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NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION

Thursday, 26 May 2022

10:00 – 13:30

To be held via Microsoft Teams

AGENDA

TIME	Agenda Item	Title	Purpose		Presenter
Opening Business					
10.00	01/0522	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/0522	Declarations of interest	Assurance	Verbal	Chair
10.05	03/0522	Service User Story Presentation – IAPT and MH Recovery Services	Assurance	Verbal	DoNTQ
10.25	04/0522	Draft Minutes of the meetings held on 31 March 2022	Approve	**Paper**	Chair
	05/0522	Matters arising and Action Log	Assurance	**Paper**	Chair
10.30	06/0522	Questions from the Public	Assurance	**Paper**	Chair
Performance and Patient Experience					
10.40	07/0522	Performance Report	Assurance	**Paper**	DoF/COO
11.00	08/0522	Quality Dashboard Report	Assurance	**Paper**	DoNTQ
11.20	09/0522	Finance Report	Assurance	**Paper**	DoF
11.30 - BREAK – 10 Minutes					
Strategic Issues					
11.40	10/0522	Report from the Chair	Assurance	**Paper**	Chair
11.50	11/0522	Report from Chief Executive	Assurance	**Paper**	CEO
12.05	12/0522	Systemwide Update	Assurance	**Paper**	DoSP
12.15	13/0522	Board Assurance Framework	Approve	**Paper**	HoCG
12.25	14/0522	Freedom to Speak Up 6 Monthly Report	Assurance	**Paper**	DoHR&OD
12.45	15/0522	Stroud Lease Business Case	Approve	**Paper**	DoF

Governance					
13.00	16/0522	Provider Licence Declarations	Approve	**Paper**	HoCG
13.10	17/0522	Working Together Advisory Group Terms of Reference	Approve	**Paper**	DoSP
13.20	18/0522	Use of the Trust Seal 2021/22	Assurance	**Paper**	HoCG
13.25	19/0522	Council of Governor Minutes – March 22	Information	**Paper**	HoCG
Board Committee Summary Assurance Reports					
NOTE	20/0522	Great Place to Work Committee (6 April)	Information	**Paper**	GPTW Chair
NOTE	21/0522	Resources Committee (28 April)	Information	**Paper**	Resources Chair
NOTE	22/0522	Quality Committee (5 May)	Information	**Paper**	Quality Chair
NOTE	23/0522	MHLS Committee (11 May)	Information	**Paper**	MHLS Chair
NOTE	24/0522	Audit & Assurance Committee (12 May)	Information	**Paper**	Audit Chair
Closing Business					
13.30	25/0522	Any other business	Note	Verbal	Chair
	26/0522	**Date of Next Meetings** **<u>Board Meetings 2022</u>** Thursday, 28 July Thursday, 29 September Thursday, 24 November	Note	Verbal	All

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Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 04/0522

MINUTES OF THE TRUST BOARD MEETING

Thursday, 31 March 2022

Via Microsoft Teams

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

IN ATTENDANCE:
Jacqui Cooper, CQC
Graham Hewitt, Trust Governor
Joy Hibbins, Member of the Public
Bob Lloyd-Smith, Healthwatch Gloucestershire
Marie Martin, CQC
Kate Nelmes, Head of Communications
Lavinia Rowsell, Head of Corporate Governance/Trust Secretary

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting. Apologies had been received from Helen Goodey.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. SERVICE USER STORY PRESENTATION

3.1 The Board welcomed Vicky Waring and Sam Darwin to the meeting who were in attendance to talk about the Community Respiratory Test and Learn Project, a project run by the Community Respiratory Physiotherapy Service for Children and Young People. The service supports children and young people with often very complex health needs to manage their respiratory needs; keeping children well at home, empowering families to support self-management and escalate needs, aiming to avoid admission to acute care.

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3.2 Following an introduction to the Test and Learn Project, the Board were shown some short videos that had been filmed by the families of some of the children who had been part of the project, discussing the service they had received and reflecting on the huge benefits they had experienced from being part of this project.

3.3 Graham Russell thanked Vicky and Sam and all the families who had contributed to the presentation. He noted the references to the project being a "pilot" and asked about the status of this. Vicky Waring advised that it was still a pilot, initially in place until April 2022, but the Trust had just received additional funding to extend the project for another year which was excellent. Steve Alvis said that the service was making such a huge difference and supporting families who were dealing with some complex challenges. He asked whether similar services to this one were in place in other Trusts. Vicky Waring informed the Board that GHC was currently an outlier for not having a commissioned service. However, colleagues regularly shared learning with services elsewhere, working closely with GHFT and Bristol.

3.4 Marcia Gallagher said that the films from the families were very moving and thanked colleagues for sharing these. She asked how long the project had been running and how many children had been involved. She also asked, if the project was extended, whether the size of the group of people the service was helping would increase. Marcia said that this was an important service and it was therefore important to be clear of the qualitative measures that could be presented to our commissioning colleagues to push for funding. Sam Darwin advised that the project had been running for just over 4 months and so far, had involved 18 families, with the input of a 0.8WTE staff member. She said that the Team was working closely with the commissioning team who had been very helpful and had provided guidance and support to ensure that relevant and sufficient data could be submitted at the end of project to strengthen the case for a commissioned service. The Board noted that a database of patients who would be eligible for the service was in place and up to 97 patients had been identified.

3.5 Angela Potter informed colleagues that she had worked in Nottingham previously where this service was well established. She offered Vicky and Sam support from members of her project management and QI team in terms of developing the offer to progress it to the business case stage.

3.6 Ingrid Barker expressed her thanks to Vicky and Sam for attending the meeting, and to those families who had contributed and shared their stories. The Trust's motto is "With you, For you" and the Community Respiratory Team really were working with families to give them the skills and knowledge to manage some very complex and challenging conditions.

4. MINUTES OF THE PREVIOUS BOARD MEETING

4.1 The Board received the minutes from the previous Board meeting held on 27 January 2022.

4.2 Steve Alvis requested an amendment at 15.5, noting that his question had related to the provision of more *local* appointments, rather than *home* appointments.

4.3 Angela Potter suggested an amendment at 16.4 in relation to the Working Together Plan. A revised sentence had been submitted to the Trust Secretariat for insertion.

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4.4 Subject to these amendments, the minutes were accepted as a true and accurate record of the meeting.

5. MATTERS ARISING AND ACTION LOG

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

5.2 At a previous meeting it was agreed that it would be helpful for the Board to receive an additional focus on Learning Disability services. This had now been scheduled for the Board seminar session taking place on 21 June.

6. QUESTIONS FROM THE PUBLIC

6.1 No questions had been received in advance of the meeting. Ingrid Barker invited members of the public present to ask any questions at this point.

6.2 Joy Hibbins asked whether the Trust was going to start using a restorative approach after patient safety incidents and adopt the key principles in future. For reference, Joy Hibbins posted an outline of the principles she had referenced. *Restorative processes have an emphasis on healing after patient safety incidents (i.e. after notifiable safety incidents that result in harm). The four main principles are: Who has been hurt and what are their needs? Who is responsible for meeting needs and what are their obligations? How can harms and relationships be repaired? How can we prevent it from happening again?* Joy added that she had written directly to the Chief Executive on this matter and was still awaiting a response. Paul Roberts acknowledged that Joy's communication had been received and that a formal response would be provided in the next few days. John Trevains offered a conversation with Joy Hibbins outside of the meeting. He provided assurance that the Trust already carried out dialogue with people who use the Trust's services and offered local resolution meetings in person; however, there were always things that could be done to improve, and he would welcome the opportunity to explore this further. **ACTION**

6.3 Bob Lloyd-Smith asked for a brief summary of the outcome from the recent CQC Report on Urgent Care. Paul Roberts advised that the CQC released its inspection report on the urgent and emergency care services in Gloucestershire on 17 March. As part of this inspection the CQC inspected urgent and emergency care services within GHC and rated them as "Good" in all five domains. Overall, the inspection of our GHC Trust services was very favourable. The report highlights areas of good practice not only in GHC but with and alongside our partners in the county. Paul Roberts said that the Trust was pleased that the inspection team recognised the skills and professionalism of our colleagues who work in our Minor Injury and Illness Units. The inspectors noted that staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them to get better. They also noted good management practices, safe provision of services, and that people could access the service when they needed it and did not have to wait too long for treatment. It was noted that where inspectors identified areas for improvement, the Trust has already or will be implementing the improvements in the very near future.

7. PERFORMANCE DASHBOARD

7.1 Sandra Betney presented the Performance Dashboard to the Board for the period February 2022 (Month 11 2021/22). This report provided a high-level view of key performance indicators (KPIs) in exception across the organisation.

7.2 The Board noted that a high-level timetable developed from the Measuring What Matters Board Seminar in June 2021 had been integrated into the Performance Dashboard which allows for periodic business intelligence development monitoring. There were currently four items delayed due to competing priorities, two of which should be resolved in April. The Measuring What Matters milestones will be reviewed for 2022/23 to ensure they fit the Trust's business planning priorities, specifically considering the importance of SystmOne Simplicity. The SystmOne Simplicity project has been essential to resolve inherent data quality issues within the PH clinical system and ensure that the Trust's dataset is robust and reliable for stakeholders. However, ongoing pressures across operational services and clinical system teams are impacting the speed of progress which is having an impact on some of the Trust's community (PH) reporting for the period. Wherever possible alternative evaluations have been undertaken to assure performance and indicators are expected to return in March. A revised, high-level project timeline for SystmOne Simplicity has been produced outlining key milestones.

7.3 The Board was asked to note that the recovery programme had transitioned into a 'business as usual function' with recovery leading to an integrated element of monthly Operational Governance rigour. A recovery overview was provided within the report.

7.4 There were 12 mental health key performance thresholds in exception within the dashboard that were not met for the period. Eating Disorder (ED) Services account for five indicators, with Care Programme Approach (CPA) two and Complex Psychological Interventions (CPI) two. IAPT Access remains in exception again this month. A range of demand and capacity factors are contributing to performance across these indicators. The 33n patient cohorting tool is being presented back to the organisation in March 2022. Complimenting this, focused work is being undertaken internally on demand and capacity modelling for IAPT and ED to establish multiple scenario recovery forecasts. Collectively, this will inform the pathway improvements required to recover performance.

7.5 The Board noted that there were 21 physical health key performance thresholds that that were not met for the period. However, it was important to note that 15 of these were associated to a lack of data availability through delayed SystmOne Simplicity progress. Recovery of these lines was expected in April.

7.6 In relation to Trust wide workforce indicators, the Board noted that there were currently only 3 indicators in exception this month. Positively '77: Mandatory Training' was once again compliant at 92% against a 90% threshold. A new workforce indicator; Annual Leave consumption (WF5); is currently a quarterly monitor with a cumulative 25% threshold raising to 100% by the end of the year. It was 72.6% at the end of Q3. A workplan will be developed to agree thresholds for the new items and also examine granular data below the global Trust position so that pressure areas can be exposed.

7.7 David Noyes informed the Board that there had been some positive news about some of the services. The Trust had now achieved 82% against the recruitment target to the Home First service and echocardiogram performance was now back on track. David Noyes advised that the recovery trajectory for Eating Disorder services had slipped slightly, with more referrals having been received and high levels of Covid related staff sickness. Within IAPT there were some significant challenges and discussions would be taking place with system partners.

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7.8 In response to a question from Steve Alvis in relation to physiotherapy capacity, David Noyes advised that the Trust was looking at creating career frameworks for professional development for therapists and opportunities for career development. Neil Savage added that the Trust had developed close relationships with the Health School at the University of Gloucestershire and a new Physiotherapy degree course. Plans were also in place to look at AHPs and options for international recruitment in that area.

7.9 Steve Brittan noted that the recovery programme was moving into business as usual reporting, however, he said that it would be helpful for the Board to maintain some sort of backward traceability to be able to track progress. Steve Brittan asked how many of the 19 red rated services within the recovery programme had interdependencies on the wider system. David Noyes said that there were system wide pressures, however, GHC had the solutions to recover the majority of services without wider system intervention.

7.10 Marcia Gallagher said it was good to see the progress made against many of the indicators, noting that a lot of recovery work was still required. She referred to the Complex Psychological Intervention indicator and sought assurance around patient safety and that action plans were already in place to address performance. David Noyes said that performance was at 80.9% against the target of 90%. The Trust had successfully recruited into the service, but colleagues had not yet started in post.

7.11 Sumita Hutchison referred to the increase in length of stay and asked about the impact of this on resources and the wider system. David Noyes advised that average length of stay was too high, and generated patient flow problems through the system. However, it was noted that Care home capacity was starting to open up and we are starting to see patient flows out of hospitals. David added that a whole system piece of work was taking place to review therapy offers within the community hospitals.

8. QUALITY DASHBOARD

8.1 This report provided an overview of the Trust's quality activities for February 2022. It was noted that key data was reported under the relevant CQC Domains – caring, safe, effective, responsive and well-led. The Board was asked to note that the dashboard also included the quarter 3 NED Audit of Complaints and Guardian of Safe Working compliance, as well as the summary reports from the NED Quality visits.

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

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

- Challenges continue in Eating Disorder services and their recovery. This work is reported monthly via Quality Dashboard and discussed at the Quality Assurance Group.
- Continued focus is required in relation to CPA compliance. A further reduction in compliance is reported this month due to significant workforce challenges.
- Recruitment and retention within key service critical areas remains a significant challenge. Health Care Support Worker vacancies are higher than national expectations. Enhanced NTQ support is being provided to colleagues within workforce, recognising that consistent staffing is a well-established marker of quality care.

- NTQ are developing metrics for assuring safety, experience and outcomes in key areas of service pressure through staffing challenges or demand. This is being developed in the first instance for Charlton Lane Hospital. ICT's and Eating Disorder services will follow.

8.4 Quality issues showing positive improvement:

- The Non-Executive Director (NED) Quality Visits undertaken demonstrate that despite the significant work pressures throughout the Trust, consistent examples of respectful, kind and compassionate care were observed.
- Reduction of complaints for the second consecutive month.
- The rate of percentage of respondents who indicate a positive experience of our services has been maintained at 95% (target rate) or above, for the fourth consecutive month.
- 0 post 48-hour Clostridium Difficile (C. Diff) cases were recorded in February. ICS Level
- Wheelchair service target is showing sustained improvement
- Mandatory training has reached 94% which is above the organisational target of 90% for the second consecutive month this year.

8.5 John Trevains noted that within the Trust, new initiatives and workstreams are frequently trialled and implemented using QI methodology. The two workstreams highlighted in this month's dashboard related to the improvements in the District Nursing referral process and new approaches being trialled with deteriorating patient process being delivered by Therapy colleagues.

8.6 Steve Alvis referred to pressure ulcers and asked whether problems accessing domiciliary care was impacting on this. John Trevains said that the Trust was working closely with local authority colleagues to drill down and address this. Regular detailed updates on the work taking place to manage pressure ulcers and performance was discussed at the QAG meetings and John Trevains offered the Board good assurance that GHC was seen as one of the better performing Trusts for its work in this area. The clinical pathways lead continues to work with colleagues across the trust to highlight pressure ulcers as being "everybody's business" using signposting to educational resources, evidence from data and quality improvement methodology.

8.7 The Board noted the current focus on Health Care Assistant vacancies. It was noted that 15 new HCAs had recently been recruited and new recruitment approaches were being put in place to try to speed up the process for filling vacant posts.

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

9. PATIENT SAFETY REPORT – QUARTER 3

9.1 Amjad Uppal presented the Quarter 3 Patient Safety Report, providing a summary of mental health and physical health Patient Safety Incidents reported during Q3 (1st October to 31st December 2021).

9.2 Amjad Uppal informed the Board that service provision has seen a return to more usual activity following earlier changes associated with the Covid-19 pandemic. Q3 continues to demonstrate more established incident reporting trends. The high frequency incidents within Mental Health inpatient services continue to focus on self-injurious behaviour, prevention and management of violence and aggression, and incidents relating to the violent conduct of

distressed patients during the acute phase of their illness. Physical Health hospitals, and older persons wards including Charlton Lane Hospital, report higher rates of falls and some skin integrity incidents. Of the reportable incidents, only Serious Incidents were reported (8). There were no never events or clause 4.26 events.

9.3 Work continues to improve patient safety reporting and in particular, to reduce duplication, focus on narrative to provide assurance and that the submitted reports to Trust Board and Governance Committees are commensurate with the requirement of the receiving meeting.

9.4 The Board noted this report. A Board Seminar focusing on Patient Safety and reporting would be taking place on 5 April.

10. LEARNING FROM DEATHS – QUARTER 3

10.1 The purpose of this report was to inform the Board of the learning from the mortality review processes during Quarter 3 2021/22. During the quarter, 141 Gloucestershire Health and Care NHS Foundation Trust (GHC) patients died, however, none of the patient deaths reviewed during Q3 are judged more likely than not to have been due to problems in the care provided to the patient.

10.2 Amjad Uppal informed the Board that no concerning trends or themes have been identified. Of note however, was community mental health patients age vs. deprivation which did show a correlation between reduced deprivation and living longer. A Task & Finish Group was commissioned by QAG to consider how best to promote health & well-being in vulnerable groups of the population. The inaugural meeting of this group in December 2021 was stood down due to preparations for the Covid surge but will be reinstated and an invitation extended to public health colleagues.

10.3 The learning from individual mortality reviews is now presented as 'Learning on a Page', consistent with dissemination of learning from serious incidents, clinical incidents, and complaints. This information was reported in full to February QAG.

10.4 A comprehensive version of this report containing detailed demographic and mortality data was reported to February 2022 QAG and the March 2022 Quality Committee.

10.5 Feedback from the Medical Examiner service provides significant assurance that the care provided to inpatients at the time of their death was of a good standard, that families were appreciative of the ME service input and were happy with the cause of death given, and gladly gave feedback about care when asked.

11. FINANCE REPORT

11.1 The Board received the month 11 Finance Report for the period ending February 2022.

11.2 Gloucestershire ICS has been given an overall funding envelope for the second six months of 21/22. At month 11 the Trust has a surplus of £3.24m and is working towards a full year forecast position of a surplus of £4.677m. The Trust is anticipating significant additional non-recurring income (£2.2m) from Gloucestershire CCG to cover a number of service developments and additional activity, and further income is expected to be received in March.

11.3 The cash balance at month 11 is £61.244m.

11.4 Capital expenditure was £8.998m at month 11 against a full year 21/22 Capital plan of £17.04m. Spend to date was £1.5m below the revised capital plan.

11.5 The Trust has spent £2.091m on Covid related revenue costs between April and February.

11.6 The Better Payment Policy performance is cumulatively 89% of invoices by value were paid within 30 days (95% just for February), the national target is 95%. It was noted that performance for 2021/22 had improved through the year.

11.7 The Board noted the Finance Report for month 11 and once again thanked Sandra Betney and the Finance Team for steering the Trust through these challenging and uncertain times.

12. BUSINESS PLANNING 2022/23

12.1 Sandra Betney presented this report which set out the Trust Annual Business Planning process for 2022/23 and the proposed Business Planning Objectives for operational and corporate teams.

12.2 The Business Plan had been developed in the context of the Trust's main priorities and the known key deliverables identified in the National Planning guidance for 2022/23. This report set out the business planning process that was launched in December to support Directorates and Teams in developing their business planning objectives for 2022/23. The business plan is key to the delivery of the Trust Strategy and the business planning structure is underpinned by our four strategic aims.

12.3 The report set out the known and emerging national and local priorities that have informed the business planning objectives. A business planning refresh will take place in quarter 1 to ensure the process for cross referencing objectives and alignment to resources is completed and business planning objectives and milestones will be updated to reflect any new national requirements and local priority decisions. The Trust will aim to introduce a refresh every quarter to ensure the business plan is updated and 'live' throughout the year. Sandra Betney noted that doing a refresh at the end of quarter one would enable the Trust to catch up with the system planning, as the submission was not due until the end of April, so there could be a slight misalignment between our internal business planning process and the system planning process.

12.4 The Board noted that the full business plan for 2022/23 includes 228 objectives which is an increase on previous years and demonstrates an ambitious level of delivery. To mitigate the risk of under resourcing the plan, objectives would be ranked in 'order of importance' to enable the support required to be phased across the year.

12.5 One of the key aims for the business planning process is to demonstrate a preferred balance of objectives across the strategic aims. Better Health continues to have the least objectives. This reflects the challenges faced throughout the pandemic and the need to focus activity on other priorities. It is recognised that this strategic aim is not something that can be achieved alone and the Trust will ask teams to consider how we can reappraise this theme with system partners as part of the business planning refresh.

12.6 The Board received a summary of performance on achieving the business planning objectives for 2021/22, noting just 10% of the business plan would not be achieved. This was a significant improvement in performance from the previous year and an excellent

achievement given the huge challenges faced by colleagues over the past year. Some of the key highlights included:

- Successful submission of co-produced SARC tender following successful partnership
- working with First Light.
- Successful business case for the Specialist Forensic Community Team as part of the South West Provider Collaborative improvement programme.
- Successful implementation of additional School Aged Immunisation flu vaccinations
- Successful University of Gloucestershire academic accreditation for preceptorship
- Implementation of key network link upgrades to improve user experience for staff day to day working experiences for the new fit for purpose WAN
- Payroll system merger completed successfully and new CENTROS finance system operational

12.7 Sandra Betney advised that the System plans were due for submission to NHSEI on 28 April and these would be presented in more detail at the April Resources Committee.

12.8 The Board approved the business planning objectives for 2022/23.

13. BUDGET SETTING 2022/23

13.1 Sandra Betney presented this report which set out the budget setting process for 22/23. It highlights the links with the NHSEI planning, contracting and business planning processes and sets out risks and opportunities within the financial targets that have been set for each service and directorate.

13.2 The Board noted that Budget setting for 22/23 has been completed prior to the final agreement of the contract schedule and MHIS/SDF funding. The financial regime for 22/23 is underpinned by funding envelopes given to each Integrated Care System (ICS). This is allocated between all partners in the system. The key financial aim is for the system to be in financial balance, although this is yet to be achieved for the Gloucestershire ICS.

13.3 The Trust has continued with its usual thorough process to develop a set of budgets that reflect the plans of the business and has also been mindful of the system's financial position and the resource constraints within the Gloucestershire system. The system plan shows the system consuming c£29m resources above allocation. GHC have actively supported minimising the deficit and will continue to work with system partners to achieve system financial balance.

13.4 As well as the additional non-recurrent income received in 21/22, it is currently expected that the Trust will non-recurrently receive £4m less than the draft contract schedule in 22/23, resulting in a projected £5.5m deficit.

13.5 The Board noted that this budget proposal fully reconciles to the organisation and system NHSEI submission on the 17th March. A final submission is due on 26th April and therefore the system/organisation plan will continue to develop up to that point. Any further changes to the budgets set or the Trust's forecast financial position would be brought to the attention of the Resources Committee in April.

13.6 These budgets provide a clear financial framework in which all Trust staff can continue to operate and make financial decisions and form the basis of the plans on which the Trust will deliver its business planning objectives and strategic aims for the year ahead.

13.7 National planning guidance for 22/23 provides tariff uplift funding to the system envelope of 2.8% and a 1.1% efficiency target as well as a convergence target 0.5% for Gloucestershire. The level of covid funding within the system allocation is significantly reduced.

13.8 The proposed budgets will deliver a deficit of £5.506m, although the Trust will continue to strive to identify system wide programme savings. In order to deliver the proposed budgets, recurrent cost improvement schemes of £5.5m will be required. In addition, £1.45m of non-recurrent savings will need to be found to support non-recurrent expenditure and non-recurrent cost pressures. During budget setting 58% (£3.698m) of the recurrent savings target have already been delivered.

13.9 A capital expenditure budget of £18.838m is proposed for 22/23. There are no capital disposals planned for 22/23, and work continues regarding the three sites that are planned for disposal in 23/24. The Capital Management Group has met to discuss the priorities for next year and the main focus of the programme will be the building of the new hospital in the Forest of Dean and reducing backlog maintenance. The capital programme as presented does not include additional International Financial Reporting Standard 16 (IFRS16) leases not yet entered into. IFRS16 is a change in the accounting for leases which will bring leases onto the balance sheet. An assessment of the revenue impact of this change has been incorporated into the budgets (£200k). It is assumed that national funding will be made available.

13.10 The Board noted the budget setting process and linkages within business planning and Cost Improvement Programme development processes. The Board approved the revenue and capital budgets for 22/23 and approved in principle the five-year capital plan. The Board also noted the risks associated with the proposed budgets for 22/23.

14. ANNUAL STAFF SURVEY RESULTS

14.1 The purpose of this report was to provide an update on the final results of the 2021 Staff Survey. The Board welcomed Ruth Thomas (Associate Director of Organisational Development) and Anis Ghanti (Head of Organisational Development & Leadership) to the meeting who had contributed to the production of this report.

14.2 The Trust has committed, as part of its Trust People Strategy, to giving colleagues a “Strong Voice” at work and the Staff Survey remains a key and informative component to that commitment. The Board noted that the results presented a largely positive and improving view of how staff rate the Trust as an employer. They also provided signposting to areas to prioritise for action over the coming year.

14.3 Overall within the survey, for questions where there are previous year comparisons:

- circa 60% of questions have been rated with improvements or the remained the same (54% improvements and 6% unchanged)
- 40% have had reduced ratings

- The seven Our NHS People Promise survey themes are new and have no previous year comparisons, however five out of seven (71%) of these are rated above average by colleagues in comparison with other Trusts in our benchmarking group (Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)
- Of the remaining other two themes, Staff Engagement and Morale, while both are above our benchmark average, Staff Engagement has remained unchanged and Morale has seen a 0.1 reduction from 2020 (1.6%)

14.4 The Board noted that recommendations for actions in 2022 were being worked up in more detail for a deep dive at April's Great Place to Work Committee. However, the initial recommendation is to focus on five key areas:

- Response Rates: developing further improvements in response rates
- Communication, reporting and engagement: continually improving our communications (particularly "you said, we did"), reporting and engagement with colleagues on the survey results and actions
- Team Working: revise and relaunch team working content of existing middle and senior management leadership development programmes (e.g. "Thrive" – Brilliant Essentials and Leading Better Care Together, Flourish, Five Elements of Successful Leadership) as well as resources that support and improve wider team working and a sense of team membership and cohesion
- Flexible Working: implement Agile Working toolkit and guidance, review Flexible Working Policy, Flexible Retire and Return Policy, develop recording process and KPIs for capturing and monitoring flexible working.
- Professional Group and Directorate specific action plans: drawn from their analysis of the Directorate and Professions results.

14.5 The Board noted the survey results and was assured that the Trust's strategic approach to people management, engagement, culture and communications over the past year is paying dividends. The Board also recognised that there was further improvement work to do if GHC is to become a consistent top quartile performer in the survey outcome which had been completed by colleagues in Quarter 3 (2021/22).

15. GENDER PAY GAP ANNUAL REPORT

15.1 The purpose of this report was to inform the Board of the 2021 gender pay gap across Gloucestershire Health & Care NHS Foundation Trust, to provide an update on related actions from last year, and recommended actions for the coming year.

15.2 The most recently reported average median gender pay gap in 2021 for the whole of the South West region was 16.6%, with the average median annual salary being £23,776. This means that in the South West women are typically paid 83 pence for every pound paid to a man. This compares unfavourably with a UK-wide average median gender pay gap, with the average median annual salary being £25,971, meaning that in the UK women are typically paid 85 pence for every pound paid to a man.

15.3 This report contained the statutorily required calculations, presenting the gender pay gap against the six indicators. These are the result of a snapshot of the Trusts' workforce on the required date in 2021 and are summarised below:

- Mean average gender pay gap. Women earn less than men by 17.09%. This compares with a previous 2020 gap of 18.63%.
- Median average gender pay gap. Women earn less than men by 4.31%. This compares with a previous 2020 gap of 7.55%.
- Mean average bonus gender pay gap. Women are paid less than men by 12.79%. This compares with a previous 2020 gap of 11.8%.
- Median average bonus gender pay gap. Women are paid more than men by 16.67%, this figure remains unchanged from 2020.
- Employee numbers by quartile. The proportion of men and women (when divided into four groups) ordered from lowest to highest pay shows there are a higher proportion of women in all quartiles and the gap closes with progression toward the upper quartile.

15.4 In 2021, the Trust Board approved the new People Strategy, which made a specific strategic commitment to equality, diversity and inclusion. Improving and removing the gender pay is a key element to operationally delivering on this commitment alongside our actions on the Workforce Race and Disability Equality Schemes.

15.5 Neil Savage advised that whilst this past year's data paints a modest improving picture for the Trust, it also shows that the Trust still has far to go. Importantly, it also continues to demonstrate the scale of challenge and the inherent unfairness in the nation more widely.

15.6 In line with the national requirements, the Trust and its earlier legacy organisations had previously confirmed a statement of commitment to reducing the pay gap. The Board was happy to endorse a similar statement of intent this year, as follows:

"The Board of Gloucestershire Health and Care NHS Foundation Trust confirms its commitment to ongoing monitoring and analysis of its Gender Pay Gap data and to developing the appropriate actions which will reduce and eradicate this gap over time."

"Additionally, the Board is fully committed to working in partnership with colleagues, stakeholder organisations and external agencies to learn from other organisations, apply good practice and to take innovative approaches, including positive action in its action to reduce and remove the gender pay gap."

16. CHAIR'S REPORT

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

16.2 Ingrid Barker highlighted the update within her report relating to the Well-Led Review of Leadership and Governance. Our merger in 2019 brought together two 'good' trusts, each with legacies and achievements of their own. At the last CQC inspection in 2018, a rating of 'good' was provided for the Well-Led domain. The Trust is committed to moving to an 'outstanding' rating overall. A developmental well-led review has now been scheduled to take place, commencing in April. The Trust will be working with The Value Circle to conduct this review, and to support the Trust's 'outstanding' ambition. The aim is to assess the leadership and governance of the Trust as described in the well-led framework published by NHS

Improvement and to identify developmental actions in response. This review will inform further targeted development work to secure and sustain the trust's future performance as part of continuous improvement.

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

17. CHIEF EXECUTIVE'S REPORT

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

17.2 Paul Roberts informed the Board that this had been an eventful and not very positive week for the NHS, with the publication of the Ockenden Report and public perception polls of the NHS. He said that it would be important over the coming months for the Board to collectively reflect on this in terms of the leadership of the organisation.

17.3 Since writing his report, Paul Roberts advised that the CQC had notified GHC that they would be carrying out a core services inspection at the end of April, with a Well Led inspection taking place at the end of May. Paul Roberts noted that the merger took place 2.5 years ago and it had been over four years since inspections had taken place of the predecessor organisations, so it was therefore reasonable to expect this. It was still a very challenging time for all NHS services, but the Trust welcomed the scrutiny.

17.4 Marcia Gallagher asked about the Diagnostic Programmes Board and progress with this given the limited capacity and backlogs that had been reported. Paul Roberts noted that a business case was being developed for a central diagnostic centre, to be accessible and available to all communities, with a real focus on trying to get early diagnosis. There was a lot more work to do but that was a big focus for the Board currently.

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

18. SYSTEMWIDE UPDATE

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

18.2 Angela Potter advised that the Health and Wellbeing Board and the ICS Board had both recently received a detailed review of the work taking place across the Health Inequalities agenda, recognising that much of this was multi-agency and system wide. It was suggested that some of those reports and presentations be brought into the strategy away day in May to sharpen the Board's thinking about how we specifically deliver on our better health objective.

18.3 Healthwatch Gloucestershire had published a new report in March entitled "Post-COVID syndrome, people's experiences of health care and support in Gloucestershire". The report summarises key messages from their survey (of 56 people). The aim was to understand how post-COVID syndrome (long COVID) is affecting people's health and wellbeing and to find out what care and support is available in Gloucestershire. Healthwatch worked with the Trust

to reach people who used the services. There are a number of key messages in the report which are pertinent to the Trust including the length of time waiting to hear from the service following referral and a desire for more face to face conversations.

18.4 The ICB would become a statutory organisation on 1st July 2022 and it was noted that the draft ICB Constitution was currently being finalised. A date was being set for discussion on this and the Governance Handbook by the GHC Board in the coming months.

19. FOREST OF DEAN COMMUNITY HOSPITAL DEVELOPMENT

19.1 The purpose of this report was to present for approval the final costings/Gross Maximum Price to enable the letting of the construction contract for the development of the new Community Hospital in the Forest of Dean. This included confirmation that whilst the scheme costs have risen slightly, the scheme continues to demonstrate good value for money, and remains affordable and deliverable for the Trust in terms of revenue, cash and CDEL allocations.

19.2 The Full Business Case (FBC) was approved by the Board with a Not to Be Exceeded Price (NTBE) of £23.9m for the development of a new community hospital to serve the people in the Forest of Dean in July 2021. Since that time, the final design solution has been completed and full planning permission has been obtained enabling the construction partner, Speller Metcalfe, to complete the full market testing of the works packages to enable us to now move to the completion of the Gross Maximum Price (GMP) and approve entering into the construction contract. GMP is a fixed maximum price to the Trust based on the market testing. Where cost certainty has not been possible within the supply chain our main construction partner holds a nominal contingency sum within their price.

19.3 Unfortunately, the market testing has come back outside of the NTBE price and is sitting at a total scheme value of £25.5m. Therefore, the value for money modelling, revenue modelling and cash flow have all been re-run. This paper confirms that the scheme remains both affordable in terms of cash, Capital Departmental Expenditure Limit (CDEL) and ongoing revenue requirements and the value for money assessment remains strong.

19.4 The FBC approval recognised that the business case is a multi-year scheme. The additional costs predominately fall within 22/23 and the CDEL position can be managed within the system allocation. The 23/24 position has not been finalised at this point in time but system partners are aware of the FoD requirements and the Trust's call against the CDEL allocation.

19.5 The Trust Board's self-certification on the FBC process was supported by the Regional Support Group in November 2021. Subject to the Board approving the revised parameters within this paper, the regional team will be notified of the full planning permission decision and the final GMP which were noted as outstanding commercial considerations in their review of our self-certification. A final version of the full business case will then be prepared and presented back to the FoD Assurance Committee so that all parameters match the GMP and construction contract for audit trail purposes.

19.6 This paper therefore reconfirms that the drivers for the approval of the FBC in July 2021 remain unchanged and the scheme will provide a modern, fit for purpose environment and enhanced service facilities for the people of the Forest and beyond. Therefore, delivery of the proposed investment into the new community hospital should be completed by entering into the construction contract. This is an NEC4standard Construction and Engineering

Contract. Due diligence has been sought from legal advisors DAC Beachcroft and the FoD Assurance Committee have considered the range of KPI's and contract penalties to be incorporated. Investment in this new facility will enable the re-provision of services, and subsequent closure of the existing two community hospitals, namely Lydney & District Hospital and the Dilke Memorial Hospital when the new hospital opens.

19.7 The Board approved the revised FBC value at a maximum of £25.5m for the development of a new community hospital in the Forest of Dean (noting that value engineering work will continue to reduce this further if at all possible) and the confirmation that this is affordable in both capital and revenue terms. The Board also gave delegated authority to the FoD Assurance Committee to enable the Trust to enter into an NEC4 contract for the construction of the new community hospital with Speller Metcalfe up to a value of £17.8m + VAT as soon as GMP final pricing work has been concluded.

20. MINUTES FROM THE COUNCIL OF GOVERNORS MEETING

20.1 The Board received and noted the minutes from the previous Council of Governors meeting held on 10 November 2021.

21. BOARD COMMITTEE SUMMARY REPORTS

21.1 **Great Place to Work Committee**
The Board received and noted the summary report from the Great Place to Work Committee meeting held on 2 February 2022.

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

21.3 **Mental Health Legislation Scrutiny Committee**
The Board received and noted the summary report for the MHLS Committee meeting held on 16 February 2022.

21.4 **Resources Committee**
The Board received and noted the summary report from the Resources Committee meeting held on 24 February 2022.

21.5 **Appointments and Terms of Service Committee**
The Board received and noted the summary report from the Appointments and Terms of Service Committee meeting held on 1 March 2022.
The Board also received the revised Terms of Reference for the ATOS Committee, which had been reviewed in line with best practice and the Trust's scheme of delegation and standing orders. Proposed changes to the terms of reference included amendments to provide clarity on the Committee's role in relation to the appointment of Executive Directors. The Board approved the suggested changes.

21.6 **Quality Committee**
The Board received and noted the summary report from the Quality Committee meeting held on 3 March 2022. Jan Marriott highlighted the Medical Education Annual Report, which really did demonstrate the benefits of the newly merged Trust.

21.7 **Forest of Dean Assurance Committee**
The Board received and noted the summary report from the FoD Assurance Committee meeting held on 9 March 2022.

22. ANY OTHER BUSINESS

22.1 There was no other business.

23. DATE OF NEXT MEETING

23.1 The next meeting would take place on Thursday 26 May 2022.

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

DRAFT

TRUST BOARD PUBLIC SESSION: Matters Arising Action Log – 26 May 2022

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

Meeting Date	Item No.	Action Description	Assigned to	Target Completion Date	Progress Update	Status
31 March 2022	6.2	A MOP asked whether the Trust was going to start using a restorative approach after patient safety incidents and adopt the key principles in future. John Trevains offered a conversation with the MOP outside of the meeting, welcoming the opportunity to explore this further.	John Trevains	May 2022	Follow up meeting with MOP offered with senior members of the Trust's patient safety team to explore the restorative approach in more detail	

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NHS Foundation Trust

AGENDA ITEM: 07/0522

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 26th May 2022**
PRESENTED BY:	Sandra Betney, Director of Finance and Deputy CEO
AUTHOR:	Chris Woon, Deputy Director of Business Intelligence
SUBJECT:	**Performance Dashboard April 2022/23 (Month 1)**

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

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

The purpose of this report is to
This performance dashboard report provides a high-level view of key performance indicators (KPIs) in exception across the organisation.

Performance covers the period to the end of April (Month 1 of 2022/23). Where performance is not achieving the desired threshold, operational service leads are prioritising appropriately to address issues. Where appropriate, Service led Performance Exception Action Plans (PEAP) are presented to the Business Intelligence Management Group (BIMG) and more widely account for performance indicators in exception. Service level risks are also now highlighted for reference for the first time this period.

Recommendations and decisions required
The Board are asked to:

- Note the aligned Performance Dashboard Report for April 2022/23.
- Acknowledge the impact of SystmOne Simplicity project on the operational performance reporting of some physical health indicators for the period and the mitigating actions.
- Note the report as a **significant level of assurance** that our contract and regulatory performance measures are being met or that appropriate service action plans are being developed to address areas requiring improvement

Executive summary

Business Intelligence Update
A high-level timetable developed from the Measuring What Matters Board Seminar is presented on page 3. This provides regular business intelligence development monitoring against revised milestones which were adjusted to respond to the 2022/23 business planning cycle and the priorities of the SystmOne Simplicity project.

The SystmOne Simplicity project remains a key driver to resolve inherent data quality issues within the Physical Health Community clinical system and ensure that the Trust's dataset is robust and reliable for stakeholders. Although Clinical Systems Team have adjusted capacity to recover project pace, ongoing pressures across operational services continue to impact on some of the Trust's community (PH) data quality for the period. Although some reporting visibility has returned, there is still significant data quality

cleansing activity to undertake through Quarter 1 and 2 of 2022/23. Historic activity provides some assurance to normal performance levels for these indicators and wherever possible, manual evaluations have been undertaken on validating exceptions and informing confidence in the current situation. The associated narrative should be considered for all indicators in exception. Although a revised, high-level project timeline for SystmOne Simplicity has been agreed, detailed milestones are still being finalised to recover and achieve the core phases of the project within 2022.

Recovery Update
The first Chief Operating Report authored by the Chief Operating Officer David Noyes can be found on Page 4 alongside the operational recovery overview (on page 5), which has now transitioned into an integrated element of monthly Operational Governance rigour.

Performance Update
The performance dashboard is presented from page 6. It is of note that all the indicators within this report have been in exception previously within the last 12 months.

Mental Health & Learning Disability Service (National & Local) Performance
Attention is requested to review the 9 key performance thresholds in exception within the dashboard (with associated narrative) that were not met for the period. Eating Disorder (ED) Services account for four indicators, with Care Programme Approach (CPA) two IAPT Access, CPI and Perinatal remains in exception again this month. A range of demand and capacity factors are contributing to performance across these indicators. Focused work is being undertaken internally on demand and capacity modelling for IAPT and ED to establish multiple scenario forecasts. Collectively, this will inform the pathway improvements required to recover performance.

Physical Community Health Service (National & Local) Performance
In addition, attention is drawn to a further 20 key performance thresholds in exception within the dashboard (with associated narrative) that were not met for the period. However, a number of these are anticipated data quality issues linked to delayed SystmOne Simplicity activities, as mentioned above. Through the attention of clinical services, data quality for these indicators should improve over Q1 and Q2 2022/23 in line with the Operational data quality intentions.

Although proxy indicators (meaning they don't have formal thresholds, but a proxy threshold based on nominal annual activity) and therefore not formally in exception; the following indicators are highlighted for information:

6. Number of Never Events
There was 1 Never Event reported in April 2022, the proxy threshold for Never Events is 0. This is above the SPC chart upper control limit. The never event took place in the Sexual Health Service and was subsequently successfully treated.

7. Number of Serious Incidents Requiring Investigation (SIRI)
There were 9 SIRIs reported in April 2022, the proxy threshold for SIRIs is 0. This is above SPC chart upper and lower control limits. SIRIs are counted in the month based on the declared date. Final figure for April will be 10 pending an update in Datix. SIRIs comprise 7 in Mental Health and 3 in Physical Health.

27: Inpatients Average Length of Stay
The average length of stay for inpatients in Community Hospitals was 51.7 days in April compared to 51.9 days in March. These are some of the highest figures reported to date.

Performance is above SPC chart upper control limit. 12.5% (15/120) of all discharges in April had a length of stay of 100 days or greater. Excluding these patients, the average length of stay reduces to 40.3 days. This KPI has been exceeding the upper SPC control limits since October 2021. As previously noted, the higher figures in April are due to;

- system wide delays in sourcing onward care (care home beds/ packages of care and discharge to assess beds)
- closure to visiting which has resulted in prolonged conversations with families and carers
- provision of equipment/ needs on discharge and
- staff absences which have impeded usual processes of effective discharge.

Trust Wide Service Performance

There are currently only 3 contractual Workforce indicators in exception this month. Training is not in exception. Annual leave consumption is 8% in April against an 8.3% threshold.

Non-exception reporting

It is further noted that there are additional indicators outside of threshold but are either within normal, expected variation, have a legacy 'proxy' threshold, are formally suspended or have a confirmed data quality issue that is administrative only and resolution is assured. These have not been highlighted for exception but are routinely available for operational monitoring within the online Tableau reporting server.

Risks associated with meeting the Trust's values

Where appropriate and in response to significant, ongoing and wide-reaching performance issues; an operational Performance Exception Action Plan (PEAP) or (service) Development and Improvement Plan (DIP) which outlines any quality impact, risk(s) and mitigation(s) will be monitored through BIMG.

Corporate considerations	
Quality Implications	The information provided in this report can be an indicator into the quality-of-care patients and service users receive. Where services are not meeting performance thresholds this may also indicate an impact on the quality of the service/ care provided.
Resource Implications	The Business Intelligence Service provides the support to operational services to ensure the robust review of performance data and co-ordination of the combined performance dashboard and its narrative.
Equality Implications	Equality information is monitored within BI reporting.

Where has this issue been discussed before?	BIMG 19/05/2021
Appendices:	*None*
Report authorised by: Sandra Betney	**Title: Director of Finance**

Gloucestershire Health and Care NHS Foundation Trust

Snapshot Month
April

Performance Dashboard Report & BI Update

Aligned for the period to the end April 2022 (month 1)

Business Intelligence Summary Update

The SystmOne Simplicity development continues to drive a majority of information activities. Business Intelligence (BI) services continue to prioritise key infrastructure development tasks to support this initiative wherever possible. Incompleted activities within the 2021/22 business planning cycle have been reconfigured and where apropriate profiled into the the 2022/23 business plan.

The most recent testing of the new Community Services Data Set (CSDS) submission has finally passed its internal testing successfully and we are looking to load a new CSDS to NHS Digital this month ahead of schedule. This will include Urgent Care Response (UCR) data, sourced from the newly developed warehouse. NHSE/ I has accepted this this will initially be a limited Urgent Care dataset only. Further SystmOne Unit modules will come online as they are ready through the year. A new SystmOne Simplicity project timeline is currently being refreshed for 2022/23 with increased Project Management, clinical systems and governance support. From an information reporting perspective; physical health datasets have been switched over and core reporting such as Patient Tracking Lists (PTL) are available to services. Major operational data cleansing and recording process improvements are in plan. The previous black spots of data within the performance dashboard are mostly back on line, however as anticipated there are now further data quality interventions required from services. The digital vulnerability (log4j) has now been remedied on servers and desktop products to ensure contining security of our software.

33n, the Trust's external analytical partner have shared their Mental Health cohorting tool and there are worshops with ED clinicians in May before wider roll-out to other Mental Health services. It is hoped this will lead to the consideration of a further development of a dynamic and automated Trust wide trajectory modelling tool in the year ahead.

Page 2 highlights high level progress against the **Measuring What Matters** plan.

Chief Operating Report *(page 3)* and Operational Recovery Overview *(page 4)*

Although the Recovery Programme has transitioned into a business as usual function as part of the Governance agenda, an Operational Recovery Overview has been introduced into the Performance Dashboard. This outlines Service recovery positions, changes and progress. April 2022/23 is the first period for the Chief Operating Officer's 'Chief Operating Report' which is published within the Performance Dashboard.

Performance Dashboard Summary *(from page 5)*

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

Where performance is not achieving the desired results, operational service leads are prioritising appropriately to address issues. Additionally, where appropriate, and in response to significant, ongoing and wide-reaching performance issues; an operational Performance Exception Action Plan (PEAP) which outlines appropriate risk, mitigation and actions will be monitored through BIMG. For example, specific updates have been provided by operational services over the last 12 months for areas with consistent performance challenges such as Children and Young People's Services (CYPS including CAMHS), Eating Disorder (ED) Services, Improving Access to Psychological Therapies (IAPT), Autism Spectrum Condition/ Attention Deficit Disorder (ASC/ ADHD) and Perinatal MH Services. Where PEAPs and/ or Development Improvement Plans (DIP) are in place this is noted within the commentary.

Again, for the first time a reference to Service and KPI relating Risks have been added into the performance commentary for reference.

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

Theme	(Provisional) Milestone	Target date	Progress Tracker
Data Quality matters	Tableau subscriptions and alert functionality promoted across services	Dec-21	Complete
	NQT Data quality audit schedule for 2022/23 to be agreed	by Jun 2022	Target extended from Jan 2022 due to current N capacity challenges. CST DQ Audit Planning Meet arranged for 25/04/2022.
	SystmOne Simplicity project (to improve accuracy, consistency, and service quality) to be delivered	by Dec 2022	Target extended from Oct 2022 due to Ops and C capacity challenges and increasing scale of proje
	Revised data quality reporting portfolio deployed within Tableau servers for physical health services	by Oct 2022	On target
Integration matters	Server migration to allow for reconfiguration and resolve licensing concerns	by Dec 2021	Complete
	Develop additional Board performance dashboard workforce indicators to include:		Complete
	o Deployment of monthly Vacancy Rate	by Sept 2021	Complete
	o Development of monthly (Cumulative) Annual Leave Consumption	by Oct 2021	Complete
	o Development of monthly Turnover/ Stability Rate	by Nov 2021	Complete
	Deploy first Tableau Datix Reportin Table(s) by April 2022	by April 2022	Complete
	Deliver Totara (Care to Learn) extraction by April 2022 & first report deployment by Oct 2022	by Oct 2022	On target, data flows in place
	Deliver Allocate (e-Rostering) extraction by April 2022 & first report deployment by Oct 2022	by Oct 2022	On target, data flows in place
Patients matter	Heads of Profession to liaise with Service leaders and wider stakeholders to develop the organisation's first plan for Value Based Healthcare in 2022/23	By Mar 2023	Target extended from Dec 2022 due to current C capacity challenges.
	Deploy trial of first tranche of new outcome measures	by April 2023	On target
Culture matters	Decommissioning of regular Excel physical health reporting use	by July 2022	On target
Audience matters	Review Key Performance Indicator portfolio to inform 2022/23 contract schedule and operational/ strategic needs	by Jan 2022	Completed April 2022
	Publish proposal to restructure the current performance dashboard to support various audience level perspectives	by June 2022	Target extended from April 2022 due to delay c contract schedule agreement (now resolved) an priotity of SystmOne Simplicity development nee
Format matters	Deliver immediate performance dashboard interrogation pilot for Resources Committee members	by Sept 2022	On target
Timeliness matters	Evaluate (almost) real-time transactional log shipping processing within all new system procurements and extensions, particularly when RiO and SystmOne contracts	by April 2023	On target
Analysis matters	Realising holistic business partnering across all corporate partners by January 2022	by Jan 2022	Complete
People matter	Through business partnering, Tableau user training and support will be offered from November 2021 to users from the BI service ahead of utilising the system and then ongoing whilst using it within their day-to-	from Nov 2021	Complete
	BI support guidance to support users will be made available through the intranet	from Oct 2021	Complete
	Learning & Development Service to inform Digital Competency timetable for 22/23	by April 2022	Complete
Governance matters	Cleanse proxy indicators	by June 2022	Target extended from Dec 2021 due to NQT/ Op capacity challenges. Activity now underway.
	Publish Performance Management Framework	by May 2022	Complete
	Remove superseded National and Local Performance Indicators	by July 2022	Target extended from April 2022 due to priotity SystmOne Simplicity development needs.
	Introduce ranked waiting times (over 52 weeks) summary into the performance dashboard report – provisional outline	by Sept 2022	Target extended from April 2022 due to delay c SystmOne Simplicity Project. New milestone align Operational DQ commitment.
	Introducing new internal performance indicators into performance dashboard	by July 2022	On target

Chief Operating Report April 2022

A busy month operationally, although in the past few weeks we have started to detect some early and encouraging indications that the very intense pressure within the system (caused by the combination of Covid rates and Winter) are easing slightly, in particular a very welcome steady reduction in the number of colleagues with a Covid diagnosis necessitating isolation; that said the system remains in a challenging position and changes to the demand profile could easily tip us back into escalation measures. We have also hosted colleagues from the CQC in the last month as part of their core service inspection, and look forward to the well led element of that process towards the end of May 2022.

In terms of performance, we continue to deal with some challenging areas where we aren't yet delivering at the levels we would wish to. Care Pathway Reviews are highlighted within the report, and here we have very recently introduced a revised process and approach which I anticipate should see us recover in this area within 6-8 weeks. Our IAPT services have been analysing the challenge of meeting revised trajectories against a challenging workforce picture and the Executive will review a number of putative options later in May. Regrettably we remain challenged in staffing terms for the achievement of the CPI target, but importantly we are able to mitigate the impacy of this with clients by their care being held by our Recovery services while they are waiting. As the Board are aware, our Eating Disorders service is a very significant area of concern, and is now the subject of a system led review in terms of how to re-shape and resource for the future; in the meantime the service continue to work hard on the recovery plan briefed to the board earlier this year. I'm pleased to say that we are increasingly confident of finding a suitable estates solution for the expanding Perinatal team and so I would no longer grade their position as red; indeed it is noteworthy that (as briefed to Resources Committee) we are now implementing a data threshold approach for rating recovery status of services to replace the previous subjective one. In terms of other exceptions, I am confident that we will recover the range of indicators in Childrens services around vaccinations and health check assessments which have been set back by the urgency of the Covid vaccination programme. I remain concerned about our position with regard to Podiatry and MSK services (notwithstanding a very successful recent recruitment campaign for physio into MSK), where data isn't easily available but local proxy indicators show we have a great deal of work to do, which our service are thinking through in terms of how to approach. I'm also worried about the recovery and delivery of Diabetes services as we are seeing quite a steep rise in referrals here; again this is an area for further analysis. And while Childrens OT and SaLT still look challenged, recovery plans are starting to impact, in part thanks to some successful recruiting and the introduction of digital offers. Equally, while we continue to manage extremely high numbers in the CAMHS service, I'm pleased the recovery trajectory shows that we will achieve the 4 week wait for assessment target by the end of this month; young people on this list are being helped by regular calls from the service, a new app to provide digital support and we are likely to hold several weekend clinics to tackle the backlog.

I'm pleased to report that we have enjoyed some success in recruiting to our MacMillen services and the Evening and Overnight District Nursing Teams which have eased operational risks in each. And naturally our teams continue to work long and hard to deliver the best possible services they can for our community; I've been fortunate to spend time recently in Charlton Lane, with a couple of ICTs, the Perinatal team and in North Cots & Dilke, and unfailingly find our people buoyant and focussed on excellent care. In terms of progress in the last month or so, I was really pleased to be able to re-open Tewksbury MiiU in early May (as demand for the community Covid infusion treatment could be met by the IV team), and we have managed to soft launch a pilot falls response team covering Cheltenham and Gloucester areas. Recognising that we continue to face a real challenge in terms of workforce numbers in our mental health services, we have reinvigorated a staff led group looking at all elements of the workplace to see what we could change to help with this. While similarly recruitment to the Homefirst service remains a challenge, not helped by the national recruitment situation and the cost of living crises (especially fuel costs for these high mileage staff), we continue to seek innovative and novel ways to reach out to the community and have had some success as a result. Our Community Assessment and Treatment Unit (CATU) at Tewksbury is delivering strongly and has already surged up to 10 beds, delivery early step up interventions and a short Length of stay; and we are launching in May an enhanced discharge to assess project (using Preston Ward and migrating to the new ward in Stoud) exploring new ways of working across therapy and with social care to try and deliver a reduction in length of stay and improved patient outcomes. This should give us good learning to inform a wider review of our therapy offer within the community and community hospitals pathway, which I'm pleased to say we have system support on to take forwards. Equally we are grateful for system partners support in a focussed piece of work to try and address patients who have completed their treatment pathways within our services but remain with us and have a Length of Stay over 75 days, the numbers of which are steadily reducing as a result.

David Noyes
Chief Operating Officer (COO)

Operational Recovery Overview

March 2022 (in arrears to accomodate the operational governance cycle)

Service RAGs (March 22):

	Green	Amber	Red	Total
ACPH	13	3	5	21
CYPS	21	2	4	27
MH&LD	13	5	4	22
UCASS	13	9	6	28
Hospitals	9	0	0	9
Totals	69	19	19	107

Overview of Changes in Month (March 22):

Perinatal Service – Moved from **green** to **red** recovery RAG
Rationale: Unable to recruit for planned expansion due to insufficient estates space for required service. Has been escalated to estates

Children in Care (CIC) – Moved from **red** to **amber** recovery RAG
Rationale: Interim substantive 0.9 WTE Band 6 approved to support additional capacity. Full external review ongoing

Wheelchair Assessment Centre: Stepped down from **amber** to **green** RAG
Rationale: Improvement plan completed and closed

Telecare: Stepped down from **amber** to **green** RAG
Rationale: Waiting list review complete and risk closed

MacMillian Service - New staff in posts now and building caseloads.
Continue to monitor and consider stepping down to **green** RAG next month with assurance of onward recovery

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

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health - National Requirements Gloucestershire

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

1.04: CPA (Care Programme Approach) – Formal review within 12 months [Community MH Services]
Performance for April is 84.5% (151 cases) against a performance threshold of 95% and is below the lower SPC (Statistical Process Control) limit. Most of the cases are within the Recovery Service (90 cases, 64 of which are in the East and 26 in the West).

Since the end of April, a further 15 overdue CPA reviews have been completed and the current average number of days between the due date and the end of April is 82 days and the median, 58 days.

A new process map has been designed for services to use, integrating tableau reports into the procedure, combined with admin staff issuing early warnings to staff for CPA reviews that are due.

There have been exceptionally high levels of staff absence due to Covid across teams during April and although new staff have started, there are still vacancies due to the continuing turnover of staff within teams. Patient engagement has also been a challenge as DNAs and cancellations are occurring due to patients testing positive for Covid or exhibiting symptoms.
From an assurance perspective, team managers are reviewing cases and clinical needs are being met outside of the CPA process so patient safety is not being compromised.

There is a DIP (Development Improvement Plan) for the Recovery Service.

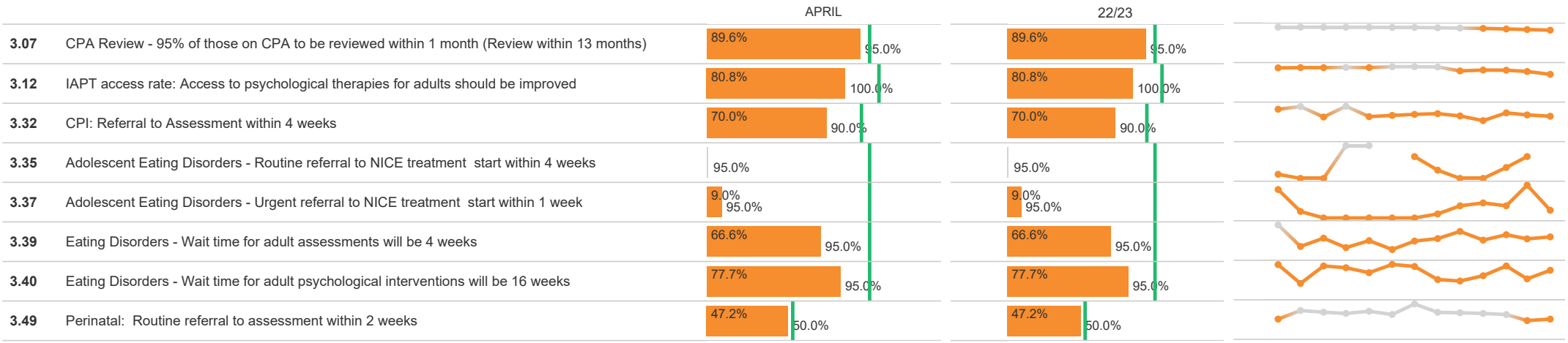
The Mental Health Commissioner has acknowledged the updated guidance from NHSE/I regarding the proposed changes to the CPA metrics. As an interim measure we will continue to report on the 12-month CPA review as a safety net until revised metrics are developed through the Integrated Community Mental Health Transformation project.

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

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health & Learning Disabilty - Local Contract



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

3.07: CPA (Care Programme Approach) – Formal review within 13 months [Community MH Services]
Performance for April is 89.6% against a performance threshold of 95% and is below the lower SPC (Statistical Process Control) limit. This indicator is a subset of 1.04 and of those non-compliant records there are 99 cases where the CPA review is not recorded as having taken place within 13 months. Of these, 66 are within the Recovery Service.

A new process map has been designed for services to use, integrating tableau reports into the procedure, combined with admin staff issuing early warnings to staff for CPA reviews that are due.

There have been exceptionally high levels of staff absence due to Covid across teams during April and although new staff have started, there are still vacancies due to the continuing turnover of staff within teams. Patient engagement has also been a challenge as DNAs and cancellations are occurring due to patients testing positive for Covid or exhibiting symptoms.

From an assurance perspective, team managers are reviewing cases and clinical needs are being met outside of the CPA process so patient safety is not being compromised.

There is a DIP (Development Improvement Plan) for the Recovery Service.

The Mental Health Commissioner has acknowledged the updated guidance from NHSE/I regarding the proposed changes to the CPA metrics. As an interim measure we will continue to report on the 12-month CPA review as a safety net until revised metrics are developed through the Integrated Community Mental Health Transformation project.

3.12: IAPT access rate: Access to psychological therapies for adults should be improved [Community MH Services]
For April, the individual access rate was 931 against a target of 1151 which equates to 80.9%.

During April the number of referrals received was 13% lower than required and the drop out rate was 20.1%, compared to a planned 15%, both of these, leading to a lower access rate.

A series of revised access trajectory models are being presented to executives during May and the preferred option will inform the access target for 2022/3.

Staffing levels remain a challenge due to significantly higher attrition in Quarter 3 of 2021/22 for PWP staff. The service has a recruitment plan in place to address these staffing losses however, achieving access targets is expected to remain a challenge until the end of the year when the current trainee cohort of staff attain qualification.

There is a DIP (Development Improvement Plan) in progress and a full options paper is to be presented to Execs in May 2022.

3.32: CPI (Complex Psychological Intervention): Referral to assessment within 4 weeks [Community MH Services]
April performance is reported at 70.0% against a performance threshold of 90% and is below the SPC (Statistical Process Control) lower limit.

There were 9 non-compliant cases in April of which 7 were seen within 5 weeks. The remaining 2 patients were seen within 6 and 9 weeks due to a DNA and a cancellation as a result of Covid.

Challenges remain with staffing levels; however, a new Lead for Working Age Adult Psychological Services has recently taken up post and there has also been successful recruitment to vacancies in both the North and South Teams. The impact of this will take a few months to be reflected in performance as they start to take up new cases.

It is noted that while waiting for CPI assessment and treatment, the client's care is held by either the Recovery or AOT services.

A PEAP (Performance Exception Action Plan) is in development. Development and Improvement plan being produced

3.35: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks [Community MH Services]
There were no young people on the waiting list that began treatment during April.

Current predictions estimate a stable waiting list recovery for under 18s accessing routine treatment within 4 weeks by October 2023.

3.37: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week [Community MH Services]
April performance is reported at 9.0% against a performance threshold of 95%. There were 10 non-compliant cases in April. An urgent treatment trajectory forecast for adolescents has been revisited with updated assumptions. This predicts a waiting list recovery of 95% for under 18s accessing urgent treatment within 1 week by October 2022; a revision from the previous model which indicated April 2022. Capacity remains a challenge and due to lack of treatment slots, it is highly likely that the next forecast model will show a further delay in recovery of this KPI.

3.39: Adult Eating Disorders: Referral to Assessment within 4 weeks [Community MH Services]
April performance is reported at 66.6% against a 95% performance threshold. There were 9 non-compliant cases reported in April.

3.40: Adult Eating Disorders: Assessment to Treatment within 16 weeks [Community MH Services]
April performance is reported at 77.7% against a 95% performance threshold. There were 2 non-compliant cases reported in April.

Note on 3.35, 3.37, 3.39 & 3.40 – Eating Disorders waiting times
The service is developing a role to work alongside system wide partners to establish a VCS (voluntary care sector) offer moving forwards. They have also successfully recruited 2 Band 7 Clinicians/Nurse prescribers, and both are now in post. Establishment and skill mix has been reviewed to increase recruitment into hard to fill posts. The team are also advertising registered professional roles at band 8b clinical psychologist, band 7 FREED (First episode Rapid Early Intervention for Eating Disorders) Champion plus further band 7, 6 and 5 registered professional roles. Three CAP (Clinical Associate Psychologist) training places have been secured starting in September 2022. The service will also host 2 "return to practice" nurses, starting in May and it is anticipated that they will then join the team fully in October 2022.

Capacity mapping for the service has indicated that the team is significantly under established to meet business as usual demands. This has been discussed and highlighted with commissioners and further investment has been secured as part of the CMHT submission and baseline investment for 2022/23. Given the significant rise in demand this is likely to require further investment for a system wide solution and will be picked up as part of the system wide transformation board.

The current wait profile for the service at the end of April indicates that 94% (661) of all patients waiting for assessment, are waiting over 4 weeks, and waiting times will continue to increase until team establishment is increased or a new model of working embedded and the service able to see routine referrals.

Demand remains high overall with a surge in urgent referrals. For adults, the number of urgent referrals in 2021/22 (212) has increased since 2020/21 (93) by 128%. For under 18s the growth has been greater: 313 in 2021/22 compared to 109 in 2020/21, an increase of 187%.

The main impact of this referral increase in young people appears to be the detrimental effect that the pandemic, lockdown and school closures have had on Children and Young Peoples' wellbeing and mental health. This is validated by the replication in demand across other teams treating CYP.

The service is accepting routine referrals, which are triaged and placed on a waiting list, however, assessment and treatment will continue to be paused throughout May 2022 and it is anticipated that this will be the case for the next 2 months. This will impact on future reported waiting times and has led to some referrals being expedited due to the patients deteriorating condition. The service is working towards reducing the urgent assessment waiting lists and bringing the urgent KPI back in line.

The service is working with BEAT (an Eating Disorders Charity) and Tic (Teens in Crisis) to see if they can offer support to those on routine waiting list.

This set of indicators has a service DIP (Development Improvement Plan) and is on the Performance Governance Tracker. Service Risk ID149. Score = 16

3.49: Perinatal Routine Referral to assessment within 2 weeks [Community MH Services]
Performance for April is 47.2% against a performance threshold of 50% and is and is below Statistical Process Control (SPC) limits.

There were 19 non-compliant cases in April. Of these 10 were seen within 3 weeks, 8 within 4 weeks and 1 within 5 weeks.

The service has work force challenges with maternity leave and staff sickness due to COVID. The service needs to recruit more staff but is significantly short of space even for the current workforce so will be unable to expand until this is resolved.

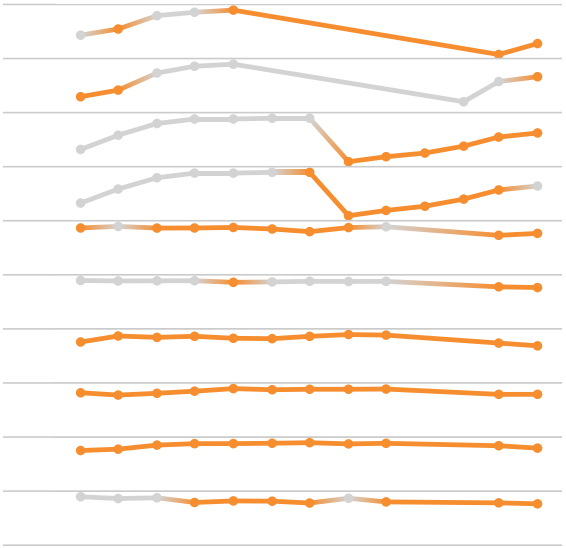
Performance Dashboard: *Physical Health - National Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - National Requirements

		APRIL	22/23
31a	HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 2	28.2% 40.0%	28.2% 31.3%
31b	HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 1	67.6% 70.0%	67.6% 38.3%
31c	Percentage of children in Reception Year with height and weight recorded	68.9% 70.0%	68.9% 69.2%
82	% of eligible children who receive vision screens at or around school entry.	67.5% 25.0%	67.5% 56.7%
84	% of live births that receive a New Birth Visit within 7- 14 days by a Health Visitor	82.8% 95.0%	82.8% 95.0%
85	% of children who received a 6-8 weeks review	84.1% 95.0%	84.1% 95.0%
86	% of children who received a 9-12 month review by the time they turned 12 months	67.2% 95.0%	67.2% 95.0%
87	% of children who received a 12 month review by the time they turned 15 months	80.9% 95.0%	80.9% 95.0%
88	% of children who received a 2-2.5 year review by 2.5 years	76.1% 95.0%	76.1% 95.0%
91	% of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence)	52.5% 58.0%	52.5% 58.0%



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

31a: HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 2
28.2% of the estimated cohort of children eligible for HPV 2nd dose in the 2021/22 academic year had been immunised at the end of April 2022. This is cumulative performance compared to April target of 40%. Overall national target at the end of the programme is 90%.

The HPV delivery has been delayed due to the requirement to prioritise covid 12- 15 vaccinations

- HPV is delivered over 2 academic years and the focus for the month of April has been the delivery of the HPV 1 programme for Year 8. However, some schools have cancelled sessions booked for April and these have been rearranged for May. To support the uptake in the Year 8 cohort, the team are following up on those Year 8's which were missed opportunities due to being absent or unwell at the time of their original session when undertaking the Year 9 2nd dose visits.
- HPV 2 delivery for the Year 9 is below target as school sessions booked for April have been cancelled by schools, these sessions have been rebooked for May
- The service has had to work in partnership with the schools to gain access and to cause minimal disruption to exams for the Year 9 cohort.
- All HPV sessions will be delivered prior to the end of the academic year.

31b: HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 1
67.6% of the estimated cohort of children eligible for HPV 1st dose in the 2021/22 academic year had been immunised at the end of April 2022. This is cumulative performance compared to April target of 70%. Overall national target at the end of the programme is 90%.

The HPV delivery has been delayed due to the requirement to prioritise covid 12- 15 vaccinations

- HPV is delivered over 2 academic years and the focus for the month of April has been the delivery of the HPV 1 programme for Year 8. However, some schools have cancelled sessions booked for April and these have been rearranged for May. To support the uptake in the Year 8 cohort, the team are following up on those Year 8's which were missed opportunities due to being absent or unwell at the time of their original session when undertaking the Year 9 2nd dose visits.
- HPV 2 delivery for the Year 9 is below target as school sessions booked for April have been cancelled by schools, these sessions have been rebooked for May
- The service has had to work in partnership with the schools to gain access and to cause minimal disruption to exams for the Year 9 cohort.
- All HPV sessions will be delivered prior to the end of the academic year.

31c. Percentage of children in Reception Year with height and weight recorded [Children and Young People Service]
68.9% of the estimated cohort of reception year children were measured for height and weight to the end April for the 2021/22 academic year National Childhood Measurement Programme (NCMP). This is cumulative performance compared with March target of 70%. Overall national target at the end of the programme is 95%.

The teams have been working hard to increase their coverage of screening since being redeployed part-time through recent months. Vision screens have achieved a similar catch up achieving 67.5% of the expected 70%. They have exceeded their expected target for NCMP for Yr6 at 72.0% compared to a cumulative April target of 70% (indicator 31d in the performance dashboard). The numbers of absences in schools appear to remain higher than pre-covid years, hence as most schools have now been visited the teams have a large number to revisits to screen children who have been absent. Health and Wellbeing Assistants (HWAs) have been supporting school aged immunisations during March, but this work is now complete, hence service expect targets to be reached soon after the Easter holidays.

82. % of eligible children who receive vision screens at or around school entry. [Children and Young People Service]
In April, 67.5% of the estimated cohort of reception year children received a vision screen, compared to the April cumulative target of 70.0%*.

The programme is delivered alongside the NCMP (see narrative within KPI 31c).

**Please note: The April threshold in the bullet chart visualisation above is incorrectly presented as 25%. The correct target is 70%. This is being corrected.*

84. % of live births that receive a face-to-face New Birth Visit within 7- 14 days by a Health Visitor [Children and Young People Service]
In April, 81 out of 473 children are showing as not having received a new birth visit within 14 days of birth. Performance was 80.8% compared to a threshold of 95% and an average of 93.2% between April – December 2021. Performance is within SPC chart upper and lower control limits.

April KPI figures are based on the updated recording methodology following changes discussed in the SystmOne Simplicity pathway meetings. Currently they may not reflect expected activity, as this would depend on the change in methodology, how far services have progressed in the SystmOne Simplicity plan, and when they started to exclusively use the new care activities. BI and the Clinical Systems Team will be supporting service leads as they review and validate the KPI figures.

85. % of children who received a 6–8-week review [Children and Young People Service]
In April, 74 out of 468 children are showing as not having received a 6-8 week review within 8 weeks. Performance was 84.1% compared to a threshold of 95% and an average of 96.6% between April – December 2021. Performance is within SPC chart upper and lower control limits.

April KPI figures are based on the updated recording methodology following changes discussed in the SystmOne Simplicity pathway meetings. Currently they may not reflect expected activity, as this would depend on the change in methodology, how far services have progressed in the SystmOne Simplicity plan, and when they started to exclusively use the new care activities. BI and the Clinical Systems Team will be supporting service leads as they review and validate the KPI figures.

86: Percentage of children who received a 9–12-month review by the time they turned 12 months. [Children and Young People Service]
In April, 159 out of 495 children are showing as not having received a 9-12 month review by the time they turned 12 months. Performance was 67.2% compared to a threshold of 95% and an average of 82.5% between April – December 2021. Performance is below the SPC chart lower control limit.

April KPI figures are based on the updated recording methodology following changes discussed in the SystmOne Simplicity pathway meetings. Currently they may not reflect expected activity, as this would depend on the change in methodology, how far services have progressed in the SystmOne Simplicity plan, and when they started to exclusively use the new care activities. BI and the Clinical Systems Team will be supporting service leads as they review and validate the KPI figures.

87: Percentage of children who received a 12-month review by the time they turned 15 months. [Children and Young People Service]
In April, 80 out of 419 children are showing as not having received a 9-12 month review by the time they turned 15 months. Performance was 80.9% compared to a threshold of 95% and an average of 87.2% between April – December 2021. Performance is within SPC chart upper and lower control limits.

April KPI figures are based on the updated recording methodology following changes discussed in the SystmOne Simplicity pathway meetings. Currently they may not reflect expected activity, as this would depend on the change in methodology, how far services have progressed in the SystmOne Simplicity plan, and when they started to exclusively use the new care activities. BI and the Clinical Systems Team will be supporting service leads as they review and validate the KPI figures.

88: Percentage of children who received a 2-2.5-year review by 2.5 years. [Children and Young People Service]
In April, 122 out of 512 children are showing as not having received a 2-2.5-year review by 2.5 years of age. Performance was 76.1% compared to a threshold of 95% and an average of 81.5% between April – December 2021. Performance is within SPC chart upper and lower control limits.

April KPI figures are based on the updated recording methodology following changes discussed in the SystmOne Simplicity pathway meetings. Currently they may not reflect expected activity, as this would depend on the change in methodology, how far services have progressed in the SystmOne Simplicity plan, and when they started to exclusively use the new care activities. BI and the Clinical Systems Team will be supporting service leads as they review and validate the KPI figures.

91: Percentage of infants being totally or partially breastfed at 6-8wks (breastfeeding prevalence). [Children and Young People Service]
In April, 224 out of 472 children are showing as not being breastfed at their 6-8 week review. Performance was 52.5% compared to a threshold of 58% and an average of 57.1% between April – December 2021. Performance is within SPC chart upper and lower control limits.

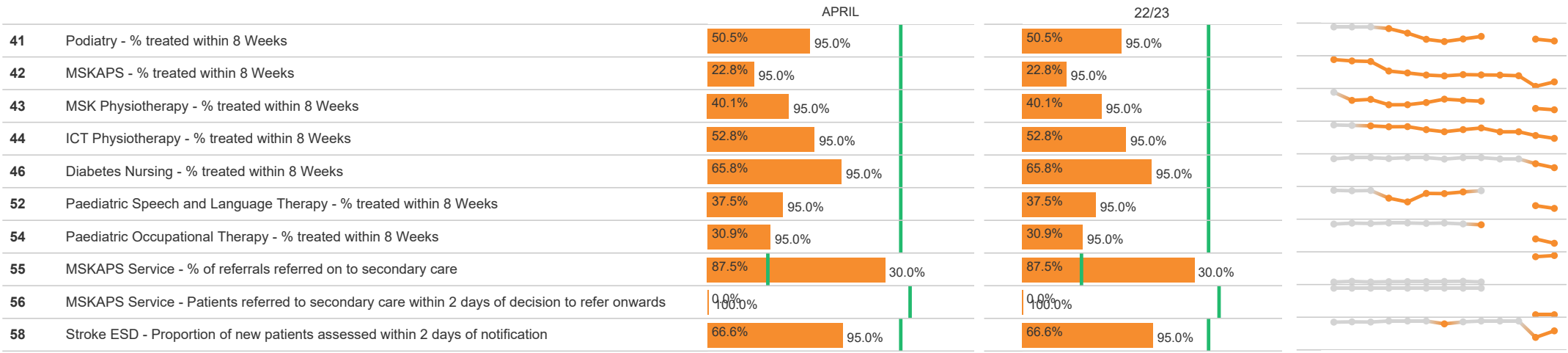
April KPI figures are based on the updated recording methodology following changes discussed in the SystmOne Simplicity pathway meetings. Currently they may not reflect expected activity, as this would depend on any changes in methodology, how far services have progressed in the SystmOne Simplicity plan, and when they started to exclusively use the new care activities. BI and the Clinical Systems Team will be supporting service leads as they review and validate the KPI figures.

Performance Dashboard: *Physical Health - Local Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - Local Requirements



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

41. Podiatry - % treated within 8 Weeks [Adult Community Services]
April compliance was 50.5% (March was 56.6%) compared to a target of 95%. 273 out of 552 patients seen in April were seen outside the 8-week target timeframe of referral to first contact. This is below SPC chart lower control limits.

Business Intelligence continues to work with the service to ensure data is captured correctly in line with agreed SystmOne Simplicity process and validated to ensure accurate reporting. The service is struggling to recover from the impact of the redeployment where waiting lists grew as clinical colleagues were deployed to other services in the early part of the year. The service has also experienced a poor response to recruitment and there are particular issues with appropriately trained colleagues for some areas of service delivery. A recovery plan is in place but this is not expected to impact 8 week RTT for some months. January and February performance figures are unavailable due the prioritisation towards current and future activity reporting. This indicator has a service DIP (Development Improvement Plan) in place.

42. MSKAPS - % treated within 8 Weeks [Adult Community Services]
April performance is currently showing as 22.8% (March was 8.5%) compared to a threshold of 95%. 44 out of 57 patients seen in March were seen outside the 8-week target timeframe of referral to first contact. This is below SPC chart lower control limit.

Business Intelligence continues to work with the service to ensure data is captured correctly in line with agreed SystmOne Simplicity process and validated to ensure accurate reporting. Although an initial recovery trajectory requires some validation, the service estimates performance recovery by November 2022. The service continues to actively review its operating model and job plans to maximise capacity within the service. This indicator has a service DIP (Development Improvement Plan) in place.

43. MSK Physiotherapy - % treated within 8 Weeks [Adult Community Services]
April performance is currently showing as 40.1% (March was 44.6%) compared to a threshold of 95%. 541 out of 904 patients were seen outside the 8-week target timeframe of referral to first contact. This is below SPC chart lower control limit.

There is now an identified lead within the team to develop a recovery plan for this indicator and work is in progress. Recruitment is also looking more promising with a plan to over recruit. It is anticipated that the service will have a recovery trajectory within Quarter 1.

Business Intelligence continues to work with the service to ensure data is captured correctly in line with agreed SystmOne Simplicity process and validated to ensure accurate reporting. These won't be fully resolved until SystmOne Simplicity is further progressed. This indicator has a service DIP (Development Improvement Plan) in place and is on the Performance Governance Tracker. Service Risk ID171/174. Score = both 9

44. ICT Physiotherapy - % treated within 8 Weeks [Adult Community Services]
April performance was 52.8% (March was 62.1%) compared to a threshold of 95%. 98 out of 208 patients seen in April were seen outside the 8-week target of timeframe of referral to first contact. This is below SPC chart lower control limit.

In physiotherapy, 56% of patients have been on the waiting list for less than 8 weeks. As waiting lists grow, a higher proportion of patients are waiting more than 8 weeks. Therefore in order to maintain equity of access the directorate will have to see a greater proportion of people who have waited longer than 8 weeks. The services continue to review waiting list profiles. Although the reported performance position is not reflective of operational reality, the service acknowledges that it is unlikely to achieve compliance with this KPI considering the existing waiting profile. All referrals are prioritised effectively by the referral centre and waiting lists are still managed in a clinically appropriate and clinically safe way.

Business Intelligence continues to work with the service to ensure data is captured correctly in line with agreed SystmOne Simplicity process and validated to ensure accurate reporting. This indicator has a service DIP (Development Improvement Plan) in place and is on the Performance Governance Tracker. Service Risk ID169/170. Score = 12&9

46. Diabetes Nursing - % treated within 8 Weeks [Urgent Care and Specialist Services]
April performance was 65.8% (March was 79.3%) compared to a threshold of 95%. 27 out of 79 patients seen in April were seen outside the 8-week target timeframe of referral to first contact. This is below SPC chart lower control limits.

The number of first contacts recorded in April is significantly higher at 79 compared to the past 11 months. This is because the data now includes telephone contacts which were not previously captured. April performance may not accurately reflect service's true performance as the data is still under development and review. Following a review the Diabetes Educational referrals have been moved to a separate caseload which will be excluded from KPI figures from May onwards.

52. Paediatric Speech & Language Therapy - % treated within 8 weeks
April performance was 37.5% (March was 46.5%) compared to a threshold of 95%. 178 out of 285 patients seen in April were seen outside the 8-week target timeframe of referral to first contact. This is below SPC chart lower control limit.

April data is captured in line with the new SystmOne simplicity process and the data is still under development and review. The reported data is not reflective of operational delivery and data quality checking is underway. The average KPI compliance for this service was 86.6% between Apr-December 2021. Business Intelligence continues to work with the service to ensure data is captured correctly in line with agreed SystmOne Simplicity process and validated to ensure accurate reporting. The service continues to be challenged by demand and capacity issues and there continues to be vacancy in the Head of Service role. This indicator has a service DIP (Development Improvement Plan) and is on the Performance Governance Tracker. Service Risk ID178. Score = 12

54. Paediatric Occupational Therapy - % treated within 8 weeks
April performance was 30.9% (March was 45.5%) compared to a threshold of 95%. 49 out of 71 patients seen in April were seen outside the 8-week target timeframe of referral to first contact. This is below SPC chart lower control limit.

April data is captured in line with the new SystmOne simplicity process and the data is still under development and review. Business Intelligence continues to work with the service to ensure data is captured correctly in line with agreed SystmOne Simplicity process and validated to ensure accurate reporting. The service continues to be challenged by demand and capacity issues and there continues to be vacancy in the Head of Service role. This indicator has a service DIP (Development Improvement Plan) in development and is on the Performance Governance Tracker. Service Risk ID243. Score = 12

55. MSKAPS Service - % of referrals referred on to secondary care
April performance was 87.5% (March was 82.1%) compared to a threshold of 30%. This is above SPC chart upper control limit. The KPI is not representative of expected activity and is under review. The current KPI methodology is picking up additional read codes for 'referred to' secondary care groups than previously. It is anticipated that the issue has increased the numerator figure. When counting the correct read codes, the April figure would be 3.7%, which is comparable to previous performance. The methodology for the KPI and the criteria for which secondary care services to count, are under review with BI and the MSKAPS service lead Sarah Nicholson to validate the position.

56. MSKAPS Service - Patients referred to secondary care within 2 days of decision to refer onwards
April performance was 0% (March was 0%) compared to a threshold of 100%. This is below SPC chart lower control limit. The KPI is not representative of expected activity and is under review. It is anticipated that the issue is that the numerator is inverted so should be 100%. The methodology is under review with the serviec lead Sarah Nicholson to validate the position.

58. Stroke ESD - Proportion of new patients assessed within 2 days of notification
The proportion of patients assessed within 2 days was 66.6% in April (March was 44.4%) against the 95% threshold. The total number of patients assessed was 27 and 9 of which were assessed over 2 days. This is below SPC chart lower control limit.

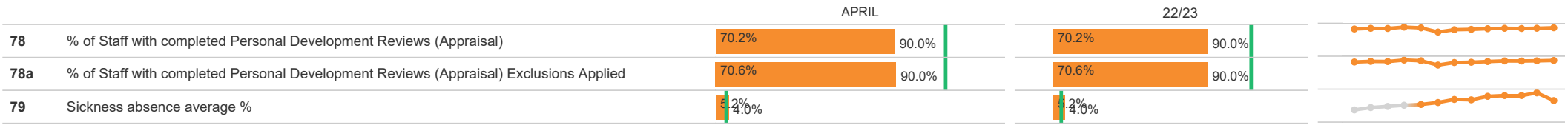
Of the 9 breaches, 2 have been identified as genuine, with a further one under review by the service. For the remaining ones, BI are reviewing the KPI processing, 5 have now been removed and performance currently shows as 85.1%, within SPC control limits. As part of the SystmOne simplicity project the methodology of this KPI has been amended and a new method of recording by the service has now commenced.

Performance Dashboard: *Trust Wide Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Trust Wide Requirements



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

78: % of Staff with completed Personal Development Reviews (Appraisal) - [Workforce]
Performance in April was 70.2% compared to a threshold of 90%. This is within the upper and lower control limits for SPC charts based on data since 2018/19 financial year to date however is shown as context for 78a below. The appraisal performance figure includes Bank Staff.

Excluding Bank staff, Trust compliance figure is 77% (with exclusions applied). Work is ongoing to reach the Trust's 90% target.

78a: % of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only. [Workforce]
Performance in April was 70.6% compared to a threshold of 90%. This is below SPC chart lower control limit. The appraisal performance figure includes Bank Staff but looks at active assignments only.

Excluding Bank staff, Trust compliance figure is 77% (with exclusions applied). Work is ongoing to reach the Trust's 90% target.

Additional Commentary for 78 and 78a
The Trust appraisal compliance figure has remained at 77% this month, the same as last month. This figure is for permanent and fixed term staff, with relevant exclusions applied. The figure including Bank Staff has also remained at 71%. It has been agreed that these two indicators will replace 78 and 78a and this development into the dashboard is currently in progress. A plan of further work and communications is ongoing to try and support the delivery of the Trust's 90% target.

Of the 7 Directorate areas, the HR Department has the highest completion rate this month at 82%, with the Operations Directorate following next with 79%. The Finance Directorate has slipped a little from 79% to 74% whilst the Strategy and Partnerships Directorate has increased its position again this month, rising from 61% to 72%. The Medical Directorate figure has improved it figures after a dip last month and is now at 67%, although the Executive Directorate has reduced again this month from 68% to 63%. The figure for the Nursing and Quality Directorate has increased by 1% this month to 59%, but still remains the lowest of all the Directorate areas.

79: Sickness absence average % rolling rate - 12 months
Sickness absence rate in April 2022 was 5.2% compared to a threshold of 4%. The figure indicates in-month sickness absence, excluding Bank Staff which has been on an increasing trajectory from April 2021 to March 2022. Performance is at the SPC chart upper control limit. April 2022 performance of 5% does not include data from the e-rostering system (Allocate) because it is not available at the time of reporting. However, fill data (incorporating Allocate) from March 2022 compared with February 2022 suggests:

- Operations Directorate sickness absence was 7.6% in March.

- Sickness absence increased in all of the sub-directorates within Operations: Adult Community MH & LD (6.8% to 7.1%), Adult Community Services PH (5.9% to 6.4%), CYPS (5.3% to 6.5%), Hospitals (8.5% to 9.7%), Operational Management (2% to 4.1%) and Urgent Care & Speciality Services (6.4% to 7.5%).

- Nursing, Therapy & Quality Directorate sickness absence was 5.4% in March. Within the Quality Assurance sub directorate, sickness absence was 13.9% in March which was a slight decrease from 14.4% in February, however it should be noted that this is a small sub directorate with a headcount of less than 10. Sub directorates which had previously sat at under 4% sickness absence have increased in March: Governance & Compliance (5.3%), NTQ Management (4.3%) and Nursing (6.1%).

- Finance Directorate sickness absence in March was 5.3%. Estates and Facilities sub-directorate reduced to 6.6% in March from 9.3% in February. Estates & Facilities has the highest sickness absence rate within the Finance directorate during this period.

- Strategy & Partnership Directorate sickness absence in March was 4.2%. Within the Quality Improvement sub directorate, sickness absence had been less than 4% but increased to 6.7% in March.

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AGENDA ITEM: 09/0522

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26th May 2022**

PRESENTED BY: Sandra Betney, Director of Finance

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 30th April 2022**

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

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

The purpose of this report is to

Provide an update of the financial position of the Trust.

Recommendations and decisions required

- The Board is asked to **note** the month 1 position
- **Approve** the increase to the Forest of Dean Community Hospital scheme of £239k
- **Approve** the increase of £73.9k to the Southgate Moorings business case

Executive summary

- Draft accounts submitted 26th April 2022, being audited by KPMG, audited accounts are due 22nd June 2022
- The Trust's position at month 1 is a deficit of £0.3m
- The Trust is forecasting a year end position of a deficit of £4.547m
- The cash balance at month 1 is £55.233m
- Capital expenditure is £0.28m at month 1
- The Trust has spent £0.2m on covid related revenue costs in April
- The final contract value for the Forest of Dean new Community Hospital was £25,739m an increase of £239k to that previously approved by Board in March 2022. Chairs approval was sought for this increase under the Emergency Powers and Urgent Decisions procedure set out within the Trust's Standing Orders. The 23/24 capital programme has been amended to reflect this increase. Trust Board are therefore asked to approve the amended scheme budget.

• Cost pressures in the Southgate Moorings capital schemes due to supply chain issues (both sourcing alternatives and time cost delays) and inflationary pressures have led to an increase in the forecast scheme cost of £73.9k. Trust Board are therefore asked to approve the amended capital plan.
Risks associated with meeting the Trust's values Risks included within the paper

Corporate considerations	
Quality Implications	
Resource Implications	
Equality Implications	

Where has this issue been discussed before?

Appendices:	*Finance Report*

Report authorised by: Sandra Betney	**Title:** Director of Finance

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Finance Report
Month 1

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Overview

- Draft accounts submitted 26th April 2022, being audited by KPMG, audited accounts are due 22nd June 2022
- There were no material amendments to the position from the Resource Committee summary in April, and the year end performance for GHC remained at a surplus of £4.09m
- The current system plan is a deficit of £24.2m
- The Trust's plan is a deficit of £4.547m, after a non recurrent income adjustment of £3.041m
- At month 1 the Trust has a deficit of £0.3m
- The Trust has recorded Covid related expenditure of £0.2m for April
- 22/23 Capital plan is £17.665m and spend to month 1 is £0.28m
- Cash at the end of month 1 is £55.3m
- Cost improvement programme has delivered £3.702m of recurring savings through budget setting. Target for the year is £5.512m.
- Better Payment Policy shows 96.5% of invoices by value paid within 30 days, the national target is 95%
- 81.2% of invoices by value were paid within 7 days
- We are working to introduce 5 year forecasts for the primary finance statements by the June Resources Committee in order to strengthen forecasting and incorporate the impact of IFRS16

GHC Income and Expenditure

Gloucestershire Health and Care
NHS Foundation Trust

Statement of comprehensive income £000	2022/23 Plan	2022/23 YTD Plan	2022/23 YTD Actuals	Variance
Operating income from patient care activities	241,311	20,109	19,802	(307)
Other operating income	6,733	561	498	(63)
Employee expenses	(190,129)	(15,844)	(15,466)	378
Operating expenses excluding employee expenses	(59,767)	(4,981)	(4,931)	50
PDC dividends payable/refundable	(2,590)	(216)	(217)	(1)
Finance expenses	(261)	(22)	0	22
Surplus/(deficit) before impairments & transfers	**(4,703)**	**(392)**	**(313)**	**79**
Remove capital donations/grants I&E impact	156	13	13	0
Surplus/(deficit)	**(4,547)**	**(379)**	**(300)**	**79**
Adjust (gains)/losses on transfers by absorption/impairments	0	0	**0**	0
Revised Surplus/(deficit)	**(4,547)**	**(379)**	**(300)**	**79**

GHC Balance Sheet

Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		2021/22	2022/23		
		Actual	Plan	Actual	Variance
Non-current assets	Intangible assets	958	958	937	(21)
	Property, plant and equipment: other	123,127	121,353	122,915	1,562
	Right of use assets	0	18,108	16,866	(1,242)
	Non-NHS receivables	542	540	540	0
	Total non-current assets	**124,626**	**140,959**	**141,259**	**300**
Current assets	Inventories	494	474	494	20
	NHS receivables	4,311	4,301	3,790	(511)
	Non-NHS receivables	6,561	6,561	6,291	(270)
	Cash and cash equivalents:	58,896	57,201	55,342	(1,859)
	Property held for sale	0	0	0	0
	Total current assets	**70,262**	**68,537**	**65,916**	**(2,621)**
Current liabilities	Trade and other payables: capital	(7,482)	(6,483)	(3,699)	2,784
	Trade and other payables: non-capital	(28,768)	(28,420)	(26,191)	2,229
	Borrowings	(109)	(1,986)	(1,986)	0
	Provisions	(4,246)	(4,096)	(4,227)	(131)
	Other liabilities: deferred income including contract liabilities	(2,409)	(2,124)	(3,392)	(1,268)
	Total current liabilities	**(43,014)**	**(43,109)**	**(39,494)**	**3,615**
Non-current liabilities	Borrowings	(1,254)	(15,512)	(15,609)	(97)
	Provisions	(2,548)	(2,548)	(2,548)	(0)
	Total net assets employed	**148,072**	**148,327**	**149,524**	**1,197**
Taxpayers Equity	Public dividend capital	128,280	128,280	128,278	(2)
	Revaluation reserve	11,188	11,188	11,190	2
	Other reserves	(1,241)	(1,241)	(1,241)	0
	Income and expenditure reserve	9,845	10,100	11,297	1,197
	Total taxpayers' and others' equity	**148,072**	**148,327**	**149,524**	**1,197**

Cash Flow Summary

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	YEAR END 21/22		ORIGINAL PLAN 22/23		ACTUAL YTD 22/23	
Cash and cash equivalents at start of period		**52,333**		**58,896**		**58,896**
Cash flows from operating activities						
Operating surplus/(deficit)	6,326		**(1,851)**		818	
Add back: Depreciation on donated assets	95		0		6	
Adjusted Operating surplus/(deficit) per I&E	**6,421**		**(1,851)**		**824**	
Add back: Depreciation on owned assets	7,101		8,816		506	
Add back: Impairment	80		0		0	
(Increase)/Decrease in inventories	224		300		0	
(Increase)/Decrease in trade & other receivables	553		224		793	
Increase/(Decrease) in provisions	1,845		(2,000)		(19)	
Increase/(Decrease) in trade and other payables	4,988		(2,175)		(2,577)	
Increase/(Decrease) in other liabilities	136		(1,879)		983	
Net cash generated from / (used in) operations		**21,349**		**1,435**		**510**
Cash flows from investing activities						
Interest received	45		0		0	
Purchase of property, plant and equipment	(14,340)		(17,665)		(4,064)	
Sale of Property	0		0		0	
Net cash generated used in investing activities		**(14,295)**		**(17,665)**		**(4,064)**
Cash flows from financing activities						
PDC Dividend Received	1,702		**49**		0	
PDC Dividend (Paid)	(2,070)		**(2,590)**		0	
Finance Lease Rental Payments	(108)		**(1,985)**		0	
Finance Lease Rental Interest	(15)		**(260)**		0	
		(491)		**(4,786)**		**0**
Cash and cash equivalents at end of period		**58,896**		**37,880**		**55,342**

Covid 1

Gloucestershire Health and Care
NHS Foundation Trust

- The Trust has spent £200k up to 30th April 2022
- Out of envelope income has been included at £109k
- Backfill costs were higher than planned but are expected to come back into line by year end

For periods up to and including 30/04/2022 (M1)	Plan 22/23 (£)	Plan ytd 22/23 (£)	Actual ytd Expenditure (£)	Actual ytd Income (£)	YTD Net (£)	Full Year Net Forecast (£)
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	500,793	41,733	**42,782**	**0**	**42,782**	**500,793**
Existing workforce additional shifts	15,000	1,250	**3,195**	**0**	**3,195**	**15,000**
Decontamination	101,119	8,427	**6,240**	**0**	**6,240**	**101,119**
Backfill for higher sickness absence	165,000	13,750	**38,702**	**0**	**38,702**	**165,000**
TOTAL IN ENVELOPE	**781,912**	**65,159**	**90,919**	**0**	**90,919**	**781,912**
COVID-19 virus testing (NHS laboratories)	865,000	72,083	**53,562**	**(53,562)**	**0**	**865,000**
Vaccine Program - Local Vaccination Service	425,000	35,417	**21,755**	**(21,755)**	**0**	**425,000**
Vaccine Program - 12-15s	480,000	40,000	**33,812**	**(33,812)**	**0**	**480,000**
TOTAL OUT OF ENVELOPE	**1,770,000**	**147,500**	**109,130**	**(109,130)**	**0**	**1,770,000**
Total	**2,551,912**	**212,659**	**200,049**	**(109,130)**	**90,919**	**2,551,912**

Capital – Five year Plan

Gloucestershire Health and Care
NHS Foundation Trust

Capital 5 year Plan	Plan	Plan ytd	Actuals to date	Forecast Outturn	Plan	Plan	Plan	Plan	
£000s	2022/23	2022/23	2022/23	2021/22	2023/24	2024/25	2025/26	2026/27	Total
Land and Buildings									
Buildings	1,508	30	257	1,508	2,400	1,000	1,000	1,000	6,908
Backlog Maintenance	1,020	20	22	1,020	1,045	1,250	1,393	1,393	6,101
Urgent Care	0		0	0	0		0	0	0
Buildings - Finance Leases	0				0	1,500	0	0	1,500
Net Zero Carbon	0				500	500	500	500	2,000
	0						0	0	
LD Assessment & Treatment Unit	0				2,000		0	0	2,000
Cirencester Scheme	0					5,000	0	0	5,000
	0						0	0	
Medical Equipment	600	0	(1)	600	500	1,030	1,030	1,030	4,190
IT									
IT Device and software upgrade	0	0	0	0	600	600	600	600	2,400
IT Infrastructure	1,036	0	3	1,036	1,300	1,300	1,300	1,300	6,236
Clinical Systems	0				350	500	250	250	1,350
Unallocated				0					
Sub Total	**4,164**	**50**	**280**	**4,164**	**8,695**	**12,680**	**6,073**	**6,073**	**37,685**
Forest of Dean	13,452	100	0	13,452	8,851	0	0	0	22,303
National Digital Programme									
Cyber Security	49		0	49					
Total of Original Programme	**17,665**	**150**	**280**	**17,665**	**17,546**	**12,680**	**6,073**	**6,073**	**59,988**
Disposals	0				(1,349)	(694)	(2,000)	0	(4,043)
Donation - Cirencester Scheme	**0**				0	(5,000)	0	0	(5,000)
Net CDEL	**17,665**	**150**	**280**	**17,665**	**16,197**	**6,986**	**4,073**	**6,073**	**50,945**
Anticipated CDEL	**17,116**				**11,116**	**11,116**	**11,116**	**11,116**	**61,580**
Brokerage	**500**								**500**
CDEL Shortfall (under commitment)					**5,081**	**(4,130)**	**(7,043)**	**(5,043)**	**(11,135)**

Final contract value for the Forest of Dean Hospital was £25,739m an increase of £239k to that previously approved by Board in March 2022. Chairs approval was sought for this increase under the Emergency Powers and Urgent Decisions procedure set out in the Trusts Standing Orders.

Capital – Southgate Moorings

Gloucestershire Health and Care
NHS Foundation Trust

- Southgate Moorings refurbishment capital scheme - £150k increase in cost forecast to the £1.1m scheme approved by the Board in January 2022
- Increase relates to technical amendments to the scheme £76.2k, and inflationary/supply chain issues £73.9k
- Technical increases of £76.9k were approved by Chief Exec under SFI powers

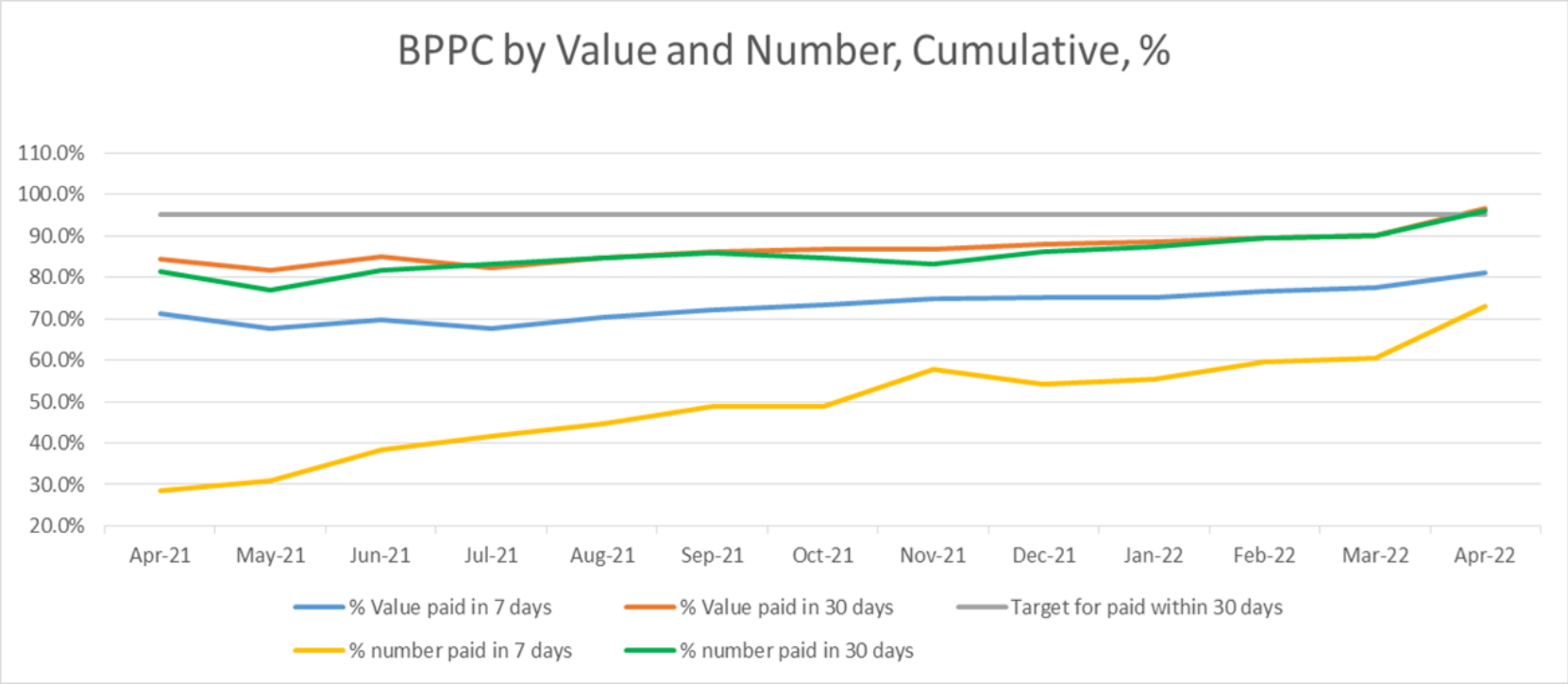
- Cost pressures due to supply chain issues (both sourcing alternatives and time cost delays) and inflationary pressures have led to a £73.9k increase in the forecast. Fees paid on a proportional basis to scheme costs have risen as a result too.
- These have not been able to be absorbed within the scheme budget. These cost pressure take the increase in scheme costs over 10% which in the SFIs requires Board approval, and may well occur in other future capital schemes. The Board is requested to approve the budget increase of £73.9k

Southgate Moorings Capital Scheme Inflationary and supply chain cost pressures	£
Inflationary pressures	40,736
Additional fees (Architect/QS/Proj Mgt)	18,000
Additional prelims (site welfare costs)	15,132
Total increase	**73,868**

Gloucestershire Health and Care
NHS Foundation Trust

Prompt Payment of Suppliers within 30 and 7 days

Better payment practice performance for 2021-22 improved through the year.
The Trust starts 2022-23 in a good position and performance for April against the 30 day metric was 96.5%
The 7 day performance for April was 81% of invoices paid



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Risks

Gloucestershire Health and Care
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Risks to delivery of the 22/23 position are as set out below, along with future risks:

Risks 22/23	22/23 Risks	Made up of: Recurring	Made up of: Non Recurring	Likelihood	Impact	RISK SCORE
Delivering Value savings not delivered	1,812	1,812	0	3	3	9
Non recurring savings not delivered	1,017	0	1,017	1	3	3
Agency costs are not able to be reduced in Hospitals	2,500	2,500	0	3	4	12
Mental Health Act White paper reforms	1,000	1,000	0	3	3	9
Capital cost inflation leads to reduced programme	3,520	3,520	0	3	4	12
Utility, fuel and waste costs may rise further due to inflation	600	600	0	4	2	8
Covid testing income not received	318	318		3	2	6
Risks 23/24	**23/24 Risks**	**Made up of: Recurring**	**Made up of: Non Recurring**	**Likelihood**	**Impact**	**RISK SCORE**
Agency costs are not able to be reduced in Hospitals	2,500	2,500	0	3	4	12
2023/24 Insufficient CDEL to fund capital programme	5,000	5,000	0	3	5	15
Total of all risks	**18,267**	**17,250**	**1,017**			

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AGENDA ITEM: 10/0522

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26th MAY 2022**

PRESENTED BY: Ingrid Barker, Chair

AUTHOR: Ingrid Barker, Chair

SUBJECT: **REPORT FROM THE CHAIR**

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

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

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

Recommendations and decisions required

The Board is asked to:

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

Executive summary

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

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

Risks associated with meeting the Trust's values
None.

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

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

Appendices:	**Appendix 1** Non-Executive Director – Summary of Activity – March and April 2022

Report authorised by:	Title:
Ingrid Barker	Chair

REPORT FROM THE CHAIR

1.0 INTRODUCTION AND PURPOSE

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

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

2.0 BOARD UPDATES

2.1 Non-Executive Director (NED) Update:

- The Non-Executive Directors and I continue to meet regularly, and meetings were held on 22nd March and 19th April. NED meetings have been helpful check in sessions as well as enabling us to consider future plans and reflect on any changes we need to put in place to support the Executive and to continuously improve the way we operate.

  At the meeting on the 19th April NEDs undertook Level 1 Data and Awareness Information Governance training facilitated by Paul Griffith-Williams, Data Protection Officer. The session ensures we are up to date with the statutory and mandatory training requirements and learning outcomes for Data Security Awareness UK Core Skills Training Framework, in line with Trust colleagues.

- The recruitment process for a Non-Executive Director to fill our current vacancy is ongoing. The closing date for receipt of applications is 2nd May. Shortlisting is taking place on 1st June and, as is customary, (virtual) focus groups are in the process of being organised for the 21st June. Final panel interviews are schedule to take place on 22nd June.

- Progress is being made in pursuing the proposal to create a nominated associate NED role from the University of Gloucestershire to secure and enhance our joint working and growing partnership.

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

2.2 Trust Board Meetings:

Board Seminars:

A seminar on Patient Safety Strategy took place on 5th April which focussed on the fundamental requirement of the Patient Safety Strategy, exposure to the Patient Safety Syllabus and promote discussion about the Board's needs to meet the

requirements of the Strategy. Amjad Uppal, Medical Director, Paul Ryder, Patient Safety Manager, Nicola Mills, Serious Incident Investigator and Sally King, Deputy Service Director facilitated the session.

Seminars on the ICS Constitution and Governance Handbook and CQC preparation session ahead of the upcoming CQC Well Lead Review took place on 10th May.

Board Development:
We continue to devote significant time to considering our Board ways of working and how we ensure that transformation remains central to the way we work, whilst the necessary focus is maintained on ensuring high quality care and colleagues' wellbeing. The following sessions have taken place:

14th April 2022 - Health and Safety Board Responsibilities. A helpful development session which was externally facilitated by Sam Alexander, a Chartered Occupational Health and Safety Consultant.

14th April 2022 - (Ways of Working) Well Led Developmental Review. An introduction to The Value Circle Review Team and their approach. Interviews with Board members have since taken place. Discussions will also be held with governors, system partners and others.

30th May – Strategic Context and Planning. This informative whole day Board development session will focus on progress in delivering the Trust's strategy; horizon scanning and analysis of the current environment and will consider the impact of the Trust's strategy to date. The day will also consider the Trust's position in the ICS to scope the implications and priorities for us of operating in an integrated care system.

An optional Board Briefing session on current property **Disposals took place on 20th April**. Board members were invited to an informal session to receive feedback on the decision of the moderation panel, comprising Angela Potter, Director of Strategy and Partnership, Sandra Betney, Director of Finance and Graham Russell, Non-Executive Director, regarding the preferred bidder(s) for the disposals of Hatherley Road and Holly House properties. Given the political and strategic importance of these issues, it gave Board Members a helpful opportunity to ask any questions about the process and the conclusions reached.

A Board Briefing session on the CQC **Well Led Inspection Process took place on the 5th May**. Colleagues from NHSEI facilitated the session. This was part of our preparation for the inspection at the end of May.

The Board Seminar and Development Programme for 2022 ensures that our commitment to continuous improvement and learning from good practice remains central to our work.

3.0 GOVERNOR UPDATES

- I continue to meet on a regular basis with the **Lead Governor Chris Witham,** and we met on 20th April along with Trust Secretary / Head of Corporate Governance Lavinia Rowsell, and Assistant Trust Secretary, Anna Hilditch, to discuss agenda planning for the Council meeting on 18th May 2022.

- The first quarterly **Staff Governor meeting** took place on 5th May. I joined the meeting along with NEDs Jan Marriott, Sumita Hutchison, Marcia Gallagher and Steve Alvis. Dates for further quarterly meeting are in the process of being finalised. We are pleased that these sessions are now regular to help develop this important grouping.

4.0 NATIONAL AND REGIONAL MEETINGS

Since the last meeting of the Trust Board in March, I have attended the following national meeting and visit:

- **NHS Confederation Mental Health Chairs' Network** – meetings take place weekly and I attend when my diary permits. At a recent meeting we were joined by Lord Victor Adebowale, Chair, NHS Confederation, who shared his reflections on the Confederation's influencing work with government regarding mental health policy.

- **Matthew Taylor, Chief Executive of NHS Confed** was welcomed to Gloucestershire on 4th May. Matthew visited a number of services in Gloucestershire including Quayside House where I, along with Helen Goodey, Director of Primary Care & Locality Development were delighted to meet Matthew. Matthew received presentations from some of the Integrated Locality Partnerships, showcasing how multi agency work, data analysis and community engagement can combine to address local priorities in innovative and effective ways.

5.0 WORKING WITH OUR PARTNERS

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

- Along with the Non-Executive Directors, I attended the **ICS NED and Lay Member Network meeting** on 12th April. Updates were received on Health Inequalities and Fit for the Future. An update was also received from the independent Chair of the ICS Board, Dame Gill Morgan. Tracey Cox was welcomed to the meeting. Tracey is the interim ICB Director of People, Culture & Engagement.

- **Meetings of the ICS Board** were held on 21st April and 19th May, where a number of important operational and strategic issues were

discussed. Partnership work is a key aspect of the County's ongoing response to Covid and the recovery work following this, and this group helps ensure effective working is supported and ensures that we are thinking jointly about the "new normal".

- I was recently invited to observe the virtual **Gloucester City Integrated Locality Partnership** meeting. I am passionate about what can be achieved through the integrated locality partnership and found the discussion a lively and informative one.

- The new **Chair of Gloucestershire Hospitals NHSFT**, Deborah Evans, formally took over from Peter Lachecki at the end of April. I and the Trust look forward to working with Deborah and continue to build upon positive working relationships. I have had an initial one to one with her and will meet Deborah on a regular basis to discuss matters of mutual interest.

- I also continue to have regular meetings with the **Independent Chair of the ICS Board, Dame Gill Morgan.**

- A number of Trust colleagues, including board members, have been meeting over recent months with our friends from the **University of Gloucestershire** in joint seminars considering sustainability, digital and multi-agency working. Again, looking at complex matters jointly provides an opportunity for synergies and potential for joint working to be explored. The Board has received a report from Professor Jane Melton on the outputs from these seminars.

6.0 WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

- On 26th April the first **Working Together Advisory Group** took place, Chaired by NED, Jan Marriott. The meeting was very well attended and included representation from Healthwatch Gloucestershire and Inclusion Gloucestershire. The Working Together Plan sets out how we will improve how we listen to, involve and work with people and the communities we serve. We believe that health and care is better when we involve the people who use our services, carers, families and the communities, ensuring people of all ages, diverse-abilities, ethnic backgrounds, faiths, sexuality, and gender are able to influence and shape our services. I look forward to future progress and continued joint working.

7.0 ENGAGING WITH OUR TRUST COLLEAGUES

- I continue to attend the Trust's Committees on a rotational basis and attended the **Great Place to work Committee** on 6th April and **Quality Committee** on 5th May.

- I undertook an informal visit to Rikenel on Wednesday 18th May. Laura Harvey, Head of Facilities Operations guided me on a tour of the building and together we met colleagues from a number of teams including estates, health

visiting, GRIP, homeless health care and working well. It was great to have the opportunity to connect with and thank some of our colleagues.

- I also attended the **Nominations and Remuneration Committee** on 4th May

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

- I continue to participate in the Trust's Reciprocal mentoring Programme and recently met with my 'buddy'. Her insights and perspectives are always challenging and informative.

Whilst drop in chats with services and colleagues continue to be mainly virtual at present, I continue to try to make myself available to support colleagues and recognise their endeavours.

I recently recorded a message to launch the **Working Together** plan and why the plan is so important to the Trust. I took the opportunity to thank everyone who contributed to shaping the first Working Together plan.

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

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

8.0 CQC INSPECTION 2022

You will be aware the Care Quality Commission carried out a full Trust inspection as part of being a newly merged Trust. Week commencing 25th April an inspection of core services took place and on 24th and 25th May, a two-day Board Well Led provider level inspection took place.

A full report following the inspections is not expected imminently, however overall the feedback has been very positive.

I would like to record my thanks to those who were inspected and those that were involved in the preparations ahead of the visits. You have all worked very hard and I am incredibly proud.

9.0 THE VALUE CIRCLE – WELL-LED REVIEW

As you are aware, The Value Circle, an organisation specialising in healthcare governance and leadership, has been commissioned to undertake an independent developmental well-led review in Q1 of 2022/23.

The aim of this review is to assess the leadership and governance of the Trust as described in the well-led framework published by NHS Improvement and to identify developmental actions in response.

Interviews with Board members and key system leaders across Gloucestershire are currently taking place along with observations of Committee meetings. We look forward to receiving the findings from the review which will be circulated in due course.

10.0 Charitable Funds Update

The Charitable Funds Committee have been undertaking a review of the future strategic direction for fundraising activities for the Trust. To support this work, it has appointed Orchard Fundraising who have been taking forward a process of stakeholder engagement and interviews to better understand the opportunities and challenges charitable activities present for a community and mental health provider such as ourselves. We would like to thank all external stakeholders who have given their time and engaged in this process. We anticipate an initial feedback session will take place at the next committee meeting on the 8th June which will then help shape our future direction.

The Trust Board is responsible, as corporate trustee, for the management of funds it holds on trust, and for meeting the latest guidance and best practice of the Charity Commission. The Charitable Funds Committee discharges these duties on behalf of the Trust Board and therefore has approved and submitted the Charitable Funds Annual Report and Accounts for 2021. These documents can be found on the Charity Commission Website.

11.0 NED ACTIVITY

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

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

12.0 CONCLUSION AND RECOMMENDATIONS

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

Appendix 1

Non-Executive Director – Summary of Activity – 1st March – 29th April 2022

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Dr Stephen Alvis	ICS NED/Lay Member Informal Meeting Quarterly 1:1 with Ingrid Barker Team Talk Meeting Rapid Response Service Quality visit Council of Governors NED Chair Appraisal Review NEDs Meeting MHHAM Forum Dental Investigation Update Senior Leadership Network NED/Exec Pairing ICS NED & Lay Member Network Meeting NED Information governance training NEDs Meeting Dental Investigation Meeting with HR Senior Leadership Network Meeting AAC Panel – Consultant in Paediatric Dentistry	Chairs Group Meeting Good Governance Institute Webinar Good Governance Institute Webinar	ATOS Committee Quality Committee Board Briefing FoD Assurance Committee Board Seminar: Risk Trust Board: Public Trust Board: Private Board Seminar: Patient Safety Strategy Board Development Session: Health and Safety Board Responsibilities Board Development Session: Well Led Developmental Review Resources Committee
Steve Brittan	Council of Governors ICS NED/Lay Member Informal Meeting Monthly catch-up meeting with James Powell Audit Marking Meeting System Deficit Meeting NED Chair Appraisal Review NEDs Meeting Resources Committee Agenda Planning ICS NED & Lay Member Network Meeting Information Governance Training NEDs Meeting 2021-22 Appraisal and Objectives Meeting		ATOS Committee Board Briefing FoD Assurance Committee Board Seminar: Risk Trust Board: Public Trust Board: Private Board Seminar: Patient Safety Strategy Board Development Session: Health and Safety Board Responsibilities Board Development Session: Well Led Developmental Review Board Development Session: Disposals Resources Committee
Marcia Gallagher	ICS NED/Lay Member Informal Meeting	Counter Fraud Annual Plan meeting	ATOS Committee

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	Women's Leadership Network NED Chair Appraisal Review NEDs Meeting Chair with 1:1 Executive Paring: Director of HR Lydney Hospital Quality Visit Council of Governors NEDs Meeting Asset Disposals Meeting IT Helpdesk meeting ICB Audit Committee Meeting ICS NED and Lay Member Network NED Chair Appraisal Review Director of finance Meeting	PwC Meeting Complaints Review Introduction meeting with BDO FoD Health Forum	Governors Nom and Rem Committee Quality Committee Board Seminar: Risk Appetite Review Board: Public Board: Private Board Briefing Board Seminar: Patient Safety Strategy Board Development Session: Health and Safety Board Responsibilities Board Development Session: Well Led Developmental Review
Sumita Hutchison	Council of Governors Diversity Network Meeting NED Chair Appraisal Review NED Meeting Sexual Health Services Quality Visit Heart Failure Service Quality Visit Catch up meeting with Nic Matthews Introduction meeting with Anis Ghanis Health and Wellbeing Strategy Meeting MHLSC Pre-Meet	Bishop's Brunch SWW HWB Guardian Network	ATOS Committee Board Briefing Board Seminar: Risk Appetite review Board: Public Board: Private Board Seminar: Patient Safety Strategy Board Development Session: Health and Safety Board Responsibilities Board Development Session: Well Led Developmental Review

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Jan Marriott	Council of Governors NEDs Meeting ICS NED/Lay Member Informal Meeting 1:1 with Manager of Berkeley House ICS Working Together Workshop Quality Assurance Group Meeting Reducing Reoffending Board Meeting 1:1 with Partnership and Inclusion Manager Information Governance Training Lead Governor and John Trevains Meeting Meeting with CEN and Mel Reed as part of Peer Support Worker Quality Visit ICS NED and Lay Member Network ICS Quality Transition Programme Board Annual Appraisal with Chair NED Meeting Colleague leaving GHC 1:1 NED/Exec Briefing Quality Assurance Group Meeting 1:1 meeting with John Trevains Working Together Advisory Group Meeting ICS Clinical Council meeting re peer review feedback ICS Working with People Meeting Launch of Civility Saves Lives	Good Governance Institute “Eradicating Health Inequalities” NHS Confed MH Network Annual Conference PwC Meeting	Quality Committee Board Seminar: Risk Appetite Review Board: Public Board: Private Great Place to Work Committee Board Development Session: Health and Safety Board Responsibilities Board Seminar: Disposals Resources Committee Meeting
Graham Russell	Council of Governors ICS Board Meeting ICS Board Development Informal Meeting with ICB Chair Chair 1:1 Site Disposal Panel ICS Board Pre-Meet Chair Appraisal GPTW Agenda Planning Meeting Senior Leadership Network	PwC Meeting	ATOS Committee Nom and Rem Committee Quality Committee FoD Assurance Committee Board Seminar: Risk Appetite Review Board Seminar: Patient safety Strategy Great Place to Work Committee Board Seminar: Patient Safety Strategy Board Development Session: Health and Safety Board Responsibilities

	NEDs Meeting ICS Board Surplus Site Disposals Meeting 1:1 with Ingrid Barker Surplus Site Disposal Interviews Working Well Quality Visit Information Governance Training		

AGENDA ITEM: 11/0522

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 May 2022**

PRESENTED BY: Chief Executive Officer and Executive Team

AUTHOR: Paul Roberts, Chief Executive Officer

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

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

This report is provided for:

Decision ☐ Endorsement ☐ **Assurance ☒** **Information ☒**

The purpose of this report is to

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

Recommendations and decisions required

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

Executive Summary

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

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

As well as updates on the activity and focus of the CEO, this report provides an update on the Trust's recent CQC inspection, the ongoing impact of Covid 19 and the continuing Vaccination Programme in Gloucestershire, as well an update on the Forest of Dean Community Hospital.

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

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

Where has this issue been discussed before?
N/A

Appendices:	Report attached

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

CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM REPORT

1.0 CHIEF EXECUTIVE CONTEXT AND ENGAGEMENT

1.1 Covid-19 and Mass Vaccination Update

Item	Data last report (w/e 29/04/22)	Data this report (at 03/05/22)
GHFT Covid-19 positive inpatients (as of 9am 03/05/22)	72	70
GHC Covid-19 positive inpatients (as of 9am 03/05/22)	1	4
Patients on Covid Virtual Ward	34	20
Vaccinations (JCVI groups 1 – 15) % vaccination of eligible population	90.2%	90.2%
Vaccinations (JCVI groups 1 – 15) % vaccination (booster dose) in eligible population	86.8%*	86.8%*
Vaccinations – Spring Booster % uptake of 2nd booster dose in eligible population	51.5%	59.8%
Contingency hotel accommodation residents in county	351	

The Spring Booster programme covering (1) Patients aged 75 and over, (2) Care Home Residents and (3) Immunosuppressed patients aged over 12 is progressing well in Gloucestershire with nearly 60% of eligible patients now having received their 2nd booster vaccination – this equates to 46,137 patients as of the 3rd May 2022.

The vaccination of Children between the ages of 5 and 11 who are not clinically vulnerable commenced on the 4th of April. The Gloucestershire delivery network has begun to vaccinate this cohort (of approximately 53,000). Currently (as of the 3rd May) 9.2% of all children in this cohort have received at least one dose at specially configured Children's clinics in around 8 locations across Gloucestershire.

IPC update

New Infection Prevention and Control (IPC) guidance was released by NHS England on Thursday April 14. This was a wide-ranging update with a lot of information for different areas of the health and care system.

Our Trust is currently working with our system partners to review and implement relevant guidance **from Monday 16 May**, which will in part involve a change in

working practices and workplaces, to return to the nationally advised pre-pandemic standards in offices and non-clinical areas.

The vast majority of Covid restrictions for the public have now officially ended. While we continue to be cautious in our clinical practice - including carrying on with wearing PPE and face masks alongside maintaining good infection prevention and control practices - we will now adapt our non-clinical practice to more flexible and blended working practices. The pandemic meant that many colleagues began working differently almost overnight. In the last two years virtual meetings and remote consultations have become standard practice for many clinicians and appropriate patients and some colleagues have been working remotely either part of the time or full time when it works for them, their team and for fulfilling their role.

Flexible, blended working has been shown to have a positive impact on health and wellbeing, it also has a positive environmental impact and can improve productivity in the right circumstances. It also makes the Trust more attractive and accessible to potential employees – which in turn will help with recruitment and retention. We will continue to reflect on these changes to ensure they work for service users as well as colleagues.

The Trust will continue to prioritise staff and patient safety and ensure we balance the need for effective policies and practises that are proactive in preventing the further spread of Covid-19 with the need to ensure that our services are accessible and that we reduce access times.

Tewkesbury Minor Illness and Injury Unit (MIIU)

Tewkesbury MIIU is now open again, between 10am and 8pm daily. Appointments are booked via our triage line – 0300 421 7777 - or via NHS111. As you may recall, the unit closed in December as it was used to deliver the neutralising monoclonal antibody treatment service to people most at risk of becoming seriously ill due to Covid.

1.2 Care Quality Commission (CQC) inspection of GHC core services

The Trust was visited by inspectors from the Care Quality Commission (CQC) during the last week of April and the first week of May, to carry out a comprehensive core services review. The Trust welcomed the inspection, which has provided an opportunity for the Trust to present the work of our teams of which we are justly proud as well as the challenges we face on a day-to-day basis.

This independent assessment will highlight any service areas for improvement, helping the Trust to achieve its core value of “always improving” as well areas of excellent practice. The visit involved approximately 22 inspectors, who visited a large number of our core services and spoke with Trust colleagues, service users and carers. No matters of urgent concern were raised by inspectors during their visit.

We are currently planning for the assessment of the "Well-Led" domain which will take place during the week of 23rd May. This focuses on our leadership and governance arrangements and will feed into our full Trust inspection report and our overall rating. Formal feedback from the inspectors is awaited and will be communicated as soon as possible. The full report is not expected until the end of July or perhaps August.

1.2.1 "Working Together" Plan

The Trust has recently launched the **"Working Together" plan.** The plan sets out how we will improve how we listen to, involve and work with the people and local communities. The Trust already has some well-regarded practice working with "experts by experience" but we now need to make this type of co-production and engagement the norm throughout all our services and the launch of this new five-year plan is an important step towards achieving this. The plan has two aims:

- To inspire each other by working together to make improvements that matter and make a difference to everyone we serve.
- To include everyone by making it easy for all people and communities to have their say, get feedback and be involved in ways that suit them.

If you would like to read our full Working Together Plan you can view it here: Working together Plan.

This plan is very relevant to the recently published **Ockenden Report** (which catalogued the serious problems with maternity services at Shrewsbury and Telford Hospital NHS Trust), whilst we do not provide maternity services, the recommendation that: "....*providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care*" (p175) is nevertheless relevant to all Trusts.

My report below includes some of the activities we have in place to ensure that colleagues can raise concerns and the equality diversity and inclusion work which is ongoing which also helps to ensure that we listen to issues which are important to our community and to patients. The Executive Team, Quality Committee and Board will reflect further on the learning within this detailed report to make sure we are working to avoid any of the issues raised impacting on people who use our Trust.

1.3 Internal engagement and developments

A virtual **Senior Leadership Network** (SLN) meeting was held on 28 April. This provided an excellent opportunity to update participants on Trust and national developments. The April session featured presentations on the updated Covid Infection Prevention Control (IPC) guidance, the recent Staff Survey results and Urgent Care and Specialist Services. A number of staff health and wellbeing and recruitment and retention updates were also provided by Neil Savage, Director of HR and OD.

A further SLN meeting was held on 24 May and update on topics discussed there will be updated on in my next report.

Monthly **Team Talk** sessions continue to be held as digital events and are led by an Executive or a Deputy. They are open for all Trust employees to attend and provide an opportunity for the Executive Team to share the latest Trust news and for staff to share their thoughts, feelings and concerns. These sessions typically cover an update on the latest Covid-19 and workforce news, and other recent items of interest. The Team Talk sessions help to ensure effective communication across the Trust and provide an opportunity for the staff voice to be heard directly by the Executive Team.

Corporate Inductions, held fortnightly, continue to provide an excellent opportunity for the executive team to welcome personally new colleagues to the Trust, introduce our core values, and ensure that everyone feels included from the outset. I was pleased to be able to welcome new starters on 11 April.

On 05 April a **Board Seminar** was held to discuss the **Patient Safety Strategy**. Dr Amjad Uppal, our Trust Medical Director, and the GHC patient safety team are working to implement the new National Patient Safety Strategy and Framework in 2022/23. This approach makes further strides to involve people who use our services to help shape the safety culture in NHS organisations.

This informative session included presentations on:

- Overview of the Patient Safety Syllabus
- Current NHS Serious Incident Framework
- Future of patient safety
- Development of Patient Safety Specialists
- Implications for our Trust Board
- Deciding our Trust's Priorities

I attended the **Board Development Session** on 14 April which reviewed the Board's Health and Safety responsibilities. The session was facilitated by Sam Alexander, a chartered occupational health and safety consultant at AMHS. The focus was on how the Board can influence safety to ensure effective risk management and compliance with legal duties. We discussed techniques for improving conditions and culture and the importance of curiosity for supporting improvement and ensuring ongoing resilient safety systems.

I attended the **Board Seminar session** held on 10 May which reviewed the transition of the Integrated Care System (ICS) to the new Integrated Care Board (ICB). The session was led by Dame Gill Morgan, Independent Chair of the ICB, Helen England, Transformation Improvement Director, and Emily Beardshall, Deputy ICS Programme Director. They presented information on the system development plan, ICS Governance and the countdown to the transition. It was a very informative session and a great opportunity for the GHC Board to gain a greater understanding of the new ICB structure and vision and contribute to the shaping of this critical development.

Weekly **Executive Director Meetings** continue, where collectively the executive team oversee the day-to-day, and longer-term executive management of the Trust. These meeting are broadened on a bi-monthly basis to morph into **Trust Senior Team Meetings**, which bring the senior managers and clinical leaders from across the Trust together to focus on recovery and delivery of the Trust's five year strategic framework. These regular meetings enable wider engagement in, and ownership of, key decisions affecting our organisation including; priority setting, system engagement and strategic planning.

I provided the Chief Executive's update at the **Non-Executive Directors meeting** on 19 April.

I attended the **Council of Governors** meeting on 18 May and provided Governors with an update on Trust activities.

The Trust has benefited from a number of excellent senior appointments over the last two months. I always welcome the opportunity for introductory meetings with colleagues joining our Senior Management team. Recently this has included:

- Mark Dray, Interim Deputy Chief Operating Officer (Physical Health)
- Ashburn Svinurai, Interim Deputy Chief Operating Officer (Mental Health)
- Grace Johnson, Head Mental Health & Learning Disability Nursing & Clinical Quality

It is very encouraging that at a time when it is challenging to recruit within the NHS, we continue to be able to recruit colleagues with relevant experience and skills who are attracted by the culture and opportunities our Trust provides.

1.4 Mental Health Focus

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

The mental health impact of the pandemic has not only had implications for individual citizens but have an impact also had an impact on all public services. We have had a number of helpful and constructive discussions with police colleagues (see below) to explore joint approaches to addressing these pressures. The aim at the establishment of the Trust to provide joined up services, which consider a service user's physical and mental health concerns, continues to be an important strand of this work.

I chaired the monthly **South West (Regional) Mental Health CEO's** meetings on 29 April and 20 May. This group acts as the overarching governance summit

for the regional South West NHS Provider Collaborative and provides an opportunity for CEO colleagues to raise key issues about mental health services across the region and to offer mutual support.

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

In Gloucestershire, I chair the **Community Mental Health Transformation (CMHT) Programme Board**. The CMHT meeting held virtually on 04 April discussed the People's Participation Board, the VCS partnership, updates from NHSE, the Black Lives Matter Mental Health report, personalised care, and the CMHT budget.

On the 4 April I took part in the **2022/2023 Mental Health Investments Standards** review, which involved colleagues from across the system. Sandra Betney, Director of Finance and Deputy Chief Executive, now leads on this work on my behalf.

NHS England hosted the **Gloucestershire Mental Health Plan review** meeting on 5th April, a number of GHC colleagues joined me at the virtual meeting to discuss the Gloucestershire system plan with the region.

The **21/22 Q4 South West Regional & National Mental Health Deep Dive meeting** took place on 12 May with NHS E/I. The meeting was chaired by Rachel Pearce, SW Mental Health SRO, and Claire Murdoch, National Director Mental Health and LDA, and discussed Quarter 4 2021/22 performance and 2022/23 plans for mental health.

On 3 May, John Trevains, Director of Nursing, Quality and Therapies and David Noyes, Chief Operating Officer, attended the **'Mental Health in Gloucestershire: Where are we now'** event hosted by Barnwood Trust at Kingsholm Stadium. The objective for the event was to contribute to having a joined-up county approach, with a shared understanding of different experiences and viewpoints relating to mental health.

On 09 May John Trevains, David Noyes, and I met with colleagues from the **Gloucestershire Constabulary**, Steve Bean, Detective Superintendent, and Sarah Simmons, Police Operational lead for Mental Health. These conversations are invaluable for achieving a collaborative approach to system-wide mental health issues.

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

1.5 **Tackling Inequalities**

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

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

I attended the **Long Term Plan – Mental Health, Learning Disability and Autism CEO Workshop** on 21 April. The COVID-19 pandemic had a significant impact on the delivery of healthcare services and in response to this, DHSC and NHSE/I are updating the Long Term Plan to set out priorities to 2024/25 for Integrated Care Boards. COVID-19 has had a significant impact on mental health, increasing the prevalence and complexity of certain mental health conditions, making this work even more critical than ever.

On 17 May I took part in the **Leading for Inclusion Workshop**, run by the NHSE SW Equality Diversity and Inclusion team. The face to face workshop provided an opportunity to finalise the Workforce Inclusion ambition across the region and gain commitment for its implementation in all South West organisations. As part of the workshop I facilitated a session on ensuring accountability for health and social care systems in improving inclusion.

I attended the **Gloucestershire Levelling Up Conference** on 19 May. The conference provided an opportunity to progress Gloucestershire County Council's new Building Back Better Strategy and take strides towards realising a shared vision to level up our communities and reduce health inequalities. The event was an excellent opportunity to hear the voices of the local communities and discuss positive experiences of good work across the county and also explore how things can be done differently to improve how we work with communities.

I am a member of the **SW Equality Diversity and Inclusion Board** and attend monthly meetings that discuss various initiatives focusing on improving the experience of NHS colleagues.

I continue to take part in the **Reciprocal Mentoring for Inclusion in GHC programme.** These sessions continue to be invaluable to help broaden perspectives and build mutual understanding.

On 29 April I met with **Reg Cobb, Senior Operations Manager for GDA**: a charity providing practical and emotional support to children, young people and adults living in Gloucestershire, Wiltshire, Swindon and South Gloucestershire who are deaf, hard of hearing or deafened. It was a privilege to meet with Reg and hear about all the fantastic work GDA do and to record a short video to help raise awareness of **Deaf Awareness Week, 2 to 8 May 2022**.

I attended the virtual **Gloucestershire Adults Board Safeguarding Roadshow** on 25th April coordinated by Gloucestershire VCS Alliance, which featured informative presentations on a variety of topics including "What is adult safeguarding" and "Digital safeguarding". As lead Chief Executive for tackling Inequalities within the Gloucestershire ICS, I presented a session on **safeguarding, equality and equity**, which explored why health inequalities are so important to us as an ICS and what action is being taken to reduce healthcare inequalities in the context of safeguarding vulnerable people.

I regularly meet with **Dominika Lipska-Rosecka, the Partnership and Inclusion Manager for GHC**, to keep abreast of the wide range of issues facing our diverse communities in Gloucestershire and discussing ways in which the Trust can help support them.

I have regular meetings with **Sonia Pearcey, the Trust's Freedom to Speak Up Guardian**. Effective speaking up arrangements help to protect patients and improve the experience of colleagues. Sonia ran two **Freedom to Speak Up Workshops** during May, to enable colleagues to input into the Trust's strategy for the next few years. This work is essential to help improve safety and to create a culture that places less emphasis on blame and more importance on transparency and learning from mistakes.

I attended the **Walk In My Shoes (WIMS)** community reverse mentoring programme meeting on 6 April March at which we progressed plans for putting this programme on a more sustainable longer term basis supported by a local third sector organisation and on behalf of the local community activists and the local NHS. I have commissioned legal advice on establishing WIMS as a properly incorporated charity. We hope to make announcement about this later in the year.

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

1.6 ICS (Integrated Care System) and System Partners

Our Trust plays an important role in the Gloucestershire system with colleagues working committedly to meet the needs of our community. I have regular meetings with the **CEO of Gloucestershire Hospitals NHS Foundation Trust (GHFT)** – Deborah Lee and the **ICS Lead / Accountable Officer for Gloucestershire Clinical Commissioning Group (GCCG)** - Mary Hutton to keep abreast of any issues facing our partner organisations.

Dame Gill Morgan, Chair, Gloucestershire ICS, and I met virtually on 20 April. We hold regular meetings to discuss matters arising across Gloucestershire. The **ICS Board**, **ICS Executive** and **ICS CEO Meetings** continue to take place monthly focusing on system-wide planning and resilience, and provide updates on organisational matters and projects. The regular meetings, held with senior colleagues across the health system, help ensure joined up working and provide a forum to discuss items affecting multiple partners.

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

On 05, 06 and 26 April I attended **system wide planning meetings** with, Gloucestershire Clinical Commissioning Group and Gloucestershire Hospitals Foundation Trust, CEO and Director of Finance colleagues. At these meetings we discussed demand, growth, productivity and performance across the Gloucestershire system.

The meeting on 6th April was chaired by Martin Wilkinson, NHSE/I Director of Performance and Improvement, and was an opportunity for ICS colleagues to discuss the progress the system is making on operational planning and recovery for 2022/23 with the NHSEI South West leadership team.

I attended the **ICS Improvement Community Development Workshop** on 11 May and delivered the 'Welcome and Overview' for the day. The interactive workshop was facilitated by Helen England and focused on the ambition, scope and future vision for the Improvement Community. One Gloucestershire ICS has set ambitious programmes of transformation to improve the health and wellbeing of the local population, which requires collaboration between teams in health and social care, patients, service users and citizens. This workshop allowed colleagues from across the system to convene and get involved in developing this refreshed strategy. I am the Executive sponsor for the Improvement Community Programme which is a co-operative network led by our system QI leads, building shared best practice and collaborating on innovative system development initiatives.

I chair the **West of England Patient Safety Collaborative Board** meetings. The latest meeting took place on 27 April. This meeting discussed the national patient safety review of 2021/22 and the network plan for 2022/23 and COPD and respiratory.

I attended the **Strategic Stakeholders Forum** on 25 April. This meeting, organised by Gloucestershire Clinical Commissioning Group, provided an update on the ICS Transition Programme and the Integrated Care Partnership (ICP) development.

The system Gold Health System Strategic Command, known as the **Gold Executive Review Group**, takes place twice weekly on Wednesdays and Fridays as part of the wider **Gloucestershire ICS Covid-19 Response Programme.** This forum has proved essential in overseeing the system response to the Covid-19 pandemic and in providing a regular liaison point between senior leaders in the NHS and social care system.

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

The Chair and I are continuing to hold our **annual meetings with MPs** to discuss Trust updates, address any concerns and ensure effective cross communication. On 23 May I met with Siobhan Baillie and Richard Graham with other senior Trust colleagues to discuss Mental Health crisis services, including the local Crisis Resolution and Home Treatment Teams.

I chaired the **Diagnostics Programme Board** on 11 April. This programme board is working on progressing the work of the developed proposals for local Community Diagnostics Hubs (CDH). This project focuses on the development and coordination of networked diagnostic services which are equitable and consistent; aiming to get the right patient to the right test, in the right location, in the fewest number of visits (and referrals) and in the shortest amount of time. The aim is to maximise the limited diagnostic capacity through triage, stratification and prioritisation which is personalised and sustainable across Gloucestershire whilst seeking to invest / innovate and expand existing services so that they meet current and future demands.

Additionally, **Kerry O'Hara, Associate Director (Diagnostics and Eye Health), Transformation & Service Redesign Directorate, Gloucestershire Clinical Commissioning Group** and I meet on a monthly basis to discuss the Diagnostics programme.

I attended the **ICS Place Based Partnership Group** meeting on 8 April. The Place Based Partnership is a planned Workstream of the ICS Transition Programme. Its purpose is to ensure our system can continue to meet current system operating arrangements and requirements alongside the transition between current and future state. The April meeting included a review of the draft Integrated Locality Partnership strategic ambition for 2022 onwards.

I provided the Chief Executive's update at the **Medical Staff Committee** (MSC) meeting on 06 May. Sandra Betney, Director of Finance and Deputy CEO, provided the Chief Executive update on my behalf at the meeting on 1 April. Active engagement with senior medical colleagues in the trust is an important aspect of my work.

1.7 Service Visits

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

On 13 April I was based at **Tewkesbury Hospital** for the whole day so I was able to meet a range of colleagues and service users**.**

I aim to continue regular service visits (following Covid-19 secure guidance). I greatly see the benefit in having these conversations with colleagues to listen, learn, and work together to help make our Trust a great place to work for all.

2.0 FOREST OF DEAN COMMUNITY HOSPITAL UPDATE

I am pleased to confirm that the main construction contract has now been signed for the construction of the new community hospital in the Forest of Dean between the Trust and Speller Metcalfe, our principle construction contractor. The preparation of the ground works (which includes things such as filling in the mine shafts and ground levelling) has already commenced under a separate enabling contract. The project structure will now shift into a more delivery focus and we will keep staff, public and stakeholders regularly updated on progress as the building takes shape.

3.0 CONCLUSION AND RECOMMENDATIONS

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

AGENDA ITEM: 12/0522

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 May 2022**

PRESENTED BY: Angela Potter, Director of Strategy & Partnerships

AUTHOR: Angela Potter, Director of Strategy & Partnerships

SUBJECT: **INTEGRATED CARE SYSTEM UPDATE**

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

This report is provided for:

Decision ☐ Endorsement ☐ Assurance ☐ Information ☑

The purpose of this report is to

This paper provides an update on the activities that are taking place across the Gloucestershire Integrated Care System (ICS).

Recommendations and decisions required

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

Executive Summary

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

- An update on various system partnership meetings including the Health Overview and Scrutiny meeting, the Health and Well-Being Board and the six Integrated Locality Partnerships.
- An update on various engagement activities that the Trust has supported
- Progress on Fit for the Future and the proposed next phase of engagement
- An update on the transition towards the new Integrated Care System

Risks associated with meeting the Trust's values

None

Corporate considerations	
Quality Implications	The Trust will make specific note of any engagement and feedback reports specific to our services and

	include them within future service reviews and developments
Resource Implications	None specific to the Trust
Equality Implications	The Trust is actively engaged in wider inequalities work and will build any findings into the Trust service developments moving forward

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

Appendices:	• ICS Accountable Officer Report (May 2022) • ICS Board Minutes (April 2022) *(Trust Board to note these are in the reading room on Diligent)*

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

INTEGRATED CARE SYSTEM UPDATE REPORT

1.0 INTRODUCTION

This paper provides Board Members with an overview and update on the activities that have been taking place across the Gloucestershire Integrated Care System (ICS).

2.0 Health & Well-Being (HWB) Board – 3rd May

The HWB received an update on the progress being made across Gloucestershire to take forward the concept of Anchor Institutions. As a large organisation that has a significant stake in the local area, GHC has identified being part of this work a key part of our strategy to reduce health inequalities. The HWB heard about the work being taken forward by the task and finish group, the mapping exercise around what activities each anchor institution is undertaking and the development of a self-assessment tool to monitor progress.

A further update on social isolation and loneliness was also provided. This had been identified as one of the seven priorities of the Health & Wellbeing Strategy recognising the county's commitment to loneliness and social isolation being recognised openly as something likely to affect us all and that we need to address. The Board received an update on the local data and baseline activities and supported the recommendation that we do not need a 'loneliness response' but a community one that offers opportunities for the creation and development of meaningful relationships and uses a strengths based approach to focus on connecting people and communities.

3.0 Adult Social Care & Communities Scrutiny – 10th May 2022

The Adult Social Care & Communities Scrutiny met on the 10 May 2022. The Trust attends this meeting in an observation capacity. The following updates were received at the meeting:

3.1 **Community Drug and Alcohol Services Update:** In December 2021 a new ten-year drugs plan was published nationally which committed additional investment to the criminal justice system and through Section 31 grants to local authorities to ensure the ambitions in the plan can be delivered. Gloucestershire will receive approximately £2.3m over the next 3 years to focus on supplemental substance mis-use treatment and recovery. The County Council are responsible for the commissioning of these services through Change, Grow, Live (CGL) and their contract has recently been extended up to 31 March 2024.

The Trust has been working in partnership with CGL to explore joint working opportunities and the opportunity of joint posts moving forward, particularly for those people who have both a mental health problem and substance mis-use issues.

There was also an update on Adult Social Care. It outlines work to progress the implementation of the *People at the Heart of Care: adult social care reform* White Paper that was published in December 2021. This white paper outlines a range of developments that Local Authorities are required to take forward including aspects around personalised care, simplifying the process for pooled budgets within the ICS, strengthening the workforce planning at an ICS level and ensuring a population health platform is in place with care coordination functionality.

The Committee also received an update on the impact of the Social Care Reforms and payment caps which come into force on the 1st October 2023 but with an expectation of councils being ready to operate from April 2023 – this is expected to cover an estimated 3,000 people per year in Gloucestershire and therefore work is being undertaken to understand how the process can be implemented and the resources required to support this.

Finally, the Committee received an update on the care market sustainability and the proposal to close four care homes across the county. The consultation for this proposal has now closed and the first draft outcomes are anticipated early May.

3.2 **Health Overview Scrutiny Committee (HOSC) – 17th May**

The HOSC meeting received an in-depth update on the current recruitment position and challenges across General Practice (GP). GP numbers have been challenged nationally due to a range of factors resulting in some GPs changing their roles from partners to salaried or locum GPs or developing portfolio careers whilst others have chosen to retire. Across the County, Gloucester City is experiencing the most challenges in terms of vacancies although all localities are affected to some degree. A variety of approaches being taken to support ongoing recruitment such as Additional Role Reimbursements (ARRs), Health Inequalities GP fellowships and GP Specialism fellowships.

The meeting also received an overview of the Fit for the Future Phase 2 engagement which is referenced separately in this report (see 5.2) and standing agenda updates on ICS system performance and delivery.

4.0 National Developments

4.1 **My Planned Care Patient Platform:** People who are waiting for care and treatment can now access information on the average waiting times to their first outpatient appointment at speciality and provider level through the www.myplannedcare.nhs.uk website. It also provides information to the public in preparing for their elective treatment.

4.2 **Strategic Approach to Volunteering in the NHS:** NHS England commissioned the Kings Fund in 2020 to explore the current picture of volunteering in NHS Trusts with the report released in May 2022. It identified the significant expansion in capacity and capability of volunteering in recent years and the role they played during the Covid 19 pandemic. However, it also recognises that volunteering may not be open to all and that Trusts may be inadvertently contributing to ongoing inequalities in this area. The report therefore provides areas for Trusts

to consider to help move from volunteering being something that provides an 'added extra' to making it an integral contribution to healthcare delivery. The Trust already has a number of these recommendations in place including a dedicated voluntary services manager and identified executive leadership and we are continuing to develop our strategic volunteering approach.

5. INTEGRATED CARE SYSTEM (ICS) UPDATES

5.1 **ICS Transition:** Trust Board members received an update from the ICS Transition Team to enable greater understanding of the current status of the process and an overview of the Integrated Care Board Constitution. This included the approach to the appointment of partner board members which will take place towards the end of May.

A Voluntary & Community Sector Alliance Agreement is current being developed along with a People and Communities Engagement Strategy. The Trust has been engaged in developing these approaches which have strong alignment with our Working Together strategy.

The ICS Bill has now received Royal Assent and the system transition remain on track to go live from the 1st July.

5.2 **Fit for the Future:** Phase 2 of the Fit for the Future transformation approach will move forward with a public engagement process currently planned between the 17 May and 29 June 2022, and then continuing conversations during the summer. The engagement continues to explore the Centre of Excellence approach at Cheltenham and Gloucester hospitals but also begins to consider wider pathways of care. Further updates and links to the engagement documents will be provided once released.

6.0 PARTNER UPDATES AND DEVELOPMENTS

6.1 **The Armed Forces Community Covenant** was first released a decade ago in February 2012 and over 50 organisations have signed or committed to sign the covenant with Gloucestershire County Council signing the covenant on the 16th March. GHC have previously signed the covenant as a recognition of the need to maintain our commitments to help all those who have served our country.
The Trust is also planning its next Better Together Partnership event with a focus on veterans which is planned to take place on the 18th July 2022. Further details will follow shortly on this.

6.2 **Forest Health Forum:** The Trust regularly attends the Forest Health Forum and this month (3 May) we were asked to provide an update on the activity within our Community Hospitals at the Dilke and Lydney and also the urgent care services across the Forest. The Trust was also able to update members on the progress for the development of the new community hospital in the Forest with the news that the construction contract had now been signed and the scheme was making good progress.

7.0 INTEGRATED LOCALITY PARTNERSHIPS (ILPS) UPDATES

All ILP's continue to meet with good input and support from GHC and wider system partners.

7.1 **Gloucester City**: The Primary Care Network (PCN) continue to progress a number of Quality Improvement initiatives to tackle health inequalities and care quality outcomes. Recent updates have been provided on some of these including: proactive cancer screening; End of Life case management by care coordinators and the implementation of MYCaW – (measure yourself concerns and wellbeing).

The MYCaW tool was tested by the Complex Care @ Home team and South Cotswolds Frailty Service and aims to support *what matters to me* conversations as part of the personalisation agenda. The evaluation has been completed demonstrating very positive results with patients reporting that they felt it supported meaningful conversations that direct personalised care goals.

7.2 **Forest of Dean**: Two new priority project groups have been established as part of the population health management approach: Substance Misuse; and Pre-diabetes. Both groups are at the stage of exploring cohorts, expanding group membership and considering next steps.

The Children and Young People Obesity and Mental Health project is progressing with asset mapping in the Cinderford area initiated and Beezee Bodies have relaunched their weight management groups for children who are obese.

7.3 **Tewkesbury:** The Tewkesbury Town Community based approach work continues to move forward with the aim of understanding and addressing highlighted issues of health and wellbeing associated with mental health, healthy lifestyles, isolation/loneliness and employment.

The PCN Frailty project has established 4 strong and steady exercise groups as part of its QI approach. The plan is to test and learn for 2 months then establish the groups to be self-sustaining.

7.4 **Stroud and Berkley Vale**: The Children's and Young Person population health management project is progressing with Stroud District Council releasing a local version of 'Little Blue book of Sunshine' for secondary school age children to support developing resilience via coping strategies and activities as well as to signpost to community resources and services e.g. young minds matter digital front door. The Berkley Vale PCN Quality Improvement project is focused on developing a support group for young people focusing on healthy eating habits and positive body image which they are linking in with the county wide eating disorder work.

7.5 **Cheltenham:** The Online Service Finder tool for CYP MH (On Your Mind Gloucestershire) was demonstrated to the ILP at its April meeting. This is an on-line tool that was developed with young people that will both help both primary care and young people themselves to navigate and refer themselves to support services. The tool can be found at https://www.onyourmindglos.nhs.uk/

Each PCN is continuing to take forward their individual quality improvement projects and build on the population health management work. Cheltenham

Borough Council also updated on the Strengthening Local Communities Grants and the opportunities that these could give to support the health inequalities agenda.

7.6 **Cotswolds:** The group updated on the continued focus on three priority areas;

(1) Life years lost which is an asset based approach to build relationships with communities within three of the wards in the area.

(2) Social isolation, loneliness and frailty using the community wellbeing service to contact people and understand what's important to them and helping engage in activities that are meaningful to people, and

(3) Healthy lifestyles and prevention focusing on understanding the support needs of people who have declined to participate in the National Diabetes Prevention Programme.

8.0 FOCUS ON PATIENT, CARER AND ENGAGEMENT

8.1 **Healthwatch Gloucestershire** – published a new report in April - *Young people speak up about the improvements they want to see in the health and care services they use.* The report summarises feedback gathered from 85 young people via on-line surveys and face to face meetings focusing on their experiences of health and social care services and the changes they would like to see made, particularly around mental health, relationships and GP care.

Young people found transition into adult services an area they would like to see further development on with clearer lines of communication between services and between health and care services. From a mental health perspective, they felt more services around early intervention could reduce the stress on emergency services and prevent young people needing mental health care in the future. They would also welcome greater involvement in making decisions about developing services aimed at supporting them. From the Trust's perspective, much of this feedback chimes with our own listening events and are areas that we will continue to focus on moving forward.

8.2 **Raising Awareness Activities**

The Trust has actively supported Mental Health Awareness week (9-15 May), Deaf Awareness week (DAW) and Maternal Mental Health Awareness week that both took place on the 2 – 8 May 2022. These are important opportunities for the Trust's teams to reach out to specific client groups or communities and to continue to highlight the service offers.

GHC has been working with the UK Council on Deafness' campaign to raise awareness on Inclusion Deafness as well as working alongside the National Deaf Children's Society to develop an introductory e-Learning package on Care to Learn which offers an introduction into Deaf Awareness, tips for effective communication, information about the National Deaf Children's Society professional training offer and signposting to the National Deaf Children's Society other free e-learning modules. Anyone can access this training package – just search Deaf Awareness on Care to Learn.

With regard to maternal mental health, it is estimated that around 20% of women experience perinatal mental illness but according to the Perinatal Mental Health Partnership UK many feel unable to seek treatment due to perceived stigma. We have also been working with @dadpaduk to support the launch of a resource for new dads in Gloucestershire. This is a free app that covers a range of issues and hands-on advice to help fathers of all ages in Gloucestershire prepare for family life. Find out more here>

8.3 **Communities Representative Group**

On Thursday 5th May, Gloucester Communities Representative Group held their first meeting at the Friendship Café on Barton Street. Gloucester is a very diverse City and this group was set up so each community has the confidence to speak to organisations to help overcome any barriers that their fellow peers encounter. These meetings will hopefully strengthen the relationships between the community and organisations and was supported by both Gloucester Neighbourhood Policing Team and GHC.

9.0 ICS ACCOUNTABLE OFFICERS REPORT

ICS Accountable Officer's report to HOSC and the ICB Board Minutes are available in the Diligent Reading Room.

10. NEXT STEPS

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

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 May 2022**

PRESENTED BY: Lavinia Rowsell, Head of Governance & Trust Secretary

AUTHOR: Lavinia Rowsell, Head of Governance & Trust Secretary

SUBJECT: **BOARD ASSURANCE FRAMEWORK**

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

The purpose of this report is to:
Provide assurance to the Board on the management of the Trust's strategic risks.

Recommendations and decisions required

The Board is asked to:
(i) **Receive and consider** the revised BAF.
(ii) **Note** the overarching risk profile for the Trust **(Page 1 BAF)**.
(iii) **Discuss** the issues highlighted for the consideration of the Board.

Executive summary

Along with the Corporate Risk Register the Board Assurance Framework (BAF) supports the creation of a culture which allows the organisation to anticipate and respond to adverse events, unwelcome trends and significant business and clinical opportunities. It helps to clarify what risks are likely to compromise the trust's strategic and operational objectives and assists the executive team in identifying where to make the most efficient use of their resources in order to improve the quality and safety of care.

The Board Assurance Framework (BAF) for 2022/23 reflects the Trust's Strategic Aims and Objectives and has been updated in light of discussions at the Board Risk Seminar held in March 2022. Overall, the risks remain largely the same with the majority of changes being in the area of workforce related risks. An overarching review of risk in this area has been undertaken. As a result, revised wording for all strategic risks has been endorsed the GPTW Committee at its meeting on 06 April 2022.

The BAF has been reviewed by individual Executive owners and Executive Team collectively and been considered at the recent round of Board Governance Committees.

- *Changes since last review:* Amendments made since last review are highlighted in red.

- *Strategic risks added or removed:*

		Rationale
Added	*Risk 14 - Cyber*	Added due to increased risk environment relating to Cyber
Removed	*Learning and Development*	Removed and added as a key control of the three revised BAF risks. Added to corporate risk register.
	Risk 1 – Impact of Covid	Removed and integrated into the *Demand for Service* Risk.

- *Movements in risk ratings:*

		Score
Risk 9	*Resources Targeted at Acute Care*	Increased 6 to 16
Risk 10	*Funding - National Economic Issues*	Increased 12 to 16

There has been a significant increase in risk scoring for both risks at the end of the last financial year. This is a result of the difference between the year-end position for 2021/2022 and the latest budget settlement for 2022/2023 which confirms that this remains a significant issue. These risks remain under constant review and an update will be provided at the meeting.

- *Issues for the attention of the Board*

Risk 5	*Recruitment and Retention* – given ongoing issues with workforce supply and national workforce planning, it is recommended that the target risk score be increased to 12.	16
Risk 13	*NHS Re-organisation* (target date 1 July) will be prioritised for review. Consideration will be given to replacing this with a risk relating to transformation as a system.	16

Risks associated with meeting the Trust's values
Ensuring a BAF is in place which helps to effectively manage Strategic Risks is a core element of the Trust's Risk Management Policy.

Corporate considerations	
Quality Implications	The Trust must have a robust approach to risk management in order to maintain the highest standards of quality care provided to patients. Identification and mitigation of risk is an important tool in being able to manage events that could have an impact.
Resource Implications	There are no financial implications arising from this paper.
Equality Implications	There are no financial implications arising from this paper.

Where has this issue been discussed before?
Governance Committees, Executive Team and Board/ Seminar, Audit and Assurance Committee.

Appendices:	Board Assurance Framework Q1 Review

Report authorised by: Lavinia Rowsell	**Title:** Head of Corporate Governance and Trust Secretary

BOARD ASSURANCE FRAMEWORK 2022-2023

Strategic Risk Description	Strategic Aim				Strategic Risk No	Risk Type(s)							Lead Committee	Initial Risk Score	Target Risk Score	Risk Score					Lead Exec	Last Exec Review	Last Comm Review	Issue to be raised By Exec / Comm. (Y/N)
	High Quality Care	Better Health	Great Place to Work	Sustainability		Quality/Outcomes	Compliance / Regulatory	Reputational	Innovation	Partnerships / Collaboration	Workforce	Finance Inc. VFM				Target Date Aim By When	Qtr 1	Qtr 2	Qtr 3	Qtr 4				
~~Covid~~	~~✓~~	~~✓~~	~~✓~~		~~1~~	~~✓~~	~~✓~~	~~✓~~			~~✓~~		~~Quality~~	~~12~~	~~9~~	~~On Target~~	~~9~~				~~Dir NTQ COO~~	~~April 2022~~	~~May 2022~~	~~N~~
Quality Standards	✓	✓			2	✓	✓	✓					Quality	12	8	On Target	8				Dir NTQ	April 2022	May 2022	N
Research & Innovation	✓	✓	✓		3			✓	✓			✓	Quality	12	6	April 2024	8				MD	April 2022	May 2022	N
Demand for Services	✓	✓			4	✓	✓	✓				✓	Resources	16	12	April 2024	16				COO	April 2022	May 2022	N
Recruitment & Retention	✓	✓	✓		5	✓					✓		GPTW	12	~~8~~ 12	April 2025	16				DIR HR& OD	April 2022	May 2022	Y
Workforce Wellbeing	✓		✓		6	✓					✓		GPTW	9	6	March 2023	9				DIR HR& OD	April 2022	May 2022	N
Culture (Internal)		✓	✓		7			✓					GPTW	9	4	April 2024	6				DIR HR& OD	April 2022	May 2022	N
Partnership Culture		✓			8	✓		✓		✓			Board	9	6	April 2024	9				Dir S&P	April 2022	May 2022	N
Resources Targeted at Acute Care	✓	✓			9	✓	✓	✓	✓			✓	Board	16	8	April 2025	16				DoF	April 2022	May 2022	N
Funding – Nat. Econ. Issues	✓	✓	✓		10				✓	✓		✓	Board	15	10	March 2024	16				DoF	April 2022	May 2022	N
Sustainability (environment)				✓	11		✓		✓	✓			Resources	12	6	March 2024	9				Dir S&P	April 2022	May 2022	N
NHS Reorganisation	✓	✓	✓		12	✓	✓	✓	✓	✓	✓	✓	Board	9	6	March 2023	9				Dir S&P	April 2022	May 2022	N

Strategic Risk Description	Strategic Aim				Strategic Risk No	Risk Type(s)							Lead Committee	Initial Risk Score	Target Risk Score	Risk Score					Lead Exec	Last Exec Review	Last Comm Review	Issue to be raised By Exec / Comm. (Y/N)
	High Quality Care	Better Health	Great Place to Work	Sustainability		Quality/Outcomes	Compliance / Regulatory	Reputational	Innovation	Partnerships / Collaboration	Workforce	Finance Inc. VFM				Target Date Aim By When	Qtr 1	Qtr 2	Qtr 3	Qtr 4				
(Internal impact)																								
NHS Reorganisation (ICS Development)	✓	✓	✓		13	✓	✓	✓	✓	✓	✓	✓	Board	16	8	July 2022	16				Dir S&P	April 2022	May 2022	N
Cyber	✓	✓	✓	✓	14	✓	✓	✓	✓	✓	✓	✓	Resources	20	8	April 2023	12				DoF	April 2022	May 2022	N

<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">ALL STRATEGIC OBJECTIVES</td><td>Board Lead:</td><td>Dir NTQ / COO</td><td>Date of review:</td><td>April 22</td></tr>
<tr><td>Risk ID:</td><td>01</td><td>Description:</td><td colspan="3" rowspan="6">Impact of Covid

There is a risk that the impact of Covid-19, places the system and the Trust's services in ongoing and unsustainable clinical and operational pressure, negatively influencing patient care in terms of patient safety, wellbeing and mortality outcomes and limited access to services exacerbated by lower staffing levels.

Link to Risk 4 - excess demand in overall impact

[Risk 1 to be removed].</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>May 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="5">Relevant Key Performance Indicators: (taken from the Performance Report/ Quality Dashboard)

• Staff vaccination levels
• Community vaccination levels
• Staff sickness
• Turnover
• Pulse survey data
• Staff wellbeing metrics
• Friends and Family Test
• Safe Staffing Levels
• In-patient covid numbers
• Length of stay</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed</td><td colspan="3">Feb 2020 (Updated Mar. 22)</td></tr>
<tr><td colspan="3"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="3">Inherent Risk Score:</td><td>4</td><td>5</td><td>20</td></tr>
<tr><td colspan="3">Current Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="3">Tolerable Risk:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="3">Target Date to Achieve Tolerable Score</td><td colspan="3">31 March 2023</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">This Risk has been included in the BAF since the start of the pandemic, although the focus has varied. The risk now highlights the ongoing nature of the pressures due to Covid.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">The current risk score reflects that covid rates within the local community and Trust estate have fallen, and the removal of all Covid restrictions and safeguards as the government moves to a policy of living with Covid. Experience gained from previous waves has been beneficial and reflected in business continuity plans. Surge planning and preparedness is underway with clear service prioritisation and redeployment plans is place if required. Impact of the variant on staff sickness being monitored and additional Health and Wellbeing support available. Enhanced IPC and covid secure measures in place. Given reduction in community transmission rates, Covid hospitalisations and number of colleagues isolating due to Covid, it is proposed that this risk be closed and integrated into the Excess Demand Risk 4. Risk 4 which has been revised in readiness for this approach.</td></tr>
</table>

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health</td><td>Board Lead:</td><td>John Trevains, Dir NTQ</td><td>Date of review:</td><td>April 22</td></tr>
<tr><td>Risk ID:</td><td>02</td><td>Description:</td><td colspan="3" rowspan="3">Quality Standards:

There is a risk that failure to:

(i) monitor & meet consistent quality standards for care and support;
(ii) address variability across quality standards;
(iii) embed learning when things go wrong;
(iv) ensure continuous learning and improvement,
(v) ensure the appropriate timings of interventions

will result in poorer outcomes for patients / service user and carers and poorer patient safety and experience.</td><td>Lead Committee</td><td>Quality</td><td>Date of next review:</td><td>May 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed
1st April 2020 (Updated Mar. 22)

Likelihood | Impact | Overall
Inherent Risk Score: 3 | 4 | 12
Current Risk Score: 2 | 4 | 8
Tolerable Risk: 2 | 4 | 8
Target Date to Achieve Tolerable Score Target Score in Place 1st April 2021</td><td colspan="4">• Number of Complaints
• Timeliness of reviews into Concerns
• Patient Safety Incidents
• Friends & Family Test measures
• Safe Staffing Levels
• Embedding learning /Quality Improvement activity reporting
• Waiting times</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">This Risk was on 2019/20 BAF. Recognising its core importance to the work of the Trust it has been confirmed as an area for ongoing monitoring at both the Board Strategic Risk Session in Jan 2021 and March 2022.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">This is a risk that has received ongoing focus during 2019/20 following the merger and has reached target risk score. The potential impact of the Covid pandemic on Quality Standards is regularly considered to ensure quality and standards are maintained. The work of the Quality Committee and their reviews of the Quality Indicators provides ongoing assurance. The development and implementation of the Quality Strategy/Framework over 2021/22, approved by the Board in July 2021, will ensure this risk is effectively managed and continues to be central to our ways of working. Publication of implementation plan for the Quality Framework was delayed due to Covid surge but has now been completed. The KPIs identified to inform the scoring of this risk are within agreed parameters but will be kept under review. Outcomes and patient experiences may be impacted by demand and capacity issues caused by Covid.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1.	Quality Dashboard	Jan & Mar 2022 (part of measuring what matters/Strategy Review)	2022/23	To be considered within development of Quality Strategy/Framework	Implementation and embedding of Quality Strategy. Work in progress on delivering this
2.	Nursing, Therapies and Quality Directorate work aligned to governance framework set within Board memorandum	As above	As above	As above	Implementation and embedding of Quality Strategy. Work in progress on delivering this
3.	Patient Safety Controls – including Freedom to Speak Up mechanisms	As above	As above	Dir NTQ	Quality Dashboard and patient safety, experience and Freedom to speak up reports consistently produced – to maintain.
4.	Patient Experience Controls	As above	As above	As above	As above
5.	Workforce Controls	As above	As above	Dir NTQ	Ongoing monitoring required to ensure urgent issues such as Covid do not restrict workforce capacity and necessary focus on improvement Safe staffing report in quality dashboard, community services staffing data being developed for 2022/23. Recovery reporting in performance report.

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Reports on Quality Standards/Performance	L2	Rec'd each Mtg	Qual/Res Comm or Board	Satisfactory	KPIs within Monthly reports reviewed ongoingly to ensure measures being used are the most appropriate and timely.
2	Reports on Service User Experience	Includes L3	monthly reports	Qual Comm/Board	Limited	Complaints waiting times closely monitored with 6 month max wait for response target in place
3	Internal Audit Report on Freedom to Speak up	L3	Mar 2020	Audit Committee	Satisfactory	Revised policy and reporting process proposed – complete
4	Reports on Freedom to Speak up actions & issues raised	L2	6 monthly Reports	Board	Satisfactory	None highlighted since recommendations within Internal Audit Report implemented.
5	Service Experience Stories to Board	L3	Every other month	Board	Satisfactory	Feedback loop from service user stories built into Quality Committee agenda cycle.

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Freedom to Speak Up revised Policy & Reporting process in place – review to ensure required impact achieved.	To be discussed at Board	FSUG	June 2022 – in progress
2	Measuring What Matters Work to be progressed	Ongoing	HoCG/DoF	Workshop held 2021/22
3	KPI Review to be implemented	High-level milestones agreed to be monitored via resources comm	DoF	In progress
4	Quality Strategy/Framework implementation to be reviewed	Overarching Trust Strategy in place for 2021/22. Quality Strategy in place and impact to be reviewed.	DoNTQ	To review July 2022
5	Quality mechanism processes KPIs to be kept under review to ensure being undertaken within required timelines.	Quality Committee to Monitor	DoNTQ	Refreshed dashboard being developed

<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health
Great Place to Work</td><td>Board Lead:</td><td>Amjad Uppal, Medical Director</td><td>Date of review:</td><td>April 22</td></tr>
<tr><td>Risk ID:</td><td>3</td><td>Description:</td><td colspan="3" rowspan="7">Research & Innovation
There is a risk that Research and Innovation are not supported through sustainable funding and are not embedded in our ways of working, resulting in failure to identify and implement leading edge practice to inform our care</td><td>Lead Committee</td><td>Quality</td><td>Date of next review:</td><td>May 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="2">Relevant Key Performance Indicators:
• Number of studies open
• Number of locally-led studies
• Trust R&D Income
• Number of clinical areas research active
• Trust R&D Budget</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td colspan="3">1/4/20 (Updated Mar. 22)</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>4</td><td>3</td><td>12</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>4</td><td>2</td><td>8</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>2</td><td>3</td><td>6</td></tr>
<tr><td colspan="2">Target Date to Achieve Tolerable Score</td><td colspan="3">1st April 2024</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Risk identified at Board Risk Seminar 14th Jan 2021. This risk brings together elements of risks within the prior year BAF relating to Research and Innovation. It was updated in March 2022 to include need to focus on sustainable funding and using leading edge practice.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)
The Research and Innovation Agenda is an area of increasing focus for the Trust. A Research Champions initiative has been put in place with 6 Research Champions to promote awareness across the Trust, including in areas we have not been traditionally research active. Positive outcome of the evaluation of the first 6 months of the value of the champion scheme but there are challenges to sustain model at same scale. Processes to ensure we can identify individuals to act as Principal Investigators are being developed. Staff availability to take on these roles whilst balancing additional demands in their main role is being kept under review. The research and innovation strategy is in development following the successful Board seminar in August 2021. Innovation Lead identified and in place. Following development of the R&I Strategy, focus will move to consideration of sustainable funding by the Executive going forward, and need to implement cutting edge practice.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1.	Staff Engagement - Research Champions in place, staff briefed on Research at induction.	1/12/21	1/12/22	Head of R&D	Evaluation undertaken. Future sustainable plans for champions model to be confirmed.
2.	Trust membership of Research4Gloucesershire – ICS Group to support collaboration and support.	1/10/21	1/10/22	Head of R&D	-
3.	Clinical Directors for research in place to support embedding research into core Trust activity	1/4/21	-	Med Dir	Research and Innovation Strategy to be completed, with focus on funding & practice
4.	Associate Director of Research links junior doctors & trainees with research activity.	1/4/21	-	Med Dir	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1.	Quarterly Reporting	L1	10/11/21	Research Overview Committee	Satisfactory	Reports to increase focus on changes to practice.
2.	Annual Report on Res & Inn to Qual Comm	L2	Oct 21	Quality Committee	Satisfactory	
3.	Research Champions Feedback	L1	10/11/21	Research Overview Committee	Satisfactory	
4.	Sponsor Reviews – (includes consideration if standards met)	L3	Ongoing	Research Overview Committee	Satisfactory (reported if issues raised)	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1.	Put in place relationships with QI and Audit to improve knowledge of research & evaluation & work together to support local projects	Discussions ongoing to map ways of working and agree processes to support	Head of R&D	In progress – informal mechanisms in place.
2.	Innovation Lead role to be put in place.	Lead identified	Med Dir	Completed
3.	Process to enable research to be built into job plans to ensure staff have dedicated time to work on projects to be developed	To be considered as element Research and Innovation Strategy	Med Dir	in progress – to complete (date TBC)
4.	Research and Innovation Strategy to be developed to pull together Res & Inn. Activities and consider overall impact on care.	Methodology for development to be considered and taken forward	Med Dir	In progress – to complete ~~end 2022~~ (date TBC)
5.	Pilot of Research Champions to be reviewed for impact	Initial 6 months from 1 Oct, extended 6 months with summer review	Exec	Completed.
6.	Implement training sessions on research to raise awareness.		Head of R&D	April 2023
7.	Executive to review funding and sustainability.		Exec	2022/23

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health</td><td>Board Lead:</td><td>Chief Operating Officer/ DoSP</td><td>Date of review:</td><td>April 2022</td></tr>
<tr><td>Risk ID:</td><td>4</td><td>Description:</td><td colspan="3" rowspan="2">Demand for Services

There is a risk of demand for services beyond planned and commissioned capacity, which cannot be managed through usual mechanisms, resulting in services not meeting the expectations of our community leading to poorer outcomes for patients and service users and-potentially reinforced health inequalities. The risk is exacerbated by the challenge of recovery from the pandemic, with potential for more disruption in the event of further spikes/variants.

It is recognised that there is an inter relation of this risk and Risk 4 Recruitment and Retention and Risk 5 staff Wellbeing.</td><td>Lead Committee</td><td>Resources</td><td>Date of next review:</td><td>May 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report)</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed</td><td colspan="3">1st April 2020 (Updated Mar. 22)</td><td colspan="4" rowspan="8">• Waiting times
• Referral and Access Reports
• Length of Stay
• No. Complaints and Compliments (access related)
• Out of Area Placements
• Increased number of individuals with long term conditions – once mechanism available to measure
• Health Inequalities key metrics
• User Satisfaction
• Levels staff sickness
• Quality Data
• Covid outbreak information</td></tr>
<tr><td colspan="3"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="3">Inherent Risk Score:</td><td>5</td><td>4</td><td>20</td></tr>
<tr><td colspan="3">Current Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td colspan="3">Tolerable Risk:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="3">Target Date to Achieve Tolerable Score</td><td colspan="3">1st April 2024</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Risks relating to demand incorporated in previous BAFs – 2021 and 2022.</td></tr>
<tr><td colspan="10">Rationale for current score: (What is the justification for the current risk score)
Demand for our services remains high. The pandemic has led to pent up demand for many services, although most continued to operate during this period, and the impact of long Covid, and the impact on staff wellbeing and retention of working through a pandemic is an area of concern. The relationship of Health and social care (and social care funding) remains to be resolved at a national level. To date relationships with Commissioners remain broadly supportive, but we need to ensure clear understanding of the volumes we are dealing with and how we are supporting Health & Care provision across the County. Progress of the Recovery programme to recover services from earlier waves of the pandemic has been impacted by the ongoing Covid surges with the focus being placed on service reprioritisation and supporting system flow. Project being undertaken to resolve data quality issues relating to physical health and the information held in the clinical system to enable an accurate waiting list position across services. However, greater system intelligence/collaboration is required to understand future demand and how our services may be further impacted by other changes/challenges within the system. Discussions are underway to commission work for accelerated demand and capacity modelling. ICS requirement that GHC share system deficit will impact on resources to meet demand. The situation is acerbated by the Covid backlog and the enduring impact of Covid to deliver our services with ongoing effect on the community and staff groups.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Contract Management Board	Monthly		DoF	
2	ICS Board	Every other month		CEO	
3	Board and Committee Monitoring	Monthly		Board	
4	Business plan – process & monitoring	Annual		CEO/Chair	
5	Relationship GCC and GCCG	Ongoing		CEO/Chair/Board	GCC not formal member ICS

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 – Operational L2 – Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Performance Report	L2	Monthly	Resources/ Board	Satisfactory	
2	ICS Operating Plan	L2	Annual	Board	Limited	ICS Control Total will impact funds available to meet demand
3	Business Plan monitoring	L2	6 monthly	Board	Satisfactory	Delays in provision guidance business plan & budget mean 6-month review planned.
4	Quality Account – including stakeholder feedback	L2/L3	Annual	Board	Satisfactory	
5	HoSC feedback	L3	Every other month	Chair/CEO/	Satisfactory	
6	Service User Feedback	L3	Annual	Board/Qual	Limited	National issue impacts, ensure comms effective
7	Quality Report	L2	Monthly	Qual Comm/Board	Satisfactory	
8.	Quality Dashboard	L2	Monthly	Qual Comm/Board	Satisfactory	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Recovery Clinics being undertaken with service leads to understand demand and capacity and determine service lines that need review with Commissioners	Change of focus due to Covid surge preparedness including service prioritisation and redeployment (as required).	COO	In progress
2.	Continue work to build capacity and understanding of self-care.	To be built into service reviews & developments. Focus on co-production for service developments to continue	COO DS&P	In progress – Anticipate incremental adoption in conjunction with ILPs in 21/22
3	Continue work to improve joined up working across the county to make best use of Gloucestershire pound	Ongoing work across ICS	Exec	**In progress**
4	Continue relationship building with GCC and County MPs	Regular Exec yearly update to GCC to continue. Regular meetings with MPs to continue.	CEO	**In progress**
5	Continue performance report monitoring & deep dives to focus on patient outcomes.	Established within agenda cycles	COO	**In progress**
6	Project to improve data quality on physical health services in SystmOne to resulting in improved reporting	6 months of data quality clerking obtained through the CSU to support project.	DoF	**In progress – Q1 2022/23**
7.	Consider further how health inequalities can be measured and targeted as a system (this links to item 6).		Exec/ICS	
8	Revised IPC Guidance in development.	Work ongoing	DN,T & Q	**In progress**

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">Great place to work
Better Health
High Quality Care</td><td>Board Lead:</td><td>N Savage D of HR & OD</td><td>Date of review:</td><td>April 22</td></tr>
<tr><td>Risk ID:</td><td>5</td><td>Description:</td><td colspan="3" rowspan="2">Recruitment & Retention

There is a risk that we fail to recruit, retain and plan for a sustainable workforce to deliver services in line with our strategic objectives.</td><td>Lead Committee</td><td>GPTW</td><td>Date of next review:</td><td>May 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:</td></tr>
<tr><td>Date Risk Identified/confirmed</td><td colspan="3">1st April 2020 (Updated Mar. 22)</td><td colspan="4" rowspan="6">• Staff Turnover
• Annual Staff Survey and Pulse Surveys
• Staff Friends and Family FFT scores - Recommend Trust as Place to Work
• Vacancy Rates
• Bank and Agency Usage
• Recruitment & Retention Report – exit trends
• Education & Development Report
• Appraisals
• Probationary periods
• Statutory & Mandatory Training Update</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td>Inherent Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td>Current Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td>Tolerable Risk:</td><td>~~2~~ 3</td><td>4</td><td>~~8~~ 12</td></tr>
<tr><td>Target Date to Achieve Tolerable Score</td><td colspan="3">1st April 2025</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Board Risk Seminar 14 Jan 2021 and related risk within 2020/21 BAF. Reworked in 2022 to focus on GHC Strategy rather than wider system and national issues.</td></tr>
<tr><td colspan="10">Rationale for current score: (What is the justification for the current risk score)
A range of revised processes and initiatives have been implemented during 2021/22 and are continuing to be developed through 2022/23. This work is now overseen by the Great Place to Work Committee and the Sustainable Staffing Oversight Group. The risk has been refocused to incorporate Learning and Development metrics and a range of operational risks developed to support progress on this strategic risk. It is recognised that many aspects of supply, terms, conditions and competitive remuneration remain outside the Trust's immediate control. It also recognises that the workforce supply pipeline for degree level registered medical, AHP and nursing roles has between a 3 and 10 year tenure. Due to this recruitment and retention will remain a significant risk, impacted by wider issues which include, funding, impact of the pandemic, shortages of staff nationally, although it is also recognised that significant progress has been made in establishing processes to support recruitment and retention. It should be noted that delays in the current registered staff pipeline will continue to significantly impact our ability to reduce this risk in the short or medium term.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	International Recruitment Programme	17/05/22	16/06/22	Exec	2-year programme – review to see benefits met and option extend/make permanent
2	Relationships number of universities to build supply New Programmes developed Uni of Glos – LD Nursing, Established RGN, RMN & Physiotherapy Degrees and student placement UoG Three Counties Medical School – local medical supply line	Ongoing	1/7/22	Exec	Lead time for RMN and Learning Disabilities degree training to complete. Sept intake on target for full cohort
3	Retention Lead Appointed	22/03/21	1/5/2022	CEO	Plan, impact & review to be taken forward
4	Recruitment Policy in place to fast track recruitment	20/04/22	30/06/22	Exec	
5	ICS Workforce Steering Group	Ongoing	11/05/22	Exec	ICS recruitment and retention plan
6	Wotton Lawn Task and Finish Group	20/04/22	30/06/22	Exec	Evaluation of pilot of retention incentives (April 22)
7	Health Care Support Worker Recruitment and Retention Project	03/03/22	30/06/22	Exec	Retention focus through targeting Health Care Support Worker interventions

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Monthly Recruitment Activity Reports	L1	Monthly	Exec	Work in progress	Recruitment Strategy to be finalised
2	Staff Survey	Ls 1,2 and 3	Mar 2022	Board	Satisfactory	
3	Retention Data	Ls 1 and 2	Ongoing	GPTW	Work in progress	
4	Turnover Data	Ls 1 and 2	Ongoing	GPTW	Satisfactory	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete In Progress Delayed Not Started
1	Draft Recruitment and Retention Framework presented to GPTW Committee April 2022. Minor amendments required before launching in May 2022.	Draft Recruitment and Retention Framework presented to GPTW Committee April 2022. Minor amendments required before launching in May 2022.	D HR&OD	In progress – target launch Q1
2	Recruitment & Retention Premium Business case in development for higher vacancy/hard to recruit areas	Band 5 RMN recruitment campaign for Wotton Lawn with recruitment and relocation premium (golden hello) trialled in 2021, however this was unsuccessful. Retention incentive also offered to Band 5 RMNs in this area. Facilities Recruitment and Retention incentive business case approved (Q4) launching Q1 2022/23	D HR&OD	**Complete**
3	Targeted temporary staff bank recruitment and review of bank incentives	Bank growth plan developed and implemented during 2021-22 resulting in an additional 89 new bank only worker and 269 bank and substantive employee assignments by the end of Q4. Bank hours demand increased from 32k to 39k. Winter bank incentive arrangements implemented until end of May 2022. 2022/23 proposals were developed and approved in May for June launch..	D HR&OD	**Complete**
4	Review and implementation Guaranteed Volume contract.	Sustainable Staffing Oversight Group in place. Contract reviewed and renewed in 2021 and other agency provider contracts under regular review.	D HR&OD	**Complete**

5	Implementation of TRAC system and QI review of recruitment process.	Implementation phase. Project governance in place.	D HR&OD	**Complete – delivered in Q4**
6	Launch of Health Care Support Worker Council and associated listening events, supporting focus on recognition and retention activity.	HCSW Council currently being advertised, alongside a series of listening events. Inaugural council to take place in June 2022.	D HR&OD	Target Q2
7	International Recruitment – additional partnering for RMNs	Target of 38 IR RN recruits for community hospitals, 37 RMNs for MH in patients and 10 RNs for community ICTs. Trust has joined a new regional collaborative to further improve the opportunity of recruiting RMNs with Aryavrat Healthcare in India.	D HR&OD	Target Q3
8	Further Recruitment KPIs	TRAC was launched in April and after the project embedding phase, additional TRAC recruitment KPIs will be developed in Q2 and launched in Q3	D HR&OD	Q2 and Q3

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<table>
<tr><td colspan="3">Strategic Aim:</td><td>Great Place to Work

High Quality Care</td><td>Board Lead:</td><td>Neil Savage, Director of HR&OD</td><td>Date of review:</td><td>April 2022</td></tr>
<tr><td>Risk ID:</td><td>6</td><td>Description:</td><td rowspan="8">Workforce Wellbeing

There is a risk that we are unable to consistently ensure the health and wellbeing of colleagues, particularly during periods of exceptional demand.</td><td>Lead Committee</td><td>GPTW</td><td>Date of next review:</td><td>May 2022</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td>1st April 2020 (Updated Mar. 22)</td><td colspan="4" rowspan="5">• Staff Survey wellbeing metrics – positive action on HWB
• Pulse survey data
• Sickness Absence KPI
• Health & Wellbeing Report</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>2</td><td>3</td><td>6</td></tr>
<tr><td colspan="2">Target Date to Achieve Tolerable Score</td><td colspan="3">1st March 23</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="5">Board Risk Seminar 14 Jan 2021 and also elements from risks within 2020/21 BAF. In 2022 the risk was refocused to reflect work done to embed and improve Health & wellbeing and now considers from ongoing perspective to ensure embedded.</td></tr>
<tr><td colspan="8">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="8">Following a month on month downward trend from May 2020 to March 2021, sickness rates have mostly climbed month on month to March 21 with current sickness absence in line with other Trusts in the South West at 7.1% (target threshold 4%). The outcome of the staff survey showed improved completion rate and better than average on seven of the nine Our NHS People Promise measurements (team working and flexible working below). Health and Wellbeing strategy received by GPTW Comm in February, with consideration of future sustainable funding arrangements. Trust hosting the system-wide Health and Wellbeing Hub which has received NHSI/E funding. Well-being line launched. Role of NED wellbeing guardian in place. Progress on mitigating actions delayed due to Covid and VCOD response/implementation, although VCOD requirement now rescinded. Draft strategic framework and annual plan will provide a basis for establishing workplace health and wellbeing priorities for 2022/2023. The 2021 Staff Survey results are being used for action plans to address areas of concern and which therefore help mitigate the risk.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Health & Wellbeing (HWB) Team in place.	19/04/22	01/04/23	Exec & Board within Business Plan & Budget setting	HWB strategic framework being updated to reflect new national framework & local needs
2	Health & Wellbeing Communication Plan in place – intranet, website	Ongoing	-	Exec/Board	
3	NED Wellbeing Lead, Exec Wellbeing Lead	19/04/22	30/06/22	Board	NED and Exec Wellbeing leads in place
4	Health & Wellbeing built into budget and business plan	22/03/22	31/03/23	Board	Sustainable Trust and SW funding
5	Staff Support processes include HWB conversations – management supervisions, 121 meetings and appraisals	19/04/22	30/06/22		Assurance Audit to confirm if staff survey highlights concerns.
6	Activities: Staff Counselling, MSK self-referral, Health & Hustle, Long Covid support, signposting Let's Talk Therapies	19/4/22	30/06/22		Covid support does not currently have recurrent funding. Services offered to be reviewed within updated strategy.

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Annual Working Well Assurance Report	L2	February 2021	GPTW	Satisfactory	
2	Internal Audit HR to review compliance with processes	L3	2019	Audit Committee	Satisfactory – following completion follow up issues	
3	Working Well Occupational Health Safe Effective Quality Review (SEQOHS) accreditation & annual assurance process	L3	2020	Exec	Satisfactory	
4	Employee Assistance Programme (VIVUP)	L3	Monthly	HR	Satisfactory	
5	Staff Survey & Pulse Surveys	L3	Annual/Quarterly	Exec/GPTW	Satisfactory	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1.	HWB strategic framework to be developed to reflect national strategy and local needs.	Planned for ~~Q1~~ Q4 2021/22	D HR&OD	**In progress** – target complete – May 2022 GPTW
2	Face to face counselling times to be reduced.	Target 1-2 weeks, has reduced from 12 to 8 weeks. Triage and signposting to VIVUP telephone counselling and Let's Talk. Private contractor support. Remote working.	D HR&OD	**In progress** – target complete 31.06.22
3	Review current HWB offer to maximise colleague take up .	Target end Q2 2022/2023	Head of OD	In progress
4	Audit of Quality HWB conversations to be undertaken if staff survey indicators raise as issue.	Not highlighted in 2021 Survey	-	Not currently required
5	Working well income generation programme to fund service provision and development.	To be reported on within revised HWB strategic framework	D HR&OD	**Completed – Q4**

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">Great Place to Work
Better Health</td><td>Board Lead:</td><td>Neil Savage, Director of HR&OD</td><td>Date of review:</td><td>April 22</td></tr>
<tr><td>Risk ID:</td><td>7</td><td>Description:</td><td colspan="3" rowspan="6">Culture (Internal)

There is a risk that we fail to deliver our commitment to having a fully inclusive and engaging culture with kind and compassionate leadership, strong values and behaviours which negatively impacts on retention and recruitment, colleagues experience and engagement and on our ability to address inequalities in service delivery (access, experience and outcomes).</td><td>Lead Committee</td><td>GPTW</td><td>Date of next review:</td><td>May 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed</td><td colspan="4">1st April 2020 (Updated Mar. 22)</td></tr>
<tr><td colspan="3"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="3">Inherent Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="3">Current Risk Score:</td><td>3</td><td>2</td><td>6</td><td colspan="4" rowspan="4">• Staff Survey and Pulse Surveys
• HR Formal Casework report
• Just & Learning Culture e-learning
• Diversity levels at Band 8 and above – area of ongoing work
• Freedom to Speaking up Data
• WRES Data
• WRED Data
• Gender Pay Gap Data
• Service User Equality Access Data – when available</td></tr>
<tr><td colspan="3">Tolerable Risk:</td><td>2</td><td>2</td><td>4</td></tr>
<tr><td colspan="3">Target Date to Achieve Tolerable Score</td><td colspan="3">1st April 2024</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Board Risk Seminar Jan 2021. Revised in April 2022 to incorporate description of targeted internal culture.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)
The organisation Values & Behaviours work was co-developed, agreed and is now embedded within key policies, reward/award process, recruitment, inductions and appraisals to help ensure the culture reflects Trust and Board commitments. The Speaking Up at Work and Freedom to Speak Up Policies plus the developing Diversity Networks which are used to inform and develop practice provide assurance that the values and behaviours are being lived throughout the organisation. The Civility Saves Lives programme is now being implemented. Leadership Development Programme (Thrive) and ICS Flourish Programme (positive action/stepping up programme) in place. Successful summer diversity event held. Equality and Diversity Lead Role appointed and revised Managing Diversity policy approved. Risk supported by operational risks. The 2021 Staff Survey results are being used for action plans to address areas of concern and which therefore help mitigate the risk.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Co-developed Values & Behaviours organisational values	20/04/22	30/06/22	Board	
2	Just culture and appreciative enquiry processes included in performance management & Disciplinary Processes	20/04/22	30/06/22	Executive	
3	Valuing Difference Leadership Strategy in place	20/04/22	30/06/22	Executive	
4	Freedom to Speak Up, Speaking up at work policies	20/04/22	30/06/22	Board	
5	Co-production commitment to service design	Ongoing		Board	Impacted by Covid restrictions

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 – Operational L2 – Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Feedback from appraisals and reward award processes	L1	Ongoing	Exec	Satisfactory	Gap between colleagues reported uptake and internal ESR records.
2	Disability Confident Leader Accreditation	L3	Ongoing	Board	Satisfactory	
3	Annual Workforce Race Equality Scheme & Action Plan	Ls 2 and 3	July 2021	Board	Satisfactory	
4	Annual Disability Equality Scheme & Action Plan	Ls 2 and 3	July 2021	Board	Satisfactory	
5	Patient & Staff Surveys	Ls 1,2 and 3	Mar 2022	Board	Satisfactory	
6	Freedom to Speak Up mechanisms report	Ls 2 and L3	Nov 2021	Board	Satisfactory	
7	Diversity Network (sub groups women, LGBTQ+, Disabled, BAME) with Lead NED in place	L2	Ongoing	Board/Exec	Satisfactory	
8	Gender Pay Gap Reporting	Ls 2 and 3	Mar 2022	Board	Satisfactory	
9	Work in Confidence in place	L2	Ongoing	Exec	Satisfactory	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1.	Senior management diversity – Bands 8 and above to be developed.	Reciprocal Mentoring and Flourish Leadership Development programmes in place and ongoing	D HR&OD	**In progress**
2	Equality &Diversity Training to be updated.	E&D Training being reviewed 2021/22 and new arrangement will be implemented after the current surge and recovery, Q1 2022/23	D HR&OD	**In progress** – target April 2022
3	Equality & Managing Diversity Policy to be updated	Being Reviewed with Trade Unions and approved by Executive Committee and JNCF following engagement with Diversity groups.	D HR&OD	**Complete**
4	Annual EDI action plan formalised, which includes key statutory requirements and stretch milestones.	Currently in development	D HR&OD	**In Progress**
5	Pre Values and Behaviours Review survey	In consideration –scoping work with UoG commenced	D HR & OD	**In Progress**

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">Better Health</td><td>Board Lead:</td><td>Angela Potter, Director of Strategy and Partnerships</td><td>Date of review:</td><td>April 22</td></tr>
<tr><td>Risk ID:</td><td>8</td><td>Description:</td><td colspan="3" rowspan="7">Partnership Culture

There is a risk that the Trust is not seen as an inclusive organisation which works actively with its patients, staff and wider community partners resulting in a lack of engagement with the organisation as a partner which impacts on our ability to deliver transformed co-produced, personalised, transformative and high-quality services and address inequalities in service delivery (access, experience and outcomes).</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>May 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report)</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed</td><td colspan="4">1st April 2020 (Updated Mar. 22)</td></tr>
<tr><td></td><td colspan="2">Likelihood</td><td>Impact</td><td>Overall</td><td colspan="4" rowspan="5">• Number of Engagement Partners
• Number of services redesigned using co production
• Number and breadth of services covered by Experts by Experience?
• Staff Diversity data reflects our community
• Patient Diversity Data reflects our community – this is information to be developed going forwards and is not yet routinely in place
• Working Together Advisory Group feedback</td></tr>
<tr><td colspan="3">Inherent Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="3">Current Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="3">Tolerable Risk:</td><td>2</td><td>3</td><td>6</td></tr>
<tr><td colspan="3">Target Date to Achieve Tolerable Score</td><td colspan="3">1st April 2024</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Discussion Board Risk Seminar 14/1/21 and elements of risks within BAF 2020/21. Updated 2022 to include “Transformed”.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)
The Trust has a strong commitment to partnership working, co-production and personalised care within its ways of working which was a central tenet within its rationale for merger. The ongoing pandemic during 2020/21 has impacted on our ability to engage face to face with service users, although other mechanisms have maintained contact and there has also been less capacity in the Trust to engage in partnership working, although there has been a higher level of partnership working through the Gloucestershire health sector and community partnership work to support delivery of the Covid vaccine across the county’s communities. Better Care Together restarted in December 2021 focussing on mental illness and inequalities with a programme across 2022 being developed. Working Together Plan developed/co-created for approval at January 2022 Board alongside proposals for embedding People Participation in Trust’s governance. New Service Development Manager role with a focus on personalisation agenda being explored. The plan aligns with the new guidance for ICS’s around engagement and involvement and the 10 principles on involvement.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Directorate for Strategy and Partnership with engaged team embedded in the communities we serve	Agreed as part merger	-	Board	Better Care events restarted
2	Joint Director with GCCG to support working with GP Network	Agreed as part merger	-	Board	
3	Expert by Experience Programme	21/22	22/23	D S&P	To ensure coverage of physical and mental health and to look at lessons from Covid
4	Governor Membership & Engagement Strategy	31/3/21	June 22	Council of Governors/Board	Action Plan to be implemented
5	Walk in My Shoes Programme	Ongoing	-	Exec/Board	To be reviewed for impact

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Friends and Family Test Patient Feedback Report	L2	Monthly (in quality report)	Quality Comm/Board	Satisfactory	
2	Compliments & Complaints Report	L2	Monthly (in quality report)	Quality Comm/Board	Satisfactory	
3	Staff Diversity Data	L2	Annual	Resources	Satisfactory	
4	Patient Diversity Data	L2	Ad hoc		Low	Reporting to be enhanced

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high-level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Better Together Events to recommence.	Forward programme for 2022 underway.	D S&P	**Completed -** Dec 2021
2	People Participation Strategic Framework to be developed	Working Together Framework developed for presentation to January Board.	D S&P	**Completed –** Jan 2021
3	Personalisation of Care to be confirmed element of co-production and service review	Personalisation of Care to be built into co-production and service review. Review of complete work programme and activities paused during covid underway. New role being developed to provide dedicated resource and focus.	D S&P	**In progress**
4	Experts by Experience Review	New induction pack being completed. Further EBE recruited and a focus on widening the range of physical and MH inputs has taken place	D S&P	**In progress**
5	Governor Membership & Engagement Action Plan	To be implemented – partners and members to be put in place	H CG&TS	**In Progress**
6	Walk in My Shoes Programme	To be reviewed for impact in July 2022	CEO	Not started
7	Patient Access and Involvement Data to be developed	To be developed and reviewed against health inequalities	D S&P	Not started

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Strategic Aim:			**Better Health** **High Quality Care**		**Board Lead:**	Sandra Betney, Director of Finance	**Date of review:** April 22
Risk ID:	**9**	**Description:**	**Resources Targeted at Acute Care** There is a risk that the ICS prioritises acute care demand over the demands of Mental Health, Community, Primary Care and Learning Disabilities resulting in under resourcing of non-acute care and restricting the ability to provide joined up care and ensure effective patient flow		**Lead Committee**	Board/ Resources	**Date of next review:** May 22
Risk Rating: (Consequence x Likelihood):					**Relevant Key Performance Indicators:** (taken from the Performance Report)		
Date Risk Identified/confirmed	1st April 2020 (Updated Mar. 22)				• To be considered		
	Likelihood	**Impact**	**Overall**				
Inherent Risk Score:	**4**	**4**	**16**				
Current Risk Score:	**4**	**4**	**16**				
Tolerable Risk:	**2**	**4**	**8**				
Target Date to Achieve Tolerable Score	**1st April 2025**						
Potential or actual origin of the risk:			Risk identified at Risk Seminar 4th Jan 2021, also an element of risk within 20/21 BAF. Revised 2022 to show link to patient flow.				

Rationale for current score:
(What is the justification for the current risk score)

Acute services tend to have a higher profile in the media, to be more easily understood by service users and are often have more growth built into funding which can mean that growth in acute services is more easily recognised and reflected in funding allocations than non-acute services. The role non-acute care plays in prevention and supporting service users post-acute care needs to be reflected in funding mechanisms to provide holistic care, which makes best use of the Gloucestershire pound, in the county. Currently the allocations of funding in the ICS remain strongly focused on the acute trust. The joint working in response to the pandemic should help to strengthen understanding of the way acute and non-acute services work most effectively in partnership, but the focus on returning acute services but "normal" needs to be achieved without reducing funding to non-acute services which have also experienced growth in demand, particularly highlighted in relation to mental health within the media, but also the position across services. The H1 and H2 processes were not necessarily skewed to acute services in the same way as growth allocations have been, although the Elective Recovery Fund was nationally acute focussed, there was agreement in system about the benefit of ERF to system as a whole. New Financial Regime contracting is again acute biased, but this may result in more pressure on acute services rather than just more funding, The latest Gloucestershire budget settlement 2022/23 confirms this remains issue of significant concern, which impacts on our services. MHIS and SDF allocations not yet agreed.

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Strong partner within ICS – maintain our voice – Chair and CEO active within ICS Board meetings and planning	Report to each Board	Each Board	Board	
2	Active engagement in ICS groups - maintain our voice	Ongoing	Each Board	Board	
3	Active lead by CEO of a number of ICS groups	Ongoing			Evidence that community care reducing acute demand.
4	ICS Pathway planning	Ongoing	Exec	Board	
5	Active member NHS Providers, Mental Health Bodies and Community Trusts	Ongoing	Each Board	Board	
5	Communications Plan	Annual- within Business Planning	Mar 22	Board	Communication has been impacted by pandemic with greater focus internal comms.
6	Independent Chair of ICS	Annual		ICS	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Annual Funding allocations	L2	Annual budget	Board	Satisfactory	
2	Interim Allocations to respond to pandemic	L2	Ongoing	Board	Satisfactory	
3	Trust media profile	L1	Reports to CEO weekly	CEO	Satisfactory	Need to reinforce reputation and knowledge of services, service quality and contribution to Glos Health System on ongoing basis
4	Benchmark data across acute, MH, Community services and LD services to demonstrate VfM	L3	Annual- gen Nov	Resources	Satisfactory	Agreed to use some Mental Health and Community KPIS in Aligned incentive Contract to highlight our services contribution to system

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Develop Evidence Base which is able to measure the role that community care plays in keeping people healthy and reducing acute demand.	Trust to put in place measures to enable this to be assessed & to work with ICS to support measurement across the system.	Exec	Not Started
2	Build knowledge base to demonstrate quantifiable results of investment in non-acute services	Trust building knowledge base and to build into communication strategy to improve understanding of impact non-acute care.	DoF	**In progress**
3	Review Communicating Business Plan and Objectives to ensure role Comms plays in maintaining reputation and profile of the Trust recognised by all Teams, with early engagement in service developments.	Comms Plan Objectives set for 2021/22 and to be kept under review to ensure internal and external comms needs balanced.	CEO	**In Progress**
4	Finance Strategy to be considered by Resources 21/22 (potential to include VFM measures and reference costs.	Business Intelligence team members of benchmarking groups to contribute to national guidance, data gathering and information held supports comparability of data. Finance plan in development.	DoF	Delayed – under consideration
5	Ensure Trust's voice is heard within the Gloucestershire ICS pilot for proposed national reorganisation of NHS	CEO and Chair active part of the ongoing discussions to ensure understanding roles of different services built into proposed new structures.	CEO	**In progress**

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health
Great Place to Work</td><td>Board Lead:</td><td>Sandra Betney, Director of Finance</td><td>Date of review:</td><td>April 22</td></tr>
<tr><td>Risk ID:</td><td>10</td><td>Description:</td><td colspan="3" rowspan="6">Funding - National Economic Issues

There is a risk that national economic issues impact on the funding settlement available for healthcare, meaning care is not adequately funded to improve and develop to meet needs, and services do not keep pace with demand and best practice, and the organisation ceases to be sustainable.</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>May 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="5">Relevant Key Performance Indicators:

• NHS Funding Settlement</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td colspan="3">1st April 2020 (Reviewed Mar 2022)</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>5</td><td>15</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>2</td><td>5</td><td>10</td></tr>
<tr><td colspan="2">Target Date to Achieve Tolerable Score</td><td colspan="3">March 2024</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Board Risk Seminar 14th Jan 2021 and elements of existing risks within the 2020/21 BAF. Reviewed and agreed maintained risk 2022.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">The pandemic has impacted on the wider economic health of the country, the potential impact of this has been reflected in proposed pay award levels for NHS Staff which has the potential ability to impact on staff recruitment and retention thus impacting on ability to resource levels of care required. The Trust's ability to directly impact on this risk is limited. The Controls, Assurances and Mitigations from risk 9 also help manage this risk. Funding for 2022/23 is below prior year and many costs are increasing which highlights significant risk. System Deficit likely to increase pressure in Gloucestershire</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Active Member NHS Providers	Ongoing	Each Board	Board	
2	Active member ICS	Ongoing	Each Board	Board	
3	Communication Plan and objective.	Annual – Bus Plan	Mar Board	CEO – ongoing	
4	Business & Financial Planning & Budget Setting processes	Annual & 6 monthly review	Sept Board	Board	These reflect internal processes to support sustainability, which are within the parameters of any funding settlement achieved by both the NHS and the local authority.
5	Financial Management processes including QuIP and CQuin	Monthly	April	Resources & Board	As above

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Management Accounts	L2	Monthly	Resources/ Board	Satisfactory	
2	Performance Reports	L2	Monthly	Resources/ Board	Satisfactory	
3	Staff recruitment & Retention data	L2	Monthly	Resources/ Board	Satisfactory	
4	Funding allocations achieved with commissioners	L2	Annual – Jan- Mar	Exec/Board	Satisfactory	
5	Updates on relationships – commissioners, GCC, GCCG, MPs, Councillors.	L2	Every other month	Board	Satisfactory	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Continue to provide information to NHS Providers to demonstrate wider impact of the NHS settlement in keeping individuals able to return to work/self-care.	Ongoing	CEO/DoF	**In progress**
2	Continue to take active role in consideration potential NHS reorganisation to attempt to minimise potential reorganisation costs (financial, time and emotional).	Ongoing	CEO	**In progress**

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">Sustainability</td><td>Board Lead:</td><td>Angela Potter, Director of Strategy and Partnerships</td><td>Date of review:</td><td>April 22</td></tr>
<tr><td>Risk ID:</td><td>11</td><td>Description:</td><td colspan="3" rowspan="7">Sustainability (environment)

There is a risk that the responding to the climate emergency is not prioritised resulting in the failure to transform and embed green practice.</td><td>Lead Committee</td><td>Resources</td><td>Date of next review:</td><td>May 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="2">Relevant Key Performance Indicators:</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed</td><td colspan="3">1st April 2020 (Updated Mar. 22)</td></tr>
<tr><td colspan="3"></td><td>Likelihood</td><td>Impact</td><td>Overall</td><td colspan="4" rowspan="4">• Green Plan in Place – Mar 22
• Targets/KPIs to be included in Green Plan</td></tr>
<tr><td colspan="3">Inherent Risk Score:</td><td>4</td><td>3</td><td>12</td></tr>
<tr><td colspan="3">Current Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="3">Tolerable Risk:</td><td>2</td><td>3</td><td>6</td></tr>
<tr><td colspan="3">Target Date to Achieve Tolerable Score</td><td colspan="3">March 2024</td><td colspan="4"></td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Reflection on Strategic Aims by Executive.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">Sustainability (environment) has been identified as an area of increased focus for the Trust. A Green Plan has been developed to support this work. Green Plan Guidance (A three-year strategy towards net zero) has been issued by NHSE/I with Trust plans required by January 2022 and system-wide plans by end March 2022. Board development session held in December 2021 to feed into Green Plan which was presented to January 2022 Board. The focus of the risk has moved from set up to taking forward of breadth of actions.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		**Last Review Date:**	**Next Review Date:**	**Reviewed by:**	**Gaps in Controls:** (What additional controls should we seek?)
1	Estates Environment Measures monitoring	Ongoing	Mar 23	Head of Sustainability	Need for a complete baseline dataset
2	Management structure to support sustainability in place – Directorate responsibility DSP and Head of Resources in Place	Nov 2020	-	DSP	Keep under review resources required to achieve impact – dedicated lead in place – will team require future expansion or use of champions
3	Relationships in place to support joint working on this issue	Ongoing	-	DSP	Sustainability action group has been established
4	Commitment to sustainability within Trust Business Plan	Mar 22	Mar 23	Board	
5	Commitment to sustainability within Trust Strategy	Mar 22	Mar 23	Board	Green Plan Signed off by the Board

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		**Lines of assurance:** L1 - Operational L2 - Board oversight L3 – Independent	**Last Received**	**Received by**	**Assurance Rating**	**Gaps in Assurance:** (What additional assurances should we seek?)
1	Estates Reporting on environmental measures within annual report	L2 L3	May 21	Board	Satisfactory (audited by External Audit)	Oversight of monitoring has been annual, need to ensure monitoring is more regular at Directorate level.
2	Procurement processes in place which include high level consideration of sustainability	L1	2020	Resources	Satisfactory	Embed sustainability within procurement at all levels.
3	Climate Emergency Reporting at Board level to contextualise this work.	L2	2020	Board	-	Need to ensure annual monitoring of this built into Board reporting to support understanding of context.

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		**Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:**	**Action Owner:**	**Deadline** [revised deadline] Complete / In Progress / Delayed / Not Started
1	Develop baseline green position, and develop and Embed Green Plan.	Head of Sustainability in place. Work ongoing to develop green baseline and then green plan with objectives and measures.	DSP	~~Oct~~ Jan 2022
2	Build partnerships to help us meet our green aspirations.	Work ongoing to identify partners who could help us meet our green aspirations. Development of links with GHT and other system partners including membership of regional green forums.	DSP	**In progress**
3	Embed sustainability considerations into Trust Procurement processes	Work ongoing to further develop sustainability considerations into Trust wide procurement processes – beyond estates procurement	DSP	**In progress**
4	Consider future reporting mechanisms for sustainability to ensure impact is recognised and built upon	Metrics for wider monitoring of sustainability to be considered as part of the green plan development	H of Sustainability	**In progress** – discussions with BI

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health
Great Place to Work</td><td>Board Lead:</td><td>Angela Potter Dir S&P</td><td>Date of review:</td><td>April 2022</td></tr>
<tr><td>Risk ID:</td><td>12</td><td>Description:</td><td colspan="3" rowspan="6">NHS Re-organisation
There is a risk that the ongoing NHS re-organisations results in diversion of time and energy, causing instability to colleagues and changes to priorities meaning the organisation is unable to deliver its long-term plan, strategies and organisational priorities, and that medium term plans may also be delayed.

It is recognised that there is an inter relation of this risk and risks 8 – Partnership Culture, Risk 4 Recruitment and Retention and that if risk 12 increases in likelihood that risks 8 and 4 are also likely to increase.</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>May 2022</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="2">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)
TBC</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td colspan="2">1st April 2020 (Updated Mar 22)</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>3</td><td>2</td><td>6</td></tr>
<tr><td colspan="2">Target Date to Achieve Tolerable Score</td><td colspan="3">March 2023</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">This Risk was recognised as a potential risk when the 2021/22 BAF was developed, as the NHS reorganisation processes have further developed (both ICS and NHSE/I) the risk has been reviewed and following Board discussion was added to the BAF in 2021/22 and confirmed in March 2022</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">As the NHS reorganisation moves forward towards becoming statute and ICSs are developed in readiness to respond to the changes detailed within the current Bill, directors, management and staff within the Gloucestershire health system are required to engage in developing revised ways of working at a time when responding to the Covid-19 pandemic and its wider impact are already stretching capacity and energy. The timeline for the implementation of ICS's has been delayed to July 2022 although work continues at system level in readiness. NHSE and I – structure regional staff</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1.	ICS Transition Group and cascade groups established	July	Jan	Boards	Ensure Board receives timely reporting and mechanisms in place for 2 way communication between Boards and ICS
2	ICS Transition Group Terms of Reference	July	Jan	Board	
3	ICS Executive and Board oversight – GHC Chair & CEO engaged	July	Jan	Board	Ensure Board receives timely reporting and mechanisms in place for 2 way communication between Boards and ICS
4	GHC Board Reporting mechanisms	Every other month	Jan	Board	Confirm Board cycle maps to ICS decision cycle. ICS key outputs map in place.
5	GHC Communication Processes	Monthly	Ongoing	Executive	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Board Strategy Reporting	L2	Every other month	Board	Satisfactory	All Board Strategies to be finalised in line with agreed timeline and agreed metrics in place for effective monitoring
2	Quality, Finance & Workforce Reporting	L2	Monthly	Board/Related Committee	Satisfactory	Exception Reporting in place and any significant changes in performance to be considered to identify if they are being impacted by this risk.
3	Staff Family and Friends Data	L3	Annual (Mar)	Board	Satisfactory	
4	Staff Pulse testing	L3	Qtrly	Board/ Committee	Satisfactory	
5						

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Ensure that performance reporting is considered through this lens to identify if performance is being impacted by this risk and remedial action considered.		DNTQ DHR&OD	
2	Ensure that Strategy achievement progress is considered through this lens to identify if performance is being impacted by this risk and remedial action considered.	Strategic oversight group mapping the organisational programmes of work with the ICS clinical programme groups and ensuring alignment and attendance.	Execs	**In progress** – November 21
3	Develop Relationships further as ICS continues to develop	Exec alignment into each of the ICS Transition workstreams with Director of Strategy & Partnerships taking an overarching co-ordination role. Bi-weekly ICS transition group meetings taking place	Execs	**In progress**
4	Annual strategy review took place to reconfirm overarching direction of travel and impacts of ICS strategy	Board Development session planned for February 2022 and April/May 2022	DS&P	**Complete**

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health
Great Place to Work</td><td>Board Lead:</td><td>Angela Potter Dir S&P</td><td>Date of review:</td><td>April 22</td></tr>
<tr><td>Risk ID:</td><td>13</td><td>Description:</td><td colspan="3" rowspan="6">NHS Re-organisation
There is a risk that the current NHS reorganisation is not taken forward through effective, constructive and committed partnership working meaning that the opportunities for ensuring the new structure best meets the long-term needs of the Gloucestershire community and the responsibilities of the different partners are not understood and recognised in its operating processes and that planned service transformations are impacted.</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>May 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="2">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)
•</td></tr>
<tr><td colspan="2">Date Risk
Identified/confirmed</td><td colspan="2">1st April 2020 (updated Mar.22)</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>2</td><td>4</td><td>8</td></tr>
<tr><td colspan="2">Target Date to Achieve Tolerable Score</td><td colspan="3">1 July 2022</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">This Risk was recognised as a potential risk when the 2021/22 BAF was developed, as the NHS reorganisation processes have further developed the risk has been reviewed and following Board discussion was added to the BAF as a Risk requiring full consideration and mitigation. In March 2022 it was agreed this risk would be retained until May 2022 & then consideration given to replacing with a risk relating to transformation as a system.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">There is a need to ensure that the proposed ways of working and implementing the new structure best meets the long-term needs of the Gloucestershire community and the responsibilities of the different partners are not understood and recognised in its operating processes. At the moment these processes are at an early stage and the need to build in necessary safeguards without creating onerous processes needs to be recognised, developed and implemented. The timeline for the implementation of ICS's has been delayed to July 2022, work continues at system level in readiness.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)			**Last Review Date:**	**Next Review Date:**	**Reviewed by:**	**Gaps in Controls:** (What additional controls should we seek?)
1.	ICS Transition Group and cascade groups established		July	Jan	Boards	Ensure Board receives timely reporting and mechanisms in place for 2 way communication between Boards and ICS
2	ICS Transition Group Terms of Reference		July	Jan	Board	
3	ICS Executive and Board oversight – GHC Chair & CEO engaged		July	Jan	Board	Ensure Board receives timely reporting and mechanisms in place for 2 way communication between Boards and ICS
4	GHC Board Reporting mechanisms		Every other month	Jan	Board	Confirm Board cycle maps to ICS decision cycle. ICS key outputs map in place.
5	GHC Communication Processes		Monthly	Ongoing	Executive	
Sources of Assurance: (How do we know if the things we are doing are having an impact?)		**Lines of assurance:** L1 - Operational L2 - Board oversight L3 – Independent	**Last Received**	**Received by**	**Assurance Rating**	**Gaps in Assurance:** (What additional assurances should we seek?)
1	Board Strategy Reporting	L2	Every other month	Board	Satisfactory	All Board Strategies to be finalised in line with agreed timeline and agreed metrics in place for effective monitoring
2	Regular Board Reporting on ICS Development	L2	Every other month	Board	Satisfactory	Ensure effective 2 way communication in place between Boards and ICS

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		**Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:**	**Action Owner:**	**Deadline** [revised deadline] Complete / In Progress / Delayed / Not Started
1	Identification of key decisions to be made as an ICS and confirmation of how Boards will be engaged agreed.	ICS Transition Plan, Structure and Workstreams identified. Milestones/outputs considered by ICS Exec and mapped to Board/Committee dates. Extended timeline.	CEO/Chair	**In progress**
2	Confirmation of escalation process for ICS decision making.	As above	CEO/Chair	**In progress**
3	Ensure ICS culture and processes reflect its new structure and purpose		CEO/Chair	**In progress**

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health</td><td>Board Lead:</td><td>Sandra Betney Dir Finance</td><td>Date of review:</td><td>April 22</td></tr>
<tr><td>Risk ID:</td><td>14</td><td>Description:</td><td colspan="3" rowspan="6">Cyber
There is a risk that we do not adequately maintain and protect the breadth of our IT infrastructure and software resulting in a failure to protect continuity/ quality of patient care.</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>May 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed</td><td colspan="4">15th March 2022</td></tr>
<tr><td colspan="3"></td><td>Likelihood</td><td>Impact</td><td>Overall</td><td colspan="4" rowspan="4">Cyber Essentials Certification</td></tr>
<tr><td colspan="3">Inherent Risk Score:</td><td>4</td><td>5</td><td>20</td></tr>
<tr><td colspan="3">Current Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="3">Tolerable Risk:</td><td>2</td><td>4</td><td>8</td></tr>
<tr><td colspan="3">Target Date to Achieve Tolerable Score</td><td colspan="3">1 April 2023</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">This Risk was identified at the Board Risk Seminar on 15th March 2022, and informed by the growing risks in the corporate risk register relating to cyber security</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">Cyber resilience is a growing area of concern given the growth in cyber-attacks on organisations, for both financial and political aims, particularly given the increased dependence on technology to deliver patient services, an area which grew exponentially during the pandemic and is expected to further increase as transformation through digital services continues to develop.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1.	Information Governance/ Digital policies and procedures	At review date		Information Governance Group/ Digital Group	
2	Continued staff awareness through communication	Ongoing			
	Anti Virus & Advanced Threat Protection	Ongoing			
	Email Scanning	Ongoing			
	Secure Boundary	Ongoing			
	Cyber Tools			ICS Cyber Group	
	Cyber Security Operations alert actions	Annual			
3.	Cyber Essentials certification	Annual	Annual	Digital Group	
4.	Information Governance Training and Testing	Ongoing			
5.	Information Governance requirements built into system development processes	Ongoing			
6.	Multi-factorial authentication implemented	Complete			

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1.	Internal Audit of DSPT	L3	June 21	Audit and Assurance Committee	Satisfactory	
2	Digital Group Reporting including phishing testing and tracking of cyber operational risks	L1	Quarterly	Resources Committee	Satisfactory	ICS Cyber Reporting to understand system risk as well as organisational risk
3	ICS Cyber reporting	L1	Regular	ICS Digital Execs	Satisfactory	
4	Annual SIRO Report	L2	Annual – last Sept 21	Board	Satisfactory	
5	Information Governance Group Reporting	L1	Quarterly – May 21	Audit and Assurance Committee	Satisfactory	
	Ad hoc cyber reports e.g. log4shell	L2		Audit and Assurance Committee		More systematic reporting to Audit and Assurance Committee

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
2	ICS Cyber Security Roadmap		Director of Finan	**Not started**
3	Implementation of immutable backups		AD IT & Clinical Systems	**In progress**
4	Cyber focus at Trust Induction		AD IT & Clinical Systems	**Not started**

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RISK MATRIX		LIKELIHOOD				
CONSEQUENCE		1	2	3	4	5
		Rare	Unlikely	Possible	Likely	Almost certain
5	Catastrophic	5	10	**15**	**20**	**25**
4	Major	4	8	12	**16**	**20**
3	Moderate	3	6	9	12	**15**
2	Minor	2	4	6	8	10
1	Negligible	1	2	3	4	5

KEY:	1 – 3 LOW RISK	4-6 MODERATE RISK	8-12 SIGNIFICANT RISK	15 and over HIGH RISK

WHO	ROLE	WHEN
Audit and Assurance Committee	To ensure that overall risk management framework is in place and working effectively. For the BAF the Committee ensures that the process of identifying, naming, managing and mitigating the risks works well, and ensures Committee challenge. The Audit & Assurance Committee will consider scoring consistency.	Quarterly (each regular Meeting)
Executive Leads	Executive Leads to update the area of the BAF which they lead on in discussion with the Trust Secretary who will own the document. Updates will be kept at high level, recognising the detailed work ongoing in the Committees which is reflected, but not duplicated in the BAF.	Quarterly – as a minimum – if there is a significant change to a risk score or a new strategic risk proposed this would be brought to the next Executive meeting.
Executive Meeting	Executive to review updates within the BAF to ensure it is considered holistically and that to review and challenge scorings, particularly when a score changes or has not changed beyond the timeframe where target score was anticipated to be achieved. Overall Executive to: (i) confirm the Qtr. Risk Score (ii) to confirm whether the Risk needs to be highlighted to the Committee. (iii) Review any proposed new risks and agree proposed addition	Quarterly
Quality/Resources/ GPTW Committee	Committees to consider the Board Assurance Framework as last item on their meeting agendas to: (i) Challenge Current Risk Scores and mitigations and controls (ii) Confirm whether the Risk needs to be highlighted to the Board or whether there is sufficient assurance on ongoing work to mitigate the risk. (iii) Review any proposed new risks and agree proposed addition (iv) Confirm the risks as set out reflect relevant issues (v) Hold the Executive Lead to account for actions and progress.	Quarterly
Board	Board to consider Board Assurance Framework to confirm (i) continues to cover all risks, or agree any proposed new risks. (ii) Note progress towards mitigating strategic risks (iii) Note current position and highlight if any further action required (iv) Ensure BAF reflects current risks – informed by horizon scanning work.	6 monthly

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AGENDA ITEM: 14/0522

REPORT TO: **TRUST BOARD PUBLIC SESSION - 26 MAY 2022**

PRESENTED BY: Sonia Pearcey, Ambassador for Cultural Change and Freedom to Speak Up Guardian

AUTHOR: Sonia Pearcey, Ambassador for Cultural Change and Freedom to Speak Up Guardian

SUBJECT: **FREEDOM TO SPEAK UP GUARDIAN SIX MONTHLY UPDATE**

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

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

The purpose of this report is to

Provide assurance to the committee:

- That speaking up processes are in place and remain open for colleagues to speak up
- That speaking up processes are in line with national requirements

Recommendations and decisions required

The Board is asked to:

- **Note** that Freedom to Speak Up processes are in place and continuing to be utilised by colleagues.

Executive summary

This report for Q3 & Q4 2021-22, gives an update from the last report, an overview of the cases, national and regional updates and the proactive work undertaken by the Freedom to Speak Up Guardian.

10 further cases were raised in Q3 & 11 in Q4, with a total of 54 cases for 2021-22. To note that in 2020-21 120 cases were raised through the Freedom to Speak Up route, compared to 60 in 2019-20.

In Q3 & Q4 within the Trust Nurses accounted for 38% of speaking up followed by Administration/Facilities colleagues and Health Care Assistants at 14% with anonymous reporting through the Work in Confidence portal at 19% for 2021-22.

In 2020-21 Nurses as a professional group accounted for the biggest portion, 32%, of speaking up cases raised through the Freedom to Speak Up route and with comparable data in 2021-22 of 28%.

In 2021-22 16% of colleagues spoke up declared a protected characteristic of disability, Race and age.

A positive speaking up culture is reflected nationally in the People Plan and People Promise, and locally in our strategic commitments to High Quality Care and being a Great Place to Work. It is a core component in our health and wellbeing offer to colleagues, in in our "Strong Voice" commitment to colleagues and the positive and further encouraging National NHS Staff Survey 2021 results.

The development of a Freedom to Speak Up Strategy has been launched within the organisation to "Develop a just culture which promotes safety through supporting people to speak up".

Appendix 1 includes data from Paul's Open Door for 2021-22. The aim is to ensure a wide range of voices are heard and themes can be shared regarding speaking up throughout the organisation.

Risks associated with meeting the Trust's values

All risks are clearly identified within the paper.

Corporate considerations	
Quality Implications	A positive speaking up culture within our workforce will ensure that patient safety matters are heard and that colleagues are supported.
Resource Implications	Specifics that are not being achieved are highlighted in the report
Equality Implications	No issues identified within this report

Where has this issue been discussed before?

- Great Place to Work Committee - 6 April 2022
- Quality Assurance Group - 22 April 2022
- Joint Negatiating and Consultative Forum - 25 May 2022

Appendices:	Paul's Open Door Data 2021-22.

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

FREEDOM TO SPEAK UP GUARDIAN UPDATE

1.0 INTRODUCTION

1.1 This bi-annual report is to give assurance to that speaking up processes are in place and remain open for colleagues to speak up, especially in these unprecedented times of Covid-19.

1.2 This paper is presented in a structured format to ensure compliance with the "Guidance for Boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts" updated published guidance July 2019 here.

1.3 Celebrate our progress in continuing to raise the bar in embedding our positive speaking up culture.

2.0 ASSESSMENT OF FTSU CASES

2.1 Speaking up for Q3 & Q4 are detailed in Table 1, which also gives an overall picture of this year compared to 2020-2021. Speaking up for these periods have been received via different routes and all anonymous cases were via the Work in Confidence system. Some colleagues may also have raised more than one concern.

Table 1

Quarter 2020-21	**Number of cases raised**	**Number of cases raised anonymously**
Q1: April - June	42	15
Q2: July - September	23	6
Q3: October - December	25	4
Q4: January - March	30	4
Quarter 2021-22		
Q1: April - June	18	5
Q2: July – September	15	3
Q3: October - December	10	3
Q4: January - March	11	1

2.2 Themes

Updated guidance on mandated data submission comes into the effect on 1 April 2022 Recording Cases and Reporting Data The following changes to the 2022-23 were made in response to feedback from Freedom to Speak Up Guardians, is more accessible and considers the needs of the broader range of organisations that are now supported by Freedom to Speak Up Guardians.

A new category has been introduced to record any case that includes an element of other inappropriate attitudes or behaviours that does not constitute bullying or harassment.

Other changes to the guidance include the following:

In line with the guidance on Developing Freedom to Speak Up Champion and Ambassador Networks (April 2021), this item has been updated to remove reference to Freedom to Speak Up Champions, Ambassadors etc. The item now reads – The number of cases raised to Freedom to Speak Up Guardians in the organisation you support in total during the reporting period.

- Definitions of bullying and harassment now include from the Advisory, Conciliation and Arbitration Service.

- The professional/worker group categories have been updated.

Other themes collected locally are systems/processes, other and ideas for learning and improvement. Some colleague may raise a concern that links to more than one category.

Table 2

Quarter	Patient safety/ quality	Bullying and/or harassment	Worker safety	Other behaviours	Systems and/or process	Other	Ideas for learning and improvement
Q1	2	8	1	5	2	0	0
Q2	0	6	0	5	2	2	0
Q3	3	3	0	4	0	1	0
Q4	2	4	1	2	3	0	1

Some examples of speaking up in Q3 & Q4 are:

- Initially raised through Work in Confidence, a colleague wanted support regarding what they described as harassment and micro-aggression that they have experienced a few years. They have accessed BAME coaching which has helped to some extent. They have now left the organisation and have requested to share their lived experience with the Freedom to Speak Up Guardian and the Equality, Diversity and Inclusion Lead.

- A colleague spoke up about their concerns regarding feeling unsafe within their work team after expressing concerns about a colleagues' absence and an increased workload. They had raised these concerns over many months with their manager and wasn't felt valued or heard. Support is ongoing with some strategies for quick wins, sign posting and actions moving forwards.

- A colleague emailed requesting to meet as sign posted to the Freedom to Speak Up Guardian from the Health & Wellbeing Line post redeployment. They were anxious to share their redeployment experiences of negative behaviours and use of foul language, especially in front of a colleague who

had only recently joined the organisation. We agreed that the Freedom to Speak Up Guardian would visit the department to further promote my role and the Trust values.

- Colleague currently accessing support from Working Well. Shared worries and concerns regarding coming back to work due to feelings of the workplace being unsafe and worried that mistakes would be made. Feels minimal support in place and not being listened to. Some solutions discussed facilitated contact with their professional head. Support in place and returning to work more confident and on a phased return.

Table 3

Quarter	Worker	Manager	*Senior Leader	Not disclosed	Protected characteristic shared
Q1	8	5	0	5	Disability-1 BAME-2
Q2	8	4	0	3	Disability-1
Q3	5	2	0	0	BAME-2
Q4	11	0	0	0	Age-1 Disability-1 BAME-1

*This category is applied to Board-level or equivalent although to maintain confidentiality this will be maintained at 0.

Table 4

Professional Group	Q1	Q2	Q3	Q4	Total
Administration, Clerical & Maintenance/Ancillary	0	3	1	2	6
Allied Health Professionals	0	1	0	1	2
Ambulance (operational)	0	0	0	0	0
Commissioning	0	0	0	0	0
Corporate Services	1	1	0	0	2
Medical and Dental	3	1	0	0	4
Not known	5	2	3	0	10
Nursing Assistants or Healthcare Assistants	0	2	1	2	5
Other	3	3	2	1	9
Public Health	0	0	0	0	0
Registered Nurses and Midwives	5	2	3	5	15
Social Care	1	0	0	0	1

In Q3 & Q4 within the Trust Nurses accounted for 38% of speaking up followed by Administration/Facilities colleagues and Health Care Assistants at 14% with anonymous reporting through the Work in Confidence portal at 19%.

Anonymous reporting figure with the Trust for 2021-22 at 20% currently remains higher than the national figure of 11.7% (2020-21 published data), 2021-22 not currently available.

Increased engagement continues with our medical and dental workforce, with the Freedom to Speak Up Guardian continuing to present at team meetings and at junior doctor inductions and with learners at the University of Gloucestershire.

Reflecting on 2021-22 Nurses as a professional group accounted for the biggest portion, 28% of speaking up cases raised through the Freedom to Speak Up route and with comparable data in 2020-21 32%. Not known colleagues were through the anonymous Work in Confidence portal. When the 'Not known' is considered, this can include an instance when an individual has not disclosed their professional group or when a colleague wishes to remain anonymous.

Work in Confidence

Work in Confidence, an anonymous, secure and independent platform remains another route for colleagues to speak up. Various colleagues are available to offer support through this platform and with the governance oversight by the Freedom to Speak Up Guardian. For 2021-22 two categories BAME and Disability were added to the platform to enable the Guardian to more easily understand 'reach' across the organisation and identify any groups which may be using the Freedom to Speak up route more frequently, or less frequently, than other groups.

Table 5

Quarter 2021-22	Number of contacts	Category
Q1	5	Bullying and/or harassment-4 Patient safety/quality-1
Q2	3	Bullying and/or harassment-2 Other-1
Q3	3	Bullying and/or harassment-1 Other-1 Cultural-1
Q4	1	Bullying and/or harassment-1

3.0 PATIENT SAFETY AND/OR WORKER EXPERIENCE FEEDBACK

Feedback is requested from all colleagues whether they have had a positive experience or not. Some feedback is shared from colleagues as below from Q3 & Q4:

- Thank you so much for you thoughtful and supportive session. You were the first person to validate my concerns and suggested positive ways forward.

- Yes, I would definitely use the Freedom to Speak Up service again. You responded very quickly and you were able to suggest ways I could address the awful behaviours in a more confident way.
- Yes, I would definitely speak up again. I feel this is a very important thing to do and wish others would feel the same way. It's the Trust's responsibility, and our duty, to care for each other as well as our patients in a safe way.
- I felt you listened to my concerns and I felt reassured you would/were able to take things further to be recognised/addressed. Thank you for all you do.
- I would speak up again and now more confident to do this in a group when I am witnessing poor behaviours and lack of respect.

All organisations which regulate or provide NHS healthcare should implement the principles and actions set out in the report Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. Within the review led by Sir Robert Francis QC, he highlighted that minority staff feel vulnerable when speaking up, as they may feel excluded from larger groups of workers.

Table 6

Quarter	Number of cases where people indicate that they are suffering disadvantageous and/or demeaning treatment (detriment)	Given your experience would you speak up again
Q1	3 (BAME -1)	Yes-8 No- Maybe-2 Don't Know-
Q2	3 (Disability-2)	Yes-7 No- Maybe- Don't Know-
Q3	2 (BAME -2)	Yes-4 No- Maybe-1 Don't Know-
Q4	2 (Disability-1)	Yes-3 No-1 Maybe- Don't Know-

For 2021-22, those colleagues that have indicated that they are suffering detriment and who shared a protected characteristic is 60%. Colleagues are further supported through dedicated health and wellbeing resources, reciprocal mentoring, and also sign posted onto to our Equality, Diversity and Inclusion networks.

4.0 LEARNING AND IMPROVEMENT

The National Guardian's Office has carried out case reviews where they received information to suggest that speaking up had not been handled in accordance with good practice. A self-review tool is now available, to identify and improve gaps in organisations' speaking up arrangements and to develop plans and actions for improvement.

The report of the independent investigation to review to raising concerns at West Suffolk NHS Foundation Trust illustrates what happens when speaking up is viewed as a threat, when those who speak up are the focus, rather than the matters raised. The focus of the review was the response to speaking up about concerns raised by staff to the executive team and the detriment to those that spoke up. This led to the Trust being downgraded in the CQC Well Led domain from outstanding to requires improvement.

The review provides learning for all organisations to not differentiate between the different ways that workers speak up. The review states "the need to recognise that even where staff raising concerns do not specifically cite Freedom to Speak Up, the concerns should be treated in the spirit of the organisation's Freedom to Speak Up policy." To also ensure that all NHS organisations are aware and have implemented the Freedom to Speak Up: Guidance for NHS trust and NHS foundation trust boards. Our Trust's self-review is continuously being reviewed with Executive team oversight due in November 2022.

On the 30 March the Ockenden review was published. Devastating experiences are at the heart of Donna Ockenden's Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust. The report highlights the tragic consequences of a culture where workers are fearful of the consequences if they speak up.

The NHS Staff Survey for 2021 has undergone significant changes, in line with the People Promise elements and themes. As a result, some of the questions which comprised the Freedom to Speak Up Index have been dropped so therefore the index will no longer be published. "Speaking Up" questions are themed within "We each have a voice that counts" and last year's survey, for the first time included a new question asking whether workers feel safe to speak up about anything that concerns them in their organisation. The question remains in this year's survey and is accompanied by a new follow-up question: "If I spoke up about something that concerned me, I am confident my organisation would address my concern".

Colleagues' ratings are generally positive and encouraging, with room for further improvements:

- Q17a "I would feel secure raising concerns about unsafe clinical practice" 82.7%, colleagues have increased their rating of the Trust by 6.9% over last year, which is 3.1% better than the benchmarked Trusts' average. Also, within the top quartile of all Trusts.

- Q17b, "I am confident that my organisation would address my concern" 69.9%, colleagues have increased their rating by 4.4% over last year, which is 5.7% better than the benchmarked Trusts' average.

- Q21e, "I feel safe to speak up about anything that concerns me in this organisation", while the benchmarked Trusts' average has dropped from 68.3% to 66.8% this year, Trust colleagues have increased their rating by 2.2% over last year to 70.5%.

- Finally, for Q21f "If I spoke up about something that concerned me I am confident my organisation would address my concern", while there isn't a previous year's question of the same format, 58.5% of Trust colleagues reported that they were confident. This is better than the benchmarked Trusts' average of 55.1%.

To be a Great Place to Work, we need to aim to be a top quartile as a best performer. To achieve this, we still have a way to go, will need to continue with our focus, attention and our new strategy which will focus on the next five years.

Linked to the NHS Staff Survey, on the 31 March the National Guardian's Office published the Freedom to Speak Up Guardian Survey 2021; The survey shows the experience of guardians amid the continued pressure of the pandemic on the healthcare sector. While the majority of guardians who responded were positive about the speaking up culture in their organisation, there are warning signs that more action is needed.

The proportion of guardians who reported a positive speaking up culture in their organisation has dropped, in line with the NHS Staff Survey results (published March 30). Only 65 % have ring fenced time and 22% more than 3 days per week.

Although the majority believed that their senior leaders understand the role of the Freedom to Speak Up Guardian, 1-in-10 of respondents say that senior leaders do not. This will be shared with the Executive Team to aid further improvements.

Further local and Trust learning is being incorporated into future plans with feedback and self-reflection with colleagues and teams.

- Work continues to further develop and strengthen the Gloucestershire ICS Guardian network and to gain a greater understanding from a national perspective regarding a future ICS model.

- Signposting colleagues to health and wellbeing resources and where appropriate raise to senior managers.

- Facilitated meetings/mediation to support and address inappropriate behaviours. Referral to OD team to offer wider team coaching and support.

- Civility and respect issues, team dynamics. Civility framework within the Civility Saves Lives programme to tackle some of these issues is being explored. Bullying and Harassment Policy is being reviewed.

- Discussion and coaching to raise the issue with line manager or appropriate person.

- Compassionate leadership and kindness role modelled to ensure a compassionate culture

- Students need to empowered to speak up through their education route as well as the placement route, so that issues are identified as soon as possible and positive action taken.

- The placement expectations for students needs to be reviewed and confirmed to ensure both registered nurses and students know the expectations moving forward.

5.0 ACTIONS TAKEN TO IMPROVE THE SPEAKING UP CULTURE ALONGSIDE ASSOCIATED WORK OF THE FREEDOM TO SPEAK UP GUARDIAN

Progress continues to further improve the speaking up culture within the organisation. The following builds upon previous significant work:

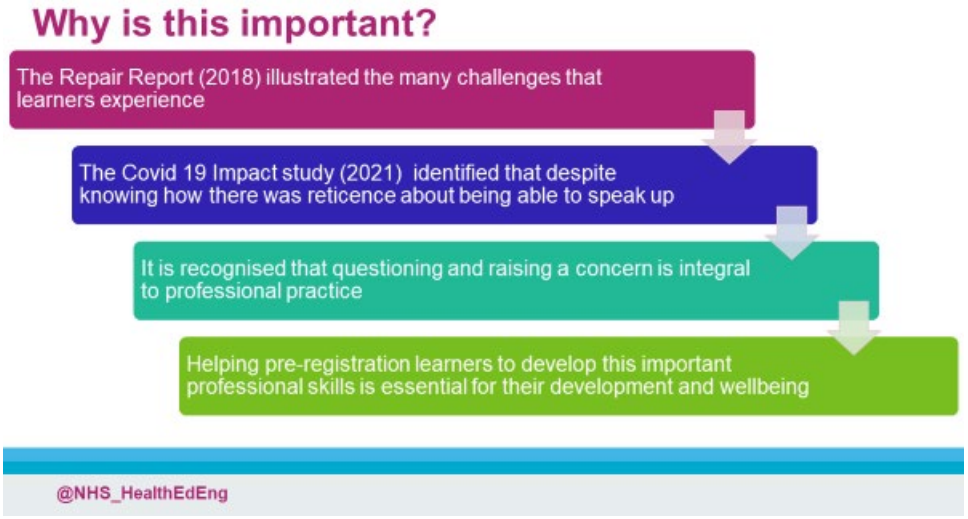
- **Freedom to Speak Up Champions** - In April 2021 the National Guardian's Office published new Guidance for Freedom to Speak Up Guardians on the Development of Freedom to Speak Up Champion and Ambassador Networks, and was to be . Engagement sessions continue with current champions to refresh, raise awareness and promote the value of speaking up. The new guidance is being implemented with current teams in the Forest of Dean Community Hospitals, Charlton Lane Hospital and Wotton Lawn Hospital as our 'Strong Voice' commitment to colleagues within our new People Strategy.

  March 2022 was a Values Month, within Children and Young People services, with week 3 focussing on speaking up. Engagement with the teams will continue to develop champions within the services.

  Some of our champions within the Trust attended the National Guardian's Office Conference for Freedom to Speak Up Guardians on 29 March 2022. The theme of this year's conference was Freedom to Speak Up – Past, Present and Future. Initial feedback has been really positive and plans are to reflect and share the learning within our speaking up plans moving forwards.

  Refreshed communications materials including posters and contact cards are being distributed to sites with continued engagement with colleagues.

- **RePAIR (reducing preregistration attrition improving retention)** - Invited by Paula Shepherd Health Education England Fellow to support this work for the South West in supporting students to speak up. On 22 March at the RePAIR Showcase event the work was presented alongside the Guardian role and some best practice within the Trust, Speaking Up – A Professional Skill.



The Learning and Development team currently have a 1st year Undergraduate Nursing Student on placement, her project following some local and national learning is supporting students to speak up. The project learning will be supported by myself to embed into practice for our learners.

- **Freedom to Speak Up Strategy** - Engagement has commenced to establish a group of people (service users and colleagues) to collaborate on the development of the Trust's Freedom to Speak Up Strategy, to identify and agree 5-year plan objectives, actions and measures of success. Two workshops are planned for May to include also colleagues' stories of speaking up, ensuring coproduction. This strategy will be developed in line with the National Guardian's Office Strategic Framework and our strategic commitments to High Quality Care and being a Great Place to Work.

- **Civility Saves Lives** - This programme of work will be led by myself with the Director of Nursing, Therapies and Quality as the Senior Reporting Officer, with project management/quality improvement support in place also.
  A coproduction approach with seven teams to design and implement a programme of Civility Saves Lives for GHC and drive behavioural change and associated benefits for patient safety to be a great place to work. The first engagement session on 27 April 2022 was very positive and next steps are being planned with support from Dr Chris Turner.

- **Follow Up - eLearning for Senior Leaders Launched**
  The third and final module of the Freedom to Speak Up eLearning package is now available on Care to Learn. This module is designed for leaders at all levels to help them foster a speaking up culture in their organisations.

Importantly, this eLearning package is available to anybody, no matter where they work in healthcare. The first module - Speak Up - is for all staff and has with the second module - Listen Up - for managers, focuses on listening and understanding the barriers to speaking up. Leaders are advised to complete the first two modules before engaging with the final Follow Up module.

- **Health and Wellbeing Hub** - Speaking Up continues to be integral to the health and wellbeing hub. The voice of colleagues is fundamental to this and learning from speaking up is feedback to the Health and Wellbeing hub to inform priorities

- **Embedding Serious Incident Learning** - Leading on this reflective team discussion approach post serious incidents to ensure compassionate leadership and just culture approaches are key.

- **Thrive Leadership Development Programme -** These the Freedom to Speak Up Guardian continues to support the delivery of 'Creating Psychological Safety' alongside Organisational Development Colleagues.

- **Diversity Networks** - The Freedom to Speak Up Guardian is an integral member of the network and offers guidance, support and leadership to the Chair of the Race and Cultural Awareness Network. The NHS People Plan commitment, which referred to a joint training programme for Freedom to Speak Up Guardians and WRES Experts will further support our inclusive speaking up agenda.

- **Co-Chair Regional Network** - The Freedom to Speak Up Guardian continues to Co-Chair the South West Freedom to Speak Up Guardian Regional Network, offering leadership peer support and advice.

Appendix 1

Paul's Open Door

Paul's Open Door is a confidential portal to share with our Chief Executive any issues colleagues think he should be aware of or ask for a response to something they are concerned about. There are also opportunities to make suggestions for improvement. This route to speaking up sits alongside others including our Freedom to Speak Up Guardian, via line managers, Staff Side, Staff Forums, Team Talk and more. Paul's Open Door is accessible via a desktop Icon on all Trust laptops.

Number of cases raised

Quarter 2021-22	Number of cases raised	Number of cases raised anonymously
Q1: April - June	1	0
Q2: July – September	4	0
Q3: October - December	23	2
Q4: January - March	49	8

Themes

	Patient safety/ quality	Bullying and/or harassment	Worker safety	Other behaviours	Systems and/or process	Other	Ideas/ learning	Thank You
Q1	0	0	0	0	1	0	0	0
Q2	0	1	0	1	1	0	1	0
Q3	1	1	2	2	6	0	6	5
Q4	0	3	5	5	24	1	9	2

- Issues around estates at SGM led to specific attention the following day by an engineer.
- Several issues raised around Petrol costs and mileage.
- Several submissions thanking the CEO for his GLOBAL message, pointing out the difficulty some people are having accessing their Vivup voucher.
- Positive comment around how there is in general a move away from autocratic leadership styles and that managers are generally really stepping up to support staff through kindness, nurturing and understanding.
- Suggestion around reaching out to community nurses to look to bolster morale and retention by consulting them on how this can happen. Able to advise of a number of engagements with the community teams including specific health and wellbeing solutions including a specifically led quality improvement triage project being launched to ensure the right care at the right time in the right place.
- Suggestion around better utilisation of the operating theatre at Tewkesbury led to the COO raising with GHFT colleagues to improve the theatre use.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 16/0522

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 May 2022**

PRESENTED BY: Lavinia Rowsell, Head of Governance and Trust Secretary

AUTHOR: Lavinia Rowsell, Head of Governance and Trust Secretary

SUBJECT: **PROVIDER LICENCE – SELF-CERTIFICATION APPROVALS**

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

The purpose of this report is to:

To provide the Board with the information and assurances required to enable it to make the required annual self-certification regarding compliance with the conditions of its provider licence and the systems and processes for ensuring such compliance.

Recommendations and decisions required

On the recommendation of the Audit and Assurance Committee, the Board is asked to:

a) **Agree** to make a declaration confirming compliance with each of the statements listed in the Corporate Governance Statement.

b) **Agree** to make a declaration of **'Confirmed'** in relation to the Governor training declaration.

c) **Agree** to make a declaration of **'Confirmed'** by the due date of 31 May in respect of systems for compliance with licence conditions (Condition G6) for the financial year just ended

d) **Agree** to publish on the Trust website the declaration in respect of systems for compliance with licence conditions (Condition G6) by 30 June.

e) Have **regard** to feedback received from Governors in respect of these declarations

Executive summary

In order to comply with NHSE/I regulatory requirements, the Board is required to make a number of declarations each year regarding compliance with the Trust's provider licence and the systems and processes for ensuring such compliance.

1. Corporate Governance Statement

It is a requirement of the governance condition of the Trust's licence that the Board signs off a Corporate Governance Statement within three months of the end of each financial year.

The Corporate Governance Statement requires the Trust Board to confirm:

- Compliance with the governance condition **at the date of the statement**; and
- **Forward compliance** with the governance condition for the current financial year, specifying (i) and risks to compliance and (ii) any actions proposed to manage such risks

In making its Corporate Governance Statement declaration, the Board can rely on a range of evidence which is summarised in Appendix 1 of this report. The Board is asked to confirm **compliance at the date of the statement** and **forward compliance**, for each section of the Corporate Governance Statement.

2. Training of Governors

The Board is required to make a declaration regarding the provision of necessary training to Governors. At its meeting on 18 May 2022, the Governors confirmed that, in their view, this was the case. Training opportunities provided for Governors are set out on page 5 of the report.

The Board is therefore recommended to make a declaration of '**Confirmed'** in respect of the provision of Governor training.

3. Compliance with Licence conditions

Foundation Trusts are also required to make an annual declaration that they have their systems and processes for compliance with provider licence conditions (General Condition G6). Appendix 2 provides evidence which the Board may rely on to make this declaration. The Board is invited to make a declaration of '**Confirmed'** in respect of both parts of this declaration.

The Board's declarations must be made *having regard to the views of Governors.* The appendices to this Board report were provided to Governors at its meeting on 18 May. The Governors noted the report and no concerns were raised in respect of systems and processes for compliance with licence conditions.

Risks associated with meeting the Trust's values

Regulatory risk the Trusts fails to make the required declarations within the prescribed timescales and/or makes and false declaration.

Corporate considerations	
Quality Implications	None
Resource Implications	None
Equality Implications	None

Where has this issue been discussed before?

These declarations are considered on an annual basis. The process involves the Executive, Council of Governors and Board. The declarations were reviewed by the Audit and Assurance Committee at its May meeting.

Appendices:	**Appendix 1:** Corporate Governance Declaration - evidence **Appendix 2:** Provider Licence conditions - overview and additional evidence

Report authorised by: Executive Team	**Date:** 3rd May 2022

PROVIDER LICENCE SELF ASSESSMENT – 2021/2022
REPORT TO THE BOARD

1.0 INTRODUCTION

1.1 The provider licence requires the Board to make a series of annual declarations to confirm the Trust's compliance with the licence conditions, and also to confirm that the Trust has and intends to keep in place systems and processes to implement appropriate standards of corporate governance.

1.2 The individual declarations comprise:

- Corporate Governance Statement
- Governor Training declaration
- Systems for Compliance with Licence Conditions declaration

1.3 A further declaration, in relation to the continued availability of resources to provide 'Commissioner Required Services' is not applicable to the Trust as it has not been formally designated by its commissioners as providing such services.

1.4 Declarations must be made by the Board, having regard to the views of Governors.

2.0 CORPORATE GOVERNANCE STATEMENT

2.1 Condition FT4 is about the systems and processes in place to ensure good governance and requires to the Trust to self-certify that this is in place. This includes compliance with the condition at the date of the statement and forward compliance for the current financial year.

2.2 The governance condition of the licence concerns the Trust's internal systems and processes. Hence, the reference to risks within the Corporate Governance declaration relate to risks to those systems and processes, rather than wider risks to the achievement of the Trust's objectives. Where a statement in the declaration indicates a risk to compliance with the governance condition of the Trust's provider licence, NHS I will consider whether any actions or other assurances are required at the time of the declaration, or whether it is more appropriate to maintain a watching brief.

2.3 The Board has during the course of the year received a number of documents which provide evidence of compliance. **Appendix 1** provides a summary of the available evidence to support the Board in making its declaration.

2.4 The Board is required to consider risks to compliance with the Trust's licence conditions, and set out mitigating actions taken to address those risks. The licence conditions are primarily concerned with the establishment of systems and processes to maintain compliance, and as such there are no obvious risks to the maintenance of such systems and processes.

2.5 Accordingly, the Board is recommended to make a declaration of **'Confirmed'** in respect of compliance at the time of the declaration, and in respect of forward compliance for the current year.

3.0 GOVERNOR TRAINING DECLARATION

3.1 Additionally, the Board is required to make a declaration that it has provided Governors with the necessary training, pursuant to Section 151 (5) of the Health and Social Care Act 2012, to enable Governors to fulfil their roles. The Act does not specify the nature or content of training to be provided.

3.2 A number of training opportunities provided by external organisations are made available to Governors throughout the year. Governors also receive a local induction, and have opportunities to learn about the work of the Trust through a series of induction meetings and presentations. Access to Trust services and site visits have been more limited due to the Covid pandemic. A detailed handbook and induction session is in place for governors and an ongoing training plan developed. In year, the Governors have taken part in a development session on the Trust strategy. The Governor meeting schedule includes two dedicated development sessions, the topics of which will be determined in discussion with Council.

3.3 The Board is therefore recommended to make a declaration of **'Confirmed'** in that it is satisfied that the Trust has provided the necessary training to Governors to ensure they are equipped with the skills and knowledge they need to undertake their role.

4.0 GENERAL CONDITION G6 – SYSTEMS FOR COMPLIANCE WITH LICENCE CONDITIONS

4.1 General Condition 6 requires that the Trust takes necessary precautions against the risk of failure to comply with the conditions of its licence, any requirements imposed by the NHS Acts, and the requirement to have regard to the NHS Constitution in providing health care services for the purpose of the NHS.

4.2 The licence condition states that the steps the Trust must take should include:

'*the establishment and implementation of processes and systems to identify risks and guard against their occurrence'*, and

'regular review of whether those processes and systems have been implemented and of their effectiveness'.

4.3 The declaration asks the Board having reviewed the evidence, to confirm (or otherwise) by the due date of 31 May 2022 that:

'*Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that,* ***in the Financial Year most recently ended****, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.'*

4.4 An overview of the provider licence conditions is given at **Appendix 2**. Much of the evidence given in support of the Corporate Governance Statement (listed at Appendix 1) may also be relied upon by the Board in order to make the declaration regarding the processes and systems in place to comply with the Trust's licence conditions and general obligations.

4.5 The Board is therefore recommended to respond '**Confirmed'** in respect of the declaration above.

4.6 The Trust is required to publish its G6 declaration by 30 June 2022. As the minutes of this meeting will not be approved by that date, a template provided by NHS Improvement will be used to publish the declaration on the Trust website.

5.0 HAVING REGARD TO THE VIEWS OF GOVERNORS

5.1 The Board is required to make the above declarations "having regard to the views of Governors". Governor views should be expressed in the context of the Council's statutory duty to hold the NEDs to account for the performance of the Board. This means that Governors should comment on the robustness of the assurance process undertaken in deciding these declarations. A separate report was made available to Governors providing assurance regarding the process for the Board to make these declarations. The appendices to this report have also been made available to Governors alongside the summary assurance report. The Governors noted the report at the meeting held on 18 May 2022 and no concerns were raised in respect of systems and processes for compliance with licence conditions.

5.2 The Board is therefore asked to have regard to the views of Governors regarding these declarations.

6.0 RECOMMENDATIONS

6.1 The Board is asked to:

f) Have **regard** to feedback received from Governors in respect of these declarations

g) **Agree** to make a declaration confirming compliance with each of the statements listed in the Corporate Governance Statement.

h) **Agree** to make a declaration of **'Confirmed'** in relation to the Governor training declaration.

i) **Agree** to make a declaration of **'Confirmed'** by the due date of 31 May 2022 in respect of systems for compliance with licence conditions (Condition G6) for the financial year just ended

j) **Agree** to publish on the Trust website the declaration in respect of systems for compliance with licence conditions (Condition G6) by 30 June 2022.

APPENDICES

Appendix 1: Corporate Governance Declaration - Evidence
Appendix 2: Provider Licence conditions - Overview and Additional Evidence

APPENDIX 1 - Corporate Governance Declaration – Evidence

AGENDA ITEM: 16/0522

GOVERNANCE STATEMENT	EVIDENCE FOR CURRENT COMPLIANCE		SUGGESTED DECLARATION
The Board is satisfied that GHC NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	• Organisational leadership through Board • Local accountability through Council of Governors • Engagement programme with stakeholders • Scheduled Board meetings including public meetings • Committee structure and Committee meeting programme • Performance dashboards to Resources Committee and Board • Quality monitoring and reporting to Quality Committee • CCG observers at Quality Committee • Quality Report and indicators • Financial reporting monthly to Board/Resources Committee • Financial control systems in place • Information Governance function and reporting • Risk management framework and governance reporting • Assignment of key risks to relevant governance Committees • Regular update and review of risk register • Datix incident reporting system • Council of Governors statutory roles in holding NEDs to account	No unmitigated risks identified	Confirmed

GOVERNANCE STATEMENT	EVIDENCE FOR CURRENT COMPLIANCE		SUGGESTED DECLARATION
	• Patient safety reports to Board and Quality Committee • Patient Stories agenda item at public Board meetings • Meeting evaluation at each Board meeting • Whistleblowing and other organisational policies and procedures in place (including Freedom to Speak Up Guardian) • External audit and internal audit programme • Clinical audit programme • Compliance with FT Code of Governance • Trust Constitution • Trust vision and values • Annual Governance Statement • Mandatory disclosures in Annual Report • Statutory and mandatory training • Corporate induction for all new starters • Fit and proper person test for Board and Governors • Revised Conflicts of Interests and Risk Management Policies • Statutory registers in place • Positive CQC inspection report • Governance arrangements regularly reviewed to ensure fit for purpose and responsive, e.g. recent addition of		

GOVERNANCE STATEMENT	EVIDENCE FOR CURRENT COMPLIANCE		SUGGESTED DECLARATION
	People Committee and Forest of Dean Assurance Committee		
The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	• Regular CEO Reports to Board highlight relevant new publications/guidance • Policy and guidance regular item at Board and appropriate Committees • External Auditor Sector development report • NHS I Bulletins received by Exec Directors and Trust Secretary • Annual Reporting Manual guidance • Compliance with FT Code of Governance confirmed in Annual Report • Legal bulletins and updates received by Trust Secretariat Team and disseminated as appropriate	No unmitigated risks identified	Confirmed
The Board is satisfied that GHC NHS Foundation Trust implements effective board and committee structures	• Annual Committee effectiveness reviews • Committee membership focused to reflect skills – based on skills identified during appointment process • Internal Audits on Governance and Risk Management • Strong clinical presence on Board • Committee summary reports to Board • Locality Governance structures • Sub-committees mapped	No unmitigated risks identified	Confirmed
The Board is satisfied that GHC NHS Foundation Trust implements clear responsibilities for its Board, for committees reporting to the Board and for	• Constitution sets out Board responsibilities • Committee duties aligned to core Board responsibilities	No unmitigated risks identified	Confirmed

GOVERNANCE STATEMENT	EVIDENCE FOR CURRENT COMPLIANCE		SUGGESTED DECLARATION
staff reporting to the Board and those committees	• Committee Terms of Reference reviewed annually and substantive changes approved by the Board • Committee agenda planners reviewed regularly • Scheme of Delegation in place setting out delegated responsibilities and powers reserved to Board and reviewed • Revised Standing Financial Instructions in place and reviewed		
The Board is satisfied that GHC NHS Foundation Trust implements clear reporting lines and accountabilities throughout its organisation	• Clear Executive portfolios • Defined management and committee structure • Chief Executive is Accounting Officer • Director of Nursing, Therapies and Quality & Medical Director lead on quality and service experience matters • Medical Director is Caldicott Guardian • Deputy CEO is Senior Information Risk Owner • Named Board member leads for Learning from Deaths, Counter Fraud, security management, Whistleblowing, Health and Safety, Safeguarding, Equality and Diversity etc • Lead Executive for each Committee • Assignment of organisational risks to appropriate Committees • Committees are accountable and report regularly to the Board	No unmitigated risks identified	Confirmed

GOVERNANCE STATEMENT	EVIDENCE FOR CURRENT COMPLIANCE		SUGGESTED DECLARATION
	• Staff appraisals and objectives processes in place		
The Board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively	• Going concern report to Audit and Assurance Committee • Board Finance Reports • Savings Plans in place • Quality Impact Assessments process in place, overseen by Quality Committee • Budget setting process • Strategic Plan • Capital Programme • Performance dashboard to Board/Quality Committee • Quality reports to Board/Quality Committee • Outcomes reporting • Clinical audit programme • Internal audit programme • External auditor in place • CQC registration • Single Oversight Framework segment 1 rating • Service/business planning process	No unmitigated risks identified	Confirmed
The Board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes to ensure compliance with the Licence holder's duty to provide timely and effective scrutiny and oversight	• Executive meetings • NED oversight on Board and Committees • Board and Committee agenda planners • Monthly performance dashboards and exception reports • Executive Engagement processes	No unmitigated risks identified	Confirmed

GOVERNANCE STATEMENT	EVIDENCE FOR CURRENT COMPLIANCE		SUGGESTED DECLARATION
	• Board visits (site visits limited due to Covid) • CQC compliance reports to Quality Committee • Overall control total achieved • Cost Improvement Programme		
The Board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes to ensure compliance with health care standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions	• Performance dashboard reports to Board/Resources Committee • Safety/quality oversight by Quality Committee • CQC/Mental Health Act compliance reports • CQC inspection report • Medical/nursing revalidation programmes • Mental Health Legislation Scrutiny Committee oversight • Executive engagement processes with staff to ensure connection in place with front line staff • Paul's Open Door • Freedom to Speak Up Guardian and advocates • Board visits (site visits limited due to Covid) • Clinical audit programme • Statutory and mandatory training requirements • Clinical policies • PLACE visits	No unmitigated risks identified	Confirmed

GOVERNANCE STATEMENT	EVIDENCE FOR CURRENT COMPLIANCE		SUGGESTED DECLARATION
	• Mental Health Act/Mental Capacity Act policies • Mental Health Act Managers in place • Quality Report • Regulatory inspection reports/action planning • Inquest reports/action planning • Quality Impact Assessments for efficiency and transformation proposals • QIAs reviewed by Medical Director & Director of Nursing, Therapies and Quality • Staff Survey action plan		
The Board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern)	• Budget setting process • Savings and transformational change programmes • Fully funded capital programme • Surpluses in previous years to achieve strong liquidity position • Use of liquidity position for strategic plan transformation • Monthly finance reports to Resources Committee and Board • Standing Financial Instructions • Mid-year financial reviews • Authorised signatory lists • Scheme of Delegation • Audit Committee Going Concern reports • Audit Committee Losses/Special Payments reports	No unmitigated risks identified	Confirmed

GOVERNANCE STATEMENT	EVIDENCE FOR CURRENT COMPLIANCE		SUGGESTED DECLARATION
	• Counter Fraud Service and annual action plan • Resources Committee oversight of development opportunities and business cases • Tender submission procedures • Governor approval process for significant transactions • NHSR Clinical Negligence Scheme for Trusts • NHSR Risk Pooling Scheme for Trusts • Annual financial plan approved by Board before the start of the year • Agency staffing controls		
The Board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making	• Board/Committee agenda planners • Monthly Finance and Performance reports • Performance Point system to provide up to date high quality data • Clinical audit programme provides assurance on data quality • Data quality policy • Data quality requirement in Information Governance Toolkit • Finance and performance reporting aligned to Board/Committee cycle • Chief Executive's Reports to Board	No unmitigated risks identified	Confirmed
The Board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes to identify and manage	• Risk register reviews by 'owning' Committees and overseen by Audit and Assurance Committees and Board	No unmitigated risks identified	Confirmed

GOVERNANCE STATEMENT	EVIDENCE FOR CURRENT COMPLIANCE		SUGGESTED DECLARATION
(including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence	• Board Assurance Framework review by Executive, Audit Committee and Board • Internal audit programme • Clinical audit programme • Risk consideration as standing Committee agenda item • Incident Reporting policy and culture • Whistleblowing policy and procedure – Freedom to Speak Up • Paul's Open Door • Quality Impact Assessments process		
The Board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery	• Annual operational planning process • Development processes involves service users and Governors, e.g. strategic development sessions • Plans aligned to commissioners' stated intentions • Resources Committee oversight • Executive oversight • Governor involvement on business plan • monitoring reports to Resources Committee • Performance reports • Finance reports • Annual Quality report – external consultation • External auditors report on Quality report – process suspended for 2021/22 in line with guidance from NHSE and NHSI	No unmitigated risks identified	Confirmed

GOVERNANCE STATEMENT	EVIDENCE FOR CURRENT COMPLIANCE		SUGGESTED DECLARATION
The Board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes to ensure compliance with all applicable legal requirements	• Access to retained lawyers • Internal and external auditors • Executive leads for each key area of business • Trust Secretariat responsible for constitutional and corporate governance matters/updates • Legal briefings/updates received from a variety of sources • Executive oversight • Information Governance policies and procedures • Clinical policies and procedures • Mental Health Legislation Scrutiny Committee and MHA Managers • Fit and proper person tests • FT Code of Governance compliance reports	No unmitigated risks identified.	Confirmed
The Board is satisfied that systems and processes in place ensure that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided	• Medical Director and Director of Nursing, Therapies and Quality and are clinicians • Non-Executive Director engagement and review provides rigorous quality challenge – a number of Non-Executive Directors are clinicians or have experience as Non-Executives at other NHS Trusts to inform their challenge • To respond to the Covid-19 pandemic, the Trust put in place a 'programme approach' with Executive Directors also having specific responsibilities within the	No unmitigated risks identified.	Confirmed

GOVERNANCE STATEMENT	EVIDENCE FOR CURRENT COMPLIANCE		SUGGESTED DECLARATION
	programme. This ensured the maintenance of focus on quality of care. The use of existing expertise and recognised key leads ensured that processes could be activated swiftly without disruption to clinical operation.		
The Board is satisfied that systems and processes in place ensure that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations	• Quality Impact Assessments for savings plans • Quality framework under development • Quality Report is key element of organisational vision and values • Quality Report defines key quality themes for the coming year • Evaluation of each Board meeting	No unmitigated risks identified	Confirmed
The Board is satisfied that systems and processes in place ensure the collection of accurate, comprehensive, timely and up to date information on quality of care	• Monthly performance dashboard to Resources Committee/Board • Performance Exception reports to Board • Update reports on Quality Report • Regular Patient Safety report to Board • Data Quality assurance processes in place	No unmitigated risks identified	Confirmed
The Board is satisfied that systems and processes in place ensure that the Board receives and considers accurate, comprehensive, timely and up to date information on quality of care	• Monthly performance dashboard to Resources Committee • Performance Exception reports to Board • Regular update reports on Quality Report • Regular Patient Safety report to Board • Performance reports to Resources Committee and Board • Data Quality assurance processes in place	No unmitigated risks identified	Confirmed

GOVERNANCE STATEMENT	EVIDENCE FOR CURRENT COMPLIANCE		SUGGESTED DECLARATION
The Board is satisfied that systems and processes in place ensure that GHC NHS foundation trust including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and considers as appropriate views and information from these sources	• Quality Report consultation • Update reports on Quality Report shared with stakeholders including Clinical Commissioning Groups, Health Watch and Overview and Scrutiny Committee, and feedback encouraged • Engagement & Communication processes • Patient survey • Staff Survey • Complaints and Comments process • Patient and Staff Friends & Family Tests • Patient Story is regular agenda item at public Board meetings • Stakeholder Engagement Events (limited due to Covid) • Quality Outcomes published through public Board papers and in Annual report • Joint Negotiating and Consultative Committee • Local Negotiating Committee and Medical Staff Committee • "One Gloucestershire" ICS Clinical and non-clinical workstreams	No unmitigated risks identified	Confirmed
The Board is satisfied that systems and processes in place ensure that there is clear accountability for quality of care throughout GHC NHS foundation trust including but not restricted to	• Quality Governance assigned to Exec Directors • Non-Exec Director oversight of Quality • Clinical Leads • Service Leads • Heads of Profession	No unmitigated risks identified	Confirmed

GOVERNANCE STATEMENT	EVIDENCE FOR CURRENT COMPLIANCE		SUGGESTED DECLARATION
systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate	• Lead Nurses • Board Committee and sub-committee structure		
The Board of GHC NHS foundation trust effectively implements systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licence holder's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.	• Board recruitment processes • Governor appointment of Non-Exec Directors • Appointment & Terms of Service Committee for Executive recruitment • Budgeted establishment • Delegated recruitment processes • Recruitment and selection policy • Appraisal and revalidation policies • Ward staffing levels information	No unmitigated risks identified	Confirmed

APPENDIX 2 - PROVIDER LICENCE CONDITIONS – OVERVIEW AND ADDITIONAL EVIDENCE

	Licence Condition	Condition summary	Evidence for compliance
General Conditions			
G1	Provision of Information	Provision of information to NHS I	Operating plan Strategic plan submission Ad hoc submissions to NHS I via portal
G2	Publication of information	Publish information as directed by NHS I	Information on website e.g. Board profiles
G3	Payment of fees to Monitor	Pay fees to NHS I as required	Not applicable - no fees requested to date
G4	Fit and Proper Persons	Not to appoint unfit persons as Directors or Governors	Directors' recruitment procedures Governor election rules *'Fit & Proper Persons: Directors'* test incorporated into Board recruitment Annual FFPT declarations by Board/Governors
G5	NHS I guidance	Have regard to NHS I guidance	Code of Governance compliance System Oversight Framework compliance
G6	Systems for compliance with licence conditions	Have systems in place to comply with licence conditions	Outlined in the appendices to this report – App 1
G7	CQC registration	Be registered with the CQC	CQC registration in place
G8	Patient eligibility & selection criteria	Set and apply transparent criteria to determine who can receive health care	Commissioner service specifications
G9	Application of Section 5 – Continuity of Services	States that the Continuity of Services conditions apply where commissioner-requested services are provided	Not applicable
Pricing			
P1	Recording of Information	Record pricing information if required by NHS I	Not required to date.
P2	Provision of Information	Provide information to NHS I	Provision of information via portal
P3	Assurance report on submissions to NHS I	Provide an assurance report re Condition P2 if required by NHS I	Not required to date
P4	Compliance with the National Tariff	Comply with national tariff	There is no national tariff in place for community and mental health contract, where tariffs apply for other areas

	Licence Condition	Condition summary	Evidence for compliance
			these are complied with as demonstrated through reports to commissioners.
P5	Constructive engagement re local tariff modifications	Engage with local commissioners re tariff modifications	Agreements in place with Gloucestershire CCG re price tariff. Regular monthly meetings take place where performance reports are presented and discussed.
Choice & competition			
C1	Patients' right of choice	Patient notified of choice of provider	Not applicable to Mental health Services In place other services as required. During Covid-19 any limitations on Patients' right of choice were in line with NHSE and NHSI direction
C2	Competition oversight	Not to restrict or distort competition	Legal advice obtained where appropriate when bidding for services/entering partnerships.
Integrated care			
IC1	Provision of integrated care	Not to act detrimentally to the provision of integrated care	Collaborative working within the One Gloucestershire system Participant in two provider collaborative – Thames Valley and Southwest Member of all ILP and on Personalised Care Board.
Continuity of services			
CoS1	Continuing provision of Commissioner Requested Services	Continue to provide CRS as specified except in certain circumstances eg with Commissioner agreement	Not applicable as Trust does not provide Commissioner Requested Services
CoS2	Restriction on the disposal of assets	Not to dispose of any asset without written consent from NHS I	No assets disposed of that provide Commissioner Requested Services
CoS3	Standards of corporate governance and financial management	Apply suitable systems of corporate and financial governance	See evidence in Appendix 1 of this report
CoS4	Undertaking from the ultimate controller	Undertaking from any parent company not to cause a breach of the provider licence	Not applicable
CoS5	Risk pool levy	To pay a risk pool levy to NHS I	Not applicable
CoS6	Cooperation in the event of financial stress	To co-operate with the NHS I and others in the event of financial stress	Not applicable

	Licence Condition	Condition summary	Evidence for compliance
CoS7	Availability of resources	Ensure and certify the availability of financial, physical and human resources for the next 12 months	Not applicable as Trust does not provide Commissioner Requested Services
NHS Foundation Trust Conditions			
FT1	Information to update the register of Ft's	Provision of certain documents to NHS I	Provision of annual accounts and annual report Provision of current version of the constitution Updates regarding relevant Board and Lead Governor changes
FT2	Payment to NHS I in respect of registration and related costs	Payment of a licence fee to NHS I	Not applicable
FT3	Provision of information to advisory panel	Provision of any information requested by an advisory panel	Not applicable – no information requested
FT4	NHS FT governance arrangements	Apply and certify appropriate systems and processes for good corporate governance	Internal Audit reports Head of Internal Audit opinion External Audit

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Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 17/0522

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 May 2022**

PRESENTED BY: Angela Potter, Director of Strategies and Partnership

AUTHOR: Angela Potter, Director of Strategies and Partnership

SUBJECT: **WORKING TOGETHER ADVISORY GROUP**

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

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

The purpose of this report is to:

Present the Working Together Advisory Group (WTAG) Terms of Reference for endorsement by the Board and provide an update on the inaugural meeting of the group that took place in April 2022.

Recommendations and decisions required

The Board is asked to:

- **Endorse** the Terms of Reference for the Working Together Advisory Group.
- **Note** the discussions that took place at the inaugural meeting

Executive summary

The Working Together Plan was approved by the Trust Board in January 2022 and sets out our approach to ensuring we have a culture that enables working with people using our services, carers, families and the communities we serve to become the normal way our Trust does business and provides quality care.

A key part of the embedding and ongoing development of this approach is the creation of a Working Together Advisory Group, chaired by a Non-Executive Director and reporting directly to the Trust Board. This is not a standard Board Committee, but is a key partnership forum that enables our service users and stakeholders to be our critical friends and provides a forum for the ongoing

development of this important agenda. The Terms of Reference (ToR) for the Group were approved at its inaugural meeting on the 21st April 2022 and are presented here for endorsement. The ToR have been also been developed in plain English to ensure inclusivity.

The Group's first meeting enabled an energised and passionate conversation around how we will take forward the future approach for this work. We were pleased to have strong support from our experts by experience and external stakeholders who gave good insight and challenge to our discussions.

It is clear that there are a number of links to be made into our future improvement and transformation work; our developing personalisation work and importantly into the locality work taking place at Integrated Locality Partnership and Primary Care Network level. Consideration is also being given as to what training the group may need to further develop our understanding and knowledge in how to take forward co-production and engage and include people across our work.

The Group recognised that the meetings need to be open and inclusive, but that there also needed to be a balance with the size of the Advisory Group attendance. It was suggested that holding potentially bi-annual wider partnership events to seek wider engagement and views would be one way that we could bridge the balance. It was also acknowledged that holding meetings out in community venues would be a further way to reach out into our communities and we would alternate this with digital sessions to again enable as inclusive an approach as possible.

Risks associated with meeting the Trust's values

None.

Corporate considerations	
Quality Implications	The Working Together Plan sets out how the Trust will achieve its strategic aims and ambitions for sustainability. It presents a real opportunity for the Trust to improve the quality of our services and experience of people and communities we serve.
Resource Implications	N/A
Equality Implications	The Working Together Advisory Group will be a key link into the One Gloucestershire Integrated Care System engagement approach and enable us to support addressing inequalities and health priorities by working with the people and local communities we serve.

Where has this issue been discussed before?

Appendices:	Appendix 1 Terms of Reference Working Together Advisory Group

Report authorised by: Angela Potter	Title: Director Strategy and Partnership

Appendix 1

TERMS OF REFERENCE

Working Together Advisory Group

1.	**Purpose and Goal**
1.1	The Working Together Advisory Group has been set up to advise, influence and organise the Trust's work as it carries out the GHC Working Together plan. The Working Together Advisory Group reports to the Trust Board. Our goal is **to have a culture of working together with the people and communities we serve throughout the Trust**
2.	**Membership**
2.1	**The members of the Working Together Advisory Group are:** • 2 Non-Executive Directors, 1 NED the Chair of the Group • Director of Strategy and Partnerships (*Executive Lead*) (or a nominated deputy) • Director of Nursing Therapies and Quality (or a nominated deputy) • Chief Operating Officer (or a nominated deputy) • Governor representatives • Expert by Experience (EbyE) representatives • Children & Young People EbyE representative **The following people will be invited to the meetings of the Group:** • Service Development Managers • Partnership and Inclusion Manager • Head of Corporate Governance/Assistant Trust Secretary • Associate Director – Quality Improvement • Associate Director – Quality • Head of Transformation • Head of Communications External partners advisers: • Healthwatch Gloucestershire rep • Inclusion Gloucestershire rep
2.2	Other Trust Officers may come to meetings, if the Advisory Group Chair agrees. For instance, these people might be Service Directors, or work in Finance. Any member of the Trust Board may come to the meetings.
3.	**Quorum**
3.1	A quorum is the smallest number of members who must be at a meeting to make decisions. The quorum for the Working Together Advisory Group is 3. At least 1 of these members must be a Non-Executive Director. At least 1 must be an Executive Director.

	If a member is unable to come to a meeting of the Advisory Group, they can nominate someone as a deputy to come in their place, provided the Chair agrees. This deputy can count towards the quorum.
4.	**Reporting Arrangements**
4.1	The Working Together Advisory Group will give an update at each routine Board meeting. It will report on its activity, telling the Board about any recommendations it has made and any progress with issues. It will let the Board know if there are any issues that the Board needs to consider or make decisions about.
4.2	The Advisory Group will let the Membership and Engagement Committee and Quality Committee know if there are any issues that these committees need to consider or make decisions about.
5.	**Powers**
5.1	This is an advisory group. It has no delegated powers from the Trust Board.
6	**Responsibilities**
6.1	The Group will advise the Board on the way the Trust involves and includes people in its work, including progress with carrying out the Working Together plan. Key roles and duties of the Advisory Group are to: • Lead in carrying out the Working Together plan to make sure that patients, carers and members of the community have a say in designing services, checking services, improving services, changing services, and other Trust activities • Develop ways to assess how much we involve and include people and measure our progress, and identify our strengths and weaknesses • Develop ways to collect feedback and hear updates from other groups and forums • Arrange training and development so everyone can learn about working together, to create a shared understanding and culture • Help improve the way the Trust communicates with people to meet their own needs and requirements • Develop new ways to involve a broader range of people in our work, as Experts by Experience, Trust members, volunteers, and Peer Support Workers • Promote our 10 principles for involving and engaging people and communities, and make sure they are used throughout the Trust • Help us to understand how to link with and work with people from different backgrounds so everyone feels welcome, to improve the Trust's work to reduce inequality and inequity and to provide services that are appropriate • Improve knowledge about different groups and the way that we communicate with them, to help the Board connect with them • Work with the ICS to improve personalisation • Receive updates from GHC Locality Partnership Groups, Membership and Engagement Committee and Quality forums. Report on these updates to the Board, to let it know about the way people and communities are being involved • Work with Gloucestershire Integrated Care System to promote involvement and co-production

	• Make sure that we listen to partner organisations • Improve the ways we get feedback about services and plans from patients and other people • Write an annual report for the Trust Board about our progress and celebrating the things we are doing well
7.	**Frequency and Review of Meetings**
7.1	The Working Together Advisory Group will usually meet 4 times a year. The Chair may agree further meetings if necessary. Virtual meetings may take place using appropriate electronic methods, if the Chair agrees.
7.2	These Terms of Reference will be reviewed once a year. If there are any changes, these will be recommended to the Trust Board for approval following approval by the Working Together Advisory Group. Once a year, the Group will assess how effective it has been in carrying out its duties
8.	**Administration (TBC)**
8.1	The Trust Secretary will make sure that the Advisory Group has support from an administrator.
8.2	Each year, the Advisory Group will agree an annual plan. This plan will set out the things which will be discussed at each meeting. This will include the work of any sub-groups it sets up, and how often they will report back to the main Advisory Group.

Version:	**Date Approved:**	**Approved by:**
Version 1.1 Draft	09/12/21	
Version 1.2 Draft	23/02/22	

The Working Together Advisory Group

The purpose of the Working Together Advisory Group

	Gloucestershire Health and Care NHS Foundation Trust wants to work together with the people we serve. We want this to happen in all our services.
	We have made a Working Together plan.
	The Working Together Advisory Group helps our Trust Board, by advising ways to make the plan happen.

The membership of the Working Together Advisory Group

	The members of the group are: • 2 Non-Executive Directors from the Trust • 3 Executive Directors from the Trust • Governors from the Trust • Experts by Experience, including children and young people
	The chairperson is a Non-Executive Director from the Trust.
	The Working Together Advisory Group can make decisions if at least 3 members are present. 1 member must be a Non-Executive Director, and 1 member must be an Executive Director. If at least 3 members are present, this is called a quorum.

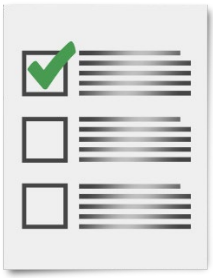
Working Together Advisory Group meetings

	The Working Together Advisory Group usually meets 4 times a year. The Chairperson might arrange extra meetings.
 	The meetings might be online, or they might be in a room. The Chairperson decides whether the meeting will be online or in a room.
	Each year, the Working Together Advisory Group agrees an annual plan. This plan sets out the things that will be discussed at each meeting.
	After each meeting, the Working Together Advisory Group tells the Trust Board about its discussions. It makes recommendations. It suggests things that the Trust Board should consider or make decisions about.

The duties of the Working Together Advisory Group

	The Working Together Advisory Group advises us on the way that we involve and include people in our work. The duties of the Advisory Group are to:

	• Make sure that patients, carers and other people in the community have a say in
	  ○ new services
	  ○ checking services
	  ○ improving services
	  ○ changes to services

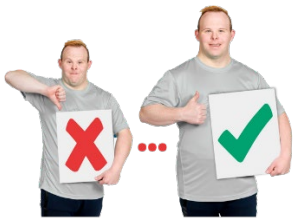
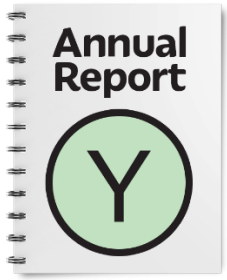
	• Develop ways to assess how much we involve and include people and measure our progress • Identify our strengths and weaknesses
	• Arrange training and development so everyone can learn about working together
	• Help improve the way we communicate with people to meet their needs and requirements

	• Develop new ways to involve more people in our work, as
	  ○ Experts by Experience
	  ○ Trust members
	  ○ Volunteers
	  ○ Peer Support Workers

	• Promote our 10 principles for involving and engaging people
	• Help us to understand how to link with people from different backgrounds so everyone feels welcome
	• Help us get to know about different groups and communicate with them
	• Work with Gloucestershire Integrated Care System to improve personalisation

The role of the Working Together Advisory Group

	• Receive updates from our
	  ○ Locality Partnership Groups
	  ○ Membership and Engagement Committee
	  ○ Quality forums

	• Work with Gloucestershire Integrated Care System to promote involvement and co-production
	• Make sure that we listen to partner organisations
	• Improve the ways we get feedback about services and plans from patients and other people
	• Write an annual report for the Trust Board about our progress and celebrating the things we are doing well

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AGENDA ITEM: 18/0522

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 May 2022**

PRESENTED BY: Lavinia Rowsell, Head of Corporate Governance/Trust Secretary

AUTHOR: Anna Hilditch, Assistant Trust Secretary

SUBJECT: **USE OF THE TRUST SEAL 2021/22**

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

The purpose of this report is to:

To provide information to the Trust Board on the use of the Trust Seal, as required by the Trust's Standing Orders, reference section 7.3.

Recommendations and decisions required

The Board is asked to **note** the use of the Trust seal for the period 2021/22 (1st April 2021 – 31st March 2022).

Executive summary

The Trust's Standing Orders require that use of the Trust's Seal be reported to the Trust Board at regular intervals. The common Seal of the Trust is primarily used to seal legal documents such as transfers of land and lease agreements. Up to the 31 March 2022, the seal has been used eight times.

Risks associated with meeting the Trust's values

All actions have been taken in accordance with the Trust Board's Scheme of Delegation and no inherent risks are to be reported to the Trust Board in the application of the Corporate Seal.

Corporate considerations	
Quality Implications	Nil
Resource Implications	Nil
Equality Implications	Nil

Where has this issue been discussed before?

Appendices:	Appendix 1: Register of Seals (1 April 2021 – 31 March 2022)

Report authorised by: Lavinia Rowsell	**Title:** Head of Corporate Governance/Trust Secretary

APPENDIX 1

Gloucestershire Health and Care NHS Foundation Trust

Register of Seals – 1st April 2021 – 31st March 2022

- Q1 & Q2 – 1st April 2021 to 30th September 2021 – 0 documents signed/sealed

Q3 – 1st October 2021 – 31st December 2021 – 4 documents signed/sealed

Seal No.	Date of Sealing	Document Description	No. of Copies	Document Signatory (1)	Document Signatory (2)	Attested by	Attested Date
19/2021	14/10/21	**Licence** between ABGP1 Ltd and ABTGP2 Ltd and GHCNHST to carry out works relating to part first floor, building 1380 – **Montpellier Court**, Gloucester Business Park	1	Paul Roberts CEO	John Trevains Director of Nursing, Quality and Therapies	Lavinia Rowsell Trust Secretary	14/10/2021
20/2021	18/11/21	**TR1 – Transferor** - Cinderford Town Council **Forest of Dean Hospital** - Steam Mills Recreation Field Deed of transfer	1	Paul Roberts CEO	Sandra Betney Director Finance / Deputy CEO	Lavinia Rowsell Trust Secretary	18/11/2021
21/2021	18/11/21	**TR1 – HM Land Registry** - Cinderford Town Council Recreation Ground at **Steam Mills Road, Cinderford** and freehold land adjoining the property	1	Sandra Betney Director of Finance and Deputy CEO	John Trevains Director of Nursing, Quality and Therapies	Anna Hilditch Assistant Trust Secretary	18/11/2021
22/2022	30/11/21	**Licence Agreement** between Chaleworth Ltd & GHCNHSFT for alterations to 2 Southgate Moorings, Southgate Street, Gloucester Docks, Gloucester	1	Sandra Betney Director of Finance and Deputy CEO	Neil Savage Director of HR & OD	Louise Moss Deputy Trust Secretary	30/11/2021

Q4 - 1st January 2022 – 31 March 2022 – 4 x documents signed/sealed

Seal No.	Date of Sealing	Document Description	No. of Copies	Document Signatory (1)	Document Signatory (2)	Attested by	Attested Date
23/2022	16/02/22	**Counterpart Lease** between Loxton Developments Ltd and GHCNHSFT re **suite 3A, Eastgate House, Gloucester.** ***Background:*** *The premises is to accommodate IAPT services and a second team. The lease term is 15 years.*	1	John Trevains Director of Nursing, Quality and Therapies	David Noyes Chief Operating Officer	Lavinia Rowsell Trust Secretary	16/02/2022
24/2022	16/02/22	**Floor plans** (signed and sealed) between Loxton Developments Ltd and GHCNHSFT re **suite 3A, Eastgate House, Gloucester.** ***Background:*** *The premises is to accommodate IAPT services and a second team. The lease term is 15 years.*	1	John Trevains Director of Nursing, Quality and Therapies	David Noyes Chief Operating Officer	Anna Hilditch Assistant Trust Secretary	16/02/2022
25/2022	21/03/22	**Deed of Release of Restricted Covenant** between The Secretary of State for Environment Food and Rural Affairs and GHCNHSFT re **Cinderford Skate Park, 1 Steam Mills Road, Cinderford, GL14 3HY**	1	John Trevains Director of Nursing, Quality and Therapies	David Noyes Chief Operating Officer	Anna Hilditch Assistant Trust Secretary	21/03/2022
26/2022	21/03/22	**Renewal Lease including Plans** – Assura Properties UK Ltd between re GHCNSHFT re **St Pauls Medical Centre, 121 Swindon Road, Cheltenham**	1	John Trevains Director of Nursing, Quality and Therapies	David Noyes Chief Operating Officer	Anna Hilditch Assistant Trust Secretary	21/03/2022

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING

Wednesday, 16 March 2022
via Microsoft Teams
MINUTES

PRESENT:	Ingrid Barker (Chair)	Nic Matthews	Graham Hewitt
	Kizzy Kukreja	Said Hansdot	Mervyn Dawe
	Julie Clatworthy	Sarah Nicholson	Ruth McShane
	Paul Winterbottom	Jenny Hincks (Part)	Dan Brookes
	Rebecca Halifax	Laura Bailey	Steve Lydon

IN ATTENDANCE: Steve Alvis, Non-Executive Director
Sandra Betney, Director of Finance (Items 11 & 12)
Steve Brittan, Non-Executive Director
Marcia Gallagher, Non-Executive Director
Anna Hilditch, Assistant Trust Secretary
Jan Marriott, Non-Executive Director
Kate Nelmes, Head of Communications
Paul Roberts, Chief Executive
Graham Russell, Non-Executive Director/Deputy Chair
Neil Savage, Director of HR & OD
Gillian Steels, Governance Support
John Trevains, Director of Nursing, Therapies and Quality

1. WELCOMES AND APOLOGIES

1.1 Ingrid Barker welcomed colleagues to the meeting.

1.2 Apologies had been received from the following Governors: Chris Witham, Juanita Paris, Tracey Thomas, Erin Murray and Karen Bennett.

1.3 Ingrid Barker welcomed Steve Lydon to his first Council of Governors meeting. Steve had been elected as a Public Governor representing Stroud and had commenced in post on 15 February.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes from the previous meeting held on 10 November 2021 were agreed as a correct record, subject to the following amendment:

7.4 - *Nic Matthews said that feedback received from the September 2021 People Pulse Survey had indicated that some colleagues felt* that they lacked confidence that speaking up processes were confidential and suggested that further work to address these concerns could be considered.

4. MATTERS ARISING AND ACTION POINTS

4.1 The actions from the previous meeting were either complete, on-going or included on this meeting's agenda.

4.2 Graham Hewitt suggested that an action from the previous meeting had not been picked up. This related to the formalising of the Governor Activity item and the provision of a template for Governors to complete in advance of Council meetings highlighting their attendance and engagement at events and meetings. Anna Hilditch advised that due to standing down the majority of engagement activities since December due to Covid it was not felt that Governors would have had the opportunity to participate in any events and there would be limited activity to report back on this occasion. However, it was noted that work was underway to get the engagement schedule back up and running and the formal template would be issued in advance of the May meeting.

5. CHAIR'S REPORT

5.1 The Council received the Chair's Report, which outlined the key activities of the Trust Chair and Non-Executive Directors up to January 2022. It was noted that this report had been presented in full to the Trust Board at its meeting on 27th January.

5.2 Ingrid Barker informed the Council that it continued to be a very busy time but that her report demonstrated that some great work was taking place, both within GHC and with wider system partners.

5.3 The Council was informed that Clive Chadhani, Non-Executive Director had resigned from the Board effective from 1 March 2022. Clive's work commitments meant that he would be required to relocate to Canada, and on this basis, he would be unable to carry out the required duties of a Non-Executive Director. It was noted that this decision had been discussed with members of the Nominations and Remuneration Committee. Work had already commenced to recruit to this vacant NED position and an update would be provided later in the meeting via the Nominations and Remuneration Committee summary report.

5.4 A number of Board development sessions had taken place over the past few months, focussing on Risk and Strategy. The Board also received a session on Place and Underserved Communities which had been excellent.

5.5 Nic Matthews asked for further information about the Gloucestershire Anchor Institutions Programme, an event that Ingrid Barker had attended in December. It was noted that this is an independent research programme championing the radical improvement of public services using locality-driven, joined-up approaches. This work has led to the development of a 'Playbook' for taking forward place-based solutions to address the causes of poor population health that often transcend the NHS. This programme will aim to develop consensus on a blueprint for action by anchor organisations to prevent further widening of health inequalities and towards improving local population health and supporting economic recovery and sustainability. Ingrid Barker said that GHC had a real role to play as part of this programme and Angela Potter would be the Executive Lead for the Trust.

5.6 Mervyn Dawe commended the Trust on its forward thinking and support for the situation in the Ukraine, noting that Listening Events had been taking place and offers of support had been given to those colleagues affected.

6. CHIEF EXECUTIVE'S REPORT

6.1 Paul Roberts provided the Council with a verbal update on key news and developments.

6.2 There remained huge pressures in the system, with an upsurge in demand for services. There was a knock-on impact on system flow with people discharged from the acute trust, into community hospitals with GHC and onwards into the social care system where delays were being seen. It was noted that 30% of community hospital beds were occupied by people who were ready to be discharged. Steve Lydon said that he would welcome a more detailed briefing to help understand the current picture around system flow and pressures. **ACTION**

6.3 An increase in demand for mental health services was highlighted, with referrals at a record high, in particular for Children and Young People's services and eating disorder services. Paul Roberts said that the Trust was looking at ways to support colleagues, including measures to speed up recruitment processes, reviewing bank staff and offering incentives. The Trust was very mindful of the continued pressure on staff at this time.

6.4 Covid continued to have a huge impact on services, with very high rates of infection. This was having an impact on capacity due to high levels of staff sickness.

6.5 Paul Roberts was pleased to announce that planning permission had now been received for the Forest of Dean Community Hospital development which was excellent news.

6.6 Paul Roberts advised that the CQC released its inspection report on the urgent and emergency care services in Gloucestershire on 17 March. As part of this inspection the CQC inspected urgent and emergency care services within GHC and rated them as "Good" in all five domains. Overall, the inspection of our GHC Trust services was very favourable. The report highlights areas of good practice not only in GHC but with and alongside our partners in the county. Paul Roberts said that the Trust was pleased that the inspection team recognised the skills and professionalism of our colleagues who work in our Minor Injury and Illness Units. The inspectors noted that staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them to get better. They also noted good management practices, safe provision of services, and that people could access the service when they needed it and did not have to wait too long for treatment. It was noted that where inspectors identified areas for improvement, the Trust has already or will be implementing the improvements in the very near future.

7. MEMBERSHIP UPDATE REPORT

7.1 The Council received this report which provided an update on Trust membership activity and statistics for the period up to 10 March 2022.

7.2 An overview of Trust membership was presented and included a breakdown of public members by constituency, ethnicity, disability and age profile. The Council was asked to note that public membership data had remained relatively static over the past few years, with little change in the statistics month on month. As of 10 March 2022, the Trust had 5964 Public members, of which 5019 are in Gloucestershire. Of these public members, 2311 receive communication from the Trust via Email.

7.3 Due to a further wave of Covid in November and December, all public engagement activities were temporarily put on hold. However, planning meetings with the Partnership and Inclusion Team have now recommenced and the monthly schedules of engagement events and activities will once again be issued to our Governors. Governors are invited to participate in and attend events, alongside our P&I Team colleagues to promote Trust membership. The schedule would be updated and reissued monthly, with copies also being sent to our Non-Executive Directors.

8. GOVERNOR ENGAGEMENT AND PRE-MEETING REPORT

8.1 Graham Hewitt had kindly chaired the Governor pre-meeting in the absence of the Lead Governor and provided a verbal report back to the Council on the key issues discussed.

8.2 In relation to the Governor Dashboard, Graham said that Governors were keen to receive clear assurances in these difficult times that everything that could be done was being done for patients. There also needed to be a clear process to ensure that the relevant assurances were being sought and received through the NEDs. Marcia Gallagher noted that Governors had access to Board minutes and committee summaries, but the Board carried out very robust discussion and challenge regularly and not always at formal meetings, so it was difficult to evidence this to provide the assurances to Governors those key issues and concerns were being addressed. It was suggested that it would be helpful for a small group of Governors and NEDs to get together and discuss these concerns in more detail and to find a way forward. **ACTION**

9. NOMINATIONS AND REMUNERATION COMMITTEE SUMMARY REPORT

9.1 The purpose of this report was to provide a summary to the Council of Governors of the business conducted at the Nominations and Remuneration Committee, held on 2 March 2022. Mervyn Dawe, Public Governor for Stroud and Member of the N&R Committee presented this report to the Council.

9.2 The Committee received the proposed process for carrying out both the Chair and Non-Executive Director appraisals for 2021/22. The Chair's Appraisal summary would be presented back to the Nominations and Remuneration Committee at its 4 May meeting, with a summary being received by the full Council in May. A final collated outcome report from the NED Appraisals would be presented to the Nominations and Remuneration Committee at its 29 June meeting, with a summary received by the full Council in July. The Committee endorsed the process and timeline for the Chair and NED Appraisals 2021/22.

9.3 As highlighted earlier in the meeting, Clive Chadhani, Non-Executive Director had tendered his resignation from the Board, effective from 1 March 2022. When appointing Clive, it was agreed that, in light of Marcia Gallagher's second term of office concluding in September 2022, and in the absence of another Non-Executive Member of the Board with an appropriate financial qualification and/or experience to take on the role of Chair of the Audit and Assurance Committee, NED recruitment would focus on succession planning in this area. Clive's resignation had provided the opportunity to review the requirements of this NED vacancy. The current NED cohort had a broad range of skills, including business, commercial, clinical and third sector experience with no immediate areas of weakness identified as demonstrated by the skills audit that had been carried out and presented to the Committee in October 2021. Following an initial discussion with members of the Board, it was proposed that the process commence to appoint a new NED against a generic role description rather than seeking a specific skill set. Applications from a diverse range of candidates would be positively sought.

9.4 Marcia Gallagher's term of office is due to end on 30 September 2022. The Trust Chair, Ingrid Barker will be coming to the end of her term in December 2023 and the recruitment process to find a successor would need to commence in May 2023. Ensuring the Trust has a strong Chair is a business-critical matter. To ensure continuation, it was proposed that Marcia Gallagher's term of office be extended to oversee the Chair appointment process in 2023, and for continuity at SID level for transition to the new Chair. The Trust constitution has a provision that states that NEDs can have their terms extended in exceptional circumstances and it is felt that having robust oversight of the Chair appointment by an experienced NED is crucial. Extending Marcia Gallagher's term would also ensure that the Trust retains expert leadership as Chair of the Audit & Assurance Committee. As highlighted above, the Trust actively sought a NED with the financial qualifications and experience to become the new Audit Committee Chair following Marcia's scheduled departure. However, with Marcia having her term extended to September 2024 the urgent need for this like for like replacement is no longer required, and the Trust will seek to commence recruitment to this position in early 2024, ensuring sufficient time is given to allow for an appropriate handover. The Committee agreed that Marcia Gallagher had a wealth of knowledge and experience as a NED and Senior Independent Director, and this was expertise that the Trust needed to retain to oversee the recruitment of a new Trust Chair. In line with the constitution the Committee fully supported and endorsed the proposed extension of Marcia's term of office by 2 years to 30 September 2024. It was noted that this extension would be subject to annual reappointment, with a full review of independence carried out. **The Council of Governors approved the extension of Marcia Gallagher.**

9.5 The Committee also endorsed the proposed approach to recruiting for a new NED, seeking candidates using an open and generic brief rather than seeking a specific skill set. It was hoped that recruitment would commence from 1 April.

9.6 The Committee received a proposal around the appointment of two Associate NEDs. The Board were supportive of the approach to developing Associate NED positions, however, more work was needed to consider the required time commitment and remuneration for these positions. It was suggested that it would be sensible to wait until the substantive NED vacancy has been filled and the Trust could carry out a further assessment of those specific skills and expertise that would be beneficial to the Board before advertising the positions. The Committee endorsed the appointment of Associate NEDs in principle, accepting that more work would be carried out to confirm the detail, including skill set, time commitment and remuneration.

9.7 The Committee also discussed and considered whether it would wish to create a formal Deputy Lead Governor role at GHC moving forward. Committee members agreed that a Deputy Lead Governor would be helpful to provide cover in times of sickness, capacity or potential conflicts of interest. It was agreed however, that the deputy should have a specific role in itself, not simply a deputising position. A proposal for what this role would entail would be created and shared at the next meeting.

10. GOVERNOR DASHBOARD

10.1 The Governors received the Governor Dashboard, presenting data up to 30 January 2022. The purpose of this dashboard was to provide a high-level overview on the performance of the Trust through the work of the Board and Committees, with particular focus on the core responsibilities of governors in holding the NEDs to account for the performance of the Board.

10.2 Kizzy Kukreja noted that appraisal compliance still remained low and one of the factors for this related to recording issues on ESR. She asked whether this had now been rectified as assurance was needed that staff were not missing more than one appraisal. Neil Savage said that huge strides had been made around the workforce indicators, with Statutory and Mandatory training now achieving 92%. There was more work required to ensure that all appraisals and attendance at training was properly recorded however, and the Great Place to Work Committee would be focussing on this at its upcoming meeting.

10.3 Graham Hewitt noted the increased level of demand and access to eating disorder and CAMHS Services. This had been discussed earlier in the meeting, where record levels of referrals had been seen for these services. Assurance was received that detailed monitoring and scrutiny took place at each of the Resources Committee meetings.

10.4 The Council of Governors were informed that the Government had revoked vaccination as a condition of deployment (VCOD) in all health and social care settings in England. This followed a reconsideration by the Government and consultation across health and social care. The amended regulations would come into force on 15 March 2022. Neil Savage informed the Council that this had not been an easy process and had taken a huge amount of time and energy from colleagues. Colleagues impacted by the decision would be supported as it had been a challenging time.

10.5 Paul Winterbottom noted that the Trust's vacancy rate had started to increase, and he asked about the Trust's workforce strategy. Ingrid Barker said that recruitment and retention was currently the Trust's top risk and a huge amount of work had taken place to review vacancies and identify key hot spot areas. It was suggested that it would be helpful for Governors to receive a copy of the Trust's latest Risk Register and Board Assurance Framework which provided a summary of the key risks and the mitigations and actions in place. **ACTION**

11. EXTERNAL AUDIT CONTRACT

11.1 Sandra Betney was in attendance to present this report which set out the evaluation process and role of the Council of Governors in the appointment of the Trust External Auditors.

11.2 KPMG LLP were originally appointed as the Trust's external auditor by the 2gether Council of Governors from 1 April 2017, following a competitive procurement process overseen by an Audit Committee working group on which Governors were in the majority. Two extension options have since been enacted and the current contract was due to end on the 31 March 2022. To provide continuity of audit services, whilst reducing the admin burden of a lengthy procurement process on all parties, it was recommended to make a direct award to KPMG through the use of a framework contract. An Audit and Assurance Committee evaluation expressed a strong level of satisfaction with KPMG's performance and it was decided to offer a further two-year contract to KPMG. This would be done whilst also undertaking an evaluation of their proposal to ensure it met value for money considerations.

11.3 The Council of Governors considered the outcome of this evaluation, noting that Mervyn Dawe and Graham Hewitt had represented the Council on the evaluation panel. The Council approved the appointment of KPMG, with the new contract commencing on 1st April 2022 for a period of two years.

12. TRUST BUSINESS PLANNING PROCESS 2022/23

12.1 The purpose of this paper was to set out the Business Planning approach for 2022/23 to ensure the Council of Governors are appropriately involved in the process and have an opportunity to give views for Board consideration.

12.2 Business planning for 2022/23 was launched against the backdrop of recovery from Covid. As a result the business planning approach was slightly delayed but continued to be developed in alignment with our internal annual business planning and budget setting cycle.

12.3 A business planning refresh is proposed at the 6 month mid-point to allow for further national guidance and in-year changes.

12.4 The business plan is key to the delivery of the Trust Strategy and the business planning structure is underpinned by the agreed strategic aims linked to each business planning objective. Directorates and Teams are currently agreeing their business planning objectives with their Executive Leads as part of the final stages of the business planning process for 2022/23.

12.5 Nic Matthews asked for assurance that the Heads of Profession had been consulted on service level performance workforce planning. Sandra Betney said that she would fully expect them to be involved and the Trust tries to make the business planning process clear and inclusive.

12.6 The Council of Governors noted this report and thanked Sandra Betney for providing the opportunity to offer feedback.

13. HOLDING TO ACCOUNT PRESENTATION

13.1 The Council received a HTA presentation from Steve Brittan, Non-Executive Director and Chair of the Forest of Dean Assurance Committee.

13.2 Steve Brittan explained that the FoD Assurance Committee was a special purpose Committee that had been established in March 2021 to provide detailed scrutiny and assurance to the Board in respect of the FoD Hospital building programme. Steve was joined on the Committee by fellow NEDs Graham Russell and Steve Alvis. Angela Potter was the Lead Executive.

13.3 The Council noted that the detailed design had been signed off by service user leads and the Full Business Case was approved by the Trust and all necessary regional approvals had been received. Full planning permission was obtained on 8 March 2022 and enabling works were now underway. The completion date for the hospital build was expected to be November 2023. The hospital design had received a BREEAM “excellent” Rating.

13.4 The main challenges of the project had been inflation, critical labour shortages and time. The Committee would continue to meet regularly to review these point, and advise the Board on its opinion of forward risks to completion.

13.5 Steve Lydon made reference to the delays to the project due to Highways, and asked whether feedback would be provided to them about the impact of these delays. Steve Brittan agreed that the delays had been unfortunate and had put risk into other elements of the project.

13.6 Mervyn Dawe noted that the hospital design included single rooms for patients. Whilst this was good for infection control and privacy and dignity compliance, he said that some people could feel isolated. The Council was informed that each room would have a built-in audio-visual screen so patients could speak to their families at any time.

13.7 Mervyn Dawe asked what the Trust would now do with the 2 existing hospital sites at the Dilke and Lydney. Steve Brittan said that 2 existing sites were programmed for disposal; however, the Trust wanted to do this with social value and to work with partners to develop the sites for the greater benefit of the communities. They had both been classed as assets of community interest. Ingrid Barker added that there was a real strength of public feeling for the Dilke and Lydney hospitals and the Trust was mindful of this.

13.8 Paul Winterbottom asked whether the hospital design had been considered for all client groups, including mental health, noting that having a first floor with balcony access may not be a suitable environment. Steve Brittan advised that the design and floor plans had been shared and consulted upon with a range of Trust colleagues and external stakeholders; however, he agreed to seek a fuller response for assurance purposes. **ACTION**

13.9 Kizzy Kukreja expressed her thanks and congratulations to Steve Brittan and all of those involved for all of the hard work, engagement, oversight and scrutiny that had taken place to get to this point.

13.10 The Council of Governors thanked Steve Brittan for his presentation and for providing assurance on the role of the Forest of Dean Assurance Committee.

14. CQC COMMUNITY MH PATIENT SURVEY RESULTS 2021

14.1 The Council received the CQC Community Mental Health Survey results and action plan, which provided a summary of the results of the 2021 survey; along with assurance that the results of the national survey have been used to identify areas of focus for practice development activity over the next 12 months.

14.2 The results received had been similar to those of previous years and the Trust was categorised as performing 'better' than most of the other mental health trusts in 5 of the 12 domains; and that the Trust remained in the top 20% performing trusts in most of the domains 9 out of 12.

14.3 The Council noted that some questions on the survey had performed weaker than previously. This had been expected due to covid related circumstances and was seen across the System.

14.4 John Trevains advised that overall the results were positive. There were some areas identified where the Trust would look to improve and the action plan was now in place.

14.5 Ruth McShane said that she would welcome the opportunity to review the results in more detail and it was agreed that a meeting would be arranged for her to meet John Trevains and Jan Marriott. **ACTION**

15. QUALITY UPDATE

15.1 The Council welcomed James Wright and Jane Stewart who were in attendance to provide an update to the Council on quality priorities and the process for producing this

year's Quality Account. It was noted that a more detailed update would be presented back at the May Council of Governors meeting.

16. COUNCIL OF GOVERNOR MEMBERSHIP AND ELECTION UPDATE

16.1 The Council received and noted this report which provided an update on changes to the membership of the Council of Governors and an update on progress with upcoming Governor elections.

17. GOVERNOR ACTIVITY UPDATE

17.1 There were no further updates provided. As discussed earlier in the meeting, the process for capturing Governor engagement activities and attendance at events would be formalised, with a template being sent out for Governors to complete in advance of future meetings. A report would then be presented at the meeting for the record. This would commence for the May Council meeting.

18. ANY OTHER BUSINESS

18.1 The Council of Governors noted that the programme had now been published for the NHSP Annual Governor Focus conference taking place virtually on 5-7 July. An email would be sent out to all Governors inviting attendance.

19. DATE OF NEXT MEETING

19.1 The next meeting would take place on Wednesday 18 May 2022 at 2.00pm.

20. PRIVATE SESSION BUSINESS

20.1 The Council of Governors received and approved the minutes from the Private session Council meeting that took place on 10 November.

COUNCIL OF GOVERNORS
ACTIONS

Item	Action	Lead	Progress
16 March 2022			
6.2	Briefing to help understand the current picture around system flow and pressures to be prepared for Governors	Trust Secretariat / Ops Team	Short update on system flow included in Governor Dashboard.
8.2	A small group of Governors and NEDs to get together and discuss the issue of seeking assurance from the NEDs in more detail and to find a way forward	Trust Secretariat	Meeting to be arranged in due course. Revised guidance and Code of Governance expected to be published later in the year which will help to inform discussion. Consultation on this to be launched at NHSP Governance Conference on 10 May.
10.5	It was suggested that it would be helpful for Governors to receive a copy of the Trust's latest Risk Register and Board Assurance Framework which provided a summary of the key risks and the mitigations and actions in place.	Trust Secretariat	Copy of Board Assurance Framework circulated to Governors with meeting papers
13.8	Steve Brittan agreed to seek a fuller response as to whether the Forest hospital design had been considered for all client groups, including mental health patients, for assurance purposes.	Steve Brittan	*"All service areas were designed with full input from the relevant clinical teams for their current intended use and were then tested out with a range of trust wide experts which included our Dementia nurses, infection control team, security colleagues and a number of Experts by Experience and carers thinking through accessibility, wayfinding and travel distances. The facility will also meet the full requirements for a changing places facility. The Forest Voluntary Action Forum also supported with a range of views and inputs into the design.* *As we move into the next stage of detailed design it is our intention to involve these stakeholders and colleagues again in the signage, colour choices etc. to again ensure full accessibility and dementia friendly standards are adhered to."*
14.5	Ruth McShane said that she would welcome the opportunity to review the MH Service User Survey results in more detail and it was agreed that a meeting would be arranged for her to meet John Trevains and Jan Marriott.	Trust Secretariat	Complete.

GREAT PLACE TO WORK COMMITTEE SUMMARY REPORT

DATE OF MEETING 6 April 2022

COMMITTEE GOVERNANCE	• Committee Chair – Graham Russell, Non-Executive Director • Attendance (membership) – 50% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

STAFF STORY

The Committee received a pre-recorded interview with a Trust Physiotherapist, who spoke about her own personal experiences through the Vaccination as a Condition of Deployment (VCOD) process. She was one of the first colleagues in the Trust to go through the VCOD process following her decision not to be vaccinated against covid-19. She spoke about how it made her feel; knowing that she faced losing her current job role within the Trust. As a result of the VCOD process, she was left feeling undervalued and unsupported.

The Trust had to comply with the government guidance; however, she felt that the process could have been delivered differently, allowing for additional support and understanding.
Following the change in the government's decision and for the VCOD process to not take place, she felt that there was a missed opportunity by the Trust to reach out to colleagues that would have been affected (like herself) saying that they were pleased not to lose them.

In response, the committee agreed that it was difficult to hear of the colleague's experience and it had raised reflection on the VCOD implementation. It was acknowledged that the process was difficult. The Committee extended their gratitude to the member of staff and thanked her for being so open and honest.

DEEP DIVE – STAFF SURVEY

The Committee received the full and final weighted and benchmarked 2021 Staff Survey results to support a deep dive into the survey findings, themes, and priorities for 2022.

There had been a good response rate to the survey with 2367 completed questionnaires received (response rate of 53%). 60% of questions had been rated with improvements or remained the same. The Trust had scored above average on seven out of the nine Our NHS People Promise themes, but scored below average on '*We work flexibly'* and '*We are a team.*' The Committee was informed of areas where the Trust was performing well. 82.7% of colleagues felt secure in raising concerns and 92% of colleagues felt they were trusted to do their jobs.

Results which had seen a variation of +/- 5% between the 2020 and 2021 results were highlighted as areas for consideration as a parameter for future objectives. The Committee received the initial plan of where the Trust intended to focus and the key actions for each.

HEALTH & WELLBEING STRATEGIC FRAMEWORK (DRAFT)

The Committee received the Health and Wellbeing Strategic Framework. The Health and Wellbeing Strategic Framework provided assurance of the good progress which had been made in developing to support and improve the health and wellbeing of the Trust's workforce

The Committee agreed the draft strategic framework, and, specifically considered and approved the aims, actions ("how") and measures set out. An implementation plan would be developed and shared with the Executive Committee for approval following additional engagement via the Senior Leadership Network, with delivery progress being reported thereafter to GPTW.

RECRUITMENT & RETENTION STRATEGIC FRAMEWORK (DRAFT)

The Committee received the Recruitment and Retention Strategic Framework, which provided an update on the ongoing work in developing the Recruitment and Retention Strategic Framework, which would be a subset of the Trust's wider corporate Strategy and the People Strategy. The framework provided an introduction, an outline of drivers and context, a summary of the proposed strategic approach, and a proposal for the Trust's five prioritised delivery pillars. It also provided a summary of key objectives, actions and a high-level implementation plan.

The Committee **reviewed** the update on the development of the Recruitment and Retention Strategic Framework, and supported the direction of travel outlined in the framework.

OTHER ITEMS RECEIVED

The Committee **received** and **noted** the Performance Report, which provided a high-level view of workforce KPIs across the Trust.
The Committee **received** the Freedom to Speak Up 6 monthly report and was assured that Freedom to Speak Up processes were in place and continued to be utilised by colleagues. The full report would be presented to the May Board meeting.
The Committee **received** and **noted** the Corporate Risk Register.
The Committee **received** and **considered** the Board Assurance Framework (BAF), and **noted** the proposed position for workforce related risks and the extension of the target dates for risks 5 and 6.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	01 June 2022

RESOURCES COMMITTEE SUMMARY REPORT

DATE OF MEETING 28 April 2022

COMMITTEE GOVERNANCE	• Committee Chair – Steve Brittan, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

FINANCE REPORT – MONTH 12

The Committee received the Finance Report for month 12 and was informed that the position received was draft and that the full and audited accounts would be submitted 22 June 2022.
The Committee was informed, in terms of risk moving forward that the agency cost position had been challenging within year. It was noted that part of the agency spend had been driven by covid costs, however, some due to vacancies and also increased acuity, which had required additional staff. This had been previously flagged in the Budget Setting paper at Trust Board. The Committee noted that the agency costs for 2021/22 were £7.769m, which was £2.29 higher than in 2020/21.
It was noted that as a System the exact amount expenditure against CDEL as plan was delivered.
The Committee was informed that the plans were submitted prior in the day reflecting a total £24m deficit across the NHS in Gloucestershire. The Director of Finance reported there were risks to delivering the plan and that the risks needed to be mitigated before committing to reducing the deficit. The Committee was informed that the principle risks were the delivery of the elective recovery and the delivery of CIPs across the System.
The Committee congratulated and thanked the Finance Team for their work and efforts.
The Committee **noted** the month 12 position.

PERFORMANCE REPORT – MONTH 12

The Committee received the Performance Dashboard for month 12, which provided a high-level view of key performance indicators (KPIs) in exception across the Trust.
The Committee was informed that the Perinatal Service had moved from green to red (RAG rating).
The Committee received the KPI breakdown and it was highlighted that IAPT access remained a challenge and recovery was being planned with stakeholders.
Transition from children services to adult services was highlighted within the KPIs. It was noted that it was not a data issue and was an oversight. The narrative was included within the report which confirmed no adverse care concerns had been caused.
The Committee was informed that the 33n patient cohorting tool was being presented to Eating Disorder Services in April 2022 and that the ambition was to use it on a larger scale over both mental health and physical health services.
The Committee noted 18 KPIs reported in exception for Physical Health, and was informed that 11 of these were anticipated data quality issues linked to delayed SystmOne Simplicity project activities.
The Committee noted the new workforce indicator on annual leave taken and services not seeing normal low annual leave carry over.
The Committee **noted** aligned Performance Dashboard Report for March 2021/22 and **acknowledged** the ongoing impact of the pandemic and service recovery on operational performance.

The Committee **noted** the report as a **significant level of assurance** that our contract and regulatory performance measures were being met or that appropriate action plans were being developed to address areas requiring improvement.

BUSINESS PLANNING REPORT – Q4

The Committee received the Business Planning Report which set out the progress made in achieving the business planning objectives for 2021/22 as at the end of quarter 4.
It was reported that only 48 (9%) milestones were not achieved by the end of the year.
The Committee commented that the work achieved was excellent.
The Committee **noted** that the final delivery of the 2021/22 business plan as at the end of quarter 4.

SYSTEM OPERATING PLAN – 22/23 SYSTEM PLAN SUBMISSION

The Committee received the System Operating Plan 2022/23 which sought endorsement on the updated position of the One Gloucestershire 2022/23 Operational Plan.
The Committee was informed that the plan had been submitted earlier in the day (in order to meet the deadline). It was noted that this had been received by the Committee prior to submission to facilitate queries and comments and no comments had been received.
The Committee **endorsed** the System Operating Plan 2022/23.

SERVICE DEVELOPMENT REPORT

The Committee received the Service Development Report which provided an update on the Trust's Service Development activities.
The Committee was informed that the tender for the Sexual Assault Referral Centre and Sexual Offences Examiner service (SARC & SOE) had been successful.
The Committee was informed that following the recent contract extension until July 2023, NHSE had confirmed the School Aged Immunisation contract had been extended for a further year until July 2024. The Trust had also been successful in the bid for additional recovery funding of £141k non-recurrent for 22/23. The Committee **noted** the contents of the report.

OTHER ITEMS RECEIVED & DISCUSSED

The Committee **received** the ICS – Financial Principles
The Committee **received** the Risk Register and **noted** the information and assurance provided.
The Committee **received** and **considered** the Board Assurance Framework (BAF).

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	30 June 2022

QUALITY COMMITTEE SUMMARY REPORT

DATE OF MEETING 05 MAY 2022

COMMITTEE GOVERNANCE	• Committee Chair – Jan Marriott, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

QUALITY DASHBOARD REPORT

The Committee received the Quality Dashboard Report, which provided an overview of the Trust's quality activities for March 2022. Recruitment and retention continued to be a significant risk in terms of impact on quality and work continued to address this.

The work which had been progressed by the outreach vaccination team was highlighted and it was noted that all schools had now been visited by the vaccination team.

Positive feedback had been received from the NED Quality Visits, which had continued despite covid 19 and winter pressures, with consistent examples of respectful, kind and compassionate care demonstrated across the Trust.

The Committee **received, noted** and **discussed** the Quality Dashboard Report.

LEARNING FROM HOSPITAL ACQUIRED COVID 19

The Committee received the Learning from Hospital Acquired Covid 19 Report, which outlined the findings, learning and recommendations from the investigations into hospital acquired COVID-19 between July 2020 and January 2021. The Committee received the Action Plan, which provided an update on progress with actions arising from the recommendations.

The next steps would be to work with ICS partners ensuring that lessons were embedded across the System. The Committee was assured that this work had already began and an update would be brought to a future Committee meeting.

INPATIENT LIGATURE REDUCTION STRATEGY UPDATE

The Committee received the Inpatient Ligature Reduction Strategy update which updated the Committee on refreshed work to provide a Trust corporate level strategy for the areas of work, both planned and currently being undertaken by the Trust to reduce deaths by ligature across all Trust inpatient units.

The framework focussed on the area of ligature reduction which supported the Trust Inpatient Zero Suicide Plan 2021/22 and also supported the overarching Trust Patient Safety Strategy that was being developed in line with the National Patient Safety strategy programme.

The Trust had invested in a nationally recognised anti-ligature door alarm system, which became fully operational at Wotton Lawn in April 2022. The anti-ligature door work in patient bathrooms at Charlton Lane Centre was due to be completed by end of May 2022.

The Committee received an example of the ligature and self-harm dashboards, which were well received. The Committee was pleased to see the Trust's continued actions to identify and mitigate ligature points and the wider work on suicide prevention.

DISTRICT NURSING MODEL – TRUST UPDATE

The Committee welcomed Steven Holmes and Nancy Farr to the meeting who shared the District Nursing Model, providing a report on what it set out to achieve, progress made and what the future plans were. The impact that the pandemic had on the implementing the model and other challenges encountered were highlighted. The presentation was well received.

OTHER ITEMS

The Committee **received** and **noted** the Quality Assurance Group Summary Report.
The Committee **received** the National Community Mental Health Survey, Action Plan update which provided the implementation plan for the actions taken forward from the results of the 2021 CQC National Community Mental Health Survey.
The Committee **received** the Draft Quality Account, which provided an update on activities and targets from the previous year's Account, and setting new objectives for the following year.
The Committee **received** and **reviewed** the Board Assurance Framework and Risk Register, and noted that an Internal Audit on the use of the BAF was currently being undertaken and will inform the further development in 2022/2023
The Committee **received** the Whole Trust Quality Management update, which provided an update on the Quality Governance Management System.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	07 July 2022

MHLS COMMITTEE SUMMARY REPORT
DATE OF MEETING 11 MAY 2022

COMMITTEE GOVERNANCE	• Committee Chair – Sumita Hutchison • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

MENTAL HEALTH ACT REFORMS WHITE PAPER AND THE RISK TO THE TRUST

The Committee received an update on Mental Health Act reforms and their likely significant impact on staffing. A business case is being developed to recruit more staff but until it is approved and the staff are in place, the likely risk to the Trust is significant. In light of this, the committee requested that the Corporate Risk register be amended to highlight risks such as non-compliance with legislation, impact on staff health and wellbeing, patients being unable to have their rights met due to lack of staffing.

UPDATE ON BLACK LIVES MATTER & MENTAL HEALTH

The Committee received an update on Black Lives Matters (BLM) and mental health and was informed that NHSI was currently exploring Gloucestershire being an early adopter site for the Patient and Carer Race Equality Framework.
The Committee **noted** the information provided.

CQC UPDATE

The Committee was informed that CQC had inspected Sexual Health Services in the previous week and feedback received had been positive. No concerns had been raised. It was reported that inspectors were impressed with the high levels of compassion and enthusiasm amongst staff; despite the apparent work pressures.

It was reported key themes explored by inspectors were around rapid tranquilisation and protocols. Ligature points and the door alarm system was also reviewed and processes in supporting patients in regards to the MHA.

MENTAL HEALTH ACT POLICIES

The Committee **endorsed** the Allocation of a Responsible Clinician policy.

OTHER ITEMS RECEIVED & DISCUSSED

The Committee received and noted the:

- Mental Health Activity Report.
- Reports of Issues Arising at MHAM Reviews.
- Corporate Risk Register.
- Review of detention issues and identification lessons learned and actions undertaken.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	20 July 2022

AUDIT & ASSURANCE COMMITTEE SUMMARY REPORT
DATE OF MEETING 12 MAY 2022

COMMITTEE GOVERNANCE	• Committee Chair – Marcia Gallagher, Non-Executive Director • Attendance (membership) – 75% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

INTERNAL AUDIT

PROGRESS REPORT: The Committee received and noted the Internal Audit progress report.

INTERNAL AUDIT REPORTS: The Committee received the following Internal Audit reports:

Internal Audit	Risk rating
Patient and Carer Experience	Low
Recruitment	Low

AUDIT PLAN 2022/2021: The Committee received the draft internal audit plan and a verbal update from the new internal auditors, BDO. The plan would be further developed through discussions with members of the Executive Team and received at the next Audit & Assurance Committee meeting. Further consideration would be given as to the focus of internal audit activity over the next year in relation to recruitment and retention given that this was one of the highest scoring risks on the Board Assurance Framework.

INTERNAL AUDIT ANNUAL REPORT & HEAD OF INTERNAL AUDIT OPINION (2021/2022): The Committee was informed that the Internal Audit Annual Report and Head of Internal Audit Opinion would be received at the next meeting of the Committee.

EXTERNAL AUDIT

PROGRESS REPORT & TECHNICAL UPDATE: The Committee received an update on recent and planned external audit activities. The Committee was informed that the interim audit had been completed and the final audit had commenced. The findings would be brought to the next meeting of the Committee. The finance team were thanked for all their work in preparing the accounts to this point.

COUNTER FRAUD, BRIBERY & CORRUPTION

PROGRESS REPORT: The Committee received and considered the following reports from the Counter Fraud Team.

- *Draft Annual Report for 2021/2022*, which would be finalised and submitted to the Committee in June.
- *The Annual Work-plan for 2022/2023* – a total of 200 days' activity had been agreed for the year. Areas of focus in the work plan reflected the outcome of the 21/22 Counter Fraud Function Standard Return which, of the twelve components; 9 were rated as green, 2 as amber and 1 as red.
- *The outcome of the local proactive exercise report on salary overpayments*. In 21/22 there had been £74k in salary overpayments. The report made a series of recommendations which had been accepted and were being implemented by HR and Finance Directorates. Salary overpayments were now reported as part of the compliance report.
- *A summary of Counter Fraud Activity since 2022.* An update on current investigations was provide. Both recent investigations related to working whilst sick.

DRAFT ANNUAL REPORT

The Committee received and considered the draft Annual Report and noted that the report had been prepared in line with the NHS Foundation Trust Annual Reporting Manual for 2021/22. The draft report would be reviewed by the External Auditors with the final version presented to the June meeting prior to submission.

DRAFT ANNUAL ACCOUNTS (INCLUDING ACCOUNTING POLICY REPORT)

The Committee received the Draft Annual Accounts which showed the draft position of the final accounts for 2021/22. The Committee:

- Noted the reconciliation from the management reported position to the Accounts
- Approved the updates to the Accounting Policies
- Reviewed the draft Accounts
- Endorsed the Trust's assessment of Going Concern and associated disclosures and recommended statements

The main accounting policy change in year was the introduction of IFRS16 leases. The Committee considered the impact of this in 2022/2023 on the Trust and System.

FINANCE COMPLIANCE REPORT

The Committee received the Finance Compliance report which provided an update on actions taken under delegated powers since the last meeting of the Committee. The Director of Finance highlighted the positive work in relation to debtors which had decreased by £2m since M9. Improvements had also been seen in the application of the Better Payment Policy with performance of 90% year to date by value with M12 performance of 96%.

The Committee welcome the inclusion of information on Staff Overpayments. The balance outstanding at 31 March 2022 was £83,679. A communications campaign was underway to highlight the importance of timely completion of variation and leaver forms.

GOVERNANCE COMPLIANCE REPORT

The Committee received the Governance Compliance Report providing assurance on the progress and achievement with meeting the required standards for registers, held and maintained in line with statutory requirements and good practice.

PROVIDER LICENCE DECLARATIONS

The Committee reviewed the required annual provider declarations and agreed to recommend these for the approval of the Board.

OTHER ITEMS RECEIVED BY THE COMMITTEE

- The Committee received and noted the **Board Assurance Framework (BAF)** noting changes since the last review. This included the addition of a new strategic risk on Cyber Security. It was agreed that a summary assurance report on cyber security would be presented to future meetings of the Committee.
- The Board received and noted the **Corporate Risk Register.** It was agreed that consideration be given to the inclusion of a risk relating to the impact of inflation on the capital programme.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	13 June 2022