with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION

Thursday 24 November 2022

10:00 – 13:30

To be held via Microsoft Teams

AGENDA

TIME	Agenda Item	Title	Purpose		Presenter
Opening Business					
10.00	01/1122	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/1122	Declarations of interest	Assurance	Verbal	Chair
10.05	03/1122	Patient Story Presentation *(End of Life Care)*	Assurance	Verbal	DoNTQ
10.25	04/1122	Draft Minutes of the meeting held on 29 September 2022	Approve	**Paper**	Chair
	05/1122	Matters arising and Action Log	Assurance	**Paper**	Chair
10.30	06/1122	Questions from the Public	Assurance	Verbal	Chair
Performance and Patient Experience					
10.40	07/1122	Quality Dashboard Report	Assurance	**Paper**	DoNTQ
11.00	08/11/22	Quality and Safety of Mental Health, Learning Disability and Autism Inpatient services	Assurance	**Paper**	DoNTQ
11.20am - BREAK – 10 Minutes					
11.30	09/1122	Performance Report	Assurance	**Paper**	DoF
11.50	10/1122	Finance Report	Approve	**Paper**	DoF
Strategic Issues					
12.00	11/1122	Report from the Chair	Assurance	**Paper**	Chair
12.10	12/1122	Report from Chief Executive	Assurance	**Paper**	CEO
12.20	13/1122	Systemwide Update	Assurance	**Paper**	DoSP
12.30pm - BREAK – 10 Minutes					
12.40	14/1122	Board Assurance Framework	Assurance	**Paper**	HoCG
12.50	15/1122	Freedom to Speak Up Report	Assurance	**Paper**	FTSU Gdn
Governance					
13.05	16/1122	Changes to Trust Constitution	Approve	**Paper**	HoCG
13.15	17/1122	Use of the Trust Seal – Q1 and Q2	Assurance	**Paper**	HoCG

Board Committee Summary Assurance Reports (Reporting by Exception)					
TO NOTE	18/1122	Great Place to Work Committee (5 October)	Information	**Paper**	GPTW Chair
TO NOTE	19/1122	Working Together Advisory Group (12 October)	Information	**Paper**	WTAG Chair
TO NOTE	20/1122	Mental Health Legislation Scrutiny Committee (19 October)	Information	**Paper**	MHLS Chair
TO NOTE	21/1122	Resources Committee (25 October)	Information	**Paper**	Resource Chair
TO NOTE	22/1122	Quality Committee (3 November)	Information	**Paper**	Quality Chair
TO NOTE	23/1122	Appointments and Terms of Service Committee (9 November)	Information	**Paper**	Trust Chair
13.20	24/1122	Audit and Assurance Committee (10 November) and Terms of Reference	Approve	**Paper**	Audit Chair
TO NOTE	25/11/22	Forest of Dean Assurance Committee	Information	**Paper**	FoD Char
Closing Business					
13.25	26/0922	Any other business	Note	Verbal	Chair
	27/0922	**Date of Next Meetings** **<u>Board Meetings 2023</u>** Thursday 26 January Thursday 30 March Thursday 25 May Thursday 27 July Thursday 28 September Thursday 30 November	Note	Verbal	All

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AGENDA ITEM: 04

MINUTES OF THE TRUST BOARD MEETING

Thursday, 29 September 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
Helen Goodey, Joint Director of Locality Development and Primary Care
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
Amjad Uppal, Medical Director

IN ATTENDANCE:
Ahmed Attia, ST6 Psychiatry Registrar (Shadowing Dr Uppal)
Alan Cole, Trust Governor
Graham Hewitt, Trust Governor
Anna Hilditch, Assistant Trust Secretary
Bob Lloyd-Smith, Healthwatch Gloucestershire
Kate Nelmes, Head of Communications
Lavinia Rowsell, Head of Corporate Governance/Trust Secretary
Jane Russell, PA to Trust Chair and Non-Executive Directors
Hannah Williams, Deputy Director of Nursing and Quality

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting. Apologies had been received from Nicola de Iongh and John Trevains.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. PATIENT STORY PRESENTATION

3.1 The Board welcomed Claire to the meeting. Claire had first presented to the Board in July 2021, so this was a fantastic opportunity to hear about how she had progressed.

3.2 Claire had suffered for much of her life with anxiety, phobia disorders and a chronic skin condition. In September 2020 Claire was referred to the Trust and colleagues from across GHC worked collaboratively to help Claire both with her physical and mental health needs.

Since the Board previously met Claire, she had moved to Honeybourne in Cheltenham, one of the Trust's recovery units.

3.3 With the help of nurses and HCAs Claire had undergone a programme of exposure therapy and psychotherapy, and she said that she was a totally different person. She had been able to overcome many of her fears such as bathing, her fear of heights, and social anxiety. Following an annual health check, Claire was diagnosed with cardiomyopathy but with the help and support of the team she was able to overcome her fear of needles to be able to be successfully treated.

3.4 Claire told the Board about her plans for the future which included a BTEC in training and education via the Recovery College and MH Nurse training. Claire said that her future was looking bright and was working with the Rethink initiative to look at future independent living arrangements, something that Claire said that she felt would never have been possible. Claire was also doing Peer Support training with the Trust and was a volunteer with Cotswold Riding for the Disabled.

3.5 Ingrid Barker led the Board in thanking Claire and congratulated her on the huge progress that she had made over the past year. Ingrid noted that Claire was working with Rethink to look at independent living options and asked about the level of support that would be provided. It was noted that this would be supported accommodation, with an allocated support worker provided by Rethink from 9-5pm. The support package was still to be confirmed, but it was noted that Claire would continue to have a care co-ordinator allocated from the Trust's Recovery Team as well.

3.6 Marcia Gallagher said that Claire was a real inspiration and welcomed Claire's plans to use her real-life experiences to teach others about what was possible. Marcia added that it was helpful as a Board to revisit patient stories like this to see what had changed. Marcia Gallagher asked Claire whether there was anything that she felt could have been improved with her care and support, or things that could have been done differently. Claire suggested that starting at Honeybourne earlier could have helped as this had made a huge difference, making reference to the opportunities available.

3.7 Angela Willan informed the Board that Claire had also undergone cataract surgery which was something she would not previously have been able to do. Angela said that she was so impressed with Claire. She had gone from not being able to leave her house to travelling independently, having a social life and was also in a relationship.

3.8 Colleagues agreed that Claire's willingness to feel better was instrumental in the progress that had been made, as it was her own hard work that had got her so far. Board members once again congratulated Claire and thanked her for coming back and speaking about her experiences.

4. MINUTES OF THE PREVIOUS BOARD MEETING

4.1 The Board received the minutes from the previous Board meeting held on 28 July 2022. The minutes were accepted as a true and accurate record of the meeting.

5. MATTERS ARISING AND ACTION LOG

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

6. QUESTIONS FROM THE PUBLIC

6.1 Bob Lloyd-Smith expressed congratulations, on behalf of colleagues at Healthwatch Gloucestershire, for the Trust's "Good" CQC inspection rating. He said that this was an excellent achievement, in a tough operating environment, and was a real credit to Trust staff and leadership.

6.2 Bob Lloyd-Smith made reference to the current cost of living crisis, and the increase in the number of suicides being reported nationally. He asked whether the Trust was seeing any trends of this nature developing and whether any preparations were being put in place to manage this. Amjad Uppal said that there was no evidence of an increase in suicide of those people open to GHC services. He said that 67 suicides had been reported in 2019, 65 reported in 2020 and 61 in 2021. Amjad said that every suicide was a tragic event, and the Trust would be keeping a very close eye on the position. There was no doubt that the cost-of-living crisis would have a real impact on vulnerable people. Ingrid Barker advised that the GHC Board had discussed the cost-of-living crisis on a number of occasions over the past few months, looking at what the Trust could do to support both its staff and patients. Neil Savage added that an ICS Cost of Living task group had been set up to look at what could be done as a system to offer support. The Trust's Charitable Funds Committee had also agreed to support the development of a hardship fund for staff and service users.

7. CQC REPORT

7.1 The Board received this report which detailed the outcome from the Core Services and Well Led inspection conducted by the CQC during April and May 2022. The Board congratulated all colleagues noting that the Trust had received an overall rating of **Good** which also included a rating of Good for "Well Led". This was an excellent achievement, particularly given the context and challenges of the last three years with the merger and Covid pandemic.

7.2 The report also provided the Board with an update on matters relating to the "Requires Improvement" rating applied to Charlton Lane Hospital earlier in 2022. Hannah Williams informed the Board that there was good assurance that the Trust had completed all "Must Do" recommendations, and there was good progress on the "Should Dos". A detailed update report on the CQC action plan was presented to the Quality Committee on a bi-monthly basis. Hannah Williams said that the Committee provided good robust challenge.

7.3 Marcia Gallagher noted that the Trust was planning to invite the CQC back to re-inspect services at Charlton Lane and asked for the proposed timescales for this. Paul Roberts advised that the CQC had a backlog of inspections to carry out due to the impact of Covid so it may not be possible for them to revisit us this year. However, GHC would ensure that it went through a robust assurance process before inviting the CQC back to ensure that all areas for improvement had been appropriately actioned. Marcia Gallagher said that a tremendous amount of work had been carried out; however, she said that as a Board it was important to have the assurance that all was well at Charlton Lane and having that external review would help to give that assurance. Hannah Williams suggested that a further discussion about assurance processes could take place at the next Quality Committee meeting. **ACTION**

7.4 Sumita Hutchison noted one of the areas of development relating to the embedding of evidence-based policies and procedures and asked how the Trust was taking this forward. Hannah Williams provided assurance that the Trust's policies were already evidence based, with clinical policies being cross referenced with NICE guidelines during their development.

She said that the issue related to how these policies were presented through governance forums to be able to provide the required level of assurance and this was the specific issue being addressed.

7.5 David Noyes informed the Board that a new Matron had now been appointed at Charlton Lane.

7.6 Graham Russell said that the Trust had received a "Good" rating, but the narrative from the CQC within their report was excellent, and he was proud of colleagues for the way they had spoken about their services and work taking place. He noted that some Mental Health services had not been inspected this time and he asked about the Trust's line of sight for those services. Hannah Williams provided assurance that the Trust triangulated and reviewed data on all services to ensure that they were running effectively, with regular checks and balances carried out.

7.7 The Board once again expressed their thanks and congratulations to all colleagues for this huge achievement. It was agreed that a detailed progress report on the CQC action plan would be presented back to the Board in January 2023, with regular updates presented in the interim at the Quality Committee to ensure continued monitoring and review. **ACTION**

8. QUALITY DASHBOARD REPORT

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

8.2 Hannah Williams 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:

- Referral to treatment times across a number of Therapy services continue to pose significant challenges. The Trusts Chief AHP is working with Therapy service leads to support the recovery plans and is able to provide assurance that those with the greatest clinical need and risk are prioritised
- The organisational focus on eating disorder services continues, acknowledging the waiting list challenges. This is a system issue with a detailed recovery plan co-produced with the Integrated Care Board and involves an independent partner to help reduce waiting times.

8.4 Quality issues showing positive improvement:

- The Trust received an overall rating for Good from the Care Quality Commission with an 'Outstanding' being awarded to the KLOE of Caring within End of life services.
- Sustained achievement of the number of complaints acknowledged within the 3-day timeframe at 100%
- CPA recovery shows further improvement this month and has maintained target of 95% for the second consecutive month this year.
- There has been an overall decrease in the total number of Pressure Ulcers reported in the organisation, this is driven by a decrease mainly in category 1 and 2 ulcers.

8.5 Steve Alvis said that the improvement in CPA compliance and complaints handling was really encouraging. He asked what support was being given to paediatric Speech and Language Therapy (SLT) and Occupational Therapy (OT) services waiting lists. Hannah Williams said that the position in SLT services was challenging. The Chief AHP was supporting colleagues with waiting times and caseloads and looking at different ways of working and prioritisation. She added that recruitment into SLT services was also a challenge. David Noyes agreed, noting that there were workforce issues that needed to be resolved. He added that there was also a high turnover within OT services. However, he said that a slow improvement was being seen in both services, but they did remain high risk.

8.6 Jan Marriott said that a presentation had been received at the last Working Together Advisory Group on some research carried out on receiving and analysing the Friends and Family Test data which it would be helpful to link in with the Quality Team. Hannah Williams advised that this link had already been established.

8.7 Making reference to the number of Rapid Tranquilisation incidences, Jan Marriott noted that the year-to-date figure was the same as that for the whole of last year. This had been acknowledged at the last Quality Committee meeting and she advised that the Committee had requested a deep dive into this at the next meeting.

8.8 Marcia Gallagher made reference to the Falls data, and she sought further assurance on the line of sight and focus for this area. Hannah Williams said that the Head of Patient Safety had started to examine the data on falls at Charlton Lane. A renewed focus on this had been given at the Countywide Falls Group, with a review taking place to ensure best practice and learning from other Trusts. Further detailed updates would be presented back to the Quality Committee.

8.9 Marcia Gallagher noted the increase of incidents on Priory Ward at Wotton Lawn during August and asked about lessons learned and when these would be implemented. Hannah Williams advised that harm minimisation approaches had recently been implemented on Dean Ward and the learning from this would be shared with Priory Ward. There had been an increase of 8 incidences of AWOL. The Positive and Safe Group, alongside the Patient Safety Team were focusing on this and drilling down on the common themes. It was agreed that an update on this work would be presented back to the Board at its next meeting in November. **ACTION**

8.10 Graham Russell asked about the quality of physical health services provided for community MH patients, noting that historically MH patients had a lower life expectancy. David Noyes advised that the Trust was bringing physical and mental health community teams into the same directorates, with co-located, holistic teams. He said that this would take time to embed but the direction of travel was welcomed and the improvements that would be seen from doing this would be most beneficial.

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

9. LEARNING FROM DEATHS – QUARTER 1

9.1 The Board received the Learning from Deaths Report, which provided the learning from the mortality review process, data analysis and outcomes for quarter 1 2022/23.

9.2 The Board was informed that there had been 175 patient deaths reported during quarter 1. None of these were judged more likely than not to have been due to problems in the care provided to the patient. The Board noted that there had been 62 inpatient deaths in Community Hospitals and Charlton Lane Hospital which was an increase from previous quarters; however, Amjad Uppal advised that this was in line with demographics.

9.3 It was reported that the most prevalent causes of death reported related to cancer, frailty of old age, respiratory and cardiovascular illness. There were 20 community mental health patient deaths, excluding those known to the service with a primary diagnosis of dementia. A comparison of the data with the previous year was highlighted within the report and it was noted the primary cause continued to be natural causes, followed by suspected suicide.

9.4 The Board was informed that there were 10 community learning disability patient deaths in quarter 1. The number of deaths that had occurred in April was significantly higher than other months and the reason for this was currently unclear. All deaths had been referred to LeDeR for review. Of the 10 learning disability patient deaths, respiratory infections were the most prevalent cause of death.

9.5 Marcia Gallagher noted that the number of deaths caused by pneumonia was falling, and she asked whether enough focus was being given to providing pneumonia injections to vulnerable people. Hannah Williams advised that this was usually administered via primary care services, however, there was good assurance that those people who were eligible to receive it were being offered it and there was good take up. In learning disability services, people were supported via the IHOT team to give and receive vaccinations.

9.6 The Board also received the Gloucestershire Learning Disability & Autism LeDeR Programme Annual Report 2021/22. Jan Marriott noted that the death rate was the same for people with moderate and mild learning disabilities. GHC provided services to people with a moderate learning disability, but the query was raised as to the support for those with a mild diagnosis, and whether more needed to be done around communications. Steve Alvis suggested that the issue of support available for people with a mild learning disability should be raised at ICS level as a system approach to this was required. This was agreed and Paul Roberts offered to raise this at a future ICS Board meeting. **ACTION**

10. PERFORMANCE DASHBOARD

10.1 Sandra Betney presented the Performance Dashboard to the Board for the period August 2022 (Month 5 2022/23). This report provided a high-level view of key performance indicators (KPIs) in exception across the organisation.

10.2 The SystmOne Simplicity programme remains a key focus to improve inherent data quality issues within the Physical Health Community clinical system and is progressing well. Full, system reflective reporting is now visible for all services. There are still some significant data quality cleansing activities to undertake by operational services through the remainder of the year. Historic activity provides some assurance to normal performance levels for these indicators and wherever possible, manual audit evaluations have been undertaken on validating exceptions to inform confidence in the current situation. Service level SystmOne Simplicity assurance milestones are being finalised to achieve the core phases of the project within 2022/23. It was noted that a report was being prepared for the Executive Team setting out the details and timescales for this complex piece of work. It was suggested that it would also be helpful to share this report with the Resources Committee. **ACTION**

10.3 The Board noted that there were 5 MH key performance thresholds in exception within the dashboard. These all related to the Eating Disorder (ED) Service. Focused work is being undertaken internally to better understand capacity for ED to inform an updated forecast model, the first draft for U19 urgent pathway was presented to stakeholders in September 2022.

10.4 There were 18 PH key performance thresholds in exception within the dashboard. Eight of these were wait time measures and it was assumed that alongside operational challenges, SystmOne Simplicity data is contributing to all of these 8 items. However, 5 indicators were in exception prior to SystmOne Simplicity. Through clinical services intervention, performance is expected to improve over the year in line with the Operational Directorates' ambitions and its operational tracker.

10.5 The Board was pleased to note that the Trust had achieved an IAPT Access Rate of 98.1% in August. This was the first time the service had been performing above 95% since November 2021.

10.6 The Board noted the Chief Operating Officer's summary report, which highlighted continued challenges with system flow, noting that 50% of our community hospital beds were occupied by people waiting for an onward placement or package of care. An update was also provided on the LGA peer review and next steps, recruitment into the Home First Team and details of the Operational Services reconfiguration which would take effect from 1 December 2022.

10.7 As discussed at previous meetings, echocardiogram performance remained challenging. A Quality Impact Assessment was being developed for onward presentation to commissioners, and the consideration of funding for an external provider.

10.8 Steve Brittan sought assurance around those services that had previously been rated as Red as part of the recovery programme and whether they had improved. At the last Board meeting, it was agreed that recovery would be brought back into business-as-usual reporting and David Noyes advised that the performance dashboard gave an accurate picture of all services. Sandra Betney added that those services within the dashboard highlighted as having a service improvement plan in place meant that they were a "Red" service and close monitoring continued.

10.9 Ingrid Barker raised the issue of autism services, having recently carried out a quality visit to the Trust's Autistic Spectrum Disorder (ASD) service. Healthwatch Gloucestershire were currently carrying out a survey seeking views of people on their experiences of autism services. Sandra Betney advised that the waiting list for the ASD service was being brought into the dashboard to allow for oversight and visibility. It was suggested that a deep dive on the Trust's ASD services could be received at a future Resources Committee meeting. **ACTION**

11. RECRUITMENT AND RETENTION UPDATE

11.1 The purpose of this report was to provide the Board with an update on the current context and progress with recruitment and retention within the Trust.

11.2 Recruitment and retention remains one of the top risks to delivery within the health and social care system within England. This risk is recognised within the Trust's BAF and is likely to continue to be included as a high risk to the delivery of the Trust's strategy and service delivery for the foreseeable future.

11.3 At the end of August 2022 there were over 500 vacancies across the Trust and a vacancy rate of 12%. Particular hot spots include registered nursing, particularly mental health inpatients and community nursing (ICTs), and health care support workers in clinical teams, such as Home First, and non-clinical teams such as Facilities. Staff Turnover was now 14% (August 2022) having historically ranged between 10 and 12% in previous years. This turnover is reflected in other NHS Trusts.

11.4 The Trust's Recruitment and Retention Strategic Framework for 2022-2027 was approved by GPTW Committee earlier in summer 2022. This new framework aims to support delivery of GHC's goal of being a Great Place to Work and Commitment 1 of the Trust's People Strategy – Model Recruitment and Retention. The framework was created following engagement with recruiting managers and colleagues and reflects what the Trust had been told through People Pulse and Staff Surveys, exit interviews and questionnaires and other feedback. The framework reflects what matters most to recruiting managers and colleagues, setting out priorities and a strategic framework for recruitment and retention over the next five years.

11.5 Neil Savage advised that the Trust continued to innovate and utilise a wide range of attraction campaigns, learning and sharing from best practice and continuously testing new approaches in our hot-spot vacancy areas.

11.6 Neil Savage informed the Board that many of the challenges being faced with recruitment and retention were not in the gift of the Trust to resolve and a similar picture was being seen nationally within the NHS. The recent pay award and pension changes had also had a negative impact in terms of retention.

11.7 Sumita Hutchison asked about the likelihood of industrial action. Neil Savage advised that the Trust was preparing and liaising closely with local Staffside representatives and managers to look at the potential impact of this. If given the go ahead, this would likely take place in quarter 4.

11.8 Steve Brittan noted that the delay from interview to start date was increasing and he asked whether the Trust had the right level of resources within the Recruitment Team to be able to manage and support this. Neil Savage advised that further resource had been brought into the Recruitment Team to bolster their capacity.

11.9 The Board noted this report and the Recruitment and Retention Strategic Framework. A further discussion on this report was scheduled for the next GPTW Committee meeting.

12. FINANCE REPORT

12.1 The Board received the month 5 Finance Report for the period ending August 2022. A revised system plan submitted to NHSE on 20th June showed a break-even position for both the system and the Trust.

12.2 At month 5 the Trust had a surplus of £0.086m. The Trust is forecasting a year end position of break even in line with the revised plan. The cash balance at month 5 is £57.13m. Capital expenditure was £3.967m at month 5 against a 2022/23 Capital plan of £17.665m. The Trust has spent £0.805m on Covid related expenditure up to August.

12.3 The Cost improvement programme has delivered £4.514m of recurring savings against the target for the year of £5.512m. The non-recurrent target is £1.15m and £0.421m has been identified. In addition to Trust savings, we have made a £160k system saving on Covid.

12.4 The Trust spent £3.786m on agency staff to month 5, and against a 30% reduction on last year this would leave the Trust £1.528m over target year to date. The Trust spent £4.851m on bank staff to month 5 and had a £9.2m under spend on substantive posts. The Board noted that the 30% reduction was a whole system target, however, the quality impact on the use of agency staff was acknowledged.

12.5 The Better Payment Policy shows 93.8% of invoices by value paid within 30 days, the national target is 95%. 84.2% of invoices by value were paid within 7 days.

12.6 The Trust had now introduced 5-year forecasts across I&E, balance sheet and cash flow statements in order to strengthen forecasting and incorporate the impact of IFRS16.

12.7 In terms of risks, Sandra Betney advised that there was a risk that the 2022/23 pay award would not be fully funded. She said that this was a complex position, but it was assumed that there would be no significant adverse impact. Other risks included inflation and increases in utility costs which it was felt would impact more on the 2023/24 financial position.

13. MEDICAL APPRAISAL ANNUAL REPORT

13.1 The Medical Appraisal and Revalidation Report provides a summary of the work that has been undertaken within the Trust to support the safe provision of clinical services through the medical practitioners working to this Designated Body aligned with national policy. The report provided assurance as to the application of national policy with regard to the regulation and Revalidation of Medical Practitioners and insight into the processes and resources that are required to undertake this work.

13.2 The Board was asked to note that this report had been presented to, discussed by and endorsed by the Quality Committee on 1st September 2022 for onward presentation and sign off by the Trust Board. The Board was content to endorse the report and agreed the submission of the Statement of Compliance to NHS England.

14. INFECTION PREVENTION CONTROL ANNUAL REPORT

14.1 The purpose of this item was to present the Trust Board with our Infection Prevention & Control Annual Report for 2021/22. The report provided the Board and the public with an overview and summary of the Trust's infection prevention and control activity during 2021/22.

14.2 The report provided good assurance that the Trust has maintained good standards of infection prevention and control throughout the year.

14.3 The Board received and endorsed the report for publication on the Trusts public facing website. It was noted that this report had also been received and endorsed for onward presentation to the Trust Board by the Quality Assurance Group (QAG) and the Executive Team. The Board expressed their thanks to all those involved in both preparing the report, and ensuring the Trust was able to maintain its good standard of compliance.

15. CHAIR'S REPORT

15.1 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 July. 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.

15.2 Following the successful appointment of our new NED, Nicola de Iongh, we have taken the opportunity to review the Non-Executive Portfolios to ensure that we best utilise the skills and experience that individual NEDs bring to our Board and Committee Structure. The revised portfolios would be implemented from October.

15.3 As previously reported, we continue to progress our intention to create two new Associate NED roles to ensure that we have in place the skills and experience at board level to successfully lead the Trust in the delivery of our strategic objectives. On 8th September, the Nominations and Remuneration Committee supported the proposal to create a nominated Associate NED role from the University of Gloucestershire to secure and enhance our joint working and growing partnership, and a developmental Associate NED position for candidates with community partnership/third sector/voluntary sector experience and expertise.

15.4 Ingrid Barker said that she was pleased to welcome Alicia Wynn to the Council of Governors as an Appointed Governor representing Young Gloucestershire. Alicia commenced in the role on 1 September and would bring a very welcome voice for young people to the table.

15.5 Ingrid informed the Board that she was delighted to be invited by NHS Providers to speak at a national webinar on 6th September on the importance of building a continuous and ongoing narrative around race equality to drive improvements against the Workforce Race Equality Standards (WRES). Ingrid Barker said that it was a great opportunity to showcase the work that the Trust has undertaken around race equality.

15.6 Ingrid Barker had carried out a visit to Wotton Lawn on 23rd August and Berkeley House on 30th August to thank colleagues for the incredible dedication and effort they put in to secure their recent 'good' CQC Rating. Other Board members had conducted similar 'thank you' visits to those services who were inspected in our recent Core Inspection. Ingrid Barker expressed her heartfelt thanks to those services involved in the recent CQC Inspection for their dedication and hard work. She also acknowledged the dedicated effort of Board colleagues who were also tested during the Well Led element of the inspection. Particularly given the context of the last three years – merger, pandemic and more – she said that she was incredibly proud of our Trust team and what has been achieved.

15.7 Following a recent meeting of the Chief Executive Appointment Committee, a decision was taken to extend the search for our CEO role for a short period. This will enable potential candidates to benefit from reviewing the feedback from our recently released Care Quality Commission Report which confirms a further improved and strong 'good' rating, which was not available during the initial period. We will involve partners, colleagues, and a range of stakeholders in the selection process in due course.

15.8 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.

16. CHIEF EXECUTIVE'S REPORT

16.1 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 July.

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

16.3 The Board was asked to note the submission of the Health Education England (HEE) Provider Self-Assessment. The Trust is a signatory to the HEE NHS Education Contract 2020 – 2024. HEE is an executive non-departmental educational public body at arms-length from the Department of Health and Social Care and accountable to the Secretary of State for alth and Social Care. The contract outlines the educational/training commitments and requirements shared by HEE and the Trust. Compliance with this contract is monitored by HEE and the Trust in two ways – firstly by a new annual self-assessment and secondly, via an annual Senior Leader Visit (last held in February 2022). It was noted that GHC's survey self-assessment was completed and was considered and approved for submission to HEE by the Executive Committee in August 2022. The response to the Trust's positive self-assessment is awaited and will be reported to the Great Place to Work Committee in due course.

16.4 A Senior Leadership Network meeting took place on 26th July, and this included a screening of "Exposed" – a film developed by the RCN and the University of Gloucestershire looking at the experiences of black nurses during Covid. Paul Roberts said that this had generated some good discussions and reiterated that the Trust would use these experiences to develop the Trust's Equality Diversity and Inclusion (EDI) agenda going forward.

16.5 Paul Roberts paid tribute to Dr Martin Ansell who had stepped down as the Trust's Deputy Medical Director. Martin had made a huge impact and would fortunately remain working part-time in his clinical older age psychiatry role within the Trust. Dr Faisal Khan had been appointed as the new Deputy Medical Director for Mental Health Services, commencing on 30th September. Ingrid Barker agreed to send a thank you note to Martin on behalf of the Board. **ACTION**

16.6 As highlighted at the July Board meeting, a review of Urgent and Emergency care services in Gloucestershire has been carried out by the Local Government Association (LGA). Paul Roberts said that there were some very real Urgent and Emergency care pressures within the system that needed to be acknowledged, which were having a detrimental impact on patients. Further discussion as a Board on this issue had been scheduled.

16.7 The Board was asked to note that October would be Speak Up month and Black History month, and events would be taking place to acknowledge this.

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

17. SYSTEMWIDE UPDATE

17.1 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).

17.2 The Gloucestershire Health and Wellbeing Partnership is a statutory Committee of the One Gloucestershire Integrated Care System (ICS), established jointly between the NHS Gloucestershire Integrated Care Board (ICB) and Gloucestershire County Council as equal partners and statutory members. Moving forward it will be known as the Gloucestershire Integrated Care Partnership as required by section 26 of the Health and Care Act 2022. The inaugural workshop session for the ICP took place on the 20th September with an initial focus on the creation of the ICP Strategy which will sit alongside the Joint Strategic Needs Assessment (JSNA) and the Health & Well-Being Strategy. This document will confirm the ongoing health and well-being priorities and an initial version is due to be completed by December 2023.

17.3 The Health & Well-being Board met on the 20th September for a development session to review the progress on the 7 health and well-being priorities. Detailed updates were received around the "We can move" programme led by Active Gloucestershire and the Mental well-being programme – both of which showed positive progress since the development of the strategy.

17.4 Healthwatch Gloucestershire was asking local people to share their views and experiences to help improve care and support for adults with autism. The survey was exploring the care and support adults with autism currently receive through assessment, diagnosis, and ongoing care. They want to learn what works well and how things might be done differently to improve the experiences and outcomes for everyone who seeks support for autism. They are also seeking to understand the barriers that make it difficult for adults with autism to get the care they need, for example, when trying to get appointments with hospitals, GPs or social services.

18. WINTER RESILIENCE PLAN

18.1 The purpose of this report was to provide the Board with an overview of the Trust's winter planning arrangements for 2022/23, including arrangements for surge management, escalation and infection control.

18.2 Matthew Steele, Head of Organisational Resilience was in attendance to the present this report. He advised that the Trust Winter Plan had been reworked this year. All of the arrangements from previous years' Operational Resilience and Capacity Plan were still in place but had been split into three plans to ensure they are effective, easy to use and meet the Trust's needs. Operational Pressures Escalation Levels (OPEL) and Service Impact and Prioritisation are now in standalone plans as they could be required throughout the year. Both documents are undergoing a full review to ensure the actions and prioritisations identified are still correct.

18.3 The Board noted that this re-shape enabled the Winter Plan to have more of a focus on managing the impacts of severe weather. The plan, which was in the final stages of development, includes Warning and Alerts, actions to be undertaken upon receipt and available capabilities such 4 x 4 vehicles and gritting arrangements. It also covers seasonal influenza management and Infection Control which are critical to keeping our services running. The Board noted that the Trust's plan also aligned to the UKHSA Cold Weather

Plan for England, the 2022/23 version of which would be released in October. Once released, this will be reviewed, and the Trust's Winter Plan would be updated as appropriate.

18.4 Marcia Gallagher welcomed this comprehensive report. She asked about the provision of generators across the Trust's estate and whether there were enough of them to cope with power cuts. Matthew Steele advised that regular tests and local planning exercises were carried out in liaison with the Estates Team and currently it was felt that there were sufficient stocks of generators and the diesel required to power them. However, Sandra Betney agreed to take this question back to the Estates Team to seek further detail and assurance for the Board. **ACTION**

18.5 The Board received this report and was assured that the Trust's Winter plan and associated Surge and Escalation arrangements would be implemented as appropriate to support the Trust's service provision arrangements.

19. STRATEGIC MILESTONE REFRESH

19.1 The purpose of this report was to present the final draft of the strategic goals and measures aligned to our Trust Strategy, for approval.

19.2 The Board participated in a development session on 30th May and took the opportunity to further develop and refine the strategic goals and measures associated with our Trust Strategy. Feedback and comments have subsequently been received from the Executive Team following a strategic executive session held on 14th July and a final review with Board members took place on 30th August.

19.3 Angela Potter advised that the output from these sessions had been incorporated in the version of the strategic goals and measures presented for sign-off by the Board. It was noted that these had been strengthened by additions around our inequalities work plan, the emphasis on learning from both our successes and our mistakes and greater clarity over the goal for the sustainability objective.

19.4 The Board noted that these metrics and measures were deliberately high level, and they were supplemented by detailed action plans and dashboards, including the Trust wide performance report and the annual business plan that were used to monitor granular levels of performance at appropriate Board Committees.

19.5 It was proposed that delivery of the Strategy would be reviewed bi-annually via the Resources Committee, aligned to the appropriate reports on the delivery of the annual business plan with an annual update and review to Trust Board supplemented by discussion at periodic Board development sessions. Following approval, work would take place to refine the summary version of the strategy and re-launch a Trust wide communication programme in conjunction with the annual business plan for 23/24 to continue to raise the profile of the strategic work across the Trust.

19.6 Two suggested additions to the goals and measures were received:

- Sumita Hutchison suggested that the "achievement of the Trust's Green Plan" should be included as a Goal under the strategic aim for Sustainability.
- It was suggested that more be included on outcomes and measuring what matters under the strategic aim for High Quality Care. **ACTION**

19.7 Subject to these suggested additions, the Board approved the Strategic goals and measures.

20. SENIOR INFORMATION RISK OFFICER (SIRO) ANNUAL REPORT

20.1 The Board received the SIRO Annual Report which provided assurance to the Board on the effectiveness of controls for Information Governance, data protection and confidentiality and to document the Trust's compliance with legislative and regulatory requirements.

20.2 The Board noted that Cyber security continues to be a very real risk to the Trust, with IT reviewing cyber threats at weekly meetings. Phishing attacks continue to be a top three cyber risk for the Trust, with the Trust experiencing 1200 phishing emails per day.

20.3 The Board took assurance that the Trust has effective systems and processes in place to maintain the security of information. It was noted that this report had been received and endorsed for onward presentation to the Trust Board by the Audit and Assurance Committee.

21. MINUTES FROM THE COUNCIL OF GOVERNORS MEETING

21.1 The Board received and noted the minutes from the previous Council of Governors meeting held on 13 July 2022.

22. BOARD COMMITTEE SUMMARY REPORTS

22.1 **Working Together Advisory Group**
The Board received and noted the summary report from the Working Together Advisory Group meeting held on 14 July 2022.

22.2 **Great Place to Work Committee**
The Board received and noted the summary report from the Great Place to Work Committee meeting held on 3 August 2022.

22.3 **Mental Health Legislation Scrutiny Committee**
The Board received and noted the summary report from the MHLS Committee meeting held on 17 August 2022.

22.4 **Audit & Assurance Committee**
The Board received and noted the summary report from the Audit and Assurance Committee meeting held on 24 August 2022.

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

22.6 **Quality Committee**
The Board received and noted the summary report from the Quality Committee meeting held on 1 September 2022. The Committee had received the Allied Health Professional (AHP) Report, which provided an update on the AHP workforce of the Trust. Jan Marriott, Chair of the Quality Committee said that this had been an excellent report and had given the Committee a real insight into the workforce challenges in this area. She suggested that it would be helpful for this report to be received at the Great Place to Work Committee for further discussion and consideration. **ACTION**

22.7 **Charitable Funds Committee**
The Board received and noted the summary report from the Charitable Funds Committee meeting held on 6 September 2022.

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

23. ANY OTHER BUSINESS

23.1 There was no other business.

24. DATE OF NEXT MEETING

24.1 The next meeting would take place on Thursday, 24 November 2022.

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

TRUST BOARD PUBLIC SESSION: Matters Arising Action Log – 24 November 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
29 Sept 2022	7.3	Further discussion about seeking external assurance around the CLC CQC Action Plan, and the processes to do this to take place at the next Quality Committee meeting.	Hannah Williams	November 2022	**Complete**. Discussion took place at Quality Committee on 3 November.	
	7.7	A detailed progress report on the CQC action plan to be presented back to the Board in January 2023	Hannah Williams / Trust Sec.	January 2023	**Complete**. Added to Board work plan for January 2023 meeting	
	8.9	An update on the work taking place to review the increase in incidents on Priory Ward at Wotton Lawn to be presented back to the Board at its next meeting in November, via the Quality Dashboard.	Hannah Williams	November 2022	**Complete.**	
	9.6	Following consideration of the LeDeR Annual Report, the issue of support available for people with a mild learning disability to be raised at ICS level as a system approach to this was required. Paul Roberts offered to raise this at a future ICS Board meeting	Paul Roberts	Nov 2022	**On Track.** Item to be raised at next ICB Board meeting taking place on 30 November 2022	

	10.2	A report was being prepared for the Executive Team setting out the details and timescales for the SystmOne Simplicity work. It was suggested that it would also be helpful to share this report with the Resources Committee	David Noyes	Nov 2022	**Complete.** Received at Resources Committee on 25 October	
	10.9	A deep dive on the Trust's Autistic Spectrum Disorder (ASD) services to be received at a future Resources Committee meeting	David Noyes		**Complete**. Item scheduled for December Resources Committee meeting	
	16.5	Ingrid Barker to send a thank you note to Martin Ansell on behalf of the Board, after stepping down from his role as Dep. Medical Director	Ingrid Barker	Nov 2022	**Complete**	
	18.4	Sandra Betney to seek further detail and assurance from the Estates Team on availability of generators across the Trust.	Sandra Betney	Nov 2022	**Complete.** Response sent directly to Marcia Gallagher for assurance on 25/10	
	19.6	Two additions to the Strategic Milestones were suggested: Green Plan reference and Outcomes related to High Quality Care	Angela Potter	Nov 2022	**Complete** and shared with colleagues	
	22.6	AHP Workforce Report to be referred to the Great Place to Work Committee for further discussion and consideration	Trust Sec.	Nov 2022	**Complete.** Referral received at GPTW Committee on 5 Oct. Item to be scheduled for future meeting.	

AGENDA ITEM: 07/1122

REPORT TO: **TRUST BOARD PUBLIC SESSION – 24 November 2022**

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

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

SUBJECT: **QUALITY DASHBOARD REPORT– OCTOBER 2022 DATA**

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

Recommendations and decisions required
Board members are asked to:

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

Executive summary

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

Quality issues showing positive improvement

- Continued reduction in the HCSW vacancy rates with a further reduction since September 2022 following additional recruitment activity.
- Using Quality Improvement methodology and Co-production to support improvements in patient experience and care following a serious incident.
- CPA rates have recovered to above target of 95% this month.
- New FFT system launched in month with the aim of increasing access for individuals to provide feedback, particularly those who use Physical Health urgent

care and community Mental Health services. Increased response rate noted within MIIU, MHICT, IAPT and Recovery.
- The Trust wide CQC action plans remain on track to complete within the agreed timescales.

Quality issues for priority development

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

Are Our Services Caring?

At the time of writing there are no complaints open over 6 months, reflecting the excellent sustained improvements made by the team. The number of new complaints received in October has increased by 5 in month to 18 with the number of open complaints in October being 40. The number of complaints acknowledged within the 3-day timeframe is sustained at 100% for the seventh successive month. FFT compliance rate declined slightly to 94% against the target of 95%, however, the overall number of completed FFT has increased in month as a result of planned changes in system infrastructure especially in mental health. MIIU's have seen the largest upturn in returns in month. The number of compliments received has increased by 17 to 151. Included in the dashboard is a summary of observations from the NED audit of complaints. Appendix 1 gives a summary of the NED Quality visits and an update on actions for those visited. The Pan Ops Management Meetings continue to monitor the feedback and this will inform future updates communicated via the quality dashboard.

Are Our Services Safe?

We have included a refreshed approach to presenting patient safety data in this month's dashboard following development work by the team. This includes a new summary view on the prevalence of patient safety incidents by categories showing how these have varied over time. In October, there were a total of 1110 incidents reported affecting patients (147 more than September). 1041 were reported as No and Low harm incidents (166 more incidents than September) and 69 Moderate, Severe and Catastrophic incidents (a reduction of 19 incidents compared to September). The top four categories are skin integrity, clinical care, treatment and procedures and self harm in October. We are continuing to closely review all falls and medication clinical incidents from Charlton Lane Hospital to support an improvement initiative by the new matron. All Incidents remain within previous reported ranges. 2 Mental Health SIRI's were reported in October. Of the 87 recommendations arising from SIRI's during 2021/22, 78 actions have been completed, 5 actions are progressing and are on track to complete on time, 4 are overdue with plans to resolve in November, 4 actions were stood down, having been reviewed with commissioners. In 22/23 we currently have 21 actions, 4 have been completed and 17

are on track to be completed on time. This month there has been an overall increase in the number of pressure ulcers attributable mainly to an increase in category 1 and 2 incidents, the majority of these are classed as unavoidable due to patient morbidity. Positively there was a reduction in the number of avoidable PU's in community hospitals. Appendix 2 provides data regarding COVID 19 activity demonstrating that there have been increases in the infection rates (HODHA) in our community Hospitals in line with national trends resulting from recent increases in cases nationally.

Are Our Services Effective?

Quality priorities updates are detailed in Appendix 3, good progress is being made in 8 domains and areas that are behind ambitions are receiving additional focus. Focusing on safeguarding related governance the following improvement has been made. We are reinforcing the expansion of adult safeguarding supervision offer to all adult teams. We have established a new Trust Safeguarding Notifications inbox to better capture the number of safeguarding referrals made to the Local Authority. This will give us robust oversight of organisational activity. The MARAC Action Plan backlog has been fully resolved at time of writing. We have an improving picture with Level 4 Adult Safeguarding Training and Children's Safeguarding Supervision compliance. A full summary of Safeguarding key performance data is provided in Appendix 4. Cardio metabolic assessment rates have increased in month, reflecting the additional training provided by the RGN's in MH inpatient settings, additional work is planned to improve compliance further. Mental Health CPA, an important proxy measure of community mental health quality, compliance has returned to required levels this month. We also report the closure of some community hospital beds to enable required estates work to take place. This month we include a summary of CQUIN activity to close of H1 (Q2) where we have achieved the requirements of 4 initiatives, and expect to have achieved the requirements of all by year end.

Are Our Services Responsive?

It is encouraging to note the Urgent referral to non-NICE treatment (1 week start) performance for adolescents with an eating disorder has shown a significant improvement this month following a period of sustained focus to address wait times. A range of measure to improve eating disorder services access times and resulting quality of care is described in the dashboard. Appendix 5 – summarises wider operational access time data which is a snap shot of activity data, created to monitor performance whilst the Operational Governance Structures were being redesigned. The information supporting the activity data is detailed in the BI Performance Dashboard that has visibility throughout the organisation. This month we are beginning to see recovery within services with 10 out of the 14 service data lines reporting an improved position. Through our work to develop excellence in learning from safety incidents we have included detail of a quality improvement project that will improve patients' experience of observations and engagement at Wotton Lawn Hospital and its effectiveness as safety intervention. This work is linked to a range of embedding learning to improve patient safety related activity currently that will be reported on in future dashboards.

Are Our Services Well – Led

International Nurse recruitment continues with 52 new colleagues now in post since January 2021. Progress has been made again this month in the reduction HCSW vacancies. We include the guardian of safe working for Q2 for information. Mandatory

training is above target for the tenth consecutive month. This achievement reflects the focus in place to ensure staff are supported to remain up to date with statutory/mandatory training. Safer staffing data acknowledges the ongoing challenges for inpatient teams, however, triangulation of the data has not identified upturns in incidents or increase in complaints linked to the services where variation of staffing levels have been evident. However, it remains a key quality concern, on the wellbeing of colleagues and limits our ability to deliver development work. The matrons and service leads are continuing to monitor the impact on staffing and ensure safe delivery of services. The Trust is working on a range for actions to address these challenges and this is further reported via the Great Place to Work Committee.

Care Quality Commission inspections and reviews

The Trust continues to make progress with the actions arising from the CQC core inspection. The Trust wide action plan is 37% complete with 61% on target for completion, there remains one action point outstanding. The MIIU action plan is 79% complete and 21% on target for completion. Charlton Lane action plan is 85% complete and 15% on target for completion. Actions have been refined to ensure they accurately reflect the areas noted by the CQC and this has led to a small update in target dates. There are regular touchpoint meetings to review progress of the actions. The MUST DO actions are scheduled for completion by 30th November. We have continued to provide regular updates to the CQC who are assured by the plans and evidence we have provided in support of completed actions.

Risks associated with meeting the Trust's values

Specific initiatives or targets that are not being achieved are highlighted in the Dashboard.

Corporate considerations	
Quality Implications	By the setting and monitoring of quality targets, the quality of the service we provide will improve
Resource Implications	Improving and maintaining quality is core Trust business.
Equality Implications	No issues identified within this report

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

Appendices:	Quality Dashboard Report

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

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Quality Dashboard 2022/23

Physical Health, Mental Health and Learning Disability Services

Data covering October 2022

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

Executive Summary

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

Are our services CARING?
At the time of writing there are no complaints open over 6 months, reflecting the excellent sustained improvements made by the team. The number of new complaints received in October has increased by 5 in month to 18 with the number of open complaints in October being 40. The number of complaints acknowledged within the 3-day timeframe is sustained at 100% for the seventh successive month. FFT compliance rate declined slightly to 94% against the target of 95%, however, the overall number of completed FFT has increased in month as a result of planned changes in system infrastructure especially in mental health. MIIU's have seen the largest upturn in returns in month. The number of compliments received has increased by 17 to 151. Included in the dashboard is a summary of observations from the NED audit of complaints. Appendix 1 gives a summary of the NED Quality visits and an update on actions for those visited. The Pan Ops Management Meetings continue to monitor the feedback and this will inform future updates communicated via the quality dashboard.

Are our services SAFE?
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Are our services EFFECTIVE?
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Are our services RESPONSIVE?
Urgent referral to non NICE treatment (1 week start) performance for adolescents with an eating disorder has shown a significant improvement this month following a period of sustained focus to address wait times. A range of measure to improve eating disorder services access times and resulting quality of care is described in the dashboard.. Appendix 5 – summarises wider operational access time data which is a snap shot of activity data that was created to monitor performance whilst the Operational Governance Structures were being redesigned. The information supporting the activity data is detailed in the BI Performance Dashboard that has visibility throughout the organisation. This month we are beginning to see recovery within services with 10 out of the 14 service data lines reporting an improved position . Through our work to develop excellence in learning from safety incidents we have included detail of a quality improvement project that will improve patients' experience of observations and engagement at Wotton Lawn Hospital and it's effectiveness as safety intervention. This work is linked to the a range of embedding learning to improve patient safety related activity currently that will be reported on in future dashboards.

Are our services WELL LED?
International Nurse recruitment continues with 52 new colleagues now in post since January 2021. Progress has been made again this month in the reduction HCSW vacancies. We include the guardian of safe working for Q2 for information. Mandatory training is above target for the tenth consecutive month. This achievement is a reflection of the focus in place to ensure staff are supported to remain up to date with statutory/mandatory training. Safer staffing data acknowledges the ongoing challenges for inpatient teams, however, triangulation of the data has not identified upturns in incidents or increase in complaints linked to the services where variation of staffing levels have been evident. However it remains a key quality concern, impacts on the well being of colleagues and limits our ability to deliver development work. The matrons for services are continuing to monitor the impact on staffing and ensure safe delivery of services. The Trust is working on a range for actions to address these challenges and this is further reported via the Great Place to Work Committee.

CQC Update
The Trust continues to make progress with the actions arising from the CQC core inspection. The Trust wide action plan is 37% complete with 61% on target for completion, there remains one action point outstanding. The MIIU action plan is 79% complete and 21% on target for completion. Charlton Lane action plan is 85% complete and 15% on target for completion. Actions have been refined to ensure they accurately reflect the areas noted by the CQC and this has led to a small update in target dates. There are regular touchpoint meetings to review progress of the actions. The MUST DO actions are scheduled for completion by 30th November. We have continued to provide regular updates to the CQC who are assured by the plans and evidence we have provided in support of completed actions.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

Quality Priorities 2022-2023:

In support of our overarching quality ambitions our physical, mental health, learning disability, children's and specialist services will continue with the following quality improvement priorities which have been agreed with commissioning bodies and will subsequently be reported upon quarterly. Full details of each Priority are contained in Appendix 3.

SUMMARY QUALITY PRIORITIES 2022-2023

Priority	Description	Status 21/22	Status 22/23 H1
1	Pressure Ulcers (PU's) - with a focus on reducing incidence and severity through improvement in the recognition, reporting, and clinical management of PU's , developing a PU collaborative within the One Gloucestershire Integrated Care System.	Achieved	. Achieved
2	Falls prevention – with a focus on reduction in medium to high harm falls based on 2020/21 data . Continuing to work to maintain a falls collaborative within the One Gloucestershire Integrated Care System.	Not achieved	Under review as per Appendix 3 - slide 41
3	End of Life Care (EoLC) - with a focus on refreshing the collaborative One Gloucestershire approach to improving EoLC across the county . This will support the 6 ambitions for Palliative and End of Life Care including improving systems to identify those eligible using the Supportive and Palliative Care Indicators Tool (SPICT), improving the access to advanced care planning and the ReSPECTV3 form, and increasing symptom management training for staff to support non - cancer patients.	Achieved	Achieved
4	Patient and Carer Experience - with a focus on incrementally reducing the time taken to provide a final response letter to people who have raised a formal complaint about Trust services improvement in completion times will be achieved quarter on quarter .	Achieved	Achieved
5	Friends and Family Test (FFT) - with a question to ask people for their views on the quality of their care, as highlighted in our 2020 CQC Audit Community Mental Health Survey action plan.	Achieved	On track – No H1 Milestones
6	Reducing suicides - with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services. We will work to the aspirations of the Zero suicide Alliance to support the aim for zero suicides within our mental health inpatient units by 2023.	Not achieved	On track – No H1 Milestones
7	Learning disabilities - a focus on the Hospital /personal Passport utilisation, and roll out of the Oliver McGowan Tier 1 and tier 2 training programme .The trust aims to train 90% of our workforce.	Achieved	On track – No H1 Milestones
8	Children's Services - transition to adult services with a focus on ensuring a safe and prompt transfer between services, developing pathways, standardising practice, and reducing delays in care . Fidelity to the care pathways will be evaluated through participation in the NCEPOD study.	Not achieved	On track – No H1 Milestones
9	Embedding learning following patient safety Incidents - with a focus on sharing and learning from experience and investigations to develop and improve standards of care . This will be measured through the numbers of post investigation embedding learning workshops delivered and the number of lessons bulletins issued. alongside implementation of the Civility Saves Lives initiative, with assurance measured against the project implementation goals and evaluation over the reporting period.	Not achieved	On track – No H1 Milestones

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

The **National** CQUINs applicable to GHC are tabled in summary below, progress reporting begins at the close of Q1. (Q3 for Flu) . Agreement reached with commissioners that reporting will be for information purposes only with no financial penalties linked to thresholds. Initial meetings have taken place with leads, BI and contracts colleagues. We have a separate CQUIN for Liaison and Diversion services. New reporting systems will primarily be manual sampling with BI working to support automated collection for the Q2 portal window which closes on 25th November. Overall we are progressing as planned and to the expectations of commissioners.

CCG Ref	Description	Mental Health	Community	Reporting Process	Status
CCG1	**Flu vaccinations for frontline healthcare workers**	✓	✓	Established process via Immform to continue as per previous years.	Commences Q3
CCG9	**Cirrhosis and fibrosis tests for alcohol dependent patients :** Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.	✓		New - National CQUIN collection .	Reporting
CCG10a	**Routine outcome monitoring in CYP and perinatal health services** : Achieving 40% of CYP and women in the perinatal period accessing MH services, having their outcomes measured at least twice	✓		Routine submission via (MHSDS)	Reporting
CCG10b	**Routine outcome monitoring in community mental health services**. Achieving 40% of adults and older adults accessing select Community Mental Health Services (CMHSs), having their outcomes measure recorded at least twice. In order to meet the requirements of this indicator, Patient Reported Outcome Measures (PROMs) data will need to be submitted (either in combination with Clinician Reported Outcome Measures (CROMs), or only PROMs) as part of the numerator for this CQUIN during the financial year	✓		At present paired outcomes are not consistently recorded. As part of the transformation to replace CPA a trial of DIALOG and DIALOG+ care planning is intended and this will give an opportunity for pared outcomes to be recorded. The implementation is in the planning stage, a workshop with experts by experience and profession having taken place, next steps is to design the staff training and implementation plan and then rollout in Q4.	
CCG11	**Use of anxiety disorder specific measures in IAPT** Achieving 65% of referrals with a specific anxiety disorder problem descriptor finishing a course of treatment having paired scores recorded on the specified Anxiety Disorder Specific Measure (ADSM).	✓		Routine submission to (IAPT) Data Set	Reporting
CCG12	**Biopsychosocial assessments by mental health liaison services** Achieving 80% of self-harm referrals receiving a biopsychosocial assessment concordant with NICE guidelines.	✓		New - National CQUIN collection .	Reporting
CCG13	**Malnutrition screening in the community - applicable to inpatients and community settings** . Achieving 70% of community hospital inpatients and community nursing contacts having a nutritional screening that meets NICE Quality Standard QS24 (Quality statements 1 and 2), with evidence of actions against identified risks		✓	New - National CQUIN collection .	Reporting Q2 - data collection in progress for November Portal close
CCG14	**Assessment, diagnosis and treatment of lower leg wounds** Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines.		✓	New - National CQUIN collection .	Reporting Q2 - data collection in progress for Nov Portal close
CCG15	**Assessment and documentation of pressure ulcer risk** Achieving 60% of community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.		✓	New - National CQUIN collection .	Reporting Q2 - data collection in progress for November Portal close.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

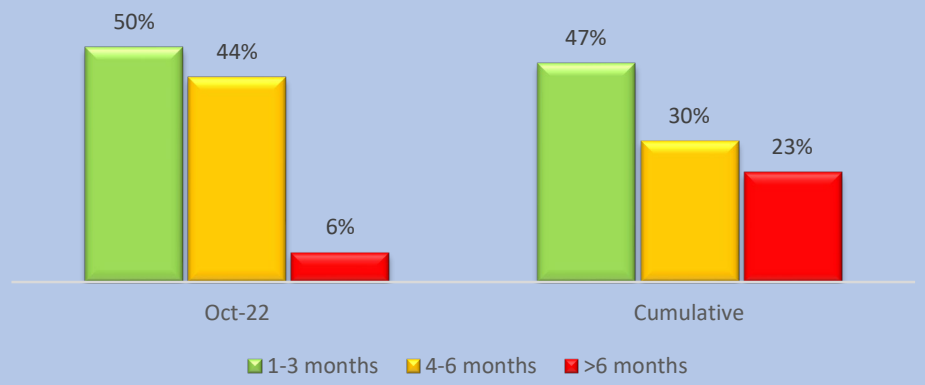
CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

No	Reporting Level	Threshold	2021/22 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022/23 YTD	R A G	Exception Report?	Benchmarking Report
Number of Friends and Family Test Responses Received	N - T	15%	16581	1167	1314	1229	1183	1354	1177	1523						8947			
% of respondents indicating a positive experience of our services	N - R	95%	94%	94%	94%	94%	95%	95%	95%	94%						94%			
Number of compliments received in month	L - R		1644	133	150	181	170	128	134	151						1047			
Number of other contacts received in month	L - R		371	34	51	40	37	46	55	54						317			
Number of concerns received in month	L - R		459	40	59	45	37	65	54	61						361			
Number of complaints received in month	N - R		120	9	8	15	10	8	13	18						81			
Number of open complaints (not all opened within month)				50	46	43	38	28	38	40									
Percentage of complaints acknowledged within 3 working days			93%	100%	100%	100%	100%	100%	100%	100%						100%			
Number of complaints closed in month				13	12	18	15	18	3	16						95			
Number of complaints closed within 3 months				3	5	9	6	13	2	8						46			
Number of re-opened complaints (not all opened within month)				7	7	5	7	6	7	8									
Number of external reviews (not all opened within month)				1	0	0	0	0	3	1									

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

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

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

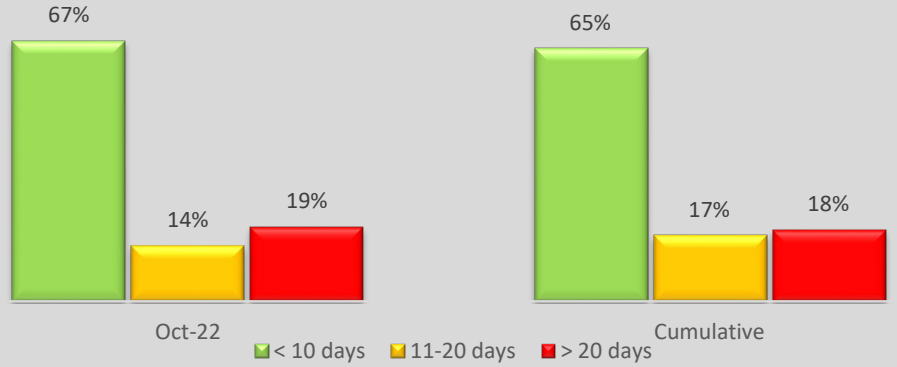


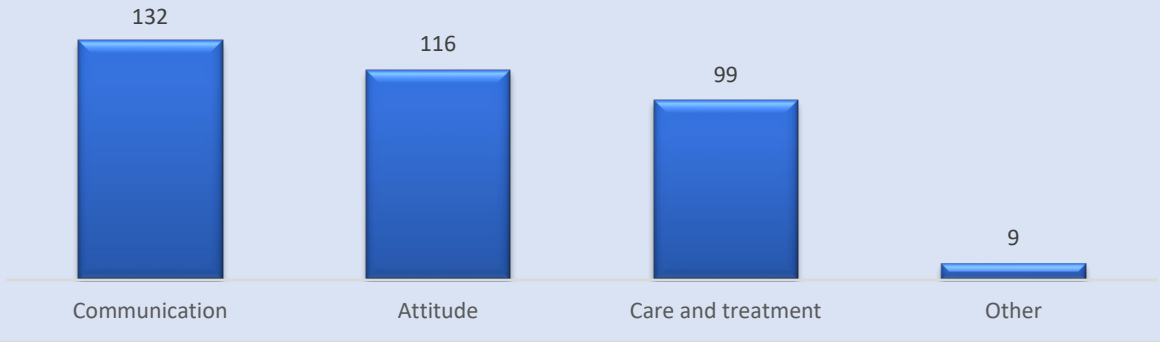
Complaints:

- **16** complaints were closed this month, of which **6** were partially upheld, **8** were not upheld, and **2** were withdrawn.
- Of these **16** complaints, most issues related to accessing services, alongside care and treatment, and communication, which are the two most common complaint areas.
- PCET are working towards closing complaints in a more timely manner and this financial year, there are KPIs relating to the length of time taken to close complaints. The chart opposite indicates performance against KPI.
- **50%** were closed within three months (target = 95%) and 44% closed within six months (target = 5%); this reflects the ongoing operational challenges within the system

Concerns:

- Of the **63** concerns that were closed this month, **3** were escalated to our formal complaints process (**95% were successfully resolved**)
- The key themes this month relate to communication and staff attitude followed by care and treatment, and access to services.
- PCET are working towards closing concerns in a more timely manner and this financial year, there are KPIs relating to the length of time taken to resolve concerns. The chart opposite indicates performance against KPI.
- **67%** were closed within 10 working days (target = 80%), and a further **14%** were closed within 20 working days (target = 20%).





Compliments:

- **151** compliments were recorded this month which consisted of 356 themes.
- This is consistent with annual trends and an improvement in a comparison for 21/22 in the same period.
- The largest compliment theme was communication, which is often one of the most common concerns/complaints received regarding our services.
- The next largest compliment theme related to staff attitude as well as care and treatment

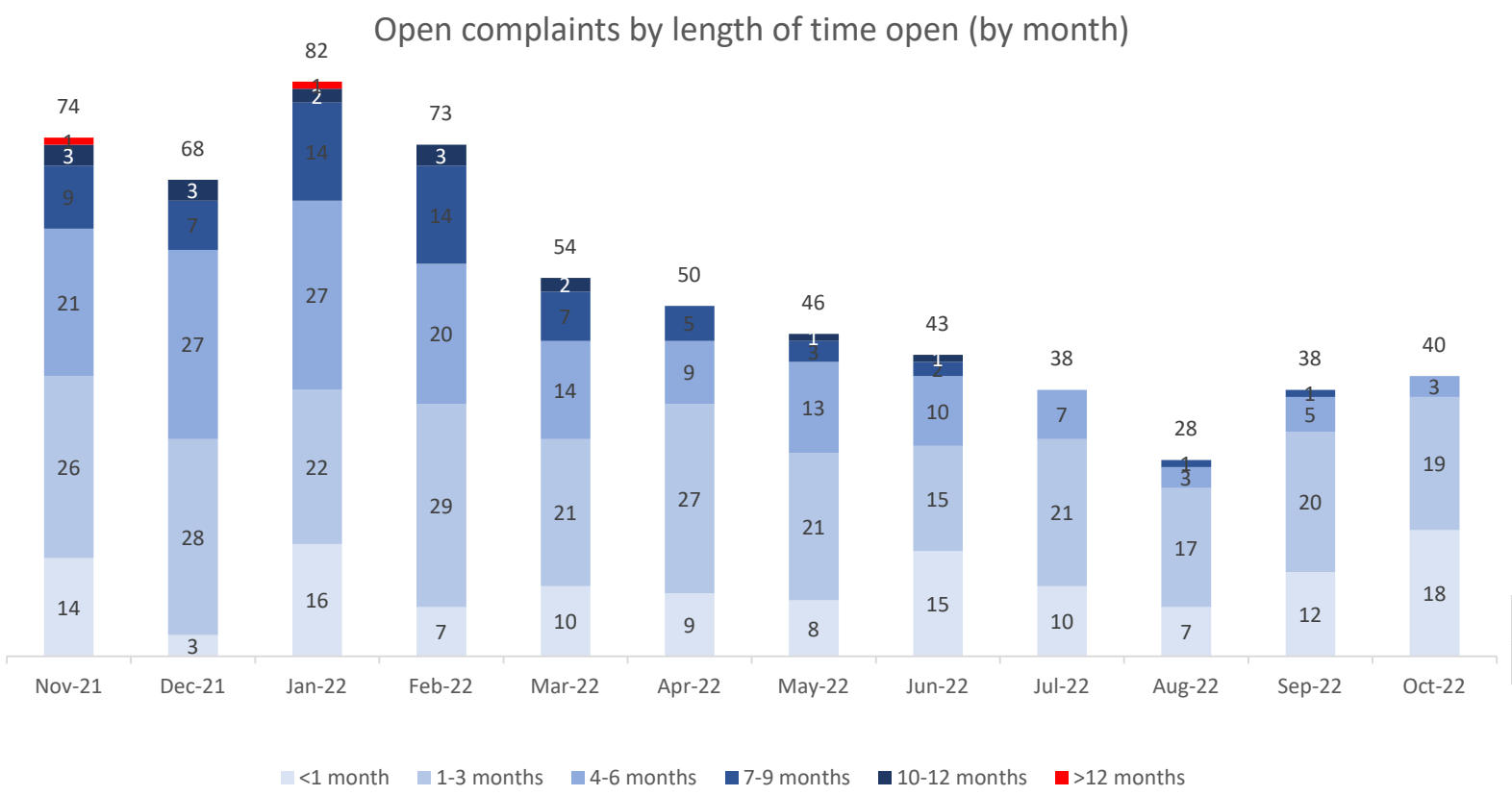
CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

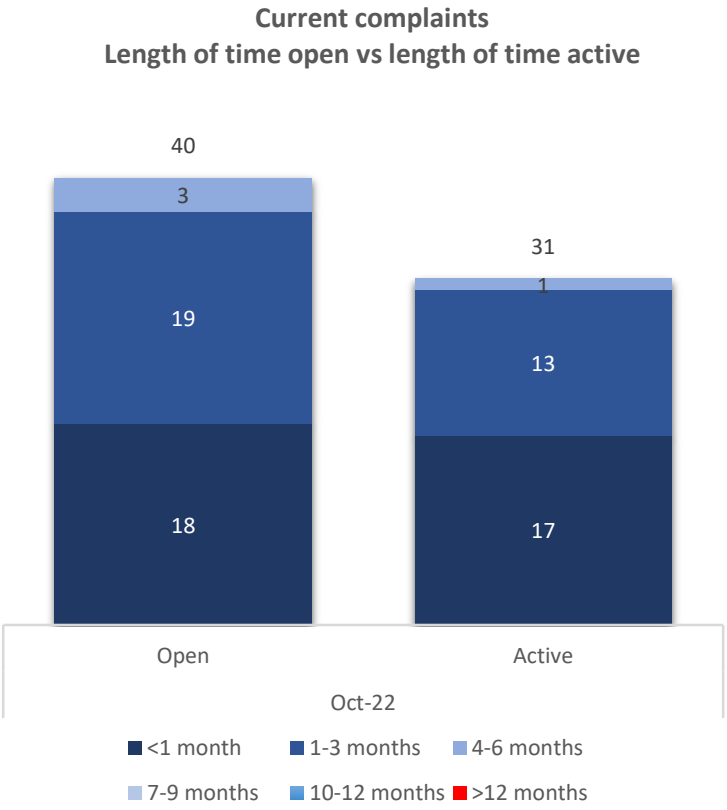
Overview of current complaints:
Of the **40** open complaints, **9** do not have agreed response times as issues have not been agreed.

Of the **31 'active'** complaints with agreed response dates, **24** are within the agreed timeframe and **7** have exceeded the initially agreed timeframes for a range of reasons including:

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

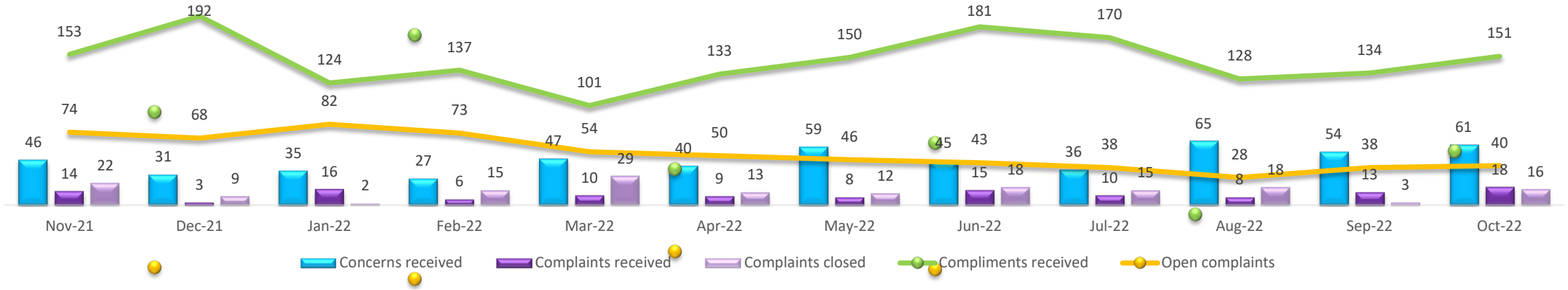
The charts below show the length of time complaints have been open (bottom left) and the number of complaints active (where issues have been agreed with the complainant) vs open complaints (bottom right).
We currently have no complaints open over 6 months old (this is a rolling figure that adjusts each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



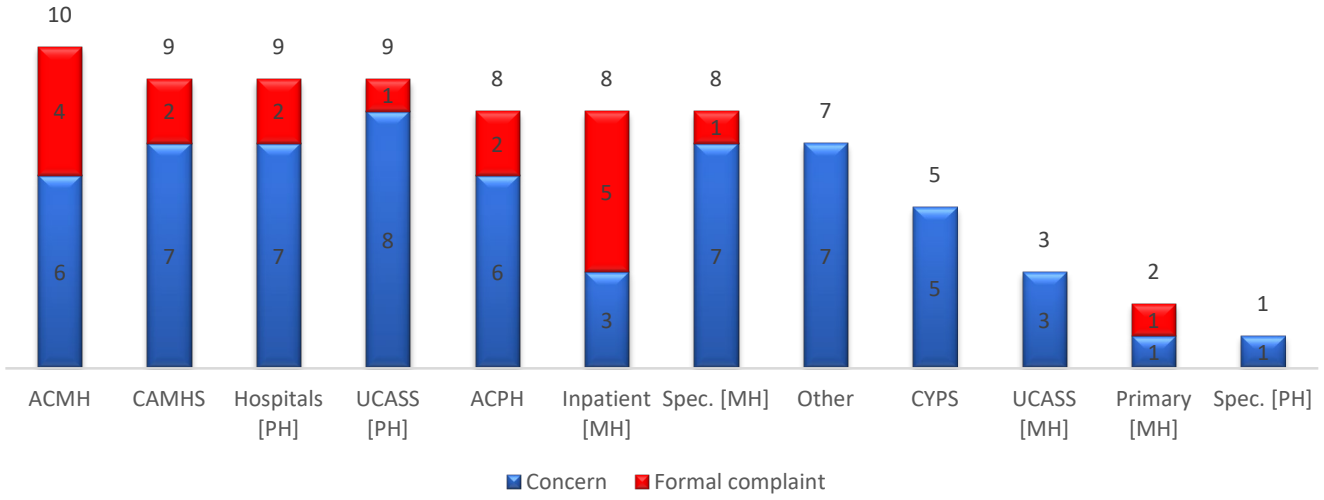


CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

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



The charts below shows which of our services were named in the **79** complaints and concerns we received last month. Our secondary care mental health community services received 13% of the feedback, followed by CAMHS, community hospitals, and UCASS physical health (each 11%).



Secondary care mental health services (13%)

Feedback is split across 3 teams:

- Recovery [4]
- Later Life [2]
- MHICT [1]

Themes focus on staff attitude along with patient care / treatment.

Community hospitals (11%)

Feedback is split as follows:

- Stroud hospital [5]
- Vale hospital [2]
- Cirencester hospital [1]

Themes are largely around staff attitude, access to services, and patient care / treatment.

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

Key indicators (% positive):

98%

Did you feel you were treated with respect and dignity?

96%

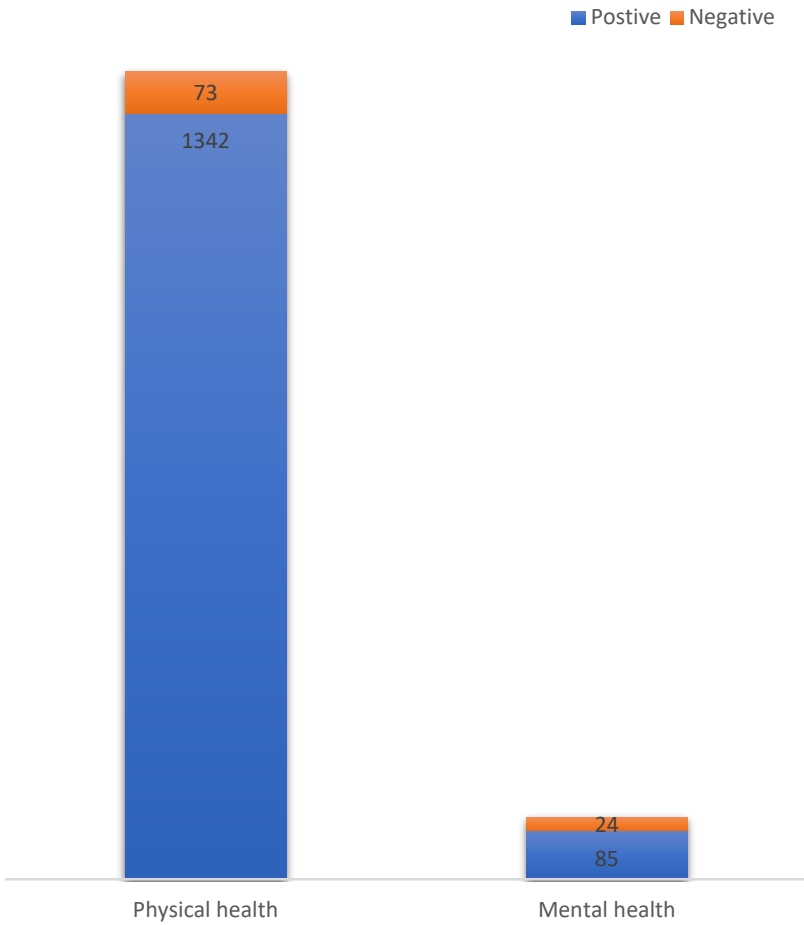
Were you involved as much as you wanted to be in decisions about your care and treatment?

98%

Did you feel the service was delivered safely and protected your welfare?

Hospitals overall	**95**	**84**	**88%**
Hospitals - physical health	62	61	**98%**
Hospitals - mental health	33	23	**70%**
Specialist overall	**351**	**334**	**95%**
Specialist - physical health	320	311	**97%**
Specialist - mental health	31	23	**74%**
Adult community overall	**219**	**198**	**90%**
Adult community - physical health	194	177	**91%**
Adult community - mental health	26	21	**81%**
Urgent care overall	**787**	**748**	**95%**
Urgent care - physical health	787	748	**95%**
Urgent care - mental health	0	0	**0%**
CYPS overall	**71**	**63**	**89%**
CYPS - physical health	52	45	**87%**
CAMHS - mental health	19	18	**95%**

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



- The new FFT infrastructure went live on 20th October 2022. In that 11 day period to 31st October, we received an additional 315 responses for our MIIUs alone (740 in total) as well as small increases for our MH services; specifically, MHICT, IAPT and Recovery and this accounts for the significant upturn in returns.
- The automated FFT link is now sent on discharge and at 12 months after referral to focus on those who have been open to services for longer periods, but not yet ready for discharge.
- We continue to encourage services to gather feedback through other methods such as electronic links, QR codes, paper and iPads.

ARE SERVICES SAFE? Non-Executive Director audit of complaints Q2 2022/23

INTRODUCTION

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

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

PROCESS

- Three complaint files closed in the quarter are randomly selected by the nominated Non-Executive Director auditor
- The Patient and Carer Experience Team completes section 1 of the audit tool and provide the auditor with copies of the initial complaint letter, the investigation report, and the final response letter.
- Having studied the files, the auditor completes sections 2 - 4
- The auditor compiles a report of their findings, to be presented at the Quality Committee and Trust Board
- Audit findings are summarized within the table on the following slide
- The Q2 2022/23 audit provides good assurance that overall, the Trust is investigating and responding to complaints appropriately.
- Delays in responses have been noted and work continues to address complaints over 3 months old. Waiting times are monitored via the monthly Quality Dashboard.

FUTURE AUDITS

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

RECOMMENDATIONS

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

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

ARE SERVICES SAFE? Non-Executive Director audit of complaints Q2 2022/23				
	Time scale of response	**Quality of investigation**	**Accessibility, style and tone of letter**	**Learning actions identified**
Complaint 1 [4462] • Mother of patient reported that CAMHS declined to amend factual inaccuracies in an assessment, despite the complainant's assertion that these are given as "complicating factors" meaning an ASC diagnosis could not be confirmed.	**LIMITED ASSURANCE** • No comments noted • Complaint response was delayed due to delays in investigation processes	**FULL ASSURANCE** • Thorough investigation of complex set of issues.	**FULL ASSURANCE** • Language was empathetic, understanding, and used accessible language. • Apologies were offered where appropriate.	**FULL ASSURANCE** • Full assurance around learning identified • Learning should be embedded • People responsible identified, but no timeline.
Complaint 2 [5588] • Patient unhappy that he has not been able to access support from the Recovery Team.	**FULL ASSURANCE** • Complaint response was sent within agreed timeframe	**LIMITED ASSURANCE** • The Preliminary investigation report did not have the details of the investigating officer, professional title, or date. • Boxes were not ticked.	**FULL ASSURANCE** • Outcome of complaint not included in letter (e.g. “upheld”) • Letter was written in a good tone	**LIMITED ASSURANCE** • Letter gives no time line therefore no way of knowing if actioned.
Complaint 3 [5845] • Son of patient complained that his mother was transferred from the acute trust to a community hospital where a week later she developed a PE and DVT and died.	**FULL ASSURANCE** • Complaint response was sent within usual timeframe	**FULL ASSURANCE** • The outcome of each issue of the complaint was identified in the investigation	**FULL ASSURANCE** • Apologies were offered where appropriate • It was clear the complaint was not upheld.	**FULL ASSURANCE** • No learning was identified however the death was discussed at the mortality review group GHCFT

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

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

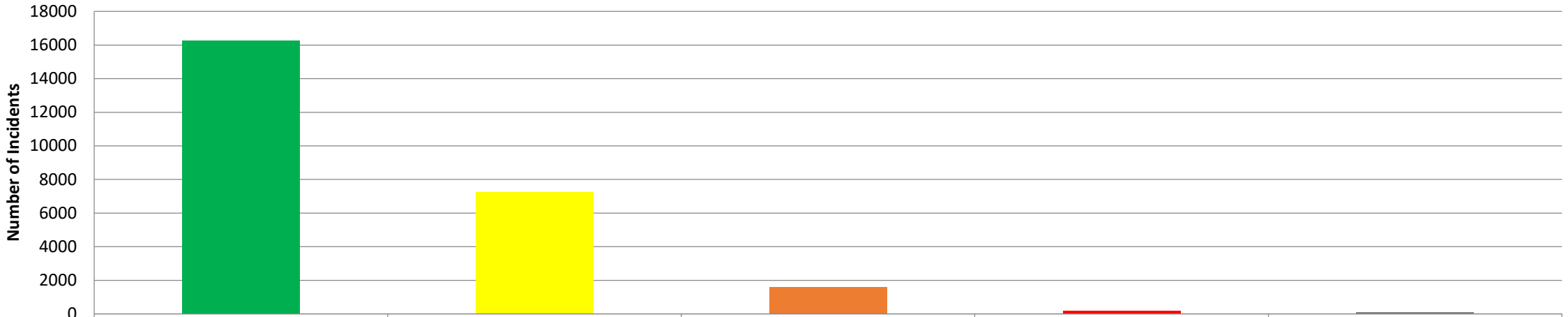
	Reporting Level	Threshold	21-22 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022-23 YTD	R / A / G	Exception Report?	Benchmarking Report
Number of Never Events	N - T	0	0	1	0	0	0	0	0	0						1			N/A
Number of Serious Incidents Requiring Investigation (SIRI)	N - R		32	10	3	1	4	2	1	2						23			N/A
No of overdue SI actions (incomplete by more than I month)	L - R		**New**	3	5	5	7	7	3	4						N/A			N/A
No of unallocated SI investigations (waiting more than 1 month for allocation).	L - R		**New**	1	0	0	0	0	0	0						0			N/A
Total number of falls (Inpatient Units, Community and Specialised services) resulting in moderate harm, severe harm or death	L - R		25	10	4	3	4	5	3	0						29			N/A
Number of Serious Incidents Requiring Investigation (SIRI) regarding self harm or attempted suicide	N - R		2	0	0	1	0	2	1	2						6			N/A
Number of Rapid Tranquilisations.	N - R		545	69	106	120	109	85	99	89						677			N/A
Total number of Patient Safety Incidents reported	L - R		12313	1216	1101	1013	1115	1046	963	1110						7576			N/A
Number of incidents resulting in low or no harm	L - R		11418	1138	993	933	1008	960	875	1041						6967			N/A
Number of incidents resulting in moderate harm, severe harm or death	L - R		895	78	108	80	107	86	88	69						609			N/A
Number of medication errors resulting in moderate, severe harm or death	L - R		5	1	0	2	0	0	0	1						4			N/A
Number of Embedding Learning meetings taking place	L - R		7	0	0	0	0	0	4	1						5			N/A
Total number of sexual safety incidents	L- R		57	9	10	17	15	11	8	15						85			

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

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

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

Patient Incidents by Reported Level of Harm 01/11/2020 - 31/10/2022



	None (no harm caused by the incident)	Low (minor harm, e.g. takes up to 1 month to rectify)	Moderate (significant but not permanent harm e.g. takes up to 1 year to rectify)	Severe (permanent or long term harm caused)	Death
Incidents	16289	7242	1614	185	112

Key highlights:

We have included in this dashboard a summary of patient safety incidents reported over the last 2 years and seek to present data that can identify patterns requiring deeper analysis. This also includes a focus summary view on the prevalence of patient safety incidents by categories including how these have adjusted over time. These themes will inform the Patient Safety Investigation strategy stakeholder event which is in its planning stages.

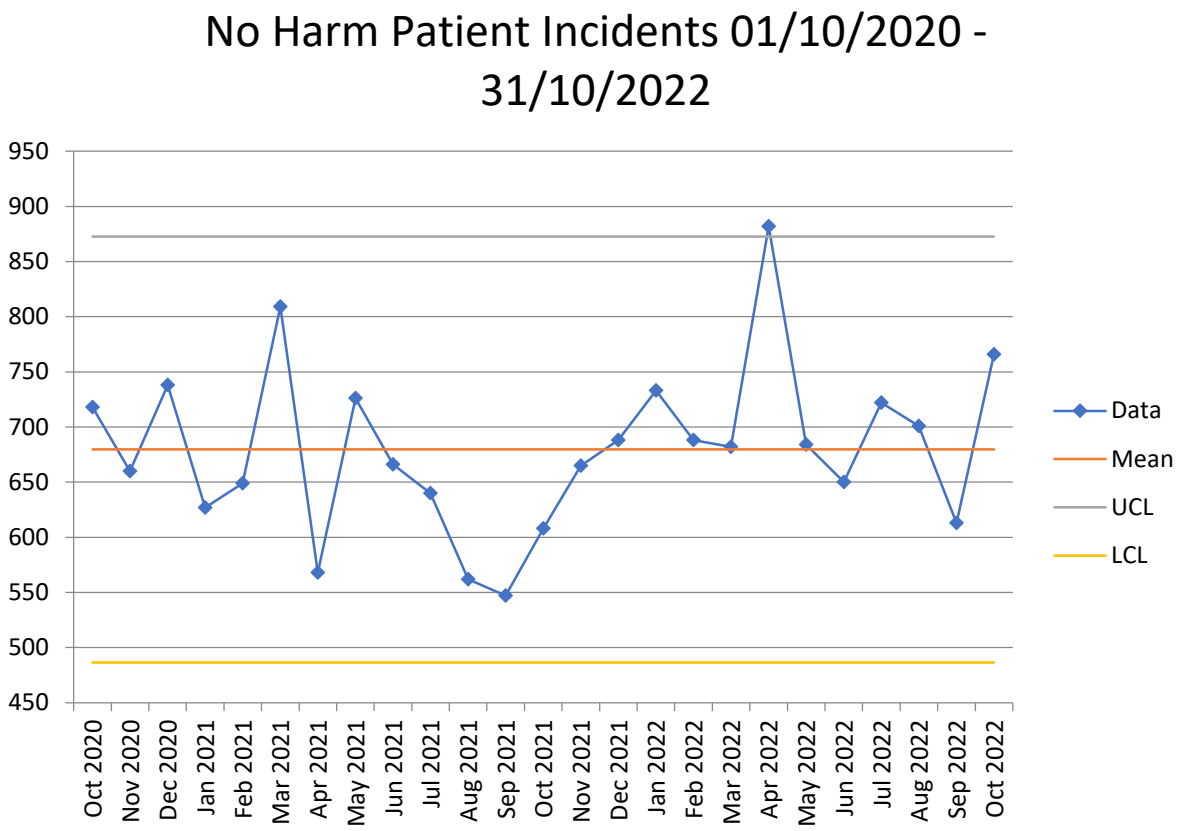
In October, there were a total of 1110 patient related incidents reported via Datix (141 more than September). 1041 were reported as No and Low harm incidents (161 more incidents than September) and 69 Moderate, Severe and Catastrophic incidents (a reduction of 20 incidents compared to September). The narrative below provides some explanation as to why there has been an increase in no and low harm incidents reported. In October 2022, the PST reviewed 21.4% of No and Low harm incidents which were reported (230 incidents were reviewed out of a total of 1065). The patient safety team has consistently reviewed a minimum of 10% of the No and Low harm incidents for 19 months. The PST are continuing to review all falls and medication clinical incidents from Charlton Lane Hospital regardless of the level of harm which will inform the quality improvement work being overseen by the new matron.

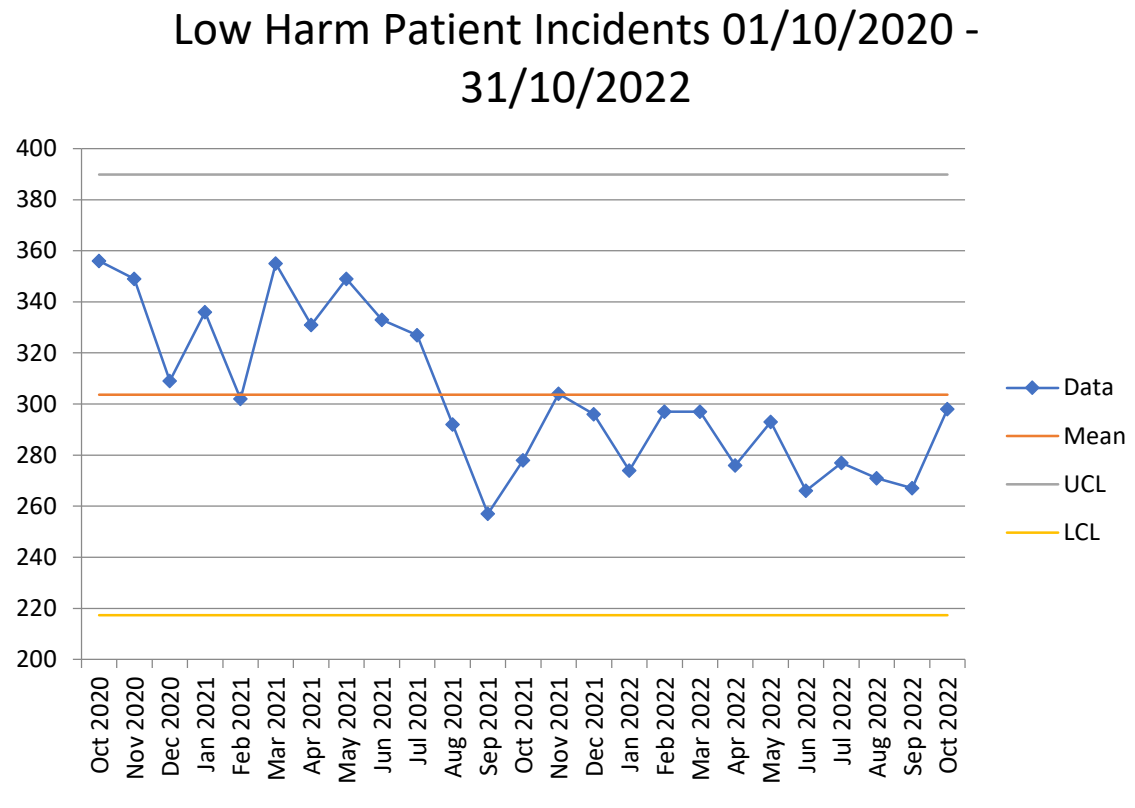
In September, we reported that Montpellier Unit, Wotton Lawn Hospital had seen an upturn in reporting of incidents (42 incidents compared to 7 incidents in August). This reflected incidents arising from enhanced support for two patients who required additional nursing , one patient was being re-titrated on their Clozapine medication and the other patient was waiting for transfer to another low secure service as a result of violence and threats to staff. Due to this enhanced support, one patient has seen an improvement and positive engagement with the team and therefore a reduction in incidents of violence and aggression. This has helped stabilise the ward environment, which has had a positive effect on the other patient. Overall this has resulted in a downturn of incidents being reported (15 incidents reported in October). Of the 15 incidents recorded, 11 have been reported as no harm, 3 have been reported as low harm and one reported as moderate harm.

The sexual safety incidents relate to mental health settings, Kingsholm, Montpellier Ward and Mulberry Ward. The incidents reported relate mainly to lewd comments and disinhibited behaviour, teams respond proactively and provide additional support to patients and colleagues who are impacted by this. For some this would include increased observation and education around relationships.

A positive reporting culture has led to an upturn in the number of restrictive intervention incidents reported in October (80) compared to September (30) by the LD IHOT team. Of the 80 reported incidents, 79 incidents were reported as a no harm and one incident was reported as low harm. The team manager reported that the team has been supporting it's service users to have the Flu and Covid 19 boosters. Although summarised as ‘restrictive interventions’, the team use precautionary holds during the vaccinations to reduce the risk of needle stick injuries from moving arms and each precautionary hold is reported on Datix. This has influenced the overall upturn in restrictive interventions being reported in October (252 restrictive interventions reported in October compared to 192 incidents reported in September).

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





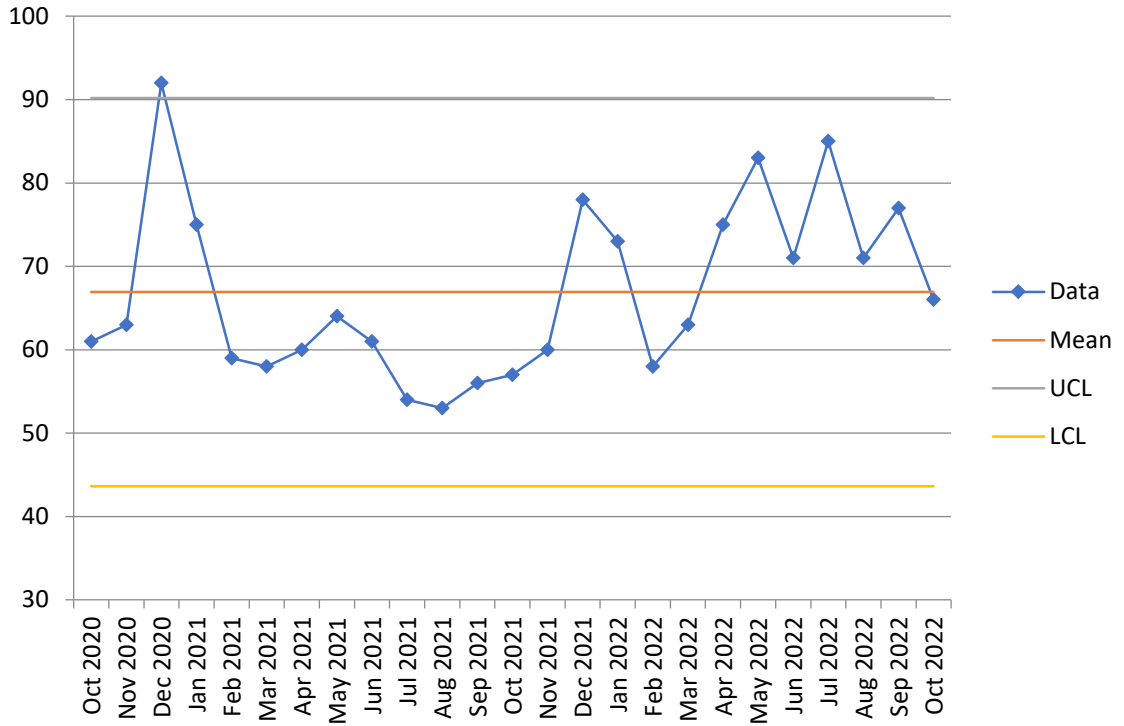
This slide provides data in the form of statistical process control charts. These enable the visualisation of change over time which is essential in tracking and monitoring improvement. Future reports will overlay other measures with this data together with narrative to; identify chronologies of events, decisions, QI activity, periods of high acuity, staffing changes and, with future reporting systems, benchmark our incident reporting against other similar providers. Data related to self-harm and ligature activity has been extracted and this can be analysed over the coming weeks. One piece of data related to self-harm incident reduction is expressed in the report.

No Harm Incidents over time - Whilst this data shows the level of reporting being generally in line with the mean there is a statistically significant fall below the mean between July and November 2021. The Patient Safety Team will seek to understand this variation.

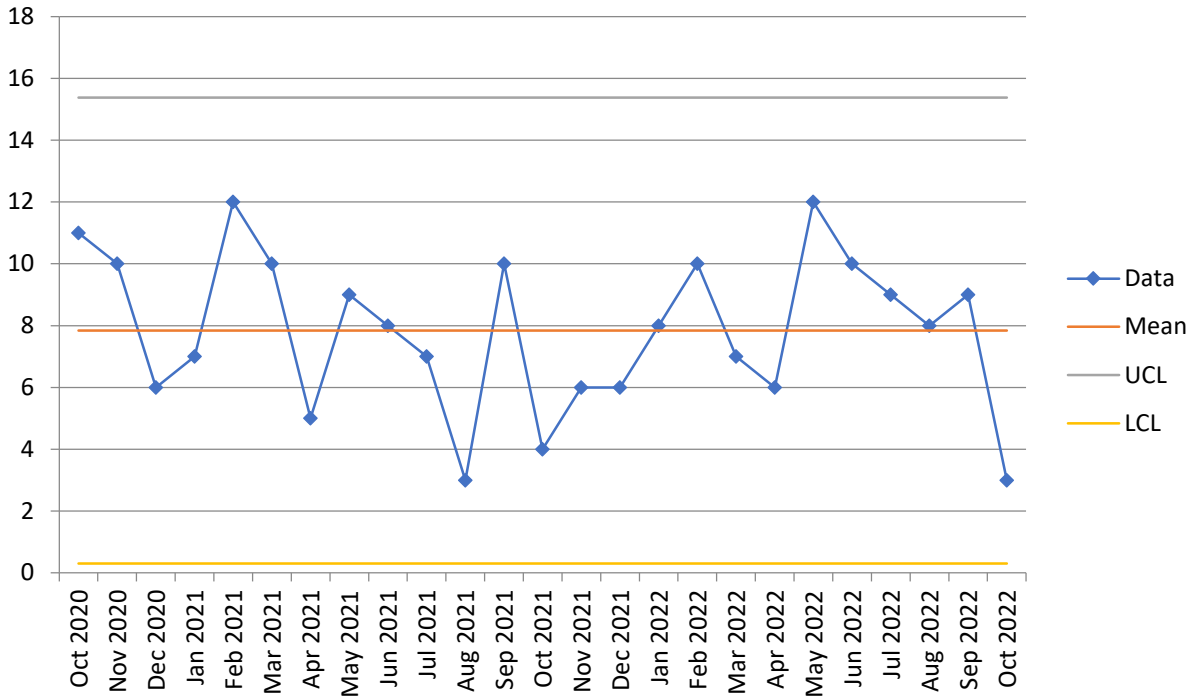
Low Harm Incidents over time - This data could be very reassuring, however the reduction visible each month for 10 months of reported low harm incidents may be accounted for in the developing rise in reported incidents of moderate harm seen on the next slide. The Patient Safety Team will develop processes to identify if we are simply reporting fewer incidents, despite numbers of actual incidents remaining static, or whether there are technical explanations such as a change in the parameters of the reporting system.

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

Moderate Harm Patient Incidents 01/10/2020 - 31/10/2022



Severe Harm Patient Incidents 01/10/2020 - 31/10/2022

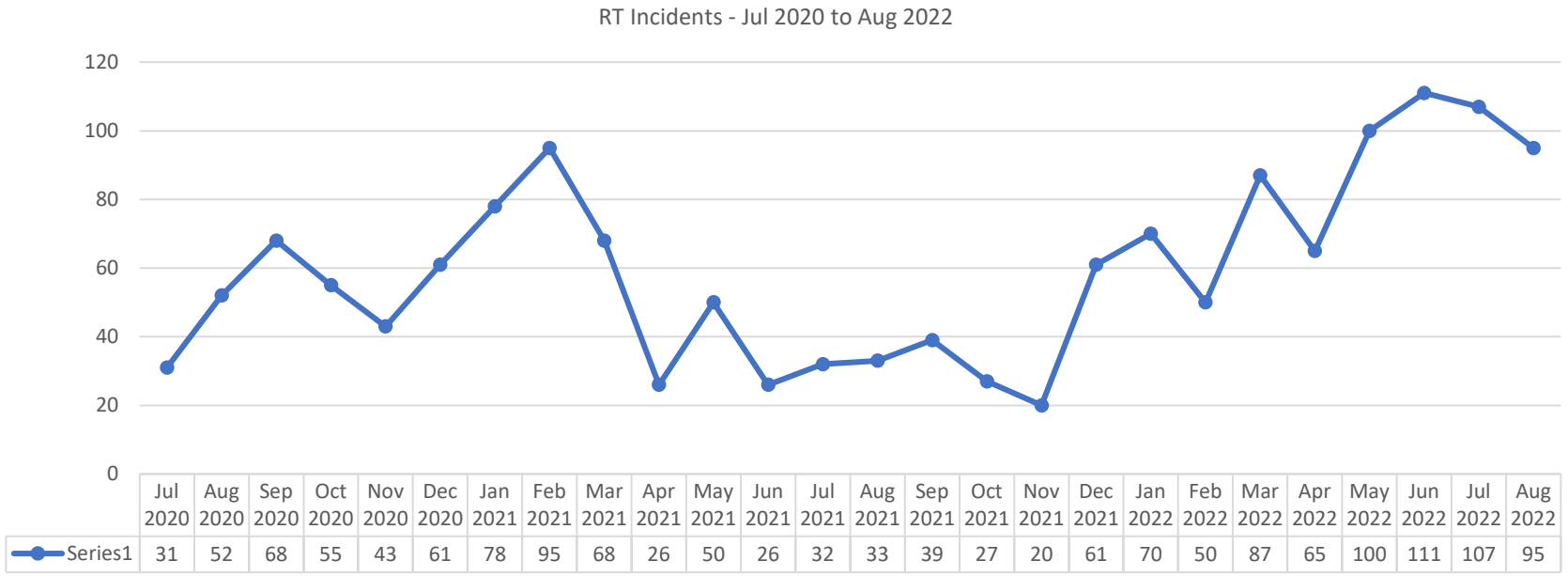


This slide provides data in the form of statistical process control charts. These enable the visualisation of change over time which is essential in tracking and monitoring improvement. Future reports will overlay other measures with this data together with narrative to; identify chronologies of events, decisions, QI activity, periods of high acuity, staffing changes and, with future reporting systems, benchmark our incident reporting against other similar providers

Moderate Harm Incidents over time - The picture emerging here, despite the mean not altering at present, is of a statistically significant rise in the number of reported moderate harm incidents. The Patient Safety Team will seek to provide the analysis of the dip seen in April to December 2021, a similar dip as seen in no harm incidents in the same period.

Severed Harm Incidents over time - Despite the down turn in month, the data reflects a largely static position in relation to severe harm events, however, notes the reduction in harm in 21/22. The patient safety team will undertake further analysis of this period to understand the changes over time and will report in future dashboards.

Initial Analysis of the rise in use of Rapid Tranquillisation



	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022
Series1	31	52	68	55	43	61	78	95	68	26	50	26	32	33	39	27	20	61	70	50	87	65	100	111	107	95

An initial review of the current rise in reported use of RT as seen from March 2022, commissioned by the Improving Care Group, has identified that 5 five wards account for 88% of both IM & Oral RT.

- Abbey Ward
- Greyfriars PICU
- Dean Ward
- Priory Ward
- Willow Ward

Key highlights:

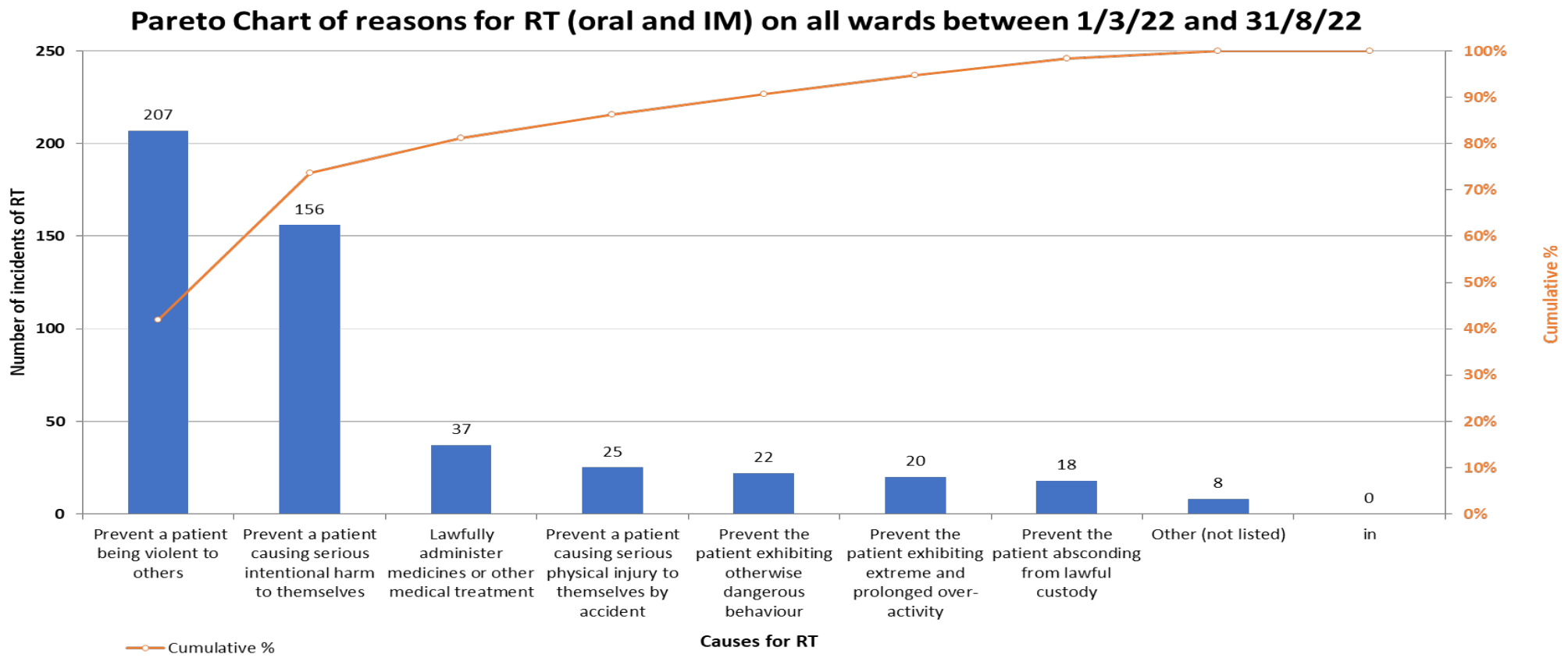
Noting an increase in the overall number of rapid tranquillisation incidents reported, the Patient Safety team have undertaken a review of the data and activity. Exploration of the dataset via Pareto Charts indicates that patients being violent to others, preventing a patient causing serious harm to themselves and lawfully administrating medicines or other medical treatment contribute to 80% of the total RT use (oral and RT). This is seen on the next slide. Further analysis into each ward's dataset clearly shows that a small proportion of inpatients account for the majority of these incidents.

Abbey Ward had the highest number of RT incidents (35%). Approximately 60% of these incidents were reported as preventing a patient harming themselves. RT is often required to alleviate distress and agitation and to reduce the level of harm being caused; particularly during incidents of self injury. 162 Datix were generated for one patient on Abbey Ward between April and August; 101 of which were incidents of self-harm. Not all incidents resulted in RT, but many did. This person frequently self injures to a degree where significant harm could occur if not managed using low level PMVA techniques (seated safe holds) and RT IM.

Similarly on Dean Ward, two individuals were attributed to the majority of RT incidents in response to either harm to self or others. There are 104 Datix for one patient between April and August and 79 Datix over a 3 month period for the other.

The Manager of Greyfriars PICU attributes the majority of RT over the last 6 months to a comparably small number of patients presenting with behavioural challenges. RT was primarily used in response to externalised aggressive behaviour towards others. External aggression is one of the 5 admission criteria for the PICU and therefore the intervention reflects the level of risk and distress seen in this clinical environment.

The Manager of Willow Ward attributes the majority of RT over the last 6 months to 3 patients who were in the latter stages of their illness and presented a risk of violence towards others. In all instances, restrictive interventions and RT interventions for these individuals are care planned and reviewed regularly in collaboration with the patients, or in their best interests through MDT processes.



Initial conclusions identify that:

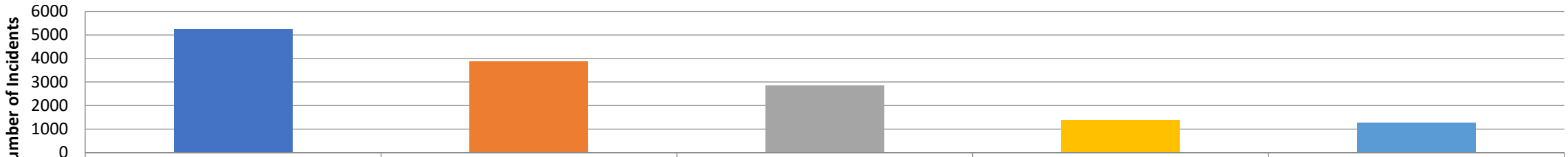
- A comparably small proportion of the inpatient population are attributed for the majority of RT administered over the last 6 months.
- The peak in RT data corelates with the high level of harm to self and others presented by this group, however, note overall numbers of self harm are reducing.
- RT is not being used frequently within the general patient population at WLH or CLH.
- Peaks will continue to occur in relation to the number of incidents of harm to self or others being presented at any one time.
- RT use is in line with local policy and is proportionate to the risk management challenges presented.

Next Steps

The Improving Care Group has commissioned a further review of the same dataset to establish if the prevalence of RT is linked in any way to vacancy rates, any clusters during the day or weekends. We will overlay this with a range of additional staffing data to include bank and agency use. This is more complex and will involve mapping agency and bank use by date and time against the use of RT. Consequently this will take longer to interrogate and will report back in December 2022. This analysis will be undertaken on Abbey Ward, Greyfriars PICU and Willow Ward.

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

Top 5 Patient Incident Categories (excluding restraint) 01/10/2020 - 31/10/2022

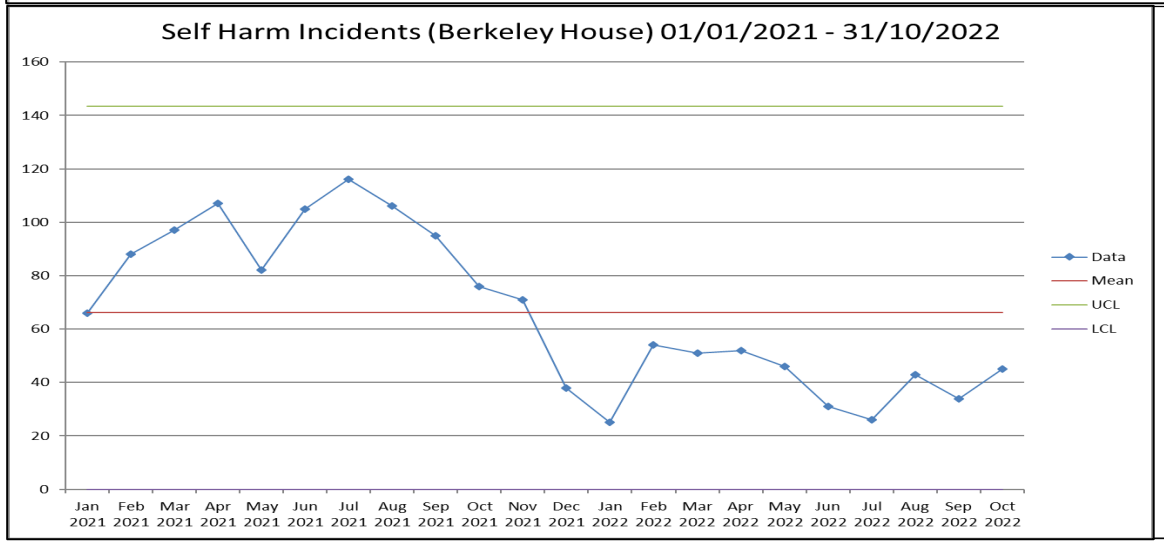


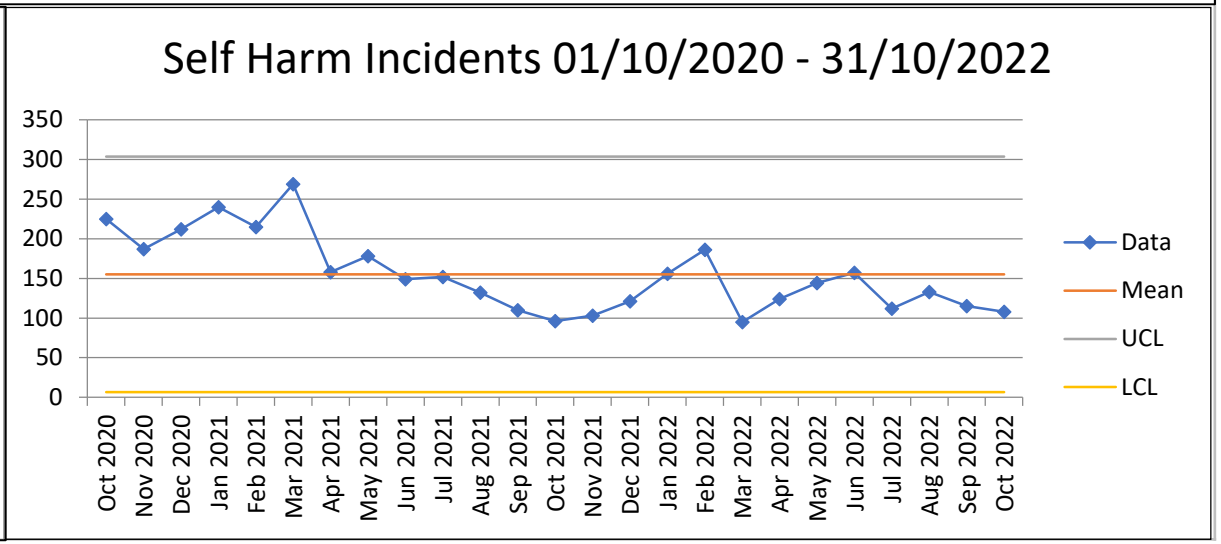
	Skin integrity (includes pressure ulcers)	Self harm / self-injurious behaviour (SIB)	Falls (including slips & trips)	Medication incidents	Clinical care, treatments and procedures
Incidents	5245	3870	2852	1401	1271

Key highlights in October

There was 62 reported incidents affecting patients assessed as a MODERATE harm and above. The four sub-categories were, Skin Integrity (Inc. Pressure Ulcers) (51 incidents), Clinical care, treatment and procedures (5 incidents), Self-harm / self injurious behaviour (SIB) (3 incidents), and medical emergency (Inc. 999 calls and onsite emergency response (3 incidents)

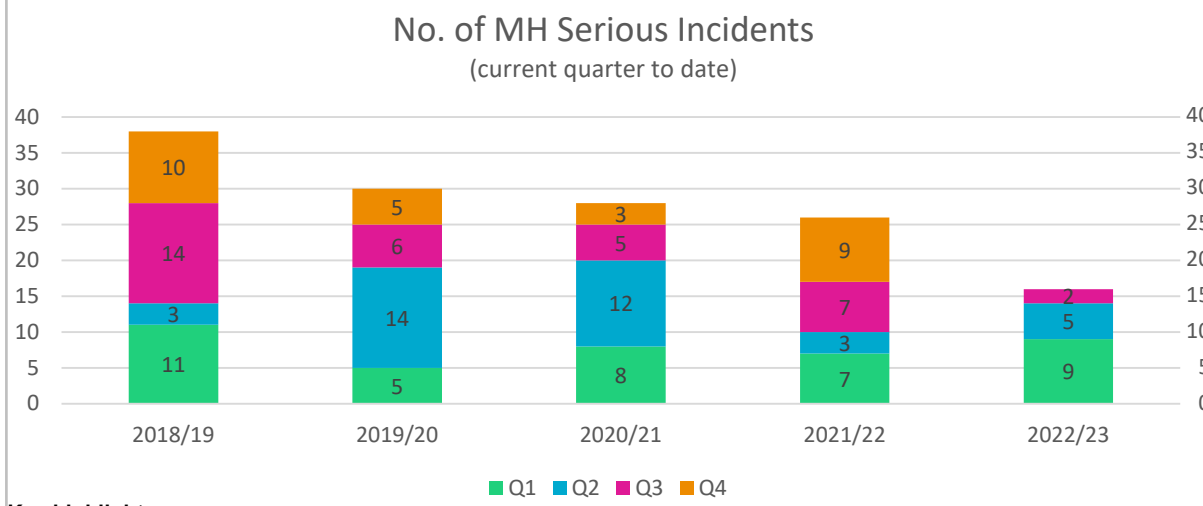
Additional information below shows activity data for the self harm incidents over a 2 years period. The pressure on services over the past 2 years has been unprecedented and there are pockets of improvement that have positively influenced our activity data. We have made good progress in the categorisation and management of skin integrity and can also attribute the Positive and Safe programme to the improvements noted in self harm incidents. The data at bottom left reveals a sustained reduction in self harm incidents in Berkely House, this correlates with a reduction in restrictive practice following a QI initiative, an expanded analysis will be shared with ICG.

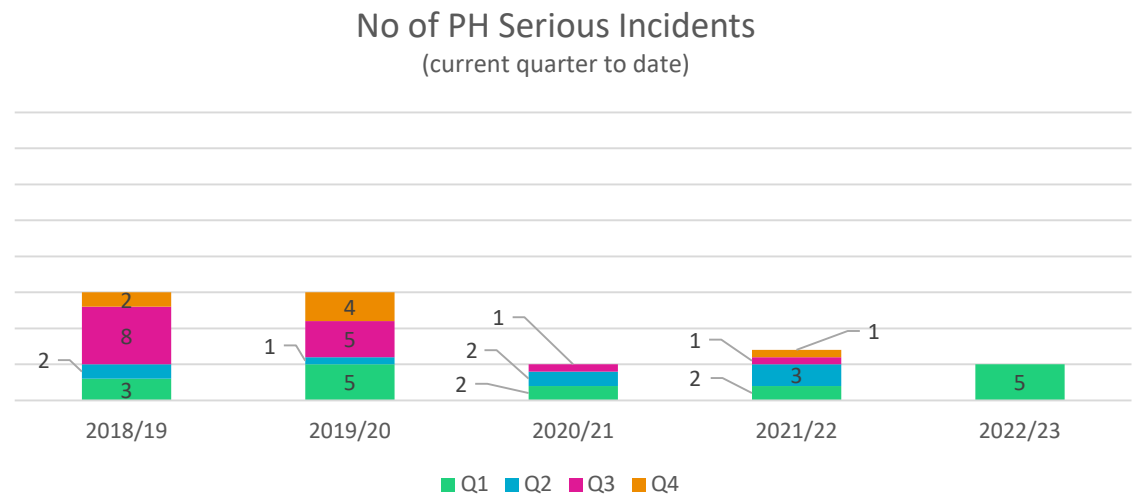




CQC DOMAIN - ARE SERVICES SAFE? – Serious Incidents and Embedded Learning

Two Mental Health SIRIs were declared in October 2022. There were no Physical Health SIRI's declared in October 2022





Key highlights:

In October, 3 initial investigations meetings were held to gain further information (3 MH). Out of these 3 incidents, 2 incidents were declared as SIRI's . The Patient Safety Team (PST) continue trialling capturing information from potential serious incidents more quickly by engaging in incident huddles, adopting an appreciative enquiry approach face to face, soon after an incident is declared. Additionally, this seeks to reduce the initial incident response (IIR) burden on clinical leaders, giving back time to support their team. This approach informed the 3 initial reviews in month and supports our approach for open and professional dialogue with clinical teams and quicker decision making around the nature of investigation required.

Throughout October we continued work on a number of our live projects:

- The Patient Safety and Quality notice boards have been ordered for Wotton Lawn Hospital, Charlton Lane Hospital, Laurel House and Berkeley House. All sites have identified staff areas for the noticeboards where there is either high foot fall or staff use for breaks. The PST have further site visits booked in November for other in-patient units where the teams have identified that the notice boards would be beneficial.
- Patient Safety Team and Duty of Candour (DoC) Lead will present at November Senior Leadership Network meeting to showcase embedded learning work which has commenced.
- Work is underway with the QI Hub to draw upon developing QI project themes to ensure that Clinical Development Manager and Patient Safety Investigators are aware of ongoing projects to ensure any actions identified from clinical reviews or investigations are reflected in the development of learning outcomes.
- The Clinical Incident and Learning Manager is continuing to work with medical staff, working towards a learning event for junior doctors in December, this learning event will cover the new Patient Safety Investigation Reporting Framework (PSIRF), themes of incidents / learning and what is meant by 'embedded learning'.

A review of the 87 recommendations arising from SIRI's during 2021/22 confirms that 78 actions have been completed, 5 actions are progressing and 4 are overdue with plans to resolve these in November. 4 actions were stood down, having been reviewed with commissioners. In 22/23 we currently have 21 actions, 4 have been completed and 17 are on track to be completed within the originally agreed timeframe. The Patient Safety Team have embarked on national patient safety investigators training with HSIB; one of the modules includes writing recommendations and generating effective actions to improve patient safety and reduce harm. The Trust Patient Safety Incident Response Plan will set the future standards for investigations and action generation.

Quality Dashboard

Improving the patient's experience of observations and engagement in Wotton Lawn Hospital

Gloucestershire Health and Care NHS Foundation Trust

A quality improvement project is underway with the aim of improving patients' experience of observations and engagement at Wotton Lawn Hospital. The steering group for the project has an expert by lived experience as the co-lead and also includes input from other experts by lived experience, staff from Wotton Lawn, and other colleagues within the Trust. This will ensure the outcomes from the project are patient-centred but also achievable and sustainable. Staff and patients on Priory and Abbey Wards are being asked to complete a survey to establish baseline data, which can then be reassessed following the implementation of the change ideas. Data relating to complaints, Datix, SIs, and compliments will also be analysed in order to evidence improvements. The steering group has started planning the first change idea, which will be to have a preference sheet inside patients' rooms to encourage engagement and personalised care. These will begin being used week commencing 21 November 2022.

About the Project

- SI investigation, observations and engagement identified as learning
- Recurrent theme in complaints and incidents
- Policy: "an opportunity for clinicians to interact in a therapeutic manner with the patient."

Aims & Objectives

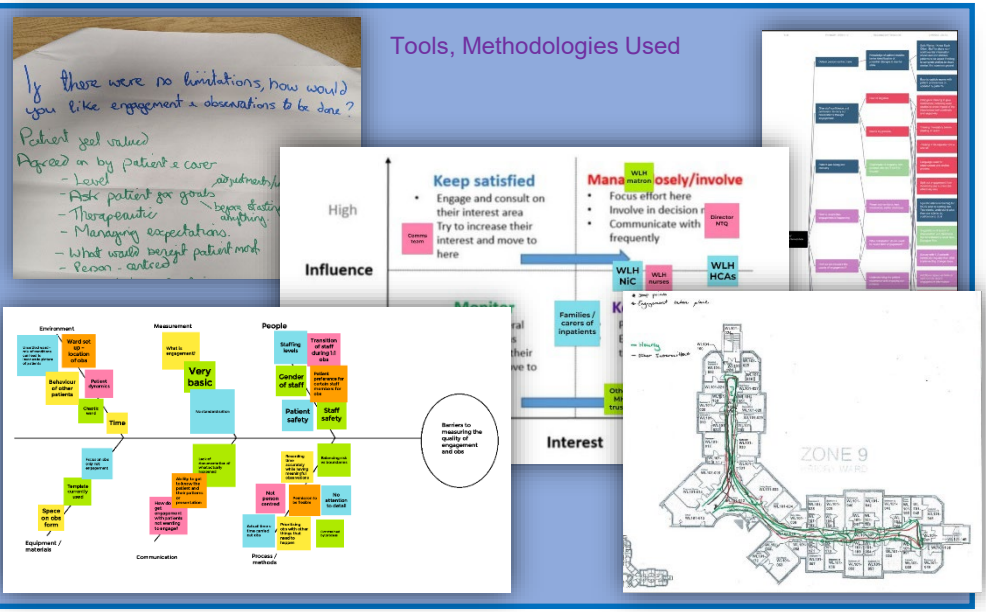
Aim: To see an improvement of 20% in patients' experience of observations and engagement on Priory Ward by March 2023.

Objectives: establish baseline data; identify measures; generate change ideas; PDSA cycles

Measurement

- **Baseline surveys** for patients and staff - **repeated** after PDSA cycles to measure improvement
- **Reduction in number of complaints** related to intervention
- **Increase in number of compliments** related to intervention
- **Reduction in number of Datix and SIs** relating to the intervention
- **Balancing measures**

Tools, Methodologies Used



How did you involve service users/carers?

Big I: Expert by Lived Experience, co-leading the project. Reflected that his experience of observation and engagement was not what the Trust would want it to be

My involvement has made me feel heard, engaged and more confident.

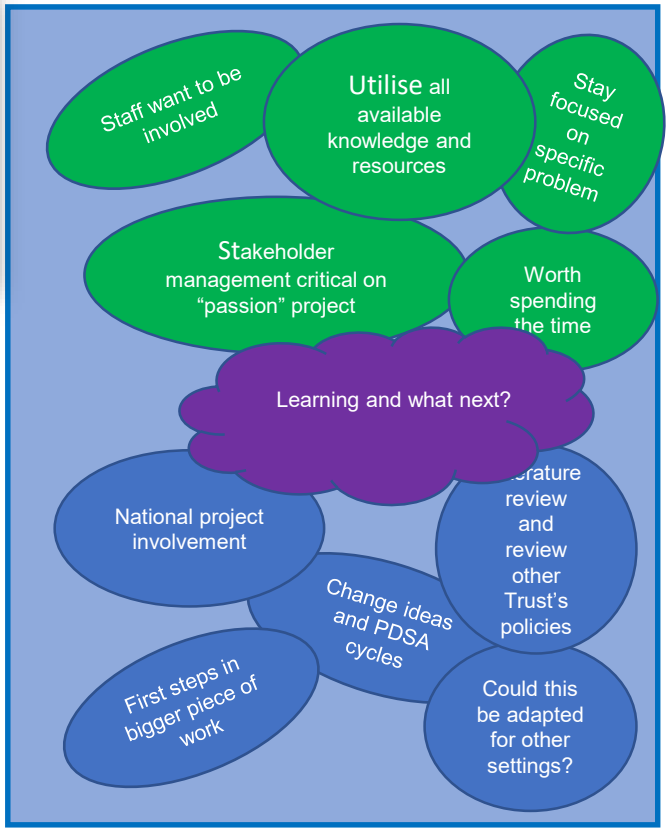
Project Outcomes, Progress & Impact

- What is engagement and how can we measure it? How will we know if we are making improvements?
- Baseline surveys, created with Experts by Lived Experience and staff
- Wards engaged and keen to gather data and try change ideas
- Wide range of change ideas – plan PDSA cycles with Experts by Lived Experience, ward staff and steering group
- Potential to share learning with national project on observations and engagement
- First step in longer-term project
- Identify governance routes

Observations felt functional and isolating.

Someone really connecting with you as a human being, even once a day, can transform your experience.

It is when you build that human relationship that recovery can begin.



Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

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

Children's	Q1 Total	Q2 Total	Oct	Nov	Dec	Q3 Total	Additional Information
SAFEGUARDING SUPERVISION							
Integrated Group Supervision sessions	42	62	20				Clinical staff working with children need to attend this supervision 3x per year. 5-6 sessions are delivered per week. Attendance at sessions is excellent, with a maximum of 8 participants per session. Feedback is sought and captured following every session.
Safeguarding Children Group Supervision Compliance			64%				In April 22 Safeguarding Group Supervision was added as an 'essential to role requirement' to staff Care to Learn Training Profiles. Sept is the first month compliance has been reported. Compliance is expected to rise as staff catch up with this requirement.
One to one Supervision sessions	4	8	3				121 Supervision is available to all upon request. In line with learning from recent child safeguarding reviews that recommend focused case reflection and discussion the team have been promoting 121 supervision across operational teams and Q2 saw a marked increase compared to Q1.
SAFEGUARDING ACTIVITY							
Advice Line Calls	142	129	51				Operational colleagues continue to make good use of the Safeguarding Advice Line. Slight increase in call relating to children in October.
Multi-Agency Request for Service Forms submitted to MASH	44	47	21				The Local Authority are unable to provide referral data and current clinical systems are unable to accurately capture this data. This is a documented risk – Risk 298. An action plan is underway to address this. LA Safeguarding Referral data is now captured via the Safeguarding Notifications Inbox.
Number of Escalations	4	5	1				This information is currently obtained from our Safeguarding Advice Line data. Further work is underway with Clinical Systems/Business Intelligence Teams to identify the number of escalations made to partner agencies.

	Q1 Total	Q2 Total	Oct	Nov	Dec	Q3 Total	Additional Information
SAFEGUARDING SUPERVISION							
Group Supervision Sessions	20	24	6				Safeguarding Adult Supervision Sessions are now offered to all clinical staff who work in Adult Services. Supervision is optional and booked via Care to Learn. Bespoke Supervision Sessions are offered for Team Leads and Managers.
SAFEGUARDING ACTIVITY							
Contacts to GHC advice Line	121	158	57				Calls to the GHC advice line re. adult safeguarding enquiries - may or may not proceed to a referral to the Local Authority. Advice Line Service Evaluation is being planned for the winter 2022.
Safeguarding Referrals made to GCC	4	27	7				This data is obtained from the Safeguarding Team Notifications Inbox. Work is underway with Clinical Systems and Business Intelligence to identify mechanisms across our clinical systems which capture this data accurately.
Escalations	2	1	1				This data is currently obtained from our Safeguarding Advice Line data, so is unlikely to give a accurate picture of referral numbers. Work is underway with Clinical Systems to identify mechanisms across our clinical systems which capture this data accurately
CASE REVIEWS							
New Safeguarding Adult Reviews/Domestic Homicide Reviews	2	1	0				No new notifications in October
Number of Reviews ongoing	11	12	12				6 Domestic Abuse Related Death Reviews, 4 Domestic Homicide Reviews, 2 SARs (1 awaiting publication) – All at varying stages of the review process.
Action Plans Ongoing	5	6	6				This includes single and multi agency action plans

Summary Notes - A full breakdown of Safeguarding Activity is outlined in Appendix 5

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

We continue the expansion of adult safeguarding supervision offer to all adult teams. We have established the GHC Safeguarding Notifications inbox to capture number of safeguarding referrals made to the Local Authority. This will provide the safeguarding team with improved oversight of organisational activity. Dedicated resources remain in place to recover the position in relation to uploading the MARAC Action Plan backlog, at the time of dashboard production it is reassuring to note that this work is now complete. We have an improving picture with Level 4 Adult Safeguarding Training and Children's Safeguarding Supervision compliance.

Challenges/risks: We have identified some variation in how Safeguarding related data is recorded on our clinical systems. We have a Safeguarding Action Plan in place to address risk and apply mitigations. We are working closely with Clinical Systems, Business Intelligence and Safeguarding Task and Finish Group working to find solutions that address risk. A monthly safeguarding audit of practice is commencing in December 2022 to test and quality assure safeguarding data..

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

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

	Reporting Level	Threshold	2021/22 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022/23 YTD	R A G	Exception Report?	Benchmarking Report
VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	98.3%	99.1%	100%	99.2%	99.1%	96.6%	98.2	98.1						98.0	G		
Number of post 48 hour Clostridium Difficile Infections (C Diff)	N	1	21	0	1	3	0	0	1	2						7	G		
Number of C Diff cases (days of admission plus 2 days = 72 hrs) - avoidable	N	0	0	0	0	0	0	0	0	0						0	N/A		
Number of MRSA Bacteraemia	N	0	0	0	0	0	0	0	0	0						0	N/A		
Total number of developed or worsened pressure ulcers	L - R	61	779	70	78	61	82	64	57	74						486	R		
Total number of Category 1 & 2 Acquired pressure ulcers	L - R	56	702	66	72	57	73	59	51	65						443	R		
Number of Category 3 Acquired pressure ulcers	L - R	0	57	3	5	3	3	3	4	8						29	R		
Number of Category 4 Acquired pressure ulcers	L - R	0	19	1	1	1	6	2	2	1						14	R		

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

HCAI

- There were two post 48-hour Clostridium Difficile (C. Diff) infections recorded in October, both within Community Hospitals, patients treated and managed as per policy.

Pressure Ulcers

- October data will require further validation checking, due to annual leave and a turnaround following the reporting period the October data is un-validated
- As in previous reporting periods it is expected that following validation there will be a large proportion of PU that are defined as unavoidable, particularly those patients who are end of life.
- It is recognised that as an organisation we will always have pressure ulcers evident within our Trust as a large proportion of patients are referred to us with an existing PU. community nursing caseloads having patients referred with existing pressure ulcers obtained whist under primary care, residing in care homes or acute hospital transfers. The pressure ulcer data is monitored via improved reporting, verification/alteration of classification and improved operational tolerances.
- There are three key factors that continue to impact on severity of pressure ulcers; Circulatory changes following Covid infection, deconditioning of patients who live at home and have become more socially isolated and physical immobility during and following Covid infection.
- There was a reduction in the number of avoidable PU in October in hospital environments (3 to 0), however an increase in ICT (7 to 13) that are currently being reviewed for data quality and potential for reclassification and learning, these can occur as a result of patients being in a non GHC environment, not being concordant with advice given and also attributable is the complexity of caseloads.
- GHC Deputy Director of Nursing has agreed with ICS peers that the arrival of the new National Wound Care Strategy provides a platform for a true system approach to the prevention, identification and management of PU across all partners. Further updates will be provided within future dashboards.

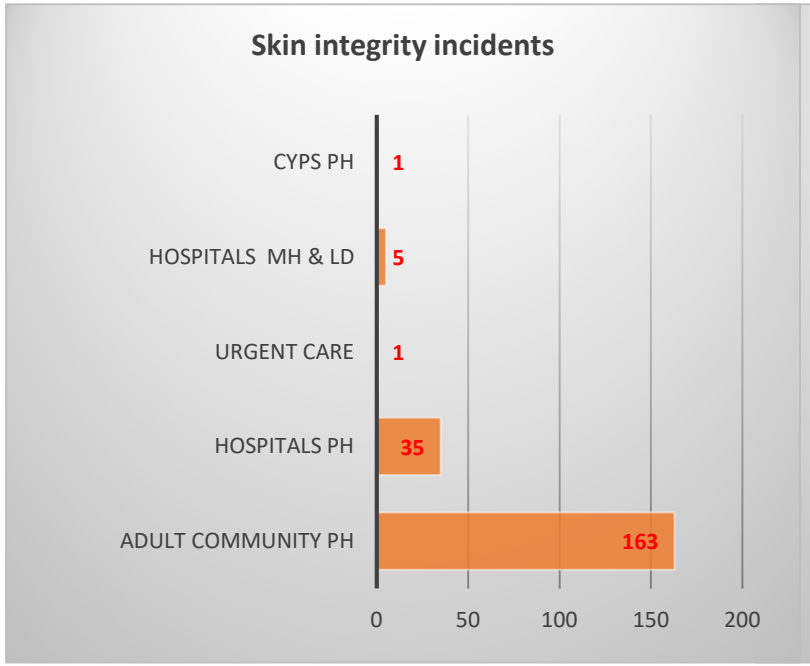
N - T	National measure/standard with target	L – I	Locally agreed measure for the Trust (internal target)
N - R	Nationally reported measure but without a formal target	L – R	Locally reported (no target/threshold) agreed
L – C	Locally contracted measure (target/threshold agreed with GCCG)	N – R/L – C	Measure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

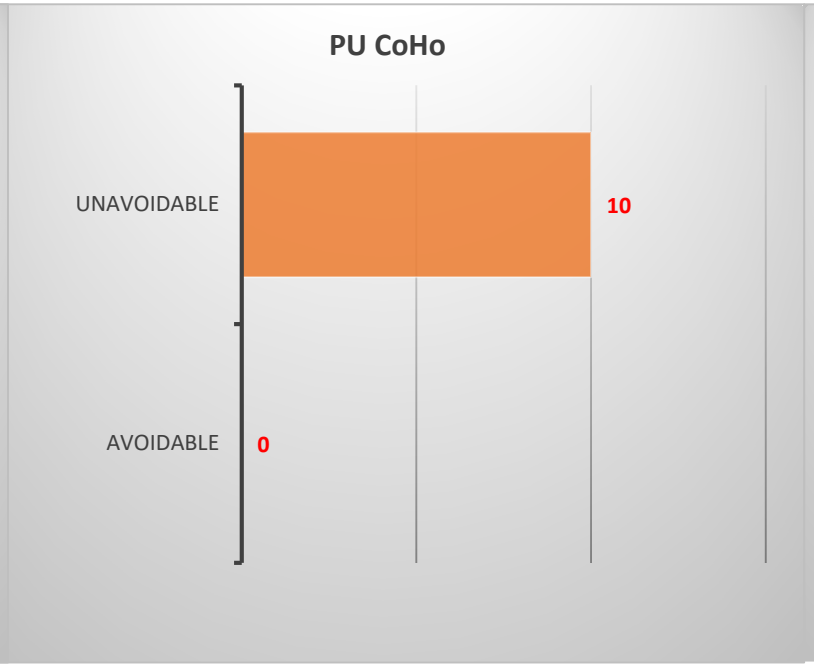
RAG Key: R – Red, A – Amber, G - Green

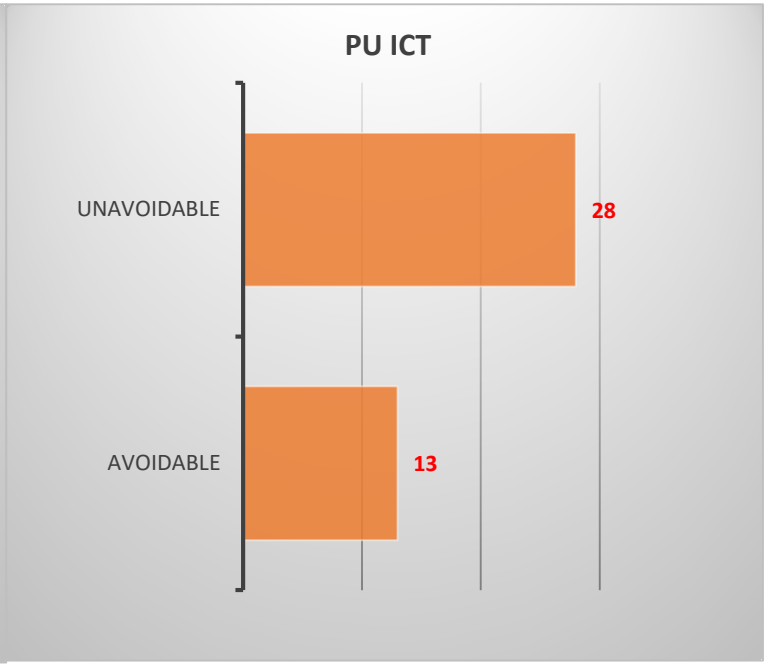
Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

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







Bar chart showing skin integrity incident reports per service.

- Adult community PH: 163
- Hospitals PH: 35
- Urgent care & specialist services: 1
- Hospitals MH & LD:5
- CYPS PH 1

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

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

Bar chart showing data reported in community PH in October 2022

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

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES WELL LED?

Safe Staffing Inpatient data – October 2022

Ward Name	**Code 1** - Min staff numbers met – skill mix non-compliant but met needs of patient		**Code 2** - Min staff numbers not compliant but met needs of patients e.g. low bed occupancy , patients on leave		**Code 3** -Min staff numbers met – skill mix non-compliant and did not meet needs of patients		**Code 4** - Min staff numbers not compliant did not meet needs of patients		**Code 5** – Other reason	
	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions
Gloucestershire										
Dean	10	1	127.5	17	0	0	0	0	0	0
Abbey	180	23	85	10	0	0	0	0	0	0
Priory	92.5	12	0	0	0	0	0	0	0	0
Kingsholm	7.5	1	0	0	0	0	0	0	0	0
Montpellier	7.5	1	0	0	0	0	0	0	0	0
Greyfriars	92.5	12	0	0	0	0	0	0	0	0
Willow	37.5	4	360	35	0	0	0	0	0	0
Chestnut	172.5	23	37.5	5	0	0	0	0	0	0
Mulberry	57.5	7	0	0	0	0	0	0	0	0
Laurel	30	3	0	0	0	0	0	0	0	0
Honeybourne	7.5	1	0	0	0	0	0	0	0	0
Berkeley House	45	5	682.5	44	0	0	0	0	0	0
Total In Hours/Exceptions	740	93	1293	111	0	0	0	0	0	0

NOTES: We have cross referenced the highest exceptions with patient safety data and patient, carer and experience data in month. Although Abbey and Chestnut have reported the highest code 1 exceptions the Matron reports this didn't impact on care delivery or patient experience. Willow Ward code 1 and Chestnut ward code 1's relate to mostly a single registered nurse being on duty, where we should be 2 nurses per day time shift. The reason for the deficit is relating to vacancy, long term sickness & Maternity. Recruitment to fill post for Charge Nurse position has been challenging, however, there is a candidate being interviewed in 2 weeks. These shifts have predominantly been filled with regular HCA's, who know the ward environment. Most of these relate to week day shifts, where the ward manager has been available to support. Willow ward Code 2' mostly relate to a vacant late shift for HCA (23 of these during this period). 20 of these shifts are also supported by a HCA twilight shift (15:10- 23:00), which increases staff numbers during these hours. The twilight shifts mitigate the code 2's and will factor in future reporting.

Mental Health & LD

Ward	Average Fill Rate %	Sickness %	Vacancy %
Dean Ward	118.52%	7.1	21.1
Abbey Ward	100.74%	3.8	28.5
Priory Ward	146.13%	17.7	23.1
Kingsholm Ward	170.16%	28.6	17.0
Montpellier	157.82%	6.3	10.1
PICU Greyfriars Ward	161.96%	9.2	29.9
Willow Ward	100.69%	9.8	25.8
Chestnut Ward	114.52%	10.4	8.7
Mulberry Ward	111.34%	8.8	7.4
Laurel House	101.34%	3.5	5.7
Honeybourne Unit	100.00%	16.1	1.0
Berkeley House	96.93%	5.6	28.2
Totals (Sept 2022)	**123.35**	**9.1**	**16.3**
Previous Month Totals	120.68	7.6	15.3

Physical Health

Ward	Average Fill Rate	Sickness %	Vacancy %
Coln (Cirencester)	79.67%	3.0	2.8
Windrush (Cirencester)	103.52%	23.7	15.2
The Dilke	109.39%	4.78	10.3
Lydney	97.08%	11.7	6.3
North Cotswolds	112.68%	3.0	7.7
Cashes Green (Stroud)	100.76%	10.2	3.7
Jubilee (Stroud)	103.55%	14.3	9.0
Abbey View (Tewkesbury)	100.11%	4.1	-3.8
Peak View (Vale)	109.51%	10.6	8.2
Totals (Sept 2022)	**103.05**	**7.6**	**7.9**
Previous Month Totals	105.21	6.8	5.6

NHSE Zero HCSW Vacancy Commitment Inc. bank – 3 month report

August	113.8
September	93.4
October	86.92

NHSE Zero HCSW Vacancy Commitment : This month there is a further reduction in the vacancy rate which is directly attributable to the ongoing recruitment project , this project contains four main strands : Recruitment, Engagement, Communications and Staff retention . Although regular turnover occurs this project is making inroads to reducing the vacancy figure with 100 recruits in the current pipeline including those originating from the ICB recruitment event .

IR/Recruitment. The project is progressing well with **67%** delivery achieved on project tasks and a dedicated IR and recruitment advisor having been recruited. **52** international colleagues have been recruited to date (from Jan 2021) 39 RGNs, 11 RMN,s and 2 Community RN's. The project separates into four strands: Recruitment, Pastoral Care, OSCE/training, Development and Finances.(Cost of living pressures).

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN – WELL LED - Quarter 2 - Guardian of Safe Working Report 2022/23

PURPOSE

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours. It was agreed with the BMA that a 'Guardian of Safe Working Hours' will be appointed in all NHS Trusts employing trainees (junior doctors) to ensure safe working practice. The role of 'Guardian of Safe Working Hours' is independent of the Trust management structure, with the primary aim to represent and resolve issues related to working hours for the junior doctors employed by it. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and will provide assurance to the Trust Quality Committee and Board or equivalent body that doctors' working hours are safe. The Guardian's Quarterly Report, as required by the junior doctor's contract, is intended to provide the Trust's Quality Committee and Board with an evidence based report on the working hours and practices of junior doctors within the Trust, confirming safe working practices and highlighting any areas of concern.

Reporting time period July 2022 – September 2022	**Guardian of Safe Working Hours: Dr Sally Morgan**
Number of doctors in training (all on 2016 contract)	**In Quarter 2 2022/23 (July - September) there were 41 doctors in training posts during this time period** • 8 Higher Trainees • 9 CT3s • 8 CT2s • 4 CT1s • 5 GP Trainees • 4 FY2s • 3 FY1s • Doctors rotated posts at end of July 2022
Exceptions in this period	• **28 on call shifts had a junior doctor gap due to sickness.** • 28 on call shifts were covered by our own junior staff acting as locums. • **3 exception reports in this time period and 1 exception report completed 28 days late from previous quarter. All relating to work in WLH/CLC** • **Junior Doctors Forum** held via Microsoft Teams on 22nd August 2022. • **GOSWH has attended the Junior Doctor Inductions** to ensure all new starters are aware of importance of exception reporting. • GOSWH has **made links with other Guardians** in the region with plans to meet up in the next quarter to discuss common issues and trends

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Appendix One

Q2 - Non Executive Directors
Quality Visits Quarterly report
September 2022

Working together

Our Non-Executive Directors' quality visits seek to:

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

Always Improving

- Non Executive Directors joined a focussed feedback session with the Director Nursing, Therapies and Quality to refine the current process of NED Quality Visits with the aim of further enhancing Board assurance
- Key outputs include:
- Evidence of ‘recommendations’ being implemented and progress made
- Quarterly slide deck presented to Trust Executive Team to strengthen implementation of recommendations
- Refreshed Quality Visit information sheet for NED’s and operational colleagues
- A yearly summary to be provided within the Quality dashboard at the end of each financial year

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Working together

Non Executive Director Quality Visits

Service and location	Date of Visit
Managing Memory Service (Q1 visit)	17th May
District Nursing Stroud (Q1 visit)	30th June
Wotton Lawn (Q1 visit)	17th May
IV Therapy Team	1st August
Homeless Healthcare Team (waiting for report)	31st August
Autistic Spectrum Condition Service	6th September
Street Triage Service	5th September
Podiatry (waiting for report)	6th September
Mental Health Liaison Team	14th September
CATU (waiting for report)	14th September
Gloucester Community Nurses (Q1 visit)	30th June

Always improving: key themes

They are continually adapting and responding to the relentless pressures they are under in creative and effective ways
Gloucester Community Nurses

The team manager is looking at new skill mixes and ways of working to make the most of the team's small resources.
Autistic Spectrum Condition Service

The team has embraced technology – both for team meetings and education, and in terms of equipment devices which enable intravenous delivery over 24 hours, such as the compounded pump. The latter equipment has reduced the number of visits required per day and empowered some service users.
IV Therapy Team

There was also evidence of the team seeking solutions in recruitment. They held a pop-up recruitment event for the reablement team, supported by social media. **Stroud ICT/District Nursing**

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Making a difference

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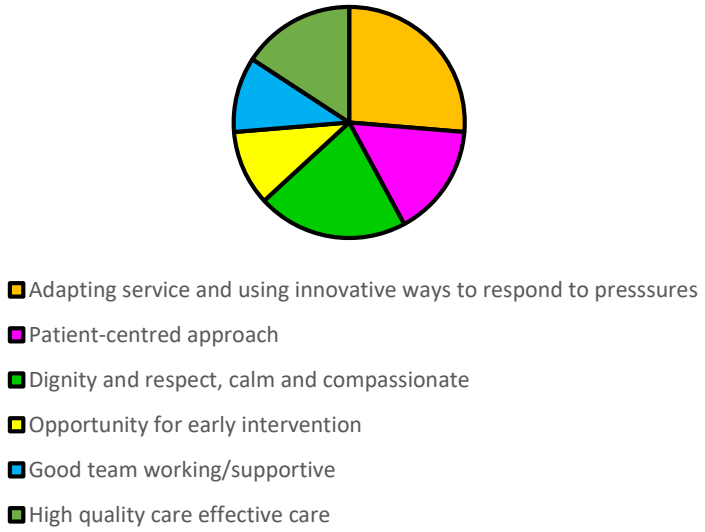


- NEDs noted that staff were doing an incredible job sometimes under difficult circumstances
- NEDs noted good team working and patients and staff were treated with compassion and respect
- Services were adapting and looking at creative ways to manage tight resources

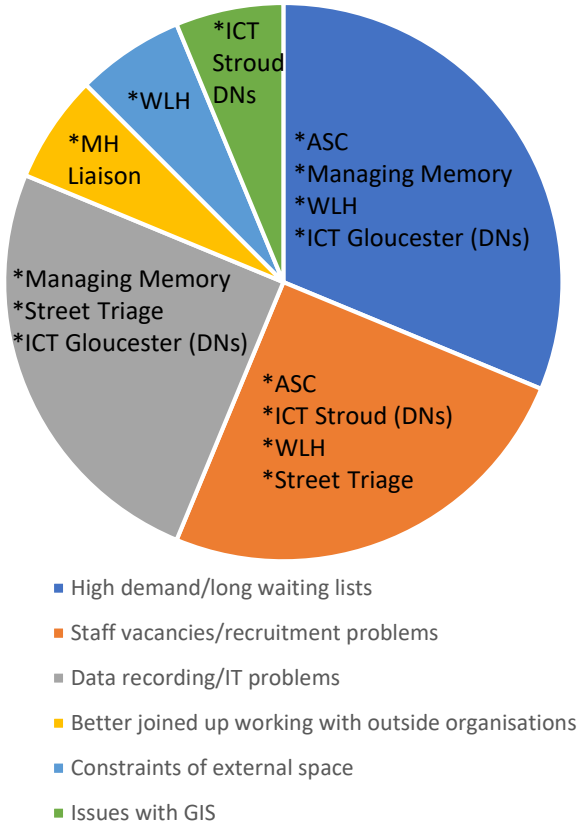
It is clear that this is a tight knit and mutually supportive team with a great deal of respect for one another's skills. **Autistic Spectrum Condition Service**

The service has been extremely effective in reducing the number of detentions **Street Triage Service**

The Matron described a number of initiatives that she has been pursuing with her team, which seem to me to be worthwhile. One example is the use of new techniques to reduce the use of bed restraints .**Wotton Lawn**

The team' treatments prevent many service users from requiring hospital inpatient or day patient treatments. This allows a more cost effective but high quality and respectful care. **IV Therapy Team**

Key areas of concern by service



Observations by NEDs:

- Many services reported high demand, the wait for ASC service is over 3 years
- Staff vacancies was an issue for most services, problems with TRAC were noted
- Financial incentives were suggested by Wotton Lawn as a means to retaining staff
- IT issues / time to input data reduced patient time

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Outcomes and learning

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SERVICE	RECOMMENDATION	ACTION	Progress
Street Triage	1. Review alternative models of service provision 2. Review IT requirements such as the use of iPads	**All recommendations are going to be overseen by Service Directors through the Pan Ops Governance Meeting**	**In progress- detail to be provided in next report**
Mental Health Liaison Team	1. Improve collaborative working between GHC and GHT and partner organisations 2. Review best practice and consider whether the work of the MHLT extend beyond assessment and signposting?	**All recommendations are going to be overseen by Service Directors through the Pan Ops Governance Meeting**	**Good work progressed re support for GHT in managing enhanced care as part of ICB project** **Further detail to be provided in next report on second action**
Gloucester Community Nurses	1. Explore ways of addressing staffing shortages 2. Review IT infrastructure	**All recommendations are going to be overseen by Service Directors through the Pan Ops Governance Meeting**	**Ongoing work re recruitment and work is progressing regarding additional targeting of potential community recruits in parent ship with University Gloucester**

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Outcomes and learning

NHS
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	RECOMMENDATION	ACTION	PROGRESS
Managing Memory Service	1. QI project to consider improvements in processes particularly data entry requirements	**All recommendations are going to be overseen by Service Directors through the Pan Ops Governance Meeting**	**Service have been asked to request QI team input via established routes Director of Nursing has requested update on progress**
ICT/District Nursing Stroud	1. Review of GIS to establish what more can the Trust do to secure a more functional system? 2. Seek wider views on Trac and what might be done to smooth out the recruitment process	**All recommendations are going to be overseen by Service Directors through the Pan Ops Governance Meeting**	**1. GCC/ICB led review of GIS in progress with GHC as key stakeholders** **2. Additional training sessions provided in response to colleagues concerns**
Autistic Spectrum Disorder Service	1. Acknowledgement of the long waiting times and how this will be addressed within the Trust. 2. Consideration of additional resource to recruit to create a more substantial team	**All recommendations are going to be overseen by Service Directors through the Pan Ops Governance Meeting**	**This has been recognised and further briefings have been provided disused. Chief Operating Officer is leading work to address. Additional updates to be supplied**

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Outcomes and learning

SERVICE	RECOMMENDATION	ACTION	PROGRESS
Wotton Lawn	1. Development of partnership with University of Gloucestershire to attract future graduates to work at WL 2. Consideration of temporary financial incentives for staff to work at WL 3. A review of the capacity of the service 4. Review of risk/benefit of the use of Covid masks 5. Maintenance inspection of external garden areas	**All recommendations are going to be overseen by Service Directors through the Pan Ops Governance Meeting**	**Work in progress re additional recruitment activity with University of Gloucestershire including delivering a joint conference for acute inpatient mental health nursing.** **Covid mask issue is subject to infection control guidance managed by the Trust Director of Nursing.** **Financial incentive schemes have been used and are being further considered.** **Awaiting update on garden inspection and review of capacity feedback.**
IV Therapy Service	1. Consider further investment to expand the service	**All recommendations are going to be overseen by Service Directors through the Pan Ops Governance Meeting**	**ICB led review commenced in November 2022 to develop service as part of ICB system flow related programme**

Outcomes and learning

	RECOMMENDATION	ACTION	PROGRESS
Heart Failure Service	1. Review career progression and banding 2. Explore integration of mental and physical health services. Can this be offered as part of this heart service?	1. SD aware (part of a wider piece of work) 2. This is part of the wider integration of services approach	**In progress- detail to be provided in next report**
Working Well	1. Explore the development of a business plan for provision of services to the private sector and other public bodies? 2. Map services provided to private sector/other public body clients, and means of sharing good practice and networks?	1. SD aware of recommendation 2. WW are existing long term members of various regional and national groups	**In progress- detail to be provided in next report**

Outcomes and learning

	RECOMMENDATION	ACTION	PROGRESS
Health Visiting Team FoD	1. Review of future service accommodation 2. Review current level of HV support	1. Review already in place 2. SD and Commissioners aware	**In progress- detail to be provided in next report**
CAMHS LD	1. Explore possibility of an OT for the service	1. Therapy review across the Trust in place	**In progress- detail to be provided in next report**
Cardiac Rehabilitation	1. Service is commissioned beyond a pilot project	1. SD aware and in discussion with the ICB	**In progress- detail to be provided in next report**
North Cotswolds ICT	1. Explore use of dual SIM mobile phones 2. Explore ways to improve base Wi-Fi 3. Explore extra support for rising fuel and time taken to reimburse expenses	1. SD aware of issues and liaising with IT 2. IT aware of geographical challenges 3. Hardship Fund in place across the Trust	**In progress – detail to be provided in next report.**
Vale MIIU	1. Explore feasibility of providing an x-ray facility seven days a week	1. This is part of the wider NHS 7 day working plan	**In progress - detail to be provided in next report**

Appendix Two
IPC/COVID 19 Data- September 2022

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

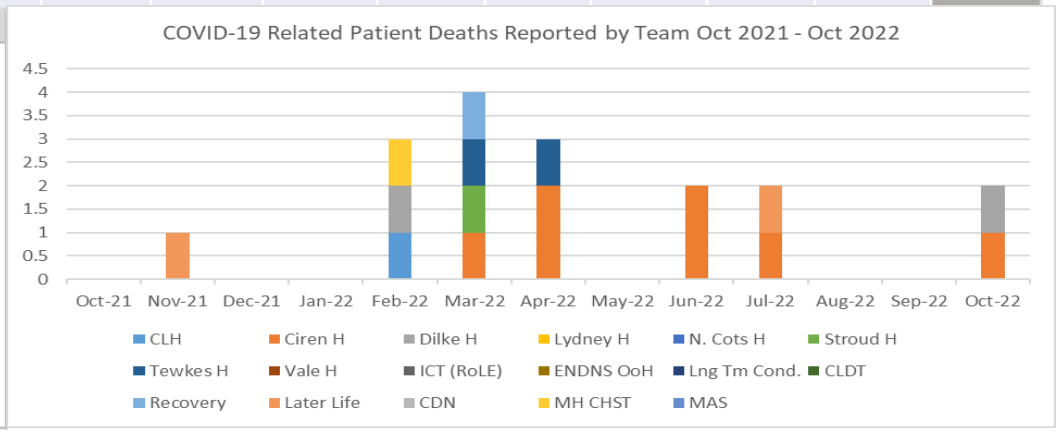
COVID-19 (Whole Trust data, reporting nationally mandated Covid-19 focused safety and activity information)

		2021/22 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022/23 YTD
No of C-19 Inpatient Deaths reported to CPNS		5	3	0	2	1	0	0	2						8
Total number of deaths reported as C-19 related.		8	3	0	2	2	0	0	2						9
No of Patients discharged from hospital post C-19 PH		77	35	33	21	15	17	18	23						162
No of Patients discharged from hospital post C-19 MH		25	12	7	10	8	9	5	5						56
Community onset (positive specimen <2 days after admission to the Trust)		24	3	2	5	12	4	5	3						34
Hospital onset (nosocomial) indeterminate healthcare associated - HOIHA (Positive specimen date 3-7 days after admission to the Trust)		18	2	0	2	2	1	5	1						13
Hospital onset (nosocomial) probable healthcare associated - HOPHA (Positive specimen 8-14 days after admission to the Trust)		10	1	0	2	2	0	4	2						11
Hospital onset (nosocomial) Definite healthcare associated - HODHA (Positive specimen date 15 or more days after admission to the Trust		92	20	8	6	27	1	25	28						115
No of staff self-isolating: new episodes in month			108	27	141	102	24	64	85						
No of staff returning to work during month			163	37	92	125	28	46	84						

Additional Information

- There were zero mental health patient community patient deaths reported in October.
- There were 2 inpatient Covid-19 related deaths reported in October where Covid was a contributory factor however not the primary cause.
- 3 cases of community onset were identified in October
- 1 case of HOIHA were identified in October
- 2 cases of HOPHA were identified in October
- 28 cases of HODHA were identified in October

This month we see an increase in HODHA cases of infection that were centred around Charlton Lane and the Dilke this mirrored a national increase in HODHA cases. All recommended IPC practices continue to be followed across all Trust areas.

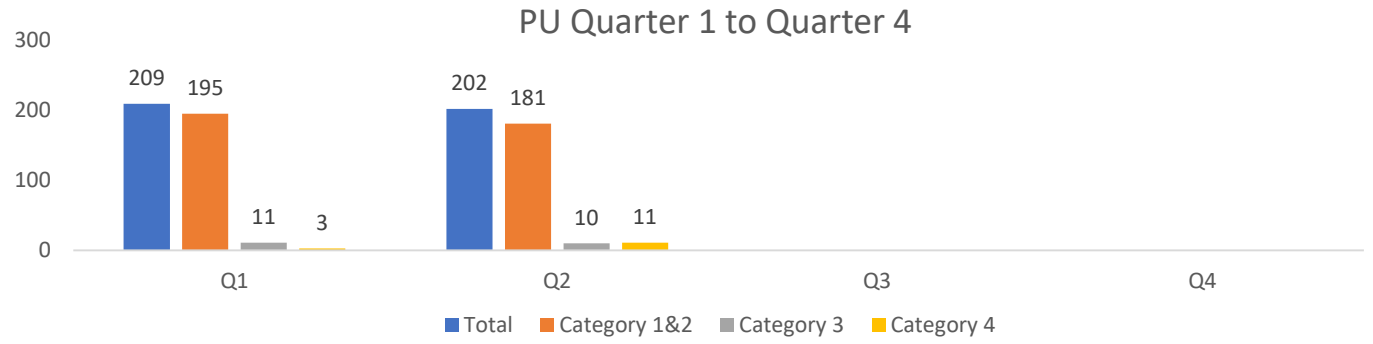


Appendix Three
Trust Quality Priorities 2022/23

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

SAFE : QUALITY PRIORITIES 2022-2023	
Standard	**1 Pressure Ulcers (PU's) - with a focus on reducing incidence and severity through improvement in the recognition, reporting, and clinical management of PU's , developing a PU collaborative within the One Gloucestershire Integrated Care System.**
Performance	**Target** – the reduction quarter on quarter in the amount and severity of pressure ulcers within GHC
Commentary	• There are three key factors that drive an increase in number and severity of pressure ulcers; Circulatory changes following Covid - 19 infection, deconditioning of patients who live at home and have become more socially isolated and physical immobility during and following Covid - 19 infection. • During Q2 there were 202 developed or worsened pressure ulcers which is a decrease of 4.4% on the Q1 figure (209). The number of category 1 & 2 pressure ulcers decreased from 195 in Q1 to 181 in Q2 which is a 7% reduction however category 3 pressure ulcers have marginally increased by 9% (1) with category 4 pressure ulcers increasing by 8 incidents. This data will build throughout the year. • As an organisation we will always have Pressure Ulcers evident within our caseloads due to localities and inpatient units having patients referred with existing pressure ulcers obtained whist under primary care, residing in care homes or acute hospital transfers. The pressure ulcer data is monitored via improved reporting, verification/alteration of classification and improved operational tolerances with emphasis being given to learning lessons from avoidable incidents. • Avoidable PU in the trust are reviewed for data quality and potential for reclassification and learning, these cases can occur as a result of patients being in a non GHC environment, not being concordant with advice given and also attributable is the complexity of caseloads • GHC Deputy Director of Nursing has agreed with ICS peers that the arrival of the new National Wound Care Strategy provides a platform for a true system approach to the prevention, identification and management of PU across all partners. Further updates will be provided within future dashboards.
Lead	NF



Target Achieved H1 Y

Target Achieved H2

Next steps : Continuation of the monthly monitoring of pressure ulcer incidents throughout the Trust and clarification as to the direction of the county wide PU collaborative.

SAFE : QUALITY PRIORITIES 2022-2023	
Standard	**2 Falls prevention with a focus on reduction in medium to high harm falls based on 2021/22 data . Developing a falls collaborative within the One Gloucestershire Integrated Care System**
Performance	**Target** – the % reduction quarter on quarter in the number of medium and high harm falls within inpatient units.
Commentary	• The number of falls recorded which resulted in medium to high harm in the second quarter of 22-23 compared to the similar timeframe in 21-22 following review, demonstrates an increase of 2 incidents. The total number of falls reported between Q1 and Q2 of the current year however, has reduced. This indicates that fewer falls are occurring in inpatient settings, however there are more with higher harm. Due to the increase in falls recorded in Q2, we are completing a risk review of all falls within the Trust. (Data in relation to higher harm falls is reactive to slight change in numbers due to the low percentage of instances in the source data.) • The leadership of the Trust wide Falls group has recently been transferred to the NQT to ensure consistency of practice, and a strong focus on evidence based falls prevention in all areas of GHC. The group will be chaired by the Deputy Director of Nursing and will now consist of key members of the Trust from both physical and mental health nursing and AHP teams, from inpatient and community areas. Also joining the group are representatives from our Patient Safety and Quality Improvement teams. • This refreshed group will look to produce and implement a strategy to reduce the number, and impact of falls in both community and inpatient settings, to improve staff and patient awareness of falls risks and to reduce variation of practice in falls prevention. The focus will be to promote a culture in which falls prevention, risk assessments and interventions are everybody's business.
Lead	HW

Year 21-22	No	Year 22-23	No
Q1	5	Q1	2
Q2	4	Q2	6
Q3	5	Q3	
Q4	13	Q4	

Target Achieved H1 N

Target Achieved H2

Next steps : Continuation of the monthly monitoring of falls throughout the Trust and analysis of themes and trends relating to the higher number of higher harm falls reported.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

SAFE : QUALITY PRIORITIES 2022-2023					
Standard	**3 End of Life Care (EoLC) - with a focus on refreshing the collaborative One Gloucestershire approach to improving EoLC across the county . This will support the 6 ambitions for Palliative and End of Life Care including improving systems to identify those eligible using the Supportive and Palliative Care Indicators Tool (SPICT), improving the access to advance care planning, the ReSPECT V3 form, and increasing symptom management training for staff to support non - cancer patients.**				
Performance	**Target** – Our aim is to enable all our staff to be compassionate, confident and competent in delivering EoLc in our hospitals and in the community				
Commentary	**Quality Priority Plan**	**Q1**	**Q2**	**Q3**	**Q4**
	GHC EoLc priorities align with the One Gloucestershire approach to improving EoLc across the county and support the Six Ambitions for Palliative and EoLc. Our aim is to enable all our staff to be compassionate, confident and competent in delivering EoLc in our hospitals and in the community.	**Compassionate:** • Achieve a continued reduction in number of EoLC complaints • Celebrate and share good practice **Confident:** • Continually provide and review the delivery of End of Life Masterclasses **Competent**: • Monitor number of people attending education and training • Consider the CQC recommendation of ensuring that EOL training is mandatory for all clinical staff	• Develop and share workstreams with Experts by Experience		Compassionate • Evaluation of annual rate of reduction against previous year. **Confident** • Annual evaluation of Masterclass feedback • **Competent** • Annual evaluation of Masterclass attendance.
Lead	DW				

• **Plan - Reduction in number of EoLc complaints** • Celebrate and share good practice/ compliments	Progress - The EoL lead is involved in complaints or concerns at an early stage to enable the families issues to be addressed in a compassionate and timely manner and at a point where a real difference can be made to the care path for the patient. Data from 2020/21 compared to 2021/22 evidenced a 60% reduction in the number of formal complaints that related to EoL. Data relating to Q4 compared to Q1 of 2022-23 shows a marginal increase from zero to 2 complaints where EoL is mentioned, the Q1 to Q2 position remains stable at 2, however the picture will develop as the year progresses with a final outcome being evident when annual data is compiled. A Word Cloud had been prepared from the content of compliments received and will be shared via the staff Intranet pages. During Q2, "Dying Matters week" took place and Service directors from community teams and CoHo's routinely share a monthly summary of compliments received and the CQC Report was shared with all GHC teams and externally. EOL care was specifically inspected across GHC, and was awarded "good" for Safe, effective, responsive and well led" and **"outstanding**" for caring.
• Plan – Continually provide and review the delivery of the EOL Masterclasses for Registered Practitioners Give consideration to the CQC recommendation to ensure that EOL training is made mandatory for clinical staff • Review training for Non registered staff	Progress – The education programme (Masterclass in End of life Care) commenced on 2nd September 2021. The classes were collaboratively developed following discussions with Community Hospital staff and District Nurse teams. Q1 – Course evaluation response, 17 people responded (14% of attendees). 100% of attendees said the course outcomes were achieved and 100% stated that the course was either very beneficial or beneficial to their present role.. EOL Masterclass dates for a complete run of all sessions Jan – Mar 2023 are being planned and will be available for staff to book onto within the next few weeks. RN Induction presentation reviewed and updated Oct 2 Plan to explore / develop and plan implementation of EOL education for non registered staff. Care Certificate has been reviewed Sept 22
• Plan - Number of people attending education and training • Develop and share workstreams with Experts by Experience	Progress – As at end of Q1 122 people had attended the End of Life Masterclass, the most popular classes being 'Recognising when someone was dying' (27 attendees) and Spinal Cord Compression (25 attendees). Q2 there were 53 attendees to 6 Masterclasses We have recruited on EbE who is already an active member of our EOL QI group and we are in discussions with a second interested EbE

Target Achieved H1	Y
Target Achieved H2	

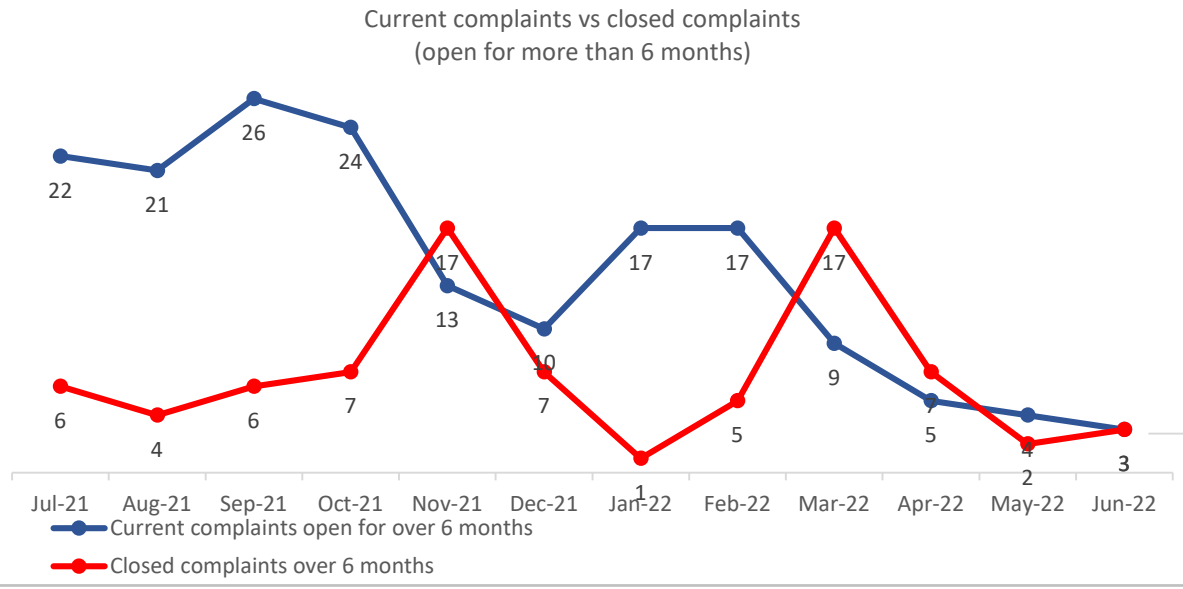
Next steps : Continuation of the Quality Priority throughout 22-23 and associated reporting of year on year analysis.

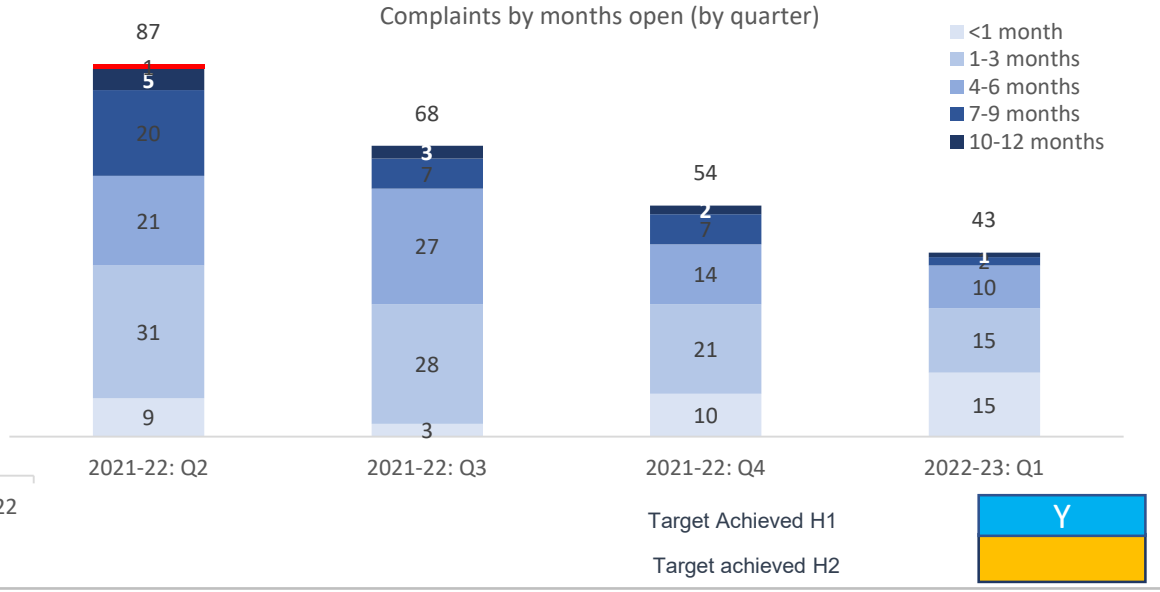
Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

RESPONSIVE : QUALITY PRIORITIES 2022-2023

Standard	**4-Patient and Carer Experience - with a focus on incrementally reducing the time taken to provide a final response letter to people who have raised a formal complaint about Trust services improvement in completion times will be achieved quarter on quarter.**
Performance	**Target** – 95% of all complaints closed within 3 months 100% of all complaints closed within 6 months
Commentary	• At the beginning Q1 of 2021/22 there were **76** open complaints, **12** of which had been open for more than six months (**16%**), and **4** of which had been open for more than twelve months (**5%**). • At the beginning Q1 of 2022/23 there were **54** open complaints, **9** of which had been open for more than six months (**16%**), and **0** of which had been open for more than twelve months (**0%**). • At the beginning Q2 of 2022/23 there are **43** open complaints, **3** of which have been open for more than six months (**7%**), and **0** of which have been open for more than twelve months (**0%**).
Lead	HW





Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

RESPONSIVE : QUALITY PRIORITIES 2022-2023	
Standard	**5 Friends and Family Test (FFT) - with a question to ask people for their views on the quality of their care, as highlighted in our 2020 CQC Audit Community Mental Health Survey action plan .**
Performance	**Target** – To establish a new question in the survey with a focus on "What really matters" to the patient continued from 21-22
Commentary Asking people for their views on the quality of their care	**Scoping exercise on Quality of Care** • A scoping exercise will take place as part of the wider Community MH Transformation work to identify what is important and meaningful to service users and carers and What Matters to Me… **Friends and Family Test** • Rollout of the new Friends and Family Test (FFT) to ensure regular feedback about care. • Copies of the FFT to be made available across all services. • Patients providing for feedback on discharge via SMS and email. • Patient providing feedback via link on Attend Anywhere • Launch of a carers FFT to seek feedback on the experience of carers who are in contact with our services – to be launched during Carers week in June 2021 • FFT, Carers FFT, and Carers survey all available on Trust website • Communications campaign to raise awareness of our feedback mechanisms **Leaflets and comment cards** • New complaints leaflets, posters and comment cards to be made available throughout all Trust service.
Lead	HW

Action	Update Q2
Scoping Exercise	• A survey question is being added to the new Friends and Family Test (FFT) in order to form a baseline for our understanding of whether patients are giving the opportunity to discuss the aspects of their care that are particularly important to them: '*Did you have the opportunity to talk about the aspects of care/treatment that matter to you?'* This is followed by a freetext question for respondents to add additional information. The new FFT process is due to be launched end October 2022.
FFT	• The new Friends and Family test (FFT) process is in currently being implemented. During Q1 the new FFT survey was designed by PCET in the updated Snap survey tool 'Snap XMP'. During Q2 the IT Applications Team and the BI Team tested the updated automated process to ensure this encompasses all Trust services where automated surveys are required. Other methods for surveying using the FFT are also being implemented by PCET, including paper, iPads, QR codes and electronic survey links. The new FFT also allows carers to provided feedback about their own experiences. The new FFT process is due to be launched end October 2022. • The current FFT question does encompass quality of care, although is broader: • <u>The question currently asked is:</u> *Overall, how was your experience of our service* (this is the National FFT question) Answer options: very good -good – neither good nor poor – poor – very poor – don't' know
Leaflets and Comment Cards	• New complaints leaflets, posters and comment cards are now available and have been distributed across the Trust

Target Achieved H1 NA

Target Achieved H2

Next steps : Continuation of the Quality Priority to 22-23 and associated reporting of year on year analysis.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

SAFE : QUALITY PRIORITIES 2022-2023

Standard	**6 Reducing suicides - with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services. We will work to the aspirations of the Zero suicide Alliance to support the aim for zero suicides within our mental health inpatient units by 2022.**
Performance	**Target** – To establish an outcome of zero suicides within our mental health inpatient units by 2023
Commentary	There will be a staged implementation of NHSE/I mandated zero Suicide Plan for inpatient MH services.
Plan 1 - The Positive & Safe Group will develop and deliver a work plan with a clear focus on suicide prevention, ligature reduction programmes, use of assistive technologies, and proactive and collaborative clinical risk management.	**Progress** • Positive & Safe Group meets bimonthly and has oversight of suicide prevention activity including routine review of themes and trends concerning self-harm and ligature incidents. • The Clinical Protocol for the Removal and Physical Management of Ligatures and Near Hanging was ratified in Q2 • Reduction of Ligature Risk Policy revised and approved July 2021 is due for revision and will include learning from the 2021/22 audit cycle. • The mental health inpatient ligature audit cycle 2022/23 has been ongoing during Q2 . All are complete except for one flat at Berkeley House. Additional governance of progress continues via quarterly Ligature Audit Action Planning Meetings chaired by Hospitals Directorate Service Director, with further oversight via quarterly Executive Led Ligature Management meetings. • Ward based suicide prevention champions are in place at WLH. • Weekly ligature and self-harm incident reports were developed and launched during Q1 and are now produced and disseminated weekly by the Patient Safety Team. These provide ward managers with near 'real time' weekly analysis of this activity.
Plan 2 – To develop a comprehensive and robust training programme focussed on suicide reduction, suicidal thinking, assessment and conversation. This will be provided for all grades of staff, across all fields, beginning with those working in inpatient settings.	• GHC now offers 2 online courses via Care to Learn 1) 'Suicidal Thoughts and Assessment' – Having the Conversation, 2) 'We need to talk about suicide' – Health Education England. • In addition, the Positive & Safe Group identified 3 other freely available online course which are indicated in the 'Its safe to talk about suicide' leaflet' these are – Zero suicide alliance -www.zerosuicidealliance.com,'Real talk' – Grassroots, 'Suicide Prevention Awareness' – The learning pool. • Statutory & Mandatory training for inpatient staff also includes assessing and managing clinical risks, searching of patients and observations and therapeutic engagement • The online training resource for undertaking inpatient ligature audits was finalised and launched during Q2 and is available for all staff via Care to Learn
Plan 3– To fully integrate, where possible, experts by experience, carers and families in the action plan to improve overall outcomes and service delivery in keeping with trust values. To further promote existing good practice such as the Letter of Hope, Little Red Book and the Stay Alive app and also to develop and implement the Its safe to talk about suicide leaflet.	• Letter of Hope relaunched and circulated via the Gloucestershire Suicide Prevention Partnership Forum during 2021/22. This was updated during Q2 to signpost people to the Gloucestershire Support after Suicide Service. It will be reprinted and distributed during Q3 • An 'Its safe to talk about suicide' leaflet was developed based on the work at Exeter University Medical School with the Alliance of Suicide Prevention Charities originally produced in Devon. The GHC version was launched on World Suicide Prevention Day 2021 and during Q1 2022/23 nearly 4000 copies were distributed across the Trust and to stakeholders. This was updated during Q2 to signpost people to the Gloucestershire Support after Suicide Service. It will also be reprinted and distributed during Q3. • The Stay Alive app was refreshed during Q2.
Plan 4– To develop specialist practitioner roles. The focus of the Advanced Nurse Practitioners will be working with complex patients at risk of harm, supporting ward teams and medical staff in assessing, managing and reducing risk inclusive of serious self-harm.	• Appointment of 3 x Advanced Nurse Practitioners (ANPs) to work with complex patients at risk of harm in MH & LD inpatient units completed. • The 3 ANPs are currently undertaking training and development

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

SAFE : QUALITY PRIORITIES 2022-2023

Standard	**6 Reducing suicides - with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services. We will work to the aspirations of the Zero suicide Alliance to support the aim for zero suicides within our mental health inpatient units by 2022.**
Performance	**Target** – To establish an outcome of zero suicides within our mental health inpatient units by 2023
Commentary	There will be a staged implementation of NHSE/I mandated zero Suicide Plan for inpatient MH services.
Plan 5 – For the Inpatient teams to continues to assist in the provision of good follow-up and transition across teams to reduce risks and ensure safe discharges.	• 48hr follow up post discharge remains a KPI for the Trust and is monitored monthly via the Performance Dashboard. • Dialogue with community mental health teams began during Q1 to consider the validity of continuing to complete the Community Mental Health Team Suicide Prevention Toolkit developed by the NPSA over a decade ago. Feedback indicates that this may no longer be fit for purpose. During Q2 Crisis and Recovery Teams agreed to embed the learning identified through the National Confidential Inquiry into Suicide and Safety In Mental Health. via the NCISH self assessment process. Work on this will commence in Q3
Plan 6 – To fully engage with the Gloucestershire Suicide Prevention Partnership Forum (GSPPF), neighbouring trusts and those further in the South to work together to share thoughts, ideas and experiences	• GHC remains an active member of the Forum and inputs actively into the multiagency twice monthly 'real time' suicide surveillance group within the county. • During 2021/22 the Trust played an active role in the GSPPF tendering process for developing a Suicide Bereavement Support Service for the County. The contract was awarded to Rethink and the Gloucestershire Support after Suicide Service was launched in March 2022. Awareness raising and signposting to this service is being promoted through the refreshed *Letter of Hope* and *Safe to Talk about Suicide leaflets.*
Lead: JW	

Target Achieved H1 NA

Target Achieved H2

Next steps : Continuation of priorities throughout the Year and year end analysis of data.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

Standard	**7 Learning Disabilities - a focus on the Hospital /Personal Passport utilisation, and roll out of the Oliver McGowan Tier 1 and tier 2 training programme. The trust aims to train 90% of our workforce.**
Performance	**Target** – To achieve a target of circa 90% of the workforce to be trained at L1 by the end of Q4. To provide an update and focus on the utilisation of patient passports .
Commentary	Oliver McGowan - Level 1 training: • The independent evaluation carried out by NDTi (the National Development Team for Inclusion) found the Gloucestershire version of Tier One training to be the most highly rated by participants. In light of this it will be this model, co-designed by GHC, Inclusion Gloucestershire and Family Partnership Solutions in Gloucestershire that will be rolled out nationally as part of the mandatory training with plans in place to use our existing e-learning package The work to convert the Gloucestershire version of Tier One training to the national offer has been completed by GHC and submitted to the National Team where it is going through final quality assurance processes. It is expected that this will be made available to ICB's shortly, followed by a Train the Trainer programme commencing in November. Discussions are taking place about the delivery model(s) for Gloucestershire. • GHC is continuing to work collaboratively with Mencap, NAS and HEE to develop a one day training package for Tier Two, which will encompass several elements of the package developed locally. • The locally developed training at both Tier 1 and Tier 2 is being provided in the interim until the national provision is available. Training dates have been advertised both on Care to Learn and on LearnPro, which is accessible to staff working across both health and social care to enable as many people as possible to access the training places. • The Compliance level for all staff (level 1) is currently at 73.5% inclusive of staff bank and 80.5% is Staff Bank staff are excluded. • 307 members of staff (GHC) have completed the Tier 2 training. • There has been enormous amounts of positive feedback received in relation to the training , some of the quotes which come from social media (e.g. Facebook and Twitter) are shown below . • We actively promote and share the My Health Passports however due to the impact of Covid the planned scoping work with other organisations such as the Hospitals Steering Group and Inclusion Gloucestershire was halted with the intention being to resume this workstream in 22/23.
Lead	KA

"The best training I've been on for a long time and I learned so much (really truly – I'm not just being kind). I though I knew stuff but realised I was working with a lot of unconscious bias. Go on the training and see for yourself"

"It made everything seem more real, more personal…. You can read about it, but to hear from someone who lives it - it brings it home, it makes it stick."

"Completed the online training and joined one of the experts by experience team members who was incredibly informative and made the session very engaging. Most definitely worth attending both training sessions to create an understanding and awareness"

"The Oliver McGowan Training is an insightful, informative and emotive training package. The training is predominately delivered by those with lived experience who truly understand the impact of conditions, diagnosis and the important discussions required in relation to their health and social care needs. I feel this training is extremely important for all health professionals in highlighting the individual behind the documentation and their desires to be seen, heard and to lead a fulfilled life. It will change my approach to communications ensuring I adhere to Ask, Listen, Do in order to achieve the most positive outcomes for the individuals themselves."

"Some of my staff did Tier 2 this week and it was brilliant… really brilliant, a must for ALL who work in the care sector. Very powerful stories. Excellent training!"

"Tier 1 of the excellent Oliver McGowan training completed today. Tears flowing at his story and missed opportunities to listen. Highly recommend staff do this training and we learn from his sadly entirely avoidable death. Ask. Listen. Do."

"Brilliant training, so powerful, highly recommended"

Target Achieved H1	NA
Target Achieved H2	

Next steps : Continuation of the Quality Priority through to Q4 22-23 and associated reporting of year on year analysis.

SAFE : QUALITY PRIORITIES 2022-2023	
Standard	**8 Children's Services - transition to adult services with a focus on ensuring a safe and prompt transfer between services, developing pathways, standardising practice, and reducing delays in care . Fidelity to the care pathways will be evaluated through participation in the NCEPOD study .**
Performance	**Target** – To engage and report in line with the NCEPOD Study.
Commentary	• In 2021-22 GHC were approached to support a NCEPOD submission around CYP with specific conditions transitioning to adult services. Data collection tools and methodology were circulated however in GHC we were not in a position to complete as we are unable to identify the cohort of children required as we don't hold diagnosis codes in electronic records and also don't see CYP in our community hospitals. The transition team who are leading and coordinating this project were contacted and agreed to send us cases from other trusts where GHC has been identified as a partner in the care delivery . • The initiative continues to 22-23, clinical questionnaires have been completed for one child for CCN, CCT PT and OT they came through as separate requests and the case notes for all have been submitted. Further data requests are awaited which will be completed as the year progresses.
Lead	JR

Target Achieved H1 NA

Target Achieved H2

Next steps : The audit has commenced and will continue when the cohort is increased, this is not within the gift of GHC to control.

SAFE : QUALITY PRIORITIES 2022-2023	
Standard	**9-Embedding learning following patient safety Incidents - with a focus on sharing and learning from experience and investigations to develop and improve standards of care . This will be measured through the numbers of post investigation embedding learning workshops delivered and the number of lessons bulletins issued. alongside implementation of the Civility Saves Lives initiative, with assurance measured against the project implementation goals and evaluation over the reporting period .**
Performance	**Target** – To deliver 5 embedded learning events by the end of Q3 and 8 embedded learning events by the end of Q4.
Commentary: **This indicator is carried forward from 21-22 where increased clinical need caused by winter pressures prevented the achievement of the H2 target.**	
Lead	JW

SI Reference	Datix	TeamGHC	Session Date	Comment
General		Charlton Lane	29-09-22	Multi disciplinary meeting to discuss embedding learning.
SI-32-22	GHC28030	Health Visiting	14-09-22	
Si-32-22	GHC28030	Health Visiting	02-08-22	
General		Wotton Lawn	13-07-22	Drop in sessions at Wotton Lawn to discuss ways to embed learning.

Narrative	Number
SI Incidents on a page included in Patient Safety Team (PST) monthly reports since April 2022	6
Clinical Incidents on a page included in PST monthly reports since April 2022	7

Target Achieved H1 NA

Target Achieved H2

Next steps : Monitoring of planning and completion of learning events to continue in order to ensure target is met by Q3.

Civility Saves Lives

This is a grass roots campaign aimed at raising awareness of the impact of incivility on team and individual performance. Incivility and rudeness is surprisingly common and on the rise, thus patient safety outcomes are affected and there is a negative impact on clinical performance. This programme is progressing with resources available on our intranet for colleagues. These resources for awareness raising include 'The Power of Civility in Healthcare', how civility leads to better outcomes and the training available on Care to Learn. Many teams are requesting support for team development sessions on this work to gain a greater understanding. A coproduction approach continues with four teams to design and implement a quality improvement programme of Civility Saves Lives, and drive behavioural change and associated benefits for patient safety to be a great place to work. The teams are Charlton Lane Hospital, Forest of Dean Hospitals, Estates and Facilities, and Information Technology and Clinical Systems. The session are planned for November with the output to determine their team outcomes and the delivery of this through a quality improvement cycle.

Appendix Four
Trust safeguarding Data

Summary information:

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

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

The Safeguarding Dashboard is presented in 3 sections:

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

Highlights:

- Expansion of adult safeguarding supervision offer to all adult teams
- Completion of Safeguarding Adult Audit which identified areas for improvement and development
- Establishment of GHC Safeguarding Notifications inbox to capture number of safeguarding referrals made to the Local Authority
- Progress uploading the MARAC Action Plan backlog – backlog will be cleared by end of November 2022
- Improving picture with Level 4 Adult Safeguarding Training and Children's Safeguarding Supervision compliance

Challenges/risks:

- Capturing Safeguarding Related Data in an accurate and consistent manner on Clinical Systems – Safeguarding Action Plan in place to address risk and apply mitigations. Clinical Systems, Business Intelligence and Safeguarding Task and Finish Group working to find solutions that address risk. Monthly safeguarding audit of practice commencing in December 2022 to quality assure safeguarding practice.

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Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

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

	Q1 Total	Q2 Total	Oct	Nov	Dec	Q3 Total	Additional Information
SAFEGUARDING SUPERVISION							
Integrated Group Supervision sessions	42	62	20				Clinical staff working with children need to attend this supervision 3x per year. 5-6 sessions are delivered per week. Attendance at sessions is excellent, with a maximum of 8 participants per session. Feedback is sought and captured following every session.
Safeguarding Children Group Supervision Compliance			64%				In April 22 Safeguarding Group Supervision was added as an 'essential to role requirement' to staff Care to Learn Training Profiles. Sept is the first month compliance has been reported. Compliance is expected to rise as staff catch up with this requirement.
One to one Supervision sessions	4	8	3				121 Supervision is available to all upon request. In line with learning from recent child safeguarding reviews that recommend focused case reflection and discussion the team have been promoting 121 supervision across operational teams and Q2 saw a marked increase compared to Q1.
SAFEGUARDING ACTIVITY							
Advice Line Calls	142	129	51				Operational colleagues continue to make good use of the Safeguarding Advice Line. Slight increase in call relating to children in October.
Multi-Agency Request for Service Forms submitted to MASH	44	47	21				The Local Authority are unable to provide referral data and current clinical systems are unable to accurately capture this data. This is a documented risk – Risk 298. An action plan is underway to address this. LA Safeguarding Referral data is now captured via the Safeguarding Notifications Inbox.
Number of Escalations	4	5	1				This information is currently obtained from our Safeguarding Advice Line data. Further work is underway with Clinical Systems/Business Intelligence Teams to identify the number of escalations made to partner agencies.
CHILD DEATH NOTIFICATIONS							
Expected	1	4	1				Expected deaths are infants with known life limiting conditions or cases of extreme neonatal prematurity.
Unexpected	9	6	1				Gloucestershire Child Death Overview Process is followed for each unexpected death. Cause of each death has not yet been formally reported, No deaths in Q2 or September identified safeguarding concerns.
RAPID REVIEWS/LCSPR'S							
Number of Serious Incident notifications made to LA	1	3	1				1 SIN notification made in October. This case is progressing to a Rapid Review to be held on 15.11.22.
Number of Rapid Reviews attended	1	2	2				The Safeguarding Team participated in 1 Rapid Review and 1 Non Statutory Review in October. The recommendation to the National Panel is that the case taken to Rapid Review should progress to a LCSPR.
Number of LCSPR's in progress	2	2	2				1 Gloucestershire LCSPR awaiting publication - single and multi-agency action plan in progress. 1 joint Surrey/Glos LCSPR - no GHC involvement
MASH HEALTH TEAM ACTIVITY							
Children researched/info shared	2,372	2,242	772				MASH activity remains high. Slight reduction in number of children researched by health to inform MASH decision making in August. This is expected and in line with the usual drop in Safeguarding referrals in August when children are not in School.
Adults researched/info shared	189	195	94				Higher number of adults researched during October that in previous months. This is due to the re-introduction of the high risk morning meeting.
MASH strategy meetings attended	107	86	50				The MASH health team attend 100% of strategy discussions they are invited to. Significantly higher number of Strategy Discussions in October – this is due to the re-introduction of the high risk morning meeting.
Demographic information sharing	452	575	149				MASH health are frequently asked for demographic data from children's social care - this is due to referral data quality and incomplete data.
AUDITS							
Single Agency	0	0	0				Safeguarding Children Audit is due. Audit Tool revised and sample currently being gathered. Audit to commence November 2022.
Multi-Agency sub group activity	1	1	0				
UNDER 18'S ADMISSIONS							
Number of under 18's admitted to Adult MH Wards	1	0	0				No children were admitted to adult mental health wards in October
Number of under 18's assessed under S.136 of the MHA 83/07	9	6	2				Activity is within normal ranges when comparing against year on year trends.
OTHER WORKSTREAMS							
Allegations management – number of referrals to/from the LADO	0	2	0				There were no LADO referrals in October.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

GHC - Safeguarding Dashboard 2022/22 Adults safeguarding Data

	Q1 Total	Q2 Total	Oct	Nov	Dec	Q3 Total	Additional Information
SAFEGUARDING SUPERVISION							
Group Supervision Sessions	20	24	6				Safeguarding Adult Supervision Sessions are now offered to all clinical staff who work in Adult Services. Supervision is optional and booked via Care to Learn. Bespoke Supervision Sessions are offered for Team Leads and Managers.
SAFEGUARDING ACTIVITY							
Contacts to GHC advice Line	121	158	57				Calls to the GHC advice line re. adult safeguarding enquiries - may or may not proceed to a referral to the Local Authority. Advice Line Service Evaluation is being planned for the winter 2022.
Safeguarding Referrals made to GCC	4	27	7				This data is obtained from the Safeguarding Team Notifications Inbox. Work is underway with Clinical Systems and Business Intelligence to identify mechanisms across our clinical systems which capture this data accurately.
Escalations	2	1	1				This data is currently obtained from our Safeguarding Advice Line data, so is unlikely to give a accurate picture of referral numbers. Work is underway with Clinical Systems to identify mechanisms across our clinical systems which capture this data accurately
CASE REVIEWS							
New Safeguarding Adult Reviews/Domestic Homicide Reviews	2	1	0				No new notifications in October
Number of Reviews ongoing	11	12	12				6 Domestic Abuse Related Death Reviews, 4 Domestic Homicide Reviews, 2 SARs (1 awaiting publication) – All at varying stages of the review process.
Action Plans Ongoing	5	6	6				This includes single and multi agency action plans
MAPPA							
Level 2 Meetings Held	17	12	*				Data unavailable monthly. Will be reported quarterly.
Level 2 Meetings Attended	17	12					
Level 3 Meetings Held	8	3					
Level 3 Meetings Attended	8	3					
PREVENT							
Number of Prevent Referrals Made	0	0	0				No Prevent concerns raised with the safeguarding team in October.
Information requests received & completed from Police/Channel	7	10	3				100% response to all police and channel panel information sharing requests, supportive effective planning and decision making.
MARAC							
Families screened/researched	351	356	117				Stable MARAC activity
No.of children open to MH Services	22	32	13				Slight increase in children open to mental health services – highlights the emotional impact of Domestic Abuse on Children
No.of victims open to MH Services	38	33	16				Link to the impact of domestic abuse on mental health
No.of perpetrators open to MH Services	34	51	19				Slight increase in domestic abuse perpetrators open to mental health services in October.
Un-uploaded MARAC Action Plans		700*	132				Significant progress made in clearing Action Plan backlog in October – now 132 un-uploaded plans, originally 1050. Un-uploaded plans means there is a risk that operational staff may not may not have access to important DA multi-agency action plans which might inform risk assessments and care planning. However important to note that un-uploaded plans are for clients not currently open to our services. Once backlog is cleared, risk will not re-occur, as MARAC administrator now in post and able to upload action plans as they are received. – At time of worting tis rpoert the backlog has been completely resolved.
DOLS - No. of referrals for standard authorisation from:							
Mental Health Services Total	2	6	2				Continued pattern of overall total of DOLS applications
Mental Health Services Authorised	2	3	0				
Physical Health Services Total	23	16	2				Physical health urgent applications (not requiring LA authorisation)
Physical Health Services Authorised	0	0	0				Nil authorised as patients have moved on before being application assessed.
AUDITS							
Single Agency - Safeguarding Related	1	1	0				
Multi Agency Sub - Group Related	1	2	0				
OTHER WORKSTREAMS							
Allegations management - use of PiPoT	1	1	1				1 new allegation against a member of staff made in October. Allegations Management Process being followed.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

GHC - Safeguarding Dashboard 2022/22 Training and Partnerships Data							
	Q1 Total	Q2 Total	Oct	Nov	Dec	Q3 Total	Additional Information
TRAINING							
Level 1 - Induction	97%	97%	95%				Overall a minor variation in month which the team continually monitor.
Level 2 – Think Family	86%	85%	83%				Level 2 training consistently between 83-88% compliance
Level 3 – Multi-Agency Child Protection	84%	82%	80%				Training promoted across the CYPS directorate to improve performance at every opportunity.
Level 3 Adult Protection	83%	81%	75%				Expected drop in compliance and this course is added to the training profile of former GCS staff who previously were required to complete only to Level 2.
Level 4 Adult Protection	27%	28%	56%				This training has just been applied to staff training profile following a review of staff training requirements. As expected training compliance is improving as staff catch up and complete the training – Therefore no RAG rating applied.
PREVENT:							
Level 1	97%	97%	94%				Continued high level of compliance with Level 1 Prevent Training
Level 2		83%	81%				Prevent Training was reviewed in Q1 and 'stand alone' Level 2 Training introduced as no longer available within the Think Family Training, as a result it will take several months for staff to catch up with the necessary Level 2 prevent training, improved compliance is expected.
Level 3	88%	88%	92%				The review of Prevent Training in Q1 identified that a large group of Adult Services Staff did not have Prevent Level 3 attached to their Learning Profiles, this has been rectified, but as a result current compliance has dropped, but is now accurate. As staff catch up with training compliance in October has began to rise.
SAFEGUARDING RELATED PARTNERSHIP MEETINGS							
Quality & Improvement in Practice (QiiP)	1	1	*	*	*		* The data for these fields are reported on a quarterly basis and will updated in the December reporting period. This group of meetings all run at different frequencies throughout the year and summaries will be provided on a quarterly basis.
MASH subgroup	1	1	*	*	*		
Child Death Overview Panel (CDOP)	1	2	*	*	*		
Strategic Health Group (ICS)Child	1	2					
GSCP Child Exploitation Subgroup	1	1					
GSAB Board Audit Group	1	1	*	*	*		
GSAB Management Meeting	1	1	*	*	*		
GSAB Safeguarding Adults Review Sub Group (SAR)	1	1	*	*	*		
GSAB Fire Safety Subgroup	1	1	*	*	*		
Business Planning Sub Group	1	1	*	*	*		
Policy & Procedure	1	0	*	*	*		
MARAC Strategic Management Board	1	0	*	*	*		
Gloucestershire Prevent Partnership Board	2	1	*	*	*		
MAPPA Strategic Management Board	0	1	*	*	*		
Strategic Health Group (ICS)Adults	1	0	*	*	*		
Domestic Abuse Board Operational Group		1					

Appendix Five
Trust Operational Data Extract

Additional information:

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

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

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

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES RESPONSIVE?

	Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	R A G	Exception Report	Benchmarking Report
Referral to Treatment physical health																			
Podiatry - % treated within 8 Weeks	L - C	95%	74.0%	49.6%	45.9%	41.4%	41.8%	37.1%	38.1	35.1%						41.28%	R		
ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	85.75%	54.3%	50.6%	56.3%	51.1%	61.8%	59.0%	65.9%						57.52%	R		
ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	88.48%	66.4%	66.7%	63.8%	71.1%	72.8%	61. 6%	69.7%						67.56%	R		
Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	82.6%	39.3%	43.8%	41.4%	41.8%	36.9%	36.3%	62.0%						42.9%	R		
Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	97.6%	87.1%	89.8%	87.0%	88.6%	92.5%	84.7%	87.5%						88.6%	R		
Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	95.1%	35.0%	13.9%	11.6%	14.6%	15.2%	19.5%	3.3%						15.7%	R		
Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R	3,279	18644	1144	1203	1097	1128	998	1027	1051						7648			
Wheelchair Services Adults : New referrals assessed within 8 weeks	L - C	90%	74.0%	87. 5%	73.2%	85.3%	83.0%	75.8%	82.1%	85.3						81.34%	A		
Wheelchair Services : Under 18's new referrals assessed within 8 weeks	L - C	90%	91.94%	100%	75.0%	53.8%	87.5%	72.7%	100%	78.9%						80,42%	R		
Mental Health Services (CPA and Eating Disorders)																			
CPA Review within 12 Months %	N - T	95%	90.3%	88. 1%	92. 9%	94.8	96. 7%	96.4	94.5	95.3						94.1%	A		
Adolescent Eating Disorder - routine referral to NICE treatment start within 4 weeks %		95%	32.4 %		0.0%	0.00%	0.00%	16.6%	85.7	61.5%						36.85%	R		
Adolescent Eating Disorder - Urgent referral to NICE treatment start within 1 week %		95%	10.8 %	7. 1%	0.0%	0%	0.00%	5.5%	0.0%	20%						3.67%	R		
Adolescent eating Disorder - Urgent referral to non NICE treatment start within 1 week %		95%	14.2%			0%	0.00%	0.00%	33.3%	100%						12.5%	R		
Eating disorders - Wait time for adult assessments will be 4 weeks %		95%	58.2	59.0%	38.8%	57.1%	44.4%	50.0%	50.0%	55.00%						50.99%	R		
Eating disorders - Wait time for adult psychological interventions will be 16 weeks %	N – T	95%	75%	71.4%	80.0%	50.0%	25.0%	76.4%	55.5%	75.o%						67. 1%	R		

Additional information

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

Wheelchair Services: In October, 11 out of 75 routine adults were seen outside of timeframe, 4 out of 19 routine under 18's were seen outside time frame. 1 out of 8 priority referrals for adults were seen outside timeframe with all under 18's priority being seen within timescale. The backlog of patients is attributable to increasing demand for service coupled with vacancies and sickness within teams. There does not appear to be any related incidents or increase in complaints linked to these areas.

Mental Health : CPA rates have recovered to meet target this month and it is hoped that this is a sustainable position acknowledging the risk that workforce challenges and prioritisation of urgent clinical activity could have upon recovery.

Eating Disorders: Actions to date, wait list validation exercise completed, ringfenced assessment slots allocated and reported on weekly, improvement co-ordinator post established, refreshed standards on urgent/ routine clarification, partnership with BEAT to support those waiting for FBT, Bespoke forecasting model built, workforce resources mapped and planned, RHED caseload reviewed and reduced from c200 to around 50, current discussions with Orri (private provider) to outsource treatment for 80, 16- 19 year olds. TiC plus now working with 35 people and attend CEDS triage weekly. Proactive vacancy management and recruitment continues.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES EFFECTIVE?

	Reporting Level	Threshold	2021/22 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022/23 YTD	R / A / G	Exception Report?	Benchmarking Report
Community Hospitals																			
Bed Occupancy - Community Hospitals	L - C	92%*	95.19%	89.9%	90.4%	89.5%	89. 5%	97.8%	97. 9%	98.1%						98.1%			
*** Indicates optimum occupancy to enable flow**																			
Early Intervention in psychosis EIP: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	N - T	60%	90%	66.6%	83.3%	75.0%	75.0%	66.6%	75.0%	33.3%						67.6%	G		
Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered																			
Inpatient Wards	N - T	95%	68%	78%	82%	75%	72%	75%	78%	78%						78%	R		
Community	N - T	90%	28%	NA	22%	24.6%	30.54%	39%	49.9%	55%						55.9%	R		
Improving access to psychological therapies (IAPT): Proportion or people completing treatment who move to recovery (from IAPT database). Waiting time to begin treatment (from IAPT minimum dataset	N - T	50%	52.1%	50.5	48.9%	51.5%	50.6%	50.3	50.3	51.1%						50.4%	G		
Admissions to adult facility of patient under 16yrs	N - R		1	0	0	0	0	0	0	0						0	N/A		
Inappropriate out of area placements for adult mental health services	N - R	Occupied bed days	918	25	64	114	190	167	28	31						619	G		
Children's Services – Immunisations			2021/22 Outturn	Academic Year 2021/22 - Target 90% of all 2 immunisations by end of academic year (July 2022) and new cohort 1st immunisations					Academic Year 2022/23 - Target 90% of all 2 immunisations by end of academic year (July 2023) and new cohort 1st immunisations. Programme start date to be confirmed.										
HPV Immunisation coverage for girls aged 12/13 years old (Target for all 2 immunisations to be completed) HPV 2 begins March 2022	N - T	90%*	76.9%	40% / 30.0%	70% / 75.3	80% / 76.2%	85% / 77.0%	90% / 79.1%											.
Childrens Services - National Childhood Measurement Programme			2021/22 Academic Year	Academic Year 2021/22 - Target 95% of children measured by end of academic year - Cumulative target (July 2022) programme commences November 2021					Academic Year 2022/23 - Target 95% of children measured by end of academic year - Cumulative target (July 2023) programme commences end of October.										
Percentage of children in Reception Year with height and weight recorded	N - T	95%*	96.2%	70% / 69.9%	80.0% / 83.1%	95% / 93.3%	95% / 96.2%												
Percentage of children in Year 6 with height and weight recorded	N - T	95%*	96.1%	70% / 72.0%	80% / 79.7%	95.0% / 87.6%	95% / 96.1%												

Additional Information

NCMP: New year programme commenced 31st October 2022.
Children's services Immunisations: New year programme commenced 31st October.
OOA :31 days relating to 1 acute patients.
EIP: 3 non-compliant cases were reported in October. One patient was offered an appointment but did not attend, the next appointment that could be offered (and was attended) was outside of timeframe, one patient was on a Mother and Baby Unit with difficulties joining a virtual MDT, however the patient has now been seen. The remaining patient is known to the team and is a re-referral and therefore does not require an assessment but has been entered on the clinical system as a new case so the data set has been adjusted
Cardio-metabolic assessment – Teams are supported by two Physical Health Nurses within WLH and CLH. Ongoing development work is taking place to improve the current collection methods for this metric.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

Additional KPIs - Physical Health

	Reporting Level	Threshold	2021/22 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022/23 YTD	R / A / G	Exception Report?	Benchmarking Report
Proportion of eligible children who receive vision screens at or around school entry.(Cumulative target)		95%*	97.7%	70.0% 71.8%	80.0% 88.1%	95.0% 95.0%	95% 97.7%	Programme starts end of October 2022											
Number of Antenatal visits carried out			467	34	43	39	60	52	55	36						319	NA		
Percentage of live births that receive a face to face, telephone or video NBV (New Birth Visit) within 7- 14 days by a Health Visitor		95%	92.3%	92.6%	91.3%	92.0%	91.5%	94.%	93.0%	92.6%						92.5%	A	Y	
Percentage of children who received a face to face, telephone or video 6-8 weeks review.		95%	95.50%	86.8%	93.0%	90.3%	85.6%	93.0%	87.4%	95.0%						90.2%	A	Y	
Percentage of children who received a 9-12 month review by the time they turned 12 months.		95%	81.5%	79,6%	82.8	82.0%	82.3%	73.4%	76.8%	79.8%						79.4%	R	Y	
Percentage of children who received a 12 month review by the time they turned 15 months.		95%	86.8%	83.0%	81.6%	77.0%	78.5%	82.8%	82.6%	82.3%						81.07%	A	Y	
Percentage of children who received a 2-2.5 year review by 2.5 years.		95%	81.3%	76.1%	79.7%	82.5%	65.0%	84.4%	80.8%	85.2%						78.95%	R	Y	
Percentage of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence).		58%	56.7%	53.0%	53.1%	55.3%	50.8%	54.7%	54.4	54.3%						53.71%	A		
Breastfeeding- % of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks		80%	81. 5%	82.1%	76.3%	79.7%	81.6%	77.6%	81.4%	81.1%						80. 0%	G		
Average Number of Community Hospital Beds Closed		0	1.36	0	0	.1	2.0	1.0	6.0	11.0						.59	A		

Additional Information

Information on this page is triangulated with performance reporting with improvements being made in recovering the reported position. The Simplicity data quality project has impacted upon the accuracy of data in the physical health teams in this and in prior reporting periods**.** From an operational perspective the compliance data is understood to be higher than that reported above and teams are working to ensure that data is correctly recorded first time in systems to remove the need for validation and re entry. From a quality perspective there have not been any adverse indicators reported in terms of safety or experience noting that some targets are not achieved in the data above. We are expecting to be able to report a further improved position. The average number of community hospital beds closed increased as this reflects the transition between Coln Ward and Thames Ward which was a planned transition.

Health Visiting:

- **NBV and Child reviews**: There remains identified recording errors in relation to NBV and child reviews, however the impact of the Simplicity project is lower this month but offset by higher numbers of families requesting appointments out of timeframe due to holidays and not prioritising HV contact. Operational compliance figures are still higher than those listed therefore teams are working to ensure each service has an “aide memoire” to ensure consistent input of data to avoid inconsistency. Record keeping training and data review continues to take place to update all practitioners with regard to the required new ways of recording.
- **Breastfeeding**: The breastfeeding rates are similar to last month and the % of mothers continuing with breastfeeding has remained above target.. There is a programme of work with other stakeholders, infant feeding champions in place and updates are sent to all HV teams giving reminders to liaise/refer to locality infant feeding champion with any queries or support when required . The team continues to support colleagues to improve compliance, rates reflect similar challenges in partner organisations.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES WELL LED?

	Reporting Level	Threshold	2021/22 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022/23 YTD	RAG	Exception Report?	Benchmarking Report
Mandatory Training	L - I	90%	90.33%	92.4%	92.6%	92.1%	91.3%	91.9%	90.2	90.2						90. 2%	G		
% of Staff with completed Personal Development Reviews (Appraisal)	L - I	90%	67.72%	77.0%	78%	79%	79%	82%	83%	**81%**						81%	R	Y	
Sickness absence average % Rate	L - I	<4%	7.2%	6.5%	5.3%	6.0%	6.6%	5.4%	5.8%	6.5%						N/A	R	Y	

Additional information

- **Mandatory training -** Is at 90.2% overall, which is above target for the tenth consecutive month.This achievement is a reflection of the focus in place to ensure staff are up to date with statutory/mandatory training, to maintain the current position and achieve improvement wherever possible.
- **Appraisal** - Is at 81% (active assignments only, excluding bank). The figure has decreased slightly since last month which triangulates with an increase in the number off staff self isolating and off sick but still demonstrates a . lowly increases and demonstrates a 4% increase through the year.
- **Sickness absence** - At 6.5% in month indicates an increase from the previous month of 0.7%. Rates remain high and above target and correlates with the increase in staff who were self isolating in October. Data is now automatically received from workforce providing a robust single data source. This data can vary from BI source data as that stream does not include information from E-roster and is subject to timing.

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AGENDA ITEM: 08/1122

REPORT TO: **TRUST BOARD PUBLIC SESSION – 24 November 2022**

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

AUTHOR: John Trevains, Director of Nursing Therapies & Quality

SUBJECT: **QUALITY AND SAFETY OF MENTAL HEALTH, LEARNING DISABILITY AND AUTISM INPATIENT SERVICES – NHS ENGLAND REQUEST FOR TRUST BOARDS**

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 provide the Trust Board with information and assurance on Trust practices to maintain and improve the quality and safety of mental health, learning disability and autism inpatient services. As described within recent communications from NHS England following the disturbing and unacceptable events presented within the BBC Panorama documentary about abusive care at an NHS Trust in Manchester.

This report describes the Trust's initial actions regarding the letter, describes at a high-level existing Trust safeguards and outlines future work to guide a Board level discussion on this important matter.

Recommendations and decisions required

The Board is asked to:

- **Note** and **discuss** the content of this report
- **Support** the proposed actions

Executive summary

Claire Murdoch the NHSE National Director, Mental Health wrote to all Mental Health, Learning Disability and Autism provider Trusts on 30th September following the BBC Panorama documentary about failures of care at the Edenfield Centre, a medium secure forensic mental health hospital managed by Greater Manchester Mental Health

NHS Foundation Trust. This documentary showed disturbing hidden camera footage of patients being abused by NHS care staff.

This paper provides our Trust analysis of the issue in regard to our services, it highlights our high risk areas for Board awareness and describes our safeguarding and mitigating actions.

In conclusion the paper outlines future work to be progressed inclusive of

- Connection with national supporting programmes of work
- Development of the current Trust Quality Dashboard to present closed culture risk rated assurance
- Discussions to be progressed with commissioners to explore increased access to advocacy and work with community partners

Risks associated with meeting the Trust's values

The provision of good quality care that is delivered compassionately, legally and in line with nationally mandated standards is essential to meeting our Trust values.

Corporate considerations	
Quality Implications	Yes, relates to safety, experience and outcomes
Resource Implications	Yes, specifically workforce and advocacy costs of note
Equality Implications	Yes, vulnerable patient groups

Where has this issue been discussed before?
Trust Executive meeting 15/11/2022

Appendices:	N/A

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

QUALITY AND SAFETY OF MENTAL HEALTH, LEARNING DISABILITY AND AUTISM INPATIENT SERVICES

1.0 INTRODUCTION

1.1 This report provides the Trust Board with information and assurance on Trust practices to maintain and improve the quality and safety of mental health, learning disability and autism inpatient services, as described within recent communications from NHS England (NHSE) following the disturbing and unacceptable events presented within the BBC Panorama Documentary about abusive care at an NHS Trust in Manchester.

1.2 Claire Murdoch the NHSE National Director, Mental Health wrote to all Mental Health, Learning Disability and Autism provider Trusts on 30th September following the BBC Panorama documentary about failures of care at the Edenfield Centre, a medium secure forensic mental health hospital managed by Greater Manchester Mental Health NHS Foundation Trust. This documentary showed disturbing hidden camera footage of patients being abused by NHS care staff.

1.3 The letter included a request for Boards to review the safeguarding of (inpatient) care in your organisation and identify any immediate issues requiring action now; including but not limited to:

a. freedom to speak up arrangements,

b. advocacy provision,

c. complaints,

d. CETRs and ICETRs, (a detailed type of care review used in learning disabilities and autism services)

e. other feedback on services.

and; long term segregation/seclusion matters

1.4 The NHSE communication offered the following questions for Board discussion

We all have a responsibility to our patients and their families to ensure they receive the best possible care, treated with dignity and compassion in safe surroundings. It is vital boards ask:

- could this happen here?

- how would we know?

- how robust is the assessment of services and the culture of services?

- are we visible enough and do we hear enough from patients, their families and all staff on a ward e.g. the porter, cleaner, HCAs?

1.5 As the Trust designated Executive responsible for Safeguarding, the Trust Director of Nursing, Therapy and Quality leads work that endeavours to address

this important matter. They have taken a lead on the Trust's initial actions to respond to inform the Trust Board via this paper.

2.0 Scope and Context

2.1 The Trust provides a wide range of inpatient mental health and learning disability services across Gloucestershire. For the purposes of this discussion it is helpful to first focus on areas that would be considered more at risk of being deemed a "closed culture" as noted in the NHSE letter.

2.2 "Closed culture" is a helpful descriptive term often used by the Care Quality Commission (CQC 2022) to describe "a poor culture in a health or care service that increases the risk of harm. This includes abuse and human rights breaches. The development of closed cultures can be deliberate or unintentional – either way it can cause unacceptable harm to a person and their loved ones." The scenes relayed in the BBC documentary are very much descriptive of a closed culture.

2.3 The CQC outlines that Closed Cultures are more likely to develop in services where:

- people are removed from their communities
- people stay for months or years at a time
- there is weak leadership
- staff lack the right skills, training or experience to support people
- there is a lack of positive and open engagement between staff and with people using services and their families

2.3.1 In these services, people are often not able to speak up for themselves – which can be through lack of communication skills, lack of support to speak up or abuse of their rights to speak up.

2.3.2 The CQC Closed Culture related work has applied to services that can be described as locked environments or areas where open access is restricted. A range of helpful material on this from CQC are available to Trusts. For Board awareness CQC visited both Berkley House and Montpelier ward as part of a national closed culture review in 2019.

2.4 With regards to our Trust services our hierarchy of inpatient mental health learning disability services at raised risk of being a Closed Culture can be considered specifically as follows

- Berkley House – Learning Disabilities Assessment and Treatment
- Montpelier Ward – Mental Health Forensic Low Secure

2.5 However, in the interest of best patient care as an integrated mental and physical health focused Trust we should consider a spectrum of risk of closed cultures across all our inpatient services; noting the vulnerable patient groups we care for not just in our mental health and learning disability settings. This should also be extended to the work our physical health community hospitals provide with frail and elderly patients. Board colleagues will recall the well-publicised failings of care

described via the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis 2013).

2.6 Objectively, all our Trust inpatient services are potentially vulnerable to delivering poor care due to a complex range of organisational and individual factors ranging from staffing issues, frail/vulnerable patients, organisational mandated tasks that divert staff from care giving through to an individual's personal values and behaviours that in turn can lead to poor care. The negative impacts of these factors are well described in work carried out following the Mid Staffs work by Professor John Paley (2014) and its principles are helping to inform our Trust actions regarding assurance of existing and development of additional safeguards.

2.7 Future work will seek to describe our spectrum of closed culture risk inclusive of all inpatient care areas in our Trust.

2.8 This report describes the Trust's initial actions regarding the Board questions within the letter, describes at a high level existing Trust safeguards and outlines future work.

3.0 Trust Actions

3.1 On receipt of the NHSE letter the Trust scheduled this paper to be an agenda item in public at the next Trust's Public Board, to enable a Board level discussion to be held in public aided by information contained within this paper.

3.2 Montpellier clinical focus group exercise

Noting a range of sources for "closed culture" monitoring assurance being well established regarding Berkley House, our initial priority (noting the BBC document being focused on secure mental health services) first focused on Montpellier Ward via a clinic focus group session to test our collective views on levels of assurance and risks.

3.3 A structured meeting was facilitated with a wide range of multi-disciplinary colleagues working in and for services that support the work of Montpelier Ward. In brief, a good level of assuring information was put forward this includes confidence in a range of mitigating practices which included:

- Evidence of external advocacy input into the ward
- Regular welfare visits and involvement from Hospital Chaplain
- Peer led involvement of recently discharged service users in
  - Patient meetings on the ward
  - Interviewing for new recruits to the ward
- Frequent family engagement on the ward
- Service specific patent rated experience/quality tools being used
- Low use of seclusion type interventions with no "traditional" seclusion or extended segregation used
- Skill mix on ward is weighted towards good usage of "exercise and physical health" practitioners with high levels of therapy input delivering high levels of community access and activity

- Patients on Montpellier Ward participated positively in a BBC News article on the impact of Covid on Mental Health inpatient units in 2020
- All patients are subject to enhanced care plan approach reviews and Home Office monitoring
- Montpellier Ward is not an isolated unit, it is located amongst Wooton Lawn services on the large hospital site in Gloucester

3.4 The service has a culture of raising concerns appropriately internally through Human Resources routes regarding staff matters and issues relating to the use of restrictive practices. A recent new lead medical appointment commented favourably on the positive attitude of staff on Montpellier Ward. We receive good feedback from NHSE Specialist Commissioning quality monitoring activity. The unit has a CCTV monitoring system in many areas of the unit and the team receive support from the Trust security management specialists.

3.5 **Berkeley House**

The risk of Berkeley House being considered a closed culture is well recognised by the Trust and the service commissioners at NHS Gloucestershire. A range of protective practices and monitoring arrangements are in place to mitigate this risk and provide positive assurance as detailed:

- All patients are subject to externally coordinated Care and Treatment Review care plans via NHS England and NHS Gloucestershire.
- Every patient in the service has a Positive Behavioural Management Plan. This plan sets out a framework that allow staff to identify behavioural indicators, distraction techniques and de-escalation plans to prevent the patient reaching the point of Seclusion
- Where seclusion is deemed necessary and proportionate to the risk we have clear guidance for staff to manage the period in seclusion and this is in line with the safeguards outlined in the Mental Health Act Code of Practice.
- Each patient has an independent advocate who visits the unit and spends time with them once a month.
- The young person located at Berkeley House receives additional input from education colleagues external to the Trust.
- All patients at Berkeley House have facilitated contact with their families alongside supported access to the local community
- CCTV monitoring is in place at Berkeley House and there is a culture of raising concerns related to restrictive practices
- The unit has been subject to a number of NHSE and regulator visits. Its rating was recently raised from *Requires Improvement* to *Good* by the CQC following an inspection visit in May 2022.

3.6 **Identified Risks**

From clinical discussion the main key risks for both these areas are maintaining good levels of regular staffing and reducing reliance on agency workers. Berkeley House currently has a high vacancy factor (31.4%), predominantly for health care support worker level positions. Berkley House colleague's work hard to maintain safe levels of care supplemented by agency, of note they report very low rates of

staff sickness and absence. Montpellier vacancy factor is currently 10.1 % set against a Mental Health inpatient average of 15%. A range of Trust activity is in progress to seek to address these deficits.

3.7 **Trust Learning**

Leaning lessons from quality issues at Charlton Lane Hospital (CQC Requires Improvement rating March 2022). As a Trust we recognised the impact of high quality clinical leadership alongside staffing levels support; with additional clinical and organisation development support to safeguard quality. As a Trust we must keep this learning at the centre of work related to closed culture risks.

4. High Level Trusts Quality Governance Arrangements and Safeguards

4.1 The following section provides a brief outline of other related Trust governance approaches and processes as noted in the NHSE letter to inform the Board discussion.

4.2 **Freedom to Speak Up arrangements** – The Trust has an established Freedom to speak up processes overseen by the Trust Guardian that is reported regularly to Board. This work is supported via a range of mechanisms and routes that Trust colleagues can use to raise concerns through *Pauls Open Door*, the *Work in Confidence* portal and other Trust wellbeing routes.

4.3 **Complaints** - The Board receive regular information on complaints and associated patient experience information. This information includes themes and also the Trust experience team work closely with both Safeguarding and Patient Safety to address any issues of potential concerns that arise. Berkley House and Montpelier ward do not feature significantly in terms of complaints or concerns being raised.

4.4 **Patient safety reports** – The Board and the Trust Quality Committee receive regular information on patient safety incidents. This includes details on the use of restrictive practices and harms; alongside reports related to safeguarding activity in the Trust. Trust management receive a weekly report on use of restrictive practices across the Trust and there are ongoing programmes that seek to reduce restrictive practices.

4.5 **Clinical Supervision** - The restorative benefit of good quality clinical supervision in healthcare services is well established. Our Trust practitioners are trained and managed to recognise this and they engage in regular supervision. We know from our quality monitoring work that good levels of supervision take place across the Trust. However we currently have some limitations in the effectiveness of our supervision recording systems to provide high standards of assurance that is being delivered.

4.6 **Quality Governance** – In brief, the Trust delivers a comprehensive approach regarding quality governance, regulated by the CQC and subject to scrutiny by a range of external stakeholders such as NHSE, Gloucestershire ICB amongst others. This work is reported to Board regularly via the Quality Dashboard, in the interest of best patient care we should challenge ourselves that we have detail

relating to closed culture risk easily visible within this report in the spirit of good *Board to Ward line of sight* quality governance.

4.7 **Other arrangements** – There are other Trust activities the support work in addressing close culture risks, these include the following

- Non-Executive Director Quality Visits
- Trust focus on culture and staff well being
- Values based recruitment approaches
- Other patient experience work such as Friends and Family Tests, PLACE inspections and similar activity

5. Further actions and development

5.1 We are connecting on this matter with both the national NHSE Mental Health Quality Team and also the National Mental Health and Learning Disabilities Nurse Director Network (MHLDND). Both these bodies are conducting development work on this issue and we will stay abreast of these national developments regarding assessment tools and protective actions. We have utilised a helpful checklist devised by the MHLDND to inform our review work to date.

5.2 The Director of Nursing Therapies and Quality will work with the Quality Committee on enhancing current reporting to explore how closed culture related risks and Trust mitigating actions can be better communicated at Board level. This must include not just the high risk areas identified in this paper but the spectrum of risk across all our inpatient areas.

5.3 As noted in this paper protective factors via access to good quality advocacy and input from local expert by experience groups/providers are highly regarded in our Trust by patients, carers and clinical colleagues. It would be helpful for the Trust Board to support discussions with commissioners on how as a system we better support these providers to provide additional activity into Trust services to help safeguard care.

References:

Care Quality Commission (2022) - How CQC identifies and responds to closed cultures - How CQC identifies and responds to closed cultures - Care Quality Commission

Francis. R. (2013) - Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

Paley. J (2014) - Cognition and the compassion deficit: the social psychology of helping behaviour in nursing

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AGENDA ITEM: 09/1122

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 24 November 2022**
PRESENTED BY:	Sandra Betney, Director of Finance & Deputy CEO
AUTHOR:	Chris Woon, Deputy Director of Business Intelligence
SUBJECT:	**PERFORMANCE REPORT OCTOBER 2022/ 23 (MONTH 7)**

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 October (Month 7 of 2022/23). Where performance is not achieving the desired threshold, operational service leads are prioritising appropriately to address issues. Where appropriate, Service led Governance updates are presented to the Business Intelligence Management Group (BIMG) and more widely account for performance indicators in exception. Formal service level improvement plans and risks are also highlighted where appropriate.

Recommendations and decisions required
The Board are asked to:

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

Executive summary

Business Intelligence Update
2022/23 Business Intelligence business planning highlights are presented on page 1 alongside a high-level Measuring What Matters timetable on page 3. The Measuring What Matters milestones and next steps are being reconfigured into a strategic portfolio for 2023/24 and a proposal will be brought to Executive in the coming months. An initial outline is being drawn up.

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

confidence in the current situation. The associated narrative should also be considered for all indicators in exception.

Chief Operating Report
A Chief Operating Report authored by the Chief Operating Officer can be found on Page 4.

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 with the exception of newly escalated, legacy proxy indicators which are reintroduced from October.

- **Mental Health & Learning Disability Service (Local) Performance**

Attention is requested to review the 8 MH key performance thresholds in exception within the dashboard (with associated narrative) that were not met for the period. 4 relate to the Eating Disorder (ED) Service. 3.11 IAPT Recovery is above threshold but has seen special cause variation in the last 7 reporting periods (performance below average) which may indicate a step change in the system. Commentary is provided.

- **Physical Community Health Service (National & Local) Performance**

In addition, attention is drawn to a further 16 PH key performance thresholds in exception within the dashboard (with associated narrative) that were not met for the period. 7 are wait time measures and it is assumed that alongside operational challenges, SystmOne Simplicity data appears to be *contributing* to all of these 7 items. However, 6 indicators were in exception prior to SystmOne Simplicity. Through clinical services intervention, performance is expected to improve over the year as outlined within the Operational Directorates' operational tracker.

- **Trust Wide Service Performance**

The indicators of; Sickness Absence, WF2 Turnover and WF3 Cumulative Leave are all in exception for the period. Sickness absence remains above the 4% threshold at 5%. This October position does not yet include data from the e-rostering system (Allocate) because this is unavailable at the time of publishing the performance dashboard.

- **Non-exception reporting**

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

The performance items of note for the period are highlighted from page 20. Examples include: positive Urgent Care Response performance, SystmOne Simplicity improvement examples for physical health, Retrospective data recording improvement (1.07), Vacancy detail, Eating Disorder National submission update, Integrated Care System (ICS) Ambulance performance and Physical Health waiting time profiles.

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

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

Where has this issue been discussed before?	BIMG 17/11/2022

Appendices:	*None*

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

Gloucestershire Health and Care NHS Foundation Trust

Snapshot Month
October

Performance Dashboard Report & BI Update

Aligned for the period to the end October 2022 (month 7)

Business Intelligence Summary Update

The SystmOne Simplicity (S1S) operational tracker now outlines the key operational milestones to satisfy a 'data quality state' over 2022/23.

The first reporting for the Datix Risk Module and Training and Development was shared with system owners for further validation and feedback. Once further established, this will be progressed into integrated dashboards. Key finance reporting items are also being discussed with an intention to add into integrated dashboards. Supplier side technical issues with Allocate are resolved but have delayed planned progress so programmed activity has been remapped into 2023. Further data field information is required within the Appraisal information data source module and this has been escalated with the Supplier who are investigating a solution. This is still outstanding.

Page 2 highlights high level progress against the original **Measuring What Matters** plan which initiates a range of performance agendas. 19 items of 28 (68%) are now completed, the remaining 9 are on schedule. Progress has been made in developing the Measuring What Matters agenda into a wider strategic portfolio for 2023/24. A proposal will be presented to Executives in preparation for 2023/24.

The final pages (from Page 16) of the Performance report presented indicators not in exception but are highlighted for recognition of positive progress and notable improvements.

Chief Operating Report

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

Performance Dashboard Summary *(from page 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.

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

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

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

Theme	(Provisional) Milestone	Target date	Progress Tracker
Data Quality matters	Tableau subscriptions and alert functionality promoted across services	Dec-21	Complete
	Data quality audit schedule for 2022/23 to be agreed	by August 2022	CST monthly Audit Index and Audit Summary in place and monitored, NQT responsibilities to be reconfigured into Measuring What Matters Portfolio
	SystmOne Simplicity project (to improve accuracy, consistency, and service quality) to be delivered	by April 2023	On timeline
	Revised data quality reporting portfolio deployed within Tableau servers for physical health services	by Oct 2022	Complete
Integration matters	Server migration to allow for reconfiguration and resolve licensing concerns	by Dec 2021	Complete
	Develop additional Board performance dashboard workforce indicators to include:		Complete
	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 Report in Table(s) by April 2022	by April 2022	Complete
	Deliver Totara (Care to Learn) extraction by April 2022 & first report deployment by Oct 2022	by Dec 2022	Initial Training & Development reporting drafts deployed for service validation
	Deliver Allocate (e-Rostering) extraction by April 2022 & first report deployment by Oct 2022	by April 2023	Supplier's API solution unstable but reestablished and back into work plan for 2022/23
Patients matter	Heads of Profession to liaise with Service leaders and wider stakeholders to develop the organisation's first plan for Value Based Healthcare in 2022/23	By Mar 2023	Reconfiguring into Measuring What Matters Strategic Portfolio
	Deploy trial of first tranche of new outcome measures	by April 2023	Reconfiguring into Measuring What Matters Strategic Portfolio
Culture matters	Decommissioning of regular Excel physical health reporting use	by July 2022	Completed
Audience matters	Review Key Performance Indicator portfolio to inform 2022/23 contract schedule and operational/ strategic needs	by Jan 2022	Completed
	Publish proposal to restructure the current performance dashboard to support various audience level perspectives	by Jan 2023	Performance Indicator engagement workshops completed. Next stage to present first proposal to BIMG in December 2022.
Format matters	Deliver immediate performance dashboard interrogation pilot for Resources Committee members	by Sept 2022	Presented Integrated Dashboard prototype in August 2022
Timeliness matters	Evaluate (almost) real-time transactional log shipping processing within all new system procurements and extensions, particularly when RiO and SystmOne contracts	by April 2023	Reconfiguring into Measuring What Matters Strategic Portfolio
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 Nov 2022	Agreed proxy indicators re introduced into Performance Dashboard.
	Publish Performance Management Framework	by May 2022	Complete
	Remove superseded National and Local Performance Indicators	by Jan 2023	Performance Indicator engagement workshops completed. Next stage to present first proposal to BIMG in December 2022.
	Introduce ranked waiting times (over 52weeks) summary into the performance dashboard report – provisional outline	by Nov 2023	Within November 2022 Performance Dashboard
	Introducing new internal performance indicators into performance dashboard	by Jan 2023	Performance Indicator engagement workshops completed. Next stage to present first proposal to BIMG in December 2022.

Chief Operating Officer's Report October 2022

David Noyes, Chief Operating Officer (COO)

Board colleagues will be aware that the Newton Europe diagnostic work is approaching culmination, and indeed colleagues from Newton will be attending Board to present an update on their conclusions. This important work reflects the priority given by our system Chief Executive group to focus on the Urgent and Emergency Care area, and the review has very helpfully highlighted some potential areas for improvement in every part of the system. Newton colleagues are now de-briefing, and have already presented at Health Overview and Scrutiny, as well as within GHC to both the Executive group and the senior Ops team. There are three key areas for GHC to focus upon, which are improvements to the referral management and effectiveness of Rapid Response, some improvements to the effectiveness and consistency of Homefirst teams, and (likely along with a system wide review of our approach) the effectiveness of the falls service. Plans are already being formulated to make progress in each of these areas. As reported to Resources Committee last month, we have as part of our winter planning created six escalation beds across our estate, which in agreement with GHFT colleagues we are using to facilitate earlier in the day flow which supports Acute flow. Notwithstanding that flow from our services remains an ongoing challenge, with between 30 and 40% of our bedded and Homefirst capacity taken up by patients who have completed their treatment pathway with us, we have been achieving good levels of bedded support for our Acute colleagues, with often a list of less than 10 patients in GHFT waiting on transfer to a community ward. Our Homefirst performance isn't consistently strong, and recently has fallen back largely due to the absence (sickness) of the teams operational manager and the planned migration of the teams to a digital (System 1) platform, which takes some time in terms of training and set up. That said, and notwithstanding the recruitment environment, we do have the right capacity in place now to achieve at least 40 starts a week if we were able to achieve flow out at completion of treatment.

We have agreed with ICS colleagues that we will conduct a strategic review of the future use of the county's Community Hospital estate, really with a view to the potential to expand the successful CATU model across the county while at the same time taking the opportunity to look at the scale and depth of the therapy offer we could generate; the latter (with the right investment) offer an opportunity to enable us to help people regain greater independence and so potentially be able to be discharged home without any reliance on a care package (or much reduced).

Elsewhere, the consultation period having closed, and having adjusted to reflect a lot of useful feedback, the reconfiguration of the operational directorates will take effect on 1 December, which will configure our services to take the next steps in delivering more integrated services in the manner outlined in the Trust merger business case. We have a full OD programme planned to support the changes, which starts with team development sessions with the ops leaders along with their Clinical Director and (new) Head of Quality and Professions colleagues. Our development work on Length of Stay in our Mental Health units continues with a second workshop planned for early December; still early days but the adoption of new approaches to board rounds and a more rigorous approach appears to be bearing some early fruit in terms of easing the pressure on bed availability.
Pleasingly we continue to make good progress in tacking the enormous challenge in our eating disorders service, with urgent adolescent referrals now being seen within a week, and now that this highest of the high priority areas is in a better place we are starting to make progress with the Adults list and able to flex some capacity to treatments. The board have been aware for some time about concerns we had regarding the Children's OT service, which unfortunately have had a set back; notwithstanding that we have some recruitment plans which should come to fruition in December, following a deep dive into progress we have taken the difficult decision to close the service to routine referrals for an initial 4 weeks to enable a re-set (details are within the performance report). We have continued to work with commissioning colleagues on the issue of Echo, including sharing with them the QIA we completed; ultimately the ICS are not able to resource the additional capacity that we had sourced and recommended, which is unfortunate – the latest recovery trajectory from GHFT colleagues does however indicate that the service will be fully recovered by Feb. Unfortunately, our projected recovery of Podiatry forecast for December looks challenging now due to staffing issues (a combination of sickness, leavers and unsuccessful recruitment) and hence that recovery plan is being revised and refreshed. In better news I am seeing strong progress in our ICT physio and OT areas with implementing new aide memoires/ SoPs to improve data accuracy under the Sys1 simplicity project, both areas which had previously been flagging as a worry.

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

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health - National Requirements Gloucestershire

		OCTOBER	22/23	
1.07	New psychosis (EI) cases treated within 2 weeks of referral	0.0% 60.0%	67.6% 60.0%	

<u>Performance Thresholds not being achieved in Month</u> - *Note this indicator has not been in exception previously within the last twelve months.*

1.07: New Psychosis (EI) cases treated within 2 weeks of referral [Community MH Services]
October is reported at 0% against a performance threshold of 60%. There were 3 non-compliant cases reported in October.

One patient was offered an appointment but did not attend. The next appointment that could be offered and which the client did attend was outside of the required 2 weeks.

One patient was on a Mother and Baby Unit and the team experienced difficulties in joining a virtual MDT. Following this the patient and partner proved hard to engage. The patient has now been seen.

The remaining patient is known to the team and does not require an assessment but has been entered on the clinical system as a new case. The team have been advised that this can be corrected on the clinical system and will then no longer show as non-compliant. The patient was an in-patient at the time of referral and an attempt was made to engage via an MDT during the 2 weeks but was unsuccessful as a Mental Health Act Assessment was in progress.

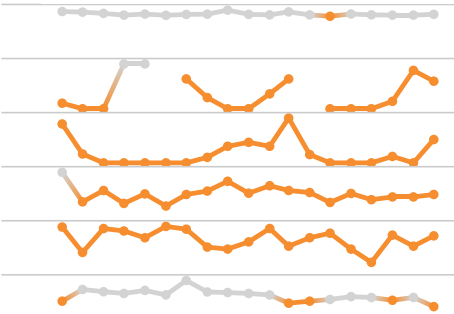
Performance Dashboard: *Mental Health & Learning Disability - Local Contract (Including Social Care)*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health & Learning Disabilty - Local Contract

		OCTOBER	22/23
3.11	IAPT recovery rate: Access to psychological therapies for adults should be improved	51.1% (50.0%)	50.4% (50.0%)
3.35	Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	61.5% (95.0%)	46.8% (95.0%)
3.37	Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week	20.0% (95.0%)	3.6% (95.0%)
3.39	Eating Disorders - Wait time for adult assessments will be 4 weeks	55.0% (95.0%)	50.9% (95.0%)
3.40	Eating Disorders - Wait time for adult psychological interventions will be 16 weeks	75.0% (95.0%)	67.0% (95.0%)
3.49	Perinatal: Routine referral to assessment within 2 weeks	38.2% (50.0%)	49.3% (50.0%)



Mental Health Social - Local

		OCTOBER	2022
4.05	% of WA & OP service users on the caseload who have a carer, who have been offered a carer's assessment	89.7% (90.0%)	91.3% (90.0%)

<u>Performance Thresholds not being achieved in Month</u> - *Note all indicators have been in exception previously within the last twelve months. To note, 4.05 has been in exception in previous periods but retrospective data updates have resolved previous performance compliance.*

3.11: IAPT recovery rate: Access to psychological therapies for adults should be improved [Community MH Services]
In October, the recovery rate was 51.1% against a performance threshold of 50% and is within SPC (Statistical Process Control) limits; however, shows a special cause variation as the last 7 months have been below the average of 52%.
During the pandemic, the recovery rate increased, and it is thought that this was influenced by the service making quick adaptations to deliver online therapy as well as individuals having time to fully engage in their therapy. This has led to an inflated average across the period.
The high recovery rate was an exception in the Southwest as most other services were not meeting the national KPI of 50%. Since the end of lockdown, the recovery rate has returned to its pre-pandemic state, and the service continue to meet the National KPI. This has also been maintained despite sub-contracting to 2 external therapy providers.

3.35: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks [Community MH Services]
October performance is reported at 61.5% against a performance threshold of 95%. There were 5 non-compliant cases in October. The numbers reported against this KPI continue to remain low as routine referrals are assessed and held on a waiting list for treatment. The cases currently reported are due to instances where there has been a deterioration in the illness and treatment has been expedited

3.37: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week [Community MH Services]
October performance is reported at 20% against a performance threshold of 95%. There were 8 non-compliant cases in October.

Note on 3.35 to 3.38 NICE and non-NICE treatments and age range
At commencement of the under 18's national performance measures, guidance included a list of specified NICE treatments that would "stop the clock". As the service also provide other treatments specifically for patients with Avoidant Restrictive Food Intake Disorder, it was agreed with Commissioners that this would be reported separately to avoid inconsistencies between local and national reporting.
Discussions are now happening at a national level to recognise other treatments that will "stop the clock" and it has been agreed with commissioners to report the start of all treatment within the same indicator. It was anticipated that reporting will come into line with this agreement during September, however the service is still in the process of reviewing the current types of treatment recorded.
National guidelines state that the young peoples' indicators include those aged 18 and under, therefore we have brought the KPIs into line with national reporting and Adolescent now includes those that are referred before their 19th birthday.

3.39: Adult Eating Disorders: Referral to Assessment within 4 weeks [Community MH Services]

October performance is reported at 55% against a 95% performance threshold. There were 9 non-compliant cases reported in October.

3.40: Adult Eating Disorders: Assessment to Treatment within 16 weeks [Community MH Services]
October performance is reported at 75% against a 95% performance threshold. There were 5 non-compliant cases reported in October.

Note on 3.35, 3.57, 3.39 & 3.40 – Eating Disorders waiting times
The service continue to make referrals and support self-referrals to both BEAT (an Eating Disorders Charity) and Tic (Teens in crisis).
Letters have been sent to all those waiting for FBT requesting that they self-refer to the BEAT 'Developing Dolphins' programme whilst they are waiting for individual treatment. BEAT can work with up to 60 families by December 2022 and are commissioned to work with up to 120 families in total. BEAT have received 34 referrals thus far and are in the process of providing course start dates to carers and families.
The team continue to try and work with TIC plus, however, finding a suitable cohort of service users to refer has been challenging and uptake has been low despite the commissioning of 100 places. The team has referred 35 patients to the Tic TEDS programme. Tic are now attending the EDS triage and a support officer is now actively contacting patients to support the referral.

By reducing assessments overall and by non-substantive staff completing assessments the service has been able to utilise substantive clinician capacity to start FBT (family based therapy) treatments.

New starters are in post for the Clinical Psychologist and 2x Assistant clinicians. The 1x Band 5 clinician and 2 x Band 4 assistant clinicians are currently subject to recruitment checks. 3 x CAP Trainees will be graduating mid-November and will start a Band 6 role immediately after graduation. 3x CAPs (Clinical Associate Psychologists) training places have been secured for assistant clinicians from the team with university placements. The course commences January 2023. The service is currently hosting 1 return to practice nurse who is due to be able to re-register in early November.
Recently 3 x B6 12 month secondments were placed to advert but with no applicants. Due to a staff vacancy the post can now be advertised as a permanent post, with the anticipation that this will attract applicants and will allow for any suitable non-successful applicants to be offered the secondment posts. A request for agency staff has been made, however no suitable applicants responded.

Overall waiting list numbers are improving based on a significant reduction in overall caseload and numbers since June 2022. The caseload at this point was 1384 with the latest figure at 992. This allows for some patients to be assessed and treated more quickly based on the overall reduction in service pressure and the potential for increased capacity. The adolescent urgent assessment waiting list has improved dramatically over the past few months and the service are now able to offer all adolescents an assessment within a week of referral. Treatment waiting times however remain a challenge.
The Business Intelligence service are continuing to work closely with the service and with more stability recently introduced into the patient pathways are progressing work on capacity and forecast models for both assessment and treatment

The first draft of an Under 19 urgent model was presented to the service in mid-September for discussion and agreement of assumptions used. This model will determine the clinical capacity available for the remaining models: Under 19s routine, Adult urgent and Adult routine.

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

3.49: Perinatal: Routine referral to assessment within 2 weeks [Community MH Services]
October performance is reported at 38.2% against a performance threshold of 50% and is below SPC (Statistical Process Control) limits. There were 21 non-compliant cases in October.

The service continues to have work force challenges with 3 vacancies, awaiting new staff to take up posts, long-term sickness and maternity leave. The new members of staff are expected to be in post in November and December and the service will be able to increase the number of available sessions in the assessment clinics.

4.05: WA and OP service users on the caseload who have a carer, carer is offered a carer's assessment [Community MH Services]
October performance is reported at 89.7% against a performance threshold of 90% and is below SPC (Statistical Process Control Limits)

The majority of the cases are within the Managing Memory Service(64), Recovery Service (52) and Later Life Service(39).

Team managers have been briefed to remind staff to complete this relevant section on Rio.
This is monitored by the West each Monday at mangers meeting, monthly via Forum and individual supervision. Staff are reporting that work has been done on this but was after the data freeze date.

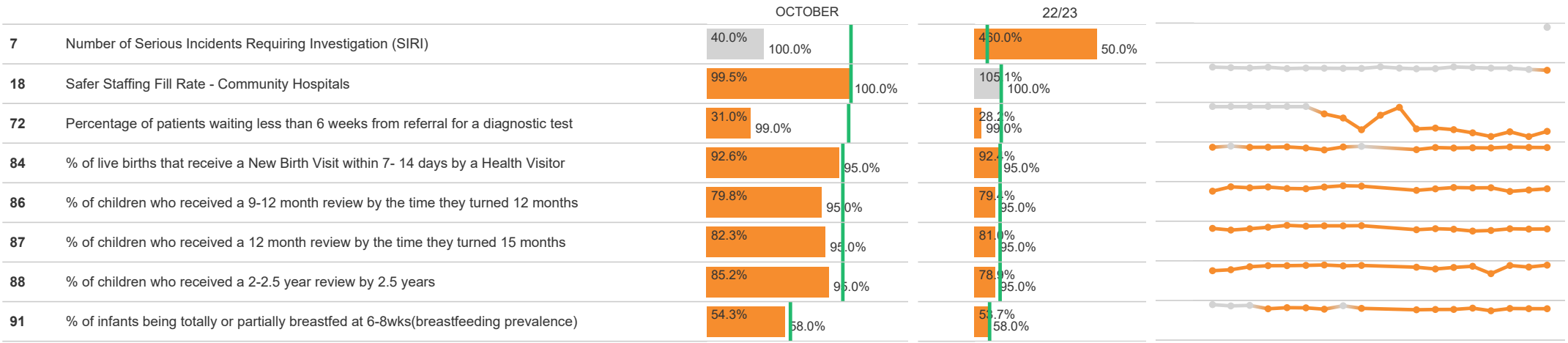
The Carer's assessment process has changed and although it is the clinical teams' responsibility to record if the patient has a carer, a referral is now made to the Carers Hub in Gloucestershire where the decision is made on whether to offer and assessment. This has been recognised and this indicator is not being carried forward in the 22/23 contract, although indicator 4.04 (Clients asked if they have a carer) will remain.

Performance Dashboard: *Physical Health - National Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - National Requirements



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

7. Number of Serious Incidents Requiring Investigation (SIRI) [Datix - Trust wide]
There was 2 SIRI reported in October 2022 compared to a threshold of 5. This is within SPC chart upper and lower control limits. SIRIs are counted in the month based on the declared date.

Both SIs were for Mental Health, 1 Inpatient and 1 Adult Community.

18. Safer Staffing Fill Rate - Community Hospitals
October performance was 99.5% (September was 102.1%) compared to a threshold of 100%. This is between the SPC chart upper and lower control limits.

72: Percentage of patients waiting less than 6 weeks from referral for a diagnostic test [Urgent care]
GHC is no longer responsible for the national submission for this activity which is now made by Gloucestershire Hospitals NHS FT.

Submitted data (by GHNHSFT) for GHC patients in October 2022 indicates a performance of 31% (compared with 16.5% in September) against a threshold of 99%. 191 out of 277 patients referred for an echocardiogram had been waiting 6 weeks or more for the scan at the end of October 2022. Performance is below the SPC chart lower control limit.

Waiting list is reflective of backlog for echocardiograms at GHNHSFT. Performance looks more favourable in October due to a higher number of patients currently waiting less than 6 weeks (higher no. of referrals in Oct) which has increased the denominator.

GHNHSFT has highlighted capacity issues with reducing the backlog which consists of waiting list and unscheduled tests. The cardiology department has put measures in place including working with an external contractor to provide echocardiograms to reduce the backlog. However, unfortunately, the contracted company has been unable to provide adequate staff to support clearing the backlog. By November 2022, GHNHSFT will have 3 members from the contracted company coming in to support with echos (roughly an extra 73 per week when committing fully to their suggested days).

According to GHC Heart Failure service, on 1st November 2022, 34 patients are on the Priority Echo waiting list for an echocardiogram, and 302 patients on the Routine Echo Waiting list. 28 patients are still to be triaged for Echo. The service has informed that they now reject incomplete referrals from primary care, who will then have to re-refer the patients with all the required information, instead of leaving the referral open.

On 2nd November, the service had a meeting with GRHNHSFT, who are hoping to clear the backlog of Echos in the next 8 weeks, as part of their recovery plan. However, capacity planning for next year remains a work in progress. The Service is looking into their joint referral process to make it more streamline, and are developing a joint SOP. The Service is meeting with regard to the booking office process on 11th November, and is continuing to try and get access to request Echos via ICE. GRH are helping with this.

84. % of live births that receive a face-to-face New Birth Visit within 7- 14 days by a Health Visitor [Children and Young People Service]
In October, 39 out of 533 children are showing as not having received a new birth visit within 14 days of birth. Performance was 92.6% (September was 93.0%) compared to a threshold of 95%. Performance is within SPC chart upper and lower control limits.

Contributing factors
- Reasons for breaches include: 12 in NICU/hospital will be seen on discharge, 10 parental choice to be seen out of timeframe- all seen, 6 seen out of timeframe due to staff capacity, 4 no access visit within timeframe then seen out of timeframe, 2 Recording errors remain although amended and linked to appointment, both seen day 10, 2 declined HV contact, 1 moved into county, seen by 3 weeks, 1 child placed out of county in foster placement, 1 declined new birth visit in timeframe due to midwife visiting- seen day 15.
- Changes due to Simplicity impacting on recording errors- significantly reduced
- Bank staff being utilised for universal work, so can be out of timeframe where bank are only available on certain days
- 50% increase in the number of babies admitted to NICU from August- October
- Staffing capacity impacting on number of babies being seen out of timeframe.

Improvement Plan
- Within service, it has been identified that amendments need to be relinked to original appointment. This has reduced the number of remaining recording errors. There are 2 this month which remain and need to be explored with BI as contacts were in timeframe.
- Recruitment continues to be able to meet all service demands

86: Percentage of children who received a 9–12-month review by the time they turned 12 months. [Children and Young People Service]
In October, 114 out of 565 children are showing as not having received a 9-12 month review by the time they turned 12 months. Performance was 79.8% (September was 76.8%) compared to a threshold of 95%. Performance is within the SPC chart upper and lower control limits.

The national target for this KPI is 95%. Local Commissioners (Gloucestershire County Council) have agreed a target of 90% in quarters 3 and 4 for 2022/23.

The Health Visiting service have identified the cases where the patient was seen within timeframe but are showing as breaches due to recording errors as a result of the SystmOne Simplicity Project. When excluding these recording errors from the overall performance figure, the percentage seen within timeframe is represented in the operational delivery figure which is 80.0% for October. The service is continuing to review with the Clinical Systems and BI team why, once amended, these records continue to show as breaches.

Contributing factors
- Reasons for breaches include: 30 Appointment booked out of timeframe due to staffing capacity (booked by 13 months), 24 Delayed by parent (all completed by 13 months), 24 DNAx1, 12 movements in or out, 5 Recording errors- were amended but not linked to appointment, one to be queried with BI, 6 DNA x2 (3 had further contact and then declined, 3 having further contacts), 4 declined appointment, 2 cancelled by service, 2 child has developmental diagnosis, 1 delayed for prematurity
- Vacancies in the CNN line (both in permanent practitioners and COMF practitioners have impacted on the delivery of the appointments being within timeframe. Recruitment and movement of practitioners to areas of need continues.
- Capacity, cancellations and parental choice does not always allow for DNA x1s to be re-booked in within timeframe
- Parents do not have to engage with the health visiting service

Improvement Plan
- Month on month increase in ASQs achieved in timeframe
- Reduction in the number of recording errors since the service record keeping training
- Additional hours and bank work to be offered to CNNs to be able to support demand
- Reduction in the number of parents declining and DNA appointments
- Reviewed all KPIs with nursery nurses and administrators to remind them of timeframes of mandated contacts and that DNAs to be rebooked within the child being 12 months of age
- SMS sent to all parents/carers prior to appointment being sent to inform them that their child is due an appointment
- Reminders and demonstration to all practitioners to use S1 SMS to remind parents of appointment for ASQ
- Review wider Scope of ASQ tool and using with children with additional needs

87: Percentage of children who received a 12-month review by the time they turned 15 months. [Children and Young People Service]
In October, 96 out of 543 children are showing as not having received a 9-12 month review by the time they turned 15 months. Performance was 82.3% (September was 82.0%) compared to a threshold of 95%. Performance is within the SPC chart upper and lower control limits.

The national target for this KPI is 95%. Local Commissioners (Gloucestershire County Council) have agreed a target of 90% in quarters 3 and 4 for 2022/23.

Contributing factors
- Reasons for breaches include: 23 out of timeframe due to staffing capacity, all completed, 20 declined appointment, 17 DNAx1 all rebooked for 2nd appointments, 12 parental choice to be seen out of timeframe

- 10% (10/91) movements in and out, 6 DNA x2, all having further contacts, 2 delayed for prematurity, 2 cancelled by service initially, completed by 14 months, 2 appears correct and completed in timeframe - to discuss with BI, 1 child has medical diagnosis, no ASQ at this time, 1 missing child
- Vacancies in the CNN line (both in permanent practitioners and COMF practitioners have impacted on the delivery of the appointments being within timeframe. Recruitment and movement of practitioners to areas of need continues.
- Capacity, cancellations and parental choice does not always allow for DNA x1s to be re-booked in within timeframe
- Parents do not have to engage with the health visiting service

Improvement Plan
- Reduction in the number of recording errors since the service record keeping training
- Additional hours and bank work to be offered to CNNs to be able to support demand
- SMS sent to all parents/carers prior to appointment being sent to inform them that their child is due an appointment
- Reminders and demonstration to all practitioners to use S1 SMS to remind parents of appointment for ASQ
- Review wider Scope of ASQ tool and using with children with additional needs

Commentary continues on next page...

88. % of children who received a 2-2.5 year review by 2.5 years [Children and Young People Service]
In October Performance was 85.2% (September was 80.6%) compared to a threshold of 95%. 71 out of 480 children are showing as not having received a 2-2.5 year review by 2.5 years. Performance is within SPC chart upper and lower control limits.

The national target for this KPI is 95%. Local Commissioners (Gloucestershire County Council) have agreed a target of 90% in quarters 3 and 4 for 2022/23.

Contributing factors
• Reasons for breaches include: 24 Movements out, 16 DNA x2 (12 then declined, 4 having further contact), 12 declined appointment, 9 Recording errors remain in data, (4 have been re-corrected, 5 need further review with BI to identify reason. All families have been seen for contact.), 7 DNAx1, 2 parental choice to be seen out of timeframe, 1 Specialist level of offer- child has ASQ at age 22 months and 31 months
• Increase in the number of children that have moved out of the county that are impacting on the data
• Capacity and parental choice does not always allow for DNA x1s to be booked in within timeframe
• Parents do not have to engage with the health visiting service
• Vacancies in the CNN line (both in permanent practitioners and COMF practitioners have impacted on the delivery of the appointments being within timeframe. Recruitment and movement of practitioners to areas of need continues.

Improvement Plan
• Reduction in the number of parents that are declining the appointment
• Reduction in the number of DNAx2
• Additional hours and bank work to be offered to CNNs to be able to support demand

91: Percentage of infants being totally or partially breastfed at 6-8wks (breastfeeding prevalence) [Children and Young People Service]
In October 224 out of 491 children are showing as not being breastfed at their 6-8 week review. Performance was 54.3% (September was 54.4%) compared to a threshold of 58%. Performance is within SPC chart upper and lower control limits.

Contributing Factors
• 8 babies –movements out/in of the area are counted within the data
• 1 who declined the HV Service but notes left open to open to future offers
• 4 unable to be contacted despite best efforts of the HV
• 1 baby re-admitted to hospital.
• 1 baby in NICU.
• 12 out of time frame due to staff capacity-now all completed. These issues were addressed at Staff Mandatory Record Keeping Training again on 3rd Oct and will be included in reviewing the Slow Weight Gain Policy, plus has been added to the New Birth Benchmarks/SOP to book the 6 week review at the New Birth Visit to reduce them being missed at later re-allocations due to staff/bank staff/staff illness.
• 3 families requested to be seen late/out of time-frame.
• The breastfeeding figures are recognised to be negatively countered by breastfeeding difficulties that start with initiation in Midwifery and affect the stats at 2 weeks when families are received into the service and subsequently the stats at 6-8 weeks.
• The Midwifery Service continue to be severely short staffed which is extensively impacting on the specialist feeding service in midwifery, tongue tie service in midwifery and Midwifery training updates have been stopped; the Infant Feeding Team Staff have handed in their notice/left so new recruitment is required for the posts.
• The Breastfeeding figures are above target again this month for Health Visiting percentage of mothers still breastfeeding at 6 weeks that were at 2 weeks.
• Staff not only leaving the Trust, despite New Starters joining, there is known to be recruitment and retention issues across the UK for Health Visiting, so is affecting staffing capacity. Staff/Infant Feeding Keyworkers who have joined other projects in the Trust have informed the Infant Feeding Lead they can offer less time to supporting breastfeeding mums, or that they feel overloaded with Health Visiting Work and are generally stressed.

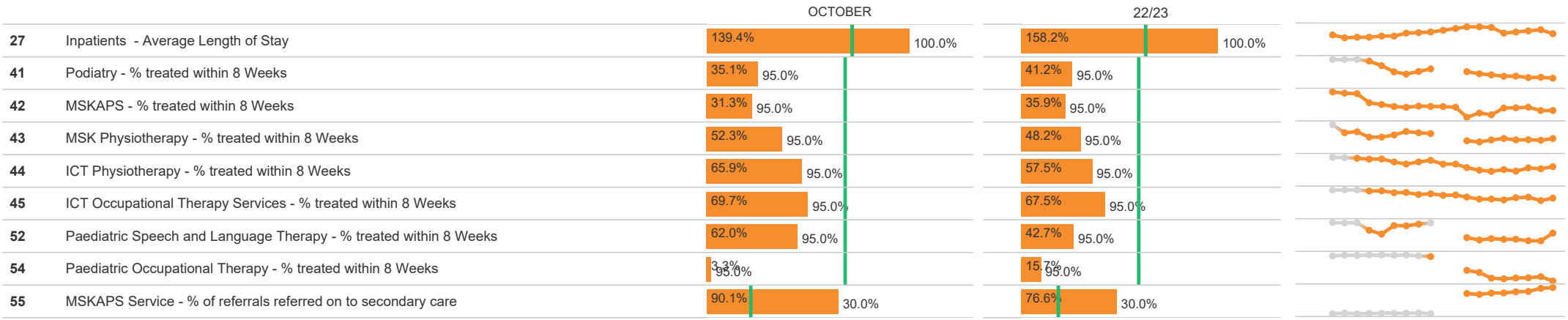
Improvement Plan
• Flexibility to provide new starter training, prior to their full training
• New Infant Feeding Keyworkers have expressed an interest to support breastfeeding mums, replaced those that stepped down to do other projects such as Steps Ahead.
• Infant Feeding Keyworker Event Day was held 17th October, focusing on the role and future plans
• Regular meetings commenced are continuing between Infant Feeding Lead Midwife, Infant Feeding Lead Health Visitor and Local Breastfeeding Support Groups to focus on slow weight gain
• Infant Feeding Lead Health Visitor organised/chaired the first National Infant Feeding Network Sub-Group focusing on strategy plans regarding slow weight gain theme across the UK since the Pandemic and next meetings planned on-going.
• Work has commenced scoping an Infant Feeding strategic plan as part of the re-commenced Gloucestershire Infant Feeding Strategic Partnership Board Meetings (GIFSP). First initial planning meeting Sept 2022 and whole members meeting held in Oct 2022.

Performance Dashboard: *Physical Health - Local Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - Local Requirements



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

27: Inpatients Average Length of Stay [Hospitals]
The average length of stay for inpatients in Community Hospitals was 53 days in October (46 days in September) compared to a threshold of 38 days. Performance is above the SPC chart upper control limit. The figure includes Community Assessment and Treatment Unit (CATU) patients as it is not currently possible to exclude patients who are no longer considered CATU but remain in a Tewkesbury bed.

10.5% (11/105) of all discharges in October had a length of stay of 100 days or more. Excluding these patients, the average length of stay reduces to 43 days. This KPI has been exceeding the upper SPC control limits since October 2021.

All wards and sites report reduced discharge ability throughout October, impacted by low Home First starts, minimal domiciliary care access and a number of people being in CATU who were re-categorised as community hospital patients early into their stay, utilising beds for extended periods. A system risk is being articulated to reflect the impact of reduced discharges on stroke patients' rehabilitation and recovery as well as mental wellbeing. Work continues at all sites to enable early discharge, but many of these earlier offers are reliant upon community support which is not being sourced currently.

41. Podiatry - % treated within 8 Weeks [Adult Community Services]
October compliance was 35.1% (September was 38.1%) compared to a target of 95%. 452 out of 697 patients seen in October, were seen outside the 8-week target timeframe of referral to first contact. Performance is below SPC chart lower control limits.

The Podiatry service continues to fail to meet its 8-week Referral to treatment (RTT) performance following recommencement of data in March 22. The service is still recovering from the impact of redeployment earlier this year, where waiting lists grew as clinical colleagues were deployed to other services.

The waiting list is currently 2215 (07.11.22 - PTL) and it has been increasingly difficult to catch-up with this backlog due to the service carrying significant vacancy – current rate of 15.25%. Recruitment and retention continue to impact recovery. 1.0 B6 started in post this month. 1.0 B7 has been offered a role (predicted start Feb 22) but there was not suitable candidate for another B7 role interviewed in October. Unfortunately, 0.8 B6 leaves this month with a further 1.0 B6 and 1.0 B7 leaving in December.

The service continues to advertise vacancy and is working to increase capacity within the existing workforce. Recovery is expected to be delayed due to the additional vacancies impacting in December.

A Service Improvement plan is in place.

42. MSKAPS - % treated within 8 Weeks [Adult Community Services]
October performance was 31.3% (September was 31.1%) compared to a threshold of 95%. 294 out of 428 patients seen in October were seen outside the 8-week target timeframe of referral to first

contact. This is below SPC chart lower control limit.

Although the performance has remained the same, the number seen for first treatment contacts from April to October has increased, and the waiting list has remained stable during that period.
It has been another challenging month with covid sickness and bereavement leave. The impact of the Additional bank holiday in September resulted in 43 New appointments requiring rebooking, despite these patients being accommodated into alternative dates in the ledgers this has had an impact on waiting times.

Taking the absence into consideration, contacts remain high demonstrating a real achievement and commitment to the service improvement plan and positive onward trajectory.

The new Development role will commence mid-November and the new APS post holder starts December 19th. This increase to the establishment should positively impact the performance in the new year.

A Service Improvement plan is in place for the service.

43. MSK Physiotherapy - % treated within 8 Weeks [Adult Community Services]
October performance was 52.3% (September was 46.6%) compared to a threshold of 95%. 605 out of 1,271 patients seen in October were seen outside the 8-week target timeframe of referral to first contact. This is below SPC chart lower control limit.

The performance remains stable at present but there is an increasing demand, with referrals into the service remaining consistently high, at 1922 in October, compared to a monthly average of 1783 for FY 2021-22.

Impact of the additional bank holiday resulted in 100 New Patient Appointments needing to be re allocated which has meant an increase in waits.

The service is continuing to work through a Service Improvement Plan, which includes data cleansing and recruitment. There is a known national workforce issue, and consequently, it is challenging to recruit to vacant posts. Other options are being considered.

A Service Improvement Plan is in place.

44. ICT Physiotherapy - % treated within 8 Weeks [Adult Community Services]
October performance was 65.9% (September was 59.0%) compared to a threshold of 95%. 98 out of 288 patients seen in October were seen outside the 8-week target of timeframe of referral to first contact. This is below the SPC chart lower control limit.

The service went live on 28th June with changes to recording treatment contacts in line with the SystmOne Simplicity project. Business Intelligence and the Clinical Systems teams will continue to work with the service to ensure data is captured correctly in line with these changes and validated to ensure accurate reporting. As a result of the changes the service is currently unable to view the first contact activity by therapists that takes place within the MDT referral centres. This is an important part of the true picture of the patient experience in regard to this KPI. BI and clinical systems teams continue to work on this.

Waiting lists remain high, reflecting not only demand but also the pressure of recruitment challenges and the focus on supporting the Home First Reablement pathway, an area of activity not yet full recording on SystmOne. This is about to change with the move to SystmOne of the GCC (Gloucestershire County Council) employed colleagues working in Home First and Reablement.

Business Intelligence continues to work with the service to ensure data is captured correctly in line with agreed SystmOne Simplicity process, and to restore the provision of data analytics to pre simplification levels.

The service continues to implement improvement to SOPs for clinical contact recording. It is anticipated this should lead to a performance improvement from December.

This indicator has a service DIP (Development Improvement Plan) in place and is on the Performance Governance Tracker.

Commentary continues on next page...

45. ICT Occupational Therapy Services - % treated within 8 Weeks [Adult Community Services]
October performance was 69.7% (September was 61.6%) compared to a threshold of 95%. 192 out of 634 patients in October were seen outside the 8-week target timeframe of referral to first contact. This is below the SPC chart lower control limit.

The service went live on 28th June with changes to recording treatment contacts in line with the SystmOne Simplicity project. Business Intelligence and the Clinical Systems teams will continue to work with the service to ensure data is captured correctly in line with these changes and validated to ensure accurate reporting. As a result of the changes the service is currently unable to view the first contact activity by therapists that takes place within the MDT referral centres. This is an important part of the true picture of the patient experience in regard to this KPI. BI and clinical systems teams continue to work on this.

Waiting lists remain high, reflecting not only demand but also the pressure of recruitment challenges and the focus on supporting the Home First Reablement pathway, an area of activity not yet full recording on SystmOne. This is about to change with the move to SystmOne of the GCC (Gloucestershire County Council) employed colleagues working in Home First and Reablement.

Business Intelligence continues to work with the service to ensure data is captured correctly in line with agreed SystmOne Simplicity process, and to restore the provision of data analytics to pre simplification levels. The service continues to implement improvement to SOPs for clinical contact recording. It is anticipated this should lead to a performance improvement from December. This service has a Service Improvement Plan in place and is on the Performance Governance Tracker.

52. Paediatric Speech & Language Therapy - % treated within 8 weeks
October performance was 62.0% (September was 36.3%) compared to a threshold of 95%. 85 out of 224 patients in September were seen outside the 8-week target timeframe of referral to first contact. This is below SPC chart lower control limit.

Contributing factors: The service continues with vacancies in key clinical roles. October vacancy rate was 12%. New staff recruited in July have not yet been able to start in post due to delays in recruitment process and lengthy notice periods. New starters and returners from maternity leave at the end of September have not been able to start clinical work quickly because of a lack of IT equipment.

Estates access and availability remains a challenge with a loss of non-NHS estates and an increase in therapists needing access to clinic space for resumption of face-to-face activity following the pandemic. In order to resume group interventions to reduce the waiting times, estates are needed that can support this. Digital poverty in parts of the county means some families do not have the choice of a virtual appointment being offered sooner. There are additional challenges in predicting and resourcing rural and isolated clinics.

SystmOne Simplicity work continues to be challenging as cleansing activities and quality checks further reduces capacity of the clinicians – though there is now a static plan which has improved the position. The service Patient Tracking List (PTL) is receiving weekly cleansing to reach an acceptable state and until this occurs breaches may continue to appear incorrectly. Work is ongoing to review exceptions, processes, amending incorrect data and recording exception narratives.

Risk: Risk 178: CYPS Speech and Language Service Capacity. Score 9

Impact: There were 85 exceptions identified in October 2022, though not meeting KPI target, this is marked improvement for the service and highlights the increased accuracy of data now additional time is invested in it.

The majority of exceptions (77) were seen within 18 weeks which is in line with National Guidance (nineteen of these were seen between 13 and 18 weeks). Eight were seen over 18 weeks from referral. Currently 356 children are waiting for episodes of care in community clinics following initial appointment with waiting times of approximately 9 months. The wait time remains static though it is promising that the number of children waiting has begun to reduce.

A ‘Clinical Risk’ matrix continues to be used to prioritise referrals and to monitor changing needs alongside a general policy of allocating children who have waited the longest.

Improvement Plan:
- This is a ‘red’ RAG rated service for recovery. The service has a Recovery and Improvement Plan in place, which was last reviewed and updated end of Q2 2022.
- 1.0 Band 5 WTE recruited started September 22 and one 0.6 B5 returned following maternity leave.
- 1.0 WTE Band 6 recruited – due to start October – delayed to November due to slow recruitment process.
- 0.2 additional time to band 4 for PTL work and 0.4 additional band 4 clinical time agreed to start Jan 23.
- The service continues to offer additional hours as an interim support measure
- Changes to introduce stammering triage calls and adapting the mainstream advice line.
- Implementing changes to screening procedures based on clinical expertise to reduce risk of screening errors.
- Recently new estates were secured for the Cheltenham locality. Work is underway to make these spaces operational. Further estates are still required alongside plans for optimal usage and there is ongoing work between the CYPS Directorate and Estates Team to find solutions. Offerings for part days do not always suit clinical delivery and days worked.

54. Paediatric Occupational Therapy - % treated within 8 weeks
October performance was 3.3% (September was 19.5%) compared to a threshold of 95%. 86 out of 89 patients seen in October were seen outside the 8-week target timeframe of referral to first contact. This is below SPC chart lower control limit.

Contributing factors: This service remains significantly challenged by a number of issues and the impact of these issues are more severe than initially realised.

Workforce Position:
- This team continues to work severely under-established and does not have capacity to manage current demands. Current service vacancy rate is 25.7% . This includes a vacancy for Head of Service.
(22.48wte funded establishment with 16.71wte contracted and in post).
- Recruitment in the last few months has been much more successful, but external candidates remain in the on-boarding pipeline and therefore there have not yet improved the capacity, resilience, or stability of the workforce position.
- During the pandemic the team's technicians were redeployed to support critical services creating significant waits for equipment reviews where activity was paused. This is still being addressed and has not yet been recovered.
- The team sickness absence has been higher than the Trust threshold for the past 12 months. In October it was the lowest it had been for more than 1 year, at 4.6%, a reduction from 8.6% in September.

Demand:
- SEND: Across all children's therapy services the numbers of new ECHP requests and Tribunal process health based reports have increased significantly with no matching of growth investment. A risk has been added to the trust risk register to reflect the demands impacting on core delivery and further increasing wait times for community core services for all the therapy services (risk reference 243 - score 12).

- System Changes: Changes in other areas of the health system has resulted in a higher number of referrals into CYPS OT around behaviour, parenting advice and mental health. The high level of health anxiety in the general population has also resulted in an increased need for universal support and resources. Changes in demand have led to a bottle neck of referrals at the service front door. To manage demand and mitigate risk, urgent cases and referrals continue to be prioritised. This is creating long (and increasing) waits at the front door for lower-level needs and for routine follow up care.

- Contracts: Generic caseloads and system flow, compounded by competing priorities from the service's multiple specifications and SLAs, has disenabled robust prioritisation across the different clinical pathways and resulted in complex and inefficient internal processes.

Data Quality Confidence: Due to the ongoing challenges faced by this service, it continues to be difficult to progress with SystmOne simplicity work streams as cleansing activities and quality checks further reduces capacity of the clinicians. The service Patient Tracking List (PTL) still needs to be reviewed and cleansed to an acceptable state. Until this occurs historic breaches will continue to appear incorrectly. Due to this the service is currently unable to make intelligence-led decisions or have confidence that its performance data reflects operational reality.

Impact:
Waiting Times:
- The PTL suggests there are 821 referrals waiting for treatment with 385 new referrals waiting to be screened.
- In October 86 children and young people were seen outside of the locally agreed 8 week RTT target.
- The administrative team are receiving an increasing number of calls and contacts regarding wait times for the service.
- There is continued high stress throughout the workforce. Substantial support is required to manage this and support staff needs currently.

Safety:
- There are continued issues around community equipment ordering and delivery, which is further impacting on clinical time. This is also on the Trust risk register with oversight from the Head of Patient Safety.
- There is current review regarding the level of risk within the service due to the number of holding lists, waiting lists and worklists being managed. Caseloads needs to be thoroughly reviewed across the entire service to ensure that any risk is identified and managed appropriately. Pathways and processes within the service then need reviewing to ensure efficiency and safety in future practice.

Improvement Plan:
- An urgent quality review of the service is required to fully understand the service position and risks. The Deputy Service Directors, Operational Governance Lead and Team Lead are initiating this work. The review is supported by the Service Director CYPS, Senior Operational and NTQ Leads. A comprehensive position paper will then be shared with the Executive Team.
- A remedial action plan will be developed following the quality review with regular update and oversight in both quality and operational forums.
- A health and welfare package will be put in place to support the team.
- Front door processes have been established and are being implemented with immediate effect to manage demand and address screening backlog.
- Referral criteria agreed to manage demand alongside B7 daily screening rota and agreed criteria for universal, targeted and specialist offers
- Risk matrix developed to support clinical prioritisation
- Created a B7 Team Lead post to jointly manage the service with the DSD in the absence of a Head/ Manager. The Team Lead came into post in September 2022.
- Recruitment of 3wte Band 5s and 1wte Band 6 (on-boarding), completed 1.2wte Band 7 (internal), RTW of 1wte B7 increasing capacity in B7 line, 3wte Band 6 roles out to advert, Staff Bank – B4s targeting equipment review list, Head of Service interview 14th November 22

- Weekly Band 7 Leadership meetings and fortnightly whole team meetings
- Augmenting service delivery using Staff Bank
- Band specific competencies being developed with support from OT HoP. Band 4 competencies completed. Band 7 in development currently.
- Regular data quality reports are now being shared
- Staff training on new S1 recording methodologies completed with regular updates and demonstrations in staff meetings.
- Setting up caseload trackers for all staff to support safe caseload management
- for essential to role training
- Career development framework in development

55. MSKAPS Service - % of referrals referred on to secondary care
October performance was 90.1% (September was 87.4%) compared to a threshold of 30%. This is above SPC chart upper control limit.

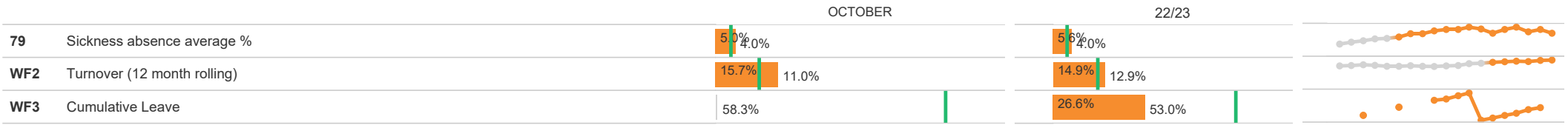
The current KPI methodology is picking up additional read codes for ‘referred to’ secondary care groups than previously. It is anticipated that the issue has increased the numerator figure. The methodology for the KPI and the criteria for which secondary care services to count, are under review with Business Intelligence team and the MSKAPS service lead to validate the position.

Performance Dashboard: *Trust Wide Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Trust Wide Requirements



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

79: Sickness absence average % rolling rate - 12 months
Sickness absence rate in October 2022 was 5.0%. The figure indicates in-month sickness absence, excluding Bank Staff. Threshold is 4%.

October 2022 performance of 5.0% does not include data from the e-rostering system (Allocate) because it is not available at the time of reporting. September performance including this was at 5.8% which was above the SPC upper control limit. Data (incorporating Allocate) from September 2022 compared with August 2022 suggests:

Operations Directorate sickness absence was 6.3% in September.
Sickness absence in September increased for all sub-directorates within Operations with the exception of CYPS where sickness absence decreased (4.5% to 4.0%).
The sub-directorates where sickness absence increased are Adult Community MH & LD (6.7% to 6.8%), Adult Community Services PH (6.4% to 6.9%). Hospitals (6.1% to 7.2%), Urgent Care & Speciality Services (5.0% to 6.0%)
Operational Management sub-directorate sits below the sickness absence threshold (3.4%)

Nursing, Therapy & Quality Directorate sickness absence was 4.5% in September.
Within the Quality Assurance sub-directorate, sickness absence has remained at 9.3% from July to September. It should be noted that this is a small sub directorate with a headcount of less than 10.
Governance & compliance sub-directorate sickness absence also increased to 5.1% in September (3.5% in August).

Finance Directorate sickness absence was 5.9% in September.
Estates and Facilities sub-directorate sickness absence increased from 5.6% in August to 7.7% in September. Estates & Facilities has the highest sickness absence rate within the Finance directorate during this period.

Finance sub-directorate sickness absence also increased to 4.6% in September (3.6% in August).
This reflects the sickness absence information on Tableau on 07/11/2022.

WF2. Turnover (12 month rolling) [Workforce]
Turnover (LTR) was 15.75% in October (for the 12 months 1 November 2021 – 31 October 2022) against a 11% threshold. There are 192 teams out of the 463 (41%) across the Trust which have had a turnover level over 14% over the last 12 months.

Lydney Hospital facilities team had the highest turnover average of 66% followed by MHICT- IAPT Cotswold & Vale at 59%, Cirencester Hospital – OPD at 41% and ICT TWNS DN at 39%.

At a staff group level, Estates and Ancillary was highest at 20% with Additional clinical service Administrative *and* Clerical groups at 17% and 16% respectively. Some teams have low workforce numbers or are actively restructuring so these teams may expect a higher turnover. Breaking the data down by age groups, there appears to be higher turnover for younger and older staff. Under 20s have the highest Turnover at 38% followed by those in the 21-25 age band at 30%.

WF3. Cumulative Leave [Workforce]
At the end of October, percentage of annual leave taken across the Trust was 53% compared to the a cumulative threshold of 58.3%. Contracts and Planning team have the lowest percentage leave taken at 37% followed by Medical at 39%, Adult community PH Mgmt. & Admin at 47% and Urgent Care & Specialist services MH at 49%.

Note: This figure was received post publication of the performance dashboard snapshot hence why current performance isn't shown within the bullet chart above. This will be updated next month.

o Urgent Care Response – Referral to Treatment

Although not currently a contractual KPI; the crisis response within 2hours performance position is presented below. The indicator is compliant against a National expectation of 70% (from Dec 2022) and data has been validated for 2022/23. This indicator will be introduced formally into the dashboard as a Nationally monitored indicator next year. The expected 2day response indicator is also in place and is being monitored ahead of anticipated National reporting for 2023/24. Performance is very strong against these metrics.

Last updated: 26/10/2022 08:40:34

2 Hr Response - Crisis response intermediate care within 2 hours

	202122					202223						
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Within 2hrs	27	19	38	46	153	163	151	140	186	220	200	184
Above 2hrs	16	10	16	17	59	76	46	48	68	59	39	43
Total RTT records (2hr response)	43	29	54	63	212	239	197	188	254	279	239	227
% compliance 2 hour response	62.8%	65.5%	70.4%	73.0%	72.2%	68.2%	76.6%	74.5%	73.2%	78.9%	83.7%	81.1%

2 Day Response - Crisis response intermediate care

	202122					202223						
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Within 2 days	4	36	31	35	50	64	43	46	13	10	2	2
Above 2 days	0	0	0	0	0	0	0	0	0	0	0	0
Total RTT records (2 day response)	4	36	31	35	50	64	43	46	13	10	2	2
% compliance 2 day response	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

o 85. % of children who received a 6-9week review

Postiively, the service have achieved 95% threshold for first time since SystmOne Simplicity changes to recording were introduced. Recording is now more reflective of operational performance however there are still a few anomalies to be addressed.

o 40. Adult Speech and Language Therapy - % treated within 8 Weeks [Adult Community Services]

October performance was 93.6% (September was 86.0%) compared to a target of 95%. 16 out of 250 patients seen in October were outside the 8-week target timeframe of referral to treatment. Performance is within SPC chart control limits. This positive progress in performance is representative of the positive incremental performance the service has made over the year.

o 1.07: New Psychosis (EI) cases treated within 2 weeks of referral [Community MH Services]

Although not escalated due to known data recording issues, September performance (was at 50%) has been corrected and is now reported as compliant at 75%.

o WF5. Vacancy [Workforce]

Overall vacancy rate across the Trust was 12.15% in October, compared to a newly agreed threshold of 20%. This is a slight change from September. This threshold was increased from the nominal 8% having reviewed the current performance and compared to National Benchmarking 2020/21.

Ashley Intermediate Care Unit has a vacancy percentage rate of 80.39% (4.1WTE), AO Medical 77.86% (4.22WTE), Sexual Health Pregnancy Advice Service 64.42% (5.07WTE), MH Contact Centre 62.49% (13.46WTE), Wotton Lawn- Peripatetic Team 53.85% (3.5WTE), CAMHS MH Outreach 48.12% (7.05WTE), Children Complex Care 45.2% (7.07WTE) and Fac-Rikenel 45.18% (2.81WTE).

Looking at occupational groups, Psychiatry (MH Nurses) have the highest vacancy rate of 17.5% (90.83 WTE), Occupational Therapists at 15.3% (30.35 WTE), Chiropody/Podiatry at 15.4% (6.51 WTE), Speech & Language Therapy at 16.9% (11.79 WTE) and Community Nursing at 13.9% (128.67 WTE).

o Eating Disorder Data Submission developments

NHS Digital is looking for all Trusts to migrate CYPS Eating Disorder performance data *('Waiting times for incomplete pathways for an Eating Disorder' and 'Waiting times for patients started treatment for an Eating Disorder')* from the Strategic Data Collection Service (SDCS) into the Mental Health Services DataSet (MHSDS) in February 2023. Currently, data is submitted into both. Before this is possible these data submissions need to align and the Trust is currently engaging with NHS Digital to understand and resolve any issues to support this development.

o Urgent & Emergency Care - Ambulance

As an urgent action from NHS England; Trusts are now asked to formally report Ambulance handovers and response times as a system performance measure at Board meetings. Please see the below for Gloucestershire ICS in October 2022.

For ambulances this should be Cat 1 against 7 minutes standard and Cat 2 against 18 minute standard.
For handovers, the interim contractual position for 2022/23 is 65% within 15 minutes, 95% within 30 minutes and none more than an hour.

Indicator	Metric	Good is	National Target	Local Target	Latest Performance	Trend	Latest Reporting Period	Latest Benchmarking			Reporting Period	Quartile (Q1 = High, Q4 = Low)
									better than	worse than		
S020a	Average Ambulance Response Times (Category 1)	Low	7 minutes		00:11:04 Gloucester ICS		October 2022	00:11:06 Gloucester ICS	00:11:10 SWASFT	00:09:19 England	Sept 2022	
S020b	Average Ambulance Response Times (Category 2)	Low	18 minutes		00:44:12 Gloucester ICS		October 2022	00:48:11 Gloucester ICS	01:08:53 SWASFT	00:47:59 England	Sept 2022	
S020c	Average Ambulance Response Times (Category 3)	Low	120 minutes		02:09:44 Gloucester ICS		October 2022	02:29:37 Gloucester ICS	02:50:19 SWASFT	02:42:28 England	Sept 2022	
S020d	Average Ambulance Response Times (Category 4)	Low	180 minutes		02:55:08 Gloucester ICS		October 2022	02:01:04 Gloucester ICS	03:22:56 SWASFT	03:12:34 England	Sept 2022	
	Ambulance Conveyance Rates (% incidents conveyed)	Low			41.57 Gloucester ICS		October 2022	40.75 Gloucester ICS	49.38 Other South West ICS	56.95 England	Sept 2022	

o Physical Health Services Waiting Time Profiles

Business Intelligence have developed Maximum, Median and Mean (Average) waiting time reports to present service patients waiting (in weeks) for a first clinical contact within Physical Health services. It must be acknowledged that this is a generic tool that doesn't allow for the nuances of specific clinical pathways and therefore may not offer great value to all services. However, alongside the existing Patient Tracking List (PTL), this is designed as a proactive tool to raise awareness to patient waits *presented* within the clinical system so that further validation can be undertaken. Furthermore, improvements to data quality capture and service experience can then be made. This will be discussed within BIMG in November and taken to services to further validate and examine outlier cases which will likely be data quality issues.

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AGENDA ITEM: 10/1122

REPORT TO: **TRUST BOARD PUBLIC SESSION – 24 November 2022**

PRESENTED BY: Sandra Betney, Director of Finance

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 31st October 2022**

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

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

The purpose of this report is to

Provide an update of the financial position of the Trust.

Recommendations and decisions required

The Board to:

- **note** the month 7 position
- **Approve** the revised capital programme

Executive summary

- A revised system plan submitted on 20th June showed a break-even position for both the system and the Trust
- The Trust's position at month 7 is a surplus of £1.103m
- The Trust is forecasting a year end position of break even
- The cash balance at month 7 is £54.8m
- Capital expenditure is £6.742m at month 7
- The Trust has spent £0.779m on covid related revenue costs for Apr-Oct
- Additional agency and bank spend analysis will be included in next month Resources Committee paper
- The Board are asked to note the changes to the capital programme.
- The LD Assessment Centre has moved from 23/24 to 24/25. The estimated value of £2m is unchanged whilst the system revises its commissioning priorities
- Future years of the programme have also been amended to reflect rephasing and the inclusion of some additional IFRS16 leases

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?
Monthly reports to Resources Committee and Trust Board

Appendices:	Finance Report

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

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Finance Report
Month 7

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

Overview

- The Trust submitted a revised breakeven plan on 20th June
- At month 7 the Trust has a surplus of £1.103m, and a forecast of break even in line with the revised plan
- Although the Trust anticipates the likely year end surplus will be £1.9m it has not formally adjusted it
- The Trust has recorded Covid related expenditure of £0.779m up to October
- 22/23 Capital plan is £17.665m and spend to month 7 is £6.742m against the plan of £3.859m
- Cash at the end of month 7 is £54.759m
- Cost improvement programme has delivered £4.812m of recurring savings against the target of £5.612m, an increase of £106k on last month
- Non Recurrent target is £1.15m and all of this has now been delivered
- In addition to Trust savings we have made a £160k system saving on covid
- The Trust spent £5.42m on agency staff to month 7, and against a 30% reduction on last year this would leave the Trust £2.259m over year to date. The run rate for agency spend is £774k per month this year compared to £672k last year.
- The Trust spent £7.683m on bank staff to month 7, and had an £14.3m under spend on substantive posts
- Better Payment Policy shows 95.2% of invoices by value paid within 30 days, the national target is 95%
- The 7 day performance at the end of October was 86.7% of invoices paid
- The Board are asked to approve the updated 5 year capital programme

GHC Income and Expenditure

Gloucestershire Health and Care
NHS Foundation Trust

Statement of comprehensive income £000	2022/23 Plan	2022/23 YTD budget	2022/23 YTD Actuals	2022/23 Variance	2022/23 Full Year Forecast	2023/24 Forecast £000s	2024/25 Forecast £000s	2025/26 Forecast £000s	2026/27 Forecast £000s
Operating income from patient care activities	245,075	144,029	142,860	(1,169)	247,401	242,133	245,777	249,484	253,253
Other operating income **	6,733	8,628	10,824	2,197	18,151	13,746	13,835	13,916	13,962
Employee expenses	(189,346)	(116,611)	(113,781)	2,830	(198,246)	(190,110)	(192,772)	(195,469)	(198,239)
Operating expenses excluding employee expenses	(59,767)	(34,474)	(37,390)	(2,916)	(64,842)	(63,464)	(64,428)	(65,422)	(66,407)
PDC dividends payable/refundable	(2,590)	(1,511)	(1,750)	(239)	(3,000)	(2,690)	(2,790)	(2,890)	(2,990)
Finance Income	0	0	385	385	600	600	600	600	600
Finance expenses	(261)	(152)	(101)	51	(189)	(180)	(180)	(180)	(180)
Surplus/(deficit) before impairments & transfers	**(156)**	**(91)**	**1,047**	**1,138**	**(125)**	**35**	**42**	**39**	**0**
Remove capital donations/grants I&E impact	156	91	56	(35)	125	150	145	140	140
Surplus/(deficit)	**0**	**(0)**	**1,103**	**1,103**	**0**	**185**	**187**	**179**	**140**
Adjust (gains)/losses on transfers by absorption/impairments	0	0	**0**	0	0				
Revised Surplus/(deficit)	**0**	**(0)**	**1,103**	**1,103**	**0**	**185**	**187**	**179**	**140**

- Future years forecasts based on recurrent with inflation, savings assumptions applied. Non recurrent income and costs are excluded.
- 2023/24 forecast based on target position and assumes delivery of £1m savings deferred from 22/23

Agency Analysis

Gloucestershire Health and Care
NHS Foundation Trust

Pay Analysis	Spend Oct 2021	Spend Oct 2022	Year to date 22/23	Year to date run rate 22/23
	£000's	£000's	£000's	£000's
Substantive Staff **under spend variance**	428	4,082	14,344	2,049
Bank spend	-563	-1,312	-7,683	-1,098
Agency spend	-618	-852	-5,420	-774
TOTAL	**-753**	**1,918**	**1,241**	**177**

GHC Balance Sheet

Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		2021/22	2022/23				2022/23	2023/24	2024/25	2025/26	2026/27
		Actual	Revised Plan	YTD Plan	YTD Actual	Variance	Full Year Forecast	Forecast £000s	Forecast £000s	Forecast £000s	Forecast £000s
Non-current assets	Intangible assets	958	958	958	924	(34)	814	814	814	814	814
	Property, plant and equipment: other	123,127	132,826	121,768	124,960	3,192	133,566	143,113	141,789	139,112	138,185
	Right of use assets*	0	25,742	18,548	17,445	(1,103)	23,406	21,184	18,962	16,740	14,518
	Receivables	542	518	528	522	(6)	304	280	256	232	208
	Total non-current assets	**124,626**	**160,044**	**141,802**	**143,851**	**2,049**	**158,089**	**165,390**	**161,820**	**156,897**	**153,724**
Current assets	Inventories	494	194	344	494	150	494	494	494	494	494
	NHS receivables	4,311	4,111	4,211	7,710	3,499	4,210	4,160	4,110	4,080	4,050
	Non-NHS receivables	6,561	6,561	6,561	3,169	(3,392)	6,369	5,869	5,769	5,719	5,669
	Cash and cash equivalents:	58,896	42,539	52,105	54,759	2,654	47,843	40,336	44,108	49,160	52,428
	Property held for sale	0	0	0		0	0	0	0	0	0
	Total current assets	**70,262**	**53,405**	**63,221**	**66,132**	**2,911**	**58,917**	**50,860**	**54,482**	**59,454**	**62,642**
Current liabilities	Trade and other payables: capital	(7,482)	(7,483)	(4,483)	(2,361)	2,122	(7,361)	(7,361)	(7,361)	(7,361)	(7,361)
	Trade and other payables: non-capital	(28,768)	(25,848)	(28,065)	(28,561)	(496)	(28,286)	(28,286)	(28,286)	(28,286)	(28,286)
	Borrowings*	(109)	(1,986)	(1,986)	(1,662)	324	(1,662)	(1,662)	(1,662)	(1,662)	(1,662)
	Provisions	(4,246)	(2,646)	(3,196)	(4,179)	(983)	(4,179)	(3,679)	(3,679)	(3,679)	(3,679)
	Other liabilities: deferred income including contract liabilities	(2,409)	(909)	(1,619)	(5,738)	(4,119)	(2,608)	(2,608)	(2,608)	(2,608)	(2,608)
	Total current liabilities	**(43,014)**	**(38,872)**	**(39,349)**	**(42,500)**	**(3,151)**	**(44,095)**	**(43,595)**	**(43,595)**	**(43,595)**	**(43,595)**
Non-current liabilities	Borrowings	(1,254)	(22,639)	(14,735)	(15,057)	(322)	(21,608)	(21,467)	(21,332)	(21,202)	(21,077)
	Provisions	(2,548)	(2,548)	(2,548)	(2,548)	(0)	(2,548)	(2,548)	(2,548)	(2,548)	(2,548)
	Total net assets employed	**148,072**	**149,390**	**148,391**	**149,878**	**1,487**	**148,755**	**148,640**	**148,827**	**149,006**	**149,146**
Taxpayers Equity	Public dividend capital	128,280	129,502	128,280	128,280	(0)	128,629	128,329	128,329	128,329	128,329
	Revaluation reserve	11,188	11,188	11,188	11,188	(0)	11,188	11,188	11,188	11,188	11,188
	Other reserves	(1,241)	(1,241)	(1,241)	(1,241)	0	(1,241)	(1,241)	(1,241)	(1,241)	(1,241)
	Income and expenditure reserve*	9,845	9,941	10,164	11,651	1,487	10,179	10,364	10,551	10,730	10,870
	Total taxpayers' and others' equity	**148,072**	**149,390**	**148,391**	**149,878**	**1,487**	**148,755**	**148,640**	**148,827**	**149,006**	**149,146**

Cash Flow Summary

Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	YEAR END 21/22		YTD ACTUAL		FULL YEAR FORECAST		2023/24 Forecast £000s	2024/25 Forecast £000s	2025/26 Forecast £000s	2026/27 Forecast £000s
Cash and cash equivalents at start of period		**52,333**		**58,896**		**58,896**	**47,843**	**40,336**	**44,108**	**49,160**
Cash flows from operating activities										
Operating surplus/(deficit)	6,326		1,962		2,476		**2,455**	**2,557**	**2,649**	**2,710**
Add back: Depreciation on donated assets	95		42		72		0	0	0	0
Adjusted Operating surplus/(deficit) per I&E	**6,421**		**2,004**		**2,548**		**2,455**	**2,557**	**2,649**	**2,710**
Add back: Depreciation on owned assets	7,101		4,739		7,923		8,572	8,772	8,972	9,222
Add back: Impairment	80		0		0		0	0	0	0
(Increase)/Decrease in inventories	224		0		0		0	0	0	0
(Increase)/Decrease in trade & other receivables	553		12		530		574	174	104	104
Increase/(Decrease) in provisions	1,845		(67)		(67)		(500)	0	0	0
Increase/(Decrease) in trade and other payables	4,988		(759)		(583)		0	0	0	0
Increase/(Decrease) in other liabilities	136		3,779		299		0	0	0	0
Net cash generated from / (used in) operations		**21,349**		**9,708**	**0**	**10,650**	**11,101**	**11,503**	**11,725**	**12,036**
Cash flows from investing activities										
Interest received	45		385		600		600	600	600	600
Purchase of property, plant and equipment	(14,340)		(11,940)		(17,811)		(17,546)	(12,680)	(6,073)	(6,073)
Sale of Property	0		0		0		1,349	7,454	2,000	0
Net cash generated used in investing activities		**(14,295)**		**(11,555)**	**0**	**(17,211)**	**(15,597)**	**(4,626)**	**(3,473)**	**(5,473)**
Cash flows from financing activities										
PDC Dividend Received	1,702		0		49		**0**	**0**	**0**	**0**
PDC Dividend (Paid)	(2,070)		(1,392)		(3,000)		**(2,690)**	**(2,790)**	**(2,890)**	**(2,990)**
Finance Lease Rental Payments	(108)		(803)		(1,377)		**(180)**	**(180)**	**(180)**	**(180)**
Finance Lease Rental Interest	(15)		(96)		(165)		**(141)**	**(135)**	**(130)**	**(125)**
		(491)		**(2,291)**	**0**	**(4,492)**	**(3,011)**	**(3,105)**	**(3,200)**	**(3,295)**
Cash and cash equivalents at end of period		**58,896**		**54,759**	**0**	**47,843**	**40,336**	**44,108**	**49,160**	**52,428**

Covid

- The Trust has spent £779k up to October 2022
- Out of envelope NHSE income has all been accrued at £328k as per expenditure (excluding testing charged to GHFT)
- Vaccine programme Reservist income and expenditure £147k has been excluded as it will be now managed by the ICB
- Vaccine programme Recruitment & Retention £117k not yet spent but accrued

For periods up to and including 31/10/22	Original Expenditure Plan 22/23 (£)		Actual ytd Expenditure (£)	Forecast Expenditure (£)	Actual ytd Income (£)	YTD Net (£)	Full Year Net Forecast (£)
Stock Management	281,900	164,442	**161,172**	**276,294**	**0**	**161,172**	**276,294**
Covid Response Management	116,039	67,689	**60,782**	**85,782**	**0**	**60,782**	**85,782**
Covid Secure	59,844	34,909	**11,382**	**11,382**	**0**	**11,382**	**11,382**
High Touch Point Cleaning	43,010	25,089	**1,492**	**1,492**	**0**	**1,492**	**1,492**
Staverton Lease	33,311	19,431	**16,737**	**45,689**	**0**	**16,737**	**45,689**
Additional shifts & backfill for higher sickness absence	150,000	150,000	**123,714**	**123,714**	**0**	**123,714**	**123,714**
Decontamination	67,808	39,555	**10,788**	**10,788**	**0**	**10,788**	**10,788**
Vaccine Program - Local Vaccination Service M6-12			**64,942**	**240,733**	**0**	**64,942**	**240,733**
TOTAL IN ENVELOPE	**751,912**	**501,115**	**451,009**	**795,874**	**0**	**451,009**	**795,874**
COVID-19 virus testing (NHS laboratories)	533,000	310,917	**181,225**	**181,225**	**(181,225)**	**0**	**0**
Vaccine Program - Local Vaccination Service M1-5	415,865	242,588	**139,164**	**139,164**	**(139,164)**	**0**	**0**
Vaccine Program - Recruitment & Retention	0	0	**117,181**	**117,181**	**(117,181)**	**0**	**0**
Vaccine Program - Lead Employer	0	0	**395**	**395**	**(395)**	**0**	**0**
Vaccine Program - 12-15s	484,642	282,708	**70,904**	**70,904**	**(70,904)**	**0**	**0**
TOTAL OUT OF ENVELOPE	**1,433,507**	**836,212**	**508,870**	**508,870**	**(508,870)**	**0**	**0**
Testing undertaken on behalf of GHFT			-181,225	-181,225	181,225	0	0
NHSE Net Expenditure over Income	**2,185,419**	**1,337,328**	**778,654**	**1,123,519**	**(327,645)**	**451,009**	**795,874**

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	2022/23	2023/24	2024/25	2025/26	2026/27	Total
Land and Buildings									
Buildings	1,508	350	1,304	1,508	2,400	1,000	1,000	1,000	6,908
Backlog Maintenance	1,020	170	33	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				274	3,319	0	0	3,593
Net Zero Carbon	0				500	500	500	500	2,000
	0						0	0	
LD Assessment & Treatment Unit	0				0	2,000	0	0	2,000
Cirencester Scheme	0					5,000	0	0	5,000
	0						0	0	
Medical Equipment	475	90	214	475	500	1,030	1,030	1,030	4,065
Fleet vehicles	125			125					125
IT									
IT Device and software upgrade	0	0	0	0	600	600	600	600	2,400
IT Infrastructure	1,036	100	(24)	1,036	480	1,300	1,300	1,300	5,416
Clinical Systems Vision	1,671			1,671	2,241	3,161	1,250	250	8,573
Unallocated				0					
Sub Total	**5,835**	**710**	**1,526**	**5,835**	**8,040**	**19,160**	**7,073**	**6,073**	**46,181**
Forest of Dean	13,452	3,100	5,215	13,452	8,851	0	0	0	22,303
National Digital Programme									0
Cyber Security	49	49	0	49					49
Total of Original Programme	**19,336**	**3,859**	**6,742**	**19,336**	**16,891**	**19,160**	**7,073**	**6,073**	**68,533**
Disposals	0				(3,849)	(2,454)	(2,000)	0	(8,303)
Donation - Cirencester Scheme	**0**				0	(5,000)	0	0	(5,000)
Net CDEL	**19,336**	**3,859**	**6,742**	**19,336**	**13,042**	**11,706**	**5,073**	**6,073**	**55,230**
Anticipated CDEL	**17,165**			**17,165**	**11,116**	**11,116**	**11,116**	**11,116**	**61,629**
Brokerage	**500**			**500**					**500**
Frontline Digitisation funding	**1,671**			**1,671**	**1,841**	**1,841**			**5,353**
CDEL Shortfall / (under commitment)	**0**			**0**	**85**	**(1,251)**	**(6,043)**	**(5,043)**	**(12,252)**
New Leases									
Vehicles	1,144	1,144		286					286
Equipment	146	146		0					0
Buildings	8,431	0		6,216					6,216
									0
Total	**9,721**	**1,290**	**0**	**6,502**	**0**	**0**	**0**	**0**	**6,502**

Forest of Dean costs greater than plan as materials bought in advance to reduce inflation risk.

Extra CDEL of £1.671m for additional frontline digitisation funding IT for 22/23 and future years

Business case on Accommodation in South of FoD to Board March or May 2023

5 year plan has been updated to reflect updated information. 23/24 plan close to balance

Risks

Gloucestershire Health and Care
NHS Foundation Trust

Risks to delivery of the 22/23 position are as set out below, along with future risks:
Mental Health Act white paper implications have largely been moved into 23/24

Risks 22/23	22/23 Risks	Made up of: Recurring	Made up of: Non Recurring	Likelihood	Impact	RISK SCORE
Delivering Value savings not delivered	800	800	0	3	3	9
Mental Health Act White paper reforms	200	200	0	3	1	3
Utility, fuel and waste costs may rise further due to inflation	400	400	0	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
Mental Health Act White paper reforms	650	650	0	3	2	6
Programme savings to be delivered *	500	500	0	3	2	6
Pay award for 22/23 is not recurringly funded	475	475	0	3	2	6
Capital cost inflation leads to reduced programme	1,100	0	1,100	4	3	12
Risk of loss from disposal of land and building sales	300	0	300	2	2	4
Capital - Insufficient CDEL to fund capital programme	2,500	2,500	0	2	4	8
Total of all risks	**9,425**	**8,025**	**1,400**			

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AGENDA ITEM: 11/1122

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 24th NOVEMBER 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

Following a competitive recruitment process involving partners, colleagues and a range to stakeholders, I am delighted to announce that we have appointed Douglas Blair as Trust Chief Executive Officer. Douglas will take up the role in 2023 following the retirement in March of Paul Roberts.

Douglas is currently Managing Director of Wiltshire Health and Care, which delivers adult community health and learning disability services in Wiltshire, a role he has held since its establishment in July 2016. He joined the NHS in 2006, with Associate Director and Director roles in South Gloucestershire Primary Care Trust, the South West Strategic Health Authority and NHS England before being appointed as Director of Community Services at Great Western Hospitals NHS Foundation Trust in 2014, which led to him establishing Wiltshire Health and Care as an NHS partnership.

Prior to his time in the NHS, Douglas was a civil servant, having being accepted into the Civil Service Fast Stream in 1998. His government roles included homelessness policy,

rural policy, the Scottish Cabinet secretariat and the reform and transformation of the prosecution service in Scotland. His first career was as a sound engineer, working for EMI at Abbey Road Studios.

I would like to formally place on record my personal thanks and those of the Board to Paul for his continued commitment and dedication to the Board and Trust. I would also like to thank Neil and his team for their support and expertise throughout the process.

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 – September and October 2022

Report authorised by:	**Title:**
Ingrid Barker	Chair

REPORT FROM THE CHAIR

1. INTRODUCTION AND PURPOSE

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

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

2. BOARD UPDATES

2.1 Non-Executive Director (NED) Update:

- The Non-Executive Directors and I continue to meet regularly as a group, and meetings were held on 13th October and 17th November. NED meetings are helpful check in sessions as well as enabling us to consider future plans and reflect on any changes we need to put in place to support the Executive and to continuously improve the way we operate.

- I am delighted to advise that Lorraine Dixon, Head of the Health and Social Care School at the University of Gloucestershire has accepted the role of **Honorary Associate Non-Executive Director** for the Trust. Lorraine's appointment will secure and enhance our joint working and growing partnerships with the University. Lorraine will join the Trust on 24th November and we very much look forward to welcoming her to the Trust and Board.

- We are currently recruiting for **new Associate NED** with community partnership/third sector/voluntary sector experience and expertise. With a keen eye on succession planning and talent management, this will be a developmental position. Applications from a diverse range of candidates are being positively sought to ensure ongoing and improved diversity on the Board. Fundamentally, we are seeking an individual with strong connections to the county who shares upholds our values. The closing date for applications is 2 December 2022 so I hope to be in a position to provide the outcome of this process to the Board in January.

- 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 Development:

- We continue to devote significant time to our Board Development Programme and how we ensure that transformation remains central to the way we work, whilst the necessary focus is maintained on ensuring high quality care and colleagues' wellbeing. We are currently designing the next phase of Board development programme and the Head of Governance and I have met with a number of potential partners to discuss this.

- A seminar on **Speaking Up took place on 1st November**. The session was led by Sonia Pearcey, Ambassador for Cultural Change and Freedom to Speak Up Guardian. Sonia was joined by Tania Hamilton, Equality, Diversity and Inclusion Lead and Neelam Mehay, Senior Manager, Speaking Up support scheme/FTSU Advocacy and Learning from NHS England. The Board focused on how to be an effective ally for Speaking Up and reflected on various pieces of work which will support our drive to continually improve on our cultural journey.

3. GOVERNOR UPDATES

- I had an introductory meeting with **Alicia Wynn** on 11th October. Alicia joined the Council in September as an Appointed Governor representing Young Gloucestershire. We will be engaging further with local partner organisations in the coming months to seek to fill our remaining two appointed Governor positions.

- I continue to meet on a regular basis with the **Lead Governor Chris Witham,** and we met on 20th October along with Assistant Trust Secretary, Anna Hilditch, to discuss agenda planning for the Council meeting on 1st December and matters relating to our Council of Governors.

- I attended the **Quarterly Staff Governor meeting** with NEDs on 8th November and the topic for discussion was management of change. The meeting was well attended by Staff Governors and NEDs.

- I would like to express my thanks to **Karen Bennett**, Staff Governor for Management and Administration who will be coming to the end of her term as a Governor on 26th November.

- In October we commenced the nomination process to elect two new staff Governors: one representing Management and Administration colleagues, and one representing Nursing staff. I am pleased that we received 3 nominations from colleagues wishing to stand as a Governor representing Management and Administration colleagues. The election for this position is currently underway and will close on 24 November. It was disappointing however that the Trust received no nominations on this occasion from our nursing colleagues. On hearing this news, I attended a Senior Leadership Network meeting to talk

about the important role that staff Governors play as part of our Council, and further work will take place to promote this role to colleagues across the Trust. We are hopeful that this position will be filled in the next round of elections.

- On Thursday 10 November I chaired an Extraordinary Council of Governors meeting. The purpose of this meeting was for the Governors to approve the appointment of the new Chief Executive Officer. Governors received the recommendation from the Appointments and Terms of Service Committee and were fully assured that the recruitment process had been thorough and robust, and there had been good engagement from Governors, Trust colleagues and external partners as part of the selection process. The Council of Governors approved the appointment.

- Due to scheduling challenges, our usual November Council of Governors meeting will take place on 1 December 2022 when the Council will receive a holding to account presentation from Non-Executive Director Jan Marriot in her capacity as Chair of the Quality Committee and Working Together Advisory Group.

4. NATIONAL AND REGIONAL MEETINGS

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

- **NHS Confederation Mental Health Chairs' Network** – meetings take place weekly and I attend when my diary permits. On 13th October, we were joined by Ian Trenholm, CQC Chief Executive to discuss learning from the recent Panorama programme featuring the Edenfield Centre. At our recent meeting we were joined by Lord Victor Adebowale, Chair of the NHS Confederation who shared his reflections and thoughts on the current political situation, the health service as it is now and investment and workforce and Professor Andrew Corbett-Nolan, Chief Executive at GGI who spoke about Population Health Management committees which are starting to appear in NHS Trusts.

- **NHS Providers Annual Conference** – 15th and 16th November. This year's theme was resilience with a focus on resilient services, resilient communities and resilience for the future. Unfortunately, due to diary commitments, I was unable to attend however the Chief Executive, Des Gorman and Sumita Hutchison were in attendance. Further details of the conference will be contained in the Chief Executive's report.

5. WORKING WITH OUR PARTNERS

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

- Along with the Chief Executive, I attend a meeting of the County Council's joint meeting of the **Health Overview and Scrutiny Committee** and **Adult Social**

Care and Communities Scrutiny Committee on 18th October. This meeting primarily focused on NHS Gloucestershire Winter Sustainability Plan (2022/23) and the CQC Gloucestershire Hospitals NHS Foundation Trust Inspection report. A progress report was received on the Health and Wellbeing Board's seven strategic priorities and the outcomes of the recent. Gloucestershire Levelling Up Our Communities Conference.

- The Trust's **Annual Informal meeting with Gloucestershire County Council's Health Overview Scrutiny Committee** was held by Teams on 19th October. The Chief Executive provided an overview of Trust activities over the last 12 months and presentations were received from David Noyes (Chief Operating Officer) on Home First and Reablement; Dawn Allen (Service Director) on the Community Assessment Treatment Unit (CATU); Andy Telford (Programme Lead) on Community Mental Health Transformation (CMHT) and Naomi Willmott (Service Team Manger) on Individual Placement Support Employment Service. Naomi Said who has lived experience of accessing employment support from our service, also joined the meeting and shared her experiences. It was great to understand first-hand how our services can make such a difference.

  HOSC Members expressed their grateful thanks to colleagues for their very informative updates and presentations. I would also like to put on record my thanks to colleagues for taking the time out of their extremely busy schedules to attend the meeting with HOSC to talk about the important work they undertake for the Trust to help provide a broad understanding of the wide range of GHC's work within the County.

- Along with the Trust's Non-Executive Directors and Lead Governor Chris Witham, I attended the **ICS NED & Lay Member Network Meeting** on **20th October** where we received an update from the Chair of the ICB, Dame Gill Morgan.

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

- **ICB Board Development Sessions** take place on a monthly basis and the Chief Executive, Graham Russell and I attended on **26th October**.

- I met with **Councillor Stephan Fifield**, **Chair of the Gloucestershire County Council Social Care Scrutiny Committee** on **2nd November**. It was an opportunity for Councillor Fifield and I to discuss informally adult social care services.

- The Chief Executive, Graham Russell and I joined Board members at the **ICB Board Retreat** which took place on 8th November. Further details of the workshop will be contained in the Chief Executive's report.

- The **Chair of the Gloucestershire Hospitals NHSFT**, **Deborah Evans**, and I continue to meet on a regular basis to discuss matters of mutual interest. I am keen to develop our mutual understanding of our Trusts' work together and to develop this further, a series of **joint Chair visits** to each other's services are in the process of being organised and will take place during December.

- On **25th October**, the Chief Executive and I met with **Deborah Evans, Chair** and **Deborah Lee, Chief Executive** of the **Gloucestershire Hospitals NHSFT**. The meeting was an opportunity to jointly discuss system pressures and processes.

- On **15th November**, I was invited by **Gloucestershire Hospitals NHSFT** to join the formal interview panel for Non-Executive Director recruitment

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

- Meetings with **Gloucestershire ICB Chairs** take place virtually on a regular basis.

- I met informally with **Jane Cummings, ICB Non-Executive Director** on 9th November. Jane and I discussed matters of mutual interest.

6. WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

- Angela Potter, Director of Strategy and Partnerships and I held a quarterly meeting with the **Chairs of the County's Leagues of Friends** on 10th November. This was an opportunity for the Trust to provide updates on a number of important activities that have been taken place over the last few months, including an update on the Forest of Dean Hospital, Fit for the Future and our Minor Injury Units. The next meeting will be held in March.

- In my last report, I referred to the reopening of **Stroud Hospital's Jubilee Ward** and **Minor Injuries and Illness Unit** following a **£2.5 million refurbishment**.

  The event, on **Wednesday 12 October**, marked the completion of a significant modernisation to some of the oldest parts of the hospital, which originally opened in 1875. The reopening was co-hosted by Stroud Hospitals League of Friends Chair Roma Walker. The League of Friends donated approximately £500,000 towards the project.

  Matron Liz Lovett and former League of Friends chair Gordon Horner performed the official ribbon cutting before guests, including Stroud MP Siobhan Baillie, toured the upgraded facilities.

- Along with NHS Board members, I was delighted to be invited to **'Through the Lens'** photography exhibition and screening of a short film called **'Gloucester Glory'** on 16th November. Both projects formed part of **'Unreflected**

Reflections' – a project created by members of the local Muslim community which highlighted their historic experiences in Gloucester. The exhibition was chaired by Ismail Kholwadia and included the opportunity to reflect on shared experiences and discuss how the NHS in Gloucestershire could build closer partnerships with the Muslim community.

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

  Siobhan Baillie, MP for Stroud, on 18th November
  Richard Graham, MP for Gloucester, on 18th November
  Alex Chalk, MP for Cheltenham, on 2nd December
  Sir Geoffrey Clifton-Brown, MP for Cotswolds on 14th December and,
  Laurence Robertson, MP for Tewkesbury, on 3rd March 2023

  Unfortunately, **Mark Harper, MP for the Forest of Dean** was unable to join the meeting scheduled to take place on 28th October. The meeting is the process of being rearranged.

7. ENGAGING WITH OUR TRUST COLLEAGUES

- On 3 November we celebrated the long service of colleagues who have worked in the NHS for 20, 30 and 40 years. Our **annual Long Service Recognition event** was held at Churchdown Community Centre and I had the pleasure of celebrating with colleagues and presenting recipients a certificate to commemorate their service. It was a lovely occasion and a great opportunity to thank our colleagues. This year, for the first time, volunteers and experts by experience were also recognised alongside substantive employees.

- I am **informally visiting** the Trust's services across the county and I am pleased to have visited the Montpellier Unit at Wotton Lawn on 25th October where I met Sarah Campbell, Modern Matron and Trust colleagues.

- I was proud to join the CEO in celebrating **World Menopause Day** on 18th October, and sign the Trust's Menopause Workforce Pledge acknowledging our commitment to considering and improving the support provided to colleagues going through the menopause in the Trust.

- I continue to attend the Trust's Committees on a rotational basis and I regularly attend the **Working Together Advisory Committee.** I attended the Working Together Advisory Committee on 12th October and Quality Committee on 3rd November. Unfortunately, due to diary commitments, I was unable to join the **Mental Health Legislation Scrutiny Committee** on 19th October.

- I joined the **Senior Leadership Network Meeting** on 27th October and at the meeting I provided an update on the CEO recruitment.

- As part of the **Forest Hospital build**, I joined Trust colleagues from Dilke and Lydney hospitals in the signing of the new hospital steel frame on **26th October**. It was an exciting opportunity for me and colleagues to visit the site and witness the progress made to date.

- **Nominations and Remuneration Committee** took place on 2nd November.

- **Appointment and Terms of Service Committee (ATOS)** was held on 9th November.

- **Armistice Day (also known as Remembrance Day) - 11th November**
  Armistice Day was marked with a virtual Act of Remembrance via Teams, and included a reading from one of our Trust veterans and a two-minute silence at 11am.

- 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.

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

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

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

8. NED ACTIVITY

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

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

9. CONCLUSION AND RECOMMENDATIONS

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

Appendix 1

Non-Executive Director – Summary of Activity – 1st September – 31st October 2022

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Dr Stephen Alvis	Clinical Excellence Awards Meeting 2 Bite Sized Briefings Dental Investigation Update with Director of HR and OD 1:1 with Nicola de Iongh Mental Health Act Managers' Forum Risk Assessment training for Mental Health Act Managers AAC Interviews Bite-Sized Briefing NEDs Meeting DNTQ re quality visits Dietetic AHP Meeting Rapid Falls Service, Quality Visit AAC Interview	Good Governance Institute Webinar GGI Festival of Governance Good Governance Institute Webinar MHAM Personal Development Review Good Governance Institute Webinar	Quality Committee Board Seminar: Transforming LD Services Trust AGM Board – Public Board – Private Resources committee
Steve Brittan	Quarterly meeting with Chair ICB System Resources Meeting Governor Briefing Session: CQC Inspection Report Senior Leadership Network Meeting Resources Committee Agenda Planning Meeting Quality Visit to CATU NEDs Meeting ICS NED & Lay Member Network Meeting		Trust AGM Board – Public Board – Private Resources Committee
Marcia Gallagher	1:1 with Chair CEO Interview Panel Meeting Street Triage Service Quality Visit	Forest of Dean Health Forum GGI-Let's talk about Local Government Forest of Dean Health Forum AGM	Quality Committee Charitable Funds Committee

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	ICB Audit Committee Meeting with Head of Governance Women's Leadership Network Meeting with Director of Finance Security and Health & Safety Team meeting National Health Professions Day visit – Montpellier Allotment CEO Longlisting NEDs Meeting DNTQ re quality visits CEO Shortlisting ICB NED & Lay Member Network Later Life Team Quality Visit Senior Leadership Network Meeting with Head of Governance Meeting with Phillip Mantay	Audit of Complaints	Board Seminar: Transforming LD Services Board Development with The Value Circle Board – Public Board – Private Trust AGM
Sumita Hutchison	1:1 with Neil Savage Governor Briefing Session: CQC Inspection Report Podiatry Service Quality Visit Meeting with Gill Morgan Women's Leadership Network NEDs Meeting DNTQ re quality visits ICS NED & Lay Member Network Telephone meeting with Chair Catch up meeting with James Powell Senior Leadership Network Meeting 1:1 with Steve Brittan	NHS Providers Risk Management Workshop NHS Providers Finance Workshop	Charitable Funds Committee Governor Briefing Session: CQC Inspection Report Board Seminar: Transforming LD Services Board Development with The Value Circle Trust AGM Board – Public Board – Private MHLS Committee Resources Committee

Jan Marriott	CQC thank you visit to CYP Physical Health Team Meeting with CEO Interview Panel 1:1 w colleague re job interview Meeting with Head of Facilities; HR; Inclusion Glos and County Council Employment lead re Trust employment of people with a learning disability 1:1 with FTSU Ambassador Meeting re Professional Nursing and Midwifery Council QI Celebratory Event 1:1 with Chair Longlisting for CEO recruitment NED Meeting Quality Visit reports meeting Shortlisting for CEO recruitment Meeting with Community Hospitals Association Quality Visit meeting Chair of Working Together Advisory Group Meeting	Cheltenham Know your Patch Meeting	Quality Committee Board Seminar: Transforming LD Services Board Development with The Value Circle Board – Public Board – Private Quality Assurance Group Meeting
Graham Russell	ICB Board 1:1 with Chair Mental Health Liaison Team Quality Visit Governors CQC Briefing ICB HR Leads discussion ICB Board Development		Quality Committee Nom and Remuneration Committee Trust AGM Board – Public Board – Private Board Seminar: Transforming LD Services Board Development with The Value Circle Great Place to Work Committee

Nicola de Iongh	Introduction meeting with Lavinia Rowsell Introduction meeting with Steve Alvis Governors CQC Briefing Introduction meeting with Amjad Uppal Introduction meeting with John Trevains Introduction meeting with Chris Witham ICB NED & Lay Member Network Senior Leaders Network Meeting Rapid Falls Service, Quality Visit	NHS Providers Finance Training	Trust AGM Board Development with The Value Circle Board – Private Great Place to Work Committee Resources Committee

AGENDA ITEM: 12/1122

REPORT TO: **TRUST BOARD PUBLIC SESSION – 24 November 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 we remain on managing the impact of continuing service pressures across all services and on recovery of services from the impact of the pandemic. In the context of these operational pressures, we prioritise meeting the needs of our service users, supporting colleagues, and achieving the aims set out in our Trust Strategy.

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

As well as updates on the activity and focus of the CEO, this report provides an update on several trust developments such as works at Cirencester hospital, the launch of the hardship fund and recent Trust awards.

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 Infection Prevention Control update

There have been no significant changes since the update provided in the September Board report. Infection Prevention Control colleagues continue to monitor community transmission rates, alongside the Covid-19 situation in our hospitals, and we are using a pragmatic, risk-assessed face mask policy, requiring teams to implement the most suitable approach dependant on the service they are operating in.

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

1.2 Work on Cirencester Wards

Work to improve the patient experience as well as fire safety on the wards at Cirencester hospital began at the end of September.

Our Trust is upgrading the fire compartmentalisation on both Windrush and Coln wards as well as changing to single-sex accommodation for patients during this three-month upgrade. National NHS guidance encourages the provision of single-sex accommodation for the safety, privacy, and dignity of service users. After this work, the 28-bed Coln ward will be used for female patients and 21-bed Windrush ward for male patients.

A temporary Thames ward, which until recently was used to care for patients during the refurbishment at Stroud hospital, will be used while the work is carried out.

1.3 Launch of the Trust Hardship Fund

On our behalf as Trustees of our Charitable Funds the Committee has agreed to offer a new hardship fund to help colleagues who may be experiencing exceptional financial difficulties, particularly during the current cost of living crisis.

The fund has a simple application process and colleagues experiencing genuine financial hardship can apply for grants of up to £500, for support with urgent expenses they are struggling to meet.

Similarly, colleagues who become aware of someone needing urgent support during the course of their work may also submit an application on behalf of patients or service users.

The fund is limited and will only be granted to those who can evidence that they are in an "*in extremis*" circumstance. Once the fund is spent, we will close applications pending any further donations to the Trust's Charitable Funds.

Grants are available for anyone who is employed by or volunteers with GHC (including Experts by Experience).

1.4 NHS Community Mental Health Survey Benchmark Report 2022

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

1.5 Armistice Day

We held a Trust-wide virtual Act of Remembrance via Microsoft Teams on Friday 11th November to mark Armistice Day and remember our fallen heroes and the sacrifices made by our armed forces personnel in the line of duty. It was hosted from Edward Jenner Court and included poetry readings by representatives from our Veterans' Group and a two-minute silence at 11am.

Veterans Steering Group Lead Jonathan Thomas and Nicola Shilton, our Locality Inclusion Lead, Partnership Team (and herself a veteran), laid a wreath on behalf of the Trust and the NHS at Gloucester Railway Station on Remembrance Day, as part of the Poppies to Paddington initiative.

1.6 Internal engagement and developments

A virtual **Senior Leadership Network** (SLN) meeting was held on 27th September. These meetings take place monthly and provide an opportunity to discuss leadership issues critical to delivering the Trust strategy and mission.

The September meeting focussed on the ***Exposed: Racism and the Pandemic film.*** ***"Exposed"*** is a documentary about the racism nurses and mid-wives experienced before, during and after the pandemic. It is a very powerful film that seeks to address racism in the context of health responses to the pandemic. This film has been supported by the Royal College of Nursing and produced by Sheffield Hallam University and helps promote discussions calling for systemic change. Following the film, there was an opportunity for discussion, questions, and answers with a panel of experts. We were pleased to welcome one of the nurses featured in the film to the panel, who shared her insights and experiences with the team. This thought provoking and reflective session was extremely valuable for the work the Trust is doing to drive change in addressing systematic inequalities.

The SLN meeting on 27th October updated the senior team on several important issues, including new CEO recruitment and governor election updates from the Trust Chair. Our Head of Patient Safety and Learning presented on the Trust's approach to implementing the new **National Patient Safety strategy**, and updates were

provided on the Health Education England Allied Health Professionals support workforce education and career development programme and the Reciprocal Mentoring scheme. See section 1.8 'Tackling Inequalities' below for further information on the scheme.

Monthly **Bite-Size** briefing sessions continue to be held as digital events and are led by an Executive or a Deputy. They are open for all Trust employees to attend and provide an opportunity for the Executive team to share the latest Trust news and information and for staff to share their thoughts, feelings, and concerns. These sessions typically cover an update on the latest Covid-19 and workforce news, and other recent items of interest. The Bite-Size sessions help to ensure effective communication across the Trust and provide an opportunity for the staff voice to be heard directly by the Executive team. I led the session on 14th November.

I chaired October's **Staff Forum** on 20th October, which was focussed on **Quality Improvement.** Tanya Stacey and Claire Lait from the Trust's Quality Improvement hub presented an introduction to Quality Improvement methodologies, involving an interactive exercise. Colleagues who joined the session had an opportunity to bring along questions, comments, and observations for discussion.

On 28th September the team held their virtual **Quality Improvement Celebration Event**, which included a talk by Dr Amar Shah, Consultant Forensic Psychiatrist and Chief Quality Officer at East London NHS Foundation Trust. Numerous Trust colleagues who have undertaken QI projects also presented throughout the event to highlight the valuable work the hub does in promoting a culture of continuous improvement throughout GHC and beyond.

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

Weekly **Executive Director Meetings** continue, where collectively the Executive team oversee the day-to-day, and longer-term executive management of the Trust. These meetings are broadened on a bi-monthly basis for the **Trust Senior Team Meetings**, which bring senior management and clinical leaders from across the Trust together to provide advice to the Executive on the direction and operational management of the Trust and provide feedback on staff experience. These regular meetings enable wider engagement in, and ownership of, key decisions affecting our organisation including priority setting, system engagement and strategic planning.

At the **Trust Senior Team Meeting** on 11th October, I provided the Chief Executive update, which included a summary of the Trust Board meeting held on 29th September, and Angela Potter, Director of Strategy and Partnerships, provided an update on ICS developments. Tina Craig, Professional Head of Podiatry, delivered a presentation on "Raising the profile of AHP's" and there was a lively discussion on improving compliance rates for statutory and mandatory training. The Patient and

Carer Experience Team provided a snapshot of their service and there were updates from the Diversity Network.

I attended the **Joint Negotiating and Consultative Forum** (JNCF) on 23rd November (after this report was written) to provide the Chief Executive update.

I provided the Chief Executive's update at the **Non-Executive Directors meeting** on 17th November. Sandra Betney, Deputy CEO, attended the meeting on 13th October and 17th November to provide the Chief Executive update on my behalf.

I, along with other members of the Executive team, attended the **GHC Senior Lead Engagement Visit** on 7th November with Health Education England (HEE). The purpose of these annual visits is to discuss all of the education and training delivered within our Trust. A key part of the visit was reviewing and discussing our latest HEE Self-Assessment and there was an opportunity to discuss the key areas highlighted by the review.

I met with **Sue Doheny, South West Regional Chief Nurse**, on 7th October as part of her visit to the Trust. Sue, accompanied by John Trevains, Director of Nursing, Quality and Therapies, visited several the Trust services, including Montpellier ward and the allotment. We welcomed the visit, which provided an opportunity to discuss current challenges and highlight some of the excellent work our services are delivering to the local community.

I took part in the Executive Director **Incident and Command training session** on 19th October. This session provided face to face training from the organisational resilience team to ensure the Executive team are prepared to respond effectively to major incidents should the need arise.

I attended the Trust's **Integrated Business Planning and Budget Setting Launch 23/24** on 1st November. The virtual event was attended by most of the Executive team and the Trust's senior team. It is an important meeting as it provides an opportunity to set out the Trust priorities for the coming year and support the development of the business planning objectives in line with the Trust's strategic goals and objectives.

On 2nd November members of the Executive team and I met with the **Learning Disability Consultants** to discuss a range of issues the team had raised. The meeting covered an overview of the current situation in learning disability services and a more in-depth review of a number of key issues. It was a valuable opportunity for discussion and engagement with senior clinical colleagues which is vital for ensuring we meet our one of our core Trust values of "always improving".

I attended the **Appointment and Terms of Service Committee** meeting on 9th November.

I attended the **Long Service Awards** on 3rd November to celebrate and recognise the long service of over 60 colleagues. Further information is included in the Chair's report.

1.7 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.

On 15th November the trial took place of one of a former patient, William Warrington, he pleaded guilty to the manslaughter of his parents Valerie and Clive. These horrific events put everything else within mental health services into perspective. The Trust is following the mandated serious investigation process which, now the criminal justice process has come to an end can proceed to a conclusion and which, following scrutiny by regulators, will be shared with the family. The Trust has through trusted third parties expressed condolences and regret to the family.

I chaired the **South West Mental Health Programme Board** on 19th October. The Board looks to develop, implement and support the long-term plan, ambitions, and South West-wide mental health priorities. At the October meeting the Board discussed the South West Mental Health Strategy, the letter from Claire Murdoch regarding the quality and safety of inpatient mental health care (following the recent BBC panorama), and the governance and leadership arrangements for Mental Health within the ICB's. There was also a discussion on perinatal mental health, including the system responses to regional review findings.

I chaired the monthly **South West (Regional) Mental Health CEO's** meeting on 21st October. At this meeting I handed over the chair of this group to Dominic Hardisty, Chief Executive of Avon and Wiltshire Partnership NHS Trust, in light of my decision to retire at the end of March 2023.

This group acts as the overarching governance summit for the regional South West NHS Provider Collaborative and provides an opportunity for CEO colleagues to raise key issues about mental health services across the region and to offer mutual support. The meeting on 21st October focussed on the Mental Health framework, winter planning and anticipated pressures and an update on the workforce task group. I attended a further meeting on 18th November, which was chaired by Dominic.

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.

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.

In Gloucestershire, I chair the **Community Mental Health Transformation (CMHT) Programme Board**. The programme has been tasked with designing and developing new and integrated models of primary and community mental health care. This community-based offer spans both community provision and dedicated core services and is built around Primary Care Networks (PCNs) that will utilise and expand our local VCSE offers to support new and sustained ways of working to deliver improved health outcomes and reduce health inequalities.

Angela Potter, Director of Strategy and Partnerships, chaired the CMHT meeting on 3rd October on my behalf. The meeting largely focussed on the Partnership Board terms of reference and an update on programme delivery and budget and financial monitoring. There were also updates on the People Representation Action Board and the VCS partnership.

On 31st October I sat on the successful **AAC panel for Consultant Old Age Psychiatrist**. These are vital appointments for our Trust and the panel included our Medical Director, a Non-Executive Director, Royal College Representative, Trust Consultant and an Expert by Experience.

I had a meeting with our **Trust Lead for the Arts Therapies: Music, Art, Drama & Dance Movement** on 4th November. I welcomed the opportunity to learn more about all of the Arts Psychotherapies offered within the Trust and how they make a positive difference to people's lives. This short video provides an insight into what happens in group sessions, what these sessions mean to the adult service users and how it helps their mental health - https://www.youtube.com/watch?v=GMRSvV1PJMQ

1.8 Tackling Inequalities

October was **Black History Month 2022** and we were pleased to celebrate the diverse heritage and cultures of our staff at GHC and, in particular, those of African and Caribbean heritage. Our theme for this year's event was '**Time for Change: Action Not Words'**.

Our Trust was proud to be one of the main sponsors for the free multiagency event at the **Music Works** in Gloucester on 21st October, where NHS, local government and care sector employers connected with the community and local talent in celebration of Black History Month. Organisers put together an event to share Caribbean food and music and the screening of the powerful and ground-breaking film **"Exposed – Racism and the Pandemic".**

October was also **Menopause Awareness Month** and the 18th October **World Menopause Day; a** day which aims to raise awareness and highlight the support options available for improving the health and wellbeing of women affected by menopause. To celebrate our Trust's 'menopause journey' and demonstrate our Trust's commitment to actively supporting and informing colleagues affected by the menopause, I, along with the Trust Chair, signed the Menopause Workplace Pledge.

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

I am part of the **Health Inequalities Panel** established by Gloucestershire County Council and the ICS. This is designed to provide oversight of the wider inequality agenda and in particular to provide co-ordination of the Health and Wellbeing Programme and the ICS Programme. I attended a meeting on 21st November to discuss the future of this forum now that the ICB and ICP are established.

Our **reciprocal mentoring programme**, aimed at enhancing equality, diversity and inclusion within our Trust, has now been extended to reach out across Gloucestershire at an ICS (system wide) level. Reciprocal mentoring is where individuals from minority groups work as equal partners with senior leaders in the process of learning from each other. The aim is to build a mutually beneficial understanding and insight into the difficulties and barriers colleagues from minority groups often face. Expressions of Interest for the scheme opened on 27th October and we hope to be able to provide further updates soon.

We continue to progress the work we are doing with **Walk In My Shoes (WIMS) a** community led group providing a pathway for better communication and services between the NHS and BAME communities in Gloucester. We are supporting WIMS in progressing its ambition to become an incorporated charity and hope to be in a position to finalise the necessary documentation over the coming months.

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.

1.9 Speaking Up

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. October was National Freedom to Speak Up Month and the Trust celebrated our fifth annual Speak Up Month, raising awareness of Freedom to Speak Up and the impact it can bring for patient safety, inclusion and wellbeing. The theme was **"Freedom to Speak Up for Everyone"** with each week having a specific focus – to Speak Up for Safety, Civility and Inclusion. I wrote a blog, which was circulated to all Trust colleagues, to emphasise the importance of encouraging a culture of speaking up and how we can support staff to do so as part of their everyday practice.

On 14th October I joined the **South West Regional Freedom to Speak Up Guardian Meeting,** facilitated by Sonia Pearcey, to deliver a presentation on "My own "speak up" journey". The CQC in their recent inspection report commented very positively on the Trust's approach to speaking up, noting that "staff felt able to raise concerns without fear of retribution" and that staff were aware of the process and

role of the Freedom to Speak Up Guardian. It is hoped that by sharing our work, we can help to support other organisations in the South West to develop their own speaking up culture.

On 1st November we held a Board Session with Speaking Up where we welcomed Neelam Mehay, Senior Manager, Speaking Up support scheme/FTSU Advocacy and Learning from NHS England. More detail is provided in the Chair's report.

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

1.10 ICB (Integrated Care Board) and System Partners

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

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

ICB Public Board and **ICB Strategic Executive** meetings take place monthly, with a focus on system-wide planning and resilience. Sandra Betney and John Trevains join me as members of the ICB Strategic Executive forum. The regular meetings, held with senior colleagues across the health system, provide updates on organisational matters and projects and help ensure joined up working by providing a forum to discuss items affecting multiple partners.

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

- ICB Board Development Session on 26th October. At this session there was an update on the Risk Appetite and Board Assurance Framework, Place, Locality and Neighbourhood Integration and the Integrated Care strategy.
- ICB Board Development Day on 8th November. The session focussed on developing relationships and building trust to enable effective working during challenging periods to empower colleagues working directly with service users.
- Extraordinary ICB Board Meeting on 21st November. The session focussed on Advice and Guidance Award of Contract.

At the recent meeting of **NHSE SW Regional Support Group**, the segmentation of NHS organisations within the ICS was considered in line with the NHS Oversight Framework and on the recommendation of the ICB. GHC has been assessed as being in segment 2 for quarter 2 – Plans that have the support of system partners in place to address areas of concern. As a Trust, the Director of Finance is undertaking an exercise to map the metrics driving the segmentation decisions. This will inform future board reporting.

The system Gold Health System Strategic Command, known as the **Gold Executive Review Group**, takes place on Wednesdays as part of the wider **Gloucestershire ICS Covid-19 Response Programme.** In the past this forum proved essential in overseeing the system response to the Covid-19 pandemic and now provides a regular liaison point between senior leaders in the NHS and social care system to discuss urgent and emergency care.

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

I had an introductory meeting with **Siobhan Farmer**, new to her **Director of Public Health** role at Gloucestershire Country Council. Although I already know Siobhan well from her previous work in the system, I welcomed the opportunity to discuss her new role and the work our teams are currently progressing.

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

I attended the **South West Chief Executives Forum** in London on 14th October. The main focus of the meeting was identifying key strategic priorities for SW organisations moving forward. The sharing of examples of good working practice, alongside reviewing operating models and data, helps provide focus for strategic planning during these challenging times. The discussions were informed by contributions from Dr Anna van Poucke, Global Head of Healthcare KPMG International and Rosaleen Blair, Founder and Chair of Alexander Mann Solutions. The meeting allowed time for wider discussions on a number of topics, including approaches to supporting improvement. These conversations are vital in helping to challenge practices and drive change to bring about improvements for patients and staff.

I chaired the inaugural meeting of the **One Gloucestershire Improvement and Innovation Board** on 6th October. The aim of the programme is to nurture an improvement culture across One Gloucestershire that can drive the system's ambitious programmes for transformation. The meeting addressed the next steps from the programme partners launch event and the role of the senior leadership team in delivering a system wide culture for improvement. The group reviewed the terms of reference and membership and discussed the key next steps and challenges in building a strategic framework.

On 18th October, along with the Trust Chair, I attended the County Council's joint meeting of the **Health Overview and Scrutiny Committee (HOSC)** and **Adult Social Care and Communities Scrutiny Committee (ASCC)**. On 19th October we hosted the **Gloucestershire Health & Care Annual Briefing with Gloucestershire County Council Health Overview and Scrutiny Committee.** Further detail on these meetings is included in the Chair's report.

There was a further meeting of the **HOSC** and **ASCC Scrutiny Committee** on 15th November. David Noyes, Chief Operating Officer, attended on behalf of the Trust. In response to issues impacting on urgent and emergency care systems in Gloucestershire this meeting focused solely on the delivery of this care. During the meeting, members received an update on the conclusions and findings of recent diagnostic work undertaken by consultants, Newton Europe, in partnership with Gloucestershire County Council and NHS Gloucestershire.

There have been a number of meetings, as a system, organisation and individually, to discuss the work that **Newton Europe** is undertaking on improving urgent and emergency care and system flow (as highlighted as part of the **Local Government Association (LGA) Urgent and Emergency Care (UEC) Peer Review**). Newton Europe has undertaken in-depth diagnostic work across the system using data analysis, live studies and key stakeholder engagement. This work has also involved several case review workshops where practitioners discuss different patient pathways/journeys to better understand the impact of internal and external factors. Cases are reviewed one by one, using a multi-disciplinary approach, to identify good practice and any learning. As a system we will be continuing to progress this vital work over the coming months. We aim to continue to involve and engage colleagues in this programme as it moves from diagnosis to implementation.

There have also been a number of system meetings to discuss pertinent issues facing the region, including the role out of the **county-wide Falls Service**. This specialist service is hoped to provide a proactive and preventative model to assist at the early stage of falling and injury. The service is provided by clinical staff who attend a call from someone who has had a non-injurious fall to support them off the floor and ensure they are clinically safe to remain at home. The team have an equipped vehicle with suitable lifting apparatus. It is important that these issues are discussed with senior system colleagues so that effective solutions can be sought and implemented.

I have chaired meetings in relation to the use of **registered mental health nurses (RMNs)** at the Gloucestershire Hospitals Foundation Trust (GHFT). GHC has been working alongside colleagues at GHFT to review current processes in order to identify opportunities for improvement in efficiency, productivity and patient welfare in the deployment and utilisation of RMNs. This piece of work is a great example of collaborative working across the system to improve the care delivered to our community.

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

The Chair and I are in the process of holding our annual meetings with MPs to discuss Trust updates, address any concerns and ensure effective cross communication. The Chair with Sandra Betney deputising for me held meetings as follows:

- 18 November – Richard Graham MP
- 18 November – Siobhan Baillie MP

We have further meetings scheduled for the end of November and in to December.

Additionally, on 21st October, we had a face-to-face meeting with **Laurence Robertson MP**, attended by John Trevains, Director of Nursing, Quality and Therapies, Amjad Uppal, Medical Director, and James Wright, Associate Director of Patient Safety, Quality & Clinical Compliance, to discuss the review of access control at one of our mental health inpatient hospitals. **Alex Chalk, MP** for Cheltenham visited Wotton Lawn earlier in the month to see these services in person in a visit hosted by James Wright.

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

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

On 1st November I met with **Sally Byng, Barnwood Trust Chief Executive**. Barnwood Trust is a charitable foundation which aims to create the best possible environment in Gloucestershire for disabled people and people with mental health challenges to make the most of their lives. We value greatly the contribution of the charities we work with in Gloucestershire and it was a pleasure to meet with Sally to discuss the work of our organisations and how to continue to build on our partnership working.

The **Medical Staff and Dentistry Committee (MSDC)** convened on 7th October and 4th November. I attended to provide the Chief Executive update. The **Local Medical Council (LMC)** convened on 10th November. Dr Amjad Uppal, Medical Director, and I attended the meeting. Active engagement with senior medical colleagues in the

trust is an important aspect of the work of the Chief Executive and wider Executive team.

On 16th November members of my Executive team attended the **Unreflected Reflections - Voices Gloucester**, hosted by the **Friendship Café**. The event was held at Sanger House, Gloucestershire ICB headquarters, and showcased 'Through the Lens' photography and a short film called 'Gloucester's Glory'. Both projects form part of 'Unreflected Reflections' – a project created by members of the local Muslim community to shed some light into their history in Gloucester. The event, for NHS Board members and Equality, Diversity, and Inclusion leads, was chaired by Ismail Kholwadia. It included the opportunity to reflect on the experiences shared and discuss how the NHS in Gloucestershire can build a closer partnership with our Muslim community.

1.11 National Events / Activity

I attended the national **BME Leadership Network's annual Black History Month lecture** on '**Race, science and the NHS'** on 12th October. **Dr Adam Rutherford,** scientist, author and broadcaster, drew on themes from his latest book (Control: The Dark History and Troubling Present of Eugenics) to discuss the potential impact of new gene-editing techniques and how scientific racism and eugenics ideology, both past and present, have contributed to racism within the NHS and wider society. It was an interesting and thought-provoking talk, which also provided a welcome opportunity to speak to other members of the BME Leadership Network.

I attended Amanda Pritchard's **NHS National Leadership Event** on 13th October. The purpose of this face-to-face event in London was to build on the progress made at the Leadership event in April and provide a further opportunity to work together as a single leadership team on the immediate priorities and key longer-term strategic issues for the NHS. There were breakout sessions covering topical issues, including urgent and emergency care and ambulances, frailty, falls and admission avoidance, discharge, elective and cancer and workforce. This was a useful and informative event which provided an opportunity for networking and sharing effective and improved ways of working.

On 15th and 16th November, Sumita Hutchinson, Non-Executive Director, Des Gorman, Deputy Director of Strategy and Partnership and I attended the **NHS Providers Annual Conference** in Liverpool. The theme for this year's conference was resilience, focussing on resilient services, resilient communities, and resilience for the future. It was an opportunity to listen to keynote speakers and expert case studies, join roundtable discussions, and get involved in interactive debate. I welcomed the chance to connect with colleagues and be part of the wider discussions on how we can respond collaboratively to address health inequalities in the sector.

1.12 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 within their working environment and how they address the challenges presented by the ever-changing circumstances. I value the opportunity to be able to continue to meet with colleagues and patients, and to be on hand to discuss any topics or issues they would like to raise.

On 12th October I visited **Southgate Moorings** in Gloucester to meet members of the team and look around the dental and lymphoedema services, which have recently undergone refurbishment. I also met with several Allied Health Professionals (AHPs) whilst at Southgate Moorings, ahead of the **National AHPs Day** (14 October), to celebrate the work of our dedicated AHPs.

To mark the day, AHP colleagues had the opportunity to connect, network, celebrate, enjoy cake and pick up new AHP lanyards and pens at venues across the Trust. Members of our Trust Board, including Executive and Non-Executive Directors, paid visits to various sites and services to join the celebrations. On our intranet and social media there were video clips from AHP colleagues across the Trust bringing short reflections on their work, teamwork, career choices and outcomes.

On 21st October I visited the **Brownhill Centre**, part of St Paul's Medical Complex, where the Trust's Eating Disorder Service is based. The service is experiencing exponential growth in demand which has led to long waits for treatment and assessment. I welcomed the opportunity to meet with the operational lead and the wider team and discuss how they are coping with the unprecedented pressures.

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

2.0 AWARDS

So Glos Awards

We were crowned winners of the **Public Sector Excellence** category at the **SoGlos Gloucestershire Business Awards 2022**. More than 300 guests gathered for the evening at the University of Gloucestershire's Business School at its Oxstalls campus in Gloucester for the awards ceremony and networking, made possible by co-headline sponsors Hazlewoods and Willans LLP solicitors. John Trevains, Director of Nursing, Therapies collected the award on behalf of the Trust.

Defence ERS Silver Award

Our Trust celebrated the news earlier this year that we had been awarded the **Defence Employer Recognition Scheme (ERS) Silver Award**, in recognition of its commitment and support for defence personnel.

The ERS encourages employers to support defence and inspire others to do the same. The scheme encompasses bronze, silver and gold awards for employer organisations that pledge, demonstrate or advocate support to defence and the

armed forces community, including existing or prospective employees who are members of the community, and align their values with the **Armed Forces Covenant**. The Trust signed up to the Armed Forces Covenant in December 2019, which demonstrates the fact that GHC is Armed Forces-friendly and open to employing reservists, armed forces veterans (including the wounded, injured and sick), cadet instructors and military spouses/partners.

Our Trust's commitment to driving improvements in NHS care for defence personnel and their families was further recognised in May last year, we were named a **Veteran Aware Trust**. The Trust benefits enormously from having quite a number of veterans as colleagues. They bring a range of skills and experience that benefit us all. In turn, we are pleased to support veterans and their families through the Covenant.

Wessex RFCA recently hosted 'His Majesty's Lord-Lieutenant's Awards for Gloucestershire' at Hatherley Manor, Gloucester, at which recipients of this year's silver Defence ERS accreditation were presented with their awards by the Lord Lieutenant of Gloucestershire, Mr Edward Gillespie OBE DL.

3.0 INDUSTRIAL ACTION

On 9th November the Royal College of Nursing (RCN) announced the outcome of its ballot on industrial action. Industrial action will go ahead on a date yet to be announced between the end of November and May 2023.

Other unions, including the Chartered Society of Physiotherapy (CSP), Unite, the British Medical Association and Unison are also balloting their members over industrial action.

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

The Trust has been working with national, regional and local partners to plan for this for some time. If strike action does go ahead, there will be an impact on Trust services. However, it's important to highlight that we have tried and tested **Emergency Planning and Resilience Response** measures in place to manage service disruptions, including industrial action. Our local Trust and system planning will focus on ensuring patient / service user safety and that urgent and priority services are maintained. We will aim to ensure any impact on day-to-day services is minimised as much as possible.

Further information and guidance will be issued to colleagues and managers in due course, and we will continue to work in partnership with local trade union colleagues to ensure that patients and colleagues are supported during this time.

4.0 CONCLUSION AND RECOMMENDATIONS

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

AGENDA ITEM: 13/112

REPORT TO: **TRUST BOARD PUBLIC SESSION – 24 November 2022**

PRESENTED BY: Angela Potter, Director of Strategy and Partnerships

AUTHOR: Angela Potter, Director of Strategy & Partnerships

SUBJECT: **SYSTEMWIDE 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:

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

Risks associated with meeting the Trust's values
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:	

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

INTEGRATED CARE SYSTEM UPDATE REPORT

Introduction

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

1. Health Overview Scrutiny Committee (HOSC) and Annual Meeting

The Health Overview & Scrutiny Committee have joined the Trust for their annual informal meeting on the 19th October. The Trust had the opportunity to highlight a number of key service developments and covered updates on the Community Assessment & Treatment Unit (CATU) development, the Individual Placement Support & Employment service and the Community Mental Health Transformation programme. The presentations were well received and it has been agreed there will be a greater focus on mental health services at the December HOSC meeting.

The HOSC meeting on the 18th October had a focus on the recent Care Quality Commissions inspection at Gloucestershire Hospitals Trust and there is a further session scheduled for the 15th November which will have a focus on the diagnostic work that has been ongoing across the urgent care system by Newton Europe.

2. Integrated Care Partnership (ICP)

The ICP are continuing to lead the development of the system wide ICP Strategy which is due for publication at the end of December 2022. A systemwide workshop was held on the 20th October which was attended by Angela Potter, Director of Strategy & Partnerships to ensure input into this work. There have also been a series of presentations at forums such as the Trust's Executive Committee and the Integrated Locality Partnerships to maximise the engagement opportunities on the development of this strategy within the short timeframe that has been set.

The strategy will be presented to the Trust Board for endorsement in due course.

3. Health & Well-Being (HWB)

The Health & Well-being Board continues to be a statutory requirement within the new system architecture. It remains in an interim format until the Terms of Reference are signed off at the end of December.

The meeting held on the 20th October received a presentation on the developing ICP strategy and a detailed update on the strategic housing priority which has clear links across to the Community Mental Health Transformation work which has a housing workstream due to come on line shortly.

4. National & System Developments

4.1 Care Quality Commission - Community Mental Health Survey 2022

The Care Quality Commission (CQC) has published its findings from its annual community mental health survey, looking at people's experiences of NHS community mental health services.

In line with the past two years, the organisation of care is an area where the majority of people reported good experiences. Ninety-six per cent of respondents said they knew how to contact the person organising their care if they had a concern. There were also a higher proportion of respondents reporting positive experiences regarding the responsiveness of care and care planning than in other areas.

However, CQC identified a number of areas for improvement including in relation to: accessing care; crisis care; involvement in care; support and wellbeing; and communication. These areas for improvement broadly match findings from last year's survey.

Each Trust that participates receives a benchmarking report and the Trust's will be used through the various quality forums to identify areas of ongoing learning.

4.2 Care Quality Commission report – Who I am matters

The CQC has published it report *Who I Am Matters* which assesses the experience of being in an acute hospital for people with a learning disability and autistic people based on visits to eight hospitals between February and March 2022. The review was one of several recommendations made following the death of Oliver McGowan.

Whilst their report acknowledges that there were some examples of people doing great practice, people with a learning disability and autistic people are still not being given the quality of care and treatment they have a right to expect when they go to hospital.

Specific challenges include hospitals lacking effective systems for identifying people, particularly autistic people who do not have a learning disability, which means that staff are not always aware of an individual's needs, and so are unable to put in place the reasonable adjustments people have a right to expect.

The results from these surveys will be used by the Trust to continue to assess and learn where our services can be improved.

5. Fit for the Future

The engagement for phrase 2 of the programme has now concluded and will be presented to HOSC shortly to determine whether there is a need for a public consultation for any of the planned changes.

6. Partner Updates and Developments

6.1 Healthier Lifestyle Programme

Gloucestershire County Council have approved £450,000 of funding per year to fund a healthier lifestyles programme for children and young people aged 4 to 18 (and up to 25 for those with special educational needs and disabilities). This will equate to £3.6m of investment in a programme that will run from April 2023.

Childhood obesity is a serious threat to the health, wellbeing and life chances of children and young people and has risen significantly during the Covid pandemic. Without intervention, childhood obesity tends to carry on into adulthood and can cause serious health complications like heart disease and diabetes.

The healthier lifestyles programme will work in partnership with local communities and builds on work that the Integrated Locality Partnerships have been championing in Gloucester and the Forest of Dean to understand family and community strengths, and what the potential barriers are to people making changes to their behaviour, such as poor mental wellbeing, financial challenges, lack of time and energy, and difficulties accessing, planning and preparing affordable healthy food.

6.2 Enhanced mental wellbeing support available for adults in the county.

A six week consultation has been undertaken to understand the public views on proposals for a new mental wellbeing service bringing together the previous helplines and well-being offers.

The service will now provide anonymous support on a drop-in basis for people experiencing mild-moderate issues with their mental and emotional wellbeing, such as anxiety, stress, or low mood; alongside support for self-harm and can be accessed over the phone or via text/webchat. It will not require a referral from a professional. Advisors will also be trained in supporting people with self-harm, and support will also be available for friends and carers.

Support for self-harm will still be available for under 18s when the contract for the current helpline ends. Children and young people wanting anonymous, ‘drop in’ support for self-harm will be signposted to the TIC+Chat helpline. TIC+ can also provide face to face counselling for young people.

6.3 Rural Mini-bus pilots

Gloucestershire County Council has launched a £1.35m rural minibus pilot in the Cotswolds

A bespoke minibus service, called The Robin commenced in the southern area of the Forest of Dean on 17 October and North Cotswolds from the 24 October.

The Robin will provide on-demand services that will fill a gap where there is no bus provision linking bus stops in hamlets or village centres to local transport hubs and train stations, making existing public transport services more accessible. Services will run from 7am until 7pm except for bank holidays and journeys can be booked over the phone or via an app.

This is a creative pilot and timely given the issues with Stagecoach in the county. The county council was one of only 17 successful local authorities that applied, to the Department for Transport's Rural Mobility Fund.

6.4 Cost of Living Support hubs

Gloucestershire County Council has brought together a wealth of information from the public and third sector, to help everyone get faster access to the support they need during the cost-of-living challenges. It is currently based online, with hardcopy alternatives being made available shortly.

The 'Support Hub' is split into five key areas - money, food, energy, warm spaces, and protecting health and wellbeing and sits alongside the launch of a warm bank offer called 'Warm and Welcome'.

This will allow residents to access free warm and welcoming spaces within libraries which will be warm places to relax with the provision of hot drinks, free access to internet and Wi-Fi, charging points for devices as well as signposting to further advice and support.

6.5 Rough Sleeping Initiative

Gloucestershire councils have been awarded £2.9 million in the latest round of the government's Rough Sleeping Initiative (RSI). The funding has been awarded to the Gloucestershire Housing Partnership, made up of the six district councils, the county council, the Integrated Care Board and Office of the Police and Crime Commissioner.

The scheme has supported a reduction in rough sleeping in the county over the past five years through a range of services that address the factors which lead to rough sleeping: ranging from help to access immediate accommodation and longer-term housing, to assistance around mental health, addictions problems and other common challenges.

People can contact StreetLink if they see anyone sleeping rough so can that outreach teams can offer them support. It can be accessed via phone on 0300 500 0914 or via the StreetLink app or website, www.streetlink.org.uk

6.6 Gloucester City Council Priorities Engagement

Gloucester City Council has launched a consultation for the proposed budget for 2023/2024 which is due to be approved in February next year. People are being asked to give their views on how the Council should spend taxpayers' money across a wide range of services including waste collections, street cleaning, combatting rough sleeping or helping to address climate change.

The council continues to deal with the financial impact of the pandemic and other budget pressures and as a result continues to look for ways to save money. Its recent move to offices above the Eastgate Shopping Centre which are owned by the council,

will see ongoing yearly savings of around £200,000. The consultation will close on 15 January 2023.

7. Integrated Locality Partnerships (ILPs) Updates

All ILP's continue to meet with good input and support from GHC and wider system partners with a number holding face to face sessions in November.

All ILPs have continued to focus on the Cost of Living crisis and the co-ordination of information across the statutory and voluntary sectors. Primary Care Networks (PCNs) are actively identifying people who are at increased vulnerability to cost of impacts and proactively send information and resources out.

The ILPs have all received the ICS Voluntary Sector Memorandum of Understanding for endorsement and have had an engagement session on the development of the Integrated Care Partnership Strategy.

Cheltenham ILP have focused on updates around the Warm Cheltenham initiative and a crowd funding approach to cover costs, strengthening Local communities grants which has seen 18 applications for health and wellbeing grants from local groups.

Forest of Dean ILP noted that Forest Voluntary Action Forum are working closely with Gloucestershire Gateway Trust who are in the process of building a consortium of schools and community groups to bid for the upcoming Children and Family Centres contracts.

Julie Mackie from the Strategy & Partnerships Directorate has been leading a group working on Childrens & Young People's Obesity and Mental Health for the last 18 months and they have been asked to present at the Kings Fund national conference on the 8 November.

Gloucester City ILP noted that the Matson Health Equalities partnership continues to meet and the Jigsaw Cooperative is to be registered as a charity.

The ILP also received an updated on the Gloucester Hospitals capital investment programme which received £44.5m of capital investment in 2018/19 for the development of the estate as follows:

- Gloucester Royal Emergency Department (ED) redevelopment which will see it increased its overall size by 58% to support the expected increase in ED activity over the next 10 years. The first phrase is due to be completed in November 2022 and rest of the extension by May 2023.
- Acute Medical Unit (AMU) will see a space expansion enabling an additional 17 beds allocated to its compliment.
- Same Day Emergency Care will see an increase in capacity of consultation rooms, patient bays (trollies/chairs) following the Dermatology service moving to the Aspen Centre
- Cheltenham General Hospital (CGH) will see 2 new operating theatres and a new day surgery unit.

8. Focus on Patient, Carer and Engagement

Children and Adolescent Mental Health colleagues speaks at the Cheltenham Literature Festival

Dr Rajesh Gowda (Consultant Psychiatrist) and Charlie Presley (Specialist Inclusion Lead) attended a 'Teenage Headspace' panel at Cheltenham Literature Festival.

They listened to students' experiences of mental health, ideas and priorities around positive mental health and discussions about what matters to young people when it comes to wellbeing.

15 Steps Challenge – Children's and Young People Services (CYPS)

Youth Experts by Experience are undertaking 15 Step Challenges across several Trust sites during November. The purpose of the 15 Step Challenge is to explore what service users think about our clinics and environments, concentrating on first impressions and experience improvement recommendations. The impressions gained during the challenge are fed back to teams so that they can change what could be better, but also celebrate what they do well.

We have 4 Youth Expert by Experiences supporting this and the final report will be shared at the Trust's CYPS Governance Meeting.

Healthwatch Survey

Gloucestershire's NHS and care providers have asked Healthwatch Gloucestershire to help identify the difficulties and barriers that exist and the improvements and solutions people would like to see with regarding to accessing digital healthcare.

This is an anonymous survey and participation can be through a group discussion, 1-1 conversation or by this link to complete a survey by 31 December 2022.

Anchor Institution Activity

GHC is progressing the development of an Anchor Institution Strategic Framework with 2 mini-workshops completed to set the scene and start to identify its purpose and issues in covering the 5 main areas of focus: Employment; Procurement and Contracting; Buildings and Estates; Environment; Partnering in Place.

The Countywide Anchor network continues to meet and is proposing a system wide Memorandum of Understanding and a Charter.

9. NEXT STEPS

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

AGENDA ITEM: 14/1122

REPORT TO: **TRUST BOARD PUBLIC SESSION – 24 November 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:

- **Receive** and **consider** the revised BAF
- **Note** the overarching risk profile for the Trust **(Page 1 BAF – Appendix 1)**
- **Consider** the issues highlighted from Board Committees for the attention on 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 BAF for 2022/23 reflects the Trust's Strategic Aims and Objectives. It is regularly reviewed by individual Executive owners and the Executive Team collectively and is considered at each round of Board Governance Committees.

- *Changes since last review:* Recent amendments made since during the last review are highlighted in red.
- *Strategic risks added or removed since last Board review (May 2022):* None
- *Movements in risk ratings since last Board review (May 2022):*

		Score
Risk 1	*Quality and Standards*	Increased from 8 to 12
Risk 5	*Workforce Wellbeing*	Increased 9 to 12
Risk 8	*Resources Targeted at Acute care*	Decrease 16 to 12
Risk 9	*Funding – National Economic Issues*	Decrease 16 to 12

- *Issues for the attention of the Board*

Risk 1	*Quality and Standards:* The majority of KPIs identified to inform the scoring of this risk are within agreed parameters excluding waiting times/access and ongoing challenges with safe staffing. In light of this and with reference to the reduction in CQC rating at Charlton Lane and impact of staffing challenges on quality, the risk score has been increased. Additional mitigations have been put in place to reflect this.	**12**
Risk 4	*Recruitment and Retention:* This risk has undergone detailed review following agreement that the target risk score be increased to 12. The rationale for this was due to those factors outside the control of the Trust including the ongoing issues with workforce supply, demand, population demographics, pay award and government decision not to adopt a national workforce. Progress with the mitigating actions was detailed in the Recruitment and Retention report to September Board.	**16**
Risk 5	*Workforce Wellbeing:* In recognition of the risk associated with, and impact of, the end of funding for the Workforce Wellbeing line in 2023, the risk score has been increased to 12.	**12**

Risks 9 and 10 relating to funding will be kept under close review as we learn more about the financial position for 2023/2024.

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 ▪ Board / Seminar ▪ Audit and Assurance Committee

Appendices:	Board Assurance Framework Q3 Review

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

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				
Quality Standards	✓	✓			1	✓	✓	✓					Quality	12	8	April 2024	8	12	12		Dir NTQ	Sept 2022	Aug 2022	Y
Research & Innovation	✓	✓	✓		2			✓	✓			✓	Quality	12	6	April 2024	8	8	8		MD	Sept 2022	Aug 2022	N
Demand for Services	✓	✓			3	✓	✓	✓				✓	Resources	16	12	April 2024	16	16	16		COO	Sept 2022	Aug 2022	N
Recruitment & Retention	✓	✓	✓		4	✓					✓		GPTW	12	~~12~~	April 2025	16	16	16		D HR& OD	Sept 2022	Aug 2022	Y
Workforce Wellbeing	✓		✓		5	✓					✓		GPTW	9	6	March 2023	9	9	12		D HR& OD	Sept 2022	Aug 2022	Y
Culture (Internal)		✓	✓		6			✓					GPTW	9	4	April 2024	6	6	6		D HR& OD	Sept 2022	Aug 2022	N
Partnership Culture		✓			7	✓		✓		✓			Board	9	6	April 2024	9	9	9		Dir S&P	Sept 2022	Aug 2022	N
Resources Targeted at Acute Care	✓	✓			8	✓	✓	✓	✓			✓	Board	16	8	April 2025	16	12	12		DoF	Sept 2022	Aug 2022	N
Funding – Nat. Econ. Issues	✓	✓	✓		9				✓	✓		✓	Board	15	10	March 2024	16	12	12		DoF	Sept 2022	Aug 2022	N
Sustainability (environment)				✓	10		✓		✓	✓			Resources	12	6	March 2024	9	9	9		Dir S&P	Sept 2022	Aug 2022	N
NHS Reorganisation	✓	✓	✓		11	✓	✓	✓	✓	✓	✓	✓	Board	9	6	March 2023	9	9	9		Dir S&P	Sept 2022	Aug 2022	N
Cyber	✓	✓	✓	✓	12	✓	✓	✓	✓	✓	✓	✓	Resources	20	8	April 2023	12	12	12		DoF	Sept 2022	Aug 2022	N

<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health</td><td>Exec Risk Owner</td><td>John Trevains, Dir NTQ</td><td>Date of review:</td><td>Oct 22</td></tr>
<tr><td>Risk ID:</td><td>01</td><td>Description:</td><td colspan="3" rowspan="2">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>Jan 23</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)
• 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
• Vacancy rates – aggregate position</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td colspan="3">1st April 2020 (Updated Mar. 22)</td><td colspan="4" rowspan="5"></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>4</td><td>12</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>4</td><td>12</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">1st April 2024 ~~2021~~</td><td colspan="4"></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">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 majority of KPIs identified to inform the scoring of this risk are within agreed parameters excluding waiting times/access and ongoing challenges with safe staffing. In light of this and with reference to the reduction in CQC rating at Charlton Lane and impact of staffing challenges on quality, the risk score has been increased. Additional mitigations have been put in place to reflect this.</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10">149/273: Eating Disorders, 165: Core CAMHS Waiting List, 180: Mental Health Act Changes, 190: Safe Staffing; 196 Demand and Capacity MH Inpatient Beds. 114: Acquired Pressure Ulcers; 114 Safeguarding. 107: Ligatures, 160: Patient Doc Storage, 211: Delayed Onward Transfer, 247: Agency and Bank Reliance, 232/243: CYPS, 222: Echocardiogram capacity. 280: Out of Area Placements, 294 C&YP with SEND, 293: ADHD/ASC Waiting List</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. Safe staffing report in quality dashboard, community services staffing data being developed. 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 and regularly review 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
6	CQC action-planning and review in response to improvements plan	Quality Committee review in June/ Board Ju.ly	DoNTQ	Ongoing

7	Ongoing review and prioritisation for recruitment focus of safer staffing hotspots	See Risk 4 (Recruitment and Retention)	DoNTQ / DHR&OD	Ongoing

Strategic Aim:			**High Quality Care** **Better Health** **Great Place to Work**	**Exec Risk Owner**	Amjad Uppal, Medical Director	**Date of review:** Oct 22
Risk ID:	**2**	**Description:**	**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	**Lead Committee**	Quality	**Date of next review:** Jan 23

Risk Rating: (Consequence x Likelihood):			
Date Risk Identified/confirmed	**1/4/20** (Updated Mar. 22)		
	Likelihood	**Impact**	**Overall**
Inherent Risk Score:	**4**	**3**	**12**
Current Risk Score:	**4**	**2**	**8**
Tolerable Risk:	**2**	**3**	**6**
Target Date to Achieve Tolerable Score	**1st April 2024**		

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

Potential or actual origin of the risk:	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.

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 draft research and innovation strategy has been considered by the Executive team and will be presented to the Board later this calendar year. As part of the strategy, a business case for the sustainable funding for a core research function is in development. Medial Lead for Innovation in place to work alongside the R&I team. There are no concerns in achieving the tolerable risk score by April 2024.

Links to Risk Register

[to be added]

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 Research4Gloucestershire – 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. CD for research for physical health
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	10/11/22	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 (Dec 2022)
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~~ (Dec 2022)
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.	Business case in development	Exec	2022/23

Return to Summary Page

Strategic Aim:			**High Quality Care** **Better Health**	**Exec Risk Owner**	David Noyes, COO	**Date of review:**	Oct 22
Risk ID:	**3**	**Description:**	**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.	**Lead Committee**	Resources	**Date of next review:**	Jan 23
Risk Rating: (Consequence x Likelihood):				**Relevant Key Performance Indicators:** (taken from the Performance Report)			
Date Risk Identified/confirmed	1st April 2020 (Updated Mar. 22)			• 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 available • Health Inequalities key metrics • User Satisfaction • Levels staff sickness • Quality Data • Covid outbreak information			
	Likelihood	**Impact**	**Overall**				
Inherent Risk Score:	**5**	**4**	**20**				
Current Risk Score:	**4**	**4**	**16**				
Tolerable Risk:	**3**	**4**	**12**				
Target Date to Achieve Tolerable Score	**1st April 2024**						
Potential or actual origin of the risk:			Risks relating to demand incorporated in previous BAFs – 2021 and 2022.				
Rationale for current score: (What is the justification for the current risk score)							
Demand for our services remains high. The pandemic and subsequent enduring pressure on has had an ongoing impact on staff wellbeing and retention. The relationship between Health and social care (and social care funding) remains to be resolved at a national level, this continues to manifest itself locally, but the system has invested in a Newton Europe diagnostic intervention which may indicate areas for improvement. To date relationships with Commissioners remain 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. We are now in the early stages of work to define the future capacity and capability required of the community estate with a view to enhancing our service offer to support independence. We maintain a full suite of service improvement plans with are regularly reviewed at operational and governance level. 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.							
Links to Risk Register							

149/273: Eating Disorders, 165: Core CAMHS Waiting List, 190: Safe Staffing; 196 Demand and Capacity MH Inpatient Beds. 211: Delayed Onward Transfer, 247: Agency and Bank Reliance, 232/243: CYPS, 222: Echocardiogram capacity. 280: Out of Area Placements, 285: Cost of Living Crisis, 294 C&YP with SEND, 293: ADHD/ASC Waiting List

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	Monhly		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	Res Comm/Board	Satisfactory	Improved integrated reporting
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	Complete – review of service improvement plans
2.	Continue work to build capacity and understanding of self-care and develop more admission avoidance schemes.	To be built into service reviews & developments. Focus on co-production for service developments to continue	COO DS&P	In progress –incremental adoption in conjunction with ILPs
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. Progressing well with improvements in data recording and quality seen.	DoF	31 March 2023
7	Consider further how health inequalities can be measured and targeted as a system (links to item 6).		Exec/ICS	
8	Development and continuation of CATU at Tewkesbury	Business case developed - decision point with commissioners	COO	**Complete**
9	Embed learning from enhanced pathway 2 project and system wide therapy review.	Project underway, full evaluation December 2022	COO	**In progress**
10	OD intervention to address length of stay for acute mental health services.	In planning stage. OD sessions to be undertaken in September. First session held 22 Sept 2022.	COO/MD	May 2023

11	Integrated reporting in newly configured performance report	Executive objective for 23/24. Service profile reports in the interim	Exec				

Strategic Aim:			**Great place to work** **Better Health** **High Quality Care**	**Exec Risk Owner**	N Savage D of HR & OD	**Date of review:**	Oct 22
Risk ID:	**4**	**Description:**	**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.	**Lead Committee**	GPTW	**Date of next review:**	Jan 22
Risk Rating: (Consequence x Likelihood):				**Relevant Key Performance Indicators:**			
Date Risk Identified/confirmed	1st April 2020 (Updated Mar. 22)			• Staff Turnover • Annual Staff and Pulse Surveys • Staff Friends and Family FFT scores • Vacancy Rates • Bank and Agency Usage • Recruitment & Retention Report – exit trends • Education & Development Report • Appraisals • Probationary periods • Statutory & Mandatory Training Update			
	Likelihood	**Impact**	**Overall**				
Inherent Risk Score:	**4**	**4**	**16**				
Current Risk Score:	**4**	**4**	**16**				
Tolerable Risk:	**3**	**4**	**12**				
Target Date to Achieve Tolerable Score	**1st April 2025**						
Potential or actual origin of the risk:	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.						

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, Executive 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 with, for example, our local RNLD degree programme only just commenced in September 2022 and the 3 Counties Medical School opening now delayed a year to Sept 2023. 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.

Links to Risk Register

149/273: Eating Disorders, 165: Core CAMHS Waiting List, 180: 247: Agency and Bank Reliance, 232/243: CYPS, 222: Echocardiogram capacity. 280: Out of Area Placements, 285: Cost of Living Crisis, 294 C&YP with SEND, 293: ADHD/ASC Waiting List

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 for RMN, RGN and AHP	17/05/22	30/01/23	Exec	Programme under monthly review.
2.	Relationships with a 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 RN LD degree training to complete i.e 2025.
3.	Recruitment Policy in place to fast track recruitment	20/04/22	01/04/23	Exec	Policy under review to accommodate TRAC developments
4.	ICS Workforce Steering Group	Ongoing	11/05/22	Exec	ICS recruitment and retention plan
5.	Wotton Lawn Task and Finish Group	24/07/22	30/09/22	Exec	Completed
6.	Health Care Support Worker Recruitment and Retention Project	24/07/22	30/10/22	Exec	Retention focus through targeting Health Care Support Worker interventions. Analysis of leaver data – Winter 2022
7.	Recruitment and Retention Strategic Framework	24/07/22	30/09/22	Exec and GPTW	Evaluation of effectiveness of action plan

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 to SSOG	L1	Monthly	Exec	Work in progress	Recruitment Strategy to be finalised
2	Staff Survey and Staff FFT	Ls 1,2 and 3	August 2022	GPTW	Satisfactory	
3	Retention Data	Ls 1 and 2	Ongoing	GPTW	Work in progress	Partnership review of data with Staff Side - scheduled for September 22 JNCF
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	Launch of Recruitment and Retention Framework.	Draft Recruitment and Retention Framework presented to GPTW Committee April 2022 and approved and launched in June 2022. R&R progress report presented to Board Sept 2022.	D HR&OD	**Complete**
2	Recruitment & Retention Premium Business case in development for higher vacancy/hard to recruit areas	Interim financial incentivisation* for Home First/Reablement, Facilities/ Mental Health (WLH)	D HR&OD	**Complete**
3	Targeted temporary staff bank recruitment and review of bank incentives	Bank rates were increased from July 1st, late booking incentives were removed. Sustained increase to the number of bank hours worked and an increase to number opting to join the bank.	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	HSCW Recruitment and Retention Project	HCSW Council launched June 2022. Joint ICS HCSW recruitment event at the end of September 2022, supported by Indeed.	D HR&OD	**April 2023 - Ongoing**

7	International Recruitment – additional partnering for RMNs	35 MH Nurses, Community ICT's: 10 Nurses, Community Hospitals: 38 Nurses	D HR&OD	Ongoing
10	Return to practice	Review opportunities to increase RTP recruits for 2023 cohort	D HR&OD	Q4
11	Remuneration Review	2022 pay review paid at end Sept. Work to calculate the implications of paying the Living Wage underway. Will require ICS and regional consultation.	D HR&OD	Q4
12	ICS Providers Cost of Living Support review	ICS wide cost Cost of Living support review commended in July 22, with further recommendations expected at end Q2.	D HR&OD	Ongoing
13	Launch International AHP Recruitment	Following the successful bid for AHP International funding we have secured NHS England support to recruit 6 Occupational Therapists (4 for ICTs, 2 for CYPS) and a Podiatrist.	DHR&OD/DNTQ	Q4
14	Maximise student placement activity for 2022	Engagement with HEIs, ICS and internal stakeholders to optimise student placement activities (in May and June for September intake)	DHR&OD	Complete
15	Improved long term nursing workforce supply modelling	A "Supply Scenario Modelling (Optioneering) Tool Scoping Workshop" is being run with Health Education England assistance.	DHR&OD	Q3

Return to Summary Page

Strategic Aim:			**Great Place to Work** **High Quality Care**		**Exec Risk Owner**	Neil Savage, D of HR&OD	**Date of review:** Oct 2022
Risk ID:	**5**	**Description:**	**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.		**Lead Committee**	GPTW	**Date of next review:** Jan 23
Risk Rating: (Consequence x Likelihood):					**Relevant Key Performance Indicators:**		
Date Risk Identified/confirmed	1st April 2020 (Updated Mar. 22)				• Staff Survey wellbeing metrics – positive action on HWB • Pulse survey data • Sickness Absence KPI • Health & Wellbeing Report		
	Likelihood	**Impact**	**Overall**				
Inherent Risk Score:	~~3~~ 4	3	~~9~~ 12				
Current Risk Score:	3	3	9				
Tolerable Risk:	2	3	6				
Target Date to Achieve Tolerable Score	**1st March 23**						
Potential or actual origin of the risk:			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.				

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

Sickness absence has climbed steadily since 2021, up to 6.4%, however reduced back to 5.4% at the end of August 2022 (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). The Trust has a dedicated Health and Wellbeing NED. A Health and Wellbeing Strategic Framework was developed this year and approved by the GPTW Committee in summer 2022, after significant engagement with colleagues to establish our workplace health and wellbeing priorities. The Trust hosts the system-wide Mental Health and Wellbeing Line, funded through NHSI/E until April 2023, our Health and Wellbeing team have been instrumental in the launch of the Health and Wellbeing Champions initiative (scheme launched in May 22). The 2021 Staff Survey results have been used to inform action plans to address areas of concern, which therefore help mitigate the risk. Colleagues rated the Trust better than the NHS-wide, South West providers and benchmark Trust group rating on "We are safe and healthy". In recognition of the risk associated with the end of funding for the Wellbeing Line in 2023, the risk score has been increased to 12.

Links to Risk Register

285: Cost of Living; 283: Verbal agression

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.	24/07/22	01/04/23	Exec & Board within Business Plan & Budget setting	
2	Health & Wellbeing Communication Plan in place – intranet, website	Ongoing	-	Exec/Board	Further communications. Launch of the HWB Strategic Framework.
3	NED Wellbeing Lead, Exec Wellbeing Lead & HWB Champions	24/07/22	30/09/22	Board	NED and Exec Wellbeing, and HWB Champions leads in place
4	Health & Wellbeing built into budget and business plan	24/07/22	31/03/23	Board	Sustainable Trust and SW funding for core OH services. MH Hub subject to long term ICS funding
5	Staff Support processes include HWB conversations – management supervisions, 121 meetings and appraisals	24/07/22	30/09/22		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	24/07/22	30/09/22		Covid support does not currently have recurrent funding. Services offered to be reviewed within updated strategy.
7	Health & Wellbeing Strategic Framework in place				

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	June 2022	GPTW	Satisfactory	
2	Internal Audit HR to review compliance with processes	L3	2022	Audit Committee	Satisfactory – following completion follow up issues	
3	Working Well Occupational Health Safe Effective Quality Review (SEQOHS) accreditation & annual assurance process	L3	Dec 2021	Exec	Satisfactory	Next SEQOHS external assessment is October 2022.
4	Employee Assistance Programme	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.	Approved by GPTW August 2022	D HR&OD	**Completed**
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**

Return to Summary Page

Strategic Aim:			**Great Place to Work** **Better Health**		**Exec Risk Owner**	N Savage, D of HR&OD	**Date of review:** Oct 22
Risk ID:	**6**	**Description:**	**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).		**Lead Committee**	GPTW	**Date of next review:** Jan 23
Risk Rating: (Consequence x Likelihood):					**Relevant Key Performance Indicators:**		
Date Risk Identified/confirmed	1st April 2020 (Updated Mar. 22)				• 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 • WDES Data • Gender Pay Gap Data • Service User Equality Access Data – when available		
	Likelihood	**Impact**	**Overall**				
Inherent Risk Score:	**3**	**3**	**9**				
Current Risk Score:	**3**	**2**	**6**				
Tolerable Risk:	**2**	**2**	**4**				
Target Date to Achieve Tolerable Score	**1st April 2024**						
Potential or actual origin of the risk:			Board Risk Seminar Jan 2021. Revised in April 2022 to incorporate description of targeted internal culture.				

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. A new Freedom To Speak Up Policy is in the final stages of development following receipt of the new national template policy. The Trust received positive compliments on its Freedom To Speak Up approach and culture in the 2022 Care Quality Commission report, noting that more publicity was still needed.

Links to Risk Register

[to be added]

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	27/09/22	31/12/22	Board	Post-merger review of effectiveness of values and behaviours
2	Just culture and appreciative enquiry processes included in performance management & Disciplinary Processes	24/07/22	30/01/23	Executive	Learning from HR casework 'lessons learnt' event and wider benchmarking
3	Valuing Difference Leadership Strategy in place	27/09/22	31/12/22	Executive	Effectiveness review (Q3)
4	Freedom to Speak Up, Speaking up at work policies	27/09/22	31/12/22	Board	Under review
5	Co-production commitment to service design	Ongoing		Board	Impacted by Covid restrictions
6	Learning and Development Strategic Framework	24/07/22			

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	Aug 2022	Exec	Satisfactory	
3	Annual Workforce Race Equality Scheme & Action Plan	Ls 2 and 3	July 2021	Board	Satisfactory	2022 plan to be presented to GPTW Oct 2022
4	Annual Disability Equality Scheme & Action Plan	Ls 2 and 3	July 2021	Board	Satisfactory	2022 plan to be presented to GPTW Oct 2022
5	Patient & Staff Surveys	Ls 1,2 and 3	Mar 2022	Board	Satisfactory	
6	Freedom to Speak Up 6 monthly report	Ls 2 and L3	Nov 2021	Board	Satisfactory	
7	Diversity Network (sub groups women, LGBTQ+, Disabled, RCAN) 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. Flourish review scheduled.	D HR&OD	**In progress**
2	Equality &Diversity Training to be updated.	New ED focussed 'safer recruitment' training implemented. E&D Training being reviewed 2021/22 and new arrangement will be implemented after the current surge and recovery, Q1 2022/23 - "Dignity at Work practice review - Just and Learning Culture"	D HR&OD	**Delayed** - 22/23 business planning objective
3	Equality & Managing Diversity Policy to be updated	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	Values and Behaviours Review survey	Scoping work with UoG commenced delivery through Qs 3 and 4.	D HR & OD	**In progress – 31/03/23**
6	Review of Apprenticeship (widening access) policy	Planned for end 2022/23	ADELD	**Not started**

Return to Summary Page

<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">Better Health</td><td>Exec Risk Owner</td><td>Angela Potter, Director of Strategy and Partnerships</td><td>Date of review:</td><td>Oct 22</td></tr>
<tr><td>Risk ID:</td><td>7</td><td>Description:</td><td colspan="3" rowspan="6">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>Jan 23</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>Date Risk Identified/confirmed</td><td colspan="2">1st April 2020 (Updated Mar. 22)</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. Not yet in place
• Working Together Advisory Group feedback</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td>Inherent Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td>Current Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td>Tolerable Risk:</td><td>2</td><td>3</td><td>6</td></tr>
<tr><td>Target Date to Achieve Tolerable Score</td><td colspan="3">1st April 2024</td><td colspan="4"></td></tr>
<tr><td colspan="4">Potential or actual origin of the risk:</td><td colspan="6">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)</td></tr>
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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 Covid 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. Working Together Advisory Group established and SDM roles in place but not sufficiently embedded to reduce the overall risk.
Links to Risk Register
[to be added]

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	
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	Ongoing recruitment has a focus on young people and physical health issues – continue to review
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. Scoping and workplan to be presented to WTAG in October	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. Ongoing recruitment programme – focus on young experts and those with physical health conditions	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

Return to Summary Page

Strategic Aim:			**Better Health** **High Quality Care**		**Exec Risk Owner**	Sandra Betney, Director of Finance	**Date of review:** Oct 22
Risk ID:	8	**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:** Jan 23
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:	**3**	**4**	**12**				
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. This remains issue of concern, due to significant acute demand and financial pressures, although resource skew is potentially mitigated by agreed MHIS. Not all community based SDF allocations are agreed, and therefore investment likely to be part year.

Links to Risk Register [to be added]

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. Relationship management mapping exercise completed and presented to Exec Team – further Board engagement ongoing	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. 3 x Executive Directors attending strategic Executives and relevant ICS Committees that have commenced	CEO	**In progress**

Return to Summary Page

Strategic Aim:			**High Quality Care** **Better Health** **Great Place to Work**	**Exec Risk Owner**	Sandra Betney D of F	**Date of review:**	Oct 23
Risk ID:	**9**	**Description:**	**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.	**Lead Committee**	Board	**Date of next review:**	Jan 23
Risk Rating: (Consequence x Likelihood):				**Relevant Key Performance Indicators:**			
Date Risk Identified/confirmed	1st April 2020 (Reviewed Mar 2022)			• NHS Funding Settlement			
	Likelihood	**Impact**	**Overall**				
Inherent Risk Score:	**3**	**5**	**15**				
Current Risk Score:	**4**	**3**	**12**				
Tolerable Risk:	**2**	**5**	**10**				
Target Date to Achieve Tolerable Score	**March 2024**						
Potential or actual origin of the risk:			Board Risk Seminar 14th Jan 2021 and elements of existing risks within the 2020/21 BAF. Reviewed and agreed maintained risk 2022.				

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

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. Whilst Gloucestershire has been able to submit a balanced plan following additional inflation pressures. There are still considerable risks to delivery and although the national pay award has been confirmed as funded there appears to be a cost pressure to the system arising from the pay awards.

Links to Risk Register

285: Cost of Living Crisis; 292; Forest of Dean

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**

Return to Summary Page

Strategic Aim:			**Sustainability**	**Exec Risk Owner**	Angela Potter, Director of S&P	**Date of review:**	Oct 22
Risk ID:	**10**	**Description:**	**Sustainability (environment)** There is a risk that responding to the climate emergency is not prioritised resulting in the failure to transform and embed green practice.	**Lead Committee**	Resources	**Date of next review:**	Jan 23
Risk Rating: (Consequence x Likelihood):				**Relevant Key Performance Indicators:**			
Date Risk Identified/confirmed	1st April 2020 (Updated Mar. 22)			• Green Plan in Place – Mar 22 • Targets/KPIs to be included in Green Plan			
	Likelihood	**Impact**	**Overall**				
Inherent Risk Score:	4	**3**	**12**				
Current Risk Score:	3	**3**	**9**				
Tolerable Risk:	2	**3**	**6**				
Target Date to Achieve Tolerable Score	**March 2024**						
Potential or actual origin of the risk:			Reflection on Strategic Aims by Executive.				

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

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. External funding becoming more challenging. Sustainability programme taking out of Capital plan to fund FoD Hospital. Status update and mapping exercise against the ICS Green plan update to be presented to October Resources Committee.

Links to Risk Register

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	ICS Sustainability Group not yet 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 22	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. Green Implementation action plan developed and Strategic Sustainability Action Group established to drive Green actions across the Trust.	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. Joint development of the ICS Green Plan bringing together all health organisations individual plans. ICS Sustainability group to be established	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

Return to Summary Page

<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health
Great Place to Work</td><td>Exec Risk Owner</td><td>Angela Potter Dir S&P</td><td>Date of review:</td><td>Oct 2022</td></tr>
<tr><td>Risk ID:</td><td>11</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 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>Jan 23</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="2">Date Risk Identified/confirmed</td><td>1st April 2020 (Updated Mar 22)</td><td colspan="4" rowspan="4">Risk wording updated July 2022 to reflect ongoing impact on exec/non-exec</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><td colspan="4" rowspan="2"></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">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">With the establishment of the ICS on 1st July 2022 directors, management and staff within the Gloucestershire health system are required to engage in revised ways of working including a new range of Board and Committee commitments whilst continuing to deliver within the already stretched capacity. 3 Execs on ICS Strategic Executive Level group.</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10"></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 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
2.	GHC membership and representation on ICB Board and Committees	July	Oct	Boards	Ensure Board receives timely reporting and mechanisms in place for 2 way communication between Boards and ICS
3.	GHC Board Reporting mechanisms	Every other month	Jan	Board	
4.	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 Strategy alignment with ICS
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	

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 perfwormance 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**
3	Develop Relationships further as ICS continues to develop	NEDs and Execs aligned to agreed ICS Committees. CEO a member of the ICB and agreed attendance at the ICS Executive	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**

Return to Summary Page

<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health</td><td>Exec Risk Owner</td><td>Sandra Betney Dir Finance</td><td>Date of review:</td><td>Oct 22</td></tr>
<tr><td>Risk ID:</td><td>12</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>Jan 23</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)
Cyber Essentials Certification</td></tr>
<tr><td colspan="2">Date Risk
Identified/confirmed</td><td colspan="3">15th March 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>4</td><td>5</td><td>20</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>2</td><td>4</td><td>8</td><td colspan="4"></td></tr>
<tr><td colspan="2">Target Date to Achieve Tolerable Score</td><td colspan="3">1 April 2023</td><td colspan="4"></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>
</table>

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. The likelihood remains high due to threat of an attack from Russian based on 'imminent threat' status from the national cyber security centre, high level score of last GHC phishing test undertaken in 2021, Log4Shell cyber-vulnerability and recent local Council cyber-attack and ransomware attack on supplier of provider EPR system. Multifactor authentication has been implemented, windows defender for office 365 for top individuals targeted for phishing, progressed as county with Log4shell work to patch system vulnerabilities. Outcome of recent phishing exercise does not support a reduction in current risk score. Cyber essentials certification place.
Links to Risk Register
135: Cyber Attack – Windows 20028; 32: IT reliance; 215: Phishing

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			
3.	Anti Virus & Advanced Threat Protection	Ongoing			
4.	Email Scanning	Ongoing			
5.	Secure Boundary	Ongoing			
6.	Cyber Tools			ICS Cyber Group	Work in progress with ICS Cyber Team
7.	Cyber Security Operations alert actions	Annual			
8.	Cyber Essentials Plus certification	Annual	Annual	Digital Group	Independent assessment/testing Oct 2022
9.	Information Governance Training and Testing	Ongoing			
10	Information Governance requirements built into system development processes	Ongoing			
11	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 22	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	Update in line with best practice required following recent internal audit.
4	Annual SIRO Report	L2	Annual – last Aug 22	Board	Satisfactory	
5	Information Governance Group Reporting	L1	Quarterly – Aug 22	Audit and Assurance Committee	Satisfactory	
6	Ad hoc cyber reports e.g. log4shell	L2	As required	Audit and Assurance Committee		More systematic reporting to Audit and Assurance Committee to commence Aug 22

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.	ICS Cyber Security Roadmap	In discussion.	DoF	**Not started**
2.	Implementation of immutable backups	Project in place with third party.	AD IT & Clinical Systems	**In progress – ~~Sept 22~~ Dec 22**
3.	Cyber focus at Trust Induction and targeted training for those requiring extra support.	Further phishing exercise planned with targeted intervention.	AD IT & Clinical Systems	**Not started**

Return to Summary Page

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

Return to Summary Page

AGENDA ITEM: 15/1122

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 24 NOVEMBER 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.	

This report is provided for:

Decision ☐ Endorsement ☐ Assurance ☑ Information ☐

The purpose of this report is to

Provide assurance to the Board:

- 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 Q1 & Q2 2022-23, 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.

This report was received and discussed at the Great place to Work Committee held on 5 October.

19 cases were raised in Q1 & 20 in Q2, a slight increase on the first two quarters of 2021-22 of 33. There was a total of 54 cases raised to the Freedom to Speak Up Guardian in 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.

2020-21 was unprecedented times and the data for 2021-22 is lower than the national figures.

Since my last report the National Guardian's Office (7 July 2022) published the latest national annual speaking up data, which summarises the themes and learning from the speaking up data shared by Freedom to Speak Up Guardians.

A positive speaking up culture is reflected nationally in the People Plan and People Promise, and locally in our strategic commitments to High Quality Care and being a Great Place to Work. It is a core component in our health and wellbeing offer, in our 'Strong Voice' commitment to colleagues, and this was reflected in our recent CQC inspection.

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

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

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?
This report was received and discussed at: • Great Place to Work Committee - 5 October 2022 • Quality Assurance Group (QAG) – 21 October 2022

Appendices:	Paul's Open-Door Data for Q1 & Q2 2022-23.

Report authorised by: John Trevains	**Title:** DoNTQ

FREEDOM TO SPEAK UP GUARDIAN UPDATE

1. 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, listened to and follow up action occurs and colleagues are feedback to with outcomes.

1.2 This paper is presented in a structured format to ensure compliance with the newly published, June 2022, Freedom to Speak Up: A guide for leaders in the NHS and organisations delivering NHS services.

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

2. ASSESSMENT OF FTSU CASES

2.1 The National Guardian's Office (7 July 2022) published the latest annual speaking up data, which summarises the themes and learning from the speaking up data shared by Freedom to Speak Up Guardians.

Since my last report the National Guardian's Office (7 July 2022) published the latest national annual speaking up data, which summarises the themes and learning from the speaking up data shared by Freedom to Speak Up Guardians

The number of cases brought to them last year remains at the record level set in 2020/21 (20,362, compared with 20,388 in 2021/22). Within our Trust this wasn't the picture as less cases were brought to the Freedom to Speak Up Guardian. Colleagues are speaking up through the Freedom to Speak Up route, although are using other routes including peer and line management support.

In total Freedom to Speak Up Guardians have handled over 75,000 cases since the National Guardian's Office first started collecting data in 2017.

Nationally the percentage of cases which were raised anonymously has reduced to 10.4%, in GHC this was 26%. Although this is higher than the national figure, very few organisations have invested in an anonymous reporting portal i.e. Work in Confidence.

In response to concerns being raised during the pandemic, the National Guardian's Office introduced a new reporting category of worker safety in 2021/22.

National data suggests that poor behaviours remain a cause for concern, with the highest proportion of all cases - over a third (32.3%) - including an element of behaviours, such as bullying/harassment**.** This is a rise from 30.1% last year. Data for this category in GHC for 2021/22 was 39%. To better understand the nature of these behaviours being reported, from April 2022, the National Guardian's Office replaced this category with two new categories: bullying and harassment, and elements of inappropriate attitudes or behaviours. GHC data for Q1&Q2 are 13% and 53%. Reflecting on the Table 2 this would indicate that our bullying and harassment data is now lower since the categories have been redefined.

Speaking up for Q1 & Q2 are detailed in Table 1. Speaking up for these periods have been received via different routes and some colleagues may also have raised more than one concern. New guidance Recording Cases and Reporting Data Guidance for Freedom to Speak Up Guardian was effective from April 2022 and only anonymity cases to the Freedom to Speak Up Guardian are to be included. Cases raised through the Work in Confidence portal to other colleagues can be found on table 5.

Table 1

Quarter 2021-22	**Number of cases raised**
Q1: April – June	18
Q2: July – September	15
Q3: October – December	10
Q4: January – March	11
Quarter 2022-23	
Q1: April – June	19
Q2: July – September	20

2.2 Themes

Table 2

	Patient safety/ quality	**Bullying and/or harassment**	**Worker safety**	**inappropriate attitudes or behaviours**	**Systems and/or process**
Q1	2	2	11	12	4
Q2	0	3	12	9	5

Some examples of speaking up in Q1 & Q2 are:

- A colleague spoke up about concerns regarding potential fraud by a member of their team. The colleague was asked to submit timesheets for authorisation and they were uncomfortable with what they perceived as lack of honesty in hours/training attended. The colleague was supported with the initial referral to the fraud team to investigate.

- A colleague shared their experiences of what they described as harassment. Their own behaviour started to change, they were afraid of being in the same work area and felt very vulnerable. This was shared with the Executive team who listened, validated and managed the speaking up experience with a 'strong moral compass' (as described by a colleague).

- The health and wellbeing of the colleague was affecting her ability to work and carry out her role due to the extreme heat in her area. She was supported to share some potential solutions regarding the air flow in the area. An aircon machine was fitted after she described as '9 years of feeling like this'. She is once again enjoying work.

Table 4

Professional Group	Q1	Q2	Total
Allied Health Professionals	3	2	5
Medical and Dental	0	1	1
Registered Nurses and Midwives	7	4	11
Administrative and clerical	1	3	4
Additional professional scientific and technical	0	0	0
Additional clinical services	7	6	13
Estates and ancillary	1	3	4
Healthcare scientists	0	0	0
Students	0	1	1
Not Known	0	0	0
Other	0	0	0

In Q1&Q2 within the Trust, additional clinical services as a group accounted for 33% of speaking up followed by registered nurses at 28%. Additional clinical services are colleagues that directly support those in clinical roles. In addition, support to nursing, allied health professionals and other scientific staff are included. They also have significant patient contact as part of their role. Within GHC this was mainly health care support workers.

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 with the governance oversight by the Freedom to Speak Up Guardian. New guidance (April 2022) states that only cases raised directly to the Freedom to Speak Up Guardians are included in the data specific to Freedom to Speak Up. Within the two most recent quarters colleagues accessed support through others not the Freedom to Speak Up Guardian via the portal.

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
Quarter 2022-23		
Q1	3	Inappropriate behaviour-1 Other-2
Q2	1	Other-1

3. PATIENT SAFETY AND/OR WORKER EXPERIENCE FEEDBACK

Feedback is requested from all colleagues whether they have had a positive experience or not. All colleagues are asked 'Given your experience would you speak up again? Yes, no or maybe'. Some narrative feedback is shared from colleagues as below from Q1 & Q2:

- Yes, I would speak up again. I took a long time thinking over whether to speak up in this instance, and it was difficult to take that step, but after I had done it, I was glad I did. I don't know if I will still feel the same in the future as it is early days and there could possibly be repercussions down the line.

- Yes - without hesitation! I was always sceptical about the idea of freedom to speak up, it didn't feel like it was something that I would ever feel the need to use. Then a colleague started acting inappropriately towards me and others so I needed to let someone know. I felt that my line manager would not have been able to help but though freedom to speak up I was able to report it anonymously and was given choices about what happened next. I was well supported throughout the process; my concerns were taken seriously and appropriate action was taken. I couldn't recommend the service enough.

- Yes, I would definitely use the Freedom to Speak Up service again. I am so impressed with the way (colleague) has got things moving. He is our Knight in Shining Armour. What a hero. Every Trust needs a (colleague). I have to say he is very easy to talk to. He is also sorting out another issue that I've asked help on. So, thank you for being there.

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)
Q1	3 (Disability 1)
Q2	0

Colleagues are further supported through dedicated health and wellbeing resources and also sign posted onto to our Equality, Diversity and Inclusion networks.

4. LEARNING AND IMPROVEMENT

- In my last report to the Trust Board in May 2022, I was able to share 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.

  I was able to share with the Care Quality Commission in our recent inspection examples where the Executive Team have been really responsive to cases of speaking up. This has happened very recently which I shared with you where the colleagues that had spoken up described feeling listened to, validated and supported through out.

- 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. This is currently being developed to identifying our own Trust areas for improvement.

  The next case review that The National Guardian's Office will be carrying out is of NHS Ambulance Trusts in England. This is in response to consistent findings that the speaking up culture in NHS Ambulance Trusts tended to be more challenged compared to other trust types. Further information can be found here.

- NHS England in June 2022 published its new and updated national Freedom to Speak Up policy, which is applicable to primary care, secondary care and integrated care systems. The refreshed materials also include learning from the previous separate versions for primary care and NHS

trusts to ensure a consistent approach, and signpost to a wider variety of support. A further webinar with NHS England is imminent to progress this policy and in the GHC it is being reviewed through the new HR Core Policy Group.

Together with NHS England, the National Guardian's Office also published new and updated Freedom to Speak Up guidance and a Freedom to Speak Up reflection and planning tool.. All trust boards are to be able to evidence this by the end of January 2024. This tool was included in a call to action with the Trust Board Development session early this month.

NHS England has launched its redesigned 'Speaking Up Support Scheme' which aims to support past and present NHS workers who have experienced an adverse impact on both their professional and personal lives. This has been supported within the Trust with colleagues' sign posted on as necessary.

- On 1st November 2022, the Board Development Session focused on Speaking Up. I was joined by Tania Hamilton our Equality, Diversity and Inclusion Lead and Neelam Mehay, Senior Manager: Speaking Up support scheme/FTSU Advocacy and Learning at NHS England. Neelam was a previous Freedom to Speak Up Guardian at The Royal Wolverhampton NHS Trust. The session covered: How to be an effective Ally for Freedom to Speak Up reflecting on data, speaking up and our own behaviours. Also there was a call to action for our Trust Board following the below from NHS England to be implemented by January 2024;

    - Freedom to speak up National policy for the NHS
    - Freedom to speak up – a guide for leaders in the NHS and planning toolkit
    - Speaking up support scheme
    - Freedom to Speak Up across the NHS - FutureNHS Collaboration Platform

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.

- 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 with work ongoing with the University of Gloucestershire to embed Freedom to Speak Up across all education pathways.

5. PROACTIVE WORK TO FURTHER IMPROVE OUR 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.

National Speak Up Month - October was National Freedom to Speak Up Month and as an organisation with colleagues we celebrated our fifth annual Speak Up Month, raising awareness of Freedom to Speak Up and the impact it can bring for patient safety, inclusion and our own wellbeing. The theme was **'Freedom to Speak Up for Everyone'** with each week having a specific focus – to Speak Up for Safety, Civility and Inclusion.

Throughout the month we highlighted the impact of a positive speaking up culture and the safety of people who use and work in our services is core to how we work.

Week 1 #SpeakUpForSafety highlighted the importance of speaking up about anything that gets in the way of great care relating to patient care and our own safety.

We will also be focusing on how we learn and improve for the benefit of patients and colleagues and that duty of candour within an organisation improves where there is a positive and open culture.

Week 2 #SpeakUpForCivility focused on being kind to colleagues and not forgetting to be kind to yourself. Civility Saves Lives say that 'Almost all excellence in healthcare is dependent on teams, and teams work best when all members feel safe and have a voice'. The new resources available within the Trust will be shared further to increase awareness.

Week 3 #SpeakUpForInclusion was about promoting inclusion and breaking down the barriers to enable us all to feel safe to speak up and be heard. This week we are also celebrating Black History Month and further promoting our staff networks.

Week 4 FTSUForEveryone brought together us all and what we can do as individuals to make a difference regardless of job role, background or circumstance. The focus was on refreshing our champion network and inviting new colleagues to be champions (this was a strong ask from the engagement strategy sessions). The offer will be for support and training with ongoing development, a Champion Network at GHC (aiming to develop one in the South West with other Guardians) with learning opportunities and celebrations too. Further promotion of speaking up, eLearning and how we can all make a pledge.

Throughout the month we also promoted the Staff Survey to give everyone a voice.

Freedom to Speak Up Strategic Framework – An initial draft was shared with colleagues during Speak Up Month to further collaborate on its development and also will link to the national reflection too. This will include agreeing on a 3-year plan of objectives, actions and measures of success.

Civility Saves Lives – Harm from disrespect has been identified as the next frontier in patient safety efforts (Clark 2019), and fostering a culture of civility and respect within GHC further supports the delivery of our values and behaviours.

This programme is progressing with resources available on our intranet for colleagues. These resources for awareness raising include 'The Power of Civility in Healthcare', how civility leads to better outcomes and the training available on Care to Learn. Many teams are requesting support for sessions on this work to gain a greater understanding.

A coproduction approach continues with four teams to design and implement a quality improvement programme of Civility Saves Lives, and drive behavioural change and associated benefits for patient safety to be a great place to work. The teams are Charlton Lane Hospital, Forest of Dean Hospitals, Estates and Facilities, and Information Technology and Clinical Systems. Three of the four team initial quality improvement sessions have taken place this month.

The causes of incivility in each team have been explored and the impact this is having on their own health and wellbeing which will then impact patient safety. A reflective fishbone was completed on potential incidences of rudeness from the previous 12 months and the themes emerging are processes, environment, people and patients.

With support from organisational development team, a working group will design how they capture baseline data around rudeness in a safe way to ensure staff and patient psychological safety. This will include goals, change ideas and data/results to demonstrate improvement.

NHS Patient Safety Strategy - Safer culture, safer systems, safer patients - The foundations for safer care: to realise this vision the NHS will build on 2 foundations, a patient safety culture and a patient safety system.

'Culture change cannot be mandated by strategy, but its role in safety cannot be ignored. 'Just cultures' in the NHS are too often associated with fear and blame. Fear is still too prevalent across the NHS, particularly in relation to involvement in patient safety incidents.

Within this the features of a strong patient safety culture links to highlighted work of Psychological Safety for staff, Diversity, compassionate leadership, being open to learning and at its core a positive culture requires kindness and civility.

Within the Trust there are many enablers currently in place to further develop a positive patient safety culture, freedom to Speak Up eLearning and specific modules within the Thrive Leadership Development Programme to name a few.

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 – I continue to Co-Chair the South West Freedom to Speak Up Guardian Regional Network, offering leadership peer support and advice. I have submitted my intention to the National Guardian's Office to step down from the 1st April 2023.

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
Quarter 2022-23		
Q1: April - June	34	7
Q2: July - September	26	6

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
Q1	0	4	1	0	11	1	1	4
Q2	1	3	9	1	10	2	8	2

- Several issues raised around Petrol costs and mileage, alongside issue with overtime payments and payment adjustments
- Several issues raised around communications about a proposed restructure and how staff were not engaged before the announcement was made
- Several suggestions around staff uniform changes
- Continued comments around parking at EJC
- Compliments about specific managers and how well they support their teams
- Thanks for the thank you days
- Several suggestions for example having a 'Big Shout Out' weekly email to all trust colleagues.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 16/1122

REPORT TO: **TRUST BOARD PUBLIC SESSION – 24 November 2022**

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

AUTHOR: Anna Hilditch, Assistant Trust Secretary

SUBJECT: **CHANGES TO THE TRUST CONSTITUTION**

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 present the Board with the proposed revisions to the Trust Constitution for approval.

Recommendations and decisions required

The Board is asked to:

- **Approve** the changes to the Trust Constitution.

Executive summary

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

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

There are some areas of the Constitution where a more significant change has been made, and these sections are highlighted within the Constitution which is attached as an appendix. These changes have previously been discussed and supported by the Trust's Executive Team and the Governors' Nominations and Remuneration Committee.

Risks associated with meeting the Trust's values

Corporate considerations	
Quality Implications	
Resource Implications	
Equality Implications	

Where has this issue been discussed before?
Nominations and Remuneration Committee (1 Nov) Executive Team (8 Nov)

Appendices:	App 1 - Trust Constitution – November 2022 App 2 – Procedural sections being transferred to Standing Orders

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

CHANGES TO TRUST CONSTITUTION

1. INTRODUCTION

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

2. PROPOSED CHANGES

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

2.2 There are some areas of the Constitution where a more significant change has been made, and these sections are highlighted below, and within the Constitution which is attached as an appendix. These changes have previously been discussed and supported by the Trust's Executive Team and the Governors' Nominations and Remuneration Committee.

2.3 The key changes are as follows:

- Additional restrictions on Membership **(Section 8)**
- Clarification on the tenure of Appointed Governors **(Section 12 and Annex 3)**
- NED and Chair Terms of Appointment **(Section 28)** - The Constitution was updated as part of the Trust merger in October 2019 to reflect the different terms of appointment and provisions to be applied to the Non-Executive Directors and Trust Chair. This related to those NEDs joining the newly formed Trust from 2gether (the acquiring Trust) and GCS (the acquiree). The current wording used in the Constitution means that those NEDs appointed by 2gether, could be appointed in exceptional circumstances for an additional period of 3 years over and above their original 6-year appointment (subject to annual reviews). Those NEDs appointed by GCS, or directly to GHC do not have the same right to have their appointments extended, even in exceptional circumstances. The current wording also makes no reference to the possible extension of the Trust Chair, only NEDs. By way of providing equity for all NEDs, and in line with the NHS Code of Governance, it is proposed that the Constitution at section 28 is updated accordingly.

2.4 The Constitution has also been updated to change all references from NHS Improvement (NHSI) to NHS England (NHSE) throughout.

2.5 Those procedural sections moved out of the main Constitution into the Standing Orders are:

- Council of Governors - standards of business conduct
- Interest of officers in contracts
- Canvassing of Directors
- Relatives of Directors or Officers

3. NEXT STEPS

3.1 The Constitution will undergo a further review in early 2023 once the new NHS Code of Governance comes into effect, to ensure that it remains compliant and in line with good practice.

3.2 The approval of the revised Constitution is a two-stage process which requires
(i) approval of the Board; and
(ii) the Council of Governors

3.3 If approved by the Board, the revised Constitution will be presented at the Council of Governors meeting on 1 December for approval.

3.4 Once approval has been received, the revised Constitution will then be updated on the Trust's website and sent to NHSE. As the proposed changes to the Constitution do not relate to an amendment to the powers or duties of the Council of Governors, these changes will not require presentation and approval at the next Annual Members' Meeting.

4. RECOMMENDATIONS

4.1 The Trust Board is asked to **approve** the changes to the Trust Constitution.

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST

Constitution

November 2022

GHC NHS Foundation Trust Constitution

TABLE OF CONTENTS

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1. Introduction

1.1 The name of the foundation trust is Gloucestershire Health and Care NHS Foundation Trust (the Trust). The Trust is a public benefit corporation authorised under the NHS Act 2006, with effect from 1 July 2007 under its former name of 2gether. The functions of the Trust are conferred by this legislation.

1.2 The headquarters of the Trust is Edward Jenner Court, 1010 Pioneer Avenue, Brockworth, Gloucester GL3 4AW.

1.3 As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable.

2. Principal purpose and other purposes

2.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

2.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

2.3 The Trust may provide goods and services for any purposes related to:

(a) the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

(b) the promotion and protection of public health

2.4. The Trust may also carry out activities other than those mentioned in paragraphs 2.1 to 2.3 above for the purpose of making additional income in order to better carry out its principal purpose.

2.5 Without prejudice to the principal purpose, the Trust may:

2.5.1 fulfil the social care functions of any local authority as specified by an agreement under Section 75 of the 2006 Act;

2.5.2 provide goods and services, including education, training and research and other facilities for purposes related to the provision of health care, in accordance with its statutory duties and the terms of the Trust's authorisation;

2.5.3 carry out research in connection with the provision of health care and make facilities and staff available for the purposes of education, training or research carried out by others

which together shall be the Trust's other purposes; and

2.5.4 form, acquire an interest in, invest in, participate in, and dispose of any interest in, joint ventures and partnerships, whether incorporated or not, carrying out any activity the Trust is authorised to carry out.

2.6 The Trust may also carry out activities other than those mentioned in paragraph 2.5 above subject to any restrictions in the terms of the 2006 Act and provided they do not conflict with the Trust's principal or other purposes. These activities must be for the purpose of making additional income available in order to carry out the Trust's principal purpose.

3. Powers

3.1 The powers of the Trust are set out in the 2006 Act.

3.2 The powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

3.3 Any of these powers may be delegated to a committee of directors, or to an executive director.

4. Membership and constituencies

4.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

(a) a public constituency or

(b) a staff constituency

5. Application for membership

5.1 An individual who is eligible to become a member of the Trust by virtue of living in the Public Constituency may do so on application to the Trust.

5.2 It is the responsibility of members to ensure their eligibility and not the Trust, but if the Trust is on notice that a member may be disqualified from membership, they shall carry out all reasonable enquiries to establish if this is the case.

6. Public Constituency

6.1 An individual who lives in the area specified in Annex 1 as the area for a Public Constituency may become or continue as a member of the Trust.

6.2 Those individuals who live in an area specified as an area for any public constituency are referred to collectively as the Public Constituency.

6.3 The minimum number of members in each area for the Public Constituency is specified in Annex 1.

6.4 An eligible individual shall become a member upon entry to the membership register pursuant to an application by them.

6.5 On receipt of an application for membership and subject to being satisfied that the applicant is eligible the Trust shall cause the applicant's name to be entered in the Trust's register of members

Termination of membership

6.6 A member shall cease to be a member of the Public Constituency if they –

(a) submits their resignation in writing to the Trust

(b) cease to live in the area specified as the Public Constituency

(c) fail or cease to fulfil the requirements set out in paragraph 8 of this constitution.

6.7 At the discretion of the Trust, where a member consistently fails to respond to requests to confirm interest in continuing membership, the Trust may remove the member's name from the register of members

7. Staff Constituency

7.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

(a) They are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

(b) They have been continuously employed by the Trust or a recognised predecessor under a contract of employment for at least 12 months.

7.2 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

7.3 The Staff Constituency shall be divided into 3 descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

7.4 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

Automatic membership by default – staff

7.5 An individual who is eligible to become a member of the Staff Constituency

shall become a member of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless they inform the Trust that they do not wish to do so.

7.6 On being satisfied that the applicant is eligible the Trust shall cause the applicant's name to be entered in the Trust's register of members

Termination of membership

7.7 A member shall cease to be a member of the Staff Constituency if they –

(a) submit their resignation from membership in writing to the Trust;

(b) leave the Trust's employment; or

(c) fail or cease to fulfil the requirements set out in paragraph 8 of this constitution.

7.8 Members who are no longer eligible to be members of the Staff Constituency by virtue of having left the employment of the Trust may apply to become members of the appropriate Public Constituency.

8. Restriction on membership

8.1 An individual member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

8.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

8.3 An individual may not become or continue as a member of the Trust where in the last five years they have perpetrated a serious incident of violence towards any facilities of the Trust, or against any of the Trust's employees or registered volunteers, or staff contracted to provide a service for the Trust in association with their employment with the Trust, or the Trust's patients or visitors. Such incidents may be further defined in an applicable Trust policy. Notwithstanding anything contained in this constitution, no person who ceases to be a member of the Trust pursuant to this paragraph shall be re-admitted to membership except by a decision of the Board of Directors.

8.4 An individual may not become or continue as a member of the Trust if, in the opinion of the Board of Directors, and after following any applicable procedures as required by this constitution, there are reasonable grounds to believe that they are likely to act in a way that is detrimental to the interests of the Trust.

8.5 An individual must be at least 11 years old to apply to become a Public member of the Trust.

9. Annual General Meeting

9.1 The Trust shall hold an annual meeting of its members (Annual General Meeting). The Annual General Meeting shall be open to members of the public.

10. Council of Governors – composition

10.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed governors.

10.2 The composition of the Council of Governors is specified in Annex 3.

10.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

Appointed Governors

10.4 There shall be up to five Appointed Governors, as set out in Annex 3 of this constitution.

11. Council of Governors – election of governors

11.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules.

11.2 The Model Election Rules, as published by the Department of Health and Social Care from time to time, shall be deemed part of this constitution.

11.3 A variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this constitution for the purposes of paragraph 46 of the constitution (Amendment of the Constitution). For the avoidance of doubt, the Trust cannot amend the Model Election Rules.

11.4 An election, if contested, shall be by secret ballot.

12. Council of Governors – tenure

12.1 An elected governor may hold office for an initial period of up to 3 years.

12.2 An elected governor shall be eligible for re-election at the end of their term for one further period of up to 3 years. They may not hold office for longer than 2 consecutive terms, regardless of the length of each term.

12.3 An elected governor who has completed two consecutive terms of office at the Trust shall be eligible to stand again for election following a break of at least 3 years.

12.4 An elected governor shall cease to hold office if they cease to be a member of the constituency or class by which they were elected.

12.5 A Local Authority Appointed Governor may hold office until they are replaced by the organisation which nominated them, or until the appointing organisation withdraws its sponsorship, whichever is the sooner.

12.6 Subject to paragraph 12.7, an appointed governor who is not a Local Authority Appointed Governor:

12.6.1 may hold office for an initial period of up to 3 years;

12.6.2 shall be eligible for re-appointment at the end of their term for one further period of up to 3 years. They may not hold office for longer than 2 consecutive terms, regardless of the length of each term; and

12.6.3 in respect of an appointed governor who has completed two consecutive terms of office at the Trust, shall be eligible to stand again for election or re-appointment following a break of at least 3 years.

12.7 An appointed governor who is not a Local Authority Appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of them.

13. Council of Governors – disqualification and removal

13.1 The following may not become or continue as a member of the Council of Governors:

13.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

13.1.2 a person who has made a composition or arrangement with, or granted a Trust deed for, his/her creditors and has not been discharged in respect of it;

13.1.3 a person who within the preceding five years has been convicted in the British Isles of any offence where a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her.

13.1.4 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986).

13.1.5 a person who has within the preceding two years been dismissed, other than for reasons of redundancy or sickness, from any paid employment with a health service body.

13.1.6 a person whose tenure of office as the chairman or as a member or director of a health service body has been terminated on the grounds

that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest

13.1.7 a person who is an executive or non-executive director of the Trust

13.1.8 a person who is an executive director or non-executive director of another health service body, save where the Chair and Chief Executive are satisfied that any proposed or existing concurrent appointment would not constitute a conflict of interests which could not be managed or avoided.

13.1.9 a person who is a governor of another health service body, save where the Chair and Chief Executive are satisfied that any proposed or existing concurrent appointment would not constitute a conflict of interests which could not be managed or avoided.

13.1.10 a person who is undergoing a period of disqualification from a statutory health or social care register. This provision shall not apply where a person's registration lapses or their name has been removed at their own request, for example following retirement.

13.1.11 a person subject to a director's disqualification order made under the Company Directors Disqualification Act 1986

13.1.12 a person who has been disqualified from being a member of a relevant authority under the provisions of the Local Government Act 2000

13.1.13 a person who has not attained the age of 16 at the date they are nominated for election or appointment.

13.1.14 in the case of an appointed governor, a person whose appointing body withdraws its sponsorship of the governor.

13.1.15 in the case of an elected governor, a person who ceases to be a member of the constituency or class of constituency that they represent.

13.1.16 a governor who has failed to abide by the Trust's Code of Conduct for Governors.

13.1.17 a person who is the subject of an Order under the Sexual Offences Act 2003, or any subsequent legislation.

13.1.18 a person who is included in any barred list maintained by the Disclosure and Barring Service (or any successor body) or any equivalent list maintained under the laws of Scotland or Northern Ireland

13.1.19 a person who is a vexatious complainant as determined in accordance with the Trust's complaints procedure

13.1.20 a person who has been abusive or violent towards Trust staff or contractors;

13.2 Following election or appointment, and henceforth on an annual basis, governors shall be required to confirm that they are not disqualified from the office of Governor under any provision within section 13 of this Constitution.

13.3 Where a person has been elected or appointed to be a governor and subsequently becomes disqualified for appointment, they shall notify the Trust Secretary in writing of such disqualification at the earliest opportunity.

14. Termination of tenure

14.1 If it comes to the notice of the Trust Secretary (either at the time of the governor's appointment or later) that the governor is disqualified under the provisions of paragraph 13 of this constitution, they shall immediately declare that the person in question is disqualified and notify them in writing to that effect. Upon receipt of any such notification, that person's tenure of office, if any, shall be terminated and they shall cease to act as a governor.

14.2 A governor may resign from office at any time during the term of that office by giving notice in writing to the Trust Secretary.

14.3 If a governor fails to attend three consecutive general meetings of the Council of Governors their tenure of office is to be terminated at the next meeting unless the other governors (by a simple majority) are satisfied that:-

(a) the absence was due to a reasonable cause; and

(b) they will be able to start attending meetings of the Council of Governors again within such a period as they consider reasonable.

14.4 The Council of Governors may terminate the tenure of a governor (regardless of their record of attendance), by a three quarters majority of the Council of Governors voting, if it is satisfied that they:

14.4.1 have failed to sign and deliver to the Trust Secretary a statement in the form required confirming acceptance of the Code of Conduct for Governors

14.4.2 have expressed opinions which are incompatible with the values of the Trust

14.4.3 have acted or persist in acting in a manner prejudicial to the best interests of the Trust

14.5 Standing Orders shall provide for the procedure to be adopted in connection with motions to terminate the tenure of governors.

15. Vacancies

15.1 Where membership of the Council of Governors ceases within 12 months of election, public and staff governors shall be replaced by the candidate in the same constituency and class with the next highest number of votes at the last election. If the vacancy cannot be filled by this method the Trust will commence another election process at the earliest opportunity, in accordance with the Model Election Rules.

15.2 Appointed governors are to be replaced in accordance with the processes set out in the relevant paragraphs of this constitution.

16. Council of Governors – duties and responsibilities

16.1 The general duties and responsibilities of the Council of Governors are –

(a) to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and

(b) to represent the interests of the members of the trust as a whole and the interests of the public

16.2 The trust will take steps to ensure that governors are equipped with the skills and knowledge they require in their capacity as such.

16.3 The specific powers and duties of the Council of Governors are:

16.3.1 in a general meeting to:

(a) appoint or remove the Chair of the Trust and the other non-executive directors. The removal of the Chair or a non-executive director shall require the approval of three quarters of the total number of governors;

(b) approve the appointment of the Chief Executive of the Trust by the non-executive directors;

(c) decide the remuneration and allowances and the other terms and conditions of office of the non-executive directors;

(d) appoint or remove the Trust's auditor;

(e) receive and consider the Trust's annual accounts, any auditor's reports on those annual accounts, and the annual report of the Board of Directors no later than September each year;

(f) appoint one of the non-executive directors to be the deputy Chair of the Trust, following a recommendation by the Trust Chair.

16.3.2 to be consulted by the Board of Directors regarding the information to be included in the Trust's annual plan;

16.3.3 to respond as appropriate when consulted by the Board of Directors;

16.3.4 to require one or more directors to attend a meeting of the Council of Governors for the purpose of obtaining information about the trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or the directors' performance);

16.3.5 to approve the entering into of any significant transaction;

16.3.6 to authorise an application for a merger, acquisition, separation or dissolution of the Trust;

16.3.7 to exercise such powers and to discharge such other duties as may be conferred on the Council of Governors under this constitution.

16.4 Where the Council of Governors believes it to be necessary it may appoint co-opted advisors. It may seek nominations for co-opted advisors from voluntary and community sector organisations operating in any field connected to the work of the Trust.

16.5 Co-opted advisors may speak at meetings of the Council of Governors but may not vote and will not count towards any quorum.

16.6 The co-opted advisors are to be appointed by the Council for such period and in accordance with such process as may be approved by the Council of Governors at a general meeting.

17. Council of Governors – meetings of governors

17.1 The Trust Chair (i.e. the Chair of the Board of Directors, appointed in accordance with the appropriate provisions of this constitution) or, in their absence the Deputy Chair (appointed in accordance with the appropriate provisions of this constitution), shall preside at meetings of the Council of Governors. In the absence of the Trust Chair and Deputy Chair a non-executive director nominated by the Trust Chair shall preside at meetings of the Council of Governors.

17.2 An absent governor may not vote at a meeting of the Council of Governors, save in exceptional circumstances where alternative arrangements have been agreed in advance with the Trust Chair on advice of the Trust Secretary as provided for in the Standing Orders. Absence is defined as being not present

(either physically or via teleconference, video conference or other electronic means) at the time of the vote.

17.3 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

17.4 The Council of Governors is to hold up to 6 scheduled meetings per year.

18. Council of Governors – committees and sub-committees

18.1 The Council of Governors may appoint committees consisting of its own members to assist in carrying out the functions of the Council of Governors. A committee appointed under this paragraph may appoint a sub-committee where permitted by that committee's terms of reference.

19. Council of Governors – referral to the Panel

19.1 In this paragraph, 'the Panel' means a panel of persons appointed by NHS England to which a governor of an NHS foundation trust may refer a question as to whether the Trust has failed or is failing –

(a) to act in accordance with its own constitution

(b) to act in accordance with the provision made by or under Chapter 5 of the 2006 Act

19.2 A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

20. Declarations of Governors' interests and register of interests

20.1 Each governor has a duty to avoid a situation in which the governor has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

20.2 Each governor has a duty not to accept any benefit from a third party by reason of being a governor (save for low value gifts and hospitality as permitted by the Trust's policy on Managing Conflicts of Interest) for doing (or not doing) anything in that capacity. Where such a benefit is offered to a governor, the governor must decline that offer and report the matter to the Trust Secretary.

20.3 If a governor has a pecuniary, personal, family, loyalty or other interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor must declare such interests as soon as they become aware of them, in accordance with policies agreed from time to time by the Trust in respect of conflicts of interest.

20.4 Examples of interests which should be declared include, but are not limited to:

(a) directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).

(b) ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

(c) majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.

(d) an office or position of authority in another organisation in the field of health and social care.

(e) any connection with a voluntary or other organisation contracting for NHS services.

(f) research funding/grants that may be received by an individual or their department.

(g) interests in pooled funds that are under separate management.

(h) any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks.

(i) membership of clubs, societies or organisations whose purpose may include furthering the business or personal interests of their members by undeclared or informal means. Such organisations include Masonic lodges and societies whose membership consists of professional and business people.

(j) any other commercial interest in a matter under discussion at a meeting of the Council of Governors.

(k) any other employment or business or other relationship of theirs, or of a member of their family or of someone with whom they have a close personal relationship, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

20.5 At the time any interest is declared, it should be recorded in the Council of Governors minutes as appropriate. Any changes in interests should be declared at the next Council of Governors meeting following the change occurring. Governors must inform the Trust Secretary in writing within 7 days of becoming aware of the existence of any relevant or material interest.

20.6 Governors' directorships of companies or ownerships/directorships in companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in subsequent annual reports.

20.7 The Chair may exclude a Governor from a meeting (or part thereof) of the Council of Governors, or any committee of the Council of Governors, where any contract, proposed contract or other matter in which they are determined by the Chair to have an interest, is under consideration.

20.8 In the case of family or close personal relationships the interest of one party shall, if known to the other, be deemed for the purposes of this paragraph 20 to be also an interest of the other.

20.9 If Governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair or Trust Secretary. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

Register of governors' interests

20.10 The Trust Secretary will ensure that a register of interests is established to record formally declarations of interests of governors. In particular the register will include details of all directorships and other relevant and material interests which have been declared, as defined in the relevant Trust policy on Managing Conflicts of Interests.

20.11 The details of governors' interests recorded in the register will be kept up to date by the Trust Secretary who will ensure any changes to interests declared are incorporated promptly.

20.12 The register will be available to the public and the Chair will take reasonable steps to bring the existence of the register to the attention of the local population and to publicise arrangements for viewing it.

20.13 The register of governors' interests will be reviewed by the Audit Committee at least annually.

21. Council of Governors – travel expenses

21.1 The Trust may pay travelling and other reasonable expenses to members of the Council of Governors at rates determined by the Trust.

22. Council of Governors – remuneration

22.1 Governors are not permitted to receive remuneration.

23. Code of Conduct for Governors

23.1 The Council of Governors will adopt its own Code of Conduct for Governors.

24. Council of Governors – Standing Orders

24.1 The Council of Governors will adopt Standing Orders for the practice and procedure of the Council of Governors. Such Standing Orders will NOT form part of this constitution and any amendments to Standing Orders shall not constitute a variation of the terms of this constitution for the purposes of the paragraph relating to amendment of the constitution.

25. Board of Directors – composition

25.1 The Trust is to have a Board of Directors, which shall comprise both executive and non-executive directors.

25.2 The Board of Directors is to comprise:

(a) a non-executive chair; and,

(b) no fewer than 5 but no more than 7 other non-executive directors; and

(c) no fewer than 5 but no more than 7 executive directors.

25.3 One of the executive directors shall be the Chief Executive.

25.4 The Chief Executive shall be the Accounting Officer.

25.5 One of the executive directors shall be the finance director.

25.6 One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

25.7 One of the executive directors is to be a registered nurse or a registered midwife.

25.8 The aggregate number of non-executive directors (including the Trust Chair) is to be more than half of the Board of Directors.

26. Board of Directors – general duty

26.1 The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

27. Board of Directors – qualification for appointment as a non-executive director

27.1 A person may be appointed as a non-executive director only if –

(a) they are a member of the Public Constituency, and

(b) they are not disqualified by virtue of any other provision set out in the constitution.

28. Board of Directors – appointment and removal of the Trust Chair and other non-executive directors

28.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Trust Chair and the other non-executive directors. A nominations committee shall be established to make recommendations to the Council of Governors in respect of appointments made under this provision.

28.2 The Trust Chair and other non-executive directors are to be appointed by the Council of Governors following a process of open competition, as agreed by the Nominations and Remuneration Committee.

28.3 Non-Executive directors (including the Trust Chair):

(a) subject to paragraph 28.3(b), shall be appointed for an initial term of up to 3 years, and may be reappointed at the end of that term for a further term of up to 3 years, subject to a maximum of 6 consecutive years. Any proposed re-appointment shall be subject to satisfactory performance appraisal carried out in accordance with procedures which the Council of Governors has approved; and

(b) in exceptional circumstances may be reappointed for further term(s) of 1 year beyond the term(s) set out in paragraph 28.3(a), up to a maximum of 3 consecutive years in total. Any proposed reappointment under this paragraph shall be subject to annual re-appointment, rigorous review and a satisfactory appraisal carried out in accordance with procedures which the Council of Governors has approved.

28.4 Removal of the Trust Chair or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

29. Board of Directors – appointment and powers of Deputy Chair

29.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the current non-executive directors as Deputy Chair, on recommendation of the Trust Chair.

29.2 Any director so appointed may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair. The Council of Governors may thereupon appoint another non-executive director as Deputy Chair in accordance with the provisions of this Constitution.

29.3 Where the Chair has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Deputy Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes his/her duties, as the case may be; and references to the Chair in this

constitution shall, so long as there is no Chair able to perform those duties, be taken to include references to the Deputy Chair.

30. Board of Directors - Senior Independent Director

30.1 The Board of Directors shall appoint one of the independent non-executive Directors to be the Senior Independent Director, in consultation with the Council of Governors. The Senior Independent Director should be available to members and Governors if they have concerns which contact through the normal channels of Chair, Chief Executive or Finance Director has failed to resolve or for which such contact is inappropriate.

31. Board of Directors - appointment and removal of the Chief Executive and other executive directors

31.1 The non-executive directors shall appoint or remove the Chief Executive.

31.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

31.3 A committee consisting of the Trust Chair, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

32. Board of Directors – disqualification

32.1 The following may not become or continue as a member of the Board of Directors:

32.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

32.1.2 a person who has made a composition or arrangement with, or granted a Trust deed for, his/her creditors and has not been discharged in respect of it.

32.1.3 a person who within the preceding five years has been convicted in the British Isles of any offence where a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her.

32.1.4 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986).

32.1.5 in the case of a non-executive director, a person who is no longer a member of the public constituency.

32.1.6 a person who has within the preceding two years been dismissed, otherwise than by reason of redundancy or ill health from any paid employment with a health service body.

32.1.7 a person whose tenure of office as a chairman or as a member or director of a health service body has been terminated on the grounds that their appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

32.1.8 a person who is undergoing a period of disqualification from a statutory health or social care register. This provision shall not apply where a person's registration lapses or their name has been removed at their own request, for example following retirement.

32.1.9 a person who has been disqualified from being a member of a relevant authority under the provisions of the Local Government Act 2000

32.1.10 a person subject to a director's disqualification order made under the Company Directors Disqualification Act 1986

32.1.11 a person who is the subject of an Order pursuant to the Sexual Offences Act 2003 or any subsequent legislation.

32.1.12 a person who is included in any barred list maintained by the Disclosure and Barring Service (or any successor body) or any equivalent list maintained under the laws of Scotland or Northern Ireland

32.1.13 a person who does not meet, either upon appointment or subsequently, the Fit and Proper Person Requirements for directors, as specified in the Trust's provider licence.

32.1.14 a person who is a governor of another health service body, save where the Chair and Chief Executive are satisfied that any proposed or existing concurrent appointment would not constitute a conflict of interests which could not be managed or avoided.

32.1.15 a person who is an executive director or non-executive director of another health service body. This exclusion shall not apply in the context of any joint appointments in contemplation of a merger or acquisition in accordance with section 56/section 56A of the 2006 Act, or in the context of a joint local health system-wide appointment, or where the Chair and Chief Executive are satisfied that any proposed or existing concurrent appointment would not constitute a conflict of interests which could not be managed or avoided.

32.1.16 a person who is a vexatious complainant as determined in accordance with the Trust's complaints procedure

32.1.17 a person who has been abusive or violent towards Trust staff or contractors;

33. Board of Directors – meetings

33.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

33.2 Before holding a meeting in public, the Board of Directors must send a copy of the agenda to the Council of Governors. As soon as practicable after holding a meeting, the Board must send a copy of the minutes to the Council of Governors.

34. Board of Directors – standing orders

34.1 The Board will adopt Standing Orders for the practice and procedure of the Board of Directors. Such Standing Orders will NOT form part of this constitution and any amendments to Standing Orders shall not constitute a variation of the terms of this constitution for the purposes of the paragraph relating to amendment of the constitution.

35. Declarations of directors' interests and register of interests

35.1 The duties that a director of the Trust has by virtue of being a director include in particular:

35.1.1 A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

35.1.2 A duty not to accept a benefit from a third party by reason of being a director, (save for low value gifts and hospitality as permitted by the Trust's policy on Managing Conflicts of Interest) for doing (or not doing) anything in that capacity. Where such a benefit is offered to a director, the director must decline that offer and report the matter to the Trust Secretary.

35.1.3 If a director has a pecuniary, personal, family, loyalty or other interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Board, the director must declare such interests as soon as they become aware of them to the Trust Secretary and to the Board in accordance with policies agreed from time to time by the Trust in respect of Managing Conflicts of Interest.

35.2 Examples of interests which should be declared include, but are not limited to:

(a) directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).

(b) ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

(c) majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.

(d) an office or position of authority in another organisation in the field of health and social care.

(e) any connection with a voluntary or other organisation contracting for NHS services.

(f) research funding/grants that may be received by an individual or their department.

(g) interests in pooled funds that are under separate management.

(h) any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks.

(i) membership of clubs, societies or organisations whose purpose may include furthering the business or personal interests of their members by undeclared or informal means. Such organisations include Masonic lodges and societies whose membership consists of professional and business people.

(j) any other commercial interest in a matter under discussion at a meeting of the Board.

(k) any other employment or business or other relationship of their, or of a member of their family or of someone with whom they have a close personal relationship, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

35.3 At the time any interest is declared, it should be recorded in the Board minutes as appropriate. Any changes in interests should be declared at the next Board meeting following the change occurring. Directors must inform the Trust Secretary in writing within 7 days of becoming aware of the existence of any relevant or material interest.

35.4 Directors' directorships of companies or ownership/directorship of companies likely or possibly seeking to do business with the NHS should be published in the Board's annual report. The information should be kept up to date for inclusion in subsequent annual reports.

35.5 Where the Trust Chair or chair of a Board committee determines that a director has an interest in any contract, proposed contract or other matter under consideration, the director may be excluded from that meeting or part thereof.

35.6 The Trust Board may exclude the Chair or a director of the Board from a meeting of the Board while any contract, proposed contract or other matter in which they have an interest is under consideration.

35.7 In the case of family or close personal relationships the interest of one party shall, if known to the other, be deemed for the purposes of this paragraph 35 to be also an interest of the other.

35.8 If directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair or Trust Secretary. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

35.9 The duty to avoid a conflict of interest is not infringed if the matter has been authorised in advance by the Trust Board.

35.10 In relation to the duty not to accept a benefit from a third party, 'third party' means a person other than:

(a) the Trust, or

(b) a person acting on its behalf.

35.11 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

35.12 Any declaration required by this paragraph must be made before the Trust enters into the transaction of arrangement.

35.13 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

35.14 A director need not declare an interest –

35.14.1 If, or to the extent that, the directors are already aware of it;

35.14.2 If, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered –

(a) by a meeting of the Board of Directors, or

(b) by a committee of the directors appointed for the purpose under the constitution.

35.15 Any remuneration, compensation or allowance payable by the Trust to the Chair or a director shall not be treated as a pecuniary interest for the purpose of the provisions of this constitution.

Register of directors' interests

35.16 The Trust Secretary will ensure that a register of interests is established to record formally declarations of interests of directors. In particular the register will include details of all directorships and other relevant and material interests which have been declared, as defined in the relevant Trust policy on conflicts of interests.

35.17 The details of directors' interests recorded in the register will be kept up to date by the Trust Secretary who will ensure any changes to interests declared are incorporated promptly.

35.18 The register will be available to the public and the Chair will take reasonable steps to bring the existence of the register to the attention of the local population and to publicise arrangements for viewing it.

35.19 The register of directors' interests will be reviewed by the Audit Committee at least annually.

36. Board of Directors – remuneration and terms of office

36.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Trust Chair and the other non-executive directors.

36.2 The Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

36.3 The remuneration and allowances for non-executive directors, as set by the Council of Governors, are to be published in the annual report.

37. Registers

37.1 The Trust shall have:

(a) a register of members showing, in respect of each member, the constituency to which they belong and, where there are classes within it, the class to which they belong;

(b) a register of members of the Council of Governors;

(c) a register of interests of governors;

(d) a register of directors; and

(e) a register of interests of the directors.

38. Registers – inspection and copies

38.1 The Trust shall make available for inspection by members of the public the registers specified in paragraph 40, except in the circumstances set out below or as otherwise prescribed by regulations.

38.2 The Trust shall not make available for inspection by members of the public any part of its registers which shows details of any member of the Trust (other than a governor or a director) if the member so requests.

38.3 So far as the registers are required to be made available:

(a) they are to be available for inspection free of charge at all reasonable times; and

(b) a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

38.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

39. Documents available for public inspection

39.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times and on the Trust's website:

(a) a copy of the current constitution;

(b) a copy of the latest annual accounts and of any report of the auditor on them, and

(c) a copy of the latest annual report;

39.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times and on the Trust's website:

(a) a copy of any order made under Section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report, 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

(b) a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

(c) a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

(d) a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

(e) a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.

(f) a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J power to extend time), 65KA (Monitor's decision), 65KB Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (secretary of State's response to re-submitted final report) of the 2006 Act.

(g) a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

(h) a copy of any final report published under section 65I (administrator's final report) of the 2006 Act.

(i) a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act

(j) a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

39.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

39.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

40. Auditor

40.1 The Trust shall have an auditor.

40.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

41. Audit committee

41.1 The Trust shall establish a committee of independent non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

42. Accounts

42.1 The Trust must keep proper accounts and proper records in relation to the accounts.

42.2 NHS England (or any successor body) may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts

42.3 The accounts are to be audited by the Trust's auditor.

42.4 The Trust shall prepare in respect of each financial year annual accounts in such form as NHS England may, with the approval of the Secretary of State, direct.

42.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

43. Annual report, forward plans and non-NHS work

43.1 The Trust shall prepare an Annual Report and send it to NHS England.

43.2 The Trust shall give information as to its forward planning in respect of each financial year to NHS England.

43.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

43.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

43.5 Each forward plan must include information about:

(a) the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

(b) the income it expects to receive from doing so

43.6 Where a forward plan contains a proposal to conduct activities other than the provision of goods and services for the purposes of the health service in England the Council of Governors must:

(a) determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of other functions, and

(b) notify the directors of the Trust of its determination

43.7 A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half the members of the Council of Governors of the Trust voting approve its implementation.

44. Presentation of the annual accounts and reports to the governors and members

44.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

(a) the annual accounts

(b) any report of the auditor on them

(c) the annual report.

44.2 The Trust may combine a meeting of the Council of Governors convened for this purpose with the Annual General Meeting.

44.3 The documents shall also be presented to members of the Trust at the Annual General Meeting by at least one member of the Board of Directors in attendance.

45. Instruments

45.1 The Trust shall have a seal.

45.2 The seal shall not be affixed except under the authority of the Board of Directors.

46. Amendment of the constitution

46.1 the Trust may make amendments to the constitution only if –

(a) More than half the members of the Council of Governors of the Trust voting approve the amendments, and

(b) More than half of the members of the Board of Directors of the Trust voting approve the amendments.

46.2 Amendments made under paragraph 46.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act.

46.3 Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust) –

(a) At least one member of the Council of Governors must attend the next Annual General Meeting and present the amendment, and

(b) The Trust must give the members an opportunity to vote on whether they approve the amendment.

46.4 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

46.5 Amendments by the Trust of its constitution are to be notified to NHS England. For the avoidance of doubt, NHS England's functions do not include a power to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

47. Mergers etc. and significant transactions

47.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

47.2 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

47.3 'Significant transaction' means any transaction with a value equal to or greater than 20% of the Trust's income, assets or capital, excluding the Trust's principal contract with commissioners setting out the services to be delivered by the Trust in a given year.

48. Dispute Resolution Procedures

48.1 In the event of dispute between the Council of Governors and the Board of Directors:

(a) In the first instance the Trust Chair on advice of the Trust Secretary, and such other advice as the Trust Chair may see fit to obtain, shall seek to resolve the dispute.

(b) If the Trust Chair is unable to resolve the dispute they shall appoint a special committee comprising equal numbers of directors and governors to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute.

(c) If the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Trust Chair may refer the dispute to an external mediator appointed by the Centre for Dispute Resolution or such other organisation as they consider appropriate

49. Indemnity

49.1 Members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution

of their Council or Board functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust.

50. Dissolution of the Trust

50.1 The Trust may not be dissolved except order of NHS England, in accordance with section 57A of the 2006 Act, following authorisation of a relevant application by the Council of Governors in accordance with the relevant paragraph of this constitution, or by order of NHS England under section 65LA of the 2006 Act.

51. Relationship with the County Council

51.1 Where the Trust has entered into a partnership agreement pursuant to the 2006 Act with a County Council:

(a) it will be contractually accountable to the County Council for the performance of County Council functions under such agreement

(b) it may establish a joint committee pursuant to regulation 10 of the partnership regulations, or such other board or officer group with delegated authority from the Board of Directors to oversee the arrangements as the Board of Directors see fit.

51.2 Subject to any delegation of functions to any group established under the paragraphs above, the function of supervising the management of the County Council functions shall vest in the Board of Directors or a single director nominated by the Board.

51.3 In the event that any such partnership agreement establishes a pooled fund within the meaning of the partnership regulations, then subject to the terms of the agreement and the provisions of the Partnership regulations regarding the role of the Pooled Fund Manager. The responsibility for any pooled fund hosted by the Trust shall be vested in the Board of Directors.

52. Interpretation and definitions

52.1 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

52.2 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

52.3 References in this constitution to legislation include all amendments, replacements or re-enactments made.

52.4 In this constitution:

the 2006 Act is the National Health Service Act 2006

the 2012 Act is the Health and Social Care Act 2012

Local Authority Appointed Governor means a member of the Council of Governors appointed by one or more local authorities whose area includes the whole or part of the area set out in Part 1A or, as the case maybe, Part 1B of Annex 1 to this constitution

NHS England is the organisation (or any successor body) responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.

voluntary organisation is a body, other than a public or local authority, the activities of which are not carried on for profit.

the **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act. The Chief Executive is the Accounting Officer.

Director means executive or non-executive director of the Board as the context permits. For the avoidance of doubt, the Chair is a non-executive director.

Executive director means a director who is an officer of the Trust.

ANNEX 1 – THE PUBLIC CONSTITUENCY

Name of constituency	Area	Minimum no. of members	Number of governors
Cheltenham	The electoral area of Cheltenham Borough Council	100	2
Cotswold	The electoral area of Cotswold District Council	100	2
Forest	The electoral area of Forest of Dean District Council	100	2
Gloucester	The electoral area of Gloucester City Council	100	2
Stroud	The electoral area of Stroud District Council	100	2
Tewkesbury	The electoral area of Tewkesbury Borough Council	100	2
Greater England and Wales	All other electoral wards in England and Wales save those electoral wards that fall within the Cheltenham, Cotswold, Forest, Gloucestershire, Stroud, and Tewkesbury constituencies.	100	1

ANNEX 2 – THE STAFF CONSTITUENCY

Name of Staff Class	**Description**	**Minimum no. of members**	**Number of governors**
the medical dental and nursing staff class	Staff who are registered with the General Medical Council; or Staff who are registered with the General Dental Council; or Staff who are registered with the Nursing and Midwifery Council	100	3
the health and social care professions staff class	Staff who are either: allied health professionals and psychologists who are registered with the Health and Care Professions Council or any successor body; or social workers registered with the Health and Care Professions Council or Social Work England, or any successor body; or individuals who are employed wholly or mainly in direct clinical and care roles but not eligible for membership of those classes described above	100	2
the management, administrative and other staff class.	individuals who are management or administrative staff or others entitled to be members of the staff constituency who do not come within those classes described above	100	2

ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

1.1 The Trust will have a Council of Governors consisting of public, staff and appointed governors.

1.2 The Council of Governors is to comprise:

Elected Governors:

Category of Governor	Number of Governors
Public governors:	
• Cheltenham	2
• Cotswold	2
• Forest	2
• Gloucester	2
• Stroud	2
• Tewkesbury	2
• Greater England and Wales	1
Staff governors:	
• Medical Dental and Nursing staff class	3
• Health and Social Care Professions staff class	2
• Management, administrative and other staff class	2
Appointed governors*:	
• Gloucestershire County Council	1
• Inclusion Gloucestershire	1
• Young Gloucestershire	1
Total	**23**

** The Trust may have a maximum of 5 Appointed Governors at any one time. Subject to this maximum number, Appointed Governors will be approved by the Trust Board and Council of Governors, and this Annex 3 shall be amended to reflect any such appointments in accordance with this constitution.*

1.3 Subject to paragraph 1.4 below, of the three (3) Staff Governors in the Medical Dental and Nursing class:

1.3.1 one (1) seat shall be reserved for a nurse;

1.3.2 one (1) seat shall be reserved for a doctor; and

1.3.3 one (1) seat shall be reserved for a doctor, dental professional or nurse.

1.4 The electoral constraints set out herein will apply to all Staff Governor seats in the Medical Dental and Nursing staff class, regardless of the number of Staff Governors being elected from that staff class at any particular time.

APPENDIX 2

CHANGES TO TRUST CONSTITUTION

PROCEDURAL SECTIONS TO BE TRANSFERRED TO STANDING ORDERS

20. Standards of business conduct

Canvassing of, and recommendations by, governors in relation to appointments

20.1 Canvassing of governors directly or indirectly for any appointment with the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the constitution shall be included in application forms or otherwise brought to the attention of candidates.

20.2 A governor shall not solicit for any person any appointment with the Trust or recommend any person for such appointment: but this paragraph of this Constitution shall not preclude a governor from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

20.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, and which are not part of the recruitment process must be declared to the panel or committee.

Relatives of Governors

20.4 Candidates for any staff appointment shall, when making application, disclose in writing to the Trust whether they are related to any governor. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to dismissal.

20.5 Every governor shall disclose to the Trust Secretary any relationship between himself/herself and a candidate of whose candidature that governor is aware.

20.6 On election or appointment, governors should disclose to the Trust whether they are related to any other governor or holder of any office in the Trust.

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36. Interest of officers in contracts

36.1 Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with him/her has any pecuniary interest, direct or indirect, shall declare their interest by giving notice in writing of such fact to the Trust Secretary as soon as practicable.

36.2 An officer should also declare to the Trust Secretary any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

36.3 The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

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37. Canvassing of and recommendations by directors in relation to appointments

37.1 Canvassing of directors of the Trust Board or of any committee of the Trust directly or indirectly for any appointment with the Trust shall disqualify the candidate for such appointment. The contents of this paragraph 37 shall be included in application forms or otherwise brought to the attention of candidates.

37.2 Directors of the Trust Board shall not solicit for any person any appointment with the Trust or recommend any person for such appointment; but this paragraph 37 shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

37.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, and which are not part of the formal recruitment process (other than genuine requests for information about the organisation by a prospective employee, or participation in discussion groups) must be declared to the panel or committee.

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38. Relatives of directors or officers

38.1 Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

38.2 The Chair and every director and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

38.3 On appointment, directors (and prior to acceptance of an appointment in the case of executive directors) should disclose to the Trust whether they are related to any other director or holder of any office in the Trust.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 17/1122

REPORT TO: **TRUST BOARD PUBLIC SESSION – 24 November 2022**

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

AUTHOR: Anna Hilditch, Deputy Trust Secretary

SUBJECT: **USE OF THE TRUST SEAL**
Q1 (1 APRIL - 30 JUNE 2022)
Q2 (1 JULY - 30 SEPTEMBER 2022)

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 reporting period 1 1st April – 30th September 2022.

Executive summary

The Trust's Standing Orders require that the use of the Trust's Seal, be reported to the Trust Board at regular intervals. The common Seal of the Trust is primarily used to seal legal documents such as transfers of land, lease agreements. Since the last report to the Board on the 26 May 2022, the seal has been used four times during the 1st April 2022 – 31 September 2022.

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 (Q1 & Q2 April 2022 - September 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 (Q1: 1st April – 30 June 2022 – Q2: 1st July – 31 September 2022)

Seal No.	Date of Sealing	Document Description	No. of Copies	Document Signatory (1)	Document Signatory (2)	Attested by	Attested Date
27/2022	07/04/22	**Underlease / Schedule of Condition** between GHCNHSFT and the Landlord Chaleworth Ltd re **2 Southgate Moorings**, Southgate Street, Gloucester Docks, Gloucester, ***Background:*** *Lease renewal – Schedule of Condition forms part of the overall lease agreement.*	1	Sandra Betney Director of Finance and Deputy CEO	David Noyes Chief Operating Officer	Lavinia Rowsell Trust Secretary	07/04/22
28/2022	07/04/22	**Deed of Covenant** between GHCNHSFT and the Council of the City of Gloucester re **2 Southgate Moorings**, Southgate Street, Gloucester Docks, Gloucester ***Background:*** *agreement to pay GCC the service charges that they impose on all businesses that operate out of properties at the docks for the upkeep/maintenance.*	1	Sandra Betney Director of Finance and Deputy CEO	David Noyes Chief Operating Officer	Lavinia Rowsell Trust Secretary	07/04/22
29/2022	07/04/22	**Deed of Surrender** re **2 Southgate Moorings**, Southgate Street, Gloucester Docks, Gloucester between GHCNHSFT and the Landlord Chaleworth Ltd ***Background:*** *states that GHC is surrendering the existing agreement in favour of the new agreement/renewal.*	1	Sandra Betney Director of Finance and Deputy CEO	David Noyes Chief Operating Officer	Lavinia Rowsell Trust Secretary	07/04/22

Seal No.	Date of Sealing	Document Description	No. of Copies	Document Signatory (1)	Document Signatory (2)	Attested by	Attested Date
30/2022	29/04/22	**Form of Agreement** re **new Community hospital in Cinderford** between GHCNHSFT and Speller Metcalfe Malvern Ltd ***Background:*** *Contract for the construction of the new Forest of Dean Community Hospital*	1	Sandra Betney Director of Finance and Deputy CEO	Angela Potter Director of Strategy and Partnerships	Lavinia Rowsell Trust Secretary	29/04/22

GPTW COMMITTEE SUMMARY REPORT

DATE OF MEETING 5 October 2022

COMMITTEE GOVERNANCE	• Committee Chair – Graham Russell, Non-Executive Director • Attendance (membership) – 83.3% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

STAFF STORY – RE-ABLEMENT/ HOMEFIRST STAFF COMPETENCY FRAMEWORK

A presentation was shared with the Committee about the innovative development and implementation of an on-boarding and competency framework for new colleagues within the HomeFirst reablement team. This was well received and the Committee praised the work which had been progressed.

DEEP DIVE – EDUCATION & DEVELOPMENT

The Committee undertook a deep dive reviewing Education and Development led by Ruth Thomas and Lucy Blandford. The presentation aided a discussion on the wide range and remit of teams within Learning and Development; and also considered how the Trust's ambition of being a *learning organisation* would be further developed.

The Committee thanked Ruth Thomas and Lucy Blandford for the presentation shared.

RECRUITMENT & RETENTION UPDATE

The Committee received the Recruitment and Retention update, which provided an update on the context and progress with recruitment and retention within the Trust.

The Director of HR & OD informed the Committee there was assurance of control mechanisms in place, evidenced in the Corporate Risk Register and the Board Assurance Framework; also, partnerships with various universities and long-term pipeline plans with key professionals.

The Committee discussed what could be done to improve the situation and identified the requirement for further engagement with the Trust Senior team on recruitment and retention. This would be included on a future Senior Team Meeting agenda.

The Committee **noted** and **discussed** the update on national and local context and progress with recruitment and retention within the Trust.

WDES / WRES ACTION PLAN

The Committee received the WRES / WDES Action Plan, which provided an update on the Trust's 2022/23 Action Plan in response to the Trust's Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) data.

The Committee's approval was sought for the updated Action Plan with summary data and was informed following approval, it would be uploaded onto the Trust's public facing website by 31st October 2022. It was noted that this was a national requirement.
The Committee **approved** the 2022/23 WDES / WRES action plan.

OTHER ITEMS RECEIVED

The Committee **received** and **noted**:

- the Performance Report – Workforce KPIs.
- the Workforce Risks
- the Board Assurance Framework
- the Freedom to Speak Up 6 monthly report and received assurance that processes in place continued to be utilised by colleagues
- Summary reports of Management Groups & ICS Meetings including:
    - Workforce Management Group
    - Joint Negotiating and Consultative Forum
    - Local Negotiating Committee
    - ICS Workforce Steering Group
    - ICS OD Steering Group

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.
- **Note** the approval of the WDES / WRES Action Plan

DATE OF NEXT MEETING	**8 December 2022**

WORKING TOGETHER ADVISORY GROUP SUMMARY REPORT

DATE OF MEETING: 12 OCTOBER 2022

COMMITTEE GOVERNANCE	• Chair – Jan Marriott, Non-Executive Director

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

Working with People and Communities (10 Steps Training)

The Group was presented with an overview of the NHSE *Working in Partnership with People and Communities* Guidance. This statutory guidance was released in July 2022 and outlines the ambition for health and care systems to build positive, trusted and enduring relationships with communities to improve services, support and outcomes for people. It emphasises the need to listen, engage in an ongoing and iterative manner and respond to what matters to communities. There is a focus on listening to people who have been marginalised and those who experience the worst health inequalities. The Group agreed that it would be important to review this guidance against the Trust's existing Working Together Plan.

The Group welcomed Caroline Smith, Engagement and Inclusion Manager for NHS Gloucestershire who spoke to a presentation on Working with People and Communities and 10 Steps Training, which reiterated the 10 principles of listening and engaging with communities.

Recovery College and Peer Support Workers

Mel Reed, Consultant Occupational Therapist gave the Group a presentation on Peer Led Self-Management and Lived Experience.

One Gloucestershire's Integrated Care System recognises that by working together we can build a healthier Gloucestershire; supporting people to live well and providing high-quality joined-up care when people need it. Peer support workers and lived experience practitioners bridge the gap between statutory and non-statutory services. Peer led self-management aligns with One Gloucestershire's Health and Wellbeing Partnership; working to develop healthy, active communities for the longer-term and improving the health, wellbeing and care of our communities.

Transforming and aligning peer led self-management and a commitment to growing our lived experience workforce would strengthen our ambition to offer an integrated health approach to serving our people and communities ambition.

The Group agreed that the aspirations were outstanding. Further work would be taking place over the coming months and a further update would be presented back to the Group at a future date.

Personalisation in GHC

Michelle Scofield, Service Development Manager with a lead for Personalised Care was in attendance at the meeting to share an update on the personalised care workstreams and future developments. Some developments included:

- Work had taken place to review the Trust's corporate induction programme and a short presentation slot would now be included within future induction programmes on personalised care.
- Links had been established with community teams to understand the Personal Health Budgets offer
- Linked into the Mental Health Transformation work, specifically the Personalised care plans development
- Supporting development of Mental Health inpatient care plans

The Group noted that a lot of good work was taking place. Due to time restrictions, it was agreed that a further update would be presented back to the group at the next meeting.

Any other business
The Group asked that the timing and scheduling of meetings be reviewed to ensure that sufficient time was given to all agenda items at the meetings. More time and opportunity was needed for Group members to contribute with their wealth of knowledge and experience.

ACTIONS REQUIRED BY THE BOARD
The Board is asked to:

- **Note** the contents of the report.

DATE OF NEXT MEETING	11 January 2023

AGENDA ITEM: 20/1122

MHLS COMMITTEE SUMMARY REPORT

DATE OF MEETING 19 October 2022

COMMITTEE GOVERNANCE	• Committee Chair – Sumita Hutchison, Non-Executive Director • Attendance (membership) – 75% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

AMHP UPDATE

The Committee received the AMHP Service Update Report for quarter 2.
The Committee was informed that it was business as usual for the AMHP Service and that the service was doing well. The AMHP Service had experienced positive recruitment, which had given the AMHPs more stability.
It was reported issues with transport remained and an interim transport policy and interim agreement for increased use of private transport remained in place. This was a great benefit to both the individual being admitted and the AMHP service enabling a swifter response when an ambulance was required. Further work was underway on the development of the transport policy and this was discussed regularly at team meetings.
The Committee **noted** the report for assurance.

ROLLING AUDIT OF DETAINED PATIENTS AND THE REMINDER TO THEM ABOUT THEIR RIGHTS

The Committee received the Rolling Audit of Detained Patients and the Reminder to them About Their Rights, which informed of an audit of the recording on RiO of verbal provision and reminders to patients' subject to the MHA of information about their rights. The Committee was informed that an audit was carried out on RiO of a record of patients that had verbally been reminded of their rights and highlighted the results within the report, for both patients subject to hospital detention and also patients subject to CTOs.
The Committee was informed that 96% of patients subject to hospital detention had their rights reminded, and 53% of patients subject to CTOs had their rights reminded to them.
The Committee **noted** the limited assurance provided by the audit and the ongoing action being taken by the Operational Group.

RISK REGISTER

The Committee received the Risk Register which provided information and assurance in respect of the risk in which the MHLS Committee had oversight responsibility for.
The Committee was informed of the one risk in which it had responsibility for; Risk ID 180 - Mental Health Act Changes – *There is a risk that new government legislation will have a significant impact on clinician and administrative workloads. This is because a Government review of the mental health act looks like increasing safeguards for patients and significantly increasing responsible clinician workload. There is a potential impact on provision of clinical services.*
It was reported the risk score of risk 180 (above) had reduced to a 12 and the target review date had been amended to December 2023. The risk was reviewed by the Medical Director at the regular Risk Management Group (RMG) meetings.

The Committee **noted** the information and assurance provided.

REVIEW OF MCA PRACTICE, DOLS APPLICATIONS UPDATE REPORT & LIBERTY PROTECTION SAFEGUARDS UPDATE

The Committee received the Review of MCA Practice, DoLS Applications update Report and Liberty Protection Safeguards update.
The Committee was informed that MCA champions had been set up and there were currently 15 champions across services within the Trust.
It was reported the first LPS Implementation Group meeting had taken place and would meet every two months going forward.
The Committee was informed that a report on the implementation process was being prepared for the attention of the Trust Board. The report would advise on the Trust's need to develop a cohort of staff with Best Interest Assessor (BIA) training so that they would be able to complete conversion training to become Approved Mental Capacity Professionals (AMCPs). It was noted that this would be a new role that would become part of the LPS process.
The Committee **noted** the information provided in relation to DOLS activity and LPS implementation.

OTHER ITEMS RECEIVED

The Committee:

- **Received** and **noted** the Mental Health Operational Group update.
- **Noted** the Review of CQC Monitoring Visits verbal update.
- **Received** and **noted** the minutes of the MHAM Forum.
- **Received** and **noted** the MHA Receipt and Scrutiny Policy and the Renewal of Detention and Extension of CTO.
- **Received** and **noted** the Review of Detention Issues, Identification of 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	**25 January 2023**

AGENDA ITEM: 21/1122

RESOURCES COMMITTEE SUMMARY REPORT

DATE OF MEETING 25 October 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 6

The Committee received the Finance Report for month 6, which provided an update of the financial position of the Trust. The Trust was not yet in the position to have timely feeds on the System position through monthly reporting. No changes were being reported to the forecast outturn at present to NHSE.
The Committee was informed that it would be explored as to whether backlog maintenance schemes and/or the Forest of Dean scheme could be brought forward and it was noted the capital report to be received by the Trust Board in November would show a different position due to this. The Committee was informed that further discussions would be held relating to the disposals of Hatherley and Holly House which would aim to reduce the impact of CDEL. The Committee was further informed of the removal of the *non-delivery of non-recurring savings in 22/23* risk; which had been removed due to the savings being fully identified. The Committee also noted that the pay award for 22/23 being not fully funding had been removed, but recurring underfunding for 23/24 onwards has been added as a risk. The Committee **noted** the month 6 financial position.

SYSTMONE SIMPLICITY PROJECT

The SystmOne Simplicity Programme Progress and Assurance Report was shared with the Committee which informed that SystmOne was an electronic patient records system which kept clinical records of patients. The background of the project was shared with the Committee and it was reported that the project was initiated in June 2021. The Simplification agenda was originally scoped to address the significant variation in configuration and data capture across the 42 community physical health modules configured in the system with c1900 individual users. The key challenges of the implementation were discussed, and it was noted that cultural changes was the key challenge encountered.

The milestones of the plan were shared, and the high level of detail was noted. The Committee was informed of the six work streams within the programme.

The Committee agreed that an update on SystmOne Simplicity Project would be included in the Performance Dashboard to be received at the next committee meeting.

The Committee thanked Mark Dray, Sarah Haxton, David Noyes and Chris Woon for their presentation and the positive work which had been progressed.

INTEGRATED BUSINESS PLANNING & BUDGET SETTING PROCESS 2023/24

The Committee received the Integrated Business Planning and Budget Setting Process 2023/24, which set out the budget setting process and the current planning and financial assumptions. The Director of Finance reported that the approach to the integrated business

planning and budget setting had been aligned to the Trust's strategic aims and also the business goals, financial targets and the HFMA sustainability checklist.
The Committee noted that the plan presented related to internal processes; which would then feed in to the System Processes. The Committee was informed that there was a clearer process between the business planning process and the transformation pipeline with ensuring any objectives which became projects had the relevant oversight by the Strategic Oversight Group (SOG).

The Committee **approved** the Integrated Business Planning & Budget-Setting approach; and **noted** the assumptions set out in the financial framework and the risks identified.

SERVICE DEVELOPMENT REPORT

The Committee received the Service Development Report which provided an update on the Trust's service development activities and income streams. The achievements made were reported and it was highlighted the implementation of the SARC and SOE contract commenced 1 October 2022 and that the contract value was c£7m over seven years.

DELIVERY OF THE TRUST'S GREEN PLAN – UPDATE

The Committee received an update on the delivery of the Trust's Green Plan, and noted that the Green Plan was the Trust's three-year sustainability strategy to deliver on national Net Zero requirements, and also to recognise the wider role in enabling sustainability across the Trust; as well as the Integrated Care Board and wider system. A presentation outlining the development of the Green Plan and the achievements made by the Trust so far was shared with the Committee. The Board approved three-year Green Plan design was complete and would be launched by the Communications team in the upcoming weeks. Four sustainability priorities were highlighted within the Green Plan, these were: Net Zero, Sustainable Models of Care, Equity and Procurement, and Workforce and Systems Leadership. The Committee **noted** the positive progress with delivery of the Green Plan.

CORPORATE RISK REGISTER

The Committee received the Corporate Risk Register and the following changes were highlighted:

- *Risk 273 – Eating Disorder Service – medical resource*; had reduced from a risk score of 16 to 12 since the previous meeting.
- *Risk 265 – presentation to closed MiiUs – risk of patient harm and impact on hospital staff* had reduced from a risk score of 12 to 6, and therefore had been removed from the Corporate Risk Register.

The Committee **noted** and discussed the information and assurance provided.

OTHER ITEMS RECEIVED

The Committee:

- **Received** and **noted** the Performance Dashboard Report and the assurance provided.
- **Received** and **noted** the Business Plan Report – Q2 and the delivery of the 2022/23 business plan.
- **Received, considered** and **noted** the Board Assurance Framework

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**22 December 2022**

QUALITY COMMITTEE SUMMARY REPORT

DATE OF MEETING 3 November 2022

COMMITTEE GOVERNANCE	• Committee Chair – Jan Marriott, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

CLINICAL PRESENTATION – LYMPHOEDEMA SERVICE

The Committee welcomed Vickie Mathias, Lymphoedema Clinical Lead to the meeting, who shared a presentation on the Lymphoedema Services. The Lymphoedema Service was a small service with a large caseload currently at 1257 patients. Photographs of Lymphoedema patients were shared with the Committee, highlighting the complexity of the cases. Approximately half of the caseload was cancer related.

The Committee was informed of the achievements of the Lymphoedema team and it was highlighted that staff within the service were retained with no one leaving the service, showing that staff were happy within the team and with how the service was run. It was also noted that Vicki Mathias had received a national Cavell award.

The challenges patients faced within the service were discussed and it was reported that patients who had received their Covid vaccinations had noticed a bad impact on their lymphoedema. The Committee was informed that since Covid, there had been a noticeable increase in lymphoedema referrals due to cancer.

The impact of the cost of living crisis was discussed and it was reported patients were reporting not being able to afford the cost of public transport; which consequently meant an increase in home visits for the service. Also disabled parking was difficult for the clinic

The Committee thanked Vickie Mathias for her presentation and the hard work progressed with the Lymphoedema Service.

TRUST WIDE CQC UPDATE – ACTION PLAN PROGRESS REPORT

The Committee received the Trust-Wide CQC update and Action Plan Progress Report which provided an update on the progress of the Trust's action plans in response to the CQC Urgent Care inspection, the Trust Core (including Charlton Lane Hospital) and Well Led inspections. The Committee received assurance that all CQC actions were being progressed well. The Must Do actions and the Should Do actions were shared with the Committee and it was noted that 100% of the Wotton Lawn Must Do actions had been completed. All actions would be reviewed as part of the fidelity testing pilot, which would provide good quality evidence.

The Committee **noted** the progress of the actions and the assurance regarding the ongoing oversight from the CQC Managers and Quality Team, in particular the updates around the statutory requirements and completion of a number of the actions.

CHARLTON LANE HOSPITAL QUALITY UPDATE

The Committee received the Charlton Lane Hospital Quality Update describing the progress made on the comprehensive approach to improvement at Charlton Lane Hospital, Willow Ward. The Committee was informed that an improvement action plan was put in place following concerns raised regarding safeguarding and quality of care matters in November 2021 and the CQC visit which followed.

Following the issues reported, an investigation was carried out and an action plan was developed in response to the feedback received. The main themes which the action plan was focused on, included:

- Improving nursing visibility on the ward
- Ward Manager office detached from the ward
- Risk of staff not feeling confident / able to speak up
- Staff understanding of safeguarding and its processes
- Staff understanding of Mental Capacity Act and its processes
- Improving support / development of Registered Nurses
- Improving support / development of Health Care Assistants

The Committee was informed of the recommendations which had been actioned and implemented. The ward manager/nursing office had been relocated on Willow Ward following feedback of senior visibility being further required. The Committee was assured that Sonia Pearcey, Freedom to Speak Up Guardian had been involved with supporting the speaking up culture on Willow Ward and had conducted a number of targeted visits and increased her availability and visibility to staff across the hospital. Colleagues had also been encouraged to become Freedom to Speak Up champions.

The Committee **noted** the progress on actions reported.

QUALITY DASHBOARD REPORT

The Committee received the Quality Dashboard Report, which provided a summary assurance update on the progress and achievement of quality priorities and indicators across Trust's physical health, mental health and learning disability services.
A reduction in HCSW vacancy rates for the period of 20.4% for the first time this financial year was reported.
There had been a continued overall decrease in the total number of pressure ulcers reported within the Trust, and it was noted that the amount of pressure ulcers reported was below the threshold.
Challenges remained with access in to a number of services and Eating Disorders was highlighted as a key challenge within the report.
The inclusion of safeguarding data within the dashboard was highlighted and the Committee was informed that Safeguarding teams were working with business intelligence and operational teams in order to improve the recording of patient and family's data quality.

The Committee **received**, **noted** and **discussed** the September 2022 Quality Dashboard.

OTHER ITEMS RECEIVED

The Committee:

- **Received, considered** and **noted** the Board Assurance Framework
- **Received** and **noted** the Corporate Risk Register
- **Received** and **noted** the contents of the Quality Assurance Group Summary Report and the assurance provided.
- **Received** and **noted** the Research & Development Annual Report.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**12 January 2023**

APPOINTMENTS AND TERMS OF SERVICE COMMITTEE SUMMARY REPORT

DATE OF MEETING: 9 NOVEMBER 2022

COMMITTEE GOVERNANCE	• Committee Chair – Ingrid Barker, Trust Chair • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

LOCAL CLINICAL EXCELLENCE AWARDS (CEAs)

The Committee received this report which provided oversight of the latest annual Clinical Excellence Awards process and sought endorsement of the local Employer Based Award Committee's recommendations. The Trust's policy for local Consultant Clinical Excellence Awards (CEAs) complies with national requirements and guidance agreed between the Department of Health, NHS Employers and the British Medical Association (BMA). This is annually reviewed and approved in partnership with our Local Negotiating Committee.

33 Consultants were eligible to apply during this round. 15 applications were received. There were no five-year review applications. The criteria against which applications are considered is set in the national guidance and covers the five key domains of practice:

1. Delivering a High Quality Service
2. Developing a High Quality Service
3. Managing a High Quality Service
4. Research
5. Teaching and Training

On the basis of the strength of evidence and the related scoring by the panel members, the EBA Committee concluded that it would make 2 awards of 3 CEAs, 5 awards of 2 CEAs, and 7 awards of a single CEA.

The ATOS Committee was pleased to see more diversity in the applications received this year, and thanked colleagues for their continued efforts to increase awareness and to provide support to applicants. The Committee noted that the Trust's LCEA process was robust and thorough and was happy to approve the recommendations from the EBA Panel on the awarding of CEAs.

GENDER PAY GAP UPDATE

The purpose of this report was to inform the ATOS Committee of the 2022 gender pay gap across Gloucestershire Health & Care NHS Foundation Trust, to provide an update on related actions from the last report alongside an outline of proposed next steps.

While this past year's data again presents a modest improving picture for the Trust, it also shows that there is still has far to go. It also continues to demonstrate the scale of challenge and the inherent unfairness in the nation more widely. At scale and sustainable improvements ultimately require amendments to national legislation, continued application of good practice, such as positive action, alongside changes in education, careers advice, flexible working, and leadership culture that consistently values diversity.

Discussion took place about the appointment of staff on the lower bands of the AfC pay scales, specifically Bands 1 & 2. It was noted that Trusts had now closed entrance to new Band 1 roles, in line with national terms, and these colleagues were given the option to accept Band 2 roles. Across NHS Trusts a small number of Band 1 colleagues rejected this offer, as it meant they

would lose benefits / Universal Credit and be worse off from a pay rise. All GHC colleagues in this situation are provided with an annual review opportunity to accept a Band 2 role. The number of Band 1 colleagues within GHC had now reduced to under 20 (October 2022). An ICS People Committee had been set up and further discussion would be taking place to look at lower banded roles, in light of the cost-of-living crisis and the living wage.

The Committee welcomed this update. It was noted that this progress report would be presented at the Women's Leadership Network, the Workforce Management Group and the Great Place to Work Committee for consultation. ATOS Committee members asked that a further report be presented back at the next meeting taking on board the discussions held at those forums, as well as national learning, and asked that the addition of targets against the identified actions be considered.

CHIEF EXECUTIVE AND EXECUTIVE DIRECTOR REMUNERATION REVIEW

The purpose of this report was to provide the Committee with an update on the most recent national very senior managers (VSMs) pay award guidance from NHS England for 2022/23.

The Committee considered this report, taking into account the national guidance and benchmarking data. The Committee discussed the need for equity and was also mindful of the current cost-of-living crisis. The Committee approved the recommendations set out in the report in relation to the Chief Executive and Executive Director pay award.

CHIEF EXECUTIVE APPOINTMENT

The Committee received this report which set out the recommendations for the appointment of a new Chief Executive. The Committee previously approved the recruitment process to appoint a successor to Paul Roberts, current CEO, who retires at the end of March 2023. Regular updates on progress with this search and appointment process have been provided.

The search process included national advertising and was managed through an Executive Search Agency – Odgers Berndtson. The robust selection process included preliminary interviews, background checks, discussion groups, use of psychometric tests, and a formal interview.

Following the formal interviews on 7 November, the interview panel recommended the appointment of Douglas Blair to the post of Chief Executive from a provisional start date of 1st April 2023 (to be confirmed). The ATOS Committee approved this appointment, noting that it was also subject to approval by the Council of Governors. The terms and conditions of the appointment were considered and agreed.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	January 2023

AUDIT & ASSURANCE COMMITTEE SUMMARY REPORT

DATE OF MEETING 10 November 2022

COMMITTEE GOVERNANCE	• Committee Chair – Marcia Gallagher, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

INTERNAL AUDIT

The Committee **noted** progress with the internal audit plan for 2022/2023 and with the implementation and follow up of internal audit recommendations from previous audits.

The Committee received and **considered** the Internal Audit on Adult Safeguarding which received a moderate assurance rating for design opinion and limited assurance rating for design effectiveness resulting in 2 high and 4 medium risk recommendations. The Director of Nursing Therapies and Quality attended the meeting to discuss the findings with the Committee and expressed his disappointment in the lack of progress in this area. An action plan was in place to address areas of concern which would be delivered in partnership with the operations directorate to drive improvements in the recording of safeguarding concerns and address data quality issues.

The Committee **considered** the outcome of the NHSE mandated HFMA Financial Sustainability Internal Audit. Overall the Trust demonstrated a high level of compliance with the questions set out in the Audit. The Director of Finance (DoF) confirmed that the audit had supported an improvement plan already underway in the Directorate.

EXTERNAL AUDIT – PROGRESS REPORT & TECHNICAL UPDATE

The Committee **received** the External Audit Progress Report and Technical Update and noted that planning for the 22/23 external audit would commence shortly.

COUNTER FRAUD, BRIBERY & CORRUPTION

The Committee **received** the Counter Fraud, Bribery & Corruption Progress Report; noting that there had been three new allegations of fraud since the previous meeting which were being investigated. A Fraud Prevention Notice was highlighted relating to a successful mandate fraud against an NHS organisation using a Chief Finance Officer mandate fraud methodology. The Director of Finance confirmed that information relating to this had been circulated to relevant colleagues.

FINANCE COMPLIANCE REPORT

The Committee **noted** the compliance report. Particular attention was paid to staff overpayments currently standing at c£98k. The DoF reported that this was primarily the result of the late submission of leaver forms and a review of the leaving process was underway. Aged debtors had increased by £2m to £9.66m since July. The Committee was assured that this figure would decrease at year end and the debts were not at high risk of non-payment.

BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER

The Committee **considered** the BAF and the Corporate Risk Register. A number of risks were referred to governance committees for further review. It was agreed that going forward, the Audit ad Assurance Committee would be the oversight committee for cyber related risks.

CYBER SECUIRTY ASSURANCE REPORT

The Committee received the Assurance Report. The Trust had been successfully in passing the Cyber Essentials Plus Accreditation. Congratulations were extended to the team involved. System level collaboration on cyber security was discussed and the need for standardised reporting at assurance committee level identified.

COMMITTEE EVALUATION AND TERMS OF REFERENCE

The Committee **noted** the positive outcome of the Committee's annual evaluation process and agreed actions to improve triangulation of assurance between governance committees. The terms of reference had been reviewed and minor amendments **recommended** for Board approval in November (Appendix 1)

OTHER ITEMS

The Committee:

- **Welcomed** Julie Soutter, Chair of the ICB Audit Committee to the meeting as an observer.
- **Received** the Finance Compliance Report, noting progress with aged debtors.
- **Received** the **noted** the Audit & Assurance Committee Annual Effectiveness Assessment which had a positive outcome. The terms of reference had been reviewed and no changes were proposed.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**9 February 2023**

APPENDIX 1

TERMS OF REFERENCE

AUDIT AND ASSURANCE COMMITTEE

1.	**Purpose**
1.1	The Audit and Assurance Committee will provide the Board of Gloucestershire Health and Care ~~Services~~ NHS Foundation Trust with an independent and objective review of its governance and assurance processes; including internal control, risk management, financial systems, financial information and compliance with laws, guidance and regulations governing the NHS.
2.	**Membership**
2.1	~~Three~~ Four Non-Executive Directors as core members, one of whom will be appointed Chair. Any other Non-Executive Trust Board Member, (except the Chair) may attend the meetings and would contribute to the quorum. At least one member of the Committee shall have recent, relevant financial experience and a relevant financial qualification. The Chair of the Board shall not be a member of the Committee but may attend by invitation. Executive Directors shall not be members of the Committee but may be invited to attend. The Chief Executive shall not be a member of the Committee but will be invited to attend to discuss the Annual Report, ~~Quality Report,~~ Annual Accounts and the assurance process for the Annual Governance Statement **In attendance:** Director of Finance or deputy Local Counter Fraud Specialist at least twice a year Head of Corporate Governance or Deputy Internal Auditors (every meeting) External Auditors (minimum twice a year) At least once a year the Committee will meet privately with the external and internal auditors and the Local Counter Fraud Specialist, all of whom additionally have a right to direct access to the Chair of the Committee. The Local Counter Fraud Specialist will be entitled to attend every meeting of the Committee.
2.2	Other Officers or Directors of the Trusts may attend at the discretion of the Chair.
3.	**Quorum**
3.1	Three Members.
4.	**Reporting Arrangements**
4.1	The Audit and Assurance Committee will update each routine Board meeting on its activity, highlighting decisions made, issues being progressed and concerns requiring further consideration or decision by the Board.
4.2	The Committee will report to the Board annually on its work in support of the Annual Governance Statement.
4.3	The Committee will advise any key issues or concerns which require consideration by another of the Board's committees. The Chair will work with the Chairs of other Board Committees to ensure that where there are apparent overlaps in the work of the Committees, which will inevitably arise from time to time, every effort is made to ensure that duplication of work is avoided.

5.	Powers
5.1	The Trust's Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation shall apply to the Audit and Assurance Committee.
5.2	The Committee is authorised to obtain any external legal or other independent professional advice it considers necessary.
5.3	The Committee is authorised to establish sub-groups, to which it can delegate specific tasks or functions, whose activities it will monitor through the groups minutes or reports depending on the tasks or functions undertaken. The Committee will approve the terms or reference of the sub groups.
6	**Responsibilities**
6.1	Governance, Risk Management and Internal Control The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. In particular, the Committee will review the adequacy of: • all risk and control related disclosure statements (in particular the Annual Governance Statement and, the Annual Report ~~and the Quality Report~~), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board • the underlying assurance processes, including the Board Assurance Framework, that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements • the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification • the effectiveness of the arrangements in place by which staff may, in confidence, raise concerns, particularly the Freedom to Speak Up procedures • the policies and procedures for all work related to fraud and corruption • the systems to secure value for money • information governance and cyber security processes • the Trust's insurance arrangements • the operation of the Board's Committees to ensure that the Trust's governance responsibilities can be achieved The Committee will maintain responsibility for the oversight of risk management across the Trust, oversee all risk management processes, including review of the Board Assurance Framework, the overarching Corporate Risk Register and other risks as determined by the risk stratification matrix to ensure their effectiveness. In carrying out this work the Committee will utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these functions. It will also seek reports and assurances from other committees, directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This work should provide assurance that Board Committees adequately assure the Board that risks are appropriately managed

6.2	Internal Audit The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by: • consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal, • review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework • consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources • ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation • annual review of the effectiveness of internal audit, including independence and objectivity
6.3	External Audit The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by: • consideration of the performance of the External Auditor, including consideration of independence and objectivity • discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring coordination, as appropriate, with other External Auditors in the local health economy • reviewing all External Audit reports, including agreement of the annual audit letter and any work carried outside the annual audit plan, together with the appropriateness of management responses. • ~~Reviewing the External Auditor's review of the Quality Report, prior to approval and submission of the Quality Report to NHS Improvement~~ The Committee will assist the Council of Governors to discharge its duties in respect of the appointment of the External Auditors.
6.4	Financial Reporting The Committee shall review the Annual Report and Financial Statements before submission to NHSI, focusing particularly on: • the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee • changes in, and compliance with, accounting policies and practices • unadjusted mis-statements in the financial statements • major judgemental areas • significant adjustments resulting from the audit The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board. This will include: • recommending updates to the Trust's Standing Orders, Standing Financial Instructions, and Scheme of Delegation; monitoring compliance and approving any waivers • approving any schedules of losses and non HR special payments.

	• reviewing the schedule of debtor/creditor balances ~~over 6 months old and over £5,000 or 2% of the aggregate amount, whichever is the greater~~.
6.5	Engagement Ensure effective on-going engagement and communication with all relevant internal and external stakeholders, including staff, service users, the public, ~~Commissioners~~ the Integrated Care Board and other professional partners, as appropriate to the Committee's duties and remit.
7.	**Frequency and Review of Meetings**
7.1	The Committee will meet a minimum of five times per year
7.2	These Terms of Reference will be reviewed annually, with any change recommended to the Trust Board for approval following approval by the Audit & ~~Risk~~ Assurance Committee. This review will include a self-assessment of its effectiveness in discharging its responsibilities as set out.
8.	**Administration**
8.1	The Trust Secretary will ensure appropriate support is provided to the Committee.

Version:	**Date Approved:**	**Approved by:**
Version 1	06/11/19	Approved by Audit and Assurance Committee
Version 1	28/11/19	Approved by Trust Board
Version 2	05/11/20	Approved by Audit and Assurance Committee
Version 2	25/11/20	Approved by Trust Board
Version 3	10/11/21	Reviewed and confirmed by Audit and Assurance Committee
Version 4	11/11/22	Approved by Audit and Assurance Committee
Version 4	24/11/22	Approved by Trust Board (TBC)

AGENDA ITEM: 25/1122

FOD ASSURANCE COMMITTEE SUMMARY REPORT

MEETING BY CORRESPONDENCE

COMMITTEE GOVERNANCE	• Committee Chair – Steve Brittan, Non-Executive Director • Attendance (membership) – N/A • Quorate – N/A

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

Work Stream Status			
Overall RAG:		**Previous RAG:**	

Forest of Dean Assurance Committee members received a report (via correspondence on 21 October) which provided an update on the overall programme progress of the new Forest of Dean hospital project plan.

Progress to Date
Highlight reports from each workstream continue to be received and monitored by the Programme Board.

Construction Progress
Phase 2 of the steel frame is being installed along with the 1st Floor concrete flooring. The Construction works remain on programme to date.

Spellers are paying very active attention to the stability of their supply chain. It has been necessary to source an alternative roofing and cladding provider due to issues with the previously identified contractor. In this instance an alternative provider has been identified with no anticipated impact to programme or budget.

A further Building Control site visit has been made with no items of concern raised.

BREEAM – The Trust remains on track to receive BREEAM excellent rating for the project.

Planning Update
We have had positive dialogue with the District Council regarding the Electrical Vehicle Charging Points (EVCPs) and they have verbally accepted our proposals and evidence for the 7kw chargers as planned within our scheme. We will now complete the necessary paperwork to amend the planning condition which will take approximately 12 weeks for the condition to be formally lifted.

Further conditions will be discharged as the project progresses.

Equipment
As part of the value engineering work at contract sign we recognised that the Trust could make some savings by supplying and fitting certain items of equipment ourselves as opposed to engaging Spellers supply chain to undertake this. We are therefore reviewing the full equipment schedule to ensure clarity.

There remains ongoing investigation of the suitability of transferring any dental equipment across from alternative Trust sites that are no longer in use.

An issue was identified with regard to the X-ray layout in that the ceiling void did not allow sufficient space for the fitting of the x-ray gantry along with the proposed M&E plant. A redesign of layout has been agreed in agreement with specialist staff, IPC, and the site Radiographer.

Operational Updates

The Whole Hospital Policy to inform final sign off of plans is now being developed and a first draft is being shared with the estates workstream to ensure clear inter-relationships as the scheme develops towards commissioning. This will enable full understanding of areas such as reception opening hours, out of hours access, emergency alarm response across all teams, panic alarm response across all teams, parking, staff equipment collection, drop off, access routes/ timing (for staff, visitors, patients, trolleys, goods, etc).

Early Warning Notices and Compensation Events

There is a clear tracking and approval process for Early Warning Notices (EWN) and the conversion of any of these into a Compensation Event which would then have a draw against the Trust's held contingency.

Finances

At the end of August, £6.1m has been spent with a further £1.1m spend incurred (but not yet invoiced) in September. The Project Team are working closely with Speller Metcalfe Ltd to ensure cash flow in 22/23 and 23/24 aligns to available budget. Work is progressing with Liaison to capture VAT reclaim from the site enhancement works package.

Other

Cinderford Town Council continue to face challenges securing discharge of the Skatepark planning conditions and the associated costs of their full drainage solution. We continue to provide support to find a solution that all parties can sign up to and monitor any risk that this may pose to the Trust.

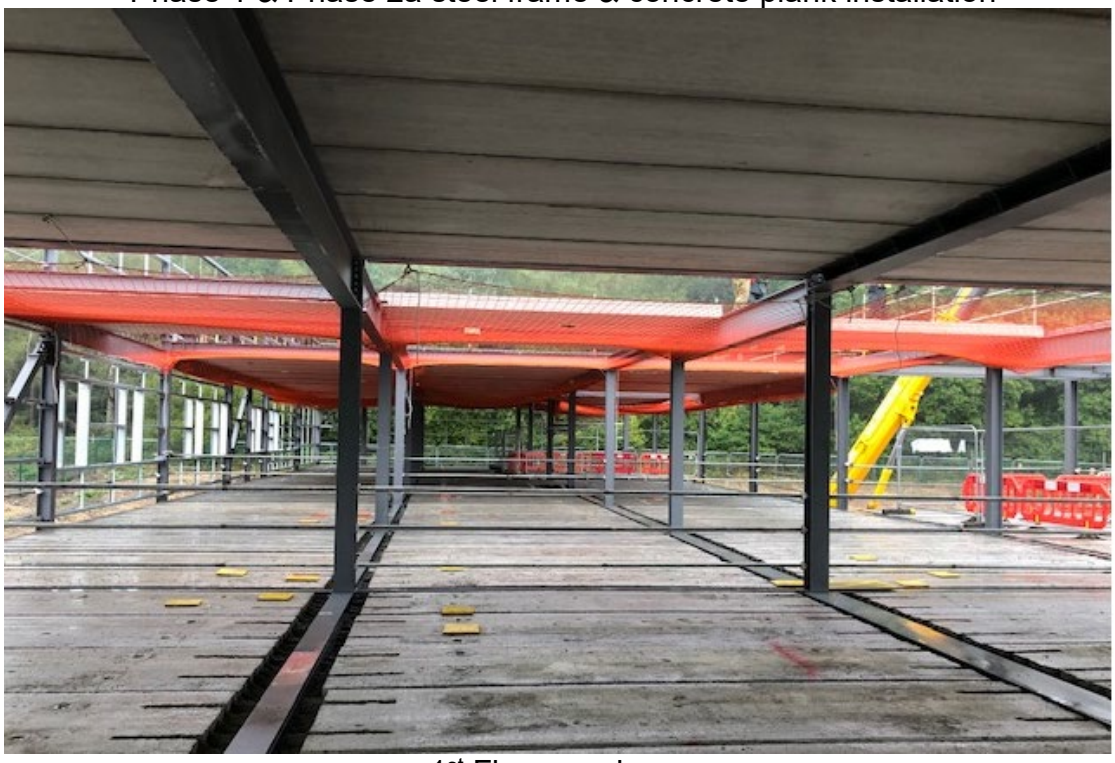
Actions / issues / concerns requiring escalation

None at this time.

Key risks and issues

- Inflation risk continues to rise and will be reviewed and has now been added to the corporate risk register.
- The cost of the equipment schedules is needing careful monitoring and may place pressure on the available budgets.
- The delivery of a suitable solution for the skatepark may present future risks should CTC be unable to reach an affordable compromise solution.

Phase 1 & Phase 2a steel frame & concrete plank installation



1st Floor ward area

Phase 1, 2 and 3 Steel frame with car park works in foreground

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary and the assurance provided that the scheme remains on track and is making good progress