with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Trust Board
The Friendship Café, Gloucester
28 November 2019 at 10:00 am – 1:00 pm
AGENDA

Agenda item	Title	Purpose	Paper attached	Presenter
Opening Business				
1.	**Apologies for Absence and Confirmation the Meeting is Quorate**	To note	Verbal	Chair
2.	**Declarations of Interest**	To note	Verbal	Chair
3.	**Service User Story** Experience with Gloucestershire Recovery Team	To note	Discussion	Director of Nursing, Therapies & Quality
4.	**Minutes of the previous 2g & GCS Board Meetings 26th September 2019**	For Approval	Paper A1 Paper A2	Chair
5.	**Matters Arising and Action List**	To note	Paper	Chair
6.	**Chair's Report**	To note	Paper	Chair
7.	**Chief Executive's Report**	To note	Paper	Chief Executive
8.	**Questions from the Public**	To note	Paper	Chair
Performance and Patient Experience				
9.	**Service Experience Quarterly Report**	To note	Paper	Director of Nursing, Therapies & Quality
10.	**Quality Report** - **April – September Previous GCS** - **Quarter 2 previous 2g**	To note	Paper	Director of Nursing, Therapies & Quality
11.	**Audit of Complaints**	To note	Paper	Maria Bond, NED
12.	**Performance Report**	To note	Paper	Director of Finance
13.	**Finance Report**	To note	Paper	Director of Finance
14.	**Board Assurance Framework - To receive initial BAF currently under development**	To note	Paper	Interim Trust Secretary
15.	**Learning Lessons to Improve People Practices**	To note	Paper	Director of Human Resources and Organisational Development
Items for Decision				
16.	**Terms of Reference - Resources Committee**	For Approval	Paper	Chair
17.	**Terms of Reference - Audit & Assurance Committee**	For Approval	Paper	Chair
18.	**Terms of Reference - Quality Committee**	For Approval	Paper	Chair

Agenda item	Title	Purpose	Paper attached	Presenter
19.	**Gloucestershire Care Services NHS Trust Charities - Trustees' Report and Financial Statement for year ended 31 March 2019**	To receive & approve	Paper	Chair
20.	**Standing orders for the practice and procedure of the board of directors**	For Approval	Paper	Interim Trust Secretary
Items for noting				
21.	**Council of Governors Minutes 18TH June 2019**	To note	Paper	Chair
22.	**2g Mental Health Legislation Scrutiny Committee - September**	To note	Paper	Committee Chair
23.	**Mental Health Legislation Scrutiny Committee - November**	To note	Verbal	Committee Chair
24.	**Quality Committee Summary - October & November**	To note	Paper	Committee Chair
25.	**Audit and Assurance Committee Summary - November**	To note	Paper	Committee Chair
26.	**Resources Committee Summary - October**	To note	Paper	Committee Chair
Closing business				
27.	**Any other Business**	To note	Verbal	Chair
28.	**Date of Next Meeting** Wednesday 29th January at Forest Green Rovers, Nailsworth	To note	Verbal	

AGENDA ITEM: 4.1

[2]GETHER NHS FOUNDATION TRUST

BOARD MEETING
FOREST HILLS GOLF CLUB, COLEFORD
26th September 2019

PRESENT

Ingrid Barker, Joint Trust Chair
Sandra Betney, Joint Director of Finance
Maria Bond, Non-Executive Director
John Campbell, Director of Service Delivery
Marcia Gallagher, Non-Executive Director
Sumita Hutchison, Non-Executive Director
Jane Melton, Director of Engagement and Integration
Colin Merker, Deputy Chief Executive
Angela Potter, Director of Strategy and Partnerships
Paul Roberts, Joint Chief Executive
Neil Savage, Joint Director of HR & Organisational Development
John Trevains, Director of Quality
Dr Amjad Uppal, Joint Medical Director

IN ATTENDANCE

Richard Cryer, Non-executive Director (GCS)
Lisa Evans, Assistant Trust Secretary
Jan Marriott, Non-Executive Director (GCS)
Sue Mead, Non-Executive Director (GCS)
Kate Nelmes, Head of Communications
Candace Plouffe, Chief Operating Officer (GCS)
Nick Relph, Non-Executive Director (GCS)
Michael Richardson, Deputy Director of Nursing (GCS)
Graham Russell, Non-Executive Director (GCS)
David Seabrooke, Interim Trust Secretary
David Smith, Executive Director for Transition (GCS)
Nicola Strother Smith, Non-Executive Director (GCS)

Hilary Bowen, Member of the Public
Chris Ward, Member of the Public

1. WELCOMES, APOLOGIES AND INTRODUCTIONS

1.1 Apologies were received from Nikki Richardson, Jonathan Vickers, Duncan Sutherland and Helen Goodey.

2. DECLARATIONS OF INTERESTS

2.1 The Board noted all joint appointments. The Director of Engagement and Integration's appointment to Gloucestershire's Integrated Care System was noted as was her recent appointment to the University of Gloucestershire as a visiting professor; the Chair congratulated the Director of Engagement and Integration on this appointment.

3. SERVICE USER STORY

3.1 The Director of Engagement and Integration reported that studying excellence in healthcare could create new opportunities for learning and improving resilience and staff morale. The Board noted that World Gratitude Day had been held earlier that week and comments from patients, carers and people from the communities served by both Trusts were reported. These offered gratitude, thanks and appreciation for the work done by colleagues in all areas of both Trusts.

3.2 These expressions of thanks were received from a family whose mother had been an inpatient on Coln Ward, from an elderly patient on Windrush, another from a patient who had been on the Vale Stroke Ward, from a patient who had stayed at Tewkesbury Hospital and from the family for the care shown to their mother when she had been an inpatient at the Dilke. The Board also noted a number of expressions of thanks regarding the care provided by 2gether. These included a letter from a service user who had been close to suicide when she had called the Crisis team for help, another comment from a former student nurse which said how impressed she had been by the care and compassion provided by the Trust and correspondence from the military regimental association for the care provided in Herefordshire. The Board also noted a letter from a local teacher who had been cared for in Wotton Lawn and who was now offering his services as a volunteer.

3.3 The Deputy Director of Nursing reported that there would be hundreds of interactions taking place across both Trusts. He said that while the Trusts must continue to concentrate on safety it was important to consider these 'always' events too. The Chair thanked all those involved in making the presentation and said that it gave the Board a real sense of pride in the work of the two Trusts.

4. MINUTES OF THE PREVIOUS MEETINGS

- **Minutes of the Meeting held on 25th July 2019**

4.1 The minutes of the 25th July were agreed as a correct record.

5. MATTERS ARISING AND ACTION LOG

5.1 The Board reviewed the action points, noting those that were complete or progressing to plan.

5.2 There were no matters arising.

6. QUESTIONS FROM THE PUBLIC

6.1 There were no questions from the public.

7. LEADERSHIP AND STRATEGY

- **Annual Review of the Risk Register**

7.1 This item was withdrawn as it had been considered at a previous meeting.

- **Chair's report**

7.2 The Board received and noted the Chair's Report. The Chair continued to visit the services across both Trusts and had attended two Celebration Events at Walls Clubs. Both events had recognized the many achievements of each Trust and also the long service of colleagues. An annual celebratory tea party for volunteers and Experts by Experience had taken place at Bowden Hall in Gloucester and the Chair reported that for the first time this event involved volunteers from both Trusts.

7.3 The Board noted that following a personal invitation made by the Trust Chair to Professor Ted Baker, CQC Chief Inspector of Hospitals, a visit was made by him to Wotton Lawn Hospital on 15th August. The Chair thanked the Director of Quality for facilitating this visit; the Director of Quality reported that staff feedback following the visit was extremely positive.

7.4 The Board noted that the Council of Governors had appointed an interim Lead Governor at a recent meeting. This role would continue until February when a full review of the Council would take place following the appointment of new Gloucestershire Care Services staff Governors. The Council of Governors had also approved the appointment of Graham Russell as Vice Chair of the Trust and noted that Marcia Gallagher had been appointed as Senior Independent Director.

- **Chief Executive's Report**

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

7.6 The Board noted that the Chief Executive continued to attend a range of meetings across both Trusts and a number of meetings with local MPs. He also reported that a competitive recruitment process had taken place for the Head of Corporate Governance position and the successful candidate would take up the post on 2nd January.

7.7 The Chief Executive updated the Board on the progress with the merger and on the engagement programme for Fit for the Future. The Board noted that the engagement programme for Fit for the Future had commenced in August and continued with a series of workshops and opportunities for discussion across the County. A formal engagement hearing would take place in October followed by a "Citizen's Jury" in November/December which would focus on the "Centres of Excellence" element of the programme.

7.8 The Director of Service Delivery reported that the Trust continued to follow national guidance on EU exit and was responding to information requests from the Department of Health and Social Care/ NHS England/Improvement.

- **One Gloucestershire Integrated Care System Update**

7.9 The Chief Executive provided an update to Board members on the progress of key programme and projects across Gloucestershire's Integrated Care System (ICS).
It was noted that Gloucestershire's Sustainability & Transformation Plan had commenced year three of four in April 2019 continuing priorities against the central transformation programmes. Refreshed delivery plans were in place that would transition the system into delivering against the Long Term Plan. The Board noted the key achievements of the ICS which included completion of the "what matters to you" engagement on the deliverables within the Long Term Plan. Work had continued to seek additional transformational funding for the county to support being at the forefront of developments in care. The ICS Strategic Stakeholder Group had been relaunched and the ICS Non-Executive Network continued to meet to further increase communication between partner organisations.

- **Medical Director – Annual Report and Revalidation update**

7.10 The Medical Director reported that Medical Appraisal had continued to be instituted within the Trust, aligned with national policy. The Board noted that the Medical Appraisal Committee had instituted a work plan that would further deliver assurance annually and sustain quality. It was noted that at the end of March 2019 88.6% of Doctors had a valid appraisal, 10.1% of non-compliant doctors were explained by exclusion criteria such as being a new starter or long term sick leave and 1.3% (equivalent to 1 doctor) was accounted for by short term delay and that doctor had since completed an annual appraisal.

7.11 The Board was assured that Doctors' revalidation was effectively managed with no non-engagement referrals. The recruitment processes provided appropriate safety and quality

checks aligned with national policy and best practice and use of locum practitioners was being monitored and used to sustain service commitments and activity appropriately.

7.12 The Medical Director reported that during 18/19 the Medical Appraisal Committee had welcomed Ivars Reynolds, a long established MH Act Manager to the Committee in order to provide Lay oversight of its work and input in to medical appraisal.

7.13 The Board agreed the content and submission of the Statement of Compliance to NHS England and this was signed by the Chair on behalf of the Trust.

- **Interim People Plan (NHS E/I)**

7.14 The Director of HR and OD reported that the NHS People Plan formed part of the overall Implementation Plan for the NHS Long Term Plan (LTP) and comprised:

  - An Interim People Plan published in June 2019
  - A full 5-year plan within two months of the final 2019/20 Spending Review – likely to be around Christmas / New Year 2020

7.15 The Board noted the Interim People Plan which laid the foundations nationally for the workforce transformation necessary to bring about and make a reality of the new service models and ways of working. The current focus was on the immediate actions for 2019/20 and the Plan set out a transformative vision for the NHS workforce. The key themes were noted and the Director of HR and OD reported that locally, a number of workshops and engagement events had taken place on developing the new merged Trust's People Strategy since the launch of the interim People Plan. Further engagement processes were planned after completion of the Phase 3 structural organisations.

7.16 The development of the Gloucestershire and Herefordshire ICS and STP LTP workforce narratives and numbers was noted as a current top priority and additional local priorities included developing the new Trust's Recruitment & Retention and Health and Well-being strategies. The Director of HR and OD also updated the Board on the aims of the future People Strategy. He confirmed that the HR team were working with Finance to ensure that the Strategy was deliverable and that new groups were being set up which would link with the Director of Strategies and Partnerships. Marcia Gallagher reported that she would like a focus at Board on Workforce to ensure the Board was fully informed of the challenge facing the system. The Director of HR and OD confirmed that the Risk Register and Board Assurance Framework identified where the issues were, he added that the Resources Committee had started to receive ICS updates. Marcia Gallagher asked if issues were quantified and the Director of Finance reported that she was working with other Directors of Finance to agree the direction of travel.

7.17 The Chair noted the good work taking place and reported that there was much more work to be done by the Trust and the ICS. The excellent Friends and Family test results were noted.

8. REPORTS FROM COMMITTEES

- **Service Experience**

8.1 The Director of Engagement and Integration reported that the Service Experience Report provided a high level overview of feedback received from service users and carers in Quarter 1 2019/20. The Board noted that learning from people's experiences was key and the Board was assured that service experience information had been reviewed, scrutinised for themes, and considered for both service-specific and general learning across the organisation.

- **Governance Committee**
  - **Governance Committee Updates – 28th June 2019 and 30th August 2019**

8.2 The Board received and noted the summary reports from the Governance Committee meetings held on 28th June and 30th August 2019.

8.3 At the June meeting the Governance Committee had received a report on Berkeley House which detailed work being done around extended segregation. The Director of Quality reported that work was being carried out by the Quality and Clinical Risk Sub-Committee. It was noted that no further feedback had been received from the CQC.

8.4 Maria Bond reported that the August meeting had received a presentation from the Therapeutic allotment team at Horton Road, Gloucester; a Service user had attended that meeting and had described the importance of the project. It was noted that the team had requested urgent funding for repairs and the Director of Service Delivery agreed to look into this.

ACTION: The Director of Service Delivery to update the Board on progress with the funding for repairs to the Therapeutic Allotment Project at Horton Road, Gloucester.

  - **NED Audit of Complaints**

8.5 A Non-Executive Director Audit of Complaints was conducted covering three complaints that had been closed between 1 April and 30 June 2019.

8.6 Sumita Hutchison had carried out the audit and reported that three cases were chosen at random for review. The Board noted that overall the investigations were thorough and comprehensive, however Sumita recommended that more be done to understand the service the complainant would have wanted to receive. The Board members noted that this information was not clear. Sumita also said that the response letter was not in plain language and some service users may not understand it. The Director of Engagement and Integration thanked Sumita for carrying out the review and reported that the Service Experience team took important learning from these audits.

  - **Learning from Deaths Q1**

8.7 The Medical Director reported data on Learning from Deaths for the period April to June 2019 (Q1 2019/20). The Board noted that changes to the selection criteria and the Mortality Review function – RCPsych SJR adopted in November 2018, applied to open deaths and incorporated into the Learning from Deaths process.

8.8 The Board noted that 72 deaths had been closed without further review due to being open to solely ACI-Monitoring caseloads (38) or excluded due to a primary diagnosis of dementia and over 70 years of age (34). 1 death raised a cause for concern within the Trust, which was escalated to a Clinical Incident Investigation by the Mortality Review Committee.

8.9 The Medical Director reported that 1 key post, vacant since August 2018 had now been recruited to following Director approval and the substantive Patient Safety Administrator was now in post.

  - **Guardian of Safe Working Report Q1**

8.10 The Medical Director presented the Quarterly report from the Guardian of Safe Working and the Board noted that this report would be considered by the CQC, GMC, and NHS employers as key data during reviews. The purpose of the report was to give assurance to

the Board that the doctors in training were safely rostered and their working hours were complaint with the TCS.

8.11 The Medical Director assured the Board that all new Psychiatry Trainees, Foundation Trainees and GP Trainees rotating into a Psychiatry placement were now on the new 2016 Terms and Conditions of Service with occasional exceptions. There were currently 42 trainees (junior doctors) working in the 2gether NHS Foundation Trust, all on the new Terms and Conditions of Service on different sites.

8.12 The Board noted that the 'exception' reporting process, which was part of the new Juniors Doctors Contract enabled them to raise and resolve issues with their working hours and training. The trainees could raise 'exception reports' for excessive hours worked, missed breaks, or missed educational opportunities and this system was now well established in the Trust. These 'exception reports' where possible had been resolved by the preferred option of time off in lieu (TOIL); those where TOIL would impact on colleagues' workload or educational opportunities had received payments. It was noted that exception reports may also trigger work schedule reviews and if necessary fines could be imposed on the Trust by the Guardian of Safe Working if issues remained unresolved. It was reported that exception reporting rates were variable between different sites. The Board noted that full engagement remained a challenge and this work was being progressed.

- **Quality Report**

8.13 The Director of Quality provided the Board with the first review of the Quality Report priorities for 2019/20. The report showed the progress made towards achieving targets, objectives and initiatives identified in the Annual Quality Report, the Board noted that all Quality Indicators were fully met in Quarter 1 with one exception:

  - 3.5 – Further develop a quality improvement led approach to robustly embed lessons learned following serious incidents.

8.14 The Board noted that the Patient Safety Team had worked through the zero suicide initiative and reducing restrictive practice groups to progress this indicator. The Director of Quality reported that further work had been paused whilst the Phase 3 merger management of change process was completed. However, the work would be taken forward through the combined Trust quality team in Q3 & 4.

8.15 There continued to be detailed monthly focus on indicators 1.2 – Discharge Care Planning and 3.3 Reduction in use of prone restraint to gain improved consistency of practice. A mid Quarter 2 review of information showed that two targets would not be met, however the Board noted the progress made to date and the actions in place to improve and sustain performance where possible.

- **Delivery Committee Update –21 August 2019**

8.16 The Board received the summary reports from the Delivery Committee meeting held on 21 August and on 24 September 2019. The reports and the assurances provided were noted.

- **Audit Committee Update – 2g**

8.17 The Board received a summary report from the Audit Committee meeting held on 7 August 2019. The reports and the assurances provided were noted.

- **Audit Committee Annual report 2018/19 – 2g**

8.18 The Board noted that the Committee's terms of reference required that it reported to the Board, at least annually, on its performance against its terms of reference, and on its work in support of the Annual Governance Statement.

8.19 The Board received and noted an overview of the Committee's work in the last financial year and of the work of the Committee in overseeing internal control mechanisms in the Trust, in support of the Annual Governance Statement.

9. MONITORING REPORTS

- **Financial Report Prior month 5**

9.1 The Director of Finance reported that the Trust's month 5 position was a surplus of £539k: in line with the planned surplus. The month 5 forecast outturn was an £803k surplus which was in line with the Trust's control total. The Board noted that PSF accounted for £985k of this and the Trust had an Oversight Framework segment of 1 at September 2019.

9.2 The agency cost forecast was £4.669m which would be £183k above last year's expenditure total and £1.533m above the agency ceiling, however a number of actions were being put in place and were beginning to bring this forecast down. The Director of Finance reported that the agency spend forecast was now in line with the plan.

9.3 The cash balance at month 5 was £21.0m which was £5.3m above the plan and capital expenditure was £1.276m at month 5. The Director of Finance reported that the Trust had identified £585k of recurring savings up to August 2019 which was £150k behind the plan.

9.4 Marcia Gallagher noted £150,000 of Out of County bed costs and asked if this was likely to worsen. The Director of Finance reported that this had not been flagged as a risk and the Director of Service Delivery reported that there was continued focus on this, however he added that there was significant pressure on bed stock which related to acuity levels.

- **Performance Dashboard Operational Exceptions Report – Prior month 5**

9.5 The Director of Service Delivery reported on the performance of the Trust's Clinical Services for the period to the end of August, (month 5 of the 2019/20 contract period); against NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators. The Board noted that this dashboard had been reviewed by the Delivery Committee at its meetings earlier that week.

9.6 The Board noted that of the 156 performance indicators, 80 were reportable in August with 71 being compliant and 9 non-compliant at the end of the reporting period. Where performance was not compliant, Service Directors were taking the lead to address issues and work was ongoing in accordance with agreed Service Delivery Improvement Plans to address the underlying issues affecting this performance.

9.7 The following 9 key performance thresholds were not met for the Trust for August 2019:

Gloucestershire CCG Contract Measures

- 3.12 – IAPT access rate
- 3.24 – IAPT DNA rate

The Director of Service Delivery reported that the IAPT Recruitment and Retention Plan had worked well over the previous year. The Board noted that the Service was currently over recruited but this was helping to reduce in-stage waits. The Board noted that the Trust had been unsuccessful in gaining any additional funding from the CCG. The 22% access rates would not be met and the Trust was now aiming for 20.5%

- 3.35 – Adolescent Eating Disorders – Routine referral to NICE treatment within 4 weeks
- 3.36 – Adolescent Eating Disorders – Routine referral to non-NICE treatment within 4 weeks

- 3.37 – Adolescent Eating Disorders – Urgent referral to NICE treatment within 1 week
- 3.39 – Adult Eating Disorders: Wait time for assessments will be 4 weeks
- 3.40 – Adult Eating Disorders: Wait time for psychological intervention will be 16 weeks

The Director of Service Delivery reported that there was a current focus on Eating Disorders Services to improve waiting times and support was being provided to the service by the IAPT Service Manager. The Board noted that the Mental Health Trailblazers had led to workforce challenges in CYPS where there were current vacancy rates of over 30%. A recruitment and retention plan had been developed and the Director of Service Delivery was working with NHS England to look new ways of working.

Gloucestershire Social Care Measures

- 4.06 – Eligible service users for Social Care have a Personal Budget

The Board noted that ongoing dialogue was taking place with Commissioners regarding some of the content (select indicators and thresholds) within Gloucestershire's 2019/20 contract (Schedule 4). There had been resolution regarding the 2018/19 indicators where thresholds had been increased for 2019/20, however, negotiations continued for the indicators that were new for this financial year.

Herefordshire CCG Contract Measures

- 5.13 – CYP Access: Percentage of CYP in treatment against prevalence

- **6 Monthly Safe Staffing**

9.8 The Director of Quality updated the Board regarding the revised safe staffing guidance issued by the National Quality Board (NQB) in July 2016. The report also included related updates through the developmental inpatient quality dashboard and temporary staffing. The Board noted the national reporting requirements, latest developments and the latest data in the required format, Local Trust exception reporting, update of agency use across wards and confirmation of achievement of the NQB expectations

9.9 The Board noted that national reporting fill rates continued to be uploaded monthly and reported to the Governance Committee on behalf of the Board. From April 2018 the Trust had been mandated to also include the Care Hours Per Patient Day (CHPPD) within the upload. The Trust continued to have strong compliance with planned versus actual fill rates which were over 98% compliant for July 2019.

9.10 The Board noted that the Trust continued to use high levels of agency locum medics, nursing and agency IAPT workers. The current predicted forecast for total agency spend for 2018/19 was £4.697m; this remained above the NHSI control total of £3.134m.

9.11 The Director of Quality reported that from 16th September 2019 there were new NHSI agency rules that required Trusts to stop using off-framework agency cover for non-clinical and unregistered clinical shifts (e.g. HCAs), and to no longer use agency workers in admin and estates (with some exceptions). The Board noted that the Trust remained within the scope of this new guidance and work continued to eliminate off framework agency usage.

9.12 The Board noted that all National Quality Board expectations had been achieved as per guidance. Some areas were currently being progressed further such as workforce development, safe staffing reviews and ensuring diversity of the workforce was representative of the communities served by the Trust. The Board was significantly assured on safe staffing and monthly reporting.

- **Operational Resilience and Capacity Plan (Winter Plan)**

9.13 The Director of Service Delivery reported that the Trust was required to demonstrate its ability to adapt to variations in demand throughout the year, with particular emphasis placed on the winter period (November – March). The Operational Resilience and Capacity Plan represented the core aspects of the assurance process and were submitted to Gloucestershire and Herefordshire Clinical Commissioning Groups annually as part of the health system assurance process.

9.14 The Board noted the process for developing and approving a joint plan for Gloucestershire Health and Care NHS Foundation Trust along with the risks and associated mitigation planned by the Trust to manage disruptions during the winter period.

10. FOR INFORMATION

Governance Update - Use of the seal

10.1 The Board noted the use of the Trust seal for the reporting period April – June 2019/20.

11. ANY OTHER BUSINESS

11.1 Nicola Strother Smith asked if the Gloucestershire Care Services Charitable Funds would need to be closed down. The Director of Finance reported that this would not be necessary as the balance would transfer into the 2gether Charitable Fund. There would be a consolidated position but no separate account.

11.2 The Chief Executive reported that the Secretary of State for Health and Social Care had signed off the merger by acquisition of 2gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust. The Board noted that an announcement would be made later that day.

12. DATE OF THE NEXT MEETING

12.1 The next Board meeting would take place on Thursday 28th November 2019, at The Friendship Café, Gloucester

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

AGENDA ITEM: 4.2

GLOUCESTERSHIRE CARE SERVICES NHS TRUST

BOARD MEETING
FOREST HILLS GOLF CLUB, COLEFORD
26th September 2019

PRESENT	Ingrid Barker, Joint Trust Chair Sandra Betney, Joint Director of Finance Richard Cryer, Non-executive Director Jan Marriott, Non-Executive Director Sue Mead, Non-Executive Director Candace Plouffe, Chief Operating Officer Angela Potter, Director of Strategy and Partnerships Nick Relph, Non-Executive Director Paul Roberts, Joint Chief Executive Graham Russell, Non-Executive Director Neil Savage, Joint Director of HR & Organisational Development David Smith, Executive Director for Transition Nicola Strother Smith, Non-Executive Director Dr Amjad Uppal, Joint Medical Director
IN ATTENDANCE	Maria Bond, Non-Executive Director (2g) John Campbell, Director of Service Delivery (2g) Lisa Evans, Assistant Trust Secretary (2g) Marcia Gallagher, Non-Executive Director (2g) Sumita Hutchison, Non-Executive Director (2g) Jane Melton, Director of Engagement and Integration (2g) Colin Merker, Deputy Chief Executive (2g) Kate Nelmes, Head of Communications (2g) Michael Richardson, Deputy Director of Nursing David Seabrooke, Interim Trust Secretary John Trevains, Director of Quality (2g) Hilary Bowen, Member of the Public Chris Ward, Member of the Public

1. WELCOMES, APOLOGIES AND INTRODUCTIONS

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Governors. The Council of Governors had also approved the appointment of Graham Russel as Vice Chair of the Trust and noted that Marcia Gallagher had been appointed as Senior Independent Director.

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7.7 The Chief Executive updated the Board on the progress with the merger and on the engagement programme for Fit for the Future. The Board noted that the engagement programme for Fit for the Future had commenced in August and continued with a series of workshops and opportunities for discussion across the County. A formal engagement hearing would take place in October followed by a "Citizen's Jury" in November/December which would focus on the "Centres of Excellence" element of the programme.

7.8 The Director of Service Delivery reported that the Trust continued to follow national guidance on EU exit and was responding to information requests from the Department of Health and Social Care/ NHS England/Improvement.

7.9 The Chief Operating Officer updated the Board on Community Stroke Rehabilitation Performance. The Board noted that the Sentinel Stroke National Audit Programme (SSNAP) had been completed by the new Community Stroke Rehabilitation Unit and was pleased to note that an 'A' had been received against the national benchmark standards; this was the highest grade possible. There were areas for improvement and some scores to be further analysed in order to understand their rating; however the Board was delighted to note that the unit delivered high quality care to the people of Gloucestershire.

- **One Gloucestershire Integrated Care System Update**

7.10 The Chief Executive provided an update to Board members on the progress of key programme and projects across Gloucestershire's Integrated Care System (ICS).
It was noted that Gloucestershire's Sustainability & Transformation Plan had commenced year three of four in April 2019 continuing priorities against the central transformation programmes. Refreshed delivery plans were in place that would transition the system into delivering against the Long Term Plan. The Board noted the key achievements of the ICS which included completion of the "what matters to you" engagement on the deliverables within the Long Term Plan. Work had continued to seek additional transformational funding for the county to support being at the forefront of developments in care. The ICS Strategic Stakeholder Group had been relaunched and the ICS Non-Executive Network continued to meet to further increase communication between partner organisations.

- **Medical Director – Annual Report and Revalidation update**

7.11 The Medical Director reported that during the appraisal year 2018/19, Gloucestershire Care Services NHS Trust had employed 11 medical colleagues, 1 of whom was due revalidation during that period. That doctor had recently joined GCS and had had insufficient appraisals during the revalidation cycle and therefore the Responsible Officer recommended deferral of revalidation for a further year. The Responsible Officer made 3 positive recommendations for the 3 medical colleagues due revalidation in the appraisal year

2019/20. In terms of engagement with appraisal, there was 100% compliance. The Board noted that significant work had been undertaken to ensure that the Trust was discharging its responsibilities for medical appraisal and revalidation.

7.12 The Board noted the report and approved the Statement of Compliance, completed by the Responsible Officer to confirm the Trust's compliance with the statutory Responsible Officer duties. This was signed by the Chief Executive and would be submitted to NHS England by 27 September 2019. The Board agreed to continue to fund external appraisal costs until each doctor was transferred to an in-house appraiser.

- **Interim People Plan (NHS E/I)**

7.13 The Director of HR and OD reported that the NHS People Plan formed part of the overall Implementation Plan for the NHS Long Term Plan (LTP) and comprised:

- An Interim People Plan published in June 2019
- A full 5-year plan within two months of the final 2019/20 Spending Review – likely to be around Christmas / New Year 2020

7.14 The Board noted the Interim People Plan which laid the foundations nationally for the workforce transformation necessary to bring about and make a reality of the new service models and ways of working. The current focus was on the immediate actions for 2019/20 and the Plan set out a transformative vision for the NHS workforce.

7.15 The key themes were noted and the Director of HR and OD reported that locally, a number of workshops and engagement events had taken place on developing the new merged Trust's People Strategy since the launch of the interim People Plan. Further engagement processes were planned after completion of the Phase 3 structural organisations.

7.16 The development of the Gloucestershire and Herefordshire ICS and STP LTP workforce narratives and numbers was noted as a current top priority and additional local priorities included developing the new Trust's Recruitment & Retention and Health and Well-being strategies. The Director of HR and OD also updated the Board on the aims of the future People Strategy. He confirmed that the HR team were working with Finance to ensure that the Strategy was deliverable and that new groups were being set up which would link with the Director of Strategies and Partnerships. Marcia Gallagher reported that she would like a focus at Board on Workforce to ensure the Board was fully informed of the challenge facing the system. The Director of HR and OD confirmed that the Risk Register and Board Assurance Framework identified where the issues were, he added that the Resources Committee had started to receive ICS updates. Marcia Gallagher asked if issues were quantified and the Director of Finance reported that she was working with other Directors of Finance to agree the direction of travel.

7.17 The Chair noted the good work taking place and reported that there was much more work to be done by the Trust and the ICS. The excellent Friends and Family test results were noted.

8. REPORTS FROM COMMITTEES

- **Quality and Performance Committee update - 29th August 2019**

8.1 The Board received an update report from the Quality and Performance Committee meeting held on 29th August 2019. The reports and the assurances provided were noted.

- **Resources Committee update**

8.2 Graham Russell reported that the recent meeting of the Resources Committee had received

updates on Finance, Quality Standards and progress with the Forest of Dean Hospital. Community Dental Services were discussed and the Committee had noted the improved waiting times. Reference Costs, Workforce and Staffing reports were reviewed and a number of HR policies were approved.

The Chair thanked Graham for all of his work during his time as Chair of the Resources Committee.

- **Audit and Risk Assurance Committee update**

8.3 Richard Cryer reported that the last meeting of the Audit and Risk assurance Committee had focussed on the handover of work to the new Audit Committee. Marcia Gallagher had attended and Richard assured the Board that most of the Committees outstanding actions would be completed before the merger.

8.4 Marcia Gallagher thanked Richard Cryer for his help with the transition and reported that she had learned a lot from him.

9. MONITORING REPORTS

- **Financial Report Prior month 5**

9.1 The Director of Finance provided the Board with an overview of the Trust's month 5 position. The Board noted that the Control Total surplus was £2.256m including £1.626m of Provider Sustainability Funding (PSF). Capital spend plan was £2.93m of in-year CRL request, plus £0.75m of multi-year CRL allocation for the Forest of Dean hospital giving a total of £3.68m. The Cost Improvement Plan (CIP) target was £5.3m and the Agency spending ceiling was £1.865m. Income potential Commissioning for Quality and Innovation (CQUIN) and Quality, Innovation, Productivity and Prevention (QIPP) were £1.06m and £3.9m respectively; It was noted that contracts had not yet been signed, with milestones and proportional values for respective periods not yet allocated.

9.2 The Director of Finance confirmed that the month 5 full year performance forecast was on plan, subject to the risks noted. She added that 2019/20 and 2020/21 risks had come down and good progress was being made on the Capital Forecast.

- **Quality and Performance Report – GCS**

9.3 The Deputy Director of Nursing summarised the key highlight and exceptions in the Trust for August 2019. The Board noted that the Quality and Performance Committee had reviewed the July 2019 data at its meeting on 29th August 2019. It was noted that there had been a decline in the New Harms only data within Safety Thermometer. This had now been rectified and resubmitted nationally; Safety Thermometer data (August) for Harm Free Care was now 93.89% and for New Harms was only 98.5%.

9.4 The Deputy Director of Nursing reported on the three key service areas in which the Trust had had challenges in offering timely services:

- Adult Speech and Language Therapy services
- Musculoskeletal (MSK) Therapy services
- Integrated Community Teams therapy services

9.5 These areas continued to be subject to in depth reviews and/or focus to improve performance against the locally set 8 week referral to treatment key performance indicator.

9.6 It was noted that for the first time for this reporting year Mandatory training compliance had shifted to green (91.08%) and the Trusts sickness absence rates had reduced further to 4.76%.

9.7 Nicola Strother Smith noted that there had been positive feedback from families on the Quality Dashboards for the Community Hospital Inpatient and Minor Injury and Illness units. The Board noted that these dashboards were updated monthly and were displayed at each of the units. The Director of Quality (2g) reported that he was looking into how these dashboards could be utilised for the 2g services.

- **Operational Resilience and Capacity Plan (Winter Plan)**

9.8 The Director of Service Delivery (2g) reported that the Trust was required to demonstrate its ability to adapt to variations in demand throughout the year, with particular emphasis placed on the winter period (November – March). The Operational Resilience and Capacity Plan represented the core aspects of the assurance process and were submitted to Gloucestershire and Herefordshire Clinical Commissioning Groups annually as part of the health system assurance process.

9.9 The Board noted the process for developing and approving a joint plan for Gloucestershire Health and Care NHS Foundation Trust along with the risks and associated mitigation planned by the Trust to manage disruptions during the winter period.

10. FOR INFORMATION

Governance Update - Use of the seal

10.1 The Board received and noted the assurance on the Trust's compliance for the year 2019/20, with statutory register maintenance relating to the:

- Register of Declaration of Interests (Directors)
- Register of Declaration of Interests (all Budget Holders)
- Register of Fit and Proper Persons Test
- Register of Gifts and Commercial Sponsorship
- Register of Seals

11. ANY OTHER BUSINESS

11.1 Nicola Strother Smith asked if the Gloucestershire Care Services Charitable Funds would need to be closed down. The Director of Finance reported that this would not be necessary as the balance would transfer into the 2gether Charitable Fund. There would be a consolidated position but no separate account.

11.2 The Chief Executive reported that the Secretary of State for Health and Social Care had signed off the merger by acquisition of 2gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust. The Board noted that an announcement would be made later that day.

12. DATE OF THE NEXT MEETING

12.1 The next Board meeting would take place on Thursday 28th November 2019, at The Friendship Café, Gloucester

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

TRUST PUBLIC BOARD: PUBLIC SESSION - Matters Arising Action Log – as at November 2019

Key to RAG rating:

- Action completed (items will be reported once as complete and then removed from the log).
- Action deferred once, but there is evidence that work is now progressing towards completion.
- Action on track for delivery within agreed original timeframe.
- Action deferred more than once.

Minute reference (Item No.& Date)	Item	Action Description	Assigned to	Target Completion Date	Progress Update	Status
10/0718	Medical Revalidation process	Propose similar framework be considered for dentists	Medical Director	Ongoing	Continues to be under consideration	
13/0918	E&D	Board Session to be arranged for shadow board	Chair	Closed	Board Development Programme in place to be reviewed to identify date for E&D.	
10.1	Fit Bits	Joint Chief Executive to consider how the work being undertaken with Fit Bits could be shared with the Board.		Closed	Updated in CEO report	

AGENDA ITEM: 06

Report to:	**Gloucestershire Health and Care NHS Foundation Trust Board – 28th November 2019**
Author:	**Ingrid Barker, Chair**
Presented by:	**Ingrid Barker, Chair**
SUBJECT:	**Report from the Chair**

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

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

PURPOSE OF REPORT

To update the Board and members of the public on my activities and those of the Non-Executive Directors to demonstrate the processes we have in place to inform our scrutiny and challenge of the Executive and support effective Board working.

RECOMMENDATIONS

That the Board note the report and the assurance provided.

EXECUTIVE SUMMARY

Executive Summary

This is my first report since the formal merger of Gloucestershire Care Services with 2g NHS Foundation Trust – to create Gloucestershire Health and Care NHS Foundation Trust.

This is a process which I have been updating you on regularly in my reports since we, as two separate organisations, agreed our Strategic Intent over two years ago to increase our commitment and focus on integrated care designed around our service users and informed by our tremendous team of skilled and experienced colleagues.

The process was supported by our regulators following some challenging sessions to ensure both Trusts had fully understood how the new Trust would work in future and achieve its stated strategic aims.

I am delighted that having achieved the formal process successfully, and without the delays and issues a number of mergers have been subject to, we are now in a position to put in place all the building blocks to achieve our strategic aims.

The entire board has brought a huge amount of skill and commitment, working exceptionally hard during the last two years, to bring about a successful transaction and 'safe landing' for our new Trust. As the inaugural Chair of Gloucestershire Care Services, which was newly created in 2013, I am able to build upon my personal experience of working as part of a team leading the creation of a new organisation to develop our new ways of working in Gloucestershire Health and Care NHS Foundation Trust. The whole Board is committed to working together to make sure it is not just our name that has changed! I am confident that the work that has been going on behind the scenes of the formal merger process and the commitment of the new Board will ensure this – and look forward to telling you more in my future reports.

As well as looking forward I would also like to formally thank all the former Board members of ^{2}gether NHS Foundation Trust and Gloucestershire Care Services, both recent members and those who served across the Trusts in the past, for their roles in building such strong organisations, focused on their service users, that were ready on 1st October to take their next steps together.

My report also includes updates on:

- Working with our system partners
- Working with our colleagues
- National and Regional Meetings attended and any significant issues highlighted

Corporate Considerations	
Quality implications	-
Resource implications:	-
Equalities implications:	-
Risk implications:	-

WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?			
Working together	Yes	Always improving	Yes
Respectful and kind	Yes	Making a difference	Yes

1. Introduction and Purpose

This report seeks to provide an update to the Board on the Chair and Non-Executive Directors activities in the following areas:

- Board Development
- Working with our system partners
- Working with our colleagues
- National and Regional Meetings attended and any significant issues highlighted

1.1 Board Development

A Board Development session was held on 23rd October and helped to further build Board engagement and integrated working. This is part of an ongoing programme of facilitated board development, a major priority over the coming months for these sessions being the development of our new Trust strategy

In response to the advice received from Grant Thornton as part of the scrutiny of our transaction process, the Board has agreed with the Governors' Nomination and Remuneration Committee that we should appoint an Associate Non-Executive Director (NED), to strengthen the organisational memory and knowledge of the previously Gloucestershire Care Services Trust (GCS) as a bridge into the new organisation, especially in relation to the quality governance of those services. I am delighted that Sue Mead, previously a NED with GCS, has agreed to take on this role, initially for a three month period, but potentially for up to a year. Sue will focus particularly on attending Board meetings and the Quality Committee and will have a monthly commitment of approximately two days. Colleagues will know that Sue brings a wealth of experience from her previous executive and non-executive roles from which we will benefit greatly.

The NED team has now finalised its portfolio of responsibilities which are attached as Appendix 1 for information. For the outstanding 7th NED appointment we are seeking a GP with strong networks in local primary care and interviews are taking place early in December for this role.

1.2 National and Regional Meetings

Along with Sumita Hutchison (Non-Executive Director), John Campbell (Chief Operating Officer) and Des Gorman (Head of Programmes and Change Management) I attended the **NHS Providers Annual Conference** held in Manchester on 8th and 9th October. This year's conference focused on **ambition to reality** – exploring how providers are embracing new opportunities with a realistic eye on the need to recover performance, stabilise the sector's finances and invest to transform. As always, I came away inspired with some ideas that we will consider as a Board in the months ahead.

I was represented at the **NHS Provider Community Network** meeting on 31st October by Vice-Chair Graham Russell. The agenda included an introduction to the neighbourhood integration project; a case study sharing learning from One Northern Devon's work to integrate services; a case study to share learning from Guy's and St. Thomas NHSFT work on key areas emerging from the Ageing Well programme; an update on the Long Term Plan and an update on IPPR's Better Health and Care Programme: Primary and Community Care Reform. Again ideas which will inform future Board thinking.

I attended the **NHS Providers Board** on 6th November where matters discussed included NHS Providers and STPs/ICS representation and Provider collaboration – policy position. Board colleagues have been briefed separately on this meeting. It was the final meeting with Dame Gill Morgan in the chair and we were pleased to welcome Sir Ron Kerr, the incoming Chair of NHS Providers, as an observer to the meeting.

These events help to ensure NHS Trusts are working collectively to deliver the Long Term Plan and that time is not spent unnecessarily reinventing wheels when another Trust has been through a detailed process with proven good practice as an outcome.

1.3 Working with our Partners

I have continued my regular meetings with key stakeholders and partners; highlights are as follows:

Along with the CEO, I attended meetings of the **Gloucestershire ICS Board on 29th October and 26th November.** Matters discussed at the meeting on 29th October included Health and Employment deep dive conversation with NHSE/I and DHSC/DWP WHU; updates on Fit for the Future, Primary Care Strategy, Place Based Work and the Long Term Plan.

A verbal update will be given about matters discussed at the meeting held on 28th November.

A meeting of the **Gloucestershire's ICS Chairs** took place on 19th November.

Along with the Chief Executive, the Director of Strategy and Partnerships (Angela Potter) and the Deputy Chief Operating Officer (Eddie O'Neil) I attended a regular meeting of the **Gloucestershire Health Overview and Scrutiny Committee** (HOSC) on 19th November. The meeting considered performance across the health and care system. Matters discussed included Improving Access to Psychological Therapies (IAPT); the power of technology to improve the quality of NHS Services; Memorandum of Understanding (to enable the committee to be clear as to what constitutes a substantial variation or development in a health service and to clarify the role of Scrutiny).

A meeting of the **Gloucestershire Health & Wellbeing Board** took place on 5th November. The Trust's representative at this Board is now the Director of Strategy and Partnerships (Angela Potter). This was a development session where the aim

was to explore the complex overlaps between the Health & Wellbeing Board and Safer Gloucestershire agendas; promote a shared appreciation of key themes spanning the HWB and Safer Gloucestershire and to understand how both Boards communicate and collaborate together.

I chaired the interview panel for the **ICS Independent Chair** on 4th November and an announcement regarding the appointment will be made shortly.

Following a request received from the **Vice-Chancellor of the University of Worcester**, the Trust's Medical Director, Dr. Amjad Uppal, and I met with Professional David Green on 21st November to discuss the Three Counties Medical School and how we might work together in the future.

I have been represented at a number of important **Herefordshire** meetings by Non-Executive Director, Duncan Sutherland, as summarised in the NED activity report later in this paper.

1.4 Working with the Communities and People We Serve

The Trust's excellent series of **Better Care Together events** have continued including:

2nd October – **Focus on Learning Disabilities (Opportunity, Inclusion and Equality)** – this session was chaired jointly by Tim Heaven and Jan Marriott (Non-Executive Director) - Joint Chairs of the Learning Disabilities Partnership Board. We also heard from local projects such as the Treasure Seekers Police Cadets and had a briefing on national initiatives in learning disability services from a service user perspective.

18th November – **Our Joint Intent** – this event was arranged for the Voluntary and Community Sector (VCS Alliance) and gave an update on the newly formed Trust.

27th November – **Celebrating Community Assets, people, places and partners**. This session is in partnership with Birmingham University and the Community Hospitals Association. We will hear from people who use our community services (both hospitals and other services), those who support them as volunteers, members of the Leagues of Friends and Carers and community organisations.

These sessions continue to be key to how we develop our organisation as we move forward. We really appreciate the time that our community are giving to support these key activities – we really do need your continuing help to achieve our aims, and events like these will become part of our ongoing co-production processes. I recognise that many people are volunteers and certainly all are juggling a range of responsibilities which makes the level of engagement we are achieving even more remarkable.

I attended the **Chancellor's Lecture** at the University of Gloucestershire on the evening of 4th November where the guest speaker was Paul Farmer, former CEO of MIND, who presented a lecture entitled "Changing the Mindset – how we started to

think differently about mental health". This was an informative lecture, interspersed with campaign clips, which demonstrated how far our communities have moved in their thinking about mental health – and the work still required to improve mental health. In response to a question I was pleased to hear Paul's welcome for the development of Gloucestershire Health and Care NHS Foundation Trust and the work that we do to integrate physical and mental health care.

I will be joining the **GGPET** (Gloucestershire GP Education Trust) as a Trustee, and met with Sadaf Haque on 7th November to find out more about their role in supporting the Gloucestershire GPs. I am very pleased to have been invited to be a Trustee, a reflection of the way the Trust continues to build its relationships with GPs.

I was delighted to be invited by the Lord Lieutenant, Edward Gillespie OBE, to join him at the **Summerfield Charitable Trust** meeting on 13th November. This organisation makes huge investments in the wellbeing of Gloucestershire and I was pleased to understand more about how they work and see how we complement each other.

1.5 Engaging with our Trust Colleagues

On 1st October, the entire Board, along with other senior managers, undertook visits to as many services as possible in the Trust, meeting with our colleagues and handing out 'Welcome Packs' to mark the new organisation. I know all of us enjoyed doing this and received a warm welcome from our colleagues. I made two visits during the day to the various wards at Wotton Lawn and an evening visit to Tewkesbury hospital.

In addition I have carried out the following visits to Trust services:

24th October – Governor visit to Cirencester Hospital
30th October – Homeless Healthcare team meeting. I also accompanied Katie Conlon to meet partners in P3 at the safe space projects in Gloucester and Cheltenham
31st October – Dilke Hospital, Cinderford
7th November – Governor visit to the allotment project in Horton Road, Gloucester which supports people from nearby inpatient services.

A meeting of the **Council of Governors** took place on 14th November where we received a presentation from Andy Telford on Homeless Mental Healthcare: the people and the service. We also received a presentation on quality and clinical governance in the new Trust by John Trevains, Director of Nursing. As always, these are important sessions focusing on matters of key concern

Following on from the decision made by the Council of Governors to create a "**Review and Refresh" working group** to look at shaping how the Council of Governors will work together in the future following the merger of 2gether and Gloucestershire Care Services Trusts, the first meeting took place on 14th November which was facilitated by the Trust's Director of Strategy and Partnership, Angela

Potter, in conjunction with Des Gorman, the Trust's Head of Programmes and Change Management. At this session we reviewed the working of the Council of Governors to date; talked about transitions to new ways of working and discussed next steps and action planning.

Along with a number of Senior Managers and Non-Executive Directors I attended the **NHSLA Reciprocal Mentoring Programme** on 22nd November. A verbal update on this event will be available at the meeting.

I was pleased to attend the **Senior Leaders Network on 26th November** where the guest speaker was Julian Moss, Assistant Chief Constable, who spoke about Adverse Childhood Experiences (ACEs), which was previously discussed at Board and highlighted as an area which would benefit from wider discussion within the Trust.

I continue to have a range of **1:1 sessions with Executive and Non-Executive** colleagues as part of my regular activities.

2. NED activity

Activities undertaken by the Trust's Non-Executive Directors are detailed below:

Graham Russell
Launch date activity at Cirencester Hospital
Quality, Resources, Audit and Nomination/Remuneration Committees
Board Development
Better Care Together event on Learning Disabilities
NHS Providers Community Network (on behalf of Trust Chair)

Jan Marriott
Launch date activity at Colliers Court
Co-Chaired Better Care Together Event re Learning Disability
Joined Bren McInerney to celebrate his BEM
Lord Lieutenant's Awards Ceremony for people who work or volunteer with the Reserve Forces and Cadet Movement (on behalf of Trust Chair)
Board Development
Visit to the Dilke Memorial Hospital to update Quality Visit Report which focused on SystmOne and its impact on nursing/patient care
Visit to Mental Health Liaison Team at Gloucester Royal Hospital
Senior Leaders Forum (2)
Meetings with Trust colleagues: Hazel Braund, Sonia Pearcey, Ian Main, Lisa Dervan
Audit, Quality, and Mental Health Legislation Scrutiny Committees
New Model of Community Nursing presentation
Met Chief Executive of the Gloucestershire Campaign to Protect Rural England
First planning meeting for the Big Health and Wellbeing Day 2020
Better Care Together Community Assets Event
Met CCG Locality Managers for Cheltenham and Tewkesbury

Sue Mead
Quality Committee
Meeting with Trust Chair
Meeting with Trust CEO

Maria Bond
Launch date activity at Weavers Croft
Review of Audit Committee
MHAM Forum and Dementia Training
Extraordinary Board
Board Development
Delivery Committee
Quality Committee
Visit to Tewkesbury Community Hospital
Meeting at Pullman Place with Neil Calder

Marcia Gallagher
Launch date activity at Dilke Hospital
1:1 meeting with Trust Chair
Board Development
1:1 with Non-Executive Director
Audit Committee
Serious Incident Reviews (2) – Hereford
Council of Governors meeting
Governors Review and Refresh group
Visit to the Vale Hospital, Dursley

Sumita Hutchison
Launch date activity at Edward Jenner Court
Visits to:
- George Moore Clinic
- Charlton Lane Hospital
- Oak House
- Horton Road allotment project
- Children's Hub, Quedgeley

NHS Providers Annual Conference, Manchester
Board Development
Quality Committee
People Participation Task and Finish Group
NHS Providers NED induction
NHSLA Reciprocal Mentoring Programme

Duncan Sutherland
Hereford Senior Managers Network
Hereford ICAB (2 meetings)
Hereford Health & Well-being Board
Meeting with Hereford CCG (2 meetings)
Hereford & Worcester ICS Executive Forum

Resources Committee
Herefordshire Governors
Mental Health Legislation Scrutiny Committee
Board Development

3. Conclusion and Recommendations

The Board is asked to **NOTE** the report and the assurance provided.

Non-Executive Director Portfolios – October 2019 (APPENDIX 1)

	Locality	Audit *	Resources	Quality	MH Act	Charitable Funds	RemCom/ATOS	Champion
Sumita	Gloucester	-	✔ (Vice-Chair)	✔	-	✔ Chair	✔	Equality and Diversity Climate Protection
Marcia (SID)	Forest	✔ (Chair)	-	-	-	✔ (Vice-Chair)	✔	Counter-fraud, Security and Procurement
Maria	Cotswold	✔ (Vice-Chair)	-	✔ (Chair)	-	-	✔	Emergency Planning
Duncan	Herefordshire	-	✔	-	-	-	✔	Safeguarding
Graham (Vice-Chair)	Stroud	✔	✔ (Chair)	-	-	✔	✔	
Jan	Cheltenham or Tewkesbury	-	✔	✔ (Vice-Chair)	✔ (Chair)	-	✔	FTSU Learning Disabilities Learning from Death
GP	Cheltenham or Tewkesbury	-	-	✔	✔ (Vice-Chair)	-	-	

***All NEDs are members but 3 are nominated as regular attendees**

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 07

Report to:	Gloucestershire Health and Care NHS Foundation Trust Board – 28th November 2019
Author:	Paul Roberts, Chief Executive & Executive Team
Presented by:	Paul Roberts, Chief Executive
SUBJECT:	**Report from the Chief Executive and Executive Team**

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

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

PURPOSE OF REPORT

To update the Board and members of the public on my activities and those of the Executive Team.

RECOMMENDATIONS

To **NOTE** the report.

EXECUTIVE SUMMARY

This report is my first since the formal transition from 2gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust to Gloucestershire Health and Care NHS Foundation Trust.

This week marks almost eight weeks since the merger date and I am pleased to formally record that our main priority, to **ensure a safe 'day one'** and to enable colleagues to continue to concentrate on **delivering the high quality services** our communities need and expect, was delivered.

This was supported by the comprehensive planning through the transaction and transition planning that has been ongoing for the last two years, led by strong and effective leadership from both Executive Teams. I would like to formally thank them,

and also to wish well the members of the Board who have not transitioned with us. We were fortunate to have such skilled, knowledgeable, experienced and committed individuals with us on the key stages of this important journey.

We are now able to move forward with even more concentration on the key driver for the merger – transformation. I am excited to see how with colleagues and service users and their families and carers we can make change our services to better meet their needs – something I know that I and the rest of the Board are passionate about.

The Report also updates on:

- CEO Engagement
- Partnership Activities
- National and Regional meetings attended
- Herefordshire Integrated Working Developments
- Key Statutory Responsibilities
- Brexit Preparedness

Corporate Considerations	
Quality implications	-
Resource implications:	-
Equalities implications:	-
Risk implications:	-

WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?			
Working together	Yes	Always improving	Yes
Respectful and kind	Yes	Making a difference	Yes

Report authorised by:	**Date:**
Chief Executive Officer & Executive Team	18 11 19

Where has this issue been discussed before?
-
What wider engagement has there been?

Appendices:	

1. Chief Executive Engagement

I remain committed to spending a significant proportion of my time vising front-line services and meeting frontline colleagues in a variety of settings in both organisations and continue to be impressed and heartened by the professionalism and commitment of colleagues across the organisations and in the pride that they take in the delivery of, in many cases, outstanding services. Across the merger date this was reinforced by me and the rest of the Board as we took the opportunity to celebrate with colleagues across the Trust and to ensure everyone knew who to turn to if they had any worries. I was proud to see that throughout this period of change colleagues continued to focus on giving the best care possible to our communities.

I have continued to attend a range of meetings including:

Council of Governors meetings, including the Review and Refresh Working Group - these are reported on in the Joint Chair's report and elsewhere in this agenda.

Corporate Induction – I have welcomed new colleagues at three sessions on 30th September, 28th October and 25th November, where I gave the Executive overview. I plan to attend, representing the Board, as many of these sessions as possible in the future as I am keen to demonstrate from day 1 that as an Executive team we are approachable and open to ideas. New starters have fed back positively this approach.

Senior Leadership Network – two meetings have been held:
31st October - where we received a presentation from the Trust's Freedom to Speak up Guardian, Sonia Pearcey, along with a presentation on Homeless Mental Health – the people and the service, by Andy Telford, Deputy Service Director (Operations). Jan Marriot gave the NED introduction.
26th November – the guest speaker at this meeting is scheduled to be Assistant Chief Constable Julian Moss, who will be talking about Adult Childhood Experiences (ACEs). A verbal update will be given at Board.

These sessions continue to be really helpful opportunities to discuss Trust and county wide issues across the wider Trust leadership.

I attended the **Communications Team monthly meeting** on 5th November – no fireworks but a clear session setting out their commitment to engaging effectively with colleague and our community.

The Trust's excellent series of **Better Care Together events** have continued including:

2nd October – **Focus on Learning Disabilities (Opportunity, Inclusion and Equality)** – this session was chaired jointly by Tim Heaven and Jan Marriott (Non-Executive Director), Joint Chairs of the Learning Disabilities Partnership Board. We also heard from the Treasure Seekers Police Cadets.

18th November – **Our Joint Intent** – this event was arranged for the Voluntary and Community Sector (VCS Alliance and gave an update on the newly formed Trust.

27th November – **Celebrating Community Assets, people, places and partners**. This session is in partnership with Birmingham University and the Community Hospitals Association. We will hear from people who use our community services (both hospitals and other services), those who support them as volunteers, members of the Leagues of Friends and Carers and community organisations.

These sessions continue to be key to how we develop our organisation as we move forward.

We really appreciate the time that our community are giving to support these key activities – we really do need your continuing help to achieve our aims, and events like these will become part of our ongoing co-production processes. I recognise that many people are volunteers and certainly all are juggling a range of responsibilities which makes the level of engagement we are achieving even more remarkable.

I attended the **joint JNCC/JNCF** meeting on 6th November. As usual this was an effective meeting with attendees prepared to raise concerns and issues – again a demonstration of the open organisation we are determined to foster.

I hosted a **Team Talk session** at Tewkesbury Hospital on 11th November. Other members of the Executive cover other venues across the county and we pull together themes from feedback which again help to ensure effective communication across the Trust. The importance of communication is one that was highlighted during the merger and remains an area we are concentrating on.

I participated in a **Governor visit** on 8th November to Pullman Place. I always enjoy the opportunity to visit services, and to do this in the company of governors reinforces this. I get to see the services from another perspective and to see again the commitment of governors' to their role. We are fortunate to have governors who are willing to give their time so willingly.

Along with a number of Board colleagues and senior managers I attended the **NHSLA reciprocal mentoring programme** on 22nd November. I am very supportive of mentoring programmes as a way to develop individuals and was pleased to get involved.

I was invited to give the keynote speech at the **Research 4 Gloucestershire conference** on 25th November. This event was about the Importance of Research in the Trust – an increasingly important area for us going forward, I was pleased to see that even with so many demands on colleagues' time that the foundations set in place last year continue to have been built on.

I continue to hold **regular meetings with Executive Directors and senior managers** from both Trusts.

2. Partnership Working

I continue to have regular meetings with the **CEO of Gloucestershire Hospitals NHS Foundation Trust (GHFT)** and the **Accountable Officer for Gloucestershire Clinical Commissioning Group (GCCG).** I also continue to attend regular meetings of the **ICS Board** and **ICS Executive** which are focused on taking forward our joint One Gloucestershire ambitions.

Fit for the future
The engagement programme for Fit for the Future commenced in August and continues with a series of workshops and opportunities for discussion across the County. A **formal engagement hearing** took place on 24th October, but due to the announcement of the General Election on 12th December, the programme has had to be put on hold.

Along with the Trust Chair, the Director of Strategy and Partnerships (Angela Potter) and the Deputy Chief Operating Officer (Eddie O'Neil) I attended a regular meeting of the **Gloucestershire Health Overview and Scrutiny Committee** (HOSC) on 19th November. The meeting considered performance across the health and care system. Matters discussed included Improving Access to Psychological Therapies (IAPT); the power of technology to improve the quality of NHS Services; Memorandum of Understanding (to enable the committee to be clear as to what constitutes a substantial variation or development in a health service and to clarify the role of Scrutiny).

As part of my work with the Gloucestershire ICS, I continue to lead on three major strategic works streams including chairing a meeting of the **Diagnostics Programme Board on 7th November** and the **Urgent Care Project Board** (part of the Fit for the Future programme) on 25th October.

I was pleased to be invited to attend the **GHFT staff awards** event held at the Hatherley Manor Hotel on the evening of 27th November.

I attended a regular meeting of the **Medical Staffing Committee** on 1st November.

3. Herefordshire Integrated Working Developments

Colin Merker, Managing Director of Herefordshire Mental Health and Learning Disabilities Services and Duncan Sutherland Non-Executive Director continue to be heavily engaged in working with colleagues in **Herefordshire and Worcestershire** to further develop partnership working.

At the 2gether private Board meeting in late September Board reached a conclusion that we cannot provide the level of corporate capability and resources we need to within Herefordshire to appropriately represent services within the Herefordshire and Worcestershire (H&W) STP.

Supporting the work of both the Gloucestershire ICS and H&W STP has stretched a number of colleagues and we have had to reach a conclusion that this is not sustainable.

[2]gether provided services in Herefordshire for eight years and is **immensely proud** of how we can demonstrably show improvement year-on-year. The Board knows that **services in Herefordshire 'punch above their weight'** and that colleagues openly voice that they have benefited from being part of 2gether and would rather remain with the merged organisation.

Whilst it would be an easy decision for the Board to agree this, our values drive us to ensure that **the needs of our service users and carers come first.** In order that we can achieve this so that our Herefordshire services can continue to develop and improve, we have recommended to Herefordshire Clinical Commissioning Group that they support us in moving services to Worcestershire Health and Care NHS Trust, who provide Community Physical Health, Mental Health and Learning Disability Services across Worcestershire. This recommendation has been accepted and the transaction and transition will proceed.

This week we have been talking to our Herefordshire Senior Leadership Forum and with all Herefordshire colleagues through a series of briefings, about our Board discussions and recommendations.

This will be a **significant time of change for our Herefordshire colleagues** and we are committed to supporting them in a safe and successful transition to Worcestershire Health Care NHS Trust, if Herefordshire CCG accepts our recommendations, as we believe they will.

Along with Colin Merker, I attended the **Hereford Senior Manager Network** on 11th November to ensure that staff have the opportunity to raise concerns.

I met with **Jesse Norman, MP for Hereford/South Herefordshire** on 1st November where I updated Mr. Norman on the merger of [2]gether and Gloucestershire Care Services NHS Trusts and planned future ways of working as described above.

4. National and Regional meetings attended

A meeting of the **NHS Providers Community Network** was held on 31st October and the Trust was presented by Vice-Chair Graham Russell. This is reported on more fully in the Chair's report.

I attended a meeting of the **South West Chief Executives** on 13th November where the main theme of the meeting was Care of the Elderly and the role CEOs can play in improving services for older people. Given the demographics within the County and my personal experience with elderly parents this is a matter close to my heart and one on which I am always keen to raise the profile.

I also attended a meeting of the **South West Mental Health Chief Executives** on 15th November where we had presentations from Sean Duggan, CEO of Mental Health Network who gave an update on the national picture and an update on new care models by Melanie Walker MBE, CEO of Devon Partnership NHS Trust. The chance to learn from a Trust which has a track record of effective innovation was very informative.

5. EU Exit

The Trust continues to follow national guidance on this issue and respond to information requests from the Department of Health and Social Care/ NHS England/Improvement.

6. Key Statutory Responsibilities

I would like to formally record the holders of the following key posts within Gloucestershire Health and Care NHS Foundation Trust:

Amjad Uppal, Medical Director - Caldicott Guardian

Sandra Betney, Director of Finance - Chief Information Officer and SIRO (Senior Information Risk Officer)

Sandra Betney, Director of Finance – Lead Executive Director - Health & Safety

Sandra Betney, Director of Finance – Lead Anti-Fraud and Corruption Director

John Trevains, Director of Nursing, Therapies & Quality – Freedom to Speak Up – Executive Lead

Jan Marriott - Freedom to Speak Up – Non-Executive Lead

Sonia Pearcey – Freedom to Speak Up Guardian

AGENDA ITEM: 8

TRUST BOARD, 28th NOVEMBER 2019

Public Questions

"How will the evaluation report on Workforce Race Equality Standard (WRES) be used within the Trust?"

Trust response:

We have used a number of resources to inform our Workforce Race Equality Standard (WRES) action plan. These have included review of the 2019 "A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS" - the WRES Leadership Strategy, the Long Term Plan, evaluation of the legacy Trusts' NHS Workforce Race Equality Standard data and reference to the "Evaluation of the NHS Workforce Race Equality Standard". The latter provided an independent report on an initial evaluation of the national data in January 2019.

The Trust has a named Executive responsible for ensuring commitment and momentum, and, the Board as a whole has committed to delivering improvements in equality and diversity through its adoption of a Valuing Difference Leadership strategy and action plan, which includes the roll out of Reciprocal Mentoring across the Trust, the formation of a Valuing Difference Staff Network alongside the annual WRES action plan.

The WRES actions are being taken forward operationally by the Workforce Management Group chaired by the Director of HR and OD, and reported via the Board's Resources Committee.

Most recently, at the end of October 2019, the Trust also received from Yvonne Coghill, the national Director - WRES Implementation Team, aspirational targets for the legacy Trusts. These are being considered at the next Workforce Management Group's meeting and will be incorporated into our action plan. These include 10-year ambition modelling and targets for increased recruitment of BME staff into more senior levels of the workforce.

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AGENDA ITEM: 9.0

Report to:	Gloucestershire Health and Care NHS Foundation Trust Board – 28th November 2019
Author:	Angie Fletcher, Patient Experience Team Manager & Marit Endresen, Patient Survey Manager
Presented by:	John Trevains, Director of Nursing, Therapies & Quality
SUBJECT:	Service Experience Report Quarter 2 2019/20

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

This report is provided for:

Decision | Endorsement | **Assurance** | **Information**

PURPOSE OF REPORT

This paper provides

1. An overview of people's reported experience of 2gether NHS Foundation Trust (*part of Gloucestershire Health and Care NHS Foundation Trust since 1st October 2019)* services between 1st July 2019 and 30th September 2019. It provides examples of the learning that has been achieved through service experience reporting, and an update on activity to enhance service experience. Appendix 1

2. An overview of people's reported experience of Gloucester Care Services NHS Trust's (*part of Gloucestershire Health and Care NHS Foundation Trust since 1st October 2019)* services between 1st July 2019 and 30th September 2019. Appendix 2

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

RECOMMENDATIONS

The Trust Board is asked to

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

1. Note the contents of these reports.

2. Consider the format of the separate reports and provide an opinion regarding the structure and format of the subsequent merged report.

EXECUTIVE SUMMARY

Mental health services

(1) Assurance
This Service Experience Report provides a high level overview of feedback received from service users and carers in Quarter 2 2019/20. Learning from people's experiences is the key purpose of this paper, which provides assurance that service experience information has been reviewed, scrutinised for themes, and considered for both service-specific and general learning across the organisation.

Significant assurance that the organisation has listened to, heard and understood Service User and carer experience of ^{2}gether's services.
This assurance is offered from a triangulation of information gathered across all domains of feedback including complaints, concerns, comments and compliments. Survey information has been triangulated to understand service experience.

Significant assurance that service users value the service being offered and would recommend it to others.
During Quarter 2 82% of people who completed the Friends and Family Test said that they would recommend ^{2}gether's services, this is the similar to the previous quarter (n=87%).

Limited assurance that people are participating in the local survey of quality in sufficient numbers.
During Quarter 2 2019/20 the response rate has decreased significantly. Following a review of our processes and a desire to seek more feedback, a new system to manage Trust feedback was commissioned that commenced in Quarter 4 2018/19. This has brought us in line with processes used by Gloucestershire Care Services NHS Trust in preparation for our newly formed merged Trust. During quarter 2 we have identified ongoing challenges with the changeover in systems of FFT data processing.

Significant assurance that services are consistently reporting details of compliments they have received.
Compliments continue to be reported to the Service Experience Department. Numbers have decreased slightly during Quarter 2 and work continues to increase reporting by colleagues throughout the Trust.

Significant Assurance that complaints have been acknowledged in required timescale
During Quarter 2 94% of complaints received were acknowledged within 3 days.

<u>Limited assurance</u> that all people who complain have their complaint dealt with by the initially agreed timescale.
47% of complaints received final response letters within timescales agreed with the complainant. This is a slight decrease from the previous quarter (53%). The SED are working hard with Trust colleagues to ensure that future complaints are investigated and responded to in a timely way.

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

(2) Recommended learning and improvement
The Trust continues to seek feedback about service experience from multiple sources on a continuous basis.
This quarter concerns and complaint themes continue to focus on communication issues by our services with service users and/or their carers. Colleagues across the Trust are working hard to develop practice in this area.

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

- We must make sure that we talk to and listen to all those involved in a person's care.

- We must make sure that people understand our explanations and the information that we give them.

(3) Risk issues
Survey response rates continue to be lower than hoped; this area is identified as having *limited assurance* within the Quarter 2 report.
This risk is logged on the Trust Risk Register and a structured plan is in place led by SED to increase response numbers.

From 1st October onwards the Patient Experience Department will have a dedicated survey lead and work stream to focus on seeking feedback via differing survey methods with the aim of increasing response rates and obtaining more opinion and meaningful data about the services that we provide.

<u>Physical health services</u>

This report provides a summary of complaints, concerns and compliments raised during Qtr. 2 2019-20 and an overview of the Friends and Family Test results during this period. One complaint was referred to the Parliamentary Health Service Ombudsman during this Quarter.

Corporate Considerations	
Quality implications	Patient and carer experience is a key component of the delivery of best quality of care. The report outlines what is known about experience of [2]gether's & GCS services in Q2 2019/20 and makes key recommendations for actions to enhance quality.
Resource implications:	The report offers assurance to the Trust that resources are being used to support best service experience.
Equalities implications:	The report offers assurance that the Trust is attending to its responsibilities regarding equalities for service users and carers.
Risk implications:	Feedback on service experience offers an insight into how services are received. The information provides a mechanism for identifying performance, reputational and clinical risks. This paper offers limited assurance on 2 aspects covered by the report and the team are working with operational and clinical colleagues in order to identify and mitigate any risks associated with this. The team closely monitor performance indicators relating to areas of limited assurance and regularly review the mitigating actions accordingly.

WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?			
Working together	P	Always improving	P
Respectful and kind	P	Making a difference	P

Report authorised by: Gordon Benson, Associate Director of Clinical Governance & Compliance	**Date:** 30.10.19

Where has this issue been discussed before? **Quality Committee – 7th November 2019** **Quality Assurance Group – 15th November 2019**
What wider engagement has there been?

Appendices:	Appendix 1 – Service Experience Report (2G) Appendix 2 – Gloucester Care Services; Complaints, Concerns , Compliments and FFT update

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Service Experience Report

Gloucestershire and Herefordshire Mental Health and Learning Disability services provided by 2gether NHS Foundation Trust

(Since 1st October 2019 2gether NHS Foundation Trust is known as Gloucestershire Health and Care NHS Foundation Trust)

Quarter 2

1st July 2019 to 30th September 2019

"We want to express our appreciation of the care our son received because it was timely and professional and has made a rapid recovery and we felt fully supported at all times."

CRHTT, Gloucestershire

Thank you for all the support you and the LD team gave us putting everything needed together to enable us to support the service user in the last few years.

CLDT, Herefordshire

working together | always improving | respectful and kind | making a difference

Main office: Edward Jenner Court, Pioneer Avenue, Gloucester Business Park, Brockworth, Gloucester, GL3 4AW
Chair: Ingrid Barker Chief Executive: Paul Roberts

Contents

Key

NHS	National Health Service
PALS	Patient Advice and Liaison Service
CYPS	Children and Young People Service
SED	Service Experience Department
CEO	Chief Executive Officer
IAPT	Improving Access to Psychological Therapies
PHSO	Parliamentary and Health Service Ombudsman
CQC	Care Quality Commission
CHI ESQ	Children's Experience of Service Questionnaire
CAMHS	Child and Adolescent Mental Health Service
Mental Health Act	Mental Health Act
LGO	Local Government Ombudsman
Q1	Quarter 1 (previous quarter 2019/20)
FFT	Friends and Family Test (survey)
2gether NHS Foundation Trust	Since 1st October 2019 2gether NHS Foundation Trust is known as Gloucestershire Health and Care NHS Foundation Trust

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

Service Experience Report

Gloucestershire and Herefordshire Mental Health and Learning Disability services provided by 2gether NHS Foundation Trust

1st July 2019 to 30th September 2019

Complaints 	**18** complaints were made this quarter. This is less than last time (Q1=29). We want people to tell us about any worries about their care. This way we can help to make things better.	↓
Concerns 	**59** concerns were raised through PALS. This is more than last time (Q1=54).	↑
Compliments 	**376** people told us they were pleased with our service. This is less than last time (Q1=466). We want teams to tell us about every compliment they get.	↓
FFT 	**82%** of people said they would recommend our service to their family or friends. This is about the same as last time (Q1=85%).	↔
Quality Survey 	Gloucestershire: **72** people told us what they thought. This is less than last time (Q1=102) Herefordshire: **8** people told us what they thought. This is a lot less than last time (Q1=124) We want more people to tell us what they think.	↓ (number of replies)
We must listen 	We must make sure that we talk to and listen to all those involved in a person's care. We must make sure that people understand our explanations and the information that we give them.	

Key

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

Section 1 – Introduction

1.1 Overview of the paper

1.1.1 This paper provides an overview of people's reported experience of ²gether NHS Foundation Trust (*part of Gloucestershire Health and Care NHS Foundation Trust since 1st October 2019)* services between **1st July 2019 and 30th September 2019**. It provides examples of the learning that has been achieved through service experience reporting, and an update on activity to enhance service experience.

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

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

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

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

1.2 Strategic Context

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

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

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

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

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

Section 2 – Emerging Themes about Service Experience

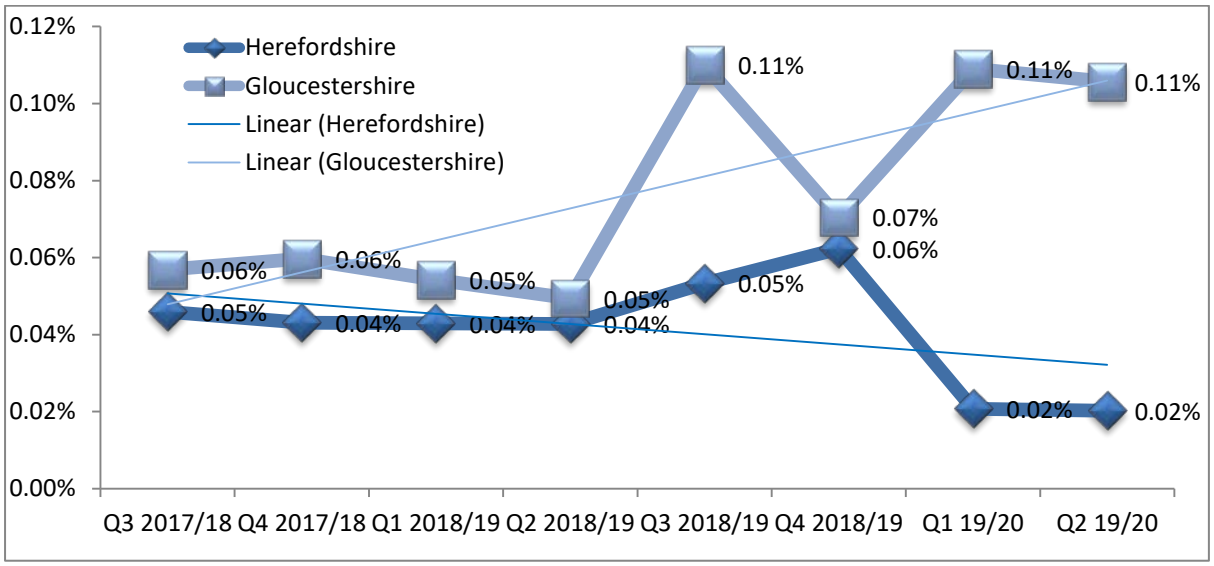
2.1 Complaints

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

Table 1: Number of complaints received this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	16	↓	The number of complaints reported in Gloucestershire is much fewer than the previous quarter (Q1=28)	Significant
Herefordshire	2	↑	The number of complaints reported in Herefordshire is more than the previous quarter (Q1=1)	Significant
Total	18	↓	The total number of complaints received has decreased from the previous quarter (Q1=29)	Significant

Figure 1: Trend line of complaints received over time in Herefordshire and Gloucestershire. Figure 1 also illustrates quarterly % numbers of people who complain in relation to the actual number of individual contacts made with services.



2.1.2 Figure 1 shows the percentage of complaints received in relation to the number of individual contacts made with our services during each quarterly period since Q3 2017/18. During Quarter 2 2019/20 Gloucestershire and Herefordshire experienced no change in the rate of complaints received in relation to individual contacts. Whilst there have been minor fluctuations quarter by quarter, a continual low level of complaints to contacts has been observed over time.

2.1.3 Table 2 summarises our responsiveness. This quarter has seen a continued high level of responsiveness from our Service Experience Department when acknowledging complaints, although is slightly lower than the previous quarter.

Table 2: Responsiveness

Target	% Number	Direction compared with Q3	Interpretation	Assurance
Acknowledged with three days	94%	↑	**17 of 18** complaints were acknowledged within target timeframes, which is slightly higher than last quarter (Q1=93%)	Significant
Response received within agreed timescales	47%	↓	This is slightly lower than last quarter (Q1=53%). 16 letters of response were not received by the complainant within the timescale agreed (30 were due out in this quarter).	Limited
Concerns escalated to complaint	5%	↓	Of 62 concerns closed (Q1=65 closed), three were escalated to a formal complaint; this is less than last quarter (Q1=9%)	Significant

2.1.4 16 complaint responses were not received within initially agreed timescales. Nine responses were late due to delays in the investigation being returned to SED, four due to SED resources, and three due to delays within our quality review processes. On each occasion the complainant was contacted in order to provide an explanation, an apology, and an expected date that our response would be sent to them.

2.1.5 The merger of 2gether NHS Foundation Trust with Gloucestershire Care Services NHS Trust to create Gloucestershire Health and Care NHS Foundation Trust will allow development of our Service Experience Department to review the way complaints are managed in order that response times our improved.

2.1.6 The SED continue to monitor delayed response rates carefully, working closely with operational and corporate colleagues to ensure that our Complaints Policy is adhered to in relation to all aspects of complaint handling.

Table 3: Satisfaction with complaint process

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

2.1.6 In Quarter 2, three recently closed complaints were reopened. One is awaiting a Local Resolution Meeting, one reopened because a clinic letter required amendment, and another reopened for additional investigation following a request for clarification from the complainant

2.1.7 Analysis of data is undertaken by the SED in order to identify any patterns or themes. Analysis of complaints closed during Quarter 2 is shown by the status of complaint outcome (Table 4).

Table 4: Outcome of complaints closed this quarter

Outcome	No.	%	
Not upheld *No element of the complaint was upheld*	10	38%	Following feedback from complainants and stakeholders, the Trust no longer uses the terms upheld/partially upheld/not upheld within our

Partially upheld *Some elements of the whole complaint were upheld*	13	50%	response letters. However, the outcomes of investigations are recorded and required for national reporting purposes. In total, 26 complaints were closed this quarter. This is more than the number of complaints closed in Quarter 1 (n=23). 54% of the complaints closed this quarter had at least some or all issues of complaint upheld. This is more than Quarter 1 (43% upheld/partially upheld).
Upheld *All elements of the whole complaint were upheld*	1	4%	
Withdrawn *All elements of the whole complaint were withdrawn*	2	8%	

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

2.1.8 Table 5 shows the outcome following investigation of complaints in relation to the staff group involved in individual issues of complaint. Nursing and Medical colleagues have the most amount of contacts with people and continue to feature as the staff groups most frequently involved in complaints received. It is reassuring to see that following investigation the numbers of investigations that are partially or fully uphold the issues raised is low.

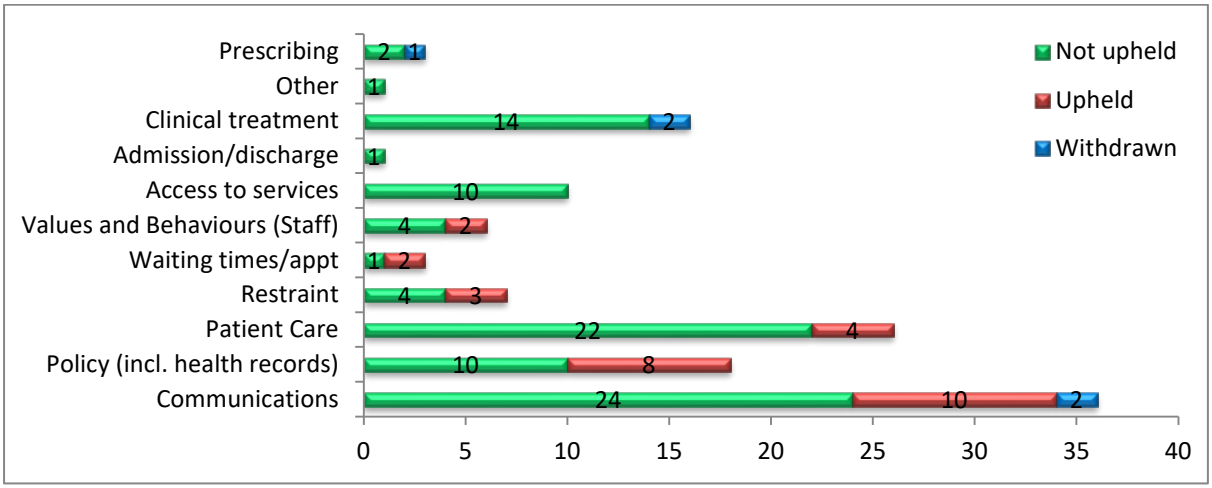
Table 5: Breakdown of closed complaint issues by staff group

	Not upheld	**Upheld**	Withdrawn	Total
Medical	28	**11**	5	44
Nursing	36	**10**	0	46
HCA	3	**1**	0	4
Social Worker	5	**0**	0	5
AHPP	3	**5**	0	8
PWP	4	**0**	0	4
Other	1	**1**	0	2
No staff involved	13	**1**	0	14
Total	93	**29**	5	127

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

2.1.9 Table 6 provides an overview of the issues of complaint in the context of the investigation outcome (upheld or not upheld). Analysis of this information shows that the main themes emerging from the Q2 issues of complaint that were upheld (n=29) following investigation, related to aspects of the reported experience of ***communication*** and ***policy (incl. health records)***.

Table 6: Overarching closed complaint themes (by subject and outcome)



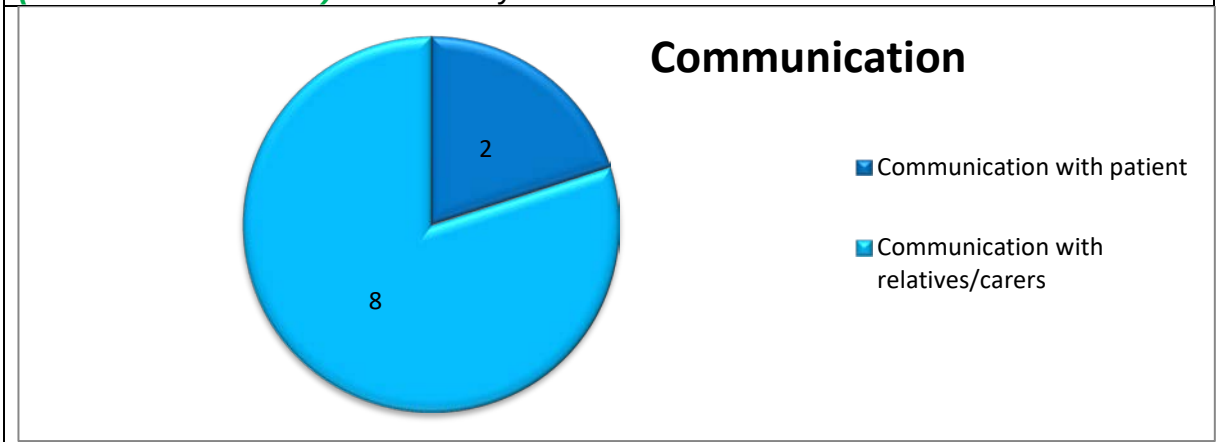
2.1.10 Communication and care and treatment are recurrent themes found to be reported as issues of complaint that are also found to dominate thematic data nationally.

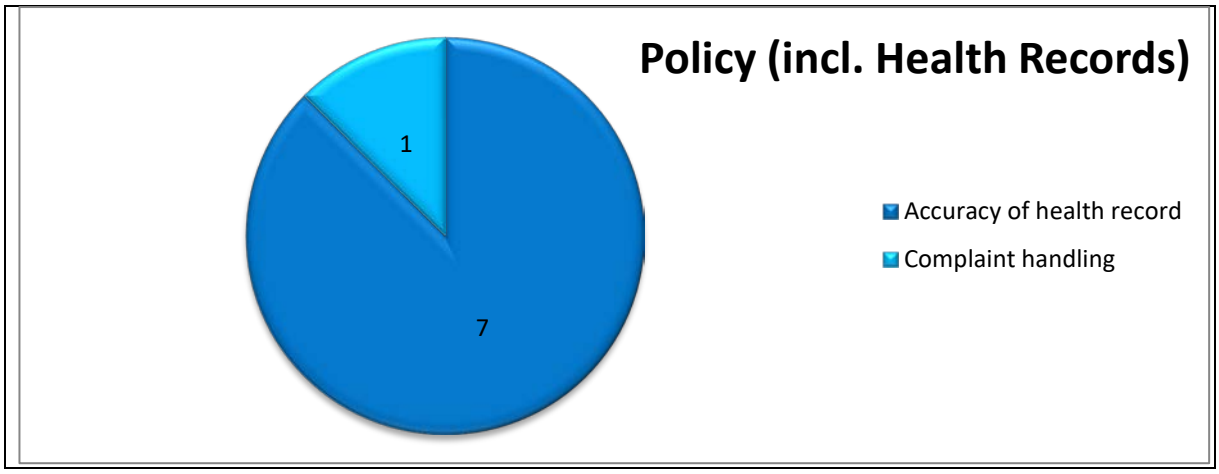
Following the investigation of complaints raised these areas are found to have a low level of issues being upheld. The area with the greatest number of issues upheld following investigation relate to ***communication*** and ***policy (incl. health records)***, further analysis of this is shown in Figure 2.

Figure 2: Review of identified complaint themes

Breakdown of upheld complaint issues

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





2.1.11 SED have undertaken further analysis of the issues of complaint relating to aspects of policy, procedure and health records that were upheld following investigation of these matters and found that the majority of issues related to a multifaceted complaint that reviewed written communication that was found to contain factual inaccuracies.

The SED have continued to work with operational colleagues throughout Quarter 2 to implement systems of learning from service experience feedback. Practice notes detailing learning from complaints continue to be produced monthly and disseminated throughout our locality governance boards for onward review and discussion by our teams and services. The learning from issues represented in Figure 2 has been included in this quarter's practice notes and is detailed further in section 3 of this report.

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

Table 8: Examples of complaints closed and action taken

Example	You said	We did	Assurance
Communication	A family complained that when the service user did not return from leave as planned they were not informed until they contacted the ward to check on the service user's welfare	We reminded staff of the actions required when identifying a service user has not returned from leave within what the Section 17, risk assessment and care plans say, and to ensure that risk assessments and care plans reflect all agreements they have for managing a service	Significant

Example	You said	We did	Assurance
		user's leave	
Care and treatment	A service user complained that a consultant psychiatrist did not recall prescribing anti-psychotic medication for her a few weeks earlier.	A discussion documented in the health record suggested that the consultant had a discussion with nursing staff regarding what medication may be helpful for this service user and the nurse agreed to discuss this option with the GP to consider prescribing. Where shared health care recording systems are not available it is good practice for medical colleagues to record clinical discussions with GPs and other colleagues regarding patient care	Significant

2.2 Concerns

2.2.1 Our Trust endeavours to be responsive to feedback and to resolve concerns with people at the point at which they are raised. This has resulted in complaint numbers being maintained at a lower level and a corresponding increase in the number of PALS contacts over time. Data regarding the concerns received by our SED have been analysed and are reflected in Table 9.

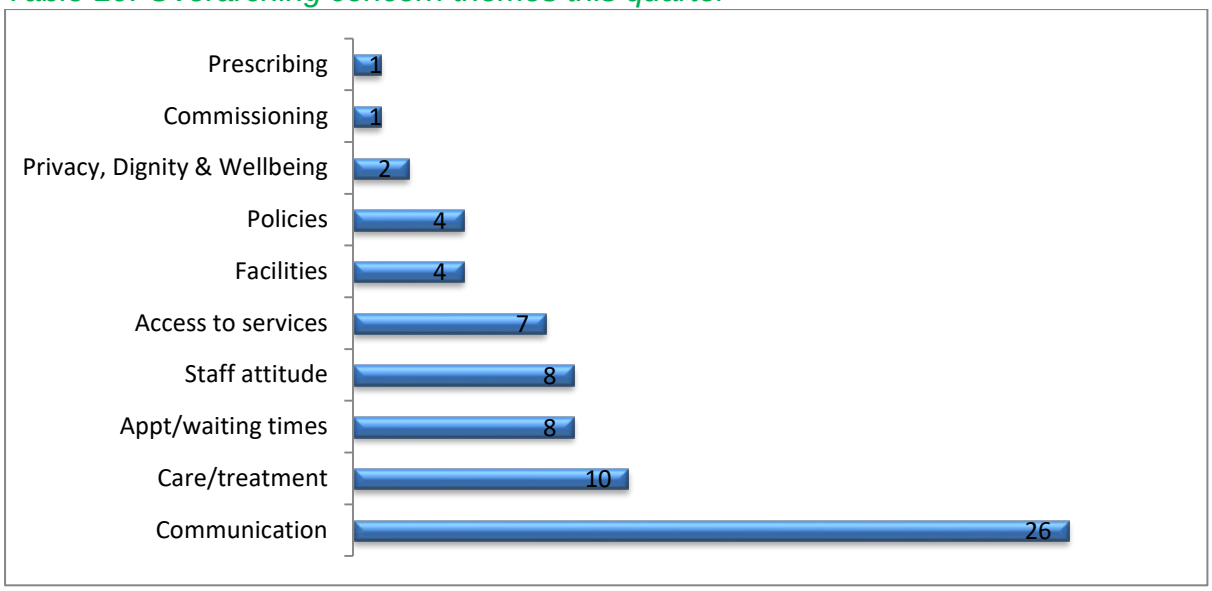
Table 9: Number of concerns received this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	47	↑	The number of concerns raised in Gloucestershire is more than the last quarter (Q1=44)	Significant
Herefordshire	10	↑	The number of concerns raised in Herefordshire is more than the last quarter (Q1=7)	Significant
Corporate	2	↓	The number of concerns raised relating to corporate services is slightly less than last quarter (Q1=3)	Significant
Total	59	↑	The number of concerns raised is higher than last quarter (Q1=54)	Significant

2.2.2 The number of concerns raised remains relatively consistent with previous quarters and has increased slightly in comparison to last quarter. The themes of concerns raised during this quarter are captured in Table 10.

There were also 75 other contacts with our Service Experience Department during Quarter 1 (Q1=55) covering a range of topics.

Table 10: Overarching concern themes this quarter



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

2.2.3 Table 10 outlines the themes from concerns that have been closed this quarter. The main theme identified is ***Communication***, which is also a recurrent theme within analysis of issues of our formal complaints and is found to tie in closely with the theme of policy procedure and health records in terms of explaining what our services are able to offer in order to meet people's expectations of the support and services that are available.

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

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

Staff group	No	
Medical	18	Our Nursing and Medical colleagues represent the largest staff group in the Trust with the greatest number of contacts with service users and carers. Work is ongoing to ensure that professional leads are made aware of any themes relating to their staffing group.
Nursing	16	
Other	12	
Admin	4	
Psych.Wellbeing	4	
Social Worker	2	
Hotel Services	1	
HCA	1	
None	13	

2.2.5 Examples of concerns and actions taken during this quarter are shown in Table

Table 12 Examples of concerns and action taken:

Example	You said	We did	Assurance
Care and treatment	Service user feels that the team are patronizing and feels he would like to change psychiatrist and Care coordinator	SED arranged with team for new team to be allocated and informed service user	Significant
Mental Health Act	Service user raised concerns about being illegally detained under the Mental Health Act	Explained reason and rationale for detention with Service User who remain dissatisfied - escalated to formal complaint	Significant
Noise	Member of public complained about noise from an inpatient area	Discussed with matron – email sent to all relevant staff to remind them to close any opened windows or doors to lessen the noise when service users are being noisy. Escalated to the Estates Department to see if there is any further solution to lessening the noise.	Significant

2.2.5 PALS Visits

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

2.2.5.2 During each visit the SED PALS Officers visited the designated wards and community hub to speak with service users and families/carers.

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

- Liaison with ward staff and users to resolve queries relating to the ward environment.
- Note compliments regarding services and staff from carers and service users
- Request information to respond to our Friends and Family Test
- Offer support to give feedback about Trust services

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

- Feedback about food served on the wards has been mixed with some service users reporting too much food and others saying the portions are too small. Some feel the quality of the food is bad, others say it is excellent
- Varied views about the ward environment with some people saying the ward was too loud and others commenting that they felt safe and enjoyed the activities on offer
- Feedback about the ward staff has been mainly positive in nature, such as, staff are all very good, supportive, and approachable. Other comments related to busy staff not always being available, and there not being enough staff on the ward

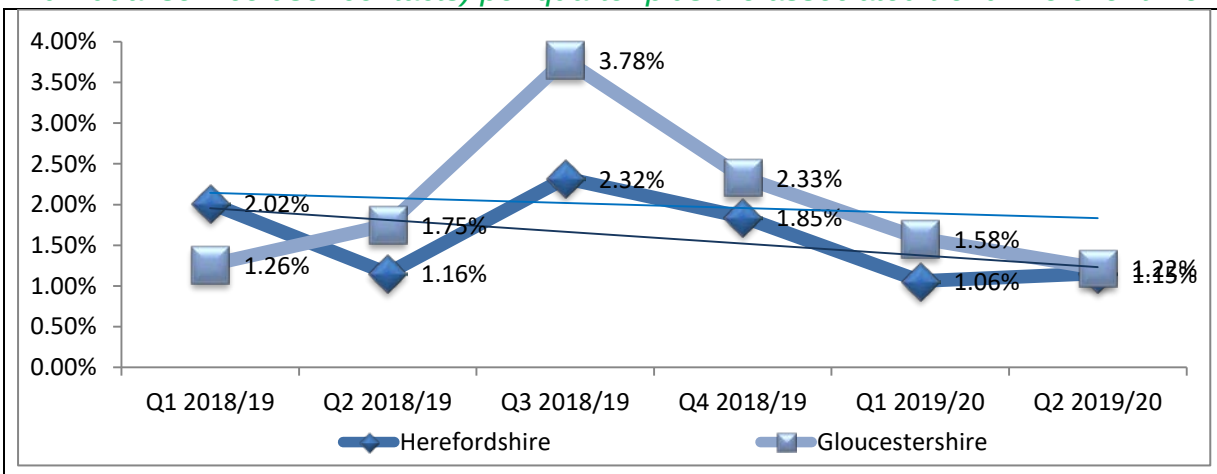
2.2.5.5 The majority of feedback given has been positive and any issues raised were reported directly to the ward for timely resolution wherever possible. A summary report of each visit is sent by the PALS Officers to the Ward Manager, Modern Matron, Deputy Director of Nursing, Estates and Facilities and Locality Governance Lead.

2.3 Compliments

2.3.1 The SED continues to encourage the reporting of compliments received by Trust services. **376** compliments were received this quarter. This is a

decrease when compared to Quarter 1 (n=466). A dedicated email address is set up to simplify the process for colleagues to report compliments that they have received: 2gnft.compliments@nhs.net. Figure 3 shows the percentage of compliments to contacts as reported during Quarter 2 and the previous 4 quarters.

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



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

Examples of compliments received during this quarter:

I've had a wonderful time volunteering at Oak house, Herefordshire. It's been a fantastic opportunity and I've very much enjoyed myself. Thank you for your support and for finding me such a great opportunity.

Oak House, Herefordshire

I wanted to thank you for running the health event yesterday – I found it incredibly beneficial and came away with a lot of knowledge and resources

Learning Disabilities Health Facilitation, Gloucestershire

We want to express our appreciation of the care our son received. It was so timely and professional. Our son has made a rapid recovery and we felt fully supported at all times. Many of the Crisis staff spent a long time listening and talking to our son so he was able to voice his fears and frustrations as he moved through the healing process and he felt safe and acknowledged.

Crisis Team, Herefordshire

I would like to tell you how much I appreciate all the work that you have done for me.

Psychology Service, Gloucestershire

2.4 Complaints referred for external review following investigation by our Trust

2.4.1 Current open referrals for external review:

Table 13: current open referrals for external review

Reviewing organisation	Date of first contact from reviewing organisation	Date official investigation confirmed	Current status of referral	Assurance Level
LGO (172)	23/01/2018	03/04/2018	22/08/2019: closed by LGO following completion of their suggested recommendations, financial remedy and Trust apology	
PHSO (1243)	04/09/2018	29/10/2018	Investigation ongoing	
PHSO (415)	18/10/2018	24/01/2019	Investigation ongoing	
PHSO (1498)	19/03/2019	Declined	15/07/2019: PHSO declined to investigate	
PHSO (1359)	30/04/2019	Status unconfirmed	Awaiting further update from PHSO	
PHSO (2538)	03/05/2019	Status unconfirmed	Awaiting further update from PHSO	
PHSO (2478)	22/05/2019	Declined	12/09/2019: PHSO declined to investigate	
PHSO (1567)	24/05/2019	Status unconfirmed	Awaiting further update from PHSO	

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

2.4.2 Referrals made for external review of complaint this quarter

No referrals were made to the PHSO during this quarter by complainants requesting an external review of complaints that had previously been investigated by and responded to by our Trust.

2.4.3 Completed external complaint investigations

Two complaints referred for external review were declined for investigation by the PHSO during quarter 2.

2.5 Surveys

2.5.1 'How did we do?' Survey

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

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

2.5.1.3 For the past 3 years we have utilised an external provider to input and manage our survey feedback. Following a review of our processes and a desire to seek more feedback, a new system to manage Trust feedback has been commissioned that commenced in Quarter 4 2018/19. This has brought us in line with processes used by Gloucestershire Care Services NHS Trust in preparation for our newly formed merged Trust.

2.5.1.3From 1st October onwards the Patient Experience Department will have a dedicated survey lead and work stream to focus on seeking feedback via differing survey methods with the aim of increasing response rates and obtaining more opinion and meaningful data about the services that we provide.

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

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

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

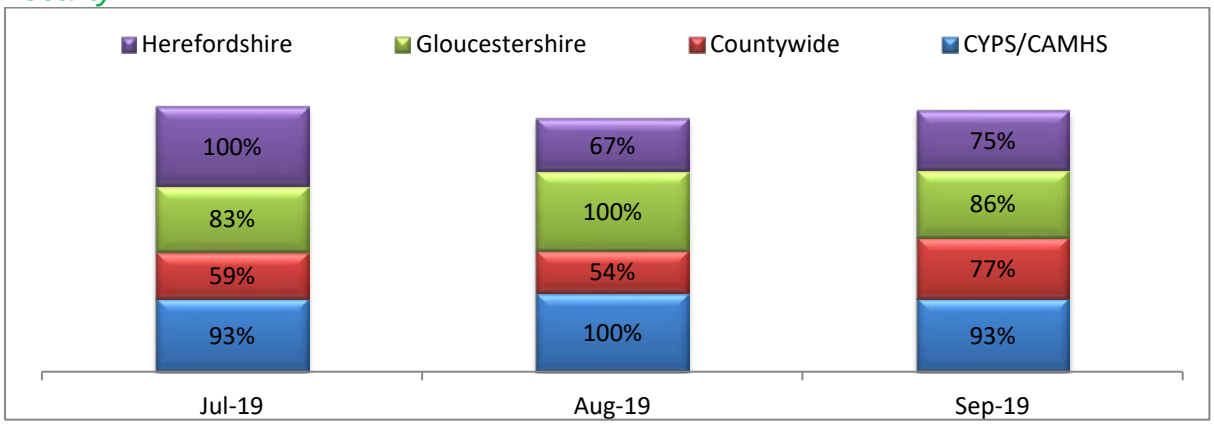
2.5.2.2 Table 14 details the Trust-wide number of responses received each month. The FFT score is the percentage of people who stated that they would be 'extremely likely' or 'likely' to recommend our services. The FFT questionnaire is available in all Trust services.

Table 14: Returns and responses to Friends and Family Test

	Number of responses	FFT Score (%)
July 2019	76 (60 positive)	79%
August 2019	40 (33 positive)	83%
September 2019	53 (46 positive)	87%
Total	169 (139 positive) **(last quarter = 732)**	**82%** **(last quarter = 85%)**

2.5.2.3The FFT score for our Trust this quarter is about the same as last quarter. The response rate has decreased significantly however we have identified ongoing challenges with the changeover in systems of FFT data processing and SED are working hard to remedy this difficulties.
The current FFT score suggests that the majority of people who responded to our survey experienced a high level of satisfaction with the services that we provide.

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

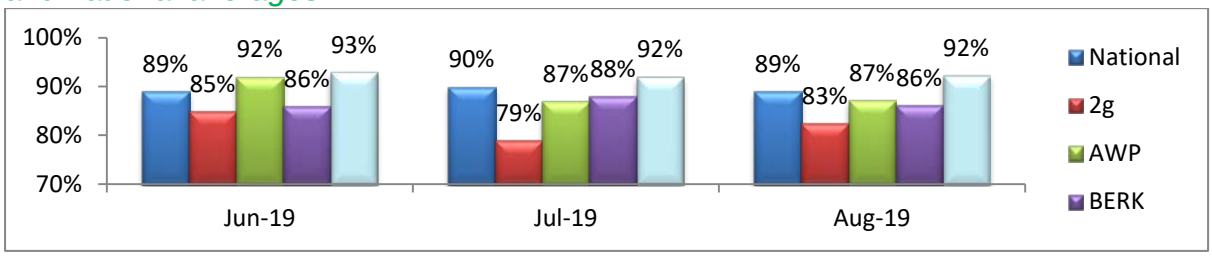


2.5.2.5 The FFT score for our Trust has remained about the same this quarter; this continues to be encouraging news following disappointing decreases seen in previous quarters last year.

SED continue to monitor FFT scores and undertake further analysis of scores to identify any areas that are influencing lower ratings.

2.5.2.6 Figure 5 shows the FFT Scores for June, July, and August 2019, (the most recent data available) compared to other Mental Health Trusts in our region, and the average of Mental Health Trusts in England. Whilst our Trust has not achieved the highest percentage of recommendation compared with some neighbouring Trusts, our response rates have increased suggesting that the feedback is reflective of a larger group of respondents. This gives some assurance and can be triangulated with national scores of patient survey.

Figure 5: Friends and Family Test Scores – comparison between the regional data and national averages[2]



2.5.3 How did we do?

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

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

Question	County	No. of responses	Target Met?
Were you involved as much as you wanted to be in agreeing the care you receive?	Gloucestershire	64 (51 positive)	**79%** TARGET 84%
	Herefordshire	8 (6 positive)	
Have you been given information about who to contact outside of office hours if you have a crisis?	Gloucestershire	72 (53 positive)	**74%** TARGET 71%
	Herefordshire	8 (6 positive)	
Have you had help and advice about taking part in activities that are important to you?	Gloucestershire	58 (42 positive)	**74%** TARGET 64%
	Herefordshire	8 (7 positive)	
Have you had help and advice to find support for physical health needs if you have needed it?	Gloucestershire	62 (55 positive)	**89%** TARGET 73%
	Herefordshire	8 (7 positive)	

2.5.3.2 Feedback from the Quality Survey along with the annual National Community Mental Health survey results helped us to identify the need to increase the involvement of people in the development of their care plans. This is the focus of our work to implement an Always Event as part of the NHS England campaign and an increased drive for co-production across our services.

2.5.3.3 Although response rates for the survey have increased over time the level of response continues to be lower than we would like. During Quarter 2 we have

[2] 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

continued to implement a new system to capture survey feedback with aim to increase the number of responses we receive to both aspects of the 'How did we do?' survey.

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

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

2.5.4.2Feedback questionnaires are sent to people following the initial assessment and after discharge from the service. Quarter 2 feedback suggests that people are largely satisfied with these elements of the Let's Talk service.
Work is in progress to review and analyse data and feedback received from the IAPT-PEQ for future quarterly reporting to identify themes and trends in this area.

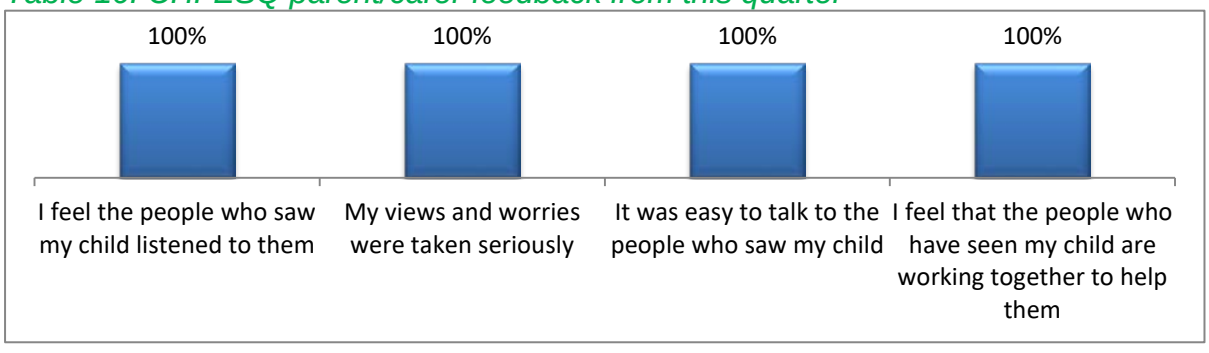
2.5.5 Children and Young People Service (CYPS)

2.5.5.1 CYPS gather service feedback using the Experience of Service Questionnaire, known as CHI-ESQ which is a nationally designed survey to gain feedback from children, young people and their parents/carers. There are three versions of the CHI-ESQ survey, these are identified by age and role type as follows: Age 9 -11 yrs, Age 12 -18 yrs and Carer or Parent.

All the surveys ask questions based upon the same theme but are presented differently in an age appropriate format.

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

Table 16: CHI-ESQ parent/carer feedback from this quarter



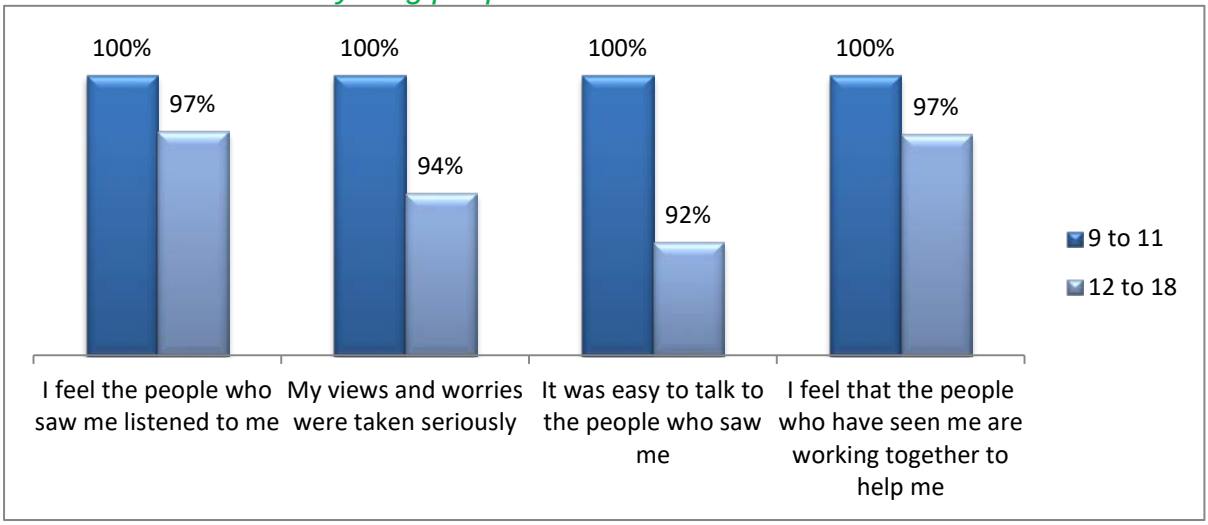
Examples of some feedback given by carers/parents:

I found it very difficult not to have any feedback and not know how my daughter was feeling or what I could do to help

The support and care given by the team has been amazing and helped us through a very difficult time

The service has been very good and I hope funding for youth services and mental health in general is increased to continue helping people when they need it the most

Table 17: Children and young people feedback



2.5.5.3 This information is shared with CYPS colleagues so that it can be used by them to deliver service improvements.

Examples of some feedback given by children and young people:

Section 3 – Learning from Service Experience Feedback

Section 3.1 – learning themes emerging from individual complaints

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

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

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

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

Practice Note number	Organisational Learning
2915 (part one)	• Staff to be reminded of the importance of post-PMVA restraint requirements for physical monitoring for up to 24 hours and if this is not required then appropriate RiO entry to be completed • Staff to be reminded of the importance of the MERT Assessor being present for every planned and unplanned restraint

Practice Note number	Organisational Learning
	• Staff to be reminded of the importance of a post restraint debrief for the service user, and if this is offered and declined to record this on RiO • Staff to be reminded to complete Positive Behavioural Support Plans (PBSP) as per PMVA Policy • Staff to be reminded to return beds (along with any other furniture moved) to their position pre-restraint
2915 (part two)	• Staff to be reminded of the actions required when identifying a service user has not returned from leave within what the Section 17, risk assessment and care plans say • Staff to be reminded of ensuring that risk assessments and care plans reflect all agreements they have for managing a service user's leave so that there is no confusion and they are followed
2770 (part one)	• When medications are prescribed or recommended for prescription, it should be made clear: when that should be, whether the review is expected in secondary or primary care, and who is responsible for following up the recommendations • Systems could be improved in relation to communication between health professionals – this will be brought to the attention of relevant staff to look at ways in which this can be improved within our services going forward
2770 (part two)	• Ensure clearer liaison between mental health and physical health providers – if a Frequent Attender Plan exists for use in the acute hospital, then reference to its existence and a copy of it should be available in RiO • The coming implementation of the (Joining Up Your Information) JUYI service across all Gloucestershire services will give the general hospital teams access to the crisis and contingency plans

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

Effective dissemination of learning across the organisation is vital to ensure ²gether's services are responsive to people's needs and that services continue to improve. Service Experience feedback has continued to contribute to our learning from Incidents, Complaints and Claims.

Section 3.3 – Assurance of learning and action from aggregated learning themes from Quarter 1 2019/20

The learning shown in Table 18 is shared with localities via practice notes on a monthly basis who disseminate these amongst colleagues and feedback learning and actions through our Quality & Clinical Risk Committee (QCR) where aggregated learning themes are identified and compiled to be included in the Learning ²gether from Incidents, Complaints and Claims reports. The process by which learning is

embedded within the organisation is described our *Policy for Continuous Improvement (Aggregated Learning Policy).*

Gloucester Care Services NHS Trust physical health complaints, concerns, compliments and Friends and Family Test (FFT) update

1. Introduction and Purpose

The purpose of this report is to inform the Committee of complaints, concerns and compliments received during Qtr. 2 2019-20 (July-September 2019). The report also provides an overview of the Friends and Family Test (FFT) responses during this period.

2. Complaints

Between 1st July and 30th September 2019 the Trust received 10 complaints. Two of the complaints are still under investigation and one is awaiting feedback from Gloucestershire Hospitals NHS Foundation Trust before a full response can be compiled.

The breakdown of the eight complaints is as follows:

- Minor Injuries and illness Unit, Stroud (1)
- Community Nursing Service (Gloucester 2, Stroud 1)
- MSK Physiotherapy Service (1)
- Podiatry Service (1)
- Sexual Health Service (2)
- Gloucestershire Wheelchair Service (1)
- CYPs Complex care Service (1)

See detailed information at Appendix 1.

3. Concerns

During Qtr. 2 2019-20 the Trust received 107 concerns; this number is in line with the average number (the current average is 105 per quarter).

In summary, the main trends from these concerns include:

- *Minor Injuries and illness Units (MIiUs):* As in the previous quarter a high proportion – 25 of the 107 concerns – involved the MIiUs. The prevalent topics are waiting times; patients not being kept informed whilst waiting, and that to patients it appears that they are being kept waiting even though there are no other patients around and the MIiU does not seem to be busy. Of the 25 concerns, eight also involved the lack of/reduced x-ray facilities, including patients being kept waiting so long that when they are seen and referred to x-ray, then that facility is closed and the patient either has to attend acute hospital A&E, an alternative MIiU or to return to the MIiU the next day.
- *MSK Physiotherapy*: This service continues to receive administrative concerns (five this Quarter); generally because some people struggle with the online self-referral form. Some patients say they are not clear what to

expect from a MSK Physiotherapy appointment i.e. will they be assessed, treated there and then, or referred on and to where?

- *Inpatient care, Community Hospitals*: There have been six concerns this Quarter regarding inpatient care, including the reduced level of physiotherapy available on the wards (towards rehabilitation) and unsatisfactory liaison with the patient's family regarding patient discharge arrangements. There have, however, been practical improvements made to discharge procedures in the last year, prompted by concerns raised previously. Subsequently there has been a quantifiable reduction in the concerns raised regarding hospital discharge in recent months.
- *Community (District) Nursing*: There were eight concerns raised regarding Community Nursing care; four of these were due to delayed or postponed home visits. The others were regarding communications and co-ordination with other services (e.g. GPs, Community Palliative Care). In every case the pressure upon the Community Nursing services (including staff shortages) was a clear factor.

4. Compliments

The Trust received 463 compliments in the reporting period; the number of compliments has increased significantly as more GCS Services have the facility to input their own compliments onto the Datix reporting system.

- *The Elmbury Suite at Tewkesbury Hospital* (mainly cataract procedures) continues to generate a high number of compliments; 33 this quarter.
- *Inpatients and their families* have also provided many compliments for the care on the community hospital inpatient wards; all of the hospitals have received many compliments. Stroud, Cirencester and Tewkesbury Hospitals have slightly more than the others this quarter.
- *The MIIUs* received 27 compliments between them; nine of these were for the Forest MIIUs at both The Dilke and Lydney Hospitals. These most often refer to the kindness and skill of the nurses and the friendliness of the reception staff too.
- *The Sexual Health Service* received 12 compliments in the reporting period.

5. Parliamentary Health Service Ombudsman (PHSO)

For the period 1st July to 30th September 2019, one case was reported as referred to the PHSO, however the PHSO made the decision not to investigate.

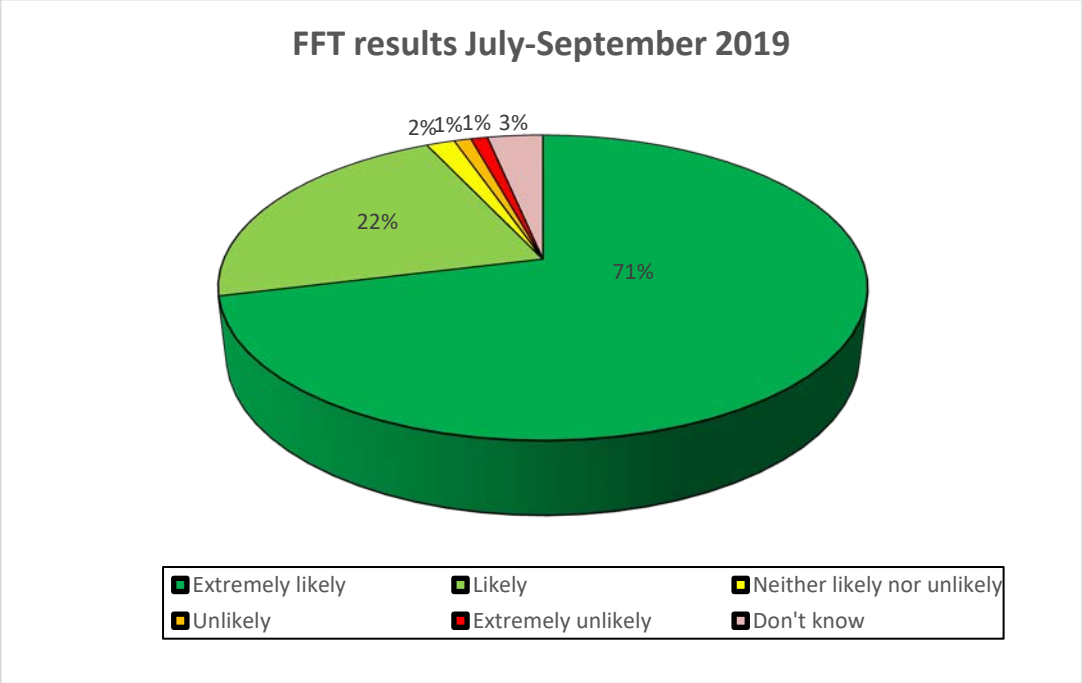
6. *Non-Executive Director (NED) Audit of Complaints*

No audits have taken place during 2019-2020

7. Friends and Family Test (FFT)

During Qtr. 2, 9,248 responses were received giving a response rate of 14% on average. This is slightly below the expected 15% target which is mainly due to no CYPs Immunisation FFTs being undertaken during August and some services seeing a slight decrease in responses during the summer period, which is not unusual for this time of the year.

93% of the respondents said they were extremely likely or likely to recommend the service, as illustrated in the graph below:



The word cloud below shows an overview of feedback from patient across all services:

8. Conclusion

The number of complaints were slightly lower than average and the number of concerns during this quarter were in line with the Trust average. The Trust

continues to see an increase in the number of compliments due to self-reporting on Datix.

The FFT results showed a slight decrease in the response rate; this was mainly due to some services receiving less response over the summer period and no CYPs immunisation FFTs being completed during August. 93% of respondents were extremely likely or likely to recommend the service; this is in line with the average score.

Appendix 1 – Details of complaints received Quarter 2 2019/20

Ref	Locality (service)	Concerns	Identified Actions	Status
10614	CYPs Complex Care Team (named professional)	Parents of child with complex needs questioning the professionalism of a named member of staff who have been raising concerns about their family to other professionals without their knowledge and without being directly involved in their	**UPHELD** **Team leader** The evidence would suggest currently there are gaps in performance in what are key roles and responsibility in the skills matrix for a band 7 team leader: • *Managing a team's competency in record keeping, holding difficult conversations and developing and maintaining up to date and accurate personalised care packages.* • *Managing the team's access to Safeguarding processes and supervision options.* • *Record keeping* • *Confidentiality and information sharing / gaining consent* • *Manging and facilitating the CHC framework to deliver reactive person centred packages of care that address unmet need by managing and coordinating a clear assessment and review framework.* • *Communication with families* **The investigation and interviews held have highlighted some additional CYPS service delivery learning opportunities:** **Training needs:** • *The Complex Care Team and Team Leader would benefit from training on managing difficult conversations.* • *In addition the use of the safeguarding advice line would also support practice if staff do have concerns and need clarification on whether an unmet need is a safeguarding concern.*	**Completed (action plan to be confirmed and updated)**

Ref	Locality (service)	Concerns	Identified Actions	Status
			Communication: • *Rotas to be provided in a reasonable timeframe to allow families to plan other commitments/arrangements* • *Negotiate variable day hours with family* • *Open transparent conversations with parents and clear accurate documentation in the home and on S1* • *Consent to be sought prior to sharing of information by all staff members* • *All CYPS services to regularly communicate with parents to develop packages that are responsive to need and availability* **Record keeping** • *Staff would benefit from a training session on record keeping and an update on S1* • *All staff to record all activity, conversations and concerns/issues raised* • *All professional conversations to be documented in the record.* • *Templates to be developed for the service to reflect all aspects of care delivery.* **Service delivery of Complex Care Team** • *Staff to consider unmet need in partnership with the family and other services involved in care delivery, consider provision of sensory equipment for staff to use during sessions and for families to borrow according to need.* • *Staff to consider alternative ways of meeting needs if traditional routes are restricted, and place the child at the centre of the care working in partnership with the family to provide personalised care.* • *Team to send representation to TAC meetings to ensure participating in joint working opportunities*. **Service delivery of AHP Community Offer**	

Ref	Locality (service)	Concerns	Identified Actions	Status
			• *Reactive caseload management of complex children is required to ensure unmet need is supported adopting a flexible place based approach. If a child is unable to access planned episodes of care in the designated venue the services should review and offer an alternative community package. There is evidence to support that the Occupational Therapy service did this however Physiotherapy have not provide a care package in an alternative venue e.g. the home. The parents report Speech and language therapy have provided good quality care , however it has been scheduled around the need to provide a report for a meeting rather than a clearly defined package around EM's need.* **Key worker – Care Coordinator** • *Children with complex care needs regardless of tertiary service involvement may benefit from the services of the Well Child Nurse care co-coordinator to provide a keyworker/advocate function.*	
10668	MSK Physiotherapy	Client felt the Physio acted on incorrect information	**NOT UPHELD** No actions required; care provided appropriate and to the expected standard. Apology given for confusion in communication.	**Completed**
10720	Stroud MIIU	Incorrect treatment following dog bite (no antibiotics offered)	**UPHELD**	**Completed (action plan to be confirmed and updated)**
10802	Sexual Health Service	Patient experiencing complication following termination of pregnancy		**Not completed – awaiting feedback from GHDT**

Ref	Locality (service)	Concerns	Identified Actions	Status
10819	District Nursing Team, Gloucester	Complaint regarding the level of input from District Nursing Team in the last few days of life (complaint from daughter)	**UPHELD**	**Completed (action plan to be confirmed and updated)**
10907	District Nursing Team Stroud (Dursley)	Complaint regarding the level of input from District Nursing Team in the last few days of life (complaint from husband)	**NOT UPHELD** Clinical aspects of complaint not upheld, however there are communication issues that need to be addressed and therefore actions to take forward.	**Completed (action plan to be confirmed and updated)**
10909	Sexual Health service	Confidential letter sent to incorrect address and opened by someone else	**UPHELD** • **Feedback to team, individual and/or manager:** Feedback findings to individuals involved (nurse and lead nurse). Ensure learning is also fed back to department. • **Ensure note system changed – newest referral/note at front:** Change filing system and ensure that this is communicated to entire team • **Develop SOP appendix 3 - discharge letter inside the take home bag:** Review and amend SOP to clarify that discharge letter should be placed in take home bag. SOP to be ratified • **Consider use of PO BOX address:** Discuss with Trust the possibility of using a PO BOX address on prepaid envelopes • **Review HIV filing system:** Review HIV system in light of this and consider if filing system should also be amended	**Completed (action plan to be confirmed and updated)**
10977	Podiatry	Patient not happy with reassessment of needs appointment	**NOT UPHELD** No actions required; care provided appropriate and to the expected standard. Apology given for confusion in communication.	**Completed**
11033	District Nursing Service,	Complaint from daughter of patient who was looked after by DN Team in		**Under investigation**

Ref	Locality (service)	Concerns	Identified Actions	Status
	Gloucester	Great Western Court		
10782	Wheelchair Service	Concerns around length of time to provide new wheelchair for 7 year old boy. Joint with GCCG		**Under investigation**

AGENDA ITEM: 10.1

Report to:	**Gloucestershire Health and Care NHS Foundation Trust Board – 28th November 2019**
Authors:	Ian Cormack Senior Business Intelligence Analyst; Michael Richardson, Deputy Director of Nursing
Presented by:	John Trevains, Director of Nursing, Therapies & Quality and Michael Richardson, Deputy Director of Nursing
SUBJECT:	**Quality Report (Physical Health Services -formerly Gloucestershire Care Services NHS Trust - GCSNHST) September 2019 data**

Can this subject be discussed at a public Board meeting?	YES
If not, explain why	NA

This report is provided for:

Decision | Endorsement | **Assurance** | **Information**

PURPOSE OF REPORT

This report summarises the key highlight and exceptions in the Trust's Quality Report for Physical Health Services (September 2019 data).

RECOMMENDATIONS

The Trust Board is asked to:

- Discuss, Note and Receive the Quality Report

EXECUTIVE SUMMARY

Key Areas to note

Are our services Caring?

- There have been 27 complaints, 204 concerns and 852 compliments as of 30 September 2019
- Our Friends and Family Test response rate in September has increased to 15.9%

from 11.5% in August.
- The proportion of patients indicating 'Likely' or 'Extremely Likely' to recommend our services was 92.6% in September 2019, reduced from 94.1% in August 2019 (mean 94.15%).

Are our services Safe?

- Safety Thermometer: Based on new harms only, the Trust achieved harm-free care of 97.8% in September which is below our internally set target of 98% but above the national benchmark of 97.5%
- Safety Thermometer: Overall harm free care remains below the target of 95% and is reflective of wider system prevalence of harms recorded. Meetings are currently underway with system partners and commissioners to focus on a systems approach to addressing the harms, starting with pressure ulcers. Note that there is also a deep dive paper on current quality improvement (QI) pressure ulcer prevention activities within the Trust at this quality committee.
- There were **5** Clostridium Difficile Infections recorded in September in Community Hospitals, this is above the in-month trajectory. These case were not connected and occurred across different sites. This will be monitored carefully over the ensuing months. All cases are being examined at the countywide assurance group. There have been **8** cases year to date against a year end threshold of **12**. There have been no further cases reported in October 2019
- There was a never event for a wrong tooth extraction in August 2019; the report has concluded that human factors combined with the need to improve some processes was the root cause. An action plan is currently being implemented to address these.

Quality Priorities

The Quality Priorities in this report are based on a mixture of metrics and audits and pertain to the Quality Account priorities of the previous GCSNHST. Where audits or actions are reported on a quarterly basis a RAG rating is applied.

This month the committee is asked to take particular note of:

- Medication incidents: This programme aims to improve the quality of reporting of low and no harm incidents to detect early warnings of possible issues and themes. Work continues to source and develop e-learning, essential for role training to support safe and secure management of medicines for colleagues; the work is overseen by the medicines optimisation group. A deep dive of this issue will be presented at the next Quality Committee.
- Wound care: This QI initiative aims to increase the quality of wound assessments and management countywide in order to reduce clinical variation and improve wound healing rates. The post 4 week assessment metrics from the first audit (22%) were below the expected standard of 60%. This is being addressed partly through a new SystmOne wound assessment and treatment template for all services as well as many other activities which are detailed in the Wound care slide of the quality report.
- Pressure Ulcer Prevention: It is encouraging to note that the decrease in pressure ulcers is currently to trajectory.
- Nutrition and Hydration: This QI programme aims to increase the use of nutrition

and hydration assessments in all appropriate settings. The most recent audit results were below the expected standards and an action plan is being implemented. It is recommended that a deep dive analysis is presented to the next Quality Committee.

- End of Life Care: The new RESPECT form to aid conversations and record patients' preferences for their End of Life Care was launched on 10 October 2019. Training and educational resources for colleagues are being delivered and are also available on the Trust's intranet.
- The Deteriorating Patient: While community hospitals encouragingly have exceeded trajectory there has been a fall in National Early Warning Score baseline assessments in community teams. A deep dive is currently underway to understand fully the root cause of this issue which in part appears to be SystmOne recording or capture. An audit approach is being adopted. An update will be provided at the next committee.
- Falls prevention and management: The Trust is participating in the national CQUIN to i) improve recording of lying and standing blood pressures, ii) document rationale for prescribing hypnotic or anxiolytic medications and iii) complete mobility assessments in 24 hours. The medication standard is at 100 % although the 80% standard for the other two metrics has still to be achieved. Note also The Vale, Dilke and Stroud hospitals are slightly outside of the target for Injurious falls per 1,000 bed days in 2019/20 and this is being addressed locally. A Statistical Process Control (SPC) analysis is currently underway by the Performance Team to map whether there is an association between percentage of assessments completed each month against falls and injurious falls at each site. This will be reported on next month.

Public facing Quality Dashboards in Community Hospitals and Minor Illness and Injury Units (MilUs)

The data presented on this slide (13) is to aid managers to populate their local dashboards. The Performance team is currently formulating charts to determine whether there are any trends in the variation of quality indicators at the respective sites. This will be available for the next Quality report.

Corporate Considerations	
Quality implications	The report highlights areas where quality indicators have and have not reached the expected thresholds with RAG ratings and actions detailed where appropriate.
Resource implications:	The report offers assurance to the Trust that resources are being used to support quality, safety and best service experience.
Equalities implications:	Trends in variation of quality indicators across the Trust are currently being established which may identify equality implications later in year
Risk implications:	Where appropriate some quality indicators are also captured and managed via the Trust's risk register.

WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?			
Working together	P	Always improving	P
Respectful and kind	P	Making a difference	P

Report authorised by:	Date:

Where has this issue been discussed before? Respective Quality Improvement Groups pertaining to the Trust's Quality Priorities**.** **Quality Committee – 7th November 2019** **Quality Assurance Group – 15th November 2019**
What wider engagement has there been? NA

Appendices:	Appendix 1: Quality Report – September data Appendix 2: Further SPC charts

Abbreviations:

GCSNHST – Gloucestershire Care Services NHS Trust (previous Trust that delivered physical health community services)

QI – Quality Improvement

MiIU – Minor Illness and Injury Unit

SPC – Statistical Process Control

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

Quality report

Physical Health Services (formerly Gloucestershire Care Services NHS Trust)

Data covering April to September 2019

working together | always improving | respectful and kind | making a difference

Executive Summary

Gloucestershire Health and Care NHS Foundation Trust

This report contains the Quality measures and Quality priority section from the previous Quality and Performance report. A separate report is produced covering the Performance metrics.

Are Our Services Caring?

- Friends and Family Test response rate in September was **15.9%** which was increased from **11.5%** in August.
- The proportion of patients indicating 'Likely' or 'Extremely Likely' to recommend our services was **92.6%** in September, reduced from **94.1%** in August (Apr-2017 – Sep-2019 mean **94.15%**).

Are Our Services Safe?

- Safety Thermometer Harm free score was **92.9%** in September, reduced from **93.5%** in August, target (95%), and below the mean **93.86%** (Apr-2017 – Sep-2019) although this is based on a reducing sample size.
- Based on new harms only, the Trust achieved harm-free care of **97.8%** in September, reduced from **98.5%** in August, (target 98%) (Apr-2017 – Sep-2019 mean **98.1%**).
- There were **five** Clostridium Difficile Infections recorded in September in Community Hospitals. Whilst this is above the in-month trajectory, year-end prediction remains on target.
- There was **one Never Event** recorded in **August**. This was a wrong tooth extraction carried out within the Community Dental Service.

Quality Priorities

Quality Priorities for 2019/20 included in this report are based on a mixture of metrics and audits. Where audits or actions are to be reported on a quarterly basis a RAG rating will be applied and updated during the quarter to provide an update of progress towards completion of audits or actions.

Quality Dashboard

- The Trust compiles a quality dashboard covering the Community Hospital Inpatient and Minor Injury and Illness Units, updated on a monthly basis and displayed within each of the units. This is featured on page 13 of this report.

Statistical Process Control (SPC) Charts

- The criteria for exception reporting in this report uses SPC charts to identify where performance falls outside of control limits, and is viewed in conjunction with RAG ratings. This report contains a number of SPC charts and is supported by a separate SPC Addendum pack that covers all measures within the Quality dashboard in this report and Performance Dashboard within the Performance report.

Quality Dashboard

NHS
Gloucestershire Health and Care
NHS Foundation Trust

CQC DOMAIN - ARE SERVICES CARING?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report August Figure
1	Friends and Family Test Response Rate	N - T	15%	14.5%	17.7%	19.4%	16.7%	15.1%	11.5%	15.9%							16.1%		No - within SPC limits	G	
2	% of respondents indicating 'extremely likely' or 'likely' to recommend service	N - R L - I	95%	92.7%	93.4%	92.7%	92.7%	92.7%	94.1%	92.6%							93.0%		No - within SPC limits	G	96.2%
3	Number of Compliments	L - R	1,317	1,317	124	104	180	178	132	134							852			G	
4	Number of Complaints	N - R	42	42	6	5	6	2	5	3							27			G	
5	Number of Concerns	L - R	485	485	40	32	23	40	34	35							204			G	

CQC DOMAIN - ARE SERVICES SAFE?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report August Figure
6	Number of Never Events	N - R		0	0	0	0	0	1	0							1			G	
7	Number of Serious Incidents Requiring Investigation (SIRI)	N - R		11	0	2	3	0	0	0							5			G	
8	Number of Serious Incidents Requiring Investigation (SIRI) where Medication errors caused serious harm	N - R		0	0	0	0	0	0	0							0			G	
9	Total number of incidents reported	L - R		4,443	398	410	342	424	371	344							2,289			G	
10	% incidents resulting in low or no harm	L - R		96.4%	97.2%	95.1%	94.4%	95.5%	95.7%	93.9%							95.3%			G	
11	% incidents resulting in moderate harm, severe harm or death	L - R		3.6%	2.8%	4.9%	5.6%	4.5%	4.3%	6.1%							4.7%			G	
12	% falls incidents resulting in moderate, severe harm or death	L - R		1.8%	3.1%	3.1%	2.9%	0.0%	4.9%	0.0%							2.3%			G	
13	% medication errors resulting in moderate, severe harm or death	L - R		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%							0.0%			G	
14	Number of post 48 hour Clostridium Difficile Infections	N - R L - C	1*	15	0	0	1	1	1	5							8	G		G	
15	Number of MRSA bacteraemias	N - R L - C	0	0	0	0	0	0	0	0							0	G		G	
16	Number of MSSA Infections	L - R	0	0	0	0	0	0	0	0							0			G	
17	Number of E.Coli Bloodstream Infections	L - R	0	2	0	0	0	0	0	0							0			G	
18	Safer Staffing Fill Rate - Community Hospitals	N - R		100.2%	102.0%	100.7%	101.3%	99.7%	100.8%	99.7%							100.7%			G	
19	VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	96.9%	99.5%	98.9%	97.0%	95.5%	96.1%	95.9%							97.1%	G		G	
20	Safety Thermometer - % Harm Free	N - R L - C	95%	93.7%	94.3%	92.6%	93.4%	94.4%	93.5%	92.9%							93.5%	R	Pg. 12	A	
21	Safety Thermometer - % Harm Free (New Harms only)	L - I	98%	98.1%	98.3%	98.1%	98.4%	98.4%	98.5%	97.8%							98.3%	G		A	97.5%
22	Total number of Acquired pressure ulcers	L - R		728	79	63	56	64	60	59							381			G	
23	Total number of grades 1 & 2 Acquired pressure ulcers	L - R		671	74	59	60	59	56	54							362			G	
24	Number of grade 3 Acquired pressure ulcers	L - R		52	5	4	3	4	4	4							24			G	
25	Number of grade 4 Acquired pressure ulcers	L - R		5	0	0	0	1	0	1							2			G	

*In-month threshold (i.e. September)

N - T	National measure/standard with target	L – I	Locally agreed measure for the Trust (internal target)
N - R	Nationally reported measure but without a formal target	L – R	Locally reported (no target/threshold) agreed
L – C	Locally contracted measure (target/threshold agreed with GCCG)	N – R/L – C	Measure that is treated differently at national and local level, e.g. nationally reported/local target

RAG Key: R – Red, A – Amber, G - Green

Quality Priority | Are Service Safe?

1. Medication Incidents

Outcome: Improve learning from "no-harm" and "low-harm" medication incidents to enhance patient safety

Gloucestershire Health and Care NHS Foundation Trust

This priority will enable (1) identification and theming of factors contributing/causing low and no harm medication incidents and (2) recommendations to address identified themes

Improve the learning from "no-harm" and "low-harm" incidents		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Actions		Establish a baseline of quality of reporting of harm reported medication incidents using quality audits - Completed, see below.			Quality Improvement working group will establish a training needs analysis on baseline data and agree actions required to improve quality of reporting			Implementation of actions agreed from Qtr. 2			A repeat audit of harm reported medication incidents will be performed to determine if the aims of the outcome have been achieved		
Low/no harm incidents have been investigated and closed by end of each quarter	Target				45%			60%			75%		
	No-harm medication incidents	Baseline: 32%			25%								
	Low-harm medication incidents	Baseline: 29%			57%								
Low/no harm incidents should state the medication involved	Target				91%			95%			100%		
	No-harm medication incidents	Baseline: 87%			85%								
	Target				80%			90%			100%		
	Low-harm medication incidents	Baseline: 71%			57%								
Low/no harm incidents should state the indication for the medication involved	Target				33%			66%			100%		
	No-harm medication incidents	Baseline: 0%			30%								
	Low-harm medication incidents	Baseline: 0%			0%								

Additional information:

Performance

There were 18 medication incidents with Community Physical Health Services responsibility reported in August.

- 2 resulted in low harm
- 16 resulted in no harm

SPC charts show the number of medication incidents, no harm medication incidents and low harm medication incidents to be within control limits (normal variation).

Actions

- Work continues to source and develop e-learning, essential for role training to support safe and secure management of medicines for colleagues.
- Medicines Optimisation group to discuss the results and agree next steps.
- The data from Qtr. 2 shows further improvement is needed to achieve the targets.

2. Mental Capacity Act

Outcome: Improve the usage of mental capacity assessments in our hospital and community settings to ensure that individuals who lack the ability to make decisions are the focus of any decisions made, or actions taken on their behalf

Mental capacity Act and DoLS operational practice
Reference – 559
Rating – 12

The philosophy of the Mental Capacity Act 2005 (MCA) is to ensure that individuals who lack the capacity to make specific decisions are the focus of any decisions, or actions taken, on their behalf. It is a legal requirement to carry out an assessment when a person's capacity is in doubt. MCA needs to become a "business as usual" exercise, to ensure that the Trust is compliant with legislation and to achieve optimum benefits to our patients and families. Metrics will focus on the completion of the MCA2 and Deprivation of Liberty Safeguards (DoLS) assessments for significant decisions.

MCA Metrics		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Has an MCA2 been completed for restrained or restricted patients in our community hospitals? (Baseline from March 2019 audit 11%. Measured from dip test audit mid quarter)	Target	15%			30%			60%			90%		
	Actual	33%			Audit available end October 2019			Audit available end December 2019			Audit available end March 2020		
Has a deprivation of Liberty Safeguards application been made for all patients who do not have capacity to consent to being restricted or restrained? (Baseline 22% from March 2019 audit)	Target	25%			40%			60%			90%		
	Actual	33%			Audit available end October 2019			Audit available end December 2019			Audit available end March 2020		

Actions:

- Training for ward staff by Mental Health Liaison nurses during September and December 2019, with additional training in March 2020.

3. "Better Conversations" and Personalised Care

Outcome: Develop a programme of personalised care planning to enable patients to manage their long term conditions more effectively

Personalised care is a priority in the Long Term Plan, with a stated objective that it should become "business as usual across the health and care system". In the ICS workforce strategy the vision is to see this facilitated by a health coaching approach, called "Better Conversations". It is noted that both the GCS and 2Gether NHS FT contracts for 2019-20 include a commitment to work with the GCCG to develop "5 core measurable statements for the ICS personalised care programme that define outcomes for patients and success". This programme will directly feed in to this growing body of work.

NHSE have committed to "*consider, develop and test the most appropriate personalised care activity metrics*" including the development of a new Long Term Conditions Patient Recorded Outcomes Measure (PROM).

The Patient Activation Measure (PAM) will be a key tool in these early stages. Patient "activation" describes the knowledge, skills and confidence a person has in managing their own health and care. The concept of patient activation links to all the principles of person-centred care, and enables the delivery of personalised care that supports people to recognise and develop their own strengths and abilities. Services included will be MacMillan Next Steps, Self Management, Diabetes Education, and part of the ICTs (Complex Care at Home and Berkeley Vale ICT where health coaching training has taken place).

Actions completed:

- Improved PAM data flows in place from external partners now which will support analysis and operational use of this data (although it remains a complex process and a headwind to timely reporting).
- Following productive initial discussions will be meeting with Countywide Services Leads (23 Oct) and Children and Young People's Service Leads (27 Nov) to seek to bring some of these services into the evidence base for personalised care planning and as users of the PAM tool.

Better Conversations and Personalised Care Measures	Qtr. 1	Qtr.2	Qtr. 3	Qtr. 4
Number of care planning conversations taking place for the identified cohorts	Set by individual teams and based on relevance to patient cohort(s)	This is happening, however more work is required to report from S1	Available end December 2019	Available end March 2020
Number of patients completing a Patient Activation Measure (PAM) questionnaire	Baseline: 1,500 per annum; target + 30%	Numbers are stable rather than rising but this is attributable to specific difficulties within 2 services and these are now resolved/resolving. Expect to recover lost ground	Available end December 2019	Available end March 2020
Number of patients completing a second PAM	Baseline: 500 per annum; target + 30%	This is increasing in line with target	Available end December 2019	Available end March 2020
The use of PAM data to tailor interventions to further the personalisation agenda	Narrative reporting - commenced June 2019 in Complex Care at Home, MacMillan Next Steps	Progressing well. Embedded in 2 services and embryonic in others	Available end December 2019	Available end March 2020
Delivery of a quarterly qualitative report detailing ongoing developmental activities and examples of good practice, patient stories and shared learning	Linked to quarterly PAM data; most teams dependent upon CCG feed and Qtr. 1 data; delivery expected during Qtr.2	Some case studies produced and shared with system partners as well as internally. Increasing anecdotal evidence of successes but failed thus far to produce "formal" report	Available end December 2019	Available end March 2020

4. Catheter Management

Outcome: Quality Improvement programme to improve management of catheters in community settings

Gloucestershire Health and Care NHS Foundation Trust

Long term catheters whilst beneficial for some patients are also associated with morbidity. Infections (including sepsis) and other complexities which include anxiety over unpredictability of catheter problems (e.g. sudden blockage), difficulties managing away from home (e.g., taking equipment on holiday), sense of physical restraint, limited clothing choices, interruptions to sleep due to discomfort or pulling, and self-identity issues.

It has been identified that some patients appear to have clinically unnecessary urinary catheters in situ; the above risks and problems can therefore impact on the safety, morbidity and quality of life of these cohorts of patients.

Catheter Management metrics	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4
Reduce the amount of community nursing contacts to patients between planned routine catheter changes to manage catheter associated problems.	Target	95% of baseline	90% of baseline	85% of baseline
	Set targets for use in Qtrs. 2 to 4 Baseline: 3,900 Contacts per quarter (1,300 per month)	5% reduction	Available end December 2019	Available end March 2020
Reduce the number of (clinically unnecessary) urinary catheters inserted in the community setting.	Establish baseline and set targets for use in Qtrs. 2 to 4 Delay due to determining percentage of patients whose first catheter insertions were not on GCS Nurse caseloads, or may have a positive TWOC* outcome	Delayed data capture continuing through October, report available November	Audit available end December 2019	Audit available end March 2020

* TWOC – Trial Without Catheter to determine if clinically indicated.

Actions completed:

- There is a 5% overall reduction in contacts in the 3 months sampled. This is positive progress as evidence suggests contacts to urinary catheter related problems increase over the summer months, due to warmer weather and associated dehydration.
- A countywide continence formulary is in final stages of development between the Continence Specialist Lead, the CCG and the Head of Community Nursing. This will standardise equipment in use, identify best value for money and reduction in unwarranted variation which will help improve practice. This is now appraised by the Trust and agreed.
- ICTs, Community Hospitals and the Evening & Overnight Community Nursing Services have each been asked to bring PDSA proposals for the next meeting in October to identify and commence local, small scale projects to improve catheter care in those areas.
- Measuring nightly contacts in the evening and overnight service to review whether this has reduced catheter related problems. The initial scoping in May 2019 showed 39 contacts in 1 week for out of hours (excluding weekend daytime) difficulties.
- Established the learning and development offer regarding catheter (and bowel) assessment and management and this is in the process of being booked into the 2020 plans and will be available to book via ESR.
- Joined up work with the CCG on reduction of bacteraemia and presentation due to follow at NHSI event in November – collaborative work with infection control.
- Scoping use of Pure Wick device for use in inpatient ward areas for immobile patients – awaiting outcome of trials in GHFT first – would be a less invasive device for mobility restricted patients such as those at end of life or post neurological injury.
- Issued 1,000 hydration information flyer to patient's over the summer promoting fluids to preserve catheter patency.
- Joining agreeing a revised catheter passport document and urinary catheter policy for use across One Gloucestershire – aim for completion by the end of the year.

Quality Priority | Are Service Safe?

5. Wound Care

Outcome: Increase the quality of wound assessments and management countywide in order to reduce clinical variation and improve wound healing rates

Gloucestershire Health and Care NHS Foundation Trust

This priority builds on the 2017-2019 CQUIN which was put in place nationally following UK studies that identified inconsistencies in the assessment and management of wounds and the opportunities to improve both efficiency of working and patient outcomes.
There are two principle reasons why wound assessment has been targeted:

1. A need to improve the quality and consistency of care delivered.
2. A need to reduce the cost burden of wounds. Clinical practice and wound outcomes should ultimately improve.

The Trust has been working to improve wound care as per the 2017-19 CQUIN, performance from Qtr. 4 of year 2 of the CQUIN is used below as a baseline for the Quality Improvement.

Wound Care Metrics		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
To increase the number of patients who receive a fully compliant assessment (to the "leading change adding value" clinical assessment domains of the 2017-19 wound assessment CQUIN) on admission to Community Nursing caseloads, Complex Leg wound services, Podiatry Service or Inpatient Settings from baseline.	Target	**30%**						**40%**			**60%** by the end of Year 1 of the QI project. Metrics to be reviewed again if project goes in to Year 2		
	Actual	25.0%						Audit available end December 2019			Audit available end March 2020		
To increase the number of patients who have received a full wound assessment according to the "leading change adding value" Clinical Assessment domains of the 2017-19 wound assessment CQUIN AND whose wounds have healed within 4 weeks.	Target	**60%**						**65%**			**70%**		
	Actual	22.0%						Audit available end December 2019			Audit available end March 2020		

Actions completed:

A revised education offer for all aspects of wound assessment is under development – this includes all areas where wound assessment will be discussed and will be:

- A primary (core) wound assessment and tissue viability offer.
- A refresher offer for wound assessment to be undertaken every 3 years for those regularly practicing.
- A revised offer for primary complex leg wound assessment & management.
- A refresher offer for complex leg wound assessment & management to be undertaken every 3 years for those regularly practicing.
- A new offer called Specialist Tissue Viability Therapies which will cover assessment for and use of complex therapies which includes Topical Negative Pressures and larvae therapy.
- A new offer called Advanced Practice Tissue Viability which will cover non-surgical debridement, exudate management, risk assessment and major on senior decision making.

Pressure risk and prevention as well as management is covered in all relevant sessions.

We are presently trialling a new SystmOne wide wound assessment and treatment template for all services – plan to go live next month currently in 'Do' stage of PDSA with 'Study' planned for next meeting.
Other actions:

- Working with the CCG on countywide resources for all areas to aid clinical decision making.
- Refreshed the link to G-Care from S1 and applied pathways there.
- Working on more pathways with the CCG to go countywide.
- Reviewed the burns policy – now ready to relaunch with MIIU help.
- Held 50+ new formulary awareness sessions countywide.
- In the process of agreeing a new tiered approach to wound education, including pressure ulcers, lymphedema, tissue viability, leg ulcers, topical negative pressure systems and larvae.

6. Pressure Ulcers

Outcome: Build on our success of reducing pressure ulcers by working with the NHSI Stop the Pressure Collaborative framework. This will focus on specific community programmes to reduce pressure ulcers

The prevention of pressure ulcers remains one of our top priorities with regards to patient safety. Despite great strides in the past 2 years our aim will be to continue to monitor the number and incidence of pressure ulcers and to continue to drive our reduction plans forward. Metrics for measuring performance therefore are:

1. Pressure ulcers will continue to reduce across our patient facing services where our span of influence can have an impact.
2. Quality improvement methodology continues to target areas of high incidence and as a response to incident reports to understand the issues, current focus on Cotswolds, Cheltenham and Forest hospitals to showcase improvement. The PDSA cycle will report quarterly on these areas and will include a qualitative report.

Plans also include working collaboratively with GHFT and / or care homes where specific incidences or themes demonstrate the potential for system wide learning. Qualitative reporting will also include case studies where pressure ulcers have been managed and healed, following the patient journey and taking in to account other factors such as nutrition and hydration.

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Pressure Ulcers		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Acquired Pressure Ulcers will continue to reduce across patient facing services where our span of influence can have an impact	Target (Number of avoidable acquired pressure ulcers over total pressure ulcers)	**8%** (2018-19 Q4 baseline 8.9%)			**7%**			**6%**			**5%**		
	Actual	8.6%			7%			Audit available end December 2019			Audit available end March 2020		
	Number of acquired and avoidable pressure ulcers	37			24								
	Total number of pressure ulcers in audit	430			365								

Preventing Pressure Ulcers update:

- There is improved recognition of risk and increased reporting of earlier skin integrity damage. Evidence that the posture and risk management approach to education is improving patient safety.
- Community Hospitals commenced first quality improvement PDSA cycle on 2 wards across the Forest Community Hospitals and 45 clinical colleagues have taken part in the workshops.
- North Cotswolds Physiotherapy and Occupational Therapy leads are commencing 'everybody's business awareness training' (September 2019) to focus on risk assessment and posture. This approach is as a result of the #stopthepressure PDSA results which highlighted training to reduce avoidable harm should focus on holistic assessment and posture management. Baselines from DATIX data will be available to review the efficacy of the training.
- North Cotswolds and Cheltenham ICT's are using the training materials to support governance and learning and each locality has access to DATIX reporting for their locality.

Risks
(Pressure Ulcers)
Reference – 562 - Rating – 12

Compliance with published standards from NHS Improvement (July 2018) and National Reporting and Learning System (NRLS) (March 2019) have been achieved. Definitions of acquired and inherited have been updated on the Datix incident reporting system. This has completed the outstanding actions from the gap analysis report for the Quality and Performance Committee (July 2018): Pressure ulcer developed or worsened during care by this organisation (previously: *acquired*). Pressure ulcer present before admission to this organisation (previously: *inherited*).

Benchmarking: In the 'Rate of new grade 2,3,4 avoidable pressure ulcers acquired in a Community Hospital setting per 1,000 occupied bed days' the Trust submitted a figure of 0.35 in August. The benchmarking figure is 1.24 for Community Hospital settings.

Gloucestershire Health and Care NHS Foundation Trust

7. Nutrition and Hydration

Outcome: Increase the use of nutrition and hydration assessments in all appropriate settings in order for patient's to be optimally nourished and hydrated

The quality improvement group is adopting a Quality Improvement methodology and the metrics include:

- Patients will have a baseline MUST on admission to wards or clinical caseloads (the maximum time frame is 72 hours for in-patient settings or 2 visits for Integrated Community Teams - ICTs).
- An audit approach to measure performance will be used until more reliable reporting can be assured from SystmOne.
- Qualitative, quarterly reporting will also be included as part of the Quality Improvement approach (using a PDSA methodology). This will focus on reviewing samples of patients where MUST scores have triggered the need for interventions to establish whether patients are being managed appropriately and to a high quality. This will include all aspects of the patient's care such as food charts, supplements, referrals to dieticians and impacts on other aspects of care such as the prevention or healing of pressure ulcers.

Nutrition and Hydration metrics 2019/20 (performance from audit data)						
Service area	Baseline		Q1	Q2	Q3	Q4
ICTs	December 2018 audit 66%	Target	65%	70%	75%	95%
		Actual	66.0%	65.0%	Audit end December 2019	Audit end March 2020
Community Hospitals	March 2019 audit 80%	Target	80%	85%	90%	95%
		Actual	91.4%	76.0%	Audit end December 2019	Audit end March 2020

Actions completed:

- Electronic audit tool tested in Cirencester Community Hospital by senior clinicians; reported to be user friendly and time efficient.
- Request and tool sent to each Community Hospital Matron for snapshot data entry for each patient. Some data entries were confused, however these were removed from the sample to ensure they did not adversely affect the sample.
- Priority to further review the tool and support clinical colleagues with data entry during November & December.

8. End of Life Care

Our aim will be to embed as "business as usual" with dedicated leadership.

End of Life Care improvements will continue to be reported during 2019/20.

- Percentage of patients on an End of Life template has not increased. Efforts are focussing on our Community teams as Community Hospitals consistently use the template in most cases.

End of life Care	Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Percentage of Community Hospital inpatients who have End of Life care recorded on SystmOne EoL template	81.0%	77.8%	100.0%	90.0%	87.5%	82.4%	91.7%						
Percentage of all Trust patients who have End of Life care recorded on SystmOne EoL template	48.6%	49.3%	52.2%	52.8%	56.2%	57.9%	53.9%						
Number of patients who have End of Life care recorded on SystmOne EoL template	n/a	75	83	75	82	77	55						
Number of patients who died in the month	n/a	152	159	142	146	133	102						

Actions completed:

- The exemption criteria has now been applied and although the completion rate for the Community Hospitals has improved, the overall completion rate remains at 53.9%. Review of SystmOne data is planned to see if other reasons why the End of Life template is not being consistently used can be identified.
- ReSPECT launch countywide on 10th October 2019. Training and educational resources for colleagues are available on the Trust intranet.
- National Audit of Care at End of Life (NACEL): completed the collection of data and the audit is now closed.
- Mortality Reviews (Stroud Community): this remains on hold due to temporary loss of support from the GP involved due to re-structuring in primary care.
- Mortality Reviews (Homeless Health Care): initial meeting held. Actions identified - establish a support system for the nurses following the death of a patient (emotionally/psychologically) particularly for sudden deaths, and to understand how the lack of housing can affect the quality of care at the end of life and to identify best practice for this patient group.
- There has been an improvement in recording due to exclusions being applied to the cohort of patients counted for any unexpected deaths, or deaths within 24 hours of referral/admission, and patients referred to the Physiotherapy and Occupational Therapy services (with the exception of the Palliative Care Occupational Therapists).

9. The Deteriorating Patient

Outcome: Continue to train and support front line colleagues to recognise and manage deteriorating patients to ensure that they are managed quickly and effectively

The metrics are:

- All patients admitted onto Trust caseloads (Community and Inpatients) will have their NEWS recorded as a baseline. This will be measured with a snapshot audit which also extracts information about deterioration, recognition of sepsis and appropriate escalation.
- The qualitative data from the snapshot) audits will establish whether rapidly deteriorating patients have been identified and escalated appropriately within the service where their care is being managed (according to the Trust policy action cards).

For some patients this will include looking to assess whether there were any challenges evident to colleagues identifying early enough that the patient was deteriorating and at risk of sepsis and to identify key issues that may be used to develop further measures for improvement. For example, this may be clinical practice such as the frequency of observations once a NEWS has raised above a certain threshold for a patient – or around ensuring the NEWS scale 2 is used is for patients who have COPD with a clinically diagnosed oxygen (O_2) deficit and therefore need prescribed oxygen (O_2) at an lower rate (88-92).

NEWS Recording Targets 2019/20 (performance from audit data)						
Service area	**Baseline**		**Q1**	**Q2**	**Q3**	**Q4**
Community Hospital In-patients	March 2019 audit 89%	Target	89%	91%	93%	95%
		Actual	92%	98%	Audit end December 2019	Audit end March 2020
ICTs	March 2019 audit 33%	Target	33%	40%	50%	60%
		Actual	54%	31%	Audit end December 2019	Audit end March 2020

Actions completed:

- Community hospitals removed from risk register due to their percentage compliance with NEWS assessments.
- Quality Improvement work commenced at the end of April with North Cotswold Community Nurses using a PDSA approach to understand why the recording of NEWS was low. Subsequent mid point data had improved, however SystmOne data captured is still lower than expected. Therefore all new patients in Qtr. 2 will be audited for baseline NEWS compliance.
- Participation in National Sepsis programmes to raise awareness.

Quality Priority | Are Service Safe?

10. Falls Prevention and Management

Our aim will be to embed as "business as usual" with dedicated leadership.

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The Trust will be participating in a national CQUIN associated with falls and especially with regards to:

- Lying and standing blood pressures
- Rationale for documenting prescribed hypnotic or anxiolytic medications
- Mobility Assessments

Falls Prevention and Management	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD RAG
Quarterly national CQUIN. Percentage of patients meeting **all three** actions shown individually below:	80%		28.4%			43.8%								R
CQUIN element 1: Lying and Standing Blood Pressure recorded on SystmOne at least once	80%	55.6%	51.3%	53.3%	60.8%	60.3%	67.3%							R
CQUIN element 2: No hypnotics, antipsychotics or anxiolytics prescribed **or** rationale for prescribing documented	80%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%							G
CQUIN element 2: Mobility assessment completed within 24 hours **or** walking aid provided within 24 hours	80%	41.5%	38.8%	50.3%	72.3%	60.3%	61.9%							R
Mobility assessment completed at any time during inpatient spell	No Target	67.7%	74.5%	85.0%	94.6%	87.2%	85.7%							
% of those assessed where a walking aid was not required	No Target	88.2%	83.7%	87.2%	85.4%	87.0%	88.1%							
Post fall SWARM completed	80%	N/A	78.5%	79.4%	91.0%	90.5%	93.0%							G

Actions required:

The national CQUIN identifies three key actions that should be completed as part of a comprehensive multidisciplinary falls intervention and result in fewer falls, bringing length of stay improvements and reduced treatment costs. The three key actions which must **all** be completed are:

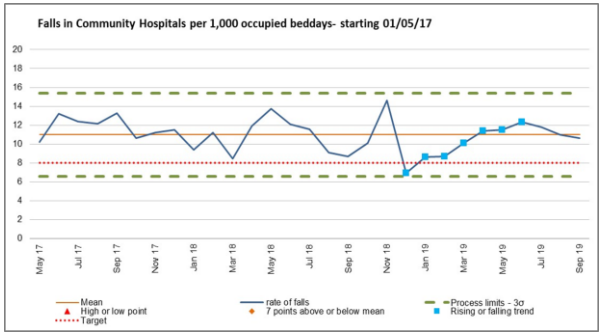
- Lying and standing blood pressure recorded.
- No hypnotics or anxiolytics prescribed, or rationale documented.
- Mobility assessment completed or walking aid provided within 24 hours.

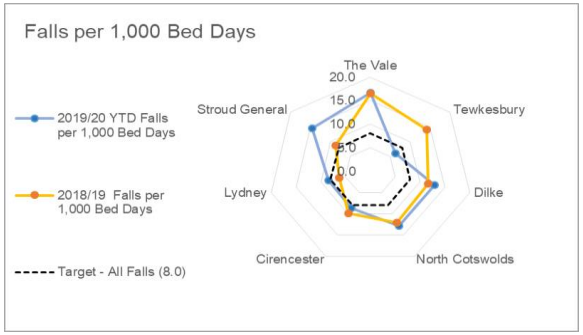
Work continuing with colleagues to ensure lying and standing blood pressure are recorded on SystmOne at least once during admission.

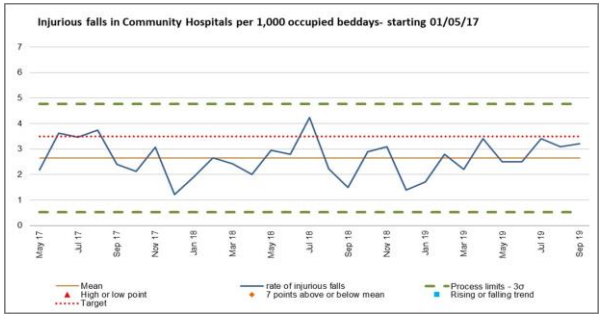
Mobility assessment in SystmOne has been moved to the 6 hour assessment template from the 48 hour assessment template.

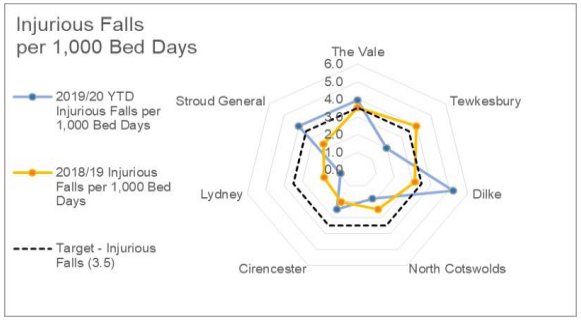
Actions completed:

- Reminder to colleagues to ensure lying and standing blood pressure is recorded on SystmOne on admission (observations are usually recorded on the paper NEWS chart). Added box to SystmOne to enable 'not appropriate' to be selected, e.g. if patient hoisted or unwell/end of life.
- Pop-up box on e-prescribing module so that if hypnotics or anxiolytics are prescribed, the prescriber has to provide their clinical rationale – this is a mandatory field. This went live on 11th June 2019.
- Post falls SWARM completed now a mandatory field on DATIX to enable reporting. Changes made to post falls protocol to make clearer that post falls SWARM should be completed immediately after a fall. This is now being evidenced by significant improvements.









The SPC charts show all falls and injurious falls to be within control limit.

The internal target of 8 falls per 1,000 occupied bed days is close to the lower control limit and below the mean, and only achieved in December 2018 suggesting this may need to be reviewed.

73.6% of all falls reported in the year to date are **without harm.**

Radar charts show 2019/20 total falls and injurious falls per 1,000 bed days compared to 2018/19 and to target.
All units with the exception of Tewkesbury are outside of the falls per 1,000 bed days target in 2019/20.
The Vale, Dilke and Stroud are outside of the target for Injurious falls per 1,000 bed days in 2019/20.
Actions to reduce falls rates include ensuring assessments are completed, actions based on post falls SWARMs and ensuring walking aids are available.

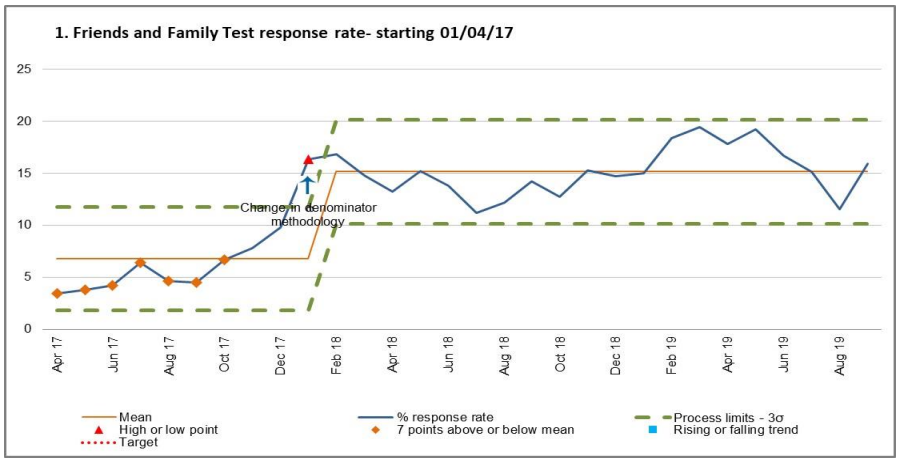
Quality | Are Services Caring?

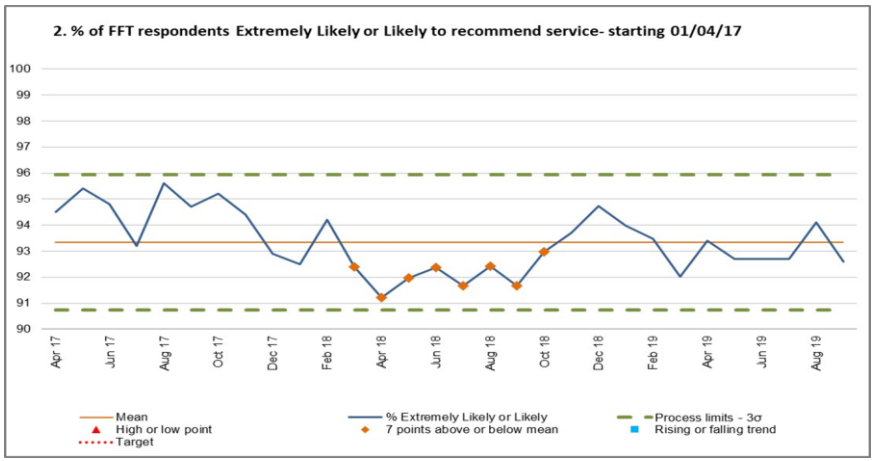
Patient Experience

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES CARING?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report August Figure
1	Friends and Family Test Response Rate	N - T	15%	14.5%	17.7%	19.4%	16.7%	15.1%	11.5%	15.9%							16.1%		No - within SPC limits	G	
2	% of respondents indicating 'extremely likely' or 'likely' to recommend service	N - R L - I	95%	92.7%	93.4%	92.7%	92.7%	92.7%	94.1%	92.6%							93.0%		No - within SPC limits	G	96.2%
3	Number of Compliments	L - R	1,317	1,317	124	104	180	178	132	134							852			G	
4	Number of Complaints	N - R	42	42	6	5	6	2	5	3							27			G	
5	Number of Concerns	L - R	485	485	40	32	23	40	34	35							204			G	





Additional information related to performance	What actions have been taken to improve performance?
Friends and Family Test (FFT) response rate SPC chart shows a decrease in response rate since May 2019 with increase in September 2019. The percentage of FFT respondents recommending our services has been on, or close to the mean for six months.	• There was a continued decrease in the overall response rate in August and this will continue to be monitored. The largest decrease was seen in Children's Immunisation Team along with a decrease from Inpatient Wards. • The response rate has risen in September to be above the 15% threshold. • The overall satisfaction rate (likelihood of recommending the service) has seen a small decrease since August but is back in line with previous months at 92.6%

Note: there is no formal benchmark for the level of 'extremely likely'/'likely' response to the Friends and Family Test, but the average from NHS Benchmarking Network for August is 96.2%.

SPC charts for Concerns, Complaints and Compliments show the following:
Concerns – Number of Concerns within normal variation.
Complaints – Number of Complaints within normal variation.
Compliments – Number of Compliments within normal variation based on the recalculated mean.

Exception Report | Are Services Safe?

Safety Thermometer

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES SAFE? RAG Key: R – Red, A – Amber, G - Green

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report August Figure
20	Safety Thermometer - % Harm Free	N - R L - C	95%	93.7%	94.3%	92.6%	93.4%	94.4%	93.5%	92.9%							93.5%	R	Pg. 15	A	
21	Safety Thermometer - % Harm Free (New Harms only)	L - I	98%	98.1%	98.3%	98.1%	98.4%	98.4%	98.5%	97.8%							98.3%	G		A	97.5%

Additional information related to performance

- The overall sample number has decreased from 522 in August to 410 in September. Decrease principally due to three Community teams not providing September surveys, potentially impacting the overall performance.
- Harm free care remains below target at **92.9%** in September.

What actions have been taken to improve performance?

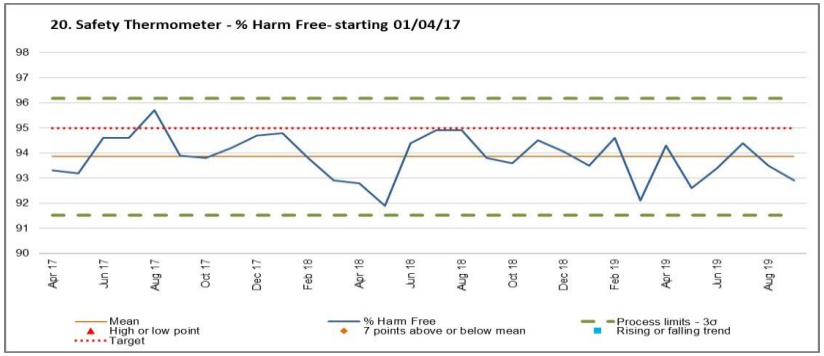
- Quality Improvement projects are being planned or currently underway to build on the success of reducing pressure ulcers over the past year which will align with our quality priorities for 2019-20.

There are three Quality Improvement projects currently in progress:

- North Cotswold ICT community nursing.
- Forest Community Hospitals.
- Alongside AHP's 'Everybody's Business' training on risk assessment & posture management. Project will focus on prevention of pressure ulcers by identifying those at risk across AHP professions. This has previously been highlighted as an issue.

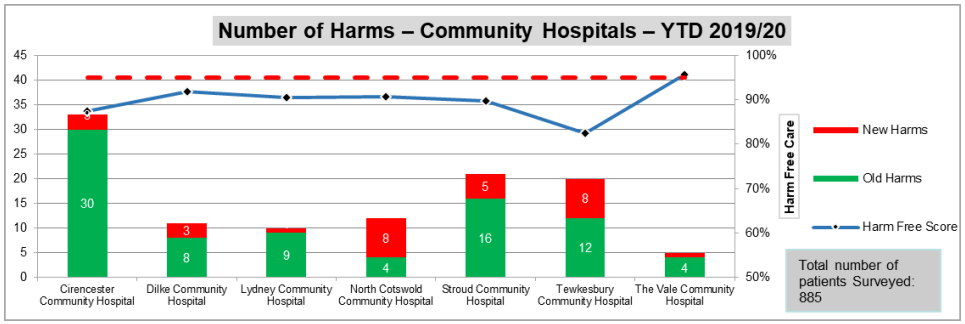
Risks
Pressure Ulcers
Reference – 562, Rating – 12

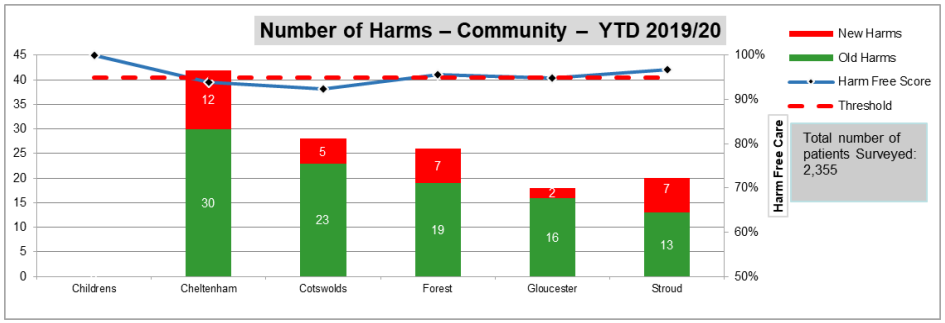
- **Benchmarking:** In the 'Safety Thermometer – Percentage of 'Harm Free Care (New Harms Only)' measure, the Trust submitted a figure of 98.5% in August. The benchmark is 97.5% for August.



Safety Thermometer Harm Free Care within normal variation. However target consistently missed.

SPC Charts have been reviewed for other harms: VTE harms fluctuate above and below the mean – but remain within control limits and are very low numbers. UTI / Catheter harms show a steady reduction over the period. Falls resulting in harm fluctuate above and below the mean – but remain within control limits and are very low numbers.





Quality | Are Services Caring?

Quality Dashboards

NHS
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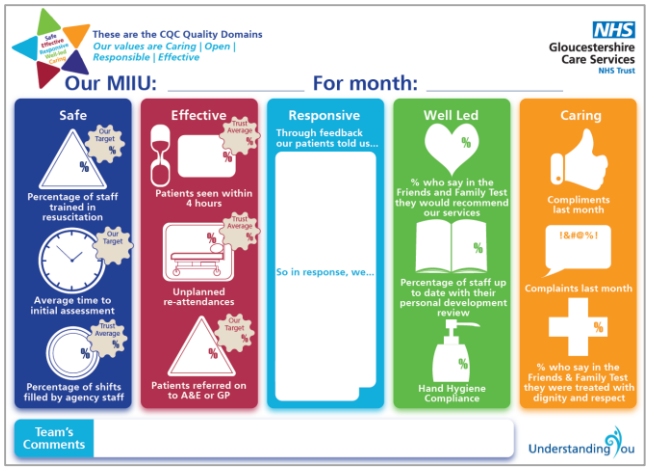
Community Hospital inpatient and Minor Injury and Illness units Quality dashboards

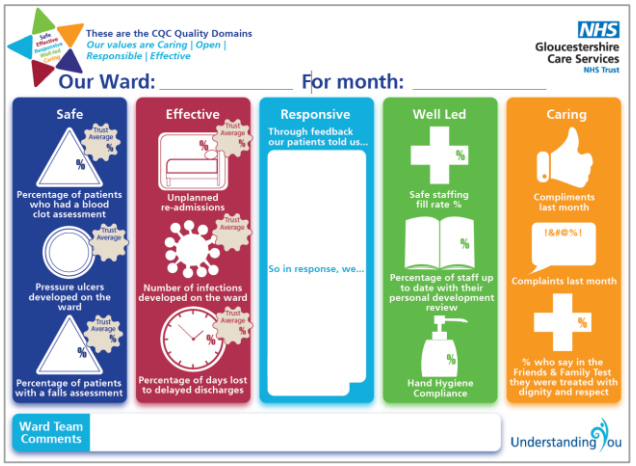
Sep-19	Safe	Safe	Safe	Effective	Effective	Effective	Well Led	Well Led	Well Led	Caring	Caring	Caring
CoHos	% Patients - Blood Clot (VTE) Assessment	Pressure Ulcers Developed (Acquired)	% Patients - Falls Assessment	% Unplanned Re-admissions (CoHo 30 Days)	Number of Infections	% Days lost to Delayed Discharges	% Safe Staffing fill rate	% Staff up to date PDR	% Hand Hygiene Compliance	Compliments	Complaints	% in FFT say treated with Dignity & Respect
Trust Average	95.9%	1	97.1%	11.4%	0.6	2.1%						
Cirencester - Coln Ward	100.0%	1	100.0%	8.7%	0	8.7%	96.8%	87.8%	90.0%	2	0	92.0%
Cirencester - Windrush Ward	100.0%	0	100.0%	25.0%	1	0.0%	95.4%	65.5%	100.0%	2	0	100.0%
Dilke - Forest Ward	92.0%	1	88.9%	9.7%	0	0.5%	96.5%	97.4%	90.0%	23	0	100.0%
Lydney	95.2%	1	95.2%	8.7%	0	7.4%	98.5%	92.7%	90.0%	0	0	90.0%
North Cots - Cotswold View Ward	91.7%	1	100.0%	12.0%	0	2.1%	103.8%	79.4%	100.0%	0	0	100.0%
Stroud - Cashes Green Ward	100.0%	1	100.0%	10.5%	1	0.0%	91.2%	74.3%	100.0%	7	0	100.0%
Stroud - Jubilee Ward	100.0%	2	100.0%	5.6%	1	0.0%	89.3%	79.3%	80.0%	4	0	90.0%
Tewkesbury - Abbey View Ward	93.3%	4	92.9%	11.8%	1	0.0%	109.6%	61.8%	100.0%	0	0	100.0%
Vale	92.3%	2	100.0%	15.4%	1	0.0%	99.8%	95.4%	Not available	6	0	93.0%
Winchcombe	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
MIIUs	% Staff Trained in Resuscitation (Target: 92%)	Average Time to Initial Assessment (Target: 15 min)	% of shifts filled by agency staff	% Patients seen within 4 hours	% Unplanned Reattendances	% Referred on to A&E or GP (Target: 4.4%)	% Who say in the FFT they would recommend our services	% Staff up to date PDR	% Hand Hygiene Compliance	Compliments	Complaints	% in FFT say treated with Dignity & Respect
Trust Average			2.5%	99.2%	1.4%							
Cirencester MIIU	100.0%	10:00	1.8%	99.8%	1.3%	Not available	96.9%	100.0%	100.0%	1	0	93.0%
Dilke MIIU	100.0%	13:00	2.6%	98.9%	0.5%	Not available	94.7%	81.8%	100.0%	1	0	96.0%
Lydney MIIU	100.0%	12:00	2.6%	99.2%	0.8%	Not available	92.8%	100.0%	100.0%	3	0	97.0%
NCH MIIU	100.0%	08:00	0.0%	99.9%	1.5%	Not available	97.1%	100.0%	100.0%	2	0	100.0%
Stroud MIIU	100.0%	14:00	5.1%	98.9%	1.2%	Not available	93.2%	75.0%	100.0%	1	0	91.0%
Tewkesbury MIIU	100.0%	10:00	1.7%	97.8%	2.8%	Not available	90.5%	100.0%	100.0%	0	0	92.0%
Vale MIIU	100.0%	10:00	3.9%	100.0%	2.1%	Not available	96.0%	100.0%	100.0%	0	0	90.0%



The Trust compiles a quality dashboard covering the Community Hospital Inpatient and Minor Injury and Illness Units, updated on a monthly basis and displayed within each of the units.

The dashboard includes measures from the Safe, Effective, Well Led and Caring domains.

The table above illustrates the data for September 2019 and compares each of the units with the Trust average. The data is copied onto posters which are visible in public areas (examples shown on this slide).



AGENDA ITEM: 10.2

Report to:	Gloucestershire Health and Care NHS Foundation Trust Board – 28th November 2019
Author:	Gordon Benson, Associate Director of Clinical Governance & Compliance.
Presented by:	John Trevains, Director of Nursing, Therapies & Quality
SUBJECT:	Quarter 2 Quality Report (Mental Health Services)

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

This report is provided for:

Decision | Endorsement | **Assurance** | **Information**

PURPOSE OF REPORT

To review the Quarter 2 Quality Report for mental health services previously provided by 2gether NHS Foundation Trust.

RECOMMENDATIONS

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

EXECUTIVE SUMMARY

Assurance

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

Overall, there is one target which is not met:

2.1 – 79% of the patient survey responses indicate that they were involved as much as they wanted in agree their care. This was 5% lower than the target of 84%. There will be a focused push to implement an Always Event as part of the NHS England campaign to try an increase this percentage.

Improvements/developments

Services continue to monitor discharge planning on a monthly basis to improve performance (Indicator 1.2) however, Gloucestershire performance has dropped this quarter whereas Herefordshire performance has improved. The combined position maintains performance at a higher level that last year.

With regard to Indicator 3.5 - Further develop a quality improvement led approach to robustly embed lessons learned following serious incidents; We have been working through our zero suicide initiative and reducing restrictive practice groups to progress this indicator. Further work had been paused whilst we completed the Phase 3 merger management of change process. We will be driving this work forward through the combined Trust quality team in Q3 & 4.

During Quarter 3, the Nursing, Therapies & Quality Senior Team will consider a revised harmonised format for the Quality Report to bring together the physical and mental health indicators of the predecessor organisations, taking note of NHS England guidance with regard to mandated content and structure of the final report.

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

WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?			
Working together	P	Always improving	P
Respectful and kind	P	Making a difference	P

Report authorised by: John Trevains, Director of Nursing, Therapies & Quality	**Date:** 30.10.19

Where has this issue been discussed before? **Quality Committee – 7th November 2019** **Quality Assurance Group – 15th November 2019**
What wider engagement has there been?

Appendices:	

with you, for you

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Quality Report 2019/20

CONTENTS

Part 1: Statement on Quality from the Chief Executive

Introduction

To be completed at year end.

Part 2.1: Looking ahead to 2020/21

Quality Priorities for Improvement 2020/21

These will be considered during Quarter 4 and will reflect priorities spanning both physical and mental health care.

Effectiveness

User Experience

Safety

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

Review of Services

To be completed at year end.

Participation in Clinical Audits and National Confidential Enquiries

To be completed at year end.

Participation in Clinical Research

To be completed at year end.

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

A proportion of [2]gether NHS Foundation Trust's income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between [2]gether NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2019/20 and for the following 12 month period are available electronically at **www.2gether.nhs.uk/cquin**

2019/20 CQUIN Goals

Gloucestershire

Gloucestershire Goal Name	Description	Goal weighting	Expected value	Quality Domain
CCG 2: Staff Flu Vaccinations.	Improving the uptake of flu vaccinations for front line staff	.25	£199000	Safety
CCG4: 72 hour follow up Post Discharge : Routine Submission to MHSDS	72 hour follow up is a key part of the work to support the Suicide Prevention Agenda. The NCE into Suicide and Safety in Mental Health found that the highest number of deaths occurred on day 3 post discharge.	.25	£199000	Safety
CCG 5 :Mental Health Data Quality: MHSDS (a)Data Quality Maturity Index (b) Mental Health Data Quality Interventions:	Accurate data is a key enabler for improvement in MH services The MHSDS DQMI score is an overall assessment of data quality for each provider, based on a list of key MHSDS data items. The MHSDS DQMI score is defined as the mean of all the data item scores for percentage valid & complete multiplied by a coverage score for the MHSDS. Achieving 70% of referrals where the second attended contact takes place between Q3-4 with at least one intervention (SNOMED CT procedure code) recorded using between the referral start date and the end of the reporting period.	.25	£199000	Safety
CCG 6: Use of Anxiety Disorder Specific Measures in IAPT: Routine submission to IAPT Data Set.	Achieving 65% of referrals with a specific anxiety disorder problem descriptor finishing a course of treatment having paired scores recorded on the specified Anxiety Disorder Specific Measure	.5	£398000	Safety

Herefordshire

Herefordshire Goal Name	Description	Goal weighting	Expected value	Quality Domain
CCG 2: Staff Flu Vaccinations.	Improving the uptake of flu vaccinations for front line staff	0.25	£52800	Safety
CCG4: 72 hour follow up Post Discharge :	72 hour follow up is a key part of the work	0.25	£52800	Safety

Herefordshire Goal Name	Description	Goal weighting	Expected value	Quality Domain
Routine Submission to MHSDS	to support the Suicide Prevention Agenda. The NCE into Suicide and Safety in Mental Health found that the highest number of deaths occurred on day 3 post discharge.			
CCG 5 :Mental Health Data Quality: MHSDS (a)Data Quality Maturity Index (b) Mental Health Data Quality Interventions:	Accurate data is a key enabler for improvement in MH services The MHSDS DQMI score is an overall assessment of data quality for each provider, based on a list of key MHSDS data items. The MHSDS DQMI score is defined as the mean of all the data item scores for percentage valid & complete multiplied by a coverage score for the MHSDS. Achieving 70% of referrals where the second attended contact takes place between Q3-4 with at least one intervention (SNOMED CT procedure code) recorded using between the referral start date and the end of the reporting period.	0.25	£52800	Safety
CCG 6: Use of Anxiety Disorder Specific Measures in IAPT: Routine submission to IAPT Data Set.	Achieving 65% of referrals with a specific anxiety disorder problem descriptor finishing a course of treatment having paired scores recorded on the specified Anxiety Disorder Specific Measure	0.25	£52800	Safety
5.Preventing ill health by risky behaviours – Alcohol and Tobacco	To offer advice and interventions aimed at reducing risky behaviour in admitted patients	0.25	£52800	Safety

Low Secure Services

Low Secure Goal Name	Description	Goal weighting	Expected value	Quality Domain
Maintenance of healthy weight	Substantial consequential health benefits and cost savings.	1.25	£24592	Effectiveness

Liaison Diversion

Low Secure Goal Name	Description	Goal weighting	Expected value	Quality Domain
Maintenance of healthy weight	Substantial consequential health benefits and cost savings.	1.25	£24592	Effectiveness

The total potential value of the income conditional on reaching the targets within the CQUINs during 2019/20 is £1,294,257.00 of which xxxx (to be completed at year end) was achieved.

In 2018/19, the total potential value of the income conditional on reaching the targets within the CQUINs was £2,440,000.00 of which £2,440,000.00 was achieved

2020/21 CQUIN Goals

To be completed at year end.

Statements from the Care Quality Commission

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

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

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

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

The CQC has not taken enforcement action against [2]gether NHS Foundation during 2019/20 or the previous year 2018/19.

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

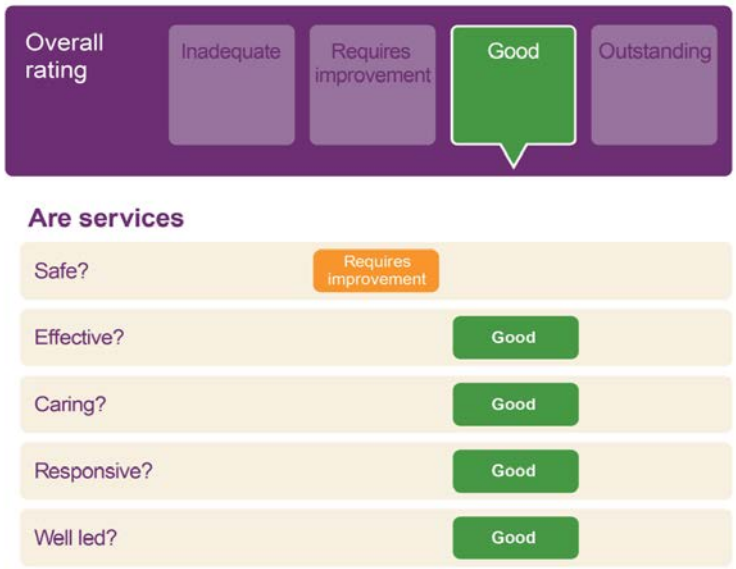
CQC Inspections of our services

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

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

New Ratings from latest review

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



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

In 2019/20 we are contributing to the CQC National review of seclusion and Long term segregation.

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

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

Quality of Data

To be completed at year end.

Information Governance

To be completed at year end.

Clinical Coding

[2]gether NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2019/2020 by the Audit Commission.

Learning from Deaths

During 1 July 2019 – 30 September 2019 136 patients of [2]gether NHS Foundation Trust died (correct as of 26 October 2019). This comprised the following number of deaths which occurred in each month of that reporting period:

46 in July,

55 in August,
35 in September.

The terminology used to describe the stages of Mortality Review changed in December 2018 following publication of the Royal College of Psychiatrists' Structured Judgement Review (SJR) documentation. The Mortality Review Committee (MoReC) adopted this methodology in January 2019 following discussion and agreement by the MoReC. The LD Mortality Review Group (LD MRG) have decided to continue with the Care Record Review (CRR) of LD patient deaths in order to facilitate continuity with the LeDeR process.

Following discussion at MoReC and at countywide Mortality Steering Groups in both Gloucestershire and Herefordshire, it was agreed to exclude from active review those patients open for ACI Monitoring only and those with a primary diagnosis of dementia who are over 70 years old. MoReC had become very aware that older people with dementia die as a natural consequence of the illness process resulting in limited learning from this cohort of patients. There will be a continued focus on those 70 years and under.

At the time of writing this paper, a total of 5 RCPsych Structured Judgment Reviews (SJRs) at MoReC and Care Record Reviews (CRRs) at LD MRG had been completed for deaths occurring in 2019/20 Q2.

MoReC was unable to meet in August 2019 due to a significant level of annual leave, which meant quoracy could not be established.

The number of deaths occurring in each month of 2019/20 Q2 for which a SJR, CRR, Clinical Incident (CI) investigation or Serious Incident (SI) investigation has been completed is:

4 in July,
2 in August,
0 in September.

The above figures do not include current open SJRs, CRRs, CI Investigations and SI Investigations for deaths which occurred during 2019/20 Q2.

For the above figures, 0 deaths representing 0.0% of the 136 patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided [2]gether NHS Foundation Trust to the patient. In relation to each month, this consisted of:

0 representing 0% for July
0 representing 0.0% for August
0 representing 0% for September.

At time of writing this paper, 18 deaths, representing 13.0% of the 136 patient death incidents occurring in 2019/20 Q2 were still open and undergoing mortality review. 7 incidents were awaiting death information, which included toxicology results, and 5 were awaiting SJR by MoReC or CRR by LD MRG. There were 5 open SI Investigations and 0 open CI Investigations.

During 2019/20 Q2, following SJRs of patient deaths, together with patient deaths brought for discussion only, MoReC has made the following Recommendations:

- Following the review of the expected death of an 89 year old inpatient at Stonebow Unit, the Committee noted that during the tos and fros to Hereford County Hospital, it was not clear in the notes that the patient continued to have capacity, which should have indicated a MCA assessment. Although the patient's family was included and were in agreement not to move the patient to a nursing home with best interests in mind, the Committee noted there was no evidence that a MCA2 was completed or that DoLS was considered. The

Committee decided to reflect back to HfD Locality, via the locality's Deputy Medical Director, that frail and elderly inpatients need to have regular assessments of their capacity and where serious medical decisions are taken, they need to be accompanied by a MCA2.

- Following the review of the death of a 94 year old patient who had recently been discharged from CLH, the Committee noted that whilst an inpatient in CLH, the patient had been assessed as lacking capacity and was then discharged without a diagnosis of dementia. The Committee noted that no investigation took place to ascertain whether the patient was low due to depression. The Committee recommended that clinicians be more vigilant and think more holistically by considering all possibilities. This recommendation was taken to the OPS Consultants Meeting and also to the MHARS Team Manager. The Deputy Medical Director for Operations has agreed to facilitate Mini ACE training for psychologists going forward.

- Following the review of two expected deaths of inpatients suffering with dementia at CLH where usual doses of EOL medications struggled to control symptoms, the Committee noted that Palliative Care Consultant had recommended increasing doses above and beyond that of the norm. The Committee noted that patients dying of dementia seem often to require higher doses of EOL medications to control their symptoms and concluded that some research in this area would be worthwhile. Mulberry Ward Manager has agreed to discuss with Palliative Care Nurses the possibility of research regarding doses of EOL medications for patients suffering with dementia, including an audit of what is currently being prescribed.

Part 2.3: Mandated Core Indicators 2019/20

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 2018-19	Quarter 2 2018-19	Quarter 3 2018-19	Quarter 4 2018-19	Quarter 1 2019-20
[2]gether NHS Foundation Trust	97.6%	98.4%	97.7%	99.1%	100%
National Average	95.8%	95.7%	95.5%	95.5%	95.1%
Lowest Trust	73.4%	88.3%	81.6%	83.5%	86.1%
Highest Trust	100%	100.%	100%	100%	100%

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

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

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

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

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

	Quarter 1 2018-19	Quarter 2 2018-19	Quarter 3 2018-19	Quarter 4 2018-19	Quarter 1 2019-20
[2]gether NHS Foundation Trust	99.4%	99.4%	98.9%	99.3%	100%
National Average	98.1%	98.4%	97.8%	98.1%	98.2%
Lowest Trust	85.1%	81.4%	78.8%	88.2%	84.0%
Highest Trust	100.00%	100.00%	100%	100%	100%

[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;

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

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

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

	Quarter 2	Quarter	Quarter	Quarter	Quarter

	2018-19	3 2018-19	4 2018-19	1 2019-20	2 2019-20
[2]gether NHS Foundation Trust 0-15	0%	0%	0%	0%	0%
[2]gether NHS Foundation Trust 16 +	6.1%	7.8%	5.6%	4.0%	5.8%

[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.

[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 responded positively to " if a friend or relative needed treatment I would be happy with the standard of care provided by the Organisation"

	NHS Staff Survey 2016	NHS Staff Survey 2017	NHS Staff Survey 2018	NHS Staff Survey 2019
[2]gether NHS Foundation Trust Score	72.6%	74.2%	74.5%	Not yet reportable
National Average Score	58.9%	61.2%	61.3%	
Worst Trust Score	44.1%	41.6%	38.2%	
Best Trust Score	82.2%	86.5%	80.8%	

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

- For the third year running, all staff in post were invited to take part in the survey. Previously the survey had only been sent to a random sample of staff. The overall response rate in the most recent survey was **40.55%** (reduced from 44% the previous year). This equated with **863** staff taking the time to contribute their views. The survey provides a rich and accurate picture of the staff views on the Trust's services to date.

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

- Improve response rates
- Improve further staff engagement
- Improve the quality of appraisals
- Improve our Safe Environment by reducing Bullying and Harassment
- Improving our Quality of Care

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 2016	NHS Community Mental Health Survey 2017	NHS Community Mental Health Survey 2018	NHS Community Mental Health Survey 2019
[2]gether NHS Foundation Trust Score	8.0	8.0	7.7	Not yet reportable
National Average Score	Not available	Not available	Not available	
Lowest Score	6.9	6.4	5.9	
Highest Score	8.1	8.1	7.6	

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

- [2]gether is categorised as performing 'better' than the majority of other mental health Trusts in 5 of the 11 domains and 'about the same' as the majority of other mental health Trusts in the remaining 6 domains.

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

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

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

	1 April 2018 - 30 September 2018				1 October 2018 - 31 March 2019			
	Number	Rate*	Severe	Death	Number	Rate*	Severe	Death
[2]gether NHS Foundation Trust	2385	68.2	2	14	2872	79.64	6	15
National	169,041	-	548	25.21	187,449	-	556	1312
Lowest Trust	16	24.9	0	110	3	14.92	0	0
Highest Trust	9204	114.3	129	1286	9058	118.87	118	77

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

[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.

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

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

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

- Developing a suite of reports and Dashboards to aid monitoring of incidents on wards to assist staff in identifying themes and trends plus hot spots.

Part 3: Looking Back: A Review of Quality during 2019/20

Introduction

The 2019/20 quality priorities were agreed in May 2019.

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 2019/2020

Effectiveness		2017 - 2018	2018 - 2019	Q2 2019-2020
1.1	To improve the physical health of patients with a serious mental illness on CPA by a positive cardio metabolic health resource (Lester Tool).	**Achieved**	**Achieved**	**Achieved**
1.2	To further improve personalised discharge care planning in adult and older peoples wards, including the provision of discharge information to primary care services within 24hrs of discharge.	**Not achieved**	**Not achieved**	**Maintained**
1.3	To ensure that joint Care Programme Approach reviews occur for **all** service users who make the transition from children's to adult services.	**Not achieved**	**Achieved**	**Achieved**
User Experience				
2.1	Were you involved as much as you wanted to be in agreeing the care you will receive? **> 84%**	**Not achieved**	**Achieved**	**Not achieved**
2.2	Have you been given information about who to contact outside of office hours if you have a crisis? **> 71%**	**Achieved**	**Achieved**	**Achieved**
2.3	Have you had help and advice about taking part in activities that are important to you? **> 64%**	**Achieved**	**Achieved**	**Achieved**
2.4	Have you had help and advice to find support to meet your physical health needs if you needed it? **> 73%**	**Achieved**	**Achieved**	**Achieved**
Safety				
3.1	Reduce the proportion of patients in touch with services who die by suspected suicide when compared with data from previous years. This will be expressed as a rate per 1000 service users on the Trust's caseload.	**Not achieved**	**Achieved**	**Achieved**
3.2	Detained service users who are absent without leave (AWOL) will not come to serious harm or death. We will report against 3 categories of AWOL as follows; harm as a consequence of: 1. Absconded from escort 2. Failure to return from leave 3. Left the hospital (escaped)	**Achieved**	**Achieved**	**Achieved**
3.3	To increase the use of supine restraint as an alternative to prone restraint	**Not Measured**	**Not achieved**	**Achieved**
3.4	To ensure that 100% of service users within Berkeley House have a bespoke restrictive intervention care plan tailored to their individual need.	**Not measured**	**Achieved**	**Achieved**
3.5	To further develop a quality improvement led approach to robustly embed lessons learned following serious incidents.	**Not measured**	**Not measured**	**On Target**

Easy Read Report on Quality Measures for 2018/2019

Quality Report 	This report looks at the quality of [2]gether's services. We agreed with our Commissioners the areas that would be looked at.	
Physical health 	We increased physical health tests and treatment for people using our services. We met the target.	↑
Discharge Care Plans 	More people had all parts of their discharge care plan completed at the end of the quarter than previously. There is improvement being made. We met the target.	↔
Care (CPA) Review 	All people moving from children's to adult services had a care review. We met the target.	↑
Care Plans 	79% of people said they felt involved in their care plan. This is less than the target (84%).	↓
Crisis 	74% of people said they know who to contact if they have a crisis. This is more than the target (71%). We met the target.	↑

Activity 	74% of people said they had advice about taking part in activities. This is more than the target (64%). We met the target.	↑
Physical Health 	89% of people said they had advice about their physical health This is more than the target (73%). We met the target.	↑
Suicide 	There were fewer suicides compared to this time last year. We met the target	↑
AWOL 	In patients who were absent without leave did not come to serious harm or death. We met the target.	↑
Face down restraint 	We have reduced the number of face-down restraints this year but we are still doing more of these than face up restraints. We met the target.	↑
Physical Intervention Care Plans 	Everyone at Berkley House has one of these. We met the target.	↑
Learning from serious incidents 	We are working hard to learn from serious incidents so that fewer people will come to harm. We aim to have met this target by March 2019.	↔

Effectiveness

In 2019/20 we remain committed to ensure that our services are as effective as possible for the people that we support. For the second consecutive year we set ourselves 3 targets against the goals of:

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

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

Within Quarter 2, the [2]gether NHS Foundation Trust has committed to offer a full cardio metabolic check to all inpatients and all SMI/CPA service users in the community. Our target for compliance remains at; 90% of inpatients and 75% of community patients will receive the health check and will have any associated interventions offered if required.

Regular auditing continues to ensure compliance, and feedback to nursing teams is sent monthly. Current audits indicates that we are meeting these targets.

There are robust systems in place to ensure existing staff continue to receive refresher training, and that all new staff receive information on physical health checks on their induction to the Trust. Work continues to update the Health &Lifestyle form on the electronic patient record to include details of national screening, dental and contraception options available for service users. Further training will be rolled out to staff Trust wide later in the year.

Successful physical health clinics continue to run at Pullman Place, Gloucester and 27a St Owen Street, Hereford providing service users in the community access to physical health checks in an environment with staff who are familiar to them. Such is the success of the physical health clinics, it is hoped to employ a Physical Health Nurse for one day a week to take a lead on developing the clinics further within Pullman Place.

The Trust has purchased nine ECG machines for the community hubs. These will provide the opportunity for routine ECG screening for possible cardiac anomalies for patients who are at an increased cardio metabolic risk, largely due to medication side effects and lifestyle factors. Training for staff to take ECG's has been provided by the Physical Health Facilitator, and refresher training for medics to interpret ECG's will be held internally by the Trust own medical team.

Alongside this health screening work, [2]gether continues to increase access to physical health treatment for service users. The Quality Improvement initiative 'Well Woman Wednesdays' at Wotton Lawn Hospital, where ladies are offered a full range of advice and success to cervical screening in house, has now been expanded to the community Hub. This has enable service users to access this vital screening in an environment they are familiar with.

[2]gether has continued to work with “Equally Well” which is a national collaborative to support the physical health of people with a mental illness. The Trust have been working with the Royal College of Nursing to collaborate with a parity of esteem/lived experience project with service users. This will involve offering ECG screening to patients within their own home if they are unable to attend the community hub,

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 2016/17 we focused on making improvements to discharge care planning to ensure that service users are actively involved in shared decision making for their discharge and the self-management care planning process. Identical criteria are being used in the services across both counties as follows:

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

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

		Current compliance (Q1 2019/20)	Direction of travel and previous compliance (Q1 2019/120)
1.	Has a Risk Summary been completed?	100%	⇔100%
2.	Has the Clustering Assessment and Allocation been completed?	94%	⇧92%
3.	Has HEF been completed? (LD only)	100%	⇔100%
4.	Has the Pre-Discharge Planning Form been completed?	32%	⇧23%
5.	Have the inpatient care plans been closed within 7 days of discharge?	28%	⇧26%
6.	Has the patient been discharged from bed?	100%	⇔100%
7.	Has the Nursing Discharge Summary Letter to Client/GP been sent within 24 hours of discharge?	87%	⇩93%
8.	Has the 48 hour follow up been completed if the Community Team are not doing it?	67%	⇩82%

Overall compliance for the Trust (Gloucestershire and Herefordshire) for Quarter 2 was **75%** compared to **75%** in Quarter 1; this means compliance has stayed the same across the Trust this year and has been maintained at a higher percentage than at year end 2018/19. Overall

compliance for Gloucestershire only for Quarter 2 was 72% compared to 76% in Quarter 1, this means there has been a 4% decrease in compliance. Overall compliance for Herefordshire only for Quarter 2 was 78% compared to 74% in Quarter 1, this means that there has been a 4% increase in compliance.

During Quarter 2 of 2019/20 there were 78 discharges from Herefordshire and 166 from Gloucestershire. The total number of discharges across the Trust was 244.

Quarter 1 results from the audits against these standards are seen below.

Gloucestershire Services

	Compliance				
Criterion	**Year End (2018/19)**	**Quarter 1 (2019/20)**	**Quarter 2 (2019/20)**	**Cumulative (2019/20)**	**Direction of Travel**
Overall Average Compliance	**69%**	**76%**	**72%**	**74%**	⇩
Chestnut Ward	84%	85%	69%	77%	⇩
Mulberry Ward	70%	74%	72%	73%	⇩
Willow Ward	69%	70%	67%	68.5%	⇩
Abbey Ward	70%	75%	84%	79.5%	⇧
Dean Ward	71%	82%	85%	83.5%	⇧
Greyfriars PICU	58%	70%	71%	70.5%	⇧
Kingsholm Ward	72%	70%	70%	70%	⇔
Priory Ward	76%	87%	78%	82.5%	⇩
Montpellier Unit	61%	62%	50%	56%	⇩
Honeybourne	64%	78%	61%	69.5%	⇩
Laurel House	71%	79%	83%	81%	⇧
Berkeley House	63%	N/A		N/A	

Herefordshire Services

Criterion	**Year End (2018/19)**	**Quarter 1 (2019/20)**	**Quarter 2 (2019/20)**	**Cumulative (2019/20)**	**Direction of Travel**
Overall Average Compliance	**71%**	**74%**	**78%**	**76%**	⇧
Cantilupe Ward	78%	78%	71%	74.5%	⇩
Jenny Lind Ward	70%	73%	76%	74.5%	⇧
Mortimer Ward	66%	75%	82%	78.5%	⇧
Oak House	65%	71%	83%	71%	⇧

We are currently maintaining this target but there is a risk that this may not be achieved at year end.

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

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

Results from 2018-19 transitions are also included below so that historical comparative information is available.

2018-19 Results

Gloucestershire Services

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

Herefordshire Services

Criterion	Compliance Quarter 1 (2018/19)	Compliance Quarter 2 (2018/19)	Compliance Quarter 3 (2018/19)	Compliance Quarter 4 (2018/19)
Joint CPA Review	100%	Not applicable	100%	100%

2019-20 Results

Gloucestershire Services

Criterion	Compliance Quarter 1 (2019/20)	Compliance Quarter 2 (2019/20)	Compliance Quarter 3 (2019/20)	Compliance Quarter 4 (2019/20)
Joint CPA Review	100%	Not applicable		

Herefordshire Services

Criterion	Compliance Quarter 1 (2019/20)	Compliance Quarter 2 (2019/20)	Compliance Quarter 3 (2019/20)	Compliance Quarter 4 (2019/20)
Joint CPA	100%	100%		

Review				

We are pleased to report that during Quarters 1 & 2 2019/20 all young people who transitioned into adult services had a joint CPA review. This is consistent with last year's performance.

To improve our practice and documentation in relation to this target, a number of measures were developed and implemented during 2018-19 as follows:

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

These measures will continue to be used to promote good practice into 2019/20.

We are currently meeting this target.

User Experience

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

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

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

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

Data for Quality Survey (Quarter 2 2019/20 – July to September 2019) results:

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

Question	County	Number of responses	Target Met?
Were you involved as much as you wanted to be in agreeing the care you receive?	Gloucestershire	64 (51 positive)	79% TARGET 84%
	Herefordshire	8 (6 positive)	
	Total	72 (57 positive)	

This target has not been met.

Whilst we recognise that we have not met this target this quarter a high level of positive experiences have been received from those who responded.

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

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

Question	County	Number of responses	Target Met?

Have you been given information about who to contact outside of office hours if you have a crisis?	Gloucestershire	72 (53 positive)	74% **TARGET 71%**
	Herefordshire	8 (6 positive)	
	Total	80 (59 positive)	

This target has been met.

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

Question	County	Number of responses	Target Met?
Have you had help and advice about taking part in activities that are important to you?	Gloucestershire	58 (42 positive)	74% **TARGET 64%**
	Herefordshire	8 (7 positive)	
	Total	66 (49 positive)	

This target has been met.

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

Question	County	Number of responses	Target Met?
Have you had help and advice to find support for physical health needs if you have needed it?	Gloucestershire	62 (55 positive)	89% **TARGET 73%**
	Herefordshire	8 (7 positive)	
	Total	70 (1626 positive)	

This target has been met.

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

Although response rates for the survey have increased over time the level of response continues to be lower than we would like. During Quarter 2 we have continued to implement a new system to capture survey feedback with aim to increase the number of responses we receive to both aspects of the 'How did we do?' survey.

From 1st October 2019 onwards the Patient Experience Department will have a dedicated survey lead and work stream to focus on seeking feedback via differing survey methods with the aim of increasing response rates and obtaining more opinion and meaningful data about the services that we provide.

Friends and Family Test (FFT)

FFT responses and scores for Quarter 2, 2019/20

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

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

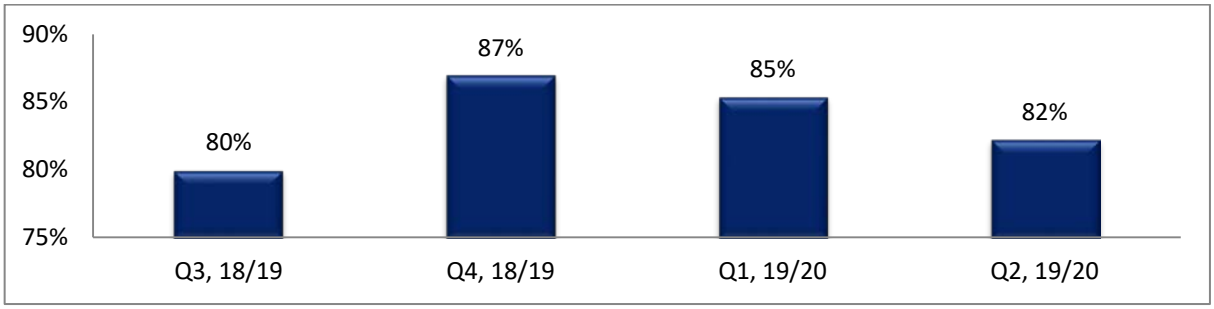
The table below details the number of combined total responses received by the Trust each month in Quarter 1. The FFT score is the percentage of people who stated that they would be 'extremely likely' or 'likely' to recommend our services. These figures are submitted for national reporting.

	Number of responses	FFT Score (%)
July 2019	76 (60 positive)	79%
August 2019	40 (33 positive)	83%
September 2019	53 (46 positive)	87%
Total	169 (625 positive) **(last quarter = 732)**	**82%** **(last quarter = 85%)**

The FFT score for our Trust has remained about the same this quarter; this continues to be encouraging news following disappointing decreases seen in previous quarters last year.

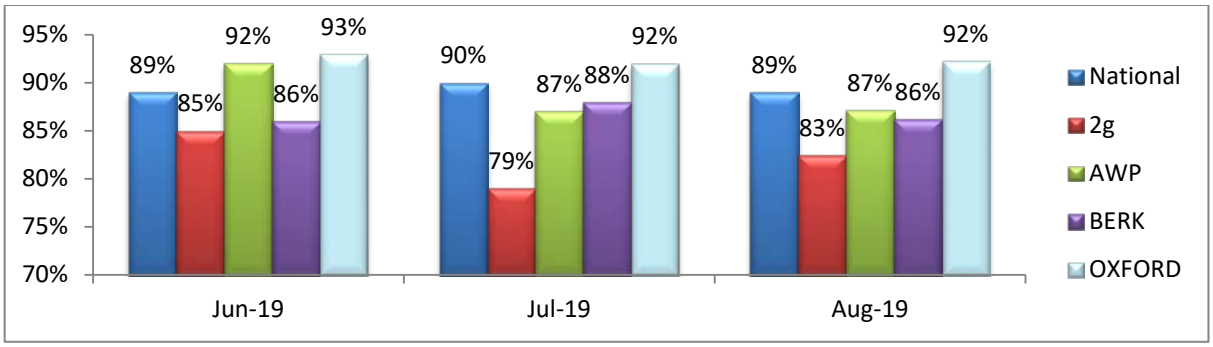
SED continue to monitor FFT scores and undertake further analysis of scores to identify any areas that are influencing lower ratings.

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



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

The chart below shows the FFT scores for June, July, and August 2019 (the most recent data available) compared to other Mental Health Trusts in our region and the national average. Our Trust consistently receives a high percentage of recommendation although we have achieved lower scores than other Trusts in our region in recent quarters. This is a reversal from previous years and does not triangulate with our positive National Survey scores (September 2019 data are not yet available)



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

Complaints

To be completed at year end

Safety

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

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

There are 3 associated targets.

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

We aim to minimise the risk of suicide amongst those with mental disorders through systematic implementation of sound risk management principles. In 2013/14, during which year we reported **22** suspected suicides, we set ourselves a specific quality target for there to be fewer deaths by suicide of patients in contact with teams and we have continued with this important target each year. Sadly the number increased and during 2016/17 we reported **26** suspected suicides and in 2017/18 the number of reported suspected suicides increased to **28.** We are pleased to report that by the end of 2018/19 the number had reduced and that we reported **25** suspected suicides. At the end of Quarter 2 2019/20, 10 suspected suicides had been reported as seen in Figure 1.

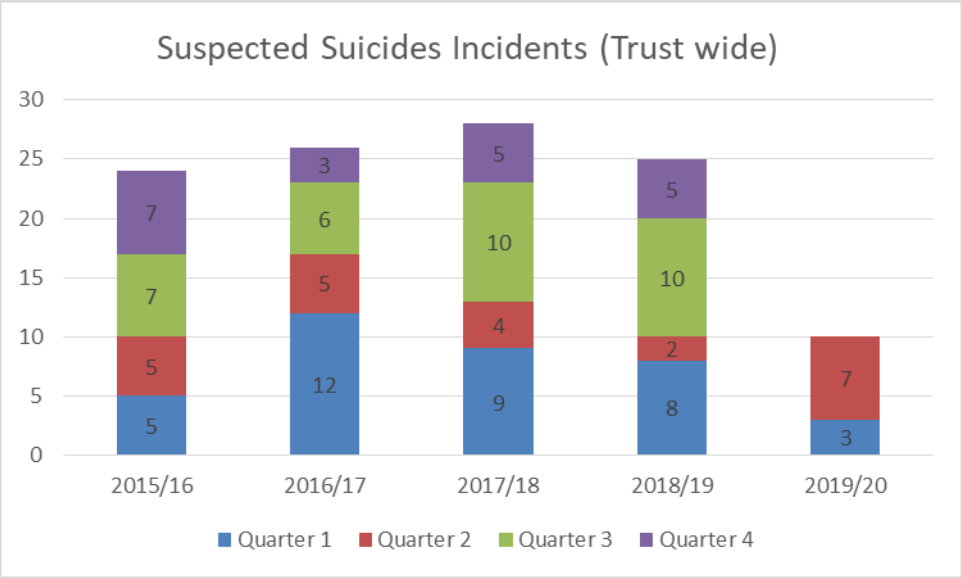


Figure 1

What we also know is that we are seeing more and more service users on our caseload year on year, so we measured this important target differently this year. This is also reported as a rate per 1000 service users on the Trust caseload. The graph in Figure 2 shows this rate from 2014/15 onwards for all Trust services covering Herefordshire and Gloucestershire, and we are aiming to see the median value (green line) get smaller. During 2015/16, 2016/17 and 2017/18 the median value was 0.09. By the end of 2018/19 the median value reduced to 0.06 and at the end of Quarter 2 2019/20 this has reduced further to 0.04.

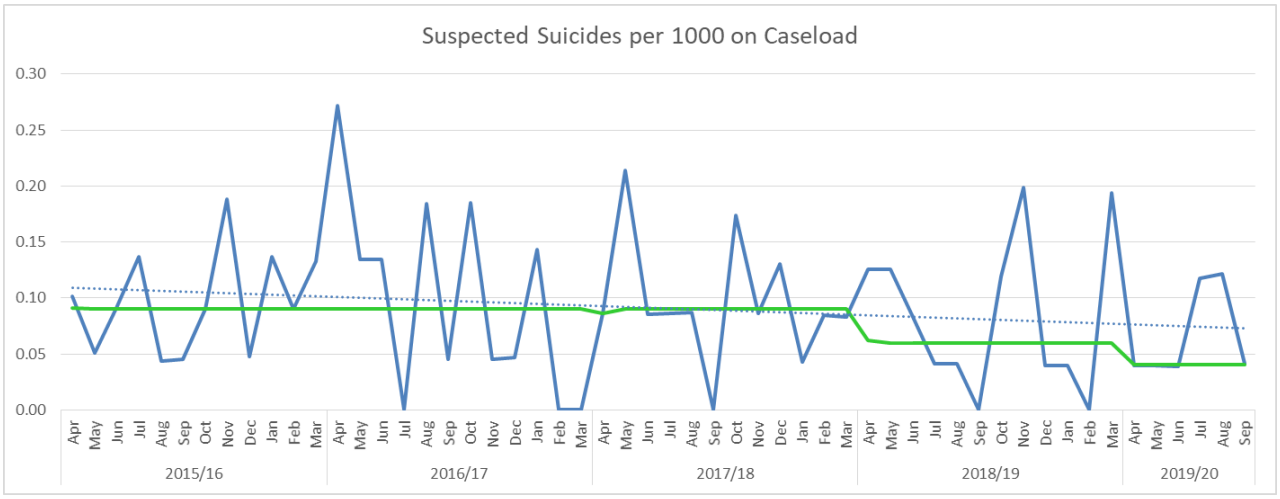


Figure 2

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

In 2019/20 we are working with partners in our ICS and Public health to further improve suicide reduction approaches such as the “Zero Inpatient Suicide initiative”

We are currently meeting this target.

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

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

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

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

In **2017/18** we reported **170** occurrences of AWOL (142 in Gloucestershire and 28 in Herefordshire detailed in the table below). There are a number of factors which influence this, including open wards, increased numbers of detained patients in our inpatient units, increased acuity, and on occasion, service users who leave the hospital without permission multiple times. **190** occurrences were reported during **2017/18.**

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

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

None of these incidents led to serious harm or death.

At the end of **2018/19** the following occurrences of AWOL were reported.

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	62	66	16	**144**
Herefordshire	46	0	0	**46**
Total	**108**	**66**	**16**	**190**

None of these incidents led to serious harm or death.

At the ends of Quarter 2 2019/20 the following cumulative occurances were reported.

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total

Gloucestershire	54	39	9	**102**
Herefordshire	23	1	2	**26**
Total	**77**	**40**	**7**	**128**

None of these incidents led to serious harm or death.

We are meeting this target

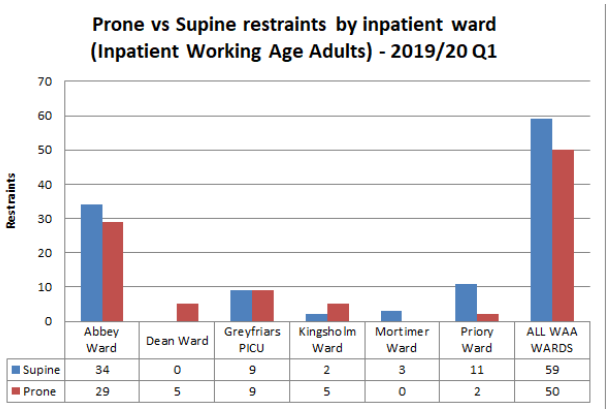
Target 3.3 To increase the use of supine restraint as an alternative to prone restraint (on all adult wards & PICU)

The use of prone restraint (face down) is sometimes necessary to manage and contain escalating violent behaviour, however it is also a response that has potential to cause harm to an individual. As a Trust we want to minimise the use of this wherever possible through therapeutic engagement and occupation in the inpatient environment; alongside effective de-escalation techniques and alternatives to prone restraint.

The Trust has a sub group focused on reducing physical restraint, in line with national guidance, reporting into our Trust Governance Committee. From reviewing our restraint data in detail over the past 3 years, we have seen a reduction in physical restraint and a positive increase in the use of supine restraint as an appropriate and safer alternative to prone restraint. This is due to active promotion of techniques used.

In 2018/19 our quality aim was to see a continued increase in the use of supine restraint as an alternative to prone restraint. During the year there were 124 prone restraints and 121 supine restraints, a difference of 3 more prone restraints. We, therefore, missed our 2018/19 quality improvement target for prone restraints to be lower than supine restraints, however, clinical staff made good progress in this area and our analysis of the challenge has indicated where clinical exceptions have led to the use of prone restraint over supine.

In 2019/20 we will continue doing further work to address this including additional work on training staff in alternative injection sites, the development of new approaches to alternatives to prone restraint and, of course, on-going work to reduce all forms of restraint in inpatient services.



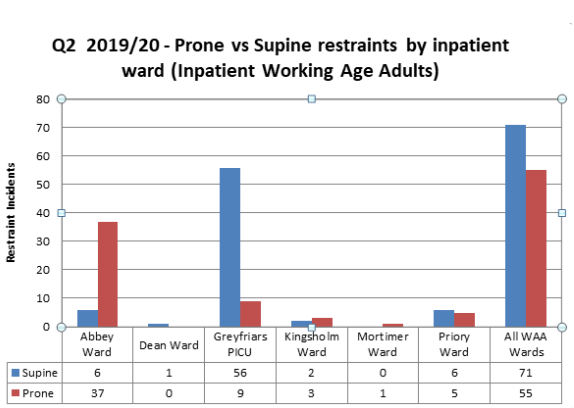


Figure 3

Figure 3 above shows a ward by ward comparision of the use of these techniques during Quarters 1 & 2 . The higher use of prone restraint on Abbey Ward is predominantly due to one patient who has specifically requested to be restrained (when such intervention is required) in the prone position.

Figure 4 below shows the spread of all physical inteventions used on our adult wards and the PICU during Quarter 2 and it is reassuring to note that, wherever possible, the least restrictive practices e.g seated or precautonary holds are used. Supine or prone restraint are only used when a person's safety becomes compromised.

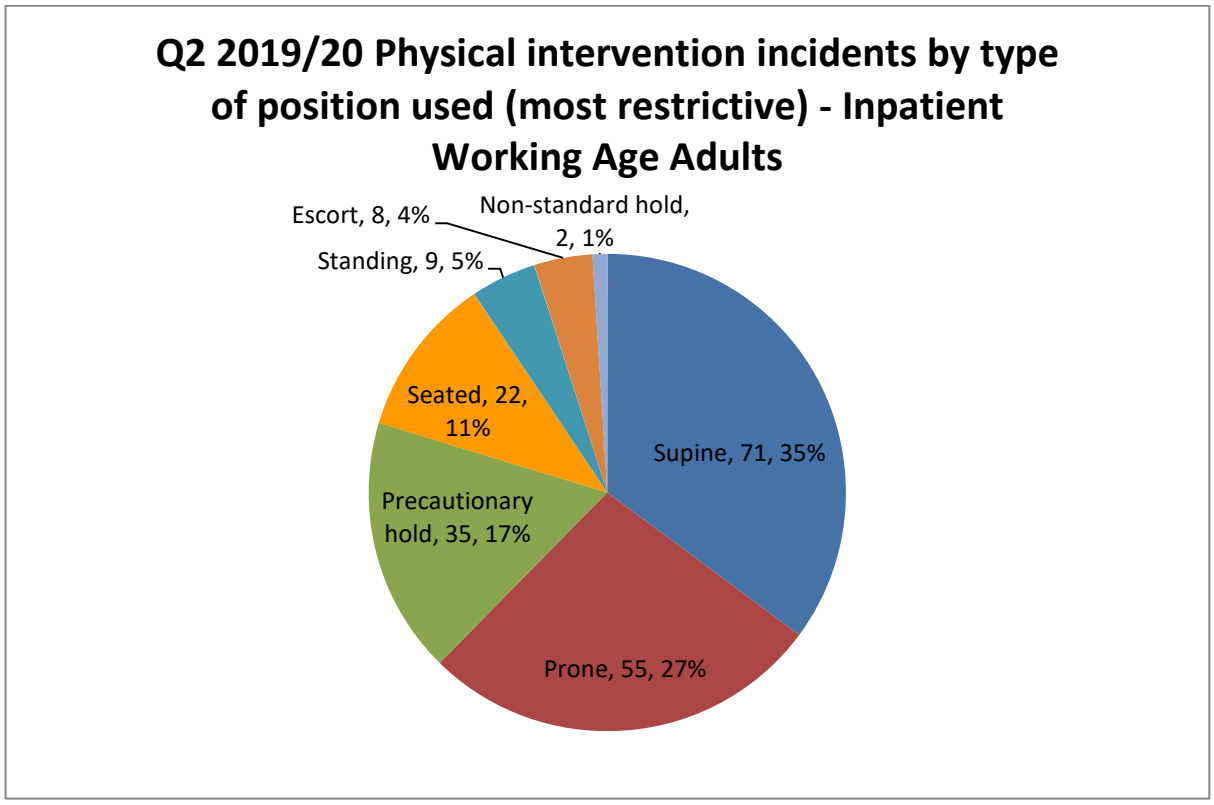


Figure 4

We are currently meeting this target.

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

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

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

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

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

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

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

All these plans are written following assessment and advice obtained from PBM trainers about any patient specific interventions (1 staff member at Berkeley House is also a PBM trainer). Also included in these plans are sensory interventions formulated by an occupational therapist which are implemented at associated primary and secondary phases appropriate for each individual.

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

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

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

We are currently meeting this target.

Target 3.5 To further develop a quality improvement led approach to robustly embed lessons learned following serious incidents.

The Trust Serious Incident Review Process was reviewed during Quarter 4 2018/19 by Price Waterhouse Coopers (PWC) internal audit team. PWC assessed the effectiveness of the change in the Trust's Serious Incidents Requiring Investigation (reporting mechanisms, examined the processes in place for implementing relevant SIRI action plans and how lessons learned identified are shared across the Trust.

PWC Conclusion

Overall, the SIRI process has seen significant improvements in terms of timely submissions of SI reports, whilst also maintaining the quality. Investigations are undertaken by the central investigation team with the support of a relevant team manager, which has improved the quality, as the reports are now prepared by dedicated experts. There have been improvements in the process including overall turnaround time in producing reports, consistency in the quality of the reports, and the utilisation of a family liaison officer to support the families impacted, there is further scope to strengthen key areas that impact on the SIRI process and ensure the foundation and outcome of the investigations process is sustainable.

PWC raised 4 recommendations for Trust action

1. There is a robust and effective mechanism to share lessons learned across the Trust, however there is a scope to enhance the implementation in practice, embed the learning and the assurance mechanisms to determine effectiveness.

2. The incident policy document is not up to date and wholly reflective of the current process around engaging with local CCGs and related reporting mechanisms, elements were identified which would benefit from further clarity and detail matched to current activities and reporting mechanism.

3. The terms of reference for the SI action plan subcommittee has not been updated since April 2016 when the sub committee was formed there are opportunities to update the TOR and ensure it is reflective of current activities, roles and responsibilities.

4. Recommendations and actions arising from the serious incident reports should be measurable and realistic to ensure full implementation across the Trust a Sample tested found this not to be consistently the case

Action Taken to address

These recommendations have all been actioned and reported to the Trust audit committee. Work is on-going via the Quality Team regarding improving embedding lessons learned from serious incidents and this will be monitored and evaluated by the Quality Governance System within Gloucestershire Health & Care NHS Foundation when it becomes a legal entity from 1 October 2019.

We anticipate meeting this target by year end 2019/20.

Serious Incidents reported during 2018/19

By the end of Quarter 2 2019/20, **19** serious incidents were reported by the Trust; the types of these incidents reported are seen below.

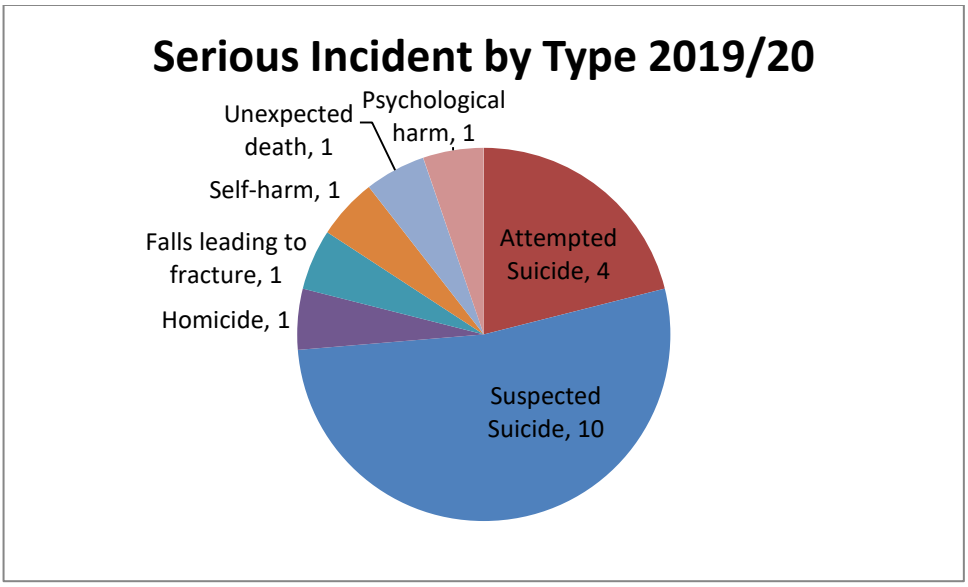


Figure 5

All serious incidents were investigated by a dedicated resource of clinicians, all of whom have been trained in root cause analysis techniques.

Wherever possible, we include service users and their families/carers to ensure that their views are central to the investigation, we then provide feedback to them on conclusion and copies of our investigation reports. During 2018/19 we continued to develop processes to provide improved support to people bereaved by suicide and in May 2018 18 staff were trained in Postvention techniques by the charity Suicide Bereavement UK. These trained staff now act voluntarily as Family Liaison Officers (FLOs) and are allocated to support families of service users on our caseload who have died by suspected suicide. We have plans for 2019/20 to train more staff in working positively with families.

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

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

Duty of Candour

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

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

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

poster regarding this on every staff notice board. During the CQC comprehensive inspection of our services in 2015, they reviewed how the Duty of Candour was being implemented across the Trust and provided the following comments in their report dated 27 January 2016.

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

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

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

Freedom To Speak Up – Quality Account Statement

[2]gether NHS Foundation Trust have fully integrated the need for staff to speak up in line with the recommendations from the Robert Francis report following the Mid Staffordshire enquiry and also subsequent enquiries that have highlighted the need for staff to have various pathways through which to raise concerns. These have been integrated into the Trusts 'Speaking up at Work Policy' which describes the various routes that staff can employ in order to raise concerns. The following information outlines the current provision within the Trust in regard to how staff can raise concerns freely and without suffering detriment from doing so.

In October 2016 [2]gether NHS Foundation Trust appointed a Freedom to Speak up Guardian whose role is to help:

- protect patient safety and the quality of care
- improve the experience of workers
- promote learning and improvement

The Freedom to Speak up Guardian does this by ensuring that staff are supported in speaking up and that barriers to speaking up are addressed. They also help to ensure that a positive culture of speaking up is fostered and that any issues raised are used as opportunities for learning and improvement. To enhance the role, Freedom to Speak Up advocates have also been appointed who assist individuals to consider the available options to raise concerns and to identify appropriate routes to do so.

The Trusts 'Speaking up at Work Policy' clearly states that staff who genuinely raise a concern will not be at risk of losing their job or suffering any form of detriment or retribution as a result. Provided that they are acting in good faith, it does not matter if they are mistaken or if there is a genuine explanation for their concerns. It goes on to describe how, should any individual subject an employee to victimisation or harassment due to making a qualified disclosure, this would be seen and treated as a serious disciplinary offence.

Other options available to staff within the Trust include:

Dignity at Work Officers – A Dignity at Work officer is a member of staff who undertakes this role in addition to their day to day job. They have been identified as someone who has the skills, understanding and empathy that makes them approachable to other staff. They are volunteers.
Their role is to provide support and guidance to anyone who feels that they are a victim of harassment or bullying in the workplace. They will provide unbiased and confidential independent

advice as to the options available and try to help you gain an insight into what can be done about a situation. During 2018, we recruited and trained additional Dignity at Work Officers.

Speak in Confidence – Speak In Confidence is a web-based system enabling staff to have an anonymous and confidential dialogue about issues that you may be concerned about, with a manager of your choice (there is a list of managers to choose from on the system which also includes the Trusts Freedom to Speak up Guardian to enable anonymous reporting to occur) Speak In Confidence has been introduced primarily to support staff who are subjected to inappropriate behaviour but who do not feel able to raise the issue through existing channels. The need for an alternative method of reporting issues was highlighted by the 2014 Staff Survey.Additionally, the Trust is now working in partnership with Gloucestershire Care Service NHS Trust to train and support Freedom to Speak Up Advocates. These are staff members who are provided with training and a network to improve further how staff can access advice and be signposted appropriately.

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

[2]gether NHS Foundation Trust has continued to build on the work previously reported under the umbrella of "Sign up to Safety". Sign up to Safety has evolved since its launch in 2014 and over time has narrowed its mission to focus on safety culture. The Patient Safety and Quality improvement initiatives are ongoing and some embedded as part of the way we do things here, demonstrating how a safety culture is in development. Monitoring is ongoing but reported every 6 months via the Trust Governance Committee. An example of this is the Trust's ongoing commitment to the South of England Mental Health Collaborative and the work developing around sharing the learning from deaths in mental health where an expert by experience is working in partnership with clinicians to understand ligature risks and ultimately learn together to improve safety.

NHSI Indicators 2019/2020

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

		National Threshold	2017-2018 Actual	2018-2019 Actual	2019-2020 Actual
1	Early Intervention in psychosis EIP: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	50%	**70%**	**72%**	**73%**
2	Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered routinely in the following service areas: -inpatient wards -early intervention in psychosis services -community mental health services (people on CPA)		**95%** **92%** **90%**	90% 92% 78%	
3	Improving access to psychological therapies (IAPT): Proportion or people completing treatment who move to recovery (from IAPT database) Waiting time to begin treatment (from IAPT minimum dataset - treated within 6 weeks of referral - treated within 18 weeks of referral	50% 75% 95%	**50%** **67%** **85%**	**52%** **96%** **96%**	**50.5%** **99%** **99%**
4	Admissions to adult facilities of patients under 16 years old.		**1**	**0**	**0**
5	Inappropriate out-of area placements for adult mental health services		**24**	**52**	**6**

Community Survey 2018

To be completed when the national survey results are published.

Staff Survey 2018

To be completed when the national survey results are published.

PLACE Assessment 2018

To be completed when results are published.

Annex 1: Statements from our partners on the Quality Report

To be completed at year end.

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

To be completed at year end.

Annex 3: Glossary

ADHD	Attention Deficit Hyperactivity Disorder
BMI	Body Mass Index
CAMHS	Child & Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
CPA	Care Programme Approach: a system of delivering community service to those with mental illness
CQC	Care Quality Commission – the Government body that regulates the quality of services from all providers of NHS care.
CQUIN	Commissioning for Quality & Innovation: this is a way of incentivising NHS organisations by making part of their payments dependent on achieving specific quality goals and targets
CYPS	Children and Young Peoples Service
DATIX	This is the risk management software the Trust uses to report and analyse incidents, complaints and claims as well as documenting the risk

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

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

Annex 4: How to Contact Us

About this report

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

Paul Roberts
Chief Executive
2gether NHS Foundation Trust
Edward Jenner Court
Pioneer Avenue
Gloucester Business Park
Brockworth
Gloucester
GL3 4AW

Telephone: 0300 421 8100 Email: 2gnft.comms@nhs.net

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 0300 421 7146.

Agenda Item 11

Report to:	Gloucestershire Health and Care NHS Foundation Trust Board –
Author:	Maria Bond, Non-Executive Director
Presented by:	Maria Bond, Non-Executive Director
SUBJECT:	**NON EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS QUARTER**

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

EXECUTIVE SUMMARY

A Non-Executive Director Audit of Complaints was conducted covering three complaints that had been closed during Quarter 2 2019/20.

RECOMMENDATIONS

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

1. INTRODUCTION

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

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

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

2. SUMMARY OF FINDINGS

2.1 Case 1

Summary of Complaint

This complaint concerned the way a patient was treated in her appointment with a Consultant Psychiatrist in a Recovery Team. The patient was the complainant.

The complainant's view was that she was not listened to, her problems were not taken seriously and the consultants approach was cold and thoroughly empathic. The consultant had not read the patients information ahead of the appointment which resulted in the patient having to describe difficult history which had been recorded in the notes . The report sent had inaccuracies. The patient subsequently sought advice privately but this report will not be available to the Trust until after this investigation.

There was a further letter to John Campbell checking the qualifications of the Consultant involved.

Audit Findings

The various elements of the complaint were investigated by a Consultant Psychiatrist in another Recovery Team. The investigation explained that the Consultant involved was sorry that his appointment and words had been interpreted in the way they had and he was sorry for that. The investigation provided an explanation for the points raised and agreed to amend the report as requested by the complainant.

The complainant apparently asked not to be contacted as part of the investigation but was, an apology was included in the CEO letter.

The tone of the CEO letter was apologetic and gave an explanation for each point of complaint. The letter was very lengthy, 8 pages long. The letter responded to the points but I didn't get the sense that the patient was fully listened to which was her original complaint, particularly in regard to notes not being read ahead of an appointment. I found no response in regard to the letter addressed to John Campbell in regard to the Consultants qualifications.

Some local and organisational learning were identified and it was clear how this would be addressed locally but did not document how this would be tested to check for imbedding. '

Having an investigator who undertakes a same role may influence the findings of the investigation in that they may not be totally objective and look at it with a critical eye.

Conclusion of the Author

I would offer full assurance against the timeliness aspect. In regard to the other aspects I would offer limited assurance.

2.2 Case 2

Summary of complaint.

The complaint concerned the treatment of a young person aged 11with Autism and the lack of crisis support for children of this age and under.

There are 12 issues raised in the complaint but in the main they concentrate on the lack of service and/or communication.

Audit Findings

The various elements of the complaint were thoroughly investigated. The complainant, child's mother, was spoken to as part of the investigation. The investigation concluded a number of areas where an apology should be offered.

The tone of the CEO letter was apologetic whilst being clear in response to the issues raised. The letter was particularly good at identifying the actions that had subsequently taken place to deal with the issues raised. The letter does say a care plan would be provided separately but this could have been included within the letter to provide re-assurance of system improvement in delayed communication.

Organisational learning is identified albeit not specially mentioned as organisational learning. There is no plan for how this learning will be incorporated to improve services.

Conclusion of auditor

I would offer partial assurance in regard to the timeliness aspect as the response was delayed. I would offer significant assurance against the investigation but limited on the learning for the organisation. I would offer significant assurance in regard to the CEO letter and would have offered full had the care plan been included.

2.3 Case 3

Summary of complaint

The complaint concerned an appointment with a Counselling Psychologist from the Complex Psychological Intervention Team and the subsequent letter received. The complaint had painful childhood and adulthood experiences and felt she wasn't listened to and was offended by her experience with our services.

Audit findings

Not all the original complaint letters/telephone transcripts appear to be in the report. The audit findings are therefore mainly based on the 2g letter confirming the issues of complaint. The various elements of the complaint were investigated but the report is poorly set out and at times confusing to the reader. The complainant was spoken to as part of the investigation and the conversation has been transcribed as part of the report.

The tone of the CEO letter was apologetic but could have been more empathic at the beginning of the letter recognising how difficult this is for the complainant. The letter did address the issues raised but could have been

more supportive in offering advice going forward as this person is clearly still in need of help.

Individual and organisational learning was identified and a plan recommend for how to implement the individual learning. However, there was no plan identified for organisational learning.

Conclusion of auditor
I would offer full assurance in regard to the timeliness aspect and limited assurance in regard to the investigation, CEO letter and organisational learning.

3 RECOMMENDATIONS

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

3.2. A standardised template for complaint investigations would ensure consistency in the way investigations are undertaken and learning identified. A clear plan for identification of learning and how it will be imbedded needs to be part of the template.

AGENDA ITEM: 12

Report to:	Board Committee
Author:	Chris Woon, Associate Director of Business Intelligence (BI)
Presented by:	Sandra Betney, Director of Finance
SUBJECT:	**Combined Performance Dashboard (Oct 2019/ Month 7)**

Can this subject be discussed at a public Board meeting?	Yes
If not, explain why	N/A

This report is provided for:

Decision | Endorsement | **Assurance** | Information

PURPOSE OF REPORT

This *combined* performance dashboard report provides a high level view of key performance indicators (KPIs) across the newly formed organisation. Further detail can be presented in person through the interactive BI tool Tableau, however hard copies of headline performance position are provided for audit over the following pages.

This month's performance dashboard report has – for the first time - brought together activity from our two legacy organisations into a single automated presentation. For ease of consumption on this occasion the visualisation is separated into the following reporting sections;

- MH – National Requirements (NHS Improvement & DoH)
- MH - Local Contract Gloucestershire (including Social Care)
- MH – Local Contract Herefordshire
- Community - National Requirements (Gloucestershire)
- Community - Local Requirements (Gloucestershire)

This interim layout and formatting has been chosen to ensure comparative alignment across legacy services. We will iteratively improve this presentation over the remainder of the year to refine the indicator list from showing all indicators short of a threshold, to an exceptional basis showing only the indicators that have the potential to carry contractual, financial, reputational or quality risk and/ or present outside of normal variation/ confidence intervals. The parameters of this methodology are being developed.

Performance covers the period to the end of October (month 7 of the 2019/20 contract period) which is the first operational month of the new organisation.

Where performance is not compliant, operational service leads are addressing issues and work is ongoing in accordance with our agreed service delivery improvement plans to address the underlying issues impacting performance.

More detail and action is provided in the performance report below.

RECOMMENDATIONS

The Board are asked to:

- Note the aligned Performance Dashboard Report for October 2019.
- Accept the report as a **significant level of assurance** that our contract and regulatory performance measures are being met or that appropriate action plans are in place to address areas requiring improvement.
- Be assured that there is ongoing work to review all of the indicators not meeting the required performance threshold. This includes a review of the measurement and data quality processes as well as clinical delivery and clinical practice issues.

EXECUTIVE SUMMARY

Your specific attention is drawn to the following 15 key community performance thresholds were not met for October 2019:

Community - Nationally Reported Measures

- 31: Bed days lost due to delayed discharge as percentage of total bed days
- 72: Percentage of patients waiting less than 6 weeks from referral for a diagnostic test
- 75: Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place of work
- 80: SUS+ (Secondary Uses Service) Data Quality Validity (available in arrears)

Community - Locally Reported Measures

- 41: Podiatry - % treated within 8 Weeks
- 43: MSK Physiotherapy - % treated within 8 Weeks
- 44: ICT Physiotherapy - % treated within 8 Weeks
- 45: ICT Occupational Therapy Services - % treated within 8 Weeks
- 53 Paediatric Physiotherapy - % treated within 8 Weeks
- 55: MSKAPS Service - % of referrals referred on to secondary care
- 67: Wheelchair Service: Adults: New referrals assessed within 8 weeks
- 68: Wheelchair Service: Adults: Priority referrals seen within 5 working days
- 69: Wheelchair Service: Under 18s: New referrals assessed within 8 weeks
- 78: % of Staff with completed Personal Development Reviews (Appraisal)
- 78a: % of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only

We draw your attention to the following 9 MH key performance thresholds were not met for October 2019:

MH – National Requirements (NHS Improvement & DoH)

- 2.21: No children under 18 admitted to adult in-patient wards

MH - Local Contract Gloucestershire (including Social Care)

- 3.15: CYPS Referral to assessment within 4 weeks
- 3.35: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks
- 3.36: Adolescent Eating Disorders: Routine referral to non-NICE treatment within 4 weeks
- 3.39: Eating Disorders: Wait time for Adult Assessments will be 4 weeks
- 3.40: Eating Disorders: Wait time for Adult psychological interventions will be 16 weeks
- 4.01: % of people getting long-term services in a residential or community care reviewed/re-assessed in last year
- 4.06: Eligible service users for social care have a personal budget

Planned dialogue continues with Gloucestershire Commissioners regarding their proposals for indicators that are new for this financial year (2019/20). Ambiguity to definitions and recording practice is delaying reporting at this time.

MH – Local Contract Herefordshire

- 5.13: CYP Access: percentage of CYP in treatment

ADDITIONAL BI UPDATE

The BI service structure has been confirmed and business partners have been selected to support the agreed operational service directorates;

- Hospitals directorate
- Urgent Care directorate
- Adult Community directorate
- Children & Young People directorate
- Specialist Services directorate (including dental, sexual health, therapies and specialist equipment and specialist mental health).
- And Herefordshire as a County.

Alongside the Business Intelligence Management Group (BIMG), a new reporting cycle has been proposed to support the organisation's new governance arrangements and support functions (such as operations, finance and workforce) are being engaged to try to bring a consistent reporting rhythm which provides assurance and informs business decisions.

To manage the significant development workload, mitigate risk and ensure success, key tasks are being prioritised to ensure the continuity of business critical reports are maintained and business as usual functions protected.

This does not detract from the ambition for a wider delivery of a comprehensive, integrated BI framework. However the completion or c-date will be undertaken over a longer timeframe. Based on the extensive and important legacy reporting suite and the wider change tasks ahead it is therefore proposed that this migration should be steadily

transitioned to accommodate the expiry of existing BI tool contracts (by April 2021). This approach does not preclude early transition wherever possible and in many instances this will be achieved earlier during 20/21 (to release the maintenance commitment).

In the first instance it has been identified that – assuming current operational, commissioner and national reporting is maintained - the following new developments are absolute deliverables over 'business as usual' in 2019/20;

- *Combined* corporate performance dashboard (October 2019 data) delivered in November 2019 to Executives and monthly from that point.
- In the first instance, and in the majority of cases the current commissioner, operational and national reporting can be maintained in its current form from 1st October 2019 until April 2020. However there will be an internally beneficial formatting change to Tableau to release resources.
- Key Performance Indicators (KPIs) are reviewed across all service specifications with Commissioners to deliver a new portfolio of Gloucestershire service measures for April 2020 that offer high decision value (efficacy and efficiency) and proportionate measurement effort.
- A review of KPI exception parameters will be completed across all services to produce a tiered business critical visualisation for Executives and supporting Governance functions (by January 2020). This will provide a clearer perspective on meaningful organisation performance and inform purposeful decision making.
- Locality visualisations developed further across mental health services to include SPC and trend analysis visualisations (Q4 2019/20).
- Server capacity, infrastructure evaluation and development (Q3 2019/20).
- New Tableau front page navigation for all BI consumers (including legacy BI tools) (Jan 2020, deferred due to IT domain changes)
- Existing data source adjustments (to support data quality monitoring and historic activity) in new environment (Q4 2020).
- Data source replication (prioritisation for ESR, Integra and Datix) (Q4 2020, dependant on GL and ESR progress)

Within 2020/21 the headline priority deliverables will be;

- Key financial reporting is in place to support the new General Ledger (GL) for April 2020.
- BAU routine workforce BI reporting (Q1 2020 dependant on interdependencies of GL)
- Final legacy GCS reports migrated to Tableau (Q2 2020)
- Complete data sources replication for complimentary systems (Q3 2020)
- Supplementary system sources brought into BI reporting (Datix, Service Experience, Q4 2020)
- Integrated Business Intelligence Performance Dashboard (Q4 2021) for Board/ Resources Committee (incorporating full BI stack).
- Birtie decommissioning (Q4 2021)

PLEASE NOTE THAT THE DELIVERY OF THIS BI DEVELOPMENT TIMETABLE IS DEPENDANT ON THERE NOT BEING AN INCREASE IN DEMAND ON CURRENT CORPORATE/ OPERATIONAL BAU & ADHOC REPORTING.

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

WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?			
Working together	**P**	Always improving	**P**
Respectful and kind	**P**	Making a difference	**P**

Report authorised by:	Date:
Sandra Betney, John Campbell & John Trevains (through BIMG)	21/11/2019

Where has this issue been discussed before?
Business Intelligence Management Group (BIMG)
What wider engagement has there been?
Through operational Performance & Finance (P&F) Meetings with Operational Service Leads.

Appendices:	*None*

Performance Dashboard Report

Aligned for the period to the end October 2019 (month 7)

The Resources Committee is asked to:

Note the aligned Performance Dashboard Report for October 2019.
Accept the report as a significant level of assurance that our contract and regulatory performance measures are being met or that appropriate action plans are in place to address areas requiring improvement. Be assured that there is ongoing work to review all of the indicators not meeting the required performance threshold. This includes a review of the measurement and data quality processes as well as clinical delivery and clinical practice issues.

Performance Dashboard: *Mental Health - National Requirements (NHS Improvements & DOH)*

KPI Breakdown

Mental Health - National Requirements Gloucestershire

		OCTOBER	YTD	
2.21	No children under 18 admitted to adult in-patient wards	98.5% -1.5%	99.1% -0.9%	

Mental Health - National Requirements Herefordshire

		OCTOBER	YTD	
2.21	No children under 18 admitted to adult in-patient wards	97.3% -2.7%	98.8% -1.2%	

Performance Thresholds not being achieved in Month

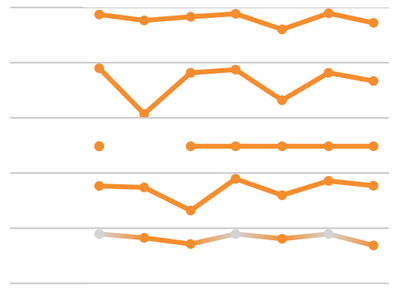
2.21: No children under 18 admitted to adult in-patient wards
There were 2 admissions of under 18s to adult wards in October. One in Gloucestershire and one in Herefordshire.

Performance Dashboard: *Mental Health - Local Contract (Including Social Care) Gloucestershire*

KPI Breakdown

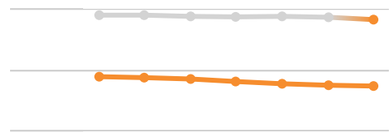
Mental Health - Local Contract Gloucestershire

		OCTOBER	YTD
3.15	95% accepted referrals receiving initial appointment within 4 weeks (excludes YOS, substance misuse, inpatient and crisis/home treatment and complex engagement) (CYPS)	25.6% -69.4%	28.2% -66.8%
3.35	Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	40.0% -55.0%	41.7% -53.3%
3.36	Adolescent Eating Disorders - Routine referral to non-NICE treatment start within 4 weeks	0.0% -95.0%	0.0% -95.0%
3.39	Eating Disorders - Wait time for adult assessments will be 4 weeks	36.6% -58.4%	33.7% -61.3%
3.40	Eating Disorders - Wait time for adult psychological interventions will be 16 weeks	77.1% -17.9%	89.6% -5.4%



Mental Health - Social Care Gloucestershire

		OCTOBER	YTD
4.01	Percentage of people getting long term services, in a residential or community care reviewed/re-assessed in last year	91.3% -3.7%	96.4% 1.4%
4.06	Eligible Service Users for Social Care have a Personal Budget	38.2% -46.8%	42.0% -43.0%



Performance Thresholds not being achieved in Month

3.15: CYPS Referral to assessment within 4 weeks
This is a quarterly reportable indicator but is presented 'in-month' for information. From Q1 2019/20, Commissioners agreed to suspend the Referral to Treatment KPI for the duration of the 4 week wait pilot to allow for service redevelopment. No similar decision has yet been taken for this indicator. The Service Director is intending to clarify with Commissioners whether a similar suspension agreement will apply for this KPI. This proposal has been raised at the CCG's Performance, Finance & Information Group (PFIG).

3.35: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks
There were 6 non-compliant cases in October.
One client's appointment which was within the required 4 weeks unfortunately had to be cancelled by the service due to a family illness. The next appointment available for CBT treatment was 10 weeks after referral.
The remaining 5 clients were offered and attended the 1st available appointments which were 7 weeks after referral.

3.36: Adolescent Eating Disorders: Routine referral to non-NICE treatment within 4 weeks
There were 3 non-compliant cases in October.
Two clients were offered and attended the 1st available appointment which was 7 weeks after referral.
The remaining client was difficult to contact. Once contact was made they were offered the first available appointment which was in week 10.

3.39: Eating Disorders: Wait time for Adult Assessments will be 4 weeks
There were 26 non-compliant cases in October.
In 4 cases the assessment was not attended due to DNAs and client cancellations. The wait for these clients ranged from 10 weeks to 16 weeks.
For the remaining 22 cases, the 1st available appointment was offered. The average wait from referral to assessment for these clients was 7 to 8 weeks.

3.40: Eating Disorders: Wait time for Adult psychological interventions will be 16 weeks
There were 8 non-compliant cases reported in October.
One client waited 23 weeks as they cancelled appointment offered and then requested to seen on a Friday only.
One client is a patient on Dean Ward and earlier treatments have not been recorded. The service is following this up.
One client, again, requested Friday's only and was seen at the first available appointment which was 20 weeks after assessment.
The remaining 5 clients began treatment at the next available appointments.

4.01: % of people getting long-term services in a residential or community care reviewed/re-assessed in last year
There are 21 cases where the client does not have a Care Management review or CPA review recorded as having taken place within the past 12 months.

4.06: Eligible service users for social care have a personal budget
It is apparent that the methodology we are using is outdated. The service is liaising with the CCG and GCC to review the definitions and advise on reframing. We have approached our Commissioners to advise them of the situation and they support us in reworking the indicator.

Performance Dashboard: *Mental Health - Local Contract Herefordshire*

KPI Breakdown

Mental Health - Local Contract Herefordshire

		OCTOBER		YTD		
5.13	CYP Access: Number and percentage of CYP entering treatment (30% of prevalence)	63.9%	-36.1%	77.6%	-22.4%	

Performance Thresholds not being achieved in Month

5.13: CYP Access: percentage of CYP in treatment

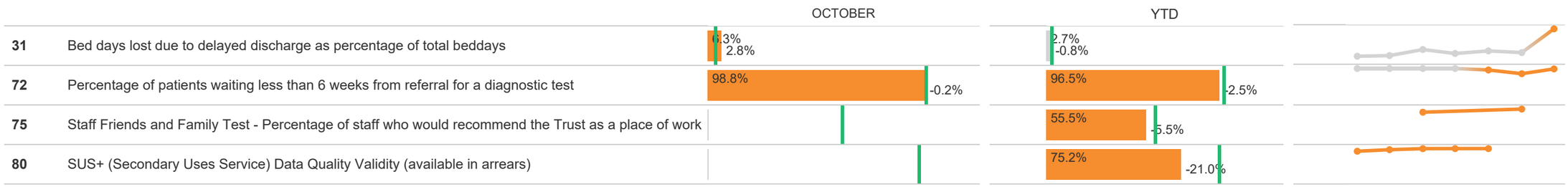
The performance threshold for 2019/20 remains at 30% of prevalence which equates to 973 young people accessing treatment during 2019/20. We are 156 below the anticipated number required to achieve this at the end of October.

Performance Dashboard: *Community - National Requirements Gloucestershire*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Community - National Requirements Gloucestershire



Performance Thresholds not being achieved in Month

31: Bed days lost due to delayed discharge as percentage of total bed days
October 2019 was the first month that the 3.5% target was missed since October 2017. Community Hospitals that recorded bed days lost due to delayed transfer of care in excess of 3.5% were Stroud (11.9%), Cirencester (8.6%), Lydney (6.8%) and Dilke (5.5%).

72: Percentage of patients waiting less than 6 weeks from referral for a diagnostic test
There are ongoing discussions with GHFT regarding the Echocardiography contract. Several clinics were cancelled by GHFT in July and August meaning there was not sufficient clinic capacity and patients could not be seen within the timeframe. This has had a knock-on impact into October.

75: Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place of work
38.22% of the Staff FFT responders are general managers, senior and administrative staff. Actions include continuing to increase our approach to engagement. Our communications and overall approach to the merger has encouraged staff participation and feedback and we are continuing to run regular pulse checks. We have developed an action plan in response to the staff survey.

80: SUS+ (Secondary Uses Service) Data Quality Validity (available in arrears)
Decrease in performance in 2019/20 due to issues with submission of Emergency Care Data Set which is now resolved. The Trust will be resubmitting the data in October 2019 which covers the full financial year from April 2019 and data quality rating anticipated to return to green rating.

Performance Dashboard: *Community - Local Requirements Gloucestershire*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Community - Local Requirements Gloucestershire

		OCTOBER		YTD		
41	Podiatry - % treated within 8 Weeks	59.8%	-35.2%	75.9%	-19.1%	
43	MSK Physiotherapy - % treated within 8 Weeks	75.9%	-19.1%	70.7%	-24.3%	
44	ICT Physiotherapy - % treated within 8 Weeks	76.2%	-18.8%	79.3%	-15.7%	
45	ICT Occupational Therapy Services - % treated within 8 Weeks	81.9%	-13.1%	83.6%	-11.4%	
53	Paediatric Physiotherapy - % treated within 8 Weeks	76.6%	-18.4%	83.2%	-11.8%	
55	MSKAPS Service - % of referrals referred on to secondary care	1.6%	-28.4%	18.3%	-11.7%	
67	Wheelchair Service: Adults: New referrals assessed within 8 weeks	22.4%	-67.6%	29.4%	-60.6%	
68	Wheelchair Service: Adults: Priority referrals seen within 5 working days	0.0%	-95.0%	20.7%	-74.3%	
69	Wheelchair Service: Under 18s: New referrals assessed within 8 weeks	44.4%	-45.6%	56.5%	-33.5%	
78	% of Staff with completed Personal Development Reviews (Appraisal)	80.6%	-9.4%	84.5%	-7.2%	
78a	% of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only	85.8%	-4.2%	84.8%	-6.8%	

41: Podiatry - % treated within 8 Weeks
Detailed Podiatry review including the demand and capacity analysis has been presented to Quality and Performance Committee. The current action plan has a focus on three main areas:

1. SystmOne process review and redesign to improve data quality and performance reporting.
2. Review and redesign care pathway by speciality level to improve efficiency.
3. Redesigned workforce plan based on demand and capacity outcome findings.

43: MSK Physiotherapy - % treated within 8 Weeks
Ongoing discussions continue with the Commissioners concerning the mismatch of demand versus capacity, noting this is a similar issue across both community MSK therapy providers.

44: ICT Physiotherapy - % treated within 8 Weeks
In the first 6 months of 2019/20, the Physiotherapy service saw 63.3% of people within 4 weeks of referral. 95% of people seen year to date were seen within 17-18 weeks. When the activity in the referral centre is included, performance increases to 77.9%. There is an ongoing issue with vacancy recruitment, with overall pressure across all localities. Locum cover secured and therefore improvements should be evident over the next quarter.

45: ICT Occupational Therapy Services - % treated within 8 Weeks
In the first 6 months of 2019/20, the OT service saw 65.7% of people within 4 weeks of referral. 95% of people seen year to date were seen within 13-14 weeks. When the activity in the referral centre is included, performance increases to 91.8%. There has been a 7% increase in referrals compared to last year. Vacancies, particularly in Gloucester locality and in more junior roles (i.e. Band 5) have also impacted on target achievement. The service has secured clinicians via temporary contract and are actively seeking locums, recognising there is a further 2 years in the re-structuring of the service model to align to the revised commissioning intentions and resources available.

53: Paediatric Physiotherapy - % treated within 8 Weeks
Internal recovery action plan, monitored by Service lead and clinician actions reviewed in supervision. Induction of 2 new WTEs with anticipated additional capacity coming on line over next 2 months. 1 remaining vacancy, recruited to and new therapist to start in November. The service is working with Business Intelligence team to create Demand and Capacity model.

55: MSKAPS Service - % of referrals referred on to secondary care
There continues to be a delay in the recording of referrals on via the eRS system which is affecting the reporting of this measure. The level recorded in October is not reflective of actual referrals on and will increase in subsequent months.

67: Wheelchair Service: Adults: New referrals assessed within 8 weeks
Target continues to be missed. 13 out of 58 referrals were assessed within the 8 week timeframe. The service transitioned onto SystmOne during September 2019, data quality checking and reporting development is ongoing.

68: Wheelchair Service: Adults: Priority referrals seen within 5 working days
Target continues to be missed. 1 priority referral received was not seen within 5 working days. The service transitioned onto SystmOne during September 2019, data quality checking and reporting development is ongoing.

69: Wheelchair Service: Under 18s: New referrals assessed within 8 weeks
Target continues to be missed. 8 out of 18 referrals were assessed within 8 weeks. The service transitioned onto SystmOne during September 2019, data quality checking and reporting development is ongoing.
A new contract has now been agreed and signed off, which means that we are now paying for echocardiograms. GHFT will be allowing patients to book into any of their available slots, using their staff and clinic times, thereby expanding patient choice to 7 days a week. GHFT staff will be booking the patients into their system, but will also be given training to update the details on our SystmOne.

78: % of Staff with completed Personal Development Reviews (Appraisal)
Developing PDR for colleagues returning to work following a period of sickness, maternity leave, secondments etc. Revised PDR paperwork for bank, staff who are retiring/ leaving and lower banded posts has been piloted and ..

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Finance Report
Month 7

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Gloucestershire Health & Care Overview

Gloucestershire Health and Care
NHS Foundation Trust

- This first half of this report outlines the financial position for Gloucestershire Health and Care NHS Foundation Trust (GHC). For reference the financial position for GHC in the first half of the report is the combination of months 1-12 for 2gether NHSFT and 7-12 for Gloucestershire Care Services (GCS). The second half of the report outlines the final position for Gloucestershire Care Services, months 1-6.
- The year to date surplus for GHC is on plan at £1.0m. The full year forecast is to deliver a control total of £2.156m, but there are significant risks to this if the Trust cannot deliver its recurring CIP Schemes. PSF accounts for £2.042m of the control total surplus.
- The revised agency ceiling for GHC is £4.250m. The year to date actual is £3.320m which is over the spend plan by £1.159m. The full year forecast spend is £6.342m, which is £2.092m, or 49%, above the agency ceiling, and leads to a 3 in the Single Operating Framework for the agency metric.
- The Cost Improvement Plan (CIP) target for the merged Trust is £5.402m. The CIP amount removed so far is £0.881m.
- Capital spend for GHC is £1,665k. The plan for the merged Trust is £7.082m
- Cash balance at the end of month 7 for GHC is £5.5m above the plan at £39.7m. All of the increase in cash relates to underspends on capital against plan.

GHC Income and Expenditure

Gloucestershire Health and Care
NHS Foundation Trust

The year to date performance at Month 7 is on plan at £0.956m surplus.

The Trust anticipates it will meet its full year planned surplus of £2.156m.

A number of operational directorates are in deficit YTD, including Social Care, Entry Level and the Medical Directorate although the Social Care expenditure overspend is matched with additional income for the over performance in Community Care. A number of Corporate directorates are in deficit YTD and forecast. This is predominantly due to the asset lives cost pressure, agreed non-recurrent costs funded by Trust underspends, and still to be identified savings.

	Aggregated 2g & GCS		2g months 1-7 and GCS mth 7			2g months 1-12 and GCS mth 7-12		
Statement of comprehensive income £000	2017/18	2018/19	2019/20			2019/20		
	Full Year Actual	Full Year Actual	Plan	Actual	Variance	Plan	Full Year Forecast	Variance
Operating income from patient care activities	220,232	228,678	78,736	79,846	1,110	175,304	179,207	3,903
Other operating income exc PSF	8,415	9,390	3,273	4,864	1,591	6,149	7,998	1,849
Provider sustainability fund (PSF) income	5,557	6,444	606	606	0	2,042	2,042	0
Employee expenses	(163,685)	(169,910)	(61,911)	(61,768)	143	(136,592)	(140,297)	(3,705)
Operating expenses excluding employee expenses	(74,613)	(63,303)	(18,432)	(21,218)	(2,786)	(41,805)	(43,942)	(2,137)
PDC dividends payable/refundable	(3,973)	(3,345)	(1,341)	(1,445)	(104)	(3,034)	(3,026)	8
Other gains / losses	9	120	25	97	72	57	140	83
Surplus/(deficit) before impairments & transfers	**(8,067)**	**8,074**	**956**	**981**	**25**	**2,121**	**2,122**	**1**
Add back impairments	15,731	(283)	0	0	0	0	0	0
Remove capital donations/grants I&E impact	105	(212)	26	28	2	69	69	0
Surplus/(deficit) inc PSF	**(2,405)**	**7,579**	**982**	**1,009**	**27**	**2,190**	**2,191**	**1**
Surplus/(deficit) exc PSF	**(7,962)**	**1,135**	**376**	**403**	**27**	**148**	**149**	**1**
Control total including PSF	**2,869**	**3,912**	**961**	**961**	**0**	**2,156**	**2,156**	**0**

GHC Balance Sheet

Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		Aggregated 2g & GCS	2g months 1-7 and GCS mth 7			2g months 1-12 and GCS mth 7-12		
		2018/19	2019/20 Year to Date			2019/20		
		Full Year Actual	Plan	Actual	Variance	Plan	Forecast	Variance
Non-current assets	Intangible assets	2,819	2,576	2,597	21	2,269	2,295	26
	Property, plant and equipment: other	114,893	115,885	114,121	(1,764)	117,855	114,392	(3,463)
	Total non-current assets	**117,712**	**118,461**	**116,718**	**(1,743)**	**120,124**	**116,687**	**(3,437)**
Current assets	Inventories	288	288	245	(43)	288	245	(43)
	NHS receivables	9,051	8,443	8,823	380	8,511	8,456	(55)
	Non-NHS receivables	8,066	7,606	5,850	(1,756)	6,224	5,724	(500)
	Cash and cash equivalents:	32,474	34,269	39,737	5,468	33,682	27,518	(6,164)
	Property held for sale	500	500	500	0	500	500	0
	Total current assets	**50,379**	**51,106**	**55,155**	**4,049**	**49,205**	**42,443**	**(6,762)**
Current liabilities	Trade and other payables: capital	(1,780)	(1,155)	(289)	866	(1,655)	(1,572)	83
	Trade and other payables: non-capital	(11,184)	(11,357)	(10,051)	1,306	(11,190)	(1,996)	9,194
	Borrowings	(76)	(76)	(200)	(124)	(2)	(2)	0
	Provisions	(371)	(371)	(751)	(380)	(371)	(604)	(233)
	Other liabilities: deferred income includin	(10,259)	(10,398)	(14,515)	(4,117)	(9,044)	(9,044)	0
	Total current liabilities	**(23,670)**	**(23,357)**	**(25,806)**	**(2,449)**	**(22,262)**	**(13,218)**	**9,044**
Non-current liabilities	Borrowings	(1,821)	(1,710)	(1,568)	142	(1,638)	(1,638)	0
	Provisions	(616)	(686)	(680)	6	(451)	(451)	0
	Total net assets employed	**141,984**	**143,814**	**143,819**	**5**	**144,978**	**143,823**	**(1,155)**

Taxpayers Equity	Public dividend capital	126,956	126,956	125,181	(1,775)	126,956	125,181	(1,775)
	Revaluation reserve	7,098	7,098	7,098	0	7,098	7,098	0
	Other reserves	(1,241)	(1,241)	(1,241)	0	(1,241)	(1,241)	0
	Income and expenditure reserve	9,171	11,001	12,781	1,780	12,165	12,785	620
	Total taxpayers' and others' equity	**141,984**	**143,814**	**143,819**	**5**	**144,978**	**143,823**	**(1,155)**

Capital – Multi-Year Plan

Gloucestershire Health and Care
NHS Foundation Trust

	2gether mths 1-12 and GCS mths 7-12								
	GHC Plan		YEAR TO DATE	FORECAST OUTTURN	Plan	Plan	Plan	Plan	Plan
£000s	2019/20		2019/20	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Land and Buildings									
Buildings	2,821		203	2,046	8,482	7,600	2,500	2,500	1,000
Backlog Maintenance	1,874		675	2,083	1,220	1,300	1,050	1,050	250
Urgent Care	1		0	0	475	0	0	0	0
Information Technology									
IT Device and software upgrade	299		120	266	600	600	600	600	600
IT Infrastructure	1,575		643	1,631	1,529	300	1,400	300	300
Medical Equipment	**512**		24	914	280	1,030	1,030	1,030	3,330
Total	**7,082**		**1,665**	**6,940**	**12,586**	**10,830**	**6,580**	**5,480**	**5,480**

Year to Date capital spend is £1,665k.

Cash Flow Summary

Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	ACTUAL YTD 19/20		FORECAST 19/20	
Cash and cash equivalents at start of period		**33,553**		**33,553**
Cash flows from operating activities				
Operating surplus/(deficit)	2,324		5,007	
Add back: Depreciation on donated assets	28		34	
Adjusted Operating surplus/(deficit) per I&E	**2,352**		**5,041**	
Add back: Depreciation on owned assets	1,935		4,095	
Add back: Impairment	0		0	
(Increase)/Decrease in inventories	0		0	
(Increase)/Decrease in trade & other receivables	2,534		3,111	
Increase/(Decrease) in provisions	147		0	
Increase/(Decrease) in trade and other payables	1,615		(7,545)	
Increase/(Decrease) in other liabilities	279		(1,075)	
Net cash generated from / (used in) operations		**8,862**		**3,627**
Cash flows from investing activities				
Interest received	97		140	
Purchase of property, plant and equipment	(1,747)		(7,148)	
Sale of Property	0		529	
Net cash generated used in investing activities		**(1,650)**		**(6,479)**
Cash flows from financing activities				
PDC Dividend Received				
PDC Dividend (Paid)	(1,000)		(3,026)	
Finance Lease Rental Payments	(28)		(157)	
		(1,028)		**(3,183)**
Cash and cash equivalents at end of period		**39,737**		**27,518**

Risks

Gloucestershire Health and Care
NHS Foundation Trust

Risks to delivery of the 2019/20 position are as set out below:

Gloucestershire Health & Care Risks	19/20 Risk at month 07	Made up of: Rec		Likelihood
Delivery of Cost Improvements incl. Challenge Scheme CIPs	450	2,650		Almost Certain
Unidentified Planned CIP for Differential Schemes:	150	150		Possible
Agency costs increase above the forecast	250			Possible
VAT changes impacting recovery on Systm1 19/20 (FY £80k in position)	0	80		Almost Certain
QIPP risk share and milestones	500			Possible
CQUIN	200			Possible
Asset lives depreciation impact - 2g	450	450		Possible
Asset lives Dep'n & PDC impact - GCS acceptance (FY £540k in position)		540		Certain
Out of County bed costs are greater than forecast	100			
A failure to control costs due to some risks materialising leads to the Trust to miss its FTC and lose PSF	777			Unlikley
	2,877	**3,870**		

Health Economy Risks	Proabability	Risk £000)	Opportunity (£000)
Delivery of GHFT control total	Likely	10,196	
Delivery of CCG control total	Likely	7,500	
System Control Total PSF Risk	Unlikely	99	
		17,795	

Single Operating Framework Ratings

Current FT Financial Risk Rating - Single Oversight F Framework
Use Of Resource

Finance and use of resources rating				
Metric	Audited PY 31/03/2019 Year ending	Plan 31/03/2020 Year ending	Actual 31/10/2019 YTD	Forecast 31/03/2020 Year ending
Capital service cover rating	1	1	1	1
Liquidity rating	1	1	1	1
I&E margin rating	1	1	1	1
I&E margin: distance from financial plan	1	1	1	1
Agency rating	3	1	3	3
Risk ratings after overrides	1	1	1	1

Gloucestershire Health and Care
NHS Foundation Trust

Gloucestershire Care Services

Finance Report

April – September 2019

Overview

- The Final Accounts for GCS, months 1-6, are currently being audited by External Audit.
- No significant issues have been identified to date by the audit.
- The Trust ended the period with a surplus of £0.903m, in line with the plan.
- The agency ceiling was £1.116m and the GCS spend for months 1-6 was £1.116m.
- Cost Improvement Plan (CIP) target for GCS months 1-6 was £2.268m and the amount of savings delivered was £2.848m.
- Capital spend was £1,055k against a six month plan of £1.737m.
- Cash balance at the end of month 6 was £0.4m above plan at £18.9m. All of the increase in cash related to underspends on capital against plan.

Gloucestershire Care Services Income & Expenditure

Gloucestershire Health and Care NHS Foundation Trust

Statement of comprehensive income £000	2018/19	2019/20 Month 1 - 6		
	Full Year Actual	Plan	Actual	Variance
Operating income from patient care activities	112,668	56,834	57,131	297
Other operating income exc PSF	2,099	759	895	136
Provider sustainability fund (PSF) income	3,962	569	569	0
Employee expenses	(80,782)	(42,331)	(42,141)	190
Operating expenses excluding employee expenses	(31,719)	(13,926)	(14,689)	(763)
PDC dividends payable/refundable	(1,739)	(1,032)	(905)	127
Other gains / losses	(56)		(5)	
Surplus/(deficit) before impairments & transfers	**4,433**	**873**	**855**	**(13)**
Add back impairments	885			
Remove capital donations/grants I&E impact	(249)	30	48	18
Surplus/(deficit) inc PSF	**5,069**	**903**	**903**	**5**
Surplus/(deficit) exc PSF	**1,107**	**334**	**334**	**5**
Control total including PSF	**3,078**	**903**	**903**	**0**

GCS Balance Sheet

Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		2018/19	2019/20 Year to Date		
		Full Year Actual	Plan	Actual	Variance
Non-current assets	Intangible assets	829	658	667	9
	Property, plant and equipment: other	63,315	63,475	62,794	(681)
	Total non-current assets	**64,144**	**64,133**	**63,461**	**(672)**
Current assets	Inventories	288	288	245	(43)
	NHS receivables	5,800	5,355	5,263	(92)
	Non-NHS receivables	2,978	2,978	3,667	689
	Cash and cash equivalents:	17,837	18,435	18,916	481
	Total current assets	**26,903**	**27,056**	**28,091**	**1,035**
Current liabilities	Trade and other payables: capital	(1,454)	(829)	(116)	713
	Trade and other payables: non-capital	(9,518)	(9,518)	(9,325)	193
	Borrowings	(76)	(76)	(200)	(124)
	Provisions	(371)	(371)	(751)	(380)
	Other liabilities: deferred income including contract liabilities	(389)	(389)	(1,291)	(902)
	Total current liabilities	**(11,808)**	**(11,183)**	**(11,683)**	**(500)**
Non-current liabilities	Borrowings	(1,593)	(1,487)	(1,368)	119
	Total net assets employed	**77,646**	**78,519**	**78,501**	**(18)**
Taxpayers Equity	Public dividend capital	80,276	80,276	80,276	0
	Revaluation reserve	4,679	4,679	4,679	0
	Other reserves	(2,398)	(2,398)	(2,398)	0
	Income and expenditure reserve	(4,911)	(4,038)	(4,056)	(18)
	Total taxpayers' and others' equity	**77,646**	**78,519**	**78,501**	**(18)**

Capital and Cost Improvement Programmes

Gloucestershire Health and Care
NHS Foundation Trust

Gloucestershire Care Services NHST CAPITAL PROGRAMME	Months 1-6		
	Plan £000's	Actual £000's	Variance £000's
Buildings	1,136	859	277
Backlog Maintenance	50		50
Urgent Care	25		25
Network Replacement	0	11	(11)
Laptops	100		100
Medical Equipment	426	132	294
Forest of Dean	0	53	(53)
TOTAL	**1,737**	**1,055**	**682**

Gloucestershire Care Services NHST COST IMPROVEMENT PROGRAMME	Months 1-6		
	Plan £000's	Actual £000's	Variance £000's
Trust 1.25% Scheme	1,372	1,372	0
Differential - Hospitals	84	178	94
Differential - ICTs	199	93	(106)
Differential - Countywide	318	446	128
Differential - CYPS	256	256	0
Differential - Urgent Care	2	4	2
Differential - Human Resources	32	32	0
Differential - Executive	1	1	0
Differential - Finance Directorate	4	4	0
Challenge Schemes - TBC	0	462	462
TOTAL	**2,268**	**2,848**	**580**

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AGENDA ITEM: 14

Report to:	Gloucestershire Health and Care NHS Foundation Trust Board – 28th November 2019
Author:	Simon Crews, Interim Head of Governance
Presented by:	Simon Crews, Interim Head of Governance
SUBJECT:	**Board Assurance Framework**

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

This report is provided for:

Decision **Endorsement** Assurance Information

PURPOSE OF REPORT

To update the Board on the development process for the Board Assurance Framework for the new Trust and to allow oversight of this key assurance driver.

RECOMMENDATIONS

(i) To **NOTE** the approach to the development of the Board Assurance Framework.

(ii) **ENDORSE** the Board Assurance Framework development, recognising that it is a work in progress which will be further developed once the Strategic Objectives are finalised.

(iii) Provide feedback off line to support the iterative process**.**

EXECUTIVE SUMMARY

1. Introduction

Risk Management is fundamental to the safe and effective functioning of the Trust. The Trust Board maintains overall responsibility for the management of risk across the organisation, with Strategic Risks being articulated within the Trust's Board Assurance Framework.

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2. **The agreed Board Memorandum - Financial Reporting Procedures set out the following detail relating to the Board Assurance Framework:**

## Board Assurance Framework

"The design of the Board Assurance Framework (BAF) will be discussed at the Shadow Board. It is proposed to adopt the NHS standard format and to use the BAF identify risks to the delivery of the new Trust's strategic objectives and also to capture the controls and assurance in relation to strategic risks. The board will consider the arrangements for reviewing the BAF and the relationship with the corporate risk register.

Strategic risks are defined as those risks that, if realised, could affect the way in which the Trust exists or operates.

Strategic risks will be identified by Directors, and will be aligned to the Trust's strategic objectives. The nominated lead for each strategic risk will be responsible for identifying controls and sources of assurance to ensure that these controls operate effectively. Any gaps will be identified and action plans put in place to strengthen controls Risks will be assigned to board or board committees for consideration at each meeting to provide appropriate visibility, monitoring and assurance.

The BAF will be fully reviewed by the Board three times a year, and it will support the Chief Executive in completing the Annual Governance Statement at the end of each financial year In addition the BAF will be reviewed by the Audit Committee.

The development and maintenance of the BAF is the responsibility of the Head of Corporate Governance (Trust Secretary).

Strategic Risks are those risks which could fundamentally effect the way in which the Trust operates, and that could have a detrimental effect on the Trust's achievement of its strategic objectives."

3. **Process to Date**

**3.1 Risk Appetite** - The Board met in May and July 2019 to agree its risk appetite - a key element of its risk management process.

**3.2 The Risk Management Policy** has been put in place – as detailed within the agreed Board Memorandum – Financial Reporting Procedures.

**3.3 Strategic Objectives Development**- Recognising that the refining of the Strategic Objectives for the Gloucestershire Health and Care NHS Foundation Trust, is a process still being taken forward, to enable an interim Board Assurance Framework to be put in place until the Board have their development and review session on it in February 2020, the Strategic Objectives from within the Strategic Intent have been reduced to their core elements to provide a
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starting point which can then be used as a building block further down the process.

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**3.4 Executive Engagement -** The Executive reviewed an initial draft of a Board Assurance Framework at their meeting on 22nd October 2019 and agreed a number of steps to refine the draft. This included a further refinement of the interim Strategic Objectives Set out within **3.5 below**. This process was informed by guidance from the Director of Strategy and Partnerships, recognising her key role in supporting the development of strategy.

It was agreed that the draft format for the Board Assurance Framework be reviewed to ensure ease of use.

It was agreed that the Executives would review the draft in detail in individual sessions to refine the focus of the document.

**3.5 Draft Strategic Objectives (N.B. interim** until the Board undertakes the further detailed work described above**):**

**Outstanding Care**
**Personalised Experience**
**Engaged, Empowered and Skilled Workforce**
**Strong System Leader and Partner**
**Innovation and Research Driven**
**Best Value**

**3.6 Non-Executive Engagement**

The Chair of the Audit and Assurance Committee has had the opportunity for an initial review.

Non-Executives will have the opportunity to feed in off line.

The Chair will also be provided with an opportunity to feed in off line (with the development process reviewed by the Chair and Chief Executive).

**3.7 Board Review**

Following these processes the interim Board Assurance Framework, is provided as a working document. This will ensure the Board can receive and reflect on key assurances at this early stage of its operation, and position it effectively for the next stages of development.

This iterative development process is in line with that being used by the Trust to support its strategic development.

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| Corporate Considerations | |
|---|---|
| *Quality implications* | Quality promotion and achievement is central to the strategic objectives |
| *Resource implications*: | Resource implications are recognised as key risks which will be reflected within the Board Assurance Framework. |
| *Equalities implications:* | The proposed strategic objective of personalisation will ensure equalities are core to this work. |
| *Risk implications:* | The effectiveness of the Board Assurance Framework is the strategic centre of the risk management process which is central to the governance framework for the Trust. |

| WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)? | | | |
|---|---|---|---|
| Working together | P | Always improving | P |
| Respectful and kind | P | Making a difference | P |

| Report authorised by: | Date: |
|---|---|
| | |

| Where has this issue been discussed before? Within Executive |
|---|
| |
| **What wider engagement has there been? -** |
| |

| Appendices: | None |
|---|---|
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Board Assurance Framework

The design of the Board Assurance Framework (BAF) adopts the NHS standard format and identifies risks to the delivery of the new Trust's strategic objectives and also to capture the controls and assurance in relation to strategic risks.
Strategic risks are defined as those risks that, if realised, could affect the way in which the Trust exists or operates.

Strategic risks will be identified by Directors, and will be aligned to the Trust's strategic objectives. The nominated lead for each strategic risk will be responsible for identifying controls and sources of assurance to ensure that these controls operate effectively. Any gaps will be identified and action plans put in place to strengthen controls Risks will be assigned to board or board committees for consideration at each meeting to provide appropriate visibility, monitoring and assurance.

The BAF will be fully reviewed by the Board three times a year, and the Audit Assurance Committee three times a year and it will support the Chief Executive in completing the Annual Governance Statement at the end of each financial year In addition the BAF will be reviewed by the Audit Committee.

Strategic Risks are those risks which could fundamentally effect the way in which the Trust operates, and that could have a detrimental effect on the Trust's achievement of its strategic objectives.

1.1 Risk Appetite - The Board met in May and July 2019 to agree its risk appetite - a key element of its risk management process.

1.2 The Risk Management Policy has been put in place – as detailed within the agreed Board Memorandum – Financial Reporting Procedures.

1.3 Strategic Objectives Development- Recognising that the refining of the Strategic Objectives for the Gloucestershire Health and Care NHS Foundation Trust, is a process still being taken forward, to enable an interim Board Assurance Framework to be put in place until the Board have their development and review session on it in February 2020, the Strategic Objectives from within the Strategic Intent have been reduced to their core elements to provide a starting point which can then be used as a building block further down the process.

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1.1 Strategic Risks - Summary of strategic risks

Trust strategic objectives	Ref	Strategic risks Risk	RAG	Exec Lead	Assurance Body	Inherent Risk Score	Current Risk Score	Target Risk Score
Strong System Leader and Partner	SR1	There is a risk that we fail to support and progress effective working within the health and care system and cannot fully achieve the benefits of integration targeted within the Strategic Intent for the merged Trust and meet the NHS Long Term plan.		CEO	Board	12 3x4	**8** **2x4**	4 1x4
Strong System Leader and Partner	SR2	There is a risk that services are not sustainable and do not continue to improve and develop to meet needs.		CEO	Board	12 3x4	**8** **2x4**	4 1x4
Outstanding Care	SR3	There is a risk that failure to: (i) meet consistent quality standards for care and support; (ii) address variability across quality standards; or (iii) reconcile conflicting quality standards or guidance, will result in poorer outcomes for patients/service user and carers and poorer patient safety and experience.		Dir Quality	Quality Committee	12 3x4	**8** **2x4** **On Target**	8 2x4
Outstanding Care	SR4	There is a risk that the Trust does not maintain robust focus on either/or mental and physical health.		CEO	Board	15 3x5	**10** **2x5**	5 1x5
Personalised Experience	SR5	There is a risk that we fail to keep service users and carers at the heart of what we do and do not deliver genuine co-production.		Chief Operating Officer	Quality Committee	12 3x4	**8** **2x4**	4 1x4

Trust strategic objectives	Strategic risks							
	Ref	Risk	RAG	Exec Lead	Assurance Body	Inherent Risk Score	Current Risk Score	Target Risk Score
Engaged, Empowered and Skilled Workforce	SR6	There is a risk that we are unable to recruit and retain the workforce we need to meet our ambitions to: provide outstanding, joined up care maintain colleague well-being minimise use of agency and bank staff.		Dir HR & OD	Resources Committee	16 4x4	**16** **4x4**	8 2x4
Engaged, Empowered and Skilled Workforce	SR7	There is a risk that we fail to establish a culture which : engages and empowers colleagues engendering a sense of collective ownership supports discretionary innovation.		Dir HR & OD	Resources Committee	16 4x4	**12** **3x4**	4 1x4
Innovation and Research Driven	SR8	There is risk that we don't enable colleagues to support Innovation and Research through appropriate: funding, time and focus and strategic drivers.		Dir Quality & Medical Director	Quality Committee	9 3x3	**9** **3x3**	6 2x3
Innovation and Research Driven	SR9	There is a risk that we do not have in place structures and processes which enable colleagues to look beyond the organisation to identify leading edge practice to inform practice.		Dir Quality & Medical Director	Quality Committee	9 3x3	**9** **3x3**	6 2x3
Best Value	SR10	There is a risk that the One Gloucestershire transformation plans become frustrated and impact on our individual Trust aims and objectives and the whole system plans.		CEO	Board	16 4x4	**16** **4x4**	8 2x4

Trust strategic objectives	Strategic risks							
	Ref	Risk	RAG	Exec Lead	Assurance Body	Inherent Risk Score	Current Risk Score	Target Risk Score
Best Value	SR11	There is a risk we **do not** maintain robust internal controls (Including financial) and governance systems; resulting in potential financial and organisational instability.		Dir Finance	Resources Committee Audit & Assurance Committee	12 3x4	**8** **2x4**	4 1x4
Best Value	SR12	There is a risk we do not achieve our individual organisations financial sustainability and contribute to whole system sustainability.		Dir Finance	Resources Committee	12 3x4	**8** **2x4**	8 2x4
Best Value	SR13	There is a risk that the transfer of Herefordshire Services to Worcestershire Health and Care NHS Trust impacts on our capacity to progress our strategic objectives before April 2020		MD Herefordshire	Board	12 3x4	**4** **2x4**	4 1x4

Strategic Objective		Strong System Leader and Partner
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR1		There is a risk that we fail to support and progress effective working within the health and care system and cannot fully achieve the benefits of integration targeted within the Strategic Intent for the merged Trust and meet the NHS Long Term plan.

Type	Quality	**Executive Lead**	Director of Nursing	Med Director

Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019
Previous Meeting Risk Score	-	-	-	**Date of Review**	Nov 2019
Current Risk Score	2	4	8	**Date Next Review**	Feb 2020
Tolerable (Target) Score	1	4	4	**Date to Achieve Target**	March 2021

Key 2019/20 Deliverables	**Update**
Overall 5 Year Trust Strategy developed	Ongoing – to be taken forward within Board Development Sessions

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
CEO & Chair members of the Integrated Care System – engaged in all processes.	Reports to Board on ICS work, priorities & action plans	Board	ICS Governance requires further development	ICS Memorandum of Understanding, including delegation & ways of working	June 2020	ICS Chair	New ICS Chair in post from 1/1/2020
Director of Locality and Primary Care Post – Joint post with Clinical Commissioning Group which has embedded ongoing partnership working with Primary Care	Reports to Board	Board	Deputy MD Community Health Services & Clinical Director Hospital Services not yet appointed.	Appointments to be put in place	June 2020	Medical Director	

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Executives membership & leadership of key ICS Groups, Local Medical Committee, Primary Care Networks	Feedback from Groups	Management	Executive capacity during transition implementation phase can mean lack of time to engage.	Up-skilling next layer of management team	June 2020	CEO	Development planning ongoing
Effective Engagement in the Primary Care Networks (PCN)	Reports to Board & Executive	Board	Capacity to personalise support and take forward actions from PCN.	Development of roles below directors to enhance capacity. Development processes planned	Sept 2020	CEO	Development planning ongoing
Long Term Plan integrated into strategic planning work	Strategic Intent & approved Merger documentation	External – NHSE/I	-	-	-	-	-
Director of Strategy and Partnerships post Partnership work is Board level focus and supports capacity	Board Strategic Discussions	Management & Board	-	-	-	-	
Links to Risk Register 975 – Gloucestershire Hospitals NHS Foundation Trust – to Trust incident reporting and feedback process.							

Strategic Objective		Strong System Leader and Partner
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR2		There is a risk that services are not sustainable and do not continue to improve and develop to meet needs.

Type	Quality	**Executive Lead**	Director of Nursing	Med Director

Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019
Previous Meeting Risk Score	-	-	-	**Date of Review**	Nov 2019
Current Risk Score	2	4	8	**Date Next Review**	Feb 2020
Tolerable (Target) Score	1	4	4	**Date to Achieve Target**	March 2021

Key 2019/20 Deliverables	**Update**
ICS Strategy Implemented taking forward One Gloucestershire proposals	Ongoing – to be taken forward within Board Development Sessions

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
ICS Board ensures focus is on sustainability across the Gloucestershire health sector	Reports to Board	Board	Experts by Experience embedded in 2g ways for working and needs to be reviewed, customised and, then embedded across the wider Trust.	Co-production methodology implementation.	July 2020	Chief Operating Officer	
Fit for the Future Engagement	Board involvement in Fit for the Future Engagement	Board	Council of Governors to reflect the wider Trust need to be appointed and developed.	Appointment process to be carried forward,	July 2020	Chair	Development session to consider ways of working & development needs took place 14/11/19

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Co-production central to Trust's operation and this is being built into ways of working and ways of reviewing practice.	Development work of Director of Strategy and Partnerships and Chief Operating Officer	Management					
Gloucestershire Health Finance Directors meet regularly to ensure up to date understanding of the financial position across the Gloucestershire Health economy	Reports to Executive and Board	Management and Board					
Executive involvement in development of key pathways within ICS.	Reports to Board	Management & Board					
Links to Risk Register							
944 – QIPP Risk share							

Strategic Objective		**Outstanding Care**
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR3		There is a risk that failure to: (i) meet consistent quality standards for care and support; (ii) address variability across quality standards; or (iii) reconcile conflicting quality standards or guidance, will result in poorer outcomes for patients/service user and carers and poorer patient safety and experience.

Type	Quality		**Executive Lead**	Director of Nursing	Med Director

Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019
Previous Meeting Risk Score	-	-	-	**Date of Review**	
Current Risk Score	**2**	**4**	**8**	**Date Next Review**	Feb 2020
Tolerable (Target) Score	2	4	8	**Date to Achieve Target**	Ongoing

Key 2019/20 Deliverables	**Relevant Key Performance Indicators**
Quality Strategy in place with Performance Measures	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Patient Safety Controls: Clinical Risk Management Processes, Risk Management Strategy & Policy, Patient Safety Team	Reports to Quality Committee and sub Committees	Management & Board	Quality Committee frequency of meeting and combined quality report not yet in place.	During transition phase Quality Committee will meet on a monthly basis and separate Quality Reports will continue for at least 6 months to ensure breadth of focus. .	Ongoing	Director of Nursing	

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Patient experience controls (including compliments, complaints and learnings identified).	Reports to Quality Committee	Management	Experts by Experience not embedded within community services	Experts by Experience actions to be embedded	July 2020	Director of Nursing	
Co-production actions	Reports to Quality Committee	Management	Co-production to be further developed across the combined Trust.	Co-production to be further developed and embedded across the combined Trust	July 2020	Chief Operating Officer	
Workforce Controls – safe staffing processes and ways of working	Reports to Resources Committee and Quality Committee.	Management	Staff turnover and staff sickness which may lead to agency staff who have less knowledge of Trust processes and procedures	Staff recruitment and Retention actions	Ongoing	Dir HR & OD	
Freedom to Speak Up and Whistleblowing processes fully embedded across Trust.	Reports to Board	Board					

Links to Risk Register
116 – If Agency Management control is not effective then this may impact on quality and safety of services as well as the Trust's overall financial controls. 173 – That we fail to recruit the medical and nursing staff which may impact on patient safety and service delivery 203 – reduced consultant psychiatrist capacity in Wotton Lawn and Crisis Services 562 – There is a risk that acquired pressure ulcer incidence and prevalence remains at unacceptable high levels within the Trust in community services. 809 – There is a risk we do not attract and retain key clinical staff we will be unable to meet service demands which may have an impact on patient care. 777 = No microbiologist access – IV Therapy, Rapid Response and IVT.

Strategic Objective		Outstanding Care
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR4	⟷	There is a risk that the Trust does not maintain robust focus on either/or mental and physical health.

Type	Quality	**Executive Lead**	Director of Nursing	Med Director

Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	3	5	15	**Date Identified**	Nov 2019
Previous Meeting Risk Score	-	-	-	**Date of Review**	Nov 2019
Current Risk Score	**2**	**5**	**10**	**Date Next Review**	Feb 2020
Tolerable (Target) Score	1	5	5	**Date to Achieve Target**	Nov 2020

Key 2019/20 Deliverables	**Relevant Key Performance Indicators**
Quality Strategy in place with Performance Measures	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Patient Safety Controls: Clinical Risk Management Processes, Risk Management Strategy & Policy, Patient Safety Team	Reports to Quality Committee and sub Committees	Management & Board	Quality Committee frequency of meeting and combined quality report not yet in place.	During transition phase Quality Committee will meet on a monthly basis and separate Quality Reports will continue for at least the first 6 months to ensure focus continues across the breadth of the new Trust's services.	Ongoing	Director of Nursing	

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Management Structure developed through merger process to ensure focus on mental and physical health continues to be a focus, whilst not acting as a barrier to integration.	Management Structure	Management	Medical Strategy	To develop Medical Strategy	Nov 2020	Medical Director	Director of Strategies and Partnerships is developing Strategy development infrastructure to support development.
Co-production and engagement activities with carers, service users and staff reflect the need to ensure integration is not achieved at the expense of necessary specialism and that all relevant groupings are appropriately engaged.	Co-production and engagement methodology	Management	Quality Strategy	To develop Quality Strategy	Nov 2020	Director of Nursing	Director of Strategies and Partnerships is developing Strategy development infrastructure to support development.
Board composition reflects the need to ensure the history and legacy of each precursor Trust is maintained and that the Board has the skills to challenge to enforce appropriate focus on both areas of activity.	Board appointment process and Development processes	Board NHSE/I	Service User feedback process do not currently review against this commitment for early indications.	To be incorporated in review process as the systems are integrated.	Dec 2020	Director of Nursing	
Medical Committee and Staff Forum support feedback mechanism from staff across the Trust to ensure focus is maintained.	Reports to Executive	Management	Membership for Trust may not currently reflect spectrum of service users.	Focus on Membership with aim balance of service users across the Trust's provision	Sept 2020	CEO	
Links to Risk Register							

Strategic Objective		Personalised Experience
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR5	⟷	There is a risk that we fail to keep service users and carers at the heart of what we do and do not deliver genuine co-production.

Type	Strategic	**Executive Lead**	Chief Operating Officer	Med Director

Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019
Previous Meeting Risk Score	-	-	-	**Date of Review**	Nov 2019
Current Risk Score	2	4	8	**Date Next Review**	Feb 2020
Tolerable (Target) Score	1	4	4	**Date to Achieve Target**	Nov 2020

Key 2019/20 Deliverables	**Relevant Key Performance Indicators**
Co-production Methodology embedded across Trust.	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Patient Safety Controls: Clinical Risk Management Processes, Risk Management Strategy & Policy, Patient Safety Team	Reports to Quality Committee and sub Committees	Management & Board	Quality Committee frequency of meeting and combined quality report not yet in place.	During transition phase Quality Committee will meet on a monthly basis and separate Quality Reports will continue for at least the first 6 months to ensure focus continues across the breadth of the new Trust's services.	Ongoing	Director of Nursing	

Co-production and engagement activities with carers, service users and staff reflect the need to ensure integration is not achieved at the expense of necessary specialism and that all relevant groupings are appropriately engaged.	Co-production and engagement methodology	Management	Quality Strategy	To develop Quality Strategy	Nov 2020	Director of Nursing	Director of Strategies and Partnerships is developing Strategy development infrastructure to support development.
Patient experience controls (including compliments, complaints and learnings identified).	Reports to Quality Committee	Management	Experts by Experience not embedded within community services	Experts by Experience actions to be embedded	July 2020	Director of Nursing	
Links to Risk Register							

Strategic Objective		Engaged, Empowered and Skilled Workforce
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR6		There is a risk that we are unable to recruit and retain the workforce we need to meet our ambitions to: provide outstanding, joined up care maintain colleague well-being minimise use of agency and bank staff

Type	Workforce			**Executive Lead**	Director of HR
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Resources Committee
Inherent (without controls being applied) Risk Score	4	4	12	**Date Identified**	Inherited risk from 2g and GCS
Previous Meeting Risk Score				**Date of Review**	
Current Risk Score	4	4	12	**Date Next Review**	Feb 2020
Tolerable (Target) Score	2	4	8	**Date to Achieve Target**	

Key 2019/20 Deliverables	**Relevant Key Performance Indicators**
Workforce Plan in place	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Workforce planning processes.	Reports to Resources Committee	Board	National approach to NHS pension limits impacts on recruitment & retention	Lobbying at national level with NHS Providers and NHS Employers	Ongoing	Dir. HR & OD	
Implementation of the Interim People Plan	Reports to Resources Committee	Board	Lack of up to date or inaccurate workforce planning data	Promotion of system approach to workforce planning, including shared career pathways	March 2021	Dir. HR & OD	
Monitoring of Agency Use & Vacancies	Reports to Executive, Temporary Staffing Usage Group & Resources	Management & Board		Increased frequency of Temporary		COO and Dir. HR & OD	

	Committee			Staffing Group to fortnightly with additional workstream task and finish groups			
Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Safe Staffing Reports	Reports to Quality Committee	Board					
Recruitment & Retention Plans and actions	Reports to Resources Committee	Board	Trust doesn't commission all training.	Completion of Staff workforce planning training and programme of workforce planning workshops with support from HEE.	July 2020	Dir. HR & OD	
Skills Mix Reviews	Reports to Chief Operating Officer & Executive	Management					
Career pathway developments	Reports to Executive	Management					
Partnership arrangements with academic organisations.	Reports to Resources Committee	Board					
Vacancy Monitoring	Reports to Resources Committee	Board					
Temporary Staffing Board	Reports to Executive	Management	Limited Resources for promoting Trust jobs and enabling innovative approaches to recruitment & retention	Recruitment Action Plan and New recruitment strategy & action plan – ensuring best use of funds available	December 2019 March 2020	Dir. HR & OD	
Flexible working, retire and return options	Reports to Executive	Management					

Co-production of opportunities, working patterns etc with staff	Staff Friends and Family Test and staff survey	External					

Links to Risk Register

Risk 48 – That we fail to secure, retain and develop the workforce and evolve the organisation culture necessary to deliver our strategic objectives.
Risk 173 – That we fail to recruit to the medical and nursing workforce which may impact on patiene safety and service delivery
Risk 116- If Agency Management Control is not effective then this may impact both on quality and safety of services as well as the Trust's overall financial control.

Strategic Objective		**Engaged, Empowered and Skilled Workforce**
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR7	⟺	There is a risk that we fail to establish a culture which : engages and empowers colleagues engendering a sense of collective ownership supports discretionary innovation

Type	Sttrategic	**Executive Lead**	Director of HR & OD	

Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	4	4	16	**Date Identified**	Nov 2019
Previous Meeting Risk Score	-	-	-	**Date of Review**	
Current Risk Score	**3**	**4**	**12**	**Date Next Review**	Feb 2020
Tolerable (Target) Score	1	4	4	**Date to Achieve Target**	March 2020

Key 2019/20 Deliverables	**Relevant Key Performance Indicators**
Implementation of the Interim People Plan	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Values developed through co-production	Reports to Board	Board	Strategic Objectives to be fully developed	Strategic Objectives to be developed using co-production	June 2020	CEO	

				principles			
Interim People Plan	Reports to Resources Committee	Board	Full implementation of Plan	Communication & implementation through Strategy	Sept 2020	Director of HR & OD	
Bettercare together engagement processes	Reports to Board	Board	Implementation outcomes of Bettercare together	Outcomes to be built into strategies	Sept 2020	Director of Strategy & Partnerships	
Heads of Professional Knowledge Network in place	Reports to Director of Nursing	Management					
Research Knowledge Partnership in place	Reports to Executive	Management					
Freedom to Speak Up Guardian & supporting processes	Reports to Board	Board					
Colleague Communication & Engagement activities	Reports to Executive	Management					
Staff Surveys	Reports to Resources Committee and Board	Board					
Paul's Open Door	Reports to Board	Board					
Links to Risk Register							

Strategic Objective		Innovation and Research Driven
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR8	⟷	There is risk that we don't enable colleagues to support Innovation and Research through appropriate: funding, time and focus and strategic drivers

Type	Quality	**Executive Lead**	Director of Nursing	Med Director

Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	3	3	9	**Date Identified**	Nov 2019
Previous Meeting Risk Score	-	-	-	**Date of Review**	Nov 2019
Current Risk Score	**3**	**3**	**3**	**Date Next Review**	Feb 2020
Tolerable (Target) Score	2	3	6	**Date to Achieve Target**	Feb 2021

Key 2019/20 Deliverables	**Relevant Key Performance Indicators**
Research Strategy in place with Performance Measures	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Research Actions & Activities	Reports to Quality Committee	Board	Research Strategy in development	Put in place Research Strategy	March 2021	Medical Director	
Annual Research Conference	Reports to Executive	Management	Trust 5 year Strategic Plan	To be developed	June 2020	CEO	
Learnings from Incidents, Complaints and compliments	Reports to Quality Committee	Board	Medical Strategy	To be developed	March 2021	MD	
Good Practice Identification & Follow Up process	CQC working group	Management	Quality Strategy	To be developed	March 2021	Director of Quality	
Training & Development Activities	Reports to Executive	Management					
Quality Improvement Unit activities	Reports to Executive	Management					

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Bettercare together activities	Reports to Board	Managements					
Links to Risk Register							

Strategic Objective		Innovation & Research Driven
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR9		There is a risk that we do not have in place structures and processes which enable colleagues to look beyond the organisation to identify leading edge practice to inform practice.

Type	Quality	**Executive Lead**	Director of Nursing	Med Director

Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	3	3	9	**Date Identified**	Nov 2019
Previous Meeting Risk Score	-	-	-	**Date of Review**	Nov 2019
Current Risk Score	**3**	**3**	**3**	**Date Next Review**	Feb 2020
Tolerable (Target) Score	2	3	6	**Date to Achieve Target**	Jan 2021

Key 2019/20 Deliverables	**Relevant Key Performance Indicators**
Research Strategy in place with Performance Measures	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Research Actions & Activities	Reports to Quality Committee	Board	Research Strategy in development	Put in place Research Strategy	March 2021	Medical Director	
Annual Research Conference	Reports to Executive	Management	Trust 5 year Strategic Plan	To be developed	June 2020	CEO	
Learnings from Incidents, Complaints and compliments	Reports to Quality Committee	Board	Medical Strategy	To be developed	March 2021	MD	
Good Practice Identification & Follow Up process	CQC working group	Management	Quality Strategy	To be developed	March 2021	Director of Quality	
Training & Development Activities	Reports to Executive	Management					
Quality Improvement Unit activities	Reports to Executive	Management					

Links to Risk Register

Strategic Objective		Best Value						
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**						
SR10		There is a risk that the One Gloucestershire transformation plans become frustrated and impact on our individual Trust aims and objectives and the whole system plans..						
Type		Strategic			**Executive Lead**	CEO		
Risk Rating		**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Board		
Inherent (without controls being applied) Risk Score		3	4	12	**Date Identified**	Nov 2019		
Previous Meeting Risk Score					**Date of Review**			
Current Risk Score		3	4	12	**Date Next Review**	Feb 2020		
Tolerable (Target) Score		2	4	8	**Date to Achieve Target**			
Key 2019/20 Deliverables					**Update**			
One Gloucestershire Engagement complete and clear road map in place.								
Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls		Key Actions To Address	Target to Complete	Action Owner	Action Update
Engagement Plan in place	Report to Board	Board	Original timeline revised, impact of updated timeline required.		Impact of updated timeline to be considered against other key strategic activities, eg Hospitals in Forest of Dean	Feb 2020	Dir Strat & Partnerships	
External Specialist Advice to ICS to support engagement process	ICS Board Board	External & Board						
Ongoing ICS Updates to ICS Board & Board	Reports to Board to support scrutiny, challenge & openness in working	External & Board						
Links to Risk Register								

Strategic Objective		Best Value
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR11		There is a risk we do not maintain robust internal controls (Including financial) and governance systems; resulting in potential financial and organisational instability.

Type	Strategic			**Executive Lead**	CEO
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Board
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019
Previous Meeting Risk Score				**Date of Review**	
Current Risk Score	3	4	12	**Date Next Review**	Feb 2020
Tolerable (Target) Score	2	4	8	**Date to Achieve Target**	March 2020

Key 2019/20 Deliverables	**Update**
Budget and CIP targets to be achieved	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Clinical and corporate governance arrangements enable controls to be effectively managed.	The sub-Board Committee structure provides assurance on all corresponding controls to the Trust Board.	Board	Combined Quality Reporting development is ongoing	Integrated Quality Report to be developed	July 2020	Director of Quality	
Committee / reporting structures enable controls to be monitored and reviewed.	Internal Audit – pre planning for merger & post merger	External	External Audit Report Feedback	Year End Report	May 2020	Dir Fin	
Internal and external audit and plans provides additional scrutiny	Reports by Internal & External Audit to Audit Committee	External					

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
The Trust's Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation in place	Based on best practice	Management	External Review to be undertaken.	Internal Audit to Review	March 2020	Dir of Finance	
Robust project structure and governance framework in place to ensure continual monitoring and reporting with clear escalation			Full range of Strategies not yet in place	Agreed strategies to be developed & put in place	Sept 2020	Dir. Strategies & Partnerships (with Board)	
Links to Risk Register							
116 – Agency Usage Control 177 – Cost Improvement Plan Delivery							

Strategic Objective		Best Value
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR12	⟺	There is a risk we do not achieve our individual organisation's financial sustainability and contribute to whole system sustainability

Type	Financial			**Executive Lead**	Dir Finance
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Board
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019
Previous Meeting Risk Score	-	-	-	**Date of Review**	Nov 2019
Current Risk Score	2	4	8	**Date Next Review**	Feb 2020
Tolerable (Target) Score	2	4	8	**Date to Achieve Target**	March 2020

Key 2019/20 Deliverables	**Update**
Budget and CIP targets to be achieved	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Budget Setting	Board Reports	Board	Budget Management processes for new Trust to be implemented	Budget Management Cycle to be implemented	March 2020	Director of Finance	
Finance Report	Board Reports & Resources Committee Reports	Board	Finance systems in integration	Finance system integration processes to be completed	April 2020	Director of Finance	
Agency Usage and Temporary Staffing Group	Reports to Resources Committee	Board	Development of shared services provision				
Budget Planning within Financial Memorandum	Board Report	Board					

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
ICS Financial Plan Monitoring	Board Report	Board					
Links to Risk Register							
116 – Agency Usage Control 177 – Cost Improvement Plan Delivery							

Strategic Objective		Best Value
Risk Ref :	Latest Rating and Direction of Travel	Risk Description
SR13		There is a risk that the transfer of Herefordshire Services to Worcestershire Health and Care NHS Trust impacts on our capacity to progress our strategic objectives before April 2020.

Type	Strategic	Executive Lead	CEO	Managing Dir Herefordshire

Risk Rating	Likelihood	Impact	Total	Assurance Committee	Board
Inherent (without controls being applied) Risk Score	3	4	12	Date Identified	Nov 2019
Previous Meeting Risk Score	-	-	-	Date of Review	
Current Risk Score	2	4	8	Date Next Review	Feb 2020
Tolerable (Target) Score	1	4	4	Date to Achieve Target	March 2020

Key 2019/20 Deliverables	Update
Herefordshire Service Transfer of services completed	

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Managing Director Herefordshire Mental Health and Learning Disabilities	Reports to Board	Board	Potential financial impact on Trust	Potential impact being fully reviewed	Dec 2019	Dir Finance	
NED with dedicated lead for Herefordshire	Reports to Board	Board					
Partnership working with Herefordshire and Worcestershire Health System	Reports to Board	Board					

Links to Risk Register

Definitions

The overall risk ratings below are calculated as the product of the Probability and the Severity

LEVEL	INJURY / HARM	SERVICE DELIVERY	FINANCIAL / LITIGATION	REPUTATION / PUBLICITY
5 CATASTROPHIC	Fatality, Multiple fatalities or large number injured or affected.	Complete breakdown of critical service/ 'Significant under-performance' against key targets.	Losses; claims/damages; criminal prosecution, over-spending; resourcing shortfall: >£1M.	National adverse publicity/reputation irreparably damaged.
4 Major (HIGH)	Fatality/multiple serious injuries/major permanent loss of function/increased length of stay or level of care >15 days.	Intermittent failures of a critical service/'under-performance against key targets'.	£501K - £1M	Adverse national publicity
3 Moderate (MEDIUM)	Semi-permanent harm (1 month-1 year). Increased length of stay / level of care 8-15 days, >1 month's absence from work.	Failure of support services/under-performance against other key targets'.	£51K - £500K	>3 days local media publicity
2 Minor (LOW)	Short-term injury (<1 month). Increased length of stay or level of care <7 days, 3 days-1 month absence for staff.	Service Disruption	£11K - £50K	<3 days local media publicity
1 (Insignificant)	No harm. Injury resulting in <3 days' absence from work for staff.	No service disruption	<£10K	

LIKELIHOOD SCORE		
Level		
5	Almost certain	Will occur frequently given existing controls
4	Likely	Will probably occur given existing controls
3	Possible	Could occur given existing controls
2	Unlikely	Not expected to occur given existing controls
1	Rare	Not expected to occur, except for in exceptional circumstances, given existing controls

RISK RATING MATRIX

Likelihood	IMPACT				
	1	**2**	**3**	**4**	**5**
5	**5** (LOW)	**10** (MEDIUM)	**15** (HIGH)	**20** (CATASTROPHIC)	**25** (CATASTROPHIC)
4	**4** (LOW)	**8** (MEDIUM)	**12** (MEDIUM)	**16** (HIGH)	**20** (CATASTROPHIC)
3	**3** (LOW)	**6** (MEDIUM)	**9** (MEDIUM)	**12** (MEDIUM)	**15** (HIGH)
2	**2** (LOW)	**4** (LOW)	**6** (MEDIUM)	**8** (MEDIUM)	**10** (MEDIUM)
1	**1** (LOW)	**2** (LOW)	**3** (LOW)	**4** (LOW)	**5** (LOW)

Impact Score x Likelihood Score = Risk Rating:

AGENDA ITEM 15

Report to:	Gloucestershire Health and Care NHS Foundation Trust Board – 28th November 2019
Author:	Neil Savage, Director of HR and OD
Presented by:	Neil Savage, Director of HR and OD
SUBJECT	**Learning Lesson To Improve People Practices**

This Report is provided for:			
Decision	Endorsement	Assurance	To Note

EXECUTIVE SUMMARY

This report sets out a response to the letter of 24 May 2019 from Baroness Dido Harding to NHS Trust Chairs and Chief Executives entitled "Learning lessons to improve our people practices". The letter is attached as an appendix to the report.

The letter details the findings of an independent analysis by an advisory group following the tragic death of an NHS nurse, Amin Abdullah, in 2016.

The purpose of the report is to provide assurance to the Board of Directors around the recommendations made in the letter. Whilst this report identifies strong compliance against the recommendations, there are some recommended actions to deliver further improvement.

These include:

- ✓ Launching a new internal training programme in Quarter 4 2020
- ✓ Disciplinary Policy to be updated to expressly include formalization of the Workforce Buddy arrangements
- ✓ Additional more explicit internal and external signposting for support to be included in the policy as an appendix, to include for example, the NHS Practitioner Health Programme
- ✓ Anonymized case work database to be reported twice per year to the Trust's operational Workforce Management Group, which is chaired by the Director of HR and OD
- ✓ A quarterly Performance Panel, consisting of the Director of HR & OD, the Director of Nursing, Quality and Therapies and the Medical Director with a nominated Non-Executive to be initiated to review all cases on an anonymized basis
- ✓ The next WDES and WRES annual board reports to include focus on whether there are apparent unfairness or bias against colleagues on the basis of race and disability

RECOMMENDATIONS

The Board of Director is asked to consider this report, support the finding of significant assurance and to support the recommended actions outlined above.

Corporate Considerations	
Quality implications:	The Trust uses external reports, guidance and best practice to inform, develop and review its people management practices. The content of this report links to the following three CQC Domains: Safe: patients, staff and the public are protected from abuse and avoidable harm. Caring: staff involve and treat everyone with compassion, kindness, dignity and respect. Well-led: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Resource implications:	Existing internal resource and capacity cover off existing practices and the proposals contained within the recommendations arising out of the Trust's review of Baroness Harding's letter.
Equalities implications:	Equality and diversity is a core element of the Trust's people management practices, policies and procedures. Equality and diversity implications have been considered in the review and development of the new Trust's disciplinary processes. Recommendations are applicable to all colleagues equally. Policies are subject to Equality Impact Assessments, and WRES & WDES standards also apply.
Risk implications:	If the Trust does not learn lessons from reflection and the learnings and recommendations from external reports it will fail to develop a high quality people management culture with negative impact on recruitment, retention and colleague morale. This will limit its ability to deliver its strategy, aims and objectives, ultimately impacting on the quality of patient care.

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

WHICH TRUST VALUE(S) DOES THIS PAPER PROGRESS OR CHALLENGE?			
Working together	P	**M**aking a difference	P
Always improving	P		
Respectful and kind	P		

Reviewed by:		
Neil Savage – Director of HR and Organisational Development	Date	November 2019

Where in the Trust has this been discussed before?		
Staff Side Chair Workforce Management Group	Date	18 November 2019 20 November 2019

What consultation has there been?		
	Date	

Explanation of acronyms used:	GHC = Gloucestershire Health & Care NHS Foundation Trust GMC = General Medical Council NMC = Nursing and Midwifery Council HCPC = Health and Care Professions Council MHPS = Maintaining High Professional Standards in the NHS BMA = British Medical Association SPF = Social Partnership Forum HRD = HR Directors

1. INTRODUCTION

1.1 Following an independent report into a tragic event involving Amin Abdullah, an employee, at Imperial College Healthcare NHS Trust, Baroness Dido Harding wrote to all Trust Chairs and Chief Executives earlier this year (Appendix 1), setting out new guidance relating to the management and oversight of local investigation and disciplinary procedures.

1.2 This report provides an outline for the Board as to where the Trust's processes and procedures are in relation to the guidance and also sets out some additional further actions aimed at further improving our people management practices and culture.

2 THE GUIDANCE

2.1 The letter and guidance provide seven key areas of focus for Trusts to consider and review. Following a summary below of the Trust's recently adopted Just and Learning Culture Principles, these seven areas are then outlined below, along with the Trust's current position against each.

2.2 **Just and Learning Culture Principles**

In partnership with the Trust's JNCF and the One Gloucestershire SPF, the Trust has been developing and adopting a "just and learning culture" for its people management practices. This month, this has also been agreed by the South West Regional SPF as the single area of partnership working with all South West Trust's HRDs for 2020. This puts equal emphasis on learning and balanced accountability for both individuals and their employer.

In the case of an incident or adverse event it is an approach that instinctively asks what was responsible, not who was responsible, but it is not the same as an uncritical anything goes culture. There will be some situations where the disciplinary procedure as set out in the Trust's policy will clearly be appropriate and this will be determined by the Trust on an individual case basis.

In all other circumstances the principles of a just and learning culture provide an alternative and supportive mechanism by:

- ✓ Recognising that every employee has a valuable role to play and a unique contribution to make that will ensure the highest possible standards of care are delivered and sustained
- ✓ Providing a supportive approach to improving and changing behaviour and practice within the Trust
- ✓ Creating a culture of openness and increased reporting of incidents where equal emphasis is placed on accountability and learning
- ✓ Encompassing a more proactive approach to acting on improvements either at a personal or organisational level in order to learn from experience and prevent or reduce mistakes or risk
- ✓ Creating of a culture of openness with an emphasis on improvements leads to the establishment of trust between colleagues and managers
- ✓ Enabling employees to feel confidence in the organisation, be able to see their involvement/contribution recognised and making a difference in the service provided

In line with the principles of a just and learning culture the Trust seeks to gather the initial facts to gain understanding of a situation that has occurred before making any

decision on how to proceed and if alternative duties or suspension is required. This includes considering:

- ✓ Details of the issue from the employee's perspective
- ✓ The knock on effects (where applicable) of the incident/issue/practice
- ✓ The behaviours/actions of employees during the situation

Part of this approach also requires that at every stage in the disciplinary process the employee is kept advised of the nature of the allegations and is given the opportunity to state their case with the support of a colleague or trade union representative before any decision is made.

Importantly, the approach has also led the Trust to implement a process from October 2019 onwards of offering a "workplace buddy" to those undergoing an investigation or disciplinary process. This is an individual from another areas who is available to them for support and advice.

2.3 **Adhering to best practice**

The Trust's Disciplinary Policy is applicable to all colleagues irrespective of profession and is the procedural route to address conduct issues. This has been developed in partnership with our local Trade Union and Professional Associations and agreed through the Joint Negotiating and Consultative Forum. This policy has been reviewed very recently (June to September) and is deemed compliant with the ACAS statutory code of practice on disciplinary and grievance procedures and current NMC, HCPC and GMC related guidance.

The Trust's main disciplinary policy is further supplemented for medical colleagues with a Disciplinary Policy for Medical Staff. This was developed in partnership locally with the BMA and complies with the national requirements of Maintaining High Professional Standards (MHPS) in the NHS and also follows the General Medical Council's (GMC) "Principles of a good investigation". Through this the Medical Director, Associate Medical Director and / or Director of HR and OD, seek independent advice from the Practitioner Performance Advice Service (PPAS), which was formally known as the National Clinical Assessment Service (NCAS), and the Medical Director notifies the GMC in the event of an investigation being considered and / or launched.

The Trust ensures that independence and objectivity is maintained at all stages of the processes by appointing investigating officers, case managers and panel members who have had no previous decision making and involvement in the matters in question. The Trust also ensures that supporting colleagues or representatives to the interviewees are not witnesses in their own right for the matter in hand. Where appropriate, external advice is sought and external panel members are appointed, for example in matters of clinical judgement. Recent examples include seeking advice from Colleges, the GMC and having external medical directors or consultants on panels. External investigating officers can also be appointed, if necessary, to ensure objectivity and independence.

2.4 **Applying rigorous decision-making methodology**

The Trust's policy and practice aims to resolve matters at the lowest possible level, as close to the issue as possible. To that end, the Disciplinary Policy provides for an initial fact-finding to be undertaken to ascertain whether the matter can be dealt with informally or whether a full investigation is required. This initial fact finding is undertaken with the support and advice of a professionally qualified Human

Resources practitioner providing a level of independence in the decision- making processes.

Consideration is given to other Trust policy or guidance frameworks which may be more appropriate for use in the circumstance, including:

- ✓ Dignity at Work Policy
- ✓ Improving Performance Policy
- ✓ Pay Progression Policy
- ✓ Redeployment Policy
- ✓ Supporting Attendance Policy
- ✓ Checklist for Amended Duties, Suspension and Accelerated Process

The Trust's policy and practice steer minor conduct issues to being dealt with effectively by way of a structured discussion between the line manager and the colleague. This enables a swift resolution outside of the formal disciplinary procedure. The discussion outlines the standards expected of the colleague and the desired required improvement in their conduct.

In cases where an investigation is deemed necessary, a Commissioning Manager (or Case Manager for medics) oversees the investigation and an investigating officer appointed to undertake the investigative work. On conclusion of an investigation the report is reviewed by the Commissioning Manager (or Case Manager for medics), with professional advice from HR, to determine whether there is a case to answer and if so, whether the Disciplinary Accelerated Process (i.e. a fair blame fast track) route may be appropriate to be offered or whether full hearing is required. Ultimately this provides a degree of independence between the officer undertaking the investigation and the individual deciding what steps are to be taken following the investigation.

In the event that the case proceeds onwards to a hearing, a different manager who has had no previous involvement in the case is nominated as Chair of the Panel and is supported by a different professional HR practitioner. In medical cases where professional judgement is under question, an external panel member is sought in accordance with the requirements of MHPS. This may be a specialty consultant from another Trust or alternatively another organisation's Medical Director. Similarly, in the event of an appeal, this is heard by a different Appeal Panel Chair, again with a different HR practitioner, neither of whom have had any prior involvement in the process. On occasions, the Trust will bring in an external HR practitioner from another Trust to support the panel, for example, in the event that the case has already involved all the HR practitioners.

Considerations as to whether or not colleagues need to be suspended ("exclusion" for medics), pending or during an investigation are carefully managed with clear policy guidance and an extensive checklist (i.e. Checklist for Amended Duties, Suspension and Accelerated Process). This process aims at ensuring that suspension is always a last resort where it is deemed necessary for safety or integrity of the process. Alternatives such as temporary redeployment or amendment to duties are explored in advance of suspension.

2.5 Ensuring people are fully trained & competent to carry out their role

Historically internal training, or where required, external training, has been provided for managers and senior clinicians involved in investigations and hearings in both out legacy Trusts. Externally, the Trust has sent medics and senior HR Managers involved in managing processes or investigating on NCAS / NHS Resolution training.

A new internal programme is now being developed for GHC for launching in Quarter 4 2020.

Professional advice is currently available throughout by HR colleagues who have been trained and who are accredited members of the Chartered Institute of Personnel and Development (CIPD). HR colleagues are additionally provided with opportunities for further training and refreshers through masterclasses put on by Trust solicitors.

Trade Union and Professional Association members are all provided with internal union training on appointment to becoming a local representative.

Internal trained mediators are also available to provide an option of facilitated mediation where this is considered more appropriate to disciplinary action in the case of interpersonal difficulties between colleagues. Externally, the Trust had access to and has previously used professionally trained ACAS mediators too.

Similarly, trained Dignity At Work Officers are also available to support, advice and signpost colleagues.

ACTION:

New internal training programme to be launched in Quarter 4 2020.

2.6 **Assigning sufficient resources**

The appointment of Commissioning Officers / Case Managers and Investigating Officers and is undertaken by the relevant manager with the advice of senior HR team members, including the Deputy Director and the Director of HR and OD. A key and explicit aspect of the HR operations team, the Commissioning Manager / Case Managers and Investigating Officers' roles is to keep on top of timescales for the investigation, report-writing, hearings and the conclusion of the processes. A professional HR practitioner is allocated to support Commissioning / Case Managers and Investigating Officers, with a different HR practitioner sitting on panels at all levels to provide advice and support.

2.7 **Safeguarding people's health & wellbeing**

Colleagues who are subject to investigations are informed at the outset of the internal support available through our Working Well website, face-to-face Occupational Health services, counselling, HR and local and / or national Trade Union representatives and support. In terms of occupational health formal support, colleagues can either self-refer or have a management referral made for them. Additionally, where appropriate, colleagues may be signposted externally to the NHS Resolution and its Practitioner Performance Advice service which is available to both colleagues and employers. In cases where a colleague appears distressed at the outset, or those who are deemed as being likely to be distressed through the process, a management referral is made to Occupational Health for advice and support. Colleagues are informed and regularly reminded through processes that access to Occupational Health support is available at any time.

On the commencement of an investigation a meeting is held with the colleague(s) who is (are) subject to the investigation to inform them of the reasons for the investigation and the process to be followed. This is confirmed formally with them, together with the allegations and terms of reference for the process. The

Commissioning Manager / Case Manager and Investigating Officer roles all explicitly include the responsibility for regular communications with colleagues throughout the investigation to keep them apprised of progress and any unavoidable delays. Where a colleague is suspended, the Case Manager is responsible for keeping the employee informed of progress in the investigation.

Since October 2019, the Trust has implemented an approach of offering a Workplace Buddy to colleagues undergoing both grievance and disciplinary processes in the Trust.

Actions:

Disciplinary Policy to be updated to expressly include formalization of the Workforce Buddy arrangements.

Additional more explicit internal and external signposting for support to be included in the policy as an appendix, to include for example, the NHS Practitioner Health Programme.

2.8 **Board-level oversight**

Data relating to HR Case work, including numbers of disciplinary and grievance cases, locations, colleague details, Commissioning Manager / Case Manager and Investigating Officer, commencement of cases, review dates and ultimate duration of process, number and duration of suspensions, is collated and overseen by the Senior HR and OD team, with Deputy and Director level oversight on a monthly basis.

Additionally, disciplinary case numbers are reported at locality boards, which feed into Executive Directors.

In cases of medical investigations and disciplinaries, a Non-Executive Director is allocated to provide additional oversight and scrutiny.

Actions:

Anonymized case work database to be reported twice per year to the Trust's operational Workforce Management Group, which is chaired by the Director of HR and OD. This review process will include analysis of whether colleagues with protected characteristics fare better or worse than other colleagues.

A quarterly Performance Panel, consisting of the Director of HR & OD, the Director of Nursing, Quality and Therapies and the Medical Director with a nominated Non-Executive to be initiated to review all cases on an anonymized basis, reporting to the Board of Directors private meeting agenda. An option could be to make this a private section of the Resources Committee once a quarter.

The next WDES and WRES annual reports to include further focus on whether there are apparent unfairness or bias against colleagues on the basis of race and disability.

3. CONCLUSIONS & RECOMMENDATIONS

3.1 The Board can take significant assurance that the Trust has appropriate and supportive arrangements in place for handling disciplinary processes and

investigations. Most of the recommended actions set out in the letter and guidance document are already in place within the Trust. However, the review also recognises that there are areas where further improvements can be made to continuously improve our people management practices and culture. Actions to address these are included in section 2 above.

3.2 The Board of Director is asked to consider this report, support the finding of significant assurance and to support the recommended actions outlined above.

Gloucestershire Health & Care NHS Foundation Trust
Resources Committee
TERMS OF REFERENCE

1.	**Purpose**
1.1	The Resources Committee will be a crucial part of developing a sustainable, transformative, innovative and forward looking organisation.
1.2	The Resources Committee will be responsible for making recommendations to the Trust Board in respect of business development opportunities, in addition to major business cases that require capital investment.
1.3	The Resources Committee will ensure relevant Strategies are in place, ensuring the Trust has an appropriate: • HR/OD Strategy • Workforce Strategy • Finance Strategy • Estates Strategy • Commercial Strategy • Communication and Engagement Strategy • Digital Strategy • Clinical/Operational Services Strategy The Committee will maintain an overview of procedures for and performance in respect of business planning, sustainability, performance, investment and capital expenditure procedures, and transformation. Maintain robust oversight of the implementation of the strategies and where performance or activities are not in line with proposed timescales or budgets, oversee the development and discharge of action plans to ensure improvement.
1.4	Undertake high-level, exception based monitoring of the delivery of workforce, financial and operating performance to ensure that the Trust is operating in line with its annual plan objectives Business Planning.
2.	**Membership**
2.1	Four Non-Executive Directors, one of whom will be appointed Chair (the Chair may not be the same person as the Chair of the Audit and Assurance Committee) Director of Finance and Director HR & OD (Executive Leads) Chief Operating Officer Director of Strategy & Partnerships Director of Nursing, Quality & Therapies **In attendance:** Deputy Director HR Deputy Director of Finance Deputy COO Placed Based Services Deputy COO CYPS and Specialist Services Head of Organisational Development & Improvement Head of Corporate Governance /Deputy Trust Secretary
2.2	Other Officers of the Trust may attend at the discretion of the Committee Chair. Any other Trust Board Member may attend the meetings and will count towards the quorum.
3.	**Quorum**
3.1	**Four** members, at least two of whom should be Non-Executive Directors and two should be

	Executive Directors. Where a member is unable to attend a meeting of the Committee, that member may, with the agreement of the Committee Chair, nominate a deputy who will count towards the quorum.
4.	**Reporting Arrangements**
4.1	The Resources Committee will update each routine Board meeting on its activity, highlighting decisions made, issues being progressed and issues requiring further consideration or decision by the Board.
4.3	The Committee will highlight any key issues or concerns to the Audit and Assurance Committee or the Quality Committee which require consideration by one or both of these committees.
5.	**Powers**
5.1	The Trust's Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation shall apply to the Resources Committee.
5.2	The Committee is authorised to establish sub-groups, to which it can delegate specific tasks or functions, whose activities it will monitor through the groups minutes or reports depending on the tasks or functions undertaken. The Committee will approve the terms of reference of the sub groups.
6	**Responsibilities**
6.1	<u>Annual Plan Delivery and Future Development</u> To oversee the Trust's business planning process and agree principles and approach for internal budget setting and the development of directorate business plans, including workforce plans, linked to the Trust's strategic aims . To review the Trust's Annual Plan, including medium and long term plans required by NHS Improvement Gloucestershire System Plans, to confirm that the financial plan supports the Trust's wider strategy; to scrutinise assumptions underpinning the financial modelling and advise the Trust Board accordingly. To take an overview of the Trust's performance against financial and performance objectives ensuring that resources are being appropriately managed to deliver effective and efficient services, receiving advice regarding remedial action being taken as necessary by the Executive Team and ensure regular reports are provided to the Trust Board . Assure that the Trust's Cost Improvement Programme (CIP), CQUIN (Commissioning Quality and Innovation) and QIPP (Quality Innovation, Productivity and Prevention) Schemes are delivering to time, and therefore that all necessary efficiencies are being achieved and reflected within financial reports. To monitor key financial ratios against current and strategic plans, particularly those required by NHS Improvement, and agree any appropriate action. To monitor Trust Reference Costs, PLICS and SLR and report any significant implications from variances against national averages or historical trends to the Trust Board. To oversee the development and implementation of a Trust marketing strategy and routinely consider market share analysis reports and business development opportunities and assess any identified business risks. To confirm that the Trust manages its asset base efficiently and effectively and to confirm capital projects of significant value, whether related to property or other assets, are properly

	identified, managed and controlled. This definition relates equally to both the acquisition of assets and to their disposal.
6.2	**HR and Workforce:** To review the Trust's Human Resources and Organisational Development Strategy, its further development and implementation, its links to clinical service and financial strategies and ensure it supports the delivery of efficient and effective healthcare and meets all legislative duties and national targets. To take a strategic view of the Trust's workforce plans to ensure that they are robust and support the delivery of the Trust's financial and clinical objectives. To seek assurance that the Trust's HR Strategy and function is operating effectively, ensuring that it is developing and routinely reviewing appropriate HR performance indicators and benchmarks to report to the Board of Directors. To receive exception performance reports, with due explanation, ensure remedial actions are taken as necessary by the Executive Team and regular reports provided to the Board of Directors. To liaise with the Quality Committee, to co-ordinate HR plans. To oversee HR Policy Development within the Trust, reviewing and approving on behalf of the Trust Board policies and procedures that, under the Trust's Standing Orders, require Board approval and fall within the scope of the Committee's terms of reference, elsewise receive assurance from the appropriate management committee around the implementation of a robust process for the review and approval of relevant policies. To ensure that the Trust has an effective Workforce Communications and Engagement Strategy
6.3	**Estates Strategy:** To review the Trust's Estates Strategy, its formulation, development and implementation, its links to service and financial strategies and compliance with all legislative duties, system strategies and national targets and thus ensure that the Trust's capital assets are properly and effectively utilised. To seek assurance on behalf of the Board of Directors that the Estates Strategy is linked to the delivery of the Trust's financial and clinical service objectives; that there is an up to date asset register linked to service provision; there is effective space utilisation and a robust disposal policy for redundant estate. To seek assurance on behalf of the Board of Directors that the Trust has appropriate strategies relating to the environment and sustainability and policies are effectively implemented and monitored.
6.4	**Investment Strategy:** To scrutinise business cases for all major capital investments (all material and significant investments) to provide assurance to the Board of Directors that in reaching its decision on the business case it has complied with the independent regulator's requirements and that it has considered any other factors which the Committee feels is relevant to the decision. To approve to progression of ITT stage of strategically significant tenders or tenders requiring the commitment of resources above a limit set in the Trust's Scheme of Delegation. To recommend to the Board of Directors, and, on approval, oversee and regularly review all Trust policies and procedures with respect to investment strategy in line with current NHS guidance and relevant accounting standards to ensure the delivery of agreed financial

	objectives. To agree principles and approach for substantial or material contracts and be a point of referral in negotiations if required. To agree principles and approach for lease arrangements. To review all business cases to confirm Trust resources are focussed on relevant areas
6.5	<u>Business Development</u> Consider, review and advise the Trust Board, in respect of any proposals for significant new business development opportunities, including tender submissions and bid status, ensuring that these will minimise financial and clinical risk, and increase service effectiveness and efficiency. Undertake a regular review of provider competition and potential business partners in the county and wider health economy and maximise business opportunities. Review the Trust's business development plans and all underlying principles. Review any market analysis undertaken by, or on behalf of, the Trust.
6.6	<u>Governance</u> Ensure that the indicators and outcomes used to evaluate financial and workforce performance are appropriate to enable the Board to monitor the organisation's adherence to its vision, values and strategic objectives. Ensure that all risks as appropriate to the Committee are captured and recorded, and that salient risks are escalated to the Board Assurance Framework: moreover, identify and enact all mitigations as may be relevant.
7.	**Frequency and Review of Meetings**
7.1	The Committee will usually meet 6 times a year. The Chair may agree further meetings if necessary. Virtual meetings may, at the discretion of the Committee Chair, may take place using appropriate electronic methods.
7.2	These Terms of Reference will be reviewed annually, with any change recommended to the Trust Board for approval following approval by the Resources Committee. This review will include a self-assessment of its effectiveness in discharging its responsibilities as set out.

Version Control

Version 1	24/10/19	Approved by Resource Committee

Audit and Assurance Committee
TERMS OF REFERENCE

1.	**Purpose**
1.1	The Audit and Assurance Committee will provide the Board of Gloucestershire Health and Care Services NHS Foundation Trust with an independent and objective review of its governance and assurance processes; including internal control, risk management, financial systems, financial information and compliance with laws, guidance and regulations governing the NHS.
2.	**Membership**
2.1	Three Non-Executive Directors as core members, one of whom will be appointed Chair. Any other Non-Executive Trust Board Member, (except the Chair) may attend the meetings and would contribute to the quorum. At least one member of the Committee shall have recent, relevant financial experience. The Chair of the Board shall not be a member of the Committee but may attend by invitation. Executive Directors shall not be members of the Committee but may be invited to attend. The Chief Executive shall not be a member of the Committee but will be invited to attend to discuss the Annual Report, Quality Report, Annual Accounts and the assurance process for the Annual Governance Statement **<u>In attendance:</u>** Director of Finance or deputy Local Counter Fraud Specialist at least twice a year Head of Corporate Governance or Deputy Internal Auditors (every meeting) External Auditors (minimum twice a year) At least once a year the Committee will meet privately with the external and internal auditors and the Local Counter Fraud Specialist, all of whom additionally have a right to direct access to the Chair of the Committee. The Local Counter Fraud Specialist will be entitled to attend every meeting of the Committee.
2.2	Other Officers or Directors of the Trusts may attend at the discretion of the Chair. In addition, up to two nominated Governors may observe the proceedings of the Committee in order to provide assurance to the Council of Governors and to assist in holding the Non-Executive Directors to account for the performance of the Board.
3.	**Quorum**
3.1	Three Members.
4.	**Reporting Arrangements**
4.1	The Audit and Assurance Committee will update each routine Board meeting on its activity, highlighting decisions made, issues being progressed and concerns requiring further consideration or decision by the Board.

4.2	The Committee will report to the Board annually on its work in support of the Annual Governance Statement.
4.3	The Committee will advise any key issues or concerns which require consideration by another of the Board's committees. The Chair will work with the Chairs of other Board Committees to ensure that where there are apparent overlaps in the work of the Committees, which will inevitably arise from time to time, every effort is made to ensure that duplication of work is avoided.
5.	**Powers**
5.1	The Trust's Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation shall apply to the Audit and Assurance Committee.
5.2	The Committee is authorised to obtain any external legal or other independent professional advice it considers necessary.
5.3	The Committee is authorised to establish sub-groups, to which it can delegate specific tasks or functions, whose activities it will monitor through the groups minutes or reports depending on the tasks or functions undertaken. The Committee will approve the terms or reference of the sub groups.
6	**Responsibilities**
6.1	<u>Governance, Risk Management and Internal Control</u> The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. In particular, the Committee will review the adequacy of: • all risk and control related disclosure statements (in particular the Annual Governance Statement and, the Annual Report and the Quality Report), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board • the underlying assurance processes, including the Board Assurance Framework, that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements • the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification • the effectiveness of the arrangements in place by which staff may, in confidence, raise concerns, particularly the Freedom to Speak Up procedures • the policies and procedures for all work related to fraud and corruption • the systems to secure value for money • information governance processes • the Trust's insurance arrangements • the operation of the Board's Committees to ensure that the Trust's governance responsibilities can be achieved The Committee will maintain responsibility for the oversight of risk management across the Trust, oversee all risk management processes, including review of the Board Assurance Framework, the overarching Corporate Risk Register and other risks as determined by the risk stratification matrix to ensure their effectiveness. In carrying out this work the Committee will utilise the work of Internal Audit, External Audit and

	other assurance functions, but will not be limited to these functions. It will also seek reports and assurances from other committees, directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This work should provide assurance that Board Committees adequately assure the Board that risks are appropriately managed
6.2	Internal Audit The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by: • consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal, • review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework • consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources • ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation • annual review of the effectiveness of internal audit, including independence and objectivity
6.3	External Audit The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by: • consideration of the performance of the External Auditor, including consideration of independence and objectivity • discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring coordination, as appropriate, with other External Auditors in the local health economy • reviewing all External Audit reports, including agreement of the annual audit letter and any work carried outside the annual audit plan, together with the appropriateness of management responses. • Reviewing the External Auditor's review of the Quality Report, prior to approval and submission of the Quality Report to NHS Improvement The Committee will assist the Council of Governors to discharge its duties in respect of the appointment of the External Auditors.
6.4	Financial Reporting The Committee shall review the Annual Report and Financial Statements before submission to NHSI, focusing particularly on: • the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee • changes in, and compliance with, accounting policies and practices • unadjusted mis-statements in the financial statements • major judgemental areas • significant adjustments resulting from the audit

	The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board. This will include: • recommending updates to the Trust's Standing Orders, Standing Financial Instructions, and Scheme of Delegation; monitoring compliance and approving any waivers • approving any schedules of losses and non HR special payments. • Review the schedule of debtor/creditor balances over 6 months old and over £5,000 or 2% of the aggregate amount, whichever is the greater.
6.5	Engagement Ensure effective on-going engagement and communication with all relevant internal and external stakeholders, including staff, service users, the public, Commissioners and other professional partners, as appropriate to the Committee's duties and remit.
7.	**Frequency and Review of Meetings**
7.1	The Committee will meet a minimum of five times per year
7.2	These Terms of Reference will be reviewed annually, with any change recommended to the Trust Board for approval following approval by the Audit & Risk Assurance Committee. This review will include a self-assessment of its effectiveness in discharging its responsibilities as set out.
8.	**Administration**
8.1	The Trust Secretary will ensure appropriate support is provided to the Committee.

Version Control

Version 1	6/11/19	Approved by Audit and Assurance Committee

QUALITY COMMITTEE

TERMS OF REFERENCE

Constitution

1. The Board hereby resolves to establish a committee of the Board to be known as the Quality Committee. The Committee has no executive powers other than those delegated by these terms of reference. The Chair and Deputy Chair of the Committee will be Non-executive Directors appointed by the Board.

Membership

2. Core Membership:

- 3 Non-Executive Directors
- Director of Nursing, Therapies & Quality
- Medical Director
- Chief Operating Officer

In attendance:

- Deputy Director of Nursing, Therapies and Quality
- Associate Director of Clinical Governance and Compliance
- Associate Director of Quality Assurance and Development
- Interim Deputy Medical Director – Patient Safety and Governance
- Head of Corporate Governance
- Board Committee Secretary
- Directors, clinicians and managers for specific agenda items as required
- Representative from Gloucestershire CCG
- Representative from Herefordshire CCG
- Observer from the Council of Governors
- Expert by Experience

Provided the Chair or Secretary is notified in advance, members of the Committee may nominate a suitably qualified substitute to attend the meeting in their absence

Quorum

3. Three members including one Non-executive and two Executive Directors. In exceptional circumstances, and with the prior agreement of the Chair, the meeting shall be deemed quorate with at least one Non-Executive member and one of the Executive Director members present, provided that a suitable substitute has been identified for the other Executive Director, in accordance with section 2 of these terms of reference.

Frequency of Meetings

4. The Committee will normally meet bi-monthly.

Authority

5. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the committee. The committee is authorised by the Board to obtain outside legal or other independent advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6. The committee may establish sub groups or working groups as required.

7. On behalf of the Board, the Committee is authorised to approve local policies, procedures, annual reports and plans that relate to its areas of responsibility.

Purpose

8. The purpose of the Quality Committee is to hold the Executive Directors to account for the establishment, maintenance and monitoring of appropriate integrated systems, processes and reporting arrangements for the management of all aspects of clinical governance and associated risk, and to provide onward assurance to the Board on all aspects of the Committee's work.

Duties of the Quality Committee

9. The duties of the Committee are as follows:

General

10. To provide leadership for an open, responsive and documented approach to clinical risk management and clinical governance which actively involves staff at all levels and, where appropriate, service users, carers and the public.

Patient Safety

11. To seek assurance that the Trust develops, monitors and maintains a Quality Strategy and annual plan that addresses safety, quality and the outcomes experienced by patients and carers and that fulfils and is consistent with the requirements of the CQC. This will include:

- Delivering a programme of clinical safety, effectiveness and quality improvement;
- Monitoring safeguarding partnership arrangements for both children and adults;
- Ensuring the professional regulation of staff and that clinical professional training supports the provision of safe services;
- Ensuring that Cost Improvement Plans are accompanied by a Quality Impact Assessment which has been appropriately completed.

Patient Experience

13. To seek assurance on the standards of care and services provided (and associated outcomes) giving particular attention to risk and the need to treat people equitably, with dignity and respect at all times and, taking into account individual needs, preferences and choices, as appropriate.

14. To seek assurance that feedback from service users, carers and the public about service provision and quality is properly evaluated and responded to.

Risk

15. To seek assurance that risk management is integrated into decision making at all levels and creates an environment for learning and continuous improvement. This will be achieved through;

- Monitoring of allocated corporate and strategic risks from the Trust's risk register, ensuring that potential risks at strategic and operational levels are systematically identified, assessed and, as far as is reasonably practicable, mitigated.
- Ensuring that responsibilities for the management of Health and Safety at Work and Fire Safety Regulations are effectively discharged.

Compliance and Regulation

16. To seek assurance that the Trust's services are delivered in accordance with regulatory and other requirements of the DoH, CQC, NHSI and NHS Resolution and that evidence of this is systematically generated, reviewed and catalogued. This will include;

- Thematic analysis of, and learning from, incidents, complaints and claims;
- Monitoring arrangements for the safe, efficient, ethical and lawful use of information;
- Ensuring that there are arrangements for ethical review and research governance which comply with national guidelines;

Effectiveness

17. Seek assurance regarding the development and implementation of the Trust clinical audit plan and the follow up of audit results ensuring that it is in line with the Trust's strategic objectives and supports the Board Assurance Framework.

18. To seek assurance from the Quality Assurance Group, and other sub-groups, regarding matters defined within their respective terms of reference.

Reporting

19. The minutes of Quality Committee meetings shall be formally recorded and a report of the meeting submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

20. The Committee will review its performance against its terms of reference and report the findings of its assessment to the Board at least once annually.

Other Matters

21. The Committee shall be supported administratively by the Head of Corporate Governance.

22. The Committee will agree an annual plan which will outline the business to be discussed at each meeting. This will include the content and frequency of reports from sub-groups.

Version Control

Version 1	16/10/19	Approved by Quality Committee

Charity number: 1096480

GLOUCESTERSHIRE CARE SERVICES NHS TRUST CHARITIES

TRUSTEES' REPORT AND FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 MARCH 2019

GLOUCESTERSHIRE CARE SERVICES NHS TRUST CHARITIES

CONTENTS

GLOUCESTERSHIRE CARE SERVICES NHS TRUST CHARITIES

REFERENCE AND ADMINISTRATIVE DETAILS OF THE CHARITY, ITS TRUSTEES AND ADVISERS FOR THE YEAR ENDED 31 MARCH 2019

Trustees

Gloucestershire Care Services NHS Trust is the sole corporate Trustee of Gloucestershire Care Services NHS Trust Charities.

Trust Board members during the period were:

Ingrid Barker, Chair
Paul Roberts, Chief Executive Officer
Susan Field, Director of Nursing
Mike Roberts, Medical Director (until 31st January 2019)
Richard Cryer, Non-Executive Director
Susan Mead, Non-Executive Director
Nicola Strother Smith, Non-Executive Director
Jan Marriott, Non-Executive Director
Graham Russell, Non-Executive Director
Sandra Betney, Director of Finance
Candace Plouffe, Chief Operating Officer
Nick Relph, Non-Executive Director
David Smith, Interim Director of Transition, Non-Voting (until 30th June 2018)
Amjad Uppal, Medical Director (from February 2019)
Neil Savage, Director of Human Resources / Organisational Development (from 1st July 2018)

Charity registered number

1096480

Principal office

Edward Jenner Court
Unit 1010 Pioneer Avenue
Gloucester Business Park
Brockworth
Gloucestershire
GL3 4AW

Independent auditor

KPMG LLP
Statutory Auditor
66 Queen Square
Bristol
BS1 4BE

Bankers

Royal Bank of Scotland Group plc
Redheughs Avenue
Edinburgh
Scotland
EH12 9JN

REFERENCE AND ADMINISTRATIVE DETAILS OF THE CHARITY, ITS TRUSTEES AND ADVISERS FOR THE YEAR ENDED 31 MARCH 2019

Advisers (continued)

Solicitors

Field Fisher LLP
Riverbank House
2 Swan Lane
London
United Kingdom
EC4R 3TT

Accountants

Randall & Payne LLP
Chargrove House
Main Road
Shurdington
Cheltenham
GL51 4GA

TRUSTEES' REPORT
FOR THE YEAR ENDED 31 MARCH 2019

The Trustees present their annual report together with the audited financial statements of the charity for the 1 April 2018 to 31 March 2019.

Structure, Governance and Management

Gloucestershire Care Services NHS Trust is the Corporate Trustee of Gloucestershire Care Services NHS Trust Charitable Fund.

Gloucestershire Care Services NHS Trust is the main beneficiary of the Charity and is a related party by virtue of being the Corporate Trustee. By working in partnership with the Trust the Charitable Funds are used to best effect. When deciding upon the best use of the Charitable Funds, the Corporate Trustee takes into consideration the main activities, objectives, strategies and plans of the proposed beneficiary.

Gloucestershire Care Services NHS Trust is due to be acquired by 2Gether NHS Foundation Trust on 30 September 2019. Whilst Gloucestershire Care Services NHS Trust will cease to operate on the conclusion of the transaction, the services currently provided by the Trust will continue within the new entity. This will not impact the charity status and the new entity will become the main beneficiary of the Charity.

The Charity's unrestricted fund was established using the model declaration of trust. The restricted funds were separately registered under the group Charity. All funds held at the date of registration either formed part of the unrestricted or restricted funds. Subsequent donations and gifts received by the Charity have been added to those fund balances within the existing charity.

The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objects of each fund and by designating funds; in this way the Trustee is able to respect the wishes of the donors, to benefit patient care and advance the good health and welfare of patients and staff. The charitable funds available to spend are held within the fund categories in note 10 of the accounts.

Non-Executive members of the Trust's Board of Directors are appointed by NHS Improvement. Executive members of the Board are subject to recruitment by the NHS Trust Board.

Members of the Trust Board and the Charitable Funds Committee are not individual Trustees but act as agents under charity law on behalf of the Corporate Trustee.

All Board members undertake an induction programme on appointment and are encouraged to participate in relevant training programmes as appropriate.

The Charitable Funds Committee is responsible for the overall management of the Charitable Funds. The Committee is required to:

a) Ensure that the Trust applies all charitable funds in accordance with NHS and Charities legislation, including current guidance issued by the Charity Commission.
b) Maintain oversight of the continued relevance and application of the organisation's Declaration of Trust.
c) Oversee the functions performed by the Trust's Director of Finance and the Chief Executive with regard to the investment, accounting and reporting on the use of charitable funds. .
d) Conduct the operational management of the Trust's charitable funds.
e) Provide quarterly updates and an annual report to the Trust Board in its capacity as Corporate Trustee, in respect of the management of the Trust's charitable funds.
f) Oversee the appointment of an investment advisor to provide professional advice on investment strategies, and approve individual purchases and sales of investment holdings.
g) Ensure that all investments are made in line with the Trust's guiding principles, namely that investments:
   • are low risk;
   • optimise medium-term return through a combination of capital growth and interest or dividend receipt

- avoid areas which may be considered inappropriate for a Healthcare organisation e.g. manufacturers of tobacco, alcohol and arms;
- are restricted to the explicit conditions or purpose of each donation, bequest or grant.

h) Routinely review the financial status of all individual funds, and monitor the overall performance of the charitable fund portfolio.
i) Proactively ensure that all funds are used for the purpose(s) intended by the donor, bequest or grant.
j) Receive the annual accounts of the Trust's charitable funds for consideration and recommendation to the Trust Board.
k) Ensure effective ongoing engagement with all relevant internal and external stakeholders, as appropriate to the Committee's duties and remit.

During the year ending 31 March 2019 the Charitable Funds Committee comprised:

- Nicola Strother Smith, Chair of the Committee and Non-Executive Director
- Sandra Betney, Director of Finance
- Susan Field, Director of Nursing
- Richard Cryer, Non-Executive Director
- David Smith, Interim Director of Transition (until 30th June 2018)
- Neil Savage, Director of Human Resources/Organisational Development (from 1st July 2018)

During the year a joint sub-committee has operated with Great Western Hospital NHS Foundation Trust Charitable Funds to manage the Brokenborough legacy reflecting the one third interest they hold in the legacy.

During the year ending 31 March 2019 the Brokenborough sub-committee comprised:

- Nicola Strother Smith, Chair of the Committee and Non-Executive Director
- Kevin McNamara, Director of Strategy, Great Western Hospital NHS Foundation Trust
- Jemima Milton, Non-Executive Director, Great Western Hospital NHS Foundation Trust
- Sandra Betney, Director of Finance
- David Smith, Interim Director of Transition (until 30th June 2018)
- Neil Savage, Director of Human Resources/Organisational Development (from 1st July 2018)

The accounting records and the day-to-day administration of the funds are dealt with by Randall & Payne, Chargrove House, Shurdington Road, Shurdington, Cheltenham, GL51 4GA supported by the Finance Department located at Edward Jenner Court, 1010 Pioneer Avenue, Gloucester Business Park, Gloucester, GL3 4AW.

The charity has no employees, however utilises the work of NHS staff, the Trust Board and also has committees to oversee operational matters.

Risk Management

The amount of funds held in respect of charitable funds is currently considered too small to support an investment portfolio. The Trustee does not consider there to be any major risks associated with the charitable funds due to the nature of the charitable activities undertaken. Funds spent during the year will be no more than the balance held.

No transaction can be approved without a signatory of either the Director of Human Resources or the Director of Finance. Plans to spend over £2,000 must be signed off by the Director of Nursing and then presented to the next Trustees' meeting for approval.

The Trust provides accounting facilities for the funds using an outsourced bookkeeping facility. The financial position of any fund can be known at any time, as each fund has a unique code which is debited or credited at the time of a transaction, through the cloud accounting package. Transactions are processed through the ledger system. Any balance owing to or from the fund is transferred between the Trust Fund Account and Gloucestershire Care Services NHS Trust's bank account during the financial year.

Reserves Policy

The Trustee has established a reserves policy as part of their plans to provide support to the services provided by Gloucestershire Care Services NHS Trust. The Trustee calculates the reserves as that part of the Charity's unrestricted income funds that is freely available, after taking account of designated funds.

The reserves currently stand at:

Total Unrestricted funds of	£42,000
Less designated funds	£40,000
Total reserves	£2,000

The charity aims to expend all funds within two years of receipt, except where funds are being saved for a specific purpose. The charity foresees a need to only maintain reserves sufficient to provide certainty of funding to cover the support costs for example administrative and governance costs of the Charity in the short term. The total amount of spend for support costs in 2018/19 is £14k which means the reserves are currently below the expected level. The intention of the charity is to increase the reserves towards the target level during 2019.

Objectives and Activities

The core vision of the charity is to enhance the care and treatment of service users accessing NHS services within Gloucestershire Care Services NHS Trust, by raising funds to support high priority areas which are beyond the scope of government funding.

The core activities of the charity are for the benefit of the patients of Gloucestershire and the staff employed by Gloucestershire Care Services NHS Trust.

To achieve its vision and objects the charity is working to:

- Develop key messages to better connect with the communities served in Gloucestershire to increase awareness of the charity and the ways in which donors can support the Trust.
- Provide support, guidance and encouragement for colleagues to access funds for projects that align to the vision of the charity.
- Deliver practical improvements to the service user environment.
- Encourage new and existing supporters to engage with the charity using a range of media including email, the post, website and telephone.

The charity will achieve these plans by:

- Generating income through a variety of means;
- Supporting Trust colleagues development to enable them to provide excellent clinical and service user centric care;
- Improving the quality of service user care and experience;
- Effectively managing charitable funds available;
- Improving environments for service users, carers and the Trust colleagues;
- Approving grants which will make a real difference, particularly in respect of support for specialist clinical study and/or research that has the potential to impact on the treatment and well-being of service users and carers.

This Fund focuses on the following areas of activity:

- Nightingale - to support nurses and allied health professionals to deliver the very best care
- Awards4All – General Support
- Environmental – supports the creation of quiet spaces and calmer environmentally friendly areas to help
- Helping Hands – support for patients and service users in times of need e.g. provision of food or clothing for vulnerable adults or children

The Charity has adopted “Caring for Gloucestershire" as a trading name.

Achievements and performance

The charity is proud to support people from across the county at their time of need, crisis or illness, and is able to provide this help as a result of the generous donations and legacies of local people, organisations and the wider community, and also through the inspirational fundraising activities of NHS colleagues and other organisations and individuals.

Over the years many individuals have benefited from the kindness of others.

Examples of some of the good causes the charity has sponsored this year include:

- Specialist Equipment
- Christmas related activities for patients and staff
- Volunteer Support

The Trust works actively with the local League of Friends within its area and formally records its gratitude for their support.

The consolidation of funds has created greater understanding of the range of the charity’s remit and the charity plans to reinforce links with each locality in which it operates.

Key Performance Indicators

Key performance indicators are not currently used due to the limited activity within the charity.

Use of Volunteers

Support is provided by volunteers, however this is minimal due to the current limited activity of the charity.

Future Plans

During 2018/19 Gloucestershire Care Services NHS Trust announced and started to take forward plans for a merger with 2gether NHS Foundation Trust. At this stage the Charity is planned to continue as a separate charity. Going forward into 2019/20 the Charity has plans to consider its operation in the light of the merger. Work to further develop the Brokenborough investment land legacy will also be taken forward.

After making appropriate enquiries, the trustees have a reasonable expectation that the charity has adequate resources to continue in operational existence for the foreseeable future. For this reason they continue to adopt the going concern basis in preparing the financial statements. Further details regarding the adoption of the going concern basis can be found in the Accounting Policies.

Financial Review

The net assets of the charitable fund as at 31 March 2019 were £195,000 (2018: £196,000). Overall net assets have decreased by 0.5 percent in the year. In this financial year legacy income was £10,000 and donations decreased by 31 percent. Overall expenditure of £31,000 was 6 percent lower than last year. In this financial year £7,000 (2018 £10,000) was spent on patient and staff welfare activities.

The income for the year was £30,000 (2018: £54,000), the reduction in income during the year is due to one-off donations classified as other income in the prior year financial statements that have not been received in the current year, the income is as follows:

- Legacies of £10,000 (2018: £0)
- Donations of £20,000 (2018: £54,000)

Expenditure for the year totalled £31,000 (2018: £32,000), the expenditure is as follows:

- Expenditure on charitable activities of £31,000 (2018: £32,000).

Service users and Gloucestershire Care Services NHS Trust colleagues have benefited greatly from the generosity of family, friends, colleagues and the wider community who have made donations to the charitable fund. Further information about the particular funds can be obtained in the first instance from the charity website http://www.caringforglos.org.uk/.

Statement of Trustees' responsibilities in respect of the Trustees' Annual Report and the Financial Statements

Under the trust deed of the charity and charity law, the Trustees are responsible for preparing the Trustees' report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice). The Trustee has elected to prepare the financial statements in accordance with FRS 102, the Financial Reporting Standard applicable in the UK and Republic of Ireland.

The law applicable to charities in England & Wales requires the Trustee to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources of the charity for that period. In preparing these financial statements, the Trustee is required to:

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charities SORP;
- make judgments and accounting estimates that are reasonable and prudent;
- state whether applicable UK Accounting Standards have been followed, subject to any material departures disclosed and explained in the financial statements;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in operation.
- states whether the financial statements comply with the Trust Deed and rules, subject to any material departures disclosed and explained in the financial statements

TRUSTEES' REPORT (continued)
FOR THE YEAR ENDED 31 MARCH 2019

The Trustee is required to act in accordance with the Trust Deed and the rules of the Charity, within the framework of trust law. The Trustee is responsible for keeping proper accounting records that are sufficient to show and explain the charity's transactions and disclose with reasonable accuracy at any time the financial position of the charity and enable them to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the trust deed. They are also responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

This report was approved by the Trustees, on and signed on their behalf by:

Nicola Strother Smith
Trustee

INDEPENDENT AUDITOR'S REPORT TO THE TRUSTEES OF GLOUCESTERSHIRE CARE SERVICES NHS TRUST CHARITIES

Opinion

We have audited the financial statements of Gloucestershire Care Services NHS Trust Charities ("the charity") for the year ended 31 March 2019 which comprise the statement of financial activities, balance sheet and related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the charity's affairs as at 31 March 2019 and of its incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with UK accounting standards, including FRS 102 *The Financial Reporting Standard applicable in the UK and Republic of Ireland*; and
- have been prepared in accordance with the requirements of the Charities Act 2011.

Basis for opinion

We have been appointed as auditor under section 145 of the Charities Act 2011 (or its predecessors) and report in accordance with regulations made under section 154 of that Act.

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the charity in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

The impact of uncertainties due to the UK exiting the European Union on our audit

Uncertainties related to the effects of Brexit are relevant to understanding our audit of the financial statements. All audits assess and challenge the reasonableness of estimates made by the directors, related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All of these depend on assessments of the future economic environment and the charity's future prospects and performance.

Brexit is one of the most significant economic events for the UK, and at the date of this report its effects are subject to unprecedented levels of uncertainty of outcomes, with the full range of possible effects unknown. We applied a standardised firm-wide approach in response to that uncertainty when assessing the charity's future prospects and performance. However, no audit should be expected to predict the unknowable factors or all possible future implications for a charity and this is particularly the case in relation to Brexit.

Going concern

The trustees have prepared the financial statements on the going concern basis as they do not intend to liquidate the charity or to cease its operations, and as they have concluded that the charity's financial position means that this is realistic. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

INDEPENDENT AUDITOR'S REPORT TO THE TRUSTEES OF GLOUCESTERSHIRE CARE SERVICES NHS TRUST CHARITIES

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least a year from the date of approval of the financial statements. In our evaluation of the trustees' conclusions, we considered the inherent risks to the charity's business model, including the impact of Brexit, and analysed how those risks might affect the charity's financial resources or ability to continue operations over the going concern period. We have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the charity will continue in operation.

Other information

The trustees are responsible for the other information, which comprises the Trustees' Annual Report. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. We are required to report to you if:

- based solely on that work, we have identified material misstatements in the other information; or
- in our opinion, the information given in the Trustees' Annual Report is inconsistent in any material respect with the financial statements.

We have nothing to report in this regard.

Matters on which we are required to report by exception

Under the Charities Act 2011 we are required to report to you if, in our opinion:

- the charity has not kept sufficient accounting records ; or
- the financial statements are not in agreement with the accounting records; or
- we have not received all the information and explanations we require for our audit.

We have nothing to reports in these respects.

Trustees' responsibilities

As explained more fully in their statement set out on page 7, the trustees are responsible for: the preparation of financial statements which give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

INDEPENDENT AUDITOR'S REPORT TO THE TRUSTEES OF GLOUCESTERSHIRE CARE SERVICES NHS TRUST CHARITIES

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at:
www.frc.org.uk/auditorsresponsibilities.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the charity's trustees as a body, in accordance with section 145 of the Charities Act 2011 (or its predecessors) and regulations made under section 154 of that Act. Our audit work has been undertaken so that we might state to the charity's trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and its trustees as a body, for our audit work, for this report, or for the opinions we have formed.

Rees Batley
for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants

66 Queen Square
Bristol
BS1 4BE
Date:

KPMG LLP is eligible to act as an auditor in terms of section 1212 of the Companies Act 2006

GLOUCESTERSHIRE CARE SERVICES NHS TRUST CHARITIES

STATEMENT OF FINANCIAL ACTIVITIES
FOR THE YEAR ENDED 31 MARCH 2019

	Note	Unrestricted funds 2019 £000	Restricted funds 2019 £000	Total funds 2019 £000	*Total funds 2018 £000*
Income from:					
Donations and legacies	2	**27**	**3**	**30**	*29*
Charitable activities	3	**-**	**-**	**-**	*25*
Total income		**27**	**3**	**30**	*54*
Expenditure on:					
Charitable activities		**(27)**	**(4)**	**(31)**	*(32)*
Total expenditure	4	**(27)**	**(3)**	**(31)**	*(32)*
Net income / expenditure before other recognised gains and losses		**-**	**(1)**	**(1)**	*22*
Net movement in funds		**-**	**(1)**	**(1)**	*22*
Reconciliation of funds:					
Total funds brought forward		**42**	**154**	**196**	*174*
Total funds carried forward		**42**	**153**	**195**	*196*

BALANCE SHEET
AS AT 31 MARCH 2019

	Note	£000	2019 £000	*£000*	*2018 £000*
Fixed assets					
Investment property	7		**150**		*150*
Current assets					
Debtors	8	**9**		*6*	
Cash at bank and in hand		**47**		*58*	
		56		*64*	
Creditors: amounts falling due within one year	9	**(11)**		*(18)*	
Net current assets			**45**		*46*
Net assets			**195**		*196*
Charity Funds					
Restricted funds	10		**153**		*154*
Unrestricted funds	10		**42**		*42*
Total funds			**195**		*196*

The financial statements were approved by the Trustees on and signed on their behalf, by:

Sandra Betney, Director of Finance

The notes on pages 14 to 21 form part of these financial statements.

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2019

1. Accounting policies

1.1 Basis of preparation of financial statements

The financial statements have been prepared to give a 'true and fair' view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a 'true and fair' view. This departure has involved following the Charities SORP (FRS 102) published on 16 July 2014 rather than the Accounting and Reporting by Charities: Statement of Recommended Practice effective from 1 April 2005 which has since been withdrawn.

The financial statements have been prepared under the historical cost convention with items recognised at cost or transaction value unless otherwise stated in the relevant notes to these accounts. The financial statements have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and Charities Act 2011.

The Charity constitutes a public benefit entity as defined by FRS 102, and as a small charity is exempt from the requirement to prepare a cashflow statement.

The Charity has adequate resources to continue in operational existence for the foreseeable future. For this reason, the Trustee considers it appropriate to adopt the going concern basis in preparing the accounts.

Gloucestershire Care Services NHS Trust is due to be acquired by 2Gether NHS Foundation Trust on 30 September 2019. Whilst Gloucestershire Care Services NHS Trust will cease to operate on the conclusion of the transaction, the services currently provided by the Trust will continue within the new entity. This will not impact the charity status and the new entity will become the main beneficiary of the Charity.

1.2 Income

All income is recognised once the charity has entitlement to the income, it is probable that the income will be received and the amount of income receivable can be measured reliably.

For legacies, entitlement is taken as the earlier of the date on which either: the charity is aware that probate has been granted, the estate has been finalised and notification has been made by the executor(s) to the Trust that a distribution will be made, or when a distribution is received from the estate. Receipt of a legacy, in whole or in part, is only considered probable when the amount can be measured reliably and the charity has been notified of the executor's intention to make a distribution. Where legacies have been notified to the charity, or the charity is aware of the granting of probate, and the criteria for income recognition have not been met, then the legacy is treated as a contingent asset and disclosed if material.

1. Accounting policies (continued)

1.3 Expenditure

Expenditure is recognised once there is a legal or constructive obligation to transfer economic benefit to a third party, it is probable that a transfer of economic benefits will be required in settlement and the amount of the obligation can be measured reliably. Expenditure is classified by activity. The costs of each activity are made up of the total of direct costs and shared costs, including support costs involved in undertaking each activity. Direct costs attributable to a single activity are allocated directly to that activity. Shared costs which contribute to more than one activity and support costs which are not attributable to a single activity are apportioned between those activities on a basis consistent with the use of resources. Central staff costs are allocated on the basis of time spent, and depreciation charges allocated on the portion of the asset's use.

Charitable activities and Governance costs are costs incurred on the charity's educational operations, including support costs and costs relating to the governance of the charity apportioned to charitable activities.

1.4 Interest receivable

Interest on funds held on deposit is included when receivable and the amount can be measured reliably by the charity; this is normally upon notification of the interest paid or payable by the Bank.

1.5 Debtors

Trade and other debtors are recognised at the settlement amount after any trade discount offered. Prepayments are valued at the amount prepaid net of any trade discounts due.

1.6 Cash at Bank and in hand

Cash at bank and in hand includes cash and short term highly liquid investments with a short maturity of three months or less from the date of acquisition or opening of the deposit or similar account.

1.7 Liabilities and provisions

Liabilities are recognised when there is an obligation at the Balance sheet date as a result of a past event, it is probable that a transfer of economic benefit will be required in settlement, and the amount of the settlement can be estimated reliably. Liabilities are recognised at the amount that the charity anticipates it will pay to settle the debt or the amount it has received as advanced payments for the goods or services it must provide. Provisions are measured at the best estimate of the amounts required to settle the obligation. Where the effect of the time value of money is material, the provision is based on the present value of those amounts, discounted at the pre-tax discount rate that reflects the risks specific to the liability. The unwinding of the discount is recognised within interest payable and similar charges.

1.8 Financial instruments

The charity only has financial assets and financial liabilities of a kind that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at their settlement value with the exception of bank loans which are subsequently measured at amortised cost using the effective interest method.

1. Accounting policies (continued)

1.9 Fund accounting

General funds are unrestricted funds which are available for use at the discretion of the Trustees in furtherance of the general objectives of the charity and which have not been designated for other purposes.

Restricted funds are funds which are to be used in accordance with specific restrictions imposed by donors or which have been raised by the charity for particular purposes. The costs of raising and administering such funds are charged against the specific fund.

1.10 Tax position

Gloucestershire Care Services NHS Trust Charitable Fund is considered to pass the tests set out in Paragraph 1 Schedule 6 Finance Act 2010 and therefore it meets the definition of a charitable trust for UK income tax purposes. Accordingly, the charity is potentially exempt from taxation in respect of income or capital gains received within categories covered by Part 10 Income Tax Act 2007 or Section 256 of the Taxation of Chargeable Gains Act 1992, to the extent that such income or gains are applied exclusively to charitable purposes.

1.11 Fixed asset investments

Investment land is valued at fair value at the year end.

1.12 Irrecoverable VAT

Irrecoverable VAT is charged against the category of Expenditure for which it was incurred.

2. Income from donations and legacies

	Unrestricted funds 2019 £000	**Restricted funds 2019 £000**	**Total funds 2019 £000**	*Total funds 2018 £000*
Donations	**17**	**3**	**20**	*29*
Legacies	**10**	**-**	**10**	*-*
Total donations and legacies	**27**	**3**	**30**	*29*
Total 2018	*29*	*-*	*29*	

3. Income from charitable activities

	Unrestricted funds 2019 £000	Restricted funds 2019 £000	Total funds 2019 £000	*Total funds 2018 £000*
Donations and gifts	-	-	-	*25*
Total 2018	*5*	*20*	*25*	

4. Analysis of expenditure by expenditure type

	Donations and gifts £000	Total 2019 £000	*Total 2018 £000*
Direct costs			
Medical & surgical equipment	**4**	**4**	*2*
Patients welfare & amenities	**5**	**5**	*9*
Staff welfare & amenities	**2**	**2**	*1*
Research/publications	**-**	**-**	*1*
Furniture & fittings	**5**	**5**	*2*
Grounds & gardens	**1**	**1**	*-*
Total direct costs	**17**	**17**	*15*
Support costs			
Other support costs	**14**	**14**	*17*
Total expenditure	**31**	**31**	*32*
Total 2018	*32*	*32*	

During the year ended 31 March 2019, the charity incurred the following Governance costs:
£3,600 *(2018 - £4,000)* included within the table above in respect of Donations and gifts.

5. Net income/(expenditure)

During the year, no Trustees received any remuneration (2018 - £NIL).
During the year, no Trustees received any benefits in kind (2018 - £NIL).
During the year, no Trustees received reimbursement of expenses totalling (2018 - £NIL).

Recharge staff costs

	2019 £000	*2018 £000*
Gross salaries	**1**	*-*

The analysis above represents amounts charged to the Charity for staff employed by the NHS Trust. All staff are on standard NHS terms and conditions and are contracted to work with the NHS Trust.
(included within the table above in respect of donations and gifts)

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2019

6. Auditors' remuneration

The Auditor's remuneration amounts to an Audit fee of £3,600 (2018 - £3,600) and related solely to the Audits in both financial years, no other work was undertaken.
(included within the table above in respect of donations and gifts)

7. Investment property

	Freehold investment property £000
Valuation	
At 1 April 2018 and 31 March 2019	**150**

The only investment asset included in the accounts is for land at Brokenborough which is valued at the level that it was transferred from NHS Gloucestershire Primary Care Trust in March 2013 and is not depreciated. On 9th July 2015 an agreement was made between Gloucestershire Care Services (GCS) NHS Trust and Great Western Hospitals NHS Foundation Trust (GWH), recognising GWH's one third interest in the land whilst acknowledging that legal ownership remains vested in GCS NHS Charities Brokenborough Fund.

8. Debtors

	2019 £000	*2018 £000*
Trade debtors	**9**	*2*
Prepayments and accrued income	**-**	*4*
	9	*6*

9. Creditors: Amounts falling due within one year

	2019 £000	*2018 £000*
Trade creditors	**1**	*2*
Accruals and deferred income	**10**	*16*
	11	*18*

10. Statement of funds

Statement of funds - current year

	Balance at 1 April 2018 £000	Income £000	Expenditure £000	Transfers in/out £000	Balance at 31 March 2019 £000
Unrestricted funds					
Nightingale fund	**22**	**9**	**(9)**	**(1)**	**21**
Environment fund	**10**	**1**	**(2)**	**-**	**9**
Helping Hands fund	**-**	**-**	**(1)**	**1**	**-**
Awards for All	**10**	**7**	**(15)**	**-**	**2**
Awards for All – Stroud General Hospital	**-**	**10**	**-**	**-**	**10**
	42	**27**	**(27)**	**-**	**42**
Restricted funds					
Brokenborough fund	**143**	**-**	**-**	**-**	**143**
J Page fund	**2**	**-**	**-**	**-**	**2**
Big Lottery	**9**	**-**	**(4)**	**-**	**5**
Groundwork	**-**	**3**	**-**	**-**	**3**
	154	**3**	**(4)**	**-**	**153**
Total of funds	***196***	***30***	***(31)***	***-***	***195***

Statement of funds - prior year

	Balance at 1 April 2017 £000	*Income £000*	*Expenditure £000*	*Transfers in/out £000*	*Balance at 31 March 2018 £000*
General funds					
Nightingale fund	16	9	(3)	-	21
Environment fund	2	11	-	(3)	9
Helping Hands fund	2	-	(5)	3	-
League of Friends	-	5	(5)	-	2
Awards for All	19	9	(18)	-	10
	39	34	(31)	-	42

10. Statement of funds (continued)

Restricted funds

Brokenborough fund	133	10	-	-	143
J Page fund	2	-	-	-	2
Big Lottery	-	10	(1)	-	9
	135	20	(1)	-	154
Total of funds	***174***	***54***	***(32)***	***-***	***196***

Summary of funds - current year

	Balance at 1 April 2018 £000	Income £000	Expenditure £000	Balance at 31 March 2019 £000
General funds	**42**	**27**	**(27)**	**42**
Restricted funds	**154**	**3**	**(4)**	**153**
	196	**30**	**(31)**	**195**

Summary of funds - prior year

	Balance at 1 April 2017 £000	*Income £000*	*Expenditure £000*	
General funds	*39*	*34*	*(31)*	*42*
Restricted funds	*135*	*20*	*(1)*	*154*
	174	*54*	*(32)*	*196*

11. Analysis of net assets between funds

Analysis of net assets between funds - current year

	Unrestricted funds 2019 £000	Restricted funds 2019 £000	Total funds 2019 £000
Investment property	**-**	**150**	**150**
Current assets	**39**	**7**	**56**
Creditors due within one year	**(7)**	**(4)**	**(11)**
Difference	**10**	**-**	-
Total	**42**	**153**	**195**

11. Analysis of net assets between funds (continued)

Analysis of net assets between funds - prior year

	Unrestricted funds 2018 £000	*Restricted funds 2018 £000*	*Total funds 2018 £000*
Investment property	-	150	150
Current assets	60	4	64
Creditors due within one year	(18)	-	(18)
Total	*42*	*154*	*196*

12. Related party transactions

During the year none of the members of the NHS Bodies Boards of Directors or key management staff or person(s) related to them have undertaken any transactions with or been beneficiaries of the Charity. Neither the Corporate Trustee nor any members of the NHS Bodies have received honoraria, emoluments or expenses, and have not purchased Trustee indemnity insurance.

The Trust has recharged the cost of staff time incurred to the Charity of £750 (2018: £0). At the year end there was an amount outstanding of £750. No members of the Trust's Board of Directors have received honoraria, emoluments or expenses from the Charity during the year.

The ultimate controlling party of the Charity is Gloucestershire Care Services NHS Trust. Copies of the Trust's 2018/19 Annual Report and Financial Statements are available on the Trust's website https://www.glos-care.nhs.uk/

GLOUCESTERSHIRE HEALTH AND CARE
NHS FOUNDATION TRUST

STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

November 2019

Section **CONTENTS** *Page*

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS

1.1 Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders on which s/he should be advised by the Chief Executive and Trust Secretary.

1.2 Any expression to which a meaning is given in the National Health Service Act 2006, as amended, or in the Constitution of the Trust shall have the same meaning in these Standing Orders and in addition:

1.2.1 **"Accounting Officer"** means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

1.2.2 **"Trust"** means the Gloucestershire Health and Care NHS Foundation Trust.

1.2.3 **"Board"** means the Trust Board as established pursuant to the Constitution collectively as a body.

1.2.4 **"Budget"** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

1.2.5 **"Budget holder"** means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

1.2.6 **"Chair"** is the person appointed by Council of Governors to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

1.2.7 **"Chief Executive"** means the chief officer of the Trust.

1.2.8 **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

1.2.9 **"Committee"** means a committee or sub-committee created and appointed by the Trust.

1.2.10 **"Committee Members"** means persons formally appointed by the Board to sit on or to chair specific committees.

1.2.11 **"Contracting and procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services,

building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

1.2.12 **"Director of Finance"** means the Chief Financial Officer of the Trust.

1.2.13 **"Funds held on trust"** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under the 2006 Act. Such funds may or may not be charitable.

1.2.14 "**Director"** means executive or non-executive director of the Board as the context permits. For the avoidance of doubt, the Chair is a non-executive director

1.2.16 "**Constitution**" means the constitution of the Trust as approved by Monitor (or any successor body) and annexed to the Authorisation

1.2.17 **"Nominated officer"** means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

1.2.18 **"Non-executive director"** means a director of the Trust Board who is not an officer of the Trust and is appointed by the Council of Governors in accordance with the Constitution.

1.2.19 **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

1.2.20 **"Executive Director**" means a director who is an officer of the Trust.

1.2.21 **"Trust Secretary"** means a person appointed to provide advice on corporate governance issues to the Board and the Chairman and monitor the Trust's compliance with the law, Standing Orders, and Department of Health/NHS Improvement guidance.

1.2.22 **"SFIs"** means Standing Financial Instructions.

1.2.23 **"SOs"** means Standing Orders.

1.2.24 **"Deputy Chair"** means the non-executive director appointed by the Council of Governors to take on the Chair's duties if the Chair is absent for any reason.

1.2.25 "**NHS Improvement**" is the organisation succeeding the body corporate known as Monitor, as provided by section 61 of the 2012 Act.

1.2.26 "**The 2006 Act**" means the National Health Service Act 2006

1.2.27 "**The 2012 Act"** means the Health and Social Care Act 2012

1.2.27 "**Council of Governors**" means the council established as the Board of Governors pursuant to the constitution and the 2006 Act

2. THE TRUST BOARD: COMPOSITION, TENURE AND ROLE OF DIRECTORS

2.1 Terms of office of the Chair and non-executive directors

The arrangements for tenure of office of the Chair and non-executive directors and for the termination of the Chair's and non-executive directors' terms of office are contained in the constitution.

2.2 Appointment and powers of Deputy Chair

In accordance with the constitution, the Council of Governors shall appoint one of the directors who is not also an executive director, to be Deputy Chair, for such period, not exceeding the remainder of his/her term as a non-executive director of the Trust, as they may specify on appointing him/her.

2.3 Where the Chair has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Deputy Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes his/her duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Deputy Chair.

2.4 Joint Directors

Where more than one person is appointed jointly as an executive director those persons shall, in terms of the composition of the Board as defined by the constitution, count as one person.

2.5 Where the office of director is shared jointly by more than one person:

(a) either or both of those persons may attend or take part in meetings of the Board;

(b) if both are present at a meeting they should cast one vote if they agree;

(c) in the case of disagreements no vote should be cast;

(d) the presence of either or both of those persons should count as the presence of one person for the purposes of determining whether a meeting of the Board is quorate.

2.6 **Roles of Board members**

The Board will function as the corporate decision-making body of the Trust; executive and non-executive directors will be full and equal directors. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

Executive directors

2.7 Executive directors shall exercise their authority within the terms of the constitution, these Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

Chief Executive

2.8 The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the **Accounting Officer** for the Trust and shall be responsible for ensuring the discharge of financial obligations in line with the requirements of the NHS Foundation Trust Accounting Officer Memorandum for Foundation Trust Chief Executives.

Director of Finance

2.9 The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its Board of Directors and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of financial obligations.

Non-executive directors

2.10 The non-executive directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as directors of the Trust or when chairing a committee of the Trust which has delegated powers.

Chair

2.11 The Chair shall be responsible for the operation of the Board and shall chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment

and with relevant provisions contained in the constitution and these Standing Orders.

2.12 The Chair shall liaise with the Trust's Nominations and Remuneration Committee appointed by the Council of Governors over the appointment of new non-executive directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

2.13 The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

Trust Secretary

2.14 The Trust Secretary will provide advice to the Board and the directors on corporate governance issues and will monitor the Trust's compliance with the law, the constitution, Standing Orders, and guidance on governance issued by NHS Improvement or other relevant regulatory/governmental body.

2.15 **Corporate role of the Board**

All business shall be conducted in the name of the Trust.

2.16 All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.17 The powers of the Trust established under statute shall be exercised by the Board meeting in formal session

2.18 The Board shall define and regularly review the functions it exercises.

2.19 **Schedule of matters reserved to the Board and Scheme of Delegation**

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the Scheme of Delegation.

3. MEETINGS OF THE BOARD OF DIRECTORS

3.1 **Calling meetings**

Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine. Meetings of the Board may be held in public or in private at the discretion of the Board.

3.2 The Chair may call a meeting of the Board at any time.

3.3 One third or more members of the Board may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the directors signing the requisition may forthwith call a meeting.

3.4 **Notice of meetings and the business to be transacted**

Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be despatched to every director, or to the usual place of residence of each director, so as to be available to directors at least 5 clear days before the meeting. The notice shall be issued by the Chair or by an officer authorised by the Chair to issue it on their behalf. Want of service of such a notice on any director shall not affect the validity of a meeting. The agenda shall normally constitute notice of a meeting.

3.5 In the case of a meeting called by directors in default of the Chair calling the meeting, the notice shall be issued by those directors.

3.6 No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under relevant provisions in these Standing Orders.

3.7 A director desiring a matter to be included on an agenda shall make his/her request in writing to the Chair or the Trust Secretary at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chair.

3.8 Before each public meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website at least three clear days before the meeting.

3.9 **Agenda and supporting papers**

The agenda specifying the business proposed to be transacted will be sent to directors 5 clear days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, save in emergency and with the agreement of the Chair.

3.10 **Petitions**

Where a petition has been received by the Trust the Chair shall include the petition as an item for the agenda of the next meeting.

3.11 **Notice of Motion**

Subject to the provision of Standing Orders relating to 'Motions: Procedure at and during a meeting' and 'Motions to rescind a resolution', a director of the Board wishing to move a motion shall send a written notice to the Trust Secretary who will ensure that it is brought to the immediate attention of the Chair.

3.12 The notice shall be delivered at least 10 clear days before the meeting. The Trust Secretary shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.13 **Emergency Motions**

Subject to the agreement of the Chair, and subject also to the provision of Standing Orders relating to 'Motions: Procedure at and during a meeting', a director of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

3.14 **Motions: Procedure at and during a meeting**

A motion may be proposed by the Chair of the meeting or any director present. It must also be seconded by another director.

Contents of motions

3.15 The Chair may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Trust Board;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

Amendments to motions

3.16 A motion for amendment shall not be discussed unless it has been proposed and seconded.

3.17 Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board.

3.18 If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

Rights of reply to motions

3.19 The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

3.20 The director who proposed the substantive/original motion shall have a right of reply at the close of any debate on the motion.

Withdrawing a motion

3.21 A motion, or an amendment to a motion, may be withdrawn.

Motions once under debate

3.22 When a motion is under debate, no motion may be moved other than:

a) an amendment to the motion, or;

b) the adjournment of the discussion, or the meeting, or;

c) that the meeting proceed to the next business, or;

d) that the question should be now put, or;

e) the appointment of an 'ad hoc' committee to deal with a specific item of business, or;

f) that a director be not further heard, or;

g) a motion resolving to exclude the public, including the press

3.23 In those cases where the motion is either that the meeting proceeds to the ‘next business’ or ‘that the question be now put’ in the interests of objectivity these should only be put forward by a director who has not taken part in the debate and who is eligible to vote.

3.24 If a motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.25 **Motion to Rescind a Resolution**

Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the director who gives it and also the signature of three other directors, and before considering any such motion of which notice shall have been given, the Trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

3.26 When any such motion has been dealt with by the Trust Board it shall not be competent for any director other than the Chair to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.27 **Chair of meeting**

At any meeting of the Trust Board the Chair if present, shall preside. If the Chair is absent from the meeting, the Deputy Chair (if the Board has appointed one), if present, shall preside.

3.28 If the Chair and Deputy Chair are absent, such director (who is not also an executive director of the Trust) as the directors present shall choose shall preside.

3.29 **Chair's ruling**

The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.30 **Quorum**

No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and directors (including at least one executive director of the Trust and one non-executive director) is present.

3.31 An officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

3.32 If the Chair or director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be

recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.33 **Voting**

Save as provided in Standing Orders relating to 'Suspension of Standing Orders' and ' Variation and Amendment of Standing Orders', every question put to a vote at a meeting shall be determined by a majority of the votes of directors present and voting on the question. In the case of an equal vote, the person presiding (i.e. the Chair of the meeting) shall have a second or casting vote.

3.34 At the discretion of the Chair all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

3.35 If at least one third of the directors present so request, the voting on any question may be recorded so as to show how each director present voted or did not vote (except when conducted by paper ballot).

3.36 If a director so requests, their vote shall be recorded by name.

3.37 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

3.38 A manager who has been formally appointed to act up for an executive director during a period of incapacity or temporarily to fill an executive director vacancy shall be entitled to exercise the voting rights of the executive director.

3.39 A manager attending the Trust Board meeting to represent an executive director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive director. An officer's status when attending a meeting shall be recorded in the minutes.

3.40 For the voting rules relating to joint directors see Standing Order 3.7.

3.41 **Suspension of Standing Orders**

Except where this would contravene any statutory provision or the Standing Orders relating to the quorum, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board are present (including at least one executive director of the Trust and one non-executive director) and that at least two-thirds of those directors present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

3.42 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and directors of the Trust.

3.43 No formal business may be transacted while Standing Orders are suspended.

3.44 The Audit Committee shall review every decision to suspend Standing Orders.

3.45 **Variation and amendment of Standing Orders**

These Standing Orders do not form part of the nstitution of the Trust. Anamendments to Standing Orders shall not constitute a variation of the terms of the constitution.

3.46 **Record of Attendance**

The names of the Chair and directors present at the meeting shall be recorded.

3.47 **Minutes**

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

3.48 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate.

3.49 **Admission of public and the press**

Subject to the Chair's decision as to whether a particular meeting should be open to the public, members of the public (including members of the Trust) and representatives of the press may attend all meetings of the Board of Directors except where the Board resolves that the public (including members of the Trust) and representatives of the press be excluded from all or part of a meeting on the following grounds:

a) that any publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, or;

b) for other reasons stated in the resolution and arising from the nature of the business or the proceedings that the Board of Directors believes are special reasons for excluding the public and representatives of the press from the meeting in accordance with the constitution, or;

c) to enable the business of the meeting to be conducted without interruption or disruption

3.50 Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public shall be confidential to the directors of the Board.

3.51 Directors and officers or any employee of the Trust in attendance shall not reveal or disclose the contents of confidential papers or minutes relating to confidential papers outside of the Board of Directors meeting, without the express permission of the Chair. This prohibition shall apply equally to the content of any discussion during the Board of Directors meeting which may take place on such reports or papers.

3.52 The right of attendance referred to above carries no right to ask questions or otherwise participate in the meeting.

3.53 Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Board of Directors. Such permission shall be granted only upon resolution of the Board of Directors.

3.54 **Observers at Trust Board meetings**

The Board will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

3.55 **Questions from the Public**

At each ordinary meeting of the Trust Board held in public there shall be up to 30 minutes set aside for written and oral questions from the public.

3.56 An oral question under this procedural standing order may be asked with the consent of the Chair and within the 30 minutes set aside for written and oral questions under this provision.

Written question for the Board Meeting

3.57 People who live or work in the areas where the Trust delivers services or are affected by the work of the Trust may direct a written question to:

- the Chair of the Trust Board;
- the Chief Executive of the Trust;
- a director of the Trust with responsibility; or

- a chair of any other Trust Board committee, whose remit covers the subject matter in question;

on any matter that is within the powers and duties of the Trust.

Notice of questions

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

Response

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

3.60 A copy of all written questions and written answers circulated at the meeting will be attached to the signed copy of the minutes of the meeting.

Additional Questions or Oral Questions without Notice

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

3.62 An answer to an oral question will take the form of either:

a) a direct oral answer; or

b) if the information required is not easily available, a written answer which will be sent to the questioner and circulated to all directors of the Trust Board.

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

Chair's Discretion not to respond to questions

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

a) are not on any matter that is within the powers and duties of the Trust, or;

b) are defamatory, frivolous or offensive, or;

c) are substantially the same as a question that has been put to a meeting of the Trust Board in the past six months, or;

d) would require the disclosure of confidential or exempt information.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 **Appointment of Committees**

The Trust Board may appoint committees of the Trust.

4.2 The Board shall determine the membership and terms of reference of committees and where appropriate, of sub-committees and shall if it requires to, receive and consider reports of such committees.

4.3 **Joint Committees**

Joint committees may be appointed by the Trust pursuant to regulation 10 of the partnership regulations with a local authority. Such committees will not replace the statutory governance arrangements for the Trust.

4.4 Any committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the Trust, appoint sub-committees consisting wholly or partly of members of the committees or joint committee (whether or not they are directors of the Trust or health bodies in question) or wholly of persons who are not directors of the Trust or health bodies in question or the committee of the Trust or health bodies in question.

4.5 **Applicability of Standing Orders and Standing Financial Instructions to Committees**

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term “Chair” is to be read as a reference to the Chair of other committees as the context permits, and the term “director” is to be read as a reference to a member of other committees also as the context permits. There is no requirement to hold meetings of committees established by the Trust in public.

4.6 **Terms of Reference of Committees**

Each such committee shall have such terms of reference and powers and be subject to such conditions, as the Board shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.7 Changes to committee terms of reference shall require the approval of the Board, and such changes shall not be subject to the section of the constitution concerning amendments to the constitution.

4.8 **Delegation of powers by Committees to Sub-Committees**

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Trust Board.

4.9 **Approval of Appointments to Committees**

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither directors nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.10 **Appointments for Statutory functions**

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with any relevant regulations or guidelines.

4.11 **Committees established by the Trust Board**

The committees, sub-committees, and joint-committees established by the Board are:

Audit Committee

4.12 Having regard for the requirements of the NHS Codes of Conduct and Accountability, the 2006 Act, the Audit Code for NHS Foundation Trusts and the Code of Governance issued by NHS Improvement, an Audit Committee will be established and constituted to provide the Trust Board with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The terms of reference will be approved by the Trust Board and reviewed on a periodic basis.

Appointments and Terms of Service Committee

4.13 Having regard for the requirements of the Code of Governance of NHS Foundation Trusts issued by NHS Improvement, an Appointments and Terms of Service Committee will be established and constituted.

4.14 The committee will comprise the Chair and the non-executive directors. The Chief Executive and the Director of Human Resources and Organisational Development shall normally be in attendance, except where their own remuneration or terms of service are under discussion.

4.15 The purpose of the committee will be to determine for the Trust Board appropriate appointments and remuneration and terms of service for the Chief Executive and other executive directors including:

a) all aspects of salary (including any performance-related elements/bonuses);

b) provisions for other benefits, including pensions and cars;

c) arrangements for termination of employment and other contractual terms.

d) the appointment of the Chief Executive may be proposed by this committee but is subject to the approval of the Council of Governors.

4.16 The Committee will also consider succession planning for executive directors of the Board

Charitable Funds Committee

4.17 In line with its role as a corporate trustee for any funds held in trust, either as charitable or non charitable funds, the Trust Board will establish a Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

Other Committees

4.18 The Board may also establish such other committees as required to discharge the Trust's responsibilities.

4.19 **Voting rights on Committees**

Only directors who are members of Committees may vote.

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 The Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of these Standing Orders or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit.

Emergency powers and urgent decisions

5.2 The powers which the Board has reserved to itself may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise

of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

Delegation to Committees

5.3 The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

Delegation to Officers

5.4 Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

5.5 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

5.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance to provide information and advise the Board in accordance with statutory requirements. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

Duty to report non-compliance with Standing Orders

5.7 If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/ PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 In accordance with the Trust's Policy on the development of policies and procedural documents, the Trust will from time to time agree and approve Policy statements/ procedures which will apply to all or specific groups of staff employed by Gloucestershire Health and Care NHS Foundation Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board or Committee minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Approval of any revision to such policies and procedures will be a matter for the Trust Board, its committees or an executive director, as appropriate.

6.3 These Standing Orders must be read in conjunction with the following:

a) any governance policy for Trust staff;

b) any disciplinary procedures adopted by the Trust.

c) any policies approved by the Trust relating to conflicts of interest or business conduct

d) any guidance issued by the Department of Health or a relevant regulatory body

6.4 Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

7. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

7.1 The common seal of the Trust shall be kept by the Chief Executive or a nominated manager by him/her in a secure place.

7.2 Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.

7.3 The Chief Executive shall keep a register in which he/she, or another manager of the Trust authorised by him/her, shall enter a record of the sealing of every document. Use of the seal will be reported to the Board quarterly.

7.4 Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any executive director.

7.5 In land transactions, the signing of certain supporting documents may be delegated to managers as set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

[2]GETHER NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING
TUESDAY 18th JUNE 2019
BUSINESS CONTINUITY ROOM, RIKENEL, GLOUCESTER

PRESENT:

Ingrid Barker (Chair)	Rob Blagden	Vic Godding
Cherry Newton	Said Hansdot	Miles Goodwin
Mervyn Dawe	Faisal Khan	Anneka Rose
Jo Smith	Hilary Bowen	Bren McInerney
Nic Matthews	Ann Elias	Carole Allaway-Martin
Stephen McDonnell		

IN ATTENDANCE: Sandra Betney, Joint Director of Finance and Commerce
Maria Bond, Non-Executive Director
John Campbell, Director of Service Delivery
Angela Cooper, Clinical Lead Urgent Care (GCS)
Lisa Evans, Assistant Trust Secretary
Marcia Gallagher, Non-Executive Director
Ruth Kyne, Matron, Charlton
John McIlveen, Trust Secretary
Sandra Betney, Joint Director of Finance
Kate Nelmes, Head of Communication
David Seabrooke, Interim Trust Secretary (GCS)
John Trevains, Director of Quality
Jonathan Vickers, Non-Executive Director
Paul Roberts, Joint Chief Executive
Neil Savage, Joint Director of HR and Organisational Development

1. WELCOMES AND APOLOGIES

1.1 Apologies for the meeting had been received from Colin Merker, Jane Melton, Duncan Sutherland, Nikki Richardson, Sumita Hutchison, Kate Atkinson, Jan Furniaux, Lawrence Fielder, Stephen McDonnell, Mike Scott, Simon Smith, Alison Feher, Katie Clark, Amjad Uppal, and Jade Brooks

1.2 Paul Roberts introduced Sandra Betney to the Governors. He reported that she had been recently appointed as the Joint Director of Finance for 2gether and GCS. Bren McInerney congratulated Sandra Betney on her appointment and asked that the thanks of the Council be recorded for all of work Andrew Lee had done on behalf of the Council and the Trust. Paul Roberts reported that a formal goodbye was being arranged for Andrew Lee and Ingrid Barker reported that he had been a hugely valued member of the Board.

2. DECLARATION OF INTERESTS

2.1 Carole Allaway-Martin notified the Council that she is an elected member of Gloucestershire County Council, and the Chair of the Council's Health Overview and Scrutiny Committee.

2.2 Mervyn Dawe reported that he would be representing a family at an inquest.

3. COUNCIL OF GOVERNOR MINUTES

3.1 The minutes of the Council meeting held on 14 March 2019 were agreed as a correct record.

4. MATTERS ARISING AND ACTION POINTS

4.1 The Council reviewed the actions arising from the previous meeting and noted that the majority of these were now complete or progressing to plan.

5. CHIEF EXECUTIVE'S REPORT

5.1 Paul Roberts presented his report to the Council, highlighting a number of key areas for the Governors to note.

5.2 Paul gave an update on key national communications and a summary of progress against local developments and initiatives. The Governors noted the extensive engagement activities that had taken place during the past month by both the CEO and the Executive Team, and the importance of these activities in order to inform strategic thinking, raise awareness of mental health, build relationships and influence the strategic thinking of others.

5.3 Progress on the strategic intent to merge [2]gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust (GCS) was noted. The Governors noted that encouraging progress was being made and the merger was now at a key stage in the process. The Full Business Case was recently submitted to NHS Improvement and following consultation the name for the joint Trust had been agreed as Gloucestershire Health and Care NHS Foundation Trust, as long as the merger was approved. The Chief Executive reported that Grant Thornton were at the Trust this week and NHSi would be attending the following week. Interviews would be undertaken with staff.

5.4 It was noted that a visit by the Parliamentary Ombudsman and his team had taken place the previous day. It was hoped that this would forge better connections with providers particularly around complaints resolution. Paul reported that he had been pleased with their feedback and he thanked the staff involved.

5.5 Paul reported that interviews for the Director of Strategy and Partnerships had taken place and Angela Potter was the preferred candidate. Angela had worked in the Nottinghamshire Health Care system as a Director for the past 8 years and her current role was very similar to this post. Paul also reported that John McIlveen would be leaving the Trust later this year and a Head of Corporate Governance was being recruited. The Governors also noted that the Trust had not been successful in appointing a GP NED and recruitment for this post continued.

5.6 The Annual Mental Health and Wellbeing event would be taking place on 2nd July at Walls Club in Barnwood. Governors were encouraged to attend.

6. CHAIR'S REPORT

6.1 Ingrid Barker presented her regular report for the Trust Board which set out her activities and key developments. The report also provided an overview of 2gether Non-Executive Director (NED) activity. This report was noted.

7. GOVERNOR OBSERVATION AT BOARD COMMITTEES

7.1 There was no feedback provided to the Council on observations of Board Committee meetings which had taken place since the last Council of Governors meeting. No Governors had been available to attend the Delivery Committee meetings on 24 April or 22 May or Development Committee on 21st May.

7.2 Cherry Newton said that the reminders of the upcoming meetings dates sent to Governors at quite short notice. It was agreed that the dates of Committees would be sent out again to Governor Observers.

ACTION: Dates of Committees to be sent out again to Governor Observers.

8. MEMBERSHIP REPORT

8.1 Kate Nelmes provided a full analysis of the 2018/19 financial year membership data for 2gether NHS Foundation Trust.

8.2 Governors were reminded that in September 2016, the Council agreed the Trust's current Membership Strategy. Our focus had been on retaining members and recruiting new members, with a specific emphasis on recruiting young members, members from black, Asian and minority ethnic backgrounds and men, who were all under-represented.

8.3 Kate reported that it had been necessary to carry out a data cleansing activity when the Genera Data Protection Regulation (GDPR), came into effect in May 2018. This had a significant impact on membership figures. It also meant we were no longer able to automatically transfer staff members to public members when they left the Trust's employment. All leavers were now written to and asked to actively 'opt in' to membership.

8.4 Despite the data cleansing exercise Kate reported that there were 8,116 members of our Trust at the end of the 2018/19 financial year. This represented an increase of 311 members (4%) over the year, including an increase of 6% for Herefordshire. The Governors noted that the Police Open day had been a particularly successful event and the Trust had recruited around 100 members.

8.5 Rob Blagden asked Kate if she had actively worked to achieve the targets for BAME members. Kate reported that the BAME membership target was achieved, as was the target for Herefordshire. However work continued to achieve the targets set for the Cotswolds and for young people.

8.6 Kate reported that the Key Performance Indicators for 2019/20 were:

- A 5% increase in members recruited in Herefordshire.
- A 5% increase in members recruited in the Cotswolds.
- A 5% increase in membership among men.
- A 5% increase in membership among younger people (under 21s).
- A 5% increase in membership among people from a Black and Minority Ethnic background.
- At least 50% of all new members recruited express an interest in the work of community physical health services.

8.7 Bren suggested that the Communications Team should work with voluntary groups who may be able to use their local connections to encourage members to come forward. Bren also asked if the Trust planned to do any further work with Glos FM Community Radio. Kate said that she would contact them again to discuss options for further work.

ACTION: Kate Nelmes to contact Gloucester FM to discuss options for further work.

8.8 Hilary reported that she could not see how Governors could change their details on the Trust Website and Kate agreed to check if this needed to be made clearer.

ACTION: Kate Nelmes to check if the website could be updated to make it clearer how Governors could update their details.

9. GOVERNOR ACTIVITY

9.1 Hilary Bowen had visited Alexandra Wellbeing House and reported that she had been very impressed by the facilities available there.

9.2 Cherry Newton reported that she had visited Hereford Disability United meetings and had discussed Mental Health and Crisis Intervention.

9.3 Miles Goodwin reported that he had attended Health Watch in Hereford. The Governors noted that Bob Lloyd-Smith one of the Trust's Mental Health Act Managers had been appointed as the new Chair of Health Watch in Gloucestershire.

9.4 Bren McInerney thanked Paul Roberts, Carole Allaway-Martin, Hazel Braun and Candace Plouffe for attending a local school. He reported that the school was looking to arrange a Health and Wellbeing day for parents. Paul and Carole agreed that they had really enjoyed the day and Ingrid thanked Bren for making the arrangements.

10. NON-MERGER ITEMS FOR DISCUSSION FROM GOVERNORS PRE-MEETING

10.1 Rob Blagden noted that papers for this meeting had been sent only by email rather than being printed and posted for Governors. It was agreed that in future papers for public governors would be posted out.

ACTION: Council of Governors papers to be posted out to public governors.

10.2 Rob asked that a new Governor Visits schedule be produced. It was agreed that visits would be arranged to Pullman Place and GCS sites.

ACTION: Governor visits schedule to be produced to include visits to Pullman Place and GCS sites.

11. ANY OTHER BUSINESS

11.1 Mervyn Dawe encouraged Governors to listen to 'All in the Mind' on Radio 4. The Governors also noted that Radio 4's 'Women's Hour' was focussing on CAMHS issues that week.

12. DATE OF NEXT MEETING

12.1 The next meeting will be at 3pm on Thursday 11 July, in the Business Continuity Room at Rikenel, with the Governor pre-meeting starting at 1.30pm.

Business Continuity Room, Trust HQ, Rikenel		
Date	**Governor Pre-meeting**	**Council Meeting**
2019		
Tuesday 14 May	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 11 July	1.30 – 2.30pm	3.00 – 5.00pm
Tuesday 10 September	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 14 November	9.00 – 10.00am	10.30 – 12.30pm

Council of Governors
Action Points

Item	Action	Lead	Progress
14th March 2019			
10.7	Governors to receive the outcome report on the audit of last year's quality indicator on suicide.	John Trevains	
11.3	Short briefing report to be circulated to Governors ahead of future Holding to Account sessions	John McIlveen	**To be developed post-merger.**
13.1	Mervyn Dawe to email his question about Values Week consultants to Ingrid Barker, Paul Roberts and Rob Blagden.	Mervyn Dawe	
13.4	Carole Allaway-Martin to share carers group contact details with Paul Roberts	Carole Allaway-Martin	
18th June 2019			
7.2	Dates of Committees to be sent out again to Governor Observers.	Trust Secretariat	Complete. Sent out by email to all Governor Observers.
8.7	Kate Nelmes to contact Gloucester FM to discuss options for further work.	Kate Nelmes	
8.8	Kate Nelmes to check if the website could be updated to make it clearer how Governors could update their details.	Kate Nelmes	
10.1	Council of Governors papers to be posted out to public governors.	Trust Secretariat	Complete.
10.2	Governor visits schedule to be produced to include visits to Pullman Place and GCS sites.	Trust Secretariat	On the agenda for this meeting.

ITEM 22

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: MH Legislation Scrutiny Committee

DATE OF COMMITTEE MEETING: 11 September 2019

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

REVIEW OF CQC MONITORING VISITS

The Committee received an overview of CQC visits including Key Performance Indicators which monitored the CQC action statement returns and the percentage of Gloucestershire and Herefordshire actions that had breached their original target dates.

The Committee noted the action statement reports that remained open within the Gloucestershire and Herefordshire areas. The Committee received an overview of the data collection and audit activity that was carried out annually to identify any gaps in compliance with the Mental Health Act. The themes identified through internal monitoring and external inspections were used to determine areas of additional work and any subsequent monitoring requirements. The Committee was fully assured on the processes and structures in place for the receipt, scrutiny, investigation, reporting and where necessary, escalation of issues associated with CQC Monitoring Visit Reports. There was full assurance on the processes in place to address observations made by the CQC; structures were in place to ensure the timely review and where necessary implementation of improvements to operational systems and processes. There were no outstanding actions in relation to Herefordshire, with two incomplete actioned in Gloucestershire with relation to Honeybourne Ward and the Committee was assured that one of these actions had since been completed and the other was progressing.

MONITORING OF PROVISION OF PATIENTS' RIGHTS

The Committee received an update on an audit of the recording of the provision of rights to patients subject to the Mental Health Act. It was noted that there was a significant level of assurance of the verbal provision of rights to detained patients. There was a more limited level of assurance in relation to Community Treatment Order (CTO) patients, however the Committee was assured that CTO patients would be aware of their rights through written information provided at regular intervals. It was agreed that the Operational Group would look into the causes behind the lower percentage of CTO patients having their rights recorded and reminders up-to-date. This would be reported back to the Committee.

LIBERTY PROTECTION SAFEGUARDS IMPACTS AND RISKS AND REVIEW OF DoLS APPLICATIONS/UPDATE REPORT

The Committee received a report which set out the legal process in place for the deprivation of liberty safeguards (DoLS). The Committee noted the change in the law which would see DoLS replaced with the Liberty Protection Safeguards; this change was due to come into force in October 2020. The Committee discussed affected patients across community hospitals and received assurance that conversations were taking place with colleagues in Gloucestershire Care Services. It was agreed this item would remain on the agenda for the next meeting.

MHA POLICIES – SCT CONCERNS OF THE FAMILY

The Committee received a review of a random selection of health records to provide assurance of compliance with the policy for responding to carers' and relatives' concerns.
The Committee noted that the health records of 20, out of 51, CTO patients had been reviewed. The review indicated that the carers/relatives of 45% of CTO patients raised concerns which were followed

up; there was no record of the carers/relatives of the remaining 55% raising concerns, but the health records indicated ongoing contact with them, enabling a concern to be raised and addressed if necessary.

The Committee asked for further clarification around how the Trust recorded the percentages as it was felt that this report offered full assurance.

REVIEW OF MHA/MCA/DoLS TRAINING

The Committee received a report on Mental Health Legislation Training. It was noted that following an inspection visit in October 2015, the CQC raised a concern that Trust staff had a lack of knowledge around the new MHA Code of Practice and the Mental Capacity Act (2005), including the Code of Practice. As a result, a number of actions were agreed, including the introduction of a mandatory read briefing document in November 2015, followed by the implementation of a bespoke e-learning course in July 2016.

The Committee noted that training compliance figures had been steadily increasing since the introduction of the course from an average of 62.8% in December 2016, to an average of 97.5% in September 2019. Two non-mandatory training courses continued to be offered to staff, aimed at providing more detailed specialist training.

RECOMMENDATIONS FOLLOWING THE WESSELY REPORT

The Committee received an update on the Implications of the Wessely Report for the use of the MHA in Gloucestershire. It was noted that the Government had said that there would be a new MHA following the Independent Review in December 2018 chaired by Professor Sir Simon Wessely. The review's recommendations were designed to transform the law on the detention and compulsory treatment of people with serious mental health problems around four principles:

- Choice and Autonomy – ensuring people's views and choices were respected;
- Least Restriction – ensuring the Act's powers were used in the least restrictive way;
- Therapeutic Benefit – ensuring people were supported to get better so they can be discharged from the Act;
- The Person as an Individual – ensuring people were viewed and treated as rounded individuals.

The Committee was advised that the implications did not appear to be very significant and that the Trust was in a good position to respond to most recommendations.

OTHER ITEMS

The Committee also:

- Carried out a review of the Risk Register. It was noted that one risk met the reporting criteria with a risk score of 12 - Section 12 Approved Doctors. It was noted that there were no significant issues to report with Section 12 availability and there had been no detrimental effect on the provision of services. Work was to be undertaken around the Section 12 Solutions app and trials would be conducted in October to determine its usefulness. The Committee requested further assurance to be provided at the next meeting.
- Received the minutes of the Operational Group and noted the Operational Group Terms of Reference.
- Received the minutes of the MHA Managers Forum

ACTIONS REQUIRED BY THE BOARD

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

with you, for you

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AGENDA ITEM: 24

Report to:	Trust Board 28 November 2019
Author:	John Trevains, Director of Nursing, Therapies & Quality Gordon Benson, Associate Director of Clinical Governance & Compliance
Presented by:	Maria Bond, Non- Executive Director
SUBJECT:	**Quality Committee – Key Issues to highlight to the Board**

Can this subject be discussed at a public Board meeting?	
If not, explain why	

This report is provided for:

Decision | Endorsement | **Assurance** | **Information**

PURPOSE OF REPORT

The Quality Committee meetings took place on 16 October 2019 & 7 November 2019 and this report provides an overview of the activities reviewed. It also highlights achievements made as well as how the Trust is responding to areas of risk and where improvements need to be made.

RECOMMENDATIONS

The Board is asked to discuss, note and receive the contents of the Quality Committee briefing paper.

EXECUTIVE SUMMARY

<u>16 October 2019 meeting</u>

1. **GCS & 2G Legacy Reports**
   The Committee received a handover of key issues which were previously handled by the GCS Quality & Performance Committee and the 2G Governance Committee. To ensure that no gaps in the handover of information occur during the process of transition to the new Quality Governance structure, a 'safety

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netting' approach has been mandated. This means that no existing sub-committee or group will cease to function in the new Trust until it's function has been absorbed into the new reporting structure.

2. **Patient Safety Report**
   The Committee noted that in mental health services there were 3 Serious Incidents Requiring Investigation (SIRI) that were declared in September 2019: 2 serious incidents for Gloucestershire and 1 for Herefordshire. There had been 0 Never Events occurring within the services since the NRLS devised the original list of 8 Never Events in 2009.

   In physical health services, there were four SIRIs that were declared to the CCG during Quarter 2, one of which was a Never Event related to an incorrect tooth extraction performed on a 9 year old child. A robust investigation is ongoing.

3. **Safe Staffing Report**
   Safe staffing information has been published for Trust mental health services for the months of August & September in line with national requirements. Physical health service staffing data was also received. The Committee noted that whilst safe staffing levels were maintained, there is significant reliance on bank and agency workers, and there is a workforce risk currently. A progress report regarding this risk will be provided at the November Quality Committee.

4. **Qualitative & Quantitative Risk Audit (Mental Health & LD Services)**
   The audit demonstrated consistency in quantitative compliance with the risk management policy in terms of the proportion of service users with a risk assessment, and that there was encouraging evidence that clinicians were completing the risk summaries and the level of risk was consistently being recorded.

5. **Assessment & Care Management Audit (Mental Health & LD Services)**
   The Committee noted the general qualitative improvement in the record with good triangulation of information across the care plans, crisis contingency plans and risk assessments. The report outlined a recommendation that ACM audits should continue at 6 monthly intervals moving forward and reported to the Committee and disseminated for ongoing learning and action; additionally, the Quality Assurance Group would receive monthly updates against the 5 key trajectory targets.

6. **Integrated Clinical Audit Assurance Report**
   A merged clinical audit programme that detailed the audits that had been set to be undertaken within the 2019/20 financial year was reviewed. It was reported that of the 268 audits on the programme, 39 (15%) had been completed within the financial year, and of these 30 had achieved a RAG rating of Green. Of the remaining audits, 167 were marked as a high priority for completion. It is projected that these audits will be completed by year end.
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7. **Merged Risk Management**
   The Committee received a risk register listing the corporate risks from both legacy Trusts. The report had been produced from the two separate Datix systems used by both Trusts, and additional work had been undertaken to ensure the consistency of information. High scoring risks of 12 and above were noted. There is significant assurance that adequate reports could be provided to board committees to meet risk management responsibilities in a timely manner.

8. **Terms of Reference**
   The Committee approved its Terms of Reference.

**7 November 2019 meeting**

1. **Duty of Candour**

   The CQC is being more assertive with exercising it power to fine NHS Trust regarding DoC breaches. There has been contact with Royal Cornwall Hospitals Trust, the subject of recent fines in terms of their learning and remedial actions. The Quality Team are conducting a piece of work to review our Trust approach to ensure we are in line with best practice and national standards.

2. **Deep Dive Template**

   The Committee approved the use of a template which would enable succinct analysis of a particular issue or challenge. In addition to the clinical and safety components detailed, patient & carer feedback will also be added, as well as organisational impact and equality issues.

3. **Clinical Presentation – Pressure Ulcers**
   A deep dive presentation on pressure ulcers was received; these remain an area of variation in care across the Trust. Progress is noted through QI initiatives and compliance with published standards from NHSI has been achieved. Acquired pressure ulcers were reported at 7% of the total audit sample for Q2 data, but there remains a need for improvement.

4. **Safe Staffing**
   There is still a significant risk around our current workforce across the Trust.
   - Inpatient Nursing vacancy circa RMN 30% and RN 20%
   - Abbey Ward currently has 45% vacancies against establishment
   - Medical vacancy level covered by locums at Wotton Lawn Hospital is 70%
   - RMN staff moving from inpatient units to community posts for promotion or specialisation.
   - There were less RMN students recruited in 2019 than in 2018.
   - There is a variation in acuity / LOS requiring additional staff.

   To mitigate this risk a number of actions will be undertaken by the Quality Directorate as follows:
   - An urgent “sense check” re safe staffing numbers and escalation procedures to inform a dynamic consideration of the need to reduce bed numbers.
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- There is currently work underway with framework agencies around providing RMN cover to avoid the use of Thornbury, this requires funding circa £200k which the Exec team has approved.
- A detailed recovery plan is being developed at Wotton Lawn Hospital.
- Student early recruitment has commenced including outside of local routes University of the West of England and University of Worcestershire.
- 6 RNA to RMN posts who qualify in 2021 – progression funding is approved.
- We have re-introduced rolling 3 monthly HCA recruitment events and monthly for Berkeley House HCA's.
- There is a focus on achieving a full-compliment of the peripatetic teams in Wotton Lawn Hospital, Charlton Lane Hospital and the Stonebow Unit.

**5. Patient Safety Reports**

A merged Q2 mental health incidents and physical health incident report was reviewed. The Committee noted that incident data capture is reported via the 2 legacy Datix systems for GCS (physical health incidents) and 2G (mental health incidents). Within mental health services the 3 most reported incident types are physical interventions (restrain) including rapid tranquillisation, self- harm and falls. There is significant assurance that with episodes of restraint, the least restrictive options are considered foremost.

In physical health services A total of 513 PH clinical incidents (including patient falls) moderate and above were reviewed by the Clinical Governance Team of which 79 (15%) required additional investigation during Q2. Of these 16 (20%) required a concise investigation, 9 (11%) were then reviewed at a Multidisciplinary Incident Review Meeting and 1(1%) was declared as a Never Event (wrong tooth extraction in a 9 year old child).

One SIRI was declared within MH services in Gloucestershire in October.

**6. Patient Experience Reports**

Q2 reports were received summarising complaints, concerns & compliment activity from both GCS and 2G. FFT survey information was also received. The Patient & Care Experience Team are working towards the production of a merged, unified report for Q3. The main theme from complaints across both physical and mental health services is communication; we must make sure that we talk to and listen to all those involved in a person's care, and we must make sure that people understand our explanations and the information we give them.

**7. Legacy GCS/2G Quality Account/Reports**

Q2 reports were received summarising progress against quality priorities. A harmonised report will be developed to provide integrated information in the future. The Committee was concerned about 5 Clostridium Difficile Infections recorded in September in Community Hospitals, above the in-month trajectory. This will be monitored carefully over the ensuing months. All cases are being examined at the countywide assurance group. There have been 8 cases year to date against a year end threshold of 12.
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| Corporate Considerations | |
|---|---|
| *Quality implications* | Implications are clearly referenced in the report. |
| *Resource implications*: | The significant risk implications around workforce resource are noted. |
| *Equalities implications:* | None |
| *Risk implications:* | Implications are clearly referenced in the report. |

| WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)? | | | |
|---|---|---|---|
| Working together | P | Always improving | P |
| Respectful and kind | P | Making a difference | P |

| Report authorised by: | Date: |
|---|---|
| | |

| Where has this issue been discussed before? |
|---|
| Quality Committee 7 November 2019 |
| **What wider engagement has there been?** |
| |

| Appendices: | |
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AGENDA ITEM: 25

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Audit and Assurance Committee

DATE OF COMMITTEE MEETING: 6th November 2019

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

ADOPTION OF TERMS OF REFERENCE

The Committee received a refreshed Terms of Reference for the Audit and Assurance Committee which had been revised in line to reflect the new organisation. The terms of reference were agreed subject to ratification at the Trust Board meeting.

2G AUDIT COMMITTEE – SELF ASSESSMENT 2019

The Committee received the largely positive self-assessment report. New Service Level Agreements were currently being drafted and would be shared once in place.

REVIEW OF THE STANDING FINANCIAL INSTRUCTIONS AND SCHEME OF DELEGATION

The Committee received the revised Standing Financial Instructions and Scheme of Delegation. Previous versions from the two Trusts had been used as a baseline for the review. Where there was a higher level of accountability this had been adopted within the revisions. Subject to a number of amendments, the papers were approved on behalf of the Board.

INTERNAL AUDIT

The Committee received an internal audit report regarding Communications and Engagement. It noted that consideration had been given to the two recommendations in relation to dissemination of information from the meetings and frequency. The Senior Leadership Network meetings would take place bi-monthly from May 2020 at the same membership level. This report had an outcome of 'low risk'.

The Committee received the CIPs Audit reports for 2G and GCS and were assured that transformational elements would be considered when mapping for future schemes.

The GCS Annual Report was a mid-year pre-merger report resulting in an outcome of 'low risk'. A full declaration could not be issued as a full range of areas had not been reviewed, however, a disclaimer opinion is not unusual in the circumstances where merger arrangements are underway.

The Internal Audit Plan for 2019-20 was received and the Committee noted that mapping of future activity would now take place.

The Committee received the Progress Report and noted that the two action trackers would now be compiled into one report.

EXTERNAL AUDIT REPORT

The Committee received the six month audit report for GCS which completed the audit schedule. An audit plan would be presented to the next Committee meeting.

It was noted that an asset valuation exercise would be undertaken by PSEC and would be completed by the end of the current financial year.

Accounts would be submitted to the February Audit and Assurance Committee meeting and then to the Trust Board meeting in March for approval.

COUNTER FRAUD PROGRESS REPORT AND ANNUAL REPORT

The updated policy concerning Counter Fraud, Bribery and Corruption was presented to the Committee and was approved.

The Committee received an updated Anti-Bribery and Corruption Statement that would be considered by the Executive Team and then made available on the Trust's websites.

Anti-Bribery assessment exercises would take place in high-risk areas of the Trust, such as Finance, Recruitment and Procurement.

REVIEW OF COMMITTEE RISKS

The Committee noted the plan for the two Datix systems to be consolidated into one by the 1st April 2020. Once considered at Risk Management Group meetings, a formal Risk Report would be submitted to each Quality Committee.

It was proposed that the Risk Report should be further developed to show where risks are linked, the cross-referencing of actions and if a Root Cause Analysis had taken place.

COMPLIANCE REPORT

A consolidated compliance report was received by the Committee and it was noted that the Committee would in future receive improved detail about aged debtors, including those exceeding six months. A formal review of the outstanding debts would be brought to the next Audit and Assurance Committee meeting.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to note the contents of this summary

SUMMARY PREPARED BY: Marcia Gallagher **ROLE**: Committee Chair

DATE:

with you, for you

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AGENDA ITEM: 26

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Resources Committee

DATE OF COMMITTEE MEETING: 24 October 2019

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

GLOUCESTERSHIRE LONG TERM PLAN

The Committee received an update presentation on the ICS Long Term Plan A final submission was due during November, and the ICS were reaching out receive feedback.

FINANCE REPORTS – MONTH 6

The Committee received the month 6 finance reports for both legacy Trusts and noted that NHSi ratings were included within the reports

The Committee noted that the month 6 financial positions for both Trusts were in line with planned surpluses, with £0.8m for 2gether and £0.9m for GCS; however, both Trusts had seen an increase and overspend in agency expenditure, which was seen as a top financial risk. The Agency Management Group would be reporting to the Committee going forward with fortnightly reports to the Executives Team meeting so as to provide full oversight and assurance. This group would need to focus on how to address the number of multifaceted issues that were contributing to agency expenditure.

It was noted that Recruitment and Retention was a significant issue particularly in terms of Nursing and HCAs, and so agency staffing was required to fill the gaps in each team.

PERFORMANCE REPORT

The Committee received September performance reports for both Mental and Physical Health services for Month 6 against NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

The Committee agreed that the Trust needed to undertake a review on which local and commissioned targets were important to the organisation, both in terms of transformation and delivery, so as to limit the number of long-term performance indicators against both Physical and Mental Health services.

EU EXIT UPDATE

The Committee received an EU Exit briefing update paper on arrangements made by the Trust, regional and national NHS preparations, and the outcomes of any national calls or weekly meetings. It was assured that the Trust was as prepared as it could be,

HR INDICATORS REPORT

The Committee received three papers which provided updates on 2gether's Quarter 2 KPI performance, GCS' September KPI performance, and staff turnover for September 2019. Assurances were received that there would be an integrated report going forwards for the new Trust, and that there would be an upcoming merger of the legacy Trust's ESR systems which would result in more efficient data gathering and collating.

The Committee noted significant assurances in relation to 2gether's statutory and mandatory training compliance, .

The Committee was assured that there hadn't been a sharp increase in staff turnover over the two legacy Trust's as a result of the merger over the prior few months.

OTHER ITEMS

The Committee also:

- Approved of the minutes for the legacy Development, Delivery and Resources & Performance Committees.
- Approved the draft Terms of Reference for the Committee.
- Received an update on the Trust's progress regarding HR policy harmonization, development and review.
- Received a verbal update on the progress of the Workforce Race Equality and Disability Scheme (WRES) action plan.

ACTIONS REQUIRED BY THE BOARD

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