Council of Governors Meeting

Tuesday 17th January 2017 at 10.30 – 12.30pm
In the Business Continuity Room, Rikenel, Gloucester

AGENDA

Item	Time	Title and Purpose	Reference
1	10.30	Welcome and Apologies	Verbal
2		Declaration of Interests	Verbal
3	10.35	Minutes of the Previous Meeting held on 10 November 2016	Paper A
4		Matters Arising and Action Points	
5	10.40	Review of Meeting Evaluation Sheet	Paper A2
Formal Business and Exception Reporting			
6	10.45	Quality Report Audit Process & Quality Priorities for 2017/18	Paper B
7	10.55	Non-Executive Director Recruitment Process Update	Paper C
8	11.05	Review of Governor Observation at Board Committees	Paper D
9	11.15	Service Planning Objectives	Paper E
Service Focussed Presentations and Information Sharing			
10	11.25	Chief Executive's Report (inc. STP Update)	Verbal
Governor Responsibilities and Holding to Account			
11	11.40	Increasing Engagement	Presentation
Membership and Governor Involvement			
12	12.10	Membership Update	Paper F
13	12.15	Key Issues for Discussion from Governor Pre-meeting	Verbal
14	12.20	Governor Activity	Verbal
Any other Business			
15	12.25	Any other business	Verbal
16	12.30	Date of Next Meetings Please see overleaf	Verbal

Council of Governor Meetings

Business Continuity Room, Trust HQ, Rikenel		
Date	**Governor Pre-meeting**	**Council Meeting**
2017		
Tuesday 17 January	9.00 – 10.00am	10.30 – 12.30pm
Thursday 9 March	1.30 – 2.30pm	3.00 – 5.00pm
Tuesday 9 May	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 13 July	9.00 – 10.00am	10.30 - 12.30pm
Tuesday 12 September	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 9 November	1.30 – 2.30pm	3.00 – 5.00pm

2gether Board Meetings

2017		
Thursday 26 January	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 30 March	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 25 May	10.00 – 1.00pm	Kindle Centre, Hereford
Thursday 27 July	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 28 September	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 30 November	10.00 – 1.00pm	Kindle Centre, Hereford

Governor Visits to Trust Sites

Venue	Location	Date	Time
TBC	TBC	TBC	TBC

TEAM CHARTER

This Team Charter is collectively agreed by Governors, Non-Executive Directors and Executive Directors. Our aim is everything we do is aligned to the Trust's purpose of "Making Life Better". Our actions, attitudes and behaviours will support the Trust's vision "To be the Provider and Employer of choice delivering sustainable, high quality, cost effective, inclusive services" and will be in line with Trust values described below.

Trust Values	We will
Seeing from a service user's perspective	We will work collectively "making life better" through ensuring the views of our service users and carers are represented in improving our services.
Excelling and improving	We will all take responsibility for this organisation and for working together. We will celebrate success and maximise best practice. We will ensure that debates, conversations and decisions benefit from both an expert and non-expert perspective.
Responsive	We will accept actions and targets and deliver on them individually and collectively in a timely manner. We will learn from our experiences. We will be flexible and adaptable.
Valuing and respectful	We will value differences and show respect to all those with whom we work and have contact. We will say what we feel openly and directly, and use language that demonstrates respect for other peoples' views. We will resolve conflict with sensitivity. We will respect rules of confidentiality.
Inclusive, open and honest	We all have a responsibility to bring our views and experiences to debates, and we will demonstrate that each person's views have equal value. We will encourage others to speak, we will listen to understand and be informed. We will give praise openly and publicly. Our feedback will be honest and delivered with courtesy and sensitivity.
Can do	We will always try to problem solve. We will be proactive, positive and look for opportunities and innovations. We are open and willing to change position and compromise.
Efficient, effective, economic and equitable	We will appropriately plan and prepare for events and meetings to make best use of our time and the time of others. We will check and challenge our own and others understanding in a timely and appropriate manner to enable the work of the Council of Governors and the Trust to be effective.

The Role of Governors

NHS Foundation Trusts share all the same values, quality and safety standards as NHS Trusts, but they are 'owned' by their members who elect a Council of Governors to represent the views of members, patients, staff, partner organisations and the public.

This means that the Council of Governors is an important link between our local communities and staff, and the Trust Board, which has the responsibility of running the organisation and preparing the Trust's strategy. The Council of Governors works alongside the Trust's Board of Directors to help local communities and staff have a greater say in the strategic direction of the Trust, and how services are developed and delivered by the Trust.

The main roles of Council of Governors as set out by the Government are to:

- Represent the interests of the people within their constituency or partner organisation, report feedback on our services and, wherever possible, how they could be improved.
- Hold Non-Executive Directors to account for the Board's performance.

In [2]gether, the Council of Governors fulfils these roles by:

- Meeting with service users, carers, members and the public in their local community or staff group, to listen to their experiences and ideas and to provide feedback to the Trust, especially if a particular issue is seen as a trend.
- Commenting for the membership on the Board's strategic direction and annual planning, before it is finalised.
- Participating in Trust initiatives to inform local communities, partner organisations and staff about the Trust's plans, and celebrate achievements.
- Questioning the Non-Executive Directors about the performance and effectiveness of the Board and its Committees.
- Conducting formal business such as:
    - Appointing and, if appropriate, removing the Trust Chair and the Non-Executive Directors.
    - Having a say in the appointment of the Chief Executive.
    - Approving the appraisal process for the Chair and Non-Executive Directors.
    - Appointing and, if appropriate, removing the Trust's External Auditors.
    - Receiving the Trust's annual report and accounts (once these have been laid before Parliament) in order to understand the Trust's performance.
    - Approving major transactions such as acquisitions, mergers or large tenders.

[2]GETHER NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING
THURSDAY 10 NOVEMBER 2016
BUSINESS CONTINUITY ROOM, RIKENEL, GLOUCESTER

PRESENT:

Ruth FitzJohn *(Chair)*	Hazel Braund	Alan Thomas
Vic Godding	Jo Smith	Dawn Lewis
Rob Blagden	Paul Toleman	Mervyn Dawe
Cherry Newton	Jenny Bartlett	Hilary Bowen
Tristan Lench	Ann Elias	Katie Clark
Richard Butt-Evans	Said Hansdot	Svetlin Vrabtchev
Pat Ayres		

IN ATTENDANCE: Colin Merker, Deputy Chief Executive
Marcia Gallagher, Non-Executive Director
Alan Gillespie, Member of the Public
Andrew Lee, Director of Finance & Commerce
John McIlveen, Trust Secretary
Quinton Quayle, Non-Executive Director
Nikki Richardson, Non-Executive Director
Andrew Smart, Head of Communications (Item 12)
Carol Sparks, Director of Organisational Development
Jonathan Vickers, Non-Executive Director
Charlotte Hitchings, Non-Executive Director
Bren McInerney, Member of the Public

1. WELCOMES AND APOLOGIES

1.1 Apologies for the meeting had been received from Roger Wilson, Paul Grimer, Jennifer Thomson and Amjad Uppal. Shaun Clee had also sent his apologies, and Colin Merker would deputise for Shaun at the meeting.

1.2 Governors were asked to welcome Hazel Braund, Appointed Governor from Herefordshire CCG, who had taken over that role from Simon Hairsnape.

2. DECLARATION OF INTERESTS

2.1 Hilary Bowen asked the Council to note that she was a Governor of the Barnwood Trust. This had previously been recorded as Barnwood "House" Trust and would be corrected.

2.2 Al Thomas informed the Council that he had been appointed as Vice Chair of Healthwatch Gloucestershire.

3. COUNCIL OF GOVERNOR MINUTES

3.1 The minutes of the Council meeting held on 14 July were agreed as a correct record, subject to a change in the attendance list as Kate Nelmes had not attended the meeting.

4. MATTERS ARISING, ACTION POINTS AND EVALUATION FORM

4.1 The Council reviewed the actions arising from the previous meeting and noted that the majority of actions had been completed, or were progressing to plan. The inclusion of more detail against "completed" actions was helpful by way of tracking progress and adding additional assurance of completion.

4.2 With regard to action 10.11, Alan Thomas said that he could not find the new Performance Information section on the Governor Portal. John McIlveen agreed to check and update the portal if necessary and notify Governors accordingly. The Council agreed that action 10.11 would therefore remain open.

5. REVIEW OF LAST MEETING'S EVALUATION FORM

5.1 Ruth FitzJohn noted that following the last meeting, a number of issues had been raised through the meeting evaluation forms. The Trust had provided a written response to this feedback given the range and number of responses received. Governors were asked to return evaluation forms from future meetings to the Assistant Trust Secretary either at the end of the meeting, or at most within 3 days, so as to give Executive Directors sufficient time to respond, where necessary, to any issues raised.

ACTION: Governors to return evaluation forms to the Assistant Trust Secretary within three days of each Council meeting

5.2 The Council noted that the evaluation forms seemed to be working well, and Governors had generated some constructive feedback and learning points which the Trust would take on board. These included achieving the right balance between written reports in advance and verbal reports at the meeting, the timings allocated to agenda items, the balance between conciseness and detail in written reports, the need to be aware of body language at meetings, and the need to avoid acronyms. Comments in the evaluation forms about improved engagement and partnership between the Board and the Council were welcomed.

5.3 Some feedback would have benefitted from more detail, and the Council agreed to review the evaluation form in 2017 to provide more space for explanatory comment. This review would take place as part of a wider review of the Board/Governor development programme.

ACTION: Evaluation form to be reviewed as part of a wider review of the Board/Governor development programme to provide more space for explanatory comment

6. CHIEF EXECUTIVE'S REPORT

6.1 Colin Merker gave the Chief Executive's report to the Council of Governors, which is intended to draw Governors' attention to key areas for awareness, information or for exploring further if of sufficient interest. The Council was assured that the content of this verbal report would be captured fully in the minutes in order to provide Governors with a written record.

National Initiative Funding

6.2 The Trust has recently been working with CCG colleagues in both Herefordshire and Gloucestershire in relation to a number of bids for National Initiative monies around “Perinatal Mental Health Services” and “Place of Safety Services”.

6.3 The Perinatal Mental Health Services funding was recurrent funding, which would be available on a year on year basis, to fund the ongoing service delivery. The Place of Safety funding was capital funding which would be available as a one-off to fund a defined capital development, and would not cover any ongoing running costs associated with either the service that would operate from the capital development and/or the cost of the capital development itself.

6.4 In Gloucestershire the Trust has been awarded funding for the development of a Perinatal Mental Health Service. This service will enable the Trust to significantly improve services that will undoubtedly benefit many mums and young children within Gloucestershire. Unfortunately the Trust’s bid for a similar service in Herefordshire and Worcestershire was unsuccessful.

6.5 2gether has however been successful in Herefordshire in being awarded capital funding to support the development of a Health Based Place of Safety, as part of our Stonebow inpatient services unit. The capital development will take until September/October 2017 to complete and during this time we will continue to work with CCG colleagues and in particular Police colleagues to progress the proposals around the operational/clinical services development, which will need to be put in place for the Health Based Place of Safety to become fully operational.

6.6 This is a significant service development for Herefordshire which will offer great benefits to people bought into our care under Section 136 of the Mental Health Act and will help us address an issue that has been of concern to Herefordshire Health and Police partners for some time. Gloucestershire already has a purpose-built Health-Based Place of Safety on the Wotton Lawn Hospital campus, known as the Maxwell Centre.

6.7 2gether has also been successful in Gloucestershire in being awarded capital funding to support the development of a Children and Young Persons Community-Based Place of Safety. This development will provide the facilities for us to develop an alternative to Wotton Lawn for children and young people who require some form of supported care, pending their possible transfer to an age-appropriate inpatient service and/or a return home with an appropriate community package of care. This innovative service development will span input from across all of Gloucestershire's children's services, the Voluntary Sector and our own services.

Wye Valley Trust

6.8 Colin Merker informed the Council that Wye Valley Trust (WVT) in Herefordshire was formally brought out of special measures by CQC last week. This is good news for the health care system overall, as all partners been working together to support WVT colleagues in the work they have been progressing to support the necessary improvements in the Acute Services they provide. This news has been a great boost for WVT staff for whom the placement in special measures

had a significant impact upon morale. As WVT move out of special measures, 2gether is aware that there will be changes in their senior leadership team and we will need to work closely with the incoming team so that the progress we have been making towards delivering integrated community mental health and physical health care services, alongside GP services, maintains the pace and programme we have established, and on which we have briefed members previously.

Sustainability and Transformation Plans – Herefordshire & Worcestershire and Gloucestershire

6.9 Both Gloucestershire and Herefordshire will be starting to share their individual Sustainability Transformation Plans (STP) that we have been working on over the last year in the coming weeks ahead.

6.10 As the various Partner and Stakeholder briefing material becomes available for each area over the next couple weeks, the Trust will ensure that Governors are kept sighted on this information as far as possible.

2017/18 and 2018/19 contract offers

6.11 On the 4th November 2016, The Trust received its two-year contract offers from both of our commissioners, Herefordshire and Gloucestershire CCG's. These contract offers have to be fully developed, agreed and signed off by the end of December 2016 and whilst the outline offers are in line with what 2gether had anticipated, they need to be informed by the agreed STP development plans for 2017/18, which are still being finalised/agreed at the current time. A further briefing on this issue will be available for Governors in January.

ACTION: Further STP briefing to be provided to Governors in January 2017

IAPT Recovery Plan

6.12 At the end of October 2017 the Trust achieved the first significant milestone in its IAPT recovery plans, whereby we now have nobody in Herefordshire or Gloucestershire waiting over 18 weeks for access to services. We will keep Governors briefed as our action plan progresses.

HSE Investigation Outcome

6.13 Governors will recall the tragic events of July 2014 and the death of a colleague, Sharon Wall, at our Montpelier inpatient services unit. The Trust has now heard from the HSE in relation to the conclusions from their investigation that has been ongoing for the last two years.

6.14 Their conclusions are that there is no further regulatory action that they need to progress in relation to the Trust. The Trust's thoughts remain with Sharon's family and friends for whom these events continue to have a profound impact.

6.15 As we have shared this outcome with our services and the staff directly involved in the incident, we know it has helped them find some closure and move on from the events. 2gether has implemented a range of improvements following our review of the incident, which hopefully will avoid similar future events

reoccurring. The learning and improvements we have made will be shared at a Regional/National level to help improve safety across services nationwide.

Gloucestershire Health and Social Care Awards

6.16 On Tuesday evening (8th November 2016), the Trust's Crisis Team was awarded the place of Mental Health Team of the Year at the Gloucestershire health and social care awards. Governors may also remember one of our senior social workers, Steve Keech, who unfortunately died earlier this year. Steve was also recognised at the awards for his significant input into Social Care practice. He was awarded the place of Social Care Professional of the Year. Steve's partner and members of his family were there to receive his award.

Other Items for Discussion

6.17 Hilary Bowen asked what arrangements were in place to support unaccompanied refugee children. Colin Merker replied that our services were open to all regardless of their point of origin. The Trust could call on specialist support and translation services if required.

6.18 Alan Thomas said that he believed that Governors were required to have a role in signing off the operational plan submission, and he asked about the process for involving Governors ahead of the submission date on 23 December, given that there was no Council meeting scheduled before then. Colin Merker referred to guidance from NHS England which confirmed that it was for the Board to sign off the plan before submission, but that Boards should have regard to the views of Governors in preparing the Trust's forward plans. The timescale for submission was considerably shorter than on previous occasions, but it was agreed that it was important for the Trust to involve Governors. Colin therefore suggested that a small working group be convened which could review the draft plan and provide feedback in to the Board before final submission on 23 December. The Council of Governors welcomed this suggestion, and Alan Thomas, Dawn Lewis, Rob Blagden and Mervyn Dawe agreed to take part in the working group.

ACTION: Governor working group to be convened (Alan Thomas, Dawn Lewis, Rob Blagden and Mervyn Dawe) to review the draft operational plan and provide feedback to the Board before the December submission

7. LEAD GOVERNOR REPORT

7.1 Rob Blagden presented the Lead Governor report and informed the Council that he had taken part in the Board Committee observation trial, having attended several meetings of the Delivery Committee. Rob informed the Council that he had witnessed a robust assurance and challenge process by the Committee, and outlined some of the specific topics which the Committee had considered. These included benchmarking arrangements, workforce indicators, and assurance reports about IT systems.

7.2 Rob said that his access to the Committee had been supported by the Trust, and that the observation process had been particularly valuable as it presented the only opportunity for Governors to see Non-Executive Directors in action. Rob noted that the observation trial would be reviewed in January, and urged other

Governors to take advantage of the opportunity to observe Board Committees should the process continue.

8. APPOINTMENT OF DEPUTY CHAIR AND SID

Nikki Richardson left the meeting at this point

8.1 The Council received a report concerning the appointment of a Deputy Chair and a Senior Independent Director. The appointments were required as Charlotte Hitchings, who currently held both roles, would be leaving the Trust at the end of the month to take up the role of Chair of Avon and Wiltshire Partnership NHS Trust. The report noted that the Deputy Chair appointment was a matter for Governors, while the appointment of a SID was a matter for the Board. Both roles must be drawn from the existing group of Non-Executive Directors. The report recommended that Nikki Richardson be appointed to both roles with effect from 1 December, and that she receive additional combined remuneration of £2500 per year for undertaking these roles.

8.2 Rob Blagden commented that while he was happy to endorse the recommendations in the report, Governors had not been involved in the process to select the candidate for Deputy Chair due to the timing of Charlotte's departure, and Rob suggested that the process might be reviewed for the future, perhaps to involve the Nomination and Remuneration Committee. Ruth FitzJohn said that had the Trust had longer to plan, a more extensive process would have been undertaken.

8.3 Mervyn Dawe asked how the additional remuneration for these roles had come about. Ruth FitzJohn explained that historically each role had attracted a separate additional payment. However, a previous Council had agreed to combine these two payments into one, given that the same person would be undertaking both roles.

8.4 The Council noted the recommendation to appoint Nikki Richardson to both roles until further notice, but felt that aligning the appointment with Nikki's term of office as a NED would be more appropriate. The Council therefore agreed to appoint Nikki Richardson as Deputy Chair with effect from 1 December 2016, until the end of her first term of office on 31 January 2018. The Council noted that Ruth FitzJohn would be recommending to the Board that Nikki also be appointed as the Senior Independent Director for the same term. The Council agreed that these roles should attract a combined additional remuneration of £2500 per year.

8.5 The Council thanked Charlotte Hitchings for her service and support, and wished her well in her new role.

Nikki Richardson re-joined the meeting at this point

9. PROPOSAL FOR APPOINTMENT OF A NON-EXECUTIVE DIRECTOR

9.1 The Council received a report from Carol Sparks regarding the appointment process for a new Non-Executive Director, which was required to bring the Board up to its full complement following Charlotte Hitchings' resignation.

9.2 The Council noted that the Trust uses an agency - Gatenby Sanderson - to undertake executive searches and to screen potential candidates. The Trust pays for this service only once a successful appointment is made. Following the last NED recruitment exercise, a number of highly eligible candidates have come forward to enquire about additional NED vacancies, meaning that the Trust would not need to utilise Gatenby Sanderson's network of contacts in order to produce a field of candidates, but could instead use its local contacts and hold a local recruitment process which would achieve a cost saving. The Council was assured that such a process would be robust and transparent, and would include local press advertising as well as national online advertising. There would be no dilution in the standards required of candidates. The Council noted that were the local recruitment to prove unsuccessful, a full recruitment process would be undertaken as usual through Gatenby Sanderson.

9.3 Paul Toleman asked how potential candidates could apply for the position if they did not see the advertisement. Carol Sparks agreed that if Governors knew of any prospective candidates, those candidates should contact Carol who would ensure that they were fed into the recruitment process. In response to a question from Mervyn Dawe, Carol Sparks confirmed that there were no contractual barriers to the Trust's suggested course of action, and that Gatenby Sanderson had agreed to screen at cost any candidates identified through the Trust's local recruitment.

9.4 The Council agreed to implement a local recruitment process to facilitate the appointment of a Non-Executive Director, and should this prove to be unsuccessful, to utilise the full resources of Gatenby Sanderson as the Trust's Executive Search agency.

10. BOARD/GOVERNOR DEVELOPMENT PROGRAMME REPORT

10.1 The Council received a close down report setting out the outputs from the joint Board and Governor Development Programme which had begun in 2015. The Council noted the developments arising from the programme, which had been delivered through working groups comprising Board members and Governors. These developments included a revised induction process, a Team Charter, a Council of Governor meeting evaluation form, a signposting document to assist Governors in directing queries about Trust services to the right person, a role description for Governors, and a revised Holding to Account process. The development programme had been a standing agenda item for Council meetings throughout 2016.

10.2 The Council agreed that the joint development work had produced some excellent outcomes.

10.3 The Council agreed that it would be helpful to review those outcomes, and that the best way to do so would be through a further development day, including both Board members and Governors, in a month when there was no Council meeting.

10.4 The Council therefore agreed to review the outcomes of the Board/Governor development programme by means of a development day for Board and

Governors which would be held in June 2017. The Trust Secretary would confirm the date and venue as soon as possible.

ACTION: Board/Governor development day to be arranged for June 2017 to review the outcomes of the Board/Governor development programme

11. HOLDING TO ACCOUNT – FINANCIAL ASSURANCE

11.1 Marcia Gallagher and Andrew Lee gave the Council a presentation focussing on the work of the Audit Committee in holding the Executive Directors to account for service and financial delivery performance, and in particular in terms of financial assurance. The Audit Committee's purpose is to provide the Board with a means of independent and objective review of financial and corporate governance, assurance processes and risk management. The Committee scrutinises the actions of management in delivering the Trust's objectives, strategy and regulatory/contractual obligations. The Committee receives assurance on compliance and performance in all areas, and because the Audit Committee comprises only NEDs who are members of other Board Committees, information can be triangulated to ensure consistency with other reports, and thus provide more robust assurance.

11.2 The Committee focuses on the clear identification of risk, mitigating actions and assurance, and looks for more detail if the assurance offered isn't clear. In her role as Audit Committee Chair Marcia signs the Trust's annual accounts to say that they are a fair and positive record. As Audit Committee Chair, Marcia also monitors the recommendations from Internal Audit reviews, to determine whether actions arising from those recommendations are completed in a timely way. At the last Audit Committee meeting there were only two Internal Audit recommendations outstanding, and Marcia had since received assurance over the telephone that these were being actioned.

11.3 Marcia outlined how she uses her 40 years' NHS finance experience, and the knowledge gained as a qualified accountant, to be assured about the Trust's financial performance and sustainability. In order to receive assurance on the financial position, Marcia meets Andrew Lee on a monthly basis to review the finance reports as part of her 'confirm and challenge' process. Marcia has ad hoc telephone conversations with Andrew to clarify any issues or queries which might arise between these scheduled meetings.

11.4 The key areas which she focusses on to receive that assurance include:

- reviewing the cash flow forecast in Board reports, and discussing queries with Andrew Lee in his role as the Director of Finance
- reviewing how promptly the Trust pays its bills. A slow-down in payments could signify forthcoming cash problems
- reviewing outstanding bills at the end of the financial year to determine how these might affect the Trust in the future
- reviewing how efficiently the Trust chases up monies owed to it
- monitoring the rate at which the Trust spends money throughout the year, in order to be assured that it will meet its control total target set by the regulator

11.5 As the Audit Committee Chair Marcia also needs to be assured that the Trust's savings plans are robust and deliverable, as these savings not only enable to

the Trust to meet its financial control totals but also to invest in safe and more effective services for patients. While the monetary impact of these savings plans is important, great emphasis is placed on the quality impact of any savings proposal. Quality Impact Assessments (QIAs) are conducted for each savings plan, in line with national good practice, and in her role as a member of the Board Marcia focusses on the assurances provided in the finance report that set out when QIAs have been, or are expected to be undertaken for each savings scheme, and the impact on quality of each savings plan.

11.6 Marcia and other members of the Board had received a mid-year finance review which had been undertaken by the Finance Team, in line with good practice. Andrew Lee outlined for Governors some of the key points contained in the mid-year review, which showed that the Trust expects to deliver its 2016/17 Financial Control Total, and the Trust's plans for 2017/18 anticipated a recurring balance position. Governors noted the expected financial outturn position for the years up to and including 2020/21.

11.7 A number of actions had been taken as a result of the mid-year review exercise. These included the re-introduction of financial performance reviews in all areas of the Trust, the review of planned maintenance, removal of all budget underspends on a monthly basis, and a review of the capital programme. Marcia and the other NEDs on the Board had thoroughly examined the content of the review and Marcia was assured that there was no 'bias for optimism' in the assumptions it contained.

11.8 Marcia concluded by noting some of the financial assurances available to Governors:

- In previous years the Trust has received an unqualified audit opinion from the External Auditors, which is a good result.
- Internal and External Audit plans are in place
- A Counter Fraud plan is in place
- The Trust currently has the highest possible rating from NHS Improvement. This will remain the case when the assessment rating methodology changes later this year.
- The Trust's CQC inspection produced an overall rating of 'Good.
- The Trust received a good outcome from its external Well Led Review of Governance.

11.9 Hilary Bowen asked about the Trust's performance in paying its bills. Andrew Lee replied that the Trust paid at least 90% of its bills within 30 days, which was the required standard, and paid 80% of its bills within 10 days.

11.10 Mervyn Dawe said that he felt reassured by Marcia and Andrew's presentation, and asked whether the Trust was required to maintain a reserve to ensure that it could meet its financial obligations for a period of time. Andrew Lee replied that Trusts were required to maintain a facility to meet one month's obligations. Trusts could either maintain this facility with a bank, (which would incur a cost), or as at 2gether, could keep money in the bank.

11.11 Rob Blagden asked whether Marcia was confident that she is aware of all risks to the Trust, and that these risks are being managed appropriately. Marcia replied that it was not possible to mitigate all risks, as some of these were

outside the Trust's control. Marcia confirmed that in terms of financial risk she is as assured as she can be at the moment, but once contracts are signed with commissioners, more assurance will be available.

11.12 Rob also asked how Sustainability and Transformation Plans would affect the Trust's finances. Andrew Lee replied that STPs would allow for a fixed amount of growth in terms of income, which had not been the case previously as the Trust was on block contract arrangements with its commissioners. Achievement of CQUIN (Commissioning for Quality and Innovation) payments would also provide additional funding for the Trust, but would depend on performance targets being achieved.

11.13 Jenny Bartlett asked how NEDs could be assured that cost savings plans were robust. Marcia replied that all savings plans were rated red, amber or green according to the timing of the savings delivery. NEDs would look for delivery of savings at the rate agreed. Marcia informed the Council that she had recently asked for a change in the way savings information was presented so that NEDs could be clearer about the year to date position regarding savings. Marcia also confirmed that if a savings plan goes off target, the Trust would look for alternative savings to compensate.

11.14 Alan Thomas informed the Council that he felt assured by what he had heard, and that it reflected his experience as a Governor observing the Audit Committee, where NEDs were persistent in their questioning in order to receive good assurance.

11.15 The Council thanked Marcia Gallagher and Andrew Lee for their presentations which had been very helpful and informative.

12. MEMBERSHIP REPORT

12.1 Andrew Smart provided an update for the Council of Governors about membership activity, the membership development plan and Governor Engagement Events.

12.2 In terms of membership statistics, the Council noted that there continued to be a steady increase in the number of members, including in respect of under-represented groups.

12.3 Plans were being made for Governor engagement events, including an event at Gloucester College's Cheltenham Campus in February 2017, and a possible event at Stroud College soon after.

12.4 Hilary Bowen asked whether efforts to increase membership might also increase pressure on the Trust's services. Ruth FitzJohn replied that if people needed the Trust's services, we were happy for them to come to us, but membership was not directly linked to service use. The Trust was seeking to recruit more members in order to support the work of the Trust and raise the profile of mental health.

12.5 Mervyn Dawe asked if Governors could be issued with a recruitment pack which could be handed out at Governor events to prospective members for

them to fill in on the spot. Andrew Smart agreed to provide Governors with membership materials.

ACTION: Andrew Smart to supply Governors with a membership recruitment pack to aid with new member recruitment

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

13.1 Rob Blagden said that a number of the key discussion points from the pre-meeting had already been raised and responded to elsewhere in the meeting.

13.2 A request was made that thought be given as to how Governors might support the Trust when information appeared in the media whether information about key media issues could be shared with Governors as appropriate. Colin Merker agreed to consider this issue and report back to the Council.

ACTION: Colin Merker to consider how Governors could be kept briefed on key media issues.

14. GOVERNOR ACTIVITY

14.1 Governors updated the Council about activities they had undertaken in their role as a Governor.

15. ANY OTHER BUSINESS

15.1 Mervyn Dawe brought to Governors' attention a recent report in The Guardian regarding a shortage of mental health nurses, and asked what plans the Trust had to recruit nursing staff. Ruth FitzJohn replied that this was not primarily an issue for Council, but asked Carol Sparks to prepare a briefing note for Governors about the current state of vacancies and the process for recruitment.

ACTION: Carol Sparks to produce a briefing note for Governors regarding current nursing staff vacancies and recruitment process.

15.2 Mervyn Dawe asked about the cost to the Trust of Out Of County placements. Ruth FitzJohn replied that this was not an issue for Governors, but asked Colin Merker to provide a short note to Governors explaining the situation regarding Out Of County Placements and any costs to the Trust. Ruth FitzJohn informed the Council that the choice of placement was a matter for commissioners, not the Trust.

ACTION: Colin Merker to produce a briefing note for Governors regrading Out Of County Placements and any associated costs to the Trust

15.3 Cherry Newton asked whether the Trust has a plan to reduce suicide. John McIlveen agreed to post the Trust's Suicide Prevention Strategy onto the Governor portal.

ACTION: Suicide Prevention strategy to be posted on the Governor portal

15.4 A Governor recommended Radio 4's All in the Mind as a good source of information about mental health issues.

16. DATE OF NEXT MEETINGS

Council of Governor Meetings

Business Continuity Room, Trust HQ, Rikenel		
Date	**Governor Pre-meeting**	**Council Meeting**
2017		
Tuesday 17 January	9.00 – 10.00am	10.30 – 12.30pm
Thursday 9 March	1.30 – 2.30pm	3.00 – 5.00pm
Tuesday 9 May	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 13 July	9.00 – 10.00am	10.30 - 12.30pm
Tuesday 12 September	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 9 November	1.30 – 2.30pm	3.00 – 5.00pm

Board Meetings

2017		
Thursday 26 January	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 30 March	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 25 May	10.00 – 1.00pm	Hereford
Thursday 27 July	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 28 September	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 30 November	10.00 – 1.00pm	Hereford

CONFIDENTIAL

The public session of the Council of Governors meeting closed at 16.55 in order for the Council to consider the following confidential item of business.

17. APPOINTMENT OF EXTERNAL AUDITOR

17.1 Marcia Gallagher presented a report concerning the appointment of an External Auditor. The appointment of the External Auditor is a matter for the Council of Governors, and the Council had previously established a task and finish group to manage the process and make a recommendation to Council. The group comprised three Governors (Rob Blagden, Roger Wilson and Alan Thomas), Marcia (as the Chair of the Audit Committee) and Stephen Andrews, the Deputy Director of Finance. Technical and administrative support had been provided respectively by the Senior Procurement Manager at Procurement Shared Services.

17.2 The Council noted the process which the group had gone through, which included the use of a framework agreement to invite bids from suitable firms, agreement of a scoring and evaluation methodology for bids, initial scoring of submissions from the three bidders, presentations to the group from those bidders.

17.3 The Council noted that three bids were received, from Grant Thornton, KPMG, and Deloitte (the Trust's current auditor). All firms submitted very similar prospective costs, as would be expected from a very competitive market.

17.4 Following the presentations, at which Governors were able to ask questions about the presentations themselves and the bid which the firm had submitted, a final scoring exercise was conducted. On the basis of the combined scores, KPMG achieved the highest overall score, and a contributory factor had been the additional services which KPMG could offer to the Trust. Alan Thomas confirmed that the selection process had been an objective one.

17.5 Rob Blagden informed the Council that while a change in External Auditor would mean some additional work for the Trust's finance team, it would be beneficial for 2gether to have a fresh pair of eyes looking at the Trust's finances, given recent events in the local health economy.

17.6 Svetlin Vrabtchev asked about the criteria for extending the contract of the External Auditor. Marcia Gallagher replied that it was up to the Trust as to whether any permitted contract extension would be allowed, and that decision would be based on the performance of the auditor during the contract.

17.7 The Council agreed the recommendation of the task and finish group and appointed KPMG as the Trust's External Auditor with effect from 1 April 2017, for an initial period of 3 years with the option to extend for a further two periods of 1 year each. The fee would be £48,700 per year, excluding VAT which is reclaimed by the Trust.

Council of Governors – Action Points

Item	Action	Lead	Progress
13 September 2016			
10.11	Governor Portal to be updated with a new section for the Performance Dashboard	Anna Hilditch	**Complete** Governor Portal and Handbook has been fully updated to include the performance dashboard reports. A network error was reported to the web developers in October but this has now been rectified and all documents have been uploaded.
12.2	Information about the Governor observation at Board Committees and upcoming engagement events to be shared with all Governors	Anna Hilditch	A review of the Board Committee observation trial will be taking place at the January 2017 Council meeting. Following this a new schedule of meetings will be issued and all Governors will be given the opportunity to participate in the process of observation
10 November 2016			
5.1	Governors to return evaluation forms to the Assistant Trust Secretary within three days of each Council meeting	Governors	Noted
5.3	Evaluation form to be reviewed as part of a wider review of the Board/Governor development programme to provide more space for explanatory comment	Trust Secretariat	Will be reviewed at joint Board/Governor Development session proposed for June 2017
6.11	Further STP briefing to be provided to Governors in January 2017	Trust Secretariat	**Complete** On agenda for January meeting
6.18	Governor working group to be convened (Alan Thomas, Dawn Lewis, Rob Blagden and Mervyn Dawe) to review the draft operational plan and provide feedback to the Board	Trust Secretariat / Andrew Lee	**Complete** Working Group to take place on 12 December to enable feedback to be given to the Board in time for the 23 December submission
10.4	Board/Governor development day to be arranged for June 2017 to review the outcomes of the Board/Governor development programme	Trust Secretariat	**Complete** Provisional date of Thursday 29th June at 2.00 – 5.00pm proposed for this development session
12.6	Andrew Smart to supply Governors with membership recruitment packs	Kate Nelmes	**Complete** Packs produced and offered to Governors. Proposal to distribute these at the January Council meeting unless requested to send in advance
13.2	Colin Merker to consider how Governors could be kept briefed on key media issues.	Colin Merker	Verbal update at the January meeting
15.1	Carol Sparks to produce a briefing note for Governors regarding current nursing staff vacancies and recruitment process.	Carol Sparks	**Complete** Sent out with hard copy of papers for January Council meeting

15.2	Colin Merker to produce a briefing note for Governors regrading Out Of County Placements and any associated costs to the Trust	Colin Merker	Briefing to be emailed to Governors in advance of January meeting, with hard copies available at the meeting for circulation.
15.3	Suicide Prevention strategy to be posted on the Governor portal	Anna Hilditch	**Complete** Gloucestershire Suicide Prevention Strategy and the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness have both been uploaded onto the portal under "Key Documents and Publications"

2gether NHS Foundation Trust
EVALUATION OF COUNCIL OF GOVERNORS MEETINGS

Name…12 Governors…… (optional) **Date of Meeting** …10 November 2016…

	Please tick as appropriate:	**Yes**	**No**	**N/A**
Seeing from a service user's perspective				
1.	Did we consider relevant topics from a service user perspective? *If no, describe what we missed:* • **As far as was possible and appropriate given the content of the meeting** • **Comments all through Audit Chair presentation about "true purpose"**	10		2
Excelling and improving				
2.	Did we hear both expert and non-expert perspectives in our meeting? *If no, please describe what we could have done to ensure other perspectives were heard:* • **Good NED input**	12		
Responsive				
3.	Did we deliver on any targets or actions that were due?	12		
Valuing and Respectful				
4.	Did the language we use demonstrate respect for others? • **Good to be reminded of body language and respect** • **Especially in valuing challenging feedback**	11	1	
Inclusive, open and honest				
5.	Were the conversations at the pre-meeting open, inclusive and non-judgmental about the topics on the Council's agenda? *If no, what needs to be different:* • **Pre-meeting – difficult to Chair. Lead Governor does a great job**	9		3
6.	Did you feel able to contribute to debate and decision making at the Council of Governors meeting? *If not please explain what prevented you from doing so:* • **Opportunities were available if the need was there**	12		
Can do				
7.	Did we identify opportunities and innovations? *If we should have done but didn't, say what stopped us:* • **Came up with new actions in the meeting in response to comments** • **Membership packs for Governors – took this suggestion up**	11		1

	Please tick as appropriate:	Yes	No	N/A
Efficient, effective, economic and equitable				
8.	Did the agenda and papers arrive in plenty of time? (at least 4 working days before the meeting) • **Need papers earlier/14 days before meeting**	11	1	
9.	Were the agenda and papers i) Concise? ii) Informative? iii) Easy to follow? iv) At an appropriate level of detail? v) Clearly state the recommendations? • **Some papers have too much detail**	11 12 12 12 12	1	
10.	Were reports / papers presented concisely and succinctly?	12		
11.	Please list any reports which did not meet the above aims:			
12.	Please list any reports you found particularly helpful and say why: • **Holding to account presentation was helpful and well balanced** • **Good precis of slides in NED presentation which enabled more time for Q&A** • **Finance presentation excellent and good time for questions**			
13.	Were the items submitted to Council appropriate for the discussion / decision making?	12		
14.	Was the right amount of time spent debating the right issues? *If no, and too much time was spent debating a particular issue, which one?*	12		
15.	Were you clear about the facts, evidence, or points of view that were used to enable the Council of Governors to make decisions? *If no, how could we make this clearer:* • **Needed more on deputy Chair and SID position process** • **More transparency needed – demographics etc**	10	2	
16.	Did the Council receive clear, well-thought through advice from Trust staff or Board members? *If not please indicate any areas where you would have liked more support/ advice/clarification:* • **Closer communication needed with Governors**	12		

Please amplify your answers or provide any other comments/concerns/future agenda items or training/development needs or ideas to improve the Council (please continue on back if necessary).

Best Aspect of Meeting:	Worst Aspect of Meeting:
• Constructive feel to the discussions. Issues and challenges managed well. • Chair, Exec and NED members responded openly and clearly • Excellent holding to account session that clearly separated NED role from management role • Keeping to the timetable • Holding to account presentation • Finance HTA session was excellent – good for NED to be answering most of the assurance questions • Time keeping	• Governors are still not entirely clear on their role within the governance structure of the Trust, but definite improvements • Room too hot – more tea and coffee needed

Agenda Item 6 **Enclosure** **Paper B**

Report to: Council of Governors – 17 January 2017
Author: Gordon Benson, Assistant Director of Governance & Compliance
Presented by: Gordon Benson, Assistant Director of Governance & Compliance

SUBJECT: **Quality Report Audit Process & Quality Priorities for 2017/18**

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

EXECUTIVE SUMMARY

Quarter 2 Quality Report

This is the Council of Governors review of the Quality Report priorities for 2016/17. 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 confirmed targets which will not be met by year end:
    1. 1.3 – Joint CPA reviews for young people transitioning to adult services
    2. 3.2 – Reduction in the number of detained patients who are AWOL
- There is limited assurance that target 3.1 – Reduction in the numbers of reported deaths by suspected suicide, and target 3.3 – 5% reduction in the number of prone restraints on adult wards/PICU will be met.
- These targets will continue to receive considerable focus through operational management systems, wider work streams such as the Patient Safety Improvement Programme, and sub-committees such as the Positive & Safe Sub-Committee.

Improvements

- The data within relates to Quarter 2 and will, therefore, be subject to change throughout the year as the supportive evidence base grows.
- There have been sustained improvements across all User Experience targets, 48hr follow up and Personalised Discharge Care Planning which demonstrate that measures put in place to improve performance in these areas by Service Directors have been effective. These will continue to receive focus throughout the year.

A copy of Quarter 2 2016-17 Quality Report is included for information as Appendix 1.

The Quarter 3 report is currently being drafted. The Quarter 3 report will be more fully populated and also information on other quality improvements we have made to services.

Audit Recommendations 2015-16

The external assurance audit in 2015 -16 identified 7 recommendations. These are shown in Appendix 2, together with the Trust's management response and an update on progress made. There is currently 1 recommendation outstanding, this relates to ratification of the *Assessment & Care Management Policy*. It is anticipated that this will be approved by 31 January 2017.

Audit Process 2016-17 Quality Report

NHS Improvement guidance is currently unavailable for the external assurance report which will be provided by Deloittes; however, Deloittes understand that it is unlikely there will be significant changes in the Quality Report assurance requirements. Therefore, in keeping with previous guidance we are working on the assumption that one locally chosen Governor indicator will still be required in addition to two mandated indicators. On this basis the Governors are asked to give consideration to which of the indicators they would like subject to audit. This decision must be made no later than **31 January 2017** as Deloittes will be completing initial testing 28 February – 3 March 2017. Final testing will conclude 18-20 April 2017.

For information, the potential options for auditing are as follows:

Mandated Indicators:

- Minimising delayed transfers of care;
- Admissions to inpatient services had access to crisis resolution home treatment teams;
- 100% enhanced Care Programme Approach (CPA) patients receive follow-up contact within seven days of discharge from hospital;

Effectiveness:

- To increase the number of service users with a LESTER tool intervention, alongside increased access to physical health treatment**;**
- To improve personalised discharge care planning in:
    a. Adult inpatient wards and;
    b. Older people's wards.
- To ensure that joint Care Programme Approach reviews occur for **all** service users who make the transition from children's to adult services.

User Experience:

- Were you involved as much as you wanted to be in agreeing what care you will receive? **> 78%**
- Were you involved as much as you wanted to be in decisions about which medicines to take? **> 73%**
- Do you know who to contact out of office hours if you have a crisis? **>71%**

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

Safety:

- Reduce the numbers of deaths by suicide of people in contact with services.
- Reduce the number of people who are absent without leave from inpatient units who are formally detained;
- To reduce the number of prone restraints by 5% year on year (on all adult wards & PICU) based on 2015/16 data.
- **95%** of adults will be followed up by our services within 48 hours of discharge from psychiatric inpatient care

2017-18 Quality Report Development

We are currently considering quality priorities for inclusion in the 2017-18 Quality Report working with colleagues within the organisation and externally. If the Council of Governors have suggestions for potential indicators, please can these be provided to the Director of Quality & Assistant Director of Governance & Compliance no later than **31 January 2017**.

RECOMMENDATIONS

The Council of Governors is asked to:

A. Note the progress being made in the Quarter 2 Quality Report.
B. Note the progress made against recommendations from the 2015-16 external audit process.
C. Agree the indicators they would like subject to audit.
D. Consider potential Quality Indicators/Quality Priorities for 2017/18 and provide this by 31 January 2017.

Corporate Considerations	
Resource implications:	Collating the information has resources implications regarding collation and presentation of information.
Equalities implications:	This is referenced in the report
Risk implications:	Specific initiatives that are not being achieved are highlighted in the report.

WHICH TRUST KEY STRATEGIC OBJECTIVES DOES THIS PAPER PROGRESS OR CHALLENGE?			
Quality and Safety	P	Skilled workforce	P
Getting the basics right	P	Using better information	P
Social inclusion	P	Growth and financial efficiency	
Seeking involvement	P	Legislation and governance	P

WHICH TRUST VALUES DOES THIS PAPER PROGRESS OR CHALLENGE?			
Seeing from a service user perspective			
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	9 January 2017

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
	Date	

Explanation of acronyms used:	

1. CONTEXT

1.1 Every year the Trust is required by statute to produce a Quality Report, reporting on activities and targets from the previous year's Report, and setting new objectives for the following year.

To ensure appropriate oversight of the Quality Report, we produce an update for the Governance Committee every quarter, identifying progress or otherwise against the Report.

By carrying out this exercise on a regular basis, any deviation from the objectives, actual or potential, can be identified and rectified at an early stage rather than at the year's end.

2. AUDIT PROCESS

2.1 Monitor guidance is currently unavailable for the external assurance report but it is proactive to prepare for the potential for Governors to choose an indicator to audit. The external audit process will commence in March 2017 with onsite testing completed in mid-April 2017

3. 2017-18 QUALITY REPORT DEVELOPMENT

3.1 Currently there is development taking place on the quality priorities for inclusion in the 2017-18 Quality Report. This includes taking account of:

1. What commissioners are requesting
2. CQUINs – quality payments
3. Patient Safety Improvement Programme
4. Discussions with Healthwatch in both counties
5. Discussions with clinicians and managers

3.2 The Governor Working Group in previous years has identified that a set of principles should be applied when identifying future quality priorities. These principles should have indicators that

a) seek to:

- find, celebrate, share and maintain good practice,
- determine where practice which can be improved

b) Be measureable across all geographical locations where services are provided, so that results can be both aggregated and individually compared for the purpose of internal benchmarking. Also where appropriate reflecting specific local requirements, a local indicator could be chosen.

c) Refer to historical data, where available to identify and show any change in quality over time.

d) In addition to identified measurable indicators, there should also be quality reporting on the outcome measures and indicators used in services to demonstrate effective

interventions as well as other key quality measures such as the number of under 18 admissions into adult mental health inpatient units.

In considering this, applying the principles described above, the trust will consider drafting measureable indicators in the following areas for endorsement by the Council of Governors at its March 2017 meeting:

- Effectiveness
- User experience
- Safety

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Quality Report 2016/17

Quarter 2

CONTENTS

Part 1: Statement on Quality from the Chief Executive

Introduction

This will be completed at year end.

Part 2a: Looking ahead to 2017/18

Quality Priorities for Improvement 2017/18

This will be completed at year end.

Effectiveness

These will be developed during Quarter 4

User Experience

These will be developed during Quarter 4

Safety

These will be developed during Quarter 4

Part 2b: Statements relating to the Quality of NHS Services Provided

This will be completed at year end.

Participation in Clinical Audits and National Confidential Enquiries

This will be completed at year end.

Participation in Clinical Research

This will 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 2016/17 was conditional on achieving quality improvement and innovation goals agreed between [2]gether NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed CQUIN goals for 2016/17 are available electronically at http://www.2gether.nhs.uk/cquin

2016/17 CQUIN Goals

Gloucestershire

Gloucestershire Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
Young Peoples Transitions	This CQUIN will improve outcomes in young people transitioning from [2]gether Young People's Services to Adult Mental Health Services.	.80	£564256	Effectiveness
Perinatal Mental Health	This CQUIN will focus on quality improvement across the perinatal mental health pathway to promote integration, knowledge and skills of staff and improve outcomes for women and families.	1.7	£1199044	Effectiveness

Herefordshire

Herefordshire Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
1a (b) National CQUIN – Staff health and wellbeing	The introduction of health and wellbeing initiatives covering physical activity, mental health and improving access to physiotherapy for people with MSK issues	.25	£41100	Effectiveness
1b National CQUIN – Staff health and wellbeing	Healthy food for NHS staff, visitors and patients	.25	£41100	Effectiveness
1c National CQUIN - Staff health and wellbeing	Improving the uptake of flu vaccinations for front line staff	.25	£41100	Safety
Improving Physical Healthcare	The purpose of this CQUIN is twofold. Firstly, to improve the physical health of service users who	.25	£41100	Effectiveness
Local CQUIN personalised relapse prevention plans for adults	Personalised relapse prevention plans for adults accessing services, specifically Assertive Outreach Team and Early Intervention Service	0.52	£85488	Safety
Local CQUIN personalised relapse prevention plans for Children and Young People	Personalised relapse prevention plans for young people accessing services, specifically children and young people accessing and using CAMHS services	0.52	£85488	Safety
Local CQUIN 3 – Frequent attenders	Care and management for frequent attenders to WVT Accident and Emergency	0.46	£75624	Safety

Low Secure Services

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

The total potential value of the income conditional on reaching the targets within the CQUINs during 2016/16 is £2,219,300 of which we anticipate £2,219,300 will be achieved.

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

2017/18 CQUIN Goals

These will be developed during Quarter 4.

Statements from the Care Quality Commission

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

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

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

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

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

CQC Inspections of our services

[2]gether NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2015/16. The Care Quality Commission undertook a planned comprehensive inspection of the Trust week commencing 26 October 2015 and published its findings on 28 January 2016. The CQC rated our services as GOOD, rating **2** of the **10** core services as “outstanding” overall and **6** “good” overall.

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

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

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

[2]gether NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

- The Trust has developed an action plan in response to the **15** "must do" recommendations, and the **58** "should do" recommendations identified by the inspection.

[2]gether NHS Foundation Trust has made the following progress by 30th June 2016 in taking such action:

- Setting up a Project Group to manage all actions through to their conclusion;
- Progressing and monitoring the associated actions with reporting to both the CQC and local CCGs

Changes in service registration with Care Quality Commission for 2016/17

There have been no requests to change our registration with the CQC this year.

Quality of Data

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

This will be completed at year end.

Information Governance Toolkit

This will be completed at year end.

Clinical Coding Error Rate

This will be completed at year end.

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

Introduction

The 2016/17 quality priorities were agreed in May 2016.

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

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

Summary Report on Quality Measures for 2016/2017

		2015 - 2016	Quarter 2 2016 - 2017
Effectiveness			
1.1	To increase the number of service users (all inpatients and all SMI/CPA service users in the community, inclusive of Early Intervention Service, Assertive Outreach and Recovery) with a LESTER tool intervention (a specialist cardio metabolic assessment tool) alongside increased access to physical health treatment**.**	**Achieved**	**Achieved**
1.2	To improve personalised discharge care planning in: a) Adult inpatient wards and; b) Older people's wards.	**Achieved**	**Achieved**
1.3	To ensure that joint Care Programme Approach reviews occur for **all** service users who make the transition from children's to adult services.	**-**	**Not achieved**
User Experience			
2.1	Were you involved as much as you wanted to be in agreeing what care you will receive? **> 78%**	**78%**	**86%**
2.2	Were you involved as much as you wanted to be in decisions about which medicines to take? **> 73%**	**73%**	**79%**
2.3	Do you know who to contact out of office hours if you have a crisis? **>71%**	**71%**	**80%**
2.4	Has someone given you advice about taking part in activities that are important to you? **> 48%**	**48%**	**75%**
Safety			
3.1	Reduce the numbers of deaths by suspected suicide (pending inquest) of people in contact with services when comparing data from previous years.	**24**	**17**
3.2	Reduce the number of detained patients who are absent without leave (AWOL) when comparing data from previous years. Reported against 3 categories of AWOL as follows: 1. Absconded from an escort 2. Did not return from leave 3. Absconded from a ward	**13** **23** **78** **114 total**	**14** **28** **80** **122 total**
3.3	To reduce the number of prone restraints by 5% year on year (on all adult wards & PICU) based on 2015/16 data.	**120**	**102**
3.4	**95%** of adults will be followed up by our services within 48 hours of discharge from psychiatric inpatient care.	**90%**	**97%**

Effectiveness

In 2016/17 we remained committed to ensure that our services are as effective as possible for the people that we support. We set ourselves 3 targets against the goals of:

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

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

There is a long established association between physical comorbidity (the presence of multiple illnesses) and mental ill health. People with severe and enduring mental health conditions experience reduced life expectancy compared to the general population. People with Schizophrenia and Bipolar disorder die on average, 20 to 25 years earlier than the general population, largely because of physical health problems. These include coronary heart disease, diabetes, respiratory disease, greater levels of obesity and metabolic syndrome.

In 2014/15 the Trust introduced the LESTER screening tool within the inpatient services, as part of the National Physical Health Commissioning for Quality and Innovation (CQUIN) payment framework. The LESTER tool is a way of identifying service users at risk of cardiovascular disease and to implement interventions to reduce any risk factors identified. Specific areas covered in the tool are, diabetes, high cholesterol, high blood pressure, increased body mass index, smoking, diet and exercise levels, and substance and alcohol misuse.

In 2015/16 the National Physical Health CQUIN was repeated within the inpatient services and was extended to include the Early Intervention teams within Herefordshire and Gloucestershire. We successfully achieved full compliance with this CQUIN and using the same methodology for both the inpatients and community teams, the Trust achieved overall 93% compliance (see Figure 1)

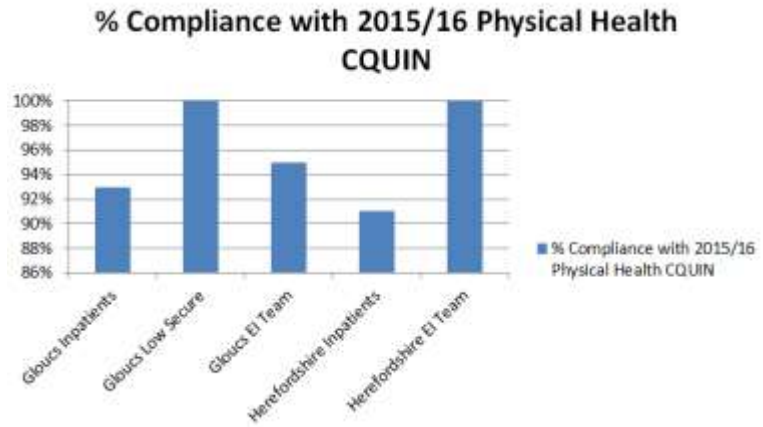

Figure 1

This year 2016/17 the Physical Health CQUIN has been adapted slightly to continue to build on the good work already in place. The sample group has now been extended to include both inpatients and patients from all community mental health teams who have a diagnosis of psychosis and are on CPA. (This year the CQUIN only relates to Herefordshire, however internal audits continue within Gloucestershire to ensure standards are maintained trust wide).

In order to support this work a substantial Lester Tool training programme for both inpatient areas and community mental health teams has been undertaken by the Physical Health Facilitator. The training department have also facilitated a one day Physical Health Awareness course, designed to complement the Lester tool training and increase staff awareness of coronary heart disease, chronic obstructive pulmonary disease and diabetes. All teams currently working with the Lester tool have an allocated 'lead' professional who receives regular feedback regarding progress in implementing and completing the Lester tool.

Within quarter two, the Trust has reviewed and updated the established pathways which are currently in place for both Inpatients and the Early Intervention teams. For example; the Department of Health's Alcohol Guidelines Review published in January 2016 suggested that the level of recommended units of alcohol for men and women to be lowered to14 units a week, this change has been highlighted to staff and the new figures changed on documentation. For the Recovery and Assertive Outreach Teams, for whom this was a new initiative, extra training was put in place to ensure that staff were aware of the various pathways available to patients, if identified whilst using the Lester Tool.

The medical doctor's induction programme includes a section on the Lester tool. This training focuses on the role of the medical teams to support the Lester tool as well as an overview of the need for increased physical health screening for patients with serious mental illnesses.

The roll out of the screening programme within the community teams highlighted the need for a standardisation of physical health equipment needed as a minimum to undertake the screening. A set stock list is now available for community teams to access and the training team have offered a clinical skills training package for staff that are unfamiliar with how to use the equipment. Lack of staff trained in venepuncture skills again was highlighted as a potential barrier to completing the Lester tool and a group of staff have now received this training and are competent to take the blood samples needed.

A "Physical Health Clinic" has been established at the community base in Hereford to enable staff to complete the Lester tool in a suitable environment; however staff are also able to screen patients at home if they are unable to attend the clinic.

Documentation has been highlighted as an issue nationwide, in that physical health information (screening details and interventions offered) are currently documented in multiple locations within the Electronic Patient Record RiO. The Trust received access to 'open RiO' in May 2015 which enabled the Trust to make changes to the Electronic Patient Record. Work has taken place to streamline where Physical Health information is recorded within the Electronic Patient Record RiO system. This will improve the way in which information can be audited and fed back to the clinicians. This system has now gone live and staff are now familiar with the new pages within RiO. Feedback from staff so far has been positive and appears to reduce the need for duplication of data.

Work continues to revise and update the Physical Health information pages within the Trust intranet. It is hoped to be a central point for obtaining information regarding the Lester tool, along with general physical health information, updates, audits and quality improvement projects.

Following the success of the Physical Health Day for staff and patients at Wotton Lawn hospital in January 2016, a second similar event is planned for February 2017. External providers invited to attend include; The Independence Trust, Stop Smoking Service, Slimming World, Sexual Health clinic and Dental Access Centres. The Trust's Working Well team, dietician and health and exercise practitioners will also be represented.

The Trust is continuing with its plans to achieve "Smoke Free" status in spring next year, and ground work is being undertaken by a small team to ensure this transition takes place smoothly. The annual Flu vaccination programme is currently being rolled out across the Trust and it is hoped to increase the number of staff and patients immunised this year.

We are currently meeting this target.

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

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

This year identical criteria are being used in the services across both counties as follows:

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

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

Results from the Quarter 2 audit against these standards are seen below.

<u>Gloucestershire Services</u>

Criterion	Compliance Quarter 4 (2015/16)	Compliance Quarter 1 (2016/17)	Compliance Quarter 2 (2016/17)
Overall Average Compliance (Gloucestershire)	**75% (712/950)**	**73%**	**77%**
Chestnut Ward	84% (62/74)	83%	88%
Mulberry Ward	75% (83/110)	77%	86%
Willow Ward	59% (37/63)	66%	68%
Abbey Ward	72% (113/158)	73%	75%
Dean Ward	79% (169/215)	73%	76%
Greyfriars PICU	50% (13/26)	64%	71%
Kingsholm Ward	75% (55/73)	72%	72%
Priory Ward	80% (173/217)	77%	81%
Montpellier Unit	50% (7/14)	42%	50%
Honeybourne	N/A	68%	78%
Laurel House	N/A	56%	67%

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

Overall compliance in Gloucester with these standards has increased during Quarter 2; there will be an increased focus on this important work during Quarter 3.

Herefordshire Services

Criterion	Compliance Quarter 4 (2015/16)	Compliance Quarter 1 2016/17)	Compliance Quarter 2 (2016/17)
Overall Average Compliance (Herefordshire)	**N/A**	**73%**	**74%**
Cantilupe Ward	**N/A**	77%	85%
Jenny Lind Ward	**N/A**	65%	76%
Mortimer Ward	**N/A**	72%	70%
Oak House	**N/A**	67%	78%

There is no 2015/16 data for Herefordshire. This is due to the audit criteria changing from the original set of questions which were influenced by the West Midlands Quality Review which agreed a differing set of standards within Herefordshire. As the audit widened to the whole Trust across two counties, the criteria within the audit changed to reflect the standards outlined within the clinical system in relation to discharge care planning. It is seen that overall compliance has improved during Quarter 2.

Of the seven individual criteria assessed, overall compliance has improved in both counties in all areas except in the following:

1. Has the Pre-Discharge Planning Form been completed?
2. Have the inpatient care plans been closed within 7 days of discharge?

Services will, therefore, be focusing on these elements to promote improvement.

We are currently meeting this target.

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

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

Gloucestershire Services

During Quarter 1, there were 7 young people who transitioned into adult services, of these 7, 6 (86%) had a joint CPA review. All young people received input from the relevant services but this is not clearly documented within RiO.

During Quarter 2, 5 young people were transitioned from CYPS to adult services. All of these (100%) had a joint CPA review with CYPS and adult services staff present.

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

Compliance improved during Quarter 2 and now needs to be maintained at 100%.

Herefordshire Services

During Quarter 1, there were 3 young people who transitioned into adult services, of these 3, 1 (33%) had a joint CPA review. All young people received input from the relevant services but this is not clearly documented within RiO.

During Quarter 2, there were 2 young people who transitioned into adult services, of these 1 (50%) had a joint CPA review. The one young person who did not receive a joint CPA review was having their care coordinated by a new member of staff who was unfamiliar with process.

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

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

- Transition will be included as 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 17.5 years open to CYPS. Team Managers will monitor those who are coming up to transition and discuss in supervision.

We have not met this target.

User Experience

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

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

Local surveys using the same questions have been implemented in our community and inpatient settings using a paper based survey method. This has been across the Trust in both Gloucestershire and Herefordshire, and below are the cumulative responses to the returned service user questionnaires at year end. A combined total percentage for both counties is provided for these questions to mirror the methodology used by the CQC Community Mental Health Survey, as this does not differentiate by county.

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

Questions	**Treatment Setting**	Sample Size **Glos**	Number 'yes' **Glos**	Sample size **Hereford**	Number 'yes' **Hereford**	**Total %** giving 'yes' answer
Question 1 Were you involved as much as you wanted to be in agreeing what care you will receive? > 78%	Inpatient	7	6	12	10	**86%**
	Community	63	52	30	28	
	Total Responses	70	58	42	38	

This target has been met.

Target 2.2 Were you involved as much as you wanted to be in decisions about which medicines to take? > 73%

Questions	**Treatment Setting**	Sample Size **Glos**	Number 'yes' **Glos**	Sample size **Hereford**	Number 'yes' **Hereford**	**Total %** giving 'yes' answer
Question 2 Were you involved as much as you wanted to be in decisions about which medicines to take? **> 73%**	Inpatient	7	6	12	9	**79%**
	Community	52	43	26	19	
	Total Responses	59	49	38	28	

This target has been met.

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

Questions	Treatment Setting	Sample Size Glos	Number 'yes' Glos	Sample size Hereford	Number 'yes' Hereford	Total % giving 'yes' answer
Question 3 Do you know who to contact out of office hours if you have a crisis? **>71%**	Inpatient	7	6	12	8	**80%**
	Community	59	45	29	27	
	Total Responses	66	51	41	35	

This target has been met.

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

Questions	Treatment Setting	Sample Size Glos	Number 'yes' Glos	Sample size Hereford	Number 'yes' Hereford	Total % giving 'yes' answer
Question 4 Has someone given you advice about taking part in activities that are important to you? **> 48%**	Inpatient	7	7	12	9	**75%**
	Community	61	38	29	28	
	Total Responses	68	45	41	37	

This target has been met.

Friends and Family Test (FFT)

FFT responses and scores for Quarter 2

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

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

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

	Number of responses	FFT Score (%)
July 2016	242	93%
August 2016	382	86%
September 2016	430	92%
Total	**1,087 (Q1 = 643)**	**90% (Q1 = 94%)**

Table 1

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

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

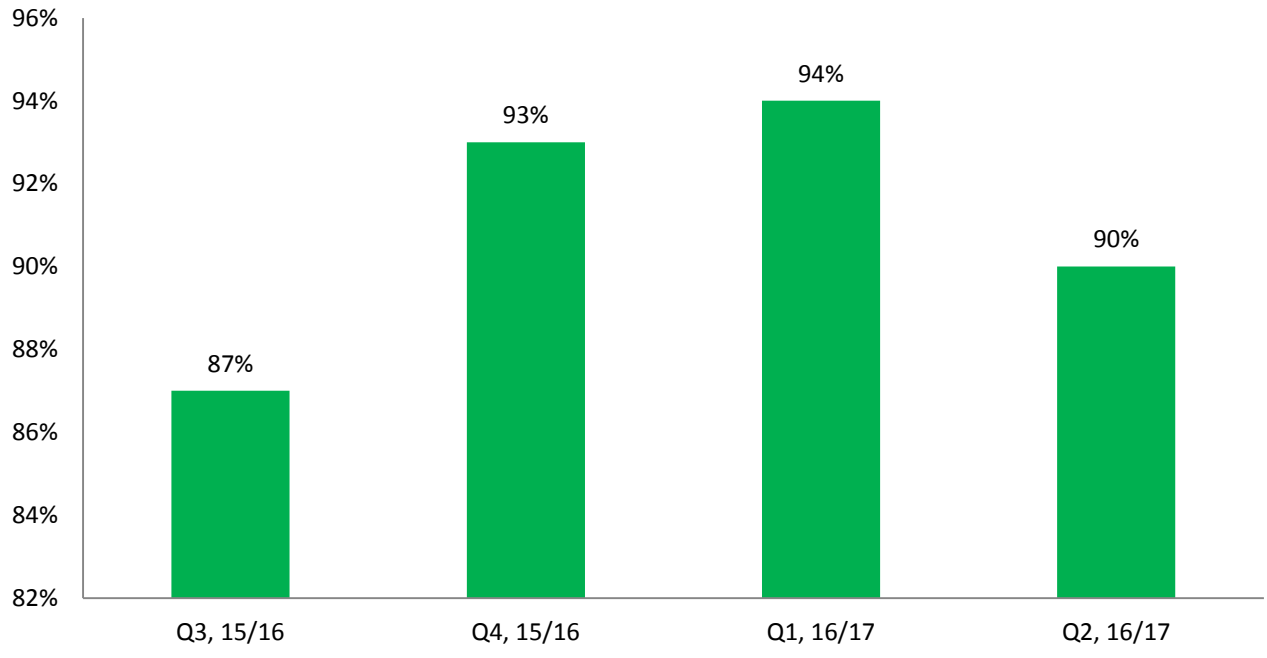

Figure 2

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

The following graph shows the FFT Scores for the past six months, including this quarter. The Trust receives a consistently high percentage of recommendation scores (*September 2016 data for England is not yet available*)

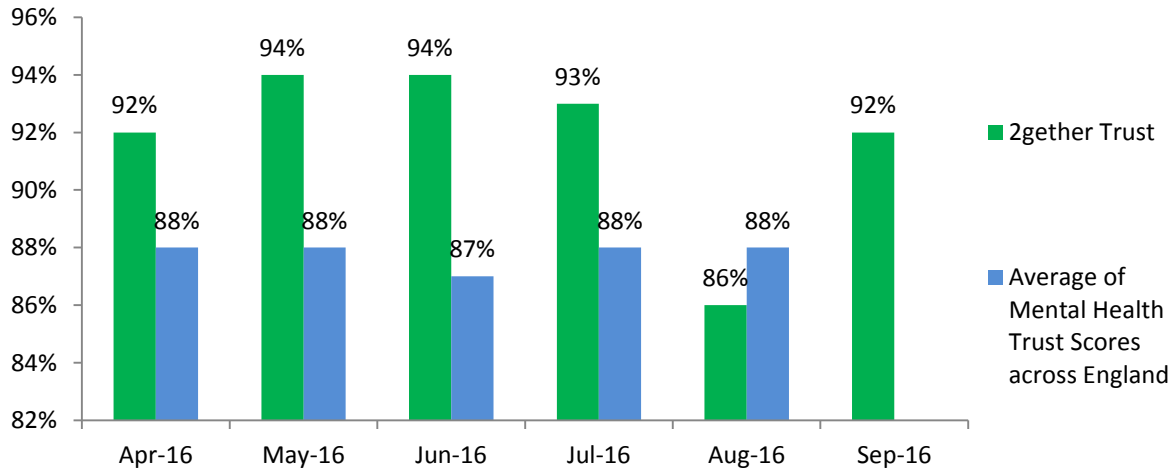

Figure 3

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

The following graph shows the FFT Scores for June, July and August 2016 (the most recent data available). The Trust receives a consistently high percentage of feedback. (*September 2016 data for the region is not yet available*)

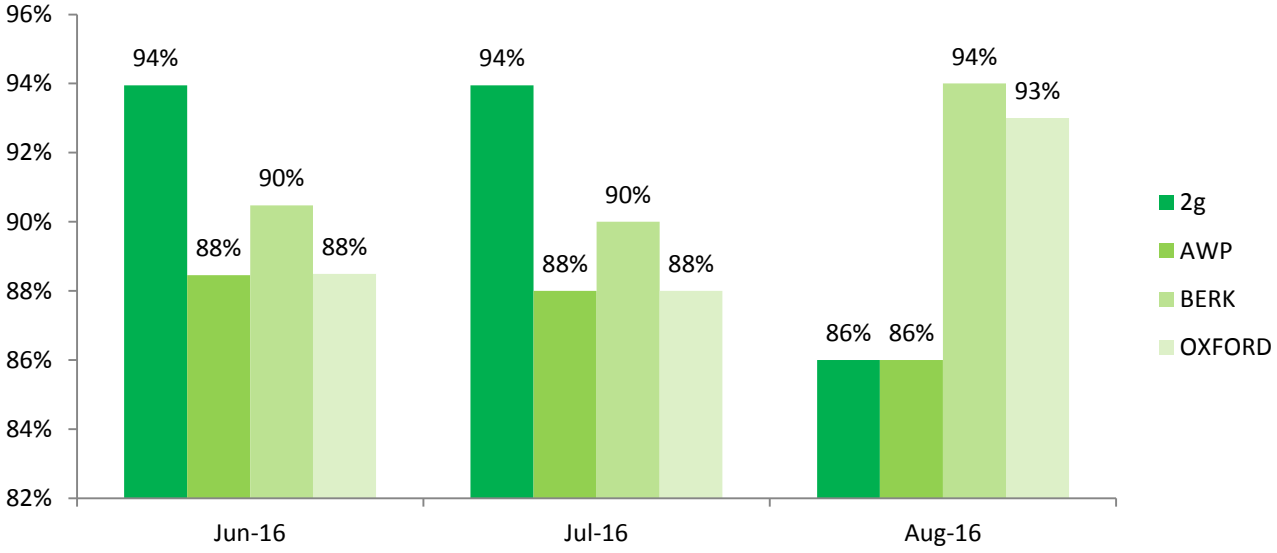

Figure 4

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

Complaints

This will 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 we assess the safety of those who use our services as well as providing a safe environment for service users, staff and everyone else that comes into contact with us. In this domain, we have set ourselves 4 goals to:

- Minimise the risk of suicide of people who use our services;
- Ensure the safety of people detained under the Mental Health Act;
- Reduce the number of prone restraints used in our adult inpatient services:
- Ensure we follow people up when they leave our inpatient units within 48 hours to reduce risk of harm.

There are 4 associated targets.

Target 3.1 Reduce the numbers of deaths relating to identified risk factors of people in contact with services when compared data from previous years.

We aim to minimise the risk of suicide amongst those with mental disorders through systematic implementation of sound risk management principles. In 2013/14 we set ourselves a specific quality target for there to be fewer deaths by suicide of patients in contact with teams and we have continued with this important target each year. Last year we reported **24** suspected suicides, **4** more than last year, therefore we did not meet the target. This year has seen a marked rise in these tragic incidents during Quarter 1 and at the end of Quarter 2 we have reported **17** suspected suicides.

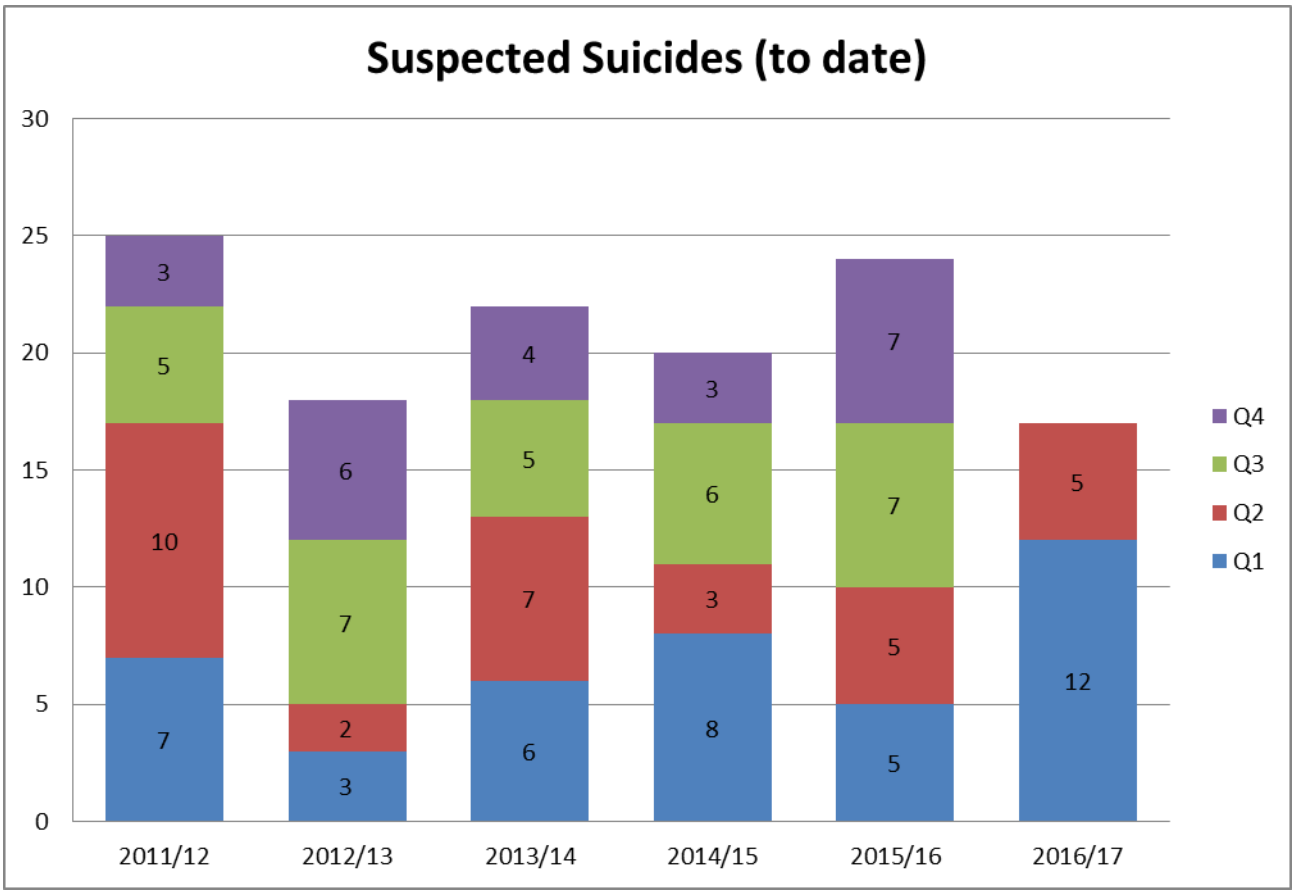

Figure 5

This information is provided below in Figures 6 & 7 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 services in each county are configured differently to reflect individual commissioning requirements.

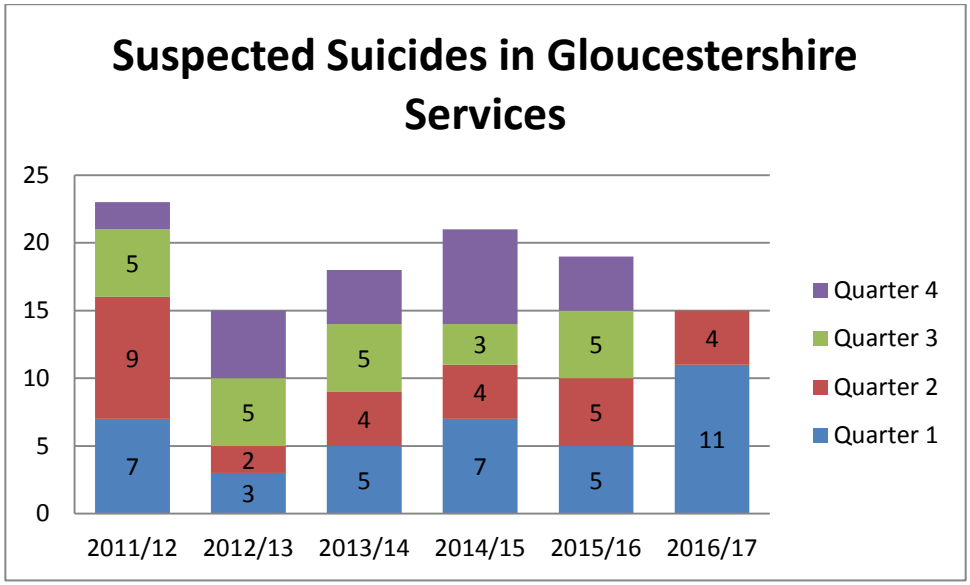

Figure 6

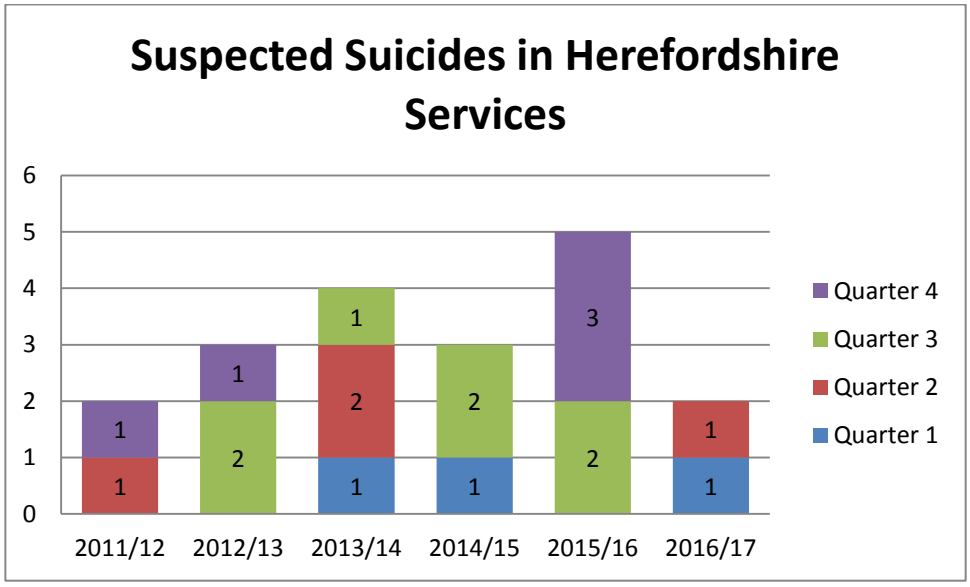

Figure 7

Whilst we report all deaths which appear to be as a consequence of self-harm as suspected suicide, ultimately it is the coroner who determines how a person came by their death. Figure 8 provides the number of suicide, open and narrative conclusions following an inquest being heard for the same cohort of service users. The outcome of inquests for each county is subsequently provided in Figures 9 & 10.

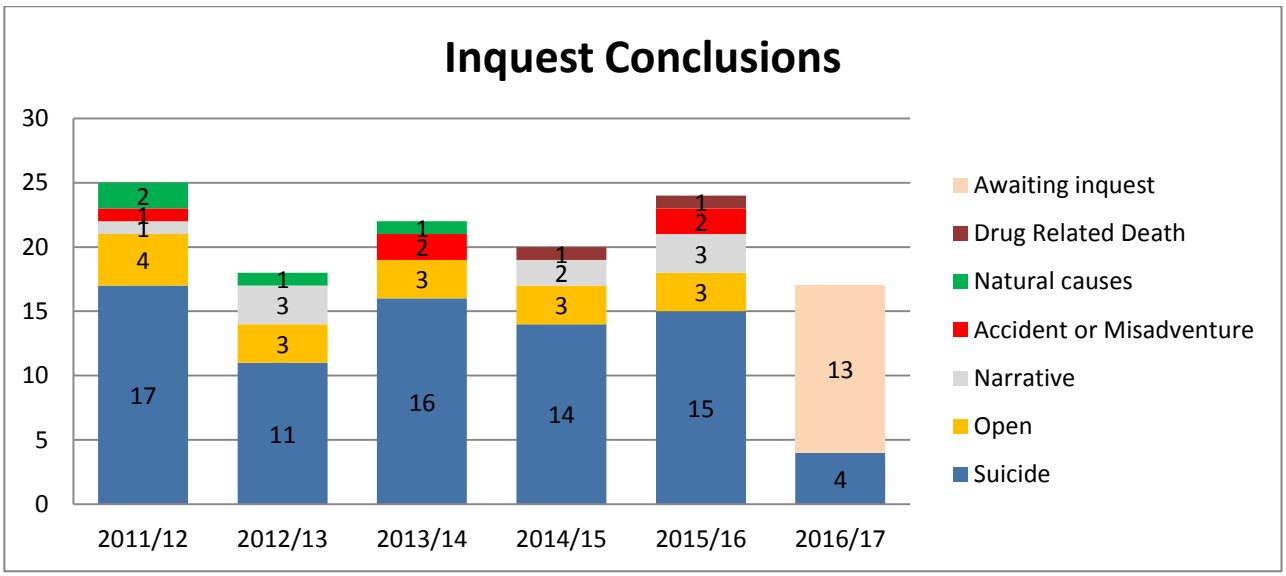

Figure 8

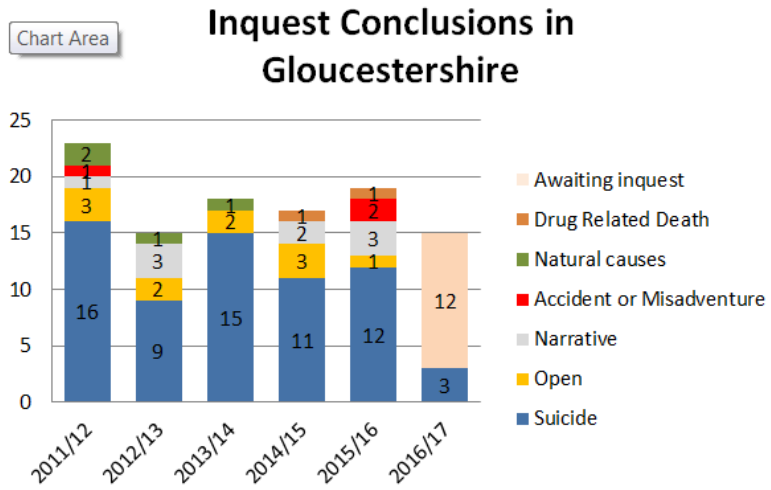

Figure 7

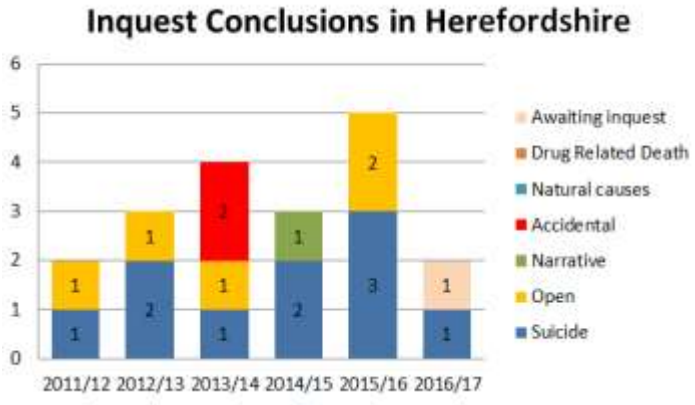

Figure 8

The Trust is an active member of the Gloucestershire Suicide Prevention Partnership Forum (GSPPF). This Forum brings together key stakeholders in the county to develop and deliver a countywide suicide prevention strategy and action plan and contribute to reducing the stigma around suicide and self-harm.

We are currently meeting this target as the total number remains below 24; however we have reported more suspected suicides in Quarters 1 & 2 this year than in the previous 4 years and there is a high risk that this target will not be met.

Target 3.2 Reduce the number of people who are absent without leave from inpatient units who are formally detained.

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

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

During 2015/16 **114** episodes of AWOL were been reported with the overall target being met, but there was an increase of **9** incidents where service users absconded from a ward. Therefore, we want to continue with this indicator as a quality priority during 2016/17. A breakdown of the 3 categories of AWOL for each county showing the year-end figures for 2015/16 and the Quarter 1 figures for 2016/17 are seen below.

Herefordshire

	Total 2015/16	Quarter 1 2016/17	Quarter 2 2016/17	Quarter 3 2016/17	Quarter 4 2016/17
Absconded from a ward	23	15	9		
Did not return from leave	4	2	1		
Absconded from an escort	4	2	0		
Totals for year	**31**	**29**			

Gloucestershire

	Total 2015/16	Quarter 1 2016/17	Quarter 2 2016/17	Quarter 3 2016/17	Quarter 4 2016/17
Absconded from a ward	55	20	36		
Did not return from leave	19	9	16		
Absconded from an escort	9	3	9		
Totals for year	**83**	**93**			

A total of **122** episodes of AWOL for Quarters 1 & 2 which now exceeds the total number of AWOL for the year 2015/16.

For the category “Did not return from leave” the team on Mortimer Ward at the Stonebow Unit in Hereford have tested out, and now use “Leave Cards”. These are cards given to patients, along with a conversation on what the expectations of returning from leave are as agreed. For example, planned leave arrangements can be documented on the back of the credit card sized “leave card”, explicitly showing the time due to return and a prompt to contact the ward team if unable to return by the agreed time. The hospital/ward contact numbers are provided on the other side of the cards also.

This piece of work is part of the greater understanding around AWOLS that has developed through measurement and focus. Levels of harm from AWOLS have reduced over time although reported numbers of AWOLs have generally increased. From Quarter 3 we will start reporting on the levels of harm to detained patients as a consequence of their absconding.

There will be a continued focus on positive engagement within our inpatient services to try to reduce the number of occasions where detained patients abscond from the ward environment.

We have not met this target.

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

This is a new target for 2016/17. During 2015/16, the Trust developed an action plan to reduce the use of restrictive interventions, in line with the 2 year strategy – Positive & Safe: developed from the guidance Positive and Proactive Care: reducing the need for restrictive interventions. This strategy offered clarity on what models and practice need to be undertaken to support sustainable reduction in harm and restrictive approaches, with guidance and leadership by the Trust Board and a nominated lead.

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

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

As use of prone restraint (face down) is sometimes necessary to manage and contain escalating violent behaviour, it is also the response most likely to cause harm to an individual. Therefore, we want to minimise the use of this wherever possible through effective engagement and occupation in the inpatient environment. All instances of prone restraint are recorded and this information was used to establish a baseline in 2015/16. Overall, there were **121** occasions when prone restraint was used in our acute adult wards and PICU and the breakdown of this information by month is shown in Figure 9 below.

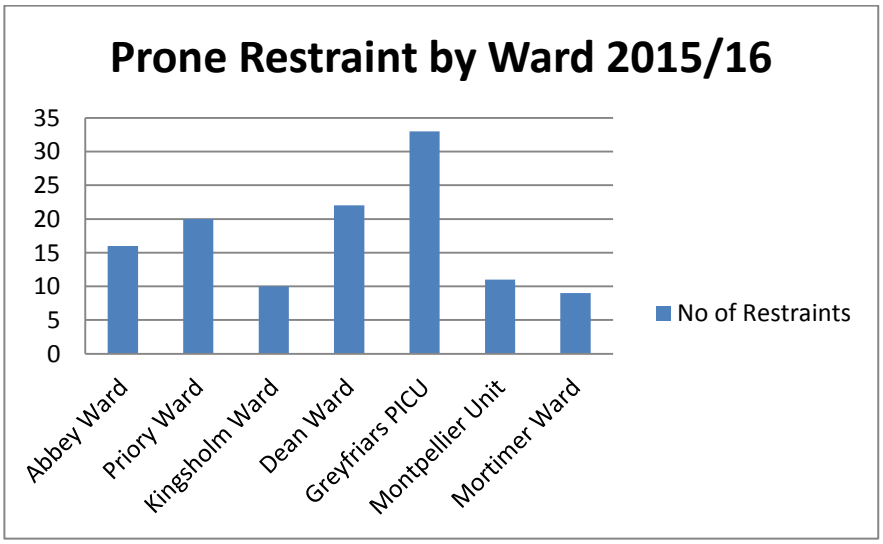

Figure 9

At the end of Quarter 2, **102** instances of prone restraint were used as seen in Figure 10 which is a significant increase.

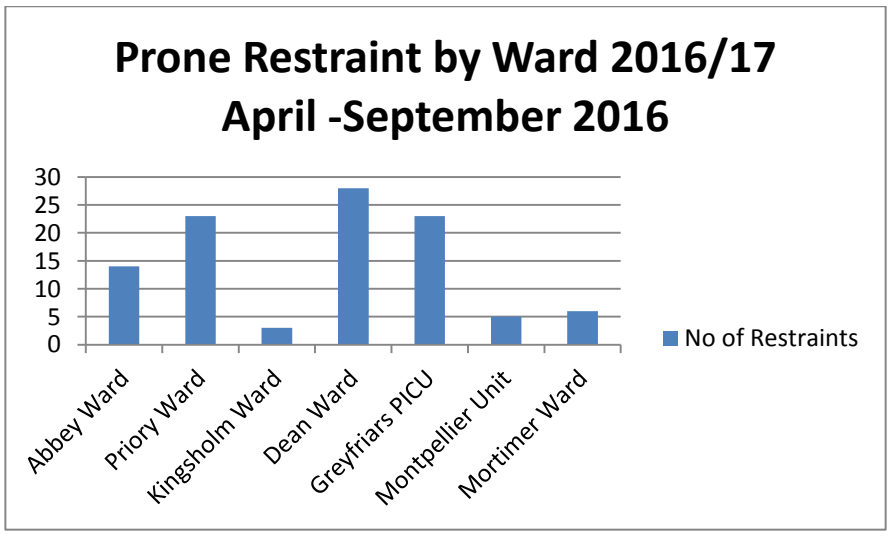

Figure 10

Analysis of the data has identified that not all of these incidents are, in fact, episodes of prone restraint, rather the application of precautionary holds for individuals who place themselves face down whilst holding items being used for the purpose of self-harm. These precautionary holds are fleeting and the person is released as soon as the item has been safely removed. A new category of "Precautionary/Non-Standard Hold" has, therefore, been added to DATIX and the wards advised of this. These episodes will be reviewed in detail and re-categorised where appropriate, so it is anticipated that these figures will change when next reported in Quarter 3.

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

Each year, the Trust engages in the NHS Mental Health Benchmarking exercise, which all English NHS Trusts who are providers of secondary mental health services participate in. This enables individual organisations to compare trends and benchmark themselves against the national data. Figure 11 below shows that the Trust reports incidences of prone restraint slightly above the national average.

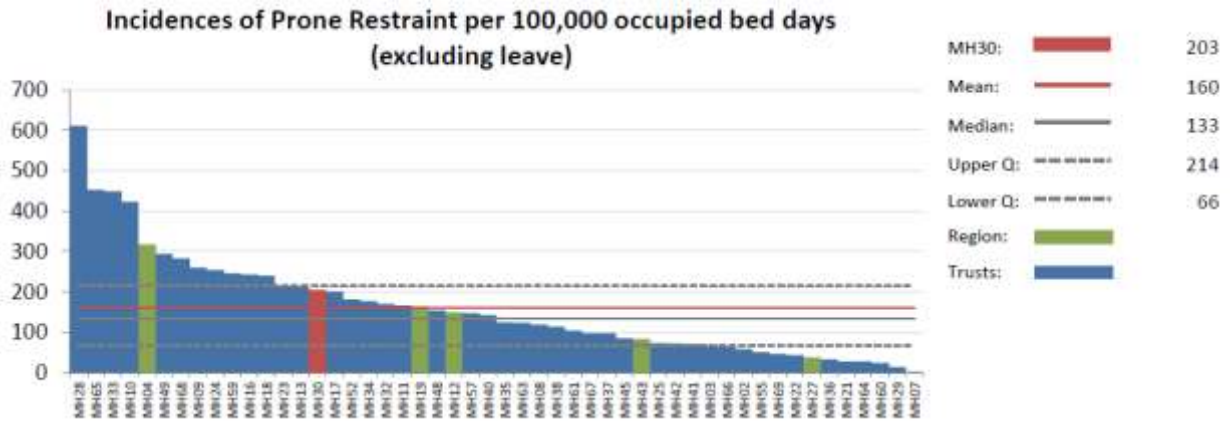

Figure 11

We are currently meeting this target as the total number remains below 121; however there is a high risk that the 5% reduction target may not be met at year end.

Target 3.4 95% of adults will be followed up by our services within 48 hours of discharge from psychiatric inpatient care

This is a local target and one which we first established as a quality target in 2012/13. The national target is that 95% of CPA service users receive follow up within 7 days[1].

Discharge from inpatient units to community settings can pose a time of increased risk of self-harm for service users. The National Confidential Inquiry into Suicides and Homicides[2] recommended that *'All discharged service users who have severe mental illness or a recent (less than three months) history of self-harm should be followed up within one week'*

One of the particular requirements for preventing suicide among people suffering severe mental illness is to ensure that follow up of those discharged from inpatient care is treated as a priority and that care plans include follow up on discharge. Although the national target for following up service users on CPA is within 7 days, in recognition that people may be at their most vulnerable within the first 48 hours, we aim to follow up 95% of people within these 2 days. This has been an organisational target for two years, and the cumulative figures for each year end are seen in the table below.

During 2015/16 we took the opportunity to review our practices and policies associated with both our 7 day and 48 hour follow up of patients discharged from our inpatient services. Whilst the adjustments we have undertaken have strengthened the patient safety aspects of our follow up contacts, introducing these changes have led to an impact on our in year performance, in comparison to our previous year's performance against these performance standards. In the case of our 48 hour local stretch target, our 2015/16 organisational performance fell to **90% (**Herefordshire services followed up **91%** (**25** breaches) of people discharged from inpatient care and Gloucestershire services have followed up **90%** (**83** breaches) which is below our stretch target.

We are confident that the practice changes we introduced have strengthened the patient safety aspects of this measure and that our performance in both our 7 day and 48 hour follow ups will ultimately return to being well above the national performance requirement and our local stretch target.

At the end of Quarter 2, Herefordshire services followed up **98%** (**2** breaches) of people discharged from inpatient care and Gloucestershire services followed up **96%** (**8** breaches). This gives an overall organisational compliance of **97%.** Each of these breaches will be reviewed to establish if there are any themes and trends, and the learning from this review will be used to promote practice.

	Target	2012-13	2013-14	2014-15	2015-16	2016-17 Q2
Gloucestershire Services	>95%	89%	95%	95%	90%	96%
Herefordshire Services	>95%	70%	95%	92%	91%	98%

We are currently meeting this target.

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

Serious Incidents reported during 2016/17

At the end of Quarter 2 2016/17, **22** serious incidents were reported by the Trust, and the types of incidents reported are seen in Figure 12.

Figure 13 overleaf shows a 6 year comparison of reported serious incidents. The most frequently reported serious incidents are “suspected suicide” and attempted suicide which is why we will continue into 2016/17 with a target to reduce suicide of people in contact with services. All serious incidents are investigated by a senior member of staff who has been trained in root cause analysis techniques. Wherever possible, 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. We also share copies of our trust investigation reports regarding “suspected suicides” with the Coroners in both Herefordshire and Gloucestershire to assist with the Coronial investigations.

There have been no Department of Health defined “Never Events” within the Trust during 2016/17. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

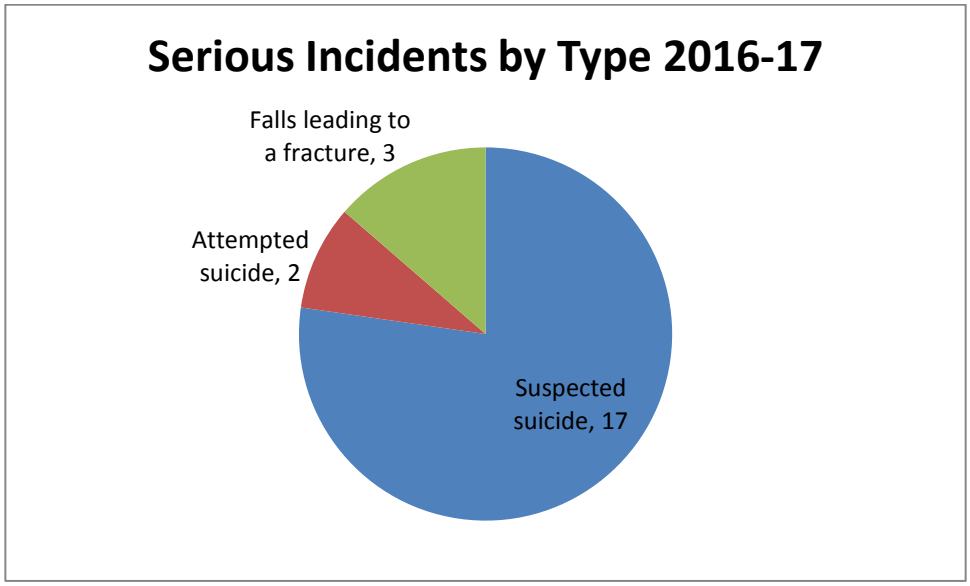

Figure 12

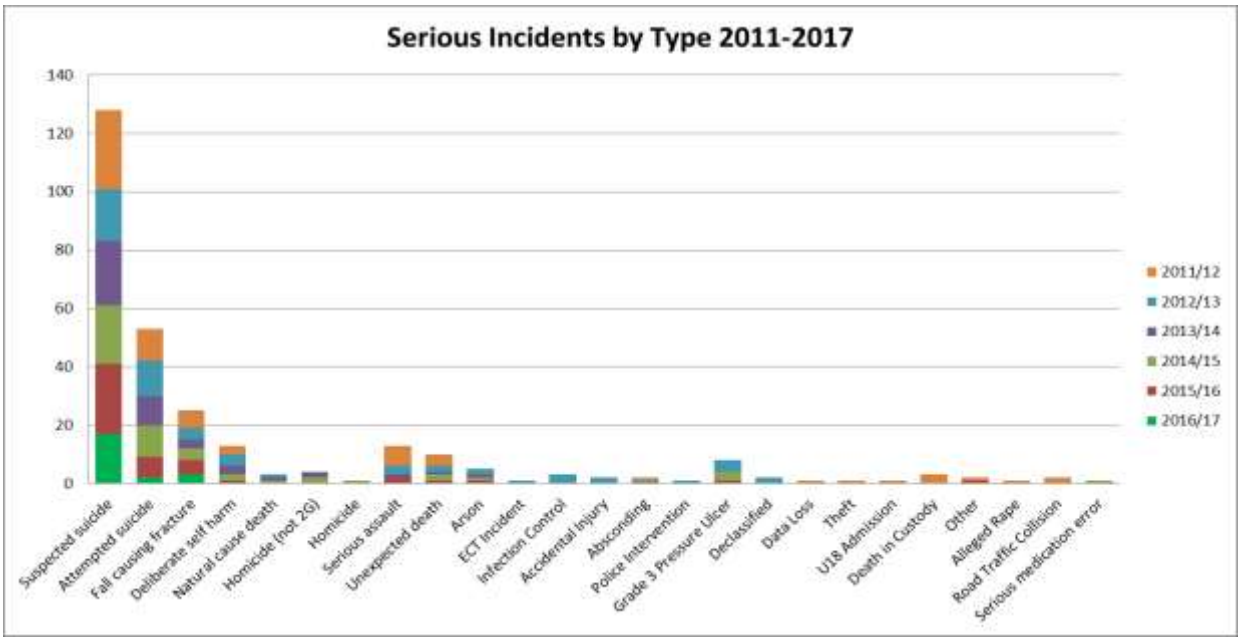

Figure 13

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 provided training sessions through our Quality Forums and given all staff leaflets regarding this. There is also a poster regarding this on every staff notice board.

During the CQC comprehensive inspection of our services, they reviewed how the Duty of Candour was being implemented in 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.

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

Indicators & Thresholds for 2016/2017

The following table shows the 10 metrics that were monitored during 2016/17. These are the indicators and thresholds from NHS Improvement (NHSI) and follow the standard Department of Health national definitions. Note that some are also the Trust Quality targets, and some may have more stretching targets than Monitor require as a threshold.

		2013-2014 Actual	2014-2015 Actual	2015-2016 Actual	National Threshold	2016-2017 YTD
1	Clostridium Difficile objective	1	3	0	0	**2**
2	MRSA bacteraemia objective	0	0	0	0	**0**
3	7 day CPA follow-up after discharge	99.1%	97.73%	95.63%	95%	**97.32%**
4	CPA formal review within 12 months	96.4%	97.1%	99.35%	95%	**99.03%**
5	Delayed transfer of care	0.12%	0.06%	1.02%	≤7.5%	**1.80%**
6	Admissions gate kept by Crisis resolution/home treatment services	99.1%	99.57%	99.74%	95%	**99.30%**
7	Serving new psychosis cases by early intervention teams	100%	100%	63.56%	50%	**69.57%**
8	MHMDS data completeness: identifiers	99.7%	99.71%	99.57%	97%	**99.85%**
9	MHMDS data completeness: CPA outcomes	80.6%	97.06%	97.42%	50%	**97.60%**
10	Learning Disability – six criteria	6	6	6	6	**6**

Mandated Quality Indicators 2016 -2017

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

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

	Quarter 1 2015-16	Quarter 2 2015-16	Quarter 3 2015-16	Quarter 4 2015-16	Quarter 1* 2015-16
[2]gether NHS Foundation Trust	98.4%	97%	97.2%	98.10%	97.1%
National Average	97%	96.8%	96.9%	97.2%	96.2%
Lowest Trust	88.8%	83.4%	50%	80%	28.6%
Highest Trust	100%	100%	100%	100%	100%

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

- During 2015/16 we have taken the opportunity to review our practices and policies associated with both our 7 day and 48 hour follow up of patients discharged from our inpatient services. Whilst the adjustments we have undertaken have strengthened the patient safety aspects of our follow up contacts, introducing these changes have led to an impact on our in year performance, in comparison to our previous year's performance against these performance standards. Our 7 day performance has fallen to just over 95% in Gloucestershire and just over 96% in Herefordshire which are lower than our previous year's performance, but still above the national performance requirement of 95 %. We are confident that the practice changes we have introduced have strengthened the patient safety aspects of this measure and that our future years performance in both our 7 day and 48 hour follow ups will return to being well above the national performance requirement and our local stretch target as in previous years.

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

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

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

	Quarter 1 2015-16	Quarter 2 2015-16	Quarter 3 2015-16	Quarter 4 2015-16	Quarter 1* 2016-17
[2]gether NHS Foundation Trust	99.5%	98.6%	100%	98.4%	98.9%
National Average	96.3%	97%	97.5%	98.2%	98.1%
Lowest Trust	18.3%	48.5%	61.9%	84.3%	78.9%
Highest Trust	100%	100%	100%	100%	100%

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

- Staff respond to individual service user need and help to support them at home wherever possible unless admission is clearly indicated;
- During 2015/16, crisis teams also gate kept admissions to older people's services beds within Gloucestershire.

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

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

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

	Quarter 2 2015-16	Quarter 3 2015-16	Quarter 4 2015-16	Quarter 1 2016-17	Quarter 2 2016-17
[2]gether NHS Foundation Trust 0-15	0%	0%	0%	0%	0%
[2]gether NHS Foundation Trust 16 +	7%	10%	6%	7%	6%
National Average	Not available	Not available	Not available	Not available	Not available
Lowest Trust	Not available	Not available	Not available	Not available	Not available
Highest Trust	Not available	Not available	Not available	Not available	Not available

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

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

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

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

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

	NHS Staff Survey 2012	NHS Staff Survey 2013	NHS Staff Survey 2014	NHS Staff Survey 2015
[2]gether NHS Foundation Trust Score	3.19	3.46	3.61	3.75
National Median Score	3.54	3.55	3.57	3.63
Lowest Trust Score	3.06	3.01	3.01	3.11
Highest Trust Score	4.06	4.04	4.15	4.04

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

- The National Staff Survey does not report directly on this question but does report on 'Staff recommendation of the trust as a place to work or receive treatment'. This key finding is derived from the responses to three linked questions relating to care of patients, recommending the organization as a place to work and being happy with the standard of care provided by the organisation. The response to the component questions was more positive in 2015 than in the previous three surveys indicating increasing satisfaction with the trust as a place to receive treatment and to work as perceived by staff. The 2015 survey also shows the trust score continues to move ahead of the median score for other like-type trusts;

- The National Staff Survey results continues to be complemented by the introduction of the Staff Friends and Family Test that has now been in operation since April 2014 giving staff the opportunity to voice their opinion on the trust as an employer and provider of care, confidentially in three questionnaires during the year. In the most recent survey held in March 2016, 85% of respondents said they would be likely or extremely likely to recommend the trust to friends and family as a place to receive care or treatment;
- The staff survey showed an increase in the percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver;
- Staff have reported an increase in the level of motivation at work. Whilst the improved level of staff satisfaction is encouraging, the trust is very careful to also take note of feedback from colleagues who are less satisfied and where possible to address these concerns.

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

- Administering the National Staff Survey entirely online in 2015 in response to staff feedback;
- Publicizing the Staff Friends and Family Test results widely in each quarter (excluding Quarter 3 which corresponds with the National Staff Survey). This has continued to prove to be a popular medium for staff to feedback how they perceive the trust as an employer and provider of care. Close monitoring of feedback from these regular surveys highlight areas where not only improvements can be made but also to celebrate success;
- Using the Trust's intranet, known as [2]getherNet to provide a more accessible resource for staff. This is the main method of communication throughout the Trust and development continues with feedback from staff. Work is continuing to ensure easy access to information relating to support available for the health and wellbeing of staff and of a range of benefits available locally for colleagues;
- Increasing the visibility of senior managers including a regular programme of site visits by Executive and Non-Executive Directors.

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 2012	NHS Community Mental Health Survey 2013	NHS Community Mental Health Survey 2014	NHS Community Mental Health Survey 2015
[2]gether NHS Foundation Trust Score	8.4	8.7	8.2	7.9
National Average Score	Not available	Not available	Not available	Not available
Lowest Score	8.2	8.0	7.3	6.8
Highest Score	9.1	9.0	8.4	8.2

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

- The survey results for this set of questions are broadly similar to the previous three years when compared with the national scores. In fact, in relation to previous years, [2]gether's scores are nearer the higher scores nationally. There is still work to do to enhance service experience and some of the actions being taken are reflected in the points below.

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

- Ensuring that people are involved in the development and review of their plan of care including decisions about their medication
- Understanding people's individual interests and circumstances beyond health care.
- Signposting and supporting individuals to other agencies for social engagement
- Ensuring that service users are provided with information about who can be contacted out of office hours should they need support in a crisis.
- Providing information about getting support from people who have experience of similar mental health needs.

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

	1 April 2015 – 30 September 2015				1 October 2015 – 31 March 2016			
	Number	Rate*	Severe	Death	Number	Rate*	Severe	Death
[2]gether NHS Foundation Trust	1,464	39.61	1	6	1,371	39.01	1	5
National	144,850	-	492	992	146,325	-	501	1167
Lowest Trust	8	6.46	0	0	25	14.01	0	0
Highest Trust	6,723	83.72	74	95	5,572	85.06	51	91

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

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

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

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

- Re-auditing its Incident Reporting Systems (DATIX) to improve the processes in place for the timely review, approval of, and response to reported patient safety incidents.
- Appointing a Datix Systems Manager, upgrading the Trust's DATIX system and making the Incident Reporting Form more "user friendly";
- Setting up a DATIX User Group.

Community Survey 2016

This will be added following publication of the survey.

Staff Survey 2015

This will be added following publication of the results.

Annex 1: Statements from our partners on the Quality Report

These will be provided at year end.

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

This will 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
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 2gether NHS Foundation Trust.
ROMs	Routine Outcome Monitoring (ROMs)
SIRI	Serious Incident Requiring Investigation, previously known as a "Serious Untoward Incident". A serious incident is essentially an incident that occurred resulting in serious harm, avoidable death, abuse or serious damage to the reputation of the trust or NHS. In the context of the Quality Report, we use the standard definition of a Serious Incident given by the NPSA
SMI	Serious mental illness
VTE	Venous thromboembolism is a potentially fatal condition caused when a blood clot (thrombus) forms in a vein. In certain circumstances it is known as Deep Vein Thrombosis.

Annex 4: How to Contact Us

About this report

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

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

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

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

Other Comments, Concerns, Complaints and Compliments

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

You can give us feedback about our services by:

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

Alternative Formats

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

Recommendations for improvement

Appendix 2

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)	Update/Comments	Status
7 day follow up	It is recommended that the Trust follows Monitor Quality Account Guidance for 7 day follow ups. We identified 173 instances between April 2015 and February 2016 where a patient was discharged and followed up on the same day. Per Monitor Guidance the 7 day period should commence the day after discharge. Furthermore we identified that patients who were readmitted within 7 days of discharge were not excluded from the indicator, contrary to Monitor Guidance.	Our 7 day and 48 hour follow up policy will be amended to make it clear that follow up starts after midnight on the day of discharge. The policy will include clear examples. The change in policy and practice will be issued to staff through a practice notice. Responsible Officer: Alison Curson, Deputy Director of Nursing Timeline: June 2016 Process for updating Council of Governors: Mid-year review and report September/October 2016.	H	The *Procedure for Discharge from Inpatient Units including 48 hour Follow Up* has been reviewed to incorporate the recommendation, and following significant consultation approved in January 2017 A Practice Notice was issued in June 2016 to provide clarity regarding date of discharge being “Day Zero”	Complete
7 day follow up	It is recommended that the data and time of discharge is always supported by the progress notes. We identified five instances where the date and time of discharge was not substantiated by the progress notes. We also identified two instances where the date of	A practice notice will be issued to staff to remind them to record the date and time of discharges. A data quality report will be produced so that this area can be reviewed on an ongoing basis. Responsible Officer: Practice Notice – Alison Curson, Deputy Director of Nursing, Data Quality – Steve Moore, Head of Information	H	The *Procedure for Discharge from Inpatient Units including 48 hour Follow Up* has been reviewed to incorporate the recommendation, and following significant consultation approved in January 2017 Data Quality reports are produced monthly and	Complete

	discharge was only supported after reading multiple progress note entries.	Timeline: Practice Notice – June 2016, Data Quality Reporting – July 2016. Process for updating Council of Governors: Mid-year review and report September/October 2016.		accessed via SharePoint.	
7 day follow up	It is recommended that clinicians are reminded of the requirements for progress notes to be written with clarity and to validate notes. In our 7 day follow up additional testing of 55 patient records we identified 29 who were not clearly identified as a follow up. In 25 records the entry to the progress notes noted that the face to face or telephone contact was a follow up. One record did not support the new follow up appointment. We also identified two records with unvalidated notes.	A practice notice will be issued to staff to remind them about the need for clarity and validation of notes. We have an ongoing programme of audit/improvement around clarity and validation of notes/records and this issue will be included in the scope of that project. Responsible Officer: Practice notice – Alison Curson, Deputy Director of Nursing. Audit of notes – Matthew Edwards, Assistant Director of Quality, Assurance and Transformation. Timeline: Practice notice – June 2016. Audit reports – ongoing throughout the year in line with the audit plan. Process for updating Council of Governors: Mid-year review and report September/October 2016.	H	The *Procedure for Discharge from Inpatient Units including 48 hour Follow Up* has been reviewed to incorporate the recommendation, and following significant consultation approved in January 2017 The RiO Team issued guidance regarding validation of notes/records in June 2016	Complete

Crisis	It is recommended that clinicians are reminded of the criteria that should be followed when assessing patients being admitted through the Mental Health Crisis Resolution Team. We evidenced that, from a sample of 36 Crisis patients, four instances where the type of admission should have been "Admission via Mental Health Crisis Resolution Team". On review of their progress notes there was clear evidence that the Crisis Teams were involved before admission. However, they were coded as "Planned" / "Booked" or "General Medical Practitioner".	A practice notice will be issued to staff to remind them of the criteria for assessing patients being admitted via the Mental Health Crisis Resolution Team. A data quality report will be explored in order to understand if an ongoing overview of this measure can be provided to Team Managers and Clinicians. Responsible Officer: Practice notice – Colin Merker, Director of Service Delivery. Data Quality – Steve Moore, Head of Information. Timeline: Practice notice – June 2016. Data Quality reporting – July 2016. Process for updating Council of Governors: Mid-year review and report September/October 2016.	H	A Practice Notice was issued in January 2017 regarding Crisis Team "gatekeeping" admissions. Data Quality reports are produced monthly and accessed via SharePoint.	Complete
Inpatient Discharge Care Planning	It is recommended that sample testing for an audit is undertake at a consistent point after each quarter end and that audit questions are qualified by a time period. It is important that audit questions include a timeframe for compliance – for example the audit for Gloucestershire included the question "Have	The audit question "Have inpatient care plans been closed?" will be amended to read "Have inpatient care plans been closed within 7 days of discharge?". The Assessment Care Management Policy will be amended to reflect timeframes for compliance for closure of care plans. Audits will be planned into the audit plan so they occur at a	H	The *Assessment & Care Management Policy* has been reviewed to incorporate the recommendation. The Policy is currently in final review by the Director of Quality for sign off.	Awaiting approval.

	inpatient care plans been closed?". We identified 14 patients who had their care plans closed at the time of the Trust Audit. However, nine of those patients care plans were not closed in a timely manner. For example a patient discharged on the 10/7/15 had their inpatient care plans closed on the 9/10/15. Also, audits should occur at a consistent point after each quarter – we identified that audits for this indicator took place at varying times after each quarter – for example the Gloucester Q4 audit occurred in mid March.	consistent point after each quarter. Responsible Officer: Matthew Edwards, Assistant Director of Quality, Assurance and Transformation and Marie Crofts, Director of Quality and Nursing. Timeline: Before the commencement of the first quarterly audit 2016-17. 30th June 2016 quarterly on 2016-17 audit plan (with comparable timeframes for data collection for each quarter). Process for updating Council of Governors: Mid-year review and report September/October 2016.			
Inpatient Discharge Care Planning	It is recommended that where an audit involves an element of clinical judgment, a second clinician is involved to moderate the judgment to ensure consistency in the year. We identified the Hereford audit included the question "Has consideration been given to the West Midland Quality Review Service mental health quality standards on care planning (GN-103/GP-	Qualitative audits are undertaken by professionally registered clinicians. The process is overseen by an audit officer. The Trust can ensure that within the quality assurance and audit department the audits are moderated by an appropriate qualified clinician. This will not involve all audits being rechecked. Responsible Officer: Paul Ward, Modern Matron, Herefordshire Timeline: n/a	M	The audit undertaken within this years' Trust Clinical Audit Programme is a quantitative audit against a set or criteria extracted from the Trust policy on Discharge Care Planning (ACM). The audit is undertaken by a Clinical Audit Officer (non-qualified – as no clinical judgement is required) and the same auditor undertakes all four quarterly audits throughout the year.	Complete

	103/GN593)". On review of our Q1 sample the clinician admitted they had been strict in the interpretation of the standard and in some instances, having completed the entire audit, some records marked as breaching the standard would actually comply.	Process for updating Council of Governors: Mid-year review and report September/October 2016.			
Inpatient Discharge Care Planning	It is recommended that the Trust reviews its processes for maintaining the accuracy of data used in audits. We identified four instances where the Trust's audit data did not match the information held in RiO.	The Trust will review its current audit processes and look to amend if appropriate or necessary. Responsible Officer: Matthew Edwards, Assistant Director of Quality, Assurance and Transformation and Marie Crofts, Director of Quality and Nursing. Timeline: n/a Process for updating Council of Governors: Mid-year review and report September/October 2016.	M	The Trust's Clinical Audit & Quality Assurance Team has reviewed its audit process and multiple data quality tests are undertaken throughout the year. When any anomalies become apparent, wider audit samples are undertaken. Year to date – no anomalies have been found.	Complete

Agenda item 7 **Enclosure Paper C**

Report to: Council of Governors Meeting – 17 January 2017
Author: Anna Hilditch, Assistant Trust Secretary
Presented by: Neil Savage, Director of Organisational Development

SUBJECT: **Non-Executive Director Appointment Process**

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

EXECUTIVE SUMMARY

- The Nominations and Remuneration Committee has delegated authority from the Council of Governors to oversee the appointments process for Non-Executive Directors of the Trust, including the Trust Chair.
- The Council received a report at its November 2016 meeting regarding the appointment process for a new Non-Executive Director, which was required to bring the Board up to its full complement following Charlotte Hitchings' resignation.
- The Council noted that the Trust uses an agency - Gatenby Sanderson - to undertake searches and to screen potential candidates for Board appointments.
- Following the last NED recruitment exercise in May 2016, a number of potentially suitable candidates had come forward to enquire about additional NED vacancies, leading to a view from the Trust that a full national search campaign involving Gatenby Sanderson's may not be needed to produce a satisfactory field of candidates. It was felt that a locally focused recruitment process could be successful and also achieve a cost saving.
- The Council agreed that should the local recruitment campaign prove unsuccessful, a full national recruitment process would be undertaken in partnership with Gatenby Sanderson.
- Subsequent to this approval, the advert for the NED post went live in the local press in Gloucestershire, Herefordshire and Worcestershire and more widely online in November, with a closing date of Friday 9 December.
- By the closing date, 5 applications had been received and the long listing discussion took place on 14 December with Gatenby Sanderson and the Trust.
- The long listing recommendations concurred that there were only two applicants who fully met the role specification. The proposal was put forward to the governor members of the interview panel that the Trust put both candidates forward to interview without the need of the originally scheduled shortlisting meeting. Copies of these candidates' CVs and applications were shared at this point, with governor members being asked to confirm that they were happy with this approach.
- Despite initial agreement to this approach, subsequent discussions took place about the suitability of the candidates and it was agreed that a formal shortlisting meeting would be arranged.

- The shortlisting meeting took place on 4 January 2017 and was attended by all members of the interview panel - Rob Blagden, Mervyn Dawe, Jennifer Thomson (via phone), Ruth FitzJohn and Nikki Richardson. The meeting was also attended by the Director of OD and the Chief Executive.
- At this meeting, the Trust Chair provided a verbal update on the process that had been carried out thus far.
- Following a review of Gatenby Sanderson's longlisting recommendations, the Chair then asked the Governors individually for their views on the applicants' match to the role specification and whether or not they should be put forward to full interview stage. Following careful debate it was agreed that none of the applicants should be put forward to interview.
- Having concluded this it was agreed that the discussion groups and interviews scheduled for 6 January would be cancelled.
- It was then proposed that the following week's Nominations and Remuneration Committee receive a verbal update from the panel's Governors alongside a summary report of the process and be asked to support the recommendations made by the interview panel.
- Specifically, a recommendation would also be made suggesting that a governor short-life working group be set up, supported by the Director of OD, to review, develop options and make recommendations for the future provision of NED appointments to the full Council meeting in March 2017. This would look particularly at membership, process and support for the Nominations and Remuneration Committee and the governor interview panel.

- At the Nominations and Remuneration Committee meeting held on 10 January 2017, the Committee agreed to both:-
  - inform the Council that the current recruitment cycle had been completed without appointment, and,
  - recommend that the above short-life working group be convened.
- It was also agreed that Council would be apprised of the following specific learning points from the most recent local recruitment campaign:-

1. The specific skills requirement for Human Resources / Organisational Development expertise for the 7th NED appointment had not been discussed and agreed with Governors in advance of the advertising.
2. There was some avoidable ambiguity around the use and role of the Trust's contracted search agency Gatenby Sanderson for this recruitment campaign. Some governors had assumed that the use of a local recruitment campaign would mean that the agency wouldn't be used for any advertising or other elements of the process.
3. The meeting agreed that the long listing which had been managed by Gatenby Sanderson and reported back to the Trust, should have involved a representative from the governors' interview panel.
4. It was also agreed that the governors' interview panel should have had access to all applications, not just the long listing recommendations, prior to the discussion about shortlisting.
5. In hindsight, the governors on the interview panel felt they shouldn't have accepted the long listing recommendations. However, it was acknowledged that the governors and the Trust had worked quickly and appropriately to review and remedy this.

6. The meeting concluded that the current approach of an ad hoc Nominations and Remuneration Committee appeared to have led to a situation where the process did not feel as owned by the Council as it should be.
7. Finally, there was a discussion on respective roles in the NED appointment process. This discussion confirmed that the Nominations and Remuneration Committee leads and controls the appointment process on the behalf of the Council of Governors. In support of this the Trust provides administrative support and advice to both the Committee and the interview panel.

RECOMMENDATIONS

The Council is asked to:

- **NOTE** the summary of the process and lessons learned highlighted above
- **NOTE** that the current recruitment cycle has been completed without appointment
- **SUPPORT** the recommendation that a short-life working group is formed, with the support of the Director of Organisational Development, to review the process, develop options and make recommendations for the future provision of NED appointments. This group would report back to the full Council meeting in March 2017.

2GETHER NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS
NOMINATIONS AND REMUNERATION COMMITTEE
10 JANUARY 2017

Present	Ruth FitzJohn, Trust Chair Rob Blagden, Staff Governor – Management and Administration Mervyn Dawe, Public Governor – Stroud Vic Godding, Public Governor - Cheltenham
In Attendance	Anna Hilditch, Assistant Trust Secretary John McIlveen, Trust Secretary Neil Savage, Director of Organisational Development

1. WELCOME AND APOLOGIES

1.1 Apologies were received from Al Thomas and Amjad Uppal.

2. MINUTES OF PREVIOUS MEETING

2.1 The Committee received and approved the minutes from the previous meeting held on 24 May 2016.

3. NON EXECUTIVE DIRECTOR RECRUITMENT

3.1 The Committee received a report which set out the process that had been followed for the recruitment of a new Non-Executive Director, which was required to bring the Board up to its full complement following Charlotte Hitchings' resignation. This process had been outlined and approved by the Council of Governors at its November 2016 meeting.

3.2 Following the last NED recruitment exercise in May 2016, a number of highly eligible candidates had come forward to enquire about additional NED vacancies, leading to a view that the Trust might not need to utilise Gatenby Sanderson's full search process to produce a satisfactory field of candidates, but could instead use its local contacts and hold a local recruitment process which would achieve a cost saving. The Council agreed that should the local recruitment campaign prove unsuccessful, a full national recruitment process would be undertaken in partnership with Gatenby Sanderson.

3.3 Subsequent to this approval, the advert for the NED post went live in the local press and online in November, with a closing date of Friday 9 December. By the closing date, 5 applications had been received and the long listing discussion took place on 14 December with Gatenby Sanderson and the Trust. The long listing concurred that there were only two applicants who fully met the role specification. The proposal was put forward to the Governor members of the interview panel that the Trust put both candidates forward to interview without the need of the originally scheduled shortlisting meeting. Copies of these candidates' CVs and applications were shared at this point, with Governor members being asked to confirm that they were happy with this approach. Despite initial agreement to this approach, subsequent discussions took place about the suitability of the candidates and it was agreed that a formal shortlisting meeting would be arranged.

3.4 The shortlisting meeting took place on 4 January and was attended by all members of the interview panel - Rob Blagden, Mervyn Dawe, Jennifer Thomson (via phone) Ruth FitzJohn and Nikki Richardson,. The meeting was also attended by the Director of OD and the Chief Executive. At this meeting, the Trust Chair provided a verbal update on the process that had been carried out thus far.

3.5 Following a review of Gatenby Sanderson's longlisting recommendations, the Chair then asked the Governors individually for their views on the applicants' match to the role specification and whether or not they should be put forward to full interview stage. Following careful debate it was agreed that none of the applicants should be put forward to interview. Having concluded this it was agreed that the discussion groups and interviews scheduled for 6 January would be cancelled.

3.6 The Committee discussed the process and it was agreed that this had been broadly followed; however, a number of suggestions for how this could have been improved were put forward, as follows:

- The job description and personal specification were not shared in advance with Governors and there was no discussion about the specialist knowledge or skills required from this round of NED recruitment
- There was some ambiguity about the use of Gatenby Sanderson (GS), with Governors believing that the Trust would be leading the recruitment without the assistance of GS on this occasion. It was not felt that the extent of their involvement had been made clear enough.
- The longlisting discussion took place with GS and the Trust Chair and Chief Executive. The Committee felt that some Governor involvement should have been included as part of this process and that the Governors on the interview panel should have had access to all applications from the outset, not just the Gatenby Sanderson recommendations, to best inform both their views on the longlisting recommendations and decisions on the final shortlisting.
- When the applications and CVs of the shortlisted candidates were originally shared with members of the interview panel, these should have been reviewed in a timelier manner to assess whether the candidates were suitable to go forward for interview.
- There was a general consensus that holding a recruitment process over the Christmas period (November – January) quite often resulted in a limited number of applications for such positions

3.7 The Committee noted the process that had been followed and supported the decision of the interview panel in cancelling the planned interviews and stopping the current recruitment. The Committee also agreed to the proposed review of the recruitment process for NED appointments by a short life Governor working group supported by the Director of OD.

3.8 The Committee discussed the importance of the role of the Nominations and Remuneration Committee in leading and controlling the NED and Chair recruitment process, and it was agreed that the short life working group would be asked to include a review of the make-up and function of the Committee.

3.9 It was proposed that the outcome of this review would be presented back to the full Council meeting in March.

4. ANY OTHER BUSINESS

4.1 The Committee noted that the appraisal process for the Chair and Non-Executive Directors was due to commence at the beginning of March. A full review of the appraisal process was carried out in 2016 and the Committee agreed that the 2017 process should follow this previously approved form. One addition this year would be to invite all Governors to provide free-form comments on individual NEDs as part of their appraisals. A structured questionnaire for the Chair's appraisal would be sent out as in previous years.

5. DATE OF NEXT MEETING

5.1 The next meeting of the Committee would take place in early May to receive the outcome report from the Chair and NED appraisals.

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

Report to: Council of Governors – 17 January 2017
Author: John McIlveen Trust Secretary
Presented by: Rob Blagden, Lead Governor

SUBJECT: **Governors' Observation of Board Committees**

This Report is provided for:			
Decision	Endorsement	Assurance	Information

EXECUTIVE SUMMARY

In May 2016, the Council supported a proposal to trial Governor observation at Board Committees by way of supporting Governors in their statutory duty to hold the Non-Executive Directors to account for the performance of the Board.

Governor observation at the Audit Committee had been taking place for some time. This trial would cover four additional Committees - Delivery, Development, Governance and Mental Health Legislation Scrutiny. By observing these Committee proceedings, Governors would be able to take assurance that the Non-Executive Directors are effectively leading and controlling the Trust, and report that assurance back to the Council as part of the holding to account process.

A protocol was developed to provide a framework for Governors to observe the process by which the Non-Executive Directors on each Committee take assurance, and to ensure that the Governor's attendance does not in any way inhibit the candour and transparency which is part of the normal working of the Committee.

It was agreed that a review of the Observation trial would be carried out in January 2017 to see whether this was working effectively and whether those Governors participating in the trial had felt that this had been of benefit to them.

Due to timescales and conflicting appointments, no trial has yet commenced for the Mental Health Legislation Scrutiny Committee, and for the same reasons, only one meeting of the Development Committee has been observed.

RECOMMENDATIONS

Governors are asked to:

1. Decide whether the trial of Governor observation of Board Committees has been useful and should be continued; and if so,
2. Decide whether the current observation process should continue in its present form, or whether changes are required
3. Confirm the names of 2 Governor observers per Committee
4. Agree to review the Governor observation process at the January 2018 Council of Governors meeting.

Governor Observation Trial 2016

Attendance

Committee	Date	Governor Observation
Audit	13 April	Al Thomas
	25 May	Al Thomas
	3 August	Al Thomas
	2 November	Al Thomas
Governance	17 June	Vic Godding / Jo Smith
	15 July	Vic Godding / Jo Smith
	19 August	Vic Godding / Jo Smith
	16 Sept	Vic Godding / Jo Smith
	21 October	Vic Godding
	18 November	Vic Godding / Jo Smith
	16 December	Vic Godding / Jo Smith
Development	20 July	Jenny Bartlett
Delivery	24 August	Rob Blagden
	27 September	Rob Blagden
	26 October	Rob Blagden

APPENDIX 1

PROTOCOL FOR GOVERNOR OBSERVATION OF BOARD COMMITTEES

Purpose

A trial programme of Governor observation of key Board Committees has been designed to support the Governors in their statutory duty to hold the Non-Executive Directors to account for the performance of the Board. The trial will cover four Committees - Delivery, Development, Governance and Mental Health Legislation Scrutiny. Governors already attend the Audit Committee as observers.

By observing Committee proceedings, Governors will be able to take assurance that the Non-Executive Directors are effectively leading and controlling the Trust, and report that assurance back to the Council as part of the holding to account process.

In undertaking this duty, Governors must act in the best interests of the Trust, and adhere to the Trust's values and the Governors' code of conduct.

Key principles

1. The Council should nominate two Governor observers per Committee. One of these Governors will attend the relevant Committee meeting to observe proceedings. The two nominated Governors may therefore wish to alternate attendance at the Committee.

2. The focus for Governors must be limited solely to observing and reporting back to the Council of Governors on the NED-led assurance process. Governors should not seek to form a view of or report back on the content of the meeting or the specific issues being discussed, which are within the purview of the Committee and the Board rather than the Council of Governors.

3. Papers for each Committee meeting will be made available on the day, in order for Governors to be able to follow the meeting. However, Governors will not be members of the Committee and will not participate in the meeting.

4. Committees discuss confidential material, and Governors must maintain that confidentiality. Occasionally matters discussed include sensitive or person-identifiable information, and Governors may be asked to leave the room for the duration of such discussions, to maintain the person's confidentiality.

5. It is important that the candour and transparency which has been developed at Committees continues, and that staff attendees do not feel inhibited by the presence of a Governor. Should the Committee chair become aware that this may be the case, the Committee chair reserves the right to halt the observation process and ask the Governor to leave until any concerns raised by attendees have been resolved to the satisfaction of all parties.

6. The Governor observation trial will be reviewed at the January Council of Governors meeting annually.

APPENDIX 2

BOARD COMMITTEES OVERVIEW 2017

Delivery Committee – meets monthly usually on Wednesdays, at 9.00am

The Committee's purpose is to ensure a high quality patient service through the efficient, effective and economic delivery of service and infrastructure operations, in line with Trust plans and strategic objectives.

Specific duties include:

- oversight of the delivery of clinical services throughout the Trust, ensuring consistency with local and national standards, contractual requirements and appropriate professional advice
- holding to account those responsible for the financial and performance objectives of the Trust
- monitoring the Trust's reference costs
- monitoring implementation of the Trust's estates and information management strategies

Maria Bond chairs this Committee. The Committee meets in the Business Continuity Room at Rikenel

Next meetings: 25 January, 22 February, 24 March, 26 April*, 24 May, 28 June, 26 July, 30 August*, 22 Sept, 25 Oct, 24 Nov, 20 Dec*

Governance Committee – meets bi-monthly, usually on Fridays, at 11.00am

The Committee's purpose is to ensure that the Trust establishes monitors and maintains appropriate integrated systems, processes and reporting arrangements for the management of all aspects of clinical governance and risk.

Specific duties include:

- ensuring the development and monitoring of a clinical governance strategy and annual plan
- ensuring capture and analysis of all complaints, incidents and compliments, and ensuring that action is taken to prevent recurrence and embed learning
- oversight of information governance, ensuring compliance with legislation and national standards
- establishment and monitoring of the Trust's strategic risk management objectives and plans

Nikki Richardson chairs this Committee. The Committee meets in the Business Continuity Room at Rikenel

Next meetings: 17 February, 21 April, 16 June, 18 August, 20 Oct, 15 Dec

Development Committee – meets monthly, usually on Wednesdays, at 9.30am

The Committee oversees the preparation of business strategies and plans, scrutinises business cases, and seeks assurance about capital expenditure. It reviews the competitiveness of teams and services within the Trust, and has specific oversight of a number of key enabling strategies which support the Trust's strategic objectives.

Specific duties are to seek assurance:

- that suitable business development opportunities, both trust wide and at service level are identified, evaluated and pursued
- that the competitiveness of localities/services is reviewed, to include benchmarking, cost/price comparison, marketing strategy and customer initiatives
- that strategies are in place to cover all elements of the Trust's activities and scrutinise those strategies that fall within the Committee's remit
- that capital programmes are in place and regularly monitored

Jonathan Vickers chairs this Committee. It meets in the Board Room at Rikenel

Next meetings: 15 February, 15 March, 19 April*, 17 May, 21 June, 19 July, 16 Aug*, 20 Sept, 18 Oct, 15 Nov, 13 Dec*

Mental Health Legislation Scrutiny Committee – meets bi-monthly, usually on Wednesdays, at 9.30am

The Committee receives assurance that the Trust has appropriate systems, processes and reporting arrangements to comply with the Mental Health Act, Mental Capacity Act and Human Rights Act and associated codes of practice. It receives findings from Mental Health Act Commissioner visits, and oversees Mental Health Act Managers' recruitment, training and performance.

Specific duties include

- seeking assurance that all Trust staff acting on the Hospital Managers' behalf are competent to undertake their delegated tasks.
- seeking assurance about the arrangements to ensure that documents relating to detained patients are completed and reviewed
- seeking assurance about the procedures to inform detained patients and their nearest relatives about their rights under the Mental Health Act.

Quinton Quayle chairs this Committee. It meets in the Business Continuity Room at Rikenel

Next meetings: 8 March, 10 May, 12 July, 6 Sept, 8 Nov

Meetings marked with * are holding slots only and are likely not to take place unless urgent business needs to be discussed.

Agenda item 9 **Enclosure Paper E**

Report to: Council of Governors – 17 January 2017
Author: Nikki Taylor, Contracts Manager
Presented by: Nikki Taylor, Contracts Manager

SUBJECT: **Service Planning 2017-18 – Draft Plan**

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

EXECUTIVE SUMMARY

- Service Planning – update, developments and feedback on progress
- Paper is being presented to Governors requesting feedback
- Countywide and Gloucestershire locality Service Plan now combined as agreed in 2016
- Appendix A – Objectives for each Corporate Directorate
- Appendix B – Objectives for each Service Directorate

RECOMMENDATIONS

Governors are asked to comment on the service objectives.

Corporate Considerations	
Quality implications	None
Resource implications:	None
Equalities implications:	None
Risk implications:	Financial and Reputational

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

Reviewed by:		
Director of Finance & Commerce	Date	11 January 2017

Where in the Trust has this been discussed before?		
Performance is discussed at monthly Delivery Committee	Date	

What consultation has there been?		
None	Date	N/A

Explanation of acronyms used:	APR – Annual Planning Review E – Engagement FCT – Financial Control Total NHSI – NHS Improvement Q – Quality S – Sustainability STP – Sustainability and Transformation Plans

1. Context

1.1 Every year the trust develops service plans for the forthcoming financial year (April – March.) The service plans contain objectives to provide continuous quality of care to service users, carers, staff and volunteers within financial constraints. These service plans are an integral part of the Trusts Strategy and Operational plans.

1.2 This paper details the service planning process and timescales for 2017/18 and provides an update on completed and planned activities.

1.3 It was agreed last year that Countywide and Gloucestershire localities combine their Service Plan in response to their joined committee structures, and anticipated management restructure.

2. Service Planning Process and Update

2.1 In order to produce the planning submissions required by NHSI the trust undertakes both a service planning and budget setting process. The process runs between October and March, leading to final presentation and sign-off at Trust Board in March.

2.2 Revisions have been agreed last year to the service planning template to include:

- Less objectives (minimum 3 - maximum 5)
- Objectives to be SMART (Specific, Measurable, Achievable, Realistic and Time bound)
- A single service plan for corporate services - each support service providing one objective

2.3 Details of the services objectives are included in Appendix A. Final Plans to be submitted to Development Committee on 15 March 2017.

2.4 This report outlines the process, the Directorate and Corporate objectives detailing, measurement, timeline, benefit, dependencies and their alignment with the Trusts Strategic objectives. Any feedback on the report is requested by 30 January 2017.

3. Progress

3.1 Draft locality service planning reports have been discussed and presented at CSM meetings, locality boards and locality forums.

3.2 Service objectives have been extracted from the full service planning document and are detailed below for final consideration.

4. Engagement

4.1 Feedback and views on the trust objectives and service plans have been, and are being sought through:

- Staff engagement in Localities
- Locality boards
- Development Committee
- Council of Governors

5. Analysis of Objectives (to be updated)

6. Timetable

The timetable for completion of the process is:

Date	Action
18 November 2016	Service Planning Process Starts
9 December 2016	Draft Service Plans returned to Business Development
31 December 2016	Draft Budgets Agreed
17 January 2017	Governor Review
18 January 2017	Development Committee Review
30 January 2017	Feedback to Directorates
20 February 2017	Final Service Plans returned to Business Development
6 March 2017	Executive Review
15 March 2017	Development Committee Review
30 March 2017	Trust Board Sign Off

Draft Service Plans 2016/17

Objective	Measurement	Timeline	Benefit	Assumptions / Dependencies	Risk/Mitigation (Impact should the objective not be achieved)	Q, E, S
Organisational Development						
1.Maximising Our Recruitment & Retention						
(a) During 2017/2018 the recently centralised recruitment process will be sustainably embedded across the Trust.	Continue to achieve all employment checks being completed within 6 weeks (from 12 weeks previously).	Ongoing	Staff will take up post more quickly, reducing bank/agency use and costs, improving service continuity and care quality.	Dependant on existing recruitment team, with no additional workforce to support the increased number of vacancies being processed.	Risk - 6 week standard is missed due to sickness or significantly increased workload. Impact -cost and quality. Mitigate - planning & temporary staff.	Q, E, S
(b) Targeted focus on key recruitment areas: • Herefordshire • IAPT • MHARS • Perinatal Services	Supported & well-managed recruitment that achieves the requisite establishment for new services and hard to recruit areas.	Q4 by 31 March 2018	The Trust will be able to further reduce agency spend and deliver new services.	The Trust is able to attract and retain the required number of staff.	Risk - unable to recruit & staff services due to approach & labour market. Impact - quality, contract, income & costs. Mitigate - planning, creative approaches & bank.	Q, E, S
(c)NHS Jobs Tracker will be rolled out to all managers.	Managers will be able to immediately view their own recruitment data, streamlining the process for the Workforce team, and enabling production of performance reports.	Q1 from April 2017	Accurate, timely reporting and management of data and vacancy timelines and progress. Easy to access recruitment tracker with all information in one portal.	Dependent on management training and support via HR.	Risk – roll out delay due to sickness or lack of buy in. Impact – failure to improve recruitment data & scrutiny. Mitigate – planned training & on-going support.	Q, E, S

(d) Deliver an e-DBS passport within Gloucestershire NHS organisations.	As part of the STP work agree criteria for DBS checks and a related passport across Gloucestershire services.	Q4 by 31 March 2018.	Support joined up recruitment processes and potentially reduces cost to organisations across Gloucestershire.	Agreement can be reached with external organisations which use different DBS systems and have different levels of DBS checks for their staff.	Risk – failure to get countywide agreement. Impact – cost & delay. Mitigate – STP HR / OD processes.	Q, E, S
(f) Continued attendance at Local and National Recruitment Events promoting Hereford and Gloucester as a place to work and live.	To increase awareness of the posts that the Trust offers, and benefits of working for the Trust.	Ongoing throughout 2017/2018.	Raises the profile of the Trust and awareness of the good work that the Trust achieves.	Dependant of recruitment team and managers to support the events.	Risk – marketing and venues. Impact – low or no ROI. Mitigate – combined countywide labour market knowledge, experience & planning.	Q, E, S
(g) Support recruitment to the Associate Practitioner and Student Practitioner roles.	Increase in workforce & ability to resource from internal sources more effectively.	Ongoing throughout 2017/2018.	Support new roles and new ways of working.	Additional increase in recruitment will have an impact of the recruitment team with current establishment.	Risk – local management/staff bank failure to allocate practitioner shifts. Impact – poor student recruitment, ROI & unfilled bank shifts. Mitigate – current work stream to resolve this.	Q, E, S
(h) Agree a process to retain staff after retirement.	Increase in workforce & ability to resource from internal sources more effectively.	Q4 by 31 March 2018.	Increase in workforce and retention of knowledge and skills.	Being able to be supportive and flexible to ensure work life balance, and consideration regarding new roles, e.g. mentors.	Risk- failure to agree process. Impact – inability to increase retention & bank fill. Mitigate – planned discussions / agreement with staff side & managers.	Q, E, S
2. Ensuring We Have Great Training & Leadership Development						
(a) Ensure the Trust is maximising the effectiveness of the Learn 2gether Training System to support staff training & development.	Average training times (via E-Learning) are reduced by 10%.	Ongoing throughout 2017/2018.	Average training times (via E-Learning) are reduced by 10%.	Effective communications and provision of on-going training and support for users and managers.	Risk – failure to embed use by managers & staff. Impact – low use & compliance. Mitigate – management	Q, E,

					training, briefing & communications.	S
(b) Use the Apprenticeship Levy to help support identified training and development needs within the Trust.	All of the Trusts training levy is fully utilised.	Ongoing throughout 2017/2018 & 2018/19. The levy comes into effect in April 2017. The first levy 'pot' needs to be used within 24 months.	The Apprenticeship levy will be utilised to provide effective training and development opportunities, in line with Trust objectives, and to prevent the need for additional expenditure from other sources.	Training expenditure and provision will need to be reviewed and changed as required to ensure the levy is more effectively utilised. This may require changes to current recruitment processes and may need/offer the opportunity to develop new roles.	Risk – failure to appoint & train adequate apprenticeships. Impact – cost/loss of levy income, reputation. Mitigate – Planned Management & Exec comms, Workforce redesign.	Q, E, S
(c) Revise the Trust's current management development processes to deliver the outcomes specified in the new regulator's (NHSI) Leadership Framework.	A new programme will be developed and agreed, with a set of outcomes designed to deliver the Leadership Framework, including the stages currently in development.	Initial plans will be in place to enable phased implementation from April 2017.	Revising current programmes in line with the Leadership Framework will help equip our leaders with the skills needed to develop high quality local health and care systems and to use improvement methods to redefine service delivery plans in line with the STP.	Revise the Trust's current management development processes to deliver the outcomes specified in the new Leadership Framework.	Risk – currently unknown delivery costs, inability to redesign existing programmes around framework. Impact – failure to deliver high quality leadership framework / regulator requirement. Mitigate – business planning, use of countywide STP, HESW & NHS Leadership Academy	Q, E, S
(d) Review the Trust's Training Needs Analysis (TNA) for Statutory and Mandatory training to ensure best use of resources and fit to requirements.	A new, revised and collectively agreed TNA will be developed and which will be used to add training to individual staff profiles.	The TNA will be agreed by December 2017 and in place and operational by March 2018.	A new TNA will continue to provide Trust assurance of staff competency but will also ensure that statutory and mandatory training is delivered in the most efficient way possible and that it effectively supports the needs of Trust staff and services.	There will need to be an effective forum for reviewing training requirements and it is likely there may be some disruption to training provision (and possibly compliance rates) whilst training processes/requirements are changed.	Risk – failure to agree process, changes to training requirements. Impact – poor ROI & use of related resources. Mitigate – short life working group, use of Subject Matter experts & Exec sponsorship.	Q, E, S

Quality (including Nursing, Social and Allied Health Professionals						
1. To be compliant with the recommendations in NICE Guideline PH48, Smoking: acute, maternity and mental health services) to ensure that 2gether trust premises (including grounds and vehicles) are smoke-free by no later than 31 December 2018.	All service users who come into the 2gether inpatient units in Gloucestershire and Hereford will be offered Nicotine Replacement Therapy within 30 minutes of admission and supported during admission should they wish to quit smoking.	All 2gether inpatient sites to be smoke free commencing April 2017.	Smoke free environment in Trust buildings and grounds, resulting in harm reduction and better quality of life for service users an increase life expectancy.	All clinical in-patient staff to receive Smoking Cessation Awareness training by 3rd April 2017 All registered nurses within in-patient units to receive Nicotine Replacement Therapy training by 3rd April 2017. Each ward will have at least one person trained as a Level 2 quit advisor (Gloucestershire) All patients admitted will have their smoking status recorded and the level of intervention.	Training not taken up. Nicotine Replacement Therapy too expensive for the trust to prescribe. Staff do not support the smoke free agenda.	Q
2. Ensure all serious incident investigations are investigated in a caring and compassionate way through building on and improving family/carer engagement and active involvement. That families are supported to engage with the process, have their questions/concerns heard and that they receive open, honest and transparent feedback on conclusion of an investigation in an empathetic manner.	All families and carers will be contacted and involved within the investigation process unless they decline to be involved- using 'Hundred Families' experience as a benchmark for a measure of quality.	All serious incident investigations will comply by end of first Quarter 2017. This standard will be maintained throughout the year.	Improved learning, candour and accountability in line with the CQC "Review of the way NHS Trusts review and investigate the deaths of patients in England." (December 2016) Families will feel the organisation has listened to and heard their story and used this to learn and improve practice	Band 7 Serious Incident Investigator posts will be created and recruited to (1 WTE x 12 month secondment, augmented by several staff recruited to same role via Staff Bank for use as required) Working closely with 'Hundred Families' organisation to improve empathetic and appropriate engagement and involvement of families within each investigation	Failure to actively involve families/carers will constitute a regulatory breach. Failure to involve families appropriately may result in failure to learn appropriately from serious incidents and not improve practice	Q

Engagement and Integration						
Triangle of Care Implementation of year 2/3 Triangle of Care standard programme in Community Services in Gloucestershire and Herefordshire including:	Information and communication strategy Self-assessment 1 and subsequent implementation of action plan in year 2 Locality working with carers and carers organisations to ensure their input into process – monthly meetings Carer survey 1 Carer Survey 2 Carer Aware Training rollout to community staff throughout the year	 End April 2017 End March 2017 June 2017 November 2017 End April 2017	Improved service experience for both patients and carers. Improved patient safety through better carer involvement. Improved relationship with carer organisations.			QES
Membership Form a new Membership Advisory Group	**Quarter 1** First group meeting and setting of aims and objectives **Quarter 2** Second group meeting and development of membership recruitment programme **Quarter 3** Third group meeting and relaunch of Membership Newsletter **Quarter 4** Fourth group meeting and review of year	**Quarter 1** First group meeting with agreement on what the aims and objectives are (i.e. increase membership, extend reach, review membership materials, review newsletter) **Quarter 2** Second group meeting and development of membership recruitment programme (i.e. programme of events, membership packs) **Quarter 3** Third group meeting and launch of 'new look' membership newsletter **Quarter 4** Fourth group meeting, review of year and progress to date	As a Foundation Trust we are held accountable by our Members. Our Members elect our Board of Governors and have a say in how our services are delivered. They are a vital link between us and the communities we serve. Our members do not engage with our work as much as we would like them to. We need to encourage further involvement, and in particular recruit new members from hard to reach groups.	**Dependencies:** • Members • Governors		QES

Estates and Facilities						
Delivery of Gloucester Hub at Pullman Place	Absolute relating to benefit	Complete & Operational end Q3 2017	**From Full Business Case** • Estate Strategy KPI 2.2 Functional Suitability • Estate Strategy KPI 5.2 Roll out of IT solution to reduce daily reliance on team bases • Estate Strategy KPI 5.3 • Net reduction in the gross area of team bases • Estate Strategy KPI 6.2 • Reduce carbon footprint by 34% by 2020 based on 2008 footprint • Access – city centre for public transport • Parking for carers – accessibility • Parking for Staff • Estate Strategy KPI 5.1 Operational efficiency • Estate Strategy KPI 5.1 Team functional relationship • Timeliness – risk prolongation	Business case remains valid	Business as normal	Q S
Delivery of in-house catering and cleaning service	Absolute relating to benefit	Complete & Operational end Q3 2017	**From Full Business Case** • Direct control over cleaning quality • Flexibility in the management of catering for the needs of patients • Ability to introduce ATP swabbing • Catering and Cleaning managers and staff accountable to the Trust • Ability to introduce zero cost changes without a financial consequence • Ability to change Catering meals supplier to improve	Business case remains valid	Continued poor performance	Q ES

			quality • Improved assurance on Food Hygiene, Breakaway and Statutory and Mandatory Training • Reduced management time trying to ineffectively affect change • Ability to meet the National Standards of Cleanliness • Catering • Cleaning staff will become integrated with the ward team			
Information Technology						
Complete ICTT Device Rollout	All community clinicians in Herefordshire and Gloucestershire have mobile working laptops	By end June 2017 at the latest. This includes mop up post completion of main rollout.	Flexible working and service development to improve quality and sustainability of services.	Teams adopt new ways of working to embrace opportunities offered by new technology.		QS
Plan rollout of devices to in patient ward locations	Test market and work with clinicians to agree best ward based mobile device. Procure and rollout.	Select device by June 2017, rollout in remainder of FY 17/18.	Increased mobile access to information.	Wards want mobile tablet style devices and will benefit from them.		QES
Roll out new network connectivity in Gloucestershire	Support CITS project to roll out replacement network connections and switches to Gloucestershire sites.	Rollout during FY 17/18	More reliable network on modern supported hardware.	CITS will manage and deliver on time and on budget		QES
Develop joint working with CITS	Team attend GRH team brief each month. Joint project meetings weekly. New accommodation.	During whole of FY 17/18 with review in September 2017.	Progress towards single shared IT dept. Service offering improved for colleagues.	CITS staff engage in the process and see benefit in a single service.		QES
Upgrade VoIP controller software and investigate future options	Update firmware and support contracts in place. Future solutions considered and costed.	Q1 FY 17/18	Reliable supportable platform.	Upgrade is affordable and supplier available to schedule work out of hours.	Risk to support of essential platform.	QS
Review Office 365 collaboration tools	Further testing and rollout to key teams.	Q1 testing, Q2 clinician testing, Q3 rollout plan.	Modern unified collaboration solution.	Trust will manage revenue funding to support paper free. Comms support for rollout		QS

Improve video conferencing availability and range of use cases	New cameras tested and rolled out to more meeting rooms across Gloucestershire and Herefordshire.	Q1 new hardware tested, Q2 rollout and comms	Reduced travel, faster access to knowledge pool, patient consultations.			QES
Plan future Microsoft licensing arrangements.	Provide formal options paper with costs.	Q1 compile costs, Q2 compile paper and present to Partnership Board.	Supportable future computer network.	Finances transition from capital to revenue for licensing moving forwards.	Without revenue funding of circa £200k software will be unsupportable putting access to clinical systems at risk.	QS
Programme Management Office – STP Transformation						
To support the Trust in the delivery of change and Transformation	Percentage of projects facilitated by the PMO delivered on time	Full year	Transformation and change will be delivered in a structured manner providing a process audit trail and governance	All projects are aligned with the Trust's objectives	Failure to deliver Trust objectives	Q
A review of the role of the PMO and its contribution to the delivery of change and transformation and the production of an action plan for delivery.	Completion of the review Delivery of 17/18 elements of the action plan.	Q1 Q4	Ensure that the role of the PMO is compatible with the direction of travel of the Trust	Project management is an integral part of the delivery of change and transformation	Inefficient delivery of change and transformation	S
Finance						
To Follow						
Information Team						
To Follow						

Service Objective	Benefit	Risk/Mitigation	Risk Rating	QES
CYPS and CAMHS				
1 Participation in Herefordshire Develop participation in Hereford CAMHS with the dedicated CLD Participation Worker to include group engagement and feedback opportunities and completion of the First 15 steps survey	This will enable feedback and engagement with CYP and their families/carers who use the service, to make improvements to service delivery and development services are developed. Feedback will contribute to an Action Plan for improvements	Due to the limited time available from the Participation Worker (2 days per month) this may not result in high levels of engagement and participation.	6	QE
2 Participation in Gloucestershire Develop an Action Plan for 2017/18 from the Takeover challenge events in 2016/17 and identify key priorities. Improve information available to CYP about participation.	Listening to service user feedback and acting to improve services is a key priority for the trust		9	QES
Conduct a baseline survey of numbers of CYP attending Participation activities and establish plans to increase engagement	Opening the access to participation will benefit more patients using the service and allow for greater feedback and support to transform services. It will also help build confidence in recovery	CYP may not want to participate in the activities and events offered	9	QES
3. Website Development Develop and launch a new joint website for CYP and their families/carers for Gloucestershire CYPS and Hereford CAMHS to include self-help information as well as information about services and support	More information about our core services will benefit patients and their families and provide greater transparency. Self-help information will build capacity and resilience and support recovery	New website will need to reflect t differences in service commissioning in Glos & H'fd. It will be important to make it accessible for CYP using the service incl. those with LD	8	QE
4. Routine Outcome Monitoring (ROMs) Improve compliance with the collection, inputting and use of ROMs in clinical practice by meeting targets agreed with commissioners in the DQUIP (Data Quality Improvement Plan) 90% Choice Appointments with a Current View (CV); 60% Choice Appointments with an RCAD or SDQ; 25% of Partnership Appointments with a paired outcome measure rising to 30% by Q3	This will meet new targets set by local commissioners for information about outcomes and compliance with the national CAMHS Minimum Dataset. It will support greater clinical use of ROMs in Risk Assessments as outlined in a recent SIRI Action Plan	ROMs are collected on paper (except the CV) and inputted onto RiO causing a paper trail and a delay in being accessible to clinicians. Cultural change is still required to enable staff to use ROMs effectively	12	QES
5. **Personalised Care Plans** Utilise the learning from the CAMHS CQUIN to develop an Action Plan for the use of personalised care plans for C&YP across CYPS and CAMHS	CYP will have personalised Care Plans to support their treatment goals and strategies. This will support better engagement, outcomes and transparency in what is delivered by the service	Personalised Care Plans may not readily fit with RiO. Will require clinical engagement to ensure CYP understand/ engage with the process	9	QE
6. Learning Disability Service Herefordshire Develop school based clinics in the special schools in Herefordshire by consulting with schools about needs and practicalities, identifying key school professionals to exchange information and support developments, delivering clinics and reviewing progress in January 2018	School based clinics are potentially more efficient and effective and produce better outcomes in terms of communicating with school professionals, ensuring CYP are not out of school, attendance at relevant multi agency meetings and building holistic plans for the CYP	This will alter the way LD services have been delivered in Hereford but this may prove to add value to LD support and interventions	6	QES
Devise and deliver Parenting Programmes with support from Gloucestershire LD	Use the Gloucester model to deliver enhanced support to parents and carers	Capacity to organise and deliver with small number of staff	4	QES

Service Objective	Benefit	Risk/Mitigation	Risk Rating	QES
6. **Learning Disability Service Gloucestershire** Introduce the transition 'ready steady go' programme with all young people with a learning disability and support the implementation of the hello documentation for adult CLDT services, All documents will be produced in easy read versions	Improving the transition to adult services and improving communication and understanding for service users and their families/carers will support more sustainable transitions and better outcomes	Capacity to develop and deliver the resources	6	Q E S
To develop and implement easy read care plans for children and young people with a learning disability	Care Plans are key in understanding treatment goals and engaging with CYP in these. Easy Read versions will support better understanding, engagement and outcomes	Capacity to develop and deliver the resources and support the roll out for patients	6	Q E S
Staff Appraisals – 95% of staff will have an appraisal by end of September 2017, 100% by end of March 2018 Figures provided separately as the two services have different commissioners and reporting requirements	Benefits: promotes and improves staff engagement as well as establishes a sense of personal ownership and contribution to overall service planning and delivery	CYPS and CAMHS are not able to maintain Trust compliance targets for appraisals across all CYPS and CAMHS teams	6	Q E S
100% staff will receive statutory/mandatory training by end of March 2018 Figures provided separately as the two services have different commissioners and reporting requirements	Benefits: competent workforce to deliver high quality, safe and effective clinical services	CYPS & CAMHS is not able to maintain Trust compliance targets for mandatory and statutory training across all CYPS and CAMHS teams	8	Q E S
4% sickness levels will be achieved throughout the year. Figures provided separately as the two services have different commissioners and reporting requirements	Benefits: maintaining necessary staffing levels to deliver high quality, safe and effective clinical services and reduce need to employ agency or bank staff	CYPS and CAMHS is not able to maintain Trust compliance targets regarding sickness levels	6	S
Countywide and Gloucestershire Localities				
One Gloucestershire: the STP Plan for the County: • Engaging with in new approaches which deliver health and care services around the needs of local populations	2G will build relationships with provider organisations to improve health outcomes for people with mental health concerns and the wider population	Engagement across each locality requires a time commitment from clinical and management teams. CSMs will provide a coordination role to ensure engagement / facilitate staff to attend key GP Cluster forums		Q E S
Specialist Perinatal Community Mental Health Team development (in conjunction with support from Project Management Office) to support 88 women in 17/18	Providing a Specialist Perinatal Community Mental Health Team will ensure a more accessible, timely and equitable service for women and their families in Gloucestershire	**Risk**: challenge to existing estate footprint **Mitigation**: interim Team base identified and Team scoped into Pullman Place development **Risk**: delay in recruitment **Mitigation**: key operational staff identified for potential secondments		Q E S
Staff Appraisals – 95% of staff will have an appraisal by end of September. 100% by March 2018	Staff engagement, opportunity to discuss and set objectives and plan service/personal development			Q E S
100% staff will receive statutory/mandatory training by end of March	Trained workforce, continuity of quality, safe	The implementation of the Learn 2gether		Q

Service Objective	Benefit	Risk/Mitigation	Risk Rating	QES
2018	services	system (a phased plan to March 2017 to improve compliance and accuracy of reporting)		ES
4% sickness levels will be achieved throughout the year	Continuity of Service, quality of service maintained, reduction in number of bank staff			S
Herefordshire				
Crisis Team – to reduce the number out of county in-patient admissions	Quality of care maintained, staff and families can stay engaged with client. Reduced costs of admissions			QS
Community Teams: to develop closer working with GPs & health community teams	Service user benefits from closer clinical working, with some potential for efficiency savings for the health economy	Implementation is delayed and momentum not maintained.		QES
Proactive employment to reduce vacancies and use of bank and agency staff	Continuity of Service, quality of service maintained, reduced expenditure on bank and agency staff	Not being able to appoint to posts.		QES
Staff Appraisals – 95% of staff will have an appraisal by end of September. 100% by March 2018	Staff engagement, opportunity to discuss and set objectives and plan service/personal development			QES
100% staff will receive statutory/mandatory training by end of March 2018	Trained workforce, continuity of quality, safe services			QES
4% sickness levels will be achieved throughout the year	Continuity of Service, quality of service maintained, reduction in number of bank staff			S

Agenda item 12 **Enclosure No** **Paper F**

Report to:	Council of Governors Meeting - 17 January 2017
Author:	Kate Nelmes, Communications Manager
Presented by:	Jane Melton, Director of Engagement and Integration
SUBJECT:	**Membership Report including Data Update**

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

EXECUTIVE SUMMARY

This report provides a brief membership report to inform the Council of Governors about:

* The membership activity and development plan
* Information for members
* Governor Engagement Events
* Information about membership (year to date)

RECOMMENDATIONS

That the Council of Governors notes the content of this report

Corporate Considerations	
Quality Implications:	An active and representative group of members will assist the organisation to understand the experience of its service and contribute to the goal of inclusion and engagement.
Resource implications:	Membership activity requires continued resource to realise the benefits of a strong membership engagement and contribution.
Equalities implications:	Understanding the diversity of membership will assist to enable recruitment and retention of members to best effect.
Risk implications:	There are risks of marginalising certain groups within the local community if attention is not paid to membership demographics. Without Governor engagement in the Membership Development Planning sessions there is a risk that opportunities to develop membership will be missed.

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

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

Reviewed by:		
Jane Melton	Date	9 Jan 2017

Where in the Trust has this been discussed before?		
	Date	
What consultation has there been?		
	Date	

Explanation of acronyms used:	N/A

1. Membership Activity and Development Plan

1.1 Our new membership campaign strategy was presented to the Council of Governors in September 2016, and is now being enacted. Progress to date includes the recruitment of our new Membership Volunteer, meetings with representatives of the Black and Minority Ethnic Community to discuss encouraging membership, and consultation with young people about what would encourage them to become Trust members. We have also purchased new materials to enhance our membership stands, including a gazebo for outdoor events. We are now using iPads to recruit members electronically and are exploring options for introducing a new membership database, which will enable us to use new engagement methods.

1.2 We recently collated membership packs for Governors, and it is hoped that these will prove useful. If there are any other initiatives that would help Governors with membership activity, please let the Communications Manager know.

1.3 A recent review of our membership database has highlighted a large number of ‘undeliverable’ newsletters, sent either by post or via email. We estimate that cleansing the database of these members (many of whom have moved without leaving a forwarding address) could lead to a loss of 100 members approximately.

2. Information for Members

2.1 The latest edition of our membership newsletter, Up2Date, was printed and issued in December. It was a 'festive special', which included a calendar/wall planner. The next edition will be published in March.

2.2 We sent all Trust members who receive our updates via email a festive message, linking to a festive wellbeing film on our YouTube channel.

3. Governor Engagement Events

3.1 Plans are being made for the next Governor engagement event, being held at Gloucestershire College's Cheltenham campus at 5.30pm on Time to Talk Day – 2 February. We are hoping to organise an event at Stroud College soon after.

4. Information about Membership

Information about the membership of ^{2}gether NHS Foundation Trust is provided in Tables 1, 2 and 3 below. The key to the colour coding in the tables is as follows:

- More than 5% increase in members recruited
- Public membership numbers remain approximately the same (within 5%)
- More than 5% reduction in membership numbers

4.1 The headline message is that, as of 31 December 2016 we have 145 more public members than we had at the end of 2015/16.

Table 1: Public, Staff and total Membership Data as at 31 December 2016

Membership Type	End of 2015/16	31 Dec 2016	Direction compared to final 2015/16 figures	Change in membership numbers
Public Membership	5155	5300	↑	+ 145 (2.8%)
Staff Membership*	2318	2437	↑	+ 119 (5%)
Total Membership	7473	7737	↑	+ 264 (3.5%)

Table 2: Characteristics of Public Members by disability and gender at end December 2016

Membership characteristic	End of 2015/16	31 Dec 2016	Direction compared to final 2014 /15 figures	Change in membership numbers
Disability (public membership only)	709	705	↓	-4 (0.6%)
Men (public membership only)	1828	1849	↑	+ 21 (1%)
Women (public membership only)	3327	3451	↑	+ 124 (3.7%)

*this includes colleagues with all types of employment contract

Table 3: Public Membership within each constituency

Constituency	End of 2015/16	31 Dec 2016	Direction compared to final 2015 /16 figures	Change in membership numbers
Cheltenham	818	879	↑	+61 (7.5%)
Cotswolds	377	376	↓	-1 (0.3%)
Forest of Dean	531	546	↑	+15 (3%)
Gloucester	1385	1397	↑	+12 (1%)
Stroud	786	811	↑	+25 (3.2%)
Tewkesbury	606	593	↓	-13 (2%)
Herefordshire	315	347	↑	+32 (10%)
Greater England	337	351	↑	+14 (4.1%)
TOTAL public membership to date this year			↑	145 (2.8%)