²GETHER NHS FOUNDATION TRUST

BOARD MEETING

WEDNESDAY 27 MARCH 2019 AT 9.30AM
BUSINESS CONTINUITY ROOM, RIKENEL

AGENDA

9.30	1	**Apologies**	
	2	**Declaration of Members Interests**	
9.35	3	**Minutes of the Board meeting held on 30 January 2019**	**PAPER A**
	4	**Action Points and Matters Arising**	
	5	**Questions from the Public**	
IMPROVING QUALITY			
9.40	6	**Patient Story Presentation**	**VERBAL**
10.10	7	**Service Experience Report**	**PAPER B**
10.20	8	**Quality Report (Quarter 3)**	**PAPER C**
10.30	9	**Safe Staffing 6 monthly Update**	**PAPER D**
10.35	10	**CQC Action Plan**	**PAPER E**
10.45	11	**Performance Dashboard Report – February 2019**	**PAPER F**
10.55	12	**Seclusion Update**	**VERBAL**
11.05	13	**Learning from Deaths Q3**	**PAPER G**
11.15	14	**Guardian of Safe Working Report**	**PAPER H**
11.25	15	**Staff Survey**	**PAPER I**
11.35	16	**Chief Executive's Report**	**PAPER J**
IMPROVING SUSTAINABILITY			
11.45	17	**Summary Financial Report**	**PAPER K**
11.50	18	**Changes to the Trust Constitution**	**PAPER L**
12.00	19	**Gender Pay Gap Annual Report**	**PAPER M**
12.10	20	**Board Committee Summaries** • Delivery Committee – 29 January and 27 February • Development Committee – 14 March • Governance Committee – 22 February	**PAPER N1** **PAPER N2** **PAPER N3**

INFORMATION SHARING (TO NOTE ONLY)			
12.20	21 22	**Chair's Activity Report** **Council of Governor Minutes – January 2019**	**PAPER O** **PAPER P**
	23	**Any Other Business** • Arrangements for Trust AGM • Provider Licence Declaration	
12.30	24	**Date of Next Meeting** Wednesday 6 June 2019 , Business Continuity Room, Rikenel	

PUBLIC QUESTIONS PROTOCOL

Written questions for the Board Meeting

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

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

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

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

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

Oral Questions without Notice

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

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

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

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

Exclusions

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

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

For further information, please contact the Trust Secretary/Assistant Trust Secretary on 0300 4217113. Public questions can be submitted for Trust Board meetings by emailing: lisa.evans23@nhs.net

[2]GETHER NHS FOUNDATION TRUST

BOARD MEETING
RIKENEL, GLOUCESTR
30 JANUARY 2019

PRESENT

Ingrid Barker, Joint Trust Chair
Maria Bond, Non-Executive Director
John Campbell, Director of Service Delivery
Marcia Gallagher, Non-Executive Director
Sumita Hutchison, Non-Executive Director
Andrew Lee, Director of Finance
Jane Melton, Director of Engagement and Integration
Colin Merker, Deputy Chief Executive
Paul Roberts, Joint Chief Executive
Neil Savage, Joint Director of Organisational Development
Duncan Sutherland, Non-Executive Director
Dominique Thompson, Non-Executive Director
John Trevains, Director of Quality
Dr Amjad Uppal, Medical Director
Jonathan Vickers, Non-Executive Director

IN ATTENDANCE

Anna Hilditch, Assistant Trust Secretary
John McIlveen, Trust Secretary
Bren McInerney, Member of the Public
Kate Nelmes, Head of Communications
Sue Russell, Member of the Public (Item 6)

1. WELCOMES, APOLOGIES AND INTRODUCTIONS

1.1 Apologies were received from Nikki Richardson.

1.2 Ingrid Barker welcomed Sumita Hutchison to her first Board meeting. Sumita had been appointed as a NED to the 2gether Board from 14 January 2019. Sumita is a lawyer by background and a social care commissioner. In addition, she is one of the founding members of the Mayoral Bristol Commission for Race Equality and a member of the Women's Commission (Bristol).

2. DECLARATIONS OF INTERESTS

2.1 Marcia Gallagher informed the Board that she had been appointed as Chair of Crossroads Care, Forest of Dean from 1 December 2018.

2.2 Jonathan Vickers declared a conflict of interest arising from discussion about Changes to the Trust Constitution paper, being received later in the meeting.

3. MINUTES OF THE PREVIOUS MEETING HELD ON 29 NOVEMBER 2018

3.1 The minutes of the meeting held on 29 November were agreed as a correct record, subject to the following amendment:

- 5.3 – The Director of Engagement and Integration noted that she had not personally attended the Herefordshire Community Games held on 26 September, as stated in the minutes; however, she had received direct feedback about the excitement and energy, and the real passion for this event from both service users and members of staff in attendance.

4. MATTERS ARISING AND ACTION POINTS

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

5. QUESTIONS FROM THE PUBLIC

5.1 The Board had received 3 questions in advance of the meeting under the Public Questions Protocol from Bren McInerney, Trust Governor/Member of the public. These had related to the Trust's plan for addressing health inequalities and the Trust's commitment to diversity and inclusion. The questions and the Trust's responses were read out in full for information. It was noted that the responses would also be emailed to the submitter following the meeting, and would be included in full in the minutes of this meeting as an appendix.

5.2 Bren McInerney thanked the Board for responding to his questions, advising that he had offered these questions by way of seeking constructive challenge. He said that he was not sure if the Trust had achieved the aims yet but there was certainly no doubt about the commitment and advocacy in this area. The Chief Executive said that there were some real opportunities in the merger transformation plans to address these areas further.

5.3 Duncan Sutherland noted that Bren McInerney had been asked to look into this specific area at a national level and he therefore suggested that it would be helpful for Bren to work with Trust colleagues to outline in more detail what he would expect to see.

6. PATIENT EXPERIENCE PRESENTATION

6.1 The Board welcomed Sue to the meeting who was in attendance to talk about her experiences of caring for her husband Nick, who had suffered for over 40 years with bi-polar disorder and alcohol dependency. Sue spoke about the difficulties of caring for Nick and the effect that this had had on her personally and on her own mental health.

6.2 Sue spoke about the complex area of "dual diagnosis", and the need for professionals to communicate properly to ensure that a solid joined up plan was in place for the service user. It was noted that there was the need for a cultural shift in this area, with referrals to mental health services sometimes rejected until the drug/alcohol issue had been addressed which was very unhelpful. A "whole person" approach was needed.

6.3 Sue told the Board about the difficulties that she had experienced with sharing information, noting that she had struggled to share useful information about her husband and his condition with staff at 2gether. This was not a breach of confidentiality and staff should have been willing to take this information on board.

6.4 Nick developed bowel cancer and a liver tumor in 2009 and was taken into acute services to receive chemotherapy. Nick recovered from this but reverted back to heavy drinking. In May 2018 Nick was once again hospitalised with alcoholic liver disease, where sadly he passed away in June.

6.5 Sue had been volunteering with 2gether and acting as an Expert by Experience for 13 years. In that time she had worked closely with John Chilton, 2gether's Consultant Nurse for Dual Diagnosis. Together they had developed a training package for staff and Sue attended to give this training 4 times a year. Sue had also led in the setting up of a Dual Diagnosis family support group, which was sponsored by the University of Gloucestershire. This had been put in place as a 6 month pilot but had now been extended.

6.6 Since Nick had passed away, Sue said that she was more determined to look after her own health and had started attending a bereavement support group at her local church. She said that 2gether had also been very supportive. Money had been donated at Nick's funeral which would go towards funding for more support for people with complex needs. Sue informed the Board that she valued her role as a volunteer with the Trust and wanted to assist in developing services any way she could.

6.7 Ingrid Barker thanked Sue for telling her story, and passed on condolences for her loss. She said that there was a lot to take on board from Sue's experiences but it seemed as though Sue had made some very positive steps in terms of moving forward. The Board would take some time to digest the story and then discuss this and any potential actions going forward at its meeting later in the day.

6.8 The Director of Engagement and Integration also expressed her thanks to Sue for attending the meeting and for all of the work that she carried out and her contribution to 2gether as a volunteer and expert by experience. The work that she had developed alongside John Chilton was very valuable.

7. PERFORMANCE DASHBOARD

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

7.2 The Board noted that of the 194 performance indicators, 69 were reportable in November with 64 being compliant and 5 non-compliant at the end of the reporting period. Where performance was not compliant, Service Directors were taking the lead to address issues.

7.3 The Director of Service Delivery was pleased to advise that this was the first month for a long time that 2gether had achieved all of its IAPT performance targets. This included targets for referral to treatment, access and recovery in both Gloucestershire and Herefordshire. The Board expressed its congratulations and thanks to all those involved, and to the NED members of the Delivery Committee who had robustly reviewed, scrutinised and challenged this performance on a monthly basis.

7.4 The Board noted that 3 of the non-compliant indicators at the end of November related to Eating Disorders. The Director of Service Delivery advised that a presentation had been received from the Eating Disorder service at the last Delivery Committee. A new model for ED services had been agreed with commissioners and it was planned that these targets would be achieved by year end. The Chief Executive said that he had recently carried out a visit to the ED Team, noting the enthusiasm for services, with all staff signed up to the services and service model being provided.

7.5 Duncan Sutherland asked about the current performance with Under 18 Admissions to adult acute wards. The Board noted that the number of Under 18 admissions made in Gloucestershire and Herefordshire this year had reduced and there was a much improved picture in this area. A report had been received at the last Delivery Committee which had analysed all Under 18 admissions, including length of stay and reasons for admission. Despite the improvement in performance so far this year, the Board was assured that a huge amount of work continued to be carried out both locally and nationally to address the continued shortage of inpatient provision for CYPS.

7.6 The Director of Engagement and Integration had attended the most recent Gloucestershire HCOSC Meeting, where a presentation of 2gether's performance was given. She said that councilors had discussed this and had asked for more mental health performance data to be included within their reports in future. This was a very positive development which would enable more open public scrutiny. Discussions were now taking place to agree exactly what data would be submitted and when.

7.7 The Board noted the dashboard report for Month 8 of 2018/19, and the assurance that this provided.

8. CHIEF EXECUTIVE'S REPORT

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

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

8.3 The Board noted that the "NHS Long Term Plan" had been published during early January and a summary of this was attached as an appendix to the report. The Board would be considering the implications of the plan in a development session in the near future.

8.4 2gether has identified Andrew Lee, Director of Finance, as its Executive Lead for preparedness for the EU Exit. He will be working with the Gloucestershire Business Continuity teams and NHSE to ensure appropriate preparations are in place across the county. The Trust has also put in place an operational working group to support this process.

8.5 Meetings of the Senior Leadership Network continue on a monthly basis. Approximately 100 managers attended these meetings, with a 50/50 split between 2gether and GCS. It was a great forum for networking and engagement, with presentations received at each meeting from NHS partner organisation Chief Executives. The Chief Executive said that NEDs would be very welcome to attend these meetings and it was agreed that future meeting dates would be circulated for information.

ACTION: Future meeting dates for SLN to be circulated to NEDs for information.

8.6 In relation to the proposed merger with GCS, the Board noted the positive feedback received from NHSi on the Strategic Case, with no red flags identified. Discussion about the timescales for the merger had taken place and feedback would be presented back to the Board later in the day.

8.7 The Trust had now announced both the NED and Executive appointments to the Shadow Board. This had followed a very robust recruitment process and the Chief Executive said that he was pleased with the high caliber of colleagues appointed.

8.8 The Chief Executive continued to be actively engaged with both the development work and the ongoing activity with the "One Gloucestershire" Integrated Care System (ICS). The Chief Executive had taken on a leadership role for Diagnostics and Quality Improvement.

The Board noted that Chris Creswick, former Gloucestershire ICS Chair had now stepped down and an interim Chair was being sought. The recruitment process to the substantive post was also underway.

8.9 The Deputy Chief Executive provided the Board with an update on the current work and discussions taking place with Herefordshire CCG about the future of Herefordshire services. Colin Merker had been appointed on a fixed term basis as the Managing Director for Herefordshire, whilst continuing in the role of Deputy Chief Executive for 2gether. A briefing to staff and Trust Governors had been sent out the previous day providing an update on future plans. This would also be shared more widely with Trust partners and stakeholders.

8.10 The Director of Engagement and Integration advised that an AHPP conference had taken place in December which had been very well attended and received. Thanks and congratulations were passed to those colleagues who had arranged for this conference to take place.

9. SUMMARY FINANCIAL REPORT

9.1 The Board received the summary Finance Report that provided information up to the end of December 2018. The month 9 position was a surplus of £650k which was in line with the planned surplus. The month 9 forecast outturn was an £834k surplus in line with the Trust's control total. In December the Trust had its Single Oversight Framework segment improved from 2 to 1. This means the Trust has moved to 'maximum autonomy' and is an indication that the Trust is now deemed to require the lowest level of oversight and support from NHS Improvement due to strong and sustained performance. The Trust has a Finance and Use of Resources metric of 2.

9.2 The agency cost forecast is £4.394m, a decrease of £0.020m on last month's projection and £1.260m above the Agency Control Total. This reduction is due to lower than anticipated IAPT agency spend in December.

9.3 National planning guidance for 2019/20 has been released and the Financial Control Total (FCT) for 2019/20 has been reduced to an £803k surplus. An initial assessment of the new FCT indicates it is achievable and that the Trust should accept the FCT proposed.

9.4 The Trust is progressing well with budget setting for next year and will be presenting a report to the Executive Committee in February. £1.0m of recurring savings have been identified up to December 2018. The Trust has a year-end cash projection of £14.8m which is £5.0m greater than the plan.

9.5 The Director of Finance advised that the Trust was on track with its CIP and mitigations were in place to manage any concerns that may arise before year-end.

10. CHANGES TO THE TRUST CONSTITUTION

10.1 The Board received this report which set out proposed changes to the Trust constitution. These changes fell into two main categories:

- those which put in place provisions connected with the merger of [2]gether and Gloucestershire Care Services NHS Trust (GCS); and
- those included as part of a general update of the document, or to provide additional clarity to existing provisions/process.

10.2 The Trust Secretary provided a summary of the main changes that were proposed, which included:

- Extension of the current Greater England public constituency to include Wales
- Provision for an additional 3 staff Governors, one in each of the three staff classes and initially reserved to GCS employees
- Expansion of the Medical and Nursing staff class to include dental professionals
- Provisions to ensure that within the expanded Medical, Dental and Nursing staff class, two Governor seats are reserved for nurses, one is reserved for a doctor, and the final one is reserved for either a doctor or a nurse. This provision will ensure that the number of Governors in this staff class remains representative of staff numbers in these professions
- Renaming of the former Health and Social Care and Support staff class to become the Health and Care Professions staff class. This new name is more commensurate with the professional role that these colleagues play in delivering care, and recognises changes in the regulatory bodies for professionals in this staff group
- Change of the Trust's corporate address to Edward Jenner Court
- Updating of provisions regarding the acceptance of benefits, in line with Trust policy
- Enabling an extension of non-Shadow Board Non-Executive Director (NED) terms of office beyond the current 6 year maximum, to provide resilience and capacity until the merger takes effect
- Reference to a revision of Standing Orders which enables voting in absence under certain circumstances. The relevant Standing Order has already been amended by the Council of Governors. The Board's agreement is required only in respect of this reference in the constitution.

10.3 The Board was asked to note that those changes relating to the composition of the Council of Governors, and to public constituencies and staff classes, would have no effect on any sitting Governor.

10.4 A request was made that the newly named "Health and Care Professions" staff class include clear reference to psychology staff, as well as AHPs.

ACTION: "Health and Care Professions" Governor staff class to include reference to psychology staff, as well as AHPs.

10.5 It was noted that any changes to the Trust constitution must be agreed both by the Board and the Council of Governors. The Council of Governors approved these changes at its meeting on 15th January 2019. Following a review of the main changes proposed, the Board also approved the revised Constitution, noting that the majority of changes would take effect immediately, with those related directly to the merger only being actioned once the transaction had taken effect.

11. BOARD COMMITTEE REPORTS – DELIVERY COMMITTEE

11.1 The Board received the summary report from the Delivery Committee meeting held on 28 November. This report and the assurances provided were noted.

11.2 A further Committee meeting had taken place the previous day on 29 January and a written summary from this meeting would be available for the next meeting. The Board was asked to note that the Trust had achieved all of its CQUIN targets at the end of quarter 3, which, what with everything else that was going on was excellent.

12. BOARD COMMITTEE REPORTS – DEVELOPMENT COMMITTEE

12.1 The Board received the summary report from the Development Committee meeting held on 12 December. This report and the assurances provided were noted.

12.2 The Committee received a review of the Capital Programme at month 7 of the financial year 2018/19. At month 7 capital expenditure was £1,080k; an under spend of £361k against the NHS Improvement Plan of £1,441k and an under spend of £234k against the Trust's Revised Budget Plan of £1,314k. Following an Executive review of the major capital schemes the M12 forecast capital expenditure was £3,828k with £1,771k of forecast spend being re-profiled to 2019/20. A challenge was raised around the timing of the Trusts capital spending; with much due to take place in the final quarter of the year. The finance team had had conversations with scheme leads and there was a good level of assurance that these items would take place.

13. BOARD COMMITTEE REPORTS – GOVERNANCE COMMITTEE

13.1 The Board received the summary report from the Governance Committee meeting that had taken place on 21 December. The Board noted the summary report and the assurances provided.

13.2 It was agreed that it would be helpful to have a Board overview on progress with implementing the CQC action plan. The Director of Quality advised that it was hoped that the action plan would be complete and fully closed down in the coming few weeks. It was noted that the Trust received regular visits from the CQC to Trust sites and services so there was good active engagement taking place with them on an ongoing basis and the CQC feedback was that 2gether was prompt and robust in responding to any queries raised by inspectors. It was agreed that a full report on the CQC inspection action plan would be presented to the Board in March for assurance.

ACTION: CQC inspection action plan to be presented to the Board in March for assurance.

14. BOARD COMMITTEE REPORTS – MH LEGISLATION SCRUTINY COMMITTEE

14.1 The Board received the summary report from the MH Legislation Scrutiny Committee meeting that had taken place on 14 November. The Board noted the summary report and the assurances provided.

14.2 The Committee had received an update on a change in the Code of Practice for Extra Care Areas and Seclusion. The Board noted that 2gether had a differing view on seclusion from the CQC and meetings with senior CQC managers were taking place to ensure that 2gether was meeting the necessary requirements. The issue that had been raised related to the recording of seclusion, not the physical use of seclusion and the Board was assured that 2gether was fully compliant with the MHA which was very important to note. A report on the use of seclusion was scheduled to come to the Trust Board for assurance in March.

15. INFORMATION SHARING REPORTS

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

- Chair's Report
- Council of Governors Minutes – November 2018
- Use of the Trust Seal (Quarter 3) – The seal was not used during Quarter 3

15.2 The Board noted the assurance regarding engagement activities by both the Trust Chair and NEDs, provided by the Chair's report. Ingrid Barker said that she had visited Wotton Lawn and Tewkesbury Hospital on Christmas morning, and she joined the rest of the Board in thanking all staff and colleagues for their continued support and commitment.

16. ANY OTHER BUSINESS

16.1 There was no other business.

17. DATE OF THE NEXT MEETING

17.1 The next Board meeting would take place on Wednesday 27 March 2019 at 10.00am at Rikenel, Montpellier, Gloucester, GL1 1LY

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

BOARD MEETING
ACTION POINTS

Date of Mtg	Item ref	Action	Lead	Date due	Status/Progress
30 Jan 2019	8.5	Future meeting dates for SLN to be circulated to NEDs for information.	Kate Nelmes	Jan 2019	
	10.4	"Health and Care Professions" Governor staff class to include reference to psychology staff, as well as AHPs.	John McIlveen	Jan 2019	
	13.2	CQC inspection action plan to be presented to the Board in March for assurance.	John Trevains	March 2019	Item added to agenda planner for March Board meeting

Appendix A

2gether NHS Foundation Trust Board 30th January 2019

Question from the public
What joined up plan does [2]gether NHS Foundation Trust have to address health inequalities within the Trust.

Trust Response
Addressing health inequalities through 'inclusion' is one of the fundamental values of [2]gether NHS Foundation Trust. In day to day practice, we challenge ourselves to consider health inequalities through every interaction and development. The Trust has had a firm commitment to the principles of social inclusion for many years and has led a significant number of innovative and joined-up pieces of work to support people who may present with a range of protected characteristics. The Trust has invested in a dedicated team for progressing Social Inclusion and the achievements have had local, national and international reach supporting our ability to influence change. In recent years we have developed our research portfolio to ensure that we contribute to further discovery to achieve the very best mental health care for all. These initiatives have enabled us to lead further development and realize better service experience for people who use our services, their families and resident communities.

The commitment to reduce health inequalities also features in our administrative processes. For example, authors of all Board and Committee papers are required to consider the implication of equalities in reference to the matter in hand. We undertake Equality Impact Assessments on new initiatives and Quality Impact Assessments as we strive for efficiency in our work. Our plans and developments for tackling health inequalities are coproduced at our Stakeholder Committee and in other Trust forums and are described and challenged in regular reports to the Board via the Trust's Development, Governance and Delivery Committees.

Our commitment to tackling inequality extends not only to people who use our services but also in our support for colleagues. Our "Managing Diversity Policy" describes the value that we place on tackling inequality for all. Our enabling strategies and Trust policies have the goal of equality as a golden thread running through them.

There is more to do to reduce health inequalities further. We will continue with our commitment with partners in our system in both Herefordshire and Gloucestershire to address health inequalities.

Question from the Public
What joined up plan does [2]gether NHS Foundation Trust have for addressing health inequalities with their partner organisations?

Trust Response
Our Board took the decision to merge with Gloucestershire Care Services with the explicit goal to achieve a positive impact on local health inequalities. We have established a

shared programme of work with Gloucestershire Care Services called the Better Care Together which aims to transform care for people of all ages, to reduce health inequalities.

We are also working collaboratively with other system partners (NHS, Local Authority, Primary Care and the Community and Voluntary sector) through the One Gloucestershire Integrated Care System (ICS) and the Herefordshire and Gloucestershire Strategic Transformation Partnership (STP). Addressing heath inequalities is of key importance in this work and forms part of the criteria for the development of delivery plans in a joined up manner.

We anticipate the further development of the local Health Inequalities Action Plan overseen by the Health and Wellbeing Boards in Gloucestershire and Herefordshire and are committed to take part in offering leadership in this process.

Question from the Public

Does [2]gether NHS Foundation Trust have a clear narrative of diversity and inclusion that is agreed by the Board and effectively communicated to staff, and which staff at every level can have confidence in?

Trust Response

Yes. The Trust has approached its commitment to and requirements for equality, diversity and inclusion through a variety of joined-up approaches. These include a focus on a general workforce Organisational Development action plan, developing our Workforce Race Equality Scheme (WRES), Equality and Diversity Training and Induction courses, a Disability Confident Leader work stream and the requirement for Equality Impact Assessments for policies and procedures. We have dedicated and varied communication mechanisms to support cascade and adoption of this best practice.

We produce an Annual Report on the Social Inclusion activities that are undertaken across the organisation and with community partners. Performance updates in relation to our engagement strategy and plans are reported to the Trust's Development Committee.

The Trust has been recognised locally and nationally for its work to progress inclusion and equality in a number of ways. For example, in 2017, the trust was selected for National Diversity and Inclusion Programme[1]. In 2018, members of the Trust were invited to present at a National conference of the NDTi. This was to provide exemplars of best practice about involving people who use services and 2gether's Experts by Experience programme and our Recovery College initiative were featured. Trust practitioners have also led nationally on the development of the Health Equalities Framework (HEF)[2] which is a tool to identify the factors that determine health inequalities of people with learning disabilities. In addition, the Trust has worked closely with Time to Change to pioneer the development of a nationally published workbook, which we have implemented in local clinical and

[1] **https://www.2gether.nhs.uk/trust-selected-national-diversity-inclusion-programme/**

[2] https://www.ndti.org.uk/uploads/files/The_Health_Equality_Framework.pdf

administrative teams, for tackling the stigma that people can feel when using NHS services[3].

We believe that the culture of inclusion enables our colleagues to use their expertise and talent to lead with confidence to make life better and reduce health inequalities.

In their independent scrutiny of [2]gether NHS Foundation Trust in 2018, the Care Quality Commission noted that '*Staff reported that the trust promoted equality and diversity in its day-to-day work and provided opportunities for career progression*'[4].

[3] https://www.time-to-change.org.uk/about-us/about-our-campaign/professionals

[4] https://www.cqc.org.uk/sites/default/files/20180327_2gether_nhsft_RTQ_evidence_appendices_INS2-4616493937.pdf

Agenda Item 7 **PAPER B**

Report to:	Trust Board – 27th March 2019
Author:	Angie Fletcher, Service Experience Clinical Manager Lauren Edwards, Deputy Director of Engagement and Integration
Presented by:	Jane Melton, Director of Engagement and Integration
Subject:	**Service Experience Report Quarter 3 2018/19**

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

EXECUTIVE SUMMARY

(1) Assurance
This Service Experience Report provides a high level overview of feedback received from service users and carers in Quarter 3 2018/19.

Learning from people's experiences is the key purpose of this paper, which provides assurance that service experience information has been reviewed, scrutinised for themes, and considered for both service-specific and general learning across the organisation. The report offers:

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

Significant assurance from the results of the local Friends and Family Test that service users value the service being offered and would recommend it to others.
During Quarter 3, 80% of people who completed the Friends and Family Test said that they would recommend 2gether's services. Response rates have continued to increase this quarter meaning that more feedback was received. This may have an impact on the overall FFT score.

Limited assurance that people are participating in the local survey of quality in sufficient numbers.
Our **How did we do?** survey was launched during Quarter 1 2017/18. Whilst feedback given by respondents has generally been positive, response rates remain lower than hoped for. Encouragingly, Quarter 3 2018/19 has seen an increase in the

numbers of responses received. Our SED are continuing to embed a new system to receive, collate and analyse feedback to encourage more responses to our surveys. It is anticipated that this system will be in place by the end of Quarter 4 2018/19.

Significant assurance that services are consistently reporting details of compliments they have received.
Compliments continue to be reported to the Service Experience Department. Numbers have significantly increased during Quarter 3 and work continues to increase reporting by colleagues throughout the Trust.

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

Significant assurance that all people who complain have their complaint dealt with by the initially agreed timescale.
81% of complaints were closed within timescales agreed with the complainant. This is lower than the previous quarter (92%). The SED are working hard with Trust colleagues to ensure that future complaints are investigated and responded to in a timely way.

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

Significant assurance from independent auditors regarding the quality of our processes **to learn from service experience** feedback (overall rating: Low Risk).

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

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

- We must listen to carers and relatives even though we may not be able to share information with them.
- We must ask people how they want us to contact them

RECOMMENDATIONS

The trust Board is asked to:

- Note the contents of this report

Corporate Considerations	
Quality Implications	Patient and carer experience is a key component of the delivery of best quality of care. The report outlines what is known about experience of ^{2}gether's services in Q3 2018/19 and makes key recommendations for actions to enhance quality.
Resource Implications	The Service Experience Report offers assurance to the Trust that resources are being used to support best service experience.
Equalities Implications	The Service Experience Report offers assurance that the Trust is attending to its responsibilities regarding equalities for service users and carers.
Risk Implications	Feedback on service experience offers an insight into how services are received. The information provides a mechanism for identifying performance, reputational and clinical risks. This paper offers limited assurance on one aspect covered by the report and the SED are working with operational and clinical colleagues in order to identify and mitigate any risks associated with this. The SED closely monitor performance indicators relating to areas of limited assurance and regularly review the mitigating actions accordingly.

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

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

Reviewed by:		
Jane Melton Director of Engagement and Integration	Date	14th February 2019

Where in the Trust has this been discussed before?		
Quality and Clinical Risk Sub-committee	Date	15th February 2019
Trust Governance Committee		22nd February 2019

What consultation has there been?		

Explanation of acronyms used:	
NHS	National Health Service
PALS	Patient Advice and Liaison Service
CYPS	Children and Young People Service
SED	Service Experience Department
HR	Human Resources

CEO	Chief Executive Officer
BME	Black and Minority Ethnic Groups
IAPT	Improving access to psychological therapies
PHSO	Parliamentary and Health Service Ombudsman
CQC	Care Quality Commission
CHI ESQ	Children's Experience of Service Questionnaire
CAMHS	Child and Adolescent Mental Health Service
MHA	Mental Health Act
MCA	Mental Capacity Act
CCG	Clinical Commissioning Group
Q2	Quarter 1 (previous quarter (2018/19)
FFT	Friends and Family Test (survey)

2gether
Making life better

2gether
NHS Foundation Trust

Service Experience Report

Quarter 3

1st October 2018 to 31st December 2018

"Excellent service from nurse on first visit and excellent service and care from consultant on second visit."

Memory Assessment Service, Gloucestershire

"They put my mind at ease in a caring manner after testing me for dementia."

Memory Assessment Service, Herefordshire

Contents

Key

NHS	National Health Service
PALS	Patient Advice and Liaison Service
CYPS	Children and Young People Service
SED	Service Experience Department
HR	Human Resources
CEO	Chief Executive Officer
IAPT	Improving Access to Psychological Therapies
PHSO	Parliamentary and Health Service Ombudsman
CQC	Care Quality Commission
CHI ESQ	Children's Experience of Service Questionnaire
CAMHS	Child and Adolescent Mental Health Service
Mental Health Act	Mental Health Act
LGO	Local Government Ombudsman
Q2	Quarter 2 (previous quarter 2018/19)
FFT	Friends and Family Test (survey)

Service Experience Report

1st October 2018 to 31st December 2018

Complaints 	**22** complaints were made this quarter. This is a more than last time (Q2=14). We want people to tell us about any worries about their care. This way we can help to make things better.	↑
Concerns 	**79** concerns were raised through PALS. This is less than last time (Q2=89).	↓
Compliments 	**767** people told us they were pleased with our service. This is a lot more than last time (Q2=479). We want teams to tell us about every compliment they get.	↑
FFT 	**80%** of people said they would recommend our service to their family or friends. This is about the same as last time (Q2=79%).	↔
Quality Survey 	Gloucestershire: **153** people told us what they thought. This is a lot more than last time (Q2=54) Herefordshire: **29** people told us what they thought. This is more than last time (Q2=18) We want more people to tell us what they think.	↑ (number of replies)
We must listen 	We must listen to carers and relatives even though we may not be able to share information with them. We must ask people how they want us to contact them.	

Key

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

Section 1 – Introduction

1.1 Overview of the paper

1.1.1 This paper provides an overview of people's reported experience of [2]gether NHS Foundation Trust's services between **1st October 2018 and 31st December 2018**. It provides examples of the learning that has been achieved through service experience reporting, and an update on activity to enhance service experience.

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

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

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

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

1.2 Strategic Context

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

1.2.2 [2]gether NHS Trust's Service User Charter, Carer Charter and Staff Charter outline the commitment to delivering our values and this is supported by our vision for best Service Experience:

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

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

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

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

Section 2 – Emerging Themes about Service Experience

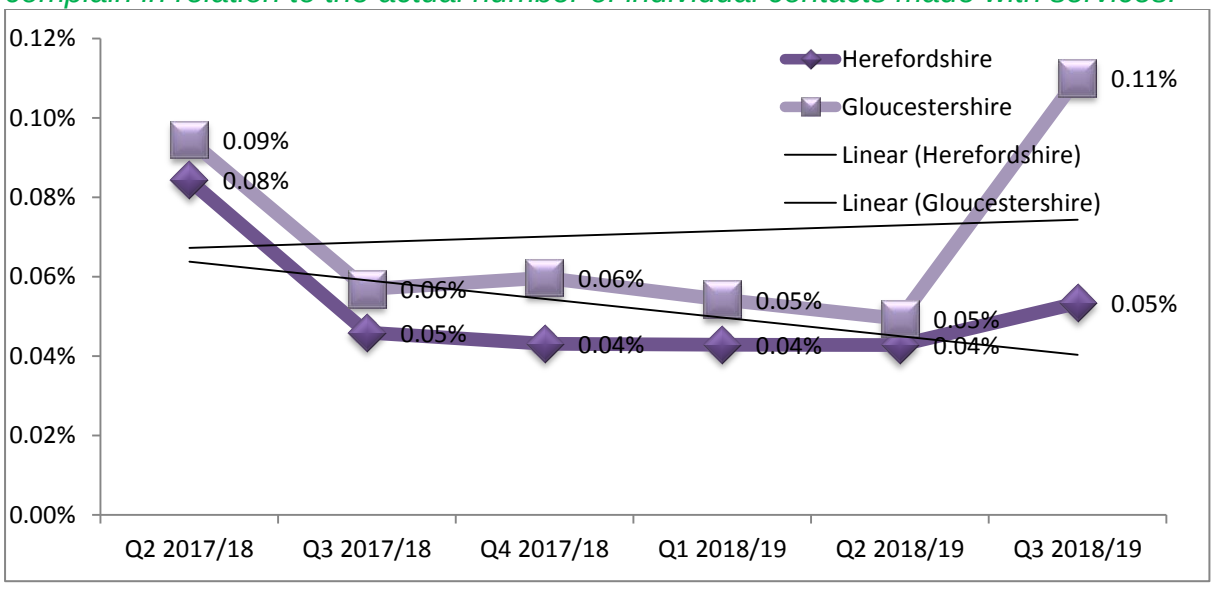
2.1 Complaints

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

Table 1: Number of complaints received this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	19	↑	The number of complaints reported in Gloucestershire has increased from the previous quarter (Q2=12)	Significant
Herefordshire	2	↔	The number of complaints reported in Herefordshire is consistent with the previous quarter (Q2=2)	Significant
Corporate	1	↑	The number of complaints relating to our corporate services has increased from the previous quarter (Q2=0)	Significant
Total	22	↑	The total number of complaints received has increased from the previous quarter (Q2=14)	Significant

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



2.1.2 Figure 1 shows the percentage of complaints received in relation to the number of individual contacts made with our services during each quarterly period since Q1 2017/18. Whilst there have been minor fluctuations quarter by quarter, a continual low level of complaints to contacts has been observed over time. Complaints in Gloucestershire in the first two quarters of this year have been maintained at an usually low level, Quarter 3 recorded a rise, however, the current total number of complaints received during the first three quarters of this year remains in line with previous yearly totals.

2.1.3 Table 2 summarises our responsiveness. This quarter has seen an improvement in the percentage of complaint responses received by complainants within the agreed timescale.

Table 2: Responsiveness

Target	% Number	Direction compared with Q2	Interpretation	Assurance
Acknowledged with three days	100%		**All** complaints were acknowledged within target timeframes (Q2=100%)	**Full**
Response received within agreed timescales	81%		This is lower than last quarter (Q2=92%). Three letters of response were not received by the complainant within the timescale agreed.	**Significant**
Concerns escalated to complaint	4%		Of 77 concerns closed (Q2=86 closed), 3 were escalated to a formal complaint; this is slightly more than last quarter (Q2=2%)	**Significant**

2.1.4 Three complaint responses were not received within initially agreed timescales. Two were overdue as relevant people were not available to contribute to the investigation process – in one case this was the complainant, and in the other case the investigation was delayed due to the absence of a key member of staff. The third response was overdue because of a delay within our quality review processes. On each occasion the complainant was contacted in order to provide an explanation, an apology, and an expected date that our response would be sent to them.

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

Table 3: Satisfaction with complaint process

Measure	Number (numerical direction)		Interpretation	Assurance
Reopened complaints	1		This figure is less than the previous quarter (Q2=3)	**Significant**
Local Resolution Meetings	0		This figure is less than the previous quarter (Q2=1)	**Full**
Referrals to external review bodies	2		Two complaints were referred for external review (Q2=0). See Table 13 for more detail.	**Full**

2.1.6 In Quarter 3, a recently closed complaint was reopened and is currently under re-investigation by our Trust. Two complainants contacted PHSO for review of their concerns during Quarter 3; this is reported in more detail in section 2.4 of this report.

2.1.7 Analysis of data is undertaken by the SED in order to identify any patterns or themes. Analysis of complaint themes from complaints closed during Quarter 3 is shown by the status of complaint outcome (Table 4) and by staff group involved in individual issues of complaint (Table 5).

Table 4: Outcome of complaints closed this quarter

Outcome	No.	%	
Not upheld *No element of the complaint was upheld*	7	47%	Following feedback from complainants and stakeholders, the Trust no longer uses the terms upheld/partially upheld/not upheld within our response letters. However, these categories are required to be recorded for national reporting purposes.
Partially upheld *Some elements of the whole complaint were upheld*	8	53%	In total, 15 complaints were closed this quarter. This is less than the number of complaints closed in Quarter 2 (n=24).
Upheld *All elements of the whole complaint were upheld*	0	0%	53% of the complaints closed this quarter had at least some or all issues of complaint upheld. This is similar to Quarter 2 (54% upheld/partially upheld).

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

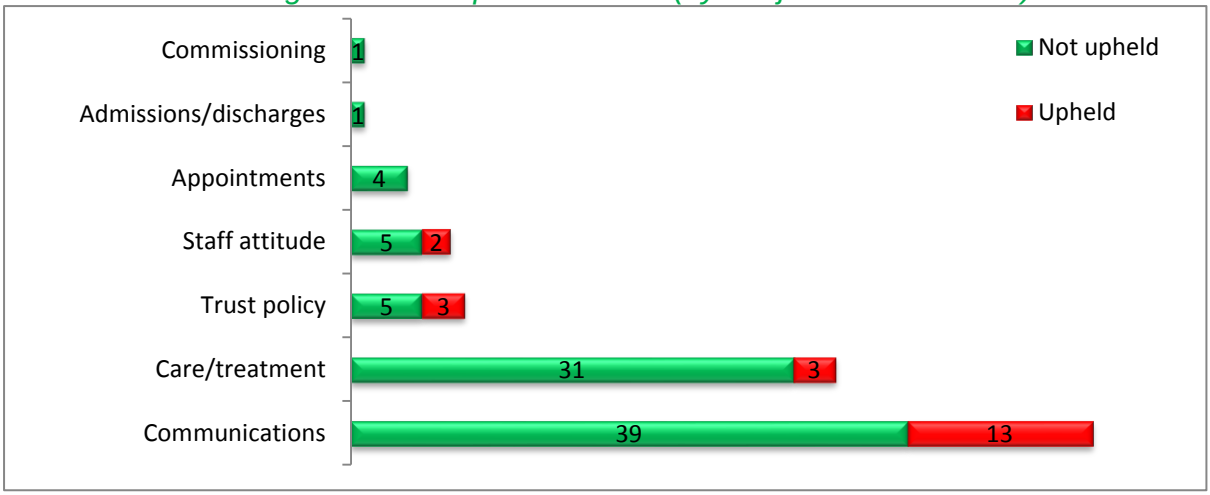
Table 5: Breakdown of closed complaint issues by staff group for Quarter 3

	Not upheld	Upheld	Total
Admin	18	2	20
Medical	18	1	19
Nursing	39	15	54
Healthcare Assistant (HCA)	2	0	2
Psychologist	8	3	11
No staff involved	1	0	1
Total	86	21	107

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

2.1.8 Table 6 provides an overview of the issues of complaint in the context of the investigation outcome (upheld or not upheld). Analysis of this information shows that the main theme emerging from the Q3 issues of complaint that were upheld following investigation, related to aspects of the reported experience of **communication**.

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

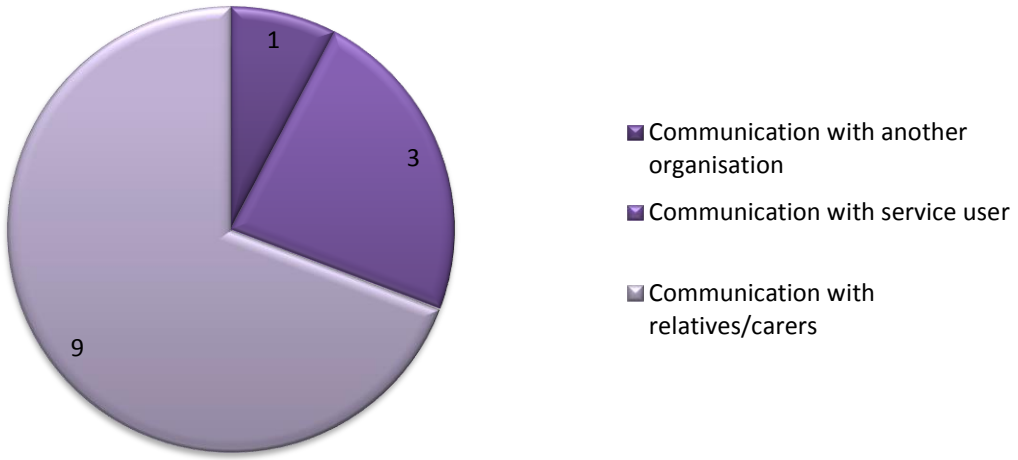


2.1.9 Further analysis of upheld issues relating to **communication** is shown in Figure 2.

Figure 2: Review of identified complaint themes

Breakdown of upheld complaint issues

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



2.1.10 Communication is a recurrent theme found following the investigation of complaints raised with our Trust and is also found to dominate thematic data nationally. Further analysis of this theme shows that the areas that were upheld for a variety of different reasons such as responsiveness, insensitive discussions and inaccuracy of information. No common themes within this element of upheld complaint issues were found during this quarter's review.

The SED have continued to work with operational colleagues throughout Quarter 3 to implement new systems of learning from service experience feedback. Practice notes detailing learning from complaints are now produced monthly and disseminated throughout our locality governance boards for onward review and discussion by our teams and services. The learning from

issues represented in Figure 2 has been included in this quarter's practice notes and is detailed further in section 3 of this report.

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

Table 8: Examples of complaints closed and action taken

Example	You said	We did	Assurance
Access to services	My son was assessed today, but will not get any treatment for four months	We apologised and explained that your son's presentation did not meet the threshold for a more urgent appointment at that time. We also signposted you to other areas of support available to you and your family.	Significant
Care and treatment	I do not feel supported by my Care Co-ordinator: my request for my support worker to manage my care plan was refused	We explained why your care plan should be managed by a Care Co-ordinator and explained the role of Care Co-ordinators versus that of Support Workers.	Significant
Clinical assessment	The report following my assessment was inadequate and lacked necessary detail. I also felt the assessment process was aimed at children rather than adults	We offered an apology and clarified the assessment and report process. We also explained that we use a standard assessment process, and gave you information about this.	Significant

2.2 Concerns

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

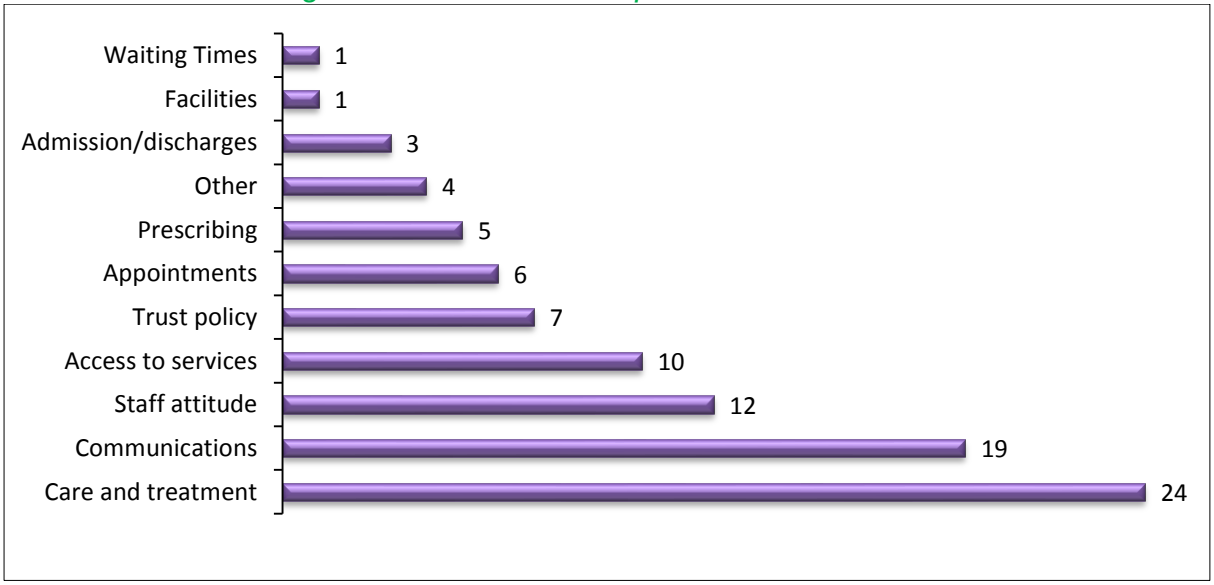
Table 9: Number of concerns received this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	60	⇔	The number of concerns raised in Gloucestershire is similar to the last quarter (Q2=63)	Significant
Herefordshire	14	⇔	The number of concerns raised in Herefordshire is similar to the last quarter (Q2=16)	Significant
Corporate	5	↓	There are fewer concerns relating to corporate services compared to last quarter (Q2=10)	Significant
Total	79	↓	The number of concerns raised is lower than last quarter (Q2=89)	Significant

2.2.2 The number of concerns raised remains relatively consistent with previous quarters but has reduced slightly by comparison to last quarter.

There were also 60 other contacts with our Service Experience Department during Quarter 3 (Q2=103) covering a range of topics. This continues to offer assurance us that people are continuing to access the SED as a resource to respond to queries relating to our Trust, whilst the number of complaints and concerns received remain low compared to the number of clinical contacts.

Table 10: Overarching concern themes this quarter



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

2.2.3 Table 10 outlines the themes from concerns that have been closed this quarter. The main theme identified is ***Care and Treatment***, which is also a recurrent theme within analysis of issues of our formal complaints.

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

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

Outcome	No	
Nursing	33	As outlined in Table 5, nursing represents the largest staff group in the Trust and has the greatest number of contacts with service users and carers. Work is ongoing to ensure that professional leads are made aware of any themes relating to their staffing group.
Medical	21	
None	12	
Other	5	
PWP	5	
HCA	4	
Social Worker	3	
OT	2	
Hotel Services	1	
Pharmacist	1	
Porter	1	
Psychologist	1	
Receptionist	1	
SaLT	1	

2.2.5 Examples of concerns and actions taken during Quarter 3 are shown overleaf in Table12.

Table 12 Examples of concerns and action taken:

Example	You said	We did	Assurance
Care and treatment	My current care package does not meet my needs	We liaised with your care team and asked them to clarify your care package with you, including giving you your care plan in an easy read format	**Significant**
Support	I am an inpatient and the unit I am at is not making reasonable adjustments for my Autism Spectrum Condition	We met with you to discuss what reasonable adjustments you felt you needed, and then liaised with the Matron to make them aware of your concerns	**Significant**
Food	I am an inpatient on a restricted diet. I find the food to be tasteless and boring	We contacted the catering manager at our hospital who met with you to discuss your requirements / preferences and developed a new menu with you	**Significant**

2.2.5 PALS Visits

2.2.5.1 Patient Advice and Liaison Service (PALS) visits are undertaken in our clinical services to ensure that people's concerns are heard and resolved as soon as possible. Visits to Wotton Lawn Hospital and Charlton Lane Hospital in Gloucestershire, and Stonebow Unit in Herefordshire, were undertaken during Quarter 3. PALS also visited Pullman Place and are planning visits to other community hubs in the near future.

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

2.2.5.3 PALS provided the following types of support and assistance during visits undertaken in Quarter 3:

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

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

- Feedback about food served on the wards – both positive and negative reports given

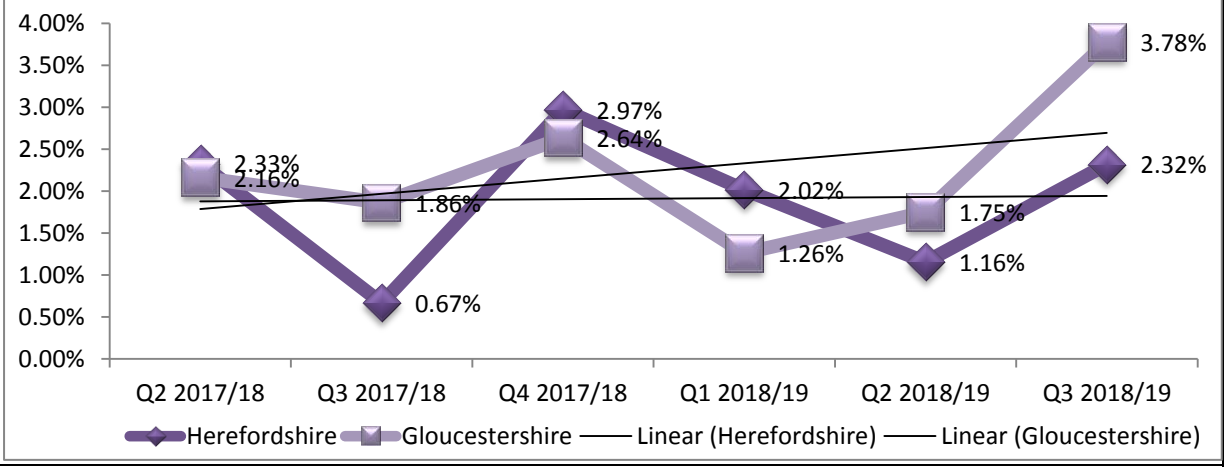
- Mixed views about the ward environment – comments ranged from wards being very clean, and whilst some found the wards a bit boring, others enjoyed it.
- Differing feelings regarding detention under the Mental Health Act – some felt it beneficial, others did not agree with it
- Feedback about the ward staff – this has been mainly positive in nature with descriptions such as “brilliant” and “supportive”. Other comments have related to staff not always being available as they’re busy

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

2.3 Compliments

2.3.1 The SED continues to encourage the reporting of compliments received by Trust services. **767** compliments were received this quarter. This is an increase when compared to Quarter 2 (n=479). A dedicated email address is set up to simplify the process for colleagues to report compliments that they have received: 2gnft.compliments@nhs.net. Figure 3 shows the percentage of compliments to contacts as reported during Quarter 3.

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



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

Examples of compliments received during Quarter 3:

Thank you so much for your email, you’ve been really helpful and sympathetic.
SED, Corporate

To all of the caring staff who were here for me, who answered my many questions, for your night shifts, for your early mornings, and all the hours in between, for your upbeat humour, your smiling faces, with much gratitude and hope you also receive the kindness you give return to you tenfold.
Dean Ward, Wotton Lawn

You will always be very special to me because I learned to trust you, talk to you, be honest with you and you've helped me discover myself.

Eating Disorders Team, Gloucestershire

The environment is clean, welcoming and friendly. We were impressed with the attention to detail regarding signage and everything that was there for the patients benefit. I would be happy for any member of my family or friends to be in Charlton Lane. So much good work is being done; unless you visit you have no idea. Every member of staff is committed to doing the very best for all of the patients.

Willow Ward, Charlton Lane Hospital

2.4 Complaints referred for external review following investigation by our Trust

2.4.1 Current open referrals for external review:

Table 13: current open referrals for external review

Reviewing organisation	Date of first contact from reviewing organisation	Date official investigation confirmed	Current status of referral
PHSO (86)	25/01/2017	07/08/2017	Investigation ongoing – draft findings released.
LGO (172)	23/01/2018	03/04/2018	Investigation ongoing
PHSO (1655)	06/06/2017	30/04/2018	Investigation concluded on 28/11/2018 with no actions or recommendations for our Trust.
PHSO (1243)	04/09/2018	29/10/2018	Investigation ongoing
PHSO (415)	18/10/2018	Status unconfirmed	Awaiting further update from PHSO
PHSO (1061)	27/11/2018	Status unconfirmed	Awaiting further update from PHSO

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

2.4.2 Referrals made for external review of complaint this quarter

There were two referrals made to the PHSO during this quarter by complainants requesting an external review of complaints that had previously been investigated by and responded to by our Trust. The PHSO have not confirmed the status of these referrals as yet.

2.4.3 Completed external complaint investigations

PHSO:
The PHSO concluded one investigation (1655) this quarter and informed us that their investigation found no failings by our Trust.

The PHSO have released draft findings to us regarding their investigation of a complaint (86) previously investigated by our Trust. At this stage their findings do not

indicate any recommendations or actions for our Trust. A final report is due in Quarter 4 for wider circulation.

2.5 Internal Audit report 2018/19 - *Learning from Service Experience Feedback*

2.5.1 Audit overview

During Quarter 3 an internal audit focusing on ***Learning from Service Experience Feedback*** was undertaken, as part of our internal audit plan for 2018/19.

The audit specifically focussed on the quality and effectiveness of learning from complaints, concerns, and compliments within our Trust and reviewed our governance structure and policies in place, complaint investigation and learning processes, and whether learning is being effectively disseminated across the Trust.

As part of the audit interviews were conducted with Trust managers, 10 complaint investigations were reviewed, and an online survey was circulated to staff across localities within the Trust to capture their views of the complaints and compliments process and the dissemination of relevant learning.

2.5.2 Audit Findings

Findings from the ***Learning from Service Experience Feedback audit*** were shared with us in November 2018 and submitted to our Audit Committee for review and assurance of Trust processes.

The audit found that whilst our current systems allow for the timely investigation of complaints and capturing of learning points, the dissemination to all operational staff would benefit from improvement.

The audit findings noted 1 medium and 1 low recommendation outlined below:

1. *Learning from complaints and compliments are not effectively disseminated in the localities (Medium)*
2. *Time allocation for conducting investigations (Low)*

2.5.3 Looking forward, next steps

Following review of the audit findings a working group has been set up with representatives from our locality governance leads and our Service Experience department.

The group first met in December 2018 review the findings alongside our current systems to inform a Trust wide improvement action plan focusing on the areas identified.

The development and implementation of this action plan remains ongoing throughout Quarter 4.

2.6 Surveys

2.6.1 'How did we do?' Survey

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

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

2.6.1.3 For the past 3 years we have utilised an external provider to input and manage our survey feedback. Following a review of our processes and a desire to seek more feedback, a new system to manage Trust feedback has been commissioned to commence in Quarter 4 2018/19. This will bring us in line with processes used by Gloucestershire Care Services NHS Trust. Previous arrangements continued until the end of December 2018.

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

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

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

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

Table 14: Returns and responses to Friends and Family Test in Q3

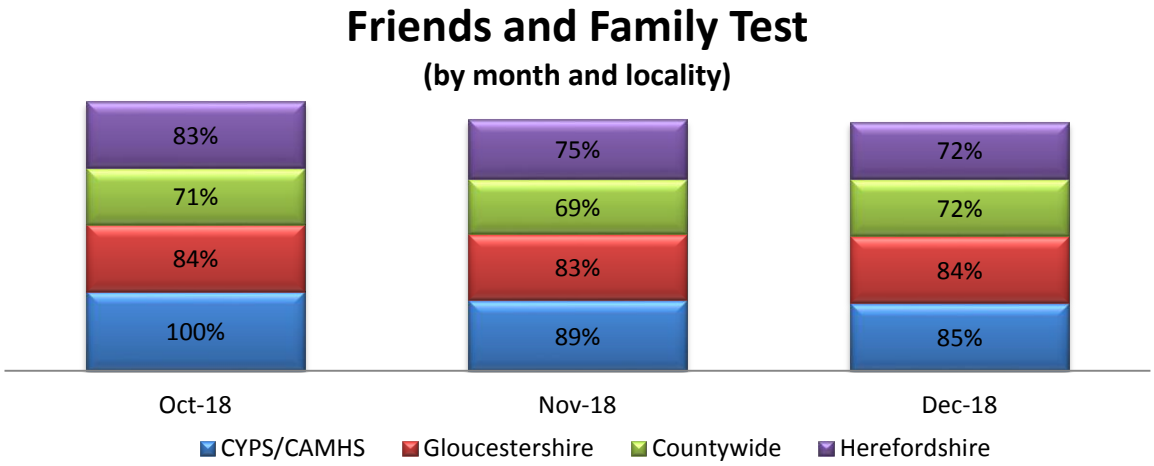
	Number of responses	FFT Score (%)
October 2018	395 (324 positive)	82%
November 2018	374 (296 positive)	79%
December 2018	277 (219 positive)	79%
Total	**1046** (839 positive) **(last quarter = 1020)**	**80%** **(last quarter = 79%)**

2.6.2.3 As reported during 2017/18 some difficulties have continued when sending text messages to people due to the recording of telephone numbers on RiO. Work continues to raise colleagues' awareness of how to record mobile telephone numbers within RiO. The response rate to the text messages that

were sent successfully during Quarter 3 has been encouraging, with a response rate of 22% (Q2=29%).

2.6.2.4 Quarter 3 FFT response rates have slightly increased. However response rates continue to be lower than we would like to allow robust statistical analysis of emerging themes or trends.

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



2.6.2.5 The FFT score for our Trust has increased slightly this quarter; this is encouraging news following disappointing decreases seen in previous quarters of this year.

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

Further analysis has shown that we continue to receive a relatively low number of responses to the FFT survey. The responses are widely spread from across our services, meaning that statistical significance is impacted, for example a service that receives only one response in total that does not recommend the service has a score of 0% recommendation. This in turn impacts our Trust's overarching FFT score.

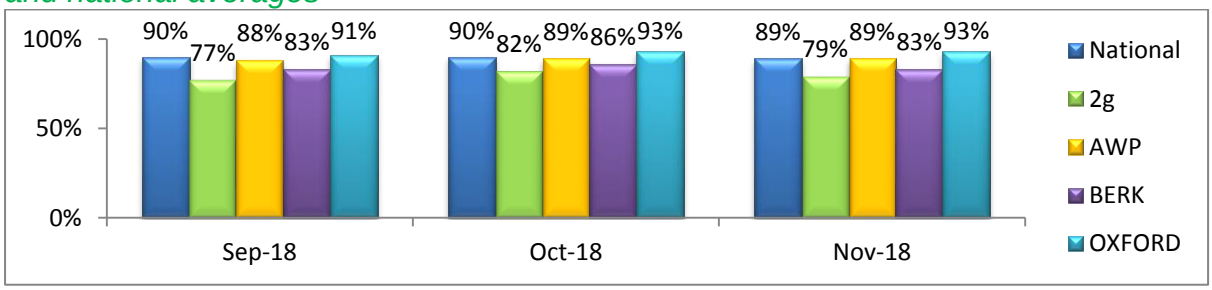
Since our introduction of seeking FFT feedback by text messaging we have had more feedback from our inpatient and liaison services across the Trust. The scores received for these areas do contribute to a low level of recommendation of Trust services. Comments when given alongside these ratings have been analysed for any emerging themes and indicate that often people do not feel that they needed intervention by these services and therefore would not recommend them.

Our Let's Talk services in both Gloucestershire and Herefordshire receive a high proportion of responses that contribute to our FFT scores, whilst the majority of feedback from these services is positive, those who would not recommend it comment that it is due to the waiting time for an appointment. This information is fed back to our locality managers who have been working to improve waiting times in this area.

It is anticipated that the implementation of our new system to seek FFT feedback from Quarter 4 onwards will enable us to gradually increase our response rates to allow statistical significance when analysing scores and responses.

2.6.2.6 Figure 5 shows the FFT Scores for September, October, and November 2018, (the most recent data available) compared to other Mental Health Trusts in our region, and the average of Mental Health Trusts in England. Our Trust consistently receives a high percentage of recommendation although we have achieved lower scores than other Trust's in our region in recent quarters. This is a reversal from previous years and does not triangulate with our positive National Survey scores (*December 2018 data are not yet available*)

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



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

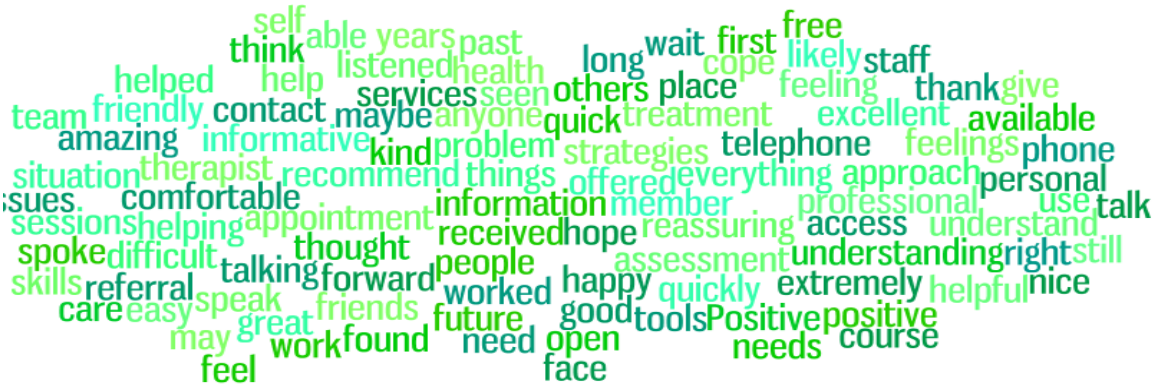
Friends and Family Test Comments

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

Figure 6: Comments taken from FFT responses during Quarter 3

Negative comments:

Positive Comments:

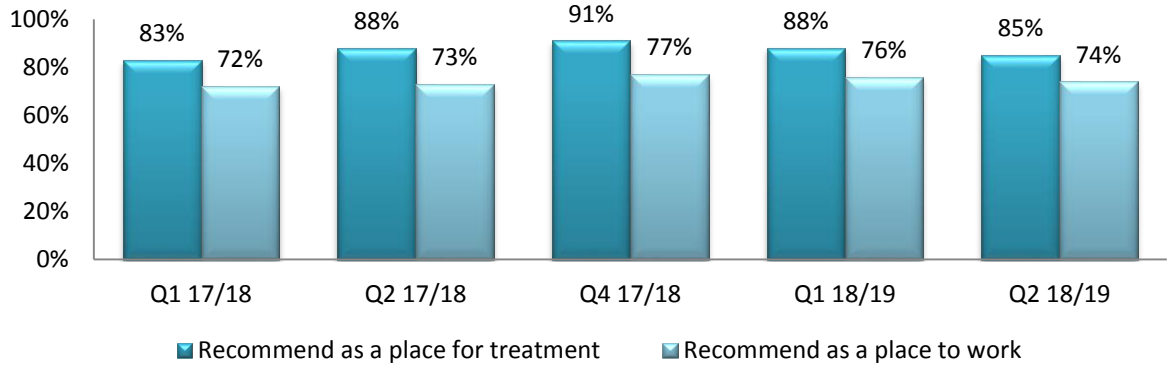


2.6.3 [2]gether Staff Friends and Family Test (FFT) feedback

Our staff are asked about their experience of working for our Trust during quarters 1, 2 and 4 each year. In Quarter 3 of each year the FFT is replaced by the annual Staff Survey.

Figure 6 shows the latest staff FFT scores along with previous quarters.

Figure 6: Staff Friends and Family Test Scores



2.5.3.1 For the past two quarters the results of the Staff FFT continue to align closely with the observed trend seen from service user feedback. Comparison of the two FFT scores suggests that over the past year, our staff are slightly more likely to recommend Trust services than service users.

2.6.4 How did we do?

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

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

Question	County	No. of responses	Target Met?
Were you involved as much as you	Gloucestershire	135 (106 positive)	**80%**

wanted to be in agreeing the care you receive?	Herefordshire	29 (25 positive)	TARGET 84%
Have you been given information about who to contact outside of office hours if you have a crisis?	Gloucestershire	138 (113 positive)	84% TARGET 71%
	Herefordshire	26 (24 positive)	
Have you had help and advice about taking part in activities that are important to you?	Gloucestershire	127 (101 positive)	82% TARGET 64%
	Herefordshire	26 (24 positive)	
Have you had help and advice to find support for physical health needs if you have needed it?	Gloucestershire	127 (105 positive)	84% TARGET 73%
	Herefordshire	27 (25 positive)	

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

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

2.6.4.4 Although response rates for the survey have increased over time the level of response continues to be lower than we would like. The introduction of new systems in Quarter 4 2018/19 to capture survey feedback aims to increase the number of responses we receive to both aspects of the How did we do? survey.

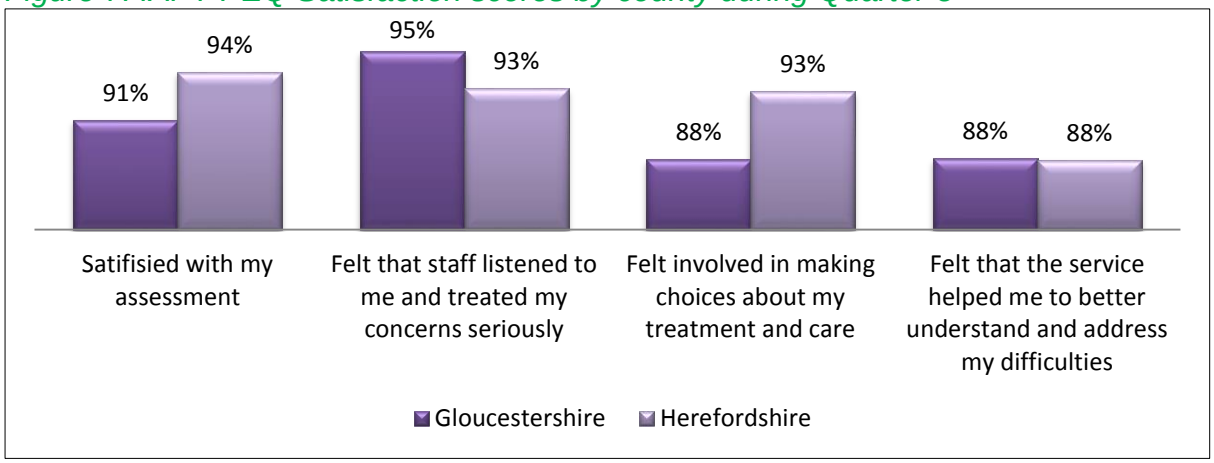
2.6.5 Improving Access to Psychological Therapies – Patient Experience Questionnaire (IAPT PEQ)

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

2.6.5.2 Feedback questionnaires are sent to people following the initial assessment and after discharge from the service. Quarter 3 feedback (figure 7) shows that people are largely satisfied with these elements of the Let's Talk service.

2.6.5.3 This information is shared with colleagues from IAPT Let's Talk so that it can be used by them to deliver service improvements. The free text comments from surveys received during Quarter 3 have been reviewed and analysed by SED to look for possible contributory factors to those scores that are less than 90%. The majority of comments received are extremely positive about our Let's Talk services, the remainder of comments continue to reflect findings from Quarter 2 and relate to length of waiting time to access the service or length of time between initial assessment and commencement of therapy sessions.

Figure 7: IAPT PEQ Satisfaction scores by county during Quarter 3



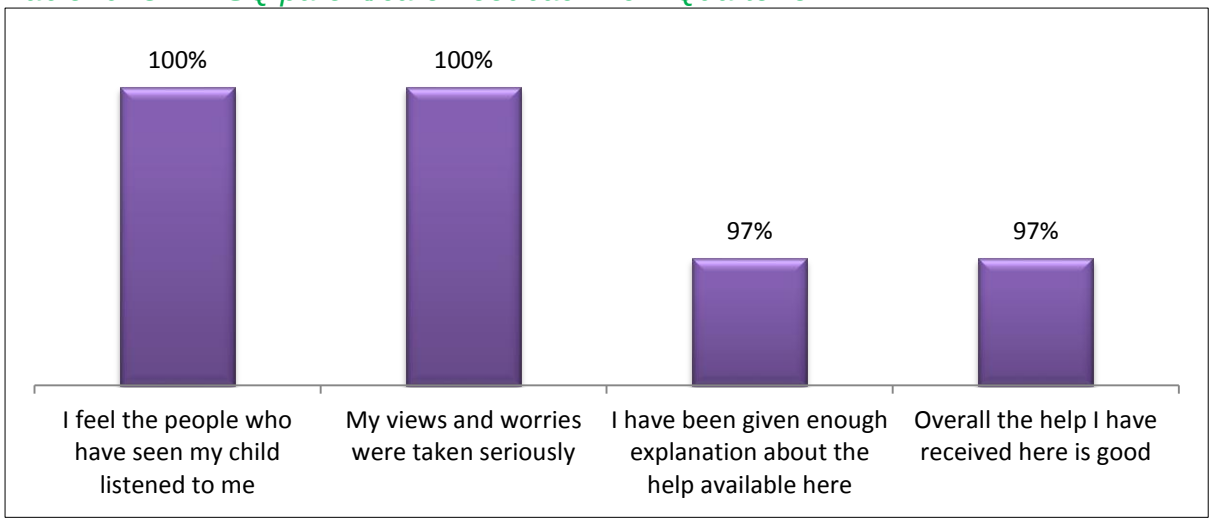
2.6.5.4 The IAPT PEQ seeks comments from people about the service that they have received. A selection of comments for Q3 responses are shared below:

2.6.6 Children and Young People service (CYPS)

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

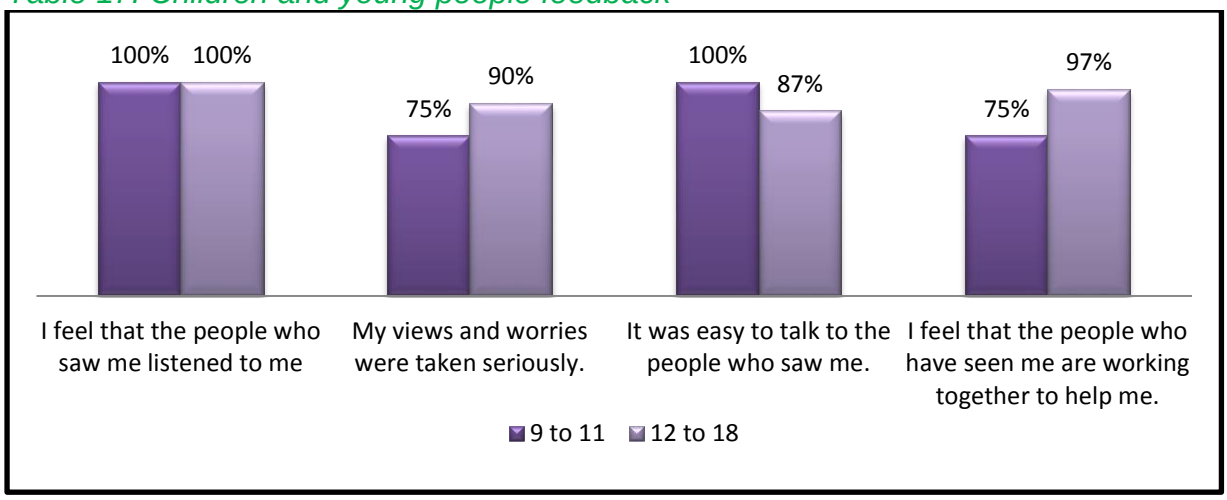
2.6.6.2 Tables 16 and 17 reflect responses to questions asked to the differing groups of respondents during Quarter 3.

Table16: CHI-ESQ parent/carer feedback from Quarter 3



Examples of some feedback given by carers/parents:

Table 17: Children and young people feedback



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

Examples of some feedback given by children and young people:

2.6.7 Crisis Team Feedback Survey led by Service Users - Gloucestershire

During Quarters 2 and 3 of 2018/19, 18 surveys were returned giving feedback on the service that our Gloucestershire Crisis Teams provide.
The number of Service Users who responded to the survey was approximately 1% of those seen by the Crisis Teams over the relevant period. It is not recorded how many survey forms were handed out.

Analysis of the **18** responses received by the survey project group found that:

67% found it easy to contact the Crisis Team

100% found that the Crisis Team did well in managing risks to safety and making them feel safe

94.5% found that the Crisis Team did well in meeting 2gether Trust Values

100% found that the recovery plan met their needs well or quite well

The 18 responses reviewed suggest that Service Users were largely very satisfied with the help provided by our Gloucestershire Crisis Teams, although the small number of responses must be acknowledged.

A selection of comments received from survey respondents:

Section 3 – Learning from Service Experience Feedback

Section 3.1 – learning themes emerging from individual complaints

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

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

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

Table 18: Trust-wide points of learning from Service Experience feedback Q3 closed complaints disseminated to localities via Practice Notes– assurance of actions to be sought from locality leads

Practice Note number	Organisational Learning
1907	Whilst it is important to maintain confidentiality, consideration should be given to applying Common Sense Confidentiality to allow staff to offer reassurance to families.
1995	Staff are reminded to check with service users if they are happy to discuss their care over the telephone before doing so.

Practice Note number	Organisational Learning
2219 *(inpatient services)*	When a service user is noted as missing from a ward it should be reported and followed up in a timely way. It should be formally recorded in health records whether a grace period is to be allowed if a service user fails to return from unescorted leave. Ensure clear, accurate, and factual notes are recorded on RiO

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

Effective dissemination of learning across the organisation is vital to ensure ²gether's services are responsive to people's needs and that services continue to improve. Service Experience feedback has contributed to the *Learning ²gether from Incidents, Complaints and Claims* report issued within the Trust on 1st December 2017.

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

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

Agenda item 8 **Paper C**

Report to: Trust Board – 27 March 2019
Author: Jane Stewart – Compliance Manager
Presented by: John Trevains – Director of Quality

SUBJECT: **Quality Report: Report for 3rd Quarter 2018/19**

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

EXECUTIVE SUMMARY

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

Assurance

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

- Overall, at Q3, there is one target which is not being met:

    1. 2.1 – Numbers of service users being involved in their care

- KPMG, our external auditors, have commenced initial testing on the two indicators that the NHSI Guidance has mandated as required for the external assurance audit for the Quality Report.

    1. Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral.

    2. Inappropriate out-of-area placements for adult mental health services

- Our Trust approach is that our Trust Governors have the opportunity to select an additional quality indicator for external audit. At their March 2018 Council meeting, Trust Governors were asked to select a chosen indicator for audit purposes and at time of writing their decision is awaited. The Board will receive a further update when this decision is received.

Improvements and developments.

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

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

- Consultation with both internal and external stakeholders has been undertaken through the Governance committee, quality contracting rounds and Trust Governors to agree the quality priorities for 2019/20. In recent years the Trust has continued with consistent indicators, this gives the Trust and stakeholders a time line of comparable data. New indicators could be considered being selected as we have evidenced continuous achievement year on year in some areas. This is countered by the view that, as we are going through a period of change, keeping consistent indicators provides a good measure that quality has not been affected by merger activity, as we endeavour to achieve outstanding regulatory status. Alongside the aforementioned positive aspect that continued measurement allows comparison of data on recognised important indicators.

- The recommendation of our consultation is that we will be continuing our current set of quality indicators. We will be seeking to stretch targets to increase levels of achievement where we have consistently archived objectives and we are adding two additional measures to the existing ones to further enable quality improvement in key areas. These will be delivered as Quality Priority "Focus" Projects in 2019/20.

  These two areas are

  - **Personalised Discharge Care Planning**

    Focus on patient involvement, crisis planning and community transitions. To be achieved through quality improvement approaches. Target >80% compliance against 8 specific measures.

  - **Embedding Learning from Serious Incidents**

    Focus on further development of quality improvement led approaches to robustly embedding lessons learned following incidents, to include an evaluation of achievement.

RECOMMENDATIONS

The Board is asked to:

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

- Note the decision made to continue with current set of quality indicators for 2019/20 following consideration and consultation.

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

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

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

Reviewed by:		
John Trevains, Director of Quality	Date	18/03/2019

Where in the Trust has this been discussed before?		
Governance Committee	Date	February 2019

What consultation has there been?		
Discussed in paper	Date	Feb/March 2019

Explanation of acronyms used:	

1. CONTEXT

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

Quality Report 2018/19

Quarter 3

CONTENTS

Part 1: Statement on Quality from the Chief Executive

Introduction

To be completed at year-end

Part 2.1: Looking ahead to 2019/20

Quality Priorities for Improvement 2018/19

To be completed at year-end

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

Review of Services

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

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

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

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

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

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

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

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

Participation in Clinical Audits and National Confidential Enquiries

To be completed at year-end

Participation in Clinical Research

To be completed at year-end

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

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

2018/19 CQUIN Goals

Gloucestershire

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

Herefordshire

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

Low Secure Services

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

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

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

2019/20 CQUIN Goals

To be completed when this information becomes available

Statements from the Care Quality Commission

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

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

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

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

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

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

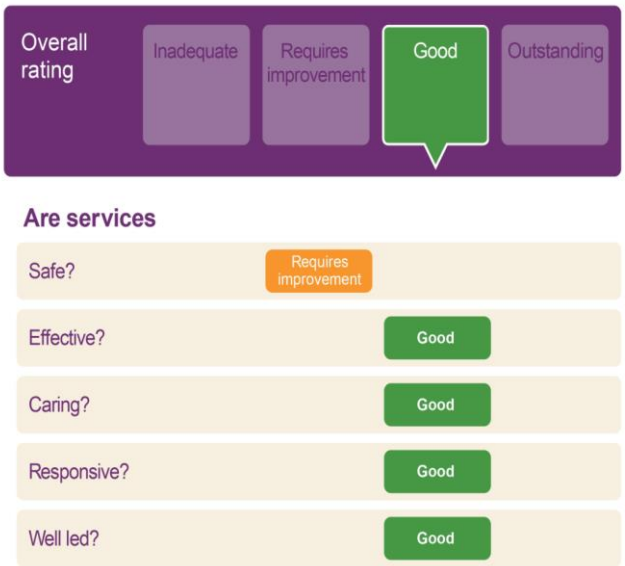
CQC Inspections of our services

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

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

New Ratings from latest review.

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



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

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

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

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Quality of Data

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

To be completed at year-end

Information Governance

To be completed at year-end

Clinical Coding

To be completed at year-end

Learning from Deaths

To be completed at year end.

Part 2.3: Mandated Core Indicators 2018/19

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

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

	Quarter 2 2017-18	Quarter 3 2017-18	Quarter 4 2017-18	Quarter 1 2018-19	Quarter 2
[2]gether NHS Foundation Trust	98.5%	99.6%	98.4%	97.6%	98.4%
National Average	96.7%	95.4%	95.5%	95.8%	95.7%
Lowest Trust	87.5%	69.2%	87.2%	73.4%	88.3%
Highest Trust	100%	100%	100%	100%	100.00%

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

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

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

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

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

	Quarter 2 2017-18	Quarter 3 2017-18	Quarter 4 2017-18	Quarter 1 2018-19	Quarter 2 2018-19
[2]gether NHS Foundation Trust	100%	99.5%	98.6%	99.4%	99.4%
National Average	98.6%	98.5%	98.7%	98.1%	98.4%
Lowest Trust	94%	84.3%	93.7%	85.1%	81.4%
Highest Trust	100%	100%	100%	100.00%	100.00%

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

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

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

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

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

	Quarter 3 2017-18	Quarter 4 2017-18	Quarter 1 2018-19	Quarter 2 2018-19	Quarter 3 2018-19
[2]gether NHS Foundation Trust 0-15	0%	0%	0%	0%	0%
[2]gether NHS Foundation Trust 16 +	10.4%	5.8%	6.2%	6.1%	7.1%
National Average	Not available	Not available	Not available	Not available	Not available
Lowest Trust	Not available	Not available	Not available	Not available	Not available
Highest Trust	Not available	Not available	Not available	Not available	Not available

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

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

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

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

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

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

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

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

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

Taking steps to

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

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

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

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

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

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

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

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

	1 April 2017 – 30 September 2017				1 October 2017-31 March 2018			
	Number	Rate*	Severe	Death	Number	Rate*	Severe	Death
[2]gether NHS Foundation Trust	2585	73.19	2	20	2901	83.69	2	28
National	167,477	-	532	1212	166787	-	569	1331
Lowest Trust	68	16	0	0	1	14.88	0	0
Highest Trust	6447	126.4	89	83	8134	96.72	121	138

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

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

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

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

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

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

Part 3: Looking Back: A Review of Quality during 2018/19

Introduction

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

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

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

Summary Report on Quality Measures for 2018/2019

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

Easy Read Report on Quality Measures for 2018/2019

Quality Report 	This report looks at the quality of [2]gether's services. We agreed with our Commissioners the areas that would be looked at.	
Physical health 	We increased physical health tests and treatment for people using our services. We met the target.	↑
Discharge Care Plans 	More people had all parts of their discharge care plan completed at the end of the quarter than previously. We have met the target.	↑
Care (CPA) Review 	All people moving from children's to adult services had a care review. We met the target.	↑
Care Plans 	80% of people said they felt involved in their care plan. This is less than the target (84%). We have not met the target. We are doing lots of work to get better at this.	↓
Crisis 	84% of people said they know who to contact if they have a crisis. This is more than the target (71%). We met the target.	↑
Activity 	82% of people said they had advice about taking part in activities. This is more than the target (64%). We met the target.	↑
Physical Health 	84% of people said they had advice about their physical health This is more than the target (73%). We met the target.	↑

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

Effectiveness

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

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

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

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

Within quarter three, we have reviewed interoperability of data and IT systems between secondary and primary care, to facilitate flow of information on physical health issues for people with SMI. For the past 18 months, physical health information for both inpatients and community patients has been electronically recorded on a 'Health and Lifestyle form' within our electronic patient record (RiO). This information can be updated and edited as necessary and is shared with primary care on discharge from an inpatient stay or annually at CPA review for our community patients. A secure email system is used to ensure data is transferred safely and securely to the individual GP practice. This process is now embedded in practice and timescales for delivery of this information is adhered to.

Our successful physical health clinics continue to run at Pullman Place and 27a St Owen Street, providing service users in the community access to physical health checks in an environment with staff who are familiar to them. Attendance at these clinics is growing and it is hoped to provide a similar service at Leckhampton Lodge in Cheltenham this year. Staff from Cheltenham Recovery Teams have visited Pullman Place to see how the clinic is run and to observe their good practices.

It is hoped that the Trust will purchase ECG machines for the community hubs within the next financial quarter. This will provide the opportunity for routine ECG screening for possible cardiac anomalies for our patients who are at an increased cardio metabolic risk largely due to medication side effects and lifestyle factors. Training for staff to take ECG's will be provided by the Physical Health Facilitator, and refresher training for medics to interpret ECG's will be held internally by our own Medical team.

Alongside the CQUIN work, [2]gether continues to increase access to physical health treatment for service users. Following the successful secondment of a general trained nurse working within Wotton Lawn Hospital in Gloucestershire, a second general nurse has been appointed to provide a similar service for inpatients at the Stonebow Unit in Hereford. Furthermore, we now have a general nurse working within the recovery units in Cheltenham one day a week to provide physical healthcare to our patient's there.

[2]gether has continued to work with “Equally Well” which is a national collaborative to support the physical health of people with a mental illness. We have also been approached from the RCN to collaborate with a parity of esteem/lived experience project where we hope to involve some experts by experience.

We have met this target.

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

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

The following criteria are being used in the services across both counties as follows:

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

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

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

Gloucestershire Services

Criterion	Year End Compliance (2016/17)	Year End Compliance (2017/18)	Compliance Quarter 1 (2018/19)	Compliance Quarter 2 (2018/19)	Compliance Quarter 3 (2018-19)
Overall Average Compliance	**72%**	**73%**	**71%**	**65%**	**71%**
Chestnut Ward	85%	**83%**	**84%**	**86%**	**84%**

Mulberry Ward	79%	73%	72%	65%	71%
Willow Ward	71%	69%	69%	64%	71%
Abbey Ward	75%	78%	74%	64%	73%
Dean Ward	73%	73%	73%	63%	74%
Greyfriars PICU	62%	64%	53%	56%	60
Kingsholm Ward	72%	72%	73%	68%	74%
Priory Ward	80%	80%	73%	67%	76%
Montpellier Unit	57%	64%	71%	57%	67%
Honeybourne	70%	65%	58%	54%	67%
Laurel House	65%	81%	83%	71%	64%

*Berkeley House was not included in the audit as there were no discharges in Q3 2018-19.

Herefordshire Services

Criterion	Year End Compliance 2016/17)	Year End Compliance (2017/18)	Compliance Quarter 1 (2018/19)	Compliance Quarter 2 (2018/19)	Compliance Quarter 3 (2018/19)
Overall Average Compliance	**74%**	**71%**	**71%**	**70%**	**71%**
Cantilupe Ward	85%	82%	79%	81%	74%
Jenny Lind Ward	71%	68%	69%	63%	73%
Mortimer Ward	69%	65%	67%	65%	65%
Oak House	70%	68%	67%	NA	NA

*Oak House did not have any discharges during Q2 2018-19.

Overall compliance for the Trust (Gloucestershire and Herefordshire) for Quarter 3 was 71% compared to 68% in Quarter 2, this means there has been a 3% increase in compliance. Overall compliance for Gloucestershire only for Quarter 3 was 71% compared to 65% in Quarter 2, this means there has been a 6% increase in compliance. Overall compliance for Herefordshire only for Quarter 3 was 71% compared to 70% in Quarter 2, this means there has been a 1% increase in compliance.

During Quarter 3 of 2018/19 there were 77 discharges from Herefordshire and 199 from Gloucestershire. The total number of discharges across the Trust was 276.

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

		Current compliance (Q3)	Direction of travel and previous compliance (Q2)
1.	Has a Risk Summary been completed?	100%	⇔100%
2.	Has the Clustering Assessment and Allocation been completed?	94%	⇧92%
3.	Has HEF been completed? (LD only)	100%	N/A
4.	Has the Pre-Discharge Planning Form been completed?	35%	⇧27%
5.	Have the inpatient care plans been closed within 7 days of discharge?	8%	⇩11%
6.	Has the patient been discharged from bed?	100%	⇧99%
7.	Has the Nursing Discharge Summary Letter to	90%	⇧87%

	Client/GP been sent within 24 hours of discharge?		
8.	Has the 48 hour follow up been completed if the Community Team are not doing it?	77%	⇧51%

Of the seven individual criteria assessed, compliance has increased for 5 criteria, remained the same for 1 criterion, and decreased for 1 criterion.

It has been noted by the data collector that more often than not, the patient care plans are not being closed within 7 days of discharge and this is often the case each quarter. Compliance is vert low at just 8%.

3. Has HEF been completed (LD only)
There was 1 patient recorded as having a Learning Disability and the HEF had been completed for them therefore this was 100% compliant.

This Target has been met.

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

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

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

2017-18 Results

Gloucestershire Services.

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

Herefordshire Services

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

2018-19 Results

Gloucestershire Services

Criterion	Compliance	Compliance	Compliance	Compliance

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

Herefordshire Services

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

During Quarter 3 all young people who transitioned into adult services had a joint CPA review. .

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

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

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

We met this target.

User Experience

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

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

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

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

Data for Quality Survey (Quarter 3 2018/19 – October to December 2018) results:

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

Question	County	Number of responses	Target Met?
Were you involved as much as you wanted to be in agreeing the care you receive?	Gloucestershire	135 (106 positive)	80% TARGET 84%
	Herefordshire	29 (25 positive)	
	Total	164 (131 positive)	

This target has not been met.

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

Question	County	Number of responses	Target Met?
Have you been given information about who to contact outside of office hours if you have a crisis?	Gloucestershire	138 (113 positive)	84% TARGET 71%
	Herefordshire	26 (24 positive)	
	Total	164 (137 positive)	

This target has been met.

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

Question	County	Number of responses	Target Met?
Have you had help and advice about taking part in activities that are important to you?	Gloucestershire	127 (101 positive)	82% TARGET 64%
	Herefordshire	26 (24 positive)	
	Total	153 (125 positive)	

This target has been met.

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

Question	County	Number of responses	Target Met?

Have you had help and advice to find support for physical health needs if you have needed it?	Gloucestershire	127 (105 positive)	**84%** **TARGET 73%**
	Herefordshire	27 (25 positive)	
	Total	154 (130 positive)	

This target has been met.

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

Although response rates for the survey have increased over time the level of response continues to be lower than we would like. The introduction of new systems in Quarter 4 2018/19 to capture survey feedback aims to increase the number of response we receive to both aspects of the How did we do? survey

Friends and Family Test (FFT)

FFT responses and scores for Quarter 3, 2018/19

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

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

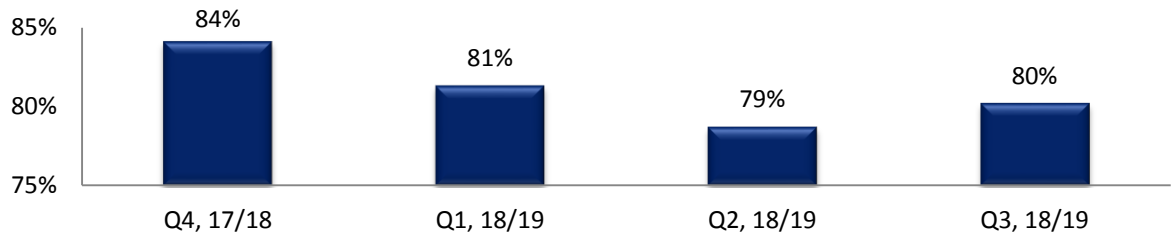
The table below details the number of combined total responses received by the Trust each month in Quarter 3. The FFT score is the percentage of people who stated that they would be 'extremely likely' or 'likely' to recommend our services. These figures are submitted for national reporting.

	Number of responses	FFT Score (%)
October 2018	395 (324 positive)	82%
November 2018	374 (296 positive)	79%
December 2018	277 (219 positive)	79%
Total	**1046** (839 positive) **(last quarter = 1020)**	**80% (last quarter = 79%)**

The FFT score for our Trust this quarter has continued to decrease in line with an observed drop during previous quarters. This is disappointing when compared with our national survey results and compliments which suggest a high level of satisfaction with the services that we provide.

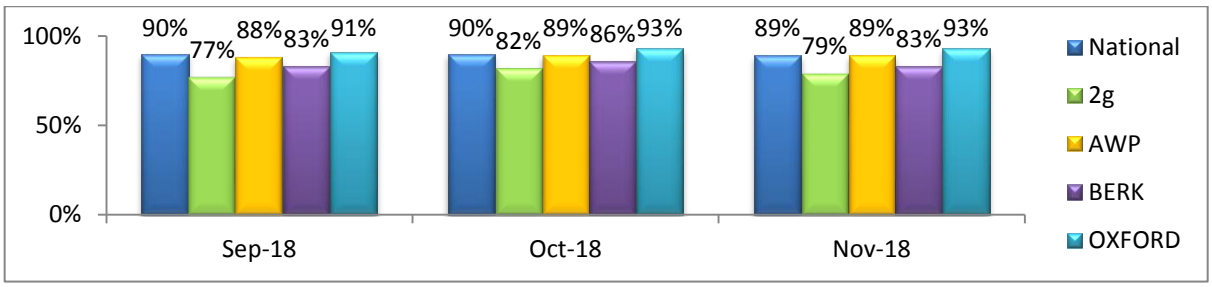
SED have undertaken further analysis of this quarter's FFT scores to review for any areas that are influencing decreased scores and are sharing with operational colleagues for further follow up and action.

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



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

The chart below shows the FFT scores for September, October, and November 2018 (the most recent data available) compared to other Mental Health Trusts in our region and the national average. Our Trust consistently receives a high percentage of recommendation although we have achieved lower scores than other Trusts in our region in recent quarters. This is a reversal from previous years and does not triangulate with our positive National Survey scores (December 2018 data are not yet available)



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

Complaints

To be completed at year-end

Safety

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

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

There are 3 associated targets.

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

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

year the number of reported suspected suicides was **28.** By the end of Quarter 3 2018/19 we reported **22** suspected suicides. This is seen in Figure 4.

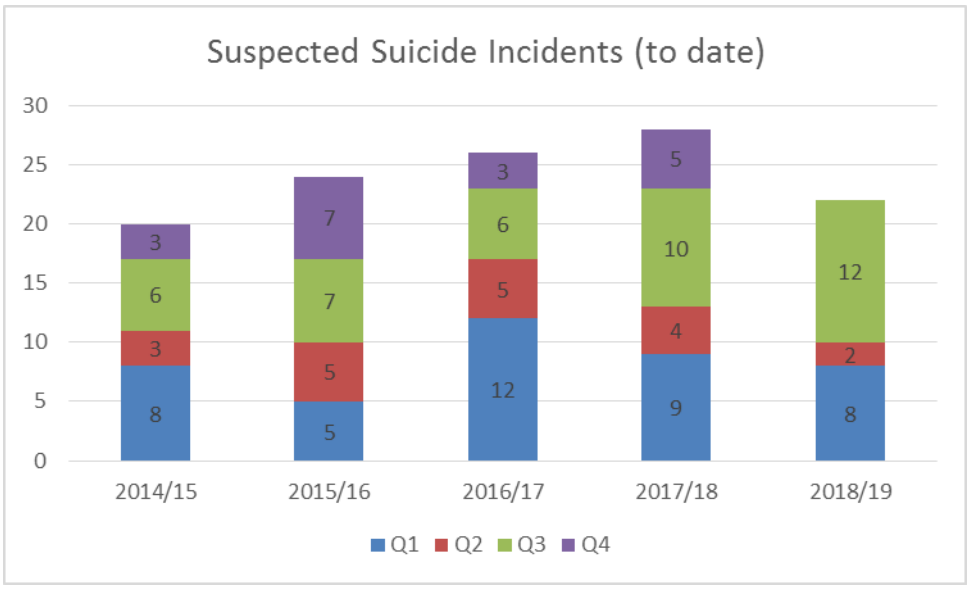


Figure 4

What we also know is that we are seeing more and more service users on our caseload year on year, so we measured this important target differently this year. This is also reported as a rate per 1000 service users on the Trust caseload. The graph in Figure 5 shows this rate from 2014/15 onwards for all Trust services covering Herefordshire and Gloucestershire, and we are aiming to see the median value (green line) get smaller. During 2015/16, 2016/17 and 2017/18 the median value was 0.09. By the end of Quarter 3 2018/19 the median value has fallen to 0.08.

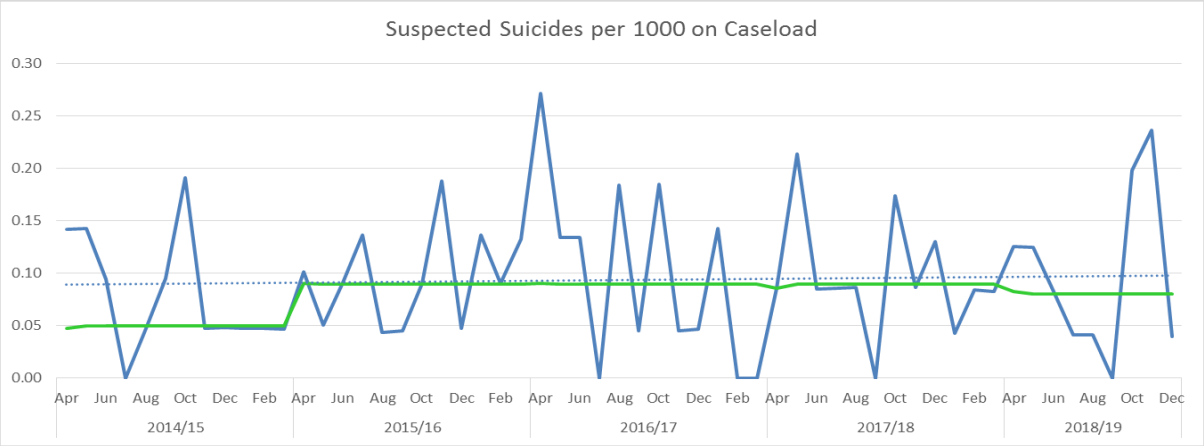


Figure 5

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

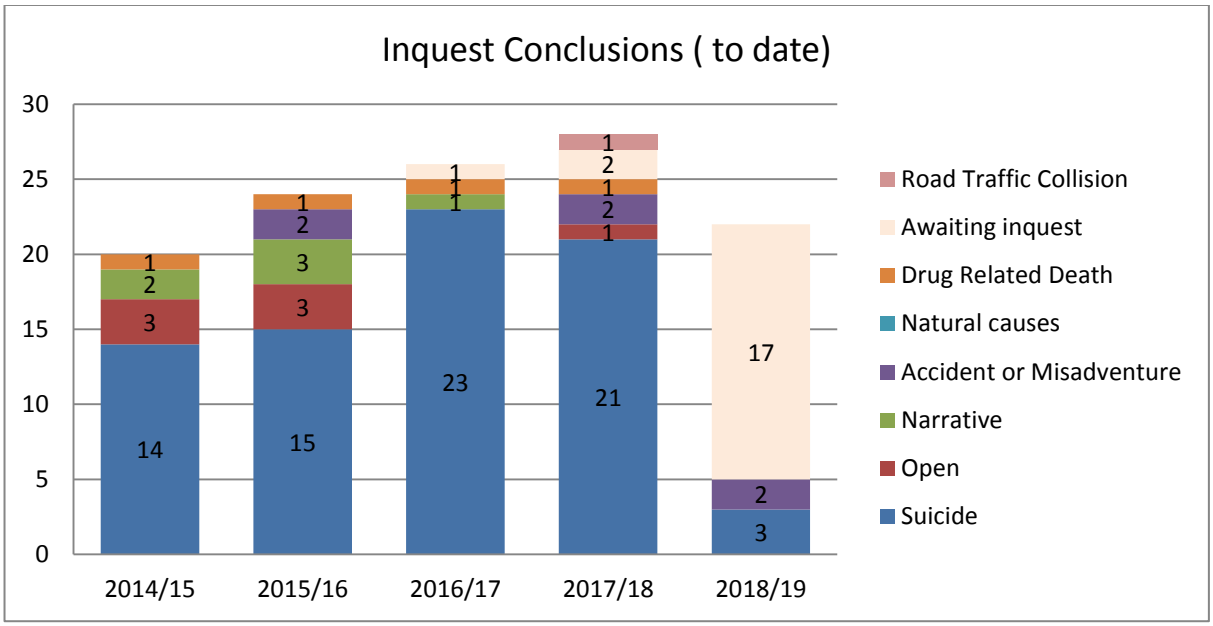


Figure 6

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

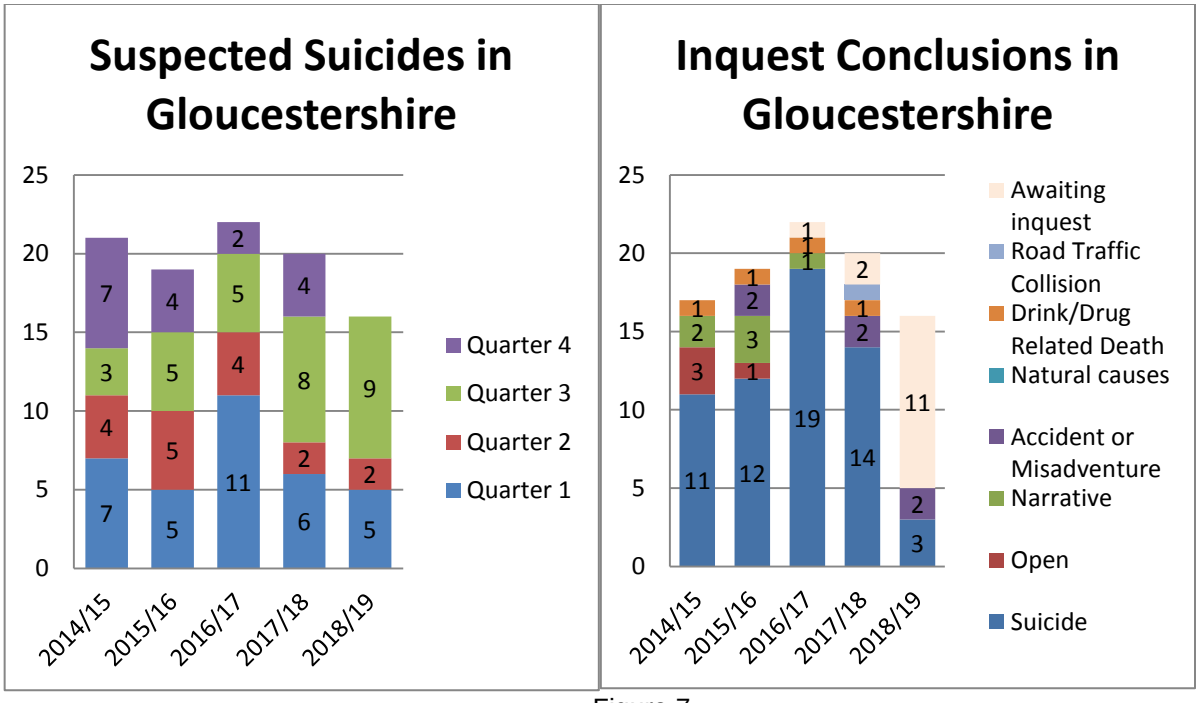


Figure 7

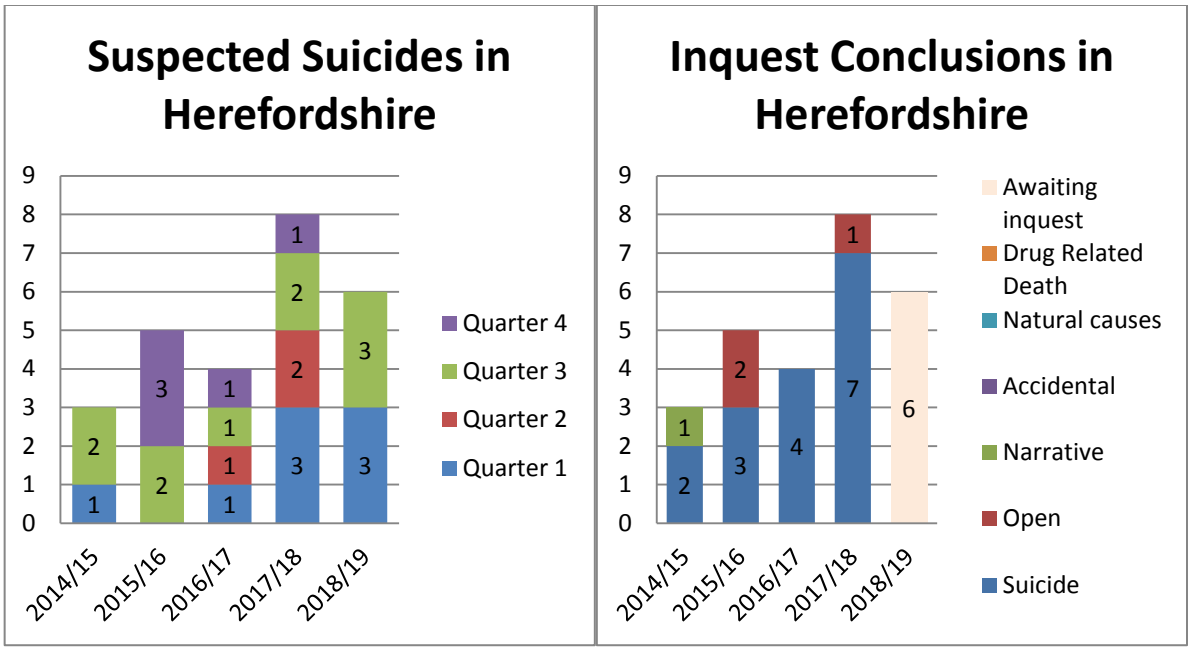


Figure 8

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

We are currently meeting this target.

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

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

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

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

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

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

None of these incidents led to serious harm or death.

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

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

None of these incidents led to serious harm or death.

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

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

None of these incidents led to serious harm or death.

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

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

None of these incidents led to serious harm or death.

At the end of **Quarter 2 2018/19** the following occurrences of AWOL have been reported.

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	16	15	1	**32**
Herefordshire	18	0	1	**19**
Total	**Q2 34**	**Q2 15**	**2**	**51**

None of these incidents led to serious harm or death

At the end of **Quarter 3 2018/19** the following occurrences of AWOL have been reported.

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	11	20	8	**39**
Herefordshire	2	0	1	**3**
Total	**Q3 13**	**Q3 20**	**Q3 9**	**42**

None of these incidents led to serious harm or death

We are meeting this target

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

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

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

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

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

At the end of 2016/17, **211** instances of prone restraint were used which was an overall increase and by the end of 2017/18, **229** instances of prone restraint were used so we did not see a 5% reduction by year end.

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

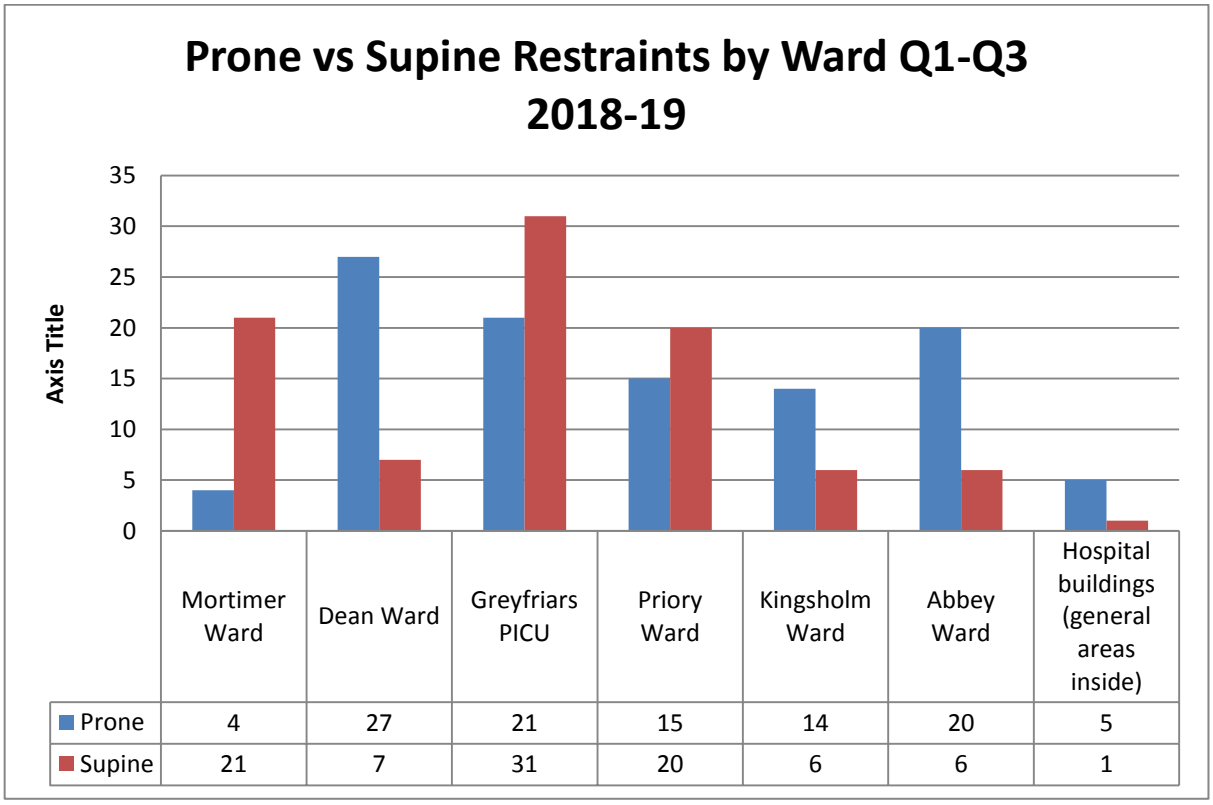


Figure 9

Figure 9 shows that during Quarters 1 & 2 and 3 **106** instances of prone restraint were used compared to **92** instances of supine. Figure 10 below compares 2017/18 and 2018/19 prone restraint data and from this analysis it is clear that the use of prone restraint has reduced by greater than 5% this year.

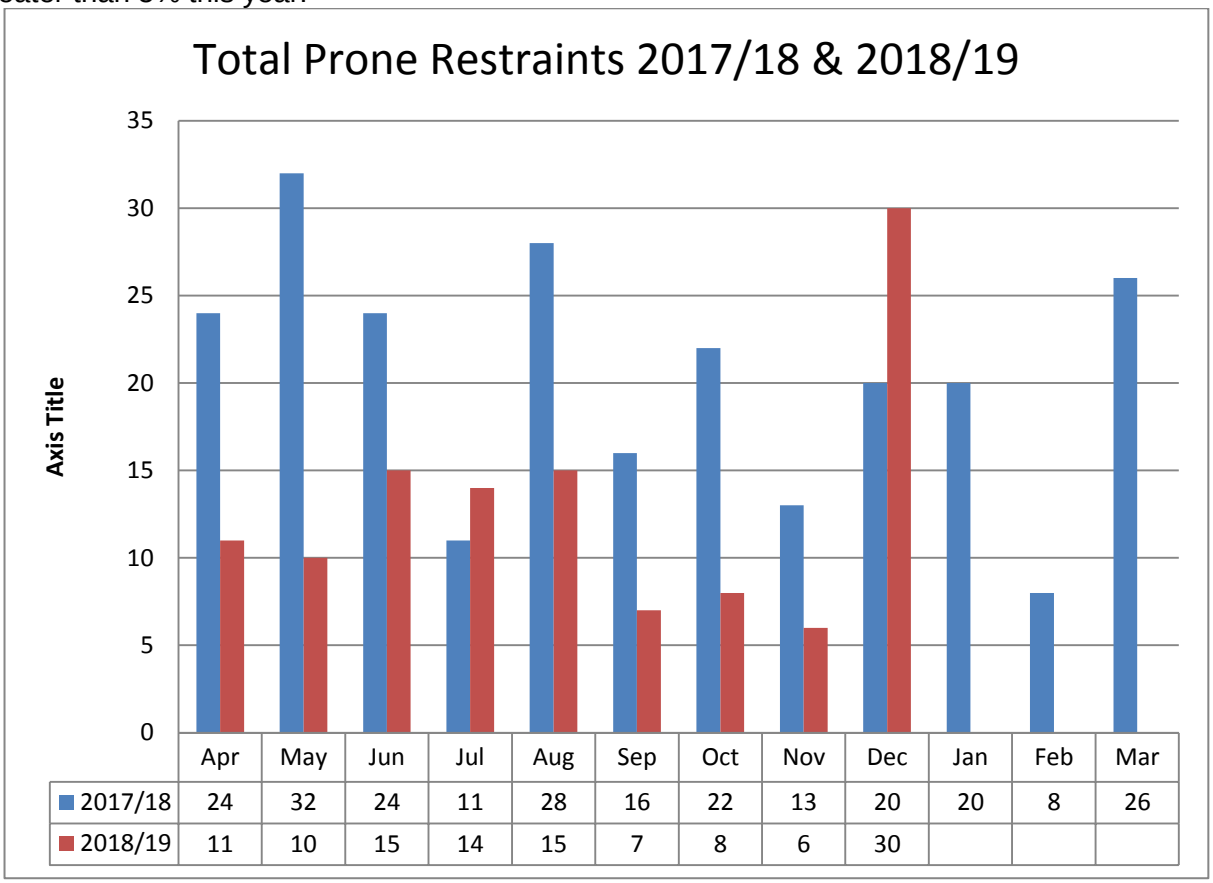


Figure 10

We are on trajectory to meet this target.

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

Berkeley House currently has 7 patients all of whom have specific care plans for Positive Behaviour Management (PBM) interventions, these care plans are on RiO and a copy of an accessible care plan is available for the patient.

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

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

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

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

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

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

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

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

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

We have met this target.

Serious Incidents reported during 2018/19

By the end of Quarter 3 2018/19, **28** serious incidents were reported by the Trust; the types of these incidents reported are seen below in Figure 11.

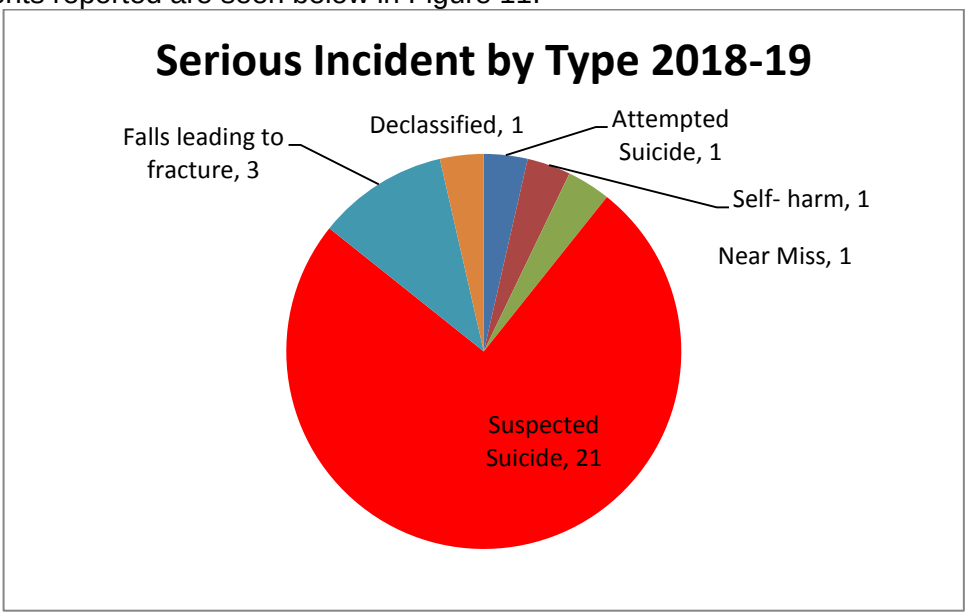


Figure 11

Figure 12 shows a 4 year comparison of reported serious incidents. The most frequently reported serious incidents are “suspected suicide” and attempted suicide which is why we continue to focus on suicide prevention activities in partnership with stakeholders. All serious incidents were investigated by senior members of staff, all of whom have been trained in root cause analysis techniques. To further improve consistency of our serious incident investigations we appointed a whole time equivalent Lead Investigator commenced this important work in May 2017, and 2 further dedicated Investigating Officers are now available via the Trust’s Staff Bank.

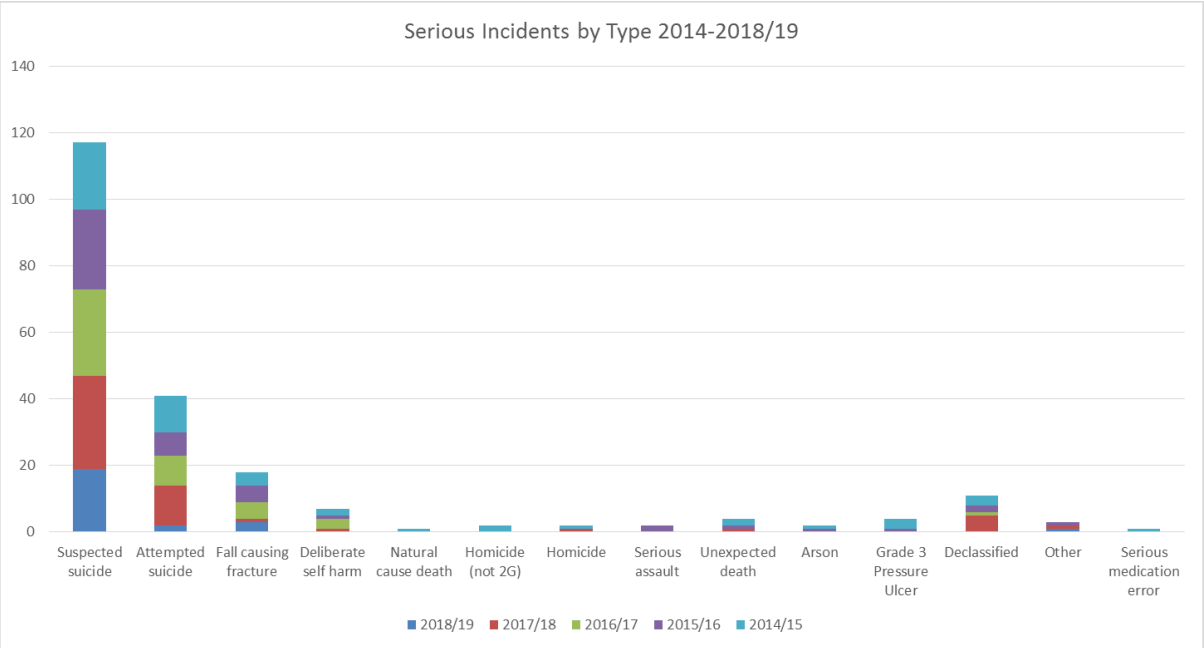


Figure 12

Wherever possible, we include service users and their families/carers to ensure that their views are central to the investigation, we then provide feedback to them on conclusion and copies of our investigation reports. During 2016/17 we engaged the Hundred Families organisation to deliver 'Making Families Count' training to 51 staff to improve our involvement of families and a further 20 staff attended an additional Hundred Families workshop regarding 'Involving Families in Serious Incidents' in November 2017. During 2018/19 we continue to develop processes to provide improved support to people bereaved by suicide and in May 2018 18 staff were trained in Postvention techniques by the charity Suicide Bereavement UK. These trained staff now act voluntarily as Family Liaison Officers (FLOs) and are allocated to support families of service users on our caseload who have died by suspected suicide.

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

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

Duty of Candour

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

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

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

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

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

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

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

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

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

NHSI Indicators 2018/2019

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

		2016-2017 Actual	National Threshold	2017-2018 Actual	2018-2019 Actual
1	Early Intervention in psychosis EIP: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	**71.3%**	50%	**70%**	**72%**
2	Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered routinely in the following service areas: -inpatient wards -early intervention in psychosis services -community mental health services (people on CPA)	 - - -		 **95%** **92%** **90%**	 **YE**
3	Improving access to psychological therapies (IAPT): Proportion or people completing treatment who move to recovery (from IAPT database) Waiting time to begin treatment (from IAPT minimum dataset - treated within 6 weeks of referral - treated within 18 weeks of referral	**-** **37.8%**	50% 75% 95%	**50%** **67%** **85%**	**52%** **96%** **96%**
4	Admissions to adult facilities of patients under 16 years old.	**-**		**1**	**0**
5	Inappropriate out-of area placements for adult mental health services	**-**		**24**	**33**

Community Survey 2018

To be completed at year-end

Staff Survey 2018

To be completed at year-end

PLACE Assessment 2018

Site Name	Cleanliness	Food Overall	Organisational Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Overall 2gether Trust Score: (taken from Organisation Average)	**99.64%**	**94.60%**	**92.43%**	**98.37%**	**93.11%**	**99.20%**	**90.18%**	**91.19%**
BERKELEY HOUSE	**100.00%**	**94.66%**	**90.79%**	**99.45%**	**100.00%**	**99.45%**	**N/A**	**93.77%**
CHARLTON LANE	**100.00%**	**96.55%**	**94.51%**	**100.00%**	**94.53%**	**99.84%**	**99.02%**	**92.69%**
WOTTON LAWN	**99.94%**	**95.04%**	**92.80%**	**100.00%**	**93.75%**	**99.88%**	**N/A**	**89.52%**
HONEYBOURNE	**99.13%**	**94.89%**	**91.10%**	**100.00%**	**94.53%**	**99.59%**	**N/A**	**92.43%**
LAUREL HOUSE	**100.00%**	**94.34%**	**88.87%**	**100.00%**	**94.53%**	**99.64%**	**N/A**	**95.92%**
STONEBOW UNIT	**98.62%**	**91.93%**	**91.20%**	**92.93%**	**89.49%**	**97.59%**	**81.53%**	**91.77%**
OAK HOUSE	**100.00%**	**N/A**	**N/A**	**N/A**	**90.32%**	**96.88%**	**N/A**	**86.67%**
National Average MH/LD	98.40%	90.60%	88.80%	92.30%	91.00%	95.40%	88.30%	87.70%
National Average	98.50%	90.20%	90.00%	90.50%	84.20%	94.30%	78.90%	84.20%
lowest	74.80%	60.70%	49.50%	48.10%	53.90%	68.80%	45.60%	50.20%
highest	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Key

At or above MH/LD National Average	
Below England MH/LD average	

These results are very positive and for the first time since PLACE began the Trust is above the national average for Mental Health and Learning Disability settings in all six domains. The overall results clearly demonstrate how as a Trust we are improving the quality of the non-clinical services provided to our patients.

Cleanliness performed really well this year and the Trust overall score was over 1% higher than the National average, with four of the seven sites assessed scoring 100%.

The Food assessment scored well this year and the Trust overall score was 4% higher than the National average. The ward 'food tasting' scored particularly well this year with four out of six sites scoring 100% for taste, texture, temperature and appearance.

In comparison with our local healthcare partners in Gloucestershire we achieved a higher average domain score than GCS and GHT in all domains.

In terms of individual site ranking Charlton Lane achieved the highest site average score of 97.14 followed closely by Berkeley House who achieved 96.87%

Annex 1: Statements from our partners on the Quality Report

To be completed at year-end

To be completed at year-end

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

To be completed at year-end

Annex 3: Glossary

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

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

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

Annex 4: How to Contact Us

About this report

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

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

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

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

Other Comments, Concerns, Complaints and Compliments

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

You can give us feedback about our services by:

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

Alternative Formats

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

Agenda Item 9 **PAPER D**

Report to: Trust Board – 27th March 2019
Author: John Trevains, Director of Quality
Presented by: John Trevains, Director of Quality

SUBJECT: **6 Monthly Safe Staffing Update**

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

EXECUTIVE SUMMARY

This paper provides an update regarding revised safe staffing guidance issued by the National Quality Board (NQB) in July 2016. This paper also includes related updates through the developmental inpatient quality dashboard and temporary staffing.

This 6 monthly update outlines :

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

National reporting with regards to fill rates continues to be uploaded monthly and reported to the Governance Committee on behalf of the Board. From April 2018 the Trust has been mandated to also include the Care Hours Per Patient Day (CHPPD) within the upload. The Trust continues to have strong compliance with planned versus actual fill rates – over 97% compliant for January 2019. Appendix 2 details the latest figures presented at the Governance Committee in February 2019.

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

This paper also includes an updated quality dashboard (Appendix 1) for the inpatient wards which is a requirement of the NQB guidance – ensuring triangulation of both staffing; workforce indicators and patient experience. This

report indicates that some wards experience higher rates of sickness and turnover but this is an improving picture compared to the September 2018 report.

The Quality dashboard will continue to be developed to include community services over the next 6-12 months. The Trust Quality Management Team is working to develop this dashboard into a tool that can be used on monthly frequency to further improve *board to ward* line of sight quality assurance.

Regarding NQB expectations, this report confirms achievement of all expectations as per guidance. Some areas are currently being progressed further such as workforce development, safe staffing reviews and ensuring diversity of the workforce is representative of the communities we serve.

ASSURANCE

This update paper gives **SIGNIFICANT ASSURANCE** on current progress and monthly reporting.

RECCOMENDATIONS

The Board is asked to:

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

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

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

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

Reviewed by:		
John Trevains, Director of Quality	Date	21st March 2019

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

What consultation has there been?		
N/A	Date	

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

1. **CONTEXT**:

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

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

The Trust Board received the last 6 monthly update in September 2018. The Governance Committee continues to receive bi-monthly reports detailing staffing levels across all inpatient sites as well as updates regarding the use of temporary staffing.

This 6 monthly update outlines :

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

2. PROGRESS ON THE NQB REVISED KEY EXPECTATIONS

Following on from the detailed update regarding the NQB expectations through the September 2018 6-monthly paper, this report confirms achievement of all expectations as per the guidance. Some areas of work continue to be progressed

further, such as workforce development, safe staffing reviews, and ensuring diversity of the workforce is representative of the communities we serve.

Quality Dashboard Development

The Quality dashboard has been developed since the September 2018 report to Trust board. The Trust Quality Management Team is working to develop this dashboard into a tool that can be used on a monthly basis to further improve *board to ward* line of sight quality assurance. We are seeking to engage with other Trusts nationally to learn from other areas successes in devising effective quality dashboards.

Please note that this is a developmental dashboard, there are a number of inherent data quality issues within it and it is subject to further development. Caution should be applied to how Wards/Units staffing levels and quality indicators are interpreted in terms of either positive or negative patient outcomes. The RAG rating is currently subjective and will be further developed and aligned to national/local quality/contractual indicators.

We have now included Safeguarding Level 2 and Level 3 for Children and Adults along with Infection Control training compliance. We have also included within this report agency percentage by ward. These additions are to provide a rounded overview of care metrics that can infer overall quality issues for attention.

The previous report in September 2018 identified a number of wards reporting significantly higher sickness absence than the Trust inpatient target of 4.5%. Work has been carried out with ward managers and matrons to further understand the impact of this. Although most of the inpatient wards are still RAG-rated “red”, 10 out of 16 inpatient wards have shown improvement in their sickness absence since September 2018. Work will continue around managing further reductions of sickness absence levels across our inpatient units.

This report shows an improved position on staff turnover on our inpatient wards with 12 of the 16 wards seeing a percentage reduction, with a significant reduction being seen on Montpellier (13.86% in the September 2018, 0% in January 2019).

Future updates to the Trust Board regarding quality dashboard development will be provided separately to this paper an include a detailed narrative analysis of its outputs.

3. NATIONAL GUIDANCE

In line with National Quality Board (NQB) and NHSI guidance the Trust continues to publish the fill rates as directed by the previous national guidance. This is uploaded

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

The Trust continues to report high fill rates. Appendix 2 outlines the national safe staffing requirement for January 2019. Since September 2018, actual fill rates have improved by a further 1% to over 97% compliant against planned levels.

4. LOCAL TRUST EXCEPTION REPORTING

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

4.1 Ward specific information

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

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

In summary for January 2019:

- No staffing issues were escalated to the Director of Quality or the Deputy Director of Nursing.
- Where staffing levels are below planned fill rates of 100% for qualified nurses, this was usually offset by increasing staffing numbers of unqualified staff based on ward acuity and dependence and the professional judgement of the nurse in charge of the shift.
- Over **97.86%** of the hours exactly complied with the planned staffing levels.

- Only **1%** of the hours during January 2019 had a different staff skill mix than planned, however overall the staffing numbers were compliant and the needs of the patients were met.
- **0.53%** of the hours during January had a lower number of staff on duty than the planned levels, however this met the needs of the patients on the ward at the time.

Internal exceptions January 2019
Wotton Lawn

- Greyfriars
    - The Code 1 exceptions are due to current x2 HCA vacancies and x1 qualified sickness.
- Priory
    - The Code 1 exceptions were due x2 qualified vacancies. HCAs utilised in place of qualified nurse on occasion (where this has been possible) in order to avoid incurring agency costs. On one occasion a HCA shift was filled by a bank qualified nurse due to availability and drive to save agency costs.
- Abbey
    - The Code 1 and 2 exceptions were due to vacancies/sickness.
- Kingsholm
    - The Code 1 exceptions were due to staff sickness.
- Montpellier
    - The Code 1 and 2 exceptions were due to staff sickness.

Charlton Lane January 2019

- Willow Ward
    - 6 code 1 exceptions. Minimum staffing numbers not compliant but met the needs of the patients. The ward was considered safe and there was no harm to patients.
    - 8 code 2 exceptions, staffing numbers compliant but the skill mix was non-compliant however met the needs of the patients. The ward was considered safe and there was no harm to patients.
- Mulberry Ward
    - 1 code 1 exception, staffing numbers compliant but the skill mix was non-compliant however met the needs of the patients. The ward was considered safe and there was no harm to patients.
- Chestnut Ward
    - 4 code 1 exceptions, staffing numbers compliant but the skill mix was non-compliant however met the needs of the patients. The ward was considered safe and there was no harm to patients.
    - 2 code 2 exceptions. Minimum staffing numbers not compliant but met the needs of the patients. The ward was considered safe and there was no harm to patients

Berkeley House January 2019

- One code 1 and 14 code 2 exceptions were reported for January. This is a decrease of 12 from the 27 exceptions reported for December 2018. This was partly due to one individual returning from long term sickness.

- Current staffing pressures include 5 staff not available as either on maternity leave or pregnant (light duties), and another on a career break, three of whom are returning February and March.

- Recruitment continues to take place, remains challenging but we are seeing improvement, where we are not losing staff at a higher rate than we can recruit into.

- Currently we have 3 band 2 vacancies and four band 3 vacancies.

- Authorisation for a Band 6 Clinical Specialist post; this has now been shortlisted with 2 applicants, one internal.

- A band 7 Speech and Language Therapist post for across Berkeley House and LDISS advertised; 2 applicants with the interviews being held on the 15th Feb.

- Berkeley House is noted internally as a “hard to recruit into area” and this meant that special measures can be implemented to encourage and support recruitment.

- Where there are staffing shortfalls during the week, the team management, and at times Matron, assist in covering where possible to ensure patients activities and safety is not compromised.

Stonebow - Herefordshire January 2019

- There were a very small number of code 1 exceptions only across the unit in January.

- The higher HCA fill rate on the older age wards is when additional staff are required when acuity is high. Any high fill rate for qualified staff is usually due to the additional management days created when possible for the deputy ward managers. This is also increased on Jenny Lind ward due to some training being cancelled.

Exception reporting in hours – all wards January 2019

			Exception Code 1	Exception Code 2	Exception Code 3	Exception Code 4	Exception Code 5
Ward	Bed number	Number of required staff hours in the month	Minimum staff numbers met – skill mix non-compliant but met needs of patients	Minimum staff numbers not compliant but met needs of patients	Minimum staff numbers met – skill mix non-compliant and did not meet needs of patients	Minimum staff numbers not compliant and did not meet needs of patients	Minimum staffing # and skill mix not met. Resulting in clinical incident / harm to
Dean	15	3150	0.00	0.00	0.00	0.00	0.00
Abbey	18	3150	132.50	7.50	0.00	0.00	0.00
Priory	18	3150	177.50	0.00	0.00	0.00	0.00
Kingsholm	15	3150	15.00	0.00	0.00	0.00	0.00
Montpellier	12	3450	52.50	17.50	0.00	0.00	0.00
Greyfriars	10	3900	317.50	0.00	0.00	0.00	0.00
Willow	16	4350	45.00	60.00	0.00	0.00	0.00
Chestnut	14	2925	30.00	15.00	0.00	0.00	0.00
Mulberry	18	3150	7.50	0.00	0.00	0.00	0.00
Laurel	13	1950	127.50	0.00	0.00	0.00	0.00
Honeybourne	10	1950	0.00	0.00	0.00	0.00	0.00
Berkeley House	7	8400	7.50	200.00	0.00	0.00	0.00
Herefordshire							
Mortimer	21	3105	0.00	0.00	0.00	0.00	0.00
Cantilupe	10	3105	23.00	0.00	0.00	0.00	0.00
Jenny Lind	8	1725	11.50	2.00	0.00	0.00	0.00
Oak House	10	1725	0.00	11.50	0.00	0.00	0.00
Total		52,335.0	947.00	313.50	0.00	0.00	0.00

5. USE OF TEMPORARY STAFFING

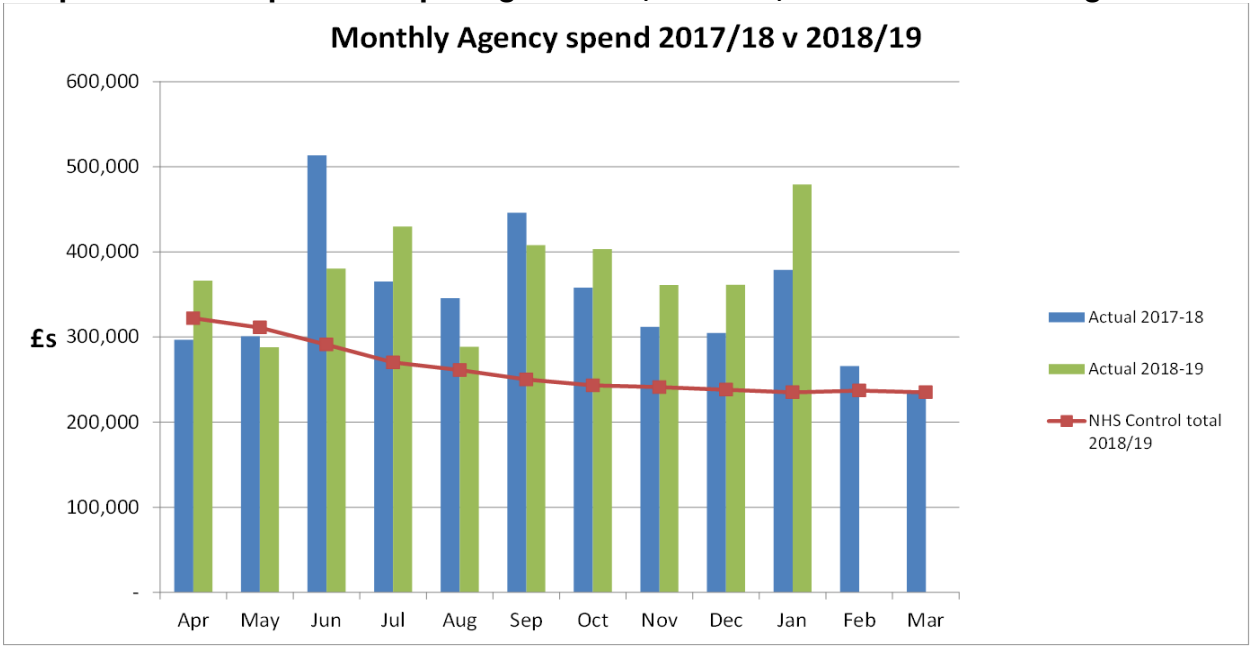
- The Temporary Staffing Project Board meets on a monthly basis, is chaired by the Director of Quality, and includes representation from all services. The Project Board reviews agency spend patterns and reviews the effectiveness of the planned mitigating activities.
- The Trust is a pilot site for the DoHSC Flexible Bank Project - scheduled to complete 31 March 2019. As a consequence of this pilot the Trust now offers bank staff a weekly pay option; continues to grow the number of staff on the bank (particularly roles that create the greatest agency demand); has introduced a mobile phone app that simplifies for staff the booking of bank shifts; and has integrated information from ESR into the Staff Bank and e-rostering systems to avoid the duplication of staff records.
- The 2018/19 agency spend is projected to exceed the 2017/18 spend due to challenging access targets and recruitment issues within the IAPT service, and qualified nursing vacancies. The actions described in later sections should mitigate some areas of spend (see Table 1 and Graph 1 below):

Table 1: Agency spend, NHSI ceiling, and straight line forecast

AGENCY SPEND INFORMATION UPTO 31st JANUARY 2019

	Actual 2016-17	Actual 2017-18	NHS Ceiling	Spend to date 2018-19	Straight line Forecast 2018-19
151MED - Medical Agency	2,041,540	1,974,301	1,503,888	1503368.14	1,804,042
153NMHV - Nursing Agency	2,379,314	1,383,636	1,049,677	1325040.01	1,590,048
154STT - Scientific Therapeutic and Technical Agency	694,451	562,854	427,001	871929.99	1,046,316
160ADM - Admin and Clerical Agency	197,484	128,395	97,405	13052.73	15,663
161HCA - Support agency	122,081	73,856	56,030	52244.53	62,693
164OTH - Other employees Agency	56,878	-0	-0	0.2	0
Total	**5,491,748**	**4,123,041**	**3,134,000**	**3,765,636**	**4,518,763**

Graph 1: Actual spend comparing 2017/18, 2018/19, and the NHSI ceiling



Nursing / HCA

- HCA agency spend remains low. The 2018/19 forecast of £383k is £166k less than the 2017/18 spend, and is also below the NHSI target of £416.7k. The HCA Peripatetic Teams that were introduced from mid-2017 are largely the cause of the reduced HCA agency – a spend that in 2016/17 was £1.13m.
- The forecast gross RMN agency spend of £1.207m for 2018/19 is higher than 2017/18, largely due to vacancies. Also, shifts that should have been provided under the Guaranteed Volume Contract are often covered by significantly more expensive Thornbury workers, however, the additional cost of Thornbury above the standard agency rate is recovered from the contractor.
- The value of credit notes to cover the use of Thornbury from the beginning of the Guaranteed Volume Contract on 01/09/18 (originally with MSI and taken over by Medacs 19/11/18) to 31/12/18 was £73,402. Additionally, further cost avoidance of £20k has been realised through the original contractor's early exit penalty. The credit note in respect of Thornbury shifts for the final quarter of 2018/19 is projected to be less than £30k – reduced through the improving Medacs fill rates. This cost avoidance activity should result in a net reduction in nursing agency spend for the year of circa £120k.
- Medacs currently provides the Guaranteed Volume Contract, taking over at short notice from the original contractor 18/11/18. Although it has not yet been able to provide all 42 shifts required under the contract, the Trust is working with them to transition to full delivery, and meets monthly to ensure delivery.
- A review meeting on 13/02/2019 identified improved shift provision, and agreed an initiative around training that envisages rapid improvement towards full contract provision of the minimum shift cover – improvement has already been achieved.
- Following the interim changes agreed in late December, the December fill rate of 54% improved to 64% in January 2019, 87% in February 2019 and a forecast 90% fill rate in March 2019.

IAPT

- The agency spend for IAPT remains high due to access targets and recruitment issues, and subsequently is a focus for the Temporary Staffing Project Board, and a monthly assurance update is produced.
- The actions to retain and recruit staff have been effective, and are reflected in reduced turnover rates and the achievement of target access rates.
- Although the IAPT spend for 2018/19 will exceed the 2017/18 spend, through the implementation of a Master Vendor Contract (Sugarmans), and successful recruitment and retention initiatives, agency costs are being contained. Sugarmans acknowledge that they experienced challenges at the outset of the contract, and have made proposals around marketing, recruitment, and supply chain management to address the issues.
- Sugarmans have engaged with the wider supply chain in Q4 to obtain cover, but with limited success – and reflects a general market shortage. However, it

is expected that Q1 will show an improved position, and will be monitored through the monthly management meeting with the master vendor.

- Sugarmans have indicated that a home working model would produce a greater supply and could be implemented quickly. The Trust is exploring this option, especially any associated risks around governance and delivery.

Medical

- The medical locum agency spend 2018/19 is forecast to be lower than 2017/18.
- There are currently 9.6 vacancies, and agency locums are being used, and although challenging, recruitment continues.
- Financial savings can be achieved by employing a higher percentage of locums through direct engagement rather than through umbrella companies. This enables the recovery of VAT, and is in line with HMRCs preferred method of engaging locums. Four of the 12 agency locums currently used are employed through Direct Engagement.

Domestic Staff

- There are 9 vacancies (4.33 wte) and, with the exception of a Rikenel post held pending the outcome of staff relocations, they all currently out to advert.
- Only 4 of those vacancies are being covered by agency staff, and the forecast 2018/19 agency spend of £56k is lower than the 2017/18 spend of £62.5k.

AHP

- There are currently 14.82 vacancies, but none are covered by agency staff.
- All vacancies are being actively recruited.
- Historically it has been hard to recruit against SALT vacancies and consequently they have been included in the 'refer a friend' scheme.
- An AHP workforce review has commenced and aims to map current difficult to recruit areas and anticipated future areas of challenge, and explore creative solutions. This will complete by end March 2019 and inform the wider workforce strategy development.

6. CONCLUSION:

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

7. RECOMMENDATIONS:

The Board is asked to:

- Note the current assurance against the revised NQB guidance and safe staffing levels
- Note development work with the Trust inpatient quality dashboard and plans to extend to community teams.
- Note monthly reporting and compliance with fill rates
- Note current position regarding temporary staffing

Developmental dashboard - note data quality issues and that this dashboard is subject to further development

Note RAG rating is subjective and will be subject to further development and alignment to national indicators

Information regarding Data	
Safer Staffing	For month of January 2019
Workforce & Training	Rolling 12 months
Quality Indicators	Cumulative in year totals (April 18 - Jan 19)

Staffing

Bed Information				Day		Night		Day				Night			
				Registered nurses	Care Staff	Registered nurses	Care Staff	Registered nurses		Care staff		Registered nurses		Care staff	
Wards	Current established beds	Ward average occupancy (month) % including leave	Ward average occupancy (month) % excluding leave	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours
Abbey Ward, WLH	18	97%	91%	106.5%	161.3%	100.0%	296.8%	930	990	1395	2250	620	620	310	920
Dean Ward, WLH	15	101%	94%	94.1%	113.7%	96.8%	119.4%	1395	1313	930	1058	620	600	310	370
Kingsholm Ward, WLH	15	96%	92%	89.3%	120.2%	100.0%	129.0%	1395	1245	930	1118	620	620	310	400
Priory Ward, WLH	18	99%	93%	97.6%	103.2%	100.0%	100.0%	930	908	1395	1440	620	620	310	310
Greyfriars, WLH	10	90%	89%	101.6%	101.1%	98.4%	103.2%	930	945	1395	1410	620	610	620	640
Montpellier WLH	12	99%	91%	79.0%	127.4%	100.0%	130.7%	1395	1103	1395	1778	620	620	620	810
Chestnut Ward, CLH	14	103%	97%	99.2%	99.0%	100.0%	103.2%	930	923	2325	2303	310	310	930	960
Mulberry Ward, CLH	18	98%	93%	100.0%	125.2%	100.0%	143.6%	930	930	1163	1455	310	310	620	890
Willow Ward, CLH	16	99%	96%	103.2%	118.8%	100.0%	100.0%	930	960	1395	1658	310	310	620	620
Berkeley House	7	99%	99%	114.5%	94.6%	135.5%	84.6%	930	1065	4650	4398	310	420	2790	2360
Honeybourne	11	91%	84%	78.5%	123.7%	100.0%	100.0%	698	548	698	863	310	310	310	310
Laurel House	13	101%	92%	86.0%	119.4%	100.0%	100.0%	698	600	698	833	310	310	310	310
Oak House	10	79%	73%	98.4%	103.2%	100.0%	100.0%	713	702	357	368	356.5	357	356.5	356.5
Mortimer Ward, SB	20	93%	86%	96.8%	198.9%	100.0%	196.8%	713	690	1070	2128	356.5	357	1069.5	2104.5
Jenny Lind Ward, SB	8	95%	90%	100.0%	124.0%	100.0%	100.0%	713	713	357	442	356.5	357	356.5	356.5
Cantilupe Ward, SB	11	82%	78%	100.0%	108.1%	100.0%	104.8%	1070	1070	713	771	713	713	713	747.5

	Agency	Workforce		Training/Supervision							
Wards	Agency Rate%	Turnover by WTE %	Sickness Absence - Trustwide Inpatient Target 4.5%	Appraisal Compliance %	Infection Control Training Compliance - Trustwide Target 90%	Level 2 Children Safeguarding Training Compliance Trustwide Target 90%	Level 2 Adults Safeguarding Training Compliance Trustwide Target 90%	Level 3 Children Safeguarding Training Compliance Trustwide Target 90%	Level 3 Adults Safeguarding Training Compliance Trustwide Target 90%	Statutory and Mandatory Training % - Trustwide Target 90%
Abbey Ward, WLH	**9.68%**	9.48%	9.38%	81.00%	93.80%	79.00%	100.00%	79.00%	100.00%	83%
Dean Ward, WLH	**17.88%**	10.65%	5.35%	100.00%	91.30%	71.00%	50.00%	71.00%	50.00%	77%
Kingsholm Ward, WLH	**4.14%**	2.82%	6.93%	79.00%	68.40%	90.00%	100.00%	90.00%	100.00%	90%
Priory Ward, WLH	**8.92%**	9.16%	6.68%	57.00%	95.50%	85.00%	100.00%	85.00%	100.00%	87%
Greyfriars, WLH	**14.84%**	2.82%	10.00%	88.00%	79.40%	85.00%	100.00%	85.00%	100.00%	88%
Montpellier WLH	**3.07%**	0.00%	7.64%	56.00%	76.50%	88.00%	100.00%	88.00%	100.00%	83%
Chestnut Ward, CLH	**5.50%**	3.52%	6.90%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	88%
Mulberry Ward, CLH	**1.53%**	7.65%	3.43%	76.00%	84.00%	83.00%	100.00%	83.00%	100.00%	83%
Willow Ward, CLH	**1.76%**	18.37%	7.33%	75.00%	75.00%	83.00%	100.00%	83.00%	100.00%	83%
Berkeley House	**4.08%**	10.52%	4.10%	98.00%	93.10%	87.00%	50.00%	87.00%	100.00%	85%
Honeybourne	**0.00%**	13.42%	5.64%	89.00%	90.00%	94.00%	100.00%	94.00%	100.00%	90%
Laurel House	**3.31%**	1.88%	7.01%	96.00%	80.80%	94.00%	100.00%	94.00%	67.00%	85%
Oak House	**0.64%**	0.00%	2.72%	71.00%	93.80%	92.00%	67.00%	92.00%	67.00%	91%
Mortimer Ward, SB	**9.58%**	16.62%	7.00%	61.00%	69.60%	65.00%	67.00%	65.00%	67.00%	73%
Jenny Lind Ward, SB	**13.54%**	15.28%	5.76%	100.00%	75.00%	100.00%	100.00%	100.00%	100.00%	94%
Cantilupe Ward, SB	**17.76%**	0.00%	6.51%	45.00%	78.60%	84.00%	50.00%	84.00%	100.00%	83%

Quality indicators (which may or may not be linked to nurse staffing)

Wards	Formal complaints	Medication incidents Total	Medication incidents resulting in harm	RT Incidents	MRSA Bacteraemia	Clostridium difficile infection (CDI)	Falls total	Falls *with harm	SIRIs	AWOLs of detained patients	AWOLs of detained patients * with harm	Prone Restraint	Supine Restraint	Total restraints * with harm	RAG Score: Green = 0 - 1 trigger Amber = 2 - 3 triggers Red = 4 or more triggers
Abbey Ward, WLH	3	24	0	47	0	0	23	4	0	27	0	21	6	1	
Dean Ward, WLH	2	18	4	50	0	0	17	3	0	6	0	28	7	10	
Kingsholm Ward, WLH	3	11	0	25	0	0	11	2	0	8	0	14	8	2	
Priory Ward, WLH	2	17	1	51	0	0	17	5	0	40	3	18	25	15	
Greyfriars, WLH	0	9	0	49	0	0	5	0	0	4	0	22	33	41	
Montpellier WLH	1	11	0	0	0	0	1	0	0	2	0	0	0	0	
Chestnut Ward, CLH	0	4	0	11	0	0	98	3	0	0	0	0	0	0	
Mulberry Ward, CLH	1	34	0	39	0	0	82	19	0	2	0	0	8	14	
Willow Ward, CLH	0	14	0	29	0	1	127	19	2	1	0	0	18	11	
Berkeley House	0	6	0	2	0	0	19	4	0	0	0	0	546*	479*	
Honeybourne	0	2	0	0	0	0	4	1	2	1	0	0	0	0	
Laurel House	0	18	1	0	0	0	5	2	0	0	0	0	0	0	
Oak House	0	0	0	0	0	0	1	0	0	2	0	0	0	0	
Mortimer Ward, SB	2	16	0	39	0	0	9	0	0	33	0	4	21	12	
Jenny Lind Ward, SB	0	12	0	10	0	0	5	2	0	4	0	1	1	2	
Cantilupe Ward, SB	0	8	0	44	0	0	33	3	1	0	0	5	1	2	

* = These relate to the reported episodes of restraint as captured on Datix. Due to the exceptionally high volume of interventions the absolute number of individual interventions is captured manually and much higher.
(reported "harms" are predominantly low level harm as described in accordance with national guidance and are manged and reported through Trust mechanisms)

Appendix 2 January 2019 – National safe staffing upload

NURSING STAFF FILL RATES	Day				Night				Day		Night		TOTAL STAFFING DAY/NIGHT		STAFF GROUP		CHPPD			
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - All staff DAY (%)	Average fill rate - All staff NIGHT (%)	Average fill rate - registered nurses/mid wives (%)	Average fill rate - care staff (%)	Midnight Occupancy	Registered nurses/ midwives	Care staff	Overall
Jan-2019	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours												
Gloucestershire																				
WL- Dean Ward	930	990	1395	2250	620	620	310	920	106.45%	161.29%	100.00%	296.77%	139.35%	165.59%	103.87%	185.92%	451	3.6	7.0	10.6
WL- Abbey Ward	1395	1313	930	1058	620	600	310	370	94.09%	113.71%	96.77%	119.35%	101.94%	104.30%	94.91%	115.12%	540	3.5	2.6	6.2
WL- Priory Ward	1395	1245	930	1118	620	620	310	400	89.25%	120.16%	100.00%	129.03%	101.61%	109.68%	92.56%	122.38%	538	3.5	2.8	6.3
WL- Kingsholm Ward	930	908	1395	1440	620	620	310	310	97.58%	103.23%	100.00%	100.00%	100.97%	100.00%	98.55%	102.64%	450	3.4	3.9	7.3
WL- Montpellier Unit	930	945	1395	1410	620	610	620	640	101.61%	101.08%	98.39%	103.23%	101.29%	100.81%	100.32%	101.74%	340	4.6	6.0	10.6
WL- Greyfriars PICU	1395	1103	1395	1778	620	620	620	810	79.03%	127.42%	100.00%	130.65%	103.23%	115.32%	85.48%	128.41%	302	5.7	8.6	14.3
CL - Willow Ward	930	923	2325	2303	310	310	930	960	99.19%	99.03%	100.00%	103.23%	99.08%	102.42%	99.40%	100.23%	492	2.5	6.6	9.1
CL - Chestnut Ward	930	930	1163	1455	310	310	620	890	100.00%	125.16%	100.00%	143.55%	113.98%	129.03%	100.00%	131.56%	430	2.9	5.5	8.3
CL - Mulberry Ward	930	960	1395	1658	310	310	620	620	103.23%	118.82%	100.00%	100.00%	112.58%	100.00%	102.42%	113.03%	506	2.5	4.5	7.0
WA - Laurel House	698	600	698	833	310	310	310	310	86.02%	119.35%	100.00%	100.00%	102.69%	100.00%	90.32%	113.40%	383	2.4	3.0	5.4
WA - Honeybourne	698	548	698	863	310	310	310	310	78.49%	123.66%	100.00%	100.00%	101.08%	100.00%	85.11%	116.38%	278	3.1	4.2	7.3
LD - Berkeley House	930	1065	4650	4398	310	420	2790	2360	114.52%	94.57%	135.48%	84.59%	97.89%	89.68%	119.76%	90.83%	199	7.5	34.0	41.4
Herefordshire																				
SB - Cantilupe Ward	713	690	1070	2128	356.5	357	1069.5	2104.5	96.77%	198.92%	100.00%	196.77%	158.06%	172.58%	97.85%	197.85%	284	3.7	14.9	18.6
SB - Jenny Lind Ward	713	713	357	442	356.5	357	356.5	356.5	100.00%	123.98%	100.00%	100.00%	107.99%	100.00%	100.00%	111.99%	240	4.5	3.3	7.8
SB - Mortimer Ward	1070	1070	713	771	713	713	713	747.5	100.00%	108.06%	100.00%	104.84%	103.23%	102.42%	100.00%	106.45%	563	3.2	2.7	5.9
WA - Oak House	713	702	357	368	356.5	357	356.5	356.5	98.39%	103.23%	100.00%	100.00%	100.00%	100.00%	98.92%	101.61%	277	3.8	2.6	6.4

Agenda item 10 **PAPER E**

Report to:	Trust Board, 27 March 2019
Author:	Matthew Edwards, Associate Director Quality Assurance & Transformation
Presented by:	John Trevains, Director of Quality
SUBJECT:	**CQC/Trust Quality Improvement Plan**

This Report is provided for:

Decision Endorsement **Assurance** **To note**

EXECUTIVE SUMMARY

- The 2018 CQC/Trust Quality Improvement Plan which had 11 "Must do "actions and 23 "Should do" actions have been reviewed and is now completed. The completion improvement plan has been discussed and agreed with our allocated CQC lead officers. We have now moved the ongoing work identified within the plan into our "business as usual" quality development/CQC compliance workstream.

- It should be noted that the Trust has a two-step procedure whereby "local assurance" is provided by the individual services; however, the Trust goes above this level of assurance and has implemented a second level of verification labelled "total assurance". The trust only gives full assurance of compliance when the action has had time to become embedded, and if necessary assurance has been provided that the action is being undertaken trust wide.

- All the "local assurance" scores are now green which means that they have been allocated a full assurance level and the organisation could close down the 2018 CQC action Plan.

- With regard to the total assurance Trust wide (the second additional level), there are at present 9 of the original 11 "Must do " actions currently allocated a "Full" assurance level of compliance and 2 being allocated a "Significant" level of assurance . Of the 23 original "Should do" recommendations 21 are now shown as having "Full" assurance

and 2 have been allocated a significant level of assurance.

- To gain further assurance in regard to the observations made by the CQC following their previous two visits to Berkeley House a comprehensive internal peer review has been carried out. The outcome of that internal peer review has found that the service is rated internally as Good overall.

- The remaining actions will now become "Business as Usual" on the Organisational TQI Action Plan and will be monitored and challenged via the QCR Sub Committee.

- The Trust is working with GCS colleagues to progress integration of CQC registration, compliance reporting and work towards the merged organisation achieving "outstanding" regulatory compliance status.

- Regular face to face meetings with the CQC are in place where progress is reported and issues discussed. Our CQC lead officers' feedback positively that have no significant areas of concern about our Trust and that we are considered responsive and proactive regarding quality issues.

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RECOMMENDATIONS

The Board are asked to:

- Note the progress achieved by the CQC/TQI Project Group and to agree the transfer of monitoring of the remaining actions to the QCR Sub Committee as 'business as usual'.

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Corporate Considerations	
Quality implications	Adherence to CQC regulations and recommendations is essential to assuring delivery of quality services for users and their families
Resource implications:	These have been included in Capital Budgets.
Equalities implications:	Adherence to CQC regulations and recommendations is essential to assuring delivery of quality services for users and their families
Risk implications:	Compliance with CQC outcomes is core business; if the organisation is found by CQC to be non-compliant then there

	may be concerns regarding safety and quality of our services for users and their families. In addition this can lead to regulatory action taken which impacts on the governance rating given by Monitor

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

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

Reviewed by: John Trevains Director Of Quality		
	Date	19/03/2019

Where in the Trust has this been discussed before?		
Governance Committee QCR Sub Committee	Date	Quarterly reporting March 2019

What consultation has there been?		
Trust wide Communications	Date	

Explanation of acronyms used:	CQC - Care Quality Commission QCR - Quality and Clinical Risk Sub Committee TQI - Trust Quality Improvement 2gft - ^{2}gether NHS Foundation Trust GCS – Gloucestershire Care Services

1. Context

1.1 Following the last CQC inspection in 2018 a CQC/TQI project plan was produced which outlined both the ‘Must do’ and ‘Should do’ recommendations that were provided as feedback following this inspection.

1.2 It should be noted that the organisation has a two-step procedure whereby “local assurance” is provided by the individual services; however, the Trust goes above this level of assurance and has implemented a second level of verification labelled “total assurance”. The trust only gives full assurance of compliance when the action has had

time to become embedded, and if necessary assurance has been provided that the action is being undertaken trust wide.

1.3 This paper details the 'must do' actions and the 'should do' actions where the Trust has reached in regard to addressing those actions and the continuing work being undertaken, where necessary, to achieve this.

2. Current position

Trust wide assurance

2.1 Following the 2018 CQC inspection there were 11 'must do' actions and 23 'should do' actions that required further consideration. Appendix 1 details a full action plan which outlines actions and assurance received. From that number, at the time of writing this report, there are 2 'must do' actions outstanding and 2 'should do' actions outstanding. A breakdown of each of the identified actions, a description of actions taken and current assurance can be found in Table 1.

Must do/should do actions outstanding	Local assurance	Total assurance	Remedial action
The trust must ensure that staff on Jenny Lind ward have access to regular supervision sessions and team meetings, as in line with the trust policy. (Regulation 18) Audit of supervision policy compliance.			• The facility to enter the details of supervision sessions have been added to learn 2gether and is at present being tested in order to be rolled out Trust wide from 1st April, this will enable electronic data capture in the future. Intention is to add to Quality Dashboard. Monitoring of this work stream has transferred to business as usual via QCR. • Clinical Audit to be undertaken in Q1 2019. Monitoring of this work stream has transferred to business as usual via QCR.

The trust must ensure there is appropriate soundproofing to maintain confidentiality at the Linden centre and Park House. (Regulation 10)			• Approval for work granted in Feb 2019, Quotes to be obtained in March 2019 and anticipated works complete April 2019.Monitoring transferred to business as usual via estates quarterly monitoring review.
The trust should ensure that staff always offer patients a copy of their care plan, and document they have done so.			• Reporting to be moved to business as usual and to be included in the Quality Care and Safety committee quarterly report utilising the ACM dashboard to monitor improvement. • RiO trainers to ensure that all staff are shown how to record this on the clinical system in order for this to be reflected on the ACM dashboard.
The trust should ensure that the staff update the risk assessments regularly in patient records.			• Monitoring continues through the ACM dashboard and identified within the 5 trajectory priorities around recording within the clinical record. Reporting against this occurs regularly within the QCR committee. • Reporting to be moved to business as usual and to be included in the QCR quarterly report

Table 1

2.2 It should be noted that all the “local assurance” scores are now green which means that the organisation can close down the 2018 CQC action Plan. To provide assurance regarding this the overall CQC action plan was reviewed by the Assistant Director of Quality Assurance and Transformation, Quality Assurance Manager and Compliance Manager considering what is known to have been achieved based on the evidence available.

Berkeley House assurance

2.3 To address the observations made by the CQC following their 2018 inspection a comprehensive internal peer review has been carried out within Berkeley House. The comprehensive internal peer review objectives were to review the range and availability of interventions offered by the Berkeley House Team and to evaluate the quality of the records available for its inpatients. This would assist in making a judgement as to whether the must do and should do actions made following the last CQC comprehensive review had been implemented. The review team used a combination of Key Lines of Enquiry (KLOE's) outlined within the CQC inspection guidelines which have been locally selected to reflect the observations made following the 2015 and 2018 CQC inspections. This also included the recommendations made following the last internal peer review. To enhance the process and see the unit from a service user perspective the internal review also included an adapted 15 step challenge structure within it. This was adapted to ensure that Experts by Experience could participate fully in this process.

2.4 Berkeley House had 5 'must do' actions and 11 'should do actions'. It should be noted that there are now no outstanding 'must do' or 'should do' actions for Berkeley House. This outcome was confirmed through a rigorous internal review process as described above.

2.4 The review of the service and the report in relation to the findings has now been completed and the findings confirm that the observations made by the CQC have now been fully addressed with significant assurance being gained from this. Internally the service was rated as Good overall. The report was reviewed by the Assistant Director of Quality Assurance and Transformation, Quality Assurance Manager and Compliance Officer to ensure that all CQC recommendations had been addressed and that the evidence that supported this was robust. This was confirmed and at that point full assurance was allocated and it was agreed that ongoing monitoring of Berkeley House should become 'business as usual'.

2.5 The recommendations included within the peer review report suggest that the service should now strive to achieve an outstanding rating in keeping with the aspirations

within the wider organisation and will be included within the Trusts wider improvement plan.

3.0 Next steps

3.1 The board are asked to note the contents of this report and the level of assurance that it provides.

3.2 The trust is currently reviewing it Quality Improvement Plan moving forward with a view to achieving an outstanding rating with the CQC. To support this, the Trust is currently facilitating a joint (2GFT and GCS) internal CQC meeting as it moves toward the merger of the two organisations. This is chaired by the Director of Quality and other key stakeholders within the respective organisations to ensure that the newly merged organisation strives to achieve an outstanding rating with the CQC.

3.3 To support this process the Trust is currently approaching service Directors to identify the next round of internal peer reviews. In doing so priorities will be identified in regard to where further assurance is required to meet the standards expected of an outstanding service and organisation.

Agenda item 11 Paper F

Report to: Trust Board – 27th March 2019
Author: Chris Woon, Head of Information Management and Clinical Systems
Presented by: John Campbell, Director of Service Delivery

SUBJECT: **Performance Dashboard Report for the period to the end of January 2019 (month 10)**

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

EXECUTIVE SUMMARY:

Overview

This month's report sets out the performance of the Trust's Clinical Services for the period to the end of January 2019 (month (10) of the 2018/19 contract period, against our NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

Of the 194 performance indicators, 94 are reportable in January with 88 being compliant and 6 non-compliant at the end of the reporting period.

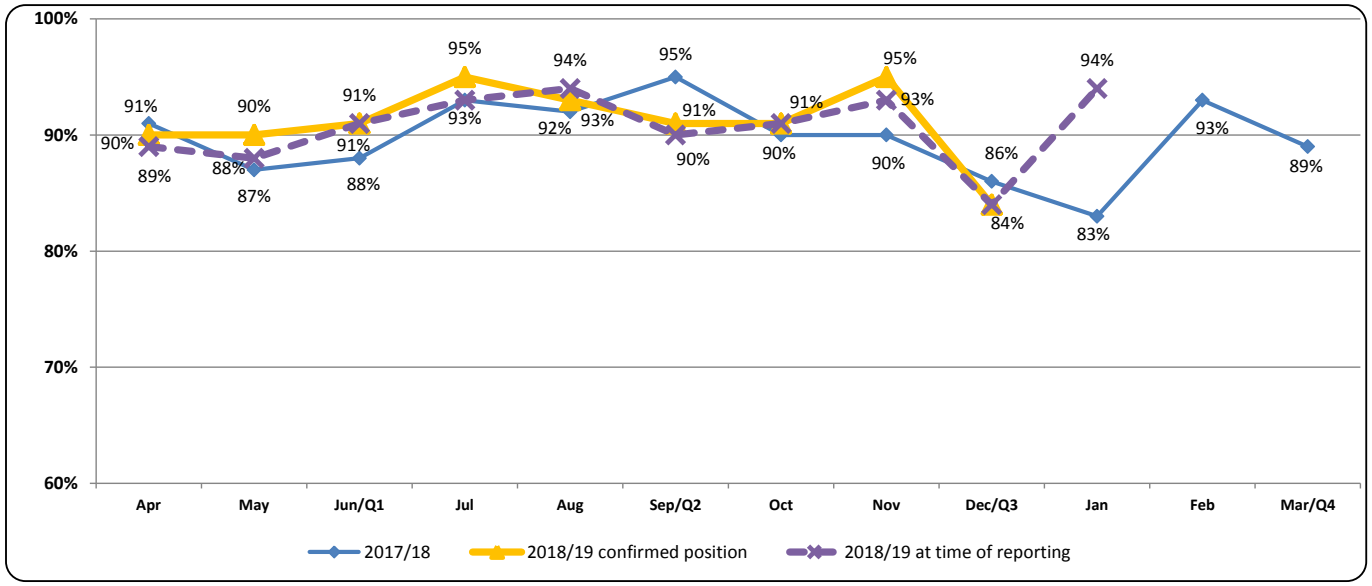
Where performance is not compliant, Service Directors are taking the lead to address issues and work is ongoing in accordance with our agreed Service Delivery Improvement Plans to address the underlying issues affecting this performance.

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

The following table summarises our performance position as at the end of January 2019 for each of the KPIs within each of the reporting categories.

Indicators Reported in Month and Levels of Compliance							
Indicator Type	Total Measures	Reported in Month	Compliant	Non Compliant	% non-compliance	Not Yet Required or N/A	NYA
NHSi Requirements	14	13	13	0	0	1	0
Never Events	17	17	17	0	0	0	0
Department of Health	10	8	8	0	0	2	0
Gloucestershire CCG Contract	89	26	22	4	15	62	1
Social Care	15	13	12	1	8	2	0
Herefordshire CCG Contract	24	17	16	1	6	7	0
CQUINS	25	0	0	0	0	25	0
Overall	194	94	88	6	6	99	1

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



The confirmed positions for November and December have not changed since December's report, however the confirmed position for October has increased due to the following indicator now being reported as compliant for this month:

- 3.37: Percentage of crisis assessments undertake by MHARS on CYP age 16-25

Although performance isn't necessarily of current concern, the following key performance areas remain a priority for the Trust as they have the potential to carry contractual, financial, reputational or quality risk:

- Under 18 admissions to Adult Inpatient Wards (2.21)
- Improving Access to Psychological Therapies (IAPT)
  - Recovery (3.17, 5.08), Access (3.18, 5.09a) & Waiting times (1.09 & 1.10)
- CYPS/ CAMHS Level 2 and 3 Referral to Treatment waiting times (3.26 & 3.27)
- Eating Disorders (ED) Waiting times (3.63, 3.64, 3.65, 3.67 & 3.68)

Summary Exception Reporting

The following 6 key performance thresholds were not met for the Trust for January 2019:

Gloucestershire CCG Contract Measures

- 3.63 – Adolescent Eating Disorders – Routine referral to NICE treatment within 4 weeks
- 3.64 – Adolescent Eating Disorders – Routine referral to Non-NICE treatment within 4 weeks
- 3.67 – Adult Eating Disorders: Wait time for assessments will be 4 weeks
- 3.68 – Adult Eating Disorders: Wait time for psychological interventions will be 16 weeks

Gloucestershire Social Care Measures

- 4.10 – Percentage of services users with a Personal Budget receiving Direct payments

Herefordshire CCG Contract Measures

- 5.07 – VTE (Venous Thromboembolism) risk assessment for all inpatients

RECOMMENDATIONS

The Delivery Committee is asked to:

- Note the Performance Dashboard Report for January 2019.
- Accept the report as a significant level of assurance that our contract and regulatory performance measures are being met or that appropriate action plans are in place to address areas requiring improvement.
- Be assured that there is ongoing work to review all of the indicators not meeting the required performance threshold. This includes a review of the measurement and data quality processes as well as clinical delivery and clinical practice issues.

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

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

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

Reviewed by:		
John Campbell	Date	February 2019

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

What consultation has there been?		
Not applicable.	Date	

Explanation of acronyms used:	
	AKI Acute kidney injury ARFID Avoidant restrictive food intake disorder ASCOF Adult Social Care Outcomes Framework CAMHS Child and Adolescent Mental health Services C-Diff Clostridium difficile CLDT Community Learning Disability Teams CPA Care Programme Approach CQUIN Commissioning for Quality and Innovation CRHT Crisis Home Treatment CSM Community Services Manager CYPS Children and Young People's Services DNA Did not Attend ED Emergency Department EI Early Intervention EWS Early warning score GARAS Gloucestershire Action for Refugees and Asylum Seekers HoNoS Health of the Nation Outcome Scale IAPT Improving Access to Psychological Therapies IST Intensive Support Team (National IAPT Team) KPI Key Performance Indicator LD Learning Disabilities MHARS Mental Health Acute Response Service MHL Mental Health Liaison MRSA Methicillin-resistant Staphylococcus aureus MUST Malnutrition Universal Screening Tool NHSI NHS Improvement NICE National Institute for Health and Care Excellence PBS Personal Behaviour Support plan PICU Psychiatric Intensive Care Unit SI Serious Incident SUS Secondary Uses Service VTE Venous thromboembolism YOS Youth Offender's Service

1. CONTEXT

This report sets out the performance Dashboard for the Trust for the period to the end of January 2019, month 10 of the 2018/19 contract period.

1.1 The following sections of the report include:

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

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

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

2.1 The following tables outline the performance in each of the performance categories within the Dashboard as at the end of January 2019. Where indicators have not been met during the reporting period, an explanation is provided relating to the non-achievement of the Performance Threshold and the action being taken to rectify the position.

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

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

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

DASHBOARD CATEGORY - NHSI REQUIREMENTS

NHS Improvement Requirements				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	14	14	14	14
	0	0	0	0
	13	13	13	13
NYA	0	0	0	0
NYR	0	0	0	0
N/A	1	1	1	1

Performance Thresholds not being achieved in Month

None

Cumulative Performance Thresholds Not being Met

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

Changes to Previously Reported Figures

None

Early Warnings / Notes

None

NHS Improvement Requirements

ID	Performance Measure (PM)		2017/18 Outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
1								
1.01	Number of MRSA Bacteraemias	PM	0	0	0	0	0	0
		Gloucestershire	0	0	0	0	0	
		Herefordshire	0	0	0	0	0	
		Combined Actual	0	0	0	0	0	
1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	<3	0
		Gloucestershire	0	0	0	0	0	
		Herefordshire	0	0	0	0	0	
		Combined Actual	0	0	0	0	0	
1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	99%	98%	97%	100%	98%	
		Herefordshire	99%	100%	100%	100%	99%	
		Combined Actual	99%	99%	97%	100%	98%	
1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	98%	99%	98%	98%	98%	
		Herefordshire	98%	99%	99%	98%	98%	
		Combined Actual	98%	99%	98%	98%	98%	
1.05	Nationally reported - Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Gloucestershire	3.2%	4.5%	1.4%	1.1%	2.7%	
		Herefordshire	2.4%	2.7%	2.8%	5.4%	2.1%	
		Combined Actual	3.0%	4.1%	1.7%	2.1%	2.6%	
1.05b	- Delayed Discharges - Outliers	PM						
		Gloucestershire	10.1%	8.1%	9.4%	6.6%	7.8%	
		Herefordshire	12.5%	3.6%	5.0%	0.7%	2.9%	
		Combined Actual	10.7%	7.1%	8.3%	5.2%	6.6%	
1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	99%	97%	100%	97%	99%	
		Herefordshire	100%	100%	100%	100%	100%	
		Combined Actual	99%	98%	100%	98%	99%	
1.07	New psychosis (EI) cases as per contract	PM	72	48	54	60	60	72
		Gloucestershire	80	63	70	82	82	
		PM	24	16	18	20	20	24
		Herefordshire	31	19	20	22	22	
		PM	96	64	72	80	80	96
		Combined Actual	111	82	90	104	104	
1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	53%	53%	53%	53%	53%
		Gloucestershire	71%	67%	71%	75%	70%	
		Herefordshire	68%	100%	100%	100%	86%	
		Combined Actual	70%	73%	75%	79%	73%	

NHS Improvement Requirements

ID	Performance Measure (PM)		2017/18 Outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Gloucestershire	69%	99%	99%	99%	97%	
		Herefordshire	59%	99%	99%	98%	93%	
		Combined Actual	67%	99%	99%	99%	96%	
1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	88%	99%	99%	99%	98%	
		Herefordshire	75%	99%	99%	100%	94%	
		Combined Actual	85%	99%	99%	99%	98%	
1.11	**MENTAL HEALTH SERVICES DATA SET PART 1 DATA COMPLETENESS: OVERALL**	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%	
1.11a	Mental Health Services Data Set Part 1 Data completeness: DOB	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	100.0%	100.0%	100.0%	100.0%	100.0%	
		Herefordshire	100.0%	100.0%	100.0%	100.0%	100.0%	
		Combined Actual	100.0%	100.0%	100.0%	100.0%	100.0%	
1.11b	Mental Health Services Data Set Part 1 Data completeness: Gender	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%	
1.11c	Mental Health Services Data Set Part 1 Data completeness: NHS Number	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	100.0%	100.0%	100.0%	99.9%	
		Herefordshire	99.9%	100.0%	100.0%	100.0%	100.0%	
		Combined Actual	99.9%	100.0%	100.0%	100.0%	99.9%	
1.11d	Mental Health Services Data Set Part 1 Data completeness: Organisation code of commissioner	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	100.0%	100.0%	100.0%	100.0%	100.0%	
		Herefordshire	100.0%	100.0%	100.0%	100.0%	100.0%	
		Combined Actual	100.0%	100.0%	100.0%	100.0%	100.0%	
1.11e	Mental Health Services Data Set Part 1 Data completeness: Postcode	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.8%	99.8%	99.7%	99.7%	99.8%	
		Herefordshire	99.9%	99.7%	99.7%	99.7%	99.8%	
		Combined Actual	99.8%	99.7%	99.7%	99.7%	99.8%	
1.11f	Mental Health Services Data Set Part 1 Data completeness: GP Practice	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.6%	99.7%	99.7%	99.6%	99.6%	
		Herefordshire	99.7%	99.9%	99.9%	99.9%	99.9%	
		Combined Actual	99.7%	99.7%	99.7%	99.7%	99.7%	

NHS Improvement Requirements

ID	Performance Measure (PM)		2017/18 Outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
1.12	**MENTAL HEALTH SERVICES DATA SET PART 2 DATA COMPLETENESS : OVERALL**	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	94.7%	96.4%	96.6%	96.7%	96.6%	
		Herefordshire	90.9%	89.2%	88.5%	88.8%	89.8%	
		Combined Actual	94.1%	95.3%	95.4%	95.5%	95.6%	
1.12a	Mental Health Services Data Set Part 2 Data completeness: CPA Employment status last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	89.4%	94.5%	94.8%	94.8%	94.9%	
		Herefordshire	86.4%	82.2%	81.0%	81.4%	82.5%	
		Combined Actual	88.9%	92.7%	92.7%	92.8%	93.1%	
1.12b	Mental Health Services Data Set Part 2 Data completeness: CPA Accommodation Status in last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	96.6%	96.2%	96.4%	96.6%	96.6%	
		Herefordshire	87.1%	87.7%	86.4%	86.5%	88.0%	
		Combined Actual	94.9%	94.9%	94.9%	95.0%	95.3%	
1.12c	Mental Health Services Data Set Part 2 Data completeness: CPA HoNOS assessment in last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	98.2%	98.5%	98.6%	98.6%	98.3%	
		Herefordshire	99.2%	97.7%	98.2%	98.6%	98.8%	
		Combined Actual	98.4%	98.4%	98.6%	98.6%	98.4%	
1.13	Learning Disability Services: 6 indicators: identification of people with a LD, provision of information, support to family carers, training for staff, representation of people with LD; audit of practice and publication of findings	PM	6	6	6	6	6	6
		Gloucestershire	6	6	6	6	6	
		Herefordshire	6	6	6	6	6	
		Combined Actual	6	6	6	6	6	

DASHBOARD CATEGORY – DEPARTMENT OF HEALTH PERFORMANCE

DoH Performance				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	27	27	27	27
🔴	0	1	0	1
🟢	25	24	25	25
NYA	0	0	0	0
NYR	1	1	1	0
N/A	1	1	1	1

Performance Thresholds not being achieved in Month

None

Cumulative Performance Thresholds Not being Met

2.21: No children under 18 admitted to adult inpatient wards

To date there have been 5 admissions of under 18s to adult wards, 2 in Gloucestershire and 3 in Herefordshire. There were 11 admissions of under 18s in 2017/18.

Changes to Previously Reported Figures

None

Early Warnings

None

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

2.21: No children under 18 admitted to adult inpatient wards

Unfortunately the annual performance threshold is zero and it has not been met therefore the performance for the year will be non-compliant. Historic performance indicates that without changes in the tier 4 services arrangements - outside of the remit of ^{2}gether - we will not be able to meet this indicator.

DOH Never Events

ID	Performance Measure (PM)		2017/18 Outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
2								
2.01	Wrongly prepared high risk injectable medications	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.02	Maladministration of potassium containing solutions	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.03	Wrong route administration of oral/enteral treatment	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.04	Intravenous administration of epidural medication	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.05	Maladministration of insulin	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.06	Overdose of midazolam during conscious sedation	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.07	Opioid overdose in opioid naive patient	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.08	Inappropriate administration of daily oral methotrexate	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.09	Suicide using non collapsible rails	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.10	Falls from unrestricted windows	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.11	Entrapment in bedrails	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.12	Misplaced naso - or oro-gastric tubes	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.13	Wrong gas administered	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.14	Failure to monitor and respond to oxygen saturation - conscious sedation	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.15	Air embolism	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.16	Severe scalding from water for washing/bathing	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.17	Mis-identification of patients	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	

DOH Requirements

ID	Performance Measure (PM)		2017/18 Outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
2.18	Mixed Sex Accommodation - Sleeping Accommodation Breaches	PM	0	0	0	0	0	0
		Gloucestershire	0	0	0	0	0	
		Herefordshire	0	0	0	0	0	
		Combined	0	0	0	0	0	
2.19	Mixed Sex Accommodation - Bathrooms	Gloucestershire	Yes	Yes	Yes	Yes	Yes	
		Herefordshire	Yes	Yes	Yes	Yes	Yes	
		Combined	Yes	Yes	Yes	Yes	Yes	
2.20	Mixed Sex Accommodation - Women Only Day areas	Gloucestershire	Yes	Yes	Yes	Yes	Yes	
		Herefordshire	Yes	Yes	Yes	Yes	Yes	
		Combined	Yes	Yes	Yes	Yes	Yes	
2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0	0
		Gloucestershire	6	0	2	0	2	
		Herefordshire	5	0	0	0	3	
		Combined	11	0	2	0	5	
2.22	Failure to publish Declaration of Compliance or Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	Gloucestershire	Yes	Yes	Yes	Yes	Yes	
		Herefordshire	Yes	Yes	Yes	Yes	Yes	
		Combined	Yes	Yes	Yes	Yes	Yes	
2.23	Publishing a Declaration of Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	Gloucestershire	Yes	Yes	Yes	Yes	Yes	
		Herefordshire	Yes	Yes	Yes	Yes	Yes	

DOH Requirements

ID	Performance Measure (PM)		2017/18 Outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
2.24	Serious Incident Reporting (SI)	Glos	33	4	3	1	21	
		Hereford	18	2	0	2	10	
2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	100%	100%	100%	100%	100%	
		Herefordshire	100%	100%	N/A	100%	100%	
2.26	Interim report for all SIs received within 5 working days of identification (unless extension granted by CCG)	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	100%	100%	100%	100%	100%	
		Herefordshire	100%	100%	N/A	100%	100%	
2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	100%	NYR	NYR	NYR	100%	
		Herefordshire	100%	NYR	NYR	NYR	100%	
2.28	SI Report Level 3 - Independent investigations - 6 months from investigation commissioned date	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	N/A	N/A	N/A	N/A	N/A	
		Herefordshire	N/A	N/A	N/A	N/A	N/A	
2.29	SI Final Reports outstanding but not due	Gloucestershire	5	4	3	1	9	
		Herefordshire	2	2	0	2	5	

DASHBOARD CATEGORY – GLOUCESTERSHIRE CCG CONTRACTUAL REQUIREMENTS

Gloucestershire Contract				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	89	89	89	89
🔴	3	16	4	18
🟢	21	29	22	33
NYA	1	12	1	8
NYR	59	21	59	19
N/A	5	11	3	11

Definition Note

3.64: Adolescent Eating Disorders: Routine referral to Non-NICE treatment within 4 weeks
3.66: Adolescent Eating Disorders: Urgent referral to Non-NICE treatment within 1 week

"*Non-NICE treatment*" is a locally defined term used to transparently present all intervention activity within our Eating Disorder (ED) services such as Avoidant/ Restrictive Food Intake Disorder (ARFID). Due to the lack of NICE treatment codes for certain interventions this activity would otherwise be lost or incorrectly impact our NICE performance indicators. There are low incidences of non-NICE treatments (hence the common recording of Not Applicable).

Performance Thresholds not being achieved in Month

3.63: Adolescent Eating Disorders–Routine referral to NICE treatment within 4 weeks
3.64: Adolescent Eating Disorders–Routine referral to Non- NICE treatment within 4 weeks

There were 9 non-compliant cases in January: The service is looking into the effect a large increase in referrals in both December and January (63% on same period last year) will have on the current trajectory model.

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

3.68: Adult Eating Disorders: Wait time for psychological interventions will be 16 weeks

Work has been carried out to remodel the Adult pathway and understand the increase in demand on the service.

Based on the current trajectory model, we anticipate that these indicators will be compliant before the end of this financial year.

Cumulative Performance Thresholds Not being Met

3.21: To send Inpatient discharge summaries electronically within 24 hours to GPs

Matrons of Wotton Lawn Hospital, Charlton Lane Hospital, and Gloucester Recovery Units continue to raise awareness to improve the process.

3.26 & 3.27: CYPS: Referral to treatment within 8 & 10 weeks

We are non-compliant for Quarters 1, 2 and 3 of this financial year. Work is ongoing within our service delivery team to resolve.

3.35: Care plan audit to show all dependent children and under 18s living with adults

This is one of four targeted areas for improvement which the Trust is taking forward. Trust Service Directors continue to be given trajectories for improvement which will be monitored through the Delivery Committee. Audit results will be shared with Service Directors to help inform this improvement work.

3.36: CYPS Transition to Adult (Recovery) Service

There is 1 non-compliant case recorded in Quarter 1, 3 non-compliant cases recorded in Quarter 2 and 2 non-compliant cases recorded in Quarter 3.

These cases have been investigated and are due to erroneous data entry. All clinical interventions were completed in the required time. We do not propose amending these cases on RiO due to the complexity and time required by the clinical service and clinical systems team to correct all the relevant entries.

For all cases there is assurance from the service that there was no risk to the client.

3.53 - 3.55: Patients with Dementia have weight assessments on admission, at weekly intervals and near discharge.

Weight recording is embedded into clinical practice but further methodology improvements are being introduced to better represent clinical service delivery. The clinical systems team have added recording options to RIO to capture the instances within the clinical system when it has not been clinically appropriate to weigh a patient. Reporting on these has started in Quarter 4.

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

3.65: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week
This indicator is compliant for both November and December and January, but is cumulatively non-compliant due to previous month's performance before the implementation plan began to take effect.

3.67: Adult Eating Disorders: Wait time for assessments will be 4 weeks
3.68: Adult Eating Disorders: Wait time for psychological interventions will be 16 weeks
A responsive implementation plan has been developed to improve wait times. The recruitment element of this is complete and waiting times have begun to reduce as more patients will be assessed and treated.

Based on our current trajectory model, we anticipate that these indicators will be compliant before the end of this financial year.

3.70: Patients on the LD Challenging behaviour pathway have a single positive behaviour support plan within 30 days (CLDT: 60 days)
This remains difficult to monitor and actively manage as there is not yet an automated way to know who is on the Behaviour Pathway. Alterations to RiO to allow this are expected in the next financial year.

For Quarter 3 a manual audit of 40 files found 5 people on the challenging behaviour pathway. Of these, 2 clients had been put onto the pathway since April 2018 with a PBS plan being on RiO for 1 of these. Performance is therefore reported at 50% against a threshold of 60%. Records show that for the case without a PBS plan the clinicians remain engaged with family and carers in formulating the PBS plan.

3.78 Perinatal: Urgent referrals with High Risk Indicators seen within 48 working hours
There were 2 non-compliant cases in Quarter 2. 1 case was incorrectly recorded as an urgent case and due to complexity of correcting on RiO will not be amended. The other case was seen within 48 hours and 28 minutes. The service has confirmed that there was no risk to the client.

3.80: Perinatal preconception advice: Referral to assessment within 8 weeks

There have been 3 cases where assessment did not take place within 8 weeks.

During Quarter 2, one client was seen within 9 weeks due to a shortage of staff. The client was under the care of the Recovery service and therefore was not at risk.

During Quarter 3, there were 2 cases. Both clients were offered an appointment within the required time-frame but chose not to take these appointments and were seen outside of the required time. There was no clinical risk to either of these clients.

3.83: Perinatal: Number of women asked if they have a carer
Staff are being asked to complete missing assessments and to ensure that information is recorded for all women on the caseload. This indicator is impacted by clients that are referred to the Perinatal Team from other services where carer information has not been already been completed.

3.84: Perinatal: Number of women with a carer offered a carer's assessment
Staff are being asked to complete missing assessments and to ensure carers go on to have a carer's assessment. This indicator is impacted by clients that are referred to the Perinatal Team from other services where this information has not already been completed.

Changes to Previously Reported Figure

3.37: Percentage of crisis assessments undertake by MHARS on CYP age 16-25
The 1 non-compliant record recorded for October was due to a data entry error. This has been corrected on RiO and this indicator can now be reported as compliant for October.

Early Warnings/Notes

None

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

3.18 IAPT Access rate:
Following discussions with Gloucestershire Commissioners, the expected access rate for 2018/19 has been lowered from 19% to 17%. We are forecasting that we will be compliant at the end of 2018/19.

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Access Target	1.25%	1.29%	1.33%	1.40%	1.42%	1.42%	1.42%	1.42%	1.42%	1.42%	1.42%	1.42%
Actual	1.29%	1.33%	1.30%	1.41%	1.45%	1.49%	1.62%	1.53%	1.17%	1.50%		
Access Target year	15.00%	15.50%	16.00%	16.80%	17.00%	17.00%	17.00%	17.00%	17.00%	17.00%	17.00%	17.00%
Actual	15.48%	15.96%	15.60%	16.92%	17.40%	17.88%	19.44%	18.36%	14.04%	18.00%		

3.21: To send Inpatient discharge summaries electronically within 24 hours to GP
The performance threshold is 100% and as not met in Quarters 1, 2 and 3; performance for 2018/19 will be non-compliant.

3.26 & 3.27 CYPS: Referral to treatment within 8 & 10 weeks
Although work is ongoing and issues being addressed the trajectory produced has indicated that we will not achieve compliance until April 2020.

3.53 - 3.55: Patients with Dementia have weight assessments on admission, at weekly intervals and near discharge.

This is the first year this indicator has been reported, therefore, although we are optimistic, it is too early to predict whether we will be compliant at the end of the Financial Year.

3.63 – 3.65: Adolescent Eating Disorders: Waiting Times

Based on our current trajectory model we anticipate that these indicators will be compliant before the end of this financial year. We would like to test this model against actual performance over the next few months before we update the forecast to compliant.

3.67 – 3.68: Adult Eating Disorders: Waiting times

As above

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
	B. NATIONAL QUALITY REQUIREMENTS							
3.01	Zero tolerance MRSA	PM	0	0	0	0	0	0
		Unavoidable	0	0	0	0	0	
3.02	Minimise rates of Clostridium difficile	PM	0	0	0	0	<3	<3
		Unavoidable	0	0	0	0	1	
3.03	Duty of candour	PM	Report	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant	Compliant	Compliant	
3.04	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS,	PM	99%	99%	99%	99%	99%	99%
		Actual	100%	100%	100%	100%	99%	
3.05	Completion of Mental Health Services Data Set ethnicity coding for all detained and informal Service Users	PM	90%	90%	90%	90%	90%	90%
		Actual	99%	98%	100%	100%	99%	
3.06	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	PM	90%	90%	90%	90%	90%	90%
		Actual	99%	99%	99%	99%	99%	
	C. Local Quality Requirements							
	Domain 1: Preventing People dying prematurely							
3.07	Increased focus on suicide prevention and reduction in the number of reported suicides in the community and inpatient units	PM	Report				Annual	Report
		Actual	28				NYR	
3.08	To reduce the numbers of detained patients absconding from inpatient units where leave has not been granted	PM	< 144		< 36		<108	< 144
		Actual	122		35		93	
3.09	Compliance with NICE Technology appraisals within 90 days of their publication and ability to demonstrate compliance through completion of implementation plans and costing templates.	PM	Report				Annual	Annual
		Actual	N/A				NYR	
	Domain 2: Enhancing the quality of life of people with long-term conditions							
3.10	2G bed occupancy for Gloucestershire CCG patients	PM	> 91%	> 91%	> 91%	> 91%	> 91%	> 91%
		Actual	93%	96%	95%	96%	95%	
3.11	Care Programme Approach: 95% of CPAs should have a record of the mental health worker who is responsible for their care	PM	95%	95%	95%	95%	95%	95%
		Actual	100%	100%	100%	100%	100%	
3.12	CPA Review - 95% of those on CPA to be reviewed within 1 month (Review within 13 months)	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	99%	100%	100%	99%	
3.13	Assessment of risk: % of those 2g service users on CPA to have a documented risk assessment	PM	95%		95%		95%	95%
		Actual	99%		99%		99%	
3.14	Assessment of risk: All 2g service users (excluding those on CPA) to have a documented risk assessment	PM	85%		85%		85%	85%
		Actual	97%		95%		96%	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
3.15	People within the memory assessment service with a working diagnosis of dementia to have a care plan within 4 weeks of diagnosis	PM	85%	85%	85%	85%	85%	85%
		Actual	93%	98%	95%	97%	94%	
3.16	AKI (previous CQUIN 1516) 95% of pts to have EWS score within 12 hours	PM	95%		95%		95%	95%
		Actual	98%		100%		99%	
	Domain 3: Helping people to recover from episodes of ill-health or following injury							
3.17	IAPT recovery rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%	50%
		Actual	51%	50%	51%	51%	52%	
3.18	IAPT access rate: Access to psychological therapies for adults should be improved	PM	15.00%	1.42%	1.42%	1.42%	17.00%	17.00%
		Actual	13.32%	1.53%	1.17%	1.50%	18.00%	
3.19	IAPT reliable improvement rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%	50%
		Actual	70%	67%	69%	69%	67%	
3.20	Care Programme Approach (CPA): The percentage of people with learning disabilities in inpatient care on CPA who were followed up within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Actual	100%	NA	NA	NA	NA	
3.21	To send :Inpatient and day case discharge summaries electronically, within 24 hours to GP	PM	Report		100%		100%	Report
		Actual	93%		83%		88%	
	Domain 4: Ensuring that people have a positive experience of care							
3.22	To demonstrate improvements in staff experience following any national and local surveys	PM	Report				Annual	Annual
		Actual	Compliant				NYR	
3.23	Number of children in crisis urgently referred that receive support within 24 hours of referral by CYPS	PM	95%		95%		95%	95%
		Actual	100%		N/A		100%	
3.24	Children and young people who enter a treatment programme to have a care coordinator - (Level 3 Services) (CYPS)	PM	98%	98%	98%	98%	98%	98%
		Actual	99%	98%	98%	98%	99%	
3.25	95% accepted referrals receiving initial appointment within 4 weeks (excludes YOS, substance misuse, inpatient and crisis/home treatment and complex engagement) (CYPS)	PM	95%		95%		95%	95%
		Actual	98%		96%		96%	
3.26	Level 2 and 3 – Referral to treatment within 8 weeks , excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	80%		80%		80%	80%
		Actual	78%		40%		43%	
3.27	Level 2 and 3 – Referral to treatment within 10 weeks (excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	95%		95%		95%	95%
		Actual	86%		46%		49%	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
3.28	Adults of working age - 100% of MDT assessments to have been completed within 4 weeks (or in the case of a comprehensive assessment commenced within 4 weeks)	PM	85%	85%	85%	85%	85%	85%
		Actual	90%	99%	98%	93%	93%	
	Vocational Services (Individual Placement and Support)							
3.29	100% of Service Users in vocational services will be supported to formulate their vocational goals through individual plans (IPS)	PM	98%		98%		98%	98%
		Actual	100%		NYA		100%	
3.30	The number of people on the caseload during the year finding paid employment or self-employment (measured as a percentage against accepted referrals into the (IPS) Excluding those in employment at time of referral - Annual	PM	50%				50%	50%
		Actual	NYA				NYR	
3.31	The number of people retaining employment at 3/6/9/12+ months (measured as a percentage of individuals placed into employment retaining employment) (IPS)	PM	50%				50%	50%
		Actual	NYA				NYA	
3.32	The number of people supported to retain employment at 3/6/9/12+ months	PM	50%				50%	50%
		Actual	NYA				NYA	
3.33	Fidelity to the IPS model	PM	90%				90%	90%
		Actual	100%				NYR	
	General Quality Requirements							
3.34	GP practices will have an individual annual (MH) ICT service meeting to review delivery and identify priorities for future.	PM	Annual				Annual	Annual
		Actual	NYA				NYR	
3.35	Care plan audit to show : All dependent Children and YP <18 living with adults know to Recovery, MAHRS, Eating Disorder and Assertive Outreach Services. Recorded evidence in care plans of impact of the mental health disorder on those under 18s plus steps put in place to support.(Think family)	PM	Qtr 4		75%		75%	75%
		Actual	82%		NYA		61%	
3.36	Transition- Joint discharge/CPA review meeting within 4 weeks of adult MH services accepting :working diagnosis to be agreed, adult MH care coordinator allocated and care cluster and risk levels agreed as well as CYPS discharge date.	PM	100%		100%		100%	100%
		Actual	0%		0%		13%	
3.37	Number and % of crisis assessments undertaken by the MHARS team on CYP age 16-25 within agreed timescales of 4 hours	PM	90%	90%	90%	90%	90%	90%
		Actual	NYR	100%	100%	100%	100%	
3.38	MHARS Wait time to Assessment: Triage wait time 1 hour (Emergency assessments within 1 hour of triage)	PM		TBC	TBC	TBC	TBC	TBC
		Actual		50%	100%	100%	86%	
3.39	MHARS Wait time to Assessment: Full Assessment 4 hours (Urgent assessments within 4 hours of triage)	PM	90%	TBC	TBC	TBC	TBC	TBC
		Actual	NYR	100%	80%	100%	75%	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
	New KPIs for 2017/18							
3.40	LD: To deliver specialist support to people with learning disabilities in accordance with specifically developed pathways	PM	95%		66%		66%	95%
		Actual	100%		70%		70%	
3.41	LD: To demonstrate a reduction in an individual's health inequalities thanks to the clinical intervention provided by 2gether learning disability services.	PM	Report		TBC		TBC	TBC
		Actual	Compliant		80%		80%	
3.42	LD: People with learning disabilities and their families report high levels of satisfaction with specialist learning disability services	PM	75%		75%		75%	75%
		Actual	Compliant		NYA		100%	
3.43	LD: To ensure all published clinical pathways accessed by people with learning disabilities are available in easy read versions	PM	95%				95%	95%
		Actual	100%				NYR	
3.44	LD: The CLDT, IHOT & LDISS will take a proactive and supportive role in ensuring the % uptake of Annual Health Checks for people with learning disabilities on their caseload is high	PM	75%				75%	75%
		Actual	80%				NYR	
3.45	Of those supported by 2g to access AHC 100% are then further supported with their Health Action Plans & screening	PM					100%	75%
		Actual					NYR	
3.46	IAPT DNA rate	PM	<16%	<16%	<16%	<16%	<16%	<16%
		Actual	13%	15.9%	15.5%	13%	14%	
3.47	IAPT Equity of Access for Service Users: aged 65 and over on the caseload				TBC		TBC	TBC
		Actual			5%		7%	
3.48	IAPT Equity of Access for Service Users: Numbers of BAME on the caseload				TBC		TBC	TBC
		Actual			133		284	
3.49	IAPT Clinical productivity by Groups and 1:1 sessions for: Hi Intensity				> 18 per week		> 18 per week	> 18 per week
		Actual			N/A		N/A	
3.50	IAPT Clinical productivity by Groups and 1:1 sessions for: Lo Intensity				> 18 per week		> 18 per week	> 18 per week
		Actual			N/A		N/A	
3.51	IAPT treatment outcomes: Women in the Perinatal period showing reliable improvement in outcomes between pre and post treatment	PM	50%	50%	50%	50%	50%	85%
		Actual	75%	76%	70%	69%	72%	
3.52	% of CYP entering partnership in CYPS have pre and post treatment outcomes and measures recorded				TBC		TBC	TBC
		Actual			NYA		NYA	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
3.53	Patients with Dementia have weight assessments on admission	PM			85%		85%	85%
		Actual			63%		67%	
3.54	Patients with Dementia have weight assessments at weekly intervals	PM			85%		85%	85%
		Actual			71%		69%	
3.55	Patients with Dementia have weight assessments near discharge	PM			85%		85%	85%
		Actual			57%		55%	
3.56	Patients with Dementia have delirium screening on admission	PM			85%		85%	85%
		Actual			NYA		NYA	
3.57	Patients with Dementia have delirium screening at weekly intervals	PM			85%		85%	85%
		Actual			NYA		NYA	
3.58	Patients with Dementia have delirium screening near discharge	PM			85%		85%	85%
		Actual			NYA		NYA	
3.59	CPI: Referral to Assessment within 4 weeks	PM	85%	85%	85%	85%	85%	85%
		Actual	91%	97%	100%	93%	95%	
3.60	CPI: Assessment to Treatment within 16 weeks	PM	85%	85%	85%	85%	85%	85%
		Actual	99%	98%	97%	97%	97%	
3.61	Comprehensive audit in relation to timeliness and quality of discharge communication (non-medical)						Report	
		Actual					NYA	
3.62	Daily submission of information to inform the daily escalation level	PM		Report	Report	Report	Report	Report
		Actual		NYA	NYA	NYA	NYA	
3.63	Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	PM	95%	95%	95%	95%	95%	95%
		Actual	29%	91%	80%	50%	47%	
3.64	Adolescent Eating Disorders - Routine referral to non-NICE treatment start within 4 weeks	PM	95%	95%	95%	95%	95%	95%
		Actual	9%	N/A	N/A	0%	10%	
3.65	Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week	PM	95%	95%	95%	95%	95%	95%
		Actual	64%	100%	100%	100%	76%	
3.66	Adolescent Eating Disorders - Urgent referral to non-NICE treatment start within 1 week	PM	95%	95%	95%	95%	95%	95%
		Actual	N/A	N/A	100%	100%	100%	
3.67	Eating Disorders - Wait time for adult assessments will be 4 weeks	PM	95%	95%	95%	95%	95%	95%
		Actual	36%	85%	90%	44%	68%	
3.68	Eating Disorders - Wait time for adult psychological interventions will be 16 weeks	PM		95%	95%	95%	95%	95%
		Actual		52%	70%	77%	58%	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
3.69	LD Health facilitation - awareness and support for all stakeholders including reasonable adjustments support to reduce health inequalities						Annual	
		Actual					NYR	
3.70	LD: Patients on the LD challenging behaviour pathway have a single positive behaviour support plan (containing primary, secondary and reactive interventions) completed within 30 days of allocation to clinician (CLDTs: 60 days)	PM			66%		66%	95%
		Actual			50%		50%	
3.71	LD: Active involvement in Care and Treatment Reviews & Blue Light protocol meetings to prevent admission and actively support and plan for integration/discharge in the community: 100% completion of the CTR Provider Checklist prior to CTR meetings	PM					100%	100%
		Actual					NYR	
3.72	LD: Active involvement in Care and Treatment Reviews & Blue Light protocol meetings to prevent admission and actively support and plan for integration/discharge in the community: 75% CTRs being completed within 10 days of admission to Berkeley House	PM					75%	75%
		Actual					NYR	
3.73	CYP report being satisfied or more than satisfied with service experience	PM					Report	Report
		Actual					NYR	
3.74	CYP report being satisfied or more than satisfied following Transition to Adult services	PM					Report	Report
		Actual					NYR	
3.75	CYP report being satisfied or more than satisfied with Transition to Adult Services: 95% of CYP asked to complete Service Questionnaire	PM					95%	95%
		Actual					NYR	
3.76	Perinatal: Urgent Referral to Assessment within 4 - 6 hours - During working hours (unless otherwise negotiated with referrer or patient) in conjunction with Crisis Team	PM			95%		95%	95%
		Actual			NYA		NYA	
3.77	Perinatal: Out of hours emergencies assessed by MHARS to be discussed with the Specialist Perinatal Service the next working day	PM					95%	95%
		Actual					NYR	
3.78	Perinatal: Urgent referrals with High risk indicators (following telephone screening) will be seen with 48 working hours	PM			95%		95%	95%
		Actual			N/A		60%	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
3.79	Perinatal: Preconception advice - Referral to assessment within 6 weeks	PM			50%		50%	95%
		Actual			25%		62%	
3.80	Perinatal: Preconception advice - Referral to assessment within 8 weeks	PM			90%		90%	90%
		Actual			50%		77%	
3.81	Perinatal: Routine referral to assessment within 2 weeks	PM			50%		50%	95%
		Actual			68%		72%	
3.82	Perinatal: Routine referral to assessment within 6 weeks	PM			95%		95%	95%
		Actual			100%		99%	
3.83	Perinatal: Number of women asked if they have a carer	PM	80%		80%		80%	80%
		Actual	82%		78%		78%	
3.84	Perinatal: Number of women with a carer offered carer's assessment	PM	90%		90%		90%	90%
		Actual	90%		75%		75%	
3.85	Perinatal: Women and families views inform the development of the service via a service user forum	PM					Report	Annual
		Actual					NYR	
3.86	Perinatal: all perinatal care plans to be reviewed within 3 months	PM			95%		95%	95%
		Actual			NYA		NYA	
3.87	Perinatal: Reduction in number of episodes of Crisis	PM					Report	Report
		Actual					NYR	
3.88	GARAS: Accepted referrals receive an initial assessment appointment within 6 weeks	PM			95%		95%	95%
		Actual			NYA		NYA	
3.89	GARAS: percentage of referrals completing the course of therapy	PM			90%		90%	90%
		Actual			NYA		NYA	

Schedule 4 Specific Measures that are reported Nationally

Performance Thresholds not being achieved in Month

2.21: No children under 18 admitted to adult inpatient wards
None

Changes to Previously Reported Figures
None

Early Warnings / Notes
None

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

2.21: No children under 18 admitted to adult inpatient wards
See earlier note on Page 10.

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

ID	Performance Measure (PM)		2017/18 Outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
NHSI 1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	<3	0
		Actual	0	0	0	0	0	
NHSI 1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	98%	97%	100%	98%	
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	3.2%	4.5%	1.4%	1.1%	2.7%	
NHSI 1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	97%	100%	97%	99%	
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	53%	53%	53%	53%	53%
		Actual	71%	67%	71%	75%	70%	
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Actual	69%	99%	99%	99%	97%	
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Actual	88%	99%	99%	99%	98%	
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
DoH 2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0	0
		Actual	6	0	2	0	2	
DoH 2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%	100%
		Actual	100%	100%	100%	100%	100%	
DoH 2.26	Interim report for all SIs received within 5 working days of identification (unless extension granted by CCG)	PM	100%	100%	N/A	100%	100%	100%
		Actual	100%	100%	100%	100%	100%	
DoH 2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM	100%	100%	100%	100%	100%	100%
		Actual	100%	NYR	NYR	NYR	100%	

DASHBOARD CATEGORY – GLOUCESTERSHIRE SOCIAL CARE

Gloucestershire Social Care				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	15	15	15	15
	1	1	1	1
	12	12	12	12
NYA	0	0	0	0
NYR	0	0	0	0
N/A	2	2	2	2

Performance Thresholds not being achieved in Month

4.10: Percentage of services users with a Personal Budget receiving Direct payments
The service has been reviewing their processes to check that they are interpreting the direct payment methodology appropriately – and have identified that the arrangements for some service users do not meet the threshold. Our new personalisation project will aim to increase both direct payments and personal health budgets. 181 people hold a personal budget in January, with 24 receiving direct payments. 28 is the threshold.

Cumulative Performance Thresholds Not being Met
As above

Changes to Previously Reported Figures
None

Early Warnings/Notes
None

Gloucestershire Social Care

ID	Performance Measure		2017/18 outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
4.01	The percentage of people who have a Cluster recorded on their record	PM	95%	90%	90%	95%	95%	95%
		Actual	98%	99%	100%	100%	99%	
4.02	Percentage of people getting long term services, in a residential or community care reviewed/re-assessed in last year	PM	95%	95%	95%	95%	95%	95%
		Actual	97%	96%	98%	97%	98%	
4.03	Ensure that reviews of new packages take place within 12 weeks of commencement	PM	80%	80%	80%	80%	80%	80%
		Actual	74%	100%	100%	92%	99%	
4.04	Current placements aged 18-64 to residential and nursing care homes per 100,000 population	PM	13	13	13	13	13	13
		Actual	9.44	9.10	8.85	9.10	9.10	
4.05	Current placements aged 65+ to residential and nursing care homes per 100,000 population	PM	22	22	22	22	22	22
		Actual	16.54	21.79	21.79	21.79	19.45	
4.06	% of WA & OP service users on caseload asked if they have a carer	PM	80%	80%	80%	80%	80%	80%
			88%	85%	85%	87%	87%	
4.07	% of WA & OP service users on the caseload who have a carer, who have been offered a carer's assessment	PM	90%	90%	90%	90%	90%	90%
		Actual	91%	93%	92%	93%	93%	
4.08a	% of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC	TBC
		Actual	43%	38%	39%	37%	37%	
4.08b	Number of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC	TBC
		Actual	521	584	602	591	602	
4.09	% of eligible service users with Personal budgets	PM	80%	80%	80%	80%	80%	80%
		Actual	95%	99%	100%	100%	99%	

Gloucestershire Social Care

ID	Performance Measure		2017/18 outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
4.10	% of eligible service users with Personal Budget receiving Direct Payments (ASCOF 1C pt2)	PM	15%	15%	15%	15%	15%	15%
		Actual	19%	13%	13%	13%	13%	
4.11	Adults subject to CPA in contact with secondary mental health services in settled accommodation (ASCOF 1H)	PM	80%	80%	80%	80%	80%	80%
		Actual	87%	87%	88%	87%	88%	
4.12	Adults not subject to CPA in contact with secondary mental health service in settled accommodation	PM	90%	90%	90%	90%	90%	90%
		Actual	96%	97%	97%	97%	97%	
4.13	Adults subject to CPA receiving secondary mental health service in employment (ASCOF 1F)	PM	13%	13%	13%	13%	13%	13%
		Actual	18%	17%	16%	16%	16%	
4.14	Adults not subject to CPA receiving secondary mental health service in employment	PM	20%	20%	20%	20%	20%	20%
		Actual	21%	23%	24%	23%	23%	

DASHBOARD CATEGORY – HEREFORDSHIRE CCG CONTRACTUAL REQUIREMENTS

Herefordshire Contract				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	24	24	24	24
🔴	1	2	1	2
🟢	15	14	16	16
NYA	0	0	0	0
NYR	0	0	0	0
N/A	8	8	7	6

Performance Thresholds not being achieved in Month

5.07: VTE risk assessment for all inpatients
There was 1 non-compliant case during January. Verbal assurance that the assessment had been completed on the day of admission was given but it was not recorded in the clinical record. The patient was found to be at risk and treatment was given. The assessment was completed again so that it could be appropriately recorded.

Cumulative Performance Thresholds Not being

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

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

5.19: CYP Access: percentage of CYP in treatment against prevalence
The performance threshold for 2018/19 is 30% of prevalence, which equates to 973 young people having accessed treatment during 2018/19. We are currently 111 below the anticipated number required to achieve this at the end of January.
Although 2018/19 activity to this point is comparable to 2017/18 figures, based on the required trajectory to meet the end of year target of 30%, 111 less young people have accessed treatment than would be required at this point. Referral, treatment and DNA rates are relatively stable.

It is believed that improvements in the quality and consistency of CHOICE assessment and strict adherence to thresholds, along with more awareness and consistency in signposting, has limited treatment numbers. This feels positive as we feel that the right people are accessing our specialist service. We believe that we are treating all CYP who are referred to us for Tier 3 concerns within our commissioned specification.

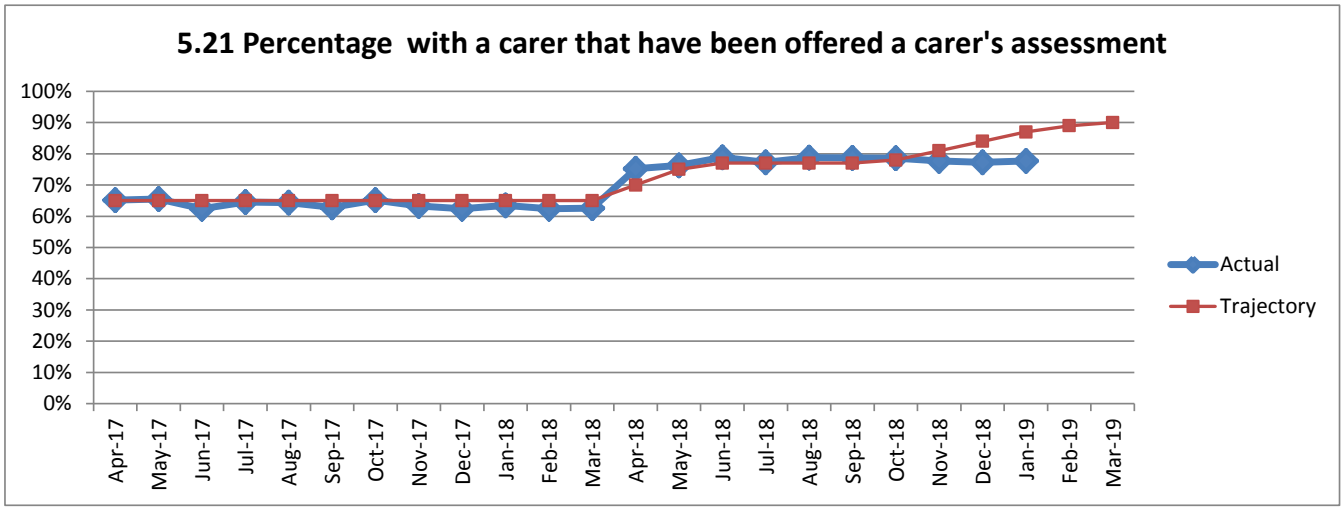
Additionally, more efficient practices in our team mean that many CYP do not require a second appointment. Much of core CAMHS work is indirect, via consultation and advice, and we are working to capture this activity within our clinical system more accurately. We have been linking with Commissioners to scope options to increase access but this may require resourcing and/ or revision to the service specification. This is being discussed with Commissioners.

Changes to Previously Reported Figures

None

Early Warnings / Notes

5.21: Percentage with a carer that have been offered a carer's assessment
The following chart monitors progress against a trajectory to reach 90% by March 2019.



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

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

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

5.19: CYP Access: Percentage of CYP in treatment against prevalence
We have treated 784 CYP at the end of January against a target of 895. We need to treat 189 CYP in February and March to meet the 973 figure. That is significantly more than we treated in last year's Q4 so it is unlikely that we will meet the 30% target over the year.

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 Outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
5.01	Duty of Candour	Plan	Report	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant	Compliant	Compliant	
5.02	Completion of a valid NHS number field in metal health and acute commissioning data sets submitted via SUS.	Plan	99%	99%	99%	99%	99%	99%
		Actual	100%	100%	100%	100%	100%	
5.03	Completion of Mental Health Services Data Set ethnicity coding for all service users	Plan	90%	90%	90%	90%	90%	90%
		Actual	100%	100%	100%	100%	99%	
5.04	Completion of IAPT Minimum Data Set outcome data for all appropriate service users	Plan	90%	90%	90%	90%	90%	90%
		Actual	100%	100%	100%	100%	100.0%	
5.05	Zero tolerance MRSA	Plan	0	0	0	0	0	0
		Unavoidable	0	0	0	0	0	
5.06	Minimise rates of Clostridium difficile	Plan	0	0	0	0	0	0
		Unavoidable	0	0	0	0	0	
5.07	VTE risk assessment: all inpatient service users to undergo risk assessment for VTE	Plan	95%	95%	95%	95%	95%	95%
		Actual	98%	100%	100%	94%	99%	
5.08	IAPT Recovery Rate: The number of people who are below the caseness threshold at treatment end	Plan	50%	50%	50%	50%	50%	50%
		Actual	49%	52%	50%	58%	53%	
5.09a	IAPT Roll-out (Access Rate) - IAPT maintain 15% of patient entering the service against prevalence	Plan		1.25%	1.25%	1.25%	11.91%	15.00%
		Actual		1.43%	1.21%	1.29%	15.48%	
5.09b	IAPT Roll-out (Access Rate) - Number accessing service	Plan	2,178					
		Actual	1,977	1,460	1,637	1,825	1,825	
5.10a	Dementia Service - number of new patients aged 65 years and over receiving an assessment	Plan	540	45	45	45	450	540
		Actual	667	59	47	72	634	
5.10b	Dementia Service - total number of new patients receiving an assessment	Plan						
		Actual	711	64	50	77	677	

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 Outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
5.11	Patients are to be discharged from local rehab within 2 years of admission (Oak House). Based on patients on ward at end of month.	Plan	80%	80%	80%	80%	80%	80%
		Actual	100%	90%	90%	90%	90%	
5.12	All admitted patients aged 65 years of age and over must have a completed MUST assessment	Plan	95%	95%	95%	95%	95%	95%
		Actual	100%	100%	100%	100%	99%	
5.13	Any attendances at ED with mental health needs should have rapid access to mental health assessment within 2 hours of the MHL team being notified.	Plan	80%	80%	80%	80%	80%	80%
		Actual	89%	100%	93%	100%	92%	
5.14	Attendances at ED, wards and clinics for self-harm receive a mental health assessment (Mental Health Liaison Service)	Plan	85%	85%	85%	85%	85%	85%
		Actual	96%	100%	96%	97%	97%	
5.15	CYP Eating Disorders: Treatment waiting time for routine referrals within 4 weeks - NICE treatments	Plan	95%	95%	95%	95%	95%	95%
		Actual	96%	N/A	100%	100%	88%	
5.16	CYP Eating Disorders: Treatment waiting time for routine referrals within 4 weeks - non-NICE treatments	Plan	95%	95%	95%	95%	95%	95%
		Actual	N/A	N/A	N/A	N/A	N/A	
5.17	CYP Eating Disorders: Treatment waiting time for urgent referrals within 1 week - NICE treatments	Plan	95%	95%	95%	95%	95%	95%
		Actual	80%	100%	N/A	100%	100%	
5.18	CYP Eating Disorders: Treatment waiting time for urgent referrals within 1 week - non-NICE treatments	Plan	95%	95%	95%	95%	95%	95%
		Actual	N/A	N/A	N/A	N/A	100%	
5.19	CYP Access: Number and percentage of CYP entering treatment (30% of prevalence)	Plan - %		8.5%	6.5%	5.5%	92.0%	100%
		Actual %		7.6%	4.9%	6.2%	80.8%	
		Plan - numbers		83	63	53	895	973
		Actual - numbers		74	48	60	784	

Herefordshire Carers Information

ID	Performance Measure		2017/18 Outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
5.20	Working Age and Older People service users on the caseload asked if they have a carer. (Only includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan						
		Actual	67%	88%	88%	89%	89%	
5.21	Working Age and Older People service users on the caseload who have a carer who have been offered a carer's assessment. (Includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan						
		Actual	63%	78%	77%	78%	78%	
5.22	Working Age and Older People service users/carers who have accepted a carers assessment. (Only includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan						
		Actual	28%	24%	23%	23%	23%	

Schedule 4 Specific Measures that are reported Nationally

Performance Thresholds not being achieved in Month
None

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

2.21: No children under 18 admitted to adult inpatient wards
See earlier note on Page 10.

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

ID	Performance Measure (PM)		2017/18 Outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
NHSI 1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	<3	0
		Actual	0	0	0	0	0	
NHSI 1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	100%	100%	100%	99%	
NHSI 1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%	95%
		Actual	98%	99%	99%	98%	98%	
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	2.4%	2.7%	2.8%	5.4%	2.1%	
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	53%	53%	53%	53%	53%
		Actual	68%	100%	100%	100%	86%	
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Actual	59%	99%	99%	98%	93%	
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Actual	75%	99%	99%	100%	94%	
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
DoH 2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0	0
		Actual	5	0	0	0	3	

DASHBOARD CATEGORY – GLOUCESTERSHIRE CQUINS

Gloucestershire CQUINS				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	12	12	12	12
🔴	0	0	0	0
🟢	0	7	0	9
NYA	0	0	0	0
NYR	12	5	12	3
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
None

Early Warnings
None

Gloucestershire CQUINS

ID	Performance Measure (PM)		2017/18 Outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
	CQUIN 1							
7.01a	Improvement of health and wellbeing of NHS Staff	PM	Qtr 4		Report		Report	Report
		Actual	Awarded		NYR		NYR	
7.01b	Healthy food for NHS staff, visitors and patients	PM	Qtr 4		Report		Report	Report
		Actual	Awarded		NYR		NYR	
7.01c	Improving the update of flu vaccinations for frontline clinical staff	PM	Qtr 4		Report		Report	Report
		Actual	Awarded		NYR		NYR	
	CQUIN 2							
7.02a	Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with psychoses	PM	Qtr 4		Report		Qtr 1	Report
		Actual	Awarded		NYR		Awarded	
7.02b	Improving Physical healthcare to reduce premature mortality in people with SMI: Collaboration with primary care clinicians	PM	Qtr 4		Report		Qtr 3	Report
		Actual	Awarded		Compliant		Compliant	
	CQUIN 3							
7.03	Improving services for people with mental health needs who present to A&E	PM	Qtr 4		Report		Qtr 3	Report
		Actual	Awarded		Compliant		Compliant	
	CQUIN 4							
7.04	Transition from Young People's Service to Adult Mental Health Services	PM	Qtr 4		Report		Qtr 2	Report
		Actual	Awarded		NYR		Awarded	
	CQUIN 5							
7.05a	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco screening	PM	Qtr 4		Report		Qtr 3	Report
		Actual	Awarded		Compliant		Compliant	
7.05b	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco brief advice	PM	Qtr 4		Report		Qtr 3	Report
		Actual	Awarded		Compliant		Compliant	
7.05c	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco referral and medication	PM	Qtr 4		Report		Qtr 3	Report
		Actual	Awarded		Compliant		Compliant	
7.05d	Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol screening	PM	Qtr 4		Report		Qtr 3	Report
		Actual	Awarded		Compliant		Compliant	
7.05e	Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol brief advice or referral	PM	Qtr 4		Report		Qtr 3	Report
		Actual	Awarded		Compliant		Compliant	

DASHBOARD CATEGORY – LOW SECURE CQUINS

Low Secure CQUINS				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	1	1	1	1
	0	0	0	0
	0	1	0	1
NYA	0	0	0	0
NYR	1	0	1	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
None

Early Warnings
None

Low Secure CQUINS

ID	Performance Measure (PM)		2017/18 Outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
	CQUIN 1							
8.01	Reducing the length of stay in specialised MH services	PM	Qtr 4		Report		Qtr 3	Report
		Actual	Awarded		Compliant		Compliant	

DASHBOARD CATEGORY – HEREFORDSHIRE CQUINS

Herefordshire CQUINS				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	12	12	12	12
	0	0	0	0
	0	7	0	9
NYA	0	0	0	0
NYR	12	5	12	3
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
None

Early Warnings
None

Herefordshire CQUINS

ID	Performance Measure (PM)		2017/18 Outturn	November-2018	December-2018	January-2019	(Apr-Jan) Cumulative Compliance	Forecast 18/19 Outturn
7								
	CQUIN 1							
9.01a	Improvement of health and wellbeing of NHS Staff	PM	Qtr 4		Report		Report	Report
		Actual	Awarded		NYR		NYR	
9.01b	Healthy food for NHS Staff, Visitors and Patients	PM	Qtr 4		Report		Report	Report
		Actual	Awarded		NYR		NYR	
9.01c	Improving the uptake of Flu vaccinations for Front Line Clinical Staff	PM	Qtr 4		Report		Report	Report
		Actual	Awarded		NYR		NYR	
	CQUIN 2							
9.02a	Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with psychoses	PM	Qtr 4		Report		Qtr 1	Report
		Actual	Awarded		NYR		Awarded	
9.02b	Improving Physical healthcare to reduce premature mortality in people with SMI: Collaborating with primary care clinicians	PM	Qtr 4		Report		Qtr 3	Report
		Actual	Awarded		Compliant		Compliant	
	CQUIN 3							
9.03	Improving services for people with mental health needs who present to A&E	PM	Qtr 4		Report		Qtr 3	Report
		Actual	Awarded		Compliant		Compliant	
	CQUIN 4							
9.04	Transition from Young People's Service to Adult Mental Health Services	PM	Qtr 4		Report		Qtr 2	Report
		Actual	Awarded		NYR		Awarded	
	CQUIN 5							
9.05a	Tobacco screening	PM	Qtr 4		Report		Qtr 3	Report
		Actual	Awarded		Compliant		Compliant	
9.05b	Tobacco brief advice	PM	Qtr 4		Report		Qtr 3	Report
		Actual	Awarded		Compliant		Compliant	
9.05c	Tobacco referral and medication offer	PM	Qtr 4		Report		Qtr 3	Report
		Actual	Awarded		Compliant		Compliant	
9.05d	Alcohol screening	PM	Qtr 4		Report		Qtr 3	Report
		Actual	Awarded		Compliant		Compliant	
9.05e	Alcohol brief advice or referral	PM	Qtr 4		Report		Qtr 3	Report
		Actual	Awarded		Compliant		Compliant	

Agenda item 13 **Paper G**

Report to: Trust Board, March 2019
Author: Dr Amjad Uppal, Medical Director and Paul Ryder, Patient Safety Manager
Presented by: Dr Amjad Uppal, Medical Director

SUBJECT: **Learning from Deaths Report**

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

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

EXECUTIVE SUMMARY

The data presented represents those available for the period October to December 2018 (Q3 2018/19).

Changes to the selection criteria and the Mortality Review function – RCPsych SJR adopted in November 2018, applied to open deaths and incorporated into the Learning from Deaths process.

111 deaths have been closed without further review due to being open to solely ACI-Monitoring caseloads (58) or excluded due to a primary diagnosis of dementia and over 70 years of age (53).

1 deaths raised a cause for concern within a partner organisations during Q3 2018/19. That death was raised with the organisation's Mortality Lead. There were no concerns about care provision within 2gether.

There has been a key post vacant since August 2018. The Patient Safety Manager is now recruiting a substantive PST Administrator.

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

RECOMMENDATIONS

The Board is asked to note the contents of this Mortality Review Report which covers Quarter 3 of 2018/19.

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

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

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

Reviewed by:		
	Date	

Where in the Trust has this been discussed before?		
Mortality Review Committee (MoReC)	Date	21 March 2019

What consultation has there been?		
	Date	

Explanation of acronyms used:	

1. INTRODUCTION

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

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

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

- number of deaths
- number of deaths subject to case record review (now SJR Part 2+)
- number of deaths investigated under the Serious Incident framework (and declared as serious incidents)
- number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care
- themes and issues identified from review and investigation (including examples of good practice)
- actions taken in response, actions planned and an assessment of the impact of actions taken.

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

1.5 This paper offers the subsequent iteration of data for the period October to December 2018.

2. PROCESS

2.1 All 2gether Trust staff are required to notify, using the Datix system, the deaths of all Trust patients. This comprises anyone open to a Trust caseload at the time of their death and who dies within 30 days of receiving care from 2gether. Following discussion at Mortality Review Committee (MoReC) in and at countywide Mortality Steering Groups in both Gloucestershire and Herefordshire, it was agreed to exclude from active review those open for ACI Monitoring only and those with a primary diagnosis of dementia who are over 70 years old. MoReC had become very aware that older people with dementia die whilst this had resulted in very little learning from this cohort of patients. There will be a continued focus on those 70 years and under.

2.2 Mandatory mortality reviews are required for:

- All patients where family, carers, or staff have raised concerns about the care provided.
- All patients with a diagnosis of psychosis or eating disorders during their last episode of care, who were under the care of services at the time of their death, or who had been discharged within the 6 months prior to their death.

- All patients who were an inpatient in a mental health unit at the time of death or who had been discharged from inpatient care within the last month.
- All patients who were under a Crisis Resolution & Home Treatment Team (or equivalent) at the time of death (noting that these deaths will likely be categorised as Serious Incidents).

2.3 The format of a Mortality Review was modified following the publication of the Royal College of Psychiatrists Structured Judgement Review in January 2019. With regard to process detail, “Table Top Reviews” are now referred to as SJR Part 1, and “Care Record Reviews” are SJR Part 2+ (including parts 2-7). The RCPsych SJR is attached for reference. The parts of the review consider:

- Part 1 The allocation and initial review or assessment of the patient (this is usually completed within Datix only) resulting in a Mazars categorisation
- Part 2 The ongoing care of the patient, including both physical health and mental health
- Part 3 Care during admission
- Part 4 Care at the end of life
- Part 5 Discharge planning
- Part 6 An option for organisations to rate particular aspects of care the reviewers feel is necessary for that individual
- Part 7 Overall care

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

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

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

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

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

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

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

Category 1: "not due to problems in care"

Category 2: "possibly due to problems in care within ^{2}gether"

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

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

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

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

3. DATA

3.1 The data presented below represents those available for the period October to December 2018.

3.2 111 deaths have been closed without further review due to being open to solely ACI-Monitoring caseloads and/or with a primary diagnosis of dementia and over 70 years of age. 20 death incident reports were rejected due to not being on an open caseload at the point of their death (or within 1 month of discharge).

3.3 No deaths have raised a cause for concern within 2gether and one concern was raised with a partner organisation during Q3 2018/19.

4. CONCLUSION

4.1 This, the Q3 report for 2018/19 of mortality review data under the Learning from Deaths policy focusses on the progress made during Q3.

4.3 The new bank Patient Safety Team Administrator, Zoë Lewis, joined the team on 29 October 2018, after the post had remained vacant since August 2018. Zoë has made a significant impact on the outstanding and overdue Mortality reviews as is demonstrated by the current quarterly “Open Mortality Reviews” data shown. At the end of Q2 there were 184 open cases (96 for Q2 alone) and as of end Q3 there remain 29 open cases. Substantive recruitment has begun following Director agreement.

4.4 By Q3 2018/19, it was projected that significant progress would be made regarding the number of Q1-Q2 2018/19 death incidents being reviewed. There is good assurance that this is the case. Furthermore, the PST Administrator has requested access to the SystmOne records database in order to further enhance her ability to collect relevant data following patient deaths. This should further improve the time taken to completed Part 1 reviews.

4.5 Mortality Review Committees have convened regularly since November 2018. However, whilst learning from these reviews is limited, the active review of patient deaths does provide assurance that End of Life Care and the care provided to our patients is of an excellent quality which seldom results in unexpected deaths, natural or otherwise.

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

- SI-13-19
- SI-14-19
- SI-15-19
- SI-16-19

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

Financial Year 2018-2019

Q3 MoReC Figures - correct up to 30 December 2018

Closed Mortality Reviews

Month	Closed ACI Caseload Deaths	Deaths excluded from full Table Top Review	Closed Following RCPsych SJR Section 1			Closed Following RCPsych SJR Part 2+			Closed Following Serious Incident Review			Total
			Category 1: Not Due to Problems in Care	Category 2: Possibly Due to Problems in Care within 2gether	Category 3: Possibly Due to Problems in Care Within an External Organisation	Category 1: Not Due to Problems in Care	Category 2: Possibly Due to Problems in Care within 2gether	Category 3: Possibly Due to Problems in Care Within an External Organisation	Category 1: Not Due to Problems in Care	Category 2: Possibly Due to Problems in Care within 2gether	Category 3: Possibly Due to Problems in Care Within an External Organisation	
Oct-18	27	14	2	0	0	3	0	1	4	0	0	51
Nov-18	17	18	0	0	0	1	0	0	3	0	0	39
Dec-18	14	21	0	0	0	0	0	0	2	0	0	37
	58	53	2	0	0	4	0	1	9	0	0	127

Open Mortality Reviews

Month	Awaiting Information to Complete Part 1	Awaiting Part 1 Review	Awaiting Part 2+ (MoReC)	Awaiting Clinical Review (SI's)	Total	Quarterly Total
Oct-18	6	0	1	0	7	29
Nov-18	6	0	2	2	10	
Dec-18	6	0	6	0	12	
	18	0	9	2	29	

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SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-15-19

Incident Category:

The patient survived a fractured neck of femur following a fall on a 2gether Trust Inpatient Unit

What happened?

- **The patient had fallen after attempting to stand from a lounge chair.**
- **Staff gave immediate assistance and called an ambulance when a possible fractured neck of femur was identified. The patient underwent a successful hip operation and was discharged to a Nursing Home.**

What did the Investigation find?

- **During the admission the patient's physical health issues were monitored and treated appropriately in liaison with General Medicine colleagues.**
- **Staff followed the Service User Falls Pathway on each occasion that the patient had a fall and Fall Reviews were carried out by the Physiotherapy Team and Medical staff.**
- **There was a lack of consistency in recording the change of the patient being at a MODERATE risk of fall from a LOW risk.**
- **The patient's allergy to an antibiotic had not been recorded into correct RiO section and had not been included on a referral to Podiatry.**
- **The care plan and RAG-rated behaviour plan did not include the use of PRN medication and Positive Behavioural Management which had been appropriately administered during the admission.**

What can we learn from this incident? (What does this remind us about good practice? What can we change?)

- **All staff to record significant clinical information in regard to changes in Risk level and allergies in the appropriate sections of RiO electronic clinical records, to ensure it is easily located when required.**
- **All staff to record and embed the use of PRN medication and Positive Behavioural Management techniques into RAG-rated behavioural Care Plans.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-16-19

Incident Category:

Patient Death

What happened? ***(Describe the incident)***

- **The patient was found deceased at their home address with medication and alcohol found close by.**

What did the Investigation find? ***(What was done well? Did anything go wrong?)***

- **The patient had been experiencing acute anxiety, hypervigilance and had a working diagnosis of Complex Post-Traumatic Stress Disorder. The patient also had a history of alcohol abuse.**
- **The patient was in the process of being transferred to a different team, so that longer term support could be provided. This was anxiety provoking for the patient.**
- **The patient had received correspondence regarding attendance at a benefits assessment, which caused the patient acute distress.**
- **The patient received a good level of care from the mental health services and the teams had provided flexible and responsive care to the patient and the most appropriate way forward for on-going support was always considered.**

What can we learn from this incident? ***(What does this remind us about good practice? What can we change?)***

- **The waiting list for Cognitive Behavioural Therapy (Step 3) is longer than the Trust's target of 95% of people being seen within 18 weeks. The work currently being undertaken to reduce the waiting times will continue.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-13-19

Incident Category:

Patient death

What happened? ***(Describe the incident)***

- **The patient was found deceased at their home address by police after they did not meet a family member at a lunch engagement.**

What did the Investigation find? ***(What was done well? Did anything go wrong?)***

- **The patient had a long history of mental health difficulties including depression, anxiety, substance misuse and a chronic bulimic eating disorder.**
- **The patient had been offered a range of services, but had a history of disengagement from the services provided.**
- **At the time of the patients death, anti-depressants had been re-started, the clinical presentation was improving and the risk of suicide was assessed as low.**
- **There was a longer than normal waiting time to be seen by the Eating Disorder Service due to a high number of referrals into the team.**
- **The Eating Disorders Team are only able to offer appointments at their base in Cheltenham and the patient was unable to travel to that base.**
- **Although risks and onward referral to other teams were considered, it was not always documented within the patients clinical notes.**
- **There was good evidence of consistent, notable practice in care throughout a period of three years.**

What can we learn from this incident? ***(What does this remind us about good practice? What can we change?)***

- **All assessment of risk and clinical decisions around referring on to other teams should be documented within the patient's clinical notes.**
- **Offering appointments at different localities may enhance the availability of a service.**

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SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-14-19

Incident Category:

Patient harm: Death

What happened? ***(Describe the incident)***

- **The patient was found deceased at home having taken an overdose of medication.**

What did the Investigation find? ***(What was done well? Did anything go wrong?)***

- **The patient had experienced distressing and debilitating symptoms of depression, impacted by physical health problems, which left the patient coping with significant fatigue and a lack of motivation to engage in pleasurable activities.**
- **Over the past 7 years the patient had engaged in short term support from Mental Health Services both Psychological and Pharmacological. Thorough and comprehensive assessments of the patient's mental health and risks were in place and the Care Plan was in accordance with the patient's wishes and preferences. The patient had been consistently assessed as LOW risk of suicide.**
- **When a recent referral was received from the patient's GP, the GP was not liaised with in regards to changing the status from Urgent to Routine.**
- **The patient's spouse felt unsure how best to support the patient and struggled to understand their mental health issues and the options of treatment offered**

What can we learn from this incident? ***(What does this remind us about good practice? What can we change?)***

- **The Contact Centre Manager to monitor the improvements already made to the communication with General Practitioners when triaging referrals and for the Referrer Information sheet to clearly explain the criteria for an "Emergency", "Urgent" and "Routine" response.**
- **Patients and their families will be offered clear verbal and written information regarding their mental health conditions and treatment options early in their engagement with services.**

Agenda item 14 **PAPER H1**

Report to: Trust Board, November 2018
Author: Dr Nader Abbasi, Consultant & Guardian of Safe Working Hours
Presented by: Dr Amjad Uppal, Medical Director

SUBJECT: **Guardian of Safe Working Hours Quarterly Report covering May, June, July 2018**

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

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

EXECUTIVE SUMMARY

All new Psychiatry Trainees, Foundation Trainees and GP Trainees rotating into a Psychiatry placement are now on the new 2016 Terms and Conditions of Service with occasional exceptions. There are currently 35 trainees (junior doctors) working in the 2gether NHS Foundation Trust, all on the new Terms and Conditions of Service on different sites.

The 'exception' reporting process, which is part of the new Juniors Doctors Contract enables them to raise and resolve issues with their working hours and training. The trainees can raise 'exception reports' for excessive hours worked, missed breaks, or missed educational opportunities and this system is now well established in the Trust. These 'exception reports' where possible have been resolved by the preferred option of time off in lieu (TOIL); those where TOIL will impact on colleagues' workload or educational opportunities have received payments. Exception reports may also trigger work schedule reviews and if necessary fines can be imposed on the Trust by the Guardian of Safe Working if issues remain unresolved. Exception reporting rates are variable between different sites.

The Quarterly Board report from the Guardian which summarises all exception reports, work schedule reviews and rota gaps, and provides assurance on compliance with safe working hours by both the employer and doctors in approved training programs, will be considered by CQC, GMC, and NHS employers as key data during reviews. The purpose of the report is to give assurance to the Board that the doctors in training are safely rostered and their working hours are complaint with the TCS.

RECOMMENDATIONS

1) The Board is asked to note the content of this paper, in particular in regard to on going challenges within Hereford Junior doctors' rota.

2) There have been some enhancement in salaries paid to the trainees in Hereford based on data received from exception reports regarding out of hours work. This is under review.

Corporate Considerations	
Quality implications	Implementing the new contract is a DoH requirement justified by a need to ensure consistent quality of care and working conditions for junior doctors.
Resource implications:	There is a cost implication of implementation of the new contract. It is important that the Trust avoids fines due to non-compliance.
Equalities implications:	Nil
Risk implications:	Financial risk if the Trust breaches, a number of issues have been identified in the implementation phase which are identified in the report, together with the plans to resolve them.

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

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

Reviewed by:		
Dr Amjad Uppal	Date	21 March 2018

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
	Date	

Explanation of acronyms used:	CQC – Care Quality Commission DME – Director of Medical Education HEE – Health Education England

1.0 CONTEXT

1.1 The safety of patients is of paramount importance for the NHS and staff fatigue is a hazard both to patients and the staff. The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours. It was agreed during negotiations with the BMA that a 'Guardian of Safe Working Hours' will be appointed in all NHS Trusts employing trainees (junior doctors) to ensure safe working practice.

1.2 The role of 'Guardian of Safe Working Hours' is independent of the Trust management structure, with a primary aim to represent and resolve issues related to working hours for the junior doctors employed by it. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and will provide assurance to the Trust Board or equivalent body that doctors' working hours are safe.

1.3 The work of Guardian will be subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by the continued scrutiny of the quality of training by Health Education England (HEE). These measures should ensure the safety of doctors and therefore of patients.

1.4 The Trust has invested in relevant software to help monitor the 'Exception Reports' in line with national guidance and the system is relatively well established in the Trust now.

1.5 The Guardian's Quarterly Report, as required by the junior doctor's contract, is intended to provide the Board with an evidence based report on the working hours and practices of junior doctors within the Trust, confirming safe working practices and highlighting any areas of concern.

2. THE GUARDIAN OF SAFE WORKING HOURS REPORT

2.1 Exception Reporting

The Trust uses 'Allocate' as the reporting software system, which appears to function reasonably well for this purpose.

Since beginning of May 2018 till end of July 2018, 16 exception reports have been generated and a break down has been provided in following tables.

2.2 The table below shows the number of trainee posts available and filled by junior doctors in training.

Grade	Trainees	Glos	Hereford	New Contract	Old Contract
F1	5	4	1	5	0
F2	4	3	1	4	0
GP	6	4	2	6	0
CT	9	8	1	9	0
ST	11	10	1	11	0
Total	**35**	**29**	**6**	**35**	**0**

Exception reports by site	
Gloucester	0
Hereford	16
Total	16

Exception reports by grade						
Grade	F1	F2	GP	CT	ST	Total
	0	0	6	10	0	16

Exception reports, response time					
	Addressed within 48 hrs	Addressed within 7 days	Addressed in longer than 7 days	Addressed by Guardian	Still open
F1	0	0	0	0	0
F2	0	0	0	0	0
GP	5	0	0	0	1
CT	9	1	0	0	0
ST	0	0	0	0	0
Total	14	1	0	0	1

2.3 Out of 16 reports in this period all have been related to hours. We had 15 resolutions and

1 of exception reports is still open at the time pending a meeting with educational supervisor.

Resolutions have included:

- 1/16 No further action
- 9/16 time in lieu agreed
- 5/16 overtime payment agreed
- 1/16 pending meeting with Educational Supervisor
- 5/16 required work schedule reviews in this period, which needs to be considered designing next rota.

There are some historical reports open from previous period and we are in discussion with the software provider Allocate to find a way to resolve this problem in future. These reports have not been closed down by trainees who have left the Trust.

2.5 Work Schedule reviews

During this rota since November 17 we've had no formal work schedule reviews although it has been recommended through some of the reports outcome. We need to be aware that all of the work schedule recommendations are within Hereford rota where there is shortage of trainees.

2.6 Locum Booking and Vacancies

2.6.1 During this period 23 shifts have been covered by agency doctors for on-call shifts. There was a full time agency junior doctor working in Gloucester, and one working in Hereford for a month and half in this time period.

2.6.2 In this time period we had one Foundation Year 2 level doctor who could not complete on calls at all and another Core Trainee level doctor who could not do night shift duties.

2.7 Fines

2.7.1 At this stage no fines have as yet been applied as although there are difficulties with Hereford Rota there has been no breach..

3.0 Challenges:

3.1 Completion of Exception Reports / Knowledge of the System: Both junior doctors and their supervisors need to be more disciplined in meeting and resolving issues highlighted through the exception reports as soon as possible. A number of reports are not attended to in a timely manner. The Guardian will continue to support junior doctors and supervisors in resolving these issues as soon as possible.

3.2 Software System: The Trust uses a nationally procured system for medical staff rotas called 'Allocate Software System', this system is now used for Exception reporting. All our junior doctors and educational supervisors are registered with the system. There are some issues with the system, which are nation wide and not limited to our Trust, and have been highlighted to the software company.

3.3 Junior doctor rota: Since changing rota in Gloucestershire to working 'waking' nights there has been a significant decline in number of exception reports. There are concerns

regarding time allocated to average working hours during on calls in Hereford. It seems that this is the main reason behind the exception reports raised from Hereford. We are gathering information from junior doctors through junior doctors' forum.

3.4 Workload: The new contract does have workload implications for the Guardian, administrator, DME, Educational and Clinical supervisors when a trainee submits an exception report. The amount of time spent depends on the number of exception reports submitted and it is too early to make a judgment about this currently.

3.5 Administrative support for the Guardian role: The Guardian is being assisted by admin from medical staffing and they have been very supportive in introducing the new system and answering queries from users.

3.6 Junior Doctors Forum: Our Junior Doctors Forum predates the introduction of the new contract and has been further strengthened by the Guardian and the DME meeting quarterly. The attendance by junior doctors has been variable despite a proactive approach by the current junior doctors' rep to engage colleagues.

4. Exception Reports and Fines

4.1 There have been 16 exception reports during this period with 1 still open and needs addressing by the concerned doctor and their supervisor. It is a significant improvement that we did not have any exception reports raised by our Gloucestershire junior doctors.

4.2 All 16 exception reports raised related to Hereford rota although we had an increase in on-call call out hours but it still does not seem to cover the work done. There are on going discussions between the Guardian, DME, Postgraduate Tutor in Hereford and medical staffing for further changes and alteration to rota.

4.3 There has been no breach of contract to initiate any fines against the Trust yet.

5. Networking

5.1 The Guardian has attended the annual national training and is a member of the regional forum of Safe Working Guardians as well as having email contact with a number of other Guardians in the region to share updates and experiences. Intelligence from this network suggests that the level of exception reporting has been similar across Trusts within the region. The Guardian also regularly meets with the Director of Medical Education.

5.2 There is a national view that there is a surge of exception reports in February and August every year when new junior doctors start in posts. This usually settles when junior doctors become familiar with the system and their work schedules. We have included a presentation by Guardian in all Induction Programs of Trust to address this issue.

6.0 CONCLUSION

6.1 All of our junior doctors now are on the new contract and committed to use the exception reporting system to ensure safe working practice. Information gleaned from the exception reports enables the DME to keep informed of the challenges and threats to the provision of quality Trainee placements at the Trust.

6.2 The Exception Reporting process allows Trainees to give the Guardian notice of working unsafe hours. It is important that these issues are resolved in a timely manner.

6.3 The Guardian of Safe Working Quarterly Report provides assurance that trust is positively engaged with its junior doctors via a number of routes and meetings. There was a surge of exception reports at the start of the implementation of the new contract but this has improved significantly with better understanding of the system through regular presentations at Induction and to the trainees and their supervisors.

6.4 There are on going concerns regarding the number of exception reports raised by Hereford trainees, which is due to insufficient average hours allocated to on calls in their work schedules and shortage of trainees. The out of hours on call hours were re adjusted in the work schedules following learning from previous exception reports but this needs further work.

7.0 RECOMMENDATIONS

7.1 The Board is asked to read and note of this report from the Guardian of Safe Working.

7.2 Junior doctor work schedules in Hereford remain a challenge due to the long-standing shortage of trainees in the region and time allocated to on calls.

Agenda item 14 **Paper H**

Report to:	Trust Board, February 2019
Author:	Dr Nader Abbasi, Consultant & Guardian of Safe Working Hours
Presented by:	Dr Amjad Uppal, Medical Director
SUBJECT:	**Guardian of Safe Working Hours Quarterly Report covering August, September, October 2018**

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

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

EXECUTIVE SUMMARY

All new Psychiatry Trainees, Foundation Trainees and GP Trainees rotating into a Psychiatry placement are now on the new 2016 Terms and Conditions of Service with occasional exceptions. There are currently 40 trainees (junior doctors) working in the 2gether NHS Foundation Trust, all on the new Terms and Conditions of Service on different sites.

The 'exception' reporting process, which is part of the new Juniors Doctors Contract enables them to raise and resolve issues with their working hours and training. The trainees can raise 'exception reports' for excessive hours worked, missed breaks, or missed educational opportunities and this system is now well established in the Trust. These 'exception reports' where possible have been resolved by the preferred option of time off in lieu (TOIL); those where TOIL will impact on colleagues' workload or educational opportunities have received payments. Exception reports may also trigger work schedule reviews and if necessary fines can be imposed on the Trust by the Guardian of Safe Working if issues remain unresolved. Exception reporting rates are variable between different sites.

The Quarterly Board report from the Guardian which summarises all exception reports, work schedule reviews and rota gaps, and provides assurance on compliance with safe working hours by both the employer and doctors in approved training programs, will be considered by CQC, GMC, and NHS employers as key data during reviews. The purpose of the report is to give assurance to the Board that the doctors in training are safely rostered and their working hours are complaint with the TCS.

RECOMMENDATIONS

1) The Board is asked to note the content of this paper, in particular in regard to on going challenges engaging trainees and educational supervisors in exception reporting process

2) There have been some enhancement in salaries paid to the trainees in Hereford based on data received from exception reports regarding out of hours work. This is under review.

Corporate Considerations	
Quality implications	Implementing the new contract is a DoH requirement justified by a need to ensure consistent quality of care and working conditions for junior doctors
Resource implications:	There is a cost implication of implementation of the new contract. It is important that the Trust avoids fines due to non compliance.
Equalities implications:	Nil
Risk implications:	Financial risk if the Trust breaches, a number of issues have been identified in the implementation phase which are identified in the report, together with the plans to resolve them.

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

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

Reviewed by:		
Dr Amjad Uppal	Date	21 March 2019

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
	Date	

Explanation of acronyms used:	CQC – Care Quality Commission DME – Director of Medical Education HEE – Health Education England

1.0 CONTEXT

1.1 The safety of patients is of paramount importance for the NHS and significant staff fatigue is a hazard both to patients and to the staff themselves. The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours. It was agreed during negotiations with the BMA that a 'Guardian of Safe Working Hours' would be appointed in all NHS Trusts employing trainees (junior doctors) to ensure safe working practice.

1.2 The role of 'Guardian of Safe Working Hours' is independent of the Trust management structure, with a primary aim to represent and resolve issues related to working hours for the junior doctors employed by it. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and will provide assurance to the Trust Board or equivalent body that doctors' working hours are safe.

1.3 The work of Guardian will be subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by the continued scrutiny of the quality of training by Health Education England (HEE). These measures should ensure the safety of doctors and therefore of patients.

1.4 The Trust has invested in relevant software to help monitor the 'Exception Reports' in line with national guidance and the system is relatively well established in the Trust now.

1.5 The Guardian's Quarterly Report, as required by the junior doctor's contract, is intended to provide the Board with an evidence based report on the working hours and practices of junior doctors within the Trust, confirming safe working practices and highlighting any areas of concern.

2. THE GUARDIAN OF SAFE WORKING HOURS REPORT

2.1 Exception Reporting

The Trust uses 'Allocate' as the reporting software system, which appears to function reasonably well for this purpose.

Since beginning of August 2018 till end of October 2018, 13 exception reports have been generated and a break down has been provided in following tables.

2.2 The table below shows the number of trainee posts available and filled by junior doctors in training.

Grade	Trainees	Glos	Hereford	New Contract	Old Contract
F1	5	4	1	5	0
F2	5	3	2	5	0
GP	6	4	2	6	0
CT	11	10	1	11	0
ST	13	12	1	13	0
Total	**40**	**33**	**7**	**40**	**0**

Exception reports by site	
Gloucester	13
Hereford	0
Total	13

Exception reports by grade						
Grade	F1	F2	GP	CT	ST	Total
	8	0	1	3	1	13

Exception reports, response time					
	Addressed within 48 hrs	Addressed within 7 days	Addressed in longer than 7 days	Addressed by Guardian	Still open
F1	0	0	2	0	6
F2	0	0	0	0	0
GP	0	0	0	0	1
CT	1	0	0	0	2
ST	1	0	0	0	0
Total	2	0	2	0	9

2.3 All 13 reports in this period have been related to hours. We have had 10 resolutions and 3 of exception reports are still open at the time pending a meeting between trainees and their educational supervisors. It is also important to mention that although 10 have been resolved 6 of them still remain open due to late meeting or not being 'closed' by trainees.

Resolutions have included:

- 2/13 No further action
- 8/13 time off in lieu agreed
- 0/13 overtime payment agreed
- 3/13 pending meeting with Educational Supervisor
- None required work schedule reviews in this period, which is an improvement compare to previous period.

There are some historical reports still open from previous period and we are in discussion with the software provider Allocate to find a way to resolve this problem in future. These reports have not been closed down as trainees responsible have left the Trust.

2.5 Work Schedule reviews

During this rota since August 2018 we have had no formal work schedule reviews recommended in reports. It is important to note that we had no exception report from our trainees in Hereford following amendments to their work schedules.

2.6 Locum Booking and Vacancies

2.6.1 During this period two on call shifts were covered by agency doctors in Gloucester. There was a locum clinical fellow in Hereford and one in Gloucester both on rota and non-agency.

2.6.2 In this time period we had one GP trainee in Gloucester who could only complete two on call nights at a time.

2.7 Fines

2.7.1 At this stage no fines have yet been applied, as there has been no breach.

3.0 Challenges:

3.1 Completion of Exception Reports / Knowledge of the System: Both junior doctors and their supervisors need to be more disciplined in meeting and resolving issues highlighted through the exception reports. A high number of reports are not attended to in a timely manner. The Guardian will continue to support junior doctors and supervisors in resolving these issues as soon as possible. There were some difficulties with closure of reports due to locum supervisors who had no account with Allocate. It was decided in these situations trainees' tutor step in for the purpose of exception report and outcome.

3.2 Software System: The Trust uses a nationally procured system for medical staff rotas called 'Allocate Software System', this system is now used for Exception reporting. All our junior doctors and educational supervisors are registered with the system. There were some misunderstandings between Hereford trainees in regard to their access to the system. This

was resolved in a timely manner. We also checked with trainees and they didn't need to access the system while it was sorted.

3.3 Junior doctor rota: Since changing rota in Gloucestershire to working 'waking' nights there has been a significant decline in number of exception reports. The reports we had during this period from Gloucester not related to night shifts and mainly due to daytime workload which resulted in staying beyond allocated time. There have had no exception reports during the period of this report from Hereford due to an update in their work schedules.

3.4 Workload: The new contract does have workload implications for the Guardian, administrator, DME, Educational and Clinical supervisors when a trainee submits an exception report. The amount of time spent depends on the number of exception reports submitted and it is too early to make a judgment about this currently.

3.5 Administrative support for the Guardian role: The Guardian is being assisted by admin from medical staffing and they have been very supportive in introducing the new system and answering queries from users.

3.6 Junior Doctors Forum: Our Junior Doctors Forum predates the introduction of the new contract and has been further strengthened by the Guardian and the DME meeting quarterly. The attendance by junior doctors has been variable despite a proactive approach by the current junior doctors' rep to engage colleagues.

4. Exception Reports and Fines

4.1 There have been 13 exception reports during this period with 3 still open and needs addressing by the concerned doctor and their supervisor. It is a significant improvement that we did not have any exception reports raised by our Hereford junior doctors.

4.2 All 13 exception reports raised were related to Gloucester rota. There were a late response throughout the reports, which was due to some of our supervisors being temporary and locum this has been addressed by asking tutors to step in and arrange a meeting with trainees to outcome the report in a timely manner.

4.3 There has been no breach of contract to initiate any fines against the Trust yet.

5. Networking

5.1 The Guardian has attended the annual national training and is a member of the regional forum of Safe Working Guardians as well as having email contact with a number of other Guardians in the region to share updates and experiences. Intelligence from this network suggests that the level of exception reporting has been similar across Trusts within the region. The Guardian also regularly meets with the Director of Medical Education.

5.2 There is a national view that there is a surge of exception reports in February and August every year when new junior doctors start in posts. This usually settles when junior doctors become familiar with the system and their work schedules. We have included a presentation by Guardian in all Induction Programs of Trust to address this issue.

6.0 CONCLUSION

6.1 All of our junior doctors now are on the new contract and committed to use the exception reporting system to ensure safe working practice. Information gleaned from the exception reports enables the DME to keep informed of the challenges and threats to the provision of quality Trainee placements at the Trust.

6.2 The Exception Reporting process allows Trainees to give the Guardian notice of working unsafe hours. It is important that these issues are resolved in a timely manner.

6.3 The Guardian of Safe Working Quarterly Report provides assurance that trust is positively engaged with its junior doctors via a number of routes and meetings.
Since the implementation of the junior doctors' contract, there were initially more exception reports then regular induction programme presentations and involvement through the junior doctors' forum resulted in improved trainee feedback and a significant reduction in exception reports. No fines have been made since introduction of the new junior doctors' contract.

6.4 There has been significant improvement in number of exception reports that were generated by Hereford trainees. We had no reports during the period covered by this report as a result of collective work by Guardian of safe working hours, HR and DME. Work schedules of Hereford trainees were updated following data received from exception reports and discussions at Junior Doctors Forums.

6.5 There were a number of reports from Gloucestershire over this period mainly related to inpatient jobs. It is important to clarify that these reports were not related to night shifts. They were as a result of daytime workload resulting in doctors staying beyond their contracted hours. There is a need for improvement in medical cover arrangements in Wotton Lawn Hospital and this is being considered.

7.0 RECOMMENDATIONS

7.1 The Board is asked to read and note of this report from the Guardian of Safe Working.

7.2 Engagement of educational supervisors and trainees with exception report process remains a challenge. We are addressing this through regular presentations at Inductions and other training opportunities.

Survey Coordination Centre

NHS England

2Gether NHS Foundation Trust

2018 NHS Staff Survey

Benchmark Report

Contents

Introduction

This benchmark report for 2Gether NHS Foundation Trust contains results for themes and questions from the 2018 NHS Staff Survey, and historical results back to 2014 where possible. These results are presented in the context of the best, average and worst results for similar organisations where appropriate. Data in this report is weighted to allow for fair comparisons between organisations.

Please note: q1, q10a, q19f, q23d-q28a and q29-q31b are not weighted or benchmarked because these questions ask for demographic or factual information.

Full details of how the data is calculated and weighted are included in the Technical Document, available to download from our results website.

The structure of this report

Introduction

- Introduction
- Using the report
- Organisation details

Provides a brief introduction to the report, including the graphs used throughout.

The '**Organisation details**' page contains key information about the organisation's survey and its benchmarking group.

Theme results

- Overview
- Trends
- Detailed information

The ten themes provide a high level overview of the results for an organisation.

The '**Detailed information**' sub-section contains the question results that feed into each theme.

Question results

- Your job
- Your managers
- Your health, well-being and safety at work
- Your personal development
- Your organisation
- Background details

Results from all questions, structured by the questionnaire sections.

Appendices

- Response rate trends
- Significance testing of themes
- Tips on action planning and interpreting results

'**Significance testing of themes**' contains comparisons for the 2018 and 2017 theme scores.

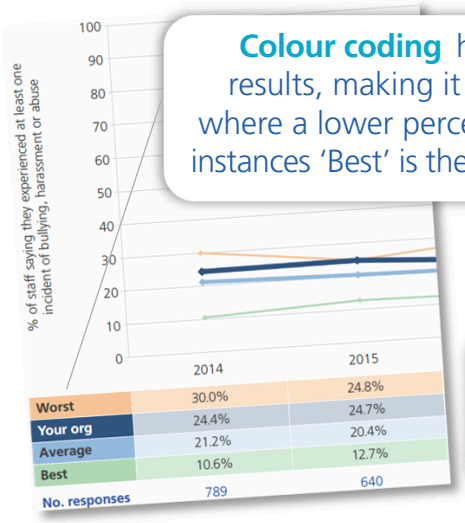
Using the report

Key features

Question number and text (or the theme) specified at the top of each slide

Slide headers are **hyperlinked** throughout the document. '2018 NHS Staff Survey Results' takes you back to the contents page (which is also hyperlinked to each section), while the rest of the text highlighted in bold can be used to navigate to sections and sub-sections

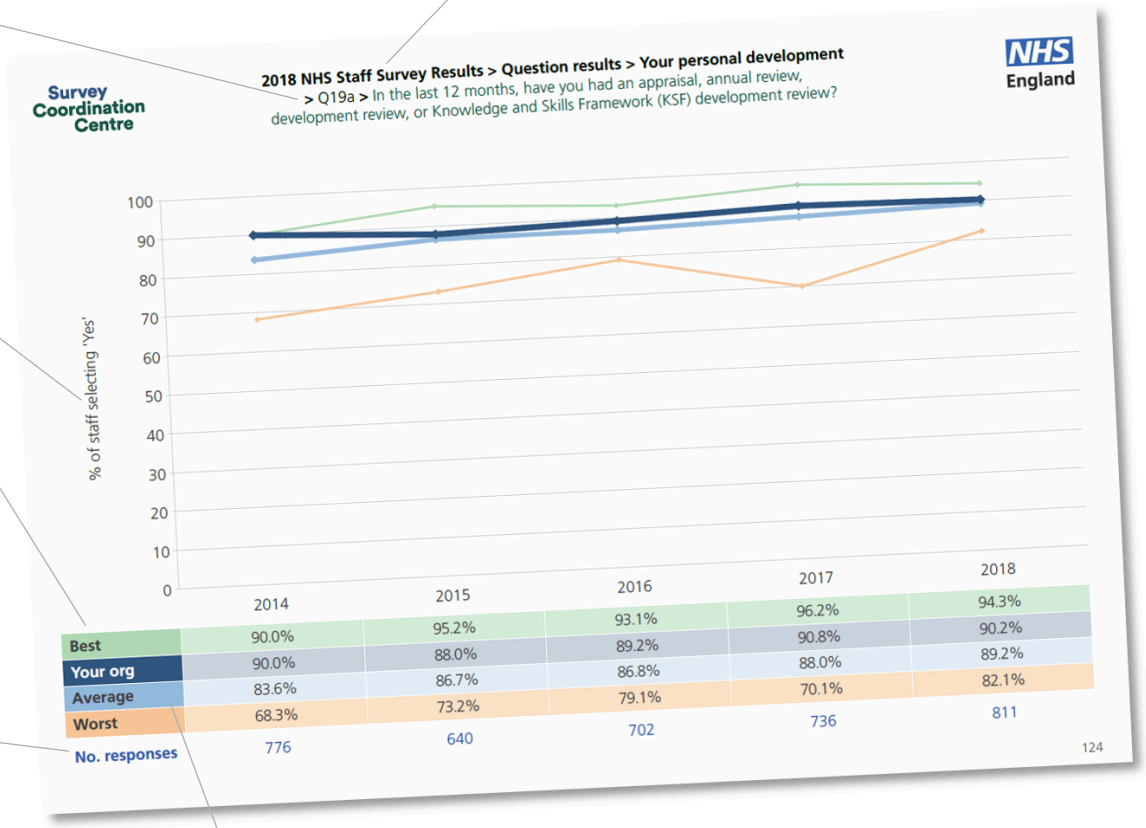
Question-level results are always reported as percentages; the **meaning of the value** is outlined along the axis. Themes are always on a 0-10pt scale where 10 is the best score attainable



Colour coding highlights best / worst results, making it easy to spot questions where a lower percentage is better – in such instances 'Best' is the bottom line in the table

Keep an eye out!

Number of responses for the organisation for the given question



'Best', 'Average', and 'Worst' refer to the **benchmarking group's** best, average and worst **results**

Tips on how to read, interpret and use the data are included in the Appendices

Organisation details

2Gether NHS Foundation Trust

2018 NHS Staff Survey

Organisation details

Completed questionnaires **863**

2018 response rate **40%**

See response rate trend for the last 5 years

Survey details

Survey mode **Online**

Sample type **Census**

This organisation is benchmarked against:

Mental Health / Learning Disability Trusts

2018 benchmarking group details

Organisations in group: **24**

Average response rate: **54%**

No. of completed questionnaires: **36,844**

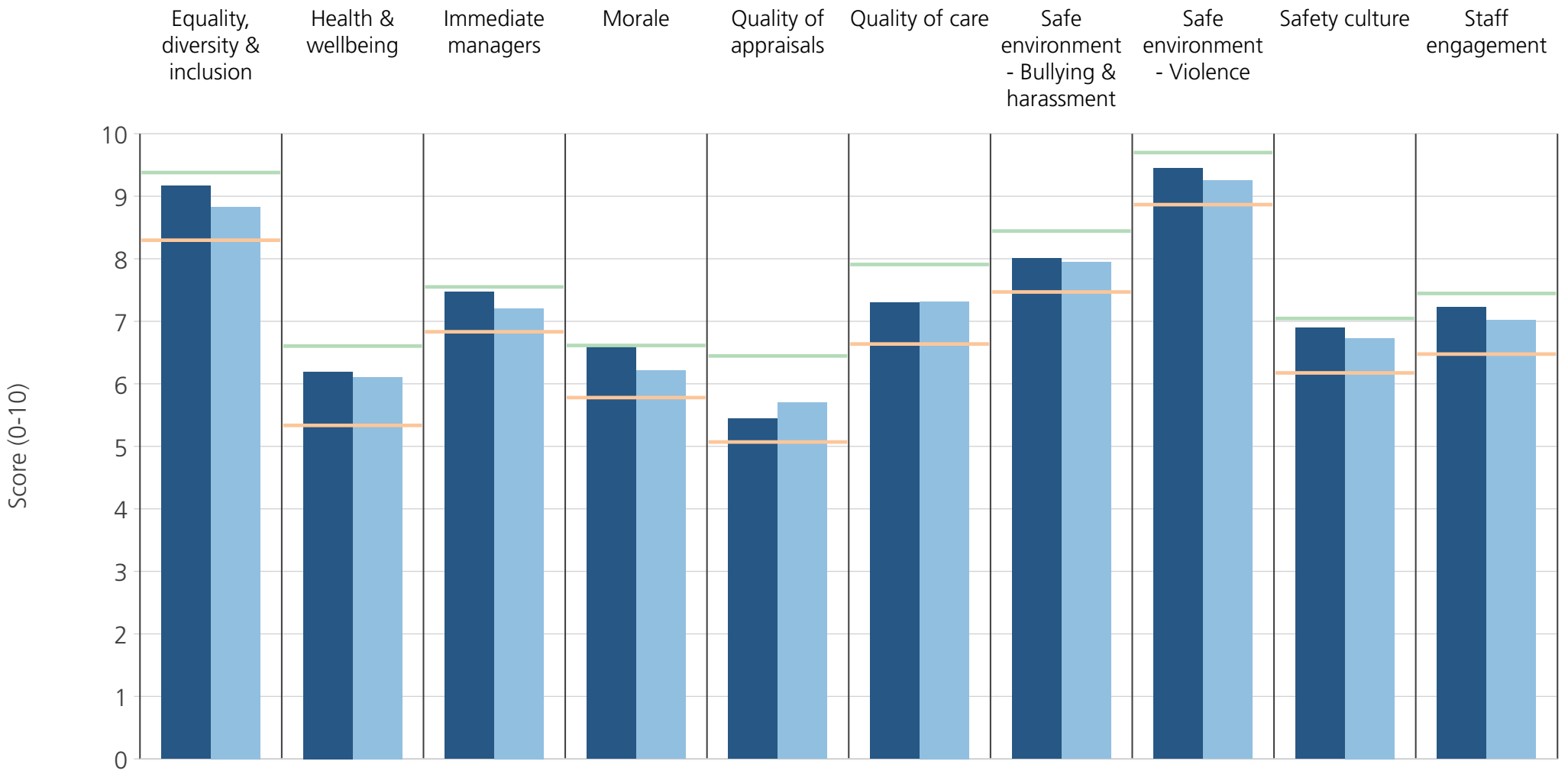
Survey Coordination Centre

NHS England

Theme results

2Gether NHS Foundation Trust

2018 NHS Staff Survey Results



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.4	6.6	7.5	6.6	6.4	7.9	8.4	9.7	7.0	7.4
Your org	9.2	6.2	7.5	6.6	5.4	7.3	8.0	9.4	6.9	7.2
Average	8.8	6.1	7.2	6.2	5.7	7.3	7.9	9.3	6.7	7.0
Worst	8.3	5.3	6.8	5.8	5.1	6.6	7.5	8.9	6.2	6.5
No. responses	851	855	857	845	741	672	849	845	852	862

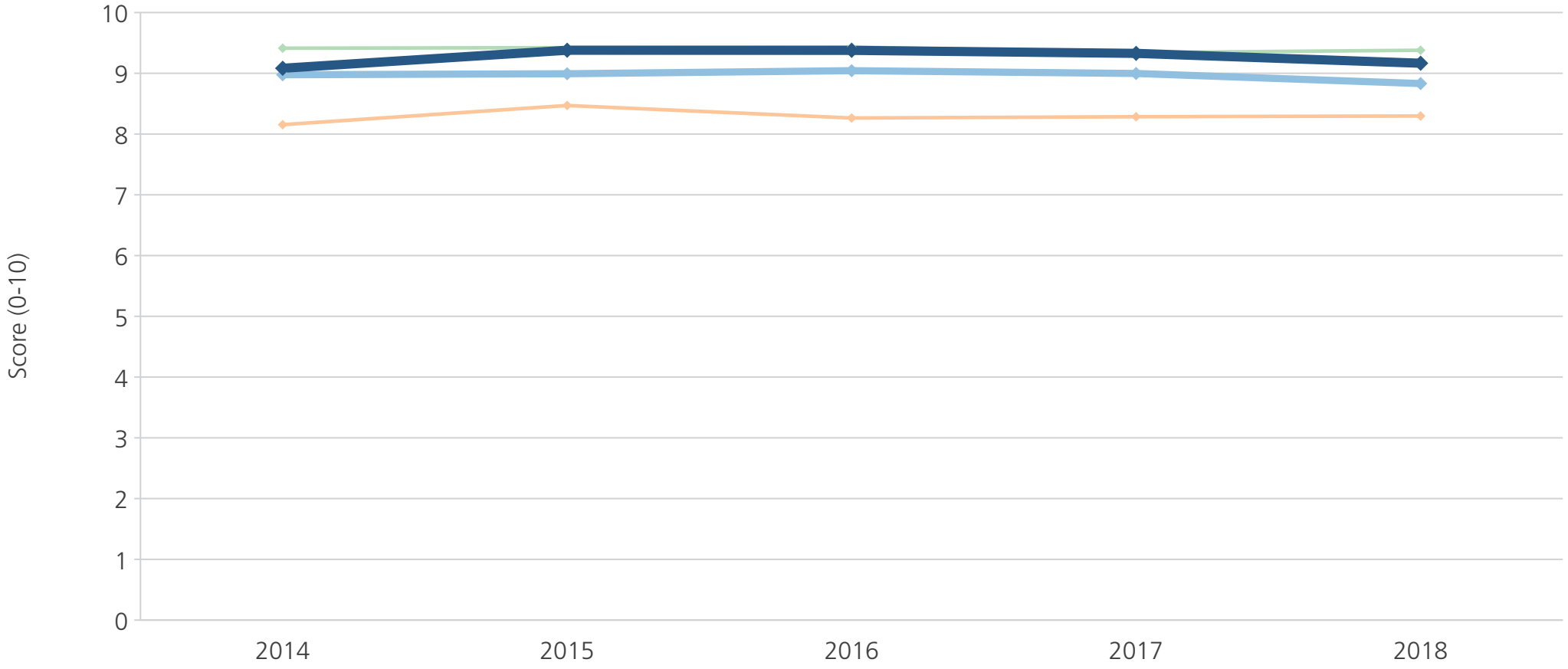
Survey Coordination Centre

NHS England

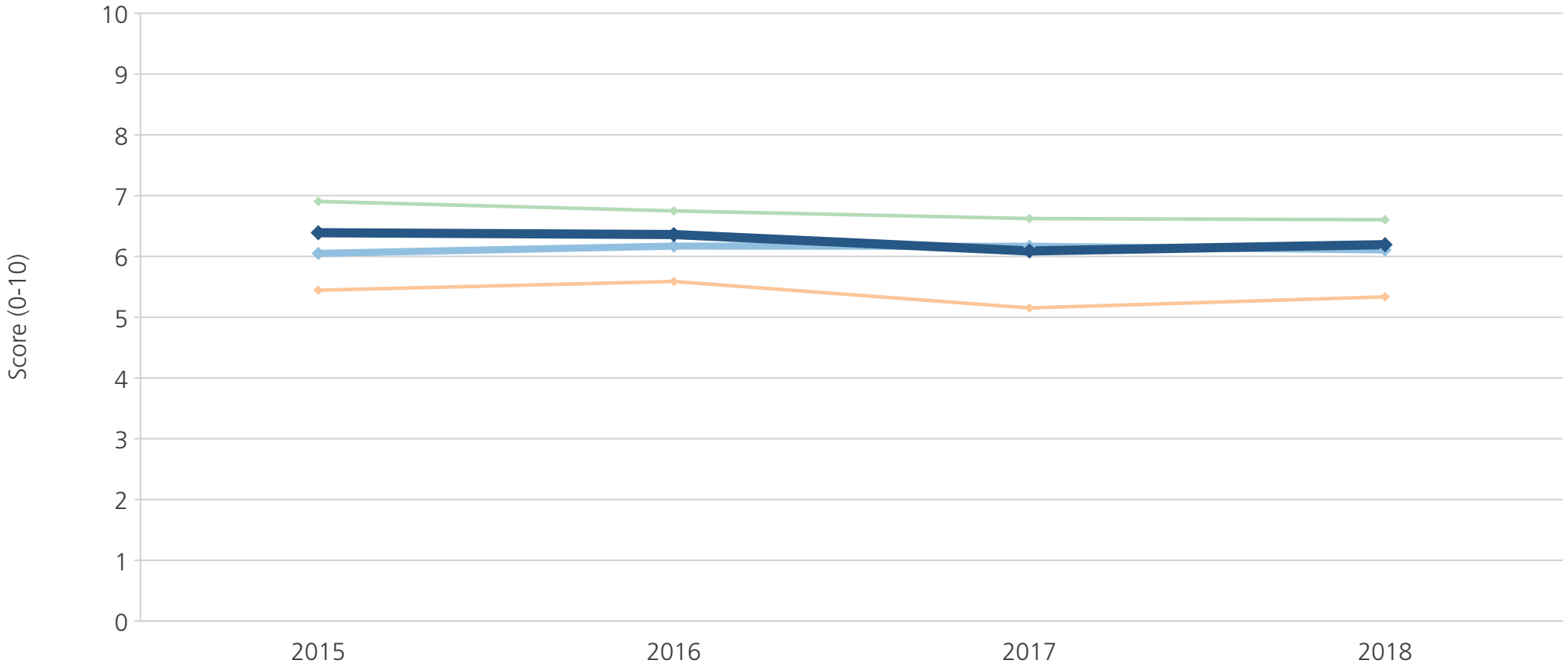
Theme results – Trends

2Gether NHS Foundation Trust

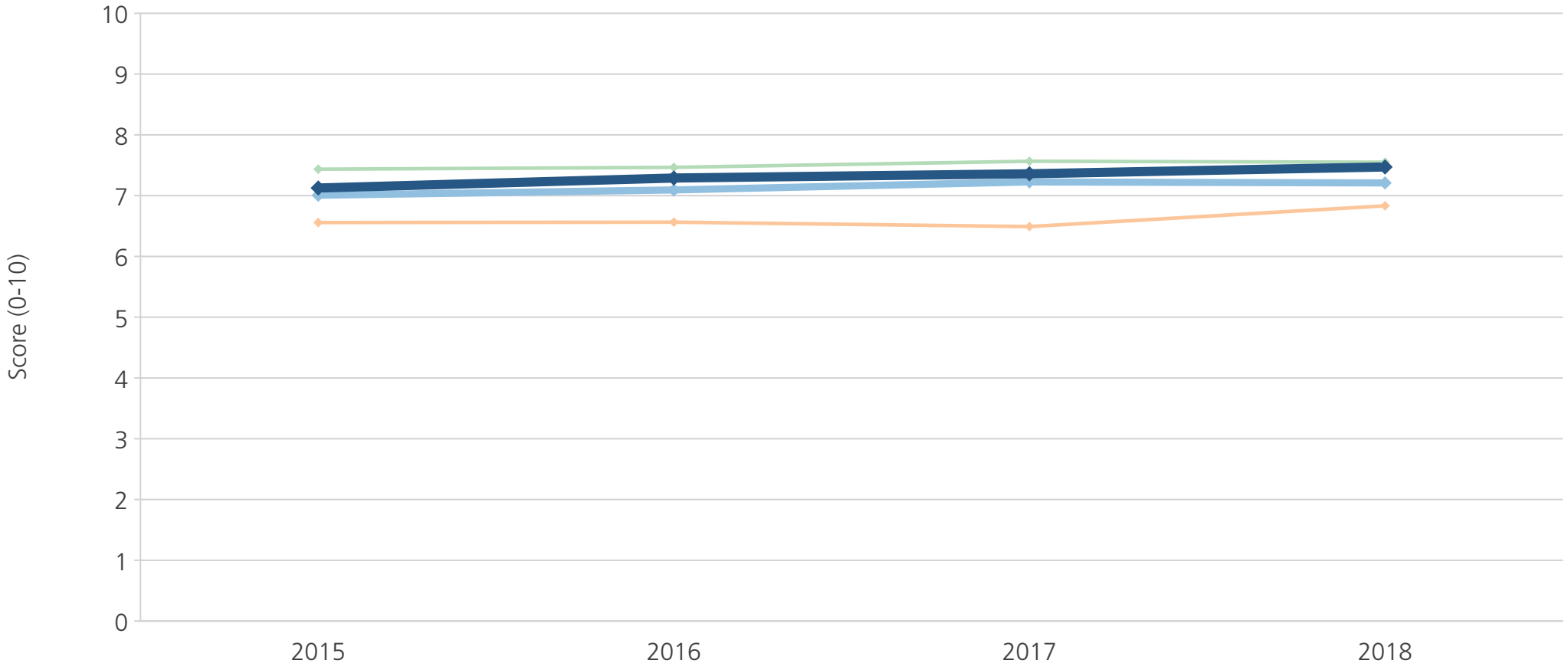
2018 NHS Staff Survey Results



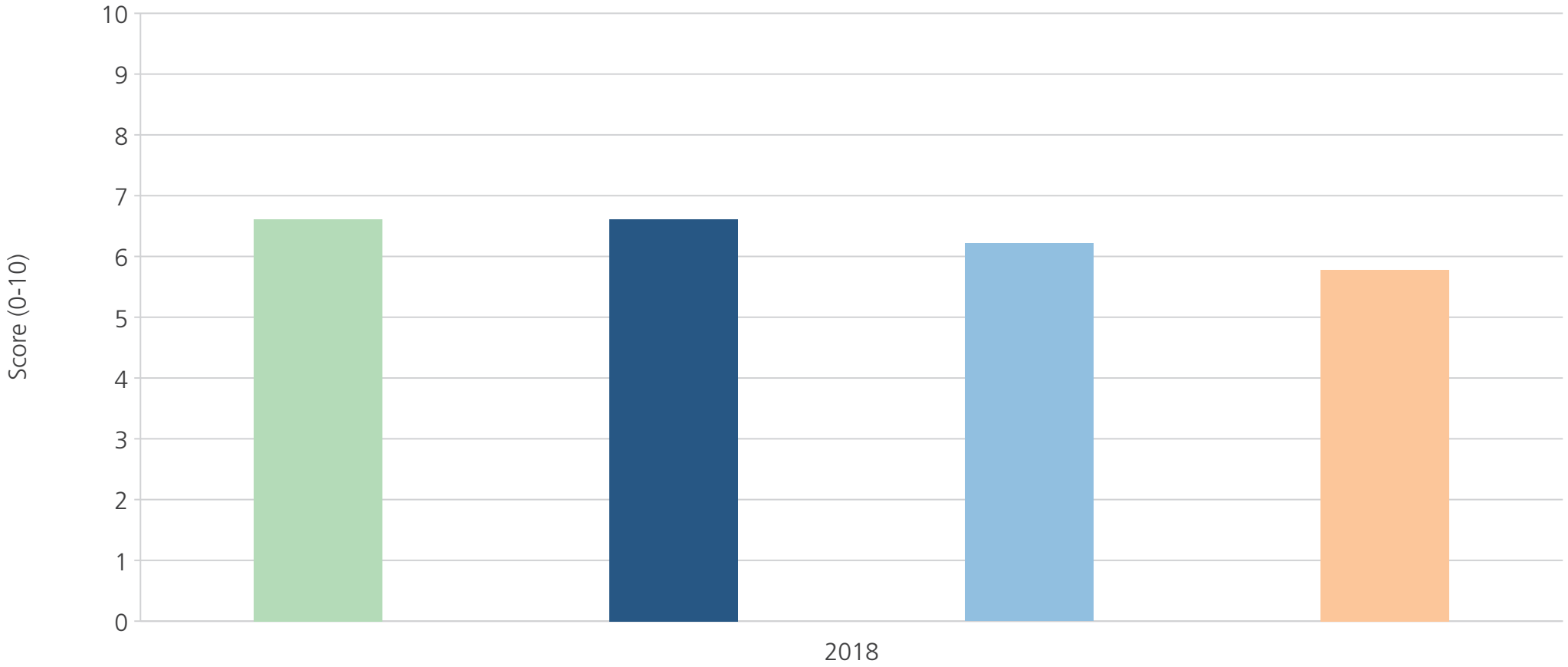
	2014	2015	2016	2017	2018
Best	9.4	9.4	9.4	9.3	9.4
Your org	9.1	9.4	9.4	9.3	9.2
Average	9.0	9.0	9.0	9.0	8.8
Worst	8.2	8.5	8.3	8.3	8.3
No. responses	340	296	765	903	851



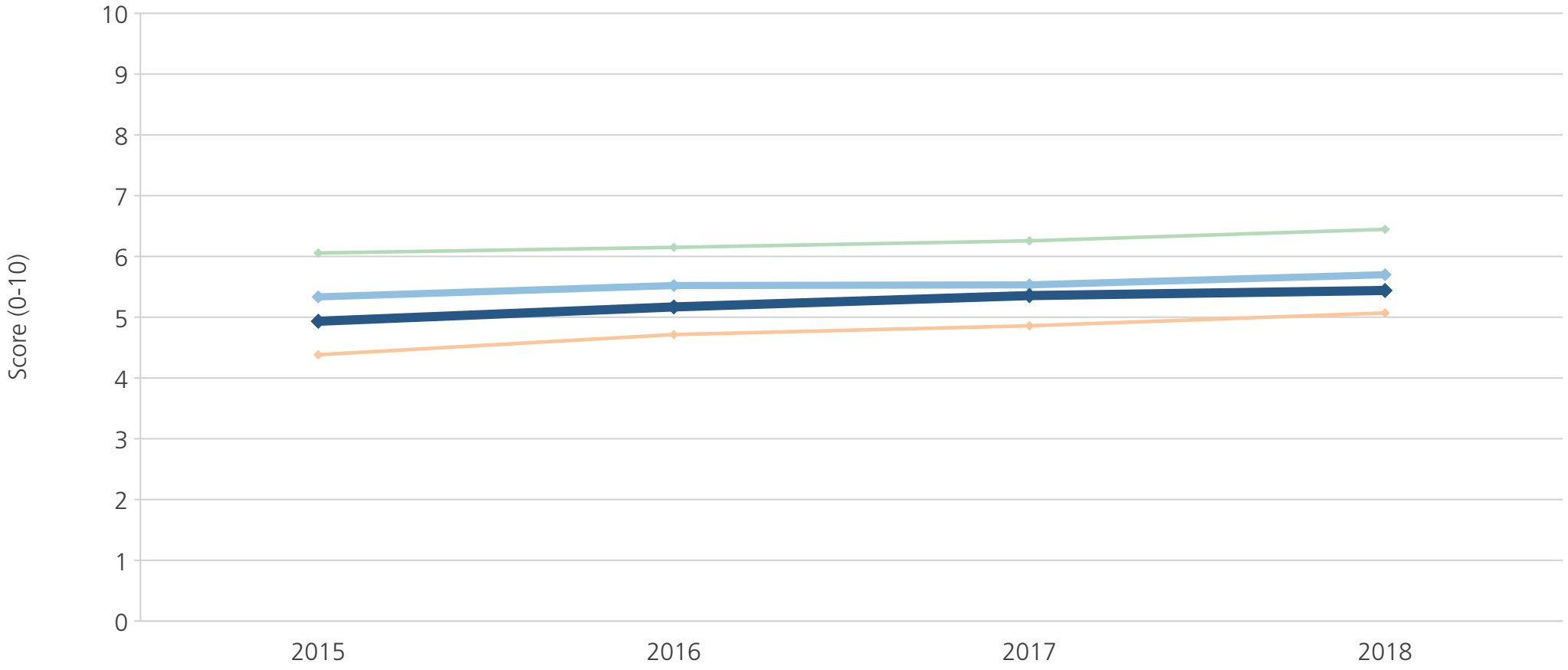
	2015	2016	2017	2018
Best	6.9	6.7	6.6	6.6
Your org	6.4	6.4	6.1	6.2
Average	6.0	6.2	6.2	6.1
Worst	5.4	5.6	5.2	5.3
No. responses	296	773	911	855



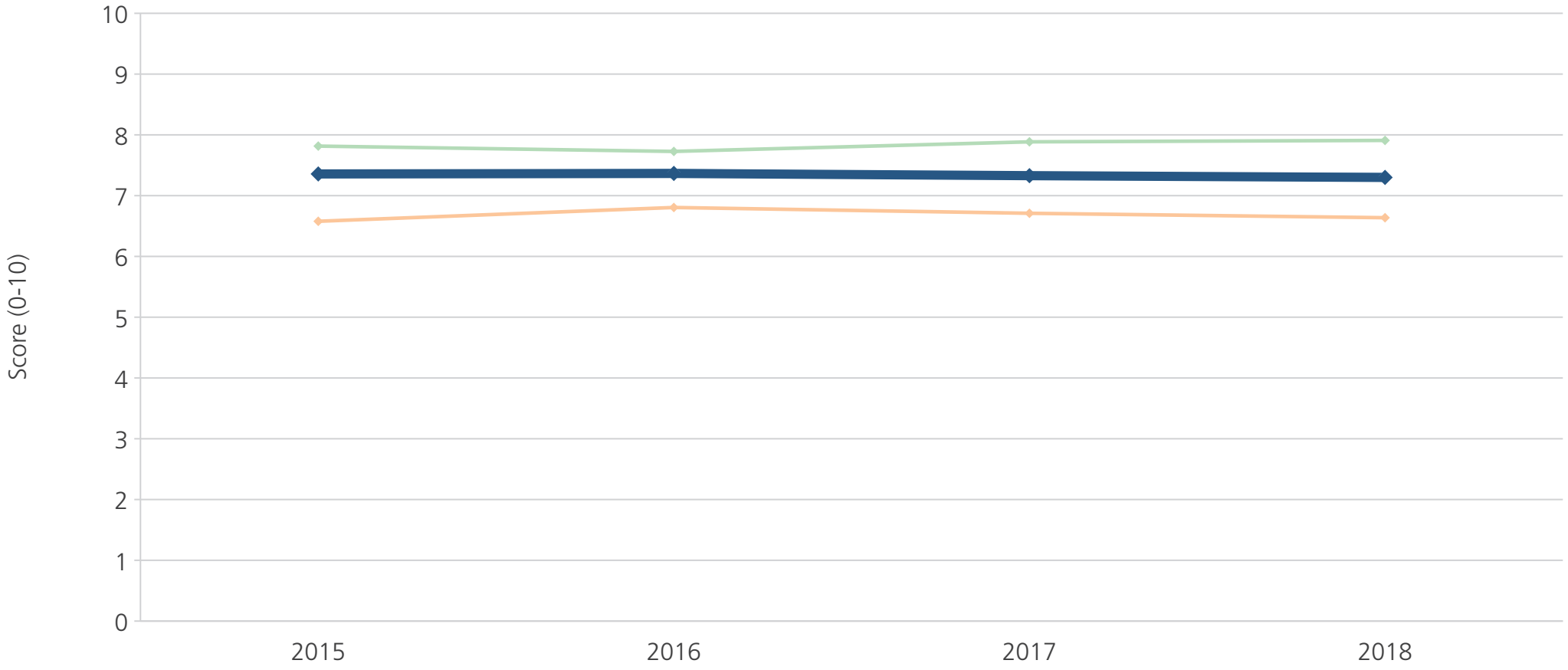
	2015	2016	2017	2018
Best	7.4	7.5	7.6	7.5
Your org	7.1	7.3	7.4	7.5
Average	7.0	7.1	7.2	7.2
Worst	6.6	6.6	6.5	6.8
No. responses	295	771	911	857



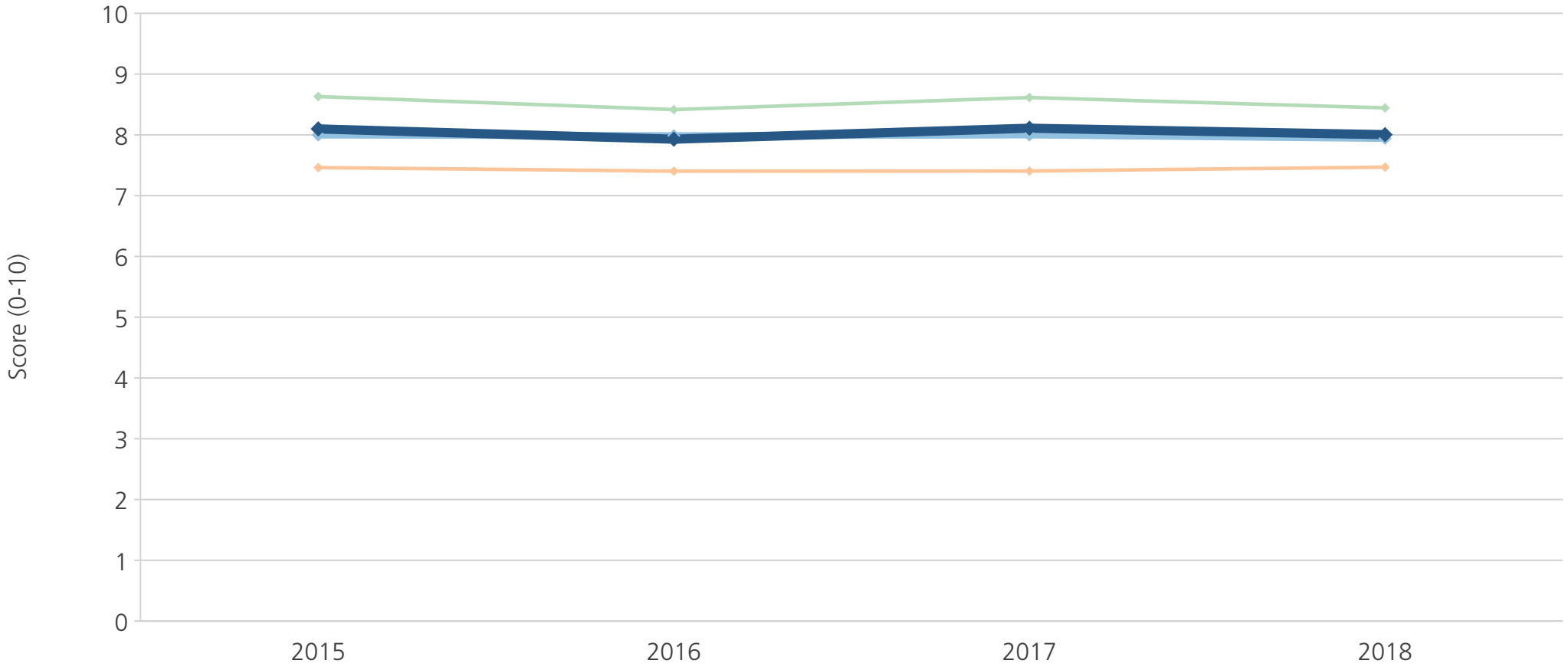
Best	6.6
Your org	6.6
Average	6.2
Worst	5.8
No. responses	845



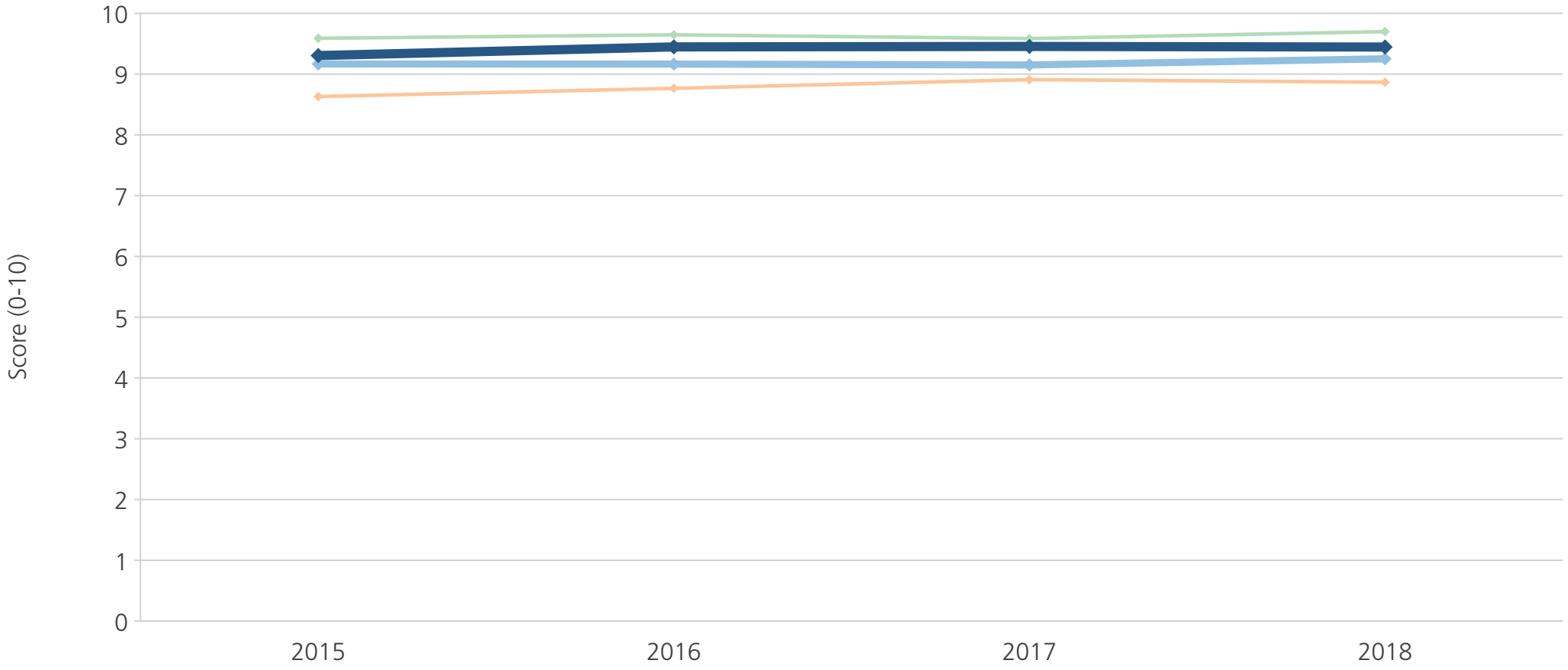
	2015	2016	2017	2018
Best	6.1	6.1	6.3	6.4
Your org	4.9	5.2	5.4	5.4
Average	5.3	5.5	5.5	5.7
Worst	4.4	4.7	4.9	5.1
No. responses	255	677	803	741



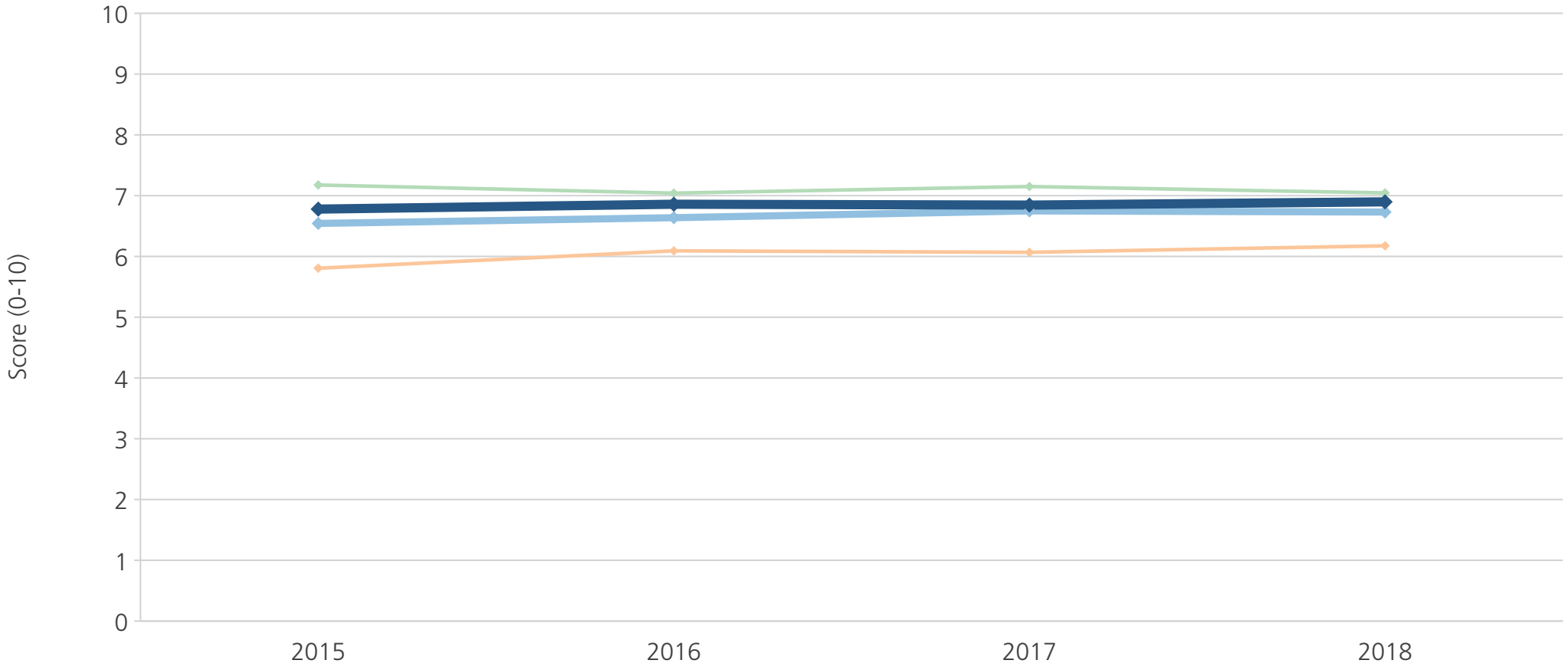
	2015	2016	2017	2018
Best	7.8	7.7	7.9	7.9
Your org	7.4	7.4	7.3	7.3
Average	7.4	7.4	7.3	7.3
Worst	6.6	6.8	6.7	6.6
No. responses	235	596	723	672



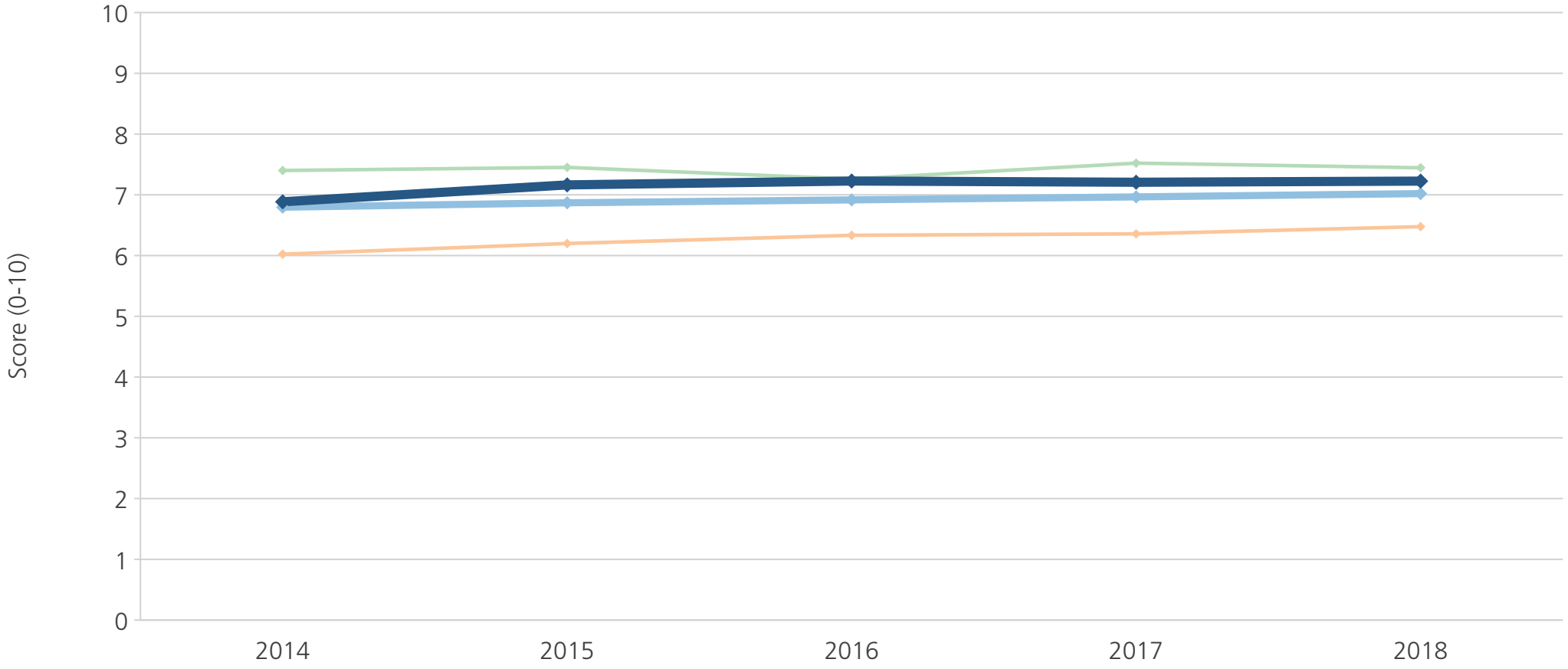
	2015	2016	2017	2018
Best	8.6	8.4	8.6	8.4
Your org	8.1	7.9	8.1	8.0
Average	8.0	8.0	8.0	7.9
Worst	7.5	7.4	7.4	7.5
No. responses	291	766	904	849



	2015	2016	2017	2018
Best	9.6	9.6	9.6	9.7
Your org	9.3	9.4	9.5	9.4
Average	9.2	9.2	9.2	9.3
Worst	8.6	8.8	8.9	8.9
No. responses	293	768	907	845



	2015	2016	2017	2018
Best	7.2	7.0	7.2	7.0
Your org	6.8	6.9	6.8	6.9
Average	6.5	6.6	6.7	6.7
Worst	5.8	6.1	6.1	6.2
No. responses	294	770	910	852



	2014	2015	2016	2017	2018
Best	7.4	7.5	7.3	7.5	7.4
Your org	6.9	7.2	7.2	7.2	7.2
Average	6.8	6.9	6.9	7.0	7.0
Worst	6.0	6.2	6.3	6.4	6.5
No. responses	341	297	776	918	862

Survey Coordination Centre

NHS England

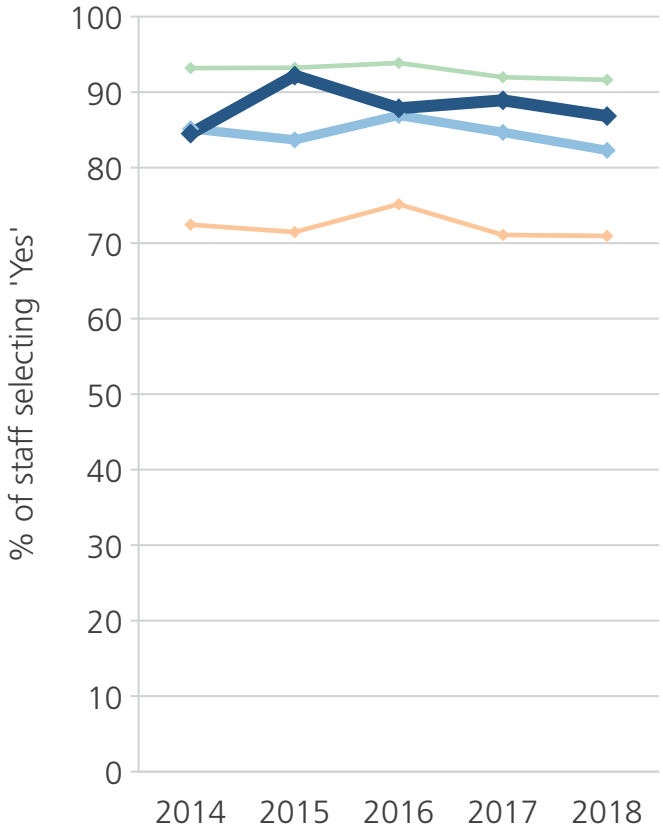
Theme results – Detailed information

2Gether NHS Foundation Trust

2018 NHS Staff Survey Results

Q14

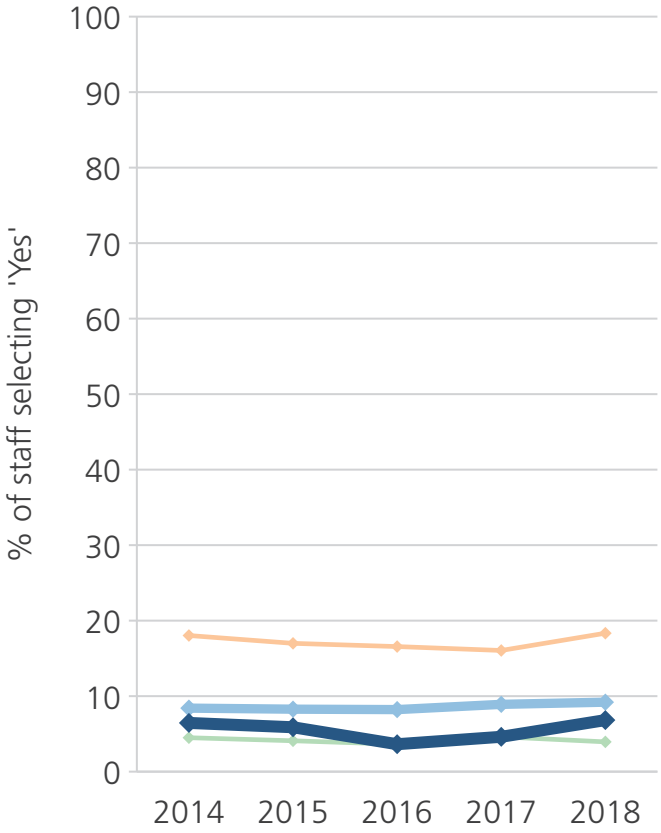
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



	2014	2015	2016	2017	2018
Best	93.2%	93.2%	93.9%	92.0%	91.6%
Your org	84.5%	92.2%	87.9%	88.9%	86.8%
Average	85.1%	83.7%	86.9%	84.7%	82.3%
Worst	72.4%	71.5%	75.2%	71.1%	71.0%

Q15a

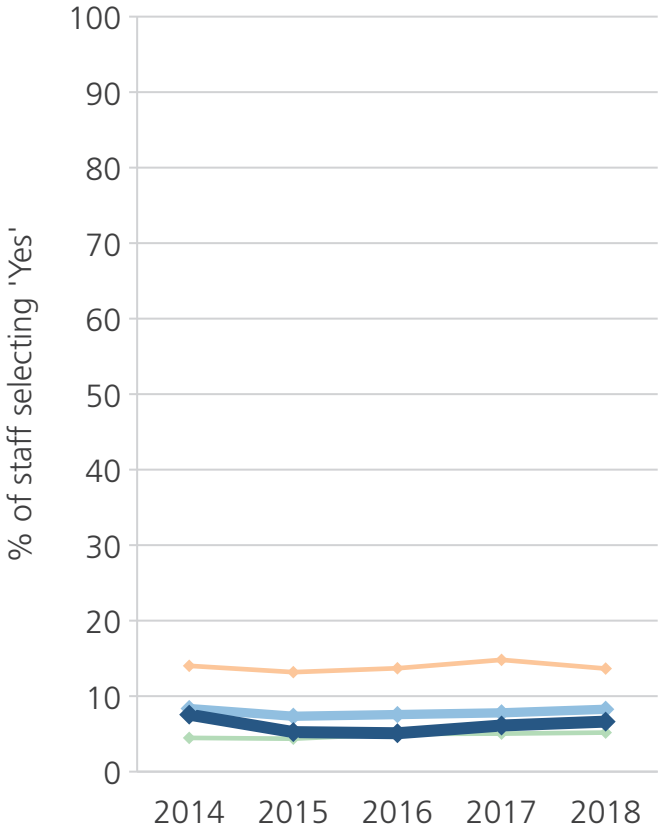
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?



	2014	2015	2016	2017	2018
Worst	18.0%	17.0%	16.6%	16.0%	18.3%
Your org	6.5%	5.9%	3.6%	4.6%	6.8%
Average	8.4%	8.3%	8.2%	8.9%	9.2%
Best	4.5%	4.1%	3.6%	4.6%	3.9%

Q15b

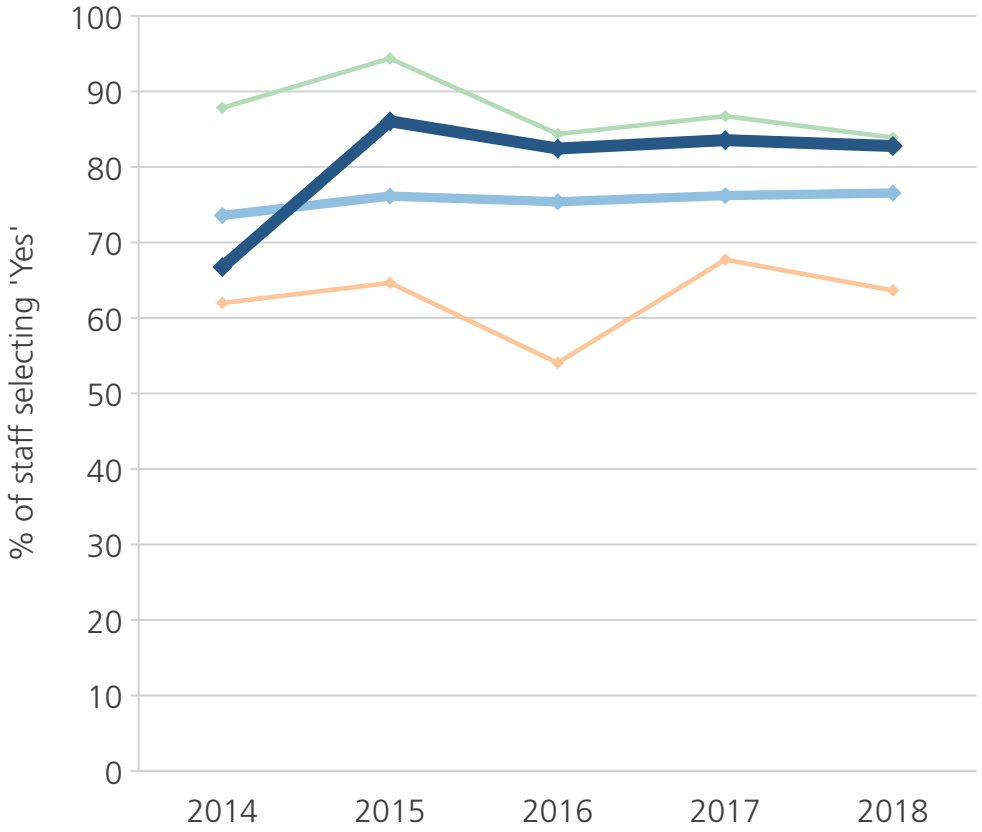
In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?



	2014	2015	2016	2017	2018
Worst	14.0%	13.2%	13.7%	14.8%	13.7%
Your org	7.6%	5.2%	5.1%	6.1%	6.6%
Average	8.4%	7.3%	7.6%	7.8%	8.3%
Best	4.5%	4.4%	5.0%	5.0%	5.2%

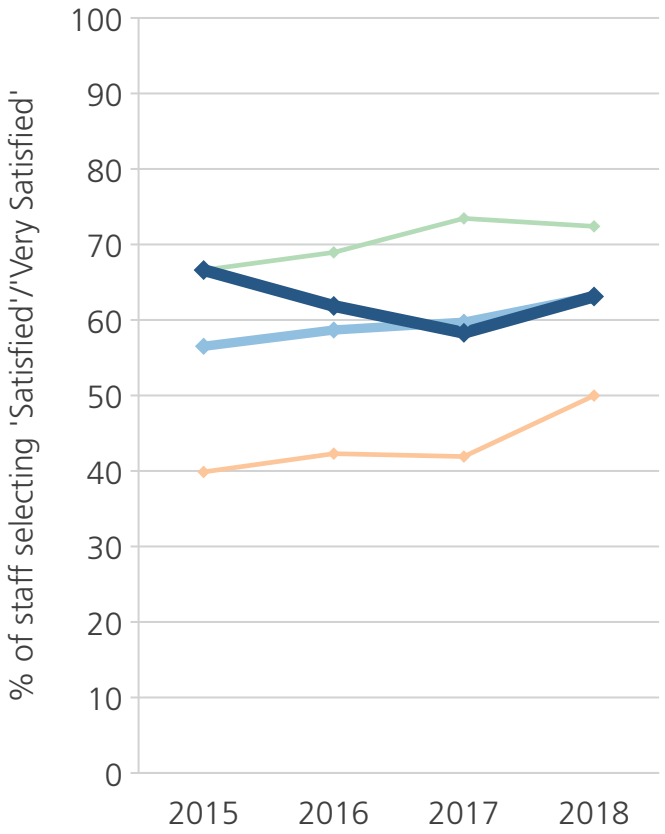
Q28b

Has your employer made adequate adjustment(s) to enable you to carry out your work?



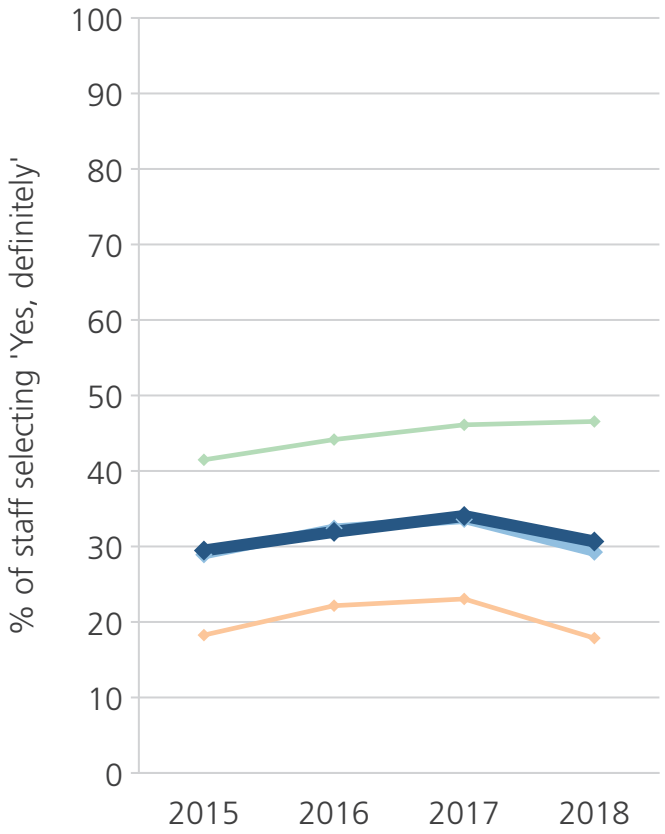
	2014	2015	2016	2017	2018
Best	87.8%	94.4%	84.4%	86.7%	83.9%
Your org	66.7%	86.1%	82.4%	83.6%	82.8%
Average	73.6%	76.1%	75.4%	76.2%	76.5%
Worst	62.0%	64.6%	54.1%	67.7%	63.6%

Q5h
The opportunities for flexible working patterns



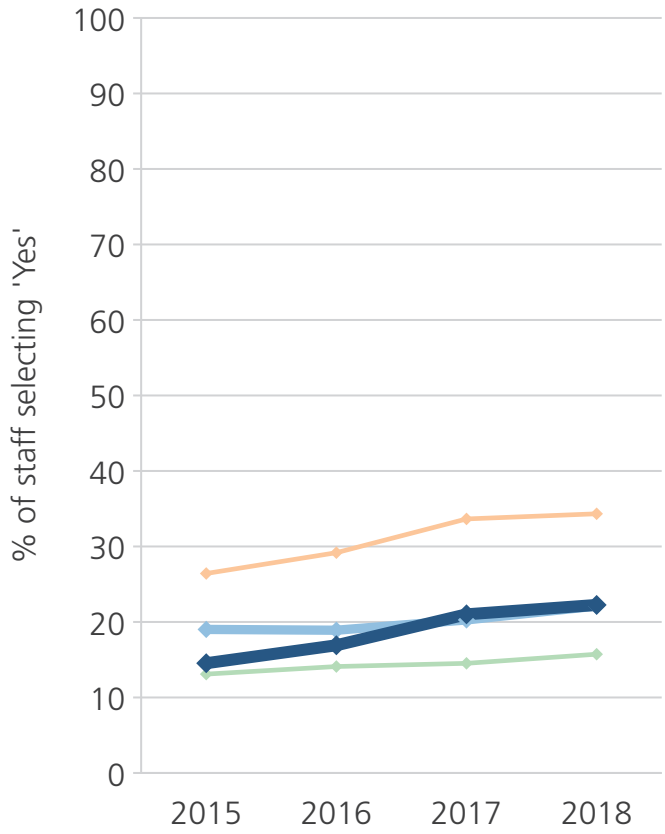
	2015	2016	2017	2018
Best	66.6%	69.0%	73.5%	72.4%
Your org	66.6%	61.9%	58.3%	63.1%
Average	56.5%	58.7%	59.7%	63.1%
Worst	39.9%	42.3%	41.9%	50.0%

Q11a
Does your organisation take positive action on health and well-being?



	2015	2016	2017	2018
Best	41.5%	44.2%	46.1%	46.6%
Your org	29.5%	31.9%	34.0%	30.7%
Average	28.9%	32.4%	33.6%	29.2%
Worst	18.3%	22.2%	23.0%	17.9%

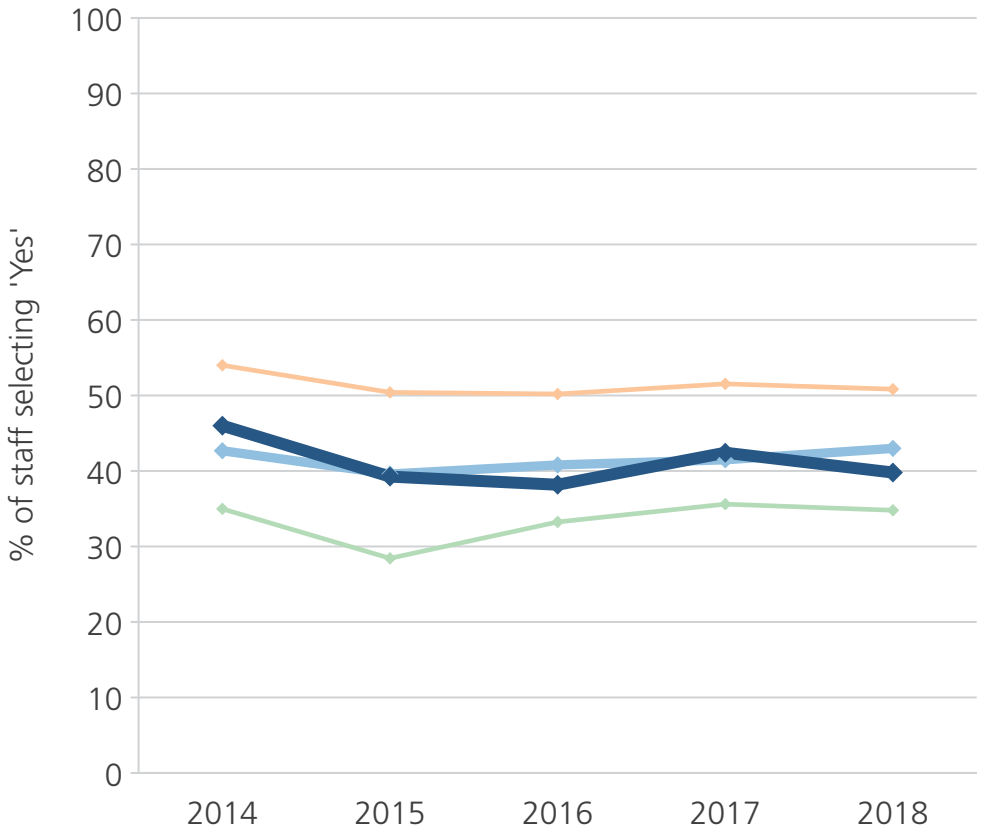
Q11b
In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?



	2015	2016	2017	2018
Worst	26.4%	29.2%	33.6%	34.3%
Your org	14.5%	16.9%	21.0%	22.3%
Average	19.0%	18.9%	20.3%	22.1%
Best	13.1%	14.1%	14.5%	15.7%

Q11c

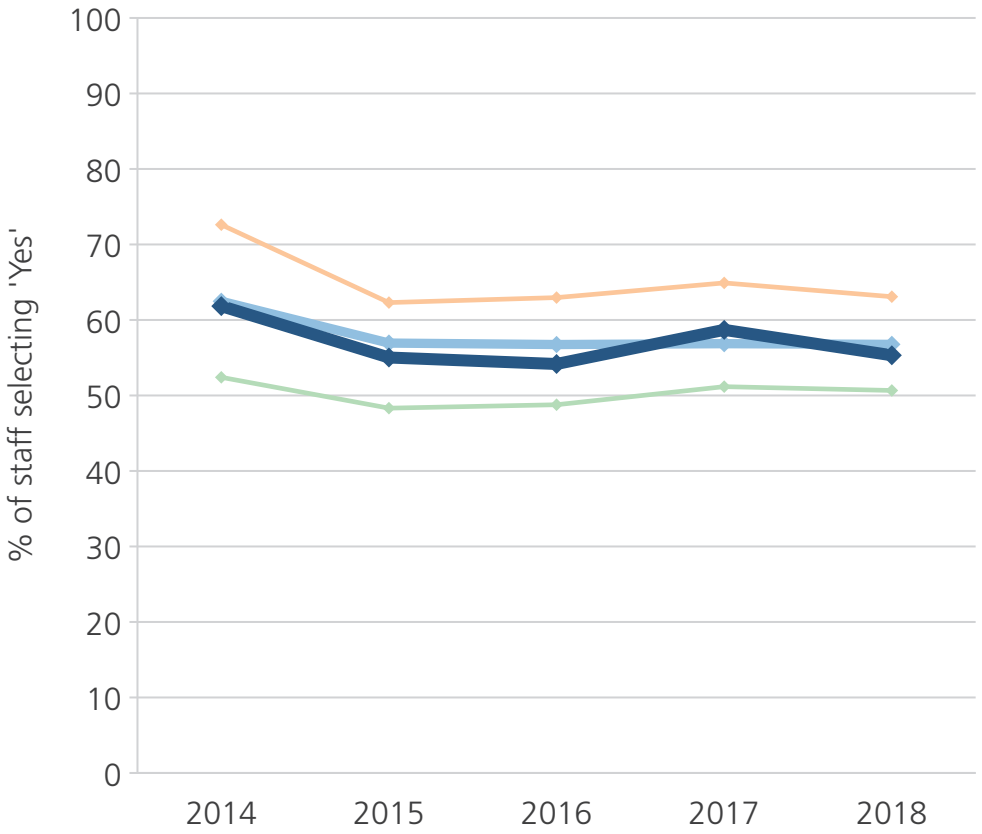
During the last 12 months have you felt unwell as a result of work related stress?



	2014	2015	2016	2017	2018
Worst	54.0%	50.4%	50.2%	51.5%	50.8%
Your org	46.0%	39.3%	38.2%	42.4%	39.8%
Average	42.7%	39.6%	40.8%	41.5%	43.0%
Best	35.0%	28.4%	33.2%	35.6%	34.8%

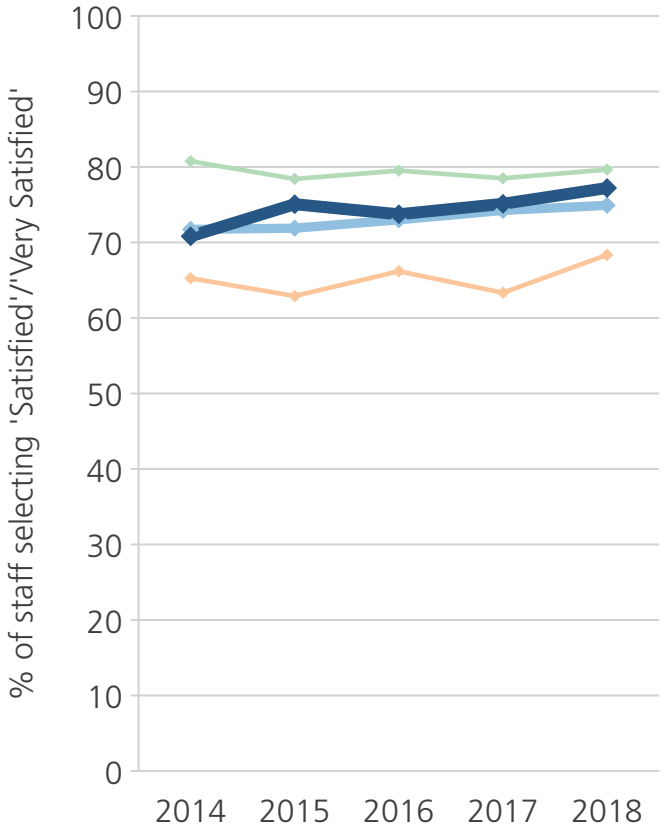
Q11d

In the last three months have you ever come to work despite not feeling well enough to perform your duties?



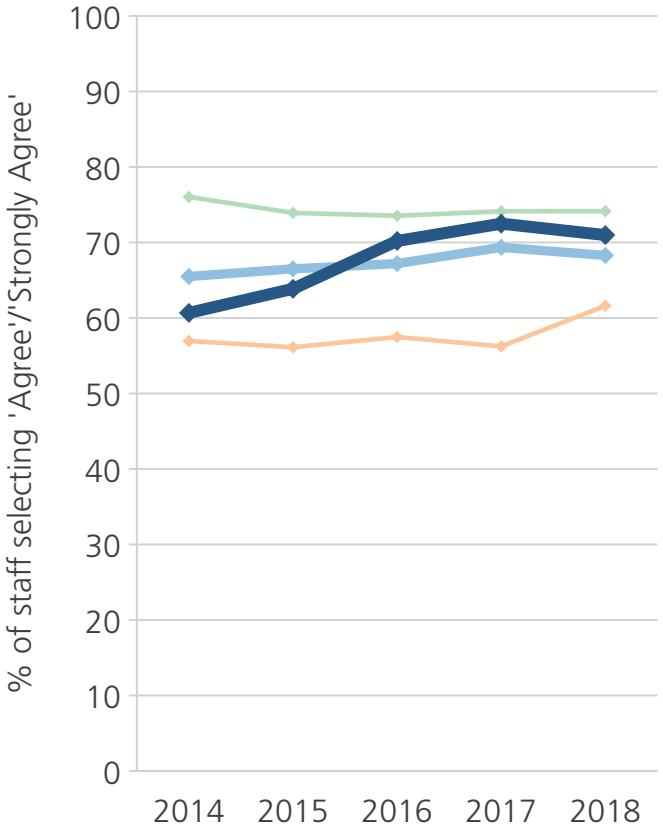
	2014	2015	2016	2017	2018
Worst	72.6%	62.3%	63.0%	64.9%	63.1%
Your org	61.8%	55.0%	54.2%	58.7%	55.3%
Average	62.5%	56.9%	56.7%	56.9%	56.8%
Best	52.4%	48.3%	48.8%	51.2%	50.7%

Q5b
The support I get from my immediate manager



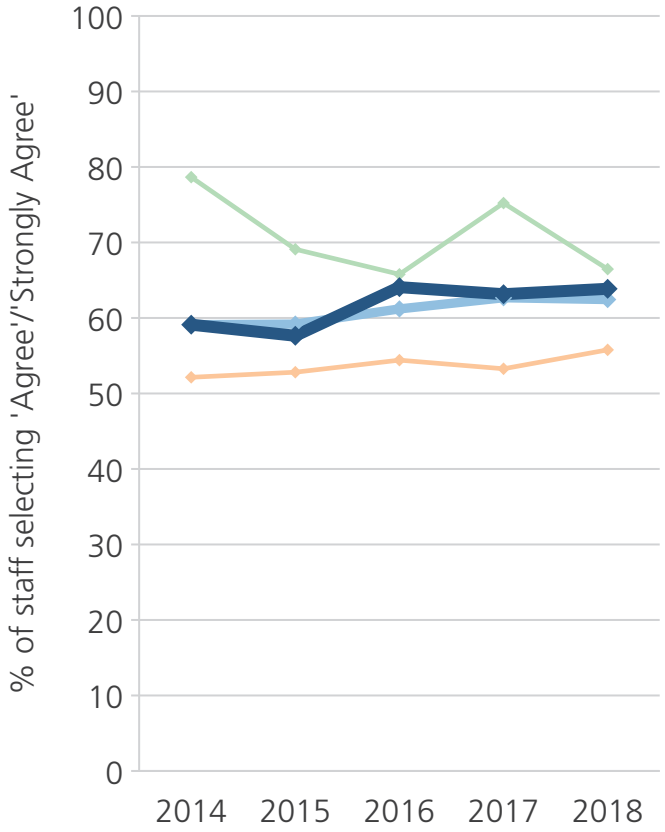
	2014	2015	2016	2017	2018
Best	80.8%	78.4%	79.5%	78.5%	79.7%
Your org	70.8%	75.1%	73.7%	75.1%	77.2%
Average	71.7%	71.9%	73.0%	74.2%	74.9%
Worst	65.3%	62.9%	66.2%	63.3%	68.4%

Q8c
My immediate manager gives me clear feedback on my work



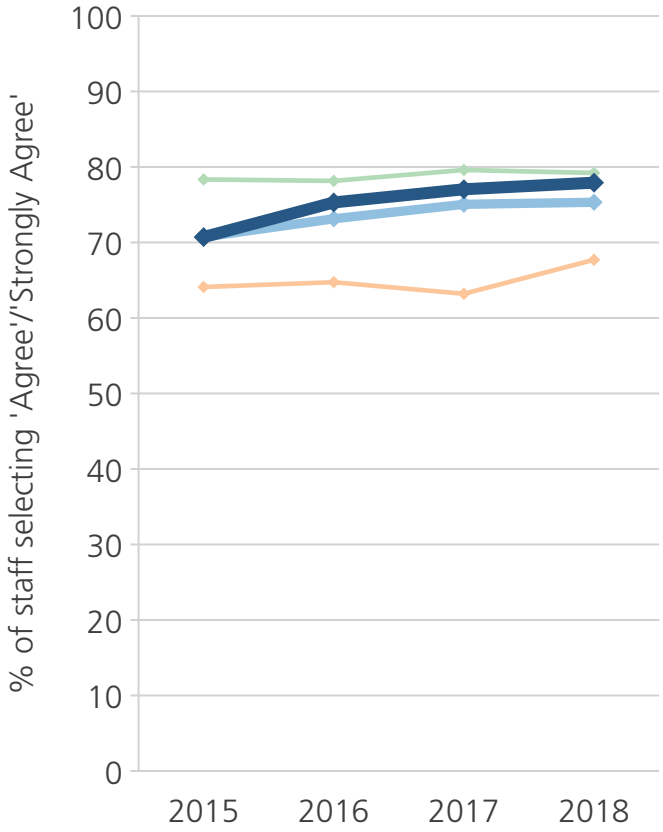
	2014	2015	2016	2017	2018
Best	76.0%	73.9%	73.5%	74.1%	74.1%
Your org	60.7%	63.9%	70.2%	72.5%	71.0%
Average	65.5%	66.5%	67.2%	69.4%	68.3%
Worst	57.0%	56.1%	57.5%	56.2%	61.6%

Q8d
My immediate manager asks for my opinion before making decisions that affect my work



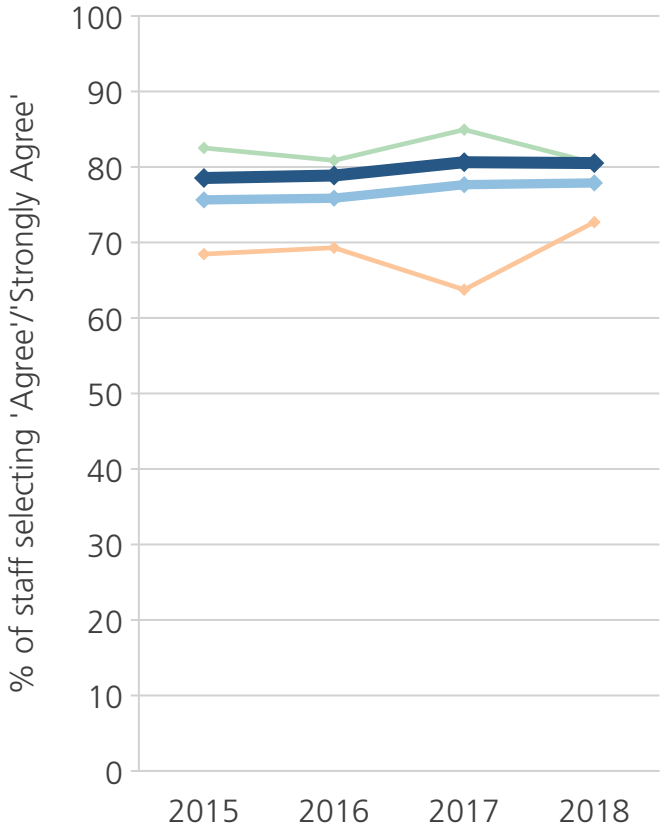
	2014	2015	2016	2017	2018
Best	78.7%	69.1%	65.8%	75.2%	66.5%
Your org	59.1%	57.6%	64.1%	63.1%	63.9%
Average	59.1%	59.2%	61.2%	62.7%	62.4%
Worst	52.1%	52.8%	54.4%	53.3%	55.8%

Q8f
My immediate manager takes a positive interest in my health and well-being



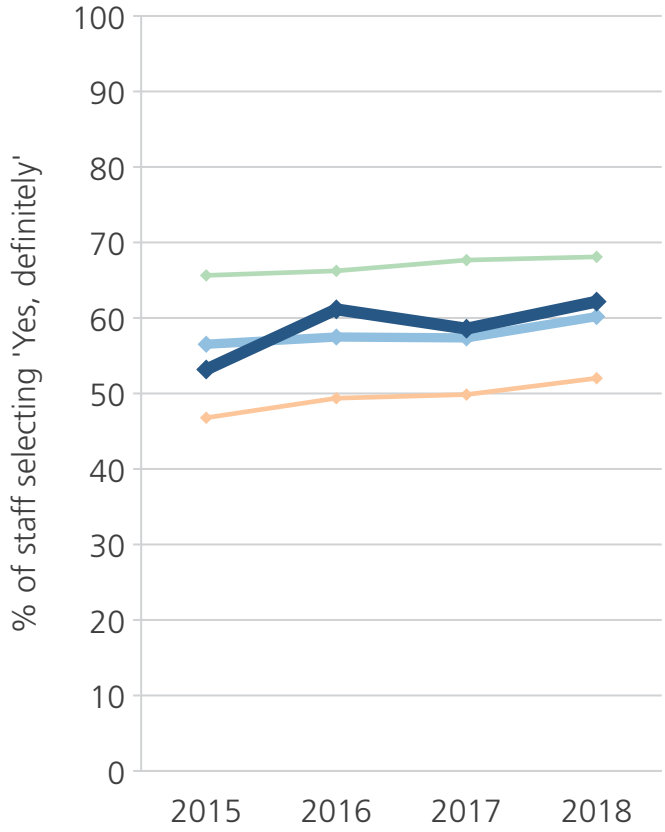
	2015	2016	2017	2018
Best	78.3%	78.2%	79.6%	79.2%
Your org	70.7%	75.3%	77.0%	77.9%
Average	70.7%	73.1%	75.1%	75.3%
Worst	64.1%	64.7%	63.2%	67.7%

Q8g
My immediate manager values my work



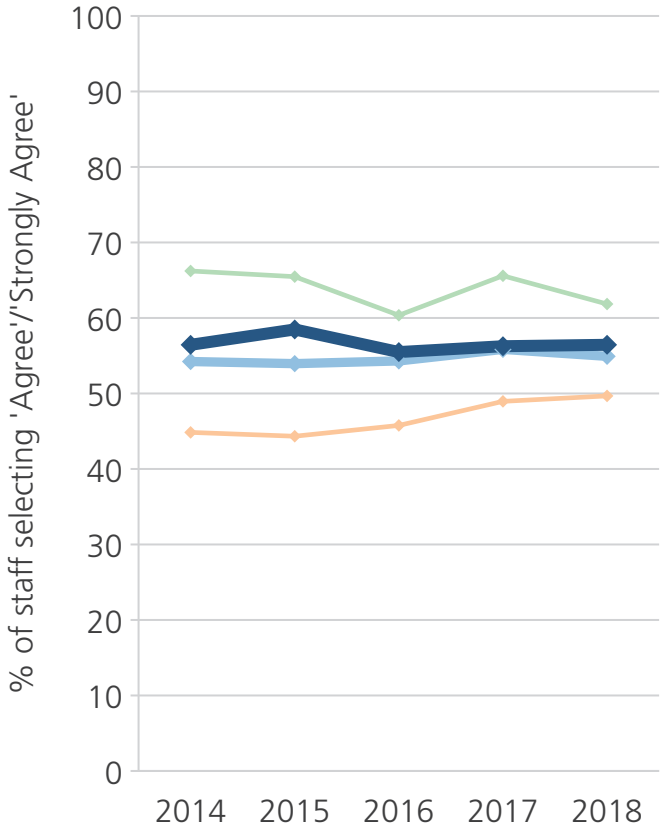
	2015	2016	2017	2018
Best	82.5%	80.9%	84.9%	80.5%
Your org	78.5%	78.9%	80.6%	80.5%
Average	75.6%	75.9%	77.7%	77.9%
Worst	68.5%	69.3%	63.7%	72.7%

Q19g
My manager supported me to receive this training, learning or development



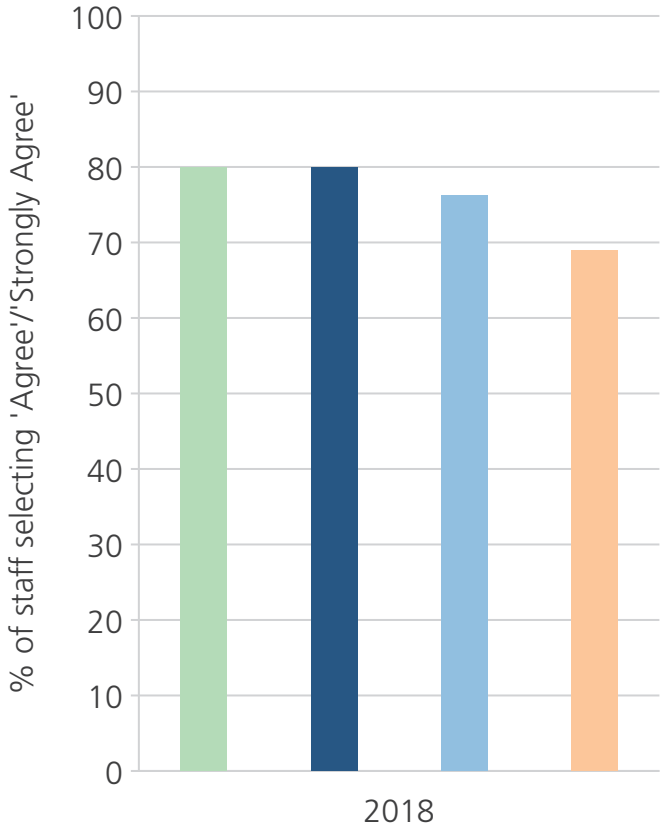
	2015	2016	2017	2018
Best	65.6%	66.2%	67.7%	68.1%
Your org	53.2%	61.1%	58.6%	62.2%
Average	56.5%	57.5%	57.4%	60.2%
Worst	46.8%	49.4%	49.9%	52.0%

Q4c
I am involved in deciding on changes introduced that affect my work area / team / department



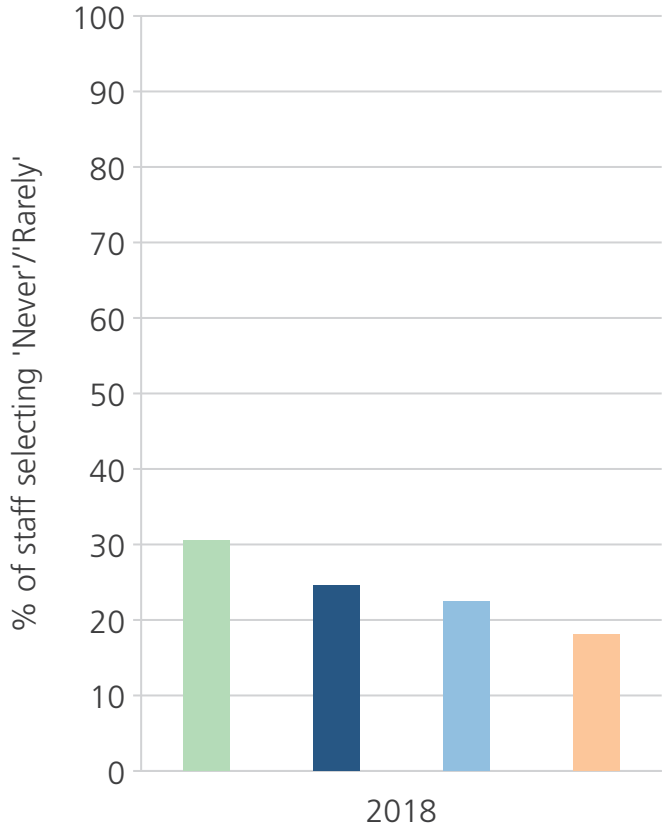
	2014	2015	2016	2017	2018
Best	66.2%	65.5%	60.4%	65.6%	61.8%
Your org	56.4%	58.5%	55.5%	56.3%	56.4%
Average	54.2%	54.0%	54.3%	55.8%	54.9%
Worst	44.8%	44.3%	45.8%	49.0%	49.7%

Q4j
I receive the respect I deserve from my colleagues at work



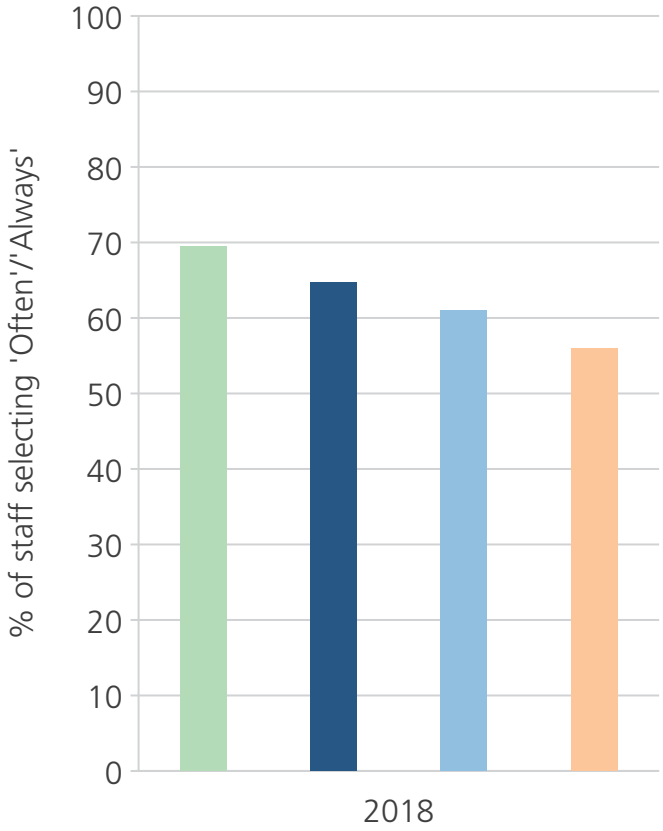
	2018
Best	79.9%
Your org	79.9%
Average	76.2%
Worst	68.9%

Q6a
I have unrealistic time pressures



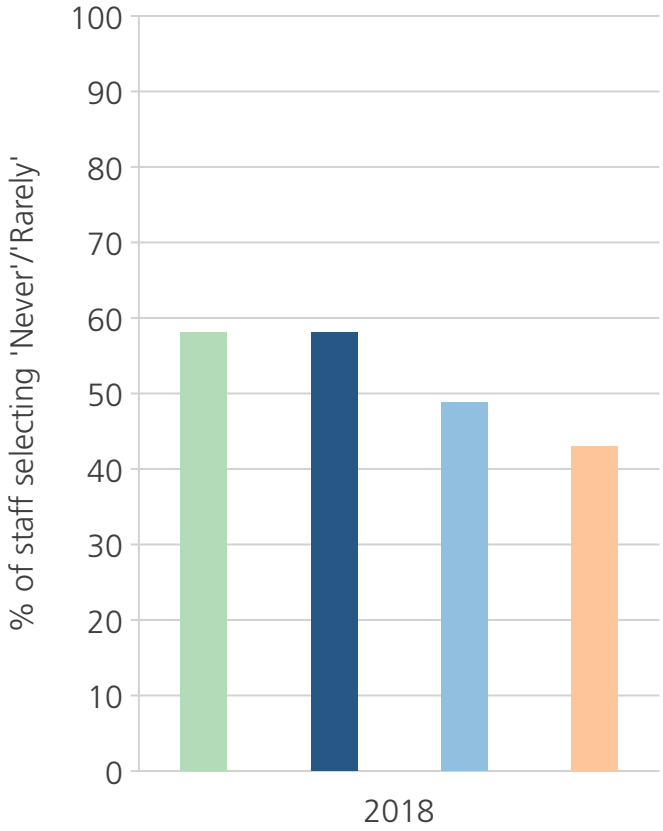
	2018
Best	30.5%
Your org	24.6%
Average	22.5%
Worst	18.1%

Q6b
I have a choice in deciding how to do my work



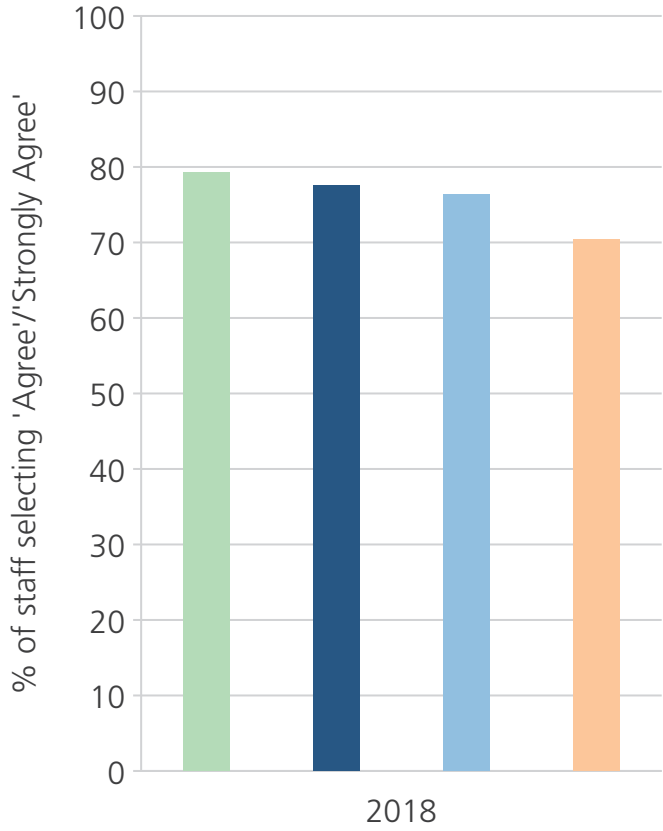
Best	69.4%
Your org	64.7%
Average	61.0%
Worst	55.9%

Q6c
Relationships at work are strained



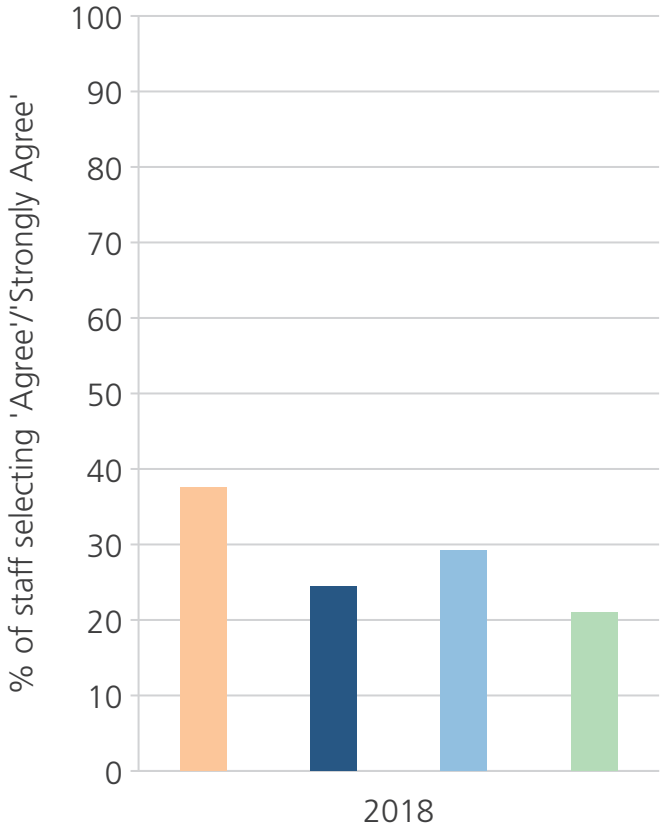
Best	58.0%
Your org	58.0%
Average	48.8%
Worst	43.0%

Q8a
My immediate manager encourages me at work



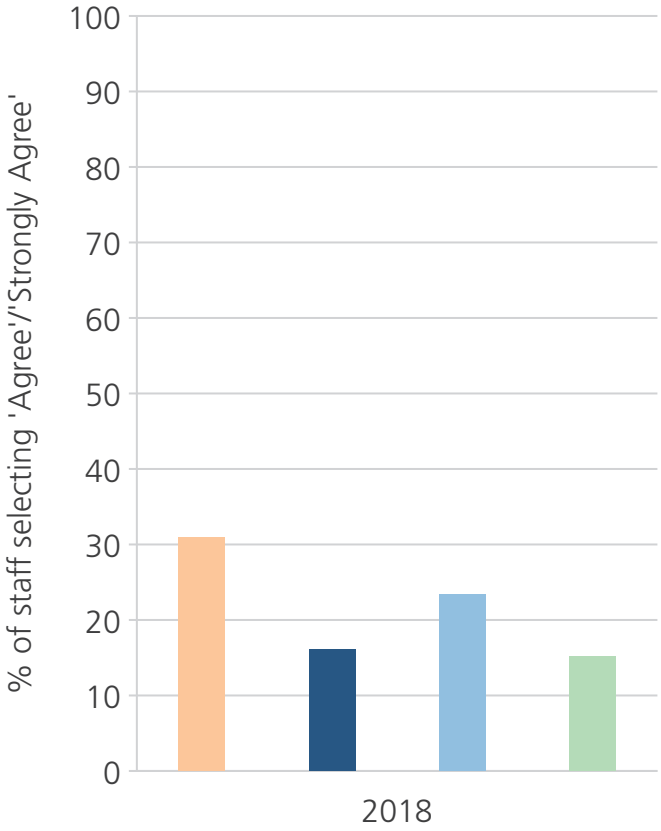
Best	79.3%
Your org	77.5%
Average	76.4%
Worst	70.4%

Q23a
I often think about leaving this organisation



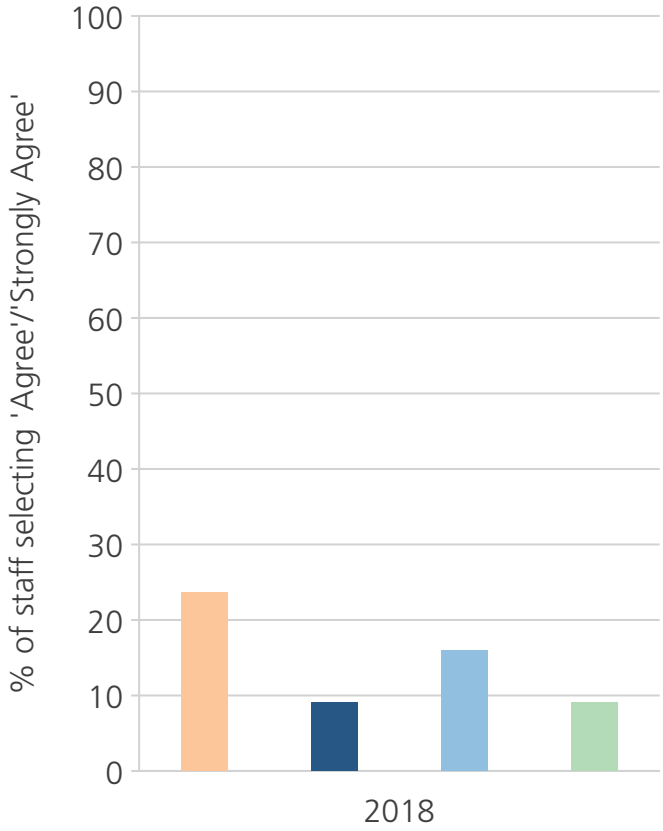
Worst	37.6%
Your org	24.4%
Average	29.2%
Best	20.9%

Q23b
I will probably look for a job at a new organisation in the next 12 months



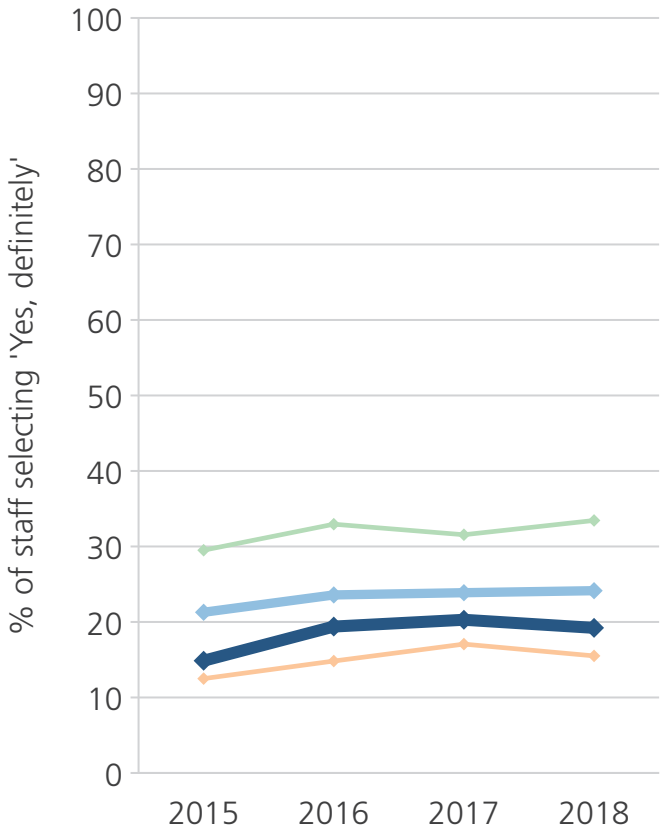
Worst	30.9%
Your org	16.1%
Average	23.3%
Best	15.1%

Q23c
As soon as I can find another job, I will leave this organisation



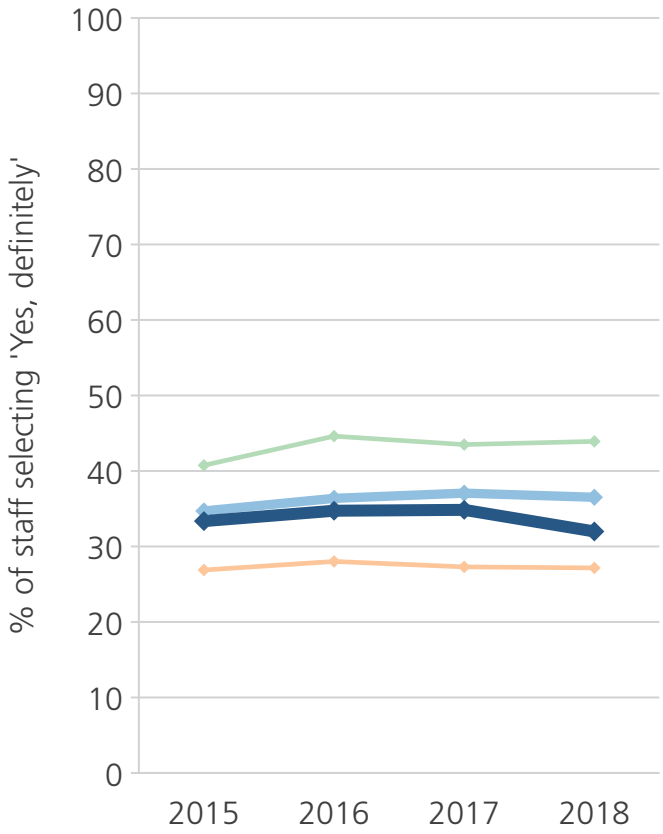
Worst	23.7%
Your org	9.1%
Average	15.9%
Best	9.1%

Q19b
It helped me to improve how I do my job



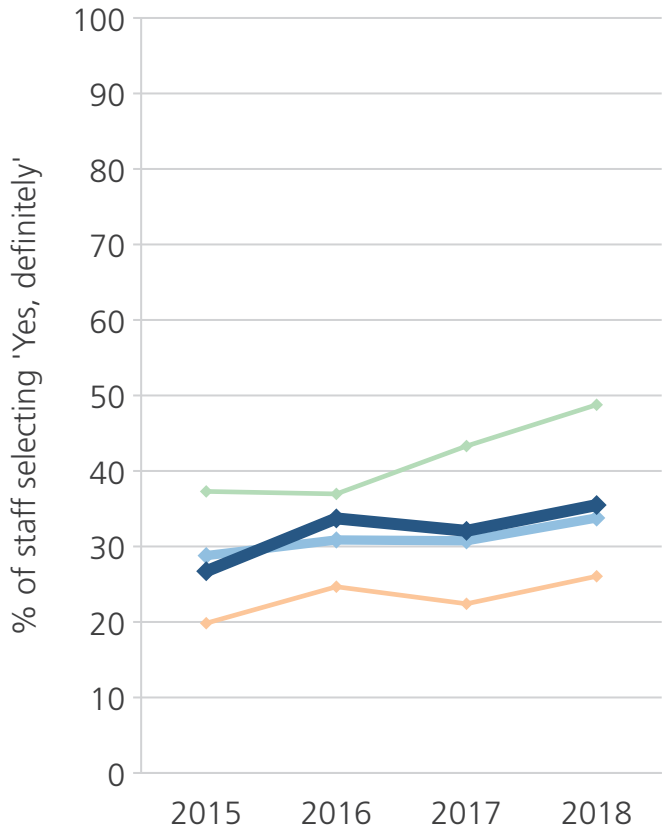
Best	29.5%	33.0%	31.6%	33.4%
Your org	14.9%	19.4%	20.3%	19.2%
Average	21.3%	23.6%	23.9%	24.1%
Worst	12.5%	14.8%	17.1%	15.5%

Q19c
It helped me agree clear objectives for my work



Best	40.8%	44.6%	43.5%	43.9%
Your org	33.4%	34.7%	34.8%	32.0%
Average	34.7%	36.4%	37.1%	36.5%
Worst	26.9%	28.0%	27.3%	27.2%

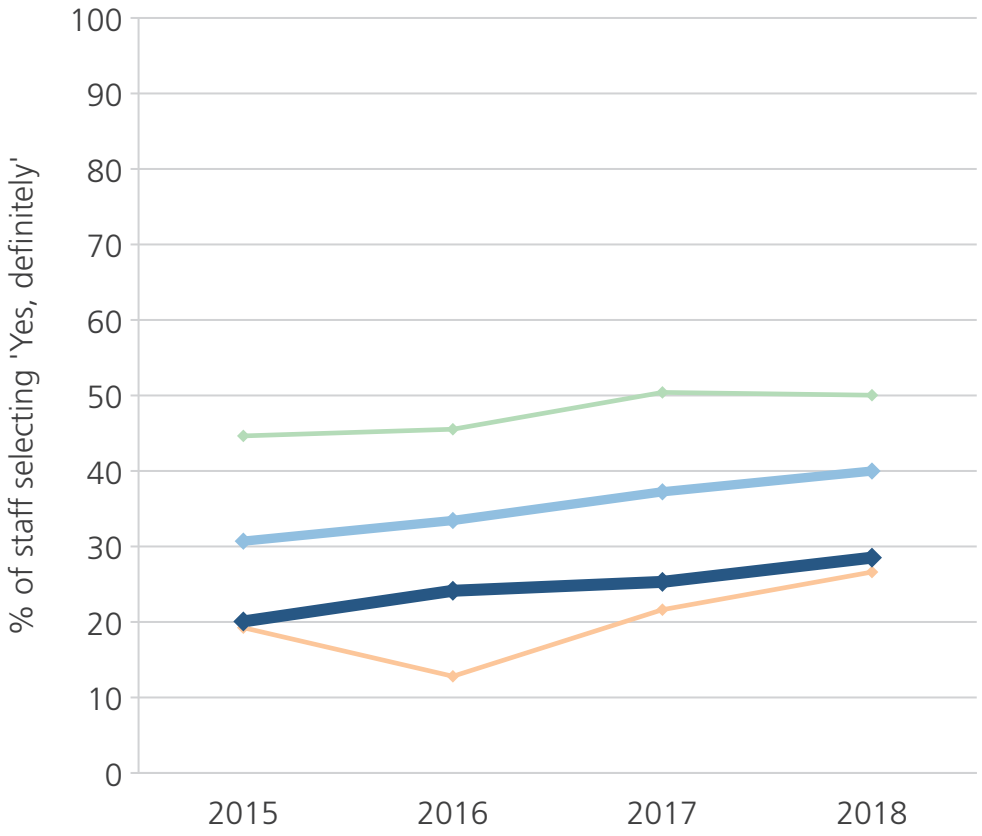
Q19d
It left me feeling that my work is valued by my organisation



Best	37.3%	37.0%	43.3%	48.8%
Your org	26.7%	33.7%	32.1%	35.5%
Average	28.8%	30.9%	30.8%	33.8%
Worst	19.8%	24.7%	22.4%	26.1%

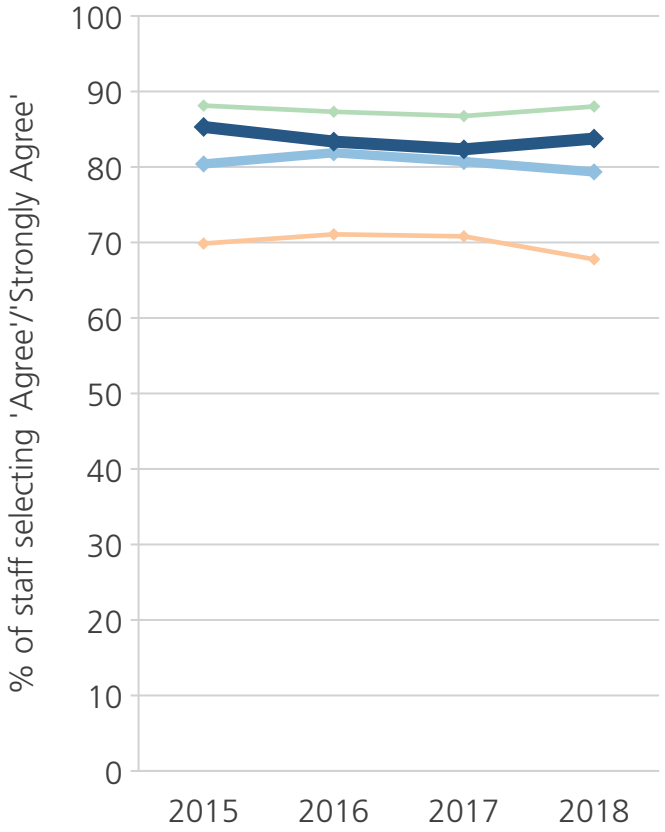
Q19e

The values of my organisation were discussed as part of the appraisal process



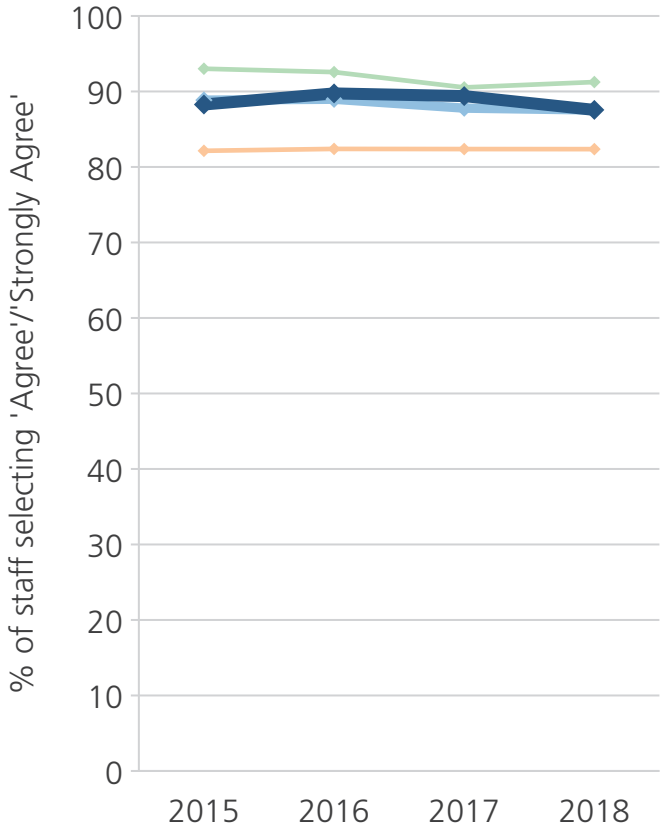
	2015	2016	2017	2018
Best	44.6%	45.5%	50.4%	50.0%
Your org	20.1%	24.1%	25.3%	28.5%
Average	30.7%	33.4%	37.2%	40.0%
Worst	19.2%	12.8%	21.6%	26.6%

Q7a
I am satisfied with the quality of care I give to patients / service users



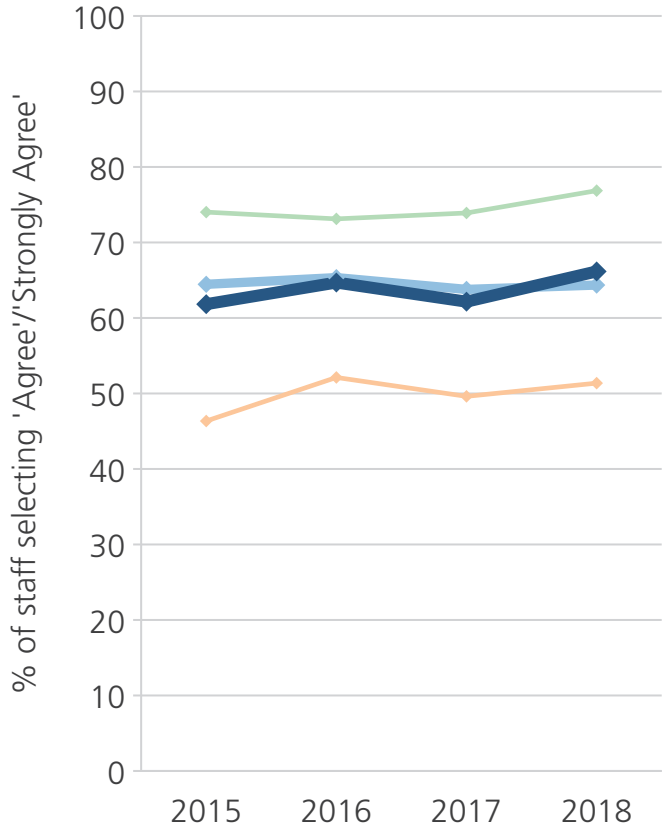
	2015	2016	2017	2018
Best	88.1%	87.3%	86.7%	88.0%
Your org	85.3%	83.4%	82.3%	83.8%
Average	80.4%	81.9%	80.7%	79.3%
Worst	69.9%	71.1%	70.8%	67.8%

Q7b
I feel that my role makes a difference to patients / service users



	2015	2016	2017	2018
Best	93.0%	92.6%	90.5%	91.2%
Your org	88.3%	89.7%	89.4%	87.6%
Average	88.9%	89.0%	87.8%	87.5%
Worst	82.1%	82.4%	82.4%	82.4%

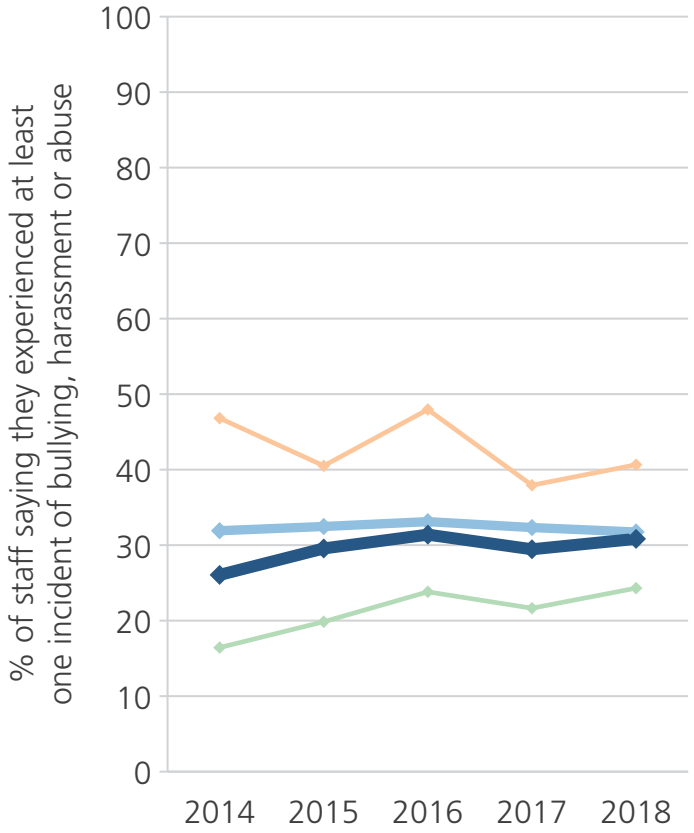
Q7c
I am able to deliver the care I aspire to



	2015	2016	2017	2018
Best	74.0%	73.1%	73.9%	76.9%
Your org	61.8%	64.7%	62.2%	66.2%
Average	64.5%	65.3%	63.8%	64.4%
Worst	46.4%	52.1%	49.6%	51.4%

Q13a

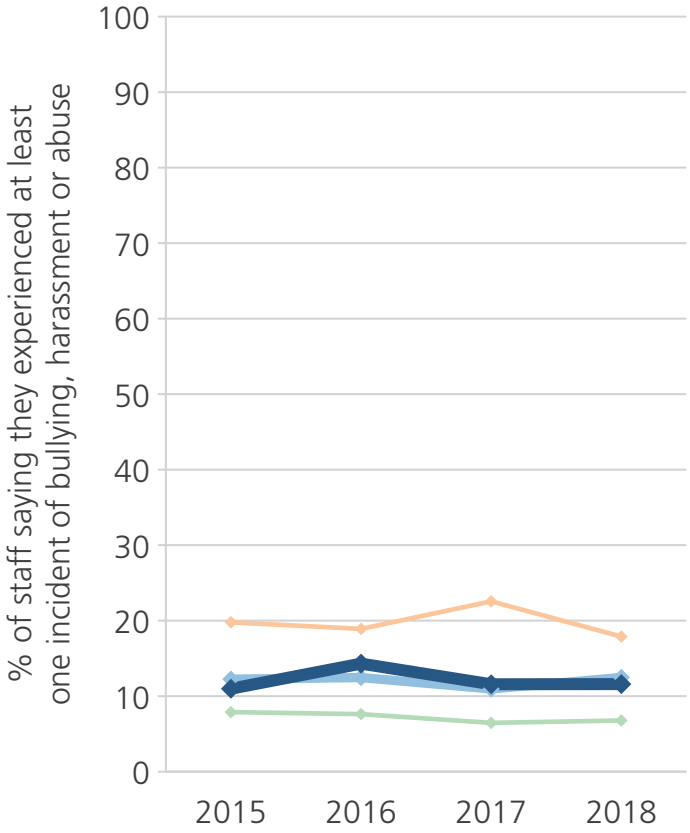
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?



	2014	2015	2016	2017	2018
Worst	46.8%	40.5%	48.0%	37.9%	40.6%
Your org	26.1%	29.6%	31.4%	29.5%	30.8%
Average	31.9%	32.5%	33.1%	32.3%	31.7%
Best	16.4%	19.9%	23.8%	21.6%	24.3%

Q13b

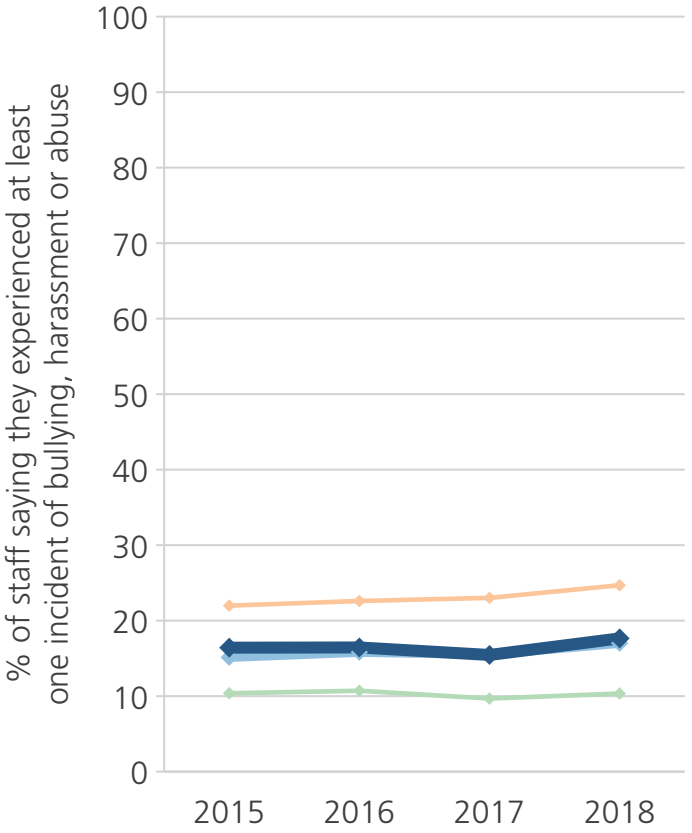
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?



	2015	2016	2017	2018
Worst	19.8%	18.9%	22.6%	17.9%
Your org	11.0%	14.3%	11.6%	11.6%
Average	12.2%	12.5%	11.0%	12.5%
Best	7.9%	7.6%	6.5%	6.8%

Q13c

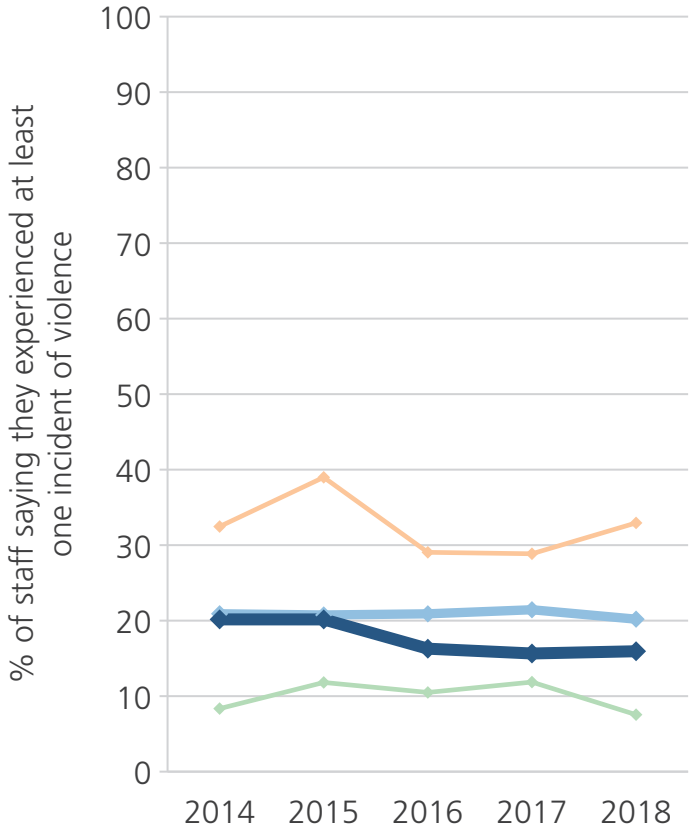
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?



	2015	2016	2017	2018
Worst	22.0%	22.6%	23.0%	24.7%
Your org	16.4%	16.4%	15.5%	17.7%
Average	15.1%	15.8%	15.5%	17.0%
Best	10.4%	10.7%	9.7%	10.3%

Q12a

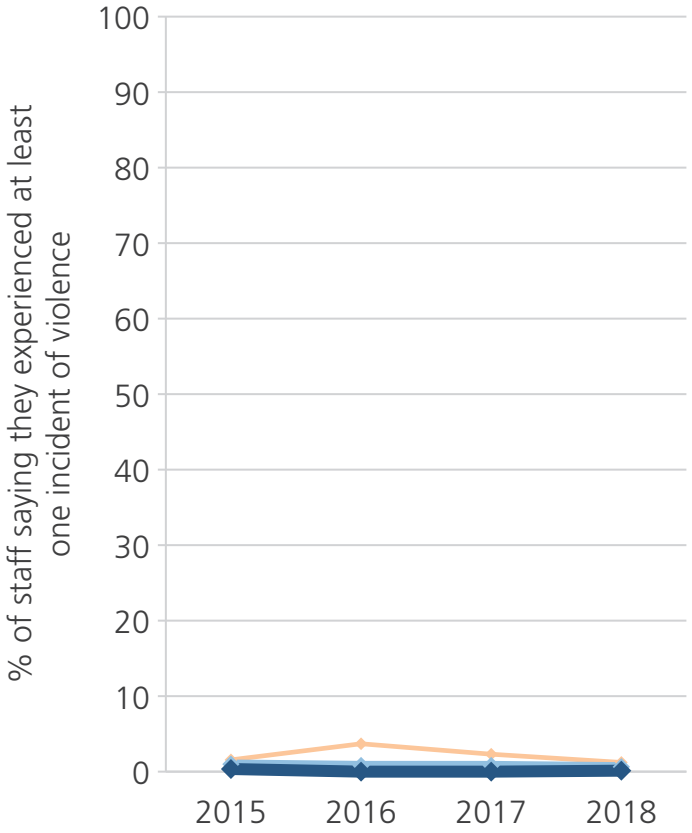
In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?



	2014	2015	2016	2017	2018
Worst	32.5%	39.0%	29.0%	28.9%	32.9%
Your org	20.2%	20.2%	16.3%	15.6%	15.9%
Average	20.9%	20.8%	20.9%	21.4%	20.2%
Best	8.4%	11.8%	10.5%	11.9%	7.5%

Q12b

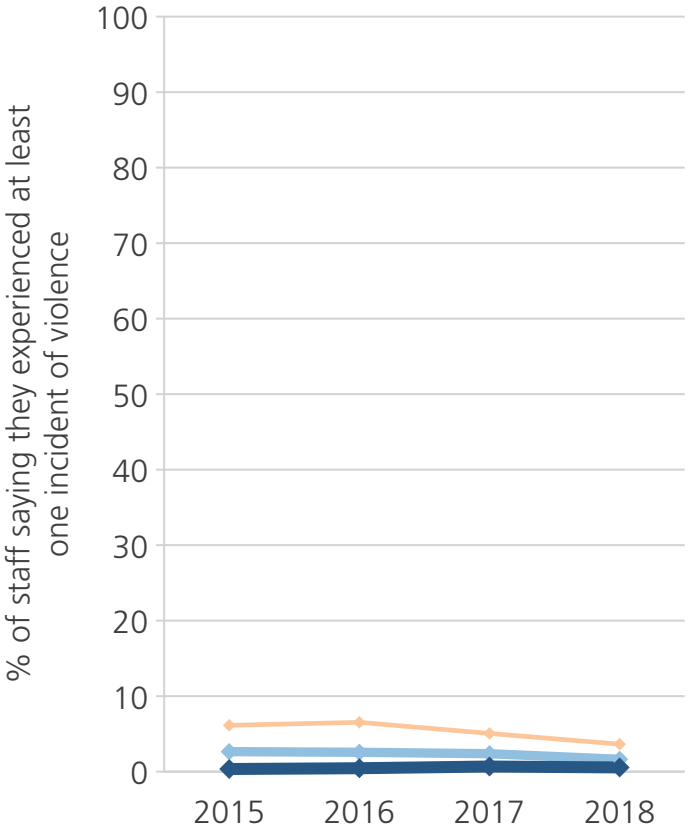
In the last 12 months how many times have you personally experienced physical violence at work from managers?



	2015	2016	2017	2018
Worst	1.6%	3.7%	2.3%	1.2%
Your org	0.3%	0.0%	0.0%	0.1%
Average	1.0%	0.8%	0.8%	0.6%
Best	0.0%	0.0%	0.0%	0.0%

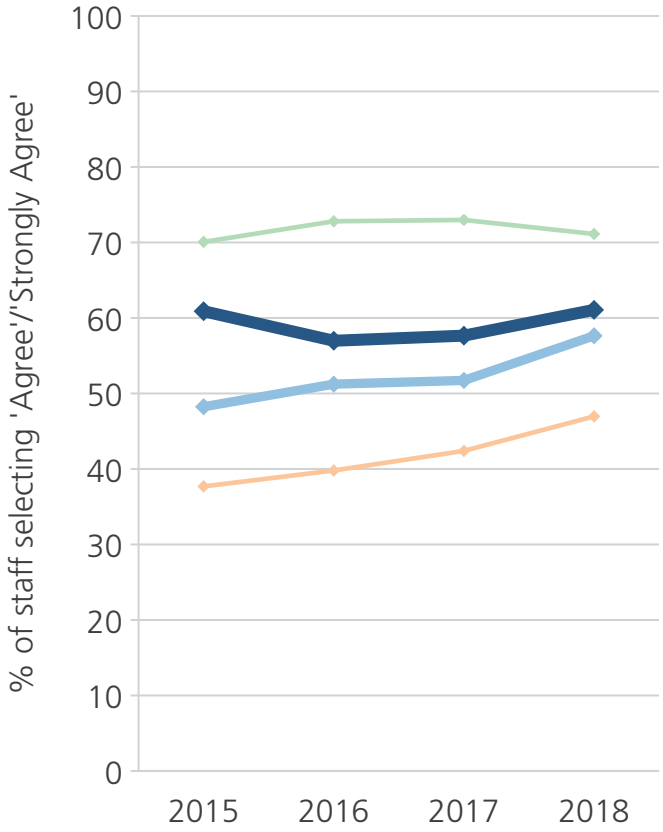
Q12c

In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?



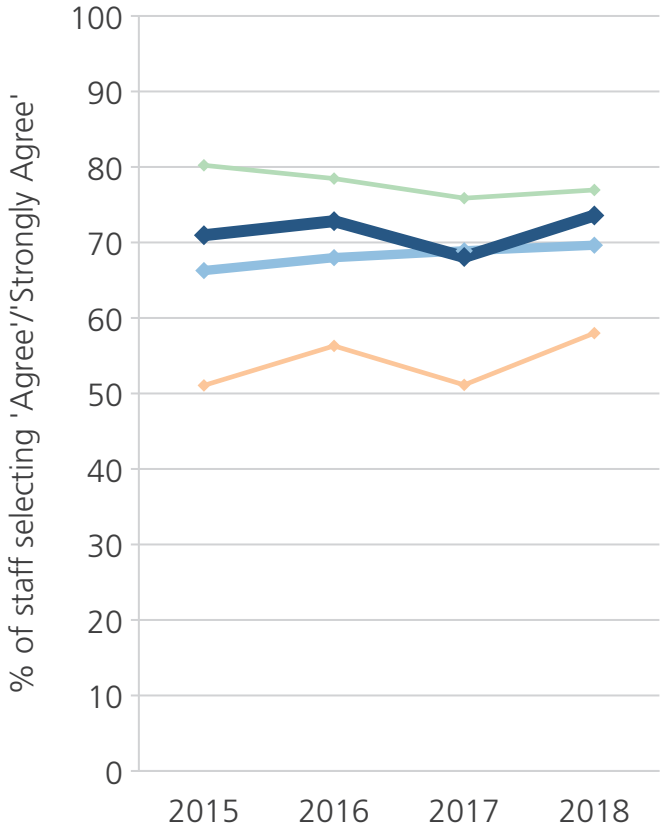
	2015	2016	2017	2018
Worst	6.1%	6.5%	5.1%	3.6%
Your org	0.4%	0.5%	0.7%	0.6%
Average	2.6%	2.6%	2.4%	1.6%
Best	0.4%	0.0%	0.5%	0.4%

Q17a
My organisation treats staff who are involved in an error, near miss or incident fairly



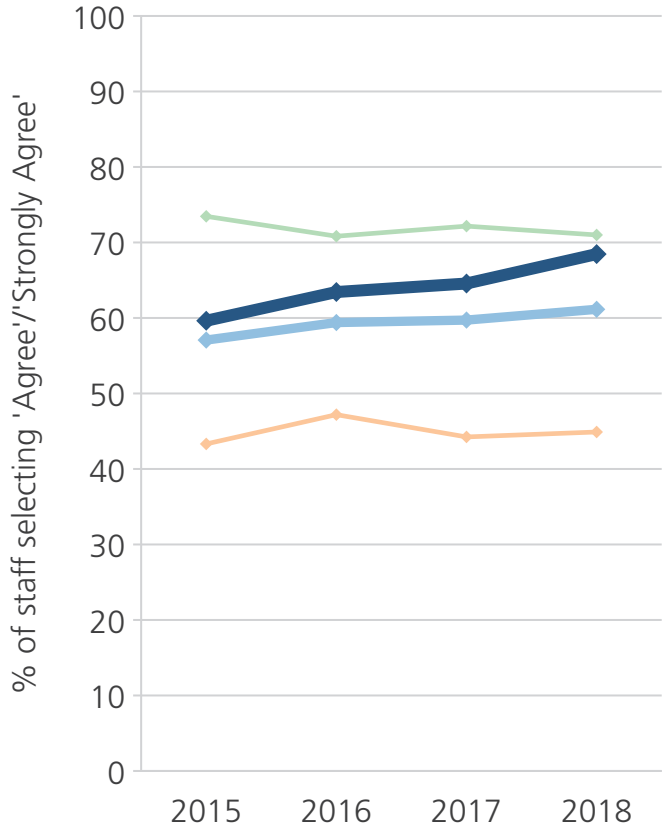
	2015	2016	2017	2018
Best	70.1%	72.8%	73.0%	71.1%
Your org	60.9%	57.0%	57.7%	61.1%
Average	48.2%	51.2%	51.7%	57.6%
Worst	37.7%	39.8%	42.4%	47.0%

Q17c
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again



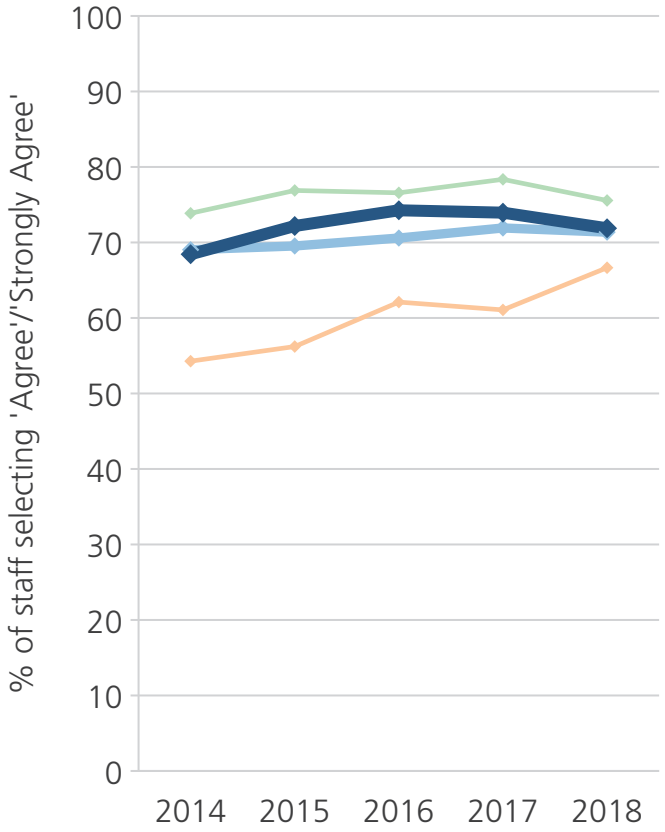
	2015	2016	2017	2018
Best	80.2%	78.5%	75.9%	77.0%
Your org	71.0%	72.8%	68.1%	73.6%
Average	66.3%	68.0%	68.9%	69.6%
Worst	51.1%	56.3%	51.1%	58.0%

Q17d
We are given feedback about changes made in response to reported errors, near misses and incidents



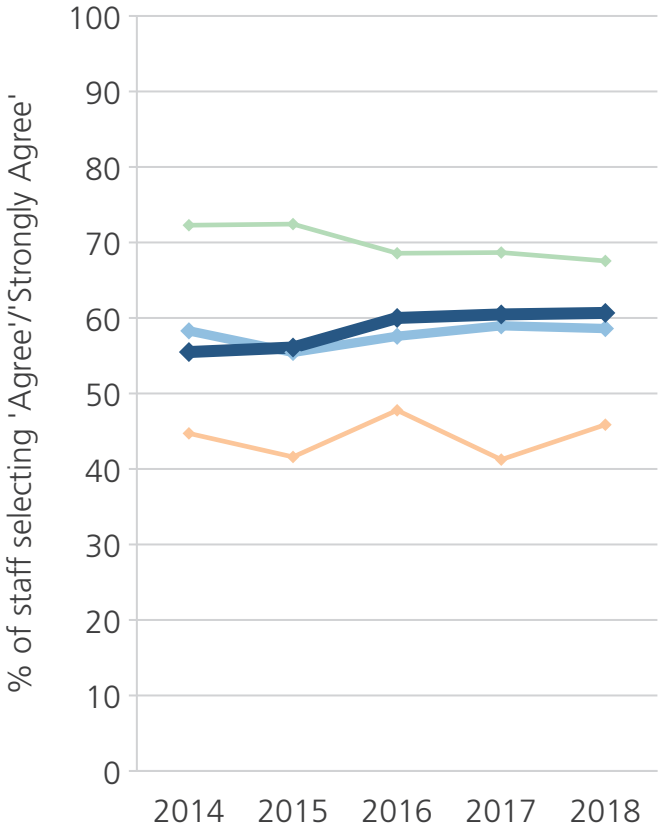
	2015	2016	2017	2018
Best	73.5%	70.8%	72.2%	71.0%
Your org	59.6%	63.4%	64.6%	68.5%
Average	57.1%	59.4%	59.7%	61.1%
Worst	43.3%	47.2%	44.2%	44.9%

Q18b
I would feel secure raising concerns about unsafe clinical practice



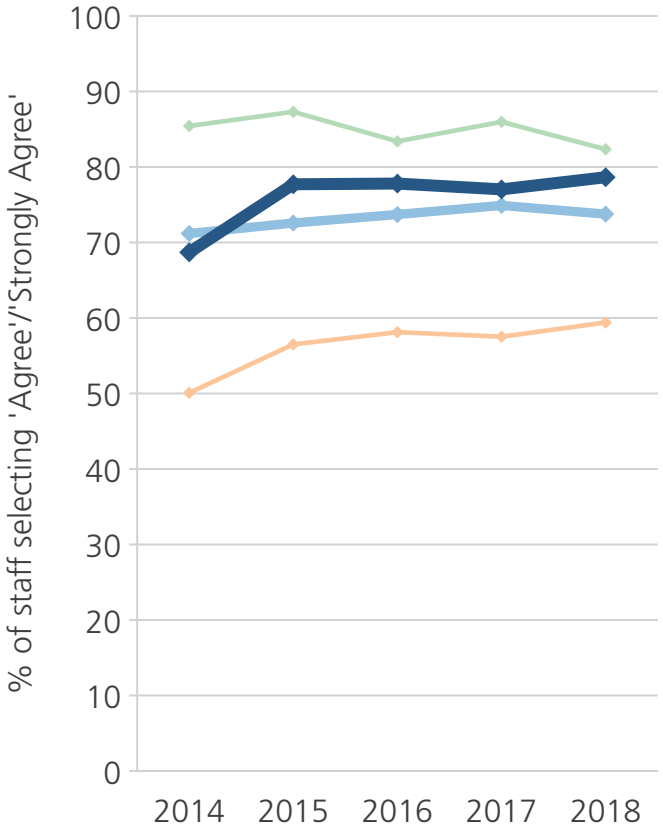
	2014	2015	2016	2017	2018
Best	73.9%	76.9%	76.6%	78.4%	75.6%
Your org	68.4%	72.2%	74.3%	73.9%	71.9%
Average	69.0%	69.5%	70.6%	71.9%	71.4%
Worst	54.3%	56.2%	62.1%	61.1%	66.7%

Q18c
I am confident that my organisation would address my concern



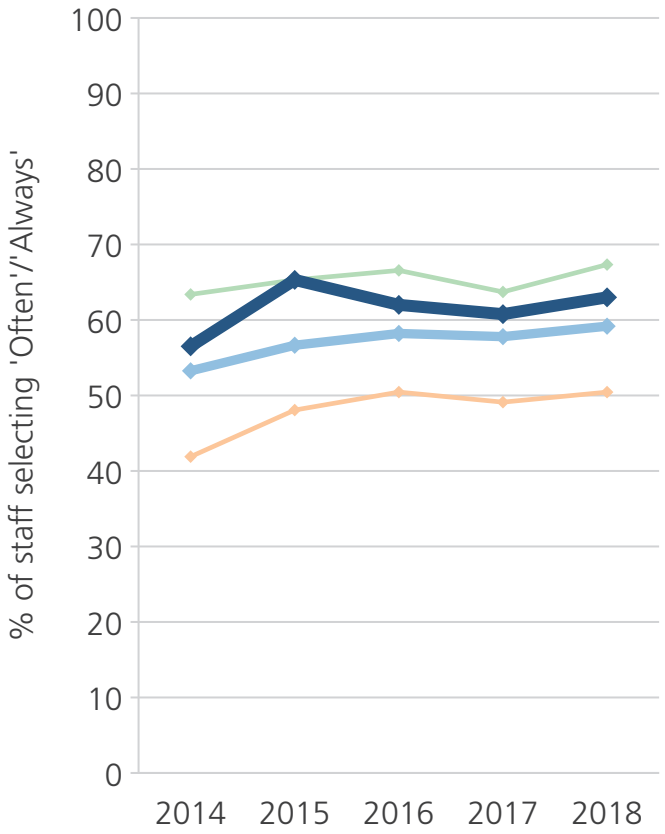
	2014	2015	2016	2017	2018
Best	72.3%	72.4%	68.6%	68.7%	67.6%
Your org	55.5%	56.1%	60.0%	60.5%	60.7%
Average	58.3%	55.4%	57.6%	59.0%	58.6%
Worst	44.7%	41.6%	47.8%	41.2%	45.9%

Q21b
My organisation acts on concerns raised by patients / service users



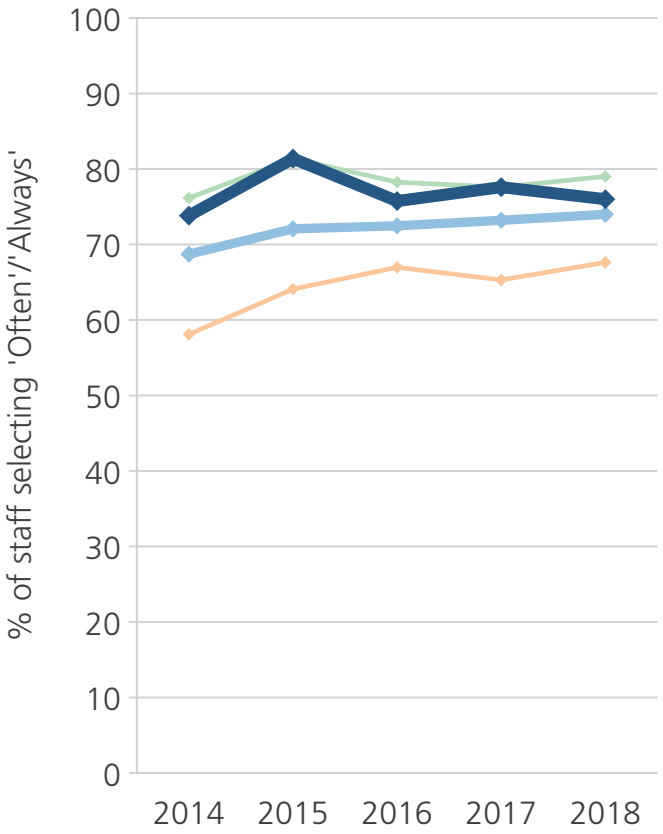
	2014	2015	2016	2017	2018
Best	85.4%	87.3%	83.4%	86.0%	82.3%
Your org	68.7%	77.7%	77.8%	77.0%	78.6%
Average	71.2%	72.6%	73.7%	74.9%	73.8%
Worst	50.1%	56.5%	58.1%	57.5%	59.4%

Q2a
I look forward to going to work



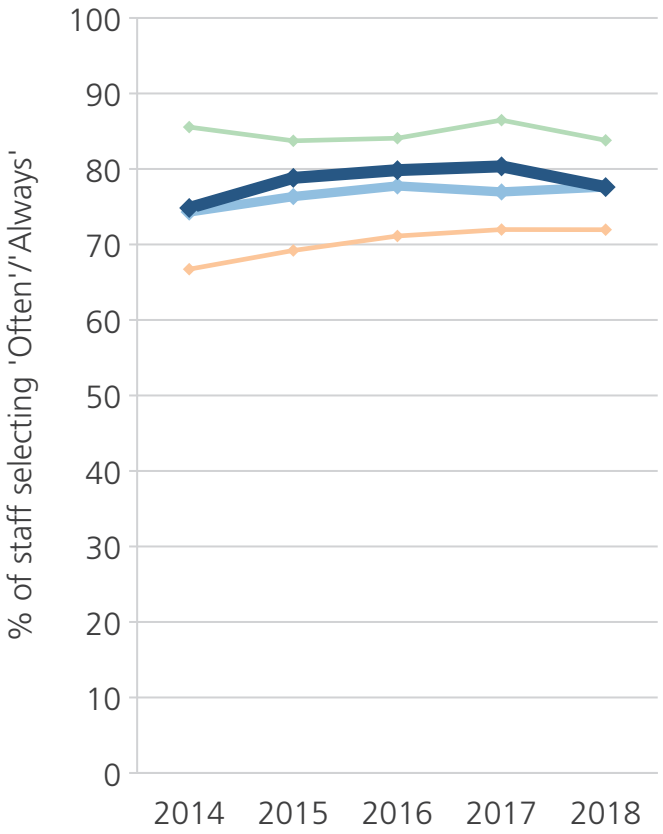
	2014	2015	2016	2017	2018
Best	63.4%	65.3%	66.6%	63.7%	67.3%
Your org	56.5%	65.3%	62.0%	60.8%	63.0%
Average	53.3%	56.7%	58.2%	57.8%	59.2%
Worst	41.9%	48.1%	50.4%	49.1%	50.4%

Q2b
I am enthusiastic about my job



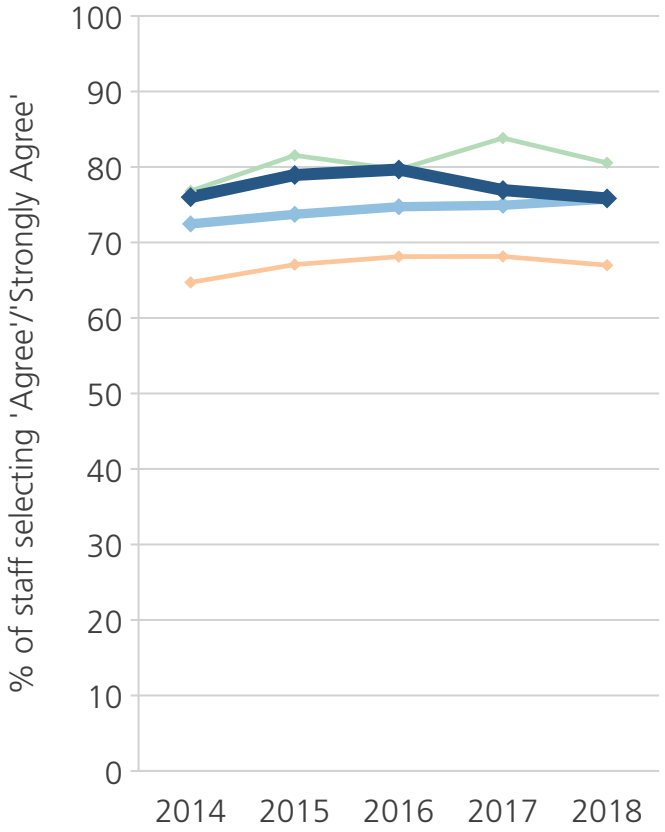
	2014	2015	2016	2017	2018
Best	76.2%	81.4%	78.2%	77.6%	79.0%
Your org	73.8%	81.4%	75.7%	77.6%	76.0%
Average	68.7%	72.1%	72.5%	73.2%	74.0%
Worst	58.1%	64.1%	67.0%	65.3%	67.6%

Q2c
Time passes quickly when I am working



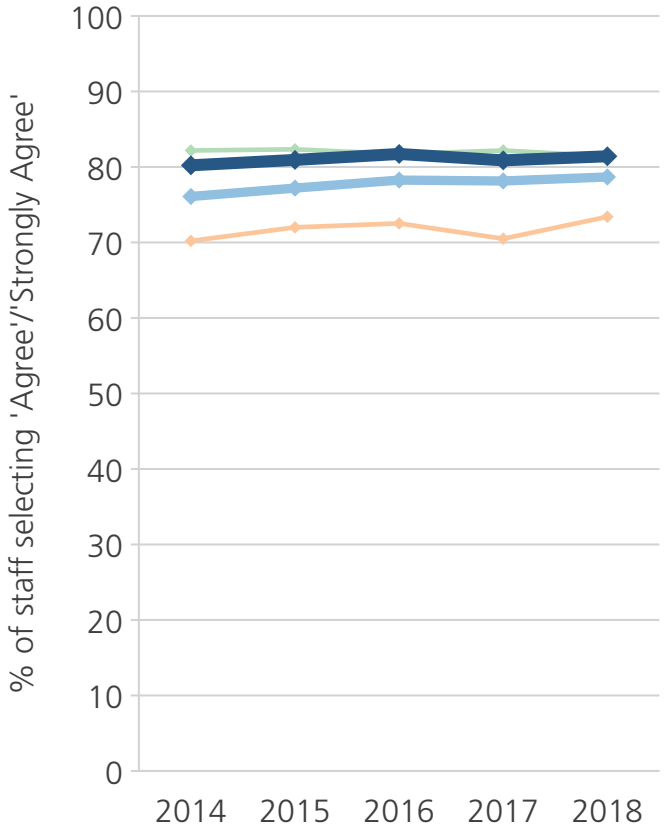
	2014	2015	2016	2017	2018
Best	85.5%	83.7%	84.1%	86.5%	83.8%
Your org	74.8%	78.8%	79.8%	80.3%	77.6%
Average	74.3%	76.3%	77.8%	77.0%	77.6%
Worst	66.7%	69.2%	71.1%	72.0%	72.0%

Q4a
There are frequent opportunities for me to show initiative in my role



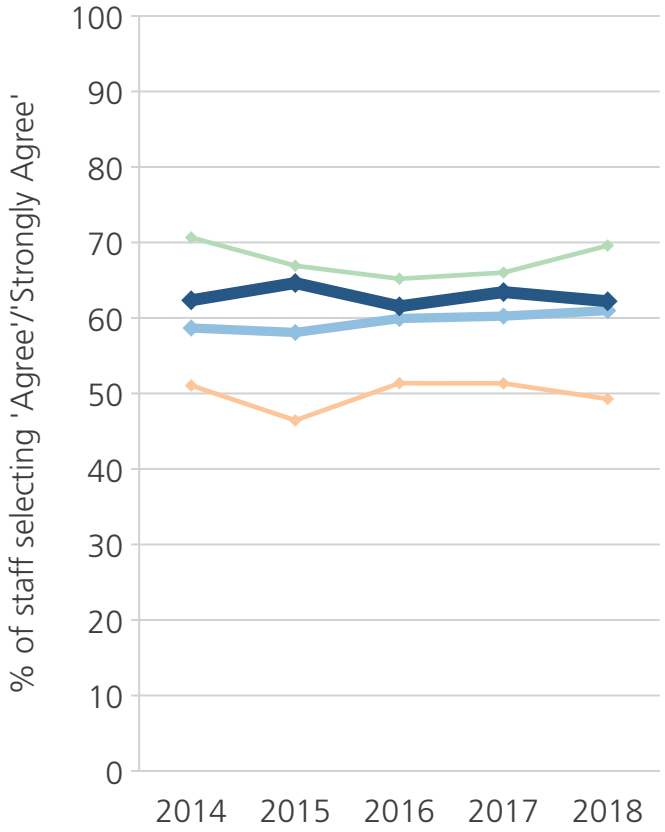
	2014	2015	2016	2017	2018
Best	76.8%	81.5%	79.7%	83.8%	80.5%
Your org	76.0%	78.9%	79.7%	76.9%	75.8%
Average	72.5%	73.7%	74.7%	74.9%	75.7%
Worst	64.7%	67.1%	68.1%	68.1%	67.0%

Q4b
I am able to make suggestions to improve the work of my team / department



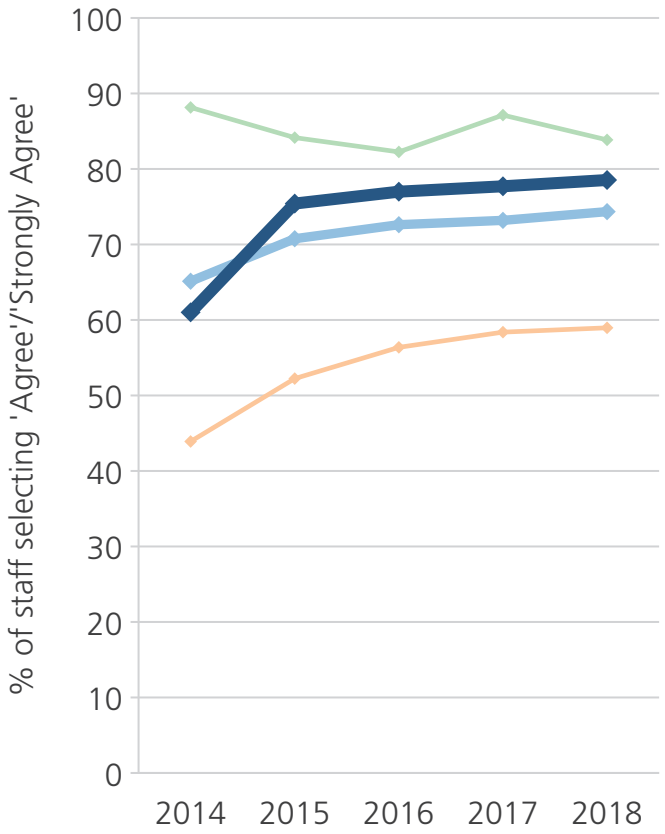
	2014	2015	2016	2017	2018
Best	82.2%	82.3%	81.7%	82.2%	81.4%
Your org	80.2%	80.9%	81.7%	80.9%	81.4%
Average	76.1%	77.2%	78.3%	78.1%	78.7%
Worst	70.2%	72.0%	72.5%	70.5%	73.4%

Q4d
I am able to make improvements happen in my area of work



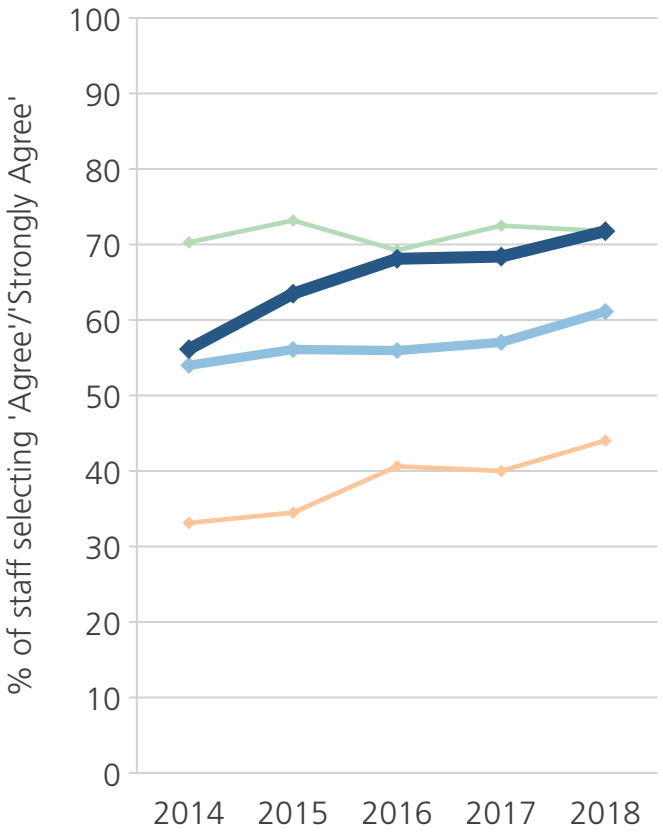
	2014	2015	2016	2017	2018
Best	70.7%	66.9%	65.2%	66.0%	69.6%
Your org	62.3%	64.6%	61.5%	63.4%	62.2%
Average	58.7%	58.1%	59.9%	60.2%	61.0%
Worst	51.1%	46.4%	51.4%	51.3%	49.3%

Q21a
Care of patients / service users is my organisation's top priority



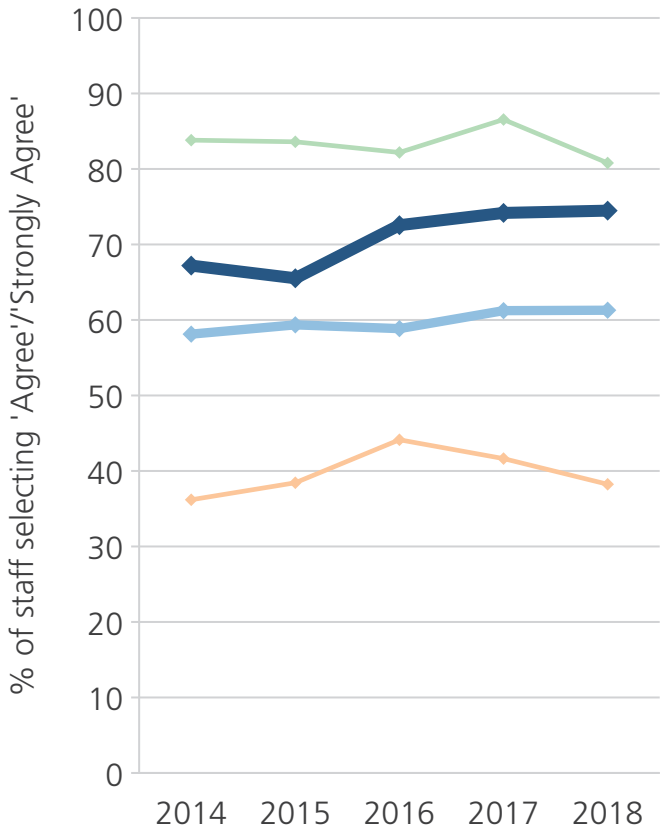
	2014	2015	2016	2017	2018
Best	88.1%	84.2%	82.3%	87.1%	83.9%
Your org	61.0%	75.4%	77.0%	77.7%	78.5%
Average	65.1%	70.8%	72.6%	73.2%	74.3%
Worst	43.9%	52.2%	56.4%	58.4%	59.0%

Q21c
I would recommend my organisation as a place to work



	2014	2015	2016	2017	2018
Best	70.3%	73.2%	69.2%	72.5%	71.8%
Your org	56.1%	63.5%	68.1%	68.4%	71.8%
Average	54.0%	56.1%	55.9%	57.0%	61.1%
Worst	33.1%	34.5%	40.6%	40.0%	44.0%

Q21d
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



	2014	2015	2016	2017	2018
Best	83.8%	83.6%	82.2%	86.5%	80.8%
Your org	67.2%	65.5%	72.6%	74.2%	74.5%
Average	58.1%	59.4%	58.9%	61.2%	61.3%
Worst	36.2%	38.4%	44.1%	41.6%	38.2%

Survey Coordination Centre

NHS England

Question results

2Gether NHS Foundation Trust

2018 NHS Staff Survey Results

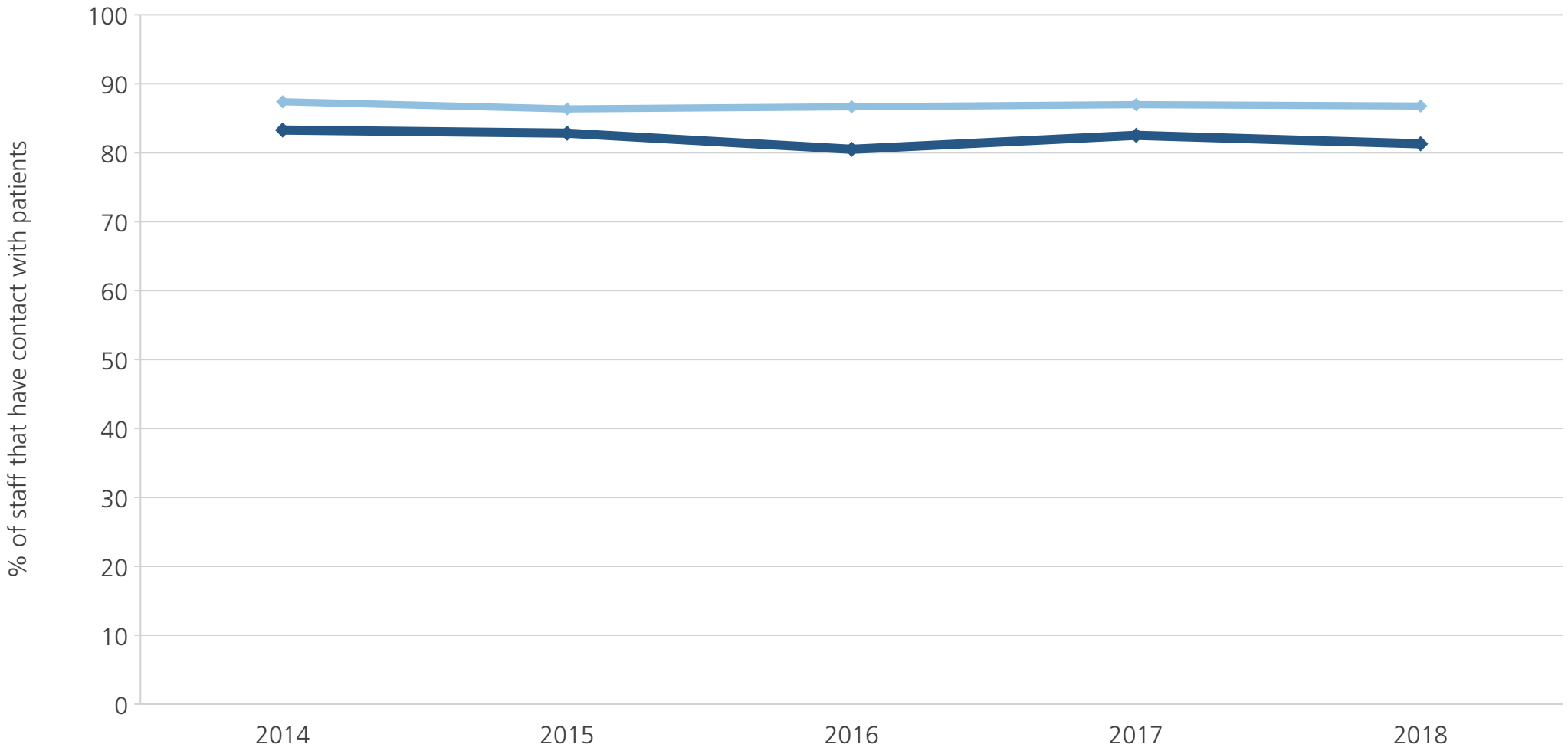
Survey Coordination Centre

NHS England

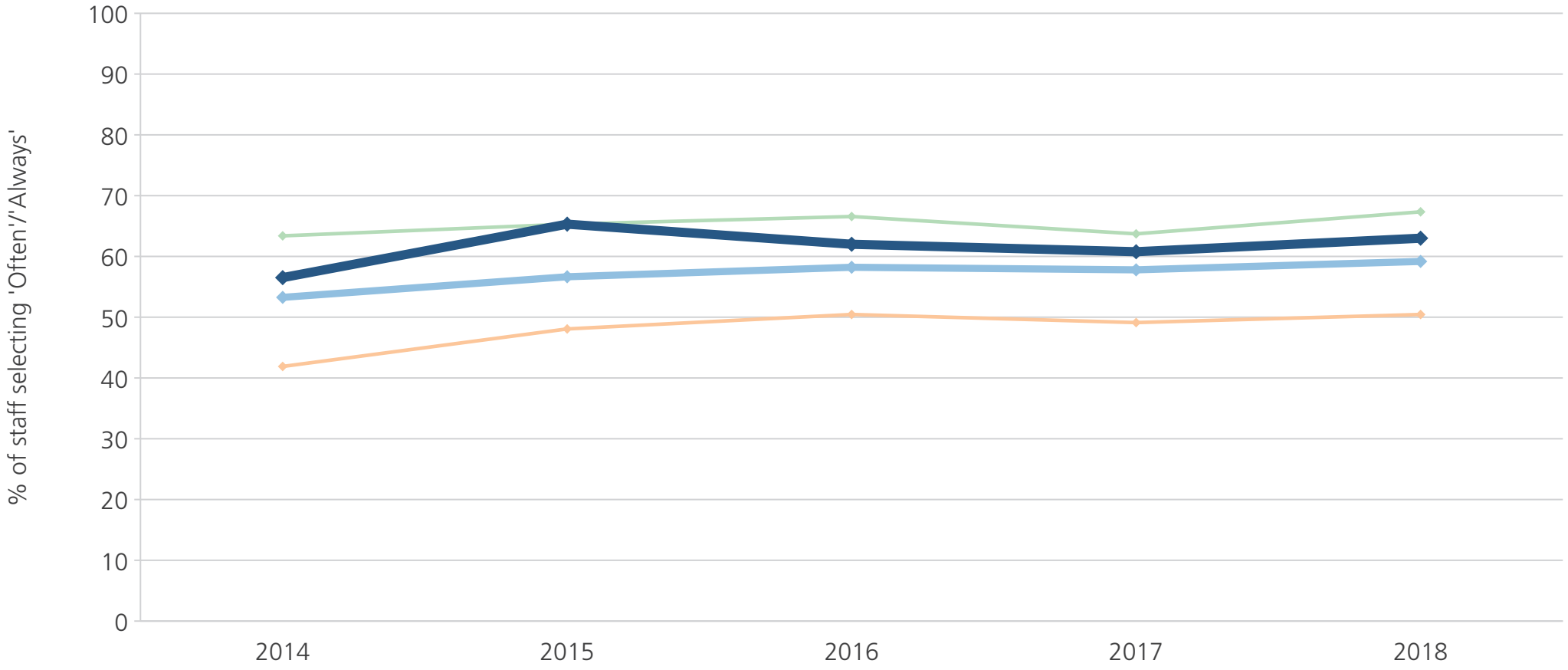
Question results – Your job

2Gether NHS Foundation Trust

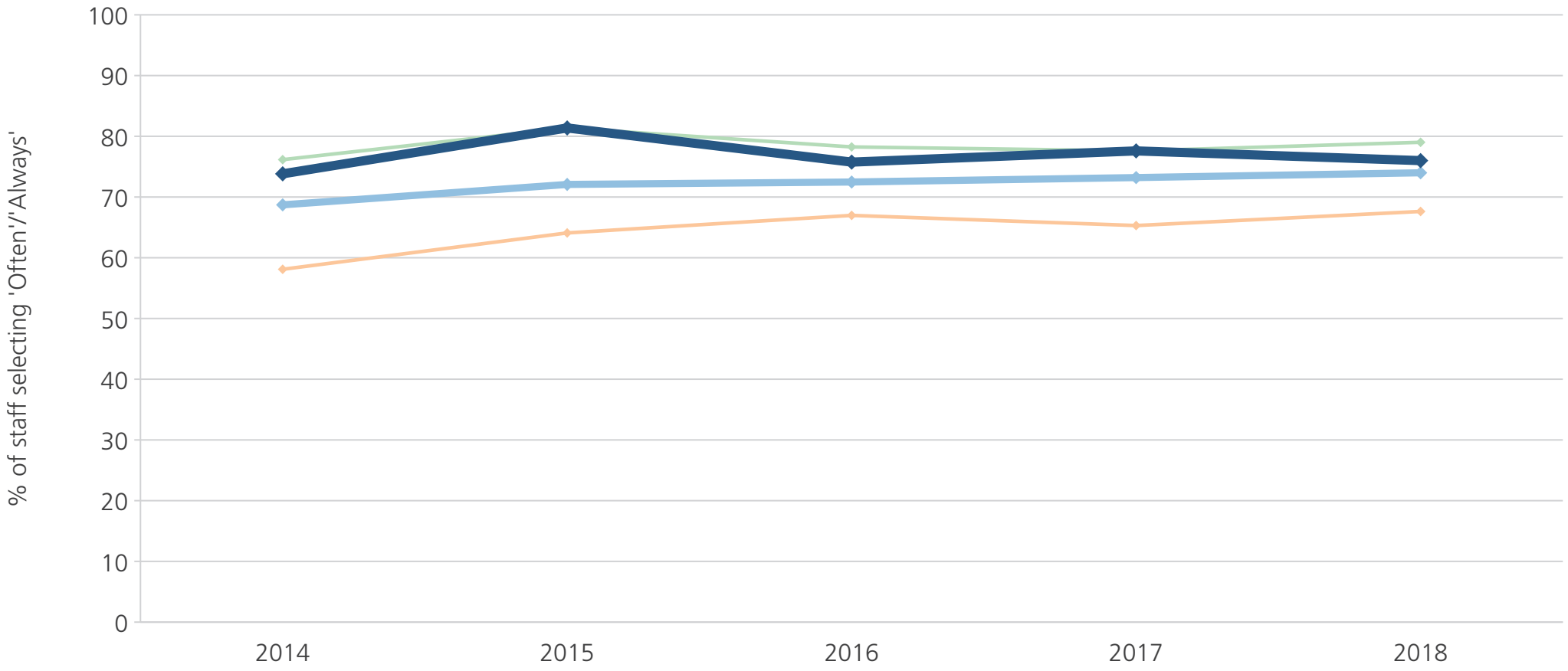
2018 NHS Staff Survey Results



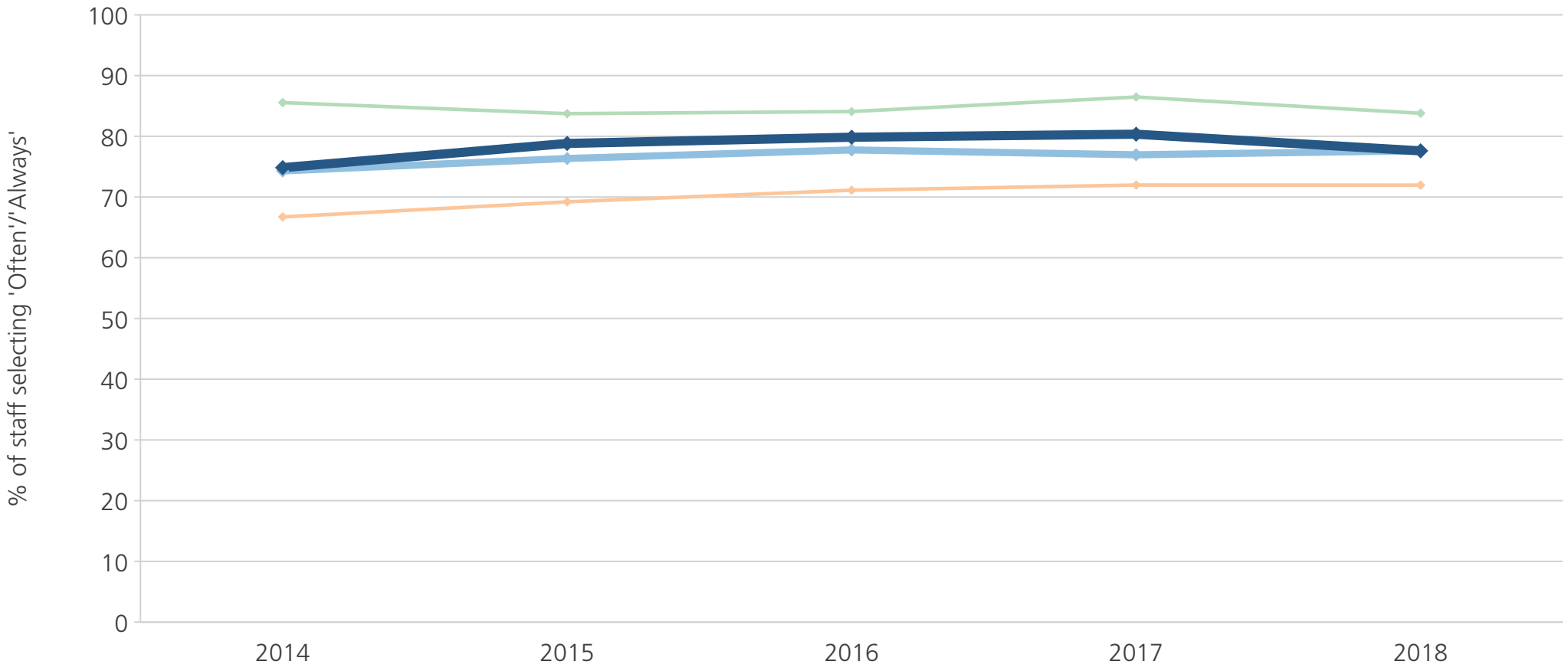
	2014	2015	2016	2017	2018
Your org	83.3%	82.8%	80.5%	82.5%	81.3%
Average	87.4%	86.3%	86.7%	87.0%	86.8%
No. responses	335	297	769	915	855



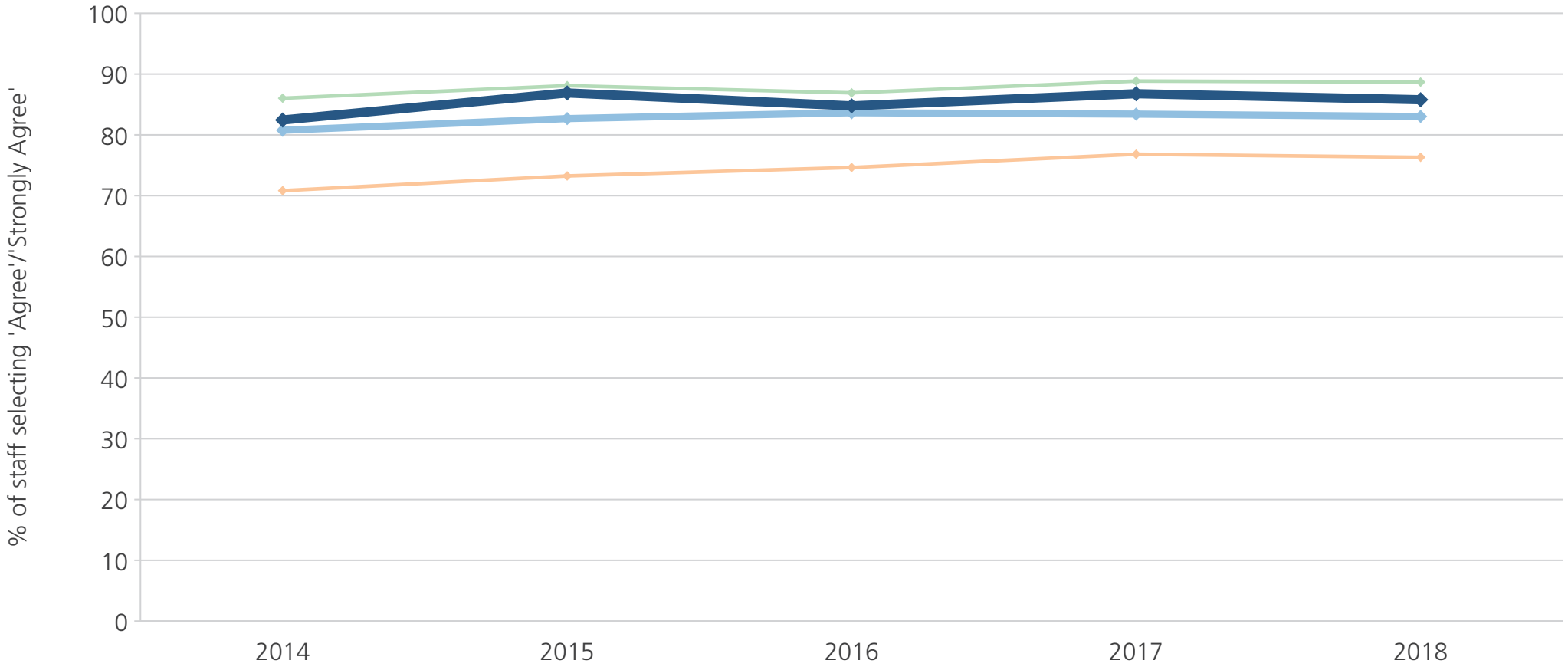
	2014	2015	2016	2017	2018
Best	63.4%	65.3%	66.6%	63.7%	67.3%
Your org	56.5%	65.3%	62.0%	60.8%	63.0%
Average	53.3%	56.7%	58.2%	57.8%	59.2%
Worst	41.9%	48.1%	50.4%	49.1%	50.4%
No. responses	331	296	774	911	862



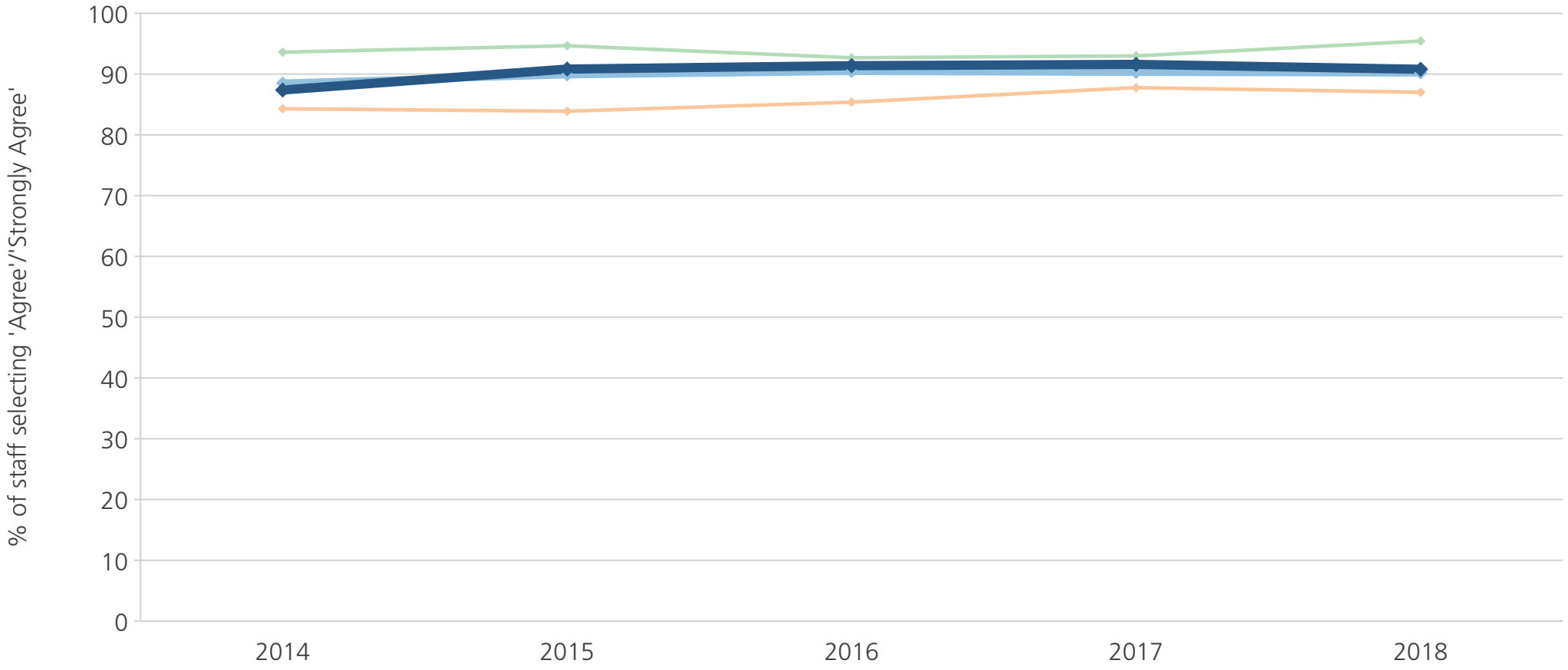
	2014	2015	2016	2017	2018
Best	76.2%	81.4%	78.2%	77.6%	79.0%
Your org	73.8%	81.4%	75.7%	77.6%	76.0%
Average	68.7%	72.1%	72.5%	73.2%	74.0%
Worst	58.1%	64.1%	67.0%	65.3%	67.6%
No. responses	331	295	771	913	859



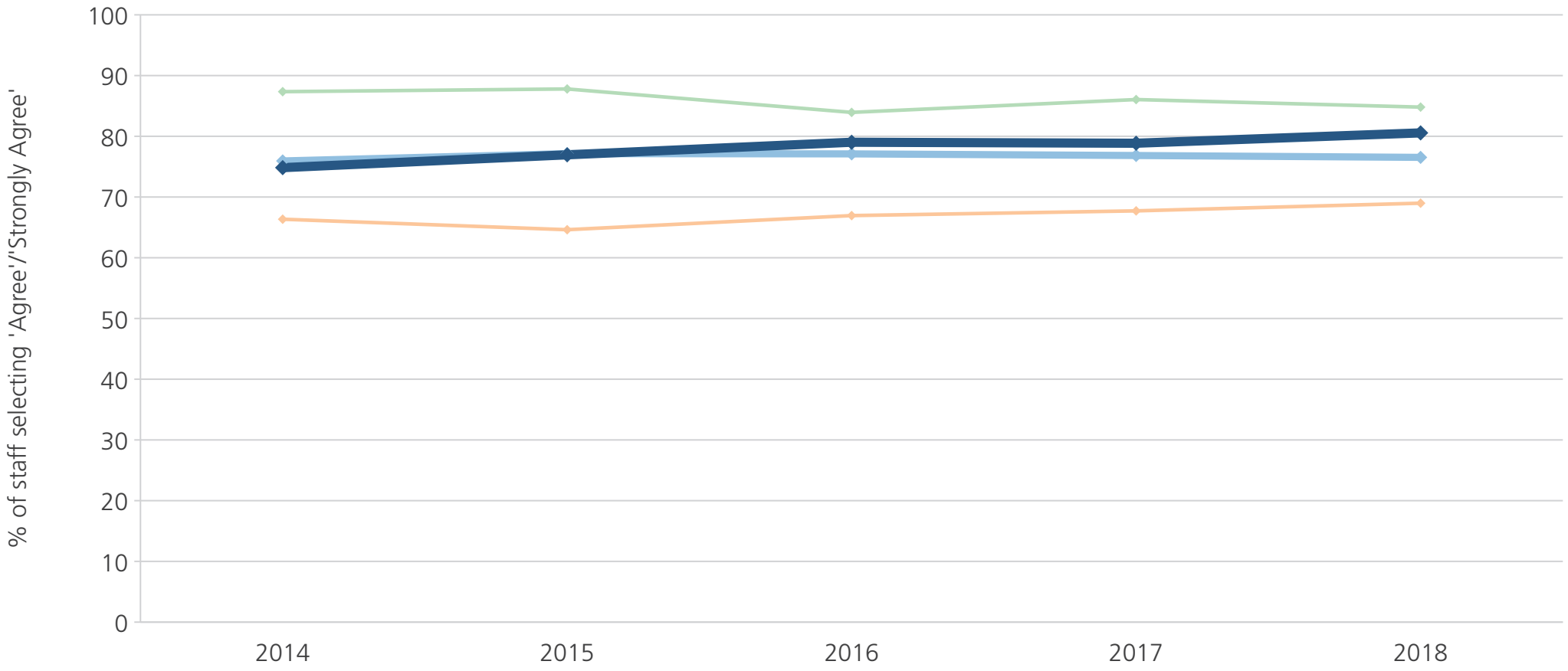
	2014	2015	2016	2017	2018
Best	85.5%	83.7%	84.1%	86.5%	83.8%
Your org	74.8%	78.8%	79.8%	80.3%	77.6%
Average	74.3%	76.3%	77.8%	77.0%	77.6%
Worst	66.7%	69.2%	71.1%	72.0%	72.0%
No. responses	331	295	770	912	857



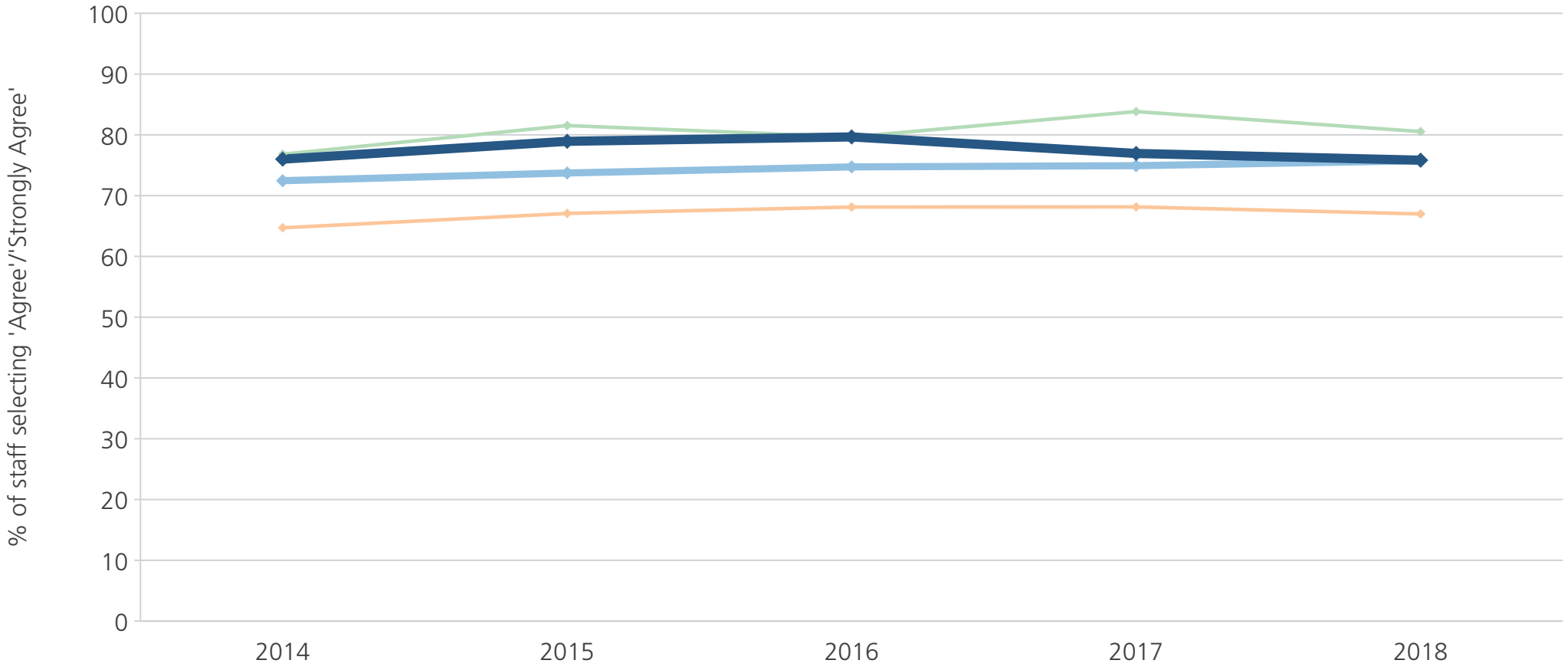
	2014	2015	2016	2017	2018
Best	86.0%	88.1%	86.9%	88.8%	88.7%
Your org	82.4%	86.9%	84.8%	86.8%	85.8%
Average	80.8%	82.7%	83.6%	83.4%	83.0%
Worst	70.8%	73.2%	74.6%	76.8%	76.3%
No. responses	337	296	764	909	854



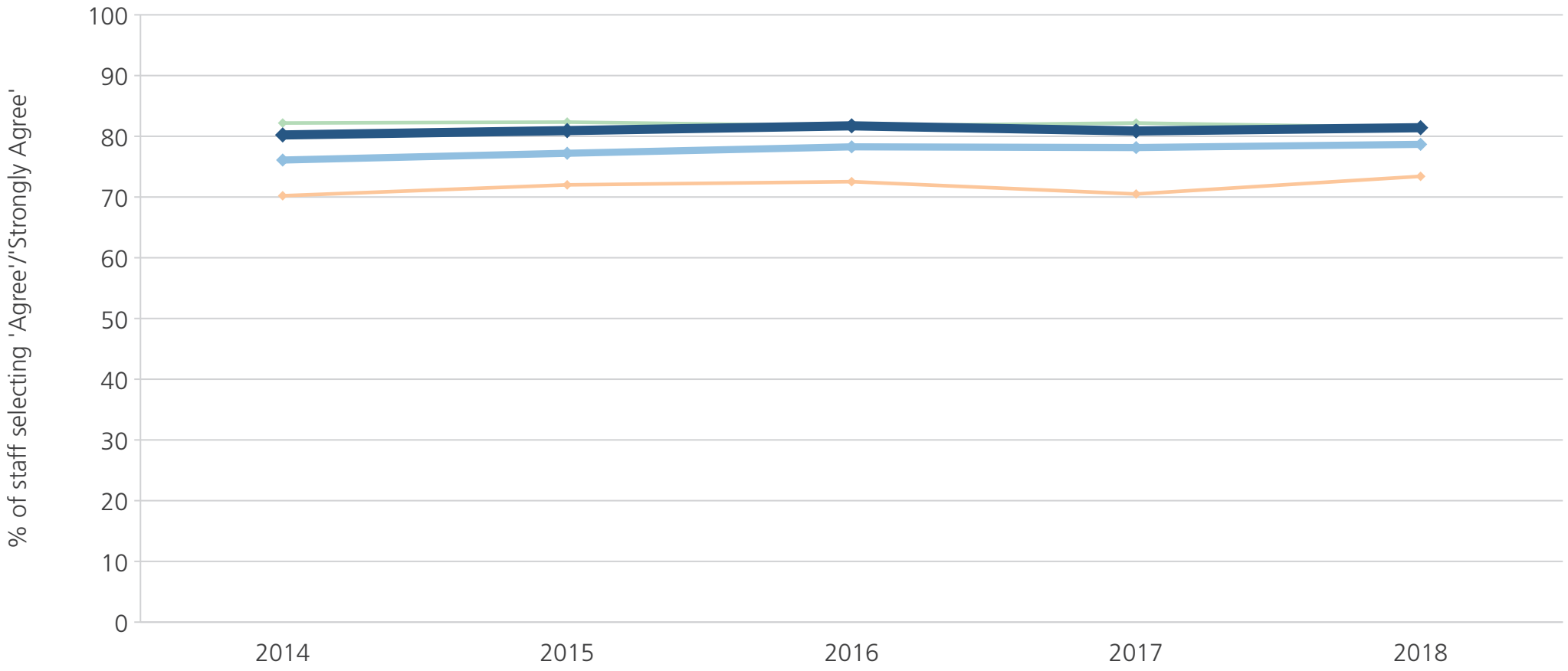
	2014	2015	2016	2017	2018
Best	93.6%	94.7%	92.7%	93.0%	95.4%
Your org	87.4%	90.8%	91.4%	91.6%	90.8%
Average	88.5%	89.9%	90.4%	90.3%	90.2%
Worst	84.3%	83.9%	85.4%	87.8%	87.0%
No. responses	335	295	764	907	852



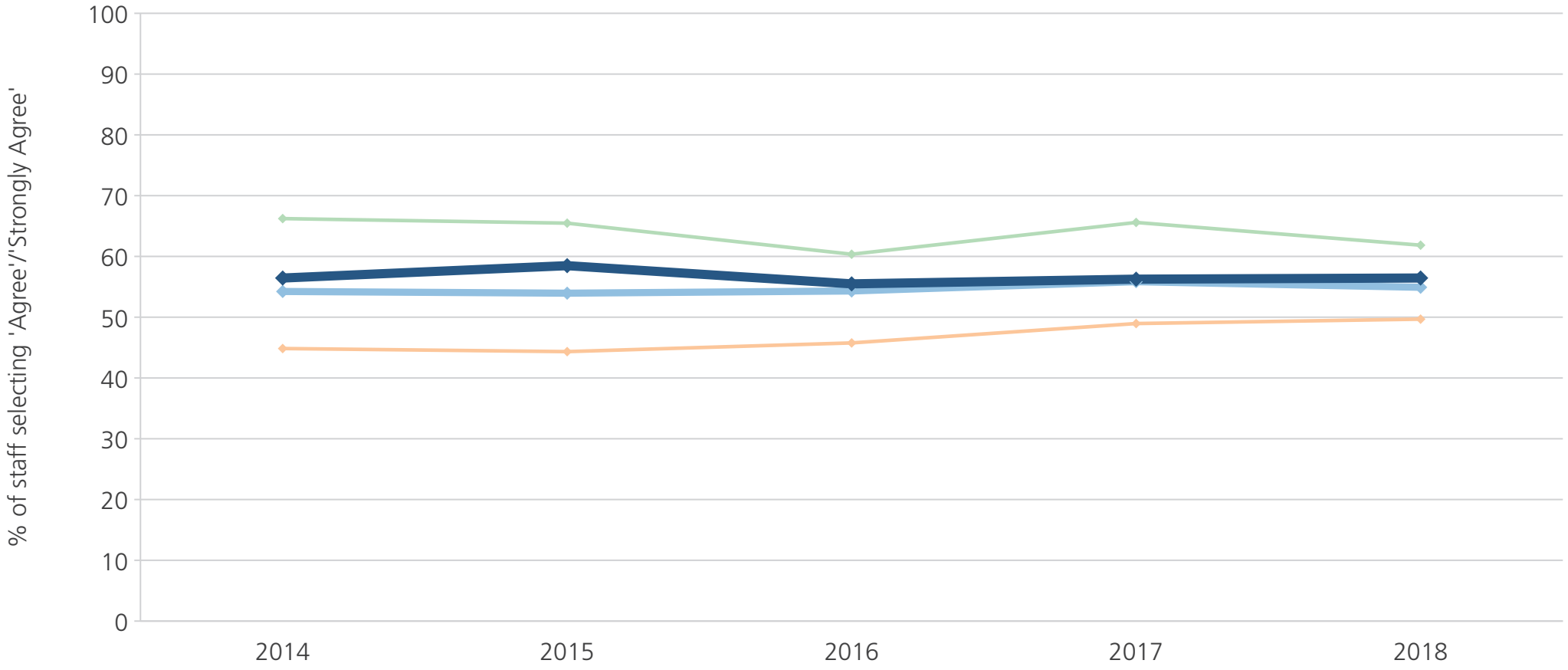
	2014	2015	2016	2017	2018
Best	87.3%	87.8%	83.9%	86.0%	84.8%
Your org	74.8%	76.9%	79.0%	78.9%	80.6%
Average	75.9%	77.1%	77.1%	76.8%	76.5%
Worst	66.3%	64.6%	66.9%	67.7%	69.0%
No. responses	337	294	764	906	851



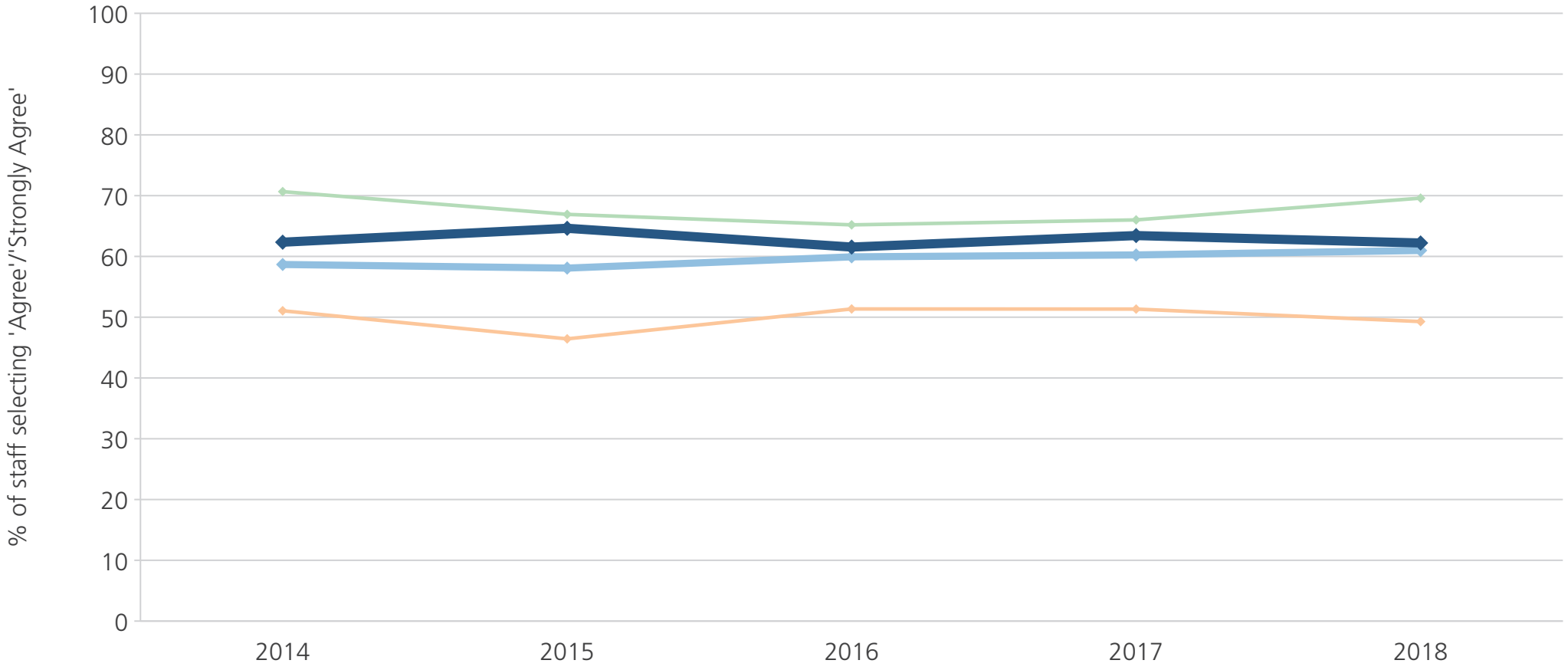
	2014	2015	2016	2017	2018
Best	76.8%	81.5%	79.7%	83.8%	80.5%
Your org	76.0%	78.9%	79.7%	76.9%	75.8%
Average	72.5%	73.7%	74.7%	74.9%	75.7%
Worst	64.7%	67.1%	68.1%	68.1%	67.0%
No. responses	339	298	776	919	862



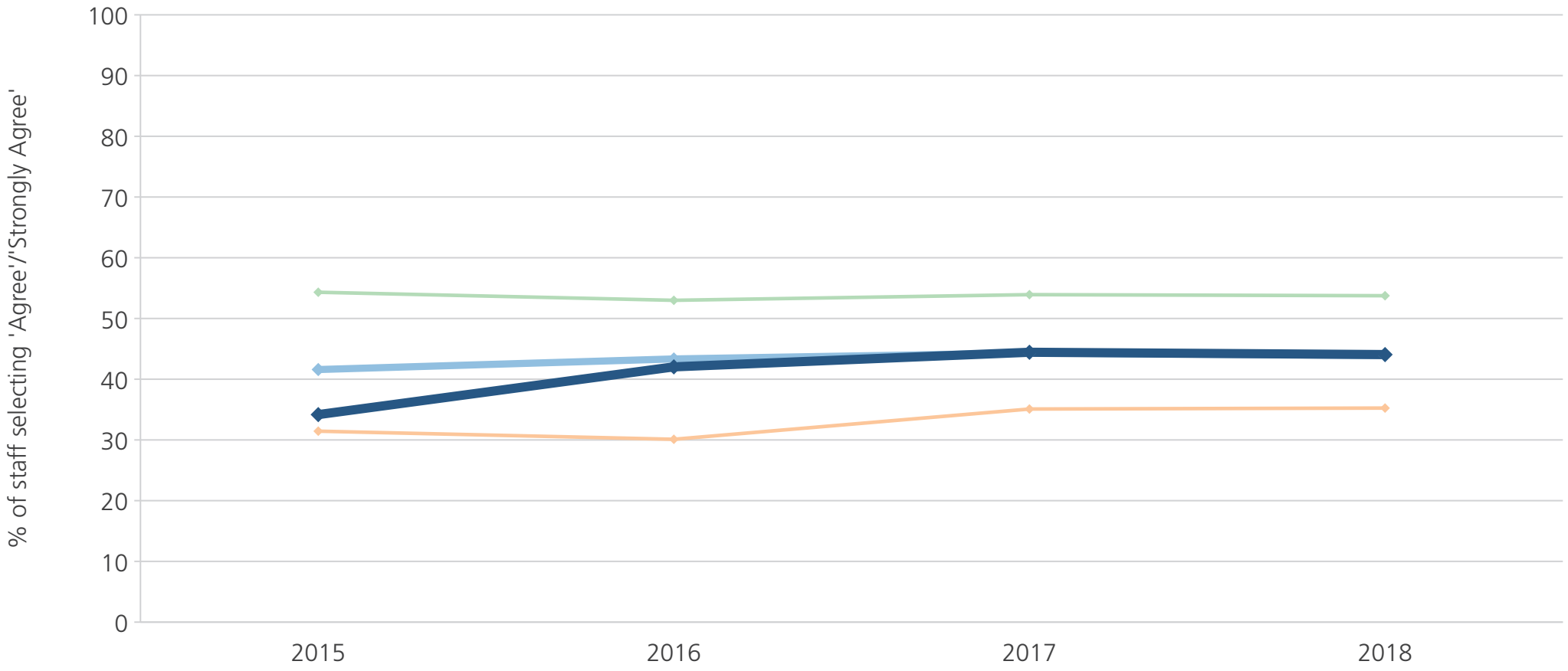
	2014	2015	2016	2017	2018
Best	82.2%	82.3%	81.7%	82.2%	81.4%
Your org	80.2%	80.9%	81.7%	80.9%	81.4%
Average	76.1%	77.2%	78.3%	78.1%	78.7%
Worst	70.2%	72.0%	72.5%	70.5%	73.4%
No. responses	337	298	775	917	857



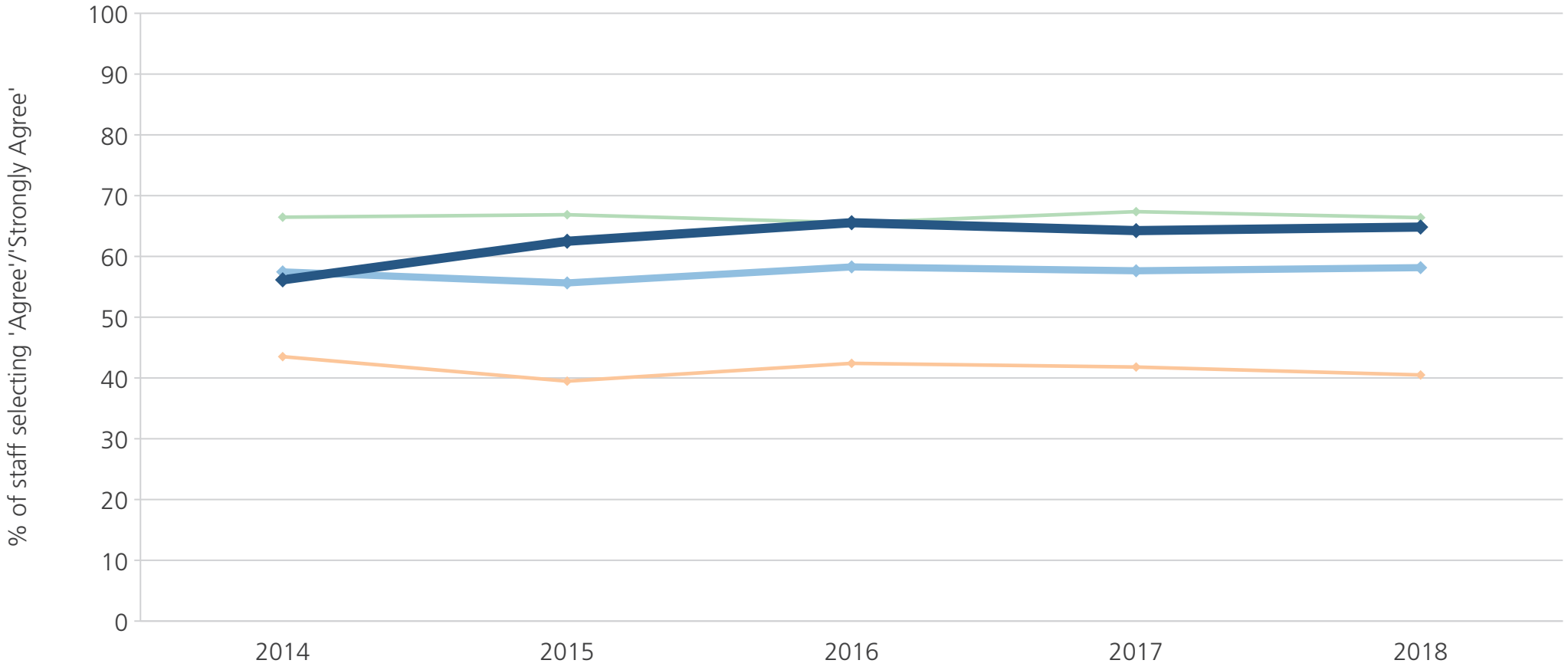
	2014	2015	2016	2017	2018
Best	66.2%	65.5%	60.4%	65.6%	61.8%
Your org	56.4%	58.5%	55.5%	56.3%	56.4%
Average	54.2%	54.0%	54.3%	55.8%	54.9%
Worst	44.8%	44.3%	45.8%	49.0%	49.7%
No. responses	339	298	773	917	859



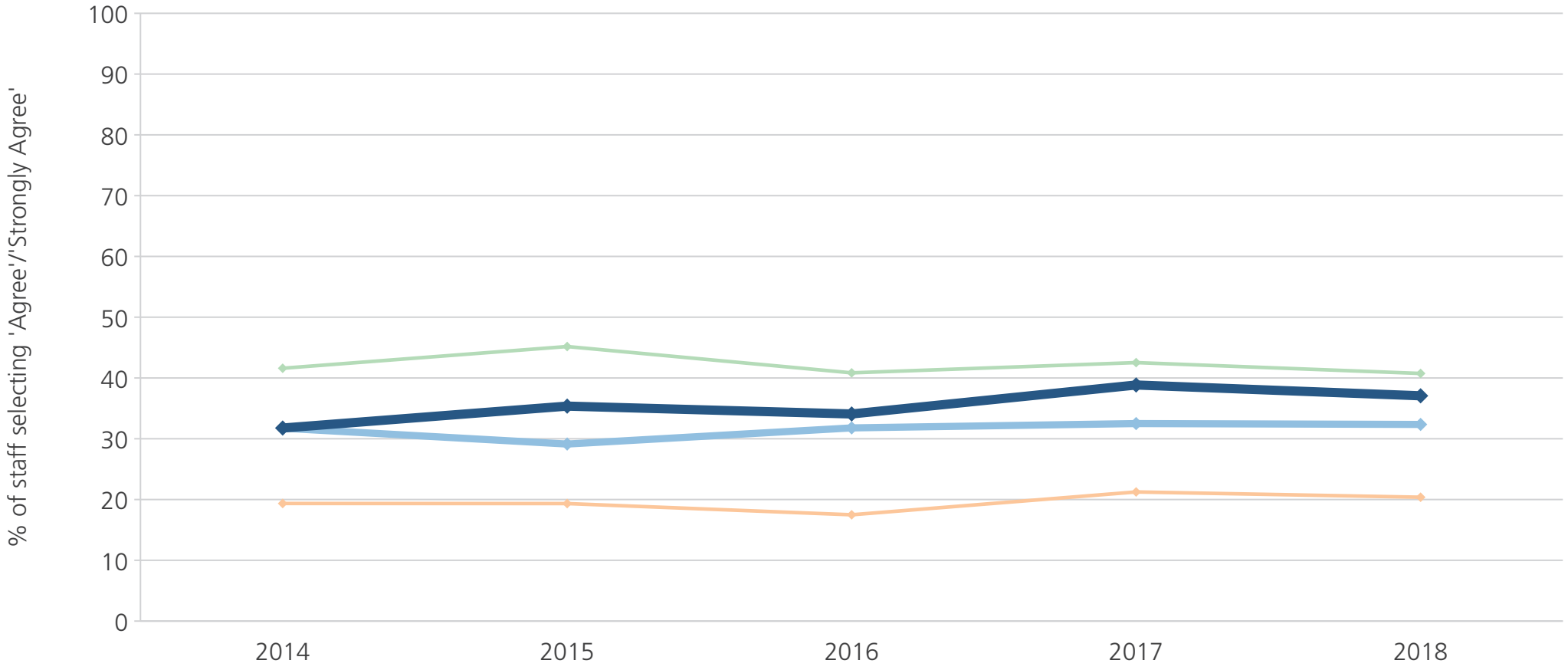
	2014	2015	2016	2017	2018
Best	70.7%	66.9%	65.2%	66.0%	69.6%
Your org	62.3%	64.6%	61.5%	63.4%	62.2%
Average	58.7%	58.1%	59.9%	60.2%	61.0%
Worst	51.1%	46.4%	51.4%	51.3%	49.3%
No. responses	339	297	772	915	857



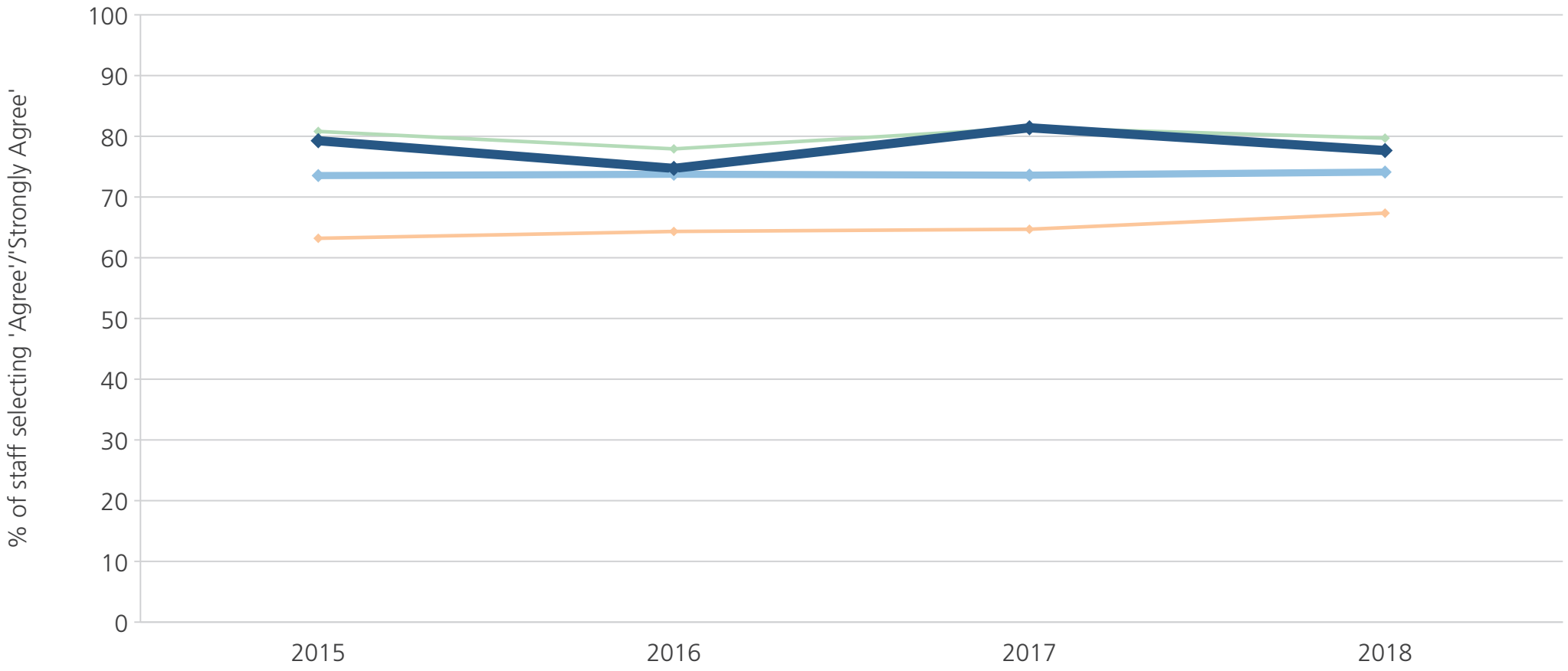
	2015	2016	2017	2018
Best	54.3%	53.0%	53.9%	53.7%
Your org	34.2%	42.0%	44.4%	44.1%
Average	41.6%	43.3%	44.3%	43.9%
Worst	31.4%	30.1%	35.1%	35.2%
No. responses	298	773	917	857



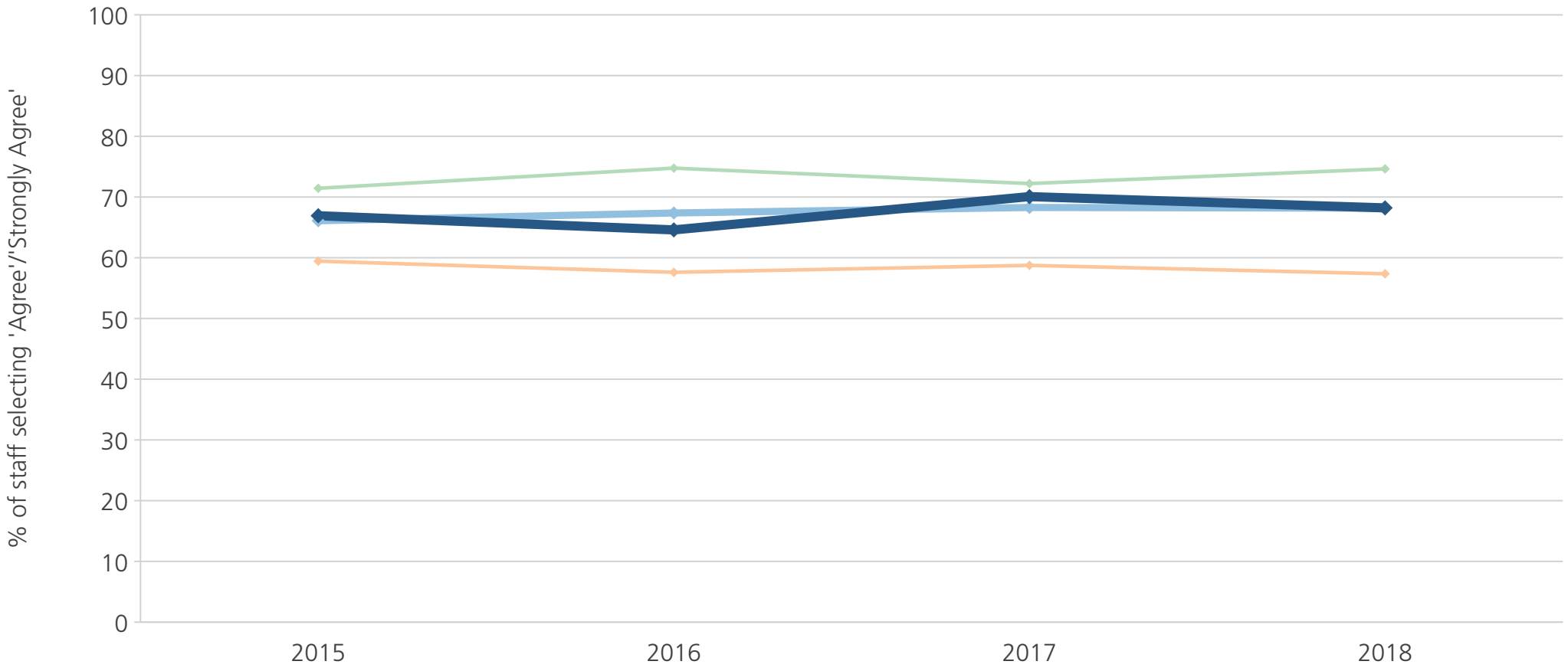
	2014	2015	2016	2017	2018
Best	66.5%	66.9%	65.5%	67.4%	66.4%
Your org	56.1%	62.5%	65.5%	64.2%	64.8%
Average	57.5%	55.6%	58.3%	57.6%	58.2%
Worst	43.5%	39.5%	42.4%	41.8%	40.5%
No. responses	337	297	773	915	859



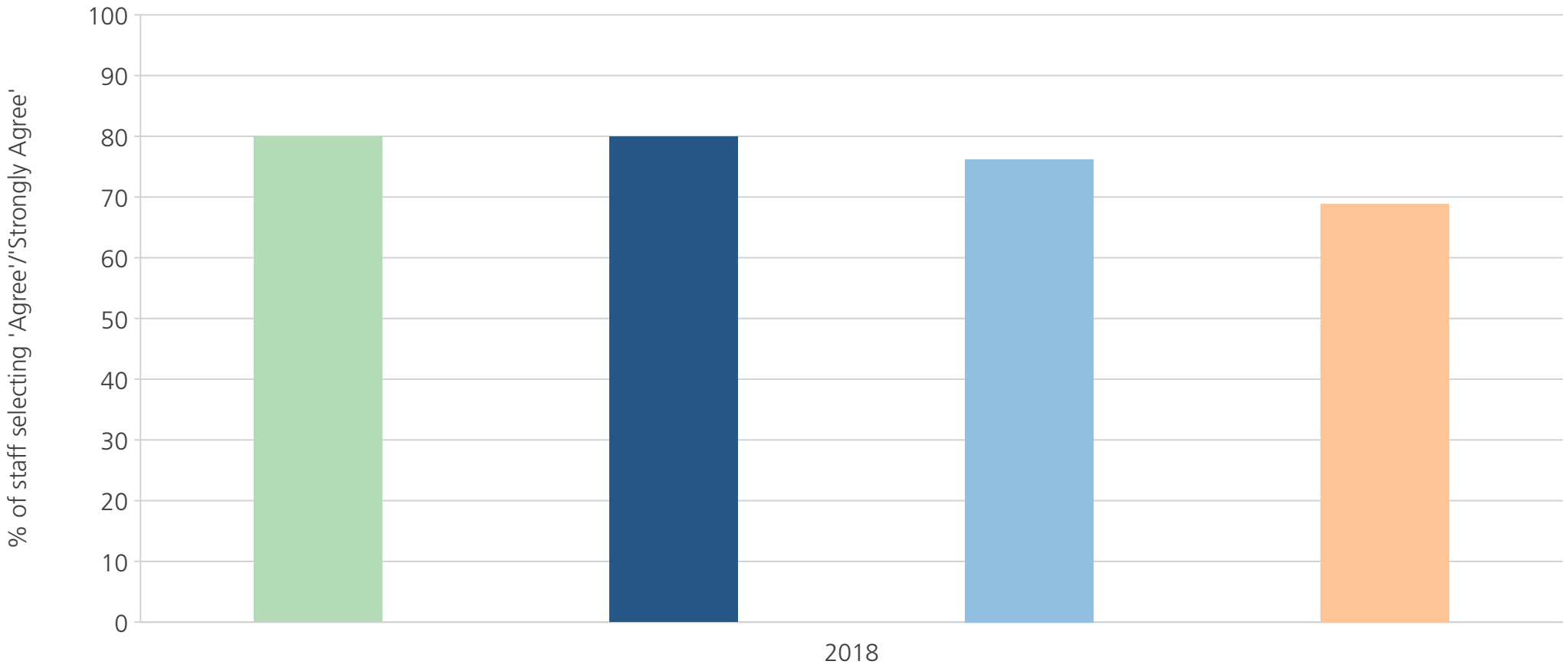
	2014	2015	2016	2017	2018
Best	41.6%	45.2%	40.8%	42.5%	40.7%
Your org	31.8%	35.4%	34.1%	38.8%	37.1%
Average	31.7%	29.1%	31.8%	32.5%	32.4%
Worst	19.4%	19.3%	17.5%	21.2%	20.4%
No. responses	338	296	772	915	858



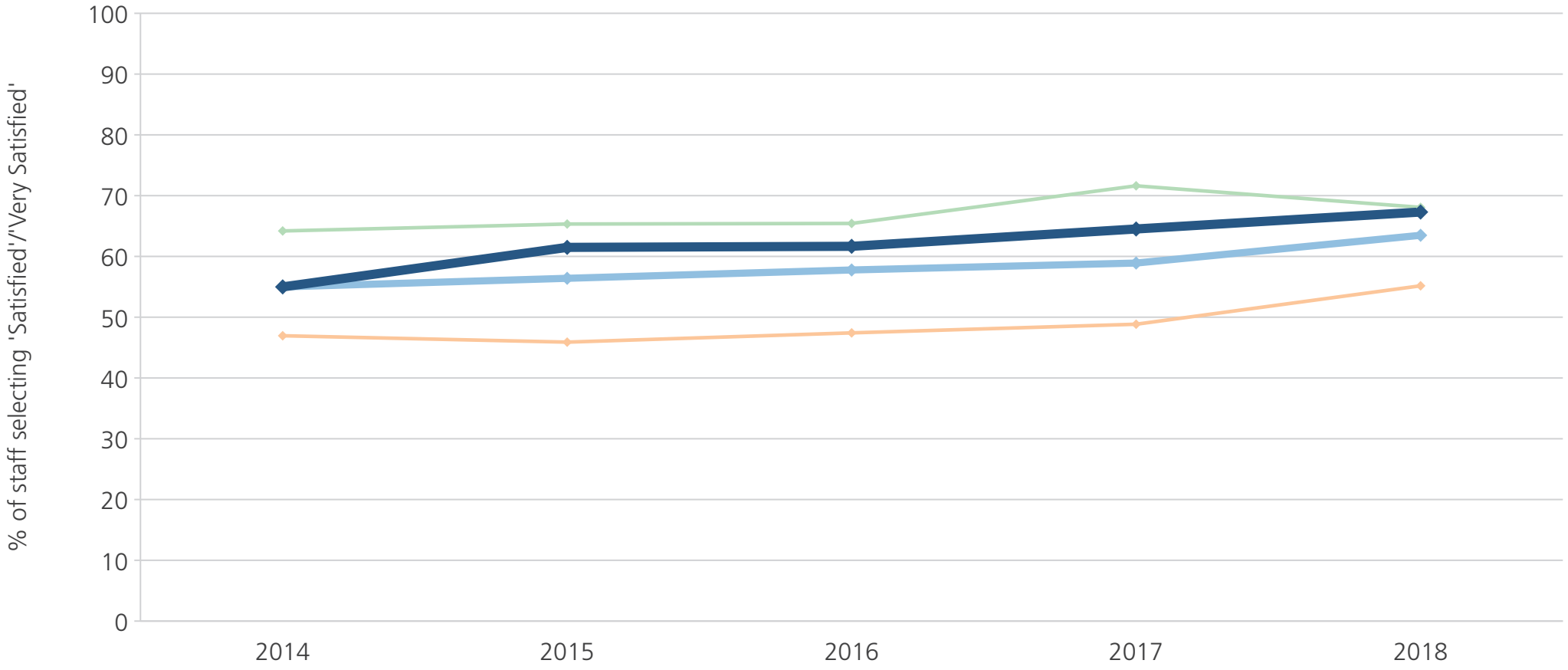
	2015	2016	2017	2018
Best	80.8%	77.9%	81.4%	79.7%
Your org	79.3%	74.7%	81.4%	77.7%
Average	73.5%	73.7%	73.6%	74.1%
Worst	63.2%	64.3%	64.7%	67.3%
No. responses	292	769	908	847



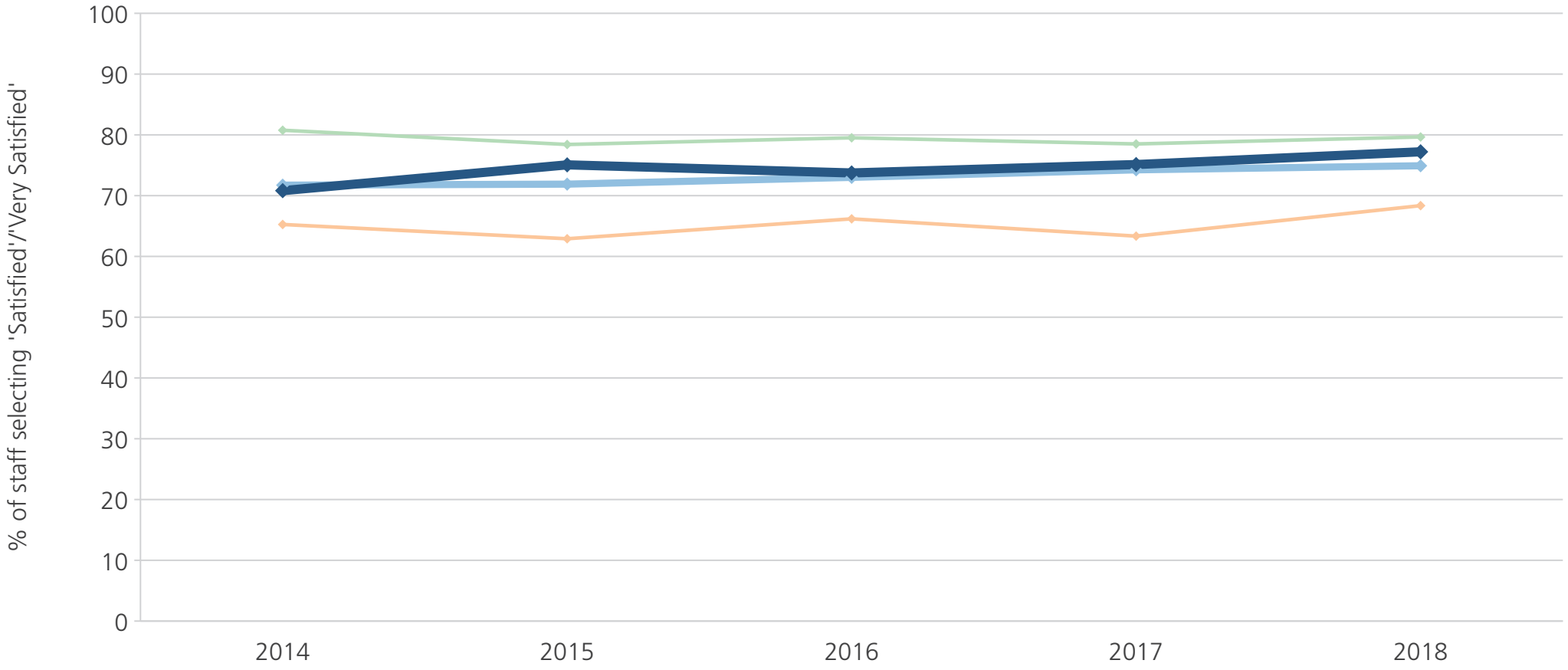
	2015	2016	2017	2018
Best	71.4%	74.8%	72.2%	74.6%
Your org	66.9%	64.6%	70.1%	68.2%
Average	66.1%	67.4%	68.3%	68.2%
Worst	59.4%	57.6%	58.7%	57.4%
No. responses	295	772	915	857



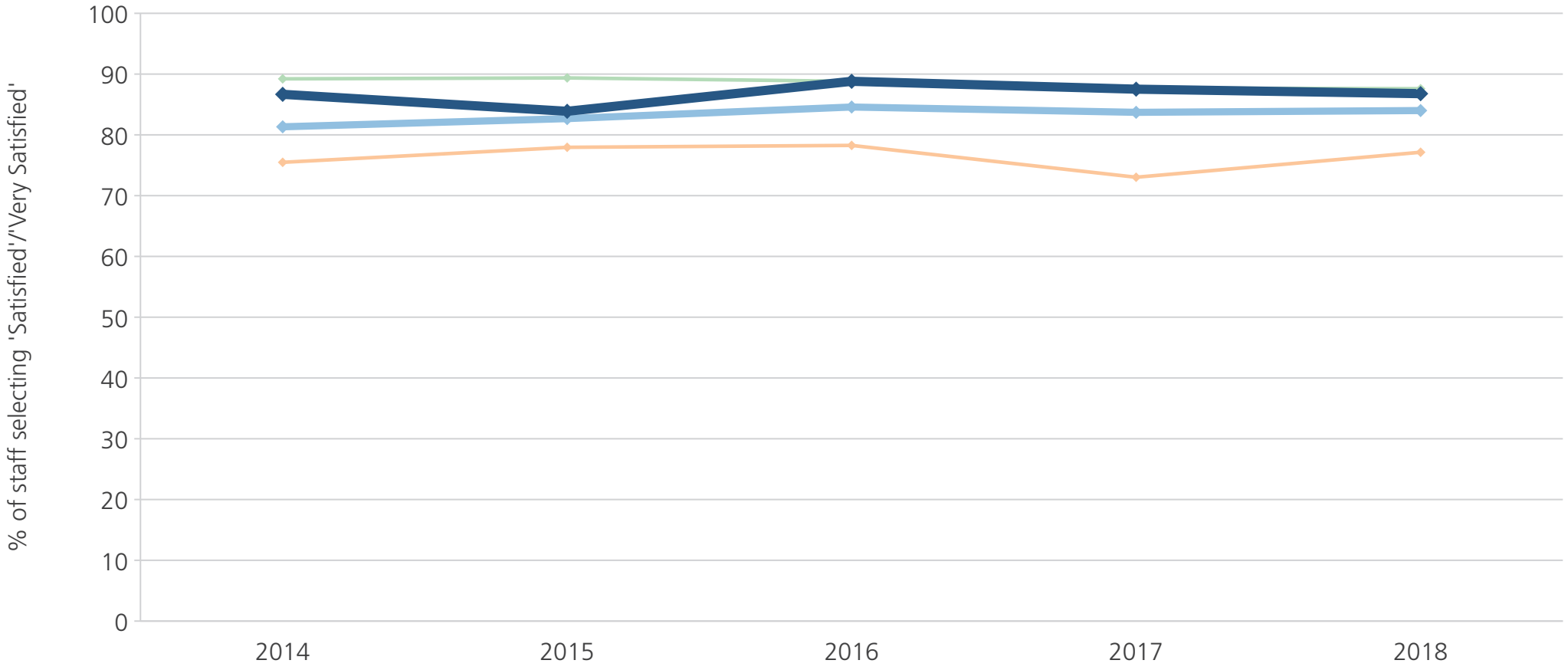
Best	79.9%
Your org	79.9%
Average	76.2%
Worst	68.9%
No. responses	858



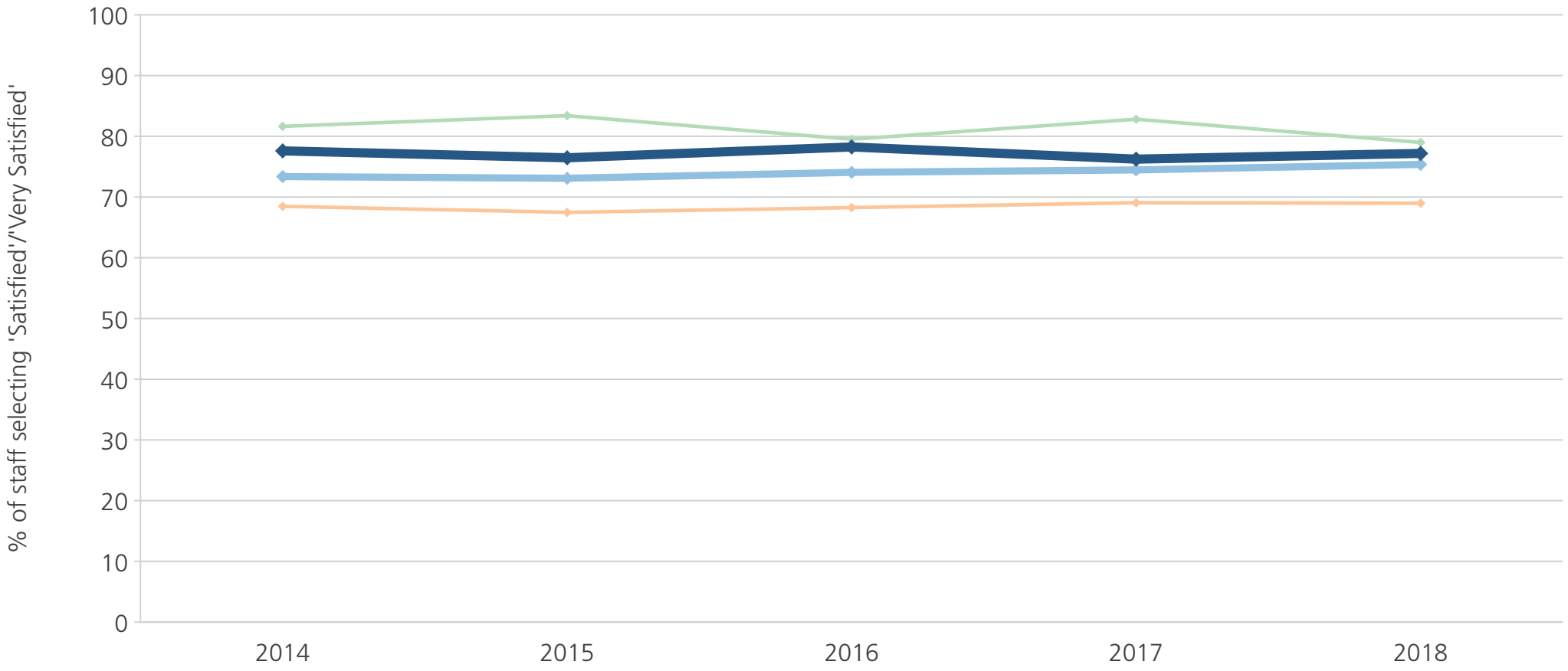
	2014	2015	2016	2017	2018
Best	64.2%	65.3%	65.4%	71.6%	68.1%
Your org	55.0%	61.5%	61.7%	64.5%	67.3%
Average	55.0%	56.4%	57.8%	58.9%	63.5%
Worst	46.9%	45.9%	47.4%	48.8%	55.2%
No. responses	342	296	772	911	857



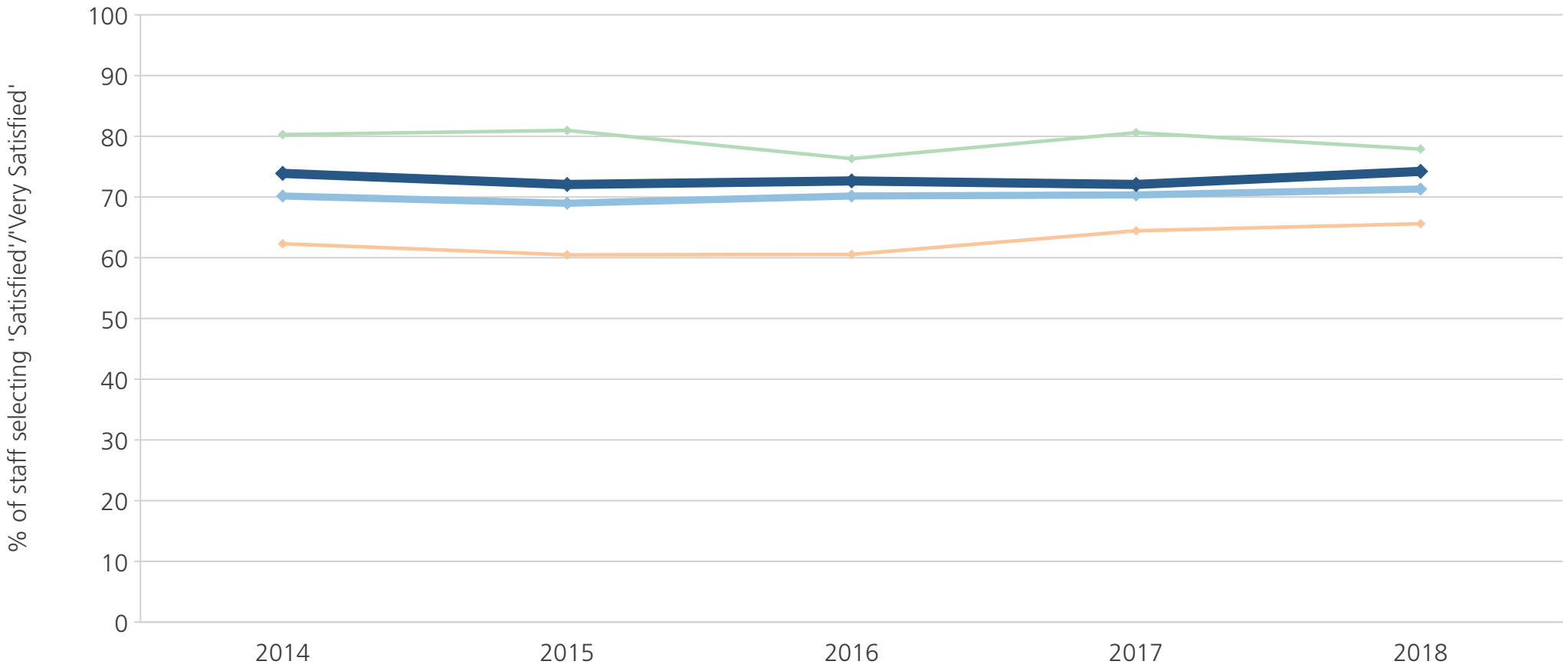
	2014	2015	2016	2017	2018
Best	80.8%	78.4%	79.5%	78.5%	79.7%
Your org	70.8%	75.1%	73.7%	75.1%	77.2%
Average	71.7%	71.9%	73.0%	74.2%	74.9%
Worst	65.3%	62.9%	66.2%	63.3%	68.4%
No. responses	342	297	773	912	858



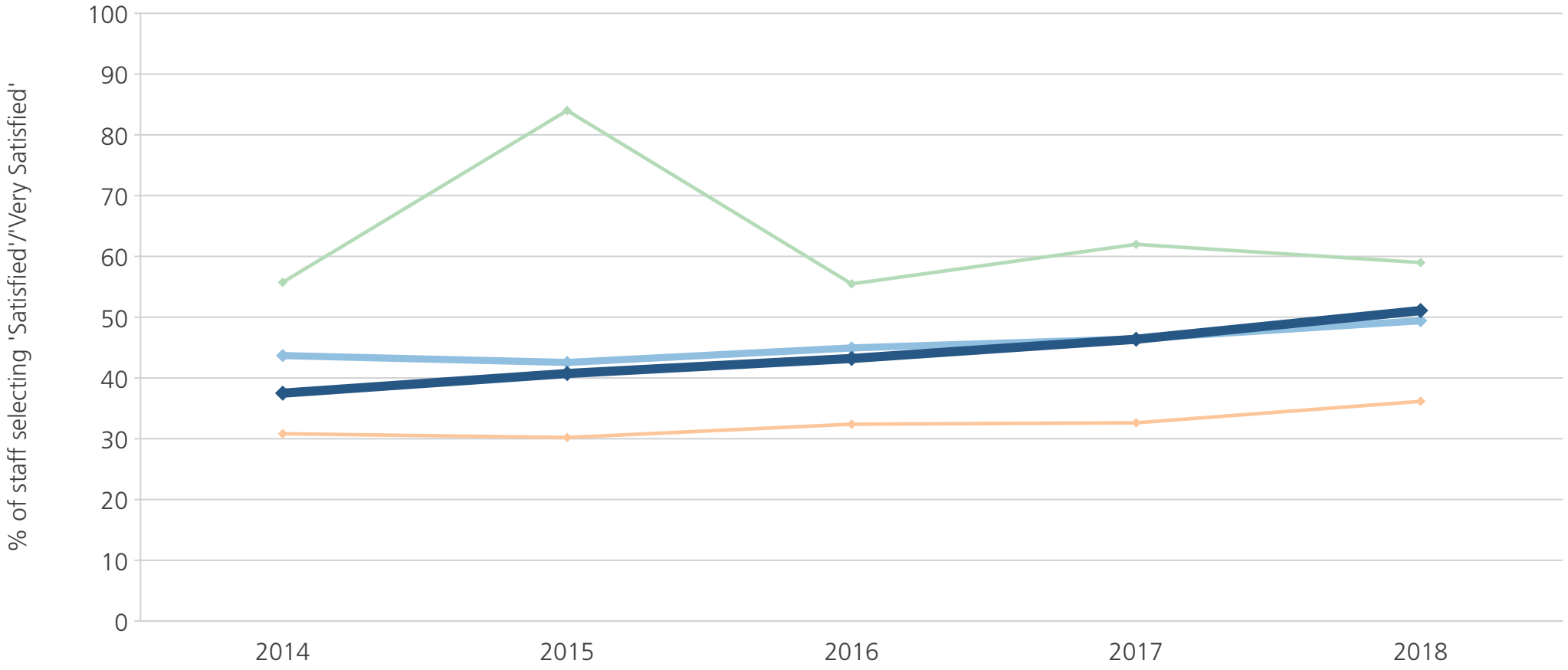
	2014	2015	2016	2017	2018
Best	89.2%	89.4%	88.8%	87.7%	87.6%
Your org	86.7%	83.9%	88.8%	87.5%	86.8%
Average	81.3%	82.7%	84.6%	83.7%	84.0%
Worst	75.5%	78.0%	78.3%	73.0%	77.1%
No. responses	342	296	774	912	859



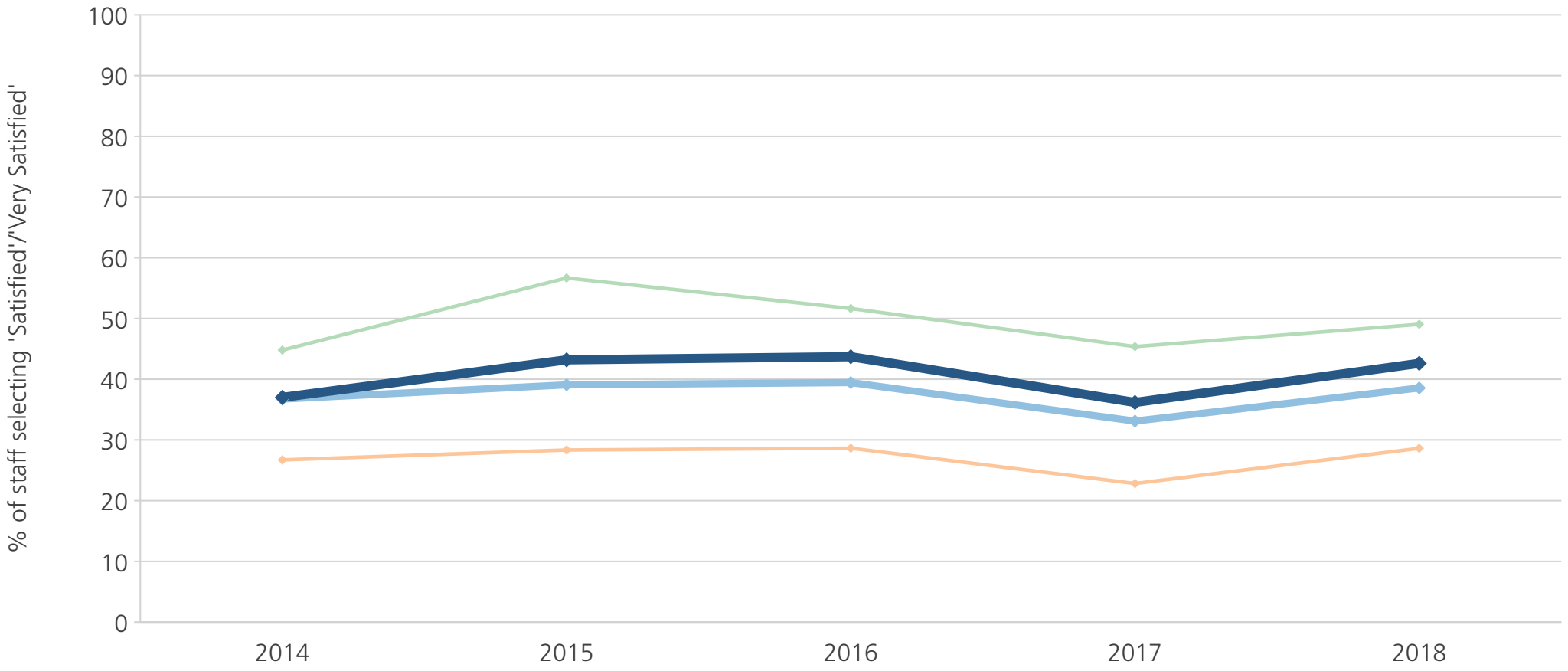
	2014	2015	2016	2017	2018
Best	81.6%	83.4%	79.5%	82.8%	79.0%
Your org	77.6%	76.5%	78.2%	76.2%	77.2%
Average	73.4%	73.1%	74.1%	74.5%	75.4%
Worst	68.5%	67.5%	68.3%	69.1%	69.0%
No. responses	341	297	772	914	856



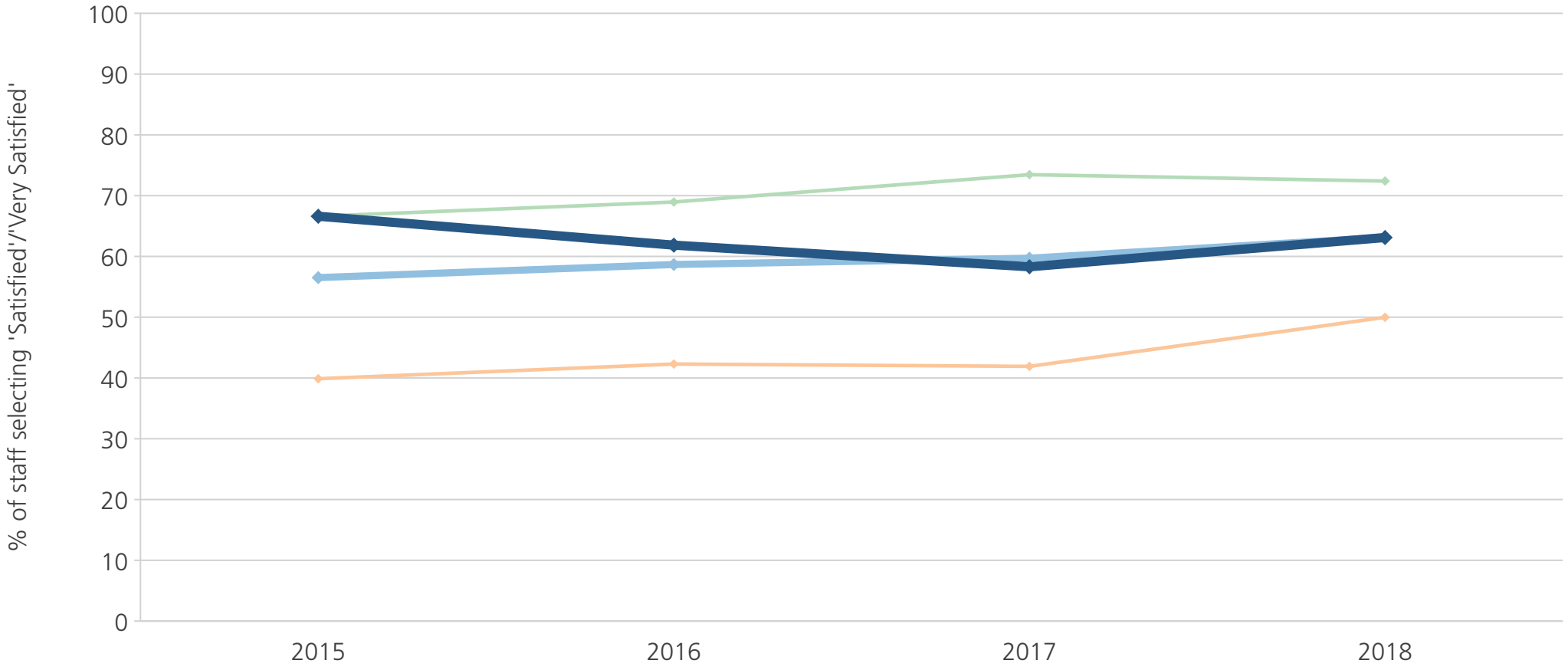
	2014	2015	2016	2017	2018
Best	80.3%	81.0%	76.3%	80.6%	77.9%
Your org	73.9%	72.1%	72.6%	72.1%	74.2%
Average	70.2%	69.0%	70.2%	70.3%	71.3%
Worst	62.3%	60.5%	60.5%	64.4%	65.6%
No. responses	340	297	773	912	857



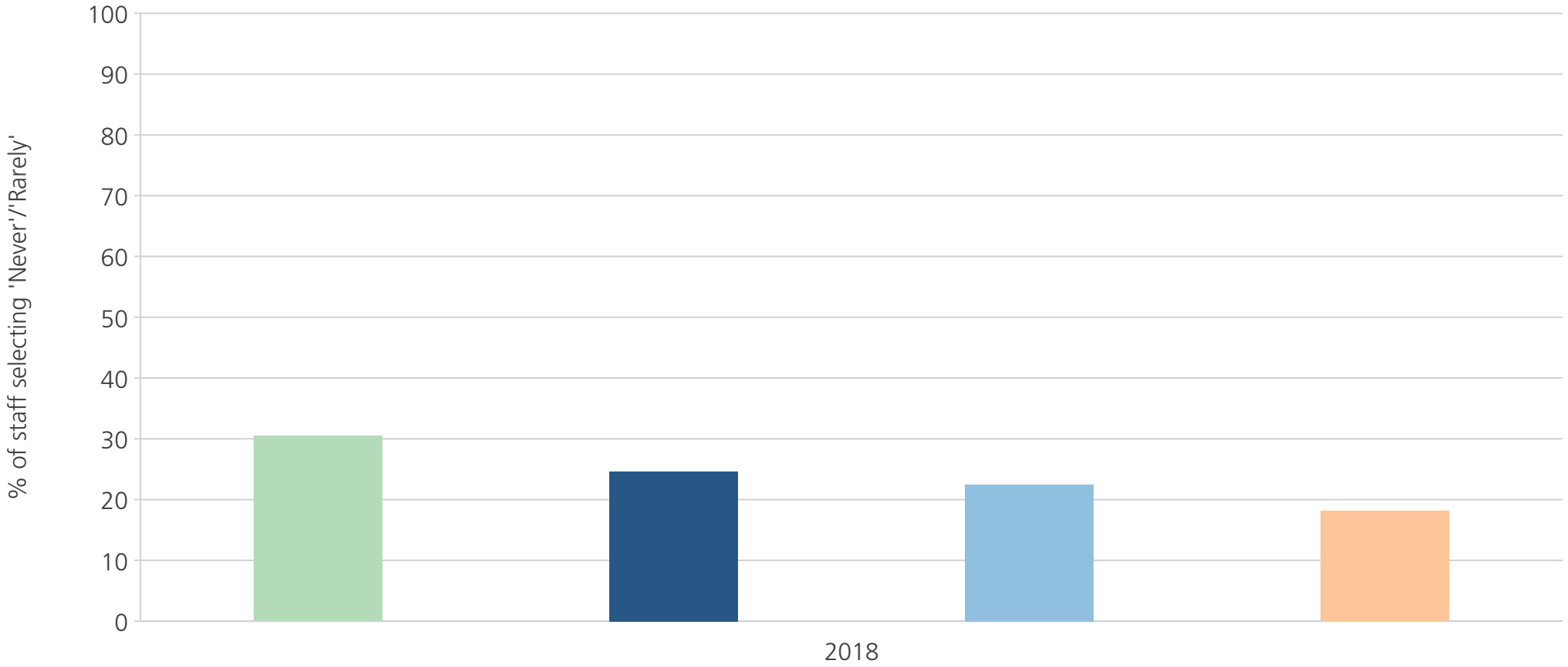
	2014	2015	2016	2017	2018
Best	55.7%	84.0%	55.5%	62.0%	59.0%
Your org	37.5%	40.7%	43.2%	46.4%	51.1%
Average	43.7%	42.6%	44.9%	46.4%	49.4%
Worst	30.8%	30.2%	32.4%	32.6%	36.2%
No. responses	342	297	772	912	853



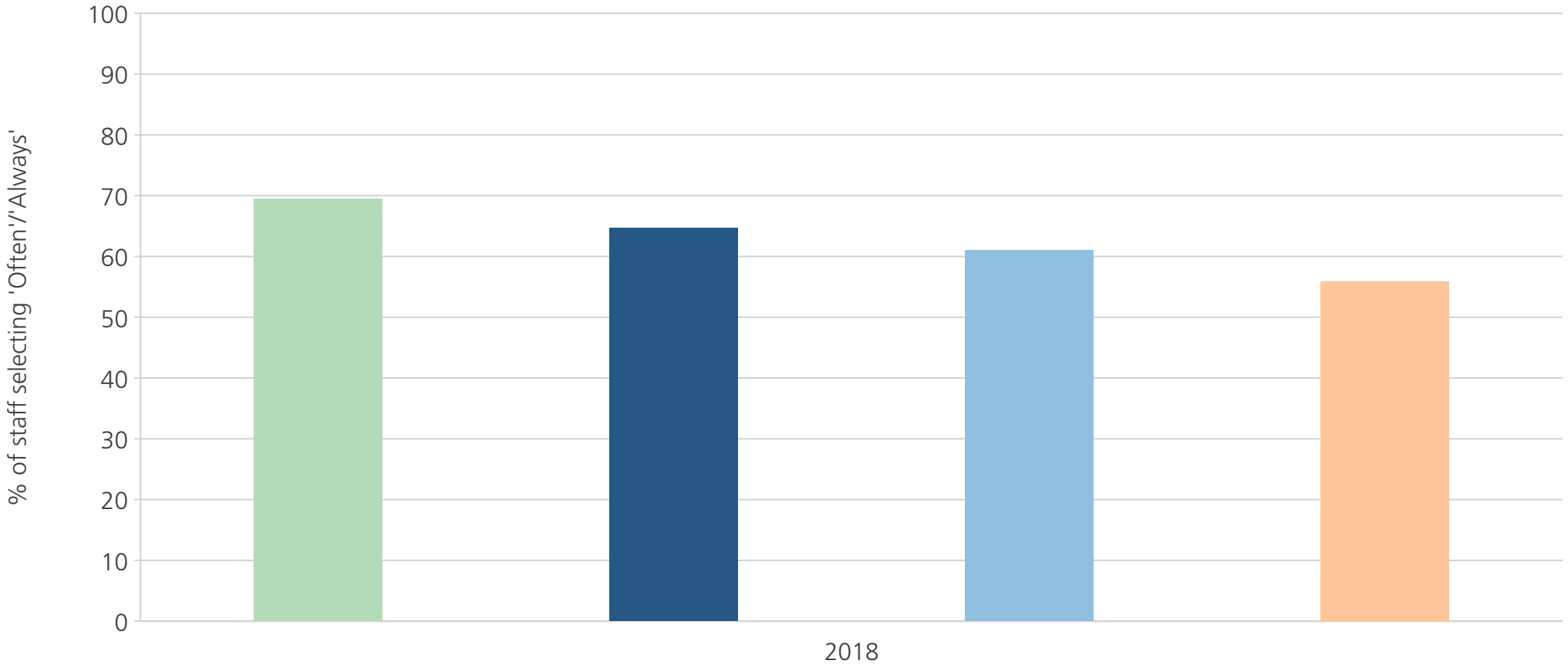
	2014	2015	2016	2017	2018
Best	44.8%	56.7%	51.6%	45.4%	49.0%
Your org	37.0%	43.2%	43.7%	36.2%	42.6%
Average	36.7%	39.1%	39.4%	33.1%	38.6%
Worst	26.7%	28.3%	28.6%	22.8%	28.6%
No. responses	339	297	772	910	855



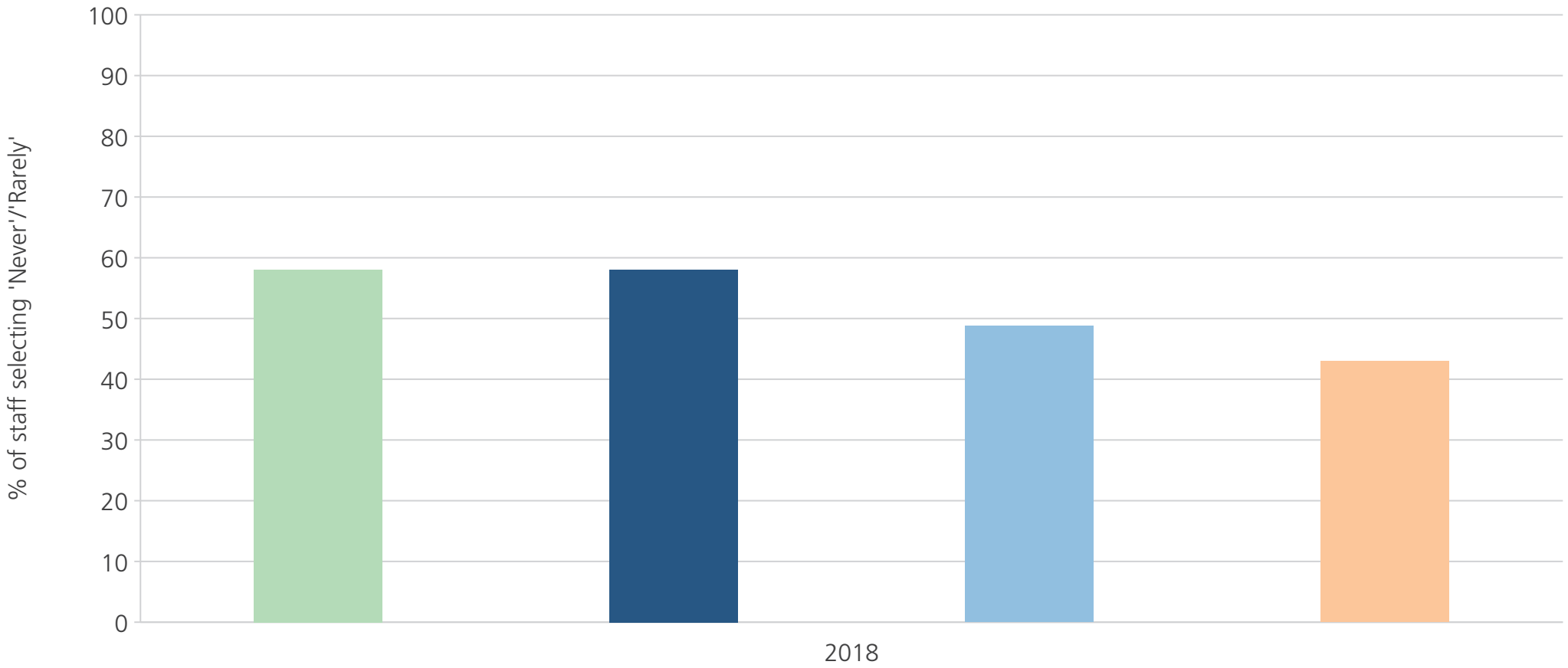
	2015	2016	2017	2018
Best	66.6%	69.0%	73.5%	72.4%
Your org	66.6%	61.9%	58.3%	63.1%
Average	56.5%	58.7%	59.7%	63.1%
Worst	39.9%	42.3%	41.9%	50.0%
No. responses	296	770	908	856



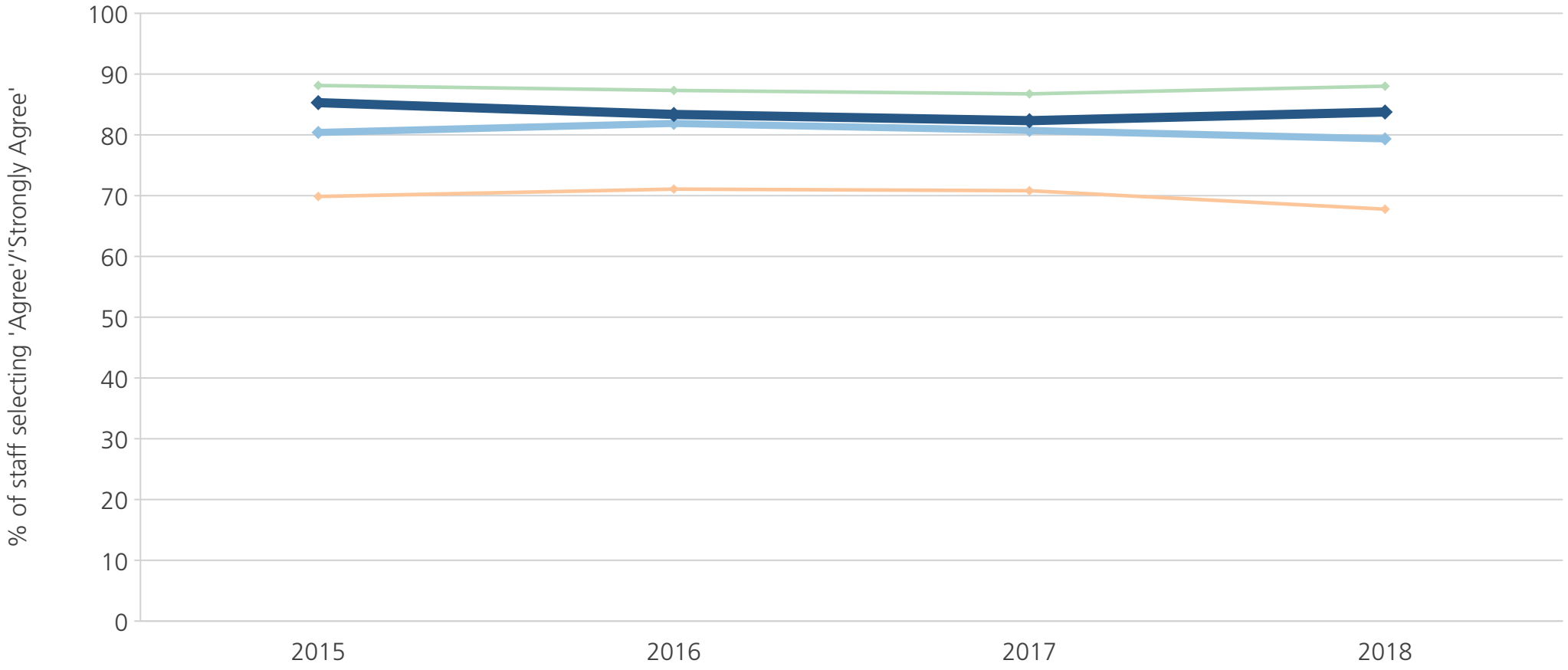
Best	30.5%
Your org	24.6%
Average	22.5%
Worst	18.1%
No. responses	843



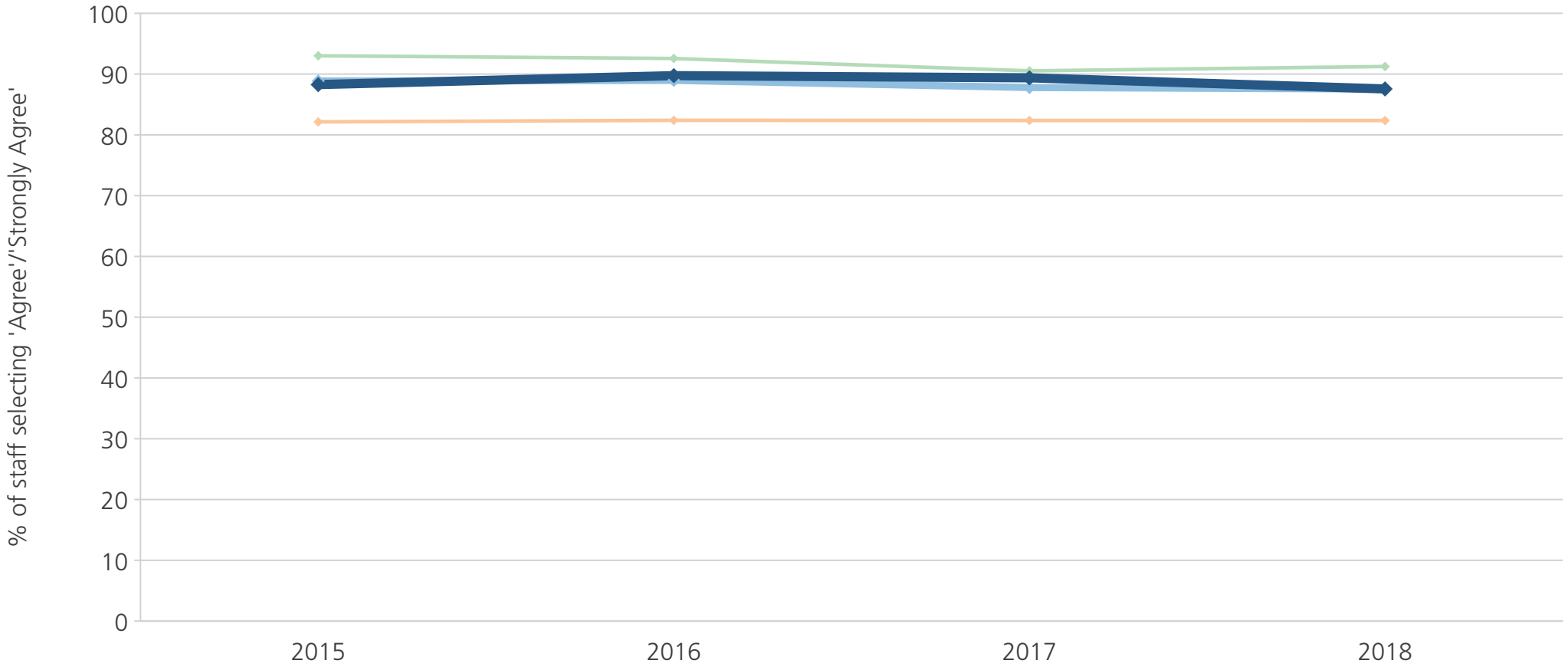
Best	69.4%
Your org	64.7%
Average	61.0%
Worst	55.9%
No. responses	842



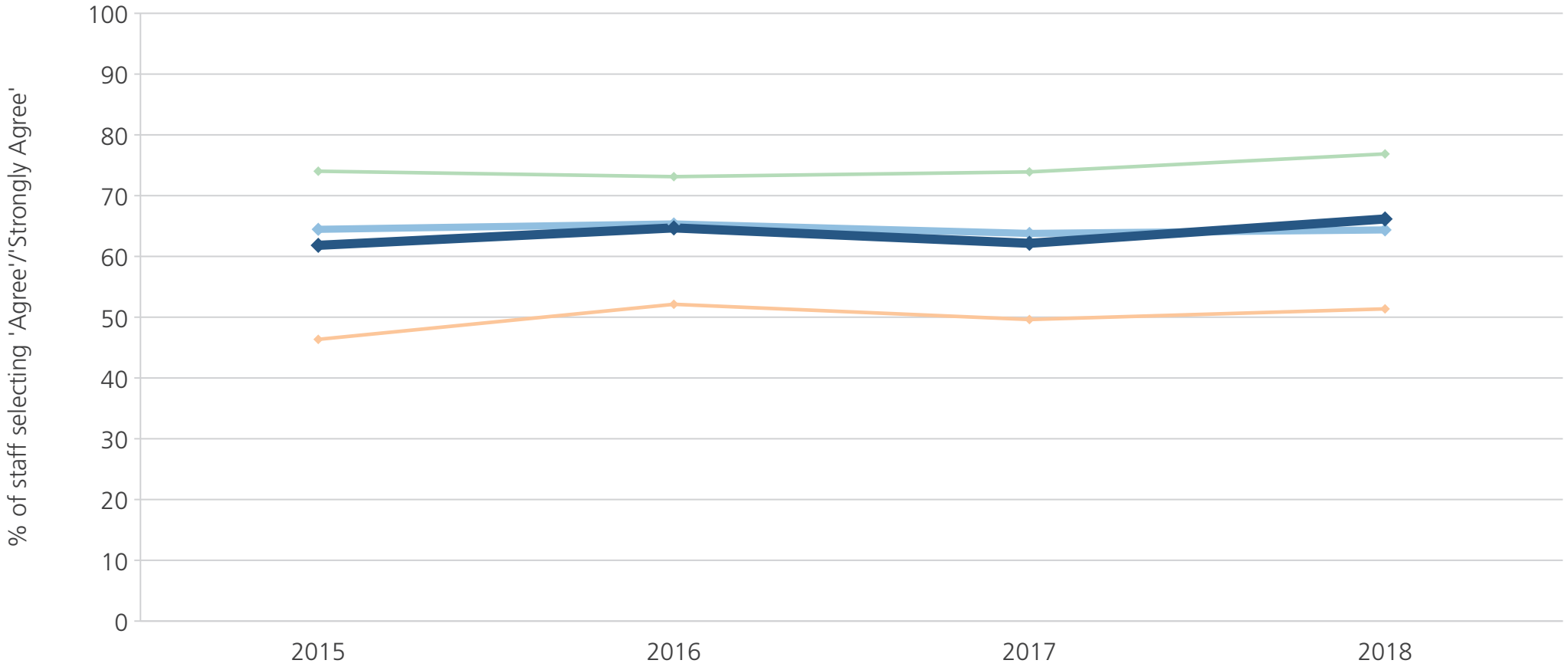
Best	58.0%
Your org	58.0%
Average	48.8%
Worst	43.0%
No. responses	843



	2015	2016	2017	2018
Best	88.1%	87.3%	86.7%	88.0%
Your org	85.3%	83.4%	82.3%	83.8%
Average	80.4%	81.9%	80.7%	79.3%
Worst	69.9%	71.1%	70.8%	67.8%
No. responses	232	588	710	660



	2015	2016	2017	2018
Best	93.0%	92.6%	90.5%	91.2%
Your org	88.3%	89.7%	89.4%	87.6%
Average	88.9%	89.0%	87.8%	87.5%
Worst	82.1%	82.4%	82.4%	82.4%
No. responses	261	682	809	757



	2015	2016	2017	2018
Best	74.0%	73.1%	73.9%	76.9%
Your org	61.8%	64.7%	62.2%	66.2%
Average	64.5%	65.3%	63.8%	64.4%
Worst	46.4%	52.1%	49.6%	51.4%
No. responses	231	589	716	660

Survey Coordination Centre

NHS England

Question results – Your managers

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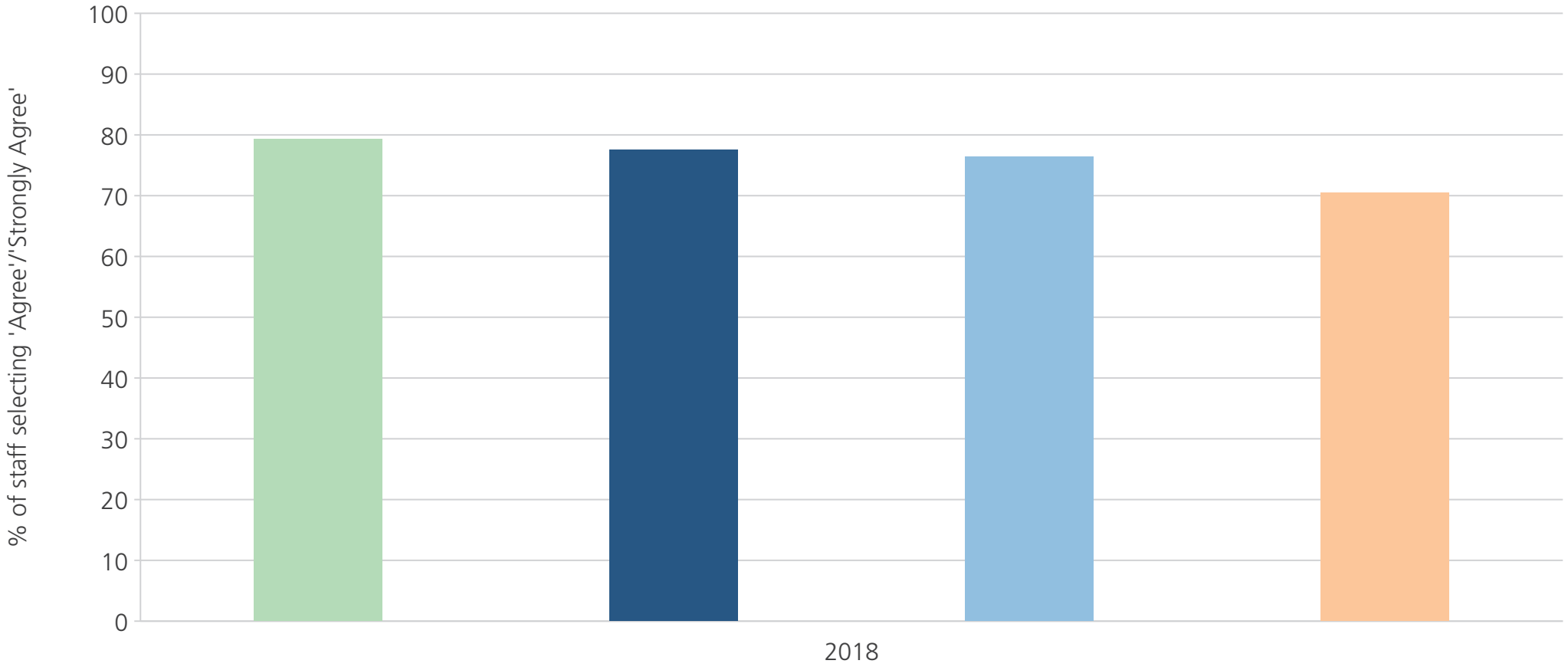
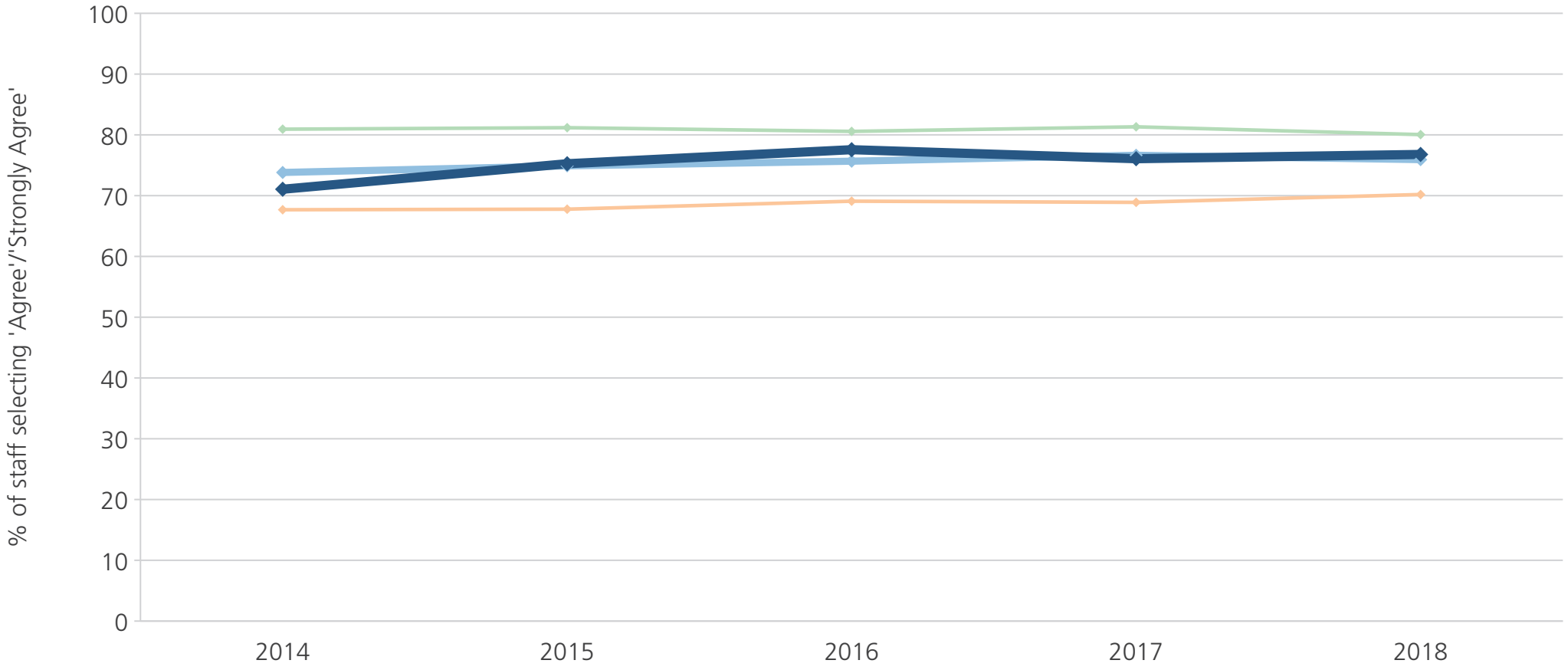
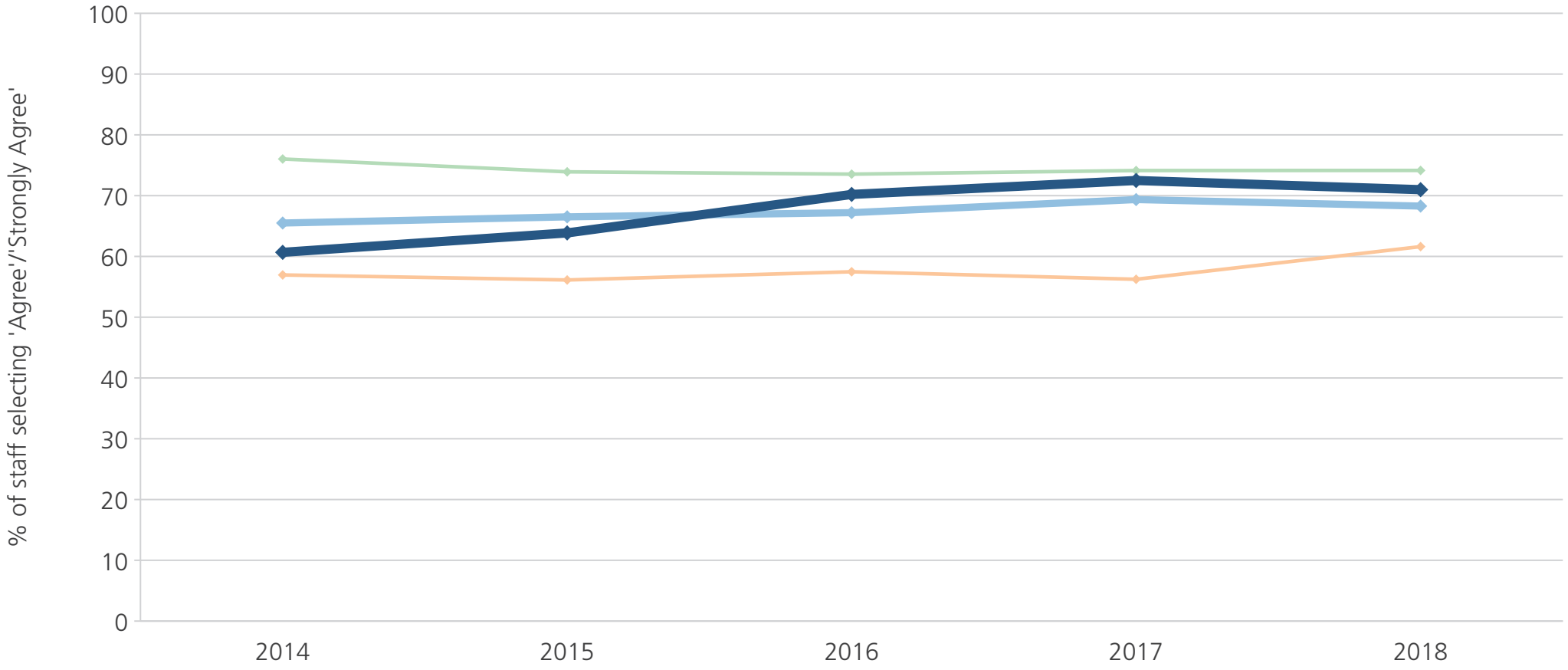
2018 NHS Staff Survey Results



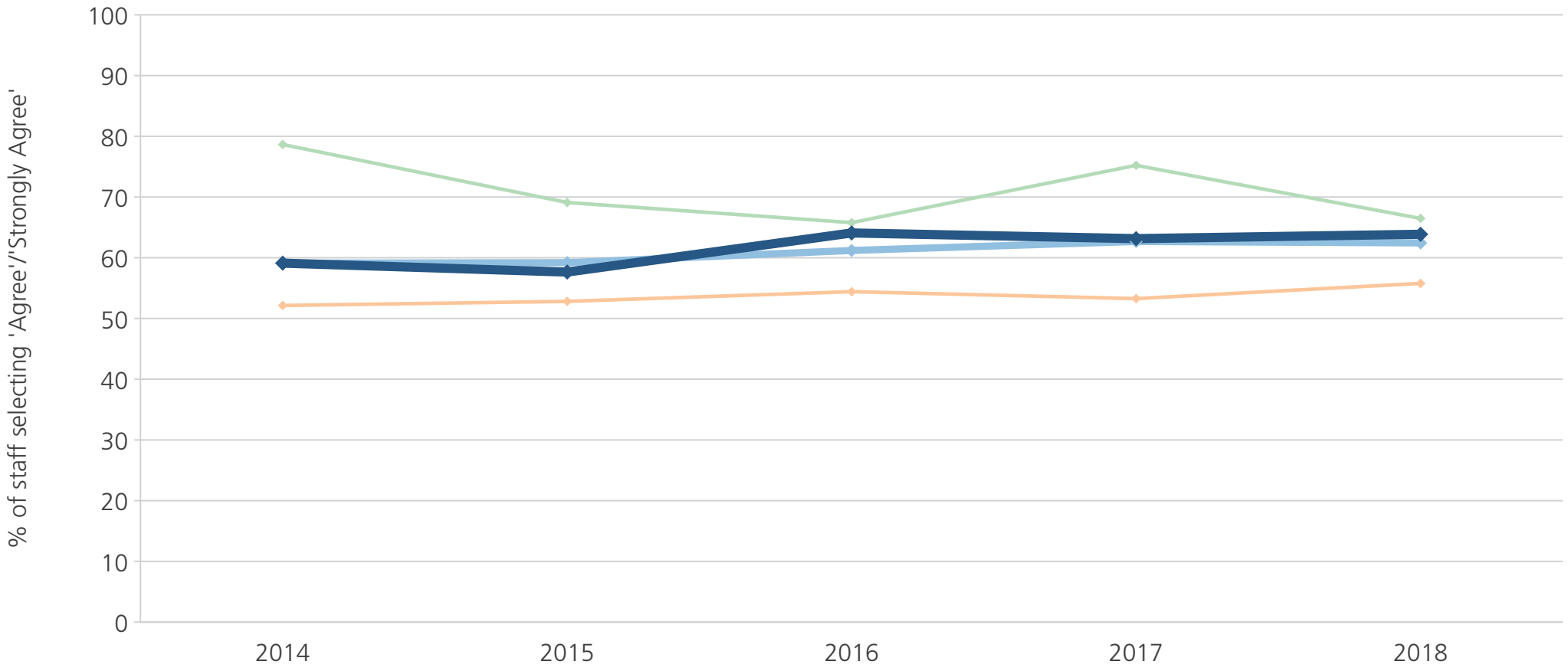
Best	79.3%
Your org	77.5%
Average	76.4%
Worst	70.4%
No. responses	857



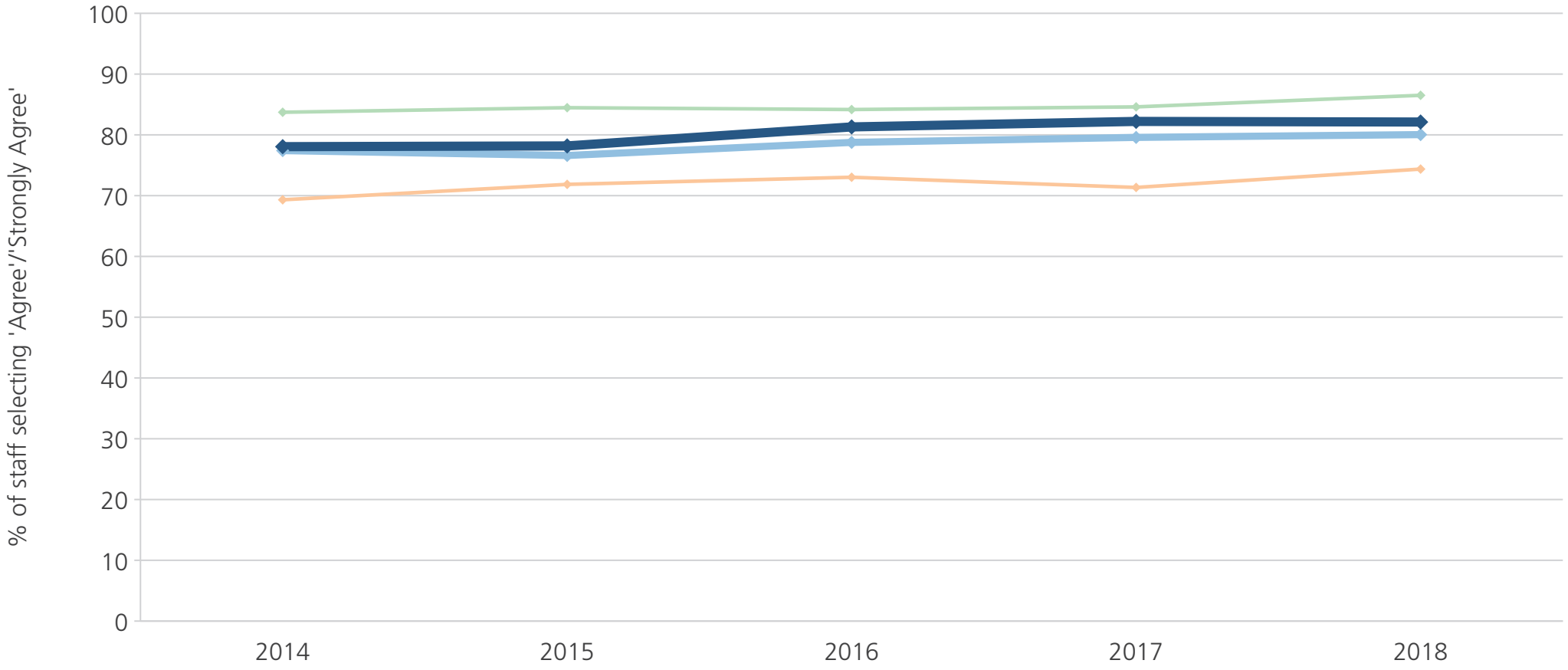
	2014	2015	2016	2017	2018
Best	80.9%	81.2%	80.6%	81.3%	80.0%
Your org	71.1%	75.3%	77.6%	76.1%	76.8%
Average	73.8%	74.9%	75.7%	76.6%	75.9%
Worst	67.7%	67.8%	69.1%	68.9%	70.2%
No. responses	341	295	771	910	855



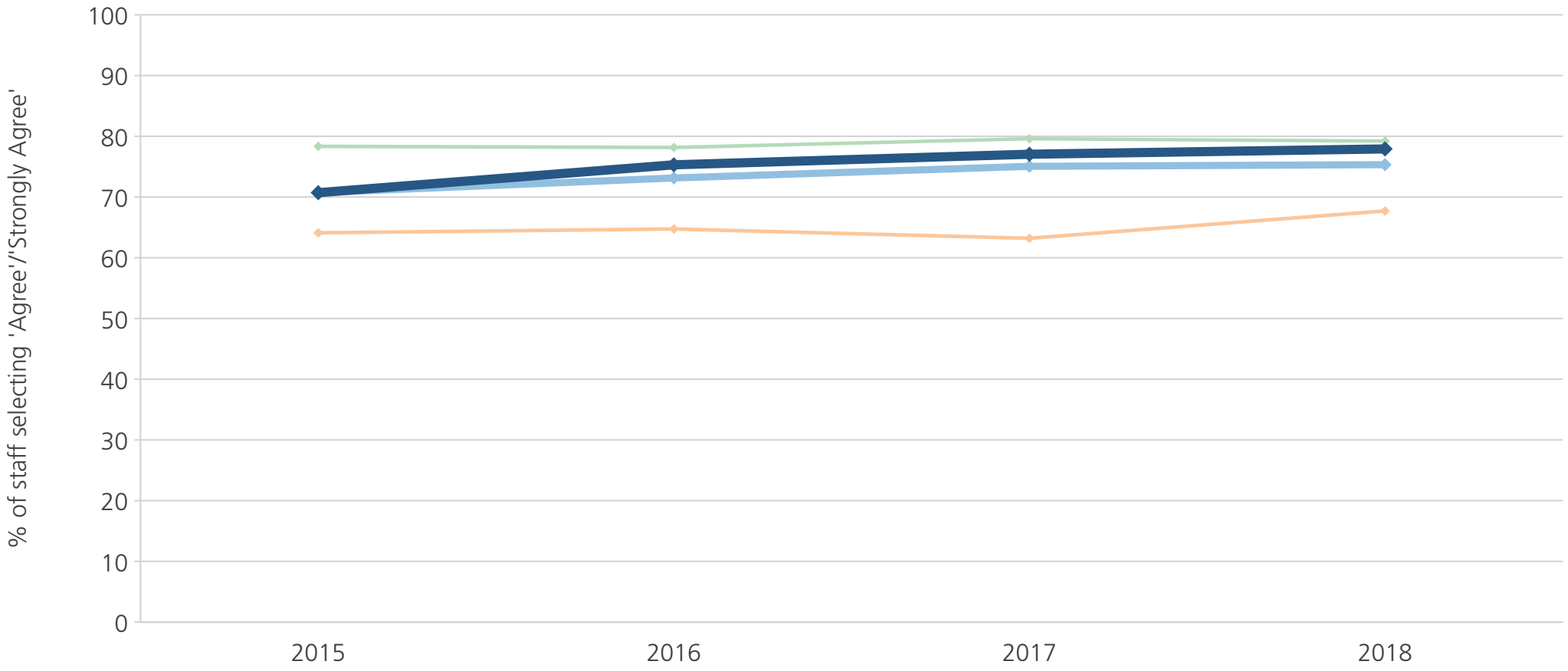
	2014	2015	2016	2017	2018
Best	76.0%	73.9%	73.5%	74.1%	74.1%
Your org	60.7%	63.9%	70.2%	72.5%	71.0%
Average	65.5%	66.5%	67.2%	69.4%	68.3%
Worst	57.0%	56.1%	57.5%	56.2%	61.6%
No. responses	341	295	771	910	856



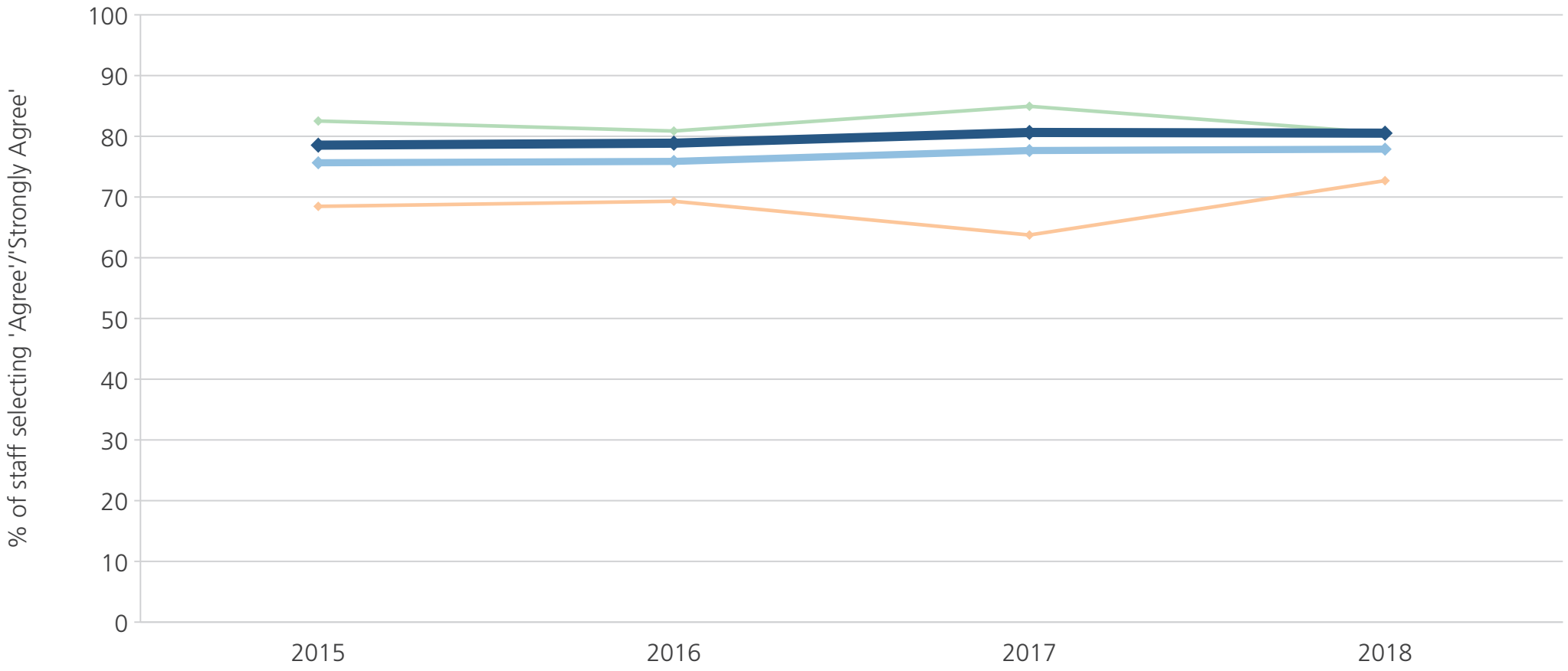
	2014	2015	2016	2017	2018
Best	78.7%	69.1%	65.8%	75.2%	66.5%
Your org	59.1%	57.6%	64.1%	63.1%	63.9%
Average	59.1%	59.2%	61.2%	62.7%	62.4%
Worst	52.1%	52.8%	54.4%	53.3%	55.8%
No. responses	341	293	769	909	856



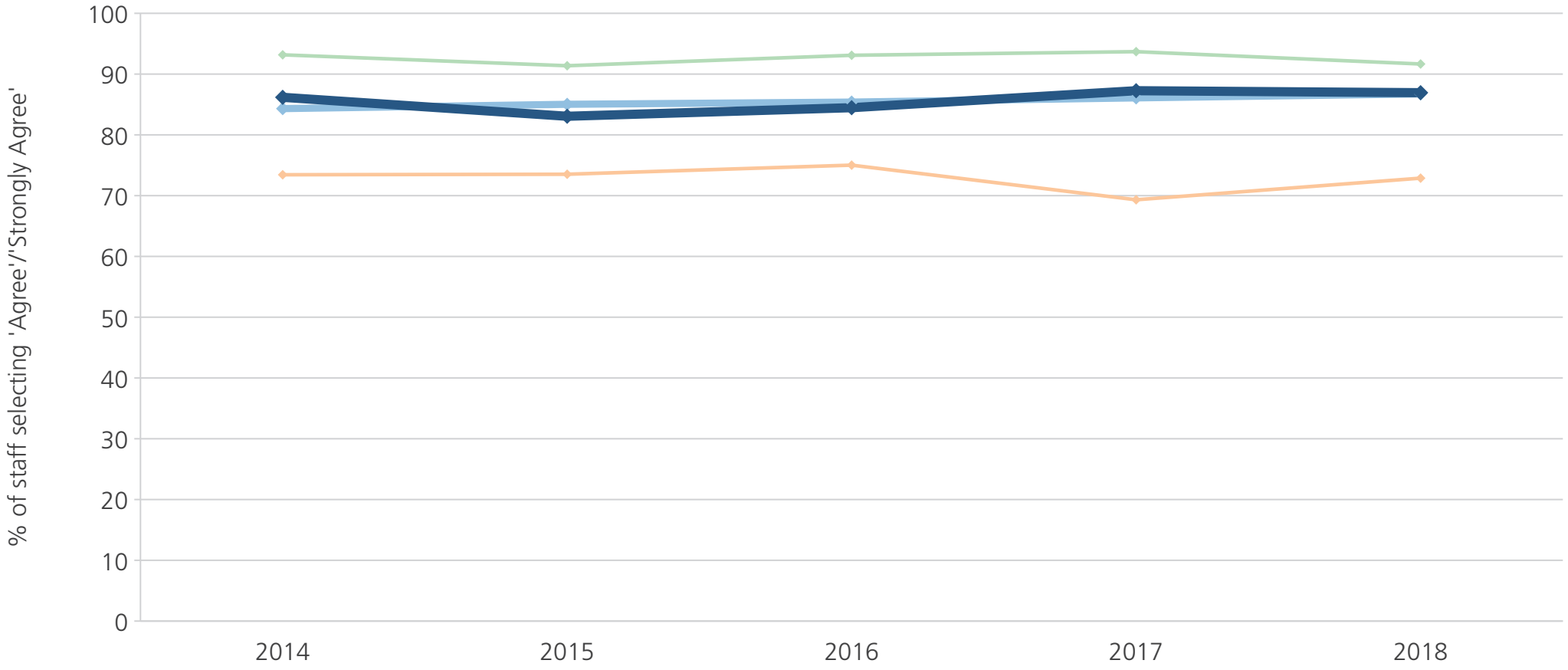
	2014	2015	2016	2017	2018
Best	83.7%	84.5%	84.2%	84.6%	86.5%
Your org	78.1%	78.2%	81.3%	82.2%	82.1%
Average	77.4%	76.6%	78.8%	79.6%	80.0%
Worst	69.3%	71.9%	73.0%	71.3%	74.4%
No. responses	341	295	770	911	855



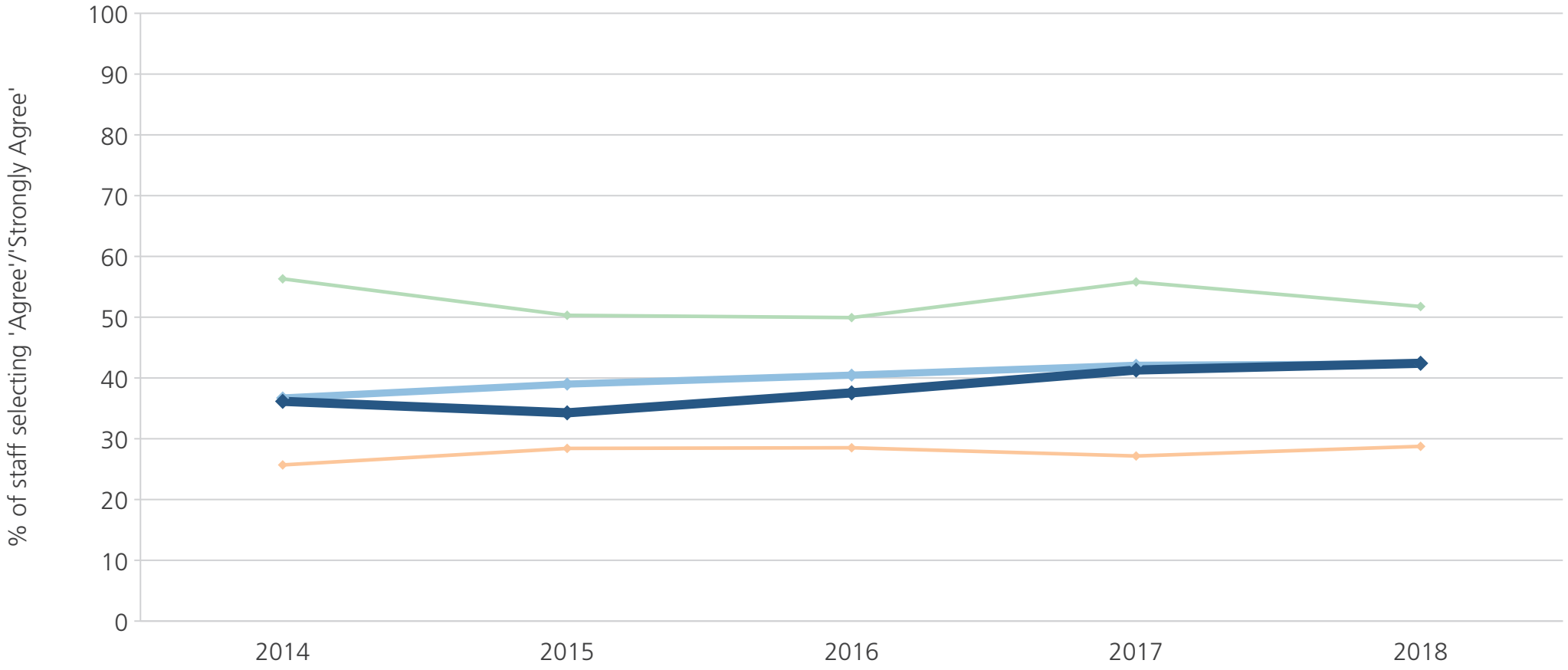
	2015	2016	2017	2018
Best	78.3%	78.2%	79.6%	79.2%
Your org	70.7%	75.3%	77.0%	77.9%
Average	70.7%	73.1%	75.1%	75.3%
Worst	64.1%	64.7%	63.2%	67.7%
No. responses	295	770	911	856



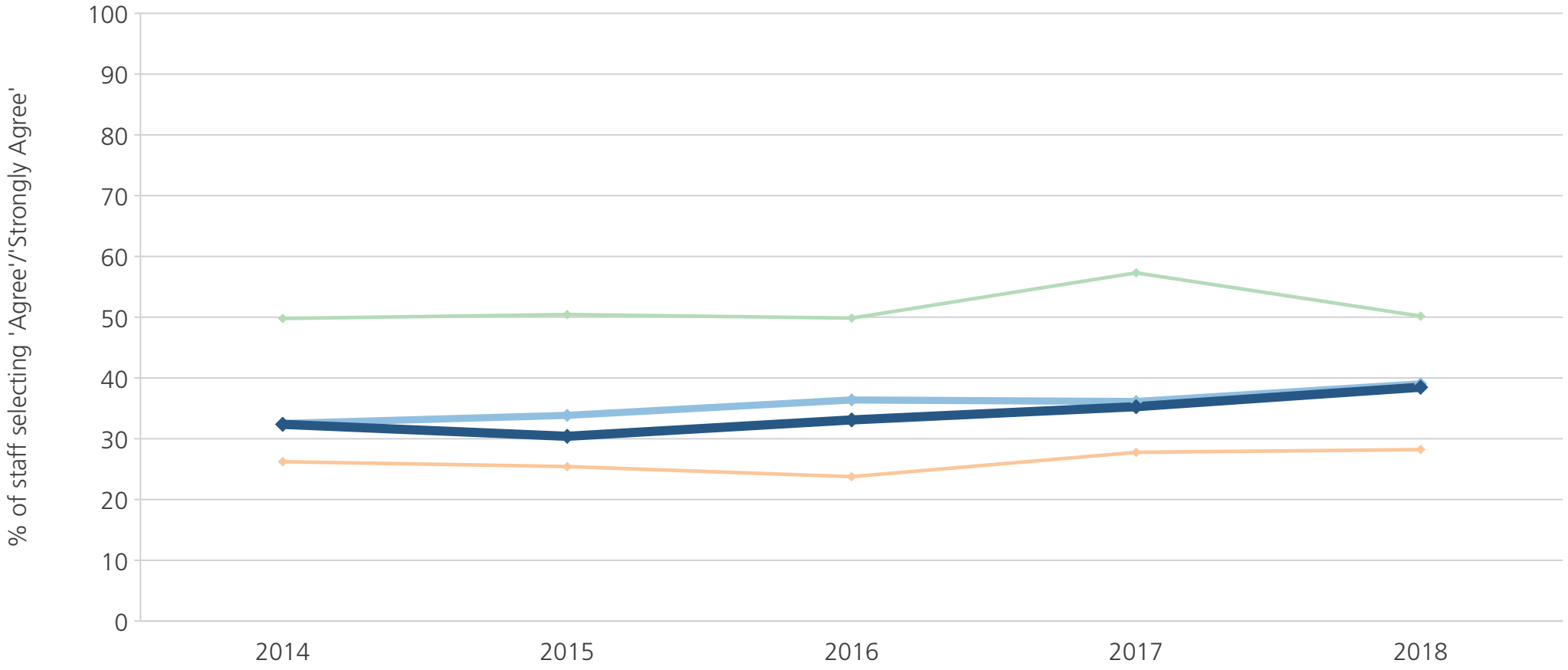
	2015	2016	2017	2018
Best	82.5%	80.9%	84.9%	80.5%
Your org	78.5%	78.9%	80.6%	80.5%
Average	75.6%	75.9%	77.7%	77.9%
Worst	68.5%	69.3%	63.7%	72.7%
No. responses	295	771	911	853



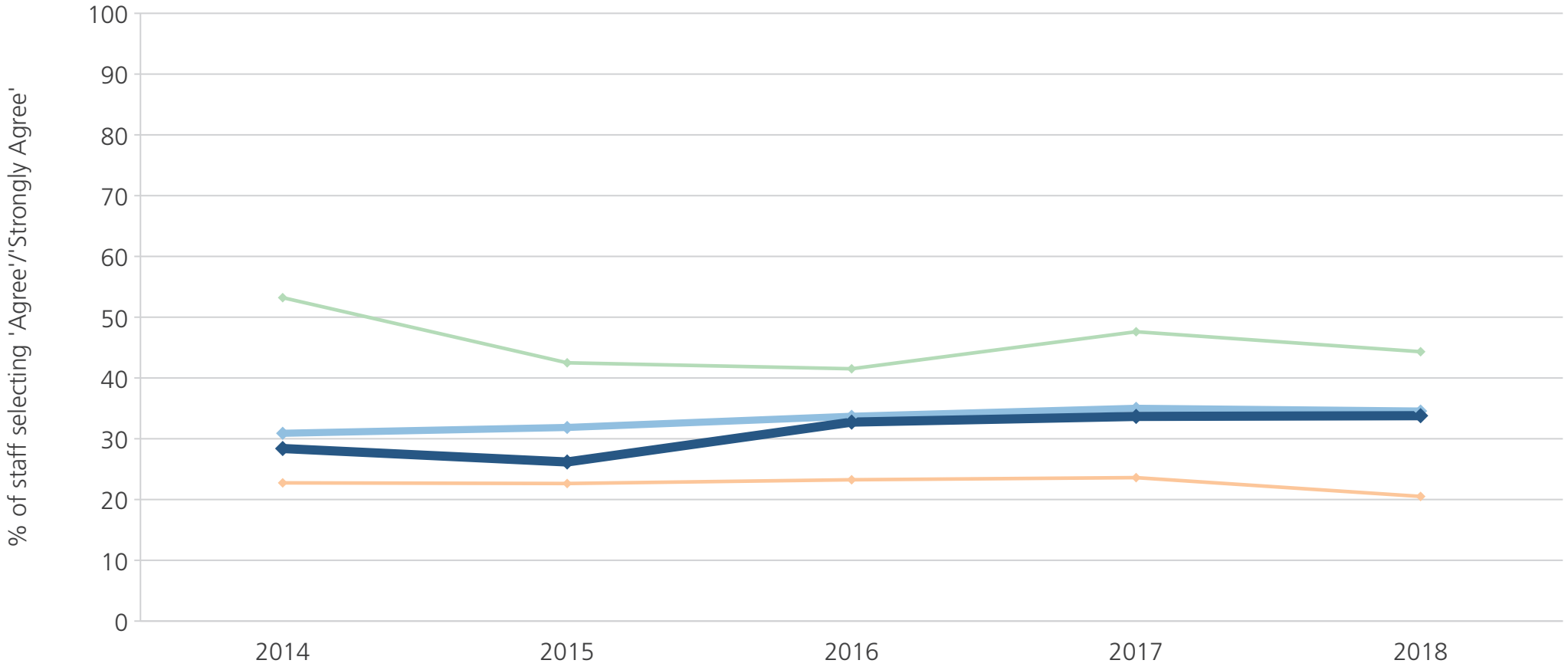
	2014	2015	2016	2017	2018
Best	93.2%	91.4%	93.1%	93.7%	91.7%
Your org	86.2%	83.1%	84.5%	87.3%	86.9%
Average	84.3%	85.0%	85.4%	86.1%	86.7%
Worst	73.4%	73.5%	75.0%	69.3%	72.9%
No. responses	343	296	774	911	855



	2014	2015	2016	2017	2018
Best	56.3%	50.3%	49.9%	55.8%	51.8%
Your org	36.2%	34.3%	37.6%	41.3%	42.4%
Average	36.7%	39.0%	40.5%	42.1%	42.3%
Worst	25.7%	28.4%	28.5%	27.2%	28.7%
No. responses	343	296	771	911	855



	2014	2015	2016	2017	2018
Best	49.8%	50.4%	49.8%	57.3%	50.2%
Your org	32.4%	30.4%	33.1%	35.3%	38.5%
Average	32.5%	33.8%	36.4%	36.1%	39.0%
Worst	26.2%	25.4%	23.8%	27.8%	28.2%
No. responses	343	296	773	911	855



	2014	2015	2016	2017	2018
Best	53.2%	42.5%	41.5%	47.6%	44.3%
Your org	28.4%	26.2%	32.7%	33.7%	33.8%
Average	30.9%	31.9%	33.7%	35.0%	34.6%
Worst	22.7%	22.6%	23.3%	23.6%	20.5%
No. responses	343	296	772	912	855

Survey Coordination Centre

NHS England

Question results – Your health, well-being and safety at work

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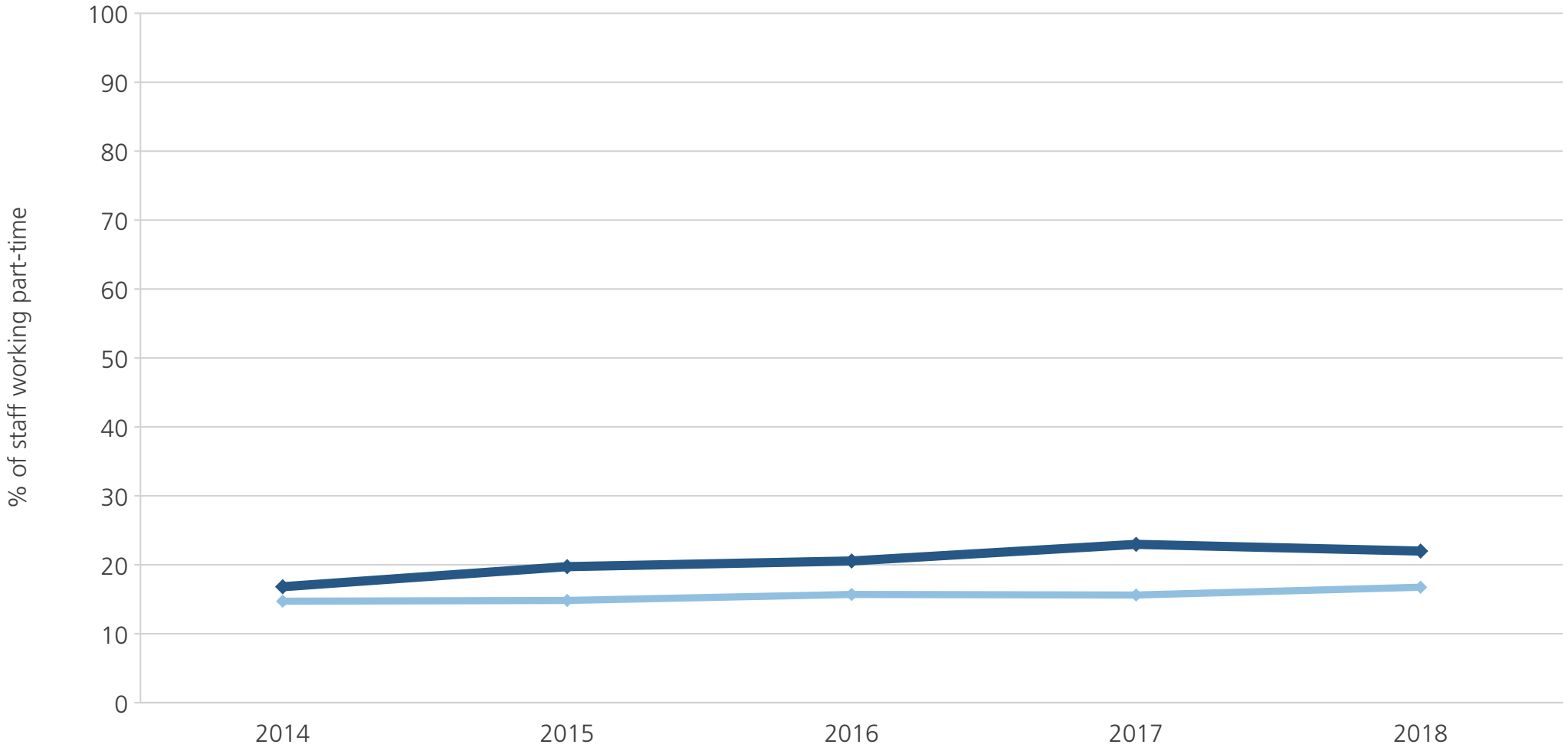
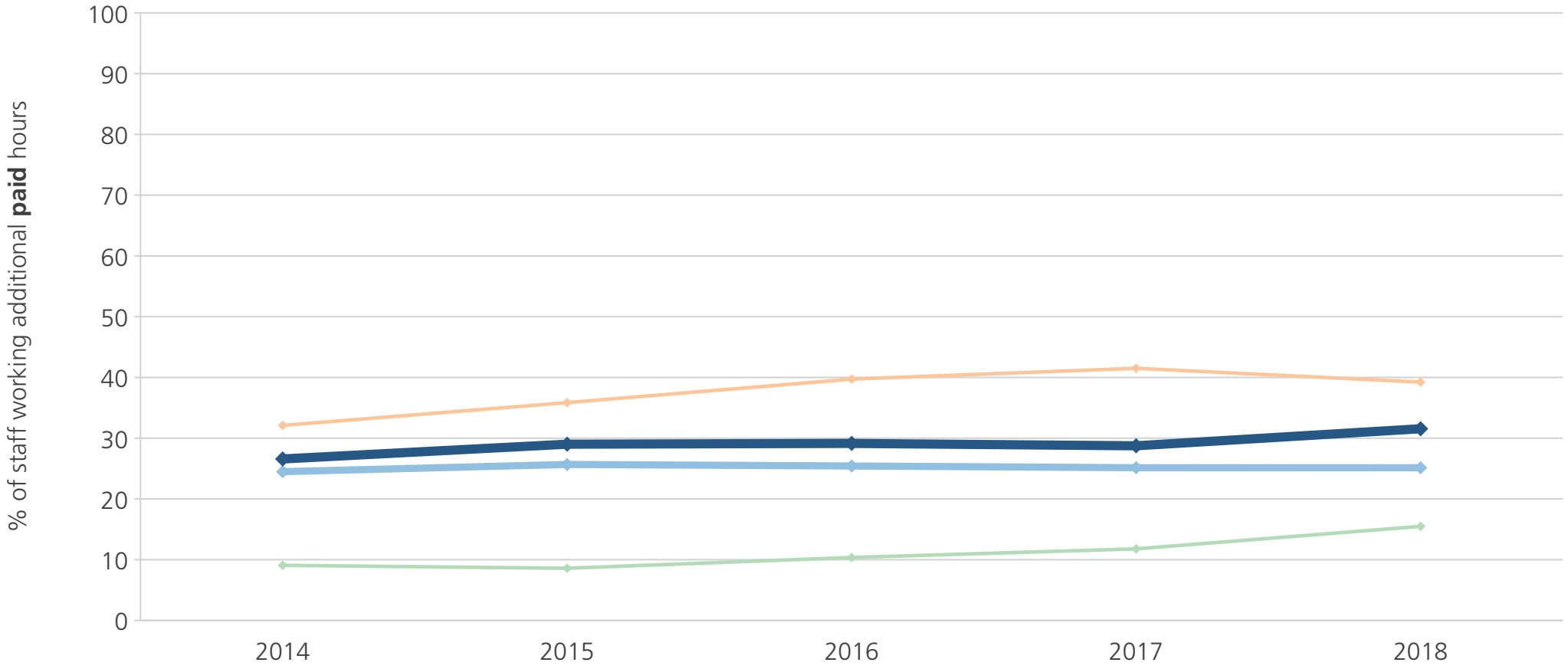
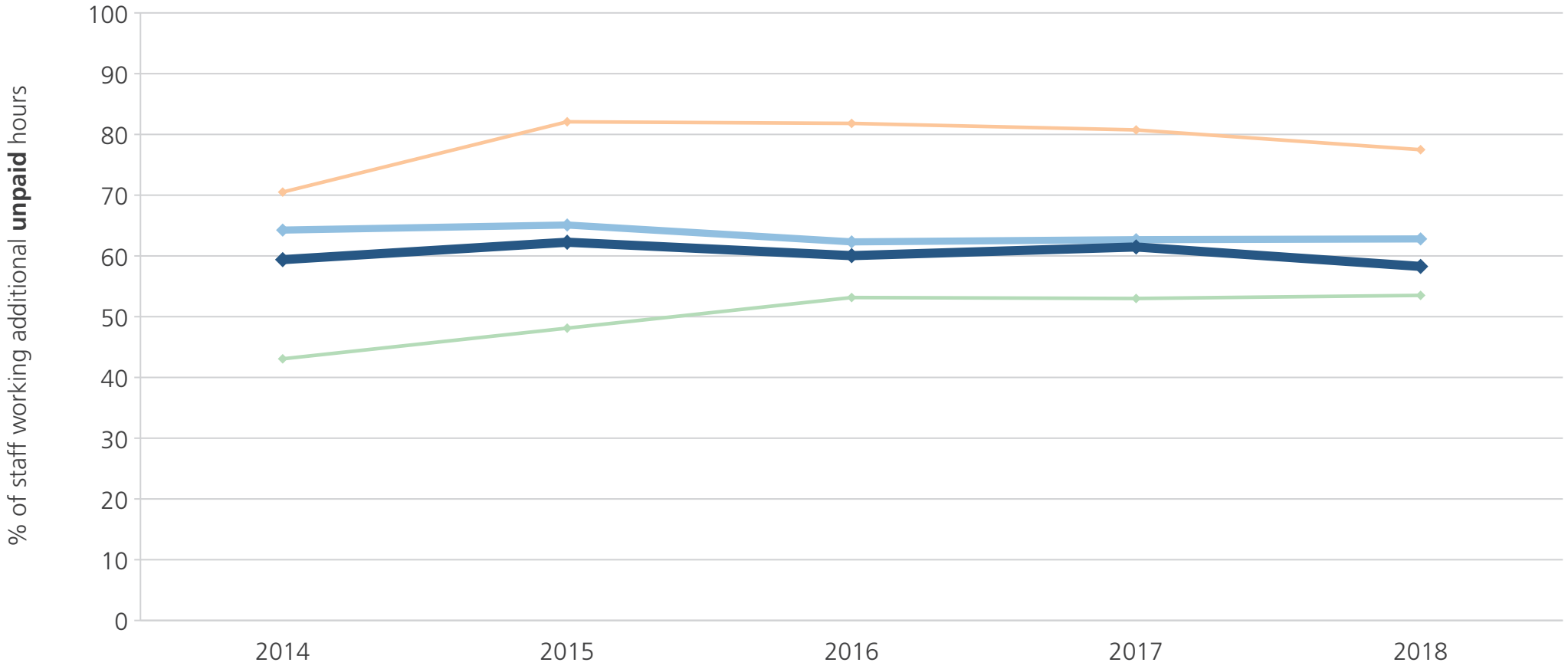
2018 NHS Staff Survey Results



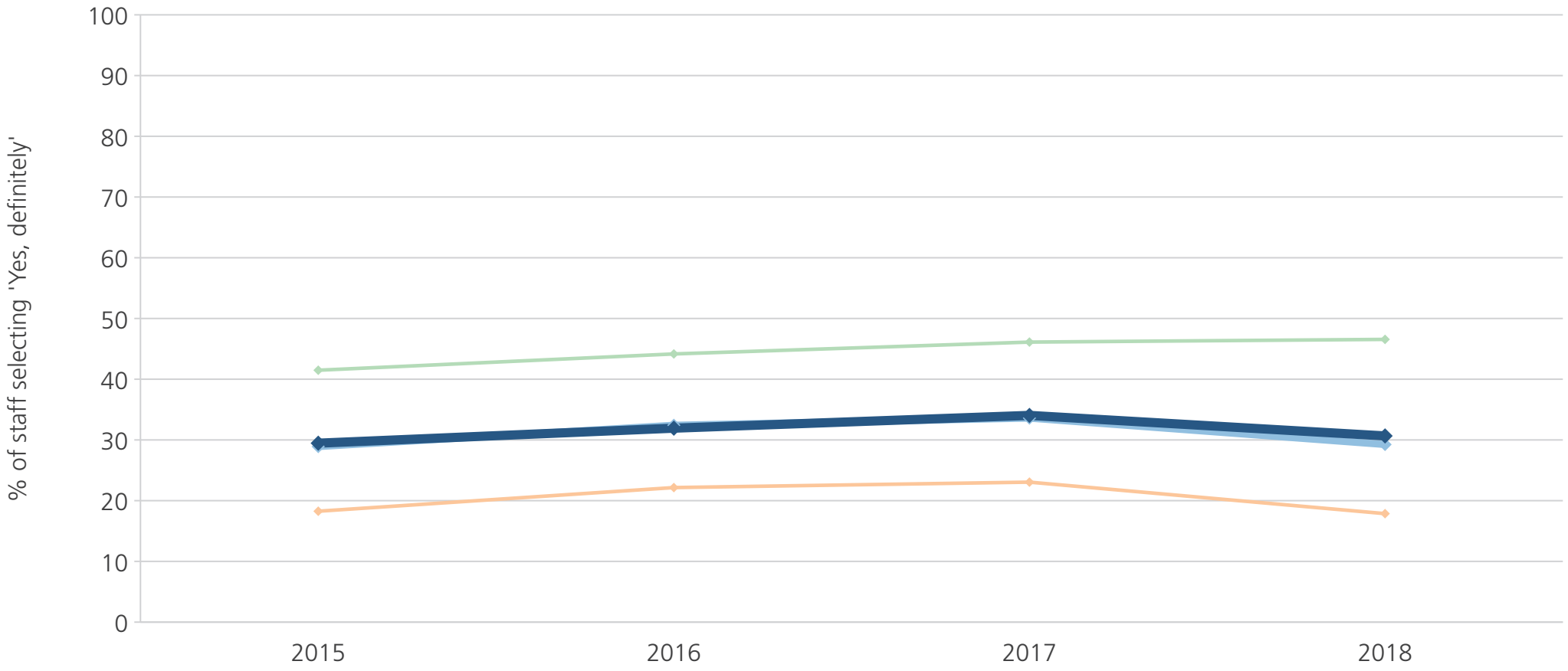
	2014	2015	2016	2017	2018
Your org	16.8%	19.7%	20.5%	23.0%	22.0%
Average	14.7%	14.8%	15.7%	15.6%	16.7%
No. responses	339	294	764	871	805



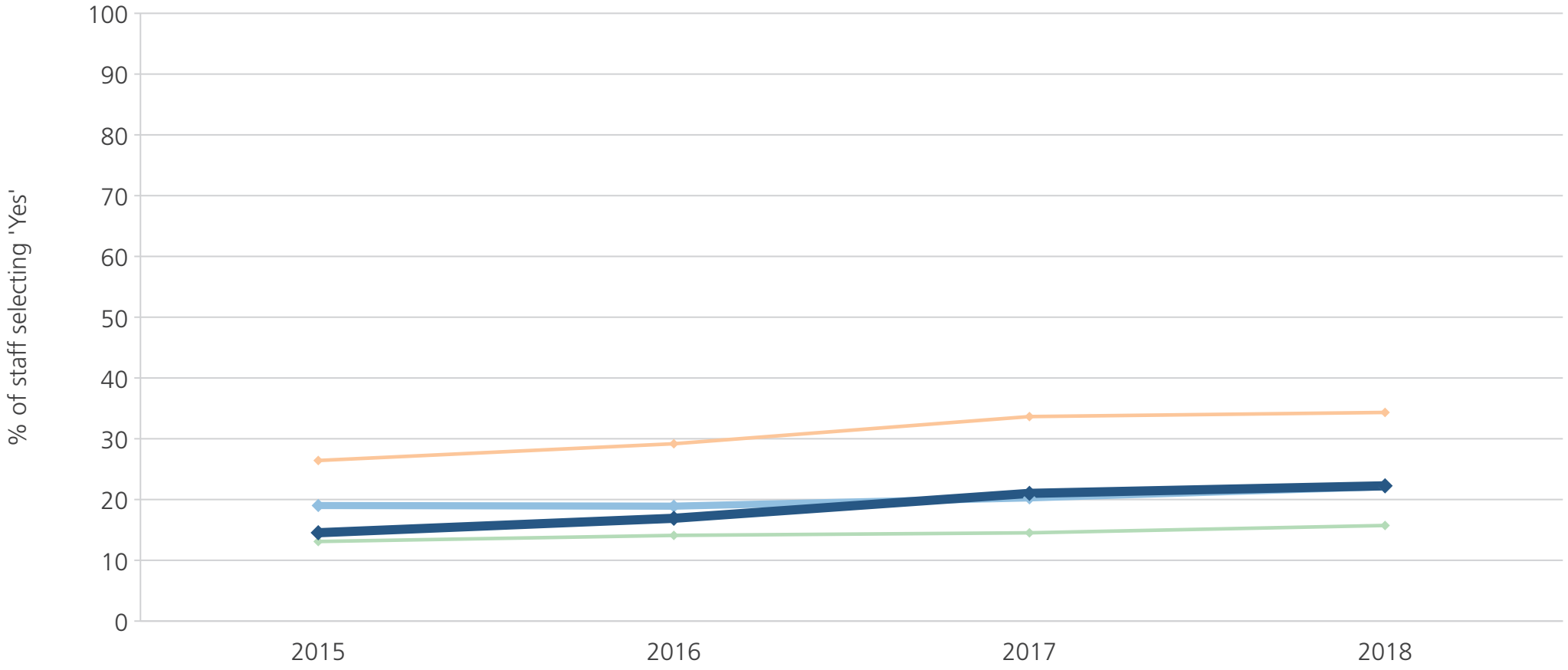
	2014	2015	2016	2017	2018
Worst	32.1%	35.9%	39.7%	41.5%	39.2%
Your org	26.6%	29.0%	29.1%	28.7%	31.6%
Average	24.5%	25.7%	25.4%	25.1%	25.1%
Best	9.1%	8.6%	10.4%	11.8%	15.5%
No. responses	331	292	745	877	828



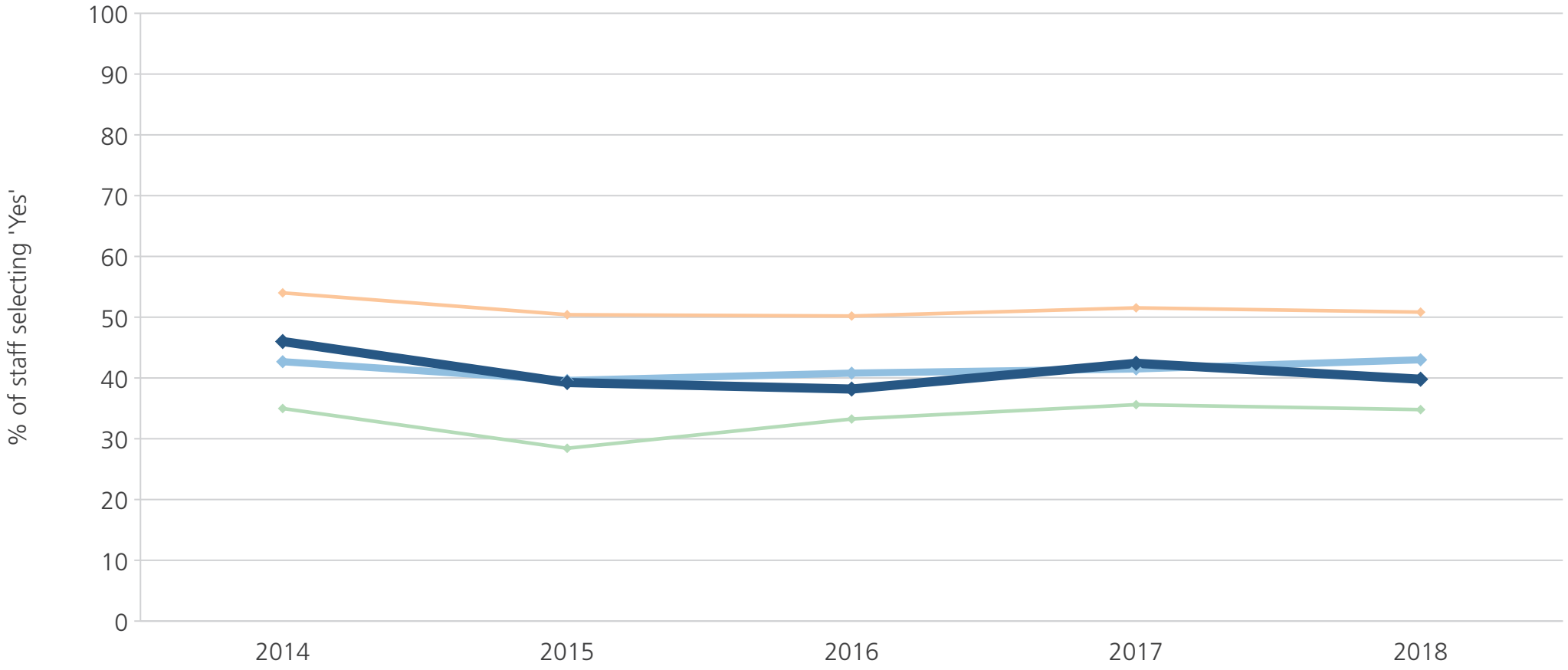
	2014	2015	2016	2017	2018
Worst	70.5%	82.1%	81.8%	80.7%	77.5%
Your org	59.4%	62.3%	60.0%	61.5%	58.3%
Average	64.3%	65.1%	62.3%	62.7%	62.8%
Best	43.1%	48.1%	53.2%	53.0%	53.5%
No. responses	334	293	753	885	832



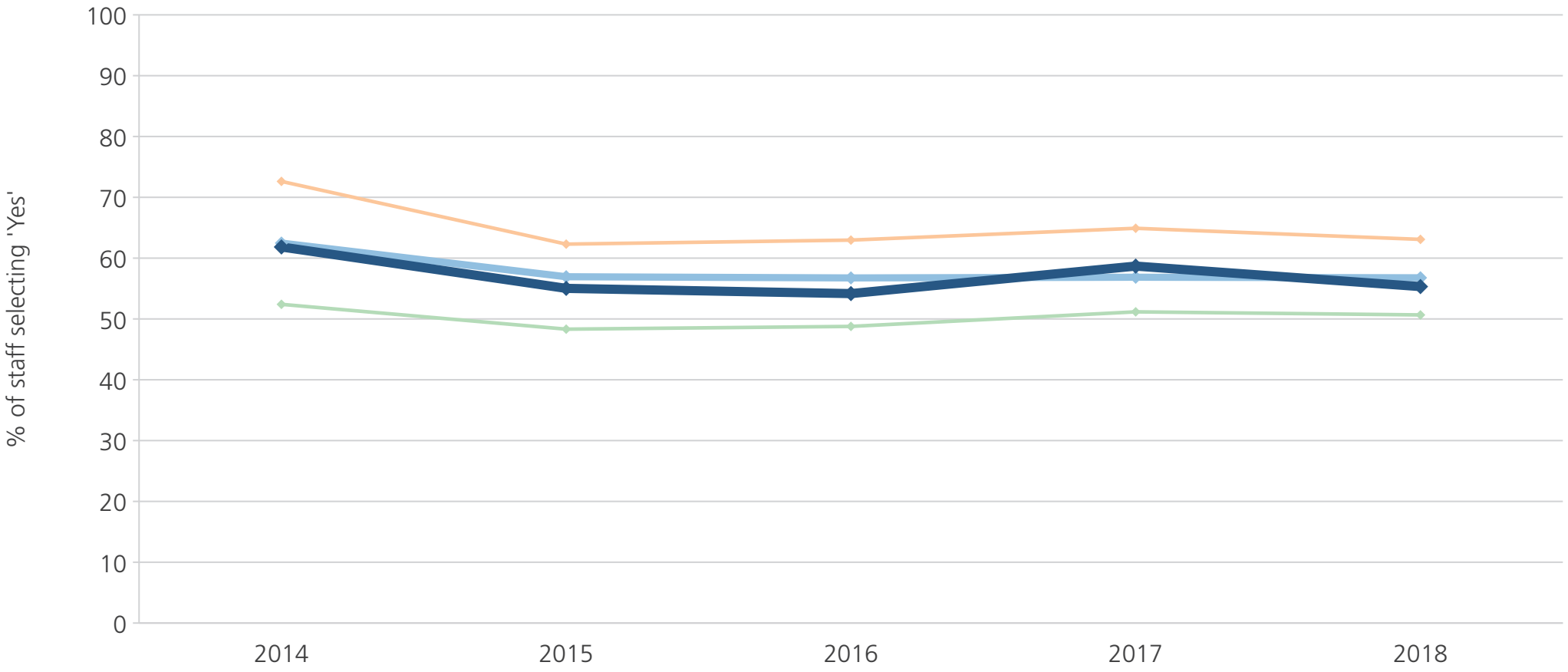
	2015	2016	2017	2018
Best	41.5%	44.2%	46.1%	46.6%
Your org	29.5%	31.9%	34.0%	30.7%
Average	28.9%	32.4%	33.6%	29.2%
Worst	18.3%	22.2%	23.0%	17.9%
No. responses	294	766	904	847



	2015	2016	2017	2018
Worst	26.4%	29.2%	33.6%	34.3%
Your org	14.5%	16.9%	21.0%	22.3%
Average	19.0%	18.9%	20.3%	22.1%
Best	13.1%	14.1%	14.5%	15.7%
No. responses	295	769	907	854

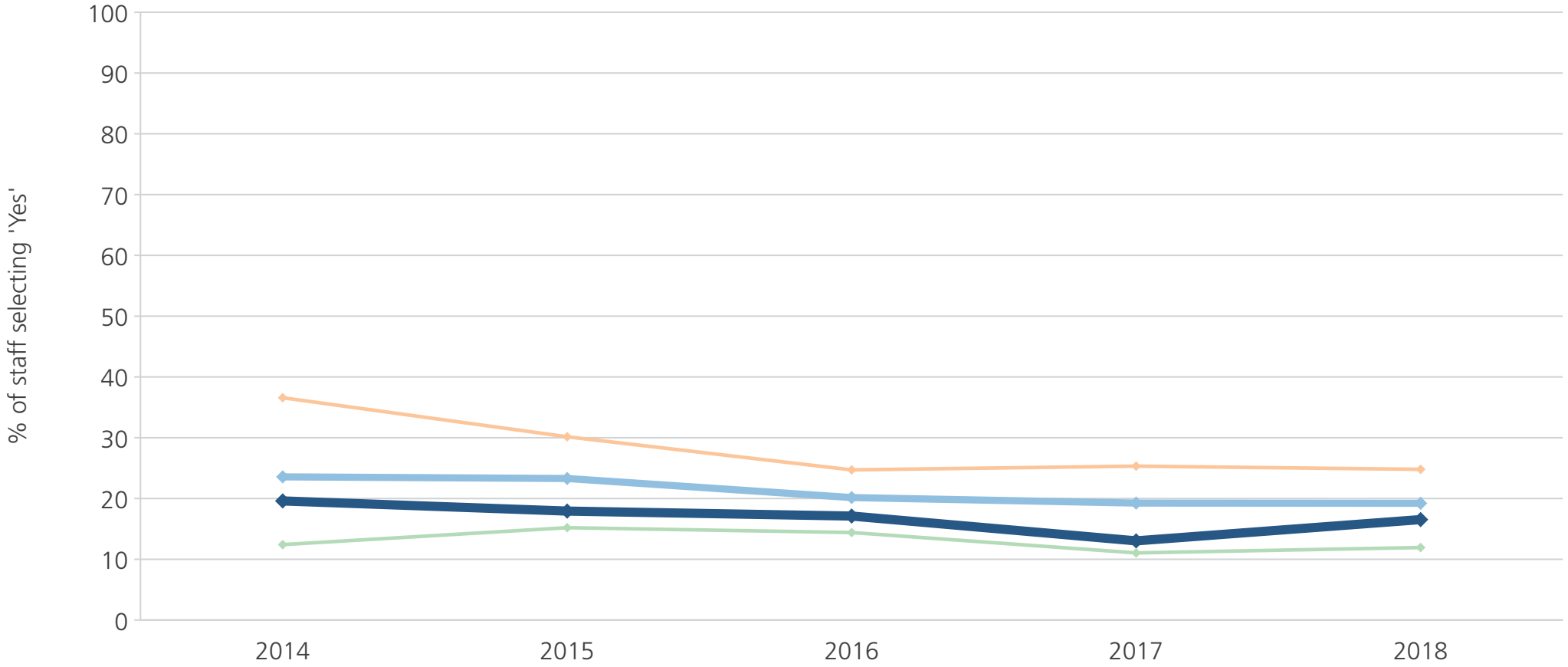


	2014	2015	2016	2017	2018
Worst	54.0%	50.4%	50.2%	51.5%	50.8%
Your org	46.0%	39.3%	38.2%	42.4%	39.8%
Average	42.7%	39.6%	40.8%	41.5%	43.0%
Best	35.0%	28.4%	33.2%	35.6%	34.8%
No. responses	335	296	768	907	854



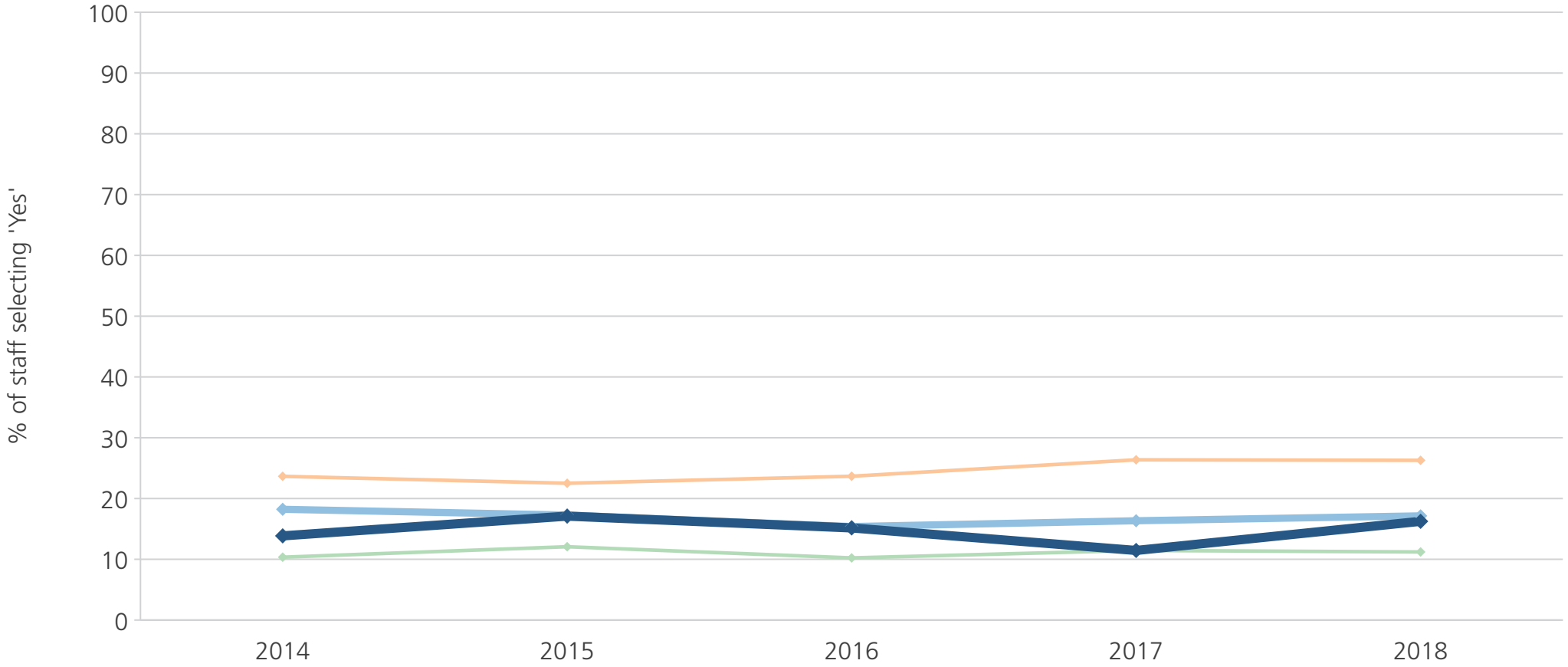
	2014	2015	2016	2017	2018
Worst	72.6%	62.3%	63.0%	64.9%	63.1%
Your org	61.8%	55.0%	54.2%	58.7%	55.3%
Average	62.5%	56.9%	56.7%	56.9%	56.8%
Best	52.4%	48.3%	48.8%	51.2%	50.7%
No. responses	341	296	769	910	854

Note: This question was only answered by staff who selected 'Yes' on q11d.



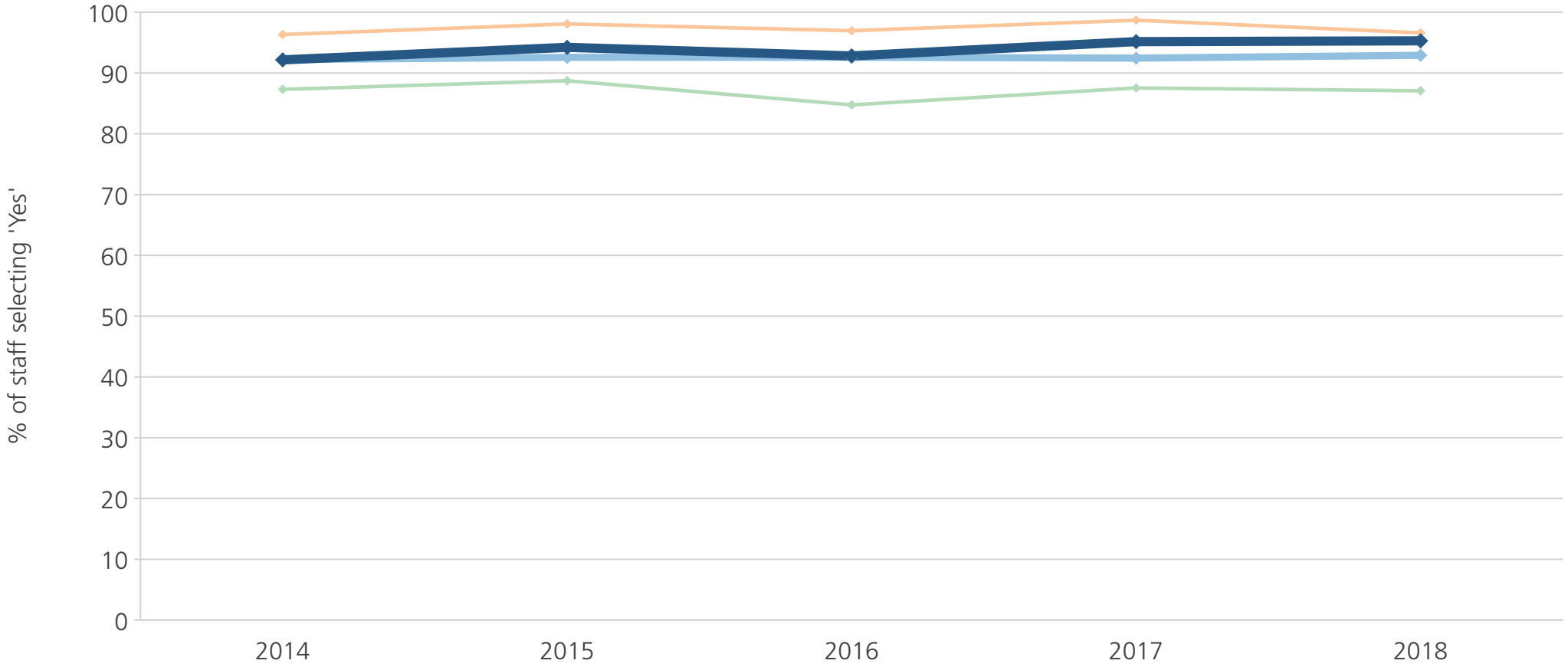
	2014	2015	2016	2017	2018
Worst	36.6%	30.2%	24.7%	25.3%	24.8%
Your org	19.6%	17.9%	17.1%	13.0%	16.5%
Average	23.6%	23.3%	20.2%	19.2%	19.2%
Best	12.4%	15.2%	14.4%	11.1%	11.9%
No. responses	210	166	406	527	464

Note: This question was only answered by staff who selected 'Yes' on q11d.

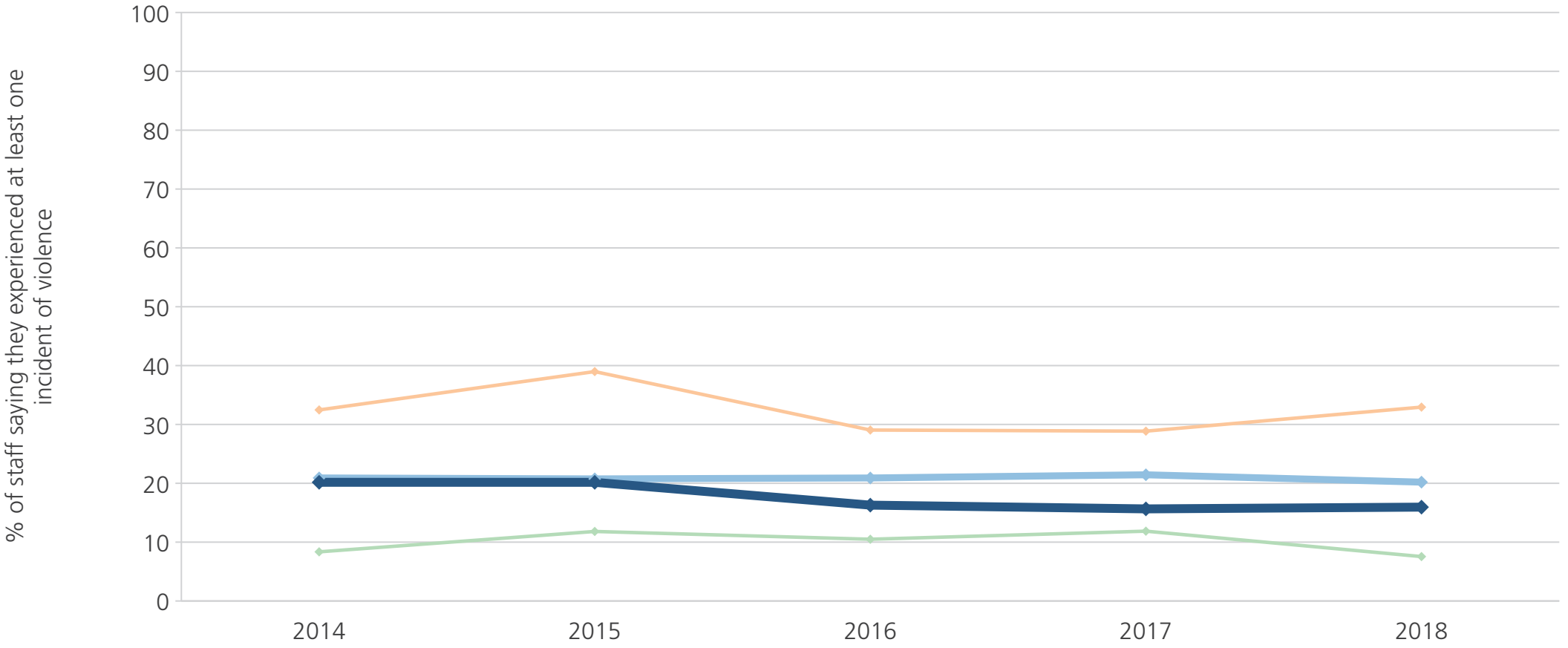


	2014	2015	2016	2017	2018
Worst	23.7%	22.5%	23.7%	26.4%	26.3%
Your org	13.9%	17.1%	15.2%	11.5%	16.2%
Average	18.2%	17.3%	15.4%	16.3%	17.1%
Best	10.3%	12.1%	10.2%	11.5%	11.2%
No. responses	211	166	404	523	464

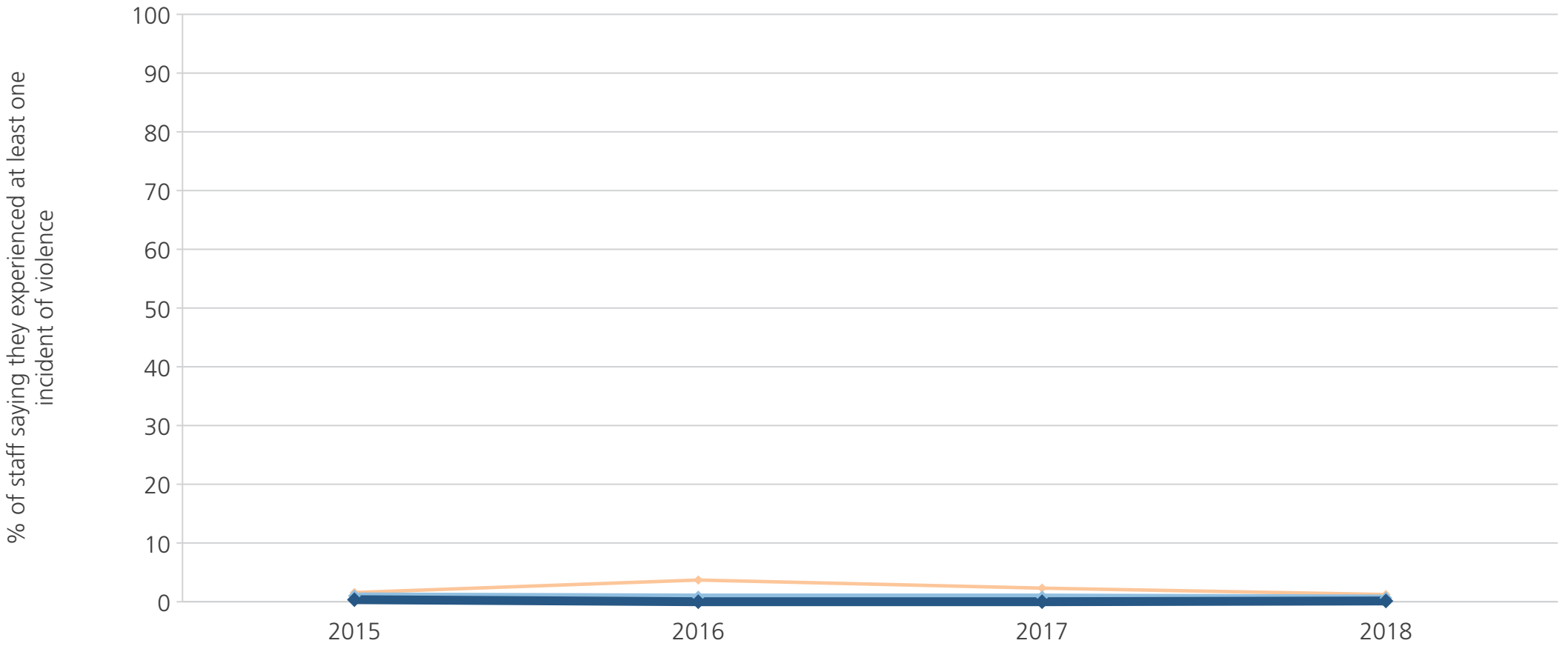
Note: This question was only answered by staff who selected 'Yes' on q11d.



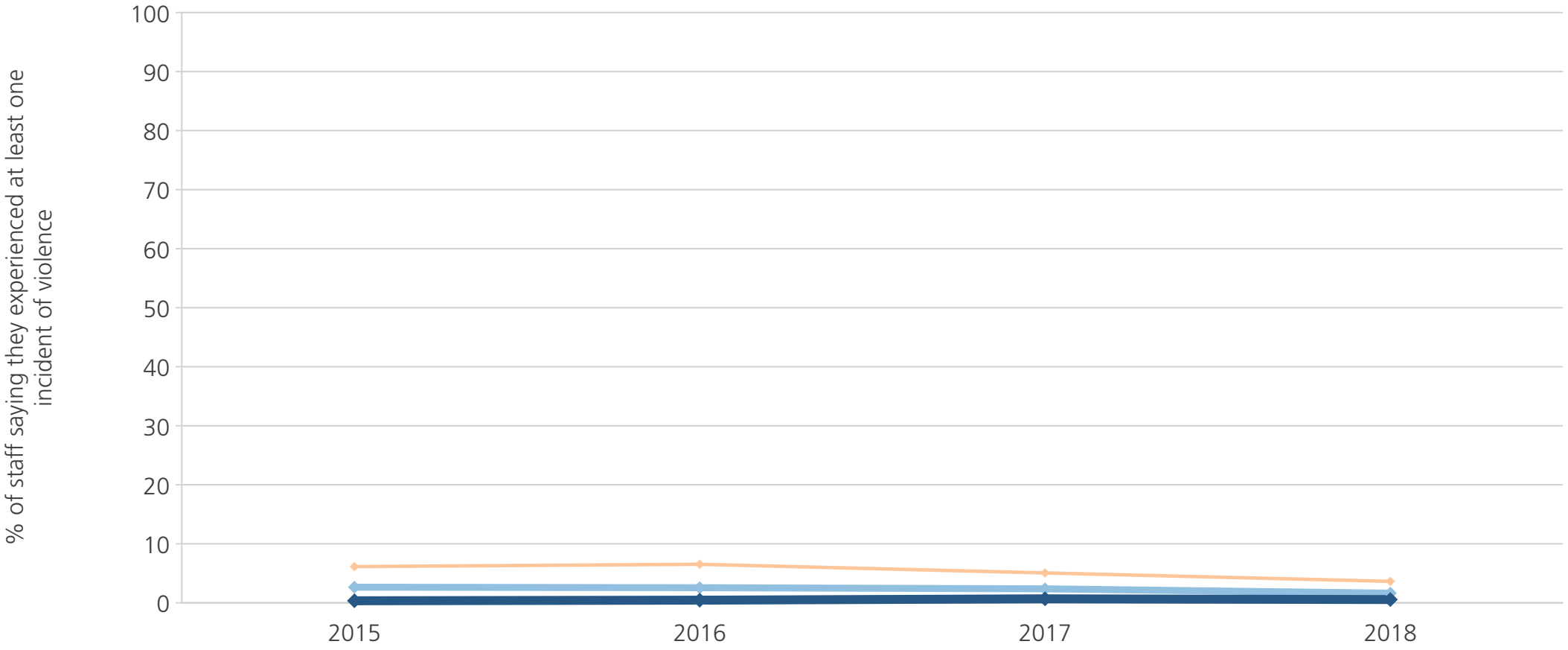
	2014	2015	2016	2017	2018
Worst	96.3%	98.1%	97.0%	98.7%	96.6%
Your org	92.2%	94.2%	92.8%	95.2%	95.3%
Average	92.2%	92.6%	92.6%	92.4%	92.9%
Best	87.3%	88.7%	84.8%	87.5%	87.1%
No. responses	211	166	402	525	465



	2014	2015	2016	2017	2018
Worst	32.5%	39.0%	29.0%	28.9%	32.9%
Your org	20.2%	20.2%	16.3%	15.6%	15.9%
Average	20.9%	20.8%	20.9%	21.4%	20.2%
Best	8.4%	11.8%	10.5%	11.9%	7.5%
No. responses	340	293	769	906	843

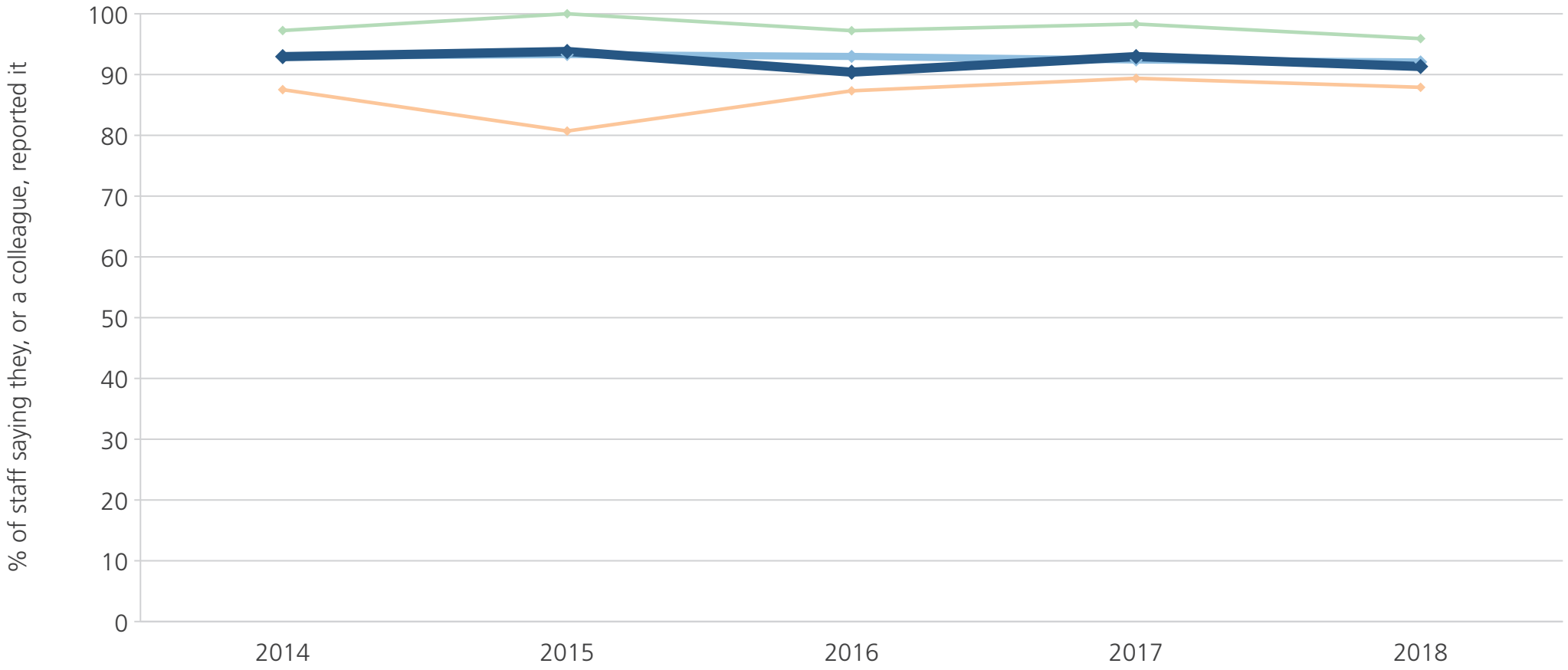


	2015	2016	2017	2018
Worst	1.6%	3.7%	2.3%	1.2%
Your org	0.3%	0.0%	0.0%	0.1%
Average	1.0%	0.8%	0.8%	0.6%
Best	0.0%	0.0%	0.0%	0.0%
No. responses	293	768	906	841

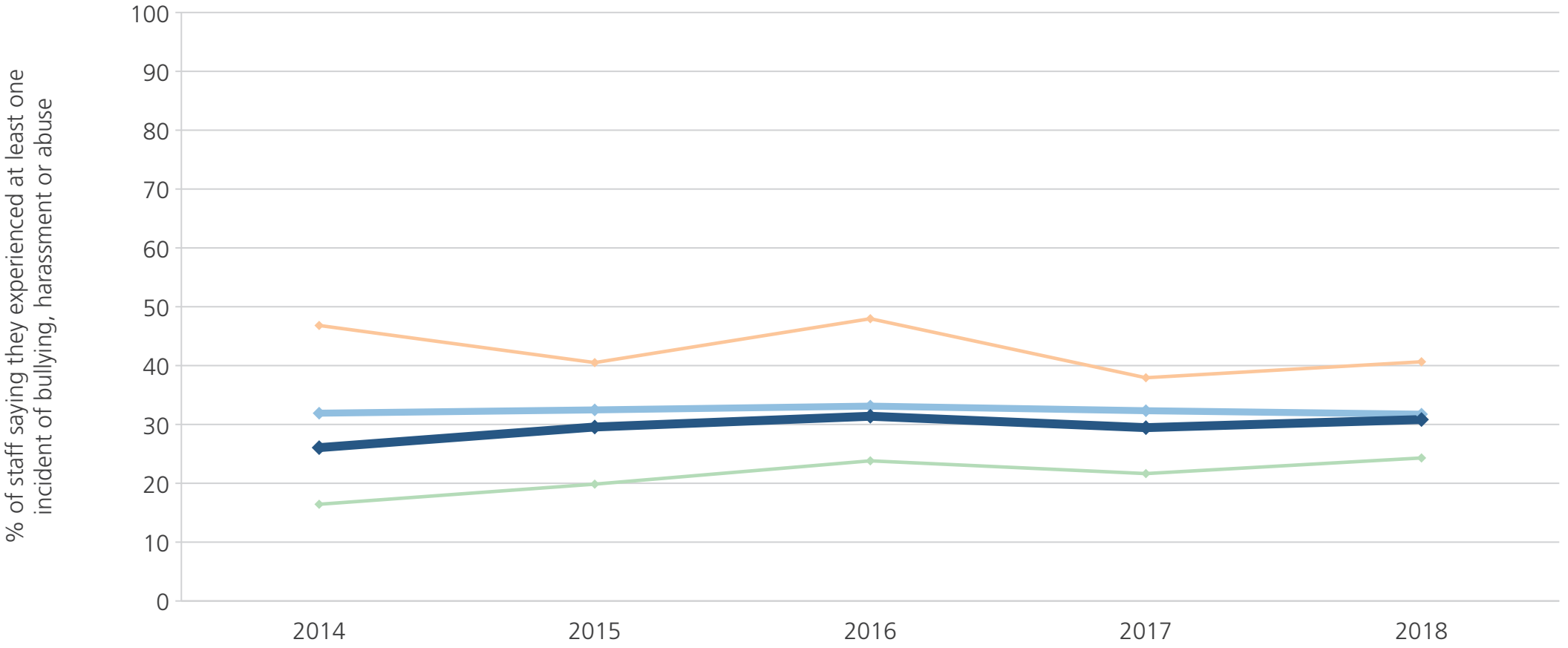


	2015	2016	2017	2018
Worst	6.1%	6.5%	5.1%	3.6%
Your org	0.4%	0.5%	0.7%	0.6%
Average	2.6%	2.6%	2.4%	1.6%
Best	0.4%	0.0%	0.5%	0.4%
No. responses	291	764	899	836

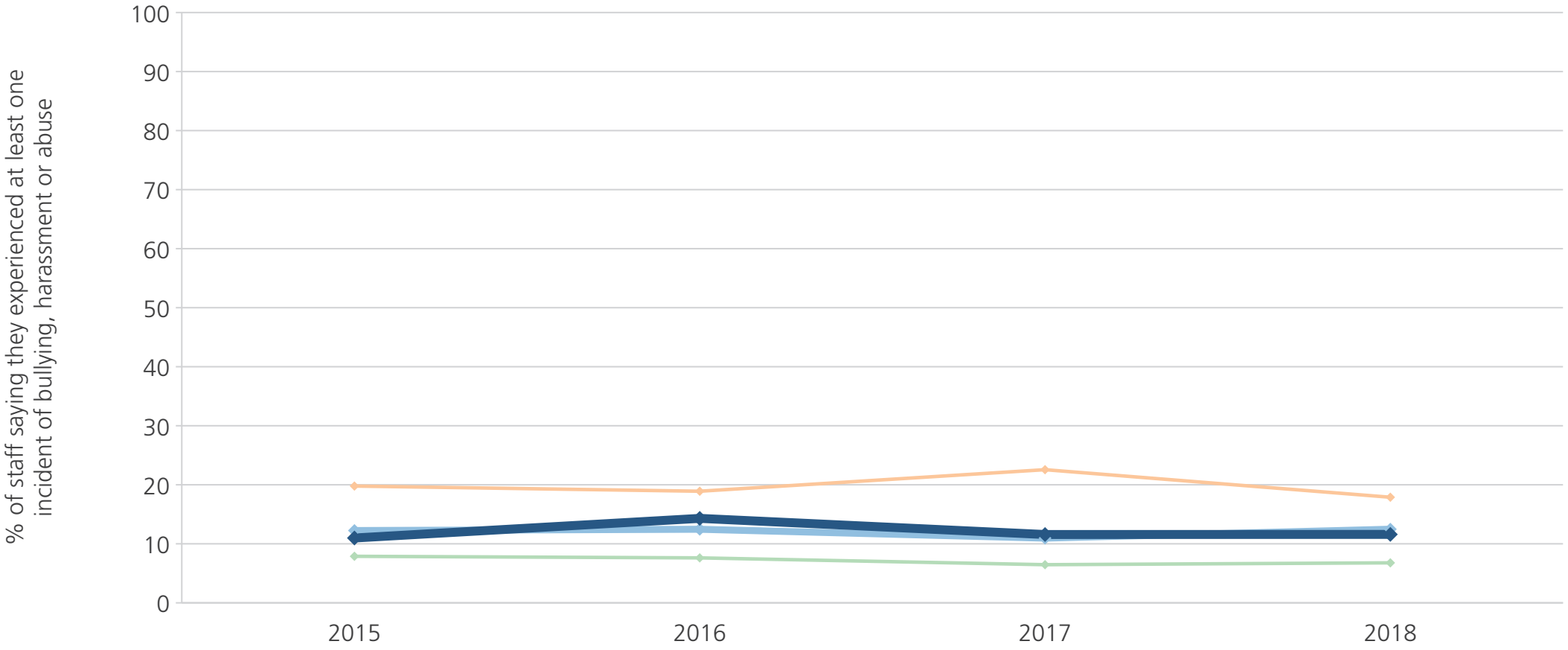
Note: This question was only answered by staff who reported experiencing at least one incident of violence in the last 12 months.



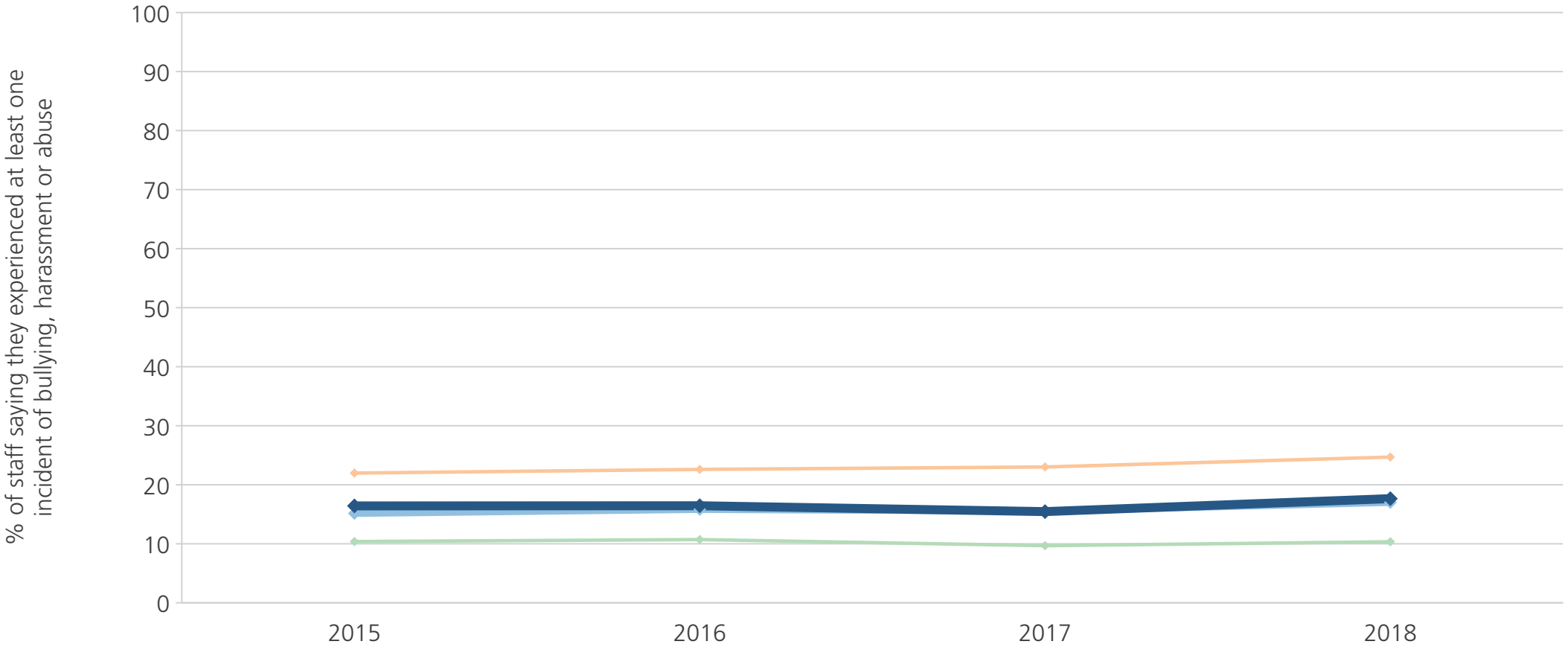
	2014	2015	2016	2017	2018
Best	97.2%	100.0%	97.2%	98.3%	95.9%
Your org	92.9%	93.8%	90.4%	93.0%	91.3%
Average	93.0%	93.3%	93.0%	92.4%	92.1%
Worst	87.5%	80.7%	87.3%	89.4%	87.9%
No. responses	61	50	114	124	98



	2014	2015	2016	2017	2018
Worst	46.8%	40.5%	48.0%	37.9%	40.6%
Your org	26.1%	29.6%	31.4%	29.5%	30.8%
Average	31.9%	32.5%	33.1%	32.3%	31.7%
Best	16.4%	19.9%	23.8%	21.6%	24.3%
No. responses	338	293	766	903	849

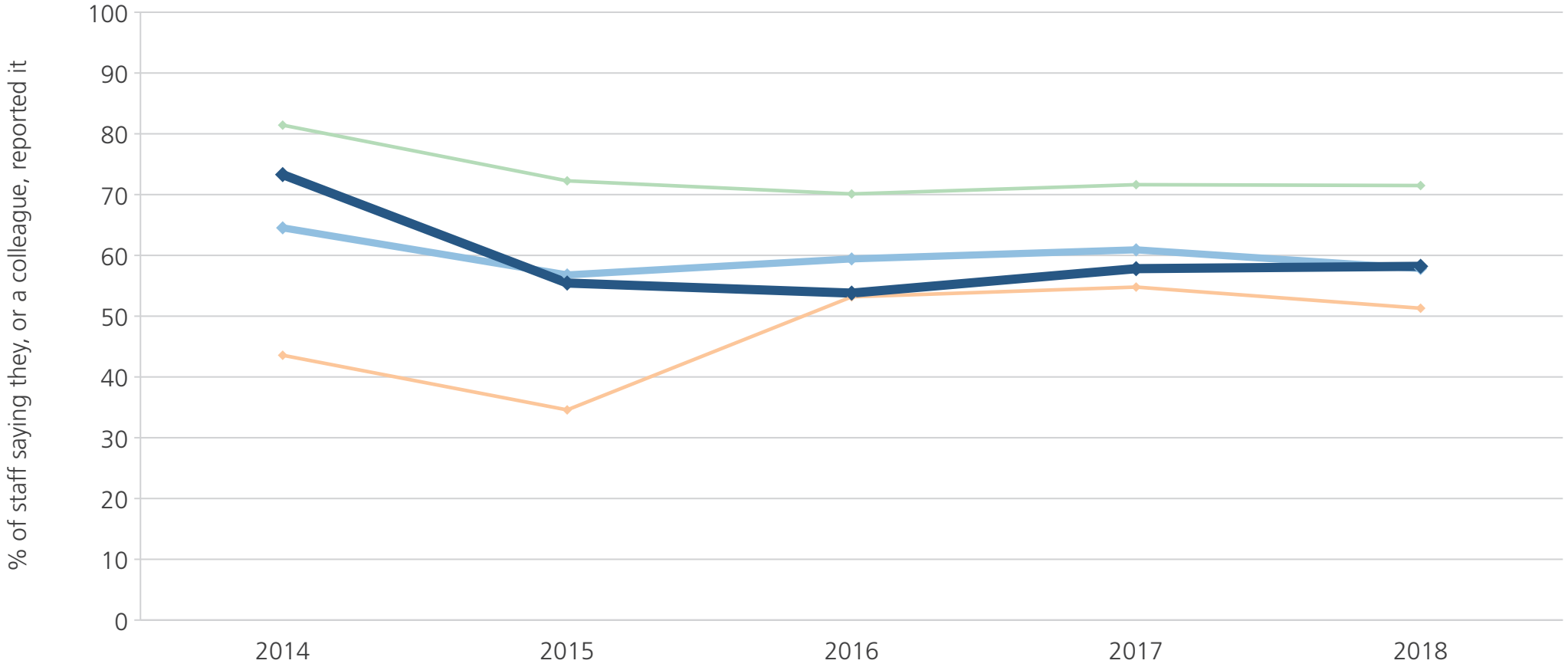


	2015	2016	2017	2018
Worst	19.8%	18.9%	22.6%	17.9%
Your org	11.0%	14.3%	11.6%	11.6%
Average	12.2%	12.5%	11.0%	12.5%
Best	7.9%	7.6%	6.5%	6.8%
No. responses	289	766	900	842

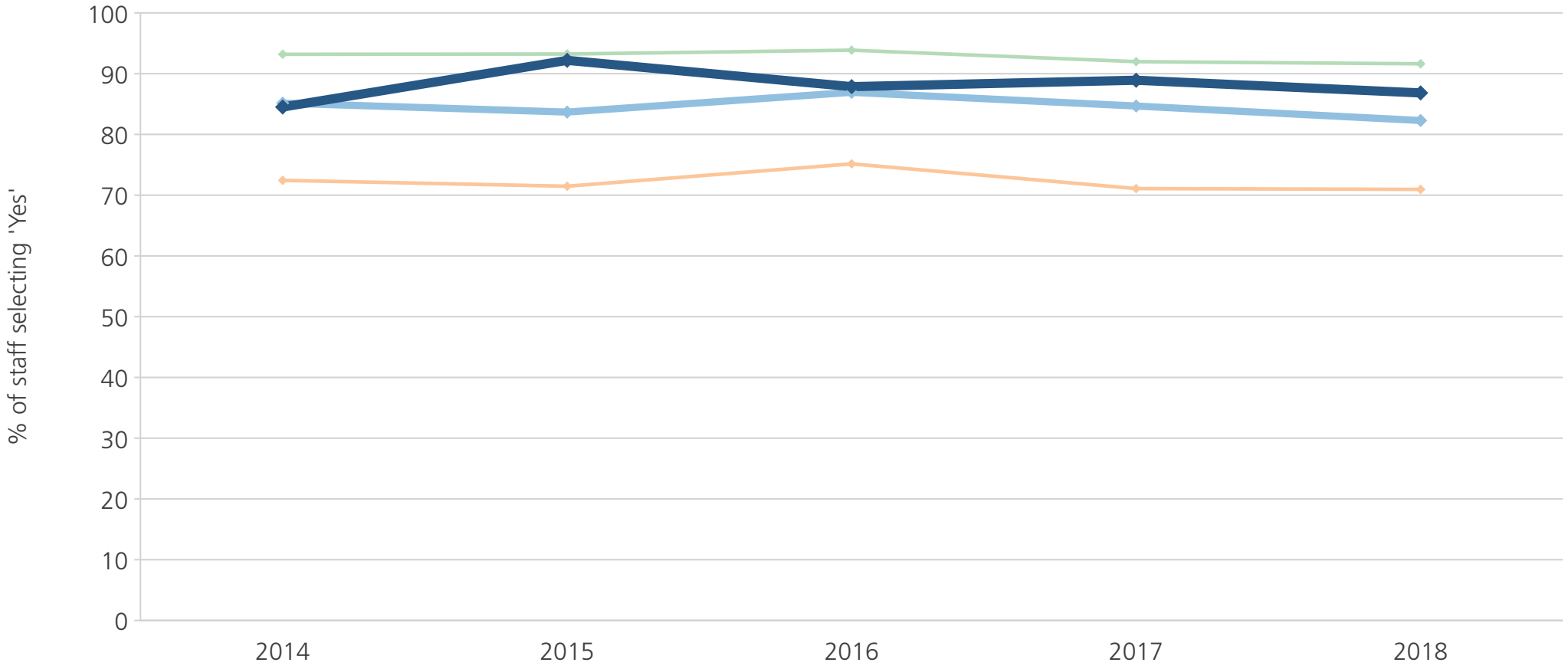


	2015	2016	2017	2018
Worst	22.0%	22.6%	23.0%	24.7%
Your org	16.4%	16.4%	15.5%	17.7%
Average	15.1%	15.8%	15.5%	17.0%
Best	10.4%	10.7%	9.7%	10.3%
No. responses	289	765	891	842

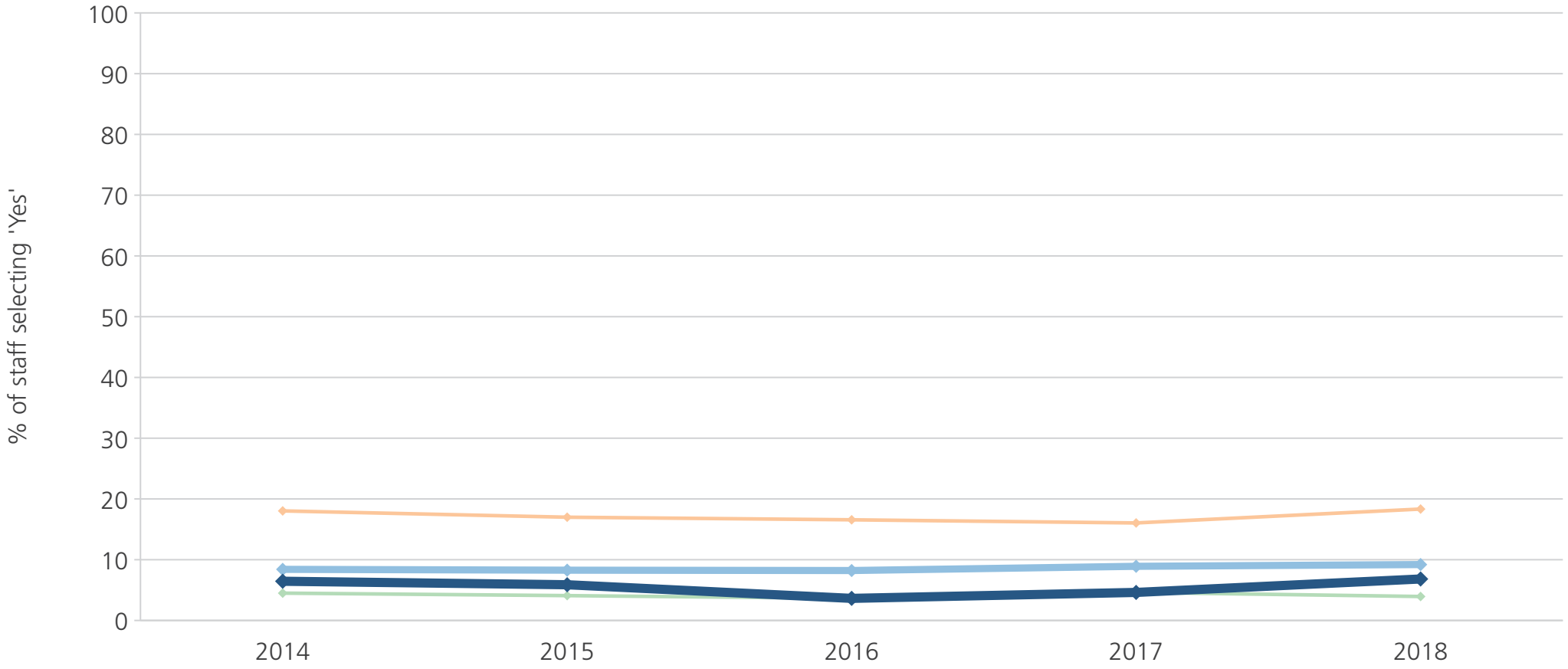
Note: This question was only answered by staff who reported experiencing at least one incident of harassment, bullying or abuse in the last 12 months.



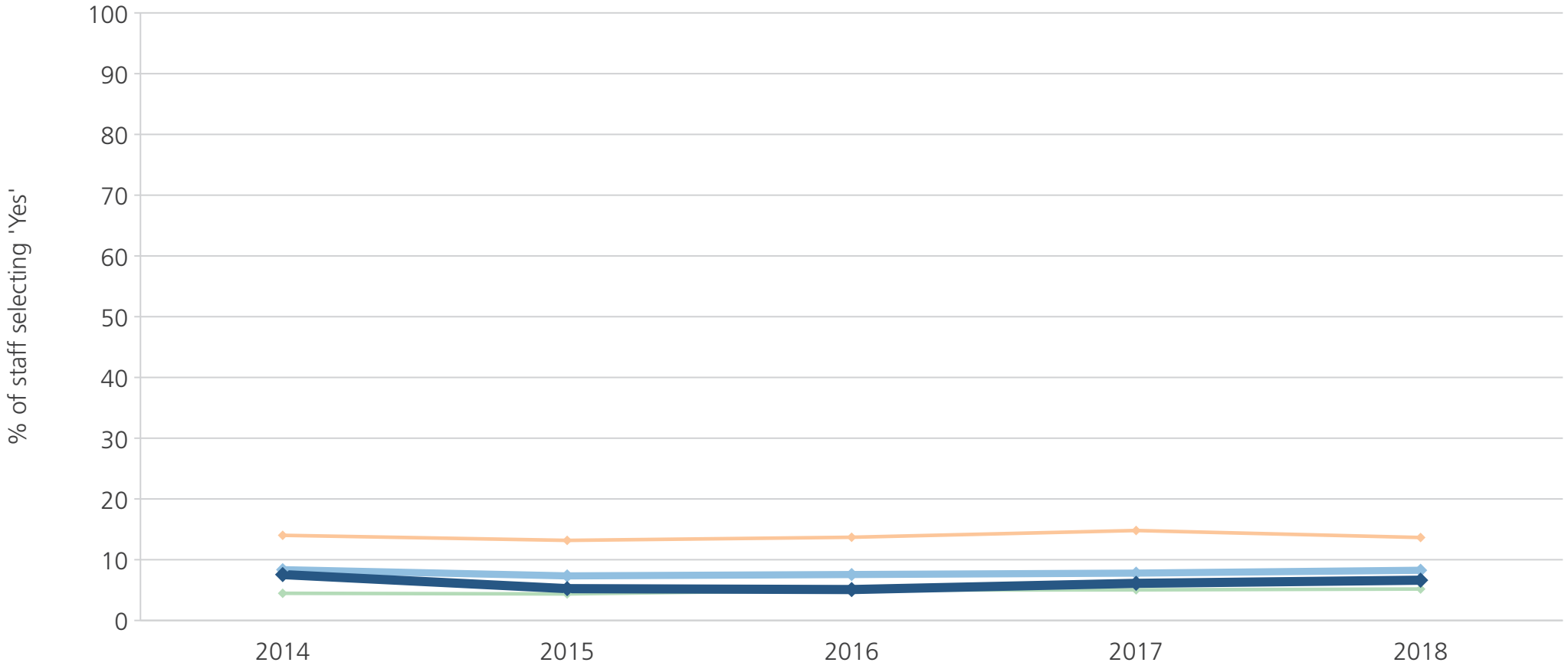
	2014	2015	2016	2017	2018
Best	81.4%	72.3%	70.1%	71.6%	71.5%
Your org	73.3%	55.4%	53.8%	57.8%	58.2%
Average	64.5%	56.8%	59.4%	60.9%	57.8%
Worst	43.6%	34.6%	53.2%	54.8%	51.3%
No. responses	76	107	304	343	294



	2014	2015	2016	2017	2018
Best	93.2%	93.2%	93.9%	92.0%	91.6%
Your org	84.5%	92.2%	87.9%	88.9%	86.8%
Average	85.1%	83.7%	86.9%	84.7%	82.3%
Worst	72.4%	71.5%	75.2%	71.1%	71.0%
No. responses	231	208	507	614	562

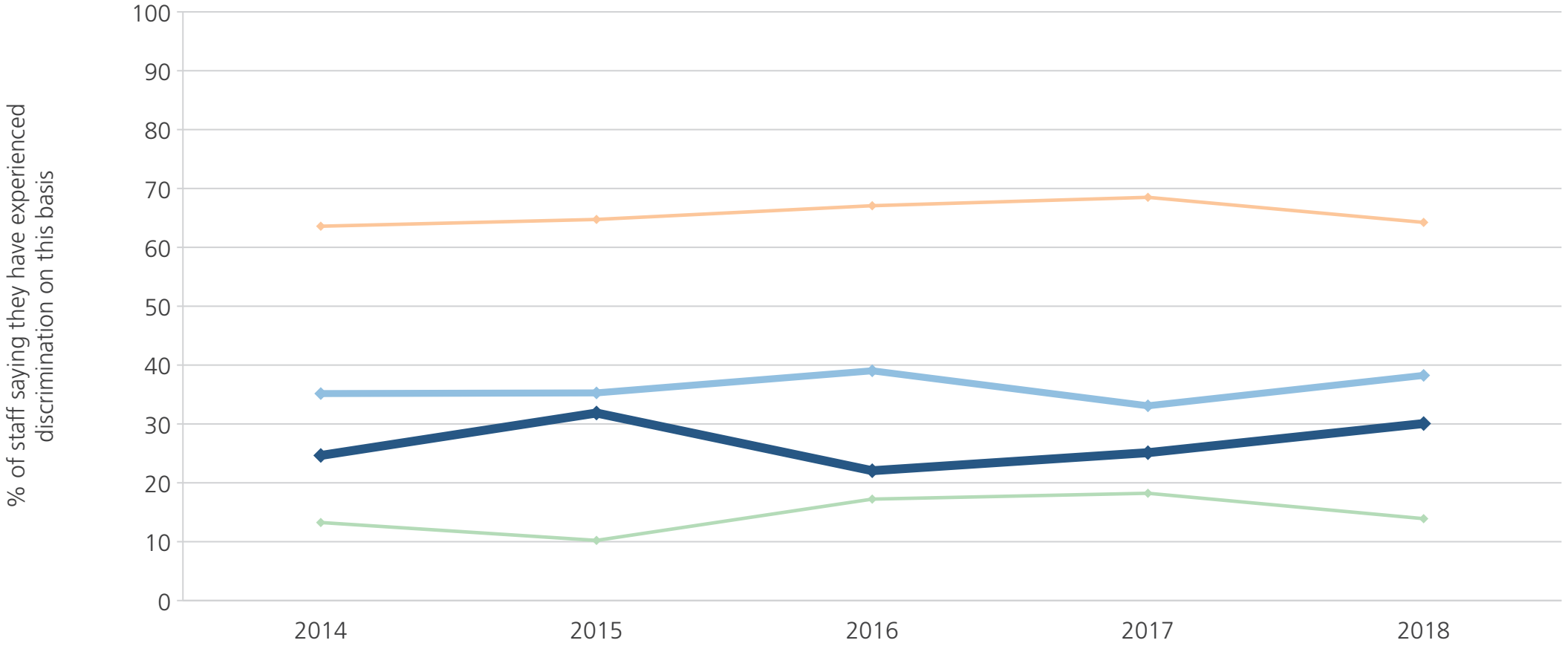


	2014	2015	2016	2017	2018
Worst	18.0%	17.0%	16.6%	16.0%	18.3%
Your org	6.5%	5.9%	3.6%	4.6%	6.8%
Average	8.4%	8.3%	8.2%	8.9%	9.2%
Best	4.5%	4.1%	3.6%	4.6%	3.9%
No. responses	338	295	766	906	853



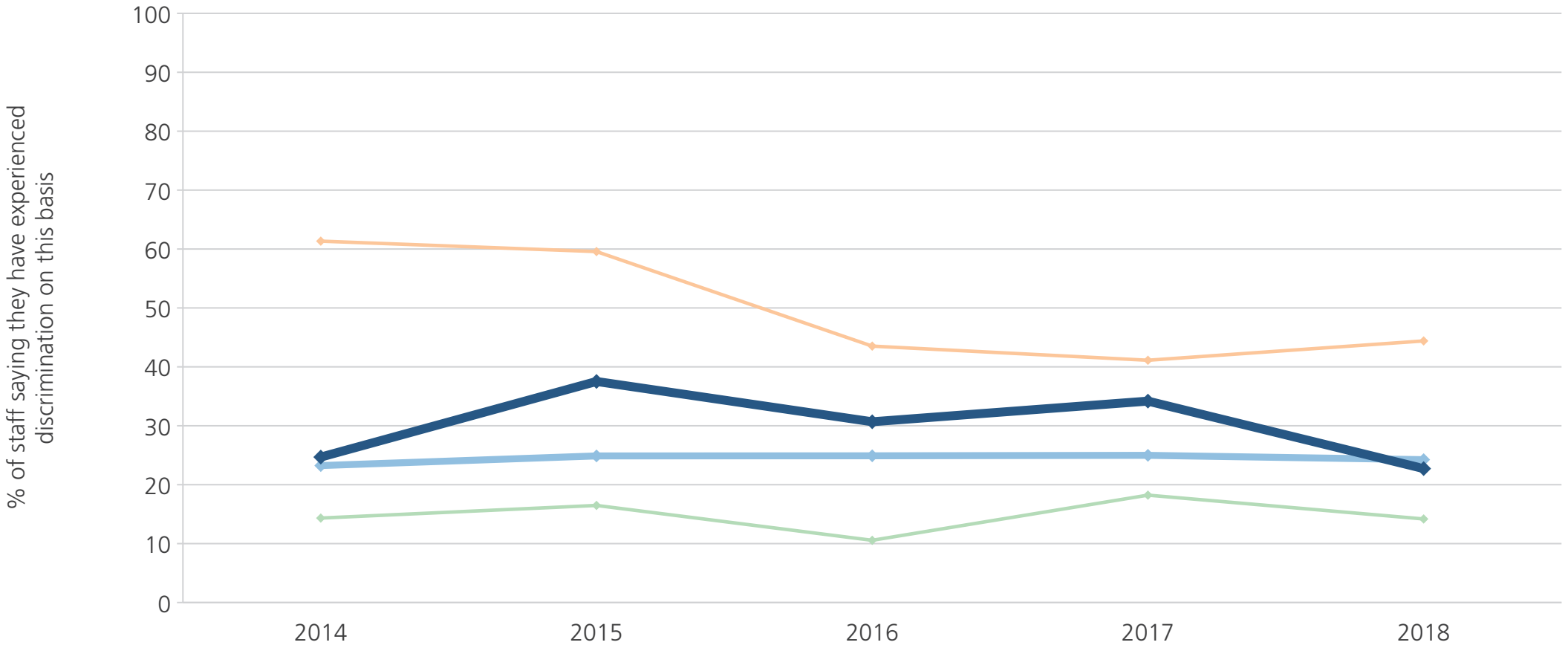
	2014	2015	2016	2017	2018
Worst	14.0%	13.2%	13.7%	14.8%	13.7%
Your org	7.6%	5.2%	5.1%	6.1%	6.6%
Average	8.4%	7.3%	7.6%	7.8%	8.3%
Best	4.5%	4.4%	5.0%	5.0%	5.2%
No. responses	340	294	764	900	844

Note: This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



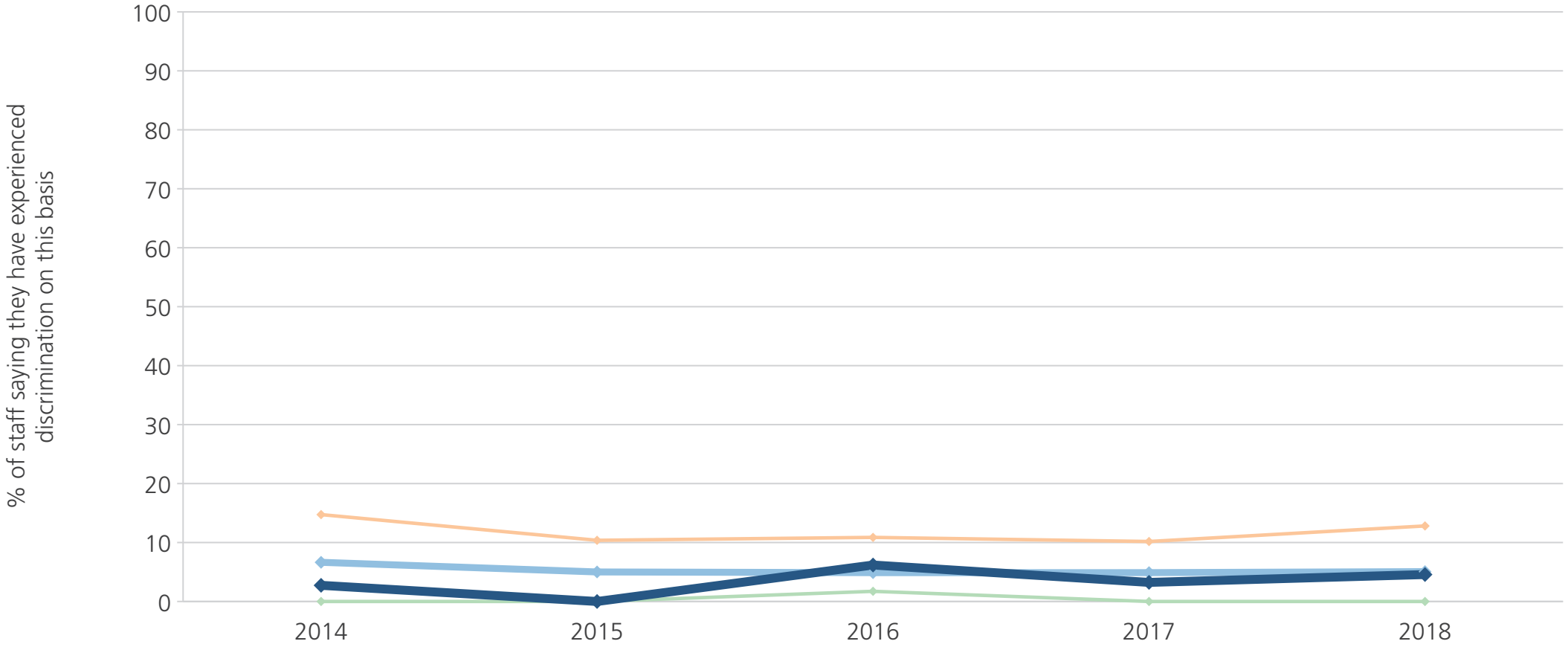
	2014	2015	2016	2017	2018
Worst	63.6%	64.7%	67.1%	68.5%	64.2%
Your org	24.6%	31.9%	22.1%	25.1%	30.1%
Average	35.2%	35.3%	39.0%	33.1%	38.2%
Best	13.3%	10.2%	17.2%	18.2%	13.9%
No. responses	35	28	57	86	87

Note: This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



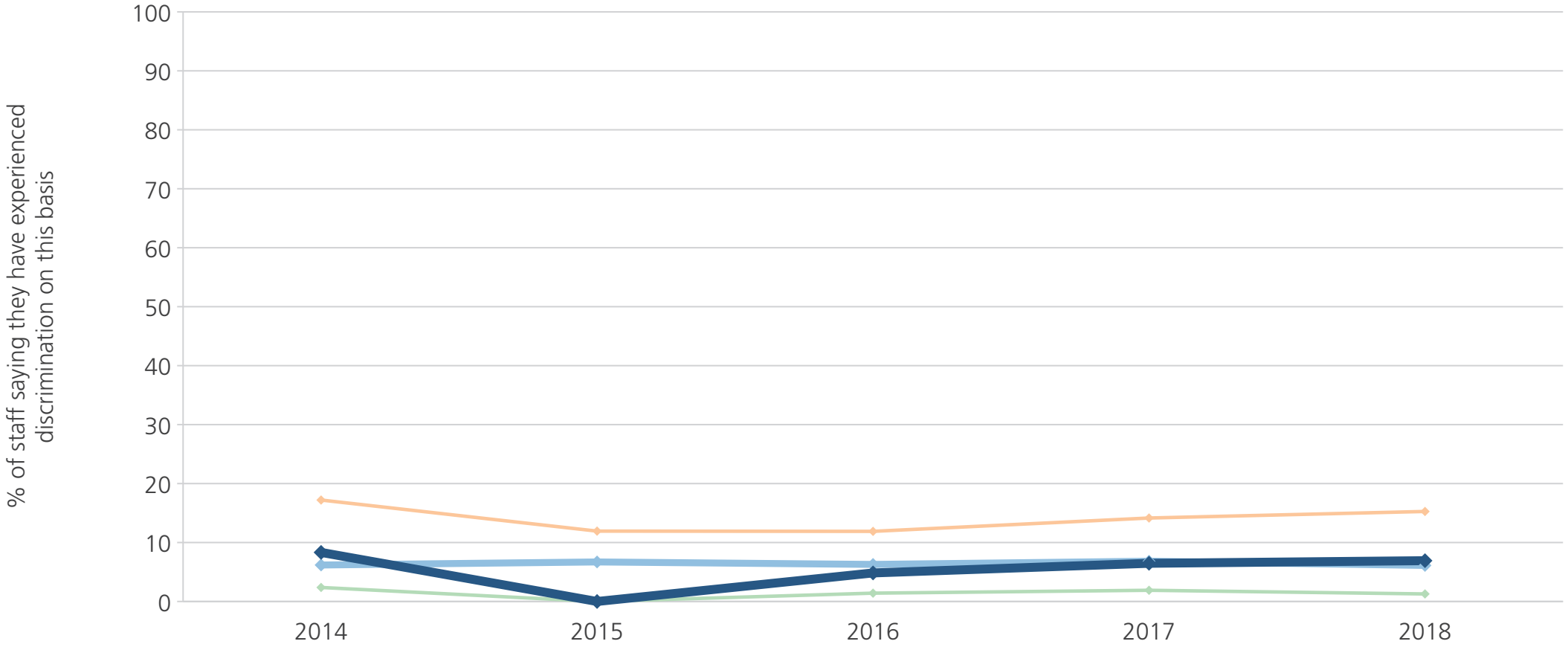
	2014	2015	2016	2017	2018
Worst	61.3%	59.6%	43.5%	41.1%	44.4%
Your org	24.7%	37.5%	30.7%	34.2%	22.7%
Average	23.2%	24.9%	24.9%	25.0%	24.2%
Best	14.3%	16.5%	10.6%	18.2%	14.2%
No. responses	35	28	57	86	87

Note: This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



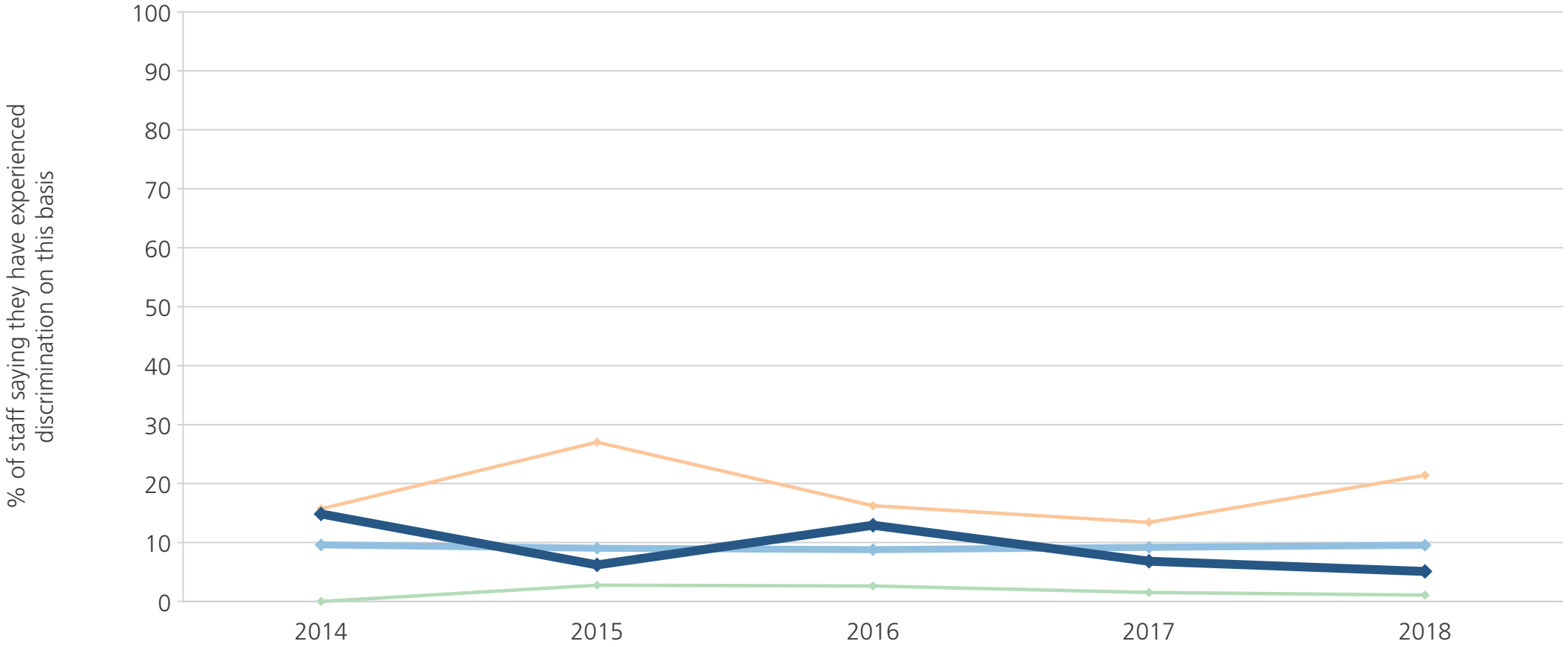
	2014	2015	2016	2017	2018
Worst	14.7%	10.4%	10.9%	10.2%	12.8%
Your org	2.7%	0.0%	6.2%	3.2%	4.6%
Average	6.6%	5.0%	4.9%	4.9%	5.1%
Best	0.0%	0.0%	1.7%	0.0%	0.0%
No. responses	35	28	57	86	87

Note: This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



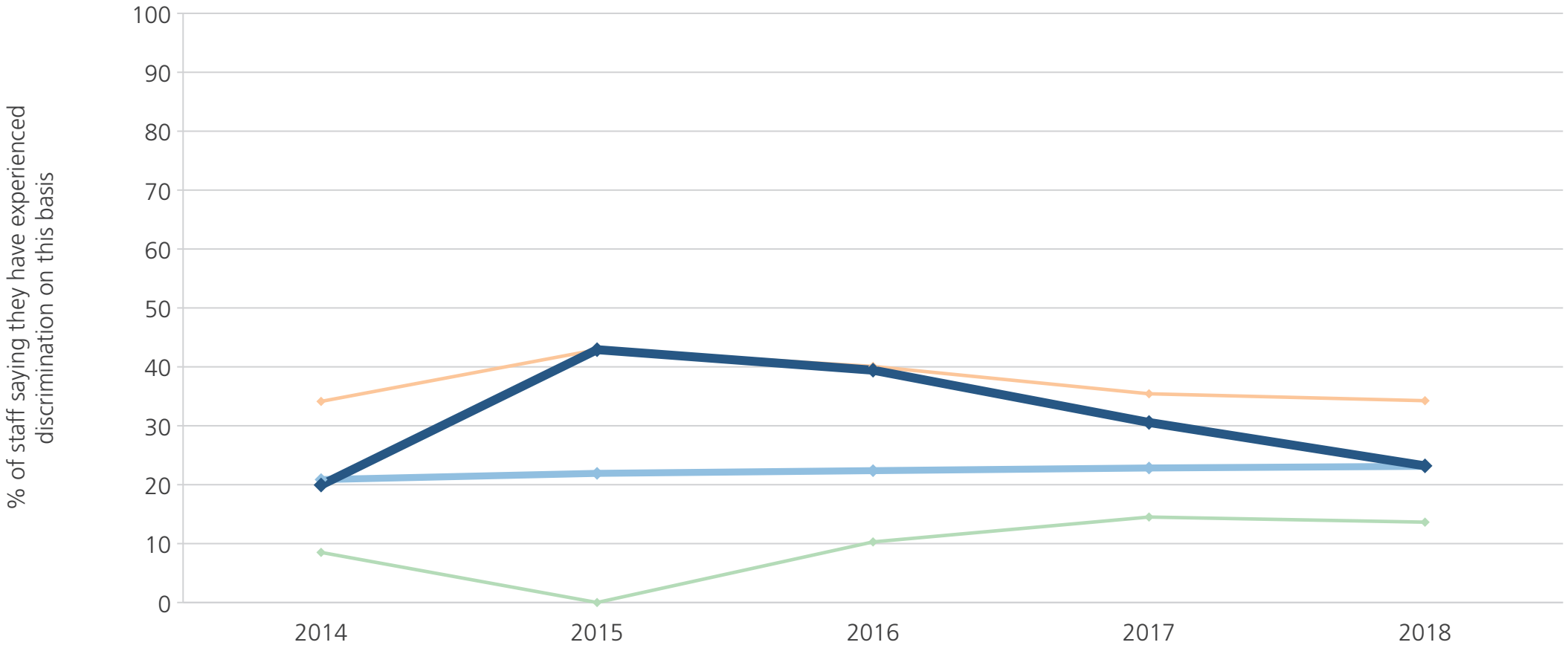
	2014	2015	2016	2017	2018
Worst	17.2%	11.9%	11.9%	14.2%	15.3%
Your org	8.3%	0.0%	4.8%	6.5%	6.9%
Average	6.2%	6.7%	6.3%	6.8%	6.1%
Best	2.4%	0.0%	1.4%	1.9%	1.3%
No. responses	35	28	57	86	87

Note: This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



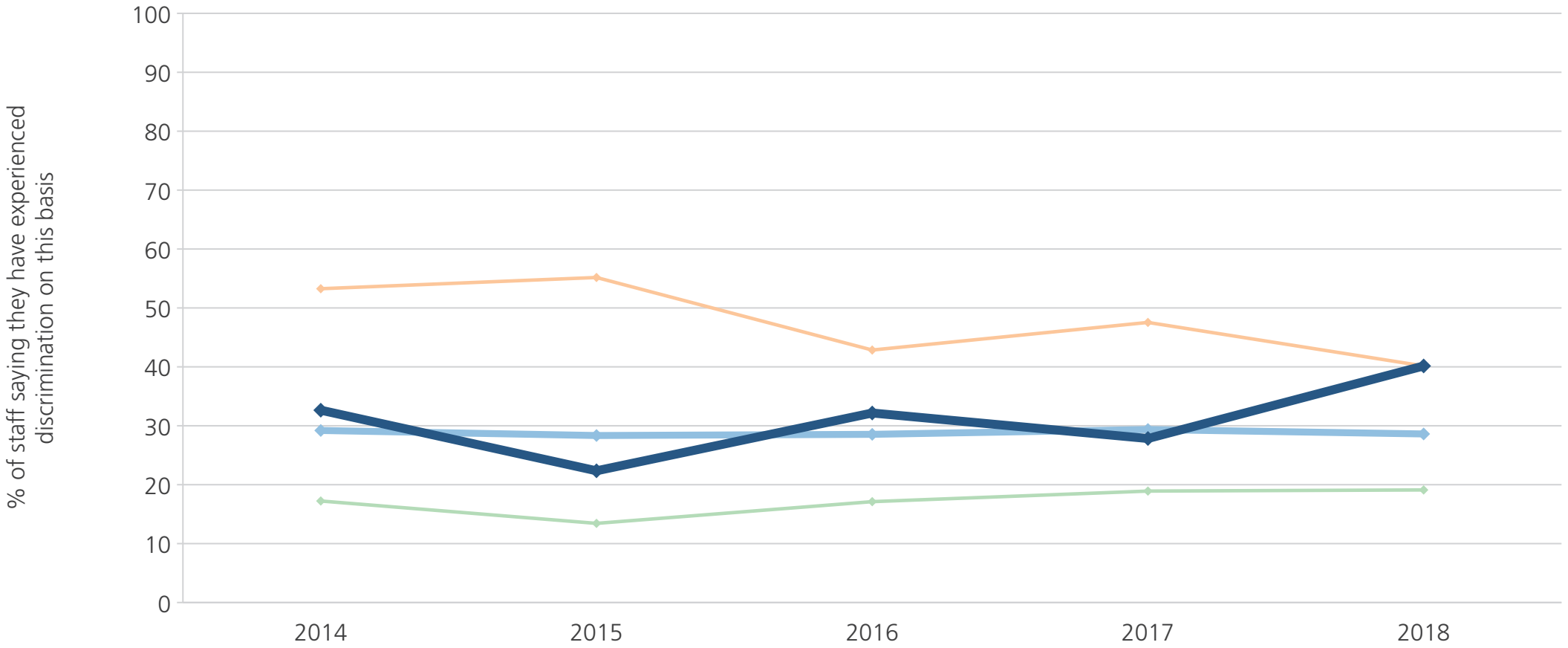
	2014	2015	2016	2017	2018
Worst	15.7%	27.0%	16.2%	13.4%	21.4%
Your org	14.8%	6.2%	12.9%	6.8%	5.1%
Average	9.6%	9.0%	8.8%	9.2%	9.5%
Best	0.0%	2.8%	2.6%	1.5%	1.1%
No. responses	35	28	57	86	87

Note: This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.

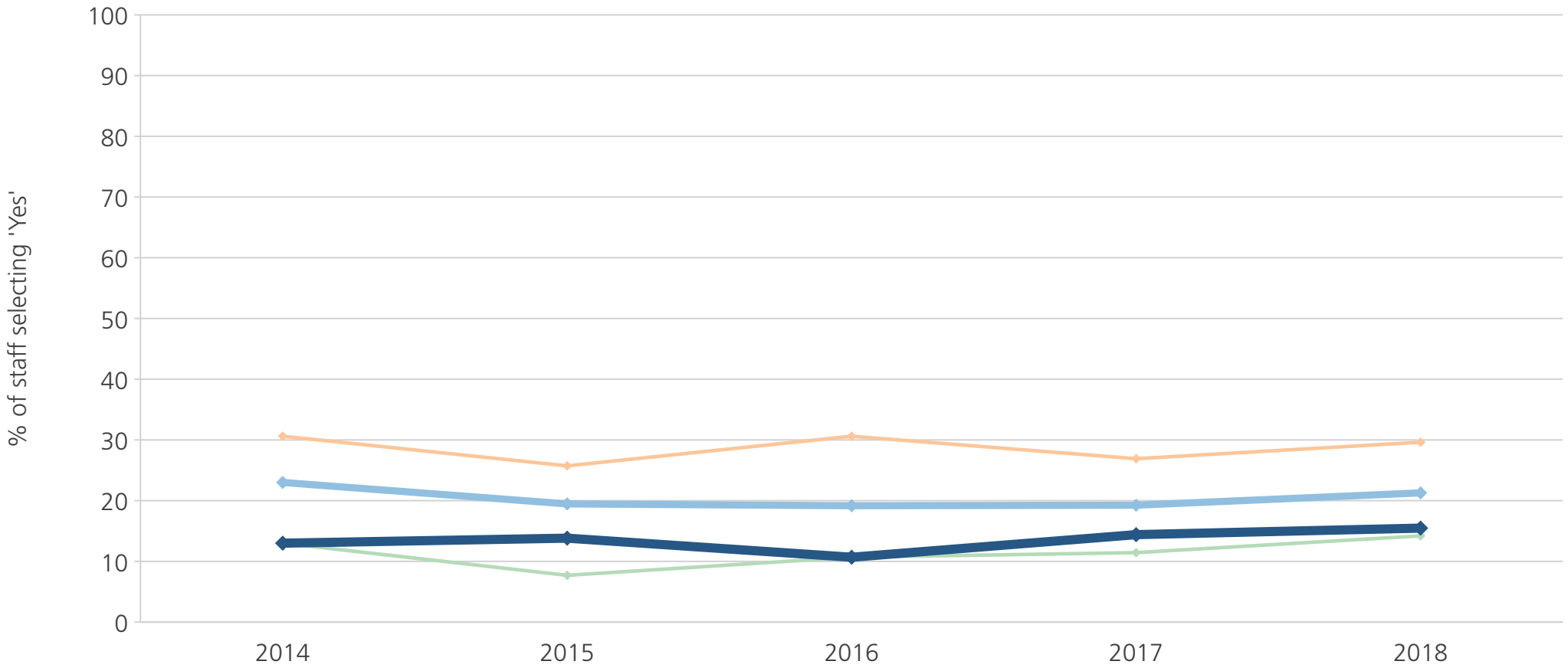


	2014	2015	2016	2017	2018
Worst	34.1%	42.9%	40.1%	35.4%	34.3%
Your org	19.9%	42.9%	39.4%	30.6%	23.2%
Average	20.9%	21.9%	22.4%	22.8%	23.1%
Best	8.5%	0.0%	10.3%	14.5%	13.6%
No. responses	35	28	57	86	87

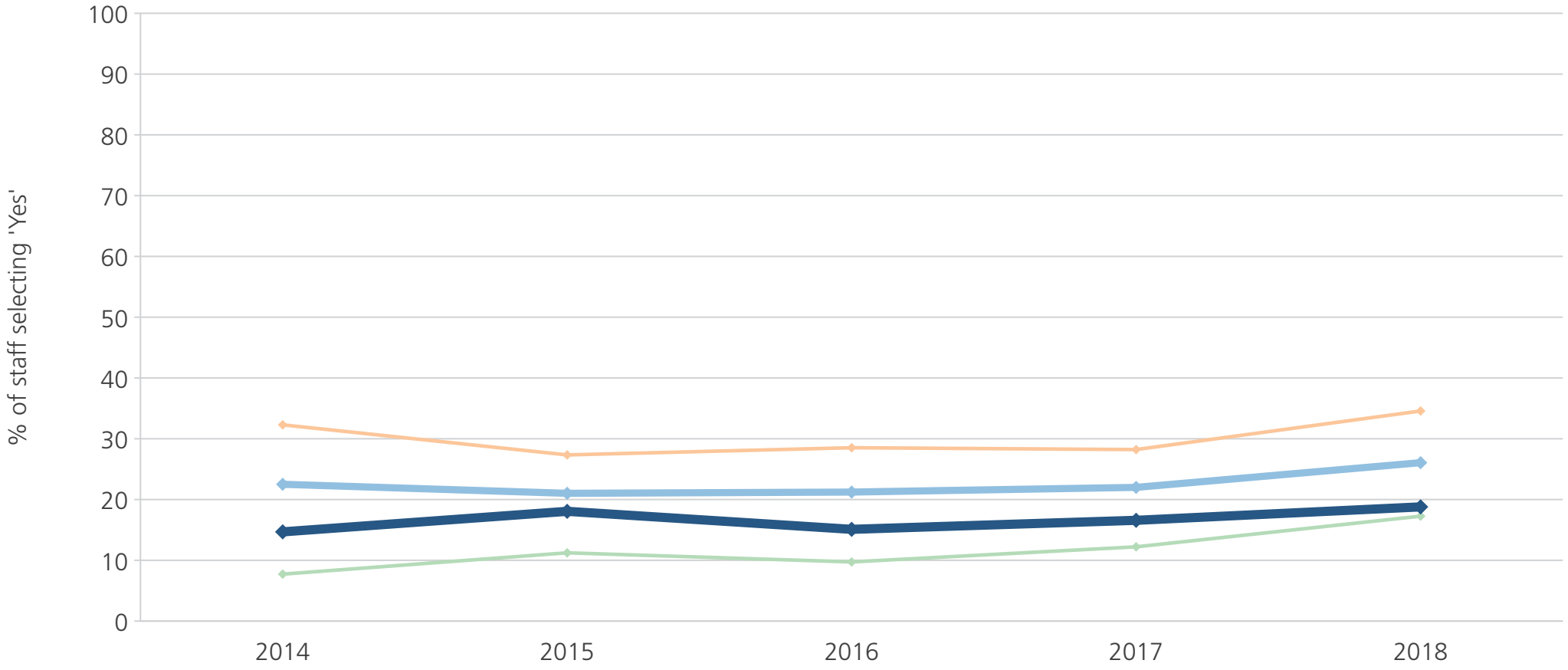
Note: This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



	2014	2015	2016	2017	2018
Worst	53.3%	55.2%	42.9%	47.5%	40.2%
Your org	32.6%	22.4%	32.2%	27.8%	40.2%
Average	29.2%	28.3%	28.5%	29.4%	28.6%
Best	17.2%	13.4%	17.1%	18.9%	19.1%
No. responses	35	28	57	86	87

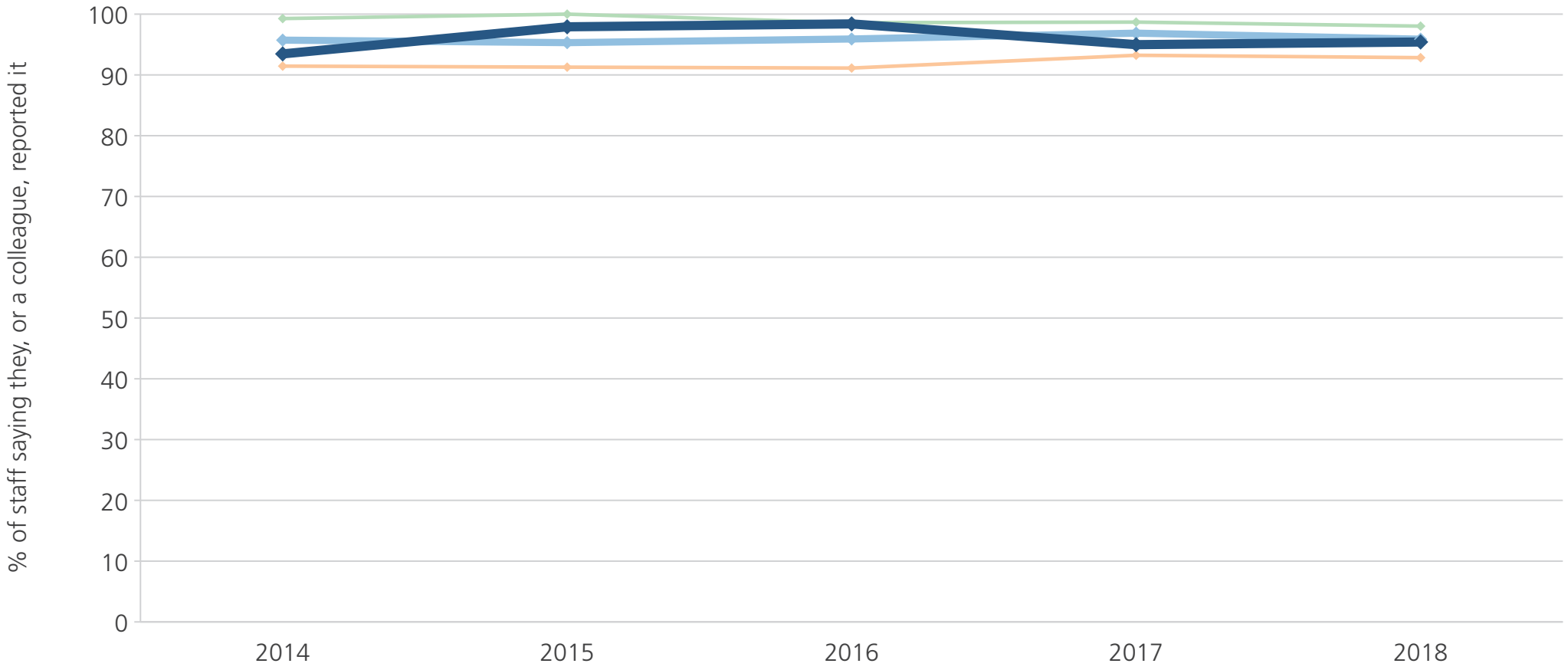


	2014	2015	2016	2017	2018
Worst	30.6%	25.7%	30.6%	26.9%	29.6%
Your org	13.0%	13.8%	10.7%	14.4%	15.5%
Average	23.0%	19.5%	19.2%	19.3%	21.3%
Best	13.0%	7.7%	10.7%	11.4%	14.2%
No. responses	338	295	763	903	851

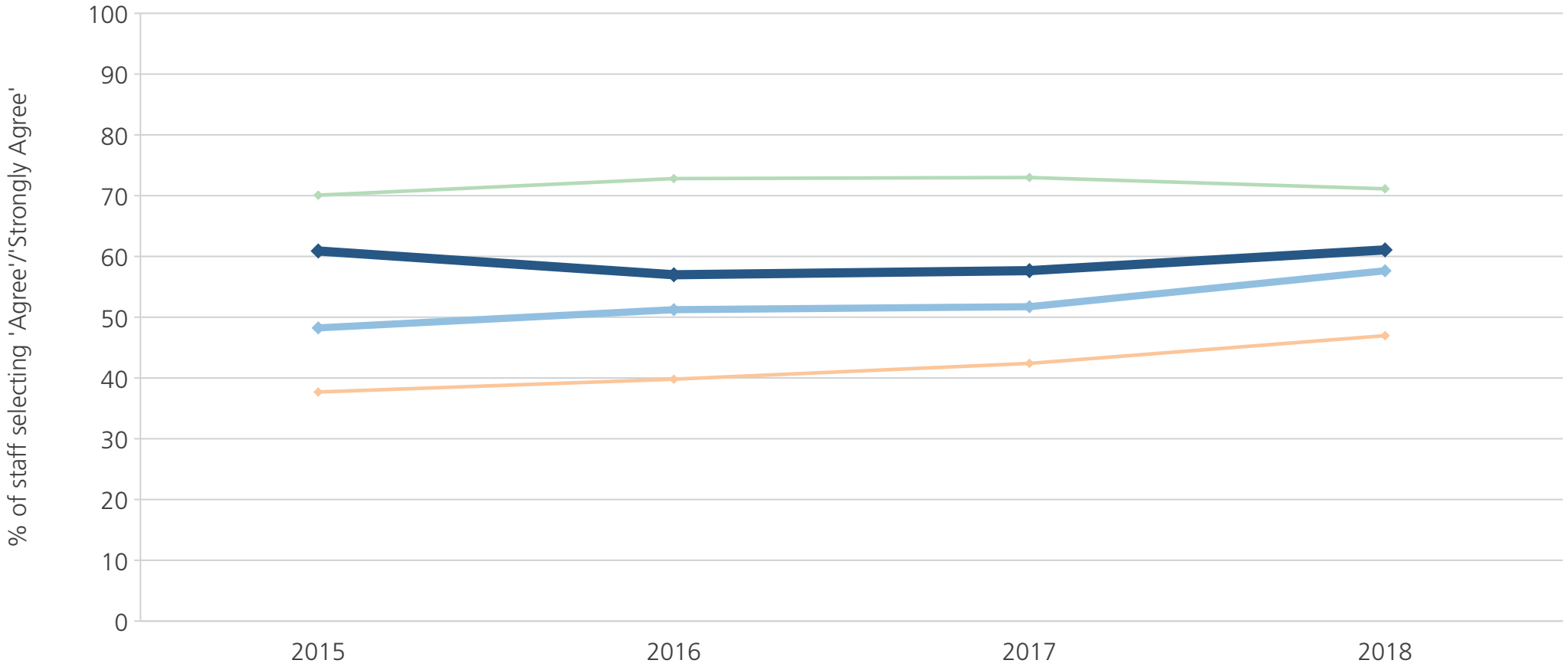


	2014	2015	2016	2017	2018
Worst	32.3%	27.3%	28.5%	28.2%	34.6%
Your org	14.7%	18.1%	15.1%	16.6%	18.8%
Average	22.5%	21.0%	21.2%	22.0%	26.1%
Best	7.7%	11.2%	9.7%	12.2%	17.3%
No. responses	335	295	760	903	849

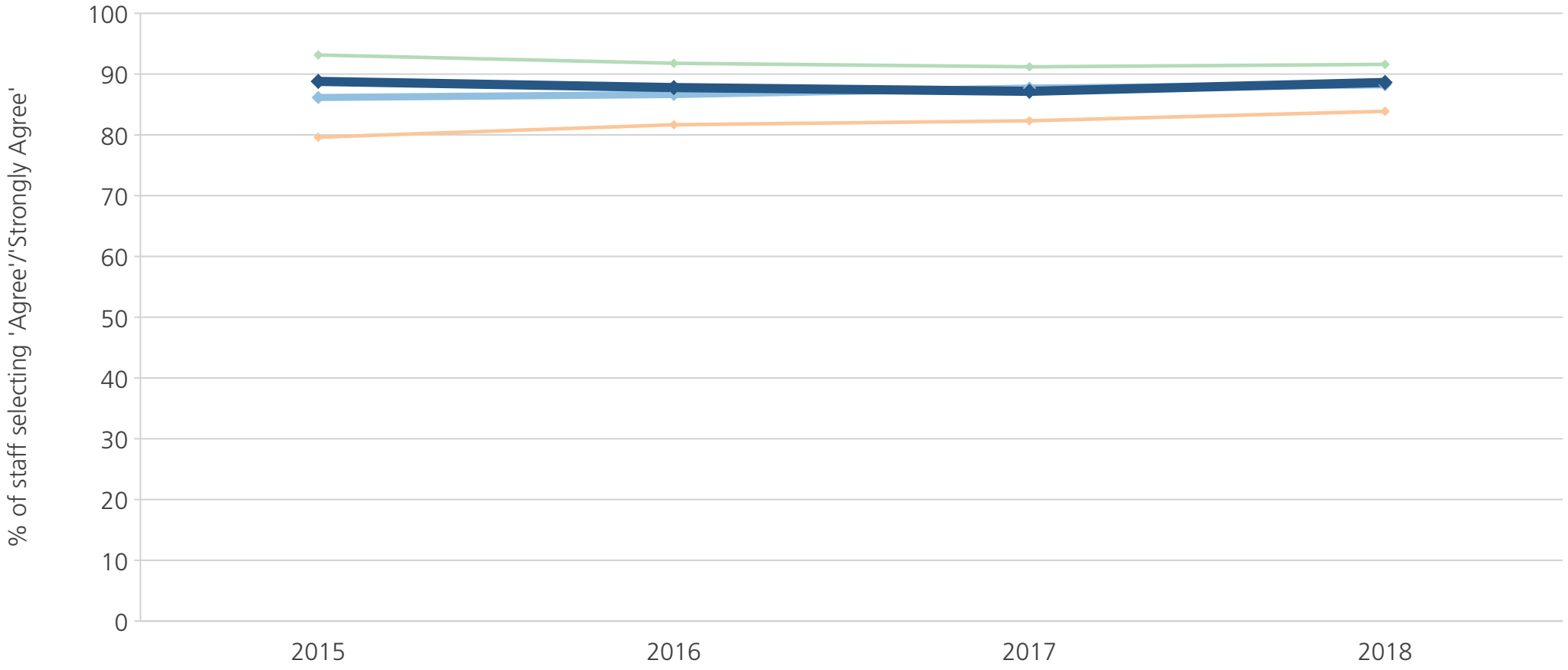
Note: This question was only answered by staff who reported observing at least one error, near miss or incident in the last month.



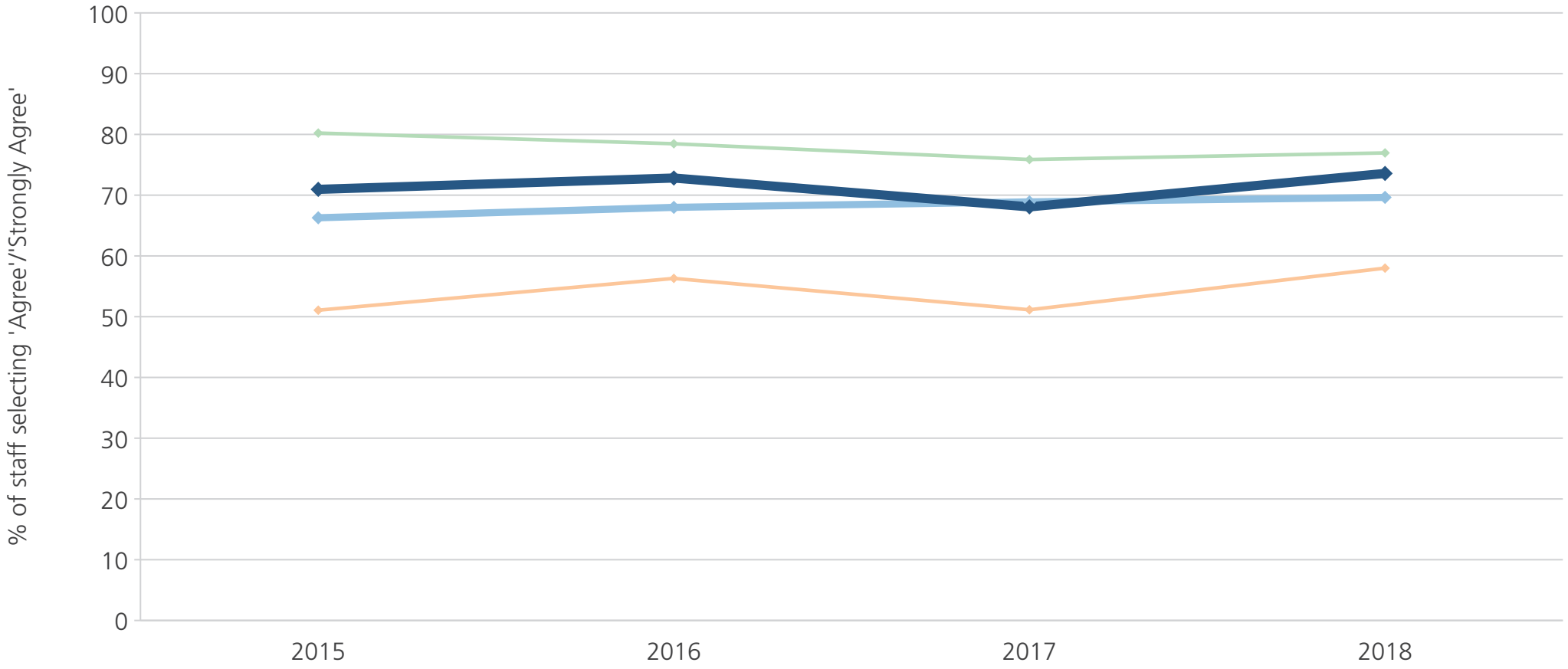
	2014	2015	2016	2017	2018
Best	99.3%	100.0%	98.6%	98.7%	98.0%
Your org	93.5%	97.9%	98.4%	95.0%	95.4%
Average	95.7%	95.3%	95.9%	96.9%	95.9%
Worst	91.4%	91.3%	91.1%	93.2%	92.8%
No. responses	62	54	125	167	159



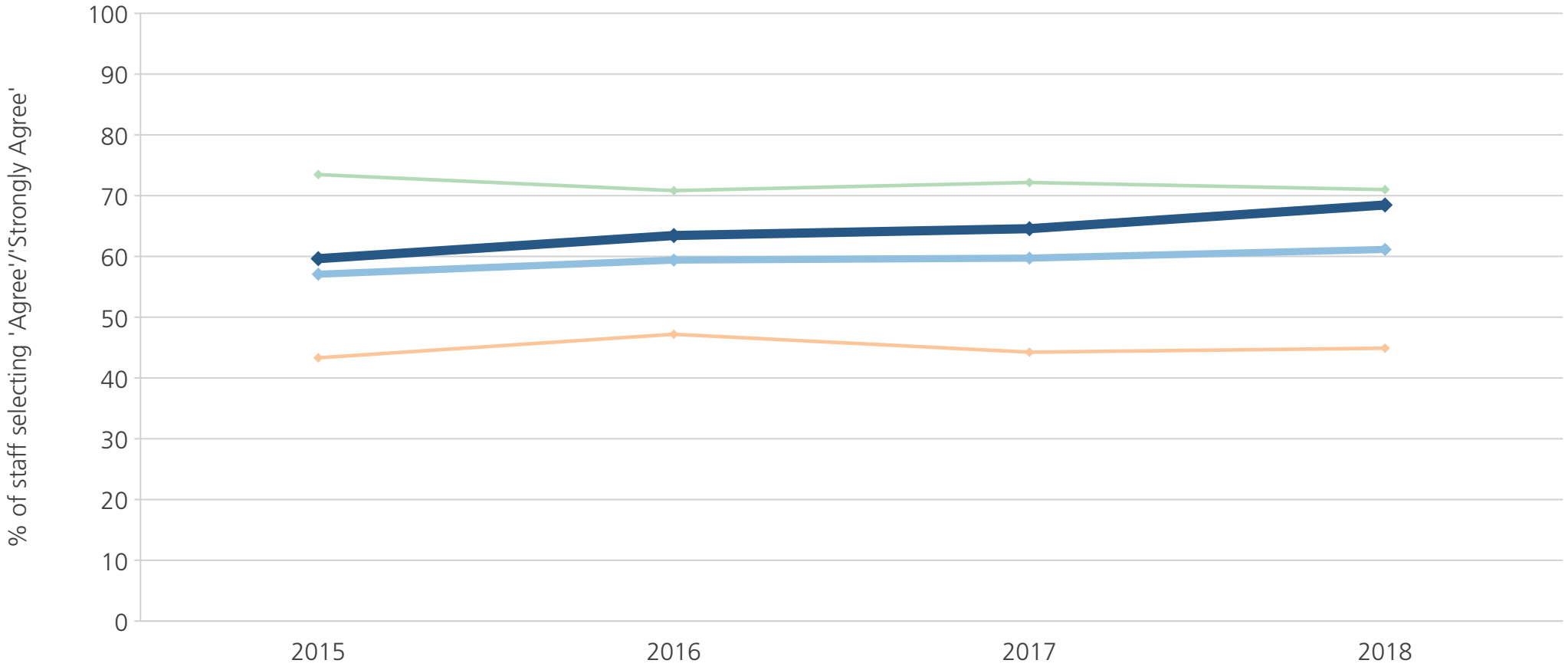
	2015	2016	2017	2018
Best	70.1%	72.8%	73.0%	71.1%
Your org	60.9%	57.0%	57.7%	61.1%
Average	48.2%	51.2%	51.7%	57.6%
Worst	37.7%	39.8%	42.4%	47.0%
No. responses	221	601	732	624



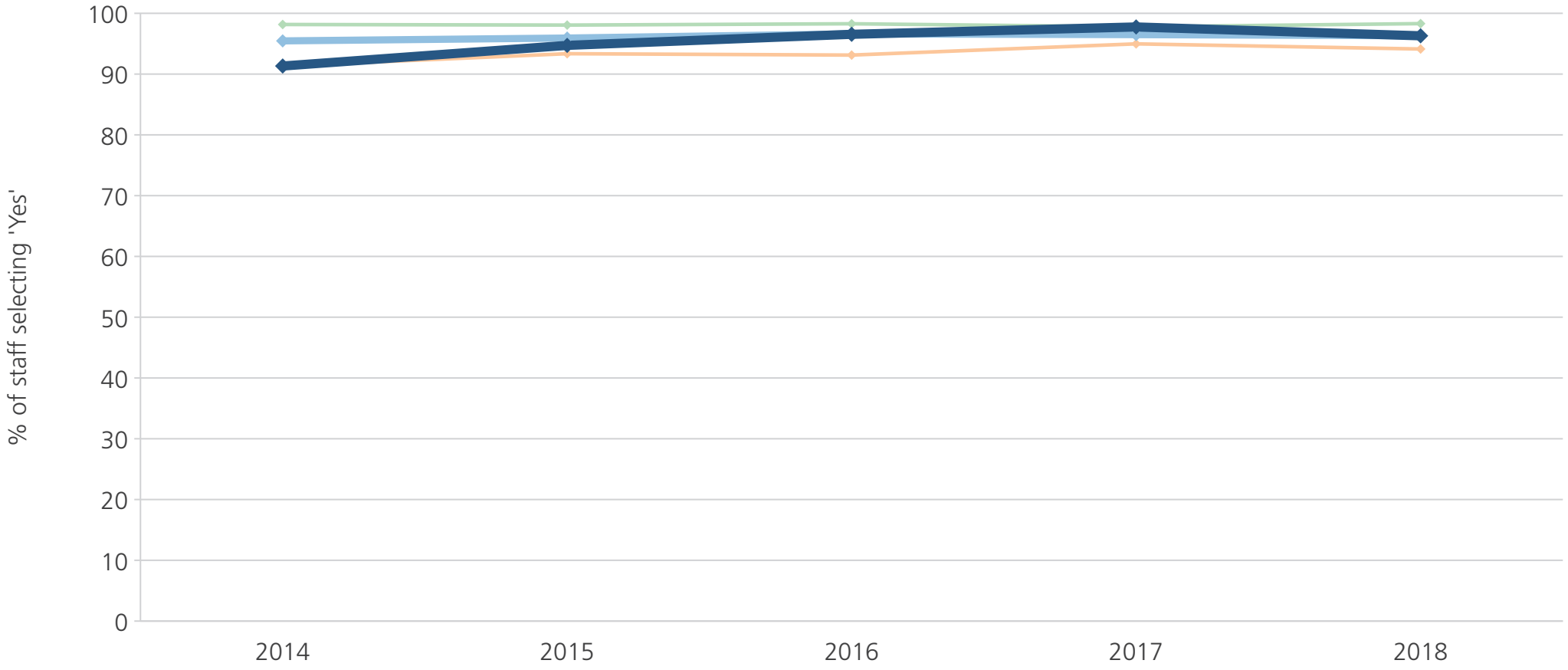
	2015	2016	2017	2018
Best	93.1%	91.8%	91.2%	91.6%
Your org	88.8%	87.8%	87.2%	88.6%
Average	86.1%	86.6%	87.7%	88.2%
Worst	79.6%	81.7%	82.3%	83.9%
No. responses	288	755	883	816



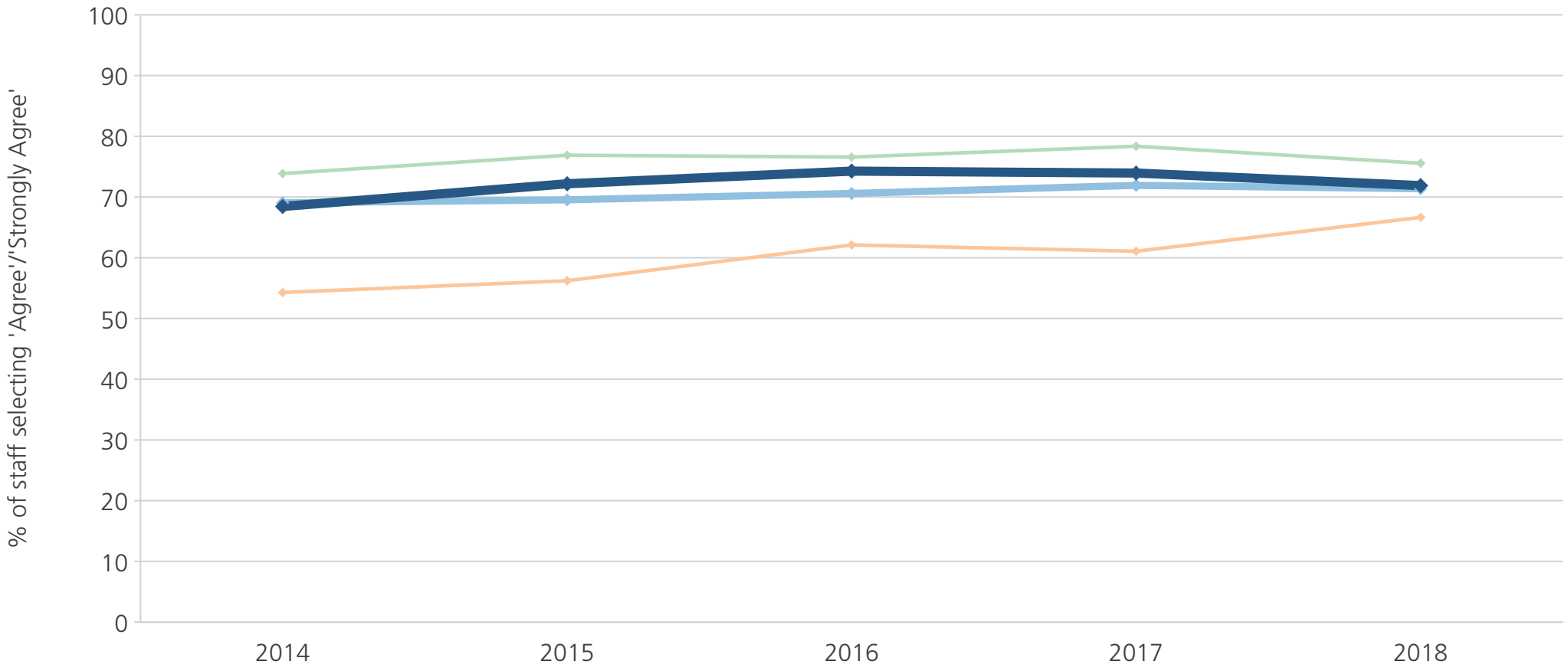
	2015	2016	2017	2018
Best	80.2%	78.5%	75.9%	77.0%
Your org	71.0%	72.8%	68.1%	73.6%
Average	66.3%	68.0%	68.9%	69.6%
Worst	51.1%	56.3%	51.1%	58.0%
No. responses	262	675	820	737



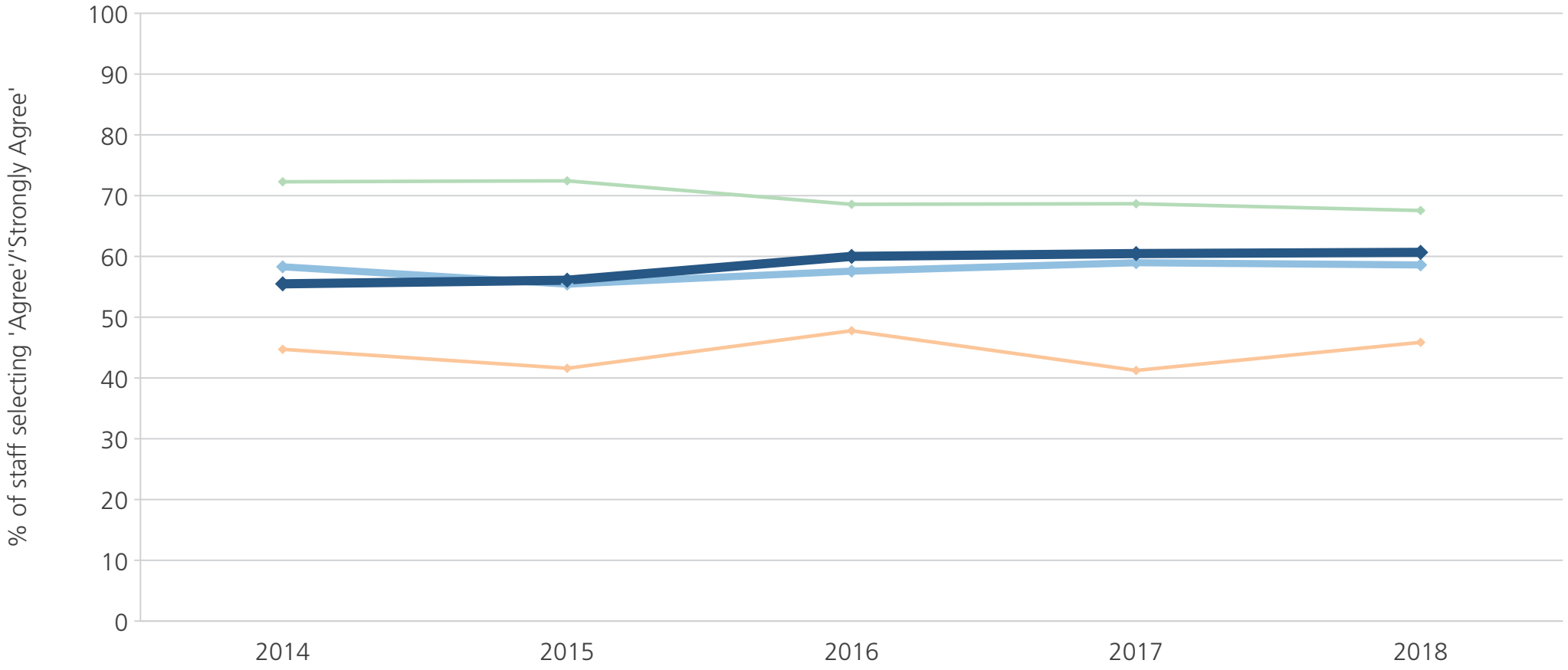
	2015	2016	2017	2018
Best	73.5%	70.8%	72.2%	71.0%
Your org	59.6%	63.4%	64.6%	68.5%
Average	57.1%	59.4%	59.7%	61.1%
Worst	43.3%	47.2%	44.2%	44.9%
No. responses	267	694	825	759



	2014	2015	2016	2017	2018
Best	98.2%	98.1%	98.3%	97.8%	98.3%
Your org	91.3%	94.7%	96.5%	97.8%	96.3%
Average	95.5%	95.9%	96.6%	96.5%	96.3%
Worst	91.3%	93.4%	93.1%	95.0%	94.1%
No. responses	300	260	707	841	793



	2014	2015	2016	2017	2018
Best	73.9%	76.9%	76.6%	78.4%	75.6%
Your org	68.4%	72.2%	74.3%	73.9%	71.9%
Average	69.0%	69.5%	70.6%	71.9%	71.4%
Worst	54.3%	56.2%	62.1%	61.1%	66.7%
No. responses	341	293	770	907	854



	2014	2015	2016	2017	2018
Best	72.3%	72.4%	68.6%	68.7%	67.6%
Your org	55.5%	56.1%	60.0%	60.5%	60.7%
Average	58.3%	55.4%	57.6%	59.0%	58.6%
Worst	44.7%	41.6%	47.8%	41.2%	45.9%
No. responses	341	293	769	906	852

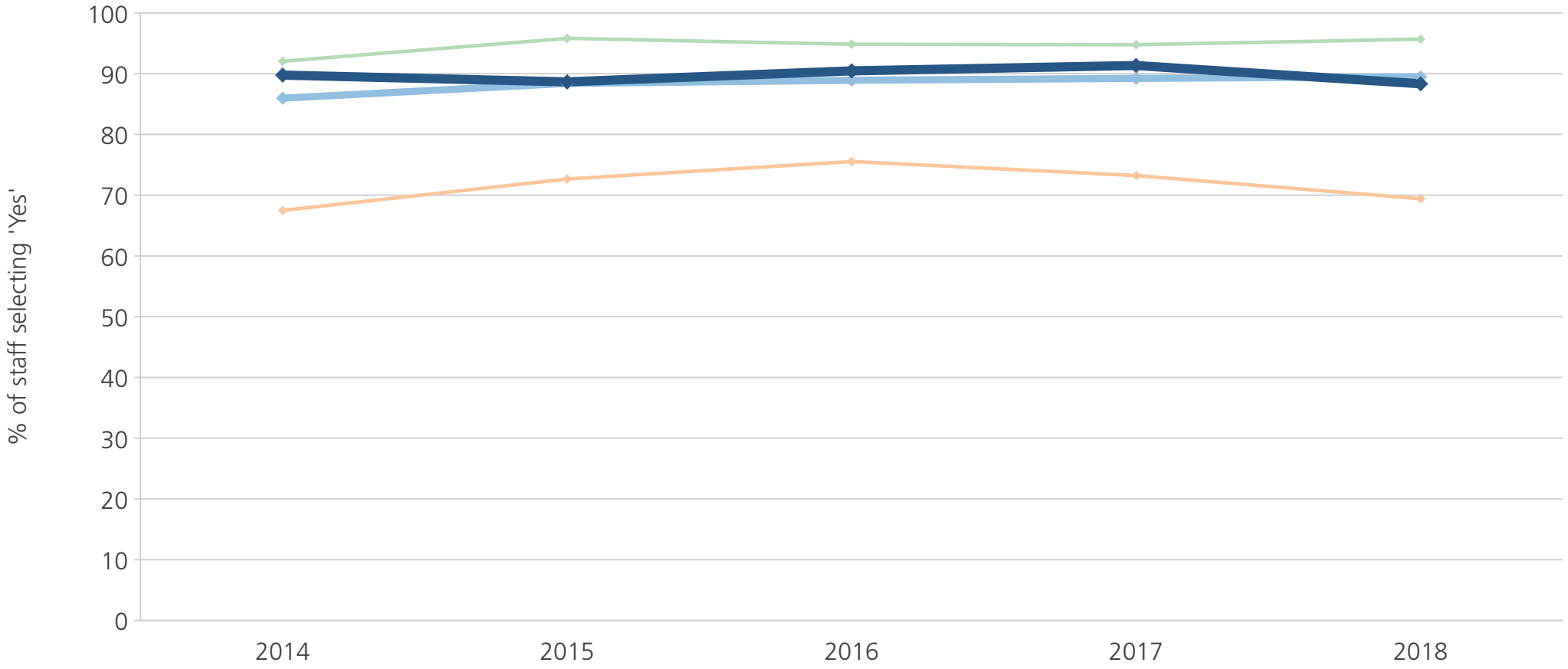
Survey Coordination Centre

NHS England

Question results – Your personal development

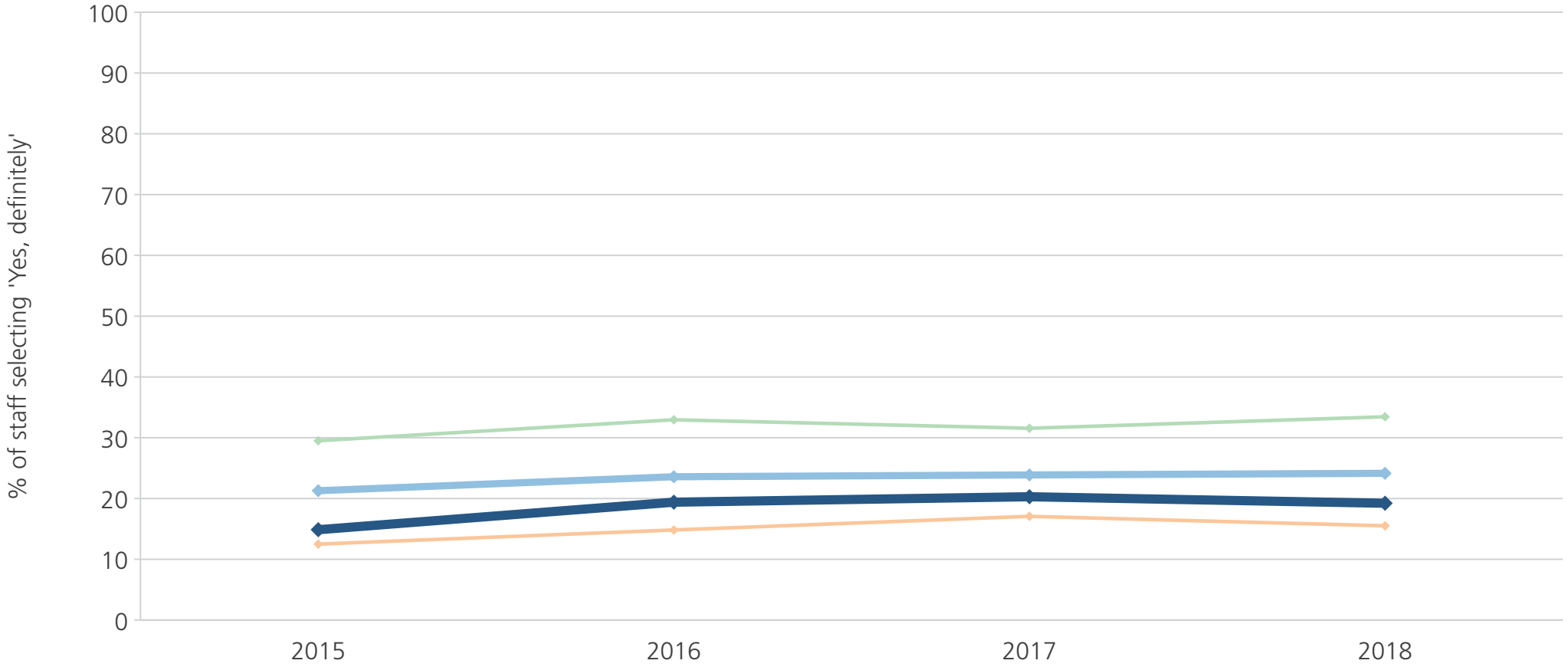
2Gether NHS Foundation Trust

2018 NHS Staff Survey Results



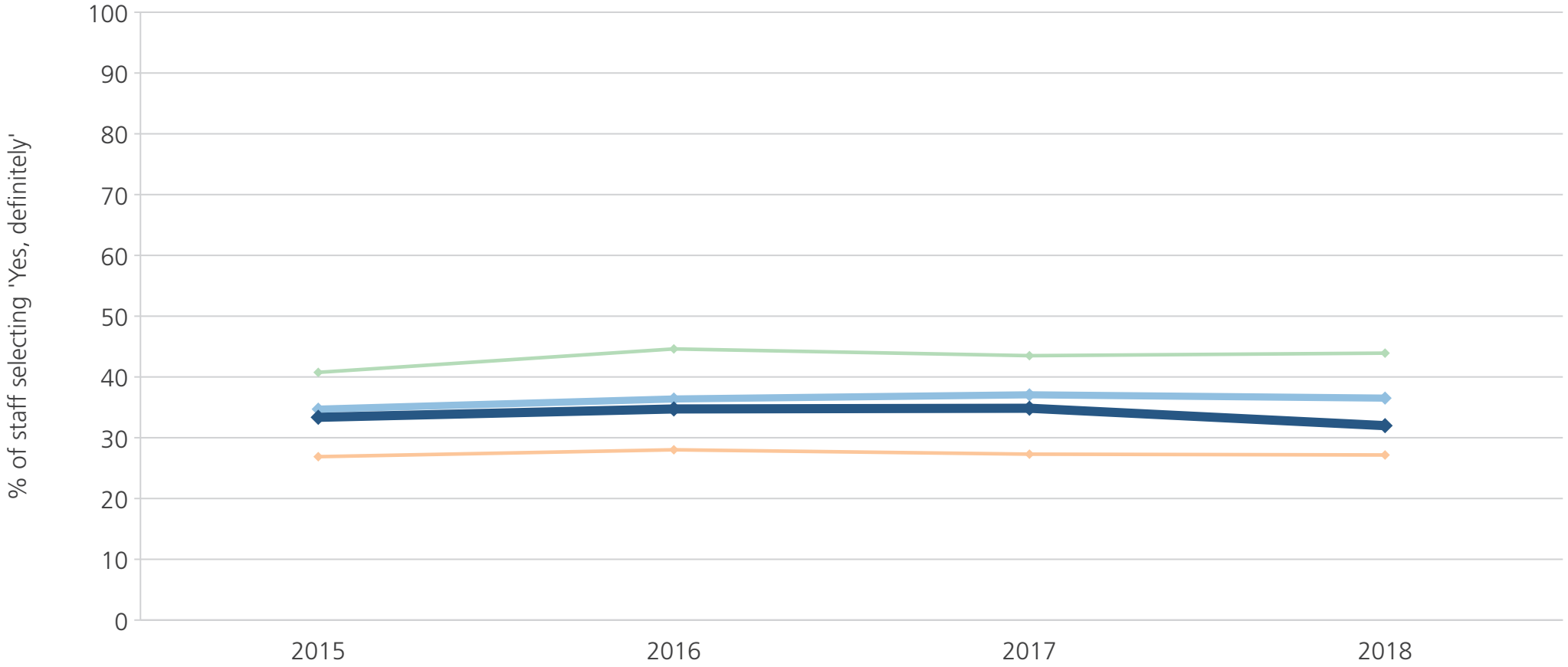
	2014	2015	2016	2017	2018
Best	92.0%	95.8%	94.8%	94.8%	95.7%
Your org	89.8%	88.7%	90.5%	91.3%	88.3%
Average	86.0%	88.4%	88.9%	89.2%	89.5%
Worst	67.5%	72.7%	75.5%	73.2%	69.4%
No. responses	340	289	750	879	835

Note: This question was only answered by staff who selected 'Yes' on q19a.



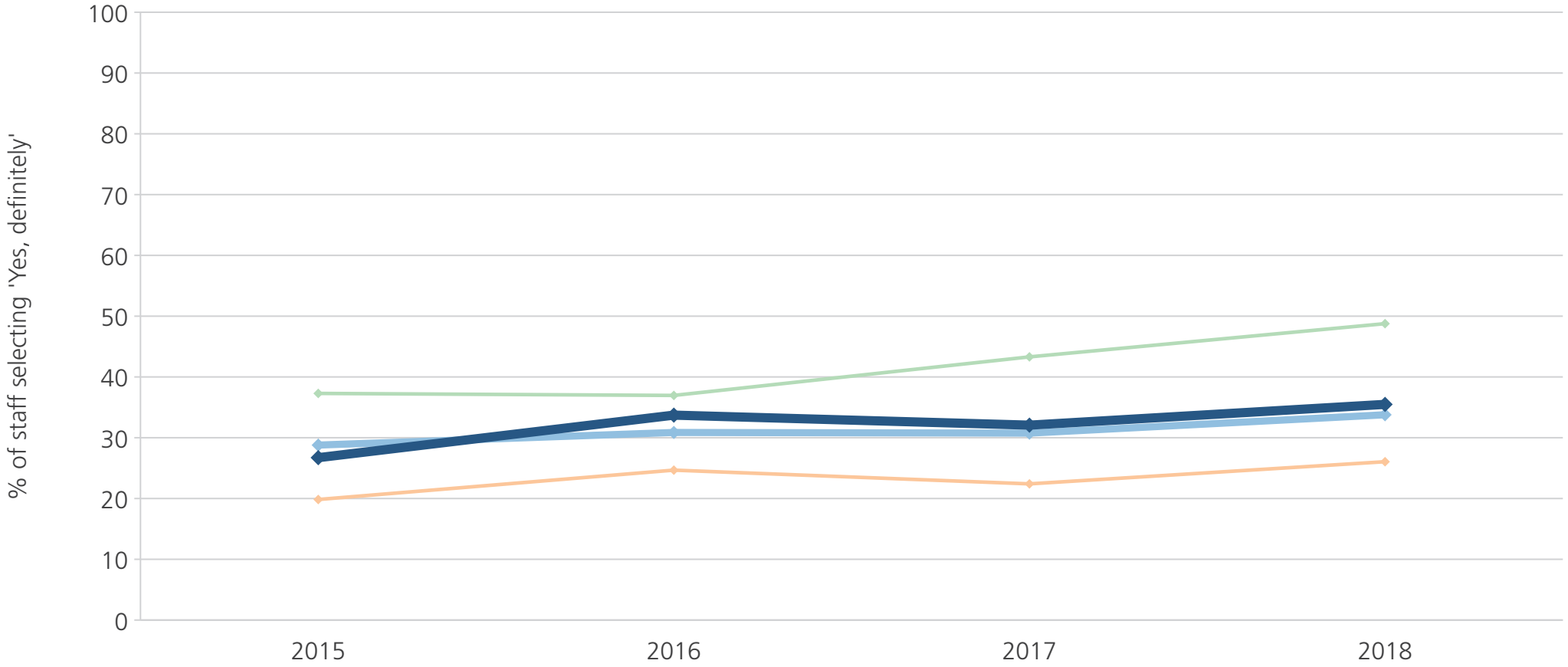
	2015	2016	2017	2018
Best	29.5%	33.0%	31.6%	33.4%
Your org	14.9%	19.4%	20.3%	19.2%
Average	21.3%	23.6%	23.9%	24.1%
Worst	12.5%	14.8%	17.1%	15.5%
No. responses	253	677	801	740

Note: This question was only answered by staff who selected 'Yes' on q19a.



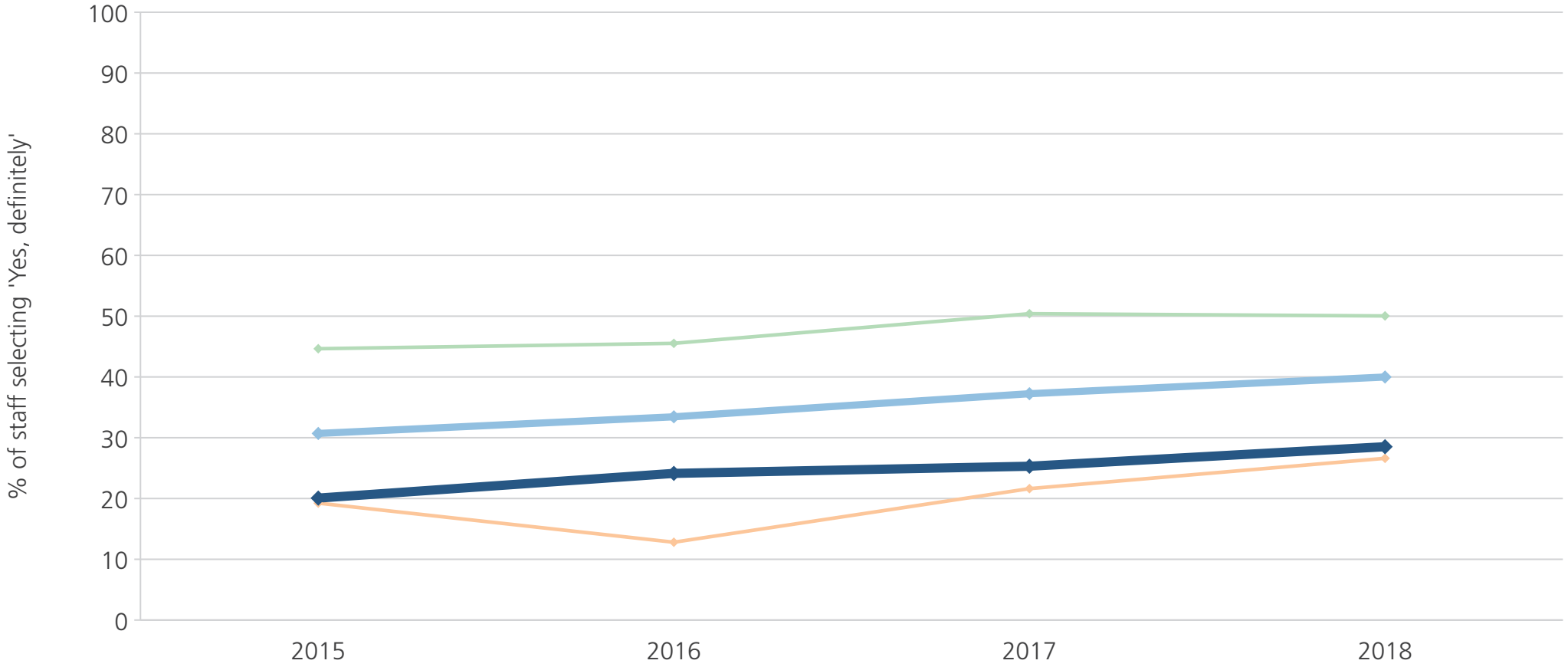
	2015	2016	2017	2018
Best	40.8%	44.6%	43.5%	43.9%
Your org	33.4%	34.7%	34.8%	32.0%
Average	34.7%	36.4%	37.1%	36.5%
Worst	26.9%	28.0%	27.3%	27.2%
No. responses	254	675	799	738

Note: This question was only answered by staff who selected 'Yes' on q19a.



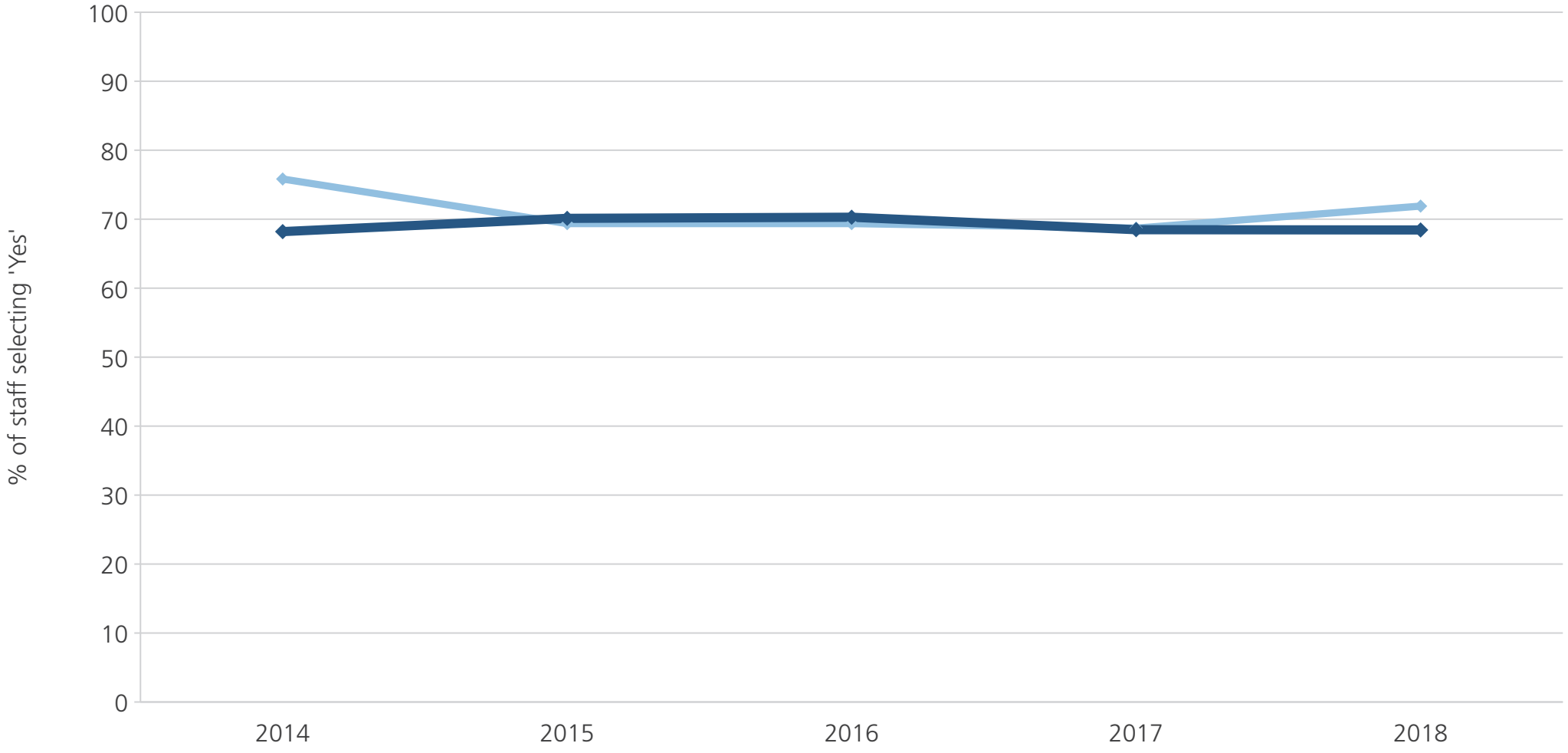
	2015	2016	2017	2018
Best	37.3%	37.0%	43.3%	48.8%
Your org	26.7%	33.7%	32.1%	35.5%
Average	28.8%	30.9%	30.8%	33.8%
Worst	19.8%	24.7%	22.4%	26.1%
No. responses	254	675	800	733

Note: This question was only answered by staff who selected 'Yes' on q19a.



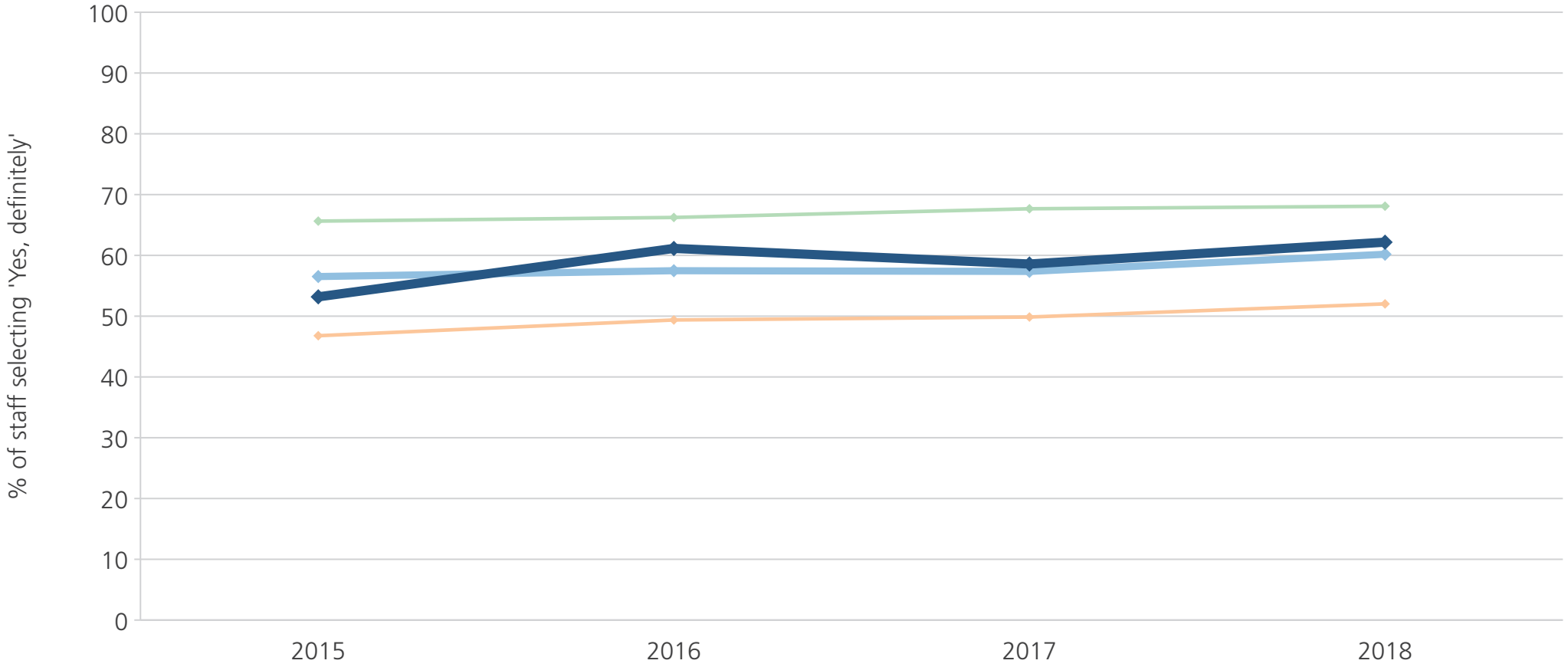
	2015	2016	2017	2018
Best	44.6%	45.5%	50.4%	50.0%
Your org	20.1%	24.1%	25.3%	28.5%
Average	30.7%	33.4%	37.2%	40.0%
Worst	19.2%	12.8%	21.6%	26.6%
No. responses	255	671	795	733

Note: This question was only answered by staff who selected 'Yes' on q19a.

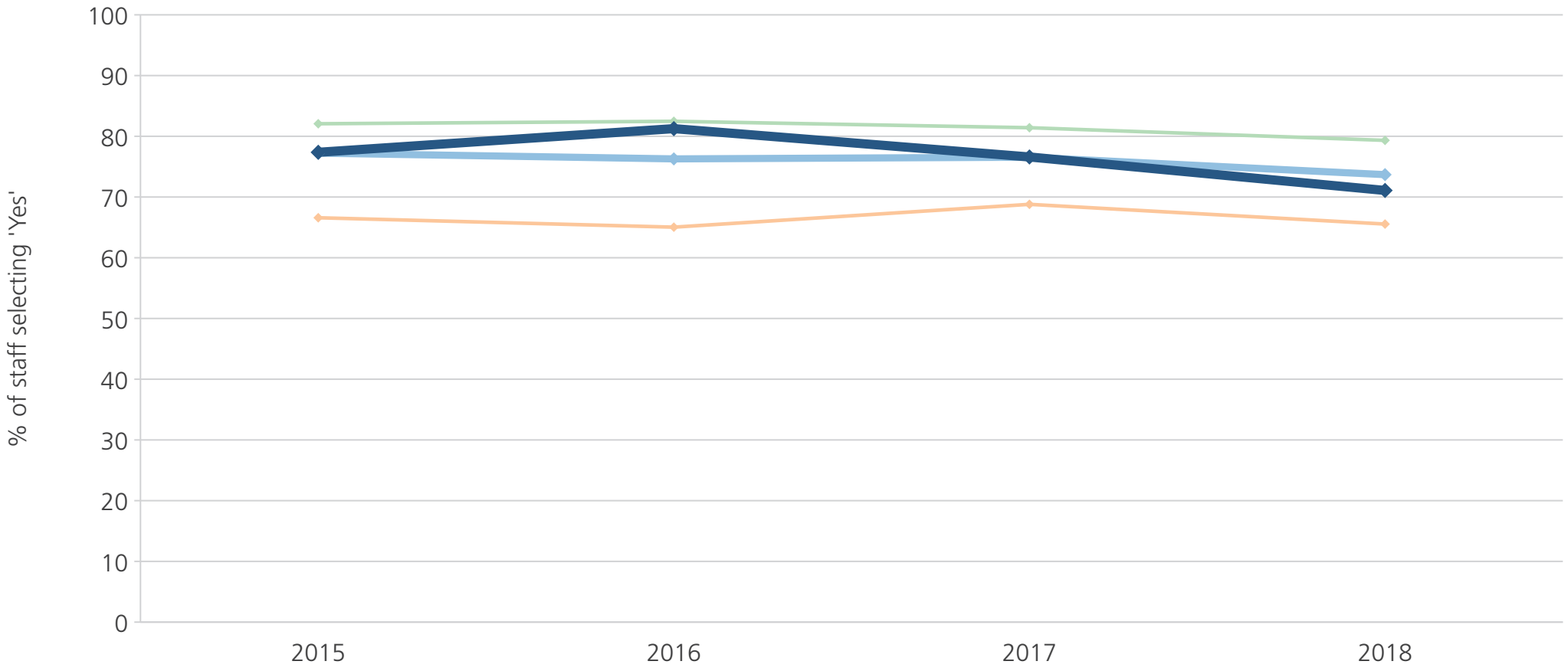


	2014	2015	2016	2017	2018
Your org	68.2%	70.1%	70.3%	68.5%	68.4%
Average	75.8%	69.4%	69.4%	68.7%	71.9%
No. responses	305	251	673	793	735

Note: This question was only answered by staff who selected 'Yes' on q19f.



	2015	2016	2017	2018
Best	65.6%	66.2%	67.7%	68.1%
Your org	53.2%	61.1%	58.6%	62.2%
Average	56.5%	57.5%	57.4%	60.2%
Worst	46.8%	49.4%	49.9%	52.0%
No. responses	175	470	543	495



	2015	2016	2017	2018
Best	82.1%	82.5%	81.4%	79.3%
Your org	77.4%	81.3%	76.6%	71.1%
Average	77.2%	76.3%	76.6%	73.7%
Worst	66.6%	65.0%	68.8%	65.5%
No. responses	290	750	882	837

Survey Coordination Centre

NHS England

Question results – Your organisation

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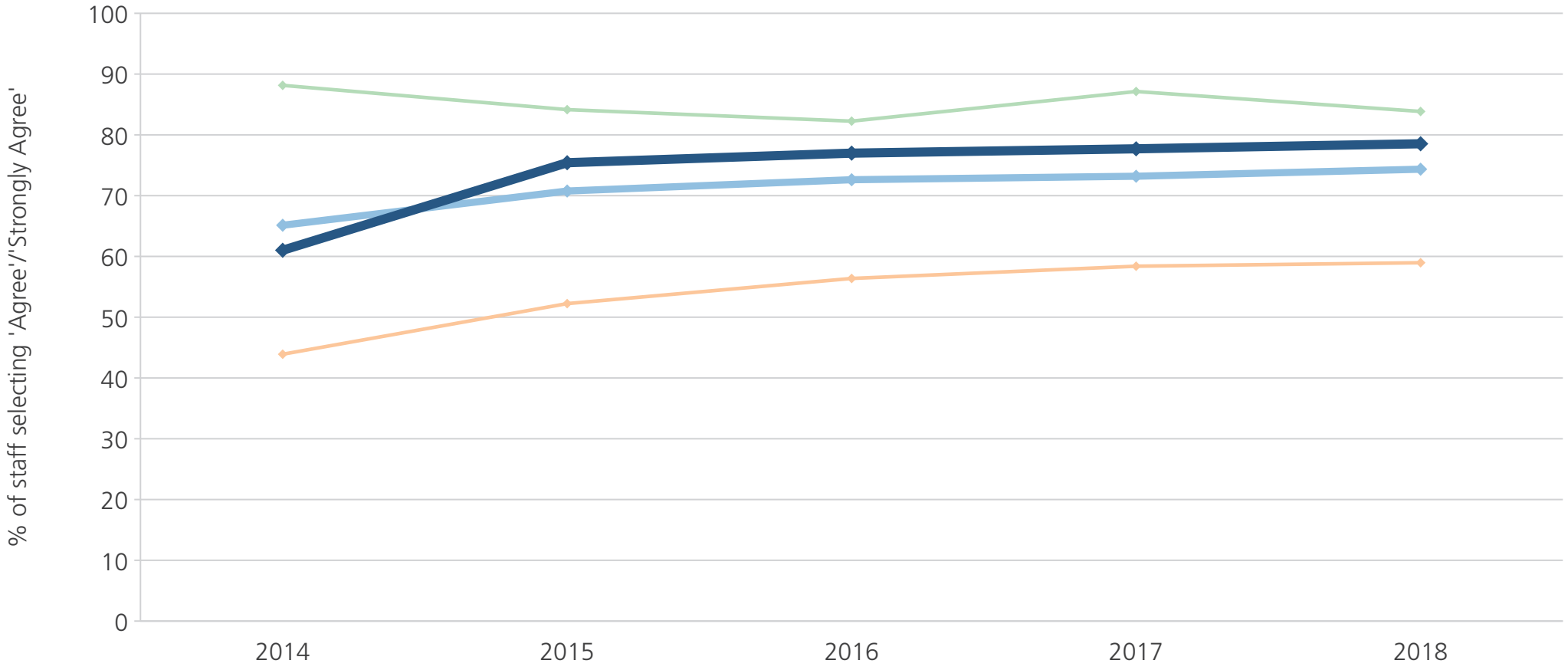
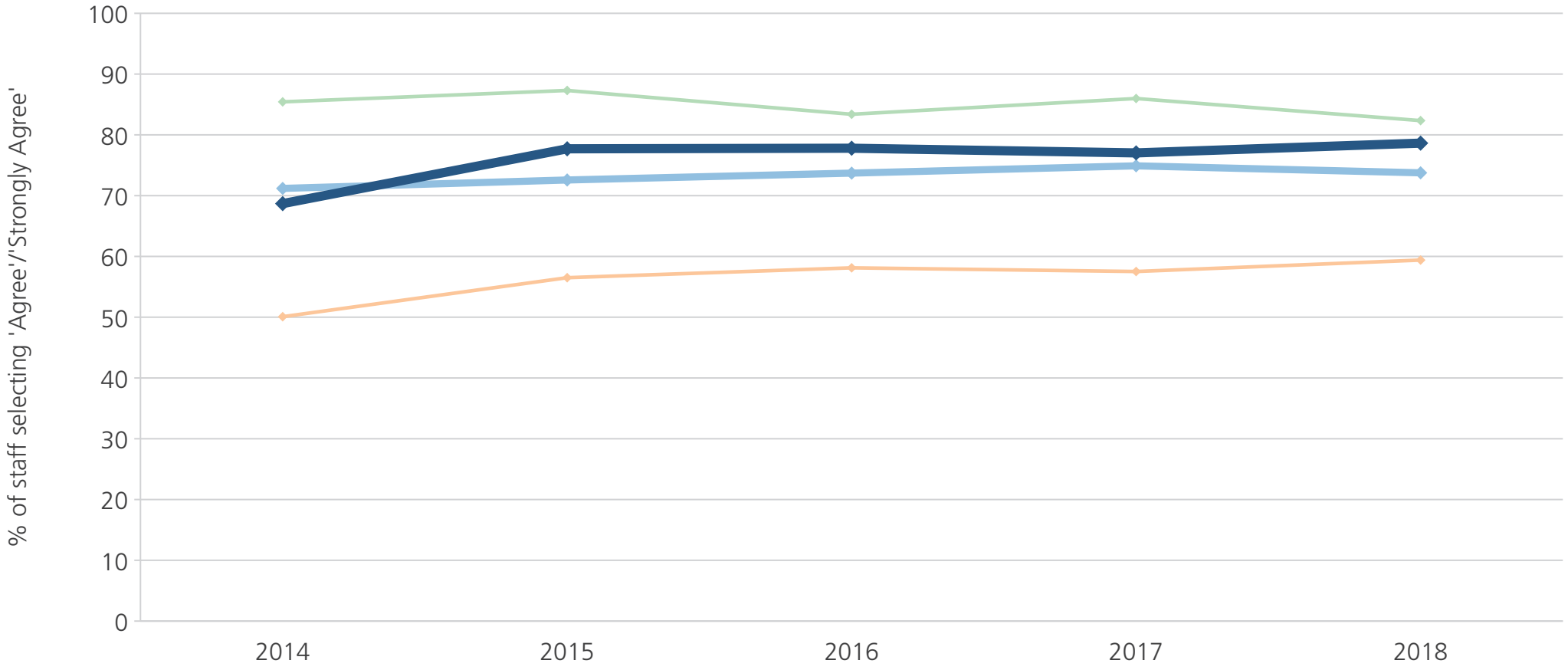
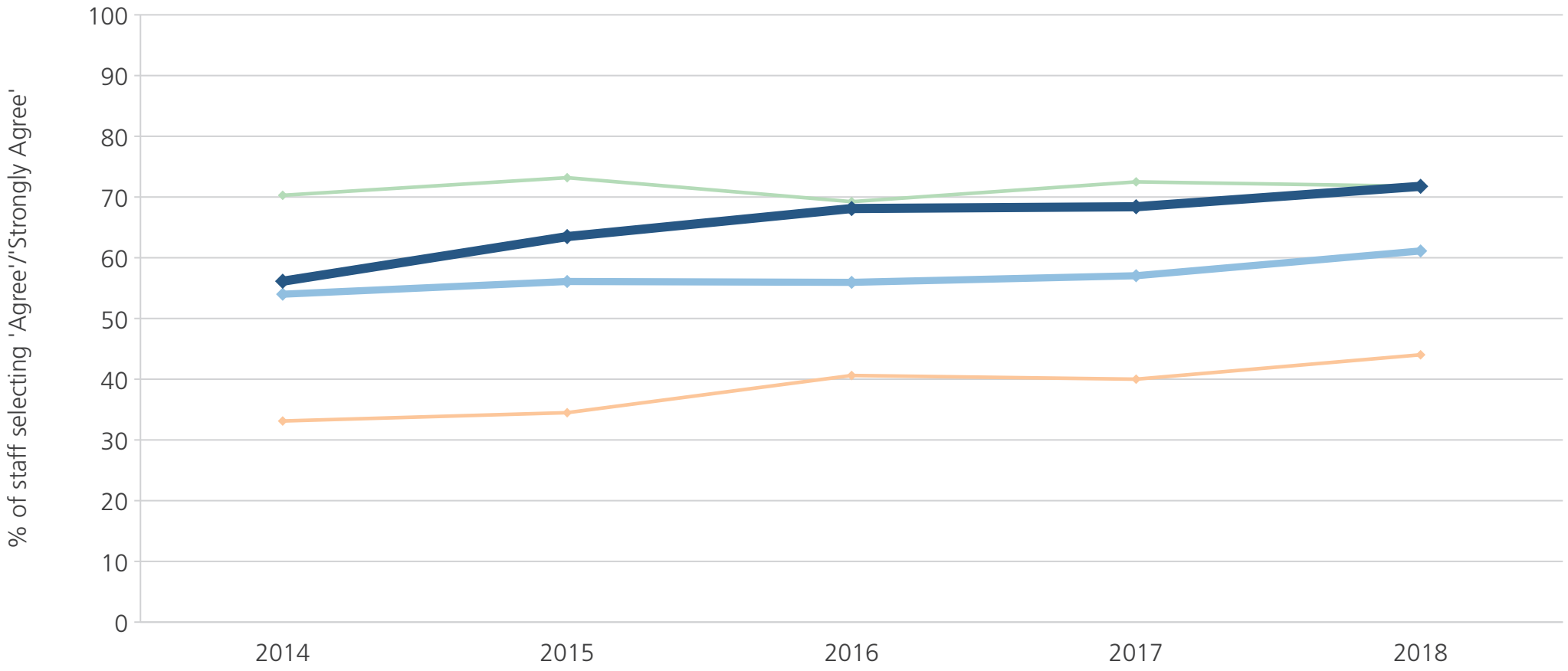
2018 NHS Staff Survey Results



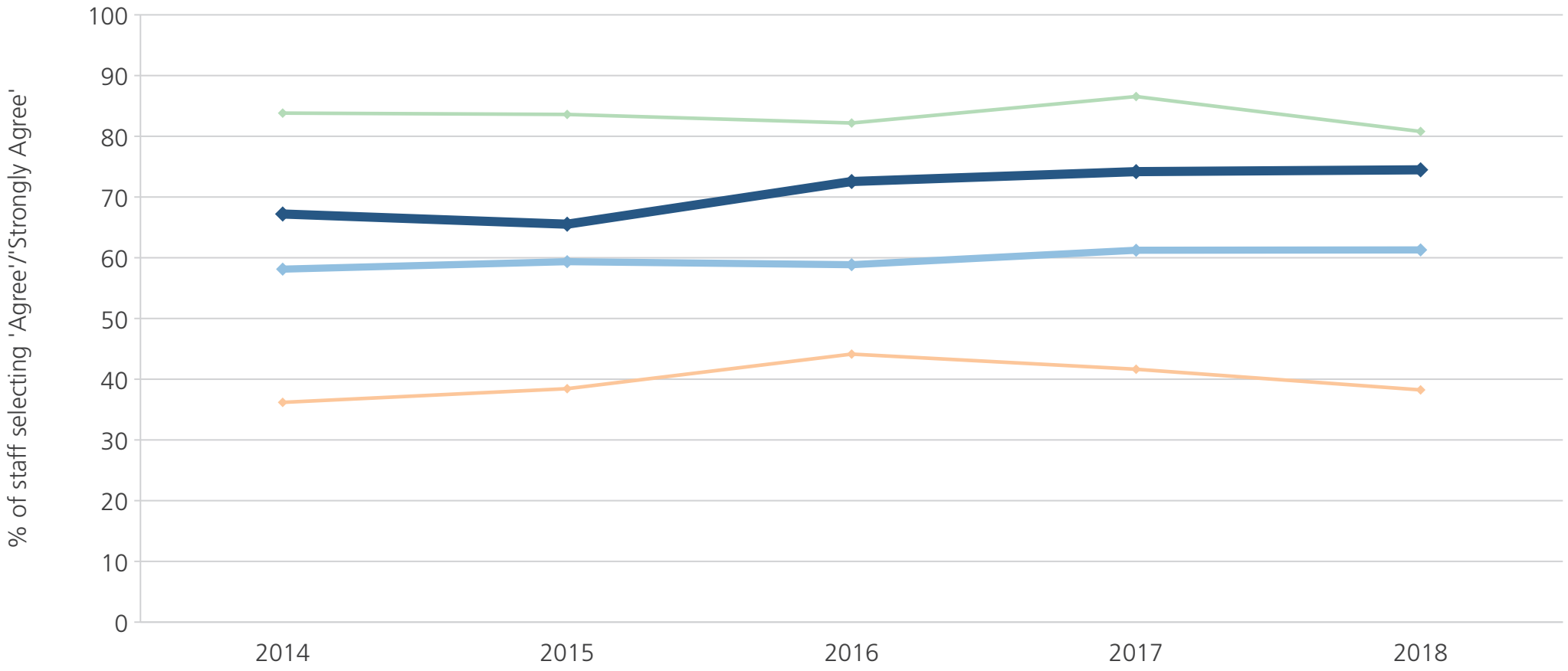
	2014	2015	2016	2017	2018
Best	88.1%	84.2%	82.3%	87.1%	83.9%
Your org	61.0%	75.4%	77.0%	77.7%	78.5%
Average	65.1%	70.8%	72.6%	73.2%	74.3%
Worst	43.9%	52.2%	56.4%	58.4%	59.0%
No. responses	341	290	764	900	846



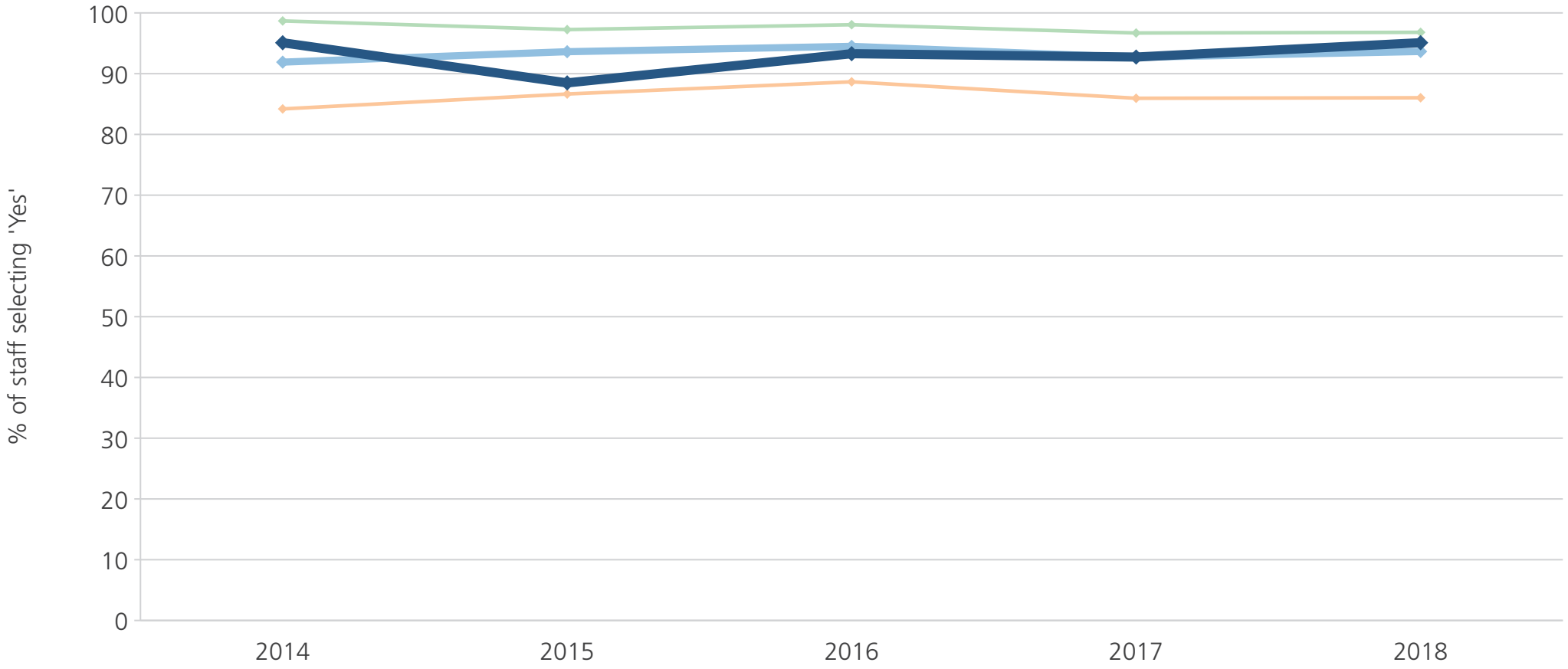
	2014	2015	2016	2017	2018
Best	85.4%	87.3%	83.4%	86.0%	82.3%
Your org	68.7%	77.7%	77.8%	77.0%	78.6%
Average	71.2%	72.6%	73.7%	74.9%	73.8%
Worst	50.1%	56.5%	58.1%	57.5%	59.4%
No. responses	341	291	762	901	841



	2014	2015	2016	2017	2018
Best	70.3%	73.2%	69.2%	72.5%	71.8%
Your org	56.1%	63.5%	68.1%	68.4%	71.8%
Average	54.0%	56.1%	55.9%	57.0%	61.1%
Worst	33.1%	34.5%	40.6%	40.0%	44.0%
No. responses	340	291	763	900	845

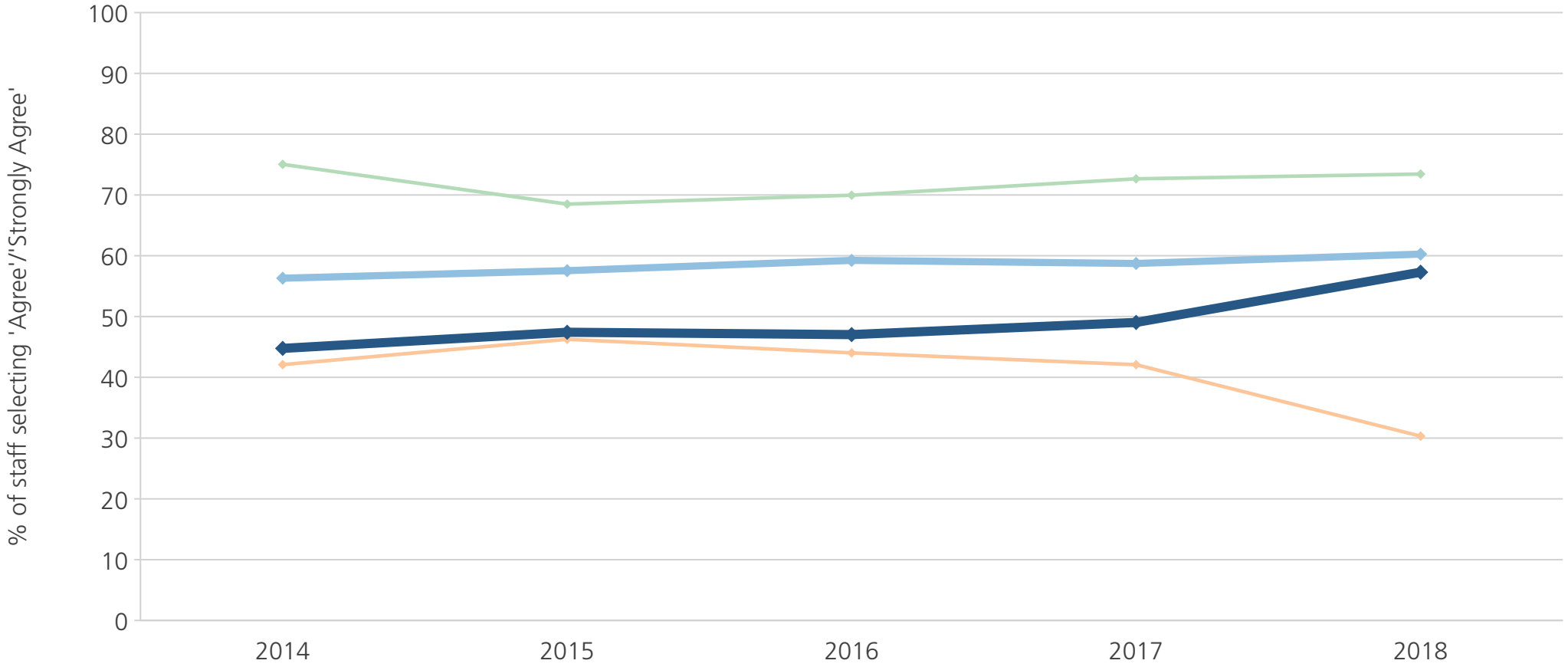


	2014	2015	2016	2017	2018
Best	83.8%	83.6%	82.2%	86.5%	80.8%
Your org	67.2%	65.5%	72.6%	74.2%	74.5%
Average	58.1%	59.4%	58.9%	61.2%	61.3%
Worst	36.2%	38.4%	44.1%	41.6%	38.2%
No. responses	341	288	762	901	844



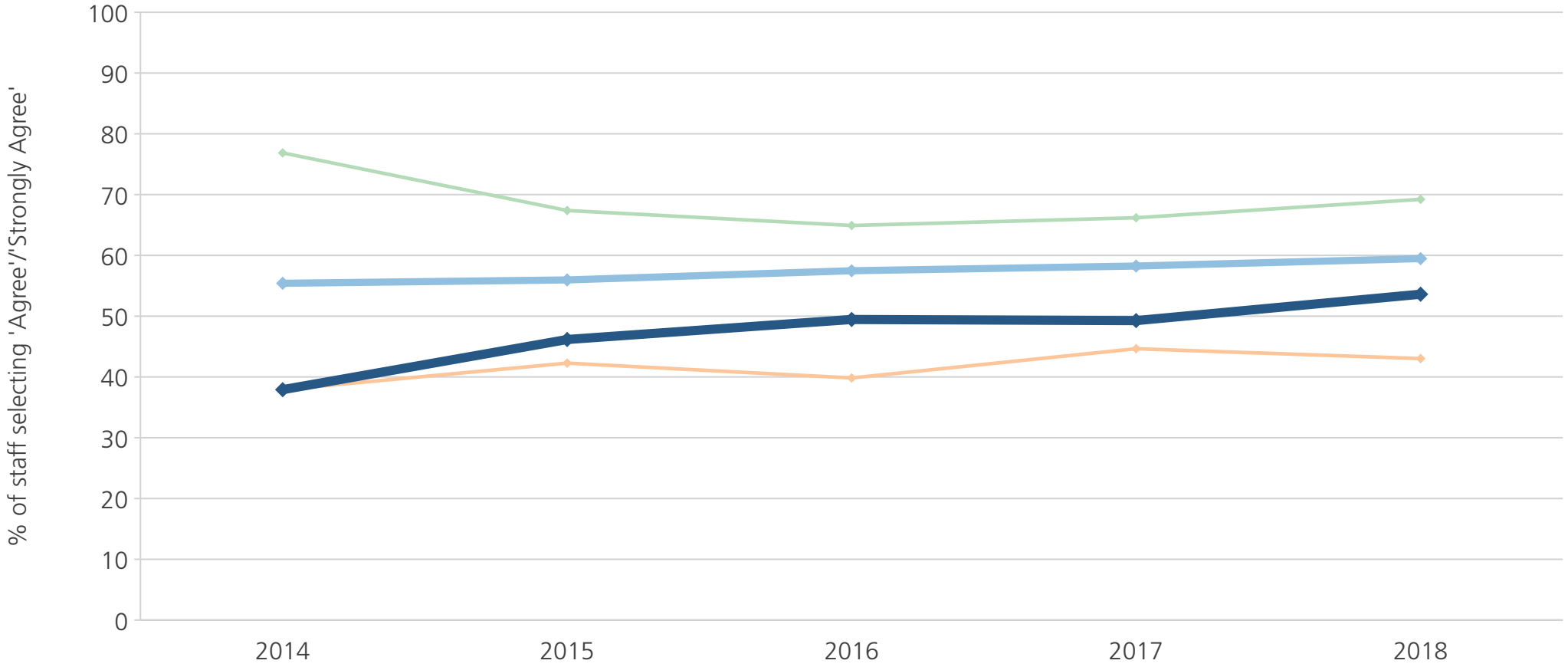
	2014	2015	2016	2017	2018
Best	98.7%	97.3%	98.1%	96.7%	96.8%
Your org	95.1%	88.5%	93.3%	92.7%	95.1%
Average	91.9%	93.6%	94.5%	92.7%	93.6%
Worst	84.2%	86.6%	88.7%	85.9%	86.0%
No. responses	259	222	562	666	620

Note: This question was only answered by staff who selected 'Yes' on q22a.

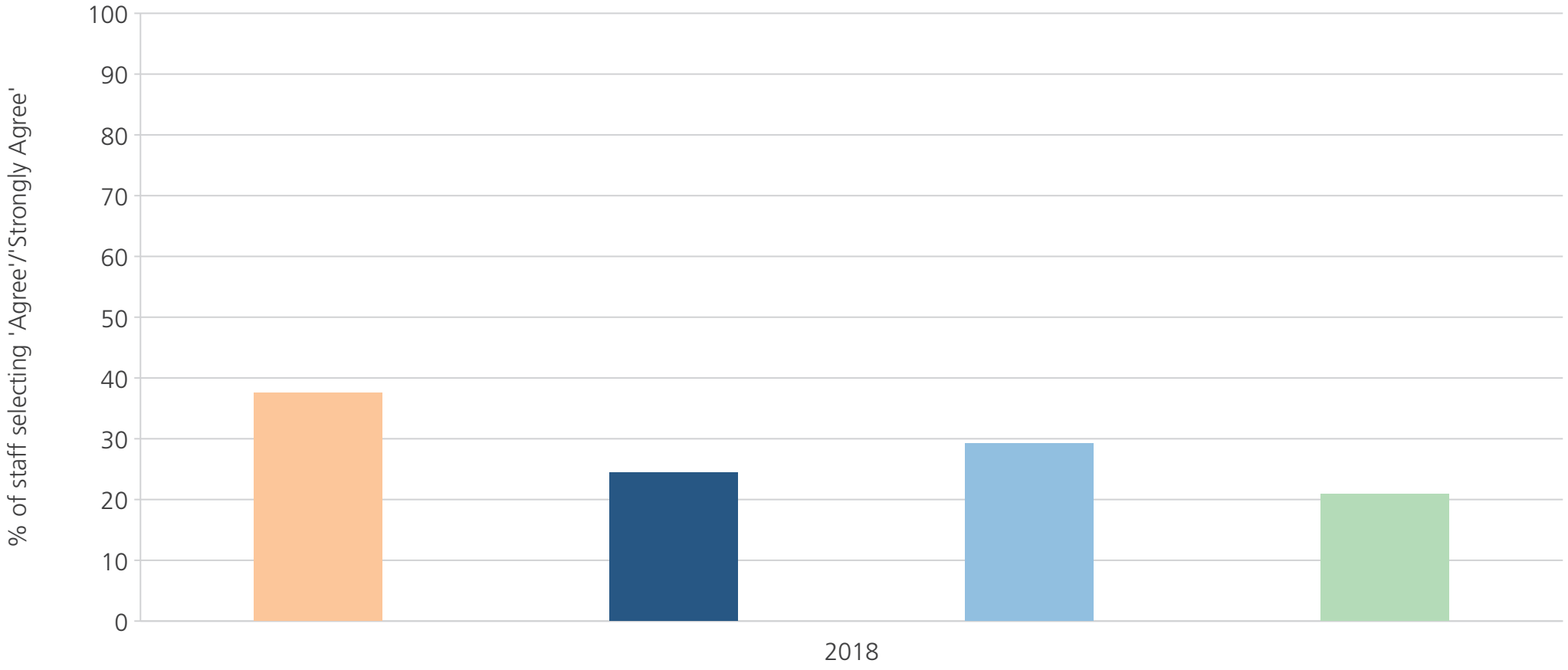


	2014	2015	2016	2017	2018
Best	75.0%	68.5%	70.0%	72.7%	73.4%
Your org	44.8%	47.4%	47.0%	49.0%	57.3%
Average	56.3%	57.5%	59.2%	58.7%	60.3%
Worst	42.1%	46.3%	44.0%	42.1%	30.3%
No. responses	235	185	493	584	551

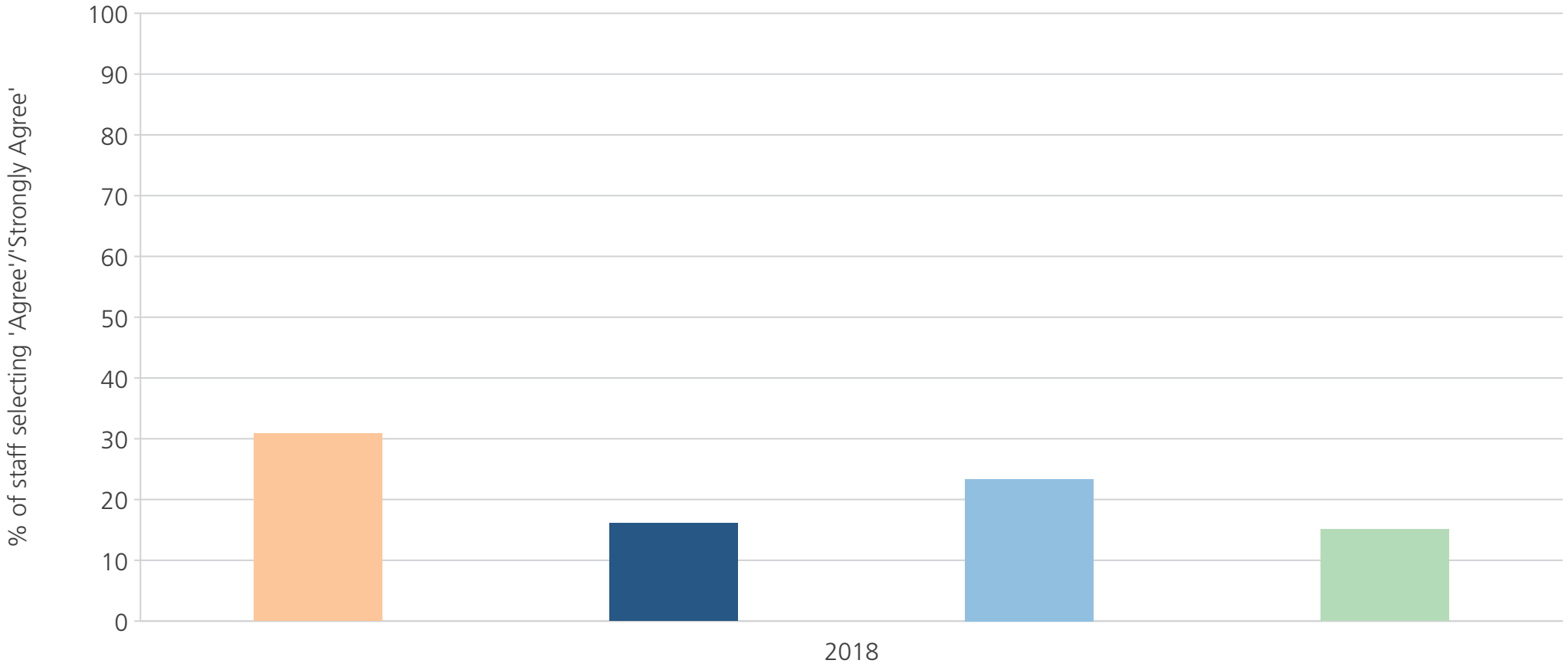
Note: This question was only answered by staff who selected 'Yes' on q22a.



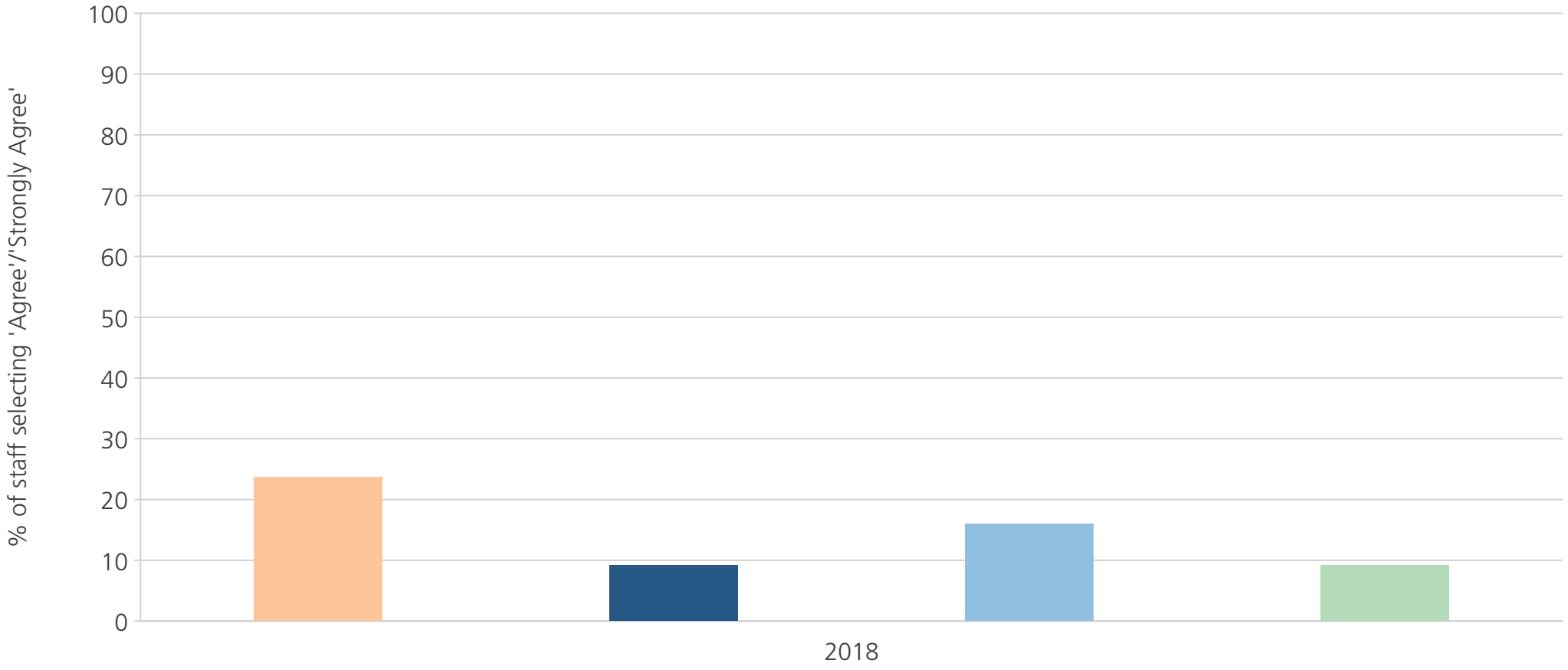
	2014	2015	2016	2017	2018
Best	76.9%	67.4%	64.9%	66.2%	69.2%
Your org	37.9%	46.2%	49.5%	49.3%	53.6%
Average	55.4%	56.0%	57.5%	58.2%	59.5%
Worst	37.9%	42.3%	39.8%	44.6%	43.0%
No. responses	212	162	440	525	499



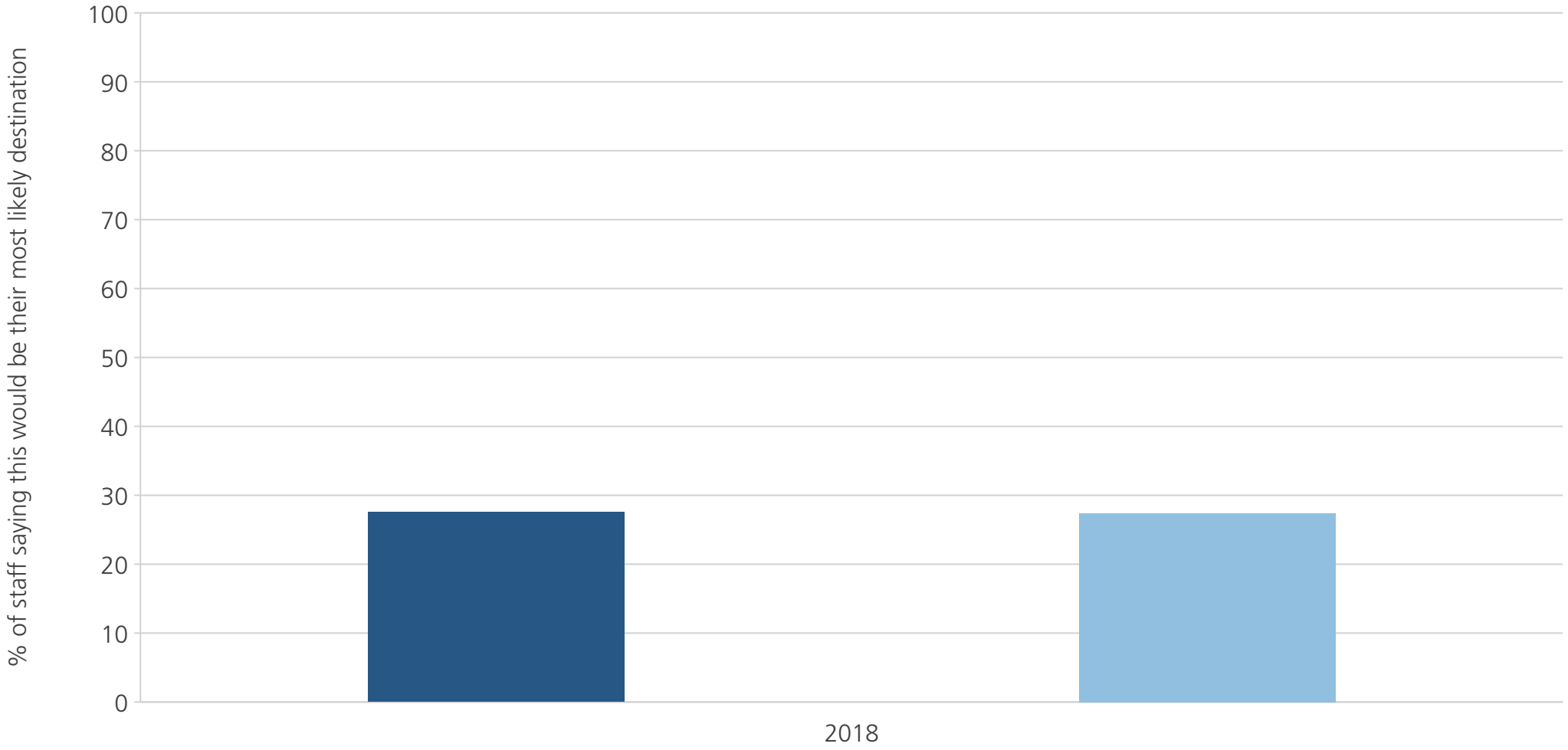
Worst	37.6%
Your org	24.4%
Average	29.2%
Best	20.9%
No. responses	846



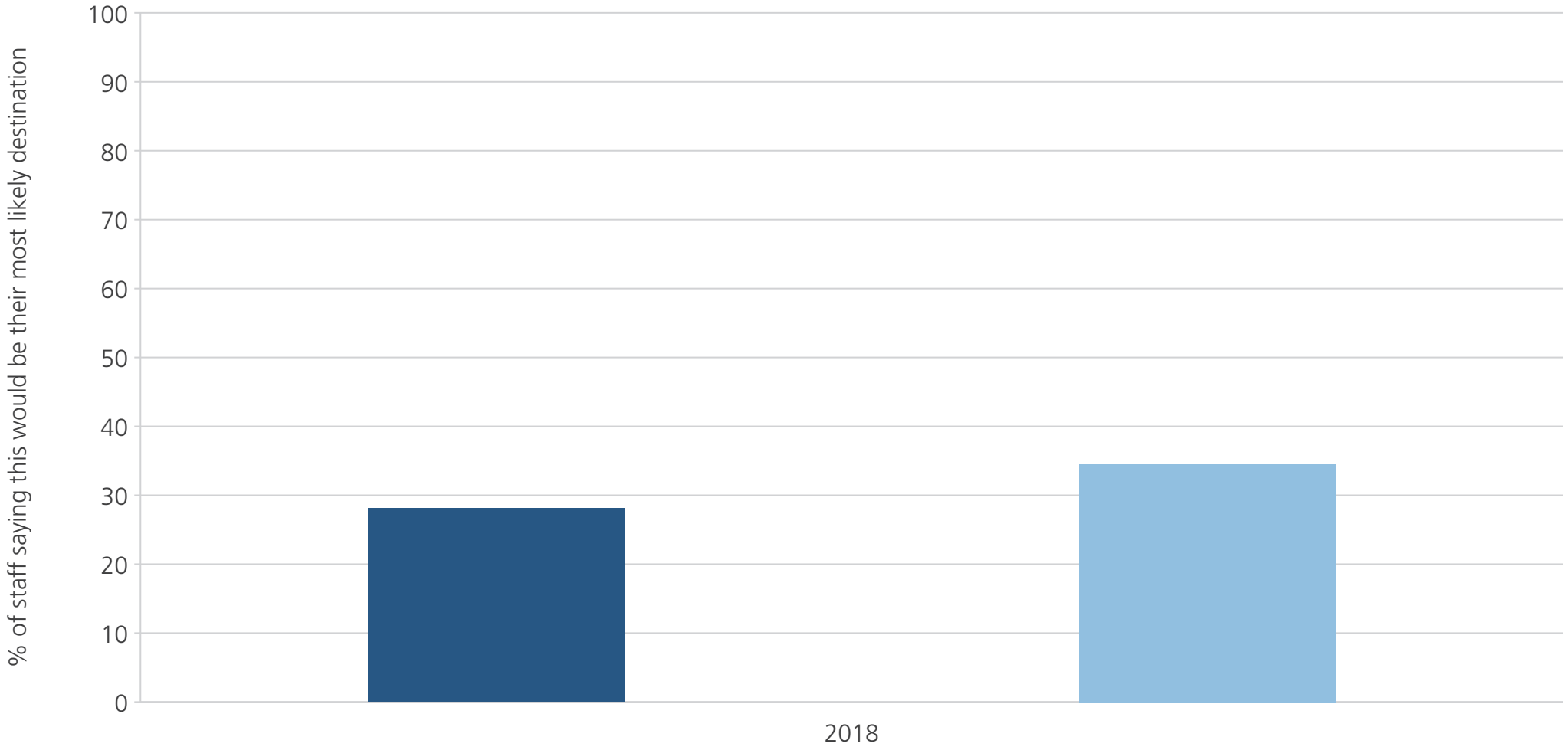
Worst	30.9%
Your org	16.1%
Average	23.3%
Best	15.1%
No. responses	847



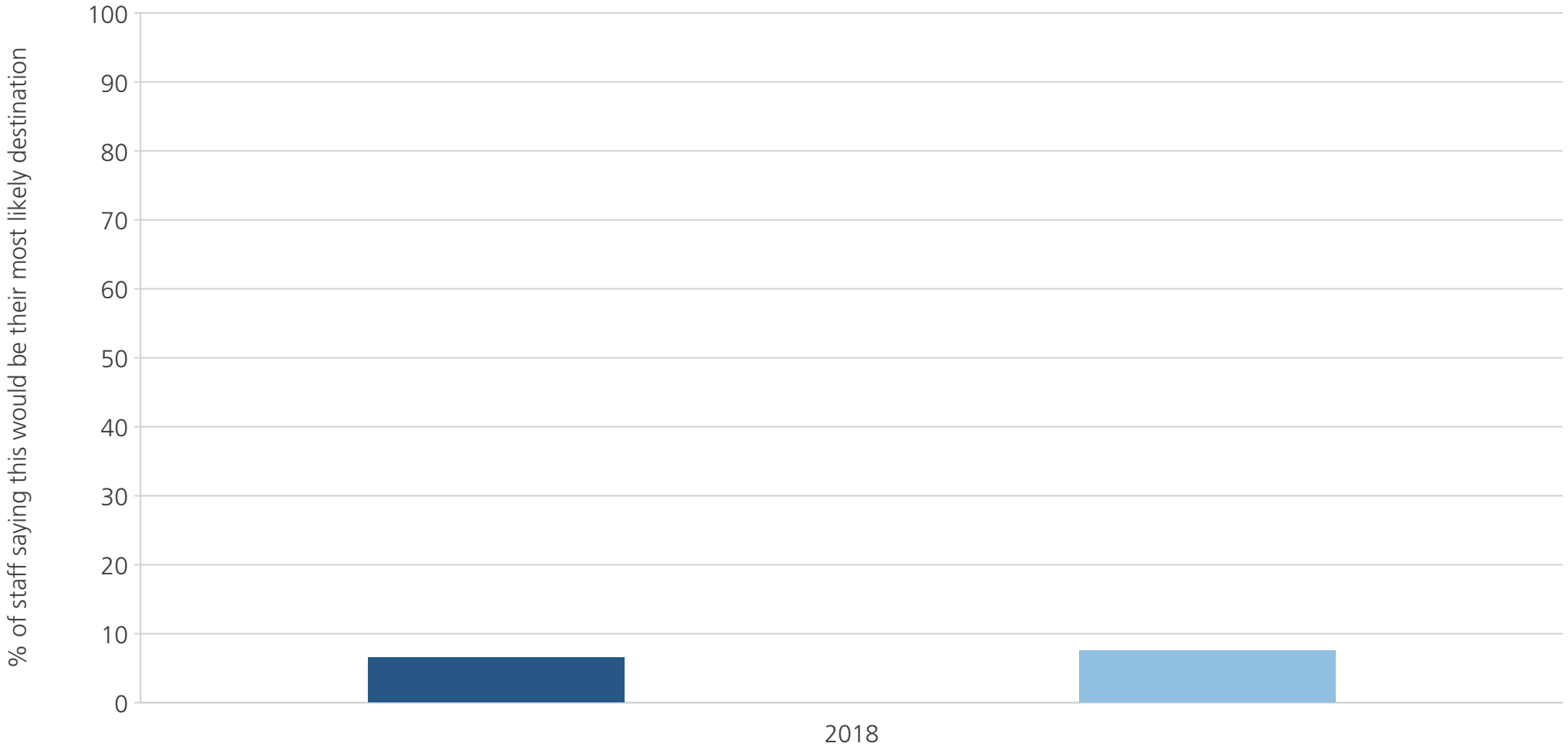
Worst	23.7%
Your org	9.1%
Average	15.9%
Best	9.1%
No. responses	846



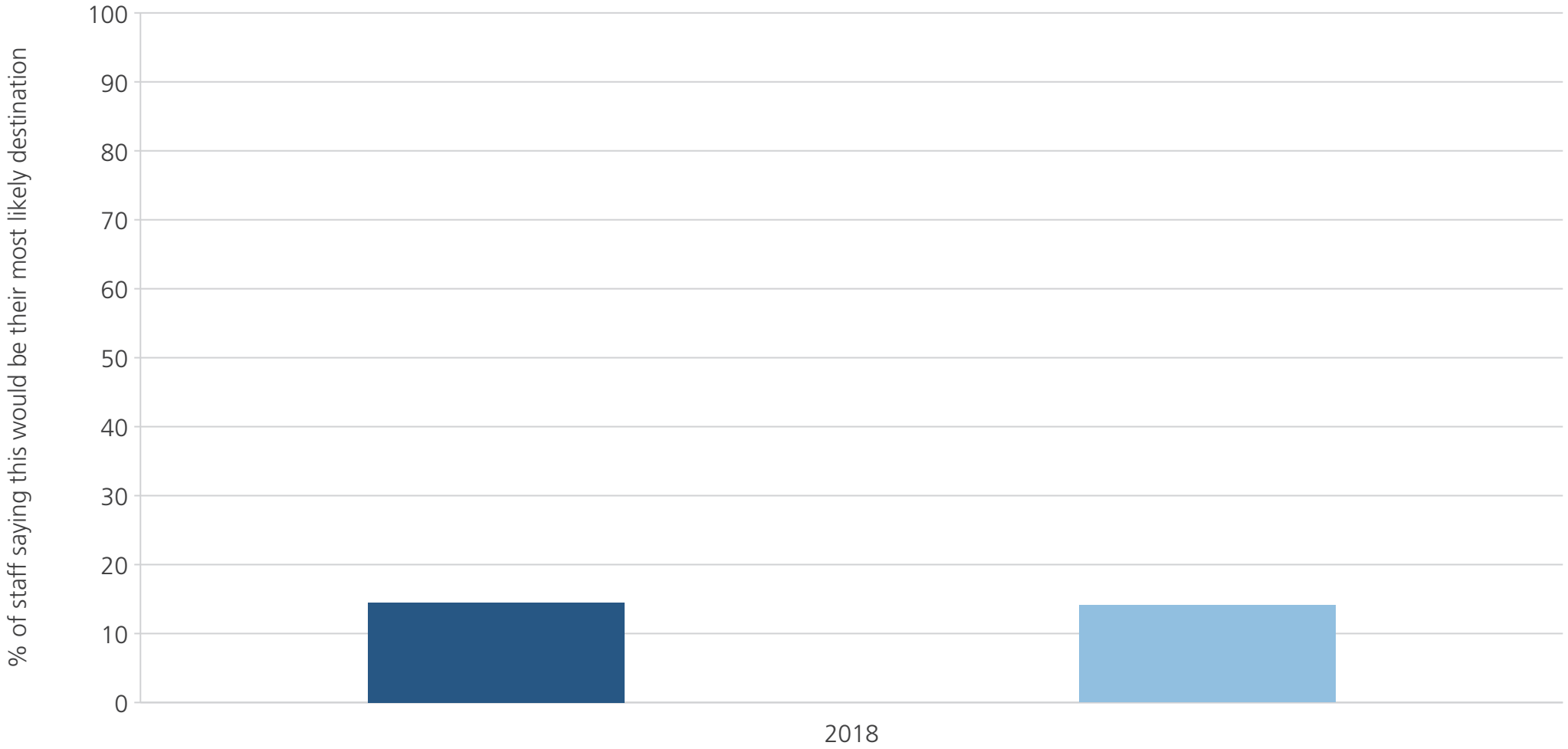
	2018
Your org	27.6%
Average	27.4%
No. responses	352



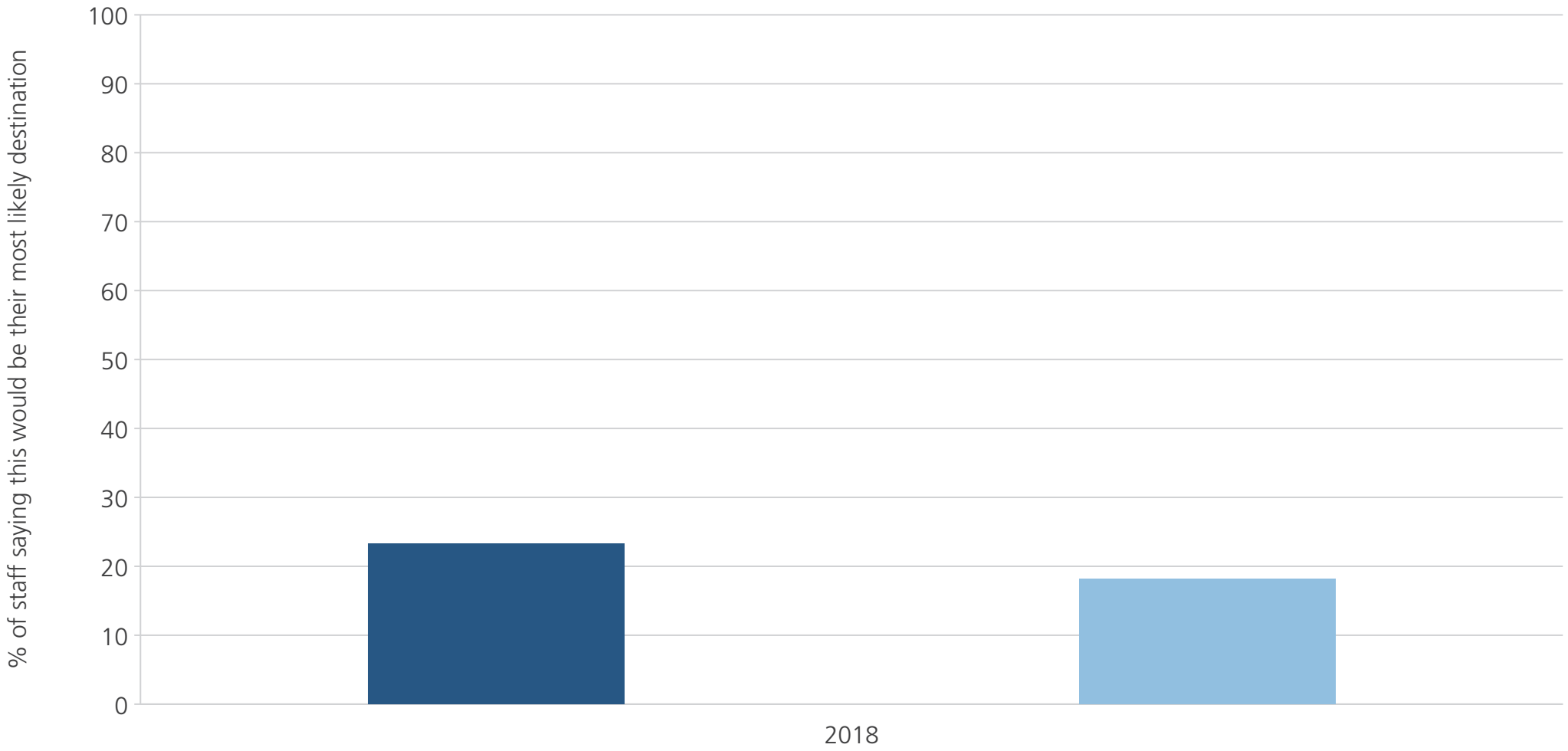
Your org	28.1%
Average	34.5%
No. responses	352



	2018
Your org	6.5%
Average	7.6%
No. responses	352



	2018
Your org	14.5%
Average	14.1%
No. responses	352



	2018
Your org	23.3%
Average	18.2%
No. responses	352

Survey Coordination Centre

NHS England

Question results – Background details

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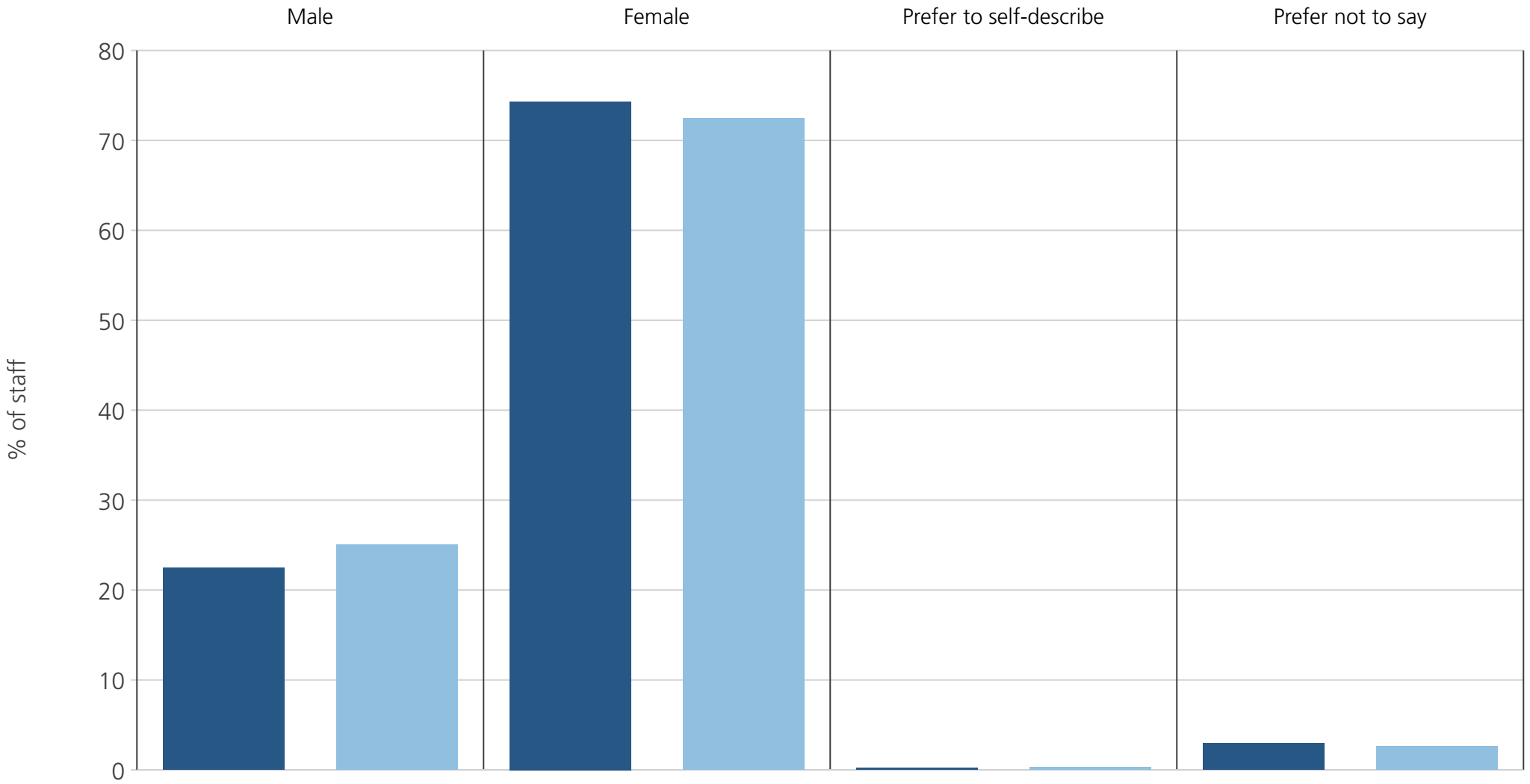
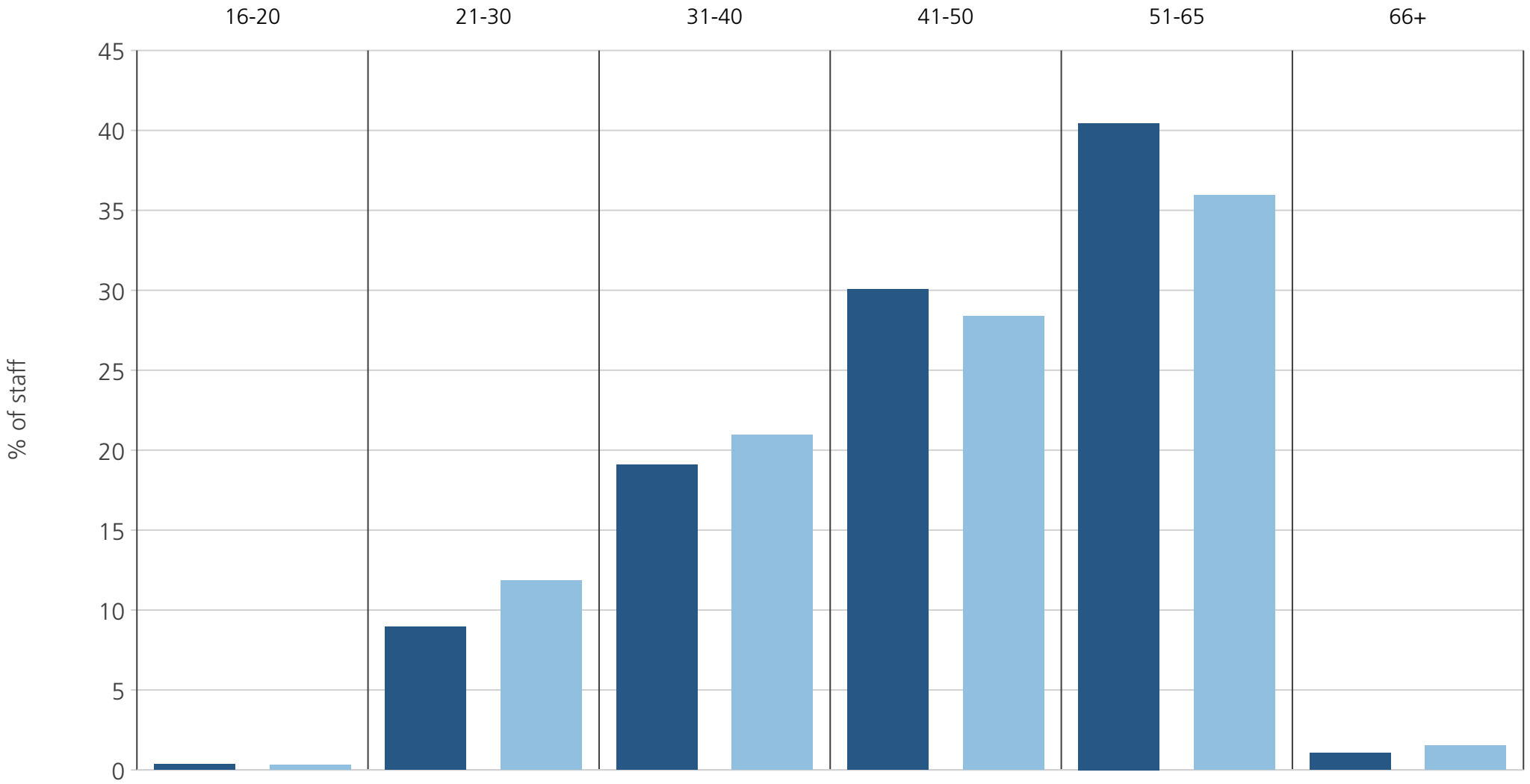
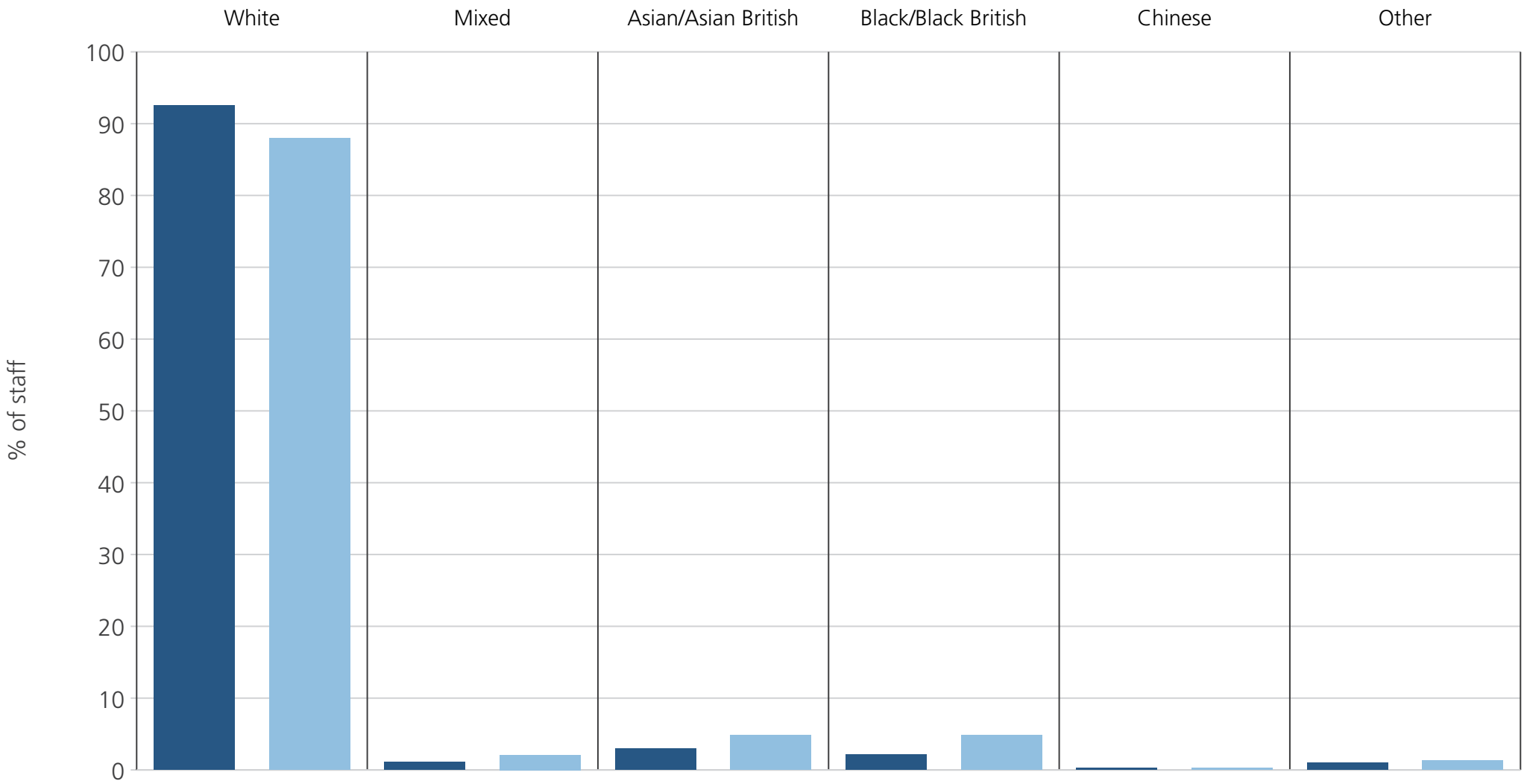
2018 NHS Staff Survey Results



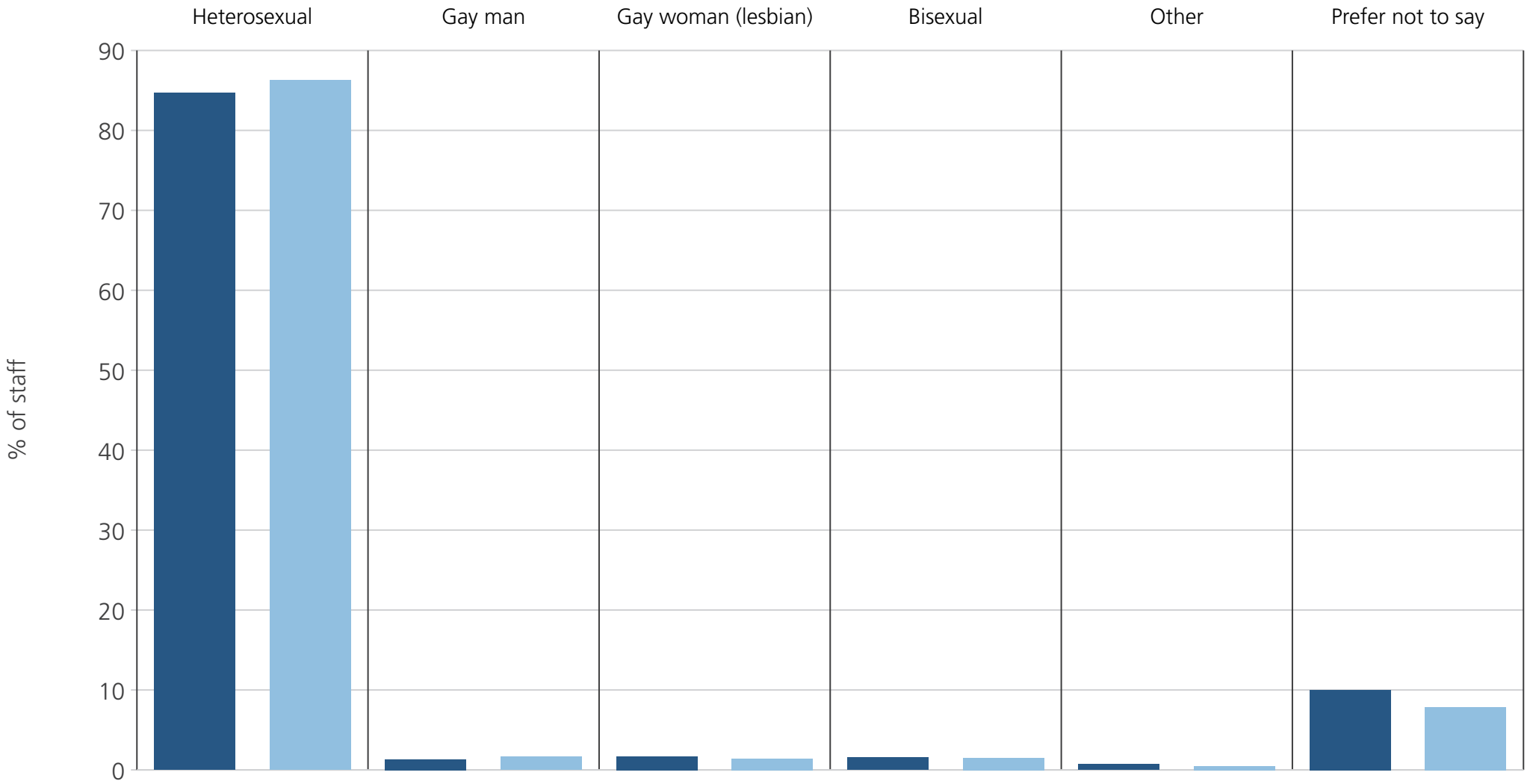
	Male	Female	Prefer to self-describe	Prefer not to say
Your org	22.5%	74.3%	0.2%	3.0%
Average	25.0%	72.5%	0.3%	2.6%
No. responses	841	841	841	841



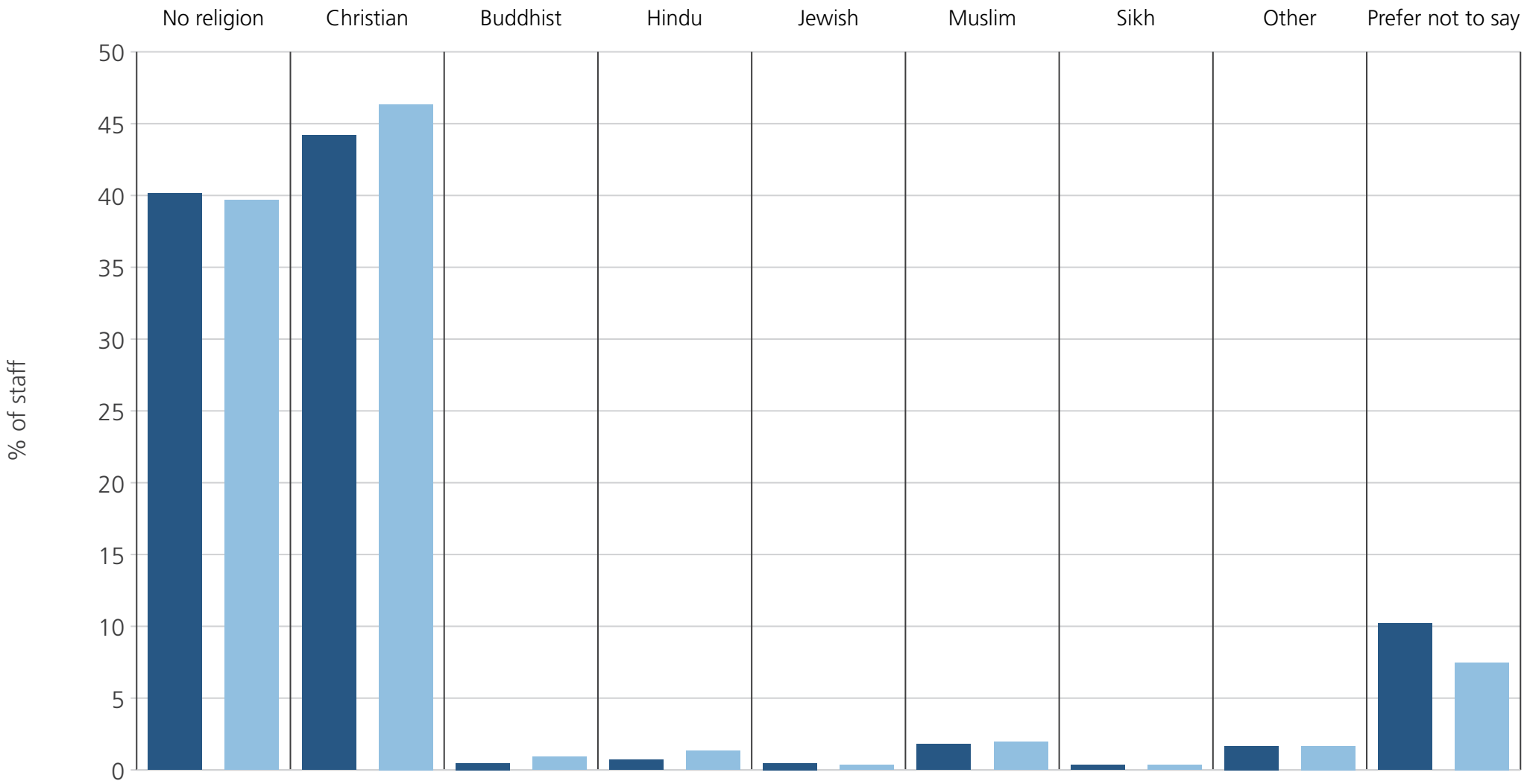
	16-20	21-30	31-40	41-50	51-65	66+
Your org	0.4%	8.9%	19.1%	30.1%	40.5%	1.1%
Average	0.3%	11.9%	21.0%	28.4%	35.9%	1.5%
No. responses	838	838	838	838	838	838



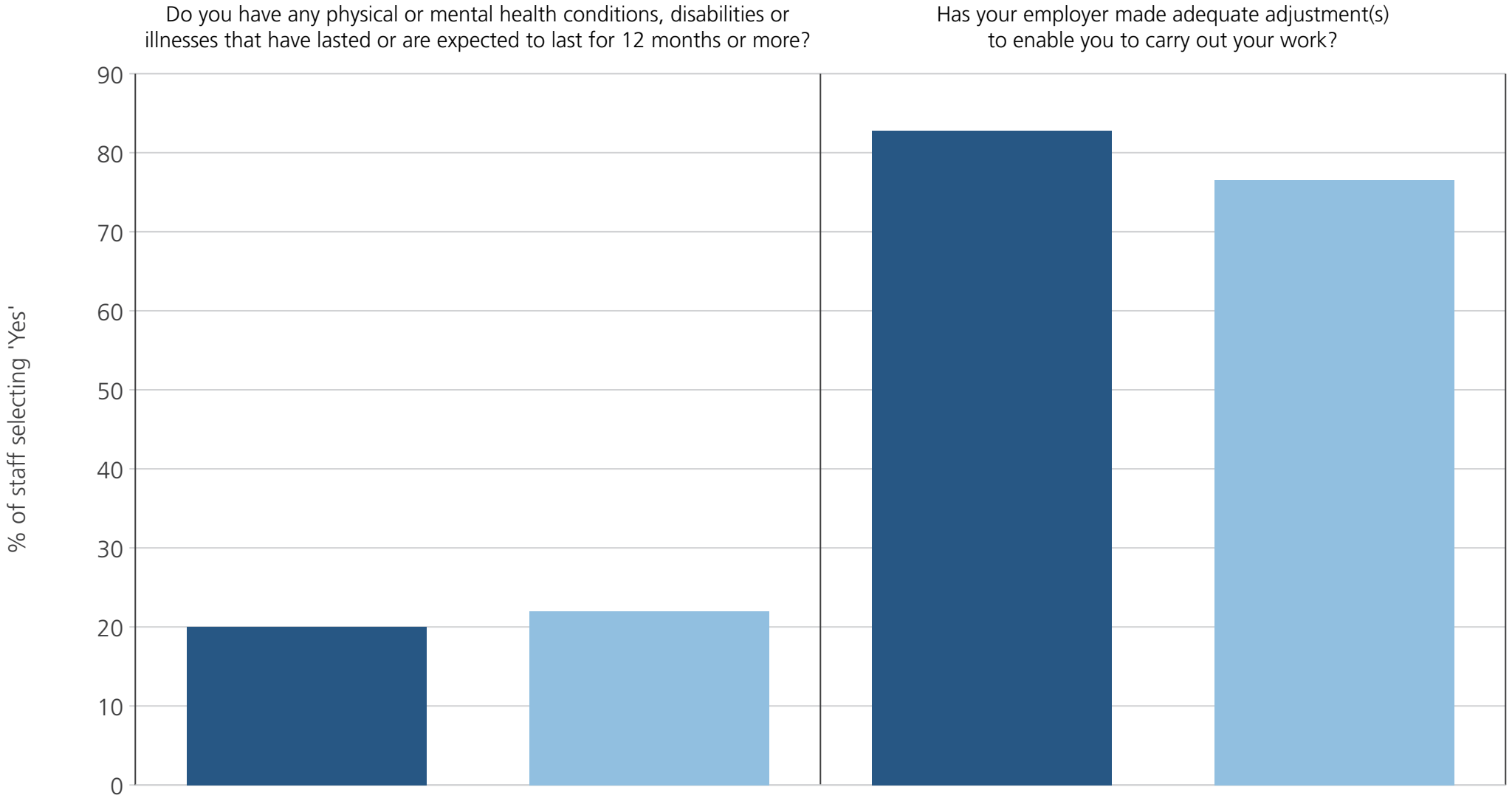
	White	Mixed	Asian/Asian British	Black/Black British	Chinese	Other
Your org	92.6%	1.1%	3.0%	2.2%	0.2%	1.0%
Average	87.9%	2.1%	4.8%	4.8%	0.3%	1.3%
No. responses	834	834	834	834	834	834



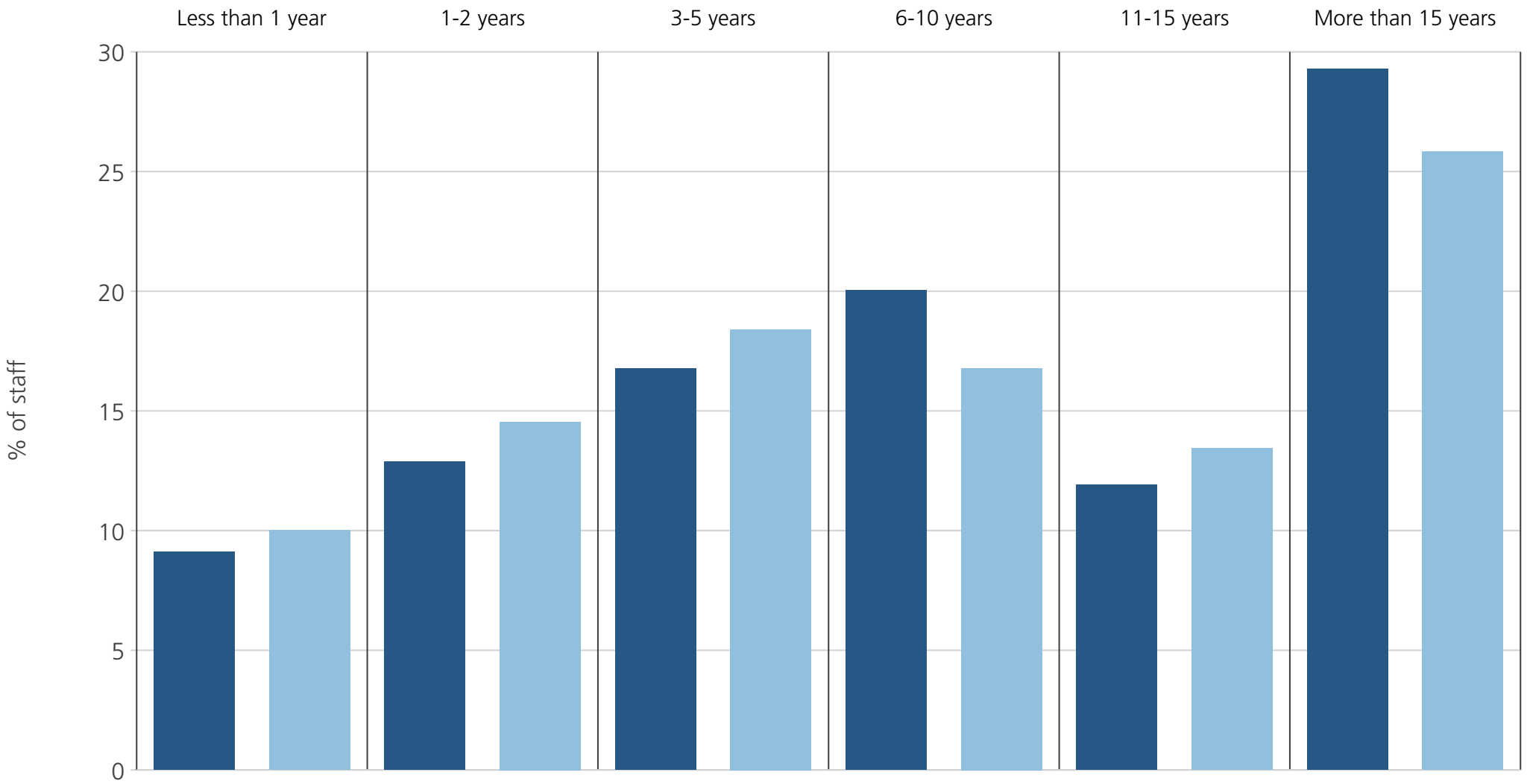
	Heterosexual	Gay man	Gay woman (lesbian)	Bisexual	Other	Prefer not to say
Your org	84.7%	1.3%	1.7%	1.6%	0.7%	10.0%
Average	86.3%	1.7%	1.4%	1.5%	0.5%	7.8%
No. responses	830	830	830	830	830	830



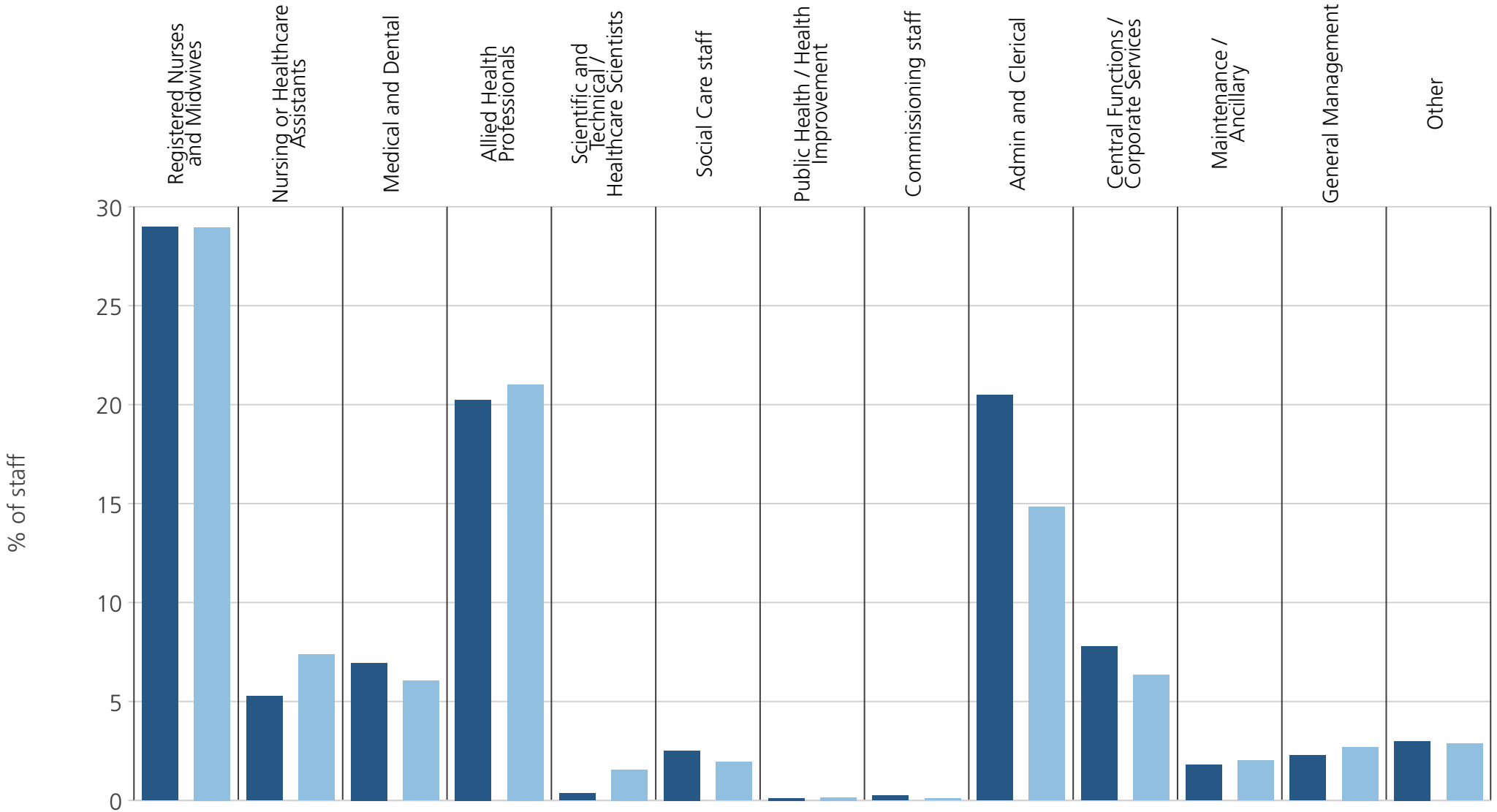
	No religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other	Prefer not to say
Your org	40.1%	44.2%	0.5%	0.7%	0.5%	1.8%	0.4%	1.7%	10.2%
Average	39.7%	46.4%	0.9%	1.3%	0.3%	2.0%	0.4%	1.7%	7.5%
No. responses	842	842	842	842	842	842	842	842	842



	Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more?	Has your employer made adequate adjustment(s) to enable you to carry out your work?
Your org	20.0%	82.8%
Average	22.0%	76.5%
No. responses	839	97

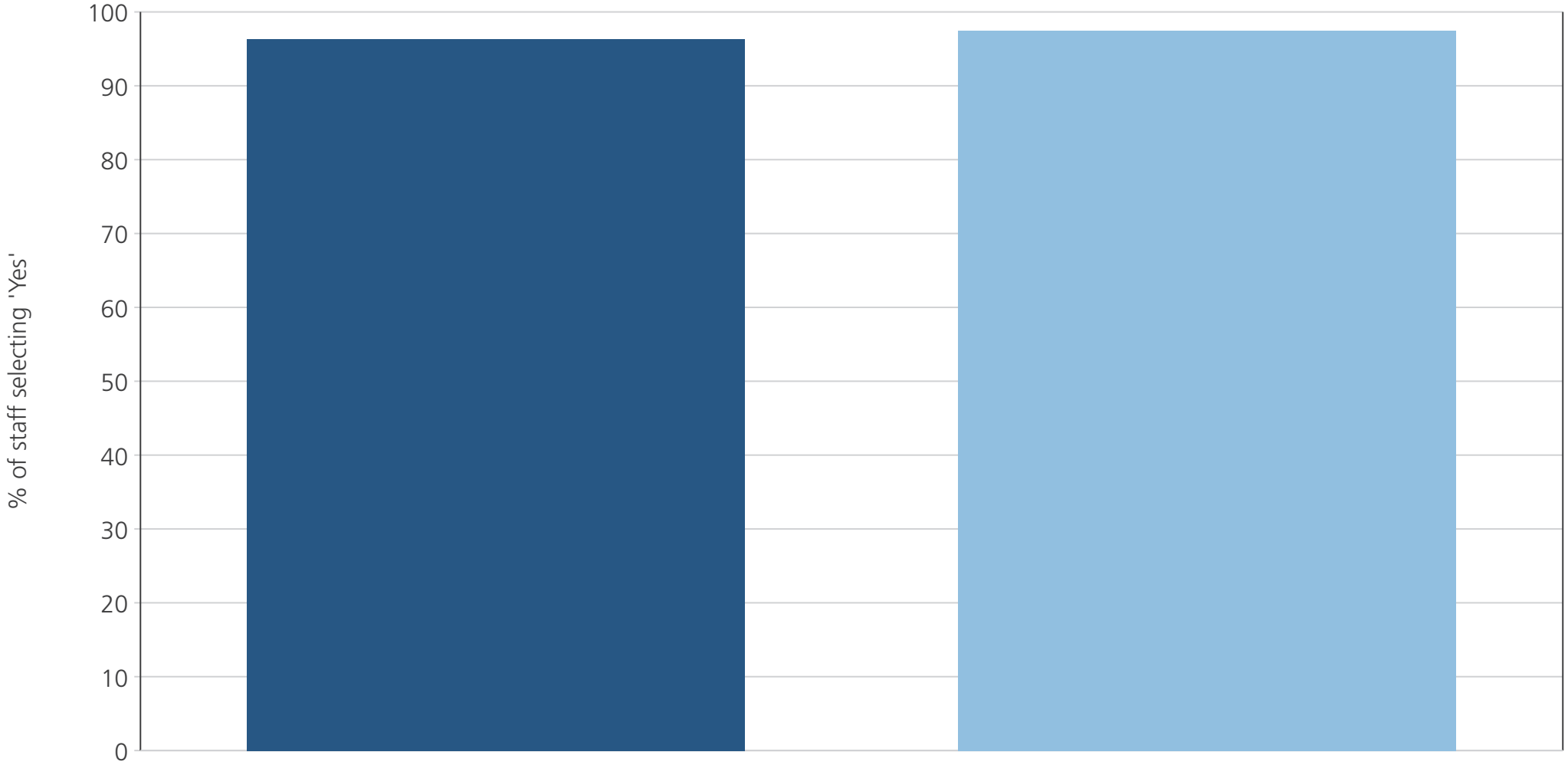


	Less than 1 year	1-2 years	3-5 years	6-10 years	11-15 years	More than 15 years
Your org	9.1%	12.9%	16.8%	20.0%	11.9%	29.3%
Average	10.0%	14.5%	18.4%	16.8%	13.4%	25.8%
No. responses	823	823	823	823	823	823

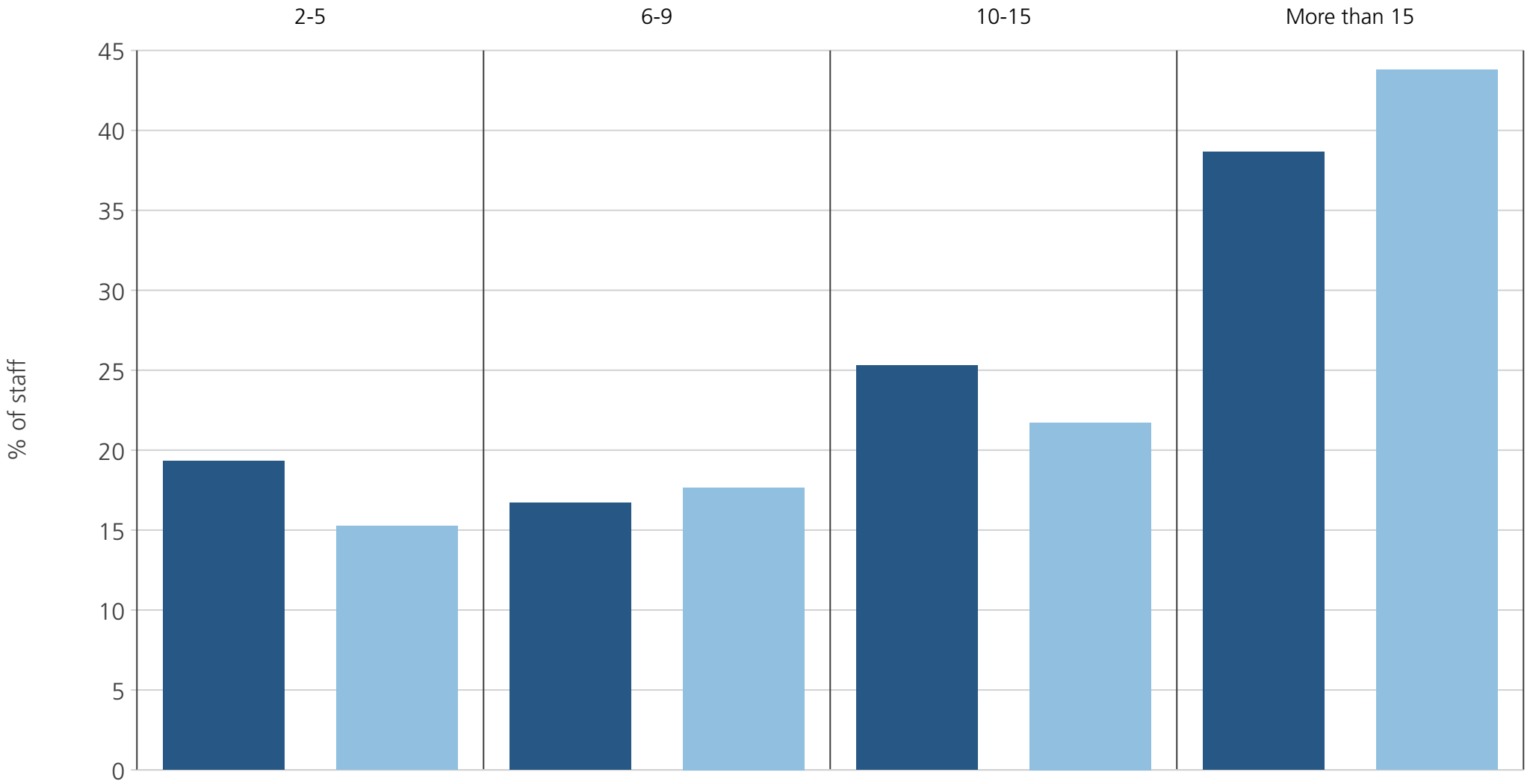


	Registered Nurses and Midwives	Nursing or Healthcare Assistants	Medical and Dental	Allied Health Professionals	Scientific and Technical / Healthcare Scientists	Social Care staff	Public Health / Health Improvement	Commissioning staff	Admin and Clerical	Central Functions / Corporate Services	Maintenance / Ancillary	General Management	Other
Your org	29.0%	5.3%	6.9%	20.2%	0.4%	2.5%	0.1%	0.2%	20.5%	7.8%	1.8%	2.3%	3.0%
Average	29.0%	7.4%	6.0%	21.0%	1.6%	1.9%	0.2%	0.1%	14.8%	6.3%	2.0%	2.7%	2.9%
No. responses	835	835	835	835	835	835	835	835	835	835	835	835	835

Do you work in a team?



Your org	96.3%
Average	97.5%
No. responses	843



	2-5	6-9	10-15	More than 15
Your org	19.3%	16.7%	25.3%	38.7%
Average	15.3%	17.7%	21.7%	43.8%
No. responses	802	802	802	802

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Appendices

2Gether NHS Foundation Trust

2018 NHS Staff Survey Results

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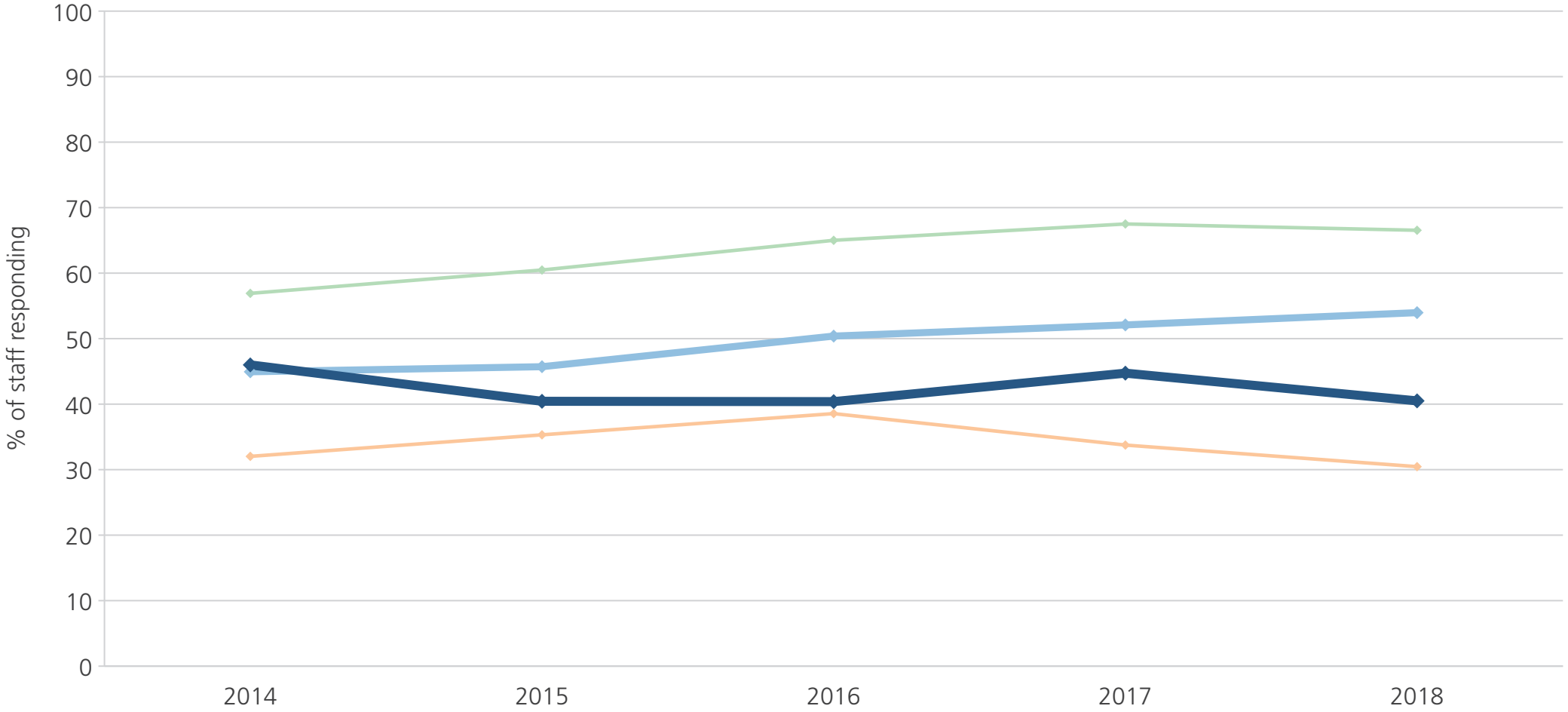
Appendix A: Response rate

2Gether NHS Foundation Trust

2018 NHS Staff Survey Results



	2014	2015	2016	2017	2018
Best	56.9%	60.5%	65.0%	67.5%	66.5%
Your org	46.0%	40.4%	40.4%	44.7%	40.5%
Average	44.9%	45.7%	50.4%	52.1%	54.0%
Worst	32.0%	35.3%	38.6%	33.8%	30.5%

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Appendix B: Significance testing - 2017 v 2018 theme results

2Gether NHS Foundation Trust

2018 NHS Staff Survey Results

The table below presents the results of significance testing conducted on this year's theme scores and those from last year*. It details the organisation's theme scores for both years and the number of responses each of these are based on.

The final column contains the outcome of the significance testing: ↑ indicates that the 2018 score is significantly higher than last year's, whereas ↓ indicates that the 2018 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

Theme	2017 score	2017 respondents	2018 score	2018 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.3**	903	**9.2**	851	Not significant
Health & wellbeing	**6.1**	911	**6.2**	855	Not significant
Immediate managers	**7.4**	911	**7.5**	857	Not significant
Morale		0	**6.6**	845	N/A
Quality of appraisals	**5.4**	803	**5.4**	741	Not significant
Quality of care	**7.3**	723	**7.3**	672	Not significant
Safe environment - Bullying & harassment	**8.1**	904	**8.0**	849	Not significant
Safe environment - Violence	**9.5**	907	**9.4**	845	Not significant
Safety culture	**6.8**	910	**6.9**	852	Not significant
Staff engagement	**7.2**	918	**7.2**	862	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

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Appendix C: Tips on using your benchmark report

2Gether NHS Foundation Trust

2018 NHS Staff Survey Results

Data in the new benchmark reports

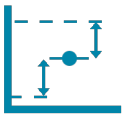
The following pages include tips on how to read, interpret and use the data in this report. The **suggestions are aimed at users who would like some guidance on how to understand the data** in this report. These suggestions are by no means the only way to analyse or use the data, but have been included to aid users transitioning from the previous version of the benchmark report and those who are new to the Staff Survey.

Key changes to note

There are a number of differences in this benchmark report compared to the old style of benchmark reports, that was used prior to the 2018 survey, which are worth noting

- Key Findings have been replaced by themes. The themes cover ten areas of staff experience and present results in these areas in a clear and consistent way. All of the ten themes are scored on a 0-10 scale, where a higher score is more positive than a lower score. These theme scores are created by scoring question results and grouping these results together. **Please note that you cannot directly compare Key Finding results to theme results.**

- A key feature of the new reports is that they **provide organisations with up to 5 years of trend data** across theme **and** question results. Trend data provides a much **more reliable indication of whether the most recent results represent a change from the norm** for an organisation than comparing the most recent results to those from the previous year. Taking a longer term view will help organisations to identify trends over several years that may have been missed when comparisons were drawn solely between the current and previous year.



- **Question results are now benchmarked** so that organisations can make comparisons to their peers on specific areas of staff experience. Question results provide organisations with more granular data that will help them to identify particular areas of concern. This benchmarking has been extended to the trend data that is available so that organisations can identify how results on each question have changed for themselves and their peers over time by looking at a single graph.

1. Reviewing theme results

When analysing theme results, it is easiest to start with the **theme overview** page to quickly identify areas which are doing better or worse in comparison to other organisations in the given benchmarking group.

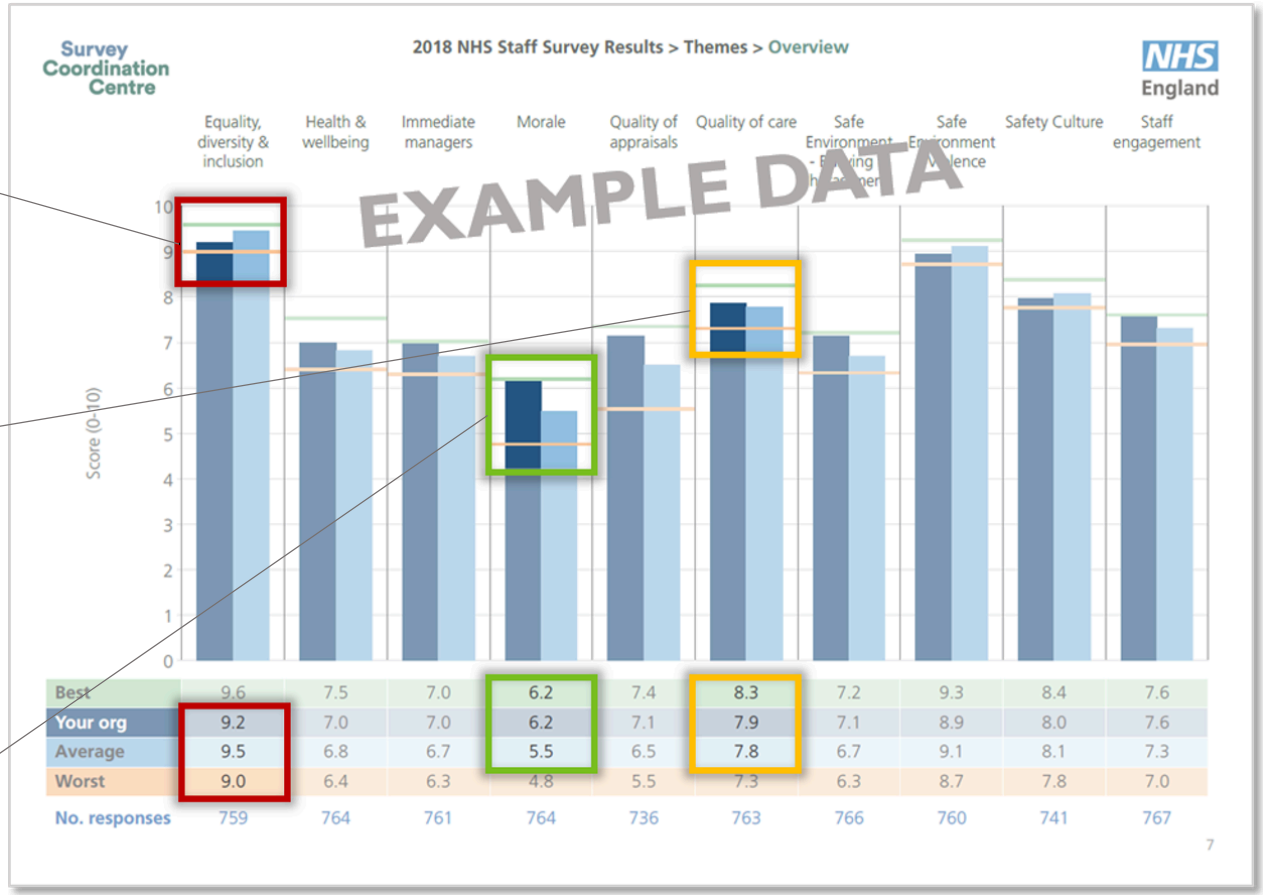
It is important to **consider each theme result within the range of its benchmarking group 'Best' and 'Worst' scores**, rather than comparing theme scores to one another. Comparing organisation scores to the benchmarking group average is another important point of reference.

Areas to improve

- By checking where the 'Your org' column/value is lower than the benchmarking group 'Average' you can quickly identify areas for improvement.
- It is worth looking at the difference between the 'Your org' result and the benchmarking group 'Worst' score. The closer your organisation's result is to the worst score, the more concerning the result.
- Results where your organisation's score is only marginally better than the 'Average', but still lags behind the best result by a notable margin, could also be considered as areas for further improvement.

Positive outcomes

- Similarly, using the overview page it is easy to identify themes which show a positive outcome for your organisation, where 'Your org' scores are distinctly higher than the benchmarking group 'Average' score.



Only one example is highlighted for each point

- Positive stories to report could be ones where your organisation approaches or matches the benchmarking group's 'Best' score.

2. Reviewing theme results in more detail

Review trend data

Trend data can be used to identify measures which have been consistently improving for your organisation (i.e. showing an upward trend) over the past years and ones which have been declining over time. These charts can **help establish if there is genuine change in the results** (if the results are consistently improving or declining over time), or whether a change between years is just a minor **year-on-year** fluctuation.

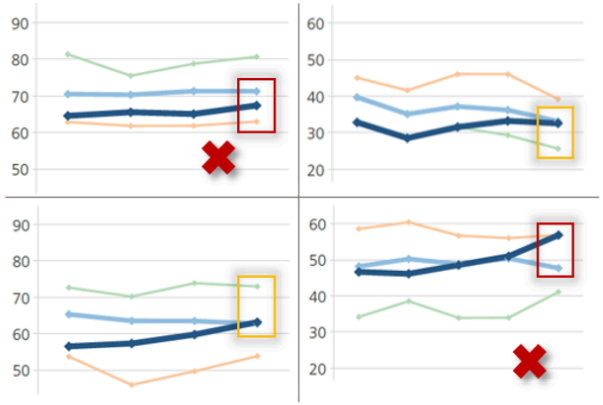
	2014	2015	2016	2017	2018
Best	6.3	6.5	6.3	6.3	6.2
Your org	5.7	5.8	5.8	6.0	6.2
Average	5.8	5.7	5.8	5.6	5.5
Worst	4.7	4.8	4.4	4.8	4.8
No. responses	344	803	668	738	764

Benchmarked trend data also allows you to review local changes and benchmark comparisons at the same time, allowing for various types of questions to be considered: e.g. how have the results for my organisation changed over time? Is my organisation improving faster than our peers?

Review questions feeding into the themes

In order to understand exactly which factors are driving your organisation's theme score, you should review the questions feeding into the theme. The **'Detailed information'** section contains the questions contributing to each theme, grouped together, thus they can be reviewed easily without the need to search through the 'Question results' section. By comparing 'Your org' scores to the benchmarking group 'Average', 'Best' and 'Worst' scores for each question, the **questions which are driving your organisation's theme results can be identified**.

For themes where results need improvement, action plans can be formulated to **focus on the areas where the organisation's results fall between the benchmarking group average and worst results**. Remember to keep an eye out for questions where a lower percentage is a better outcome – such as questions on violence or harassment, bullying and abuse.



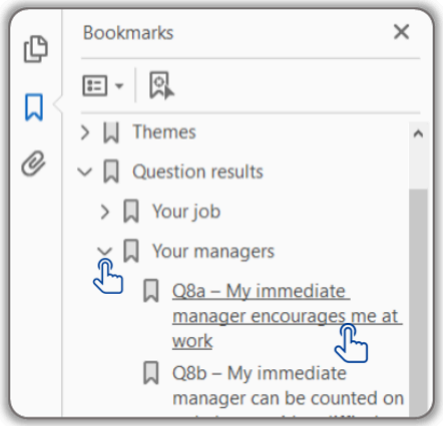
✖ = Negative driver, org result falls between average & worst benchmarking group result for question

3. Reviewing question results

This benchmark report displays results for all questions in the questionnaire, including benchmarked trend data wherever available. While this a key feature of the report, at first glance the amount of information contained on more than 110 pages might appear daunting. The below suggestions aim to provide some guidance on how to get started with navigating through this set of data.

Identifying questions of interest

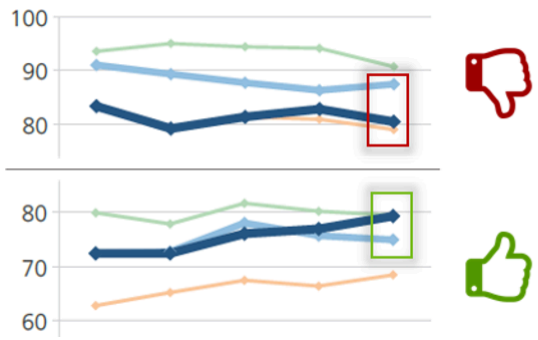
Use the bookmarks bar to navigate directly to questions of interest



- **Pre-defined questions of interest – key questions for your organisation**
  - Most organisations will have questions which have traditionally been a focus for them. Questions which have been targeted with internal policies or programmes, or whose results are of heightened importance due to organisation values or because they are considered a proxy for key issues. Outcomes for these questions can now be assessed on the backdrop of benchmark and historical trend data.
  - **Note:** The bookmarks bar allows for easy navigation through the report, allowing subsections of the report to be folded, for quick access to questions through hyperlinks.

- **Identifying questions of interest based on the results in this report**

  The methods recommended to review your theme results can also be applied to pick out question level results of interest. However, **unlike themes where a higher score always indicates a better result, it is important to keep an eye out for questions where a lower percentage relates to a better outcome** (see details on the 'Using the report' page in the 'Introduction' section).



- [To identify areas of concern]: look for questions where the organisation value falls between the benchmarking group average and the worst score, particularly questions where your organisation result is very close to the worst score. Review changes in the trend data to establish if there has been a decline or stagnation in results across multiple years, but consider the context of how the trust has performed in comparison to its benchmarking group over this period. A positive trend for a question that is still below the average result can be seen as good progress to build on further in the future.
- [When looking for positive outcomes]: search for results where your organisation is closest to the benchmarking group best result (but remember to consider results for previous years), or ones where there is a clear trend of continued improvement over multiple years.

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Appendix D: Additional reporting outputs

2Gether NHS Foundation Trust

2018 NHS Staff Survey Results

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Additional reporting outputs

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Below are links to other key reporting outputs which complement this report. A full list and more detailed explanation of the reporting outputs is included in the Technical Document.

Supporting documents

Basic Guide: Provides a brief overview of the NHS Staff Survey data and details on what is contained in each of the reporting outputs.

Technical Document: Contains technical details about the NHS Staff Survey data, including: data cleaning, weighting, benchmarking, theme/KF calculations, historical comparability of organisations and questions in the survey.

Other local results

Key Finding results spreadsheet: Response rate & KF results for every organisation (2017 & 2018). The results are compared and the difference between years is tested for statistical significance.

Local Breakdowns: Dashboards containing results for each organisation broken down by demographic characteristics. Data is available for up to five years where possible.

Directorate Reports: Reports containing theme results split by directorate (locality) for 2Gether NHS Foundation Trust.

National results

National Trend Data and **National Breakdowns**: Dashboards containing national results – data available for five years where possible.

Agenda item 15 **PAPER I**

Report to: Trust Board, 27 March 2019
Authors: Nick Grubb, Assistant HR Director
Neil Savage, Joint Director of HR & Organisational Development
Presented by:
SUBJECT: 2018 NHS National Staff Survey

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

EXECUTIVE SUMMARY

This report presents a summary of the 2018 Annual Staff Survey which was published on 26th February 2019.

The survey was carried out between October and early December 2018. All staff in post on 1st September 2018 were invited to take part in the confidential online survey. The response rate was 40.5%, down from 44.7% in the previous (2017) survey. The Trust's results have been benchmarked against the usual comparator group of 24 Mental Health and Learning Disability trusts, the average response rate for this group being 54%. A reduction in the response was expected in light of the culture survey and pulse surveys also being undertaken at the time.

Significant changes have been made to the reporting of the 2018 survey. The findings are now grouped into 10 "Themes", replacing the previous 32 "Key Findings". For consistency and ease of use, the results are shown over a period of 5 years to clearly demonstrate trends. All themes are now scored consistently on a scale of 1-10. The national report also shows question level data enabling users to drill down into the findings rather than rely on the summaries expressed through the discontinued Key Findings. The results are also presented visually throughout the report making it easier for users to incorporate specific findings with internal reports and presentations.

Overview of results

Of the 10 Themes:

- The Trust was better than average in 8 and below average in 2.
- The themes where the Trust scored highest in were "Equality, Diversity & Inclusion" and "Safe Environment – Violence".
- The lowest scoring Theme for the Trust was the "Quality of Appraisals".
- Staff engagement received a top quartile score of 7.2, against a best in class score of 7.4, an average score of 7 with a worse score of 6.5 out of a possible 10.

Of the survey questions that were asked in 2017 and again in 2018:

- 42.5% had improved over 2017
- 22.5% stayed the same as 2017
- 35% had reduced scores compared to 2017

There were also 11 questions asked for the first time in 2018. Of these:-

- 75% were better than the average response rate for comparator MHLDTs
- 25% were the same as the average response rate for comparator MHLDTs

RECOMMENDATIONS

The Board of Directors is asked to:

- Note a rating of significant assurance on staff experience and engagement within the Trust
- Note the report, its conclusions and recommendations
- Note that the relevant outcomes in the survey will inform the NHS Workforce Disability Equality Standard and the NHS Workforce Race Equality Standard Action Plans, both of which need to be completed by August 2019.

Corporate Considerations	
Quality implications	The results are part of a range of feedback that reflect how staff view the Trust, including the quality of the services it provides and of the Trust as an employer.
Resource implications:	The delivery of actions arising will be managed within existing resources.
Equalities implications:	The Survey's limited equalities monitoring across all protected characteristics reduces the usefulness of the evidence to support actions to reduce barriers and improve staff experience particularly regarding race. However, it provides some useful pointers which will be taken forwards in actions
Risk implications:	The results of the Survey are published nationally and locally. Perception and knowledge of results may impact the view service users, carers and other stakeholders have of the Trust. In addition, the results can impact the Trust's ability to demonstrate that it is an employer of choice with the resultant effect on recruitment and retention.

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

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

Reviewed by:		
Neil Savage, Joint Director of HR & Organisational Development Executive Directors	Date	February and March 2019

Where in the Trust has this been discussed before?		
People Committee	Date	20 March 2019
Executive Directors		February 2019
Delivery Committee		26 March 2019
What consultation has there been?		
JNCC	Date	

Explanation of acronyms used:	MHLDT – Mental Health/Learning Disability Trusts QH – Quality Health ESR – Electronic Staff Record NHSE – NHS England

1. Introduction

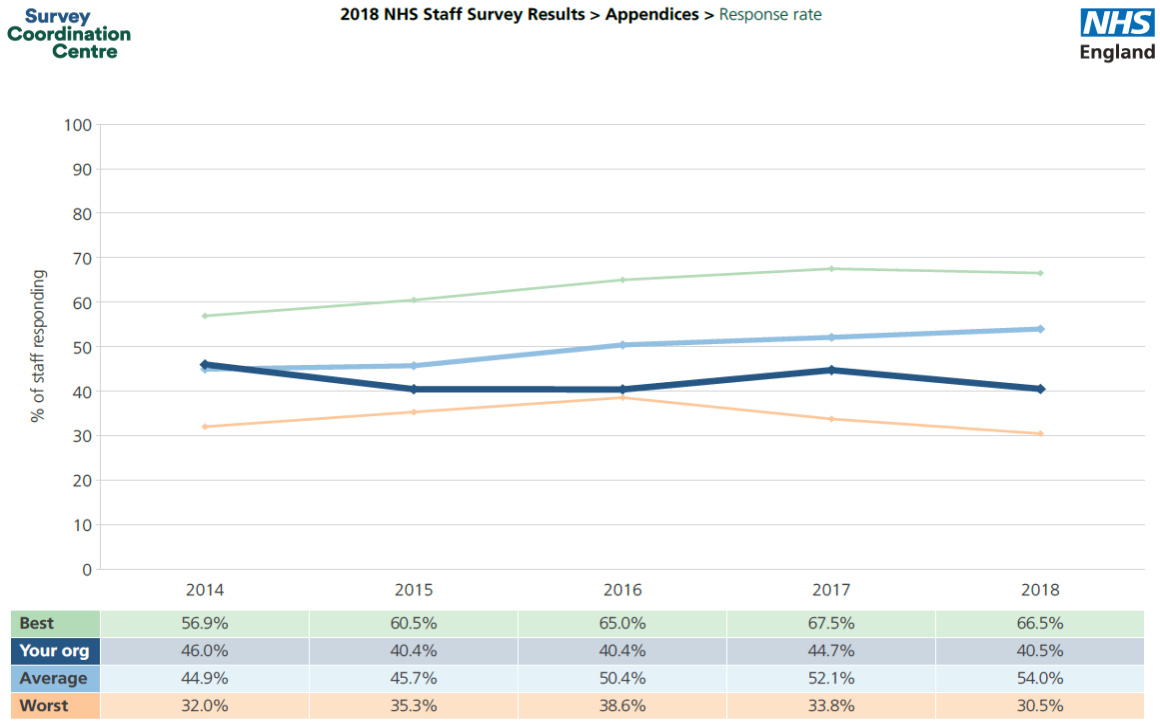
1.1 The Trust participates in the NHS Annual Staff Survey, a requirement of the Department of Health. The Survey is carried out by our independent contractor Quality Health (QH). The Trust provided a full staff listing extracted from the Electronic Staff Record (ESR).

1.2 All colleagues in post on 1st September 2018 were invited to take part. All responses were returned directly to QH who confidentially held and managed the data. The Trust does not know who responded to the survey.

2. Response to the Survey

2.1 The survey was responded to by 863 colleagues or 40.5%. This marked a decrease from 920 (44.7%) responses in 2017. The 2018 Survey took place between October and December 2018. Table 1 shows the comparative response rate over 5 years. 2016 was the first year that all staff were invited to take part. Previously the survey was sent to a random sample of 750 staff.

Table 1



	2014	2015	2016	2017	2018
Best	56.9%	60.5%	65.0%	67.5%	66.5%
Your org	46.0%	40.4%	40.4%	44.7%	40.5%
Average	44.9%	45.7%	50.4%	52.1%	54.0%
Worst	32.0%	35.3%	38.6%	33.8%	30.5%

3. Changes

3.1 Significant changes were made to Staff Survey reporting for 2018. The report is now shown through a series of Themes instead of the Key Findings of previous surveys.

3.2 The 10 Themes have been designed to provide a balanced overview of organisational performance on staff experience and are benchmarked against our comparator group of 24 MHLDTs. The Themes are scored consistently on a scale of 1-10, replacing the previous mix of percentages and weighted summary scores.

3.3 In addition to the new Themes, question level data has been presented for all questions from the core questionnaire. Question level data has also been benchmarked.

3.4 The Themes are replicated in a second report based on the division of results requested annually by the Trust. Results are available for Staff Groups and Directorates and are benchmarked against the overall trust scores.

3.5 All results are displayed graphically and show trends that have developed over the previous 5 annual surveys. The intent is that readers can see at a glance how staff have viewed the Trust over this period and to highlight whether there has been significant developments or year on year fluctuations. The new format is easier to share through presentations across the Trust and enable heads of the localities, directorates and professions to see where work is needed to maintain or improve experience.

3.6 The purpose of this report is to highlight the changes that have been made to the survey reporting and to draw out some of the more significant findings. The full report

is attached as **Appendix A.** The new format will make it easier for the reader to focus on the information they need.

4. Themes and Headlines

4.1 Key Findings have been replaced by 10 Themes. Table 2 has been extracted from the benchmark report and shows the 10 Themes with the latest scores compared with the 2017 survey. It also shows that although throughout the survey there were improvements and some worsening of results, none were statistically significant.

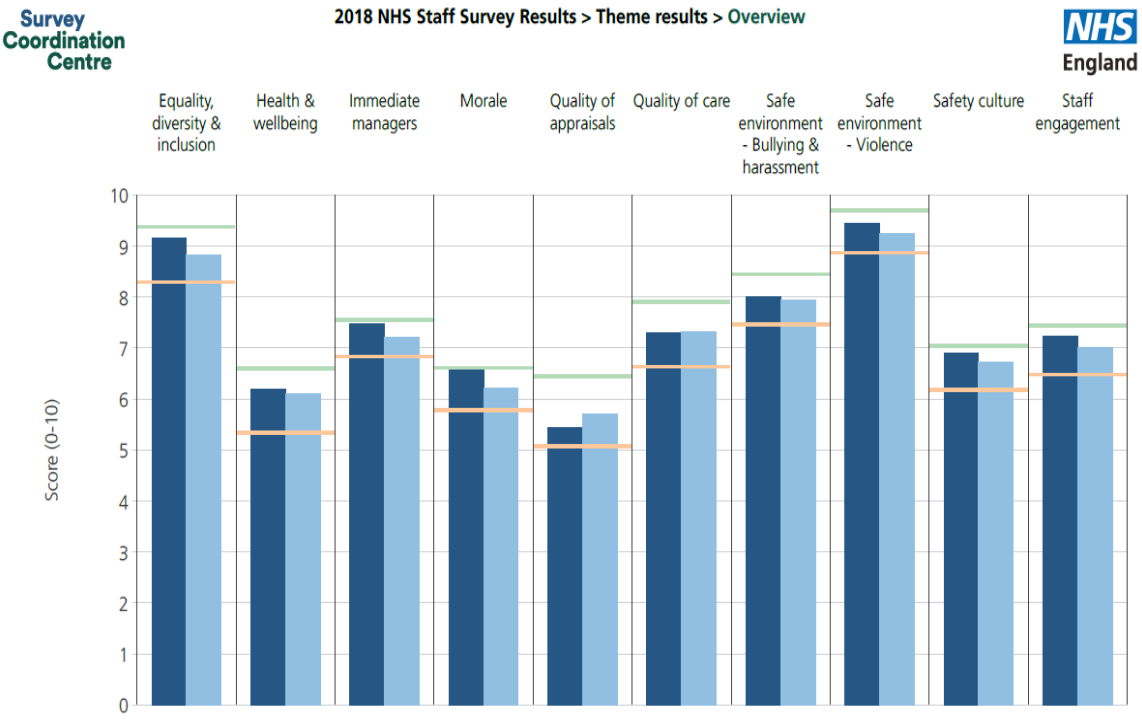
Table 2

Theme	2017 score	2017 respondents	2018 score	2018 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.3**	903	**9.2**	851	Not significant
Health & wellbeing	**6.1**	911	**6.2**	855	Not significant
Immediate managers	**7.4**	911	**7.5**	857	Not significant
Morale		0	**6.6**	845	N/A
Quality of appraisals	**5.4**	803	**5.4**	741	Not significant
Quality of care	**7.3**	723	**7.3**	672	Not significant
Safe environment - Bullying & harassment	**8.1**	904	**8.0**	849	Not significant
Safe environment - Violence	**9.5**	907	**9.4**	845	Not significant
Safety culture	**6.8**	910	**6.9**	852	Not significant
Staff engagement	**7.2**	918	**7.2**	862	Not significant

4.2 The Themes are closely related to the Key Findings of previous surveys but results are shown against a scale of 1-10. The Theme of ‘Morale’ has no direct comparison as it is new for 2018.

4.3 Effectively, 3Themes showed a small improvement, 3 reduced slightly and 3 remained the same.

Table 3



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.4	6.6	7.5	6.6	6.4	7.9	8.4	9.7	7.0	7.4
Your org	9.2	6.2	7.5	6.6	5.4	7.3	8.0	9.4	6.9	7.2
Average	8.8	6.1	7.2	6.2	5.7	7.3	7.9	9.3	6.7	7.0
Worst	8.3	5.3	6.8	5.8	5.1	6.6	7.5	8.9	6.2	6.5
No. responses	851	855	857	845	741	672	849	845	852	862

2

4.4 Table 3 highlights the overall results of each Theme benchmarked against the best, worst and average scores from our comparator group. [2]gether staff reported that we were above average in eight of the Themes. This table also clearly demonstrates that the Trust performed significantly better than the worst results in each Theme. The scores also show that [2]gether matched the best results in the comparator group for 'Immediate Managers' and 'Morale'. The quality of appraisals was consistently the lowest result for the Trust throughout the Benchmark Report.

4.5 Looking at the 5 years' worth of trends behind each of the themes:-

Equality and Diversity has remained consistently above average and apart from some small fluctuations has mirrored the best results for MH/LD trusts over the 5-year period. The detailed information taken from the question level data from which the theme is comprised shows that the trust has been consistently better than average, although never best for equal opportunities and career progression. The Trust has performed well with relatively low numbers of staff reporting discrimination although there is clearly more work to be done. The Trust has also shown to be clearly above average when making reasonable adjustments to enable staff to continue working rising from a low point in 2014.

Health and wellbeing has shown little change but has been consistently and significantly better than the worst results. However, when analysing the question

level data leading to this finding there have been clear fluctuations over the review period. It is notable that since the introduction of the Rapid Access to Physiotherapy Service, the number of colleagues reporting that the Trust takes positive action on health and well-being has fallen whilst the number saying they have experienced musculoskeletal (MSK) problems has increased. Interestingly, the number of days of sickness for MSK reasons has notably reduced.

Immediate managers are viewed positively by colleagues and this trend has improved slightly year-on-year and has always been above average. The question level data show more obvious movement in people's opinion, usually positive and above average. It appears from the Benchmark Report that ²gether managers are held in much higher regard than in the worst performing trusts.

Morale is a theme newly introduced to the 2018 report. The Trust received a score of 6.6 from a possible 10 matching the best score in the comparator group. Although roughly a quarter of staff say they think about leaving, 16% say they may look for another job in the next 12 months but only 9% say they would leave as soon as they find another job.

Quality of appraisals was by far the Theme that produced the worst results for the trust, being below average across the review period. Each of the questions that inform the theme was well below average. Only 19% said that their appraisal helped them improve how they do their job although 35% said that it left them feeling valued.

Quality of care has consistently mirrored the average results for MH/LD trusts. The Directorates Report shows that Medical and Nursing staff have a less positive view of the quality of care that the Trust provides. Only Countywide Services and Herefordshire Locality staff reported that the quality of care was higher in their area than in the Trust as a whole. CYPS & CAMHS, Gloucestershire South, Entry level Services and Gloucestershire North staff reported that the quality of care they provide was lower than the overall Trust score.

Safe environment - bullying & harassment is a Theme where there are mixed results from the question level data. With the exception of 2017, there has been a steady increase in the number of people saying they have experienced unacceptable behaviour from patients, relatives and the public. There has been a levelling out of the number of people saying they experienced this from their managers after a significant spike in 2016. There has also been a marked increase in this behaviour from other colleagues. It should be noted that the Trust results are significantly better than the worst performing comparator. The staff groups showing the worst results in this area were Estates & Ancillary, Medical and Nursing.

Safe environment – violence is a Theme that shows very little overall change during the review period. There has been a decline in the number of staff reporting that they had experienced physical violence from service users, relatives and the public. Additional Clinical Services and Nursing show the worst results. There are however a very small number of staff who say they have experienced physical

violence from managers or other colleagues. These results have changed little over the years but a review of casework has consistently failed to identify any cases.

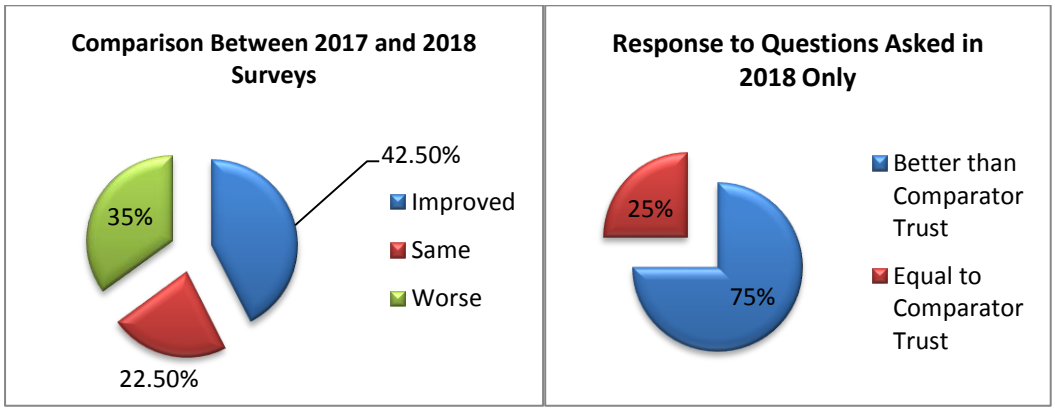
Safety culture has remained constant over the review period. Each of the component questions show fluctuating results although there has been a downturn in the number of people saying they would feel secure raising concerns about unsafe practice. However more people than ever believe that the organisation acts on concerns raised by service users.

Staff engagement is the final theme. This has remained constant and has always been above average. Although staff motivation has fluctuated somewhat, it has never fallen below average. Staff recommending the organisation as a place to work has improved significantly from 56% in 2014 to 72% in 2018, reflected in the quarterly Staff Friends and Family Test. Recommending the trust as a place to receive treatment has showed a similar improvement from 67% to 75% over the review period.

5. Question level data

5.1 It is not intended that the question level data be examined here given the total number of questions asked. The presentation of the data makes it easier to analyse but it is worthy of note that 42% of questions asked showed an improvement. Table 4 illustrates how staff responded to the questionnaire. Table 5 shows how staff responded to the questions asked for the first time in the 2018 survey.

Table 4



6. Demographics

6.1 The benchmark report also presents a picture of the trust based on the background of the respondents to the survey.

- 74% of respondents were female
- 40% of respondents were aged between 51 and 65
- 93% were white
- 85% were heterosexual
- 44% were Christian
- 20% reported that they had a disability
- 29% had more than 15 years' service

6.2 A study of the demographics and questions linked to protected characteristics will be analysed as part of the 2019 WRES (Workforce Race Equality Standard) submission and the introduction of the new WDES (Workforce Disability Equality Standard).

7. Conclusions

- The 2018 Staff Survey received a lower response rate than in the previous year but still provides a robust and representative data set that presents an accurate view of the Trust.

- Overall the results are encouraging with no major swings in opinion. However, the quality of appraisals does give some cause for concern and a review of the effectiveness of the current system will need to be reviewed.

- The new format can be used to enable the various localities, directorates and heads of profession to review results in their own areas, informing local action plans. Localities will be asked to come up again with 2 or 3 local actions.

- The results will be widely shared via Senior Leadership Network, JNCF, LNC and Team Talk with focus groups in April to inform an action plan for Executive agreement for late April and Delivery Committee in May, which is likely to include a focus on (1) 'Quality of appraisals' , (2) 'Quality of care' and (3) 'Safe environment – Bullying and harassment', while also ensuring that we don't miss opportunities for keeping up the activities and approaches that deliver our stronger scoring Theme (e.g. staff engagement).

- These results can be used in association with the Pulse Survey and Staff Friends and Family Test to formulate a wider view of the Trust and enable additional improvement actions to be taken.

- Comparison with the results of the survey from Gloucestershire Care Services has been undertaken and will help inform the process of integration as the two Trust merge. The Shadow Board will receive a comparison report at its next meeting.

- Further comparisons can be viewed on-line against the national results and against other trusts in our geographic area 9.

8. Recommendations

The Board of Directors is asked to:

- Note a rating of significant assurance on staff experience and engagement within the Trust

- Note the report, its conclusions and recommendations

- Note that the localities will agree 2 to 3 actions to supplement a Trust-wide action plan to be brought back to the Delivery Committee for late April / May

- Note that the relevant outcomes in the survey will inform the NHS Workforce Disability Equality Standard and the NHS Workforce Race Equality Standard Action Plans, both of which need to be completed by August 2019.

Agenda item 16 **PAPER J**

Report to: 2gether NHS Foundation Trust Board –27 March 2019
Author: Paul Roberts, Joint Chief Executive
Presented by: Paul Roberts, Joint Chief Executive

SUBJECT: **Chief Executive's Report**

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

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

EXECUTIVE SUMMARY

Recognising the Strategic Intent work and my role as both Chief Executive of Gloucestershire Care Services and 2gether this report reflects the breadth of my activity across both Trusts. I remain accountable separately for the performance in each of these roles.

The Report also provides an overview of Gloucestershire Care Services operational service activity.

RECOMMENDATIONS

The Board is asked to note the contents of this report.

Corporate Considerations	
Quality implications:	As Noted
Resource implications:	As Noted
Equalities implications:	As Noted
Risk implications:	As Noted

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

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

Reviewed by:		
Chief Executive	Date	*January 2019*

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
N/A	Date	

Explanation of acronyms used:	

1. CHIEF EXECUTIVE ENGAGEMENT

I remain committed to spending a significant proportion of my time visiting front-line services in both organisations and continue to be impressed and heartened by the professionalism and commitment of colleagues across the organisations and in the pride that they take in the delivery of, in many cases, outstanding services.

Services I have visited in recent weeks include:

Gloucestershire Care Services:

The Vale Hospital to visit our newly opened Stroke Rehabilitation Unit – it was fantastic to see the team has come together in just a short period of time to offer an exemplar service for the county which provides specialist services to help individuals who have experienced a stroke to return to their homes.

^{2}gether Services:

Recognising the ongoing review of service configuration within Herefordshire I have been meeting groups of colleagues in Herefordshire to explore with them our opportunities to provide the same type of joined up services we are working towards in Gloucestershire with our colleagues within the Herefordshire health care system. Colleague focus on maintaining the strong support for individuals, for which we already recognised, is central to this review. Colin Merker, Herefordshire Managing Director at 2gether NHS Foundation Trust (^{2}gether) is key to taking forward this work and is recognised within the system for his commitment to the Herefordshire Community.

Joint interaction

As the strategic intent progresses colleagues from both trusts are now regularly engaging together.

I have continued a range of meetings with other colleagues including:

Team Talk – Weavers Cross – it is great to find that increasingly Team Talks contain a mix of colleagues from the two Trusts – an ongoing opportunity to build relationships to start improving what we do now. We took the opportunity to update colleagues on merger developments and to hear back from them how it feels on the ground – two way communication processes are at the heart of how we want to work.

Medical Staffing Committee - these sessions enable me to understand the concerns and aspirations of this group, and to consider, jointly, future plans.

I continue to meet regularly with colleagues to progress our Better Care together Programme and am delighted that over the next 6 months we are putting in place a range of stakeholder events with key note speakers to inspire and illuminate best practice, but resting on a bedrock of our service users and stakeholders and colleagues to ensure as we go forward our transformation is driven by co-production and engagement. It is a very exciting reminder of what the merger process aims to achieve.

I have also enjoyed taking part in a number of leadership/development events. I continue to be impressed by the strength of leadership at both Trusts and their clear passion for quality improvement with service users central to all we do. The Senior Leadership Network – a monthly two way session which updates Senior Leaders on key issues and gains their input on how to move forward is an important element of this. The February session considered the principles and processes for developing the next stage of our organisational structure, following the appointment of the shadow board as updated in my January Report. We also heard from Margaret Willcox OBE Director of Adult Social Care – who gave an interesting insight into both how social care is supported within the county, but also her own personal drivers.

2 Progress on the strategic intent to merge Gloucestershire Care Services NHS Trust (GCS) with 2gether NHS Foundation Trust

Merger Timeline

An updated merger timeline is provided for completeness at **appendix 1**

Council of Governors

We continue to meet regularly with the Council of Governors and are keeping them updated with the plans to merge. They continue to provide the external scrutiny on behalf of our communities which is a very helpful process.

Trust Name

An update on this was provided to 2gether's Council of Governors, at its meeting on 14th March and proposals are now being taken forward. It is expected that a name, based on NHSE Guidelines, and stakeholder feedback will be confirmed by the Boards shortly. This selection process is part of the necessary preparation for potential merger, allowing us to meet Care Quality Commission registration requirements and ensure that any transition is smooth and does not cause confusion to service holders, BUT is not an indication that the proposed merger is already signed off. We recognise the ongoing work which is in progress to satisfy our own Boards that this is the solution that best meets the needs of our communities and ensures the resilience and high quality services which we already provide as separate Trusts.

3 Partnership Working

3.1 "One Gloucestershire" Integrated Care System (ICS)

An update from on the work of the ICS is a separate item on the agenda.

I continue to be engaged with both the development work in this area and the ongoing activity, including taking the leadership role on the Diagnostics Board and Quality Improvement.

There has been recent significant work across the system considering future ways of working and priorities for the year ahead. This work has increasing focus as we go forward, recognising the direction of travel within the Long Term Plan

3.2 Herefordshire Integrated Working Developments

With Colin Merker, Deputy Chief Executive, 2gether I continue to be heavily engaged in working with colleagues in Herefordshire and Worcestershire to further develop partnership working.

3.4 Local Medical Council

These are a regular, valuable meeting which help to bring together key concerns across the county. At the February meeting we had discussed current issues.

4. South West Chief Executive Officer (CEO) Forum

I attended useful update sessions which outlined issues which will be key to future planning and considered how we make best use of resources.

5. Valuing Your Involvement'

I'm pleased to update on the important work being led across both Trusts by Jane Melton, 2gether Director of Engagement and Social Inclusion and Linda Gabaldoni, GCS Head of Organisation Development and Improvement to ensure the new organisation has the values which are key to us as Boards, our colleagues, our service users and our communities.

A significant number of people took part in an initial conversation in October 2018 about the importance of co-developing a strong set of shared values for our new, merged organisation. Colleagues from GCS and 2gether as well as people who use services and their loved ones were included.

Our 'Valuing Your Involvement' programme is locally designed and builds on the committed effort of the initial work and what we learnt from it. It represents the second phase of our work to agree the underpinning and guiding values and is being led by the Director of Engagement and Integration at 2gether NHS FT.

Colleagues from both organisations are engaging in meaningful conversation about the principles which will guide our everyday work, transform our offer to the local population and aim to provide outstanding services. This work involves a dedicated, collaborative approach.

The program also involves inviting more people with lived experience to take part in our work. We are strengthening our Expert by Experience program so that we can involve people in co-developing our new organisation in a number of ways. Colleagues are also being invited to make short films to share their views about values based practice.

Progress

- We have held 10 Valuing Your Involvement sessions and approximately 220 colleagues have participated to date.
- Participating colleagues have been from across GCS and 2gether, including senior managers, corporate services, joint staff representatives, hospital and community clinical colleagues.
- Most of the sessions have been held as part of existing meetings in venues local to the teams involved in both Herefordshire and Gloucestershire.
- Most sessions have included both GCS and 2gether colleagues.
- The majority of the sessions have included Executive Directors and some sessions have involved Non-Executive Directors.
- Colleagues have offered feedback and expressed that they value the chance to hear from and ask questions directly to Executives about the merger progress.
- All but one has involved an Expert by Experience.
- Stories of lived experience that have been shared have been powerful and very well received by colleagues. Colleagues have remarked how these narratives really help us to remember how important it is to practice with a strong set of shared values.
- Feedback from the sessions has been overwhelmingly positive.
- The GCS and 2gether intranet now have a section dedicated to the development of values. The pages include vox pops from participants in addition to the Frequently Asked Questions.

Next Steps
The outputs from the sessions are being collated and an early analysis has been undertaken. A fuller analysis will be undertaken, in a collaborative manner, when all the data have been gathered.

A further 11 sessions are scheduled and we predict that 400 – 500 colleagues will have taken part by the end of April in line with the plan.
It is anticipated that a full report will be provided to the Boards of GCS and 2gether in May 2019.

I am delighted with the level of engagement which demonstrates the importance of this work to everyone in both organisations – I am committed to our values embodying how we work not being words on a strapline.

6. Safeguarding Children Arrangements are Changing

'Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children' is national statutory guidance which sets out intentions about how inter-agency working for promoting the welfare of children from all backgrounds, in all settings should happen. The new *'Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children'* was published Summer 2018 and replaces the previous 2016 publication. These changes as a result of this revised guidance are beginning to come into effect across Gloucestershire.

The Trust and its colleagues continue to have a responsibility of working within the different safeguarding children's framework especially as one of the most prominent *Working Together 2018* changes is the replacement of Local Safeguarding Children Boards (LSCBs) with Safeguarding Partners. This transition will be complete by no later than September 2019.

In future, Safeguarding Partners will consist of three agencies: local authorities, clinical commissioning groups, and chief officers of police. For Gloucestershire this will Chris Spencer, Director of Children's Services, GCC, Mary Hutton, Accountable Officer GCCG and Julian Moss Assistant Chief Constable for Gloucestershire Constabulary. These Safeguarding Partners will work with relevant appropriate Gloucestershire agencies including GCS to safeguard and protect children. All three Safeguarding Partners have equal responsibility for fulfilling the role which is different and shift from this responsibility previously "sitting" with local authorities.

These Safeguarding Partners will be responsible for working with the Trust and its colleagues to safeguard and protect children across Gloucestershire. Schools, colleges, and educational providers will also be expected to have a higher profile with the Safeguarding Partners.

There will also be an identified Child Safeguarding Practice Review Panel which will have the responsibility for identifying and overseeing reviews of serious child safeguarding incidents that raise complex issues or become important on a national scale. It will also be this panel that will be responsible for deciding how the system

learns lessons on a national level, while local responsibility will land with the Safeguarding Partners mentioned above.

With regards to the Child Death Review Process and with the removal of Local Safeguarding Children Boards, the responsibility for ensuring that child death reviews are undertaken with a Child Death Overview Panel now lies with Child Death Review Partners, which will be made up of local clinical commissioning groups and local authorities. The new guidance states, *"Child death review partners may, if they consider it appropriate, model their child death review structures and processes on the current Child Death Overview Panel (CDOP) framework."* The new guidance also makes it clear that a review should be carried out for the deaths of all children who are normally resident in the local area, and if appropriate, for non-resident children who die in the local area. Further supporting guidance about the CDOP process was published November 2018 and Gloucestershire remains in a favourable position to meet the new requirements due to the well-established arrangements already in place.

There is also a new section included in *Working Together 2018* placing emphasis on organisational responsibility towards people who work in positions of trust. The guidance states, *"Organisations and agencies working with children and families should have clear policies for dealing with allegations against people who work with children."* The Trust and other Gloucestershire statutory partners has had policies such as these in place for a considerable amount of time and; therefore these changes in particular relate more specifically to all schools, Early Years settings, child carers, healthcare professionals, children's homes, voluntary, charity, social enterprise, faith-based organisations, and private sectors.

7. OFSTED

Children's Services Partnership Working

Trust colleagues continue to support the Countywide Children's Services Improvement Board set up following the last OFSTED inspection and subsequent inadequate rating of GCC Children's Social Care (CSC) services.

OFSTED monitoring visits continue with the most recent taking place in January. There remains a mixed picture of improvement clearly suggesting there is steady progress being made by CSC however, there remain concerns about the pace and sustainability of the changes that are being seen. The focus of the last OFSTED visit was on safeguarding teenagers and the outcomes of this last visit has now been published https://files.api.ofsted.gov.uk/v1/file/50054390 and; provides some specifics about the challenges faced by social workers with this age group.

As health partners we will continue to work with CSC. Our practitioners and especially our public health & safeguarding nurses are working directly with these most vulnerable group of children. Alongside this, there remain a number of significant challenges faced by CSC and One Gloucestershire generally including:

- The number of Children in Need reaching a 12-month high in January
- Although the number of children subject to a protection plan has continued to decline since the peak in August 2018 (down 9%) the number of children subject to a protection plan remains 32% higher than in January 2018.
- There are 707 children in care; an increase of 10% compared to 12 months ago.
- The level of readmissions to care is rising and expected to exceed previous years (21% year to date).
- Caseloads remain high

8. National Developments

8.1 Spring Statement

We note the key aspects highlighted below and await clarity over the coming months on the position for the health and care system and individual organisations.

- The Chancellor of the Exchequer Philip Hammond has presented his Spring Statement to the House of Commons.
- Hammond confirmed that the government will hold a spending review which will conclude alongside the Budget.
- This will set departmental budgets, including three year budgets for resource spending, if an EU exit deal is agreed.
- The government has launched a review of private financing options for public infrastructure and said it will no longer procure PFI-type projects that are "off-balance sheet".

8.2 NHS England publishes response to consultation feedback on Integrated Care Provider (ICP) Contract

We note the recent response from NHS England following a consultation held about a new contract which can help local health and care communities provide better care for patients. We are excited about the potential opportunities for moving forward with greater integration and await further guidelines on how this will be taken forward based on the outcomes from the consultation detailed below.

Around 3,800 written responses and feedback from stakeholder events across the country were received about plans for an Integrated Care Provider (ICP) Contract, which will be an option to help local systems integrate care.

The feedback will be used to further develop the ICP Contract, which will be available in its updated form as an option for use in local health and care systems from spring 2019.

The recent NHS Long Term Plan highlighted integration of services as a key aim: making sure that everyone can receive high quality care that is coordinated around their individual needs.

Integration is delivered through providers and commissioners working more closely together. But services are currently bought through a range of contracts which do not

always relate clearly to each other, with terms and conditions, funding and incentive arrangements which are not always aligned.

The ICP Contract will give commissioners the option to commission services through a single contract, to build in integration and remove operational barriers.

An ICP Contract will give one lead provider responsibility for the integration of services for the local population, specifically to enable integration of primary medical services with other health and care services.

The ICP Contract will be made available for use by commissioners in a controlled and incremental way, conditional on successful completion of NHS England and NHS Improvement assurance through the Integrated Support and Assurance Process (ISAP).

We expect ICP Contracts will be held by NHS organisations or other public bodies.

Neither use of the ICP Contract nor adoption of lead provider models for integration will be mandatory: they will be options for local commissioners and their providers to consider.

The Long Term Plan and recent five year GP contract framework announced the development of Primary Care Networks (PCNs). Where commissioners and providers decide to develop an ICP, it will work with and support the development of local PCNs, through greater integration within neighbourhoods and improved at-scale working to deliver primary care and community services.

In response to consultation feedback, further requirements around financial controls, transparency and accountability will be developed before the ICP Contract is made available for use.

9. EU Exit

The Trust continues to follow national guidance on this issue and respond to information requests from the Department of Health and Social Care and currently are confident with the measures the Trust is implementing.

10. Operational Service Overview

10.1 System flow and Resilience

4 Hour Accident and Emergency Performance target

For February, Emergency department attendances were 418, the same as last month and 6.6% above the agreed contractual levels. Year to Date (YTD) attendances are 5.4% above contracted levels as at Month 11, equating to an additional 23 attendances a day.

In February Accident and Emergency 4 hour performance was 86.1%, an increase on January's performance of 84.5% but below the STF target of 90%. The Minor Injury and Illness Unit (MIIU) 4 hour performance was 99% for February and is 98.9% YTD. Therefore 4 hour performance across the county, including MIIU, was 90.2% for February and is 92.9% YTD.

Focus on Patient Flow and Reducing Length of Stays

The system has been focussed on reducing the number of patients on the acute wards with a length of stay greater than 7 days (known as stranded patients) with some success. Proportionally, admitted patients with a length of stay above 7 days have reduced when compared to this time last year, with 19.2% in February 2019 compared to 22.5% in February 2018.

Our Community hospitals have focused on a similar improvement programme recognising that we continue to have patients who have significant length of stays which could be reduced with greater focus on discharge and improved access to community resources to support them going to an alternative setting. This is reflected in our Bed occupancy rates with February rate at 95.2%, a reduction from the January performance level of 96.2%. The higher occupancy levels reflects the anticipated pressures over winter and although our year to date position has risen to 93.6% and over the contractual target of 92%, this is significantly below the 208/19 YTD position of 96.7%

Delayed Transfer of Care (DToC)

The above work has certainly supported an improved Delayed Transfer of Care (DToC) position during this busy winter period. The GHFT DToC rate has achieved the national target in January, with a rate of 2.99% (against the 3.5% target). This achievement has also been due to improved weekend staffing resource for adult social care this winter, reducing the time taken for social care assessments to be completed, and an increase workforce in the county council brokerage team who have reduced delays in securing support packages to facilitate more timely discharges.

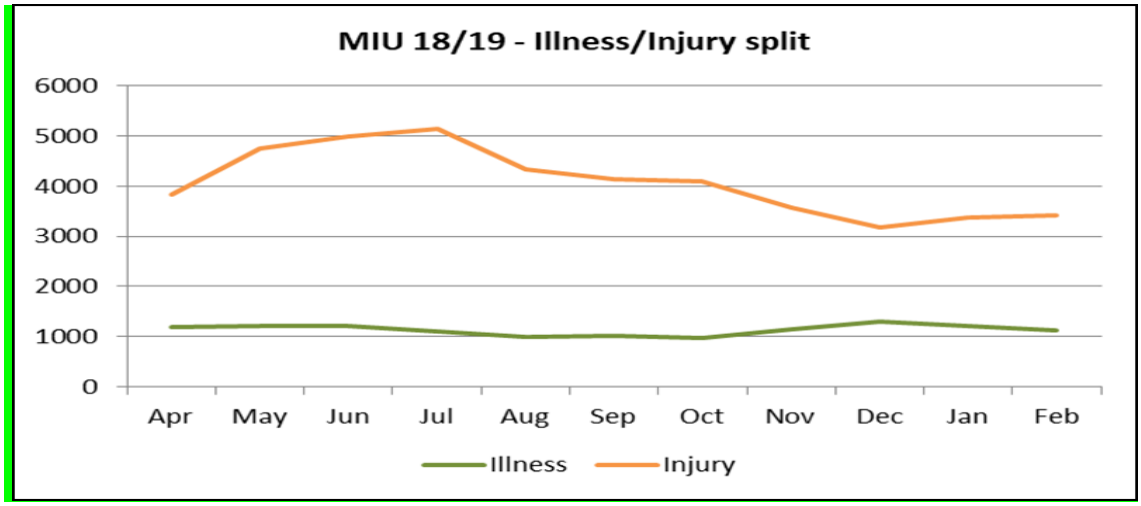
Gloucestershire Care Services NHS Trust DToC rate for January remained below target at 0.6%.

2gether NHS Foundation Trust overall DToC rate has maintained the improved performance seen in December reporting a DToC rate of 1.1% in January.

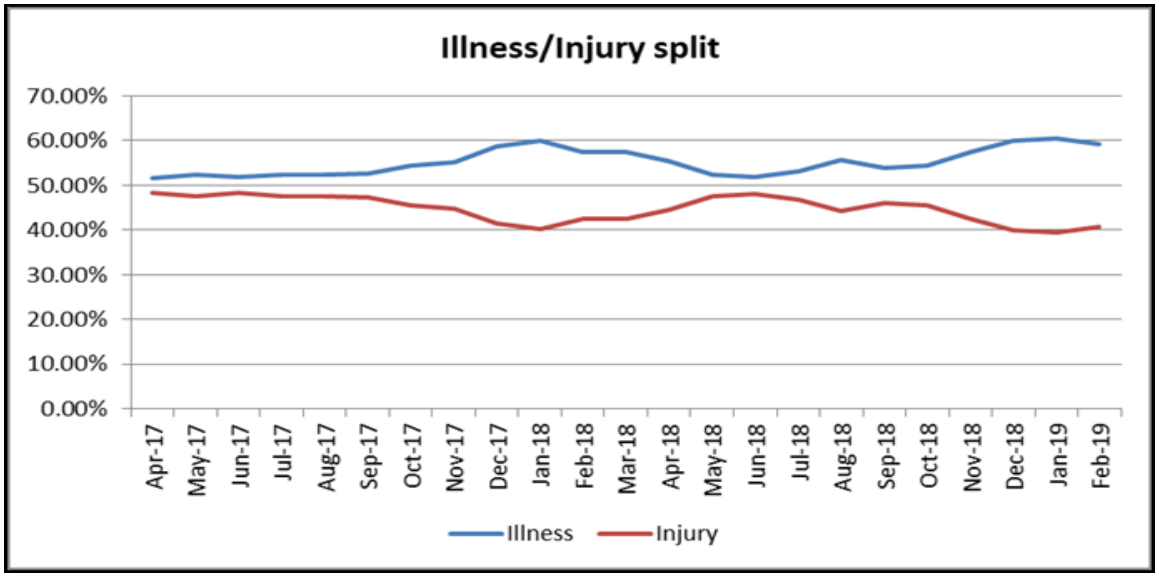
Understanding Urgent and Emergency Care Activity

The Accident and Emergency Delivery board has begun to review the type of activity undertaken by both the two urban Emergency departments as well as the MIIU, to understand the impact of primary care improved access on presentations to these settings and potential impact of implementing Urgent Treatment centres.

For MIIU settings, Injury attendances equate to 78% of total attendances (YTD) and minor illness at 22%. As expected there is a peak in injury presentations in the summer months.



In the Emergency Departments, the split of attendances for injury is 59.3% and illness is 40.7%.The seasonal trend shows a higher proportion of illness occurring during winter months.



With agreement on how to monitor the injury/illness split further analysis will occur to understand minor vs major injury and illness presentations in the A&E departments to understand the potential impact of implementing Urgent Treatment centres in the urban areas.

10.2 Operational Service Development and Challenges

10.2.1 Timely Access to Services:

February performance has seen modest improvements in providing services in a timely way, particularly within the Integrated Community teams. As previously noted,

detailed action plans are in place and are monitored regularly with further scrutiny occurs in the Quality and Performance board subcommittee.
Adult speech and language therapy service continues to be challenging, has a robust remedial action plan, and although the service is achieving the 18 weeks constitutional target, is significantly underperforming on the 8 week local access target, achieving only 54.3% in February.

Additional agency resource has been secured to address the gaps in workforce in the community which were in place has had a positive impact.

There is also a significant amount of change at the senior leadership level following retirement of the previous Head of Service. Although a new operational lead is in place, additional leadership is being sought to accelerate the required changes to transform the service and improve performance.

The physiotherapy service 8 week Referral to treat target in both the Musculoskeletal Core service and Integrated Community Teams has not been achieved in February, which is a result of a high level of vacancies in the physiotherapy workforce across all Adult services alongside rising demand outstripping capacity.

The Head of Adult Physiotherapy has reviewed workforce in all service areas, has provided recommendations on ensuring safe, quality service provision and is actively involved in a recruitment campaign targeted at newly qualified physiotherapists. In the interim agency workforce is being used where available to improve the waiting times for the services.

Ongoing discussions continue with our Commissioners in relation to the Adult Occupational therapy service provision in our Integrated Community teams, and the level of resource required to support timely service. It is the view of the Head of the ICTs that the service is working in a more productive way, with good progress in implementing the service model, but the demand management, diverting referrals away from the ICTs, has not yet been fully realised.

10.3 Service Updates and Key County / Locality Developments

10.3.1Temporary Changes to Radiology Services in all Community Hospitals

Ongoing work continues with our system partners in relation to reinstating the radiology services back to the original service levels before the temporary reduction occurred in November 2018.

As previously reported there has been additional days that have been provided into both North Cotswolds and Tewkesbury hospitals however as this coverage is being provided via Agency and Bank contracts there is variability on what day is offered at these sites.

The reduction in hours is having some impact on MIIU services, but not significant as demonstrated in the table below, which details the number of patients from MIIU referred onward into Gloucestershire Hospitals Foundation NHS trust sites for an x-ray.

Of note is the variability of onward referral which is being further investigated by the team. Cirencester is extremely low in onward referrals, but it is likely that patients may be referred to Swindon should an urgent x-ray is clinically identified. Tewkesbury has a high number of referrals and likely due to the nearest alternative x-ray service being at the two acute sites.

Xray referrals to GHFT from 19th November 2018 (16 weeks)

Source: Destination on departure S1

Site	Count of Patient	Number per week
Cirencester Community Hospital	1	0.06
Dilke Community Hospital	8	0.06
Lydney Community Hospital	13	0.8
North Cotswold Community Hospital	29	1.8
Stroud Community Hospital	33	2.1
Tewkesbury Community Hospital	70	4.4
The Vale Community Hospital	33	2.1
Grand Total	**187**	**11.7**

Ongoing updates are being provided to Gloucestershire Health and Care Health and Overview scrutiny committee with the next meeting on the 21st May 2019.

10.3.2 Stroud and Berkeley Vale Locality

The specialist stroke rehabilitation inpatient unit, located within Peak View Ward, at Vale Community Hospital opened at the beginning of February 2019.
The purpose of the new unit is to bridge the current gap in post-stroke care in Gloucestershire; giving people who have suffered a stroke maximum opportunity to recover and adapt in the best possible environment. Specialist rehabilitation is widely recognised as an essential part of recovery after stroke, providing significant health and social care benefits for patients over the longer term.

The unit is there for patients who no longer need specialist medical care at Gloucestershire Royal Hospital (GRH), but still require stroke rehabilitation that cannot be delivered at home. The unit, which has 14 specialist stroke beds, is staffed

by a multidisciplinary team including doctors, nurses, physiotherapists, speech and language therapists, occupational therapists, rehabilitation assistants and hotel services. A psychologist will be joining the team soon.

By providing a community bed-based service at Vale Community Hospital the aim is to continue the rehabilitation journey for patients following a stroke in a suitable, fit-for-purpose environment. When patients no longer need inpatient specialist stroke rehabilitation, and if it is safe and effective for them to have rehabilitation in their own home, they will receive ongoing support from community stroke specialist nurses or the Early Supported Discharge (ESD) community team, including community stroke specialist nurses, specialist therapists and rehabilitation assistants.

The opening of the unit at Vale Community Hospital means Gloucestershire has its own dedicated community stroke rehabilitation service for the first time, in line with national recommendations for therapy provision following a stroke.

10.3.3 Forest of Dean Locality

Progression with the new Community Hospital for the Forest of dean continues, with key areas of work being the review of the identified sites in the Cinderford area, and an options appraisal undertaken (which includes the site selection criteria identified in the Strategic Case for Change, as well as those criteria recommended by the Citizens' Jury). This will be presented to the Trust Board in the form of a confidential Outline Business case, and is scheduled to be completed in the next few months.

Following agreement with the outline business case, a full business case will be completed and include the engagement work being planned with commissioners and system partners which will have a focus on services that will be offered in the new Community hospital alongside the other community services offered in this locality.

10.3.4 Gloucester City Locality Update

The health visitors and school nursing teams previously based at Finlay Hub in

Gloucester moved in January 2019 into new accommodation at the 2gether Trust Rikenel building.

Renovation works have been completed to accommodate the two teams, who now enjoy a brand-new, open-plan office suite on the first floor. As well as enjoying a more spacious, fit-for-purpose base, the teams now have access to a clinical room, which they share with the speech and language therapy team.

Prior to their move, the teams were located behind Finlay Community School, on Finlay Road in Gloucester. Plans by the school to expand its site to double its pupil intake helped prompt the move, but this was not the only factor.

11.0 Trust Colleagues Invited to Celebration Event at the House of Commons

Lord Willis of Knaresborough hosted a reception on behalf of the Nursing and Midwifery Council (NMC) and Health Education England (HEE) in celebration of the first nursing associates joining the NMC register. Karen Pudge, Widening Access and Apprenticeship Lead, and Scott Walker, Trainee Nursing Associate, received a personal invitation from Lord Willis, requesting the pleasure of their company at the celebration event, which was held in early February 2019.

In 2016, Gloucestershire was named as one of 24 early implementer sites to deliver training for this new, important NHS nursing role. The training for Gloucestershire's 32 nursing associates commenced in 2017, with the initiative aiming to create over 1,000 new nursing associates nationally. The nursing associate role sits alongside existing fully-qualified registered nurses and other clinical support roles to deliver care to patients, and the first cohort of One Gloucestershire's nursing associates are due to qualify and register with the NMC early this summer 2019 which is great news.

The University of Gloucestershire has been instrumental in providing the training for these nursing associate roles, in collaboration with the Gloucestershire Clinical Commissioning Group and Gloucestershire Care Services NHS Trust, 2gether NHS Foundation Trust, and Gloucestershire Hospitals NHS Foundation Trust Nurses have a hugely important role in community services and we believe that the skilled nursing associate workforce will offer greater support to our registered nurses, and ensure that the Trust continues to provide high-quality person-centred care.

Internal Board Engagement

02.01.19	The Director of Organisational Development chaired, and the Director of Engagement and Integration attended, the Joint JNCC/JNCF meeting
03.01.19	Members of the Executive Team attended a Joint Business Executive team meeting
	The Director of Engagement and Integration held a Cultural Values Development meeting with 2g/GCS colleagues
04.01.19	The Director of Engagement and Integration participated in a Vision & Values Core Project Team meeting with 2g/GCS colleagues
	The Medical Director held a relatives meeting following death of a patient and serious incident review process
	The Medical Director attend the Medical Staffing Committee

07.01.19	Members of the Executive Team attended an Executive Committee Meeting
	Members of the Executive Team attended a Programme Management Executive Workshop along with GCS colleagues
	The Director of Organisational Development participated in Corporate Induction
	The Director of Quality Attended the Programme Management Executive Meeting
08.01.19	The Deputy Chief Executive attended an Accommodation meeting
	The Deputy Chief Executive and Director of Service Delivery attended a Community Learning Disabilities Team meeting
	The Director of Finance and Commerce attended a Transition Work Stream Assumptions Review meeting
	The Director of Engagement and Integration attended a Co-Creation of Trust Values meeting with 2g/GCS colleagues
09.01.19	The Director of Organisational Development attended a Workforce, Education & Develop Group
	The Medical Director attended a CYPS consultant meeting
10.01.19	The Medical Director attended the Local Medical Committee meeting
14.01.19	The Executive Directors lead Team Talk sessions throughout the Trust
15.01.19	The Director of Finance and Commerce chaired an SLR/PLICS meeting with senior members of the Finance and Commerce Directorate as well as representatives from GCS
	Members of the Executive Team attended the Trusts Council of Governors meeting
	The Director of Organisational Development and Director of Engagement and Integration attended the 2g Council of Governors meeting
16.01.19	The Director of Organisational Development chaired a Joint HR Team meeting with colleagues from 2g and GCS
	The Director of Service Delivery attended the Mental Health Legislation Scrutiny Committee
18.01.19	The Director of Engagement and Integration chaired a QCR Sub-Committee meeting

	The Director of Engagement and Integration attended a Co-Creation of Trust Values meeting with 2g/GCS colleagues
	The Director of Quality Chaired the QCR Sub-committee meeting
21.01.19	Members of the Executive Team attended an Executive Committee Meeting
	The Director of Finance and Commerce participated in Corporate Induction
22.01.19	The Director of Engagement and Integration attended a Joint Occupational Therapist Professional Advisory Group for 2g/GCS
	The Medical Director attended an Inquest at Gloucestershire Coroner's Court.
23.01.19	The Director of Engagement and Integration met with senior colleagues from the Engagement and Integration Directorate
	The Medical Director held a senior engagement visit with Health Education England and Severn Deanery
	The Director of Quality chaired the Temporary Staffing Demand Project Board
24.01.19	The Director of Organisational Development chaired a Safety, Health & Environment Committee meeting
	The Deputy Chief Executive, Director of Organisational Development and Medical Director attended an Local Negotiating Committee meeting
	The Director of Engagement and Integration attended a Research and Innovation Workshop with colleagues from 2g/GCS
	The Director of Service Delivery attended a Psychiatry Liaison meeting
25.01.19	The Director of Engagement and Integration conducted an executive Drop In Session
28.01.19	The Medical Director met with Andy Seymour from the CCG.
29.01.19	Members of the Executive Team attended a Senior Leadership Networks meeting
	The Director of Service Delivery attended The Trust Delivery Committee
30.01.19	Members of the Executive Team attended a Shadow Board meeting

	Members of the Executive Team attended the Trust Board meeting
31.01.19	The Director of Engagement and Integration attended a Co-Creation of Trust Values meeting with 2g/GCS colleagues
01.02.19	The Director of Service Delivery attended a Datix RIDDOR Issues Meeting
	The Medical Director attended the Medical Staff Committee
04.02.19	The Director of Engagement and Integration and Deputy Chief Executive lead the corporate induction presentation for new members of staff
	Members of the Executive Directors attended a Shadow Executive Team Meeting
	Members of the Executive Committee attended a Programme Management Meeting
	The Director of Quality attended the Programme Management Executive Meeting
05.02.19	Members of the Executive Team attended a Joint Board Development meeting
	The Director of Service Delivery attended a Transition Plan meeting with GCS colleagues
	The Director of Service Delivery attended a Transition Plan meeting with GCS colleagues
06.02.19	The Director of Organisational Development chaired the Joint JNCC/JNCF meeting and the Deputy Chief Executive attended the meeting
	The Director of Service Delivery attended a staff drop in session regarding the Merger / Relocation
	The Director of Service Delivery and Deputy Chief Executive joined a conference call regarding Beds at Stonebow
07.02.19	The Director of Organisational Development chaired a Joint HR Team meeting with colleagues from 2g and GCS
	Members of the Executive Team attended a 2g and also a Joint 2g/GCS Executive Committee meeting
11.02.19	Members of the Executive Team conducted Team Talk sessions across the Trust sites

	Members of the Executive Team attended a Shadow Executive Team meeting
	The Director of Organisational Development held a joint Senior Management Team meeting with colleagues from 2g/GCS
	The Director of Engagement and Integration conducted an executive Drop In Session
	The Director of Engagement and Integration and Director of Service Delivery attended Better Care Together Transformation Board
	The Director of Quality attended a Legionella Responsible Person Course
12.02.19	The Deputy Chief Executive conducted staff briefings across multiple sites in Hereford
	The Director of Quality attended a Legionella Responsible Person Course
13.02.19	The Director of Finance and Commerce attended Audit Committee
	The Director of Organisational Development and Director of Service Delivery attended Shadow Board
	The Director of Quality attended a Legionella Responsible Person Course
14.02.19	The Director of Quality chaired the 2gether Safeguarding Board
	The Director of Quality visited clinical teams at Pullman Place
15.02.19	The Director of Engagement and Integration chaired the Research Overview sub-committee
	The Director of Service Delivery attended a meeting regarding Qualifying Student Nurses in 2019
	The Director of Quality Chaired the QCR sub-committee
18.02.19	The Deputy Chief Executive and Director of Service Delivery lead at Corporate induction for new staff
	Members of the Executive team attending a Shadow Executive Team meeting
	The Deputy Chief Executive and Director of Service Delivery attended Programme Management Executive meeting

19.02.19	The Director of Finance and Commerce chaired a Brexit Operational Implementation Group meeting
	The Director of Quality visited GCS clinical Services at The Dilke Hospital
21.02.19	The Director of Finance and Commerce attended the Transformation Project Board
	Members of the Executive team attended a Joint 2g/GCS Executive Committee meeting
22.02.19	The Medical Director attended the Governance Committee
	The Director of Quality attended Trust Governance Committee
25.02.19	Members of the Executive team attended a 2g Executive Committee meeting
	Members of the Executive team attending a Shadow Executive Team meeting
26.02.19	The Director of Finance and Commerce chaired a Capital Review Group meeting
27.02.19	The Director of Finance and Commerce conducted an executive Drop in Session
	The Director of Service Delivery attended Trust Delivery Committee
	The Director of Engagement and Integration presented a Values Session
28.02.19	Members of the Executive Team attended a Senior Leadership Networks meeting

Board Stakeholder Engagement

04.01.19	The Director of Finance and Commerce attended a Reporting Account Tender meeting with a senior procurement manager
07.01.19	The Deputy Chief Executive attended a Cheltenham Integrated Locality Partnership meeting
	The Director of Finance and Commerce attended a Gloucestershire Resource Steering Group with colleagues from local organisations
08.01.19	The Deputy Chief Executive attended a STP Health Estates meeting with colleagues from Gloucestershire Clinical Commissioning Group

	The Director of Organisational Development chaired the ICS Workforce Steering Group meeting
	The Director of Engagement and Integration chaired the One Gloucestershire Tackling Mental Health Stigma Group
	The Director of Quality Attended Clinical Programme Board
09.01.19	The Director of Service Delivery attended an IRIS Project Board meeting
	The Director of Service Delivery and Director of Finance and Commerce attended an IAPT Recovery Plan meeting
	The Deputy Chief Executive attended a Forest of Dean Integrated Locality Board
10.01.19	The Deputy Chief Executive attended a New Models of Care Board with colleagues from Gloucestershire Clinical Commissioning Group
11.01.19	The Deputy Chief Executive attended meeting regarding the Development of Locality Boards with colleagues from Why Valley trust
14.01.19	The Deputy Chief Executive attended a One Herefordshire Health and Care meeting with members of Hereford CCG
15.01.19	The Director of Service Delivery attended Gloucestershire Health and Care Overview and Scrutiny Committee with colleagues from Glos County Council
	The Deputy Chief Executive attended a Programme Development Group Meeting
	The Director of Engagement and Integration attended a Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC)
16.01.19	The Director of Finance and Commerce attended a Trust Contract Management Board meeting with colleagues from CCG
	The Deputy Chief Executive and Director of Finance and Commerce attended a System Finance and Pressures meeting with colleagues from HCCG
	The Director of Quality attended Contract Management Board with Herefordshire CCG
	The Director of Quality attended Clinical & Quality Review Forum with Herefordshire CCG

17.01.19 The Director of Finance and Commerce attended an IT Partnership Board meeting with senior colleagues from GCCG and GHT

The Deputy Chief Executive attended am ICS Delivery Board meeting with GCCG colleagues

18.01.19 The Deputy Chief Executive and Director of Finance and Commerce met with the Chief Information Officer for NHSE

21.01.19 The Director of Engagement and Integration, Director of Service Delivery and Director of Finance and Commerce attended a Swindon MIND & 2gether Quarterly Strategic Partnership meeting

The Deputy Chief Executive was on the interview panel for Director of Performance for NHS South Worcestershire CCG

22.01.19 The Director of Engagement and Integration attended an ICS Clinical Reference Group meeting

The Deputy Chief Executive attended an STP Partnership Board regarding Long Term Plan

The Director or Service Delivery attended a Dementia CPG Board meeting with GCCG

The Director of Quality attended a contract meeting with Gloucestershire CCG

23.01.19 The Deputy chief Executive and Director of Service Delivery attended a meeting with GCS and CCG colleagues regarding Structure of Integrated Locality Boards

The Deputy Chief Executive attended a Primary Care Home Workshop

The Director of Service Delivery attended a Service Development meeting with Kingfisher Treasure Seekers

The Director of Service Delivery attended a Children's Improvement Board meeting with Gloucester Council

24.01.19 The Director of Engagement and Integration had a conversation with Healthwatch Gloucestershire

25.01.19 The Director of Engagement and Integration had an Engagement/Communications meeting with colleagues from GCCG and GCS

28.01.19 The Director of Finance and Commerce attended a Resources Steering Group meeting with Gloucestershire CCG at Sanger House

	The Director of Finance and Commerce attended a meeting regarding IT Convergence with colleagues from GCCG and GHFT
	The Deputy Chief Executive attended Hereford Hot House Week meetings regarding Strategy and Governance and Integrated Care Delivery.
	The Director of Service delivery met with the Chief Super Intendent of Gloucester Constabulary
29.01.19	The Director of Engagement and Integration attended an STP Clinical Reference Group workshop
	The Deputy Chief Executive attended Hereford Hot House Week meetings regarding Urgent Care and Operational Delivery
31.01.19	The Director of Finance and Commerce attended a meeting on Mental Health and System Impacts with colleagues from HCCG
	The Director of Organisational Development attended the GCS Board of Directors meeting
	The Director of Engagement and Integration presented an item at the GCS Board of Directors meeting
	The Deputy Chief Executive attended Hereford Hot House Week meetings regarding Models and Pathways and MH and System Impacts
01.02.19	The Deputy Chief Executive attended Hereford Hot House Week Round Up meetings
04.02.19	The Director of Organisational Development chaired the ICS Social Partnership Group meeting
	The Deputy Chief Executive attended the Cheltenham Integrated Locality Board meeting
05.02.19	The Director of Engagement and Integration attended a Research 4 Gloucestershire Steering Group meeting
	The Deputy Chief Executive attended a ILP/PCN working Group meeting
	The Director of Quality attended a contract meeting with Gloucestershire CCG
06.02.19	The Director of Organisational Development took part in the Interim ICS Independent Chair interview panel

07.02.19	The Deputy Chief Executive and Director of Service Delivery both participated in the recruitment process for the Chief Operating officer at Gloucestershire Hospitals NHS FT
08.02.19	The Deputy Chief Executive and Director of Service Delivery were interviewed by The Kings Fund
	The Deputy Chief Executive attended a Reflections from Hot House Week meeting in Hereford
11.02.19	The Director of Finance and Commerce and Deputy Chief Executive attended an LDR Executive Steering Group with senior colleagues from several organisations
12.02.19	The Director of Organisational Development chaired the ICS Workforce Steering Group meeting
	The Director of Service Delivery attended a Dementia Steering Group meeting
13.02.19	The Director of Engagement and Integration attended a Values Session Away Day with colleagues from 2g/GCS
	The Director of Service Delivery attended an Away Day for Learning Disability Services and CPD Session
19.02.19	The Deputy Chief Executive attended an ICA Programme Board meeting
	The Deputy Chief Executive attended an STP Partnership Board meeting
	The Director of Quality attended a contract meeting with Gloucestershire CCG
20.02.19	The Director of Finance and Commerce attended a One Herefordshire Financial Delivery meeting with colleagues from several Herefordshire organisations
	The Director of Finance and Commerce and Director of Service Delivery attended the Trust Contract Management Board with colleagues from HCCG
21.02.19	The Deputy Chief Executive attended an ICS Delivery Board with colleagues from GCCG
	The Director of Quality attended the Gloucestershire Safeguarding Adults Board
22.02.19	The Director of Quality held a teleconference with the NHSI Quality Team

25.02.19 The Director of Finance and Commerce attended a Resources Steering Group meeting with Gloucestershire CCG at Sanger House

The Director of Finance and Commerce and Deputy Chief Executive attended a LDR Executive Steering Group meeting

The Director of Quality attended a Learning Disabilities Steering Group Meeting

26.02.19 The Director of Engagement and Integration chaired the One Gloucestershire Tackling Mental Health Stigma Group

The Director of Engagement and Integration attended an ICS Clinical Reference Group meeting

The Deputy Chief Executive and Director of Service Delivery attended a Dementia CPG Board meeting with GCCG colleagues

The Deputy Chief Executive attended an ICS Board with GCCG

The Director of Service Delivery participated in a EPMA Bid Interview with NHS Improvement

27.02.19 The Director of Organisational Development attended the Gloucestershire Local Workforce Advisory Board (LWAB) meeting

The Deputy Chief Executive attended a Herefordshire and Worcestershire Digital Workshop

28.02.19 The Deputy Chief Executive and the Director of Finance and Commerce met with representatives from Greenway Properties regarding Holly House/Coney Hill

National Engagement

09.01.19 The Director of Engagement and Integration teleconferenced in to a Royal College of Occupational Therapists (RCOT) Fellowship Committee meeting

10.01.19 The Director of Engagement and Integration attended a Joint Local Clinical Research Network strategic meeting event in Bristol

15.02.19 The Director of Organisational Development attended a South West HR Directors Network meeting in Taunton

18.02.19 The Director of Quality chaired a Learning Into Action National Meeting via teleconference

28.02.19 The Director of Engagement and Integration attended a ‘The role of AHP Leaders in Public Health and Prevention’ event in Manchester

Agenda item **Paper K**

Report to:	Trust Board, 27th March 2019
Author:	Stephen Andrews, Deputy Director of Finance
Presented by:	Andrew Lee, Director of Finance and Commerce

SUBJECT: **Finance report for period ending 28th February 2019**

Can this report be discussed at a public Board meeting?	No
If not, explain why	This report contains commercially sensitive information

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

EXECUTIVE SUMMARY

- The month 11 position is a surplus of £778k which is in line with the planned surplus.
- The Trust incurred significant out of county bed costs in February after having to place service users in private provider beds outside of Gloucestershire and Herefordshire due to all beds in Acute Mental Health and PICU being full.
- The month 11 forecast outturn is an £834k surplus in line with the Trust's control total despite the significant additional out of county bed day costs. There remains the potential for the Trust to receive incentive PSF payments of £42k if we deliver this forecast position which would take the surplus to £876k.
- The Trust has a Single Oversight Framework segment of 1 and a Finance and Use of Resources metric of 2.
- The agency cost forecast is £4.459m, a decrease of £0.068m on last month's projection and £1.325m above the Agency Control Total. This decrease is due to lower than anticipated Medical and IAPT agency spend in February.
- National planning guidance for 2019/20 has been released. The Financial Control Total (FCT) for 2019/20 has been reduced to an £803k surplus. The Trust Board has confirmed it will accept the new FCT.
- The Trust is progressing well with budget setting for next year and is presenting a separate report to the Board in March.
- The Trust has identified £1.75m of recurring savings up to February 2019.
- The Trust has a year end cash projection of £15.9m which is £6.1m greater than the plan.

RECOMMENDATIONS

It is recommended that the Board:

- note the month 11 position
- note the risks inherent in the financial projections

Corporate Considerations	
Quality implications:	None identified
Resource implications:	Identified in the report
Equalities implications:	None
Risk implications:	Identified in the report

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

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

Reviewed by: Andrew Lee, Director of Finance and Commerce		
	Date	21st March 2019

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
	Date	

Explanation of acronyms used:	IAPT – Improving Access to Psychological Therapies PICU – Psychiatric Intensive Care Unit

1. CONTEXT

The Board has a responsibility to monitor and manage the performance of the Trust. This report presents the financial position and forecasts for consideration by the Board.

2. EXECUTIVE SUMMARY

The following table details headline financial performance indicators for the Trust in a traffic light format driven by the parameters detailed below. Red indicates that significant variance from plan, amber that performance is close to plan and green that performance is in line with plan or better.

Indicator	**Measure**		**Comments**
NHS I Oversight	Single Oversight Framework Segment	1.0	as at Dec 2018
Use of Resources	Financial Risk rating	2.0	as at Feb 2019
Income	FOT vs FT Plan	102.7%	
Operating Expenditure	FOT vs FT Plan	102.9%	
Year end Cash position	£m	15.9	
PSPP	%age of invoices paid within 30 days	93.0%	86% paid in 10 days
Capital Income	Monthly vs FT Plan	170.3%	sale of Fieldview, Coleford House & London Rd
Capital Expenditure	Monthly vs FT Plan	64.9%	£1,797k expenditure.

The parameters for the traffic light dashboard are as follows;

Indicator	RED 	AMBER 	GREEN 
NHS I FOT segment score	>3	2.5 - 3	<2.5
Use of Resources Score	>3	2.5 - 3	<2.5
INCOME FOT vs FT Plan	<99%	99% - <100%	=>100%
Expenditure FOT vs FT Plan	>101%	>100% - 101%	=<100%
CASH	<£8m	£8-£10m	>£10m
Public Sector Payment Policy - YTD	<=80%	>80% - <95%	>=95%
Capital Income - Monthly vs FT Plan	<90%	90% - 100%	>100%
Capital Spend - Monthly vs FT Plan	>115% or <85%	110% - 115% or 85% to 90%	>90% to <110%

- The financial position of the Trust at month 11 is a surplus of £778k which is in line with the planned surplus (see appendices 1 & 8).
- Income is £2,563k over recovered against budget and operational expenditure is £2,611k over spent, and non-operational items are £53k under spent.

The table below highlights the performance against expenditure budgets for all localities and directorates for the year to date, plus the total income position.

Trust Summary	Annual Budget £000	Budget to Date £000	Actuals to Date £000	Variance to Date £000	Year End Forecast £000	Year End Variance £000
Cheltenham & N Cots Locality	(5,307)	(4,860)	(4,692)	168	(5,162)	145
Stroud & S Cots Locality	(6,119)	(5,600)	(5,469)	131	(5,999)	121
Gloucester & Forest Locality	(4,560)	(4,159)	(4,131)	29	(4,475)	85
Social Care Management	(5,033)	(4,617)	(5,723)	(1,107)	(6,283)	(1,249)
Entry Level	(6,313)	(5,769)	(5,631)	138	(6,415)	(102)
Countywide	(32,274)	(29,598)	(30,202)	(605)	(32,772)	(498)
Children & Young People's Service	(6,823)	(6,256)	(5,694)	562	(6,202)	620
Herefordshire Services	(13,626)	(12,486)	(12,475)	12	(13,719)	(94)
Medical	(15,368)	(14,066)	(14,820)	(754)	(16,102)	(734)
Board	(1,423)	(1,304)	(2,630)	(1,326)	(3,111)	(1,688)
Internal Customer Services	(1,864)	(1,708)	(1,650)	59	(1,794)	70
Finance & Commerce	(6,388)	(5,884)	(6,338)	(454)	(6,710)	(322)
HR & Organisational Development	(3,493)	(3,202)	(2,966)	235	(3,263)	230
Quality & Performance	(3,171)	(2,907)	(2,918)	(11)	(3,299)	(128)
Engagement & Integration	(1,502)	(1,375)	(1,393)	(18)	(1,524)	(22)
Operations Directorate	(1,046)	(959)	(1,071)	(112)	(1,168)	(122)
Other (incl. provisional / savings / dep'r	(4,989)	(4,563)	(4,308)	255	(4,733)	256
Income	120,133	110,087	112,890	2,803	123,566	3,433
TOTAL	**834**	**774**	**778**	**4**	**834**	**0**

The key points are summarised below;

In month

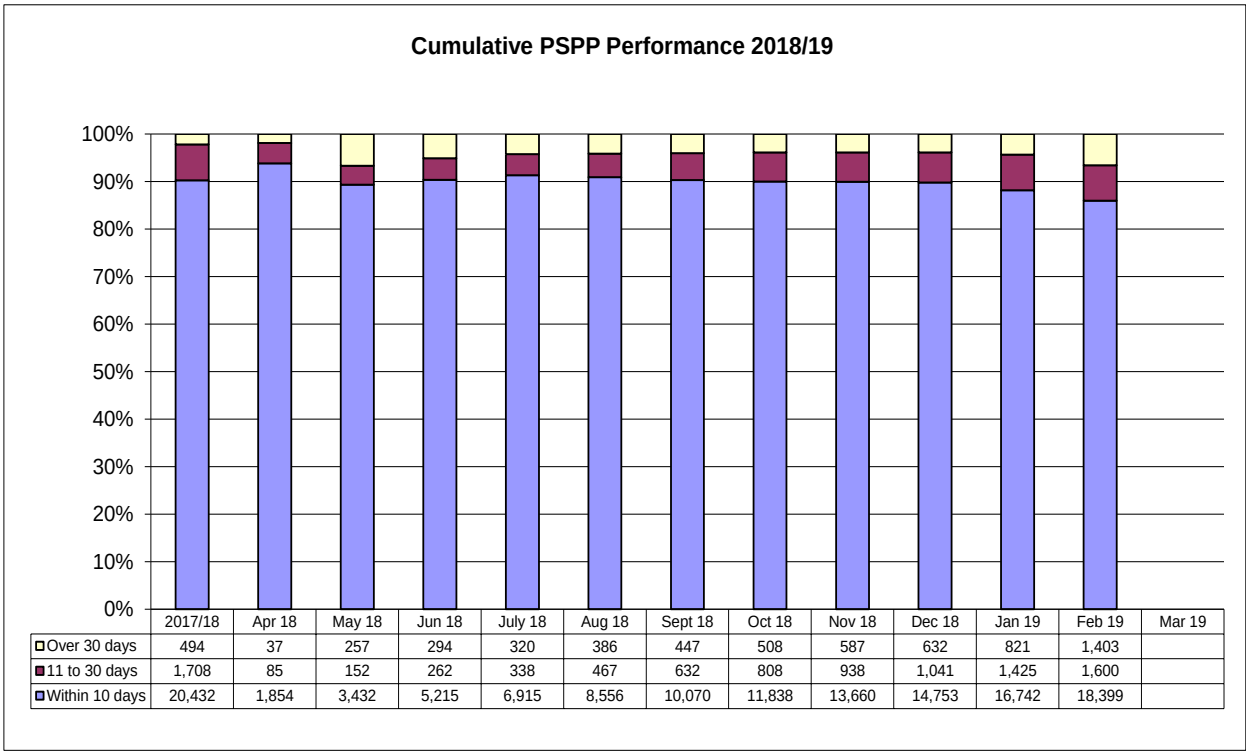
- The Social Care Management over spend relates to Community Care and is offset by additional income
- Countywide is over spent predominantly due to out of county bed costs and Complex Care patient costs. Both of these issues saw cost increases of c.£150k in February as a result of the Acute Mental Health and PICU bed capacity being full in January/February across the Trust
- The Childrens Services under spend relates to vacancies and project expenditure not yet fully committed
- The Medical over spend has been caused by agency expenditure - £1.619m year-to-date
- The over spend on Board relates to Improving Patient Safety spend, merger costs and STP OD project spend for which there is some income to cover all three issues
- Finance and Commerce is over spent on maintenance, telephony and COIN although some is offset by income
- HR & Organisational Development is under spent due to vacancies across a number of departments
- Income is over recovered due to additional income for activity related Community Care work and additional development funds which weren't budgeted

Forecast

- The Social Care Management forecast over spend relates to Community Care and is offset by additional income
- The Countywide services forecast over spend was increased by £400k due to out of county bed costs
- The Medical forecast over spend is due to anticipated continuing usage of agency during 2018/19
- The forecast over spend on Board is linked to expenditure on STP OD projects for which there is some budget in reserves
- Finance and Commerce's forecast over spend is caused by increased maintenance and COIN (IT network) costs

PUBLIC SECTOR PAYMENT POLICY (PSPP)

The cumulative Public Sector Payment Policy (PSPP) performance for month 11 is 86% of invoices paid in 10 days and 93% paid in 30 days. The cumulative performance to date is depicted in the chart below and compared with last year's position:



	2017/18	Apr 18	May 18	Jun 18	July 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Over 30 days	494	37	257	294	320	386	447	508	587	632	821	1,403	
11 to 30 days	1,708	85	152	262	338	467	632	808	938	1,041	1,425	1,600	
Within 10 days	20,432	1,854	3,432	5,215	6,915	8,556	10,070	11,838	13,660	14,753	16,742	18,399	

	10 days		30 days	
	In month	**YTD**	**In month**	**YTD**
Number paid	1,673	18,399	1,837	19,999
Total Paid	2,414	21,402	2,414	21,402
%age performance	**69%**	**86%**	**76%**	**93%**
Value paid (£000)	4,963	60,497	5,065	62,579
Total value (£000)	5,358	64,953	5,358	64,953
%age performance	**93%**	**93%**	**95%**	**96%**

Agenda item 17 **Paper L**

Report to:	Trust Board, 27 March 2019
Author:	John McIlveen, Trust Secretary
Presented by:	John McIlveen, Trust Secretary
SUBJECT:	**Change to the Trust Constitution**

This Report is provided for:			
Decision	Endorsement	Assurance	Information

EXECUTIVE SUMMARY

A change to the Trust's Constitution is proposed which will incorporate the Trust's new name, once agreed and appropriately notified to stakeholders, into the constitution. The revised clause makes the change of name conditional upon the merger with Gloucestershire Care Services taking effect. It is for the Boards of both Trusts to agree the name of the new Trust.

The Council of Governors agreed at its meeting on 14th March to make this change, subject to a slight change to the proposed wording which has been incorporated into the paper before the Board today.

If agreed by the Board today, the revision will be incorporated in to the Trust Constitution, but will have no effect unless and until the merger is formally approved.

RECOMMENDATIONS

- That the Board approves an amendment to the Trust's Constitution, renaming the Trust based on the final name determined by the Boards of both 2gether and Gloucestershire Care Services NHS Trust when they meet at the end of March.

Corporate Considerations	
Quality Implications:	None identified
Resource implications:	None identified
Equalities implications:	None identified
Risk implications:	None identified

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

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

Reviewed by:		
	Date	

Where in the Trust has this been discussed before?		
Council of Governors	Date	14 March 2019
What consultation has there been?		
N/A		

Explanation of acronyms used:	N/A

1. Change to the Trust Constitution

1.1 A Trust's name is recorded in its constitution. A change will be required to the Trust Constitution to note formally the change of name. The following amendment, in the form of an additional clause as shown in red text, is proposed:

The name of the foundation trust is 2gether NHS Foundation Trust (the Trust). The Trust is a public benefit corporation authorised under the NHS Act 2006, with effect from 1 July 2007. The functions of the Trust are conferred by this legislation.

In the event that the Trust acquires Gloucestershire Care Services NHS Trust under section 56A of the National Health Service Act 2006, the name of the Trust will be XXXXXXX

1.2 This amendment is therefore conditional upon the merger taking effect. Should the merger not take place, this new clause will become redundant and the Trust will continue to be known as 2gether. Once the merger does take effect, the new clause will take effect without the need for agreeing further amendments to the Constitution. Other references to 2gether (such as in page footers) will subsequently be amended.

1.3 The Council of Governors agreed this amendment at its meeting on 14th March. If agreed by the Board today, the amendment will therefore become part of the Trust's Constitution, but will have no effect unless and until the merger is formally approved.

2. Recommendations

2.1 The Board is asked to:

- approve the above change to the constitution.

Agenda item 19 **PAPER M**

Report to:	Board of Directors
Authors:	Nick Grubb, Assistant HR Director, Neil Savage, Director of HR and Organisation Development
Presented by:	Neil Savage, Director of HR and Organisation Development

SUBJECT: **Gender Pay Gap Reporting 2018**

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

EXECUTIVE SUMMARY

Current Gender Pay Gap legislation requires NHS Trusts to publish annually a series of calculations that highlight the gender pay gap across the workforce. The information must be published on the Trust website and Gov.UK by 30 March 2019.

This will be the second year that organisations with 250 or more employees, public and private sector, must publish gender pay gap information on their website and on the Government's website.

Recent HMRC figures suggest that being a woman in Gloucestershire reduces pay income by 26%, meaning that being a woman in the county means that their earnings will be nearly £9,000 less per annum than men. This picture reflects a similar pattern more widely across the South West, with women having an average pre-tax income of £25,000 compared to £33,987 per annum for men. The picture is similar at a national level.

This report contains the statutorily required calculations, presenting the gender pay gap within ²gether NHS Foundation Trust against the six indicators. These are the result of a snapshot of the Trust's workforce on 31st March 2018 as required and are summarised below:

- Mean average gender pay gap – Females earn 22% less than males
- Median average gender pay gap - Females earn 16% less than males
- Mean average bonus gender pay gap – Females are paid 35% less than males
- Median average bonus gender pay gap – Females are paid 0.3% less than males
- 44% of males receive a bonus payment (Consultant Clinical Excellence Awards) compared with 13% of females
- Proportion of males and females when divided into four groups ordered from lowest to highest pay - there are a higher proportion of females in all quartiles although the gap closes with progression toward the upper quartile

Therefore the Trust's gender pay gap reveals that female colleagues earn 22.6% less

than male colleagues, which is higher than in the previous reporting year (20.84%).

This evidences that while colleagues are paid on the basis of equal opportunities compliant pay and terms of conditions, because of key contributors such as working patterns, part-time working, job tenure, Clinical Excellence Award bonus payments and career breaks, females earn significantly less than males in the Trust.

The data also shows that on the 31st of March 2018 the Trust's gender pay gap was the result of a disproportionate number of men in more senior Agenda for Change roles, more men in Executive Director roles with longer NHS and director-level experience, alongside a disparity of Clinical Excellence Awards being applied for and issued to male Consultants compared to females.

RECOMMENDATIONS

The Board is asked to note and debate this report, supporting the proposal that a further short life working group be established to review the detailed data, compare with other NHS employers and advise on any proposed actions to close the gender pay gap.

Corporate Considerations	
Quality implications:	The Trust strives to provide equality for all colleagues, leading to increased levels of colleague satisfaction and ultimately improved patient care.
Resource implications:	By failing to recognise and address issues of equality, colleague turnover could increase and also increase the amount of casework by responding to claims of detrimental treatment.
Equalities implications:	The Equalities Act 2010 sets out the duties of the Trust and the Equality and Human Rights Commission give clear guidance which the Trust should endeavour to meet. This report is intended to progress the agenda to meet these duties and guidance and to ensure compliance.
Risk implications:	Failure to provide equality of opportunity may result in claims of discrimination and damage to the reputation to the Trust as a fair employer.

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

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

Reviewed by:		
Neil Savage, Joint Director of HR and Organisation Development	Date	15 March 2019

Where in the Trust has this been discussed before?		
Board of Directors	Date	28 March 2018
Appointment and Terms of Service Committee		20 March 2019

What consultation has there been?		
N/A	Date	

Explanation of acronyms used:	CEA – Clinical Excellence Awards

1. Context – what is gender pay gap reporting?

Legislation requires employers with more than 250 employees to publish annually a range of statutory calculations showing how large the pay gap is between their female and male employees. There are two sets of regulations, one mainly for private and voluntary sectors, which became effective from 5th April 2017. The second, mainly for public sector organisations, took effect from March 2017 and was required to be reported by the end of March 2018.

The second round of reporting is required to be published on the Government's website and the Trusts' own website on 30th March 2019 and will be based upon a snapshot of the workforce on 31st March 2018.

These results must be accompanied by a written statement of confirmation from the Chief Executive or another appropriate person. An action plan should also be published outlining how the organisation plans to reduce the gender pay gap.

It should be noted that gender pay reporting is different to equal pay. This is important and a point that is often confused and misunderstood when considering the gender pay gap.

Equal pay deals with the differences in pay between men and women doing the same or similar jobs or jobs of equal value. It is unlawful to pay people unequally because of their gender and has been since the adoption of the UK's Equal Pay Act in 1970 which prohibited any less favourable treatment between men and women in terms of pay and conditions of employment.

The gender pay gap shows the difference in the **average (or mean) pay** between all men and all women in the workforce. If the workforce has a high gender pay gap, this may indicate a number of issues to deal with, and the individual calculations may help to identify what those issues are.

NHS Agenda for Change terms and conditions of service contain the national pay and conditions of service for NHS colleagues other than very senior managers and medics.

The majority of ²gether NHS Foundation Trust colleagues work under the central NHS terms and conditions known as "Agenda for Change". These arrangements were introduced in 2004 with the express intention of removing and avoiding pay inequalities. Agenda for Change covers more than 1 million people and harmonises their pay scales and career progression arrangements across traditionally separate pay groups. Colleagues are expected to move up the pay bands irrespective of gender. The Agenda for Change (AfC) Job Evaluation process enables jobs to be matched to national job profiles and allows Trusts to evaluate jobs locally to determine in which AfC pay band a post should sit.

Medical and Dental colleagues have different sets of Terms and Conditions, depending on their seniority. However, these too are based on the principles of equal opportunity and are set across a number of pay scales for basic pay, which have varying thresholds within them. Directors are usually appointed on Hay or other equal opportunity job evaluation related methods and regularly benchmarked using national surveys.

2. Gender Pay Gap Indicators

Employers must publish the results of six calculations showing their:

1. Average gender pay gap as a mean average
2. Average gender pay gap as a median average
3. Average bonus gender pay gap as a mean average
4. Average bonus gender pay gap as a median average
5. Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
6. Proportion of males and females when divided into four groups ordered from lowest to highest pay.

It should be noted that Consultant Medical colleagues are the only employees to receive bonus payments within the Trust in the form of either national or local Clinical Excellence Awards. Directors and Senior Managers do not receive any bonus or performance related pay.

3. Gender Pay Gap Analysis (31st March 2018 Snapshot)

Table 1 - ²gether NHS Foundation Trust headcount as at 31st March 2018 (exc. Staff Bank)

Payband	Female	% make up	Male	% make up
Band 1	43	72%	17	28%
Band 2	82	85%	15	15%
Band 3	355	79%	95	21%
Band 4	178	89%	21	11%
Band 5	268	78%	76	22%
Band 6	374	79%	100	21%
Band 7	163	73%	60	27%
Band 8a	51	65%	28	35%
Band 8b	42	78%	12	22%
Band 8c	11	61%	7	39%
Apprentice		0%	1	100%
Band 8d	4	44%	5	56%
Band 9		0%	2	100%
Board Member	2	33%	4	67%
Medical	53	50%	54	50%
Student	13	76%	4	24%
Grand Total	**1639**	**77%**	**501**	**23%**

These percentages remain identical to last year's data although there is a minor variation in the headcount numbers.

Table 2 - 2gether NHS Foundation Trust Staff Bank headcount as at 31st March 2018

Payband	Female	% make up	Male	% make up	Grand Total
Band 1	4	57%	3	43%	7
Band 2	31	84%	6	16%	37
Band 3	148	79%	40	21%	188
Band 4	26	87%	4	13%	30
Band 5	54	86%	9	14%	63
Band 6	52	79%	14	21%	66
Band 7	14	93%	1	7%	15
Band 8a	8	100%		0%	8
Band 8b	2	100%		0%	2
Medical		0%	1	100%	1
Student	7	88%	1	13%	8
Grand Total	**346**	**81%**	**79**	**19%**	**425**

These percentages remain similar to last year's data which was 79% and 21% respectively.

Table 3a – Average and Median Hourly Rates – all eligible staff and pay schemes

Gender	Avg. Hourly Rate	Median Hourly Rate

Male	£19.65 (£19.23)	£16.21 (£16.54)
Female	£15.29 (£15.22)	£13.59 (13.88)
Difference	£4.36 (£4.01)	£2.61 (£2.67)
Pay Gap %	22.16% (20.84%)	16.13% (16.12%)

(Last year's figures in brackets)

The above figures show a statistically insignificant widening of the gender pay gap as measured by average hourly rate and median hourly rate.

Table 3b – Change in average hourly rate

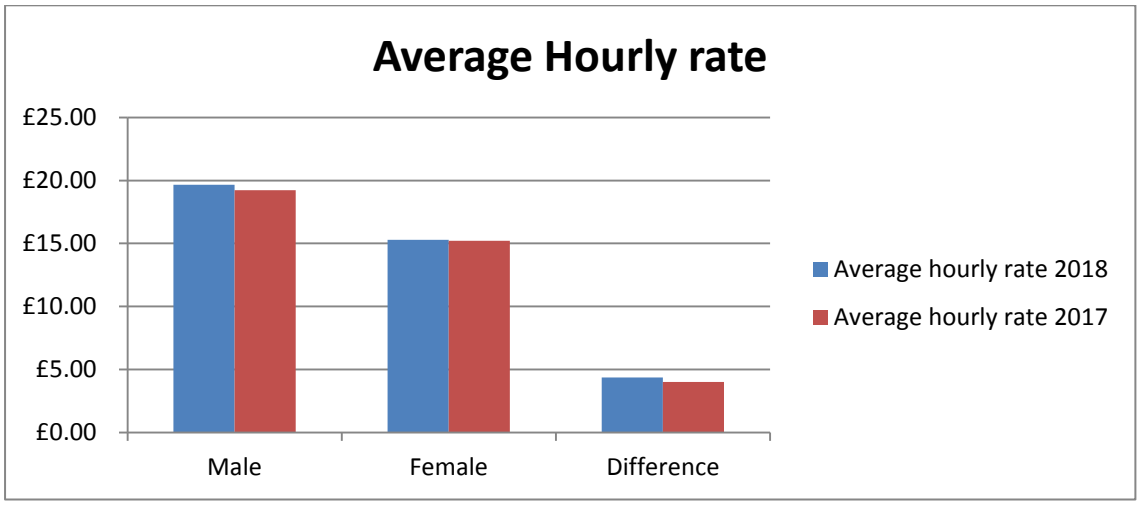


Table 4a – Number of employees – Q1=Low, Q4=High

Quartile	Female	Male	Female %	Male %
1	457.00 (436)	100.00 (93)	82.05 (82.42)	17.95 (17.58)
2	452.00 (467)	106.00 (103)	81.00 (81.93)	19.00 (18.07)
3	434.00 (430)	123.00 (120)	77.92 (78.18)	22.08 (21.82)
4	370.00 (359)	188.00 (190)	66.31 (65.39)	33.69 (34.61)

(Last year's figures in brackets)

The above figures show a static workforce in terms of gender breakdown, and this is shown pictorially in the bar chart below in Table 4b.

Table 4b – Percentage of staff in each quartile

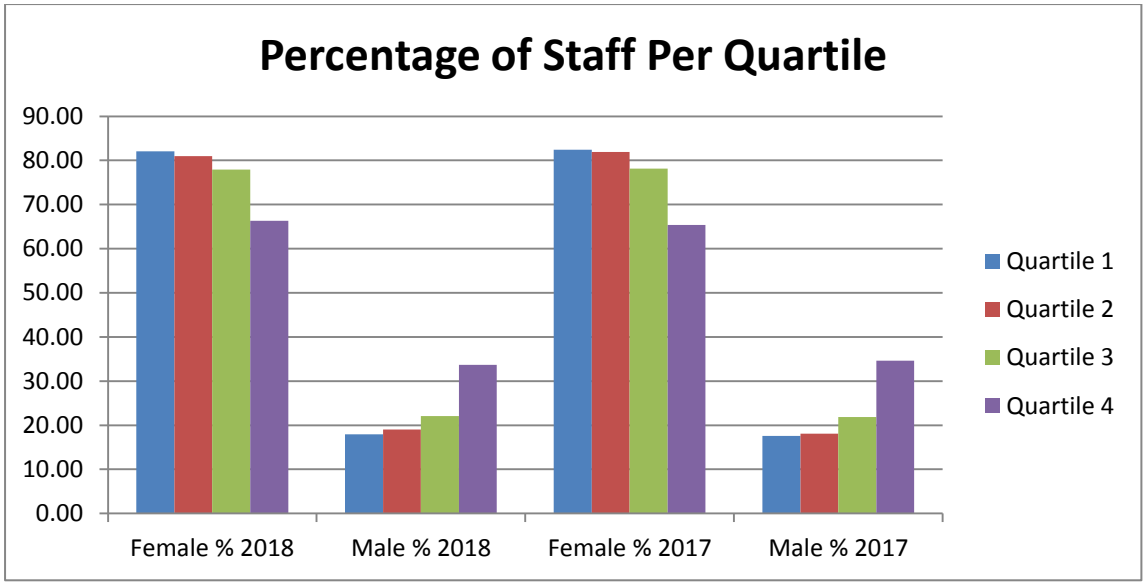


Table 5a – Average Bonus* Gender Pay Gap

Gender	Avg. Pay	Median Pay
Male	£11,808.54 (£14,824.13)	£7,810.23 (£10,445.60)
Female	£7,704.98 (£11900.12)	£7,786.35 (£5,967.20)
Difference	£4,103.57 (£2,924.01)	£23.88 (£4,478.4)
Pay Gap %	34.75 (19.72)	0.31 (42.87)

The above figures show an increase in the gender pay gap, and this is also displayed pictorially in the bar chart below in Table 5b.

Table 5b – Average Bonus Gender Pay Gap

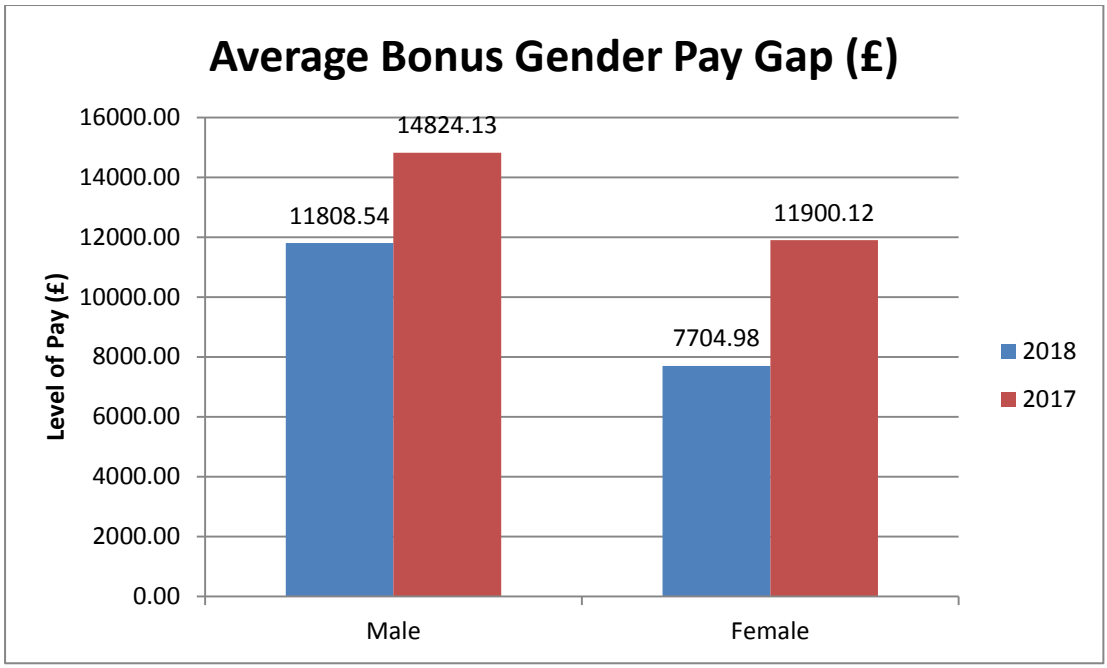


Table 6 – Proportion of males and females receiving a bonus* against the total

Total Medical Staff	Gender		% of total		Number of staff receiving bonus		% of staff receiving a bonus	
	Males	Females	Males	Females	Male	Female	Male	Female
107 (2018)	54	53	50%	50%	24	7	44%	13%
95 (2017)	49	45	52%	47%	21	6	43%	13%

*Clinical Excellence Awards – medical staff only

The above data shows there has been a statistically insignificant increase in the number of male consultants receiving a Clinical Excellence Award and no percentage change in the number of female consultants receiving an award.

4. Conclusions

The headline figure based on all eligible Trust employees and pay schemes indicates that women are paid 22.16% less on average than men. This shows an increase in the gender pay gap from 20.84% in the first year of reporting. Table 3 shows that whilst both men and women are both receiving a higher hourly average rate, the male average hourly rate has increased by 42p whilst the average rate for women has increased by only 7p per hour. Table 3b highlights the difference graphically.

The gap for median (middle point) earnings is much closer, standing at 16.13% less for women.

The data shows that 77% of the Trust's substantive (i.e. Non-Bank) workforce are women, and, ideally, an analysis would show this broadly reflected in each Agenda for Change pay band, Medical and Dental pay and Executive Board level pay. However, as with the previous year, this is not the case with the percentage of women reducing at the senior end of the pay scale. This can be seen in tables 4a and 4b. With less posts typically available at senior level, there are clearly less opportunities for promotion and therefore less opportunities to progress to the highest levels of pay. Even allowing for the availability of promotional opportunities, the pay gap will only close gradually due to incremental progression and the time taken to rise through the pay bands. Changes in working patterns and choices about career breaks will also factor into this.

Gender pay gap reporting has to include all earnings including bonus payments. As the only payments that fall into this category are Clinical Excellence Awards (CEA) that can be applied for and awarded to Medical Consultants. Although there was an even divide in the numbers of male and female consultants, considerably more men apply for these and are awarded these payments than women, thereby being a significant contributing factor to the Trust's overall mean gender pay gap. This is a pattern repeated across the NHS, particularly in Acute, Acute Specialist and Mental Health Trusts, and one which typically does not factor in Community Trusts in view of the low numbers of medics. However, both male and female colleagues were in receipt of lower CEAs during the reporting period and the median bonus pay gap is almost equal between male and female Consultants.

The gender pay gap is also significant at Executive Director level with the average hourly rate 34% lower for females than males. Five of seven post holders were men and the four NHS-typical highest paying Executive roles all had men within them. This snapshot was taken when Marie Croft was in post as Director of Quality and will widen further for the third report to follow later this year in view of the further increased number of male appointments made as part of the Shadow Board appointments.

It should be noted that of the organisations that had uploaded their second year gap report by January 2019, circa half of them have shown improvement[1] and around 1 in 7 had reported no change. The Personnel Today article also points out that the departure of a single senior female in certain companies could lead to a 5% increase in their gender pay gap in view of the small numbers of colleagues working at a senior level.

The Trust has regularly stated its full commitment to equality of opportunity across the whole organisation and should recognise from the most recent data that there remains much work to do to close the gender pay gap. Progress is unlikely to be

[1] Jo Faragher, Personnel Today 16th January 2019

achieved quickly or exclusively by internal organisational actions, requiring a wider societal shift in attitudes and behaviours.

The Trust can make a difference and narrow the gap by taking some short and medium term actions. As an example, given the success in increasing the BAME representation at Board level for both Executive and Non-Executive Director since 2017, a similar approach should be adopted to highlight that for senior vacancies, while we welcome all applicants, we are currently under-represented by women. We can also apply the similar "all other things being equal" approach taken to the recent Non-Executive Director appointments, to senior appointments, allowing positive action to be taken. Positive action is lawful under the Equality Act.

An action plan is required to work toward closing the gap, accepting that there is no 'quick fix'.

5. Recommended Actions

The following actions have been considered and supported by the Appointment and Terms of Service Committee and are recommended for the Board's consideration and support:-

Indicator(s)	Result(s)	Action(s)	Timeframe & Lead
Average bonus gender pay gap as a mean average	Female CEA awards are less than male CEA awards	1.Review the Trust's CEA Scheme against equalities requirements and recommend actions for implementation prior to the next round planned for Q3/Q4 2019/20.	End Q2 2019/20 – Alison Wilmott-Miller, Interim Deputy Director of HR, supported by Tracey Harper, Senior HR Manager
Average bonus gender pay gap as a median average, and, proportion of men receiving a bonus payment and proportion of women receiving a bonus payment	Female CEA awards are less than male CEA awards, and, Significantly higher percentages of men are awarded CEA awards than women.	2.Annual joint letter to all female consultants to encourage applications for CEA and offer bespoke support with application submissions. 3.Annual CEA presentation and workshop to be provided to all consultant colleagues with focussed encouragement for women to attend.	End Q2 2019/20 – Neil Savage, Director of Organisational Development, and Amjad Uppal, Medical Director.

Average gender pay gap as a mean and median average, and, proportion of men and women when divided into four groups ordered from lowest to highest pay.	Women Directors receive less pay than male colleagues.	4.The Appointment and Terms of Service Committee (ATOS) to proactively take into account Gender Pay Gap data and considerations in all future Executive Director appointments, pay or wider VSM pay decisions	Immediate and on-going. Joint Chair and Director of HR and Organisation Development.
Average gender pay gap as a mean and median average, and, proportion of men and women when divided into four groups ordered from lowest to highest pay.	Women receive less pay than male colleagues.	5.Executive Directors proactively take into account Gender Pay Gap data and considerations in all future senior management appointments or pay considerations. 6.Executive Directors and VSM to work with HR colleagues to proactively signpost female colleagues to the Trust's Women's Leadership Network and to discretionary training, development and secondment opportunities. New Leadership strategy to clearly state approach to ensuring equality of opportunity and positive action. This will require talent management and succession planning to be undertaken with a positive action approach. 7.HR and Managers to ensure that recruitment processes have diverse representation. 8.Review our "unconscious bias"	Immediate and on-going. Director of HR and Organisation Development supported by Interim Deputy Director of HR,

		training content currently provided with Values Based Recruitment training. 9.HR to work with Communication to ensure all Managers and colleagues are aware of career break, paternity and adoption leave options. 10. Board Members to be supported, and where necessary trained, in offering targeted mentoring, coaching and reverse mentoring and coaching to female colleagues and those with protected characteristics.	
Average gender pay gap as a mean and median average, and, proportion of males and females when divided into four groups ordered from lowest to highest pay	Women earn less than men as a mean and median average although the gap is less for Agenda for Change colleagues There are a higher proportion of women in all quartiles although the gap reduces in each quartile. The gap closes significantly in the upper quartile.	11.Joint GCS and 2G working group to further investigate findings and advise on possible actions that may enable the gap to be closed.	End Q2 2019 / 20 – Neil Savage, Director of Organisational Development, supported by Nick Grubb and Sue Heafield.

Furthermore, an initial review of the Trust's Staff Survey results (and Staff Friends and Family Test results) do not present clear patterns or indicators that easily inform potential action, however, this will be further explored in Q1 2019/20 and also discussed by the Director of HR and Organisation Development with regional and national bodies.

Finally, the Board is asked to note that the Director of HR and Organisation Development will work with Communications colleagues to ensure the requisite gender pay gap information is published on the Government and Trust websites.

PAPER N1

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Delivery Committee

DATE OF COMMITTEE MEETING: 27 February 2019

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PERFORMANCE DASHBOARD

The Committee received the Performance Dashboard setting out the performance of the Trust for the period to the end of January 2019. Of the 194 performance indicators, 94 were reportable in December with 88 being compliant and 6 non-compliant at the end of the reporting period. Where performance was not compliant, Service Directors were taking the lead to address issues and work was ongoing in accordance with agreed Service Delivery Improvement Plans to address the underlying issues affecting performance.

FINANCE UPDATE

The month 10 forecast outturn was an £834k surplus, in line with the Trust's control total. There was the potential for the Trust to receive incentive PSF payments of £62k and if this position was delivered this would take surplus to £0.896m. The Committee noted that there would not be as much spent on Capital projects as was anticipated; major building work was not going ahead at present, work at Acorn House was planned for next year and Montpellier was likely to progress in the next financial year. However, the Committee was assured that planned maintenance was going ahead and there was no high risk maintenance outstanding.

The Committee was assured that the Trust was progressing well with budget setting for next year. £1.1m of recurring savings up to January 2019 had been identified and the Trust had a year end cash projection of £13.6m which was £3.8m greater than the plan.

IMPLEMENTATION OF THE CYPS LD SERVICE

The Delivery Committee received an update on the work undertaken in the CYPS LD Service since the last update in October 2018. The report provided the context for the service review and developments. The Committee noted the overview of the process of review and redesign of the current provision for Children with learning disabilities and their families currently underway in conjunction with GCS and CCG colleagues.

89 children were currently on the waiting list, with 27 months being the longest wait. Therefore agreement was reached to go ahead with the recruitment of a further 2.0 WTE Band 6 Nurses. The wait list was pro-actively managed and reviewed weekly, a process was in place for escalation of concerns and team linked with special schools in the local area.

The Committee agreed that reviews should be taking place and recorded in RiO. It was noted that it was more appropriate for some children on the waiting list to be signposted to other services. John Campbell asked that an independent review of the waiting list take place to provide assurance that it was appropriate for those children on the waiting list continued to wait. The review would also confirm that reviews and contact with the children on the waiting list was taking place and provide a plan to set out how the issues in the service would be addressed. An update would be provided in April.

The Committee noted the work undertaken in conjunction with commissioners and in line with the 'Better Care Together' agenda to establish a project which would review existing provision and pathways.

FINANCIAL SHARED SERVICES – KEY PERFORMANCE INDICATORS

Alex Gent reported on the Shared Services Key Performance indicators for 17/18. Information on the customer satisfaction survey was included and the Committee noted that rating was below target. The response rate was very low (100 surveys were sent out with 50 returned) and in some cases end users were dissatisfied in areas that were outside the remit of the service. A follow-up survey would be issued to provide a clearer picture and it was agreed that the results of that survey would be included in the next report.

The Committee noted that the Shared Service did not score well for value for money. However it was reported that payslip costs had not changed and additional work would be undertaken to understand this. This would be included in the next report to this Committee.

FINANCIAL SHARED SERVICES – UPDATE ON RETROSPECTIVE ORDERS

The Committee was updated on purchase orders created after the date of the invoice (retrospectively) for the period 1 April 2018 to 31 December 2018. During that period a total of 7,342 purchase orders were raised with1,548 raised retrospectively. This represented 21% of total orders raised.

42% of the retrospective orders were for agency payments and it was hoped that this would improve with the new contract. All others were where staff had waited for invoices to come in before raising an order and Alex suggested that additional training for staff may be required.

The Committee requested some additional information on the types of payments where purchase orders were being raised retrospectively. It was agreed that analysis of the retrospective orders, along with the risks and what could be done to make improvements would be provided to the Chair.

OUT OF COUNTY – LENGTHS OF STAY

Countywide Bed Occupancy was in excess of 92% (excluding leave) and currently a number of Gloucestershire individuals were receiving mental health treatment in Out of Area Placements (OAP's). Countywide Services had therefore been asked to outline current Lengths Of Stay (LOS) of the inpatient facilities, to highlight present challenges and to recommend future investigation to eliminate OAP's.

Countywide and Locality Services were to implement daily Skype Interface meetings to support timely discharge, where any identified organisation blockage would be resolved and Countywide Complex Care would provide daily updates for all of those individuals placed in OAP's and seek to support repatriation into locality services at the earliest opportunity.

The Committee noted the developments taking place in Countywide around admissions to inpatient services. This included development of robust plans to facilitate criteria led discharges less dependent on consultant presence. John Campbell reported that this was a significant risk to the Trust and it was agreed that an update report would be provided bi-monthly at this Committee.

OTHER ITEMS

- The Committee received the Locality exception reports from the Gloucestershire and Coutywide Localities
- The Committee received Dementia Demand Management updates for Gloucestershire, Herefordshire and Countywide Localities.
- The Committee was updated on the progress with the Perinatal Mental Health Community Services Development Fund. An application for funding for training on DBT skills and Compassionate Focused Therapy was approved by Health Education England.

ACTIONS REQUIRED BY THE BOARD

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

PAPER N1

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Delivery Committee

DATE OF COMMITTEE MEETING: 29 January 2019

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PERFORMANCE DASHBOARD

The Committee received the Performance Dashboard setting out the performance of the Trust for the period to the end of December 2018. Of the 194 performance indicators, 127 were reportable in December with 107 being compliant and 20 non-compliant at the end of the reporting period. Where performance was not compliant, Service Directors were taking the lead to address issues and work was ongoing in accordance with agreed Service Delivery Improvement Plans to address the underlying issues affecting performance.

ASSERTIVE OUTREACH – DEMAND MANAGEMENT

Herefordshire

The Committee received an update on developments within the Assertive Outreach Team for Herefordshire in 2018/19 these included:

- The development of robust discharge processes to ensure discharges were planned in advance
- The development of outcome measures
- The development of skilled based groups

The Committee noted that there had been fluctuations in referrals, contacts and discharges since 2012/13 but all had remained fairly consistent over the last six years. There was no waiting list for Assertive Outreach treatment

Gloucestershire

The Assertive Outreach Teams in Gloucestershire were compliant for the 6 Contractual Key Performance Indicators. The Committee noted Since 2014/2015 referrals, caseload, face to face contacts and discharges had been lower than the five year average and this was projected to continue in 2018/2019. The caseload length of stay had increased from 43 months in 2012 to 53 months in 2018, and there were variations in caseload length of stay across the Assertive Outreach Teams. 97% of Assertive Outreach Team patients were subject to the Care Programme Approach suggesting that the service was in line with the Service Specification. 54% of patients on the Assertive Outreach Teams caseload were diagnosed with Paranoid Schizophrenia and 16% with Schizoaffective Disorder; 11% of patients did not have a recorded diagnosis. Provisional data suggested that the overall average score on the Outreach Engagement Scale had improved across all three domains of medication compliance, agreement with treatment and basic relationships, and active participation and openness.

EATING DISORDERS SERVICE – EFFECTIVENESS UPDATE

The Committee received an overview of the Trust's Eating Disorders Service. The new Eating Disorders model was created to respond to an increase in referrals. Previously there had been long waiting lists for CBT-E treatment and a new system was required to address a number of issues in order to improve access and waiting times and treatment delivery. A high number of referrals were being received from GRH and work was being undertaken with the acute Trust. Three new teams were

created within the Community team with clearly defined roles and team Leads. The new model had seen the introduction of CBT T, Time limited treatment and Early intervention programmes. The numbers on the waiting list and the average waiting times had been reduced. Going forward the service would continue to monitor performance and to recruit new staff.

SERVICE PLAN – 6TH MONTHLY UPDATE

The Committee received an update the on the progress for Q2 against the Trust Service Plan Objectives for 2018/2019. The Committee noted the Objectives and the clear link to the Trust's Strategic Plan Objectives and Professional feedback. The increased link between service plan objectives and appraisals for managers was noted.

The Committee noted that additional Corporate Services had been included in Service Planning for this financial year and overall there were 65 objectives across the Trust. At the end of Q2 2018/19, there were six Red, 25 Amber and 34 Green objectives; 6 out of 9 of the Directorates had one 'red' objective. These would be worked on during Q3 and Q4 and the Committee noted that at this point last year, there was less progress against the Green objectives.

IAPT REPORT

The key issues for the Delivery Committee to be aware of this month. This included the in-stage waiting list backlog clearance. In both Counties, the backlog waiting list was the most significant concern. Waiting list numbers had increased in December due to the availability of staffing and the increased access planned in October and November to ensure Q3 Access achievement. In both Counties a range of actions and initiatives were being undertaken to address the backlog.

Access rates for December 2018 were above the Q3 recovery plan target for Herefordshire and in line with the Q3 recovery plan target for Gloucestershire. The Committee noted that the Q3 plan included over achievement in October and November to mitigate against lower access achieved in December when there are fewer working days. Recovery rates for December 2018 were above the national 50% target for Gloucestershire and Herefordshire and waiting time thresholds were currently being met.

OTHER ITEMS

- The Committee received the Locality exception reports from the Herefordshire Localities and CYPS and CAMHS localities
- An update report on the IRIS Project (CYP Service provision) was received and the progress since this was last reported to the Committee was noted. The Committee noted the key priorities and key challenges for the service and agreed that a further update report would be provided in April or by exception.
- The Committee received the Countywide Locality Review
- The Committee received the CQUIN report and noted that all CQUINs had been agreed for this year. The Committee was pleased to note that all reports for Herefordshire, Gloucestershire and Low Secure were deemed compliant for Q1 and Q2 of 18/19. Significant assurance was provided at this stage of the year in relation to the delivery of the 18/19 CQUINs.
- The Committee received the Review of the Delivery Committee Risks and noted that there were currently no Top 5 Risks allocated to the Delivery Committee. A new risk around Brexit had been assessed by the Executive and was included now in the Top 5 Risks for the Trust. Oversight of this risk was likely to be allocated to the Delivery Committee

ACTIONS REQUIRED BY THE BOARD

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

2gether Making life better

2gether NHS Foundation Trust

PAPER N2

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Development Committee

DATE OF COMMITTEE MEETING: 14 March 2019

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

REVIEW OF THE CAPITAL PROGRAMME

The Committee received a review of the Capital Programme. At month 10 capital expenditure was £1,557k which was an under spend of £1,147k against the NHS Improvement plan (£2,704k) and was an under spend of £1,007k against the Trust's revised budget plan (£2,564k). A number of programmes had suffered slippage, but many of these were due to factors outside the Trust's control. After a review of the 2018/19 programmes that will not be accessed and spent this financial year the M12 forecast capital expenditure is £2,716k with £1,131k of forecast spend being re-profiled to 2019/20.

The Committee received an update on current and proposed estate disposals, noting that the one disposal planned for 2019/20, would be Denmark Road, which would be used to offset merger costs. Receipts for the disposal of Westridge would be received in April, and would therefore be a 2019/20 financial benefit.

2019/20 FINANCIAL PLAN

The Committee received the draft Financial Plan, noting that this would be received by the March Board.

The Committee reviewed the draft plan in detail, and noted the agreed control total, and the underlying position for 2019/20 which is one of financial balance. The Committee noted the cost pressures as set out in the draft plan, and that unavoidable cost pressures have been built into the plan. Business cases would be drafted in respect of remaining cost pressures.

The Committee noted that all savings in the 2019/20 Cost Improvement Programme had been fully identified, and that 2gether was the only local Trust in this position to date.

The Committee reviewed the capital programme for 2019/20, noting that two major scheme which were unable to be progressed in 2018/19 would move forward in 2019/20. These would be ensuite works to Montpellier Ward, and planning work on developing a new 4-bedded Learning Disabilities Assessment and Treatment facility.

The Committee noted that while the financial position was more optimistic than in previous years, due to successful financial management last year, there were still risks to the achievement of the plan. However, these risks are less than in previous years.

2019/20 SERVICE PLAN

The Committee reviewed the Service Plan for 2019/20, and was pleased to note improvements compared to previous versions, in respect of making objectives measurable, and in keeping the number of objectives to a manageable level.

The Committee noted that reporting against achievement of these objectives was now on a 6-monthly basis to the Delivery Committee. Year-end performance against objectives would be set out in the Q4 report to the Delivery Committee.

OTHER BUSINESS

Other items considered by the Committee included:

- An update on progress against the Engagement Tactical Plan targets in Q3
- A summary report from the Stakeholder Sub-Committee
- A summary report from the Research Overview Committee
- A scheduled review of the Committee's terms of reference. No amendments were felt necessary.
- Strategy alignment. The Committee reviewed the work being done as part of the merger Transition programme in relation to alignment of strategies, and agreed to recommend that the Shadow Board, via the Transition Board and the Shadow Executive, be responsible for future oversight of this work.

ACTIONS REQUIRED BY THE BOARD

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

Jonathan Vickers
Committee Chair

PAPER N3

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Governance Committee

DATE OF COMMITTEE MEETING: 22 February 2019

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PATIENT SAFETY AND SERIOUS INCIDENT REPORT

The Committee received an overview and analysis of serious incident reporting to commissioners and high level monthly trend analysis, including Never Events. 3 new SIs were reported during January; 1 serious incident reported for Gloucestershire and 2 serious incidents were reported for Herefordshire. No Never Events had occurred within Trust Services and the Committee was significantly assured that the Trust had robust processes in place to report and learn from serious incidents. The trend of reported suspected suicides was demonstrating a small increase across the last 4 years. The Committee noted the inquests which had taken place during November, January and February 2019 was noted.

The Committee received an overview and analysis of Datix reports regarding patient care within clinical teams for Quarter 3 2018/19. The Committee was assured that the trend of violence-related incidents at Charlton Lane Hospital continued to demonstrate a decrease. The gently increasing trend in reporting of detained absconders in Gloucestershire continued but it was noted that there was no harm associated with these incidents. The trend in Herefordshire was flat and Q3 demonstrated a decrease in actual numbers of detained absconders.

Limited numbers of medication incidents were reported in Herefordshire, 7 were reported for Laurel House, however the Committee noted that this could be due to very good levels of reporting of missed doses. There continued to be limited reporting within Community Teams in both counties. 0 Serious Incidents reported for the North Locality and this was being investigated for any learning.

A number of improvements and developments taking place across the Trust in relation to Patient Safety were noted.

USE OF EXTERNAL TEMPORARY STAFFING

The Committee received an update on the use of temporary staffing (agency) during 2018/19.
The predicted forecast was for an agency spend slightly above the 2017/18 outturn, and above the 2018/19 control total. In order to mitigate the agency spend a number of actions were underway and planned, with the objective to prepare for a positive start to 2019/20.

The Committee noted that the Guaranteed Volume Contract for RMNs had started on 19th November 2018 and the Trust currently had all locum vacancies covered and the contractors ability to fill the 42 Shifts required by the contract stood at 92%. All of those staff would have undertaken all Trust Statutory and Mandatory training and positive feedback was being received from localities about the quality and consistency of the provision.

Agency spend for IAPT remained high due to access targets and recruitment issues and was a focus for the Temporary Staffing Project Board. It was agreed that IAPT figures would be taken out of the total figures for temporary staffing usage. Medical locum agency spend 2018/19 was forecast to be lower than 2017/18. However, this was due to doctors not being available

CLINICAL AUDIT PROGRAMME – DRAFT AUDIT PLAN FOR THE COMING YEAR

The Committee noted the contents of the report for information and assurance purposes. The list of audits to be removed from the 2018-2019 audit programme was agreed and the Committee also agreed the audit programme for 2019-2020.

CQC COMPLIANCE

The Committee received the CQC/Trust Quality Improvement Plan. There were 11 "Must do "actions and 23 "Should do" actions now being reviewed. There were at present 6 of the original 11 "Must do" actions that were now allocated a "Full" assurance level of compliance with the CQC recommendations and 5 being allocated a "Significant" level of assurance of compliance. Of the 23 original "Should do" recommendations 7 were now shown as having "Full" assurance of compliance and 16 had been allocated a significant level of assurance, these 16 all related to Berkeley House.

In order to gain further assurance in regard to certain observations made by the CQC following their previous two visits to Berkeley House a comprehensive internal peer review had been carried out. Initial feedback suggested that there were no areas of concern. The outcome of this review would be reported to CQRG in Gloucestershire on the 14th March 2019 and CQRF in Herefordshire on 20th March 2019 with the intention that this would be signed off and monitored on an ongoing basis through 'business as usual'. This would also be reported to the CQC by way of providing further assurance.

The remaining actions would be monitored as "Business as Usual" in the Organisational TQI Action Plan and would be monitored and challenged via the QCR Sub Committee. Regular face to face meetings with the CQC were still taking place where progress was reported and any issues discussed.

The Committee was not assured by this report and it was agreed that additional evidence of work taking place against all actions at the next meeting

NHS IMPROVEMENT LEARNING DISABILITIES STANDARDS BENCHMARKING EXERCISE

The Committee received the first Learning Disability Improvement Standards for NHS Trusts. These standards were intended to help organisations measure the quality of service they provided to people with learning disabilities and autism.

The NHS Improvement reported that the experience of care for this vulnerable group of people often remained poor. It was anticipated that the data collection would identify some organisational exemplars alongside highlighting themes for improvement. It would also provide information about Trusts compliance with the standards and enable organisations to provide the necessary assurance for delivering the outcomes that people with learning disabilities along with their families should expect from the NHS.

The Committee noted the recommendations to be considered in future service planning. These recommendations were being discussed throughout the Trust and a plan was to be produced. The Committee would receive a further update in June.

OTHER ITEMS

- The Committee received the Safe Staffing data for December 2018 and January 2019 and significant assurance was received regarding the levels of staffing on all wards during this time.
- The Committee received the Quality Report, the Service Experience Report Quarter 3 2018/19, the CQC Survey Results and Action Plan and the Risk Register Review.
- The Committee also received a presentation on Berkeley House and a report which detailed Lessons learned from feedback in Gloucestershire Localities.

ACTIONS REQUIRED BY THE BOARD

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

Agenda item 21 **PAPER O**

Report to: Trust Board, 27 March 2019
Author: Ingrid Barker, Trust Chair
Presented by: Ingrid Barker, Trust Chair

SUBJECT: **JOINT CHAIR'S REPORT**

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

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

INTRODUCTION AND PURPOSE

Recognising the Strategic Intent work and my role as both Chair of ²gether and Gloucestershire Care Services this report format has been revised to reflect the breadth of my activities across both Trusts. The production of a joint report does not impact on my existing accountability as the appointed Chair of each Trust.

The Report also provides an overview of 2gether Non-Executive Director (NED) activity.

RECOMMENDATIONS

This report is for information and the Board is invited to note the report.

1. INTRODUCTION AND PURPOSE

This report seeks to provide an update to both Boards on Chair and Non-Executive Director activities in the following areas:

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

1.1 Strategic Intent Update – Moving Towards Developing an integrated Physical and Mental Health Care Offer with ²gether NHS Foundation Trust

The work in the two Trusts to move forward the Strategic Intent continues, with progress and overall monitoring being maintained through the agreed governance processes.

Shadow Board

The shadow board has now formally taken on the role that was being performed by the Strategic Intent Leadership Group. The shadow board's remit reflects its role in proposing strategic direction in relation to the merger to the two existing statutory trust boards for decision. There have been two meetings of the Shadow Board which are helping to build team relationships as well as taking forward key areas of work to enable the proposed new organisation to meet our ambitious agenda whilst keeping safe the achievements of both current trusts. Meetings are continuing on a monthly basis and the Kings Fund is assisting us in facilitating shadow board development sessions over the coming months.

1.2 Board Development

A Joint Board Development session was held on Tues 5th February which considered the Long Term Financial Modelling which will be a key element of the Full Business Case to be considered by the Shadow Board, the statutory Boards and NHS Improvement.

The session also included a crucial item on developing our new organisation's values. This values workshop with the two Boards was the first of a number of similar workshops being run across both Trusts, building on work undertaken in November. We are committed to co-production and engagement in shaping the new organisation, during its formation and then embedding it into its DNA. We were therefore very pleased to have a valued Expert by Experience taking part in our session. We had positive feedback from her on the opportunity to be involved and she ensured that it was not a token involvement by engaging fully with the group discussions and reinforcing the importance of listening to service users before doing anything else if we want to really get the best out of every contact.

1.3 National and Regional Meetings

Nicola Strother Smith, Vice-Chair for Gloucestershire Care Services (appointed on 25th January 2019), attended a meeting of the **South West Chairs'** on my behalf on 28th February, where items included presentations from Susan Frith, CEO for the NHS Counter Fraud Authority and Yvonne Coghill, CBE, who talked about workforce race equality in the NHS and the picture for the South West.

I attended a meeting of the **NHS Providers Board on 6th March** where we discussed key issues facing the NHS and considered further the ambitions and opportunities within the Long Term Plan. Inevitably NHS finances were also an issue of key consideration given the approaching end of year and ongoing planning for next financial year. We also discussed the progressing merger of NHSI and NHSE who are developing further their future ways of working and leads. Board members have already been briefed on this meeting.

On 19th March I attended a meeting of the **NHS Providers Chairs and Chief Executives** where we heard from Dr Aiden Fowler, National Director of Patient Safety for NHS Improvement, Baroness Dido Harding, Chair of NHS Improvement, Simon Stevens, Chief Executive of NHS England and Chris Hopson, Chief Executive of NHS Providers. Again, I have shared a briefing with Board colleagues.

1.4 Working with our Partners

Maintaining **business as usual** remains a priority across both organisations. As part of this I have continued my regular meetings with key stakeholders and partners including:

Chairing the interview panel for the **Gloucestershire Interim ICS Independent Chair** on 6th February. Nick Relph, currently a Non-Executive Director at Gloucestershire Care Services, was appointed to this position following an interview with the Chairs of the Integrated Care System (this includes the Chair of the Health and Wellbeing Board). Nick will build on the work of Chris Creswick, the previous Independent Chair.

I was invited to be part of the panel for a **Question Time event** held at the University of Gloucestershire on 7th February. The panel, chaired by Dame Janet Trotter, included Richard Graham MP, Mark Hawthorne, Leader of the County Council, the CEO of the Local Enterprise Partnership, and other civic leaders. There was lively debate on a range of topics dear to the heart of our communities including, of course, the NHS.

Alex Chalk MP spent some time with the Trust on 1st March where he met a range of colleagues within the Rapid Response Team and visited the Community Wellbeing Café and met a Community Matron. We were pleased to be able to help Alex understand more fully the breadth and range of our services and the support we provide to help the wider health system.

Graham Russell and Marcia Gallagher (Non-Executive Directors) represented me at the **Gloucestershire ICS Board** held on 26th February and were updated on plans for the coming year as the Integrated Care System develops further.

A regular meeting of the **Gloucestershire Health and Care Overview and Scrutiny Committee** (HCOSC) took place on 5th March. I attended the meeting with the Joint Chief Executive. The meeting considered the NHS Long Term Plan, performance across the health and care system and an update on the Integrated Care System.

I was represented at the **Hereford Health & Wellbeing Board** on 5th March by Duncan Sutherland, Non-Executive Director (2gether). Items discussed included Director of Public Health Annual Report 2017; future arrangements and priorities for the Joint Strategic Needs Assessment; Better Care Fund Q2 and 3 report 2018/19; Homeless Link Health Needs Audit and Herefordshire & Worcestershire Dementia Strategy 2019-24.

A meeting of the **Gloucestershire Health & Wellbeing Board** took place on 19th March, where I was represented by Marcia Gallagher, Non-Executive Director (2g). Items discussed included the Joint Health and Wellbeing Strategy and Integrated Locality Partnerships. The increasing development of working together across organisations to best meet the needs of our communities is very heartening.

The Joint Chief Executive and I held our **quarterly meeting with the Chairs of the County's Leagues of Friends** on 12th March. Kathy Campbell, Head of Urgent Care for Gloucestershire Care Services gave a talk about the Trust's Rapid Response service helping to highlight the importance of services provided in people's homes rather than hospitals. The Chair of the Friends of Lydney hospital, Tony Midgely, announced that he will be stepping down from the role at the forthcoming AGM. Tony has been both a stalwart supporter of GCS Trust and a fierce champion of the interests of the people of Lydney and will be sorely missed as our 'critical friend'. We are, as always, very grateful

to all our Leagues of friends for their friendship, challenge and generosity. Stroud LoF has been particularly generous recently in its contribution to the refurbishment of cashes green ward, of which more anon.

Regular meetings with the **Gloucestershire ICS Partner Chairs** and the **Hereford and Worcestershire STP Chairs** continue to take place. I attended the Gloucestershire meeting on 5th March and was represented at the Hereford and Worcestershire meeting by Marcia Gallagher on 12th March. These meetings help support understanding of system issues and ensure partners are working together as effectively as possible.

I acted as the independent assessor for the **interview panel for a Non-Executive Director at Worcestershire Health and Care Trust** on 21st March. This is a sister organisation which provides mental health and community services and is a key partner in the Herefordshire and Worcestershire STP.

1.3 Working with the Communities and People We Serve

I visited the **Nelson Trust Women's Centre** in Gloucester on 6th February, and met with Niki Gould, Head of Women's Community Services. Following on from my visit to the Sober Parrot in Cheltenham on 22nd January, I was invited to a follow up meeting with Dame Janet Trotter and John Trolan on 20th March at the Hub Bistro in Gloucester. Once again I was impressed by the support these services provide – and the way they personalise it to focus on the individual - and what really matters to them.

1.6 Engaging with our Trust Colleagues

I continue to meet regularly with Trust colleagues at GCS and 2gether and visit services at both Trusts to inform my triangulation of information.

On 14th February I visited **Stroud Community Hospital** to view the newly refurbished **Cashes Green Ward** and on 7th March I visited the **Vale Hospital** on 7th March to view the **new Stroke Unit.** It was great to see the new facilities and see from the perspective of service users that they were already making a difference. Thank you to the estates and operational teams who worked so hard to make the changes with minimal disruption elsewhere. Thank you too to the Leagues of Friends for their generous help and support with these changes.

On 13th March I attended a visit to a service user with Sue Lear, one of the physiotherapists for 2gether who works in one of the community learning disability teams .A key concern for a Board member is ensuring they have a real understanding of what is happening in front line care, so it was great to get to have a chance to see how care is delivered in someone's home. The visit was an object lesson in why integration matters. This gentleman needs a range of health and social care support from our two trusts, primary care and social care, as well as the third sector. Sue's enthusiasm and commitment, and the way she quickly built a rapport with the service user was inspiring to see.

I chaired the **Council of Governors** meeting on 14th March, as always an important meeting focusing on matters of key concern for our community. The Council is an insightful group who take their responsibilities very seriously and we are committed to continuing to engage with them in coming months to help inform and support their future decision making.

I was invited to attend the **Senior Leadership Forum on 26th March** as part of the Boards' ongoing commitment to our wider leadership team. It is always enjoyable to spend time with the leaders of both Trusts as they consider how best we can work together. My short presentation was the first of a series of similar introductions to shadow NEDs so that colleagues have a chance to meet board members of the proposed merged organisation.

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

2. NED activity

Shadow NEDs and **Joint NEDs meetings** were held on 12th February at Edward Jenner Court and on 20th March at Pullman Place. Bi-monthly meetings have been arranged going forward and it is planned to hold these at service venues.

Other activities undertaken by the 2Gether NEDs:

Marcia Gallagher-February Activities Report

- Prepared for and attended a Joint Board Development session
- Attended a meeting with Deborah Homa as part of Kings Fund Board Development
- Met with the Director of Quality Nursing and Therapies
- Attended a Shadow Board NEDs meeting
- Attended a Joint NEDs meeting
- Prepared for and Chaired the 2GFT Audit Committee
- Attended the Audit Committee of GCS
- Prepared for and attended a Shadow Board meeting
- Prepared for and attended a Gloucestershire Audit Chairs meeting at Sangar House
- Prepared for and participated a MHAM hearing at Berkeley House
- Prepared for and attended the Gloucestershire Strategic Forum meeting

Marcia Gallagher-March Activities Report

- Visit to Charlton Lane re Lunch with Dementia clients
- Observed the Mental Health and Wellbeing Board at the Guildhall
- Prepared for and attended the Herefordshire and Worcestershire STP Chairs meeting
- Attended the New Highways Charity meeting
- Prepared for and attended the Governors meeting
- Prepared for and attended a Shadow Board meeting
- Met with the 2GFT Finance Director to review the Financial Plan for 2019/20
- Prepared for and attended the Gloucestershire Health and Wellbeing Board for Chair
- Attended a Shadow NEDs meeting
- Prepared for and attended an ATOS/Rem com meeting
- Attended a Joint NEDs meeting
- Observed the LD Partnership Board meeting at Shire Hall
- NED/Lay Members meeting at Sangar House
- Attended the Leadership Forum at the Dowty Club
- Prepared for and attended the Delivery Committee

- Prepared for and attended the 2GFT Board meeting

Nikki Richardson February / March Activities

- Attended Board Development session
- Attended joint NED meeting x2
- Prepared for and attended Audit Committee
- Prepared for and chaired Governance Committee
- Attended Senior Leadership Forum
- Telephone discussion with Director of OD
- Prepared for and attended Nom & R.E.M. Committee
- Attended MHAM Hearing
- Prepared for and attended CoG
- Prepared for and attended ATOS

Jonathan Vickers February /March Activities

- Prepared for and attended a meeting of the audit committee
- Prepared for and attended a meeting of the New Highways board
- Prepared for and attended a board meeting
- Held conversations with executive and non-executive colleagues on trust matters
- Prepared for and chaired a meeting of the development committee
- Attended a values session
- Prepared for and attended a Council of governors meeting

3. Conclusion and Recommendations

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

[2]GETHER NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING
TUESDAY 15 JANUARY 2019
BUSINESS CONTINUITY ROOM, RIKENEL, GLOUCESTER

PRESENT:

Ingrid Barker (Chair)	Rob Blagden	Vic Godding
Jan Furniaux	Bren McInerney	Miles Goodwin
Anneka Rose	Faisal Khan	Jo Smith
Nic Matthews	Katie Clark	Jenny Bartlett
Kate Atkinson	Stephen McDonnell	Graham Adams
Ann Elias		

IN ATTENDANCE: Anna Hilditch, Assistant Trust Secretary
John McIlveen, Trust Secretary
Jane Melton, Director of Engagement and Integration
Colin Merker, Deputy Chief Executive
Kate Nelmes, Head of Communication
Nikki Richardson, Non-Executive Director
Paul Roberts, Joint Chief Executive
Neil Savage, Joint Director of HR and Organisational Development
John Trevains, Director of Quality

1. WELCOMES AND APOLOGIES

1.1 Apologies for the meeting had been received from Mike Scott, Lawrence Fielder, Alison Feher, Cherry Newton, Mervyn Dawe, Said Hansdot, Carole Allaway-Martin, Hilary Bowen and Jade Brooks.

1.2 Ingrid Barker informed the Council that Jade Brooks had been nominated as the new Herefordshire CCG appointed Governor.

1.3 Xin Zhao, Public Governor for Gloucester had tendered her resignation. Xin had found it difficult to attend Council meetings due to work commitments and had made the decision to stand down. Xin had expressed her thanks for the opportunity to stand as a Trust Governor and wished her fellow Governors well for the future.

2. DECLARATION OF INTERESTS

2.1 There were no new declarations of interest.

3. COUNCIL OF GOVERNOR MINUTES

3.1 The minutes of the Council meeting held on 8 November 2018 were agreed as a correct record.

4. MATTERS ARISING AND ACTION POINTS

4.1 The Council reviewed the actions arising from the previous meeting and noted that the majority of these were now complete or progressing to plan.

4.2 Bren McInerney had taken an action away to speak to his contacts at Gloucester FM radio to ask them to consider a focus on mental health and membership. Gloucester FM Radio Station is a well-established community radio station operating from the Barton and Tredworth ward in Gloucester. They have a radio licence for playing music of a black origin, but are very much a local community radio station that covers community topics impacting across all communities. On 17 December, Bren, Kate Nelmes (Communications lead at 2gether NHS Foundation), Anthony Dallimore (Communications Director at NHS Gloucestershire Clinical Commissioning Group) and the Directors of Gloucester FM Radio Station (Carl and Derrick Francis) met for an hour to discuss how to go forward with a health topic(s). Bren reported that this informal discussion was very positive and it was agreed that the NHS bodies would further discuss amongst themselves what was possible for this moment and any further collaborative working in the future and discuss this with GFM going forward.

5. IMPROVING ACCESS TO PSYCHOLOGICAL THERAPY (IAPT) PRESENTATION

5.1 The Council welcomed Alex Burrage and Rosemary Neale to the meeting who were in attendance to provide an update to Governors on the work and current performance of the Trust's IAPT service (Let's Talk).

5.2 IAPT began nationally in 2008 to transform the treatment of adult anxiety disorders and depression, providing evidence-based psychological therapies. Nationally 900,000 people access support each year. Let's Talk covers Gloucestershire and Herefordshire and referral to the service is via GP, health professionals or self-referral via telephone/online. Therapy is based on Cognitive Behavioural Therapy provided by Psychological Wellbeing Practitioners (PWPs) and High Intensity Therapists. Support is also offered through Guided self-help, Educational courses, One to one and Online, i.e. Silver Cloud. The service aims to treat a range of conditions, including:

- Depression
- Generalised Anxiety Disorder
- Health anxiety
- Social anxiety
- Panic disorder
- Obsessive Compulsive Disorder
- Post Traumatic Stress Disorder
- Phobias
- Post Natal Depression

5.3 The Council received the referral, recovery and access statistics for both Gloucestershire and Herefordshire over the past 5 years, and noted that there had been a steady increase in performance, with projected recovery rates for both counties being 52%.

5.4 Rosemary Neale advised that one of the services' top priorities related to Long Term Health Conditions. It was noted that more than 15 million people in England (30% pop) have one or more long-term conditions and research consistently demonstrates that people with long-term conditions are two to three times more likely to experience mental health problems than the general population. There is a suggestion that 12-18 per cent of all NHS expenditure on long-term conditions is linked to poor mental health. By integrating IAPT services

with physical health services the NHS can provide better support to this group of people and achieve better outcomes, which was one of the main aims of the current merger process with Gloucestershire Care Services. The Council noted some of the current projects and pilots being carried out to develop services to address long term health conditions.

5.5 Bren McInerney welcomed the work that was being planned on Long term health conditions and asked about engagement with local communities around this. Alex Burrage said that a stakeholder committee was being set up in Gloucestershire, led by Commissioners, to drive forward the LTC work and this would involve wide engagement with local communities and patients.

5.6 Miles Goodwin asked whether the Let's Talk service offered smoking cessation. It was noted that it didn't; however, 2gether had multiple interventions in place with excellent signposting for those service users wishing to stop smoking. A successful smoking cessation programme had now been introduced at all inpatient units, with no smoking permitted on Trust grounds.

5.7 Vic Godding asked about the age range of people who would have access to the Let's Talk service. Alex Burrage advised that the service was for adults only (18+), however, children and young people's IAPT services were in development and if young people got in touch with Let's Talk they would be signposted to where to get appropriate support.

5.8 Kate Atkinson said that there would be a number of service users who didn't have access to the internet, or be able to use public transport, and she therefore queried how the service could adapt to ensure equal access to these people. Alex Burrage agreed that accessibility to services was key. The service would make the necessary adjustments, with treatment being offered by phone but also with local groups taking place and face to face appointments set up at the service users' GP surgery.

5.9 Rob Blagden noted that there had been an increase in referrals to the service but there had also been an increase in outcomes too which was excellent to see. He asked whether the Trust's IAPT services were fully staffed, and also about any NHSi scrutiny of the service. Rosemary Neale said that the Trust had been able to over recruit to the service and additional investment had been received from commissioners for the service to ensure that capacity could be maintained whilst still being able to meet key access targets. Jan Furniaux said that there had been an improvement in access rates, recovery and waiting lists but a huge amount of work was continuing to ensure that this performance was maintained. She said that NHSi were still monitoring the services; however, they had recently improved the Trust's segment scoring to a 1 (scale of 1-4) which meant that we now had full autonomy over our services which was excellent news.

5.10 The Governors thanked Alex and Rosemary for attending the meeting and for the huge amount of work that was taking place within the service. There was huge enthusiasm for more joint working with GCS and the bringing together of physical and mental health and this was clear from the presentation.

6. CHIEF EXECUTIVE'S REPORT

6.1 Paul Roberts presented his report to the Council, highlighting a number of key areas for the Governors to note.

6.2 Paul expressed his thanks to those Governors who had taken part in the discussion groups as part of the Shadow Executive Director appointments process. Lots of discussion and consultation was currently taking place around the name for the newly merged organisation. A report would be presented back to the Council at its March meeting for a decision. In terms of office moves, Paul advised that there were lots of benefits being realised from the co-location of staff at Edward Jenner Court. He acknowledged that the moves had not all gone smoothly, but any issues were now being ironed out with a firm plan in place for all future team moves.

6.3 The CQC's National Community Mental Health Patient Survey Results 2018 for 2gether's services in Herefordshire and Gloucestershire were published at the end of November. Once again, service users have rated the care provided through 2gether's services in the top 20% of mental health services in England. In 5 out of the 11 sections of the survey we score 'Better' than 80% of other Trusts who took part. These results represent a further improvement when compared to our results from last year's patient feedback in the same survey. The results are a testament to the expert and dedicated effort that colleagues are making to understand need, involve and respond well to people who use our services and their carers. Graham Adams asked about those areas where improvement was still required, noting in particular the 2 amber indicators. It was agreed that further information about these specific areas, and all areas where focus would be placed this year would be shared with Governors. A working group had taken place last year for Governors to drill down into the detail of both the Patient Survey and the National Staff Survey results. It was suggested that once the Staff survey results were published this may be a helpful way forward.

ACTION: Short life working group of Governors to be set up to drill down into detail of Staff Survey and Patient Survey (April/May)

6.4 The Council of Governors noted the remainder of the report and thanked the Chief Executive for the update which was always welcomed.

7. CHAIR'S REPORT

7.1 Ingrid Barker produced a regular report for the Trust Board which set out her activities and key developments. Following discussion with the Lead Governor, it was agreed that this report would also be shared with the Council of Governors, for information. The report also provided an overview of 2gether Non-Executive Director (NED) activity. This report was noted.

8. CHANGES TO THE TRUST CONSTITUTION

8.1 The Council received this report which set out proposed changes to the Trust constitution. These changes fell into two main categories:

- those which put in place provisions connected with the merger of 2gether and Gloucestershire Care Services NHS Trust (GCS); and
- those included as part of a general update of the document, or to provide additional clarity to existing provisions/process.

8.2 John McIlveen provided a summary of the main changes that were proposed, which included:

- Extension of the current Greater England public constituency to include Wales
- Provision for an additional 3 staff Governors, one in each of the three staff classes and initially reserved to GCS employees
- Expansion of the Medical and Nursing staff class to include dental professionals
- Provisions to ensure that within the expanded Medical, Dental and Nursing staff class, two Governor seats are reserved for nurses, one is reserved for a doctor, and the final one is reserved for either a doctor or a nurse. This provision will ensure that the number of Governors in this staff class remains representative of staff numbers in these professions
- Renaming of the former Health and Social Care and Support staff class to become the Health and Care Professions staff class. This new name is more commensurate with the professional role that these colleagues play in delivering care, and recognises changes in the regulatory bodies for professionals in this staff group
- Change of the Trust's corporate address to Edward Jenner Court
- Updating of provisions regarding the acceptance of benefits, in line with Trust policy
- Enabling an extension of non-Shadow Board Non-Executive Director (NED) terms of office beyond the current 6 year maximum, to provide resilience and capacity until the merger takes effect
- Reference to a revision of Standing Orders which enables voting in absence under certain circumstances. The relevant Standing Order has already been amended by the Council of Governors. The Board's agreement is required only in respect of this reference in the constitution.

8.3 The Council noted that those changes relating to the composition of the Council of Governors, and to public constituencies and staff classes, would have no effect on any sitting Governor.

8.4 It was noted that any changes to the Trust constitution must be agreed both by the Board and the Council of Governors. The Trust Board would be receiving this report for approval at its January meeting. The Council of Governors approved these changes, and if also approved by the Board, the majority of changes to the Constitution would take effect immediately, with those related directly to the merger only being actioned once the transaction had taken effect.

9. CHANGES TO STANDING ORDERS

9.1 This report set out a proposed change to Standing Orders for the Council of Governors.

9.2 Currently, Standing Orders and the Trust Constitution prevent a Governor voting by proxy. The Council requested a change so that any Governor who was

unavoidably absent (for example by being away on a pre-arranged holiday) would be able to vote on the merger transaction. The proposed change, drafted on the advice of the Trust's legal advisers, allows a Governor who cannot attend a meeting where a vote is to take place, to cast their vote beforehand by email. The amended provision specifies the circumstances in which such voting is permissible, and the process for voting in absence.

9.3 The relevant clause from the Standing Orders was discussed, with the existing wording and proposed new wording presented.

9.4 Bren McInerney asked who would make the final decision about what would be classed as "exceptional circumstances" for a Governor who was unable to attend a meeting where a vote would be taking place. John McIlveen said that the Trust Chair would make the final decision. Bren said that he wanted it to be recorded in the minutes from this meeting that he would like this clause to be amended to state that the Trust Chair should liaise with the Lead Governor to make any final decision.

9.5 The Governors noted that there were no other changes required to the Standing Orders at this time. This proposed change was agreed and would take effect immediately. It was noted that changes to Standing Orders for the Council of Governors did not require the approval of the Board.

10. FEEDBACK FROM GOVERNOR OBSERVATION AT BOARD COMMITTEES

10.1 A number of Board and Board Committee meetings had taken place since the Council of Governors last met in November 2018 and Governors had been present in an observation capacity at some of these meetings.

- MH Legislation Scrutiny Committee – 14 November 2018
  Both Cherry Newton and Carole Allaway Martin had attended this meeting. Neither Governor was present to provide feedback.

- Delivery Committee – 28 November 2018
  Kate Atkinson had attended this meeting.

- Development Committee – 12 December 2018
  There had been no Governor attendance at this Committee meeting. The Council noted that Bren McInerney had volunteered to take up the second Governor observation post at this Committee and would be in attendance at future meetings.

- Governance Committee – 21 December 2018
  Vic Godding and Jo Smith had attended this Committee meeting. Both agreed that the meeting was well chaired, and had run to time. People presenting at the meeting did so clearly and succinctly.

11. MEMBERSHIP DATA REPORT

11.1 Our Membership Advisory Group (MAG) last met on 5 December 2018. Discussion centred on finalising the updated membership form, the content of membership packs and increasing membership – particularly among less well represented groups. The group is particularly focussed on the membership

priorities agreed in May 2018 - increasing membership across Herefordshire, the Cotswolds, young people, people from a Black, Asian and Minority Ethnic background, and men. Statistically, these are the areas where we are least well represented. The MAG will next meet on 6 March, in Hereford.

11.2 A short term working group has also been formed, at the request of the Strategic Intent Leadership Group (SILG), to focus on increasing membership among people who use the services of Gloucestershire Care Services NHS Trust in light of our forthcoming merger. The group first met on 14 November 2018 and will meet again on 16 January 2019. Our aim is to ensure that, prior to our merger, we have a membership body that more appropriately represents the interests of people served by both Trusts.

11.3 Kate Nelmes advised that the Trust continued to promote membership at events, via social media and through the Trust website. Membership was recently promoted alongside GCS at the Age Concern Christmas Carol Service, in Gloucester Cathedral. Our Social Inclusion Team continues to promote membership at the wide range of events they attend with our partners and stakeholders. We have also recently recruited a membership volunteer to assist with membership promotion.

11.4 Our most recent membership newsletter was published in December. The next edition will be published in mid-April. We may issue an e-flyer in the interim, with an update on the latest position with our merger.

11.5 Governors continue to support recruitment of new members, and engagement with people who use our services or care for those who do. This has included links being built with a local community radio station, and plans for a stand in Herefordshire for Time to Talk Day, in February.

11.6 Kate Nelmes informed the Council that not all membership targets were being met at this stage, however, she was confident that this would be the case by year end.

11.7 Bren McInerney asked about the forms of social media that the Trust was using to promote membership, and also whether the Trust was in touch with local groups around the county about how best to engage with them – and also how they could help us to promote membership. Kate Nelmes said that a number of meetings had taken place with local community groups and a recent meeting with young people had generated some excellent ideas of how to better engage with younger people, including changes to the membership welcome pack. Currently the Trust used Facebook, Twitter and Instagram as its main social media outlets and it was noted that there had been a big increase in followers over the past few months.

11.8 The Council noted the Membership activity report and acknowledged the work taking place regularly to promote Trust membership.

12. GOVERNOR ENGAGEMENT OPPORTUNITIES

12.1 This report provided a brief overview of ways in which Governors can engage with their constituents and support the expansion of our membership body.

Effective engagement will ensure that our Council represents a robust and inclusive membership body, reflecting the views and needs of all of the communities we currently serve and will serve in the future.

12.2 Graham Adams said that as a relatively new Governor, he was struggling to understand how he could engage properly with his constituents. Kate Nelmes advised that Governors currently participated in a range of events and in the past few years, Governors have hosted specific membership events in a range of venues, including Cheltenham, Stroud, Cirencester, Gloucester and Hereford.

12.3 Different, more varied, methods of engagement were discussed, including Focus groups, 'Drop-in' opportunities to pre-existing community groups (by arrangement) and working with Communications to produce an 'e bulletin' for constituents. It was noted the Mike Scott had recently sent out a targeted email (via the Communications Team) to members of the Greater England constituency. Kate Nelmes agreed to pull some potential engagement options together and these would be shared with all Governors, inviting people to come back to her with any preferences.

ACTION: Kate Nelmes to develop a short survey for Governors, asking people to come back with preferences on how they may wish to engage with constituents going forward

13. GOVERNOR ACTIVITY

13.1 There was no further activity reported, other than that already discussed at the meeting.

14. ANY OTHER BUSINESS

14.1 The Council was asked to note that Katie Clark had been successfully reappointed as a Staff Governor representing Management and Administration Staff. A well contested election had taken place in December for this post. Katie's reappointment was for a further term of 3 years. Governors congratulated Katie on her reappointment.

14.2 Bren McInerney led Governors in expressing their thanks to all Trust staff who had worked to continue to provide safe services over the Christmas and new year period.

15. DATE OF NEXT MEETING

Business Continuity Room, Trust HQ, Rikenel		
Date	**Governor Pre-meeting**	**Council Meeting**
2019		
Thursday 14 March	9.00 – 10.00am	10.30 – 12.30pm
Tuesday 14 May	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 11 July	1.30 – 2.30pm	3.00 – 5.00pm
Tuesday 10 September	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 14 November	9.00 – 10.00am	10.30 – 12.30pm

Council of Governors
Action Points

Item	Action	Lead	Progress
15 January 2019			
6.3	Short life working group of Governors to be set up to drill down into detail of Staff Survey and Patient Survey (April/May)	Trust Secretariat	Governors to let Trust Secretariat know if they would wish to participate in a meeting, to be scheduled for mid-April time
12.3	Kate Nelmes to develop a short survey for Governors, asking people to come back with preferences on how they may wish to engage with constituents going forward	Kate Nelmes	**Complete** E-survey produced and emailed out on 7 March