider Checklist prior to CTR meetings	PM			100%		100%	100%
		Actual			NYA		NYA	
3.72	LD: Active involvement in Care and Treatment Reviews & Blue Light protocol meetings to prevent admission and actively support and plan for integration/discharge in the community: 75% CTRs being completed within 10 days of admission to Berkeley House	PM			75%		75%	75%
		Actual			NYA		NYA	
3.73	CYP report being satisfied or more than satisfied with service experience	PM					Report	Report
		Actual					NYR	
3.74	CYP report being satisfied or more than satisfied following Transition to Adult services	PM					Report	Report
		Actual					NYR	
3.75	CYP report being satisfied or more than satisfied with Transition to Adult Services: 95% of CYP asked to complete Service Questionnaire	PM					95%	95%
		Actual					NYR	
3.76	Perinatal: Urgent Referral to Assessment within 4 - 6 hours - During working hours (unless otherwise negotiated with referrer or patient) in conjunction with Crisis Team	PM			95%		95%	95%
		Actual			NYA		NYA	
3.77	Perinatal: Out of hours emergencies assessed by MHARS to be discussed with the Specialist Perinatal Service the next working day	PM					95%	95%
		Actual					NYR	
3.78	Perinatal: Urgent referrals with High risk indicators (following telephone screening) will be seen with 48 working hours	PM			95%		95%	95%
		Actual			100%		100%	
3.79	Perinatal: Preconception advice - Referral to assessment within 6 weeks	PM			50%		50%	95%
		Actual			100%		100%	
3.80	Perinatal: Preconception advice - Referral to assessment within 8 weeks	PM			90%		90%	90%
		Actual			100%		100%	
3.81	Perinatal: Routine referral to assessment within 2 weeks	PM			50%		50%	95%
		Actual			75%		75%	
3.82	Perinatal: Routine referral to assessment within 6 weeks	PM			95%		95%	95%
		Actual			97%		97%	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
3.83	Perinatal: Number of women asked if they have a carer	PM	80%		80%		80%	80%
		Actual	82%		90%		90%	
3.84	Perinatal: Number of women with a carer offered carer's assessment	PM	90%		90%		90%	90%
		Actual	90%		92%		92%	
3.85	Perinatal: Women and families views inform the development of the service via a service user forum	PM					Report	Annual
		Actual					NYR	
3.86	Perinatal: all perinatal care plans to be reviewed within 3 months	PM			95%		95%	95%
		Actual			NYA		NYA	
3.87	Perinatal: Reduction in number of episodes of Crisis	PM					Report	Report
		Actual					NYR	
3.88	GARAS: Accepted referrals receive an initial assessment appointment within 6 weeks	PM			95%		95%	95%
		Actual			NYA		NYA	
3.89	GARAS: percentage of referrals completing the course of therapy	PM			90%		90%	90%
		Actual			NYA		NYA	

Schedule 4 Specific Measures that are reported Nationally

Performance Thresholds not being achieved in Month
None

Changes to Previously Reported Figures

Early Warnings / Notes

1.02: Number of C Diff cases – avoidable
A patient on Willow Ward, Charlton Lane tested positive for C diff in May. A root cause analysis was undertaken at the end of June. The outcome of this, being that the case was unavoidable; however, it still needs to be taken to the countywide CDiff assurance group for final confirmation.

For transparency the case is assumed to be avoidable until final confirmation is received.

Although we are showing this indicator as non-compliant for May. The performance threshold for the whole financial year is less than 3 cases; therefore we have shown the cumulative total as compliant.

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

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

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

ID	Performance Measure (PM)		2017/18 Outturn	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
NHSI 1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	<3	0
		Actual	0	1	0	0	1	
NHSI 1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	96%	96%	97%	97%	
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	3.2%	0.8%	1.7%	1.7%	1.7%	
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%	97%	98%	99%	
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	53%	53%	53%	53%	53%
		Actual	71%	33%	80%	70%	74%	
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Actual	69%	93%	93%	96%	93%	
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Actual	88%	97%	97%	98%	97%	
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
DoH 2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0	0
		Actual	6	0	0	0	0	
DoH 2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%	100%
		Actual	100%	100%	100%	100%	100%	
DoH 2.26	Interim report for all SIs received within 5 working days of identification (unless extension granted by CCG)	PM	100%	100%	100%	N/A	100%	100%
		Actual	100%	100%	100%	100%	100%	
DoH 2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM	100%	100%	100%	100%	100%	100%
		Actual	100%	100%	NYR	NYR	100%	

DASHBOARD CATEGORY – GLOUCESTERSHIRE SOCIAL CARE

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

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
None

Early Warnings/Notes
None

Gloucestershire Social Care

ID	Performance Measure		2017/18 outturn	April-2018	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
4.01	The percentage of people who have a Cluster recorded on their record	PM	95%	95%	95%	95%	90%	95%	95%
		Actual	98%	99%	99%	99%	99%	99%	
4.02	Percentage of people getting long term services, in a residential or community care reviewed/re-assessed in last year	PM	95%	95%	95%	95%	95%	95%	95%
		Actual	97%	95%	97%	97%	97%	97%	
4.03	Ensure that reviews of new packages take place within 12 weeks of commencement	PM	80%	80%	80%	80%	80%	80%	80%
		Actual	74%	100%	100%	100%	100%	100%	
4.04	Current placements aged 18-64 to residential and nursing care homes per 100,000 population	PM	13	13	13	13	13	13	13
		Actual	9.44	9.61	9.10	9.10	8.35	9.10	
4.05	Current placements aged 65+ to residential and nursing care homes per 100,000 population	PM	22	22	22	22	22	22	22
		Actual	16.54	17.90	18.67	19.45	21.01	19.45	
4.06	% of WA & OP service users on caseload asked if they have a carer	PM	80%	80%	80%	80%	80%	80%	80%
			88%	88%	88%	86%	85%	85%	
4.07	% of WA & OP service users on the caseload who have a carer, who have been offered a carer's assessment	PM	90%	90%	90%	90%	90%	90%	90%
		Actual	91%	93%	92%	91%	91%	91%	
4.08a	% of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC	TBC	TBC
		Actual	43%	41%	42%	42%	41%	41%	
4.08b	Number of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC	TBC	TBC
		Actual	521	542	551	560	554	554	
4.09	% of eligible service users with Personal budgets	PM	80%	80%	80%	80%	80%	80%	80%
		Actual	95%	95%	97%	98%	98%	97%	

Gloucestershire Social Care

ID	Performance Measure		2017/18 outturn	April-2018	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
4.10	% of eligible service users with Personal Budget receiving Direct Payments (ASCOF 1C pt2)	PM	15%	15%	15%	15%	15%	15%	15%
		Actual	19%	17%	17%	17%	16%	16%	
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%	80%
		Actual	87%	87%	87%	87%	87%	87%	
4.12	Adults not subject to CPA in contact with secondary mental health service in settled accommodation	PM	90%	90%	90%	90%	90%	90%	90%
		Actual	96%	96%	96%	95%	96%	96%	
4.13	Adults subject to CPA receiving secondary mental health service in employment (ASCOF 1F)	PM	13%	13%	13%	13%	13%	13%	13%
		Actual	18%	17%	17%	18%	16%	16%	
4.14	Adults not subject to CPA receiving secondary mental health service in employment	PM	20%	20%	20%	20%	20%	20%	20%
		Actual	21%	22%	22%	21%	21%	21%	

DASHBOARD CATEGORY – HEREFORDSHIRE CCG CONTRACTUAL REQUIREMENTS

Herefordshire Contract				
	In month Compliance			Cumulative Compliance
	May	Jun	Jul	
Total Measures	24	24	24	24
🔴	3	1	1	3
🟢	14	15	16	15
NYA	0	0	0	0
NYR	0	0	0	0
N/A	7	8	7	6

Performance Thresholds not being achieved in Month

5.19: CYP Access: percentage of CYP in treatment against prevalence
We are 5 below the expected number of young people accessing treatment in July.
.

Cumulative Performance Thresholds Not being

5.09a: IAPT achieve 15% of patients entering the service against prevalence
As this service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee. Trajectory plans and an associated investment envelope has been agreed with Herefordshire CCG in order to meet the 19% access target by quarter 4 2018/19. A service improvement development plan is being produced.

We are reporting this indicator as cumulatively non-compliant as we are not yet at 19%

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

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

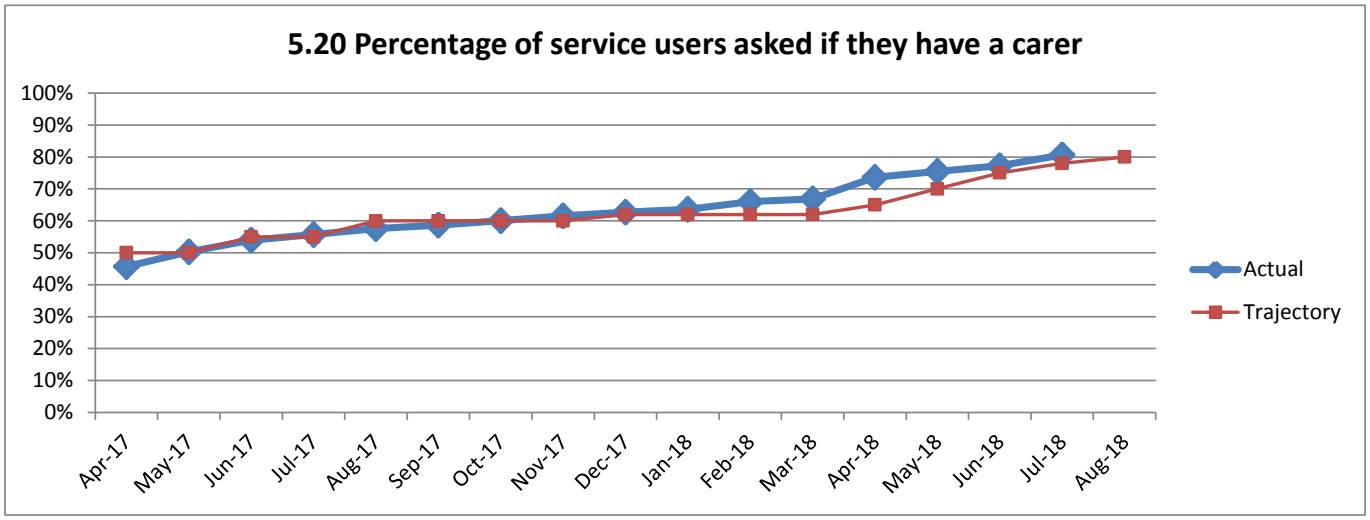
5.19: CYP Access: percentage of CYP in treatment against prevalence
The performance threshold for 2018/19 is 30% of prevalence, which equates to 973 young people having accessed treatment during 2018/19. We are currently 39 below the anticipated number required to achieve this at the end of July

Changes to Previously Reported Figures

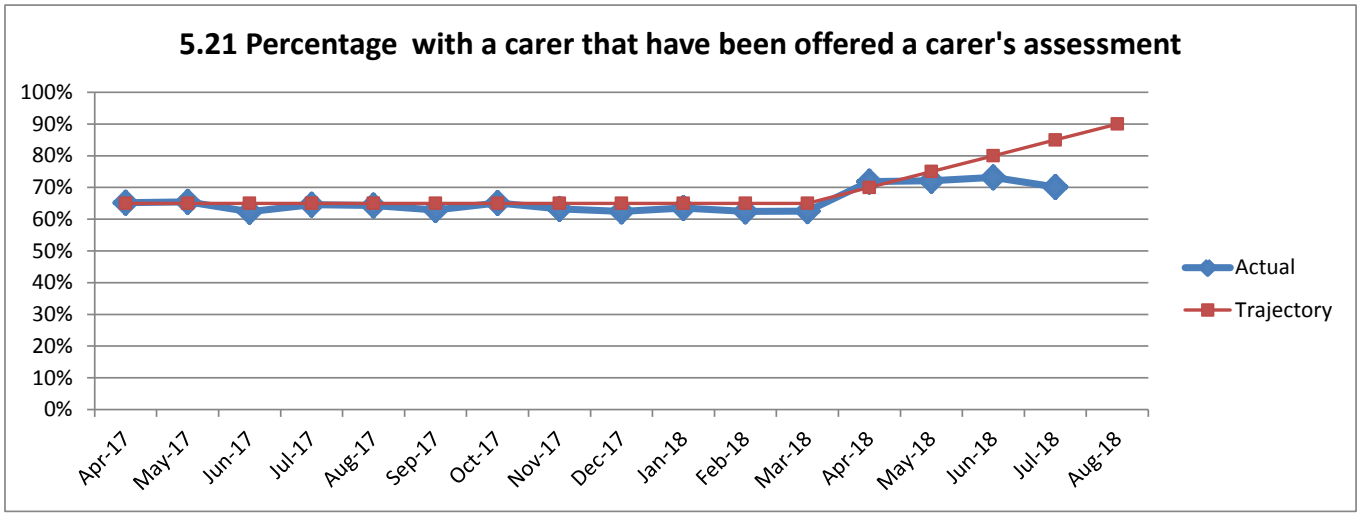
5.09a: IAPT Access Rate
April, May and June previously reported as non-compliant are now reported as compliant due to a change in the access rate trajectory which has been updated after negotiations with Commissioners**.**

Early Warnings / Notes

5.20: Percentage of service users asked if they have a carer
The following chart monitors progress against a trajectory to reach 80% by August 2018.



5.21: Percentage with a carer that have been offered a carer's assessment
The following chart monitors progress against a trajectory to reach 90% by August 2018.



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

5.09a: IAPT roll-out (access rate) – IAPT maintain 15% of patient entering the service against prevalence:
See earlier note on Page 31.

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

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

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

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 Outturn	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
5.01	Duty of Candour	Plan	Report	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant	Compliant	Compliant	
5.02	Completion of a valid NHS number field in metal health and acute commissioning data sets submitted via SUS.	Plan	99%	99%	99%	99%	99%	99%
		Actual	100%	100%	100%	100%	100%	
5.03	Completion of Mental Health Services Data Set ethnicity coding for all service users	Plan	90%	90%	90%	90%	90%	90%
		Actual	100%	100%	100%	97%	99%	
5.04	Completion of IAPT Minimum Data Set outcome data for all appropriate service users	Plan	90%	90%	90%	90%	90%	90%
		Actual	100%	100%	100%	100%	100%	
5.05	Zero tolerance MRSA	Plan	0	0	0	0	0	0
		Unavoidable	0	0	0	0	0	
5.06	Minimise rates of Clostridium difficile	Plan	0	0	0	0	0	0
		Unavoidable	0	0	0	0	0	
5.07	VTE risk assessment: all inpatient service users to undergo risk assessment for VTE	Plan	95%	95%	95%	95%	95%	95%
		Actual	98%	100%	100%	100%	99%	
5.08	IAPT Recovery Rate: The number of people who are below the caseness threshold at treatment end	Plan	50%	50%	50%	50%	50%	50%
		Actual	49%	42%	62%	61%	52%	
5.09a	IAPT Roll-out (Access Rate) - IAPT maintain 15% of patient entering the service against prevalence	Plan		1.10%	1.10%	1.13%	19.00%	19.00%
				1.14%	1.06%	1.26%	15.12%	
5.09b	IAPT Roll-out (Access Rate) - Number accessing service	Plan	2,178	317	476	640	640	2190
		Actual	1,977	338	492	675	675	

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 Outturn	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
5.10a	Dementia Service - number of new patients aged 65 years and over receiving an assessment	Plan	540	45	45	45	180	540
		Actual	667	76	56	57	254	
5.10b	Dementia Service - total number of new patients receiving an assessment	Plan						
		Actual	711	80	60	64	272	
5.11	Patients are to be discharged from local rehab within 2 years of admission (Oak House). Based on patients on ward at end of month.	Plan	80%	80%	80%	80%	80%	80%
		Actual	100%	100%	100%	100%	100%	
5.12	All admitted patients aged 65 years of age and over must have a completed MUST assessment	Plan	95%	95%	95%	95%	95%	95%
		Actual	100%	100%	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	89%	88%	87%	82%	88%	
5.14	Attendances at ED, wards and clinics for self-harm receive a mental health assessment (Mental Health Liaison Service)	Plan	85%	85%	85%	85%	85%	85%
		Actual	96%	93%	98%	96%	96%	
5.15	CYP Eating Disorders: Treatment waiting time for routine referrals within 4 weeks - NICE treatments	Plan	95%	95%	95%	95%	95%	95%
		Actual	96%	100%	100%	100%	75%	
5.16	CYP Eating Disorders: Treatment waiting time for routine referrals within 4 weeks - non-NICE treatments	Plan	95%	95%	95%	95%	95%	95%
		Actual	N/A	N/A	N/A	N/A	N/A	
5.17	CYP Eating Disorders: Treatment waiting time for urgent referrals within 1 week - NICE treatments	Plan	95%	95%	95%	95%	95%	95%
		Actual	80%	100%	N/A	N/A	100%	
5.18	CYP Eating Disorders: Treatment waiting time for urgent referrals within 1 week - non-NICE treatments	Plan	95%	95%	95%	95%	95%	95%
		Actual	N/A	N/A	N/A	100%	100%	
5.19	CYP Access: Number and percentage of CYP entering treatment (30% of prevalence)	Plan - %		14.0%	9.5%	8.5%	46.0%	100%
		Actual %		11.1%	9.7%	8.0%	33.7%	
		Plan - numbers		136	92	83	447	973
		Actual - numbers		108	94	78	408	

Herefordshire Carers Information

ID	Performance Measure		2017/18 Outturn	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
5.20	Working Age and Older People service users on the caseload asked if they have a carer. (Only includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan						
		Actual	67%	75%	77%	81%	81%	
5.21	Working Age and Older People service users on the caseload who have a carer who have been offered a carer's assessment. (Includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan						
		Actual	63%	72%	73%	70%	70%	
5.22	Working Age and Older People service users/carers who have accepted a carers assessment. (Only includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan						
		Actual	28%	26%	25%	27%	27%	

Schedule 4 Specific Measures that are reported Nationally

Performance Thresholds not being achieved in Month

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.

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

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

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

ID	Performance Measure (PM)		2017/18 Outturn	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
NHSI 1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	<3	0
		Actual	0	0	0	0	0	
NHSI 1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	100%	100%	95%	99%	
NHSI 1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%	95%
		Actual	98%	98%	98%	96%	97%	
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	2.4%	2.1%	1.6%	3.6%	1.8%	
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	53%	53%	53%	53%	53%
		Actual	68%	67%	100%	100%	78%	
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Actual	59%	83%	94%	90%	86%	
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Actual	75%	84%	97%	93%	89%	
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
DoH 2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0	0
		Actual	5	1	0	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	9	0	9
NYA	0	0	0	0
NYR	12	3	12	3
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
None

Early Warnings
None

Gloucestershire CQUINS

ID	Performance Measure (PM)		2017/18 Outturn	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
	CQUIN 1							
7.01a	Improvement of health and wellbeing of NHS Staff	PM	Qtr 4		Report		Report	Report
		Actual	Awarded		NYR		NYR	
7.01b	Healthy food for NHS staff, visitors and patients	PM	Qtr 4		Report		Report	Report
		Actual	Awarded		NYR		NYR	
7.01c	Improving the update of flu vaccinations for frontline clinical staff	PM	Qtr 4		Report		Report	Report
		Actual	Awarded		NYR		NYR	
	CQUIN 2							
7.02a	Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with psychoses	PM	Qtr 4		Report		Report	Report
		Actual	Awarded		Compliant		Compliant	
7.02b	Improving Physical healthcare to reduce premature mortality in people with SMI: Collaboration with primary care clinicians	PM	Qtr 4		Report		Report	Report
		Actual	Awarded		Compliant		Compliant	
	CQUIN 3							
7.03	Improving services for people with mental health needs who present to A&E	PM	Qtr 4		Report		Report	Report
		Actual	Awarded		Compliant		Compliant	
	CQUIN 4							
7.04	Transition from Young People's Service to Adult Mental Health Services	PM	Qtr 4		Report		Qtr 1	Report
		Actual	Awarded		Compliant		Compliant	
	CQUIN 5							
7.05a	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco screening	PM	Qtr 4		Report		Qtr 1	Report
		Actual	Awarded		Compliant		Compliant	
7.05b	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco brief advice	PM	Qtr 4		Report		Qtr 1	Report
		Actual	Awarded		Compliant		Compliant	
7.05c	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco referral and medication	PM	Qtr 4		Report		Qtr 1	Report
		Actual	Awarded		Compliant		Compliant	
7.05d	Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol screening	PM	Qtr 4		Report		Qtr 1	Report
		Actual	Awarded		Compliant		Compliant	
7.05e	Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol brief advice or referral	PM	Qtr 4		Report		Qtr 1	Report
		Actual	Awarded		Compliant		Compliant	

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
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
None

Early Warnings
None

Low Secure CQUINS

ID	Performance Measure (PM)		2017/18 Outturn	May-2018	June-2018	July-2018	(Apr-Jul) Cumulative Compliance	Forecast 18/19 Outturn
	CQUIN 1							
8.01	Reducing the length of stay in specialised MH services	PM	Qtr 4		Report		Qtr 1	Report
		Actual	Awarded		Compliant		Compliant	

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	9	0	9
NYA	0	0	0	0
NYR	12	3	12	3
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
None

Early Warnings
None

Herefordshire CQUINS

ID	Performance Measure (PM)		2017/18 Outturn	May-2018	June-2018	July-2018	(Apr-jul) Cumulative Compliance	Forecast 18/19 Outturn
7								
	CQUIN 1							
9.01a	Improvement of health and wellbeing of NHS Staff	PM	Qtr 4		Report		Report	Report
		Actual	Awarded		NYR		NYR	
9.01b	Healthy food for NHS Staff, Visitors and Patients	PM	Qtr 4		Report		Report	Report
		Actual	Awarded		NYR		NYR	
9.01c	Improving the uptake of Flu vaccinations for Front Line Clinical Staff	PM	Qtr 4		Report		Report	Report
		Actual	Awarded		NYR		NYR	
	CQUIN 2							
9.02a	Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with psychoses	PM	Qtr 4		Report		Qtr 1	Report
		Actual	Awarded		Compliant		Compliant	
9.02b	Improving Physical healthcare to reduce premature mortality in people with SMI: Collaborating with primary care clinicians	PM	Qtr 4		Report		Qtr 1	Report
		Actual	Awarded		Compliant		Compliant	
	CQUIN 3							
9.03	Improving services for people with mental health needs who present to A&E	PM	Qtr 4		Report		Qtr 1	Report
		Actual	Awarded		Compliant		Compliant	
	CQUIN 4							
9.04	Transition from Young People's Service to Adult Mental Health Services	PM	Qtr 4		Report		Qtr 1	Report
		Actual	Awarded		Compliant		Compliant	
	CQUIN 5							
9.05a	Tobacco screening	PM	Qtr 4		Report		Qtr 1	Report
		Actual	Awarded		Compliant		Compliant	
9.05b	Tobacco brief advice	PM	Qtr 4		Report		Qtr 1	Report
		Actual	Awarded		Compliant		Compliant	
9.05c	Tobacco referral and medication offer	PM	Qtr 4		Report		Qtr 1	Report
		Actual	Awarded		Compliant		Compliant	
9.05d	Alcohol screening	PM	Qtr 4		Report		Qtr 1	Report
		Actual	Awarded		Compliant		Compliant	
9.05e	Alcohol brief advice or referral	PM	Qtr 4		Report		Qtr 1	Report
		Actual	Awarded		Compliant		Compliant	

Agenda Item **7** **Enclosure** **Paper C**

Report to: Trust Board – 26 September 2018
Author: Gordon Benson, Assistant Director of Governance & Compliance
Presented by: Marie Crofts, Director of Quality

SUBJECT: **Quality Report: Report for 1st Quarter 2018/19**

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

EXECUTIVE SUMMARY

This is the first review of the Quality Report priorities for 2018/19. The quarterly report is in the format of the annual Quality Report format.

Assurance

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

- Overall, there are 2 targets which are consistently not being met:

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

Improvements/developments

- There continues to be a sustained focus on the unmet targets, particularly in discharge care planning as the target remains consistently unmet. It was agreed at QCR on 17 August 2018 that the required standards within the ACM Policy would be reviewed to establish the value and impact of the 8 defined criteria and, if indicated, agree revised and more effective criteria. Until this work is concluded, Localities will report on performance against this target at each monthly QCR.

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

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

RECOMMENDATIONS

The Board is asked to:

- Note the progress made to date and actions in place to improve/sustain performance where possible.

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	17 August 2018

Where in the Trust has this been discussed before?		
QCR	Date	17 August 2018
Governance Committee	Date	31 August 2018

What consultation has there been?		
	Date	

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

1. CONTEXT

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

Quality Report 2018/19

Quarter 1

CONTENTS

Part 1: Statement on Quality from the Chief Executive

Introduction

To be completed at year-end

Part 2.1: Looking ahead to 2019/20

Quality Priorities for Improvement 2018/19

To be completed at year-end

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

Review of Services

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

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

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

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

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

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

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

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

Participation in Clinical Audits and National Confidential Enquiries

To be completed at year-end

Participation in Clinical Research

To be completed at year-end

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

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

2018/19 CQUIN Goals

Gloucestershire

Gloucestershire Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
1a (a) National CQUIN – Staff health and wellbeing	To achieve a 5 percentage point improvement in 2 of the 3 NHS annual staff survey questions on Health and Wellbeing	0.3	£75133	Effectiveness
1b National CQUIN – Staff health and wellbeing	Healthy food for NHS staff, visitors and patients		£75133	Effectiveness
1c National CQUIN - Staff health and wellbeing	Improving the uptake of flu vaccinations for front line staff		£75133	Safety
2 National CQUIN - Improving Physical Healthcare 3a	- To reduce premature mortality by demonstrating cardio metabolic assessment and treatment for patients with psychoses.	0.3	£180320	Effectiveness
2 National CQUIN - Improving Physical Healthcare 3b	- To reduce premature mortality - Improved communication with GPs		£45080	Effectiveness
3. Improving Services for people with mental health needs who present to A & E.	Care and management for frequent attenders to Accident and Emergency	0.3	£225400	Safety
4. Transitions out of Children and Young People's Mental Health Services.	To improve the experience and outcomes for young people as they transition out of (CYPMHS)	0.3	£225400	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	£225400	Effectiveness

Herefordshire

Herefordshire Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
1a (a) National CQUIN – Staff health and wellbeing	To achieve a 5 percentage point improvement in 2 of the 3 NHS annual staff survey questions on Health and Wellbeing	0.3	£19066	Effectiveness
1b National CQUIN – Staff health and wellbeing	Healthy food for NHS staff, visitors and patients		£19066	Effectiveness
1c National CQUIN - Staff health and wellbeing	Improving the uptake of flu vaccinations for front line staff		£19066	Safety
2 National CQUIN - Improving Physical Healthcare 3a	- To reduce premature mortality by demonstrating cardio metabolic assessment and treatment for patients with psychoses.	0.3	£45760	Effectiveness
2 National CQUIN - Improving Physical Healthcare 3b	- To reduce premature mortality - Improved communication with GPs		£11440	Effectiveness
3. Improving Services for people with mental health needs who present to A & E.	Care and management for frequent attenders to Accident and Emergency	0.3	£57201	Safety
4. Transitions out of Children and Young People's Mental Health Services.	To improve the experience and outcomes for young people as they transition out of (CYPMHS)	0.3	£57201	Effectiveness
5.Preventing ill health by risky behaviours – Alcohol and Tobacco	To offer advice and interventions aimed at reducing risky behaviour in admitted patients	0.3	£57201	Effectiveness

Low Secure Services

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

The total potential value of the income conditional on reaching the targets within the CQUINs during 2018/19 is £2,390,000.

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

2019/20 CQUIN Goals

To be completed when this information becomes available

Statements from the Care Quality Commission

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

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

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

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

The CQC has not taken enforcement action against [2]gether NHS Foundation during 2018/19 or the previous year 2017/18.

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

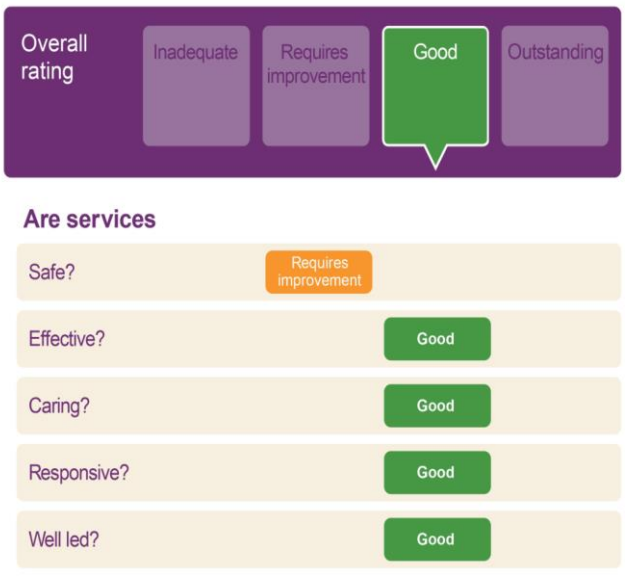
CQC Inspections of our services

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

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

New Ratings from latest review.

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



The inspection found that there were some aspects of care and treatment in some services that needed improvements to be made to ensure patients were kept safe. However, the vast majority of services were delivering effective care and treatment.The Trust has developed an action plan in response to the 11 “must do” recommendations, and the 23 “should do” recommendations identified by the inspection and is managing the actions through to their completion.

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

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

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Quality of Data

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

To be completed at year-end

Information Governance

To be completed at year-end

Clinical Coding

To be completed at year-end

Learning from Deaths

To be completed at Quarter 2.

Part 2.3: Mandated Core Indicators 2018/19

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

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

	Quarter 4 2016-17	Quarter 1 2017-18	Quarter 2 2017-18	Quarter 3 2017-18	Quarter 4 2018-19
[2]gether NHS Foundation Trust	99.2%	99.2%	98.5%	99.6%	98.4%
National Average	96.8%	96.7%	96.7%	95.4%	95.5%
Lowest Trust	84.6%	71.4%	87.5%	69.2%	87.2%
Highest Trust	99.4%	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 4 2016-17	Quarter 1 2017-18	Quarter 2 2016-17	Quarter 3 2017-18	Quarter 4 2018-19
[2]gether NHS Foundation Trust	100%	100%	100%	99.5%	98.6%
National Average	98.8%	98.7%	98.6%	98.5%	98.7%
Lowest Trust	90%	88.9%	94%	84.3%	93.7%
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.

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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 2017-18	Quarter 2 2017-18	Quarter 3 2017-18	Quarter 4 2017-18	Quarter 1 2018-19
[2]gether NHS Foundation Trust 0-15	0%	0%	0%	0%	0%
[2]gether NHS Foundation Trust 16 +	5.9%	7.3%	10.4%	5.8%	6.2%
National Average	Not available	Not available	Not available	Not available	Not available
Lowest Trust	Not available	Not available	Not available	Not available	Not available
Highest Trust	Not available	Not available	Not available	Not available	Not available

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

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

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

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

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

	NHS Staff Survey 2014	NHS Staff Survey 2015	NHS Staff Survey 2016	NHS Staff Survey 2017
[2]gether NHS Foundation Trust Score	3.61	3.75	3.84	3.86
National Median Score	3.57	3.63	3.62	3.67
Lowest Trust Score	3.01	3.11	3.20	3.26
Highest Trust Score	4.15	4.04	3.96	4.14

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

- For the second year running, all staff in post were invited to take part in the survey. Previously the survey had only been sent to a random sample of staff. The overall response rate in the most recent survey was **45%** (improved from 40% the previous year). This equated with **921** staff taking the time to contribute their views (up from 777 the previous year). The 2017 survey has arguably provided the richest and most accurate picture of the staff views in the Trust to date.

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

Taking steps to

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

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

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

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

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

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

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

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

	1 October 2016 – 31 March 2017				1 April 2017 – 30 September 2017			
	Number	Rate*	Severe	Death	Number	Rate*	Severe	Death
[2]gether NHS Foundation Trust	2,474	72.05	2	17	2,585	73.19	2	20
National	157,141	-	538	1233	167,477	-	532	1212
Lowest Trust	68	11.17	0	0	68	16	0	0
Highest Trust	6,447	88.21	72	100	6,447	126.47	89	83

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

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

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

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

- Establishing a Datix User Group to improve the processes in place for the timely review, approval of, response to and learning from reported patient safety incidents;

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

Part 3: Looking Back: A Review of Quality during 2017/18

Introduction

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

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

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

Summary Report on Quality Measures for 2018/2019

Effectiveness		2016 - 2017	2017 - 2018	2018- 2019
1.1	To improve the physical health of patients with a serious mental illness on CPA by a positive cardio metabolic health resource (Lester Tool). 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**	**Achieved**
1.2	To further improve personalised discharge care planning in adult and older peoples wards, including the provision of discharge information to primary care services within 24hrs of discharge.	**Achieved**	**Not achieved**	**Not achieved**
1.3	To ensure that joint Care Programme Approach reviews occur for **all** service users who make the transition from children's to adult services.	**Not achieved**	**Not achieved**	**Achieved**
User Experience				
2.1	Were you involved as much as you wanted to be in agreeing what care you will receive? **> 84%**	**Achieved**	**Not achieved**	**Not achieved**
2.2	Do you know who to contact out of office hours if you have a crisis? **>71%**	**Achieved**	**Achieved**	**Achieved**
2.3	Has someone given you advice about taking part in activities that are important to you? **> 64%**	**Achieved**	**Achieved**	**Achieved**
2.4	Have you had help and advice to find support to meet your physical health needs if you needed it? **> 73%**	**Achieved**	**Achieved**	**Achieved**
Safety				
3.1	Reduce the proportion of patients in touch with services who die by suspected suicide when compared with data from previous years. This will be expressed as a rate per 1000 service users on the Trust's caseload.	**Not achieved**	**Not achieved**	**Achieved**
3.2	Detained service users who are absent without leave (AWOL) will not come to serious harm or death. We will report against 3 categories of AWOL as follows; harm as a consequence of: 1. Absconded from escort 2. Failure to return from leave 3. Left the hospital (escaped)	Not measured	**Achieved**	**Achieved**
3.3	To increase the use of supine restraint as an alternative to prone restraint	**Not achieved**	**Not achieved**	**On Target**
3.4	To ensure that 100% of service users within Berkeley House have a bespoke restrictive intervention care plan tailored to their individual need.	Not measured	Not measured	**Achieved**

Easy Read Report on Quality Measures for 2018/2019

Quality Report 	This report looks at the quality of [2]gether's services. We agreed with our Commissioners the areas that would be looked at.	
Physical health 	We increased physical health tests and treatment for people using our services. We met the target.	↑
Discharge Care Plans 	Less people had all parts of their discharge care plan completed at the end of the quarter than previously. We have not met the target. We are doing lots of work to get better at this.	↓
Care (CPA) Review 	All people moving from children's to adult services had a care review. We met the target.	↑
Care Plans 	80% of people said they felt involved in their care plan. This is less than the target (84%). We have not met the target. We are doing lots of work to get better at this.	↓
Crisis 	87% of people said they know who to contact if they have a crisis. This is more than the target (71%). We met the target.	↑
Activity 	88% of people said they had advice about taking part in activities. This is more than the target (64%). We met the target.	↑
Physical Health 	84% of people said they had advice about their physical health This is more than the target (73%). We met the target.	↑

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

Effectiveness

In 2018/19 we remained committed to ensure that our services are as effective as possible for the people that we support. For the second consecutive year we set ourselves 3 targets against the goals of:

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

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

The 2018/19 Physical Health CQUIN includes all service users with an active diagnosis of psychosis (using the CQUIN specified ICD-10 codes) who are either an inpatient or who have access to community services including; Assertive Outreach Team (AOT), Recovery Teams, Community Learning Disability Teams (CLDT's), Older Age Services (OP's) and Children and Young Persons Services (CYPS). The sample group for this year will include patients from both counties.

Within quarter one, an internal audit to ensure physical health assessment and interventions data are being recorded appropriately was carried out, covering all inpatient wards and community teams. We are pleased to report that the audit showed the following rates of compliance trust wide:

- **Inpatients 95%**
- **Community Mental Health Services 78%**

The results provide assurance that staff are embedding the process of cardio metabolic screening within their routine practice and service users are receiving these important health checks. Intervention pathways have been updated to ensure that service users are receiving the most up to date health advice and treatment options.

Successful physical health clinics are running at Pullman Place and 27a Owen Street, providing service users in the community access to physical health checks in an environment with staff who are familiar to them. The clinics run weekly and it is envisaged to be able to offer an ECG service at the clinics.

[2]gether presented the successful implementation of physical health checks in the community at a regional conference held by NHS England in July 2018. Since this event, [2]gether has been approached by several Trusts asking to visit to see in practice how physical health checks are carried out.

We have worked closely with the training department to ensure that both initial and refresher training of physical health for patients with a serious mental illness, and the screening and recording of results is built into statutory and mandatory training programmes. A Lester Tool e-learning programme has been developed to ensure all staff have access to training, and face to face training sessions continue to be held.

Alongside the CQUIN work, [2]gether continues to increase access to physical health treatment for service users. Following the successful secondment of a general trained nurse working within Wotton

Lawn Hospital in Gloucestershire, the post has now become a substantive position. This will ensure patients receive access to services normally only available from a practice nurse at a GP surgery. It is planned to employ another general trained nurse to offer a similar service within the Stonebow Unit in Hereford.

Physical health training for [2]gether staff continues to be offered and well attended. The recent procurement of anatomically correct models can facilitate refresher training in phlebotomy and catheterisation, keeping staff competencies up to date without the need to attend training outside of the organisation.

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

The inaugural meeting for the collaborative is to be held at the Royal College of nursing in London in September 2018.

We have met 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)	Year End Compliance (2017/18)	Compliance Quarter 1 (2018/19)
Overall Average Compliance	**69%**	**72%**	**73%**	**71%**
Chestnut Ward	84%	85%	**83%**	**84%**
Mulberry Ward	75%	79%	**73%**	**72%**
Willow Ward	59%	71%	**69%**	**69%**
Abbey Ward	72%	75%	**78%**	**74%**
Dean Ward	79%	73%	**73%**	**73%**
Greyfriars PICU	50%	62%	**64%**	**53%**
Kingsholm Ward	75%	72%	**72%**	**73%**
Priory Ward	80%	80%	**80%**	**73%**
Montpellier Unit	50%	57%	**64%**	**71%**
Honeybourne	N/A	70%	**65%**	**58%**
Laurel House	N/A	65%	**81%**	**83%**

* 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 average compliance in Gloucester for these standards during this year is **71%** which is a 2% reduction on the 73% achieved in 2017/18, 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 next year.

Herefordshire Services

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

Quarter 1 average compliance in Herefordshire for these standards during this year is **71%** which is the same as at year-end 2017/18. There will be an increased focus on ensuring that these standards are met throughout next year.

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

		Current compliance (Q1)	Direction of travel and previous compliance (Q4)
1.	Has a Risk Summary been completed?	100%	⇔ 100%
2.	Has the Clustering Assessment and Allocation been completed?	85%	⇩ 87%
3.	Has HEF been completed? (LD only)	100%	⇔ 100%
4.	Has the Pre-Discharge Planning Form been completed?	25%	⇩ 30%
5.	Have the inpatient care plans been closed within 7 days of discharge?	20%	⇩ 22%
6.	Has the patient been discharged from bed?	100%	⇔ 100%
7.	Has the Nursing Discharge Summary Letter to Client/GP been sent within 24 hours of discharge?	83%	⇩ 93%
8.	Has the 48 hour follow up been completed if the Community Team are not doing it?	74%	⇩ 94%

Of the eight individual criteria assessed, compliance has remained the same for three criteria, and decreased for the remaining 5 criteria.

Has HEF been completed (LD only).This was only applicable to three patients who were recorded as having a Learning Disability. This was fully compliant as a HEF had been completed for all three patients.

This target has not been met.

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

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

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

2017-18 Results

Gloucestershire Services.

Criterion	Compliance Quarter 1 (2017/18)	Compliance Quarter 2 (2017/18)	Compliance Quarter 3 (2017/18)	Compliance Quarter 4 (2017/18)
Joint CPA Review	100%	100%	100%	75%

Herefordshire Services

Criterion	Compliance Quarter 1 (2017/18)	Compliance Quarter 2 (2017/18)	Compliance Quarter 3 (2017/18)	Compliance Quarter 4 (2017/18)
Joint CPA Review	100%	100%	Not applicable	Not applicable

2018-19 Results

Gloucestershire Services

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

Herefordshire Services

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

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

To improve our practice and documentation in relation to this target, a number of measures were developed during 2017-18 as follows:

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

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

We met this target.

User Experience

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

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

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

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

Data for Quality Survey (Quarter 1 2018/19 – April to June 2018) results:

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

Question	County	Number of responses	Target Met?
Were you involved as much as you wanted to be in agreeing the care you receive?	Gloucestershire	41 (30 positive)	80% TARGET 84%
	Herefordshire	25 (23 positive)	
	Total	66 (53 positive)	

This target has not been met.

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

Question	County	Number of responses	Target Met?
Have you been given information about who to contact outside of office hours if you have a crisis?	Gloucestershire	36 (29 positive)	87% TARGET 71%
	Herefordshire	24 (23 positive)	
	Total	60 (52 positive)	

This target has been met.

Target 2.3 Have you had help and advice about taking part in activities that are important to you? > 64%

Question	County	Number of responses	Target Met?
Have you had help and advice about taking part in activities that are important to you?	Gloucestershire	33 (27 positive)	**88%** **TARGET 64%**
	Herefordshire	23 (22 positive)	
	Total	56 (49 positive)	

This target has been met.

Target 2.4 Have you had help and advice to find support for physical health needs if you have needed it? > 73%

Question	County	Number of responses	Target Met?
Have you had help and advice to find support for physical health needs if you have needed it?	Gloucestershire	38 (29 positive)	**84%** **TARGET 73%**
	Herefordshire	23 (22 positive)	
	Total	61 (51 positive)	

This target has been met.

Quality survey targets were reviewed and refreshed in line with the launch of the **How did we do?** Survey. Three out of the four targets set have been exceeded. This is good news and suggests that, of those people who responded to the survey, most are feeling supported to meet their needs and explore other activities. The one target that hasn't been fully achieved this quarter continues to receive a high percentage of positive responses. Going forward for 2018/19, targets were reviewed in line with the national Community Mental Health Survey undertaken by the CQC. Targets have been set using the CQC response data rather than this year's results of the Quality Survey questions

Friends and Family Test (FFT)

FFT responses and scores for Quarter 1, 2018/19

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

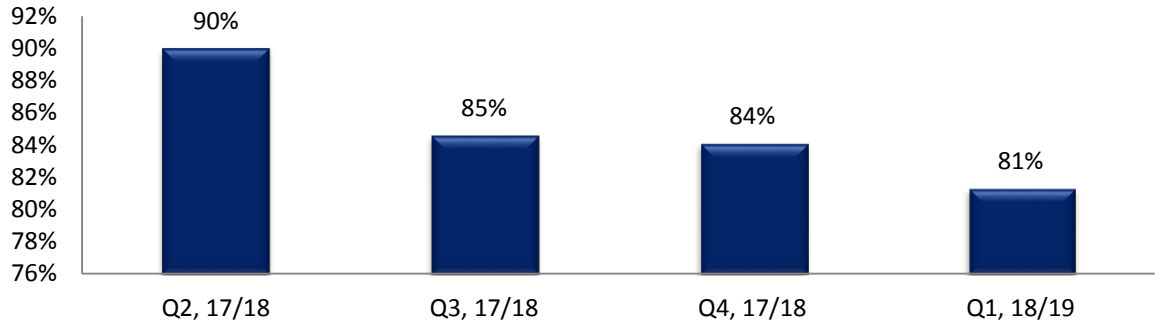
Our Trust played a key role in the development of an Easy Read version of the FFT. Roll out of this version ensures that everybody is supported to provide feedback.

The table below details the number of combined total responses received by the Trust each month in Quarter 1. The FFT score is the percentage of people who stated that they would be 'extremely likely' or 'likely' to recommend our services. These figures are submitted for national reporting.

	Number of responses	FFT Score (%)
April 2018	302 (244 positive)	81%
May 2018	281 (222 positive)	79%
June 2018	375 (313 positive)	83%
Total	**958** (779 positive) **(last quarter = 950)**	**81%** **(last quarter = 84%)**

The Quarter 1 response rates are similar to the previous quarter. The **How did we do?** Survey was initially launched as a paper based survey. From 1 November 2017 the survey was distributed via text message to those people discharged from our community and inpatient services. The text messages ask the FFT questions and provide a link for people to complete additional Trust Quality Survey questions. This method has continued to be embedded during Quarter 1 2018/19 with good response.

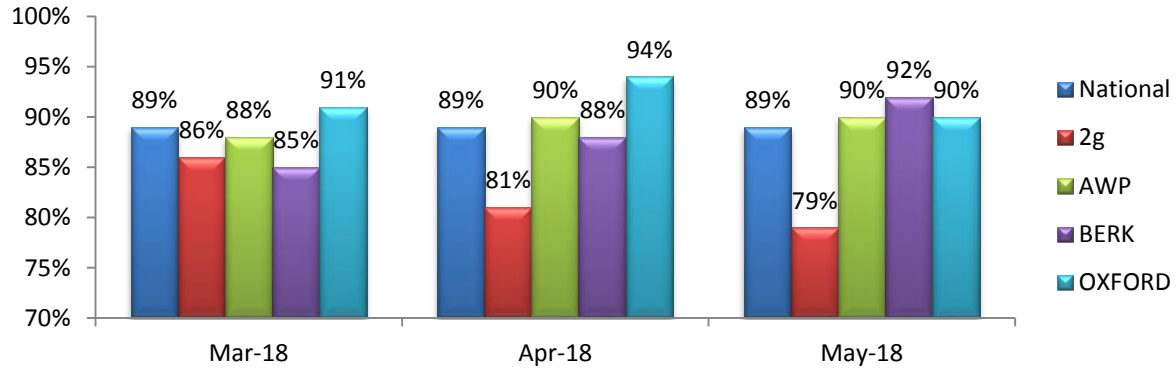
FFT Scores for 2gether NHS Foundation Trust for the past year. The following graph shows the FFT Scores for the past rolling year, including this quarter. The Trust receives consistently positive feedback.



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

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

The chart below shows the FFT scores for March, April and May 2018 (the most recent data available) compared to other Mental Health Trusts in our region and the national average. Our Trust consistently receives a high percentage of recommendation in line with other Mental Health Trusts in the region (June 2018 data is not yet available).



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

Complaints

To be completed at year-end

Safety

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

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

There are 3 associated targets.

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

We aim to minimise the risk of suicide amongst those with mental disorders through systematic implementation of sound risk management principles. In 2013/14, during which year we reported **22** suspected suicides, we set ourselves a specific quality target for there to be fewer deaths by suicide of patients in contact with teams and we have continued with this important target each year. Sadly the number increased and during 2016/17 we reported **26** suspected suicides and last year the number of reported suspected suicides was **28.** During Quarter 1 2018/19 we reported 8 suspected suicides which is lowest number reported during quarter 1 since 2015/16. This is seen in Figure 4.

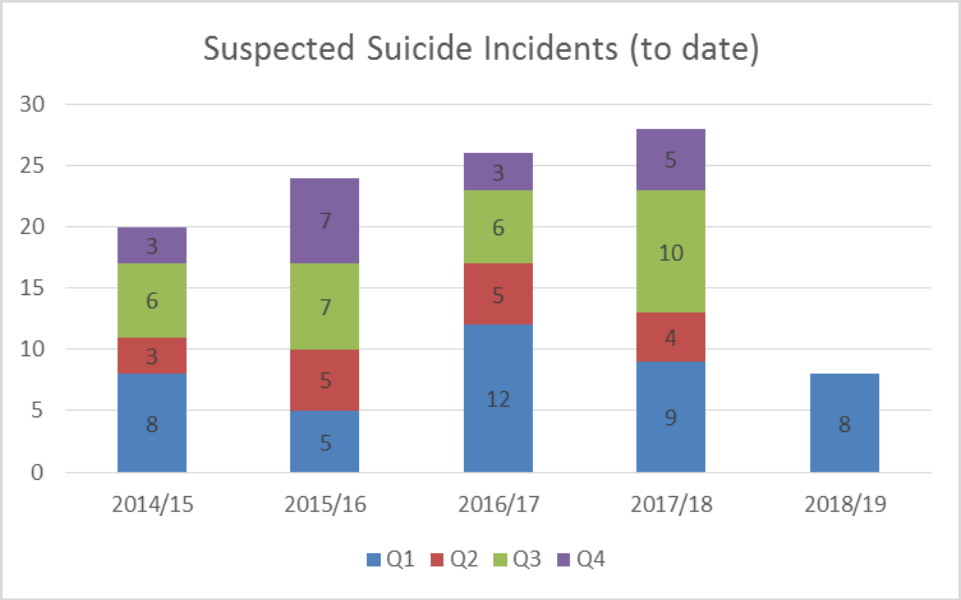


Figure 4

What we also know is that we are seeing more and more service users on our caseload year on year, so we measured this important target differently this year. This is also reported as a rate per 1000 service users on the Trust caseload. The graph in Figure 5 shows this rate from 2014/15 onwards for all Trust services covering Herefordshire and Gloucestershire, and we are aiming to see the median value (green line) get smaller. During 2015/16, 2016/17 and 2017/18 the median value was 0.09. At the end of Quarter 1 2018/19 the median value remained at 0.09.

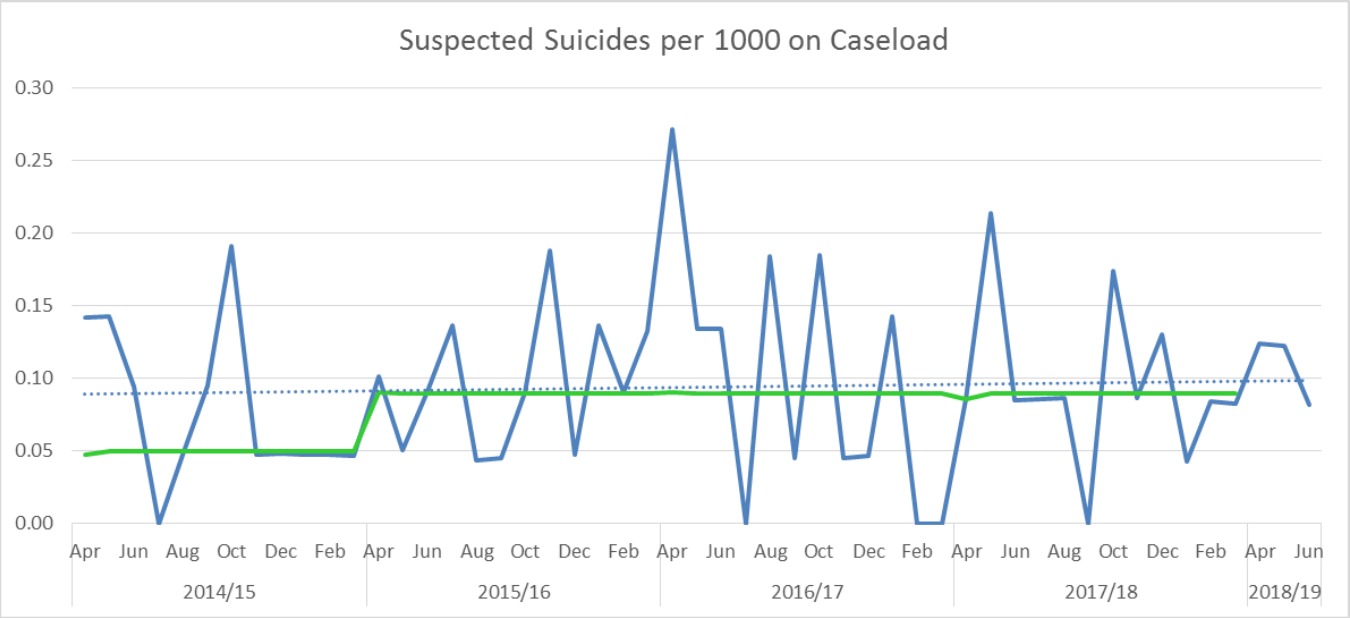


Figure 5

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

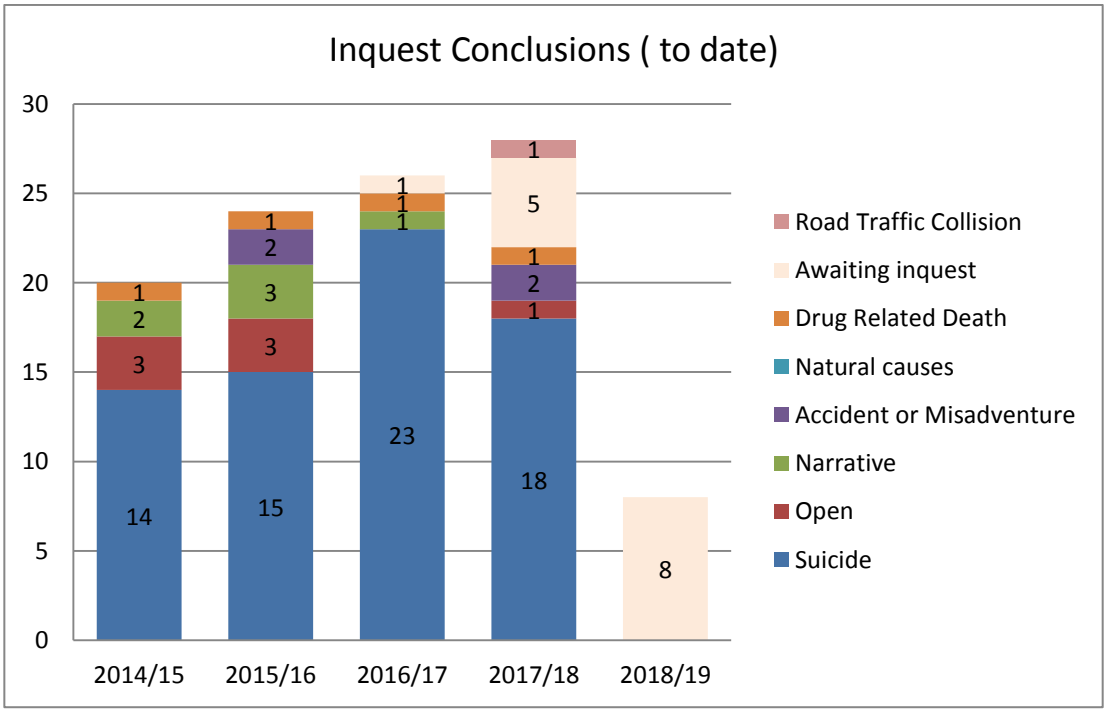


Figure 6

Information is provided below in Figures 7 & 8 for both Gloucestershire and Herefordshire services separately. It is seen that greater numbers of suspected suicides are reported in Gloucestershire services. There is no clear indication of why the difference between the two counties is so marked, but it is noted that the population of people in contact with mental health services in Gloucestershire is greater, and the overall population of Gloucestershire is a little over three times that of Herefordshire (based on mid -2015 population estimates).

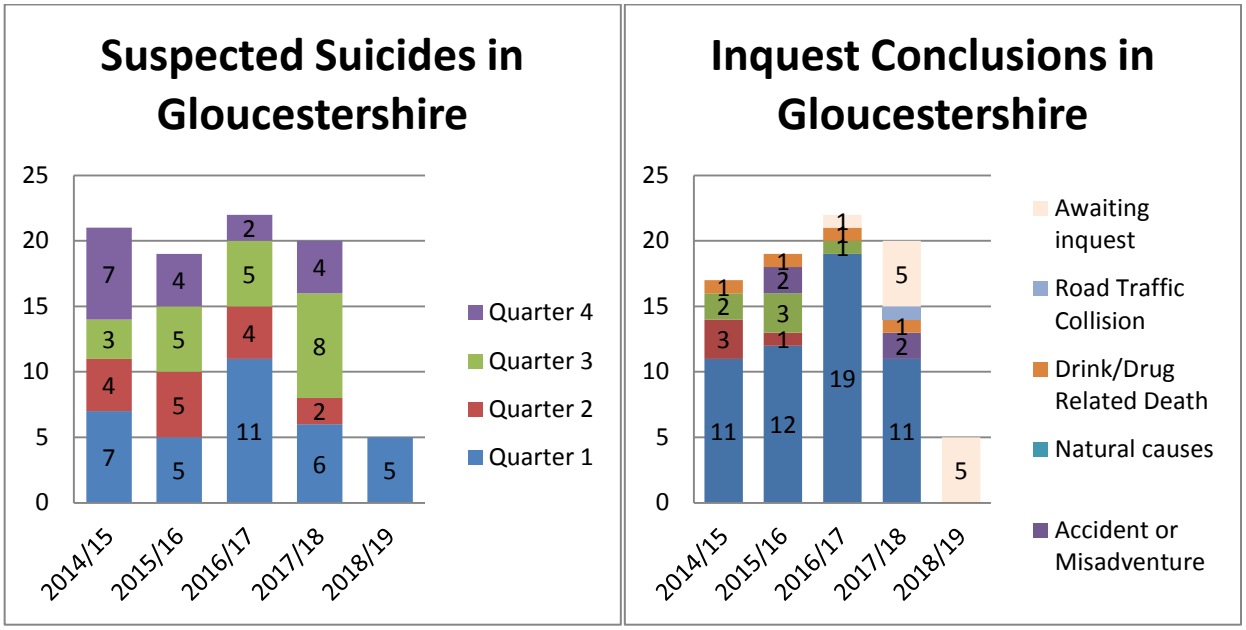


Figure 7

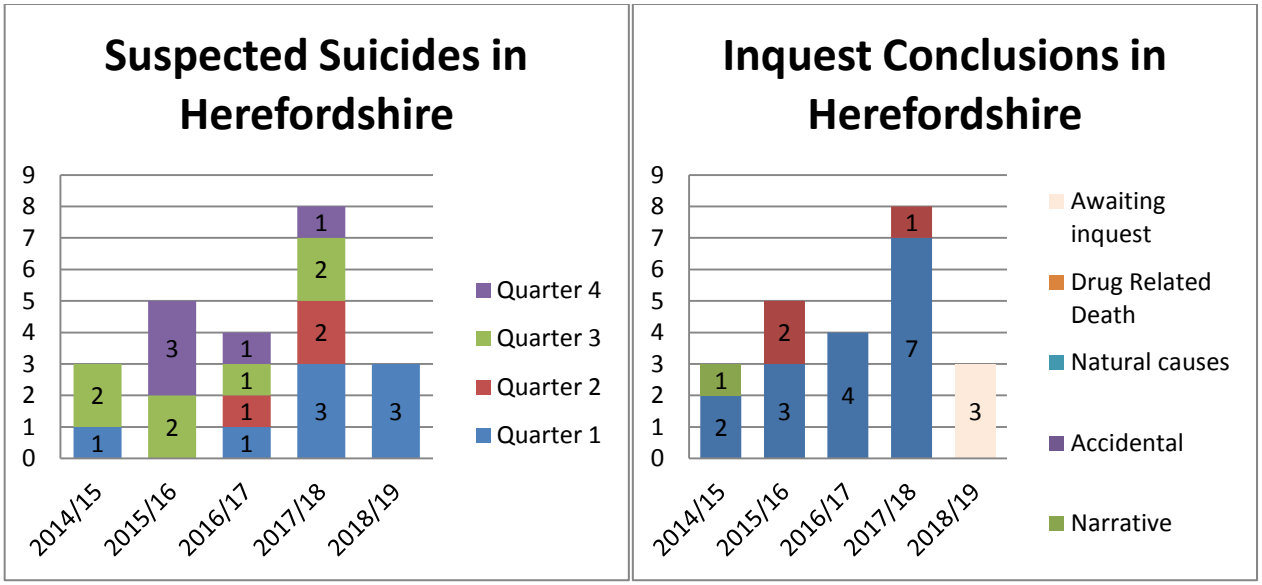


Figure 8

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

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

2gether Making life better

We are meeting this target.

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

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

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

What we want to ensure is that no detained service users who are AWOL come to serious harm or death, so this year we are measuring the level of harm that people come to when absent.

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

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

None of these incidents led to serious harm or death.

In **2016/17** we reported **211** occurrences of AWOL (162 in Gloucestershire and 49 in Herefordshire detailed in the table below) so there was a considerable increase in the numbers of people who were AWOL. There are a number of factors which influence this, including open wards, increased numbers of detained patients in our inpatient units, increased acuity, and on occasion, service users who leave the hospital without permission multiple times. **170** occurrences were reported during **2017/18.**

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

None of these incidents led to serious harm or death.

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

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

None of these incidents led to serious harm or death.

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

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

None of these incidents led to serious harm or death.

We are meeting this target

Target 3.3 To increase the use of supine restraint as an alternative to prone restraint (on all adult wards & PICU)

During 2015/16, the Trust developed an action plan to reduce the use of restrictive interventions, in line with the 2 year strategy – Positive & Safe: developed from the guidance Positive and Proactive Care: reducing the need for restrictive interventions. This strategy offered clarity on what models and practice need to be undertaken to support sustainable reduction in harm and restrictive approaches, with guidance and leadership by the Trust Board and a nominated lead. Overall, we wished to reduce the use of prone restraint by 5% year on year.

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

- Support the reduction of all forms of restrictive practice;
- Promote an organisational culture that is committed to developing therapeutic environments where physical interventions are a last resort;
- Ensure organisational compliance with the revised Mental Health Act 1983 Code of Practice (2015) and NICE Guidance for Violence and Aggression;
- Oversee and assure a robust training programme and assurance system for both Prevention & Management of Violence & Aggression (PMVA) and Positive 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 which was an overall increase and by the end of 2017/18, **229** instances of prone restraint were used so we did not see a 5% reduction by year end.

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

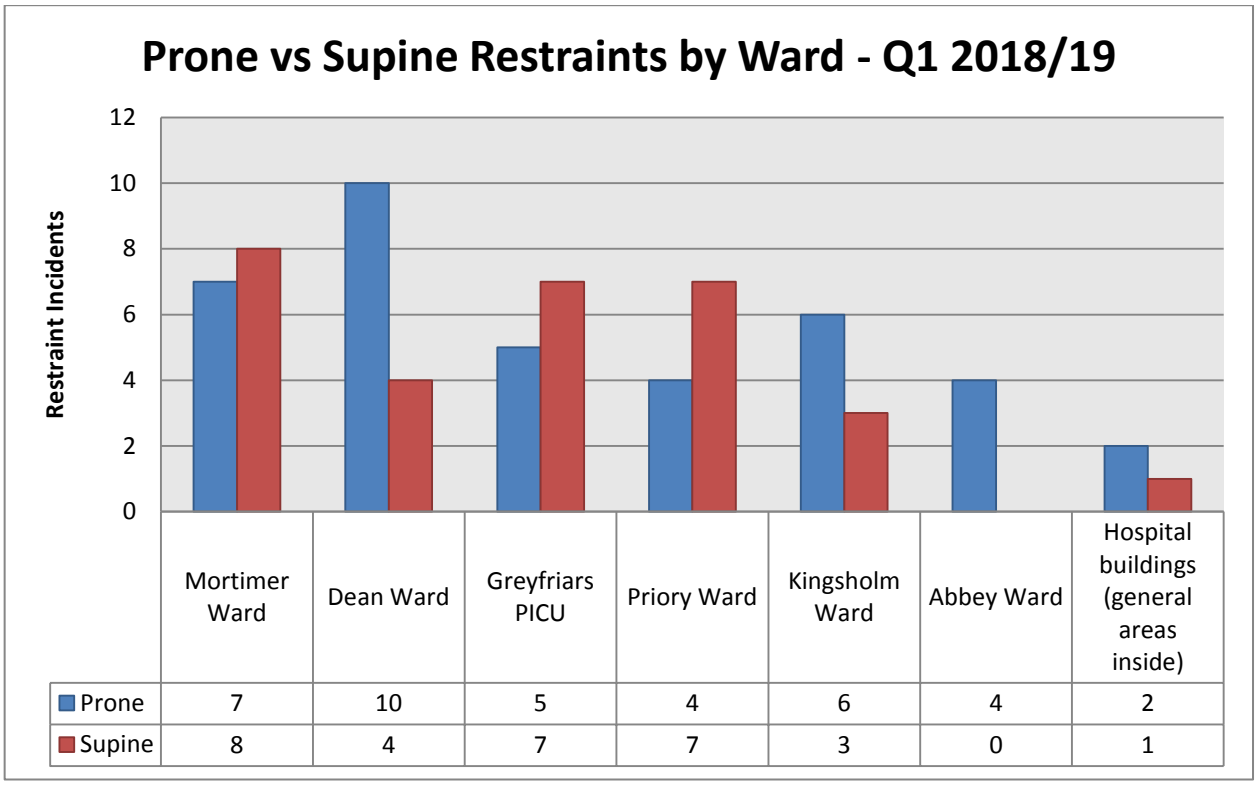


Figure 9

Figure 9 shows that during Quarter 1 **38** instances of prone restraint were used compared to **30** instances of prone. Figure 10 below compares 2017/18 and 2018/19 (Quarter 1) prone restraint data and from this analysis it is clear that the use of prone restraint has reduced by greater than 5% this year.

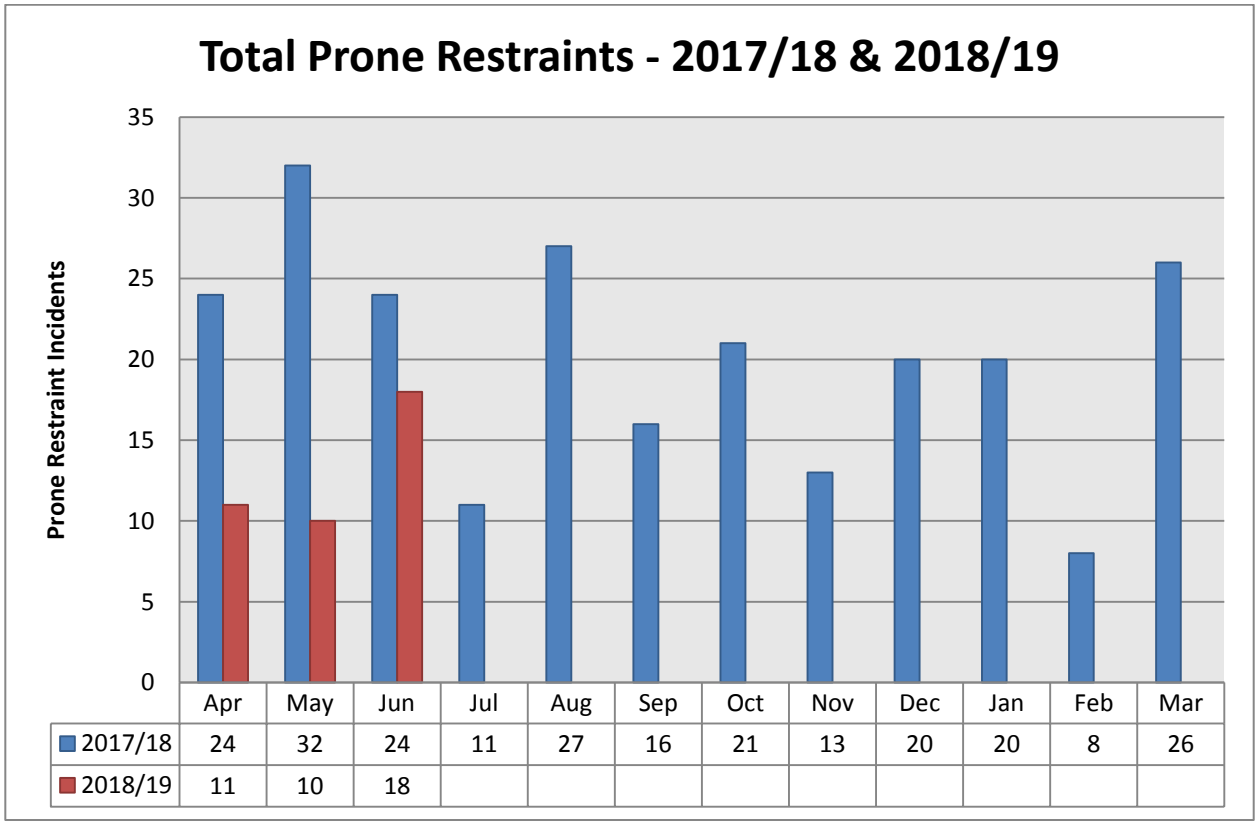


Figure 10

We are on trajectory to meet this target.

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

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

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

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

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

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

Alongside these patients have activity care plans providing information on preferred activities, likes and dislikes and implementation of activities for each individual.

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

There are staff debriefs after any incidents of intervention, during which they are able to reassess and evaluate interactions and change care plans accordingly to better meet patient needs.

We have met this target.

Serious Incidents reported during 2018/19

By the end of Quarter 1 2018/19, **11** serious incidents were reported by the Trust; the types of these incidents reported are seen below in Figure 12.

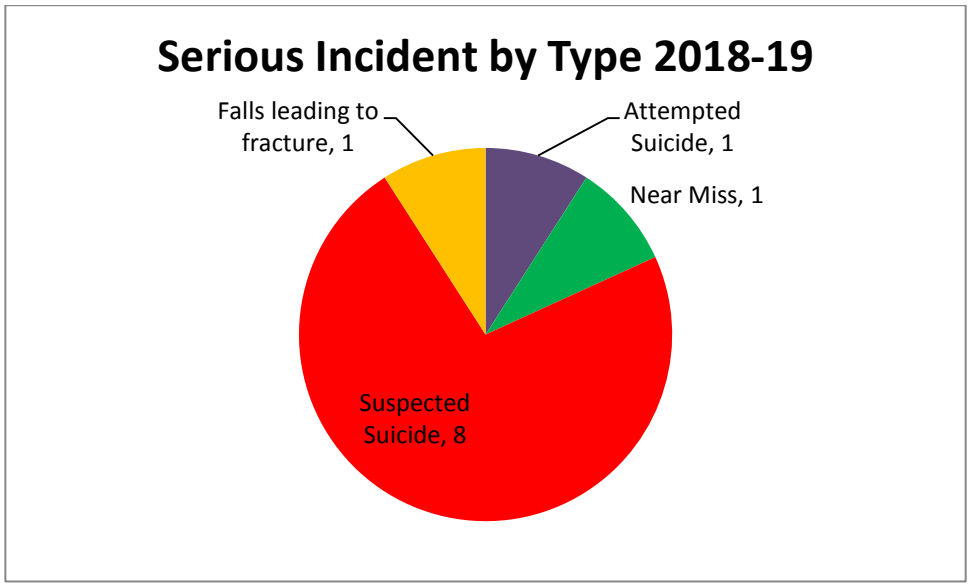


Figure 11

Figure 13 shows a 4 year comparison of reported serious incidents. The most frequently reported serious incidents are "suspected suicide" and attempted suicide which is why we continue to focus on suicide prevention activities in partnership with stakeholders. All serious incidents were investigated by senior members of staff, all of whom have been trained in root cause analysis techniques. To further improve consistency of our serious incident investigations we appointed a whole time equivalent Lead Investigator commenced this important work in May 2017, and 2 further dedicated Investigating Officers are now available via the Trust's Staff Bank.

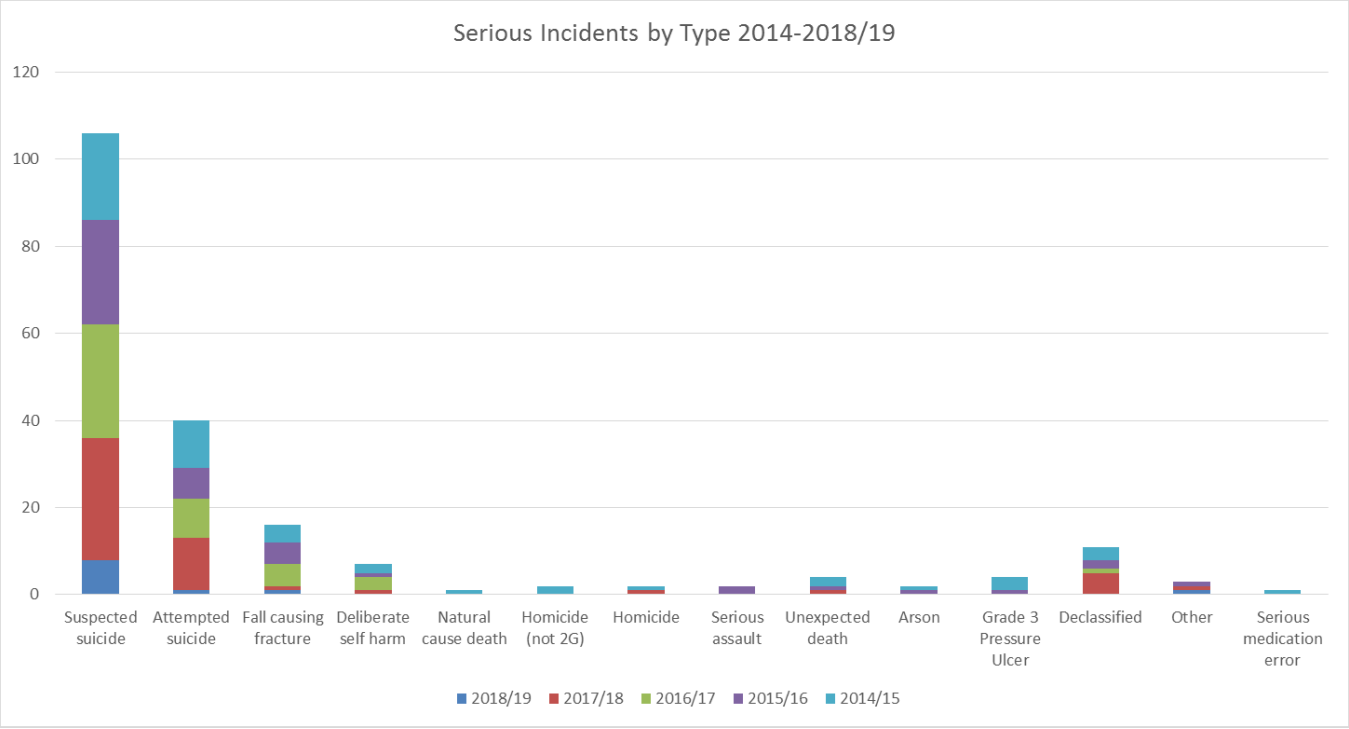


Figure 12

Wherever possible, we include service users and their families/carers to ensure that their views are central to the investigation, we then provide feedback to them on conclusion and copies of our

investigation reports. During 2016/17 we engaged the Hundred Families organisation to deliver 'Making Families Count' training to 51 staff to improve our involvement of families and a further 20 staff attended an additional Hundred Families workshop regarding 'Involving Families in Serious Incidents' in November 2017. During 2018/19 we will also be developing processes to provide improved support to people bereaved by suicide and in May 2018 18 staff were trained in Postvention techniques by the charity Suicide Bereavement UK.

The Trust also shares copies of our investigation reports regarding "suspected suicides" with the Coroners in both Herefordshire and Gloucestershire to assist with the Coronial investigations.

There have been no Department of Health defined "Never Events" within the Trust during 2018/19. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Duty of Candour

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

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

To support staff in understanding the Duty of Candour, we have historically provided training sessions through our Quality Forums and given all staff leaflets regarding this. There is also a poster regarding this on every staff notice board. During the CQC comprehensive inspection of our services in 2015, they reviewed how the Duty of Candour was being implemented across the Trust and provided the following comments in their report dated 27 January 2016.

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

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

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

We are aware that further work is required to ensure that all incidents of moderate harm are appropriately reported and that the service user experiencing this harm is fully informed and supported. This will be a key area of further development and consolidation throughout 2018/19.

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

[2]gether NHS Foundation Trust signed up to this campaign from the outset and was one of the first 12 organisations to do so. Within the Trust the campaign is being used as an umbrella under which to sit all patient safety initiatives such as the NHS South of England Patient Safety and Quality Improvement

Mental Health Collaborative, the NHS Safety Thermometer, Safewards interventions and the Reducing Physical Interventions project. Participation in SUP2S webinars has occurred, and webinar recordings are shared with colleagues. A Safety Improvement Plan has been developed, submitted and approved. Monitoring of progress as a whole is completed every 6 months via the Trust Governance Committee, but each work stream has its own regular forum and reporting mechanisms.

NHSI Indicators 2018/2019

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

		2016-2017 Actual	National Threshold	2017-2018 Actual	2018-2019 Actual
1	Early Intervention in psychosis EIP: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	**71.3%**	50%	**70%**	**75%**
2	Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered routinely in the following service areas: -inpatient wards -early intervention in psychosis services -community mental health services (people on CPA)	 - - -		 **95%** **92%** **90%**	**YE**
3	Improving access to psychological therapies (IAPT): Proportion or people completing treatment who move to recovery (from IAPT database) Waiting time to begin treatment (from IAPT minimum dataset - treated within 6 weeks of referral - treated within 18 weeks of referral	**-** **37.8%**	50% 75% 95%	**50%** **67%** **85%**	**53%** **90%** **94%**
4	Admissions to adult facilities of patients under 16 years old.	**-**		**1**	**0**
5	Inappropriate out-of area placements for adult mental health services	**-**		**24**	**12**

Community Survey 2018

To be completed at year-end

Staff Survey 2018

To be completed at year-end

PLACE Assessment 2017

To be completed at year-end

Annex 1: Statements from our partners on the Quality Report

To be completed at year-end

The Royal College of Psychiatrists

To be completed at year-end

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

To be completed at year-end

Annex 3: Glossary

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

Monitor	Monitor is the independent regulator of NHS foundation trusts. They are independent of central government and directly accountable to Parliament.
MRSA	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. It is also called multidrug-resistant
MUST	The Malnutrition Universal Screening Tool is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.
NHS	The National Health Service refers to one or more of the four publicly funded healthcare systems within the United Kingdom. The systems are primarily funded through general taxation rather than requiring private insurance payments. The services provide a comprehensive range of health services, the vast majority of which are free at the point of use for residents of the United Kingdom.
NICE	The National Institute for Health and Care Excellence (previously National Institute for Health and Clinical Excellence) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.
NIHR	The National Institute for Health Research supports a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.
NPSA	The National Patient Safety Agency is a body that leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector.
PBM	Positive Behaviour Management
PHSO	Parliamentary Health Service Ombudsman
PICU	Psychiatric Intensive Care Unit
PLACE	Patient-Led Assessments of the Care Environment
PROM	Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective.
PMVA	Prevention and Management of Violence and Aggression
RiO	This is the name of the electronic system for recording service user care notes and related information within ^{2}gether NHS Foundation Trust.
ROMs	Routine Outcome Monitoring (ROMs)

SIRI	Serious Incident Requiring Investigation, previously known as a “Serious Untoward Incident”. A serious incident is essentially an incident that occurred resulting in serious harm, avoidable death, abuse or serious damage to the reputation of the trust or NHS. In the context of the Quality Report, we use the standard definition of a Serious Incident given by the NPSA
SMI	Serious mental illness
VTE	Venous thromboembolism is a potentially fatal condition caused when a blood clot (thrombus) forms in a vein. In certain circumstances it is known as Deep Vein Thrombosis.

Annex 4: How to Contact Us

About this report

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

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

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

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

Other Comments, Concerns, Complaints and Compliments

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

You can give us feedback about our services by:

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

Alternative Formats

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

Agenda Item: 8 **Enclosure: Paper D**

Report to: [2]gether NHS Foundation Trust Board – 26 September 2018
Author: Angie Fletcher, Service Experience Clinical Manager
Presented by: Jane Melton, Director of Engagement and Integration

Subject: **Service Experience Report Quarter 1 2018/19**

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

EXECUTIVE SUMMARY

(1) Introduction

This Service Experience Report provides a high level overview of feedback received from service users and carers in Quarter 1 2018/19. The key purpose of this paper is to offer assurance that the trust listens to people's experiences and learns from valuable feedback and takes action as a result.

(2) Summary of learning from feedback

Our Trust continues to seek feedback about service experience from multiple sources on a continuous basis. During Quarter 1 positive feedback continues to dominate the total feedback received about our Trust.
Feedback obtained from compliments, surveys and general comments about our services and Trust colleagues demonstrate that generally service users and carers value the services that we provide.
Feedback gained from the investigation of complaints about aspects of our Trust suggests that we should continue to focus our efforts on improving communication with service users, their families and carers, taking time to ensure that information is given clearly, timely and in a way that is easily understood.

(3) Assurance

Assurance is provided to the Governance Committee 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 generally value the service being offered and would recommend it to others.
During Quarter 1, 81% of people who completed the Friends and Family Test said that they would recommend ^{2}gether's services. This score is a slight dip from the previous quarter but relatively consistent with the previously scores from 2017/18.

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 2017/18. Whilst feedback given by respondents has generally been positive, response rates remain lower than hoped for. Changes to the systems used to capture and analyse survey feedback are underway to be implemented in Quarter 3 2018/19 with the aim to increase the number of response we receive.

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

Full Assurance that complaints have been acknowledged in required timescale
During Quarter 1 100% of complaints received were acknowledged within 3 days.

Significant assurance that all people who complain have their complaint dealt with by the initially agreed timescale.
90% of complaints received a response to their complaint within the agreed timescales. This is a notable increase from the previous Quarter (75%). The SED have worked hard with Trust colleagues to achieve this. The good progress made during Quarter 1 will be continue to be developed to ensure that future complaint responses are received by complainants in a timely way.

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

An update on complaints referred for external review following investigation by our Trust is included within this report that allows feedback from independent review of complaints investigated by our Trust

(2) Areas of improvement/further development

There continues to be a sustained focus on sharing and embedding learning from service experience feedback. The Service Experience Department and locality governance leads have developed new systems during Quarter 1 to share learning and recommendations from complaints using practice notes that are cascaded from Locality Management Boards to Trust colleagues.

Work continues on our intranet site to detail learning from service experience feedback ensuring that it is freely available to all Trust colleagues.
Our Non-Executive Director audits of complaints continue on a quarterly basis giving

us feedback and assurance about the way we investigate and respond to the complaints we receive.

In response to the one area of limited assurance identified, a robust review has been undertaken of the way we receive and process survey feedback. Work has been undertaken with our Gloucestershire Care Services NHS Trust colleagues to learn from alternative methods and increase response rates. New arrangements to gather and analyse survey feedback will be implemented during Quarter 3 2018/19.

RECOMMENDATIONS

The Board is asked to:

- Note the contents of this report and scrutinise the information provided

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 2018/19 and makes key recommendations for actions to enhance quality.
Resource Implications	The Service Experience Report offers assurance to the Trust that resources are being used to support best service experience.
Equalities Implications	The Service Experience Report offers assurance that the Trust is attending to its responsibilities regarding equalities for service users and carers.
Risk Implications	Feedback on service experience offers an insight into how services are received. The information provides a mechanism for identifying performance, reputational and clinical risks. This paper offers limited assurance on 1 aspect covered by the report and so the SED are working with operational and clinical colleagues to implement alternative arrangements to commence in Quarter 3. The SED closely monitor performance indicators relating to areas of limited assurance and regularly review the mitigating actions accordingly.

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

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

Reviewed by:		
Jane Melton, Director of Engagement and Integration	Date	August 2018

Where in the Trust has this been discussed before?		
Governance Committee		August 2018

What consultation has there been?		

Explanation of acronyms used:	
NHS	National Health Service
2g	2gether NHS Foundation Trust
PALS	Patient Advice and Liaison Service
CYPS	Children and Young People Service
SED	Service Experience Department
HR	Human Resources
CEO	Chief Executive Officer
BME	Black and Minority Ethnic Groups
IAPT	Improving access to psychological therapies
PHSO	Parliamentary and Health Service Ombudsman
LGO	Local Government Ombudsman
CQC	Care Quality Commission
CHI ESQ	Children's Experience of Service Questionnaire
CAMHS	Child and Adolescent Mental Health Service
MHA	Mental Health Act
MCA	Mental Capacity Act
CCG	Clinical Commissioning Group
Q4	Quarter 4 (previous quarter 2017/18)
FFT	Friends and Family Test (survey)
GCS	Gloucestershire Care Service NHS Trust

2gether
Making life better

2gether
NHS Foundation Trust

Service Experience Report

Quarter 1

1st April 2018 to 30th June 2018

"Thank you to everyone involved in my care, which was amazing, amazing, amazing. It has made a positive impact on my mental health and I'm very grateful."

CHTT, Herefordshire

"Many thanks for the care you have given to me and my partner over the past few months."

CRHTT, Gloucestershire

Contents

Key

NHS	National Health Service
PALS	Patient Advice and Liaison Service
CYPS	Children and Young People Service
SED	Service Experience Department
HR	Human Resources
CEO	Chief Executive Officer
BME	Black and Minority Ethnic Groups
IAPT	Improving Access to Psychological Therapies
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CQC	Care Quality Commission
CHI ESQ	Children's Experience of Service Questionnaire
CAMHS	Child and Adolescent Mental Health Service
Mental Health Act	Mental Health Act
MCA	Mental Capacity Act
CCG	Clinical Commissioning Group
Q4	Quarter 4 (previous quarter 2017/18)
FFT	Friends and Family Test (survey)

Service Experience Report

1st April 2018 to 30th June 2018

Complaints 	**17** complaints were made this quarter. This is more than last time (Q4 = 15). We want people to tell us about any worries about their care. This way we can help to make things better.	↑
Concerns 	**61** concerns were raised through PALS. This is the more than last time (Q4=48).	↑
Compliments 	**396** people told us they were pleased with our service. This is less than last time (Q4=712). We want teams to tell us about every compliment they get.	↓
FFT 	**81%** of people said they would recommend our service to their family or friends. This is almost the same as last time (Q4=84%).	↔
Quality Survey 	Gloucestershire: **41** people told us what they thought. This is a lot less than last time (Q4=85) Herefordshire: **25** people told us what they thought. This is more than last time (Q4=21) We want more people to tell us what they think.	↓ (number of replies)
We must listen 	We must explain the services that we can provide and how this will be done. We must record information accurately.	

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 2018 and 30th June 2018**. It provides examples of the learning that has been achieved through service experience reporting, and an update on activity to enhance service experience.

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

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

- A synthesis of service experience reported to ²gether NHS Trust
- Patient Advice and Liaison Service (PALS)
- Meetings with stakeholders
- ²gether quality surveys
- National Friends and Family Test (FFT) responses

1.1.4 **Section 3** provides examples of the learning that has been identified through analysis of reported service experience and the subsequent action planning.

1.2 Strategic Context

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

1.2.2 ²gether 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 ²gether's Service Experience Strategy (2013) (see below). The Service Experience Strategy will be reviewed and updated during 2018/19 in collaboration with our stakeholders.

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

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

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

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

Section 2 – Emerging Themes about Service Experience

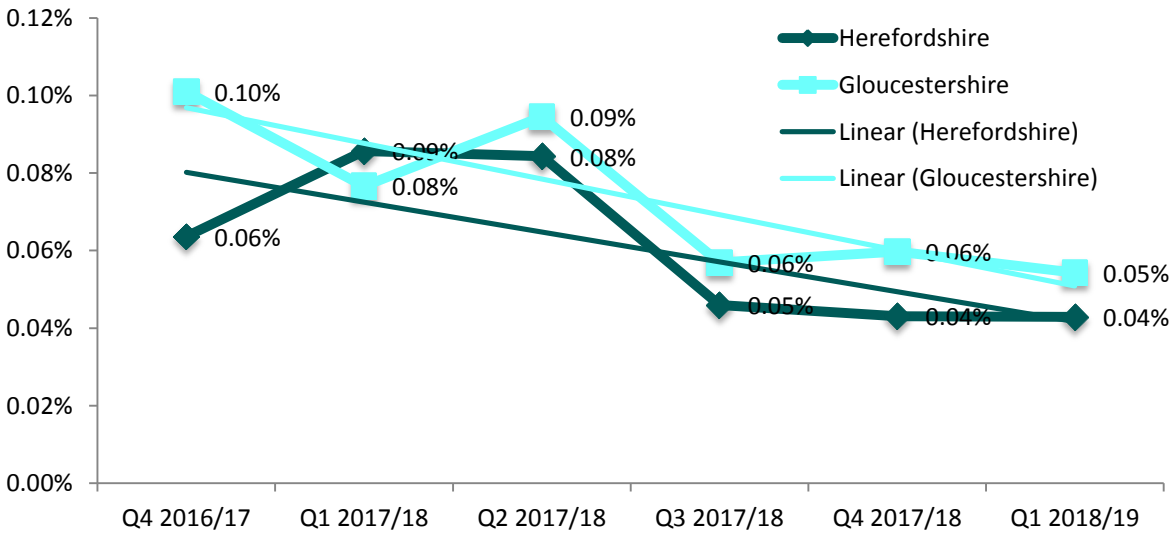
2.1 Complaints

2.1.1 Formal complaints to NHS service providers are highly governed and responses must follow specific procedures (for more information, please see the Trust's Policy and Procedure on Handling and Resolving Complaints and Concerns). We value feedback from those in contact with our services as this enables us to make services even more responsive and supportive. We encourage people to let us know if they are concerned so that we can resolve issues at the earliest possible opportunity.

Table 1: Number of complaints received this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	15	↑	The number of complaints reported in Gloucestershire has slightly increased from the previous quarter (Q4 n=13)	Significant
Herefordshire	2	↔	The number of complaints reported in Herefordshire is consistent with the previous quarter (Q4 n=2).	Significant
Total	17	↑	The total number of complaints received has slightly increased from the previous quarter (Q4 n=15)	Significant

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



2.1.2 Figure 1 shows the percentage of complaints received in relation to the number of individual contacts made with our services during each quarterly period since Q4 2016. Whilst there have been minor fluctuations quarter by quarter, a continual low level of complaints to contacts has been observed with a gradual downwards trend over time.

2.1.3 Table 2 summarises our responsiveness. This quarter has seen an improvement in the percentage of complaints closed within the initially agreed timescale.

Table 2: Responsiveness

Target	% Number	Direction compared with Q3	Interpretation	Assurance
Acknowledged with three days	100%	⟷	**All** complaints were acknowledged within target timeframes (Q4=100%)	**Full**
Response received within agreed timescales	90%	↑	This is higher than last quarter (Q4=75%). One letter of response was not received by the complainant by the date agreed.	**Significant**
Concerns escalated to complaint	3%	↓	Of 60 concerns closed (Q4=46 closed), 2 were escalated to a formal complaint; this is less than last quarter (Q4=9%)	**Significant**

2.1.4 One complaint response was not received within agreed timescales; it was overdue by one day. The complainant was contacted in order to provide an explanation, an apology, and an expected date that our response would be sent to them.

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

Table 3: Satisfaction with complaint process

Measure	Number (numerical direction)		Interpretation	Assurance
Reopened complaints	6	↑	This figure is more than the previous quarter (Q4 n=3)	**Significant**
Local Resolution Meetings	1	⟷	This figure is the same as the previous quarter (Q4 n=1)	**Significant**
Referrals to external review bodies	2	↑	Two complaints were referred for external review (Q4 n=1). See Table 13 for more detail.	**Significant**

2.1.6 In Quarter 1 a total of six complaints were reopened. Four of those were complaints that closed during Quarter 1 2018/19 (total closed Q1=12), the remaining two were closed in previous quarters. One local resolution meeting occurred and the complaint was closed following this. Two additional complaints were referred to the PHSO for review; we are awaiting confirmation as to whether these will be investigated.

2.1.7 Analysis of data is undertaken by the Service Experience Department in order to identify any patterns or themes. Analysis of complaint themes from complaints closed during Quarter 1 is shown by the status of complaint outcome (Table 4) and by staff group involved in individual issues of complaint (Table 5).

Table 4: Outcome of complaints closed this quarter

Outcome	No.	%	
Not upheld *No element of the complaint was upheld*	4	33%	Following feedback from complainants and Experts by Experience, the Trust no longer uses the terms upheld/partially upheld/not upheld within response letters. However, these categories are required to be recorded for national reporting purposes. In total, 12 complaints were closed this quarter. This is the same as Quarter 4 (n=12). 58% of the complaints closed this quarter had at least some or all issues of complaint upheld. This differs from Quarter 4 (83% upheld/ partially upheld).
Partially upheld *Some elements of the whole complaint were upheld*	5	42%	
Upheld *All elements of the whole complaint were upheld*	2	17%	
Withdrawn *Complaint was withdrawn*	1	8%	

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

Table 5: Breakdown of closed complaint issues by staff group for Quarter 1

Outcome	Total No.*	Upheld	Not upheld	Withdrawn
Medical	6	3	3	0
Nursing	26	11	13	2
Psychology	6	2	4	0
HCA	1	0	1	0
Admin	4	3	1	0
No staff group	2	2	0	0

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

Quarter 1 figures show nursing as the main staff group identified within complaints. Nursing represents the largest staff group in the Trust and has the greatest number of individual contacts with service users and carers.

Work is ongoing to ensure that professional leads are aware of any themes relating to professional groups.

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

2.1.8 Table 6 provides an overview of the issues of complaint in the context of the investigation outcome (upheld or not upheld). Analysis of this information shows that the main themes emerging from the Q1 issues of complaint that were upheld following investigation, related to aspects of the reported experience of **communication** and **care and treatment**.

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

Table 6: Overarching closed complaint themes

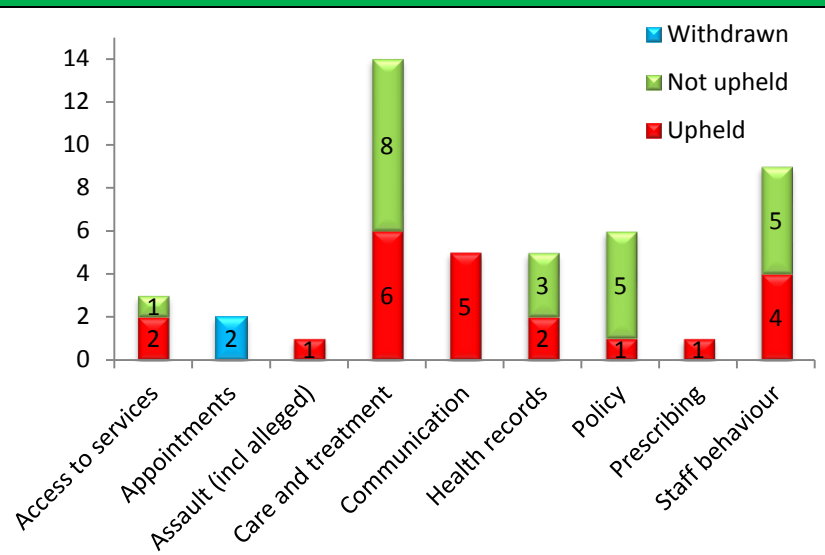
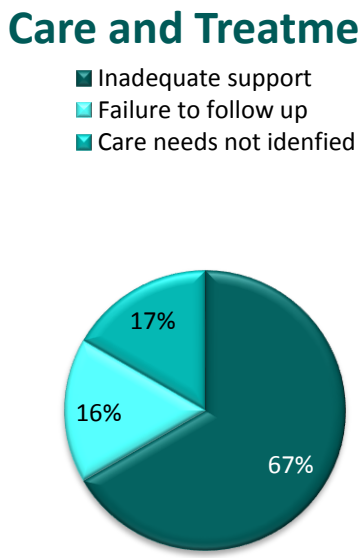
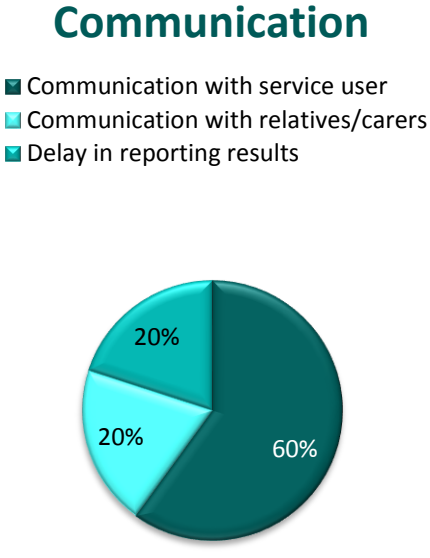
Theme	Chart showing number of issues raised and their outcome
Access to services *Access to treatment/drugs*	
Appointments *Waiting times*	
Assault (incl alleged) *Between service users*	
Care and treatment *e.g. observation, support*	
Communication *Internal and external*	
Health records *Accuracy of records*	
Policies *e.g. not followed*	
Prescribing *All aspects of prescribing*	
Staff behaviour *Values and attitude*	

Figure 2: Review of identified complaint themes

Breakdown of upheld complaint issues

Our Trust takes all concerns very seriously. The themes reflected below demonstrate the outcomes of complaint issues that have been investigated and upheld. The main upheld complaint themes relate to, ***care and treatment*** and ***communication*** the issues are analysed further below:





2.1.10 Further analysis of issues of complaint relating to *Care and Treatment* shows that the majority of issues raised in this area related to inadequate support being provided by our services. A review of learning from our complaint investigations found that this tied in closely with the theme of *Communication* with service users and relatives that has also emerged from analysis of upheld complaint investigations. People felt unsupported as the role and remit

of our services had not been fully explained and people had a different expectation of the service they would receive when compared with the service that they actually received.

The SED have been working hard with operational colleagues throughout Quarter 1 to implement new systems of learning from Service Experience feedback. Practice notes detailing learning from complaints are now produced monthly and disseminated throughout our locality governance boards for onward review and discussion by our teams and services. The learning detailed in Figure 2 has been included in this quarter's practice notes.

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

Table 8: Examples of complaints closed and action taken

Example	You said	We did	Assurance
Care and treatment	My partner needed support and I was left with no option other than to pay for care – why?	Our investigation found that an administration error meant that you had to pay for private care. We apologised, reimbursed the costs, and took steps to prevent this reoccurring in the future.	**Significant**
Access to services	My relative has been assaulted whilst an inpatient, and remains on the ward with the assailant – this is unacceptable	We agreed that this situation is very difficult, in part due to support needs of both involved. We apologised and explained that we are working hard with relevant agencies to find alternative suitable support.	**Significant**
Communication	Following my relative's assessment we did not receive a written report for nearly three months – why?	We investigated and found that the assessment report was not sent within expected timeframes. We apologised and were able to offer reassurance that agreed actions were completed despite the report not being written up in a timely way.	**Significant**

2.2 Concerns

2.2.1 Our Trust endeavours to be responsive to feedback and to resolve concerns with people at the point at which they are raised. This has resulted in complaint numbers being maintained at a lower level and a corresponding increase in the number of PALS contacts. **DatixWeb**, a service experience recording and reporting system, has continued to be used for this quarter. Trends have been analysed and are reflected in Table 9.

Table 9: Number of concerns received this quarter

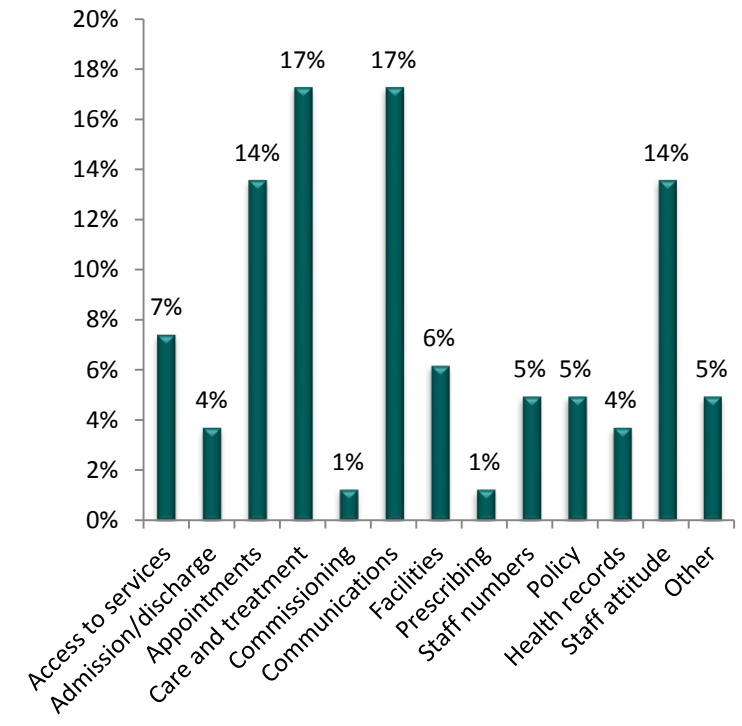
County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	46	↑	The number of concerns raised in Gloucestershire is higher than the last quarter (Q4 n=37)	Significant
Herefordshire	10	↔	About the same number of concerns have been raised in Herefordshire compared to the last quarter (Q4 n=9)	Significant
Corporate	4	↑	There are more concerns relating to corporate services compared to last quarter (Q4 n=2)	Significant
Total	60	↑	The number of concerns raised is higher than last quarter (Q4 n=48)	Significant

2.2.2 The number of concerns raised remains relatively consistent with previous quarters but has risen slightly by comparison to last quarter. The increase is mainly due to the ongoing rotation of PALS visits to our inpatient services seeking feedback from those who use our services. There were also 53 other contacts with our Service Experience Department during Quarter 1 covering a range of topics. This provides us with the assurance that more people are contacting the SED with queries although the number of concerns and complaints received remains consistently low.

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

Table 10: Overarching concern themes this quarter

Theme	No.*
Access to services *Treatment or medication*	6
Admission/discharge *Community or inpatient*	3
Appointments *e.g. cancelled, staff DNA*	11
Commissioning *e.g. lack of services*	1
Communication *Internal and external*	**14**
Facilities *e.g. temperature*	5
Care and Treatment *e.g. observation, support*	**14**
Prescribing *e.g. failure to prescribe*	1
Health records *e.g. accuracy*	3
Policies *e.g. Health Records, MHA*	4
Staff attitude *Behaviour and actions*	11
Staff numbers *e.g. short staffing*	4
Other *e.g. loss of belongings*	4



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

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

Outcome	No	%
Administrative staff	5	6%
Medical	**12**	**15%**
Estates	4	5%
Nursing	**32**	**40%**
Psychological Wellbeing	7	9%
Psychologist	3	4%
Social Worker	4	5%
None	11	14%
Other	3	4%

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

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

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

Table 12 Examples of concerns and action taken:

Example	You said	We did	Assurance
Appointments and waiting times	I have been waiting a long time for CBT and missed an appointment because I was under the care of the crisis team; I was subsequently discharged.	We contacted the Team Manager who reviewed your original place on the waiting list prior to discharge and you were offered an appointment two weeks' later.	**Significant**
Access to services	My daughter is in an inpatient unit hundreds of miles away which is too far for us to be involved in her care.	We worked with NHS England, to transfer your daughter closer to home allowing you to visit and be involved in her care.	**Significant**
Communication	The receptionist who took my call seemed rushed and I did not appreciate their manner.	We contacted the Admin Team Manager who apologised and agreed to discuss this with the reception team as this is one of the most important aspects of their role.	**Significant**
Policy	A person I know has expressed suicidal intent on many occasions and I would like them to have a Mental Health Act assessment	We explained the process of requesting a Mental Health Act Assessment, and put you in touch with our Crisis Team for support.	**Significant**

2.2.5 PALS Visits

2.2.5.1 Patient Advice and Liaison Service (PALS) visits are undertaken in our clinical services to ensure that people's concerns are heard and resolved as soon as possible. Visits to Wotton Lawn Hospital and Charlton Lane Hospital in Gloucestershire, and Stonebow Unit in Herefordshire, were undertaken during Quarter 1.

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

2.2.5.3 PALS provided the following types of support and assistance during visits undertaken in Quarter 1:

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

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

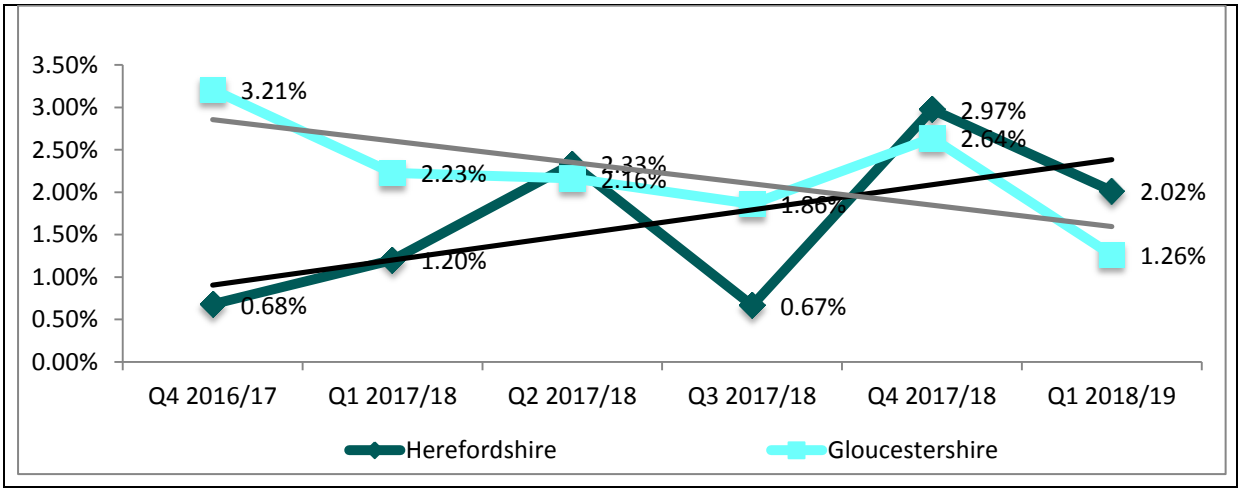
2.2.5.5 The following **emerging themes** have been identified from analysis of PALS reports following visits to our inpatient services across our Trust:

- Feedback about food served on the wards – both positive and negative reports given
- Concerns raised about the temperature of our inpatient wards during the recent heatwave – escalated via ward managers at time of visit.
- Disagreement regarding detention under the Mental Health Act
- Feedback about the ward staff – this has been mainly positive in nature

2.3 Compliments

2.3.1 The SED continues to encourage the reporting of compliments received by Trust services. **396** compliments were received this quarter. This is a decrease when compared to Quarter 4 (n=712). A dedicated email address is set up to simplify the process for colleagues to report compliments that they have received: 2gnft.compliments@nhs.net. Figure 3 shows the percentage of compliments to contacts as reported during Quarter 1.

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



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

Examples of compliments received during Quarter 1:

Thank you for all your care it got 'me' back.
Occupational Therapy, Charlton Lane Hospital

He is wonderful and took the time to listen to my boys.
CAMHS, Herefordshire

Thank you so much for getting me the backrest. It is just what I wanted, I slept so well last night.
CLDT, Gloucestershire

The lady I was seeing was very helpful and has helped me a lot.
CYPS, Gloucestershire

I recently spent four weeks in Mortimer Ward and wanted to thank the nursing staff and medical team for all that they did to help my recovery. I especially appreciated the patience shown by the ward staff and all the care that they provided throughout my stay on the ward.
Mortimer Ward, Stonebow

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

2.4.1 Current open referrals for external review:

Table 13: current open referrals for external review

Reviewing organisation	Date of first contact from reviewing organisation	Date official investigation confirmed	Current status of referral
PHSO	25/01/2017	07/08/2017	Investigation ongoing
LGO	23/01/2018	03/04/2018	Investigation ongoing
PHSO	06/06/2017	30/04/2018	Investigation ongoing

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

2.4.2 Referrals made for external review of complaint this quarter

The PHSO informed us that two complainants had contacted them to request a review of their complaint and for relevant information to be sent to them. We are awaiting contact from the PHSO following their review of this information.

2.4.3 Completed external complaint investigations

PHSO: Following review of a complaint raised with our Trust, the PHSO have informed us that they did not uphold the complaint and commented that the psychiatrist involved had been very thorough in his assessment and treatment. This has been fedback to those involved in this complaint.

2.5 Surveys

2.5.1 'How did we do?' Survey

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

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

2.5.1.3 For the past 3 years we have utilised an external provider to input and manage our survey feedback. Following a review of our processes and a desire to seek more feedback, a new system to manage Trust feedback has been commissioned to commence in Quarter 3 2018/19. Our preferred provider will bring us in line with processes used by Gloucestershire Care Services NHS Trust. Existing arrangements will continue until the end of September 2018.

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

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

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

2.5.2.2 Table 14 details the Trust-wide number of responses received each month. The FFT score is the percentage of people who stated that they would be 'extremely likely' or 'likely' to recommend our services. The FFT questionnaire is available in all Trust services.

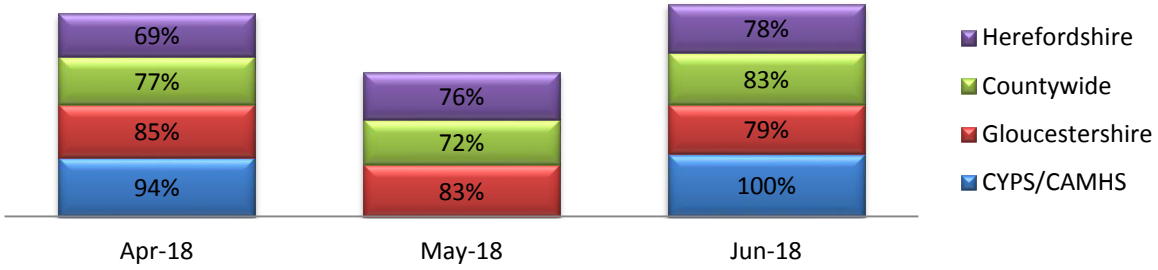
Table 14: Returns and responses to Friends and Family Test in Q1

	Number of responses	FFT Score (%)
April 2018	302 (244 positive)	81%
May 2018	281 (222 positive)	79%
June 2018	375 (313 positive)	83%
Total	**958** (779 positive) **(last quarter = 950)**	**81%** **(last quarter = 84%)**

2.5.2.3 As reported during 2017/18 some difficulties have continued when sending text messages to people due to the recording of telephone numbers on RiO. Work continues to raise colleague's awareness of how to record mobile telephone numbers within RiO. The response rate to the text messages that were sent successfully during Quarter 1 has been encouraging, with a response rate of 25% (Q4 = 30%).

2.5.2.4 Quarter 1 FFT response rates have slightly increased, continuing the quarterly rise seen during 2017/18. When analysing responses it is encouraging to see that a high percentage of the responses received by text message are from people who have had contact from our inpatient services. This has historically been an area where survey feedback has been difficult to obtain. Figure 4 shows the breakdown of Trust FFT scores between our service localities.

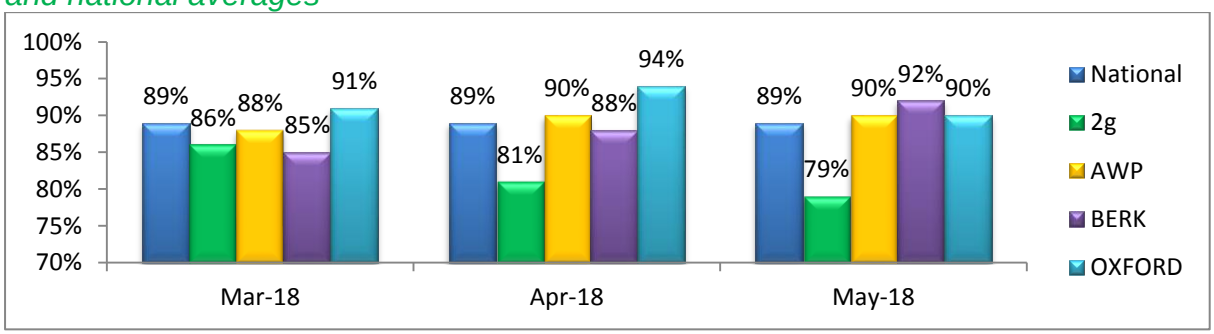
Figure 4: FFT percentage of respondents recommending our services by month and locality



2.5.2.5 The FFT score for this quarter is similar to the previous quarter; with a small dip observed in May 2018. This dip may be contributed to by the lack of CYPS FFT feedback uploaded during this month due to administration difficulties. SED will continue to monitor and analyse FFT data on a locality basis.

2.5.2.6 Figure 5 shows the FFT Scores for March, April and May 2018 (the most recent data available) compared to other Mental Health Trusts in our region, and the average of Mental Health Trusts in England. Our Trust consistently receives a high percentage of recommendation although we have not achieved such high scores as other Trusts in our Region in recent quarters. This is a reversal from previous years and does not triangulate with our positive National Survey scores (*June 2018 data are not yet available*)

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

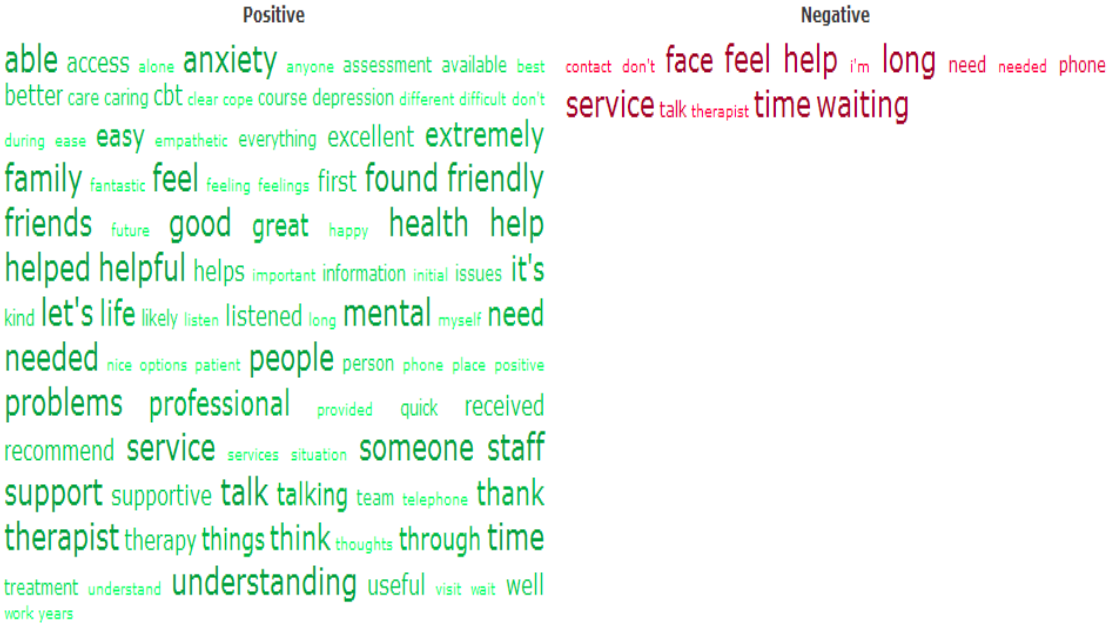


2g – 2gether NHS Foundation Trust // AWP – Avon and Wiltshire Mental Health Partnership NHS Trust, BERK – Berkshire Healthcare NHS Foundation Trust // OXFORD – Oxford Health NHS Foundation Trust

Friends and Family Test Comments

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

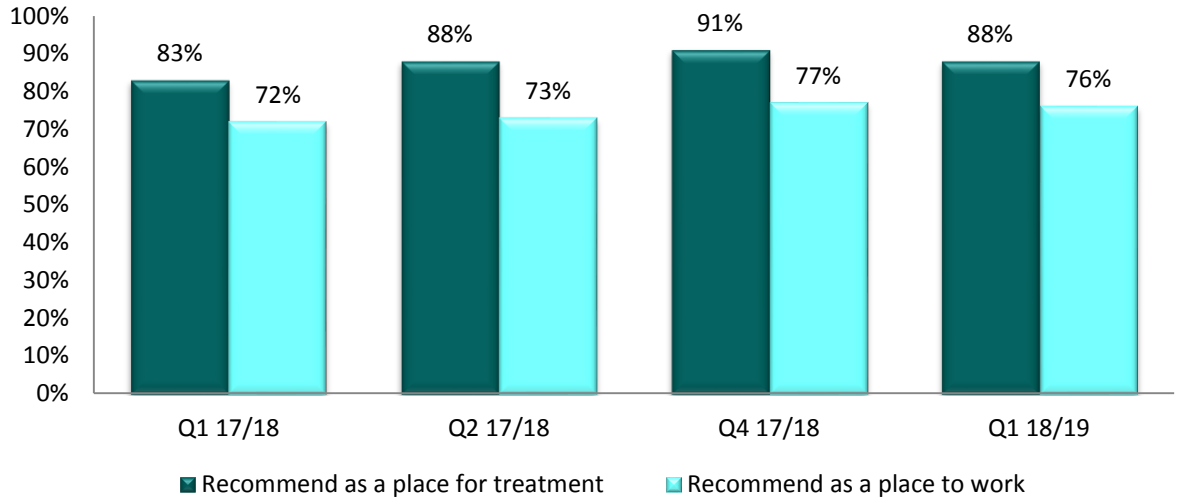
Figure 6: Comments taken from FFT responses during Quarter 1



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

Our staff are asked about their experience of working for our Trust during quarters 1, 2 and 4 each year. In Q3 the FFT is replaced by the annual Staff Survey.
Figure 6 shows the latest staff FFT scores.

Figure 6: Staff Friends and Family Test Scores



2.5.3.1 The results of the Staff FFT continue to align closely with those of service user feedback. Comparison of the two FFT scores suggests that over the past year, our staff are slightly more likely to recommend Trust Services than services users.

2.5.4 How did we do?

2.5.4.1 The How Did We Do? survey (Quality Survey questions) provides people with an opportunity to comment on key aspects of the quality of their treatment. It was initially launched as a paper-based survey in April 2017. From 1st November 2017 the survey was distributed via text message to people who were discharged from our community and inpatient services. The text message asks the FFT questions and provides a link for people to complete additional Trust Quality survey questions.

2.5.4.2 Quality survey targets were reviewed and refreshed for the commencement of Quarter 1 2018/19. Three out of the four targets set have been exceeded. This suggests that, of those people who responded to the survey, most are feeling supported to meet their needs and explore other activities. The one target that hasn't been fully achieved this quarter continues to receive the majority of positive responses. Table 15 shows responses in relation to set targets for this quarter.

Table 15: How Did We Do? Quality survey questions and responses

Question	County	No. of responses	Target Met?
Were you involved as much as you wanted to be in agreeing the care you receive?	Gloucestershire	41 (30 positive)	**80%** **TARGET 84%**
	Herefordshire	25 (23 positive)	
Have you been given information about who to contact outside of office hours if you have a crisis?	Gloucestershire	36 (29 positive)	**87%** **TARGET 71%**
	Herefordshire	24 (23 positive)	
Have you had help and advice about taking part in activities that are important to you?	Gloucestershire	33 (27 positive)	**88%** **TARGET 64%**
	Herefordshire	23 (22 positive)	
Have you had help and advice to find support for physical health needs if you have needed it?	Gloucestershire	38 (29 positive)	**84%** **TARGET 73%**
	Herefordshire	23 (22 positive)	

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

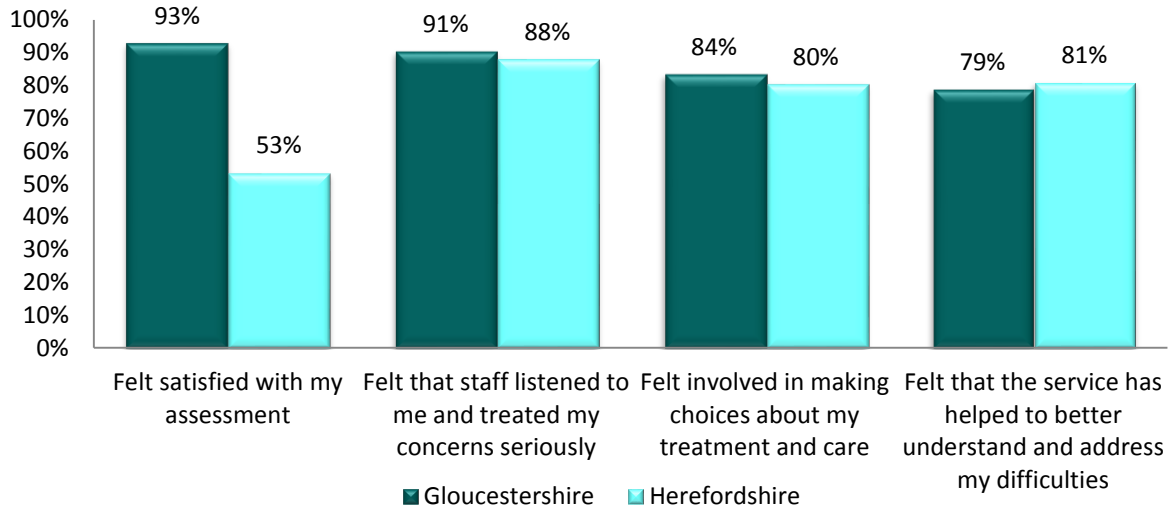
2.5.4.4 Although response rates for the survey have increased the level of response continues to be lower than we would like. The introduction of new systems in Quarter 3 2018/19 to capture survey feedback aims to increase the number of response we receive to both aspects of the How did we do? survey.

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

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

2.5.5.2 Feedback questionnaires are sent to people following the initial assessment and after discharge from the service. Quarter 1 feedback (figure 7) shows that people are largely satisfied with these elements of the Let's Talk service.

Figure 7: IAPT PEQ Satisfaction scores by county during Quarter 1



2.5.5.3 This information is shared with colleagues from IAPT Let's Talk so that it can be used by them to deliver service improvements. The dip in the assessment satisfaction score for Herefordshire will be flagged to operational managers.

2.5.5.4 The IAPT PEQ seeks comments from people about the service that they have received. A selection of comments for Q1 responses are shared below:

Very helpful. Just talking to someone has helped.

I preferred the CBT one to one but the waiting list is 6 months so have been offered therapy via phone instead which is okay.

In general the service is good but only for people with certain problems. Sadly not all areas covered.

It has been good to have the experience. I am nervous about the 1 to 1 work but I realise it is a part of the whole.

So far I feel supported and not bullied nor pressured or forced into something don't want to do.

Efficient, friendly and kind but to the point. I felt listened to and not rushed.

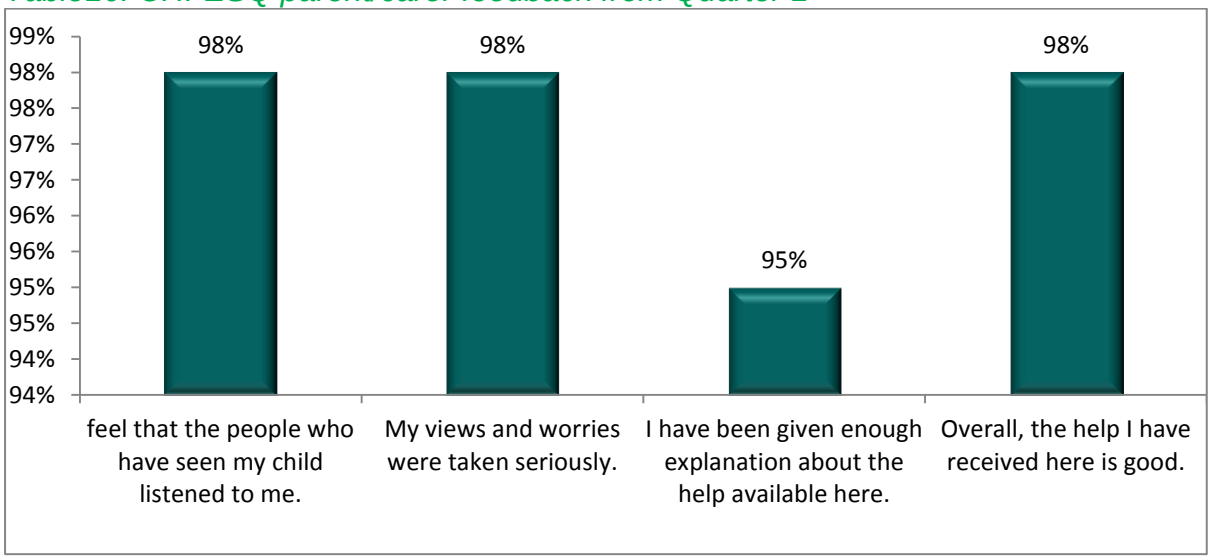
I had some useful help from the service and it has given me some tools to aid my recovery. But the waiting list is too long.

2.5.6 Children and Young People service (CYPS)

2.5.6.1 CYPS gather service feedback using the Experience of Service Questionnaire, known as CHI-ESQ. CHI-ESQ is a nationally designed survey to gain feedback from children, young people and their parents/carers. There are three versions of the CHI-ESQ survey used, these are identified by age and role type as follows: Age 9 -11 yrs, Age 12 -18 yrs and Carer & Parent. All the surveys ask questions based upon the same theme but are presented differently in age appropriate format.

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

Table16: CHI-ESQ parent/carer feedback from Quarter 1



Examples of some feedback given by Carers & Parents:

Really listened to us and worked with us as a family. He built a great relationship with our son and has helped us enormously we all now have the necessary tools to deal with and cope with melt downs. He really helped me understand my son's behaviour.

Consistency - kind people. Very logical thought processes.

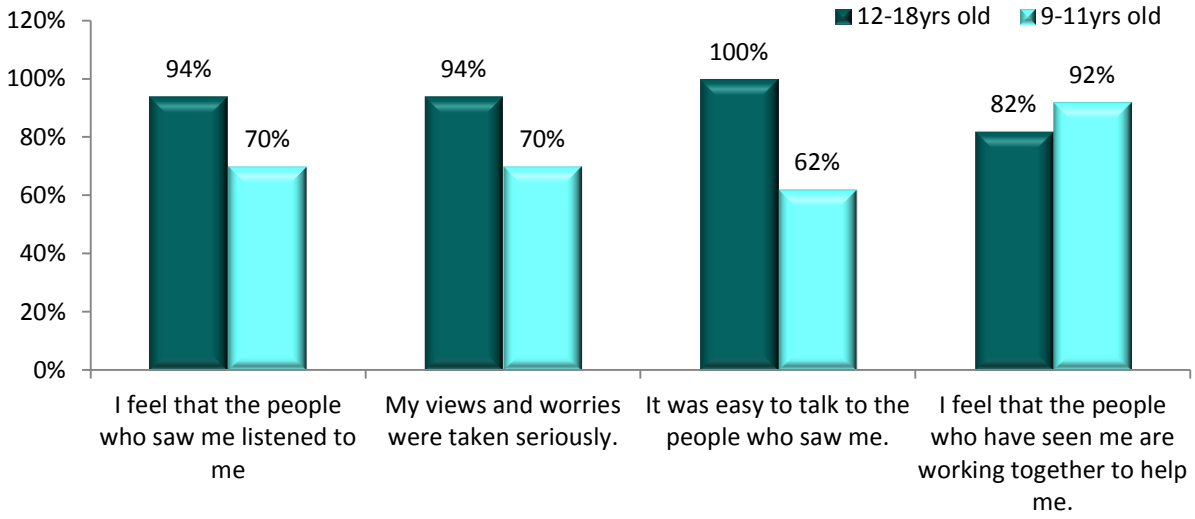
I would just like to thank you for giving me my daughter back! At one point I never thought I would see her smile again. She was in a very dark place but now she is back and happier than she has been in many years.

It was a great service and I felt listened to and the strategies to help my child are useful.

On the whole I feel the service encompassed and met all of the needs my child was experiencing. It rose to a difficult challenge and provided a positive outcome, sending us on our way with possibilities for further support.

If there is a relapse it would be preferable to see the same person in order not have to repeat sessions.

Table 17: Children and young people feedback



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

Examples of some feedback given by children and young people:

I feel listened to and I have been able to somewhat recover and though I still have down days, I can manage it better.

My therapist actually tried to get stuff done.

There was sometimes silences in the sessions which felt awkward.

The fact that they listened to me and didn't judge me. I liked how they went away and thought about ways to help me outside of session time and I loved the effort they put into my care.

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

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

Effective dissemination of learning across the organisation is vital to ensure [2]gether's services are responsive to people's needs and that services continue to improve.

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

Table 18 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 18: Points of learning from Service Experience feedback Q1 closed complaints disseminated to localities via Practice Notes– assurance of actions be sought from locality leads

Practice Note number	Organisational Learning
1272	When potential safeguarding concerns are discussed in referral/team meetings it should be documented whether safeguarding procedures have already been followed by the referrer, or what action needs to be taken and by whom Call handlers/clinicians in each locality should have the names and contact numbers for managers in other localities who can be contacted when needed if local managers are unavailable. Calls made to administration and/or reception colleagues requesting contact from clinical staff from service users should be logged, including the arrangements agreed about when they will be contacted. Where available Health Records should be checked before initial assessments so clinicians can raise any issues in a more therapeutic context
1359	We should request specialist knowledge and assistance from our Trust colleagues when caring for people with additional needs such as Autistic Spectrum Conditions to ensure that the appropriate care and support is provided.
1399	When sending information to other external agencies/services we should always check the contact details thoroughly especially when we have not communicated with before - telephone to discuss and clarify contact arrangements before sending written information We should always explain our referral processes and pathways to service users and carers to ensure that they are aware of what happens next. We should feedback to service users and carers (where appropriate) the outcomes of the decisions we make about care.
1513	Careful consideration should be taken when a service user with additional needs such hearing impairment or learning disability is admitted to one of our psychiatric inpatient units. This is to make sure that responsible adjustments are in place to ensure care needs are met.

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

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

Table 19: Points of learning from Service Experience feedback Q1 2018/19 – action plan has been completed

Organisational Learning	Assurance of actions	Date received
Care Co-ordinators should ensure that care planning meetings include contributions from all those involved in the service user's care as well as clearly explaining the care and support provided by each professional/agency.	***Gloucestershire Localities:*** Care co-ordinators will be reminded to ensure that care planning meetings include contributions from all those involved in the service user's care as well as clearly explaining the care and support provided by each professional/agency. This will be discussed at Localities Delivery and Governance meeting and cascaded through Clinical Forums in each locality. ***Countywide:*** Care co-ordinators will be reminded to ensure that care planning meetings include contributions from all those involved in the service user's care as well as clearly explaining the care and support provided by each professional/agency. This will be discussed at the Countywide Locality Management Board (CLMB) and cascaded through services as outlined below: • Learning added to the in-patient managers agenda across all in-patient sites, cascaded to all managers to take back to their teams via team meetings. • Learning added to the Community Teams monthly team business meetings as well as in 1:1 supervision sessions with staff and email where appropriate. ***Herefordshire:*** New service leaflet being produced as part of Quality Service Improvement and Redesign (QSIR) project ''Always '' Point of care project in place supported by NHSI. ***CYPS:*** Practice note to be circulated to all CYPS/CAMHS staff.	**June/July 2018**

Organisational Learning	Assurance of actions	Date received
When colleagues are answering telephone calls they should ascertain what or who calls are related to in order to ascertain who the best placed member of staff on duty is to take the call.	***Gloucestershire Localities:*** All staff (including admin and clinical) will be reminded to enquire as to what or who calls are related to in order to ascertain who the best placed member of staff on duty is to take the call. This will be discussed at Localities Delivery and Governance meeting and cascaded through Clinical Forums in each locality. ***Countywide:*** All staff (including admin and clinical) will be reminded to enquire as to what or who calls are related to in order to ascertain who the best placed member of staff on duty is to take the call. This will be discussed at the Countywide Locality Management Board (CLMB) and cascaded through services as outlined below: • Learning added to the in-patient managers agenda across all in-patient sites, cascaded to all managers to take back to their teams via team meetings. • Learning added to the Community Teams monthly team business meetings. ***Herefordshire:*** Locality Governance leads will disseminate this reminder back to team, meetings. Message will also be disseminated through Governance meeting minutes. ***CYPS:*** Request for CYPS admin lead to circulate guidance, this will be raised further at Delivery Committee.	**June/July 2018**
We should ensure that guidance for providing and writing reports is available to our colleagues.	***Gloucestershire Localities:*** When the guidance has been developed and approved it will be discussed at Localities Delivery and Governance meeting and cascaded through Clinical Forums in each locality. ***Countywide:*** When the guidance has been developed and approved it will be discussed at CLMB and cascaded through services as outlined below: • Learning added to the in-patient managers agenda across all in-patient sites, cascaded to all managers to take back to their teams via team meetings.	**June/July 2018**

Organisational Learning	Assurance of actions	Date received
	• Learning added to the Community Teams monthly team business meetings as well as in 1:1 supervision sessions with staff and email where appropriate. ***Herefordshire:*** When the guidance has been developed and approved it will be discussed at Localities Governance meeting and cascaded throughout our services. ***CYPS:*** When the guidance has been developed and approved it will be discussed at Localities Governance meeting and cascaded throughout our services.	
We must clearly communicate what services are provided by which organisations and work closely other organisations to provide more joined up care for service users with complex mental and physical health problems.	***Gloucestershire Localities:*** Clinicians will be asked to explain which organisation provides each element in a person's plan of care in order to provide more joined up care for service users with complex mental and physical health problems and manage expectations. This will be discussed at Localities Delivery and Governance meeting and cascaded through Clinical Forums in each locality. ***Countywide:*** Clinicians will be asked to explain which organisation provides each element in a person's plan of care in order to provide more joined up care for service users with complex mental and physical health problems and manage expectations. This will be discussed at the Countywide Locality Management Board (CLMB) and cascaded through services as outlined below: • Learning added to the in-patient managers agenda across all in-patient sites, cascaded to all managers to take back to their teams via team meetings. • Learning added to the Community Teams monthly team business meetings as well as in 1:1 supervision sessions with staff and email where appropriate. ***Herefordshire:*** Hereford services directory now in place. To re circulate via governance attendance list.	**June/July 2018**

Organisational Learning	Assurance of actions	Date received
	CYPS: Seeking further advice and guidance from SED before disseminating to CYPS/CAMHS staff	
Where indicated we must ensure that letters contain a clear rationale for a decision, and an acknowledgement if the service user has expressed that they do not agree with the decision.	***Gloucestershire Localities:*** Clinicians are reminded to ensure that letters contain a clear rationale for a decision, and an acknowledgement if the service user has expressed that they do not agree with the decision. This will be discussed at Localities Delivery and Governance meeting and cascaded through Clinical Forums in each locality. ***Countywide:*** Clinicians are reminded to ensure that letters contain a clear rationale for a decision, and an acknowledgement if the service user has expressed that they do not agree with the decision. This will be discussed at the Countywide Locality Management Board (CLMB) and cascaded through services as outlined below: • Learning added to the in-patient managers agenda across all in-patient sites, cascaded to all managers to take back to their teams via team meetings. • Learning added to the Community Teams monthly team business meetings as well as in 1:1 supervision sessions with staff and email where appropriate. ***Herefordshire:*** Locality Governance leads will disseminate this reminder back to team, meetings. Message will also be disseminated through Governance meeting minutes ***CYPS:*** Practice note to be circulated to all CYPS/CAMHS staff.	**June/July 2018**
Healthcare records should be reviewed as part of the referral decision-making process and consideration taken to joint triage and review cases involving multiple	***Gloucestershire Localities:*** Clinicians will be reminded that Healthcare records should be reviewed as part of the referral decision-making process and consideration taken to joint triage and review cases involving multiple teams working with individuals. This will be discussed at Localities Delivery	**June/July 2018**

Organisational Learning	Assurance of actions	Date received
teams working with individuals	and Governance meeting and cascaded through Clinical Forums in each locality. ***Countywide:*** Clinicians will be reminded that Healthcare records should be reviewed as part of the referral decision-making process and consideration taken to joint triage and review cases involving multiple teams working with individuals. This will be discussed at the Countywide Locality Management Board (CLMB) and cascaded through services as outlined below: • Learning added to the in-patient managers agenda across all in-patient sites, cascaded to all managers to take back to their teams via team meetings. • Learning added to the Community Teams monthly team business meetings as well as in 1:1 supervision sessions with staff and email where appropriate. ***Herefordshire:*** Locality Governance leads will disseminate this reminder back to team, meetings. Message will also be disseminated through Governance meeting minutes. ***CYPS:*** Practice note to be circulated to all CYPS/CAMHS staff.	

Agenda Item 10 **Enclosure Paper E**

Report to: 2gether NHS Foundation Trust Board – 26 September 2018
Author: Jonathan Vickers, Non-Executive Director
Presented by: Jonathan Vickers, Non-Executive Director

SUBJECT: **NON EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS QUARTER 1 2018/19**

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

EXECUTIVE SUMMARY

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

RECOMMENDATIONS

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

1. INTRODUCTION

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

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

2. PREPARATION

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

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

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

3. SUMMARY OF FINDINGS

3.1 Case 1

This complaint concerned an incident in which an in-patient had been attacked and injured by another in-patient.

It took time to agree the precise substance of the complaint but, once established, the various elements of it were thoroughly investigated. There was a question over whether the investigator had tried hard enough to contact the complainant. And the report and letter could have appeared over-complicated. There were also observations in the letter that could have been more irritating than placatory ("the unpredictable nature of this attack meant that it was an unpredictable event", and "we have taken on board [the patient's] experience").

A request for compensation has followed, and remains unresolved.

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

3.2 Case 2

This was a complaint from an in-patient about how she was treated by staff.

The wording of the complaint, and the variety of the alleged interactions, made the investigator's task difficult. The result however was a number of sound conclusions and some clear actions needed for improvement. In the light of the complainant's style of writing, it may be that further attention could have been given to simplifying the wording of the response letter.

I would offer *full* assurance against the first two aspects, and *significant* assurance against the others.

3.3 Case 3

This unfortunate case arose from a misunderstanding of a GP's dementia diagnosis.

The investigation was thorough, and rightly acknowledged some shortcomings, as did the response letter.

Again, I would offer *full* assurance against the first three aspects, and *significant* assurance against the fourth.

4. SUMMARY

4.1 Overall, it is noticeable that the quality and timeliness of our handling of complaints has continued to improve, as has the tone of our response letters. The identification of learning points is also more systematic, and it seems that the learning is now being taken seriously and widely disseminated, though this is not something that the audit process covers.

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

Report to: Trust Board – 26th September 2018
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 :

- Quality dashboard for inpatient units (Appendix 1)
- National reporting requirements, latest developments and the latest data in their required format (Appendix 2)
- Local Trust exception reporting
- Update of agency use across wards
- Confirmation of achievement of the NQB expectations

National reporting with regards to fill rates continues to be uploaded monthly and reported to the Governance Committee on behalf of the Board. From April 2018 the Trust has been mandated to also include the Care Hours Per patient Day (CHPPD) within the upload. The Trust continues to have high compliance with planned v actual fill rates - over 96% compliant for July 2018. Appendix 2 details the latest figures presented at the Governance Committee in August 2018.

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

This paper also includes a updated quality dashboard (Appendix 1) for the inpatient wards which is a requirements of the NQB guidance – ensuring triangulation of both staffing; workforce indicators and patient experience. This indicates some wards have higher rates of sickness and turnover and other indicators which are RAG rated red. The wards and Matrons will be asked to review their units and sites and work with the Director of Quality and the Director of Organisational Development to explore this further.

The Quality dashboard will be developed to include all services over the next 6-12 months.

Following on from the detailed update regarding the NQB expectations in March this report confirms achievement of all expectations as per the guidance. Some areas are currently being progressed further such as workforce development; safe staffing reviews and ensuring diversity of the workforce is representative of the communities we serve.

ASSURANCE

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

RECCOMENDATIONS

The Board is asked to:

- Note the current assurance against the revised NQB guidance and safe staffing levels
- Note monthly reporting and compliance with fill rates
- Note current position regarding temporary staffing

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	18th Sept 2017

Where in the Trust has this been discussed before?		
Every 6 months at Board	Date	September 2017
		March 2018

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:

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

The Trust Board received the last 6 monthly update in March 2018. 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 6 monthly update outlines :

- Quality dashboard for inpatient units (Appendix 1)
- National reporting requirements, latest developments and the latest data in their required format (Appendix 2)
- Local Trust exception reporting
- Update of agency use across wards
- Conformation of achievement of NQB expectations

2. PROGRESS ON THE NQB REVISED KEY EXPECTATIONS

Following on from the detailed update regarding the NQB expectations through the last 6 monthly paper, this report confirms achievement of all expectations as per the guidance. Some areas are currently being progressed further such as workforce development; safe staffing reviews and ensuring diversity of the workforce is representative of the communities we serve.

Specific actions focusing on workforce development have continued. The BSc in Mental health Nursing has been validated by the Nursing and Midwifery Council (NMC) and course participants have commenced this month. This is a significant achievement. In addition we have clinicians commenced on the Advanced Clinical Practitioner course at the University of Worcester this month. This will not only offer a career progression for colleagues but seek develop practitioners in areas such as psychical health monitoring and non-medical prescribing.

The Quality dashboard will be further developed to include all services over the next 6-12 months. The current Quality dashboard indicates some wards which have higher rates of sickness and turnover and other indicators which are RAG rated red. The Wards and Matrons will be asked to work with the Director of Quality and the Director of Organisational Development to explore this further and understand the impact.

3. NATIONAL GUIDANCE

The National Quality Board (NQB) and NHSI have led on a number of toolkits in relation to safe staffing for both inpatient and community services. The guidance for mental health and learning disability has recently been published and the Director of Quality and deputy Director of Nursing will be reviewing all staffing in teams and wards over the coming months.

https://improvement.nhs.uk/resources/safe-staffing-mental-health-services
https://improvement.nhs.uk/resources/safe-staffing-improvement-resources-learning-disability-services

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. From April 2018 the Trust is mandated to publish the Care Hours Per Patient Day (CHPPD) for all wards. A process is in place to do this as required.

Appendix 2 outlines the national safe staffing requirement for July 2018. 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 2018:

- No staffing issues were escalated to the Director of Quality or the Deputy Director of Nursing.
- Where staffing levels dipped below the planned fill rates of 100% for qualified nurses this was usually offset by increasing staffing numbers of unqualified staff based on ward acuity and dependence and the professional judgement of the nurse in charge of the shift.
- Over **96.5%** of the hours exactly compiled with the planned staffing levels.
- Over **2%** 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 the patients were met.
- **0.5%** 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.

Internal exceptions July 2018

Wotton Lawn

- Greyfriars
  - Continues to have 3 x Band 5 vacant posts and HCA sickness.
- Abbey
  - Code 1's owing to qualified vacancy and/or sickness, patient needs met and covered by HCA's.
- Priory
  - Currently have a number of vacant posts whilst awaiting new starters in September. Code 1 are owing to running with two qualified nurses rather than three if the ward cannot fill the shifts with substantive staff or cover with regular bank staff.

Charlton Lane July 2018 – minimal exceptions this month

Berkeley House July 2018

- Exception reporting due to same reasons as in June 2018.

Stonebow - Herefordshire July 2018

- There are minimal exceptions across the unit this month.
- The code 2 exceptions for Oak were due to low bed occupancy and the redeployment of 1 qualified nurse to Mortimer Ward.
- The code 3 exception for Cantilupe was agency withdrawal and unable to get replacement

Exception reporting in hours – all wards July 2018

			Exception Code 1	Exception Code 2	Exceptio n Code	Exception Code 4	Exceptio n Code
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	Minimum staff numbers not compliant and did not meet needs of patients	Minimum staffing # and skill mix not met. Resulting in clinical incident / harm to
Dean	15	3255	42.50	0.00	0	0	0
Abbey	18	3255	300.00	15.00	0	0	0
Priory	18	3255	355.00	0.00	0	0	0
Kingsholm	15	3255	17.50	10.00	0	0	0
Montpellier	12	3565	7.50	32.50	0	0	0
Greyfriars	10	4030	360.00	10.00	0	0	0
Willow	16	4495	15.00	0.00	0	0	0
Chestnut	14	3022.5	37.50	7.50	0	0	0
Mulberry	18	3255	0	7.50	0	0	0
Laurel	12	2015	195.00	0	0	0	0
Honeybourne	10	2015	195.00	0	0	0	0
Berkeley House	8	8680	7.50	102.50	0	0	0
Herefordshire							
Mortimer	21	3208.5	0	0	0	0	0
Cantilupe	10	2991.5	74.00	50.50	11.50	0	0
Jenny Lind	8	1782.5	0.00	14.50	0	0	0
Oak House	10	1782.5	23.00	11.50	0	0	0
Total		52,125.0	1630.00	205.00	11.50	0	0

5. USE OF TEMPORARY STAFFING

- The Director of Quality continues to chair the Temporary Staffing Project Board on a monthly basis and now has a focus on use of medical locums and IAPT spend. In addition the Board continues to ensure a grip on inpatient nursing spend through the embedding of actions already in place. This includes a procurement exercise to ensure a consistent supply of 6 RMN in a 24 hour period across both Counties. We have some concerns regarding the current provider but this is being managed well.
- The Trust submitted a bid to work with NHSI as one of the national bank pilot and has been successful in its bid. This offers financial resource (£50K) and support which is very helpful going forward in terms of embedding progress within staff bank

Table 1 below: Agency spend against NHSI ceiling and straight line forecast without mitigation.

	Actual 2016-17	Actual 2017-18	NHS Ceiling	2018-19	Straight line Forecast 2018-19
151MED - Medical Agency	2,041,540	1,974,301	1,503,888	682441.71	2,047,325
153NMHV - Nursing Agency	2,379,314	1,383,636	1,049,677	508670.07	1,526,010
154STT - Scientific Therapeutic and Technical Agency	694,451	562,854	427,001	244622.75	733,868
160ADM - Admin and Clerical Agency	197,484	128,395	97,405	8097	24,291
161HCA - Support agency	122,081	73,856	56,030	20712.46	62,137
164OTH - Other employees Agency	56,878	-0	-0	-115	-345
Total	**5,491,748**	**4,123,041**	**3,134,000**	**1,464,429**	**4,393,287**

- The Trust is expecting a significant rise in agency spend within IAPT services owing to access targets and recruitment issues. This is a focus within the temporary staffing board and a monthly assurance update is occurring. The Trust is working on a master vendor contract with suppliers to ensure we have a consistent approach to agency use and spend through staff bank- rather than this being managed by the service.

- In addition we are now issuing trainees a substantive contract which has significantly affected our recruitment positively. All current trainees have accepted this offer.

MEDICAL AGENCY SPEND

The Trust currently has 8 WTE medical staffing vacancies.

All except one (Consultant in CAMHS/CYPS) are currently filled via agency locum staff. These are actively being recruited to with one successful appointment made on the 3rd August 2018, another interview scheduled and an Advanced Trainee 'Acting Up' in a Consultant post for 3 months. Once these appointments are made this will have a significant impact on reducing agency costs going forwards.

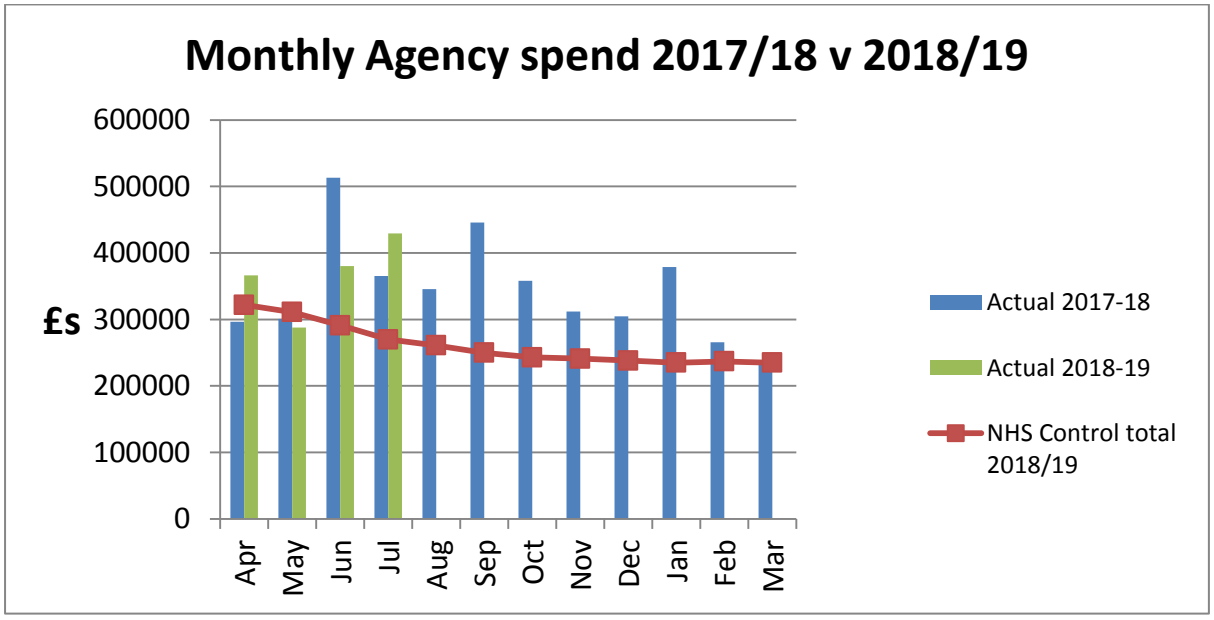
During August 2018 we have had to have a number of short term agency locums in both Herefordshire and Gloucester order to provide cover for annual and

planned sickness leave; this is a peak annual leave period and is expected. Herefordshire has required additional cover due to staff changes and shortages. A number of strategy meetings were held in July and August with key staff to ensure that appropriate cover was still in place; however mitigating actions to ensure the Stonebow unit could stay functioning was that it was closed to any Gloucestershire patients.

Recruitment for substantive posts both at Consultant and SAS level remains difficult due to lack of suitable candidates; however progress is being made slowly on reducing the number of agency locums and we have successfully transferred some to Trust fixed term contracts. The majority of our agency locums are only on short term contracts to cover annual leave or sickness (6 out of 10). The new cohort of junior doctors started in August 2018.

Agency spend has increased in 2 months out of the 4 this financial year however there was a significant reduction against 2017-18 spend in June. The graph below (Table 2) does indicate we are significantly away from the NHSI control target set for each month.

Table 2 below:



Agency spend and use continues to be monitored through the Governance Committee on a bi-monthly basis and through the executive director chaired Temporary Staffing Board monthly. Much work is underway to reduce spend in the areas identified above.

6. CONCLUSION

In summary the Trust is progressing well with all of the expectations within the revised NQB guidance and will use continue to use and develop the quality dashboards to further triangulate quality indicators.

7. RECOMMENDATIONS

The Board is asked to:

- Note the current assurance against the revised NQB guidance and safe staffing levels
- Note monthly reporting and compliance with fill rates
- Note current position regarding temporary staffing

Wards/Units staffing level and quality indicators, patient experiences which may or may not be linked to nurse staffing

Information regarding Data	
Safer Staffing	For month of July 2018
Workforce & Training	Rolling 12 months
Quality Indicators	Cumulative in year totals April -July

Appendix 1 Quality Dashboard

Bed Information				Staffing																																	
				Day		Night		Day				Night					Workforce & Training				Quality indicators (which may or may not be linked to nurse staffing)																	
				Registered nurses	Care Staff	Registered nurses	Care Staff	Registered nurses		Care staff		Registered nurses		Care staff		Agency	Workforce		Training/Supervision																			
Wards	Current established beds	Ward average occupancy (month) % including leave	Ward average occupancy (month) % excluding leave	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	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	Agency Rate%	Turnover by WTE %	Sickness Absence	Appraisal Compliance %	Statutory and Mandatory Training %	Formal complaints	Medication incidents Total	Medication incidents resulting in harm	RT Incidents	MRSA Bacteraemia	Clostridium difficile infection (CDI)	Falls total	Falls *with harm	SIRIs	AWOLs of detained patients	AWOLs of detained patients * with harm	Prone Restraint	Supine Restraint	Total restraints * with harm	RAG Score: Green = 0 - 2 trigger Amber = 3 - 4 triggers Red = 5 or more triggers
Abbey Ward, WLH	18	99%	92%	79.57%	134.68%	90.32%	119.35%	1395	1110	930	1253	620	560	310	370		4.59%	10.05%	32%	88.5%	2	8	0	16	0	0	2	1	0	6	0	9	2	0	
Dean Ward, WLH	15	104%	95%	99.19%	120.43%	96.77%	161.29%	930	923	1395	1680	620	600	310	500		1.88%	7.31%	79%	91.0%	2	5	0	27	0	0	14	3	0	2	0	12	4	3	
Kingsholm Ward, WLH	15	96%	93%	99.19%	105.38%	96.77%	116.13%	930	923	1395	1470	620	600	310	360		13.80%	10.57%	82%	84.7%	1	6	0	10	0	0	9	2	0	4	0	7	3	0	
Priory Ward, WLH	18	99%	96%	76.88%	141.13%	90.32%	119.35%	1395	1073	930	1313	620	560	310	370		4.68%	6.82%	86%	87.4%	1	4	0	16	0	0	5	2	0	19	2	5	7	2	
Greyfriars, WLH	10	93%	93%	81.18%	120.92%	83.87%	132.26%	1395	1133	1395	1688	620	520	620	620		5.85%	10.30%	88%	93.5%	0	4	0	14	0	0	4	0	0	0	0	5	5	3	
Montpellier WLH	12	99%	90%	96.77%	100.54%	96.77%	100.00%	930	900	1395	1403	620	600	620	620		13.86%	8.00%	82%	87.5%	0	2	0	0	0	0	1	0	0	0	0	0	0	0	
Chestnut Ward, CLH	14	105%	97%	100.00%	102.58%	100.00%	98.39%	930	930	1163	1193	310	310	620	610		6.30%	7.01%	73%	92.5%	0	0	0	7	0	0	39	2	0	0	0	0	0	0	
Mulberry Ward, CLH	18	97%	92%	100.00%	118.28%	100.00%	103.23%	930	930	1395	1650	310	310	620	640		10.27%	6.43%	89%	90.3%	0	14	0	6	0	0	22	7	0	0	0	0	1	2	
Willow Ward, CLH	16	103%	100%	105.65%	96.13%	100.00%	101.08%	930	983	2325	2235	310	310	930	940		18.93%	6.58%	87%	87.0%	0	4	0	3	0	1	59	8	1	0	0	0	4	1	
Berkeley House	6	100%	100%	132.26%	92.26%	129.03%	85.66%	930	1230	4650	4290	310	400	2790	2390		10.82%	6.04%	86%	90.5%	0	1	0	1	0	0	8	3	0	0	0	0	276**	167**	
Honeybourne	10	91%	83%	70.97%	129.03%	100.00%	100.00%	698	495	698	900	310	310	310	310		0.00%	6.21%	95%	93.7%	0	0	0	0	0	0	1	0	1	1	0	0	0	0	
Laurel House	13	100%	91%	69.89%	126.88%	100.00%	103.23%	689	488	698	885	310	310	310	320		1.91%	4.19%	78%	90.9%	0	6	0	0	0	0	3	0	0	0	0	0	0	0	
Oak House	10	62%	59%	96.77%	123.42%	100.00%	100.00%	713	690	357	440	356.5	357	356.5	356.5		6.78%	0.93%	94%	89.0%	0	0	0	0	0	0	0	0	0	1	0	0	0	0	
Mortimer Ward, SB	22	92%	86%	100.00%	191.94%	100.00%	174.19%	1070	1070	713	1369	713	713	713	1242		7.91%	5.50%	43%	69.3%	1	6	0	26	0	0	5	0	*	25	0	6	12	9	
Jenny Lind Ward, SB	8	94%	89%	98.39%	154.00%	100.00%	129.03%	713	702	357	549	356.5	357	356.5	460		15.40%	5.46%	71%	85.6%	0	6	0	3	0	0	3	0	*	3	0	0	0	0	
Cantilupe Ward, SB	12	60%	56%	82.54%	119.64%	50.00%	243.45%	713	589	1070	1280	713	357	496	1207.5		8.89%	2.65%	81%	83.8%	0	3	0	6	0	0	15	1	*	0	0	1	0	0	

* = A medication disposal SIRI was reported for the Stonebow Unit In May 2018 regarding Bio Bins. It has not been possible to attribute this to a specific ward, so has been attributed to the hospital site.
** = These relate to the reported episodes of restraint as captured on Datix. Due to the exceptionally high volume of interventions the absolute number of individual interventions is captured manually and much higher.

Appendix 2 July 2018 – National safe staffing upload

NURSING STAFF FILL RATES	Day				Night				Day		Night		TOTAL STAFFING DAY/NIGHT		STAFF GROUP		CHPPD			
	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 (%)	Average fill rate - All staff DAY (%)	Average fill rate - All staff NIGHT (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Midnight Occupancy	Registered nurses/ midwives	Care staff	Overall
Jul-2018	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												
Gloucestershire																				
WL- Dean Ward	930	923	1395	1680	620	600	310	500	99.19%	120.43%	96.77%	161.29%	111.94%	118.28%	98.23%	127.86%	436	3.5	5.0	8.5
WL- Abbey Ward	1395	1110	930	1253	620	560	310	370	79.57%	134.68%	90.32%	119.35%	101.61%	100.00%	82.88%	130.85%	518	3.2	3.1	6.4
WL- Priory Ward	1395	1073	930	1313	620	560	310	370	76.88%	141.13%	90.32%	119.35%	102.58%	100.00%	81.02%	135.69%	523	3.1	3.2	6.3
WL- Kingsholm Ward	930	923	1395	1470	620	600	310	360	99.19%	105.38%	96.77%	116.13%	102.90%	103.23%	98.23%	107.33%	415	3.7	4.4	8.1
WL- Montpellier Unit	930	900	1395	1403	620	600	620	620	96.77%	100.54%	96.77%	100.00%	99.03%	98.39%	96.77%	100.37%	348	4.3	5.8	10.1
WL- Greyfriars PICU	1395	1133	1395	1688	620	520	620	820	81.18%	120.97%	83.87%	132.26%	101.08%	108.06%	82.01%	124.44%	296	5.6	8.5	14.1
CL - Willow Ward	930	983	2325	2235	310	310	930	940	105.65%	96.13%	100.00%	101.08%	98.85%	100.81%	104.23%	97.54%	461	2.8	6.9	9.7
CL - Chestnut Ward	930	930	1163	1193	310	310	620	610	100.00%	102.58%	100.00%	98.39%	101.43%	98.92%	100.00%	101.12%	402	3.1	4.5	7.6
CL - Mulberry Ward	930	930	1395	1650	310	310	620	640	100.00%	118.28%	100.00%	103.23%	110.97%	102.15%	100.00%	113.65%	476	2.6	4.8	7.4
WA - Laurel House	698	488	698	885	310	310	310	320	69.89%	126.88%	100.00%	103.23%	98.39%	101.61%	79.16%	119.60%	370	2.2	3.3	5.4
WA - Honeybourne	698	495	698	900	310	310	310	310	70.97%	129.03%	100.00%	100.00%	100.00%	100.00%	79.90%	120.10%	269	3.0	4.5	7.5
LD - Berkeley House	930	1230	4650	4290	310	400	2790	2390	132.26%	92.26%	129.03%	85.66%	98.92%	90.00%	131.45%	89.78%	186	8.8	35.9	44.7
Herefordshire																				
SB - Cantilupe Ward	713	589	1070	1280	713	357	496	1207.5	82.54%	119.64%	50.00%	243.45%	104.80%	129.36%	66.27%	158.86%	150	6.3	16.6	22.9
SB - Jenny Lind Ward	713	702	357	549	356.5	357	356.5	460	98.39%	154.00%	100.00%	129.03%	116.92%	114.52%	98.92%	141.51%	211	5.0	4.8	9.8
SB - Mortimer Ward	1070	1070	713	1369	713	713	713	1242	100.00%	191.94%	100.00%	174.19%	136.77%	137.10%	100.00%	183.06%	567	3.1	4.6	7.7
WA - Oak House	713	690	357	440	356.5	357	356.5	356.5	96.77%	123.42%	100.00%	100.00%	105.66%	100.00%	97.85%	111.71%	190	5.5	4.2	9.7

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

Report to: Trust Board – 26th September 2018
Author: Marie Crofts, Director of Quality
Presented by: Marie Crofts, Director of Quality

SUBJECT: **Nursing Framework: A Call to Action**

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

EXECUTIVE SUMMARY

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

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

The senior nurses within the Trust are keen to have this framework for action signed off as they have put much effort into its development. An implementation plan will be developed to identify specific outcomes to be measured.

The framework has been reviewed at the Executive Committee and by the NEDs represented on the Development Committee.

All feedback has been taken into account to produce this final version.

RECCOMENDATIONS

The Board is asked to:

- Endorse the Nursing Framework / Strategy for 2018-2020

Corporate Considerations	
Quality implications	The Nursing strategy / framework is a key document for the nursing workforce as a whole to drive improvements at all levels. It is best practice for the nursing workforce to have a professional strategy to work to which replicates the national professional body of nursing
Resource implications:	No additional resource is necessary at the current time
Equalities implications:	This document applies to all service users and carers
Risk implications:	No risks identified.

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 Alison Curson, Deputy Director of Nursing Nursing Professional Advisory Group	Date	24th Sep 2018 August / Sept 2018 August 2018

Where in the Trust has this been discussed before?		
Executive Committee	Date	Sept 2018
Development Committee (by the NEDs)		Sept 2018

What consultation has there been?		
See above Nursing workforce	Date	Over last 12 months

Explanation of acronyms used:	

2gether
NHS Foundation Trust

NURSING FRAMEWORK FOR ACTION

2018-2020

www.2gether.nhs.uk/nursing

NURSING FRAMEWORK FOR ACTION
2018-2020

Introduction to our Nursing Strategy

Marie Crofts
Director of Nursing and Quality

It is my absolute pleasure and privilege to have led the development of this strategy for the nursing workforce across our services. It continues to inspire me that we have such as wonderful, committed and compassionate group of nurses who, at every level, want to support our service users and their families to achieve the best possible outcomes. I am extremely proud of our senior nurses, who have led the way with professionalism and dedication.

This strategy, for 2018-20, is the product of many nurses (both qualified and unqualified) throughout the organisation who have attended workshops and fed into the process. The end result has been developed from what they feel as a highly skilled professional group they have achieved and what they will be focusing on in the next two years. As you can see much has been achieved.

This document has been guided, of course, by both the national and local context and more fundamentally by the 'Leading Change, Adding Value' framework (2016) developed by our Chief Nursing Officer for England, Professor Jane Cummings. We have used the 'Triple Aims' to highlight achievements and impact and look to drive further improvements, led by the nursing workforce alongside our multi-disciplinary colleagues.

There are huge positive changes over the next two years including our merger with GCS and the Integrated Care System developments. Nevertheless, the nursing workforce have been clear that they wished to publish a strategy for 2018-20 to enable them to focus on key deliverables whilst being keen to review this next year and continue to identify benefits of which improve the physical and mental health care of our local population.

Strong and compassionate leadership is key to setting the scene for future delivery of high quality care and within our nursing workforce we can indeed be sure the contribution will be enormous.

Well done!

NURSING
FRAMEWORK
FOR ACTION
2018-2020

Influencing and Achieving: A Call to Action

This locally developed nursing framework builds on the 'Leading change: Adding Value' framework produced by the Chief Nursing Officer for England. Using this as a model for improvement, the nursing workforce has identified key drivers and strategic aims which need a focus over the coming two years.

Alongside this, the proposed merger of [2]gether NHS Foundation Trust with Gloucestershire Care Service NHS Trust offers many further opportunities to improve outcomes for our service users and their families.

This 'Call to Action' focuses on opportunities for the nursing workforce to influence gaps and ensure by working in partnership with service users and their families we will continue to have a sustainable, highly skilled workforce fit for the future.

To achieve this, the workforce will need to:

- Develop nurse leaders for the future who are highly visible and compassionate
- Be key players across the Integrated Care System and lead system wide change to improve health outcomes
- Increase life expectancy of our service users ensuring access to health care and treatment consistent with the general population
- Drive Quality Improvements through embedding QI methodology at all levels
- Develop and embed digital solutions to care improvements
- Develop the workforce creating new innovative roles and opportunities at all levels for a sustainable future

The following pages of this framework describe more detailed actions to achieve the above.

NURSING FRAMEWORK FOR ACTION
2018-2020

OUR 10 COMMITMENTS

Commitments 2017/18	Health & Wellbeing: *What have we achieved?*	Care & Quality: *What have we achieved?*	Funding & Efficiency: *What have we achieved?*	Looking forward: *What are we achieving during 2018/20 in ²gether.*
1. We will promote a culture where improving the population's health is a core component of the practice of all nursing, midwifery and care staff	✓ Introduction and embedding of the Lester tool for service users across both counties ✓ Pioneered and embedded the use of the Health Evaluation Framework within Learning Disability (LD) services ✓ Development and delivery of physical health awareness training (for those with LD) using a multi-agency approach within Herefordshire ✓ Development and implementation of physical health resource (nurse) within Wotton Lawn Hospital ✓ Introduction and embedding of Smokefree environments from April 2017 in Gloucestershire and January 2018 in Herefordshire ✓ Introduction of Physical health training days for clinicians (eg diabetes; wound care)	✓ Achievement of the CQUIN related to risky behaviour ✓ Achievement of the CQUIN related to improving physical health of service users with serious mental illness ✓ Achievement of health and wellbeing for staff CQUIN ✓ Working with schools to ensure early help for young people (pilot to now be rolled out across Gloucestershire) ✓ Implemented the Stay Alive App to support those service users in crisis and reduce suicides ✓ Embedding of 'Learning From Deaths' through being part of LeDeR reviews and whole health economy reviews	✓ Within Learning Disability we are establishing links and training with Primary Care to raise profile of Annual Health Check Health and screening for service users ✓ Increased physical health clinics using unqualified workforce including venepuncture ✓ Suicide Prevention Training and identifying risk factors for Gloucestershire GPs	• **Staff wellbeing: To promote the counselling service and fast access to mental health care for staff** • **Dementia services: to further roll out the pilot regarding Community Dementia Nurses (CDN) working in primary care** • **Learning Disability:** 1. **Embedding the Stopping Over Medication of People with a learning disability or autism or both (STOMP) programme within LD services across both counties** 2. **Embedding of mortality review process and learning** • **Working Age Adults: Continuation of the physical health work – including smoking cessation and obesity reduction work** • **Children and Young Peoples Services: Embedding of routine physical health checks**

OUR COMMITMENTS

Commitments 2017/18	Health & Wellbeing: *What have we achieved?*	Care & Quality: *What have we achieved?*	Funding & Efficiency: *What have we achieved?*	Looking forward: *What are we achieving during 2018/20 in ²gether.*
2. We will increase the visibility of nursing and midwifery leadership and input in prevention	✓ Director of Quality and Deputy Director engaged in external health prevention work and promoting health promotion within the organisation such as smoking cessation ✓ Undertaking board level patient safety visits ✓ Consultant nurses and lead nurses highly visible within the nursing workforce ✓ Delivery of locality CPD days for nurses ✓ Introduction and embedding of supervision protocol and matrix	✓ Inspiring Innovation events held through the year ✓ Lead nurse role modelling behaviours (eg attendance at CYPS Safeguarding supervision and team meetings) ✓ Director of Quality undertaking regular clinical shifts and attending practice meetings	✓ Highly trained nurse leaders in Quality Improvement methodology at all levels such as QSIR; Q fellows; ✓ Development of key cross agency programmes of QI such as dementia	• **Ensure all senior nurses are highly visible and accessible and role model high standards of professionalism at all times** • **Continued roll out of CPD events with senior nurse input** • **Photographs of staff to be included in emails to ensure all colleagues are aware of key members of the nursing workforce and promote accessibility** • **Development of mental health nurses Twitter account for ²gether** • **Embedding QI into all we do linked to the Quality Strategy and Quality indictors** • **Ensuring appropriate representation across STP areas and input into developing** • **Input to Herefordshire Learning Disability Strategy**
3. We will work with individuals, families and communities to equip them to make informed choices and manage their own health	✓ Raising the profile of 'Making Every Contact Count ' training (MECC) to influence behaviour and health choices ✓ Embedding of the 'Triangle of care' ✓ Implementation of Advanced Care Directives across adult and older peoples services ✓ Improving access to Annual Health checks ✓ Big Health Check Days involving multiple agencies and community groups to help keep well	✓ Continued involvement in LD Partnership Board ✓ Co-production of care plans and involving service users in their care and treatment ✓ Embedding the LESTER tool across services to improve the physical health of our service users ✓ Dementia pilots in the South to enhance service provision with primary care ✓ Development and implementation of the Stay Alive App	✓ Nurse pilot within GP practices in Gloucester ✓ Nurse practitioners encouraging service users to attend GL1 project to enhance their physical activity	• **Continue and build on advanced care directives/ planning** • **Improving offer to carers within inpatient settings for for example carers group within Charlton Lane** • **Ensuring all our information is accessible through 'Easy Read' care pathways and care plans** • **Developing links with faith communities to support Children and Young People** • **Development of new roles such as Advanced Clinical Practitioners and Nursing Associates which will focus on improving physical health of service users and their families** • **Continue work on smoking cessation to enable people to have the necessary support they need to quit - e.g. e-cigarette pilot at WottonLawn Hospital**

OUR COMMITMENTS

Commitments 2017/18	Health & Wellbeing: *What have we achieved?*	Care & Quality: *What have we achieved?*	Funding & Efficiency: *What have we achieved?*	Looking forward: *What are we achieving during 2018/20 in ²gether.*
4. We will be centred on individuals experiencing high value care	✓ Working with service users and clinicians to co-produce care plans; including crisis contingency plans ✓ Development of a 'Street Triage' pilot with the police ensuring people can access mental health assessments when in crisis	✓ Working with experts by experience within LD Gloucestershire and Herefordshire to deliver quality checks ✓ Encouraging feedback from service users through national patient survey and Friends and Family Test (FFT) ✓ All the young people who are offered an intervention in CYPS have a personalised care plan ✓ Development of activity coordinators at Charlton Lane Hospital to improve care for older people with dementia ✓ Development and embedding least restrictive interventions programme and rapid tranquilisation approach	✓ Development of CLDT one care pathway work in order that individuals receive the same high standard of evidenced based care wherever they live	• **Participating in NHSE Always Event to enhance co co-production of care plans in a systematic and consistent way** • **Continued work to develop authentic co-produced care and treatment plans with service users** • **Continuing with physical health improvement work** • **Review of risk assessment and management using best practice to update policy and practice** • **Continued involvement in South of England QI collaborative to ensure we focus on best practice** • **Involvement in national 'Restrictive Interventions' programme** • **Ensuring quality indicators are driven by what improvements in care are locally needed**
5. We will work in partnership with individuals, their families, carers and others important to them	✓ Embedding of the Triangle of Care across services to hear the voice of families and carers ✓ Effective engagement of young people through the participation groups within CYPS	✓ Parents-carers attendance at CPA reviews, multi-agency meetings, parenting courses, Family therapy and DBT skills parenting sessions within CYPS ✓ Delivery of epilepsy clinics using a bespoke approach for people with Learning Disability and their families	✓ Person centred approach though the implementation of GP pilot in Gloucester - access to immediate secondary care resources where appropriate	• **Encouraging service users and families to be actively involved in designing and development of new services and buildings** • **Building on team feedback and encouraging active learning from this and improvement of services locally** • **Further embedding and testing of the Triangle of Care to ensure this approach becomes routine** • **Develop and progress work around parental mental health and the importance of listening to young carers (e.g. alongside Gloucestershire Young Carers)**

OUR COMMITMENTS

Commitments 2017/18	Health & Wellbeing: *What have we achieved?*	Care & Quality: *What have we achieved?*	Funding & Efficiency: *What have we achieved?*	Looking forward: *What are we achieving during 2018/20 in [2]gether.*
	✓ Training and development (with Hundred Families charity) of family liaison officers to work with families following serious incidents ✓ Development and delivery of family PBM training to give families the skills to support their loved ones	✓ Use of evidenced based family interventions approaches within Early Intervention services routinely ✓ Delivery of Parental Mental Health workshops to encourage clinicians to see the 'whole family'		• **Further developing the role of the family liaison officer and working closely with charities to support this work**
6. We will actively respond to what matters most to our staff and colleagues	✓ Delivery of several good practice and celebration events ✓ Development of a clear supervision policy and protocol ✓ Delivery of Care and Compassion events promoting resilience for staff including 'Glimpse of Brilliance' approach ✓ Access to 'Speak in Confidence' system ✓ High visible presence of lead and consultant nurses supporting staff in all areas ✓ Delivery of Health and Wellbeing CQUIN	✓ Ensuring supportive revalidation of all nurses ✓ Ensuring access to training and development – ensuring skills and knowledge are relevant for emerging local health priorities ✓ Delivery of events for nurses including acknowledgment of 'International Nurses Day'	✓ Keeping people well (staff and service users) through access to flu vaccination programme	• **Using NQB safe staffing guidance review all teams in line with these principles** • **Delivery of further training and update days for nurses** • **Develop and sponsor nurses to enhance skills through the Advanced Clinical Practitioner programme** • **Ensure qualified Nursing Associates have access to a career pathway** • **Continue to work with University of Gloucestershire to deliver a sustainable qualified RMN workforce for the future** • **Build on apprenticeship programmes for nurses**

OUR COMMITMENTS

Commitments 2017/18	Health & Wellbeing: *What have we achieved?*	Care & Quality: *What have we achieved?*	Funding & Efficiency: *What have we achieved?*	Looking forward: *What are we achieving during 2018/20 in ²gether.*
7. We will lead and drive research to evidence the impact of what we do	✓ Publishing within key journals related to mental health practice and innovation ✓ Senior nurses supported to undertake research and achieve PhDs ✓ Input into developing Fritchie Research Centre ✓ Development of 'red folders' for patients with Dementia to enhance their care pathway	✓ Development of Loft House Suite (CLH) and associated research article ✓ Positive and safe work – reducing restrictive interventions ✓ Publication of Randomised Control Trial (RCT) searching within inpatient units	✓ Embedding MECC to ensure meaningful contact with service users with regard physical health improvements ✓ Development and embedding of the 5 step approach for Dementia	• **Supporting the nursing workforce to participate in service evaluation / research and writing for publication** • **Embedding use of evidence based practice such as family interventions** • **'Dogs for good' pilot at Charlton Lane Hospital and Tewkesbury community team** • **Dementia care mapping** • **STOMP clinic evaluation** • **Involving mental health student nurses in research debates and practice**
8. We will have the right education, training and development to enhance our skills, knowledge and understanding	✓ Delivery of a programme of CPD for nurses ✓ Individual speciality away days ✓ Participated in the national RePAIR programme – identifying reasons for high levels of attrition post qualifying ✓ Commitment to student nurse whilst on placement and sponsoring others whilst training in both counties ✓ In-house training for all CYPS and CAMHS clinicians provided on a rolling programme	✓ Embedding Care Certificate for new HCAs ✓ Access to opportunities for nurses to develop through training ✓ Focussed QI opportunities for nurses – QSIR; Q Fellows; South of England Collaborative ✓ Access for Nurses to develop skills re: AMHP training and non-medical prescribing ✓ Development of the newly validated BSc in mental health nursing at the local higher education institutions (HEIs)	✓ National contribution to LD recruitment ✓ Nursing associate programme ✓ Apprenticeships ✓ Succession planning ✓ Adult student nurses – UoG pilot with Care Home Support Team – CLIP model and increase capacity for mentors	• **Continued support and collaboration with the University of Gloucestershire and embedding of the locally developed BSc in mental health nursing to sustain nurses for the future** • **Develop Advanced Clinical Practitioner roles to offer a career pathway** • **Expanding capacity to ensure RN (adult) student nurses develop skills in mental health** • **Develop a competency framework and 'offer' for all nurses at each level regarding skills and knowledge and opportunities for development** • **Embed Trainee Nursing Associate opportunities for unqualified nursing workforce** • **Developing nurses with leadership skills** • **Continuing and embedding of Quality Improvement skills across the nursing workforce**

OUR COMMITMENTS

Commitments 2017/18	Health & Wellbeing: *What have we achieved?*	Care & Quality: *What have we achieved?*	Funding & Efficiency: *What have we achieved?*	Looking forward: *What are we achieving during 2018/20 in ²gether.*
9. We will have the right staff in the right places at the right time	✓ Delivery of NHS Improvement national programmes – e-rostering and observation and engagement ✓ Development of newly validated BSc in MH Nursing at University of Gloucestershire ✓ Development of the Trainee Nursing Associate programme with local HEI's in both Counties ✓ Ensuring a resilience workforce which is valued through a number of initiatives including 'Care and Compassion' events ✓ Shared best practice through the South of England Qi collaborative	✓ Continuing to ensure safe staffing requirements are met on all wards as per National Quality Board guidance and reported to Board ✓ Development of a Quality Dashboard for inpatient areas to triangulate information and use locally within hospital sites ✓ Specific nursing clinical pathway development within CYPS ✓ Development of the pilot Street Triage nurse led service ✓ Increase in MH Liaison response to ensure timely assessment ✓ Increase in nursing workforce within MHARs and development of age-appropriate training for nursing staff	✓ Full implementation of e-rostering ✓ Reduction in reliance on agency nursing staff within inpatient units ✓ Participation in the NHSI national staff retention programme ✓ Sponsoring nursing students to complete their MH nurse training and ensuring a sustainable workforce following registration ✓ Encourage student nurses to complete shifts as HCAs in preparation for qualifying	• **Nurse-led reviews of all teams capacity and capability levels using the safe staffing in mental health National Quality Board guidance, ensuring best use of resources** • **Develop innovative ways to recruit and retain staff such as the '²gether offer' for staff at each band/level** • **Continuing to work alongside local HEI's to develop new roles within the nursing workforce such as Advanced Clinical Practitioner roles** • **Continuing to support nurses to undertake the non - medical prescriber courses and act as independent prescribers** • **Consideration of rotational and other posts for newly qualified nurses** • **Skill mix review on inpatient wards** • **Work locally and nationally to raise the profile of mental health nursing through campaigns such as the #MentalHealthNursing hashtag**

OUR COMMITMENTS

Commitments 2017/18	Health & Wellbeing: *What have we achieved?*	Care & Quality: *What have we achieved?*	Funding & Efficiency: *What have we achieved?*	Looking forward: *What are we achieving during 2018/20 in ²gether.*
10. We will champion the use of technology and informatics to improve practice, address unwarranted variations and enhance outcomes	✓ Improved reporting within LD services using the HEF on ✓ Annual Health Check status now available on RIO front screen ✓ Increased access to mobile working for staff in both counties ✓ Young people's co-production and ownership of their care plans through access to photographing their individual care plan on their mobile phone	✓ Specific inpatient programmes of work such as LD – use of iPads and RAG charts / updated hourly ✓ Involvement in national 'Reasonable Adjustment Flagging' project ✓ Evidence based care ✓ Academic Health Science Network - way of working with technology and monitoring physical health ✓ Embedding use of the Staying alive app ✓ Development of CYPS website and use of online resources and apps shared with young people and families	✓ Use of e-rostering and safe care within inpatient units ✓ Introduction of Digital Dictation ✓ Introduction and improved use of video conferencing	• **Promote a culture that enables staff to develop and learn electronic and digital solutions** • **Embrace technology and informatics to guide and improve care and self-management** • **Development of an electronic MAS referral tool** • **In line with national requirements seek to support the increased uptake and use of theSummary Care Record (additional information)** • **Support increased use of social media for the nursing workforce as a way of gaining better data- for example use of 'Hackathons'** • **Share best practice through the South of England Qi Collaborative and other networks**

Agenda item 13 **Enclosure No** **Paper H**

Report to: [2]gether Board Meeting – 26 September 2018
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 2017/18**

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 2017/18.

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	Date	21 September 2018

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 IPC (T) – Infection Prevention and Control (team) WEEB – Water, Environment, Equipment and Buildings group WVT – Wye Valley Trust MRSA – Meticillin Resistant Staphylococcus aureus MSSA – Meticillin Sensitive Staphylococcus aureus GRE – Glycopeptide Resistant Enterococci ATP - adenosine triphosphate PLACE – Patient Led Assessments of the Care Environment PCR – polymerase chain reaction (sensitive laboratory detection test)

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 2017/18 and comments on future working proposals.

2. OVERVIEW OF INFECTION CONTROL ACTIVITIES DURING 2017/18.

The full programme of infection prevention and control activities continued as usual during 2017/18. The influenza season during this year was particularly challenging with very high numbers of an influenza B strain not covered by the vaccine, as well as coinciding with the Norovirus season. This led to inpatient outbreaks of influenza and Norovirus needing to be managed by the ward with support from infection prevention and control despite achieving high vaccine uptake.

The audit programme was comprehensive but with some variable results particularly in Herefordshire. Further details are given in the section on audit.

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 remained 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. The specialised infection prevention and control teams (IPCTs) supporting the trust remained outsourced by contract to Wye Valley Trust for Herefordshire and Gloucestershire Care Services NHS Trust for Gloucestershire. With the merger of 2gether and Care Services these arrangements will be reviewed for the new emergent trust.

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, community workers and estates and facilities.

3.2 Reporting to the Trust Board

The 2016/17 annual infection control report was presented to the Governance committee in August 2017 and to main Board in September 2017. No additional reports on infection control risks or incidences have been required during the year 2017/18.

3.3 Infection Prevention and Control and Decontamination Meetings

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, and representatives from Hotel Services and Estates and Facilities. Other representatives such as service leads attend according to the agenda.

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. Focus Group and WEEB agendas overlap on common areas of Estates and Facilities

such as cleaning, catering, and waste disposal and these meetings are held during months when there is no ICC. The Focus Group is chaired by Louise Forrester and staff can bring any infection control issues to this group for discussion and resolution or escalation.

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.

4. HEALTHCARE ASSOCIATED INFECTIONS Level of Assurance: Significant

4.1 MRSA

During 2017/18 there were no MRSA bacteraemias reported against a tolerance level of zero (within tolerance therefore).

No MRSA acquisitions were reported: patients carrying MRSA on admission to inpatient units are detected from time to time but this has not lead to spread of MRSA.

MRSA admission screening is in place for higher risk patients in Charlton Lane and Stonebow wards (Cantilupe and Jenny Lind). An audit in Herefordshire showed poor compliance with MRSA admission screening (Cantilupe 50% and Jenny Lind 79%). The IPCT extended education to the wards and increased monitoring put in place. Re-audit at the end of quarter 4 of 2017/18 showed improved compliance of 100% and 85% for Cantilupe and Jenny Lind respectively. Further re-audit at the end of quarter 1 2018/19 showed an improvement to 100% compliance for Cantilupe and 93% for Jenny Lind.

4.2 Clostridium difficile

No cases of toxin positive C. difficile infection were detected during 2017/18.
A case of C. difficile carriage was detected (PCR positive/EIA negative) from a patient transferred to Herefordshire county hospital. The patient was discharged back to Mortimer ward well. This case is not reportable to the mandatory reporting scheme.

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

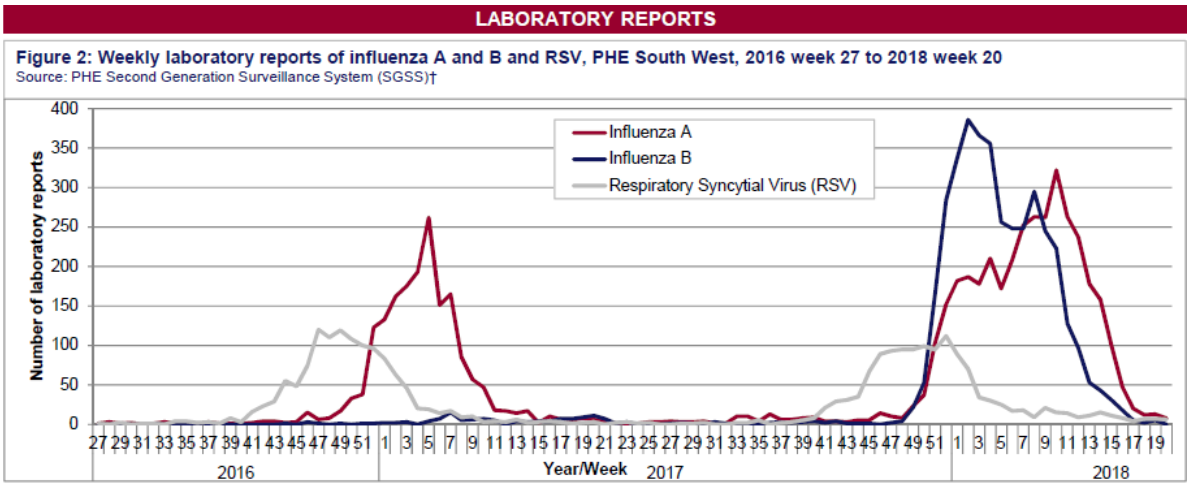
There were no reported GRE or E. coli bacteraemias from Gloucestershire or Herefordshire.

One case of MSSA bacteraemia was reported. This patient had developed foot wounds due to a tendency to drag their feet along the floor whilst choosing to use a wheelchair. Wound care was challenging due to patient reluctance to engage with the treatment plan. Antibiotic treatment was given in Herefordshire county hospital and the patient discharged to their own home. A review meeting was held on the 19th July at the Stonebow Unit. Apart from stopping the patient from using the wheelchair, the treatment and care was appropriate however the issue of training and competence for wound care was raised.

4.4 Outbreaks and Incidents

4.4.1 Influenza

The influenza season of 2017/18 started in December 17 and was a significantly more severe season, particularly for influenza B. The strain of influenza B that caused most of the outbreak was not covered by the vaccine (see PHE data below). Therefore despite good vaccine uptake amongst staff of 76% (3rd highest mental health trust), there were ward outbreaks related to influenza.



In Gloucestershire there were outbreaks on Dean, Priory and Willow wards all during February 2018.

i) On Dean ward an outbreak of both influenza B and Norovirus was detected. 6 patients and 5 staff were diagnosed with influenza B whereas 4 patients and 3 staff suffered from Norovirus. The unit was closed for 21 days with 15 bed days lost.
ii) On Priory ward a 7 day outbreak affected 10 patients but no staff. Influenza B was detected but no bed days were lost as the unit remained full.
iii) On Willow ward 7 cases of influenza B were detected but since the patients remained in their rooms the unit was not closed and no bed days lost.

Total: 23 patients and 5 staff with Influenza B. 15 bed days lost (also due to Norovirus).

In Herefordshire 3 individual patients were diagnosed with influenza but there were no outbreaks.

Learning from the 2017/18 season included consideration of who to 'fit test' for FFP3 masks used with close care of an infected patient. Pre-emptive training will take place before the 2018/19 influenza season.
The forthcoming season is not expected to be as severe, partly due to circulating strains, and partly due to quadrivalent vaccine being recommended for staff and patients at risk and adjuvated vaccine recommended for elderly patients with poorer vaccine response. Vaccine uptake however still needs to be high to protect both staff and patients (target over 75%).

4.4.2 Viral Gastroenteritis outbreaks

There were a total of 3 outbreaks of diarrhoeal illness during 2017/18, 2 in Gloucestershire and 1 in Herefordshire (apart from the joint influenza/Norovirus outbreak on Dean as above):

i) At Berkeley House in January 2018 4 patients and 6 staff were affected over 10 days with a diarrhoeal illness (no proven organism). Since the unit was full no bed days were lost.
ii) On Mulberry ward, Charlton Lane 4 patients and 4 staff were affected over 9 days with Norovirus. 5 bed days were lost.
iii) On Mortimer ward, Stonebow 4 patients and 2 staff were affected with Norovirus. 4 bed days were lost.

Other individuals were detected with diarrhoea and vomiting but not leading to ward outbreaks. In all cases the viral gastroenteritis policy was implemented.

Combining all outbreaks fewer bed days were lost than last year despite a similar number of patients and staff affected.

HOSPITAL / UNIT	BED DAYS LOST	PATIENTS AFFECTED	STAFF AFFECTED
Total 2017/18	**24**	**35**	**17**
Total 2016/17	**75**	**30**	**20**
Total 2015/16	**3**	**10**	**9**
Total 2014/15	**24**	**28**	**32**

4.4.3 Other

During 2017/18, as usual the IPC teams visited the Gloucestershire and Herefordshire inpatient units on a regular basis with telephone support in between on the usual wide range of infection prevention and control topics as well as IPC related Estates issues such as IPC aspects of the refurbishment of Oak House and the Herefordshire 136 suite extension.

There was an assurance visit by trust representatives from Estates and Facilities as well as IPC, to the Central Laundry facility in Burton on Trent as set within the contract. The facility is compliant with HTM01-04 Decontamination of Linen for Health and Social Care, 2013.

5. AUDIT **Level of Assurance: Significant**

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.

5.1 Inpatient area audits: Gloucestershire

Location/Audit Scores	2013/14	2014/15	2015/16	2016/17	2017/18
Honeybourne	**93%**	**91%**	**96%**	**89%**	**92%**
Laurel House	**Deferred**	**90%**	**97%**	**95%**	**90%**
Hollybrook	**92%**	**86%**	**93%**	**97%**	
Berkeley House					**97%**
Berkeley House bungalow					**90%**
Abbey Ward, Wotton Lawn	**86%**	**91%**	**92%**	**90%**	**94%**
Dean Ward, Wotton Lawn	**85%**	**91%**	**93%**	**85%**	**90%**
Greyfriars, Wotton Lawn	**95%**	**97%**	**89%**	**90%**	**90%**
Kingsholm Ward, Wotton Lawn	**91%**	**85%**	**93%**	**89%**	**94%**
Priory Ward, Wotton Lawn	**88%**	**85%**	**95%**	**89%**	**93%**
Montpellier Ward, Wotton Lawn	**92%**	**92%**	**88%**	**82%**	**90%**
Maxwell 136 Suite	**84%**	**90%**	**89%**	**86%**	**82%**
Wotton Lawn Therapies (OT/Physio)	**OT: 86% Physio: 87%**	**For 2015/16**	**OT 88% Physio: 89%**	**89%**	**88%**
ECT	**96%**	**For 2015/16**	**97%**	**96%**	**97%**
Chestnut ward, Charlton Lane	**81%**	**88%**	**90%**	**91%**	**89%**
Mulberry ward, Charlton Lane	**85%**	**92%**	**93%**	**92%**	**92%**
Willow ward, Charlton Lane	**82%**	**86%**	**92%**	**90%**	**91%**

Location/Audit Scores	2013/14	2014/15	2015/16	2016/17	2017/18
Charlton Lane therapies (OT/Physio)			85%	92%	93%

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	2017/18
Pullman Place					94%
Acorn House				84%	87%
Avon House	80%		86%		81%
Brownhill Centre		74%	88%	85%	86%
Cirencester Memorial Centre		66%		79%	86%
Colliers Court				95%	
Evergreen House				87%	
Fritchie Centre				92%	
Leckhampton Lodge				73%	
Lexham Lodge					
Lexham Pavilion				58%	65%
Park House	64%		87%	85%	
Tyndale Centre			46%	70%	87%
Stanway centre				80%	78%
Weavers Croft	64%	97%	90%	90%	

Not all outpatient units are audited annually. Overall as auditing is embedded improved scores are seen, particularly in comparison to previous units that relocated to Pullman Place.

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

Location	Audit Frequency	2014/15	2015/16	2016/17	2017/18
Jenny Lind- Ward	Annual	76%	87%	74%, re-audit 94%	87%
Mortimer- Ward	Annual	84%	84%	91%	73%
Cantilupe - Ward	Annual	66%	87%	93%	86%
Day care	Annual	90%	88%	87%	70%
ECT	Annual		87%	98%	
Crisis team, Stonebow					57%
Oak House	Annual	84%	90%	86%	81%
27a St Owen Street	2 yearly		40%		51%

Rose Cottage	2 yearly		97%		
Etnam street	2 yearly		85%		50%
The Knoll	2 yearly		93%		46%
CAMHS	2 yearly		51%		40%
Belmont	2 yearly		95%		56%

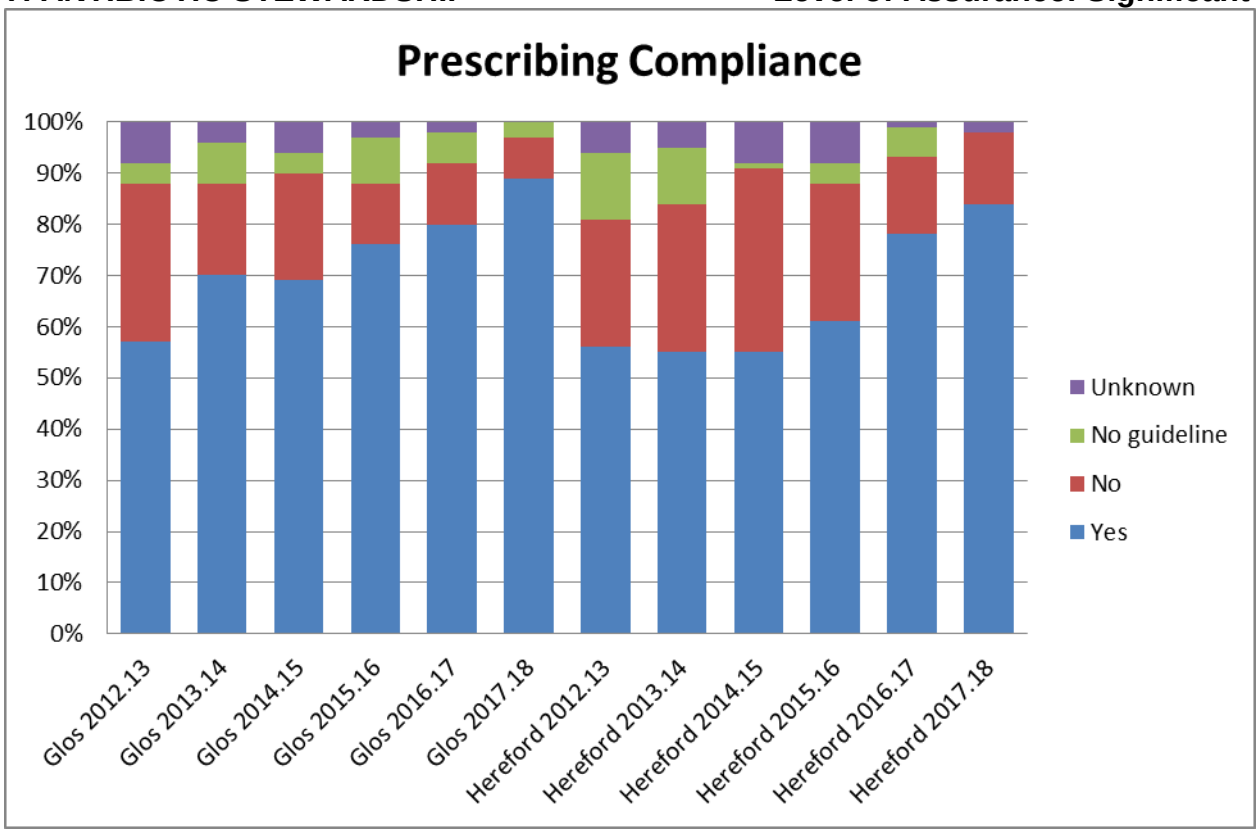
Cleanliness and tidiness were common themes that were fed back through the audit process. All areas are required to send back action plans in response to the audit findings and ensure all issues are resolved.

The annual mattress audit took place in January 2018. Compliance with standards was 97% (compared to 96% the previous year).

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 2017/18 the compliance for the 2 periods was 95% and 96% 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 prescriptions are reviewed by ward pharmacists who advise on use of antibiotics if the choice, dose or duration is not according to guidelines. Antibiotic guideline booklets have been distributed to junior

doctors and are available on line and provide prescribing advice for most common conditions however are currently in need of updating. The guidelines are based on the national Public Health England guidelines.

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.

8. INFECTION PREVENTION AND CONTROL EDUCATION Level of Assurance: Significant
Infection control education is delivered by both face to face training and by e-learning.
In March 18 the overall trust compliance was 85.3% for clinical staff and 94.6% for non-clinical staff. There were no significant differences between Gloucestershire and Herefordshire staff groups.

For inpatient ward staff data comparing 2017 and 2018 is given below:

Training Compliance figures	**May 17**	**March 18**
Wotton Lawn Hospital		
Ward	**Compliance**	
Abbey	100%	100%
Priory	77.3%	80.0%
Kingsholm	100%	84.2%
Greyfriars	97.2%	96.9%
Montpellier	89.5%	85.3%
Dean	90.5%	54.2%
Charlton Lane Hospital		
Ward	**Compliance**	
Willow	89.2%	71.0%
Mulberry	95.8%	75.0%
Chestnut	100%	90.9%
Recovery Inpatients		
Ward	**Compliance**	
Laurel House	92%	86.4%
Honeybourne	100%	94.7%
LD Inpatients		
Ward	**Compliance**	
Berkeley House	89.4%	90.7%
Stonebow Unit		
Ward	**Compliance**	
Jenny Lind	100%	100%
Mortimer	91.7%	75.0%
Cantilupe	91.3%	90.9%
Oak House	100%	96.7%

9. INFECTION CONTROL & ESTATES AND FACILITIES Level of Assurance: Significant

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 and Commerce

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. On the 1st July 2017 the catering and cleaning in Herefordshire, formerly managed by Sodexo, in Herefordshire was brought in-house, under a dedicated Herefordshire Facilities Manager and Deputy.

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. In the last 12 months the Estates and Facilities Department has started to set up a number of multidisciplinary subject specific 'safety groups'; in particular there is now a Water Safety Group, which meets twice a year attended by the Authorising Engineer Water and the DIPC.

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 Summer 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 to continue; however from Q3 there will be at £30k budget allocated to redecoration prioritised by the Matrons and Community Service Managers.

9.2 Performance

PLACE is now in its sixth year and the 2018 assessments took place between April and May this year. The aim of PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient care experience. The assessment looks at 6 domains: Cleanliness; Food and Hydration; Privacy, Dignity and Wellbeing; Condition, Appearance and Maintenance; Dementia; and Disability.

National results were analysed and released by NHS Digital on 16th August 2018. The Trust has achieved very positive results placing us above the UK national average for Mental Health and Learning Disability settings in all of the six domains for the first time since PLACE began in 2013.

On the following page table 9.2a displays our scores benchmarked against other NHS organisations:

Table 9.2a

Organisation Name	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability	Domain Average (Org Food and Ward Food
2GETHER NHS FOUNDATION TRUST	99.64%	94.60%	92.43%	98.37%	93.11%	99.20%	90.18%	91.19%	**94.65%**
GLOUCESTERSHIRE CARE SERVICES NHS TRUST	99.42%	90.38%	89.49%	91.52%	86.14%	94.98%	84.45%	88.22%	**90.60%**
WORCESTERSHIRE HEALTH AND CARE NHS TRUST	99.54%	94.49%	96.46%	92.89%	89.18%	93.15%	77.69%	87.32%	**90.23%**
WYE VALLEY NHS TRUST	93.40%	90.32%	91.72%	89.89%	76.50%	90.28%	75.27%	78.13%	**83.98%**
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	98.91%	84.44%	79.15%	86.40%	79.03%	93.84%	71.21%	81.32%	**84.79%**
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	96.71%	83.79%	79.40%	84.79%	72.08%	89.55%	69.21%	69.29%	**80.11%**

We achieved a higher average domain score when benchmarked against our local healthcare partners in Gloucestershire, Herefordshire and Worcestershire.

Of the six domains the Trust has improved on last year with some significant gains in Cleanliness and Food particularly at Stonebow and Oak House. In addition, Oak House made almost a 19% gain on last year's Condition, Appearance and Maintenance score.

The tartan rug (table 9.2b) below scores sites against the 2018 national benchmarks (green if the trust is at or above the score for the upper quartile and amber if the trust scores between the and the upper quartile and the national average, red if the trust scores below the national average for 2018:

Table 9.2b

Site Code	PLACE Site Type	Cleanliness		Food		Privacy, Dignity and Wellbeing		Condition, Appearance & Maintenance	
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%
		2018	99.94%	2018	95.04%	2018	93.75%	2018	99.88%
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%
		2018	100.00%	2018	96.55%	2018	94.53%	2018	99.84%
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%
		2018	100.00%	2018	94.34%	2018	94.53%	2018	99.64%
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%	2017	100.00%
		2018	99.13%	2018	94.89%	2018	94.53%	2018	99.59%
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%
		2018	98.62%	2018	91.93%	2018	89.49%	2018	97.59%
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%
		2018	100.00%	2018	n/a	2018	90.32%	2018	96.88%
BERKELEY HOUSE	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%
		2018	100.00%	2018	94.66%	2018	100.00%	2018	99.45%

The national average score for Cleanliness in Mental Health and Learning Disabilities is 98.4%. The Trust's overall score this year is 99.64% which is over 1% higher than the national average and an increase on last year's score of 97.21%. All sites scored above the national average which is an excellent achievement. In addition, Berkeley House, Charlton Lane, Laurel House and Oak House all scored 100%.

There were poor cleaning results for Stonebow last year with a drop in over 10% compared to the previous year. However this year there was an increase of almost 9% on 2017's score placing Stonebow above the national average. It was anticipated that this would be the case now that 2gether has control and influence over schedules, frequencies and standards following the TUPE of all Sodexo staff into an in-house service. There were poor cleaning results for Oak House last year with a score of 79.87%, however this year Oak House scored a resounding 100% which is a remarkable achievement. On a site by site basis, four 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 99.64%, a 2.4% increase on last year's 97.21%.

Window cleaning continues to be an issue for the Trust and was highlighted as a cleanliness concern on several sites. There is a clear need for a Trustwide window cleaning contract however this is currently not funded by the Trust.

The Condition, Appearance and Maintenance score has been poor at Oak House for the past 5 years however this year they scored 96.88% which is their highest score since PLACE began in 2013 and represents an increase of nearly 19% on last year's score.
Disability is a relatively new domain added 2 years ago in 2016. Overall as a Trust [2]gether scored well achieving 91.19% which still remains above the national average but represents a drop in just over 4% on last year.

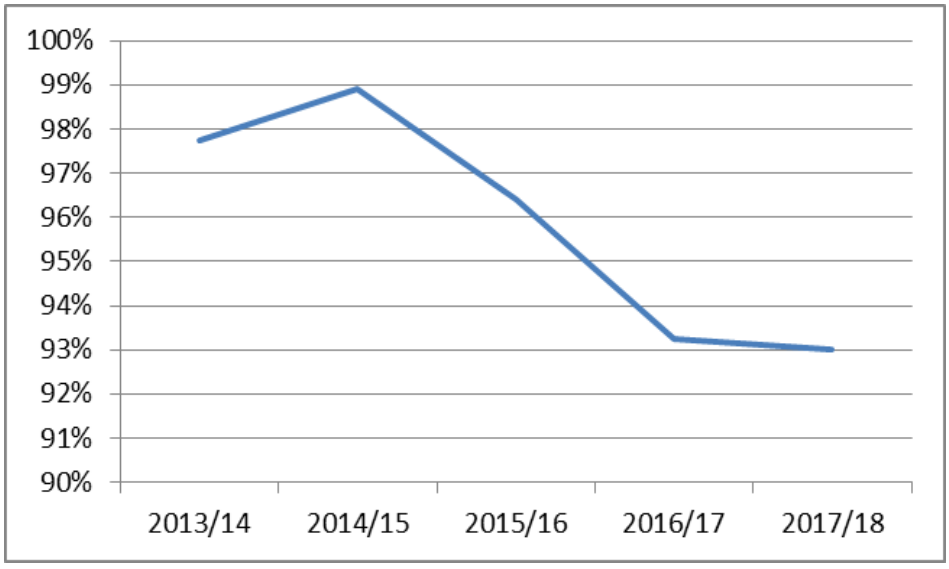
9.3 Catering and Cleaning
In the last 12 months we have had a new Facilities Manager in post in Herefordshire who has led the successful transfer and implementation of catering and cleaning services across the county.

The Facilities department has updated the cleaning policy and the food hygiene and safety policy this year and has commented on the Linen & Laundry Policy.

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 a result of a successful trial at Charlton Lane the Infection Control Committee agreed to the roll out of a flat-mopping microfibre system on site. This new system will be implemented once agreement on costs of equipment have been finalised with the preferred supplier.

Cleaning and swabbing audits continue to take place on a monthly basis.

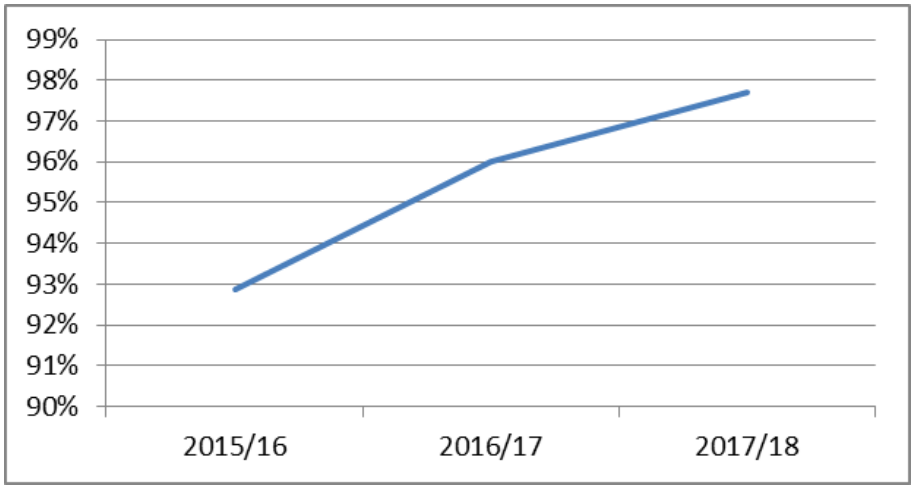
Trust Annual Cleanliness audit scores in Herefordshire:



For 4 years the Trust believed that Sodexo were providding accurate cleaning audit scores yet upon closer scrutiny it was revealed that the correct processes weren't being adhered to and their high scores didn't reflect our concerns with cleanliness issues identified in the environment. When the Trust took the service back in house we commenced our own cleaning audits and believe that the 93% scored this year is a more accurate reflection of where we are but anticipate a higher score next year.

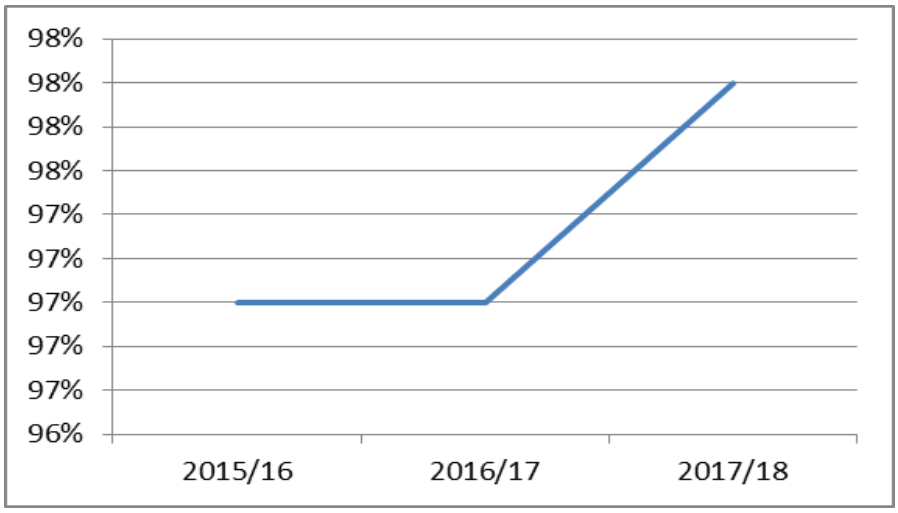
Trust Annual Cleaning audit scores for Gloucestershire are as follows:

Charlton Lane:



Charlton Lane has improved year on year since 2015/2016.

Wotton Lawn:



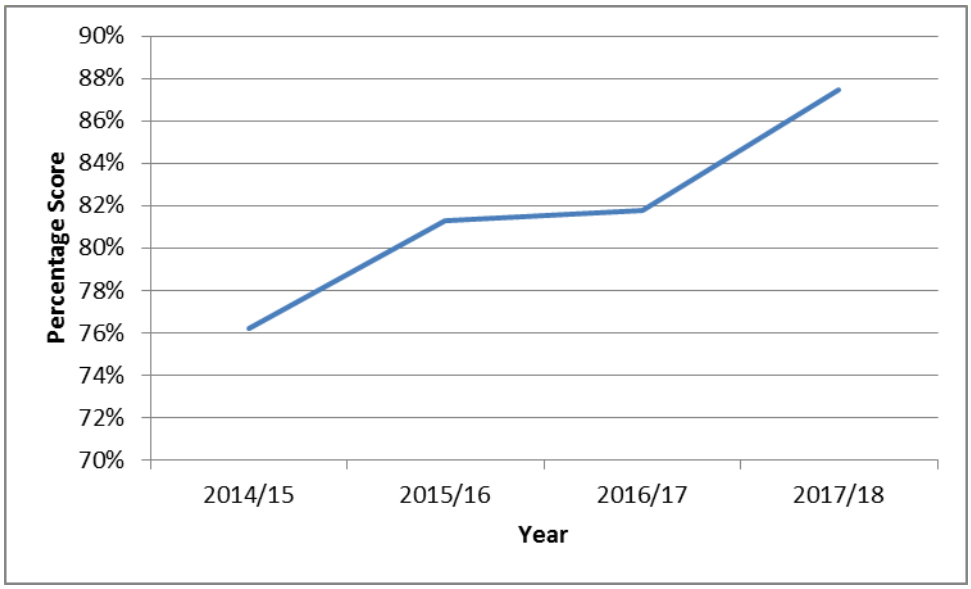
Wotton Lawn sustained their high level of 97% in 2015/16 to 2016/17 and increased to 98% this year.

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 87% in Q1 to 90.45% in Q4 has been observed.

The data below includes both the environment and patient equipment for all inpatient sites.

Trust Annual Pass Scores for ATP Swabbing



Food Hygiene

The Trust have recently engaged in conversations with GCS Facilities colleagues regarding the re-introduction of external annual catering audits of our food premises as Safegard chose to discontinue this service last year. Following negotiations in September this is expected to commence during Q3 this year.

Apart from Brownhills, 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 is the fact that Oak House retained their '5' despite the EHO visiting during a kitchen refurbishment.

[2]gether NHS FT Food Hygiene Ratings as at 6th September 2018

Site	Address	Latest Food Hygiene Rating	Date Of last Inspection	Inspection Risk Category	Inspection Frequency
Berkeley House	Berkeley Close, Cashes Green, Stroud GL5 2JG	5	06/09/2018	E	Every 3 Years
Wotton Lawn Hospital	Mayhill Way, Gloucester GL1 3WL	5	11/07/2018	D	Every 2 Years
Laurel House	121 Swindon Road, Cheltenham, GL51 9EZ	5	09/02/2018	D	Every 2 Years
Oak House	45 Barton Road, Hereford HR4 0AY	5 (AES)*	05/02/2018	E	Every 3 Years

Charlton Lane Hospital	Charlton Lane, Leckhampton, Cheltenham GL53 9DZ	5	23/10/2017	D	Every 2 Years
Stonebow Unit	Stonebow Road, Hereford HR1 2BN	5	26/07/2017		
Honeybourne	121 Swindon Road, Cheltenham GL51 9EZ	5	16/06/2017	C	Every 18 Months
Brownhills Centre	121 Swindon Road, Cheltenham GL51 9EZ	5	02/11/2016	D	Every 2 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, Lorne Stewart and NHS PS have achieved 100% compliance on Statutory and Mandatory maintenance throughout 2017/18.

9.5 Building Improvements

During 2017/18 the Trust's spent £4,484,000 of its Capital Programme on the Trust Estate, which is a £2.7m reduction on the previous year, but broadly in line with 2015/16. The Programme areas of expenditure are outlined in the following table:

Programme	**2017/18 Spend on the Estate**
Gloucestershire Major Capital (Pullman Place)	£3,791,000
Herefordshire Major Capital (136 suite and Stonebow Dining Room)	£160,000
Minor Capital Improvements (CLC flooring, Dishwashers, WL family room & thymatron)	£160,000
Fire Precautions (Trust wide fire compartmentation survey)	£55,000

Health and Safety	£68,000
Security	£11,000
Patient Safety (anti lig, greyfriars flooring, abbey clinic, WL specialist beds)	£167,000
Estate Infrastructure (Montpellier roof, Berkley boiler & WL entrance water leak)	£72,000
Total	**£4,484,000**

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.

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 completed in early 2018	
	

9.6 Water Management

The Trust's independent Authorising Engineer for water management undertook audits of the water management systems during August 2017 and March 2018.

The Trust has monitored the 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. As a consequence the chlorine dioxide plant has been turned off and removed; as it made no contribution to water quality.

A new flushing record has been developed and launched. 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; 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.

Over the last 12 months a Water Safety Group has been established and has met twice, to reflect changes in the water safety HTM 04 and ACOP L8. The Water Safety policy is currently being reviewed to reflect these changes and accompany procedures are being reviewed and new procedures being written.

CONCLUSIONS

[2]gether NHS Foundation Trust continues to control the risk of healthcare associated infections, and the risk of acquisition for patients, staff and visitors remains low. The trust also maintains good antibiotic stewardship. This report 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
12th September 2018

Agenda item 14 **Enclosure Paper I**

Report to: Trust Board, 26 September 2018
Author: Dr Amjad Uppal, Medical Director and Paul Ryder, Patient Safety Manager
Presented by: Dr Amjad Uppal, Medical Director

SUBJECT: **Learning from Deaths Report**

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

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

EXECUTIVE SUMMARY

The data presented represents those available for the period April to June 2018 (Q1 2018/19).

18 deaths have been closed without further review due to being referred into services, assessed and either not offered a service following assessment, or declined the service offered. A further 68 deaths have been closed without further review due to being open to solely ACI-Monitoring caseloads. Additional processing of those deaths remaining open will increase both of these figures.

No deaths have raised a cause for concern either within 2gether or with partner organisations during Q1 2018/19.

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

RECOMMENDATIONS

The Board is asked to note the contents of this Mortality Review Report which covers Quarter 1 of 2018/19.

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

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

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

Reviewed by:		
Dr Amjad Uppal	Date	20 September 2018

Where in the Trust has this been discussed before?		
Mortality Review Committee (MoReC) *Sadly, this committee was postponed due to illness*	Date	20 July 2018

What consultation has there been?		
	Date	

Explanation of acronyms used:	

1. INTRODUCTION

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

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

1.3 Since Quarter 3 2017/18, the Trust Board has received a quarterly (or as prescribed nationally) dashboard report to a public meeting, following the format of Appendix D, including:

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

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

1.5 This paper offers the subsequent iteration of data for the period April to June 2018.

2. PROCESS

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

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

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

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

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

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

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

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

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

Category 1: "not due to problems in care"

Category 2: "possibly due to problems in care within [2]gether"

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

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

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

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

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

3. DATA

3.1 The data presented below represents those available for the period April to June 2018.

3.2 18 deaths have been closed without further review due to being referred into services, assessed and either not offered a service following assessment, or declined the service offered. A further 68 deaths have been closed without further review due to being open to solely ACI-Monitoring caseloads. Additional processing of those deaths remaining open will increase both of these figures.

3.3 No deaths have raised a cause for concern either within 2gether or with partner organisations during Q1 2018/19.

4. CONCLUSION

4.1 This, the Q1 report for 2018/19 of mortality review data under the Learning from Deaths policy, is limited following the unexpected departure from the Patient Safety Team of the Mortality Review Administrator. This has caused additional delays in appropriately processing Datix incident reports and in obtaining basic cause of death information from GP surgeries, local partner NHS providers' PALS offices and the Coroner's Office.

4.2 Recruitment to the Administrator post is currently held whilst the Learning from Deaths Policy is reviewed and revised during its annual review cycle. In the interim, a Bank B4 Administrator has been identified and will provide some support to the Patient Safety Team until a more permanent solution is identified, beginning 24 September 2018.

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

4.4 The learning derived from Q1 2018/19 is limited to Serious Incidents. MoReC meetings has not produced significant learning during Q1 2018/19. April, May and June deaths recorded within Datix have been partially processed. The Datix Mortality Review Dashboard indicates there are 91 deaths yet to be processed for this period. The Dashboard configuration does need to be revisited and this work is awaiting the attention of the Datix System Manager.

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

- SI-01-19
- SI-02-19
- SI-03-19
- SI-04-19
- SI-05-19
- SI-06-19
- SI-07-19 and
- SI-08-19

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

Financial Year 2018-2019

June MoReC Data

Closed Mortality Reviews

Month	Closed ACI Caseload Deaths	Closed Following Table-Top Review Only			Closed Following Care Record Review			Closed Following Serious Incident Review			Total	Quarterly Total	Unable to Review	
		Category 1: Not Due to Problems in Care	Category 2: Possibly Due to Problems in Care within 2gether	Category 3: Possibly Due to Problems in Care Within an External Organisation	Category 1: Not Due to Problems in Care	Category 2: Possibly Due to Problems in Care within 2gether	Category 3: Possibly Due to Problems in Care Within an External Organisation	Category 1: Not Due to Problems in Care	Category 2: Possibly Due to Problems in Care within 2gether	Category 3: Possibly Due to Problems in Care Within an External Organisation				
Apr-18	28	0	0	0	2	0	0	3	0	0	33			0
May-18	24	0	0	0	0	0	0	3	0	0	27	77	0	0
Jun-18	16	0	0	0	1	0	0	0	0	0	17			0
Jul-18											0			
Aug-18											0	0	0	
Sep-18											0			
Oct-18											0			
Nov-18											0	0	0	
Dec-18											0			
Jan-19											0			
Feb-19											0	0	0	
Mar-19											0			
	68	0	0	0	3	0	0	6	0	0	77			

Open Mortality Reviews

Month	Awaiting Information to Complete Table-Top Review	Awaiting Table Top Review	Awaiting Care Record Review (MoReC)	Awaiting Clinical Review (SI's)	Total	Quarterly Total
Apr-18	0	36	1	0	37	
May-18	0	33	0	2	35	96
Jun-18	0	23	1	0	24	
Jul-18	0	16	0	0	16	
Aug-18					0	16
Sep-18					0	
Oct-18					0	
Nov-18					0	0
Dec-18					0	
Jan-19					0	
Feb-19					0	0
Mar-19					0	
	0	108	2	2	112	

Agenda item 15 **Enclosure Paper J**

Report to: Trust Board, 26th September 2018
Author: Dr E Abbey, Consultant Psychiatrist, Medical Appraisal Committee Member & Dr A Uppal, Medical Director
Presented by: Dr A Uppal, 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 2018 demonstrate that at that time 88.6% of Doctors had a currently valid appraisal. 10.1% non-compliant are explained by exclusion criteria such as being a new starter or long term sick leave. There are 1.3% (equivalent to 1 doctor) who at that point were classified as being non-compliant; this 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 Amjad Uppal	Date	

Where in the Trust has this been discussed before?		
Medical Appraisal Committee	Date	25th April 2018
Governance Committee	Date	31st August 2018

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 2017 – 31st March 2018**
Author:	**Dr Emma Abbey** ***On behalf of Medical Appraisal Committee***
Prepared for:	**Trust Board via Trust Governance Committee**

1. Executive summary

Of the 79 doctors requiring appraisal during the last year 70 (88.6 %) were compliant as at 1st April 2018; this is very close to the high rate of compliance achieved in the previous year (90.9% end of 2017); and represents a sustained improvement (75% end of 2014, 89.5% end of 2015, 90.9% end of 2016).

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, scoring at least 5 out of 6 (equating to 'Excellence') in all core standards. No required actions were recommended and many areas of good practice noted. Verification Visits are expected on a 5-yr cycle. Each year a quality assurance audit of appraisal outputs is conducted; to date this has demonstrated year-on-year improvement in quality, providing significant validation and assurance to 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 maintain 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; this includes a year-end away half-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 Terms of Reference of the Medical Appraisal Committee, with wording amended to reflect that the Gloucestershire MSC and Hereford Division are involved in appointments to the MAC, and to remove the reference to members' locality and specialty.
- Review and update of the medical appraisal policy, with tighter RO scrutiny of appraisees who withhold consent for their appraisal outputs to be audited for quality assurance
- Further refinement of the user-friendly guide for completion of appraisal portfolios (including how to obtain data, and what supporting information to include)

- Development, printing and circulation 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 the aim of 3 year terms
- Completion of the annual quality assurance audit and further improvement in systems for disseminating learning from this
- Continued review of the currently active list and consideration of how the gender ratios can be improved
- 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 and ongoing 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 ease and transparency 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 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 (held back by continuing 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 79 doctors requiring appraisal during the last year 70 (88.6 %) were compliant as at 1st April 2018; this is very close to the high rate of compliance achieved in the previous year (90.9% end of 2017); and represents a sustained improvement (75% end of 2014, 89.5% end of 2015, 90.9% end of 2016).

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 22 trained medical appraisers within the establishment of non-training grade doctors, compared with 21 in the previous year. There had been an intentional reduction in 2015-16, with a significant number of appraisers removed from the list due to not meeting the minimum requirements for appraisals conducted each 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 merger with GCS will bringan additional 12 doctors into the Trust workforce. These doctors currently receive appraisal via an external source who has a contract to undertake all of their appraisals. The committee anticipate that over the next 3 years

these doctors will transition over to using the current 2gether appraisal system. This will increase the requirement for appraisers within the Trust.

The MAC have set minimum numbers of completed appraisals required in a 2 year period by an appraiser. These standards were introduced in October 2014 and enforced at the end of the first 2 year cycle in Oct 2016; 8 appraisers were then removed from the active list. Appraisers have also 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.

During this appraisal year the committee has considered the ratio of female to male appraisers within the Trust. The gender ratio of appraisers was calculated compared to the body of medical staff within 2gether. The committee were advised of the following figures:

2g No of Doctors	Total	Male	Female	Female:male ratio 1:1.6
	79	49	30	
	100%	62%	38%	
2g No of Appraisers	Total	Male	Female	Female:male ratio 1:2.7
	22	16	6	
	100%	72.5%	27.5%	

The proportion of female appraisers is already lower than the proportion of female doctors in 2gether; moreover the majority of female medics are part-time. Previously the committee agreed that the minimum numbers of appraisals done every 2 year period and the update training requirements for appraisers are independent of the appraiser's working pattern. During the next appraisal year Dr Major, in his capacity as MAC Chair will write to female medical staff to encourage them to become appraisers in an effort to address the gap.

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. A comparator report is received each year from NHS England and allows the Trust to benchmark itself against other Trusts. As 2gether NHSFT is comparatively small compared to other Trusts, a small number of doctors can make a significant difference

to percentages quoted. Taking that into account, the benchmark data information for 2016-17 was reassuring and all agreed that no further action was required.

Overall the Trust was highly commended and scored at least 5 out of 6 (equating to 'Excellence') in all 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 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 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 appraisees after all completed appraisals. Return rates are typically very high. Once completed, these are screened by the Medical Director's office and reviewed quarterly by the MAC. Collated (anonymised) feedback covering the entire appraisal year is circulated to all appraisers, and individualised (anonymised) feedback to appraisers. Summarised feedback has previously been benchmarked against feedback collated from other similar organisations (and 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 conducted in April 2018 by all members of the MAC, using a nationally recognised medical appraisal QA tool. New

appraisers were audited at the time of completion to avoid delay in scrutiny, in case there was problem with appraiser quality.

12 (17% of all) completed appraisal summaries were audited for completeness and quality; 4 were automatically audited because they were done by new appraisers; 8 were randomly selected. Consent was sought from individual appraisees. Results were reviewed at an away day and an action plan subsequently developed, including:

- Preparation of a comprehensive audit report,
- 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. This year the average score form the Excellence Tool stayed the same but the number of points graded absent (0) was significantly lower, indicating a more uniform high standard of appraisal documentation. 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 (one completed cycle per 5 years) 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 11 revalidation recommendations were due; for 10 of the 11 (91%) positive recommendations were made; the remaining 1 (9%) was recommended for deferral. 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. All pre-employment checks for substantive doctors are completed before employment is started. 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

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.

Two doctors are 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 a doctor is flagged as non-compliant, combined with the limited range of exceptions, mean that 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 impacts 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 taken part in this process and thus for the first year of any practice have not undertaken appraisal whilst they are collecting data. This is a nationally recognised issue and one further expanded on in the 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 and will be further reviewed in October 2018. Priorities for the MAC for the next year include ongoing consideration of ways to improve patient and public involvement in appraisal and revalidation processes; further refinement of the number and nature of active qualified medical appraisers within the organisation, with particular focus this year on gender inequality; and continuing focus on moving beyond compliance towards further quality improvement.

The MAC will investigate individual cases where appraisal is not 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 annual appraisal are not 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 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 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 undertaken and 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 snapshot compliance figures do not reflect annual uptake of appraisal but are primarily a function of the way data is collected. In any year the expected outturn is 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)	**9**
Maternity leave during the majority of the ‘appraisal due window’	0
Sickness absence during the majority of the ‘appraisal due window’	2
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	2
New starter more than 3 months from appraisal due date	3
Postponed due to incomplete portfolio/insufficient supporting information	1
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

		Frequency (% in brackets)		
Number	**Criterion**	absent	room for improvement	well done
1	Includes whole scope of work?	0	7 (58)	5 (42)
2	Free from bias?	0	0	12 (100)
3	Challenging & supportive?	0	2 (17)	10 (83)
4	Exceptions explained?	0	0	12 (100)
5	Reviews & reflects?	0	3 (25)	9 (75)
6	Review of previous PDP?	1 (8)	3 (25)	8 (67)
7	Encourages excellence?	0	1 (8)	11 (92)
8	Gaps identified?	1 (8)	4 (33)	7 (58)
9	SMART PDP?	0	3 (25)	9 (75)
10	Relevant PDP?	1 (8)	3 (25)	8 (67)

Annual Report Template Appendix C

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2017 to 31 March 2018	
Recommendations completed on time (within the GMC recommendation window)	10 (Positive) 1 (Deferral)
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	10 (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	1		
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				
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 2018 who have undergone formal remediation between 1 April 2017 and 31 March 2018 *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)				2
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	2
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?	1
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	1
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
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	2
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	6
Temporary employed doctors	5
Locums brought in to the designated body through a locum agency	37
Locums brought in to the designated body through 'Staff Bank' arrangements	N/A
Doctors on Performers Lists	N/A
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	N/A
TOTAL	48

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	6	6				6	6					6				
Temporary employed doctors	5	5				5	5					5				
Locums brought in to the designated body through	37	37				37	37					37				

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	48	48				48	48					48				

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	37	15	13	9	37
Obstetrics/Gynaecology					
Accident and Emergency					

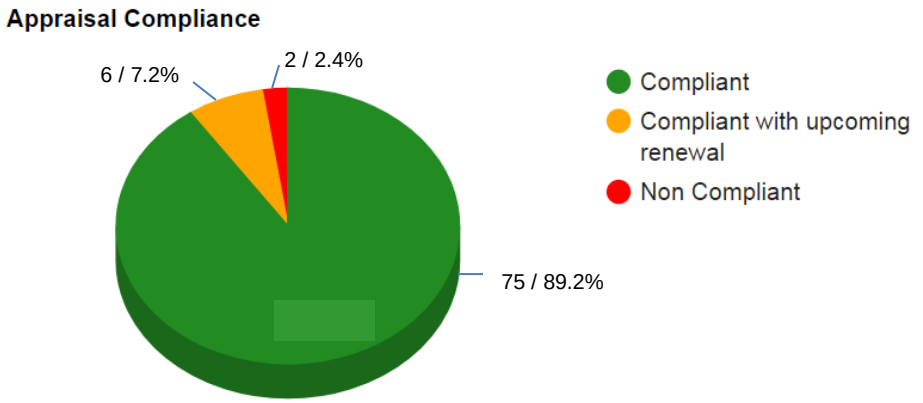
Anaesthetics					
Radiology					
Pathology					
Other – Occ Health					
Total in designated body (This includes all doctors not just those with a prescribed connection)					
Number of individual locum attachments by duration of attachment (each contract is a separate 'attachment' even if the same doctor 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	3	3	3		
3 days to one week	3	3	3		
1 week to 1 month	3	3	3		
1-3 months	10	10	10		
3-6 months	8	8	8		
6-12 months	7	7	7		
More than 12 months	3	3	3		
Total	37	37	37		

APPENDIX F

2gether NHSFT Medical Appraisal Compliance at 18.09.18

Appraisal Month Compliance

97.6% Appraisal Compliance



98.8% have started an Online Appraisal

Overall 82 out of 83 medics have started an online appraisal.
80 out of 81 compliant medics have started an online appraisal.
2 out of 2 non compliant medics have started an online appraisal.
0 out of 0 medics with unknown compliance have started an online appraisal.

NHS England

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/No [delete as applicable]

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments:

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments:

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:

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:

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:

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Comments:

[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:

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:

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

    Comments:

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

[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:	Board of Directors – 26 September 2018
Authors:	Rob Newman, Freedom To Speak Up Guardian, Neil Savage, Joint Director of HR & Organisational Development
Presented by:	Rob Newman, Freedom To Speak Up Guardian, Neil Savage, Joint Director of HR & Organisational Development

SUBJECT: **Freedom to Speak Up – Organisational Self Review**

This Report is provided for:

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

EXECUTIVE SUMMARY

Effective Freedom to Speak Up arrangements help to protect service users, carers, staff, the public and the Trust, improving the quality of our service provision and employment experiences.

Having a healthy speaking up culture which is embedded in a culture of continuous improvement is a required indicator of the Care Quality Commission Well-led domain.

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

RECOMMENDATIONS

The Board of Directors is asked to agree in principle with the self-assessment review and note that there is a NHS Improvement submission required at the end of September 2018.

Corporate Considerations	
Quality implications:	It is critical for staff to be able to challenge the delivery of poor quality services and unsafe practices at the earliest opportunity. Freedom to Speak up and other related policies, procedures, processes and guidance provides appropriate and effective framework and culture for concerns to be raised in a safe and supportive manner. The same arrangements require effective responses and resolution to concerns.
Resource implications:	Arrangements and related staffing resources are funded within existing resources.
Equalities implications:	There are suitable options for staff to raise concerns or issues which should enable any individual to do so regardless of one or more protected characteristic.
Risk implications:	If the Trust fails to have an open and transparent culture, staff will not feel empowered to raise issues or concerns. This would risk wrong-doing, malpractice, unsafe practices and poor use of resources. It would also risk failure in challenging and addressing the issues in hand. This could leave the Trust open to litigation.

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

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	
Valuing and respectful	P	Efficient	
Reviewed by:			
Neil Savage, Joint Director of HR & Organisation Development		Date	September 2018

Where in the Trust has this been discussed before?		
Executive Committee	Date	September 2018

What consultation has there been?		
Joint Negotiating and Consultative Committee	Date	September 2018

Explanation of acronyms used:	JNCC – Joint Negotiating and Consultative Committee NHSI - NHS Improvement NED – Non-Executive Director FTSU – Freedom to Speak Up FTSUG - Freedom to Speak Up Guardian

FREEDOM TO SPEAK UP SELF-ASSESSMENT REVIEW

1 INTRODUCTION

1.1 Effective Freedom to Speak Up arrangements help to protect service users, carers, staff, the public and the Trust, improving the quality of our service provision and employment experiences.

1.2 Having a healthy speaking up culture which is embedded in a culture of continuous improvement is a required indicator of the Care Quality Commission Well-led domain.

1.3 In line with national regulatory requirements, the Trust has recently undertaken a self-assessment process required by the regulator. This has involved discussions with the Freedom to Speak Up Guardian, Joint Director of HR & Organisational Development, Staff Side and the Gloucestershire Care Services FTSUG. The FTSUG has a scheduled meeting with the Non-Executive Lead for FTSU week commencing the 24th September 2018. The Executive Committee has endorsed the self-assessment.

1.4 It is the intention that following discussion at the Trust Board the outcomes of the attached self-assessment will be submitted as required to NHS Improvement at the end of September.

2 BACKGROUND

2.1 NHS Improvement (NHSI) published national guidance in summer 2018 about how NHS organisations evaluate their speaking up arrangements. This guidance was for NHS Trust and Foundation Trust Boards. There are clear expectations within this guidance, which include:

- Leaders being clear about their roles and responsibilities in relation to FTSU and to actively share the speaking up culture
- Leaders being knowledgeable and that there is a clear vision with staff feedback, patient safety and experience and continuous improvement
- That there is a visible FTSU Guardian and that this role is integral with a Trusts FTSU strategy
- That feedback is effectively triangulated with other appropriate data in order to identify emerging issues and; that learning is widely shared
- That Trust Boards are involved in measuring and evaluating any impact of changes

2.2 The new national guidance also sets out clear milestones for all NHS organisations to work towards. These are summarised overleaf:

Milestone	Date
Trust self-assessment	July/August 2018
NHSI teams liaising with NHS trusts in order to seek assurances that NHS Trusts have a FTSU vision, with strategy and action plans being developed	September 2018
NHSI team seeking assurance that NHS Trust action plans are being put into place	December 2018
NHS I team seeking assurances that improvements and change are being made and can be evidenced by NHS Trusts	March 2019
Ongoing feedback with regards to FTSU	March 2019 onwards

2.3 The Care Quality Commission are expected to take a keen interest in progress, as was evident in the Trust's most recent assessment visit.

3 FTSU SELF-ASSESSMENT OUTCOMES

3.1 The outcomes of the Trust's FTSU self-assessment can be seen in Appendix 1. Out of the 69 assessment criteria the Trust has rated itself:

- Green - 37
- Amber - 32
- There are no red ratings

3.2 This is a similar rating to the outcomes of Gloucestershire Care Services self-assessment.

3.3 This self-assessment process is expected to be a dynamic on-going requirement which will be tested out by NHSI, the CQC and staff themselves.

3.4 The assessment process has highlighted that although the Trust has:

- strived to continuously raise the profile of FTSU
- has a well-established FTSU Guardian in place with clear plans in place e.g. FTSU advocates

3.5 There is still a need to develop and agree a formal written FTSU strategy for the Trust. Other Trusts are in the same position, and the National Guardian's Office has been asked if there is expected to be a national template for this, but an answer has not yet been received. There are however, high levels FTSU plans and activities in place, which are aligned and integral to other Trust strategies e.g. Organisational Development and Training.

3.6 Therefore, it should be noted that some of the amber ratings within the self-assessment tool are due to the word “strategy” that NHSI have used (the Trust’s FTSU Guardian is exploring this issue further with local FTSU colleagues within the South West and with National Guardian’s Office).

3.7 We strongly believe our approach to FTSU activities is the right one as there has been a positive impact. FTSU visibility across the Trust is good with positive staff feedback. The past two year’s consistent scores in the Staff Survey on Key Finding 31 (Staff confidence and security in reporting unsafe clinical practice) would also support our approach.

4 CONCLUSION & RECOMMENDATIONS

4.1 Like most other NHS organisations, the Trust has developed its approach to FTSU over the last 2 years and continues to strive for continuous improvement. There is much more to do in terms of developing our strategy and a related action plan, but good progress has been maintained to date.

4.2 The Board of Directors is asked to:

- Note and approve the Self-Assessment for submission to NHS Improvement by the end of September 2018

- Note that a refreshed Freedom To Speak Up Policy (previously known as Whistleblowing) will be presented to Governance Committee in October 2018 for consideration and approval

- Note that the FTSUG will continue to work in partnership with Gloucestershire Care Services’ FTSUG, to co-train FTSU Advocates, and to jointly develop a local strategy and action plan for presentation to the Board’s Governance Committee in Q4

- Note that going forwards the FTSUG will now present bi-annual reports on progress to the Board of Directors

National Guardian
Freedom to Speak Up

NHS
Improvement

Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

September 2018

How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Our expectations			
Leaders are knowledgeable about FTSU			
1.Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.		Further engagement & communications necessary in light of the new May 2018 guidance and the policy refresh.	Senior Leadership Forum presentation People Committee presentation Annual Audit Committee Whistleblowing reports Staff Leaflets & Staff Handbook Policy Review Summer 2018 (Going to October Board Committee) Going forwards via proposed 6-monthly FTSU Board reports/presentations

			1:1 meetings with key Board members
2.Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.		Update Presentation to & discussion with Board of Directors Implementation of new 6-monthly FTSU Board reports/presentations Update Presentation to Leadership Forum Include case studies in future Board reports Consider related Staff Story at Board meeting FTSU vison and strategy to be developed FTSU case studies to communicate the learning that has occurred Learning action plan to	FTSU principles are outlined on intranet & regularly communicated across the Trust CQC Inspection outcome Previous annual Audit Committee Whistleblowing reports FTSU feedback Quarterly Staff FFT outcomes Annual Staff Survey results

		be shared at QCR	
3.They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.		A Leadership Development strategy is under review. Chair and CEO are working with the King's Fund to create a new Board Development Programme (Summer 2018). This will inform the new Leadership Strategy Include explicit sessions in future development programmes Further strengthen Induction briefing Evaluate Five Elements of Successful Leadership Programme & agree 2018/19 next programme	All new leaders joining the Trust are briefed on FTSU and receive the Staff Handbook which has a page dedicated to FTSU Current Organisational Development Strategy is strongly values based and include speaking out and raising concerns, culture and values

4.Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.		Strategy to be developed using best practice, national, regional and local guidance. In light of new Board members etc., needs refresh via the proposed update presentation to & discussion with Board of Directors Include vision for FTSU in Merger Business Case Include in proposed values and behaviours work stream for new organisation Ensure inclusion in Values work stream for the merger with April LLP	CQC Outcomes Report Through the evidencing of the Trust values and the related Board feedback sheets Planned Board reports
Leaders have a structured approach to FTSU			

5.There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.		FTSU Vision and Strategy work commenced Strong link to speaking up in Board and Safety visits Action plan to be developed	Vision and Strategy will be presented to Board Committee & Board
6.There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.		Policy recently reviewed and amendments will be taken to October Governance Committee Scheduled for JNNC consultation, People Committee & Governance Committee in September / October 2018	Policy is visible on the intranet Current policy generally reflects principles of the model national policy. The revised policy updates and strengthens provisions.
7.The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian)and it aligns with existing guidance from the National Guardian.		Strategy being developed in partnership with GCS Initial conversations commenced with staff	Annual review of The Strategy will be required as FTSU is in its infancy, and presented by the Guardian to Board

		side Freedom to Speak Up Advocate training commenced August and will support the strategy	Report to be presented to committee and Board
8.Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.		Compliance with the policy is regularly reviewed by FTSUG Progress against the strategy will be included in routine reporting to Governance / Audit Committees and Trust Board Feedback and data is submitted nationally and this is used to inform & set objectives of the FTSUG	Action plan and strategy to be presented to Governance Committee when complete and via Board reporting
Leaders actively shape the speaking up culture			
9.All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.		FTSUG visible across the Trust Freedom to Speak Up	Include examples anonymised as necessary in Lessons

		Advocate joint training with GCS commenced in August 2018, with further training for managers and senior leaders planned for late Autumn 2018 Needs to be further strengthened and progressed as part of the strategy development and implementation	Learned briefings
10.They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.		This could have further evidencing through reports, learning assurance framework and QCR Board visits and safety visit programme to continue, ensuring linkages to any areas where concerns have been raised Intelligence from	QSIR roll out programme South West Safety Collaborative Trust objectives Values and behaviours Values based recruitment Paul's Open Door Programme

		feedback of those that speak up	
11. Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.		Smart Survey FTSU.	Staff Survey results 2017 Board Visits Safety Visits Smart Surveys Team Talk Paul's Open Door Speak In Confidence
12.Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.		The FTSUG is open and transparent with the autonomy to act independently across the Trust Stronger future Medical Director and Director of Quality linkage and meetings are being put in place.	Regular 121s with FTSU and key directors FTSU reports Policy review partnership

13.Senior leaders model speaking up by acknowledging mistakes and making improvements.		Senior leaders model and demonstrate	Quality, Service Improvement and Redesign (QSIR) Values and behaviours Examples of changed Dignity / Disciplinary outcomes and procedural approaches
14.The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.		Specific FTSU Survey to benchmark data Continued visibility across GCS and the South West, and promotion of the role Continual / regular communications	Leaflet Intranet page Presentations Team Talk Induction Staff Handbook Staff Survey results Data to NGO
Leaders are clear about their role and responsibilities			
15.The trust has a named executive and a named non-executive director responsible for speaking up and both		Both are updated , with any guidance from the	Maria Bond (NED)

are clear about their role and responsibility.		NGO Both supportive through open door	Neil Savage (ED)
16.They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.		Additional scheduled joint meetings to be established to include Medical Director and Director of Quality.	Regular 121 meetings FTSU and ED lead Meetings with FTSU and Deputy / CEO
17.Other senior leaders support the FTSU Guardian as required.		Senior leaders have requested support from the FTSUG	When needed in relation to individual cases.
Leaders are confident that wider concerns are identified and managed			
18.Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.		Programme of regular data triangulation to be established	Data needs to be accessible with scheduled Board reporting
19.The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.		Open access to be maintained	Access fully available when needed.

Leaders receive assurance in a variety of forms			
20.Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.		Vision to be completed, in line with strategy and FTSU policy	Planned FTSU Survey results. Future Staff Survey results.
21.Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers		Further conversations needed with JNCC, LNC and staff focus groups	Previous focus groups have been held Planned Board reporting Visibility when out and about meeting colleagues
22.Speak up issues that raise immediate patient safety concerns are quickly escalated		See 10 & 19 above	No FTSUG issues about patient safety concerns not being escalated swiftly. Supervision and other routes available.
23.Action is taken to address evidence that workers have been victimised as a result of speaking up,			No evidence or concerns have been escalated or raised to

regardless of seniority			suggest this.
24.Lessons learnt are shared widely both within relevant service areas and across the trust		FTSU element of Lessons Learned Communications programme to be strengthened. Schedule QCR attendance	
25.The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented		Consider building into audit programme to be established, including peer audits. Awaiting advice from NGO re auditing and information regional on auditing FTSU	
26.FTSU policies and procedures are reviewed and improved using feedback from workers		Use feedback to influence future review of Policy / Procedure. Policy to be reviewed yearly to ensure best practice as a rapidly	Actively involved staff side in production of Policy.

		changing environment (currently 3 year review)	
27.The board receives a report, at least every six months, from the FTSU Guardian.		Move from annual to six-monthly reporting	Six-monthly reporting starting now
Leaders engage with all relevant stakeholders			
28.A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.		Conversations to take place with focus groups and long-term conversations group, and strategy/plans developed To be included in the strategy, vision and plan	Early conversations taken place with BAME group.
29.Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.			Feedback from regulators and commissioners. GCCG requested report 2017. Not previously requested, although staff survey FFT results routinely considered.

30.Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).		See 27 above	
31.The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.		See 46 below	
32.Reviews and audits are shared externally to support improvement elsewhere.		See 25 above – once completed to be shared widely	
33.Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture			
34.Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians			FTSU meets with CQC Other local, regional & national Guardians GMC Liaison advisor for Gloucestershire

35.Senior leaders request external improvement support when required.			
Leaders are focused on learning and continual improvement			
36.Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.			
37.Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.			Local, regional & national Guardians engagement Local, regional & national HRD, DoN engagement
38.Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.			Regular FTSUG sense checks of guidance & case reviews Case Reviews of Speaking Up / Speaking In Confidence
39.Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and		Audit programme Qualitative feedback	

encourage the same throughout the organisation.			
40.The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.		Future reporting to include matrix/data that would support the Executive lead to deliver on point 40 Strategy to be developed with early work progressing	
41.The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.		The policy has previously been reviewed every 3 years, going forwards this will be annually.	
42.A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told		Audit required to confirm & assure Qualitative feedback suggests outcomes would rate b & c as green	Annual review of data to continue as reported to the NGO

of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored			
43.Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.		Case Studies / Board meeting staff presentations	Visibility, comms, intranet, meetings with colleagues whilst maintaining confidentiality
Individual responsibilities			
Chief executive and chair			
44.The chief executive is responsible for appointing the FTSU Guardian.			FTSUG appointed in 2016 by the Chief Executive
45.The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.		Progress against the future strategy and action planning	Dedicated time within a substantive role Current progress measured through reporting and 1-1 with

			the FTSUG
46.The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.		Ensure inclusion in next 2018/19 Annual report	FTSU mentioned throughout the latest Annual Report
47.The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.			Trust FTSUG is a member & regular attender to the regional and national networks
48.Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.			Communications & meetings in place and / or available
Executive lead for FTSU			

49.Ensuring they are aware of latest guidance from National Guardian's Office.			The NGO weekly & other bulletins are received by the FTSUG. Information of urgency is highlighted to the Director of OD or at 1:1s
50.Overseeing the creation of the FTSU vision and strategy.		This will be presented to the Governance Committee for approval and Board with an action plan as previously highlighted	Discussions have commenced and engagement in progress for the vision and strategy
51.Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian.		Consider the inclusion of the Non-executive Director for Speaking Up to be included in future recruitment. The Job Description to be re-reviewed against NGO guidance	As with point 44 above, On review through the merger harmonisation processes.
52.Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and		Consider cross cover with GCS FTSU	Role sits within a substantive full time role. FTSUG able to adapt time to meet the

there is cover for planned and unplanned absence.			needs of staff
53.Ensuring that a sample of speaking up cases have been quality assured.		Quality assurance process to be developed Consider Biannual audit of cases	Discussions have other FTSU leads as no consistent process at present The FTSUG has commenced discussions with the Director of OD
54.Conducting an annual review of the strategy, policy and process.		See point 4 above	
55.Operationalising the learning derived from speaking up issues.		Consider attending QCR	Link to point 36 Learning fed back to operational teams & directors as appropriately
56.Ensuring allegations of detriment are promptly and fairly investigated and acted on.		FTSU Advocates will be more widely used to support processes and people going forwards	FTSUG continues to provide visible and open access FTSUG acts in an

			independent capacity to support any colleagues who feels they have suffered detriment
57.Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.		Needs further triangulation of information to monitor outcomes and through future Board reporting after strategy and action plan is agreed	Current progress on policy and process is discussed through 1:1s with Senior colleagues / Director of OD
Non-executive lead for FTSU			
58.Ensuring they are aware of latest guidance from National Guardian's Office.			Regular meetings with NED lead.
59.Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.		Needs to be progressed following the agreement of the strategy	Non-Executive Director continues to support the FTSU agenda
60.Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.		Needs to be progressed following the agreement of the strategy	Board development alongside the new Culture and Values delivery within the organisational merger

			Freedom to Speak Up Advocate training and development in progress with Board support
61.Role-modelling high standards of conduct around FTSU.			As above
62.Acting as an alternative source of advice and support for the FTSU Guardian.			
63.Overseeing speaking up concerns regarding board members.		Narrative and data to be included in the quarterly returns and learning to be assured	Available to review with the FTSUG any potential and reported concerns
Human resource and organisational development directors			
64.Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.			FTSUG has presented at People Committee. Professional and supportive relationship with HR colleagues and each understands the particulars regarding independence and

			confidentiality
65.Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.		Consider HR Advocate role includes HR colleagues and consider HR team training on FTSU	HR staff well briefed on FTSU. Staff Side Chair trained as Advocate
66.Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.		Consider clauses for Contactors / Tendering / Procurement to ensure FTSU is understood and reported	Values Based Recruitment training for managers and Experts by Experience FTSU Advocate training is further increasing visibility & support for colleagues E-learning through HEE available for all colleagues Face to face sessions for managers & team meetings provided to ensure they respond positively to issues raised

			To support further training, promotion and knowledge to support all colleagues including volunteers
Medical director and director of nursing			
67.Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.		Consider formal scheduling of 1:1 meetings	Open door policy and support available when needed urgently
68.Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.		As above	As above
69.Ensuring learning is operationalised within the teams and departments that they oversee.		Consider formalising reporting and operationalisation of learning in strategy & action plan.	Completed on an ad hoc basis currently

Agenda item 17 **Enclosure Paper L**

Report to: 2gether NHS Foundation Trust Board – 26th September 2018
Author: Paul Roberts, Joint Chief Executive
Presented by: Paul Roberts, Joint Chief Executive

SUBJECT: **Chief Executive's Report**

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

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

EXECUTIVE SUMMARY
This paper provides the Board with:

1. A summary of headline news against Quality, Sustainability and Engagement criteria
2. An overview of engagement by Board members

RECOMMENDATIONS

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

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

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

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

Reviewed by:		
Chief Executive	Date	*September 2018*

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
N/A	Date	

Explanation of acronyms used:	

1. Chief Executive Engagement

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

Services I have visited in recent weeks include:

The **Children and Young People/Child and Adolescent Mental Health (CYPS/CAMHS)** management team at Acorn House. These are services hugely dependent on our partnerships with local government colleagues in education and social care where the strain that these functions are under is very clear (local government has taken the brunt of austerity savings in recent years).

Eating disorder service in Cheltenham - the team were returning from a training event where they were learning to deliver a new programme directed mainly at schools on body consciousness. The aim is to provide early or perhaps timely learning, for adolescent girls to help them think differently about body image and the pressure that society, particularly through social media, puts on them. This team is so full of enthusiasm and positivity that I left encouraged and enthused.

2. Progress on the strategic intent to merge ^{2}gether NHS Foundation Trust with Gloucestershire Care Services NHS Trust (GCS)

The development of outstanding integrated mental and physical health services firmly rooted in local communities is the **vision** that lies behind the proposed merger of ^{2}gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust. This vision is a major vehicle for delivering both the One Gloucestershire Programme. This vision will remain central to the complex work required to ensure this merger happens over the coming months.

As part of this process we now have in place a programme Better Care Together to ensure the delivery of benefits for service users, communities and colleagues of the merger. As part of this process we have just launched a major staff and service user engagement programme, to take place in mid-October. This will involve a significant number of us working together to formulate the vision, values and culture we want for our new organisation. These events will be really important – they will help us shape our future together. There is a huge amount of evidence (from the King's Fund and others) to show that healthy cultures in NHS organisations are crucial to ensuring the delivery of high-quality patient care.

Other activity within this programme involves encouraging teams within the Trusts to work together to help deliver benefits for service users as soon as possible. Given how key this programme is to the merger ambitions I am pleased to advise that I have now put in place a dedicated lead, Hazel Braund, who has been seconded to the Trusts from Herefordshire Clinical Commissioning Group where she led service strategy, partnership development, community service transformation and service development. She will build on the strong foundations put in place by Susan Field, Director of Nursing GCS, supported by Amjad Uppal, Medical Director ^{2}gether and Jane Melton Director Engagement and Integration ^{2}gether. As executive clinicians on our two Boards Susan, Amjad and Jane will remain fully involved in offering executive clinical leadership for the programme as it progresses.

I recently attended the **Learning Disability Away Day**, this included discussion on LD services in our proposed merged organisation - services for people with a Learning Disability are central to our merger, perhaps even symbolic of our proposed transformation! People with an LD are not defined by an illness either mental or physical yet they can be severely disadvantaged in accessing the services the rest of us take for granted. Improving the joined-up support for people with a learning disability will be a test of our success.

The Trust Boards are on track to consider the **Strategic Case** within their private Board sessions today. This follows review by the Trusts' Strategic Intent Leadership Group which is monitoring the merger process, the Executive and Non-Executive Directors, key clinicians and, very importantly, the ^{2}gether Council of Governors.

The development of the Strategic Case has been a thorough and comprehensive process which keeps at its heart the difference to service users we are working to achieve. It has involved colleagues from both Trusts working together to test the premise within the Strategic Intent and ensure that it deliver for the people of Gloucestershire. The Strategic Case, once thoroughly tested by both Boards will, if approved, then progress to NHSI for consideration. The next stage in the process will be the development of the full Business Case informed by feedback from NHSI.

This will continue to involve clinical colleagues and further develop involvement of service users.

Work is ongoing to put in place the appointment processes for the shadow Board which is another key next step in the merger process.

3. National issues

3.1 Policy Creation – the voice of health and social care staff

Secretary of State Matt Hancock has set out plans to give 3.1 million health and care staff in England a voice in the day-to-day creation of policy.

He is launching a new digital platform called 'TalkHealthandCare', which staff can use to post ideas, questions and challenges for government.

The platform will be available on computers, phones and tablets. It will continually update to reflect the views and ideas of staff. The platform will also include events, forums and webinars for staff across the country.

TalkHealthandCare has been launched following feedback from staff that too often they do not feel valued at work.

Some of the known issues that TalkHealthandCare will seek views on include:

- improving shift patterns and juggling home and work lives
- speeding up the use of helpful technologies that cut out paperwork
- training and development

In particular, the Secretary of State has expressed concern about the high number of reports of bullying and harassment. He has reiterated his wish to ensure these issues are not accepted and 'put in the too difficult pile'.

The department is also launching a new workforce panel of staff who the Secretary of State will meet with as a sounding board on issues affecting health and care staff across the country.

3.2 The Government response to the Learning Disabilities Mortality Review (LeDeR) Programme Second Annual Report

The government has just issued its response to the Learning Disability Mortality Review 2nd Annual Report.

The second annual report of LeDeR, published in May, was an important reminder of the work to do. The government has accepted all of the report's recommendations. The Department of Health and Social Care and NHS England have been working with NHS Improvement, NHS Digital, Health Education England, Public Health England and the Care Quality Commission to develop considered responses to, and implement, the annual report's recommendations. Most importantly the government has highlighted the need for health and care staff to have the right training to support people with a learning disability, their families and carers; to ensure that perceptions

of learning disability do not prevent a robust assessment of physical health, and that staff can make personalised, reasonable adjustments to care. The government are taking steps to make this happen and a consultation on the training required is now in progress.

These commitments are welcomed by GCS and 2gether.

4. Gloucestershire Safeguarding Partnership arrangements: Working Together to Safeguard Children (2018)

The Gloucestershire's Safeguarding Children Board, is putting in place the actions required to implement the new Working Together guidance (July 2018); resulting from legislative changes (Children Act 2004 as amended by the Children and Social Care Act 2017). Gloucestershire's Safeguarding Partnership arrangements will transition over the next 12 months with. Gloucestershire's Clinical Commissioning Group assuming the lead for all Health organisations regarding Safeguarding children. An initial meeting of the three partners has taken place in July, with senior representation from GCCG Accountable Officer, Assistant Chief Constable, Gloucestershire Police and the Director of Children Services, GCC.

The CCG aims to fully support all Health partners in their safeguarding responsibilities as well as continuing to seek assurance that health providers and Primary Care colleagues fulfil their statutory requirements for Safeguarding Children. For Gloucestershire, there is also the ongoing work to evidence improved outcomes for children, through the work of the Ofsted multi-agency Improvement Board. Provider Trusts and CCG are represented by Nurse Directors, which is valuable and welcomed by that Board.

The Strategic Safeguarding Children Health Group is a forum to provide oversight and work by provider Trusts. Providers are represented by Named Professionals; Primary Care and wider health representation. The Group is led by the Designated Professionals. The updated Terms of Reference will seek greater responsibility to receive quality assurance data pertinent to evidencing the work of health to demonstrate health's partnership role in effectively safeguarding children. The Group seeks to reflect the diversity and depth of work undertaken in health as well as identify and draw strength where health services collaborate and work together.

The Strategic Health Group will be accountable to the GSCB or its successor.

5. Engagement

Internal Board Engagement

02.07.18 The Deputy Chief Executive attended the Cheltenham Integrated Locality Board

The Deputy Chief Executive and Director of Service Delivery attended a meeting regarding the relocation of the CAMHS services in Herefordshire

The Director of Service Delivery attended a meeting with the Deputy Chief Operating Officer from Gloucestershire Care Services ('GCS')

The Director of Quality attended a QMT meeting

03.07.18	The Deputy Chief Executive attended a Dementia Pilot monthly meeting
	The Deputy Chief Executive attended a Complex Care meeting with Gloucestershire Clinical Commissioning Group ('GCCG')
04.07.18	The Director of Finance and Commerce participated in a conference call with Senior managers in Herefordshire
04.07.18 & 05.07.18	The Deputy Chief Executive facilitated several teleconferences with Senior managers in Herefordshire
05.07.18	The Executive Directors attended an Executive Committee meeting
	The Director of Service Delivery attended a teleconference for the relocation of the CAMHS services in Herefordshire
	The Director of Organisational Development attended the LNC meeting
	The Director of Organisational Development attended a 2gether exhibition and open day at Blackfriars Priory
06.07.18	The Director of Engagement and Integration met with senior colleagues from the Engagement and Integration Directorate
09.07.18	The Deputy Chief Executive conducting induction session for new staff
	The Director of Organisational Development attended a meet and greet induction for new staff
	The Deputy Chief Executive and Service Director for Herefordshire meeting with a Service User
	The Executive Directors attended an Executive Development meeting
	The Director of Service Delivery meeting with the Service Development Manager from GCS
	The Director of Service Delivery meeting with the Finance Director from GCS
	Members of the Executive Team conducted Team Talk sessions across the Trust sites
	The Director of Finance and Commerce attended a team away day with senior managers from the Finance and Commerce directorate at Chase Hotel
10.07.18	The Director of Service Delivery attending an IAPT review meeting

	The Director of Quality attended a Lead Nurse meeting
11.07.18	The Deputy Chief Executive, Director of Quality and Director of Service Delivery meeting with Learning Disability Clinical Directors and Senior Managers
	The Deputy Chief Executive attended the Forest of Dean Integrated Locality Board
	The Director of Quality conducted a Board visit to Herefordshire Learning Disability Services
	The Director of Quality attended a Council of Governors meeting.
	The Director of Engagement and Integration conducted a Patient Safety Visit to the OT Team at Charlton Lane Hospital
	The Director of Engagement and Integration conducted a Board visit to the Managing Memory 2gether Team at Charlton Lane Hospital
	The Director of Engagement and Integration chaired a discussion meeting regarding Big Health Check Day 2019 with several colleagues.
	The Director of Organisational Development led a Merger Workshop with senior managers from the HR and Organisational Development Directorates in both Trusts
12.07.18	The Director of Organisational Development conducted interim Deputy HR Director Interviews
	The Director of Organisational Development attended a Council of Governors meeting
	The Director of Organisational Development conducted a Board Visit to the Quality & Clinical Audit Department at Rikenel
13.07.18	The Director of Service Delivery attended a meeting regarding All Age Psychological Liaison
16.07.18	The Director of Finance and Commerce chaired an Estates Discretionary Spend Meeting with senior members of the Finance and Commerce Directorate
17.07.18	The Director of Quality attended a Care Quality Commission Action Plan meeting
	The Director of Finance and Commerce met with the Director of Service Delivery and senior colleagues from the Finance and Commerce Directorate regarding ODP/A's from Gloucestershire Hospitals Trust

18.07.18	The Director of Organisational Development met with the Director of Quality and Assistant Directors for both Directorates regarding the NHSI Retention Programme
19.07.18	The Executive Directors attended an Executive Committee meeting
	The Executive Directors attended a Joint Business Executive Team meeting
	The Director of Service Delivery attended a meeting regarding Action for Children's contract
	The Director of Organisational Development chaired a Safety, Health & Environment Committee
20.07.18	The Director of Quality attended the QCR Sub Committee meeting
23.07.18	The Director of Service Delivery attended Corporate Induction
	The Director of Finance and Commerce gave a presentation at Corporate Induction
	The Director of Engagement and Integration attended Corporate Induction for a meet and greet
	The Deputy Chief Executive and Director of Quality attended a meeting to continue discussions regarding Herefordshire
	The Executive Directors attended an Executive Development meeting
24.07.18	The Deputy Chief Executive attended the Joint Negotiation Consultative Committee meeting
	The Deputy Chief Executive met with the newly appointed Non-Executive Director
	The Director of Quality attended the Temporary Staffing Demand Project Board
25.07.18	The Director of Service Delivery attended the Delivery Committee
	The Director of Quality attended a Quality / Complaints meeting
	The Director of Quality attended a meeting regarding Hereford Controlled medication
30.07.18	The Deputy Chief Executive and Director of Organisational Development participated in the recruitment for the Director of Quality appointment

01.08.18	The Deputy Chief Executive conducted a board visit to the LDISS Team at Pullman Place
	The Director of Quality and Director of Finance and Commerce attended Audit Committee
02.08.18	Members of the Executive Team attended a Joint – Informal Executive Team Meeting
03.08.18	The Deputy Chief Executive participated in the recruitment of a Consultant Psychiatrist
	The Director of Service Delivery attended a Hereford Locality Board meeting
	The Director of Service Delivery attended a Hereford staffing issues/deployment meeting
06.08.18	Members of the Executive Team attended an Executive Development session
	The Director of Finance and Commerce and Director of Engagement and Integration attended meet and greet at Corporate Induction
08.08.18	The Deputy Chief Executive attended a meeting regarding the Construction and evaluation of the PMH specialist Nurse pilot
	The Director of Finance and Commerce and Director of Engagement and Integration attended Development Committee
09.08.18	The Director of Finance and Commerce attended a Shared Services Partnership Board meeting
	The Director of Engagement and Integration met with senior colleagues from the Engagement and Integration Directorate
10.08.18	The Director of Service Delivery organised a telephone conference with colleagues regarding working age adult beds within the Trust The Director of Engagement and Integration participated in Interviews for Director of Clinical Research
13.08.18	The Executive Team attended a Programme Management Executive meeting along with colleagues from Gloucester Care Services
14.08.18	The Executive Team attended a Joint Board Development meeting along with colleagues from Gloucester Care Services
15.08.18	The Deputy Chief Executive and Director of Quality attended a meeting regarding the Future Direction of Travel for Hereford

	The Deputy Chief Executive and Director of Organisational Development attended the Strategic Intent Leadership Group with colleagues from Gloucester Care Services
16.08.18	The Executive Directors attended an Executive Committee meeting
	The Executive Directors attended a Joint Business Executive Team meeting
	The Director of Quality attended a Learning Disabilities Action Plan meeting
17.08.18	The Deputy Chief Executive attended a Forest of Dean Internal Discussions meeting
	The Director of Service Delivery attended a Vision and Values, The Steering group
	The Director of Service Delivery attended a Hereford staffing meeting
	The Director of Quality and Director of Engagement and Integration attended the QCR Sub Committee
	The Director of Quality attended a Nursing Strategy meeting
20.08.18	The Deputy Chief Executive and the Director of Organisational Development participated in Trust Corporate Induction
	Members of the Executive Team attended a Transformation Programme Board meeting
21.08.18	The Director of Quality attended a meeting regarding Herefordshire Pharmacy Contract
22.08.18	The Deputy Chief Executive and Director of Service Delivery participated in a conference call regarding Bank Holiday beds and staffing
23.08.18	The Director of Organisational Development conducted a Board Visit with the Service Experience Team at Rikenel
	The Director of Organisational Development chaired People Committee
24.08.18	The Deputy Chief Executive and Director of Quality attended a meeting regarding the Direction of Travel for Hereford MH Services
	The Deputy Chief Executive attended a meeting regarding GP correspondence in the Forest of Dean
	The Director of Quality attended the Temporary staffing demand project board

	The Director of Quality attended a Quarterly medicines management meeting
28.08.18	The Director of Finance and Commerce chaired the Capital Review Group meeting
	The Director of Organisational Development attended the Strategic Intent Leadership Group with colleagues from Gloucester Care Services
29.08.18	The Director of Organisational Development attended the Nomination & Remuneration Committee meeting
30.08.18	The Executive Team attended a Board meeting regarding One Gloucestershire Urgent care
31.08.18	The Executive Team attended a Senior Leadership Networks meeting
	The Deputy Chief Executive was part of the AAC Panel
	The Director of Quality attended an All Age Task and Finish Group
	The Director of Quality attended Governance Committee

Board Stakeholder Engagement

02.07.18	The Deputy Chief Executive attended an Integrated Care Services Action Learning Set meeting for Herefordshire and Worcestershire
	Members of the Executive Team attended the Programme Management Executive workshop at GCS
	The Director of Finance and Commerce attended the Transaction Leadership Group at GCS
03.07.18	Members of the Executive Team attended the Senior Leadership Networks meeting at the Hallmark Hotel, Gloucester
04.07.18	The Deputy Chief Executive attended a meeting with representatives from Cinderford Developments and the Head of Estates
	The Deputy Chief Executive attended a Countywide IT Services meeting held in Cheltenham at the Gloucestershire Hospitals NHS FT site
05.07.18	The Deputy Chief Executive attending the STP Delivery Board for Gloucestershire
	The Director of Service Delivery met with the Associate Director of Commissioning from GCCG

	The Director of Quality attended a SOBS conference
	The Director of Organisational Development attended an NHS 70 Tea Party at Tewkesbury Hospital
06.07.18	The Deputy Chief Executive and Director of Service Delivery met with Commissioners regarding ADHD discussions
	The Deputy Chief Executive attend the Medical Steering Committee meeting
	The Director of Quality participated in a conference call with PAPYRUS regarding support of families
	The Director of Organisational Development participated in a Skype call about the creation of an ICS People Framework with the Deputy CEO from Gloucestershire Hospitals Trust and the Managing Director from All Mighty You Consulting
09.07.18	The Deputy Chief Executive participating in the recruitment for the Chief Information Officer post for Gloucestershire Hospitals NHS Trust
10.07.18	The Deputy Chief Executive attend the Integrated Care Alliance Programme Board for Herefordshire
	The Deputy Chief Executive and Director of Quality met with representatives from CQC
11.07.18	The Director of Service Delivery attending the Mental Health Legislation Committee meeting as Executive lead
	The Director of Service Delivery attending the Charitable Funds Committee
	The Executive Directors of the Board attending a Joint Board Development meeting being held at GCS
12.07.18	The Deputy Chief Executive participating in the recruitment of the Deputy Director of HR
	The Deputy Chief Executive attended an Integrated Care Services Action Learning Set meeting for Herefordshire and Worcestershire
	The Director of Quality attended the NHS Gloucestershire CCG Annual General Meeting
	The Director of Organisational Development chaired an ICS Workforce Steering Group meeting with members of GCS, CCG, and Gloucestershire Hospitals Trust

	The Director of Organisational Development attended the GCCG Annual General Meeting
13.07.18	The Deputy Chief Executive attended the Local Digital Roadmap refresh meeting with GCCG
	The Deputy Chief Executive and Director of Service Delivery attended a meeting with Mental Health Commissioners
16.07.18	The Deputy Chief Executive met with the new Transformation Programme Director for the GCCG
	The Director of Finance and Commerce attended a Transaction Leadership Group meeting with GCS
	The Director of Finance and Commerce took part in a conference call with CCG, GCS, Dorset CCG, and Gloucestershire Hospitals Trust
	The Director of Organisational Development took part in a conference call with a member of GCS and a senior member of the Organisational Development Directorate regarding Implementing the Carter Report
	The Director of Organisational Development attended a Senior Management Team Business meeting with GCS
17.07.18	The Deputy Chief Executive attended the Local Digital Roadmap Infrastructure Delivery Group meeting held at Gloucestershire Hospitals NHS FT
	The Director of Quality and the Director of Engagement and Integration attended a STP Clinical Reference Group meeting with GCCG
	The Deputy Chief Executive attended a meeting with GCS's Non-Executive Directors at GCS
	The Director of Service Delivery and Director of Finance and Commerce attended a meeting with Herefordshire CCG regarding IAPT
	The Director of Engagement and Integration attended a Herefordshire Adults & Wellbeing Scrutiny Committee at Shire Hall in Hereford
18.07.18	The Director of Service Delivery attended the LD Quality and Performance Steering Group meeting held at Avon House in Tewkesbury
	The Director of Service Delivery attended the Wye Valley Annual General meeting

The Director of Finance and Commerce met with the Integration Programme Director from GCS to discuss the Strategic Case documentation for the merger

The Director of Finance and Commerce met with the Integration Programme Director from GCS and the Internal Audit Manager from PwC for a Transaction Governance Audit

The Director of Engagement and Integration met with colleagues from Healthwatch Gloucestershire

The Director of Organisational Development attended the Herefordshire and Worcestershire LWAB meeting at the University of Worcester

The Director of Organisational Development attended the Strategic Intent Leadership Group meeting at Edward Jenner Court

19.07.18 The Executive Directors attended the Joint AGM for ²gether and GCS at the University of Gloucestershire in Cheltenham

20.07.18 The Deputy Chief Executive attending a data sub group for the Cheltenham Integrated Locality Board in Cheltenham

The Executive Director's attended the annual ROSCAs Award evening

23.07.18 The Director of Finance and Commerce took part in a conference call with an Internal Auditor from PwC regarding a Finance Review

24.07.18 The Deputy Chief Executive attended a Dementia CPG Board meeting with Commissioners

The Director of Service Delivery attended a teleconference, hosted by PWC regarding an internal audit

The Director of Service Delivery and Director of Quality attended the Children's Services Improvement Board being held at the County Council

The Director of Engagement and Integration participated in a teleconference with PWC regarding "Patient experience in relation to complaints handling review"

25.07.18 The Director of Service Delivery and Director of Engagement and Integration attended a Swindon & Gloucestershire Mind wellbeing facility meeting

The Director of Finance and Commerce attended a teleconference with PWC to discuss an internal audit

	The Director of Finance and Commerce attended a Resources Steering Group meeting with GCCG at Sanger House
	The Director of Engagement and Integration participated in a teleconference call with CCG for the Forest of Dean Healthcare Infrastructure Board
26.07.18	The Executive Director's attended the Trust Board meeting
	The Director of Engagement and Integration attended an event held by Cobalt Health
27.07.18	The Director of Service Delivery attended an IAPT meeting with Commissioners
30.07.18	The Director of Quality attended a Hereford Controlled Drugs meeting with colleagues in Herefordshire.
	The Director of Quality participated in a conference call with CQC colleagues
	The Director of Quality attended a meeting with Commissioners regarding new guidance for Safeguarding children
	The Director of Engagement and Integration attended a Transformation Meeting with GCS
31.07.18	The Deputy Chief Executive attended the Gloucester City Place Based Pilot Board meeting
	The Deputy Chief Executive attended an Integrated Locality Board and Integrated Care Services funding meeting with Commissioners
	The Deputy Chief Executive attend an Integrated Locality Board Development meeting with Commissioners
	The Director of Quality attended the GSCB Executive meeting with colleagues from Gloucestershire Council.
	The Director of Organisational Development attended the SWLA Board Meeting in Taunton representing 2gether and the wider Gloucestershire ICS
01.08.18	The Director of Service Delivery attended a COO / Strategic winter planning meeting with Commissioners
	The Deputy Chief Executive and Director of Service Delivery attended an 24/7 AMHP model meeting with Commissioners
02.08.18	Members of the Executive Team attended a Transformation hypothesis testing workshop along with colleagues from Gloucester Care Services

	The Deputy Chief Executive attended a STP Delivery Board with Commissioners
	The Director of Quality conducted a community visit to St James Inner City Farm
	The Director of Finance and Commerce participated in the Interview process for Head of Procurement with Gloucestershire Hospitals Trust
03.08.18	The Director of Engagement and Integration participated in a meeting with Collaboration for Leadership in Applied Health Research and Care West (CLAHRC West)
06.08.18	The Deputy Chief Executive attended a Cheltenham Integrated Locality Board meeting
	The Director of Service Delivery participated in a conference call with PWC regarding internal audit progress
	The Director of Finance and Commerce attended an Estates SOC Meeting with GCS
07.08.18	The Deputy Chief Executive attended Gloucester Countywide IM&T Steering Group
	The Director of Finance and Commerce attended a Partnership Board Meeting with Gloucestershire Hospitals Trust
08.08.18	The Director of Engagement and Integration participated in a conference call with PWC regarding a Transaction Governance Review
09.08.18	The Deputy Chief Executive attended a meeting with a colleagues from Herefordshire Clinical Commissioning Group
	The Director of Organisational Development chaired an ICS Workforce Steering Group meeting
10.08.18	The Deputy Chief Executive and Director of Quality took part in a conference call with the Trusts Solicitors
13.08.18	The Deputy Chief Executive and Director of Quality meet with Care Quality Commission colleagues
	The Director of Service Delivery attended a meeting regarding Adult acute admissions with Herefordshire Commissioners
	The Director of Organisational Development participated in a call with PWC regarding a HR Recruitment & Induction audit review

14.08.18 The Deputy Chief Executive attended an Integrated Care Alliance programme Board meeting in Hereford

The Deputy Chief Executive attended a Wash Up date for ALS with Worcester Commissioners

The Director of Engagement and Integration attended a Third Culture Project Team meeting with GCS

16.08.17 The Deputy Chief Executive attended an Extraordinary STP Delivery Board with GCCG

The Director of Organisational Development attended a Forest of Dean Seminar with GCCG and GCS

20.08.18 The Deputy Chief Executive and Director of Quality took part in a conference call with the Trusts Solicitors

21.08.18 The Deputy Chief Executive attended a LDR Infrastructure Delivery Group Meeting at GRH

The Director of Quality took part on a conference call regarding Allied Health Professionals Rostering and care hour per patient day.

The Director of Organisational Development met with representatives from Liaison about Direct Engagement

22.08.18 The Deputy Chief Executive attended a Forest of Dean - EXTRA Integrated Locality Board

29.08.18 The Deputy Chief Executive and Director of Finance and Commerce attended a Trust Contract Management Board meeting with GCCG

The Director of Finance and Commerce attended a Resources Steering Group with GCCG

The Director of Organisational Development attended the Gloucestershire Local Workforce Advisory Board (LWAB) meeting

30.08.18 The Director of Organisational Development attended an ATOS meeting, 2gether Board meeting and GCS Board meeting

National Engagement

04.07.18 The Director of Service Delivery attended the South West CAMHS New Care Model Workshop held in Taunton, Somerset

05.07.18 The Director of Engagement and Integration attended an NHS 70 event in London

05.07.18 The Director of Finance and Commerce attended the Healthcare

& 06.07.18 Financial Management Association conference in Nottingham

10.07.18 The Director of Organisational Development attended a NHS Providers Networking meeting in London

12.07.18 The Director of Service Delivery attended the NHS Providers Networking meeting in London

16.07.18 The Director of Service Delivery attended a Co-Production event being hosted by Worcestershire Care NHS Trust in Worcester

13.08.18 The Director of Organisational Development participated in a HRD Network Chairs conference call on behalf of the South West

Agenda item 18 **Enclosure No** **Paper M**

Report to: 2gether NHS Foundation Trust Board 26th September 2018
Author: Stephen Andrews, Deputy Director of Finance
Presented by: Andrew Lee, Director of Finance and Commerce

SUBJECT: **Finance report for period ending 31st August 2018**

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

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

EXECUTIVE SUMMARY

- The month 5 position is a surplus of £405k which is in line with the planned surplus.
- The month 5 forecast outturn is an £834k surplus in line with the Trust's control total.
- The Trust currently has an Oversight Framework segment of 2, and a Finance and Use of Resources metric of 1 which is the best achievable.
- The 2018/19 contracts with Gloucestershire CCG, Herefordshire CCG, NHS England and Worcestershire Joint Commissioning Unit have been signed.
- The agency cost forecast is £4.182m, a decrease of £0.211m on last month's projection. This would be £1.048m above the Agency Control Total.
- The Trust has identified £767k of recurring savings up to August 2018 which is ahead of plan.
- The Trust has a year end cash projection of £13.5m which is £3.7m greater than the plan.
- The backdated element of the national pay award for April to June has been paid to staff in August. Budget of £1.229m has been added to income and pay to match the funding received from the Department of Health and Social Care. The Trust has calculated that the pay award funding is £55k below the level required and is an additional cost pressure to the Trust. Funding arrangements for the Medical staff pay award have not yet been announced and this could lead to an additional cost pressure too.

RECOMMENDATIONS

It is recommended that the Board:

- note the month 5 position
- note the risks inherent in the financial projections

Corporate Considerations	
Quality implications:	None identified
Resource implications:	Identified in the report
Equalities implications:	None
Risk implications:	Identified in the report

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

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

Reviewed by: Andrew Lee, Director of Finance and Commerce		
	Date	17th September 2018

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
	Date	

Explanation of acronyms used:	See footnotes

1. CONTEXT

The Board has a responsibility to monitor and manage the performance of the Trust. This report presents the financial position and forecasts for consideration by the Board.

2. EXECUTIVE SUMMARY

The following table details headline financial performance indicators for the Trust in a traffic light format driven by the parameters detailed below. Red indicates that significant variance from plan, amber that performance is close to plan and green that performance is in line with plan or better.

Indicator	**Measure**		**Comments**
NHS I Oversight	Single Oversight Framework Segment	2.0	as at June 2018
Use of Resources	Financial Risk rating	1.0	as at Aug 2018
Income	FOT vs FT Plan	101.9%	
Operating Expenditure	FOT vs FT Plan	102.0%	
Year end Cash position	£m	13.5	
PSPP	%age of invoices paid within 30 days	96.0%	91% paid in 10 days
Capital Income	Monthly vs FT Plan	193.8%	sale of Fieldview & Coleford House
Capital Expenditure	Monthly vs FT Plan	81.9%	£708k expenditure.

The parameters for the traffic light dashboard are as follows;

Indicator	RED 	AMBER 	GREEN 
NHS I FOT segment score	>3	2.5 - 3	<2.5
Use of Resources Score	>3	2.5 - 3	<2.5
INCOME FOT vs FT Plan	<99%	99% - <100%	=>100%
Expenditure FOT vs FT Plan	>101%	>100% - 101%	=<100%
CASH	<£8m	£8-£10m	>£10m
Public Sector Payment Policy - YTD	<=80%	>80% - <95%	>=95%
Capital Income - Monthly vs FT Plan	<90%	90% - 100%	>100%
Capital Spend - Monthly vs FT Plan	>115% or <85%	110% - 115% or 85% to 90%	>90% to <110%

- The financial position of the Trust at month 5 is a surplus of £405k which is in line with the plan (see appendices 1 & 8).
- Income is £742k over recovered against budget and operational expenditure is £701k over spent, and non-operational items are £38k over spent.

The table below highlights the performance against expenditure budgets for all localities and directorates for the year to date, plus the total income position.

Trust Summary	Annual Budget £000	Budget to Date £000	Actuals to Date £000	Variance to Date £000	Year End Forecast £000	Year End Variance £000
Cheltenham & N Cots Locality	(5,260)	(2,191)	(2,105)	86	(5,127)	133
Stroud & S Cots Locality	(6,054)	(2,522)	(2,492)	30	(5,984)	70
Gloucester & Forest Locality	(4,484)	(1,869)	(1,831)	38	(4,427)	57
Social Care Management	(5,034)	(2,104)	(2,595)	(491)	(6,124)	(1,091)
Entry Level	(5,927)	(2,587)	(2,441)	147	(5,878)	48
Countywide	(31,923)	(13,284)	(13,179)	105	(32,099)	(176)
Children & Young People's Service	(6,805)	(2,838)	(2,640)	198	(6,550)	255
Herefordshire Services	(13,659)	(5,684)	(5,682)	2	(13,899)	(240)
Medical	(15,472)	(6,447)	(6,706)	(259)	(15,811)	(339)
Board	(1,425)	(594)	(955)	(361)	(2,488)	(1,063)
Internal Customer Services	(1,864)	(777)	(750)	27	(1,847)	17
Finance & Commerce	(6,460)	(2,643)	(2,870)	(227)	(6,580)	(120)
HR & Organisational Development	(3,494)	(1,456)	(1,278)	178	(3,280)	213
Quality & Performance	(3,172)	(1,322)	(1,277)	45	(3,292)	(120)
Engagement & Integration	(1,490)	(621)	(628)	(7)	(1,528)	(39)
Operations Directorate	(1,165)	(486)	(524)	(38)	(1,288)	(122)
Other (incl. provisional / savings / dep'r	(4,883)	(1,902)	(2,129)	(228)	(4,673)	210
Income	119,404	49,725	50,486	761	121,710	2,306
TOTAL	**834**	**401**	**405**	**3**	**834**	**1**

The key points are summarised below;

In month

- Budgets have been increased in line with additional pay award funding and all back pay has now been paid
- The Social Care Management over spend relates to Community Care and is offset by additional income
- The Medical over spend has been caused by agency expenditure - £90k in month 5 and £772k year-to-date
- Finance and Commerce is over spent on telephony and COIN although some is offset by income
- Other expenditure is overspent due to increased depreciation costs
- Income is over recovered due to additional income for activity related Community Care work and additional development funds which weren't budgeted

Forecast

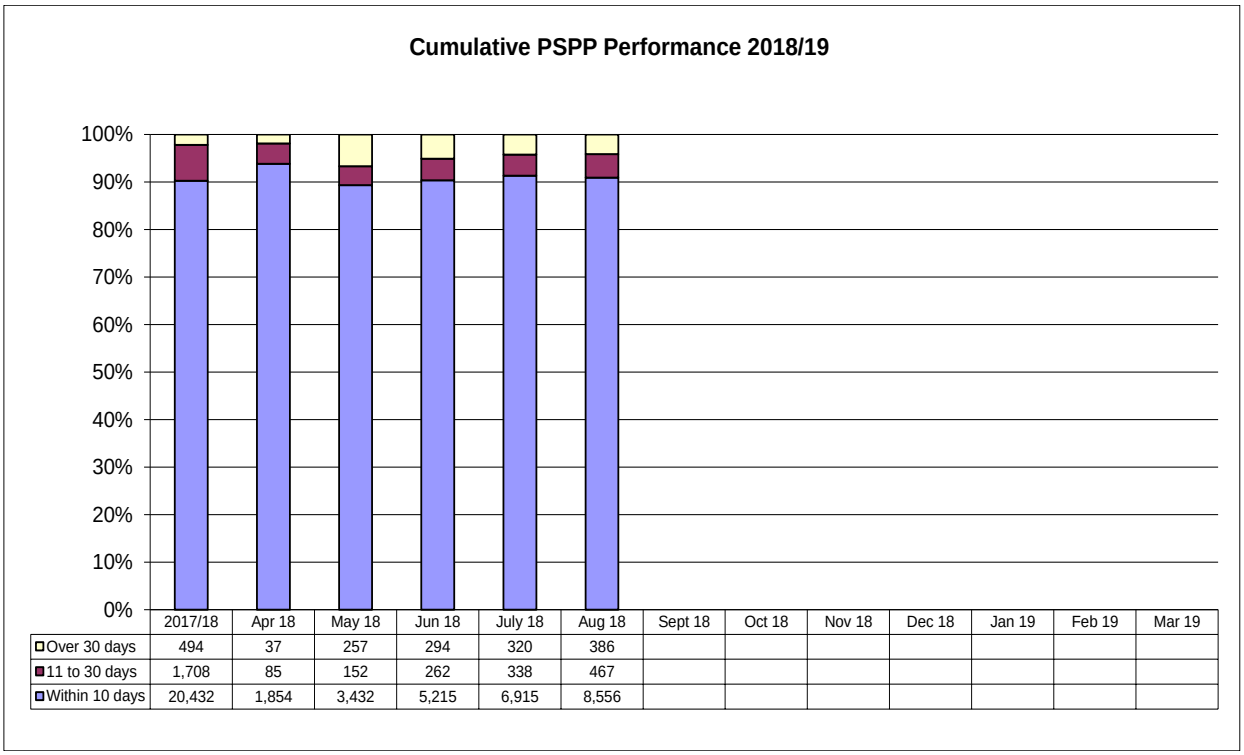
- The Social Care Management forecast over spend relates to Community Care and is offset by additional income
- The Entry directorate forecast has improved due to agreed changes to access targets for 2018/19
- The Herefordshire services forecast over spend is expected due to specialling costs and cost pressures caused by difficulties in recruiting to the wards. The

specialling costs are matched with additional income of £180k

- The Medical forecast over spend is due to anticipated continuing usage of agency during 2018/19
- The forecast over spend on Board is linked to expenditure on STP OD projects for which there is some budget in reserves.

PUBLIC SECTOR PAYMENT POLICY (PSPP)

The cumulative Public Sector Payment Policy (PSPP) performance for month 5 is 91% of invoices paid in 10 days and 96% paid in 30 days. The cumulative performance to date is depicted in the chart below and compared with last year's position:



	2017/18	Apr 18	May 18	Jun 18	July 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Over 30 days	494	37	257	294	320	386							
11 to 30 days	1,708	85	152	262	338	467							
Within 10 days	20,432	1,854	3,432	5,215	6,915	8,556							

	10 days		30 days	
	In month	**YTD**	**In month**	**YTD**
Number paid	1,652	8,556	1,776	9,023
Total Paid	1,838	9,409	1,838	9,409
%age performance	**90%**	**91%**	**97%**	**96%**
Value paid (£000)	5,208	26,617	5,437	27,558
Total value (£000)	6,338	29,235	6,338	29,235
%age performance	**82%**	**91%**	**86%**	**94%**

Agenda Item 19 **PAPER N**

Report to: Trust Board, 26 September 2018
Author: John McIlveen, Trust Secretary
Presented by: John McIlveen, Trust Secretary

SUBJECT: AMENDMENT TO THE TRUST CONSTITUTION

This Report is provided for:			
Decision	Endorsement	Assurance	Information

EXECUTIVE SUMMARY

- As a foundation trust, 2gether has a constitution which sets out its governance framework. The Trust's constitution may be amended with the agreement of both the Council of Governors and the Board.
- Currently the constitution limits the term of office for Non-Executive Directors to two terms of up to three years each.
- Non-Executive Directors of an NHS Trust are appointed by NHS Improvement, and would normally serve for eight years in total.
- This means that when appointments are made to the Shadow Board, existing 2gether NEDs in their second term of office may be disadvantaged, as Governors would not be able to offer terms of office which took those NEDs beyond the current six year maximum.
- Accordingly a change to the constitution is proposed which would allow NEDs appointed to the Shadow Board to serve up to three terms, each of up to three years. As required by the Foundation Trust Code of Governance, any term beyond six years in total would be subject to annual review and reappointment.
- This will provide more of a level playing field for NEDs from both Trusts, and will ensure continuity by retaining valuable expertise, experience and organisational memory through the transition period.
- The amended section of the constitution is shown below. Paragraph 29.4 is the main addition to the original version, which is also shown below for comparison.
- The proposed amendment has been agreed by the Trust's legal advisers, Bevan Brittan.
- The proposed amendment was agreed by the Council of Governors at its meeting on 11 September. Therefore, if approved by the Board, the amendment will take effect immediately.

RECOMMENDATIONS

The Board is asked to:

- Agree the recommended amendment to the Trust constitution

Corporate Considerations	
Quality implications:	It is important to ensure that the valuable expertise and experience offered by NEDs is retained during the transition.
Resource implications:	None identified
Equalities implications:	This amendment will ensure that [2]gether NEDs are not disadvantaged in terms of appointments to the Shadow Board through being at or near the end of their current terms of office.
Risk implications:	None identified.

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

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

Reviewed by:		
Neil Savage, Joint Director of HR and Organisational Development Ingrid Barker, Trust Chair	Date	5 September 2018

Where in the Trust has this been discussed before?		
Nomination and Remuneration Committee Council of Governors	Date	29 August 2018 11 September 2018

What consultation has there been?		
Joint Chair and CEO	Date	22 August 2018

Explanation of acronyms used:	NED – Non-Executive Director NHS I – NHS Improvement

1. CURRENT CONSTITUTIONAL PROVISION

29. Board of Directors – appointment and removal of the Trust Chair and other non-executive directors

29.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Trust Chair and the other non-executive directors.

29.2 The Trust Chair and other non-executive directors are to be appointed by the Council of Governors following a process of open competition.

29.3 Non-executive directors (including the Trust Chair) shall be appointed for an initial term of up to three years, and may be reappointed at the end of that term for a further term of up to three years.

29.4 A non-executive director (including the Trust Chair) who has completed two consecutive terms of office in 2gether NHS Foundation Trust shall be eligible to apply again for appointment following a break of at least 3 years.

29.5 Removal of the Trust Chair or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

2. PROPOSED AMENDMENT

29. Board of Directors – appointment and removal of the Trust Chair and other non-executive directors

29.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Trust Chair and the other non-executive directors.

29.2 The Trust Chair and other non-executive directors are to be appointed by the Council of Governors following a process of open competition.

29.3 Non-executive directors (including the Trust Chair) shall be appointed for an initial term of up to three years, and may be reappointed at the end of that term for further terms of up to three years, subject to a maximum of six consecutive years save where paragraph 29.4 of this constitution applies.

29.4 Where an existing non-executive director of the Trust is appointed to the Shadow Board he/she may, following completion of six consecutive years of office (calculated from the date of first appointment to the Trust Board of Directors), serve for a further period of up to three years, subject to annual review and reappointment by the Council of Governors.

29.5 A non-executive director (including the Trust Chair) who has completed six consecutive years of office in accordance with paragraph 29.3 or such other consecutive period in accordance with paragraph 29.4 of this constitution, as applicable, shall be eligible to apply again for appointment following a break of at least 3 years.

29.6 Removal of the Trust Chair or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

29.7 For the purposes of this paragraph 29, "Shadow Board" shall mean the directors appointed to the Board of Directors in anticipation of the Trust's acquisition of Gloucestershire Care Service NHS Trust under section 56A of the National Health Service Act 2006.

2gether Making life better

2gether NHS Foundation Trust

PAPER O1

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Audit Committee

DATE OF COMMITTEE MEETING: 1 August 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

INTERNAL AUDIT

Internal Audit Progress Report

The Committee received the Internal Audit Progress Report outlining progress against the Internal Audit plan. Two final reports had been issued to date, and the Committee noted the scheduling for remaining reviews. The Committee also noted continuing good progress in closing actions from previous reviews, with no actions being overdue.

Internal Audit – Violence & Aggression Review (Low Risk)

The Committee received the final review report on violence and aggression, which was given an overall classification of low risk. The report identified one medium risk finding, namely that while risk assessments had been formulated for each location within the Trust, not all staff members employed in those areas had read the assessments. Two low risk findings related to further opportunities for training, and clarification of the timeframe for reviewing the Positive Behavioural Management policy. The Committee welcomed the progress in managing violence and aggression as set out in the report, and noted that this progress was a good example of information being triangulated across Committees.

Internal Audit – Human Resources (Medium Risk)

The Committee received the final review report on HR Objectives and Appraisals, which received an overall classification of medium risk. There were two medium risk findings, relating to a lack of regularity in the timings of appraisals being carried out, and the lack of an escalation process for staff to raise a concern should their appraisal not take place. Five low risk findings were identified, relating to non-compliance with the guidance on how many staff individual managers should appraise, incomplete appraisal documentation, inconsistent objective setting, lack of appraisal training for managers, and potential improvements to appraisal documentation. The Committee's view was that sound appraisal processes were essential for the merger with Gloucestershire Care Services to progress, and noted that Neil Savage, Director of Organisational Development, would be bringing a report to the Delivery Committee regarding action plans arising from this review. The Committee also discussed whether supervision data was being adequately captured, and whether Learn 2Gether could be a medium for this. This issue would be considered by the Governance Committee.

COUNTER FRAUD ANNUAL REPORT

The Committee received the Counter Fraud Annual Report, summarising the key counter fraud activity undertaken during 2017/18, including:

- 40 fraud awareness sessions 25 of which were delivered to new starters at corporate induction,
- A counter fraud survey which showed strong levels of counter fraud, bribery and conflict of interest awareness among staff
- Reviewing (together with Internal Audit) procurement procedures within shared services
- Data matching exercises on the National Fraud Initiative database
- Delivery of the planned 145 days of counter fraud activity overall

The Committee received the Counter Fraud update for Q1 of 2018/19, and noted the activity undertaken. The report identified principle areas of risk for organisations involved in a merger, and the Committee was assured that these were largely mitigated in the case of 2gether and GCS by virtue of both organisations sharing the same counter fraud provider. The Committee noted that Audit Committee Chairs of all the Gloucestershire Trusts were scheduled to meet in the next week to discuss governance issues around Integrated Care Systems and Sustainability and Transformation Plans for the County.

STANDING FINANCIAL INSTRUCTIONS

The Committee received the Standing Financial Instructions for the Trust which had been reviewed in full, following a partial update in August 2017. Financial delegation limits had not been changed, but SFI's had been revised in terms of contracting and procurement to reflect current good practice. The Committee asked the Director of Finance to produce for Committee members a list itemising the revisions to SFI's, and agreed to delegate authority to the Committee Chair to approve the revisions should these be deemed satisfactory.

AUDIT COMMITTEE ANNUAL REPORT

The Committee received the Annual Report setting out the Committee's activities in relation to its terms of reference during 2017/18. The Annual Report is attached for the Board to note.

COMMITTEE TERMS OF REFERENCE

The Committee received its terms of reference which had been subject to a scheduled review. Two minor changes were made to clarify that the Trust Chair may attend a meeting of the Committee by invitation, and that Executive Directors should attend in rotation. The Board is asked to note these minor changes to the Committee's terms of reference.

OTHER ITEMS

The Audit Committee also:

- Received the standing report on waivers over £25k, and noted the two waivers in the reporting period.
- Received the External Audit progress report and technical update
- Received and noted the Losses and Special Payments report
- Reviewed and noted the Board Assurance Map.
- Reviewed the Risk Register.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to note the contents of this summary, and specifically the Committee's Annual Report, and the minor changes to the Committee's terms of reference.

SUMMARY PREPARED BY: Marcia Gallagher ROLE: Committee Chair

DATE: 1 August 2018

2gether NHS Foundation Trust

Audit Committee Annual Report 2017/18

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. This membership enables the Committee to triangulate information and assurance received at other Board's Committees, each of which is chaired by a member of the Audit Committee.

1.3 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.

1.4 The Committee met 6 times during the period 1 April 2017 to 31 March 2018, 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. The October 2017 meeting was an extraordinary meeting to receive a report on joint leadership arrangements with Gloucestershire Care Services. Each meeting was quorate.

1.5 Attendance by members at the Committee during the period was as follows:

	12/04/2017	24/05/2017	02/08/2017	19/10/2017	01/11/2017	07/02/2018
Marcia Gallagher (Chair)	✓	✓	✓	✓	✓	✓
Jonathan Vickers			✓	✓	✓	✓
Nikki Richardson	✓		✓	✓	✓	✓
Duncan Sutherland	✓	✓		✓	✓	✓
Quinton Quayle	✓	✓	✓	✓	✓	✓
Maria Bond	✓	✓	✓	✓	✓	✓

1.6 The following were in attendance at the Committee during the period:

	12/04/2017	24/05/2017	02/08/2017	19/10/2017	01/11/2017	07/02/2018
Andrew Lee, Director of Finance & Commerce	✓	✓	✓	✓	✓	✓
Stephen Andrews, Deputy Director of Finance		✓	✓		✓	✓
Lee Sheridan, Head of Counter Fraud					✓	✓
Lisa Evans, Board Committee Secretary	✓	✓			✓	✓
Marie Crofts, Director of Quality						
John McIlveen, Trust Secretary	✓	✓			✓	✓

Rayna Kibble, Local Counter Fraud Specialist	✓		✓			
Jon Brown, KPMG[1]			✓		✓	✓
Duncan Laird, KPMG					✓	✓
Dominique Lord, PWC					✓	✓
Ian Howse, Deloitte[2]		✓				
Gordon Benson, Asst Director of Governance		✓				
Shaun Clee, Chief Executive		✓				
Ruth FitzJohn, Trust Chair[3]		✓				
Tanya Hartley, Asst Director of Finance		✓				
Anna Hilditch, Asst Trust Secretary			✓			
Lynn Pamment, PWC					✓	✓
Claire Edge, Deloitte	✓					
Kate Nelmes, Head of Communications		✓				
Natalie Tarr, PWC	✓		✓			
Alan Bourne-Jones, Risk Manager			✓		✓	✓
Angela Cox, Financial Shared Services	✓		✓			
Alex Gent, Financial Shared Services	✓		✓			
Neil Savage, Director of Organisational Development				✓		✓
Rebecca Walters, Executive Assistant				✓		

1.7 Meeting of the Committee on 1 November 2017 and 7 February 2018 were each observed by Governors Ann Elias and Mike Scott, who provided 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

[1] KPMG became the Trust's external auditors on 1 April 2017

[2] Deloitte's contract as external auditors ended on 31 March 2017

[3] The Trust Chair is not a member of the Audit Committee, but may attend a meeting of the Committee by invitation. Ruth FitzJohn left the Trust on 31 December 2017.

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, and also had regard to the Assurance Map (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 Corporate Risk Register and the Assurance Map at regular intervals in order to provide challenge and receive assurance that strategic and corporate risks are being adequately monitored.

2.6 The Committee received an assurance report regarding preparations for the introduction of the General Data Protection Regulation.

2.7 The Committee reviewed and approved a revised policy for the management of conflicts of interest which introduced more robust controls as recommended by NHS England.

2.8 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 2016/17 Annual Report.

2.9 The Committee reviewed the Register of Directors' Interests, and the Register of Gifts and Hospitality.

2.10 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. This will be particularly important as preparations for the merger with Gloucestershire Care Services proceed, with the attendant risk that management focus on the merger process coupled with finite executive capacity might impact on the maintenance of 'business as usual'.

2.11 Internal Audit

2.12 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 2017/18
- Considered the findings of internal audit in relation to work on the following issues

  - Corporate Governance & Risk Management
  - Information Governance
  - Data Quality & Performance Management
  - Contracting – Financial Shared Services
  - Ligatures
  - Procurement phase 1
  - Procurement phase 2

- HR- Bank & Agency
- Service Line Reporting
- Information Security - Phishing
- Estates and Capital – phase 1
- Core Financial Systems
- Cost Improvement Plan
- Estates phase 2 – Pullman Place

2.13 All audit reports were classified as either Medium or Low risk. The audits produced a total of 43 findings, the same as the previous year. There were 25 Low, 17 medium and 1 high risk-rated findings, and a further 8 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.

2.14 A number of these audits were undertaken at the Committee's request in order to examine areas where known areas of risk exist. The one high risk finding related to the review of Information Security, which was a review conducted at the Trust's request. The finding related to poor awareness among employees on the security risks associated with phishing emails as well as other common forms of cyber-attack. An action plan was drawn up to address this and simplified cyber security guidance was developed and publicised to staff through newsletters, and via wallpaper on Trust computers which promoted greater awareness of the need for good cyber security.

2.15 The Committee has been pleased to note during the year continued good performance in terms of 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.

2.16 **External Audit**

- The Committee received and noted the final audit in respect of the 2016/17 Financial Accounts and the 2016/17 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 2017/18.
- 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.

2.17 The Committee was pleased to note the effective and efficient handover of external audit duties from Deloitte (whose contract ended on 31 March 2017) to KPMG who were appointed by the Council of Governors as the Trust's External Auditor from 1 April 2017. KPMG have provided a similarly effective audit service during their first year.

2.18 **Private Meeting with the Auditors**

2.19 The Committee Chair met privately with internal and external auditors in May 2017, and again on October 2017. 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.

2.20 Other Assurance Functions

2.21 The Committee has reviewed the findings of other significant assurance functions where appropriate, and has considered any governance implications for the Trust. A particular focus for the Committee was the implementation of actions resulting from an Internal Audit review of Procurement Shared Services which produced a high risk classification. During the year the Committee sought and challenged assurance on actions to address weaknesses identified during the audit review. The final Internal Audit review published in July 2017 was rated as low risk and produced only 1 advisory finding

2.22 The Committee received regular Counter Fraud updates, and received the Counter Fraud Annual Report for 2016/17 and the Counter Fraud action plan for 2017/18. The planned total of 145 days of counter fraud activity was delivered during 2016/17 across the 4 generic areas of Counter Fraud activity as defined by NHS Protect. The areas of activity for 2016/17 were apportioned thus: 85 to 'Strategic Governance' 'Inform and Involve', and 'Prevent and Deter' and 60 to 'Hold to Account'. One proactive exercise was undertaken during the year, namely a joint exercise with Internal Audit relating to procurement.

2.23 The NHS Protect self-review tool provided assurance that the Trust was compliant with NHS Protect's Standards for Providers, with the overall level of risk being rated as 'Green' the same rating as for the previous year. Two areas relating to Financial Shared Services were rated as amber, and these were subsequently addressed during the 2017/18.

2.24 The Committee Chair met privately with the Head of Counter Fraud in February 2018. No concerns were reported on either side.

2.25 Management

2.26 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

- assurance about the specification for a joint Internal Audit tender ;
- assurance on revisions to the Trust's Standing Financial Instructions;
- updates and assurance on implementation of actions within the Pullman Place review

2.27 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.

2.28 Financial Reporting

2.29 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.

2.30 The Committee has visibility at each meeting (with the exception of the final accounts meeting) on waivers over £25k applied in the preceding period. This reporting includes nil returns.

2.31 The Committee reviewed the 2016/17 financial statements and annual report at the May 2017 meeting prior to recommending the final accounts for Accounting Officer signature, in line with authority delegated by the Board.

2.32 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 2017 Board.

3.3 The Committee reviewed its terms of reference during the year.

3.4 The Committee convened an extraordinary meeting in October 2017 to review and endorse proposals for joint leadership arrangements as part of the ongoing merger process involving ^{2}gether and Gloucestershire Care Services NHS Trust.

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. The work of the Committee in the last financial year, and the triangulation of information and assurance received both at the Audit Committee and at other Committees chaired by members of the Audit Committee, has enabled the Audit Committee to conclude that the Trust's systems are in the main sound, reliable and robust.

Marcia Gallagher
Chair, Audit Committee

PAPER O2

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Delivery Committee

DATE OF COMMITTEE MEETING: 25 July 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PERFORMANCE DASHBOARD

This month's report set out the performance of the Trust for the period to the end of June 2018 against NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

Of the 202 performance indicators, 127 were reportable in June with 116 being compliant and 11 non-compliant at the end of the reporting period. The Committee noted the Performance Dashboard Report and accepted the report as a significant level of assurance that Trust contracts and regulatory performance measures were being met or that appropriate action plans were in place to address areas requiring improvement. The Committee was assured that there was ongoing work to review all of the indicators not meeting the required performance threshold. This included a review of the measurement and data quality processes as well as clinical delivery and clinical practice issues.

IAPT SERVICE IMPROVEMENT PLAN

The Committee received an overview of the key issues relating to the progress made within IAPT Services for both Gloucestershire and Herefordshire. The report updated the Committee on all aspects of the IAPT recovery plans.

The report identified risks relating to the delivery of the Trust's agreed recovery plan. The key issues for the Committee to be aware of this month were:

- In stage waiting list backlog clearance: The change in recording methodology and the reclassification of assessment appointment to assessment / treatment appointments moves the majority of the waiting list to 'in stage waiting' for a second treatment appointment. Recovery plans had been remodelled in both counties to reduce the backlog waiting list.
  For Gloucestershire the plan would require additional investment which was to be discussed with Commissioners and in Herefordshire the plan required a reduction in Access rates which had now been agreed with Commissioners.
- Access rates for June 2018 were below target for both Herefordshire and Gloucestershire (for Q1, Gloucestershire missed the recovery plan Access target by 5 patients). We have further refined our daily access reports to enable more detailed assessment slot planning.
- Recovery rates for June 2018 were above the national 50% target for Gloucestershire and Herefordshire.
- Waiting time thresholds – Nationally, waiting time thresholds were reported against 2 measures (First Treatments and Discharges) and the Committee noted performance against targets for June 2018.

LOCALITY REVIEW – CYPS / CAMHS

The Committee received a Locality Review which set out the work of CYPS and CAMHS. Recent data demonstrated that a quarter of all children were likely to have a diagnosable condition and it was important that the Trust worked in conjunction with the Acute Trust. There was concern that referral rates could increase excessively, but it was suggested that national data would support requests from the Trust for additional funding.

For 2gether CYPS and CAMHS both services were rated 'Good' by the CQC; some issues were noted with buildings in Herefordshire which would be resolved shortly when the service moved to a new

location.

The risk around recruitment was noted; with a national shortage of qualified staff reported. Herefordshire found it particularly difficult to recruit, however measures to improve the situation were being explored.

WORKFORCE INDICATORS

The Committee received the quarter one performance against the Trust's Workforce Key Performance Indicators (KPI). The report detailed compliance for statutory and mandatory training, appraisal and sickness absence and workforce turnover. The report also provided a comparison with other organisations which enabled the Trust to benchmark performance.

The Committee was assured that the 2018/19 KPI for statutory and mandatory training had been met in quarter 1 with compliance at an average of 91%. Appraisal compliance was below the 90% revised target with an average of 87% for the first three months of quarter 1 2018/19.

Overall sickness absence had increased when compared with the same period in 2017/18. In May 2018 the Trust's 12-month rolling average for sickness absence was 5.10% which was 0.31% higher than the same period in 2017. The proportion of long term vs short term sickness absence was generally in line with other NHS Trusts in England. A number of measures were being undertaken to deliver compliance, however given the Trust's previous performance, assurance that the sickness absence target would be met in 2018/19 was limited.

Turnover was monitored on a monthly basis and although there was no key performance indicator for turnover it was important to ensure that turnover was maintained within reasonable levels. The average turnover for quarter 1 2018/19 was 9.30%.

PREMISES ASSURANCE MODEL

In 2010 the Department of Health launched the voluntary Premises Assurance Model (PAM) to support the NHS in improving the quality and safety of NHS premises while improving efficiency and effectiveness. This was the second year the Trust had completed the voluntary Estates and Facilities self-assessment and remained 'Good' in all domains. There were now no 'inadequate' areas, reduced 'requires major improvement' and 'requires minor improvement' and additional 'good' and 'outstanding areas'. For 2018 additional fields, that were out of the direct management of Estates and Facilities, had been completed and the Trust had developed a new domain for Counter Fraud – in which the Trust was outstanding.

OTHER ITEMS

- The Committee received on update regarding the Trust's response to the recent and continued hot weather. The Committee was assured that systems and structures were in place to safeguard patients and staff during this time.
- The Committee received an update on the current position of the Perinatal Mental Health Community Services Development Fund.
- Locality exception report were received from the Gloucestershire and Countywide localities.
- The Committee received a report on the Trust's Reference Costs (RCIs) comparing these with the national averages and against a selection of mental health providers. The report also compared the Trust Reference Costs against the same selection of mental health providers for the period 2016/17. Of the eleven providers selected for comparison, the Trust RCI of 113 was the second highest average cost along with that of AWP. The highest was 120 for South London & Maudsley NHSFT. This indicated that 2gether's services on average worked out to be 13% higher than the national average. Work was continuing to improve the reference costs and costing within the Trust and a report on PLICS and SLR was requested which would provide a better understanding of service line management.
- The Committee received a Demand Management report for the Herefordshire Crisis and Home Treatment Teams.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to note the content of this report, and specifically the assurances received around the financial position.

PAPER O2

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Delivery Committee

DATE OF COMMITTEE MEETING: 29 August 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

MH BED PRESSURES

The Committee received an update on issues around bed pressures across the Trust. Over the last few months occupancy had been at 96 – 97%. There were various reasons for this which included delayed transfers of care and clinicians not wanting to discharge patients too early. Clinical Managers needed support to make timely discharges and the varied experience and effectiveness of managers was noted. The average length of stay on Kingsholm ward was 44 days compared to 29 days on Priory.

It was currently felt that there were enough beds available. The Locality needed to work to reduce delays in discharges and improvements to the bed management process were taking place; this included a request to Commissioners for an increase from a 5 to 7 day week for the bed manager post.

There were no Trust patients out of county at this time other than 3 in PICU; these were counted separately as this was for specialist care. It was agreed that a further update on the position would be provided at the Delivery Committee in October.

PERFORMANCE DASHBOARD

This month's report set out the performance of the Trust for the period to the end of July 2018 against NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

Of the 194 performance indicators, 91 were reportable in July with 85 being compliant and 6 non-compliant at the end of the reporting period. Where performance was not compliant, Service Directors were taking the lead to address issues with a particular focus continuing to be on IAPT service measures.

CQUIN IMPLEMENTATION

The Committee received assurance that all reports for Herefordshire, Gloucestershire and Low Secure were deemed compliant for Q4 of 17/18. Therefore, there was no shortfall in the CQUIN income for the financial year 17/18.

The Committee was significantly assured on the delivery of the 18/19 CQUINs. All streams were currently rated as amber and these were being monitored closely through the CQUIN workshops chaired by the Director of Quality.

IAPT SERVICE IMPROVEMENT PLAN

The Committee received an overview of the key issues relating to the progress made within IAPT Services for both Gloucestershire and Herefordshire. The report updated the Committee on all aspects of the IAPT recovery plans.

The report identified risks relating to the delivery of the Trust's agreed recovery plan. The key issues for the Committee to be aware of this month were:

- In stage waiting list backlog clearance: The change in recording methodology and the reclassification of assessment appointment to assessment / treatment appointments moved the majority of the waiting list to 'in stage waiting' for a second treatment appointment.
- Recovery plans had been modelled in both counties to reduce the backlog waiting list. For Gloucestershire the plan required additional investment which had been requested via Commissioners. Additionally, a revised Access trajectory was to be proposed to Commissioners in September, which would enable the backlog to be reduced earlier. For Herefordshire a revised Access trajectory had been discussed and agreed with Commissioners in principle. Formal agreement was anticipated in September. The Committee noted that:
- Access rates for July 2018 were marginally below the recovery plan target for Gloucestershire (16.78% against a 16.8% target) and above recovery plan target for Herefordshire at 15.12% (against a 15% target)
- Recovery rates for July 2018 were above the national 50% target for Gloucestershire and Herefordshire.
- Waiting time thresholds – nationally, waiting time thresholds were reported against 2 measures – 6 and 18 week referral to treatment. Performance against these targets was noted.

OTHER ITEMS

- The Committee received a verbal update on Financial Performance at the end of July 2018. The Trust was on target to deliver the planned surplus. At the end of July the Trust had a list of known risks and these were being actively worked on. A review of the Cost Improvement Process would come to the Delivery Committee in October.
- The Committee received locality exception reports for Herefordshire and CYPS/CAMHS.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to note the content of this report, and specifically the assurances received around the financial position.

2gether Making life better

2gether NHS Foundation Trust

PAPER O3

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Development Committee

DATE OF COMMITTEE MEETING: 8 August 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PROGRAMME OF ENABLING STRATEGIES

This paper offered assurance to the Committee that a programme and schedule to align enabling strategies and policies for 2gether and GCS was underway. A report would be presented back at the October meeting once the schedule was fully populated.

SOCIAL INCLUSION ANNUAL REPORT 2017/18

The Committee received the Social Inclusion Team annual report. This was a very comprehensive report which demonstrated the huge amount of work carried out by the SI Team. Strong partnership working was also demonstrated.

The Committee highlighted one of the initiatives "Rambling Rabbits" which was a fortnightly walking group, providing people who use Trust services with a regular opportunity to get out, be physically active and connect with their surroundings and other people. The Committee received assurance that clinical teams and GPs were fully aware of how to access and refer service users to this group. It was agreed that this report would be shared with the Trust's Governors for information as it offered excellent assurance about the breadth of work that the team was involved in.

CAPITAL EXPENDITURE

The Committee received a verbal update on the indicative timeframe for major capital schemes. Five major schemes were discussed. The Committee asked that a written update be provided on these within the next report.

The Trust was planning to spend approx. £2.5m on capital in 2018/19 and this would be confirmed as part of the mid-year financial review which would take place during October. It was noted that attendance at the Capital Control Group had improved which was pleasing. Non-Executive Directors were invited to attend these meetings for information, and dates would be provided for future sessions.

The Committee received a verbal update on current and planned estates disposals. Approval for disposals was delegated to the Trust Board and although disposals had been included within the capital plan which was approved previously, these had not been explicit. It was therefore requested that any recommendations regarding property disposals be drawn out and included as a separate recommendation in all future reports. Assurance was received however that the Audit Committee had been sighted on this.

OTHER ITEMS

- The Committee received and noted the Joint Working 'Function of Engagement' document, which set out the functions of engagement required to support and facilitate our shared strategic intent.
- The Committee received the new Engagement and Communication Strategy delivery plan for 2018/19 and the plan for monitoring progress against the actions. It was noted that more measurable actions/metrics had been included and these clearly linked to the Trust's key objectives. A lot of work was already underway and the Committee would receive a progress report on Q1 and Q2 activity at its October meeting.
- The Committee received a verbal update on research developments and the second stage of the Research 2gether Strategy delivery plan which set out the ongoing objectives to ensure the aims of the Research Strategy are met across the strategy domains.

ACTIONS REQUIRED BY THE BOARD

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

PAPER O4

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Governance Committee

DATE OF COMMITTEE MEETING: 31 August 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PATIENT SAFETY AND SERIOUS INCIDENT REPORT

Patient Safety/Serious Incident Update Report

The Governance Committee received an overview and analysis of serious incident reporting to commissioners and high level monthly trend analysis, including Never Events. 2 new SIs were reported during July 2018 both in Gloucestershire. No Never Events had occurred within Trust Services and the Committee was significantly assured that the Trust had robust processes in place to report and learn from serious incidents.

The Open Actions Report demonstrated overdue actions from the 2017/18 SI Action Plans at the request of the Committee. The Action Plan for 2016/17 was fully complete and the Committee was pleased with this progress.

The Committee noted that a new ruling by the High Court had determined that the conclusion of suicide was now to be determined on the civil standard of proof 'the balance of probabilities' as opposed to 'beyond all reasonable doubt'. Serious incident investigations had improved in quality with demonstrable evidence of active engagement of families in the process. The investigation team was now funded on a recurring basis. The significant development for this year was to be the introduction of appropriately trained 2gether Family Liaison Officers to provide improved bereavement support for families and carers.

Q1 Patient Safety Incident & Near Miss Report and Analysis

The Committee received an overview and analysis of Datix reports regarding patient care within clinical areas for Quarter 1 2018/19. The Committee was assured that there had been a further dip in the reporting of slips, trips and falls at Charlton Lane Hospital during this period. The gently increasing trend in reporting of detained absconders in Gloucestershire was noted but the Committee was assured that there was no harm associated with these incidents.

Future of Patient Safety Investigations

The Committee received a report from NHS Improvement on the Future of NHS Patient Safety Investigations. The Trust was well-placed to deal with an updated Framework and a report would be presented back to the Committee on what the Trust was doing to meet the proposed principles of the revised Serious Incident Framework.

RESTRICTIVE INTERVENTIONS ANNUAL REPORT

The prevention and safe management of episodes of violence and aggression was a very important area of practice within the Trust. This report focused on a review of data relating to the recording and monitoring, and use of restrictive physical interventions over a 12 month period (April 2017 – March 2018) across all appropriate areas of Trust business.

Since the introduction of the new Datix platform and the Weekly Managers Dashboard report, significant assurance could be provided that the data presented was reliable. There was

emerging and sustained evidence that there was a gradual migration from the use of Prone restraint to Supine restraint providing assurance of a cultural shift.

The number of interventions at Berkeley House remained high. However, as a result of the changes put in place and analysis by the Behaviour Support and training team, there was assurance around the accuracy of these figures. There was also greater clarity about the nature of these interventions.

The Committee agreed that there was a great deal of very positive work being carried out. An update report was requested for 6 months' time. The Committee agreed that the 2019/20 Clinical Audit Programme should include the use of Pulse Oximetry following episodes of restraint.

FOOD AND DRINK STRATEGY 2018-2021

In 2014 the Hospital Food Standards Panel's Report on standards for food and drink in NHS hospitals was published by the Department of Health. NHS England issued specific guidance for commissioners on the outcomes they should be expecting of providers in relation to excellent Nutrition and Hydration, with an expectation that these were to be achieved by March 2018. The Governance Committee had previously endorsed the adoption of the Hospital Food Standards across Trust inpatient sites, and this included the requirement to develop and maintain a local food and drink strategy.

The Committee noted the resource implications of this work, including investment in a nutritional analysis software package to ensure the food provided at inpatient sites which cook from fresh have accurate nutritional data. This purchase had been approved by the Executive Committee.

The Governance Committee endorsed the Inpatient Food & Drink Strategy and noted that an action plan was to be developed and monitored by the Quality and Clinical Risk Sub-committee.

OTHER ITEMS

- The Committee received the Quarter 1 Quality Report and the Quarter 1 Service Experience Report. Both would be presented in full to the Trust Board in September.
- The Committee received the Medical Appraisal Annual Report and approved this for onward presentation at the Trust Board
- The Committee received the Safe Staffing data for June and July 2018 and significant assurance was received regarding the levels of staffing on all wards during this time. In terms of Temporary Staffing, it was noted that there was now a focus on embedding progress made last year and additionally focusing on both medical agency spend and IAPT spend during 2018/19. The current predicted forecast for agency was above the control total. An update on staffing issues in Herefordshire was received. The Committee agreed that an additional report focussing on the use of external temporary staffing should be provided quarterly, with the Safe Staffing paper continuing to be received at each meeting.
- The Committee received the Medicines Management Annual Report
- The Committee received a report which provided a summary of the key issues and activities associated with Safeguarding Children and Adults in Herefordshire and Gloucestershire for 2017/18. The report provided the Committee with significant assurance that safeguarding was a priority function of the Trust and was being delivered as per the 4 Safeguarding Strategic Boards across Gloucestershire and Herefordshire.

ACTIONS REQUIRED BY THE BOARD

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

Agenda item 21 **Enclosure Paper P**

Report to: Trust Board, 26 September 2018
Author: Ingrid Barker, Trust Chair
Presented by: Ingrid Barker, Trust Chair

SUBJECT: **JOINT CHAIR'S REPORT**

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

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

INTRODUCTION AND PURPOSE

Recognising the Strategic Intent work and my role as both Chair of ²gether and Gloucestershire Care Services this report format has been revised to reflect the breadth of my activities across both Trusts. The production of a joint report does not impact on my existing accountability as the appointed Chair of each Trust.

The Report also provides an overview of 2gether Non-Executive Director (NED) activity.

RECOMMENDATIONS

This report is for information and the Board is invited to note the report.

1. INTRODUCTION AND PURPOSE

This report seeks to provide an update to both Boards on Chair and Non-Executive Director activities in the following areas:

- Strategic Intent
- Board Development
- Working with our partners
- Working with our colleagues
- National and Regional Meetings attended and any issues highlighted

1.1 Strategic Intent Update – Moving Towards Developing an integrated Physical and Mental Health Care Offer with 2gether NHS Foundation Trust

The work in the two Trusts to move forward the Strategic Intent continues, with progress and overall monitoring being maintained through the agreed governance processes. The Strategic Intent Leadership Group, which is made up of Non-Executives and Executives from both Trusts, has been closely involved in reviewing and testing the Strategic Case before it is formally considered by the Trust Boards ready for submission to NHS Improvement. The Council of Governors at 2gether NHS Foundation Trust, in line with their statutory responsibility in relation to "significant transactions" continue to be engaged in the merger process. As the Trusts work together we keep at the heart of all our work the needs of service users – ensuring we are looking after today's users but also thinking about how we can improve services for the future. This ambition will be central to the important work we will be undertaking in October to develop the vision and values for the merged organisation. I am delighted that both Trusts have agreed this work should progress rapidly and with the involvement of as many colleagues and service users as possible, given its importance in setting the culture for the future.

1.2 Board Development

A Joint Board Development session took place on 14th August. This was a session supported by the Kings Fund, a respected think tank that shapes health and social care policy and practice. On this occasion we heard from Chris Naylor, Senior Fellow, Policy on "Integrating mental and physical health - What are the opportunities for improving the quality of care?" about the evidence to support the need for integration of physical and mental health services. We also heard from Peter Homa, now chair of the NHS Leadership academy about his experience of mergers, drawing on his extensive experience as a NHS Chief Executive. As we take forward our strategic intent we are committed to ensuring we learn from the good practice and trail blazers already in place following integration of services in other areas – and also to identify any pitfalls that we would need to be aware of – this session was an invaluable part of this process.

A full programme of Board development is planned. These sessions are an important part of the work we are doing to bring our two Trusts together, ensuring that our shared values stay at the heart of what we are working to achieve and that best practice in both organisations is maintained and enriches our work.

1.3 Working with our Partners

Maintaining business as usual remains a priority across both organisations. As part of this I have continued my regular meetings with key stakeholders including:

- Together with the Chief Executive, meeting with University of Gloucestershire Vice-Chancellor, Stephen Marston, and Lorraine Dixon, Head of School, Health and Social Care
- Together with the Chief executive, meeting with Baroness Jan Royall to update her on Forest of Dean Hospital Review developments
- Together with the Chief executive, meeting on three occasions with David Drew MP and also with representatives from the Vale League of Friends and Stroud League of Friends

- Gloucestershire Health & Care Overview and Scrutiny Committee (HCOSC)
- Gloucestershire Health and Social Care Chairs' meeting
- Meeting of the Hereford & Worcester Chairs of Health & Social Care Organisations – represented by Nikki Richardson [2g]
- Gloucestershire Health & Wellbeing Board - represented by Nick Relph [GCS] and Nikki Richardson [2g]
- NHS Providers Chairs and Chief Executives meeting, London – represented by Graham Russell [Non-Executive Director, GCS] and Nikki Richardson [Vice-Chair, 2g]
- Meeting with Independent STP Chair, Chris Creswick
- Attending the Citizens' Jury at the Forest Hills Golf Club, Coleford
- Meeting with Peter Lachecki, chair of Gloucestershire Acute Trust
- NHS Providers Remuneration Committee (Committee Chair)
- NHS Providers Board in London
- Gloucestershire Strategic Forum
- I acted as the external assessor for the interviews for the Chair of Oxford Health NHSFT
- Two meetings with Rob Bladgen, lead governor for 2gether, and with the governors'' nominations and remuneration Committee, in preparation for the Council of Governors'meeting held on 11th September.
- Final meeting with Bilal Lala who has been on placement with GCS as part of the Insight development programme, designed to develop potential NEDs from the BAME community.

A regular meeting of the Health Care Overview and Scrutiny Committee (HCOSC) took place on 11th September where issues discussed included the impact of the Health & Wellbeing Board, along with the Urgent and Emergency Care Sustainability Plan 2018/19 (winter plan).

HCOSC Members, Cllr Eva Ward and Cllr Stephen Hirst, visited the Vale Community Hospital on 1st August, accompanied by GCS Chief Operating Officer, Candace Plouffe.

The quarterly meeting of the County's Health and Social Care Chairs took place on 11th September where we discussed the current issues facing the NHS and future plans.

Gloucestershire Health and Wellbeing Board met on 18th September 2018 - I was represented at this meeting by Nick Relph, Non-Executive Director for Gloucestershire Care Services and Nikki Richardson, Vice-Chair for 2g, as I was on annual leave. The meeting focused on Strategy Development and considered the development of a vision for the population health and wellbeing in Gloucestershire, challenges and levers across the system to support or restrict its achievement and whole system leadership.

2. WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

On 16th August, the Vale League of Friends invited the Joint Chief Executive Officer, the Chief Operating Officer for Gloucestershire Care Services and I to join them at their monthly meeting discuss the Stroke Rehabilitation Unit and understand their views and potential concerns.

The Chief Executive and I held our regular quarterly meeting on 28th August with Chairs of Leagues of Friends relating to the community hospitals.

This was followed by a meeting with David Drew, MP for Stroud, and we were also joined by representatives from the Vale League of Friends and Stroud League of Friends, where we discussed concerns and opportunities relating to the proposals to locate the Stroke Rehabilitation unit at the Vale Hospital.

Richard Graham, MP for Gloucester, spent a day with 2gether NHSFT, where his visits included the Mental Health Liaison Team, Gloucester and Forest Crisis Resolution and Home Treatment Team, Maxwell Suite, Health Based Place of Safety and Street Triage and the Contact Centre/Urgent Response Team at Waterwells.

The Joint Chief Executive and I met with Baroness Jan Royall to update her on developments relating to the Forest of Dean Community Hospitals Review.

3. ENGAGING WITH OUR TRUST COLLEAGUES

I continue to meet regularly with Trust colleagues at GCS and 2gether and visit services at both Trusts to inform my triangulation of information. I have undertaken a service visit with 2gether governors to rehabilitation units at Honeybourne and Laurel House. I visited Ambrose House in Barnwood, Gloucester and met with Jan Furniaux, Locality Director. I also attended part of the Social Care Strategy Project Board and met some of the teams based at Ambrose.

I undertook a quality visit with Gloucestershire Care Services Cardiac Rehabilitation Team and took part in an exercise session held at the Oxstalls University Campus, then sat in on a classroom session afterwards.

All these service visits sessions reinforce for me the importance of the work both Trusts provide to our community and the passion and dedication of colleagues to make a positive difference to the service users we are supporting.

I had introductory meetings with the 3 newly elected Governors for 2g - Miles Goodwin, Graham Adams and Anneka Rose – all are enthusiastic to play their part in ensuring that the best possible services are provided to the community.

4. NED ACTIVITY

Since my last Board report the Non-Executive Directors for both 2gether NHSFT and Gloucestershire Care Services NHST have held the following meetings:

- Weds 22nd August – 2g Non-Executive Directors (NEDs) met at Edward Jenner Court. The Chief Operating Officer for Gloucestershire Care Services (Candace Plouffe) was invited to attend to give an overview of GCS services and performance.
- Thurs 6th September – 2g and GCS NEDs met for separate team meetings, as well as a Joint NEDs meeting.

A schedule of NED meetings has been arranged going forward.

Other activities undertaken by the 2gether NEDs are listed at Appendix A.

APPENDIX A

NED'S KEY ACTIVITIES (August and September 2018)

Jonathan Vickers (Chair of Development Committee)

Since his last report Jonathan has;

- Reviewed and commented on audit committee papers
- Held conversations with colleagues on development committee matters
- Prepared for and chaired a meeting of the development committee
- Reviewed and commented on SILG papers
- Prepared for and attended a NED's meeting
- Prepared for and attended two Board meetings
- Prepared for and attended an ATOS meeting
- Prepared for and attended a meeting of audit committee members
- Conducted and reported on a complaints audit
- Prepared for and attended a Council meeting

Nikki Richardson (Deputy Trust Chair/SID/Chair of Governance Committee)

Since her last report Nikki has;

- Prepared for and attended Board meeting x 2
- Prepared for and attended closed Board meeting x 3
- Panel member for Director of Quality interviews
- Meeting with Director of OD
- Prepared for and attended Audit Committee
- Panel member for Consultant Psychiatrist interview
- Meeting with Joint CEO
- Meeting with Joint Chair
- Attended Joint Board Development session
- Meeting with Assistant Director of Business Continuity
- Prepared for and attended SILG
- Governor visit to Charlton Lane Hospital
- Prepared for and attended SI review
- Meeting with Director of Quality
- Attended NED meeting x2
- Prepared for and Chaired ATOS meeting
- Prepared for and Chaired Governance Committee
- Prepared for and attended Audit Committee annual review meeting
- Attended joint NED meeting
- Shadowing visit with CLDT x2
- Shadowing visit with IHOT
- Prepared for and attended Hereford & Worcester STP Chair's meeting
- Prepared for and attended CoG
- Prepared for and attended MHLS development session
- Prepared for and attended Gloucestershire Health & Wellbeing Board
- Panel member for MHAM Hearing
- Attended NHS Providers meeting

Marcia Gallagher (Chair of Audit Committee)
Since her last report Marcia has;
August
- Prepared for and Chaired the Audit Committee
- Prepared for and attended the Development Committee
- Attended a meeting of the Gloucestershire Audit Committee Chairs
- Attended a meeting of the Gloucestershire Audit Chairs with the STP/ICS Independent Chair
- Attended a GCS/2GFT joint Board development session with the Kings Fund
- Observed a Clinical Quality and Risk Committee
- Attended a 2GFT NEDs meeting
- Prepared for and attended the Delivery Committee
- Met with Chair of the Security and Resilience Board
- Prepared for and attended an ATOS Committee
- Prepared for and attended the August Board meeting
- Observed a GCS and CCG Board meeting re Forest Hospital proposal
- Prepared for and attended the Governance Committee
- Chaired Consultant interview panel

September
- Prepared for and attended a meeting of the Audit Committee NEDs
- Attended a joint meeting of GCS and 2G NEDs with the Chair
- Attended a meeting of 2G NEDs with the Chair
- Met with the Director of Finance
- Prepared for and attended the 2G Board meeting
- Prepared for and attended the Delivery Committee

Duncan Sutherland (Chair of MH Legislation Scrutiny Committee/Charitable Funds)
Since his last report, Duncan has:
- Prepared for and attended the Development Committee
- Attended a Joint NED's meeting
- Attended two SILG Meetings
- Attended a NED Meeting
- Prepared for and Attended a Board Meeting
- Attended an Audit Committee meeting re performance
- Attended a MHL Committee workshop
- Had a teleconference on the Nursing Strategy for Development Committee

Maria Bond (Chair of Delivery Committee)
Since her last report, Maria has:
August
- Prepared for and attended Audit Committee
- Prepared for and attended a Joint Board Seminar
- Telephone call with Chair
- Prepared for and attended a NED's meeting
- Telephone call with Service Delivery Director to discuss Delivery agenda
- Prepared for and Chaired Delivery Committee
- Met with Service Delivery designate prior to Delivery Meeting
- Prepared for and attended a Board Meeting
- Prepared for and attended a Governance Committee

September

- Completed an Audit Review and meeting with other NED colleagues to review the last 12months of Audit Committee
- Prepared for and attended a MHAM Forum meeting at Charlton Lane
- Prepared for and attended a Joint NED's meeting
- Attended a MHAM hearing at Pullman Place
- Attended a MHAM section 3 appeal hearing at Charlton Lane
- Prepared for and Chaired the Delivery Committee
- Met with Service Delivery Director post Delivery Committee
- Prepared for and attended a Board meeting

Dominique Thompson

Since her last report, Dominique has;

- Prepared for and attended an Audit Committee meeting
- Prepared for and attended a Delivery Committee
- Prepared for and attended a Joint Board Meeting
- Prepared for and attended a 2g NED meeting
- Had an induction meeting with the Medical Director
- Prepared for and attended a Board meeting
- Attended a Council of Governors meeting
- Took part in a scoping meeting with GP re eating disorders service and helped to draft paperwork/ service spec

[2]GETHER NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING
THURSDAY 12 JULY 2018
BUSINESS CONTINUITY ROOM, RIKENEL, GLOUCESTER

PRESENT:	Ingrid Barker (Chair)	Rob Blagden	Vic Godding
	Katie Clark	Stephen McDonnell	Jan Furniaux
	Jenny Bartlett	Hazel Braund	Mike Scott
	Jo Smith	Jennifer Thomson	Kate Atkinson
	Faisal Khan	Said Hansdot	Cherry Newton
	Bren McInerney	Carole Allaway-Martin	Nic Matthews

IN ATTENDANCE: Marie Crofts, Director of Quality
Marcia Gallagher, Non-Executive Director
Anna Hilditch, Assistant Trust Secretary
Jane Melton, Director of Engagement & Integration
John McIlveen, Trust Secretary
Colin Merker, Deputy Chief Executive
Kate Nelmes, Head of Communications
Nikki Richardson, Non-Executive Director
Paul Roberts, Chief Executive
Neil Savage, Director of Organisational Development
Jonathan Vickers, Non-Executive Director
Sandra Betney, Deputy CEO and Director of Finance (GCS)
Vincent Buscemi, Partner, Bevan Brittan
Dave Smith, Programme Director – Transition (GCS)

1. WELCOMES AND APOLOGIES

1.1 Apologies for the meeting had been received from Hilary Bowen, Ann Elias, Mervyn Dawe, Xin Zhao, and Lawrence Fielder.

1.2 Ingrid Barker welcomed Nic Matthews (Staff Governor – Clinical, Social Care and Support) and Carole Allaway-Martin (Appointed Governor – Gloucestershire County Council) to their first meeting of the Council of Governors since being appointed.

1.3 The Council noted that Dr Svetlin Vrabtchev (Staff Governor – Medical and Nursing) and Jennifer Thomson (Public Governor – Forest) had made the decision not to re-stand for a second term as a Governor. Ingrid Barker thanked them for their involvement and contributions over the past 3 years. The Council was also asked to note that Euan McPherson (Public Governor – Herefordshire) had made the difficult decision to stand down from the Council. Elections were currently underway to fill the vacant positions and the results of the election would be known at the beginning of August.

2. DECLARATION OF INTERESTS

2.1 There were no new declarations of interest.

3. COUNCIL OF GOVERNOR MINUTES

3.1 The minutes of the Council meeting held on 8 May 2018 were agreed as a correct record.

4. MATTERS ARISING, ACTION POINTS AND EVALUATION FORM

4.1 The Council reviewed the actions arising from the previous meeting and noted that these were now complete or progressing to plan.

4.2 The Council received and noted the Meeting Evaluation feedback from the last meeting in March.

5. CHIEF EXECUTIVE'S REPORT

5.1 Merger Update

5.1.1 The work in progressing the merger with Gloucestershire Care Services colleagues continues at a pace. In order to ensure that we can focus on both the merger change and day to day staffing issues robustly, Neil Savage (Director of OD) has taken on responsibility for leading the Day to Day HR teams and services within both Trusts, effective from 1 July. Dave Smith (Interim Director of HR at GCS) will take on the responsibility for leading the Transitional work aligned to the merger. These changes will be reviewed as they become embedded to ensure that they deliver the support to staff we want to provide.

5.1.2 A timetable for the merger process has now been published and it was agreed that this would be shared with Governors for information.

ACTION: Timetable for the merger process to be shared with Governors

5.1.3 Paul Roberts advised that work would commence in the autumn to look at the new shadow Board arrangements. Governors would be heavily involved in this process and further information about the Governor role in the overall merger process would be discussed in more detail later in the meeting.

5.1.4 A name for the new organisation was being proposed as this was required as part of the Strategic Outline Business Case. There were some strict rules and guidance to be taken into account, but the Trust's Communications Teams were reviewing this carefully. Consultation would be carried out on any proposals for a name.

5.1.5 The Council was aware that Marie Crofts, Director of Quality would be leaving the Trust at the end of September. It had been agreed to appoint to an Interim Director of Quality role for 2gether at this time. A Joint Director appointment would then be considered at a later stage alongside other shadow Board appointments. A discussion group of Governors would be set up as part of this recruitment process on 30 July and an invite with confirmed timings would be sent out after the meeting asking Governors to confirm if they wished to take part. The Council collectively expressed their thanks to Marie for her huge contribution to 2gether, noting that it would be hugely sad to lose her but wishing her well in her future role.

5.1.6 Rob Blagden said that Governors had discussed the merger at their pre-meeting and all had been positive about the proposals. However, he said that Governors wanted to see the outcome measures and the benefits of the merger. Sandra Betney offered the Council assurance that work was taking place to carefully look at benefits realisation and mapping and once this work was complete this would of course be shared with the Council.

5.2 Care Quality Commission (CQC)

The Council of Governors were informed that 2gether had retained its 'Good' rating overall, and improved the ratings in a number of specific service areas in its recent CQC inspection report. This follows Gloucestershire Care Service's CQC report, which saw their rating move up to Good overall as well. It was agreed that this was a fantastic achievement for both Trusts, and a sure sign that our communities can be proud of the services provided in community physical, mental health and learning disability teams in the county.

5.3. Integrated Care Systems

5.3.1 Paul Roberts provided an update to the Governors on the development of an ICS in Gloucestershire, which aims to improve the performance of primary, secondary and social care settings through a more joined-up approach. He said that there was still a lot more to do to see how this would work but it was a positive step towards joined up working. This would continue as a key agenda item for future meetings.

5.3.2 In Herefordshire 2gether was working within the Herefordshire and Worcestershire STP on a local ICS Development Programme which is intended to enable the system to bid for "Shadow Status" like Gloucestershire from 2019/20. Colleagues from the Herefordshire senior leadership team are part of this programme – ensuring that mental health and learning disability are centre stage as that work progresses.

5.4 2gether ROSCAs

It was noted that 2gether's Recognising Outstanding Service and Contribution Awards (ROSCAs) would be celebrated at Hatherley Manor, in Gloucester, on 20th July 2018. Rob Blagden said that the Governors had discussed this at their pre-meeting and a request was made that future ROSCA events try to be organised to take place either in Herefordshire or at a mid-way point between the 2 counties.

ACTION: Review of future venues for Trust events such as the ROSCAs to be carried out to ensure that there was equity for staff located in Gloucestershire and Herefordshire

5.5 First quarter Finance and Performance

At the end of the first quarter the Trust was financially healthy and generally delivering within our contract targets. IAPT services remain our biggest delivery challenge in both Gloucestershire and Herefordshire, whilst medical staffing particularly in Herefordshire also poses a number of challenges for us to

address. The Governors agreed that an update on IAPT services would be useful and requested a more detailed presentation on the current IAPT position at its next meeting in September.

ACTION: IAPT Presentation to be received at the next Council meeting in September

6. JOINT WORKING PRESENTATION – BEVAN BRITTAN

6.1 The Council of Governors welcomed Vincent Buscemi to the meeting. Vincent was a Partner with Bevan Brittan and was working with 2gether and GCS on the legal aspects of the merger process. Vincent was in attendance to present and speak to the Governors about their formal role in the merger. A copy of the presentation would be emailed to all Governors after the meeting.

ACTION: Bevan Brittan presentation to be circulated to Governors

6.2 The Governor's role is twofold:

- To hold the Non-Executive Directors, individually and collectively to account for the performance of the Trust's Board of Directors by:
  - ensuring that the Board of Directors have been thorough and comprehensive in reaching its proposals (that it has undertaken proper due diligence); and
  - that the Directors have obtained and considered the interests of Trust Members and the public as part of its decision - making process.
- Provided these assurances are obtained, the Governors should approve the joint application which must be submitted to Monitor/NHS Improvement.

6.3 It was noted that the likely timescale for the merger would be approximately 12-18 months. A more detailed timeline had been circulated earlier in the meeting and it was agreed that it would be extremely helpful for this to be updated to include the key points where Governors would need to be involved throughout the process.

ACTION: Merger timeline to be updated to include key touchpoints for Governor involvement

6.4 Mike Scott noted that the NHS Act 2006 requires that 'more than half the members of the full council of governors' must approve any application by an FT to merge with another Trust/FT or be acquired by another FT. Mike asked whether proxy voting would be accepted if Governors were on holiday when the final vote took place. John McIlveen advised that currently proxy voting was not accepted; however, the Trust would be reviewing its constitution in the coming months and this area could be changed to allow for this in future.

6.5 Mike Scott asked about the costs associated with the merger. It was noted that a high level indicative budget of £1.3m had been proposed, which would be split between the 2 organisations. The Council was assured that non-recurrent budgets were being used to fund the work and therefore no funding to services was being cut.

6.6 Stephen McDonnell said that he hadn't heard about any dis-benefits of the merger so far, and asked whether there were any "downsides" that the Governors needed to be made aware of. It was noted that this analysis would be included in the Full and Strategic Business Case. The benefits needed to outweigh any potential risks and the business case needed to demonstrate this clearly.

6.7 Nikki Richardson said that discussions about the merger had taken place at the Council of Governors previously and there was therefore a need to think about how new Governors could be brought up to speed. This was agreed as a vital piece of work, and work would commence to co-ordinate what information was shared with Governors and when, with a timeline of previously shared reports and guidance being produced and uploaded onto the Governor Portal on the Trust website.

ACTION: Pack of information and guidance to be produced for all Governors containing key documents, decision points and timeline for the merger, for people to use as reference going forward.

6.8 The Council thanked Vincent Buscemi for attending and presenting such a comprehensive overview.

7. RECEIPT OF THE ANNUAL REPORT 2017/18

7.1 The Council of Governors was informed that the Annual Report 2017/18 had been signed off by parliament and published. Governors were invited to view the Annual Report via the Trust's website. The report would be formally presented at the Trust's AGM, being held jointly with GCS on Thursday 19 July.

8. FEEDBACK FROM GOVERNOR OBSERVATION AT BOARD COMMITTEES

8.1 A number of Board and Board Committee meetings had taken place since the Council of Governors last met in May 2018 and Governors had been present in an observation capacity at some of these meetings.

- Audit Committee – 25 May
  Mike Scott had attended this meeting and said that he felt very assured by the business conducted.
- Development Committee – 19 June
  Said Hansdot had attended this meeting, which he said had run very smoothly and was well chaired.
- Delivery Committee – 23 May and 27 June
  Kate Atkinson had been in attendance at both meetings.
- Governance Committee – 29 June
  Jo Smith and Vic Godding had been in attendance at this meeting. Both said that the Committee had been very efficiently chaired by Nikki Richardson who had to deal with a large agenda in a short space of time. Vic Godding advised that he had updated the Committee Observation Checklist template and would be happy to share this with Governor colleagues for information.

- MHLS Committee – 11 July

  Cherry Newton had attended this meeting and said that it had been well chaired by Duncan Sutherland who had recently taken over the chairing role following Quinton Quayle's departure. Cherry said that there had been information about Herefordshire services discussed at the meeting however, there were no Herefordshire representatives present to provide updates at the meeting. This had been noted.

8.2 The Council was informed that an item to review Committee Observation attendance was scheduled for the next meeting in September, noting that there were a number of vacancies.

ACTION: Review of Board Committee Observation process to be carried out at the September Council meeting

9. MEMBERSHIP ACTIVITY REPORT

9.1 The Council received and noted the Membership Report which provided a brief update to inform the Council of Governors about information for members, Governor Engagement Events and information about membership.

9.2 The Membership Advisory Group last met on 13 June. The group has now revised the membership form, which will be updated both in paper form and in the online version. Work is also taking place with the 2gether IT team and Countywide IT services to create a new membership database, which should be more resilient, in anticipation of an increase in new members as we join with Gloucestershire Care Services.

9.3 Membership figures have recently reduced, following work carried out to ensure we are compliant with the General Data Protection Regulation (GDPR). There had been a reduction of 24 Public Members since the last report.

9.4 In line with our membership priorities, agreed at the Council of Governors and Board in May, we are focussing on increasing membership in Herefordshire and the Cotswolds, and among men, younger people (under 21s) and members of the Black and Minority Ethnic Community.

9.5 We continue to promote membership at events, via social media and through the Trust website. Membership was recently promoted during our NHS70 open day and exhibition, with 6 under 18s signing up as Members. We are also attending the Barton and Tredworth Cultural Fayre on 11 August, and the annual police open day in September.

9.6 The next edition of the membership newsletter will be published in late July.

10. GOVERNOR ACTIVITY

10.1 Cherry Newton had attended the Membership Advisory Group in Herefordshire, participated in the Leominster Crucial Crew event and had attended the NHS70 service at Herefordshire Cathedral.

10.2 Vic Godding had participated in the Governor visit to the Stonebow Unit. He said that this was an excellent visit and a great unit. Some feedback provided from the visit about the provision of mobile air conditioning units on the wards had now been actioned. Bren McInerney had also attended this visit and said that he wanted to ensure that appropriate thanks were passed back to the ward manager and the other staff who had hosted this visit.

10.3 Jennifer Thomson had attended a specially arranged Governor visit to CYPS services. She said that this had been a very informative session, with Team Managers from all CYPS services in attendance to provide information about their service and answer questions.

11. ANY OTHER BUSINESS

11.1 There was no other business.

12. DATE OF NEXT MEETINGS

Council of Governor Meetings

Business Continuity Room, Trust HQ, Rikenel		
Date	**Governor Pre-meeting**	**Council Meeting**
2018		
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

2018		
Wednesday 26 September	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 29 November	10.00 – 1.00pm	Kindle Centre, Hereford

Council of Governors
Action Points

Item	Action	Lead	Progress
12 July 2018			
5.1.2	Timetable for the merger process to be shared with Governors		**To be included in "Merger Reference Pack for Governors"**
5.4	Review of future venues for Trust events such as the ROSCAs to be carried out to ensure that there was equity for staff located in Gloucestershire and Herefordshire	Kate Nelmes	**Will be included for consideration as part of the 'post event evaluation'**
5.5	IAPT Presentation to be received at the next Council meeting in September	Trust Secretariat	**Presentation scheduled for November Council meeting**
6.1	Bevan Brittan presentation to be circulated to Governors		**To be included in "Merger Reference Pack for Governors"**
6.3	Merger timeline to be updated to include key touchpoints for Governor involvement		**To be included in "Merger Reference Pack for Governors"**
6.7	Pack of information and guidance to be produced for all Governors containing key documents, decision points and timeline for the merger, for people to use as reference going forward.		**To be included in "Merger Reference Pack for Governors"**
8.2	Review of Board Committee Observation process to be carried out at the September Council meeting	Trust Secretariat	**Report scheduled for September Council meeting**