with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING PUBLIC SESSION

Thursday, 26 January 2023
10:00 – 13:30
To be held via Microsoft Teams

AGENDA

Time	Agenda Item	Title	Purpose	Comms	Presenter
OPENING BUSINESS					
10:00	01/0123	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/0123	Declarations of interest	Assurance	Verbal	Chair
10:05	03/0123	Patient Story Presentation (CYP and CAMHS)	Assurance	Verbal	DoNTQ
10:25	04/0123	Draft Minutes of the meeting held on 24 November 2022	Approve	**Paper**	Chair
	05/0123	Matters arising and Action Log	Assurance	**Paper**	Chair
10:30	06/0123	Questions from the Public	Assurance	Verbal	Chair
STRATEGIC ISSUES					
10:35	07/0123	Report from the Chair	Assurance	**Paper**	Chair
10:45	08/0123	Report from Chief Executive	Assurance	**Paper**	CEO
11:00	09/0123	Systemwide Update	Assurance	**Paper**	DoSP
11:10 - BREAK – 10 Minutes					
11:20	10/0123	CQC MH Patient Survey Results 10.1 2021 Results Action Plan Update 10.2 2022 Survey Results Report	Assurance	**Paper**	DoNTQ
PERFORMANCE AND PATIENT EXPERIENCE					
11:35	11/0123	Quality Dashboard Report	Assurance	**Paper**	DoNTQ
12:05	12/0123	Learning from Deaths – Qtr 2	Assurance	**Paper**	MD
12:15 – BREAK – 10 Minutes					
12:25	13/0123	Performance Report	Assurance	**Paper**	DoF
12:45	14/0123	Finance Report	Approve	**Paper**	DoF
GOVERNANCE					
13:00	15/0123	Board Committee TOR Review 2022/23	Approve	**Paper**	HoCG
BOARD COMMITTEE SUMMARY ASSURANCE REPORTS (REPORTING BY EXCEPTION)					
TO NOTE	16/0123	Great Place to Work Committee (8 December 2022)	Information	**Paper**	GPTW Chair

Time	Agenda Item	Title	Purpose	Comms	Presenter
TO NOTE	17/0123	Charitable Funds Committee (19 December 2022)	Information	**Paper**	CF Chair
TO NOTE	18/0123	Resources Committee (22 December 2022)	Information	**Paper**	Resource Chair
TO NOTE	19/0123	Working Together Advisory Group (11 January 2023)	Information	**Paper**	WTAG Chair
TO NOTE	20/0123	Quality Committee (12 January 2023)	Information	**Paper**	Quality Chair
TO NOTE	21/0123	Mental Health Legislation Scrutiny Committee (25 January 2023)	Information	Verbal	MHLS Chair
CLOSING BUSINESS					
13:20	22/0123	Any other business	Note	Verbal	Chair
13:30	23/0123	**Dates of future Trust Board Meetings** Thursday, 30 March 2023 Thursday, 25 May 2023 Thursday, 27 July 2023 Thursday, 28 September 2023 Thursday, 30 November 2023	Note	Verbal	All

MINUTES OF THE TRUST BOARD MEETING

Thursday, 24 November 2022

Via Microsoft Teams

PRESENT:
Ingrid Barker, Trust Chair
Steve Alvis, Non-Executive Director
Sandra Betney, Director of Finance
Steve Brittan, Non-Executive Director
Marcia Gallagher, Non-Executive Director
Sumita Hutchison, Non-Executive Director
Jan Marriott, Non-Executive Director
David Noyes, Chief Operating Officer
Angela Potter, Director of Strategy and Partnerships
Paul Roberts, Chief Executive
Graham Russell, Non-Executive Director
Neil Savage, Director of HR & Organisational Development
John Trevains, Director of Nursing, Therapies and Quality
Dr Amjad Uppal, Medical Director

IN ATTENDANCE:
Graham Hewitt, Trust Governor
Anna Hilditch, Assistant Trust Secretary
Dr Faisal Khan, Deputy Medical Director
Bob Lloyd-Smith, Healthwatch Gloucestershire
Louise Moss, Deputy Head of Corporate Governance
Kate Nelmes, Head of Communications
Jane Russell, PA to Trust Chair and Non-Executive Directors

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting. Apologies had been received from Nicola de Iongh, Helen Goodey, Lorraine Dixon and Lavinia Rowsell.

1.2 Ingrid Barker informed the Board that the Trust had successfully appointed a Nominated Associate NED from the University of Gloucestershire. The appointment of Lorraine Dixon would commence today, 24th November 2022. It was noted that Lorraine was delighted to have been nominated and was looking forward to working with colleagues.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. PATIENT STORY PRESENTATION

3.1 The Board welcomed Helen to the meeting, who spoke about her experience of End of Life care for her mother, Hilda. Helen was accompanied at the meeting by Debbie Williams, End of Life Lead at GHC.

3.2 Hilda suffered with mixed vascular dementia and had a well-established care package to support her to be cared for at home as was her wish. In August 2020 Hilda's condition deteriorated and extra support was requested by Gloucester Homecare via social services. There was a significant delay in response to Helen by social services but finally in September it was recognised that Hilda was rapidly deteriorating and that a Continuing Healthcare (CHC) Fast track (FT) assessment was needed to enable Hilda to have the nursing care that she needed in her last weeks of life. This assessment was completed by a GHC Community Nurse on 11th September; however, Helen informed the Board that the nurse was only in the house to assess Hilda for 10 minutes. The CHC FT team declined the funding due to a lack of receipt of further information and evidence despite requesting this and closed Hilda's case on 17th Sept. There was no communication to Helen regarding this from either the GHC community nursing teams or adult social services and this resulted in a delay to the provision of extra care for Hilda. Hilda sadly died on 5th October 2020.

3.3 Helen summarised some of the key points from her experience. She said that she had found it difficult to speak to the Community Nursing Team as calls went through a Hub and messages appeared not to be relayed efficiently. She said that communication with the family/carers was vital, and the use of electronic records that family members could not see was difficult. Helen suggested that there needed to be an improvement in the communication between professionals. The final key point related to the CHC Fast track assessment which Helen said should have been completed in consultation with the family, not by a nurse who had had no previous contact with the patient and did not know her.

3.4 Helen informed the Board that she had made a formal complaint and positively, the complaint had been listened to and she joined the Trust's Quality Improvement Group in December 2021 as a valued expert by experience. Helen now works closely with Debbie Williams, End of Life Lead with issues identified within the End of Life group.

3.5 Marcia Gallagher said that she was sorry to hear about the issues that Helen and her family had experienced, but welcomed the knowledge that Helen was now working alongside colleagues as an Expert by Experience. Marcia asked Helen what the top 3 things would be that she would like to see changed. Helen said that conversations and agreeing what people wanted at end of life should take place in a timely manner, with the Respect form completed and available in the house for professionals to see and access. Discussions and guidance around nutrition at End of life would also be helpful. The final point Helen raised was about the importance of keeping the family in the loop – if nurses had gone into the house to visit Hilda when Helen wasn't there, there was no way for Helen to know what had happened or when they would be coming back. As previously mentioned, it was vital to keep the family involved and up to date.

3.6 Debbie Williams advised that the End of Life Quality Group was back up and running, and Helen was working alongside her and colleagues to review policies and procedures. Debbie said that there was a lot of good work taking place, including an End of Life masterclass for professionals, and work with Trust dieticians to produce guidance for patients and their families on nutrition.

3.7 The Board thanked Helen for attending and speaking so openly about her experiences. It was agreed that there was more work to be done to ensure a real joining up of palliative care services and improvements with interagency communication.

4. MINUTES OF THE PREVIOUS BOARD MEETING

4.1 The Board received the minutes from the previous Board meeting held on 29 September 2022. The minutes were accepted as a true and accurate record of the meeting.

5. MATTERS ARISING AND ACTION LOG

5.1 The Board reviewed the action log and noted that all actions were now complete or progressing to plan.

5.2 Paul Roberts informed the Board that discussions had taken place around Learning disability services, and dialogue with the ICS Chief Executive about revisiting the full strategic approach to learning disability services. This would be raised at the next ICB Board meeting, as highlighted in the action log. Jan Marriott welcomed this and asked that any review considered the work taking place at the Learning Disability Partnership Board.

6. QUESTIONS FROM THE PUBLIC

6.1 Bob Lloyd-Smith raised the issue of Independent Mental Health Advocates (IMHA) and the vital role that they played and asked whether the Board felt that there were sufficient numbers to cover both Wotton Lawn and Charlton Lane. John Trevains said that he would always welcome more and this would be explored further with commissioners as they were directly contracted by the ICB. He agreed that IMHAs played a vital role in ensuring that people's voices were heard. It was noted that the new Mental Health Act would be developing this important role further, so it was very much on the Trust's radar.

6.2 For completeness, Ingrid Barker informed the Board that a question had been received in advance of the meeting around the provision of NHS Dentistry services. Colleagues had signposted the questioner to NHS England who were the commissioners of these services.

7. QUALITY DASHBOARD REPORT

7.1 This report provided an overview of the Trust's quality activities for October 2022. It was noted that key data was reported under the relevant CQC Domains – caring, safe, effective, responsive and well-led.

7.2 John Trevains informed the Board that overall, the report demonstrated that some fantastic and dynamic work was being carried out and high-quality services were being delivered.

7.3 The report highlighted those Quality issues for priority development to the Board and it was noted that this data was triangulated with the Performance Dashboard report:

- Referral to treatment times across a number of paediatric Therapy services continue to pose significant challenges. Increased support and monitoring from NTQ has been identified in order to fully understand the issues, identify potential risk and develop recovery trajectories.
- Following a small increase (2) in the number of falls recorded which resulted in medium to high harm, NTQ are providing further senior leadership support to the Trust wide Falls prevention group. A dedicated QI resource has been identified to support colleagues to further embed evidence-based practice.

7.4 Quality issues showing positive improvement:

- Continued reduction in the Health Care Support Worker (HCSW) vacancy rates with a further reduction since September 2022 following additional recruitment activity.
- Using Quality Improvement methodology and Co-production to support improvements in patient experience and care following a serious incident.
- Care Programme Approach (CPA) rates have recovered to above target of 95% this month.
- New Friends and Family Test (FFT) system launched in month with the aim of increasing access for individuals to provide feedback, particularly those who use Physical Health urgent care and community Mental Health services. Increased response rate noted within MIIU, MH Intermediate Care Teams (ICT), IAPT and Recovery.
- The Trust wide CQC action plans remain on track to complete within the agreed timescales and feedback from the CQC has been positive on the progress made to date.

7.5 Jan Marriott said that she had carried out a visit to Cirencester Hospital and had spoken to a number of the international nurses located there. Some recent recruits had raised the issue of SystmOne and how they would have welcomed more training on how to use the system before commencing. Sandra Betney agreed to take this forward as an action with the Clinical Systems training team, to carry out a review of the methods and effectiveness of the training provided for new starters. **ACTION**

7.6 Marcia Gallagher had carried out a visit to the Cardiac Rehabilitation Team on 23 June. She said that this was an excellent service that contributed to hospital avoidance. She noted that some of the actions arising from her visit were still marked as “Action in progress” within the Quality Report and she said that she would welcome receiving an update on what progress had been made and seeing the outcome of these actions in a timely way. John Trevains said that he would ensure that more detail was made available in future reports to provide the necessary updates and assurances around the work taking place.

7.7 Graham Russell said that he had recently visited a team who were commissioned to provide services to 40 patients, however, their caseload had been 60 patients for some time. He queried whether this was likely to have an impact on the quality of the services being provided, and also on the wellbeing of the staff carrying out the home visits to provide therapy services to stroke patients. John Trevains said the situation was dynamic, however, the Trust employed professional individuals who were able to prioritise, adjust and deliver urgent care needs. All services were actively managed to ensure patient safety and care. David Noyes added that an increase in caseload could be seen across many of the services within GHC and this demonstrated the importance of clinical systems and the ability to document activity and caseloads accurately. The Board was asked to note that a business case for the Neurotherapy Service was currently in development.

7.8 The Board congratulated the Trust Complaints Team for their sustained performance in managing complaints. A lot of work had been taking place within the Team, including an increase in the involvement of people with lived experience.

7.9 Positive progress with Eating Disorder services was noted, with skill mix reviews having taken place within the service. A paper on ED services would be presented at the ICB Board meeting the following week.

7.10 Steve Brittan commented on the huge improvement in the quality of data presented at meetings, which demonstrated the real benefits of investment into the business intelligence service.

7.11 Ingrid Barker made reference to the data within the report around pressure ulcers, with 8 category 3 pressure ulcers being reported. She noted the recording of these and questioned whether those reported as "unavoidable" within the Community Hospitals – which were 24/7 supervised areas – were really unavoidable. David Noyes advised that some patients were transferred to the Community Hospitals with a pre-existing pressure ulcer, so it was important to note that they did not develop these whilst a patient with GHC.

7.12 The continuing challenges with vacancies was discussed, with some wards/units running with a 30% vacancy rate. The Board asked that a review of the measures and interventions that had been put in place to address this be carried out to look at what had worked (targeted recruitment) and what hadn't (monetary incentive) so we could look at what more could be done.

7.13 The Board once again welcomed this report, noting the developments underway and the good level of assurance provided.

8. QUALITY IN MENTAL HEALTH

8.1 This report provided the Trust Board with information and assurance on Trust practices to maintain and improve the quality and safety of mental health, learning disability and autism inpatient services, as described within recent communications from NHS England following the disturbing and unacceptable events presented within the BBC Panorama documentary about abusive care at an NHS Trust in Manchester. This report set out the Trust's initial actions regarding the letter, describing at a high-level existing Trust safeguards and outlined future work to guide a Board level discussion on this important matter.

8.2 The Board agreed that this was a helpful and comprehensive report which provided good assurance on the systems in place within the Trust. In terms of where the Trust could develop further, John Trevains advised that access to independent advocacy services was a vital and high impact factor. Protective factors via access to good quality advocacy and input from local expert by experience groups/providers were highly regarded in GHC by patients, carers and clinical colleagues. The Trust Board supported discussions with commissioners on how as a system we could better support these providers to provide additional activity into Trust services to help safeguard care.

8.3 John Trevains said that it was also important to look at the health and well-being of staff. Those people who were abusing service users could have been excellent carers; however, they themselves may have been failed by poor training, mentoring and resourcing. The organisation has a real responsibility to its colleagues. Paul Roberts added that there was a real focus on improving clinical team-based cultures. Colleagues needed to feel completely safe to call out any concerns and issues, and there was a need to explore better team dynamics. Neil Savage informed the Board that the recent staff survey results gave the Board a good indicator on team working, with those responses received from learning disability services rating "team working" higher than average and showed confidence in this area.

8.4 The Board noted this report and the assurances provided. The Board fully supported the proposed actions and developments identified.

9. PERFORMANCE DASHBOARD

9.1 Sandra Betney presented the Performance Dashboard to the Board for the period October 2022 (Month 7 2022/23). This report provided a high-level view of key performance indicators (KPIs) in exception across the organisation.

9.2 The Board received the 2022/23 Business Intelligence business planning highlights and a high-level Measuring What Matters timetable. Sandra Betney advised that the Measuring What Matters milestones and next steps were being reconfigured into a strategic portfolio for 2023/24 and a proposal would be brought to the Executive Team in the coming months.

9.3 The SystmOne Simplicity programme for physical health services continues to progress against an operational tracker which is predicting an improved and satisfactory system recording and data quality state for key event lines by the end of 2022/23. Where SystmOne Simplicity is impacting performance indicators, historic activity provides some assurance to normal performance levels for these indicators and wherever possible, manual audit evaluations have been undertaken on validating exceptions to inform confidence in the current situation.

9.4 The Board noted that there were 8 MH key performance thresholds in exception within the dashboard, with four of these related to the Eating Disorder (ED) Service. There were 16 PH key performance thresholds in exception within the dashboard. Seven of these are wait time measures and it is assumed that alongside operational challenges, SystmOne Simplicity data appears to be contributing to all of these 7 items. However, 6 indicators were in exception prior to SystmOne Simplicity. Through clinical services intervention, performance is expected to improve over the year as outlined within the Operational Directorates' operational tracker.

9.5 The Board noted the Chief Operating Officer's summary report, which highlighted continued challenges with system flow, noting that 30-40% of our community hospital beds were occupied by people waiting for an onward placement or package of care. An update was also provided on the Newton Europe review and next steps, recruitment into the Home First Team and details of the Operational Services reconfiguration which would take effect from 1 December 2022. Marcia Gallagher asked whether the Management of Change process for this reconfiguration had resulted in any grievances or appeals. David Noyes advised that none had been received to date and that a huge amount of communication and consultation/engagement with operational colleagues had taken place and feedback taken on board.

10. FINANCE REPORT

10.1 The Board received the month 7 Finance Report for the period ending October 2022. A revised system plan submitted to NHSE on 20th June showed a break-even position for both the system and the Trust.

10.2 At month 7 the Trust had a surplus of £1.103m. The Trust is forecasting a year end position of break even in line with the revised plan. The cash balance at month 7 is £54.8m. Capital expenditure was £6.742m at month 7. The Trust has spent £0.779m on Covid related expenditure up to October.

10.3 The Better Payment Policy shows 95.2% of invoices by value paid within 30 days, the national target is 95%. 86.7% of invoices by value were paid within 7 days.

10.4 The Trust spent £5.42m on agency staff to month 7, and against a 30% reduction on last year this would leave the Trust £2.259m over year-to-date. The run rate for agency spend is £774k per month this year compared to £672k last year. The Trust spent £7.683m on bank staff to month 7 and had a £14.3m under spend on substantive posts. The Board noted that the 30% reduction was a whole system target, however, the quality impact on the use of agency staff was acknowledged.

10.5 The Cost improvement programme has delivered £4.812m of recurring savings against the target of £5.612m, an increase of £106k on last month. The Non-Recurrent target is £1.15m and all of this had now been delivered. In addition to Trust savings, GHC had also made a £160k system saving on Covid.

10.6 The Board noted that the number of shifts currently using agency staff were increasing. The Sustainable Staffing Oversight Group was monitoring the position closely and it was noted that specialling and level of acuity had driven the current increase in agency and bank staffing. The Board was asked to note that GHC had recently approved an increase in bank rates to ensure that we remained in line with local partners.

10.7 Graham Russell asked for the top headlines in relation to estates rationalisation. Sandra Betney advised that work was underway focusing on estates rationalisation. The Trust had 2 – 3 sites that were not fit for purpose and a disposals plan would be put in place for these, ensuring that the importance of using this estate for social value was built into any disposal plan. The ICB Estates Strategy was also currently in development, and this was due to be published in Q1 2023/24.

10.8 The Board noted and approved the revised 5-year capital programme.

11. CHAIR'S REPORT

11.1 The Board received the Chair's Report which highlighted the activity of the Trust Chair and Non-Executive Directors since the previous meeting of the Board in September. Key areas of focus remain ensuring effective system working, ensuring equality, diversity and inclusion are at the heart of how we work as a Trust and that the voice of the Trust is heard locally and nationally to ensure the needs of our community are understood and inform policy and practice.

11.2 Following a competitive recruitment process involving partners, colleagues and a range to stakeholders, Ingrid Barker said that she was delighted to announce the appointment of Douglas Blair as Trust Chief Executive Officer. Douglas will take up the role in 2023 following the retirement in March of Paul Roberts. Ingrid expressed her thanks to all colleagues who had been involved in the recruitment process, including Governors, Board members and experts by experience. Thanks were also given to Neil Savage and his team for their support and expertise throughout the process.

11.3 As part of the Forest Hospital build, Ingrid Barker had joined Trust colleagues from the Dilke and Lydney hospitals in the signing of the new hospital steel frame on 26th October. She said that this had been an exciting opportunity to visit the site and witness the progress made to date.

11.4 The Board noted the content of the Chair's report and the activity updates included within it covering attendance at regional and national meetings and events, and local meetings with partner organisations.

12. CHIEF EXECUTIVE'S REPORT

12.1 Paul Roberts presented this report which provided an update to the Board and members of the public on his activities and those of the Executive Team since the last meeting in September.

12.2 Paul Roberts opened his report by once again expressing his huge thanks and appreciation to all Trust colleagues who continued to show outstanding resilience in light of ongoing pressures.

12.3 Paul Roberts wished to highlight that the trial had taken place in November of a former patient, William Warrington, who had pleaded guilty to the manslaughter of his parents Valerie and Clive. The Trust is following the mandated serious investigation process which, now the criminal justice process has come to an end can proceed to a conclusion and which, following scrutiny by regulators, will be shared with the family. The Trust has through trusted third parties expressed condolences and regret to the family, and support has also been offered to Trust colleagues who may have been affected by this incident.

12.4 The Trust has now received the 2022 NHS Community Mental Health Survey Benchmark Report. Paul Roberts noted that the report was generally positive with some small improvement on last year's position. The Trust is in the top five nationally for seven of the ten categories in the report. However, as always in these matters, there is further work to do. A more detailed report would come back to the Board after the report analysis and required actions have been reviewed and agreed at the Trust's Quality Committee.

12.5 The Board was assured that planning was in place and colleagues were working closely with Staffside to manage any upcoming industrial action. It was noted that action would be taking place before Christmas, but dates had not yet been confirmed.

12.6 Paul Roberts informed the Board that October was Menopause Awareness Month and 18th October was World Menopause Day; a day which aims to raise awareness and highlight the support options available for improving the health and wellbeing of women affected by menopause. To celebrate our Trust's 'menopause journey' and demonstrate our Trust's commitment to actively supporting and informing colleagues affected by the menopause, Paul Roberts and Ingrid Barker signed the Menopause Workplace Pledge.

12.7 The Board noted the content of the Chief Executive's Report and recognised the huge amount of work that continued to take place by all members of the Executive Team, locally and nationally.

13. SYSTEMWIDE UPDATE

13.1 The Board received the System Wide update report which provided an update on the activities that are taking place across the Gloucestershire Integrated Care System (ICS).

13.2 All Integrated Locality Partnerships (ILPs) continue to meet with good input and support from GHC and wider system partners with a number holding face to face sessions in November. The ILPs have continued to focus on the Cost-of-Living crisis and the co-ordination of information across the statutory and voluntary sectors. Primary Care Networks (PCNs) are actively identifying people who are at increased vulnerability to cost of impacts and proactively send information and resources out.

13.3 Youth Experts by Experience are undertaking 15 Step Challenges across several Trust sites during November. The purpose of the 15 Step Challenge is to explore what service users think about our clinics and environments, concentrating on first impressions and experience improvement recommendations. The impressions gained during the challenge are fed back to teams so that they can change what could be better, but also celebrate what they do well. Angela Potter advised that the Trust had 4 Youth Experts by Experience supporting this and the final report would be shared at the Trust's CYPS Governance Meeting.

13.4 The Board welcomed this report and the breadth of insight. There was some great work taking place around the county with system partners and stakeholders.

14. BOARD ASSURANCE FRAMEWORK

14.1 The Board Assurance Framework (BAF) supports the creation of a culture which allows the organisation to anticipate and respond to adverse events, unwelcome trends and significant business and clinical opportunities. It helps to clarify what risks are likely to compromise the trust's strategic and operational objectives and assists the executive team in identifying where to make the most efficient use of their resources in order to improve the quality and safety of care. The BAF for 2022/23 reflects the Trust's Strategic Aims and Objectives. It is regularly reviewed by individual Executive owners and the Executive Team collectively and is considered at each round of Board Governance Committees.

14.2 This report set out those changes to the BAF since the last review, Strategic risks that had been added or removed, and any movements in risk ratings since last reviewed by the Board in May 2022.

14.3 The Board noted that the scoring for *Risk 5: Workforce Wellbeing* had increased from a 9 to a 12. This was in recognition of the risk associated with, and impact of, the end of funding for the Workforce Wellbeing line in 2023. Neil Savage advised that national funding had been received to set up MH hubs and GHC had set up the Wellbeing line, however, this funding was not recurrent. It was noted that work was underway to review the Wellbeing Line to be able to analyse the outcomes, benefits etc and then to present a proposal to the ICB around future provision. It was important to note that anxiety, stress and depression were the highest reported sickness absence reasons for Trust staff.

14.4 The Board received and considered the revised BAF and noted the overarching risk profile for the Trust at Quarter 3.

15. FREEDOM TO SPEAK UP REPORT

15.1 The Board welcomed Sonia Pearcey, Freedom to Speak Up Guardian who was in attendance to present the six monthly FTSU Report to the Board for Q1 & Q2 2022-23. The report provided an update on the overview of the cases, national and regional updates and the proactive work undertaken by the Freedom to Speak Up Guardian during the period. The Board noted that this report had been received and discussed at the Great place to Work Committee held on 5 October.

15.2 It was noted that 19 cases were raised in Q1 and 20 in Q2, a slight increase on the first two quarters of 2021-22 of 33. A total of 54 cases were raised to the Freedom to Speak Up Guardian in 2021-22. In 2020-21 120 cases were raised through the Freedom to Speak Up route, compared to 60 in 2019-20.

15.3 Since the last report the National Guardian's Office (7 July 2022) published the latest national annual speaking up data, which summarises the themes and learning from the speaking up data shared by Freedom to Speak Up Guardians. A positive speaking up culture is reflected nationally in the People Plan and People Promise, and locally in our strategic commitments to High Quality Care and being a Great Place to Work. It is a core component in our health and wellbeing offer, in our 'Strong Voice' commitment to colleagues, and this was reflected in our recent CQC inspection. Positive feedback was received from the CQC, as follows:

"Staff felt able to raise concerns without fear of retribution. Work had taken place within the Trust to address concerns raised, to ensure that staff felt comfortable to speak up. We saw evidence of how the Trust had responded to concerns in one of the hospitals and had put an action plan in place to address these. The learning from this was disseminated to ensure this was embedded across the trust and address any potential cultural issues within the Trust.'

'Staff knew how to use the Freedom to Speak Up process and about the role of the Freedom to Speak Up Guardian. The Freedom to Speak Up work in the Trust was not just focused on raising concerns but was also focused on cultural changes within the Trust.'

15.4 A Board Development Session had taken place on 1 November focused on Speaking Up. Sonia Pearcey was joined by Tania Hamilton our Equality, Diversity and Inclusion Lead and Neelam Mehay, Senior Manager at NHS England. The session covered: How to be an effective Ally for Freedom to Speak Up reflecting on data, speaking up and our own behaviours. There was also a call to action for our Trust Board.

15.5 October was National Freedom to Speak Up Month and as an organisation with colleagues we celebrated our fifth annual Speak Up Month, raising awareness of Freedom to Speak Up and the impact it can bring for patient safety, inclusion and our own wellbeing. The theme was 'Freedom to Speak Up for Everyone' with each week having a specific focus – to Speak Up for Safety, Civility and Inclusion. Throughout the month we highlighted the impact of a positive speaking up culture on the safety of people who use and work in our services.

15.6 The Board noted this report and noted that Freedom to Speak Up processes are in place and continue to be utilised by colleagues.

16. CHANGES TO THE TRUST CONSTITUTION

16.1 The purpose of this report was to present the Board with the proposed revisions to the Trust Constitution for approval.

16.2 The Trust Constitution was last reviewed and approved by the Trust Board and Council of Governors in May 2021. Since that time, a full review has been carried out and the Trust has worked closely with its solicitors to ensure that all aspects of the Constitution are up to date and accurate.

16.3 In the main, the Constitution has been updated to strengthen certain areas such as disqualifications, and to ensure that gender neutral language is used throughout. On the advice of the solicitors, certain procedural sections have also been moved out into the Standing Orders for either the Trust Board or Council of Governors.

16.4 There were some areas of the Constitution where a more significant change had been proposed and it was noted that these had previously been discussed and supported by the

Trust's Executive Team and the Governors' Nominations and Remuneration Committee. The key changes related to:

- Additional restrictions on Membership (Section 8)
- Clarification on the tenure of Appointed Governors (Section 12 and Annex 3)
- NED and Chair Terms of Appointment (Section 28)

16.5 It was noted that the Constitution would undergo a further review in early 2023 once the new NHS Code of Governance comes into effect, to ensure that it remains compliant and in line with good practice.

16.6 The Board approved the changes to the Trust Constitution. It was noted that the Council of Governors would also receive this report for consideration and approval at its meeting on 1 December 2022.

17. USE OF THE TRUST SEAL

17.1 The Trust's Standing Orders require that the use of the Trust's Seal, be reported to the Trust Board at regular intervals. The common Seal of the Trust is primarily used to seal legal documents such as transfers of land and lease agreements.

17.2 Since the last report to the Board in May 2022, the seal had been used four times during the period 1st April 2022 – 31 September 2022 (Q1 and Q2 2022/23). The Board noted this report.

18. BOARD COMMITTEE SUMMARY REPORTS

18.1 **Great Place to Work Committee**
The Board received and noted the summary report from the Great Place to Work Committee meeting held on 5 October 2022.

18.2 **Working Together Advisory Group**
The Board received and noted the summary report from the Working Together Advisory Group meeting held on 12 October 2022.

18.3 **Mental Health Legislation Scrutiny Committee**
The Board received and noted the summary report from the MHLS Committee meeting held on 19 October 2022.

18.4 **Resources Committee**
The Board received and noted the summary report from the Resources Committee meeting held on 25 October 2022.

18.5 **Quality Committee**
The Board received and noted the summary report from the Quality Committee meeting held on 3 November 2022. Jan Marriott advised that the Committee had received a fantastic presentation from colleagues in the Lymphoedema Services. Good robust discussions and challenge had also taken place around the CQC Action plan, specifically related to Charlton Lane.

18.6 **Appointments and Terms of Service Committee (ATOS)**
The Board received and noted the summary report from the ATOS Committee meeting held on 9 November 2022.

18.7 **Audit & Assurance Committee**
The Board received and noted the summary report from the Audit and Assurance Committee meeting held on 10 November 2022.

The Committee had received the terms of reference which had been reviewed and minor amendments were endorsed. These were presented in full to the Board and subsequently approved.

18.8 **Forest of Dean Assurance Committee**
The Board received and noted the summary report from the FoD Assurance Committee. A report was circulated to members of the Committee providing an update on progress with the new Forest Community Hospital development.

19. ANY OTHER BUSINESS

19.1 Amjad Uppal provided a verbal update to the Board regarding an optional NHSE extension to the adoption deadline with the new LFPSE (Patient safety incident reporting system). The Patient Safety Team would seek to connect with LFPSE by the new deadline of 30 September 2023. This extension balances the need for providers to take receipt of, test, refine and customise new local risk management system (LRMS) products, without pushing the timeframe into next year's winter. The Trust would still be required to have adopted a test system by the original deadline and deployed a full transition within six months of that date. The Board noted this update and supported the decision to take advantage of the extension.

20. DATE OF NEXT MEETING

20.1 The next meeting would take place on Thursday, 26 January 2023.

Signed: **……..…..** **Dated:** **……**
Ingrid Barker (Chair)
Gloucestershire Health and Care NHS Foundation Trust

TRUST BOARD PUBLIC SESSION: Matters Arising and Action Log – 26 January 2023

- 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.

Meeting Date	Item No.	Action Description	Assigned to	Target Completion Date	Progress Update	Status
29 Sept 2022	9.6	Following consideration of the LeDeR Annual Report, the issue of support available for people with a mild learning disability to be raised at ICS level as a system approach to this was required. Paul Roberts offered to raise this at a future ICS Board meeting	Paul Roberts	Nov 2022	**Complete**. Item raised at ICB Board meeting on 30 November 2022 and meeting being arranged to discuss further.	
24 Nov 2022	7.5	Clinical Systems training team to be asked to carry out a review of the methods and effectiveness of the training provided for new starters on clinical systems such as SystmOne.	Sandra Betney	Jan 2023	**Complete**.	

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 07/0123

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26th JANUARY 2023**

PRESENTED BY: Ingrid Barker, Chair

AUTHOR: Ingrid Barker, Chair

SUBJECT: **REPORT FROM THE CHAIR**

If this report cannot be discussed at a public Board meeting, please explain why.	N/A

This report is provided for:
Decision ☐ Endorsement ☐ Assurance ☑ Information ☑

The purpose of this report is to
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 and decisions required

The Board is asked to:

- **Note** the report and the assurance provided.

Executive summary

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

- Board developments – including updates on Non-Executive Directors
- Governor activities – including updates on Governors
- Working with our system partners
- Working with our colleagues
- National and regional meetings attended and any significant issues highlighted

Risks associated with meeting the Trust's values
None.

Corporate considerations	
Quality Implications	None identified
Resource Implications	None identified
Equality Implications	None identified

Where has this issue been discussed before?
This is a regular update report for the Trust Board.

Appendices:	**Appendix 1** Non-Executive Director – Summary of Activity – November and December 2022

Report authorised by:	Title:
Ingrid Barker	Chair

REPORT FROM THE CHAIR

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 developments
- Governor activities
- Working with our system partners
- Working with our colleagues
- National and regional meetings attended and any significant issues highlighted

2. BOARD UPDATES

2.1 Non-Executive Director (NED) Update:

- The Non-Executive Directors and I continue to meet regularly as a group, and meetings took place on 18th December and 18th January. NED meetings are helpful check in sessions as well as enabling us to consider future plans and reflect on any changes we need to put in place to support the Executive and to continuously improve the way we operate. At our January meeting, we received an important update from Andy Telford on the Community Mental Health Transformation Programme.

- We recently concluded the recruitment process for our **new Associate NED** with community partnership/third sector and voluntary sector experience and expertise. As part of the interview day on 17 January, two discussion groups were held, one with board members and another comprising experts by experience and governor colleagues. I hope to be in a position to provide a further update at the board meeting.

- I continue to have regular meetings with the **Vice-Chair and Senior Independent Director**, along with individual 1:1s with all Non-Executive Directors.

2.2 Trust Board Meetings:

<u>Board Development:</u>

- We continue to devote significant time to our Board Development Programme and how we ensure that transformation remains central to the way we work, whilst the necessary focus is maintained on ensuring high quality care and colleagues' wellbeing. As reported at the November Trust Board, we are currently designing the next phase of our Board development programme and the Head of Governance and I are meeting with a number of potential partners to discuss this. An update on progress will be provided in due course.

- A seminar on **High Quality Care** took place on 14th December. This informative session was led by John Trevains, Director of Nursing, Therapies and Quality. We were also joined by Neil Cleaver, Deputy Clinical Quality Director NHSE South and Jane Cummings, Non-Executive Director and Chair of the Quality Committee at Gloucestershire ICB who provided helpful insights into the NHSE perspective on quality oversight in the new ICS world and approaches for local quality oversight in Gloucestershire as a new ICB respectively. Breakout sessions allowed time for the Board to explore how it seeks/receives assurance on the quality of services provided by the Trust and identify areas for future development.

- On 10th January we met for a Board development session focussing on **System Working**. This session, facilitated by Tim Loveridge and Sue Hillyard from the Value Circle was a follow up to the recommendations arising from our recent independent Well Led Review and allowed us time to explore our relationships and priorities as a system partner. We were pleased that Douglas Blair (CEO designate) and Lorraine Dixon (Honorary Associate NED) could join us for this important session.

- I attended the virtual **Research… Be Part of the Discovery** event on 30th November hosted by the GHC research team. The aim of the event was to inspire colleagues within the Trust to participate in research and to celebrate some of the recent research developments. I was particularly interested in the projects the Research Team have been working on which ranged from commercially sponsored drug studies to local service evaluations.

3. GOVERNOR UPDATES

- I had an introductory meeting with **Alison Hartless** on 3rd January. Ali joined the Council in December as a Staff Governor representing Management and Administration staff.

- I am pleased to report that **Jacob Arnold**, (Public Governor – Forest of Dean) has been appointed as **Deputy Lead Governor.** In addition to deputising for the Lead Governor, Chris Witham, Jacob's role will include a particular focus on our membership engagement agenda.

- I continue to meet on a regular basis with the **Lead Governor Chris Witham,** and we met on 15th December along with Trust Secretary / Head of Corporate Governance, Lavinia Rowsell, and Assistant Trust Secretary, Anna Hilditch, to discuss agenda planning for the Council of Governors development session on 18th January and matters relating to our Council of Governors.

- Our programme of visits for Trust Governors recommenced on 1st December with a visit to the Dilke Hospital. These visits offer Governors the opportunity to see our sites, speak to colleagues and to get a better understanding of the services that we provide. Non-Executive colleagues accompany Governors

at each of the visits. A schedule of future visits is in development, with one visit to be scheduled each month.

- A Council of Governors meeting took place on 1st December where the Council received a holding account presentation from Non-Executive Director Jan Marriott in her capacity as Chair of the Quality Committee and Working Together Advisory Group (WTAG). The Council also received an informative presentation from Dawn Allen, Service Director on the Community Assessment and Treatment Unit (CATU).

- A reconvened meeting of the Nominations and Remuneration Committee took place on 13th December.

- On 18th January we held a face to face Governor Development session at Churchdown Community Centre. This session focussed on Membership and Engagement and was facilitated by colleagues from NHS Providers. This was a fantastic opportunity to take a fresh look at our Membership and Engagement Strategy and to agree those areas we would wish to prioritise over the coming year. Our Governors' Membership and Engagement Committee will be meeting in February to follow up the discussions that took place. This event was also an opportunity for our Governors and Non-Executive Directors to get together over lunch.

4. NATIONAL AND REGIONAL MEETINGS

Since the last meeting of the Trust Board in November, I have attended the following national meetings and visits:

- **NHS Confederation Mental Health Chairs' Network** – Unfortunately, due to diary constraints, I was unable to attend the network meeting which took place on the 1st December however, Steve Brittan attended on my behalf. Claire Murdoch, NHS England's National Mental Health Director and Chief Executive of the Central and North West London NHS Foundation Trust provided an update on investment, capital and quality along with her insights regarding recent national health issues and reflections on the ICB. Patricia Hewitt, Chair of NHS Norfolk and Waveney Integrated Care Board (ICB) also joined the meeting to discuss her review into the oversights of the ICSs to reduce disparities and improve health across the country.

  At the meeting held on 12th January, we were joined by Kevin Lockyer, Chair of Lincolnshire Partnership NHS Foundation Trust who spoke of his previous experiences in the public sector criminal justice system as a prison governor.

5. WORKING WITH OUR PARTNERS

I have continued my regular meetings with key stakeholders and partners where views on the working of the health and care system and the way we can mutually support each other are key issues for consideration. Highlights are as follows:

- Along with the Chief Executive and Director of Strategy and Partnerships, I attended a meeting of the County Council's **Health Overview and Scrutiny Committee** on 6th December. This meeting primarily focused on recent developments in NHS Dentistry in Gloucestershire. Angela Potter, Director of Strategy and Partnership and colleagues from the ICB provided an overview of mental health services in the county provide by the Trust and more detailed information specific services including Crisis Care, Eating Disorders and the Community Mental Health Transformation Programme.

- **Meetings of the Integrated Care Board** were held on 30th November and 25th January where a number of important operational and strategic issues were discussed. Graham Russell, Vice Chair and I were in attendance. An Extraordinary **Confidential ICB Board meeting** also took place on 21st December. Further detail of these meetings is provided in the CEO's report.

- **ICB Board Development Sessions** take place on a bi-monthly basis and the Chief Executive, Graham Russell and I attended on **21st December**.

- As you will see from the NEDs activity report, they continue to represent the Trust on a variety of **ICB Committees** including; the Audit Committee, System Resources Committee and System Quality Committee.

- A meeting of the **ICB NED and Lay Member Network** took place on 15th December.

- The **Chair of the Gloucestershire Hospitals NHSFT**, **Deborah Evans**, and I continue to meet on a regular basis to discuss matters of mutual interest. To deepen our understanding of our Trusts' work together, Deborah Evans, Dame Gill Morgan and I undertook a **joint Chairs' visit** on 1st December. Our visit focussed on patient flow and included a very interesting visit to several wards in Gloucestershire Royal Hospital where I had the pleasure of meeting patients. This was followed by a visit to Cirencester Community Hospital where we met and received briefings from Iain Cockley-Adams, Deputy Service Director of Adult Community Physical Health in the Home First Team and Dawn Allen, Service Director for Physical Health Urgent Care and In-Patient. I would like to formally thank Iain and Dawn for taking time out of their busy schedule in order to facilitate the visit.

  On 13th December Deborah Evans and I visited the **Stroke Ward** at **Cheltenham General Hospital.** My thanks to Professor Mark Pietroni and Dr Kate Hellier for facilitating the visit and providing an overview of the important work undertaken.

  On 4th January, at the invitation of Professor Sarah Scott, Jane Cummings, NED for the ICB and myself visited **Gloucestershire County Council Adult Social Care Services**. The visit was very illuminating and gave us a real insight into the real pressures experienced by our Adult Social Care colleagues. My

personal thanks go to Sarah Scott and colleagues for being so generous with their time.

The visits undertaken to date have given a real insight and understanding of services and further joint visits will take place later in the year.

- On **7th December**, I was invited by **Gloucestershire Hospitals NHSFT** to join the formal interview panel for Non-Executive Director recruitment.

- **Professor Chris Whitty** will visit Gloucestershire today, 26th January and will be take part in events at Gloucester Cathedral honouring Edward Jenner's legacy. The date of Professor Whitty's visit coincides with 200 years since Edward Jenner's death. Professor Whitty will also provide a lecture on Jenner's legacy. The Chief Executive and I were honoured and delighted to be invited to attend the event.

6. WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

- I was delighted to be invited by the **Chairman of the Forest of Dean District Council** to their **Carol Concert** at St Stephen's Church in Cinderford on 6th December. It was very moving to hear Pillowell Silver Band and the local choir of Ukrainians signing their national anthem.

- Annual meetings with the County's MPs continue and the Chief Executive and I met virtually with:

  Alex Chalk, MP for Cheltenham, on 2nd December
  Sir Geoffrey Clifton-Brown, MP for Cotswolds, on 14th December

  A meeting will **Laurence Robertson, MP for Tewkesbury**, will take place on 3rd March 2023 and a meeting with **Mark Harper, MP for the Forest of Dean** is in the process of being scheduled.

- I had the pleasure of meeting with **Roger Deeks, Vice Lord-Lieutenant of Gloucestershire** on 11th January. It was an opportunity for Roger and I to discuss the Royal visit which is taking place on 13th January and informally discuss other matters of mutual interest.

- On 13th January, we were delighted and honoured to welcome **HRH Princess Royal** to the official opening of the Trust's Montpellier Therapeutic Allotment.

  The allotment site provides service users with a supportive and productive environment in which to; establishment and development roles and routines, maintain skills and develop new ones! It is a safe, supportive, inclusive environment in which service users can collaboratively work alongside therapy colleagues, and provides users with an opportunity to explore interests and engage in meaningful occupation. The site also provides an invaluable

educational facility, and helps to equip service users with the skills to begin their reintegration back into the wider community.

HRH Princess Royal was received by Roger Deeks, Vice Lord-Lieutenant of Gloucestershire. I had the pleasure of attending alongside board colleagues Sandra Betney and Graham Russell. Also in attendance were, Richard Graham MP, Odeth Richardson, Chair, Royal College of Occupational Therapists, and Trust colleagues including Victoria Woodruff, Senior Occupational Therapist and Engagement, Activity and Physical Health Team Leader who has led the development of the site and been integral in organising the visit. Many congratulations to Victoria and the team for creating such an inspiring therapeutic space.

7. ENGAGING WITH OUR TRUST COLLEAGUES

- I meet with Douglas Blair, Trust Chief Executive designate on a regular basis. The meetings are an opportunity for Douglas and I to discuss Trust business and preparations for Douglas' arrival in April.

- I am **informally visiting** the Trust's services across the county and had an informative visit to the **Eating Disorders Team** at Brownhill Centre where I met with James Lewis-Watkins, Eating Disorders Service Manager, Derek Hammond, Service Director and Sam Clark-Stone, Lead Clinician and Trust colleagues on 6th December.

- On Tuesday 20th December, I visited Gloucester Royal Hospital and the Dilke Community Hospital to speak with colleagues on the picket lines. I also visited colleagues who had chosen not to strike. The decision whether or not to strike was, I'm sure, a very difficult decision to make and would have been taken with sincerity and integrity. Along with checking on their health and wellbeing, it was also an opportunity for me ensure that colleagues feel supported in their decision

- I continue to attend the Trust's Committees on a rotational basis and I regularly attend the **Working Together Advisory Group**. I attended the **Great Place to Work Committee** on 8th December and Working Together Advisory Group on 11th January.

- Given the extremity of system pressures, I was very grateful to Holly Smith, **Integrated Patient Flow Clinical Lead** for taking time out of her busy day to meet with me in order for me to gain a greater understanding of system pressures facing the Trust as we move into 2023.

- I met with **Sonia Pearcey, Trust Ambassador for Cultural Change/Freedom to Speak Up Guardian** on 17th January. Sonia and I discussed The Guardian Service.

- On 20th December, I met with colleagues from the **OD, Learning & Development Team** where we discussed the development of a survey on the Trust's values to be undertaken with the support of University of Gloucestershire Business School colleagues.

- I joined the **Senior Leadership Network Meeting** on 24th January.

- As part of my regular activities, I continue to have a range of virtual **1:1 meetings with Executive colleagues**, including a weekly meeting with the Chief Executive and regular meetings with the Trust Secretary/Head of Corporate Governance.

As always, I continue to try to make myself available to support colleagues and recognise their endeavours.

I recorded a Vlog for colleagues following the last Board meeting which highlighted issues discussed and key decisions.

I also have an active presence on social media to fly the GHC flag and highlight great work across the county.

8. NED ACTIVITY

The Non-Executive Directors continue to be very active, attending meetings in person and virtually across the Trust and where possible visiting services.

See **Appendix 1** for the summary of the Non-Executive Directors activity for November and December 2022.

9. CONCLUSION AND RECOMMENDATIONS

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

Appendix 1

Non-Executive Director – Summary of Activity – 1st November – 30th December 2022

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Dr Stephen Alvis	1:1 with Chair CEO Board Focus Group Extraordinary Council of Governors Meeting Bite-Sized Briefing NEDs Meeting Industrial Action Drop-In Session with Ali Koeltgen NEDs Meeting ICS NED Network Meeting	GGI Webinar GGI Webinar	Board Seminar – speaking Up Quality Committee Board – Public Board – Private Board Development Session: High Quality Care Resources Committee
Steve Brittan	Private Meeting ahead of Audit & Assurance Committee ICB Resources Committee CEO Board Focus Group Extraordinary Council of Governors Meeting Introduction meeting with Nicola de Iongh NEDs Meeting Intensive Outreach Team Quality Visit Catch up with James Powell 1:1 with Chair Energy Crisis Consideration Meeting Resources Committee Agenda Planning Mental Health Chairs Weekly Conference Call GHC Council of Governors Meeting NEDs Meeting NED Informal Meeting ICS NED Network Meeting	Meeting with prospective CEO candidate	Board Seminar – speaking Up ATOS Committee Audit and Assurance Committee Resources Committee Board – Public Board – Private Board Development Session: High Quality Care Resources Committee
Marcia Gallagher	Quarterly Staff Governor Meeting Extraordinary Council of Governors Meeting Meeting with Chair and Vice Chair	Forest of Dean Health Forum	Board Seminar – speaking Up Quality Committee ATOS

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	Director of HR CEO interview panel pre-meet CEO Interviews Chair/Vice Chair Meeting Chair and NEDs Meeting 1:1 with Chair Senior Leadership Network ICB Audit Committee Visit to Dilke Hospital with Governors Women's Leadership Forum Forest Heath Forum Meeting with Director of HR and OD Winter Bug Briefing by Director of NTQ Chair and NEDs Meeting NEDs and Lay Members Meeting		Audit and Assurance Committee Board – Public Board – Private Great Place to Work Committee Nom and Rem Committee Charitable Funds Committee
Sumita Hutchison	Meeting with CEO Candidate CEO Focus Group Quarterly Staff Governor Meeting 1:1 with Director of HR & OD 1:1 with Chair NEDs Meeting Podiatry Quality Visit GHC Council of Governors Meeting NEDs Meeting NED Informal Meeting Strep A Briefing with DoNTQ Diversity Network Meeting	NHSP Annual Conference NHSP Module 1: The Chair's role in developing an effective Unitary Board Meeting with Will Mansell, The Grace Network	Board Seminar – Speaking Up ATOS Audit and Assurance Committee Board – Public Board – Private Charitable Funds Committee Great Place to Work Committee Board Development Session: High Quality Care Charitable Funds Committee
Jan Marriott	1:1 with Director of DoNTQ Staff Governor Meeting Induction meeting with Lorraine Dixon, NED Quality Assurance Group Meeting Meeting with DoNTQ/Governance Cirencester Hospital Quality Visit CEO Interviews	Treasure Seekers Christmas Pantomime	Board Seminar – Speaking Up Quality Committee ATOS Audit and Assurance Committee Board – Public Board – Private

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	Research Event Meeting with CEO Candidate Meeting with Know your Patch, Cheltenham GHC Council of Governors Meeting NEDs Meeting ICS NED Network Meeting		Board Development Session: High Quality Care System Quality Committee
Graham Russell	Director of HR CEO interview panel pre-meet CEO Interview Pre-Meet CEO Interview Panel ICB Board Development Day NEDs Meeting Joint meeting with Chair and Marcia Gallagher Joint meeting with Chair and Marcia Gallagher 1:1 with DoHR&OD 1:1 with Nicola de Iongh Research Event Presentation ICB Board Pre-Meet Visits with Allied Health Professionals NEDs Meeting Quality Visit to Greyfriars PICU Associate NED Shortlisting ICB Neighbourhood Steering Group 1:1 with Chair ICB Board Development SW & SE Regional Roadshow		Board Seminar – Speaking Up Nom and Rem Committee ATOS Audit and Assurance Committee Council of Governors Board – Public Board – Private ICB Audit Committee Council of Governors Great Place to Work Committee Nom and Rem Committee Board Development Session: High Quality Care
Nicola de Iongh	Extraordinary Council of Governors NEDs Meeting Introduction meeting with DoS&P Introduction meeting with DoHR&OD Introduction meeting with Jan Marriott Visit to Wotton Lawn and Tewkesbury Hospital with DoNTQ Introduction meeting with Steve Brittan	NHSP Race Equality Deep Dive	ATOS Council of Governors Meeting

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	Introduction meeting with Graham Russell Service Development meeting with Julie Mackie Introduction meeting with Sandra Betney NEDs Meeting		

AGENDA ITEM: 08/0123

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 January 2023**

PRESENTED BY: Chief Executive Officer and Executive Team

AUTHOR: Paul Roberts, Chief Executive Officer

SUBJECT: **REPORT FROM THE CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM**

If this report cannot be discussed at a public Board meeting, please explain why.	

This report is provided for:

Decision ☐ Endorsement ☐ Assurance ☒ Information ☒

The purpose of this report is to

Update the Board on significant Trust issues not covered elsewhere as well as on my activities and those of the Executive Team.

Recommendations and decisions required

The Board is asked to note the report.

Executive Summary

The report summarises the work led by or participated in by the Chief Executive (CEO) since the last Board meeting. In doing so it demonstrates the wide-ranging involvement and activity of the Trust and leadership team inside and outside the organisation. As an Executive Team we remain focused on managing the impact of continuing service pressures across all services and the Gloucestershire system and on recovery of services from the impact of the pandemic. In the context of these operational pressures, we prioritise meeting the needs of our service users, supporting colleagues, and achieving the aims set out in our Trust Strategy. Since the last Board meeting industrial action has provided an additional operational challenge for the team.

The report focuses on joint work, within Gloucestershire, the South-West region and more widely, to ensure we work closely with others to join-up care, share resources and learn from each other.

As well as updates on the activity and focus of the CEO, this report provides an update on several trust developments such as winter illnesses, system pressures, restructure of the operations directorate and relocation of Stroud teams.

Risks associated with meeting the Trust's values
None identified.

Corporate considerations	
Quality Implications	Any implications are referenced in the report
Resource Implications	Any implications are referenced in the report
Equality Implications	None identified

Where has this issue been discussed before?

Appendices:	One Gloucestershire - Joint Forward Approach

Report authorised by: Paul Roberts	**Title:** Chief Executive Officer

CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM REPORT

1.0 CHIEF EXECUTIVE CONTEXT AND ENGAGEMENT

1.1 Severe system pressure over and since the festive holiday period

The significant pressure most visibly evident in the ambulance services and acute emergency departments has been widely reported in the media. The Gloucestershire has been subject to these pressures in the same way as others across the country.

An OPEL Level 4 system-wide critical incident response plan was implemented on 30th December to help support ambulance services and acute services with physical health patient flow. Opel 4 is the highest level, declared when a hospital may be "unable to deliver comprehensive care" and patient safety could be compromised, a situation that many acute Trusts found themselves in during this period. A range of actions and measures were enacted across our Trust to put us in the best possible position to continue to deliver our services to the highest possible standard whilst also supporting the wider system pressures.

The critical incident response plan was downgraded to OPEL Level 3 on 13th January, although we are aware that services remain incredibly busy, and colleagues continue to work very hard in response.

I would like to **put on record our gratitude to colleagues** for all their hard work and support during these challenging circumstances. Staff continue to work resolutely to do everything they can to support our communities and population.

Our **system work with Newton Europe to improve urgent and emergency care** came to an end in November. Together with system colleagues, we are now exploring the securing of further external improvement support to realise the benefits of the diagnostic work undertaken by Newton Europe in this first phase. We feel that the depth, breadth, and rigour of the analysis was a great strength which give us a platform for significant redesign and transformation of a range of services in every organisation. The scale of what is required to improve the experience of both patients and staff and to realise the benefits mapped out by Newton Europe will be considerable and therefore the scale of support required is significant – I will brief the Board further as appropriate.

1.2 Strep A, Covid and Winter infections

Over the last couple of months there has been a lot of publicity about children experiencing Group A Streptococcal and Scarlet Fever. We have also seen an increase in cases of common winter illnesses such as coughs and colds, coupled with an increase in cases of flu and Covid.

Infection Prevention Control (IPC) colleagues continue to monitor the situation, including community transmission rates and hospital cases, and update IPC guidance as and when required. We continue to operate a pragmatic, risk-

assessed face mask policy and colleagues across the Trust have been reminded to:

- Continue to maintain good hand hygiene
- Continue to wear face masks where and when required, as per current guidance. Colleagues continue to be supported to wear a mask in all settings if they personally choose to do so.
- Have their Covid and flu vaccinations
- Not attend work if experiencing any symptoms of Covid-19 and perform a Lateral Flow Device test

At this time, we are not restricting visiting as the Trust recognises the benefit that seeing family, loved ones and friends can bring to patients, but we are ensuring precautions are in place to reduce the risk of spread to patients, visitors and staff.

The Trust continues to prioritise staff and patient safety and ensure we balance the need for effective policies and practises that are proactive in preventing the further spread of winter illnesses with the need to ensure that our services are accessible and that we reduce access times.

1.3 Operations Directorate new organisational arrangements

In July the Operations Directorate began the process of restructuring their department to help realise the benefits of becoming one Trust and to deliver more integrated care for the community. The process was guided by valuable conversations with colleagues across the directorate and beyond, taking feedback into consideration to help shape the new structure. **The new structure came into effect on 1st December**, with just one element coming into action in Spring 2023.

The new operations structure is largely **Pathway based** with the aim of achieving better patient experiences by enabling improved integration of physical health, learning disabilities and mental health pathways. There are now five operational directorates:

- Physical Health Urgent Care and Inpatient
- Mental Health and Learning Disabilities Inpatient and Urgent Care
- Community Services
- Children and Young People Services
- Countywide Services

The leadership of each directorate will be led by a **Service Director**, supported by a **Clinical Director** and there will also be **Heads of Quality and Professions** within the leadership structures who will either be nurses or therapists.

The team will be implementing a comprehensive Organisational Development programme to help the new structure settle, and naturally will review the effectiveness of the new structure over the coming months, testing and adjusting with experience.

1.4 Move for Some Stroud Teams

Teams from Stroud began 2023 with a move to the new £6.5m medical centre which has just opened in the town. Our Podiatry and Physiotherapy services take the top floor of the Five Valleys Medical Practice, in King Street, which opened on 1st December in a joint venture between Locking Hill Surgery and the Stroud Valleys Family Practice.

Stroud's MSK Physiotherapy and Hand Therapy team moved in from its base in Stroud General Hospital on 23rd and 24th January, while the Podiatry department moved from its current base at Beeches Green Health Centre on 25th January.

As well as a gym, reception and waiting area, the new location has 14 consulting or treatment rooms, bathrooms with showers, a staff room and storage and equipment rooms.

Our premises are part of a wider redevelopment of the former Woolworths building and surrounding area in Stroud town centre, which also includes a shopping centre and indoor market.

1.5 Internal engagement and developments

Virtual **Senior Leadership Network** (SLN) meetings took place on 29th November and 24th January. These meetings take place monthly and provide an opportunity to discuss leadership issues critical to delivering the Trust strategy and mission.

The November meeting focussed on the upcoming industrial action, with operational updates from David Noyes, Chief Operating Officer, and workforce updates from Ali Koeltgen, Deputy Director of HR, and Matt Steele, Head of Organisational Resilience. The recently appointed Duty of Candour Assurance Lead also gave a very interesting and informative presentation on Duty of Candour.

The SLN meeting on 24th January will be covered in the March Board report.

Monthly **Bite-Size** briefing sessions continue to be held as digital events and are led by an Executive or a Deputy. They are open for all Trust employees to attend and provide an opportunity for the Executive team to share the latest Trust news and information and for staff to share their thoughts, feelings, and concerns. These sessions typically cover an update on the latest Infection Prevention Control and workforce news, and other recent items of interest. The Bite-Size sessions help to ensure effective communication across the Trust and provide an opportunity for the staff voice to be heard directly by the Executive team. Executive colleagues and I held briefing sessions in December and January.

Weekly **Executive Director Meetings** continue, where collectively the Executive team oversee the day-to-day, and longer-term executive management of the Trust. These meetings are broadened on a bi-monthly basis

for the **Trust Senior Team Meetings**, which bring senior management and clinical leaders from across the Trust together to provide advice to the Executive on the direction and operational management of the Trust and provide feedback on staff experience. These regular meetings enable wider engagement in, and ownership of, key decisions affecting our organisation including priority setting, system engagement and strategic planning.

At the **Trust Senior Team Meeting** on 13th December, I provided the Chief Executive update, which included a summary of the Trust Board meeting held on 24th November. The main topic of the meeting was **localisation**, with focussed discussion led by the Operations Directorate. The team have developed a future vision plan for the localisation of our services, which shows where our current service provision sits in terms of geography, (i.e. countywide, locality, Primary Care Network etc.) and the aims for the future. The emphasis is to try wherever practical and feasible, to seek to deliver services in a localised setting. At the meeting the team shared their thinking and invited colleagues to contribute to help shape the concept further.

On 30th November the **GHC Research team** held their virtual **Research at GHC - Be Part of the Discovery event**, with the aim of inspiring colleagues across the Trust to get involved in research. The agenda included a talk on the challenges of being a first-time Principal Investigator and a range of presentations on research outcomes. The research team welcomed colleagues' views about barriers to engaging in research activities, as well as the benefits.

Corporate Inductions, held fortnightly, continue to provide an excellent opportunity for the Executive team personally to welcome new colleagues to the Trust, introduce our core values, and ensure that everyone feels included from the outset. Members of the Executive team joined the sessions throughout December and January to provide the executive overview and welcome. I led the session on 3rd January.

I attended the **Joint Negotiating and Consultative Forum** (JNCF) on 25th January (after this report was written) to provide the Chief Executive update.

I provided the Chief Executive's update at the **Non-Executive Directors meeting** on 13th December and 18th January.

There have been a number of effective and informative **Board development sessions** over the past two months:
14th December – High Quality Care
10th January – System Working

The details of these sessions are included in the Chair's report.

Sandra Betney, Deputy CEO and Director of Finance, along with the Chair, attended the official **opening of the Trust's Montpellier Therapeutic Allotment** on 13th January. We were delighted to welcome HRH Princess Royal and Richard Graham MP o the event. Further details are included in the Chair's report.

I also had an introductory meeting with **Lorraine Dixon, newly appointed Associate Non-Executive Director**.

I attended the **GHC Council of Governors meeting** on 1st December. Further details on this meeting are provided in the Chair's report.

1.6 **Mental Health Focus**

My own focus on mental health is local, regional and national to progress the mental health agenda as the wider impacts of the pandemic continue to manifest themselves and as mental health services consider how to recover services which have suffered significant impacts. Throughout these conversations and meetings, it is evident that all colleagues and partners believe in the importance of mental health services and are working hard to ensure the best possible service is given across the Trust.

I attended the monthly **South West (Regional) Mental Health CEO's** (now chaired by Dominic Hardisty, Chief Executive of Avon and Wiltshire Partnership NHS Trust). This group acts as the overarching governance summit for the regional South West NHS Provider Collaborative and provides an opportunity for CEO colleagues to raise key issues about mental health services across the region and to offer mutual support. The meeting on 16th December provided an update from NHS England and Improvement on discharge delays, workforce and dementia, and on the South West Provider Collaborative. There was a further meeting on 20th January (after this report was written).

The national NHS England **Mental Health Trusts CEO meetings**, chaired by Claire Murdoch, National Mental Health Director, and attended by Regional Leads and Senior Responsible Officers continue to take place on a monthly basis. These sessions provide useful updates on mental health, learning disabilities and autism, as well as provide a forum for Mental Health Trust Chief Executives to discuss any current national issues.

I have monthly meetings with **Programme Director for New Care Models, Anne Forbes** and **Director Commissioning (South West), NHS England and Improvement, Rachel Pearce** to discuss mental health service issues across the South West.

I chaired the **Community Mental Health Transformation (CMHT) Partnership Board** meeting on the 8th December. We took the opportunity to remind ourselves of the key deliverables from the transformation programme which include the development of a new place based community mental health multi-disciplinary service model across health and social care. The delivery model is aligned around our local primary care networks along with voluntary, community and social enterprise sector partners. It will enable improved access and responsiveness ensuring that people can access mental health care where and when they need it, without fear of being discharged with no appropriate support.

The programme will also deliver the key requirements set out within the NHS Long Term Plan which include physical health checks for people with Serious and Enduring Mental Illness (SMI) both within primary and secondary care services; employment support and the development and roll out of the Complex Emotional Needs service.

The Partnership received sight of the draft new model of care which is being co-produced with stakeholders, including primary care and experts by experience in the Forest of Dean. It showed a clear approach to delivering a service that has 'No wrong door' with the development of a Locality Partnership Team model whereby rather than services saying no to referrals a multi-agency approach is taken to ensuring the person reaches the right service for their needs without being sent back to their GP for a new referral. The team will be continuing to refine and test the model in the Forest of Dean prior to rolling it out to other localities across Gloucestershire in 23/24.

The team are also currently reviewing the programme budget expenditure within 22/23 to ensure we have a clear understanding of the funding allocations and requirements within 23/24. Aside of the Partnership Board, the transformation programme has a clear governance route through GHC with reports going on a monthly basis to the Mental Health & Learning Disability Transformation Board and then onward to the Strategic Oversight Group and Resources Committee.

I chaired a **Learning Disability (LD) summit meeting** on 25th January, which was attended by colleagues from GHC, including our Medical Lead for Learning Disabilities and senior commissioning colleagues from the Gloucestershire ICB to discuss Acute Care Pathway, as well as developing the ICB LD agenda. The LD agenda forms an extremely important part of our work and we are committed to the ongoing development of this service.

On 11th January I had a meeting with the **GHC Lead Clinician for the Eating Disorder Service**. The service is experiencing exponential growth in demand which has led to long waits for treatment and assessment. I welcomed the opportunity to meet with the clinical lead and discuss how they are coping with the unprecedented pressures.

1.7 Tackling Inequalities

I have continued to develop my work as **lead CEO for tackling inequality** for Gloucestershire. I regularly convene and attend meetings that seek to respond to and in the longer term prevent the systematic inequalities brought to light by the pandemic, as well as the long-standing inequalities which were already recognised.

I am part of the **Health Inequalities Panel** established by Gloucestershire County Council and the ICS. This is designed to provide oversight of the wider inequality agenda and in particular to provide co-ordination of the Health and Wellbeing Programme and the ICS Programme.

Our **reciprocal mentoring programme**, aimed at enhancing equality, diversity and inclusion within our Trust, has now been extended to reach out across Gloucestershire at an ICS (system wide) level. Reciprocal mentoring is where individuals from minority groups work as equal partners with senior leaders in the process of learning from each other. The aim is to build a mutually beneficial understanding and insight into the difficulties and barriers colleagues from minority groups often face.

We continue to progress the work we are doing with **Walk In My Shoes (WIMS)** a community led group providing a pathway for better communication and services between the NHS and minority ethnic communities in Gloucester. We are supporting WIMS in progressing its ambition to become an incorporated charity and attended a meeting with WIMS members and the appointed solicitors on 8th December to further this important work.

Equality, Diversity and Inclusion continues to be at the core of how we operate as a Trust and my involvement in the wider agenda helps us achieve our aims in this regard.

I have regular meetings with **Sonia Pearcey**, the Trust's **Freedom to Speak Up Guardian**. Effective speaking up arrangements help to protect patients and improve the experience of colleagues. I also regularly meet with **Dominika Lipska-Rosecka, the Partnership and Inclusion Manager for GHC**, to keep abreast of the wide range of issues facing our diverse communities in Gloucestershire and discussing ways in which the Trust can help support them.

Our Freedom to Speak Up work sits alongside **Paul's Open Door**, which is a completely confidential way for staff to contact me directly about issues they think I should be aware of or ask for a response to something they are concerned about. This is a well-used application, and I am reassured that colleagues feel able to raise issues with me directly.

1.8 ICB (Integrated Care Board) and System Partners

The Gloucestershire ICB organisation fulfils the commissioning functions for the region; it is responsible for overseeing the day-to-day running of the NHS locally and for developing a plan to meet the healthcare needs of the population. **Dame Gill Morgan is the Chair of the ICB** and **Mary Hutton is the CEO**. I am a Partner Member of the Gloucestershire ICB Board for Mental Health. Learning Disability and Autism.

I meet regularly with **Dame Gill** and **Mary Hutton,** to discuss matters arising across Gloucestershire and to keep abreast of any issues facing our partner organisations. I also meet with **Deborah Lee, Chief Executive of Gloucestershire Hospitals Trust**. Our Trust plays an important role in the Gloucestershire system with colleagues working committedly to meet the needs of our community.

ICB Public Board and **ICB Strategic Executive** meetings take place monthly, with a focus on system-wide planning and resilience. Sandra Betney and John Trevains join me as members of the ICB Strategic Executive forum. The regular

meetings, held with senior colleagues across the health system, provide updates on organisational matters and projects and help ensure joined up working by providing a forum to discuss items affecting multiple partners.

I am a voting member of the ICB and have attended the following **ICB Board meetings** over the past two months:

- ICB Public Board on 30th November. The agenda and papers for this meeting can be found here - 2022.11.30-Public-Board-papers-v2-1.pdf (nhsglos.nhs.uk)
- ICB Confidential Board on 30th November. The session included updates on Eating Disorders / Mental Health, the Integrated Care Partnership strategy. Share care records and the system financial position.
- ICB Extraordinary Confidential Board on 21st December. It was a single agenda item meeting, focussing on Contract Award Home Oxygen Service.
- ICB Board Development Day on 21st December. The session mainly focussed on programme delivery, prioritisation and resource allocation, and there were also updates on the Integrated Care Strategy, urgent and emergency care and winter preparedness.
- ICB Public Board on 25th January.
- ICB Confidential Board on 25th January.

The system Gold Health System Strategic Command, now known as the **ICS Strategic Escalation Group (SEG/Gold)**, continues to take place weekly on Wednesdays. In the past this forum proved essential in overseeing the system response to the Covid-19 pandemic and now provides a regular liaison point between senior leaders in the NHS and social care system to discuss urgent and emergency care. The call was stepped up to take place daily during the RCN industrial action period in order to support the system pressures.

One of our key system partners is **Gloucestershire County Council (GCC)** and the Executive Teams from GHC and GCC meet monthly to ensure good working relations and to promote collaborative working across the system.

On 1st December, along with John Trevains, Director of Nursing, Therapies and Quality, and Louise Moss, Head of Legal Services, I had a meeting with **Chris Spencer**, **Director of Children's Services** and **Ann James, Director of Children's Safeguarding & Care** at Gloucestershire Country Council (GCC). At the meeting we discussed several specific cases regarding children with complex needs and considered areas where GHC and GCC can work jointly to build improved understanding of our shared priorities and services.

I attended the fortnightly **SW Regional Chief Executives** meetings. These meetings are chaired by Elizabeth O'Mahony, South West Regional Director, and provide an opportunity for Chief Executives to review and discuss the current challenges facing them and also the wider strategic issues facing national health care systems.

On 20th December, I attended the **South West Chief Executives Meeting**, which focussed on the upcoming industrial action in the ambulance service. The meeting, chaired by Elizabeth O'Mahony, discussed essential actions that

had been identified to help support local planning and to help ensure the safety of staff and patients during the period of industrial action.

On 22nd December, Sandra Betney, Deputy CEO and Director of Finance, attended the **South West & South East Regional Roadshow** with Amanda Pritchard, CEO, David Sloman, Chief Operating Officer and Julian Kelly, Finance Director for NHS England, a call to discuss the upcoming Priorities and Operational Planning Guidance which was issued on 23 December.

Sandra Betney and I also attended a system meeting on 19th December to discuss **finance and planning for the system**. Chief Executives and Directors of Finance attended from GHC, Gloucestershire Hospitals Trust and the Gloucestershire ICB.

On 7th December I attended the **Quarter 2 22/23 SW Regional & National Mental Health Deep Dive meeting**. Rachel Pearce, Mental Health SRO (SW), and Claire Murdoch, National Director for MH and LDA, were in attendance. The meeting provided a performance overview and planning and data quality updates. All systems were given an opportunity to update the region on community mental health and staff hubs.

On 5th January, the **One Gloucestershire Improvement and Innovation Board** had its second meeting. Angela Potter, Director of Strategy and Partnerships attended on behalf of GHC. The aim of the programme is to nurture an improvement culture across One Gloucestershire that can drive the system's ambitious programmes for transformation. The meeting addressed system improvement capability and developing the strategic approach for the improvement community.

On 6th December, along with the Trust Chair and Director of Strategy and Partnerships, I attended the County Council's **Health Overview and Scrutiny Committee (HOSC).** Further detail on these meetings is included in the Chair's report.

I chaired the bi-monthly **Urgent and Emergency Mental Health Care Task & Finish Group** on 7th December. Membership includes colleagues from system partner organisations including ICB, Gloucestershire Hospitals Trust, Gloucestershire Constabulary, SWAST and Gloucestershire County Council. The group supports the implementation of the Long-Term Plan Targets for children and adults across local urgent care pathways. The group meets regularly to ensure that urgent and emergency mental health care is delivered in line with the NHS Long-Term Plan and is evidence-based to deliver the best health outcomes for those who use Urgent and Emergency Care for their Mental Health support. The Task and Finish group provide formal governance and oversight for reviewing the quality and performance of the local delivery of the Long-Term Plan.

There have also been a number of system meetings to discuss pertinent issues facing the region, including discussions on **Children and Adolescent Mental Health Services (CAMHS)** and **Eating Disorders** and how best to manage those patients on paediatric wards in the acute hospitals. The complexity and

acuity of need in young people has increased exponentially in the last couple of years and the system is working together to try and find solutions to address the increased demand and to improve the care delivered to our community.

I continue to attend the **Gloucestershire MP briefings**, led by CEOs of the Gloucestershire NHS organisations and senior County Council officers and Leaders which are currently taking place monthly.

The Chair and I are in the process of holding our annual meetings with MPs to discuss Trust updates, address any concerns and ensure effective cross communication. The Chair and I held meetings with **Alex Chalk MP** on 2nd December and with **Sir Geoffrey Clifton-Brown MP** on 14th December.

Additionally, on 12th December, I had a meeting with members of Siobhan Baillie MP office to discuss a particular constituent concern. Early in the new year, GHC's quality and training team are delivering a training session for MP offices to help the staff dealing with constituent concerns. The training will cover education around common Mental Health presentations, de-escalation training and sign-posting resources.

I continue to act as **Senior Responsible Officer** and chair for the **Diagnostics Programme Board**. This programme board is working on progressing the proposals for local Community Diagnostics Hubs (CDH). This project focuses on the development and coordination of networked diagnostic services which are equitable and consistent; aiming to get the right patient to the right test, in the right location, in the fewest number of visits (and referrals) and in the shortest amount of time. The aim is to maximise the limited diagnostic capacity through triage, stratification and prioritisation which is personalised and sustainable across Gloucestershire whilst seeking to invest / innovate and expand existing services so that they meet current and future demands.

Additionally, **Kerry O'Hara, Associate Director (Clinical Programme Group, NHS Gloucestershire** and I meet monthly to discuss the Diagnostics programme.

I chaired the quarterly **West of England Patient Safety Collaborative Board** meeting on 7th December. This was my last meeting as chair and Kevin McNamara, Chief Executive of Great Western Hospitals NHS FT, will chair the next meeting.

The purpose of the West of England AHSN Patient Safety Collaborative (PSC) is to ensure that patients and the public in the West of England can be confident that care is safer for patients based on a culture of openness, collaboration, continual learning and improvement. The PSC Programme Board carries out important work in influencing improvement in patient safety through a person-centred system-wide collaborative approach.

On 16th December I attended the **West of England AHSN Board meeting.**

The **Medical Staff and Dentistry Committee (MSDC)** convened on 2nd December and 6th January. I attended to provide the Chief Executive update at

the December meeting and Sandra Betney, Deputy CEO and Director of Finance attended the January meeting on my behalf. The **Local Medical Council (LMC)** convened on 12th January. Dr Amjad Uppal, Medical Director, and David Noyes, Chief Operating Officer attended the meeting. Active engagement with senior medical colleagues in the trust is an important aspect of the work of the Chief Executive and wider Executive team.

1.9 Service Visits

I continue to carry out **service visits** (in person – where this can be done safely). The time spent in these locations is always a very valuable experience providing substantial insight into colleagues' experiences within their working environment and how they address the challenges presented by the ever-changing circumstances. I value the opportunity to be able to continue to meet with colleagues and patients, and to be on hand to discuss any topics or issues they would like to raise.

On 15th December, the Royal Colleague of Nursing's (RCN) first day of industrial action, I visited **Gloucester Royal Hospital**, the **Dilke Memorial Hospital** and the **Vale Community Hospital** to speak with nursing colleagues on the picket lines and also visit the teams continuing to work on the wards and in MIIUs. On 20th December, the second day of RCN industrial action, I visited the **Lydney & District** and **Dilke Memorial hospitals**. This has been a stressful time for many colleagues and I, along with other members of the Executive team, have been at the forefront of ensuing all colleagues are supported, irrespective of their personal views on strike action, as we move through this process.

I aim to continue regular service visit as I greatly see the benefit in having these conversations with colleagues to listen, learn, and work together to help make our Trust a great place to work for all.

2.0 INDUSTRIAL ACTION

Healthcare trade unions have been balloting their members in recent months over industrial action and several announced the outcome of their ballots.

The following industrial action has already been taken:

- Royal College of Nursing (RCN) - 15th and 20th December and 18th and 19th January.
- Unison/GMB ambulance workers – 11th and 23rd January

Further dates are likely to be announced over the next few months by the RCN, Unison and GMB unions, as well as other unions as they publish the outcomes of their ballots.

The Trust has been working with national, regional and local partners to plan for this for some time. Strike action inevitably causes an impact on Trust services, however, we have tried and tested Emergency Planning and Resilience Response measures in place to manage service disruptions,

including industrial action. Our local Trust and system planning has focussed on ensuring patient / service user safety and that urgent and priority services are maintained. We have staff working on preparations for future strike action to ensure the impact on day-to-day services is minimised as much as possible. We have also worked collaboratively with the unions to agree derogations to ensure safe staffing levels are maintained where essential.

Naturally the Trust would like to see a resolution to the pay dispute as soon as possible. Ultimately pay is a matter for the Government and the trade unions nationally, not local employers and union representatives.

We value our colleagues and understand that fair pay and conditions are important, not only for our teams and our families but for wider reasons such as retention and recruitment. The Trust continues to work in partnership with local trade union colleagues to ensure patients and colleagues are supported and to promote respect and kindness as we work together to navigate the challenges ahead, irrespective of personal opinions on the industrial action.

3.0 NHS PROVIDER LICENCE CONSULTATION

In December, the Trust responded to the NHSE consultation on the future NHS Provider Licence. The licence sets out the conditions that healthcare providers must meet to help ensure that the health sector works for the benefit of patients, now and in the future. All providers that deliver healthcare services for the NHS are required to hold a licence, unless exempt.

The changes proposed aim to bring the licence up to date in order to reflect the new legislation and support providers in a move to more collaboration and system working.

Overall, the Trust supported the changes to the licence which reflected national expectations around system collaboration but highlighted concern regarding the potential cost of, and ability to comply with the revised digital and net zero obligations.

4.0 UPDATE ON AGENDA FOR CHANGE BANDING OF HEALTH CARE SUPPORT WORKERS

NHS Employers issued **guidance to all providers in August 2021, which redefined the Agenda for Change (AFC) banding attributed to health care support worker (HCSW) care**. This stipulated that HCSW roles at Band 2 primarily undertook personal care duties, for example, washing patients, whereas clinical care (i.e. taking observations), should sit within a Band 3 role.

NHS Employers then asked NHS Trusts to review HCSW job descriptions against the new clinical support worker profiles. The initial Trusts that carried out this work came across significant challenges, suggesting that the majority of their Band 2 HCSW roles needed to be upgraded to Band 3 roles.

The Trust has been engaging with its local Staff Side representatives and regional full time officers, with discussions held through the Joint Negotiating

and Consultative Committee and the Gloucestershire ICS Social Partnership Forum. It has also been progressing its local modelling, and ICS HRDs are now exploring options for a combined system wide approach. The modelling across all provider Trusts confirms considerable cost pressures, including a variety of back pay settlement proposals and related costs. No national funds are being provided to mitigate the impact of the changes.

Within the South West, a small number of early settlements have been reached, for example, at University Hospitals Bristol and Weston NHS Trust, North Bristol NHS Trust and Royal United Hospital Bath. These have been upheld by the Regional Social Partnership Forum as an agreeable way forward with full and final settlement back pay arrangements. Consultation and negotiations are taking place across all NHS provider Trusts in England to resolve the impact of the changes.

The Trust and ICS partners are currently in the process of finalising the related modelling with implementation group consisting of HR, Operations, Finance, Staff Side and NQT representatives. We will provide a further progress update to the Board in due course.

5.0 ONE GLOUCESTERSHIRE JOINT FORWARD PLAN APPROACH

One Gloucestershire has developed a Joint Forward Plan (JFP) to set out how the ICB and provider trusts intend to meet the physical and mental health needs of the population through arranging and/or providing NHS services, supported by local authority and VCSE partners over the next five years.

The JFP is attached as an annexe to this report for information purposes or comment.

6.0 CONCLUSION AND RECOMMENDATIONS

The Board is asked to **NOTE** the report.

One Gloucestershire
Transforming Care, Transforming Communities

Joint Forward Plan Approach

Gloucestershire Health & Care NHS FT Board – Jan 2023

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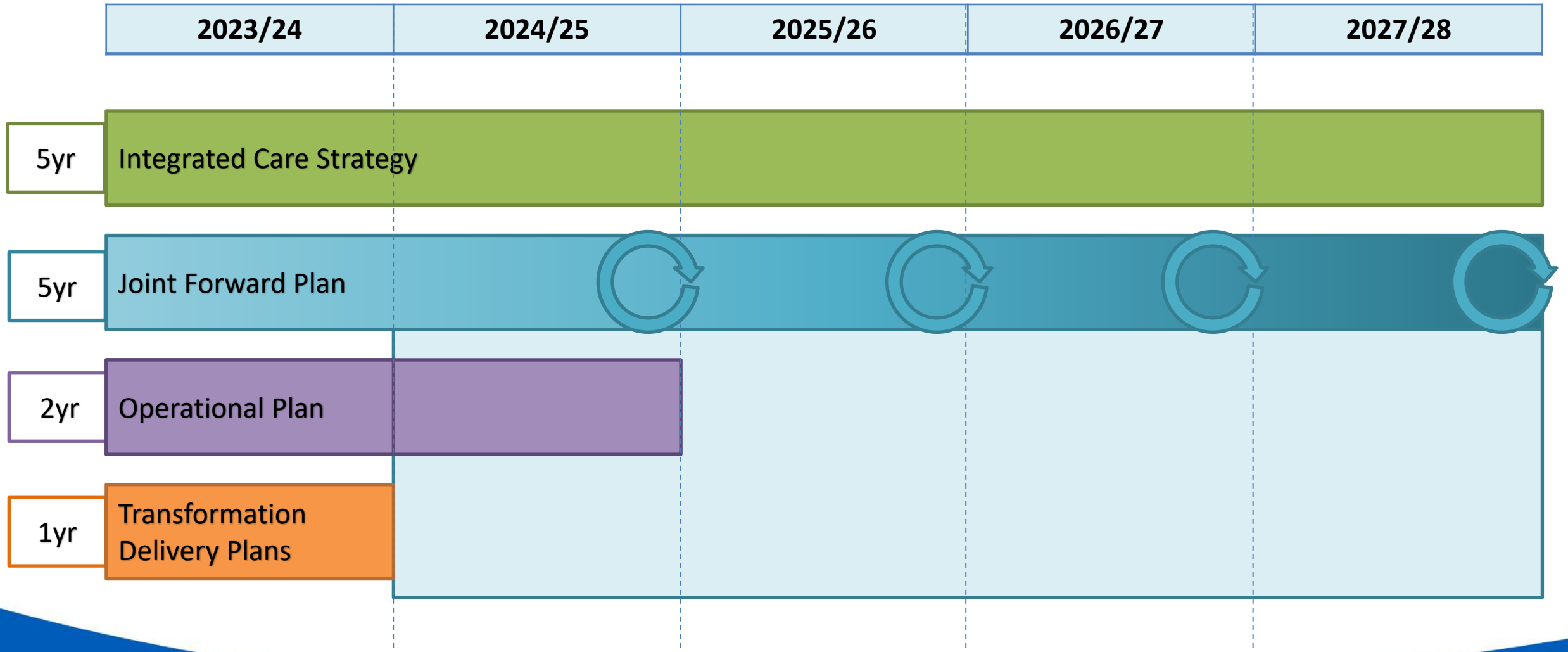
Context – the planning ask from to March 2023



Purpose of the JFP

Describe how the ICB and provider trusts intend to meet the physical and mental health needs of the population through arranging and/or providing NHS services, supported by local authority and VCSE partners

Delivery of universal NHS commitments:

1. Long Term plan
2. Annual NHS Priorities
3. Operational planning guidance

Address the four core purposes of ICS:

1. Improving outcomes in population health and healthcare
2. Tackling inequalities in outcomes, experience and access
3. Enhancing productivity and value for money
4. Helping the NHS support broader social and economic development

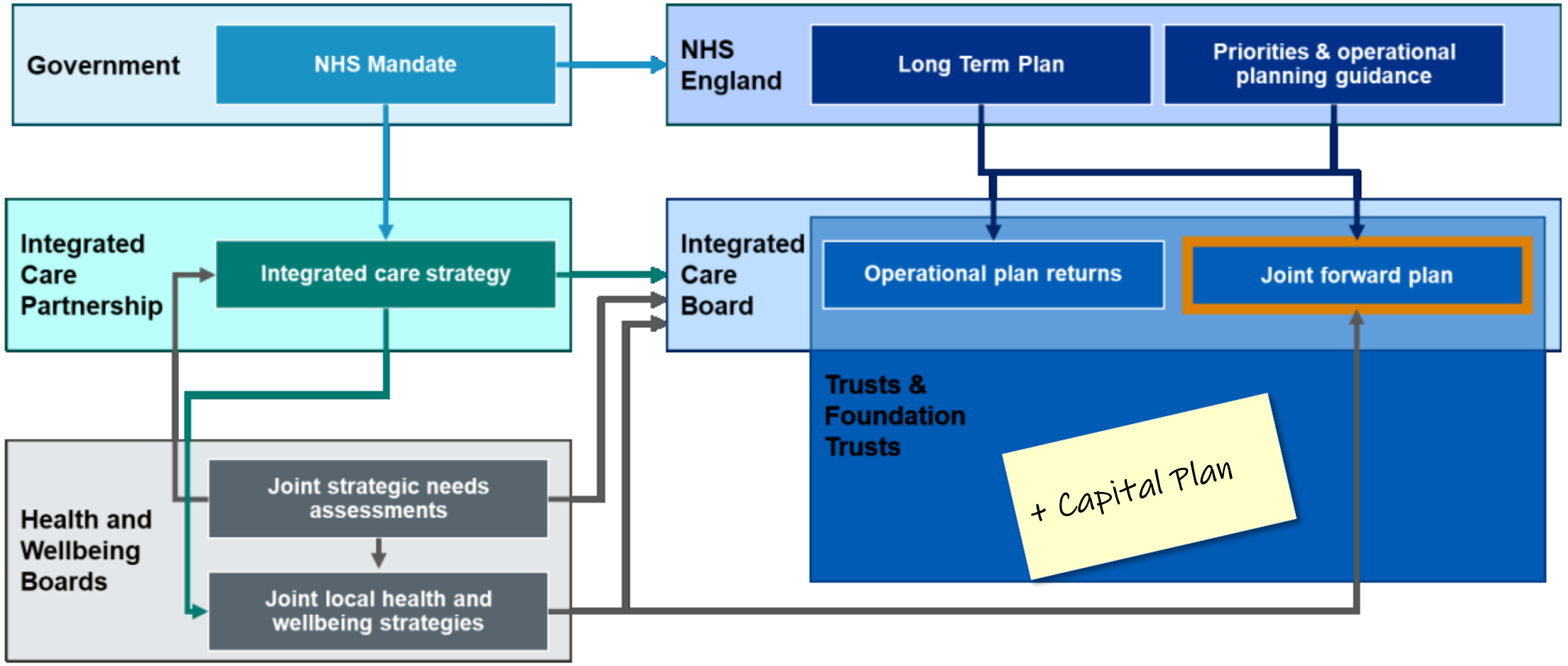
Principles

1. Fully aligned with the ambitions of the wider system partnership to meet the needs of the population as articulated in the integrated care strategy

2. Supports subsidiarity in a summarised, single, cohesive plan by building on existing local strategies and plans as well as reflecting universal NHS commitments, but does not transfer all planning activity to system level.

3. Delivery-focused, including well-defined measurable goals, trajectories and milestones aligned with the operational plans of system partners.

Legislative Framework



Approach to development

Does not need 'full formal' public consultation as building on existing plans...

1. **Engagement** (coordinated with ICP Strategy development) with primary care providers, local authority and HWB, and people & communities affected by or with significant interest in specific parts of the plan.

2. **Revision** of JFP annually before the start of each new financial year, and/or in-year if necessary.

JFP to include summary of views expressed and how they're taken into account

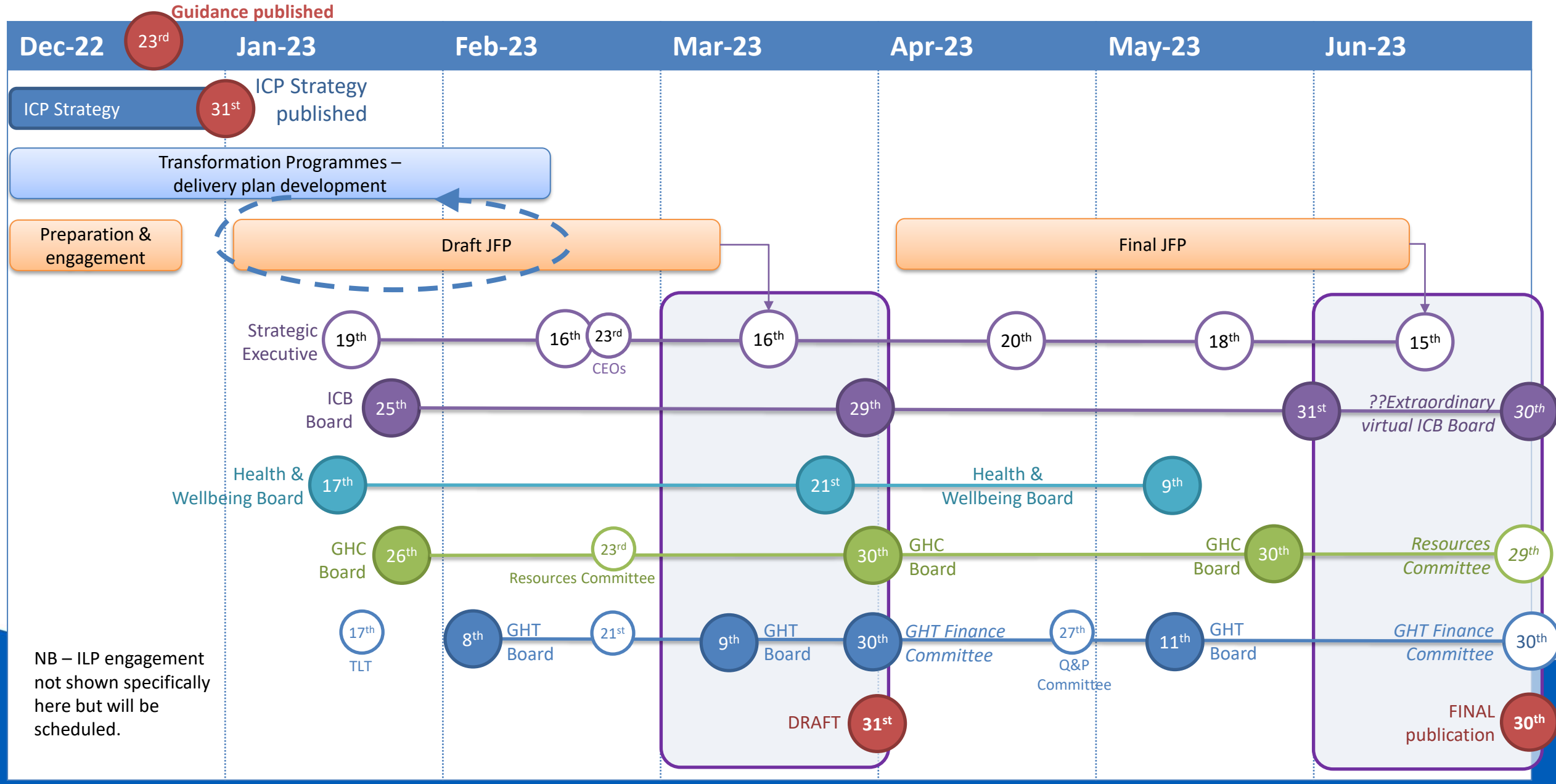
Develop ICS-wide standard approach to engagement - ⬇ duplication!

JFP sign-off timeline

Organisational Board

Organisational Committee or senior leadership team meeting

Work in progress and subject to change



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Proposed Structure – reflecting the Strategy

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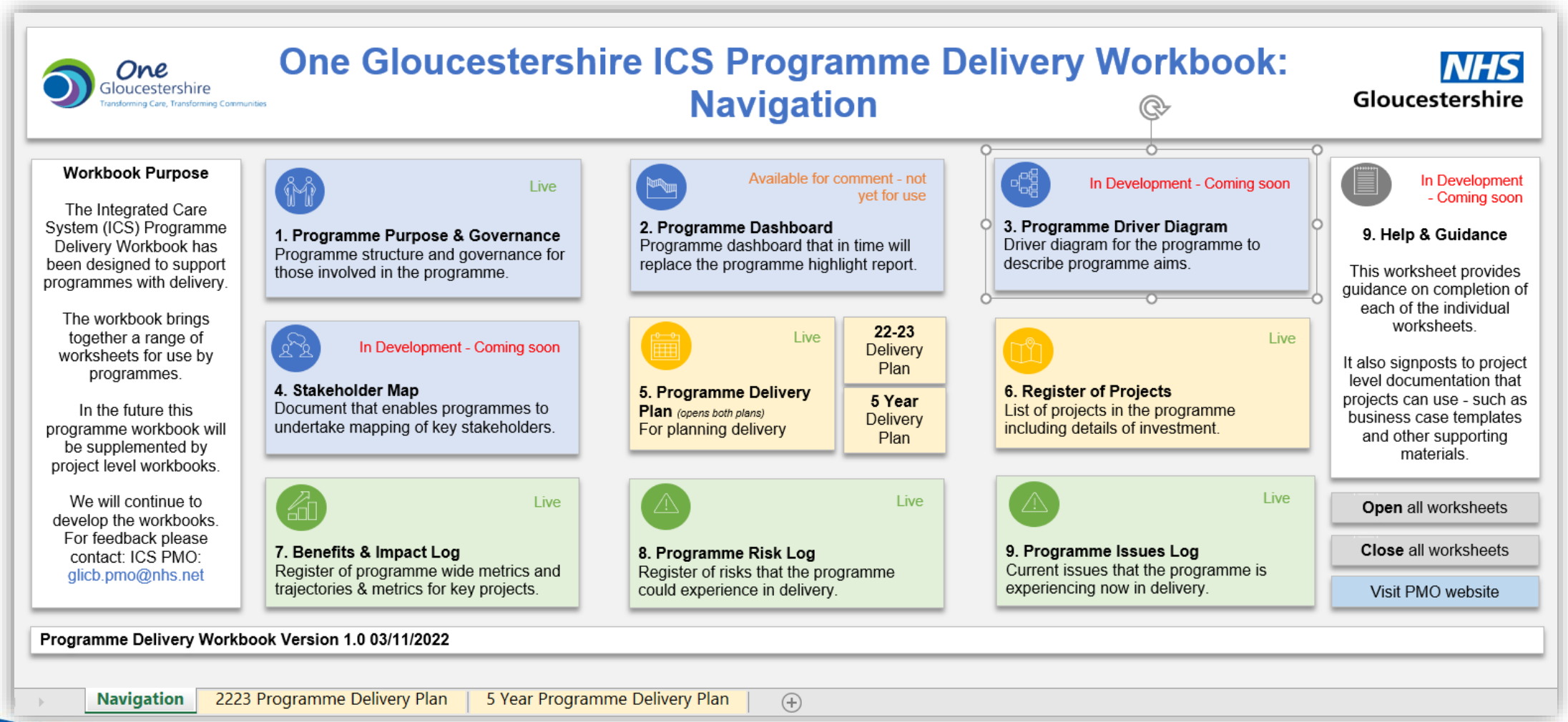
Three Overarching Pillars

Building from the ground up



Proposed structure with *estimated* number of pages

Context — 4

- Foreword
- Introduction & Purpose
- H&WB Board JFP statement
- Local Health & Care Context & Interfaces

4

- 5yr Headline & Yr 1 Priorities
- Alignment to System strategies
- Key trajectories
- *Key risks to delivery of the JFP*

Content — 36

Better Future

- *EAC-I*

Transforming

- FFTF
- Clin. Progs – Med.
- Clin. Progs – Cancer
- Meds Opt.
- Diagnostics
- LDA
- CYP
- Mat. & Neo-Natal
- Primary Care
- Ageing Well & Frailty

Improving Today

- UEC & Flow
- Planned Care/ERP
- MH - Adults
- MH - CYP

Enablers — 10

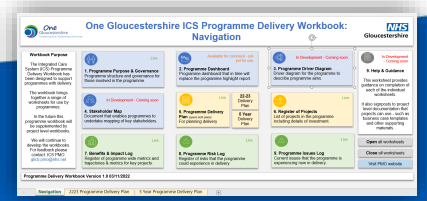
- Workforce
- Estates
- Digital & IT
- PHM
- Personalised Care

- ICS Development, QI, Innovation, Research, Evaluation & ongoing engagement — 6

50-60 pages + Appendices (incl. statutory duties matrix)

Each section to contain…

1. Purpose, SRO & Governance of programme
2. 5yr programme aims and key outcomes
3. Contribution to ICB statutory functions
4. Yr 1 & 2 programme milestones and trajectories
5. Yr 3-5 programme milestones and measures
6. How will the programme engage with people & communities?



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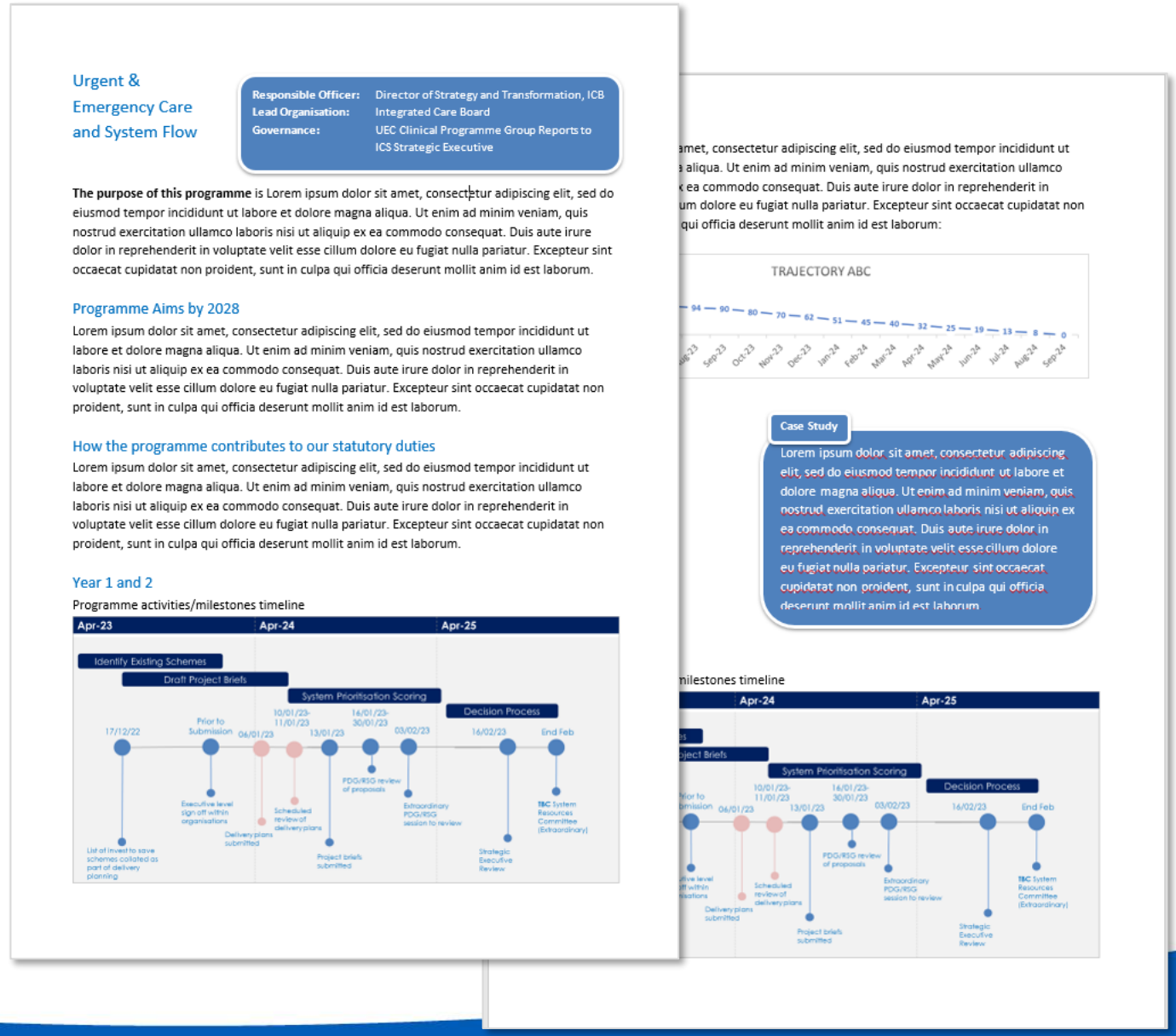
Basic mock-up example (without design or graphics)

Propose a similar approach to 2022/23 Winter Plan (though a little more detail)

Very plain language, publicly accessible

Mix of information formats – text, graphics, charts, timelines, etc.

Pop-outs e.g. Case Studies, patient/staff quotes, etc.



Urgent & Emergency Care and System Flow

Responsible Officer: Director of Strategy and Transformation, ICB
Lead Organisation: Integrated Care Board
Governance: UEC Clinical Programme Group Reports to ICS Strategic Executive

The purpose of this programme is Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua. Ut enim ad minim veniam, quis nostrud exercitation ullamco laboris nisi ut aliquip ex ea commodo consequat. Duis aute irure dolor in reprehenderit in voluptate velit esse cillum dolore eu fugiat nulla pariatur. Excepteur sint occaecat cupidatat non proident, sunt in culpa qui officia deserunt mollit anim id est laborum.

Programme Aims by 2028

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How the programme contributes to our statutory duties

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Year 1 and 2

Programme activities/milestones timeline

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Case Study

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milestones timeline

One Gloucestershire
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Legislative requirements (from Draft guidance)

Describe health services the ICB proposes to arrange to meet needs	Duty to improve quality of services	Duty to reduce inequalities	Duty to promote involvement of each patient	Workforce
Duty to enable patient choice	Duty to obtain appropriate advice	Duty to promote innovation	Duty to facilitate and promote research and use its evidence	Performance
Duty to promote education and training	Duty to promote integration	Duty to have regard to wider effect of decisions	Duty as to regard to climate change and adaptation to impacts	Digital/data
ICB involve the public in decisions about services	Addressing particular needs of children and young people	Addressing particular needs of victims of abuse	Implement joint local health and wellbeing strategy	Estates
Financial duties				Procurement/supply
				PHM
				System Dev.
				Support wider social & economic development

Additional recommended content

One Gloucestershire
Transforming Care, Transforming Communities

Legislative Requirement	Making Gloucestershire a better place for the future	Transforming what we do				Improving health and care services today
		Locality focussed approach	Tackle inequalities	Create One Workforce for One Gloucestershire	Pathway focussed change	
Describe health services the ICB proposes to arrange to meet needs						
Duty to improve quality of services						
Duty to reduce inequalities						
Duty to promote involvement of each patient						
Duty to enable patient choice						
Duty to obtain appropriate advice						
Duty to promote innovation						
Duty to facilitate and promote research and use its evidence						
Duty to promote education and training						
Duty to promote integration						
Duty to have regard to wider effect of decisions						
Duty as to regard to climate change and adaptation to impacts						
ICB involve the public in decisions about services						
Addressing particular needs of children and young people						
Addressing particular needs of victims of abuse						
Implement joint local health and wellbeing strategy						

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 January 2023**

PRESENTED BY: Angela Potter, Director of Strategy and Partnerships

AUTHOR: Angela Potter, Director of Strategy and Partnerships

SUBJECT: **INTEGRATED CARE SYSTEM UPDATE**

If this report cannot be discussed at a public Board meeting, please explain why.	

This report is provided for:
Decision ☐ Endorsement ☐ Assurance ☐ Information ☑

The purpose of this report is to
This paper provides an update on the activities that are taking place across the Gloucestershire Integrated Care System (ICS).

Recommendations and decisions required

- Trust Board is asked to **NOTE** the contents of this report.

Executive Summary

This paper provides an overview of a range of activities taking place across the Integrated Care System. This update includes:

- Meetings that have taken place including the Health Overview & Scrutiny sessions and the One Gloucestershire Health and Well-Being Partnership
- An update on Fit for the Future Phase 2 output of engagement activities.
- An update on various system partnership meetings including the six Integrated Locality Partnerships.
- An update on various engagement activities that the Trust has supported and those of other key stakeholders within the system.

Risks associated with meeting the Trust's values
No risks to report.

Corporate considerations	
Quality Implications	The Trust will make specific note of any engagement and feedback reports specific to our services and include them within future service reviews and developments
Resource Implications	None specific to the Trust
Equality Implications	The Trust is actively engaged in wider inequalities work and will build any findings into the Trust service developments moving forward

Where has this issue been discussed before?
Regular report to Trust Board.

Appendices:	

Report authorised by:	Title:
Angela Potter	Director of Strategy & Partnerships

INTEGRATED CARE SYSTEM UPDATE REPORT

INTRODUCTION

This paper provides Board Members with an overview and update on the activities that have been taking place across One Gloucestershire and wider updates where appropriate.

1.0 HEALTH OVERVIEW SCRUTINY COMMITTEE (HOSC) OF 6TH DECEMBER 2022

The Health Overview & Scrutiny Committee meeting on the 6th December received a general update from the Trust and Commissioners on the provision of mental health services. This was a general update requested following the Trust's informal meeting in November and was provided in the format of a presentation which focused on a number of service specific updates including crisis care, out of area inpatients, eating disorders, community mental health transformation and children's mental health services. This was well received by the Committee.

In addition, the Committee received an update on the provision of Dentistry from commissioning colleagues at NHS England who are responsible for the provision of primary care dentistry in Gloucestershire.

2.0 GLOUCESTERSHIRE HEALTH AND WELLBEING PARTNERSHIP (GHWP)

The GHWP are continuing to lead the development of the One Gloucestershire Health and Wellbeing Partnership Interim Integrated Care Strategy. The Trust Resources Committee received a copy of the final draft for noting at its December meeting with the final interim strategy being endorsed at its meeting on the 22nd December 2022. The final version can be accessed via the following link An Integrated Care Strategy for Gloucestershire | Get Involved In Gloucestershire (glos.nhs.uk)

The Gloucestershire Health and Well-Being Board (HWBB) has not met since the last report.

3.0 NATIONAL AND SYSTEM DEVELOPMENTS

3.1 The National Planning Guidance was released on the 23rd December 2022 and is being reviewed in line with the Trust's planning and contracting processes. The document outlines three key priority areas – recovery of core services and productivity, delivery of the key ambitions in the NHS Long Term Plan and continuing to transform the NHS for the future. The document is available through the following link PRN00021-23-24-priorities-and-operational-planning-guidance-december-2022.pdf (england.nhs.uk)

3.2 A range of system wide programme groups continue to take forward the priority action plans across the ICS. These include the Improvement Community Group; Ageing Well Programme Board and the ICS Estates Group.

Key highlights on the GHT Personalisation work include:

- development of a Best Practice Guide for colleagues to use across the Trust. We are also looking to trial the *What Matters to Me* orange folders on two wards at our mental health hospitals and with our Eating Disorders team to help us with the personalising of care plans and ensuring people have the right access to their care plans.
- clinical induction now includes a section on Personalised Care which we will evaluate and evolve as we receive feedback.
- we are looking to commence a piece of work on co-producing information and literature on Personal Health Budgets (PHB) for staff and people who use the service. This is anticipated to then develop further to ensure that our colleagues understand the PHB offer and are confident to engage with service users appropriately in this area. We are looking to trial a pilot within Wotton Lawn working with people who are preparing for discharge. Further work will be needed to understand the financial implications of PHB's in conjunction with Local Authority colleagues.

The ICS Estates Group held a workshop on the 9th December to help shape the work needed to develop the ICS Estates Strategy. A draft of this will be available for review in due course.

The Improvement Community Board also met on the 5th January 23. The team have been undertaking a system capability self-assessment to understand our levels of improvement maturity and where we need to focus our development in this area over the coming year. It was recognised that the level of resources we have focused on improvement work will be considerably stretched across 2023 taking into account the range of priorities and challenges that the system faces.

4.0 FIT FOR THE FUTURE

Engagement on Fit for the Future 2 has now concluded and the Output of Engagement Report was shared with HOSC Committee members in October 2022. It was confirmed that this meeting that Gloucestershire Hospitals NHS Foundation Trust, the ICB and NHS England had reviewed the outputs from the engagement activities and confirmed that all relevant parties had had the opportunity to participate and provide views including members of the public, all local communities, key stakeholders, voluntary and community sector partners and GP Practice Patient Participation Groups (PPG).

The Committee concluded that further public involvement would not provide additional information, such as alternatives or impacts, that could influence decision making and that the engagement undertaken to date was sufficient and therefore further public consultation was not required for Phase 2 activities. This programme will therefore continue to move to business case development and implementation where appropriate.

5.0 PARTNER UPDATES AND DEVELOPMENTS

5.1 Safeguarding Adults – Single Point of Access

In 2023 the Gloucestershire County Council (GCC) Safeguarding Adults Team will be providing a new service to professionals whereby all referrals will be screened by a

dedicated team rather than being screened through the Adult Help Desk. This dedicated team will then make the decision about appropriate next steps and provide feedback to referrers on whether the contact has been passed to the practitioners as a Safeguarding concern and provide signposting in cases where it has not. It is hoped that this will improve communication and enable a better understanding among professionals about when a safeguarding enquiry under Section 42 of the Care Act may be needed and when other routes are more appropriate

The new team is set to be launched in spring 2023 and in the run-up to this the Safeguarding Adults team will be contacting our multi agency partners to provide more information and ensure people are aware of the changes to the way contacts are handled.

5.2 Gloucestershire County Council Budget Proposals 23/24

Gloucestershire County Council has undertaken a consultation for the proposed budget for 2023/2024 which closed at the beginning of January 2023.

In the current proposals, spending for 2023/24 will reach £560 million, a rise of almost £40 million on 2022/23 levels with c£119 million committed to complete exciting infrastructure projects such as the Gloucester South-West Bypass, Arle Court Transport Hub, the flagship 26-mile cycle spine, and flood alleviation schemes like those in Nailsworth, Coleford and Pittville.

The Council is proposing committing a further £22 million into protecting the county's vulnerable children, and a further £21 million into supporting vulnerable adults and those living with a disability.

The budget proposes raising £13.4 million to help fund services through a council tax increase of 2.99%. The proposals would also see £7.3 million raised specifically to support work with the most vulnerable adults in the county through a further 2% increase in the adult social care precept.

The Council continues to challenge itself to work more effectively and as a result has identified £33 million in savings and efficiencies for next year.

6.0 INTEGRATED LOCALITY PARTNERSHIPS (ILPS) UPDATES

All ILP's continue to meet with good input and support from GHC and wider system partners. The Cost of Living crisis and the co-ordination of information across the statutory and voluntary sectors remains a key focus of activity.

All ILP's have been allocated £50k from the NHSE SW Community Investment Fund to support the health impacts of cost of living over this winter period. This funding will be used to support Community/Voluntary Community Sector organisations to provide additional, short-term positive impacts for the most disadvantaged population. ILPs are allocating the money through a host organisation to manage the distribution to ensure we minimise the burden or administrative costs and reporting ensuring maximum benefit can be achieved for our populations.

A wide range of schemes have been proposed including:

- Warm spaces including community Churches, libraries and community centres

- Warm homes/ warmth on prescription scheme expansion
- Providing food provisions
- Transportation
- MH low level support
- Extension of activity programmes to the February half term to enable families and children to have warm places to go and a meal per day

7.0 FOCUS ON PATIENT, CARER AND ENGAGEMENT

7.1 Healthwatch Gloucestershire Survey

Healthwatch are starting a new project in January 2023 exploring young people's experiences of mental health care in more depth.

They aim to connect with young people through schools and colleges and youth sports and community groups in Gloucestershire to better understand young people's experiences of mental health care and what help is currently available.

7.2 Accessible Information Standard Programme

One Gloucestershire is looking to develop a video aimed at educating and informing clinical colleagues about the Accessible Information Standard (AIS), why it is important and how they can ensure they comply with it.

The AIS is a legal obligation for NHS organisations and therefore GHC is supporting to help develop case studies from people whose experience could have been improved by better communication in a format which suits them. This will aim to include a range of people, including those with sight loss, hearing loss, learning disabilities and other needs.

7.3 Children Mental Health Week 2023 – Young People's Takeover

The Trust along with On Your Mind Glos, The Music Works, Cheltenham Literature Festival (VOICEBOX & Scribbled Self) & Cheltenham Education Partnership (CEP) are working together to invite groups of students from Gloucestershire schools (years 9 & 10) and young people not currently attending school of the same age, to share their experiences, ideas and stories around positive mental health. They will be joined by local industry experts to discuss what matters most to young people living in Gloucestershire when it comes to mental health and wellbeing, and how we can make meaningful change.

Workshops are proposed for Friday 10th February 2023.

7.4 Race Equality Week: 6-12 February 2023

Race Equality Week is a UK-wide initiative uniting thousands of organisations and individuals to address race equality barriers in the workplace. The events of 2020, including the Black Lives Matter movement and the disproportionate impact of COVID-19 on ethnic minority communities, has heightened public consciousness of race inequality.

We will be joining our ICS partners and staff networks to raise awareness of the race equality campaign and there will be a range of videos, articles, and activities taking place. The theme for Race Equality Week 2023 is #ItsEveryonesBusiness.

8. NEXT STEPS

Trust Board members are asked to **NOTE** the contents of this update report.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 10/0123

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 January 2023**

PRESENTED BY: John Trevains, Director of Nursing, Therapies and Quality, and Marit Endresen, Patient Survey Manager

AUTHOR: Marit Endresen, Patient Survey Manager

SUBJECT: **CQC 2021 COMMUNITY MENTAL HEALTH SURVEY ACTION PLAN UPDATE**

If this report cannot be discussed at a public Board meeting, please explain why.	

This report is provided for:

Decision ☐ Endorsement ☐ Assurance ☑ Information ☑

The purpose of this report is to:

- To update the Trust Board on the outcome of the actions taken forward from the results of the 2021 CQC Community Mental Health Survey.
- To provide assurance that the results of this national survey have been acted upon.

Recommendations and decisions required

The Board is asked to:

- **Note** the contents of this report
- **Receive** assurance of our ongoing commitment to deliver high-quality adult community mental health services
- **Receive** assurance that this feedback has been used to identify areas for development

Executive summary

- This paper provides an update on the actions undertaken from the results of the 2021 CQC Community Mental Health Survey.
- Interviews were undertaken with service users to further understand their experiences in relation to the questions that had received lower scores.

Risks associated with meeting the Trust's values
Feedback from service users offers a valuable insight into how services are received and perceived by those using our services. The results will be publicly available, and we have a duty to provide our assurance that the Trust is taking appropriate action to effect improvement.

Corporate considerations	
Quality Implications	This report provides assurance that the Trust is delivering quality adult community mental health services and is striving to continually improve, ensuring those who use our services are heard and listened to.
Resource Implications	Actions to develop positive service experience in the areas where scores are lower may require additional or realignment of resources
Equality Implications	The demographic results of the survey show that a very small proportion of respondents were from Black, Asian and minority ethnic (BAME) groups (n=2%, national average=10%). A higher percentage of people over 66 years of age completed our survey (n=44%, national average=37%). This has occurred for several years and reflects the local population demographic. However, these was an increased in the lowest age bracket (18-35) from 10% to 15% of responses.

Where has this issue been discussed before?
• Quality Committee, 6 January,5 May 2022 and 9th January 2023 • Council of Governors, 16 March 2022 • Quality Assurance Group, 20 May 2022 • Improving Care Group, 13 December 2022

Appendices:	Service user interview findings

Report authorised by: Hannah Williams	**Title:** Deputy Director Nursing, Therapies and Quality

CQC 2021COMMUNITY MENTAL HEALTH SURVEY ACTION PLAN UPDATE

1.0 INTRODUCTION/BACKGROUND

1.1 The Care Quality Commission (CQC) requires that all providers of NHS mental health services in England undertake an annual survey of patients in their care.

1.2 The 2021 survey of people who use community mental health services involved 54 providers in England, including combined mental health and social care trusts, Foundation Trusts and community healthcare social enterprises that provide NHS mental health services.

1.3 The Trust was categorised as performing '**better**' than most mental health trusts in 5 of the 12 domains (42%) (2020 survey: 8 out of 11, 73%). Although this is a decrease from the previous year, the Trust remains in the top 20% performing Trusts in most of the domains (9 out of 12).

2.0 AGREED ACTION AREAS

The following **three action areas** were identified:

- **Action Area 1** (Q15 and Q16) incorporates care plans and how the care provided should consider other aspects of a patient's life.
- **Action Area 2** (Q20) looks at access to Crisis Care out of hours
- **Action Area 3** (Q23) considers how medication side effects are discussed with patients.

3.0 IMPLEMENTATION OF ACTION PLAN

3.1 The action plan implementation group consists of staff representatives, including nursing, medical and non-clinical staff members, a public governor and five patient representatives from the Expert by Experience programme. The group met on four occasions: 9th June, 30th June, 1st September and 10th November 2022.

3.2 The group chose a different approach to the one initially proposed and opted to interview service users about their experiences within the identified action areas, to gain a greater understanding of why the Trust received a lower score in these questions.

3.3 A semi-structured interview approach was used, targeting current and previous community mental health service users, with experiences across a variety of Trust services. The interviews were undertaken by the Patient Survey Manager in October/November 2022, each lasting around 45 minutes. In total nine service users were interviewed. It is noted that this is a small sample size, and the findings can therefore not be generalised, however, several similar experiences were identified, and a wealth of feedback was gained through this qualitative approach.

3.6 Next steps: The findings from the interviews will be shared with relevant teams and Action Area 2 (Access to Crisis Care) is likely to be further considered as part of the Action Plan from the 2022 CQC Community Mental Health Survey, following the recent release of the 2022 survey results.

4.0 INTERVIEW FINDINGS

4.1 Summary of findings are detailed below:

Action Area 1: Involvement in care planning	Overall, the respondents were happy with many aspects of the care they had received, but it was evident that the Trust does not offer a not a standardised approach to involving service users in the production of a care plans and ongoing discussions and reviews. Those service users who were more involved, appeared overall happier with the care they had received.
Action Area 2: Access to (out of hours) Crisis care	All the respondents knew how to contact the service; however, the general view was that it is often difficult to access and receive the help you need, and that leaving a message on an answerphone is problematic at the time of crisis. A more personalised approach is needed.
Action Area 3: Medication side effects	Generally, medication side effects are discussed, but there appears to be an inconsistency in the openness and transparency around this issue. Most respondents preferred a verbal discussion followed by access to up-to-date and relevant information for further reference.

5.0 NEXT STEPS

5.1 The findings from the interviews will be shared with relevant teams and Action Area 2 (Access to Crisis Care) is likely to be further considered as part of the Action Plan from the 2022 CQC Community Mental Health Survey, following the recent release of the 2022 survey results.

5.2 The action plan report was shared at the Improving Care Group on 13th December 2022 where it was agreed to share the learning from the interviews with the Patient Safety Team to order to embed the learning within the wider Trust approach to learning assurance.

APPENDIX 1

INTERVIEW FINDINGS

The detailed findings from the service users' interviews are summarised below:

Care plans and involvement:
In general, the interviews showed positive feedback about the effects of the care received and the impact this had had on service users' lives. Those who were more involved in their care planning, appeared generally more positive about the care they had received.

Some on the service users noted that they had been involved to some extent with the production of a care plan, however the overall finding was that service users are not always fully involved and there does not appear to be a standardised approach for using co-production in care plans.

It was noted that some respondents felt that the care plan was something that was 'done to them' by the clinicians, and it is a 'tick-box' exercise rather than an aid to their care and treatment. It was evident from a service user perspective, that it is very important to be considered as a 'whole person' when a care plan is agreed. This includes mental, physical and social needs, and with reference to previous illness where relevant.

It was suggested it may be beneficial if, in addition to being involved in discussing their care plan, that service users should also be involved in actually writing up the care plan to ensure they fully understand what has been agreed and that the terminology used is meaningful to them. Some mentioned that more regular reviews would be helpful. Most respondents felt that the care plan was helpful for clinicians when caring for service users.

When asked about unmet needs, respondents generally felt that this was often resolved through discussion and problem solving, however some felt they were often left without a clear understanding of what treatment options are available to them.

Overall, the interviews found that there are some efforts being made in the Trust to make care planning more service user led, but this appears not to be a standardised approach across services, and the Trust needs to do more and make co-production standard and what is expected, both by staff and service users.

One respondent suggested that a care plan should have a summary page that would provide an overview of the service users as a person and their specific needs, medication etc, and that this was easily available to all clinicians involved in their care. This would be particularly helpful if in crisis for the Crisis Team to gain an instant insight into the person presenting to them.

The interview findings also noted that service users feel that there generally appears to be a lack of communication between Trust clinical teams, and also between services for people with mental health needs such as between the GP and mental health services.

Access to Crisis care:
All the service users who were interviewed said they know how to contact the Crisis Team when required, however the difficulty in receiving a timely response from the team was noted, and not being able to talk directly to a person at a time of crisis. Some mentioned the worry they felt when having to wait for a call-back from the team; this is not ideal at the time of a crisis. It was noted, however, that respondents generally felt that the care once they received it, was good.

Several respondents highlighted the importance of a human connection, whether face to face, drop in or appointment, or even online, but not an answering machine. People need to be listened to and receive a response at the time of crisis.

The current system is also problematic for people who are non-verbal, or unable to verbalise during a crisis. Some respondents also noted aspects around unnecessarily being prescribed new medication during crisis. Reference was also made to the need for more peer support workers, and clinicians' knowledge about signposting and onward referrals.

Some respondents felt that there is not a guarantee that the Crisis Worker who they speak to will look at their (person-centred) care plan and respond accordingly. Hence the suggestion of a summary page that provides a quick overview of a service user's characteristics and specific needs.

Overall, it was felt that the Crisis Team needs to provide a more individualised service – listen to the individual needs of each service user and respond accordingly, for example whether a practical or emotional support is necessary.

Medication side effects:
It was found that for the majority of the service users interviewed, medication side effects were discussed, and they were happy about this discussion. However, there was some discrepancy in the level of information provided. Some mentioned the need for transparency and honesty around talking about medication side effects, particularly in addressing negative effects and the potential impacts these may have. There was also mention of not being listened to, or issues being minimised, when needing to discuss side effects such as weight gain.

Most respondents said they initially preferred a verbal conversation about medication side effects, although most also wanted to have something to refer to later, either a reliable online source or a leaflet as well as talking to others with similar experiences. Being able to access all relevant information in one place was mentioned.

Similarly, to side effects, medication interactions appears to be sometimes discussed and sometimes not. It was found that they are often not considered with regards to physical medication, and that medication history is not always considered.

There was inconsistency among respondents in relation to timeliness of medication reviews, some said they received reviews regularly, and others said they never had them and were not sure if they should be having reviews.

Most respondents thought their GP/Psychiatrist should be responsible for the management of their long-term medication, but it was generally agreed that there needs to be better communication between both, in order to manage this well.

Additional comments:
When asked to make additional comments, the majority of respondents felt that overall, the care they receive is more positive than negative and they recognise how busy staff are.

Some specific issues were referred to, including:

- More transparency and openness needed, particularly in relation to medication side effects
- Medication withdrawal needs to be discussed more
- Feeling lonely when sectioned, not knowing what do
- Not being told how long you have to wait for things (other services?)
- More understanding and discussion around what's available within the system and how to access other services

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 January 2023**

PRESENTED BY: John Trevains, Director of Nursing, Therapies and Quality, and Marit Endresen, Patient Survey Manager

AUTHOR: Marit Endresen, Patient Survey Manager

SUBJECT: **CQC 2022 COMMUNITY MENTAL HEALTH SURVEY: RESULTS AND PROPOSED ACTION AREAS**

If this report cannot be discussed at a public Board meeting, please explain why.	

This report is provided for:

Decision ☐ Endorsement ☐ Assurance ☑ Information ☑

The purpose of this report is to:

- To summarise the results of the 2022 CQC National Community Mental Health survey. These results provide assurance of the quality of adult community mental health services delivered by Gloucestershire Health and Care NHS Foundation Trust.
- To provide assurance that the results of this national survey have been used to identify areas of focus for improvement over the next 12 months.

Recommendations and decisions required

The Board is asked to:

- **Note** the contents of this report
- Receive **assurance** that the Trust's strategic focus and dedicated activity to deliver best service experience is having a positive effect over time.
- Receive **assurance** that the proposed actions will be used to guide further improvement activity.

Executive summary

- The Care Quality Commission (CQC) requires all mental health trusts in England to undertake an annual Community Mental Health Survey. As in previous years, Gloucestershire Health and Care NHS Foundation Trust commissioned 'Quality Health' to undertake the 2022 national survey.

- This paper outlines the CQC's published survey results of the data collected from GHC service users. The CQC makes comparison with 53 English NHS mental health care providers' results of the same survey. The results are published on the CQC website.

- GHC is categorised as performing '**better**' or **'somewhat better'** than most of the other mental health trusts in 8 of the 12 domains (67%) (2021 survey: 5 out of 12, 42%). the Trust remains in the top 20% performing Trusts in most of the domains (9 out of 12).

- Three areas from the survey have been identified for improvement and an action plan will be co-developed with members of the Survey Reference Group.

- An infographic has been produced to support effective dissemination of findings to colleagues and local stakeholders.

**The National Survey Centre has suggested some caution is taken in comparing results with previous years due to the impact of the Coronavirus pandemic.*

Risks associated with meeting the Trust's values

Feedback from service users offers a valuable insight into how services are received and perceived by those using our services. The results will be publicly available, and we have a duty to provide our assurance that the Trust is taking appropriate action to effect improvement.

Corporate considerations	
Quality Implications	This report provides assurance that the Trust is delivering quality adult community mental health services and is striving to continually improve, ensuring those who use our services are heard and listened to.
Resource Implications	Actions to develop positive service experience in the areas where scores are lower may require additional or realignment of resources
Equality Implications	The demographic results of the survey show that a very small proportion of respondents were from Black, Asian and minority ethnic (BAME) groups (4%), this is an **increase** from 2% in the 2021 survey (national average 10%). Work will continue to encourage people from our BAME communities to take part in the survey. A higher percentage of people over 66 years of age completed our survey (52%, national average 43%). This has occurred for several years and reflects the local population demographic. It is also understood that older

	people are more likely to complete a survey request of this nature.

Where has this issue been discussed before?
Quality Committee 9th January 2023

Appendices:	Survey results infographic for sharing with colleagues and local stakeholders

Report authorised by: Hannah Williams	**Title:** Deputy Director of Nursing and Quality

CQC COMMUNITY MENTAL HEALTH SURVEY 2022: RESULTS AND PROPOSED ACTION AREAS

1.0 INTRODUCTION/BACKGROUND

1.1 Enabling people to have positive experiences of NHS services which meet their needs and expectations is a key national strategic goal and an underpinning core value of Gloucestershire Health and Care NHS Foundation Trust (The Trust).

1.2 The Care Quality Commission (CQC) requires all providers of NHS mental health services in England undertake an annual survey of patients in their care. The Trust commissioned Quality Health to carry out this work.

1.3 The 2022 involved 53 providers in England, including combined mental health and social care trusts, Foundation Trusts and community healthcare social enterprises that provide NHS mental health services.

1.4 The data collection was undertaken between February and June 2022 using a standard postal survey method. The sample was generated at random using the agreed national protocol for all clients on the CPA and Non-CPA Register, seen between 1st September and 30th November 2021.

1.5 CQC will use results from the survey to build an understanding of the risk and quality of services and those who organise care across an area. Where survey findings provide evidence of a change to the level of risk or quality in a service, provider or system, CQC will use the results alongside other sources of people's experience data to inform targeted assessment activities.

2.0 CQC 2022 COMMUNITY MENTAL HEALTH SURVEY SCORES

2.1 The results for the 2022 CQC were published on 27th October 2022. The Trust's overall results in comparison with other trusts are summarised in Table 1 below.

Table 1: Trust scores in comparison with other Trusts

Survey domain	Score	Rating
Health and care workers	7.5	Somewhat better
Organising Care	8.6	Better
Planning care	7.3	Somewhat better
Reviewing care	7.7	Better
Crisis care	6.5	Same
Medicines	7.6	Somewhat better
NHS Talking Therapies	7.3	Same
Support and wellbeing	5.5	Better
Feedback	2.5	Same
Overall views of care services	7.5	Somewhat better

Survey domain	Score	Rating
Overall experience	7.4	Better
Responsive care	8.1	Same

2.2 The Trust's response rate was 29% (358 responses). This is above the national average of 21%. However, both the Trust's and the national response rates have decreased from the 2021 survey (Trust 34%, national average 26%).

2.3 The results show that despite a slight decrease in satisfaction in some questions, the Trust scored 'better' than most of the other mental health trusts in 8 of the 12 domains (67%) (2021 survey: 5 out of 12, 42%). Caution should, however, be taken when comparing results with previous years due to the impact of the Coronavirus pandemic.

2.4 The attached infographic has been developed to share the results in a more accessible format with colleagues and local stakeholders.

2.5 Tables 2 and 3 below show where service user experience is best and where it could improve.

Table 2: Where service user experience is best

Where service user experience is best (compared with national average)
Organising care: Service users being told who is in charge of organising their care and services **Reviewing care:** Service users meeting with NHS mental health services to discuss how their care is working **Medicines** NHS Metal health worker checked with service user how they are getting on with their medicines **Support and wellbeing** Service users being given support with their physical health needs Service users being given help or advice with finding support for finding or keeping work

Table 3: Where service user experience could improve

Where service user experience could improve (compared with national average)
NHS Talking Therapies: Service users not as involved as they wanted to be in deciding which NHS talking therapies to use NHS talking therapies not explained to service users in a way they could understand **Crisis Care:** Service users not getting the help needed when they last contacted the crisis team

How service users felt about the length of time to get through to the crisis team

Organising care:
Service users not always getting the help they needed the last time they contacted the person in charge of organising their care

3.0 PRIORITY AREAS FOR IMPROVEMENT

3.1 As in previous years, GHC has scored well across most survey questions, being classed as 'better than expected' or the same as other trusts in all of the questions. However, some areas have been identified where further development and continued effort may enhance the experience of people using our services.

3.2 When comparing with the national average, there are two areas specifically identified as needing improvement, as shown in Table 4 below.

Table 4: Areas identified for action

Question	GHC 2022	All Trusts 2022	Range (all trusts)
Section 5: Crisis Care *When asked 'Would you know who to contact out of office hours within the NHS if you had a crisis? This should be a person or a team within NHS mental health services' the Trust achieved a score of 7.2 which is a significant drop from the previous year. The Trust scored lower than the national average when asked if they received the help they needed the last time they contacted the service and also how they felt about the length of time to get through to the team.*			
Q21. Thinking about the last time you contacted this person or team; did you get the help you needed?	**6.4**	6.5	5.1 – 7.9
Q22. How do you feel about the length of time it took you to get through to this person or team?	**5.9**	6.0	4.9 – 7.1
Section 7: NHS Talking Therapies *The Trust scores within this area are lower than the national average and have dropped slightly from last year, although not significantly.*			
Q29. Were these NHS talking therapies explained to you in a way you could understand?	**7.9**	8.1	6.8 – 8.8
Q30. Were you involved as much as you wanted to be in deciding what NHS talking therapies to use?	**6.7**	7.0	6.1 – 8.2
Section 2: Organising Care *The Trust generally scored well in Section 2: Organising Care, where questions are asked whether they know who is in charge of organising their care, how the care is organised and knowing how to contact this person if they have any concerns. However, the Trust scored below average when asked if they received the care they needed the last time they had contacted this person.*			
Q14. Thinking about the last time you contacted this person [person in charge of organising care], did you get the help you needed?	**7.7**	7.9	6.6 – 8.7

4.0 NEXT STEPS

4.1 These results represent a slight decrease when compared to our results from last years' service user feedback in the same survey, however caution must be shown in comparing results due to the Coronavirus pandemic. The Trust continues to score high in comparison to other trusts in most of the survey domains.

4.2 An action plan will be co-produced with senior operational and clinical leaders in partnership with the service user survey Reference Group, progress will be monitored via Improving Care Group.

4.3 A mid-year update will be provided to Quality Assurance Group. The outcome of the action plan will then be presented to the Improving Care Group before being finally presented to the Quality Committee in January 2024.

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National Survey 2022 – Community Mental Health Trusts

358 respondents

21% National Response rate

29% Our response rate

30 questions → 12 domains

Our results

- Rated better than expected in 8 of 12 domains and 10 of 30 questions.
- All scores better than or as expected, with no scores being worse than expected.

Results of 12 domains

Health and social care workers	7.5/10
Organising care	8.6/10
Planning care	7.3/10
Reviewing care	7.7/10
Crisis care	6.5/10
Medicines	7.6/10
NHS Talking therapies	7.3/10
Support and wellbeing	5.5/10
Feedback	2.5/10
Overall views of care and services	7.5/10
Overall experience	7.4/10
Care during the COVID-19 pandemic	8.1/10

Each domain compared to other trusts
- Better
- About the same
- Worse

Where service user experience is best

Organising care: Service users being told who is in charge of organising their care and services.

Reviewing care: Service users meeting with NHS mental health services to discuss how their care is working.

Medicines: NHS Metal health worker checked with service user how they are getting on with their medicines.

Support and wellbeing: Service users being given support with their physical health needs.

Service users being given help or advice with finding support for finding or keeping work.

Where service user experience could improve

NHS Talking Therapies: Service users not as involved as they wanted to be in deciding which NHS talking therapies to use. NHS talking therapies not explained to service users in a way they could understand.

Crisis Care: Service users not getting the help needed when they last contacted the crisis team. How service users felt about the length of time to get through to the crisis team.

Organising care: Service users not always getting the help they needed the last time they contacted the person in charge of organising their care.

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National Survey 2022 – Community Mental Health Trusts

Results for 30 questions

Each domain includes a number of questions.
These are each compared to other trusts using this key:

Better | About the same | Worse

Health and social care workers	7.5/10
Enough time to discuss needs	7.7/10
Understand how mental health affects life	7.4/10
Aware of treatment history	7.4/10
Organising Care	**8.6/10**
Kept informed of who organises care	8.5/10
Care organised well	8.4/10
Knowing how to contact care Co-ordinator	9.8/10
Received help needed on last contact	7.7/10
Planning care	**7.3/10**
Agreeing the care received	6.9/10
Involvement in care planning	7.8/10
Personal circumstances considered	7.2/10
Reviewing care	**7.7/10**
Discussed how care is working	7.5/10
Decisions made together	7.9/10
Crisis care	**6.5/10**
Knowing who to contact in a crisis	7.2/10
Received help needed on last contact	6.4/10
Length of time to contact team	5.9/10
Medicines	**7.6/10**
Purpose of medicines discussed	8.1/10
Medication side effects discussed	6.2/10
Medicine review in last 12 months	8.5/10
NHS Talking Therapies	**7.3/10**
Therapies explained in understandable way	7.9/10
Involved in decided type of therapy	6.7/10
Support and wellbeing	**5.5/10**
Support with physical health needs	6.1 /10
Help finding financial advice/benefits support	4.2/10
Help finding or keeping work	4.7/10
Involving family or friends	7.0/10
Feedback	**2.5/10**
ABeen asked to give feedback on quality of care	2.5/10
Overall views of care services	**7.5/10**
Enough contact with services	6.3/10
Treated with respect and dignity	8.7/10
Overall experience	**7.4/10**
Overall good experience of services	7.4/10
Responsive Care	**8.1/10**
Agreed how treatment is delivered	7.7/10
Treatment provided as agreed	8.5/10

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 January 2023**

PRESENTED BY: John Trevains, Director of Nursing, Therapies and Quality

AUTHOR: John Trevains, Director of Nursing, Therapies and Quality

SUBJECT: **QUALITY DASHBOARD REPORT-DECEMBER 2022 DATA**

If this report cannot be discussed at a public Board meeting, please explain why.	

This report is provided for:
Decision ☐ Endorsement ☐ Assurance ☑ Information ☐

The purpose of this report is to

To provide the GHC Board with a summary assurance update on progress and achievement of quality priorities and indicators across Trust Physical Health, Mental Health and Learning Disability services.

Recommendations and decisions required

Board members are asked to:

- **Receive, note** and **discuss** the December 2022 Quality Dashboard.

Executive summary

This report provides an overview of the Trust's quality activities for December 2022. This report is produced monthly for Trust Board, Quality Committee, Operational Delivery and Governance Forums for assurance.

Quality issues showing positive improvement

- Eating Disorders waits and access activity is improving with supportive actions in place to sustain progress.
- Non - Executive Director audit of complaints providing 100% "green" good assurance for the first time this year
- 37.6% of staff have completed the new national Level 1 Patient Safety Training since its launch in November 2022.
- There has been an overall decrease in the number of pressure ulcers in December with numbers dropping to the lowest overall this year with zero avoidable pressure ulcers being reported in community hospitals.

- Despite workforce challenges and caseload demand for Community Mental Health Teams, the CPA rate continues above the compliance threshold target of 95%
- There is good evidence that the additional reporting steps to monitor adult safeguarding referrals following audit feedback are working well.

Quality issues for priority development

- Safeguarding supervision activity requires support to improve attendance, noting winter pressures on workforce and vacancies.
- Whilst there is a slight increase in FFT responses from MH service areas, further work and scrutiny is required to improve the number and analysis of responses.
- Embedded Learning activity remains challenging to deliver within current resources. The Director of Nursing, Therapies and Quality has identified budget resource to expand the resources available and aim to have this available in Q1 2023/2024.
- Workforce pressures remain a key organisational challenge to maintain and improving quality in the Trust.

Are our services SAFE?

This month, in response to a request from Board colleagues we provide a summary of data relating to long length of stay in our Community Hospitals. In December, the Patient Safety Team (PST) have continued to promote the Patient Safety Syllabus E-learning Level 1 course which is aimed at all levels of staff to strengthen their approach to patient safety. To date 1882 (37.6%) of GHC staff have completed the training. In December, there were a total of 959 incidents reported affecting patients. 885 were reported as No and Low harm incidents and 74 Moderate, Severe and Catastrophic incidents. The top four categories are skin integrity, restrictive intervention, self-harm and falls. All incidents in month remain within previous reported upper and lower control limits. 3 Mental Health SIRI's were reported in December. This month there has been an overall decrease in the number of pressure ulcers attributable mainly to a reduction in category 1 and 2 incidents, the majority of these are classed as unavoidable due to patient morbidity. We provide data regarding COVID 19 matters and report an increase in the infection rates in our Community and MH Hospitals, this was expected and is in line with increased community transmission rates across England. We have provided an update on the quality improvement project that aims to improve patients' experience of observations and engagement at Wotton Lawn Hospital and the new Patient Safety Noticeboard project.

Are our services EFFECTIVE?

Notably eating disorders access performance is improving with supporting activity to sustain progress. Cardio metabolic assessment rates have increased in month within inpatient settings however there is a slight decline within community, there is a data check in place to ensure validity of data. Mental Health CPA, (an established proxy measure of community mental health quality), compliance remains at required levels this month and we include a slide exploring variations in compliance in more depth. Despite the caseload and workforce challenges that the Gloucester Recovery Team are experiencing it is encouraging to note that their compliance is above target and that the overall compliance is at 96.2%. The new GHC Safeguarding Notifications inbox is operating well and provides the Safeguarding Team with improved oversight of organisational activity. Monthly auditing of Safeguarding Adult

and Children's practice and record keeping has commenced and the MARAC action plan backlog has been cleared. There is an improving picture with Level 4 Adult Safeguarding Training, Prevent Level 3 Training, and Children's Safeguarding Supervision compliance.

International Nurse recruitment continues with 56 new colleagues now in post since January 2021 with a further 33 in active recruitment. This month there is a slight increase in the HCSW vacancies rate increasing to 84.81 WTE, further information has been requested to understand this in more detail. Safer staffing data acknowledges the ongoing challenges for inpatient teams, however, triangulation of the data has not identified upturns in incidents or an increase in complaints linked to the services where variation of staffing levels have been evident. However, it remains a key quality concern and the Trust is mindful of the impacts on the wellbeing of patients and colleagues. The matrons and team leaders are continuing to monitor the impact on staffing and ensure safe delivery of services using the escalation protocols when required. The Trust is working on a range of actions to address these challenges and this is further reported via the Great Place to Work Committee.

Are our services CARING?

At the time of writing there are no complaints open over 6 months, reflecting the sustained improvements made by the Patient Carer Experience Team. The number of new complaints received in December has reduced by 7 in month to 6 (the lowest this year) with the number of open complaints in December being 44. The nnumber of complaints acknowledged within the 3-day timeframe is sustained at 100% for the ninth successive month. FFT compliance rate increased to 93% against the target of 95% with the overall number of completed FFT in month responses also increasing especially in mental health services. We include the Q3 audit of complaints by Non-Executive Directors (NED) which provides good assurance that overall, the Trust is investigating and responding to complaints appropriately. Included in the dashboard is a summary of observations from the NED Q3 quality visits together with information on progress made against their recommendations - Appendix 4.

CQC Update

The Trust continues to make good progress with the actions arising from the CQC core inspection. The Trust wide action plan is 56% complete with 44% on target for completion within agreed timescales. The MIIU action plan is 86% complete and 14% on target for completion, fidelity checking has commenced for those actions that have been completed. The Charlton Lane action plan is 97% complete and 3% on target for completion within agreed timescales. Scheduled touchpoint meetings continue to review progress of the actions. One of the MUST DO's from the CQC Core inspection that relates to Wotton Lawn Hospital is now complete with some additional work being undertaken to fully assure the Rapid Tranquilisation actions with completion anticipated for February 2023. We have continued to provide regular updates to the CQC who are assured by the plans and evidence we have provided in support of completed actions. The Trust is undertaking self-assessment and peer review work with services that were not inspected in 2022 to provide support and assurance that these services are meeting the regulatory requirements.

Risks associated with meeting the Trust's values
Specific initiatives or requirements that are not being achieved are highlighted in the Dashboard.

Corporate considerations	
Quality Implications	By the setting and monitoring of quality outcomes this provides an escalation process to ensure we identify and monitor early warning signs and quality risks, helps us monitor the plans we have in place to transform our services and celebrates our successes.
Resource Implications	Improving and maintaining quality is core Trust business.
Equality Implications	No issues identified within this report

Where has this issue been discussed before?
Quality Assurance Group, updates to the Trust Executive Committee and bi-monthly reports to Quality Committee/Public Board.

Appendices:	Quality Dashboard Report- December 2022

Report authorised by:	**Title:**
John Trevains	Director of Nursing, Therapy and Quality.

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Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 11.1/0123

Quality Dashboard 2022/23

Physical Health, Mental Health and Learning Disability Services

Data covering December 2022

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

Executive Summary

Gloucestershire Health and Care NHS Foundation Trust

This Quality Dashboard reports quality-focussed performance, activity, and developments regarding key quality measures and priorities for 2022/23 and highlights data and performance. This data includes national and local contractual requirements. Certain data sets contained within this report are also reported via the Trust Resources Committee; they are included in this report where it has been identified as having an impact on quality matters. Feedback on the content of this report is welcomed and should be directed to John Trevains, Director of Nursing, Therapies and Quality (NTQ).

The Quality Dashboard summary is informed by the NHS England's shared single view of quality – which aims to provide high quality, personalised and equitable care for all. The primary drivers in this shared view focus on systems and processes that deliver care that is safe, effective and has a positive experience which is responsive, personalised and caring. We frame our quality reporting in line with this view. This provides an escalation process to ensure we identify and monitor early warning signs and quality risks, helps us monitor the plans we have in place to transform our services and celebrates our successes.

Are our services SAFE?

This month, in response to a request from Board colleagues and growing concerns both locally and nationally, we provide a summary of data relating to long length of stay in our Community Hospitals. The detrimental effect that a prolonged hospital admission has upon a patient is well evidenced. When a patient is deemed to ' *no longer meet the criteria to reside'* (nCTR), timely and effective discharge plans should be in place to enable a discharge. Unfortunately due to the flow and capacity challenges across the system, we are often seeing patients delayed. In December, the Patient Safety Team (PST) have continued to promote the Patient Safety Syllabus E-learning Level 1 course which is aimed at all levels of staff irrespective of role to strengthen their approach to patient safety. To date 1882 **(37.6%)** of GHC staff have completed the training on Care2Learn. In December, there were a total of 959 incidents reported affecting patients. 885 were reported as No and Low harm incidents and 74 Moderate, Severe and Catastrophic incidents. The top four categories are skin integrity, restrictive intervention, self harm and falls. All incidents in month remain within previous reported upper and lower control limits. 3 Mental Health SIRI's were reported in December. This month there has been an overall decrease in the number of pressure ulcers attributable mainly to a reduction in category 1 and 2 incidents, the majority of these are classed as unavoidable due to patient morbidity. **Appendix 1** provides data regarding COVID 19 and evidences an increase in the infection rates (HODHA) in our Community and MH Hospitals, this was expected and is in line with increased community transmission rates across England. We have provided an update on the quality improvement project that aims to improve patients' experience of observations and engagement at Wotton Lawn Hospital and it's effectiveness as a safety intervention.

Are our services EFFECTIVE?

Notably eating disorders access performance is improving with supporting activity to sustain progress. Cardio metabolic assessment rates have increased in month within inpatient settings however there is a slight decline within community, there is a data check in place to ensure validity of data. Mental Health CPA,(an established proxy measure of community mental health quality), compliance remains at required levels this month and we include a slide exploring variations in compliance in more depth. Despite the caseload and workforce challenges that the Gloucester Recovery Team are experiencing it is encouraging to note that their compliance is above target and that the overall compliance is at 96.2%. The new GHC Safeguarding Notifications inbox is operating well and provides the Safeguarding Team with improved oversight of organisational activity. We are manually recording the number of referrals to Gloucestershire County Council Safeguarding Team to ensure we remain sighted on activity, monitor cases, liaise with teams and support any enquiries. Monthly auditing of Safeguarding Adult and Children's practice and record keeping has commenced and the MARAC action plan backlog has been cleared. There is an improving picture with Level 4 Adult Safeguarding Training, Prevent Level 3 Training, and Children's Safeguarding Supervision compliance. A full summary of Safeguarding key performance data is provided in **Appendix 2.**

International Nurse recruitment continues with 56 new colleagues now in post since January 2021 with a further 33 in active recruitment. This month there is a slight increase in the HCSW vacancies rate increasing to 84.81 WTE, further information has been requested to understand this in more detail. Safer staffing data acknowledges the ongoing challenges for inpatient teams, however, triangulation of the data has not identified upturns in incidents or an increase in complaints linked to the services where variation of staffing levels have been evident. However, it remains a key quality concern and the Trust is cognisant of the impacts on the well being of colleagues. The matrons and team leaders are continuing to monitor the impact on staffing and ensure safe delivery of services using the escalation protocols when required. The Trust is working on a range of actions to address these challenges and this is further reported via the Great Place to Work Committee, this includes improved enhancements for high risk vacancies within Wotton Lawn Hospital. **Appendix 3** – summarises wider key performance operational data. We note improved compliance in paediatric physiotherapy and signs of recovery in core services; 12 out of the 14 service data lines report an improved or continued compliant position this month.

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At the time of writing there are no complaints open over 6 months, reflecting the sustained improvements made by the Patient Carer Experience Team. The number of new complaints received in December has reduced by 7 in month to 6 (the lowest this year) with the number of open complaints in December being 44. The number of complaints acknowledged within the 3-day timeframe is sustained at 100% for the ninth successive month. FFT compliance rate increased to 93% against the target of 95% with the overall number of completed FFT in month responses also increasing especially in mental health services. We include the Q3 audit of complaints by Non Executive Directors (NED) which provides good assurance that overall, the Trust is investigating and responding to complaints appropriately. Included in the dashboard is a summary of observations from the NED Q3 quality reviews together with information on progress made against their recommendations - **Appendix 4**.

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Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

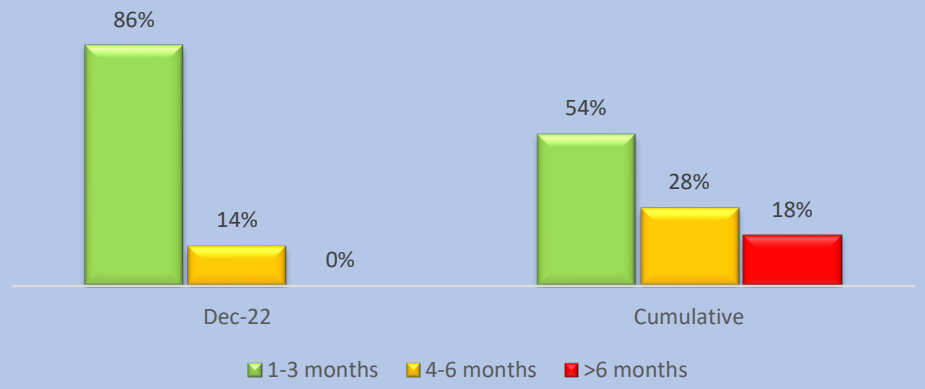
CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

No	Reporting Level	Threshold	2021/22 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022/23 YTD	R A G	Exception Report?	Benchmarking Report
Number of Friends and Family Test Responses Received	N - T	15%	16581	1167	1314	1229	1183	1354	1177	1523	2081	2104				13132			
% of respondents indicating a positive experience of our services	N - R	95%	94%	94%	94%	94%	95%	95%	95%	94%	92%	93%				94%			
Number of compliments received in month	L - R		1644	133	150	181	170	128	134	151	260	198				1505			
Number of other contacts received in month	L - R		371	34	51	40	37	46	55	54	73	49				439			
Number of concerns received in month	L - R		459	40	59	45	37	65	54	61	67	66				493			
Number of complaints received in month	N - R		120	9	8	15	10	8	13	18	13	6				100			
Number of open complaints (not all opened within month)				50	46	43	38	28	38	40	45	44							
Percentage of complaints acknowledged within 3 working days			93%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%			
Number of complaints closed in month				13	12	18	15	18	3	16	8	7				110			
Number of complaints closed within 3 months				3	5	9	6	13	2	8	6	6				58			
Number of re-opened complaints (not all opened within month)				7	7	5	7	6	7	8	5	5							
Number of external reviews (not all opened within month)				1	0	0	0	0	3	1	1	2							

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

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

CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

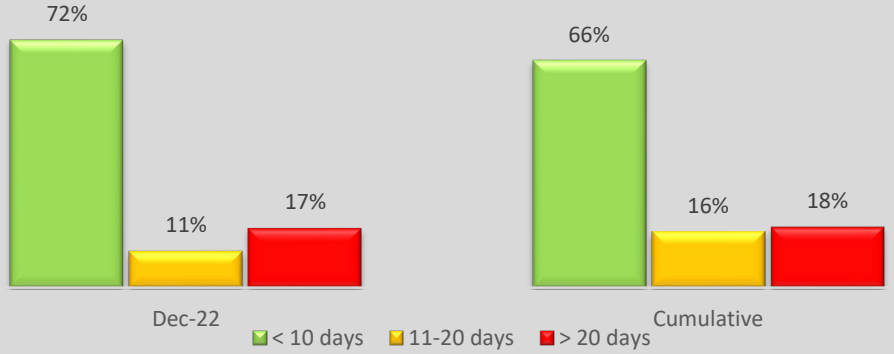


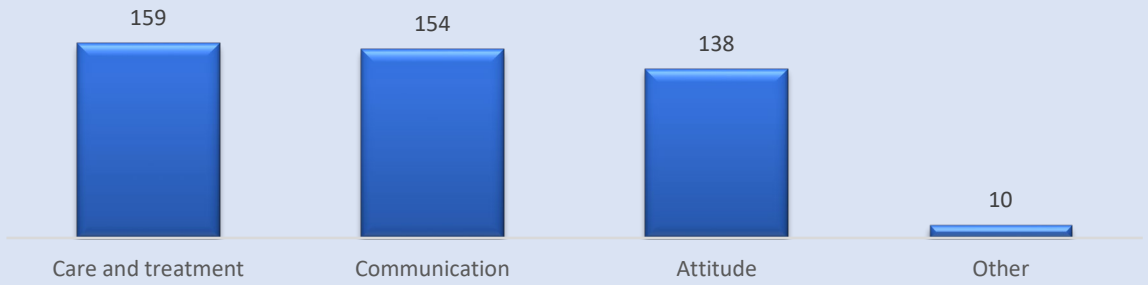
Complaints:

- **7** complaints were closed this month, of which **3** were upheld, **3** were not upheld, and **1** was withdrawn.
- Of these **7** complaints, most issues related to care and treatment, alongside access to services and communication, which are the most common complaint areas.
- PCET are working towards closing complaints in a more timely manner and this financial year, there are KPIs relating to the length of time taken to close complaints. The chart opposite indicates performance against KPI.
- **86%** were closed within three months (target = 95%) and 14% closed within six months (target = 5%)
- YTD we have closed **82%** of complaints within six months

Concerns:

- Of the **75** concerns that were closed this month, **4** were escalated to our formal complaints process (**95% were successfully resolved**)
- The key themes this month relate to communication and staff attitude along with care and treatment.
- PCET are working towards closing concerns in a more timely manner and this financial year, there are KPIs relating to the length of time taken to resolve concerns. The chart opposite indicates performance against KPI.
- **72%** were closed within 10 working days (target = 80%), and a further **11%** were closed within 20 working days (target = 20%).





Compliments:

- **198** compliments were recorded this month which consisted of 461 themes.
- This is consistent with annual trends and an improvement in a comparison for 21/22 in the same period.
- The largest compliment theme was care and treatment, which is often one of the most common concerns/complaints received regarding our services.
- The next largest compliment theme related to staff attitude and communication

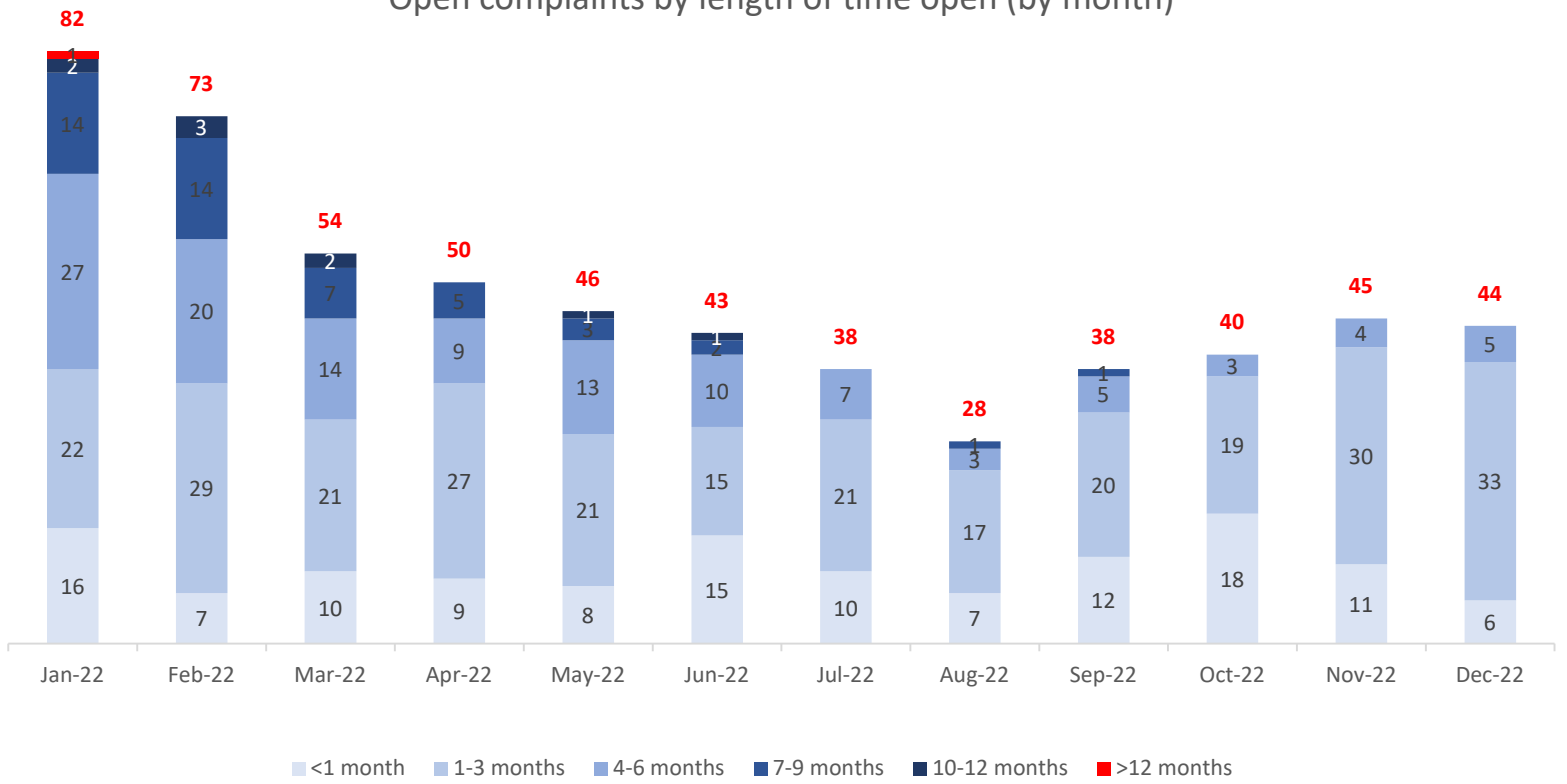
CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

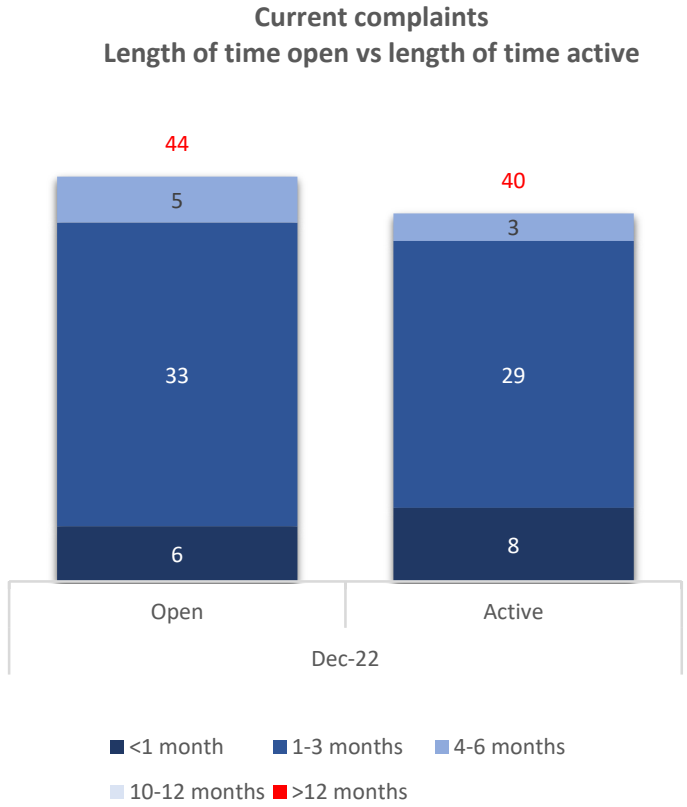
Overview of current complaints:
Of the **44** open complaints, **4** do not have agreed response times as issues have not been agreed.

Of the **40 'active'** complaints with agreed response dates, **17** are within the agreed timeframe and **23** have exceeded the initially agreed timeframes for a range of reasons including:

- Delays in the investigation process (e.g. allocating investigators, quality or timeliness of investigation report, and availability of staff for interviews)
- Work continues to address delays in the complaints process in order to minimise them where possible, including promoting awareness of KPIs/benefits to patients in providing timely responses.

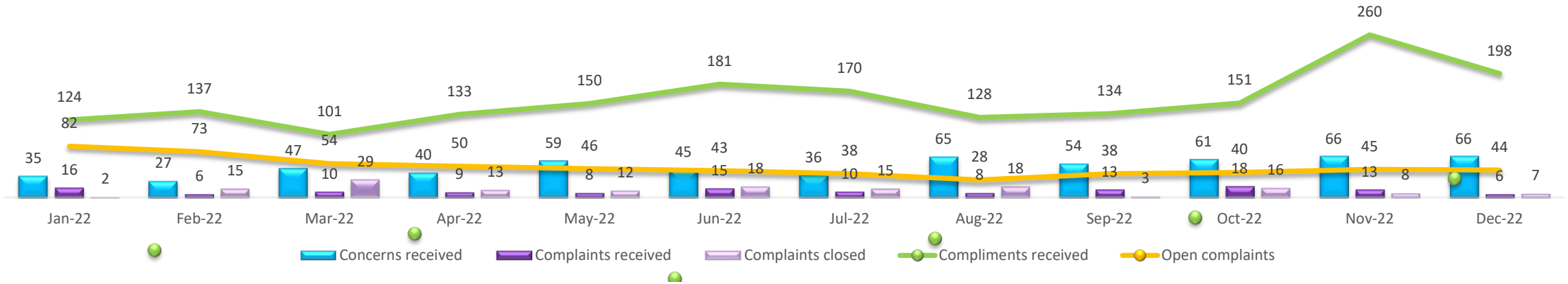
The charts below show the length of time complaints have been open (bottom left) and the number of complaints active (where issues have been agreed with the complainant) vs open complaints (bottom right).
We currently have no complaints open over 6 months old (this is a rolling figure that adjusts each month).



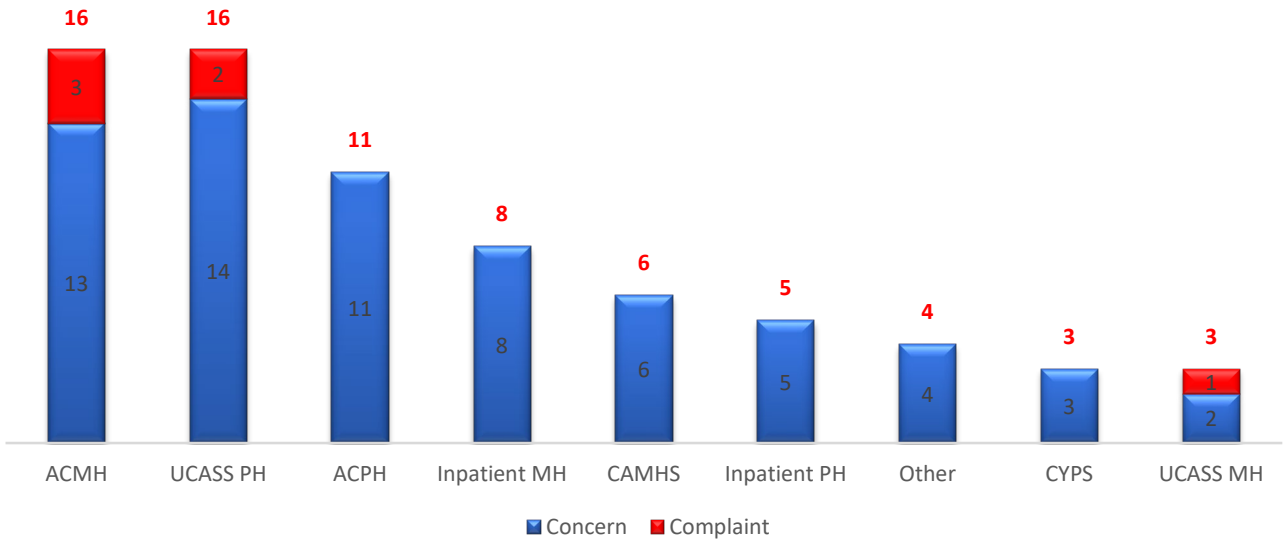


CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

The chart below gives an overview of the various types of feedback received via PCET over the past 12 months:



The charts below shows which of our services were named in the **72** complaints and concerns we received in December 2022. Our mental health community services (ACMH) and physical health urgent care services both received the most feedback (22%).



ACMH (22%)	UCASS PH (22%)
Feedback is split across 4 teams: • Recovery [9] • Memory Assessment [2] • ASC / ADHD [2] • Let's Talk [2] • Eating Disorders [1] Themes focus on accessing services, communication, and patient care / treatment.	Feedback is split as follows: • MIiU [8] • Sexual health [3] • Dental services [2] • Diabetic clinic [1] • Rapid Response [1] Again, themes are largely around staff attitude, communication, and patient care / treatment.

CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

FFT responses by service area | December 2022

Hospitals overall	**111**	**105**	**95%**
Hospitals - physical health	83	83	100%
Hospitals - mental health	28	22	79%
Specialist overall	**296**	**277**	**94%**
Specialist - physical health	258	246	95%
Specialist - mental health	38	31	82%
Adult community overall	**403**	**350**	**87%**
Adult community - physical health	354	310	88%
Adult community - mental health	49	40	82%
Urgent care overall	**1200**	**1143**	**95%**
Urgent care - physical health	1199	1142	95%
Urgent care - mental health	1	1	100%
CYPS overall	**94**	**78**	**83%**
CYPS - physical health	71	57	80%
CAMHS - mental health	23	21	91%

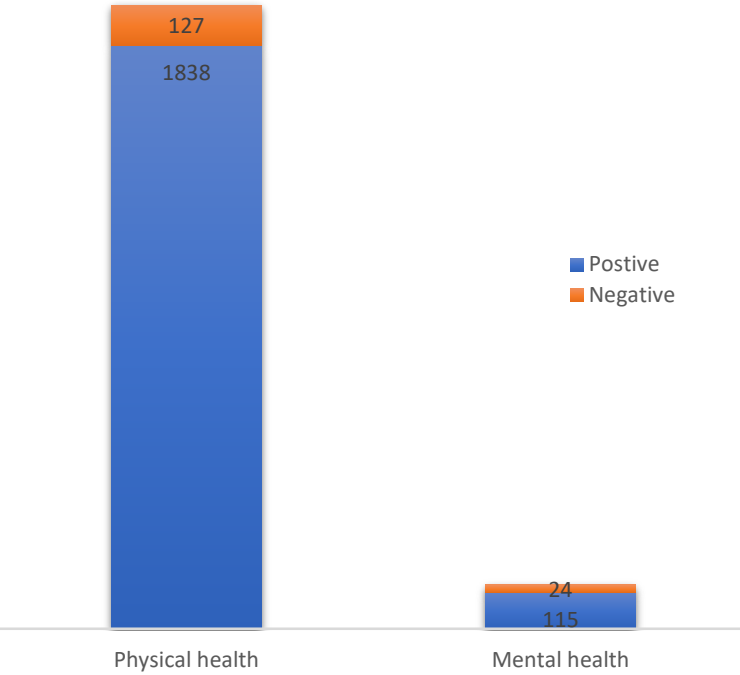
The number of FFT responses continues to increase, following the implementation of the new FFT process at the end of October.

- Patients (in most services, but not all) are automatically being sent a survey on discharge, with this we have seen an increase particularly in MH services.
- The use of a paper version, in services where this was not previously used, has also increased - particularly in mental health services.
- Options such as electronic links, iPads and QR codes are more widely being used by services than previously.
- Two new questions have been added, asking whether respondents had the opportunity to discuss aspects of care and treatment that matter to them, and if next steps and/or outcomes have been discussed
- In December, the new 'open' question offering service users the opportunity to discuss their experience with PCET generated 25 requests for contact/further action.

A slight reduction in satisfaction % is possibly due to receiving more MH responses, where we generally receive fewer positive responses than in PH services. Historically, we have seen a slightly lower satisfaction level in MH services as a percentage of feedback received.

Key indicators (% positive) December 2022

Total MH/PH FFT responses by positive/not positive response



ARE SERVICES SAFE? Non-Executive Director audit of complaints Q3 2022/23

INTRODUCTION

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

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

PROCESS

- Three complaint files closed in the quarter are randomly selected by the nominated Non-Executive Director auditor
- The Patient and Carer Experience Team completes section 1 of the audit tool and provide the auditor with copies of the initial complaint letter, the investigation report, and the final response letter.
- Having studied the files, the auditor completes sections 2-4
- The auditor compiles a report of their findings, to be presented at the Quality Committee and Trust Board

SUMMARY OF FINDINGS

- Audit findings are summarized within the table on the following slide
- The Q3 2022/23 audit provides good assurance that overall, the Trust is investigating and responding to complaints appropriately.
- Delays in responses have been noted and work continues to address the backlog of complaints. Internal KPI's are monitored via the monthly Quality Dashboard.

FUTURE AUDITS

- The Trust Secretary's office will continue to allocate the audits to NED colleagues
- An ongoing programme for NED audit of complaints has been established
- Audit reports will continue to be presented within the Quality Dashboard for the Quality Committee and for Trust Board

RECOMMENDATIONS

- To note the contents of the report
- To note the assurances provided regarding the Trust's management of complaints

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

ARE SERVICES SAFE? Non-Executive Director audit of complaints Q3 2022/23					
	Time scale of response	**Quality of investigation**	**Accessibility, style and tone of letter**	**Learning actions identified**	**Comments**
Complaint 1 [5990] • Patient complained that staff checked he is registered with a UK GP which felt like racial discrimination due to his accent. He further complained that x-ray was not available, and staff were dismissive of his concerns.	FULL ASSURANCE • Appropriate acknowledgement and clarification, plus updating of the complainant.	FULL ASSURANCE • Full and well-constructed investigation.	FULL ASSURANCE • Thoughtful and instructive response.	FULL ASSURANCE • Stated issue would be raised with relevant staff and in clinical supervision. • No timescale given.	
Complaint 2 [6209] • Son complained he was misled regarding a service specification and that no apology was given by the person who misled him, despite asking several times to speak to the person involved.	**FULL ASSURANCE** • This complaint was managed under a new (trial) process which allows early resolution where the complainant meets relevant senior staff to discuss the concerns raised.	**FULL ASSURANCE** • Under the new process of early resolution a full investigation is not required.	**FULL ASSURANCE** • A formal response is not required when following the early resolution process, although a follow-up letter is usually completed. • The complainant said he did not require a written response.	**FULL ASSURANCE** • General learning was identified from the briefing sheet that forms part of the early resolution process.	• Full efforts were made to address the complaint including a conversation with the Deputy Director of Nursing and Quality with the complainant.
Complaint 3 [6333] • Patient unhappy as she arrived for a physiotherapy appointment at Lydney Hospital to find it had been rearranged and no one had told her.	**FULL ASSURANCE** • Complaint response was sent within usual timeframe	**FULL ASSURANCE** • A thorough investigation which noted the patients telephone number recorded had a digit missing.	**FULL ASSURANCE** • Apologies were offered where appropriate.	**FULL ASSURANCE** • No timescale for learning to be implemented • A kind gesture of offering reimbursement of the financial losses incurred.	

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

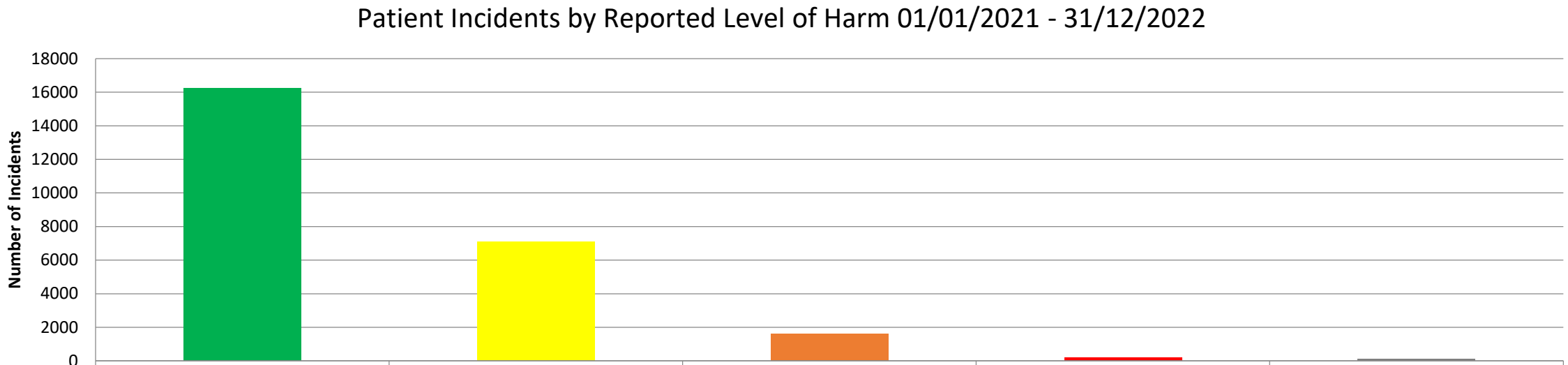
CQC DOMAIN - ARE SERVICES SAFE? INCIDENTS (Whole Trust data)

	Reporting Level	Threshold	21-22 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022-23 YTD	R / A / G	Exception Report?	Benchmarking Report
Number of Never Events	N - T	0	0	1	0	0	0	0	0	0	0	0				1			N/A
Number of Serious Incidents Requiring Investigation (SIRI)	N - R		32	10	3	1	5	2	1	2	1	3				28			N/A
No of overdue SI actions (incomplete by more than I month)	L - R		**New**	3	5	5	7	7	3	4	3	0				N/A			N/A
No of unallocated SI investigations (waiting more than 1 month for allocation).	L - R		**New**	1	0	0	0	0	0	0	0	0				0			N/A
Number of Serious Incidents Requiring Investigation (SIRI) regarding self harm or attempted suicide	N - R		2	0	0	1	0	1	0	0	0	1				3			N/A
Number of Embedding Learning meetings taking place	L - R		7	0	0	0	0	0	4	1	0	0				5			N/A
Total number of Patient Safety Incidents reported	L - R		12313	1216	1100	1012	1114	1043	973	1149	1107	959				9673			N/A
Number of incidents reported resulting in low or no harm	L - R		11418	1138	993	933	1008	960	885	1073	1021	885				8896			N/A
Number of incidents reported resulting in moderate harm, severe harm or death	L - R		895	78	107	79	106	83	88	76	86	74				777			N/A
Total number of patient falls (hospitals and inpatient units) reported as resulting in moderate harm, severe harm or death	L - R		26	8	4	1	3	4	2	0	3	2				27			N/A
Total number of medication errors reported as resulting in moderate harm, severe harm or death	L - R		5	1	0	2	0	0	0	1	1	0				5			N/A
Total number of sexual safety incidents reported	L- R		57	9	11	17	15	10	9	14	12	4				101			N/A
Total number of Rapid Tranquilisations reported	N - R		545	64	110	121	109	97	103	90	74	46				814			N/A

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-RL-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

CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Serious Incident Data



	None (no harm caused by the incident)	Low (minor harm, e.g. takes up to 1 month to rectify)	Moderate (significant but not permanent harm e.g. takes up to 1 year to rectify)	Severe (permanent or long term harm caused)	Death
Incidents	16246	7105	1596	183	107

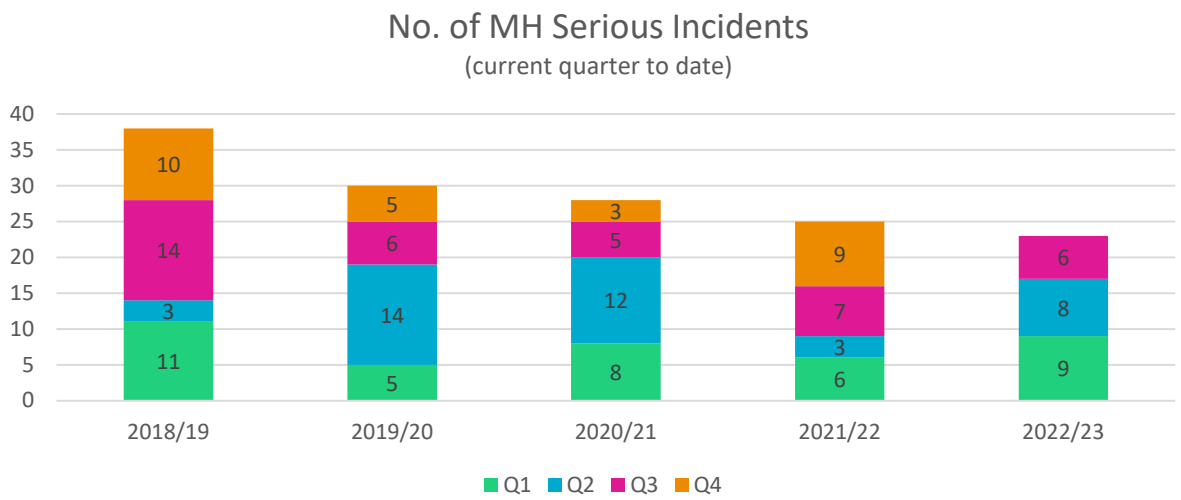
Key highlights:
We continue to include in the dashboard a summary of patient safety incidents reported over the last 2 years and seek to present data that can identify patterns requiring deeper analysis. This also includes a focus summary view on the prevalence of patient safety incidents by categories including how these have adjusted over time. These themes will be submitted as part of the work to identify our investigation priorities for 2023-24 and will be led by the Patient Safety Investigation Response Framework (PSIRF) Task and Finish Group.

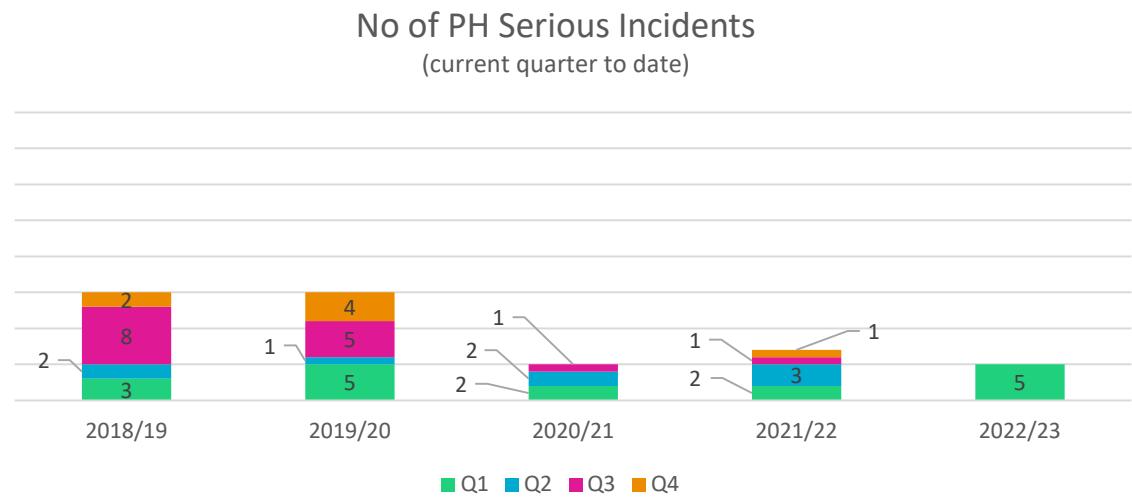
In December, there were a total of 959 patient related incidents reported via Datix (148 less than November). 885 were reported as No and Low harm incidents (136 less than November) and 74 as Moderate harm, Severe harm or Catastrophic incidents (12 less than November) The reduction in reporting is correlated to the overall reduction in normal working days in December. There were 10% fewer 'normal' days compared to November and the reduction in reporting is around 16% lower in December than November. In December 2022, the PST reviewed 15.1% of No and Low harm incidents which were reported (134 incidents were reviewed out of a total of 885). The patient safety team has consistently reviewed a minimum of 10% of the No and Low harm incidents for 20 months. The PST continues to review all falls and medication clinical incidents from Charlton Lane Hospital regardless of the level of harm which is informing a quality improvement being overseen by the new matron.

The largest reductions in incidents reported in December, compared to November, by category were Medication incidents (-22), Skin Integrity, inc. Pressure Ulcers (-22), Clinical Care, Treatment and Procedures (-17), Self Harm (-17), Equipment and medical devices (-17), Restrictive Interventions (-14), Violence and aggression to patients or the public (-14), Absconding and missing patients (-9), Information Governance (-6), Diagnosis, Imaging and Tests (-5).

CQC DOMAIN - ARE SERVICES SAFE? – Serious Incidents and Embedded Learning

Three Mental Health SIRI was declared in December 2022. There were no Physical Health SIRI's declared in December 2022





Key highlights:

The continued promotion of the Level 1 Patient Safety Syllabus has resulted in an increased uptake in training from 869 in November to 1882 (37.6% of the total workforce) at the time of writing.

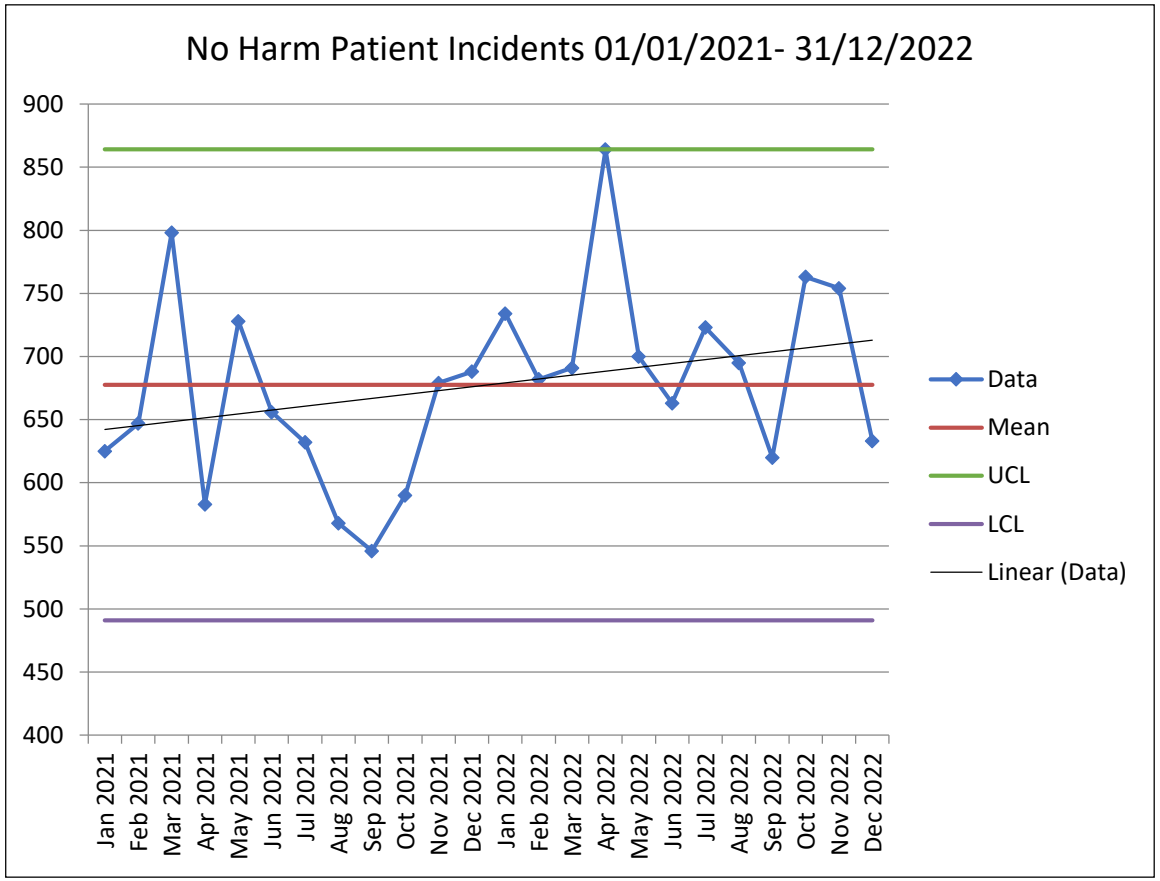
Embedded Learning:
The PST have continued to work in Wotton Lawn Hospital (WLH) on a regular basis to offer drop in sessions to staff. The team attended the Doctors' learning event held on 5th December where learning assurance and embedding learning from incidents was discussed resulting in positive feedback from those present. The first meeting of the safe and supportive observations national project took place with GHC being part of the best practice workstream, linking this national work to the ongoing learning assurance work in observations and engagement in WLH.

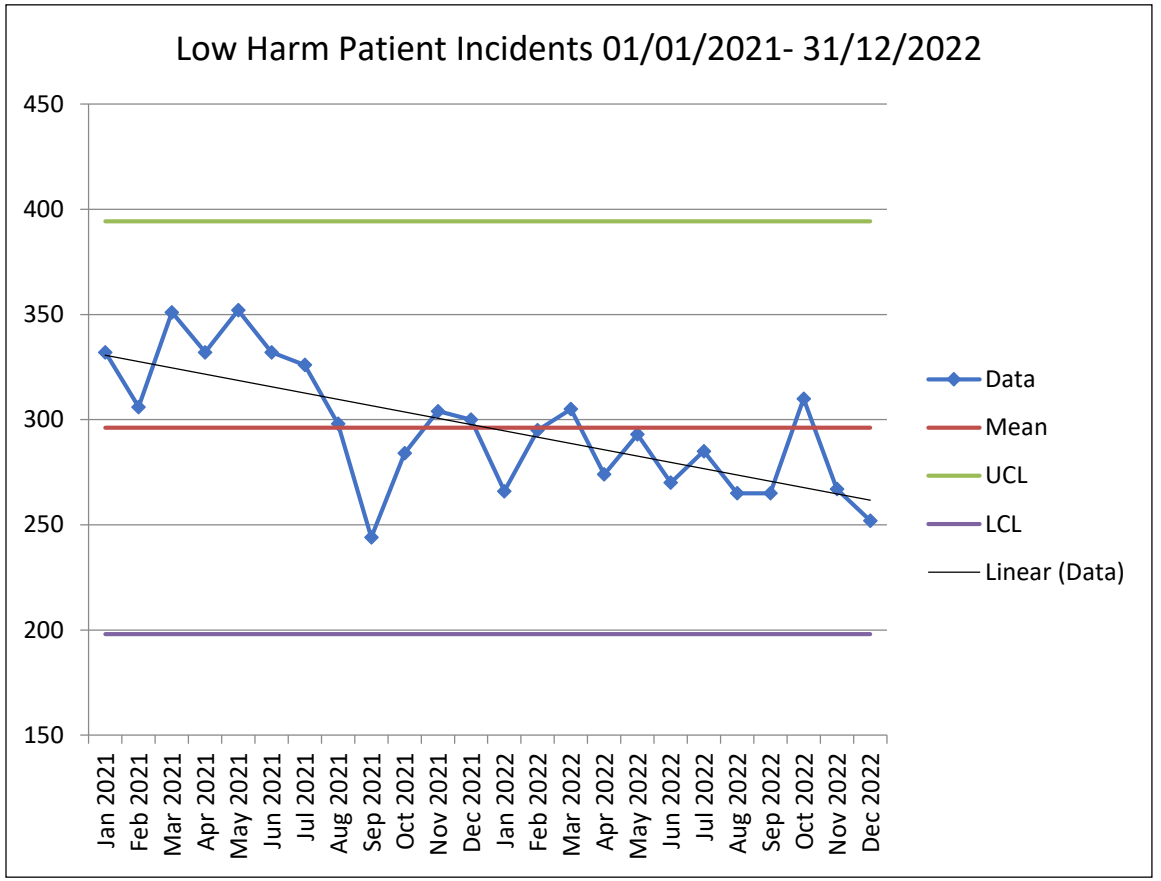
Evidence of the learning assurance that is taking place in relation to observations and engagement in WLH was provided at the inquest of a patient who sadly died whilst in service. Following this, the patient's father has requested to be part of the QI project referenced above. Patient Safety and Quality of Care noticeboards were installed in WLH and Charlton Lane Hospital and further sites are planned in January. The PST is identifying link workers at each site to keep content updated and will work with the teams to develop locally owned information. We are now looking at Community Hospital sites and considering options for Community Services. A summary of this work is provided on slide 18.

An embedding learning session was presented at a Postnatal and Neonatal Care (PNC) meeting following a SIRI within the Children & Young People Service. The PNC meeting is attended by senior clinical leaders from the "Gloucestershire Local Maternity and Neonatal System" (GLMNS) including Consultant Paediatricians, Specialist Midwives from GHNHSFT and representation from the Integrated Commissioning Board. The Head of Health Visiting for Stroud and Cotswolds represented GHC. It supported a wider discussion surrounding Biliary Atresia, neonatal/infant weight loss, signs of malnutrition and comprehensive feeding plans. The findings and lessons learned from the SIRI were reflected in the GLMNS "Readmission Audit" whereby the quality of handovers between the Community Midwifery and Health Visiting teams were cited as a contributory factor. This has highlighted opportunities to improve countywide practice to enhance outcomes for infants and their parents.

Learning Assurance Themes - A review of all of the 87 recommendations arising from SIRI's during 2021/22 confirms that 81 actions have been completed, 6 actions are progressing. In 22/23 we currently have 24 actions, 6 have been completed and 16 are on track to be completed on time, service pressures permitting. Some of these may be delayed by a further month due to team capacity.

CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Serious Incident Data



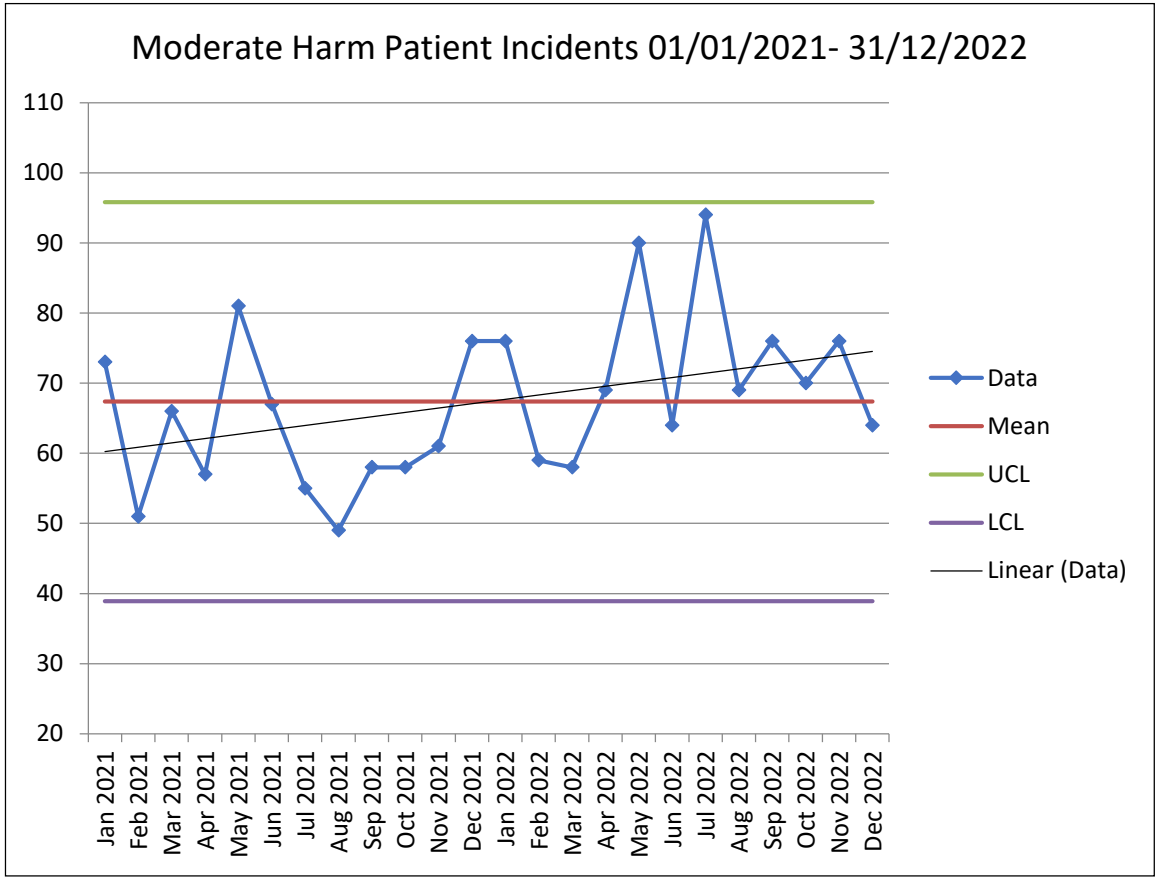


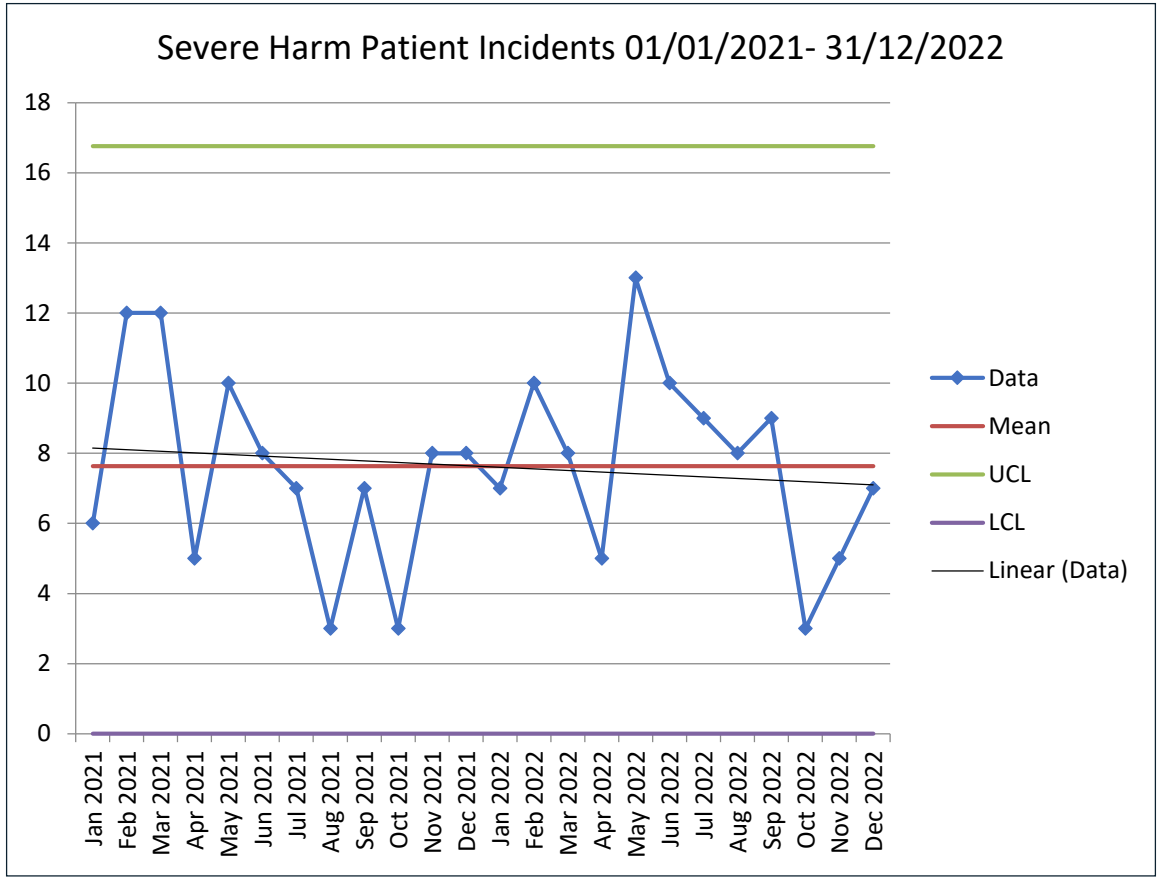
This slide provides data in the form of statistical process control charts. These enable the visualisation of change over time which is essential in tracking and monitoring improvement. Future reports will begin to overlay other measures with this data and add narrative to identify chronologies of events, decisions, QI activity, periods of high acuity, staffing changes. The functionality of the Learn From Patient Safety Events (LFPSE) will enable comparisons with other NHS organisations.

No Harm Incidents over time – This data shows the level of reporting being generally in line with the mean.

Low Harm Incidents over time - This data could be very reassuring, however the reduction visible each month for 10 months of reported low harm incidents may be accounted for in the developing rise in reported incidents of moderate harm seen on the next slide. The PST are engaged in activity to refine the reporting forms and support staff to correctly assess and grade incidents and therefore stabilise our view of current or emerging risks. Commonly there are technical explanations for a change in the profile of reporting of harm, such as a change in the parameters of the reporting system.

CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Serious Incident Data



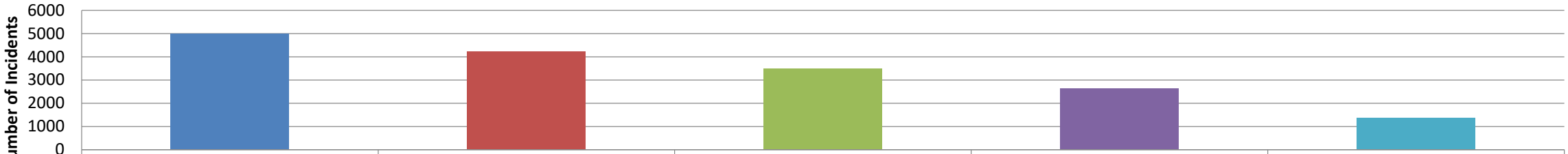


Moderate Harm Incidents over time - The picture emerging here, despite the mean not altering at present, is of a small but statistically significant rise in the number of reported moderate harm incidents that is being further explored and monitored, but remains within historical control levels. The PST monitor on a daily basis these incidents and capture these on a team tracker. We seek either additional information and assurance form the clinical team or an Initial incident review. A variable, but significant number are pressure ulcer reports and these have a defined process for capturing gaps in care planning and risk assessment and for local learning in the reporting team. Additionally, we share a number of moderate harm incidents with our colleagues at GHT who include these in to their risk awareness activity. There is a positive and open culture around reporting pressure ulcer damage within GHC. Colleagues work collaboratively with operational teams and brief them monthly on the incidents for their area and will have the freedom to examine reporting for patterns, learning and improvement activity.

Severe Harm Incidents over time - The data reflects a largely static position in relation to severe harm events, however, notes the reduction in harm in 21/22. The patient safety team is undertaking further analysis of this period to understand the changes over time and will report its findings in February.

CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Serious Incident Data

Top 5 Patient Incident Categories (excluding restraint) 01/01/2021- 31/12/2022



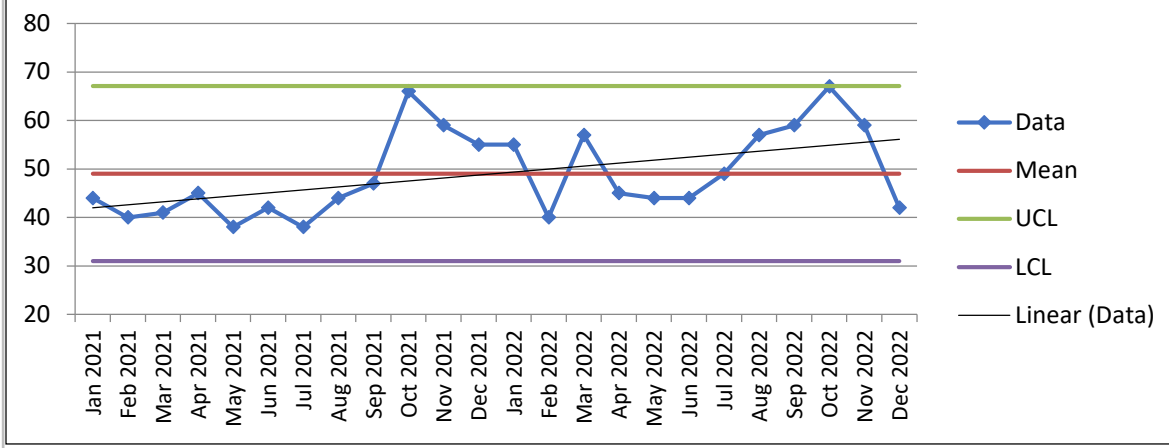
	Skin integrity (includes pressure ulcers)	Restrictive interventions, inc. PBM / PMVA, RT and bedrails	Self harm / self-injurious behaviour (SIB)	Falls (including slips & trips)	Medication incidents
X-axis	5004	4212	3490	2650	1351

Key highlights in December

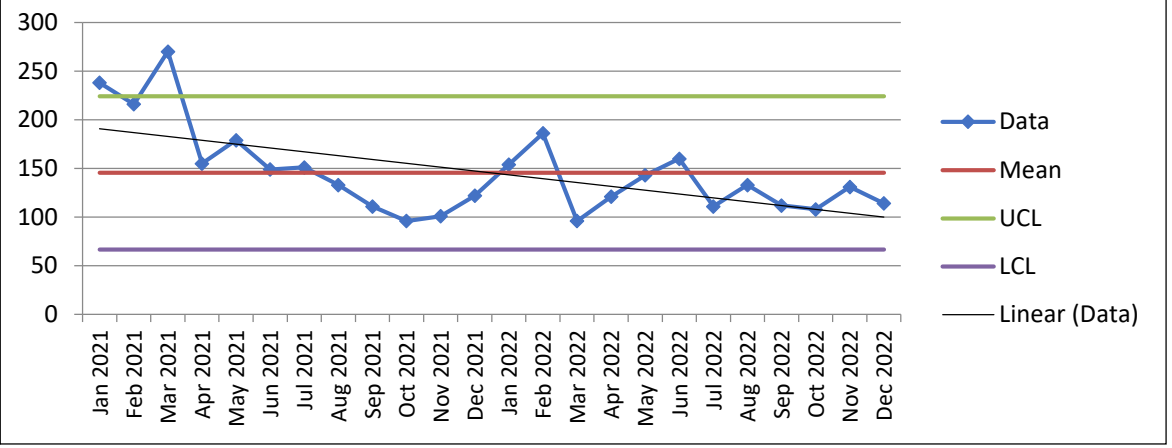
In December 2022, there were 74 patient incidents reported, (64 were moderate, 7 were severe and 3 sadly related to death). Of these 74 incidents, the five most reported categories were, Skin Integrity (Inc. Pressure Ulcers) (53 incidents), Self-harm / self injurious behaviour (SIB) (4 incidents), Death of a Patient (3 incidents), Clinical care, treatment and procedures (3 incidents) and Accidents and injuries (not falls or sharps) (2 incidents).

The chart above shows the 5 highest reported categories of patient incident (excluding restraint) over 24 months. The SPC chart below, left shows the 5th highest reported category of incident over 24 months: Clinical care, treatment and procedures. Further analysis of this information was provided to Improving Care Group (ICG) in December 2022. Additional information below shows activity data for self harm incidents over a 2 years period. The pressure on services over the past 2 years has been unprecedented and there are pockets of improvement that have positively influenced our activity data. We have made good progress in the categorisation and management of skin integrity and can also attribute the Positive and Safe programme to the improvements noted in self harm incidents.

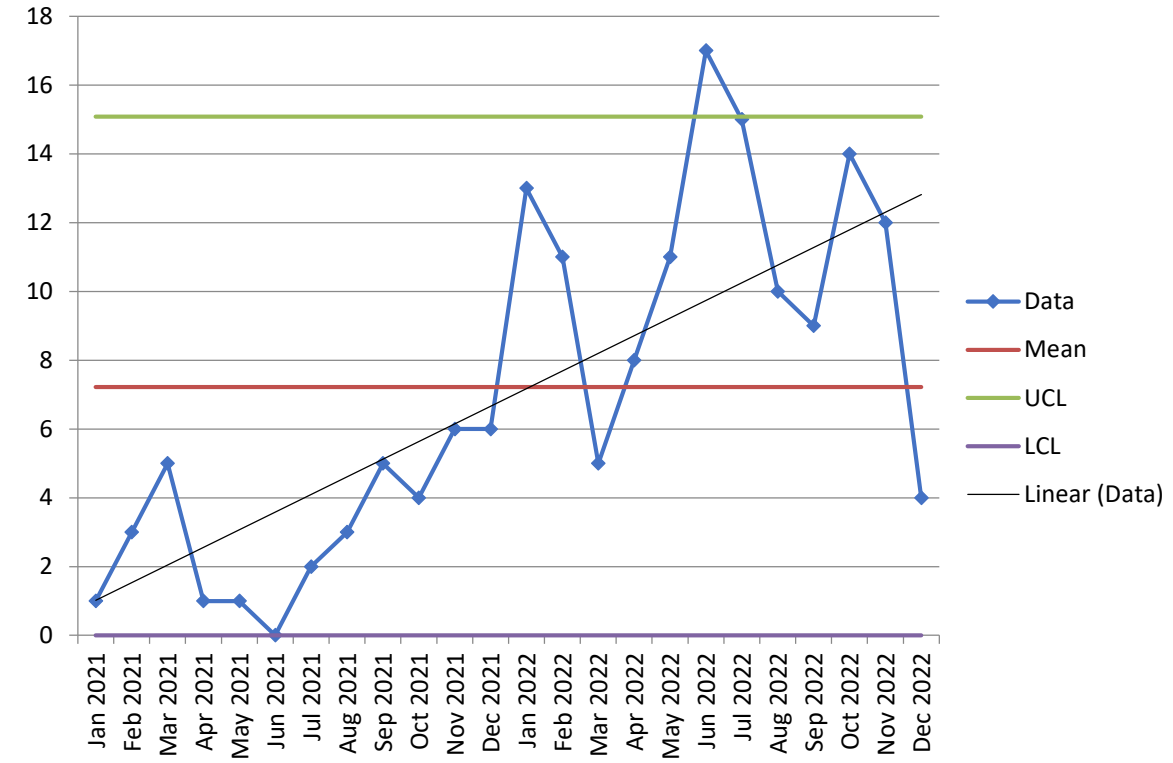
Clinical care, treatment and procedure incidents 01/01/2021- 31/12/2022

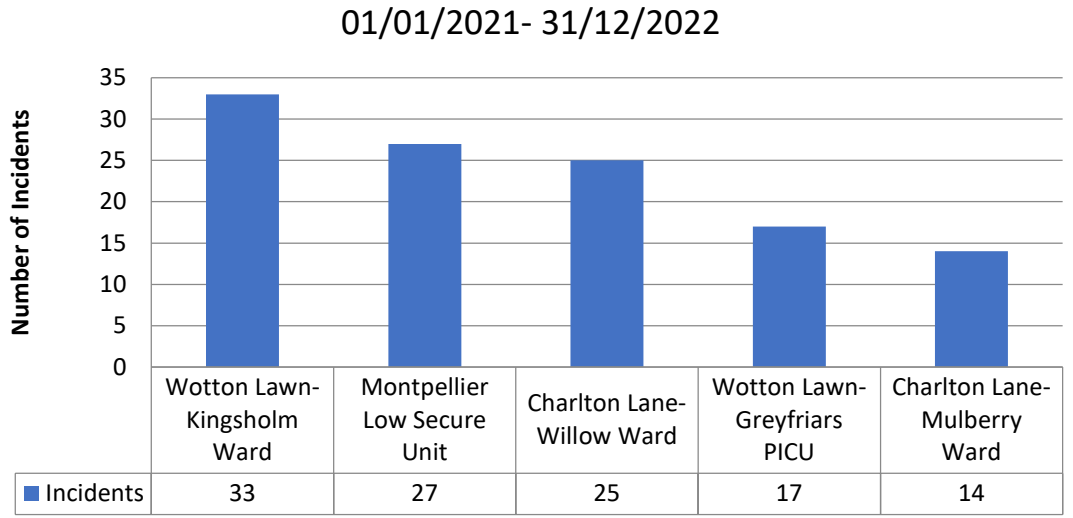


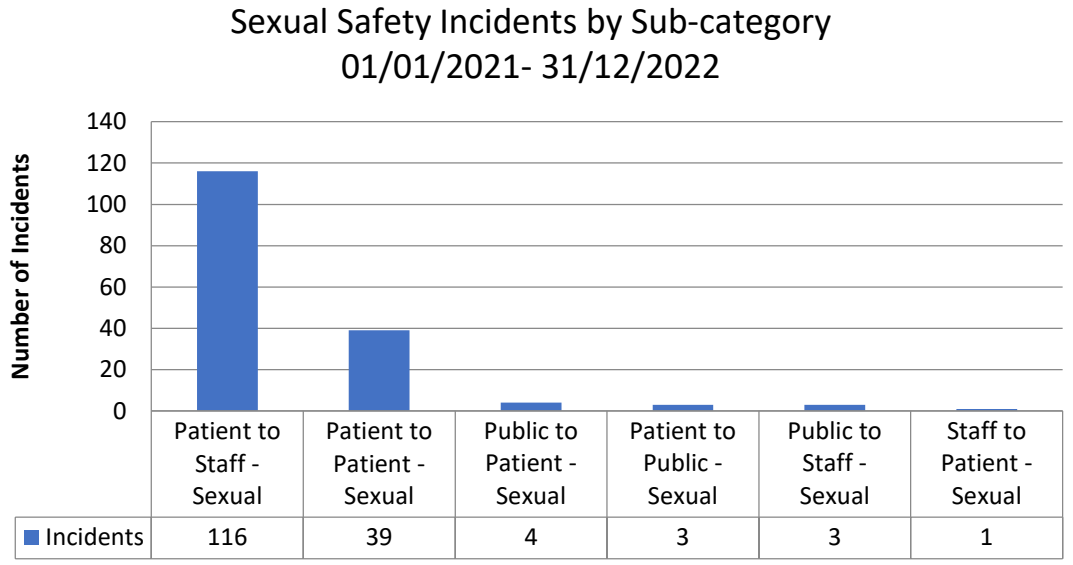
Self harm / Self injurious behaviour incidents 01/01/2021- 31/12/2022



CQC DOMAIN - ARE SERVICES SAFE? - Sexual Safety Incidents



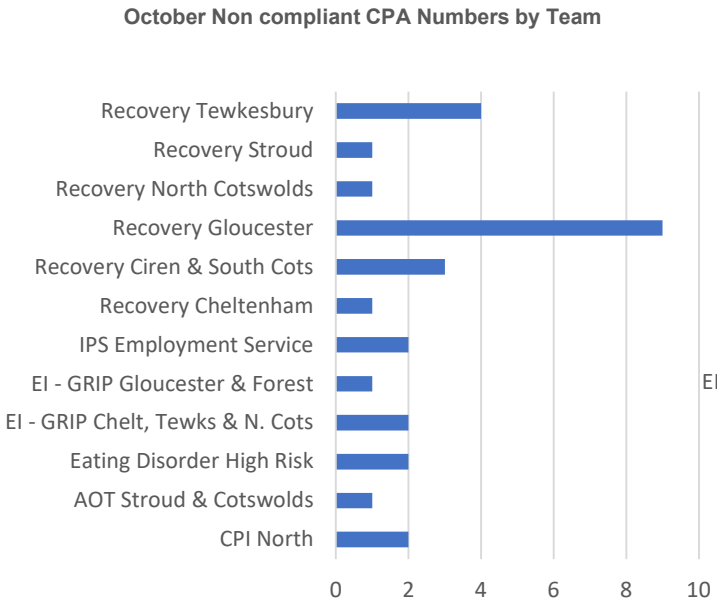


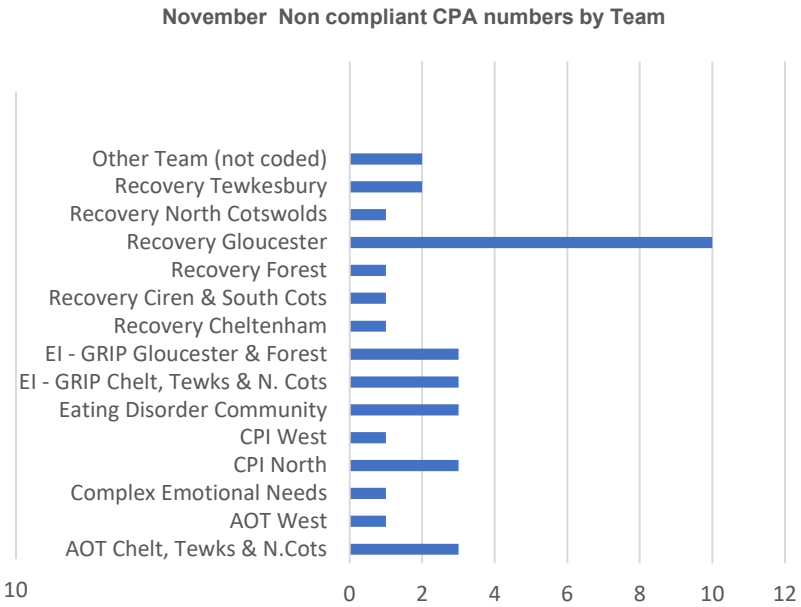


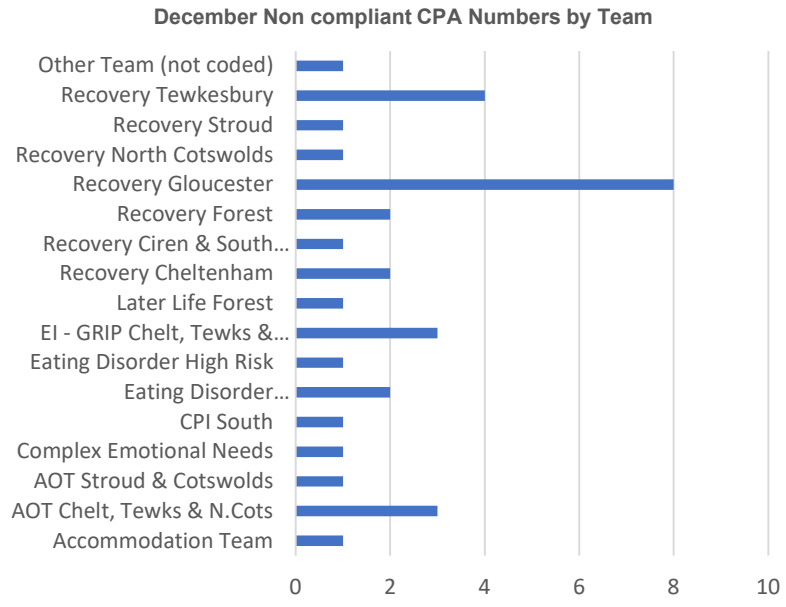
There has been an increase in reported incidents related to sexual safety. This increase was expected as this remains a relatively new area of reporting and we have invested in training colleagues in reporting all sexual safety related issues. The majority relate to disinhibited behaviour of our patients, particularly in the early periods of acute illness and includes the use of inappropriate language. Reporting levels appear to be good, reflecting a culture of reporting and openness in combination with renewed ward leadership. Sexual safety incident reporting categories were revised as per national guidance in July 2021 with subsequent reporting increasing across the categories.

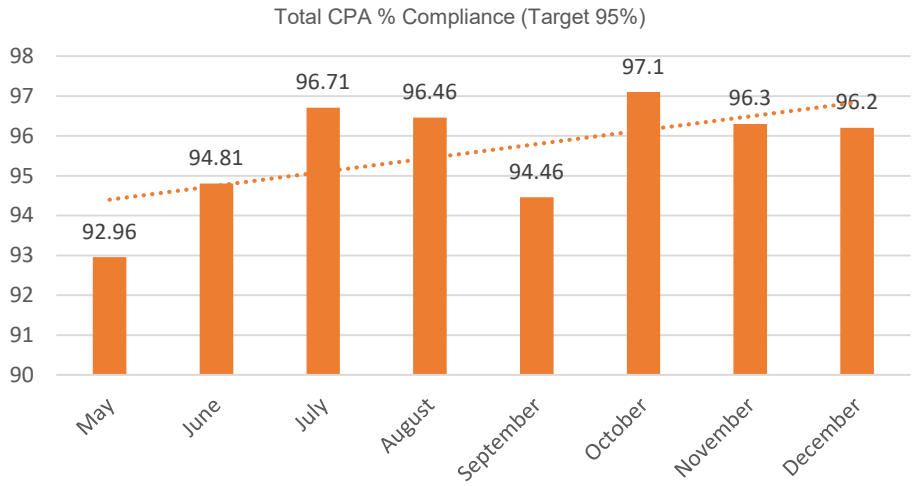
A GHC Sexual Safety Awareness Training (SSAT) pathway has been developed, aimed initially at unregistered staff. This has been piloted at Kingsholm and Willow Wards plus Berkeley House, the initial evaluation shows that different clinical areas experience different sexual safety issues, and therefore training needs to reflect this. Cashes Green Ward, Stroud General Hospital are piloting the sexual safety pathway in January 2023 after which full evaluation and identification of next steps will take place.

CQC DOMAIN - ARE SERVICES SAFE? – CPA Analysis of Recovery Position









The trend in compliance rate with CPA requirements has been showing improvement to reach or exceed the 95% expected target, however, there is a focus on the highest area of non compliant CPA meetings with patients who are open to the Gloucester Recovery Teams. This is one of the busiest teams, with the highest concentration of deprivation in the county. Gloucester also has become the largest area for supported accommodation within the county for those with MH needing accommodation. In addition, Gloucester Recovery have seen the caseload complexity and acuity significantly increase alongside an increase in the complexity of those placed in Gloucester from out of county, this includes those nearing the age of transition to adult services. There is a dedicated action plan in place to address these challenges alongside the below issues:

- Caseload size and configuration
- Increased Workforce Turnover Rate.
- Clinical Staff retention challenges
- Vacancies limiting team capacity.
- High Levels of DNA rates across recovery teams

To contextualise there are currently 904 people on the total caseloads who require CPA annual review. In total **96%** are compliant with their annual review despite the overall number (35) of cases waiting for a review beyond the 12 month period with 8 of these cases being held within Gloucester recovery.

CQC DOMAIN - ARE SERVICES Effective? – Community Hospital Delayed Patients

Long Length of Stay Patients in Community Hospital.

This is a new slide for the dashboard In response to a request from Board colleagues and growing concerns both locally and nationally. The information presents a summary of data relating to long length of stay in our Community Hospitals. For assurance, both Operational and Nursing, Therapies and Quality senior colleagues have good visibility of the data and attend appropriate system groups that identifies the impact of a long length of stay together with system meetings that seek to improve the challenges. The detrimental effect that a prolonged hospital admission has upon a patient is well evidenced. When a patient is deemed to ' *no longer meet the criteria to reside'* (nCTR), timely and effective discharge plans should be in place to enable a discharge. Unfortunately due to the flow and capacity challenges across the system, we are often seeing patients delayed. We are keen to ensure our 'super stranded' patients (over 50 days nCTR) have a continued focus and support in escalation with system partner working to expedite their discharge pathway. It is imperative we learn and shape services around the needs of the population, so by collecting data and identifying themes of the delays, we can support discharge pathways that meet the needs of the patients, and also target our approach to escalation and requests of support.

Headline Data as of January 9th 2023

There are 6 patients in total not meeting the criteria to reside for over 50 days, ranging from 52-92 days. This currently excludes time waiting in the Acute Trust prior to admission, we will add that date to future reports for completeness

- 2 are awaiting Pathway 1 - Homefirst (Glos & Chelt Locality)
- 4 are awaiting Pathway 3

Delay Themes

- Pathway 1 - Homefirst Capacity in locality and Equipment waits
- Pathway 3 - Vacancies in Care homes, Declines from Care home, Top up Fees requested, Debating rates, Family Choice on location

Pathway Zero – 'Simple Discharge' 0
No formal care arranged but could include follow up appt, district nurse or community and voluntary sector input

Pathway One 'Homefirst' – Return Home with additional Support 1
Homefirst principle with support to recovery or pre-existing Domiciliary Care that needs to be increased

Pathway Two – Bedded Recovery/Reablement/Rehabilitation 2
Bedded facilities, such as Community Hospitals, bed based reablement units with the aim to recover people to get back home

Pathway Three – Longer Term Setting 3
Short Term Residential/Nursing Respite after recognised ongoing needs, which lead to long term nursing or residential placements if not home

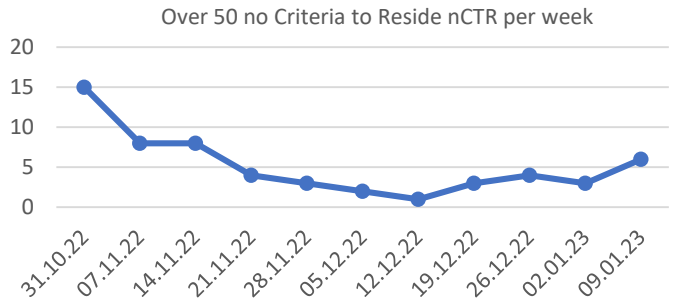


Chart 1
Showing the number of patients in a community hospital that have not met the criteria to reside for over 50 days (delayed/super stranded patient) date range: week commencing 31.10.22 – 09.01.23. Decrease in prevalence, reaching the lowest figure of 1, unfortunately now increased to 6, the aim would to be at zero.

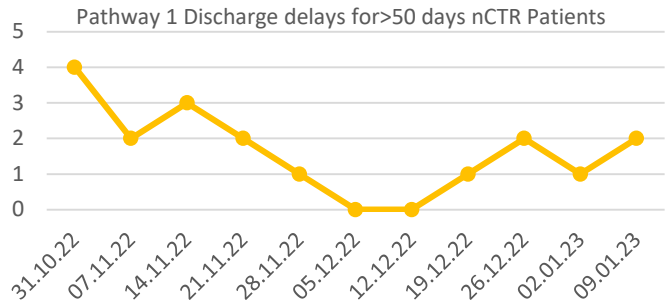


Chart 2
Showing the number of patients delayed on Pathway 1 for over 50 days. Date range: week commencing 31.10.22 – 09.01.23. **Please note 5.12 & 12.12 indicate zero waits over 50 days.**

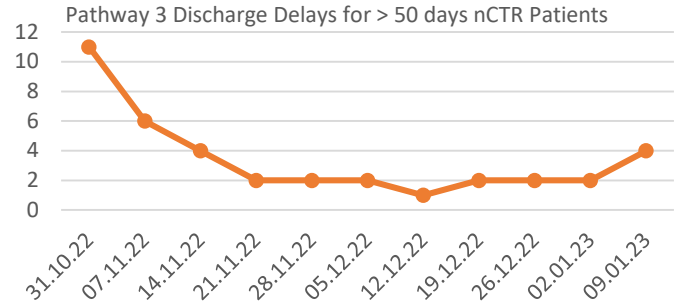


Chart 3
Showing the number of patient delayed on Pathway 3 for over 50 days. Date range: week commencing 31.10.22 – 09.01.23.

Sharing learning – Patient Safety and Quality of Care noticeboards

Following early learning from a homicide involving a mental health inpatient, it was identified that different ways of communicating with staff in inpatient settings needed to be explored. The nature of their roles means that they did not always have the opportunity to access emails and Trust-wide communications. This becomes more significant when you consider the numbers of temporary or agency colleagues that we rely on in our inpatient services.

To support the use of Trust-wide communications and the dissemination of learning, Patient Safety and Quality of Care noticeboards have been introduced. As well as sharing learning from incidents, these boards are designed to share best practice, learning and other important information from across NTQ. They will be updated monthly and link workers at each site have been identified to support this. The boards use post-it notes and emoji-style stickers to enable staff to engage with content, and this will also provide data on how the boards are used.

The next steps will be for boards to be introduced into community hospitals and for a compact version to be designed for use in community teams.

Where?

- Wotton Lawn Hospital x 4
- Charlton Lane Hospital x 2
- Berkeley House
- Laurel House

Content

- ✓ Learning on a page
- ✓ Duty of Candour
- ✓ Medicines information
- ✓ Antimicrobial stewardship
- ✓ Ligature information
- ✓ Restrictive practice
- ✓ PMVA
- ✓ Safeguarding
- ✓ Compliments

Improving the patient's experience of engagement during observation in Wotton Lawn Hospital - QI project

Work continues as per plan with the steering group meeting every fortnight. In addition to experts by lived experience and ward staff, the steering group now also includes medical staff. Information about the project was recently shared at an inquest and, as a result, a parent of a patient who died by suspected suicide in Wotton Lawn Hospital has also requested to be involved. The project aims have been expanded to ensure that our clinical practice reflects good practice. Reconnecting the evidence that a better understanding and engagement with mental health patients builds trust and has a positive impact on their care and recovery (Isay 2006, Barkham 2002, Hewitt & Coffey 2005) is a core foundation of this nursing intervention and programme of work. This will include observations made in the Bowers' 'Safewards model', which aimed to reduced the conflict and containment often experienced within inpatient settings.

With this in mind, the group is continuing to explore both quantitative and qualitative ways of measuring the patients' experience, including through the use of therapeutic questionnaires and a baseline survey, as well as data from Datix and PCET.

Patient Preference Boards

The group identified a patient preference board as first change idea they wanted to implement. Designed by experts with lived experience and initially planned to be outside the patient's room, they could then write on it in order to express preferences, including about what form engagement might take.

The boards were printed sheets of A3, with prompts for the patients such as "Today, I would like to…" and a free space for them to use as they wished. These sheets were laminated and the patients were given pens to write on them.

Initially trialled with two patients, it was decided to place them inside the patients' doors to protect their privacy and to prevent anyone else writing on them. By putting them inside the doors, staff would have to pause and notice while carrying out the observations, and could then use the content of the boards to support engagement with the patients.

Of the two patients it was initially trialled with, one engaged and one didn't, so a second patient was selected in place of the one who didn't engage.

Patient A

Shared information about how she was feeling. Requested to see an OT, which staff were able to action for her. Requested a phone call with a family member. Comments on board gave helpful insight into her mental state.

Patient B

On ward round reported feeling fine, but wrote on board he felt "severely depressed." Shy, so found it hard to approach staff. Used the board to request the results of his blood tests.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

- The Quality Improvement Hub is a dedicated Trust team of subject matter experts whose primary aim is to provide leadership to the organisation in the field of improvement science. The team seek to support the experts – the people who use our services and those that deliver them, to understand problems identified and the associated data, find change ideas, test them out at small scale, upscale as appropriate and make them sustainable using proven methodology.
- This update provides a brief overview of the Trust QI training programme- with its intention to ensure that a QI approach is embedded across the whole organisation by;
    1. Providing a complete range of training packages that demonstrate learning outcomes in alignment with the Kirkpatrick Evaluation Framework
    2. It also shows the active QI projects recorded on Life QI- the system the trust utilises to capture and share QI activity.

Quality Improvement Hub Support along the Improvement Lifecycle

1. New improvement opportunity/concept/idea

- National mandate
- New service bid
- GHC Strategic priority
- ICS/CCG mandate
- Colleagues
- Service users/Carers
- Quality Issue

- = Support for Health & Wellbeing in the Organisation
- (s) =Length of time on core CAMHS caseload
- =Improve communication and liaison between maternity service and health visiting service
- = Substance misuse in CAMHS
- + Improving management of Depo across the system in Gloucester Recovery Team
- + (s)Improving access to training opportunities for AHP support workers
- + (s)Reducing the number of band 5 therapists leaving Mental Health Intermediate Care Teams (MHICT)

2. Improvement idea scoping

- What is it
- Why are we doing it
- What are the benefits/risks
- Is the problem clear, understood and agreed
- Is there data

- = (s)Key admin contacts in GHC

3. Improvement idea initiated

- Stakeholder mapping
- Tools to understand the problem
- Baseline data
- Early team tasks
- Life QI

- = (s) Blanket Rules Review
- = (s)Effective discharge of north cots recovery patients
- = (s) Defining the OT role in Older Adults Mental Health
- = (s) Referral centre triage
- = (s)Engagement in Sustainability
- = Improving sexual safety in Mental Health inpatient areas
- = Optimising Flow in Community Hospitals
- = (s)North Cotswolds IPS referral rates
- = (s) Nutritional screening risk
- = (s) Sharing and Promoting Excellence
- = Neuro-fitness group
- = (s) MDT working in therapies CYPS
- = Referrals into the SNS continence
- = RRP Dean Ward (Reducing Restrictive Practice)

4. Improvement idea testing – e.g.: PDSAs

- Using the Model for Improvement to test change ideas
- Data to show towards progress and inform next steps

- = (s) Improving Mouthcare standards within our inpatient areas
- = Improving Medicine Administration at Lydney Hospital
- = Carers Working Group
- = Updating of the MHA administration process in accordance with the new legislation
- = (s) Observations in inpatient mental health settings
- = RRP Greyfriars Ward
- = RRP Mulberry Ward

5. Improvement idea sustained & implemented

- Evidence of sustained improvement through data
- Ongoing quality control & assurance agreed

- = Improving Access & Delivery of Family Interventions with Psychosis & bi-polar within the Early Interventions Team
- = Home First therapists using NEWS 2 (Therapies spotting the deteriorating patient and escalating appropriately)
- = Sustainability - Supporting planning of role out
- ↑ RRP Berkeley House

Key:
+ new to tracker
= no movement
↑ moved forwards
↓ moved backwards
*Restarted
(s) Silver project

Training data Dec 2022:
17 Silver – 0.4% workforce
426 Bronze - 9.2% workforce
262 Pocket QI – 5.7% workforce

Please note: we are currently reviewing the improvement cycle in order to simplify it and ensure it is a true reflection of where projects are

Directorate	No of Projects
Operations	22
Nursing, Therapies & Quality	9
Medical	0
HR and Finance	1
Strategy & Partnerships	1
Total: 33	

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

GHC - Safeguarding Dashboard 2022/22 Adults/Children's Safeguarding Data

Children's	Q1 Total	Q2 Total	Oct	Nov	Dec	Q3 Total	Additional Information
SAFEGUARDING SUPERVISION							
Integrated Group Supervision sessions	42	62	20	23	13	56	Clinical staff working with children need to attend this supervision 3x per year. 5-6 sessions are delivered per week. Attendance at sessions is excellent, with a maximum of 8 participants per session. Feedback is sought and captured following every session via a Snap Survey – feedback helps to share future sessions. GSV sessions were not offered over the Christmas period and 4 sessions we cancelled due to planned industrial action, hence fewer session delivered in December.
Safeguarding Children Group Supervision Compliance			64%	65%	59%	63%	In April 22 Safeguarding Group Supervision was added as an 'essential to role requirement' to staff Care to Learn Training Profiles. Compliance is expected to rise as staff catch up with this requirement.
One to one Supervision sessions	4	8	3	5	0	8	121 Supervision is available to all upon request. In line with learning from recent child safeguarding reviews that recommend focused case reflection and discussion the team have been promoting 121 supervision across operational teams. Q2 & Q3 figures show an increase in 121 sessions being promoted.
SAFEGUARDING ACTIVITY							
Advice Line Calls	142	129	51	72	46	169	Operational colleagues continue to make good use of the Safeguarding Advice Line.
Multi-Agency Request for Service Forms submitted to MASH	44	47	21	20	18	59	The Local Authority are unable to provide referral data and current clinical systems are unable to accurately capture this data. This is a documented risk – Risk 298. An action plan is in place with data being captured via the Safeguarding Notifications Inbox.
Number of Escalations	4	5	1	1	1	3	This information is currently obtained from our Safeguarding Advice Line data. Further work is underway with Clinical Systems/Business Intelligence Teams to identify the number of escalations made to partner agencies.
Adults	**Q1 Total**	**Q2 Total**	**Oct**	**Nov**	**Dec**	**Q3 Total**	**Additional Information**
SAFEGUARDING SUPERVISION							
Group Supervision Sessions	20	24	6	5	3	14	Safeguarding Adult Supervision Sessions are now offered to all clinical staff who work in Adult Services. Supervision is optional and booked via Care to Learn. Bespoke Supervision Sessions are offered for Team Leads and Managers. GSV sessions are cancelled if no staff are booked onto a session. Sessions were not offered over the Christmas period and sessions we cancelled due to planned industrial action, hence fewer session delivered in December.
SAFEGUARDING ACTIVITY							
Contacts to GHC advice Line	121	158	57	59	61	177	Calls to the GHC advice line re. adult safeguarding enquiries - may or may not proceed to a referral to the Local Authority. Q3 saw a increase in advice line calls.
Safeguarding Referrals made to GCC	4	27	7	5	9	21	This data is obtained from the Safeguarding Team Notifications Inbox. Work is underway with Clinical Systems and Business Intelligence to identify mechanisms across our clinical systems which capture this data accurately. For assurance this is captured manually at present.
Escalations	2	1	1	0	0	1	This data is currently obtained from our Safeguarding Advice Line data, so is unlikely to give a accurate picture of referral numbers. Work is underway with Clinical Systems to identify mechanisms across our clinical systems which capture this data accurately
CASE REVIEWS							
New Safeguarding Adult Reviews/Domestic Homicide Reviews	2	1	0	0	0	0	No new notifications in Q3 2022
Number of Reviews ongoing	11	12	12	12	12	12	6 Domestic Abuse Related Death Reviews, 4 Domestic Homicide Reviews, 2 SARs (1 awaiting publication) – All at varying stages of the review process.
Action Plans Ongoing	5	6	6	6	6	6	This includes single and multi agency action plans

Summary Notes - A full breakdown of Safeguarding Activity is outlined in Appendix 2

Safeguarding children and adults is a key element of the assessment and care management processes for staff. There are arrangements to ensure staff are appropriately trained, supervised and supported in their safeguarding related work. The Trust's Safeguarding Group monitors safeguarding activity and reports quarterly into the Quality Assurance Group. We continue the expansion of the adult safeguarding supervision offer to all adult teams. The GHC Safeguarding Notifications inbox to capture number of safeguarding referrals made to the Local Authority is operating well and this provides the Safeguarding Team with improved oversight of organisational safeguarding activity. Monthly auditing of Safeguarding adult practice and record keeping is underway and work is progressing with Clinical Systems to enable a BI solution to safeguarding reporting. Children's Safeguarding Group Supervision compliance data is now being captured, reported monthly, and shared with CYPS services. An Improving picture with Level 4 Adult Safeguarding Training, Level 2 Think Family Training, and Level 3 Prevent Training compliance and Continued 100% representation at MAPPA meetings and multiagency safeguarding partnership meetings during Q3.

Challenges/risks: We are manually recording the number of referrals to Gloucestershire County Council Safeguarding Team to ensure we remain sighted on activity and can monitor cases, liaise with teams and support any enquiries. Having identified some variation in how Safeguarding related data is recorded on our clinical systems, we continue implementing the Safeguarding Action Plan to address risk and apply mitigations. We are working closely with Clinical Systems, Business Intelligence and Safeguarding Task and Finish Group working to find solutions that address the risk. Number of staff attending Safeguarding Adult Supervision Sessions remains low. A plan is now in place for the Safeguarding Team to attend a series of operational team meetings to raise the profile of adult safeguarding and share key messages including our Safeguarding Supervision offer. We have developed a dynamic report to help teams identify compliance issues with household contacts – a validation exercise was completed in December to begin running team detail from January 2023.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES SAFE? Trust Wide Physical Health Focus

	Reporting Level	Threshold	2021/22 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022/23 YTD	R / A / G	Exception Report?	Benchmarking Report
VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	98.3%	99.1%	100%	99.2%	99.1%	96.6%	98.2	98.1	100%	97.9%				97.96	G		
Number of post 48 hour Clostridium Difficile Infections (C Diff)	N	1	21	0	1	3	0	0	1	2	1	1				9	G		
Number of C Diff cases (days of admission plus 2 days = 72 hrs) - avoidable	N	0	0	0	0	0	0	0	0	0	0	0				0	N/A		
Number of MRSA Bacteraemia	N	0	0	0	0	0	0	0	0	0	0	0				0	N/A		
Total number of developed or worsened pressure ulcers	L - R	61	779	70	77	60	79	65	57	77	68	52				605	R		
Total number of Category 1 & 2 Acquired pressure ulcers	L - R	56	702	66	71	56	69	59	53	66	64	49				553	R		
Number of Category 3 Acquired pressure ulcers	L - R	0	57	3	5	3	2	4	3	8	2	1				31	R		
Number of Category 4 Acquired pressure ulcers	L - R	0	19	1	1	1	8	2	1	3	2	2				21	R		

ADDITIONAL INFORMATION - Health Care Acquired Infections (HCAI) & Pressure Ulcers (PU)

HCAI

- There was one post 48-hour Clostridium Difficile (C. Diff) infection recorded in December, the patient was treated and managed as per policy.

Pressure Ulcers

- There is a reduction in the number of new pressure ulcers this month and as in previous reporting periods it is expected that following validation there will be a large proportion of PU that are defined as unavoidable, particularly those patients who are end of life. We continue to acknowledge that as an organisation we will always have pressure ulcers evident within our Trust as a large proportion of patients are referred to us with an existing PU, Community nursing caseloads have patients referred with existing pressure ulcers obtained whist under primary care, residing in care homes or acute hospital transfers. The pressure ulcer data is monitored via improved reporting, verification/alteration of classification and improved operational tolerances.
- The three common factors remain that will continue to impact on severity of pressure ulcers; Circulatory changes following Covid infection, deconditioning of patients who live at home and have become more socially isolated and physical immobility during and following Covid infection.
- There was a decrease in avoidable pressure ulcers this month to zero in our community hospitals (1 to 0) and 4 within ICT (12 to 4) , these can occur as a result of patients being in a non GHC environment, not being concordant with advice given and also attributable is the complexity of caseloads.
- GHC Deputy Director of Nursing has agreed with ICS peers that the arrival of the new National Wound Care Strategy provides a platform for a true system approach to the prevention, identification and management of PU across all partners- This work has been temporarily paused but will be re-established as soon as the system pressure reduces.
- The Patient Safety Team are working with the senior nursing colleagues across the inpatient and community teams to enhance the validation process to ensure incidents are reviewed earlier and learning shared with teams. The aim is to improve the data quality for teams and make incidents more accessible.

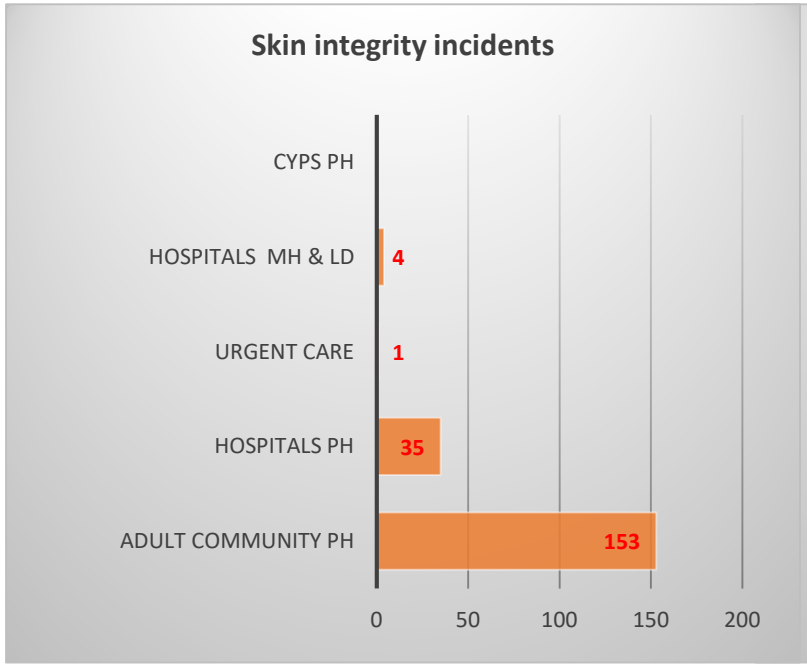
N - T	National measure/standard with target	L – I	Locally agreed measure for the Trust (internal target)
N - R	Nationally reported measure but without a formal target	L – R	Locally reported (no target/threshold) agreed
L – C	Locally contracted measure (target/threshold agreed with GCCG)	N – R/L – C	Measure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

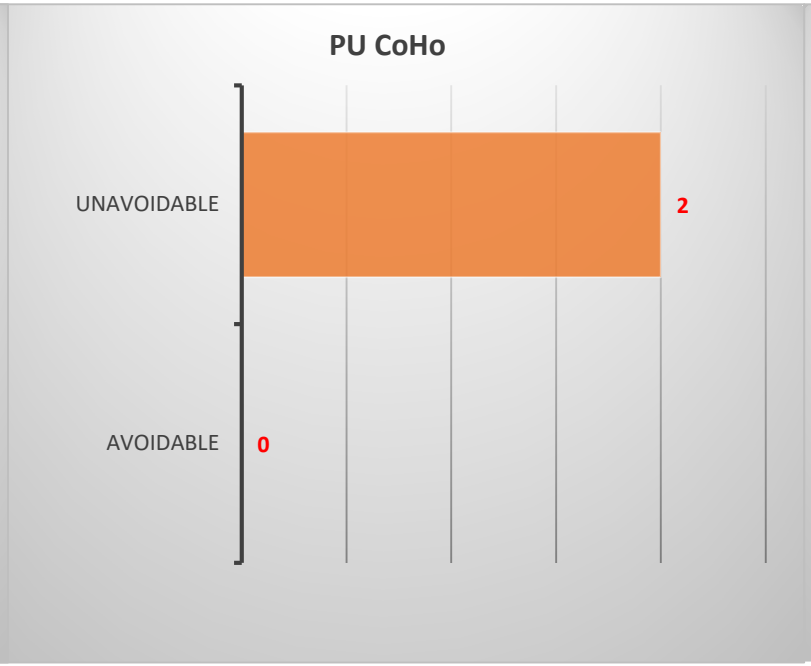
RAG Key: R – Red, A – Amber, G - Green

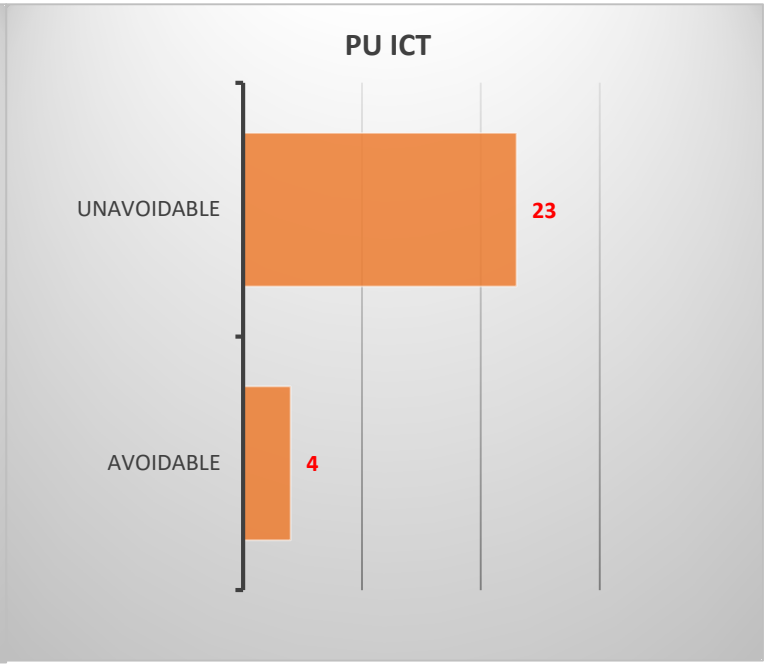
Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES SAFE?
Pressure Ulcers – December 2022 Additional Information Trust Wide







Bar chart showing skin integrity incident reports per service.

- Adult community PH: 153
- Hospitals PH: 35
- Urgent care & specialist services: 1
- Hospitals MH & LD:4
- CYPS PH 0

Bar chart showing PU's developed or worsened under GHC care (acquired) in our Community Hospitals in December 2022

- Community PH hospitals pressure ulcers that have developed or worsened under our care (acquired under our care). ***Reviewed*** as being unavoidable or avoidable because of co morbidities, patient choice (for example patients may decline to use equipment or clinical advice.)
- 2 unavoidable
- 0 avoidable

Bar chart showing data reported in community PH in December 2022

- Snapshot of Community PH pressure ulcers that have developed or worsened under our care (acquired under our care). ***Reviewed by handlers*** as being unavoidable or avoidable. These decisions may have been made because of co morbidities, patient choice (for example patients may decline to use equipment or clinical advice.)
- 23 unavoidable
- 4 avoidable

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES SAFE Safe Staffing Inpatient data – December 2022	**Code 1** - Min staff numbers met – skill mix non-compliant but met needs of patient		**Code 2** - Min staff numbers not compliant but met needs of patients e.g. low bed occupancy , patients on leave		**Code 3** -Min staff numbers met – skill mix non-compliant and did not meet needs of patients		**Code 4** - Min staff numbers not compliant did not meet needs of patients		**Code 5** – Other reason	
Ward Name	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions
Dean	0	0	35	4	0	0	0	0	0	0
Abbey	90	12	7.5	1	0	0	7.5	1	0	0
Priory	97.5	13	0	0	0	0	0	0	0	0
Kingsholm	7.5	1	7.5	1	0	0	0	0	0	0
Montpellier	7.5	1	10	1	0	0	0	0	0	0
Greyfriars	202.5	25	0	0	0	0	0	0	0	0
Willow	7.5	1	337.5	42	0	0	0	0	0	0
Chestnut	35	4	37.5	5	0	0	0	0	0	0
Mulberry	50	6	7.5	1	0	0	0	0	0	0
Laurel	7.5	1	15	2	0	0	0	0	0	0
Honeybourne	0	0	0	0	0	0	0	0	0	0
Berkeley House	37.5	5	225	21	0	0	0	0	0	0
Total In Hours/Exceptions	542.5	69	682.5	78	0	0	7.5	1	0	0

NOTES: We have cross referenced the highest exceptions with patient safety and patient carer and experience data available in month. Although Abbey, Priory and Greyfriars have reported the highest code 1 exceptions the Matrons report this didn't adversely impact on care delivery or patient experience. The majority of the code 1 exceptions occurring on Abbey Ward were attributable to RN shortages on both early and late shifts . The Priory ward code 1's related to a shortage of an RN on early and late shift . The reason for the deficit is relating to vacancy, long term sickness & Maternity. These shifts have mostly been filled with regular HCA's, who know the ward environment. Greyfriars code 1 exceptions relate predominately to RN vacancies on early and late shifts that have been backed up by experienced HCAs. The code 4 on Abbey was a result of last minute sickness. This was escalated in house and allied health professionals worked on the ward to support the shift to meet the needs of patients and support the ward staff. Initially graded a 4, however, the provision of additional staff mitigated the risk down to code 1, Although it impacted on some planned appointments, patient and staff safety was maintained. * Coln Ward variance re fill rate is due to reporting of data not matching with relocation into temporary areas due to building work

Mental Health & LD			
Ward	**Average Fill Rate %**	**Sickness %**	**Vacancy %**
Dean Ward	103.15%	9.0	24.3
Abbey Ward	100.94%	0.7	32.5
Priory Ward	139.09%	13.6	39.0
Kingsholm Ward	127.47%	25.4	17.0
Montpellier	121.13%	5.0	9.0
PICU Greyfriars Ward	134.68%	8.3	32.6
Willow Ward	98.44%	0.0	22.5
Chestnut Ward	103.41%	10.8	3.2
Mulberry Ward	103.55%	4.2	13.0
Laurel House	98.92%	7.6	9.5
Honeybourne Unit	102.96%	5.4	1.0
Berkeley House	102.28%	6.1	27.9
Totals (Dec 2022)	**111.33%**	**6.5%**	**17.4%**
Previous Month Totals	119.72	8.5	16.8

Physical Health			
Ward	**Average Fill Rate**	**Sickness %**	**Vacancy %**
Coln (Cirencester)	78.47%*	8.2	11.0%
Windrush (Cirencester)	144.57%	8.2	11.0%
The Dilke	105.57%	3.6	9.0
Lydney	97.64%	2.7	0.9
North Cotswolds	118.55%	4.3	3.6
Cashes Green (Stroud)	101.80%	4.9	1.1
Jubilee (Stroud)	95.24%	11.8	13.8
Abbey View (Tewkesbury)	99.31%	0.2	0.0
Peak View (Vale)	109.06%	3.5	10.0
Totals (Dec 2022)	**105.58%**	**5.1%**	**7.3%**
Previous Month Totals	105.64	7.7	6.6

NHSE Zero HCSW Vacancy Commitment Inc. bank – 3 month report	
October	86.92
November	81.44
December	84.81

NHSE Zero HCSW Vacancy Commitment : This month there is a slight increase in the vacancy rate however there is also an increase of 14 recruits in the pipeline raising the figure to 56 due the to the ongoing recruitment project , this project summarises to five themes:: Attraction, Innovative Recruitment, Learning and Development, Recognition and Value and Staff Retention. Although regular turnover continues this project is making progress in reducing the vacancy figure. With attention being paid to improving and enriching the working experience of HCSW staff.

IR/Recruitment. The project is progressing well with **67%** delivery achieved on project tasks and a dedicated IR and recruitment advisor having been recruited. **56** international colleagues have been recruited to date (from Jan 2021) 42 RGNs, 12 RMN,s and 2 Community ICT's. **33** potential new recruits remain in the pipeline for Jan, February and March 2023.

Appendix One
IPC/COVID 19 Data- December 2022

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

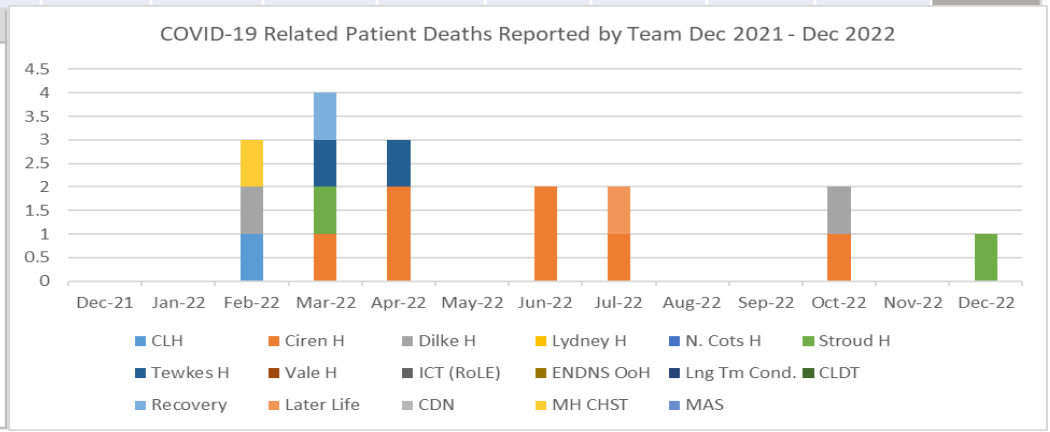
COVID-19 (Whole Trust data, reporting nationally mandated Covid-19 focused safety and activity information)

		2021/22 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022/23 YTD
No of C-19 Inpatient Deaths reported to CPNS		5	3	0	2	1	0	0	2	0	1				9
Total number of deaths reported as C-19 related.		8	3	0	2	2	0	0	2	0	1				10
No of Patients discharged from hospital post C-19 PH		77	35	33	21	15	17	18	23	24	24				210
No of Patients discharged from hospital post C-19 MH		25	12	7	10	8	9	5	5	7	0				63
Community onset (positive specimen <2 days after admission to the Trust)		24	3	2	5	12	4	5	3	3	2				39
Hospital onset (nosocomial) indeterminate healthcare associated - HOIHA (Positive specimen date 3-7 days after admission to the Trust)		18	2	0	2	2	1	5	1	3	7				23
Hospital onset (nosocomial) probable healthcare associated - HOPHA (Positive specimen 8-14 days after admission to the Trust)		10	1	0	2	2	0	4	2	1	5				17
Hospital onset (nosocomial) Definite healthcare associated - HODHA (Positive specimen date 15 or more days after admission to the Trust		92	20	8	6	27	1	25	28	4	22				141
No of staff self-isolating: new episodes in month			108	27	141	102	24	64	85	31	56				
No of staff returning to work during month			163	37	92	125	28	46	84	32	44				

Additional Information

- There were zero mental health patient community patient deaths reported in December.
- There was 1 inpatient Covid-19 related death reported in December where Covid was a contributory factor but not the primary cause.
- 2 cases of community onset were identified in December
- 7 cases of HOIHA were identified in December
- 5 cases of HOPHA were identified in December
- 22 cases of HODHA were identified in December

This month we see increasing HODHA levels with the highest number of cases being reported on Montpellier Ward (7) followed by Cashes Green (4) IPC practices continue to be followed across all Trust areas.



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Appendix Two
Trust Safeguarding Data

Summary information:

The Safeguarding Dashboard provides assurance that:

- Safeguarding activity is a Trust priority function that is closely monitored
- Safeguarding is being delivered as per the requirements of the Gloucestershire Safeguarding Adults Board (GSAB), the Safeguarding Children Partnership (GSCP), commissioning expectations, and national guidance and legislation.

Safeguarding children and adults is a key element of the assessment and care management processes for staff. There are arrangements in place to ensure that staff are appropriately trained, supervised and supported in their safeguarding related work. The Trust's Safeguarding Group monitors safeguarding activity and reports quarterly into the Quality Assurance Group.

The Safeguarding Dashboard is presented in 3 sections:

1. Safeguarding Children Activity
2. Safeguarding Adults Activity
3. Safeguarding Training Compliance and Gloucestershire Safeguarding Partnership Meeting Representation

Highlights:

- The GHC Safeguarding Notifications inbox which captures the number of safeguarding referrals made to the Local Authority is operating well. This provides the Safeguarding Team with improved oversight of organisational safeguarding activity. Monthly auditing of Safeguarding adult practice and record keeping is underway and work is progressing with Clinical Systems to enable a BI solution to safeguarding reporting.
- Children's Safeguarding Group Supervision compliance data is now being captured, reported monthly, and shared with CYPS services.
- Improving picture with Level 4 Adult Safeguarding Training, Level 2 Think Family Training, and Level 3 Prevent Training compliance.
- Continued 100% representation at MAPPA meetings and multiagency safeguarding partnership meetings during Q3.
- Continued excellent used of the Safeguarding Advice Line by children and adult services, demonstrating a good awareness of the service across the Trust.

Challenges/risks:

- Audit has identified some variation in how Safeguarding related data is recorded on our clinical systems. We have a Safeguarding Action Plan in place to address risk and apply mitigations. We are working closely with Clinical Systems, Business Intelligence and Safeguarding Task and Finish Group working to find solutions that address risk.
- Number of staff attending Safeguarding Adult Supervision Sessions remains lower than we require. A plan is now in place for the Safeguarding Team to attend a series of operational team meetings to raise the profile of adult safeguarding and share key messages including our Safeguarding Supervision offer.

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Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

GHC - Safeguarding Dashboard 2022/22 Children's Safeguarding Data

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Integrated Group Supervision sessions	42	62	20	23	13	56	Clinical staff working with children need to attend this supervision 3x per year. 5-6 sessions are delivered per week. Attendance at sessions is excellent, with a maximum of 8 participants per session. Feedback is sought and captured following every session via a Snap Survey – feedback helps to share future sessions. GSV sessions were not offered over the Christmas period and 4 sessions we cancelled due to planned industrial action, hence fewer session delivered in December.
Safeguarding Children Group Supervision Compliance			64%	65%	59%	63%	In April 22 Safeguarding Group Supervision was added as an 'essential to role requirement' on staff Care to Learn Training Profiles. Compliance is expected to rise as staff catch up with this requirement.
One to one Supervision sessions	4	8	3	5	0	8	121 Supervision is available to all upon request. In line with learning from recent child safeguarding reviews that recommend focused case reflection and discussion the team have been promoting 121 supervision across operational teams. Q2 & Q3 figures show an increase in 121 sessions being delivered. The importance of 121 supervision continues to be promoted.
SAFEGUARDING ACTIVITY							
Advice Line Calls	142	129	51	72	46	169	Operational colleagues continue to make good use of the Safeguarding Advice Line.
Multi-Agency Request for Service Forms submitted to MASH	44	47	21	20	18	59	The Local Authority are unable to provide referral data and current clinical systems are unable to accurately capture this data. This is a documented risk – Risk 298. An action plan is underway to address this. LA Safeguarding Referral data is now captured via the Safeguarding Notifications Inbox.
Number of Escalations	4	5	1	1	1	3	This information is currently obtained from our Safeguarding Advice Line data. Further work is underway with Clinical Systems/Business Intelligence Teams to identify the number of escalations made to partner agencies.
CHILD DEATH NOTIFICATIONS							
Expected	1	4	1	3	6	10	Expected deaths are infants with known life limiting conditions or cases of extreme neonatal prematurity.
Unexpected	9	6	1	1	2	4	Gloucestershire Child Death Overview Process is followed for each unexpected death. Cause of each death has not yet been formally reported. No safeguarding concerns were identified as a factor in any unexpected child deaths in Q3.
RAPID REVIEWS/LCSPR'S							
Number of Serious Incident notifications made to LA	1	3	1	0	0	1	1 SIN notification made Q3.
Number of Rapid Reviews attended	1	2	2	1	0	3	The Safeguarding Team participated in 3 Rapid Reviews in Q3. 1 is being progressed to a LCSPR.
Number of LCSPR's in progress	2	2	2	3	3	3	1 Gloucestershire LCSPR awaiting publication - single and multi-agency action plan in progress. 1 joint Surrey/Glos LCSPR - no GHC involvement. 1 LCSPR relating to a Child in Care to commence in January 2023.
MASH HEALTH TEAM ACTIVITY							
Children researched/info shared	2,372	2,242	772	813	698	2,283	MASH activity remains stable.
Adults researched/info shared	189	195	94	127	163	384	Higher number of adults researched during Q3 than in previous months this year. This is due to the re-introduction of the high risk morning meeting.
MASH strategy meetings attended	107	86	50	36	37	123	The MASH health team attend 100% of strategy discussions they are invited to.
Demographic information sharing	452	575	149	169	166	484	MASH health are frequently asked for demographic data from children's social care - this is due to referral data quality and incomplete data.
AUDITS							
Single Agency	0	0	0	1	1	1	Trust wide Safeguarding Children Audit is underway – Final report due January 2022.
Multi-Agency sub group activity	1	1	0	0	0	0	No multi-agency safeguarding audits have taken place during Q3.
UNDER 18'S ADMISSIONS							
Number of under 18's admitted to Adult MH Wards	1	0	0	0	0	0	No children were admitted to adult mental health wards in Q3.
Number of under 18's assessed under S.136 of the MHA 83/07	9	6	2	2	2	6	Activity is within normal ranges when comparing against year on year trends.
OTHER WORKSTREAMS							
Allegations management – number of referrals to/from the LADO	0	2	0	0	0	0	There were no referrals to/from LADO in Q3.

GHC - Safeguarding Dashboard 2022/22 Adults safeguarding Data

	Q1 Total	Q2 Total	Oct	Nov	Dec	Q3 Total	Additional Information
SAFEGUARDING SUPERVISION							
Group Supervision Sessions	20	24	6	5	3	14	Safeguarding Adult Supervision Sessions are now offered to all clinical staff who work in Adult Services. Supervision is optional and booked via Care to Learn. Bespoke Supervision Sessions are offered for Team Leads and Managers. GSV sessions are cancelled if no staff are booked onto a session. Sessions were not offered over the Christmas period and sessions we cancelled due to planned industrial action, hence fewer session delivered in December.
SAFEGUARDING ACTIVITY							
Contacts to GHC advice Line	121	158	57	59	61	177	Calls to the GHC advice line re. adult safeguarding enquiries - may or may not proceed to a referral to the Local Authority. Q3 saw a increase in advice line calls.
Safeguarding Referrals made to GCC	4	27	7	5	9	21	This data is obtained from the Safeguarding Team Notifications Inbox. Work is underway with Clinical Systems and Business Intelligence to identify mechanisms across our clinical systems which capture this data accurately via electronic patient records
Escalations	2	1	1	0	0	1	This data is currently obtained from our Safeguarding Advice Line data, so is unlikely to give a accurate picture of escalations. Work is underway with Clinical Systems to identify mechanisms across our clinical systems which capture this data accurately
CASE REVIEWS							
New Safeguarding Adult Reviews/Domestic Homicide Reviews	2	1	0	0	0	0	No new review notifications in Q3
Number of Reviews ongoing	11	12	12	12	12	12	6 Domestic Abuse Related Death Reviews, 4 Domestic Homicide Reviews, 2 SARs (1 awaiting publication) – All at varying stages of the review process.
Action Plans Ongoing	5	6	6	6	6	6	This includes single and multi agency action plans
MAPPA							
Level 2 Meetings Held	17	12	*			16	* Data unavailable monthly. Reported quarterly. 100% attendance at Level 2 & 3 MAPPA Meetings.
Level 2 Meetings Attended	17	12				16	
Level 3 Meetings Held	8	3				2	
Level 3 Meetings Attended	8	3				2	
PREVENT							
Number of Prevent Referrals Made	0	0	0	0	0	0	No Prevent concerns raised with the safeguarding team in Q3
Information requests received & completed from Police/Channel	7	10	3	10	2	15	Significant increase in requests in November. 100% response to all police and channel panel information sharing requests, supportive effective planning and decision making.
MARAC							
Families screened/researched	351	356	117	129	128	374	Overall a minor variation in month
No.of children open to MH Services	22	32	13	19	18	50	Marked increase in children open to mental health services – highlights the emotional impact of domestic abuse on children
No.of victims open to MH Services	38	33	16	12	9	37	Overall a minor variation in month and per quarter. Identifies link to the impact of domestic abuse on mental health
No.of perpetrators open to MH Services	34	51	19	19	19	57	Increase in domestic abuse perpetrators open to mental health services in Q3
Un-uploaded MARAC Action Plans		700*	132	0	0	0	MARAC Action Plan backlog cleared
DOLS - No. of referrals for standard authorisation from:							
Mental Health Services Total	2	6	2	2	2	6	Continued pattern of overall total of DOLS applications
Mental Health Services Authorised	2	3	0	2	2	4	
Physical Health Services Total	23	16	2	5	6	13	Physical health urgent applications (not requiring LA authorisation)
Physical Health Services Authorised	0	0	0	0	0	0	Nil authorised as patients have moved on before being application assessed
AUDITS							
Single Agency - Safeguarding Related	1	1	0	1	1	2	Monthly Safeguarding Adults dip sample auditing commenced in November 2022
Multi Agency Sub - Group Related	1	2	0	1	0	1	Participated in a detailed multi-agency audit on an individual with multiple safeguarding referrals/complexities
OTHER WORKSTREAMS							
Allegations management - use of PiPoT guidance	1	1	1	2	0	3	3 allegations this Q. 1 investigation remains on-going.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

GHC - Safeguarding Dashboard 2022/22 Training and Partnerships Data

	Q1 Total	Q2 Total	Oct	Nov	Dec	Q3 Total	Additional Information
TRAINING							
Level 1 - Induction	97%	97%	95%	93%	97%	95%	Overall a minor variation in month
Level 2 – Think Family	86%	85%	83%	88%	96%	89%	Overall a minor variation in month
Level 3 – Multi-Agency Child Protection	84%	82%	80%	85%	91%	85%	Overall a minor variation in month
Level 3 Adult Protection	83%	81%	75%	82%	88%	82%	Overall a minor variation in month
Level 4 Adult Protection	27%	28%	56%	55%	56%	56%	This training was applied to staff training profiles following a review of staff training requirements in April 2022. As expected training compliance is improving as staff catch up and complete the training. So Q4 position will enable an objective view on compliance.
PREVENT:							
Level 1	97%	97%	94%	94%	98%	95%	Continued high level of compliance with Level 1 Prevent Training
Level 2		83%	81%	83%	91%	85%	Prevent Training was reviewed in Q1 and 'stand alone' Level 2 Training introduced as no longer available within the Think Family Training, as a result it will take several months for staff to catch up with the necessary Level 2 prevent training, improved compliance is expected.
Level 3	88%	88%	92%	93%	94%	93%	The review of Prevent Training in Q1 identified that a large group of Adult Services Staff did not have Prevent Level 3 attached to their Learning Profiles, this has been rectified. Overall good compliance.
SAFEGUARDING RELATED PARTNERSHIP MEETINGS							
Quality & Improvement in Practice (QiiP)	1	1	*	*	*	1	* This group of meetings all run at different frequencies throughout the year and summaries will be provided on a quarterly basis. GHC Safeguarding Team representation at all partnership meetings.
MASH subgroup	1	1	*	*	*	1	
Child Death Overview Panel (CDOP)	1	2	*	*	*	1	
Strategic Health Group (ICS)Child	1	2	*	*	*	2	
GSCP Child Exploitation Subgroup	1	1	*	*	*	1	
GSAB Board Audit Group	1	1	*	*	*	1	
GSAB Safeguarding Adults Review Sub Group (SAR)	1	1	*	*	*	2	
GSAB Fire Safety Subgroup	1	1	*	*	*	1	
Business Planning Sub Group	1	1	*	*	*	1	
Policy & Procedure	1	0	*	*	*	1	
Gloucestershire Prevent Partnership Board	2	1	*	*	*	1	
MAPPA Strategic Management Board	0	1	*	*	*	1	
Strategic Health Group (ICS)Adults	1	0	*	*	*	1	
Domestic Abuse Board Operational Group	1	1				1	

Appendix Three
Trust Operational Data Extract

Additional information:

The information provided in the following slides is a snap shot of activity data that was created to monitor performance whilst the Operational Governance Structures were being redesigned. The information supporting the activity data is detailed in the BI Performance Dashboard that has visibility throughout the organisation. Currently the larger data set reports though:

- PFIG & Directorate Governance meetings on a monthly basis
- Business Intelligence Management Group - monthly which reports onward into the Resources Committee
- Pan Ops Directorate who escalate issues from individual Directorates which reports into QAG & Quality Committee.

In future iterations of the dashboard, the Operational Data Extract will be stood down, however, all reporting will channel through the operational governance route and an overview of data will be provided within the QAG paper to the Quality committee. This will reduce the duplication of data and the commitments on operational teams. The dashboard will focus on quality themes from services and give an overview on any enhanced surveillance in place to oversee quality in areas that have higher risk or emerging themes The dashboard will focus on quality themes from services and give an overview on any enhanced surveillance in place to oversee quality in areas that have higher risk or emerging themes.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES RESPONSIVE?

	Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	R / A / G	Exception Report	Benchmarking Report
Referral to Treatment physical health																			
Podiatry - % treated within 8 Weeks	L - C	95%	74.0%	49.6%	45.9%	41.4%	41.8%	37.1%	38.4%	35.3%	43.3%	43.6%				41.81%	R		
ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	85.75%	54.3%	50.6%	56.2%	51.1%	61.8%	58.4%	66.8%	66.0%	70.9%				60.21%	R		
ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	88.48%	66.8%	66.7%	63.5%	71. 2%	73.2%	61. 4%	69.7%	74.0%	82.0%				67.19%	R		
Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	82.6%	37.7	40.0%	40.9%	41.0%	37.4%	36.7%	61.6%	65.4%	68.7				47.67%	R		
Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	97.6%	87.2%	89.8%	87.6%	88.6%	92. 6%	85.5%	89.0%	96.1%	95.8%				90.31%	R		
Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	95.1%	35.0%	13.9%	11.6%	14.6%	15.2%	19.1%	3.3%	19.2%	11.1%				15.83%	R		
Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R	3,279	18644	1144	1203	1097	1128	998	1027	1051	1119	1361				10128			
Wheelchair Services Adults : New referrals assessed within 8 weeks	L - C	90%	74.0%	87. 5%	73.2%	85.3%	83.3%	76.2%	82.4%	85.5%	77.2%	85.9%				81.96%	A		
Wheelchair Services : Under 18's new referrals assessed within 8 weeks	L - C	90%	91.94%	100%	75.0%	53.8%	87.5%	72.7%	100%	78.9%	75.0%	90.0%				80.33%	R		
Mental Health Services (CPA and Eating Disorders)																			
CPA Review within 12 Months %	N - T	95%	90.3%	88.18%	92. 9%	94.8	96. 7%	96.4	94.4	97.1	96.3%	96.2%				94.8%	A		
Adolescent Eating Disorder - routine referral to NICE treatment start within 4 weeks %		95%	32.4 %		0.0%	0.00%	0.00%	16.6%	85.7	61.5%	50.0%	100%				48.58%	R		
Adolescent Eating Disorder - Urgent referral to NICE treatment start within 1 week %		95%	10.8 %	7. 1%	0.0%	0%	0.00%	5.5%	0.0%	20%	9.5%	43.7%				8.95%	R		
Adolescent eating Disorder - Urgent referral to non NICE treatment start within 1 week %		95%	14.2%			0%	0.00%	0.00%	33.3%	100%	0%	0%				16.67%	R		
Eating disorders - Wait time for adult assessments will be 4 weeks %		95%	58.2	59.0%	38.8%	57.1%	44.4%	46.1%	50.0%	55.0%	32.0%	68.4%				49.66%	R		
Eating disorders - Wait time for adult psychological interventions will be 16 weeks %	N – T	95%	75%	71.4%	80.0%	50.0%	25.0%	77.7%	55.5%	75.o%	57.1%	100%				68. 75%	R		

Additional information

Governance statement: - Improvements are being made in recovering the reported position with a SystmOne simplicity operational tracker now available which outlines the milestones across 2022/23 and sets out when all operational services will be expected to commit to a satisfactory data quality position**.** From an operational perspective the actual compliance data is higher than that reported above and recovery of actual against target position is beginning to show in the data lines above with teams continuing to ensure that data is correctly recorded in systems removing the need for validation and re entry. There have not been any reported adverse issues in terms of safety or experience and whilst there are targets not achieved in the data lines above, each service continues to seek improvement whist accepting the existing system limitations. To mitigate risk all services who are performing below optimum rate have recovery plans in place to manage demand which is monitored through operational and quality governance routes. Patients are triaged to assess clinical need and acuity with urgent cases being given priority, re - triage occurs as part of the process as acuity levels may alter whilst the patient is on a waiting list.

Wheelchair Services: In December there is improvement noted as 8 out of 57 routine adults and 1 out of 10 routine under 18's were seen outside time frame. All priority referrals for adults and under 18's were seen within timeframe .The backlog of patients is reducing being initially caused by increasing demand for service coupled with vacancies and sickness within teams. There does not appear to be any related incidents or increase in complaints linked to these areas.

Mental Health : CPA rates remain above target in December there is a spotlight slide earlier in the presentation which explores in more detail hot spots , trends and their causes.

Eating Disorders. Progress continues to be made to meet both the Urgent and Routine adolescent referral to NICE treatment KPI. Throughout December the team have been in a position to offer all Urgent adolescents an assessment within a week of the referral. The service is accepting routine referrals, which are triaged and placed on a waiting list. The service continues to work with BEAT (an Eating Disorders Charity) for those waiting for family based therapy (FBT) and Teens in Crisis (TIC) plus, for under-25 clients triaged as routine. The team has reduced the urgent adolescent assessment waiting list numbers and waiting times over the autumn and winter and are now able to offer patients an assessment/treatment start within a week of the referral being received where treatment is identified at the point of Assessment. The team continue to work with BEAT in referring parents/carers to the Developing Dolphins whilst clients await FBT. To date, 47 referrals have been made leaving 73 spaces. The next cohort will begin the support programme in Jan. The team referred 55 patients to the TiC TEDS programme, TiC are attending the EDS triage and a support officer is contacting patients to support the referral. 45 spaces remain available up to July 2023. .A Treatment pathway has been secured with ORRI (a specialist eating disorder centre offering intensive online treatment) for CYPS of 16, 17, 18 and 19 years of age who remain on the urgent treatment waitlists. The ORRI will treat 75 young people by March 2023. Thus far 65 patients have been identified for the ORRI treatment pathway. Letters have been sent and referrals to ORRI will follow.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES EFFECTIVE?

		Reporting Level	Threshold	2021/22 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022/23 YTD	R / A / G	Exception Report?	Benchmarking Report
Community Hospitals																				
Bed Occupancy - Community Hospitals		L - C	92%*	95.19%	89.9%	90.4%	89.5%	89. 5%	97.8%	97. 9%	98.1%	97.9%	97.3%				97.37%			
*** Indicates optimum occupancy to enable flow**																				
Early Intervention in psychosis EIP: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral		N - T	60%	90%	66.6%	62.5%	66.6%	75.0%	66.6%	75.0%	66.6%	60.0%	33.3*				64.6%	G		
Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered																				
Inpatient Wards		N - T	95%	68%	78%	82%	75%	72%	75%	78%	78%	76%	82%				82%	R		
Community		N - T	90%	28%	NA	22%	24.6%	30.54%	39%	49.9%	55%	64%	58%				58%	R		
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		N - T	50%	52.1%	50.5	49.1%	51.5%	50.6%	50.5	50.1	51.3%	51.2%	50.8%				50.6%	G		
Admissions to adult facility of patient under 16yrs		N - R		1	0	0	0	0	0	0	0	0	0				0	N/A		
Inappropriate out of area placements for adult mental health services		N - R	Occupied bed days	918	25	64	114	190	167	65	85	10	93				813	G		
Children's Services – Immunisations				2021/22 Outturn	Academic Year 2021/22 - Target 90% of all 2 immunisations by end of academic year (July 2022) and new cohort 1st immunisations					Academic Year 2022/23 - Target 90% of all 2 immunisations by end of academic year (July 2023) and new cohort 1st immunisations. Programme start date to be confirmed.										
HPV Immunisation coverage for girls aged 12/13 years old (Target for all 2 immunisations to be completed) HPV 2 begins March 2022		N - T	90%*	76.9%	40% / 30.0%	70% / 75.3	80% / 76.2%	85% / 77.0%	90% / 79.1%											.
Childrens Services - National Childhood Measurement Programme				2021/22 Academic Year	Academic Year 2021/22 - Target 95% of children measured by end of academic year - Cumulative target (July 2022) programme commences November 2021					Academic Year 2022/23 - Target 95% of children measured by end of academic year - Cumulative target (July 2023) programme commences end of October.										
Percentage of children in Reception Year with height and weight recorded		N - T	95%*	96.2%	70% / 69.9%	80.0% / 83.1%	95% / 93.3%	95% / 96.2%				10% / 15.2%	15% / 21.6%							
Percentage of children in Year 6 with height and weight recorded		N - T	95%*	96.1%	70% / 72.0%	80% / 79.7%	95.0% / 87.6%	95% / 96.1%				20% / 26.2%	25% / 31.6%							

Additional Information

NCMP: New year programme commenced 31st October 2022 figures reached target for November.
Children's services Immunisations: New year programme commenced 31st October.
OOA :93 days relating to 3 patients.(1 PICU, 2 Acute).
EIP: There were 2 non-compliant cases reported in December. These are due to dates recorded of allocation of an EI specialist care coordinator and the service are working with Clinical Systems to update RiO. Once amended, this indicator will be compliant at 100% for December.
Cardio-metabolic assessment – Teams are supported by two Physical Health Nurses within WLH and CLH. Ongoing development work is taking place to improve the current collection methods for this metric. The current support has now improved compliance rates and this focus will be maintained throughout quarter 4.

Quality Dashboard

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Additional KPIs - Physical Health

		Reporting Level	Threshold	2021/22 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022/23 YTD	R / A / G	Exception Report?	Benchmarking Report
Proportion of eligible children who receive vision screens at or around school entry.(Cumulative target)			95%*	97.7%	70.0% 71.8%	80.0% 88.1%	95.0% 95.0%	95% 97.7%	Programme starts end of October 2022			10% 15.0%	14% 21.2%	28%	40%	52%	10% 21.2%	G		
Number of Antenatal visits carried out				467	34	43	39	60	52	55	37	41	18				379	NA		
Percentage of live births that receive a face to face, telephone or video NBV (New Birth Visit) within 7- 14 days by a Health Visitor			95%	92.3%	92.6%	91.3%	93.4%	92.3%	94.2.%	93.2%	93.0%	92.9%	92.8%				92.9%	A	Y	
Percentage of children who received a face to face, telephone or video 6-8 weeks review.			95%	95.50%	88.9%	93.6%	90.5%	90.3%	94.7%	89.0%	95.4%	95.5%	94.5%				92.6%	A	Y	
Percentage of children who received a 9-12 month review by the time they turned 12 months.			95%	81.5%	82.2%	83.6	82.3%	82.8%	75.2%	77.4%	80.9%	82.6%	71.8%				79.85%	R	Y	
Percentage of children who received a 12 month review by the time they turned 15 months.			95%	86.8%	83.8%	81.9%	78.2%	81.2%	83.6%	82.3%	82.8%	74.4%	77.9%				80.6%	A	Y	
Percentage of children who received a 2-2.5 year review by 2.5 years.			95%	81.3%	76.1%	80.2%	82.9%	78.1%	84.4%	80.8%	85.8%	86.7%	83.6%				82.08%	R	Y	
Percentage of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence).			58%	56.7%	52.5%	52.2%	54.9%	50.0%	54.2%	54.2	53.5%	53.7%	57.5%				53.68%	A		
Breastfeeding- % of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks			80%	81. 5%	82.1%	76.3%	79.7%	81.6%	77.6%	81.4%	81.1%	82.0%	84.4%				80. 7%	G		

Additional Information

Governance statement: - Information on this page is triangulated with performance reporting with improvements being made in recovering the reported position. The Simplicity data quality project has impacted upon the accuracy of data in the physical health teams in this and in prior reporting periods**.** From an operational perspective the compliance data is understood to be higher than that reported above and teams are working to ensure that data is correctly recorded first time in systems to remove the need for validation and re entry. From a quality perspective there have not been any adverse indicators reported in terms of safety or experience noting that some targets are not achieved in the data above. We are expecting to be able to report a further improved position.

Health Visiting:

- **NBV and Child reviews**: There remains identified recording errors in relation to NBV and child reviews, however the impact of the Simplicity project is significantly reduced but set against this we have higher numbers of families requesting appointments out of timeframe due to holidays and not prioritising HV contact, families not being seen due to staff capacity and Bank staff being utilised for universal work, so can be out of timeframe where bank are only available on certain days. Record keeping training and data review continues to take place to update all practitioners with regard to the required new ways of recording.

- **Breastfeeding**: The breastfeeding rates are similar to last month and the % of mothers continuing with breastfeeding has remained above target. Breastfeeding prevalence is impacted by babies moving out/in to area after reaching 6-8 weeks. There is a programme of work with other stakeholders, infant feeding champions in place and updates are sent to all HV teams giving reminders to liaise/refer to locality infant feeding champion with any queries or support when required . The team continues to support colleagues to improve compliance, rates reflect similar challenges in partner organisations.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES WELL LED?

	Reporting Level	Threshold	2021/22 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022/23 YTD	RAG	Exception Report?	Benchmarking Report
Mandatory Training	L - I	90%	90.33%	92.4%	92.6%	92.1%	91.3%	91.8%	90.2	90.2	91.7%	91.9%				91. 9%	G		
% of Staff with completed Personal Development Reviews (Appraisal)	L - I	90%	67.72%	77.0%	78%	79%	79%	82%	83%	**81%**	81%	82%				82%	R	Y	
Sickness absence average % Rate	L - I	<4%	7.2%	6.5%	5.3%	6.0%	6.6%	5.4%	5.8%	6.5%	6.3%	5.4%				N/A	R	Y	

Additional information

- **Mandatory training -** Is at 91.9% overall, which is above target for the eleventh consecutive month.This achievement is a reflection of the focus in place to ensure staff are up to date with statutory/mandatory training, to maintain the current position and achieve improvement wherever possible. – **Please note we are currently undertaking further analysis at team level re areas of low compliance that potentially impact on quality for further attention and this will create metrics to feature in future main dashboard reporting for Board Assurance.**

- **Appraisal** - Is at 82% (active assignments only, excluding bank). The figure is slightly increased from last month and demonstrates a 5% overall increase through the year.

- **Sickness absence** - At 5.4% in month indicates a decrease from the previous month of 0.9%. Rates remain high and above target and in December the percentage figure equates to 8820 sickness days across the Trust. Data is now automatically received from workforce providing a robust single data source. This data can vary from BI source data as that stream does not include information from E-roster and is subject to timing.

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Appendix Four
Non Executive Directors Quarterly Service Review
Q3
Dec 2022

Living our Trust Values - *Working together*

Our Non-Executive Directors' conduct quality visits, for the purposes of Board Assurance, that seek to:

- Explore the experience of staff, patients, families and carers across our services
- Provide greater understanding and insight into the services provided by our Trust
- Contribute to assurance that our staff, patients, families and carers are given the high level of support and care expected by our Trust
- Promote a culture of listening, so that we can improve how we support and deliver our services

How we utilise the visits outputs:

- Feedback from the visits is shared with the visited service manager and relevant Director for their awareness, reflection and action
- Information from the NED's visits is discussed at the Trust Executive Committee as a scheduled agenda item to ensure that issues are recognised and suitably managed
- This information is shared at the Trust Pan-Operational Governance meeting so it's content and learning is widely shared with operational and clinical colleagues who can utilise the learning
- These visits form an important element of our Trust Quality Management System and supports a "Good Governance" model approach similar to the 3 Lines of Defence model

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Working together – Services visited in Q2 & Q3

Q2	Q3
Homeless Health Care Team	Later Life Team Collier Court
Podiatry Service	Cirencester Hospital
Community Assessment & Treatment Unit (CATU)	Rapid Response Falls Service
	Greyfriars, Wotton Lawn
	Intensive Home Treatment Team Pullman Place
	Stroud Hospital
	Crisis Team Lexham Lodge

Living our Trusts Values - Making a difference

Positive Feedback from NED colleagues (as described in visit reports)

I was impressed by its very patient focussed ethos, combined with creativity and enthusiasm to provide the best possible experience for people with LDs
Learning Disabilities – Intensive Home Treatment Service (IHOT)

My observations were that this was indeed a fantastic team and well led, delivering patient centred services that improve the quality of patents' lives.
Later Life Team

The CATU is a great example of place-based care, with a strong emphasis on co-production between CATU team, local GPs and patients and their carers/families
Community Hospital – Community Assessment & Treatment Unit (CATU)

There are many examples of kindness and compassion from the team.
Homeless Access Centre

Living our Trust Values – Making a Difference

Positive Feedback from NED colleagues (as described in visit reports)

They worked hard with their GP locums to increase the range of services they can provide. The locum GPs appear to be as passionate and committed to the client as the regular team
Homeless Access Centre

Staff from Greyfriars have been at the forefront of developing national standards within Psychiatric Intensive Care Units through active participation within the National Association of Psychiatric Intensive Care Units (NAPICU).
Greyfriars

The *Matron is creating a culture which is more empowering and engaging, so everyone feels they can make a difference.*
Cirencester Hospital

Visit Outcomes Update Q 1& 2 (1)

Service	Recommendation	Progress	Status
Street Triage	1. Review alternative models of service provision 2. Review IT requirements such as the use of iPads	**Ongoing development plans in place with Commissioners and Police Partners. IT issues previously scoped and available options were not effective. Issue being addressed further though ongoing Trust digital programmes. Discussed at Exec Committee (29/11/22) and learning shared through Operational Governance routes.**	**Closed**
Mental Health Liaison Team	1. Improve collaborative working between GHC and GHT and partner organisations 2. Review best practice and consider whether the work of the MHLT extend beyond assessment and signposting?	**Good work progressed re support for GHT in managing enhanced care as part of ICB project with MHLT as part of the enhanced offer. Good evidence of partnership working with GHT colleagues to develop service offer further. Discussed at Exec Committee (29/11/22) and learning shared through Operational Governance routes.**	**Closed**
Gloucester District and Community Nurses	1. Explore ways of addressing staffing shortages 2. Review IT infrastructure	**Ongoing work re recruitment and work is progressing regarding additional targeting of potential community recruits in partnership with University of Gloucestershire (UoG). A successful recruitment evet has been held for community nursing with UoG in December . HR have recruited a new dedicated post for recruiting and retaining nurses**	**Closed**
Managing Memory Service	1. QI project to consider improvements in processes particularly data entry requirements	**QI team input has been requested to offer support. Ops team are supporting work to improve waiting times. Discussed at Exec Committee (29/11/22) and learning shared through Operational Governance routes.**	**Closed**

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Visit Outcomes Update Q 1&2 (2)

Service	Recommendation	Progress	Status
ICT/District Nursing Stroud	1. Review of GIS to establish what more can the Trust do to secure a more functional system? 2. Seek wider views on Trac and what might be done to smooth out the recruitment process	**GCC/ICB led review of GIS in progress with GHC as key stakeholders and is on risk register.** **Additional training sessions provided in response to colleagues concerns, TRAC issues resolved.** **Discussed at Exec Committee (29/11/22) and learning shared through Operational Governance routes.**	**Closed**
Autistic Spectrum Disorder Service	1. Acknowledgement of the long waiting times and how this will be addressed within the Trust. 2. Consideration of additional resource to recruit to create a more substantial team	**This is recognised and work is being progressed with commissioners to seek to improve. Chief Operating Officer is leading work to address.** **Discussed at Exec Committee (29/11/22) and learning shared through Operational Governance routes.**	**Closed**
Wotton Lawn	1. Development of partnership with University of Gloucestershire to attract future graduates to work at WL 2. Consideration of temporary financial incentives for staff to work at WL 3. A review of the capacity of the service 4. Review of risk/benefit of the use of Covid masks 5. Maintenance inspection of external garden areas	**Work in progress re additional recruitment activity with UoG including delivering a joint conference for acute inpatient mental health nursing.** **Covid mask issue is subject to infection control guidance.** **Financial incentive schemes have been used and are being further considered.** **A large scale review of staffing levels in the context of service capacity has been completed and is being progressed to adjust baseline staffing levels.** **Estates regularly visiting Garden areas re request for maintenance.** **Discussed at Exec Committee (29/11/22) and learning shared through Operational Governance routes.**	**Closed**
IV Therapy Service	1. Consider further investment to expand the service	**ICB led review commenced in November 2022 to develop service as part of ICB system flow related programmes.** **Discussed at Exec Committee (29/11/22) and learning shared through Operational Governance routes.**	**Closed**

Visit Outcomes Update Q 1&2 (3)

Service	Recommendation	Progress	Status
Health Visiting Team FoD	1. Review of future service accommodation 2. Review current level of HV support	**Deputy Service Director is reviewing service specification for HV with commissioners ahead of potential tender.** **NTQ Quality lead for CYPS is working with Service Director re quality review for HV.** **Discussed at Exec Committee (29/11/22) and learning shared through Operational Governance routes.**	**Closed**
CAMHS LD	1. Explore possibility of an OT for the service	**Trust Chief AHP is conducting a Trust Wide Therapy review inclusive of roles within CAMHS across the Trust.** **Discussed at Exec Committee (29/11/22) and learning shared through Operational Governance routes.**	**Closed**
Cardiac Rehabilitation/ Heart Failure	1. Service is commissioned beyond a pilot project	**Service is not a pilot.** **Discussed at Exec Committee (29/11/22) and learning shared through Operational Governance routes.**	**Closed**
North Cotswolds District and Community Nursing	1. Explore use of dual SIM mobile phones 2. Explore ways to improve base Wi-Fi 3. Explore extra support for rising fuel and time taken to reimburse expenses	**IT aware of geographical challenges and are continuously seeking to support and improve matters as available infrastructure allows.** **Fuel cost situation has improved nationally. Trust made measures available to staff regarding the mileage cap at the time of this issue and Queens Nursing Institute support for community nurses and Trust support routes signposted** **Discussed at Exec Committee (29/11/22) and learning shared through Operational Governance routes.**	**Closed**
Vale MIIU	1. Explore feasibility of providing an x-ray facility seven days a week	**Shortages of X ray resources is recognised nationally and locally within the Glos ICB diagnostics working group.** **This is in part mitigated via the introduction of MIIU telephone triage ahead of boking an appointment where x-ray related cases can be directed to available resources.** **Discussed at Exec Committee (29/11/22) and learning shared through Operational Governance routes.**	**Closed**

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Visit Outcomes Update Q3 (1)

Service	Recommendation	Progress	Status
Homeless Healthcare	1. Develop a more integrated service model 2. Broaden support and provision available in particular from countrywide services 3. Improve Special Allocations Scheme (SAS) process	**Integrated model in development led by Chief Operating Office using external support re national best practice.** **To be discussed at Exec Committee (09/01/23) and learning shared through Operational Governance routes.**	**Closed**
CATU	1. Improve the recording of how patients are transferred in/out of CATU to community hospital beds 2. Explore rolling out CATU units across the County	**Established systems in place re recording transfers and reported into ops routes and ICB including NHSE "Sloman Plan" reporting.** **Roll out explored with ICB, currently not a system priority for funding.** **To be discussed at Exec Committee (09/01/23) and learning shared through Operational Governance routes.**	**Closed**
Rapid Response Falls	1. Explore reasons why there is a low up take for the service 2. Improve the information provided on the Trust website regarding the team 3. Look at upgrading the rapid response vehicle to include air conditioning	**Robustly identified via "Newton" review.** **Service development plan and wider re-commissioning work with completion date of March 2023, inclusive of new comms when re-launched.** **To be discussed at Exec Committee (09/01/23) and learning shared through Operational Governance routes.**	**Closed**
Later Life	1. Improve the information provided on the Trust website about the services provided by the teams 2. Explore the use of social workers within the teams to help facilitate packages of care	**Discussed at Exec Committee (09/01/23) and learning shared through Operational Governance routes. Changes to website info have been requested.**	**Closed**

Visit Outcomes Update Q3 (2)

Service	Recommendation	Progress	Status
IHOT	1. Explore better integration with primary care services 2. Raise awareness of what IHOT is and how it can be used	**Discussed at Exec Committee (09/01/23) and learning shared through Operational Governance routes.** **Objectively primary care integration is well established.**	**Closed**
Greyfriars Psychiatric Intensive Care Unit (PIICU)	1. Explore possibility of enhanced pay recognition to improve recruitment and retention –especially Band 5 recruitment 2. Bids for replacement furniture to support positive environment 3. Look at obtaining a replacement pool table 4. Look at additional bespoke training such as risk management training	**Enhanced pay and retention has been previously addressed through Trust schemes.** **Discussed at Exec Committee (09/01/23) and learning shared through Operational Governance routes.** **Furniture and pool table issue to be followed up though ops team.** **Training needs to be discussed with Team leader noting Trust does have risk training and CPD options available.**	**Closed**
Cirencester Hospital	1. Look at ways Corinium House could be used for accommodating staff 2. Review of volunteers re long service awards 3. Review of clinical support offered to international nurses including system1 training	**Corinium House is used when other better housing options not available.** **OD & Clinical Systems team have followed up System 1 issues following NEDS raising with additional support in place.** **Long service award to be followed up.** **Discussed at Exec Committee (09/01/23) and learning shared through Operational Governance routes.**	**Closed**

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AGENDA ITEM: 12/0123

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 January 2023**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Jo Masters, Mortality Review Officer
Gordon Benson, Quality Lead (Mortality, Engagement & Development)

SUBJECT: **LEARNING FROM DEATHS 2022/23 QUARTER 2 REPORT**

If this report cannot be discussed at a public Board meeting, please explain why.	

This report is provided for:
Decision ☐ Endorsement ☐ Assurance ☑ Information ☑

The purpose of this report is to:

The purpose of these reports is to Inform the Board of the learning from the mortality review process, data analysis and outcomes during Quarter 2, 2022/23.

It is a regulatory requirement for all NHS Trusts to identify, report, investigate and learn from deaths of patients in their care, as set out in the National Quality Board *National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care*, published March 2017.

These reports aim to present a broad range of available demographic and clinical data, and a trend analysis comparing current data with previous years as requested by the Trust Board.

The data included in this report was presented to and reviewed at the Quality Committee on 12 January 2023.

Recommendations and decisions required

The Board is asked to:

- Note the contents of this Learning from Deaths report which covers Quarter 2, 2022/23.

- **Executive summary**

Quarter 2, 2022/23 Learning from Deaths Report

- No concerning trends or themes have been identified.
- The increased reported death rate in Community Hospitals seen during Quarter 1 did not continue during this quarter and the mean age of death is 84.3 years and reflects the patient demographics; also, more patients are being transferred from the acute trust who require end of life care.
- The mean age of death of community mental health patients rose during this quarter to 76 years, however, the average age over time is considerably lower demonstrating the need for increased physical health monitoring and intervention for this cohort. The Mental Health & Learning Disability MRG meeting in January 2023 will have a focus on the initial findings of the physical health promotion work stream sitting within the Community Mental Health Team transformation project.
- Reviews of patients across community hospitals and mental health and learning disability services reveal low percentages of patients from BAME population. When the 2021 Gloucestershire Census ethnicity data is published, our mortality data will be compared to this to establish if it is representative of the local demographic.
- Cancer, frailty of old age, respiratory and cardiovascular illness remain the most prevalent causes of death, and respiratory infections remain the most prevalent cause of death of people with a learning disability, consistent with the findings from LeDeR reviews.
- 'Learning on a Page' documents are only generated where novel learning has been identified and 7 such learning summaries were generated this quarter; additionally, learning from a local LeDeR review was included.
- Feedback from the Medical Examiner service provides significant assurance that that the care provided to inpatients at the time of their death was of a good standard, that families were appreciative of the ME service input and were happy with the cause of death given, and gladly gave feedback about care when asked.

Risks associated with meeting the Trust's values

There are no identified risks associated with learning from deaths associated with the Trust's values.

Corporate considerations	
Quality Implications	Required by National Guidance to support system learning

Resource Implications	Significant time commitment from clinical and administrative staff
Equality Implications	None

Where has this issue been discussed before?
• Mortality Review Group meetings during Q2. • Quality Assurance Group 18 November 2022 • Quality Committee 12 January 2023

Appendices:	None

Report authorised by: Dr Amjad Uppal	**Title:** Medical Director

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AGENDA ITEM: 12.1/0123

Q2 2022/23 Learning from Deaths Report

Jovelyn Masters, Mortality Review Officer
Gordon Benson, Quality Lead (Mortality, Engagement & Development)

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

Overview

Gloucestershire Health and Care
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- During Q2 2022/23, 112 Gloucestershire Health and Care NHS Foundation Trust (GHC) patients died:

No. of GHC patient deaths reported during Q2 2022/23			
Jul	Aug	Sep	Total
46	31	35	**112**

- During Q2 2022/23 12 case record reviews and 11 comprehensive investigations were completed.

Number of comprehensive investigations and care record reviews completed during Q1-2 2022-23 for deaths occuring in:						
	Q2 2021-22	Q3 2021-22	Q4 2021-22	Q1 2022-23	Q2 2022-23	Total
Comprehensive investigations	0	0	7	3	0	10
Care record reviews	1	2	0	7	2	12
Total	1	2	8	10	2	22

- The numbers above do not include open comprehensive investigations and care record reviews.
- 0, representing 0.0% of the patient deaths reviewed during Q2 2022/23, were judged more likely than not to have been due to problems in the care provided to the patient.
- During Q2 2022/23 the Physical Health MRG stood down 2 meetings due to not being quorate. Once due to annual leave, and once due to sickness.

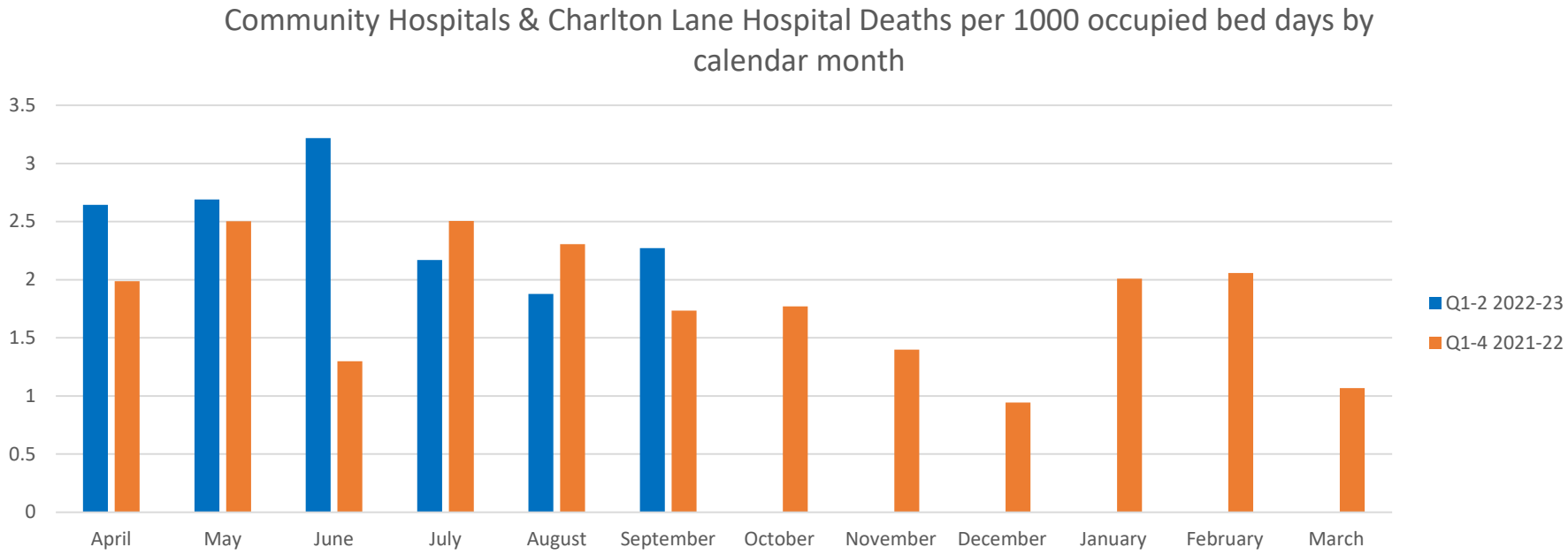
Learning Summaries

- Learning from completed mortality reviews is now presented as Learning on a Page. 8 slides showing learning during Q2 2022/23 were shared with operational services and QAG.. Learning on a Page documents are only generated where novel learning has been identified . For learning relating to comprehensive investigations, please refer to the Patient Safety Report. Learning from one LeDeR review was also included (from the LeDeR September 2022 Newsletter)

Community Hospitals & CLH Inpatient Death Rate per Month

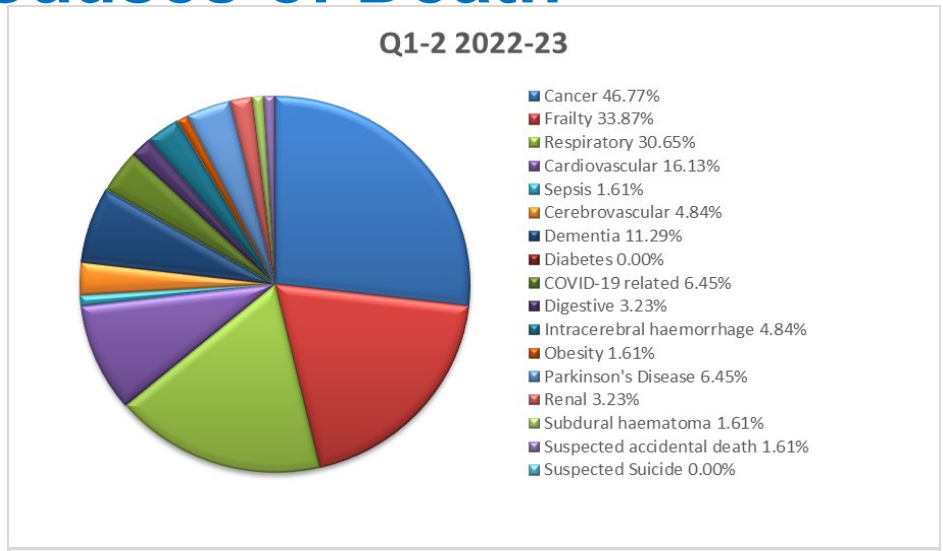
Gloucestershire Health and Care
NHS Foundation Trust

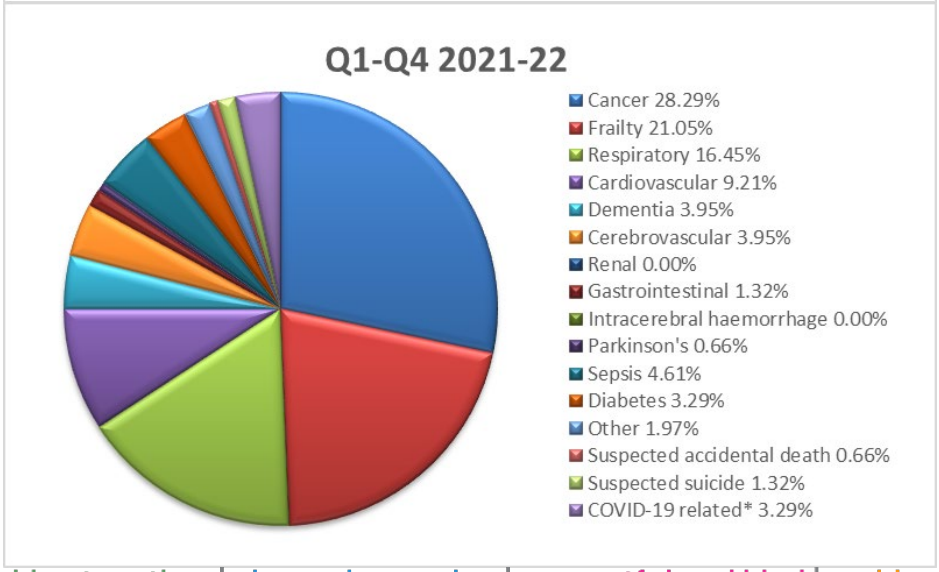
- During Q2 2022-23 there were 46 community hospital (CH) & Charlton Lane Hospital (CLH) inpatient deaths. Death rates in the chart below are given per 1000 occupied bed days. Comparison with rates observed in Q1-4 2021-22 are also shown, wherein there were 152 inpatient deaths in total for the whole financial year.



- The increased reported death rate seen during Q1 did not continue during Q2 22-23, although there was a slight upturn in September 2022. A breakdown of this data by hospital ward is shown in Slide 12

Community Hospitals & CLH Causes of Death



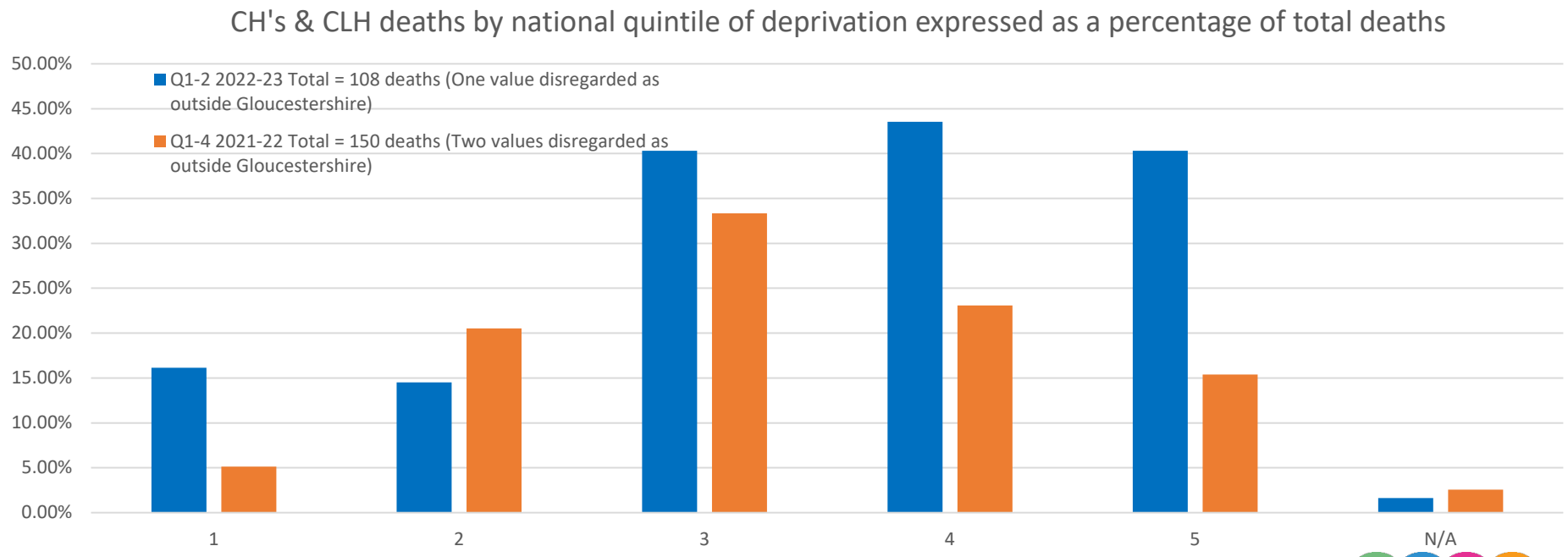


- Of the 46 CH & CLH inpatient deaths reported during Q1-2 2022-23, cancer has been recorded 14 times as the cause of death, representing the most prevalent cause of death at 46.77%, followed by Frailty of Old Age at 33.87% and then Respiratory at 30.65%. This is consistent with historical data.
- During Q1-4 2021-22, of the 152 CH & CLH patient deaths, 43 were reported as Cancer related, representing 28.29% of deaths reported.
- The next three most prevalent recorded causes of death during Q1-4 2021-22 were Frailty (21.05%), Respiratory (16.45%) and Cardiovascular (9.21%)

Community Hospitals & CLH Patient Demographics – Deprivation

Gloucestershire Health and Care
NHS Foundation Trust

The postcodes of the 46 CLH & CHs during Q1-2 2022-23 were compared against the Index of Multiple Deprivation (IMD) using information provided by Gloucestershire County Council. This data has then been compared with that of Q1-4 2021-22 and is shown below. The IMD is a measure of relative deprivation for small areas (Lower Super Output Areas, LSOAs) and is a combined measure based on 37 separate indicators reflecting different aspects of deprivation experienced by individuals living in a LSOA. The LSOAs are ranked and split into quintiles, 1 most deprived to 5 least deprived.



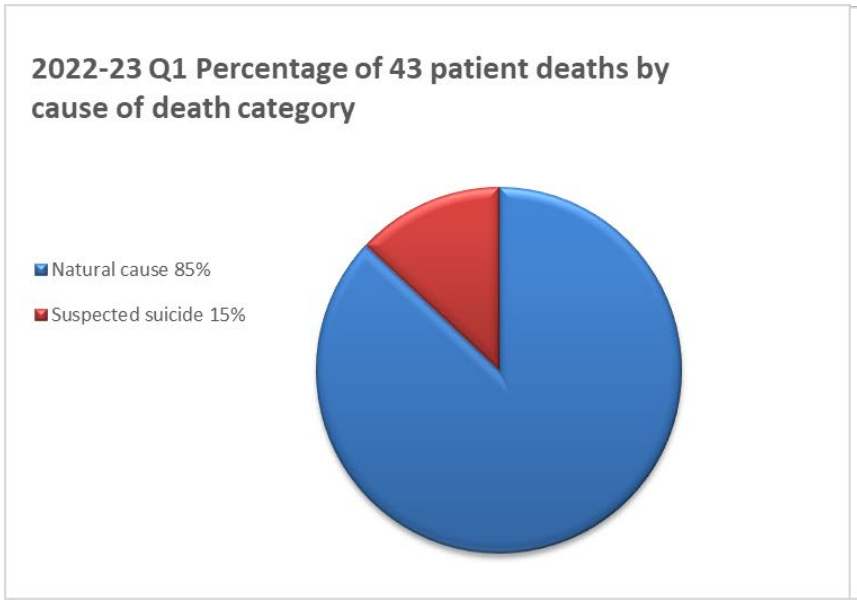
Community Mental Health Patients

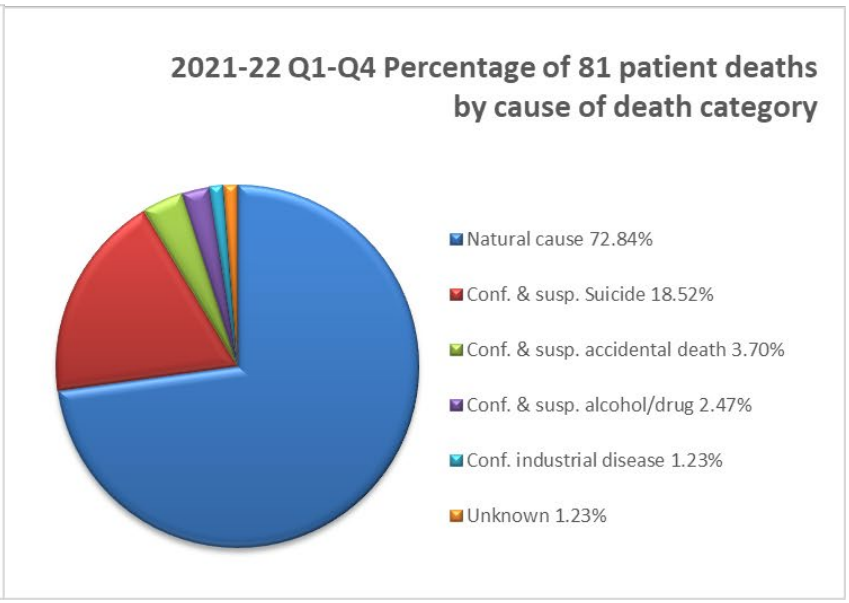
(Excluding those with a primary diagnosis of dementia and those on the MHICT caseload)

Gloucestershire Health and Care
NHS Foundation Trust

Cause of Death Category

- During Q1-2 2022-23, there were 43 community mental health patient deaths, excluding those known to MHICT services and those with a primary diagnosis of dementia. The distribution of the 27 patient deaths by cause of death category is shown below with comparison to Q1-4 2021-22 data.





Community Mental Health Patients

(Excluding those with a primary diagnosis of dementia and those on the MHICT caseload)

Gloucestershire Health and Care
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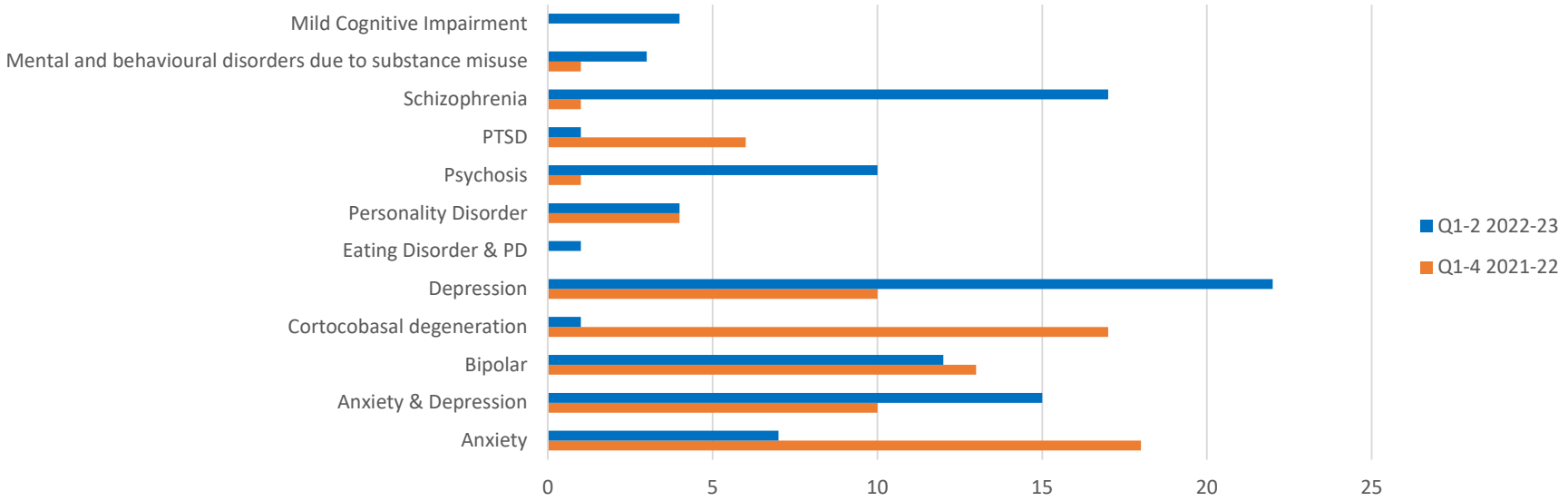
Patient Mental Health Diagnosis

- The chart below shows patient mental health diagnosis at date of death (not cause of death).

Mental Health Diagnosis (not cause of death) by percentage of total deaths Q1-2 2022-23 compared with Q1-4 2021-22

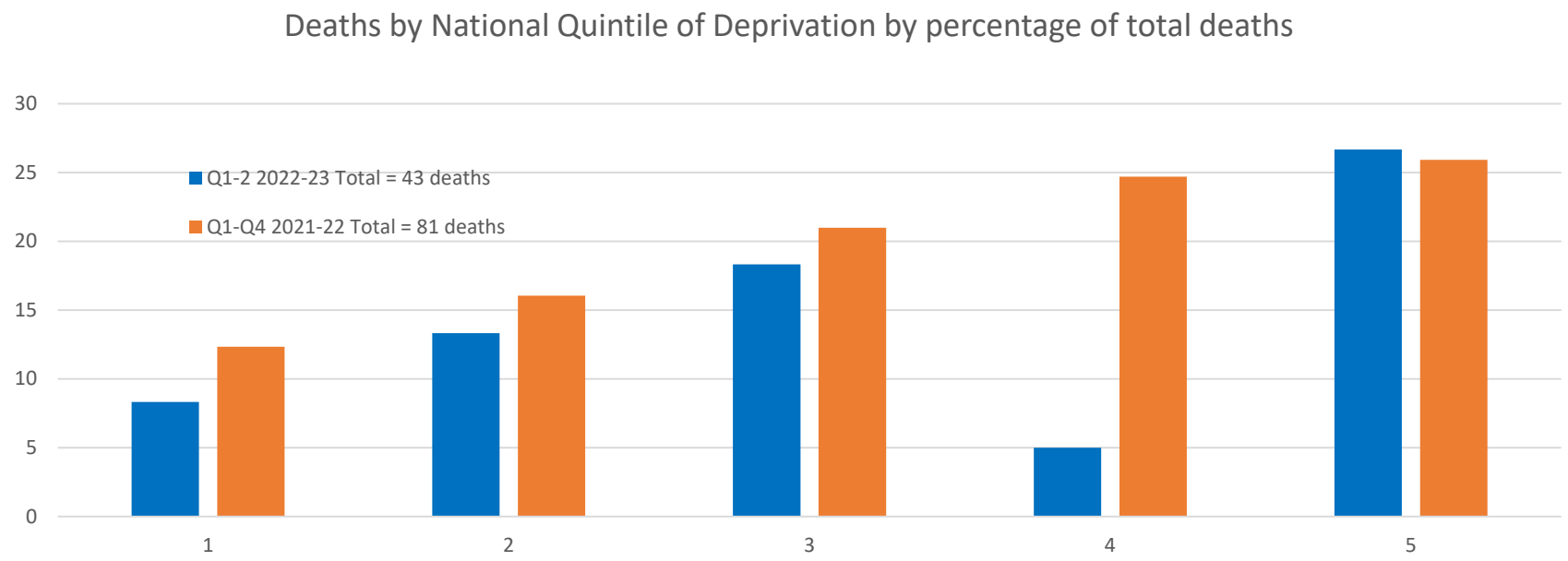


- During the period of Q1-2 2022-23, the most prevalent mental health diagnosis is Depression, followed by Schizophrenia. This is compared with Q1-4 2021-22, in which the most prevalent mental health diagnosis was Anxiety, closely followed by Cortocobasal Degeneration.

Community Mental Health Patients
(Excluding those with a primary diagnosis of dementia and those on the MHICT caseload)

Gloucestershire Health and Care
NHS Foundation Trust

Patient Demographics - Deprivation



- The distribution of the 43 Q1-2 2022-23 community mental health deaths by Index of Multiple Deprivation (IMD) 2019, national quintile of deprivation (1 most deprived, 5 least deprived), is shown in the chart above with comparison to 2021-22 Q1-Q4 data.

Community Mental Health Patients
(Excluding those with a primary diagnosis of dementia and those on the MHICT caseload)

Gloucestershire Health and Care
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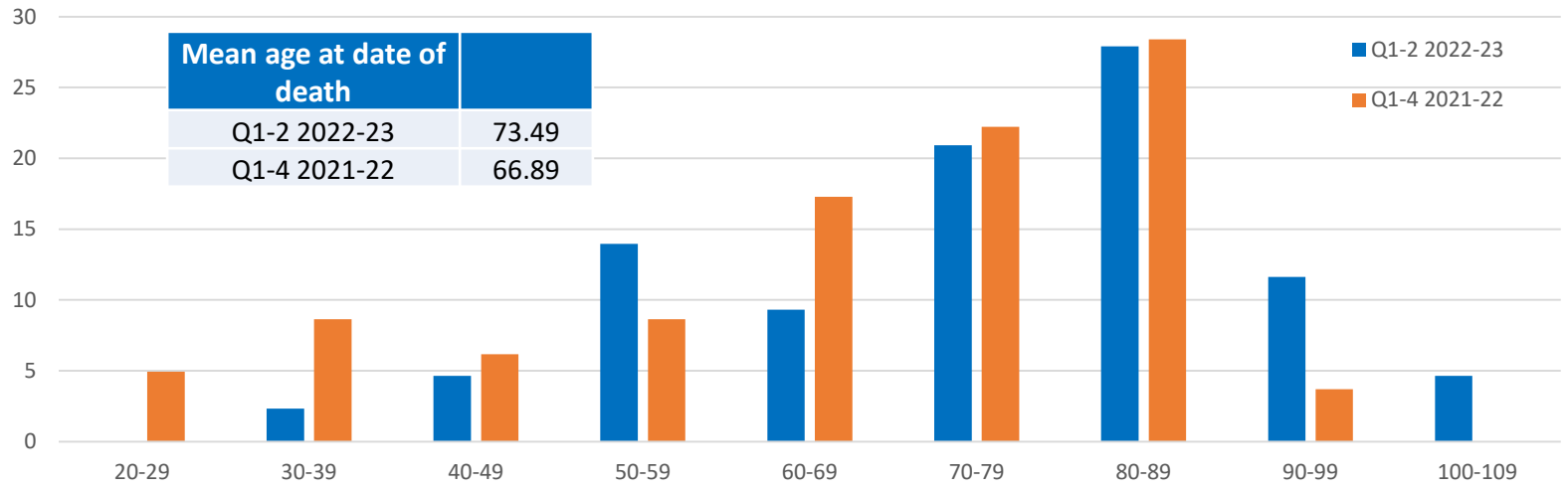
Patient Demographics – Age Group

No. of deaths per age group expressed as a percentage of total deaths



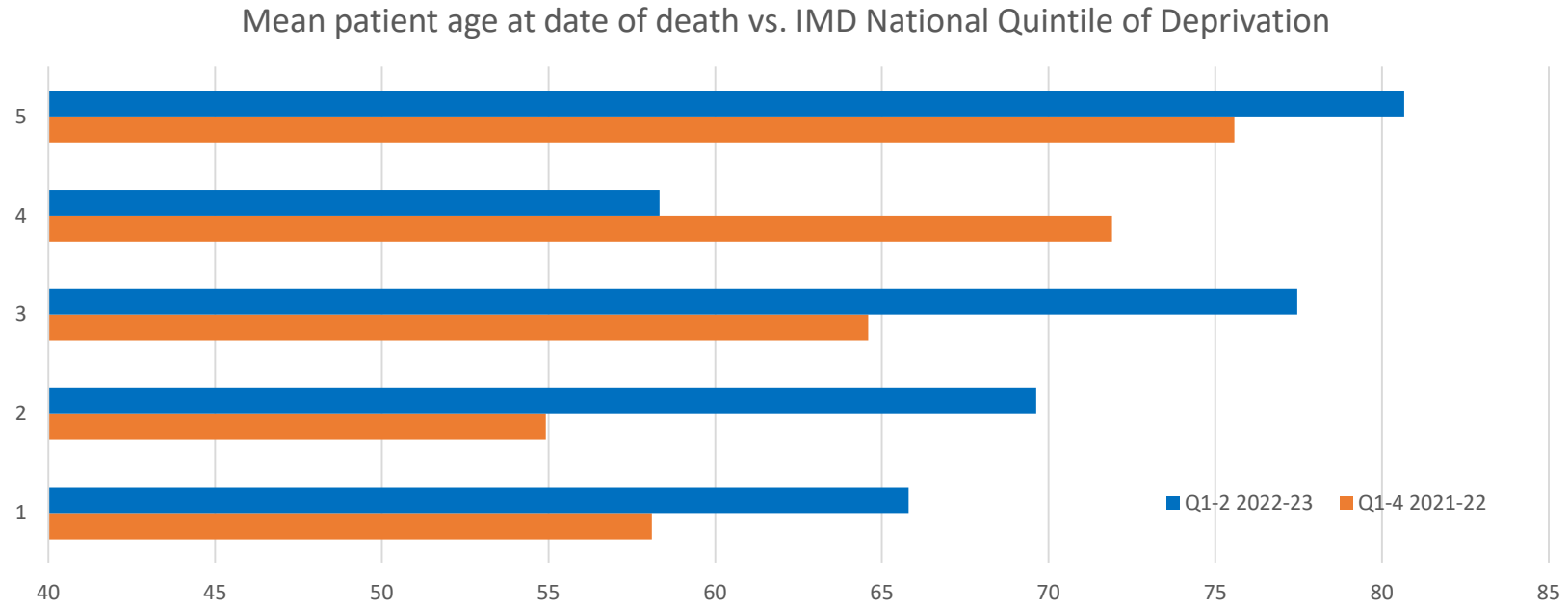
- The distribution of the 43 patient deaths during Q1-2 2022-23 by age group is shown above. The youngest patient was **36** years old and the oldest was **102** years old.
- The mean age at date of death was **76** years, higher than the mean figure for 2021-22, which was **66.89** years. The relatively young mean age of patients at date of death is consistent with accepted research indicating that people with mental health illness die on average at an earlier age than those without. This information has been fed into the physical health work stream for the Community Mental Health Teams redesign and transformation..

Community Mental Health Patients

(Excluding those with a primary diagnosis of dementia and those on the MHICT caseload)

Gloucestershire Health and Care
NHS Foundation Trust

Age vs. Deprivation



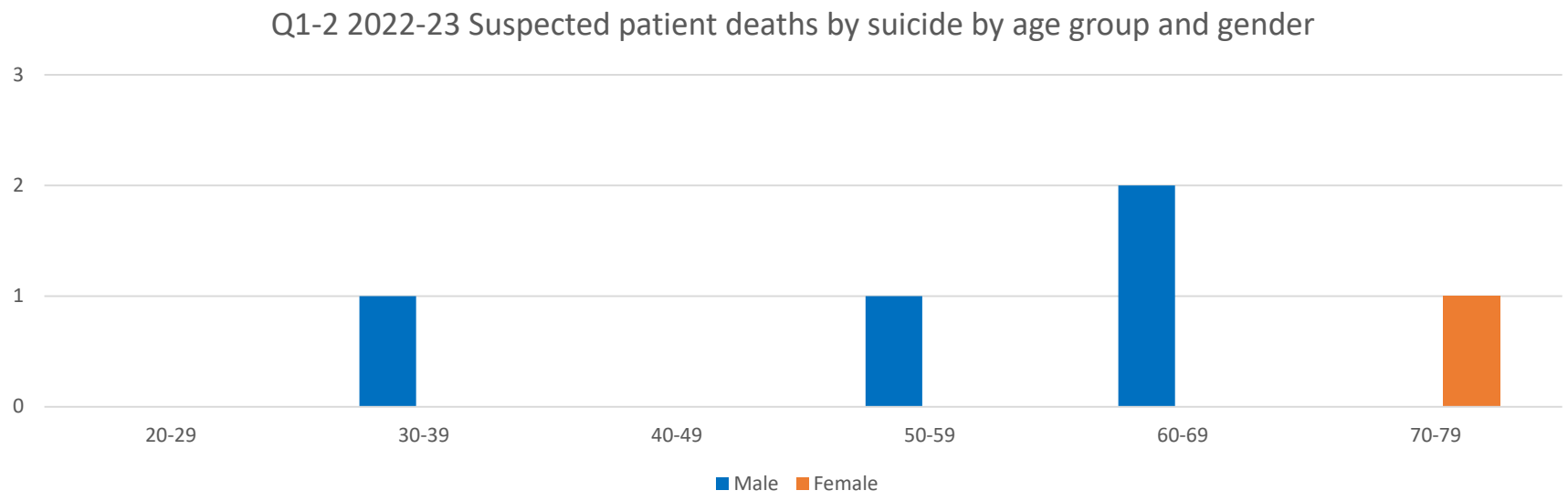
- Mean age at date of death by Index of Multiple Deprivation (IMD) 2019, national quintile of deprivation (1 most deprived, 5 least deprived), is shown in the chart above with comparison to 2021-22 Q1-Q4 data.
- The data from Q1-4 2021-22 and Q1-2 2022-23 (small data set) shows a correlation between reduced deprivation and living longer, most noticeably at quintile 5 (least deprived) and remains consistent with our historical data.

Mental Health Patients

(Excluding those with a primary diagnosis of dementia and those on the MHICT caseload)

Patient Confirmed/Suspected Suicides – Age & Gender

- During Q1-2 2022-23, there were 5 patient deaths by suspected suicide. All were patients open to community mental health teams.
- Distribution by age group and gender is shown below. There is a larger number of deaths of patients in the 60-69 age group.
- Of the 5 suspected deaths by suicide, 4 patients were male and 1 was female.

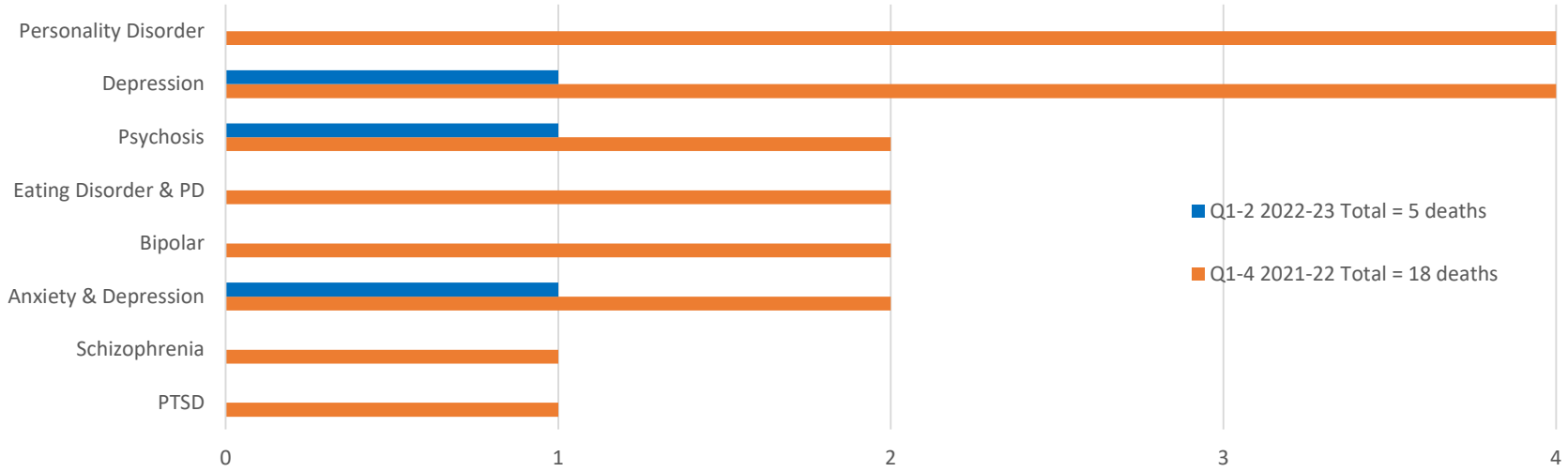


Mental Health Patients

(Excluding those with a primary diagnosis of dementia and those on the MHICT caseload)

Patient Confirmed/Suspected Suicides - Diagnosis

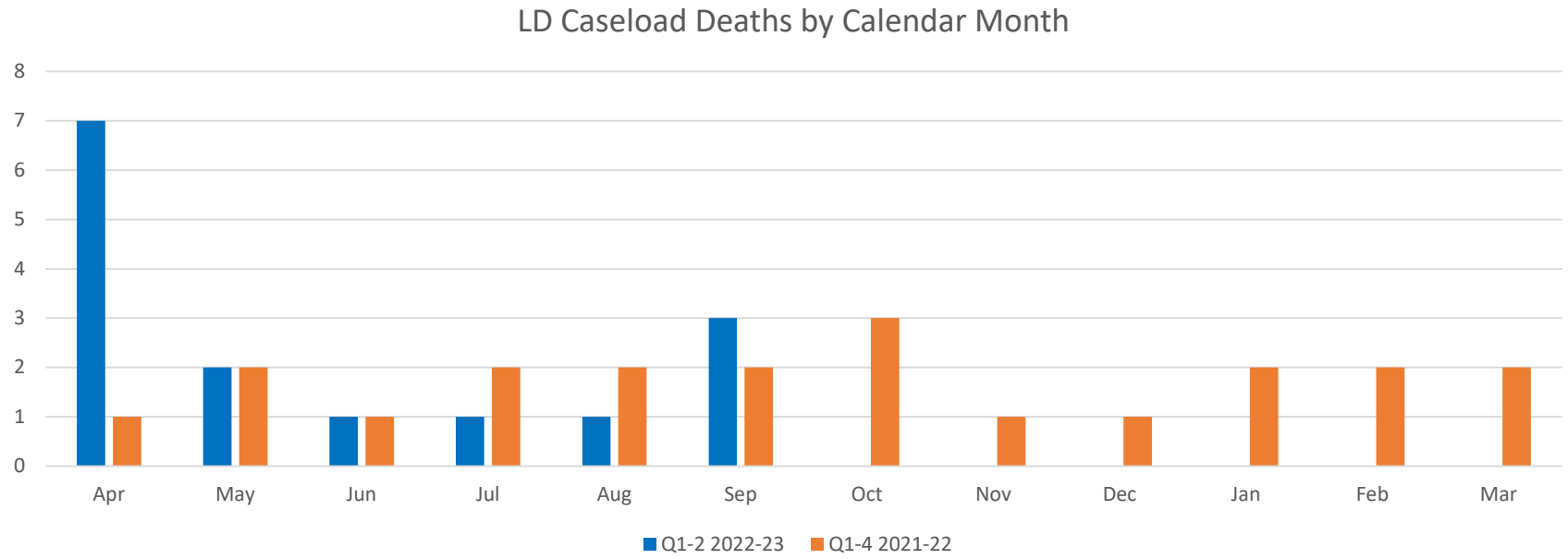
Q1-2 2022-23 Suspected suicide deaths by diagnosis compared to 2021-22 Q1-Q4



- The diagnoses of the 3 patient deaths by suspected suicide which occurred during Q1 2022-23 are shown in the chart above, which included: depression; psychosis; and anxiety & depression. There are no diagnoses documented for the 2 patient deaths that occurred in Q2 2022-23 due to no previous mental health input from GHC.
- During 2021-22 Q1-Q4 depression and personality disorder were the most prevalent patient diagnoses.

Learning Disability Patients Deaths per Month

Gloucestershire Health and Care
NHS Foundation Trust



- During Q1-2 2022-23, there were 15 deaths of patients open to trust Learning Disability (LD) caseloads. Deaths per month are shown above with comparison to 2020-21 figures, wherein there were 21 LD caseload deaths in total.
- An increase in the number of LD caseload deaths was seen in April 2022, compared to 2021-22 monthly figures. Any attributable significance of this is currently unclear. All deaths have been referred to LeDeR for review.

Learning Disability Patients Cause of Death

Gloucestershire Health and Care
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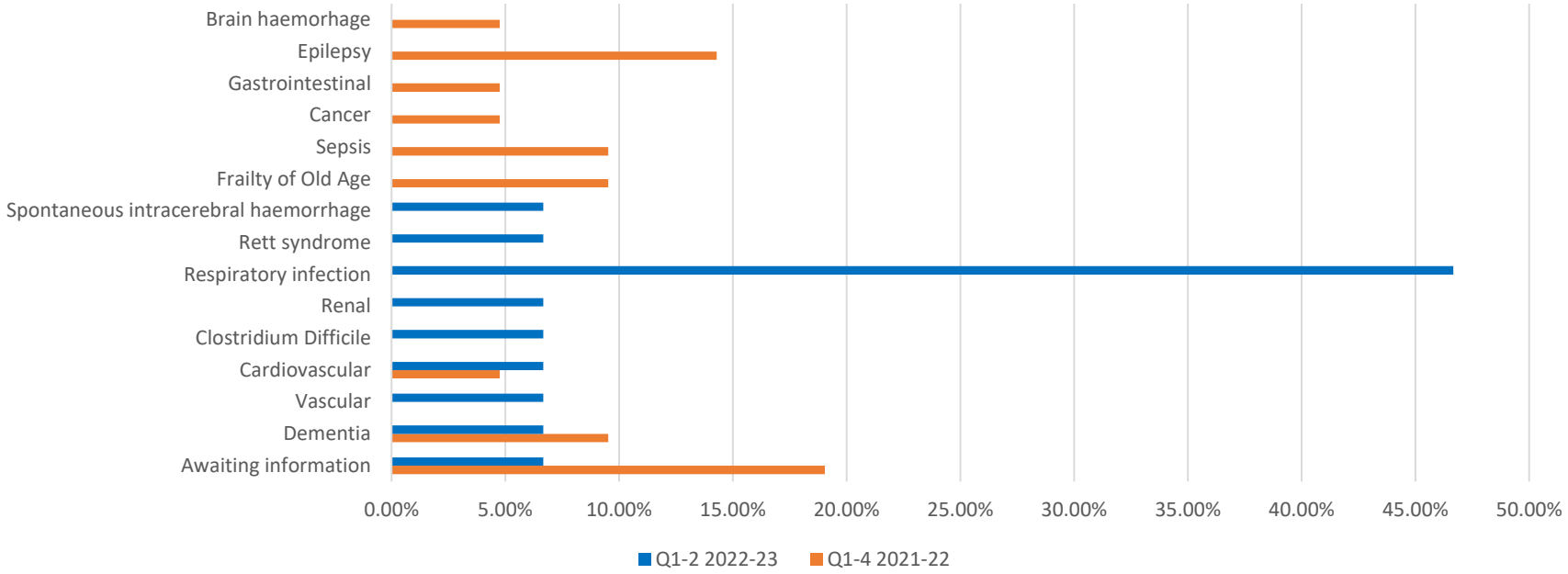
Q1-2 2022-23 and Q1-4 2021-22 causes of death categories expressed as a percentage of total deaths



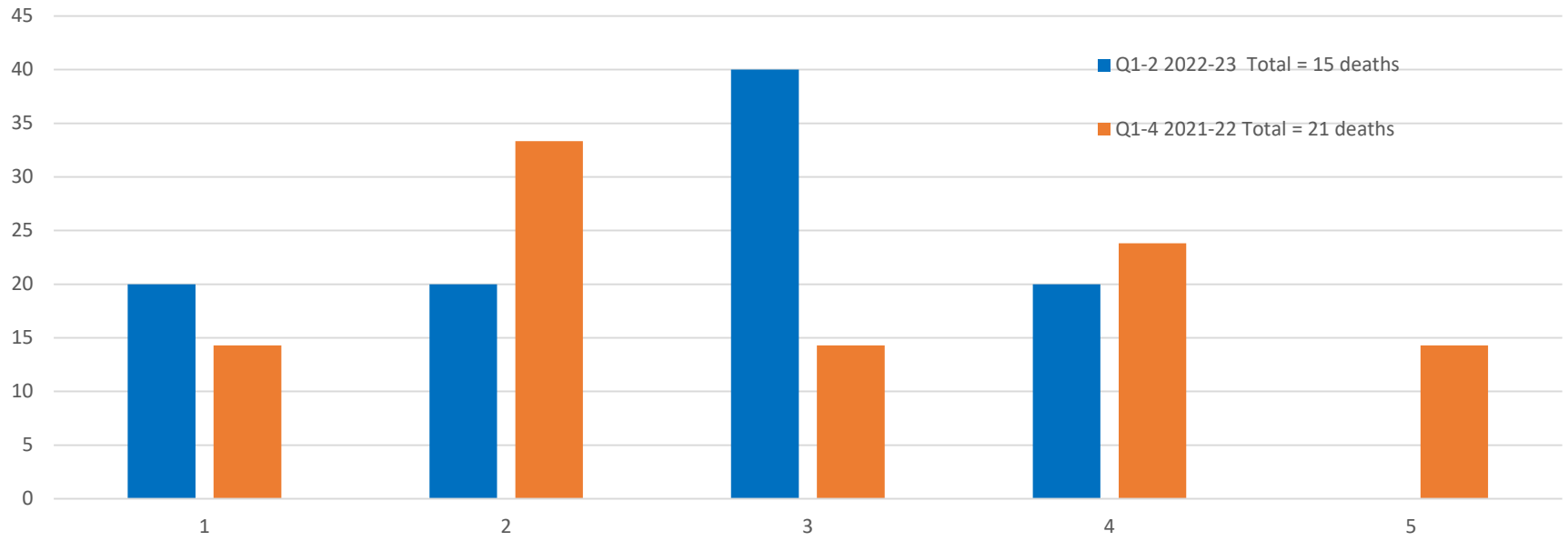
- Of the 15 LD caseload deaths occurring during Q1-2 2022-23, respiratory infections are reported to be the most prevalent cause of death.
- Respiratory infections were also the most prevalent cause of death during Q1-4 2021-22.
- During Q1-2 2022-23, **zero** LD caseload deaths were reported to be COVID-19 related.

Learning Disability Patients
Patient Demographics – Deprivation

Gloucestershire Health and Care
NHS Foundation Trust

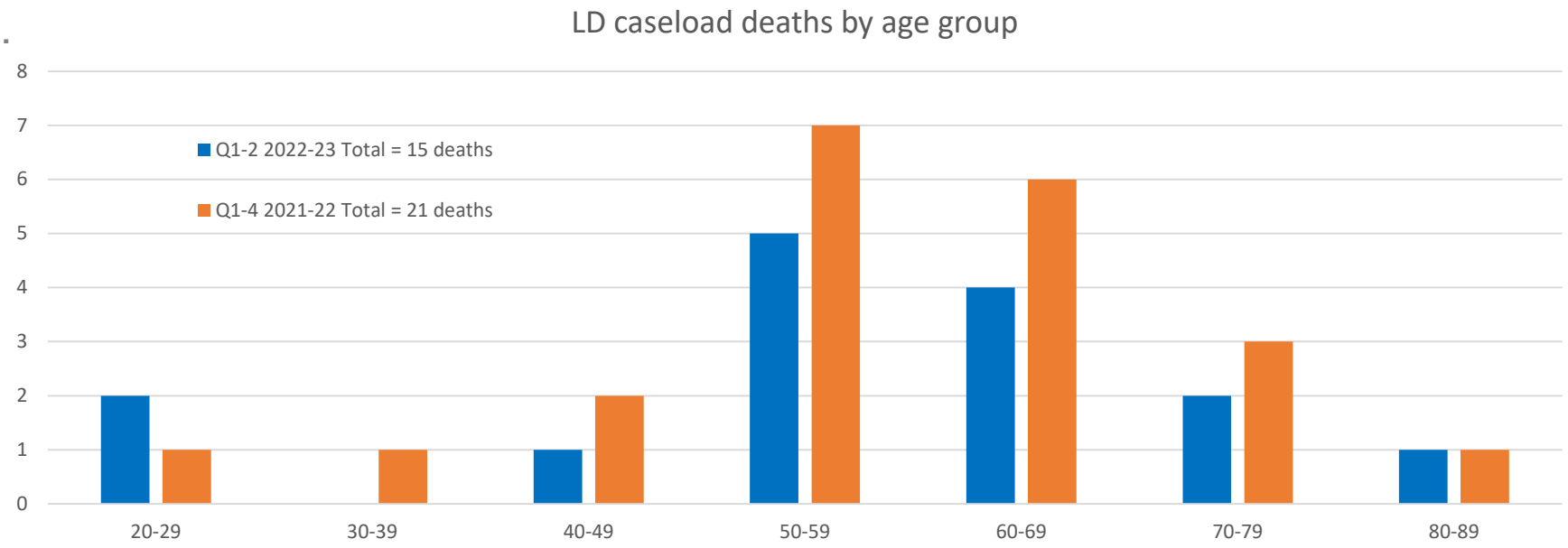
- The distribution of the 15 Q1-2 2022-23 LD caseload deaths by Index of Multiple Deprivation (IMD) 2019, national quintile of deprivation (1 most deprived, 5 least deprived), is shown in the chart below with comparison to Q1-4 2021-22 data.

LD caseload deaths by national quintile of deprivation expressed as a percentage of total deaths



Learning Disability Patients
Patient Demographics - Age Group

Gloucestershire Health and Care
NHS Foundation Trust



- The distribution of the 15 deceased patients open to LD caseloads who died during Q1-2 2022-23 by age group is shown above. The youngest patient was 20 years old and the oldest was 83 years old.
- The mean age at date of death was **58.06** years of age, which so far during 2022-23 is younger than the figure for 2021-22 at **59.0** years of age.

Medical Examiner KPIs

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD
Number of deaths generating MCCD resolved with the input of the ME service													
Number	54			51									
Number of times a MCCD is rejected by Registrar and reason this occurs	0			0									
Number of referrals to the Coronial Service													
Number	2 referred to Coroner for PM and 3 with a 100A form issued to cover MCCDs featuring unnatural events e.g., fractured hips			2 referred to Coroner for inquest. 2 patients with a 100A form issued to cover MCCDs featuring unnatural events e.g., falls									
Complaints made by bereaved relatives due to perceived delays to completion and release of MCCD (end to end timescales examined)	0												

Feedback & Learning from ME Input

Compliments - Examples received during Q2 2022-23. Full details are shared via MRG monthly

- ***Lydney Hospital.*** *Feedback from daughter: 'Care was absolutely fantastic. He could not have been in a better place . So glad that his final hours were in Lydney hospital.'*
- ***Cirencester Hospital. Feedback from wife: 'The care was very good – staff were wonderful.***
- ***Stroud Hospital. Feedback from wife: 'Incredible nurses – wonderful care'.***
- ***The Dilke Hospital. Feedback from son: 'Fully agree with cause of death and no concerns with care at all.'***
- ***Tewkesbury Hospital. Feedback from Daughter: 'staff were brilliant'.***
- ***North Cotswolds Hospital. Feedback from daughter: 'Very happy with care and no concerns with care'.***
- ***Lydney Hospital. Feedback from brother: ' wonderful care at Lydney and cause of death as expected.'***

General Learning

- *Doctors at The Vale appear unsure of the process and had issued MCCD prior to informing the ME office of the deaths etc. It would be helpful for Vale staff to be informed of standard operating procedures, as per other hospitals.* ***This was actioned and followed up by the Medical Lead for Community Hospitals.***

Complaints *None received*

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AGENDA ITEM: 13/0123

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 January 2023**

PRESENTED BY: Chris Woon, Deputy Director of Business Intelligence

AUTHOR: Sandra Betney, Director of Finance & Deputy CEO

SUBJECT: **PERFORMANCE DASHBOARD DECEMBER 2022/23 (MONTH 9)**

If this report cannot be discussed at a public Board meeting, please explain why.	

This report is provided for:
Decision ☐ Endorsement ☐ Assurance ☑ Information ☐

The purpose of this report is to:

This performance dashboard report provides a high-level view of key performance indicators (KPIs) in exception across the organisation. Performance covers the period to the end of December (Month 9 of 2022/23). Where performance is not achieving the desired threshold, operational service leads are prioritising appropriately to address issues. Where appropriate, Service led Governance updates are presented to the Business Intelligence Management Group (BIMG) and more widely account for performance indicators in exception. Formal service level improvement plans and risks are also highlighted where appropriate.

Recommendations and decisions required

The Board is asked to:

- **Note** the aligned Performance Dashboard Report for December 2022/23.
- **Note** the report as a **significant level of assurance** that our contract and regulatory performance measures are being met or that appropriate service action plans are being developed to address areas requiring improvement

Executive summary

Business Intelligence Update

2022/23 Business Intelligence business planning highlights are presented on page 1 alongside a high-level Measuring What Matters timetable on page 2. The Measuring What Matters milestones and next steps are being reconfigured into a strategic portfolio for 2023/24 and a proposal has been drafted and will be brought to Executive in the new year.

The SystmOne Simplicity programme for physical health services continues to progress against an operational tracker which is predicting an improved and satisfactory system recording and data quality state (Patient Tracking List "PTL Signoff") for all event lines by the end of 2022/23. Where SystmOne Simplicity is impacting performance indicators, a reference is provided and historic activity provides some assurance to normal performance levels for these indicators. Wherever possible, manual audit evaluations have also been undertaken on validating exceptions to inform confidence in the current situation. The associated narrative should also be considered for all indicators in exception.

Chief Operating Report
A Chief Operating Report authored by the Chief Operating Officer can be found on Page 3.

Performance Update
The performance dashboard is presented from page 4. It is of note that all the indicators within this report have been in exception previously within the last 12 months, some may have been updated with late data corrections (e.g. 1.03).

- **Mental Health & Learning Disability Service (Local) Performance**
  Attention is requested to review the 11 MH key performance thresholds in exception within the dashboard (with associated narrative) that were not met for the period. Two of these indicators are National measures that are under threshold due to late or incorrect data recording which, when corrected will present compliance. The remaining 9 are all Locally monitored indicators and within which, 3 relate to the Eating Disorder (ED) Service.

- **Physical Community Health Service (National & Local) Performance**
  In addition, attention is drawn to a further 15 PH key performance thresholds in exception within the dashboard (with associated narrative) that were not met for the period. 5 are wait time measures and it is assumed that alongside operational challenges, SystmOne Simplicity data appears to be *contributing* to all of these items. However, all indicators were in exception prior to SystmOne Simplicity. Through clinical services intervention, performance is expected to improve into Quarter 4 as outlined within the Operational Directorates' operational tracker.

- **Trust Wide Service Performance**
  The indicators of; Sickness Absence, WF2 Turnover and WF3 Cumulative Leave are all in exception for the period. Sickness absence remains above the 4% threshold at 5.4%. As usual, the November position does not include data from the E-Rostering system (Allocate) because this is unavailable at the time of publishing the performance dashboard. Therefore, the narrative breakdown reviews performance in arrears for November.

- **Non-exception reporting**
  It is further noted that there are additional indicators outside of threshold but are either within normal, expected variation, are formally suspended or have a confirmed data quality issues that are administrative only and resolution is assured. These can be seen on Page 21. These indicators are not formally highlighted for exception but are routinely available for operational monitoring

within the online Tableau reporting server. Two Eating Disorder indicators are compliant, the first time since 2021 however it is noted they are calculated from very small patient numbers.

Risks associated with meeting the Trust's values
Where appropriate and in response to significant, ongoing and wide-reaching performance issues; an operationally owned Service led Improvement Plan which outlines any quality impact, risk(s) and mitigation(s) will be monitored through BIMG.

Corporate considerations	
Quality Implications	The information provided in this report can be 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 provided.
Resource Implications	The Business Intelligence Service provides the support to operational services to ensure the robust review of performance data and co-ordination of the combined performance dashboard and its narrative.
Equality Implications	Equality information is monitored within BI reporting.

Where has this issue been discussed before?
BIMG – 19th January 2023

Appendices:	

Report authorised by:	**Title:**
Sandra Betney	Director of Finance and Deputy CEO

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Snapshot Month
December

Performance Dashboard Report & BI Update

Aligned for the period to the end December 2022 (month 9)

Business Intelligence Summary Update

The SystmOne Simplicity (S1S) operational tracker now outlines the key operational milestones to satisfy a 'data quality state' over 2022/23. This requires services to sign off their Patient Tracking Lists (PTL) when they recognise their data, are confident with their caseload numbers, an aide memoir is in place and if necessary have a service level action plan. 86% (26) are signed off and the remaining 5 units had forecast dates for the end of Quarter 3 so positions will be reviewed at the SystmOne Simplicity Board in January 2023.

Datix Risk Module and Training and Development reports are being refined before publication for operational use. Key finance reporting items are being identified to enter into integrated dashboards for April 2023. Supplier side technical issues with Allocate are resolved so work will now reinitialise to introduce e-rostering reporting in 2023/24. Further data field information is required within the Appraisal information data source module and this has been resolved so will be replacing manual monitoring in Quarter 4.

Page 2 highlights high level progress against the original **Measuring What Matters** plan which initiates a range of performance agendas. 20 items of 28 (71%) are now completed, 4 of the remaining 8 are on schedule and 3 will run into Q4. The final item to deliver Allocate e-Rostering reporting has been delayed into 2023/24 due to issues with an unstable API solution that has now been brought back online but delayed progress for 6-9months. Progress has been made in developing the Measuring What Matters agenda into a wider strategic portfolio for 2023/24. A draft proposal is now written and will be presented to Executives after going through BIMG in Quarter 4, in preparation for 2023/24.

The final pages (from Page 22) of the Performance report presented indicators not in formal exception but are highlighted for recognition of positive progress and notable improvements. These include UCR and some Eating Disorder metrics. Ambulance performance is also included for reference.

Chief Operating Report

An Executive level observation of operational performance for the period is provided through the Chief Operating Officer's *'Chief Operating Report*' on Page 3.

Performance Dashboard Summary *(from page 4)*

The dashboard provides a high level view of Key Performance Indicators (KPIs) in exception across the organisation for the period. Indicators within this report are underperforming against their threshold or are showing special cause variation (as defined by Statistical Process Control SPC rules) and therefore warrant escalation and wider oversight. To note, confirmed data quality or administrative issues that are being imminently resolved will inform any escalation decision unless there has been consecutive, unresolved issues across periods. A full list of all indicators (in exception or otherwise) are available to all staff within the dynamic, online server version of this Tableau report. Services are using this tool to monitor wider performance.

Where performance is not achieving the desired results, operational service leads are prioritising appropriately to address issues. Additionally, where appropriate and in response to significant, ongoing and wide-reaching performance issues a single performance improvement plan is held at Directorate level to outline the risks, mitigation and actions.

Specific updates have been provided by operational services to BIMG for areas with consistent performance challenges such as Eating Disorder (ED) Services and Improving Access to Psychological Therapies (IAPT). Where Performance Improvement Plans (or equivelent) are in place this is noted within the commentary. Where applicable, a reference to Service and KPI relating Risks have been added into the performance commentary for reference. Finally, areas of note are presented at the end of the report entitled 'non-exception highlights'.

Measuring What Matters Key Milestones *(December 2022 Update)*

Theme	(Provisional) Milestone	Target date	Progress Tracker
Data Quality matters	Tableau subscriptions and alert functionality promoted across services	Dec-21	Complete
	Data quality audit schedule for 2022/23 to be agreed	by August 2022	CST monthly Audit Index and Audit Summary in place and monitored, NQT responsibilities to be reconfigured into Measuring What Matters Portfolio
	SystmOne Simplicity project (to improve accuracy, consistency, and service quality) to be delivered	by April 2023	On timeline
	Revised data quality reporting portfolio deployed within Tableau servers for physical health services	by Oct 2022	Complete
Integration matters	Server migration to allow for reconfiguration and resolve licensing concerns	by Dec 2021	Complete
	Develop additional Board performance dashboard workforce indicators to include:		Complete
	○ Deployment of monthly Vacancy Rate	by Sept 2021	Complete
	○ Development of monthly (Cumulative) Annual Leave Consumption	by Oct 2021	Complete
	○ Development of monthly Turnover/ Stability Rate	by Nov 2021	Complete
	Deploy first Tableau Datix Reportin Table(s) by April 2022	by April 2022	Complete
	Deliver Totara (Care to Learn) extraction by April 2022 & first report deployment by Oct 2022	by Dec 2022	Report deployed but only published to users to validate
	Deliver Allocate (e-Rostering) extraction by April 2022 & first report deployment by Oct 2022	2023/24	Supplier's API solution remains unstable but reestablished and back into work plan for 2023/24
Patients matter	Heads of Profession to liaise with Service leaders and wider stakeholders to develop the organisation's first plan for Value Based Healthcare in 2022/23	By Mar 2023	Reconfiguring into Measuring What Matters Strategic Portfolio 2023/24
	Deploy trial of first tranche of new outcome measures	by April 2023	Reconfiguring into Measuring What Matters Strategic Portfolio 2023/24
Culture matters	Decommissioning of regular Excel physical health reporting use	by July 2022	Completed
Audience matters	Review Key Performance Indicator portfolio to inform 2022/23 contract schedule and operational/ strategic needs	by Jan 2022	Completed
	Publish proposal to restructure the current performance dashboard to support various audience level perspectives	by Mar 2023	Performance Indicator engagement workshops completed. Paper presented to BIMG in January 2023.
Format matters	Deliver immediate performance dashboard interrogation pilot for Resources Committee members	by Sept 2022	Presented Integrated Dashboard prototype in August 2022
Timeliness matters	Evaluate (almost) real-time transactional log shipping processing within all new system procurements and extensions, particularly when RiO and SystmOne contracts	by April 2023	Reconfiguring into Measuring What Matters Strategic Portfolio 2023/24
Analysis matters	Realising holistic business partnering across all corporate partners by January 2022	by Jan 2022	Complete
People matter	Through business partnering, Tableau user training and support will be offered from November 2021 to users from the BI service ahead of utilising the system and then ongoing whilst using it within their day-to-day	from Nov 2021	Complete
	BI support guidance to support users will be made available through the intranet	from Oct 2021	Complete
	Learning & Development Service to inform Digital Competency timetable for 22/23	by April 2022	Complete
Governance matters	Cleanse proxy indicators	by Nov 2022	Agreed proxy indicators re introduced into Performance Dashboard.
	Publish Performance Management Framework	by May 2022	Complete
	Remove superseded National and Local Performance Indicators	by Apr 2023	Performance Indicator engagement workshops completed. Paper presented to BIMG in January 2023.
	Introduce ranked waiting times (over 52weeks) summary into the performance dashboard report – provisional outline	by Nov 2023	Within November 2022 Performance Dashboard
	Introducing new internal performance indicators into performance dashboard	by Apr 2023	Performance Indicator engagement workshops completed. Paper presented to BIMG in January 2023.

Chief Operating Officer's Report December 2022

David Noyes, Chief Operating Officer (COO)

Operationally the last month has delivered some intense pressure, as well as some days of disruption as a result of industrial action and some severe weather. Between Christmas and New Year the pressure on the system was very significant indeed, and within the Trust we generated an additional 5 escalation beds on top of the 6 we had already in place to help manage demand. Other measures taken included deploying clinical colleagues and volunteers to work in GHFT to help our colleagues manage corridor care, and specifically to try and divert some of the excess demand to appropriate community services. We have also added some extra resilience shifts to augment Minor Injury and Illness Units to cope with extra demand, had some limited access to SWAST stack granted which has enabled us to utilise Rapid Response even more effectively, used our patient flow team as an in reach capability into both Acute settings, and made some short term adjustments to both community IV team and complex care at home to directly support into the Acute. The sustained pressure on physical health community bed stock is indicated by a current bed occupancy rate of more than 97%; this figure hasn't been below 90% since August 21 and colleagues from NTQ are supporting in studying the impact and effects, which will be shared with Quality committee.

We have also continued to work hard at trying to increase our capacity in the Homefirst team. This is very largely dependent upon achieving good flow out of the service for patients who have completed their pathway with us, and this does remain a challenge. Just before the Christmas period we did enjoy improved out flow and were able to generate more service starts as a result, and at the time of writing (20 Jan) had achieved 47 starts in a week, which is a pleasing improvement, which I would hope to sustain if we can maintain outflow. The introduction of a recruitment incentive has certainly generated very encouraging higher levels of interests in posts within the service, which naturally we are anxious to convert into applicants, and our review of productivity is underway, boosted by the completion of our digitisation of the teams (switching from paper to System1) which concluded in Dec 22.

As well as in the sphere of physical urgent and emergency care, we are also experiencing high pressure on our Acute Mental Health in patient capacity. Board colleagues will recall that we have launched a significant OD (organisational development) programme to address extended Length of Stay, which after the first workshop appeared to be bearing some fruit. Sadly the second planned event fell victim to the snow and was postponed, and we seem to have lost some momentum. As a result we have unfortunately had to place some patients in out of area beds (over and above the 4 we procured to augment over winter); this receives daily scrutiny internally and is naturally a very high priority to address, and includes daily board reviews of patients; the second workshop is re-planned for 27 Jan and I hope we will regain some momentum on this important work then.

Progress with the vital underpinning programme of 'SystmOne Simplicity' continues to be strong, with no services rated Red for assurance on data quality reported at the last programme board and all patient tracking lists on track for sign off by the end of January. Service Aide memoires have also been completed on time, with 52% signed off and complete and the remainder being processed and validated by colleagues in clinical systems and business intelligence. The programme is on track to deliver and conclude at the end of the financial year. At the same time we have started our training and education intervention with external support, to develop the confidence and competence of senior ops leaders to interpret, project and utilise data. The combination of data accuracy and the ability to pivot data should put the Trust in a stronger position in the future.

As previously briefed, recovery of our Podiatry service has sadly fallen away, and hence a refreshed recovery action plan is being drawn together. Performance in MSK remains stable, but needs to improve – we are widening the scope for recruitment in this area to include suitably qualified sports science practitioners which I hope will prove helpful. Pleasingly we are seeing some improvement in MSKAPS, and some very encouraging steady improvement in both ICT Physio and Occupational Therapy (in both cases underpinned by good progress in data quality/SystmOne Simplicity work). I am pleased that after a short hiatus we have re-opened Childrens OT services, following some significant and ongoing management interventions – performance recovery will take time, but we have had some successful recruitment and turnover has reduced so this should provide a good platform for recovery. The School aged Imms team have done well to successfully deliver the programme of flu vaccinactions to primary age children against a challenging schedule. In other areas, we are a little worried about the achievement of the IAPT access target, and simply haven't had the forecast levels of demand for the service; accordingly we are doing some rapid work on advertising and marketing in this area as well as capitalising on national rebranding. We are pleasingly delivering above 50% recovery in this area. Recovery in Eating Disorders remains very positive with urgent adolescent referrals now being offered to be seen within a week (the performance data reflects quite a high proportion of DNA); the team have significantly reduced the adolescent waiting lists over the past few months, and continue to work with a range of supporting providers to offer a range of suitable interventions which will address the backlog in treatments over time.

Performance Dashboard: *Mental Health & Learning Disability - National Requirements (NHSI & DOH)*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health - National Requirements Gloucestershire

		DECEMBER		22/23		
1.03	Care Programme Approach follow up contact within 7 days of discharge	92.5%	95.0%	96.5%	95.0%	
1.07	New psychosis (EI) cases treated within 2 weeks of referral	33.3%	60.0%	64.5%	60.0%	

Performance Thresholds not being achieved in Month - *Note that 1.03 has not been in exception previously within the last twelve months and neither indicators will be in exception after system recording corrections.*

1.03: Care Programme Approach: follow up contact within 7 days of discharge
December is reported at 92.5% against a performance threshold of 95% and is below SPC (Statistical Process Control) limits. There were 3 non-compliant cases reported in December.

These were all due to late data entry. The clinical system has been updated and this indicator is now compliant at 100% for December.

1.07: New Psychosis (EI) cases treated within 2 weeks of referral [Community MH Services]
December is reported at 33.3% against a performance threshold of 60% and is below SPC (Statistical Process Control) limits. There were 2 non-compliant cases reported in December.

These are due to dates recorded of allocation of an EI specialist care coordinator and the service are working with Clinical Systems to update RiO. Once amended, this indicator will be compliant at 100% for December

Note on November performance.
Late data entry and updates to the clinical system have been made for November and performance can now be reported as compliant at 60% (previously reported at 25%)

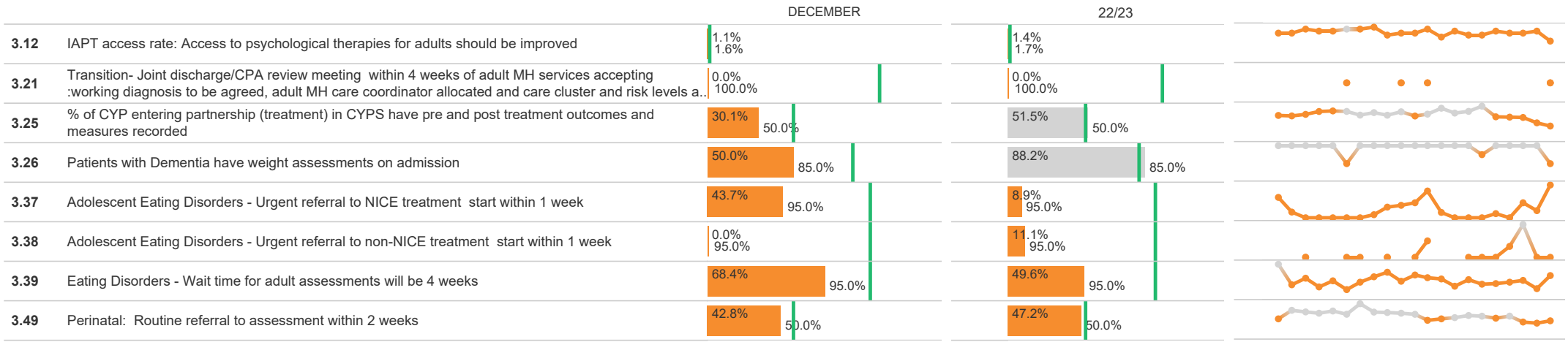
Note on October performance
Late data entry and updates to the clinical system have been made for October and performance can now be reported as compliant at 66.6% (previously reported at 33.3%)

Performance Dashboard: *Mental Health & Learning Disability - Local Contract (Including Social Care)*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health & Learning Disabilty - Local Contract



Mental Health Social - Local

Performance Thresholds not being achieved in Month - *Note all indicators have been in exception previously within the last twelve months.*

3.12: IAPT access rate: Access to psychological therapies for adults should be improved [Community MH Services]
In December , the service achieved 72.5% of its expected performance threshold. This equates to 812 people (14.2% of prevalent population) accessing the service against a target of 1232 (19.6% of prevalent population). Performance for December is below SPC (Statistical Process Control) limits.

Performance was below threshold due to the service receiving 265 fewer referrals than required to achieve access targets and a slightly higher than planned dropout rate of 15.7%.

Mental Health Analytics for the South West Region Mental Health Programme Board have identified that there has been a reduction in referrals in the South West region and this is having an effect on IAPT services being able meet access targets. The service is working hard to address this this locally and has had approval to recruit at a business/marketing manager to promote the service and increase referrals. In addition, they have continued to promote the service via two pages in local publications which include a full-page advert in the Local Answer which is delivered to 175,000 addresses in Gloucestershire.

Following a significantly high attrition in Quarter 3 of 2021/22 for PWP staff, the service recruitment plan continues to train higher numbers of trainees to build the workforce. External recruitment of qualified staff remains challenging, leaving a reliance on the trainee route. The service was unable to recruit the planned number of trainees for the January 2023 cohort, as well as the March cohort of PWP's. This has also been experienced by other IAPT services in the region. The service continues to explore other ways to diversify the workforce by recruiting a counselling lead to develop other approved IAPT treatment options which will improve choice for patients and will allow expansion of the workforce with non-CBT trained staff.

3.21: Transition of CYP to Recovery within 4 weeks
December performance is reported at 0% against a performance threshold of 100%. There was 1 non-compliant case in December.

Due to high risks presented by the young person, it was deemed clinically appropriate not to transfer over the Christmas and New Year period and a CPA (Care Programme Approach) review was scheduled for January.

3.25: CYP entering treatment have pre and post treatment outcomes recorded [CYPS MH]

December performance is reported at 29.7% against a performance threshold of 50% and is below SPC (Statistical Process Control) limits. This indicator has been within SPC control limits in previous months but has been below the performance threshold since August 2022 (Aug: 47.4%, Sep: 45.2%, Oct: 46.1%, Nov: 37.6%)

The service is analysing why there has been a reduction in compliance and has tasked Team Managers with developing action plans designed to improve the completion of routine outcome measures throughout the treatment process and increase compliance rates. Team Managers will be using additional BI reporting which enables them to monitor and ensure completion rates of routine outcome measures and will identify where additional training may be advantageous for staff.

The service has expanded its range routine outcome measures used in treatment to include the use of Goal Based Outcomes. These are not included in yet in this indicator as is in the process of being validated by the service. At this time, it is unknown what the impact of including these will have on performance.

3.26: Inpatients with Dementia have weight assessments on admission [MH Hospitals}
December performance is reported at 50% against a performance threshold of 85% and is below SPC (Statistical Process Control) limits. There was 1 non-compliant case in December.

The service was unable to weigh the patient on admission as the patient did not wish to cooperate. They were able to weigh the patient 5 days after admission.

3.37: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week [Community MH Services]
December performance is reported at 43.7% against a performance threshold of 95%. There were 9 non-compliant cases in December.

3.38: Adolescent Eating Disorders: Urgent referral to non- NICE treatment within 1 week [Community MH Services]
December performance is reported at 0% against a performance threshold of 95%. There was 1 non-compliant case in December.

3.39: Adult Eating Disorders: Referral to Assessment within 4 weeks [Community MH Services]
December performance is reported at 68.4% against a 95% performance threshold. There were 6 non-compliant cases reported in December.

Note on 3.37 & 3.38 to 3.39 – Eating Disorders waiting times
Progress continues to be made to meet both the Urgent and Routine adolescent referral to NICE treatment KPI. Throughout December the team have been in a position to offer all Urgent adolescents an assessment within a week of the referral. The performance threshold is not being achieved due to high rates of DNA, patient/family choice, and treatment not identified at assessment.

The service continues to work with BEAT (an Eating Disorders Charity) for those waiting for family based therapy (FBT) and Teens in Crisis (TIC) plus, for under-25 clients triaged as routine. There are currently 89 routine adolescent clients on the assessment waiting lists. The overall ED caseload is now 966.

The team has significantly reduced the urgent adolescent assessment waiting list numbers and waiting times over the autumn and winter. The team are now able to offer patients an assessment/treatment start within a week of the referral being received where treatment is identified at the point of assessment.

The team continue to work with BEAT in referring parents/carers to the Developing Dolphins whilst clients await FBT. To date, 47 referrals have been made which leaves 73 spaces. Parents/Carers are still referred to the programme at the point of assessment. The next cohort will begin the support programme during January.

The team continue to try and work with TIC plus in order to refer patients to a counselling programme and then discharge from the caseload. The team referred 55 patients to the TiC TEDS programme, TiC are now attending the EDS triage and a support officer is now actively contacting patients to support the referral. 45 spaces remain available up to July 2023.

<u>Workforce</u>
Establishment WTE and skill mix have been reviewed to increase recruitment into hard-to-fill posts.
3 x CAPS are now in post allowing for FBT to begin for up to 10 families.
3 x AP Trainees are to begin an 18 month course on the 3rd January 2023.
1 x new assistant clinician has recently began a role within the team and a second B4 will start on the 16th January.
1 x Band 5 ED Clinician began a role within the Day Treatment Team on the 12th December.
1 X Band 6 ED Clinician – preferred candidate ad awaiting start date.
Currently placed to advert is a 1.0 WTE Band 5, a 1.0 Band 4 Assistant ED Clinician and a 1.0 Band 4 admin lead.

Capacity mapping for the service has indicated that the team is significantly under established to meet business as usual demands. Though further investment has been secured for 22/23, this will still leave a significant shortfall. This will be picked up as part of the system wide Transformation board.

The service is working through the challenges of the potential long wait between initial assessment and subsequent treatment sessions and continues to rely on bank and staff from the wider trust offering additional hours.

The service is accepting routine referrals, which are triaged and placed on a waiting list.

The service has now secured a treatment pathway with the ORRI (a specialist eating disorder centre offering intensive online treatment) and for CYPS of 16, 17, 18 and 19 years of age who remain on the urgent treatment waitlists. The ORRI will treat 75 young people by March 2023. Thus far 65 patients have been identified for the ORRI treatment pathway. Letters have been sent and referrals to ORRI will

follow.

This set of indicators has a Service Improvement Plan and is on the Performance Governance Tracker. This is on the risk register ID 149 (Score 16)

3.49: Perinatal: Routine referral to assessment within 2 weeks [Community MH Services]
December performance is reported at 42.8% against a performance threshold of 50% and is within SPC (Statistical Process Control) limits, however, shows special cause variation with 14 months below average. There were 24 non-compliant cases in December of which 10 were seen within 3 weeks, 7 within 4 weeks , 5 within 5 weeks and 2 within 6 weeks.

The service continues to have work force challenges with 2 vacancies awaiting new staff starting, 3 staff on maternity leave and 4 members of staff on long term sick. In December the Christmas Break saw a reduction in women engaging and consequently some assessments were delayed until January 2023.

New staff are expected to start in February and May (as on maternity leave) and 1 member of staff will be returning from maternity leave in February.

The service continues to evaluate the assessment process and changes are being made to improve this further to reduce waiting times and increase access.

4.12: Ensure that reviews of new package of care take place within 12 weeks of commencement [Community MH Services]
December performance is reported at 50.0% against a performance threshold of 80% . There was 1 non-compliant case in December, this was due to service users physical health and therefore the Social worker was not able to review within the required 12 weeks.

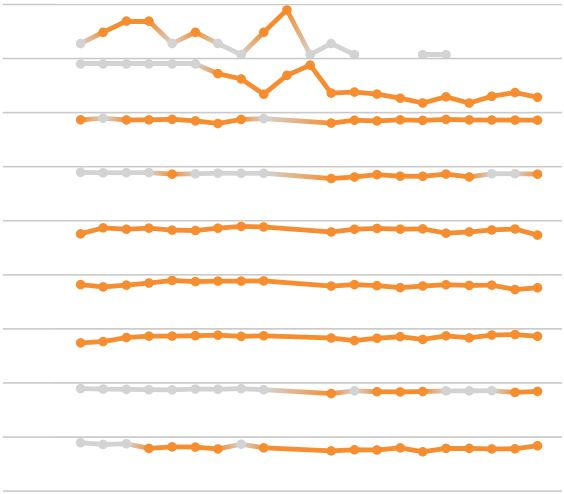
Performance Dashboard: *Physical Health - National Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - National Requirements

		DECEMBER	22/23
14	Number of post 48 hour Clostridium Difficile Infections	100.0%	100.0%
72	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	28.9% 99.0%	29.3% 99.0%
84	% of live births that receive a New Birth Visit within 7- 14 days by a Health Visitor	92.8% 95.0%	92.9% 95.0%
85	% of children who received a 6-8 weeks review	94.5% 95.0%	92.5% 95.0%
86	% of children who received a 9-12 month review by the time they turned 12 months	71.8% 95.0%	79.8% 95.0%
87	% of children who received a 12 month review by the time they turned 15 months	77.9% 95.0%	80.6% 95.0%
88	% of children who received a 2-2.5 year review by 2.5 years	83.6% 95.0%	82.0% 95.0%
90	% of infants for whom breastfeeding status is recorded at 6-8wk check	94.1% 95.0%	94.1% 95.0%
91	% of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence)	57.5% 58.0%	53.6% 58.0%



Performance Thresholds not being achieved in Month - *Note all indicators have been in exception previously within the last twelve months. 7 & 18 were previously legacy proxy indicators and not reported through the Performance Dashboard.*

14: Number of post 48 hour Clostridium Difficile Infections
There was 1 case reported in December compared to a threshold of 0. This is within the SPC chart control limits however is a National indicator therefore escalated in exception.

The case was on Lydney inpatient ward, Lydney hospital for rehab from GRH. Patient in side room as a precaution. Ward sister contacted Infection control to notify them. Medical review and treatment commenced, vancomycin as per guidelines. PPI held, bloods, fluid balance and management plan in place.

72: Percentage of patients waiting less than 6 weeks from referral for a diagnostic test [Urgent care]
GHC is no longer responsible for the national submission for this activity which is now made by Gloucestershire Hospitals NHS FT.
Submitted data (by GHNHSFT) for GHC patients in December 2022 indicates a performance of 29% (compared with 39% in November) 147 out of 207 patients referred for an echocardiogram had been waiting 6 weeks or more for the scan at the end of December 2022. Target is 99%. Performance continues to be below SPC chart lower control limits.
Looking at the figures for November, there were two large cohorts of patients between 3-4 weeks & 5-6 weeks which have rolled over into 6+ weeks for December which has affected performance %. Although still the highest group, progress has been made with the into the 13+ week waiters reducing from 128 to 65. Numbers waiting 6 weeks or less have reduced from 93 to 60 in December. GHFT confirm that the cardiology department are still using the external company to support reducing the backlog of patients.

According to GHC Heart Failure service, on 3rd January 2023, 25 patients are on the Priority Echo waiting list for an echocardiogram, and 297 patients on the Routine Echo Waiting list. 27 patients are still to be triaged for Echo. The service has informed that they now reject incomplete referrals from primary care, who will then have to re-refer the patients with all the required information, instead of leaving the referral open, on a waiting further information waiting list.

At the contract board just before Christmas GHFT confirmed that there are no long waiters and they are on top of the backlog having outsourced some of the activity. We continue to monitor the situation via the contract board until we can get back to our KPI which we agreed they could temporarily bypass until they were able to offer a stable service for all referrals. The ICB are aware of this.

84. % of live births that receive a face-to-face New Birth Visit within 7- 14 days by a Health Visitor [Children and Young People Service]
In December, 34 out of 491 children are showing as not having received a new birth visit within 14 days of birth. Performance was 93.0% (November was 92.9%) compared to a threshold of 95%. Performance is within SPC chart upper and lower control limits.

Contributing factors

Contributing factors
- Reasons for breaches include: NICU/ re-admitted to hospital - will be seen on discharge, parental choice to be seen out of timeframe- all seen, no access visit within timeframe then seen out of timeframe, Movement out of county, baby re-admitted to hospital, Recording errors remain although amended and linked to appointment (both babies seen in timeframe), parent declined HV within timeframe as midwife still visiting, Late / no notification - now seen, declined HV service, seen out of timeframe due to staff capacity
- Some families have declined contact within timeframe due to the Christmas period. Also the extended bank holidays has impacted on losing work days.
- Changes due to Simplicity impacting on recording errors- significantly reduced
- Bank staff being utilised for universal work, so can be out of timeframe where bank are only available on certain days
- Increase in the number of babies admitted to NICU from November to December
- Staffing capacity and staff sickness is impacting on the number of babies being seen out of timeframe.

Improvement Plan
- Within service, it has been identified that amendments need to be relinked to original appointment. This has reduced the number of remaining recording errors. There are 2 this month which remain and need to be explored with BI as contacts were in timeframe, this is consistent to the previous month.
- Recruitment continues to be able to meet all service demands

Service PTL signoff completed: 31/12/2022

85. % of children who received a 6–8-week review [Children and Young People Service]
In December, 27 out of 493 children are showing as not having received a 6-8 week review by the time they turned 8 weeks. Performance was 94.5% (November was 95.5%) compared to a threshold of 95%. Performance is within SPC chart upper and lower control limits.

Contributing factors
- Reasons for breaches include: parental choice to be seen out of timeframe, Out of timeframe due to staffing capacity – appointment booked, no access – appointment has been rebooked, Recording errors – all been seen, Parent Choice declined 6-8 week review, Child in NICU, currently out of county, Movement into county - had virtual contact
- Some families have declined contact within timeframe due to the Christmas period. Also the extended bank holidays has impacted on losing work days.
- Where there is a no access visit, re-booking within timeframe can be difficult due to priorities

Improvement Plan
- Within service, it has been identified that amendments need to be relinked to original appointment, although this has been undertaken, a number of recording errors remain, this in being investigated with BI.
- Recruitment continues to be able to meet all service demands

Service PTL signoff completed: 31/12/2022

86: Percentage of children who received a 9–12-month review by the time they turned 12 months. [Children and Young People Service]
In December 146 out of 522 children are showing as not having received a 9-12 month review by the time they turned 12 months. Performance was 72.0% (November was 82.6%) compared to a threshold of 95%. Performance is within the SPC chart upper and lower control limits.

Local Commissioners (Gloucestershire County Council) have agreed a target of 90% in quarters 3 and 4 for 2022/23. Pending ratification by our internal governance process in January, this will then be reflected in the dashboard.
Contributing factors
- Reasons for breaches include: Out of timeframe – staffing capacity, appointment booked by 13 months, Delayed by parent, DNA X1 rebooked out of timeframe, movements in or out, declined review, DNA x2 pursued by service but declined, Recording errors- All been amended and linked, still remain in data, DNA X2 Further contact being made, completed at 8.5 months due to developmental concerns therefore not counted in the data
- Reduction in capacity over Christmas and days lost with Bank Holidays.
- Reduction in capacity in Cotswolds, leading to increase in children seen out of timeframe. Three new CNNs recruited.
- In Gloucester it has been highlighted that the current level of clinics are not able to meet the current demand. The locality have increased capacity in clinics to accommodate more appointment availability. There were 3 episondes of CNNs having short term sickness in December and 1 LTS. Work being undertaken with the nursery nurses to ensure ASQs are prioritised within service and within their workload.
- Parents do not have to engage with the health visiting service

Improvement Plan
- Reduction in the number of recording errors since the service record keeping training
- Additional hours and bank work to be offered to CNNs to be able to support demand
- Reduction in the number of parents declining and DNA appointments
- Reviewed all KPIs with nursery nurses and administrators to remind them of timeframes of mandated contacts and that DNAs to be rebooked within the child being 12 months of age
- SMS sent to all parents/carers prior to appointment being sent to inform them that their child is due an appointment
- Reminders and demonstration to all practitioners to use S1 SMS to remind parents of appointment for ASQ

- Reminders and demonstration to all practitioners to use 3T SMS to remind parents of appointment for ASQ
- Review wider Scope of ASQ tool and using with children with additional needs

Service PTL signoff completed: 31/12/2022

Commentary continues on next page...

87: Percentage of children who received a 12-month review by the time they turned 15 months. [Children and Young People Service]
In December, 133 out of 602 children are showing as not having received a 9-12 month review by the time they turned 15 months. Performance was 77.9% (November was 74.7%) compared to a threshold of 95%. Performance is within the SPC chart upper and lower control limits.

Local Commissioners (Gloucestershire County Council) have agreed a target of 90% in quarters 3 and 4 for 2022/23. Pending ratification by our internal governance process in January, this will then be reflected in the dashboard.

- Reasons for breaches include: Staffing capacity appointment now booked and child seen out of timeframe, Parental choice to be seen out of timeframe, Declined review, DNAx1, 2nd appointment then out of timeframe
- DNA x2 having further contacts, DNA x2, had further contact and then declined, Movements in and out, cancelled by service and rebooked out of timeframe, Record error, now corrected and visit completed in timeframe, Child in Care , ASQ not due, completed out of county
- Vacancies in the CNN line (both in permanent practitioners and COMF practitioners) have impacted on the delivery of the appointments being within timeframe. Recruitment and movement of practitioners to areas of need continues.
- Capacity, cancellations and parental choice does not always allow for DNA x2s to be re-booked in within timeframe
- Parents do not have to engage with the health visiting service

Improvement Plan

- Reduction in the number of recording errors since the service record keeping training
- Additional hours and bank work to be offered to CNNs to be able to support demand
- SMS sent to all parents/carers prior to appointment being sent to inform them that their child is due an appointment
- Reminders and demonstration to all practitioners to use S1 SMS to remind parents of appointment for ASQ
- Review wider Scope of ASQ tool and using with children with additional needs

Service PTL signoff completed: 31/12/2022

88. % of children who received a 2-2.5 year review by 2.5 years [Children and Young People Service]
In December Performance was 83.6% (November was 86.7%) compared to a threshold of 95%. 90 out of 552 children are showing as not having received a 2-2.5 year review by 2.5 years. Performance is within SPC chart upper and lower control limits.

Local Commissioners (Gloucestershire County Council) have agreed a target of 90% in quarters 3 and 4 for 2022/23. Pending ratification by our internal governance process in January, this will then be reflected in the dashboard.
Contributing factors

- Reasons for breaches include: Declined ASQ, DNA x2 further contact made and then declined, Movements out, DNA x2 further contact to be made, as by parent request, Parental choice to be seen out of timeframe, appointment booked, DNAx1, completed in timeframe and records correct, Cancelled by service, Declined review by parent as child has development delay, FHA and support continues from HV service, Movement in
- Specialist x2 1 completed in timeframe and correct, 1x declined when universal, now Specialist and not engaging with HV-open to social care
- Targetedx1. Movement in, ASQ completed within timeframe, saved to incorrect referral
- Capacity and parental choice does not always allow for DNA x1s to be booked in within timeframe
- Parents do not have to engage with the health visiting service, leading to a number of declines
- Vacancies in the CNN line (both in permanent practitioners and COMF practitioners have impacted on the delivery of the appointments being within timeframe. Recruitment and movement of practitioners to areas of need continues.

Improvement Plan

- Additional hours and bank work to be offered to CNNs to be able to support demand
- Successful recruitment has been undertaken for recent vacancies. Current recruitment for vacancies from December 2022.
- There will be a time lag until new starters are able to work independently due to training
- Service wanting to retain the remaining CNNs that were employed for the COMF project to enable a smoothe transfer into substantive posts and to value the practitioners and the achievements they have made to date.

Service PTL signoff completed: 31/12/2022

Commentary continues on next page...

90: Percentage of infants for whom breastfeeding status is recorded at 6-8wk check [Children and Young People Service]
December performance was 94.5% (November was 92.1%) compared to a target of 95%. 28 out of 511 children are showing as not having their breastfeeding status recorded. Performance is within SPC chart upper and lower control limits.

Contributing Factors
- 13 babies that have been included that are out/of county/ moved out/in of the area prior/after reaching 6-8 weeks of age, and some babies that should have been closed to our service/have been closed to our service (most of these should not be on the list as the notes were already closed, or moved in/out not required during that time frame, or were completed after for legitimate reasons such as re-arranged by family/family ill - This Issue impacting our figures has been raised numerous times this year with BI. And Head of Service is aware.)
- 2 no access – appointment booked
- 1 baby re-admitted to hospital.
- 1 baby in NICU.
- 8 No reason in records. These issues were addressed at Staff Mandatory Record Keeping Training again on 3rd Oct and is included in reviewing the Slow Weight Gain Policy, plus has been added to the New Birth Benchmarks/SOP to book the 6 week review at the New Birth Visit to reduce them being missed at later re-allocations due to staff/bank staff/staff illness.
- 2 unable to contact (1 appointment booked, 1 no appointment booked)
- The breastfeeding stats are recognised to be negatively countered by breastfeeding difficulties that start with initiation in Midwifery and affect the stats at 2 weeks when we receive the families into our service and subsequently the stats at 6-8 weeks.
- The Midwifery Service continue to be severely short staffed which is extensively impacting on the specialist feeding service in midwifery, tongue tie service in midwifery and Midwifery training updates were stopped; The Infant Feeding Hospital Team Staff have handed in their notice/left so new recruitment is required for the posts.
- The Breastfeeding stats are above target again higher this month for Health Visiting percentage of mothers still breastfeeding at 6 weeks that were at 2 weeks.
- Staffing capacity issues within HV- 6-8 week universal contacts completed out of timeframe to prioritise safeguarding and NBV;
- Staff not only leaving the Trust, despite New Starters joining, there is known to be recruitment and retention issues across the UK for Health Visiting, so is affecting staffing capacity, along with staff/Infant Feeding Keyworkers who have joined other projects in the Trust who have informed the Infant Feeding Lead they can offer less time to supporting breastfeeding mums or feel too overloaded with Health Visiting Work generally stressed.

Improvement Plan
BI to review the breeches that are coming through as these are impacting on figures being below KPI targets
- Health Visiting Training updates continue to be provided flexibly to ensure all staff have access as required. Locality Team HV Brief Updates completed from April to Sept, and Group sessions continue with next year's dates booked for staff to attend.
- Infant Feeding Lead HV continues to work with Comms to update and send out key message to families via social media (Website and Facebook) – 3 x HV promotional videos launched during breastfeeding week (parent voice, role of infant feeding keyworker, breastfeeding & infant feeding) was well received with praise from staff.
- Flexibility to provide new starter training, prior to their full training
- New Infant Feeding Keyworkers expressed an interest to support breastfeeding mums, replacing those that stepped down to do other projects such as Steps Ahead, however 2 more have gone as one stepped down due to workload and the other went to do SCPHN.
- Infant Feeding Keyworker Event Day was held 17th Oct organised by Infant Feeding Lead Health Visitor and her manager Service Lead for HV, focusing on the role and future plans as a follow up day to the first one in the summer – 2 planned for next year again.
- Regular meetings commenced between Infant Feeding Lead Midwife, Infant Feeding Lead health Visitor and Local Breastfeeding Support Groups to focus on slow weight gain; Now continues with NIFIN group and NICU Infant Feeding Midwife GRH as Infant Feeding Team GRH are left by beginning of Dec.
- Infant Feeding Lead Health Visitor organised/chaired the first National Infant Feeding Network Sub-Group focusing on strategy plans regarding slow weight gain theme across the UK since the Pandemic and next meetings planned on-going, so another was held Nov.
- Work commenced scoping an Infant Feeding strategic plan as part of the re-commenced Gloucestershire Infant Feeding Strategic Partnership Board Meetings (GIFSP) = first initial planning meeting Sept 2022 and whole members meeting held in Oct 2022; awaiting next date.
- Slow Weight Gain Guidelines becomes Policy and was ratified 6th Dec at the Policy Group Meeting – added to Care to Learn and highlighted at Team Meetings and Updates for staff, plus put in HV Newsletter and new copy for G care for Doctors.
- HV Service Event 1st Dec: Reflect & Refocus – HV Infant Feeding Lead presented on HIA area Supporting Breastfeeding highlighting success is demonstrated via Stats and BFI accreditation/BFI Audits, as required to evidence for commissioners too – importance of avoiding exceptions occurring – and how infant feeding comes into all HIA areas and is everyone's responsibility.

Service PTL signoff: Not applicable to this KPI

91: Percentage of infants being totally or partially breastfed at 6-8wks (breastfeeding prevalence) [Children and Young People Service]
In December 216 out of 511 children are showing as not being breastfed at their 6-8 week review. Performance was 57.7% (November was 53.7%) compared to a threshold of 58%. Performance is within SPC chart upper and lower control limits.

See narrative for KPI 90

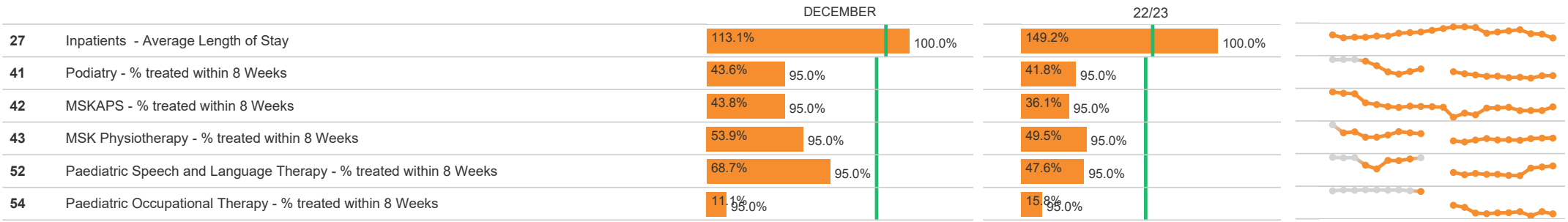
Service PTL signoff: Not applicable to this KPI

Performance Dashboard: *Physical Health - Local Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - Local Requirements



Performance Thresholds not being achieved in Month - *Note all indicators have been in exception previously in the last twelve months*.

27: Inpatients Average Length of Stay (Proxy Threshold) [Hospitals]
The average length of stay for inpatients in Community Hospitals was 43 days in December (52 days in November) compared to a threshold of 28 days. Performance is above SPC chart upper control limits.

The figure includes Community Assessment and Treatment Unit (CATU) patients as it is not currently possible to exclude patients who are no longer considered CATU but remain in a Tewkesbury bed.

8.8% (12/137) of all discharges in December had a length of stay of 100 days or more. Excluding these patients, the average length of stay reduces to 36 days. This KPI has been exceeding the upper SPC control limits since October 2021.

The higher figures are due to system wide delays in sourcing onward care for people who no longer meet the criteria to reside (nCTR) (including care home beds, packages of care and Home First placement). Improvement programmes have commenced on all wards to reduce length of stay through improved collaborative working and assessment. System conversations focusing on the long waiters continue as a priority. There was significantly stifled stroke discharge activity due to ESD capacity, which is driven by a lack of capacity in HF and PoC providers for them to discharge people into.

41. Podiatry - % treated within 8 Weeks [Adult Community Services]
December compliance was 43.6% (November was 43.3%) compared to a target of 95%. 357 out of 635 patients seen in December, were seen outside the 8-week target timeframe of referral to first contact. This is below SPC chart lower control limits.
The Podiatry service continues to fail to meet its 8-week Referral to treatment (RTT) performance following recommencement of data in March 22. The service is still recovering from the impact of redeployment in 2022, where waiting lists grew as clinical colleagues were deployed to other services. The waiting list is currently 1870 (05.01.23 - PTL) and it has been increasingly difficult to catch-up with this backlog due to the service carrying significant vacancy. Recruitment and retention continue to impact recovery and there was a poor response to the latest round of recruitment, but the service is exploring bank opportunities.
A Service Improvement plan is in place.

Service PTL signoff: Completed 30/09/2022

42. MSKAPS - % treated within 8 Weeks [Adult Community Services]
December Performance was 43.8% (November was 31.4%) compared to the 95% target with 182 out of 324 referrals treated outside 8 weeks. This is below SPC chart lower control limit.
Performance is improving, waiting list has reduced, currently standing at 7 weeks for foot and ankle and 10 weeks for all other body parts.
December was another challenging month with adverse weather, continued sickness and Christmas/New Year Leave.
The new posts have both started, following periods of induction we expect to see them up and running in February 2023.This increase to the establishment should positively impact the performance going forward this year.
A Service Improvement plan is in place for the service.

Service PTL signoff: Completed 31/12/2022

43. MSK Physiotherapy - % treated within 8 Weeks [Adult Community Services]

December performance was 53.9% (November was 54.1%) compared to the 95% target with 583 out of 1,267 referrals treated outside 8 weeks. This is below SPC chart lower control limit.
Performance remains stable at present and recruitment is underway to address vacancies. There is a known national workforce issue, and consequently, it is challenging to recruit to our vacant posts, all options are being considered.
December was another challenging month with adverse weather, continued sickness and Christmas/New Year Leave. The service is committed to continue to work through its Improvement Plan, which includes data cleansing and some new initiatives around triage and self-management.
A Service Improvement Plan is in place.

Service PTL signoff: Completed 31/12/2022

Commentary continues on next page...

52. Paediatric Speech & Language Therapy - % treated within 8 weeks
December performance was 68.7% (November was 65.4%) compared to a threshold of 95%. 61 out of 195 patients in December were seen outside the 8-week target timeframe of referral to first contact. This is below the SPC chart lower control limit.

There has been 3 months of significant improvement from pre October performance levels.

Contributing factors
The service continues with some vacancy in key clinical roles that support core service, additionally there is long-term sickness arrangement within the team, with sickness rate rising to 3.1% in December. December also sees a high number of bank holidays and annual leave within the team. This may impact our position next month. There are changes to the mainstream pathway that should allow the KPI to be met for this group of children, but children on the 'old' pathway will continue to filter through over the next month. In December, the vacancy rate was 9.9%, and 1.8WTE B6 has been lost to maternity and retirement. December saw successful recruitment to 0.6 WTE b7 and 0.8 b4 who will take up their roles in January. 0.8 Band 6 vacancy exists (unable to recruit to this in current position due to over establishment funding).
Estates access and availability remains a balancing act, resumption of face-to-face activity following the pandemic has been completed for all aspects of the service aside from Drop in which remains virtual. In order to resume group interventions to reduce the waiting times, estates are needed that can support this. Digital poverty in parts of the county means some families would not have the choice of a virtual appointment being offered sooner. The trends in locality pressures cycle and can be hard to predict and resource. This is particularly true of rural and isolated clinics which are difficult to support. This impacts service delivery when staffing changes.

The SystmOne Simplicity work continues to be challenging because cleansing activities and quality checks further reduces capacity of the clinicians – though there is now a static plan which has improved the position. The service Patient Tracking List (PTL) is receiving weekly cleansing from a band 4 clinician 0.2WTE to reach an acceptable state and until this occurs historic breaches may continue to appear incorrectly. This task cannot be handed over to non clinical staff due to the need for some judgement as to what constitutes clinical relevance. Band 7 Team Lead time is being dedicated to reviewing exceptions throughout the month, amending incorrect data and recording exception narratives. The service is obtaining detailed reports each month now of children who have been seen in the month but not had 'the clock stopped'. This will help us address staff training needs and amend activities before they show as breeches down the line.

Risk 178: CYPS Speech and Language Service Capacity. Score 6 (Reduced from 9)

The target date has been extended to March 2023. This was because of ongoing clinical capacity issues including the SystmOne Simplicity Project. Vacancies still exist within the service, but there is an improving position. Further time and capacity is required to complete the data cleansing activities as part of SystmOne Simplicity and to validate current performance positions. There is great progress within the data cleansing needs which creates optimism for an improved risk score by the agreed target date.
There is concern that there will be a reduction in staffing levels in the new financial year. 3 band 6 posts were over established and funds to cover these posts needs to be recouped by April 23. Our funded establishment will therefore reduce, so whilst the vacancy rate will appear low, we will have a net reduction in staffing. Extra hours are offered where possible, but the service is unable to fill vacant band 6 posts at this point.

The risk score was reduced to 6 in December 2022. Key factors in reducing the score were the changes to the mainstream advice line meaning families will now get advice sooner following referral. Ongoing active recruitment and additional hours being offered, improving workforce picture and stability. Gradual improvement/consistency in KPI attainment being a reflection of the service recovery journey. The early years advice line pilot continues to March 23, health visitors continue to deliver the Early Language Identification Measure (ELIM) work and SALT have digital programmes that can be shared with early years patients, settings and families.

Impact
There were 61 exceptions identified in December 2022, though not meeting KPI target, the improved position has maintained from last month. This highlights the impact of improving recruitment, correct recording of appointments on clinical systems. The process to correctly amend activities on SystmOne remains lengthy. There are arrangements in place for 0.2 Band 4 time, and support from band 7 Team lead to support this as an ongoing interest.

The majority of exceptions were seen within 18 weeks which is in line with National Guidance. Six were seen over 18 weeks from referral (last month was 18).
Five cases were offered the soonest available appointment with a mainstream therapist. These are the children who were referred before the new advice line process started (as referenced in the previous exception report) and should reduce in following months.

1 case was placed on a specialist waiting list from referral and there was delay due to needing an interpreter.
Within the cases waiting up to 18 weeks, 13 were offered sooner appointments that were not attended or cancelled. One case had 5 week delay in the referral being processed due to waiting for consent from a social worker.

Currently 493 children are waiting for episodes of care in community clinics following initial appointment with waiting times of approximately 8 months. The wait time has dropped slightly, though this is another increase in the number of children waiting. Allocation of cases will occur next week and this usually reduces the list by 70 + children when at full capacity. In the school age language service, children receive their episode of care on entry to the service and are then discharged or placed on self-initiated reviews. 203 children are waiting for support from mainstream therapists which has decreased from last month (which was an expected peak). In terms of proportions, this waiting list is predominantly consisting of new referrals with a small number of children needing follow up therapy after an initial appointment in community clinic or with a therapist no longer in the team. This number has also likely risen now that all new referrals are invited to call the advice line, some will likely not call and be discharged. Some may be discharged following the call if suitable advice can be given over the phone.

A 'Clinical Risk' matrix continues to be used to prioritise referrals and to monitor changing needs alongside a general policy of allocating children who have waited the longest and those who are returning for further therapy having been seen within the last year (our cases with ongoing and significant communication needs). The mainstream school advice line has been adapted to provide advice sooner for our school aged children. There are also plans to bring in early advice/triage calls for our children and young people who stammer. There are no formal complaints regarding waiting times.
Improvement Plan

- The service has a Recovery and Improvement Plan in place, which was last reviewed and updated end of Q2 22. Currently Red RAG rating, but risk is due to be reviewed which may impact this for the better. Current risk has reduced score to 6, but this will need to be maintained.
- Additional 0.4 band 4 brings an assistant to full time.
- 0.2 additional time to band 4 for PTL work and 0.4 additional band 4 clinical time agreed to start Jan 23.
- 0.8 WTE Band 4 appointed to work on clinic waiting for therapy list.
- 0.6 WTE Band 7 clinic lead to support clinic waiting times appointed.
- The service continues to offer additional hours as an interim support measure
- Changes to introduce stammering triage calls and adapting the mainstream advice line.
- Implementing changes to screening procedures based on clinical expertise to reduce risk of screening errors.
- Recently new estates were secured for the Cheltenham locality. Work is underway to make these spaces operational. Further estates are still required alongside plans for optimal usage and there is ongoing work between the CYPS Directorate and Estates Team to find solutions. Offerings for part days do not always suit clinical delivery and days worked. Need to investigate estates suitable for groups.
- Planned clinical planning day for whole team to work on projects such as training, resources and group planning in order to reduce waiting numbers and times.
- Ongoing investigation in to ways to use current budget most effectively and how to source additional funding to cover posts brought in during covid recovery which are now filled.

Service PTL signoff: Completed 31/12/2022

Commentary continues on next page...

54. Paediatric Occupational Therapy - % treated within 8 weeks
December performance was 11.1% (November was 19.2%) compared to a threshold of 95%. 56 out of 63 patients seen in December were seen outside the 8-week target timeframe of referral to first contact. This is below the SPC chart lower control limit.

Contributing factors

Workforce: For the past year the team's sickness absence has been significantly over threshold. December 22 was the first time in 2022 that the position is lower than Trust threshold at 3%.

Despite successful recruitment, promotions and good appetite in vacancies over the past 6 months this team continues to work severely under-established and does not have capacity to manage demands with a current vacancy rate of 24%. Throughout 2022 the service turnover rate was particularly high with the loss of key skills, experience and knowledge. Although there has been successful recruitment into roles this team are still on a journey of forming, storming and norming.
Currently there are one band 7 (0.6wte), two band 6 (2wte) and one band 4 (0.8wte) out to advert closing in January. There is one band 5 (1wte) starting in January.

Demand: SEND: Across all children's therapy services the numbers of new ECHP requests as well as number of health based reports requested through Tribunal processes have increased significantly and there has been no matching of growth investment. There is risk that increased SEND demands are impacting on core delivery and further increasing wait times for community core services. A risk has been added to the trust risk register to reflect the position for all the therapy services (risk score 12).

System Changes: Changes in other areas of the health system has resulted in a higher number of referrals into CYPS OT around behaviour, parenting advice and mental health. The high level of health anxiety in the general population has also resulted in an increased need for universal support and resources, for instance basic dressing skills and low-level handwriting needs. Ultimately, changes in demand has led to a bottle neck of referrals at the service front door. To manage demand and mitigate risk urgent cases and referrals continue to be prioritised, but this is creating long (and increasing) waits at the front door for lower-level needs and for routine follow up care.

Contracts: Generic caseloads with competing priorities from the service's multiple specifications and SLAs has disenabled robust prioritisation across the different clinical pathways and resulted in complex and inefficient internal processes.

System Flow: Phase 2 of the service recovery journey focusses on system flow. Further work and development is required around whole service caseload management, flow and robust discharge processes.

Data Quality Confidence: Despite its challenges the service continues to progress with simplicity changes with new reporting methodologies and processes being adopted by the service. The service still has limited capacity however to review or amend exception reporting on a regular basis and this is having an impact on performance.

Risk 243 – Safety of the Occupational Therapy Service (screening, assessment and treatment pathways). Score 12
Quality and safety concerns regarding the significant number on screening list, waiting lists and follow up lists without adequate oversight or management.

Risk Mitigations:
- Demand and Capacity: Partial closure of service front door with prioritisation of referrals with critical and urgent needs – 8 week arrangement.
- Resources: Universal resources and leaflets developed and patient information added to webpage.
- Comms Strategy: Notification added to service webpage.
- Letters sent to referrers advising of service position, sign posting and encouraging service users to utilise resources on webpage in the first instance. All letters (and webpage) contain contact details should needs change or if parent/ carer/ professional has concerns.
- Referrals: Electronic referral form being reviewed and updated to ensure good quality referral information is received to aid triaging.
- Screening Processes: Referral criteria now agreed. Urgent criteria now agreed. Risk matrix developed to aid clinical reasoning.
- Waiting Lists: Review of service waiting lists - screening/ F2F/ TC and Urgent are now only lists in use. All other front door waitlists reviewed, cleansed and closed.
- Treatment Lists: Head of Profession has reviewed every case waiting. Some cases moved to urgent waitlist for allocation. Datix to be completed if patient safety concerns identified.
- Review Lists: Therapy technicians reviewing equipment list and cases. Reviewing and establishing new pathway for managing equipment issue/ review processes.
- Clinical Pathways: Under review with pathway leads.
- Caseloads: All clinician held caseloads under review and being cleansed to ensure they are safe, current and prioritised.

Service priorities include:
- Screening List - enhanced capacity to tackle this list.
- Allocation of urgent referrals and cases

Improvement Plan
Phase 1 Nov 2022 to Dec 2022
Risk Management:
- Review all cases waiting to understand risk and level of needs - Completed
- Identify and manage any patient safety incidents - Completed

- All clinical staff reviewing and cleansing caseloads – In progress

Workforce:
- Head of Service appointment - Completed
- Resilient B7 Leadership structure with clinical pathway leads identified - Completed
- Safe staffing of clinical pathways – In progress
- Talent management strategies – In progress
- Active recruitment (all vacancies advertised on Trac) – Completed

Front Door:
- Robust screening process – Completed
- Clear referral criteria– Completed
- Prioritisation tools – Completed
- Risk identification tool – Completed
- Resources to support sign posting and management of referrals – Completed
- Universal digital offer – In progress
- Reduce screening list to circa. 30 referrals for BAU management – Completed

Universal Resources:
- Service Webpage updated with video resources shared from partner providers – In progress
- Universal digital resources agreed – Completed
- Patient information and videos added to website – In progress
- Electronic referral form under review to improve quality of referrals – In progress

Phase 2 Jan 2023

Demand:
- Service aims to open the front door to routine referrals again on 12th January 2023

Allocation and Booking:
- Review function, scope and framework of 'Duty Line'
- Complete review and redevelopment of allocation process required
- All clinical staff reviewing and cleansing caseloads

Caseload Hygiene and Management:
- Development of safe caseload weighting tool
- Ensure line management supervision support caseload management

Phase 3 Feb 2023 – In progress. QI project to commence end Jan/ Feb 23

Clinical Pathway Reviews:
- Pathway staffing
- Talent management
- Resource and capacity mapping and gap analysis
- Pathway criteria
- Pathway clinical competencies
- Pathway SOPs

Phase 4 Mar 2023

Discharges and Dormant Cases:
- Develop Discharge SOPs
- Equipment competencies and sign-off resources
- Escalation framework for equipment issues
- Patient Initiated Follow-Ups (PIFs)

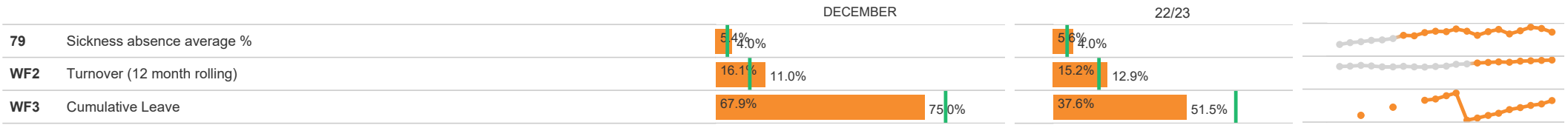
Service PTL signoff: Completed 31/12/2022

Performance Dashboard: *Trust Wide Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Trust Wide Requirements



Performance Thresholds not being achieved in Month - *Note all indicators have been in exception previously in the last twelve months.*

79: Sickness absence average % rolling rate - 12 months
Sickness absence rate in December 2022 was 5.4% compared to a threshold of 4%. This reflects the sickness absence information on Tableau on 06/01/2023. This does not include data from the e-rostering system (Allocate) because it is not available at the time of reporting. For reference, November was 6.3% (including Allocate data) and 4.8% without and was above the SPC upper control limit. The figure indicates in-month sickness absence, excluding Bank Staff.
Operations Directorate sickness absence was 6.7% in November.

Sickness absence in November decreased for a number of sub-directorates within Operations: Adult Community Services PH (6.9% to 6.3%), Hospitals (8.2% to 8%), Urgent Care & Speciality Services (6.2% to 4.5%), Operational Management (4.5% to 3.7%). The sub-directorates within Operations where sickness absence increased in November are: Adult Community MH & LD (7.6% to 8%), CYPS (5.1% to 5.2%).

Nursing, Therapy & Quality Directorate sickness absence was 5.2% in November. Within the Quality Assurance sub-directorate, sickness absence was 9.3% in November (a decrease from 11.6% in October). It should be noted that this is a small sub directorate with a headcount of less than 10. Governance & compliance sub-directorate sickness absence increased to 7.3% in November (7.2% in October).

Finance Directorate sickness absence was 5.8% in November. The sites with the highest sickness absence levels within the Facilities sub-directorate are St Paul's Campus (27.5%), Rikenel (17.2%), Cirencester Hospital (11.1%), Charlton Lane Campus (10.2%), Tewkesbury Hospital (13.7%), The Vale Hospital (12.4%), Wotton Lawn Campus (11%), Stroud Campus (11.5%). Finance Management sickness absence remained at 5.4%.

Human Resources Directorate sickness absence was 2.6% in November. Whilst the Directorate remains below target, the sub directorates with sickness absence to note are Working Well (10.5%) and HR Operations (4.2%).

WF2. Turnover (12 month rolling) [Workforce]
Turnover (LTR) was 16.11% in December (for the 12 months 1 January 2022 – 31 December 2022) compared to a threshold of 11%. There are 211 teams out of the 460 (46%) across the Trust which have had a turnover level over 11% over the last 12 months.

Lydney Hospital facilities team had the highest turnover average of 59% followed by CAMHS MH Outreach at 57%, Homeless Healthcare Team at 53%, AOT Stroud & Cotswolds 46% and Dental Urgent Care Out Of Hour at 42%.
At a staff group level, Estates and Ancillary was highest at 18.7% with Additional clinical service Administrative and Clerical groups at 18.2% and 16.6% respectively.
Some teams have low workforce numbers or are actively restructuring so these teams may expect a higher turnover.

Further work is being undertaken by our Workforce team and will be discussed within BIMG to further decide upon an appropriate way to present a Trust Turnover position and highlight areas of concern at an appropriate level within the hierarchy.

Breaking the data down by age groups, there appears to be higher turnover for younger and older staff. Under 20s have the highest Turnover at 42% (Note average headcount for under 20's is small, 26) followed by those in the 21-25 age band at 31%.

WF3. Cumulative Leave [Workforce]
At the end of December, percentage of annual leave taken across the Trust was 68% compared to the target of 75%. Medical have the lowest percentage leave taken at 51% followed by Contracts & Planning at 58%, Adult community PH Mgmt. & Admin, Corporate Governance and Urgent Care & Spec Services MH all at 63%.

o Urgent Care Response – Referral to Treatment

Although not currently a contractual KPI; the crisis response within 2hours performance position is presented below. The indicator is compliant against a National expectation of 70% (from Dec 2022) and data has been validated for 2022/23. This indicator will be introduced formally into the dashboard as a Nationally monitored indicator as part of Operational Planning in 2022/23. The expected 2day response indicator is also in place and is being monitored ahead of anticipated National reporting for 2023/24. Performance is very strong against these metrics.

Urgent care 2hr response compliance - Led by 'Crisis Response Intermediate Care 2hrs'

		FY 2023								
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2hr Response	Compliant	156	150	148	187	218	198	221	217	273
	Non-Compliant	75	46	47	68	59	39	54	49	90
	Total records	231	196	195	255	277	237	275	266	363
	Percentage	67.5%	76.5%	75.8%	73.3%	78.7%	83.5%	80.3%	81.5%	75.2%

Urgent care 2day report compliance - Led by 'Crisis Response Intermediate Care'

		FY 2023								
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2day Response	Compliant	60	43	46	13	9	2	3	5	1
	Non-compliant	0	0	0	0	0	0	0	0	0
	Total records	60	43	46	13	9	2	3	5	1
	Percentage	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

o 1.05b: Delayed Discharges – Outliers (Detained patients) [MH Hospitals]

There is no performance threshold for this indicator (it is a subset of Delayed Discharges), but it is highlighted for awareness for a second month as it is above SPC (Statistical Process Control) limits for December at 11.0%.

For information, a 'delayed transfer of care' occurs when a patient is ready to leave a hospital but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to another unit. DTOC outliers is an internal subset measure, monitoring detained patients which are otherwise excluded within the National definition of DTOC monitoring.

The percentage of bed days lost due to delayed discharge outliers has shown a steady increase since May 2022 and an analysis of December data shows that most delays are due to those waiting for nursing home placements. This is comparable to all waits for care homes across Gloucestershire and is multi-factorial with issues around staffing in care homes, rate challenges, COVID and other IPC (Infection, Prevention and Control) restrictions.

There has also been an increase in mental health activity acuity which is being seen nationally and is thought to be contributing to the increase in delayed patients that are detained. This patient profile is one of the most challenging to be place effectively with only a small provision in the county to meet these patients' needs. The team have also noted that an improved reporting and oversight structure could be contributing to the increase through identification and awareness of patients that are delayed. 1.05 Nationally Reported Delayed Discharges has risen to 4.4% in December (2.4% in November) and although not in exception (threshold 7.5%) is above average for the first time since July 2021.

o 3.30: Inpatients with Dementia have delirium screening at weekly intervals [MH Hospitals]

December performance is reported at 60.7% against a performance threshold of 85% and is within Statistical Process Control) limits therefore the indicator isn't in formal exception. There were 22 instances where screening did not take place within 7 days of the previous screening.

However, twenty of the instances were identified on a single ward (Willow), where non-compliant cases occurred due to nurse MDT workload. Staff have been asked to ensure patients are screened before their MDT meetings to increase compliance. Staff have also been reminded that in instances where patients refuse to cooperate or decline, this must be recorded on RiO to allow reporting of reasons for non-compliance

Two instances were recorded on Mulberry Wards due to late completion and has been explained as the MDT processes followed had been delayed due to bank holidays.

o 3.35: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks & 3.40: Adult Eating Disorders: Assessment to Treatment within 16 weeks [Community MH Services]

These measures are highlighted for their positive compliance positions but be mindful that low activity levels contribute to the calculation.

These measures are highlighted for their positive compliance positions but be mindful that low activity levels contribute to the calculation.

December performance for 3.35 is reported at 100% against a performance threshold of 95%. This hasn't been compliant since August 2021. There was 1 client starting treatment in December. The numbers reported against this KPI continue to remain low as routine referrals are assessed and held on a waiting list for treatment. The cases currently reported are due to instances where there has been a deterioration in the illness and treatment has been expedited.

December performance for 3.40 is reported at 100% against a 95% performance threshold. This indicator hasn't been compliant since at least April 2021. There were 5 compliant cases in December.

o 44. ICT Physiotherapy - % treated within 8 Weeks, 45. ICT Occupational Therapy Services - % treated within 8 Weeks, 46. Diabetes Nursing - % treated within 8 Weeks and 47. Bone Health Service - % treated within 8 Weeks

These four indicators have showed positive performance trends over the last few months. They are all within control limits but appear to have responded well to SystmOne Simplicity agenda and are tracking steady improvement which is expected to continue in the coming months.

o WF5. Vacancy [Workforce]

Overall vacancy rate across the Trust reduced to 11.11% at the end of December, compared to a threshold of 20%. The indicator is highlighted because workforce is highlighted as a major contributor to many performance indicators in exception. A breakdown is not currently available while ESR is being updated with the Trust's operational structural changes.

Work continues being undertaken by our Workforce and Finance teams and will be discussed further at a future BIMG to further evaluate an appropriate way to present a Trust Vacancy position and highlight areas of concern at an appropriate level within the hierarchy.

o Urgent & Emergency Care - Ambulance

As an urgent action from NHS England; Trusts are now asked to formally report Ambulance handovers and response times as a system performance measure at Board meetings. Please see the below for Gloucestershire ICS in November 2022 (the latest available at the time of reporting).

For ambulances the threshold should be Cat 1 against 7 minutes standard and Cat 2 against 18 minute standard.

For handovers, the interim contractual position for 2022/23 is 65% within 15 minutes, 95% within 30 minutes and none more than an hour.

Indicator	Metric	Good is	National Target	Local Target	Latest Performance	Trend	Latest Reporting Period	Latest Benchmarking			Reporting Period
								better than	worse than		
	esponse 1)	Low	7 minutes		00:13:36 Gloucester ICS	2021 2022	December 2022	00:10:34 Gloucester ICS	00:10:11 SWASFT	(Blank) England	Nov 2022
S020b	Average Ambulance Response Times (Category 2)	Low	18 minutes		01:57:48 Gloucester ICS	2021 2022	December 2022	00:42:47 Gloucester ICS	00:55:31 SWASFT	(Blank) England	Nov 2022
S020c	Average Ambulance Response Times (Category 3)	Low	120 minutes		05:07:38 Gloucester ICS	2021 2022	December 2022	01:49:45 Gloucester ICS	02:21:57 SWASFT	(Blank) England	Nov 2022
S020d	Average Ambulance Response Times (Category 4)	Low	180 minutes		03:55:52 Gloucester ICS	2021 2022	December 2022	01:49:27 Gloucester ICS	03:28:48 SWASFT	(Blank) England	Nov 2022
	Ambulance Conveyance Rates (% incidents conveyed)	Low			32.36 Gloucester ICS	2021 2022	December 2022	44.70 Gloucester ICS	6.06 Other South West ICS	4.28 England	Nov 2022

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AGENDA ITEM: 14/0123

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 January 2023**

PRESENTED BY: Sandra Betney, Director of Finance

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 31st December 2022**

If this report cannot be discussed at a public Board meeting, please explain why.	

This report is provided for:
Decision ☑ Endorsement ☐ Assurance ☑ Information ☐

The purpose of this report is to
Provide an update of the financial position of the Trust.

Recommendations and decisions required

The Board is asked to:
- **Note** the month 9 position
- **Approve** the revised capital programme

Executive summary
- A revised system plan submitted on 20th June showed a break-even position for both the system and the Trust
- The Trust's position at month 9 is a surplus of £2.593m
- The Trust is forecasting a year end position of break even
- The cash balance at month 9 is £54.1m
- Capital expenditure is £9.556m at month 9
- The Trust has spent £0.868m on covid related revenue costs for Apr-Dec
- The Board are asked to **note** the changes to the capital programme.
- The Cirencester Hospital scheme has moved from 2024/25 to 2025/26.
- Future years of the programme have also been amended to reflect additional Buildings spend
- CDEL reduction of £100k to disposals following District Valuer valuation

Risks associated with meeting the Trust's values
Risks included within the paper

Corporate considerations	
Quality Implications	
Resource Implications	
Equality Implications	

Where has this issue been discussed before?

Appendices:	Finance Report M9

Report authorised by:	**Title:**
Sandra Betney	Director of Finance and Deputy CEO

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AGENDA ITEM: 14.1/0123

Finance Report
Month 9

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

Overview

- The Trust submitted a revised breakeven plan on 20th June
- At month 9 the Trust has a surplus of £2.593m, and a forecast of break even in line with the revised plan
- Although the Trust anticipates the likely year end surplus will be £2.1m it has not formally adjusted it
- The Trust has recorded Covid related expenditure of £0.868m up to December
- 22/23 revised capital plan including £1.671m Digitisation funding is £19.335m and spend to month 9 is £9.556m against the plan of £8.089m
- Cash at the end of month 9 is £54.137m
- Cost improvement programme has delivered £4.917m of recurring savings against the target of £5.612m
- Non Recurrent target is £1.15m and all of this has now been delivered
- In addition to Trust savings we have made a £160k system saving on covid, and a further £400k in year
- The Trust spent £7.097m on agency staff to month 9, and against a proposed 23/24 agency cap of 3.7% of total pay the Trust would be an estimated £1.622m over year to date
- Better Payment Policy shows 95.6% of invoices by value paid within 30 days, the national target is 95%
- The 7 day performance at the end of November was 86.3% of invoices paid
- The Board are asked to approve the updated 5 year capital programme

GHC Income and Expenditure

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Gloucestershire Health and Care
NHS Foundation Trust

Statement of comprehensive income £000	2022/23 Plan	2022/23 YTD budget	2022/23 YTD Actuals	2022/23 Variance	2022/23 Full Year Forecast	2023/24 Forecast £000s	2024/25 Forecast £000s	2025/26 Forecast £000s	2026/27 Forecast £000s
Operating income from patient care activities	245,075	186,058	185,728	(330)	247,478	244,042	246,482	248,947	251,437
Other operating income **	6,733	11,331	14,290	2,959	18,605	19,100	19,291	19,484	19,679
Employee expenses	(189,346)	(150,276)	(147,023)	3,254	(196,572)	(199,976)	(201,976)	(203,996)	(206,035)
Operating expenses excluding employee expenses	(59,767)	(45,091)	(48,679)	(3,588)	(67,219)	(60,896)	(61,505)	(62,120)	(62,741)
PDC dividends payable/refundable	(2,590)	(1,943)	(2,300)	(358)	(3,200)	(2,590)	(2,616)	(2,642)	(2,668)
Finance Income	0	0	634	634	1,000	500	505	510	515
Finance expenses	(261)	(196)	(128)	68	(187)	(180)	(182)	(184)	(185)
Surplus/(deficit) before impairments & transfers	**(156)**	**(117)**	**2,522**	**2,639**	**(96)**	**0**	**0**	**(0)**	**0**
Remove capital donations/grants I&E impact	156	117	71	(46)	96	150	145	140	140
Surplus/(deficit)	**0**	**0**	**2,593**	**2,593**	**(0)**	**150**	**145**	**140**	**140**
Adjust (gains)/losses on transfers by absorption/impairments	0	0	**0**	0	0				
Revised Surplus/(deficit)	**0**	**0**	**2,593**	**2,593**	**(0)**	**150**	**145**	**140**	**140**

- Future years forecasts based on recurrent with inflation, savings assumptions applied. Non recurrent income and costs are excluded.
- 2023/24 forecast based on our target position but could be up to £2.1m worse depending on budgets set for Hospitals staffing and system negotiations about covid funding, inflation, Berkeley House, and IFRS16

GHC Balance Sheet

Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		2021/22	2022/23				2022/23	2023/24	2024/25	2025/26	2026/27
		Actual	Revised Plan	YTD Plan	YTD Actual	Variance	Full Year Forecast	Forecast £000s	Forecast £000s	Forecast £000s	Forecast £000s
Non-current assets	Intangible assets	958	958	958	1,181	223	1,115	1,115	1,115	1,115	1,115
	Property, plant and equipment: other	123,127	132,826	124,900	128,349	3,449	134,846	142,303	147,616	145,986	145,471
	Right of use assets*	0	25,742	18,177	17,184	(993)	22,466	20,244	18,022	15,800	13,578
	Receivables	542	518	524	517	(7)	517	493	469	445	421
	Total non-current assets	**124,626**	**160,044**	**144,559**	**147,232**	**2,673**	**158,945**	**164,156**	**167,223**	**163,347**	**160,586**
Current assets	Inventories	494	194	284	494	210	494	494	494	494	494
	NHS receivables	4,311	4,111	4,171	4,609	438	4,609	4,559	4,509	4,479	4,449
	Non-NHS receivables	6,561	6,561	6,561	3,449	(3,112)	6,449	5,949	5,849	5,799	5,749
	Cash and cash equivalents:	58,896	42,539	48,496	54,137	5,641	50,752	45,600	42,694	46,660	49,516
	Property held for sale	0	0	0		0	0	0	0	0	0
	Total current assets	**70,262**	**53,405**	**59,512**	**62,689**	**3,177**	**62,304**	**56,602**	**53,546**	**57,432**	**60,208**
Current liabilities	Trade and other payables: capital	(7,482)	(7,483)	(4,483)	(1,195)	3,288	(7,695)	(7,695)	(7,695)	(7,695)	(7,695)
	Trade and other payables: non-capital	(28,768)	(25,848)	(27,449)	(28,344)	(895)	(30,992)	(30,992)	(30,992)	(30,992)	(30,992)
	Borrowings*	(109)	(1,986)	(1,986)	(1,662)	324	(1,662)	(1,662)	(1,662)	(1,662)	(1,662)
	Provisions	(4,246)	(2,646)	(2,846)	(4,248)	(1,402)	(4,248)	(3,748)	(3,748)	(3,748)	(3,748)
	Other liabilities: deferred income including contract liabilities	(2,409)	(909)	(2,050)	(3,822)	(1,772)	(2,822)	(2,822)	(2,822)	(2,822)	(2,822)
	Total current liabilities	**(43,014)**	**(38,872)**	**(38,814)**	**(39,271)**	**(457)**	**(47,419)**	**(46,919)**	**(46,919)**	**(46,919)**	**(46,919)**
Non-current liabilities	Borrowings	(1,254)	(22,639)	(14,407)	(14,822)	(415)	(18,520)	(18,379)	(18,244)	(18,114)	(17,989)
	Provisions	(2,548)	(2,548)	(2,548)	(2,538)	10	(2,538)	(2,538)	(2,538)	(2,538)	(2,538)
	Total net assets employed	**148,072**	**149,390**	**148,302**	**153,289**	**4,987**	**152,772**	**152,922**	**153,068**	**153,208**	**153,348**
Taxpayers Equity	Public dividend capital	128,280	129,502	128,280	128,280	(0)	130,215	130,215	130,215	130,215	130,215
	Revaluation reserve	11,188	11,188	11,188	13,124	1,936	13,124	13,124	13,124	13,124	13,124
	Other reserves	(1,241)	(1,241)	(1,241)	(1,241)	0	(1,241)	(1,241)	(1,241)	(1,241)	(1,241)
	Income and expenditure reserve*	9,845	9,941	10,075	13,127	3,052	10,675	10,825	10,970	11,110	11,250
	Total taxpayers' and others' equity	**148,072**	**149,390**	**148,302**	**153,289**	**4,987**	**152,772**	**152,922**	**153,068**	**153,208**	**153,348**

Cash Flow Summary

Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	YEAR END 21/22		YTD ACTUAL		FULL YEAR FORECAST		2023/24 Forecast £000s	2024/25 Forecast £000s	2025/26 Forecast £000s	2026/27 Forecast £000s
Cash and cash equivalents at start of period		**52,333**		**58,896**		**58,896**	**50,752**	**45,601**	**42,694**	**46,660**
Cash flows from operating activities										
Operating surplus/(deficit)	6,326		4,188		2,733		**2,420**	**2,438**	**2,456**	**2,478**
Add back: Depreciation on donated assets	95		72		66		0	0	0	0
Adjusted Operating surplus/(deficit) per I&E	**6,421**		**4,260**		**2,799**		**2,420**	**2,438**	**2,456**	**2,478**
Add back: Depreciation on owned assets	7,101		5,781		7,766		7,757	8,615	8,925	8,810
Add back: Impairment	80		0		0		0	0	0	0
(Increase)/Decrease in inventories	224		0		0		0	0	0	0
(Increase)/Decrease in trade & other receivables	553		2,838		(162)		574	174	104	104
Increase/(Decrease) in provisions	1,845		(8)		(8)		(500)	0	0	0
Increase/(Decrease) in trade and other payables	4,988		(1,332)		2,224		0	0	0	0
Increase/(Decrease) in other liabilities	136		1,413		413		0	0	0	0
Net cash generated from / (used in) operations		**21,349**		**12,952**	**0**	**13,032**	**10,251**	**11,227**	**11,485**	**11,392**
Cash flows from investing activities										
Interest received	45		634		700		500	505	510	515
Purchase of property, plant and equipment	(14,340)		(15,820)		(19,086)		(16,841)	(19,160)	(7,073)	(6,073)
Sale of Property	0		0		0		3,849	7,454	2,000	0
Net cash generated used in investing activities		**(14,295)**		**(15,186)**	**0**	**(18,386)**	**(12,492)**	**(11,201)**	**(4,563)**	**(5,558)**
Cash flows from financing activities										
PDC Dividend Received	1,702		0		1,935		**0**	**0**	**0**	**0**
PDC Dividend (Paid)	(2,070)		(1,392)		(3,200)		**(2,590)**	**(2,616)**	**(2,642)**	**(2,668)**
Finance Lease Rental Payments	(108)		(1,012)		(1,363)		**(180)**	**(182)**	**(184)**	**(185)**
Finance Lease Rental Interest	(15)		(121)		(161)		**(141)**	**(135)**	**(130)**	**(125)**
		(491)		**(2,525)**	**0**	**(2,789)**	**(2,911)**	**(2,933)**	**(2,956)**	**(2,978)**
Cash and cash equivalents at end of period		**58,896**		**54,137**	**0**	**50,752**	**45,601**	**42,694**	**46,660**	**49,516**

Covid

Gloucestershire Health and Care
NHS Foundation Trust

- The Trust has spent £868k up to December 2022
- Out of envelope NHSE income is £328k as per expenditure (excluding testing charged to GHFT)
- Vaccine programme Recruitment & Retention £117k not yet spent but accrued

For periods up to and including 31/12/22	Original Expenditure Plan 22/23 (£)	YTD Expenditure Plan 22/23 (£)	Actual ytd Expenditure (£)	Forecast Expenditure (£)	Actual ytd Income (£)	YTD Net (£)	Full Year Net Forecast (£)
Stock Management	281,900	211,425	**193,185**	**257,580**	**0**	**193,185**	**257,580**
Covid Response Management	116,039	87,029	**56,659**	**56,659**	**0**	**56,659**	**56,659**
Covid Secure	59,844	44,883	**11,382**	**11,382**	**0**	**11,382**	**11,382**
High Touch Point Cleaning	43,010	32,258	**1,492**	**1,492**	**0**	**1,492**	**1,492**
Staverton Lease	33,311	24,983	**25,538**	**42,908**	**0**	**25,538**	**42,908**
Additional shifts & backfill for higher sickness absence	150,000	150,000	**123,714**	**123,714**	**0**	**123,714**	**123,714**
Decontamination	67,808	50,856	**10,788**	**10,788**	**0**	**10,788**	**10,788**
Vaccine Program - Local Vaccination Service M6-12			**117,899**	**206,323**	**0**	**117,899**	**206,323**
TOTAL IN ENVELOPE	**751,912**	**601,434**	**540,657**	**710,846**	**0**	**540,657**	**710,846**
COVID-19 virus testing (NHS laboratories)	533,000	399,750	**181,225**	**181,225**	**(181,225)**	**0**	**0**
Vaccine Program - Local Vaccination Service M1-5	415,865	311,899	**139,164**	**139,164**	**(139,164)**	**0**	**0**
Vaccine Program - Recruitment&Retention Program	0	0	**117,181**	**117,181**	**(117,181)**	**0**	**0**
Vaccine Program - Lead Employer	0	0	**395**	**395**	**(395)**	**0**	**0**
Vaccine Program - 12-15s	484,642	363,482	**70,904**	**70,904**	**(70,904)**	**0**	**0**
TOTAL OUT OF ENVELOPE	**1,433,507**	**1,075,130**	**508,870**	**508,870**	**(508,870)**	**0**	**0**
Testing undertaken on behalf of GHFT			-181,225	-181,225	181,225	0	0
NHSE Net Expenditure over Income	**2,185,419**	**1,676,564**	**868,301**	**1,038,491**	**(327,645)**	**540,657**	**710,846**

Capital – Five year Plan

NHS
Gloucestershire Health and Care

Capital 5 year Plan	Plan	Plan ytd	Actuals to date	Forecast Outturn	Plan	Plan	Plan	Plan	
£000s	2022/23	2022/23	2022/23	2022/23	2023/24	2024/25	2025/26	2026/27	Total
Land and Buildings									
Buildings	1,599	500	1,411	1,599	2,400	1,000	3,000	3,000	10,999
Backlog Maintenance	815	370	322	815	1,045	1,250	1,393	1,393	5,896
Buildings - Finance Leases					256	1,689	0	0	1,945
Vehicle - Finance Leases					384	239			623
Net Zero Carbon		150			500	500	500	500	2,000
Fleet Vehicles	125			125					125
							0	0	
LD Assessment & Treatment Unit					0	2,000	0	0	2,000
Cirencester Scheme						0	5,000	0	5,000
							0	0	
Medical Equipment	464	220	284	464	500	1,030	1,030	1,030	4,054
IT									
IT Device and software upgrade		0	0		0	600	600	600	1,800
IT Infrastructure	1,036	500	5	1,036	1,080	1,300	1,300	1,300	6,016
Clinical Systems Vision	1,671			1,671	2,191	3,161	1,250	250	8,523
Sub Total	**5,710**	**1,740**	**2,022**	**5,710**	**8,356**	**12,769**	**14,073**	**8,073**	**48,981**
Forest of Dean	13,452	6,300	7,534	13,452	8,851	0	0	0	22,303
National Digital Programme									0
Cyber Security	49	49	0	49					49
Wotton Lawn Clinical Treatment Roor	215			215					430
Total of Original Programme	**19,426**	**8,089**	**9,556**	**19,426**	**17,207**	**12,769**	**14,073**	**8,073**	**71,763**
Disposals	0				(3,285)	(2,454)	(2,000)	0	(7,739)
Donation - Cirencester Scheme	**0**					0	(5,000)	0	(5,000)
Total CDEL	**19,426**	**8,089**	**9,556**	**19,426**	**13,922**	**10,315**	**7,073**	**8,073**	**59,024**
New IFRS 16 Leases									
Vehicles	1,144	1,144		97					97
Equipment	146	146		49					49
Buildings	8,431	8,431		3,552					3,552
									0
Total	**9,721**	**9,721**	**0**	**3,698**	**0**	**0**	**0**	**0**	**3,698**

The Cirencester Hospital scheme has been moved from 24/25 to 25/26. Buildings spend increased in 25/26 and 26/27. CDEL reduction to disposals NBV of £100k in 23/24 based on DV valuation

Risks

Gloucestershire Health and Care
NHS Foundation Trust

Risks to delivery of the 22/23 position are as set out below, along with future risks:
HCA Band 2's to 3's added into 22/23 and 23/24 as new risks

Risks 22/23	22/23 Risks	Made up of: Recurring	Made up of: Non Recurring	Likelihood	Impact	RISK SCORE
Delivering Value savings not delivered	655	655	0	3	2	6
HCA Band 2's to 3's this year and back pay	1,632		1,632	4	3	12
Risks 23/24	**23/24 Risks**	**Made up of: Recurring**	**Made up of: Non Recurring**	**Likelihood**	**Impact**	**RISK SCORE**
Agency costs are not able to be reduced in Hospitals	2,500	2,500	0	3	4	12
Mental Health Act White paper reforms	850	850	0	3	3	9
Programme savings to be delivered *	500	500	0	3	2	6
Pay award for 22/23 is not recurringly funded	475	475	0	3	2	6
Inflation funding for 23/24 is not sufficient	757	757	0	3	3	9
Covid costs not funded	276	276	0	2	2	4
Berkeley House income reduction	380	380	0	2	2	4
IFRS 16 revenue impact not fully funded	200	200	0	3	1	3
Capital cost inflation leads to reduced programme	1,100	0	1,100	4	3	12
Risk of loss from disposal of land and building sales	400	0	400	2	2	4
HCA Band 2's to 3's	525	525	0	4	2	8
Utility, fuel and waste costs may rise further due to inflation	250	250	0	2	2	4
Total of all risks	**10,500**	**7,368**	**3,132**			

with you, for you

NHS

Gloucestershire Health and Care

NHS Foundation Trust

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

AGENDA ITEM: 15/0123

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 January 2023**

PRESENTED BY: Lavinia Rowsell, Head of Corporate Governance

AUTHOR: Anna Hilditch, Assistant Trust Secretary

SUBJECT: **BOARD COMMITTEE TERMS OF REFERENCE REVIEW**

If this report cannot be discussed at a public Board meeting, please explain why.	

This report is provided for:
Decision ☐ Endorsement ☒ Assurance ☐ Information ☐

The purpose of this report is to:

Present the Trust Board with the updated terms of reference for the Board Committees, which have undergone an annual review alongside the Committee effectiveness process.

Recommendations and decisions required

The Board is asked to:

- **ENDORSE** the revised TOR for the Board Committees

Executive summary

The Trust carries out an annual committee evaluation/self-assessment of performance which is considered good practice. Alongside this, a full review of the Committee terms of reference is carried out to take account of the outcome of the evaluation and to update in line with best practice.

The Board is presented with the following terms of reference for review and endorsement, noting that those areas where changes have been made are highlighted:

- **Great Place to Work Committee**
- **Charitable Funds Committee**
- **Resources Committee**
- **Quality Committee**

The Mental Health Legislation Scrutiny Committee meeting is scheduled to take place on 25 January. These TOR will be presented to the Board for approval at its next meeting in March 2023. The Board is asked to note that the revised TOR for the Audit and Assurance Committee were presented to and approved by the Board at its November 2022 meeting.

Risks associated with meeting the Trust's values

Corporate considerations	
Quality Implications	
Resource Implications	
Equality Implications	

Where has this issue been discussed before?
Reports have been received and considered at the Board Committees

Appendices:	Board Committee TOR • Great Place to Work Committee • Charitable Funds Committee • Resources Committee • Quality Committee

Report authorised by:	**Title:**
Lavinia Rowsell	Head of Corporate Governance / Trust Secretary

TERMS OF REFERENCE

Great Place to Work Committee

Version 4

1.	**Purpose and Ambition**
1.1	The purpose of the Great Place to Work Committee is to: • provide assurance to the Trust Board on all aspects of workforce and OD, supporting the provision of great colleague experience that enables safe, high quality, patient-centred care • ensure strategic priorities and Trust ambitions in relation to workforce and OD are delivered and any related corporate/strategic risks identified are managed • provide assurance to the Trust Board on the delivery of the Trust's People Strategy and its 6 core commitments
2.	**Membership**
2.1	Three 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). The Board Health and Well-being Champion will be included as one of the three Non-Executive Directors. Director HR & OD (Executive Lead) Chief Operating Officer (or a nominated deputy) Director of Nursing Therapies and Quality (or a nominated deputy) **In attendance:** Deputy Director of HR and OD Associate Director - OD, Learning and Development Associate Director - Workforce Systems & Planning Head of Leadership and Organisational Development FTSU Guardian Health & Safety Advisor Diversity Network representative Head of Communications Chair of Staff Side or their deputy Head of Corporate Governance /Assistant Trust Secretary
2.2	Other Officers of the Trust may attend at the discretion of the Committee Chair e.g. EDI Lead, Service Director Working Well, Head of Operational HR, Finance representative. Any other Trust Board Member may attend the meetings.
3.	**Quorum**
3.1	Three members, at least one of whom should be a Non-Executive Director and one should be an Executive Director.
3.2	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 Great Place to Work 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.
4.2	The Committee will highlight any key issues or concerns to the Audit and Assurance Committee, Resources Committee or the Quality Committee which require consideration by one or all 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 Great Place to Work Committee.
5.2	The Committee is authorised to establish sub-groups and task and finish 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 and receive written and verbal reports from them.
6	**Responsibilities**
6.1	<u>Strategy and Policy</u> To oversee progress with the implementation of the People Strategy and progress with the development and delivery of workforce, OD, cultural and quality improvement change strategies that support the Trust's strategic priorities in the context of the ICS, regional and national picture and against agreed objectives, milestones and KPIs. 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 oversee HR and OD 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.
6.2	<u>Organisational capacity</u> Seek assurance that the processes and plans used by the Trust have integrity and are fit for purpose in the following areas: • strategic approach to developing the capacity of the Trust's workforce • analysis and use of sound workforce, employment and demographic intelligence • the planning of current and future workforce capacity

	• effective recruitment and retention, including where appropriate ICS and wider regional system partners • new innovative models of care and roles • flexible working • identification of urgent workforce capacity problems and their resolution • continuous development of personal and professional skills • talent management and succession planning for continuity and organisational resilience Consider the coherence and pace of strategic plans to secure: • transformational change, service redesign and pathways of care • new and innovative ways of working • use of tools and technology • opportunities for changing practices and skills across traditional professional boundaries • joint working with partners in professional associations, trades unions, health and social care, Higher Education Institutes, third sector and other stakeholders • Widening Access and the value of apprenticeships
6.3	<u>Culture and Values</u> Seek assurance on the effectiveness of the ways in which the Trust involves and engages with colleagues, including the annual staff survey. Take a leadership role on behalf of the Board of Directors on: • securing positive progress on equality and diversity, including shaping and setting direction, monitoring progress and promoting understanding inside and outside the Trust • evaluating the impact of work to promote the values of the organisation and of the NHS Constitution • promoting staff engagement and partnership working • developing a working environment which promotes staff well-being, where people feel safe and are able to raise concerns, and where bullying and harassment are visibly and effectively addressed.
6.4	<u>Risk and Performance</u> Review and provide assurance on those elements of the Board Assurance Framework identified as the responsibility of the Committee seeking where necessary further action/assurance. Consider the control and mitigation of workforce related risks and provide assurance to the Board that such risks are being effectively controlled and managed Undertake high-level, exception-based monitoring of the delivery of workforce performance to ensure that the Trust is operating in line with its annual plan objectives.

	Provide assurance that the legal and regulatory requirements relating to workforce are met by the Trust
6.5	Compliance and Regulation To seek assurance that the Trust's services are delivered in accordance with statutory and regulatory requirements. This will include; • Standards of professional conduct • Freedom to speak up • Care Quality Commission workforce standards (with main responsibility for overall standards oversight and assurance continuing to rest with the Quality Committee • Equality, Diversity and Inclusion (e.g. WRES, WDES and Gender Pay Gap) • Well-being
6.6	Engagement Ensure effective on-going engagement and communication with all relevant internal and external stakeholders, including staff, service users, the public, the Integrated Care Board and other professional partners, as appropriate to the Committee's duties and remit.
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, 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 Great Place to Work Committee. This review will include a self-assessment of the Committee's effectiveness in discharging its responsibilities as set out.
8.	**Administration**
8.1	The Trust Secretary will ensure appropriate support is provided to the Committee.
8.2	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:	**Date:**	**Approved/Reviewed by:**
Version 1 (Draft)	27/08/2021	Received at NEDs/Execs meeting
Version 2 (Draft)	21/10/2021	Presented to GPTW Committee
Version 2.1 (Final)	13/12/2021	Presented to GPTW Committee for sign off
Version 3	27/01/2022	Approved by Trust Board
Version 4	08/12/2022	Presented to GPTW Committee
Version 4	26/01/2023	Approved by Trust Board

TERMS OF REFERENCE

Charitable Funds Committee

Version 3

1.	**Purpose**
1.1	The purpose of the Committee is to direct the management of charitable funds income and provide the Board of Trustees with assurance regarding compliance with statutory obligations.
2.	**Membership**
2.1	The Committee will comprise: • 2 Non-Executive Directors, one of whom will be appointed Chair • Director of Strategy and Partnerships (Exec Lead) (or nominated deputy) • Director of HR & OD (or nominated deputy) • Director of Finance (or nominated deputy) Given the Board's position as Corporate Trustee all Trust Board members may attend any Charitable Funds Committee Meeting. **In attendance:** • Trust Secretariat • Head of Estates – if required • Head of Financial Accounts • Head of Communications – if required
2.2	Other Officers or Directors of the Trusts may attend at the discretion of the Chair.
3.	**Quorum**
3.1	Three members of the Board of Trustees Board, at least one of whom should be a Non-Executive Director.
3.2	In the event that a member of the Committee is unable to attend a meeting, that member may nominate a deputy who will count towards the quorum at that meeting.
4.	**Reporting Arrangements**
4.1	The Charitable Funds 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.
4.2	The Committee will highlight any key issues or concerns to other Board Committees as and when required.
5.	**Powers**
5.1	The Trust's Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation shall apply to the Charitable Funds Committee.
5.2	The Committee has full delegated authority to manage the Trust's Charitable Funds on behalf of the Board of Trustees and acts as the governing body of the charity. It is authorised to approve strategies, local policies, procedures and annual reports and plans that relate to its areas of responsibility.
6	**Responsibilities**

6.1	**The following activities are within the remit of the Committee**: • Ensure compliance with all legal and regulatory requirements, including NHS guidance and Charity Commission guidance • Approve policies and procedures for the control of charity income, investments and expenditure and establish/maintain monitoring and review systems to ensure that procedures are correctly applied, • Approval of the annual financial statements and Charitable Fund annual report, • Approve the registration and objects of the Trust charities; ensuring such registrations meet the needs of the Trust's charitable purposes. • Consider applications from the fund managers for the creation of new funds and approve the governing documents under which these will be administered. • Nominate NHS officers to have delegated authority for the commitment of expenditure, management of VAT implications and liaison with the investment broker for deposits and withdrawals. • Ensure legacy income is monitored and approve the actions of the legacy officer to ensure receipt of all legacy entitlements. • Oversee the development of an investment policy for Board of Trustees approval as required. • If directed by the Board of Trustees, oversee the appointment of an investment manager and the implementation of appropriate procedures to monitor the investment arrangements and ensure compliance with the current relevant legislation. • Act as the control mechanism for any approved fund-raising appeals which may be initiated, and ensure that the appointment and control of fund-raisers is in line with current regulations and guidance • Ensure appropriate liaison with the Charity Commission and/or legal advisors to confirm/support any recommendation or action that the Trustees may wish to make. • Oversee the development of plans to increase awareness amongst staff and the wider community of the availability and potential uses of charitable funds. • Receive and consider bids for the application of monies in accordance with the Standing Financial Instructions. • Commission and review audit reports on charitable funds and initiate appropriate action. • Oversee the development of a fundraising strategy for approval by the Board of Trustees as required.
6.2	Engagement Ensure effective on-going engagement and communication with all relevant internal and external stakeholders, including staff, service users, the public, the Integrated Care Board and other professional partners, as appropriate to the Committee's duties and remit.
7.	**Frequency and Review of Meetings**
7.1	The Committee will usually meet 2 times a year. The Chair may agree further meetings if necessary. Virtual meetings, 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 Charitable Funds Committee. This review will include a self-assessment of the Committee's effectiveness in discharging its responsibilities as set out.
8.	**Administration**

8.1	The Trust Secretary will ensure appropriate support is provided to the Committee.
8.2	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:	**Date:**	**Approved by:**
Version 1	28/11/19	Approved by Trust Board
Version 2	8/12/21	Received by CF Committee
Version 3	19/12/22	Received by CF Committee
Version 3	26/01/23	Approved by Trust Board

TERMS OF REFERENCE

Resources Committee

Version 4

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: • Finance Strategy • Estates Strategy • Green Plan • Communication and Engagement Strategic Framework • Digital 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 financial and operating performance to ensure that the Trust is operating in line with its annual plan objectives Business Planning.
2.	**Membership**
2.1	Three 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 (Executive Lead) Director HR & OD Chief Operating Officer Director of Strategy & Partnerships **In attendance:** Deputy Director of Finance Associate Director, Business Intelligence Associate Director, Contracts and Planning Deputy COO Head of Corporate Governance /Assistant 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	Three 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.
4.2	The Committee will highlight any key issues or concerns which require consideration by another Governance Committee.
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	Annual Plan Delivery and Future Development To oversee the Trust's business planning process and agree principles and approach for internal budget setting and the development of directorate business 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 and 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	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.
6.3	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
6.4	Business Development 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.
6.5	Governance Ensure that the indicators and outcomes used to evaluate financial 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.
6.6	Engagement Ensure effective on-going engagement and communication with all relevant internal and external stakeholders, including staff, service users, the public, the Integrated Care Board and other professional partners, as appropriate to the Committee's duties and remit.
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, 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 the Committee's effectiveness in discharging its responsibilities as set out.

8.	Administration
8.1	The Trust Secretary will ensure appropriate support is provided to the Committee.
8.2	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:	Date:	Approved by:
Version 1	24/10/19	Approved by Resource Committee
Version 1	28/11/19	Approved by Trust Board
Version 2 (Draft)	17/12/20	Draft received by Resources Committee
Version 2	25/02/21	Approved by Resources Committee
Version 2	31/03/21	Approved by Trust Board
Version 3	25/10/21	Approved by Resources Committee
Version 4	22/12/22	Approved by Resources Committee
Version 4	26/01/23	Approved by Trust Board

TERMS OF REFERENCE

Quality Committee

Version 3

1.	**Purpose**
1.1	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.
2.	**Membership**
2.1	**Core Membership:** • 4 Non-Executive Directors • Director of Nursing, Therapies & Quality • Medical Director • Chief Operating Officer **In attendance:** • Deputy Director of Nursing • Deputy Director of Quality and Therapies • Head of Patient Safety • Associate Director of Clinical Governance and Compliance • Associate Director of Quality Assurance and Development • Head of Corporate Governance/Assistant Trust Secretary • Board Committee Secretary • Directors, clinicians and managers for specific agenda items as required • Representative from Gloucestershire ICB • Expert by Experience
2.2	Provided the Chair or Trust Secretary is notified in advance, members of the Committee may nominate a suitably qualified substitute to attend the meeting in their absence
3.	**Quorum**
3.1	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.
4.	**Reporting Arrangements**
4.1	The Quality 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.
4.2	The Committee will highlight any key issues or concerns which require consideration by another Governance Committee.

5.	**Powers**
5.1	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.
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.
5.3	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.
5.4	The Trust's Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation shall apply to the Quality Committee.
6	**Responsibilities**
6.1	<u>General</u> 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.
6.2	<u>Patient Safety</u> 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 • Receive assurance on associated patient safety areas inclusive of Medication Management, Infection Prevention and Control and Freedom to Speak Up
6.3	<u>Patient Experience</u>

	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. To seek assurance that feedback from service users, carers and the public about service provision and quality is properly evaluated and responded to.
6.4	Risk To seek assurance that clinical 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 quality & clinical related 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~~. *Note: Within Audit and Assurance Committee remit*
6.5	Compliance and Regulation To seek assurance that the Trust's services are delivered in accordance with regulatory and other requirements of the DoH, CQC, NHSE 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~~ *Note: Within Audit and Assurance Committee remit and SIRO report to Board*; • Ensuring arrangements for ethical review and research governance comply with national guidelines.
6.6	Effectiveness 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. To seek assurance from the Quality Assurance Group, and other sub-groups, regarding matters defined within their respective terms of reference.
6.7	Engagement Ensure effective on-going engagement and communication with all relevant internal and external stakeholders, including staff, service users, the public, the

	Integrated Care Board and other professional partners, as appropriate to the Committee's duties and remit.
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, 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 Quality Committee. This review will include a self-assessment of the Committee's effectiveness in discharging its responsibilities as set out.
8.	**Administration**
8.1	The Trust Secretary will ensure appropriate support is provided to the Committee.
8.2	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:	**Date:**	**Approved by:**
Version 1	16/10/19	Approved by Quality Committee
Version 1	28/11/19	Approved by Trust Board
Version 2 (Draft)	07/01/21	Draft received by Quality Committee
Version 2	04/03/21	Approved by Quality Committee
Version 2	31/03/21	Approved by Trust Board
Version 3	12/01/23	Approved by Quality Committee
Version 3	26/01/23	Approved by Trust Board

GPTW COMMITTEE SUMMARY REPORT

DATE OF MEETING: 8 DECEMBER 2022

COMMITTEE GOVERNANCE	• Committee Chair – Graham Russell, Non-Executive Director • Attendance (membership) – 66.6% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

STAFF STORY – STROKE SERVICES

The Committee received a staff story from the Stroke Services who were invited to share their experiences within the service. The Committee was informed of the work carried out by the service and it was reported that the team travelled around Gloucestershire visiting patients who had been discharged from hospital following a new stroke diagnosis. It was reported that the number of patients who were diagnosed with strokes was increasing each year, which contributed to additional pressures on the service.

The Committee was informed that initially the Stroke ESD Team were commissioned to take 40% of hospital discharges; however, this had increased to close to 60%, with no uplift in the staff numbers. It was reported that referrals had increased from approximately 230 to 400. The difficulties of seeing all of the stroke patients across the whole of Gloucestershire was shared with only 16 clinical staff working for the service.

The Committee was informed of the development of a business case for a Community Neuro Stroke Team, which was being progressed by the Operations Directorate, and it was noted that this would also include longer term conditions of Parkinson's, MS etc. Phase one and two of the business case had been approved and accepted.

Colleagues acknowledged that the service was doing well, but that further progress was dependent on the resources available. Other issues effecting the services included a relatively flat structure, technology challenges with computers and also the different systems used for recording patients' information. It was also recognised that staff were using their own vehicles for transport for visiting patients and that this had challenges in light of the persistently high fuel costs. It was noted that this was one of the reasons Executives had increased and extended the mileage reimbursement rates for those community staff who did significant mileage for their work. It was also noted that the Trust had recently approved a further computer programme to replace and update laptops.

The Committee thanked Anita Bailey and Kate Bird for their work within the Stroke Services.

DEEP DIVE – NURSING AND MIDWIFERY SELF-ASSESSMENT TOOL – RETENTION AND RECRUITMENT

The Committee undertook a deep dive into nursing retention which was led by Ali Koeltgen and Cheryl Haswell. The Committee was informed that there was a record high of almost 47,000 registered nursing vacancies within the NHS in England at present, and that recent data had shown vacancies had increased by 21% in only one year.

It was further reported that the South West had seen the highest increase in vacancies, with 3,631 current nursing gaps. This was a 37% increase from June 2021.

The nurse retention data for the Trust was shared with the Committee and the hot spot areas were highlighted. These were; Wotton Lawn, ICT's and Charlton Lane.

The Committee was informed that the NHS Nursing and Midwifery retention self-assessment tool was published in July 2022 and it was not mandatory. This then changed in September 2022 when the expectation then changed to *all trusts to complete and submit to the ICB.*

The self-assessment tool was based on two principles to support nurse retention, these were:

1) Targeted interventions for all career stages
2) Bundles of high impact interventions.

The Committee split in to two break-out groups facilitated by Ali Koeltgen and Neil Savage, where the Committee was invited to discuss two highlighted areas in which progress was low against the self-assessment criteria framework. These were:

1) Production of a flexible working dashboard/ flexible working report
2) The use of outcome data, research and insight to monitor and inform retention strategies and improvement plans.

The Committee reconvened and shared the key discussions held. These included:

- The importance for the priorities to be simple and with a sustainable approach
- The full offers available on flexible work
- The requirement for these to be explicit. It should also be discussed with colleagues how important flexible working was, staff groups to be included with discussions
- Exit interviews and how the information retrieved from the data could be used to help retain staff in the future.

The Committee thanked Ali Koeltgen and also Cheryl Haswell for their work in implementing the Nursing and Midwifery Self-Assessment Tool.

PERFORMANCE REPORT – WORKFORCE KPIS

The Committee received the Performance Report, workforce KPIs for month 7, which provided a high-level view of the KPIs across the Trust. Additional turnover, vacancy, leavers and exit questionnaire data were also presented and discussed, with a focus on hot spot areas.

ALIGNMENT OF 6 PEOPLE STRATEGY COMMITMENTS WITH THE STAFF SURVEY PEOPLE THEMES

The Committee received a report, which provided an update on the 2022 Survey's closing response rates and an analysis of options to align of 6 People Strategy Commitments with the Staff Survey People Themes, in order to get an indication of how staff are rating the Trust's delivery against the GHC Commitments.

Following consideration of options, the Committee agreed a future approach which included:

a) a more detailed analysis using individual questions /sub-question categories against the People Strategy Commitment.

ANNUAL REVIEW OF COMMITTEE EFFECTIVENESS REVIEW AND TERMS OF REFERENCE

The Committee received the Annual Review of GPTW Committee Effectiveness and Terms of Reference. The Committee noted the positive outcome of the Committee self-assessment and no issues of concern were raised. The Committee **received** the Committee Terms of Reference and **endorsed** the suggested amendment for onward presentation and sign off by the Trust Board.

OTHER ITEMS RECEIVED

The Committee:

Received and **noted** the Industrial Action update provided.
Received and **noted** the workforce Risks and Board Assurance Framework.
Received and **noted** the HR and OD Policies and Procedures update.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **NOTE** the contents of the report.

DATE OF NEXT MEETING	Wednesday 1 February 2023

CHARITABLE FUNDS COMMITTEE SUMMARY REPORT

DATE OF MEETING: 19 DECEMBER 2022

COMMITTEE GOVERNANCE	• Committee Chair – Sumita Hutchison, Non-Executive Director • Attendance (membership) – 80% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

FINANCE REPORT

The Committee received the Finance Report, which provided an overview of the Trust's Charities funds as of 30 November 2022. The funds balance as of 30 November 2022 had increased by £29k since the 31 March 2022. This was an increase from £351k to £380k.

The Committee was informed of the total income received for the period 1 April 2022 to 30 November 2022, which was £56,513. A breakdown of this was included within the report.

It was reported the total expenditure for the same period (above) was £26,871. The breakdown of this was included within the report.
The Committee was informed of 12 approved commitments at present with a total £15,357 outstanding committed to spend.

CHARITABLE FUNDS APPROVALS

The Committee received the Bid Approvals which had been made since the previous Charitable Funds Committee meeting. The Committee was informed that two bids had been approved and authorised since September 2022 with a total value of £2350.

The Committee was informed of a bid which had been submitted in excess of £2000 for the Committee's approval. The bid submitted was for the 15th Anniversary Big Health Day, which would take place on Friday 16 June 2023, Oxstalls Sports Park, Gloucester.

The Committee **reviewed** and **approved** the Big Health Day bid for £5,000.
The Committee **noted** the bids approved since the last meeting

NHS CHARITIES TOGETHER UPDATE

The Committee received the NHS Charities Together update which provided a close down report on the activities endorsed by the Committee during 2020/21 for the utilisation of the monies received from NHS Charities Together.

The Committee **noted** the final report regarding the legacy of the investments made from the NHS Charities Together donations to support the health and wellbeing of our colleagues.

ORCHARD FUNDRAISING PROGRESS REPORT

The Committee received the Orchard Fundraising Report; Next Steps, which provided an update on the activities taken over the previous quarter in order to take forward the recommendations within the Orchard fundraising report (previously received by the Committee).

The application process for reclaiming Gift Aid required registration with HMRC and this was underway. This would provide the opportunity to reclaim Gift Aid from donations made in the previous four years.

The Committee congratulated Angela Potter on the progress which had been made.

The Committee:

- **Noted** the progress on charitable funds activities including the successful award of the National Lottery Awards for All application and the submission of the capacity building grant submission to NHS Charities Together.
- **Supported** the submission of the Expression of Interest for the new grant round with NHS Charities Together focused on enhancing Green spaces
- **Considered** whether the Trust should decline to promote fundraising activities undertaken by members of staff that are for charities other than the Trust's charity within our social media or communication platforms.

HARDSHIP FUNDS UPDATE REPORT

The Committee received the Hardship Fund Update Report, which provided an update on the implementation and uptake of the cost of living Hardship Fund considered and approved by the Committee at the previous meeting; and also, to make recommendations for an extension to the scheme.

It was reported that 57 applications had been made in total. A breakdown of applications made was included within the report.

The Committee was informed that a total of £9,288 had been approved and paid from the Hardship Fund of the £12k which was previously agreed by the Committee. An additional £8k was sought to support future applications.

The Committee agreed approval for additional £5k (if deemed necessary) would be delegated to Angela potter and Neil Savage, and the Committee would be notified by email of any additional approvals made (prior to the Committee meeting in March).

The Committee **noted** the update on the Hardship Fund applications, approvals and spend to date. The Committee **considered** releasing an additional quantum of charitable funds to cover the winter and spring period.

ANNUAL ACCOUNTS FOR APPROVAL

The Committee received the Gloucestershire Health & Care NHS Foundation Trust Charities Annual Accounts and Annual Report of the Trustees for the financial year ending 31 March 2022.

The Committee was informed that an independent review had been performed and approval was sought ahead of submission in January 2023. The Committee **reviewed** and **approved** the Annual Accounts and trustee's Report.

OTHER ITEMS RECEIVED

The Committee:
Received and **noted** the Brokenborough update.
Received and **noted** the League of Friends update provided.
Received, noted and **considered** the outcome of the Committee Evaluation, and **endorsed** the suggested amendment to the Committee Terms of Reference for onward presentation to the Board.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **NOTE** the contents of the report.

DATE OF NEXT MEETING	Wednesday 8 March 2023

RESOURCES COMMITTEE SUMMARY REPORT

DATE OF MEETING: 22 DECEMBER 2022

COMMITTEE GOVERNANCE	• Committee Chair – Steve Brittan, Non-Executive Director • Attendance (membership) – 87.5% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

FINANCE REPORT – MONTH 8

The Committee received the Finance Report for month 8, which provided an update of the financial position of the Trust. The Committee was informed that the Trust remained in the position of reporting a surplus in year and then a break-even at year end. Capital expenditure was £8,868m at the end of November 2022. The cost improvement programme had delivered £4,917m of recurring savings against the target of £5,612m.
The Committee **noted** the month 8 position.

BUDGET SETTING 2023/24 UPDATE

The Committee was informed of the budget setting process for 2023/24 and an update on the work which had been progressed was received. This included the joint business planning launch and also the cost pressures being reviewed by the Executive Team.

The financial control totals were shared with the Committee and it was reported that if the budgets were set as per the control totals, the Trust would be setting a potential deficit position of £1.055m. An explanation for this was included within the report. The CIP requirement and plan were shared with the Committee, which showed the total amount of CIP required was £7.721m. The Committee was shown a breakdown of the delivery.

The next steps of the budget setting process were shared with the Committee, which concluded with the budget setting sign off by the Trust Board scheduled for 30 March 2023.
The Committee **noted** the budget setting process for 2023.

SYSTEM FINANCE

The System Finance 2023/24 update was shared with the Committee and it was reported that the ICS had begun reviewing the underlying financial position and were in the process of analysing the 2022/23 underlying position.

PERFORMANCE REPORT – MONTH 8

The Committee received the Performance Dashboard for month 6, which provided a high-level view of key performance indicators (KPIs) in exception across the Trust. All of the indicators reported had previously been in exception in the last 12 months.

The Committee was informed of seven mental health key performance thresholds in exception which were not met for the period. It was noted that five of the seven related to the Eating Disorder Service. There were 17 physical health key performance thresholds in exception for the period and the narrative for this was included within the report.

The inclusion of the Trust Wide Service Performance was highlighted in the report, which reported that Sickness Absence, WF2 Turnover and WF3 Cumulative Leave were all in exception for the period.

DEEP DIVE – ADHD AND AUTISM SPECTRUM CONDITION DISORDERS

The Committee received a deep dive in to ADHD and Autistic Spectrum Condition Disorders which provided an in depth briefing on the current strategic and operational position of the service, detailing the current performance against key performance indicators and the strategic steps taken to improve the position, and additional commissioning activities undertaken to support ongoing service delivery.

The Committee was informed of the Autism Spectrum Condition (ASC) Service provided by the Trust and it was reported that the demand on the service significantly outweighed the capacity.

It was reported that on average the team received 11 referrals each week, which equated to 572 per year. It was noted that the size of the team providing the service were a small team with only 3.5 WTE staff members. The Committee was informed that since Covid, the service had seen a 77% increase in referrals

An update on the ADHD Services provided by the Trust was also received, and like the ASC Service, the ADHD Service's demand significantly outweighed the capacity available. It was reported that the team were commissioned to provide 30 treatment review sessions per year and the team received, on average, 22 referrals each week, which equated to 1144 per year.

The Committee was informed of the referral levels before and after Covid and it was noted there had been a 200% increase in referrals received.

The Committee was assured that updates on the services would be included in the Chief Operating Officer's Report (within the Performance Dashboard Report) received at future Resources Committee meetings.

EPRR CORE STANDARDS ASSURANCE REPORT

The Committee received the EPRR Core Standards Assurance Report, which provided an update on the Trust's compliance against the NHSE Core Standards for Emergency Preparedness Resilience and Response for 2022/23. The Committee was informed that the Trust was rated as substantially compliant in the EPRR annual Core Standards Assurance for the 2022/23 period.

The Committee was informed of the three areas in which the Trust was scored as *partially* compliant; which were:

- Evacuation and shelter
- EPRR training
- Business and continuity audit

The Committee **noted** the contents of the report; and the current declared level of assurance.

COMMITTEE EFFECTIVENESS REVIEW & COMMITTEE TERMS OF REFERENCE

The Committee received the outcome of the Committee Effectiveness Self-Assessment and the Committee Terms of Reference for review. The Committee **noted** and **considered** the outcome of the committee evaluation and **received** the Committee Terms of Reference and **endorsed** the suggested amendments for onward presentation and sign off by the Trust Board.

OTHER ITEMS RECEIVED

The Committee:
Received a verbal update on the Systm1 Simplicity Project
Received and **noted** the GHC Catering Services Report.
Received and **noted** the Interim Care Strategy
Received and **noted** the Service Development Report.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **NOTE** the contents of the report.

DATE OF NEXT MEETING	Thursday, 23 February 2023

WORKING TOGETHER ADVISORY GROUP SUMMARY REPORT

DATE OF MEETING: 11 January 2023

COMMITTEE GOVERNANCE	• Chair – Jan Marriott, Non-Executive Director

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

Personalised Care Q&A/Discussion

Michelle Scofield, Service Development Manager with a lead for Personalised Care was in attendance at the meeting to share an update on the personalised care workstreams and future developments. Some developments included:

- Work had taken place to review the Trust's corporate induction programme and a short presentation slot would now be included within future induction programmes on personalised care.
- Links had been established with community teams to understand the Personal Health Budgets offer
- Linked into the Mental Health Transformation work, specifically the Personalised care plans development *(see below)*
- Supporting development of Mental Health inpatient care plans

The "What Matters to Me" Project was progressing and 6000 copies of the "What matters to me" orange folder were being distributed and piloted across services in the county.
The contents of the Folder could be tailored to services to help patients set out their care plan and it was reported that a digital version of the folder was also being created for those with sensory and/or broader physical conditions. The ICB Personalisation Board had been leading on the rollout of the pilot. The initial phase was due to complete in March 2023.

The Chair thanked Michelle for her presentation and the good work taking place in this area. It was agreed that updates would be presented back to the group as the work progresses.

Partnerships Team Restructure Update

The Group was presented with the updated organisational structure for the Strategy and Partnerships Directorate, for information and reference. The Directorate's core function was to support clinical services to deliver high quality services and undertake transformation and improvement projects.

A query was raised regarding the seemingly high number of "managers" within the team, with it being noted that there could be a public perception that this was detracting from clinical services. Due to the nature of the Team's work, it was noted that a high proportion of the team were ex-clinicians. There was also a query about the championing of experts by experience previously taken forward by the smaller Partnerships and Inclusion Team and whether experts by experience would feel as well supported. The Group noted that the structure of the partnerships team now

included a wider approach to the locality and county wide alignment of the inclusion activities which it was hoped would further enhance the Partnership Team support available.

Inclusion Activity

The Group received an update on the work taking place relating to the LIFE QI (Quality Improvement) system and the inclusion of experts by experience in those projects.

An update was also presented on Inclusion activities taking place across the Trust and an update for Quarter 4 plans and developments.

Working Together Authentic Co-production and Partnership Working: CEN Young People's Participation

The Group welcomed Jo Greenwood and Amelia Kilsby to the meeting who gave a presentation on the Complex Emotional Needs (CEN) Service. Complex Emotional Needs is a nationally adopted term referring to a collection of symptoms that we prefer to frame as responses to trauma and these are many and varied but if they interface with MH services it is likely that the impact of these responses is significant and detrimental to psychological functioning.

Jo and Amelia spoke about how they had embedded Working Together in their project/approach, which included listening to a wide range of people including many representatives from the VCS to try and identify what people outside of the Trust felt were the issues and gaps within services for people experiencing CEN. Key issues included silos, confusing criteria and a perception of a gap between Let's Talk and Secondary Care. They talked to a wide range of people using services and MH colleagues and system partners through focus groups where they gathered a wide range of data and opinions about what's missing and what matters to improve the landscape for people with CEN.

In terms of what was working well, the Group noted that a whole range of approaches to the issue of changing cultures and improving the responses that people with CEN receive had been developed. In the first year, the Team processed over 300 referrals and helped change referral pathways from entry level services to secondary care (reducing referrals by 50%) which was attributed to improved signposting which in turn improves care through people not going around in circles. A vibrant Community of Practice had been set up – a learning collaborative with VCS partners based on the principles of shared expertise and collaborative practice, and this has strengthened connections and helped the Team to champion a trauma informed commitment across the county.

In terms of challenges and barriers, some services were sceptical of the Team's 'happy to help' approach, some seemed to fear that they'd be critical of their efforts to date and some worried about admitting to struggling. There was confusion about what EbyE, LXP (Lived Experience Practitioner) and Peer Support labels all mean due to a lack of professional identity. LXP's were not always seen as highly experienced and knowledgeable practitioners in their own right, with many examples of them being viewed as practical helpers rather that designing and delivering training, policy and protocols and undertaking work as researchers as well as

providing emotional support to people presenting very high levels of risk. Funding was now a number one priority as we can see how effective the service can be but we simply don't have capacity to connect as widely and consistently as we need to. It was noted that the funding envelope was for Gloucester City only due to identified social deprivation but actually high levels of complexity are often found in the more affluent areas. The service currently receives funding for 5 Full time equivalents and this has evolved into a county wide brief due to a commitment to breaking down silos

The Group thanked Jo and Amelia for their excellent presentation. It was noted that as part of the Community Mental Health Transformation project, a CEN options appraisal was being worked up to roll out the service further across the county.

The Group congratulated the service on being one of the huge successes of the Trust in being part of a peer progression pathway through working together with experts by experience. The work of the service was hugely encouraging and the impact and power of mutuality and reciprocity, flattened hierarchy, value and trust through peer support workers could not be underestimated.

Working Together Authentic Co-production and Partnership Working

The group went into smaller breakout groups to explore authentic co-production in GHC, focussing on:

- What limitations, challenges or barriers get in the way of effective co-production
- What about those who may feel less comfortable in our setting? Who would feel less comfortable about working together?

The write up from the breakout groups would help inform future agenda discussions at the April session.

Any other business

It was agreed that a survey, similar to that carried out annually to assess the effectiveness of the Board Committees would be carried out later in the year to help gauge the success of the WTAG in format and function.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **NOTE** the contents of the report and look at "How can we further support and enhance the CEN Ways of working'.

DATE OF NEXT MEETING	Thursday, 20 April 2023

QUALITY COMMITTEE SUMMARY REPORT

DATE OF MEETING: 12 JANUARY 2023

COMMITTEE GOVERNANCE	• Committee Chair – Jan Marriot, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

NEW RISKS OR ISSUES

The Committee was informed that New Risks or Issues would be a standing agenda item going forward, where committee members and attendees were invited to raise any risks or issues for the Committee's attention.

CLINICAL PRESENTATION – SEXUAL HEALTH

The Committee welcomed Lindsay Kear, Sexual Health Service Manager and Ronnie Karadia, Clinical Development Manager to the meeting who shared a clinical presentation on the Sexual Health Services of the Trust.

The Committee was informed of the services provided by the Sexual Health Services and the work which they routinely carry out. This included the Sexual Assault and Referral Centre (SARC), Integrated Sexual Health Service, Pregnancy Advisory Service and Human Immunodeficiency Virus Service. The outstanding practice of the Sexual Health Services was shared and the Committee praised the work which had been done. This included a 95% positivity rate on the 2021-22 Friends and Family Test (FFT). The challenges and next steps were also shared with the Committee, which included data reporting and it was reported the teams were working with BI and Clinical Systems to improve.

The Committee thanked Lindsay Kear and Ronnie Karadia for the presentation provided.

QUALITY DASHBOARD REPORT

The Committee received the Quality Dashboard Report, which provided a summary assurance update on the progress and achievement of quality priorities and indicators across Trust Physical Health, Mental Health and Learning Disability services.

The Committee was informed that 869 staff had completed their Level 1 Patient Safety Training since its launch. A reduction in Healthcare Support Worker vacancy rates was seen for the period and the Committee was informed that the total reduction since September was 81.44 WTE.

The Committee was assured by the increased level of compliments received and it was recognised that it was the highest level in year.

The challenges were included within the report and it was highlighted that a number of service access targets remained behind target.

The Committee **received, noted** and **discussed** the November 2022 Quality Dashboard.

LEARNING FROM DEATH REPORT – QUARTER 2

The Committee received the Learning from Deaths Report for quarter 2, informing of the learning from the mortality review process, data analysis and outcomes during Quarter 2 2022/23 and also

learning from local Gloucestershire LeDeR reviews. The Medical Director reported there had been 112 patient deaths reported during quarter 2 of 2022/23. None of the deaths were judged to be more likely than not due to problems in the care provided to the patient.

The Committee was informed that of the inpatient deaths reported for the period; cancer was recorded as the most common cause of death in physical health patients. The Committee was informed of five suspected suicides which had occurred in the quarter 2 period. 15 Learning Disability inpatient deaths occurred for the period and the Committee was informed that the mean age at date of death was 58.6 years.

The Committee was informed that an 'end of life' dashboard would be included within the Quality Dashboard Report going forward.

ANNUAL REVIEW OF QUALITY COMMITTEE EFFECTIVENESS & TERMS OF REFERENCE

The Committee received the Annual Review of the Quality Committee Effectiveness and Terms of Reference. The Committee was informed of the positive feedback received from the Effectiveness Reviews, with the results showing that members of the Quality Committee were confident with the committee's role and how it was operating. The Committee noted the inclusion of the review of NED Champion Roles within the report, which the Quality Committee would have oversight of.

The Committee **noted** and **considered** the outcome of the committee evaluation; and **received** the Committee Terms of Reference, and **endorsed** the suggested amendments for onward presentation and sign off by the Trust Board.

OTHER ITEMS RECEIVED

The Committee:
Received and **noted** the Quality Assurance Group Summary Report
Received and **noted** the CQC Mental Health Survey Action Plan & Results

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **NOTE** the contents of the report.

DATE OF NEXT MEETING	Thursday, 2 March 2023